

OPERATIONS

Operations - Section 50.000

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Cancellation/Slow-Down Policy

Purpose:

The purpose of this procedure is to describe how units responding to medical emergencies may either slow down Code 3 to Code 1 or cancel other responding units. It is in the best interest of patient care and the public safety to slow down or cancel units responding Code 3 to emergency medical calls when it is determined that the situation or patient does not require an emergency response.

Procedure:

- A. BLS emergency medical responders may slow ALS responders to Code 1 when they determine, after initial assessment, that a patient does not require ALS treatment or the patient refuses treatment and/or transport.
- B. BLS units may cancel ALS responders if there is nothing found or the patient(s) requires only first aid. (Bandaging and simple splinting are examples.)
- C. If multiple ALS units are responding, after patient assessment, BLS units may cancel ALS Non-Transporting unit(s).
- D. BLS units may not slow or cancel ALS units because an air ambulance has been activated. After the air ambulance lands on scene, BLS units may slow or cancel ALS ground responders after the BLS unit have conferred with the flight personnel.
- E. ALS units, on scene, may slow down or cancel other responders after patient evaluation and no other units are required or additional response can be Code 1.
- F. ALS emergency medical responders may not slow down or cancel ALS ambulances because an air ambulance has been activated. After the air ambulance lands on scene ALS units may slow or cancel additional ALS responders after the ALS emergency medical responder have conferred with the flight personnel.
- G. Appropriate EMS ground response will **always** be dispatched anytime an air ambulance is activated, if not already done.
- H. An air ambulance may slow down or cancel EMS response, after scene and patient assessment and no other units are required or additional response can be Code 1. (Any Landing Zone Management response should continue, unless specifically canceled.)

Law Enforcement Agencies: [Information Only]

- A.** Law enforcement units should not cancel all EMS response, unless there is nothing found or there are no patients or victims at the scene.
- B.** Law enforcement units may slow EMS response to Code 1 when a patient requires only first aid (bandaging and simple splinting are examples), or the patient refuses treatment and/or transport.
- C.** Law enforcement units should not slow or cancel EMS response because an air ambulance has been activated. After an air ambulance lands at the scene, additional responders may be slowed or canceled after law enforcement has conferred with the flight personnel.
- D.** Law enforcement's dispatchers **will** honor a request by law enforcement units to cancel EMS responders **only** when there is nothing found or there are no patients or victims at the scene. The EMS units, for all other situations, will continue to respond per the dispatch order.

Crime Scene Response

Purpose:

Law enforcement agencies stress that their first interest on any crime scene is the preservation of life. Effective reconstruction of the crime scene must follow. EMS personnel can be of assistance by adhering to the following guidelines regarding crime scene response.

Procedure:

A. Response and Arrival:

1. EMS units responding to the scene of a reported crime should obtain information from their communications center about the nature of the incident and whether staging is required. Follow *Staging for High Risk Response* protocol.
2. As EMS and fire units move into location, there should be a conscious evaluation of physical and weather conditions around the site.
 - a. Tire tracks of suspect vehicles are often located in or adjacent to the driveway.
 - b. Driving your unit over these tracks can obliterate potentially significant evidence.
3. In any crime scene response, it is important to limit the number of personnel allowed into the scene. It may be advantageous to have one of the EMS personnel consult with police on the scene and direct the placement of vehicles and personnel response into the scene.

B. Access and Treatment:

1. When entering the area where the victim is located, it is of great importance for EMS personnel to select a single route to the victim. Maintaining a single route decreases the chance of altering or destroying evidence or tracking blood over a suspect's footprints.
2. When moving toward the victim, it is important to note the location of furniture, weapons, and other articles, and avoid disturbing them. If they need to be moved, someone should note the location the article was moved from, by whom it was moved, and where it was placed.
3. Leave all medical debris at the scene, except sharps. Sharps should be secured in a sharps container and removed.
4. Be conscious of any statements made by the victim or other persons at the crime scene. As soon as possible, write down what these statements were and report to the investigating officers.

5. In treating the victim of a crime, it is important to note the specific garments worn by the patient at the time of treatment. It is also **very** important that EMS personnel do not, if at all possible, tear the clothing off or cut through any holes, whether made by a knife, bullet, or other object.
6. The victim should be placed on a clean sheet when ready for transport.
 - a. At the hospital, please try to obtain the sheet once the victim is moved off it, fold it carefully in on itself, and secure in a paper bag and/or pillow case and give it to the investigating officer.
 - b. This is especially important in close contact crimes such as rape or serious assault and death cases.

Documentation:

- A. A detailed report that covers all aspects of your involvement at the crime scene is important in case you are later called to testify in court.
 1. These narratives should cover:
 - a. Your observations and conversations with the family or persons present at the scene.
 - b. Location of response vehicles and equipment, furniture, weapons, or clothing that has been moved.
 - c. Items that were handled by EMS responders, and your route to the victim.
 2. Avoid offering your opinions.
 3. It is best to actually quote the person's statements if possible.
- B. This narrative should be a separate document from your Prehospital Care Report form.

NOTE:

Prior to arriving on scene, EMS responders should consider the following potential crime scenes:

Home	Work	MVAs
Deaths	Domestic violence	Assaults
Fires	Suicide attempts	Near drowning

These are not all the possible scenes, just an example. If any EMS responder thinks something is not right, report it to Command or police.

Diversion System

Overview

The Greater Portland Metropolitan Area (Multnomah, Clackamas, Washington and Columbia Counties, and in coordination with Clark County, Washington) is a large geographic area with a growing population. There is a complex network of medical providers, and hospital systems servicing the area. The Portland Metro Five-County Emergency Medical System (EMS) values transporting patients to the hospital of their choice and getting patients to the right hospital for specialty services. These systems require coordination between patient transport and patient destination, ensuring continued use and availability of emergency medical resources to the community. The patient diversion guidelines exist to provide guidance for emergency departments (ED) and ambulance providers during high-capacity times. The guidelines are a collaborative effort between many stakeholders that include hospitals, ambulance providers, county oversight agencies, and the Oregon Association of Hospitals and Health Systems (OAHHS). **This protocol does not pertain to prescheduled, non-emergency, or inter-facility transports.**

Purpose

Ambulance diversion is a hospital short-term management tool used as a last resort when the patient load overwhelms ED resources after internal diversion avoidance procedures have been implemented. Ambulance diversion is not to take the place of effective patient volume management processes. This protocol defines how the Portland Metro Five-County EMS system will effectively manage situations where the diversion of an ambulance may be necessary and when such diversions may have an adverse effect on individual patient care or the EMS system.

Philosophy

The Greater Portland Metropolitan Area hospitals will make every effort to avoid the diversion of ambulances which may result in:

- A. Transporting patients away from their hospital or physician of choice.
- B. Prolonged prehospital care for unstable or critically ill patients.
- C. Prolonged transport times.
- D. Attempts by field personnel to predict the specific diagnostic and therapeutic resources needed by individual patients.
- E. Reduced ED availability to the community.
- F. Reduced ambulance availability to the community.

This protocol sets the standard that diversion should be the exception rather than the rule.

Objectives

- A. To promote efficient and effective provision of EMS services in accordance with county ambulance service plans, codes, as well as state and federal regulations.
- B. To assure hospitals develop and adhere to diversion avoidance strategies.
- C. To assure hospitals limit diversion to ED patient safety reasons and remove diversion status immediately after the patient safety issue has been resolved.

- D. To provide consistent definitions and agreed upon procedures to guide each hospital.
- E. To assure system accountability and quality improvement to facilitate the goal of limiting diversion.
- F. To report and collect meaningful data, which more accurately defines prehospital and hospital EMS demand, service consumption, and resource availability.
- G. To identify a system of accountability and quality improvement by providing diversion data to all participants monthly.

Definitions

- A. All Divert No Divert – When all hospitals in a zone go on diversion simultaneously (all close), the HOSCAP/OCS system or zone manager will immediately open all hospitals within the zone. No zone or all hospitals within a zone will be allowed to close for zone management unless authorized by the EMS medical director/zone manager for emergent reasons.
- B. Disaster Management – Epidemic, pandemic, inclement weather, man-made or natural disaster, zone management, mass casualty incident, or other circumstances that challenge emergency services abilities to continue meeting patient care demand.
- C. Diversion – The redirection of an ambulance from an intended receiving facility to an alternate receiving facility due to a sudden, unanticipated, temporary inability to receive any additional 9-1-1 patients; or safely care for additional critical/unstable patients in the ED.
- D. Inter-Facility Transfers – Hospital destination is pre-determined by physician-to-physician communication as a formal transfer.
- E. Oregon Capacity System (HOSCAP/OCS) – State owned and managed, data system for distribution of hospital status information and incident management.
- F. Regional Hospital – A medical facility designated to coordinate Mass Casualty Incident (MCI) or disaster situations co-located with Trauma Center Communications (TCC) and Medical Resource Hospital (MRH) which provides online medical control for Multnomah, Clackamas, Washington, Columbia and Clark Counties, currently located within Oregon Health Science University (OHSU).
- G. Zone Manager – An agency or facility authorized to provide coordination to pre-hospital care providers and hospitals during times of zone wide diversion.
- H. ED Diversion Status Categories:
 - 1. OPEN (**GREEN**) - The ED can accept patient(s) transported from an ambulance.
 - 2. CLOSED (**RED**) - The ED is unable to accept patient(s) transported from an ambulance; except:
 - i. Uncontrolled airway.
 - ii. Non-trauma patient too unstable to transport to another facility.
 - iii. Patient refuses alternate facility.
 - iv. Prearranged inter-facility transfer.
 - v. Pregnant patients > 20 weeks gestation or illness or injury which could have a potential life-threatening effect on the mother and/or the fetus.

