II. GENERAL PATIENT CARE (GPC)

ALERT THE GENERAL PATIENT CARE SECTION SHALL APPLY TO ALL PATIENT ENCOUNTERS UNLESS OTHERWISE NOTED IN ANY SPECIFIC TREATMENT PROTOCOL. **(NEW '20)**

A. RESPONSE

Review the dispatch information and select appropriate response.

B. SCENE ARRIVAL AND SIZE-UP

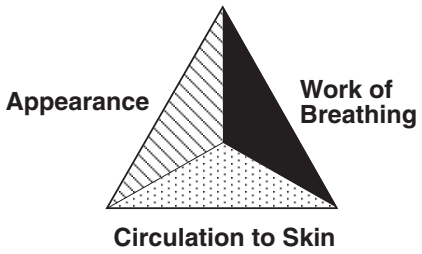
1. Consider Body Substance Isolation (BSI).
2. Consider Personal Protective Equipment (PPE).
3. Evaluate the scene safety.
4. Determine the number of patients.
5. Consider the need for additional resources.

C. PATIENT APPROACH

1. Determine the Mechanism of Injury (MOI)/Nature of Illness (NOI).
2. If appropriate, begin triage and initiate Mass Casualty Incident (MCI) procedures.

D. INITIAL ASSESSMENT

ALERT CORRECT LIFE-THREATENING PROBLEMS AS IDENTIFIED.
STABILIZE CERVICAL SPINE WHEN APPROPRIATE.



FOR PEDIATRIC PATIENTS, CONSIDER USING THE PEDIATRIC ASSESSMENT TRIANGLE.

1. Assess mental status
   a) **A**lert
   b) Responds to **V**erbal stimuli
   c) Responds to **P**ainful stimuli
   d) **U**nresponsive
2. Airway
   a) Open and establish airway using appropriate adjunct.
   b) Place patient in appropriate position.
   c) Suction airway as needed, including tracheostomy tubes.

IF A PATENT AIRWAY CANNOT BE ESTABLISHED, THE PATIENT MUST BE TRANSPORTED TO THE NEAREST APPROPRIATE HOSPITAL-BASED EMERGENCY DEPARTMENT **OR DESIGNATED FREESTANDING EMERGENCY MEDICAL FACILITY**. ONCE THE PATIENT PRESENTS TO THE HOSPITAL **OR DESIGNATED FREESTANDING EMERGENCY MEDICAL FACILITY** FOR TREATMENT OF AN EMERGENCY CONDITION, TREATMENT AND TRANSFER DECISIONS ARE THE RESPONSIBILITY OF THE HOSPITAL UNDER APPLICABLE LAW. THE CLINICIAN SHOULD STAND BY TO BE AVAILABLE FOR AND ASSIST WITH TRANSFER OF THE PATIENT IF THE HOSPITAL DETERMINES SUCH A TRANSFER IS APPROPRIATE.

IN INFANTS AND YOUNG CHILDREN, INSPIRATORY STRIDOR IS AN INDICATION OF UPPER AIRWAY FOREIGN BODY OR PARTIAL AIRWAY OBSTRUCTION. REQUEST ALS RENDEZVOUS. TRANSPORT THE PATIENT RAPIDLY AND CAUTIOUSLY AND HAVE FOREIGN BODY AIRWAY REMOVAL EQUIPMENT READY FOR IMMEDIATE USE IN CASE THE PATIENT'S AIRWAY BECOMES OBSTRUCTED.

3. Breathing
   a) Determine if breathing is adequate. Assess oxygen saturation (SpO_2) with portable pulse oximeter (required on all transport units since 2012).
      (1) If patient's ventilations are not adequate, provide assistance with 100% oxygen using Bag-Valve-Mask (BVM).
         (i) For all ages except neonates, 1 breath every 5 seconds (8–12 breaths/min) (manually-activated positive pressure oxygen delivery device is not recommended for this group)
         (ii) For a neonate, 1 breath every 3 seconds (higher rates may be required)
      (2) The decision to oxygenate will be based on the patient's clinical condition.
         (i) SpO_2 greater than or equal to 94% is considered normoxia in adults and children. Supplemental oxygen is not needed if SpO_2 greater than or equal to 94% unless the patient is in respiratory distress, acutely dyspneic, or suffering from suspected CO poisoning. Patients in severe respiratory distress may benefit from high flow oxygen from a nonrebreather (NRB).
         Note: Respiratory distress is present if the patient has retractions, nasal flaring, wheezing, stridor, or difficulty speaking.
         (ii) Unless in respiratory distress, avoid administration of high flow oxygen to patients presenting with the following conditions:
         (a) STEMI / angina
         (b) CVA / stroke
         (c) Post arrest
         (iii) CO exposure: Apply 100% oxygen via NRB mask. Maintain SpO_2 at 100%.

