

*East Region EMS and
Trauma Care Council*

*Regional Patient Care
Procedures*

*Revised, Updated, Approved
And Implemented*

May 2011

**EAST REGION PATIENT CARE PROCEDURE #1
DISPATCH OF MEDICAL PERSONNEL
Approved by DOH February 2005**

I. STANDARD:

1. *Licensed aid and/or licensed ambulance services shall be dispatched to all emergency medical incidents by the appropriate 911 center.*
2. *Verified aid and/or verified ambulance services shall be dispatched to all known injury incidents, as well as unknown injury incidents.*
3. *All licensed and verified aid and licensed and verified ambulance services shall operate 24 hours a day seven days a week. (Current WAC)*
4. *All Communication/Dispatch Centers charged with the responsibility of receiving calls for Emergency Medical Services.*

II. PURPOSE: (See County Specific Operating Procedures and Response Area Maps)

1. To provide timely care to all emergency medical and trauma patients as identified in the *Current WAC*.
2. To minimize "System Response Time" in order to get certified personnel to the scene as quickly as possible.
3. To minimize "System Response Time" in order to get licensed and or verified aid and ambulance services to the scene as quickly as possible.
4. To establish uniformity and appropriate dispatch of response agencies.

III. PROCEDURE:

1. **Following the Region's plan to promote the concept of tiered response, an appropriate licensed or verified service shall be dispatched per the above standards.**
2. **Dispatcher shall determine appropriate category of call using established Washington State EMD Guidelines.**
3. **Response shall be pre-planned by EMD response protocol. (See County Specific Operating Procedures and East Region Response Area Maps.)**

IV. DEFINITIONS

"System Response Time" for trauma means the interval from discovery of an injury until the patient arrives at the designated trauma facility. It includes:

- **"Discovery Time":** The interval from injury to discovery of the injury;

- “System Access Time”: The interval from discovery to call received;
- “911 Time”: The interval from call received to dispatch notified, including the time it takes the call answerer to:
 - Process the call, including citizen interview; and
 - Give the information to the dispatcher;
- **“Dispatch Time”**: **The interval from the call received by the dispatcher to agency notification;**
- “Activation Time”: The interval from agency notification to start of response;
- “Enroute Time”: The interval from the end of activation time to the beginning of on-scene time;
- “Patient access time”: The interval from the end of enroute time to the beginning of patient care;
- “On Scene Time”: The interval from arrival at the scene to departure from the scene. This includes extrication, resuscitation, treatment, and loading;
- “Transport Time”: The interval from leaving the scene to arrival at the health care facility.

V. QUALITY IMPROVEMENT:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

**EAST REGION PATIENT CARE PROCEDURE #2
RESPONSE TIMES**

*Revisions approved by DOH and implemented by
East Region EMS/TC Council September 2010*

I. STANDARD:

All verified ambulance and verified aid services shall respond to trauma incidents in a timely manner in accordance with current WAC.

II. PURPOSE:

1. To provide trauma patients with appropriate and timely care.
2. To establish a baseline for data requirements needed for System Quality Improvement.

III. PROCEDURES:

1. **The Regional Council shall work with all prehospital providers and Local Councils to identify response areas as urban, suburban, and rural or wilderness.**
2. **Verified ambulance and verified aid services shall collect and submit documentation to ensure the following system response times are met 80% of the time; as defined in the current WAC.**

	<u>Aid Vehicle</u>		<u>Ambulance</u>
Urban	8 minutes	Urban	10 minutes
Suburban	15 minutes	Suburban	20 minutes
Rural	45 minutes	Rural	45 minutes
Wilderness	ASAP	Wilderness	ASAP

3. **Verified ambulance and verified aid services shall collect and submit documentation to show wilderness system response times are “as soon as possible.”**

IV. DEFINITIONS:

1. **URBAN**: An unincorporated area over 30,000; or an incorporated or unincorporated area of at least 10,000 and a population density over 2,000 per square mile.
 2. **SUBURBAN**: An incorporated or unincorporated area with a population of 10,000 to 29,999, or any area with a population density of 1,000 to 2,000 per square mile.
 3. **RURAL**: Incorporated or unincorporated areas with total populations less than 10,000, or with a population density of less than 1,000 per square mile.
 4. **WILDERNESS**: Any rural area not readily accessible by public or private road.
- **“System Response Time”** for trauma means the interval from discovery of an injury until the patient arrives at the designated trauma facility. It includes:
 - **“Discovery Time”**: The interval from injury to discovery of the injury;
 - **“System Access Time”**: The interval from discovery to call received;
 - **“911 Time”**: The interval from call received to dispatch notified, including the time it takes the call

EAST REGION PATIENT CARE PROCEDURE #2 RESPONSE TIMES

*Revisions approved by DOH and implemented by
East Region EMS/TC Council September 2010*

answerer to:

- Process the call, including citizen interview; and
- Give the information to the dispatcher;
- **“Dispatch Time”**: The interval from the call received by the dispatcher to agency notification;
- **“Activation Time”**: The interval from agency notification to start of response;
- **“Enroute Time”**: The interval from the end of activation time to the beginning of on-scene time;
- **“Patient access time”**: The interval from the end of enroute time to the beginning of patient care;
- **“On Scene Time”**: The interval from arrival at the scene to departure from the scene. This includes extrication, resuscitation, treatment, and loading;
- **“Transport Time”**: The interval from leaving the scene to arrival at the health care facility.

V. QUALITY IMPROVEMENT:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

I. STANDARD:

1. All verified ambulance verified aid services and affiliated agencies shall comply with the Washington Prehospital Trauma Triage Procedures as defined in the current WAC. All verified ambulance services shall transport patients to the most appropriate designated facility
2. All verified ambulance and verified aid services shall consider activating ALS rendezvous or helicopter response - Patient Care Procedure #7 if beyond the 30 minutes transport time to a designated facility OR if transport time to the appropriate facility may be reduced by more than 15 minutes.
3. Each trauma-designated facility will determine when it is appropriate to alert verified ambulance services to divert to another trauma designated facility.

II. PURPOSE:

1. To implement regional policies and procedures for all emergency medical patients and all trauma patients who meet the criteria for trauma system activation as described in the Washington Prehospital Trauma Triage Procedure.
2. To ensure that all emergency medical and/or trauma patients are transported to the most appropriate designated facility in accordance with the current WAC.
3. To allow the receiving facility adequate time to activate their emergency medical and/or trauma response team.

