Technicians may only provide care that has been approved by the Operational Medical Director of each respective agency. In special situations, an on-line physician may authorize an ALS technician to perform a procedure outside the area guidelines but within the scope of the technician's training.

The Operational Medical Director must approve changes in medical procedures.

All issues that cannot be solved locally to the satisfaction of all those concerned may be brought to the Medical Direction Committee for recommendation.

The Operational Medical Director of each agency is ultimately responsible for all patient care. Therefore, the OMD has the right to suspend an ALS technician who fails to perform his/her duty as trained.

In order to practice as an ALS technician in this area, the technician must have the approval of the agency OMD and be released by their primary EMS agency as an EMT attendant-in-charge (AIC).

If in a life or death situation, a sole Junior ALS technician may provide ALS care within the scope of their training.

Anytime a technician operates outside the established regional guidelines, the technician should notify their OMD and may be subject to review by the OMD and/or the Medical Direction Committee.

Technicians are highly encouraged to attend all meetings where ALS calls run by their agency are discussed, and where both practical and lecture materials are reviewed.

ALS providers who are trained outside the TJEMS region and for those who are trained through a non-UVA training program must have a session involving their agency OMD or designee to evaluate their knowledge of the TJEMS Regional Guidelines as well as orient to the training and reporting process for this region with the UVA Pre-hospital program prior to actual field practice as an ALS provider.
DNR/DDNR Patients

Indications:
- Pulseless, non-breathing patient who would normally require resuscitation AND
- Possess and have on-scene, properly completed Virginia DDNR form or POST form, Section A or approved jewelry.

Procedure:
- Verify that the patient is the person named on the DDNR form.
- Cease all resuscitation efforts.
- Notify law enforcement.
- If the DDNR is imprinted with a number, this number should be documented on the PPCR/ePPCR. If the DDNR does not have a number, the provider should document the physician who signed the DDNR and their contact number.

Considerations:
- If the patient requires care and is NOT in cardiac arrest, provide care up to the limits of the DDNR and transport patient and DDNR form.
- Pre-hospital providers cannot honor other legal documents (living wills, etc.) without contacting medical command.
- DDNR forms may be overridden by patient.
- Physician Orders for life-Sustaining Treatment - forms are also acceptable, as are out-of-state DNR

Deceased Patients

Indications:
- Rigor mortis and/or lividity
- Decapitation
- Traumatic cardiac arrest upon arrival

Procedure:
- Do not resuscitate any patient who meets the above criteria.
- Notify law enforcement, if not already done so by local communications center.
- Have only 1 provider (AIC) enter the scene to confirm death via listening to apical heart sounds. Make all attempts not to disturb the scene.
- If resuscitation efforts are in progress medical command must be contacted for orders to discontinue efforts (see Documentation Policy).
The following policy outlines the minimum documentation required for each patient contact.

- **History of present illness**
  - Includes chief complaint, SAMPLE, OPQRST, and pertinent negatives

- **Physical exam**
  - Use of body systems approach is recommended

- **Complete vital signs are defined as pulse, respirations and BP (add GCS)**
  - May include pulse oximetry, capnography and pain scale as indicated,
  - Repeat and document every 15 minutes for stable patients and every 5 minutes for unstable patients,
  - Repeat and document after every medication administration,
  - BP not required in children under 3 years but parameters of perfusion should be assessed and documented (skin condition, capillary refill, mental status, distal vs. peripheral pulses),
  - Record the time all vital signs are taken,
  - Any abnormal vital sign should be repeated and closely monitored

- **Use only standard medical abbreviations.**

- **Medication administrations should include dosage, route of administration, and time of administration, assessment of response and provider who administered medication.**

- **Treatments should be listed and documented with time of procedure and provider who performed procedure as well as assessment of response.**

- **For immobilization of extremity or spine, document pulse, motor and sensation prior to and after immobilization.**

- **For IV administration, document size of catheter, location of placement, provider who initiated IV, number of attempts, type of fluid, flow rate and total amount of fluid infused at time of transfer of care. The IV site should also be labeled “field” and the gauge of the catheter.**

- **ECG interpretations should be documented. Attachment of printed strip to PPCR is recommended. Any changes in rhythm should be documented.**

- **12-leads performed in the field should be documented on the PPCR/ePPCR. A copy of the 12-lead attached to the PPCR/ePPCR is recommended.**

- **Advanced airway documentation should include method of confirmation, size of device, number of attempts, capnography and SAO2 readings, provider performing procedure, centimeters at teeth (ETT only). A separate regional airway form is also required.**

- **Medical Command orders requested (whether approved or denied) should be documented with time and name of physician as well as the exact order given. Obtain physician signature on arrival at hospital.**

- **Waste of narcotic administration must be documented with name of person wasting, witness and the amount and name of medication wasted.**

- **A copy of the PPCR should be turned over to receiving nurse as promptly as possible (this becomes part of the patient’s chart). A copy is turned into pharmacy if drug box is exchanged. If the drug box is not exchanged, a copy is turned into ED registration. The white copy is the original to be retained by the transporting agency.**
The TJEMS Drug Box Program Best Practices relate to the use of the TJEMS Drug Box. These best practices sever to provide guidance on the acquisition, storage, usage and maintenance of the drug box system. Local pharmacies may issues policies that supersede or supplement these best practices. The success of the drug box program is based on the full understanding and support of the system by EMS providers, hospital pharmacists, Operational Medical Director and emergency department attending physicians. Please contact Thomas Jefferson EMS Council at (434) 295-6146 if you have any questions or need assistance.

1. Exchanging Used Drug Boxes
   1.1. A printed or written call sheet with documented administered medication must accompany a drug box when being exchanged. Every effort should be made to include the patient’s name, date of birth, incident date and Attendant-in-Charge name. A physician signature is ONLY required if there is a variance from standing protocol. The pharmacy representative will open the out-going drug box and verify with an EMS provider the count of controlled substances (CII-V) and seal the drug box.
   1.2. If a patient is transported to a hospital not participating in the TJEMS drug box exchange, pronounced dead on scene or transferred to another agency and the drug box cannot be immediately exchanged, the following steps should be taken:
       1.2.1. Verify all unused controlled substances (CII-V)
       1.2.2. Seal the box with a different colored tag not utilized by participating hospitals
       1.2.3. Document new tag number on/in PPCR/ePPCR
       1.2.4. Write “used” across a piece of tape and place on top of box
       1.2.5. Place competed PPCR/ePPCR with used drug box
       1.2.6. Secure drug box in approved area until exchange
       1.2.7. Every effort should be made to exchange used drug box within 48 hours.

