Operations

DIVERSION SYSTEM OVERVIEW

The Greater Portland Metropolitan Area (Multnomah, Clackamas, Columbia, and Washington Counties, and in coordination with Clark County, Washington) is a large geographic area with a growing population. There is a complex network of medical providers, and hospital systems servicing the area. The Portland Metro Five County Emergency Medical System (EMS) values transporting patients to the hospital of their choice, and also getting patients to the right hospital for specialty services. These systems require coordination between patient transport and patient destination, ensuring continued use and availability of emergency medical resources to the community. The patient diversion guidelines exist to provide guidance for emergency departments and ambulance providers during high capacity times. The guidelines are a collaborative effort between many stakeholders that include hospitals, ambulance providers, county oversight agencies, and the Oregon Association of Hospitals and Health Systems (OAHHS).

This policy does not pertain to prescheduled, non-emergency, or inter-facility transports.

A. PURPOSE

Ambulance diversion is a hospital short-term management tool used as a last resort when the patient load overwhelms ED resources after internal diversion avoidance procedures have been implemented. Ambulance diversion is not to take the place of effective patient volume management processes. This protocol defines how the Portland Metro Quad-County EMS system will effectively manage situations where the diversion of an ambulance may be necessary and when such diversions may have an adverse effect on individual patient care or the EMS system.

B. PHILOSOPHY

The Greater Portland Metropolitan Area hospitals will make every effort to avoid the diversion of ambulances which may result in:

1. Transporting patients away from their hospital or physician of choice.
2. Prolonged prehospital care for unstable or critically ill patients.
3. Prolonged transport times.
4. Attempts by field personnel to predict the specific diagnostic and therapeutic resources needed by individual patients.
5. Reduced ED availability to the community.
6. Reduced ambulance availability to the community.

This protocol sets the standard that diversion should be the exception rather than the rule.

C. OBJECTIVES

1. To promote efficient and effective provision of EMS services in accordance with county ambulance service plans, codes, as well as state and federal regulations.
2. To assure hospitals develop and adhere to diversion avoidance strategies.
3. To assure hospitals limit diversion to ED patient safety reasons and remove diversion status immediately after the patient safety issue has been resolved.
4. To provide consistent definitions and agreed upon procedures to guide each hospital.
5. To assure system accountability and quality improvement to facilitate the goal of limiting diversion.
6. To report and collect meaningful data, which more accurately defines prehospital and hospital EMS demand, service consumption, and resource availability.

7. To identify a system of accountability and quality improvement by providing diversion data to all participants monthly.

D. DEFINITIONS

1. All Divert No Divert – When all hospitals in a zone go on diversion simultaneously (all close), the HOSCAP/OCS system or zone manager will immediately open all hospitals within the zone. No zone or all hospitals within a zone will be allowed to close for zone management unless authorized by the EMS medical director/zone manager for emergent reasons.
2. Disaster Management – Epidemic, pandemic, inclement weather, man-made or natural disaster, zone management, mass casualty incident, or other circumstances that challenge emergency services abilities to continue meeting patient care demand.
3. Diversion – The redirection of an ambulance from an intended receiving facility to an alternate receiving facility due to a sudden, unanticipated, temporary inability to receive any additional 9-1-1 patients; or safely care for additional **critical/unstable** patients in the ED.
4. Inter-Facility Transfers – Hospital destination is pre-determined by physician-to-physician communication as a formal transfer.
5. HOSCAP/OCS – State owned and managed, data system for distribution of hospital status information and incident management.
6. Regional Hospital – A medical facility designated to coordinate Mass Casualty Incident (MCI) or disaster situations co-located with Trauma Center Communications (TCC) and Medical Resource Hospital (MRH) which provides online medical control for Multnomah, Clackamas, Washington and Clark Counties, currently located within Oregon Health Science University (OHSU).
7. Zone Manager – An agency or facility authorized to provide coordination to pre-hospital care providers and hospitals during times of zone wide diversion.
8. ED Diversion Status Categories:
    a. OPEN (GREEN) – The ED can accept patient(s) transported from an ambulance.
    b. CLOSED (RED) – The ED is unable to accept patient(s) transported from an ambulance; except:
        i. Uncontrolled airway
        ii. Non-trauma patient too unstable to transport to another facility.
        iii. Patient refuses alternate facility.
        iv. Prearranged inter-facility transfer.
        v. Pregnant patients > 20 weeks gestation or illness or injury which could have a potential life-threatening effect on the mother and/or the fetus.
9. Trauma Diversion Status Categories:
    a. TRAUMA YELLOW – A designated trauma hospital has declared that trauma restrictions exist, and some trauma related services may be limited.
    b. TRAUMA RED – A designated trauma hospital will divert to another trauma hospital when it has exceeded its capacity of personnel, equipment, or facilities to assess and care for trauma patients.
10. Life Flight Network Status:
    a. GREEN – Available
    b. YELLOW– On stand-by for another patient
    c. RED – Unavailable

Destination Hospital/Services Abbreviation and EMS Abbreviations:

1	DC	Doernbecher Children's Hospital (located within OHSU ED)	Portland
2	EM	Legacy Emanuel Medical Center	Portland
3	EC	Legacy Randall Children's Hospital (located in Emanuel's ED)	Portland
4	GS	Legacy Good Samaritan Medical Center	Portland
5	MH	Legacy Mt. Hood Medical Center	Gresham
6	MP	Legacy Meridian Park Medical Center	Tualatin
7	SC	Legacy Salmon Creek Medical Center	Vancouver
8	PA	Adventist Medical Center	Portland
9	PM	Providence Milwaukie Hospital	Milwaukie
10	PR	Providence Portland Medical Center	Portland
11	SK	Kaiser Sunnyside Medical Center	Clackamas
12	SV	Providence St. Vincent Medical Center	Portland
13	SW	PeaceHealth Southwest Medical Center	Vancouver
14	TH	Hillsboro Medical Center	Hillsboro
15	UH	Oregon Health Sciences University Hospital	Portland
16	UC	Unity Center for Behavioral Health	Portland
17	VA	Veterans Administration Hospital	Portland
18	WF	Providence Willamette Falls Hospital	Oregon City
19	WK	Kaiser Westside Medical Center	Hillsboro
20	LF	Life Flight Network	Hillsboro
21	MW	Metro West Ambulance	Hillsboro
22	WCEO	EMS Washington County EMS Office	Hillsboro
23	AMR	American Medical Response	Portland

E. ED AMBULANCE DIVERSION CRITERIA

It is the expectation that all hospitals receiving 9-1-1 patients make every effort to be continuously open and available.

1. Diversion is not to be initiated for:
    a. Lack of in-patient staffing or inpatient/ICU beds.
    b. Key resources being reserved for anticipated elective patient care (i.e., elective surgical cases or radiological studies).
    c. Routine ED overcrowding:
        i. Full waiting room
        ii. Long waiting room time
        iii. Extended LOS of ESI 3, 4, 5s
        iv. ED boarders
2. ED diversion may be initiated under the following conditions:

    By the hospital:
    a. ED charge nurse and ED physician leader determine that the ED is reaching capacity with critical/unstable patients occupying all ED care spaces.
    b. ED charge nurse and ED physician leader have attempted to accommodate increased demand by following their internal ED surge plan yet determine that ambulance diversion is necessary to safely care for patients in the ED because:

i. There are not enough resources to safely care for additional **critical/unstable** patients in the ED.
ii. There is a loss of CT scanner capability.
iii. There is an in-house disaster which compromises patient care/safety (i.e., fire, flooding, or electrical power outage).

By the EMS system:

a. For nonstandard or extended off-load times of 35 min or greater – collaboration will occur with the EMS supervisor and affected ED(s) leadership to develop a patient placement plan.
b. Under the discretion of the EMS medical director.

3. Hospitals request diversion via HOSCAP/OCS. Hospital initiated diversion events will last no longer than two hours before HOSCAP/OCS automatically opens the hospital to ambulance traffic again and the hospital will not be allowed to request diversion for two hours.
4. In the event a hospital is unable to change their status in HOSCAP/OCS, (i.e., connection problems), the hospital may contact the zone manager to authorize the zone manager to change the hospital status in HOSCAP/OCS.
5. A hospital's diversion status at the time ambulance transport begins with a loaded patient will determine the ability of the hospital to accept patients. To ensure the up-to-the-minute ability of a hospital to accept a patient, a transporting unit will contact dispatch requesting the status of the preferred destination hospital when the patient has been loaded and as they are preparing to depart the scene. Diversion of a patient shall not occur after the transport has begun.

F. TRAUMA AMBULANCE DIVERSION CRITERIA

1. The intent of the Trauma System is that only one of the designated Level 1 Trauma Centers may divert at a time: OHSU/Doernbecher's Children or Legacy Emanuel/Randall's Children.
   a. When one of the Level 1 (adult or pediatric) trauma centers goes on diversion status, notification of diversion status to the other designated trauma center must occur. Trauma patients will then be diverted to the other trauma center.
   b. When both Level 1 trauma centers are at capacity, the Trauma Center Communications Center will be notified to begin rotating trauma patients between the two trauma hospitals until the situation has stabilized or either hospital is able to return to standard operations. The Regional Hospital may also need to do an "All Call" to other community hospitals activating the MCI or disaster system to coordinate distribution of trauma patients.

