PREHOSPITAL PATIENT CARE PROTOCOL

ADMINISTRATIVE

Section I

Rappahannock EMS Council
435 Hunter Street
Fredericksburg, VA 22401

BASIC LIFE SUPPORT/ADVANCED LIFE SUPPORT ADMINISTRATIVE PATIENT CARE PROTOCOL

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1.0 Introduction and Use

The following protocols have been approved by the Rappahannock Emergency Medical Services Council (REMSC) Medical Direction Committee as the Prehospital Patient Care Protocol for agencies in the REMSC region. These treatments were developed through input and guidance from ALS and BLS providers in the region, as well as the various medical directors. The protocols are designed to provide information on procedures providers at different levels are permitted to do and denote standing orders for certain conditions. The medical director may choose to modify certain treatment recommendations for specific conditions and may even limit performance authorization for any provider at any level. These modifications should be supported by written documentation and may be maintained in a file at the regional council or at the individual agency.

The treatment protocols are designed to give reminders and guidance for various conditions but are NOT a replacement for sound clinical judgment. As clinical guides, they are not intended to be educational documents and training should be completed PRIOR to their use to understand the information contained and the guidance that it provides. They also outline care for a typical presentation and may not fit exactly with the patient who has combined symptoms from multiple conditions. In cases where progressive care is indicated by permission for repeat orders, it is assumed that the prior care was not effective and the patient continues with symptoms or worsens. If additional treatment is not necessary you are not obligated to complete the entire treatment protocol just because it is written.

The provider may contact on-line medical control for guidance and assistance. Many of the protocols are designed to allow providers to initiate appropriate care promptly without requiring contact with medical control first. With that acknowledgment comes the medical director's expectation that providers perform complete assessments, recognize proper signs and symptoms, and provide condition-related therapy by utilizing ardent clinical assessment skills and keen critical thinking and clinical judgment. The order of treatment in the protocol may not always be appropriate for all patients and based on clinical judgment it may be modified by providers. If there are questions or uncertainties medical control should be used rather than making assumptions and providing unsuitable care.

The physician providing on-line medical control has the authority to suspend or deviate from the protocol and may provide additional or changed orders which are not specified in the regional protocol. Any order received from medical control must be reduced to writing and documented on the patient care report.

Treatment is broken into categories depending on how the physician group recommends that it be used. In previous versions there was a conditional category that addressed supplemental certification with classes like ACLS, PALS, PEPP, ITLS, etc.

It is the expectation that ALS providers (EMT-I and EMT-P) maintain certification in ACLS and PALS. Many of the treatment algorithms are based on science and information from these classes and where applicable, treatment recommendations from ACLS, PALS, and NRP are included in the protocols. All protocols are standing orders, unless otherwise noted.

A complete Prehospital Patient Care Protocol consists of all sections including Administrative, Clinical Procedures, Medical and Trauma.

A copy of this document should be kept at the emergency department (ED), each EMS agency, and in every ambulance unit in the REMSC region. Additional copies are available at www.REMSCouncil.org.

Each protocol is dated by month and year. It will be reviewed as needed by the REMSC Protocol Sub-Committee. Revisions are made to individual treatment protocols as needed and periodic complete reviews are done triennially. Any provider may submit input for changes to the regional protocols by submitting written requests and ideas to the REMS Council with attention to "protocol updates". All suggestions will be routed through the Protocol Sub-committee, who will make recommendations to the Medical Direction Committee. Once approved, changes will be made and revised pages will be issued to EMS Physicians, the ED medical staff (Medical Director), and to the individual agencies that will then be responsible for any necessary in-service training.

To ensure adequate notice to committee members, proposed changes must be submitted in writing at least 3 weeks prior to the meeting date, in order to include them in the meeting agenda. Emergency changes may be presented by the Chair via a regularly scheduled meeting.

Class I - Administrative Update - Limited to grammatical changes, updates to medication availability, or hyperlink corrections and formatting. Can be amended by staff with approval of the Regional Medical Director.

Class II - Minor Change – Medical Direction Committee approved changes to general procedure that does not change regional scope of practice or add medication. Medication dosage changes within current therapeutic ranges. May include language for clarification, but not change of practice. Requires an absence of opposition after email distribution to Medical Direction Committee and approval by Regional Medical Director otherwise will be brought to Medical Direction Committee for further discussion. Does not need to go to the Board of Directors for approval.

Class III - Major Change – Medical Direction Committee approved changes to scope of practice for any level, changes to medication or therapeutic ranges, changes to equipment or procedures. Requires endorsement of Medical Direction Committee and the Board of Directors before implementation.

Once changes have been made, dates will be updated to indicate the change and the new protocol will be posted to the internet on the REMS Council website.

Notification will be made to providers in the region through information on social media, announcements on the website, posting at the regional hospitals, and information in the newsletter and other communication devices.

2.0 Acknowledgements

The Rappahannock Emergency Medical Services Council Board of Directors would like to thank each person who took the time to review and revise our existing protocol and to write a new protocol that reflects the current standard of quality patient care for our region. As new science updates produce changes in the standard of care, we continue to revise the protocols to reflect these updates.