      (3) If available, utilize $ETCO_2$ waveform monitoring in intubated patients (required on all ALS transport units for advanced airway management since 2015).

Percent O_2 Saturation	Ranges	General Patient Care
94–100%	Normal	Give oxygen as necessary
91–93%	Mild Hypoxia	Give oxygen as necessary
86–90%	Moderate Hypoxia	Give 100% oxygen Assisting Ventilations if necessary
less than or equal to 85%	Severe Hypoxia	Give 100% oxygen Assist Ventilations If indicated, Intubate
ALERT	INACCURATE OR MISLEADING SpO_2 READINGS MAY OCCUR IN THE FOLLOWING PATIENTS: HYPOTHERMIC, HYPOPERFUSION (SHOCK), CO POISONING, HEMOGLOBIN ABNORMALITY, ANEMIA, AND VASOCONSTRICTION.	

(4) Consider carbon monoxide measurement, if available.

b) Hyperventilate the head-injured patient only if signs/symptoms of herniation are present, including posturing, loss of pupillary light response, dilation of one or both pupils, vomiting, hypertension, bradycardia, and/or irregular respirations.
   (1) If hyperventilating, use the following rates
   Adult (including adolescent 13 years of age or older): 20 breaths per minute
   Child (1-12 years of age): 30 breaths per minute
   Infant (less than 1 year of age): 35 breaths per minute
   (2) If hyperventilating, use $ETCO_2$ monitoring if available.

ALERT NEVER WITHHOLD OXYGEN FROM A PATIENT IN RESPIRATORY DISTRESS!

DEVICE	FLOW RATE	CONCENTRATION
Nasal Cannula	2–6 lpm	24–44%
Venturi Mask	Variable	24–60%
Partial Rebreather Mask	6–10 lpm	35–60%
Simple Face Mask	6–10 lpm	35–60%
Pocket Mask	12–15 lpm	50–60%
Non-Rebreather Mask	12–15 lpm	80–100%
Bag-Valve-Mask	12–15 lpm	90–100%

4. Circulation

ALERT

ONCE CONFIRMED PULSELESS, HIGH-QUALITY CONTINUOUS CPR WITH FREQUENT CLINICIAN ROTATION IS AN ESSENTIAL COMPONENT IN THE SUCCESSFUL RESUSCITATION OF THE ARRESTED PATIENT. THIS MAY BE ACCOMPLISHED THROUGH MANUAL OR MECHANICAL MEANS, AS APPROPRIATE, IN ADULTS. MECHANICAL METHODS OF COMPRESSION ARE NOT INDICATED FOR INFANTS OR CHILDREN WHO HAVE NOT YET REACHED THEIR 13TH BIRTHDAY.

PERFORM CPR WHILE PREPARING FOR RHYTHM ANALYSIS AND DEFIBRILLATION.

a) Assess pulse.
   (1) Patients within the first hour after delivery, refer to Newly Born Protocol.
   (2) Patients from one hour after birth up to those who have not reached their 13th birthday, refer to the Universal Algorithm for Pediatric Emergency Cardiac Care for BLS.
   (3) Patients 13 years of age or greater, refer to the Universal Algorithm for Adult Emergency Cardiac Care for BLS.

High Quality CPR Reference Chart for All Ages

Component	Adults and Adolescents	Children (Age 1 Year to Puberty)	Infants (Age Less Than 1 Year, Excluding Newborns)
Compression-ventilation ratio without advanced airway	***1 or 2 rescuers*** 30:2	***1 rescuer*** 30:2 ***2 or more rescuers*** 15:2	
Compression-ventilation ratio WITH advanced airway	Continuous compressions at a rate of 100-120/min Give 1 breath every 6 seconds (10 breaths/min)		
Compression rate	100-120/min		
Compression depth	At least 2 inches (5 cm) Compression depth should be no more than 2.4 inches (6 cm)	At least one-third anterior-posterior diameter of chest About 2 inches (5 cm)	At least one-third anterior-posterior diameter of chest About 1½ inches (4 cm)
Hand placement	2 hands on the lower half of the breastbone (sternum)	2 hands or 1 hand (optional for very small child) on the lower half of the breastbone (sternum)	***1 rescuer*** 2 fingers in the center of the chest, just below the nipple line ***2 or more rescuers*** 2 thumb-encircling hands in the center of the chest, just below the nipple line

b) Assess for and manage profuse bleeding, using a method appropriate for the patient's injuries **(NEW ’20)**:
   (1) Direct pressure
   (2) Wound packing
   (3) Hemostatic gauze
   (4) Tourniquet or junctional tourniquet (with jurisdictional training)
c) Assess skin color, temperature, and capillary refill.