G. MULTNOMAH COUNTY PEDIATRIC HOSPITAL ED'S

1. When one of the dedicated Multnomah County pediatric EDs (Doernbecher's Children and Randall's Children) goes on diversion status, notification of diversion status to the other designated pediatric ED must occur. Pediatric patients will then be diverted to the other pediatric ED.

2. When both Multnomah County pediatric EDs are on diversion, the OHSU zone manager will rotate destination between the two Multnomah County pediatric ED's until the situation has stabilized or one of the pediatric EDs returns to green status.

H. ZONE MANAGEMENT

Hospitals are grouped into the following geographical zones:

West Zone	Central Zone	South Zone	North Zone	East Zone
Providence St. Vincent Medical Center	Legacy Emanuel Medical Center/Randall Childrens Hospital	Kaiser Sunnyside Medical Center	PeaceHealth SW Medical Center	Portland Adventist
Legacy Meridian Park Medical Center	Legacy Good Samaritan Medical Center	Providence Milwaukie	Legacy Salmon Creek Medical Center	Providence Portland Medical Center
Hillsboro Medical Center	Oregon Health Science University/Doernbecher Childrens	Providence Willamette Falls		Legacy Mount Hood
Kaiser Westside Medical Center	Portland VA Medical Center			
	Unity Center for Behavioral Health			
Zone Manager Metro West	**Zone Manager** Regional Hospital	**Zone Manager** Regional Hospital	**Zone Manager** Regional Hospital	**Zone Manager** Regional Hospital

1. When multiple hospitals go on diversion at the same time it poses a challenge to other hospitals trying to stay open. In the event all hospitals in a zone go on diversion simultaneously, an All DIVERT NO DIVERT process will be initiated and the HOSCAP/OCS system or zone manager will immediately open all hospitals within the zone.
2. Occasionally, for emergent reasons, i.e., MCI, the zone manager may need to initiate zone management. In the event this is required to enhance the EMS system or provide for public safety the zone manager will initiate diversion by:
    a. Initiating "Active Zone Management" for the zone(s) affected and will facilitate an "all call" via the 800 MHz radio to hospitals informing them of the "Active Zone Management" status.
    b. Local ambulance providers/dispatch centers will notify their respective ambulances that zone management is in effect for the defined zone(s) and that their units are to contact the zone manager to obtain hospital destination(s).
    c. Under zone management, the zone manager will determine the destination of all ambulances within the affected zone(s).
    d. Ambulances may go outside their zone during zone management if their destination hospital is GREEN, this may be done based on patient and EMS provider agreement and following patient treatment and transport guidelines on the final destination. This includes honoring previously agreed upon destinations.

e. Rotation will continue with one patient per hospital as determined by the zone manager. Note: the rotation will not apply to the trauma hospitals for trauma entry patients. Trauma hospitals participating in zone management will adhere to the trauma diversion portion of the ambulance diversion policy located above.
f. Trauma, STEMI, stroke, pediatric, and behavioral patient care protocols will continue.
g. Prior to discontinuing zone management, the zone manager will monitor key area hospitals and ambulance providers. When system resources are above the activation threshold the zone manager may discontinue zone management.
h. When appropriate, the county EMS Medical Director will participate in this discussion for the zones within their jurisdictional boundaries.

I. DISASTER MANAGEMENT

1. Hospital destinations will be coordinated by Regional Hospital through HOSCAP/OCS and according to regionally and locally adopted EMS protocols.
2. During times of disaster management, situational status updates should be initiated and continued in four-hour operational intervals to provide updates to stakeholders.
    a. Disaster management as reported by community emergency responders.
    b. Any one facility activating their internal emergency management protocol.
    c. Actual or forecasted inclement weather.
    d. Any zone requiring persistent zone management.
    e. Circumstances as deemed appropriate by emergency operations officials or county EMS Medical Director(s).
3. Stakeholders involved in proactive (thresholds) communications may include:
    a. Medical directors/ED physicians.
    b. Managers or their designee, assistant nurse managers, charge nurses, house supervisors, AOC/AOD, executive leadership, hospital HICS members.
    c. Fire and EMS officials.
    d. Public health officials.
    e. Others, as appropriate.

J. SIGNIFICANT EVENTS PROCESS FOR DIVERSION DEVIATION:

1. Inclement weather, hazardous road conditions, heavy snow, ice storms, or other unusual conditions may prevent ambulance crews from transporting patients to their hospital of choice. County EMS authorities shall have a process in response to these unusual circumstance and significant events. The significant event process has been developed to modify operations to better manage and coordinate EMS resources during large scale incidents or inclement weather events in the Greater Portland Metropolitan Area.
2. During the significant event process:
    a. The impacted area's zone manager will be responsible for communicating the modification of EMS transport destinations to affected hospitals.
    b. Activation of the significant event process or modified EMS operations is under the authority of county EMS administration and medical direction. This

is generally done in consultation with emergency ambulance providers and hospitals as well as fire first response and emergency dispatch supervisors.

c. Dependent on the nature of the event, Regional Hospital may establish hospital destinations.
d. Consideration will be given to patients requiring specialized care such as trauma, STEMI, stroke, behavioral, burn, hyperbaric, pediatric and obstetrical patients.
e. Every effort will be made to accommodate the patient's wishes for destination, however during a significant event; determination of the most appropriate facility may consider patient and crew safety.
f. Final determination of patient destination must rest with the treating paramedic actually caring for the patient. This paramedic, in consultation with EMS operational supervisors and zone managers, as well as acting in accordance with county laws, and medical protocols, and with the ability to seek medical consultation, has the most direct knowledge of the patient's condition and conditions affecting transport.

3. The patient requires transport emergently to the closest hospital when in the judgement of the treating paramedic the patient is unstable and patient transport guidelines recommend transport to the closest hospital regardless of diversion status.
4. Anytime a patient is transported to a hospital other than the one requested the reason for the change and the destination hospital shall be documented on the Prehospital Care Report.

K. <u>ACCOUNTABILITY AND QUALITY IMPROVEMENT:</u>

1. The hospitals will:

   a. Develop an internal policy and systems to avoid diversion.
   b. Submit updated ED surge plan annually to the ED/EMS Leadership Collaborative.
   c. Ensure a hospital ED leader attends the monthly ED/EMS Leadership Collaborative meeting to review any diversion events the from the prior month and share what action planning is occurring to reduce diversion utilization.

2. County EMS will report number of hours and category of diversion to all zones based on information in HOSCAP/OCS.
3. The ED/EMS Leadership Collaborative is responsible for the monitoring of region-1 diversion hours and events, provide recommendations for quality improvement, and is responsible for the annual evaluation and revision to the Multnomah Operations Policy 50.030 Diversion System and the Quad-County consortium Ambulance Diversion Guidelines 50.015. The ED/EMS Leadership Collaborative is a cooperative effort between involved EMS agencies, hospitals, their ED managers, and ambulance providers.
4. Problems related to the implementation of these guidelines should be forwarded to the chair of the ED/EMS Leadership Collaborative.

Organizations in Support of These Guidelines

<u>HOSPITALS</u>
Adventist Medical Center
Doernbecher Children's Hospital
Hillsboro Medical Center

Kaiser Sunnyside Medical Center
Kaiser Westside Medical Center
Legacy Emanuel Medical Center
Legacy Good Samaritan Medical Center
Legacy Meridian Park Medical Center
Legacy Mt. Hood Medical Center
Legacy Salmon Creek Medical Center
Oregon Health Sciences University
Providence Milwaukie Hospital
Providence Portland Medical Center
Providence St. Vincent Medical Center
Randall Children's Hospital
PeaceHealth SW
Unity Behavioral Health
Veterans Administration Hospital
Willamette Falls Hospital
Oregon Association of Hospitals and Health Systems

COUNTY EMS REGULATORY AGENCIES FOR THE FOLLOWING COUNTIES
Washington County
Clackamas County
Clark County
Multnomah County

AMBULANCE PROVIDERS
American Medical Response
Banks Fire District
Canby Fire Department
Camas Fire Department
Clackamas County Fire District 1
Cornelius Fire Department
Forest Grove Fire & Rescue
Gaston Rural Fire District
Hillsboro Fire & Rescue
Molalla Fire Department
North Country Ambulance
Life Flight Network
Tualatin Valley Fire & Rescue

TABLE: HOSPITAL SERVICES

HOSPITAL	BURN UNIT	CARDIAC SURGERY	DECON	HELI PAD	HYPER BARIC	OB	NICU	PEDS INPATIENT	PICU	TRAUMA CENTER	CATH LAB	LVAD	STROKE INTERVENTIONAL	DIALYSIS
Adventist		X	X	X		X					X			X
Doernbecher Children's		X	X	X			X	X	X	X				X
Hillsboro Medical Center			X	X		X	X	X			X (Not 24/7)			X
Kaiser Sunnyside		X	X			X	X				X	X	X	X
Kaiser Westside			X			X								X
Randall Children's Hospital Legacy Emanuel	X	X	X	X (2)		X	X	X	X	X				X
Legacy Emanuel	X	X	X	X (2)	X	X	X	X	X	X	X		X	X
Legacy Good Samaritan			X			X					X			X
Legacy Meridian Park			X	X		X					X			X
Legacy Mount Hood			X	X		X					X			
Legacy Salmon Creek			X	X		X	X				X			X
OHSU		X	X	X (3)		X	X	X	X	X	X	X	X	X
Peace Health SW Washington		X	X	X		X	X	X		X	X		X	X
Providence Milwaukie			X											
Providence Newberg			X	X		X								X
Providence Portland				X		X	X				X		X	X
Providence St. Vincent		X	X	X		X	X	X	X		X	X	X	X
Providence Willamette Falls				X		X								
Veteran's Administration		X									X			X

Crime Scene Response – 50.020

PURPOSE:
Law enforcement agencies stress that their first priority on any crime scene is the preservation of life with reconstruction of the crime scene second. EMS personnel can be of assistance by adhering to the following guidelines regarding crime scene response.

