

# Harnett County EMS System

## POLICY INDEX

DESTINATION & TRIAGE	
<b>DEST 1</b>	Pediatric
<b>DEST 2</b>	STEMI
<b>DEST 3</b>	Stroke
<b>DEST 4</b>	Trauma & Burn

DISPOSITION	
DSP 1	Criteria for Death/Withholding Resuscitation
DSP 2	Deceased Subjects
DSP 3	Discontinuation of Prehospital Resuscitation
DSP 4	Disposition (Patient Instructions)
DSP 5	DNR & MOST
DSP 6	Patient Without a Protocol
DSP 7	Physician on Scene
DSP 8	Opioid Overdose & Misuse
DSP 20*	Patient Defined
DSP 21*	Refusal Policy
DSP 22*	Non Paramedic Transport of Patient
DSP 23*	Scene Rehabilitation

DOCUMENTATION	
<b>DOC 1</b>	Documentation & Data Quality
<b>DOC 2</b>	Documentation of Vital Signs

## EMS DISPATCH

Law Enforcement	
LEO 1*	Blood Draws
LEO 2*	Narcan Administration

MEDICAL	
<b>MED 1</b>	Drug Assisted Airway - OEMS
<b>MED 2</b>	Ketamine Program Requirements
<b>MED 20*</b>	Drug Assisted Airway - Local
<b>MED 21*</b>	Mechanical CPR Devices

# PEDIATRIC

## PED 2 Infant Abandonment

REPORTABLE INCIDENTS	
REP 1*	Child Abuse
REP 2*	Domestic Violence

Service Metrics	
SM 1	EMS Back In Service Time
SM 2	EMS Wheels Rolling Turn-Out Time

# TOXIC ENVIRONMENT

TRANSPORT	
TP 1	Air Transport
TP 2	Safe Transport of Pediatric Patients
TP 20*	Transport Policy
TP 21*	Interfacility Policy



# Pediatric EMS Triage and Destination Plan



## Pediatric Patient

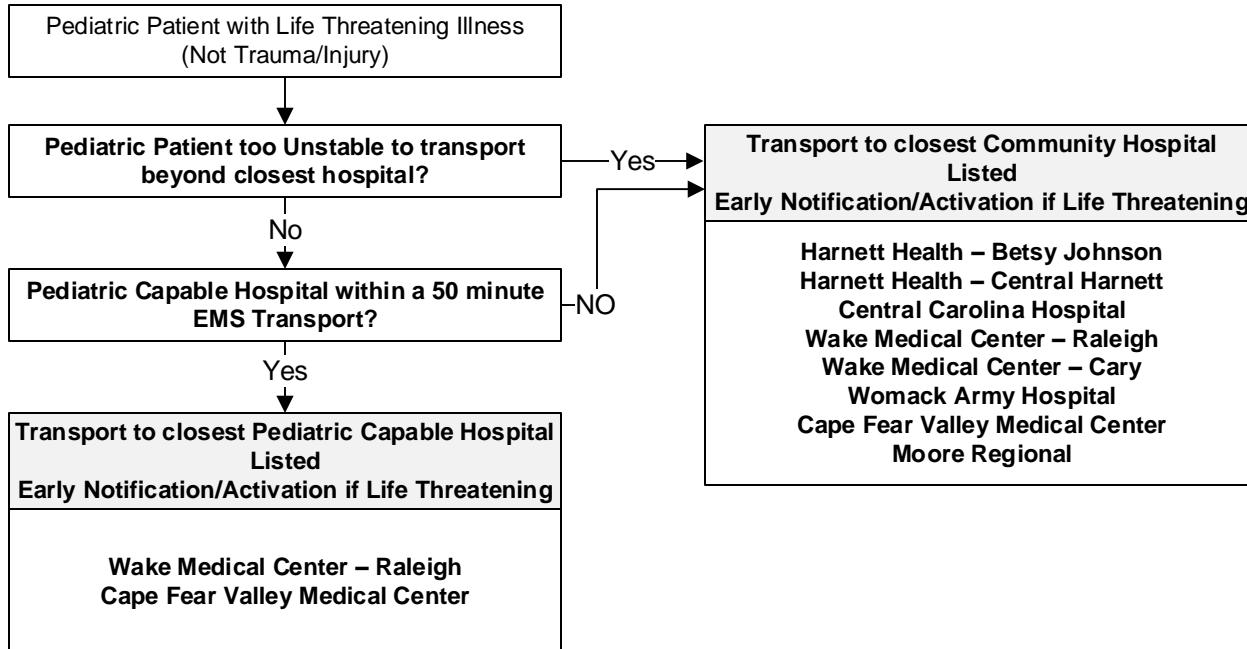
- Any patient Age 16 or less and/or weight of 49kg or less.
- Defined by those which fit on the Length-Based Medication Tape.

## Life Threatening Illness

- Decreased Mental Status (GCS <13)
- Non-Responsive Respiratory Distress
- Intubation
- Post Cardiac Arrest
- Non-Responsive Hypotension (Shock)
- Severe Hypothermia or Hyperthermia
- Status epilepticus
- Potential Dangerous Envenomation
- Life Threatening Ingestion/Chemical Exposure
- Children with Special Healthcare Needs (and destination choice based on parental request)

## The Purpose of this plan is to:

- Rapidly identify pediatric patients who call 911 or present to EMS with a life-threatening illness
- Minimize the time from EMS contact to definitive care
- Quickly diagnose patients with pediatric life-threatening illness for EMS treatment and stabilization
- Rapidly identify the best hospital destination based on symptom onset time, vital signs, response to treatment, and predicated transport time.
- Early Activation/Notification to the hospital prior to patient arrival
- Minimize scene time with a "Load and Go" approach
- Provide quality EMS service and patient care to the EMS community
- Continuously evaluate the EMS System based on North Carolina's EMS performance measures



## Pearls and Definitions

- All Pediatric Patients with a life-threatening illness must be triaged and transported using this plan. This plan is in effect 24/7/365.
- The Trauma and Burn Triage and Destination Plan should be used for all injured patients regardless of age
- All Patient Care is based on the EMS Pediatric Protocol(s)
- Pediatric Capable Hospital** = A hospital with an emergency and pediatric intensive care capability including but not limited to:
  - Emergency Department staffed 24 hours per day with board certified Emergency Physicians
  - An inpatient Pediatric Intensive Care Unit (with a physician pediatric intensivist available in-house or on call 24/7/365)
  - Accepts all EMS patients regardless of bed availability
  - Provides outcome and performance measure feedback to EMS including case review
- Community Hospital** = A Local hospital within the EMS System's Service area which provides emergency care but does not meet the criteria of a Pediatric Capable Hospital
- Pediatric Specialty Care Transport Program** = An Air or Ground based specialty care transport program that has specific pediatric training and equipment addressing the needs of a pediatric patient that can assume care of a pediatric patient from EMS or a Community Hospital and transport the patient to a Pediatric Capable Hospital

**DEST 1**



# STEMI

## EMS Triage and Destination Plan

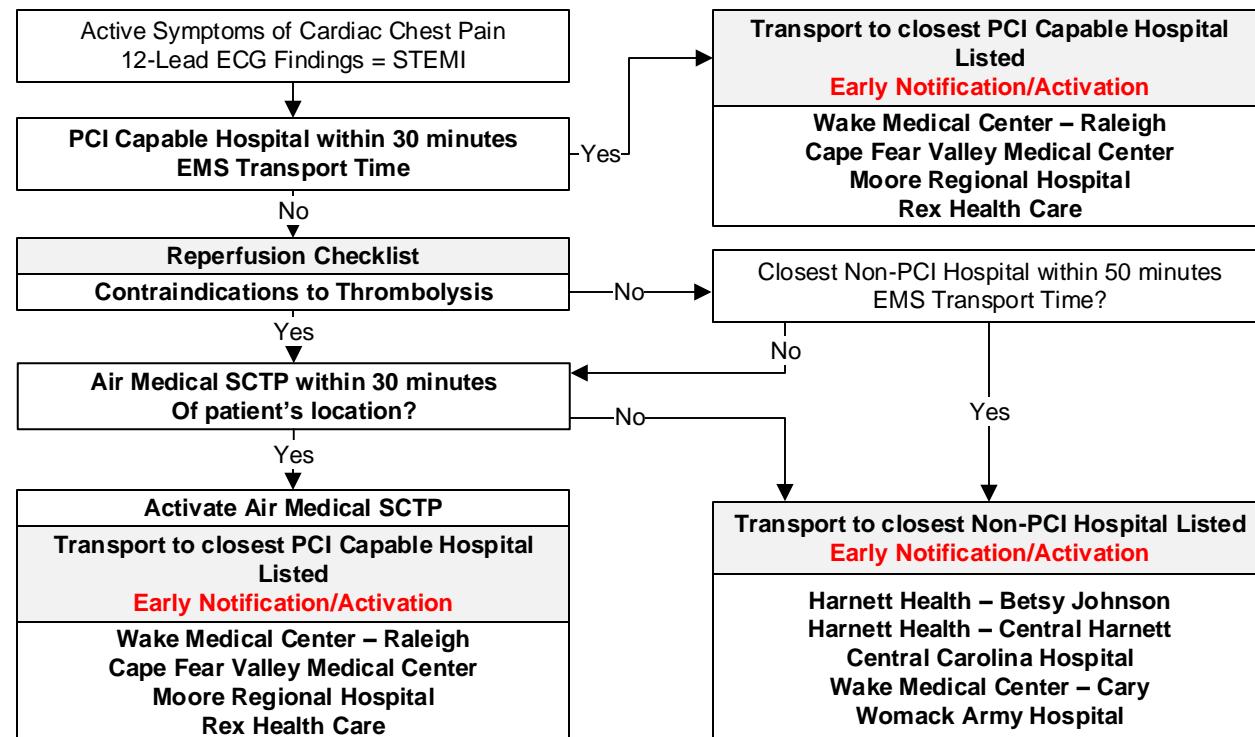


### STEMI Patient (ST Elevation Myocardial Infarction)

- Cardiac symptoms greater than 15 minutes and less than 12 hours  
**And**
- 12 Lead ECG criteria of 1 mm ST elevation in 2 or more contiguous leads  
**Or**
- Left Bundle Branch Block NOT KNOWN to be present in the past

### The Purpose of this plan is to:

- Rapidly identify STEMI patients who call 911 or present to EMS
- Minimize the time from onset of STEMI symptoms to coronary reperfusion
- Quickly diagnose a STEMI by 12 Lead ECG
- Complete a reperfusion checklist (unless being transported directly to a PCI hospital) to determine thrombolytic eligibility
- Early Activation/Notification to the hospital prior to patient arrival
- Minimize scene time to 10 minutes or less (including a 12 Lead ECG)
- Provide quality EMS service and patient care to the EMS citizens
- Continuously evaluate the EMS System based on North Carolina's STEMI EMS performance measures
- 12 Lead ECG should obtained within 5 minutes of Initial First Medical Contact



### Pearls and Definitions

- All STEMI Patients must be triaged and transported using this plan. This plan is in effect 24/7/365.
- All Patient Care is based on the Cardiac: Chest Pain and STEMI Protocol
- Consider implementing a prehospital thrombolytic program if a STEMI patient cannot reach a hospital within 90 minutes using air or ground EMS transport.
- **PCI (Percutaneous Coronary Intervention) Capable Hospital** = A hospital with an emergency interventional cardiac catheterization laboratory capable of providing the following services to acute STEMI patients. Free standing emergency departments and satellite facilities are not considered part of the PCI Capable Hospitals
  - 24/7 PCI Capability within 30 minutes of notification (interventional cardiologist present at the start of the case)
  - Single Call Activation number for use by EMS
  - Accepts all EMS patients regardless of bed availability
  - Provides outcome and performance measure feedback to EMS including case review
- **Non-PCI Hospital** = A Local hospital within the EMS System's Service area which provides emergency care including thrombolytic administration, to an acute STEMI patient but does NOT provide PCI Services
- **Specialty Care Transport Program** = An Air or Ground based specialty care transport program that can assume care of an acute STEMI patient from EMS or a Non-PCI Hospital and transport the patient to a PCI Capable Hospital.

