Operations

Ambulance Diversion Guidelines – 50.015

DIVERSION SYSTEM OVERVIEW

The Greater Portland Metropolitan Area (Multnomah, Clackamas, 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 Quad-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

To effectively manage situations in the Greater Portland Metropolitan Area where the diversion of an ambulance may be necessary due to temporary shortages of hospital Emergency Department (ED) resources and when such diversions may have an adverse effect on individual patient care or the EMS system as a whole.

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. Unacceptably 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.

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 provide definitions and agreed upon procedures if diversion of patients is determined to be necessary.
3. To identify hospitals utilizing these guidelines and their respective geographical zones in the Greater Portland Metropolitan Area that may be impacted by diversion.
4. To identify a zone management system when multiple hospitals attempt diversion simultaneously.
5. To report and collect meaningful data, which more accurately defines prehospital and hospital emergency medical services demand, service consumption, and resource availability.
6. To identify a system of accountability and quality improvement by providing diversion data to all participants on a monthly basis.

D. DEFINITIONS

1. Diversion – The redirection of an ambulance from an intended receiving facility to an alternate receiving facility due to a temporary lack of emergency resources such as staffing or bed space.
2. Inter-Facility Transfers – Hospital destination is pre-determined by physician-to-physician communication as a formal transfer.
3. 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).
4. Zone Manager – An agency or facility authorized to provide coordination to pre-hospital care providers and hospitals during times of zone wide diversion.
5. HOSCAP (www.oregonhospitals.org) – State owned and managed, data system for distribution of hospital status information and incident management.
6. Diversion Status Categories
   a. GREEN - The ED is able to accept patients transported from ambulance transports; except patients they do not normally treat.
   b. YELLOW - The ED is unable to accept patients transported from ambulance transports which require the following resources:
      i. CT SCAN – The ED is unable to take patients who may need a CT scan, examples include, but are not limited to:
         - Any brain CT (i.e. stroke, acute neurological deficit)
         - Suspected aortic aneurysm (including abdominal and/or thoracic)
         - Isolated abdominal injury which would not otherwise meet criteria for trauma system entry.
      ii. ED CRITICAL CARE – The ED is unable to take unstable patient(s). Examples of chief complaints include, but are not limited to:
         - Acute abdomen, non-traumatic
         - Chest pain
         - Coma/Sustained altered mental status
         - Respiratory distress
         - Shock
         - Status seizures
         - Acute neurologic deficit
         - A patient with a 12-Lead ECG that indicates a STEMI (contact hospital to determine ability to accept patient)
   c. RED – The ED is unable to accept patient(s) transported from an ambulance, except:
      - Uncontrolled airway
      - Non-trauma patient too unstable to transport to another facility
      - Patient refuses alternate facility
      - Prearranged inter-facility transfer
      - Pregnant patients > 20 weeks gestation or illness or injury which could have a potential life-threatening effect on the mother and/or the fetus.

d. 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.

7. Life Flight Network Status 1. GREEN – Available 2. YELLOW– On stand-by for another patient 3. RED – Unavailable
8. Destination Hospital/Services and EMS Abbreviations:

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

E. AMBULANCE DIVERSION POLICY

1. Diversion is not initiated because of:
   a. Lack of inpatient staffing or beds.
   b. Key resources being reserved for anticipated elective patient care, (i.e. elective surgical cases or radiological studies).
2. ED staff and ED physicians determine that the ED is reaching capacity and attempt to accommodate increased demand by following their internal plans.
3. The ED staff, ED physicians, and ED leadership determine that ambulance diversion is necessary in order to safely care for patients in the ED because:
   a. Critical/unstable patients occupy all suitable ED beds.
   b. There is not enough staff to safely care for additional unstable patients in the ED.
   c. There is a loss of CT scanner capability.
   d. There is an in-house disaster which compromises patient care/safety (i.e. fire, flooding, or electrical power outage).
   e. Trauma resources are unavailable (for designated trauma centers).

f. A critical resource (i.e. CATH team) is unavailable for select emergent presentations (i.e. STEMIs or acute strokes).