PROCEDURE:

A. Response and Arrival
   1. Be conscious of physical and weather conditions around the site. Tire tracks of suspect vehicles are often located in or adjacent to a driveway.
   2. Limit the number of personnel allowed onto the scene. Consult with police on the scene to direct placement of vehicles and route of personnel onto the scene.

B. Access and Treatment
   1. Select a single route to the victim. Maintaining a single route decreases the chance of altering or destroying evidence or tracking blood over a suspect's footprints.
   2. Note the location of furniture, weapons, and other articles, and avoid disturbing them. If they need to be moved, someone should note the location the article was moved from, by whom it was moved, and where it was placed.
   3. Remove from the scene all EMS generated debris that is contaminated with blood or body fluid and dispose of through established channels.
   4. Be conscious of any statements made by the victim or other persons at the crime scene. Write down what these statements were and report to the investigating officers.
   5. Note the specific garments worn by the patient at the time of treatment. It is also important not to tear the clothing off or cut through any holes, whether made by a knife, bullet, or other object.
   6. The victim should be placed on a clean sheet when ready for transport. At the hospital, please try to obtain the sheet once the victim is moved off it. Fold it carefully in on itself and give it to the investigating officers. This is especially important in close contact crimes such as rape, serious assault, and death cases.

C. Documentation
   1. A detailed report is important in case you are later called to testify in court. An incident report should be completed and should cover your observations, conversations with family or witnesses, location of response vehicles and equipment, furniture, weapons, clothing that has been moved, items that were handled, and your route to the victim.
   2. An Unusual/Supplemental Event Report may be helpful for you to complete. This is a protected document and if you are called to court may be used by you to refresh your memory of aspects of the call that are not included in the Patient Care Report.
   3. Do not offer your opinions or evaluations about the crime scene.

REMINDER:
Any location can be, or become, a crime scene. When responding, and upon arrival, if something does not appear to be right, notify police. If you suspect a crime scene, and police are not present, secure area and document what you see.

Death and Dying – 50.025

PURPOSE:
To define under what conditions treatment can be withheld or stopped.

PROCEDURE:

A. DEATH IN THE FIELD

Resuscitation efforts may be withheld if:

1. The patient has a Do Not Attempt Resuscitation (DNAR)/Do Not Resuscitate (DNR) order.
2. The patient is pulseless and apneic in a mass casualty incident or multiple patient scene where the resources of the system are required for the stabilization of living patients.
3. The patient is decapitated.
4. The patient has rigor mortis in a warm environment.
5. The patient is in the stages of decomposition.
6. The patient has skin discoloration in dependent body parts (dependent lividity).

Medical Cardiac Arrest:

1. If the initial ECG shows asystole or agonal rhythm confirmed in 3 leads, and the patient, in the responder's best judgment would not benefit from resuscitation:
   a. The PIC may determine death in the field, ***OR***
   b. Begin BLS procedures, and contact OLMC with available patient history, current condition, and with a request for advice regarding discontinuing resuscitation.
2. If after the airway is established and the asystole protocol has been exhausted the patient persists in asystole (confirmed in 3 leads) the PIC may determine the patient to be dead in the field.
3. Death in the field may be determined with $EtCO_2$ of 10 or less in patients with PEA after 30 minutes of ACLS resuscitation. For patients with $EtCO_2$ greater than 10 either continue resuscitation or contact OLMC to stop resuscitation.
4. Patients in VF should be treated and transported.

Traumatic Cardiac Arrest:

1. Traumatic arrest carries high rates of mortality, but improved outcomes have been seen in EMS witnessed arrest. Causes of arrest that may be amenable to prehospital resuscitation include severe hypovolemia, hypoxia, and tension pneumothorax.
2. A cardiac monitor may be beneficial in determining death in the field.
3. Trauma patients who have arrested prior to EMS arrival can by declared dead in the field.
4. Witnessed traumatic arrest patients and patients who deteriorate to PEA or asystole may benefit from "HAT" resuscitation. Follow the Traumatic Cardiac Arrest Protocol (10.050).

Notes & Precautions**:**

1. ORS allows a layperson, EMT or paramedic to determine "Death in the Field".
2. Consult OLMC with any doubt about the resuscitation potential of the patient.
3. A person who was pulseless or apneic and has received CPR and has been resuscitated is not precluded from later being a candidate for solid organ donation.

B. POLST ORDERS AND DECISION MAKING

1. In the pulseless and apneic patient who does not meet DEATH IN THE FIELD criteria but is suspected to be a candidate for withholding resuscitation, begin CPR and contact OLMC.
2. A patient with decision-making capacity or the legally authorized representative has the right to direct his or her own medical care and can change or rescind previous directives.
3. EMS providers may honor a DNAR/DNR order signed by a physician, nurse practitioner or physician assistant. DNAR/DNR orders apply only to the patient in cardiopulmonary arrest and do not indicate the types of treatment that a person not in arrest should receive. POLST was developed to convey orders in other circumstances.
4. Portable Orders for Life-Sustaining Treatment (POLST):
   The POLST was developed to document and communicate patient treatment preferences across treatment settings. While these forms are most often used to limit care, they may also indicate that the patient wants everything medically appropriate done. **Read the form carefully!** When signed by an allopathic physician (MD or DO), naturopathic physician, nurse practitioner, or physician assistant, POLST is a medical order and EMS providers are directed to honor it in their Scope of Practice unless they have reason to doubt the validity of the orders or the patient with decision-making capacity requests change. If there are questions regarding the validity or enforceability of the health care instruction, begin BLS treatment and contact OLMC [OAR 847-035-030 (7)] If the POLST is not immediately available, a POLST form as documented in the Electronic POLST registry hosted at MRH (503-494-7333) may also be honored.
   - Section A: Applies only when patient is in cardiopulmonary arrest.
   - Section B**:** Applies in all other circumstances.
   - For a POLST form to be valid it must include:
     i. Patient's name
     ii. Date signed (forms do not expire)
     iii. Health care professional's signature (patient signature is optional)
   - Consider providing pain/symptom management and not transporting patient if they are Comfort Measures Only, the symptoms can be managed, and the patient and caregivers on scene do not want transport to the hospital. Consider OLMC contact for advice.
5. The legally authorized representative may make decisions for the patient who is unable to make medical decisions. However, when in doubt or for unresolved conflict on the scene contact OLMC. The order is:
   a. A legal guardian
   b. A power of attorney for health care as designated by the patient on the Oregon Advance Directive
   c. Spouse or legal domestic partner
   d. Adult children
   e. Parent

6. Death with Dignity:
   If a person who is terminally ill and appears to have ingested medication under the provisions of the Oregon Death with Dignity Act, the EMS provider should:
   a. Provide comfort care as indicated.
   b. Determine who called 9-1-1 and why (i.e., to control symptoms or because the person no longer wishes to end their life with medications).
   c. Establish the presence of DNAR/DNR orders and/or documentation that this was an action under the provisions of the Death with Dignity Act.
   d. Contact OLMC.
   e. Withhold resuscitation if DNAR/DNR orders are present, and there is evidence that this is within the provisions of the Death with Dignity Act and OLMC agrees.

C. PATIENTS ENROLLED IN HOSPICE AND DYING PATIENTS

1. Look for POLST forms (contact Registry if needed) and attempt to honor patient preferences. Always provide comfort measures.
2. If the patient is enrolled in hospice or receiving palliative care, refer to Hospice and Palliative Care protocol 50.062.

D. CARE OF GRIEVING PERSONS

Resuscitation phase:

1. As time allows, give accurate and truthful updates about the patient's prognosis. If available, assign one person to interact with and support family members.
2. Consider gently removing children from the resuscitation area.
3. Depending upon the emotional state of family members, consider allowing them to watch and/or participate in a limited and appropriate way.
4. If family or friends were doing CPR prior to your arrival, commend their efforts.
5. If family or friends are disruptive consider removing them or try assigning simple tasks, such as helping bring in the stretcher, holding doors open, telling other family about the event, and calling the doctor or clergy member.
6. Be respectful. Make requests. Don't give orders.

Once death is determined:

1. Treat the recently dead with respect.
2. Tell family and friends of the death honestly. Use the words “death” or “dead”. Avoid using euphemisms such as “passed away” or “gone”.
3. Avoid using past tense terms when speaking to survivors of the recently dead.

4. Allow family and friends to express their emotions. Listen to them if they want to talk but don't push them.
5. Give factual information.
6. Genuine warmth and compassion will be more helpful than almost anything else for survivors. Don't feel it necessary to say the "right" things. Listening often provides grieving people with the most comfort.