2. Broken Drug Box Seals or Missing Controlled Substances
   2.1. Drug boxes are to be sealed at all times.
2.2. Should a seal be accidentally broken, or a drug box opened but not used, the controlled substances (CII-V) should be immediately verified and the box returned to the hospital/pharmacy to be exchanged.

2.3. Should an EMS provider find a box with a broken seal, the contents need to be inspected and inventoried. If there are controlled substances missing (Fentanyl®, morphine, Ketamine® or Versed®) or the drugs appear to have been tampered with, take the following actions:

2.3.1. Limit additional handling the box.
2.3.2. Notify local law enforcement.
2.3.3. Notify the hospital pharmacy where the box was packed.
2.3.4. Notify the agency Chief or Captain.
2.3.5. Complete and file a drug diversion form with the Office of EMS (see 12 VAC 5-31-520, D of the Virginia EMS Rules and Regulations); http://www.vdh.virginia.gov/OEMS/files_page/regulation/DrugDiversionForm.pdf
2.3.6. Have drug box inspection forms ready for police, pharmacy and Office of EMS personnel.

2.4. If the seal on the drug box is discovered missing while performing patient care or after arriving at the hospital:

2.4.1. Continue patient care, you may continue to utilize the contents of the box.
2.4.2. If the drug needed is not present consider requesting another unit to meet en route, but do not delay transport.
2.4.3. Follow the procedures listed above.

3. Drug Box Content Problems

3.1. From time to time the field provider may open a drug box to find certain medications, fluids or other supplies missing or the box may not be stocked appropriately. In these cases, a “Drug Box Incident Report” should be completed by the field provider finding the problem. After completion, the form should be returned to the pharmacy in the drug box, a copy should be faxed to TJEMS (434-295-2009) and a copy should be retained by the EMS agency. “Drug diversion” should also be reported to the Virginia Office of EMS (refer to section 2.3.5).
3.2. If the problem with a drug box is found by pharmacy staff, the “Drug Box Incident Report” should be completed and forwarded to TJEMS.

3.3. The “Drug Box Incident Reports” are stocked in the drug boxes.

4. Drug Box Inventory

4.1. An inventory of all drug boxes is to be performed by each EMS agency on a routine basis. The inventory should track drug box expiration dates and be performed with a frequency such that drug boxes do not expire. An agency may only exchange two (2) expired drug boxes at a time. The boxes should be exchanged prior to the expiration date. Pharmacies are not expected to exchange expired drug boxes after hours and on weekends.

5. Storage and Security of Drugs and Related Supplies

5.1. An area used for storage of drugs and administration devices and a drug kit used on an EMS vehicle shall comply with requirement established by the Virginia Board of Pharmacy and the applicable drug manufacturer’s recommendations for climate-controlled storage.

5.2. Drug and drug kits shall be maintained within their expiration date at all times.

5.3. Drug and drug kits shall be removed from vehicles and stored in a properly maintained and locked secure area when the vehicle is not in use unless the ambient temperature of the vehicle’s interior drug storage compartment is maintained within the climate requirements specified in this section.

5.4. An EMS agency shall notify the Office of EMS in writing of any diversion of (i.e. loss or theft) or tampering with any controlled substances, drug delivery devices or other regulated medical devices from an agency facility or vehicle. Notification shall be made within 15 days of the discovery of the occurrence.

5.5. An EMS agency shall protect EMS vehicle contents from climate extremes.

Reference: Virginia EMS Regulations 12 VAC 5-31-520.

6. Drug Box Acquisition and Entry Into the System

6.1. When an agency places an ALS vehicle in service, the agency is required to contact TJEMS for advisement of the appropriate drug boxes to be purchased. Before being
placed into the system, the drug boxes are assigned an inventory control number and are labeled by TJEMS. After receiving inventory control numbers and labeling, the boxes are taken by the agency to the closest pharmacy for initial stocking. The pharmacy will advise when the stocked drug box may be picked up by the agency.

7. **Drug Box Cleanliness**

7.1. When a drug box is used, the EMS provider is responsible for disposing of all opened or used sharps and other trash that may be in the box prior to returning the box to the pharmacy for exchange. In addition, the boxes should be cleaned and free of blood or other body fluids.

7.2. Before accepting a drug box for exchange, pharmacy staff should check to ensure that the box is clean and free of exposed sharps. If it is not, pharmacy staff should advise the EMS provider of this and require the box to be cleaned before making the exchange. If the event the box is left at the hospital during hours the pharmacy is not open, or in an ED exchange lockers, the receiving pharmacy should contact that agency and require that a representative of the agency respond immediately to clean the box. Pharmacy personnel should also complete a “Drug Box Incident Report” and forward the report to TJEMS.

8. **Drug Box Contamination and Decontamination**

8.1. It is recommended that providers access the drug box with clean hands. If possible, providers should change gloves or use hand sanitizer after providing direct patient contact.

8.2. Pharmacies will not accept boxes visibly contaminated with blood/body fluid or that have potentially been contaminated by VRE, GRE, MRSA or *C. diff (Clostridium difficile)*.

8.3. Procedures for cleaning drug boxes that are contaminated with known VRE, GRE, MRSA and *C. diff*.

8.3.1. Contamination is defined as known or suspected exposure to blood or body fluid.

8.3.2. In order to avoid contamination of the drug box, ensure that the contents of the drug box must only be touched by “clean” hands. If a gloved provider just touched a patient, they would have to remove the gloves, cleanse their hands, handle the drug, and then put gloves back-on. Or the other provider could be considered “clean” and not touch anything dirty and be responsible for handling the medications.
8.3.3. If at any time contamination is suspected, proceed with the following:

8.3.3.1. Two (2) providers will be needed
8.3.3.2. First provider holds clean basin (obtain from ED staff). Be sure that clean basin is not placed on any contaminated surface.
8.3.3.3. Second provider wears gloves and empties all medications in plastic bag into clean basin. All medications that are not in plastic bags will be discarded into Contaminated Material Boxes.
8.3.3.4. Empty drug boxes along with contaminated surfaces in ambulance must be cleaned with approved cleaner.
   8.3.3.4.1. VRE, GRE, MRSA use hospital provided cleaner
   8.3.3.4.2. C. diff. bleach wipes must be used
8.3.3.5. Rewrite ambulance report on a clean form. ADD “Drug box has been decontaminated. Medications not in plastic bags have been placed in CMC box and medications in plastic bags have been returned in clean basin.”
8.3.3.6. If controlled medications (CII-V) were not in plastic bag or have been contaminated, waste the medication in the presence of another EMS provider as witness.
8.3.3.7. Bring clean drug box, re-written and/or clean call sheet and basin of clean medications to pharmacy for drug box exchange.
8.3.3.8. Boxes used but not contaminated, it is recommended that they be completed wiped down externally before exchanging in pharmacy after use.

