Inland Counties Emergency Medical Agency

Serving San Bernardino, Inyo, and Mono Counties

Virginia Hastings, Executive Director
Reza Vaezazizi, M.D., Medical Director

DATE: May 30, 2012

TO: EMS Providers – ALS, BLS, EMS Aircraft
Hospital CEOs, ED Directors, Nurse Managers and PLNs
EMS Training Institutions and Continuing Education Providers
Inyo, Mono and San Bernardino County EMCC Members
Other Interested Parties

FROM: Virginia Hastings, Executive Director
Reza Vaezazizi, M.D., Medical Director

SUBJECT: **IMPLEMENTATION OF PROTOCOLS EFFECTIVE JULY 1, 2012**

After extensive work on behalf of the Protocol Education Committee and public comments received, the Medical Advisory Committee and the Emergency Medical Care Committees endorsed the protocols listed below effective July 1, 2012.

Reference # 6070 Cardiovascular "STEMI" Receiving Centers
8100 Continuation of Trauma Care
15010 Trauma - Adult
15050 Hospital Emergency Response Team (HERT)

Please insert and replace the enclosed policies and the Table of Contents in your EMS Policy, Procedure and Protocol Manual with the updated documents and ensure every station or facility has a reference copy. The ICEMA protocols and policies can also be found on ICEMA's website at www.ICEMA.net under Emergency Medical Services Information and select the EMS Policy, Procedure and Protocol Manual section.

Please contact Sherri Shimshy, RN, EMS Nurse Specialist, for questions related to documents in the manual. She can be reached at (909) 388-5816 or via e-mail at sshimshy@cao.sbcounty.gov.

VH/mae

Enclosures

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15050	Hospital Emergency Response Team (HERT) **NEW**	**07/01/12**

Updated 05/29/12:mae

CARDIOVASCULAR "STEMI" RECEIVING CENTERS

PURPOSE

A Cardiovascular STEMI Receiving Center (SRC) will be the preferred destination for patients who access the 9-1-1 system meeting defined criteria and show evidence of a ST-elevation myocardial infarction on a 12-lead electrocardiogram (ECG). These patients will benefit from rapid interventions via cardiac catheterization interventions.

DEFINITIONS

1. **STEMI** - ST Elevation Myocardial Infarction.

2. **PCI** - Percutaneous Coronary Intervention.

3. **STEMI Receiving Center (SRC)** - Facilities that have emergency interventional cardiac catheterization capabilities.

4. **STEMI Referring Hospital** - Facilities that do not have emergency interventional cardiac catheterization capabilities.

5. **STEMI Base Station** - Facilities that have emergency interventional cardiac catheterization capabilities that also function as a Base Station.

6. **CQI** - Continuous Quality Improvement.

7. **EMS** - Emergency Medical Services.

8. **CE** - Continuous Medical Education**.**

POLICY

The following requirements must be met for a hospital to be designated as a Cardiovascular STEMI Receiving Center by ICEMA:

1. An ICEMA approved paramedic receiving hospital which is a full service acute care facility.

2. Licensure as a Cardiac Catheterization Laboratory.

3. Intra-aortic balloon pump capability.

4. Cardiovascular surgical services permit.

5. Communication system for notification of incoming STEMI patients, available twenty-four (24) hours per day, seven (7) days per week. (i.e., in-house paging system).

6. Provide CE opportunities for EMS personnel in areas of 12-lead ECG acquisition and interpretation, as well as assessment and management of STEMI patients.

STAFFING REQUIREMENTS

The hospital will have the following positions designated and filled prior to becoming a SRC:

1. Medical Directors

   The hospital shall designate two (2) physicians as co-directors of its SRC program. One physician shall be a board certified interventional cardiologist with active PCI privileges. The co-director shall be a board certified emergency medicine physician with active privileges to practice in the emergency department.

2. Nursing Director

   The hospital shall designate a SRC Nursing Director who is trained or certified in Critical Care nursing.