III. PROCEDURES:

1. The provider must determine primary resuscitation is needed for the patient and apply per level of training.
2. The first certified EMS/TC provider determines that a patient:
 - a. Needs definitive trauma care
 - b. Meets the trauma triage criteria
 - c. Presents with factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure).
 - d. Determine if patients meet all hazards (procedure #8) criteria
3. The provider then determines what step in the Prehospital Triage Procedure that the patient's condition/injuries meet; determination of destination is made based upon the step identified and the following:
 - a. For patient meets Step 1 or Step 2 Criteria:
 1. Take the patient to the highest-level trauma center within 30 minutes transport time via ground or air transport according to DOH approved Regional Patient Care Procedures.
 - b. Patient meets Step 3 Criteria:
 1. Take the patient to the nearest designated facility. (No change)
 2. Consult county procedure, IF:
 - (a) The patient requests to bypass the nearest facility*
 - (b) EMS personnel judgment suggests that the patient be taken to a higher-level facility*
 3. On-line medical control for all counties shall be accessed per County Operating Procedures (COPs)
4. Communication will be initiated with the receiving facility as soon as possible to allow the receiving facility adequate time to activate their emergency medical and/or trauma response team.
6. *The receiving facility will notify the verified ambulance service about diversion according to COPs.*
7. Medical control and/or the receiving facility will be provided with the following information, as outlined in the Prehospital Destination Tool:
 - a. Identification of EMS agency

**EAST REGION PATIENT CARE PROCEDURE #2
RESPONSE TIMES**

*Revisions approved by DOH and implemented by
East Region EMS/TC Council September 2010*

- b. Vital signs. (Include First and/or Worst)
 - c. Level of consciousness
 - d. Anatomy of injury
 - e. Biomechanics of injury
 - f. Any co-morbid factors
 - g. Timely updates on patient status
8. All information shall be documented on an appropriate medical incident report (MIR) form accepted by the County MPD, which meets trauma registry data collection requirements as outlined in WAC.

IV. QUALITY IMPROVEMENT:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

EAST REGION PATIENT CARE PROCEDURE #2 RESPONSE TIMES

*Revisions approved by DOH and implemented by
East Region EMS/TC Council September 2010*

STATE OF WASHINGTON PREHOSPITAL TRAUMA TRIAGE (DESTINATION) PROCEDURE

Purpose

The purpose of the Triage Procedure is to ensure that major trauma patients are transported to the most appropriate hospital facility. This procedure has been developed by the Prehospital Technical Advisory Committee (TAC), endorsed by the Governor's EMS and Trauma Care Steering Committee, and in accordance with RCW 70.168 and WAC 246-976 adopted by the Department of Health (DOH).

The procedure is described in the schematic with narrative. Its purpose is to provide the prehospital provider with quick identification of a major trauma victim. If the patient is a major trauma patient, that patient or patients must be taken to the highest level trauma facility within 30 minutes transport time, by either ground or air. To determine whether an injury is major trauma, the prehospital provider shall conduct the patient assessment process according to the trauma triage procedures.

Explanation of Process

- A. Any certified EMS and Trauma person can identify a major trauma patient and activate the trauma system.** This may include requesting more advanced prehospital services or aero-medical evacuation.
- B. The first step (1) is to assess the vital signs and level of consciousness.** The words "Altered mental status" mean anyone with an altered neurologic exam ranging from completely unconscious, to someone who responds to painful stimuli only, or a verbal response which is confused, or an abnormal motor response.

The "and/or" conditions in Step **1** mean that any one of the entities listed in Step **1** can activate the trauma system.

Also, the asterisk (*) means that if the airway is in jeopardy and the on-scene person cannot effectively manage the airway, the patient should be taken to the nearest medical facility or consider meeting up with an ALS unit. These factors are true regardless of the assessment of other vital signs and level of consciousness.

- C. The second step (2) is to assess the anatomy of injury.** The specific injuries noted require activation of the trauma system. Even in the assessment of normal vital signs or normal levels of consciousness, the presence of any of the specific anatomical injuries does require activation of the trauma system.

Please note that steps 1 and 2 also require notifying Medical Control.

- D. The third step (3) for the prehospital provider is to assess the biomechanics of the injury and address other risk factors.** The conditions identified are reasons for the provider to contact and consult with Medical Control regarding the need to activate the system. They do not automatically require system activation by the prehospital provider.

Other risk factors, coupled with a "gut feeling" of severe injury, means that Medical Control should be consulted and consideration given to transporting the patient to the nearest trauma facility.

Please note that certain burn patients (in addition to those listed in Step 2) should be considered for immediate transport or referral to a burn center/unit.

Patient Care Procedures

To the right of the attached schematic you will find the words "according to DOH-approved regional patient care procedures." These procedures are developed by the regional EMS and Trauma council in conjunction with local councils. They are intended to further define how the system is to operate. They identify the level of medical care personnel who participate in the system, their roles in the system, and participation of hospital facilities in the system. They also address the issue of inter-hospital transfer, by transfer agreements for identification, and transfer of critical care patients.

In summary, the Prehospital Trauma Triage Procedure and the Regional Patient Care Procedures are intended to work in a "hand in glove" fashion to effectively address EMS and Trauma patient care needs. By functioning in this manner, these two instruments can effectively reduce morbidity and mortality.

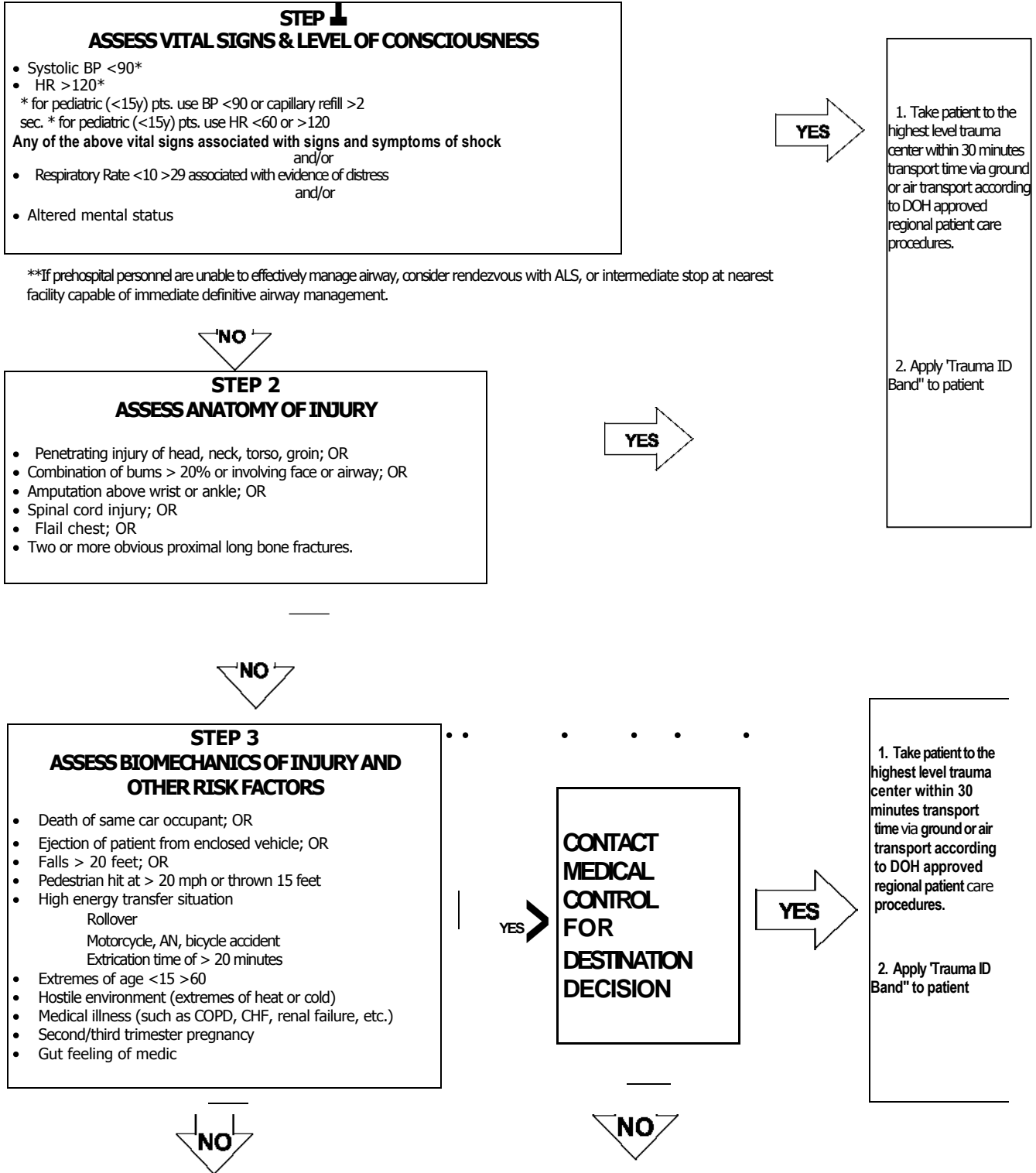
If you have any questions on the use of either instrument, you should bring them to the attention of your local or regional EMS and Trauma council or contact 1-800-458-5281.