9. Disposal of Partially-Used Controlled Medications
9.1. Partially used controlled substances (CII-V) not administered to the patient will be discarded at the hospital. The disposal must be witnessed by an EMS provider. The witness must counter-sign the Patient Care Report or designated form, where the advanced life support (ALS) provider has clearly indicated the medication wasted.

10. Variance of Drug Box Contents
10.1. Any variance of drug box contents should be communicated to TJEMS Pharmacy Committee group via email. Variances should include:
   10.1.1. Decrease in par level due to shortage
   10.1.2. Substitution of drug or supply contents
10.1.3. Medication variances will be noted on the white sticker located on top of the drug box.
Information on EVD is a dynamic situation; therefore information in this guideline may change frequently. Updates to this guideline will be posted on the TJEMS website (www.tjems.org) as they are made. At all times administrative personnel/providers/etc. are to follow the recommendations of the CDC.

**PSAP (public safety answer point):**

- During call taking process the Communication Officer are encouraged to:
  - Use travel screening tool (See Appendix A)
    - Call types to use screening tool
      - Sick person
        - N/V, fever, malaise, muscle aches, fatigue, headache, weakness
      - Hemorrhage (internal or non-traumatic)
      - Chest pain
      - Respiratory distress
      - Abdominal pain
      - Seizure
      - Unresponsive
  - Communication Officers will alert dispatched unit using the following designated regional alert information, if travel screening tool is positive:
    - Use “Fever/travel precautions” to alert responders to what type of patient they may be dealing with.
    - This designation may be different in other Regional EMS Council areas.
    - Modified responses may be in order in an effort to minimize personnel exposure
      - Recommendation for a "single" unit response (i.e. no fire apparatus, ambulance only)

**Agency Responders**

- Upon arrival
  - Send a **single responder**, adequately trained in and equipped with appropriate PPE, to:
    - Re-confirm travel screen
    - Assess patient:
      - Minimally ill patients
        - Assessment = pulse
      - More seriously ill patients
        - Assessment should be made through an indirect method (i.e.
If travel screen is confirmed to be positive, the provider should then:
- Obtain a phone number in order for VDH staff to contact the patient directly
- Call Virginia Department of Health
- Normal business hours 8am – 430pm, Monday – Friday
  - Planning District 10
    - 1-434-972-6200
  - Planning District 9 (for Madison County)
    - 1-540-948-5481
  - After hours, weekend, holidays
    - 1-866-531-3068
    - Call Order:
      - Dr. Denise Bonds = 1-434-972-6226
      - Ryan McKay = 1-434-964-8662
- Providers should expect the VDH staff to:
  - Ask further questions in regards to the travel screen
  - What type of exposures they would have had
  - Travel dates
  - Make transport decision and contact hospital in addition to the provider

Transport
- If EMS transport is determined to be necessary
  - Patient
    - Place a surgical mask on patient
  - Provider
    - Limit the number of providers in the back of the unit
  - Unit
    - Patient compartment must be “sheeted” with minimally 3mil plastic sheeting taped to the ceiling of unit using painters tape.
    - Non-disposable equipment should be moved to an exterior compartment and/or passenger seat.
    - Disposable equipment may also be moved to prevent contamination.
  - If patient is ambulatory
    - Have patient move to the unit under their own power
  - If patient is not ambulatory
    - Contact appropriate communication center; request additional personnel to respond to scene for vehicle operation and preparedness.
  - Provider is to contact appropriate hospital with a patient report via land-line (preferred), if not feasible, then radio communication can be done using the regional alert designation
- Transport to destination as facilitated by VDH.
  - UVA – transport to loading dock
    - 1-434-924-9287 to make report
  - MJH/Sentara – transport to ED
    - 1-434-654-7150 to make report
- Upon arrival at facility
  - Attendant is to remain in unit with patient
    - UVA
      - Personnel will meet unit to escort patient and crew to appropriate location
    - MJH/Sentara – ED
      - Further direction will be given upon arrival at facility
    - Other facilities
      - Follow direction of the facility

Post transport
- Providers
  - Decontamination –
    - Providers will doff and dispose of PPE utilizing CDC recommendations
      - see CDC recommendations for doffing PPE at: [http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html](http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html)
    - In appropriate area
    - The use of the “buddy system” is required
- Ambulance –
  - Decontamination
    - See appendix B
- Waste
  - If patient is transported, waste is to be left at facility
  - No patient transport
    - Follow DEQ (Virginia Dept. of Environmental Quality) recommendations at: [www.deq.virginia.gov](http://www.deq.virginia.gov)

Provider return to service criteria
- Follow recommendations of VDH
Order of substitute decision makers for incompetent patient (Virginia Code § 54.1-2986)

1. “A guardian for the patient. This subdivision shall not be construed to require such appointment in order that a health care decision can be made under this section”; or
2. “The patient's spouse except where a divorce action has been filed and the divorce is not final”; or
3. “An adult child of the patient”; or
4. “A parent of the patient”; or
5. “An adult brother or sister of the patient”; or
6. “Any other relative of the patient in the descending order of blood relationship”

Note: Girl/Boyfriends, neighbors or others with no blood relationship DO NOT qualify as legal substitute decision makers.

Criteria for any ECO: a condition that is an immediate or imminent life threat with

- A patient who “because of mental illness....or any other mental disorder or physical disorder which precludes communication or impairs judgment, is incapable of making an informed decision about providing, withholding or withdrawing a specific medical treatment…”
- Note religious caveat (i.e. Jehovah Witness) that “no person shall authorize treatment…that such person knows is contrary to the religious beliefs of the patient unable to make a decision, whether expressed orally or in writing.”
- Virginia Code § 16.1-336. Definitions:
  - “Consent” means the voluntary, express and informed agreement to treatment in a mental health facility by a minor fourteen years of age or older and by a parent or a legally authorized custodian.
  - “Incapable of making an informed decision” means unable to understand the nature, extent or probable consequences of a proposed treatment or unable to make a rational evaluation of the risks and benefits of the proposed treatment as compared with the risk and benefits of alternatives to the treatment. Persons with dysphasia or other communication disorders who are mentally competent and able to communicate shall not be considered incapable of giving informed consent.