Focusing on survivors:

1. See to it that survivors have a support system present before you leave. Consider calling TIP through EMS Dispatch, if available in your jurisdiction. Call friends, family, clergy, or neighbors to be with them. Respect the survivor's wishes to be alone.
2. Explain the next steps to them after you have pronounced death. This will include the police coming to make reports, possibly the medical examiner, and the possible need for an autopsy.
3. Contact the Medical Examiner's office as soon as possible before moving or altering the body.
4. Allow family and friends to say their good-byes if possible.
5. A chaplain may be helpful in assisting with survivors. It is advisable to call early, as the chaplains do not have code-3 capabilities.
6. Help survivors make decisions such as which people should be called. If they ask you to make calls, try to comply, mention the need to find a funeral home, if one has not already been chosen. Clergy may also be helpful with this decision.

E. DEATH OF A CHILD:

1. Do not accuse the parents of abuse or neglect but take careful note of the patient's surroundings and the general physical condition of the child.
2. Do not be overly silent, which may imply guilt to the parents.
3. Ask the parents only necessary questions and do not judge or evaluate them. Do not tell them what they "should have" been doing before your arrival.
4. Remind parents to arrange for childcare of other children.
5. Listen carefully to their statements and answer only with accurate information.
6. If there is a police investigation, tell the parents that this is routine.
7. Successful management of child deaths requires supportive, compassionate, and tactful measures.

Death Notifications – 50.030

PURPOSE:

To establish guidelines for the handling of the body and required notification following a declaration of death as outlined in ORS Chapter 146. The goal of an investigation by the medical examiner's office is to determine the cause and manner of death.

PROCEDURE:

A. If the patient appears to meet obvious death in the field criteria, have only one person enter the scene to verify death; limit access if possible. Don't move the decedent unless necessary. Document anything that was altered by your examination (e.g. unbuttoned/removed clothing, movement of the decedent, etc.).
B. Contact police for all deaths in the field except for hospice and skilled nursing facilities.
C. Upon declaration of death, the medical examiner (ME) must be contacted. Until contact is made with the ME:
    1. Do not move the body.
    2. Do not cover the body unless necessary (outside, public place). If covering the body is necessary, use a new/clean non-cloth disposable sheet or blanket such as an emergency blanket.
    3. Do not remove clothing or cleanse the body or otherwise alter the appearance of the state of the body.
    4. Do not remove any of the effects of the deceased or instruments or weapons related to the death.
    5. Do not let anyone in the area where the deceased is located.
    6. If resuscitation was attempted, do not remove IV's, advanced airways, or defib/ECG pads. Circle all IV attempts or any trauma or marks that you caused to the body with an ink pen if possible.
D. Depending on the circumstances, the ME will either respond to the scene for a full investigation or release the body to a funeral home with a limited investigation. Generally, it is best to turn the scene over to law enforcement once you have given a report.
E. You should not leave the scene without passing the scene off to law enforcement or until the ME has released you over the phone or the ME arrives at the scene and has released you.
F. The following documentation is required for declaration of death calls:
    1. Location and position the body was found.
    2. Location of evidence if moved for safety concerns (gun, knife, bat, etc.).
    3. Anything suspicious (e.g. bruises on the body, deformed arm, black eye, comments made by bystanders/relatives/friends, etc.).
    4. Name and title of individual the scene is turned over to (law enforcement, ME, another crew) and the disposition of the body.
    5. The name of the ME if the body is released with a limited investigation.
    6. Follow your individual agency's medical records policy for listing witnesses or possible witnesses with contact information.

Death Notifications – 50.030

NOTES:

A. Once the person is declared dead, your jurisdiction ends. Even law enforcement is not allowed to touch or move the body. Only the ME, Deputy ME (also referred to as a Medicolegal Death Investigator), or District Attorney, has lawful authority over the body. Any of these individuals can grant access or removal of the body.

B. Not all deaths are under the jurisdiction of the ME (e.g. patient on hospice care longer than 24 hours, patient who dies in a skilled nursing facility). However, EMS calls should be considered an ME case and reported to the ME. It is best to let the ME decide if this is their case or not.

C. Your chart may be read by the ME's office and if read, will become part of the report for cause and manner of death.

D. In smaller counties and jurisdictions, law enforcement officers may be appointed as Deputy ME's or medicolegal Death Investigators, who under the direction of the ME's office, can investigate deaths and authorize the removal of a body of a deceased person from the apparent place of death.

E. If you suspect a COVID-19 death, document the names and contact information of everyone who had contact with the person that is on scene.

F. The following information should be available, if possible, prior to contacting the ME. The ME may not ask for all this information but be ready with this information.

• Your name	• Any evidence of drug use
• Unit number	• Name of deceased
• What you were dispatched on	• Address of deceased
• How you found the patient	• Age of deceased
• Brief description of your actions	• Gender of deceased
• Whether you suspect foul play	• Medical history
• Whether death occurred at work	• Medications
• Whether death occurred while in custody	• Primary caregiver and phone number
• Whether death was the result of a crime	• Family contact
• Whether death was unattended	• Funeral home
• Whether cause of death might be from a contagious disease	

Documentation – 50.040

PROCEDURE:

A. A patient care report shall be generated for each identified patient and shall be completed on an approved State EMS patient care form.
B. Documentation shall include, at least:
    1. The patient's presenting problem.
    2. Vital signs with times.
    3. History and physical findings as directed by individual protocols.
    4. Treatment(s) provided, and time(s).
    5. If monitored, ECG strip, 12-lead ECG, and interpretation.
    6. Any change in the condition of the patient.
    7. OLMC contact:
        a. Include physician name
        b. Time of contact
        c. Orders received from physician
C. An electronic Prehospital Care Report must be submitted to a hospital or facility receiving the patient with 24 hours of the patient being transported per ORS 333-250-0310.
D. If a patient refuses treatment and/or transport, refer to Refusal and Informed Consent protocol.

Hand-Off Reports – 50.050

PURPOSE:
The transfer of care is an activity that has the potential for medical error. Patient hand-off reports between either EMS personnel on scene or between EMS personnel and hospital staff during transfer of care, needs to be delivered in a consistent and clear format to ensure accuracy and completeness of information. As many agencies are transitioning to paperless in-field reporting, the passage of detailed information from one agency to another or to the hospital becomes critically important.

PROCEDURE:
The following "DMIST" format is a guideline for both oral and/or written communications when passing information from one agency to the next as well as for reports to receiving facilities. It is understood that not all information may be available at the time of the handoff.

DEMOGRAPHICS:
- Name
- Legal Name (If Different)
- Code Status/POLST
- Age, DOB, Phone Number
- Weight in Lbs./Kg

MEDICAL COMPLAINT/MECHANISM OF INJURY:
- Chief Complaint/OPQRST
- Background/Time of Injury

ILLNESS/INJURY:
- ECG
- Stroke assessment (PPSS, C-STAT), Last Known Well
- PMHX
- Medications
- Allergies

SIGNS:
- GCS/LOC
- Lowest and Last Blood Pressure
- SpO_2
- CBG
- $EtCO_2$
- Temperature

TREATMENT:
- IV Site and Size
- Medications and Response to Treatments

Hazardous Materials Response – 50.060

PURPOSE:
Non-hazardous materials trained EMS personnel may be first on the scene of a hazardous materials situation because of shorter response times or no knowledge of dispatch that hazardous materials are involved. This protocol is intended to guide personnel who do not normally function in hazardous materials scenes. If the scene you are responding to is a known or suspected (based on information from dispatch) hazardous materials situation, stage and wait for the hazardous materials personnel. When you have arrived at the scene and find out during scene assessment that hazardous materials are involved, stage and wait for the hazardous materials personnel. All scenes (MVA, Industrial, etc.) should be considered as being a potential hazardous materials situation. The following approach procedure should be used:

PROCEDURE:

A. Approach
   1. All scenes:
      a. Be cautious all times.
      b. The reported location may be inaccurate, response into a contaminated area might occur.
      c. Approach upwind and upgrade if possible.
      d. Position vehicle well away from the incident.
      e. Communicate your actions to the 9-1-1 Center.
      f. Remember: Contaminated and/or exposed response personnel may add to the overall problem and reduce their effectiveness to help.

   2. If at any time you suspect a hazardous materials situation:
      a. Confirm that fire and police have been notified. The agency responsible for hazardous materials response may respond with different levels of personnel and equipment based upon the information received. Do not always expect a hazardous materials team to respond.
      b. If you are a first-in responder, the first priority is scene isolation.
      c. If you believe that you or your vehicle is contaminated, stage in an isolated area. KEEP OTHERS AWAY! KEEP UNNECESSARY EQUIPMENT FROM BECOMING CONTAMINATED.

B. Person in Charge
   1. If a “non-hazardous materials trained” paramedic is the first medical person on the scene, he/she should assume the role of PIC (medically) until a "hazardous materials trained paramedic" (HMP) arrives. If possible, the Incident Command Structure should be implemented.
   2. The HMP will direct all care.
   3. The HMP will determine the method of transport of the exposed patient (air vs. ground).
   4. The HMP will determine who will provide care during transport (HMP may remain in that position during transport).

C. Patient Care for the Contaminated Patient
   1. Types of incidents which may require decontamination of the patient:
      a. Radiation
      b. Biological hazards
      c. Chemical
      d. Toxic substances
   2. Contamination can occur though:
      a. Smoke
      b. Vapor
      c. Direct contact
      d. Run-off
   3. Determine the hazardous substance involved and provide treatment as directed by HMP. In the absence of an HMP, consult Poison Control through OLMC.
   4. The hazardous materials team must be contacted about removal of contaminated clothing and packaging of the patient with regard to your protection and the patient's.