Special thanks to Dr. Tania White, Regional Medical Director, for her ongoing contributions and for being open to our ideas. **Thanks to everyone who assisted in this project.**

3.0 Administrative Guidelines

A "patient" means any person with an acute symptom related to a medical and/or trauma event who receives, or should have received, health care from an EMS provider.

3.1 Abandoned Infant

3.1.1 Overview (Virginia Safe Haven Law)

The Code of Virginia § 18.2-371.1 identifies that parents may surrender their newborn infant to EMS personnel. The code reads, "… parent safely delivered the child to a hospital that provides 24-hour emergency services or to an attended rescue squad that employs emergency medical technicians, within the first 14 days of the child's life. In order for the affirmative defense to apply, the child shall be delivered in a manner reasonably calculated to ensure the child's safety…" If a provider is approached by this situation, the provider should attempt to gain as much information concerning the infant as possible from the parent. Once the infant has been turned over to EMS, the infant should be transported to the closest emergency room. Explain the situation to the Charge Nurse and be sure to document their name on your call sheet. The hospital will notify social services.

3.2 Air Medical Utilization

3.2.1 Overview

Air Medical Services (AMS) are a valuable resource in the REMSC. It is important that EMS personnel utilize consistent and appropriate criteria when requesting air medical service for assistance with patient care and transport. These criteria are consistent with national AMS utilization criteria. It is important that review of appropriate helicopter utilization be a part of EMS training, as well as a component of agency, and regional level retrospective quality improvement process.

3.2.2 Management

The helicopter is an air ambulance and an essential part of the EMS system. It may be considered in situations where:

1. The use of the helicopter would speed a patient's arrival to a hospital capable of providing definitive care and that is felt to be significant to the patient's condition, or (i.e., neurosurgery/thrombectomy, PCI, reimplantation, or other time-sensitive surgical interventions);
2. Specialty services offered by the air medical service would benefit the patient prior to arrival at the hospital (i.e., blood products, RSI/Cric/airway management, pediatric or burn specialty services needed).
3. Specialty services are needed by the patient which are not available at the local/regional level (i.e., VAD, artificial heart, STEMI complications).

Patients in cardiac arrest who are not hypothermic are generally excluded as candidates for air transport

Dispatch, Police, Fire, or EMS should evaluate the situation/condition and, if necessary, place the helicopter on standby. The helicopter may be requested to respond to the scene:

If ALS personnel request the helicopter

If BLS personnel request the helicopter when ALS is delayed or unavailable

In the absence of an EMS agency, when any emergency service requests it, if it is felt to be medically necessary

When EMS arrives, they should assess the situation. If the ***most highly trained EMS personnel on scene*** determine the helicopter is not needed, it should be canceled as soon as possible.

Air medical services may be considered in situations where the patient is inaccessible by other means, or if utilization of existing ground transport service threatens to overwhelm the local EMS system. In this case a specialty unit with rescue capabilities (i.e., hoisting equipment or FLIR) may be the most appropriate resource.

An EMS service should not wait on the scene, or delay transport to wait for the arrival of a helicopter. If the patient is packaged and ready for transport, the EMS service should initiate transport to the hospital and reassign the landing zone. The helicopter may intercept an ambulance during transport at an alternate landing site. If a hospital helipad is utilized for patient pick-up, you should notify hospital security that you will be using their LZ.

THIS IS A GUIDELINE AND IS NOT INTENDED TO SPECIFICALLY DEFINE EVERY CONDITION IN WHICH AIR MEDICAL SERVICES SHOULD BE REQUESTED. GOOD CLINICAL JUDGEMENT SHOULD BE USED AT ALL TIMES.

Transfer of Patient Care, Documentation, and Quality Improvement:

As with other instances where care of a patient is transferred, all patient related information, assessment findings, and treatment will be communicated to flight crew. At the completion of the EMS call, all of the details of the response, including, but not limited to, all patient related information, assessment findings, and treatment, must be documented on an ePCR.

With helicopter utilization, as with all EMS responses, the treatment and transportation of patients will be reviewed as a part of a Quality Improvement process.

3.2.3 Guidelines for Helicopter Utilization for Scene Response

Refer to the trauma triage and stroke/STEMI triage guidelines.

3.3 Code Gray (Refer to SCFRD IMD 2022-001)

If CPR has been initiated by EMS and circumstances arise where the prehospital provider believes resuscitative efforts may not be indicated, the provider should confirm that the patient is apneic and pulseless, and, when possible, note the ECG rhythm and verify absence of cardiac activity by auscultation and/or ultrasound. The provider should then contact medical control so that the on-line physician can decide whether or not to continue resuscitative efforts. Providers should alert on-line medical control that they have a potential “Code Gray" call.

The provider should then summarize why resuscitative efforts may not be indicated. The provider should then report the ECG rhythm and interventions performed. Then if, and only if, directed by on-line medical control, may the providers stop resuscitative efforts. If code gray orders are received while transporting (i.e., moving the patient into the ambulance), the providers are to continue non-emergency to the hospital in which the order was received. The deceased is to be taken to the emergency room. Under no circumstances will the providers take a patient directly to the morgue.

