BEFORE THE BOARD OF COUNTY COMMISSIONERS

FOR MULTNOMAH COUNTY, OREGON

ORDINANCE NO. 789

An ordinance adopting an ambulance service plan for Multnomah County pursuant to ORS 823.180.

Multnomah County ordains as follows:

Section I. Findings.

1. ORS 823.180 requires that the County develop a plan relating to the coordination of ambulance services within the County.

2. In conformance with ORS 823.180, the Board of County Commissioners has consulted with and sought advice from interested persons, cities, and districts with regard to ambulance service planning.

3. The Board of County Commissioners has considered all proposals for providing ambulance services that have been submitted for consideration, and has considered existing boundaries of cities and rural fire protection districts in establishing the ambulance service area under the plan.

4. The Board of County Commissioners heard presentations of proposed ambulance service area plans on June 23, 1993; conducted

work sessions on June 29, 1993, June 30, 1993 and July 6, 1993 to consider plan elements; and held a public hearing on July 1, 1993 to hear public testimony on submitted plans and plan elements.

5. After extensive discussion and consideration of various policy options, the Board of County Commissioners adopted an Ambulance Service Plan July 15, 1993, with the adoption of Ordinance 772. Ordinance 772 established a single ambulance service area for Multnomah County with emergency ambulance transport provided by both public and private contracted emergency ambulance providers. Ordinance 772 was referred to the voters by citizen petition. At the March 1994 election, the citizens of Multnomah County voted to repeal the Ambulance Service Plan adopted by Ordinance 772.

6. The Board of County Commissioners held an additional work session on April 19, 1994, to consider plan elements of an Ambulance Service Plan with a single provider of emergency ambulance services. Comment was invited from interested parties, and a public hearing was held on May 19, 1994 to hear public testimony on submitted plans and plan elements.

7. The Board of County Commissioners considers the April 19, 1994 work session and the May 19, 1994 public hearing to be an extension of the planning process begun in June 1993. After extensive discussion and consideration of various policy options, the Board of County Commissioners has determined that the Ambulance

Service Plan, attached hereto as Exhibit A, best serves the public interest.

8. The ambulance service plan attached hereto as Exhibit A meets the criteria set forth in OAR 333-28-100 through 333-28-130 (Oregon State Health Division Administrative Rules).

9. The Board of County Commissioners recognizes that amendments to the current EMS Code, and other actions, will be necessary to fully implement the plan adopted by this ordinance.

Section II. Adoption of Plan.

The Ambulance Service Plan attached hereto as Exhibit A is adopted. The Director of Emergency Medical Services shall promptly submit the adopted plan to the State Health Division as required by ORS 823.180.

ADOPTED this 9th day of June, 1994, being the date of its third reading before the Board of County Commissioners of Multnomah County, Oregon.

BOARD OF COUNTY COMMISSIONERS OF MULTNOMAH COUNTY, OREGON (SEAL)

Beverly Stein, Chair
Multnomah County, Oregon

REVIEWED:

LAURENCE KRESSEL, COUNTY COUNSEL
FOR MULTNOMAH COUNTY, OREGON

By _____
Jacqueline A. Weber
Assistant County Counsel

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Emergency Medical Services

Multnomah County Ambulance Service Plan

1994

ATTACHMENT A

TO THE MULTNOMAH COUNTY ORDINANCE ADOPTING AN AMBULANCE SERVICE PLAN

MULTNOMAH COUNTY, OREGON

JUNE 9, 1994

MULTNOMAH COUNTY, OREGON
AMBULANCE SERVICE PLAN

JUNE 9, 1994

MULTNOMAH COUNTY, OREGON
AMBULANCE SERVICE PLAN
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COUNTY ORDINANCE TO ADOPT THE AMBULANCE SERVICE PLAN

AMBULANCE SERVICE PLAN

SUMMARY

The Multnomah County Board of Commissioners, based on the findings, conclusions, system design options, and recommendations from participants in the ambulance service planning effort, have approved the following plan:

1. Multnomah County will comprise a single Ambulance Service Area.

2. First response to 9-1-1 medical calls will be provided by fire departments and districts with a minimum staffing standard of defibrillator trained EMT-Basic personnel.

3. Ground ambulance transport for 9-1-1 emergency calls will be provided by a single, contracted ambulance service chosen through a competitive bid process.

4. All other ambulance service will be provided by private ambulances.

5. Air ambulance services will be provided by private helicopter and airplane providers.

6. Ambulances responding to 9-1-1 emergencies will be staffed by two EMT-Paramedics.

7. Dispatch for all 9-1-1 medical emergency calls will be provided by the City of Portland, Bureau of Emergency Communications (BOEC) through a negotiated performance agreement.

8. Primary radio communications for 9-1-1 emergencies will be on the 800Mhz system. Mobile Data Terminals (MDT) will be used for dispatch and communications with the BOEC dispatch computer.

9. Medical direction and supervision will be provided by an EMS Medical Director employed by the county.

10. The EMS Program Office in the Health Department will administer the ASA and the EMS system in Multnomah County.

11. EMS will develop and maintain a pre-hospital patient care, dispatch, and hospital disposition data base for use in monitoring performance.

12. The EMS system will use the Continuous Quality Improvement process to ensure the quality and improvement of patient care.

13. The cost of ambulance transport, the EMS Medical Director, and the EMS Program Office will be financed by fees charged to people receiving care through the 9-1-1 medical response system. Some First Response costs, such as medical supplies and equipment, may be financed through the above mentioned fees.

14. Multnomah County will work with other jurisdictions to move toward a regional approach to EMS.

CERTIFICATION
OF THE
MULTNOMAH COUNTY
AMBULANCE SERVICE PLAN

The undersigned certify that pursuant to Oregon Administrative Rules 333-28-095 through 333-28-130 that:

Each ambulance service plan element contained in these rules has been addressed and considered in the adoption of this plan by the Board of County Commissioners and,

In the Board's judgment, the ambulance service area established in the plan provides for the efficient and effective provision of ambulance services and,

To the extent they are applicable, the County has complied with ORS 823.180(2)(3) and 823.310 and existing local ordinances and rules.

Dated at Multnomah County, June 9, 1994.

Beverly Stein
Chair, County Board of Commissioners

Reviewed:

Laurence Kressel
County Counsel

OVERVIEW OF MULTNOMAH COUNTY

GEOGRAPHY

Multnomah County is the most densely populated county in Oregon. It is a predominantly urban area with approximately 97% of the population residing within the urban growth boundary established by METRO. The County extends from the junction of the Willamette and Columbia Rivers on the West to the foothills of the Cascade Mountains on the East. The County covers 465 square miles.

Because of the hills in various areas of the county snow and ice can cause problems with emergency response.

The large park, forest, and watershed areas in the county may be a barrier to access by emergency vehicles and special rescue resources may be needed. While these areas are hard to reach, fortunately there are few calls for service in these areas.

POPULATION.

1990 Census data shows the following populations:

Jurisdiction	Population	Per cent of county population
City of Portland	437,398	74.9
City of Gresham	68,235	11.7
City of Troutdale	7,852	1.3
City of Wood Village	2,814	0.5
City of Fairview	2,391	0.4
City of Maywood Park	794	0.1
Unincorporated Areas (by subtraction)	64,403	11.0
Total County	583,887	100.0

In addition to the population living in Multnomah County, a large influx of people occurs during the working day increasing the population by up to 25%

EMERGENCY MEDICAL RESOURCES

There are a number of organizations within Multnomah County currently providing emergency medical services.

Fire departments and districts are the first response providers for the entire county. They respond on essentially all the 9-1-1 medical calls. There are two (2) fire departments that provide both BLS and ALS first response; Portland Fire and Gresham Fire. There are five (5) fire departments that provide service at the BLS level only.

Three ambulance companies provide response for 9-1-1 emergency calls and provide non-emergency services as well. Three other companies provide non-9-1-1 ambulance service only. All ambulances are licensed and regulated by Multnomah County EMS.

All hospitals, with the exception of one, provide emergency services and serve as receiving hospitals for the emergency ambulance services. There are two level-one trauma hospitals in the County. In addition, some patients are transported to hospitals in Washington County, Clackamas County, and Southwest Washington.

There is one air ambulance service serving the County, providing both emergency scene response and inter-facility transport.

DEFINITIONS

Definitions in italic are those found in OAR 333-28-100

"Advanced Life Support" (ALS) means those medical services that may be provided within the scope of practice of a person certified as an EMT-Paramedic as defined in ORS Chapter 823.

"Ambulance" means any privately or publicly owned motor vehicle, aircraft, or water craft that is regularly provided or offered to be provided for the transportation of persons suffering from illness, injury, or disability and licensed by the State pursuant to ORS Ch. 823.

"Ambulance services" means the transportation of an ill, injured, or disabled individual in an ambulance and, in connection therewith, the administration of prehospital medical or emergency care, if necessary.

"Ambulance Service Area" (ASA) means a geographic area that is served by one ambulance service provider and may include all or a portion of a county, or all or portions of two or more contiguous counties.

"Ambulance Service Plan" means a written document that outlines a process for establishing a county emergency medical services system. A plan addresses the need for and coordination of ambulance services by establishing ambulance service areas for the entire county and by meeting the other requirements of the rules. Approval of a plan will not depend upon whether it maintains an existing system of providers or changes the system. For example, a plan may substitute franchising for an open market system.

"Basic Life Support" (BLS) means those medical services that may be provided within the scope of practice of a person certified as an EMT-Basic as defined in ORS Chapter 823.

"Bureau of Emergency Communications" (BOEC) means the Bureau within the City of Portland that maintains the 9-1-1 telephone answering system and the dispatch service for police, fire and EMS for the County.

"CHORAL" means the on-line computer link among all the receiving hospitals within Multnomah, Clackamas and Washington Counties that provides information on the status of those hospitals for receiving ambulance transports.

"Contract Ambulance" means an ambulance authorized by the County to respond to emergency medical calls.

"County" means Multnomah County, Oregon.

"Division" means the Oregon Health Division, Department of Human Resources.

"Effective provision of ambulance services" means ambulance services provided in compliance with the county ambulance service plan provisions for boundaries, coordination, and system elements.

"Efficient provision of ambulance services" means effective ambulance services provided in compliance with the county ambulance service plan provisions for provider selection.

"Emergency Medical Dispatcher" (EMD) means a person who is certified by the Board on Public Safety Standards and Training as defined in ORS 401.735.

"Emergency" means a non-hospital occurrence or situation involving illness, injury, or disability requiring immediate medical services, wherein delay of such services is likely to aggravate the condition and endanger personal health or safety.

"Emergency Medical Services" (EMS) means those prehospital functions and services whose purpose is to prepare for and respond to medical emergencies, including rescue, all ambulance services, patient care, communications, and evaluation.

"Emergency Medical Services Medical Director" (EMSMD) means a physician employed by the County to provide medical direction to the EMS system and medical supervision to EMTs providing emergency services within the County.

"EMS Program Office" means that organizational division within the County Health Department responsible for the administration of the EMS system in the County.

"Emergency Medical Technician" (EMT) means a person certified at one of the three levels of practice defined in ORS Chapter 823.

"Expeditious (Best Effort) response" means responding to medical calls as soon as possible upon dispatch.

"Fire Ambulance (Rescue)" means an ambulance , operated by a fire service, licensed for BLS or ALS service.

"First Responder" means an organization that provides fast response to emergency medical calls by EMTs before the arrival of an ambulance. These organizations are now fire departments throughout the County.

"HEAR" means the radio frequency that may be used for ambulance to hospital and hospital to hospital radio communications.

"Medical Advisory Board" means an advisory committee appointed by the Multnomah County Board of Commissioners as defined in Multnomah County Code.

"MCC 6.32" means the current Multnomah County Code cited as the Multnomah County Emergency Medical Services Code.

"Mass Casualty Incident" (MCI) means an emergency medical incident with enough injured or ill persons to meet the requirements for scene and medical management as defined in the EMS Administrative Rules, MCI Plan.

"MED NET" means those radio frequencies that may be used for EMS dispatch, on-line medical control, and MCI communications.

"Medical Resource Hospital" (MRH) means that hospital, contracted to EMS, to provide on-line medical advice and control to EMTs.

"Non-Emergency Ambulance" means an ambulance, licensed by the County, that provides medical transportation to patients who do not require emergency response and which is licensed by the State pursuant to ORS Ch. 823.. The level of care provided is dependent upon the patient's need.

"Notification time" means the length of time between the initial receipt of the request for emergency medical service by either a provider or an emergency dispatch center (9-1-1), and the notification of all responding emergency medical service personnel.

"On-line Medical Advice (Control)" means medical direction and advice given to an EMT, by a physician, through radio or telephone as a supplement to the written patient care protocols.

"Provider" means any public, private, or volunteer entity providing EMS or ambulance services.

"Provider selection process" means the process established by the county for selection of an ambulance service provider.

"Public Safety, Answering Point" (PSAP)/ 9-1-1 means the organization that answers calls for police, fire, and emergency medical assistance that are received from persons dialing 9-1-1. This service is provided by BOEC.

"Response time" means the time between the notification of each provider and the arrival of each provider's EMS unit(s) at the incident scene.

"Rural" or "rural response zone" means those areas outside the urban growth boundary of Multnomah County.

"Urban" or "urban response zone" means those areas within the urban growth boundary of Multnomah County.

AMBULANCE SERVICE AREA BOUNDARIES

DESCRIPTION.

All of Multnomah County comprises a single ambulance service area. There is concern that the portions of the county that are rural in nature and have a low population density cannot support the ground response time standard applicable for the urban areas.

The use of the Urban Growth Boundary, developed by METRO, as a demarcation between urban and rural ambulance response time zones in the County will provide for a more realistic application of response time standards. (Attachment A)

ALTERNATIVES FOR RESPONSE TIME REDUCTION

RURAL CONSIDERATIONS

Because of the need to provide the most efficient and effective service to citizens within Multnomah County, certain areas of the County have already been deemed better served by agencies responding from outside the County. These areas are considered to be within the County ambulance service area and intergovernmental agreements specify the details of service for each of these areas. (Attachment B) The areas affected are:

- The community of Dunthorpe
- Portions of Multnomah County located in Lake Oswego.
- The Skyline area in the Northwest portion of the County.
- The area adjacent to Columbia County served by Highway 30.
- Eastern areas of Multnomah County contiguous to Clackamas and Hood River Counties.

In addition, Multnomah County EMS serves areas in other jurisdictions by similar agreements. These areas are:

- The North end of Sauvie Island located in Columbia County.
- Portions of the City of Portland located in Washington County.

It is the intent of this plan to foster regional approaches to ambulance service area planning, management, and service to reduce any negative effects on service that may be caused by political boundaries.

Therefore, in order to maximize the effectiveness of the resources available throughout the region, within 90 days from the approval of this plan, the EMS office will bring together all current and potential parties involved in EMS in Multnomah County, Clackamas County, Washington County, Columbia County, Hood River County, and the State Parks to develop a regional plan and subsequent agreements for the provision of EMS services in the area.

(A map showing the fire districts for first response, and city boundaries is included in Attachment C.)

PREVENTION

Reducing the number of inappropriate 9-1-1 calls will allow for better utilization of resources and improve cost efficiencies. There will be a program, coordinated by the EMS program office, that will have as its goal the appropriate use of 9-1-1 for emergency medical requests. All providers will participate in this effort.

In addition, the EMS office will coordinate public education programs designed to reduce injuries, promote wellness, and enhance 9-1-1 system access. This coordination will take place between ambulance services, hospitals, law enforcement agencies, other area EMS providers, and the medical community.

Current resources can be used to promote the appropriate use of 9-1-1. However, additional sources of financial support such as grants will be sought for injury prevention and other aspects of the program.

SYSTEM ELEMENTS

RESPONSE TIMES.

DISPATCH.

At least ninety (90) per cent of responses to medical calls received by the Public Safety Answering Point (PSAP - 9-1-1) will be dispatched within eighty(80) seconds.

Medical call-taking and dispatch will continue to be governed through a performance contract between Multnomah County EMS and BOEC. This contract specifies the procedures to be used for dispatch, the triage requirements for calls, pre-arrival instructions to be given to callers and the review process to be used for the medical dispatch function. The development of these criteria is the responsibility of the EMS Medical Director. (Attachment D).

RESPONSE STANDARDS.

Response time will be measured from the time BOEC dispatches a unit until the unit reports arrival at the scene of the incident. Times shall be those recorded by the BOEC dispatch computer. Response times shall be uniformly distributed throughout the urban or rural zones. The following response time standards apply only to emergency calls. Non-emergency calls dispatched by BOEC, or turned over to non-emergency ambulances, will be run in an expeditious manner.

FIRST RESPONSE

The response standard for urban First Responders is four (4) minutes, zero (0) seconds or less to at least ninety (90) per cent of medical calls.

Rural First responders will respond in an expeditious "best effort" as soon as dispatched.

AMBULANCE

Within the Urban Growth Boundary:

Contract ambulances will respond to ninety (90) per cent of medical calls in eight (8) minutes, zero (0) seconds or less. This response time presupposes the current first response staffing and time goals. Increasing the timeliness and intensity of first response may allow for longer ambulance response times. Should this be the case, this plan allows for the incorporation of those response time requirements in lieu of the eight minute requirement. Advice from the medical community (Medical Advisory Board, Physician supervisors, ACEP, and other interested physicians) will be sought regarding the efficacy of changes in the first response criteria and extended ambulance response times.

Outside the Urban Growth Boundary:

Contract ambulances will respond to at least ninety (90) per cent of medical calls in twenty (20) minutes, zero (0) seconds or less.

Frontier (minimally populated area - e.g. Bull Run water shed):

Calls will be responded to in an expeditious, "best effort" manner as soon as the unit(s) are dispatched. The important element for response into these areas is the immediate response to the dispatch to insure that help is moving toward the incident as soon as possible.

EMS PROVIDER RESPONSE LEVEL OF CARE

Multnomah County's emergency medical services will be provided using a combined system of non-transporting first response and transporting ambulances.

Emergency medical calls, when appropriate by dispatch protocol, will receive a first response.

In accordance with priority dispatch criteria employed by EMS Dispatch, first responders will be sent to identified calls and an ambulance will be dispatched to all calls.

The goal of EMS dispatch is to send to each medical call, the amount of service necessary to provide quality medical care. It is the intent of this plan to avoid duplicated or unnecessary responses, providing cost savings to the system.

Contract ambulance service will be provided by a single ambulance service. The contracted provider may not subcontract emergency ambulance service to another provider.

The fire services that maintain rescue vehicles licensed as ambulances may continue to provide ambulance response under unusual circumstances (e.g. inclement weather, unusual service demand, etc.) as allowed for by protocol.

There will be a single system status dispatch plan for the entire ASA. The appropriate first responder, and the closest ambulance, as recommended by the dispatch computer (CAD), will be dispatched to each call.

Dispatch criteria will be developed by the EMS Medical Director.

PERSONNEL (STAFFING)

FIRST RESPONSE

RURAL CONSIDERATIONS

It is the goal of this system to have all first responders trained, at a minimum, to the EMT-Basic level. Rural first responders should attempt to have at least one EMT-B at the scene of a medical call. It is recognized that because of the size and the volunteer nature of the Rural Fire Protection Districts serving

parts of Multnomah County, this training level may not be feasible soon. The EMS program will assist rural providers in the development and provision of training necessary to meet this goal.

URBAN AREAS

Portland Fire and Gresham Fire currently have all response personnel trained to the EMT Basic level and provide many ALS first response units, with at least one (1) EMT-Paramedic responding on those units. Should it be determined appropriate for the urban response and agreed to by the fire providers and the county, all responding fire units may be required to staff at the ALS level.

AMBULANCES

All ambulances providing 9-1-1 emergency response will be staffed with two (2) EMT-Paramedics.

Other licensed ambulances will be staffed with EMT-Basic or EMT-Paramedic personnel, according to the level of service.

Additional staffing standards may be set by the EMS Medical Director for critical care transfers or other specialized services.

MEDICAL SUPERVISION

EMS MEDICAL DIRECTOR

Multnomah County will employ an EMS Medical Director (EMSMD), through the Health Department, who will serve as the medical director for the EMS program and be the physician supervisor for all EMTs in the employ of providers of ambulance services in the County. In addition and by agreement, the EMSMD may serve in this same capacity for EMTs employed by other EMS providers. The EMSMD will provide medical advice to all aspects of the EMS system and will have specific authority to set uniform standards of EMS patient care for the County. These standards will include, but not be limited to:

- Dispatch and pre-arrival protocols;
- Transport triage criteria and protocols;
- County specific EMT requirements;
- Approved equipment, supplies and drugs;
- Patient care protocols;
- Medical criteria for response times; and
- Patient transfer criteria.

The EMSMD will create policies for limiting the practice of EMTs if necessary, and will ensure that these policies are carried out with adequate due process protections.

The EMSMD will also set specific standards for training and continuing education for EMTs and EMDs.

The EMSMD will assist rural volunteer fire districts in meeting the state standards for EMT training.

The EMSMD will ensure that all providers within the system participate in a quality management program designed to provide for continuous quality improvement in patient care and all other aspects of emergency medical services. This process will provide the basis for changes in medical care protocols and the educational and training standards set forth by the EMSMD.

The EMSMD may, at his or her discretion, and as funding allows, appoint assistants to help carry out the duties assigned to the EMSMD. The EMSMD however, retains the sole responsibility for all assigned duties.

The EMS program will provide office and administrative support to the EMSMD.

MEDICAL ADVISORY BOARD

An EMS Medical Advisory Board (MAB) will provide medical advice to the EMSMD.

Other committees and groups may be formed to provide specific advice to the EMSMD or the EMS program.

The MAB will provide reports to the Board of County Commissioners on the effectiveness of medical care provided by the EMS system at least annually.

(See Attachment E - EMSMD position description)

ON-LINE MEDICAL CONTROL

On-line medical control will be provided by a Medical Resource Hospital (MRH). Standards for on-line medical control and MRH operations will be set forth by the EMSMD and implemented through a performance contract with the hospital. The EMSMD will monitor the performance of the MRH contract. (Attachment F)

PATIENT CARE EQUIPMENT

Requirements for equipment and supplies will be determined by the level of service (ALS, BLS, emergency, non-emergency) provided and will be set by the EMSMD.

FIRST RESPONDERS

All first response vehicles will be required to carry medical equipment and supplies appropriate to their level of service, as defined by the EMS Medical Director.

AMBULANCES

All ambulances will be required to maintain equipment, supplies, and drugs appropriate for their level of service (ALS, BLS) as required under OAR 333-28-050 and as required by the EMSMD. Ambulances will be inspected on a regular basis, by the EMS office to determine compliance with these requirements. (Attachment G)

RURAL CONSIDERATIONS

The EMS program will assist rural first responders in obtaining the necessary equipment to maximize their response capabilities. (e.g., automatic defibrillators)

VEHICLES

FIRST RESPONDERS

First response vehicle standards are the responsibility of the agency that operates them. The vehicles must meet any medical requirements of the EMSMD.

AMBULANCES

Ambulances will meet all relevant State and Federal statutes and rules and must meet any additional requirements of the EMSMD.

TRAINING AND EDUCATION.

EMERGENCY MEDICAL TECHNICIAN (EMT) LEVELS

Training and certification required for those technicians providing ALS care will be the level of EMT-Paramedic. In addition to the requirements for State certification, the EMSMD may require additional training or education.

Training and certification for other EMTs will be at the level of EMT-Basic.

In addition to the requirements for State certification, the EMSMD may require additional training or education.

It is the goal of this plan to encourage EMT-Basic training and certification for all 9-1-1 medical call first responders. EMS will work with the first response organizations to help realize this goal.

CONTINUING EDUCATION.

All training and continuing education will be provided throughout the EMS system through a single, coordinated educational program. Resources now available and additional training resources identified will be "pooled" to allow for their maximum use. The EMSMD will establish system-wide criteria that meet the needs of all levels of EMTs in both the urban and rural settings. This will also insure that all personnel receive appropriate and consistent training. The content offered will meet certification requirements and will reflect the outcomes and findings of the quality improvement process.

The EMS Program will continue to provide periodic inservice sessions to introduce changes in patient care protocols, administrative rules, State requirements, and other pertinent information. All EMTs will be required to attend to maintain their credentials as approved by the EMSMD.

The EMSMD may require EMTs to obtain additional training and education. Provider agencies will offer training and education to their employees and other EMTs in the system as approved by the EMSMD, and as part of the coordinated EMS educational program.

The EMS educational program will specifically assist rural first responders in obtaining the training necessary to meet system goals.

QUALITY ASSURANCE

STRUCTURE

The basis for quality assurance in the County will be a Continuous Quality Improvement (CQI) process. This model, based on the Total Quality Management theory espoused by W. Edwards Deming, is currently employed in a number of service industries, including hospitals. The focus of this process is statistical quality sampling to improve uniformity and quality of patient care. It involves standardization, measurement, testing, and inspection in a continuous process of improvement and training. When problems are identified, their resolution is accomplished within the involved system components, through participation by the people responsible for the operation of these components. The EMS CQI process will bring together all members in the EMS system to identify problems and work out solutions in a structured, participatory manner. The process employed may use peer review, problem solving groups, or other methods. Problems are addressed at the appropriate level within the organization with the end goal of improved service.

PROCESS AND PROBLEM RESOLUTION

Implementation of CQI will involve the education of EMS personnel in the process and the development of data sources.

The CQI process will analyze data on all aspects of the EMS system including dispatch, response times, medical supervision and control, patient

care, EMT and EMD performance, and other components. The data will come from computer databases, patient care chart reviews and audits, complaint patterns, patient outcomes, and other relevant sources. The outcomes of the process are information, problem solving, and system improvement. These outcomes will serve as the basis for system change.

The EMS office will provide staff support for the CQI process. The CQI process is *not* oriented to fixing blame for mistakes, but to learning from the analysis and resolution of identified problems.

SANCTIONS

Ambulance service contracts will specify fines or other remedies that will be imposed if certain conditions are not met. In addition, the contracts will identify those conditions that will constitute a breach of the contract and the conditions for termination of the agreement.

The EMS ordinance and administrative rules currently allow for sanctions for non-compliance. These remedies will continue as part of the licensing process for both contract and non-emergency ambulances.

It is not the purpose of the CQI process to apply sanctions or other remedies to non-compliant providers. Any remedies employed will be identified in the contract or agreement with the provider or in the ordinance. Any remedies directed to individual EMTs will be specified in the ordinance and be the responsibility of the EMSMD.

ADMINISTRATION AND COORDINATION

PLANNING AND ADMINISTRATION

MCC 6.32 establishes the authority of the Board of County Commissioners (BCC) to develop, approve, and administer the ambulance service plan. MCC 6.32 further defines the administration of the EMS system and the license requirements for ambulance providers (contract and non-emergency).

Administration of the ambulance service plan and the EMS system will reside with the Multnomah County Health Department EMS Program Office. All medical care components of the system will be under the authority of the EMS Medical Director.

Specific relationships with contract ambulance providers, 9-1-1 dispatch, and MRH will be delineated in intergovernmental agreements and contracts. These documents will be performance based and will specify the duties, responsibilities, compensation, remedies, and other aspects of the relationship between the County and the contractor. Similar agreements will be encouraged between the County and first responders and may include compensation. Compensation shall be contingent upon the agreement by the first responder to use EMS system standards as its target response times.

The EMS Program Office will administer and monitor these agreements and make recommendations to the Commission on the continuance, renewal, or termination of the agreements.

Non-emergency ambulances will be regulated through the licensing requirements specified by ordinance. There are no restriction on the number of ambulance licenses available No other agreements are anticipated.

RATE REGULATION

The Board of County Commissioners, as part of the ambulance contracting process, will approve all rates for emergency ambulance services provided under this plan.

There will be a single charge schedule that will apply uniformly throughout the service area for services provided to 9-1-1 callers.

There will be a Rate Regulation Board (RRB) composed of EMS providers (other than in Multnomah County), business and accountancy representatives, and service users. The RRB will be responsible for the verification and appropriateness of the rates proposed in the bid process and will recommend to the Board of County Commissioners the approved initial rates. The RRB will also serve as the rate review body to hear and recommend action concerning subsequent requests for rate adjustments. Rate adjustment formulas, such as the Consumer Price Index (CPI), may be included in the agreements. The RRB recommendations will be made to the EMS Program Office and the Board of County Commissioners as part of contract approval and modification processes.

The RRB will also review any system requirements that may have a significant financial impact on the providers. If the committee determines that such an impact is present, it may recommend a rate adjustment to compensate for the requirement.

The RRB will develop specific guidelines for the rate regulation process. These will include standards by which to determine the appropriateness of requests for rate increases.

Non-emergency ambulances will not be subject to the rate determination process. Fees charged for their services will be driven by the market for such services. They will however, continue to charge only those fees that are on file with the EMS Program Office.

COMPLAINTS

Standards for the fair and equitable handling of complaints concerning pre-hospital patient care and ambulance service will be adopted by the EMS Program Office and the Medical Director.

Complaints regarding EMS provider actions or services will be received by the EMS Program Office from any source. All information relevant to the complaint will be collected and reviewed by EMS staff. The information may include dispatch records, patient care reports, invoices for service, incident reports, hospital records, interviews, and other documents. Complaints will be resolved through three mechanisms:

1. Medical care complaints will be referred to the Medical Case Review, currently provided by the EMS Quality Assurance Committee, for impartial review and recommendations. Disposition of these complaints will be handled by the EMS Medical Director.

2. Dispatch and system response complaints will be initially reviewed by EMS staff. Some complaints may be referred to the Dispatch Committee for review and recommendation. Individual case dispositions will be handled by the EMS Program Office.

3. Complaints about ambulance charges and other non-medical, provider-related complaints will be reviewed by the EMS Program staff who will be responsible for the disposition of each case.

Complaints will be concurrently forwarded to the service provider on a timely basis.

If it is determined appropriate, complaints may be referred to other agencies for disposition (e.g., District Attorney for complaints that may be of a criminal nature).

All complaints that include medical or other sensitive information about identifiable patients will be considered a function of the Quality Assurance process. Confidentiality will be protected as required by relevant statutes.

Confidentiality applies only to the patient or medical information and does not preclude the release of other information regarding complaints filed concerning providers.

Complaints and their resolutions will constitute a data source available to the Quality Improvement process. In addition, all complaint information will be available to the EMS Medical Director for use in the medical supervision of EMTs.

MUTUAL AID AGREEMENTS.

ROUTINE EMS SERVICES.

For certain portions of Multnomah County, intergovernmental agreements will allow for response from agencies outside the County. Multnomah County providers will respond into other jurisdictions under similar agreements. The areas are described earlier in this document.

UNUSUAL CIRCUMSTANCES (MCI, DISASTER)

Fire district and fire department mutual aid agreements are in place for events that overtax the resources of a given fire district.

Similar agreements will be executed on a regional basis to allow ambulances from outside the County to respond at the request of EMS Dispatch.

In addition, *all* ambulances, contract and non-emergency, licensed in Multnomah County, are required to respond to disasters and MCI when requested to do so by the EMS Program Office through BOEC dispatch.

DISASTER RESPONSES.

MASS CASUALTY INCIDENT.

The County's Mass Casualty Incident (MCI) plan is developed by a multi-disciplinary, tri-county committee and adopted under County Ordinance (MCC 6.32). This plan, and similarly adopted plans used by the counties surrounding Multnomah County provide the direction for the organization and use of resources if there is a MCI. This plan is also incorporated as an annex in the emergency management disaster plans of the County and other local jurisdictions. (Attachment H)

In an MCI, medical communication and patient destination is the responsibility of the Regional Hospital. Regional hospital is designated by the EMS program Office in conjunction with other affected counties.

In the event that resources exceeding those normally available for EMS service to the County are needed, additional ALS and BLS ambulances and other resources within the County may be used. The EMS Administrator (or BOEC, per protocol) may request the use of out-of-county resources through those jurisdiction's emergency managers. Normal staffing requirements for

ambulances may be waived under these circumstances. A resource list of potential responders is maintained at BOEC.

