

## GENERAL GUIDELINES FOR RESPONSE TO AMBULANCE CALLS

1. Receiving the call:
  - A. Information needed:
    - Name of caller
    - Call-back number and name
    - Name of patient(s)
    - Age
    - Nature of problem
    - Location/address
  
2. Assessment of the scene of the accident:
  - A. Assist fire, police, and other personnel in creating a safe environment for the evaluation and treatment of the injured person(s). Pay particular attention to continuing medical dangers, especially toxic gases, which may jeopardize rescue personnel.
  - B. Extricate using prescribed techniques. In the case of multiple victims consider designation of a safe triage area for assessment and stabilization of victims.
  - C. Be particularly cautious of potentially hazardous scenes. Accidents involving toxic chemicals can contaminate (and kill) rescuers as well as original patients. Stay *back* from hazardous scenes and work with Hazardous Materials crew to determine when the scene is safe or when the patients will be removed to safety.
  
3. Assessment of patients (quick):
  - A. Review patient rapidly, assessing the extent of their injuries and assigning a triage category:
    - 1- Red – critical (requiring treatment within minutes)
    - 2- Yellow – serious (treatment within 1-2 hours)
    - 3- Green – non-life-threatening injuries (treatment delayed for several hours)
    - 4- Black – dead at scene
  
  - B. Ambulances should deliver patients to the hospital of the patient's choosing, or as directed by the patient's physician or a member of the patient's immediate family. In life-threatening situations with no stated preference ambulances may transport to the nearest civilian hospital capable of rendering appropriate care to the patient's needs. Where possible the ambulance crew shall consult with an Emergency Physician through direct voice communications. In cases where the ambulance technician has established continuing communication with a physician and has received instruction relative to the care and treatment of the patient, that physician shall be considered as the "patient's physician" for purposes

of prehospital care. In all non-life-threatening cases where a preference is not expressed the ambulance shall deliver patients to the nearest civilian hospital with a fully staffed Emergency Department.

4. Assessment of patient (full):

See assessment protocols. Assessment should begin with critical (red) patients, and proceed to those with lesser injuries. Do not waste time on CPR if there are other patients in need of care in a multi-patient incident.

5. Stabilization:

- A. After assessment, establish priorities for required emergency care before transport. Render emergency care as defined by protocols and as directed by base station or receiving physician.
- B. The protocols of medical hierarchy will be followed (EMT, Paramedic trainee, Paramedic, Emergency Nurse, Physician). When two persons with the same qualifications arrive at the same time, the first to render care to the patient will assume responsibility of medical control until relieved by a person with higher qualifications.
- C. A physician wishing to take responsibility for a patient on the scene must identify himself as a physician and should be able to show his license: otherwise, the Paramedics are obligated to continue their treatment of the patient. If the physician assumes responsibility for the patient it is his responsibility to stay with the patient until arrival at the hospital, preferably in the transporting vehicle. If there are conflicts between physician orders and protocols, protocols shall take precedence pending direct communication with the base physician.
- D. Decide with the help of base station physician when stabilization efforts have attained maximal results and the patient should be transported. Prolonged treatment on the scene (more than 15 minutes or the first round of drugs of the cardiac arrest protocol) should only be accomplished with direct physician approval. This time limit may be modified because of extrication difficulties and transport distance (i.e., are you two minutes or two hours from the receiving hospital?), but if direct radio contact is not available, transport must be prompt. Further, it should be emphasized, that time spent on “stabilization” of the medical patient in the field may be justified, but the major trauma patient must have minimal time spent on field treatment and requires rapid transport for definitive care.

6. Communications:

- A. Notify receiving hospital of the number of patients and extent of injuries (more complete than just triage categories – unless actual disaster).
- B. Coordinate efforts with other professional personnel at the scene to make maximal use of all those with training to stabilize and transport patients.

- C. Relatives on the scene should be told briefly and courteously the status of the patient in your judgement, and the location to which the patient will be transported.
- D. Bystanders should be treated courteously, but without waste of time. Inquiries should be referred to the receiving hospital. Bystanders have no right to medical information, and you have no authority to give it out. Law enforcement officials should be used to dispense appropriate information at the scene.
- E. In the event of an emergency which threatens the well being of the Paramedic (i.e., a suddenly violent patient) the police can be notified to meet your vehicle at the hospital by contacting dispatch.

7. Transportation:

- A. Remove and transport patients from the scene in order of the severity of their injuries, according to the triage assignment and subsequent course on the scene.
- B. Stabilization and advanced life support at the scene should result in a great number of patients who are stable and can be transported without red lights and sirens. Lights and sirens are technically risky as well as stressful to the patient and should be reserved for uncontrolled and unstable situations.
- C. Patients have the right to refuse transport if they have appropriate mental capacity and are adults. If direct radio communication with hospital is available; permission not to carry should come from the resource hospital or from the patient's physician. Often direct communication between patient and physician will clarify the issues.
- D. Observe and monitor the patient en route to the hospital, monitor vital signs, and administer additional care as directed by the base station or receiving physician.