3. On-Call Physician Consultants and Staff

   A daily roster of the following on-call physician consultants and staff that must be promptly available within thirty (30) minutes of notification.

   a. Cardiologist with percutaneous coronary intervention (PCI) privileges.

   b. Cardiovascular Surgeon, if cardiovascular surgical services are offered.

   c. Cardiac Catheterization Laboratory team.

   d. Intra-aortic balloon pump nurse or technologist.

INTERNAL HOSPITAL POLICIES

The hospital shall develop internal policies for the following situations:

1. Fibrinolytic therapy protocol to be used only in unforeseen circumstances when PCI of an STEMI patient is not possible.

2. Diversion of STEMI patients **only** during times of Internal Disaster in accordance to protocol #8060, San Bernardino County Requests for Hospital Diversion Policy, (applies to physical plant breakdown threatening significant patient services or immediate patient safety issues i.e. bomb threat, earthquake damage, hazardous material or safety and security of the facility.) A written notification describing the event must be submitted to ICEMA within twenty-four (24) hours.

3. Prompt acceptance of STEMI patients from other STEMI referral centers that do not have PCI capability. Refer to ICEMA Policy Reference #8040, Interfacility Transfer of STEMI Patient.

4. Cath lab team activation policy which requires immediate activation of the team upon EMS notification when there is documented STEMI patient en-route to the STEMI center, based on machine algorhythm interpretation.

DATA COLLECTION

All required data elements shall be collected and entered in an ICEMA approved STEMI registry on a regular basis and submitted to ICEMA for review.

CONTINUOUS QUALITY IMPROVEMENT PROGRAM

SRC shall develop an on-going CQI program which monitors all aspect of treatment and management of STEMI cardiac patients and identify areas needing improvement. The program must, at a minimum, monitor the following parameters:

1. Morbidity and mortality related to procedural complications.

2. Detail review of cases requiring emergent rescue CABG.

3. Tracking of door-to-dilation time and adherence to minimum performance standards set by this policy.

4. Active participation in each ICEMA STEMI CQI committee and STEMI regional peer review process. This will include a review of selected medical records as determined by CQI indicators and presentation of details to peer review committee for adjudication.

PERFORMANCE STANDARD

In accordance with *D2B: An Alliance for Quality* guidelines, SRCs must achieve and maintain a door-to-balloon time of less than or equal to ninety (90) minutes in 75% of primary PCI patients with STEMI. If this standard is not achieved, SRC may be required to submit an improvement plan to ICEMA addressing the deficiency with steps being taken to remedy the problems.

DESIGNATION

1. The Cardiovascular STEMI Receiving Center applicant shall be designated after satisfactory review of written documentation and an initial site survey by ICEMA or its designees and completion of an agreement between the hospital and ICEMA.

2. Documentation of current accreditation from The Society of Chest Pain Centers as "Chest Pain Center with PCI" shall be accepted in lieu of a formal site visit by ICEMA.

3. Initial designation as a SRC shall be for a period of two (2) years. Thereafter, re-designation shall occur every four (4) years, contingent upon satisfactory review.

4. Failure to comply with the criteria and performance standards outlined in this policy may result in probation, suspension or rescission of SRC designation.

PATIENT DESTINATION

1. The STEMI Base Station should be considered as the destination of choice if all of the following criteria are met:

    a. Identified STEMI patients based on machine interpretation of field 12-lead ECG, verified by paramedics and approved by a Base Station physician.

    b. Total transport time to the Base Station SRC is thirty (30) minutes or less. Base hospital physician may override this requirement and authorize transport to the SRC with transport time of greater than thirty (30) minutes.

    c. STEMI Base Station contact is **mandatory** for all patients identified as possible STEMI patient. The STEMI Base Station confirms an SRC as the destination.

    d. The STEMI Base Station is the only authority that can direct a patient to a SRC.

e. The STEMI Base Station, if different from the SRC, will notify the SRC of patient's pending arrival as soon as possible, to allow timely activation of Cardiac Cath lab team at the SRC.

f. If the patient chooses bypass the recommended system STEMI center, EMS must obtain an AMA and notify the STEMI base station.