5. Disability
   a) Perform Mini-Neurologic Assessment (Pulse/Motor/Sensory).
   b) Spinal protection
      (1) The clinician shall determine the appropriate method to use in spinal protection of the patient. Infant or child car seats may NOT be used as a spinal immobilization device for the pediatric patient.
      (2) Patients who have a blunt trauma with a high-energy mechanism of injury that has potential to cause spinal cord injury or vertebral instability ***and*** one or more the following should receive spinal protection.
         (a) Midline spinal pain, tenderness, or deformity
         (b) Signs and symptoms of new paraplegia or quadriplegia
         (c) Focal neurological deficit
         (d) Altered mental status or disorientation
         (e) Distracting injury: Any injury (e.g., fracture, chest, or abdominal trauma) associated with significant discomfort that could potentially distract from a patient's ability to accurately discern or define spinal column pain or tenderness.

In addition to the above indicators for adults, the below apply to children who have not yet reached their 15th birthday.

         (f) Neck pain or torticollis
         (g) High-impact diving incident or high risk motor vehicle crash (head on collision, rollover, ejected from the vehicle, death in the same crash, or speed greater than 55 mph)
         (h) Substantial torso injury
         (i) Conditions predisposing to spine injury
      (3) If NO to all of the above, transport as appropriate.

IF PATIENT IS UNABLE TO COMMUNICATE OR APPROPRIATELY RESPOND TO THE ABOVE QUESTIONS, APPLY SPINAL PROTECTION PROTOCOL.

6. Exposure
   To assess patient's injuries, remove clothing as necessary, considering condition and environment.
7. Assign Clinical Priority
   a) Priority 1 — Critically ill or injured person requiring immediate attention; unstable patients with life-threatening injury or illness.
   b) Priority 2 — Less serious condition yet potentially life-threatening injury or illness, requiring emergency medical attention but not immediately endangering the patient's life.
   c) Priority 3 — Non-emergent condition, requiring medical attention but not on an emergency basis.
   d) Priority 4 — Does not require medical attention.
   e) In the event of a multiple casualty incident, the Simple Triage And Rapid Treatment (START and/or JumpSTART) technique will be instituted for rapid tagging and sorting of patients into priority categories for both treatment and transport.

8. Normal Vital Signs Chart

AGE	ESTIMATED WEIGHT	HEART RATE	RESPIRATORY RATE	SYSTOLIC B/P
Premature	**Less than 3 kg**	**160**	**Greater than 40**	**60**
Newborn	**3.5 kg**	**130**	**40**	**70**
3 mo.	**6 kg**	**130**	**30**	**90**
6 mo.	**8 kg**	**130**	**30**	**90**
1 yr.	**10 kg**	**120**	**26**	**90**
2 yrs.	**12 kg**	**115**	**26**	**90**
3 yrs.	**15 kg**	**110**	**24**	**90**
4 yrs.	**17 kg**	**100**	**24**	**90**
6 yrs.	**20 kg**	**100**	**20**	**95**
8 yrs.	**25 kg**	**90**	**20**	**95**
10 yrs.	**35 kg**	**85**	**20**	**100**
12 yrs.	**40 kg**	**85**	**20**	**100**
14 yrs.	**50 kg**	**80**	**18**	**110**
ADULT	**Greater than 50 kg**	**80**	**18**	**120**

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HISTORY AND PHYSICAL EXAMINATION

TRAUMA PATIENT

Significant MOI

Rapid Trauma Assessment

D Head
- Crepitation

C Chest
- Crepitation
- Respiration

A
- Paradoxical Motion
- Breath Sounds

P

B Abdomen
- Rigidity
- Distention

T Pelvis/GU
- Pain on Motion

L
- Blood, Urine, Feces

S Extremities
- Pulse/Motor/Sensory

Posterior

Baseline Vital Signs
Obtain **SAMPLE** History

Signs & Symptoms
Allergies
Medications
Pertinent History
Last Oral Intake
Events Prior