I. Trauma Diversion Status Categories:

1. TRAUMA **YELLOW** - A designated trauma hospital has declared that trauma restrictions exist, and some trauma related services may be limited.
2. TRAUMA **(RED)** - A designated trauma hospital will divert to another trauma hospital when it has exceeded its capacity of personnel, equipment, or facilities to assess and care for trauma patients.

J. Life Flight Network Status:

1. **GREEN** – Available
2. **YELLOW** – On stand-by for another patient
3. **RED** – Unavailable

Destination Hospital/Services Abbreviation and EMS Abbreviations:

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

Ed Ambulance Diversion Criteria

It is the expectation that all hospitals receiving 9-1-1 patients make every effort to be continuously open and available.

- A.** Diversion is not to be initiated for:
 - 1. Lack of in-patient staffing or inpatient/ICU beds.
 - 2. Key resources being reserved for anticipated elective patient care (i.e., elective surgical cases or radiological studies).
 - 3. Routine ED overcrowding:
 - a. Full waiting room.
 - b. Long waiting room time.
 - c. Extended LOS of ESI 3, 4, 5s.
 - d. ED boarders
- B.** ED diversion may be initiated under the following conditions:
 - 1. By the hospital
 - a. ED charge nurse and ED physician leader determine that the ED is reaching capacity with critical/unstable patients occupying all ED care spaces.
 - b. ED charge nurse and ED physician leader have attempted to accommodate increased demand by following their internal ED surge plan yet determine that ambulance diversion is necessary to safely care for patients in the ED because:
 - i. There are not enough resources to safely care for additional critical/unstable patients in the ED.
 - ii. There is a loss of CT scanner capability.
 - iii. There is an in-house disaster which compromises patient care/safety (i.e., fire, flooding, or electrical power outage).
 - 2. By the EMS system
 - a. For nonstandard or extended off-load times of 35 min or greater – collaboration will occur with the EMS supervisor and affected ED(s) leadership to develop a patient placement plan.
 - b. Under the discretion of the EMS medical director.
- C.** Hospitals request diversion via the HOSCAP/OCS. Hospital initiated diversion events will last no longer than two hours before HOSCAP/OCS automatically opens the hospital to ambulance traffic again and the hospital will not be allowed to request ED ambulance diversion again for two hours.
- D.** In the event a hospital is unable to change their status in the HOSCAP/OCS system, (i.e., connection problems), the hospital may contact the zone manager to authorize the zone manager to change the hospital status in HOSCAP/OCS.
- E.** A hospital's diversion status at the time ambulance transport begins with a loaded patient will determine the ability of the hospital to accept patients. To ensure the up-to-the-minute ability of a hospital to accept a patient, a transporting unit will contact dispatch requesting the status of the preferred destination hospital when the patient has been loaded and as they are preparing to depart the scene. Diversion of a patient shall not occur after the transport has begun.

Trauma Ambulance Diversion Criteria

- A. The intent of the Trauma System is that only one of the designated Level 1 Trauma Centers may divert at a time: OHSU/Doernbecher’s Children or Legacy Emanuel/Randall’s Children.
 - 1. When one of the Level 1 (adult or pediatric) trauma centers goes on diversion status, notification of diversion status to the other designated trauma center must occur. Trauma patients will then be diverted to the other trauma center.
 - 2. When both Level 1 trauma centers are at capacity, the Trauma Center Communications Center will be notified to begin rotating trauma patients between the two trauma hospitals until the situation has stabilized or either hospital is able to return to standard operations. The Regional Hospital may also need to do an “All Call” to other community hospitals activating the MCI or disaster system to coordinate distribution of trauma patients.

Multnomah County Pediatric Hospital Ed’s

- A. When one of the dedicated Multnomah County pediatric EDs (Doernbecher’s Children and Randall’s Children) goes on diversion status, notification of diversion status to the other designated pediatric ED must occur. Pediatric patients will then be diverted to the other pediatric ED.
- B. When both Multnomah County pediatric EDs are on diversion, the OHSU zone manager will rotate destination between the two Multnomah County pediatric ED’s until the situation has stabilized or one of the pediatric EDs returns to green status.

Zone Management

Hospitals are grouped into the following geographical zones:

West Zone	Central Zone	South Zone	North Zone	East Zone
Providence St. Vincent Medical Center	Legacy Emanuel Medical Center/ Randall Childrens Hospital	Kaiser Sunnyside Medical Center	PeaceHealth SW Medical Center	Portland Adventist
Legacy Meridian Park Medical Center	Legacy Good Samaritan Medical Center	Providence Milwaukie	Legacy Salmon Creek Medical Center	Providence Portland Medical Center
Kaiser Westside Medical Center	Oregon Health Sciences University/ Doernbecher Children’s	Providence Willamette Falls		Legacy Mount Hood
Hillsboro Medical Center	Portland VA Medical Center			
	Unity Center for Behavioral Health			
<u>Zone Manager</u> Metro West	<u>Zone Manager</u> Regional Hospital	<u>Zone Manager</u> Regional Hospital	<u>Zone Manager</u> Regional Hospital	<u>Zone Manager</u> Regional Hospital

- A. When multiple hospitals go on diversion at the same time it poses a challenge to other hospitals trying to stay open. In the event all hospitals in a zone go on diversion simultaneously, an ALL DIVERT NO DIVERT process will be initiated and the HOSCAP/OCS system or zone manager will immediately open all hospitals within the zone and no hospital in that zone will be allowed to use ambulance diversion again for two hours.
- B. Occasionally, for emergent reasons, i.e., MCI, the zone manager may need to initiate zone management. In the event this is required to enhance the EMS system or provide for public safety the zone manager will initiate diversion by:
 - 1. Initiating “Active Zone Management” for the zone(s) affected and will facilitate an “all call” via the 800 MHz radio to hospitals informing them of the “Active Zone Management” status.
 - 2. Local ambulance providers/dispatch centers will notify their respective ambulances that zone management is in effect for the defined zone(s) and that their units are to contact the zone manager to obtain hospital destination(s).
 - 3. Under zone management, the zone manager will determine the destination of all ambulances within the affected zone(s).
 - 4. Ambulances may go outside their zone during zone management if their destination hospital is GREEN, this may be done based on patient and EMS provider agreement and following patient treatment and transport guidelines on the final destination. This includes honoring previously agreed upon destinations.
 - 5. Rotation will continue with one patient per hospital as determined by the zone manager. Note: the rotation will not apply to the trauma hospitals for trauma entry patients. Trauma hospitals participating in zone management will adhere to the trauma diversion portion of the ambulance diversion policy located above.
 - 6. Trauma, STEMI, stroke, pediatric, and behavioral patient care protocols will continue.
 - 7. Prior to discontinuing zone management, the zone manager will monitor key area hospitals and ambulance providers. When system resources are above the activation threshold the zone manager may discontinue zone management.
 - 8. When appropriate, the county EMS Medical Director will participate in this discussion for the zones within their jurisdictional boundaries.

Disaster Management

- A. Hospital destinations will be coordinated by Regional Hospital through HOSCAP/OCS and according to regionally and locally adopted EMS protocols.
- B. During times of disaster management, situational status updates should be initiated and continued in four-hour operational intervals to provide updates to stakeholders.
 - 1. Disaster management as reported by community emergency responders.
 - 2. Any one facility activating their internal emergency management protocol.
 - 3. Actual or forecasted inclement weather.
 - 4. Any zone requiring persistent zone management.
 - 5. Circumstances as deemed appropriate by emergency operations officials or county EMS Medical Director(s).
- C. Stakeholders involved in proactive (thresholds) communications may include:
 - 1. DMedical directors/ED physicians.

2. Managers or their designee, assistant nurse managers, charge nurses, house supervisors, AOC/AOD, executive leadership, hospital HICS members.
3. Fire and EMS officials.
4. Public health officials.
5. Others, as appropriate.

Significant Events Process for Diversion Deviation:

- A. Inclement weather, hazardous road conditions, heavy snow, ice storms, or other unusual conditions may prevent ambulance crews from transporting patients to their hospital of choice. County EMS authorities shall have a process in response to these unusual circumstance and significant events. The significant event process has been developed to modify operations to better manage and coordinate EMS resources during large scale incidents or inclement weather events in the Greater Portland Metropolitan Area.
- B. During the significant event process:
 1. The impacted area's zone manager will be responsible for communicating the modification of EMS transport destinations to affected hospitals.
 2. The impacted area's zone manager will be responsible for communicating the modification of EMS transport destinations to affected hospitals.
 3. Dependent on the nature of the event, Regional Hospital may establish hospital destinations.
 4. Consideration will be given to patients requiring specialized care such as trauma, STEMI, stroke, behavioral, burn, hyperbaric, pediatric, and obstetrical patients.
 5. Every effort will be made to accommodate the patient's wishes for destination, however during a significant event; determination of the most appropriate facility may consider patient and crew safety.
 6. Final determination of patient destination must rest with the treating paramedic caring for the patient. This paramedic, in consultation with EMS operational supervisors and zone managers, as well as acting in accordance with county laws, and medical protocols, and with the ability to seek medical consultation, has the most direct knowledge of the patient's condition and conditions affecting transport.
- C. The patient requires transport emergently to the closest hospital when in the judgement of the treating paramedic the patient is unstable and patient transport guidelines recommend transport to the closest hospital regardless of diversion status.
- D. Anytime a patient is transported to a hospital other than the one requested the reason for the change and the destination hospital shall be documented on the Prehospital Care Report.