D. Ambulance Preparation
   1. The HMP shall determine the process needed for ambulance preparation.
   2. Remove any supplies and equipment that will be needed for patient care.
   3. Seal cabinets and drape interior, including floor and squad bench, with plastic (available from hazardous materials team).

E. Transport and Arrival at the Hospital (if requested by HMP)
   1. If an ambulance has transported a patient from an incident that is subsequently determined to involve hazardous materials exposure, scene personnel must immediately relay all relevant information to the transporting unit(s) and/or receiving facility(s) involved (via EMS dispatch or OLMC).
   2. OLMC and the receiving hospital should be contacted as soon as possible. The EMS providers should communicate the material involved, degree of exposure, decontamination procedures used, and patient condition.
   3. The ambulance should park in an area away from the emergency room or go directly to a decontamination center or area.
   4. Patient(s) should not be brought into the emergency department before the EMS providers receive permission from the hospital staff.
   5. Once the patient(s) has been released to the hospital, follow the HMP's direction and if necessary double bag the plastic sheeting used to cover the gurney and the floor. Double bag any equipment, which is believed to have become contaminated.
   6. After unloading the patient from the ambulance, check with the HMP to see where the ambulance can be safely decontaminated and whether there is equipment available for this purpose. Do not begin decontamination without direction from the HMP. After consultation with the Hazardous Materials Team leader, the HMP may recommend that the ambulance be decontaminated.
   7. Following decontamination recommendations from the HMP, decontaminate the ambulance and personnel before returning to the incident scene. When returning to the incident scene, bring bags containing contaminated materials, equipment, clothing, etc., and turn them over to the HMP.

F. EMS Personnel Exposure

1. If an EMS provider is exposed or is concerned with the possibility of exposure, medical help should be sought immediately.
2. Report all exposures to the HMP, Poison Center, supervisor, and the on-call OHDP nurse.
3. Follow your agencies guidelines for Communicable Disease: Bloodborne/Airborne Pathogens), including appropriate Personnel Exposure Report.
4. Do not return to service until cleared to do so by the HMP or Poison Center.

FOR ADDITIONAL INFORMATION SEE THE HAZMAT PROTOCOL

Hospice and Palliative Care – 50.062

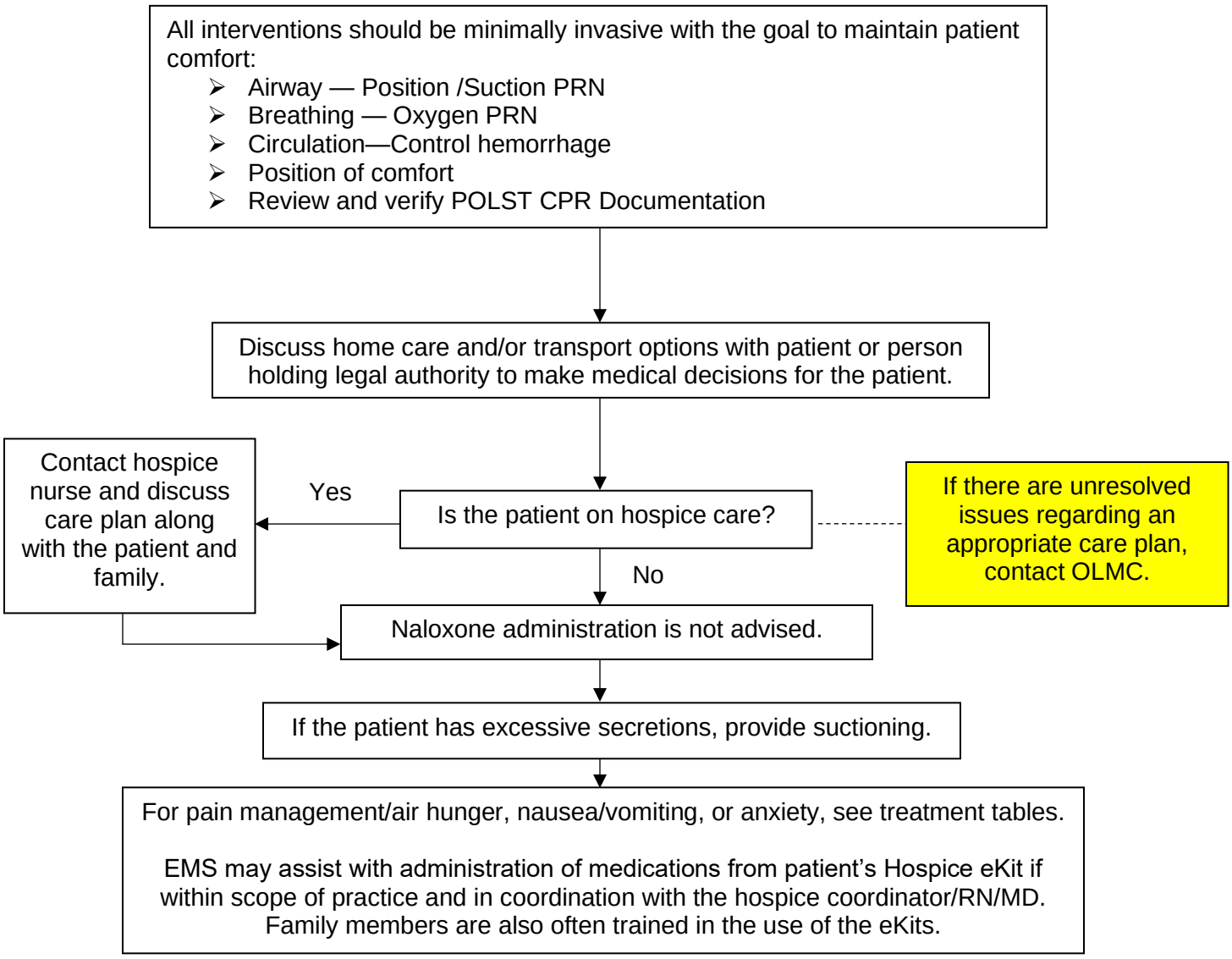
PURPOSE:
To provide guidance to the EMS provider in the care of a patient who has a life-limiting or terminal illness and prefers comfort-focused treatment.

INDICATIONS:
Patient has a life limiting or terminal illness, prefers comfort-focused treatment, and has one of the following:

A. POLST form specifying DNAR/DNR and comfort focused treatment and/or
B. Patient is enrolled in hospice care.

GOALS:

A. Reduce patient symptom distress.
B. Maintain patient dignity by aligning care with stated end-of-life preferences.
C. Affirm dying as a normal process.



Patients with decision making capacity: If the patient can communicate and has the capacity to make decisions regarding treatment and transport, consult directly with the patient before treatment or transport.

Patients without decision making capacity:
If the patient lacks the capacity to make decisions regarding treatment or transport, identify any advanced care planning in place for information relating to advanced care planning and consent for treatment, including:

- Advanced care directives
- POLST
- Guardian, healthcare power of attorney, or other accepted healthcare proxy

NOTES AND PRECAUTIONS:

A. Palliative care is specialized care for patients with a chronic and/or terminal illness which focuses on managing symptoms exacerbation and the stress of illness.
B. Hospice care is specialized care, like palliative care, for patients within the last 6 months of life.
C. Patients may not have a DNAR/DNR or POLST form completed and still be enrolled in hospice care.
D. Careful and thorough assessments should be performed to identify complaints not related to the illness for which the patient is receiving hospice or palliative care.
E. Treat dying persons with warmth and understanding. Do not avoid them. Allow them to discuss their situation, but do not push them to talk. Ask the person how you might help.
F. Many dying people are not upset by discussions of death as long as you do not take away all of their hope. Touching a dying person is important. Use words like “death”. Do not use meaningless synonyms. Give factual information.
G. Be aware of your own fears regarding death and admit when a dying person reminds you of a loved one. If a situation is too disturbing, have your partner or other members of the responding team take over.
H. Social interactions with the family may affect end-of-life care, including psychological and spiritual aspects of patient care.
I. Offer support system to help the family cope during the patient’s illness and in their own bereavement.
J. Care should be delivered with the utmost patience, kindness, and compassion.
K. PICC lines may be accessed for use by EMS with sterile techniques.
L. Emergency Kits (eKit) may be given to patients by hospice to use at home for acute symptom exacerbation. These eKits are individualized and will be different for each patient, but typically contain medications that can address pain, nausea/vomiting, anxiety, and/or secretions. Not every hospice service utilizes an eKit. Family members are frequently trained in the use of the eKit.
M. In collaboration with hospice or palliative care provider, coordinate with guardian, power of attorney, or other accepted healthcare proxy if non-transport is considered.
N. EMS providers cannot take medical orders from a hospice nurse, but their advice is often invaluable and may be followed with direction from OLMC. Providers can take orders from a hospice physician however, and this can include in the form of a written prescription which may be present in a patient’s eKit.

O. Consider OLMC if hospice or palliative care provider is not available or for on scene conflict.
P. After medication administration, if no transport occurs, care may be transferred to the hospice nurse or palliative care provider.

TREATMENT TABLES

Acute Pain/Air Hunger (uncomfortable feeling of breathing difficulty)

Severity*	Medications		
	Fentanyl (IV/IN)	Hydromorphone (IV/IM)	Morphine (IV/IM)
Mild	25 mcg	0.5 mg	2 mg
Moderate	50 mcg	1 mg	4 mg
Severe	100 mcg	2 mg	8 mg

*Consider using moderate/severe dose in opiate tolerant patients. Opiate tolerant patients have a typical daily dose of narcotic that is equivalent to ≥ 60 mg of oral morphine per day.