**DEST 2**



# STROKE and LVO Stroke

## EMS Triage and Destination Plan

### Stroke Patient

- Signs and symptoms of an acute Stroke identified on EMS Stroke Screen Assessment.

### Last Known Well (LKW)

- Refer to UP 14 Suspected Stroke Protocol

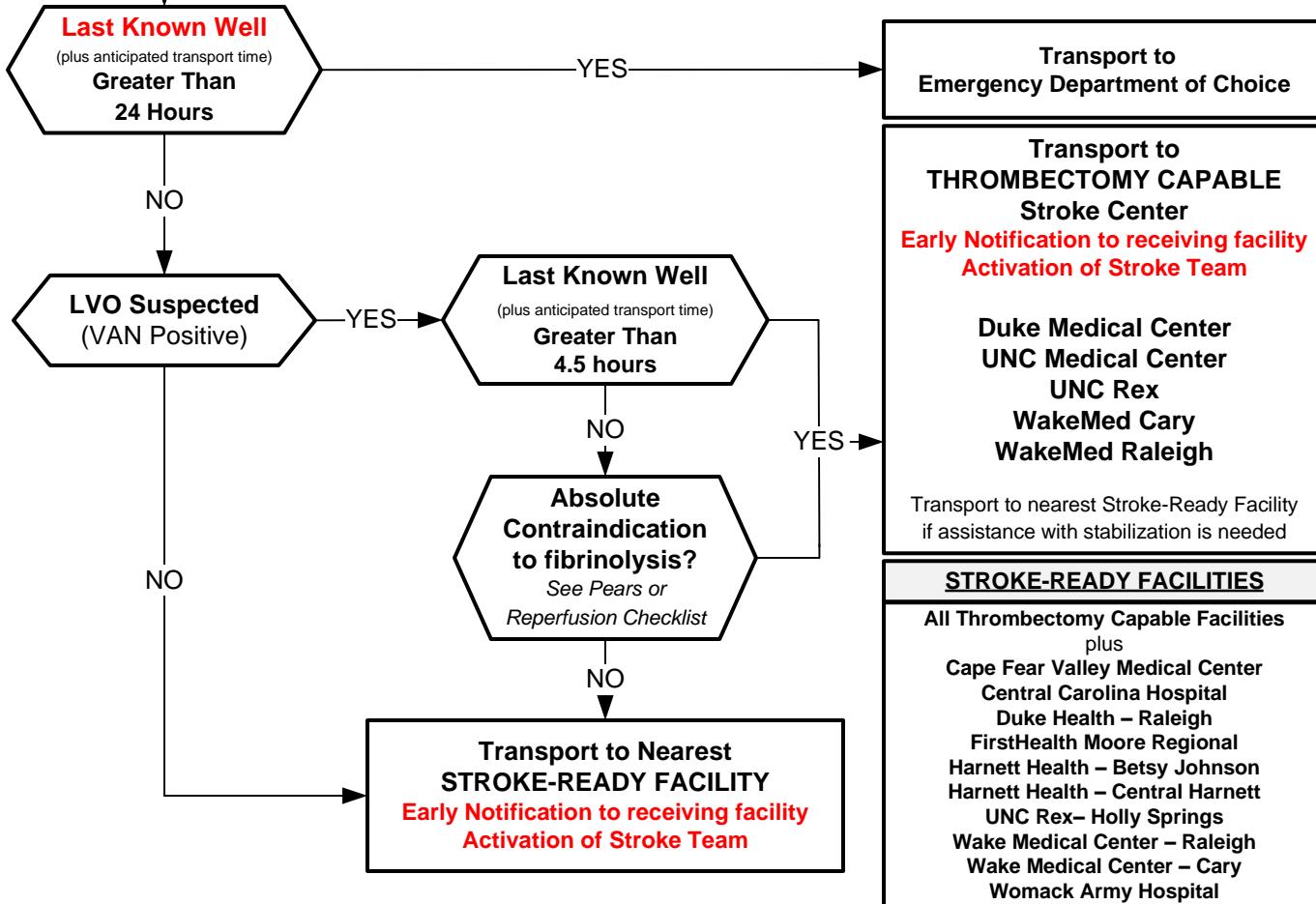
### The Purpose of this plan:

- Use plan in conjunction with UP 14 Suspected Stroke Protocol
- Rapidly identify acute Stroke patients presenting to EMS system and minimize the time from Stroke onset to definitive care
- Rapidly identify most appropriate facility destination in region
- Provide quality EMS service and patient care to the EMS system's citizens
- Maintain performance improvement of the EMS system based on NC Stroke Performance measures

**Positive Stroke Screen Tool  
(LAPSS Positive)**

**Stroke Screening Tool:  
LA Prehospital Stroke Scale**

**LVO Screening:  
VAN Exam**



### Pearls

- If unstable airway or unstable hemodynamic condition, may divert transport to closest appropriate facility.
- All Stroke patients should be triaged and transported using this plan.
- Absolute Contraindications to Fibrinolysis (tPA)

While there are additional contraindications to tPA, for the purposes of this protocol, absolute contraindications are defined as:

- \* History of structural Central Nervous System disease (age  $\geq 18$ , history of aneurysm or AV-malformation, tumors, masses, hemorrhage, etc.)
- \* Significant closed head or facial trauma within the previous 3 months

### Acute Stroke-Ready Hospital Components:

Director of stroke care, written emergency stroke care protocols and transfer agreements with a neurosurgical capable hospital, 24-hour CT capability, and ability to administer thrombolytics.

Facility may have Telemedicine / Telestroke capability for consultation with neurologic specialist.

### Thrombectomy-Capable Stroke Center:

Capable of providing mechanical thrombectomy with no day or hour limitation.

**DEST 3**

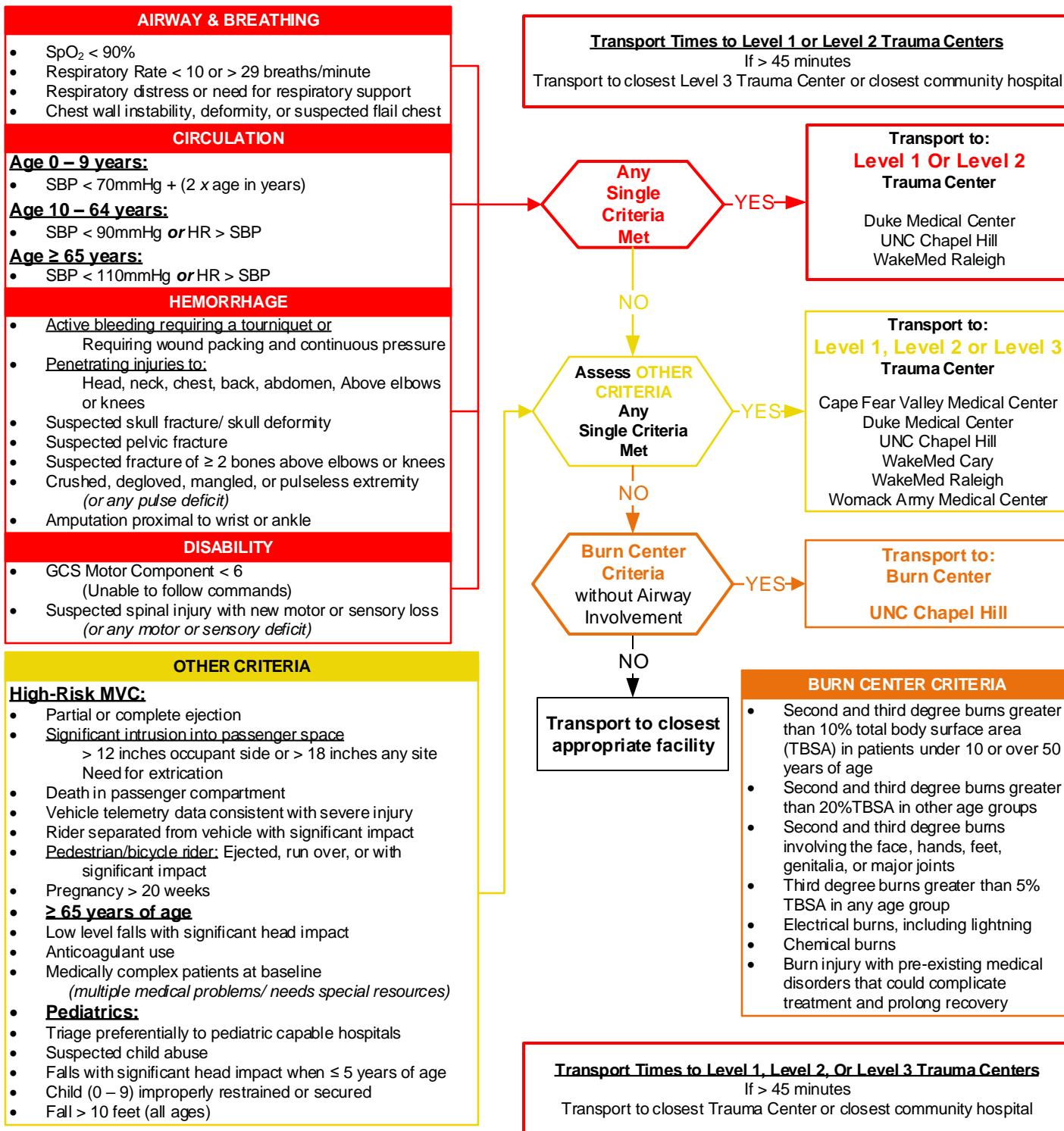


# Trauma and Burn

## EMS Triage and Destination Plan

### The Purpose of this plan:

- Rapidly perform Primary and Secondary Survey, measure Vital Signs, and assess level of consciousness.
- Rapidly identify injured patient presenting to the 911 system and minimize time from injury to definitive trauma care.
- Rapidly identify life or limb threatening injuries for EMS treatment and stabilization.
- Rapidly identify most appropriate hospital destination based on time from injury, severity of injury, and estimated transport time.
- Provide early activation/ notification to the receiving hospital of a trauma patient prior to EMS arrival.
- Minimize scene time to ≤ 15 minutes from patient extrication.
- Provide quality EMS service and patient care to citizens within the EMS system.
- Continuously evaluate the EMS system based on NCOEMS performance measures.





