Washington County EMS Operations

Ambulance Cancellation/Slow Down of EMS Responders – 80.100

In general, no responding unit, including a transport ambulance should be cancelled until:

- It is determined that there is no patient, **or**
- A patient is found and after a full assessment, that person is refusing further treatment and/or transport.
    - A patient refusal should be documented

A. **EXCEPTIONS:**

1. EMERGENCY MEDICAL RESPONDER (EMR) CERTIFIED:
   On scenes where a patient is refusing and only a certified EMR is present the EMR may only slow an ambulance to code 1. The ambulance will continue Code 1 and assess the patient.
2. EMT, AEMT, EMT-INTERMEDIATE, PARAMEDIC:

   An EMT, AEMT, EMT-Intermediate, or EMT-Paramedic may slow or cancel other responders once the patient has been evaluated and a determination is made that no other units are required.
3. POLICE/SHERIFF:
   In the past police agencies have requested a slow-down or cancellation of EMS. If dispatch information/patient information warrants it, EMS responders may use discretion in honoring the request. However, if one unit determines they should continue their response then all units should continue response at same response code.

B. **UPGRADES**:
Any responding agency personnel may request an upgrade in response. All units should respond with the same response code.

Ambulance Coordination - Major Emergencies/Modified EMS Ops – 80.200

THE WASHINGTON COUNTY EMERGENCY MEDICAL SERVICE PROGRAM (WCEMS) IS RESPONSIBLE FOR DECLARING MAJOR EMERGENCIES / MODIFIED EMS OPERATIONS (MEO).

Activation of Modified EMS Operations is under the authority of WCEMS and is generally done in consultation with operational leadership as well as EMS system stakeholders. In a catastrophic event, MEO implementation may be concurrent with making outreach to WCEMS for formal authorization. Any member of the EMS community (first responders, WCCCA, emergency management, or law enforcement) may request implementation of MEO. Requests are to be made to WCEMS via the WCEMS Program Supervisor or their designee.

A major emergency is defined as an extended event that causes a region-wide or countywide disruption of emergency medical or hospital services (e.g., snow, ice, flooding, earthquake, two or more hospitals sustain damage and are not capable of accepting patients). Periods of high ambulance demand not related to one of these types of events would not be considered a major emergency. When a major emergency is declared in Washington County, these guidelines will help guide the dispatch and coordination of emergency ambulances. The EMS response to request for medical assistance coordination will occur between the franchised emergency ambulance provider and Washington County Consolidated Communications Agency (WCCCA). The franchised emergency ambulance provider shall be responsible for the coordination of ambulance resources, including ambulance response into and out of the county as well as requests originating from within the county.

Coordination of system resources will be in line with WCCCA SOG 29. During Emergency operations, WCCCA will continue to triage incoming calls and may defer to the police / fire liaison for changes in dispatching guidelines based on available resources**.**

Modified EMS Operations allows for the selective and scalable application as required by the event or incident.

A. COORDINATION OF AMBULANCE RESOURCES

The franchisee's operations leadership (e.g., manager, supervisor) will actively manage ambulance resources within Washington County with the goal of maintaining and maximizing the availability of ambulances during an MEO event. The following known resources and actions are available to these ends; they are presented in an escalating order/level but need not be used in order and may be selectively combined as deemed necessary to manage the event/incident.

1. Ambulances may respond to, but not be committed to "stand-by" unless there is a known patient with known priority symptoms or the highest possibility that injuries may occur.
2. Activation and utilization of surge resources.
3. Ambulance Response Prioritization occurs when volume surge exceeds the immediate availability of resources, and all resources have been called upon. Calls with no specific illness/complaint and unknown injury calls may be triaged

to a first responder (fire or police) only response, with an ambulance response upon assessment and request by first responders.

4. Mutual aid plans.

B. AMBULANCE DESTINATION

Dependent on the nature of the large-scale major event or incident, WCEMS may establish hospital destination parameters to manage ambulance resources up to, and including, restricting destinations to the nearest hospital. Consideration will be given to patients requiring specialized care such as burn, hyperbaric, and obstetrical patients.

Patients shall be transported utilizing one of the following parameters:

1. Hospital of choice (normal operating procedures).
2. Restricted to Washington County EMS hospitals, as well as Legacy Meridian Park Medical Center in Clackamas County and Providence Newberg Medical Center in Yamhill County.
3. Restricted to closest Washington County EMS hospital, as well as Meridian Park Medical Center in Clackamas County and Providence Newberg Medical Center in Yamhill County.