TRANSPORT PATIENT PER REGIONAL PATIENT CARE PROCEDURES

EAST REGION PATIENT CARE PROCEDURE #3 TRAUMA TRIAGE AND TRANSPORT

STATE OF WASHINGTON PREHOSPITAL TRAUMA TRIAGE (DESTINATION) PROCEDURES EFFECTIVE DATE 1/95

- Prehospital triage is based on the following 3 steps: Steps 1 and 2 require prehospital EMS personnel to notify medical control and activate the Trauma System. Activation of the Trauma System in Step 3 is determined by medical control**



TRANSPORT PATIENT PER REGIONAL PATIENT CARE PROCEDURES

**EAST REGION PATIENT CARE PROCEDURE #3
TRAUMA TRIAGE AND TRANSPORT**

TRANSPORT PATIENT PER REGIONAL PATIENT CARE PROCEDURES

EAST REGION PATIENT CARE PROCEDURE #3A
TRIAGE & TRANSPORT OF MEDICAL AND NON-TRAUMA PATIENTS
Approved October 2002 – No Changes

I. STANDARD

All licensed ambulance services shall transport patients to the most appropriate facility in accordance with County Operating Procedures (COPs).

II. PURPOSE

1. To implement regional policies and procedures for all ***medical and non-major trauma patients who do not meet the criteria for trauma system activation*** as described in the Washington Prehospital Trauma Triage Tool.
2. To ensure that all medical and/or non-major trauma patients are transported to the most appropriate facility.

III. PROCEDURES

1. **Patients not meeting prehospital trauma triage criteria for activation of the trauma system, and all other patients will be transported to facilities based on County Operating Procedures (COPs).**

IV. QUALITY IMPROVEMENT:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

EAST REGION PATIENT CARE PROCEDURE #3A
TRIAGE & TRANSPORT OF MEDICAL AND NON-TRAUMA PATIENTS
Approved October 2002 – No Changes

EAST REGION PATIENT CARE PROCEDURE #3B
PEDIATRIC TRAUMA TRIAGE & TRANSPORT
Revisions approved by the DOH and implemented by the
East Region EMS/TC Council on September 15, 2010

I. STANDARD

1. *All verified ambulance, verified aid services, and affiliated agencies shall comply with the Washington Prehospital Trauma Triage Procedures as defined in current WAC. All verified ambulance services shall transport patients to the most appropriate designated facility.*
2. *All verified ambulance and verified aid services shall consider activating ALS rendezvous or helicopter response - Patient Care Procedure #7 - if beyond the 30-minute transport time to a designated facility OR if transport time to the appropriate facility may be reduced by more than 15 minutes.*
3. *Each trauma-designated facility will determine when it is appropriate to alert verified ambulance services to divert to another trauma designated facility.*

II. PURPOSE

1. To ensure that consideration is given to early transport of a child to the regional pediatric trauma center(s) when required surgical or medical subspecialty care of resources are unavailable.

III. PROCEDURES (Change in order of #1 and #2)

1. The provider must determine if primary resuscitation is needed for the patient and apply per level of training
2. The first certified EMS/TC provider determines that a pediatric patient:
 - A. Needs definitive trauma care
 - B. Meets the trauma triage criteria
 - C. Presents the factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure
 - D. Determine if patient meets Patient Care Procedure #8 for All Hazards Mass Casualty
3. Take the pediatric patient to the highest-level pediatric trauma center within 30 minutes transport time via ground or air transport according to DOH approved regional patient care procedures and approved County Operating Procedures (COPs).
4. If a pediatric designated facility is not available within 30 minutes, take the patient to the highest adult designated facility within 30 minutes.

IV. QUALITY IMPROVEMENT:

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

EAST REGION EMS/TC COUNCIL
REGIONAL PATIENT CARE PROCEDURE #4
INTERFACILITY TRANSFER OF PATIENTS
Revisions approved by DOH and
Implemented by East Region EMS/TC Council July 2008

I. STANDARD

1. All interfacility transfers via ground or air shall be provided by the appropriate licensed and/or verified services with personnel and equipment to meet patient needs.
2. Immediately upon determination that the patient's needs exceed the scope of practice and/or their Medical Program Director (MPD) approved protocols, or physician standing orders for non-EMS personnel, the licensed and/or verified service personnel shall advise the facility personnel that they do not have the resources to do the transfer.

II. PURPOSE

Provide a procedure that will facilitate the goal of transferring high-risk trauma and medical patients.

III. PROCEDURES

1. Medical responsibility during transport should be arranged at the time of initial contact between receiving and referring physicians. The transferring physician should write the transfer orders after consultation with the receiving physician. Facilities having transfer agreements for trauma patients are attached as a reference.
2. Prehospital MPD protocols shall be followed prior to and during transport.
3. While en-route, the transporting agency should communicate patient status and their estimated time of arrival (ETA) to the receiving facility per Medical Program Director (MPD) approved protocols or physician standing orders for non-EMS personnel.

IV. DEFINITIONS

- **Scope of Practice:** Patient care within the scope of approved level of certification and/or specialized training.
- **Facilities** are DOH designated trauma care services and licensed acute care hospitals.
- **Non-EMS Personnel:** Licensed Health Care Professionals including Physicians, Physicians Assistants, Registered Nurses, and Advanced Registered Nurse Practitioners.