Non-Significant MOI

Determine Chief Complaint

D
C
A
P
B
T
L
S

Perform Focused Examination of the Injured Site and Areas Compatible with Given MOI

Baseline Vital Signs
Obtain **SAMPLE** History

Signs & Symptoms
Allergies
Medications
Pertinent History
Last Oral Intake
Events Prior

MEDICAL PATIENT

Unresponsive Patient

Rapid Physical Examination

D Head
- Neck
  - JVD
  - Medical Alert Device

C Chest
- Breath Sounds

A Abdomen
- Rigidity
- Distention

P Pelvis/GU
- Blood, Urine, Feces

B Extremities
- MSP
- Medical Alert Device

T Posterior

L

S

Baseline Vital Signs
Obtain History of Episode
Onset
Provocation
Quality
Radiation
Severity
Time

Obtain **SAMPLE** History

Responsive Patient

Obtain History of Episode

Onset
Provocation
Quality
Radiation
Severity
Time

Baseline Vital Signs
Obtain **SAMPLE** History

Signs & Symptoms
Allergies
Medications
Pertinent History
Last Oral Intake
Events Prior

Focused Physical Exam
DCAPBTLS

Check areas suggested by **MOI** and **SAMPLE**.

CONSIDER ALS, PERFORM INTERVENTIONS, AND TRANSPORT.

DETAILED AND ONGOING ASSESSMENTS

DETAILED EXAMINATION

D

HEAD
- Scalp & Cranium
  - Crepitation
- Eyes
  - Discoloration
  - Equality
  - Foreign Bodies
  - Blood in Anterior Chamber
- Ears & Nose
  - Fluid Drainage or Bleeding
  - Discoloration
- Mouth
  - Teeth & Foreign Bodies
  - Swelling or Lacerations
  - Breath Odor
  - Discoloration

C

NECK
- Jugular Vein Distention
- Trachea Position
- Crepitation

A

CHEST
- Paradoxical Motion
- Breath Sounds
- Crepitation

P

ABDOMEN
- Rigidity
- Distention

B

PELVIS/GU
- Pain on Motion

T

EXTREMITIES
- Pulse, Motor, Sensory
- Capillary Refill

L

POSTERIOR

S

ONGOING ASSESSMENT

MEDICAL PATIENT

REPEAT INITIAL ASSESSMENT

Reassess **AVPU**
Reassess Airway
Monitor Breathing
Reassess Circulation
Monitor Skin
Confirm Clinical Priority

REPEAT & RECORD VITAL SIGNS

REPEAT FOCUSED ASSESSMENT
Especially Chief Complaint or Injuries

CHECK ALL INTERVENTIONS

Assure Oxygen Adequacy
Check Bleeding
Check Interventions
Check for Trending
Stable Pt.- Every 15 Min.
Unstable Pt.- Recommend Every 5 Min.

TRAUMA PATIENT

REPEAT INITIAL ASSESSMENT

Reassess **AVPU**
Reassess Airway
Monitor Breathing
Reassess Circulation
Monitor Skin
Confirm Clinical Priority