NOTE: Patients who are hypothermic or are victims of cold-water drowning should receive FULL resuscitative efforts. Patients with electrical injuries, including those struck by lightning that may initially be pulseless and apneic, should receive FULL resuscitative efforts as well.

Any medical equipment attached or inserted into a patient MUST remain in place once a code gray order has been received. The provider is not to remove anything from the body unless specifically directed to do so by medical control or the Medical Examiner on scene. Any such actions must be fully documented within the ePCR.

3.4 Death (DOA) Management (Refer to SCFRD IMD 2022-005)

3.4.1 Indications

Unattended deaths in the field (meaning unattended by a physician or Hospice) are the exclusive jurisdiction of the Medical Examiner. Generally, when EMS is called to verify a DOA, the scene is turned over to law enforcement who, in turn, contacts the Medical Examiner for release to a funeral home or the Medical Examiner’s office for autopsy.

If a patient is determined to be dead on arrival (DOA) or if the cessation of resuscitative efforts on scene is authorized by on-line medical control, follow local protocol concerning notification of the proper law enforcement authorities and/or medical

examiner. Should an unusual situation occur where transport may be necessary, EMS should only transport a DOA to a hospital.

NOTE: It is essential to maintain a Chain of Custody in regards to any DOA case involving the Medical Examiner. Providers should remain on scene until the arrival of either the Medical Examiner or law enforcement personnel.

3.4.2 Management

Providers should make every effort not to unnecessarily disrupt or disturb the scene. All DOA calls are a potential crime scene until proven otherwise. Document the following:

1. Apnea and pulselessness (no cardiac activity by auscultation and/or ultrasound)
2. Presence or absence of rigor
3. Approximate down time
4. A short medical history and the general condition of the scene and the body

Be attentive to the emotional needs of the patient's survivors. If possible, leave survivors in the care of family and/or friends.

NOTE: Patients who are hypothermic or are victims of cold-water drowning should receive FULL resuscitative efforts. Patients with electrical injuries, including those struck by lightning that may initially be pulseless and apneic, should receive FULL resuscitative efforts as well.

As a courtesy, share the information that you have gathered with the law enforcement official in charge on the scene. Do not assume that the officer knows that he/she is the one that should make contact with the Medical Examiner. Remember, that some newer officers may not be familiar with Medical Examiner laws. As time and conditions permit, lend whatever assistance you can to the officer and any family present.

3.5 Direct Admissions

3.5.1 Indications

Ambulance crews involved in transporting direct admission patients to hospitals should be able to return to service as quickly as possible. **All 911 calls, or calls handled by state/municipal/volunteer services, shall only take patients to the ED.** Private ambulance services serve to fill the direct admission gap. It also is important that direct admission patients be properly treated and spared unnecessary costs.

3.5.2 Management

When responding to a direct admission call, ambulance crews should notify the receiving hospital's ED as early as possible to allow the ED staff to follow-up with hospital admissions.

Upon arrival at the hospital, the AIC should speak directly with the ED charge nurse or appropriate hospital contact. The charge nurse and AIC will determine the following:

1. Is the direct admission patient's room ready?
2. Is the ambulance crew needed to take the patient to the room?
3. Is the crew available to take the patient to the room?

If the answer to any of the above questions is "no", the AIC will turn over care of the patient to the ED staff. The crew will then return to service as quickly as possible. If the answer to all of the above questions is "yes", the crew may assist as necessary.

Any complaint or problem involving a direct admission will be resolved at a later time through direct discussion between the ED nurse manager, or appropriate hospital contact, and the chief operating officer of the prehospital agency, or persons designated by those individuals.

3.6 Documentation and Confidentiality

3.6.1 Indications

Under existing Virginia law, all licensed EMS agencies are required to "participate in the prehospital patient care reporting procedures by making available...the minimum data set on forms." Licensed EMS agencies, prehospital providers, and the Commonwealth of Virginia are required to keep patient information confidential.

3.6.2 Management

Each EMS agency should, in consultation with the agency's legal counsel, develop a procedure dealing with how and when patient information will be released to the patient, the patient's family, law enforcement officials, the news media, and/or any other parties requesting the information.

The procedure **MUST** include development of a release form, which will be signed by a responsible person for that patient's information.

Documentation of patient care should, at a minimum, meet the OEMS requirements.

1. A patient care report will be written for each patient who is seen, treated and/or transported by ambulance or personnel thereof. This report should be completed on the current written/electronic Prehospital Patient Care Report (ePCR) in use by the REMSC region. For medical-legal purposes, if the provider initiates the patient-provider relationship, an ePCR should be completed.
2. If a patient refuses treatment and/or transport, documentation should include the following:
    a. The patient's full name
    b. The reason for response
    c. Reason for the patient's refusal
    d. Vital signs and times (when possible)
    e. Any physical signs or symptoms that are present
    f. Perceived competency of the patient
    g. Patient's level of consciousness
    h. Names and signatures of witnesses
    i. Signature of the patient
3. When a patient is transported, a copy of the report should be provided to the receiving hospital.