Accountability and Quality Improvement

- A. The hospitals shall develop:
 1. Develop an internal policy and systems to avoid diversion.
 2. Submit updated ED surge plan annually to the ED/EMS Leadership Collaborative.
 3. Ensure a hospital ED leader attends the monthly ED/EMS Leadership Collaborative meeting to review any diversion events the from the prior month and share what action planning is occurring to reduce diversion utilization.
- B. County EMS will report number of hours and category of diversion to all zones based on information in HOSCAP/OCS.

- C. The ED/EMS Leadership Collaborative is responsible for the monitoring of region-1 diversion hours and events, provide recommendations for quality improvement, and is responsible for the annual evaluation and revision to the Multnomah Operations Policy 50.030 Diversion System and the Five-County consortium Ambulance Diversion Guidelines 50.015. The ED/EMS Leadership Collaborative is a cooperative effort between involved EMS agencies, hospitals, their ED managers, and ambulance providers.
- D. Problems related to the implementation of these guidelines should be forwarded to the chair of the ED/EMS Leadership Collaborative.
- E. Problems related to the implementation of these guidelines should be forwarded to the Diversion and Zone Management Subcommittee.

Organizations in Support of These Guidelines

HOSPITALS

Adventist Medical Center	Providence Milwaukie Hospital
Doernbecher Children's Hospital	Providence Portland Medical Center
Hillsboro Medical Center	Providence St. Vincent Medical Center
Kaiser Sunnyside Medical Center	Randall Children's Hospital
Kaiser Westside Medical Center	PeaceHealth SW
Legacy Emanuel Medical Center	Unity Behavioral Health
Legacy Good Samaritan Medical Center	Veterans Administration Hospital
Legacy Meridian Park Medical Center	Willamette Falls Hospital
Legacy Mt. Hood Medical Center	Oregon Association of Hospitals and Health Systems
Legacy Salmon Creek Medical Center	
Oregon Health Sciences University	

COUNTY EMS REGULATORY AGENCIES FOR THE FOLLOWING COUNTIES

Clackamas County
Clark County
Columbia County
Multnomah County
Washington County

AMBULANCE PROVIDERS

American Medical Response	Gaston Rural Fire District
Banks Fire District #13	Hillsboro Fire
Canby Fire Department	Molalla Fire Department
Camas Fire Department	Metro West Ambulance
Clackamas County Fire District 1	North Country Ambulance
Cornelius Fire and Rescue	Life Flight Network
Forest Grove Fire and Rescue	Tualatin Valley Fire & Rescue

Documentation of Care

Purpose:

The purpose of this procedure is to describe what documentation is required on medical responses.

Procedure:

- A. A Prehospital Care Report shall be written for each patient evaluated, treated, or transported. The Prehospital Care Report shall be completed on an approved State EMS patient care form.
- B. Documentation should include, at least:
 1. Patient presenting problem.
 2. Vital signs, with times.
 3. History and physical findings as directed by individual protocols.
 4. Treatment(s) provided, and time(s).
 5. If monitored, ECG strip and/or 12-lead and Paramedic interpretation. Attach ECG strip.
 6. Any change in condition of patient.
 7. OLMC contact:
 - a. Include the physician name.
 - b. Time of the contact.
 - c. Orders received from the physician.
- C. If a patient refuses treatment and/or transport, refer to *Patient Disposition* protocol.

EMS Management of Lower Acuity Calls

Purpose:

To prioritize lower acuity EMS 911 triaged calls by BOEC which may be managed in a separate queue.

Procedure:

- A. BOEC workflow of low acuity call types.
 1. MCEMS will manage a list of ProQA call types for this policy and provide the list to BOEC. The list shall be generally comprised of Priority 6 call types with the exception of Protocol 17 Falls and any police requests.
 2. BOEC will triage all calls per standard operating procedure and assure they are placed in the separate queue in the BOEC CAD. Calls shall then be managed by American Medical Response (AMR). BOEC is not responsible for monitoring calls in this queue.
 3. AMR shall utilize Versaterm remote CAD for access, management, documentation, and workflow of these queued calls.
 4. If a caller calls BOEC after being placed in the AMR call queue, BOEC will re-triage utilizing ProQA and one of two outcomes may occur:
 - a. If the condition triages to a higher priority, the call shall be dispatched out as appropriate i.e. Priority 1, 2, 4, or 7.
 - b. If the phone call continues to triage out as a Priority 6, the initial CAD information shall have additional remarks added reflecting the additional phone call.
- B. AMR will manage this Priority 6 call queue following specific MCEMS provided standards.
 1. An AMR paramedic will manage this call queue 24 hours a day, 7 days a week.
 2. AMR shall be responsible for setting the resource availability criteria and informing MCEMS what the specific criteria AMR is using, prior to making any changes. This plan shall determine when appropriate resources are available to ensure both coverage of the 911 system and ability to respond to the lower acuity 911 calls in the AMR queue.
 3. When a call enters the AMR call queue, prior to moving back into BOEC Dispatch Queue (R Queue), the caller will be contacted by the AMR paramedic as soon as feasible and not more than 5 minutes, and every 15 minutes thereafter.
 4. The AMR paramedic will document all contacts with the caller/patient in the BOEC CAD in the remarks section.
 5. In the event a caller cannot be reached within 30-minutes, the Priority 6 call shall be moved to the BOEC Dispatch Queue.
 - a. The final remark should consistently be "Dispatch the call, unable to reach caller."
 6. If the caller decides not to utilize EMS for treatment and transport, this will be documented and an appropriate disposition code selected. All comments shall be entered into the CAD remarks section.
 7. No call shall remain in the AMR queue for longer than 12 hours.

EMS Management of Lower Acuity Calls

8. For additional triage resource protocols, use the current edition of *Telephone Triage Protocol for Nurses* by Julie Briggs.
9. If, after remote assessment by the AMR paramedic, the call is deemed a higher level of acuity, the ProQA call type will be rebalanced and moved to the BOEC Dispatch Queue. The logic for this should be apparent and documented in the call notes.
 - a. AMR4: AMR ALS Ambulance Code 3.
 - b. AMR2: AMR ALS Ambulance and ALS Fire Apparatus Code 3.
- C. The overriding principle is to maintain ALS ambulance coverage in the zone of the low acuity call prior to and after dispatch.
 1. It is AMR's responsibility to move low acuity calls back into the BOEC Dispatch Queue when there are enough available ambulances in the system according to the criteria AMR is using to maintain ambulances in the 911 system (See B. 2.) to run the call and maintain appropriate geographic coverage.
 - a. The logic for this should be apparent and documented in the call remarks.
 - b. The final remark should consistently be "Dispatch the call based on unit availability."
 2. Once a call has been moved to the BOEC Dispatch Queue, it shall remain there even if ambulance levels drop unexpectedly. BOEC will dispatch it out according to their normal dispatch policy and procedures and utilize a LZ unit if necessary.

MCEMS Field Surgical Response Team

Purpose:

To establish a formal mechanism for providing rapid advanced surgical care at the scene in which a higher level of on scene surgical expertise (i.e. physician field response) is requested by the on scene prehospital care provider. This protocol applies primarily to the three Oregon counties of Multnomah, Clackamas and Washington and their surrounding communities.

Definitions:

Field Surgical Response Team (FST): organized group of health care providers from a designated Oregon Level I Trauma Center, with Emergency Medical Services (EMS) Agency approval as a FST provider, who are available 24 hours/day to respond and provide a higher level of on scene surgical expertise.

Fire Incident Commander: highest-ranking official of the jurisdictional agency at the scene of the incident and responsible for the overall management of the incident.

Trauma Communications Center (TCC): serves as the control point for the 700/800 MHz is the primary point of contact when a FST is requested. The Fire IC shall contact an approved FST provider based on the incident location.

Physician Field Response: situation in which a higher level of on scene surgical expertise is warranted due to the nature of the emergency and requested by the on scene prehospital care provider.

Standard Precautions: combine the major features of Universal Precautions (UP) and Body Substance Isolation (BSI). Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These include: hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices.

TCC 800 MHZ: the radio frequency is the designated Multiple Casualty Incident (MCI) communication system.

Principles:

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

FST members should be assembled and ready to respond within 20 minutes of a request with standard life-saving equipment and in appropriate level of personal protective equipment (PPE) in accordance with the FST provider's internal policy on file with the EMS Agency.

PPE shall include universal precautions and the following as appropriate for the incident:

- Safety Goggles
- Leather Gloves

50.050 Field Surgical Response Team

- Approved NFPA Safety Helmet approved for USAR operations, ideally blue helmet with FST labeled on both sides.
- NFPA approved USAR jumpsuit or outerwear.
- National Fire Protection Association (NFPA) approved safety boot with minimum six-inch rise, steel toe, and steel shank.