DISASTERS

Planning has started that will identify how medical resources will be used if there is a disaster. For purposes of this planning, disasters are events that disrupt the normal infrastructure that is relied upon to provide daily EMS services. These could include earthquakes, floods, or other events that cause failure of communications, roads, power, medical care sites, overwhelming numbers of ill or injured, or similar problems. The plan will include initial assumptions on the availability of emergency medical care, immediate operations, and recovery from the event. This planning is a cooperative regional activity.

SPECIAL PERSONNEL AND EQUIPMENT.

HAZARDOUS MATERIAL RESPONSE (HAZ-MAT)

HAZ-MAT response is the responsibility of the fire districts and departments within Multnomah County. HAZ-MAT response plans include the determination of the hazard, its effect on people, and the appropriate neutralization, decontamination and medical care actions to take in the pre-hospital and hospital settings. (Attachment I)

Transport and receiving hospital standards for exposed patients and care givers are under development.

SEARCH AND RESCUE

Search and rescue operations are the responsibility of the Multnomah County Sheriff. The Sheriff's Office serves as incident commander for search and rescue operations. EMS and fire responders provide resources as required by the incident commander. Along with the governmental and associated volunteer resources, there is a specialized team (Reach and Treat) available from one licensee. (Attachment J)

SPECIAL EMERGENCY RESPONSE TEAM (SERT)

In addition to the standard EMS response, specialized paramedics from the fire services provide emergency medical service to the Police SERT team members. This is a function controlled by the police and not part of the normal EMS response.

SPECIALIZED RESCUE

Multnomah County, through the fire districts, has the following specialized rescue abilities:

- Extrication
- High Angle Rescue

- Trench Rescue
- Dive rescue

There are no specialized medical component to these rescue services. Medical care is provided by Fire EMTs assigned to the rescue teams. (Attachment I)

EMERGENCY COMMUNICATIONS AND SYSTEM ACCESS.

TELEPHONE

Multnomah County is served through a single Public Safety Answering Point (PSAP, 9-1-1 center) accessible by callers through Enhanced 9-1-1. EMS contracts with the Portland City Bureau of Emergency Communications (BOEC) for emergency medical triage, pre-arrival instructions, and contract ambulance dispatch. In addition, BOEC provides the same service for all police departments and fire departments and districts in the county.

DISPATCH

Current EMS call-taking and dispatch is governed by a set of protocols and procedures, developed by a committee of dispatchers, first responders, EMTs, providers, and physicians. With the proposed changes in the system, "criteria based dispatch" protocols and procedures will be recommended to the EMS Medical Director and promulgated through contracts and as formal County EMS administrative rules. EMS Dispatch at BOEC (and any other ambulance dispatch) is required to use these protocols and procedures. (Attachment K - Current protocols)

BOEC will continue to dispatch all first responders and contract ambulances. BOEC will also dispatch any fire rescues used as ambulances. Ambulances may, in the future, be dispatched by the ambulance provider if approved by the EMS Program Office.

9-1-1 medical calls are initially processed by call-takers who use the EMS approved call triage guide to determine the nature of the call and the level of emergency or non-emergency response required. (In addition, under County rules, if a person calls any ambulance company and requests service, the company must triage that request using the same triage guide that is used at BOEC and then, if the request is determined an emergency per the triage guide, pass the call information to BOEC for response.)

Call information is then sent (via computer) to the dispatcher. Through a computer aided dispatch system (CAD) , the status of all fire units and ambulances is available to the dispatcher. The dispatchers send fire and ambulance units, as appropriate, depending on the nature and location of the call.

As dispatch is under way, the call-taker (who has remained on the line) may provide the caller with pre-arrival instructions for patient care as specified in the protocols.

Depending upon the location of the call and the availability of ambulances, an out-of-county unit may be dispatched. This is accomplished by direct radio contact or by telephone to the appropriate dispatch center.

RADIO COMMUNICATIONS

Current:

All ambulance dispatch is done on (UHF) MED NET 9 (462.950).

Fire first response dispatch is done on the fire channels.

Medical direction from MRH is communicated on (UHF) MED NET 4 (463.075).

Ambulance to receiving hospital patient information is communicated on (VHF) HEAR (155.340 MHz)

MCI communication is done on (UHF) MED NET 1 (463.000)

Effective in Summer, 1994:

All the above communications will be done using a "800 MHz trunked" radio system now being installed through out the County by the City of Portland. In addition each contract unit and fire unit will be equipped with a mobile data terminal (MDT) for communication with dispatch and the CAD system. The ability to use the HEAR system will be maintained.

RECEIVING HOSPITAL AVAILABILITY

The availability of hospitals to receive ambulance patients is communicated on a computer link network (CHORAL). This system displays a number of hospital status conditions that may result in the diversion of ambulances. Receiving hospitals are required to use the CHORAL system if they wish to divert ambulances from their hospital. (Attachment L)

EMERGENCY MEDICAL DISPATCHER TRAINING

All dispatchers and call takers at both BOEC and at the ambulance companies are trained to meet Emergency Medical Dispatcher EMD standards set forth by the State Board on Public Safety Standards and Training (BPSST). The EMS Medical Director is responsible for the medical protocols used by these dispatchers and for the medical supervision of their performance and may set forth additional requirements.

WORKFORCE ISSUES

STABILITY

The ambulance provider will be required to submit a plan, as part of the contracting process, that will specify their policies and methods to insure the minimal turnover of personnel providing patient care. This plan will become part of the evaluation for contract or agreement performance.

DIVERSITY

The diversity of personnel regarding gender, race, and ethnicity in the EMS system in Multnomah County, and throughout the state leaves much to be desired. While there are many women working in the private ambulance sector, there are few in the fire services. Paramedics of African-American, Asian, Hispanic, Native American, or other minority backgrounds comprise an extremely low percentage of the EMS workforce. The State EMS division records do not contain any information on gender, racial, or ethnic background, but the State EMS Director felt that there were very few minority EMTs. To resolve this issue will take a long term commitment from the providers of EMS care, the County EMS system, and the EMT training programs.

First, each provider will submit evidence that they have in place a plan, consistent with currently applicable Federal, State, and Local laws and regulations, to promote diversity of personnel in their organization, including goals and objectives for meeting this need and the timelines anticipated. Diversity in this context includes establishing opportunities for women and minority EMTs. All provider plans will address access for minorities; fire providers will also focus on the inclusion of women as paramedics.

Second, the EMS Program will work with the EMS providers, the State EMS, and the training programs, both in Multnomah County, and in other areas, to recruit training candidates from diverse backgrounds.

TERMINATION

Termination of EMTs for retaliatory reasons or the "blacklisting" of EMTs seeking employment will be prohibited in the contracts with the County and will be cause for contract termination if it is found to have occurred.

EMPLOYEE ASSISTANCE PROGRAMS

All providers under contract to the County will be required to provide employee assistance programs (EAP).

LABOR RELATIONS

EMS providers under contract to the County will have a workable plan to insure healthy labor relations in their organizations.

PREFERENCE

As required in ORS 823.250, should a provider, initially operating under a contract authorized by this plan, be replaced by another provider, the replacement provider shall give preference to qualified employees of the previous provider for a period of six months following the date of replacement.

PROVIDER SELECTION AND EVALUATION

INITIAL ASSIGNMENT

The Board of County Commissioners designates the County Health Department as the party responsible for assuring appropriate Emergency Medical Services in the ASA. The County intends to contract for services it deems necessary for the efficient and effective provision of EMS. The Health Department EMS program office will be responsible for the proposal and contract process. The request for proposals will be developed by an independent consultant retained by the County and the evaluation of the submitted proposals will be by an independent panel, appointed by the County Health Officer in consultation with the EMS Medical Director, if hired., and consistent with County purchasing procedures. All contracts require the approval of the Board of Commissioners.

Any proposal submitted by a public or private potential ambulance provider shall disclose the full cost of the services requested in the request for proposal, including, but not limited to, materials, labor, administration, benefits, retirement, disability funding, capital expense, public relations expenditures, property and malpractice liability reserves, and other applicable operating expenses in a form required by the request for proposal process.

The RFP shall require disclosure of any history of conviction or pending claims regarding unfair employment practices, involvement with Medicare fraud, violations of the Americans with Disabilities Act, antitrust activities, or violations of any other federal, state, or local civil or criminal laws or administrative rules. This information will be considered in making a decision regarding the recipient of the contract.

FIRST RESPONSE

The County's goal is to enter into intergovernmental agreements with all fire departments and districts within the County interested in providing EMS first response. These agreements may include compensation. Compensation shall be contingent upon the agreement by the first responder to use EMS system standards as its target response time. Response times and levels of service will be specified in these agreements.

AMBULANCE SERVICE

Ambulance services for 9-1-1 emergency calls will be contracted to the most qualified provider. Selection will be through a competitive proposal process.

REASSIGNMENT

Should an ambulance provider resign their interest in providing transport services, or should the County terminate the agreement for service, the County shall exercise those provisions of the contracts and other contingencies that allow for the continuation of ambulance service while a replacement provider is selected.

APPLICATION FOR AN ASA

Applications from prospective ambulance providers will be accepted according to the provisions of the request for proposals. These provisions will include specific qualifications for prospective providers.

NOTIFICATION OF VACATING AN ASA

A notice of termination by the contract ambulance providers will be required in accordance with the provisions of the initial contract.

MAINTENANCE OF LEVEL OF SERVICE

To insure that emergency medical services are uninterrupted should a provider vacate their interest in the ASA, a one year notice will be required in the agreements with the contract ambulance provider. Penalties for insufficient notice and "fail safe" provisions will be specified in the contract.

CONTRACT EVALUATION

The contract for the transporting ambulance services will be for a term of five (5) years, with a five year renewal, if the provider meets the requirements of the contract and the renewal is approved by the Board of Commissioners. Nothing shall obligate the Board of Commissioners to renew a contract.

Sanctions tied to the performance conditions in the contract and the termination of the contract for cause, may be exercised at any time during the contract period. If the financial considerations agreed to by the parties fail to meet the explicit expectations in the documents, the contract may be terminated.

A complete review of the ambulance agreement will be required before the renewal of the agreement. The contract will include the specifics of the review process. This review will include, but not be limited to:

- Adherence to response time requirements.
- Compliance with other performance requirements.
- Meeting workforce goals such as diversity and others outlined on page 30.
- Complaints concerning service.
- Meeting the financial goals of the agreement.
- "Street level" relationships of the provider with others in the system.
- Participation in the quality improvement program and an assessment of the quality of services performed.
- Complaints concerning workforce issues.

Emergency Medical Services

Attachments to the Multnomah County Ambulance Service Plan

1994

ATTACHMENTS

A. ASA AND RESPONSE TIME ZONES

B. INTERGOVERNMENTAL AGREEMENT
RESPONSE TO MEDICAL CALLS

C. 9-1-1 FIRE DISTRICTS CITIES

D. BOEC CONTRACT

E. EMS MEDICAL DIRECTOR
POSITION DESCRIPTION

F. MEDICAL RESOURCE HOSPITAL CONTRACT

G. AMBULANCE EQUIPMENT
ALS
BLS

H. MASS CASUALTY INCIDENT PLAN

I. HAZ-MAT
SPECIALIZED RESCUE

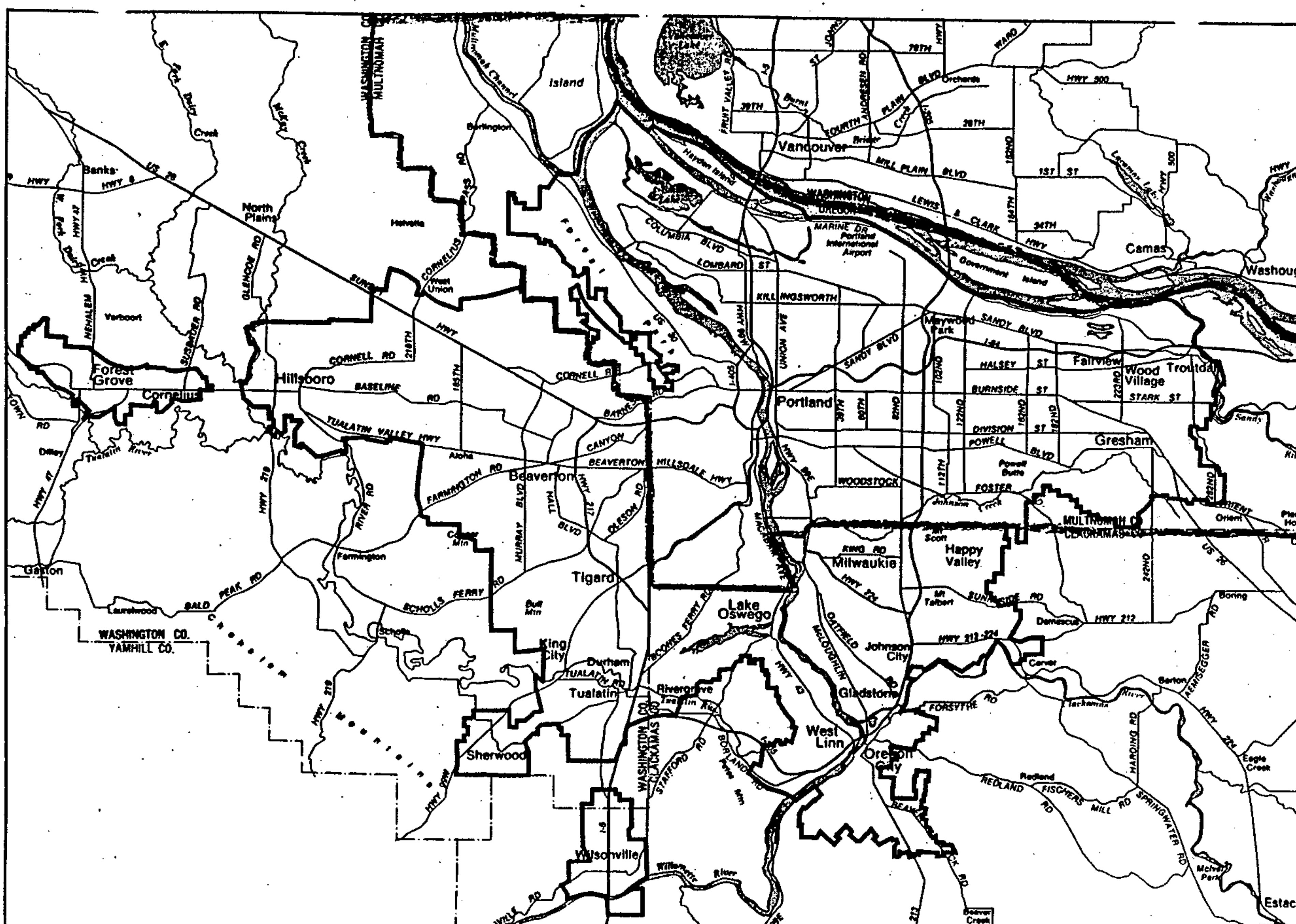
J. SEARCH AND RESCUE PROTOCOL

K. DISPATCH PROCEDURES
TRIAGE GUIDE

L. CHORAL

ATTACHMENT A

ASA MAP AND RESPONSE TIME ZONES



METRO

Urban Growth Boundary

2000 S.W. First Ave., Portland, OR 97201-5398, (503) 221-1646, 1" = 4 mi., 3-87-01

ATTACHMENT B
INTERGOVERNMENTAL AGREEMENT
RESPONSE TO MEDICAL CALLS
(EXAMPLE)

INTERGOVERNMENTAL AGREEMENT

This Agreement is entered into by and between Multnomah County and Washington County, each being a home rule political subdivision of the State of Oregon.

WHEREAS:

1. The parties each are authorized by law to provide for the efficient and effective provision of ambulance services and ORS 190.010 authorizes counties to enter into intergovernmental agreements assigning the performance of functions or services;
2. The parties, on December 4, 1989, entered into an agreement whereby Washington County authorized Multnomah County to administer the regulation of emergency medical and ambulance services under the Multnomah County Code for those areas of Washington County inside the City of Portland;
3. The parties have determined that, due to terrain and road access difficulties, patient care would be best served by authorizing Washington County to administer the regulation of emergency medical and ambulance services under the Washington County Code for a portion of Multnomah County in the West Hills/Skyline area; now it is

AGREED:

1. Effective upon adoption of this Agreement by both Counties, Washington County by and through its EMS Policy Board or successor body, shall administer the regulation of emergency medical and ambulance services under the Washington County Code and the Rules adopted thereunder, for all emergency calls originating in the West Hills/Skyline area as described in paragraph 1, Exhibit "A" which is attached and included by this reference.
2. Washington County Code Chapter 8.32 and the Rules adopted thereunder shall govern and be in full force and effect in the area covered by this Agreement. Washington County shall comply with all applicable state and federal laws, rules and regulations regarding emergency medical services.

3. Within the limits of the Oregon Tort Claims Act and Article IX, section 10, of the Oregon Constitution, Washington County shall defend, save harmless and indemnify Multnomah County and its officers, employees and agents against any and all claims or demands arising out of any and all alleged acts or omissions by Washington County or its officers, employees or agents occurring during administration of the regulation of emergency medical and ambulance services in the area covered by this Agreement.
4. Multnomah County shall have no responsibility for the cost of administering regulation of emergency medical or ambulance services in the area covered by this Agreement and shall receive no portion of any fees adopted and collected by Washington County.
5. This Agreement shall continue indefinitely, but may be terminated by either party with sixty (60) day written notice to the EMS Coordinator or Director of the other party.

Bonnie L. Hays
Chairman
Washington County
Board of Commissioners

4/19/94
Date

Attest:

Barbara Hejtmanek
Recording Secretary

Approved as to form:

Dan R Olsen
Washington County Counsel

APPROVED WASHINGTON COUNTY
BOARD OF COMMISSIONERS
MINUTE ORDER # 94-136
DATE 4-19-94

Gladys McCoy
Chair
Multnomah County
Board of Commissioners

March 17, 1994
Date

Attest:

Deborah Bogstad
Recording Secretary

Approved as to form:

Multnomah County Counsel

REVIEWED
By
MULTNOMAH COUNTY COUNSEL

APPROVED MULTNOMAH COUNTY
BOARD OF COMMISSIONERS
AGENDA # R-8 DATE 3/17/94
DEB BOGSTAD
BOARD CLERK

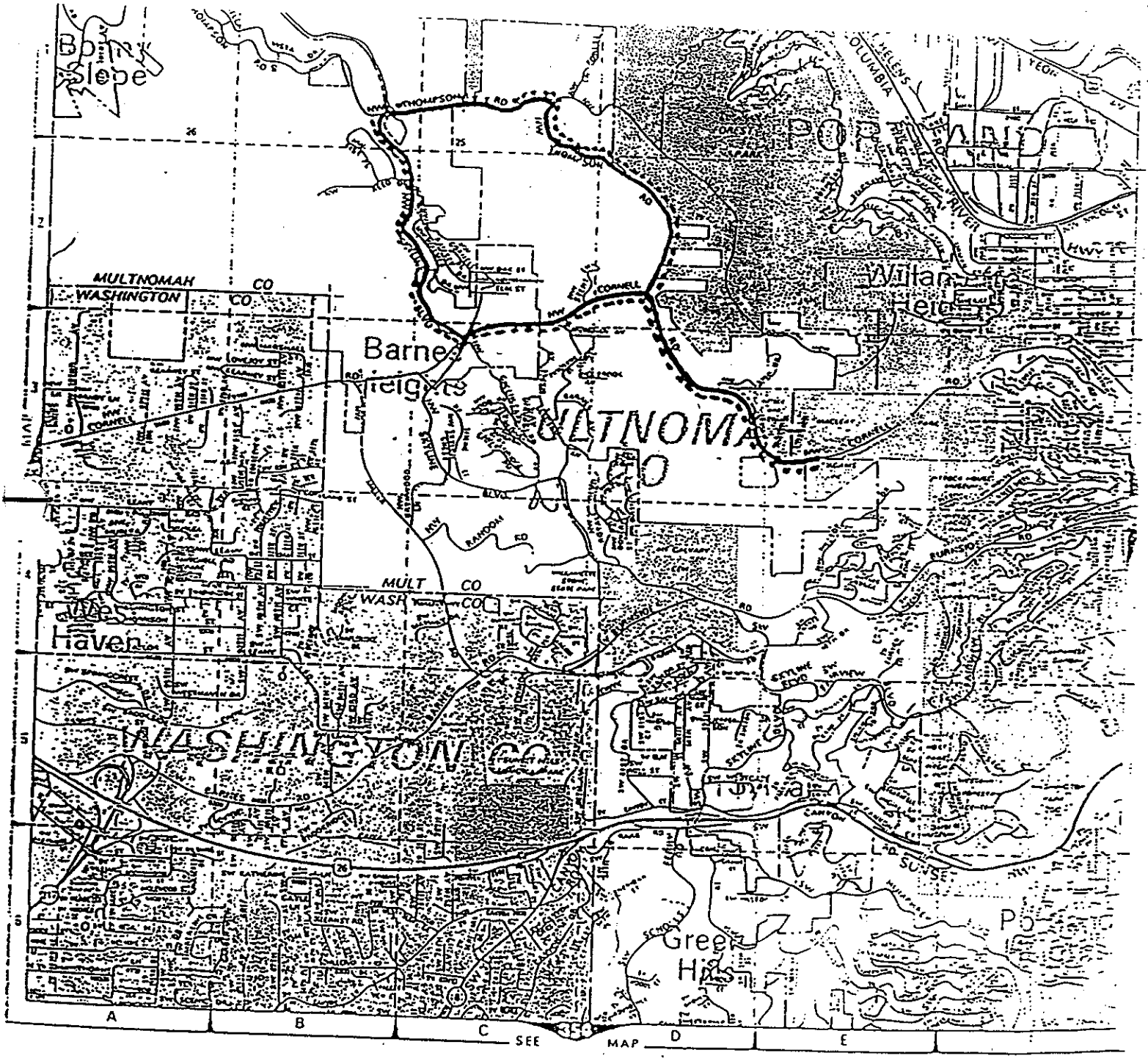
EXHIBIT "A"

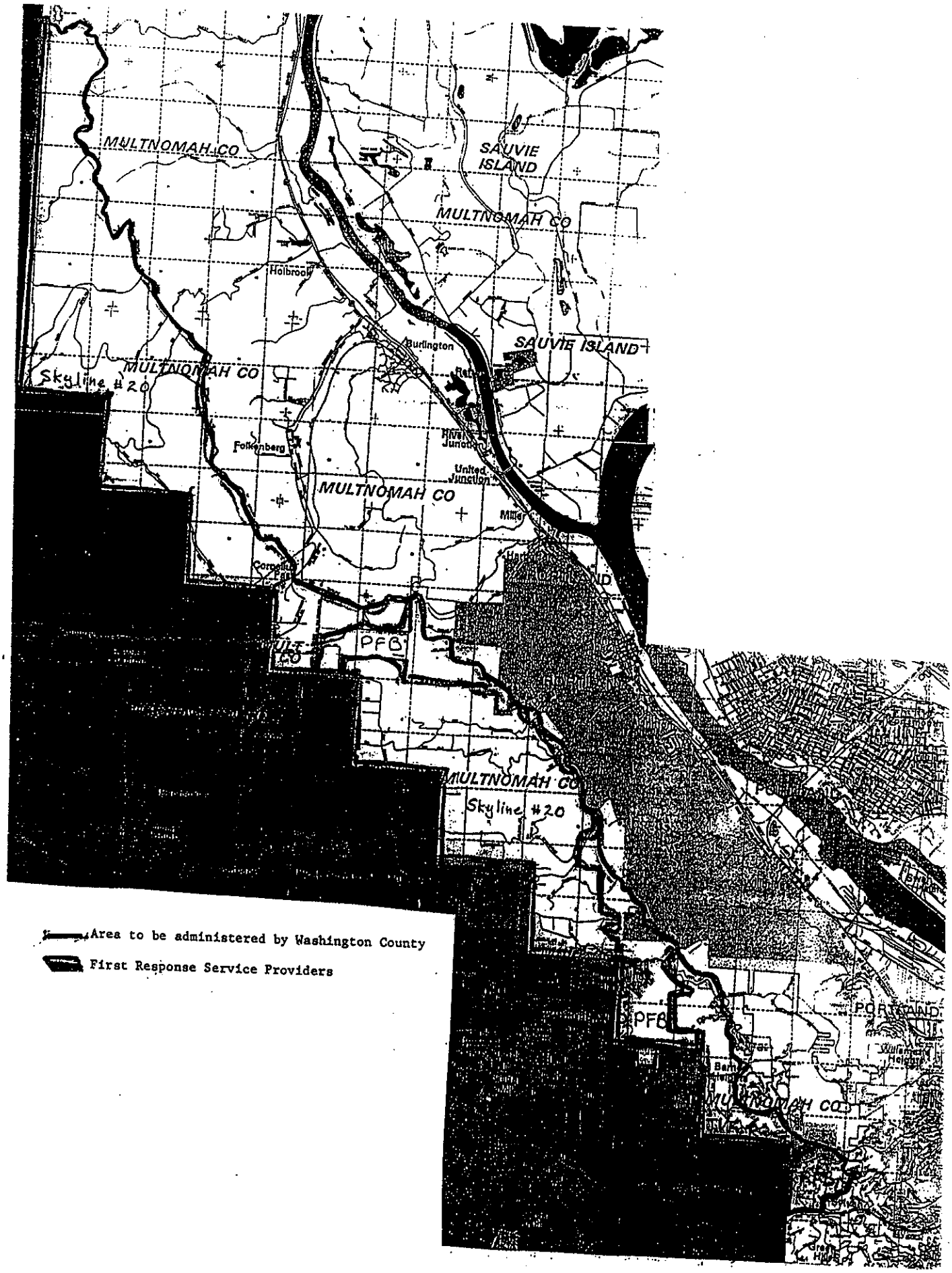
For purposes of this agreement the West Hills/Skyline area is the area bordered on the north by NW Rocky Point Road from the Washington County line to the intersection with NW Skyline Boulevard; on the east by the eastern boundary of the Skyline Boulevard right-of-way, between NW Rocky Point Road and Highway 26 (Sunset Highway); on the south by Highway 26 between SW Skyline Boulevard and the Washington County line and on the west by the Washington County line, between Highway 26 and NW Rocky Point Road.

1. Washington County Emergency Medical Services Office shall administer the regulation of emergency medical and ambulance services for the West Hills/Skyline area addressed ON AND WEST of Skyline Boulevard from Highway 26 to the intersection with NW Rocky Point Road, all roads that branch from this section of NW Skyline Boulevard, including NW Springville Lane intersecting NW Springville Road; **but excluding the section of NW Skyline Boulevard between NW Cornell and NW Thompson Roads, and all roads branching from this section.** (see Informational appendix 1.)

2. Multnomah County Emergency Medical Services shall administer the regulation of emergency medical and ambulance services for the area EAST of Skyline Boulevard including roads branching from Highway 30, to include NW Springville Lane intersecting Highway 30, and NW Skyline Boulevard between NW Cornell And NW Thompson Roads, and all roads branching from this loop. (See informational appendix 2.)

Informational Appendix #2

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Burlington
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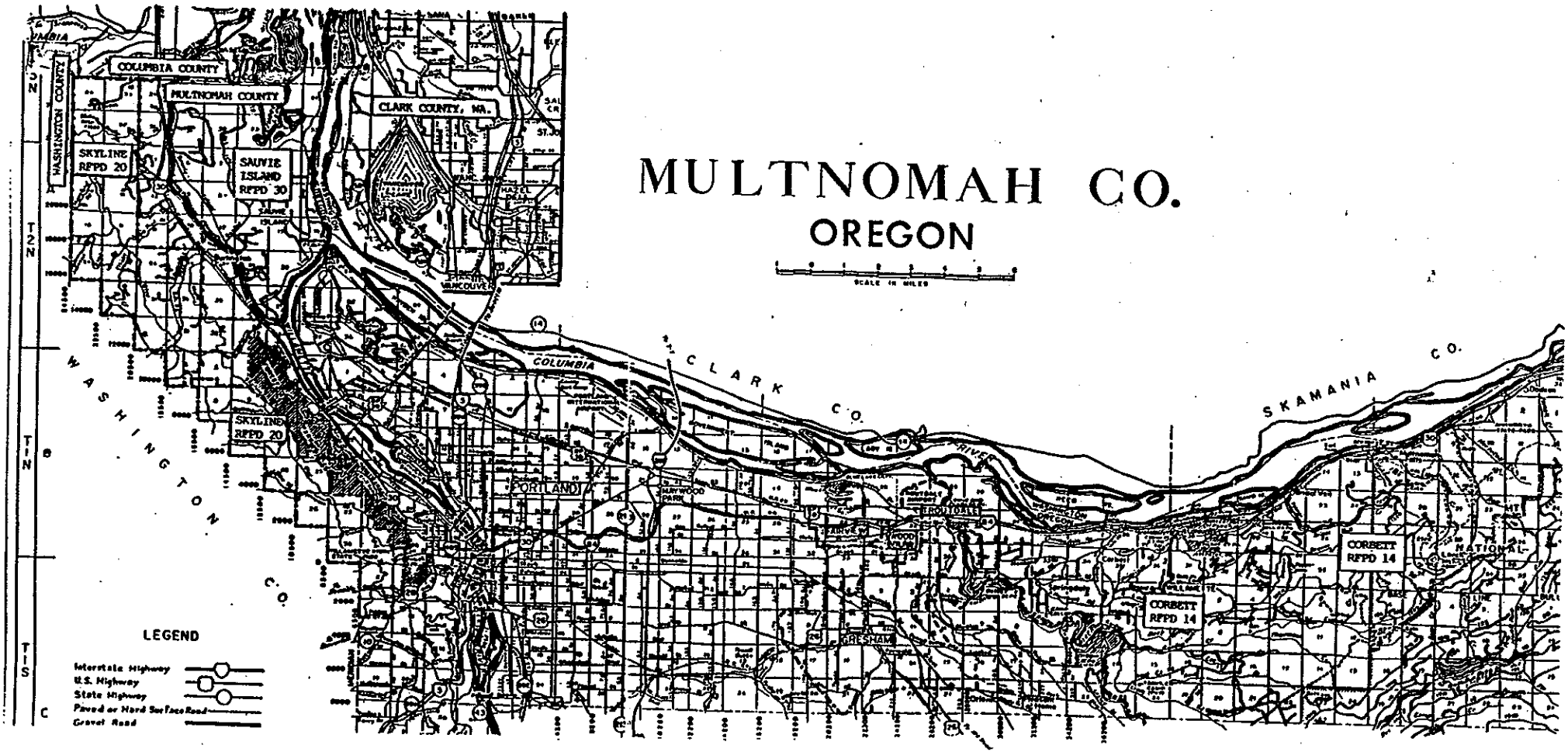
PFB
MULTNOMAH CO
Skyline #20
PFB
PORTLAND
MULTNOMAH CO
Area to be administered by Washington County
First Response Service Providers



FIRE DISTRICTS AND CITIES

ATTACHMENT D

BOEC CONTRACT

21789

EMS

Exhibit D

OCT 29 1984

PERFORMANCE AGREEMENT

BUREAU OF EMERGENCY COMMUNICATIONS

The City of Portland, hereinafter referred to as City, through its Bureau of Emergency Communications, hereinafter referred to as BOEC, and the City-County Emergency Medical Services, hereinafter referred to as EMS, agree as follows:

1. General Scope:

   City agrees to perform call receipt, dispatch, information, associated services and management of the City-County Emergency Communications/Operation Center, hereinafter referred to as Center.

2. Administrative Responsibility:

   The parties hereby agree that the City shall possess and exercise administrative authority and responsibility to manage and maintain the Center, and nothing in this Agreement shall change title to, ownership of, or access to the Center, any of its equipment or any other real and personal property of the parties.