V. QUALITY ASSURANCE

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

Patient Care Procedure #5

This Patient Care Procedure was deleted at the Recommendation of the East Region Prehospital & Transportation Committee and the Regional Council because of the implementation of NIMS (National Incident Management System).

Approval was granted by the EMS & Trauma Steering Committee and the Department of Health on September 15, 2010.

This Patient Care Procedure no longer exists.

Kimberly S. Burke
Executive Director

PATIENT CARE PROCEDURE #6
EMS/MEDICAL CONTROL – COMMUNICATIONS
Approved and Implemented in October 2002...No Changes

I. STANDARD:

1. *Communications between prehospital personnel and receiving facilities will utilize the most effective communications to expedite patient information exchange.*

II. PURPOSE:

1. To define methods of expedient communications between prehospital personnel and receiving facilities.

III. PROCEDURE:

1. The preferred communications method should be direct between an EMS prehospital provider and the facility. An alternative method of communications should be addressed in County Operating Procedures.
2. Local Medical Program Director, county councils and communications centers will be responsible for establishing communications procedures between the prehospital provider(s) and the facility (ies).
3. The provider agencies will maintain communications equipment and training needed to communicate in accordance with WAC.
4. Problems with communications affecting patient care will be reviewed by the provider agency, county council, MPD, communications center, and if necessary report to the Regional Communications Committee for review.
5. **All patient information communicated between agencies shall be in compliance with current HIPAA standards.**

IV. DEFINITION

V. QUALITY IMPROVEMENT:

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REGIONAL PATIENT CARE PROCEDURE #7

HELICOPTER RESPONSE

*Revisions approved by DOH and implemented by
East Region EMS/TC Council September 2010*

I. STANDARD:

1. *Initiate a helicopter response as soon as medically necessary.*
2. *Helicopter transport should be considered when transport time to the appropriate facility may be reduced by more than 15 minutes.*
3. *The highest level of pre-hospital EMS provider on scene may cancel the helicopter response if they determine the patient condition does not warrant air transport.*

Note: County Operating Procedures (COPS) may be added as an addendum to DOH approved PCPS to clarify implementation and operation within each county.

II. PURPOSE:

1. To define who may initiate the request for an on-scene medical helicopter and under what circumstances non-medical personnel may request on-scene helicopter service.

III. PROCEDURE:

1. The highest level of pre-hospital personnel on scene may request a helicopter be placed on standby or that a helicopter(s) be launched to the scene per COPS.

Note: If the request is to place a helicopter on standby, this helicopter and crew will remain dedicated to the standby until released by the requesting agency.

2. This call shall be initiated through the appropriate medical emergency-dispatching agency per COPS. If possible, landing zone (LZ) or rendezvous sites, and/or LZ hazard assessments, should be identified at this time.
3. The helicopter service communications staff will give an approximate .estimated time of arrival (ETA) to the scene to the dispatchers requesting service.
4. Helicopter personnel will contact ground EMS personnel as soon as possible while en-route to the scene.
5. Any citizen or law enforcement on scene may request a helicopter be launched to the scene. If a citizen requests a launch, the dispatching service receiving the helicopter request will assure that local EMS is dispatched to the scene at the same time.
6. After assessing the patient, if the highest level EMS personnel on scene determines that the patient's condition does not warrant air transport, they may cancel the responding helicopter and assume responsibility for patient care and transport.
7. Helicopter personnel shall follow an Incident Command System (ICS) that is National Incident Management System (NIMS).
8. Helicopter personnel will make radio contact with the receiving hospital as soon as possible after liftoff from the scene.

REGIONAL PATIENT CARE PROCEDURE #7

HELICOPTER RESPONSE

*Revisions approved by DOH and implemented by
East Region EMS/TC Council September 2010*

IV. DEFINITIONS:

1. **Standby:** Upon receiving the request, helicopter dispatch personnel will notify the pilot and crew of the possible flight. The crew will respond to the helicopter and load appropriate equipment. The crew will then remain at or near the helicopter until such time they are launched or released from the standby.
2. **Launch Time:** The time at which the helicopter lifts from the pad en-route to the scene.
3. **Flight time:** The estimated time from launch to the helicopter landing at the scene.
4. **Landing Zone (LZ) Hazard Assessment:** On-scene EMS will identify a helicopter-landing zone as close to the scene as safely possible. Ideally this will be a flat area, free of obstructions, a minimum of 75 feet by 75 feet during daylight and 100 feet by 100 feet at night. Personnel designating the LZ must complete a hazard assessment including, but not limited to, overhead wires, rocks, uneven surfaces, loose debris, trees, vehicles, foot traffic, and high winds. Such hazards will be relayed to the pilot as the helicopter approaches the LZ.
5. **Rendezvous:** An alternate site for patient transfer from ground ambulance to air ambulance when terrain, weather, or other restraints hinder the helicopter from landing at the requested scene or hospital. The landing zone hazard assessment shall be completed for the rendezvous LZ as for any other LZ.

V. QUALITY IMPROVEMENT:

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EAST REGION EMS/TC COUNCIL
ALL HAZARDS REGIONAL PATIENT CARE PROCEDURE #8
Mass Casualty Incident (MCI)

*Revisions approved by DOH September 2010 and Implemented Regionwide by
East Region EMS/TC Council September 2010*

- I. STANDARD:** EMS personnel, licensed ambulance and licensed aid services shall respond to a Mass Casualty Incident as identified in this document.
1. All verified ambulance and verified aid services shall respond to an MCI per the county MCI plans.
 2. Licensed ambulance and licensed aid services shall assist during an MCI per county MCI plans when requested by command through dispatch in support of county MCI Plan and/or in support of verified EMS services.
 3. EMS certified first response personnel shall assist during an MCI per county MCI plans when requested by command through dispatch in support of county MCI Plan and /or in support of verified EMS services.
 4. Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.
 5. All EMS agencies working during an MCI event shall operate within the National Incident Management System or the Incident Command System (ICS) as identified in the jurisdiction that has authority, protocol and MCI plan.
- II. PURPOSE:**
1. To develop and communicate the information of regional trauma plan section VII prior to an MCI.
 2. To implement county MCI plans during an MCI.
 3. **Severe Burns:** *To provide trauma and burn care to at least 50 severely injured adult and pediatric patients per region.*
 4. To provide safe mass transportation with pre-identified EMS personnel, equipment, and supplies per the approved County Disaster Plan and/or the Hazardous Mitigation Plan.
- III. PROCEDURES:**
1. Incident Commander (IC) shall follow the county MCI Plan to inform medical control and the disaster medical control hospital when an MCI condition exists. (Refer to county specific Department of Emergency Management Disaster Plan.)
 2. Medical Program Directors agree that protocols being used by the responding agency should continue to be used throughout the transport of the patient, whether it is in another county, region or state. This ensures consistent patient care will be provided by personnel trained to use specific meds, equipment, procedures, and/or protocols until delivery at the receiving facility has been completed.
 3. EMS personnel may use the *Prehospital Mass Casualty Incident (MCI) general Algorithm* during the MCI incident (attached).