Anxiety/Agitation

Severity	Medications				
	Midazolam (IV/IM)	Lorazepam (IV/IM)	Droperidol (IV/IM)	Haloperidol (IV/IM)	Ziprasidone (IM)
Mild/Moderate	1 mg	0.5 mg	2.5 mg	2 mg	10 mg
Severe	2 mg	1.0 mg	5 mg	4 mg	20 mg

May repeat dose in 15 minutes for IV administration, or 30 minutes for IM injections.

Nausea/Vomiting:

Medications		
Ondansetron (PO)	Droperidol (IV/IM)	Haloperidol (IV/IM)
8 mg	0.625 mg	1.25 mg

Lift Assist – 50.065

PURPOSE:
Fire and EMS resources are frequently dispatched to provide lifting assistance. This assistance can vary but often involves an individual who has fallen or slipped and is now unable to get up or return to bed without assistance. In all calls from an individual or responsible party requesting lifting assistance, a medical evaluation must be completed looking for any injury, underlying medical process that contributed to this event, or for a deterioration in functional ability.

PROCEDURE:

A. Initial evaluation should begin by assessing for any suspected medical cause or inability to mobilize (e.g. dizziness, lightheadedness, syncope, new weakness or balance problem, dehydration/poor oral intake, visual disturbance, recent illness or infection, etc.).
B. Assess vital signs to include HR, RR, BP, SpO_2. In some instances, based on patient's past medical history or provider discretion, a temperature, $EtCO_2$, and blood glucose should also be checked.
C. Determine if any acute injury or medical condition exists.
D. Ascertain the duration of down time if found on the ground/floor. Consider hypothermia, compartment syndrome, or rhabdomyolysis.
E. Determine if patient is on any oral anticoagulants which may increase risk level for unrecognized bleeding and may prompt the provider to recommend transport.

NOTES:

A. Lift assist calls can be a sentinel event for someone that is developing a medical emergency or who has crossed the threshold from being able to live independently to someone who needs a little more help (assisted living, etc.).
B. Anyone with impaired mobility that requires assistance to mobilize necessitates an assessment of their health status before deciding that the patient does not require further medical assessment.
C. A PCR will be completed on all patient contacts in which a patient receives any assessment, assistance (i.e. lift assist), advice, or treatment by EMS. The PCR may be brief, but must include vital signs, any assessment/exam provided, and documentation of the lack of a medical complaint.
D. Those who decline transport should be evaluated for medical decision-making capacity and the informed refusal process should be followed. Advise patient that they may call 911 if they develop any symptoms.
E. If vitals are unable to be obtained, this must be documented on the PCR along with a reason.
F. EMS/Fire agencies may (and are encouraged to) develop their own, more expansive and detailed documentation policies specific to their own operations.

Multiple Toxic Exposure – 50.070

PURPOSE:

To provide guidelines for emergency response personnel on scenes that involve multiple victims who have been exposed to a hazardous material or hazardous environment. This procedure would be used when MSDS and DOT information indicate that victims **may** suffer untoward effects from their exposure and need **short-term, continuing medical assessment**. It would also apply when victims are symptomatic and have been exposed to a hazardous environment that poses little risk of long-term effects, such as discharge of tear gas. *This protocol is NOT intended for use when there are symptomatic patients and the substance they were exposed to is unknown or when there is a potential for serious or long-term medical consequences.*

PROCEDURE:

A. Triage determines that there are multiple victims who have been exposed to a hazardous material or environment, and that these victims are presently asymptomatic or have been exposed to an agent that has transient effects (e.g., tear gas).

B. Triage will assist the Hazardous Materials (trained) Paramedic/EMT (HMP) in coordinating removal of the victims from the potentially hazardous environment, then isolate the victims as best as possible in a safe, well lit, and climate-controlled environment (consider using a bus or a room in a nearby building). If clothing is contaminated, removal of contaminants and proper procedures will be employed prior to isolating victims.

C. Access to and egress from the Triage and Treatment Area must be strictly controlled at all times. It is necessary to keep track of patients who are under the care of EMS providers, especially when the patient is a minor and his/her parent(s) are present. Patients should not be allowed to leave the treatment or triage area without Triage or Treatment's knowledge. It is recommended that a guard be posted at the entrance and exit to control patient movement.

D. The HMP will attempt to determine the type and level of exposure. The HMP will then contact MRH with information on the type of chemical and level of exposure. MRH will consult with Poison Control to determine any symptoms that are to be expected, the approximate timeline for onset of symptoms, and recommended treatment modalities. When possible, a three-way phone link among the scene, MRH, and Poison Center should be arranged. The HMP will report this information to Triage and to Medical.

E. All potential patients entering the area will be triage tagged and baseline vitals will be obtained and recorded. It is recommended that Triage consult with Medical and assign one EMS provider for every 8 to 10 patients. If any exposure victim starts exhibiting symptoms, they will be immediately removed to the designated Treatment Area.

F. In consultation with MRH, Triage and HMP will make a determination regarding how long the victims will be observed and the frequency of evaluating and taking vital signs of each patient. A log will be maintained of all patients treated and released. This log will include the patient's name, DOB, the date, symptoms (if any), and disposition.
   1. If the patients are asymptomatic after the designated observation time, they may be released. The HMP or Triage will individually brief the patients regarding the symptoms they should watch for and should recommend further medical evaluation by their own physician. Minor patients should only be released to their parent or guardian.
   2. Triage or the HMP will inform Medical of the number of patients being released.

G. It is recommended that Medical proceed with initiating procedures normally undertaken during an MCI. Regional shall be notified that the all-call is precautionary.

Medical Control of Scene – 50.110

PURPOSE:
The purpose of this protocol is to describe who is in charge of patient care on the scene of medical emergencies and how to resolve disputes with other medical professionals in attendance. **This protocol does not apply to MCI/MPS events where ICS is established.**

PROCEDURE:
A. EMS Providers On-Scene: The first arriving, highest certified EMS provider will be the Person-In-Charge (PIC) and will assume responsibility for directing overall patient care. The team approach to patient care assessment and treatment should be utilized by the PIC.
B. When a higher-level EMS provider arrives, in an EMS role, that individual shall assume the role of PIC, after receiving verbal report from the initial PIC.
C. The responsibilities of the PIC directing overall patient care include:
    1. Assuring that treatment, operations, and communications follow protocols.
    2. Coordinating patient care activities. This PIC must watch over the entire patient care scene activities and be sure that the patient care activities are being accomplished in a rapid, efficient, and appropriate manner.
    3. Directing other EMS providers to establish airway management, start IVs, etc.
    4. Establishing the appropriate time to be spent at the scene for doing patient care.
    5. Determining when transportation of the patient is to occur.
    6. Performing medical coordination with all agencies and personnel.
D. The PIC directing overall patient care will be held responsible and accountable for patient care activities performed at the scene and be identified on all patient care reports.
E. If a patient requires transport and the first arriving PIC is from a non-transporting agency, provision of patient care will be turned over to the transporting Paramedic or flight personnel when:
    1. The patient is placed on the transport unit's gurney, **OR**
    2. At a time agreed upon by both EMS providers, continued patient care will then become the responsibility of the transporting unit. There will be a verbal agreement any time transfer of care from one EMS provider to another takes place.

Paramedic Direction On Scene:
EMS providers take medical direction from:
- Physician Supervisors.
- Regional Protocols.
- On-Line Medical Consult (OLMC) as directed in protocols.

Physician On Scene Policy, (within office):
A. When EMS is called to a physician's office, the EMS providers should receive information from the physician and attempt to provide the service requested by the physician.
B. While in the physician's office, the physician shall remain in charge of the patient. The EMS providers may follow the direction of the physician if it is within the Scope of Practice and protocols of the PIC. Anytime there is a conflict between a physician's orders and the protocols, OLMC shall be contacted.

C. Once the patient is in the ambulance, unless the physician accompanies the patient, paramedics shall follow the protocols.

Physician On-Scene Policy, (outside office):

A. Any physician (MD or DO) at the scene of an emergency may be qualified to provide assistance to EMS providers and shall be treated with professional courtesy.
B. A licensed physician requesting control of patient care at the scene shall be:
    1. Thanked for the offer by the PIC.
    2. Advised that the EMS providers work under regional protocols and On-Line Medical Consult.
    3. Advised that we are not permitted to relinquish medical control to a physician on the scene without agreement from On-Line Medical Consult.
C. If the physician requesting control is not the patient's "physician of record," EMS providers shall be authorized to proceed under the direction of the physician ONLY IF ALL THREE OF THE FOLLOWING PROVISIONS ARE MET:
    1. OLMC is contacted and authorizes transfer of patient care.
    2. The physician agrees to accompany the patient to the hospital in the ambulance.
    3. The physician agrees to complete and sign the appropriate patient care report.
D. If communication with OLMC cannot be established, care may be provided only according to approved ALS protocols. No direction from an on-scene physician may be accepted.