3. Reports and Files:

   EMS shall have access at all times to all of BOEC's manual and automated records and files except that summary reports produced for a specific user agency shall not be disclosed

without written permission of that user. EMS shall have the right to review all computer programs written for or by the BOEC.

City and EMS agree to share with other user agencies all non user-specific information on operational data pertaining to incidents received for or dispatched as part of its periodic information processing requirements. The Center is not prohibited from using user-generated data for annual reporting and budgetary purposes. These shall be in the form of Computer Assisted Dispatch (CAD) and Mobile Data Terminals (MDT) transaction history printouts.

4. Monthly Reports:

During the period of this Agreement, City shall continue to submit monthly management reports to EMS in accordance with a mutually agreed upon format.

5. Data Retention and Dissemination:

All CAD and MDT magnetically recorded data shall be retained for a period of at least twelve months unless an extension is specifically requested. Audio tapes shall be retained for at least seven months unless EMS requests that specific audio tapes be retained for an additional period of time. Any additional costs incurred by City in the storage of CAD and MDT magnetically recorded data and audio tapes beyond the agreed upon time shall be paid by EMS.

6. Special Reports:

Special requests for nonroutine data, not readily retrievable from the CAD system shall be honored when authorized by the chief liaison with BOEC or his designee. Special requests shall be made through the Director or the Operations Manager and shall not exceed 50 cumulative hours per year of staff time, excluding requests for investigation of official complaints and incident information requested during the shift when it occurred, and shall not require the use of resources which are unbudgeted.

7. Security and Privacy:

The confidentiality and privacy of BOEC records and tapes shall be protected under a mutually agreed upon security and privacy plan consistent with relevant laws and regulations. The concerned user agency shall be consulted and give authorization prior to the release of records that are sensitive or otherwise non-routine in nature.

8. Requests for Service:

A. All citizen requests for, or complaints about EMS service, the action taken, and the ultimate disposition of said requests for service will be sent to EMS on a monthly basis.

B. Complaints received by BOEC from citizens concerning EMS members' performance will be referred directly to EMS.

Complaints from citizens about BOEC services received by EMS will be referred directly to BOEC administration.

9. System Maintenance:

Routine maintenance that will interfere with the operation of the primary system shall not be permitted unless a backup system is in place so that there is no change in service to field units. In the event that routine maintenance will require an interruption or significant reduction of service to field units, scheduling of such routine maintenance must receive prior written approval of EMS.

10. Air Time:

Air time usage and procedures on each channel will conform to all applicable Federal and State regulations. The radio log and summaries of hourly traffic shall be available on request. Operational channels will be kept open to ensure the maximum effective air time usage possible.

11. Levels of Service:

A. BOEC shall maintain and support all operations, including computer programs and software, required to provide EMS with highest level of communications service. EMS will be notified in writing at least 30 days before the implementation of any change in the BOEC's level of service or operation procedures which may impact EMS operations. Any such changes which

affect EMS operations will not be implemented without prior EMS approval.

B. EMS agrees to accept the below listed performance specifications, Net 8 service information standards, and response time requirements.

1) Police Communications Telephone Performance Specifications:

(a) "A" System Performance Specification: Overall four week (28) day average - no more than 5.5% of the calls will be delayed more than 20 seconds during any one 28 day reporting period.

(b) "B" System Performance Specifications: During periods of heavy call volume, a "B" telephone answering group may be employed to process non-emergency calls. City will report "B" system statistics regularly to EMS.

C. Response Time:

Type of Call	Monthly Average
Hot Incident & Priority 1 Calls (Code 3)	
Create to Send	1 minute (Goal)
Priority 2 (Code 1)	
Create to Send	1.8 minutes (Goal)

City agrees to attempt to reduce Priority 2 create to dispatch time average to absolute minimum.

D. Changes which have a major operational or budgetary impact on BOEC shall be implemented upon appropriate consultation with those users who are so impacted and the Commissioner-in-Charge of BOEC. Unanticipated major changes will be subject to a separate service charge mutually agreed upon prior to implementation. However, this in no way implies that the BOEC has the authority to prohibit changes in the operational policy of EMS.

E. When in the opinion of a field supervisor, an incident requires the exclusive use of a radio net, a dispatcher staffed and dedicated channel will be provided.

12. Sworn Personnel:

The maximum number of sworn law enforcement personnel assigned to BOEC on a full-time basis for all user agencies shall not exceed eight (8) sworn personnel assigned by the Portland Police Bureau, and four (4) sworn personnel assigned by Multnomah County. Assignment and transfers of sworn personnel to and from the Center will be arrived at by mutual consultation and agreement between the appropriate parties.

13. Charges for Services:

A. Charges for communications delivered by BOEC to EMS pursuant to this Agreement, unless otherwise provided herein, shall be based upon the proportion of EMS' calls for service dispatched relative to the total number of calls for law enforcement and emergency medical services

dispatched by BOEC on the basis of total dispatches over the 12 month period ending December 31st preceding the budgeted year. EMS reserves the right to verify all Center statistics and computer programs used to generate Center data.

B. Whenever additional users are added to and affect the communications system, charges will reflect the proportion set forth in Paragraph 13A, based on comparable, actual, or estimated data during the initial year and actual BOEC generated data thereafter.

C. Charges for separately contracted Multnomah County services provided to BOEC such as micowave, sworn personnel overtime and background investigations shall be set off against BOEC service charges to sheriff.

14. Billings:

Billings will be sent to EMS every 28 days beginning July 1, 1984. Payments will be due the City of Portland 30 days thereafter. Computations shall be based on statistics from thirteen 28-day periods ending on or about the previous December 31.

A. Penalty:

A penalty on late payments will be assessed at the rate of 1 per cent per month or as otherwise prescribed by the Portland City Code for late payments.

B. Reconciliation:

Reconciliation to actual user costs shall be made quarterly using the most recent previous quarter.

15. Budget and Contract Review:

EMS will have an opportunity to review and comment upon the Center's annual budget prior to its submission to City Council no later than March 31st. EMS will also have the opportunity to comment on any possible amendments to this contract at that time.

16. Report Takers:

EMS shall be responsible for setting its own policy and developing its own procedures regarding the taking of reports in lieu of dispatching field units.

17. Liability:

The City shall defend against any and all claims brought or actions filed against the Center or any of its employees, shall hold County and user agencies harmless from any and all claims of whatever nature which result from any activity of the Center not undertaken at the direction of the County or user agencies or its officers, employees or agents, and shall indemnify the County or user agencies and hold it harmless from any and all liability, loss or damage the County or user agencies may suffer as a result of claims, demands, costs or judgments against the County as a result of any Center activity so undertaken, pursuant to ORS 30.260 et seq. The County or user agencies agree to promptly notify the Center and the City's Bureau of Risk Management of any claims or demands made against the County as a result of any activity of the Center.

18. Term of Agreement:

City and EMS agree that this Performance Agreement shall take effect upon its execution and shall be retroactive to July 1, 1984 and shall continue thereafter indefinitely, but it shall be subject to modification or amendment by the parties as they may mutually agree in writing. It may be cancelled by either party at the end of the preceding fiscal year upon 90 days prior written notice.

19. Notices:

All notices pursuant to the terms of this Agreement shall be addressed as follows:

Notice to City of Portland:

Director
Bureau of Emergency Communications
2960 SE 103rd Drive
Portland, Oregon 97266

Notice to Emergency Medical Services:

Director
Emergency Medical Services
426 SW Stark Street
Portland, Oregon 97204

IN WITNESS WHEREOF, the County acting by and through its County Executive, and the City, acting by and through its Commissioner in Charge of BOEC and Auditor and pursuant to Ordinance No. _____, have caused this agreement to be executed on the dates noted below.

MULTNOMAH COUNTY, OREGON

By Dennis Buchanan/cc
Dennis Buchanan,
County Executive

Date: 10-1-84

APPROVED AS TO FORM:

Peter Kasting
John B. Leahy
County Counsel

CITY OF PORTLAND, OREGON

By _____
Commissioner Mildred A. Schwab

Date: _____

APPROVED AS TO FORM:

SIGNED

_____
Christopher A. Thomas
City Attorney

By SIGNED
Auditor Jewel Lansing

Date: _____

Contract #: 21480

162448

26339

EXHIBIT "A"

BUREAU OF EMERGENCY COMMUNICATIONS
INTERGOVERNMENTAL AGREEMENT

JUL 10 1990

THIS AGREEMENT is made and entered into by and between the CITY OF PORTLAND, party as a municipal corporation of the State of Oregon, hereinafter referred to as "City," MULTNOMAH COUNTY, a political subdivision of the State of Oregon, hereinafter referred to as "County," the CITY OF GRESHAM a municipal corporation of the State of Oregon, and the CITY OF TROUTDALE, a municipal corporation of the State of Oregon, pursuant to the authority granted in Chapter 190 of Oregon Revised Statutes.

W I T N E S S E T H:

RECITALS

WHEREAS, the City of Portland and the County have established a combined City-County emergency call receiving, dispatch and operations center at Kelly Butte known as the BUREAU OF EMERGENCY COMMUNICATIONS, hereinafter referred to as the "Center;" and

WHEREAS, the Center was equipped by, and the Microwave System purchased through, federal grants and the expenditure of City and County monies, resulting in both City and County having a proprietary interest in it, and was developed as a joint and consolidated City-County venture; and

WHEREAS, it is in the public interest to continue to own the Center jointly; and

WHEREAS, agencies of the City of Gresham and the City of Troutdale have used the services of the Center but the cities themselves have not been parties to this agreement; and

WHEREAS, it is desirable that the Cities of Gresham and Troutdale should be parties to this enabling agreement; and

WHEREAS, the City and other user jurisdictions have agreed that the Center will carry out its service functions to the community without regard to the geographical boundaries of the respective parties; and

WHEREAS, the City, and other user jurisdictions must provide for the management, operation and maintenance of the Center and have agreed that the City will control such functions on a day-to-day basis; and

WHEREAS, the City, and other user jurisdictions have agreed that the operations of the Center shall be carried out by nonsworn personnel; and

WHEREAS, Emergency Medical Dispatching was added to the Center as a new function December 9, 1980; and

WHEREAS, County-wide emergency telephone call ("911") receipt and processing for fire, police and ambulance services was implemented in the Center November 9, 1981; and

WHEREAS, ORS 401.710, et seq. (HB 3178, 1981) has, as of January 1, 1982, preempted and replaced the Multnomah County telephone tax which provided the financing base for these 911 services; and

WHEREAS, the orderly continuation of these 911 services and their financial support from state telephone tax revenues is in the mutual best interest of the City, County, and other user jurisdictions; and

WHEREAS, the Center's equipment and other personal property which makes possible the operation of the Center is purchased with monies collected for charges for service; and

WHEREAS, for executive and administrative purposes the Center will function as a bureau within the City;

NOW, THEREFORE, with the Center operating as generally indicated in the foregoing RECITALS and in consideration of the terms, conditions and convenants contained hereinbelow, the parties hereto agree as follows:

1. MISSION STATEMENT

The mission of the Center is to receive and process emergency telephone calls from the citizens of the City, and other user jurisdictions, to dispatch emergency services, and to provide quarters and facilities for command during emergency operations. For purposes of this agreement, the term "Users" means agencies of the jurisdictions that are parties to this agreement. Users shall have performance agreements as provided in Section 5 of this Agreement. The Center shall function as the Emergency Telephone system as defined in ORS 401.710, et seq., and, as such, shall:

a. Receive, process and dispatch calls for law enforcement services utilizing equipment, procedures and staffing levels to ensure the shortest response time and maximum safety to citizens consistent with effective law enforcement management.

b. Receive, process and dispatch calls for emergency medical response in support of the aims and intent of the County's Emergency Medical Services Code and rules and City Ordinance 150180.

c. Receive and process calls for Fire Service to Portland Fire Alarm Dispatch.

Subject to the conditions that there is no reduction or change in service levels and there is no increase in cost to the parties to this agreement thereby, the same or similar emergency services may be performed for other government agencies pursuant to other agreements between the City and other user agencies.

2. User-City Relationships

The Center is a joint User-City operation, the day-to-day management, operation and fiscal control of the Center is the responsibility of the City. The Center and Center's manual and automated records and files shall be accessible as provided in respective performance agremeents to authorized representatives of the City and user jurisdictions. The day-to-day administration of the Center will be the responsibility of a Civilian Director who is chosen by the City in consultation with the user agencies. Consultation shall include, but not be limited to, the following: system users shall develop a job description for the Civilian Director to be forwarded to the Director of the Portland Bureau of Personnel. At least one member of the interview panel to choose a Civilian Director will be chosen from among the non-City members of the User Board. When a civil service list is established for a Civilian Director, such list will be shared with user jurisdictions for review and comment. The Director shall report to the City but may not be dismissed without consultation with the User Board.

3. User Board

A user board, the organization and membership of which will be provided for in the performance agreements adopted by jurisdictions which are parties to this agreement is established. The user board will review proposed policy changes and advise the Center Director and/or the Commissioner in charge of the Bureau and the Executive authorities of jurisdictions with participating user agencies regarding policy changes and other matters which may be under consideration by the jurisdictions board.

4. Emergency Operations

The City, and other users shall have access to the Center to direct and dispatch such emergency operations as circumstances may require. Although the City has the administrative responsibility and authority for the management of the Center, the parties shall prepare, agree upon and abide by such procedures and protocols necessary for the joint emergency management use of the Center during emergencies. The City's emergency manager shall have the responsibility for the development of the protocols. The protocols shall include coordination with the Center's director.

5. Performance Agreement(s)

The City and the jurisdictions shall negotiate separate performance agreement(s) relating to the provision of various types of emergency telephone call processing services (911) and other services by the City to the Jurisdictions. These performance agreement(s) will contain a description of the specific types of service to be provided by the Center to the Jurisdictions, including, but not limited to, systems management, service levels, management information reports, data request processing, system and data security and privacy, service costs, and data retention and dissemination.

6. Center Personnel

The Center shall operate with nonsworn personnel. All nonsworn personnel performing emergency call processing and communication services shall be employees of the City. The parties agree that the Director of the Center shall possess and exercise administrative and management authority over all nonsworn personnel assigned to the Center.

7. Budget

(a) The City and Jurisdictions who are parties to this agreement, through their budget processes, will provide adequate resources consistent with the Center's mission. The Center shall be an appropriation unit of the City and funds necessary to operate the Center shall be appropriated by the City. The Jurisdictions reserve

the right to participate in the Center's budget process. Prior to submission for City budget review, the user jurisdictions shall receive copies of all documents relating to the Center's budget in sufficient time to review and comment upon said documents. The user jurisdictions will pay their agreed-upon proportionate share of the expenses of operating the Center as noted in the performance agreement(s) referred to in Part 5, then in effect between the parties. The performance agreements shall stipulate a formula used to determine costs to each party. The formula shall be uniformly applied to all user agencies. In the event the parties cannot agree to a budget for the Center, the City or other user jurisdictions shall have the right to terminate this agreement insofar as it regulates and provides for a relationship between the City and a user jurisdiction as provided in section 13 of this agreement.

The Center's budget will reflect the total costs incurred as a result of the Center's operation, including the use and maintenance of the County's Microwave System. The budget will provide a detailed cost analysis of those costs to be incurred in the planning, installation, operation and improvement of the emergency telephone system (911).

The costs incurred by the County for the Center's use and the County's maintenance of the County's Microwave shall be reflected in the Center's quarterly billing in accordance with the agreed-upon formula in the performance agreement then in effect between the parties. Each quarter, the County shall submit to the Director a report of all costs incurred by the County in support of the center.

8. Property Settlement Upon Termination

a) In the event this agreement is terminated, the City and Users shall mutually agree upon a monetary settlement that will compensate Users for their interests in Center equipment.

b) In recognition of City's proprietary interest in the County's microwave system, the County will, in the event of termination, provide the City with the continued use of the microwave system on a contractual basis. Charges for the City's use of the County's microwave system shall be based on the City's proportionate share of the system's operation and maintenance cost. If the County discontinues use of the microwave system, the City shall have first right to purchase the system at its fair market value.

c) If the parties cannot agree upon a monetary settlement for any such Center equipment that compensates the user jurisdictions for their interests therein, then the matter of the respective interests in such equipment or the fair market value thereof shall be determined pursuant to ORS 190.710 et seq. in consideration of the provisions of this section (number 8) of this agreement.

9. Liability

The City shall defend against any and all claims brought or

actions filed against the Center or any of its employees, shall hold Jurisdictions harmless from any and all claims of whatever nature which result from any activity of the Center not undertaken at the direction of a user or its officers, employees or agents, and shall indemnify the User and hold it harmless from any and all liability, loss or damage the User may suffer as a result of claims, demands, costs or judgments against the User as a result of any Center activity so undertaken, pursuant to ORS 30.260 et seq. Each Jurisdiction agrees to promptly notify the Center and the City's Bureau of Risk Management of any claims or demands made against any user as a result of any activity of the Center.

10. Limitations

Nothing contained in this Agreement shall be construed as a grant of any legislative power by either the City, the County, or other users, to any party or to the Center.

11. Construction

This Agreement shall be liberally construed to effect the purposes expressed herein.

12. Termination of Previous Agreements

The City and County executed the "Emergency

Communications/Operations Center Agreement" on December 19, 1974, and amending agreements on September 4, 1975, November 16, 1976, August 16, 1979, and December 15, 1983 which agreements established a combined City-County emergency call receiving, dispatch and operations center at Kelly Butte (hereinafter referred to as "Agreements"). Because the parties consider it to be in their mutual interest for said Agreements to be terminated, it is agreed between the parties that said Agreements are terminated as of the date hereof and only those rights, convenants, obligations, duties and responsibilities concerning the Center that are incorporated into this Agreement are in effect between the parties.

13. Term, Modification and Review of Contract

a) This Agreement shall take effect on the last day of signature by the authorized representatives of the parties here to, and shall continue thereafter indefinitely, but it shall be subject to modification or amendment as they may mutually agree in writing as provided in subsection d) of this section.

b) This contract may be terminated by mutual consent of the parties.

c) Any party may cease to participate in this Agreement by providing all other parties with written notice at least six (6) months

prior to July 1st of the year in which the party wishes to cease participating.

d) Any party wishing to amend the Agreement shall notify each of the other parties by providing a statement of issues and provisions which the notifying party wishes to modify and a date for the initiation of negotiation not sooner than 30 days not later than 90 days after the date of notification.

e) This Agreement shall be reviewed by the parties to this Agreement at least once every three years beginning with the date of execution of this agreement.

14. Nonassignment

Neither the City nor the County nor any other user jurisdictions may assign any function, responsibility or asset of the Center to any other governmental agency nor to any person or entity without the written consent of the other parties.

15. Notices

All notices pursuant to the terms of this Agreement shall be addressed as follows:

Notices to City - Commissioner in Charge
1220 S. W. Fifth Avenue
Portland, Oregon 97204

Notices to County -

1. Director, Emergency Medical Services
426 S. W. Stark, Second Floor
Portland, Oregon 97204

2. Sheriff, Multnomah County
Hansen Building
12240 N. E. Glisan
Portland, Oregon 97230

3. County Chair
Room 134 Multnomah County Courthouse
1021 S. W. 4th Avenue
Portland, Oregon 97204

Notices to City of Gresham- Gresham City Manager
1333 N. W. Eastman Parkway
Gresham, Oregon 97030

Notices to City of Troutdale Troutdale City Manager
104 S. E. Kibling
Troutdale, Oregon 97060

IN WITNESS WHEREOF, the County, acting by and through its County Executive, the City of Gresham, acting by and through its Mayor, and the

21480

162448

City of Troutdale, acting by and through its Mayor, and the City of Portland, acting by and through its Commissioner in charge of the Center and Auditor and pursuant to Ordinance No. _____, have caused this Agreement to be executed on the dates noted below.

MULTNOMAH COUNTY, OREGON

By Gladys McCoy
Gladys McCoy, County Chair

Date: 6/21/90

REVIEWED:

By
Laurence Kressel, County Counsel

By Bob Skipper
Bob Skipper, Sheriff

Date: May 24, 1990

CITY OF PORTLAND, OREGON

By Mick Kopf
Commissioner

APPROVED AS TO FORM:

By
City Attorney

Date: 7-6-90

By Barbara Clark
City Auditor

Date: 7/10/90

CITY OF TROUTDALE, OREGON

APPROVED AS TO FORM:

By _____
Mayor

By _____
Jim Jennings, City Attorney

Date: 6-28-90

By _____
City Manager

Date: 6-28-90

CITY OF GRESHAM, OREGON

APPROVED AS TO FORM:

By _____
Mayor

Date: 7/2/90

By _____
Thomas Sponsler, City Attorney

By _____
City Manager

Date: 6/29/90

21480

162448

ORDINANCE NO. 162448

*Authorize an intergovernmental agreement between the City, Multnomah County, Gresham and Troutdale for the provision of emergency dispatch and related services by the Bureau of Emergency Communications. (Ordinance)

The City of Portland ordains:

Section 1. The Council finds:

1. The Bureau of Emergency Communications (BOEC) provides emergency dispatch and related services to the County and other cities within Multnomah County.

2. The users of BOEC services currently contract with the City based on a Performance Agreement entered into in 1987 and subsequently amended in 1988. This agreement deals with operating policies, reporting requirements and billing methodology and procedures.

3. Broader policy issues including personnel policies, role of a user's committee, and management responsibilities are not adequately addressed in the Performance Agreements.

4. The intergovernmental agreement attached to this ordinance and marked Exhibit A addresses the broad policy issues pertaining to the operation of BOEC.

5. Multnomah County and the cities of Gresham and Troutdale have already ratified this agreement through their elected, legislative bodies.

6. Such agreements are authorized pursuant to Chapter 190 of Oregon Revised Statutes and Section 2-105(a) 4 of the Charter of the City of Portland.

21480

162448

ORDINANCE No.

NOW, THEREFORE, the Council directs:

a. The Commissioner of Public Safety and the City Auditor to execute an intergovernmental agreement with Multnomah County, and the cities of Gresham and Troutdale for the provision of emergency dispatch and related services substantially in the form of the attached Exhibit A.

Section 2. The Council declares that an emergency exists in order to immediately protect and preserve the public health, safety and welfare by insuring the continuity of emergency dispatch and related services within the Portland area; therefore, this Ordinance shall be in force and effect from and after its passage by Council.

Passed by the Council, OCT 12 1989

BARBARA CLARK
Auditor of the City of Portland
By Mary Flanagan Deputy

Commissioner Dick Bogle
David Logsdon:ug
October 5, 1989

ATTACHMENT E
EMS MEDICAL DIRECTOR
POSITION DESCRIPTION

March 5, 1993

EMS MEDICAL DIRECTOR
(Exempt/Unclassified)

DEFINITION

To provide medical supervision for all emergency medical technicians providing pre-hospital patient care within the County, and to provide medical direction to all components of the emergency medical services system.

SUPERVISION RECEIVED AND EXERCISED

Receives administrative direction from the Director, Health Department.

Exercises technical supervision over emergency medical technicians.

EXAMPLES OF DUTIES - Duties may include, but are not limited to, the following:

Develop uniform standards of emergency care within the County; solicit input regarding standards from physicians, nurses, emergency medical technicians, ambulance providers, first responder providers, hospitals, government agencies, and other interested organizations and individuals.

Accompany emergency medical technicians during the performance of medical duties for the purpose of supervision, education, and system evaluation.

Promulgate and revise, as necessary, medical care standards for: priority dispatch/pre-arrival instructions; ALS and BLS patient care protocols; hospital destination criteria; accreditation requirements for pre-hospital care personnel beyond State standards; staffing, equipment, supplies, and operational criteria for first response vehicles, ground ambulances, air ambulances, specialized critical care and mobile intensive care ambulances, and non-emergency patient transport vehicles for incorporation into licensing requirements; response times for first responders and transporting emergency ambulances; the transferring of patients between hospitals; and the provision of medical services in areas of public assembly.

Set standards for the provision of on-line medical control.

Develop and supervise a quality management program to ensure continuous improvement of all levels of care within the emergency medical services delivery systems.

Set standards and objectives, and participate in the continuing education and training of pre-hospital care personnel.

Approve emergency medical technicians for practice in the County. Establish policies and due process for the limiting of practice of emergency medical technicians, including probation, suspension, or revocation of physician orders.

Perform related duties as assigned.

QUALIFICATIONS

Knowledge of:

Principles, practices, and procedures of emergency medicine.

Principles, practices, and procedures of pre-hospital patient care.

Principles, practices, and procedures of public health.

QUALIFICATIONS (Continued)

Knowledge of: (Continued)

Federal, state, and local laws and regulations governing the practice of emergency medicine and pre-hospital emergency medical services.

Principles of supervision, training, and performance evaluation.

Ability to:

Effectively administer a variety of emergency medical care activities.

Interpret and apply applicable federal, state, and local laws, rules, regulations, and policies governing emergency medical services.

Establish and maintain cooperative working relationships with those contacted in the course of work.

Communicate clearly and concisely, both orally and in writing.

Gain cooperation through discussion and persuasion.

Supervise, train, and evaluate assigned staff.

Experience and Training Guidelines:

Any combination of experience and training that would likely provide the required knowledge and abilities is qualifying. A typical way to obtain the knowledge and abilities would be:

Experience:

Three years of increasingly responsible emergency medical services experience, including system medical direction and emergency medical technician supervision.

AND

Training:

Graduation from an accredited medical school and completion of an emergency medicine residency.

License or Certificate:

Possession of, or ability to obtain, an appropriate and valid license to practice medicine in the State of Oregon.

Board certification in emergency medicine.

ATTACHMENT F
MEDICAL RESOURCE HOSPITAL
CONTRACT

H-93-062

MULTNOMAH COUNTY
AND
OREGON HEALTH SCIENCES UNIVERSITY
EMERGENCY MEDICAL SERVICE AGREEMENT

THIS INTERGOVERNMENTAL AGREEMENT is made and entered into this 30th day of July, 1993, by and between MULTNOMAH COUNTY, a political subdivision of the State of Oregon (hereinafter referred as "COUNTY"), and the OREGON HEALTH SCIENCES UNIVERSITY, acting by and through the Oregon State Board of Higher Education on behalf of the State of Oregon (hereinafter referred to as "STATE"),

WITNESSETH:

WHEREAS, COUNTY's Health Department requires services which Contractor is capable of providing, under terms and conditions hereinafter described, and

WHEREAS, STATE is able and prepared to provide such services as COUNTY does hereinafter require, under those terms and conditions set forth; now, and

WHEREAS, Multnomah County Code (MCC) and Emergency Medical Services (EMS) rules require a single medical direction point, a single point of data collection, and research, therefore

IN CONSIDERATION of those mutual promises and the terms and conditions set forth hereafter, the parties agree as follows:

1. Term.

The term of this Agreement shall be from July 1, 1993, to and including June 30, 1994, unless sooner terminated under the provisions hereof.

2. Services.

A. STATE shall furnish on-line medical direction and comply with the following performance indicators:

1) All calls requesting on-line medical direction must be answered by the appropriate physician in fifty-five (55) seconds at least ninety percent (90%) of the time.

2) STATE must provide a process to assure that staff physicians are knowledgeable of the protocols. This process may include but not be limited to: educational sessions, tests, and inservice for protocol updates. The process must be approved by COUNTY.

3) STATE will develop a process for Standard Operating Procedures (SOP) adoption which governs on-line medical direction. COUNTY will review operating procedures prior to their implementation. STATE will adhere to the SOPs at all times. Failure to provide these SOP's for COUNTY review is a breach of Contract.

4) A plan must be developed and approved by the COUNTY which details a problem solving process for any complaint or issues presented to the STATE's medical director or communications coordinator. This plan must assure a complaint resolution which will be furnished to the COUNTY no more than thirty (30) days from date of complaint filing.

5) The STATE will implement a quality assurance/quality improvement process that reviews standards, operations, and performance, identifying problems and their solutions. This process will allow for input from COUNTY, and will report summary data and findings to the Medical Advisory Board Quality Assurance Subcommittee on a quarterly basis.

6) The STATE will participate in the COUNTY's quality assurance process by providing a staff member, when requested, and by providing medical resource hospital data and information on a timely basis as requested by the Quality Assurance Committee.

7) The Medical Resource Hospital medical director shall meet with the Multnomah County physician supervisors at their regularly scheduled meetings to discuss online medical control issues and exchange information.

B. The STATE shall provide trauma communications coordination and comply with the following performance indicators. The trauma communications coordination function is being provided at the request of the Area Trauma Advisory Board (ATAB I).

1) All trauma communication coordination requests must be answered within ten (10) seconds ninety percent (90%) of the time.

2) The STATE must develop a process which allows for Standard Operating Procedures (SOP) adoption and includes the Area Trauma Advisory Board and COUNTY review prior to implementation. The STATE will adhere to the SOPs at all times.

3) The STATE must provide a plan which details a problem solving process for any complaint. The plan must assure that the STATE has an outcome from the complaint which will be furnished to the COUNTY no more than thirty (30) days from the date of complaint filing.

C. The state will assist in provision of inservice training to emergency medical technicians in Multnomah County and comply with the following performance indicators:

1) The number of inservices which will be offered in each year is twelve (12), but is adjustable to more or fewer at COUNTY and STATE ~~discussion~~ discretion.

2) The coordination of those courses will be carried out through a joint arrangement with the STATE, COUNTY, and other hospitals in Multnomah County.

3) STATE services required are that cases and case summary for case review will be provided. One MRH physician will be in attendance to provide the case review.

D. STATE shall be responsible for central data collection for medical direction and trauma communication coordination activities. STATE shall comply with the following performance indicators:

1) STATE is to collect this data from Emergency Medical Technicians at the time that they contact STATE for on-line medical direction or Trauma Communications Coordination (TCC) functions.

2) The specific data points to be collected are referenced in appendix A.

3) Raw data points are to be provided to COUNTY for monthly periods. These will be in the form of diskettes in dBase 3 form, provided no later than the 30th of the following month.

4) The data points as described in appendix A may be modified upon the concurrence of COUNTY and STATE.

5) STATE shall provide a trauma communications center monthly report which complies with the format in appendix B.

6) The data (voice tapes, written reports, and all data points collected) is the sole property of COUNTY, which has the sole authority for release of the data. COUNTY shall prescribe guidelines to be used for the release of the data and STATE must follow these guidelines. It is the intent of guidelines that they facilitate and not impede academic research (see appendix C).

7) STATE shall also provide COUNTY proof of Joint Commission of American Hospitals (JCAH) accreditation and that it meets or exceeds all requirements of MCC 6.31.060 (A-6) and rules adopted pursuant thereto.

3. Compensation.

A. COUNTY agrees to pay STATE $10,200 based on the following terms:

1) COUNTY agrees to maintain MRH radio base station, six UHF portable radios, and the multichannel recorder used to provide MRH communications.

2) One quarter advance of the total amount upon execution of this Agreement, balance payable in three (3) quarterly installments upon receipt of billings from STATE.

3) Expenditure reports are to be sent to the EMS Director, Health Department, 426 SW Stark, 9th Floor, Portland, Oregon 97204.

B. COUNTY certifies that either federal, state or local funds are available and authorized to finance the costs of this Agreement. In the event that funds cease to be available to COUNTY in the amounts anticipated, COUNTY may terminate or reduce Agreement funding accordingly. COUNTY will notify STATE as soon as it receives notification from funding source. Reduction or termination will not effect payment for accountable expenses prior to the effective date of such action.

C. All final billings affecting Agreement payments must be received within thirty (30) days after the end of the Agreement period. Agreement payments not triggered or billed within this specified time period will be the sole responsibility of STATE.

4. Contractor is Independent Contractor

A. STATE is an independent contractor and is solely responsible for the conduct of its programs. STATE, its employees and agents shall not be deemed employees or agents of COUNTY.

B. STATE shall defend, hold and save harmless COUNTY, its officers, agents, and employees from damages arising out of the tortious acts of STATE, or its officers, agents, and employees acting within the scope of their employment and duties in performance of this Agreement subject to the limitations and conditions of the Oregon Tort Claims Act, ORS 30.260 through 30.300, and any applicable provisions of the Oregon Constitution.