2. The following factors should be considered with regards to choice of destination for STEMI patients. STEMI Base Station contact and consultation is mandatory in these and similar situations:

a. Patients with unmanageable airway, unstable cardiopulmonary condition, or in cardiopulmonary arrest should be transported to the closest receiving hospital.

b. Patients with malignant ventricular fibrillation, ventricular tachycardia, second degree type II heart block and third degree heart blocks should be considered for transport to the closest receiving hospital.

c. Patients with obvious contraindication to thrombolytic therapy should be strongly considered for transport to the closest SRC.

d. Patients with hemodynamic instability as exhibited by blood pressure less than 90 systolic and/or signs of inadequate tissue perfusion should be transported to the closest receiving hospital.

e. Patients with *sustained* ROSC should be strongly considered for transport to the closest SRC.

REFERENCE PROTOCOLS

Protocol #	**Protocol Name**
8040	Interfacility Transfer of STEMI Patient
8060	San Bernardino County Requests for Hospital Diversion Policy

CONTINUATION OF TRAUMA CARE

THIS POLICY IS FOR CONTINUATION OF TRAUMA CARE PATIENTS FROM A REFERRAL HOSPITAL (RH) TO AN ICEMA DESIGNATED TRAUMA CENTER (TC) AND CONTINUATION OF TRAUMA CARE PATIENTS BETWEEN TCs WHEN A HIGHER LEVEL OF CARE IS REQUIRED; AND SHALL NOT BE USED FOR ANY OTHER FORM OF INTERFACILITY TRANSFER OF PATIENTS.

PURPOSE

To support a system of trauma care that is consistent with American College of Surgeons (ACS) standards and ensures the minimal time from patient injury to receiving the most appropriate definitive trauma care.

DEFINITIONS

1. **Trauma Center (TC) -** A licensed general acute care hospital designated by ICEMA's Governing Board as a trauma hospital in accordance with State laws, regulations and ICEMA policies.

2. **Referral Hospital (RH) -** Any licensed general acute care hospital that is not an ICEMA designated TC.

INCLUSION CRITERIA

Any patient meeting ICEMA Trauma Triage Criteria, (Reference ICEMA Policy #15030) arriving at a non-trauma hospital by EMS or non-EMS transport.

INITIAL TREATMENT GOALS (at RH)

1. Initiate resuscitative measures within the capabilities of the facility.

2. Ensure patient stabilization is adequate for subsequent transport.

3. Transfer timeline goal is <30 minutes door-to-door-out.

4. DO NOT DELAY TRANSPORT by initiating any diagnostic procedures that do not have direct impact on IMMEDIATE resuscitative measures.

5. RH ED physician will make direct physician-to-physician contact with the ED physician at the TC.

6. The TC will accept all referred trauma patients unless they are on Internal Disaster as defined in ICEMA Policy #8060.

7. The TC ED physician is the accepting physician at the TC and will activate the internal Trauma Team according to internal TC protocols.

8. RH ED physician will determine the appropriate mode of transportation for the patient. If ground transportation is >30 minutes consider the use of an air ambulance. Requests for air ambulance shall be made to 9-1-1 and normal dispatching procedures will be followed; however, the air ambulance continuation of trauma run patient will be transported to the TC identified by the RH.

9. Simultaneously call 9-1-1 and utilize the following script to dispatch:

   "This is a Continuation of Trauma Run from ____hospital to ____Trauma Center"

   Dispatchers will only dispatch transporting paramedic units without any fire apparatus.

10. RH must send all medical records, test results, radiologic evaluations to the TC. DO NOT DELAY TRANSPORT - these documents may be FAXED to the TC.

SPECIAL CONSIDERATIONS

1. If the patient has arrived at the RH via EMS, the RH ED physician may request that transporting team remain with patient and immediately transport them once the minimal stabilization is done at the RH.

2. The RH may consider sending one of its nurses with the transporting paramedic unit if deemed necessary due to the patient's condition or scope of practice.

3. Nurse staffed critical care (ground or air) transport units maybe used; but may create a delay due to availability. Requests of nurse staffed critical care transport units must be made directly to the transporter agency by landline.