The FST medical equipment and PPE referenced above shall be predetermined, preassembled, readily available, clearly labeled, and stored in a predetermined location. Based upon the magnitude and nature of the incident, the FST and PPE may require augmentation.

The FST team members should be equipped with short-range mobile radios. If situation warrants, team members will be provided 800 MHz radios to provide intra operable communications with scene responders. This radio may be provided to team members by scene responders.

Medical Control for the incident shall be in accordance with County EMS Treatment Protocols.

Policy:

- A. Composition of a Hospital Surgical Response Team:**
 - 1. The composition of the FST team, and the identification of a Team Leader, shall be in accordance with the approved FST provider's internal policy on file with the EMS Agency. The maximum FST composition for one ambulance is three (3) individuals.
 - 2. The maximum equipment size should not be greater than 3ft x 3ft for one ambulance. (Ambulance is capable of carrying three (3) 3ft x 3ft containers)
- B. FST Team Leader Responsibilities:**
 - 1. The FST Team Leader is responsible for organizing, supervising, and accompanying members of the team to a scene where a physician field response has been requested.
 - 2. The FST Team Leader shall be familiar with base hospital operations, scene hazard training, and the EMS Agency's policies, procedures, and protocols.
 - 3. The FST Team Leader is responsible for retrieving the life-saving equipment and PPE and determining if augmentation is required based upon the magnitude and nature of the incident.
 - 4. The FST Team Leader will determine the ultimate size and composition of the team based upon the magnitude and nature of the incident.
 - 5. The FST Team Leader will report to, and be under the authority of, the Incident Commander or their designee. Other members of the FST team will be directed by the Team Leader.
- C. Activation of a Hospital Surgical Response Team**
 - 1. The anticipated duration of the incident should be considered in determining the need for a FST. Before requesting a FST, the Incident Commander should take into account that it will be a minimum of 30 minutes before a team can be on scene.

D. Activation of FST

- 1.** The Incident Commander or designee shall contact TCC by the following methods:
 - a.** Multnomah County providers will place this request through BOEC 911 Dispatch.
 - b.** BOEC 911 Dispatch center will relay this request to the OHSU Trauma Communications Center (TCC / MRH) or contact TCC directly.
 - c.** Clackamas and Washington County will contact TCC directly.
- 2.** Scene Responsibilities
 - a.** Information required from scene.
 - b.** Brief description of the incident.
 - c.** Brief description of the patient.
 - d.** Resource(s) requested.
 - e.** Scene contact with cell phone number and/or radio frequency (OPS channel).
 - f.** Location where the FST needs to report.
 - g.** Special needs or situational awareness.
 - h.** Time needed for resource (usually ASAP).
- 3.** TCC Responsibilities
 - a.** TCC will contact an approved FST provider (OHSU/Legacy Emanuel) regarding the request based on anticipated trauma center destination.
 - b.** TCC will obtain key contact information of FST (i.e. cell phone number), exact pickup location of FST and time of pickup by AMR.
 - c.** If the designated FST provider is not able to provide a mobile FST team within the prescribed timeframe, TCC should contact the other Trauma Level 1 center for their FST team.
 - d.** TCC will also assist in coordination of field communications between field providers and FST responders. If available, TCC will obtain the designated Fire/EMS radio channel for the Field Surgical Team response and the primary point of contact at the scene (including the cell phone).
 - e.** For Ground Transports
 - i.** TCC will contact AMR Dispatch Center to provide Code-3 transportation for the FST members to the scene.
 - ii.** AMR Dispatch Center will contact the on duty Multnomah County AMR Supervisor for determination of the AMR unit assigned to the call.
 - iii.** AMR responding unit will:
 - Notify BOEC Dispatch of the request for assistance and the priority (Code-1 or Code-3) needed to respond both to the hospital to pick up the FST as well as to transport the FST to the scene.
 - Notify TCC of the status of the AMR unit assigned to the call and the estimated time of arrival at the trauma hospital to pick up the FST.
 - iv.** AMR transporting unit will:
 - Update the scene with the status of the responding AMR unit.
 - Confirm the desired location of the FST team.

- f.** For Air Transports when Life Flight Network (LFN) is not on scene
 - i.** TCC will contact LFN Dispatch Center to request air transport of surgeon to the scene.
 - TCC will provide LFN dispatch with the pickup location of surgeon.
 - TCC will provide LFN dispatch with the name and weight of surgeon and equipment.
 - ii.** LFN Dispatch Center will dispatch crew (pilot, flight paramedic, and flight RN) to pick up surgeon and equipment and transport to the scene.
 - iii.** LFN responding unit will:
 - Contact LZ command when 10 minutes from the scene.
 - Assist in patient care as directed.
 - The Surgeon's medical orders will take precedence over LFN's standing patient care guidelines.
- g.** For Air Transports when LFN is on scene
 - i.** LFN will call TCC to request air transport of surgeon to the scene. TCC will identify surgeon, pick up location and when available for pickup. TCC will relay this information to LFN.
 - ii.** LFN flight paramedic will accompany pilot to pick up location and return to the scene. LFN RN will stay on scene.
 - iii.** LFN responding unit will:
 - Contact LZ command when 10 minutes from the scene.
 - Assist in patient care as directed.
 - The Surgeon's medical orders will take precedence over LFN's standing patient care guidelines.

Transportation of a Hospital Emergency Response Team:

- A.** Communication from FST to TCC
 - 1.** The FST Team Leader will organize the team and equipment in accordance with the FST provider's internal policy, and the magnitude and nature of the incident.
 - 2.** The FST Team Leader shall inform the TCC once the team has been assembled and indicate the number of team members, location of team and equipment for pick up.
- B.** AMR Transporting Unit Communication duties
 - 1.** The AMR Multnomah County responding unit will maintain contact with the scene through the appropriate operational radio channels.
 - 2.** TCC will notify the Incident Commander of the estimated ETA of the FST.

Responsibilities of a Field Surgical Team on Scene:

- A.** Upon arrival of the FST, the Team Leader will report directly to the on scene Incident Commander or the designee (i.e. Medical Branch). FST members will, at a minimum, have visible identification that clearly identifies the individual as a health care provider (physician, nurse, etc.) and a member of the FST.

- B.** Overall command of the scene will remain the Fire Incident Commander.
- C.** FST members will follow all scene safety rules in accordance of the fire operational policies including reporting to the Safety Chief and Medical Branch when appropriate.
- D.** Fire and EMS will provide assistance as needed to the FST team including medical care. Anticipated Fire/EMS roles may include the following:
 - 1.** Scene access and safety.
 - 2.** Airway and hemorrhage control.
 - 3.** Assistance with the procedure.
 - 4.** Analgesic and sedation as necessary.
 - 5.** Extrication of the patient when procedure is complete.
 - 6.** Assistance with transport of the FST team members.
- E.** Upon the conclusion of the incident, FST will contact the AMR Dispatch Center to arrange for transportation of the team back to the originating facility.

Approval Process of a Hospital Emergency Response Team:

- A.** Level I Trauma Centers interested in providing a FST must develop internal policies to meet all operational requirements.

Pertinent Protocols:

- A.** Prehospital Care Protocols.
- B.** Trauma Patient Destination.
- C.** Trauma Triage.
- D.** Multiple Casualty Incidents.
- E.** Physician at the Scene.

Hazardous Materials

General Guidelines:

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 known or suspected (based on information from dispatch) hazardous materials situations 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.

Procedure:

A. Approach

1. All scenes:

- a. Use a cautious approach at all times.
- b. The reported location may be inaccurate and response into a contaminated area might occur.
- c. Approach upwind and upgrade if possible. If unable to approach from upwind/upgrade, approach at 90° to wind and grade, if possible, with safety in mind.
- d. Position vehicles well away from problem and headed away from incident.
- e. Communicate your actions or intended actions to EMS Dispatch.
- f. Remember contaminated and/or exposed response personnel may add to the overall problem and reduce their effectiveness to help.

2. If at any time, you **suspect** a hazardous materials situation:

- a. If first-in responder, confirm that fire and police have been notified.
- b. **The agency responsible for hazardous materials responses may respond with different levels of personnel and equipment based upon the information received.**
- c. **Do not always expect a hazardous materials team to respond.**
- d. If you are a first-in responder, the first priority is scene isolation.
 - 1) **Keep others away!**
 - 2) **Keep unnecessary equipment from becoming contaminated.**
- e. If you believe that you or your vehicle is contaminated, stage in an isolated area.

B. Person-In-Charge:

1. If the Paramedic is the first medical person on the scene, he or she should assume the role of PIC (medically) until a “Hazardous Materials (trained) Paramedic”¹ (HMP) arrives. The Incident Command System shall be implemented.
2. The HMP will direct all care.
3. The HMP will determine the method of transport of the exposed patient.
4. The HMP will determine who will provide care during transport. The HMP may remain as PIC during transport.