C. COUNTY shall defend, hold and save harmless STATE, its officers, agents, and employees from damages arising out of the tortious acts of COUNTY, or its officers, agents, and employees acting within the scope of their employment and duties in performance of this Agreement subject to the limitations and conditions of the Oregon Tort Claims Act, ORS 30.260 through 30.300, and any applicable provisions of the Oregon Constitution.

5. Workers Compensation

A. STATE shall maintain Workers' Compensation insurance coverage for all non-exempt workers, employees, and subcontractors either as a carrier insured employer or a self-insured employer as provided in Chapter 656 of Oregon Revised Statutes.

6. Contractor Identification

STATE shall furnish to COUNTY its employer identification number, as designated by the Internal Revenue Service.

7. Subcontracts and Assignment

STATE shall neither subcontract with others for any of the work prescribed herein, nor assign any of STATE'S rights acquired hereunder without obtaining prior written approval from COUNTY. COUNTY by this Agreement incurs no liability to third persons for payment of any compensation provided herein to STATE.

8. Access to Records

A. STATE agrees to permit authorized representatives of COUNTY, and/or the applicable Federal or State government audit agency to make such review of the records of the STATE as COUNTY or auditor may deem necessary to satisfy audit and/or program evaluation purposes. STATE shall permit authorized representatives of COUNTY Health Department to site visit all programs covered by this Agreement. Agreement costs disallowed as the result of such audits, review or site visits will be the sole responsibility of STATE. If a Agreement cost is disallowed after reimbursement has occurred, STATE will make prompt repayment of such costs.

9. Waiver of Default.

Waiver of a default shall not be deemed to be a waiver of any subsequent default. Waiver of breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the provisions of this Agreement.

10. Adherence to Law

A. STATE shall adhere to all applicable laws governing its relationship with its employees, including but not limited to laws, rules, regulations and policies concerning workers' compensation, and minimum and prevailing wage requirements.

B. STATE shall not unlawfully discriminate against any individual with respect to hiring, compensation, terms, conditions or privileges or employment, nor shall any person be excluded from participation in, be denied the benefits or, or be subjected to discrimination under any program or activity because of such individual's race, color, religion, sex, national origin, age or handicap. In that regard, STATE must comply with all applicable provisions of Executive Order Number 11246 as amended by Executive Order Number 11375 of the President of the United States dated September 24, 1965, Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000(d)) and Section 504 of the Rehabilitation Act of 1973 as implemented by 45 C.F.R. 84.4. STATE will also comply with all applicable rules, regulations and orders of the Secretary of Labor concerning equal opportunity in employment and the provisions of ORS Chapter 659.

11. Modification

A. In the event that COUNTY's Agreement obligation is amended by a federal or state initiated change, COUNTY shall amend this Agreement through written notification of changes sent to STATE by mail. STATE shall sign the amendment and return to COUNTY within twenty (20) working days of receipt of COUNTY's notification document.

B. Any other amendments to the provisions of this Agreement, whether COUNTY or STATE initiated, shall be reduced to writing and signed by both parties.

12. Integration

This Agreement contains the entire Agreement between the parties and supersedes all prior written or oral discussions or Agreements.

13. Record Confidentiality

STATE agrees to keep all client records confidential in accordance with State and Federal statutes and rules governing confidentiality.

14. Early Termination

A. Violation of any of the rules, procedures, attachments, or conditions of this Agreement may, at the option of either party, be cause for termination of the Agreement and, unless and until corrected, of funding support by COUNTY and services by STATE, or be cause for placing conditions on said funding and/or services, which may include withholding of funds. Waiver

by either party of any violation of this Agreement shall not prevent said party from invoking the remedies of this paragraph for any succeeding violations of this Agreement.

B. This Agreement may be terminated by either party by sixty (60) days written notice to the other party.

C. Immediate termination or amendment by COUNTY may occur under any of the following conditions; or

1) Upon notice of denial, revocation, suspension or nonrenewal of any license or certificate required by law or regulation to be held by STATE to provide a service under this Agreement.

2) Upon notice if STATE fails to start-up services on the date specified in this Agreement, or if STATE fails to continue to provide service for the entire Agreement period.

3) Upon notice to COUNTY of evidence that STATE has endangered or is endangering the health and safety of clients/residents, staff, or the public.

D. Payment to STATE will include all services provided through the day of termination and shall be in full satisfaction of all claims by STATE against COUNTY under this Agreement.

E. Termination under any provision of this section shall not affect any right, obligation or liability of STATE or COUNTY which accrued prior to such termination.

15. Litigation.

A. STATE shall give COUNTY immediate notice in writing of any action or suit filed or any claim made against STATE or any subcontractor of which STATE may be aware of which may result in litigation related in any way to this Agreement.

16. Oregon Law and Forum

This Agreement shall be construed according to the law of the state of Oregon.

17. Certification Regarding Lobbying

A. No federal appropriated funds can be or will be paid, by or on behalf of the contractor, to any person for influencing or attempting to influence an officer or an employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

B. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this contract, the contractor shall complete and submit Standard Form-111, "Disclosure Form to Report Lobbying," in accordance with its instructions.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly appointed officers the date first written above.

OREGON HEALTH SCIENCES UNIVERSITY

By David C Bunnell for

Thomas G. Fox
Vice President

Date 7/30/93

93-6001786W
Federal I.D. Number

MULTNOMAH COUNTY, OREGON

By H.C. Miggins
H.C. Miggins
Acting County Chair

Date July 1, 1993

HEALTH DEPARTMENT

By: Billi Odegaard DHF
Billi Odegaard, Director

Date: 6-14-93

EMERGENCY MEDICAL SERVICES

By:
William Collins, Director

Date: 6-11-93

REVIEWED:

LAURENCE KRESSEL, County Counsel
for Multnomah County, Oregon

By:

Date: 6-24-93

APPROVED MULTNOMAH COUNTY
BOARD OF COMMISSIONERS
AGENDA # C-4 DATE 7/1/93
DEB BOGSTAD
BOARD CLERK

ATTACHMENT G

AMBULANCE EQUIPMENT

ALS

BLS

OREGON HEALTH DIVISION
EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEMS SECTION
and
MULTNOMAH COUNTY
EMERGENCY MEDICAL SERVICES OFFICE

GROUND AMBULANCE INSPECTION FORM

1993-94

❑ INITIAL INSPECTION ❑ REINSPECTION

DATE:_____ **TIME:**_____

BUSINESS NAME:_____

CONTACT PERSON:_____

BUSINESS ADDRESS:_____

_____

NON-EMERGENCY TELEPHONE NUMBER:_____

TYPE OF ORGANIZATION: ❑ FIRE DEPARTMENT ❑ HOSPITAL OPERATED ❑ PRIVATE ❑ INDUSTRIAL ❑ MUNICIPAL ❑ VOLUNTEER

LEVEL OF CARE: ❑ BLS ❑ BLS/ALS ❑ ALS TRANSFER ❑ ALS (9-1-1)

VEHICLE AVAILABILITY: ❑ ON-LINE ❑ RESERVE

MAKE OF VEHICLE:_____ **YEAR OF MANUFACTURE:**_____
LICENSE:_____ **VIN:**_____

MODEL: ❑ TYPE I ❑ TYPE II ❑ TYPE III ❑ OTHER:_____

MILEAGE:_____ (❑ > 100,000 MILES)

INSPECTION CODES:
1 = PRESENT AND IN GOOD WORKING ORDER
2 = ITEM PLACED ON VEHICLE AT TIME OF INSPECTION
3 = ITEM NOT PRESENT OR NOT IN GOOD WORKING ORDER

RATING CATEGORIES:
CRITICAL EQUIPMENT IN BOLD AND CAPS
Equipment in this category that is either missing or not in good working order shall result in the immediate suspension of the license to operate until corrected.
(A) REQUIRED FOR ALS UNITS ONLY

MECHANICAL EQUIPMENT

❒ HORN, ONE DUAL ELECTRIC
❒ SIREN, Electronic (with two speakers in grille), control functions: manual ____, wail ____, yelp ____
Note: Hi-Low function is not allowed!
❒ LIGHTING: Refer to KKK specifications for type I, II, III
O 1 O 2 O 3 HEADLAMP, White-2, with dimmer switch
O 1 O 2 O 3 FRONT SIDE MARKER LAMPS Amber--2
O 1 O 2 O 3 FRONT SIDE REFLECTOR, Amber--2
O 1 O 2 O 3 FRONT TURN SIGNAL Amber--2 (including vehicular hazard warning signal flasher)
O 1 O 2 O 3 FRONT IDENTIFICATION LAMP, Amber--3
O 1 O 2 O 3 FRONT CLEARANCE LAMP Amber--2
O 1 O 2 O 3 REAR SIDE MARKER LAMP, Red--2
O 1 O 2 O 3 REAR SIDE REFLECTORS, Red--2
O 1 O 2 O 3 REAR REFLECTORS, Red--2
O 1 O 2 O 3 REAR IDENTIFICATION LAMP Red--2
O 1 O 2 O 3 REAR CLEARANCE LAMP, Red--2
O 1 O 2 O 3 REAR STOP, Tail lamp, Red-2 (Turn signal section may be amber)
O 1 O 2 O 3 REAR BACKUP LAMP, White-1
O 1 O 2 O 3 REAR LICENSE PLATE LAMP, White-1
O 1 O 2 O 3 FRONT WARNING LIGHT, Red-1
O 1 O 2 O 3 FRONT WARNING LIGHT, White-1
O 1 O 2 O 3 REAR WARNING LIGHT, Red-2
O 1 O 2 O 3 REAR WARNING LIGHT, Amber-1
O 1 O 2 O 3 SIDE WARNING LIGHT, Red-2 per side
O 1 O 2 O 3 GRILLE WARNING LIGHT, Red-2
O 1 O 2 O 3 INTERSECTION LIGHT-1 per side
O 1 O 2 O 3 SIDE FLOODLIGHT-1 per side
O 1 O 2 O 3 REAR FLOODLIGHT, White-1
❒ SPOTLIGHT, Handheld or roof mounted-1
❒ SAFETY BELTS, With retractor devices-1 per seating position

BRAKE SYSTEM

❒ MAIN BRAKES
❒ PARKING BRAKES
❒ BACKUP ALERT ALARM, with off switch

TIRES and TIRE CHANGING EQUIPMENT

❒ FRONT TIRES, Minimum tread of 3/32", even wear
❒ REAR TIRES, Minimum tread of 3/32", even wear
❒ SPARE, minimum tread of 3/32", even wear
❒ JACK with handle
❒ LUG WRENCH

WINDOWS, WINDOW CLEANING EQUIPMENT and MIRRORS

❒ WINDSHIELD, # of rock chips ____, # of cracks ____, length ____.
❒ WINDSHIELD WIPER, Dual, electric, multi-speed
❒ WINDSHIELD WASHER
❒ WATER LEVEL: O OK O LOW
❒ WINDSHIELD DEFROSTER
❒ WINDOWS, (side and rear)
# of cracks ____, length ____.
❒ WINDOW between driver and patient compartment for Type II and III vehicles
❒ OUTSIDE MIRRORS--1 each side

ENGINE, TRANSMISSION ELECTRICAL, HEATING AND COOLING EQUIPMENT

❒ ENGINE OIL LEVEL,
O OK O low
❒ TRANSMISSION OIL LEVEL
O OK O low
❒ FAN BELTS,
O OK O worn
❒ STARTER,
O OK O difficult to start
❒ ELECTRICAL SYSTEM, with all lights on amp meter read (+)
❒ BATTERY SYSTEM, dual 12 volt system with labeled selector device
❒ SHOCK ABSORBERS,
O front O rear
❒ EXHAUST SYSTEM,
O OK O leaks
❒ TAILPIPE(s), discharge to side of vehicle
❒ HEATER,
O front **O rear**
❒ AIR CONDITIONER,
O front O rear

PATIENT CARE EQUIPMENT

OXYGEN (MEDICAL)

INSTALLED SYSTEM
❒ Tank has at least 3,000 liter(2,000 psi) capacity, contains at least 500 liters (500 psi)
❒ Compartment ventilated to outside
❒ No other equipment stored inside cabinet
❒FLOW TEST RESULTS
O acceptable O unacceptable
PORTABLE SYSTEM
❒ Tank has at least 300 liter capacity (500 psi minimum)
❒ FLOW TEST RESULTS
O acceptable O unacceptable
❒ TANKS PROPERLY SECURED
❒ FULL SPARE, tagged, sealed
❒ All tanks must be inspected and have a hydrostatic pressure test by a qualified person; tanks stamped with a date followed by a *, +, or stars are good for 10 years, all other markings after a date are good for 5 years.

AIRWAY CARE DEVICES

NASAL CANNULAS with tubing
❒ PEDIATRIC--2
❒ ADULT--3
OXYGEN NON-REBREATHER OR PARTIAL REBREATHERS MASKS, with tubing
❒ PEDIATRIC--3
❒ ADULT--3
❒ OXYGEN HUMIDIFIER--1
❒ **(A)** NEBULIZER MASKS, with tubing--4(1)
❒ **(A)** CHEST DECOMPRESSION KIT--2 (1)
❒ **(A)** TRACHEAL LUMEN AIRWAY DEVICE--2 (1)
(E. G., NU-TRAKE® type device)

BAG-VALVE-MASK VENTILATION DEVICE, DISPOSABLE (each mask must be transparent and semi-rigid)

❒ **INFANT--2 (1)**

TEST RESULTS

O acceptable **O unacceptable**

❒ **ADULT/CHILD--2 (1)**

TEST RESULTS

O acceptable **O unacceptable**

❒ **MASK SIZES--2 (1) each**
0 __, 1__, 2__, 3__, 4__, 5__

❒ NASAL AIRWAYS, 2 (1) each, PLASTIC or RUBBER: 26 Fr. ___, 28 Fr., 32 Fr. ___ (or equivalent)

❒ **ORAL AIRWAYS--2 (1), PLASTIC or RUBBER: INFANT ___, CHILD ___, SMALL ADULT ___, MEDIUM ADULT ___, LARGE ADULT ___, EXTRA LARGE ADULT ___**

❒ **(A) ET TUBES: 2 (1) each, 2.5 __, 3.0 __, 3.5 __, 4.0 __, 4.5 __, 5.0 __, 5.5 __, 6.0 __, 6.5 __, 9.0 __**

❒ **(A) ET TUBES--3 (1) each, 7.0 __, 7.5 __, 8.0 __, 8.5__**

❒ **(A)** ET TUBE HOLDER--2 (1)

(A) INTUBATION STYLETTES

❒ PEDIATRIC--2 (1)

❒ ADULT--2 (1)

SUCTION EQUIPMENT

❒ INSTALLED, (independent of oxygen supply) 1000 ml collection bottle

❒ **TEST RESULTS**

O acceptable **O unacceptable**

❒ COLLECTION BOTTLE LINERS--10 (1)

❒ **PORTABLE, (may be battery __, oxygen __, or manually powered __)**

❒ **TEST RESULTS**

O acceptable **O unacceptable**

❒ WATER for rinsing, 8 fl. oz.,

❒ **SUCTION CATHETERS**--4 (2) each
TONSIL TIP __, 6 Fr. __, 10 Fr. __,
14 Fr. __, 18 Fr. __ (or equivalent)

❒ SUCTION CONNECTING TUBING--4 (2)

❒ SUCTION CLEANING BRUSH--2 (1)

❒ **(A)** NASOGASTRIC TUBES--2 each
5 Fr. __, 14 Fr. __, 18 Fr. __ (or equivalent)

LITTERS, FASTENERS and ANCHORAGE'S

❒ **WHEELED COT, with mattress and three restraining devices (chest, hip, and knee) at least 2" with quick-release buckle--1**

❒ **SIDE or CENTER cot fastener with quick-release feature--1**

❒ FOLDING STRETCHER(s) with three restraining devices (chest, hip, and knee), at least 2" wide with quick-release buckle. Number required is based on the litter carrying capacity of unit, number:____

BACKBOARDS, MINIMUM of 4 2" WIDE

RESTRAINING STRAPS WITH QUICK-RELEASE BUCKLE (Spider® type restraint may be substituted)

❒ **SHORT or equivalent; (i.e. KED)--1**

❒ **LONG--2 (1)**

❒**PEDIATRIC--1, a modified short or long backboard is acceptable.**

❒ SCOOP STRETCHER--1

❒ EXTREMITY RESTRAINING DEVICES--8 (4)
(E. g., Flex-cuff® type)

SPLINTING MATERIALS

EXTRICATION COLLARS (soft foam rubber cervical collars are NOT allowed)

❒ TALL--2 (1)

❒ REGULAR--3 (1)

❒ SHORT--3 (1)

❒ NO-NECK--3 (1)

❒ PEDIATRIC--2 (1)

❒ PEDIATRIC NO-NECK--2 (1)

❒ HEAD IMMOBILIZER DEVICE, (foam blocks or Head-Bed™ type device)--4 (2)

EXTREMITY SPLINTS ❒ UPPER--3 ❒ LOWER--3

TRACTION SPLINTS ❒ CHILD--1 & ❒ ADULT--1, or

❒ CHILD/ADULT Combination--1

❒ PASG, ADULT --1

BANDAGING and DRESSING MATERIALS

❒ CONFORMING NON-STERILE 2" GAUZE BANDAGES--12

❒ GAUZE 4" X4" STERILE SPONGES--24

STERILE BULK DRESSINGS:

❒ 8" X 30"--4, or ❒ 7" X 8" --8

❒ **NON-POROUS 4" X 4" STERILE DRESSING--4**

❒ ADHESIVE or HYPOALLERGENIC TAPE--3 (1)
ROLL(S) 1" ____, and 2" ____

❒ BANDAGE SHEARS--2

❒ TRIANGULAR BANDAGES--4

❒ BURN SHEETS--2

OTHER PATIENT CARE EQUIPMENT

❒ **OBSTETRICAL KIT (DISPOSABLE)--2 (1)**

❒ HYPOTHERMIA THERMOMETER, protective case--1

❒ RIGID EYE SHIELDS--4 (2)

❒ EMESIS CONTAINER, 1 two liter container, with plastic liners--4 (1)

STETHOSCOPE,

❒**aduit--1**

❒ pediatric--1

ANEROID SPHYGMOMANOMETER

❒ NEONATE--1

❒ INFANT--1

❒ CHILD--1

❒ **ADULT--1**

❒ LARGE ADULT--1

PATIENT EXAM GLOVES, latex or vinyl,

❒ SMALL--1 Bx (15 pair)

❒ MEDIUM--1 BX (15 pair)

❒ LARGE--1 BX (15 pair)

❒ **FACE MASKS, DISPOSABLE--6 (2)**

❒ **HEPTA® type MASKS--1 per crewperson (plus 1 spare liner)**

❒ **PROTECTIVE EYE WEAR--1 pair per crewperson**

❒ ISOLATION GOWNS, DISPOSABLE--6 (2)

❒ BEDPAN--1

❒ URINAL--1

❒ HAND CLEANING SOLUTION, waterless--16 oz or 8 cloths

❒ CLEANING DISINFECTANT, 8 oz--1

❒ **CONTAINER(s) for used needles, 1 in each kit number: ____**

❒ **CONTAINER(s) for contaminated personal protective equipment, and non-blood contaminated waste, number: ____**

❒ **(A)** BLOOD GLUCOSE METER--1
and METER STRIPS--10 (2)

BLS AMBULANCE EQUIPMENT

❒ EPINEPHRINE 1:1,000--2 ampules
Earliest expiration date: _____
❒ ACTIVATED CHARCOAL--2 oz
Earliest expiration date: _____
❒ GLUCOSE, Liquid tube--2 oz
Earliest expiration date: _____
❒ IRRIGATION FLUID--1,000 cc total
Earliest expiration date: _____
❒ BLOOD GLUCOSE STRIPS--1 btl (5 strips)
(MAY CARRY GLUCOSE METER)

IF PARTICIPATING IN EMT-D PROGRAM;

❒ DEFIBRILLATOR, auto or semi-automatic
❒ PATIENT CABLES--2 (1)
❒ CONTACT GEL--2 (1) tubes, or
❒ PRE-GELLED DEFIB PADS--3 (1) sets
❒ MONITORING ELECTRODES--4 (1) sets
❒ ECG PAPER--3 (1) ROLLS, (if not a recording device)

ALS AMBULANCE EQUIPMENT

❒ MONITOR/DEFIBRILLATOR/PACER (Or pace unit)--with write-out, portable
❒ PEDIATRIC DEFIB PADDLES--1
❒ ADULT DEFIB PADDLES--1
❒ PATIENT CABLE--2 (1)
❒ MONITORING ELECTRODES
PEDIATRIC--3 (1) sets
ADULT--8 (2) sets
❒ PACE CABLE--2 (1) and
❒ PACING PATCHES--2 (1) set(s)
❒CONTACT GEL--2 (1) tube(s), or
❒ DEFIB PADS--4 (2) sets
❒ ECG PAPER--3 (1) roll(s)
❒ LARYNGOSCOPE HANDLE--1
❒EXTRA BATTERIES--2
LARYNGOSCOPE BLADES
❒ STRAIGHT--1 each, 0 __, 1 __, 2 __, 3 __, 4 __
❒ CURVED--1 each, 2 __, 3 __, 4__
❒ EXTRA BULBS--2 each in required sizes
McGILL FORCEPS--1 each
❒ PEDIATRIC
❒ ADULT
❒ INTRAVENOUS FLUIDS, sterile, plastic containers--8 (2) Liters minimum, 2 (1)--500 cc required
O good O expired
INTRAVENOUS FLUID TUBING
❒ INTRAVENOUS CONTROL DEVICE, (Soluset® or type device)--4 (2)
❒ MICRO DRIP SETS, may be carried as Soluset®--4 (2)
❒ REGULAR ADMIN. SETS--6 (2)
❒ BLOOD PUMP ADMIN. SETS--4 (2)
TOURNIQUETS, DISPOSABLE
❒ PEDIATRIC--2 (1)
❒ ADULT--6 (2)
INTRAVENOUS ACCESS DEVICES
BUTTERFLY DEVICES--2 each
❒ 23 Ga. ___
❒ 25 Ga. ___
OVER-THE-NEEDLE CATHETERS
❒ 24 Ga.--4 (2) each ____
❒ 22 Ga.--4 (2) each ____
❒ 20 Ga.--10 (4) each ____
❒ 18 Ga.--10 (4) each ____
❒ 16 Ga.--10 (4) each ____
❒ 14 Ga.--10 (4) each ____
❒ 12 Ga. ____, or ❒ 10 Ga. ____--2 (1) each
INTRAOSSEOUS NEEDLES
❒ 15 Ga.--2 (1) ____
❒ 18 Ga.--2 ____
SYRINGES, sterile
❒ 1cc--4 (2) ____
❒ 3 cc, ___ or ❒ 5 cc, ___ or ❒ 6 cc ___--4 (2)
❒ 10 cc __, or ❒ 12 cc ___ --4 (2)
❒ 60 cc, catheter tip--2 ____
❒ 60 cc, Luer lock--2 (1) ____
NEEDLES, straight, sterile,
❒ VACUUM TRANSFER--4 (1) ____
❒ 20 or 21 Ga.--4 (1) ____
❒ 18 or 19 Ga.--4 (1) ____
❒ FILTER NEEDLE, 18 Ga.--4 (1) ____
❒ VACUUM TUBES, clot tubes--4 (1) ____
Earliest expiration date:_____
❒ VACUUM TUBE HOLDERS--2 ____
❒ CLEANSING PADS, Alcohol or Betadine®--50 (10)
❒ BETADINE®TYPE OINTMENT (or unit dose)--2 (1) tubes or 10 (2) packets
❒ K-Y®TYPE LUBRICANT (or unit dose)--2 (1) tube(s) or 10 (2) packets
❒ MALE ADAPTER PLUGS--4 ____
❒ SODIUM CHLORIDE INJECTIBLE PRELOADS--4
Earliest expiration date:_____

COPY OF STANDING ORDERS

❒ BLS
❒ EMT-I
❒ ALS
❒ SIGNED BY SUPERVISING PHYSICIAN:
NAME:_____
DATE:_____
Must be signed and dated annually.

AMBULANCE CARRYING CONTROLLED SUBSTANCES MUST HAVE:
❒ LOCKED BOX ATTACHED TO THE INSIDE OF A LOCKED CABINET
❒ KEYS TO EACH OF THE LOCKS (THE SAME KEY CANNOT BE USED FOR BOTH LOCKS!)
❒ SIGN IN/SIGN OUT FOR EACH CONTROLLED SUBSTANCE
❒ ALL DEVICES AND EQUIPMENT NOT STORED IN CABINETS MUST BE PROPERLY FASTENED TO PREVENT ITEMS FROM MOVING ABOUT WHILE THE VEHICLE IS IN MOTION OR IF INVOLVED IN AN ACCIDENT

LINEN SUPPLIES

❒ PILLOW with plastic covering--1 for each stretcher, total #_____
❒ PILLOW CASES (cloth or paper)--6 (3)
❒ COT SHEETS (cloth or paper)--12 (6)
❒ BLANKETS--1 for each stretcher, (may be disposable), total # _____

SECURITY and RESCUE EQUIPMENT

☐ FIRE EXTINGUISHER, 5 lb., 2A-10BC type, (must be accessible from either the patient or drivers compartment--1

☐ FLASHLIGHT--2 (1)
- ☐ BATTERIES--O good O bad
- ☐ BULBS--O good O bad

☐ EXTRA SET OF PACKAGES AND DATED BATTERIES--1

☐ ROADWAY WARNING DEVICES, Flares or Red colored chemical lights--to equal 180 minutes

☐ LEATHER GLOVES--2 pair

☐ CROWBAR, 24"--1

☐ WRECKING BAR, 51"--1

Note: A pry-ax type tool may be substituted for the crowbar and wrecking bar

☐ EMERGENCY RESPONSE GUIDE BOOK, DOT, INITIAL RESPONSE TO HAZARDOUS MATERIAL INCIDENTS, 1992 or newer--1

COMMUNICATIONS EQUIPMENT AND RECORDS

RADIO O VHF O UHF O 800 MHz

List all frequencies:_____

_____

_____

☐ PATIENT CARE REPORT FORM--12 (2)
☐ REFUSAL INFORMATION FORM--6 (1)
☐ TRIAGE TAGS--25
☐ AMBULANCE USAGE RECORDS KEPT IN OFFICE
☐ MAINTENANCE RECORD KEPT IN OFFICE

PATIENT COMPARTMENT DIMENSIONS

PATIENT COMPARTMENT:

☐ LENGTH; must be at least 116" (B) and 122"(C) from the front partition the inside surface of the rear door at the floor.
ACTUAL:_____

☐ DISTANCE; must be at least 25" and not more than 30" of unobstructed space at he t head of the primary patient stretcher (measure form backrest of EMT seat to forward edge of stretcher).
ACTUAL: _____

☐ DISTANCE; must be at least 10" from the end of the stretcher to the inside surface of the rear door.
ACTUAL:_____

☐ WIDTH; must be at least 18" (+/- 6") clear aisle between primary stretcher and squad bench.
ACTUAL:_____

☐ HEIGHT; must be at least 60".
ACTUAL: _____

DOORS

☐ "DOOR OPEN" WARNING

☐ RIGHT FORWARD SIDE; must be at least
- 30" wide ACTUAL: _____
- 42" high, type II. ACTUAL:_____
- 54" high, type I & III. ACTUAL:

☐ REAR LOADING, must be at least:
- 44" wide. ACTUAL:_____
- 46" high. ACTUAL:_____

☐ BETWEEN DRIVER AND PATIENT COMPARTMENT FOR TYPE II AND III, must be at least:
- 17" wide. ACTUAL:
- 46" high. ACTUAL: _____

☐ 150 sq. in of window. ACTUAL:_____

EMBLEMS and MARKINGS

FRONT:

☐ Word "AMBULANCE" in 4" blue block letter in mirror image, centered above the grille, on an orange or white background.

☐ Star-of-Life in 3" blue emblem located to both the left and right of the word ambulance.

SIDE:

☐ Word "AMBULANCE" in 6" blue block letters on each side

☐ Star-of-Life in 16" in blue block emblem on each side

REAR:

☐ Word "AMBULANCE" in 6" blue block letters

☐ Star-of-Life in 12" blue block emblem on each rear door

TOP:

☐ Star-of-Life in a 32" blue block emblem

AMBULANCE EXTERIOR:

NEED OF BODY WORK? NO___ YES___
SPECIFY:_____

_____

NEED OF PAINTING? NO___ YES___
SPECIFY: _____

_____

CLEANLINESS: SATISFACTORY___
UNSATISFACTORY___

AMBULANCE INTERIOR:

NEED OF UPHOLSTERY WORK? O NO O YES
EQUIPMENT ORGANIZED IN A NEAT AND ORGANIZED MANNER? O NO O YES
CLEANLINESS SATISFACTORY___
UNSATISFACTORY___

DISPLAYING SIGNS, LICENSES AND CERTIFICATES

☐ Star-of-Life Ambulance 1822 B or C Sticker, Location:_____

"NO SMOKING" signs,
- ☐ Drivers Compartment
- ☐ Patient Compartment

☐ Health Division Ambulance License, Location: _____

☐ Multnomah County Ambulance License: Location:_____

☐ DEA License filed in ambulances business office

MEDICATIONS--REQUIRED BY MULTNOMAH COUNTY

☐ACTIVATED CHARCOAL, 50 gm--2 (1)
Earliest expiration date:_____
☐ADENOSINE, 6 mg--5 (5)
Earliest expiration date:_____
☐ALBUTEROL, 2.5 mg--5 (2)
Earliest expiration date:_____
☐ATROPINE, 1 mg--6 (3)
Earliest expiration date:_____
☐BRETYLOL, 500 mg--6 (3)
Earliest expiration date:_____
DEXTROSE:
☐50%, 50 cc--4 (2)
Earliest expiration date:_____
☐LIQUID--10 Gm--2 (1)
Earliest expiration date:_____
☐**DIAZEPAM, 10 mg--3 (1)
Earliest expiration date:_____
☐DIPHENHYDRAMINE--50 mg--2 (1)
Earliest expiration date:_____
EPINEPHRINE:
☐1:1000, 30 cc--2 (1)
Earliest expiration date:_____
☐1:1,000, 1 mg/cc--2 (1)
Earliest expiration date:_____
☐1:10,000, 1 mg/10 cc--10 (4)
Earliest expiration date:_____
☐FUROSEMIDE, 40 mg--4 (2)
Earliest expiration date:_____

☐GLUCAGON, 1 mg--2 (1)
Earliest expiration date:_____
☐**INAPSINE, 2.5 mg/cc--4 (2)
Earliest expiration date:_____
☐INTROPIN, 400 mg--2 (1)
Earliest expiration date:_____
LIDOCAINE
☐2%, 100 mg/ 10 cc--6 (3)
Earliest expiration date:_____
☐1 Gm in 250 cc--2 (1)
Earliest expiration date:_____
☐MAGNESIUM, 2 Gm/20cc (10%),--4 (2)
Earliest expiration date:_____
☐**MORPHINE, 10 mg--3 (1)
Earliest expiration date:_____
☐NALOXONE, 2 mg--9 (3)
Earliest expiration date:_____
NITROGLYCERINE
☐TABLETS, 0.4 mg--2 units (1), or
Earliest expiration date:_____
☐SPRAY, 0.4 mg--2 units (1)
Earliest expiration date:_____
☐SODIUM BICARB., 50 mEq/50 cc--3 (2)
Earliest expiration date:_____
☐THIAMINE, 100 mg--4 (1)
Earliest expiration date:_____

** --must be locked and counted at each shift change!

INSPECTION FINDINGS and DISPOSITION

CAN THE PERSON ASSISTING WITH THE INSPECTION LOCATE THE EQUIPMENT IN A TIMELY MANNER?
O YES O NO

☐ INITIAL INSPECTION ACCEPTABLE
* ☐ **INITIAL INSPECTION IS NOT ACCEPTABLE. THE INSPECTION REVEALS VIOLATIONS THAT CONSTITUTE AN IMMEDIATE DANGER OR THREAT TO THE PUBLIC. THE LICENSE FOR THIS VEHICLE IS IMMEDIATELY SUSPENDED AND SHALL REMAIN SUSPENDED UNTIL THE VIOLATIONS HAVE BEEN CORRECTED.**
* ☐ **INITIAL INSPECTION IS NOT ACCEPTABLE. THE INSPECTION REVEALS VIOLATIONS THAT DO NOT CONSTITUTE AN IMMEDIATE THREAT TIE THE PUBLIC. NOTIFY THE HEALTH DIVISION AND THE MULTNOMAH COUNTY EMS OFFICE IN WRITING THAT THE NON-CRITICAL VIOLATIONS HAVE BEEN CORRECTED BY: (NOT TO EXCEED 72 HOURS) DATE: _____ TIME: _____**

☐ RE-INSPECTION IS ACCEPTABLE

* ☐ **RE-INSPECTION IS NOT ACCEPTABLE. REMIT A CHECK IN THE AMOUNT OF $50.00 MADE PAYABLE TO:**
☐ **OREGON HEALTH DIVISION**
☐ **MULTNOMAH COUNTY EMS OFFICE**

☐ COPY OF THE AMBULANCE INSPECTION FORM GIVEN TO AMBULANCE SERVICE REPRESENTATIVE:

_____
NAME TIME

INSPECTION COMPLETED BY:

_____
NAME TIME

* IF AMBULANCE LICENSE IS SUSPENDED:

*** COUNTY HEALTH DEPARTMENT REPRESENTATIVE NOTIFIED:**

_____
NAME TIME

*** COUNTY AMBULANCE SERVICE PLAN ADMINISTRATOR NOTIFIED:**

_____
NAME TIME

*** OREGON STATE HEALTH DIVISION ADMINISTRATOR NOTIFIED:**

_____
NAME TIME

CREW INFORMATION:

NAME CREW 1: _____

CERTIFICATION NUMBER: _____
EXPIRATION DATE: _____

DRIVERS LICENSE EXPIRATION DATE: _____
NUMBER: _____

ACLS: O CURRENT O EXPIRED
BCLS: O CURRENT O EXPIRED

NAME CREW 2: _____

CERTIFICATION NUMBER: _____
EXPIRATION DATE: _____

DRIVERS LICENSE EXPIRATION DATE: _____
NUMBER: _____

ACLS: O CURRENT O EXPIRED
BCLS: O CURRENT O EXPIRED

CULTURES: O NO O YES
SOURCE: _____
_____

ATTACH RESULTS HERE:

ATTACHMENT H

MASS CASUALTY INCIDENT PLAN

Multnomah County

Emergency Medical Services

Mass Casualty Incident Plan

1993

MULTNOMAH COUNTY

EMERGENCY MEDICAL SERVICES

MASS CASUALTY INCIDENT PLAN

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MULTNOMAH COUNTY

EMERGENCY MEDICAL SERVICES

MASS CASUALTY INCIDENT PLAN

I. GENERAL

A. Purpose:
The Mass Casualty Incident Plan outlines the response policies and procedures for emergency medical services providers and agencies in Multnomah County to be implemented in the event of a Mass Casualty Incident (MCI).