# Trauma

## EMS Triage and Destination Plan

### Pearls

- If unstable airway or unstable hemodynamic condition, may divert transport to closest appropriate facility.
- All trauma patients should be triaged and transported using this plan daily.
- Patients not meeting RED or YELLOW criteria should be triaged to most appropriate facility in the usual fashion.
- **Expectation:** EMS agency will collaborate with their regional Trauma Center/ TRAC resources to establish point-to-point and inter-facility transport workflows for patient requiring higher level of acute care in consideration of potential EMS system impact and regional approach to trauma care.
- **Designated Trauma Centers:**
  - Hospital currently designated or with provisional level status by NCOEMS.
  - Level I, II, or III designated centers are recognized.
  - Level I and Level II are essentially equivalent in regards to clinical care.
    - Level I may have specialty care not available at Level II, such as limb reimplantation or spinal care/rehabilitation. Where differences occur, a plan should be addressed with input from regional trauma centers and the TRAC, for appropriate destination choices.
  - Free standing emergency departments are not considered part of the trauma center.
- **Burns:**
  - Isolated burn patients should be triaged to most appropriate, closest facility.
  - Burns with other penetrating or blunt trauma should be triaged using this protocol.
- **Designated Burn Center:**
  - American Burn Association (ABA) verified Burn Center co-located with a designated Trauma Center.
- **EMS Transport Times in Destination Decisions:**
  - EMS transport times should be set based on collaboration with all trauma centers/ TRAC where EMS agency routinely transports in the regional trauma system.
- **Helicopter EMS (HEMS):**
  - There is no clear evidence that define strict criteria as to which patients may benefit from HEMS transport.
  - There is no clear evidence that define transport time considerations when assessing the need for HEMS transport.
  - HEMS service should be incorporated into the regional EMS plan and participate in agency Peer Review.
  - HEMS utilization is strictly a medical decision and while life saving, can be very costly to the patient.
- **Considerations when utilizing HEMS:**
  - Patients meeting Trauma Triage and Destination RED criteria:**
    - When transport times are > 30 – 45 minutes from the Trauma Center.
    - When geographic distance is > 45 minutes from the Trauma Center.
    - When faced with an entangled or entrapped victim, add estimated extrication time to transport time.
  - Modality of transport in acute trauma depends on multiple factors, but safest and fastest should be considered, whether ground EMS, air medical EMS, or specialty/critical care ground transport.**



# Criteria for Death / Withholding Resuscitation

## Policy:

CPR and ALS treatment are to be withheld only if the patient is obviously dead or a valid North Carolina **MOST and/or Do Not Resuscitate** form (see separate policy) is present.

## Purpose:

The purpose of this policy is to:

- Honor those who have obviously expired prior to EMS arrival.

## Procedure:

1. If a patient is in complete cardiopulmonary arrest (clinically dead) and meets one or more of the criteria below, CPR and ALS therapy need not be initiated:

- Body decomposition
- Rigor mortis
- Dependent lividity
- Blunt force trauma
- Injury not compatible with life (i.e., decapitation, burned beyond recognition, massive open or penetrating trauma to the head or chest with obvious organ destruction)
- Extended downtime > 15 minutes with Asystole

2. If a bystander or first responder has initiated CPR or automated defibrillation prior to an EMS paramedic's arrival and any of the above criteria (signs of obvious death) are present, the paramedic may discontinue CPR and ALS therapy. All other EMS personnel levels must communicate with medical control prior to discontinuation of the resuscitative efforts.

3. If doubt exists, start resuscitation immediately. Once resuscitation is initiated, continue resuscitation efforts until either:

- a) Resuscitation efforts meet the criteria for implementing the **Discontinuation of Prehospital Resuscitation Policy** (see separate policy)
- b) Patient care responsibilities are transferred to the destination hospital staff.



# Deceased Subjects

## Policy:

EMS will handle the disposition of deceased subjects in a uniform, professional, and timely manner.

## Purpose:

The purpose of this policy is to:

- Organize and provide for a timely disposition of any deceased subject
- Maintain respect for the deceased and family
- Allow EMS to return to service in a timely manner.

## Procedure:

1. A cardiac monitor should be placed on all deceased subjects confirming rhythm in 2 or more leads with copies of EKG attached to report unless the decedent shows advanced decomposition or multiple blunt force injuries incompatible with human life (decapitation, burned beyond recognition, massive open or penetrating trauma to the head or chest with obvious organ destruction, etc.).
2. Do not remove lines or tubes from unsuccessful cardiac arrests/codes unless directed below.
3. Notify the law enforcement agency with jurisdiction if applicable.
4. If subject was found deceased by EMS, the scene is turned over to Law Enforcement.
5. If EMS has attempted to resuscitate the patient and then terminated the resuscitative efforts, the EMS personnel in coordination with Law Enforcement should contact the family physician (medical cases) or medical examiner (traumatic cases or family physician unavailable) to provide information about the resuscitative efforts.
6. Transport arrangements should be made in concert with law enforcement and the family's wishes, unless the deceased subject is in a public facility or involved in a motor vehicle crash then the transport unit for that area will transport the patient to the morgue.
7. If the deceased subject's destination is other than the county morgue, any line(s) or tube(s) placed by EMS should be removed prior to transport.
8. Document the situation, name of Physician or Medical Examiner contacted, the agency providing transport of the deceased subject, and the destination on the patient care report form (PCR).



# Discontinuation of Prehospital Resuscitation

## Policy:

Unsuccessful cardiopulmonary resuscitation (CPR) and other advanced life support (ALS) interventions may be discontinued prior to transport or arrival at the hospital when this procedure is followed.

## Purpose:

The purpose of this policy is to:

- Allow for discontinuation of prehospital resuscitation after the delivery of adequate and appropriate ALS therapy.

## Procedure:

1. Discontinuation of CPR and ALS intervention may be implemented **prior to contact with Medical Control if ALL of the following criteria have been met:**

- Patient must be 18 years of age or older
- Adequate CPR has been administered
- Airway has been successfully managed with verification of device placement. Acceptable management techniques include orotracheal intubation, nasotracheal intubation, Blind Insertion Airway Device (BIAD) placement, or cricothyrotomy
- IV or IO access has been achieved
- No evidence or suspicion of any of the following:
  - Drug/toxin overdose
  - Hypothermia
  - Active internal bleeding
  - Preceding trauma
- Rhythm should be confirmed in 2 or more leads with copies of strips to be retained as documentation with the appropriate patient care report
- All EMS paramedic personnel involved in the patient's care agree that discontinuation of the resuscitation is appropriate
- Refer to Protocol 19 for On-Scene Termination of Care

2. If all of the above criteria are not met and discontinuation of prehospital resuscitation is desired, **contact Medical Control.**

3. The **Deceased Subjects Policy** should be followed.

Document all patient care and interactions with the patient's family, personal physician, medical examiner, law enforcement, and medical control in the EMS patient care report (PCR).



# Disposition (Patient Instructions)

## Policy:

All patient encounters responded to by EMS will result in the accurate and timely completion of:

- The Patient Care Report (PCR) for all patients transported by EMS
- The Patient Disposition Form for all patients not transported by EMS

## Purpose:

To provide for the documentation of:

- The evaluation and care of the patient
- The patient's refusal of the evaluation, treatment, and/or transportation
- The patient's disposition instructions
- The patient's EMS encounter to protect the local EMS system and its personnel from undue risk and liability.

## Procedure:

1. All patient encounters, which result in some component of an evaluation, must have a Patient Care Report completed.
2. All patients who refuse any component of the evaluation or treatment, based on the complaint, must have a Disposition Form completed.
3. All patients who are NOT transported by EMS must have a Disposition (patient instruction) Form completed including the Patient Instruction Section.
4. A copy of the Patient Disposition Form should be maintained with the official Patient Care Report (PCR)
5. All patient care reports must be completed by the end of shift.



# North Carolina Do Not Resuscitate and MOST Form

## Policy:

Any patient presenting to any component of the EMS system with a completed **North Carolina Do Not Resuscitate (DNR)** form (yellow form) and/or **MOST (Medical Orders for Scope of Treatment)** form (bright pink form) shall have the form honored. Treatment will be limited as documented on the DNR or MOST form.

## Purpose:

- To honor the terminal wishes of the patient
- To prevent the initiation of unwanted resuscitation

## Procedure:

1. When confronted with a patient or situation involving the NC DNR and/or MOST form(s), the following form content must be verified before honoring the form(s) request.
  - The form(s) must be an original North Carolina DNR form (yellow form - not a copy) and/or North Carolina MOST form (bright pink – not a copy)
  - The effective date and expiration date must be completed and current
  - The DNR and/or MOST Form must be signed by a physician, physician's assistant, or nurse practitioner.
2. A valid DNR or MOST form may be overridden by the request of:
  - The patient
  - The guardian of the patient
  - An on-scene physician

A valid MOST form may also be overridden by the request of:

- A representative of the patient, as defined by G.S. 90-322 in this order:
  1. Guardian / Medical Power of Attorney (Must Have Legal Documentation).
  2. The patient's spouse.
  3. A majority of the patient's reasonably available parents and children who are at least 18 years of age.
  4. A majority of the patient's reasonably available siblings who are at least 18 years of age.
  5. An individual who has an established relationship with the patient, who is acting in good faith on behalf of the patient, and who can reliably convey the patient's wishes.

EMS personnel should contact **Medical Control** to obtain assistance and direction if clarification is necessary.

3. A living will or other legal document that identifies the patient's desire to withhold CPR or other medical care may be honored with the approval of **Medical Control**. This should be done when possible in consultation with the patient's family and personal physician.



# Patient Without a Protocol

## Policy:

Anyone requesting EMS services will receive a professional evaluation, treatment, and transportation (if needed) in a systematic, orderly fashion regardless of the patient's problem or condition.

## Purpose:

- To ensure the provision of appropriate medical care for every patient regardless of the patient's problem or condition.

## Procedure:

1. Treatment and medical direction for all patient encounters, which can be triaged into an EMS patient care protocol, is to be initiated by protocol.
2. When confronted with an emergency or situation that does not fit into an existing EMS patient care protocol, the patient should be treated by the **Universal Patient Care Protocol** and a **Medical Control Physician** should be contacted for further instructions.



# Physician on Scene

## **Policy:**

The medical direction of prehospital care at the scene of an emergency is the responsibility of those most appropriately trained in providing such care. All care should be provided within the rules and regulations of the state of North Carolina.

## **Purpose:**

- To identify a chain of command to allow field personnel to adequately care for the patient
- To assure the patient receives the maximum benefit from prehospital care
- To minimize the liability of the EMS system as well as the on-scene physician

## **Procedure:**

1. When a non medical-control physician offers assistance to EMS or the patient is being attended by a physician with whom they do not have an ongoing patient relationship, EMS personnel must review the On-Scene Physician Form with the physician. All requisite documentation must be verified and the physician must be approved by on-line medical control.
2. When the patient is being attended by a physician with whom they have an ongoing patient relationship, EMS personnel may follow orders given by the physician if the orders conform to current EMS guidelines, and if the physician signs the PCR. Notify medical control at the earliest opportunity. Any deviation from local EMS protocols requires the physician to accompany the patient to the hospital.
3. EMS personnel may accept orders from the patient's physician over the phone with the approval of medical control. The paramedic should obtain the specific order and the physician's phone number for relay to medical control so that medical control can discuss any concerns with the physician directly.



# Opioid Overdose/Misuse

## **Policy:**

Patients who have experienced an opioid overdose/misuse should be offered a variety of options to more appropriately manage their care where available in the community. All care should be provided within the rules and regulations of the state of North Carolina.

## **Purpose:**

- To ensure patients are offered options for treatment of opioid misuse where available.
- Provide harm reduction measures related to opioid misuse.