4. Medications may be administered by a prehospital provider upon an oral order or written standing order of an authorized medical practitioner in accordance with §54.1-3408 of the Code of Virginia. Oral orders shall be reduced to writing by the prehospital provider and shall be signed by a medical practitioner. The Regional EMS Physician, with the agency EMS Physician, shall approve all written standing orders. The prehospital provider shall make a record of all medications administered to a patient. If the patient is not transported to the hospital, or if the attending medical practitioner at the hospital refuses to sign the record, a copy of this record shall be signed by the prehospital provider. The provider will then have 7 days to get their EMS Physician's signature and get the paperwork to the pharmacy in accordance with current Board of Pharmacy regulations.
5. EMS agencies are urged to develop, in consultation with legal counsel, an incident report form for quality assurance purposes, and to document any additional information relevant to the treatment and transport of patients.
6. Agencies should have a minimum set of security guidelines for narcotics boxes. Suggestions may include the following:
    a. Video cameras of areas where locked med boxes are stored
    b. Keep a current list of providers who have keys for drug boxes
    c. Keypad entry or other such security system for storage bags
    d. Designated areas where drug boxes are to be located, both in the ambulance and in the squad bay
    e. Written policy for reprimanding offenders

3.7 Durable Do Not Resuscitate Orders (DNR)

Validity of a DNR order is determined by the DNR meeting the requirements of "Durable Do Not Resuscitate" guidelines as described by the OEMS pursuant to 12VAC5-66 which was effective July 20, 2011. Additional information and the current DNR form are available at http://www.vdh.virginia.gov/oems/ddnr/.

3.7.1 Management

The responding prehospital providers should confirm appropriate DNR status immediately upon arrival. If status cannot be confirmed, the responding prehospital providers should perform routine patient assessment and resuscitation or intervention efforts. The following procedures should be followed:

1. Determine that a valid DNR is present and in effect. It is NOT necessary that the original EMS-DNR order be present and legible copies may be accepted.
2. If the patient does not have an EMS DNR authorized, "alternate DDNR jewelry" can be honored at any time, but it must contain equivalent information to the state form.

3. A verbal order from a physician can be honored by a certified EMS provider. The verbal order may be by a physician who is physically present and willing to assume responsibility or it may be from on-line medical control.

4. Acceptable 'Durable DNR Order' shall also include a physician order for scope of treatment (POST), medical orders for scope of treatment (MOST), physician order for life sustaining treatment (POLST), or medical order for life sustaining treatment (MOLST), as well as out of state DNR's. Durable DNR orders, as well as the above comparable forms, shall be completed and signed by a licensed practitioner and signed by the patient or patient's authorized representative.
5. "Other" DNR orders include a physician's written DNR order that is in a format other than the state form is also acceptable. "Other" DNR orders should be honored by EMS providers when the patient is within a licensed healthcare facility or being transported between healthcare facilities.
6. An incomplete DNR should prompt consultation with on-line medical control. Resuscitative efforts, once begun, can only be stopped with the guidance of medical control.
7. All providers are strongly encouraged to review the Virginia DNR, as there are some limitations, such as intubation and no CPR.

Providers should use the standard ePCR for full documentation of the DNR case, including the format and authorization for DNR and/or the order number on the form and/or bracelet in the case of an EMS-DNR.

3.8 Extraordinary Care Not Covered by this Protocol

3.8.1 Indications

There may be rare cases in which a physician providing on-line medical control may feel it is absolutely necessary to direct a prehospital provider to provide care, which is not explicitly listed within protocol, in order to maintain the life of a patient.

3.8.2 Management

During consultation, both the consulting physician and the ALS provider ***must*** acknowledge and agree that the order is absolutely necessary to maintain the life of the patient. The ALS provider ***must*** feel capable, based on the instructions given by the consulting physician or previous training, of correctly performing the care directed by the consulting physician. If the ALS provider receives an order for care not covered in this protocol, and is not comfortable with performing that order, or does not agree that the order is absolutely necessary to maintain the life of the patient, the provider should proceed with the directions contained in protocol 3.11.

Anytime this authority is exercised by a REMS EMS provider a QI review will automatically occur and the provider should complete a shared-concern inquiry form to notify the REMS Council of the event.

3.9 HEAR Usage & On-Line Medical control

3.9.1 Indications

To contact appropriate medical control/ HEAR radio at hospitals.

3.9.2 Management

The presence of multiple facilities in the REMS region allows for more HEAR stations. Squad patient reports should be destination specific. A squad's call for on-line medical control should be destination specific and on-line medical control will occur with the facility that is receiving the patient.

3.9.3 Hospital Report

The region as well as the hospitals are frequently inundated with patient transport and other related patient care issues. Therefore, all effort should be made to provide as much notice as possible to the receiving facility. The report should be limited to a one-minute report that highlights important areas that will impact the receiving facility. Do not ramble on with innocent details that are not necessary; give only relevant and necessary information.

3.9.4 SCFRD 700 MHz Radio System

EMS clinicians shall notify the receiving hospital of their arrival and pertinent patient information using the SCFRD 700 MHz radio system, when possible. The following hospitals within the departments' service area are assigned a talk group on the SCFRD 700 MHz radio system:

Stafford Hospital (SH)
Mary Washington Hospital (MWH)
Spotsylvania Regional Medical Center (SRMC)
Sentara Northern Virginia Hospital (Sentara)

3.10 Impaired Field Providers

3.10.1 Indications

Field providers will NOT appear for duty, be on duty, or respond via privately-owned vehicle (POV) while under the influence of any prescribed, or over-the-counter, medications that could impair their ability to drive or otherwise provide quality patient care.