B. Information:
The following titles of the National Interagency Incident Management System (NIIMS) Incident Command System (ICS) are used:

NIIMS ICS
Emergency Center
EMS Assembly Area
Medical Branch Director
Medical Communications Group Supervisor
Medical Transportation Group Supervisor
Triage Group Supervisor
Treatment Group Supervisor

C. Definitions:

State Advanced Life Support (ALS) Unit: A unit staffed by at least two persons: one state-certified at or above the EMT 1 level and one state-certified at or above the EMT 3 level, or an RN, PA or physician trained in prehospital emergencies as defined in OAR 333-23-050 2 (a), (A) and (B).

Multnomah County ALS Ambulance: An ambulance staffed, according to Multnomah County Administrative Rule, by at least two Oregon Certified EMT 4s.

All-Call: An interhospital survey conducted on the Hospital Emergency Administrative Radio (HEAR) System to determine the number of critical and/or noncritical patients each facility can handle.

Ambulance Staging Area: Area where arriving ambulances and personnel can be assembled in close proximity to the incident.

Basic Life Support (BLS) Unit: A unit staffed by at least two persons: one state-certified at or above the EMT 1 level or an RN, PA or physician trained in prehospital emergencies.

Bureau of Emergency Communications (BOEC): A city of Portland bureau responsible for management of the Multnomah County Public Safety Answering Point (PSAP) located at Kelly Butte. This bureau coordinates 9-1-1 communications for Emergency Medical Services, Law Enforcement and Fire Services throughout Multnomah County including the cities of Portland, Gresham, Troutdale, Wood Village, and Fairview.

Critical Incident Stress Debriefing (CISD): A confidential discussion organized and performed by a Critical Response Team (CRT) composed of responders, peers, and mental health professionals. [The Critical Response Team responds to any situation faced by emergency services personnel that causes them to experience unusually strong emotional reactions which may potentially interfere with their ability to function either at the scene or later.]

Emergency Center: A facility established and equipped to perform coordination in support of a large scale emergency or disaster.

EMS Assembly Area: Area where arriving ambulances and personnel can be assembled in close proximity to the incident.

EMS Assembly Area Manager: Individual designated to manage the EMS Assembly Area(s).

EMS Dispatch: An integral part of the Bureau of Emergency Communications. EMS Dispatch functions as a central point for 9-1-1/medical call taking and dispatch. During a Mass Casualty incident, EMS Dispatch will monitor the operations frequency, assign additional requested resources, and ensure sufficient medical coverage for other EMS incidents.

Fire Alarm Dispatch (FAD): Communications center for fire services in Multnomah County.

Fire Command: Senior Fire Officer on-scene.

Fire Rescue: A fire service unit which has medical capability.

Hospital Emergency Administrative Radio (HEAR): VHF radio system coordinated by Regional Hospital during a Mass Casualty incident--used to ascertain and assemble information regarding hospital resources.

Immediate Danger Zone: Area surrounding an incident in which there is a potential danger to life. Incident Command will determine its boundaries.

Incident Command ("Command"): Radio designation and "title" of person or persons responsible for overall direction of the incident.

Incident Commander: Person designated by the public safety agency in charge to command the scene.

Jurisdiction: Multnomah County and those jurisdictions within Multnomah County.

Landing Zone (LZ): A well-marked area, 100 ft. x 100 ft., designated and secured by fire or law enforcement personnel for helicopter landing.

Medical Branch Director: An EMT 4 who coordinates all on-scene emergency medical services activities.

Medical Communications Group Supervisor: An EMT 4 who coordinates Regional Hospital communications and patient destinations with transporting ambulance assignments.

Medical Examiner: is responsible for removal of deceased from area and coordinates morgue activities.

Medical Resource Hospital (MRH): Acts as back-up to Regional Hospital in the event of Regional Hospital communications failure.

MedNets: UHF radio frequencies designated for Emergency Medical Services communications.

Morgue: Temporary area initially designated by the Medical Branch Director and Transportation Group Supervisor, where deceased victims will be taken--location may be changed by Medical Examiner.

Patient Loading Zone: Designated area adjacent to the patient treatment area, where transporting units receive and load patients.

Patient Treatment Area: Designated area where patients are brought, reassessed, and treated after initial triage and tagging by a Triage Team member. Treatment priority sections will be marked, corresponding with colors of triage tags.

Regional Hospital: Facility coordinating patient destinations with hospital resources.

Staging Area: Area where arriving fire service equipment, other vehicles and personnel stage to be in close proximity to the incident.

Transportation Group Supervisor: An EMT 4 who establishes treatment areas and supervises patient loading into transport units.

Treatment Group Supervisor: An EMT 4 who coordinates all activities in the treatment areas.

Triage: Process of sorting patients by severity of injury.

Triage Group Supervisor: An EMT 4 who coordinates triage, patient assessment, and tagging.

Triage Tag: Multicolored tie-on tag used to indicate condition and treatment priority of patients.

Triage Priority Colors:

Red - Priority 1 - Critical
Life threatening medical emergencies, i.e., airway, breathing and/or circulation problems.

Yellow - Priority 2 - Noncritical
Not as seriously injured as Priority 1 patients, but possibility exists for rapid deterioration of physical condition.

Green - Priority 3 - Ambulatory
Require treatment, but can wait for transportation without immediate threat to life.

Black - Priority 0
Expired or mortal injuries.

Triage Tagging: Method used to categorize condition of patients, according to severity of injuries. A triage team member will assign tags corresponding in color with treatment priority areas: red - priority 1; yellow - priority 2; green - priority 3; black - priority 0. The triage tag shall stay with the patient through hospital admittance.

D. Legal Authority:

Oregon Revised Statutes:

ORS 431.607 Emergency Medical Services and Trauma System

ORS 823.00 Ambulances and Emergency Personnel

ORS 823.180 County plan for ambulance and Emergency Medical Services

Oregon Administrative Rules:

333-28-000 through 333-28-063	Ambulances and Emergency Medical Technicians
333-28-095 through 333-28-130	County Ambulance Service Area Plans
333-200-000 through 333-200 090	Emergency Medical Services and Trauma Centers

Multnomah County Code:

MCC 6.32	Ambulance Services

Multnomah County EMS Administrative Rules:
Permanent and Emergency Rules

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Triage Group Supervisor: An EMT 4 who coordinates triage, patient assessment, and tagging.

Triage Tag: Multicolored tie-on tag used to indicate condition and treatment priority of patients.

Other:
State Trauma Advisory Board Plan

Area Trauma Advisory Board I Plan - April 4, 1988

E. Policy:
The Mass Casualty Incident (MCI) Protocol will be used to coordinate incidents involving ten or more total patients.

During a mass casualty incident, emergency medical services providers and agencies will conduct operations to provide immediate resources, to minimize the loss of life through prompt medical treatment in the field, and to coordinate field medical services and activities with existing medical facilities and other support services and resources.

It is an EMS policy that agencies having the responsibility to provide needed emergency services be notified of an impending or actual incident as soon as appropriate in order to initiate preparedness or response activities.

The Trauma System is NOT used for mass casualty incidents.

On-scene personnel will have authority to act in a timely manner within the incident command system at the scene.

If the first units responding to an incident are BLS or ALS staffed with only one EMT 4:

A. Medical Branch Director shall order ALS units as needed to fill the EMT 4 positions.

B. Designated BLS personnel shall perform MCI tasks normally assigned to EMT 4s until relieved.

II. LEVELS OF ACTIVITY

Level I:
An incident exists involving ten or more total patients or the potential for 10 or more patients.

Level II:
An incident exists where the number of MCI-dedicated ALS ambulances has reduced the available ALS ambulances within Multnomah County to a Minimum Coverage Level of 3 or below.

Level III:
An incident exists where the number of MCI-dedicated ALS ambulances has reduced the available ALS ambulances within Multnomah County to a potential EMS Coverage Level of 0.

III. ACTIVATION

The first arriving Advanced Life Support unit on the scene shall identify itself and advise EMS Dispatch of the following:
1. The exact location of the incident.

2. The type of incident (transportation accident, fire, explosion, etc.).
3. Environmental conditions (hazardous materials, extreme weather, etc.).
4. Number of ALS ambulances needed.
5. Immediate danger zone.
6. Assembly area.
7. Recommended routes to and from the scene.
8. Approximate number of patients.

First Fire ALS Unit:

- Provides personnel to perform duties of the Medical Branch Director and Triage Group Supervisor.

- Provides the identification vests, task cards, and triage area tarps.

(If the first arriving Fire Unit is not ALS staffed, the Triage Group Supervisor's duties may be assigned to ALS Ambulance personnel and the Transportation Group Supervisor's duties assigned to BLS fire personnel until relieved by fire ALS personnel.)

First ALS Ambulance Unit:

- Provides personnel to perform duties of the Transportation Group Supervisor and Communications Group Supervisor.

IV. COMMUNICATIONS

Field units SHOULD NOT use the HEAR system -- it is reserved for interhospital traffic. Units transporting patients should not give receiving hospitals updates or patient care reports.

MedNet 1 is the dedicated MCI channel for on-site coordination, communication with Regional Hospital and the request/direction of additional medical personnel through EMS Dispatch.

If MedNet 1 is disabled, MetNet 4 will be used. (MRH will continue to function for medical direction and non-MCI trauma communications on MedNet 4).

MCI Medical Operations:

MedNet 1 (UHF):
Medical Sector Coordinator; Communications Group Supervisor; Transportation Group Supervisor; Triage Group Supervisor; ALS Ambulances; LifeFlight; EMS Dispatch; Fire Rescues, dedicated BOEC MCI operator.

Interhospital Coordination:

HEAR System (VHF):
Regional Hospital and Area Hospitals.

Primary EMS Dispatch:

MedNet 9 (UHF):
Routine EMS Operations.
Initial assignment of units to MCI.
Reassignment of units after transport.

V. DOCUMENTATION

The Communications Group Supervisor will fill out and maintain the Mass Casualty Incident Log.

All MCI operations documents will be copied and forwarded to the Multnomah County Emergency Medical Services office within five working days.

An accounting of the expense of the Multnomah County Emergency Services Agencies may be kept and made available upon request to the Multnomah County/city Office of Emergency Management for the purpose of compiling and reporting to the county.

VI. DEMOBILIZATION

1. Appropriate callbacks will be made by agencies who made initial contacts, at the direction of the Incident Commander, 9-1-1 center will cancel units, agencies will cancel personnel.

2. Personnel-on-scene will check with Incident Command before clearing scene.

3. All agencies should consider contacting a Critical Response Team (CRT) which performs Critical Incident Stress Debriefing (CISD) for their personnel. Requests for the Oregon Critical Response Team (OCRT) may be made through Medical Resource Hospital.

VII. ACTIVITY CHECKLIST

A. Level I

An incident exists involving ten or more total patients.

Position	Task
Emergency Medical Services Dispatch	Verify Mass Casualty Incident and its location, dispatch initially requested units. If EMS Dispatch is advised that hazardous materials are involved in the incident, IMMEDIATELY notify all responding agencies. Notify BOEC supervisors, adjust staffing pattern, inform law enforcement dispatch.

Position	Task
	Relay incident information to Regional Hospital.
	Broadcast incident and frequency information to all on-line EMS units.
	Put air ambulance services on standby.
	Call all ground ambulance companies and have them put all available units on the air for potential response.
	Notify the EMS Office.
	Monitor the operations frequency and dispatch additional EMS units per request of the Medical Branch Director or Incident Commander.
	Cancel ground and air ambulances per request of Medical Branch Director or Incident Commander.
First arriving ALS Unit	Advise Emergency Medical Services Dispatch of the following:
	This is an MCI.
	The exact location of the incident.
	The type of incident (transportation accident, fire, explosion, etc.).
	Environmental conditions (hazardous materials, extreme weather, etc.).
	Number of ALS ambulances needed.
	Immediate danger zone.
	Assembly area.
	Recommended routes to and from the scene.
	Approximate number of patients.

Position	Task
First Fire ALS Unit	Provide the Medical Branch Director and Triage Group Supervisor.
	Distribute the identification vests and task cards to the Transportation Group Supervisor, Communication Group Supervisor, Triage Group Supervisor, and Medical Branch Director.
	Provide triage tags.
	Provide color coded tarps or markers for treatment areas.
Medical Branch Director	Coordinate ALL on-scene EMS activity.
	Ensure that EMS Dispatch gets pertinent incident information.
	Appoint Triage Group Supervisor.
	Order ambulances, as needed, per Communications Group Supervisor.
	Coordinate all EMS activities with Incident Command.
	Order additional resources for Medical Branch (manpower, buses, medical supplies, Red Cross, Medical Examiner, etc.).
	Delegate establishment of air ambulance Landing Zone (LZ).
	Constantly assess performance of group supervisors and make personnel changes if necessary.
Triage Group Supervisor	Perform rapid triage.
	Estimate number of patients and type of injuries, i.e., Head, peds, OB, Chest, Burns, Radiation, HazMat.

Position	Task
	Give this information to the Medical Branch Director and the Communications Group Supervisor.
	Go back, start "tagging" patients.
	Confer with Medical Branch Director to establish extrication teams.
	Ensure that no unnecessary equipment is brought into scene where patients are located.
	Move patients to treatment areas as soon as possible.
First ALS Ambulance_____	Provide EMT 4 Transportation Group Supervisor and EMT 4 Communications Group Supervisor.
Medical Communications Group Supervisor____	Establish communications with Regional Hospital on Mednet 1.
	Designate the Ambulance Assembly area. Relay location to Medical Branch Director.
	Start MCI log, using information from the Triage Group Supervisor.
	If necessary, designate a communications assistant to assure an organized flow of information from scene to Regional Hospital.
	Request additional ambulances, including BLS ambulances, if needed, via the Medical Branch Director.
	Keep a unit ready for loading in the Loading Zone at all times.
	As soon as a unit is ready to transport, tell Regional Hospital the number and type of patients on board. Regional will determine unit destination.

Position	Task
	Inform loaded ambulance of its destination, ensure its safe departure, and immediately request another ambulance to move in from the staging area to the loading zone.
Medical Transportation Group Supervisor____	Establish patient treatment areas after conferring with the Medical Branch Director regarding location.
	Establish patient loading zone. Consider proximity to treatment area and ambulance approach and exit routes.
	Assign patients from treatment area to ambulances.
	Supervise the number and priority of loading of patients.
	As soon as patients have been loaded, tell the Communications Group Supervisor the ambulance unit and number/type of patients on board. (Head, Peds, OB, Chest, Burns, Radiation, HazMat, etc.)
	If extra medical equipment is needed, request from the Medical Branch Director.
	Do not allow patients to "stack up" in the loading zone.
	If necessary, delegate the loading of ambulatory patients into buses.
Treatment Group Supervisor_____	Coordinate all activities in the treatment area with the Transportation Group Supervisor.
	Organize treatment areas and order additional medical equipment and manpower through the Medical Branch Director.
	Maintain contact with Triage Group Supervisor. Accept patients into treatment areas.

Position	Task
	Provide BLS care to patients. ALS care may be possible later in the incident when resources allow. Identify the order in which patients are to be transported. Keep the treatment area as secure as possible. If ambulatory patients are loaded onto buses or grouped together in one location, attempt to provide secure access and egress points (so patients or their parents do not leave the scene). All patients triaged must be accounted for!
Additional Arriving Ambulances	Go to the EMS Assembly Area and remain with your vehicle. Report your arrival to the Communications Group Supervisor. (EMS Assembly Area Manager if one has been designated.) Load patients as assigned by Transportation Group Supervisor. Transport to medical facility as assigned by Communications Group Supervisor and provide patient care enroute.
Additional Arriving Rescues	Respond to Staging Area. Report arrival to the Staging Area Manager; wait for assignment. If assigned as an ambulance, report to EMS assembly area and remain with your vehicle. On arrival, inform Communication Group Supervisor (EMS Assembly Area Manager if one has been designated.)
Air Ambulances	Switch to predesignated operations net for instructions and landing zone location and remain with your aircraft after landing. Load patients as assigned by Transportation Group Supervisor.

Position	Task
	Transport to medical facility as assigned by Communications Group Supervisor.
Regional Hospital	Establish contact with Communications Group Supervisor.
	Initiate HEAR System "All-Call" and relay information to others on emergency notification list.
	Coordinate patient information between field personnel and receiving hospitals.
	Coordinate transportation assignments from incident site to hospitals.
	Upon request, provide medical direction in case Medical Resource Hospital communications fail.
Medical Examiner	Direct tagging of possessions and preserve conditions at the scene for investigative agencies.
	Direct removal of the deceased from the area, and coordinate morgue activities.
Incident Commander	Oversee and manage all on-scene incident operations.
Law Enforcement	Coordinate with Incident Command.
	Perform on-scene operations and tasks according to agency procedures and Incident Command Directives.
Fire Service	Coordinate with Incident Command.
	Perform on-scene operations and tasks according to agency procedures and Incident Command directives.

B. Level II

An incident exists where the number or MCI-dedicated ALS ambulances has reduced the available ALS ambulances within Multnomah county to the minimum coverage level 3 established by Multnomah County Administrative Rules.

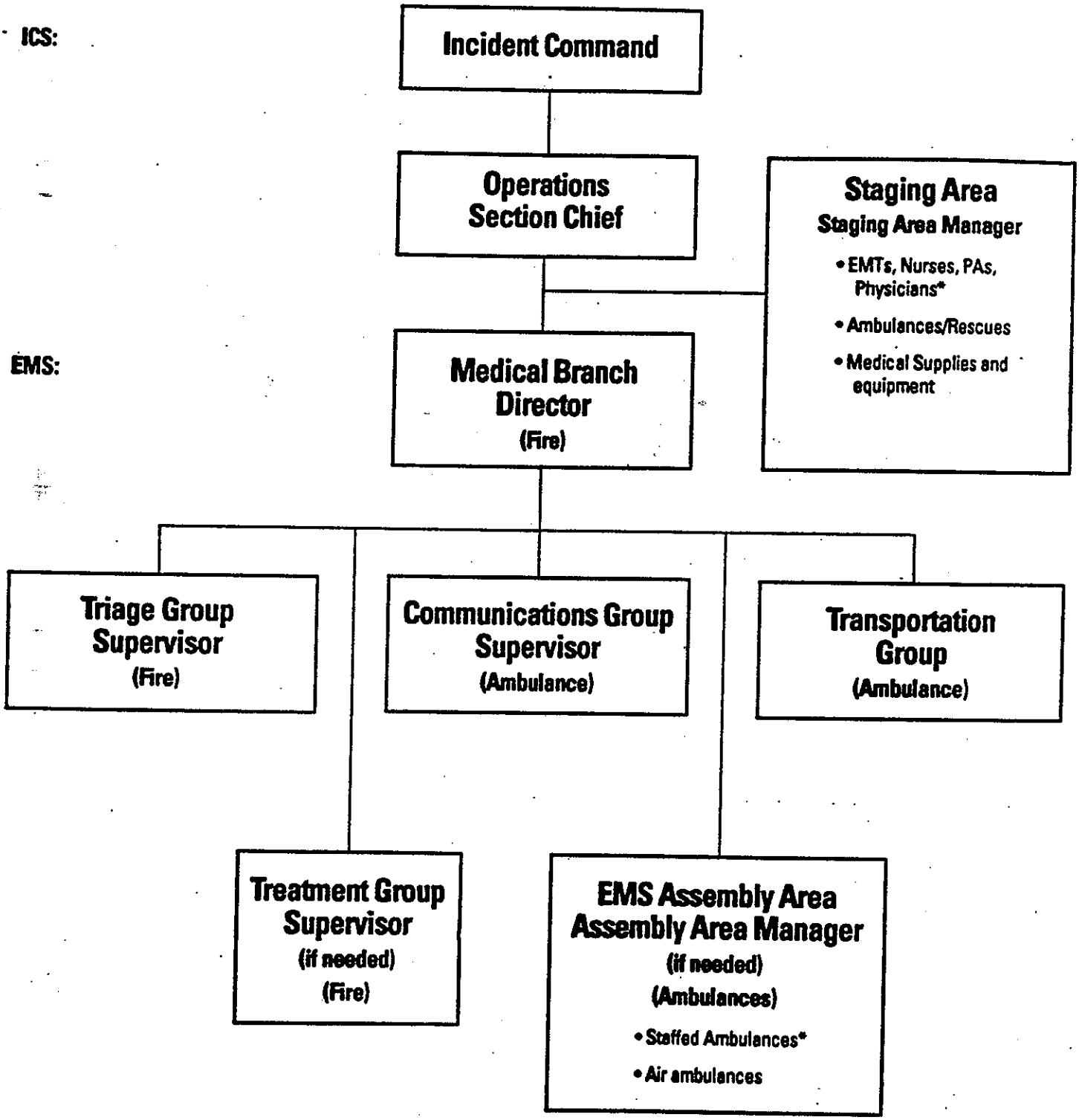
Position	Task - In Addition to Level I
BOEC	Request out-of-county ambulances as directed by Medical Branch Director.

C. Level III

An incident exists where the number of MCI-dedicated ALS ambulances has reduced the available ALS ambulances within Multnomah County to an EMS Coverage Level of 0.

Position	Task - In Addition to Level II
All Agencies	Increase support according to magnitude of incident. Coordinate arrival and dispersement of additional manpower and resources with Emergency Center and Incident Command. Notify the City/County Emergency Management Office.

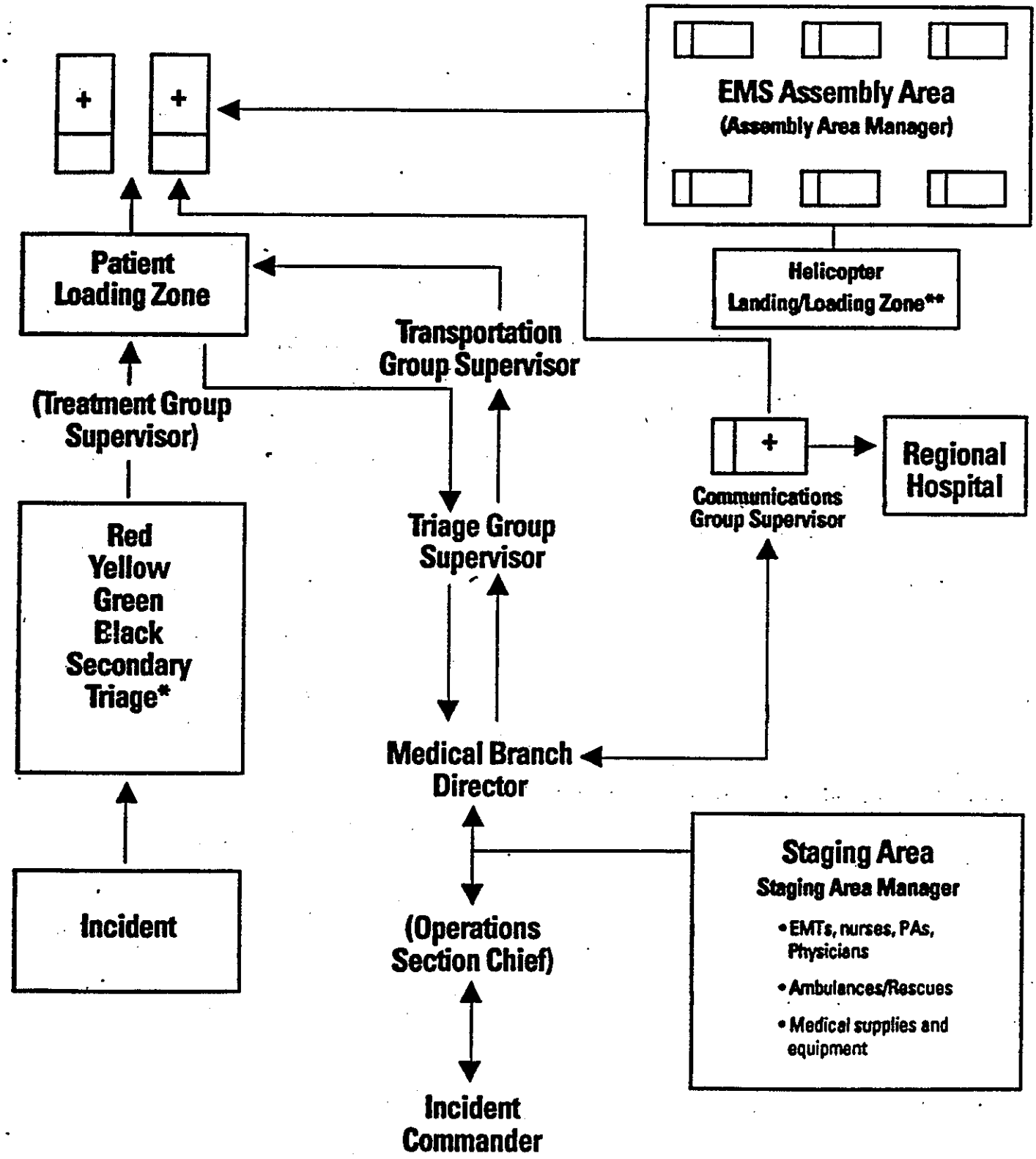
EMS Structure



*All off-duty EMS personnel who arrive at the scene will report only to the Staging Area. If needed, they will be asked to respond to a given person and/or area by the Staging Area Manager and be given visible identification.

Medical Branch Diagram

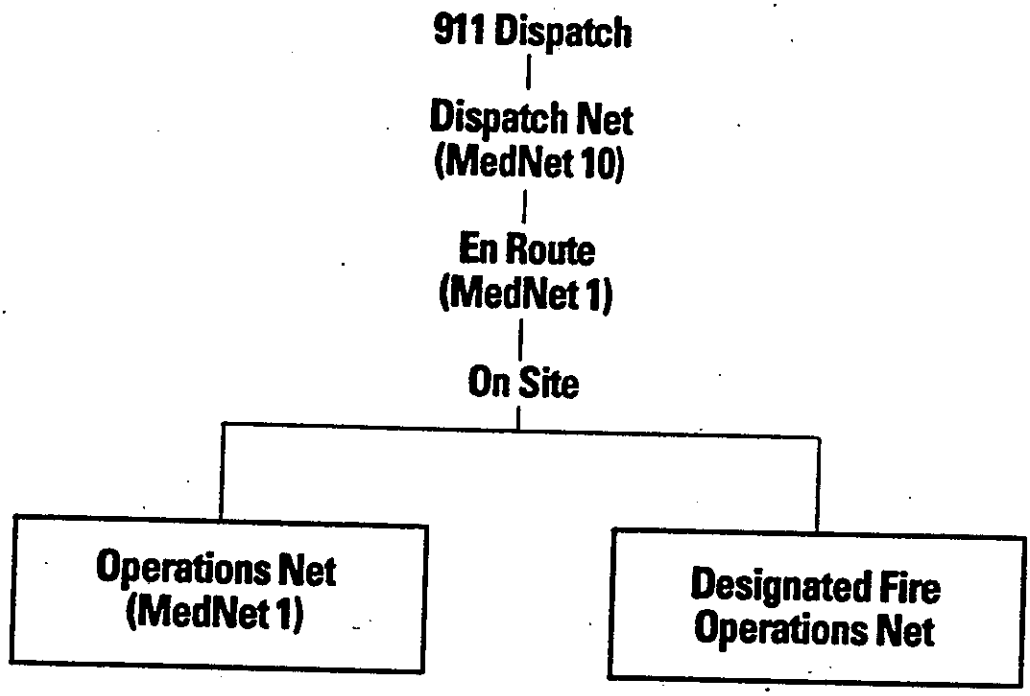
(Example)



* Diagram indicates needed triage areas. Actual designated sites will vary.

** Helicopter landing/loading zone should be placed away from areas of patient care. Actual placement will be determined by where the helicopter can land.