## **Procedure:**

1. Patients must be over 18 years of age and experienced unintentional overdose or misuse of an opioid medication(s) only. Patients must NOT have experienced cardiac arrest defined as administration of chest compressions by first responders or EMS during the incident.
2. The patient must regain a normal mental status and respiratory effort after the administration of naloxone, NOT have suicidal or homicidal ideations/intentions, and NOT ingested substance(s) for intentional self-harm.
3. Patients who have co-ingested other substances should be treated based on appropriate protocol. Consult Carolina Poison Center at 1-800-222-1222 for advice if needed.
4. Transport to an Emergency Department should be offered to all patients. For patients who decline transport to an Emergency Department, alternative destinations should be offered if available in the community. Options may include assistance with accessing inpatient treatment centers, outpatient facilities, mobile crisis solutions, addiction specialists, and/or other local treatment options.
5. In order to decline transport, the patient must meet the following criteria:
  - a) Be 18 years or older
  - b) Maintain a GCS of 15 (alert, and oriented to time, place, person, and situation)
  - c) Demonstrate decision-making capacity as outlined in Universal Protocol Pearls.
6. If patient declines transport to an Emergency Department, an additional dose of naloxone should be offered by EMS if patient consents to additional treatment. IN administration is preferable to limit the possibility of provider needle stick injury. If patient has no sober and responsible party to monitor them, EMS should offer IM administration of naloxone if patient consents to treatment. If available, a naloxone kit should be left with the patient, family, and/or friends on scene. EMS should provide brief education on how to properly use these kits and refer them to read all package related material and instructions provided by the manufacturer.
7. In addition to naloxone kits, the following items should be offered where possible/available:
  - a) Offer to properly dispose of any dirty needles in approved sharps containers.
  - b) Refer to a community peer support team if available
  - c) Provide literature outlining resources for substance misuse treatment programs in the community



# Patient Defined

## Policy:

The public deserve and require our best. In order to ensure we have provided our best, we must appropriately document every patient interaction no matter how trivial the interaction may seem. This policy serves to define a patient and potential patient, and the minimum documentation required for these interactions.

## Purpose:

- Define a patient and a *potential* patient
- Define No Patient Found (NPF)
- Define Lift Assist and Assist Public
- Define Mass Casualty Incident
- Define the minimum required documentation for each
- Define an adult, minor, and pediatric patient

## A PATIENT:

- A patient is a person who requests or needs medical attention for an illness or injury
- A patient is established by any means – directly or indirectly – and through any type encounter – scene dispatch, walk-up, or otherwise
  - Requests an evaluation for illness or injury – *called for self*
  - A request by another for evaluation of illness or injury – *called for another person*
  - Has or potentially has an illness or injury – *based on available information*
  - Circumstances would reasonably lead to illness or injury - *based on available information*

## NO PATIENT FOUND:

No patient found does not meet the above definitions. Essentially, there is no person fitting the dispatch description or above definitions of a patient.

## DEFINITION OF ADULT, MINOR, & PEDIATRIC:

### An Adult:

1. Age 18 or older
2. Emancipated minor (under 18, legally emancipated – will have documentation)
  - a. Married minor (age 16 or older – will have documentation)
  - b. Minor serving in US Military (will have military ID)

### A Minor:

1. Under 18 years old and does not meet the above criteria for adult

### A Pediatric:

1. A patient who *fits* on current Length-based Medication Tape
2. Age 16 years or less, and/or weight is *under 50 kg* ( $< 110$  pounds)



# Patient Defined

## Minimum Documentation Required:

### **NO PATIENT FOUND**

A No Patient Found will not meet these criteria for a patient. At a minimum there must be:

1. An electronic Patient Care Report (ePCR) describing the result and methods used to locate a patient in the scene description.

### **PATIENT**

All patient or potential patient encounters require a completed PCR under current protocol and documentation guidelines. At a minimum, document the following information:

1. Demographic Information
  - a. Full name
  - b. Date of birth
  - c. Full address
  - d. Phone number
  - e. Social security number (an individually unique number for tracking purposes)
2. Exam Findings – *completed or observed* (procedure 17 – 19 & protocol 64)
3. Vital Signs, based upon protocol and vital sign policy (policy 8) – *completed or observed*
4. Treatment & Interventions provided
5. Disposition as required (policy 30)
  - a. In addition to policy 30, providers must document the presence or lack of illness or injury and a thorough HPI & the patient's initial impression on page 2 in scene findings

### **LIFT ASSIST and ASSIST PUBLIC:**

As noted above, any person encountered by any means with or potentially with an illness or injury – *lift assist* – is a patient and as such requires the minimum documentation and disposition. Not included in this definition is assistance to the public such as jump-starting a car, assisting with bags, pushing a disabled vehicle to a safe area, etc. Simply put, if there is a potential for illness or injury, lift assist are a patient.



# Refusals

## Policy:

Documentation of a refusal of care and/or transport is associated with severe liability mostly on the provider's part. Our goal is not to obtain refusals, but to treat and get injured and ill patients to hospitals for further evaluation and care. **However, responsible adult patients and/or guardians have the right to decline our recommendations even at the detriment of life.**

Providers must clearly document that they used all reasonable means to provide the necessary information to the patient and/or caregiver when they decline EMS recommendations. **For this policy – “patient” means: patient, caregiver, guardian, POA, etc.**

## Purpose:

- Specify what is required on all refusals
- Provide guidance to providers on how to obtain a refusal
- Provide guidance to providers on who can refuse and who cannot refuse
- Provide guidance to providers on what information to give to patients for informed decisions about refusing treatment and/or transport

## Proper Use of Refusals:

Our goal and responsibility is to treat and transport patients; not to obtain refusals. However, responsible adult patients and/or guardians have the right to refuse, even at the detriment of life and limb. We must have a system in place to allow and adequately document the communities refusal of care and/or transport.

The highest on-scene credentialed provider should complete the refusal process. The medical director authorizes EMTs or AEMTs to obtain refusal(s) if needed during multi-patient incidents. In these circumstances, the PCR should clearly document the incident & refusal process.

- The refusal form and guidelines are used when a patient refuses any of the following:
  - Examination (physical exam, VS including ECG)
  - Any part of **recommended** treatment based on protocol (IV, medication, oxygen)
  - Transport
  - Transport to a recommended hospital (destination policies)

## WHO MAY REFUSE?

A fully alert and oriented adult patient or legally emancipated minor clearly understanding the risks and benefits of EMS recommendations and accepting all consequences for their declination.

- Must understand the information provided to them
- Must be able to make informed decisions
- Is not a danger to self or others

## WHO MAY NOT REFUSE?

- A patient who DOES NOT demonstrate understanding of the risks and benefits of EMS recommendations or the consequences of their decision to decline or
  - Suicidal ideation
  - Non-emancipated minor (See DSP 20 - Patient Defined)



# Refusals

## WHAT TO SAY TO REFUSING PATIENTS:

The refusal form (Patient Disposition Information) lists most of what should be discussed with a refusing patient. Additional information may be written under "Other Instructions" on the form.

**DO NOT DISCUSS COST, SYSTEM OR HOSPITAL STATUS OR ANY NON-CLINICAL SUBJECT THAT MAY INFLUENCE THEIR DECISION TO ACCEPT OR DECLINE TREATMENT/TRANSPORT.**

## GENERAL PATIENT REFUSAL SECTION:

- The form covers most general refusals and is used on all declinations:
  - Not sick or injured (minor MVC, etc.)
  - False alarm with person present
  - Assist without a complaint, potential illness or injury
  - Other general refusal situations
- BLS crews should await a paramedic when in doubt or an ALS exam is necessary.
- Check the appropriate box(s) and read the statement to the patient.
- Ensure understanding of the written statement:
  - If warranted, encourage them to seek further care,
  - They accept responsibility for their decision to not seek care ,
  - Assume all risks and consequences for their decision and
  - Have read and understand the situation, explanation, and form.
  - That EMS is always available and to call 911 if they change their mind.

## PATIENT INSTRUCTION SECTION:

- This section of the form covers most more serious refusals when the provider believes the patient should be treated/transported by EMS - when declining recommended treatment/transport may be detrimental to their health or life
- Ensure understanding of the written statement:
  - They've not been evaluated by a doctor,
  - EMS care is not a substitute for a doctor's care,
  - They may have a more serious unrecognized problem,
  - Although they feel fine now, they could get worse
  - By declining they are increasing their risk
  - Declining the recommended hospital may result in significant delay in care
  - Follow the form's instructions
  - Call 911 back if the situation changes

## MINIMUM DOCUMENTATION REQUIRED:

1. All demographic Information including SSN (name, DOB, address, phone).
2. Any exam findings – *completed or observed* (ASP 1 – 3 & *Protocol 64*)
3. Vital Signs, based upon protocol and vital sign policy – *completed or observed*
4. Treatment & Interventions provided
5. Disposition as required (See DSP 4 – Disposition Policy)
  - a. In addition to DSP 4, providers must *document the presence or lack of illness or injury, a thorough HPI* and the patient's *initial impression* on page 2 in scene findings.



# Refusals

## Refusal Signature Box Information:

- **Patient Signature:** When the person signs this box, they must sign and print their name.
- **Guardian Signature:** This is to be used when the patient is unable to sign for his/herself, is a minor or has a legal power of attorney. This person must sign and print their name and relationship to the patient.
- **Guardian Address:** Legal address of the Guardian signing in place of the patient.
- **Witness Signature:** This line should be completed on all refusals. The witness should not be an EMS Provider, but in the absence of any other witness, is preferable that the crew signature not be the primary care provider. If possible, the witness should be a family member or friend of the patient. Other good sources are Law Enforcement, Fire Department personnel and First Responders. When the person signing as witness, that person should actually witness the patient sign the refusal form.
- **EMS Personnel's Signature:** The primary care provider of the patient refusing transport must sign the refusal form even in the event the patient/guardian refuses to sign the form.



# Non-Paramedic Transport of Patient

## Policy:

An appropriate EMS resource will be dispatched to every request for EMS Service.

- \* For the purposes of this policy, "Paramedic, AEMT, and EMT" refer to the Harnett County EMS System credentialed personnel with no current restrictions on their clinical practice.
  - \* The provider with the highest level of Harnett County EMS System credential on scene shall conduct a detailed physical assessment and subjective interview with the patient to determine the chief complaint and level of distress. If this provider determines that the patient is stable and **ALL** patient care needs can be managed by a provider with a lower level credential, patient care may be transferred to a technician of lower certification for care while in en-route to the hospital. All personnel are encouraged to participate in patient care while on-scene, regardless of who "attends" with the patient while en-route to the hospital.
  - \* The determination of who attends should be based upon the patient's immediate treatment needs and any reasonably anticipated treatment needs while en-route to the hospital. The highest-credentialed provider on scene retains the right to make the decision to personally attend to any patient transported based on their impression of the patient's clinical condition or needs.
  - \* The highest-credentialed provider performing the initial assessment must document the findings of that assessment. Other documentation may be completed by the transporting provider. As with all documentation, all providers are responsible for the content of the patient care report. The providers signatures verify that they have reviewed and verified the accuracy of the patient care reports.
  - \* Should an EMS crew encounter a patient that meets the criteria below for non-transfer to a lower credentialed provider, or encounter any situation in which paramedic care is needed, and a paramedic is not on-scene, a paramedic should be requested to respond to the scene or intercept the EMS unit en-route to the hospital in order to participate in patient care. Depending on the circumstances, appropriate care options include:
    - a) Request for the closest paramedic unit to be dispatched to respond to the scene; wait on scene until the paramedic arrives.
    - b) Coordinate a paramedic intercept while the non-paramedic unit is en-route to the ED.
    - c) Transport directly to the ED without a paramedic if the appropriate ED is closer than the closest available paramedic unit.
- \*\* Triage and Destination Plans MUST be followed when taking into account whether the closest paramedic unit is a faster source of advanced care than transport to the ED.

Example: A patient meeting trauma criteria should still be transported to an appropriate trauma center rather than the closest ED. In this case, a paramedic intercept should be coordinated at the direction of the transporting EMS crew, considering time, distance, and urgency of need for paramedic-level interventions.