Field providers will ***not*** appear for duty, be on duty, or respond POV while under the influence of intoxicants or illegal substances, to any degree whatsoever, or with an odor of intoxicants on their breath.

3.10.2 Management

In the event that it can be reasonably thought that a provider is under the influence or have an odor of intoxicants on their breath during an emergency call, the provider shall be removed from the scene of the call, and, after an investigation where they are found to be in violation, the provider will be subject to disciplinary action by the EMS Physician.

3.10.3 Actions

The provider may be asked by the REMSC, and/or EMS Physician, to take a drug or alcohol test. If the drug/alcohol test is positive, confirmatory testing may be indicated and paid for by the individual. The provider may, at his or her own expense, have a test performed using the same sample. The above expenses may be taken care of by the individual agencies per policies.

3.11 Inability to Carry Out a Physician Order

3.11.1 Indications

Occasionally, a situation may arise in which a physician's order cannot be carried out, the ALS provider is unable to administer an ordered medication, a medication is not available, contact is not possible with on-line medical control, it is out of the provider's scope of practice, or a physician's order is inappropriate.

3.11.2 Management

If a provider is unable to carry out the physician order, the provider shall notify the consulting physician immediately that the order could not be carried out and give the reason why it could not be carried out. The provider shall then indicate on the ePCR what was ordered, and the time and the reason the order could not be carried out.

In situations where the prehospital care provider is unable to establish communications with a medical command facility after at least two attempts each, on two different means of communications, the provider may:

Provide care within their scope of practice
Follow the appropriate protocol as standing order indicated by your level of certification
Document the issue on a shared concern inquiry form and route it through the QI process.

3.12 Infection Control

3.12.1 Exposure to Blood and Body Fluid Provider Responsibilities

As soon as possible after exposure to blood and/or body fluids:
Eyes: Irrigate with clean water, saline, or sterile water
Mouth and Nose: Flush with water
Skin: Wash with soap and water
Clothing: Change contaminated clothing promptly and inspect the skin for signs of openings and contamination
Needle-sticks: Wash with soap and water

Upon arrival at the hospital ED, or as soon as possible thereafter, notify a hospital official/representative (ED physician, ED nurse manager, charge nurse) of any possible exposure (or follow your department's exposure control plan). Notify the agency's designated Infection Control Officer (ICO) as soon as possible of any possible exposure, and of emergency, non-emergency, and follow-up care.

Obtain and complete, before leaving the hospital, a REMSC infectious disease exposure report, which is available in the emergency department, or agency form (follow your department's exposure control plan).
Use one exposure report form for each provider.
Distribute copies as indicated on the report.

3.12.1.1 Exposure: Hospital Responsibilities

Notify the EMS agency's designated ICO when a patient transported by its providers is determined to have an airborne or blood borne infectious disease, and an exposure has occurred. Furnish the prehospital providers with a REMSC infectious disease exposure report(s). Providers may use their agency's form, or their designated ICO may complete this, and all other, required forms.

After receiving the completed exposure report, perform the appropriate testing on the source patient and render appropriate initial treatment to the exposed provider as determined by the ED physician (or follow your department's exposure control plan for treatment of the provider). Providers have the right to refuse treatment after informed consent.

Furnish test results to the exposed providers, and agency designated ICO, as soon as possible, or within 48 hours after the exposure (*as outlined in the Ryan White Law (Public Law 101-381*).

Notify the EMS agency's designated ICO, in writing, of the exposure, ensuring that providers get any emergency treatment indicated, and that all appropriate hospital reports are completed. Providers must contact their agency's designated ICO to report the exposure for emergency, non-emergency, or follow-up care.

All treatment for exposure management will follow the published recommendations set forth by the U.S. Public Health Department (the Centers for Disease Control and/or the Advisory Committee on Immunization Practices).

3.12.1.2 Exposure: EMS Agency Responsibilities

Appoint and educate, by the first of July each year, one individual to serve as the agency's designated ICO. This individual will be familiar with the agency's infectious disease control plan, the REMSC infectious disease exposure report, and this protocol. The individual will also be familiar with airborne and blood borne pathogens, other infectious diseases, the OSHA blood borne pathogen standard 1910.1030, and the recommendations of the CDC. The individual's name, and that of the agency's EMS Physician, will be furnished each year to the REMSC.

Ensure that decontamination procedures, according to the agency's exposure control plan, are completed ***immediately***, or as soon as possible, after the incident.

Notify the prehospital agency's designated ICO of the exposure, or possible exposure, and the actions that have been taken. Notify the designated ICO from any other agency who may have had personnel exposed during the incident.

Respond to the receiving hospital's infection control liaison immediately after receipt of written notification of an exposure. Work with the agency EMS Physician, or other designated physician, and the receiving hospital to ensure that the provider has received appropriate follow-up care, all appropriate reports have been completed and filed, and that the incident has been brought to a closure.