Communications*



Medical Branch Director
(monitor)

Medical Communications
Group Supervisor

Regional Hospital

BLS Ambulance
ALS Ambulance

Fire Rescue

Air Ambulance

Incident Commander

(Operations Section
Chief)

Medical Branch Director

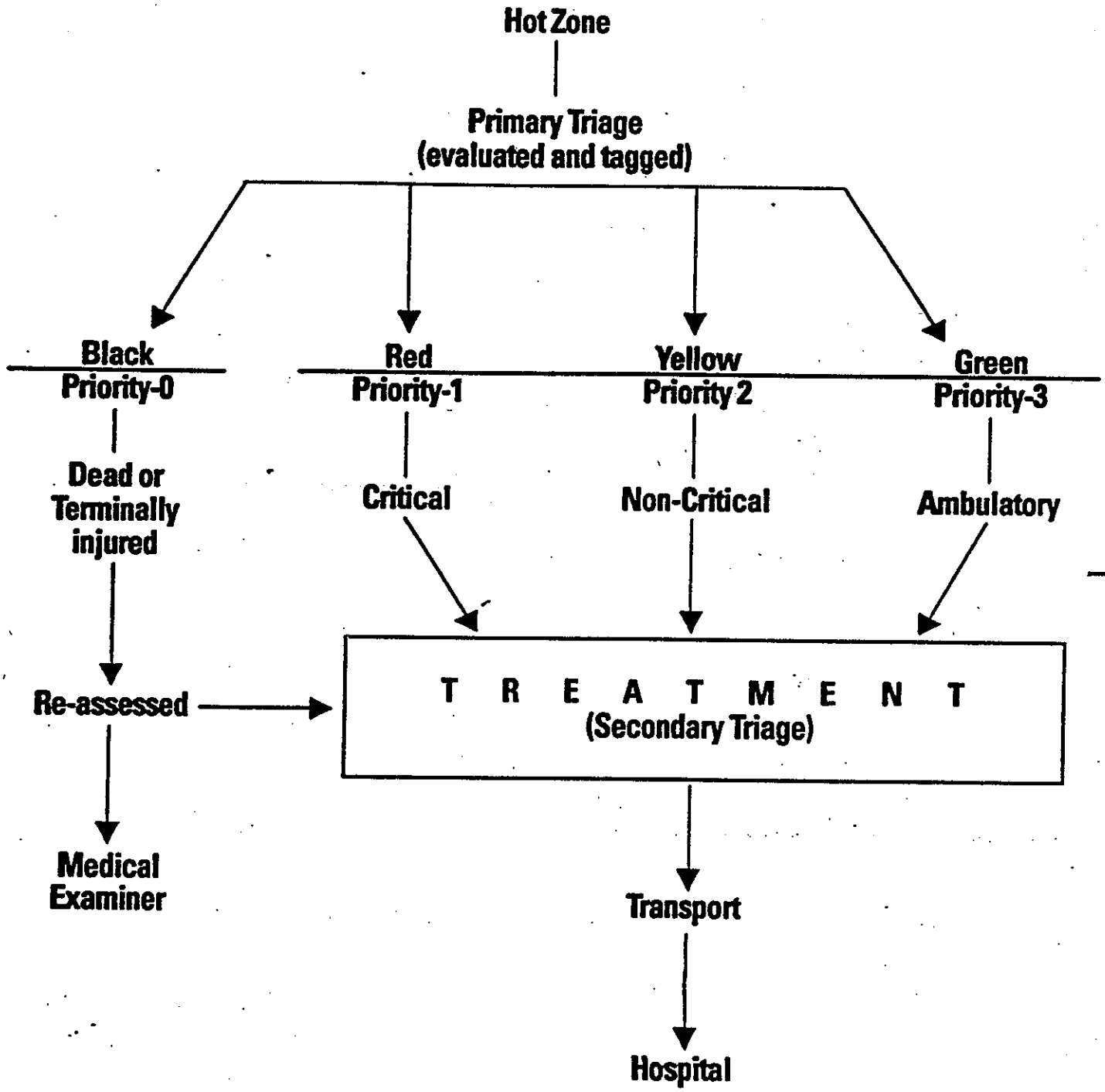
(Medical Treatment
Group Supervisor)

Medical Triage
Group Supervisor

(Extrication
Team Leader)

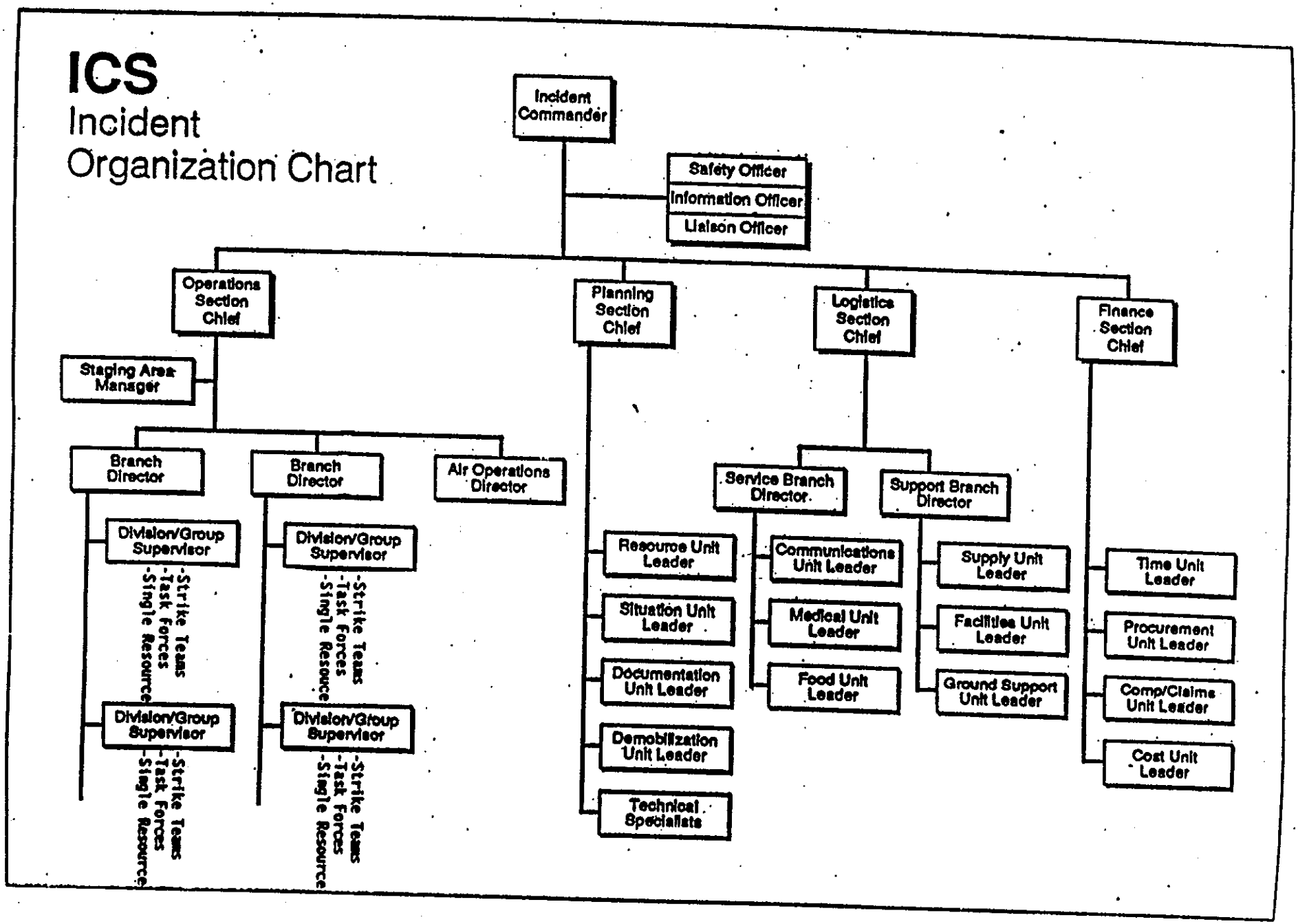
*Who has what channels.

Patient Flow



When a vehicle is available for transport, treatment shall shift from on-scene to treatment during transport.
Keeping on-scene time to a minimum consistent with good patient care is the goal.

ICS
Incident Organization Chart



ATTACHMENT I

HAZ-MAT

SPECIALIZED RESCUE

MAB Approved
11/10/89

HAZARDOUS MATERIALS

Purpose:

Paramedics may be first on the scene of a hazardous materials situation because of shorter response time or no knowledge of dispatch that hazardous materials are involved. This protocol is intended to guide paramedics 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:

I. Approach

A. All scenes:

1. Utilize a cautionary approach at all times.
2. The reported location may be inaccurate and response into a contaminated area might occur.
3. Approach upwind and upgrade if possible. If unable to approach from upwind/upgrade, approach at 90° to wind/grade if possible with safety in mind.
4. Position vehicle well away from problem and headed away from incident.
5. Communicate your actions or intended actions to EMS Dispatch.
6. Remember: Contaminated and/or exposed response personnel may add to the overall problem and reduce their effectiveness to help.

B. If at any time you suspect a hazardous materials situation:

1. If first-in responder, confirm that fire and police have been notified. a. The agency responsible for hazardous materials responses may respond with different levels of personnel and equipment based upon the information received. Do not always expect a hazardous materials team to respond.
2. If you are a first-in responder, first priority is scene isolation. KEEP OTHERS AWAY! KEEP UNNECESSARY EQUIPMENT FROM BECOMING CONTAMINATED.
3. If you believe that you or your vehicle are contaminated stage in an isolated area.

DRAFT

PORTLAND BUREAU OF FIRE, RESCUE & EMERGENCY SERVICES
INTER-OFFICE CORRESPONDENCE
(NOT FOR MAILING)

April 13, 1993

TO: Whom It May Concern

FROM: Lt. Dennis Gale

SUBJECT: Specialized Rescue/EMS Services Provided by Portland Bureau of Fire, Rescue & Emergency Services

I. HIGH ANGLE RESCUE

High angle rescue incidents are handled by specially trained and equipped units stationed in strategic locations (Stations 1, 22, 19 & 41). In addition, all of those stations have high angle rescue trained fire fighter/paramedics that provide medical care at the incidents.

II. CAVE IN RESCUE

Cave in incidents are handled by Squad 1 (specially trained personnel) using Trench Rescue 1 (special cave in equipment). These units are preceded by PFB 1st responders and PFB fire fighter/paramedic units knowledgeable about cave in rescue techniques.

III. WATER RESCUE

Specialized water rescue is provided by Portland Fire's Dive Rescue Team. This specialized 30 member team is supported by PFB first responders and PFB fire fighter/paramedic units.

IV. HAZARDOUS MATERIALS INCIDENTS

Hazardous materials incidents are handled by Haz. Mat. 23. This regional Hazardous Materials Team is assisted by specially trained Haz. Mat. paramedics from Haz. Mat. Rescue 41.

V. EXTRICATION

Extrication is normally handled by one of ten PFB truck companies stationed in strategic locations. All extrication incidents require a PFB ALS unit (medical care) and a PFB engine company (fire safety).

VI. SPECIAL POLICE OPERATIONS (S.W.A.T. TEAMS, Etc.)

Medical care at special police operations is handled by 12 specially trained fire fighter/paramedics. These "S.E.R.T./Fire Medics" received their specialized training from Portland Police Bureau's Special Emergency Response Team.

VII. SPECIAL RESCUE INCIDENTS

Special rescue incidents (elevator rescue, etc.) are normally handled by PFB Squad 1. This unit has received specialized training in these areas.

ATTACHMENT J
SEARCH AND RESCUE PROTOCOL

SEARCH AND RESCUE (SAR)

Incidents that occur in "back country" or wilderness areas often involve extended response times, specialized personnel and extrication equipment; non routine procedures for dispatch of EMS resources may need to be used.

Always notify the Sheriff's Office of any incident that occurs "on a trail; during a hike or climb," or other similar outdoor events. Per ORS #401.066, the Sheriff's Office is in charge of all Search and Rescue incidents, and is responsible for notifying, organizing, and using appropriate resources, such as the RAT Team through Buck Medical Services, the 304th Air-evac unit, etc.

There is no need for an ALS ambulance to standby at a trail head waiting for a wilderness rescue team to extract a patient. An MCSO/SAR Officer at the scene may advise BOEC to have the initially dispatched ambulance go back in service until the patient is prepared for transport; at that time the MCSO/SAR Officer will request the dispatch of appropriate transport.

RESPONSIBILITY:	ACTION:
Calltaker	1. Process the call for medical and law enforcement response. 2. Identify the need for MCSO/SAR notification when the incident type and location is verified. 3. Attempt to ascertain any access problems or unusual incident circumstances or hazards and include in the MISC. INFO. 4. Ensure that the MCSO District Officer and the MCSO Shift Sergeant have been notified. MCSO is in command of all Search and Rescue incidents. 5. Complete the call per BOEC policy.
EMS Dispatcher	1. Contact the appropriate first responder agency. **NOTE:** Certain areas in East County have no EMS first responder services (unusual MSAG info should be in call MISC. INFO.) 2. Dispatch the appropriate units. NOTE: The Buck Ambulance RAT team may be activated for response in Multnomah County ONLY on requested of the Sheriff's office

3.350 5/92

	3. Advise all responders to contact the MCSO District Officer or SAR Coordinator as soon as they arrive on scene. 4. Contact or dispatch additional EMS resources when requested by the MCSO District Office or SAR Coordinator
Dispatch Coordinator	1. Monitor all activities associated with the incident. 2. Advise all net dispatchers of NET-5 closure for SAR operations, as required. 3. When Search and Rescue is requested, make appropriate notifications.
Incident Command	1. If "command" requests a delay in dispatching an ambulance, ground or air, (while the SAR team reaches, stabilizes, packages, and extricates the patient) command is then responsible for contacting EMS Dispatch for dispatch of an appropriate transport unit. 2. Decisions about appropriate transport units should be made in consult with available medical resources at the scene.

ATTACHMENT K
DISPATCH PROCEDURES
TRIAGE GUIDE

MULTNOMAH COUNTY
EMERGENCY MEDICAL SERVICES
TRIAGE GUIDELINES
AND
PREARRIVAL INSTRUCTIONS

These Triage Guidelines are to be used by ALL licensees in Multnomah County. Any call for emergency medical assistance MUST be triaged by these standards. Any response other than 0, as defined herein, will be referred to EMS Central Dispatch per Rule 631.320 (Subsection B and F) and Rule 631.330 (Subsection A).

No licensee or EMS dispatch agency may downgrade the response as required by these standards.

Any request for medical assistance which requires an ambulance in thirty (30) minutes or less MUST be triaged by these standards.

When in doubt, use your judgement and upgrade the level of response.

REASONS FOR ANY DEVIATIONS IN TRIAGED RESPONSE LEVEL MUST BE DOCUMENTED.

•• *The use of the masculine or feminine pronoun, within text, is not meant to be gender specific* ••

This document available from:
Multnomah County EMS Office
426 SW Stark Street, 9th floor
Portland, Oregon 97204
(503) 248-3220

[Graphic Arts Unit]

Exhibit "C"

KEY QUESTIONS

CARDINAL QUESTIONS — ALWAYS ASK!

1. What is happening ?
2. Conscious ?
3. Breathing ?
4. Age/Male or Female ?

PRE-ARRIVAL INSTRUCTIONS

BREATHING CHECK: Place your ear next to his/her mouth & nose and look toward the chest. Can you feel or hear any air movement? Is there fluid, bubbles or anything else in the mouth or nose? Do you see the chest or stomach moving? Place your hand on his/her stomach. Can you feel it rising or falling?

PULSE CHECK: See Additional Information. *

DISPATCH PRIORITIES

UN 1
- -Unconscious, not breathing
- -Unconscious, not known if breathing
- -Unconscious, abnormal or possible agonal breathing

UN 3
- -Unconscious, breathing normally
- -Now conscious and breathing (if with difficulty, see BREATHING card)

ADDITIONAL INFORMATION

*** PULSE CHECK: Child/Adult:** Place your index and middle finger into the groove next to his/her Adam's Apple. DON'T PRESS TOO HARD! Feel for a pulse for 5 seconds.

Infant: Place your index and middle finger over the baby's left nipple. DON'T PRESS TOO HARD! Feel for a pulse for 5 seconds.

AGONAL BREATHING: Gasping, ineffective breaths that often occur at the time of Cardiac Arrest. The caller may describe the person as "breathing funny, breathing weird, gasping, making funny noises, etc."

SIGNS OF SHOCK:

1. Confused or sleepy ? (Key Question)

Other signs of shock are listed below and should be used as determinants when volunteered by the caller or are covered by other key questions.

2. Skin feels cool and moist
3. Pale or blue skin color
4. Nausea and/or vomiting
5. Dizzy or faint

IF TRAUMA: Pre-Arrival: "Don't move him!! If you must, try to keep his head and neck from turning or pulling, to prevent further injury."

KEY QUESTIONS		PRE-ARRIVAL INSTRUCTIONS
1.	Chest Pain ?*	
2.	Bloody or "coffee-ground" vomitus ?	If vomiting or nausea is present, turn on side.
3.	Confused or sleepy ?	If signs of shock or fainting present, lay down flat and raise legs.
4.	Dizzy or feeling faint ?	
5.	Rectal bleeding ? Dark, tarry stool ?	No food or drink.

DISPATCH PRIORITIES

* Refer to Chest Pain Card

AB 3 -Vomiting bright red blood or dark "coffee ground" substance
-Signs of Shock (confused, sleepy, dizzy, faint, etc. . .)
-Rectal bleeding/dark, tarry stool
-Any female of child-bearing age (13-50) with abdominal pain and/or bleeding

AB 0 -All others

ADDITIONAL INFORMATION

"Coffee ground" vomitus is partly digested blood from chronic internal bleeding.

Life-threatening causes:

-Ectopic Pregnancy
-Perforated or bleeding ulcer
-Ruptured spleen or liver
-Abdominal aortic aneurysm
-Myocardial Infarction (M.I.) [May simulate heartburn]

Common causes:

-Flu
-Appendicitis
-Pelvic Inflammatory Disease (P.I.D.)
-Bowel Obstruction
-Gastritis

KEY QUESTIONS

1. Difficulty breathing ?
2. Difficulty swallowing, swollen tongue ?
3. Confused or sleepy ?
4. History of allergic reaction ?
5. Suspected cause of symptoms ?

PRE-ARRIVAL INSTRUCTIONS

If signs of shock present, lay patient down and raise leg (if this does not compromise breathing).

If difficulty breathing, place in position of comfort.

If necessary, refer to appropriate sequence card for airway, breathing or CPR instructions.

If nausea or vomiting present, refer to Vomiting/ Nausea card.

DISPATCH PRIORITIES

AL 3
-Difficulty breathing
-Swollen tongue
-Signs of shock
-Previous history of severe reaction

AL 9/0
-Bites and stings with local reaction (excessive swelling at site)
-Rash and/or itching only

ADDITIONAL INFORMATION

Allergy signs/symptoms:
-Rash
-Itching
-Difficulty breathing
-Anaphylactic shock
-Abdominal pain
-History of allergic reactions in the past

Probable causes of allergic reaction:
-Medications - Penicillin most common
-Radiology dyes
-Bee, wasp, yellow jacket or hornet stings
-Seafood (mainly shellfish)
-Nuts

KEY QUESTIONS

1. Location of bite ?
2. Difficulty breathing ?
3. Uncontrolled bleeding ?
4. Confused or sleepy ?
5. Type of animal ? Where is it ?

PRE-ARRIVAL INSTRUCTIONS

If signs of shock present, lay patient down and raise legs (if this does not compromise breathing).

If difficulty breathing, place in position of comfort.*

If bleeding, apply and maintain direct pressure to wound site.**

Try to keep the animal in sight or watch where it goes, WITHOUT ENDANGERING YOURSELF.

* If necessary, refer to appropriate sequence card for airway, breathing or CPR instructions.

** If necessary, refer to Bleeding card.

DISPATCH PRIORITIES

AN	1	-Bitten on face / neck / chest
AN	3	-Difficulty breathing -Uncontrolled bleeding -Signs of shock
AN	9/0	-All others

Always notify Animal Control and, if animal still on scene, send Police.

ADDITIONAL INFORMATION

Use your judgement, upgrade if necessary (consider what happened and current circumstances).

4 ANIMAL BITES 8/92

KEY QUESTIONS	PRE-ARRIVAL INSTRUCTIONS
1. Weapon or assailant still there ? 2. Type and location of wound ? 3. Difficulty or pain in breathing ? 4. Bleeding ? 5. Confused or sleepy ? 6. Abnormal behavior / loss of consciousness ?	If signs of shock present, lay patient down and raise legs (if this does not compromise breathing). If difficulty breathing, place in position of comfort.* If bleeding, apply and maintain direct pressure to wound site.** * If necessary, refer to appropriate sequence card for airway, breathing or CPR instructions. ** If necessary, refer to Bleeding card.

DISPATCH PRIORITIES

If appropriate, advise medical responders to stand by until Police advise regarding scene safety.

AS	**1**	-Penetrating wound, GSW, stab wound
AS	**3**	-Location of wound unknown -Difficulty breathing -Excessive bleeding -Signs of shock -Blunt trauma to head or trunk with abnormal behavior or loss of consciousness
AS	**9/0**	-Minor lacerations or bruises / all others

ADDITIONAL INFORMATION

If medical units are staging, have Police advise when scene is safe for medical entry.

Central penetrating wounds (head, neck, chest, back, abdomen) are more serious than extremity wounds

Crime scenes:
Leave evidence undisturbed if possible (weapons, tracks, etc.)

Rape:
Suggest that victim should not wash clothes/self before evaluation and investigation.

5 ASSAULT / RAPE / GSW / STABBING 8/92

KEY QUESTIONS

1. Are there any other symptoms ?
2. Recent fall or trauma ?*
3. Chest pain ?*
4. Confused or sleepy ?
5. History of similar back pain ?

PRE-ARRIVAL INSTRUCTIONS

If traumatic cause, don't move him!! If you must, try to keep his head and neck from turning or pulling, to prevent further injury.

If signs of shock, lay down flat and raise legs (do not raise legs if pain was caused by traumatic injury).

If vomiting, refer to Vomiting/Nausea card.

DISPATCH PRIORITIES

*Recent Fall, Trauma or Chest Pain — also refer to appropriate card

BK 3 -Signs of shock
-Non-traumatic back pain in patients over 40

BK 0 -All others

ADDITIONAL INFORMATION

Non-traumatic causes:

-Muscle spasm
-Aneurysm
-Kidney Stones
-Kidney Infection
-Vertebral disc disease
-Pancreatitis
-Myocardial Infarction

Traumatic causes:

-Fracture of ribs or spine
-Strained back
-Ruptured disc

KEY QUESTIONS

1. Is patient violent? Suicidal? Any weapons ?
2. Medications/Possible OD/Alcohol ?
3. Head injury or trauma in past 24 hours ?
4. Headache ? (see Headache card)
5. History of diabetes, seizures, drug abuse or overdose ?
6. Past psychiatric history ?

PRE-ARRIVAL INSTRUCTIONS

Did you see any Medic-alert tags? (neck, wrist, ankle)

If first-hand (victim on phone): keep on line if possibl

If second-hand info, tell caller to:

-Observe continuously.

-Protect victim from self (if possible to do so safely).

BEWARE OF ATTACK!

DISPATCH PRIORITIES

*ALWAYS SEND POLICE ON BEHAVIOR PROBLEMS**

BE 3

-Abnormal behavior and head injury within past 24 hours

-History of diabetes, seizures, drug abuse or overdose (if suspected/confirmed overdose or DTs, refer to Overdose card)

-Patients over 40 with no known psychiatric history

Police to advise if:

-Violent with no obvious medical problems

-Threatening suicide (notify FAD if specialized rescue might be needed – bridge, jumper, water (also consider River Patrol)).

ADDITIONAL INFORMATION

Possible causes:

-Suicide attempts / threats

-Drug abuse / withdrawal

-Alcohol abuse / withdrawal or DT's

-Emotional and/or hysterical reactions

-Psychiatric problems

-Shock (acute or delayed)

-Liver or kidney failure

NOTE: Serious medical problems such as insulin shock, severe hypovolemia, hypoxia, delirium tremens (DT's), overdose, etc. often cause behavioral problems.

NOTE: Behavior problems in persons over 40 without prior psychiatric history must be assumed to be medical in nature.

KEY QUESTIONS

1. How injured ?
2. Area bleeding ? / Still bleeding ?
3. Spurting or flowing (oozing) ?
4. Confused or sleepy ?
5. Dizzy or feeling faint ?

PRE-ARRIVAL INSTRUCTIONS

If from forceful trauma, don't move him!! If you must, try to keep his head and neck from turning or pulling, to prevent further injury.
From extremities: apply and maintain direct pressure to wound site, elevate limb above heart level (unless bones appear broken). If direct pressure fails, use pressure point. *
From head/trunk: usually can be controlled with gentle direct pressure.
SIGNS OF SHOCK: lay victim down, raise legs.
Nosebleed: Pinch nostrils, have patient lean forward (to prevent swallowing/aspirating blood)

DISPATCH PRIORITIES

BL 3 -Critical (see ADDITIONAL INFORMATION section)
-Possibly critical (see ADDITIONAL INFORMATION section)
-Large laceration or significant bleeding

BL 9/0 -Not critical

ADDITIONAL INFORMATION

Types of bleeding: Arterial vs. Venous
Internal vs. External

Control: First, direct pressure/elevation
Second, pressure points *

In most cases, external bleeding is not as serious as it may seem. Bleeding is often over-treated instead of locating and treating more serious but less obvious injuries including simple airway problems.

AMPUTATION: Control bleeding (direct pressure, elevation/pressure points). Locate part, wrap in clean dry cloth or plastic, keep cool. Do not place part directly on ice/in water.

CRITICAL	POSSIBLY CRITICAL	NON-CRITICAL
Neck	Face	Nose
Groin	Abdomen	Mouth
Chest	Back	Hands
Rectal	Arms	Fingers
Vomiting/coughing up	Legs	Buttocks
Uncontrolled	Scalp	Feet
Spurting (At any location)	Urinary	Toes
Sign of shock	Vaginal **	Tongue

PRESSURE POINTS:
* Arms - Brachial Artery : Inside upper arm, just below armpit.
Legs - Femoral Artery: Halfway between groin and hip, on crease of leg.

** During Pregnancy, refer to Pregnancy card.

KEY QUESTIONS	PRE-ARRIVAL INSTRUCTIONS
1. Choking — can victim speak ? 2. Pale or blue skin color ? 3. Chest Pain ? (Refer to Chest Pain card)	If alert and breathing, keep in most comfortable position. If choking or airway obstruction or blue skin color or unable to speak: refer to appropriate sequence card for airway, breathing or CPR instructions.

DISPATCH PRIORITIES

BR 1 -Choking or airway obstruction
-Inability to speak
-Blue skin color

BR 3 -Difficulty breathing
-Known foreign body ingestion with normal breathing and difficulty swallowing

BR 0 -All others

ADDITIONAL INFORMATION

Causes of breathing difficulties:
- -Foreign object obstructing airway
- -Asthma
- -Pulmonary Embolus (blood clot in the lungs)
- -Congestive Heart Failure (CHF)
- -Acute Pulmonary Edema (fluid in the lungs)
- -Severe allergic reactions
- -Emphysema (chronic lung disease)

Breathing problems can be secondary to:
- -Stroke (CVA)
- -Diabetic problems
- -Seizures (febrile or epileptic)
- -Cardiac Arrest
- -Overdose
- -Trauma

KEY QUESTIONS

1. Is anything still burning ?
2. Cause of burn ?
   - **Chemical:** conference with FAD
   - **Electrical:** refer to Electrocution card
3. Extent of burn ?
4. Confused or sleepy ?
5. Difficulty breathing ?

PRE-ARRIVAL INSTRUCTIONS

Make sure fire is out!!
Remove burning or smoldering clothing unless it is stuck to his skin.
Remove victim from smoky area (IF SAFE).
Signs of shock : lay flat and raise legs (unless this compromises breathing).
Burns less than 20% in adults, 5% in children, cool with cool water.
Do not break burn blisters.
Liquid chemical burns: flush immediately with water until 1st Responder arrives.
Brush off dry chemicals.
If necessary, refer to appropriate sequence card for airway, breathing or CPR instructions.

DISPATCH PRIORITIES

BU 3 -Electrical or chemical burn
-Greater than 20% burns for adults, 5% for children
-Difficulty breathing
-Signs of shock
-Facial Burns
-Second or third degree burns to hands/feet/joints (especially infants or children)

USE YOUR JUDGEMENT
IF IN DOUBT, UPGRADE!

BU 4 -ALS Ambulance C-1 standby, per Fire Service request

BU 9/0 -All others

NOTE: IF FIRE INVOLVED, NOTIFY FAD - EVEN IF FIRE APPEARS OUT

ADDITIONAL INFORMATION

Types:
- -First Degree (Sunburn)
- -Second Degree ("partial thickness" = blistering of skin)
- -Third Degree ("full thickness" = damage to all skin layers)

Approximating extent:
- -"Rule of Nines" (Diagram), large areas
- -Surface of victim's palm approx. 1%

Special problems:
- -Burns of face, hands: loss of function, airway problems
- -Smoke inhalation: airway problems
- -Electrical Burns: electrical danger, associated fractures
- -Chemical Burns: contamination/hazmat
- -Radiation Burns: contamination/hazmat

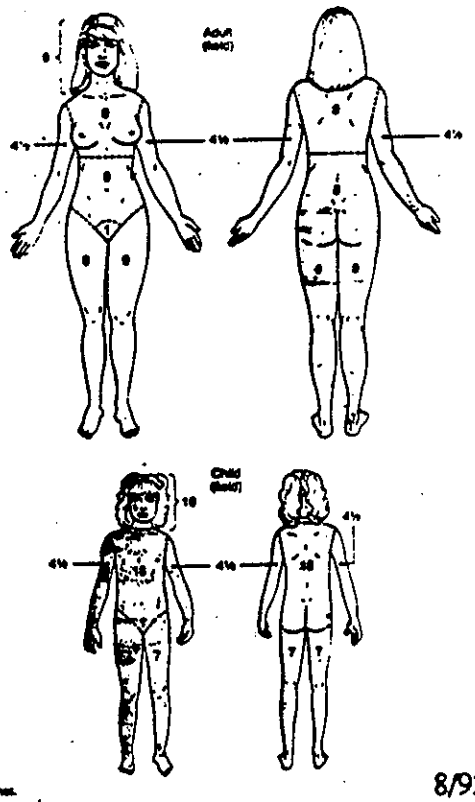


FIGURE 15-10 Rule of nines.

MAKE SURE FIRE IS OUT !!

KEY QUESTIONS

1. Chest Pain ?
2. Difficulty breathing ?
3. Pale or blue skin color ?
4. Nausea or Vomiting ?
5. Cardiac History ?
6. Abnormal heart rate (If volunteered)

PRE-ARRIVAL INSTRUCTIONS

Place victim in a comfortable position (often semi-reclining)

Loosen collar, necktie, etc.

If necessary, stay on phone with potential rescuer—CONSIDER beginning discussion of CPR

If nausea/vomiting, refer to Vomiting/Nausea card.

DISPATCH PRIORITIES

CH 1 -Chest pain with 2 or more of the following:
- Difficulty breathing
- Pale/blue skin color
- Nausea and/or vomiting
- Cardiac history
- Abnormal heart rate

CH 3 -Chest pain only (or with 1 of the above)
-Abnormal heart rate without chest pain

CH 0 -All others

ADDITIONAL INFORMATION

Critical problems:
-Heart Attack (Myocardial Infarction: "M.I.")
-Ruptured thoracic aortic aneurysm

Potentially Critical problems:
-Pulmonary Embolus:
Blood clot in lungs
-Pneumothorax:
Air outside of the lungs within the chest cavity
-Pericarditis:
Infection of the sac around the heart
-CHF (Congestive Heart Failure:
"pump failure")

Non-Critical:
-Pleurisy
-Pneumonia
-Esophagitis
-Hiatal Hernia
-Hyperventilation
-Viral illnesses

HEART ATTACK: Substernal chest pain often described as tightness, constricting band, crushing, "like someone is sitting on my chest". Possibly radiating pain to left arm, jaw, neck, or back.
-Sweating (diaphoresis)
-Nausea, "heartburn", "indigestion"
-Angina which is unusually severe or has not abated with self-administration of Nitroglycerin.

"Heart Problems" range from old rheumatic fever to benign congestive heart failure, from angina to "heart attack" (a non-specific complaint but a common one). Try to obtain symptoms which accurately pinpoint the problem. Often victims deny or fail to recognize symptoms of real heart attack. Listen for any of the above (similar descriptions.