C. TRAUMA SYSTEM ENTRIES

1. Patients meeting trauma system entry criteria shall be transported using the following parameters:
   a. Directly to OHSU or Emanuel Hospital as transportation routes allow.
   b. Impassible or compromised highways and secondary routes, transport to Providence St. Vincent Hospital Medical Center for treatment, and/or stabilization, and transfer as appropriate.
   c. Under extreme conditions, trauma patients in extremis may be transported to the closest appropriate hospital.

2. The following are required if a patient, who meets trauma system entry criteria, is diverted to a Washington County hospital:
   a. Transporting Ambulance: The patient should be banded and assigned a trauma system entry number. Contact the Trauma Communications Center (TCC) as usual and advise them of the diversion, the destination hospital, along with the normal trauma system entry information including the trauma band number.
   b. Transporting Agency: Within 24 hours, contact the Oregon Health Authority EMS and Trauma Systems Program to notify them of the diversion and provide them with the required information.

D. MANAGING, PLANNING, AND REPORTING OUT BY OPERATIONAL PERIODS

At the beginning of each operational period, the franchisee will provide WCEMS a situation and status (Sit/Stat) report. Both the operations and dispatch supervisors will participate in the Sit/Stat report call.

The Sit/Stat report should include, but not be limited to:

1. Briefing on the last operational period
2. Current situation and status
3. Specific actions to be/being taken relevant to Sit/Stat
4. General plans and expectations for the new/current operational period
5. Status and depth of ambulance and personnel resources

E. RESPONSE INTERVAL REQUIREMENTS

Dependent on the nature of the event or incident requiring the use of MEO, WCEMS may modify or lift response interval requirements.

F. MAJOR EMERGENCY / MODIFIED EMS OPERATIONS CHECKLIST

Activation of Modified EMS Operations is generally a collaborative decision between WCEMS and EMS stakeholders. As activation is being considered or has occurred, the following actions should be taken:

1. Pre-activation planning (when feasible); to include EMS System partners and stakeholders (i.e., County, Franchisee, Fire).
2. Determine operational periods and schedule sit/stat conference calls.
3. Primary notifications:
   a. WCCCA
   b. Fire departments/districts
   c. Washington County Hospitals as well as Meridian Park Medical Center and Providence Newberg Medical Center
   d. MRH
   e. Washington County EMS staff and Public Heath (PH) admin
4. Secondary notifications:
   a. Washington County Emergency Management
   b. Health Preparedness Organization (HPO) as necessary
   c. Washington County Fire Defense Board (WCFDB) (if not already completed)
   d. Clackamas County EMS
   e. Multnomah County EMS
   f. Yamhill County EMS
5. Major Emergency Guideline activation shall be broadcast on the fire dispatch channel.
6. Notify field units that they are now operating under Major Emergency Guidelines. If roadways into and out of Portland are impassible, trauma entry patients shall be transported to St. Vincent Hospital. If transport to St. Vincent Hospital is not possible, patients shall be transported to the nearest hospital.
7. Notify Washington County hospitals, as well as Meridian Park Medical Center and Providence Newberg Medical Center, patients may be transported to the nearest hospital.
8. Contact St. Vincent Hospital Emergency Department Physician and request they be prepared to accept patients that meet trauma system entry criteria. If a patient meets trauma system entry criteria and must be transported to a Washington

County Hospital, the patient must be entered into the trauma system through the Trauma Communications Center (TCC) as usual. TCC must be notified that the patient is being transported to a non-trauma designated hospital based on circumstance.

9. Notify the State EMS Office's Trauma Division that a major emergency has been declared and patients normally entered into the trauma system may be transported to St. Vincent Hospital or other non-trauma designated hospital.
10. When operations under these guidelines are terminated, notify:
    a. Field units that they can return to normal activities.
    b. Washington County hospitals, as well as Meridian Park Medical Center and Providence Newberg Medical Center.
    c. Notify St. Vincent Hospital they will no longer be receiving trauma system patients.
    d. All other EMS stakeholders.

Guidelines for BLS Transport – 80.300

ALS INCLUSION CRITERIA

- ☐ **Pediatric patients (age < 15yrs)**
- ☐ **Following complaints/conditions**
  - ☐ Chest pain
  - ☐ Shortness of breath / increased work of breathing at any time / concern for airway compromise
  - ☐ Altered LOC (or not at baseline)
  - ☐ Syncope / near syncope
  - ☐ Stroke / TIA
  - ☐ Pregnancy > 20 weeks
  - ☐ Overdose / suicide attempt
  - ☐ Behavioral disturbance that may need medication (*see notes)
  - ☐ Suspected chemical or toxic exposure
  - ☐ Seizures
  - ☐ Severe bleeding, amputation, or extremity injury with neuro deficit or without pulse
  - ☐ Isolated abdominal pain in patients > 50 years old
  - ☐ Any specialty activation (sepsis/STEMI/stroke/trauma/burns)
- ☐ **Patient receives any ALS treatment**