3.13 Inter-facility Transfer of Acutely Ill/Injured Patients

3.13.1 Indications

A physician requests an inter-facility transport of a patient for whom procedures and/or medications have been initiated that are beyond the normal scope of the EMS agency's protocol or practices. These transfers would generally not be initiated through 9-1-1 dispatch, but rather through a private service (ground or air.)

3.13.2 Management

The inter-facility transport should be performed by an ALS-equipped and ALS-staffed ambulance and should take place only after the receiving physician has conferred with the sending physician. Prior to dispatch, the sending physician/institution will provide the EMS agency with a patient report that includes the patient's condition and any special treatment the patient is receiving. If the treatment is outside of the provider's scope of practice, the agency's EMS Physician MUST be contacted for transport approval and to determine if other appropriate personnel should accompany the patient.

It is not acceptable to get orders and/or extend the scope of practice from a physician at the hospital where the transfer originates. During transport, questions regarding patient care should be directed to the transferring physician or the agency EMS Physician rather than the receiving hospital.

The Attendant-in-Charge (AIC) should request a patient report from the health care personnel on scene and should obtain the pertinent paperwork to go with the patient, including the face sheet, transport sheet, lab work, x-rays etc. If the patient is a "No
Code" or has a valid "Do Not Resuscitate" order, a written order, including a prehospital DNR order, must accompany the patient. Assessment by the AIC should not delay transport.

Once the ambulance crew arrives at the transferring or receiving hospital, and the patient's condition has deteriorated to a life-threatening situation where immediate intervention is necessary, the AIC will consult with the attending physician if he/she is available. If the attending physician is not immediately available, the AIC should contact the agency EMS Physician or on-line medical control for additional instructions.

An ALS provider may monitor and administer standard medications as ordered by the patient's transferring physician with on-line medical control as needed during transfer. The administration of any medication not covered by protocol will be recorded on the
Prehospital Patient Care Report, noting the name of the transferring physician, Medical Control contacted, dosage of the medication, and the route administered. Only approved medical control providers, EMS Physicians, and on-line medical control may give permission to deviate from protocol, unless a valid physician wishes to ride along during transport.

3.13.3 Approval

When the SCFRD ECC receives such inter-facility request, the ECC will obtain approval from the Operational Deputy Chief, or if unavailable, the on-duty Battalion Chief or EMS Supervisor.

The aforementioned supervisor will consult with requesting facility in order to make an informed decision; including a brief patient report, any special treatment including the use of medication pumps, ventilator support.

When a patient is receiving medications via a medication pump, is chemically sedated/paralyzed, is intubated and/or on a ventilator a RN or physician must accompany the patient

3.14 Patient and Scene Management

3.14.1 Management of the Patient

The AIC on the first arriving unit will have the authority for patient care and management at the scene of an emergency until relieved by a provider of higher certification. Authority for management of the emergency scene, exclusive of medical control over the patient, will rest with the appropriate on-scene public safety officials, fire, law enforcement etc.

If other medical professionals at the emergency scene offer or provide assistance in patient care, the following will apply:

1. Medical professionals who offer their assistance at the scene should be asked to identify themselves and their level of training. The prehospital provider should request that the individual provide proof of their identity if that person wants to continue to assist with patient care after the ambulance has arrived.
2. Physicians are the only medical professionals who may assume CONTROL of the patient's care. Prehospital providers should recognize the knowledge and expertise of other medical professionals and use them for the best patient care possible. All medical professionals who assist or offer assistance should be treated with courtesy and respect.
3. The authority for medical control of the prehospital provider's procedures rests in this protocol adopted by the EMS agency, the agency EMS Physician, and the Regional Medical Director.
4. A physician at the scene, who renders care to a patient, prior to arrival of an EMS unit, may retain ALS Medical authority for the patient if he/she desires. The prehospital provider will advise the physician who wants to supervise or to direct patient care that the physician MUST accompany the patient to the receiving hospital to maintain continuity of patient care. If requested, the physician will be provided access to the services and equipment of the ambulance and/or EMS agency. Documentation of these events will be complete and will include the physician's name. Should the physician not wish to ride along to the hospital with the patient, that physician's instruction may be ignored and the providers must follow their protocol.
5. If there is a conflict about patient care or treatment protocol, the prehospital provider will contact on-line medical control, via the HEAR radio or cellular telephone, for instructions. Under no circumstances should this conflict interfere with prudent patient care.

In the event there is a question about the number of patients/victims on scene, providers should make a reasonable effort to utilize all resources available to confirm that all patient/victims have been found and are accounted for.

The five levels of prehospital EMS certification recognized at this time by the Commonwealth of Virginia are as follows:

1. Emergency Medical Responder (EMR) whose authority is superseded by:
2. Emergency Medical Technician (EMT) whose authority is superseded by:
3. Advanced Emergency Medical Technician (AEMT) whose authority is superseded by:
4. Emergency Medical Technician - Intermediate (EMT-I) whose authority is superseded by:
   Emergency Medical Technician - Paramedic (EMT-P) whose authority is superseded by a Physician

The July 2022 version of the REMS protocols revised the category of Advanced Practice. The Advanced Practice designation is tied to the OEMS Scope of Practice table and Medication Formulary; this designation requires the provider to receive additional training on that particular skill/medication as designated by their current EMS Physician. They also must have specific authorization to perform/administer this skill/medication from their EMS Physician on file at the REMS Council. The duration of the EMS Physician validation will be indicated on the paperwork and limitations/duration are at the discretion of the EMS Physician. Without valid current paperwork on file at
REMS, the provider will ONLY be authorized to practice at their Virginia EMS Certification level and are NOT considered AP even with current critical care certifications.