KEY QUESTIONS	PRE-ARRIVAL INSTRUCTIONS
1. Alert ? (Able to talk normally ?) 2. Taking Insulin ? (Was it taken today ?) 3. Violent ?	Did you see any Medic-alert tags (neck, wrist, ankle)? If patient can sit up and hold a glass alone, suggest a glass of juice, sugar water, etc. If unconscious or not arousable, refer to appropriate sequence card for airway, breathing or CPR instructions.

DISPATCH PRIORITIES

DI 3 -Unconscious or confused
-Violent (send Police also)

DI 9/0 -All others

ADDITIONAL INFORMATION

NOTE: Level of consciousness is the key to determine appropriate pre-hospital response.

NOTE: Potential area for error is to confuse alcohol intoxication or DUII with hypoglycemia.

INSULIN SHOCK / HYPOGLYCEMIA (rapid onset)

Too much insulin has depleted the body's available blood sugar. Since the brain's only usable fuel is sugar, it is the first organ at risk. This is a serious medical problem if the patient is not alert. May be confused with alcohol intoxication. In insulin dependent diabetics hypoglycemia (low blood sugar) commonly occurs in late afternoon (1600 - 1700 ; peak effect if insulin taken at 0800) or midnight (if 1600 dose of insulin taken), especially if patient has not had adequate food intake.

DIABETIC COMA (gradual onset)

Unconsciousness or decreased level of consciousness secondary to the body's inability to use available blood sugar for fuel when sufficient insulin is not given. Without accurate history this problem may be difficult to tell from insulin shock. (COMA is a state of unconsciousness from which the patient cannot be aroused).

DIABETIC KETOACIDOSIS

Pre-coma state resulting from insufficient insulin. Unable to use sugar, the body burns its own tissue (fat, muscle, etc.) The ketoacids produced (ketones) are "poisonous" to the patient, making them increasingly ill. This is not a pre-hospital emergency.

KEY QUESTIONS	PRE-ARRIVAL INSTRUCTIONS
1. Is victim still in water ? 2. Time under water ? 3. Did victim dive into water ? (If traumatic injury, refer to Traumatic Injury card for pre-arrivals)	If diving or other traumatic injuries are suspected, instruct caller to avoid moving victim: try to keep his head a neck from turning or pulling, to prevent further injury. If water was very cold or victim feels very cold, suspect hypothermia. Refer to Heat/Cold card. If necessary, refer to appropriate sequence card(s) for airway, breathing or CPR instructions

DISPATCH PRIORITIES

DR 1 -Unconscious with any of the following:
- Not breathing
- Unknown if breathing
- Breathing abnormally or possibly agonal breathing

DR 3
- -Still in water, precise location not verified
- -Now conscious
- -Unconscious, breathing normally

•• Notify appropriate law enforcement agency for possible search & rescue ••
-Notify MCSO River Patrol for river incidents

ADDITIONAL INFORMATION

Victims of cold water drowning can remain under water for long periods of time before death or brain damage occurs. Cold water reduces the body's chemical need for oxygen and slows the heart rate and metabolism. Immediate CPR may be necessary when the victim is removed from the water.

Near-drowning in cold water is a type of hypothermia. In hypothermia , complete recovery may occur although the victim has been under water for one hour or longer. (A hypothermic victim should not be considered dead until he/she is rewarmed and is still lifeless).

NOTE: BE SURE TO CONSIDER TRAUMA AS POSSIBLE CAUSE/RESULT OF DROWNING.

KEY QUESTIONS	PRE-ARRIVAL INSTRUCTIONS
1. Source of electrical shock ? 2. Is victim still in contact with electrical source ? 3. Fell ? From how high ? 4. Is there a burn ? (Refer to Burn card for pre-arrival instructions)	**BEWARE OF ELECTRICAL HAZARDS** **Do not move victim unless absolutely necessary. If you must, try to keep his head and neck from turning or pulling, to prevent further injury.** Do not touch victim if still in contact with electrical source. Turn off electrical source if possible (fuse box, circuit breakers, etc.) - DONT TOUCH ANY WIRES. If necessary, refer to appropriate sequence card for airway, breathing or CPR instructions.

DISPATCH PRIORITIES

EL 1 -Unconscious
-Status unknown

EL 3 -Conscious

ADDITIONAL INFORMATION

Suspect Cardiac Arrest until consciousness and breathing verified.

Associated falls — Electrocutions occurring above the ground may result in significant falls resulting in injuries more serious than those from the electrical current itself.

Electrical burns are often deceiving in appearance as regards to severity. Internal damage from passage of current through body can be substantial with few external signs of injury.

Often entry and exit wound sites.

KEY QUESTIONS	PRE-ARRIVAL INSTRUCTIONS
1. Type of problem ? 2. Foreign body or impaled object ? 3. Any other injuries or complaints ? (also refer to appropriate card)	Lay patient down If chemical: flush eye gently with water until help arri (do not flush towards uninjured eye) If trauma, do not irrigate eye Abrasions: do not rub eye Impaled object: do not touch or remove If eyeball cut or leaking do not touch, bandage or irrigate

DISPATCH PRIORITIES

EY 3 -Chemical exposure
-Impaled object, lacerations, avulsions, punctures, orbital fractures
-Violent mechanism of injury with potential for other head/neck injury

EY 9/0 -All others

ADDITIONAL INFORMATION

Contusions:
-Orbital fractures
-Hyphema (blood in anterior chamber of eyeball)
-Retinal detachment.
-Penetrating wounds of globe.

Burns:
-Chemical : bases (lyes) are worse than acids
-Arc welding
-Flash

Contact lens problems
-A lens can hold a chemical in the eye even with irrigation.

KEY QUESTIONS

1. Cause of fall ?
2. Distance fallen ?
3. Confused or sleepy ?
4. Dizzy or feeling faint ?
5. Any obvious injuries ? (also refer to Trauma card)
6. Still down ?

PRE-ARRIVAL INSTRUCTIONS

DON'T MOVE VICTIM! If you must, try to keep his head and neck from turning or pulling, to prevent further injury.

Do not place pillow, etc. under victim's head.

Don't treat unless serious bleeding present (refer to Bleeding card).

DISPATCH PRIORITIES

FA	**1**	**-Long fall ≥20 feet** -Requires rope rescue -Signs of shock -Status unknown -Still down
FA	**3**	**-Fall <20 feet** -Signs of shock -Status unknown -Still down
FA	**9**	-"Invalid Assist" (Conference with FAD)
FA	**0**	-All others

ADDITIONAL INFORMATION

"FALLS" IS NOT A SPECIFIC DIAGNOSIS. IT COVERS MANY VARIED SITUATIONS. INQUIRE FOR SPECIFIC FACTS.

Elderly patients frequently sustain hip fractures when they fall.

A "ground level" fall (when someone is standing or sitting and just falls to the ground) may have been caused by a medical condition. Consider unconscious/fainting, seizure, stroke, etc. and go to appropriate card for additional questions.

Consider the potential for difficult extrication - industrial sites with catwalks, staircases, basements, construction sites. Advise FAD of need for additional resources.

KEY QUESTIONS	PRE-ARRIVAL INSTRUCTIONS
1. Type of injuries ? 2. Number of victims ? (consider MCI) 3. Is extrication necessary ? 4. Name of product ? (Spelling ?) 5. Are there product markings or labels ? 6. What is the source and quantity of product released ?	Do not touch victim or enter area unless the product identified and appropriate protective clothing is wo IF NO DANGER TO RESCUER, remove victim(s) from toxic environment and keep victim(s) isolated. Establish specific location for someone to meet and guide responding units to incident site. Advise caller that there may be more than one unit arriving.

DISPATCH PRIORITIES

If source is a toxic or unknown substance, do not dispatch anyone yet - CONFERENCE WITH FAD AND DISPATCH PER THEIR INSTRUCTIONS.

INFORM ALL RESPONDING PERSONNEL OF POTENTIAL DANGER, AND PROVIDE SPECIAL INSTRUCTIONS WHEN AVAILABLE - If field personnel request air ambulance, relay all HazMat info to aeromedical crew/dispatch.

HM 1 -One or more victims

HM 9 -All others

ADVISE ALL RESPONDERS TO STAGE UNTIL CLEARED FOR ENTRY BY HAZMAT UNIT(S)

ADDITIONAL INFORMATION

Toxic gasses may be colorless, odorless, and tasteless (example: Carbon Monoxide). Signs/symptoms can range from headache to unconsciousness: victim can present in any state of intoxication or altered mental status.

Very small quantities of toxic substances can be fatal.

Contamination is often not visible.

Anyone who handles a contaminated victim must also be decontaminated.

NOTE: Personnel on scene should:

Remove as much of contaminating substance as possible from victim before transporting.
If possible, wrap contaminated victim prior to transport - to reduce contamination spread.
Notify MRH/Poison Control of nature of product as soon as possible.
Notify receiving facility of situation and wait for their directions before transferring patient.

NOTE: HazMat team response or any appropriate increase in response level should be determined by FAD.

KEY QUESTIONS	PRE-ARRIVAL INSTRUCTIONS
1. Recent trauma to head ? (refer to Trauma card) 2. Any periods of unconsciousness, confusion or behavioral changes ? 3. Sudden onset ? 4. Speech or motor problems ? 5. Changes in vision ? 6. Is this the worst headache you've ever had ?	Make patient comfortable. Reassure and keep her as calm as possible.

DISPATCH PRIORITIES

HE 3
- -Periods of unconsciousness, confusion or behavioral changes
- -Sudden onset
- -Severe speech or motor problems
- -Changes in vision
- -Worst headache

HE 0
- -All others

ADDITIONAL INFORMATION

TYPES:
- -Tension
- -Sinus
- -Migraine
- -Cluster
- -Meningitis
- -Subdural Hematoma
- -Subarachnoid Hemorrhage

Since the brain is the organ of concern in victims with headache, changes in alertness, behavior, or speech and motor function (paralysis, weakness) all indicate a more serious underlying problem.

Sudden, severe onset may also suggest a more serious underlying cause.

KEY QUESTIONS		PRE-ARRIVAL INSTRUCTIONS
HEAT	1. High temperature of victim ? 2. Skin dry, face red/flushed ? 3. Confused, acting strangely, staggering ? 4. Skin cold, clammy, sweaty ? 5. Muscle Cramps ?	**HEAT** Take victim out of sunlight/hot environment. Use cool cloths/wet sheets to reduce temperature. Lie victim flat and elevate feet. If vomiting or nauseous, refer to V/N card for instructions.
COLD	1. Unresponsive ? 2. Frozen extremities ? 3. Confused or acting strangely ? 4. Length of time in cold ?	**COLD** Give nothing by mouth Avoid excessive movement Wrap with blankets Frostbite; minimal treatment -protect injured area - DO NOT RUB or immerse in hot water.

DISPATCH PRIORITIES

HEAT

HC	**1**	-High body temperature, skin dry or face red/flushed -Confused, acting strangely or staggering
HC	**3**	-Skin cold, clammy, sweaty -Muscle cramps
HC	**0**	-All others

COLD

HC	**1**	-Unresponsive -Frozen extremities
HC	**3**	-Confused or acting strangely
HC	**0**	-All others

ADDITIONAL INFORMATION

HEAT: If temperature has been taken, a "high" reading is greater than 102° F (38.8°C).

	Heat Exhaustion	Heat Stroke
Mental State------	May be disoriented----------	Confused or coma
Temperature------	Normal or low----------	Very high
Skin----------	Cool, pale, moist----------	Hot, red, dry
Pulse----------	Rapid, weak----------	Rapid, strong, full
Treatment--------	Cooling----------	Rapid cooling

HEAT STROKE IS A PROFOUND EMERGENCY !!

COLD: Consider hypothermia in the elderly, the alcoholic and the patient found outdoors, particularly during the cold/freezing seasons. It is possible to become hypothermic in temperatures above freezing, indoors as well as outdoors. Wet and/or windy environments increase risk.

Severe Hypothermia : Skin ice cold, rigid muscles, little or no heart sounds. May appear dead. Handle very gently.

"Nobody is dead until they are warm and dead"

KEY QUESTIONS

1. Specific traumatic injuries ?* Bleeding ?*
2. Trapped / caught in machinery ?
3. Fallen ?*
4. How many injured ?
5. Specific location of victim(s) ?

*If necessary, refer to appropriate card.

PRE-ARRIVAL INSTRUCTIONS

TURN OFF MACHINERY !!

Don't move victim unless location increases danger. If you must move him, try to keep his head and neck from turning or pulling, to prevent further injury.

Assign specific location for someone to meet and guide responding units — advise caller that there may be more than one unit arriving.

DISPATCH PRIORITIES

TR 1 -If extrication is needed
-If more than one victim

TR 3 -If unknown type of injuries or unknown if extrication is needed
-Any industrial/machinery accident for which specific information cannot be obtained.

ADDITIONAL INFORMATION

Generally will be a third party caller.

It is very important to determine if extrication from machinery is needed.

It is often difficult to locate the victim in plants, warehouses, hold of ships, construction sites, etc. — **GET CLEAR DIRECTIONS**

20 INDUSTRIAL / MACHINERY ACCIDENT 8/92

KEY QUESTIONS

1. Difficulty breathing ?
2. Confused or disoriented ?
3. Source of toxic substance ?
4. How many victims ?

NOTE: "Sniffing" glue, etc. is an Overdose problem - see Overdose card.

PRE-ARRIVAL INSTRUCTIONS

DO NOT TOUCH VICTIM OR ENTER AREA UNTIL PRODUC IDENTIFIED OR UNTIL PROPER PROTECTIVE CLOTHING WORN.

IF NO DANGER TO RESCUER, REMOVE VICTIM FROM TO... ENVIRONMENT AND KEEP VICTIM ISOLATED

If necessary, refer to appropriate sequence card for airway breathing or CPR instructions.

Assign specific location for someone to meet and guide responding units.

Advise caller that there may be more than one unit arriving.

DISPATCH PRIORITIES

•• IF SOURCE IS A TOXIC OR UNKNOWN SUBSTANCE, REFER TO HAZMAT CARD ••

•• NOTIFY ALL RESPONDING PERSONNEL OF POTENTIAL DANGER AND PROVIDE SPECIAL INSTRUCTIONS WHEN AVAILABLE ••

IN	1	-If patient has not been removed from toxic environment -Unconscious or condition unknown. -Difficulty breathing or confused
IN	9/0	-All others

MULTIPLE VICTIMS : Consider activation of MCI plan.

ADDITIONAL INFORMATION

Toxic gasses may be colorless, odorless and tasteless (e.g., Carbon Monoxide). Symptoms can range from headache to unconsciousness and victim can present in any state of intoxication.

Very small quantities of toxic substances can be fatal.

21 INHALATION POISONING 8/92

KEY QUESTIONS

1. What is the reason that you think he has a medical emergency ?
2. Did you see him fall ?
3. Did you see him get injured or assaulted ?
4. Is he bleeding ?
5. Is he moving ?

Get a physical description of the patient

MAKE EVERY ATTEMPT TO DETERMINE SPECIFIC FACTS AND REFER TO THE APPROPRIATE CARD

PRE-ARRIVAL INSTRUCTIONS

Did you see any medic-alert tags (neck, wrist, ankle)?

Look for and direct responders to the victim.

Inform caller that there may be a delay in response.

If necessary, refer to appropriate sequence card for airway, breathing or CPR instructions.

DISPATCH PRIORITIES

MN 9 -Unknown problem

Send CHIERS (W26) if patient located within their Central City District

Send Police if patient outside W26 area or W26 is unavailable.

If specific information is discovered after the call is dispatched, inform all responders and send additional units as needed. Add new information to the incident immediately.

ADDITIONAL INFORMATION

"MAN DOWN" IS NOT A SPECIFIC DIAGNOSIS. IT COVERS MANY VARIED SITUATIONS. INQUIRE FOR SPECIFIC FACTS.

Only one card in the Triage Guidelines asks if the caller/victim has ingested alcohol — the Overdoses/ Poisoning/Ingestion card. Information regarding a subject's state of intoxication may be offered by the caller, but this info should not be used in determining response.

The intoxicated person may also have a legitimate medical emergency — calltakers should be wary of assuming that a reportedly intoxicated person is "just a drunk". Diabetes, head injuries, and other serious medical emergencies can "mimic" inebriation.

KEY QUESTIONS

1. Confused or drowsy ?
2. What and how much ingested ?
   How long ago ?
   Alcohol also ingested ?
3. DT's or withdrawal ?

PRE-ARRIVAL INSTRUCTIONS

Gather medications / pill bottles, etc.

If appropriate, or if caller is the patient, stay on line with caller until help arrives.

If necessary, refer to appropriate cards for vomiting, airway, breathing or CPR instructions.

DISPATCH PRIORITIES

OD 1 -Unconscious

OD 3 -Confused or drowsy
-Alcohol taken with drugs
-Suspected or confirmed DT's or withdrawal
-Condition unknown

All other ingestions / overdoses : Conference with Poison Control Center and await their instructions.

ALL overdoses : refer to Police.

ADDITIONAL INFORMATION

IF THE CALLER IS THE PATIENT, KEEP HIM/HER ON THE LINE UNTIL HELP ARRIVES !

Overdose: Intentional act by victim.

Ingestion: Denotes accidental intake

Most ingestions by children can be handled by the Oregon Poison Control Center (OPCC).

All calls referred to the Oregon Poison Control Center will be evaluated by them and necessary units dispatched per recommendation. If appropriate, stay on line with OPCC until OPCC determines no need for emergency response.

Because overdose victims have a motive for their action (suicide, attention getting, a "cry for help", etc) they often are misleading about the amount or type of medication taken. They may also exhibit violent and/or unpredictable behavior. Make sure that all responders are aware of unusual circumstances!!

DT's (Delirium Tremens) is associated with alcohol withdrawal and can cause tremors, convulsions, and hallucinations. Delirium Tremens has a mortality rate of up to 20%.

Patients who are addicted to drugs may experience a severe reaction when the drug is withdrawn. These reactions are characterized by anxiety, nausea, vomiting, convulsions, delirium, profuse sweating, rapid heart rate, hallucinations, and severe abdominal cramps.

KEY QUESTIONS

1. Bleeding ? How much ?
2. Months pregnant ? First pregnancy ?
3. Type of pain ? (bearing down, contraction)
4. Frequency of pain ?
* 5. Mother pushing or baby's head crowning ?
* 6. If delivered, is baby conscious & breathing ?
7. Seizures ? (Refer to seizure card)

PRE-ARRIVAL INSTRUCTIONS

IMMINENT BIRTH: See Childbirth Sequence Ca

Do not pack anything into the vagina to control bleeding. Use pads/towels to absorb.

Do not attempt to stop delivery !

If necessary, refer to appropriate sequence card for airway, breathing or CPR instructions.

DISPATCH PRIORITIES

OB	1	-Excessive bleeding during 3rd trimester, before or after delivery. -Delivery has just occurred, is occurring now, or is imminent * -Abnormal presenting body part. -New onset seizure activity (if seizing now, refer to seizure card pre-arrivals)
OB	3	-Excessive bleeding during 1st or 2nd trimester.
OB	0	-All others

ADDITIONAL INFORMATION

* **IMMINENT:** Pains less than 2 minutes apart in first pregnancy, less than 5 minutes apart in second or more pregnancy, rapid progression of labor, head crowning or mother pushing.

In general, initial pregnancies progress through labor slower than successive pregnancies. Therefore, labor pains two minutes apart in a third pregnancy are considered more urgent than in a first pregnancy.

Stages of pregnancy:
1st trimester - 0 - 3 months
2nd trimester - 4 - 6 months
3rd trimester - 7 - 9 months (to delivery)

NOTE: Presentation of the cord, hands or feet first as baby delivers is a dire pre-hospital emergency. Often the only chance for the baby's survival is rapid transport for in-hospital care.

Contraction = Labor pains from contractions of the uterus.

Bearing down = May mean the mother is physically attempting to push the baby through the birth canal or that the mother feels that she has to move her bowels. This is caused by baby's head pressing on the mother's rectum. (birth is imminent!)

Crowning: Top of baby's head showing at vagina (birth is imminent!)

Bleeding and/or pain during the first or second trimester may be a sign of miscarriage/ectopic pregnancy or other problems.

Some bleeding always occurs at delivery. More than 5 blood-soaked pads is considered excessive bleeding (before or after delivery).

REMEMBER: After delivery there are two patients!!

If the mother tells you that "The baby is coming!" — it usually is.

KEY QUESTIONS

1. Has the seizure stopped ?
2. More than 1 seizure in a row ?
* 3. Pregnant ? (Refer to Pregnancy card)
4. High fever ?
5. Any associated trauma ? (Refer to Trauma card)

PRE-ARRIVAL INSTRUCTIONS

No CPR on seizing patient.
Do not restrain patient or force objects into his / her mo
Move dangerous objects away from patient.
Turn gently on side after seizure stops.
Don't let patient wander about.
Refer to vomiting card instructions if vomiting occurs.
Instruct caller to call back if patient has another seizure.

DISPATCH PRIORITIES

SZ 3 -Still seizing
-One or more seizures
-Febrile seizure, child 5 years or younger (even if not seizing now)

SZ 9 -Not seizing now
-If caller is patient and says he/she thinks a seizure is imminent.

SZ 0 -All others

ADDITIONAL INFORMATION

*Seizures during the third trimester of pregnancy (eclampsia) may indicate a serious complication of pregnancy which may be life threatening to the woman and child.

Also known as "fits" or epilepsy.

A seizure is an abnormal firing of brain cells, a "short circuit" resulting in random patterns of emotion or motion.

Types: Grand mal, Petit mal ("absence"), Psychomotor, Jacksonian, Focal.

Causes: Epilepsy, trauma, meningitis, cardiac arrest (specifically from hypoxia —lack of Oxygen to the brain), fever, DT's, many others.

Associated problems: Airway (patient position, secretions, vomitus), cyanosis, oral trauma (bitten tongue or cheek), fractures (from "thrashing about"), inappropriate CPR and mouth-to-mouth, post-ictal state (patient is "spaced out"), recurrent or continuous seizures (Status Epilepticus — very serious).

KEY QUESTIONS	PRE-ARRIVAL INSTRUCTIONS
1. What is different today ? 2. Confused or hard to arouse ? 3. Dizzy or feeling faint ? 4. Does something hurt ? 5. Duration of illness ? 6. Suspected cause ? History ? Dialysis or Transplant patient ? 7. Fever ?	Make patient as comfortable as possible. Monitor breathing.

DISPATCH PRIORITIES

SK 3 -Confused or hard to arouse
-Dizzy or feeling faint.
-Other signs of shock
-Dialysis patient
-Transplant patient

SK 0 -Unknown status
-Fever only, no emergency signs or symptoms.

NOTE: If vomiting the only sign or symptom, see VOMITING card.

ADDITIONAL INFORMATION

Complaints such as Cancer, Leukemia, chronic illness, dehydration, infection, meningitis, etc. elicit an emotional response from dispatchers because the terms seem serious. Stick to obtaining signs and symptoms that can be prioritized.

26 SICK PERSON / CHRONIC ILLNESS 8/92

KEY QUESTIONS

1. Confused or hard to arouse ?
2. Difficulty breathing ?
3. Headache ?
4. Victim able to move both sides of body ? (weakness/paralysis on one side ?)
5. Slurred or difficult speech ?
6. Facial droop or drooling ?
7. History of previous stroke ?

PRE-ARRIVAL INSTRUCTIONS

REASSURE VICTIM

Lay patient down.

No pillows behind head (can cause airway problem

If difficulty breathing, position of comfort (may be lying down or semi-reclining)

Check airway. If vomiting or drooling, turn head to side. If necessary, refer to appropriate card for airway, breathing or CPR instructions.

DISPATCH PRIORITIES

ST	**3**	-Confused or hard to arouse -Any difficulty breathing -Headache -Weakness or paralysis of one side -Slurred or difficult speech -Facial droop or drooling?
ST	**0**	-All others

ADDITIONAL INFORMATION

The airway may become obstructed by the patient's tongue (due to loss of gag reflex from nerve damage).

Definition: Disruption of blood flow to the brain or part of the brain due to blood clot or hemorrhage. Hemorrhage also causes increased pressure within the skull. Clots are usually spontaneous while hemorrhage is either spontaneous or traumatic.

Paralysis or weakness of one side, altered level of consciousness and respiratory changes are all common symptoms. Other than supportive care there is no specific pre-hospital treatment.

C.V.A = CerebroVascular Accident.

T.I.A. = Transient Ischemic Attack ("little stroke"= stroke-like symptoms that resolve quickly)

NOTE: Many stroke victims are unable to talk or respond, but are very aware of everything around them. Reassurance is very important. Talking about them or their condition as if they cannot hear or understand may greatly increase their feelings of helplessness, anxiety and/or panic.

KEY QUESTIONS	PRE-ARRIVAL INSTRUCTIONS
1. What happened ? (Refer to list in ADDITIONAL INFORMATION section) 2. Any injuries ? 3. Number of victims ? 4. Anyone trapped or pinned ? 5. Any hazards at the scene ? (fire, leaking fuel, hazmat, toxic fumes, etc.)	Don't move victims unless immediate danger — (fire, leaking fuel, hazmat, toxic fumes, etc.) If you must move him, try to keep his head and neck from turning or pulling, to prevent further injury. Don't treat unless serious bleeding (If necessary, refer to Bleeding card.)

DISPATCH PRIORITIES

• • IF HAZARDOUS MATERIALS / CARGO VEHICLES INVOLVED, *CONFERENCE WITH FAD* • •

TA 1 -Reported 2 or more victims (consider MCI potential)
-Victim(s) pinned in, trapped, or unconscious
-Hazards at scene with known victim(s)
-Violent Mechanism of Injury * (REFER TO LIST IN ADDITIONAL INFORMATION SECTION)

TA 3 -Known injuries

ADDITIONAL INFORMATION

***VIOLENT MECHANISM OF INJURY** = A type of incident which, by its very nature, significantly increases the possibility of serious injury due to the large amount of energy involved. Always a TA 1.

Examples:	- Auto vs. pedestrian	- Any high-speed accident
	- Auto vs. bicycle	- Passengers thrown from vehicle
	- Any motorcycle accident	- Vehicle on its top, off bridge, etc.
	- Rollover	- Extensive damage to vehicle(s)

Always inform ALL responding agencies (police, fire and/or medical) if there is any possibility of hazardous materials involved and provide special instructions when available.

In single vehicle accidents (car vs. pole, car into ditch, etc.) consider medical cause, e.g. M.I., diabetic problem fainting, etc.

Consider dispatching additional units/resources if multiple patient situation — Estimate 1 transporting unit for each 2 patients. (MCI?)

If responders at scene report no traffic accident located, notify other responding agencies.

IF IN DOUBT, UPGRADE THE RESPONSE.

KEY QUESTIONS

1. What happened ?
2. Number of victims ? (Consider MCI)
3. Victim(s) trapped or pinned ?
4. Part(s) of body injured ?
5. Open fractures ? Amputation?
6. Difficulty breathing ?
7. Confused or sleepy ?

PRE-ARRIVAL INSTRUCTIONS

Don't move victim unless immediate danger —
(fire, hazardous materials, toxic fumes, etc.)

If you must move victim, try to keep his head and neck from tu
or pulling, to prevent further injury.

Don't splint

If bleeding, apply and maintain direct pressure to wound site.

If severe bleeding or amputation, refer to Bleeding card.

Industrial Accident: see Industrial Card

DISPATCH PRIORITIES

TR 1 -CRITICAL (refer to list in ADDITIONAL INFORMATION section)
Also: -Reported two or more victims (consider MCI)
-Victim(s) pinned in, trapped or unconscious
-Hazards at scene with known victim(s)
-Violent mechanism of injury**

TR 3 -POSSIBLY CRITICAL or NON-CRITICAL (refer to list in ADDITIONAL INFORMATION section)
--with signs of shock, excessive bleeding, open fracture or amputation.

TR 9/0 -POSSIBLY CRITICAL or NON-CRITICAL (refer to list in ADDITIONAL INFORMATION section)
--with NO signs of shock, excessive bleeding, open fracture or amputation.

IF IN DOUBT, UPGRADE!!

ADDITIONAL INFORMATION

Types of Injuries:

Fracture (break)	Contusion (bruise)	Laceration (cut)
Dislocation (out-of-joint)	Abrasion (scrape)	Avulsion (torn away)

CRITICAL	POSSIBLY CRITICAL		NON-CRITICAL	
Head	Back	Clavicle	Fingers	Toes
Neck or Spine *	Pelvis/Hip	Shoulder	Hands	Feet
Chest, ribs, sternum	Femur	Genitalia	Wrist	Ankle
Abdomen	Arms	Tibia (shin)	Elbow	Knee

**VIOLENT MECHANISM of INJURY: A type of incident which, by its very nature, significantly increases the possibility of serious injury due to the large amount of energy involved.

* A patient with spinal cord injuries may have one or more of the following:
1. Tingling sensation or numbness in arms or legs
2. Inability to move
3. No pain (with obviously serious injuries)

AVOID ANY UNNECESSARY MOVEMENT WITH POSSIBLE SPINAL CORD INJURIES ! !

NOTE: IF multiple victims with known central wounds, use your judgement in determining additional respo
or notifications. Consider MCI or HazMat potential.

KEY QUESTIONS

1. Breathing ? (see Additional Info)
2. Now conscious ?
3. Cause / history of unconsciousness ? (What happened ?).

PRE-ARRIVAL INSTRUCTIONS

Did you see any medic-alert tags (neck, wrist, ankle)?

* BREATHING CHECK

** PULSE CHECK

If necessary, refer to appropriate sequence card for airway, breathing or CPR instructions.

DISPATCH PRIORITIES

UN 1

-Unconscious, not breathing
-Unconscious, not known if breathing
-Unconscious, abnormal or possible agonal breathing

UN 3

-Unconscious, breathing normally
-Semi-conscious (confused, hard to arouse) and breathing (if with difficulty, refer to BREATHING card)
-Now conscious and breathing (if with difficulty, refer to BREATHING card)

ADDITIONAL INFORMATION

*** BREATHING CHECK:** Place your ear next to his/her mouth and nose and look toward the chest. Can you feel or hear any air movement? Is there fluid, bubbles or anything else in the mouth or nose? Do you see the chest or stomach moving? Place your hand on his/her stomach. Can you feel it rising or falling?

**** PULSE CHECK: Child/Adult:** Place your index and middle finger into the groove next to his/her Adam's Apple. DON'T PRESS TOO HARD! Feel for a pulse for 5 seconds.

Infant: Place your index and middle finger over the baby's left nipple. DON'T PRESS TOO HARD! Feel for a pulse for 5 seconds.

AGONAL BREATHING: Gasping, ineffective breaths that often occur at the time of Cardiac Arrest. The caller may describe the person as "breathing funny, breathing weird, gasping, making funny noises, etc."

SIGNS OF SHOCK: Confused/sleepy; skin cool/moist, pale/blue; nausea/vomiting; dizzy/faint.

SOME CAUSES OF UNCONSCIOUSNESS:

- Cardiac Arrest (sudden onset)
- Other heart problems
- Overdose, poisoning, intoxication
- Diabetic problems
- Respiratory problems
- Seizures
- Syncope (fainting)
- Head Injury (old or new)
- Stroke (CVA)

KEY QUESTIONS

1. What is the reason that you think she has a medical problem ?
2. Does she have any known history of medical problems ?
3. Is she breathing normally ?
4. Have you spoken with her ?
5. Can she talk in her usual manner ?
6. Is she able to move ?

MAKE EVERY ATTEMPT TO DETERMINE SPECIFIC FACTS AND REFER TO THE APPROPRIATE CARD

PRE-ARRIVAL INSTRUCTIONS

Did you see any medic-alert tags (neck, wrist, ankle

Look for and direct responders to the victim.

If necessary, refer to appropriate sequence card for airway, breathing or CPR instructions.

DISPATCH PRIORITIES

UK 3 -Caller indicates severe medical problem but is unable to describe specific signs or symptoms.