EAST REGION EMS/TC COUNCIL
ALL HAZARDS REGIONAL PATIENT CARE PROCEDURE #8
Mass Casualty Incident (MCI)

*Revisions approved by DOH September 2010 and Implemented Regionwide by
East Region EMS/TC Council September 2010*

IV. QUALITY IMPROVEMENT:

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Post incident after action review is completed within 30 days. It shall be the responsibility of the agency managing the incident to coordinate the review.

V. DEFINITIONS

- **CBRNE** - Chemical, Biological, Radiological, Nuclear Explosive
- **County Disaster Plan** –Comprehensive Emergency Management Plan (CEMP)
- **Medical Control:** MPD authority to direct the medical care provided by certified EMS personnel in the prehospital EMS system.

EAST REGION EMS/TC COUNCIL
ALL HAZARDS REGIONAL PATIENT CARE PROCEDURE #8
Mass Casualty Incident (MCI)

*Revisions approved by DOH September 2010 and Implemented Regionwide by
 East Region EMS/TC Council September 2010*

<u>Prehospital Mass Casualty Incident (IC) General Algorithm</u>	
Receive dispatch	
Respond as directed	
Arrive at scene & Establish Incident Command (IC)	
Scene Assessment and size-up*	
Report to Dispatch	
Determine if mass casualty conditions exist*	
Implement county MCI plan	
Request additional resources as needed	
The dispatch center shall coordinate notification and dispatch or required agencies and resources including notification of the Regional Disaster Control Hospital (RCH). The Spokane Regional Health District (SRHD) shall be notified in events where a public health threat exists.	
Identify hazards and determine needs to control or eliminate them. Take immediate action to isolate and deny access (Site Access Control) or mitigate the hazards as necessary to prevent additional injuries. Consider possibility of terrorist attack (WMD, secondary device)	
Initiate START	
Reaffirm additional resources	
Initiate ICS 201 or similar tactical worksheet (See attached)	
Upon arrival at Medical Center, transfer care of patients to medical centers staff (medical center should activate their respective MCI Plan as necessary).	
	<p style="color: red;">*Once a command is established and a more thorough situation assessment/size up has been completed, Command shall provide an “updated report of conditions,” confirm that a “Multi-Casualty Incident” exists and provide the following information:</p> <ol style="list-style-type: none"> 1. Agency calling 2. Name and position of caller. 3. Type of incident (bus accident, aircraft accident, explosion, etc.) 4. Name of Incident 5. Confirmation of location of incident. 6. Approximate number of casualties by triage category (red, yellow, green, black) 7. Unusual circumstances or hazardous conditions, e.g., WMD 8. Command Post location. 9. Type and number of additional resources or special equipment needed 10. Best access and staging area(s) location.

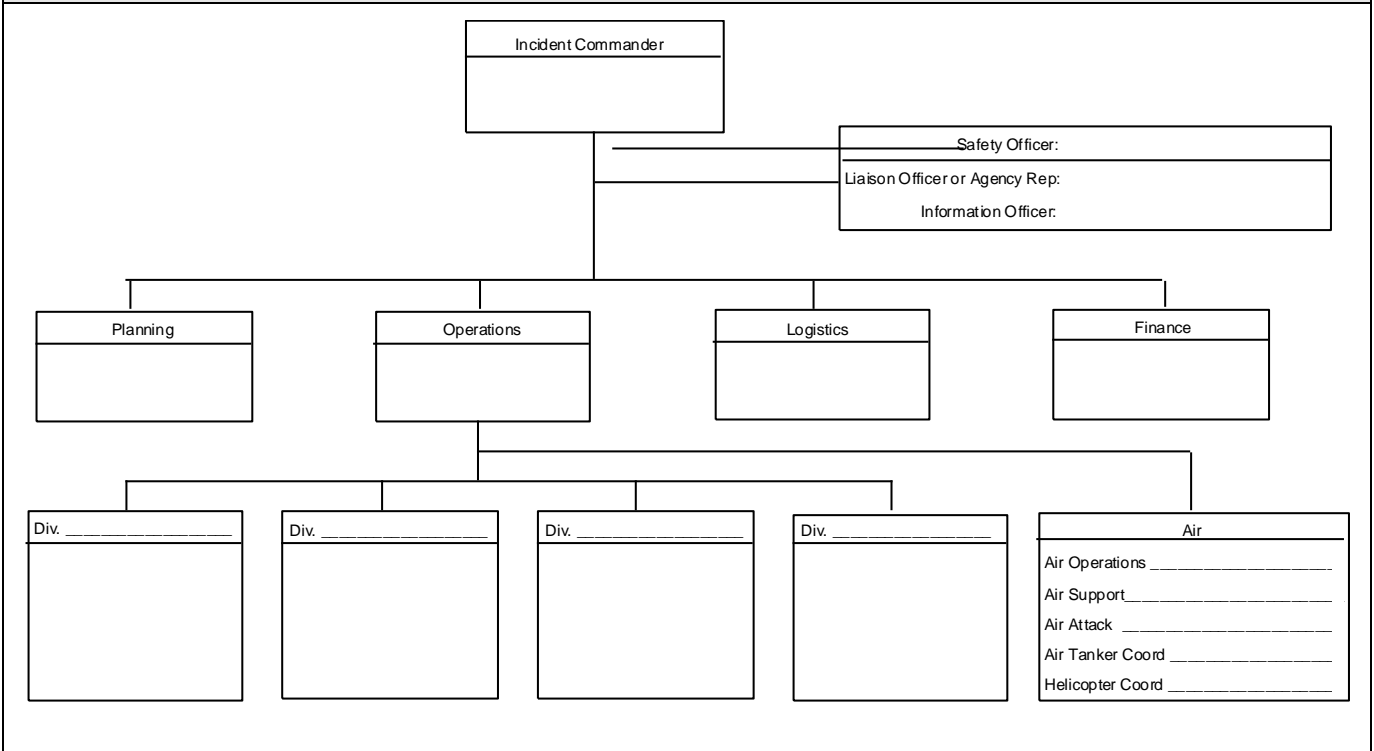
EAST REGION EMS/TC COUNCIL
ALL HAZARDS REGIONAL PATIENT CARE PROCEDURE #8
Mass Casualty Incident (MCI)
Revisions approved by DOH September 2010 and Implemented Regionwide by
East Region EMS/TC Council September 2010

Prepare transport vehicle to return to service	
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INCIDENT BRIEFING	1. Incident Name	2. Date	3. Time
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4. Map Sketch