3.15 Patient Refusal

3.15.1 Indications

1. If a patient (or the person responsible for a minor patient) refuses care after EMS providers have been called to the scene.
2. If the EMS provider knows there is an injury or illness, but the patient (or the person responsible for a minor patient) refuses care and is transported to their doctor or an ED by friends or acquaintances.

3.15.2 Management

Complete an initial assessment (including vital signs where possible) of the patient, with particular attention to the patient's neurological status. Determine if the patient is competent to make a valid judgment concerning the extent of their illness or injury, head injury, ETOH use, or other substance ingestion.

If the EMS provider has doubts about whether or not the patient is competent to refuse care, the provider should seek guidance from on-line medical control. Clearly explain to the patient, and all responsible parties, the possible risks and/or overall concerns associated with refusal of care.

The statement "risk of death and/or permanent disability" must be verbalized. Avoid performing any advanced life support procedures on a patient who has refused prehospital care.

Complete the ePCR, clearly documenting the initial assessment findings and the discussions with all involved persons regarding the possible consequences of refusing treatment and/or transport. A second EMS provider should witness the discussion. After the form has been completed, have the patient, or the person responsible for a minor patient, sign the refusal section provided on the ePCR. If possible, have two witnesses present and secure their signatures.

Patients who wish to be transported should be transported. When abuse of the 911 system is raised as a concern by a squad to the EMS Physician or the regional council, proper referral to law enforcement will ensue after notification.

Providers should realize the availability of on-line medical control for any patient contact, including refusals. EMS providers may obtain a patient refusal without contacting medical control providing the risk statement above has been made and documented.

If on-line medical control is contacted, the ePCR may be presented to the on-line physician for signature.

3.15.3 Refusing Transport to Recommended Facility

If a patient who is having a life-threatening emergency refuses transport to the recommended facility.

Determine if the patient has legal capacity and is mentally and physically competent to make decisions. If the patient is deemed not to have legal capacity or is mentally and/or physically incompetent then all reasonable measures should be used to transport the patient to the appropriate hospital having full emergency capability.

The patient having legal capacity, mental and physical competence shall be informed of the severity of their illness or injury and that not being transported immediately to the recommended hospital for treatment may mean that they could possibly suffer death, severe life altering consequences or disability. If the patient still refuses transport, the patient should be transported to the destination of their choice within the departments' service area. This must be an informed health care decision and documented accordingly. Have the patient and a witness sign the transport refusal portion documenting the patient choice. Inform on-line Medical Control of the patient's destination.

3.16 Quality Improvement

3.16.1 Indications

The REMS Quality Improvement (QI) Committee is responsible for implementing a risk management program, including ongoing evaluation of EMS systems and compliance by EMS providers to the standards of care. Each agency is also responsible for implementing a quality improvement program. Quality Management Reports are to be provided per your agency's EMS Physician.

3.16.2 Management

The REMS Regional QI Committee will provide a positive feedback system through provider input, hospital input, informal methods, and recognition events. Further, the QI Committee will make recommendations to the EMS Physician, hospital, and the Training and Guidelines Committee on training needs and policy. Squads in the REMSC region should follow approved QI policies and be involved with their EMS Physician in both commendations and disciplinary actions.

3.17 Abuse & Neglect

3.17.1 Indications

Domestic violence is physical, sexual or psychological abuse and/or intimidation, which attempts to control another person in a current or former family, dating, or household relationship.

The recognition, appropriate reporting, and referral of abuse is a critical; step to improving patient safety, providing quality health care, and preventing further abuse. Abuse is the physical and/or mental injury, sexual abuse, neglect treatment, or maltreatment of a child, senior citizen, or incapacitated adult by another person. Abuse may be at the hand of a parent, caregiver, spouse, neighbor, or adult child of the patient. The recognition of abuse and the proper reporting is a critical step to improve the health and wellbeing of these at-risk populations.

3.17.2 Precautions/Contraindications

Ensure compliance with "Mandatory Reporter" status under the Code of Virginia.
The Code of Virginia 63.2-1606 for Adult/Elder Abuse and 63.2-1509 for Pediatric Abuse identifies any emergency medical personnel certified by the Board of Health as a mandated reporter. Reports of suspected cases should be made immediately.
Assessment of an abuse case based upon the following principles:

Protect the patient from harm, as well as protecting the EMS team from harm and liability
Suspect that the patient may be a victim of abuse, especially if the injury/illness is not consistent with the reported history
Respect the privacy of the patient and family
Collect as much information and evidence as possible and preserve physical evidence.