Psych ECO (Virginia Code § 37.2-808)

Does NOT require a physician assessment to get from magistrate – family or witness to suicidal thoughts/actions/evidence of significant risk of self-harm can call magistrate and request if there exists “probable cause to believe that any person (i) has a mental illness and that there exists a substantial likelihood that, as a result of mental illness, the person will, in the near future, (a) cause serious physical harm to himself or others as evidenced by recent behavior causing, attempting, or threatening harm and other relevant information, if any, or (b) suffer serious harm due to his lack of capacity to protect himself from harm or to provide for his basic human needs, (ii) is in need of hospitalization or treatment, and (iii) is unwilling to volunteer or incapable of volunteering for hospitalization or treatment.”
Medical ECO (Virginia Code § 37.1-134.21, § 37.2-1103)

Emergency custody orders for adult persons who are incapable of making an informed decision as a result of physical injury or illness.

Requires:

Application by a licensed physician verifying that the "adult patient is incapable of making an informed decision as a result of physical injury or illness AND that the medical standard of care indicates that testing, observation and treatment are necessary to prevent imminent and irreversible harm."

The physician's opinion of incapacity shall only be rendered after:

- Either personal evaluation or electronic communication with EMS personnel on-scene regarding their evaluation
- An attempt to communicate directly (or electronically) with the adult person to corroborate the EMS assessment of incapacity
- An attempt has been made to obtain consent from the adult person
- The adult person has failed to consent

The magistrate shall ascertain that the adult person:

- Has no legally authorized person to give consent AND
- Is incapable of making an informed decision regarding necessary treatment AND
- Has refused transport AND
- Has indicated intention to resist transportation AND
- Is unlikely to become capable of making an informed decision within the time required.

Should the patient's condition change and the patient becomes capable of making an informed decision (i.e. hypoglycemia resolved), the physician must be contacted and the patient's wishes respected.

Information needed from you for magistrate to issue medical ECO ("adult person" = patient):

- Name and permanent address of "adult person" if known,
- Name of law enforcement agency on-scene (+ officer, badge # if possible)
- Name, hospital affiliation and contact number of licensed physician requesting ECO
- Present location of "adult person"
- Name and address of hospital that "adult person" is to be transported to (UVA Hospital, 1215 Lee Street, Charlottesville, VA 22908).

You may also be asked what evaluation you plan to undertake. Since you haven't seen the patient yet, but you can't legally do anything that isn't on the order unless the patient consents, you may want to be fairly broad here. Some options may be: physical exam, radiologic studies (potentially including CT scan and MRI), intravenous access, medication therapy, possible mechanical ventilation, hospital admission, laceration repair, fracture management, etc.
In the majority of situations, on-line medical command provided by hospital based communication services will meet the needs of providers faced with situations that required medical command to initiate procedures/treatments or are not addressed with standing orders or guidelines.

In the case where medical command has been sought and received, the provider will be expected to follow those orders. If the on-line medical command orders are contradictory to local guidelines, or exceed the training/certification of the provider(s), then the on-line medical command physician needs to be informed immediately that the orders cannot be carried out. In the event that there is a disagreement between the provider and the onlined medical command physician, the provider must communicate that concern to the medical command physician, and describe the reason(s) for concern in following the orders. Once this communication has occurred, if the recommended orders are within the training/certification of the provider(s) and in keeping with regional guidelines, then those orders will be expected to be carried out.

In the event that there is a disagreement between the provider(s) and the on-line medical command physician, the provider may consult with their agency OMD regarding the patient’s care as long as the agency OMD is immediately available to provide medical command. If agency OMD is immediately available and willing to assume medical command, then the agency OMD will become the on-line medical command physician on that call. The provider involved is responsible to notify the previous on-line medical command provider that this change has occurred.

If there is a physician on-scene who is adequately identified to the providers, is qualified and willing to assume responsibility for direct medical command, then that physician’s orders will supersede on-line medical command. An EMS physician who is on-scene may assume medical command even if they are not the agency OMD for the providers involved in the patient’s care.
When requesting helicopter medevac:

Contact MedCom with exact location for rendezvous. Include route numbers, any pertinent landmarks, landing zone, commander identification and radio frequency.

Provide MedCom with all available patient information and care being administered. Minimum information should include chief complaint, age, sex, weight, systolic BP, respiratory rate and Glasgow Coma Scale.

Set up a landing zone (LZ) that is at least 100 x 100 feet square and free of any obstructions or loose material (i.e. dirt, gravel or snow). Provide as level a surface as possible. Mark all four (4) corners of the landing zone with flares or other marker and place a fifth on the downwind side. Be sure to secure the markers, as the rotor wash can blow them a great distance and could possibly be a fire hazard. You can also mark the landing zone with rescue vehicles parked in a triangular fashion with their headlights on low beam until helicopter in on final approach, then no white lights (head lights or scene lights) at the landing zone. Also remember red flashing lights are an excellent way to mark your location. Landing zone courses are offered by helicopter services and ideally on LZ Coordinators who have completed this course should set up landing zones.

NEVER AIM ANY LIGHTS INTO THE PILOT’S EYES. THIS COULD DESTROY HIS/HER NIGHT VISION AND RESULT IN A CRASH!

If setting up your landing zone in the roadway, it is essential that you mark all utility lines and relay their exact location as well as any other hazards to the pilot. Utility lines must be marked with a line of flares (or other warning device) below the wires spaced 5 – 10 feet apart. Do this for all utility lines in the area. Remember utility lines are invisible from the air and can cause a catastrophe if not properly marked and identified to the pilot.

Once the aircraft has landed allow no one to approach the craft. You should only approach the aircraft after being instructed to do so by a member of the flight crew. Safety musts:

- Never approach the helicopter from the rear or on the uphill side of landing on a slope.
- Always stay in the pilot’s view.
- Even though some helicopters have high set main rotors, some do not. To be safe, always walk in a slightly crouched position.
- No hats, except firefighter helmet with chin straps fastened, under the main rotor if helicopter is running.
- Never carry anything above the level of your head and secure blankets, sheets, etc.

STAY AWAY FROM THE TAIL SECTION OF THE AIRCRAFT AT ALL TIMES!