REPEAT & RECORD VITAL SIGNS

REPEAT RAPID TRAUMA ASSESSMENT

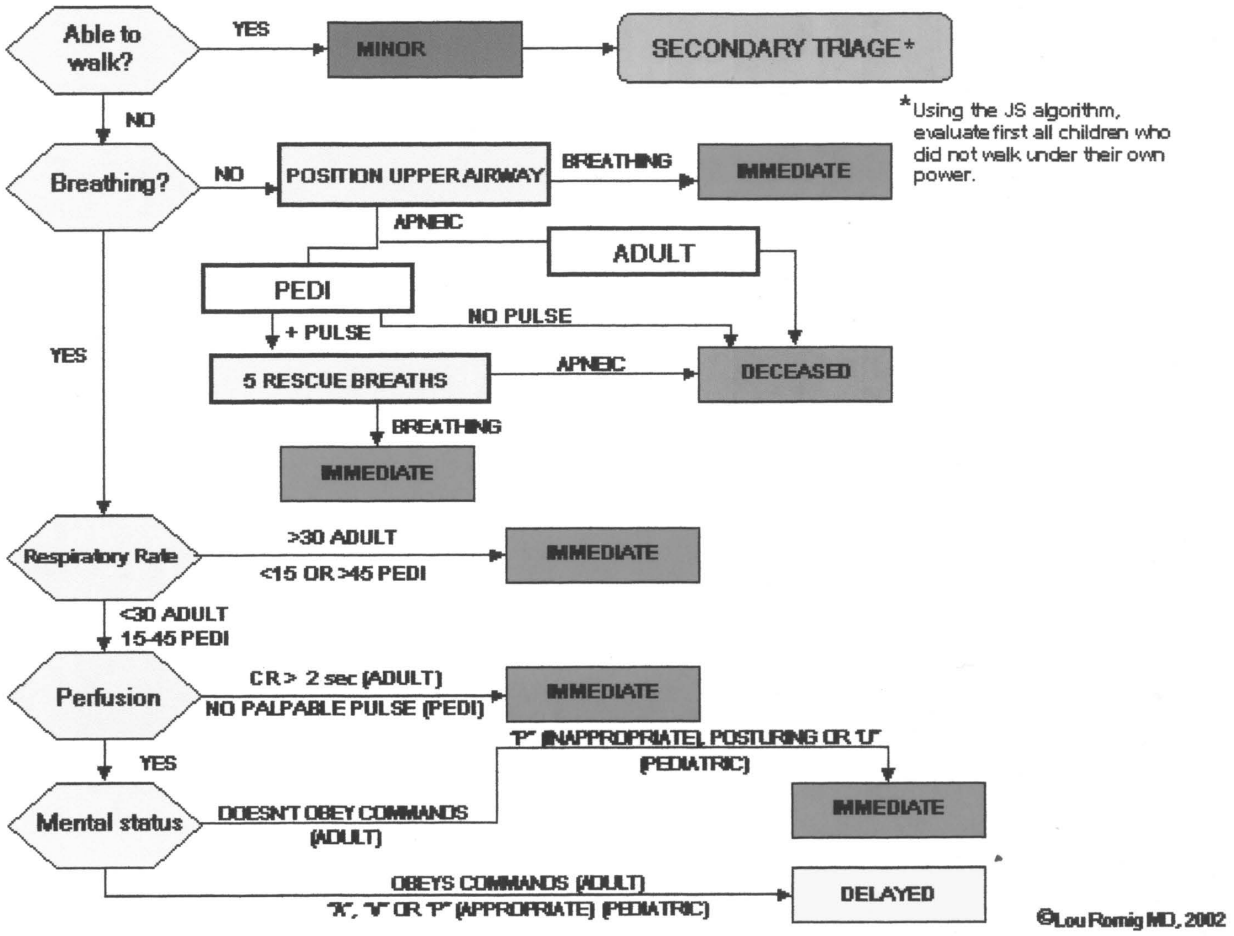
CHECK ALL INTERVENTIONS

Assure Oxygen Adequacy
Check Bleeding
Check Neck Stabilization
Check Interventions
Check for Trending
Stable Pt.- Every 15 Min.
Unstable Pt.- Recommend Every 5 Min.

CONSIDER ALS, PERFORM INTERVENTIONS, AND TRANSPORT.

Edition Date August 1, 2020
Release Date June 10, 2020

Combined START/JumpSTART Triage Algorithm



E. HISTORY AND PHYSICAL EXAMINATION/ASSESSMENT

1. Conduct a Focused Examination/Detailed Examination/Ongoing Assessment.

2. Collect and transport documentation related to patient's history (example: Emergency Information Form, Medic Alert, EMS DNR/MOLST, or jurisdictional form).

3. Clinicians should obtain and document a contact telephone number for one or more individuals who have details about the patient's medical history so that the physician may obtain and validate additional patient information.

4.  Obtain an EKG when appropriate.

ALL HEALTH CARE CLINICIANS ARE OBLIGATED BY LAW TO REPORT CASES OF SUSPECTED CHILD OR VULNERABLE ADULT ABUSE AND/OR NEGLECT TO EITHER THE LOCAL POLICE OR ADULT/CHILD PROTECTIVE SERVICE AGENCIES. DO NOT INITIATE REPORT IN FRONT OF THE PATIENT, PARENT, OR CAREGIVER (MD CODE, FAMILY LAW, § 5-704). UNDER MARYLAND LAW, EMS CLINICIANS ARE PROTECTED FROM LIABILITY IF THEY MAKE A REPORT OF CHILD/VULNERABLE ADULT ABUSE AND NEGLECT IN GOOD FAITH (COURTS AND JUDICIAL PROCEEDINGS ARTICLE § 5-620).