4. Hospitals request diversion via HOSCAP. Hospital initiated diversion events will last no longer than two hours before HOSCAP automatically opens the hospital to ambulance traffic again. It is recommended that hospitals should remain open for 30 minutes before activating diversion again.
    a. Tier 1 diversion—1 to 2 diversion activations per day: ED charge nurses, ED physicians, and ED leadership agree that diversion is necessary. Affected ED manager or designee collects thresholds data, enters into HOSCAP.
    b. Tier 2 diversion—3 to 4 diversion activations per day: ED charge nurses, ED physicians, and ED leadership agree that AD is necessary. Consider contacting hospital Administrator on Call/on Duty (AOC/AOD). Affected ED manager or designee collects thresholds data, enters into HOSCAP and considers contacting the affected 9-1-1 ambulance provider(s) with a situation report in situation, background, assessment, and recommendation (SBAR) format.
    c. Tier 3 diversion—5 or more diversion activations per day: ED charge nurses, ED physicians, and ED leadership agree that diversion is necessary. Affected ED manager or designee collects thresholds data, inputs it into HOSCAP, and considers contacting hospital AOC/AOD, executive leadership, the affected 9-1-1 ambulance provider(s), and health department(s)' EMS programs with a situation report in SBAR format.
5. Situation reports in SBAR format will provide consistent, meaningful, relevant data during extremes of ED resource demand. Situation reporting will include HOSCAP threshold data and are agreeable indicators of ED resource demand and strain.

    The HOSCAP threshold data questions are:
    01. ED wait room longest time. Of all the patients in the ED waiting room, what is the longest wait time in minutes?
    02. ED boarding – ICU. Number of ICU patients boarding in the ED.
    03. ED boarding – Inpatient. Number of inpatients boarding in the ED.
    04. ED boarding – Behavioral health. Number of behavioral health patients boarding in the ED.
    05. Are ICU resources at capacity? Is there an ICU staffing need or are all ICU beds full?
    06. Are Inpatient resources at capacity? Is there an inpatient staffing need or are all inpatient beds full?
    07. Are ED resources at capacity? Is there an ED staffing need or are all ED beds full?
    08. Are Inpatient discharge delays impacting the ability for admission? Yes/No
    09. Are scheduled surgeries expected to require more than the number of available beds? Yes/No

6. 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 in order to coordinate distribution of trauma patients.

c. Designated ED staff change their status on the HOSCAP system.
d. In the event a hospital is unable to change their status on the HOSCAP system, (i.e. connection problems), the hospital may contact the zone manager to authorize the zone manager to change the hospital status in HOSCAP.
e. 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. Every effort will be made to reopen to GREEN status as soon as possible.

7. Multnomah County Pediatric Hospital EDs.
   a. 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.
   b. 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.

F. ZONE MANAGEMENT

1. Occasionally, multiple hospitals will go on diversion at the same time. This poses a challenge to other hospitals trying to stay open to serve their community.
2. Hospitals are grouped into the following geographical zones:

West Zone	Central Zone	South Zone	North Zone	East Zone
Providence St. Vincent's	Legacy Emanuel/Randall Children's	Kaiser Sunnyside	PeaceHealth Southwest	Portland Adventist
Legacy Meridian Park	Legacy Good Samaritan	Providence Milwaukie	Legacy Salmon Creek	Providence Portland
Kaiser West Side	Oregon Health Sciences University/Doernbecher Children's	Providence Willamette Falls		Legacy Mount Hood
Tuality Community	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