3.17.3 Management

1. Assess the/all patient(s) for any psychological characteristics of abuse, including excessive passivity, compliant or fearful behavior, excessive aggression, violent tendencies, excessive crying, behavioral disorders, substance abuse, medical non-compliance, or repeated EMS requests. This is typically best done in private with the patient.
2. Assess the patient for any physical signs of abuse, especially any injuries that are inconsistent with the reported mechanism of injury. Defensive injuries (e.g., to forearms), and injuries during pregnancy are also suggestive of abuse. Injuries in different stages of healing may indicate repeated episodes of violence.
3. Assess all patients for signs and symptoms of neglect, including inappropriate level of clothing for weather, inadequate hygiene, absence of attentive caregiver(s), or physical signs of malnutrition.
4. Immediately report any suspicious findings to both the receiving hospital (if transported) and to the appropriate social services agency.

Child abuse or neglect, contact Child Protective Services at 1-800-552-7096

Elder abuse or neglect (including incapacitated adults), contact Adult Protective Services at 1-888-832-3858

If sexual abuse/assault is suspected contact your local Police/Sheriff's Dept. Patients need to be transported to a SANE (Sexual Assault Nurse Examiner) capable facility. If transporting to MWH, notify that you are transporting a" Code 27" patient. This will alert them to the need of the SANE team. Be sure to preserve all evidence which is very important to potential court proceedings. Patients should be turned over directly to hospital staff rather than placed in waiting room.

3.18 Transporting Patients to the Nearest Emergency Facility

3.18.1 Indications

Ambulances in this region will transport emergency patients to the nearest facility with full emergency capability (no urgent care businesses). No family member, friend, or even physician (except authorized on-line medical control), can instruct EMS personnel to bypass an emergency facility. With the exception of certain very specific groups such as certain types of trauma patients (burn patients, pediatrics, etc.), emergency patients should be transported to the nearest facility.

3.18.2 Management

Patients who have emergency conditions (typically cardio-respiratory events) require treatment to be the fastest possible. Transports out of the immediate region use valuable emergency resources and failure to go to the nearest qualified facility could subject the EMS community to legal consequences if the patient developed any problems during transport.

Patients who can safely tolerate a direct trip to a more distant facility (typically a tertiary care center or a preferred destination) should not be classified as emergency patients. Ambulances may bypass a closer emergency facility during a disaster, mass casualty, or similar incident to adequately distribute low priority patients to other area hospitals so as not to inundate the main area hospital. This decision will usually be made by the EMS officer at the incident in consultation with the Regional Hospital Coordination Center (RHCC) when the closest emergency facility is temporarily shut down or when they inform the EMS provider to bypass their facility due to other emergency conditions.

When there is a choice of hospitals that are equal distance and equal capabilities appropriate to the patient's condition, the patients should be given a choice of which facility they would like to go.

For example, the patient may be asked if they would prefer an HCA facility or an MWH facility. A patient could then be transported to the appropriate facility based on the patient's decision.

3.18.3 SCFRD Service Area

The service area for the SCFRD shall include the following hospitals: Stafford Hospital Center (SHC), Mary Washington Hospital (MWH), Spotsylvania Regional Medical Center (SRMC) and Sentara Northern Virginia Medical Center (SNMC). Under normal circumstances, SCFRD will only transport patients to hospitals within the department's service area. When providing mutual aid, SCFRD units will transport to hospitals within the service area of the jurisdiction requesting mutual aid. Ground transport to specialty hospitals outside of the department's service area is permitted only with the permission of the Operations Deputy Chief.

3.19 Treatment of Minors

3.19.1 Indications

Prehospital providers are called to treat a young patient and there is no parent or other person responsible for the minor present. **NOTE**: Under Virginia law, a minor is defined as a person under the age of 14 years.

3.19.2 Management

The prehospital provider may treat and/or transport any minor who requires immediate care to save his/her life or to prevent serious injury, under the doctrine of implied consent. If a minor refuses care, the provider should contact on-line Medical Control for additional instructions (see section 3.16 Patient Refusal). If a minor is injured or ill, but not critical, and no parental contact is possible, the provider should contact on-line medical control for additional instructions. The provider should always act on the side of appropriate patient care.

If the ill or injured patient is a young child and the parent is present, the prehospital provider should contact medical control and consider the following in regard to transport:

1. Transport conscious children with a parent unless it interferes with proper patient care.
2. In cases of major trauma or cardiopulmonary arrest, exercise judgment in allowing parents to accompany the child in the ambulance.
3. Allow the parent to hold and/or touch the child whenever possible.

Both parent and child will respond to open and honest dialogue. If the minor is ill and parental consent is denied, medical control should be contacted for further instructions.

3.20 Special Destinations

3.20.1 OB Patients

OB patients who have been identified as high risk or who have not completed 34 weeks of gestation will be transported to Mary Washington Hospital for its NICU capabilities unless otherwise dictated by the patient's physician.

3.20.2 Pediatric Trauma Patients

Pediatric trauma patients (age <15 years) meeting trauma routing criteria should be transported to the nearest Pediatric Trauma Center. All other pediatric trauma patients should be transported to the hospital chosen by their parent or guardian or to the closest appropriate hospital within the department's service area.

3.20.3 Patients in Police Custody

Patients in police custody and considered to have a non-life-threatening emergency will be transported to a hospital within the department's service area and designated by the custodial officer.