UK 9 -Unverified medical alarm from a licensed alarm company.
-If patient <u>can be seen</u> with obvious medical problem.

NOTE: If specific information is discovered after call is dispatched, inform responders and send additional units as needed. Add new information to the incident immediately.

ADDITIONAL INFORMATION

"UNKNOWN PROBLEM" IS <u>NOT</u> A SPECIFIC DIAGNOSIS. IT COVERS MANY VARIED SITUATIONS. INQUIRE FOR SPECIFIC FACTS.

Location of victim could suggest type of problem likely to be encountered:

Restaurant ---------- may suggest ---------- Choking
Seafood Restaurant --- may suggest ---------- Choking, severe allergic reaction
Garage ---------- may suggest ---------- Carbon Monoxide poisoning, electrocution
Bank ---------- may suggest ---------- Cardiac arrest
Park ---------- may suggest ---------- Intoxication, OD, choking, assault
Street ---------- may suggest ---------- Intoxication, cardiac arrest, seizure, OD, assault

Relay <u>type</u> of location and/or business name (if known) to responding units, not just address.

KEY QUESTIONS

1. Any other symptoms ?
2. Vomiting blood or "coffee ground" type material
3. Level of consciousness ?
4. Confused or sleepy ?

PRE-ARRIVAL INSTRUCTIONS

TRAUMA VICTIM: Don't move him!! If you must, try to keep his head and neck from turning or pulling, to prevent further injury.

If unconscious, turn head to side or roll entire body to side. Scoop matter out of mouth.

If semi-conscious, make sure victim can clear own airway. If not, assist as above.

If patient in semi-reclining position of comfort, lean them forward or to side. Laying them down may compromise breathing.

SHOCK: Lay down, elevate legs.

DISPATCH PRIORITIES

AB	**3**	-Vomiting bright red blood or dark "coffee ground" substance.
SK	**3**	-Vomiting with signs of shock
SK	**0**	-Vomiting only, no other symptoms

ADDITIONAL INFORMATION

The biggest danger from vomiting is aspiration (inhalation) of the vomitus. Whenever a patient's state of consciousness is such that they cannot protect their own airway, steps must be taken to protect the patient from aspiration (hence turning head to side, rolling body to side, etc.). Aspiration of any petroleum-based substance can cause chemical pneumonia, which can also be fatal.

Nausea can be symptomatic of a wide range of problems, from tension/nervousness to life threatening problems like heart attack or shock.

Vomiting is a normal bodily reaction to rid the stomach of its contents. In the case of food that disagrees with the body, vomiting itself may solve the problem.

Nausea/vomiting may be one of the signs of heart attack, shock, overdose of some drugs; bloody vomitus can indicate internal bleeding from ulcer, trauma, etc. "Coffee ground" vomitus is partly digested blood from chronic internal bleeding.

PRE-ARRIVAL SEQUENCE CARDS

Encourage caller to bring victim as close to phone as possible.

Ask the caller : "Do you or anyone else there know CPR ? ". If he knows CPR, find out if he needs assistance and him you can assist with telephone instruction.

Use the following statement : "Do you want to do CPR — I'll help you!!" This statement should be recited as one sentence with NO break after "CPR". Do not allow caller to say no because she doesn't know CPR. This should be a forceful and persuasive statement, but if the caller declines for any reason that is her decision and you no longer have verbal consent to proceed. Coercion should NOT be used. Callers may be physically unable to perform CPR or they might be placed in physical jeopardy by performing CPR - Allow THEM to make the decision.

Follow the sequence card exactly. Slight changes in wording can change the effectiveness of CPR. CPR is ineffective on a soft surface - ensure that the patient is on a hard surface (table or floor) before attempting chest compressions.

Reassure the caller frequently that help is on the way.

THE SEQUENCE CARDS CANNOT POSSIBLY INCLUDE THE ANSWER TO EVERY SITUATION. THE CALL-TAKER MUST MAKE DECISIONS USING JUDGEMENT AND EXPERIENCE.

The "hysteria threshold" is the point at which an operator can gain control of a seemingly hysterical or uncooperative caller, and can begin to give effective pre-arrival instructions. The calltaker must realize that this threshold exists and can be reached in almost all cases if the calltaker doesn't give up before obtaining control of the caller. "Repetitive Persistence," repeating a phrase or request over and over without changing the wording or structure, is a very effective way to reach this "hysteria threshold". Example: "You must be calm so you can help your baby" (repeat). The consistent phrase should eventually "break through" to the agitated/hysterical caller and enable the calltaker to regain control and proceed with instructions.

AIRWAY CONSIDERATIONS

Airway control and maintenance is the most important aspect of emergency care for the critically ill or injured patient. Insuring that proper instructions are given and appropriate pre-arrival sequence cards are followed is of paramount importance. There may be some patients who are obviously breathing who need types of airway management that are not included in the sequence cards.

In all situations (except pre-arrivals, DIABETIC PROBLEMS), do not encourage or sanction the giving of any food or drink prior to the arrival of responders.

Always check for and remove loose dentures if the patient needs any type of airway support.

A pillow, blanket, etc. may have been placed under the victim's head "to make him more comfortable." HOWEVER, this action can flex the neck forward and compromise/obstruct the patient's airway and/or worsen a neck injury. CAUTION YOUR CALLER TO AVOID IT.

If unconscious and vomiting, turn patient's head to side or roll entire body to side. Scoop vomitus out of mouth.
If trauma victim, "log roll" patient to side; try to keep the head and neck from turning or pulling, to prevent further injury.

If semi-conscious, make sure patient can clear his/her own airway. If not, assist as above. Patient may bite rescuer while "scooping" vomitus out. CAUTION CALLER TO BE CAREFUL!!

If patient is in a semi-reclining position of comfort, lean him forward or to the side. Laying him down may compromise his breathing. Find position most comfortable to patient and most supportive of effecti respirations.

HELP IS ON THE WAY! LISTEN CAREFULLY ! I'll tell you how to help your baby.
(If caller hysterical: YOU MUST BE CALM SO YOU CAN HELP YOUR BABY. [Keep repeating until calm.])
Bring the baby near the phone.
Is the baby still choking? Is the baby able to breathe?

CHOKING - NOT BREATHING

Is he coughing or wheezing ? — YES

NO

Is he able to speak or cry ?

NO

YES → Do not do anything now. Wait until EMT's arrive. →

NOT CHOKING - NOW BREATHING

Check his mouth for objects. If you see something, use your finger to sweep it out of the mouth.

If unconscious, slightly tilt his head BACK to keep his throat open. STAY ON THE LINE WITH ME!

** Lay him FACE DOWN across your arm or lap with his HEAD LOWER THAN HIS BODY (Support his head).
Deliver 4 sharp blows with the heel of your hand right between his shoulder blades.
Look in his mouth. Do you see an object?

NO

Lay the baby FACE UP on hard surface

YES

Use your finger to sweep it out of his mouth. Is it out? — YES

NO

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Place 2 fingers in the MIDDLE of the CHEST right BETWEEN THE NIPPLES. Make sure your FINGERS are on the CENTER of the CHEST, RIGHT BETWEEN THE NIPPLES.

PUSH with your fingertips UP AND DOWN rapidly 4 times, like you're "PUMPING" the chest.

Look in the mouth. Can you see an object? — YES

NO

Is he breathing now? — YES → If unconscious, slightly tilt his head BACK to keep his throat open. STAY ON THE LINE WITH ME!

NO

Repeat from **.

NO AGAIN

Is he breathing or moving — YES → If unconscious, slightly tilt his head BACK to keep his throat open. STAY ON THE LINE WITH ME!

NO

GO TO INFANT: MOUTH-TO-MOUTH CARD (35)

HELP IS ON THE WAY! LISTEN CAREFULLY ! I'll tell you how to help your baby. (If caller hysterical: YOU MUST BE CALM SO YOU CAN HELP YOUR BABY. [Keep repeating until calm.])

Bring her near the phone.

Put the baby flat on her back on a table or the floor.

Place your HAND UNDER her NECK AND SHOULDERS and SLIGHTLY TILT her HEAD BACK.

Is there vomit in her mouth? — YES

NO

VOMITING INSTRUCTIONS: Turn her HEAD to the SIDE. SCOOP MOUTH OUT (before you start Mouth-to-Mouth.).

REMEMBER: Do this any time vomiting occurs — YOU MUST BLOW THROUGH THE REMAINING FLUID.

Is she breathing now?

NO

YES

Maintain SLIGHT HEAD TILT and check her breathing often.

Do you or anyone else there know CPR? (If so, STAY ON THE PHONE and relay sequence to ensure they're doing it properly.)

I'm going to tell you how to give MOUTH-TO-MOUTH. First, tilt her head back like you did before.

** COMPLETELY COVER her MOUTH AND NOSE with your MOUTH.

Blow 2 SLOW BREATHS OF AIR into her LUNGS, just like you're filling up a SMALL balloon.

Watch for her chest to rise.

Go do it now and then come right back to the phone.

Did you see her CHEST RISING when you blew in the air... Did you feel the AIR GOING IN? — YES

NO

MAKE SURE HER HEAD IS TILTED BACK SLIGHTLY. (Go back to ** , repeat the sequence, and BLOW A LITTLE HARDER.) — YES - NOW

NO AGAIN

Go to INFANT: CHOKING CARD (34)

I'm going to tell you how to check for the pulse.

* Place your INDEX AND MIDDLE FINGER over her LEFT NIPPLE. DON'T PRESS TOO HARD. FEEL for a PULSE for 5 SECONDS.

Do you FEEL A PULSE?

YES

++ Continue Mouth-to-Mouth. Blow 1 SLOW BREATH into her ONCE EVERY 3 SECONDS. Go do this now, BUT DON'T HANG UP! KEEP THE LINE OPEN and tell me if she starts to breathe on her own...Is she breathing on her own?

NO

Continue Mouth-to-Mouth

YES

STOP Mouth-to-Mouth and monitor. If breathing stops again: Go back to * and repeat.

NO

Go to INFANT: COMPRESSIONS CARD (36)

HELP IS ON THE WAY! LISTEN CAREFULLY ! I'll tell you what to do next.

(Bring the baby near the phone). Place him on his back on a hard surface (table or floor).

Place 2 fingers in the MIDDLE of his CHEST right BETWEEN THE NIPPLES. Make sure your FINGERS are in the CENTER of the CHEST, RIGHT BETWEEN THE NIPPLES.

PUSH with your fingertips STRAIGHT UP AND DOWN rapidly 5 times, like you're PUMPING the chest.

Then put your HAND UNDER the NECK AND SHOULDER area so that his HEAD is SLIGHTLY TILTED BACK.

Put your MOUTH over his NOSE AND MOUTH.

* Blow in 1 SLOW BREATH OF AIR and then PUMP the CHEST again rapidly 5 times.

Repeat cycle 4 times and then come right back to the phone.

** Check for a pulse:

Place your INDEX AND MIDDLE FINGER over his LEFT NIPPLE. DON'T PRESS TOO HARD. FEEL for a PULSE for 5 SECONDS.

8/92

Do you FEEL A PULSE?

NO

Keep repeating *, checking for a pulse every 4th time. Make sure his head is tilted back to keep his airway open.

KEEP DOING IT UNTIL HELP CAN TAKE OVER OR UNTIL HE STARTS TO BREATHE ON HIS OWN.

If he starts breathing on his own: STOP CPR AND MONITOR CLOSELY.

If he STOPS breathing again: Go back to **.

YES

Maintain HEAD TILT and monitor breathing often. IF NOT breathing:

Go to ++ on INFANT: AIRWAY/MOUTH-TO-MOUTH CARD (35) and give MOUTH-TO-MOUTH instructions.

VOMITING INSTRUCTIONS:	Turn his HEAD to SIDE. SCOOP MOUTH OUT. YOU MUST BLOW THROUGH THE REMAINING FLUID.
REMEMBER: Do this anytime vomiting occurs.	

HELP IS ON THE WAY! LISTEN CAREFULLY ! I'll tell you how to help your child. (If hysterical: YOU MUST BE CALM SO YOU CAN HELP YOUR CHILD. [Keep repeating until calm.])
Bring her near the phone.

Is she still choking? Is the child able to breathe?

CHOKING - NOT BREATHING

Is she coughing or wheezing? — YES → Don't do anything now. Wait until EMT's arrive.

NO

Is she able to speak or cry? — YES → Don't do anything now. Wait until EMT's arrive.

NO

NOT CHOKING - NOW BREATHING

Check the mouth for objects. If you see something, use your finger to sweep it out of her mouth.

If unconscious, slightly tilt her head BACK to keep her throat open. STAY ON THE LINE WITH ME!

** Lay her FACE UP ON THE FLOOR. Tilt her head back slightly to open her airway.

KNEEL at her FEET, Place the HEEL of your hand just above her belly button BELOW her ribs in the middle of her stomach.

Push quickly DOWN INTO her stomach 6 times.

Look in her mouth. Do you see an object? — YES → Use your finger to sweep it out of her mouth. Is it out?

NO → Repeat from **.

YES

NO

Is she breathing now? — YES → If unconscious, LIFT HER CHIN SO HER HEAD TILTS BACK to keep the throat open. STAY ON THE LINE WITH ME!

NO

Repeat from **.

NO AGAIN

Is she breathing or moving? — YES → If unconscious, tilt her head BACK to keep her throat open. STAY ON THE LINE WITH ME!

NO

GO TO CHILD: AIRWAY/MOUTH-TO-MOUTH CARD (38).

8/92

HELP IS ON THE WAY! LISTEN CAREFULLY ! I'll tell you how to help your child. (If hysterical: YOU MUST BE CALM SO YOU CAN HELP YOUR CHILD. (Keep repeating until calm.])

Bring the child near the phone.

Put him flat on his back on a table or on the floor.

LIFT HIS CHIN SO HIS HEAD TILTS BACK.

Is there vomit in his mouth? — YES

NO

VOMITING INSTRUCTIONS: Turn his HEAD to the SIDE. SCOOP his MOUTH OUT (before you start Mouth-to-Mouth.).

REMEMBER: Do this any time vomiting occurs — YOU MUST BLOW THROUGH THE REMAINING FLUID.

Is he breathing now? — YES

NO

Do you or anyone else there know CPR? (If so, STAY ON THE PHONE and relay sequence to ensure they're doing it properly.)

Continue lifting his chin and check his breathing often.

I'm going to tell you how to give MOUTH-TO-MOUTH.

8/92

** COMPLETELY COVER his MOUTH AND NOSE with your MOUTH. If you can't, then HOLD HIS NOSE CLOSED and COMPLETELY COVER his MOUTH with your MOUTH.

Blow 2 SLOW BREATHS into his LUNGS, just like you're filling up a SMALL balloon.

Watch for his chest to rise.
Go do it now and then come right back to the phone.

Did you see his CHEST RISING when you blew in the air... Did you feel the AIR GOING IN? — YES

NO

MAKE SURE YOU ARE STILL LIFTING HIS CHIN. (Go back to **, repeat the sequence, and BLOW A LITTLE HARDER.) — YES-NOW

NO AGAIN

Go to CHILD: CHOKING CARD(37)

I'm going to tell you how to check for a pulse.

* Place your INDEX AND MIDDLE FINGER into the groove next to his ADAM'S APPLE.. DON'T PRESS TOO HARD. FEEL for a PULSE for 5 SECONDS.

Do you FEEL A PULSE?

YES

++ Continue Mouth-to-Mouth. Blow 1 SLOW BREATH into him ONCE EVERY 4 SECONDS. Go do this now, BUT DON'T HANG UP! KEEP THE LINE OPEN and tell me if he starts to breathe on his own...Is he breathing on his own?

NO

Continue Mouth-to-Mouth

YES

STOP Mouth-to-Mouth and monitor. If breathing stops again: Go back to * and repeat.

NO

Go to CHILD: CHEST COMPRESSIONS CARD (39)

8/92

HELP IS ON THE WAY! LISTEN CAREFULLY ! I'll tell you what to do next.

Bring the child near the phone. Place her on her back on a hard surface (table or floor).
Place the HEEL ONLY of ONE HAND in the MIDDLE of her CHEST right BETWEEN THE NIPPLES.
Make sure ONLY THE HEEL of one HAND is in the CENTER of her chest, RIGHT BETWEEN THE NIPPLES.

PUSH STRAIGHT UP AND DOWN with the HEEL of your hand 5 times, just like you're PUMPING the chest.
PUSH DOWN FIRMLY with the HEEL OF 1 HAND, 1 INCH. PUSH 5 times – at least 1 PUSH EVERY SECOND.

LIFT THE CHIN SO HER HEAD BENDS BACK.

COMPLETELY COVER her MOUTH AND NOSE with YOUR MOUTH. If you can't, then HOLD HER NOSE CLOSED and COMPLETELY COVER her MOUTH WITH YOUR MOUTH.

* Blow in 1 SLOW BREATH and then PUMP the CHEST again 5 times.

Repeat cycle 4 times and then come right back to the phone.

** Check for a pulse:

Slide your INDEX AND MIDDLE FINGER into the groove next to her ADAM'S APPLE. DON'T PRESS TOO HARD. FEEL for a PULSE for 5 SECONDS.

Do you FEEL A PULSE? ——— YES

NO

8/92

Keep repeating *, checking for a pulse every 4th time.

KEEP DOING THIS UNTIL HELP CAN TAKE OVER OR UNTIL SHE STARTS TO BREATHE ON HER OWN.

If she starts breathing on her own: STOP CPR AND MONITOR CLOSELY.

If she STOPS breathing again: Go back to **.

Maintain CHIN LIFT and monitor her breathing often.
IF NOT breathing:

Go to ++ on CHILD: AIRWAY/MOUTH-TO-MOUTH CARD (38) and give MOUTH-TO-MOUTH instructions.

VOMITING INSTRUCTIONS: REMEMBER: Do this anytime vomiting occurs.	Turn her HEAD to SIDE. SCOOP MOUTH OUT. YOU MUST BLOW THROUGH THE REMAINING FLUID.

HELP IS ON THE WAY! LISTEN CAREFULLY ! I'll tell you how to help him. (If caller hysterical: YOU MUST BE CALM SO YOU CAN HELP HIM. [Keep repeating until calm.])
Bring him near the phone
Can he stand?

YES

Keep him near the phone.

Is he coughing or wheezing?

YES

Reassure him. Don't do anything now. Wait until EMT's arrive. STAY ON THE LINE WITH ME!

NO

Can he breathe or talk?

YES

Reassure him. Don't do anything now. Wait until EMT's arrive. STAY ON THE LINE WITH ME!

NO

Listen carefully. I'll tell you how to do the Heimlich Maneuver.

Listen carefully to these instructions! Then go to him and do EXACTLY as I tell you- and COME RIGHT BACK TO THE PHONE.

Move BEHIND him and put your arms around his waist.

NO (victim probably unconscious or will be soon)

Is he coughing or wheezing?

NO

Can he breathe or talk?

NO

Listen carefully. I'll tell you how to do the Heimlich Maneuver.

Listen carefully to these instructions! Then go to him and do EXACTLY as I tell you- and COME RIGHT BACK TO THE PHONE.

** Make sure he is laying FACE UP on a hard surface (table or floor). STRADDLE his HIPS. Tilt his head back slightly, to open his airway.

Place your hands, one on TOP of the other, just ABOVE his belly button. With a quick THRUST, PUSH INTO his STOMACH DOWNWARD AND TOWARD HIS HEAD using your weight. Do this 6 times and return to the phone right away.

Grasp your FIST with your other hand, just ABOVE his belly button. Be sure you are BELOW the ribs and breast bone. In a quick motion, JERK HARD, INWARD AND UP, INTO his stomach. Do this 6 times and return to the phone right away.

Look into his mouth. Can you see an object?

NO

Is he breathing now?

NO

Repeat the sequence from **. and then return to the phone right away.

YES

STOP treatment.

Monitor closely.

YES

Use your FINGER to sweep it out of his MOUTH. Is it out?

NO

GO TO ADULT: AIRWAY/MOUTH-TO-MOUTH CARD (41).

YES

Can he breathe or talk now?

NO

GO TO ADULT: AIRWAY/MOUTH-TO-MOUTH CARD (41).

YES

STOP treatment. Reassure him. Monitor closely.

Is the object out and can he breathe and talk now?

YES

STOP treatment. Reassure him. Monitor closely.

NO

Repeat from * until the object is out or he loses consciousness.

If he cannot stand up any longer, go to **.

8/92

HELP IS ON THE WAY! LISTEN CAREFULLY ! I'll tell you how to help her. (If hysterical: YOU MUST BE CALM SO YOU CAN HELP HER. [Keep repeating until calm.])

Can you get the phone next to her? If so, do it NOW.

I'm going to tell you how to open her airway. LISTEN CAREFULLY to these instructions and do EXACTLY as I tell you. Lay her FLAT ON HER BACK. If there is a pillow under her head, REMOVE IT.

LIFT HER CHIN SO HER HEAD TILTS BACK.

Go do this now and come right back to the phone.

Is there vomit in her mouth?

NO

YES → VOMITING INSTRUCTIONS: Turn her head to the SIDE. SCOOP MOUTH OUT (before you start mouth-to-mouth). YOU MUST BLOW THROUGH THE REMAINING FLUID.

REMEMBER - do this any time vomiting occurs

Is she breathing now?

NO

YES → Maintain the CHIN LIFT and check her breathing often.

Do you want to do CPR - I'll help you!

YES

NO → Stop giving instructions and tell caller that help is on the way.

8/92

Do you or anyone else there know CPR? (If so, STAY ON THE PHONE and relay sequence to ensure they're doing it properly.)

I'm going to tell you how to give Mouth-to-Mouth.

Lift her CHIN up the way I told you before.

** Hold her NOSE CLOSED.

COMPLETELY COVER her MOUTH with your mouth. SLOWLY FORCE 2 DEEP BREATHS into her LUNGS just like you're blowing up a BIG balloon. Watch for her CHEST TO RISE.

Go do this now and come right back to the phone.

Did you see her CHEST RISING when you blew in the air?...Did you feel the air going in? — YES

NO

Lift the CHIN UP MORE and repeat from **.

NO AGAIN

YES NOW →

Does it feel like her throat is blocked?... That the air wasn't going in? — NO

YES

Go to ADULT: CHOKING CARD (40)

I want you to check for her pulse. *Slide your INDEX AND MIDDLE FINGER into the groove next to her ADAM'S APPLE. DON'T PRESS TOO HARD. FEEL for a PULSE for 5 SECONDS. Do you FEEL A PULSE? — YES

NO

Go to ADULT: CHEST COMPRESSION CARD (42).

Continue MOUTH-TO-MOUTH until person resumes breathing or help arrives. Give 1 BREATH /5 SECS. Recheck her pulse periodically. *

HELP IS ON THE WAY! LISTEN CAREFULLY and I'll tell you what to do next.
Can you get the phone next to him? If so, do it now.
Put him ON THE FLOOR OR A HARD SURFACE. DO IT NOW. Then come right back to the phone.

Put the HEEL of your HAND on the BREASTBONE in the CENTER of his CHEST, RIGHT BETWEEN THE NIPPLES.

Put YOUR OTHER HAND ON TOP OF THAT HAND.

Push DOWN FIRMLY with ONLY THE HEELS of your hands 2 INCHES.

Push with ONLY THE HEELS of your hands STRAIGHT UP AND DOWN 15 times. JUST like you're PUMPING THE CHEST. Do it 15 times, ONCE A SECOND...REMEMBER!

Now pinch his NOSE CLOSED AND LIFT THE CHIN AGAIN.

* SLOWLY BLOW IN 2 BIG BREATHS, then PUMP THE CHEST 15 more times. Make sure ONLY THE HEEL of your HAND is on the bone in the CENTER OF THE CHEST, RIGHT BETWEEN THE NIPPLES.

Repeat the cycle 4 times and come right back to the phone. I'll stay on the line.

Now check for a pulse: Slide your INDEX and MIDDLE FINGERS into the groove next to his ADAM'S APPLE. DON'T PRESS TOO HARD! FEEL for 5 SECONDS.

8/92

Is there a pulse? ——— YES ———→ Keep repeating *, checking for a pulse every 4th time. Maintain CHIN LIFT and check his breathing often. If NOT breathing: Continue MOUTH-TO-MOUTH. Give 1 BREATH / 5 SECONDS. Recheck pulse periodically. (refer to ADULT: AIRWAY/MOUTH-TO-MOUTH CARD (41) if necessary)

NO ↓

KEEP DOING THIS UNTIL HELP CAN TAKE OVER OR UNTIL HE STARTS BREATHING ON HIS OWN.

If he starts breathing on his own: STOP CPR AND MONITOR CLOSELY.

If he stops breathing again:
CHECK FOR A PULSE.

Is there a pulse?

NO ↓ Go back to *.

YES ↓ Continue MOUTH-TO-MOUTH. Give 1 BREATH / 5 SECONDS, until person resumes breathing or until help arrives. Recheck pulse periodically.

VOMITING INSTRUCTIONS: Turn his HEAD to the SIDE. SCOOP MOUTH OUT (before you start Mouth-to-Mouth.) YOU MUST BLOW THROUGH THE REMAINING FLUID.

REMEMBER: Do this any time vomiting occurs.

HELP IS ON THE WAY! LISTEN CAREFULLY. I'll tell you what to do.

Has she already delivered?

NO

Is the mother pushing or straining?

YES

Lay mom on her back in the center of bed or on the floor. Raise her head with pillows, but don't let her sit up and DON'T LET HER GO TO THE BATHROOM.

You will need a clean, dry cloth (washcloth OK), at least 2 clean dry towels, a blanket or extra towel and a shoelace. Go get them now - I'll stay on the phone.

With each contraction place hand against the vagina and apply firm but GENTLE pressure to keep baby's head from delivering too fast and tearing mom. As the HEAD delivers, it may turn to the side. Now clean out baby's MOUTH and NOSE with a dry cloth. As the body delivers remember BABY WILL BE SLIPPERY, BE CAREFUL!! Support baby's HEAD and SHOULDERS and hold HIPS and LEGS firmly. Wrap baby in dry towel and place on mom's stomach. If the 1st towel becomes wet, replace it with a dry towel.

CONTINUE TO CLEAN OUT THE AIRWAY AS NECESSARY - KEEP BABY WARM - COVER HEAD BUT NOT FACE.

Tie the shoelace tightly around the umbilical cord approximately 6 inches from baby. DO NOT CUT THE CORD.

Is the baby crying/breathing?

YES → Maintain baby AND Mom. Keep both warm.

NO → REFER TO INFANT: AIRWAY/ MOUTH-TO-MOUTH CARD (35).

NO

There is still some time left before delivery occurs. Calm mom, instruct her to take deep breaths between contractions.

You will need at least 2 clean dry towels, a blanket or extra towel, a clean dry cloth (washcloth OK) and a shoelace.

Go get them now. Let me know if mother begins pushing or straining with contractions.

Come right back to the phone and we'll decide what to do next.

YES

Is the baby crying/breathing?

NO

YES

BABY WILL BE SLIPPERY – BE CAREFUL! SUPPORT HIS HEAD AND SHOULDERS; HOLD HIS HIPS AND LEGS FIRMLY.

Place baby across mom's stomach.

You will need a clean, dry cloth (washcloth OK), at least 2 clean dry towels, a blanket or extra towel and a shoelace. Go get them now – I'll stay on the phone.

Clean out baby's MOUTH and NOSE with dry cloth. Dry baby off and wrap in dry towel or blanket. Cover baby's HEAD and KEEP IT WARM. DO NOT COVER FACE. Tie shoelace tightly around cord approximately 6 inches from baby. DO NOT CUT CORD.

Make sure mother is kept warm also.

8/92

INSTRUCTIONS FOR DELIVERY OF AFTERBIRTH:

When the afterbirth is delivered, (usually about 20 minutes after birth of baby) wrap it in a towel and KEEP IT. DO NOT THROW IT AWAY. The doctor will need to examine it.

ATTACHMENT L

CHORAL

C.H.O.R.A.L.

Computerized Hospital On-line Resource Allocation Link

CHORAL is a unique proprietary software system designed to establish a community-wide network that improves the allocation and efficient use of participating hospitals emergency services resources.

The CHORAL system provides:

- ✓ A means to manage the problem of hospital closures and ambulance diverts.
- ✓ A single consistent method of communicating divert status to EMS personnel.
- ✓ Documentation for hospitals to monitor their profile of diverts over a period of time for improved staffing assignments and financial analysis.
- ✓ Data for EMS systems planners to monitor and begin solving the problems of hospital diverts within their community.
- ✓ One step method of alerting the entire community of a hospitals closure or selective diverts.
- ✓ A way to help solve the problem of unequal distribution of the medically indigent public.

List of Hospitals Currently Using The CHORAL System:

In Oregon:
University Hospital, Portland
Emanuel Hospital and Health Center, Portland
Providence Medical Center, Portland
Good Samaritan Hospital & Medical Center, Portland
Portland Adventist Medical Center, Portland
Mount Hood Medical Center, Gresham
Holladay Park Medical Center, Portland
Bess Kaiser Medical Center, Portland
Kaiser Sunnyside Medical Center, Clackamas
St. Vincent Hospital, Portland
Woodland Park Hospital, Portland
Rogue Valley Medical Center, Medford
Providence Medical Center, Medford

Quest Technologies, Inc. • P.O. Box 19412, Portland, Oregon 97219 • (503)245-8850 • (800)228-0790 Fax (503)245-2368

CHORAL

(Computerized Hospital On-line Resource Allocation Link) Information Sheet

There is a growing problem of hospitals diverting patients. This practice, well described in the August 1989 jems, (Journal of Emergency Medical Services), creates several problems. Hospitals diverting patients for financial reasons unfairly burden the ultimate receiving institution. The emergency medical services system is unable to find a suitable receiving hospital for its patients. Families who believe their loved one is being transported to one hospital arrive there to find they are at the wrong facility. While preventing hospitals from ever diverting is unlikely, there is a system recently implemented in Portland, Oregon which displays hospitals' divert status to dispatch centers, the base station, and other area hospitals allowing the system to make necessary compensations.

The system is based on an interhospital computerized communications system which was previously used to monitor the status of this area's trauma hospitals. This trauma system role is described in Jack Stout's "Interface" column in the June 1988 issue of jems. In short, the earlier system relied on computers located within the emergency departments of 14 Portland hospitals. These computers were all linked to the emergency medical services system base station which in Portland is known as Medical Resource Hospital (MRH). In that system, hospitals displayed their trauma status visually on their terminal screen and that data was transmitted to all other hospitals as well as MRH which monitored the entire system and advised paramedics which of the 14 facilities were available for trauma at any given moment.

Building on that system, the Multnomah County office of Emergency Medical Services, working with the Oregon Association of Hospitals, contracted with Richard Quest of Salem, Oregon to rewrite the software so that the system will instead monitor six hospital divert categories and display that information system wide. The 911 communications center and MRH monitor system divert status so that paramedics are advised when they start to a hospital with a patient of that hospital's status. This avoids hospital shopping. Each hospital controls its own data. No hospital nor the 911 center nor MRH can change any data displayed by the other hospitals. Facility changes, after going out to the system, are saved in each hospital's own computer memory. The system divert history is stored in the MRH computer. This database will allow the EMS system to see patterns and prevalence of diverts. We have found that widely distributing information about facilities tends to keep each honest. One would think that in this information system a hospital would be tempted to display itself as being more capable that it really is. In fact, the Multnomah County experience appears to be the opposite.

The software is designed so that a hospital can provide its own compatible hardware or purchase hardware through Quest Technologies. The software allows maximum flexibility. Future changes in the screen format can be easily accomplished using a menu driven program. This program allows system planners to add or delete data points from the display as the system evolves and different needs arise. For example, other hospitals may wish to join the system or existing hospitals may add services which they want displayed on the screen. This is easily and inexpensively accomplished.

This system allows communities to monitor the divert status of all hospitals on the system. Paramedics, dispatch centers, and the base station can quickly identify an available hospital for the ambulance if the original destination is on divert. Patients then reach care more quickly.

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