3. Zone management will begin in the West, South, North or East Zones when all hospitals within it are RED. In the central zone, zone management will begin when Legacy EM, Legacy GS, and OHSU are RED. When operationally feasible, patients from the central zone who are eligible for Veteran's Assistance (VA) benefits will be transported to the Portland VA Medical Center. If a patient meets the triage requirements for Unity Center for Behavioral Health and is capable, patients can be transported to Unity Center for Behavioral Health when all hospitals are RED in any zone.
4. Steps for Activating Zone Management:
    a. If hospital resources meet the criteria for zone management, as specified in item C above, the zone manager will initiate "Active Zone Management" for the zone(s) affected. The zone manager will initiate an "all call" via the 800 MHz radio to hospitals informing them of the "Active Zone Management" status.
    b. After two hours of zone management, affected hospital managers' or designee collects data and enters into HOSCAP.
    c. 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).
    d. Under zone management, the zone manager will determine the destination of all ambulances within the affected zone(s). EMS may transport to any hospital outside of the affected zone if it is GREEN status.
    e. Ambulances may go outside their zone during zone management as long as 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.
    f. 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 sections (D), (E), and (F) of the ambulance diversion policy located above.*
    g. Trauma, STEMI, stroke, pediatric, and behavioral patient care protocols will continue.
    h. ED department zone threshold communication call should be initiated:
        i. After four hours of zone management, the first available ED manager or designee should consider initiating a threshold call with other EDs in the affected zone to discuss thresholds data and prepare consistent SBAR updates for ED leadership and ED physicians.
        ii. After four hours of zone management, the ED manager or designee should submit SBAR information obtained from thresholds communications to their hospitals' AOC/AOD and executive leadership. The first available manager or designee should consider contacting the appropriate 9-1-1 ambulance provider for the county in which the incident is located and health department(s) EMS program with an SBAR update.
    i. 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. When appropriate, the county EMS Medical Director will participate in this discussion for the zones within their jurisdictional boundaries.

        Central and East: Multnomah County

South: Clackamas County
West: Washington County
North: Clark County

G. <u>DISASTER MANAGEMENT</u> (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).

1. Hospital destinations will be coordinated by Regional Hospital through HOSCAP and according to regionally and locally adopted emergency medical services protocols.
2. During times of disaster management, thresholds data collection will be recorded in HOSCAP.
3. During times of disaster management, thresholds communications should be initiated and continued in four hour operational intervals to provide situation report 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).
    f. Stakeholders involved in proactive (thresholds) communications may include:
        i. Medical directors/ED physicians
        ii. Managers or their designee, assistant nurse managers, charge nurses, house supervisors, AOC/AOD, executive leadership, hospital HICS members.
        iii. Fire and EMS officials.
        iv. Public health officials.
        v. Others, as appropriate

H. <u>SIGNIFICANT EVENTS PROCESS FOR DIVERSION DEVIATION:</u>

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.

I. Accountability and Quality Improvement

1. The hospitals shall develop:
   a. An internal system and resources to avoid diversion.
   b. An internal policy related to diversion.
   c. Internal mechanisms to monitor diversion including number of hours and reasons why.
2. Hospitals are encouraged to track their own diversion hours via a report from the HOSCAP system.
3. County EMS will report number of hours and category of diversion to all zones based on information in HOSCAP.
4. The Greater Portland Metropolitan Area Diversion and Zone Management Subcommittee is a component of the ED/EMS Leadership Collaborative, which is established to monitor diversion hours, review diversion events, provide recommendations for quality improvement, and is responsible for the annual evaluation and revision to the Multnomah Operations Policy 50.030 Diversion System. The ED/EMS Leadership Collaborative is a cooperative effort between involved EMS agencies, hospitals, their ED managers, and ambulance providers.
5. Problems related to the implementation of these guidelines should be forwarded to the Diversion and Zone Management Subcommittee.

Organizations in Support of These Guidelines

HOSPITALS

Adventist Medical Center
Doernbecher's Children's Hospital
Kaiser Sunnyside Medical Center
Kaiser Westside Medical Center
Legacy Emanuel Children's Hospital
Legacy Emanuel Hospital
Legacy Good Samaritan Hospital
Legacy Meridian Park Hospital
Legacy Mt. Hood Medical Center
Legacy Salmon Creek Hospital
Oregon Health Sciences University
Portland VA Medical Center
Providence Milwaukie Hospital
Providence Portland Medical Center
Providence St. Vincent Medical Center