When loading your patient, a member of the flight crew will accompany you. Keep others away from the aircraft. Maintain communications with MedCom and the helicopter at all times on the frequency you initially called in on unless otherwise specified by MedCom.
Essential Elements of Information

- Patient’s name
- Age
- Chief complaint
- History
- Vital signs
  - Last set taken
- Assessment
- Treatment/s
- Transport impact
  - Any changes in the patient’s condition enroute
- "Do you have any questions for me"
Application: Those situations when EMS personnel have obtained a pre-hospital ECG suspicious for STEMI (ST-Segment Elevation MI)

1) EMS Providers should strive to achieve the National 10/10/10 goal.
   • 10 minutes from first medical contact to EKG
   • 10 minutes from EKG to Notification of Receiving Facility
   • 10 Minutes from Hospital Notification for activation of Cath Lab

2) EMS should immediately contact Medical Command, clearly identify the incoming patient as a possible STEMI, and request to talk directly with the attending ED physician for medical command – even if EMS is unable to transmit the ECG to Hospital at that time.

3) MedCom will immediately notify the ED attending, who will then talk directly with EMS about the case and ECG findings. Med Com will not refer possible STEMI cases to residents or attempt to triage EMS calls.

4) The ED attending will discuss the case with EMS and (if applicable) evaluate any transmitted ECG images. Based on available information, the ED attending can either activate the cath lab prior to patient arrival (high probability of STEMI) or delay activation (diagnosis of STEMI uncertain) until the patient is seen in the ED.

5) Note: Direct phone conversation between EMS and the ED attending is required in order to activate cath lab. Viewing of a transmitted ECG prior to activation is optimal but not required; use physician judgment.

6) ED attending should then notify the ED Team Leader (shift manager) in order to prepare the ED for a possible STEMI. Potential STEMI patients should be evaluated immediately by an ED attending or senior resident.

7) Upon arrival, EMS should immediately notify ED staff that the patient is a possible STEMI ALERT and any pre-hospital ECG’s should be immediately shown to the attending physician and ED care team.

8) At patient arrival all pre-hospital ECG’s (or a copy) should be given to the ED physician or patient care team. EMS personnel are also encouraged to seek feedback from the ED staff on each STEMI case. This is vital for quality improvement purposes and feedback.
Anytime a patient refuses treatment and transport, an EMS informed consent to refuse statement should be obtained. If your documentation system does not have the “Informed Consent to Refuse” standardized format, you will have to write the refusal out on the PPCR and then have the patient sign. The Virginia OEMS PPCR has the standardized format on the back of the original copy. Please make sure you are documenting refusals properly, this includes a full set of vital signs and any procedures deemed necessary by the attendant-in-charge (AIC) but refused by the patient (i.e. spinal immobilization, intravenous cannulation, etc.).

**Any refusal of treatment and/or transportation by or for a pediatric patient (under 4 years of age) must have Medical Control consultation.**

Refusal you write out must include the following:

- Patient is awake and orientated to: person, place and situation
- Been informed of potential need for
  - Further injury/illness care or management
  - Other: ______________________________

AND

- Been informed of the potential risks associated with the refusal of service
- Potential risk associated may include, but not limited to:
  - Undiagnosed injury or illness
  - Improper healing of injury
  - Worsening of injury or illness with or without changing signs and symptoms
  - Subsequent changes in condition including unconsciousness (coma) shock or death
  - Other: ______________________________

AND

- Understand this refusal in no way reduces my ability to recall EMS services in the future.
- Witness signatures for patient refusals may be a by-stander, law enforcement, family member, etc. The use of response personnel as witnesses to refusals should be avoided.
- Patient repeats risks back to provider.

**Emergency Custody Orders (ECO)**

A person who is:

- Experiencing a behavioral emergency
- In need of further evaluation
- Who is incapable of volunteering or unwilling to volunteer for treatment, and is either:
- An imminent danger to his/her self or others as a result of mental illness
- So seriously ill as to be substantially unable to care for his/her self.

Those that meet the above criteria may be taken into emergency custody by law enforcement and transported for evaluation by a designee of a Community Services Board to determine the need for involuntary hospitalization.

An ECO will generally not be issued for a person that you believe is in need of medical treatment but is refusing care; however, a law enforcement officer that has taken a person into custody may seek medical evaluation and treatment of the person if necessary.

A person meeting the criteria may be taken into emergency custody in two (2) ways:

- A law enforcement officer may take the person into custody without an order being issued by a magistrate and may transport the person for evaluation, or
- An Emergency Custody Order may be issued by a magistrate on the sworn petition of “any person” if he/she finds the person to be detained meets the criteria set out above, and law enforcement will serve that order.

If any of the above methods fail, contact Medical Direction.
January 3, 2002 is the effective date for the *Medicare and State Health Care Programs: Fraud and Abuse; Ambulance Replenishing Safe Harbor Under the Anti-Kickback Statue* (42 CFP Part 1001), otherwise referred to as the Ambulance Restocking Arrangements, Final Safe Harbor Conditions. The following outlines the regional process for those facilities within the Thomas Jefferson EMS Council region.

Hospitals will restock all ambulance providers who transport patients to their facility from the following category: all non-profit and governmental providers.

The restocking will include all medications, medical supplies and linen on a one-for-one basis used by ambulance providers in the treatment of the arriving patient. This includes the exchanging of opened or expired drug boxes from all agencies (for-profit or non-profit) that participate in the Thomas Jefferson EMS Council regional drug box program.

There are no charges created to the patient by the ambulance provider for the use of the aforementioned supplies and medications.

There are no charges generated to the ambulance providers for the restocking of the supplies as detailed in line 2 by the receiving facility.

Restocking of the ambulance provider pertains to both emergent and non-emergent transports.

All medications and supplies used by the ambulance provider will be documented on the agency “call report” and a copy provided to the receiving hospital. Minimum information includes the patient’s name, date of service (transport) and pertinent medications and/or supplies exchanged.

All ambulance providers within the Thomas Jefferson EMS Council must comply with all applicable Federal and state rules and regulations.

For further information regarding the Regional Ambulance Restocking Agreement or to obtain additional copies, please contact the Thomas Jefferson EMS Council at (434) 295-6146.
Once EMS has established patient contact, only the Attendant-in-Charge (AIC) or scene medical command may cancel additional resources that have been requested for patient care. Anyone not on scene shall not cancel or change the resources that have been requested without specific agreement of the AIC/scene medical command. Additional resources may include helicopters, ALS support and specialty teams.
Requirements for RSI program:

- Current NREMT-P/Paramedic certification and other training as required by agency medical director.
- Second provider on scene who is cleared to perform intubation.
- Drugs will only be administered by RSI approved provider. If allowed by agency OMD, intubation may be performed by another qualified intubator under the direct supervision of the RSI approved provider.
- Written approval for each provider by OMD of agency where RSI will be used.
- There will be 100% QI review of patient encounters.
- Maintenance of RSI approval will require continued OMD approval.