REFERENCE PROTOCOLS

Protocol #	**Protocol Name**
8060	San Bernardino County Requests for Hospital Diversion Policy
15030	Trauma Triage Criteria and Destination Policy

TRAUMA - ADULT
(15 Years of Age and Older)

Any critical trauma patient (CTP) requires effective communication and rapid transportation to the closest trauma center. If not contacted at scene, the receiving trauma center must be notified as soon as possible in order to activate the trauma team.

In Inyo and Mono Counties, the assigned base station should be contacted for determination of appropriate destination.

FIELD ASSESSMENT/TREATMENT INDICATORS

Trauma Triage Criteria and Destination Policy #15030.

ADULT TREATMENT PROTOCOL: TRAUMA Base Station Contact Shaded in Gray

BLS INTERVENTIONS	ALS INTERVENTIONS
• Ensure thorough initial assessment • Ensure patent airway, protecting cervical spine • Axial spinal stabilization as appropriate • Oxygen and/or ventilate as needed, O_2 saturation (if BLS equipped) • Keep patient warm • For a traumatic full arrest, an AED may be utilized, if indicated • Transport to ALS intercept or to the closest receiving hospital	• Advanced airway as indicated. *Unmanageable Airway:* -If an adequate airway cannot be maintained with a BVM device; **AND** -The paramedic is unable to intubate or if indicated, perform a successful needle cricothyrotomy, **Then**, transport to the closest receiving hospital and follow Continuation of Trauma Care, Protocol Reference #8100. • Monitor ECG. • IV/IO Access: Warm IV fluids when avail *Unstable:* -BP<90mmHG and/or signs of inadequate perfusion, start 2nd IV access. *Stable*: -BP>90mmHG and/or signs of adequate tissue perfusion.

BLS Continued	***ALS Continued***
	Blunt Trauma: *Unstable*: IV NS open until stable or 2000ml maximum is infused *Stable***:** IV NS TKO **Penetrating Trauma**: *Unstable*: IV NS 500ml bolus one time *Stable***:** IV NS TKO **Isolated Closed Head Injury**: *Unstable:* IV NS 250ml bolus, may repeat to a maximum of 500ml *Stable*: IV NS TKO • Transport to appropriate hospital. • Insert nasogastric/orogastric tube as indicated.
MANAGE SPECIAL CONSIDERATIONS: **Abdominal Trauma**: Cover eviscerated organs with saline dampened gauze. Do not attempt to replace organs into the abdominal cavity. **Amputations**: Control bleeding. Rinse amputated part gently with sterile irrigation saline to remove loose debris/gross contamination. Place amputated part in dry, sterile gauze and in a plastic bag surrounded by ice (if available). Prevent direct contact with ice. Document in the narrative who the amputated part was given to. • **Partial amputation**: Splint in anatomic position and elevate the extremity. **Bleeding**: • Apply direct pressure and/or pressure dressing. • To control life-threatening bleeding of a severely injured extremity, consider application of tourniquet when direct pressure or pressure dressing fails.	**MANAGE SPECIAL CONSIDERATIONS**:

BLS Continued	***ALS Continued***
Chest Trauma: If a wound is present, cover it with an occlusive dressing. If the patient's ventilations are being assisted, dress wound loosely, (do not seal). Continuously reevaluate patient for the development of tension pneumothorax. **Flail Chest**: Stabilize chest, observe for tension pneumothorax. Consider assisted ventilations. **Fractures**: Immobilize above and below the injury. Apply splint to injury in position found except: • **Femur**: Apply traction splint if indicated. • **Grossly angulated long bone with distal neurovascular compromise**: Apply gentle unidirectional traction to improve circulation. • **Check and document distal pulse before and after positioning**. **Genital Injuries**: Cover genitalia with saline soaked gauze. If necessary, apply direct pressure to control bleeding. Treat amputations the same as extremity amputations.	**Chest Trauma**: Perform needle thoracostomy for chest trauma with symptomatic respiratory distress. **Fractures**: **Isolated Extremity Trauma**: Trauma without multisystem mechanism. Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured - e.g., dislocated shoulder, hip fracture or dislocation. **IV Pain Relief**: -Morphine Sulfate 5mg IV slowly and may repeat every 5 minutes to a maximum of 20mg when the patient maintains a -BP>90mmHG and signs of adequate tissue perfusion. Document BP's every 5 minutes while medicating for pain and reassess the patient. -Consider Ondansetron 4mg slow IVP/PO as prophylactic treatment of nausea and vomiting associated with narcotic administration. ***NOTE:*** *Patients in high altitudes should be hydrated with IV NS prior to IV pain relief to reduce the incidents of nausea, vomiting, and transient hypotension, which are side effects associated with administering IV Morphine.* -Administer IV NS 250ml bolus one time.