Exception: An exception to this guidance is medical cardiac arrest; all medical cardiac arrest should have initial on-scene treatment and request for a cardiac arrest response to the scene consistent with our cardiac arrest protocols.

~~~ SEE NEXT PAGE FOR ADDITIONAL INFORMATION ~~~



# Non-Paramedic Transport of Patient

*(continued from previous page)*

\*\*\* The care of the following patients cannot be transferred to a lower level credential (i.e. to an AEMT or EMT from a Paramedic):

- 1) Any patient who requires or might reasonably require additional or ongoing medications, procedures and/or monitoring beyond the scope of practice of the lower credentialed provider. This includes any critically ill or unstable patient as advanced airway management may be required in any decompensating patient. EMT and AEMT providers may be credentialed to perform some but not all airway management, and medications associated with airway management are limited to the paramedic scope of practice by the North Carolina Medical Board.
- 2) Any patient for whom ALL EMS providers on-scene do not agree can be safely transported without a Paramedic in attendance in the patient care compartment. As a general rule, if providers are questioning who should attend the patient, a paramedic should attend the patient.
- 3) Any patient suffering from chest pain of suspected cardiac origin, cardiac arrhythmia, moderate-to-severe respiratory distress, multiple trauma, or imminent childbirth.
- 4) Post-ictal seizure patient due to the possibility of a re-occurrence of a seizure.
- 5) Patients who have been medicated on the scene may only be transferred to a technician of lower credential whose formulary includes the medications that were administered, except a patient who has received a single dose of pain medication (including opioids) and/or a single dose of anti-emetic, as the only medication outside of the receiving technician's formulary, may be transferred to a technician of lower credential.
  - a) The following criteria **MUST** be met to transfer such a patient to a technician of lower certification.
    - i.) ALL providers agree that it is unlikely that repeat doses of medication will be indicated during transport.
    - ii) The patient must be monitored on-scene for a time sufficient to ensure that an adverse reaction to the medication is unlikely.



# Scene Rehabilitation Policy

## Policy:

Scene Rehabilitation should be utilized with adult responders on fire, law enforcement, rescue operations, EMS scenes, and other gatherings as approved by the Medical Director.

## Purpose:

The purpose of this policy is to:

1. Provide evaluation and quality patient care for emergency services personnel.
2. Evaluation should consist of monitoring for life threaten signs and symptoms such as shortness of breath, chest pains, syncope, confusion, nausea/vomiting, headache or any other serious signs of distress.
3. Evaluation should consist of vital signs, orthostatic vital signs, exam of mental status, airway/breathing, skin, neck, heart, lungs, abdomen, back, extremities, and neurological assessments.

## Procedure:

1. Remove PPE, Body Armor, Chemical Suit, SCBA/Turnout Gear, and any other equipment
2. Log personnel on HCES Rehabilitation Record with time into Rehab area.
3. Obtain Vital Signs/Orthostatic Vital Signs and Record on Rehab Record.
4. Obtain Oximetry Readings of both SpO<sub>2</sub> & SpCO.
5. Assess for any signs or symptoms as listed above.
6. Allow 10 Minute Rest Period while hydrating
7. Follow Scene Rehabilitation Protocol(s) and Treatments as needed.

## Automatic Evaluation & Potential Transport Criteria:

- |                                         |                                                                      |
|-----------------------------------------|----------------------------------------------------------------------|
| 1. Chest Pains                          | 6. Inability to hold fluids down or an episode of Nausea/Vomiting    |
| 2. Shortness of Breath                  | 7. Vital Signs outside normal values after more than 30 minutes rest |
| 3. Irregular Heart Rhythms              | 8. Use of 1 SCBA Bottle (30 minutes)                                 |
| 4. 30 Minutes of Active Work            | 9. Syncopal Episode, Disorientation, and or Confusion                |
| 5. Request for transport for any reason |                                                                      |

## Response Criteria:

1. The initial response shall be one ALS unit as directed by Emergency Medical Dispatch Priority. It is acceptable for the responding EMS Resource to monitor the radio traffic of the first-in-fire resources and cancel and/or downgrade response as appropriate.
2. When arriving on the scene, the EMS Unit shall be positioned so that it does not become blocked in by arriving fire apparatus, or hose lines that will be applied from other arriving fire units. The ambulance should be quickly accessible but also have the ability to easily leave the scene.
3. The EMS Crew should report to command and/or accountability and then establish rehab. The equipment that is taken to the rehab area should include, but is not limited to, the stretcher, jump bag, ECG Monitor, Oxygen Bag, and Burn Kit (if at fire scene). Documentation of vital signs should be maintained and attached to the call documentation.
4. When available/needed, the Assistant/District Chief and/or additional response units should be notified to respond and assist with rehab and serve as Medical Operations.
5. If any Responder and/or other victim requires treatment and/or transport to the hospital, a second ALS unit will be dispatched to assume the rehab duties at the Emergency Scene. Personnel on the scene will determine the level of response for the second unit (e.g. lights and sirens vs. no lights and sirens).
6. Transport of an injured firefighter or other victim will not be delayed while waiting for a second unit to arrive. If there is an urgent need for ALS personnel on the scene, the second unit should be dispatched with lights and sirens and the injured party transported without delay. It will be ideal to have an Assistant/District Chief present to help with managing the scene.



# EMS Documentation and Data Quality

## Policy:

The complete EMS documentation associated with service delivery and patient care shall be electronically recorded into a Patient Care Report (PCR) by the end of the providers shift after the completion of the EMS event, with an EMS Data Score at/or below the state average.

## Definition:

EMS documentation of a Patient Care Report (PCR) is based on the appropriate and complete documentation of the EMS data elements as required and defined within the North Carolina College of Emergency Physician's EMS Standards ([www.NCCEP.org](http://www.NCCEP.org)). Since each EMS event and/or patient scenario is unique, only the data elements relevant to that EMS event and/or patient scenario should be completed.

The EMS Data Score is calculated on each EMS PCR as it is electronically processed into the North Carolina PreHospital Medical Information System (PreMIS). Data Quality Scores are provided within PreMIS. The best possible score is a 0 (zero) and with each data quality error a point is added to the data quality score.

A complete Patient Care Report (PCR) must contain the following information (as it relates to each EMS event and/or patient):

- Service delivery and crew information regarding the EMS Agency's response
- Dispatch information regarding the dispatch complaint, and EMD card number
- Patient care provided prior to EMS arrival
- Patient assessment as required by each specific complaint based protocol
- Past medical history, medications, allergies, and DNR/MOST status
- Trauma and cardiac arrest information if relevant to the EMS event or patient
- All times related to the event
- All procedures and their associated time
- All medications administered with their associated time
- Disposition and/or transport information
- Communication with medical control
- Appropriate signatures (written and/or electronic)

## Purpose:

The purpose of this policy is to:

- Promote timely and complete EMS documentation.
- Promote quality documentation that can be used to evaluate and improve EMS service delivery, personnel performance, and patient care to the county's citizens.
- Promote quality documentation that will decrease EMS legal and risk management liability.
- Provide a means for continuous evaluation to assure policy compliance.



# EMS Documentation and Data Quality

## Procedure:

The following procedures shall be implemented to assure policy compliance:

1. The EMS Patient Care Report (PCR) shall be completed as soon as possible after the time of the patient encounter. **The PreMIS Preliminary Report should be completed prior to leaving the destination facility unless call demand dictates otherwise, in which case documentation must be completed prior to the end of the personnel's shift.**
2. If the final PCR is not available at the time the patient is left with the emergency department or other healthcare facility, an interim report such as the PreMIS Preliminary Report Form **MUST** be provided.
3. All patient care documentation must be an accurate reflection of the patient encounter. The document must be reviewed, verify the patient encounter report accuracy, and electronically signed by all technicians involved in the patient encounter. Discrepancies in patient encounter reporting should be immediately reported to the EMS System Compliance Officer.
4. Harnett County EMS System requires that all patient care documentation be completed **prior to the end of the personnel's shift not to exceed 24 hours after the patient encounter.** NC OEMS requires that the PCR must be completed in the PreMIS System or electronically submitted to NC OEMS within 24 hours of the EMS event or patient encounter completion. The EMS data quality feedback provided at the time of the electronic submission into PreMIS should be reviewed and when possible any identified errors will be corrected within each PCR. Each PCR may be electronically resubmitted to PreMIS as many times as needed.
5. The EMS Data Quality Scores for the EMS System, EMS Agency, and individual EMS personnel will be reviewed regularly within the EMS System Peer Review Committee.



# Documentation of Vital Signs

## Policy:

Every patient encounter by EMS will be documented. Vital signs are a key component in the evaluation of any patient and a complete set of vital signs is to be documented for any patient who receives some assessment component.

## Purpose:

To Insure:

- Evaluation of every patient's volume and cardiovascular status
- Documentation of a complete set of vital signs

## Procedure:

1. An **initial** complete set of vital signs includes:
  - Pulse Rate
  - Systolic **AND** Diastolic Blood Pressure
  - Respiratory Rate
  - Pain / Severity (when appropriate to patient complaint)
  - GCS for all Injured Patients
2. When no ALS treatment is provided, palpated blood pressures are acceptable for **REPEAT** vital signs.
3. Based on patient condition and complaint, vital signs may also include:
  - Manual Blood Pressure
  - Pulse Oximetry
  - Temperature
  - End Tidal CO<sub>2</sub> (If Invasive Airway Procedure)
  - Breath Sounds
  - Level of Response
4. If the patient refuses this evaluation, the patient's mental status and the reason for refusal of evaluation must be documented. A patient disposition form must also be completed.
5. Document situations that preclude the evaluation of a complete set of vital signs.
6. Record the time vital signs were obtained.
7. Any abnormal vital sign should be repeated and monitored closely.

## 911- Response Units

1. For all patients transported by a 911-response unit, two (2) complete sets of vital signs are required.
2. Vital Signs should be obtained every 5 minutes for unstable patients and every 15 minutes for stable patients.

## Convalescent Transporting Units

1. Convalescent Transporting Units providing a return trip or discharge from a facility may obtain one (1) Initial Set of Vital Signs.\*\*
2. Convalescent Transporting Units with extended patient transport times of stable patients may obtain vital signs every 30 minutes.\*\*
3. ALS Transfers from Hospital to Hospital must follow the 911-Response Unit vital sign requirement as listed above.

\*\* If the patient has any complaints, changes in mental status, or develops any signs or symptoms additional Vital Signs must be taken as required in the 911-Response Unit requirements listed above. \*\*



# EMS Dispatch Center Time

## Policy:

The EMS Dispatch Center Time will be less than 90 seconds, 90% of the time, for all events identified and classified as an emergent or hot (with lights and siren) response.

## Definition:

The EMS Dispatch Center Time is defined as the time interval beginning with the time the initial 911 phone call rings at the 911 Communications Center requesting emergency medical services and ending with the dispatch time of the EMS Unit responding to the event.

## Purpose:

The purpose of this policy is to:

- Provide the safest and most appropriate level of response to all EMS events within the EMS System.
- Provide a timely and reliable response for all EMS events within the EMS System.
- Provide quality EMS service and patient care to the county's citizens.
- Provide a means for continuous evaluation to assure policy compliance.

## Procedure:

The following procedures shall be implemented to assure policy compliance:

1. All calls into the 911 Communications Center requesting emergency medical assistance will never be required to speak with more than two persons before a formal EMS Unit is dispatched.
2. In EMS Dispatch Centers where Emergency Medical Dispatch (EMD) has been implemented, EMS Units will be dispatched by EMD certified personnel in accordance with the standards developed by the Medical Director and the Emergency Medical Dispatch Protocols.
3. EMS Units will be dispatched hot (with lights and sirens) or cold (no lights and sirens) by the 911 Call Center based on predetermined criteria. If First Responders are dispatched as a component of the EMS response, they should typically be dispatched hot (with lights and sirens).