NOTE:

¹To be defined by the agency responsible for hazardous materials response. **Each organization will also develop a recognition method for the HMP.**

C. Patient care for the contaminated patient:

1. Types of incidents which may require decontamination of the patient:
 - a. Radiation
 - b. Chemical
 - c. Biological hazards
 - d. Toxic substances
2. Contamination can occur through:
 - a. Smoke
 - b. Vapor
 - c. Direct contact
 - d. Run-off
3. Transporting contaminated patients should be a serious concern to those involved. Patients who have been in contact with, or who are suspected of having been in contact with, hazardous substances should be transported for evaluation.
4. The hazardous materials team must be contacted about removal of contaminated clothing and packaging of the patient with regard to your protection and the patient's.
5. Determine the hazardous substance involved and provide treatment as directed by the HMP (in the absence of the HMP, consult the Poison Center through MRH).

D. Ambulance preparation:

1. The HMP shall determine the process needed for ambulance preparation.

2. Remove any supplies and equipment that would not be needed for patient care, (i.e., extra medical kits, etc.).
 3. Seal cabinets and drape interior, including floor and squad bench, with plastic or visqueen (available from hazardous materials team).
 4. Prepare stretcher by removing foam pad and placing down long backboard. Cover with plastic and tape in place if needed (available from hazardous materials team).
- E.** Transport and arrival at the hospital (if requested by HMP): If an ambulance has transported a patient from an incident that is subsequently determined to involve hazardous materials exposure, scene personnel must immediately relay all relevant information to the transporting unit(s) and/or receiving facility(s) involved (via EMS Dispatch, MRH, etc.).
1. OLMC and the receiving hospital should be contacted as soon as possible. The HMP or EMS Provider should communicate the material involved, degree of exposure, decontamination procedures used, and patient condition.
 2. The ambulance should park in an area away from the emergency department or go directly to a decontamination center or area.
 3. Patient(s) should not be brought into the emergency department before Paramedics receive permission from the hospital staff.
 4. Once the patient(s) has been released to the hospital:
 - a. Follow the HMP's direction and if necessary double bag the plastic sheeting used to cover the gurney and the floor into plastic bags.
 - b. Double bag any equipment that is believed to have become contaminated.
 5. After unloading patient from ambulance, check with the HMP to see where the ambulance can be safely decontaminated and whether or not there is equipment available for this purpose.
 - a. Do not begin decontamination without direction from the HMP.
 - b. **After consultation with the Hazardous Materials Team leader**, the HMP may recommend that the ambulance be decontaminated.
 6. Following decontamination recommendation from the HMP, decontaminate the ambulance and personnel before returning to the incident scene. If returning to the incident scene, bring bags containing contaminated materials, equipment, clothing, etc. and turn over to the HMP.
 7. Any ambulance that transports a patient who is, at the time of transport, contaminated or believed to be contaminated must be determined safe by the HMP (or the Hazardous Materials Team leader) before being placed in further transport service.
 8. It is the responsibility of the HMP (or the Hazardous Materials Team leader) to promptly provide the timely relay of information concerning all aspects of decontamination to the transporting licensee.

F. Paramedic exposure:

1. If a Paramedic is exposed or is concerned with the possibility of exposure, medical help should be sought immediately.
2. Report all personnel exposures to the HMP, OLMC, and your risk manager or supervisor.
3. Do not return to service until cleared to do so by the HMP (or Hazardous Materials Team leader), and your agency supervision.

Multiple Toxic Exposure

Purpose:

To provide guidelines for emergency response personnel on scenes that involve multiple victims who have been exposed to a hazardous material or hazardous environment. This procedure would be used when MSDS and DOT information indicate that victims may suffer untoward effects from their exposure and need **short-term**, continuing medical assessment. It would also apply when victims are symptomatic and have been exposed to a hazardous environment that poses little risk of long-term effects such as discharge of tear gas.

This protocol is NOT intended for use when there are symptomatic patients and the substance they were exposed to is unknown or when there is a potential for serious or long-term medical consequences. For these types of incidents, all patients should be transported, and EMS Providers should use the *Mass Casualty Incident* protocol.

Procedure:

- A. Triage determines that there are multiple victims who have been exposed to a hazardous material or environment and that these victims are presently asymptomatic or have been exposed to an agent that has transient effects (i.e., tear gas).
- B. Triage will assist the Hazardous Materials (trained) Paramedic/EMS Provider (HMP) in coordinating removal of the victims from the potentially hazardous environment, then isolate the victims as best as possible in a safe, well lit, and climate-controlled environment.
 1. If victim's clothing is not contaminated, consider using a bus or a room in a nearby building.
 2. If clothing is contaminated, removal of contaminants and proper procedures will be employed prior to isolating victims.
- C. Access to and egress from the Triage and Treatment Area **must be strictly controlled at all times**.
 1. It is necessary to keep track of patients who are under the care of EMS Providers, especially when the patient is a minor and his/her parent(s) are not present.
 2. Patients should not be allowed to leave the treatment or triage area without Triage or Treatment's knowledge.
 3. It is recommended that a guard be posted at the entrance and exit to control patient movement.
- D. The HMP will attempt to determine the type and level of exposure. The HMP will then contact MRH with information on the type of chemical and level of exposure.

50.070 Multiple Toxic Exposure

1. MRH will consult with Poison Control to determine any symptoms that are to be expected, the approximate time line for onset of symptoms, and recommended treatment modalities.
 2. When possible, a three-way phone link among the scene, MRH, and Poison Center should be arranged.
 3. The HMP will report this information to Triage and to Medical.
- E.** All potential patients entering the area will be triage tagged and baseline vitals will be obtained and recorded.
1. It is recommended that Triage consult with Medical and assign one EMS Provider for every 8 to 10 patients.
 2. If any exposure victim starts exhibiting symptoms, he/she will be immediately removed to the designated Treatment Area.
- F.** In consultation with MRH, Triage and HMP will make a determination regarding how long the victims will be observed and the frequency of evaluating and taking vital signs of each patient.
1. A log will be maintained of all patients treated and released. This log will include the patient's name, DOB, the date, symptoms (if any), and disposition.
 2. If the patients are asymptomatic after the designated observation time, they may be released.
 - a. The HMP or Triage will individually brief the patients regarding the symptoms they should watch for and should recommend further medical evaluation by their own physician.
 - b. Minor patients should only be released to their parent or guardian.
 3. Triage or the HMP will inform Medical of the number of patients being released.
- G.** It is recommended that Medical proceed with initiating all procedures normally undertaken during an MCI.
1. Designate treatment areas.
 2. Appoint Transportation and, if needed, Communication.
 3. Initiate an all-call.
 - a. Regional Hospital shall be notified that the all-call is precautionary in nature.
 - b. Regional Hospital will be notified by Medical or Communications (if assigned) if transport of patients is imminent.

Helicopter Emergency Medical Services

When to use Helicopter Service:

The *Trauma System* protocol directs use of the HEMS if it has the potential to save 10 minutes. Unstable medical patients may also warrant the use of HEMS transport. As always, judgment should be used, based upon specific scene circumstances.

- A. **Inner “Limited Use” Zone:** [up to 15 nautical miles from an appropriate receiving hospital] **Reasons for utilizing HEMS in the “Limited Use” zone may include:**
 - 1. Multiple patient scene
 - 2. Extended extrication, resulting in extended scene times
 - 3. Traffic impediments
 - 4. High system demands (extended ambulance ETA)
 - 5. Difficulty for ground ambulance to access the scene
- B. **Outer Zone:** [greater than 15 nautical miles from the appropriate receiving hospital]
 - 1. Consider use if overall out-of-hospital time will be decreased by more than 10 minutes:
 - a. Trauma entries
 - b. Unstable medical patients, or those in need of immediate intervention (Post cardiac arrest with ROSC, STEMI, AAA, sudden onset CVA)
 - c. Complicating patient conditions or significant underlying medical problems
 - d. Operational considerations (extended ambulance ETA, patient access, environmental considerations, multiple patient scenes)

Considerations:

- A. If more than one patient needs HEMS transport, request additional units early.
- B. Consider Landing Zone proximity to the scene, and consider a rendezvous point between the scene and hospital.
- C. It may be appropriate to cancel HEMS if a patient is packaged and ready for transport, but HEMS is still en route.

Dispatch Procedures:

- A. Standby or activation of HEMS will be requested through BOEC.
- B. Any person who has first aid or medical training may put HEMS on standby.
- C. Only on-duty public safety personnel and County EMS personnel, may activate HEMS.
- D. Units may cancel HEMS in accordance with *Cancellation/Slow Down* protocol.

Mass Casualty Incident (MCI)

The National Incident Management System (NIMS) will be used to manage all incidents.

1. Incident Command (IC) is the responsibility of the agency having jurisdiction (AHJ).
2. Each assisting agency shall retain full authority to operate within the scope of its agency operational and administrative protocols and procedures.
3. Agencies that are assisting in the support of a single jurisdiction will function under the direction of that jurisdiction's designated Incident Command.
4. Incident Command of a multi-discipline event should be predicated on the "Primary Hazard" of the event.
5. In a Unified Command, the "Lead Agency" may change as priorities change.

The Mass Casualty Incident Protocol is a tool that may be used in part or whole as determined by the on-scene Incident Commander. There is no set number of patients that will automatically initiate this protocol. If the Incident commander determines that additional resources or incident structure is needed to better manage due to the complexity of the incident, he/she shall announce to dispatch that an MCI is being declared. This may be done upon arrival or at any time during the incident.