8. Termination of run:

- A. Report your observations and care of patient to the Emergency Department staff.
- B. All pertinent observations and all treatment must be recorded on standard patient care report forms. These forms must be reviewed by the receiving physician and should be made a part of the permanent medical record. Medication orders should have the signature of the ordering physician on the trip form.
- C. All PCR forms must be reviewed under the system set up by the physician advisor. All runs involving new drugs or procedures must be specifically reviewed by the physician advisor as well as the receiving physician.

## **DESTINATION GUIDELINES EL PASO COUNTY MEDICAL SOCIETY**

Whenever possible ambulances shall deliver patients to the hospital of the patient's choosing, or as directed by the patient's physician, or as directed by a member of the patient's immediate family, provided that request is appropriate to on scene medical control.

In life-threatening situations, ambulances may contact and/or transport to the nearest civilian hospital capable of rendering the appropriate level of care for the patient's needs.

Patients without a hospital preference should be transported to the closest, most appropriate civilian hospital.

When necessary, responsibility for determining patient destination lies with the on-scene medical control.

Exception:

1. In multi-casualty incidents, the destination responsibility lies with the medical control officer on scene.
2. Police may determine hospital destination for individuals in custody or under arrest if not seriously ill or injured. In serious or critical situations, patients will be transported to the most appropriate facility, (CSPD General Order, May 6, 1988).
3. Trauma patients meeting the criteria for transport to a trauma center must be taken to an appropriate trauma center designated pursuant to the Statewide Trauma Care System Act.

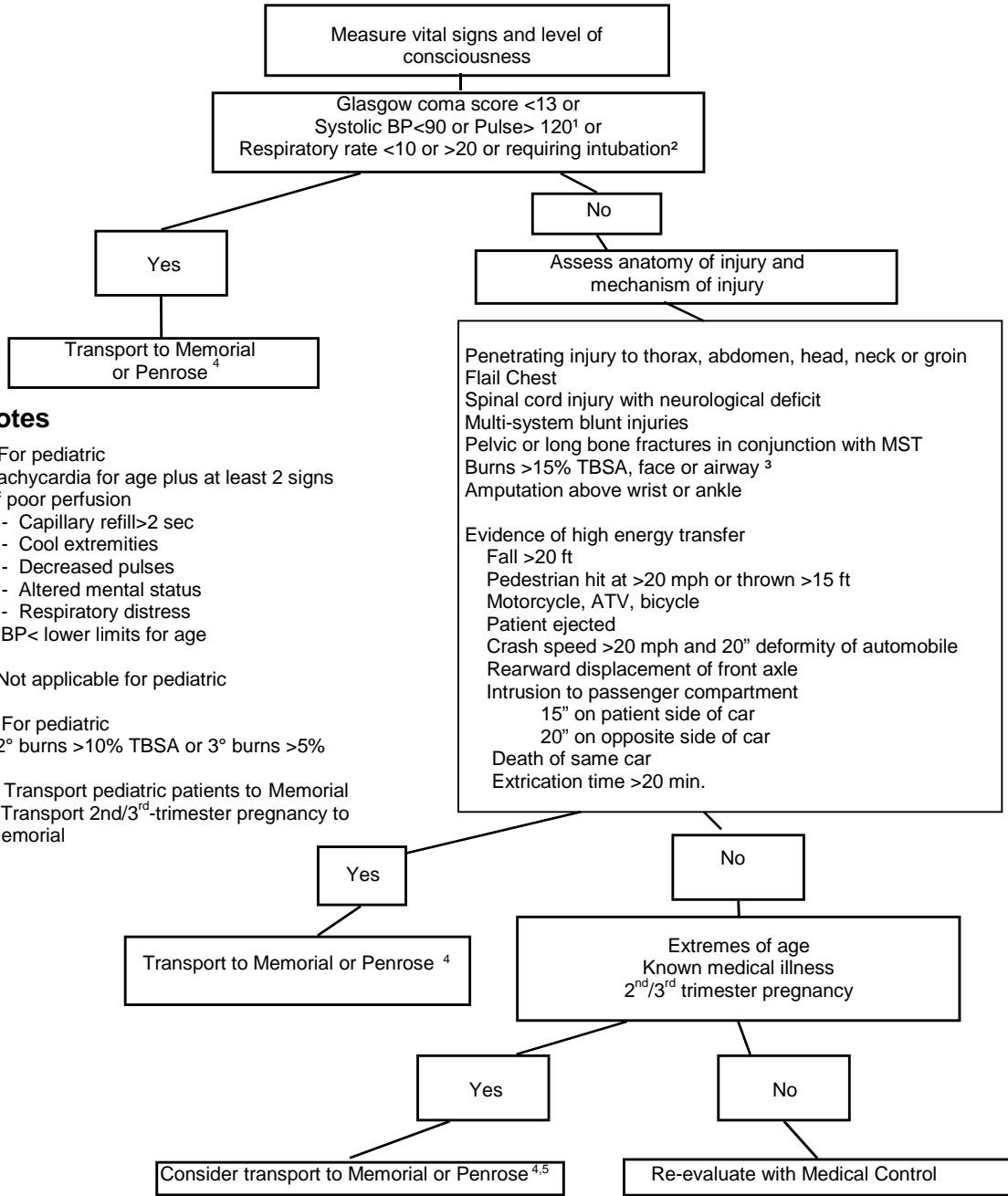
*NOTE: Trauma patients requiring a trauma team are expected to be transported to the nearest trauma center. Exceptions are outlined in the specific guidelines.*