F. TREATMENT PROTOCOLS

1. Refer to **ALL** appropriate protocols.

2. Patients who have had an impaled conducted electrical weapon used on them will be transported to the nearest appropriate facility without dart removal (exception: Tactical EMS). ANY conducted electrical weapon dart impalement to the head, neck, hands, feet, or genitalia must be stabilized in place and evaluated by a physician. An assessment must be conducted to determine if the patient meets Excited Delirium Syndrome.

3. Clinicians may assist the patient or primary caregiver in administering the patient's prescribed rescue medication.
   a) BLS clinicians may assist with the administration of the patient's fast-acting bronchodilator MDI and sublingual nitroglycerin.
   b) ALS clinicians may administer the patient's prescribed benzodiazepine for seizures, Factor VIII or IX for Hemophilia A or B, or reestablish IV access for continuation of an existing vasoactive medication.
   c) Clinicians should obtain on-line medical direction to administer other prescribed rescue medications not specifically mentioned in *The Maryland Medical Protocols for Emergency Medical Services* (e.g., hydrocortisone (Solucortef) for adrenal insufficiency). The rescue medication must be provided by the patient or caregiver and the label must have the patient's name and the amount of medication to be given.

DO NOT ADMINISTER ORAL MEDICATIONS (EXCEPT GLUCOSE PASTE) TO PATIENTS WITH AN ALTERED MENTAL STATUS.

4. For pediatric patients
   a) Pediatric section of the treatment protocol will be used for children who have **not** reached their 15th birthday (trauma) or their 18th birthday (medical), except as otherwise stated in the treatment protocol.
   b) Medication dosing
      (1) Pediatric doses apply to patients weighing less than 50 kg.
      (2) For pediatric patients equal to or greater than 50 kg, utilize adult dosing.

   c) The developmental age of the infant/child must be considered in the communication and evaluation for treatment.
      Destination consideration:
      For those patients who are 18 years of age or older who receive specialized care at a pediatric facility, consider medical consultation with a Pediatric Base Station for patient destination.
   d) Infants and children must be properly restrained prior to and during transport.
   e) A parent/guardian/care taker may remain with a pediatric patient during transport, but must be secured in a separate vehicle restraint system at all times during transport.

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G. COMMUNICATIONS

1. Communications with and through EMRC/SYSCOM are recorded. In addition, as part of the quality assurance and quality improvement process, communications with hospitals are frequently recorded. Therefore, you should assume that all your communications among EMS clinicians, hospitals, public safety communications centers, and EMRC/SYSCOM are being recorded.

ANY PATIENT WHOM THE CLINICIAN IDENTIFIES AS MEETING ANY "SPECIALTY" ALERT (E.G., TRAUMA, STEMI ALERT, STROKE ALERT, SEPSIS ALERT) REQUIRES A HOSPITAL NOTIFICATION, AND WHEN INDICATED BY PRIORITY OR NEED FOR INTERVENTION WILL HAVE ONLINE MEDICAL CONSULTATION THROUGH EMRC ON A RECORDED LINE (RADIO OR PHONE).

2. All **Priority 1** patients require online medical consultation through EMRC on a recorded line (radio or phone).
3. All **Priority 2 patients who need further therapeutic intervention(s)** that require on-line medical consultation approval shall perform on-line medical consultation through EMRC on a recorded line (radio or phone).
4. For **Priority 2 patients who have persistent symptoms but who do not need therapeutic intervention(s**) requiring on-line medical consultation approval, clinicians shall notify the receiving facility with an "information only call" through EMRC on a recorded line (radio or phone).
5. For **Priority 2 patients whose symptoms have resolved** and **Priority 3 patients** whose vital signs are within normal limits, notification may be made through EMRC on a recorded line (radio or phone) or through an EOC/EMS communication system in accordance with the standard operating procedures of the local jurisdiction.

ONLINE MEDICAL CONSULTATION MAY BE OBTAINED AT ANY TIME FOR ANY PATIENT, IF DESIRED BY THE PREHOSPITAL EMS CLINICIAN. PEDIATRIC AND SPECIALTY CONSULTATION IS ENCOURAGED FOR TRAUMA AND MEDICAL PATIENTS. CONSULTATION WITH PEDIATRIC AND SPECIALTY CENTERS SHALL OCCUR SIMULTANEOUSLY WITH A BASE STATION CONSULT.