4. Without question, exception, or hesitation, EMS Units will respond as dispatched (hot or cold). This includes both requests to respond on active calls and requests to "move-up" to cover areas of the System that have limited EMS resources available.
5. EMS Units may, at their discretion, request for a First Responder on Non-First Responder calls in situations where additional resources are required such as manpower, extreme response time of the EMS Unit, need for forcible entry, etc.



# EMS Dispatch Center Time

6. EMS Units dispatched with a cold (no lights and sirens) response, will not upgrade to a hot (with lights and sirens) response **UNLESS:**
  - Public Safety personnel on-scene requests a hot (with lights and sirens) response.
  - Communications Center determines that the patient's condition has changed, and requests you to upgrade to a hot (with lights and sirens) response.
7. An EMS Unit may divert from a current cold (no lights and sirens) call to a higher priority hot (with lights and sirens) call **ONLY IF:**
  - The EMS Unit can get to the higher priority call before it can reach the lower priority call. Examples of High Priority Calls: Chest Pain, Respiratory Distress, CVA, etc.
  - The diverting EMS Unit must notify the EMS Dispatch Center that they are diverting to the higher priority call.
  - The diverting EMS Unit ensures that the EMS Dispatch Center dispatches an EMS Unit to their original call.
  - Once a call has been diverted, the next EMS Unit dispatched must respond to the original call. A call cannot be diverted more than one (1) time.
8. Any EMS Dispatch Center Time delays resulting in a prolonged EMS Dispatch Center Time for emergent hot (with lights and sirens) events will be documented in Patient Care Report (PCR) as an "EMS Dispatch Delay" as required and defined in the North Carolina College of Emergency Physicians (NCCEP) EMS Dataset Standards Document.
9. All EMS Dispatch Delays will be reviewed regularly within the EMS System Peer Review Committee.



# Law Enforcement Blood Draw

## **Policy:**

The Harnett County EMS System supports all efforts of the Law Enforcement community to get impaired drivers off the road. Please note that only Paramedics cleared in the Harnett County EMS System are allowed to draw blood for Law Enforcement Officers (LEO). At any point in the process, EMS personnel may have to either begin transportation or respond to additional emergencies based on the Paramedic's discretion, no matter where in the process of the evidence collection they may be. In order for a Paramedic to draw blood for the officer, the subject must consent to have the procedure completed.

## **Purpose:**

To provide standard system policy for drawing blood as requested by Law Enforcement Officers in accordance with NCGS § 20-16.2, *Implied consent to chemical analysis; mandatory revocation of license in event of refusal; right of driver to request analysis* and NCGS § 20-139.1(d2), *Procedures governing chemical analyses; admissibility; evidentiary provisions; controlled-drinking programs.*

## **Procedure:**

1. Only Paramedics cleared in the Harnett County EMS System are allowed to draw blood for Law Enforcement Officers.
2. EMS units should perform blood draws when requested by Law Enforcement Officers (LEOs) due to the suspicion of a subject Driving While Impaired (DWI).
3. Transportation of a critical or "trauma" patient will not be delayed for a blood draw.
4. EMS shall not draw blood from a deceased subject.
5. The subject must be in custody and the LEO must present an appropriate Biological Blood Specimen Kit.
6. The patient must consent to the blood draw. Uncooperative patients and inappropriate manpower will never be combined with sharp needles and bloodborne pathogens for the safety of the patient, EMS crew, and the LEO.

## **Documentation:**

If called by an LEO only for a blood draw, the Run Type is listed as '911 Response (Emergency)'. The disposition should be listed as 'Assist' and the Refusal Reason listed as 'Other'. The requesting law enforcement agency should be listed in Additional Factors under Additional Agencies. The patient's name and date of birth (DOB) should be obtained. The blood draw should be entered in the Flow Chart under IV Therapy as a Blood Draw and complete the information required. No refusal is required, unless additional assessment or treatment is performed or recommended.

If asked to draw the blood of a pre-existing patient (ex: a patient you are treating at a motor vehicle crash), the report should be completed as any other based on the overall patient situation. The blood draw should be entered in the Flow Chart under IV Therapy as a Blood Draw.

The Narrative page should accurately reflect the chief complaint of the patient, or if there was not a patient chief complaint, this may be the request from the officer. For Primary Impression list 'Other' and list as the Chief Complaint "Officer requests a blood draw". The Narrative section allows you to record your narrative of the events on the call.

Any difficulties that are realized with practice of this policy should be documented in a special report and reported to the appropriate supervisor due to the legal implications of this policy.



# Narcan for Law Enforcement

**First Responder agencies, to include law enforcement are allowed to administer Narcan with the following requirements:**

- A. They must administer the Narcan under the medical oversight of the Harnett County EMS Medical Director, and be incorporated into the respective EMS System in which they are administering the Narcan.
- B. They must receive appropriate training and continuing education as approved by the Harnett County EMS Medical Director.
- C. The Narcan must be administered as part of the policy, Protocol, and procedure approved by the Harnett County EMS Medical Director and the NC Office of EMS.
- D. All administration of Narcan must be reviewed by the Harnett County EMS Peer Review Committee of the EMS System, which functions under the supervision of the local Harnett County EMS Medical Director.

**Appropriate training will include but not be limited to the following:**

1. Basic knowledge, skill, and judgment to assess the appropriateness of administration including indications and contraindications.
2. Basic knowledge of the actions, interactions, dose, IN route, side effects, and adverse effects of the drug.
3. Ability to calculate dosage correctly.
4. Ability to prepare the Narcan Atomizer and/or auto-injector correctly.
5. Ability to properly administer Narcan correctly.
6. Ability to evaluate the effects of the medication.
7. Demonstrate proper documentation techniques including the process and outcomes.
8. Report any adverse side effects or medication error immediately to Performance Improvement Committee. This is an absolute must in order to identify and correct mistakes and is not punitive.

**Credentialing Requirements:**

- Complete a basic course specific to Narcan IN which covers the policy, procedure, protocol, along with signs and symptoms of an opiate overdose. Also, correctly demonstrate medication preparation and administration.
- Repeat basic refresher course annually. Includes practical demonstration of medication preparation and administration.
- Ability to demonstrate correct administration preparation and administration at any time to Harnett County EMS Medical Director or her/his designee.
- A Narcan usage report is to be sent to the Harnett County Assistant Chief of Training within 24/48 hours of administration by the agency representative.
- All LEO Narcan will be subject to 100% QA/QI audit by Harnett County EMS Medical Direction.
- Narcan usage will be reported quarterly at the PI/PEER Review Meeting by the Harnett County EMS – Assistant Chief of Training.
- Credential records will be maintained for a period of no less than three years by agency.
- Personnel must be in good standing with his or her primary agency and the Harnett County EMS Medical Director.



# Drug Assisted Intubation – State Requirements

## **Policy:**

Drug Assisted Intubation (DAI) requires Harnett County EMS System, to follow these guidelines to ensure that this invasive procedure is performed in a safe and effective manner to benefit the citizens and guest of North Carolina.

## **Purpose:**

The purpose of this policy is to:

- Ensure that the procedure is performed in a safe and effective manner
- Facilitate airway management in appropriate patients

## **Procedure:**

1. In addition to other monitoring devices, Waveform Capnography and Pulse Oximetry are required to perform Drug Assisted Intubations and must be monitored throughout the procedure.
2. Two Paramedics or higher-level providers must be present and participate in the airway management of the patient during the procedure.
3. All staff must be trained and signed off by the EMS Medical Director prior to performing Drug Assisted Intubation.
4. A printed copy or electronic download from the monitor defibrillator including the pulse oximetry, heart rate, heart rhythm, waveform capnography, and blood pressure must be stored with the patient care report.
5. An EMS Airway Evaluation Form must be completed on all Drug Assisted Intubation Attempts.
6. The EMS Airway Evaluation Form must be reviewed and signed by the EMS Medical Director within 14 days of the Drug Assisted Intubation attempts.
7. All Drug Assisted Intubations must be reviewed by the Harnett County EMS System and issues identified addressed through the Harnett County EMS System Peer Review Committee.
8. A copy of the EMS Airway Evaluation form for each Drug Assisted Intubation must be forwarded to the appropriate OEMS Regional Office listed below at the end of each month for state review.

Central Regional Office  
2707 Mail Service Center  
Raleigh, NC 27699-2707  
Telephone: 919-855-4678  
Fax: 919-715-0498

In addition, the NC EMS Airway Evaluation Form has been revised to a one page document to improve provider compliance and promote receiving/confirming physician acceptance.

**MED 1**

This policy has been altered from the original NCCEP Policy by the local EMS Medical Director



# Ketamine Program Requirements

## Policy:

When administered outside of the Airway Drug Assisted Intubation Protocol, an EMS System or Agency must be approved by the State Medical Director and follow the guidelines below when administering Ketamine.

## Purpose:

The purpose of this policy is to:

- Ensure that Ketamine is administered in a safe and effective manner
- Facilitate use of Ketamine in appropriate patients
- Establish a reporting mechanism for state review
- 

## Procedure:

1. The EMS system or Agency must adopt NCCEP protocols unchanged or submit equivalent protocols for review.
2. Letters of support must be obtained from all receiving hospitals where patients will be delivered after administration. These letters must be submitted to the OEMS prior to approval.
3. All personnel must be trained prior to implementation.
4. All administrations must be reviewed through the established PI/QA Medical Oversight process to include hospital outcome feedback. Concerns identified must be reviewed by the Peer Review/QA committee.
5. There are two (2) components of the NCOEMS reporting process:
  - a. The EMS system or agency must submit to the OEMS a Ketamine Adverse Outcome Reporting Form and ePCR within 14 days for administrations that result in any of the following;
    - 1) Cardiac Arrest (pre-hospital or ED)
    - 2) Unanticipated intubation required after administration (pre-hospital or ED).

\*Secure Ketamine Adverse Outcome Report link: <https://nc.readyop.com/fs/4cki/786b>

- b. The EMS system or agency must submit a quarterly report to the OEMS indicating;
  - 1) The total number of administrations
  - 2) Summary of primary protocol utilizations
  - 3) Summary highlighting the PR/QA of cases that required a Ketamine Reporting Form.

\*Secure Ketamine Quarterly Report link: <https://nc.readyop.com/fs/4ckG/1544>

**\*\*IF THE REPORTING LINKS ABOVE DO NOT DIRECT YOU TO AN ACTIVE FORM, PLEASE COPY AND PASTE THE LINK INTO YOUR WEB BROWSER MANUALLY\*\***



# Drug Assisted Intubation – Personnel Requirements

## Policy:

This policy will outline the special requirements and prerequisites for DAI set forth by the Harnett County EMS System Medical Director. Clinicians seeking to obtain Harnett County EMS System credentials to perform DAI must meet the requirements outlined. All DAI cases will be reviewed by the Medical Director.

## Purpose:

The decision to DAI requires considerable knowledge of anatomical and physiological features as well as impeccable clinical decision-making skills. The safety and effectiveness of DAI must be weighed with the clinical presentation of the patient and in conjunction with factors that may affect the outcome of the procedure or overall patient care.

## Initial Requirements:

1. Document completion of 6 successful human intubations.
2. Function at the paramedic level for a minimum of 1 year, preferably in a 911 system.
3. Successfully complete an approved DAI didactic course developed by the Harnett County EMS Medical Director. Participants must pass the written testing and skills practicum overseen by the Harnett County EMS Medical Director upon completion.
4. The Harnett County EMS System Medical Director will approve all candidates prior to release to perform DAI.

## Ongoing Requirements:

1. If  $\geq 90\%$  1<sup>st</sup> pass intubation success annually, as approved by the Medical Director
    - o No further recertification training required
  2. If  $\leq 89\%$  1<sup>st</sup> pass intubation success annually, as approved by the Medical Director
    - o Must demonstrate at least one (1) successful intubation per quarter for previous two (2) years
    - o Must successfully complete 1 DAI simulation lab biennially
- AND**
- o Must successfully complete simulation lab final practical scenario and written exam with direct oversight of the Medical Director
- OR**
- o Successfully retake the Harnett County EMS DAI Training Program

## Performance Improvement:

1. Each DAI case will be reviewed by the Harnett County EMS System Medical Director in-person within 10 days following the case.