### **SPECIFIC GUIDELINES**

1. Ill or injured neonates should be taken to Memorial Hospital.
2. Seriously ill children less than 15 years of age who are likely to require treatment in an intensive care unit should be taken to Memorial Hospital.
3. All serious burn victims, without other immediate life-threatening problems, should go to Penrose or Memorial Hospital.
4. Patients with carbon monoxide poisoning who are unconscious or who have a neurologic deficit should go to Memorial Hospital.

5. Children less than 15 years of age with critical injuries, as defined by the triage decision scheme, should be transported to Memorial Hospital.
6. Adults and children 15 years of age or older with critical injuries, as defined by the triage decision scheme, should be transported to either Penrose Main or Memorial Hospital.
7. Complications of pregnancy, such as prolapsed cord, eclampsia, premature labor, or abnormal presentations should be transported to Memorial Hospital.
8. Patients with acute psychiatric problems, without other immediate life-threatening problems, can be transported to Penrose Main or Memorial Hospital.
9. When a hospital is on divert status, patient should be taken to the next most appropriate hospital.

# PREHOSPITAL TRAUMA TRIAGE DECISION SCHEME



## Notes

<sup>1</sup> For pediatric

Tachycardia for age plus at least 2 signs of poor perfusion

- Capillary refill >2 sec
- Cool extremities
- Decreased pulses
- Altered mental status
- Respiratory distress

or BP < lower limits for age

<sup>2</sup> Not applicable for pediatric

<sup>3</sup> For pediatric

2° burns >10% TBSA or 3° burns >5%

<sup>4</sup> Transport pediatric patients to Memorial

<sup>5</sup> Transport 2nd/3<sup>rd</sup>-trimester pregnancy to Memorial

**WHEN IN DOUBT, TAKE PATIENT TO A TRAUMA CENTER**

# EL PASO COUNTY PARAMEDIC AMBULANCE DIVERT POLICY

## **PREFACE:**

Recognizing the need for a uniform diversion policy for the Colorado Springs hospitals when these facilities are stressed under particular conditions, the following policy and guidelines are proposed.

## **TYPES OF DIVERT:**

### 1. CRITICAL CARE DIVERT

- A. Medical Critical Care Divert – Patients in this category would include those with serious medical problems whose in-hospital care would, in all probability, require intensive care management. Examples would include, but not be limited to, cardiac arrest, shock, coma, or chest pain of a suspected etiology requiring intensive care facilities. The hospital has determined itself unable to safely accommodate additional patients requiring these facilities.

1. Sub-categories
  - a. Adult
  - b. Pediatric (14 or under)

*(A sub-category under medical divert could also be utilized by those institutions that have specific intensive care facilities such as Peds, or ICU at such times that their capabilities are similarly over burdened.)*

- B. Trauma Critical Care Divert – Patients in this category would include those with major trauma, whose continued management carries a high probability of requiring emergency surgery. Examples would include, but not be limited to, penetrating injuries of the chest, abdomen, or head, massive blunt head injury, or major multisystem trauma. The intent of a trauma divert would be to redirect these patients to other appropriate facilities when a particular hospital has maximally utilized its surgical operating facilities at a given period of time.

1. Sub-categories
  - a. Adult
  - b. Pediatric (14 or under)

- C. CT Scan Divert – Patients in this category would include those with major trauma, acute intracranial pathology whose evaluation or management would include an urgent or emergent CT scan. Examples would include but not limited to blunt trauma to the head, possible acute cerebral vascular accident or status epilepticus.
- D. Total Critical Care Divert
  - 1. Sub-categories
    - a. Adult
    - b. Pediatric (14 or under)

## II. TOTAL AMBULANCE DIVERT

- A. Total Ambulance Divert – Under this condition all patients being transported by ambulance would be redirected to other facilities in the event that any particular hospital or its emergency department found itself maximally utilized and unable to accommodate additional patient load without compromising quality care.

A hospital could indeed be on both Critical Care Divert and Trauma Divert but still be capable of receiving ambulance traffic bearing patients not requiring the intensive care facilities outlined above under sections A and B. That is, a hospital could declare both critical care and trauma divert status without being on Total Ambulance Divert status.

We recommend that *responsibility* for designating and initiating a divert status at any hospital *should be that of the emergency physician* on duty at that institution. The decision to go on divert may be made in conjunction with nursing supervisory staff and/or hospital's administration, but notification of the hospital's divert status shall be directed by the emergency physician in charge of the department at such time.

Any divert will be initiated and terminated by contacting:

**The Other Hospital  
MED CONTROL DISPATCH: 578-6030  
AMR Dispatch  
Teller County Sheriff's Office**

Any divert will be updated every 8 hours.