Contents of RSI pack:

- Pack to be stored in secured area like drug boxes
  - 2 – Etomidate 20 mg/19g needles
  - 2 – Vecuronium 10mg with filter needles
  - 2 – 10cc sterile water diluent/30 cc syringe
  - 2 – Succinylcholine 200mg/10cc syringes
  - 2 – Ketamine 200mg vials
  - 1 – Atropine 1mg bristojet type syringe
  - 2 – 3cc syringes with 20g needles
  - 5 – 10cc syringes
  - 2 – 30cc syringes
  - 7 – 19g needles
  - 10 – alcohol prep pads

Indications for RSI:

- RSI may be done under standing orders
- Patients over 18 years of age unless specific permission given prior to procedure by medical command.
- Need for intubation:
  - Burns with suspected significant inhalation injury
  - GCS < 8 related to traumatic injury
  - Acute or impending airway loss (inability to protect airway)
    - RR < 10 or > 30
- No known contraindications to RSI drugs

Procedure:

- Preparation
  - Monitoring (continuous ECG and SpO2, and BP pre- and post-)
- Monitoring waveform capnography
- Functional laryngoscope and BVM with high flow oxygen
- Endotracheal tube(s), stylet, 10cc syringe
- Alternate airway (i.e. rescue airways and cricothrotomy equipment) immediately available
- All medications drawn up and labeled
- Patent IV
- Assess for difficult intubation: LEMON
- Suction on and ready
- Tube confirmation equipment available (EtCO2 + EDD)

- Pre-oxygenation
  - Either 100% oxygen x 5 minutes or 8 vital capacity (deep) breaths on 100% O2
  - Patient on continuous pulse oximeter monitoring

- Paralysis and induction
  - Etomidate 0.3 mg/kg (20 – 30 mg)
  - Ketamine 1-2 mg/kg/IV
  - Succinylcholine 1.5 mg/kg (120mg)
    - **Contraindicated with
      - Burns > 24 hours old
      - Crush injury > 72 hours old
      - Denervation process (i.e. para/quadriplegia)
      - Risk of hyperkalemia (i.e. ESRD)

- Confirmation of placement
  - End-tidal CO2 color change or proper waveform
  - Breath sounds auscultated over lungs, no gastric sounds
  - Secure endotracheal tube, note position

- Post-intubation management
  - Long-term paralytic: Vecuronium 0.1 mg/kg (9mg)
  - Sedation: (May be repeated as indicated)
    - Midazolam 0.1 mg/kg
    - Fentanyl 1-2 mcg/kg
    - Ketamine 1-2mg/kg
  - Continuous waveform capnography

- Paperwork
  - PPCR
  - Airway form
  - RSI form

- Exchange
  - Kit will be exchanged in return for e/PPCR + Airway form + RSI form ONLY
Scene authority and transition of patient care may occur on several levels within our system. The senior level patient care provider may assume responsibility of pre-hospital care. In the event of a multi-agency response (1st Responder agency, transport agency, etc.), the agency assigned with the task of transport shall obtain and maintain the senior level of provider care responding to the incident. If there are concerns regarding the care of the patient, Medical Control shall be consulted.

Patient Care Transfer:

The 1st Responder responsible for patient care will provide a verbal report to the assuming transport provider. Once the report is received, the transport provider assumes patient care responsibilities. The transfer of care shall be noted on the call report and/or by radio communications.

The transport provider may request the assistance from the 1st Responder agency for “manpower” for those calls that are resource intensive (cardiac arrests, major illness/injury, etc.).

Should disagreements arise between the 1st Responder responsible for initial patient care and the receiving transport provider, they should be resolved in a quiet, professional manner prior to transport. If a resolution cannot be reached prior to transport, either Medical Control may be contacted for further resolution or the 1st Responder responsible for initial patient care may be requested to accompany the patient to the receiving facility. Each agency’s OMD (or designee) shall be notified of the incident within twenty-four (24) hours.

Once ALS level of care has been initiated (IV therapy, EKG monitoring, medical administration, etc.) that same level of care must be maintained until transfer of care to the appropriate receiving facility.
MCI: S.T.A.R.T.
Operations Guideline
Reviewed: 2017
Updated: May 2015

All “walking wounded” = **GREEN**

Breathing

- NO
  - Position Airway
    - NO Respiration
      - DECEASED
    - Respiration
      - IMMEDIATE

- YES
  - Respirations Under 30/min
    - Radial Pulse Absent or Cap Refill > 2 secs
      - Control Bleeding
        - IMMEDIATE
    - Radial Pulse Present or Cap Refill ≤ 2 secs
      - Mental Status
        - Can’t Follow Simple Commands
          - IMMEDIATE
        - Can Follow Simple Commands
          - DELAYED
Unless special circumstances exist, patients who are victims of cardiac arrest, either traumatic or non-traumatic, may be candidates for resuscitative efforts to be withheld or terminated in the field in certain situations.

**Obvious signs of death:**
- Injuries incompatible with life (i.e. decapitation)
- Dependent lividity
- Rigor mortis
- Decomposition

**Termination Considerations:**

Termination of resuscitation be considered if the adult, non-traumatic, out-of-hospital cardiac arrest patient has received:
- At least 20 minutes of cardiopulmonary resuscitative efforts
- Adequate airway management
- ETCO2 reading less than 10 with effective compressions
- Intravenous/IO access

yet remains in asystole or slow pulseless electrical activity with no return of spontaneous circulation in the field.

This would include patients:
- Attended by BLS providers who have had no shocks recommended by an AED for 20 minutes,
- When 20 minutes or greater has elapsed since the last shock recommendation,
- Suffer from an EMS witnessed arrest and have not responded to 20 minutes of resuscitative efforts.

The safety of the public and providers must be considered when transporting a working cardiac arrest patient.

**Transport should not occur if the above criteria are met and on-line medical control should be consulted to terminate efforts.**

Continued resuscitative efforts:
Patients who have continued or recurrent ventricular tachycardia, ventricular fibrillation, or continued “shock” recommended by an AED are candidates for continued resuscitative efforts.