5. Current Organization



Page 23 of	6. Prepared by (Name and Position)
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Incident Name						Date
Pt #	Tag Number and/or Name	Adult Pedi Sex	Triage Tag Color	Injuries by System: List most severe first	Transport Mode and Time	To Hospital
1	#	A	R		AIR _____	DMC SHMC
		P	Y		AMB _____	VHMC HF
		M F	G		BUS/OTR _____	OTR _____
2	#	A	R		AIR _____	DMC SHMC
		P	Y		AMB _____	VHMC HF
		M F	G		BUS/OTR _____	OTR _____
3	#	A	R		AIR _____	DMC SHMC
		P	Y		AMB _____	VHMC HF
		M F	G		BUS/OTR _____	OTR _____
4	#	A	R		AIR _____	DMC SHMC
		P	Y		AMB _____	VHMC HF
		M F	G		BUS/OTR _____	OTR _____
5	#	A	R		AIR _____	DMC SHMC
		P	Y		AMB _____	VHMC HF
		M F	G		BUS/OTR _____	OTR _____
6	#	A	R		AIR _____	DMC SHMC
		P	Y		AMB _____	VHMC HF
		M F	G		BUS/OTR _____	OTR _____
7	#	A	R		AIR _____	DMC SHMC
		P	Y		AMB _____	VHMC HF
		M F	G		BUS/OTR _____	OTR _____

**PCP #8A All Hazards (MCI)
Region 9 Disaster Medical Hospital Control (DMHC)
Notification / Activation Procedure
From Regional EMS Provider to Dispatch Center**

*Approved by DOH
Implemented by East Region EMS/TC Council March 2011*

I. Standard

1. All Public Safety and EMS providers in Region 9 shall consider the capability of the community's local hospital(s) or clinic(s) prior to contacting the Disaster Medical Hospital Control (DMHC).
2. All dispatch centers in Region 9 shall coordinate with the Incident Commander at the scene and local hospital(s) or clinic(s) regarding how many potential patients will be transported prior to contacting the DMHC.

II. Purpose

1. All Public Safety, EMS providers and dispatch centers in Region 9 shall have *trigger points* to assist in determining if the Disaster Medical Hospital Control (DMHC) should be notified of potential patient surge caused by a Mass Casualty Incident (MCI) or disaster.

III. Procedures

1. EMS providers or the dispatch center should contact DMHC immediately upon notification of any of the following triggers:
 - Multiple ambulances dispatched to one incident.
 - Multi-unit housing / hotel - structure fire – burns, smoke inhalation or injuries.
 - Motor Vehicle Accidents – multi car, buses or semi trucks with Haz Mat on board.
 - Haz Mat incidents – natural gas leaks with evacuations, fuel farm fires or leaks, chlorine leaks, unknown substance exposure, train derailments with fire or Haz mat.
 - Public venues with multiple injuries or ill people.
 - Aircraft incident.
 - Explosions or building collapse.
 - Threat of IED or WMD
 - Multi agency response

- IV. QUALITY IMPROVEMENT:** The East Region Pre-hospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

EAST REGION PATIENT CARE PROCEDURE 9
CARDIAC & STROKE PATIENT DESTINATION PCP
Approved by DOH and Implemented by East Region EMS/TC Council April 2011

I. STANDARD:

1. *All Ambulance Services shall transport cardiac/stroke patients to the most appropriate categorized cardiac and/or stroke hospital.*
2. *All ambulance and aid services shall consider activating ALS rendezvous or helicopter response - Patient Care Procedure #7- if beyond the designated time requirements in the triage tool.*
3. *Each categorized cardiac and/or stroke facility will determine when it is appropriate to alert ambulance services to divert to another categorized facility.*

II. PURPOSE:

1. To implement regional policies and procedures for all cardiac/stroke patients who meet the criteria for cardiac/stroke triage activation as described in the Washington Pre-hospital Cardiac/Stroke Triage Procedure.
2. To ensure that all cardiac/stroke patients are transported to the most appropriate categorized facility as described in RCW 70.168.150 .
3. To allow the receiving facility adequate time to activate their cardiac/stroke response team.

V. PROCEDURES:

1. The first certified EMS provider determines that a patient:
 - a. Presents with signs, symptoms or past medical history suggesting a cardiac or stroke (in accordance with the Washington Cardiac/Stroke Pre-hospital Triage Procedure).
 - b. Meets the cardiac/stroke triage criteria.
2. The provider provides care for the patient as described in the Medical Program Director's (MPD) patient care protocol for cardiac or stroke patients.
3. The provider then determines destination based upon the criteria identified and the following:
 - a. For patients meeting Cardiac/Stroke Triage criteria transport destinations will comply with the triage tool and COPs
 - b. Agencies unable to meet the transport destination criteria will utilize PCP #7 for determination of transport mode.
 - c. On-line medical control for all Counties shall be accessed per County Operating Procedures (COPs).
 - d. Communication will be initiated with the receiving facility as soon as possible to allow the receiving facility adequate time to activate their cardiac/stroke response teams.

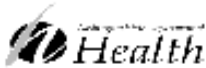
EAST REGION PATIENT CARE PROCEDURE 9
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- e. The receiving facility will notify the transporting ambulance service about diversion according to COPs.
4. Medical control and/or the receiving facility will be provided with patient information, as outlined in the Pre-hospital Destination Tool and COPs
5. All information shall be documented on an appropriate medical incident report form approved by the County MPD will be provided to the receiving hospital in accordance with state standards.
6. All categorized hospitals transferring patients to a higher level of care will ensure that all prehospital and hospital medical records follow the patient to ensure that complete data will be available for system evaluation.