BLS Continued	***ALS Continued***
	IM Pain Relief: -Morphine Sulfate 10mg IM. Document vital signs and reassess the patient. -Consider Ondansetron 4mg IM/PO as prophylactic treatment of nausea and vomiting associated with narcotic administration.
Head and Neck Trauma: Place brain injured patients in reverse Trendelenburg (elevate the head of the backboard 15-20 degrees), if the patient exhibits no signs of shock. • **Eye**: Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe – stabilize it in place with sterile saline soaked gauze. Cover uninjured eye. • **Avulsed Tooth**: Collect teeth, place in moist, sterile saline gauze and place in a plastic bag.	**Head and Neck Trauma**: Immediately prior to intubation, consider prophylactic Lidocaine 1.5 mg/kg IV for suspected head/brain injury. • Base Station Orders: -When considering nasotracheal intubation (≥15 years of age) and significant facial trauma, trauma to the face or nose and/or possible basilar skull fracture are present, trauma base hospital contact is required.
Impaled Object: Immobilize and leave in place. Remove object if it interferes with CPR, or if the object is impaled in the face, cheek or neck and is compromising ventilations.	**Impaled Object**: Remove object upon trauma base physician order, if indicated.
Pregnancy: Where axial spinal stabilization precaution is indicated, the board should be elevated at least 4 inches on the right side for those patients who have a large pregnant uterus, usually applies to pregnant females ≥ 24 weeks of gestation.	
Traumatic Arrest: CPR if indicated. May utilize an AED if indicated.	**Traumatic Arrest**: Continue CPR as appropriate. Follow Protocol #11070 Cardiac Arrest - Adult.
Determination of Death on Scene: Refer to Protocol #12010 Determination of Death on Scene.	**Determination of Death on Scene**: Refer to Protocol #12010 Determination of Death on Scene.

ALS Continued

-Severe Blunt Force Trauma Arrest:
IF INDICATED: transport to the closest receiving hospital.

-Penetrating Trauma Arrest:
IF INDICATED: transport to the closest receiving hospital.

If the patient does not meet the "Obvious Death Criteria" in the "*Determination of Death on Scene" Protocol #12010*, contact the trauma base station for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma with documented asystole in at least two (2) leads, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.

- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without trauma base station contact.

Precautions and Comments:

- Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
- Consider cardiac etiology in older patients in cardiac arrest with low probability of mechanism of injury.
- **Unsafe scene may warrant transport despite low potential for survival.**
- Whenever possible, consider minimal disturbance of a potential crime scene.

Base Station: May order additional:

- medications;
- fluid boluses.

REFERENCE PROTOCOLS

Protocol Number	Protocol Name
8100	Continuation of Trauma Care
9010	General Patient Care Guidelines
10150	External Jugular Vein Access
10030/10040	Oral Endotracheal Intubation
10080	Insertion of Nasogastric/Orogastric Tube
10060	Needle Thoracostomy
10140	Intraosseous Infusion IO
10050	Nasotracheal Intubation
10070	Needle Cricothyrotomy
10160	Axial Spinal Stabilization
10010/10020	King Airway Device
11070	Adult Cardiac Arrest
15030	Trauma Triage Criteria and Destination Policy
12010	Determination of Death on Scene

HOSPITAL EMERGENCY RESPONSE TEAM (HERT)

PURPOSE

To establish a formal mechanism for providing rapid advanced surgical care at the scene, in which a higher level of on-scene surgical expertise, physician field response, is requested by the on-scene prehospital care provider.