Any patient who exhibits return of spontaneous circulation is a candidate for continued resuscitative efforts and transport.
Victims of traumatic cardiac arrest (blunt or penetrating) may have resuscitative efforts withheld if they are found to be:

- Pulseless and apneic
- Without signs of life including:
  - Pupillary reflexes
  - Spontaneous movement (including respiratory efforts)
  - Organized ECG activity on initial assessment.

Those suffering penetrating chest injuries that are within 15 minutes of definitive care, immediate transport must be considered.

- Loss of vital signs, more than 15 minutes from trauma center – termination
- Loss of vital signs, less than 15 minutes from trauma center – transport

Any patient who has return of signs of life, including organized ECG activity, should have resuscitative efforts continued and be transported to a trauma center.

Once resuscitative efforts have been initiated, termination of those efforts must be discussed with on-line medical command. Special circumstances may exist that might modify recommendations for transport, particularly hypothermia and drowning. These recommendations do not apply to infants and children, who are frequently candidates for continued resuscitative efforts, and who should have resuscitative efforts initiated unless they exhibit obvious signs of death such as rigor and dependent lividity.
The provider with the highest level of certification on the scene should conduct patient assessment to determine chief complaint and level of distress.

If it is determined that the patient is stable and all patient care needs can be managed by the lower level provider, patient care can be transferred to a provider of lower certification for transport.

All personnel on scene are encouraged to participate in patient care while on scene regardless of who “attends” the patient while en route to hospital.

Determination of the attendant in charge should be based upon the patient’s immediate treatment needs and any reasonably anticipated treatment needs en route to the hospital.

Both the transporting provider and the provider who transferred care must complete PPCR/ePPCR documentation that covers all aspects of assessment, care and disposition.

Call types include, but are not limited to:

- Postictal seizure patients
- Patients who received medications or procedures may only be transferred to a provider of lower certification whose scope of practice includes the medications/procedures that were administered or performed with consultation with medical command
- Chest pain of suspected cardiac origin
- Moderate to severe respiratory distress
- Hypertensive crisis
- Multisystem trauma
- Imminent childbirth
- Any patient in which transport would be delayed waiting for a unit with lesser certification to arrive
- Any patient for which all EMS providers on scene do not agree can be safely transported under care of provider with lower level of certification
Persons subject to this policy:

This policy applies to persons under the age of 18 (except those who have an Order of Emancipation from a Juvenile and Domestics Relations District Court) who are in need of medical or surgical treatment, including such persons who report being sick or injured; who have obvious injury; and/or have a significant mechanism of injury which suggests the need for medical evaluation.

Authority of Parents, Guardians or Others:

Parents have the authority to direct or refuse to allow treatment of their children. A court appointed guardian, and any adult person standing in loco parentis, also has the same authority. “In loco parentis” is defined as “[I]n the place of a parent; instead of a parent; charged, fictitiously with a parent’s rights, duties and responsibilities.” Black’s Law Dictionary, 708 (5th ed. 1979). 1987-88 Va. Op. Atty. Gen. 617 “Furthermore, I would point out that § 54.325.2(6) allow any person standing “in loco parentis” to consent to medical treatment for a minor child. This signifies, in my judgment, an intent to allow any responsible adult person, who acts in the place of a parent, to consent to the treatment of a minor child, particularly in emergency situations.” 1983-84 Va. Op. Atty. Gen. 219. Such a person may be a relative, school teacher or principle, school bus driver, baby-sitter, neighbor or other adult person in whom care of the child has been entrusted.

Persons subject to policy with altered mental status:

A person meeting the criteria of paragraph 1 that is unconscious, has an altered mental status, signs of alcohol or substance abuse or head injury shall be treated under implied consent and transported, unless a parent or guardian advises otherwise. Medical control must be consulted if a parent or guardian or person in loco parentis refuses to allow treatment or transport.

Persons subject to policy under age 14:

A person meeting the criteria in paragraph 1 that is under the age of 14 shall be treated and transported unless a parent or guardian or persons in locos parentis advises otherwise. Do not delay treatment or transport for extended periods simply trying to contact a parent or guardian. If you believe that treatment is necessary, but the parent or guardian or person in loco parentis refuses to allow treatment, medical control should be consulted.

Person subject to policy aged 14 – 18:

A person meeting the criteria of paragraph 1 who is between the ages of 14 and 18 may refuse treatment and transport, unless a patient or guardian or person in loco parentis advises otherwise. If you believe that treatment is necessary, but the person refuses, an attempt should be made to contact a parent or guardian, and medical control should be consulted. If you believe that treatment is necessary, but the parent or guardian or person in loco parentis refuses to allow treatment, medical control should be consulted.
**Persons subject to policy married or previously married:**

A person meeting the criteria of paragraph 1 who is, or has been, married shall be deemed an adult for purposes of consenting or refusing medical treatment. Code of Virginia § 54.1-2969.

**Persons subject to policy that are pregnant:**

A person subject to this policy who is pregnant shall be deemed an adult for the sole purposes of giving consent for herself and her child to medical treatment relating to the delivery of her child; thereafter, the minor mother of such child shall be also deemed an adult for the purpose of giving consent to medical treatment for her child. Code of Virginia § 54.1-2969.

**Pediatric Non-transport:**

All pediatric patients under four (4) years of age who are not going to be transported after 9-1-1 access has been made will need to consult with Medical Control via UVa MedCom (434) 924-9287. Document all pertinent information including physician’s name involved with the consultation.
### UVA EMS Adult Trauma Alert Criteria

**Operations Reference**

Reviewed: 2017  
Updated: 2017

<table>
<thead>
<tr>
<th>Alpha Alerts ≥ 16 yrs</th>
<th>Beta Alerts ≥ 16 yrs</th>
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</thead>
</table>
| • All pts intubated in the field  
  • All pts with ongoing respiratory compromise, even intubated trauma transfers from OSH. Any pt with need for emergent airway. For example:  
  o Sats < 90%  
  o ETCO2: >50  
  o Massive maxillofacial trauma  
  o Airway trauma / hemorrhage  
  o Stridor  
  • Circulation:  
    o Confirmed BP < 90  
    o Trauma transfers requiring blood to maintain VS  
  • Disability:  
    o GCS < 9 with trauma mechanism  
  • Mechanism:  
    o GSW or stab wound to neck, chest or ABD  
    o GSW to extremities proximal to elbow or knee  
    o EM or Trauma Service MD discretion  
  • If any of the above criteria are met **ALPHA Alert should be activated!**  
  | • Intubated trauma transfers from OSH without ongoing respiratory distress  
  • Facial burns or singed facial hair w/ altered phonation  
  • **Circulation:**  
    o Relative hypotension BP >90 but < 100  
    o BP <110 in ages > 65 y/o  
  • **Disability:**  
    o GCS < 15 in pts w/ severe headache, N/V, or if pts taking oral anticoagulants, or Plavix  
    o GCS 9 – 13 or GCS 1 point below baseline (including GLF)  
    o New tetraplegia, hemiplegia, or persistent neurologic deficit  
    o Open or depressed skull fracture, GCS ≥ 9  
    o Known fracture to a vertebral body from outside imaging  
  • **MOI**  
    o Stable, severe system injury (e.g. known SDH / EDH, severe pelvic fx, etc.)  
    o ≥ 2 proximal long bong fx  
    o Amputation proximal to wrist or ankle, or crushed / degloved, mangled extremity  
    o Advanced pregnancy; fundus above umbilicus with abd trauma  
    o Concomitant thermal / multisystem injury  
    o TBSA ≥ 40%  
    o EM MD discretion |