  *Exceptions:

*ondansetron	*NSAIDs (e.g., ketorolac, ibuprofen)
*acetaminophen	*fluid bolus outside of observed hypotension

- ☐ **Patient requires cardiac monitoring**
- ☐ **High risk patients (e.g., transplant, Cancer receiving chemotherapy, LVAD, ESRD, ESLD)**
- ☐ **Special circumstances: Strangulation, submersion injury, heat or cold exposure**
- ☐ **Patient assessed by ALS clinician on scene who determines that ALS treatment is needed or anticipated to be needed**
- ☐ **Receiving BLS clinician on scene requests paramedic support**

*****All clinicians (ALS and BLS) must agree that this is a BLS appropriate patient. If there is disagreement, then the patient is to be transported by ALS*****

Guidelines for BLS Transport – 80.300

BLS INCLUSION CRITERIA

- ☐ **Absence of complaints/conditions noted above (ALS inclusion criteria)**
- ☐ **ALS clinician on scene approve BLS transport**
- ☐ **BLS clinician accepts transfer of patient care**
- ☐ **ALL vital signs must be within the following ranges:**
  - ☐ HR between 50 and 130
  - ☐ RR between 8 and 24
  - ☐ Sat > 90% on RA or previous prescribed home O_2
  - ☐ SBP > 90 (MAP > 65) without symptoms of hypotension (e.g., lightheaded, dizzy, diaphoresis)
  - ☐ SBP < 180 (MAP <130) without symptoms of hypertensive urgency (e.g., headache, vomiting, chest pain, altered mental status)
  - ☐ $EtCO_2$ > 25 mmHg & < 60 mmHg
- ☐ **Patients with saline lock may be transported BLS**
- ☐ **Patients already on home oxygen by mask or cannula may be transported BLS**
- ☐ **Patients with an isolated traumatic extremity injury with splinting as only intervention may be transported BLS**
- ☐ **Use of intoxicants with clearly assessed/documented decision-making capacity**

NOTES

When transferring patient care

- ☐ **Receiving and transferring clinicians should:**
  - ☐ Ensure all patient information is transferred to the receiving clinician (e.g., chief complaint, PMHx, current history, VS, care given prior to transfer of care)
  - ☐ Assist the receiving clinician until they are ready to assume patient care
  - ☐ Be willing to accompany the receiving clinician to the hospital if the patient's condition warrants or the receiving clinician requests it
- ☐ ***Patients with suicidal ideation AND no attempt may be appropriate for BLS transport**

Documentation

- ☐ **Both clinicians will complete a Patient Care Report (PCR), detailing the care given to the patient while in their care**
- ☐ **The receiving clinician must briefly document patient care given prior to receiving the patient**

Monitoring of Medications and Procedures – 80.400

The Oregon Medical Board sets the Scope of Practice for EMS Clinicians on a statewide basis. An EMS Clinician's Medical Director authorizes practice at the local level based upon protocols, within the bounds established by the state Scope of Practice. No Medical Director or other physician may direct EMS Clinicians to exceed the Scope of Practice established by the Oregon Medical Board. An EMS Clinician may not monitor and/or administer medications or procedures outside of local protocols except as detailed below.

A. **AN EMS CLINICIAN MAY EXCEED THE BOUNDS OF LOCAL PROTOCOLS UNDER THE FOLLOWING CONDITIONS:**

1. Under direct supervision of a physician for a patient not transported.
2. Under the direct supervision of a physician who accompanies the patient during transport.
3. During an inter-facility hospital transfer subject to the conditions listed below.

B. If a physician requests that an EMS Clinician exceed the bounds of local protocols during an inter-facility hospital transfer, the following information must be collected prior to the start of the transport.

C. **INFUSION OR ADMINISTRATION OF A MEDICATION**

1. Written orders detailing ordering physician name, indication, dosage(s), and considerations for administration/monitoring (preferred) **OR** documentation of verbal orders with the same details.
2. Will patient safety be compromised if the infusion/administration is held for transport?
3. Any additional physician instructions related to patient monitoring due to the procedure.

D. **MONITORING OF A PROCEDURE**

1. Written orders detailing ordering physician name, indication, and considerations for monitoring (preferred) **OR** documentation of verbal orders with the same details.
2. Will patient safety be compromised if the procedure is held for transport?
3. Any additional physician instructions related to patient monitoring due to the procedure.

EMS Clinicians will document this information in the patient care report including the attachment of any written orders.

The EMS Clinician has the right to refuse the inter-facility transport of a patient receiving a medication or procedure that they reasonably believe falls outside of their training and/or clinical abilities.