AUTHORITY

Health and Safety Code, Division 2.5, Section 1798. (a) provides that "Authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional, …at the scene of an emergency who is most medically qualified specific to the provision of rendering emergency medical care."

DEFINITIONS

1. **Hospital Emergency Response Team (HERT)** - Organized group of healthcare providers from a designated Level I or II Trauma Center, with local Emergency Medical Services (EMS) agency approval as a HERT provider, who are available twenty-four (24) hours/day to respond and provide a higher level of on-scene surgical expertise.

2. **Incident Commander** - Highest-ranking official of the jurisdictional agency at the scene of the incident and responsible for the overall management of the incident.

PRINCIPLES

1. In general, a HERT is utilized in a situation where a **life-saving** procedure, such as an amputation, is required due to the **inability to extricate** a patient. Life before limb, utilized as a life-saving measure not as a time saving measure.

2. HERT should be assembled and ready to respond within twenty (20) minutes of a request with standard life-saving equipment in accordance with the HERT provider's internal policy on file with ICEMA.

3. The standard life-saving equipment referenced above shall be predetermined, preassembled, readily available, clearly labeled, and stored in a predetermined location. Based upon the magnitude and nature of the incident, the standard life-saving equipment may require augmentation.

POLICY

1. Composition of a Hospital Emergency Response Team

    a. The composition of the HERT, and the identification of a Physician Team Leader, shall be in accordance with the approved HERT provider's internal policy on file with ICEMA.

    b. The Physician Team Leader:

        (1) Is responsible for organizing, supervising, and accompanying members of the team to a scene where a physician field response has been requested.

        (2) Shall be familiar with base hospital operations and the ICEMA's policies, procedures, and protocols.

        (3) Is responsible for retrieving the life-saving equipment and determining if augmentation is required based upon the magnitude and nature of the incident.

        (4) Will determine the ultimate size and composition of the team based upon the magnitude and nature of the incident.

        (5) Will report to, and be under the authority of, the Incident Commander or their designee. Other members of the team will be directed by the Physician Team Leader.

2. Activation of a Hospital Emergency Response Team

    a. The anticipated duration of the incident should be considered in determining the need for a HERT. Before requesting a HERT, the Incident Commander should take into account that it may be a <u>minimum of thirty (30) minutes</u> before a team can be on scene.

    b. The Incident Commander shall contact the appropriate Communications Center. The determination of the appropriate mode of transportation of the team (ground versus air) will be mutually agreed upon.

    c. The appropriate Communication Center shall contact the approved HERT provider regarding the request. The Team Leader will organize the team and equipment in accordance with the HERT provider's internal policy, and the magnitude and nature of the incident.

d. The Physician Team Leader shall inform the Communication Center once the team has been assembled and indicate the number of team members.

e. Communication Center will notify the Incident Commander of the estimated time of arrival of the HERT if they are arriving by ground transportation. When air transport is utilized, the Communication Center will dispatch the air ambulance resource and indicate the time that the HERT is assembled with the standard life-saving equipment, prepared to leave the helipad.

3. Transportation of a Hospital Emergency Response Team

a. When either ground or air transportation is indicated, the Communication Center will arrange emergency response vehicle transportation for the HERT through the Central Dispatch Office.

b. Consider use of larger (CCT or bariatic) ground or air units for transport of patient and the HERT to paramedic receiving facility.

c. Upon the conclusion of the incident, the HERT will contact the Communication Center to arrange transportation of the team back to the originating facility.

4. Responsibilities of a Hospital Emergency Response Team on Scene

a. Upon arrival of the HERT, the Team Leader will report directly to the on-scene Incident Commander. The HERT members will, at a minimum, have visible identification that clearly identifies the individual as a healthcare provider (physician, nurse, etc.) and a member of the HERT.

b. Documentation of care rendered will be completed on hospital approved trauma flow sheets (nursing notes) and physician progress notes.

5. Approval Process of a Hospital Emergency Response Team

Trauma Centers interested in providing a HERT must develop internal policies to comply with all requirements and submit evidence of the ability to meet all requirements of this policy to ICEMA for review and approval as a HERT provider.