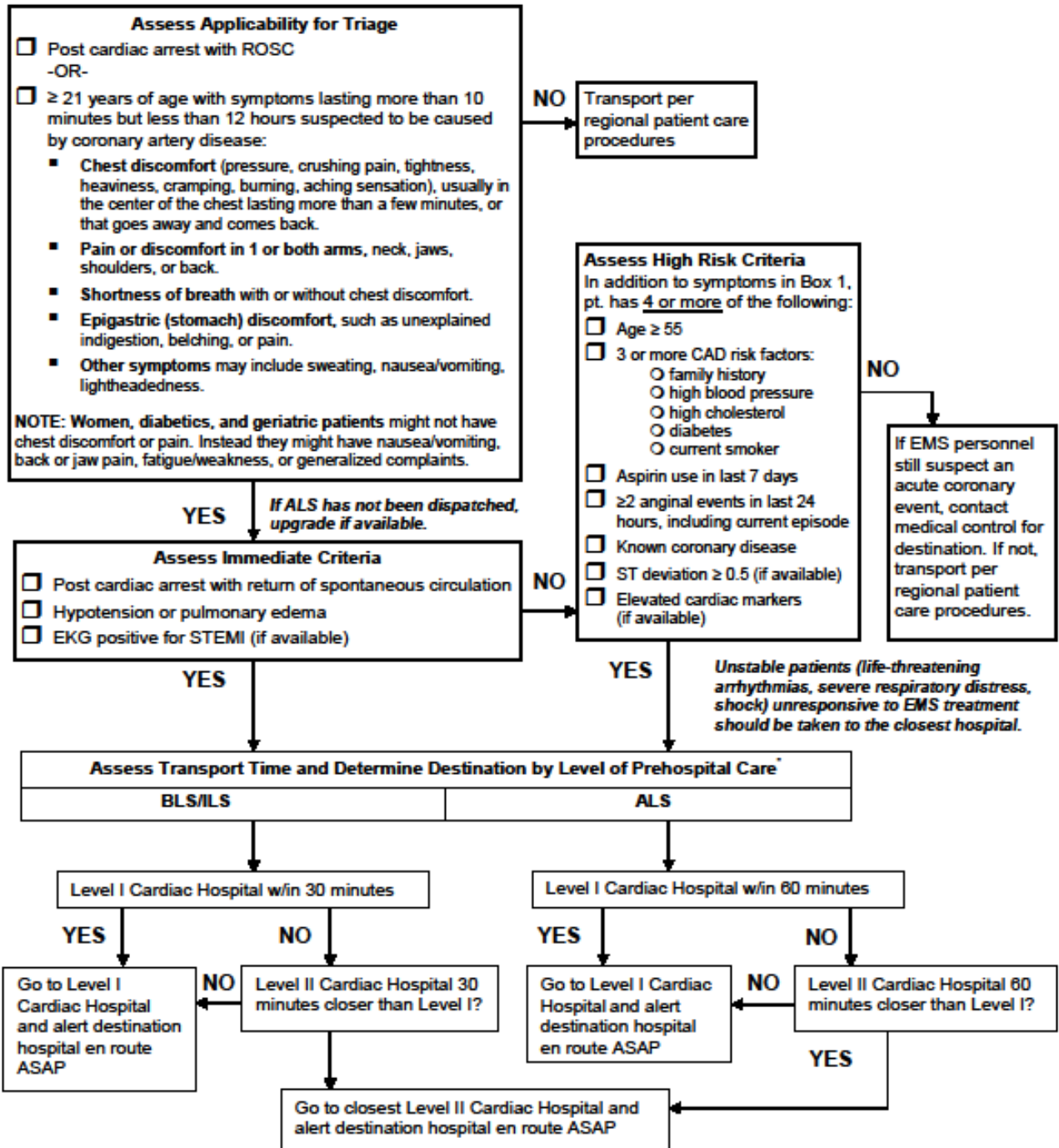
VI. QUALITY IMPROVEMENT:

The East Region Pre-hospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a local provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

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State of Washington
Prehospital Cardiac Triage Destination Procedure



* Slight modifications to the transport times may be made in county operating procedures. See page 2. Consider ALS and air transport for all transports greater than 30 minutes. If there are two or more Level I facilities to choose from within the transport timeframe, patient preference, insurance coverage, physician practice patterns, and local rotation agreements may be considered in determining destination. This also applies if there are two or more Level II facilities to choose from.

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State of Washington
Prehospital Cardiac Triage Destination Procedure

Why triage cardiac patients?

The faster a patient having a heart attack or who's been resuscitated gets treatment, the less likely he or she will die or be permanently disabled. Patients with unstable angina and non-ST elevation acute coronary syndromes (UA/NSTE) are included in the triage procedure because they often need immediate specialized cardiac care. This triage procedure is intended to be part of a coordinated regional system of care that includes dispatch, EMS, and both Level I and Level II Cardiac Hospitals.

How do I use the Cardiac Triage Destination Procedure?

- A. Assess applicability for triage** – If a patient is post cardiac arrest with ROSC, or is over 21 and has any of the symptoms listed, the triage tool is applicable to the patient. Go to the "Assess Immediate Criteria" box. **NOTE:** Women, diabetics, and geriatric patients often have symptoms other than chest pain/discomfort so review all symptoms with the patient.
- B. Assess immediate criteria** – If the patient meets any one of these criteria, he or she is very likely experiencing a heart attack or other heart emergency needing immediate specialized cardiac care. Go to "Assess Transport Time and Determine Destination" box. If the patient does not meet immediate criteria, or you can't do an ECG, go to the "Assess High Risk Criteria" box.
- C. Assess high risk criteria** – If, in addition to meeting criteria in box 1, the patient meets four or more of these high risk criteria, he or she is considered high risk for a heart attack or other heart emergency needing immediate specialized cardiac care. These criteria are based on the TIMI risk assessment for unstable angina/non-STEMI. If the patient does not meet the high risk criteria in this box, but you believe the patient is having an acute coronary event based on presentation and history, consult with medical control to determine appropriate destination. High risk criteria definitions:
- 3 or more CAD (coronary artery disease) risk factors:
 - Age \geq 55: epidemiological data for WA show that incidence of heart attack increases at this age
 - Family history: father or brother with heart disease before 55, or mother or sister before 65
 - High blood pressure: \geq 140/90, or patient/family report, or patient on blood pressure medication
 - High cholesterol: patient/family report or patient on cholesterol medication
 - Diabetes: patient/family report
 - Current smoker: patient/family report.
 - Aspirin use in last 7 days: any aspirin use in last 7 days.
 - \geq 2 anginal events in last 24 hours: 2 or more episodes of symptoms described in box 1 of the triage tool, including the current event.
 - Known coronary disease: history of angina, heart attack, cardiac arrest, congestive heart failure, balloon angioplasty, stent, or bypass surgery.
 - ST deviation \geq 0.5 mm (if available): ST depression \geq 0.5 mm is significant; transient ST elevation \geq 0.5 mm for $<$ 20 minutes is treated as ST-segment depression and is high risk; ST elevation $>$ 1 mm for more than 20 minutes places these patients in the STEMI treatment category.
 - Elevated cardiac markers (if available): CK-MB or Troponin I in the "high probability" range of the device used. Only definitely positive results should be used in triage decisions.
- D. Determine destination** – The general guideline is to take a patient meeting the triage criteria directly to a Level I Cardiac Hospital within reasonable transport times. For BLS, this is generally within 30 minutes transport time, and for ALS, generally 60 minutes transport time. See below for further guidance. Regional patient care procedures and county operating procedures may provide additional guidance.
- E. Inform the hospital en route** so staff can activate the cath lab and call in staff if necessary.

What if a Level I Cardiac Hospital is just a little farther down the road than a Level II?

You can make slight changes to the 30/60 minute timeframe. The benefits of opening an artery faster at a Level I can outweigh the extra transport time. To determine whether to transport beyond the 30 or 60 minutes, figure the difference in transport time between the Level I Cardiac Hospital and the Level II Cardiac Hospital. For BLS, if the difference is more than 30 minutes, go to the Level II Cardiac Hospital. For ALS, if the difference is more than 60 minutes, go to the level II Cardiac Hospital.

BLS examples: A) minutes to Level I minus minutes to Level II = 29: go to Level I
 B) Minutes to Level I minus minutes to Level II = 35: go to Level II

ALS examples: A) minutes to Level I minus minutes to Level II = 45: go to Level I
 B) Minutes to Level I minus minutes to Level II = 68: go to Level II

NOTE: We recommend ALS use a fibrinolytic checklist to determine if a patient is ineligible for fibrinolysis. If ineligible, transport to closest Level I hospital even if it's greater than 60 minutes or rendezvous with air transport.