- If the incident involves multiple asymptomatic patients (HazMat exposure) set up secure evaluation area. See ***Multiple Toxic Exposure protocol (50.070)***.
- During a declared MCI, the Trauma System is not in effect.
- "Licensed ambulances" are not needed for transport.
- If transport resources are limited, more than one critical patient may be placed in an ambulance.

Task Card - Medical

Reports to Incident Commander (or Operations in large incidents)

Objectives:

1. Coordinate all On-Scene EMS activity.
2. Coordinate Medical activities with Incident Commander (IC), and other ICS branches as needed.
3. Provide accountability for supervised personnel.

Actions:

- ☞ Establish Medical with Command.
- ☞ Obtain a separate working radio channel for use by Medical.
- ☞ Establish the following roles/functions and hand out vests, triage tags and task cards.
 - 📁 **Triage**
 - 📁 **Treatment**
 - 📁 **Transport**
 - 📁 **Destination** (reports to Transportation)
 - 📁 **Staging Area** (confirm area, and proper talk group)
 - 📁 **An assistant to help you with radio and face-to-face communications**
 - 📁 **Landing Zone (LZ)**
- ☞ Order additional resources and ambulances through Incident Command.
- ☞ Establish accountability system for personnel working within Medical.
- ☞ Refer to Medical checklists (see following page).
- ☞ Monitor performance of subordinates. Provide support and changes as needed.

SCENE CHECKLIST

Functional Assignments:	Tac:	Order Resources:	Tac:	HazMat
Triage		Ambulances (specify #)		Mass Decon
Treatment		Police (Secure Area)		Safety
Transportation		Buses		Rescue
Destination		Vans		
Staging Area		Medical Examiner		
Landing Zone		Red Cross		
		Specialty Teams		

OTHER ASSIGNMENTS

Incident Commander	Triage	Treatment	Transportation	Destination
				Staging Area

Task Card - Triage

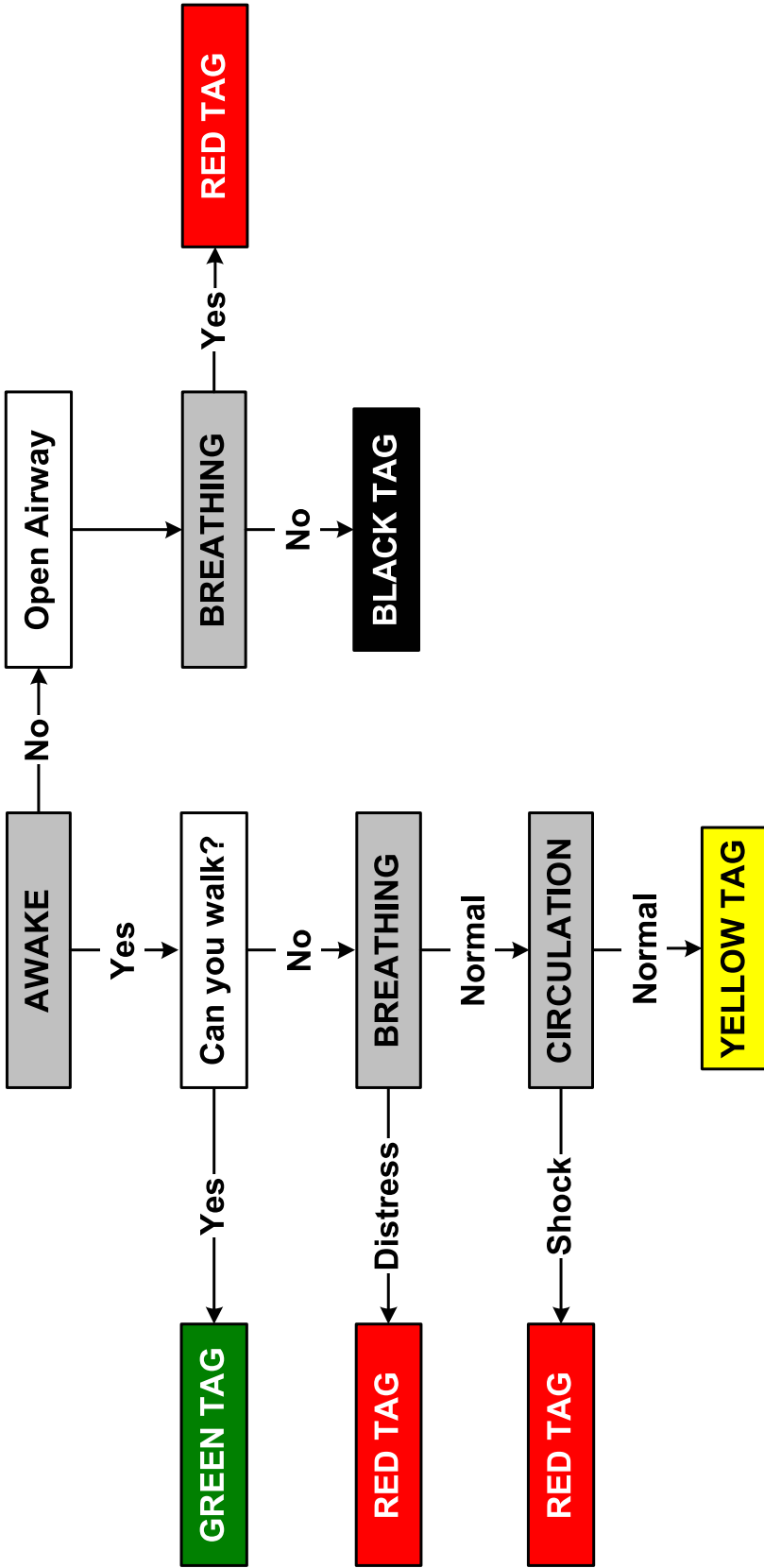
- ⓐ Manage the triage function at the incident. (Should not perform task level triage.)
- ⓐ Coordinate personnel/crews performing primary and secondary triage.
- ⓐ Maintain accountability of all triage personnel/crews.
- ⓐ Ensure rapid primary triage is performed – no more than 30 seconds per patient.
- ⓐ Ensure secondary triage point is established when necessary or that secondary triage is accomplished in place.
- ⓐ Coordinate movement of triaged patients to treatment/collection/transport area. (Order personnel and equipment as appropriate to accomplish this.)
- ⓐ Ensure appropriate patient triage log is initiated and maintained. (Multiple logs may need to be managed and information integrated depending on the scope of the incident.)
- ⓐ Relay triage information up the chain-of-command and update status as needed.
- ⓐ Assist treatment and transport supervisors/teams to locate their patients (after triage is completed).
 - In a hazardous incident, patients may not be able to be triaged until they are removed from the hazard zone.
 - Consider having crews utilize triage tags during secondary triage so that primary triage may be performed at appropriate speed.

Triage & Identify patients by category utilizing “ABC” method:

- Red*** Immediate life threat. (Must have rapid transport to survive.)
- Yellow*** Delayed. (Injuries can wait 1-3 hours before transport.)
- Green*** Ambulatory. (Injuries can wait 3+ hours before transport.)
- Black*** Dead. (No transport) Move only if needed to reach other live patients.

ABC Triage

Awake-Breathing-Circulation



Task Card - Treatment

Reports to Medical Branch (Use assigned radio channel). Coordinates with Triage and Transportation.

Objectives:

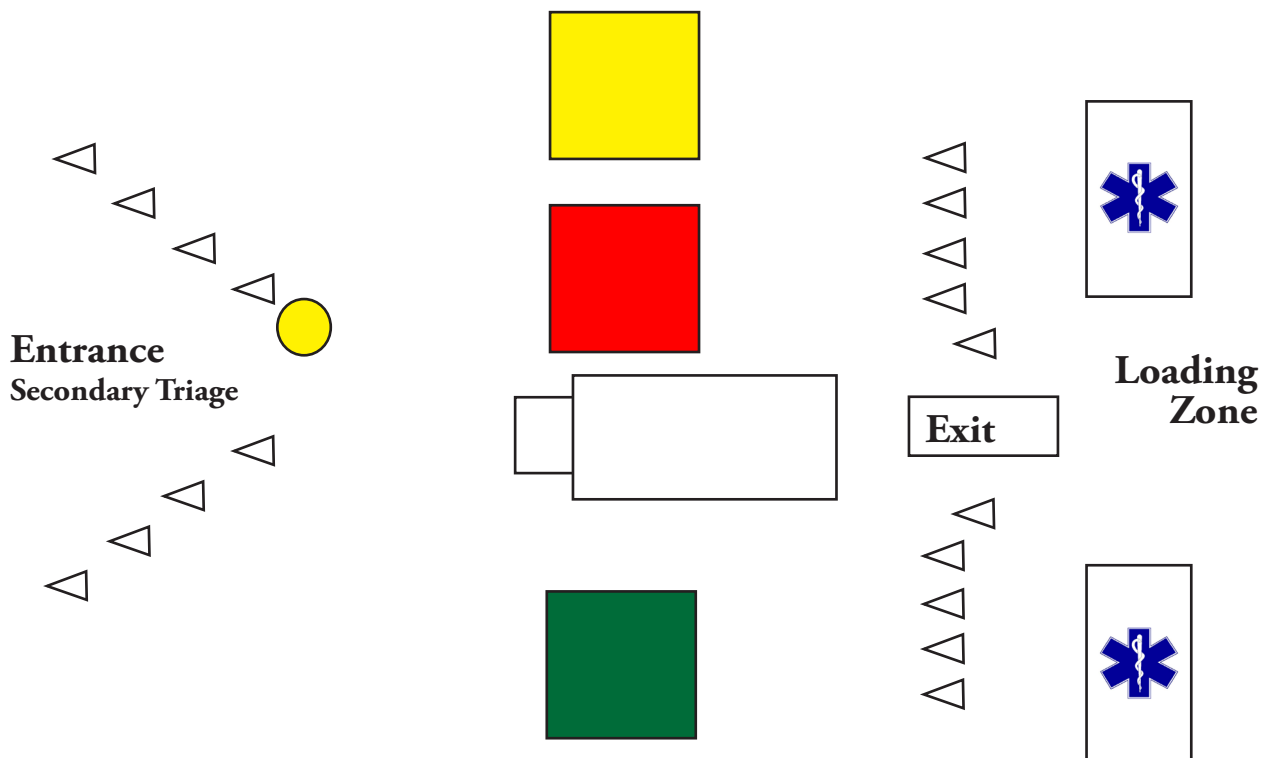
1. To rapidly treat and transport all patients.
2. Identify and establish large treatment area(s) to stabilize and care for patients until transported.
3. Coordinate all activities within the treatment area.
4. Coordinate movement of patients from treatment area(s) with Transportation.
5. Provide accountability for personnel working in Treatment.