Randall's Children's Hospital
Peace Health Southwest
Tuality Hospital
Unity Center for Behavioral Health
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
Canby Fire Department
Camas Fire Department
Clackamas County Fire District 1
Molalla Fire Department
Metro West Ambulance
North Country Ambulance
Life Flight Network
Tualatin Valley Fire & Rescue

Ambulance Diversion Guidelines – 50.015

TABLE: HOSPITAL SERVICES

HOSPITAL	BURN UNIT	CARDIAC SURGERY	DECON	HELI PAD	HYPER BARIC	OB	NICU	PEDS INPT	PICU	PSYCH IN-PATIENT	TRAUMA CENTER	CATH LAB	INR	LVAD	STROKE INTERVENTIONAL
Adventist		X	X	X		X				X		X			
Doernbecher Children's		X	X	X			X	X	X	X	X				
Kaiser Sunnyside		X	X			X				X		X		X	X
Kaiser Westside						X									
Randall Children's Hospital Legacy Emanuel	X	X	X	X (2)		X	X	X	X	X	X				
Legacy Emanuel	X	X	X	X	X	X				X	X	X	X		X
Legacy Good Samaritan		X	X			X				X		X			
Legacy Meridian Park			X	X		X						X			X
Legacy Mount Hood			X	X		X						Dx only			
Legacy Salmon Creek			X	X		X	X	X		X		Dx only			
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	Designated area		X									
Providence Newberg			X	X		X									
Providence Portland		X	X	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		X									
Tuality Community		X	X	X		X						X			
Unity Center for Behavioral Health										X					
Veteran's Administration			X							X					

COVID-19 Response – 50.017

PURPOSE:
This advisory is an overlay to existing patient care protocols and applies to the management of patients diagnosed with or suspected of having COVID-19 or an influenza like illness (ILI) based on dispatch information, patient location/context (care facility, etc.), ongoing outbreak epidemiology, and provider obtained history, judgment and other information.

PROCEDURE:

High Risk Patients, Procedure Questions and Situational Awareness

1. Does the patient have a fever, cough, or respiratory distress?
2. Is the patient or facility suspected to have COVID-19?
3. Has the patient had prior contact with a known COVID-19 patient?
4. Is the patient from a high-risk facility (Assisted Care, AFH, Nursing home, clinic, jail)?
5. Could the patient require aerosol-generating procedures?

If the answer is “yes” to any of the above questions, the patient is a high-risk patient and could be considered a potential COVID-19 patient and considerations for PPE, treatment and procedure modifications should be made as indicated below and as directed by the agency medical director.

SYMPTOMS	SIGNS
1. Fever (observed or reported)**	1. Tachypnea (RR > 24/min)
2. Shortness of breath**	2. Tachycardia (HR > 100/min)
3. Cough**	3. Hypoxia (SpO_2 < 94%)
4. URI symptoms with sore throat, rhinorrhea	4. Hypotension (MAP < 65mmHg or SPB < 90 mmHg)
5. Chest pain	
6. Confusion	
7. Headache	
8. Fatigue/Myalgia (muscle aches)	
9. Anorexia	
10. Nausea, vomiting, diarrhea	
11. Acute loss of smell/taste	
**primary symptoms	

A. Universal Patient Care

HIGH-RISK AEROSOLIZING PROCEDURES	HIGH-RISK PPE REQUIREMENTS (required for all those within 6 feet of the patient)
Bag-Valve-Mask Ventilation	**Gloves**
Endotracheal Intubation	**Eye Protection**
Supraglottic Airway Placement	**Highest Available Respiratory Protection**
Nasal and Oral Airway Placement	**Gown**
Non-Invasive Positive Pressure Ventilation	
Nebulized Treatments	
Suctioning	
Chest Compressions	

1. Wear appropriate PPE for the appropriate patient and situation.
2. Review information provided by dispatch and request additional information from dispatch as needed.
3. Although no longer strictly relevant, the patient should be questioned about a history of recent travel or contact with a known COVID-19 patient.
4. If possible, consider using reporting party (RP) phone number to communicate and obtain more information before entering a scene.
5. If possible, establish communication with the patient, family member(s) or caretaker(s), while maintaining at least 6 feet of distance.
6. If possible, have the patient move to an open area.
7. Equipment and bags (including drug boxes) should be kept >6 feet (or as far away from) the patient as possible.
8. Ensure proper provider donning/doffing for high-risk encounters/procedures. Ideally doffing should be done with a buddy to watch and ensure no personal contamination.
9. PIC should ensure or designate the role to an on-scene provider, that personnel are maintaining proper PPE and distancing themselves as much as possible from patient. If possible, personnel should stay out of the same room as the patient, if not actively providing hands-on care.
10. If possible, at a minimum, for patients with cough, shortness of breath, or fever, a simple surgical/medical mask should be given to the patient to wear over their mouth and nose.

11. If agencies have the capability to utilize remote technology (video - either onsite or remote context e.g. FaceTime, Skype, etc.) to initially screen and assess a patient, this can be considered.
12. When possible and safe, limit the number of personnel exposed to any known or potentially COVID-19 infected person. If safe for patient care, one provider should initially assess a patient.
13. When entering a care facility, including adult foster care homes, with known COVID-19 patients, consider the facility to be a high-risk area for both providers and patients and personnel exposure should be limited as feasible. Appropriate PPE should be worn inside the facility. EMS personnel are encouraged to ask facility staff to bring patients (wearing a simple mask) to a central area near the facility entrance for initial EMS evaluation.

B. PPE
1. For patient encounters with known or suspected COVID-19 infection, minimum PPE will include gloves, eye protection, and mask (N95 or greater if available). Consider gown or coveralls if in physical contact with patient.
2. If high-risk aerosolizing procedures are being performed, airborne-precautions and PPE must be used. This means, the above PPE with the addition of gowns and N95 or higher respiratory protection.

C. Patient Transport Instructions
1. Contact the receiving facility as soon as possible and advise them that you have a patient needing isolation, if available. Do not enter the ED or other patient care area until directed by the ED staff. This may include alternate locations within the facility such as temporary shelters and treatment areas.
2. Family members and contacts of patients with possible COVID-19 shall not ride in the transport vehicle except for pediatric patients or other vulnerable or special needs patients.
3. Isolate the driver from the patient compartment if possible; if unable, the driver should wear appropriate mask and eye protection.
4. During transport, vehicle ventilation settings in both compartments should be on non-recirculated mode. Open the outside air vents in the driver area and turn on the ventilation fans to the highest setting.
5. If possible, place patient in yellow emergency blanket to minimize contamination of the ambulance.

TREATMENT:

A. Cardiac Arrest
1. All cardiac arrest patients are high-risk and high-risk PPE should be worn.
2. See airway management instructions and ETI guidance.

B. Respiratory Distress

1. Airborne precautions (high-risk PPE) are needed for any aerosol generating procedures as defined previously.
2. If using a nasal cannula or NRB, a simple mask should be applied over for this equipment on a patient's face if possible.
3. All personnel in the room with a patient receiving any high-risk procedures should use appropriate high-level PPE before treatment is initiated.
4. Nebulized meds should be used as a last resort - consider other appropriate treatments first. A patient with severe respiratory distress and wheezing can still receive nebulized treatments. Perform treatments on scene and outside if possible. Nebulizer treatments should not be performed during transport.
5. Instead of nebulized treatments for asthma, consider epinephrine (0.3mg - 0.5 mg Epi 1:1000 IM every 5 minutes, repeated once). Consider using lower doses (0.1 - 0.3 mg IM) for patients > 40 years old or with known coronary artery disease.
6. If available, use an albuterol Metered Dose Inhaler (MDI) in lieu of nebulizer treatments. If patient has their own MDI, consider bringing it with you for use in route. 4 puffs of an albuterol MDI is equivalent to 1 nebulized treatment; if available, use a spacer.
7. When treating for suspected SCAPE, IV NTG bolus may be preferred over CPAP/BiPaP to decrease exposure risk to providers from COVID-19 possible patients.
8. BVMs should be equipped with Viral/HEPA filters, as available.
9. Maximize area ventilation during these procedures as able: open doors, use exhaust fans, etc.
10. In patients failing to adequately respond to supplemental oxygen (e.g. NC, NRB), consider repositioning patient to improve oxygen saturation.

C. General Airway Management

1. The most experienced provider should assume control of airway management in known or suspected COVID-19 patients.
2. The use of SGAs is considered a continuously aerosolizing procedure.
3. When using a BVM, a viral/HEPA filter must be placed between the mask and the bag, if available.

D. Non-Invasive Positive Pressure Ventilation (CPAP/BiPaP)

1. This is an aerosolizing procedure and should be considered when performing advanced airway management and donning appropriate PPE. Attempt to minimize the performance of this procedure to only when necessary for respiratory distress.
2. **DO NOT** discontinue CPAP/BiPaP upon entering the ED.

E. Advanced Airway Management

1. If advanced airway management is needed in a possible COVID-19 patient, the most experienced provider on-scene is encouraged to be the person in charge of the airway.
2. Preferred pre-oxygenation method, for perfusing patients, is with a BVM with proper facemask-seal with viral/HEPA filter. Consider DSI as the preferred method of intubation if unable to achieve proper preoxygenation levels. If no issue with preoxygenation, RSI can be used.
3. In perfusing patients, do not squeeze BVM bag before intubation attempt but hold facemask with good two-handed technique with PEEP set at 5-10 cmH_2O until initiating advanced airway attempt to maximize recruitment of alveoli.
4. In perfusing patients with no, or inadequate respiratory effort, bag patient at a standard rate.
5. For patients in cardiac arrest, bag patient per standard cardiac arrest protocol.
6. Ensure viral/HEPA filter is attached to BVM before intubation attempt, if available.
7. Intubation with video laryngoscopy (VL) and bougie is strongly preferred over direct laryngoscopy (DL). This is to maximize the distance from patient and limit exposure.
8. Endotracheal intubation is preferred over SGA.
9. If a patient responds to supplemental oxygen with SpO_2 levels above 90% (and can maintain adequate airway) defer advanced airway management and notify the hospital of a potential need for airway management upon arrival.
10. After intubation, make sure that you have the viral/HEPA filter in place on the BVM, as able, to attach to the tube. Inflate the cuff before bagging the patient.
11. Confirm tube placement using standard verification methods, including $EtCO_2$ waveform capnography.

F. Suctioning

Suctioning is a high-risk aerosolizing procedure.

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.

A. DEATH IN THE FIELD

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

Resuscitation efforts may be withheld if:

1. The patient has a "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 Do Not Resuscitate (DNR) order signed by a physician, nurse practitioner or physician assistant. 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)
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 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 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 patient is enrolled in hospice and the patient has not already done so, contact hospice if possible.
3. EMS providers cannot take medical orders from a hospice nurse, but their advice is often invaluable and may be followed with direction from OLMC.
4. Treat dying persons with warmth and understanding. Do not avoid them. Allow them to discuss their situation, but do not push them to talk.
5. Many dying people are not upset by discussions of death as long as you do not take away all of their hope.
6. Touching a dying person is important. Use words like “death”. Do not use meaningless synonyms.
7. Ask the person how you might help.
8. Give factual information.
9. Be aware of your own fears regarding death and admit when a dying person reminds you of a loved one. If a particular person is too disturbing, have your partner or other members of the responding team take over.
10. 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.

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 or not 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, and 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

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 time line 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 the Triage consult with the 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 anytime 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 Control (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 Control.
    3. Advised that we are not permitted to relinquish medical control to a physician on the scene without agreement from On-Line Medical Control.

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 Control – 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 Control (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 Control (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 chemical or physical restraint per Patient Restraint 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
    - $SpO_2 \leq 90\%$

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.

Refusal and Informed Consent – 50.117

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 *Patient Restraint* 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:

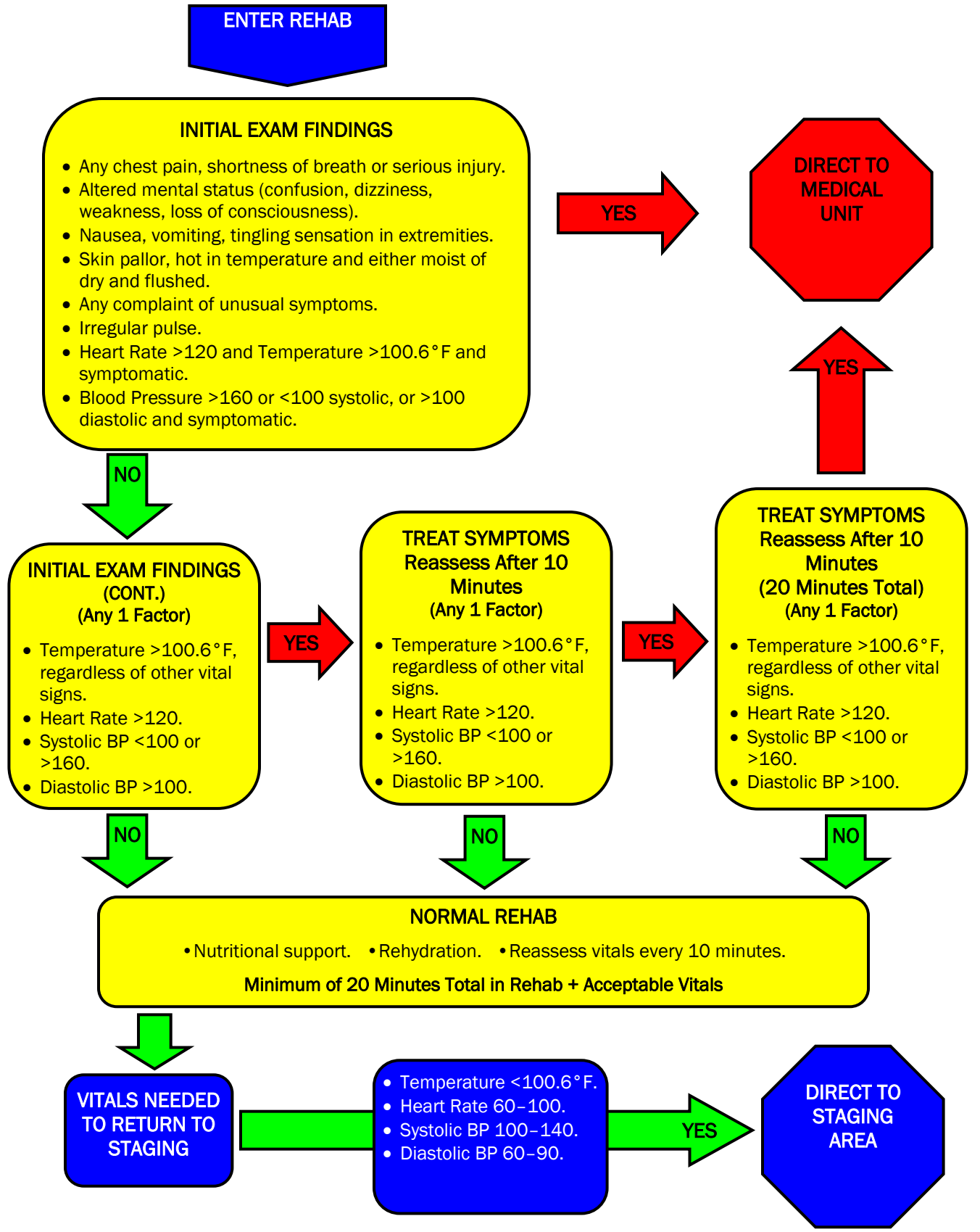
1. Findings mandating that the individual be transferred to the Medical Unit:
   a. Any chest pain, shortness of breath or serious injury.
   b. Altered mental status (confusion, dizziness, weakness, loss of consciousness).
   c. Nausea, vomiting, or tingling sensation in extremities.
   d. Skin pallor, 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
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.
YES
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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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