6. If medical consultation is genuinely unavailable, or if the time necessary to initiate consultation significantly compromises patient care, the clinician shall proceed with additional protocol directed care, so long as transport will not be significantly delayed. "Exceptional Call" must be indicated on the Patient Care Report (PCR).
7. Core essentials for communications:
   a) Assigned patient priority (1 to 4)
   b) Age
   c) Chief complaint
   d) Clinician impression
   e) Pertinent patient signs and symptoms (e.g., HR, RR, BP, Pulse Ox, and GCS) (be specific–do not use within normal limits or stable in description)
   f) Pertinent physician findings
   g) ETA

In addition, for specialty center patients:

Trauma

h) Patient Trauma Decision Tree Category (Alpha, Bravo, Charlie, Delta)
i) Number of victims if more than one
j) Describe mechanism

Stroke

k) Last known well time
l) Specific neurological findings (sensory, motor, cognitive)
m) Upon positive assessment using the Cincinnati Stroke Scale, a STROKE alert shall be made and the LAMS score will be included in the consult.

STEMI

n) 12-Lead interpretation
o) Duration of symptoms

CONSIDER ACTIVATION OF THE GO-TEAM FOR SERIOUSLY INJURED PATIENTS WHO REQUIRE A PROLONGED EXTRICATION AND WHO MEET THE INDICATIONS FOR GO-TEAM ACTIVATION.

8. Mass Casualty Incident (MCI) Communications
   a) When a local jurisdiction declares an MCI, it is extremely important to maximize patient care resources and reserve EMS communications for emergent situations. Except for extraordinary care interventions, EMS clinicians may perform all skills and administer medications within protocol during a declared MCI. When the MCI condition is instituted, the Exceptional Call box must be checked on the PCR.
   b) During an MCI, the EMS Officer-in-Charge (OIC) shall designate an EMS Communicator who shall establish appropriate communications.
   c) Reference the Multiple Casualty Incident/Unusual Incident Protocol.

H. REASSESSMENT

1. Reassess unstable patients frequently (recommended every 5 minutes).
2. Reassess stable patients at a minimum of every 15 minutes.
3. Reassess patients being discharged to home or long-term care at the beginning and end of the transport or more frequently, at the clinician's discretion.

I. DISPOSITION

1. Destination
   a) Priority 1 patients shall be triaged according to Maryland Medical Protocols to the closest appropriate hospital-based emergency department, designated trauma, or designated specialty referral center. Critically unstable patients in need of immediate life-saving interventions that cannot be provided in the field shall, with the approval of EMS system medical consultation, be diverted to the closest facility (including freestanding emergency medical facility) capable of immediately providing those interventions.
   b) Priority 2 patients shall be triaged according to the Maryland Medical Protocols to the closest appropriate hospital-based emergency department, designated trauma or designated specialty referral center unless otherwise directed by EMS system medical consultation. Stable Priority 2 patients may be referred to a freestanding emergency medical facility.
   c) Stable Priority 3 or 4 patients who do not need a time-critical intervention may be transported to the local emergency department or freestanding emergency medical facility.
   d) Patients Under Investigation (PUI) for an Emerging Infectious Disease (EID) at a residence should be transported directly to an Assessment Hospital unless total transport time is no longer than 45 minutes greater than transport to the nearest Frontline Hospital ED. If transport time is longer than 45 minutes greater than transport to the nearest Frontline Hospital ED, the patient must be transported to the closest appropriate Frontline hospital. Priority 1 and Priority 2 patients with unresolved symptoms that cannot be managed outside the hospital should be taken to the closest Frontline Hospital. Receiving hospital notification of all suspected PUI patients should be done as early as possible to allow for hospital staff to prepare. Helicopter transport is NOT indicated for the PUI patient.
   e) For Priority 2 and Priority 3 patients not meeting a specialty center destination care protocol, the EMS clinician should ask if the patient has had a hospital admission (inpatient service) within the last 30 days. If the answer is yes, the EMS clinician should transport (repatriate) the patient to that hospital as long as that hospital is not more than 15 additional minutes further than nearest hospital (or greater if allowed for by the EMS Operational Program).
2. Mode of transport (air, land, water)
   a) Medevac patients with indications for specialty referral center should be flown to the appropriate type of specialty center if not more than 10–15 minutes further than the closest trauma center. (Patients with an airway, breathing, or circulatory status who would be jeopardized by going an additional 10–15 minutes should go to the closest trauma center.)
   b) Consider utilization of a helicopter when the patient's condition warrants transport to a trauma or specialty referral center and the use of a helicopter would result in a clinically significant reduction in time compared with driving to a trauma/specialty center.