Actions:

- ① Establish treatment area(s) large enough to receive estimated number of patients. Set up area with room to expand if necessary. Provide for environmental protection of victims and allow easy ambulance access and egress. If multiple treatment areas are needed, identify each geographically. (e.g. - North/South, street name, division name, etc.). See Diagram.
- ① Order additional resources through Medical.
- ① Clearly identify treatment area entry point. Assign a person at the entrance to conduct primary or secondary triage, attach triage tags and direct patients to correct treatment area.
- ① Consider appointing “Red,” “Yellow,” and “Green” Treatment Team Leaders and assign support personnel.
- ① Establish a medical supply drop area for incoming ambulances and fire units.
- ① Provide BLS care in the treatment area until resources allow a higher level.
- ① Ensure all patients in treatment area have been tagged with a triage tag.
- ① Identify the order in which patients are to be transported. Coordinate patient movement to the loading zone with Transportation.
- ① Provide accountability for personnel working within treatment area.

Treatment Area Guidelines

- ❑ Set up treatment area WELL AWAY from hazards. Consider ambulance access/egress, wind direction and slope.
- ❑ Make it BIG. Set up in an area that will allow you to expand.
- ❑ Clearly identify entry point and exit point for patient transportation.
- ❑ Utilize colored tarps and flags to identify each treatment area.
- ❑ Separate the green area from yellow/red area. Consider separating with CBRNE unit or other natural barrier.
- ❑ Assign treatment team leaders to each area and identify them with the appropriate colored vests.



SCENE CHECKLIST

OPS Channels	Medical:	Treatment:	Transport:
Assign Treatment Team Leaders		Current Patients in Treatment Area	
RED Team Leader:		RED	
YELLOW Team Leader:		YELLOW	
GREEN Team Leader:		GREEN	
Supply:		BLACK	
Additional Company Assignments		Notes:	
Company	Assignment		

OTHER ASSIGNMENTS

Command	Operations	Triage	Staging	Destination
OPS: _____	OPS: _____	OPS: _____	OPS: _____	OPS: _____

Task Card - Transportation

Reports to Medical Branch (Use assigned radio channel)

Objectives:

1. Coordinate movement of patients from treatment area with Treatment.
2. Coordinate all activities within the loading zone.
3. Coordinate flow of transport vehicles with staging.
4. Provide accountability for personnel working in Transportation.

Actions:

- Ⓞ Establish patient loading zone.
- Ⓞ Establish one-way vehicle access/egress with Staging.
- Ⓞ Request additional resources as needed from Medical.
- Ⓞ Assign Medical Communications.
- Ⓞ Supervise patient movement to loading zone with Treatment.
- Ⓞ Monitor medical radio channel to estimate number of incoming patients.

Loading Zone Location:

Access/Egress Location:

Resources Requested:

Time	Resource	Unit/Agency
<hr/>		
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Medical Communications:

Name: _____

Unit/Agency: _____

Task Card - Destination

Reports to Transportation

Objectives:

1. Coordinate hospital destination for patients leaving the loading zone.
2. Maintain the patient transport log using web based or protocol approved alternative.

Actions:

- Ⓞ Establish communications with “Regional Hospital.” [Via MCI channel, phone number or approved alternative (800 radio MCI channel or phone 503-494-7333.)]
- Ⓞ Confirm MCI has been declared with Regional Hospital and Dispatch.
- Ⓞ Provide total number of estimated patients.
- Ⓞ Establish communication with loading zone to receive information on patients ready for transport (e.g., face-to-face, runner, radio etc.).
- Ⓞ When a unit is ready to transport, contact Regional Hospital. Provide and record the following information.
 1. **Triage Tag #'s/ UPI if available**
 2. **Triage color/category**
 3. **Adult/Pediatric**
 4. **Unit number of transporting vehicle**
 5. **Destination per Regional Hospital**
- Ⓞ Confirm hospital destination with Regional and record.
- Ⓞ Inform the transporting unit of its destination.

Task Card - Regional Hospital Coordinator

Objectives:

1. Coordinate movement of patients from the scene to the hospital.
2. Optimize patient outcomes by matching available hospital resources (both quality and quantity) with need for resources (patients).

Actions:

- ☞ Assign destination hospitals / facilities for patients identified by hospital destination coordinator.
- ☞ Assist Scene Hospital Destination Coordinator in tracking patients.
- ☞ Provide a regional hospital response to the scene.
- ☞ Complete Patient Transportation Log as follows:

Triage Tag	Triage Level RYG	Adult or Pediatric	Destination	Unit

Yellow: Scene Transportation Supervisor (i.e., Hospital Destination Coordinator)

Teal: Regional Hospital

Patient Transport Log

Triage Tag # (last 4 digits)	Triage Level R/Y/G	Adult or Pediatric	Destination	Unit #	Transport Time
	RYG				
	RYG				
	RYG				
	RYG				
	RYG				
	RYG				
	RYG				
	RYG				
	RYG				
	RYG				
	RYG				
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	RYG				

On-Scene Medical Control

Purpose:

The purpose of this protocol is to describe who is in charge of patient care on the scene of medical emergencies and how to resolve disputes with other medical professionals in attendance. This protocol is not meant to apply to MCI events.

Procedure:

- A. EMS Providers/Paramedics/Prehospital Providers On-Scene: The first arriving, highest certified EMS Provider will be the Person-In-Charge (PIC) and will assume responsibility for directing overall patient care. The team approach to patient care assessment and treatment should be utilized by the PIC.
- B. When a higher level EMS Provider arrives, in an EMS role, that individual shall assume the role of PIC, after receiving verbal report from the initial PIC.
- C. The responsibilities of the PIC directing overall patient care include:
 - 1. Assuring that treatment, operations, and communications follow protocols.
 - 2. Coordinating patient care activities.
 - a. This PIC must watch over the entire patient care scene activities and be sure that the patient care activities are being accomplished in a rapid, efficient, and appropriate manner.
 - b. If there are only two advanced EMS Providers at the scene, the PIC must do only those patient care activities (e.g., starting IVs) which will allow him/her to watch over the whole scene easily.
 - 3. Directing other EMS Providers to establish airway management, start IVs, etc.
 - 4. Establishing the appropriate time to be spent at the scene for doing patient care.
 - 5. Determining when transportation of the patient is to occur.
 - 6. Performing medical coordination with all agencies and personnel.
- D. The PIC directing overall patient care will be held responsible and accountable for patient care activities performed at the scene and be identified on all patient care reports.
- E. If a patient requires transport and the first arriving PIC is from a non-transporting agency, provision of patient care will be turned over to the transporting EMS Providers (Paramedic) or flight personnel when:
 - 1. The patient is placed on the transport unit's gurney, OR
 - 2. At a time agreed upon by both EMS Providers (Paramedic), continued patient care will then become the responsibility of the transporting unit. **There will be a verbal agreement anytime transfer of care from one EMS Provider (Paramedic) to another takes place.** Example: "I am now turning over care of this patient to you."
 - 3. Where there are two agencies responding to a call and a transfer of care occurs there will be two PICs noted on all patient care forms, identified as the "scene PIC" and the "transporting PIC."

Paramedic Direction On Scene:

EMS Providers and Paramedics take medical direction from:

- A. Provider Advisor/Supervisors
- B. Regional Protocols
- C. On-Line Medical Control (OLMC) as directed in protocols
- D. Licensed physicians on-scene (MD or DO) or PA, NP, and only as allowed in this protocol.

Provider On Scene Policy, (within office)

- A. When EMS is called to a provider's office, the EMS Providers and Paramedics should receive information from the provider and attempt to provide the service requested by the provider.
- B. While in the provider's office, the provider shall remain in charge of the patient. The EMS Providers and Paramedics may follow the direction of the provider as long as it is within the Scope of Practice and protocols of the PIC.
- C. Once the patient is in the ambulance, unless the provider accompanies the patient, the EMS Providers and Paramedics shall follow the protocols.
- D. Anytime there is a conflict between a provider's orders and the protocols, OLMC shall be contacted.