Disputes On-Scene Between EMS providers or Other Medical Professionals:

A. Disagreements about care should be handled in a professional manner and shall not detract from patient care.
B. To the extent possible, the ALS and BLS protocols shall be followed and provide the basis for resolving disputes.
C. If an unresolved dispute continues between EMS providers or other medical professionals concerning the care of a patient, **OLMC shall be contacted**.
D. If a dispute arises which results in transfer of patient care from one PIC to another, the approximate time of the transfer shall be included on the patient care report.
E. DISPUTES SHALL NOT APPEAR ON PATIENT CARE REPORTS. Written "Unusual Event Forms", or similar form should be completed pursuant to any dispute arising at the scene.

On-Line Medical Consult – 50.115

PURPOSE:

This protocol describes the steps an EMS provider should follow in contacting Medical Resource Hospital (MRH) and/or a receiving hospital for On-Line Medical Consult (OLMC) and describes the contents of the various reports.

PROCEDURE:

A. Calls to MRH or the Receiving Hospital: EMS Providers shall contact MRH or the Receiving Hospital by radio or telephone in the following situations:

1. As required by the protocols.
2. As required in approved studies.
3. As required for trauma services.
4. When On-Line Medical Consult (OLMC) is needed.

B. All scenes involving OLMC contact:

1. One person at the scene must be designated as the contact person in charge of communications. The EMS provider designated as “in charge” of communications shall contact MRH or the Receiving Hospital by the time transport has begun, including all air ambulance transports.
2. For OLMC, MRH shall be contacted if a patient’s destination is in Multnomah, Clackamas or Washington County. If an MRH physician cannot be contacted, contact the Receiving Hospital.
3. The receiving hospital should be contacted to provide patient status updates during transport for all patients except Trauma System entries.
4. If BLS responders have initiated OLMC communications, ALS responders shall continue to use that medical direction source.

C. When requesting OLMC, the following information must be relayed

1. Unit number, identity and certification level of person making contact
2. Location of the call, street address if appropriate
3. Purpose of call (Identify the protocol being followed)
4. Age and sex of patient
5. Patient’s chief complaint
6. Brief history, prior medical history, medications, and allergies
7. Vital signs
8. Pertinent physical findings
9. Treatment at scene
10. Destination hospital and ETA, including loading time

D. When contacting the TCC for trauma system patients, the following information must be relayed:

1. Unit number, identity, and certification level of person making contact
2. Location of the incident, street address if appropriate
3. Number of patients. Follow ***Multi- Casualty Incident*** protocol, if applicable
4. Age and sex of the patients
5. Trauma System entry criteria (be as specific as possible)
6. Trauma Band number(s)
7. Patient's vital signs. Specify if not taken or not present
8. Approximate ETA of patient(s) to Trauma Center; include loading time if appropriate
9. Unit number and mode of transport
10. Patient destination based on incident location or request

Refusal and Informed Consent – 50.117

PURPOSE:

- To establish the process of obtaining informed consent.
- To define which persons may be left at the scene because they are not considered in need of EMS.
- To describe the process of obtaining and documenting patient refusal.

PROCEDURE: (Refer to Refusal Flow sheet)

A. **Identified Patient:** Determine if there is an "Identified Patient":

Any individual meeting the following criteria is considered a patient:

- Has a complaint suggestive of potential illness or injury.
- Person is evaluated for potential illness or injury.
- Has obvious evidence of illness or injury.
- Has experienced an acute event that could reasonably lead to illness or injury.
- Is in a circumstance or situation that could reasonably lead to illness or injury (including behavior problems).
- Person is less than 18 years of age.

B. **Decision Making Capacity:** Consider conditions that may be complicating the patient's ability to make **an informed** decision:

- Orientation to person, place, time, or event that differs from baseline.
- Head injury.
- Drug or alcohol intoxication.
- Mental health issues.
- Language barriers (consider translator or ATT language line through dispatch).
- High risk medical conditions.

C. Identified Patient **WITH** decision making capacity who refuses **needed** treatment and/or transport:

1. Explain the risks and possible consequences of refusing care and/or transport.
2. If a high-risk medical condition exists, contact OLMC for physician assistance.
3. Enlist family, friends, or law enforcement to help convince patient.
4. If patient continues to refuse, complete the Patient Refusal Information Form and have them sign it. Give the top copy to the patient with self-care instructions.

D. Identified Patient **WITH IMPAIRED** decision-making capacity:

1. Treat and transport any person who is incapacitated and has a medical need.
2. Patients with impaired decision-making capacity should **NOT** sign a release form.
3. With any medical need, make all reasonable efforts to assure that the patient receives medical care. Attempt to contact family, friends, or law enforcement to help.
4. If deemed necessary, consult with OLMC and consider pharmacological sedation or physical restraint per Agitated Patient protocol.

E. Consent and refusal guidelines for **minors** (reflecting Oregon Revised Statutes):
   1. A child under the age of 10 cannot be left alone even if he or she is not a patient. If no responsible adult is present and the child is not a patient, contact law enforcement.
   2. Minors who are ages 15 or older and less than 18 years can consent to treatment.
   3. If a minor age 15 or older and less than 18 years is refusing treatment/transport contact OLMC.
   4. If a minor age 15 or older and less than 18 years is not transported, attempt to contact parents to inform them of the EMS call.

F. **High risk medical conditions requiring OLMC Contact**: EMS providers are required to contact OLMC for the following refusal situations:
- Suspected impaired decision-making capacity.
- Suspected high risk medical condition such as:
  - Age younger than 3 months.
  - Minor (age 17 or younger) without a patient or guardian who is refusing care.
  - Serious chief complaint (including but not limited to, chest pain/dysrhythmia, shortness of breath, BRUE, stroke like symptoms, syncope, first time seizures, poison/overdose, suspected sepsis, or suspected cervical spine injury).
  - Significant MOI or suspicion of injury.
  - You believe a patient requires evaluation.
  - Conflict on scene regarding refusal of care.
  - Suspected abuse situation involving a minor, elderly, or a person with a disability.
  - Any unconscious or altered mental status (individual or parent/guardian for a minor).
  - Sustained abnormal vital signs:
    - Pulse greater than 120 or less than 60
    - Systolic BP greater than 180 or less than 90
    - Respirations greater than 29 or less than 10
    - $SpO_2 \leq 90\%$
    - $EtCO_2$ less than 25 mmHg or greater than 60 mmHg

DOCUMENTATION:

All instances of an identified patient, with or without impaired decision-making capacity, must be fully documented on a Patient Care Form. A signed refusal form must be obtained on all patients with decision making capacity who are refusing care and/or transport against medical advice. The following is considered minimum documentation criteria:

- General appearance and level of consciousness (mental status).
- History, vital signs, and physical exam.
- Presence of any intoxicants.
- Assessment of the person's decision-making capacity.

- Risks explained to patient.
- Communication with family, friends, police, and/or OLMC.

GUIDELINES & DEFINITIONS:

A. Decision Making Capacity: The ability to make an informed decision about the need for medical care based on:
   - Accurate information given the patient regarding potential risks associated with refusing treatment and/or transport.
   - The persons perceived ability to understand and verbalize these risks.
   - The person's ability to make a decision that is consistent with his/her beliefs and life goals.

B. Impaired Decision-Making Capacity: The inability to understand the nature of the illness or injuries, or the risks and consequences of refusing care.

C. Emergency Rule: EMS providers may treat and/or transport under the doctrine of implied consent a person who requires immediate care to save a life or prevent further injury. Minors may be treated and transported without parental consent if a good faith effort has been made to contact the parents or guardians regarding care and transport to a hospital, and the patient, in the opinion of EMS provider, needs transport to a hospital. When in doubt, contact OLMC.

Refusal and Informed Consent – 50.117

ASSESS PATIENT'S MEDICAL NEED

IS THIS AN IDENTIFIED PATIENT? **(Any individual meeting the following criteria is considered a patient)**

- Has a complaint suggestive of potential illness or injury
- Person is evaluated for potential illness or injury
- Has obvious evidence of illness or injury
- Has experienced an acute event that could reasonably lead to illness or injury
- Is in a circumstance or situation that could reasonably lead to illness or injury
- Person is less than 18 years of age

NO IDENTIFIED PATIENT

ACTION

- No Information Form required

IDENTIFIED PATIENT

ASSESS ABILITY TO MAKE DECISIONS

Consider:

- Orientation to person, place, time, or event that differs from baseline
- Head injury
- Drug or alcohol intoxication
- Mental health issues
- Language barriers
- High risk medical conditions

ABLE TO MAKE DECISIONS

Ambulance transport advised but patient refuses.

-ACTION-

- **Explain risks of refusal.**
- If serious medical need exists, contact OLMC.
- Enlist family, friends, police, etc. to help convince patient.
- Complete Information Form, obtain patient signature, & give them the top copy.
- Follow *Documentation* protocol.

ABLE TO MAKE DECISIONS

With no apparent need for ambulance transport.

-ACTION-

- **PIC must agree with patient's course of action.**
- Fully document physical findings.
- Fully document advice given to patient.
- Follow *Documentation* protocol.

UNABLE TO MAKE DECISIONS

(Impaired Capacity)

-ACTION-

- Treat & transport if medical emergency exists. Use *Agitated Patient* protocol if needed.
- Make all reasonable efforts to assure patient gets medical care.
- **Consult OLMC.**
- **DO NOT have patient sign an Information Form.**

MINIMUM DOCUMENTATION

For <u>ALL</u> Identified Patients

- General appearance & level of consciousness.
- History, vital signs, & physical exam.
- Presence of any intoxicants.
- Assessment of patient's decision-making capacity.
- Any risks that were explained to the patient.
- Communications with family, police, and/or OLMC.