2. Individuals approved to perform DAI must attend all educational objectives established by the Harnett County EMS System Medical Director to maintain their EMS System DAI approval.
3. The Harnett County EMS System PEER Review Committee / Performance Improvement program reviews all DAI cases and provides feedback through quarterly meetings of the committee. All DAI cases are sent for review by the State Medical Director monthly along with supporting documentation, including ECP, NC Airway Form, ECG and EtCO<sub>2</sub> readings from each case.

## Suspension of DAI Privileges:

1. The Harnett County EMS System Medical Director may at any time suspend or revoke the privilege to perform DAI.
2. In such cases, the Harnett County EMS Medical Director may assign remedial training and will outline a plan for the clinician to follow for re-consideration of DAI approval.



# Mechanical CPR Devices

## Purpose:

The purpose of this policy is to provide guidance regarding when a mechanical CPR device may and may not be used for patients in cardiac arrest.

## Policy:

1. In general, a mechanical CPR device is generally NOT BETTER than human-performed chest compressions in terms of likelihood of ROSC or survival. Providers in our system perform excellent chest compression with high CPR fraction and quality. Therefore, two main policy statements apply:
  - a. The benefit of a mechanical CPR device in our system is realized when **TRANSPORT** of a medical cardiac arrest patient is indicated. During Transport (e.g. in the back of a moving ambulance or on a moving stretcher), mechanical CPR devices likely provide higher quality chest compressions and allow for a greater degree of provider safety.
  - b. GREAT CARE should be taken to maximize CPR fraction (i.e. minimize pauses in compressions) when a mechanical CPR device is being applied, adjusted, or during transport and transitions of care. Usual cardiac arrest practices apply, i.e. “pit crew” CPR. If we are “doing it right,” some patients will get ROSC while using the devices. In these cases, the device should stay on the patient (“paused”) in case of re-arrest.
2. The mechanical CPR device is designed and configured to mimic excellent quality chest compressions of an appropriate rate and depth for an ADULT patient. It is not always possible to know the age of a cardiac arrest patients, therefore if the ADULT cardiac arrest protocols are being used, mechanical CPR may be used, when indicated. If PEDIATRIC cardiac arrest protocols are used, mechanical CPR may NOT be utilized.
3. Contraindications for using the mechanical CPR devices are:
  - a. If it is not possible to position the device correctly on the chest per manufacturer's recommendations; and
  - b. if the patient is too small or too large for the device, per manufacturer's recommendations and system training.
4. Also, the mechanical CPR devices SHALL NOT be used for trauma arrests. Consider that the greatest chance of survival for any trauma arrest is created by rapid transport to a trauma center (refer to Traumatic Arrest Protocol) and rapid transport takes precedence in these cases.
5. Two rounds of manual compressions should be utilized prior to the application of any mechanical CPR device.
6. Mechanical CPR Devices should be utilized in both of the following situations:
  - a. Patients with ROSC (device should be placed in case of re-arrest during transport).
  - b. Patients in whom on-scene efforts have not resulted in ROSC but the code cannot be discontinued on scene (refer to Discontinuation of Prehospital Resuscitation Policy) and which the mechanical CPR device has not already been applied. In these cases, the device should be utilized immediately upon determination transport is required and used throughout the remainder of transport, as indicated.

\*\*\* If a patient that was not initially a cardiac arrest patient has an arrest during transport, the unit should pull over and call for a Cardiac Arrest response as per usual system practice. Whether or not ROSC is obtained, the mechanical CPR device (if available) should be utilized to continue transport to the ED, once pit-crew positions are established and “on-scene” priorities are completed. \*\*\*



# Infant Abandonment

## Policy:

The North Carolina Infant Homicide Prevention Act provides a mechanism for unwanted infants to be taken under temporary custody by a law enforcement officer, social services worker, healthcare provider, or EMS personnel if an infant is presented by the parent within 7 days of birth. Emergency Medical Services will accept and protect infants who are presented to EMS in this manner, until custody of the child can be released to the Department of Social Services.

*"A law enforcement officer, a department of social services worker, a health care provider as defined in G.S. 90-21.11 at a hospital or local or district health department, or an **emergency medical technician** at a fire station shall, without a court order, take into temporary custody an infant under 7 days of age that is voluntarily delivered to the individual by the infant's parent who does not express an intent to return for the infant. An individual who takes an infant into temporary custody under this subsection shall perform any act necessary to protect the physical health and well-being of the infant and shall immediately notify the department of social services. Any individual who takes an infant into temporary custody under this subsection may inquire as to the parents' identities and as to any relevant medical history, but the parent is not required to provide this information."*

## Purpose:

To provide:

- Protection to infants that are placed into the custody of EMS under this law
- Protection to EMS systems and personnel when confronted with this issue

## Procedure:

1. Initiate the Pediatric Assessment Procedure.
2. Initiate Newly Born Protocol as appropriate.
3. Initiate other treatment protocols as appropriate.
4. Keep infant warm.
5. Call local Department of Social Services or the county equivalent as soon as infant is stabilized.
6. Transport infant to medical facility as per local protocol.
7. Assure infant is secured in appropriate child restraint device for transport.
8. Document protocols, procedures, and agency notifications in the PCR.



# Child Abuse Recognition and Reporting

## **Policy:**

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

## **Purpose:**

Assessment of child abuse case based upon the following principles:

- **Protect** the life of a child from harm, as well as that of the EMS team from liability.
- **Suspect** that the child may be a victim of abuse, especially if the injury/illness is not consistent with the reported history.
- **Respect** the privacy of the child and family.
- **Collect** as much evidence as possible, especially information.

## **Procedure:**

1. With all children, assess for and document psychological characteristics of abuse, including excessive passivity, complaint or fearful behavior, excessive aggression, violent tendencies, excessive crying, fussy behavior, hyperactivity, or other behavioral disorders.
2. With all children, assess for and document physical signs of abuse, including especially any injuries that are inconsistent with the reported mechanism of injury.
3. With all children, assess for and document signs and symptoms of neglect, including inappropriate level of clothing for weather, inadequate hygiene, absence of attentive caregiver(s), or physical signs of malnutrition.
4. Immediately report any suspicious findings to both the receiving hospital (if transported) and to agency responsible for Social Services in the County. After office hours, the child protective services worker on call can be contacted by the EMS System's 911 Communication Center. While law enforcement may also be notified, North Carolina Law requires the EMS provider to report the suspicion of abuse to DSS. EMS should not accuse or challenge the suspected abuser. This is a legal requirement to report, not an accusation. In the event of a child fatality, law enforcement must also be notified.



# Domestic Violence (Partner and/or Elder Abuse) Recognition and Reporting

## Policy:

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

Elder abuse is the physical and/or mental injury, sexual abuse, negligent treatment, or maltreatment of a senior citizen by another person. Abuse may be at the hand of the caregiver, spouse, neighbor, or adult child of the patient. The recognition of abuse and the proper reporting is a critical step to improve the health and wellbeing of senior citizens.

## Purpose:

Assessment of child abuse case based upon the following principles:

- **Protect** the patient from harm, as well as that of the EMS team from harm or liability.
- **Suspect** that the patient may be a victim of abuse, especially if the injury/illness is not consistent with the reported history.
- **Respect** the privacy of the patient and family.
- **Collect** as much information and evidence as possible and preserve physical evidence.

## Procedure:

1. Assess the/all patient(s) for any psychological characteristics of abuse, including excessively passivity, complaint or fearful behavior, excessive aggression, violent tendencies, excessive crying, behavior disorders, substance abuse, medical non-compliance, or repeated EMS requests. This is typically best done in private with the patient.
2. Assess the patient for physical signs of abuse, including especially any injuries that are inconsistent with the reported mechanism of injury. Defensive injuries (e.g. to forearms), and injuries during pregnancy are also suggestive of abuse. Injuries in different stages of healing may indicate repeated episodes of violence.
3. Assess all patients for signs and symptoms of neglect, including inappropriate level of clothing for weather, inadequate hygiene, absence of attentive caregiver(s), or physical signs of malnutrition.
4. Immediately report any suspicious findings to both the receiving hospital (if transported). If an Elder or disabled adult is involved, also contact the Department of Social Services (DSS) or equivalent in the County. After office hours, the adult social services worker on call can be contacted by the EMS System's 911 Communication Center.
5. EMS Personnel should attempt in private to provide the patient with the phone number of the local domestic violence program, or the **National Hotline, 1-800-799-SAFE**.



# EMS Back in Service Time

## Policy:

All EMS Units transporting a patient to a medical facility shall transfer the care of the patient and complete all required operational tasks to be back in service for the next potential EMS event within 30 minutes of arrival to the medical facility, 90% of the time.

## Definition:

The EMS Back in Service Time is defined as the time interval beginning with the time the transporting EMS Unit arrives at the medical facility destination and ending with the time the EMS Unit checks back in service and available for the next EMS event.

## Purpose:

The purpose of this policy is to:

- Assure that the care of each EMS patient transported to a medical facility is transferred to the medical facility staff in a timely manner.
- Assure that the EMS unit is cleaned, disinfected, restocked, and available for the next EMS event in a timely manner.
- Assure that an interim or complete EMS patient care report (PCR) is completed and left with the receiving medical facility documenting, at a minimum, the evaluation and care provided by EMS for that patient (It is acceptable to leave the PreMIS Preliminary Report or equivalent if the final PCR cannot be completed before leaving the facility).
- Provide quality EMS service and patient care to the county's citizens.
- Provide a means for continuous evaluation to assure policy compliance.

## Procedure:

The following procedures shall be implemented to assure policy compliance:

1. The EMS Unit's priority upon arrival at the medical facility will be to transfer the care of the patient to medical facility staff as soon as possible.
2. EMS personnel will provide a verbal patient report on to the receiving medical facility staff.
3. EMS personnel will provide an interim (PreMIS Preliminary Report or equivalent) or final Patient Care Report (PCR) to the receiving medical facility staff, prior to leaving the facility, that documents at a minimum the patient's evaluation and care provided by EMS prior to arrival at the medical facility. A complete PCR should be completed as soon as possible but should not cause a delay in the EMS Back in Service Time.
4. The EMS Unit will be cleaned, disinfected, and restocked (if necessary) during the EMS Back in Service Time interval.
5. Any EMS Back in Service Time delay resulting in a prolonged EMS Back in Service Time will be documented in Patient Care Report (PCR) as an "EMS Turn-Around Delay" as required and defined in the North Carolina College of Emergency Physicians (NCCEP) EMS Dataset Standards Document.
6. All EMS Turn-Around Delays will be reviewed regularly within the EMS System Peer Review Committee.



# EMS Wheels Rolling (Turn-Out) Time

## Policy:

The EMS Wheels Rolling (Turn-out) Time will be less than 90 seconds, 90% of the time, for all events identified and classified as an emergent or hot (with lights and siren) response.

## Definition:

The EMS Wheels Rolling (Turn-out) Time is defined as the time interval beginning with the time the EMS Dispatch Center notifies an EMS Unit to respond to a specific EMS event and ending with the time the EMS Unit is moving en route to the scene of the event.

## Purpose:

The purpose of this policy is to:

- Provide a timely and reliable response for all EMS events within the EMS System.
- Provide quality EMS service and patient care to the county's citizens.
- Provide a means for continuous evaluation to assure policy compliance.

## Procedure:

The following procedures shall be implemented to assure policy compliance:

1. In EMS Dispatch Centers where Emergency Medical Dispatch (EMD) has been implemented, EMS Units will be dispatched by EMD certified personnel in accordance with the standards developed by the Medical Director and the Emergency Medical Dispatch Protocols.