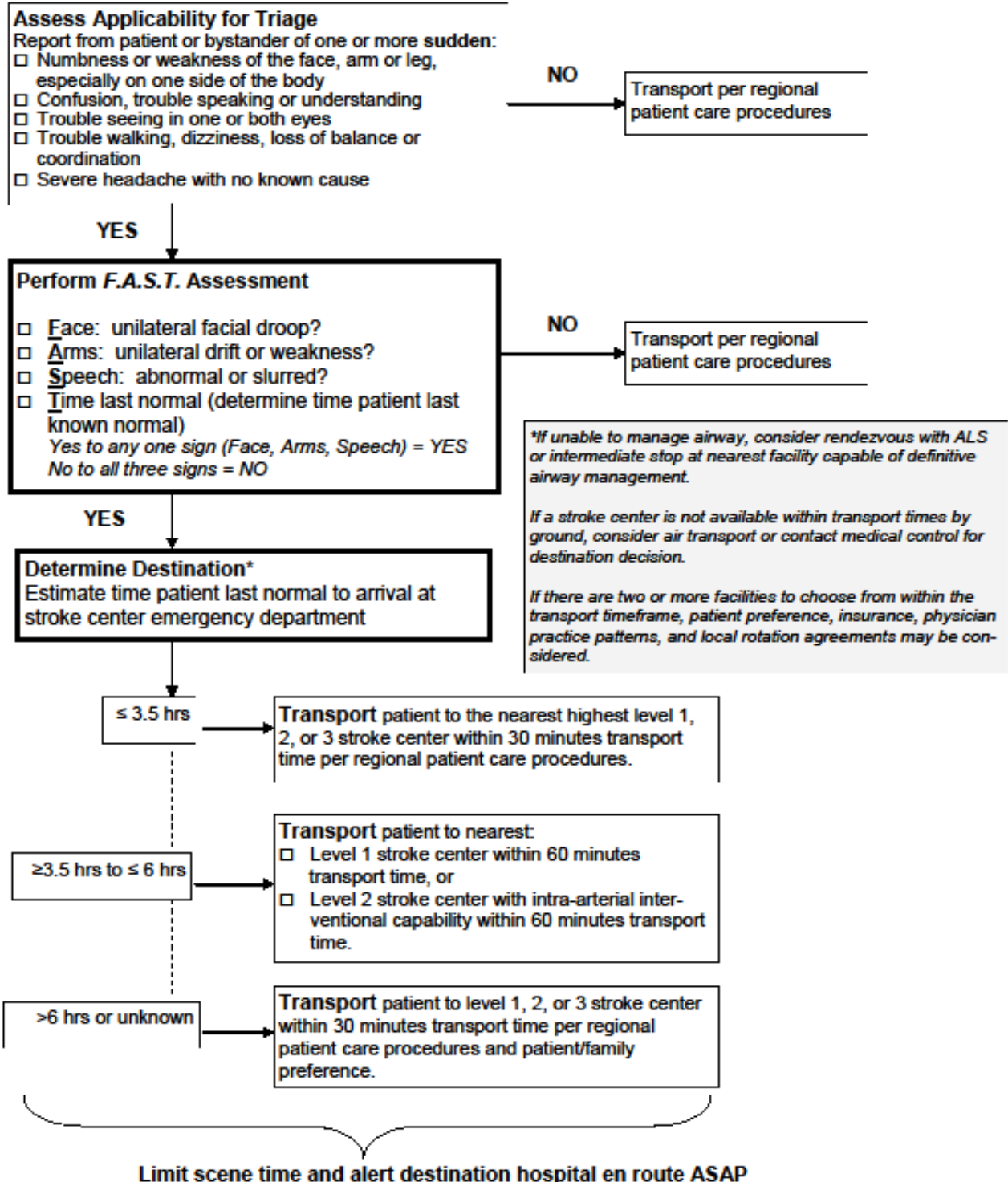
What if there are two or more Level I or II facilities to choose from?

If there are two or more of the same level facilities to choose from within the transport times, patient preference, insurance coverage, physician practice patterns, and local rotation agreements may be considered in destination decision.

EAST REGION PATIENT CARE PROCEDURE 9
CARDIAC & STROKE PATIENT DESTINATION PCP
Approved by DOH and Implemented by East Region EMS/TC Council April 2011



State of Washington
Prehospital Stroke Triage Destination Procedure



EAST REGION PATIENT CARE PROCEDURE 9
CARDIAC & STROKE PATIENT DESTINATION PCP
Approved by DOH and Implemented by East Region EMS/TC Council April 2011





State of Washington
Prehospital Stroke Triage Destination Procedure

Purpose

The purpose of the Stroke Triage and Destination Procedure is to help you identify stroke patients in the field so you can take them to the most appropriate hospital. Like trauma, stroke treatment is time-critical – the sooner a patient is treated, the better their chances of survival. Fast treatment can mean less disability, too. For strokes caused by a blood clot in the brain (ischemic), clot-busting medication must be administered within 4.5 hours from the time they first have symptoms. For bleeding strokes (hemorrhagic), time is also critical. As an emergency responder, you play a crucial role in getting patients to treatment in time.

Stroke Assessment – F.A.S.T.

The F.A.S.T. assessment tool (also known as the Cincinnati Prehospital Stroke Scale + Time) is a simple but pretty accurate way to tell if someone might be having a stroke. It's easy to remember: Facial droop, Arm drift, Speech, + Time. If face, arms, or speech is abnormal, it's likely your patient is having a stroke. You should immediately transport the patient to a stroke center. Regional patient care procedures and county operating procedures may provide additional guidance. Alert the hospital on the way. Transport should not be delayed for IV and EKG monitoring.

TEST	NORMAL	ABNORMAL
F acial droop: Ask the patient to show his or her teeth or smile.	 <p>Both sides of the face move equally.</p>	 <p>One side of the face does not move as well as the other.</p>
A rm drift: Ask the patient to close his or her eyes and extend both arms straight out for 10 seconds. The palms should be up, thumbs pointing out.	 <p>Both arms move the same or both arms do not move at all.</p>	 <p>One arm drifts down, or one arm does not move at all.</p>
S peech: Ask the patient to repeat a simple phrase such as "Firefighters are my friends."	The patient says it correctly, with no slurring.	The patient slurs, says the wrong words, or is unable to speak.
T ime: Ask the patient, family or bystanders the last time the patient was seen normal.		

Stroke warning signs:

- Sudden numbness or weakness of the face, arm or leg, especially on one side of the body
- Sudden confusion, trouble speaking or understanding
- Sudden trouble seeing in one or both eyes
- Sudden trouble walking, dizziness, loss of balance or coordination
- Sudden, severe headache with no known cause

Encourage family to go to the hospital to provide medical history, or obtain contact information for a person who can provide medical history.

Report to ED:

Possible IV t-PA contraindications: symptom onset more than 180 minutes • head trauma or seizure at onset • recent surgery, hemorrhage, or heart attack • any history of intracranial hemorrhage • minor or resolving stroke • sustained BP > 185/110, but EMS do not treat!