Physician On-Scene Policy, (outside office)

- A. Any physician (MD or DO) or PA, NP at the scene of an emergency may be qualified to provide assistance to EMS Providers and Paramedics and shall be treated with professional courtesy.
- B. A licensed provider requesting control of patient care at the scene shall be:
 - 1. Thanked for the offer by the PIC.
 - 2. Advised that the EMS Providers and Paramedics work under regional protocols and On-Line Medical Control.
 - 3. Advised that we are not permitted to relinquish medical control to a provider on the scene without agreement from On-Line Medical Control.
- C. If the provider requesting control is not the patient's "provider of record," EMS Providers and Paramedics shall be authorized to proceed under the direction of the provider-
Only if all three of the following provisions are met:
 - 1. OLMC is contacted and authorizes transfer of patient care.
 - 2. The provider agrees to accompany the patient to the hospital in the ambulance.
 - 3. The provider agrees to complete and sign the appropriate patient care report.
- D. If communication with OLMC cannot be established, care may be provided only according to approved ALS protocols. No direction from an on scene provider may be accepted.

Disputes On-Scene Between EMS Providers or Other Medical Professionals

- A. Disagreements about care should be handled in a professional manner and shall not detract from patient care.
- B. To the extent possible, the ALS and BLS protocols shall be followed and provide the basis for resolving disputes.
- C. If an unresolved dispute continues between EMS Providers or other medical professionals concerning the care of a patient, OLMC **shall** be contacted.
- D. If a dispute arises which results in transfer of patient care from one PIC to another, the approximate time of the transfer shall be included on the patient care report.
- E. **Disputes shall not appear on patient care reports.** Written “Quality Assurance Reports” should be completed following any dispute arising at the scene.

Staging for High Risk Response

Purpose:

The purpose of this protocol is to establish guidelines for the response of medical responders to incidents that involve violence, or are anticipated to be potentially violent in nature.

Violent incidents are defined as assault, shooting, stabbing, or any other type of incident in which dispatch feels medical responders may be exposed to harm as a result of a violent act.

Procedure:

A. Staging

Medical units shall stage on the following:

1. Any time dispatch directs them to do so.
2. Any time a violent incident might expose medical responders to danger, or as directed by police.
3. Any call, at the medical unit's discretion.

Note: If any responding unit decides to stage; **all other responding units shall stage.**

4. 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.
5. 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.

B. Staging Policy: When staging:

1. Stage approximately two blocks from the incident address and **out of the line of sight.**
2. Announce arrival in staging and location in clear voice, by radio.
3. Additional responding units will respond to the same staging location if possible (avoid traveling past incident address).
4. Unless traffic hazard, turn off headlights and all warning devices. Turn on four-way flashers.
5. Once staged, units will not enter the scene until the scene is declared secure by police or dispatch, or if responders are directed into the warm zone by police.

- C. It shall not be assumed that the mere presence of police on scene means that medical responders may now proceed safely into the call location. If police are on scene, call Dispatch to request verification that medical units may proceed onto the scene or stage.

Transport by Fire Apparatus

Emergency Transport of Patients with life- or limb-threatening presentation when ALS ambulances are not available.

Principles:

The use of all available transportation resources should be employed to save the life of a patient. Whenever possible, the level of resource should represent the highest level of resources available at the time of incident. This should only be used when the standard 911 emergency ambulance is not available, or significantly delayed in response.

Purpose:

In accordance with Multnomah County Code 21.406 (E), the EMS Medical Director (EMSMD) may temporarily alter staffing as necessary to meet public health needs during extraordinary circumstances which overwhelm the emergency transport system or cause a shortage of ambulances, including, but not limited to: mass casualty incidents, natural or man caused disasters, inclement weather, mass illness or epidemics.

The purpose of this procedure is to issue the standing order for when and how this shall occur, and to define those occasions that require immediate action for altering that staffing or use of staffing not consistent with normal operations.

This standing order is issued for single responses that meet all of the below criteria, and is not authorization for a continuous uninterrupted duration of time. All efforts will be made to notify the EMSMD as soon as feasible following each use of this standing order

Extraordinary Clinical Situations

Procedure:

- A.** It may be appropriate for fire department first responders to utilize non-standard modes of emergency medical transport of a patient when:
 - 1.** Waiting for an incoming transporting ambulance will delay patient transport by 5 minutes or more, determined through the BOEC/Port Dispatcher *and*,
 - 2.** After assessment, the patient exhibits one or more of the following conditions:
 - a.** Inability to establish or maintain a protected airway.
 - b.** Severe respiratory distress unresponsive to prehospital therapies.
 - c.** Circulatory failure with an inability to achieve hemodynamic stability, (i.e. severe GI bleed).
 - d.** Abnormal or imminent delivery (e.g. breech, shoulder, or prolapsed cord).
 - e.** Suspicion of an evolving MI or CVA, which might benefit from rapid intervention.
 - f.** Post cardiac arrest.
 - g.** Continuing seizures unresponsive to midazolam.
 - h.** Patients presenting in shock, other than trauma.
 - i.** Any other life-threatening condition the Paramedic believes to be time critical.
- B.** In addition to those instances above, it is appropriate for a fire department apparatus to transport a patient when a licensed physician (MD or DO) on scene orders transport by the fire department.

- C. During a Multnomah County declared emergency when authorized locations (e.g. shelters) are accepting clinically stable individuals with no medical complaints, transport to an authorized location may be completed by MCEMS authorized first responders (e.g. PSR, CHAT) to the location(s) in accordance with fire agency policies.
- D. MCEMS must be notified, when feasible, on all fire department transports.

Transport Options (in order of priority):

- A. AMR 911 ambulance staffed by two paramedics - (the standard 911 transport mode).
- B. Fire Department licensed ambulance - with at least one paramedic.
- C. Mutual aid by a licensed 911 ambulance from neighboring County - with at least one paramedic.
- D. AMR BLS ambulance - with at least one paramedic.
- E. Fire apparatus - with at least one paramedic.
- F. Any of the above options with a lower level EMS provider in place of the one paramedic
- G. Any of the above options with no licensed person to care for the patient during transport.

Determination of Closest Available Ambulance

In the event of no ambulance being assigned to a response, fire will contact BOEC/Port and request the closest available ambulance (AMR or fire). If neither AMR nor fire ambulance is available, BOEC/Port along with AMR System Status Plan Coordinator (SSPC) will determine the best resource to send and communicate with the requesting fire, what unit will be responding and estimated ETA.

Responsibility Issues

In the setting of AMR BLS ambulance with care provided by fire personnel, fire will assume all responsibility for the care of the patient with AMR assuming responsibility of the transportation and the vehicle.

The agency providing clinical care shall bring the needed equipment and supplies with them for the transport as there is wide variation in equipment and supplies across all of the non-standard modes of transport.

In the event of a BLS ambulance staffed by an AMR paramedic and EMT, the AMR paramedic will assume the responsibility for the patient per current MCEMS protocols. Fire personnel will continue to assist in patient care.

The transporting PIC shall ensure a radio report is made to the receiving hospital as soon as possible after the destination hospital is determined.

A copy of the patient care record shall be provided to the agency that performs the transport by the agency personnel that provided the clinical care during transport. Additionally, the patient care record shall be left at the receiving facility with the patient.

Communication with patient if a BLS ambulance is used and no AMR paramedic is available

If the patient is conscious and has capacity, the fire provider will inform the patient that due to the life- or limb-threatening condition, they will accompany the patient during the transport.

Transportation and Patient Destination

Purpose:

To assure respect for patient autonomy and decision-making while providing safe medical transportation. See *Transport by Fire Department Apparatus* protocol.

Procedure:

- A.** Patients should be transported to the hospital emergency department of their choice, with the following exceptions:
 - 1.** The patient is entered into the Trauma System.
 - 2.** The patient is being transported to the Burn Center.
 - 3.** The requested hospital is on Total Ambulance Divert (TAD), or diverting the patient's particular category, per the ADS System at EMS Dispatch or MRH.
 - 4.** The patient requires transport code-3 to the closest hospital (even when the closest hospital is on divert) when in the judgment of the Paramedic the patient is unstable due to one or more of the following conditions:
 - a.** Inability to establish or maintain a protected airway.
 - b.** Severe respiratory distress unresponsive to prehospital therapies.
 - c.** Circulatory failure with an inability to achieve hemodynamic stability, (i.e., severe GI bleed).
 - d.** Abnormal or imminent delivery (e.g., breech, shoulder, or prolapsed cord).
 - e.** Suspicion of an evolving MI or CVA, which might benefit from rapid intervention.
 - f.** Post cardiac arrest.
 - g.** Continuing seizures unresponsive to midazolam.
 - h.** Patients presenting in shock, other than trauma.
 - i.** Any other life-threatening condition the Paramedic believes to be time critical.
- B.** If the patient has no hospital preference transport should be to the nearest appropriate hospital emergency department.
- C.** Any time a patient is transported to a hospital other than the one requested the reason for the change and the destination hospital shall be documented on the Prehospital Care Report.