ALL REQUESTS FOR SCENE HELICOPTER TRANSPORTS SHALL BE MADE THROUGH SYSCOM.

FOR TRAUMA DECISION TREE CATEGORY CHARLIE OR DELTA, RECEIVING TRAUMA CENTER MEDICAL CONSULTATION IS REQUIRED WHEN CONSIDERING WHETHER HELICOPTER TRANSPORT IS OF CLINICAL BENEFIT.

c) If the time of arrival at the trauma or specialty referral center via ground unit is less than 30 minutes, there will generally be no benefit in using the helicopter, especially for Trauma Decision Tree categories Charlie and Delta.
d) Refer to the Trauma Decision Tree when considering use of aeromedical transport. Provide SYSCOM with the patient's category (Alpha, Bravo, Charlie, or Delta).
e) On-line medical direction should be obtained from the local trauma center and the specialty referral center when transport to the specialty center would require more than 10–15 minutes additional transport time.
   (1) Pediatric Trauma Patients: Indications as per the pediatric section of the Trauma Protocols.
   (2) Spinal Trauma Patients: Indications as per Spinal Protection Protocol.
   (3) Burn Patients: Indications as per Burn Protocol. Special note: Isolated burn patients without airway injury or other associated trauma should normally be flown to a burn center, regardless of the location of the closest trauma center.
   (4) Hand Injury Patients: Indications as per Hand Trauma Protocol. Special note: Medevac patients with appropriate indications for hand center referral should normally be flown to the hand center, regardless of the location of the closest trauma center.

3. Status

   Evaluate the need for emergent versus non-emergent transportation.

DO NOT WAIT ON-SCENE FOR ADVANCED LIFE SUPPORT. ATTEMPT TO RENDEZVOUS EN ROUTE TO THE HOSPITAL.

J. TRANSFER OF CARE/RENDEZVOUS AND TRANSITION OF PATIENT CARE ALS TO BLS

The ALS clinician-patient relationship is established when the ALS clinician initiates patient assessment and

1. ALS medication(s)* is/are administered or
2. ALS procedure(s)* is/are performed or
3. Upon ALS clinician assessment of the patient there is potential risk of deterioration.

* Based on the medication or procedure as listed in the protocol pages 182–185

ALS clinicians may only terminate their EMS clinician-patient relationship when they are assured that the patient will continue to receive care at the same or greater levels, or when they have documented with on-line medical direction that the patient's condition has improved and that patient care may be transferred safely to an EMS clinician with a lower scope of practice.

BLS clinicians have the right to decline the transition of patient care. When consensus between the clinicians cannot be gained, ALS shall get on-line medical direction.

Clinicians will relay assessment findings and treatment provided to the individual(s) assuming responsibility for the patient(s). Should an ALS clinician perform an EKG (of any type), it shall be imported into the patient care report and a copy shall be sent with the BLS unit to the receiving facility. **(NEW '20)**

K. DOCUMENTATION

A Patient Care Report (PCR) will be completed and delivered to the receiving facility as soon as possible, ideally upon transfer of care. If this is not immediately possible, clinicians must provide documentation of the patient's prehospital care on a template and in a format provided or approved by MIEMSS for inclusion in the patient care record before leaving the receiving facility, then deliver the completed PCR within 24 hours after dispatch, in compliance with COMAR 30.03.04.04.

Only the unit that pronounces death will select the "Dead on Scene" option in the PCR (eMEDS®) and thus all other units will report "Operational Support Only." If no interventions are performed, the highest level EMS clinician on scene will pronounce death and document "Dead on Scene." If BLS care was rendered by a BLS unit and then termination of resuscitation and pronouncement of death occurred, the BLS unit will select "Dead at Scene with BLS Intervention" option on the eMEDS® PCR. If ALS care was rendered by an ALS unit and then termination of resuscitation and pronouncement of death occurred, the ALS unit will select "Dead at Scene with ALS Intervention" option on the eMEDS® PCR.

L. CONFIDENTIALITY

Patient confidentiality must be maintained at all times.

M. PROFESSIONAL CONDUCT

All patients should be treated with dignity and respect in a calm and reassuring manner.