OLMC CONTACT REQUIRED

- Impaired decision-making capacity, AMS, or unconscious.
- Age < 3 months or Minor without guardian refusing care.
- Serious chief complaint (e.g. chest pain, SOB, first time seizures, suspected sepsis, BRUE, stroke like symptoms, syncope, poisoning/overdose, suspected cervical spine injury).
- Suspected abuse – child, elderly or disabled person.
- Scene conflict regarding medical care.
- Sustained abnormal vital signs/significant MOI/suspicion of injury

Rehabilitation – 50.119

PURPOSE:
To establish guidelines for the evaluation and treatment of personnel in the Rehabilitation Group (Rehab).

PROCEDURE:

A. Personnel in Rehab will undergo an initial medical evaluation that will consist of a physical assessment including mental status and vital signs (blood pressure, pulse and temperature, pulse ox and CO monitoring [if available]). All medical evaluations will be recorded on the Medical Evaluation Form.

B. Medical treatment or a resting period will be determined according to the following triage criteria based on entry findings:

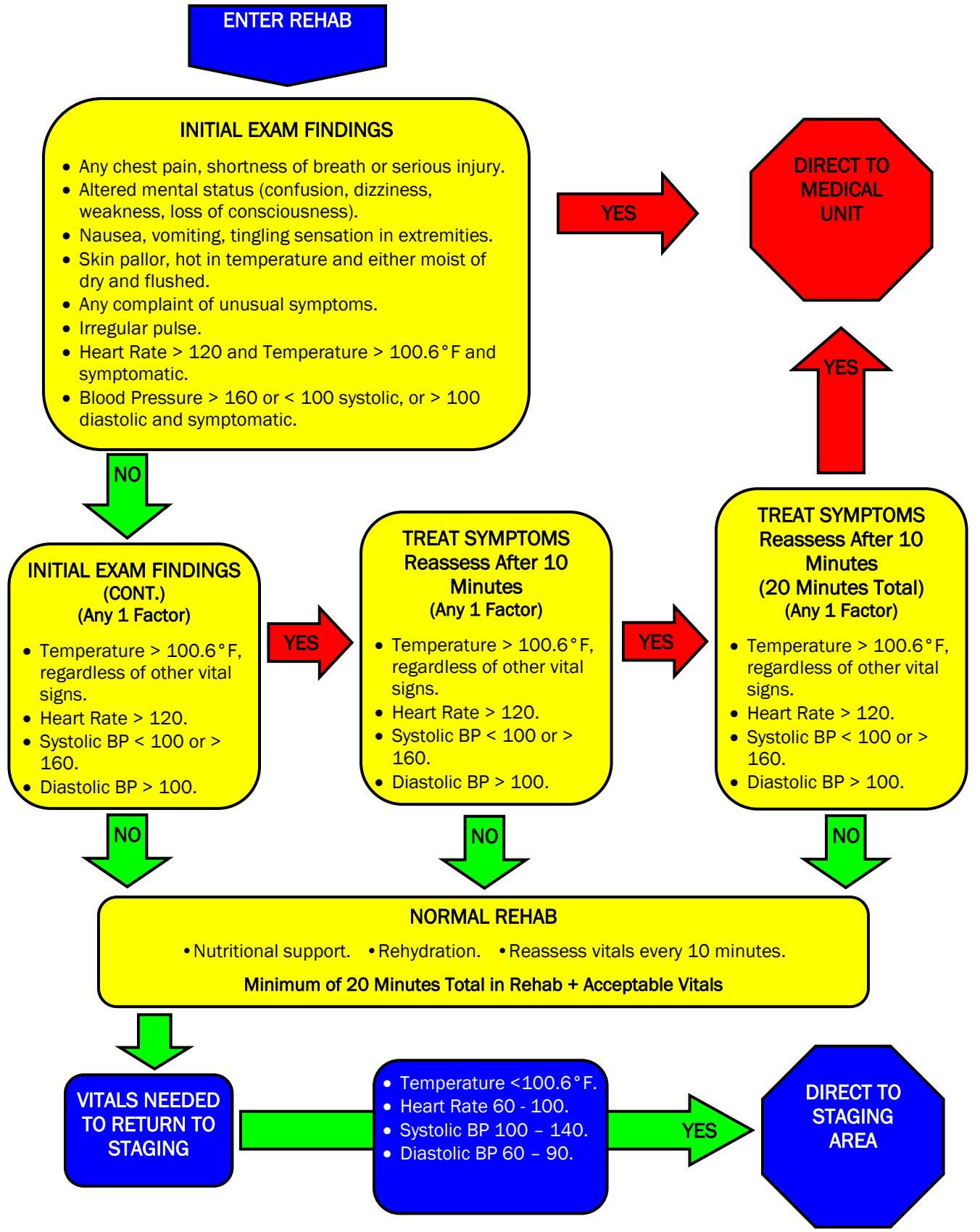
1. Findings mandating that the individual be transferred to the Medical Unit:
    a. Any chest pain, shortness of breath or serious injury.
    b. Altered mental status (confusion, dizziness, weakness, loss of consciousness).
    c. Nausea, vomiting, or tingling sensation in extremities.
    d. Skin pallor, hot in temperature and either moist of dry and flushed.
    e. Any complaint of unusual symptoms.
    f. Irregular pulse.
    g. Heart Rate > 120 and Temperature > 100.6°F and symptomatic.
    h. Blood Pressure > 160 or < 100 systolic, or > 100 diastolic and symptomatic.

2. If initial exam findings include any of the following the individual will require reassessment within 10 minutes:
    a. Temperature > 100.6°F, regardless of other vital signs.
    b. Heart Rate > 120.
    c. Systolic BP < 100 or > 160.
    d. Diastolic BP > 100.

3. If reassessment exam findings include any of the following, the individual will require an additional reassessment in 10 minutes:
    a. Temperature > 100.6°F, regardless of other vitals.
    b. Heart Rate > 120.
    c. Systolic BP < 100 or > 160.
    d. Diastolic BP > 100.

4. If, after an additional 10 minutes (20 minutes total in Rehab), reassessment exam findings include any of the following, the individual will be sent to the Medical Unit for further evaluation and/or treatment:
    a. Temperature > 100.6°F, regardless of other vitals.
    b. Heart Rate > 120.
    c. Systolic BP < 100 or > 160.
    d. Diastolic BP > 100.

5. Exam findings allowing an individual to enter Staging for reassignment include:
    a. Temperature < 100.6°F.
    b. Heart Rate 60 - 100.
    c. Systolic BP 100 - 140.
    d. Diastolic BP 60 - 90.


ENTER REHAB
INITIAL EXAM FINDINGS
• Any chest pain, shortness of breath or serious injury.
• Altered mental status (confusion, dizziness, weakness, loss of consciousness).
• Nausea, vomiting, tingling sensation in extremities.
• Skin pallor, hot in temperature and either moist of dry and flushed.
• Any complaint of unusual symptoms.
• Irregular pulse.
• Heart Rate > 120 and Temperature > 100.6°F and symptomatic.
• Blood Pressure > 160 or < 100 systolic, or > 100 diastolic and symptomatic.
YES
DIRECT TO MEDICAL UNIT
NO
INITIAL EXAM FINDINGS (CONT.)
(Any 1 Factor)
• Temperature > 100.6°F, regardless of other vital signs.
• Heart Rate > 120.
• Systolic BP < 100 or > 160.
• Diastolic BP > 100.
YES
TREAT SYMPTOMS
Reassess After 10 Minutes
(Any 1 Factor)
• Temperature > 100.6°F, regardless of other vital signs.
• Heart Rate > 120.
• Systolic BP < 100 or > 160.
• Diastolic BP > 100.
YES
YES
TREAT SYMPTOMS
Reassess After 10 Minutes
(20 Minutes Total)
(Any 1 Factor)
• Temperature > 100.6°F, regardless of other vital signs.
• Heart Rate > 120.
• Systolic BP < 100 or > 160.
• Diastolic BP > 100.
NO
NO
NO
NORMAL REHAB
• Nutritional support. • Rehydration. • Reassess vitals every 10 minutes.
Minimum of 20 Minutes Total in Rehab + Acceptable Vitals
VITALS NEEDED TO RETURN TO STAGING
• Temperature <100.6°F.
• Heart Rate 60 - 100.
• Systolic BP 100 – 140.
• Diastolic BP 60 – 90.
YES
DIRECT TO STAGING AREA

Emergency Incident Medical Evaluation Form (CONFIDENTIAL) Forward to:

Incident #: ______ Location: ______ Date: ______

Name	Unit	Time In/Out	# SCBA Cylinders	Exam Period	BP Sys	BP Dia	Pulse	Temp	Pulse Ox	Co	Notes
					If sys>160 or < 100 or Dia>100 (1)		if >120 (2)	if >100.6 (2)	<95 (3)	>0 (3)	
				INITIAL							
				10 Min							
				20 Min							
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				20 Min							

Individuals with any of the following symptoms should have aggressive treatment and may be sent to the Medical Unit:
Chest pain, weakness, dizziness, altered mental status, disorientation, headache, nausea, vomiting, muscle cramps, exhaustion, fainting, moist, pale or cool skin, abdominal cramps.

(1) Reassess in 10 minutes
(2) Hold 20 minutes; if unresolved after 20 min, send to Medical Unit
(3) Refer to Carbon Monoxide Exposure Protocol