**Other important information:**  
**IS PT ON ANTI-COAGULANTS?**

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Please be sure to include the patient’s GCS when calling a Trauma Alert.  
Do **NOT** let someone else decide if you meet Alert criteria.  
If they meet Trauma Alert Criteria, active a Trauma Alert!
Any patient should be upgraded at any time prior to admission to ICU if there is a decline in status

Please be sure to include the patient’s GCS when calling a Trauma Alert. Do NOT let someone else decide if you meet Alert criteria. If they meet Trauma Alert Criteria, active a Trauma Alert!

<table>
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<th>Alpha Alert Criteria (&lt; 16 y/o)</th>
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<tbody>
<tr>
<td><strong>Airway / breathing:</strong></td>
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<tr>
<td>o Patients who are demonstrating ongoing respiratory compromise</td>
<td>o Intubated inter-facility transfer patients without ongoing respiratory compromise.</td>
</tr>
<tr>
<td>o All intubated patients transported to UVA directly from the field</td>
<td>o Facial burns or singed facial hair with alerted phonation.</td>
</tr>
<tr>
<td>o (e.g., SAO2 &lt; 90, massive maxillofacial trauma, airway hemorrhage, stridor, or flail chest)</td>
<td><strong>Circulation:</strong></td>
</tr>
<tr>
<td>o Pre-hospital cardiac arrest (any mechanism)</td>
<td>o Initial age specific hypotension stabilized after 20 cc/kg Isotonic Crystalloid IVF.</td>
</tr>
<tr>
<td>o Patient requires fluid or blood administration to maintain blood pressure</td>
<td><strong>Disability:</strong></td>
</tr>
<tr>
<td>o GCS &lt; 9 with trauma mechanism or GCS declining by 2 with trauma mechanism</td>
<td>o GCS 9 – 13</td>
</tr>
<tr>
<td>o A V P U: responsive only to pain or unresponsive</td>
<td>o Head injury / LOC with severe persistent headache, nausea / vomiting</td>
</tr>
<tr>
<td>o New paraplegia or quadriplegia</td>
<td>o Open or depressed skull fracture, GCS &gt; 10</td>
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<tr>
<td>o Hangings, especially if any of the physiologic criteria above are present</td>
<td>o Known fracture to a vertebral body from outside imaging</td>
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<td><strong>Mechanism:</strong></td>
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<td>o GSW or stab wound to neck, thorax or abdomen</td>
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<td>o GSW to extremities proximal to elbow or knee</td>
<td>o Falls 10 feet or 2 – 3 times height of child</td>
</tr>
<tr>
<td><strong>EM OR TRAUMA SERVICE PHYSICIAN DISCRETION</strong></td>
<td>o Pedestrian or bicyclist vs. car thrown, run over or significant &gt; 20 mph impact</td>
</tr>
</tbody>
</table>

**Operations Reference**

Reviewed: 2017

Updated: February 2016
- Two or more proximal long-bone fractures or femur
- Burns > 25% TBSA or inhalation injury
- Threatened limb or complete/partial amputation proximal to wrist or ankle, crushed, degloved or mangled extremity.

**EM or TRAUMA SERVICE PHYSICIAN DISCRETION**

**PEDIATRIC TRAUMA TRANSFERS (<16 y/o)**

All trauma transfers must be evaluated in the emergency department regardless of the work-up prior to arriving at UVa. Direct admits from PICU are not trauma transfers.

An alert should be activated PTA as with any other pediatric trauma, based on their current physiologic status.

Assess special patient or system considerations

Glasgow Coma Scale < 14 or Systolic blood pressure < 90 or Respiratory Rate < 10 or > 29 (<20 in infant < one year)

YES

NO

Transport to trauma center. Pretreatment by a level I trauma hospital is indicated.

Steps 1 and 2 attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the trauma system.

Early dispatch of aeromedical evacuation provider to the scene may be the most reliable and expeditious means of achieving direct transfer of these patients to the trauma center.

Assess anatomy of injury

All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee

Flail Chest

Two or more proximal long bone fractures

Crushed, degloved, or mangled extremity

Amputation proximal to wrist and ankle

Pelvic fractures

Open or depressed skull fracture

Paralysis

YES

NO

Take to trauma center.

Assess mechanism of injury and evidence of high-energy impact

Falls

Older Adults: >20 ft. (one story is equal to 10 ft.)

Children: > 10 ft. or 2 - 3 times the height of the child

High-Risk Auto Crash

Intrusion: > 12 in. occupant site; > 18 in. in any site

Ejection (partial or complete) from automobile

Death in same passenger compartment

Vehicle automatic crash notification data consistent with high risk injury

Auto v. Pedestrian/Bicyclist Throw, Run Over, or with Significant (>20 mph) Impact

Motorcycle Crash >20 mph

YES

NO

Transport to closest appropriate hospital.

Preferentially a Level I, II, or III Trauma Center.

Age

Older Adults: Risk of injury death increases after age 55

Children: Should be triaged preferentially to a pediatric-capable trauma center

Anticoagulation and bleeding disorders

Burns

Without other trauma mechanism: Triage to burn facility

With trauma mechanism: Triage to trauma center

Time Sensitive Extremity Injury End-Stage Renal Disease Requiring Dialysis

EMS Provider Judgment

Measure vital signs and level of consciousness

Step 1

Step 2

Step 3

Step 4

Contact medical control/follow established protocol and consider transport to a trauma center or specialty care hospital

Transport according to normal operational procedures

Injury:

State Trauma Triage Guideline

Reviewed: 2017

Updated: 2017

Injury: