North Region EMS System

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Purpose To define guidelines for EMS personnel initiation of patient care.

Policy

1) Appropriate initial care, per SOP's, should be started at the point of patient contact prior to movement to the ambulance, unless the patient refuses or scene safety cannot be secured. This includes care provided by BLS or ALS EMS personnel prior to the arrival of an ambulance.
2) EMS personnel shall perform all services without unlawful discrimination.
3) Additional personnel should be requested as needed for patient care and conveyance.
4) Equipment: When responding to all requests for prehospital care, EMS personnel (EMT, Paramedic) will take the following to the initial contact with the patient:
    a. Conveyance device (ex. Stretcher, backboard, stair chair)
    b. Monitor/Defibrillator with defibrillation pads, pulse oximetry, capnography, ECG rhythm and 12L ECG capability for ALS licensed vehicles or AED for BLS licensed vehicles.
    c. Oxygen
    d. Bag(s) containing at minimum
        i. BLS and ALS licensed vehicle: personal protective/body substance isolation equipment, suction, oral and nasal airways, oxygen, oxygen delivery devices including bag-valve mask, stethoscope, BP cuff, glucose meter, hemorrhage control supplies including a tourniquet, and c-collar.
        ii. ALS licensed vehicle: advanced airway equipment including laryngoscope with blades, ET tubes, alternate airway device and cricothyrotomy equipment; vascular access supplies including IV fluid, tubing, IO and IV catheters; and first line medications including: adenosine, albuterol, amiodarone, ASA, atropine, diphenhydramine, dopamine, etomidate, epinephrine 1mg/1mL and 1mg/10mL, dextrose, ipratropium, lidocaine, midazolam, naloxone, NTG, and verapamil.
5) Indications for ALS include, but are not limited to:
    a. Abnormal vital signs (regardless of complaint)
        i. Pulse <60 or >110 or irregularity; (pediatric VS, see SOP)
        ii. Respiration <10 or >22, shallow or labored; (pediatric VS, see SOP)
        iii. Systolic BP <100 or >180; (pediatric VS, see SOP)
        iv. Oxygen saturation <95%

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b. Potential life threatening complaint/condition. Examples include:

i. CNS: altered mental status, seizure, postictal, suspected stroke/TIA, dizziness, syncope or near syncope

ii. Cardiac: chest/epigastric discomfort, suspected ACS, dysrhythmia/palpitations, heart failure, anginal equivalents

iii. Respiratory: dyspnea, shortness of breath

iv. Medical: GI bleeding, overdose/poisoning

v. Obstetrics: pregnancy complications or childbirth

vi. Trauma: Level 1-2; multiple system; penetrating injury to head, neck, torso, or proximal extremity; burns >10%

6) Advanced Life Support (ALS) care includes, at minimum:

a. ECG monitoring - must continue during transportation into the hospital emergency department until patient care is transferred to the physician/nurse

b. Oxygen, if indicated based on oxygen saturation

c. Vascular access, if IV fluid or IV medications are indicated

7) If scene is unsafe or the patient is uncooperative: The requirement to initiate care at point of patient contact or during transport may be waived in favor of assuring the patient is transported to an appropriate facility. Contact OLMC and document situation.

8) Do not discontinue care once initiated unless approval is granted by OLMC, care has been transferred to higher level personnel (e.g., ED physician/nurse, BLS transfer to ALS crew), or scene becomes unsafe. If any doubt, consult with OLMC.

9) In-field service level upgrades: All transfer of care shall be made under the direction of OLMC who shall determine the risk/benefit.

10) BLS personnel shall allow ALS personnel access to patients to determine if ALS care is needed. If ALS personnel determine the patient requires ALS care, BLS personnel shall transfer patient care to ALS personnel.

11) If BLS personnel identify that ALS is indicated: The BLS crew shall call 911/radio dispatch to request an ALS ambulance from the local municipal EMS agency, unless the initial responders are a private provider and can provide an ALS ambulance on-scene within six (6) minutes. If the BLS crew are able to transport to the nearest hospital faster than ALS can arrive, the BLS crew should contact OLMC, seeking authorization to transport providing BLS care.

12) Transferring patient care to another crew: Initial crew shall:

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a. Continue to assess and provide care until the patient is transferred to the transporting crew;

b. Provide verbal report to transporting crew that includes assessment and treatment information;

c. Complete a PCR with patient assessment and treatment information, until the point of transfer;

d. Provide written report to receiving hospital within 90 minutes.

13) Cardiac arrest: If ambulance personnel from a single vehicle response (private or municipal) identify cardiac arrest, begin BLS CPR/defibrillation and call 911/radio dispatch to request ALS from the nearest municipal EMS agency to provide an adequate number of rescuers. Do not attempt ALS interventions (e.g., advanced airway, vascular access) until adequate rescuers are available.

References http://www.ilga.gov/commission/jcar/admincode/077/077005150C03300R.html

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