2. The EMS Unit Wheels Rolling (Turn-out) time will be less than 90 seconds from time of dispatch, 90% of the time. If a unit fails to check en route within 2:59 (mm:ss), the next available EMS unit will be dispatched.
3. Without question, exception, or hesitation, EMS Units will respond as dispatched (hot or cold). This includes both requests to respond on active calls and requests to "move-up" to cover areas of the System that have limited EMS resources available.
4. An EMS Unit may divert from a current cold (no lights and sirens) call to a higher priority hot (with lights and sirens) call **ONLY IF:**
  - The EMS Unit can get to the higher priority call before it can reach the lower priority call. Examples of High Priority Calls: Chest Pain, Respiratory Distress, CVA, etc.
  - The diverting EMS Unit must notify the EMS Dispatch Center that they are diverting to the higher priority call.
  - The diverting EMS Unit ensures that the EMS Dispatch Center dispatches an EMS Unit to their original call.
  - Once a call has been diverted, the next EMS Unit dispatched must respond to the original call. A call cannot be diverted more than one (1) time.
5. Any EMS Wheels Rolling (Turn-out) Time delay resulting in a prolonged EMS Response Time for emergent hot (with lights and sirens) events will be documented in Patient Care Report (PCR) as an "EMS Response Delay" as required and defined in the North Carolina College of Emergency Physicians (NCCEP) EMS Dataset Standards Document.
6. All EMS Response Delays will be reviewed regularly within the EMS System Peer Review Committee.



# State Poison Center

## Policy:

The state poison center should be utilized by the 911 centers and the responding EMS services to obtain assistance with the prehospital triage and treatment of patients who have a potential or actual poisoning.

## Purpose:

The purpose of this policy is to:

- Improve the care of patients with poisonings, envenomations, and environmental/biochemical terrorism exposures in the prehospital setting.
- Provide for the most timely and appropriate level of care to the patient, including the decision to transport or treat on the scene.
- Integrate the State Poison Center into the prehospital response for hazardous materials and biochemical terrorism responses

## Procedure:

1. The 911 call center will identify and if EMD capable, complete key questions for the Overdose/ Poisoning, Animal Bites/Attacks, or Carbon Monoxide/Inhalation/HazMat emergency medical dispatch complaints and dispatch the appropriate EMS services and/or directly contact the State Poison Center for consultation.
2. If no immediate life threat or need for transport is identified, EMS personnel may conference the patient/caller with the Poison Center Specialist at the **State Poison Center at 800-222-1222**. If possible, dispatch personnel should remain on the line during conference evaluation.
3. The Poison Center Specialist at the State Poison Center will evaluate the exposure and make recommendations regarding the need for on-site treatment and/or hospital transport in a timely manner. If dispatch personnel are not on-line, the Specialist will recontact the 911 center and communicate these recommendations.
4. If the patient is determined to need EMS transport, the poison center Specialist will contact the receiving hospital and provide information regarding the poisoning, including treatment recommendations. EMS may contact medical control for further instructions or to discuss transport options.
5. If the patient is determined not to require EMS transport, personnel will give the phone number of the patient/caller to the Poison Center Specialist. The Specialist will initiate a minimum of one follow-up call to the patient/caller to determine the status of patient.
6. Minimal information that should be obtained from the patient for the state poison center includes:

|                           |                         |
|---------------------------|-------------------------|
| • Name and age of patient | • Substance(s) involved |
| • Time of exposure        | • Any treatment given   |
| • Signs and symptoms      |                         |
7. Minimal information which should be provided to the state poison center for mass poisonings, including biochemical terrorism and HazMat, includes:

|                         |                       |
|-------------------------|-----------------------|
| • Substance(s) involved | • Time of exposure    |
| • Signs and symptoms    | • Any treatment given |



# Air Medical Transport

## Policy:

Air transport should be utilized whenever patient care can be improved by decreasing transport time or by giving advanced care not available from ground EMS services, but available from air medical transport services (i.e. blood).

## Purpose:

The purpose of this policy is to:

- Improve patient care in the prehospital setting.
- Allow for expedient transport in serious, mass casualty settings.
- Provide life-saving treatment such as blood transfusion.
- Provide more timely access to interventional care in acute Stroke and ST-elevation myocardial infarction (STEMI) patients

## Procedure:

Patient transportation via ground ambulance will not be delayed to wait for helicopter transportation.

If the patient is packaged and ready for transport and the helicopter is not on the ground, or within a reasonable distance (i.e.; Aircraft insight, imminent landing verified), the transportation will be initiated by ground ambulance.

Air transport should be considered if any of the following criteria apply:

- Entrapped patients with > 10 minute estimated extrication time
- Multiple casualty incident with red/yellow tag patients
- Multi-trauma or medical patient requiring life-saving treatment not available in prehospital environment (i.e., blood transfusion, invasive procedure, operative intervention)
- Time dependent medical conditions such as acute ST-elevation myocardial infarctions (STEMI) or acute Stroke that could benefit from the resources at a specialty center as per the EMS System's Stroke and STEMI Plans.

Any EMS, Fire, or Law Enforcement Personnel on arrival and after evaluation of the situation, should determine if the helicopter should be dispatched to the scene.

If the scene conditions or patient situation improves after activation of the air medical transport service and air transport is determined not to be necessary, paramedic or administrative personnel may cancel the request for air transport.

Minimal Information which should be provided to the air medical transport service include:

- Number of patients
- Age of patients
- Sex of patients
- Mechanism of injury or complaint (MVC, fall, etc)



# Safe Transport of Pediatric Patients

## **Policy:**

Without special considerations children are at risk of injury when transported by EMS. EMS must provide appropriate stabilization and protection to pediatric patients during EMS transport

## **Purpose:**

To provide:

- Provide a safe method of transporting pediatric patients within an ambulance.
- Protect the EMS system and personnel from potential harm and liability associated with the transportation of pediatric patients.

## **Procedure:**

1. Drive cautiously at safe speeds observing traffic laws.
2. Tightly secure all monitoring devices and other equipment.
3. Insure that all pediatric patient less than 40 lbs are restrained with an approved child restraint device secured appropriately to the stretcher or captains chair.
4. Insure that all EMS personnel use the available restraint systems during the transport.
5. Transport adults and children who are not patients, properly restrained, in an alternate passenger vehicle, whenever possible.
6. Do not allow parents, caregivers, or other passengers to be unrestrained during transport.
7. NEVER attempt to hold or allow the parents or caregivers to hold the patient during transport.



# Harnett Co. Transport Policy

## Policy:

All individuals served by the Harnett County EMS System will be evaluated, treated, and furnished transportation (if indicated) in the most timely and appropriate manner for each individual situation.

## Purpose:

The purpose of this policy is provide the following:

- Rapid emergency EMS transport when needed
- Appropriate medical stabilization and treatment at the scene when necessary
- Protection of patients, EMS personnel, and citizens from undue risk when possible
- Provide for interfacility transport of STEMI patients when requested by local hospital(s)

## Procedure:

1. Patients meeting specialty triage and transport protocol requirements will be transported per applicable triage and transport protocols.
  - a. All trauma patients with significant mechanism or history for multiple system trauma will be transported as soon as possible. The scene time should be 10 minutes or less.
  - b. All acute Stroke and acute ST-Elevation Myocardial Infarction patients will be transported as soon as possible. The scene time should be 10 minutes or less.
  - c. Burn patients with critical or serious burns required direct transport to UNC Burn Center as per the Burn Triage and Transport protocol. Direct transports greater than 30 minutes can be made if the patient is otherwise stable. Consult with Medical Control as needed.
2. Patients not covered by specialty triage and transport protocols:
  - a. Patients in need of emergency medical care will be taken to the nearest appropriate hospital. Patients will be transported in the most efficient manner possible considering the medical condition. ALS therapy should be provided at the scene if it would positively impact patient care. Justification for scene times greater than 20 minutes should be documented.
  - b. In non-emergency situations patients should be transported to a hospital of their choice if this is their usual source of care for their current condition and/or it is deemed the patient would benefit from transport to that location. In these situations patients should be transported to the hospital of their choice as long as it is located in Harnett County or a county contiguous to Harnett County, unless:
    - i. Contraindicated by State or Local Protocol
    - ii. The assessment by a Harnett County EMS System Paramedic shows that complying with the patient's request would be injurious or cause further harm to the patient, OR
    - iii. Would put the patient at risk for deterioration of their condition due to the length of the transport.

*In these situations the patient should be transported to the closest hospital for evaluation and stabilization. Patient transfer can be arranged following emergent care and stabilization.*
  - c. If the patient has no preference, transport to the closest appropriate hospital
  - d. If the paramedic feels it is in the patient's best interest to be transported to a hospital outside of this policy, the paramedic will make the transport decision and continue patient care.
3. Transport should be accomplished by the responding EMS Agency.
4. No patient's will be transported in initial response Non-Transport Vehicles.
5. In unusual circumstances, transport in other vehicles may be appropriate when directed by EMS Administration.
6. Interfacility transport of STEMI patients from Harnett Health System Hospitals will be managed based on the availability of resources. The referring hospital will notify Harnett County 911 Communications Center for STEMI transport request. The on-duty Assistant Chief/District Chief will be notified and make arrangements for an appropriate response. If necessary the on-duty Assistant Chief/District Chief will contact the referring hospital when resources are not available.



# Harnett Co. Interfacility Transport Policy

## Policy:

Harnett County EMS System provides interfacility transport for selected patients. Harnett County prehospital providers can transport patients who have been stabilized at the transferring facility and who have on going monitoring and/or treatment that is within the providers scope of practice.

More critical patients will require transport by a critical care transport service.

## Purpose:

Provide interfacility transport of stabilized patients.

## Procedure:

As a guideline to transferring facilities, the following is a list of current medications and treatments that Harnett County EMS System can provide during transport.

- a) Monitoring of antibiotic infusions (Started at least 15 minutes prior)
- b) Crystalloid infusion including potassium with a max of 10meq/L
- c) Medication infusions of
  - a. Amiodarone
  - b. Dopamine
  - c. Dobutamine
  - d. Epinephrine
  - e. Norepinephrine
  - f. Lidocaine
  - g. Procainamide
  - h. Heparin
  - i. Insulin
  - j. Nitroglycerin (includes patch and paste)
  - k. Magnesium Sulfate
  - l. Sodium Bicarbonate containing solutions
- d) IV medication infusions will be maintained on an infusion pump and up to 4 (max) IV medications can be running at a time.
- e) Patients with central lines can be transported.
- f) Monitoring infusions of total parenteral nutrition (TPN), lipids, and vitamins
- g) Provide mechanical ventilation
- h) Provide CPAP
- i) Provide quantitative waveform capnography
- j) Monitor and continue induced hypothermia
- k) Monitor or provide Nasogastric Tubes
- l) Monitor Foley caths

\*\*NOTE: With any of the medications above, patients should be stabilized on a consistent maintenance infusion rate prior to transport.



# Harnett Co. Interfacility Transport Policy

## Procedure Continued:

The following is a list of some treatments that currently we are not able to provide. This is not all inclusive. Other treatments not listed here may require critical care transport.

- a) Intra-Aortic Balloon Pumps
- b) Or more than 4 medication drips/Infusions

The following is a listing of medications and infusions that Harnett County EMS System can transport and monitor however; we will not be able to titrate but could stop if patient condition became worse (these medications must be started at least 15 minutes prior to arrival and vital signs must be stabilized) :

- a) IIb/IIIa inhibitors
- b) Blood or Blood Products
- c) Nitroprusside
- d) Isoproterenol
- e) Oxytocin
- f) Dilantin (must be on IV Pump)
- g) Nesiritide
- h) Thrombolytics
- i) Any other medication listed on the North Carolina Medical Board Approved Medications for credentialed EMS personnel – Paramedic Level Medications.