South Central

Region Patient Care Procedures (PCPs)

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The following regulations provide guidance on the subject matter contained in this document. Please note, that this is not an inclusive list. For more information please contact a Department of Health Emergency Care System representative.

Regulations

1.1 Revised Code of Washington (RCW):

A. **RCW 18.73** – Emergency medical care and transportation services
   1. RCW 18.73.030 - Definitions

B. **RCW Chapter 70.168** – Statewide Trauma Care System
   1. RCW 70.168.015 – Definitions
   2. RCW 70.168.100 – Regional Emergency Medical Services and Trauma Care Councils
   3. RCW 70.168.170 – Ambulance services – Work Group – Patient transportation – Mental health or chemical dependency services

1.2 Washington Administrative Code (WAC):

A. **WAC Chapter 246-976** – Emergency Medical Services and Trauma Care Systems
   1. WAC 246-976-920 – Medical Program Director
   2. WAC 246-976-960 – Regional Emergency Medical Services and Trauma Care Councils
   3. WAC 246-976-970 – Local Emergency Medical Services and Trauma Care Councils

1. Level of Medical Care Personnel to Be Dispatched to An Emergency Scene

1. **PURPOSE:**
   The appropriate level of emergency, BLS, ILS, ALS personnel, aid or ambulance services will be dispatched to the emergency incident scene to provide timely patient care.

2. **SCOPE**:
   Appropriate licensed and trauma verified aid and ambulance services are dispatched to all emergency medical and trauma incidents within an identified service area.

3. **GENERAL PROCEDURES:**
   a. **Dispatch**
      i. Local EMS and Trauma Care Council's should identify primary and secondary Public Safety Answering Point (PSAP)/dispatch in each county and provide information to the Region Council of any changes.
      ii. Dispatchers should be trained in and use an Emergency Medical Dispatch (EMD) Guidelines Program to include pre-arrival instructions.
      iii. The appropriate level of service will be dispatched to the incident.
      iv. EMS services should proceed in an emergency response mode until they have been advised of non-emergent status unless advised of non-emergent status by dispatch.
      v. EMS services are responsible to update; PSAP/dispatch Center, DOH, Local and Region Councils, of any response area changes as soon as possible.
      vi. In the event a patient approaches a service seeking help or a unit happens upon an incident, PSAP/dispatch must be contacted to activate the EMS system.
   b. **Response Times**
      Response times are measured from the time the call is received by the responding agency until the time the agency arrives on scene.
   c. **Cancellation of Response Criteria**
      In coming units and on-scene EMS providers will communicate patient status report before cancelling response when practical.
      For all level EMS Agencies;
      i. The responsible party for patient care decisions is the highest-level EMS provider on scene with the patient.

ii. Communication with PSAP/dispatch that no patient is found or non-injury or the following conditions are confirmed. (Proceed if requested by law enforcement.)
    a. Decapitation
    b. Decomposition
    c. Incineration
    d. Lividity and Rigor Mortis

d. **Slow Down**
    i. Transport units may be slowed by first in on scene emergency responder.
    ii. The first in on scene unit may convey available patient information to responding transport units.

e. **Diversion to another emergency call**

An EMS transport unit may be diverted to another call when:

    i. It is obvious the second call is a life-threatening emergency and first-in EMT's and/or paramedics report that first call can await a second unit.
    ii. A second ambulance is requested to the first call.
    iii. The highest-level transport responding unit is closer to the second call and may be vital to the patient's outcome.
    iv. If Priority Dispatch System used, follow local county operating procedures (COPs) for diversion to another call.

f. **Staging/Standby**

Dispatch should provide ALL pertinent information to the responding units so they can make a determination as to whether to stage and provide the same information to law enforcement responding units. Units will advise Dispatch of intent to stage and request Law Enforcement response.

4. **APPENDICES: None**

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2. Guidelines for Rendezvous with Agencies That Offer Higher Level of Care

1. **PURPOSE:**
   To guide EMS providers to initiate rendezvous with a higher level of care while en route to a receiving hospital based on patient needs and resource availability.

2. **SCOPE**:
   BLS or ILS units may rendezvous with a higher level of care. Rendezvous is appropriate when;
   a. Patient may benefit from a higher level of care.
   b. Resources may be limited or not available.

3. **GENERAL PROCEDURES:**
   a. The BLS/ILS ambulance may request ALS ambulance rendezvous by contacting dispatch.
   b. Ground ambulance should rendezvous with a higher level of care based on patient illness or injury,
   c. Benefit to patient should outweigh increase to out of hospital time.
   d. Based on updated information, requesting units may cancel the rendezvous by contacting dispatch.
   e. EMS providers should use effective communication with all incoming and on scene emergency responders at all times with patient care as their highest priority.
   f. Communication should include patient report when appropriate.

4. **APPENDICES: None**

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3. Air Medical Services - Activation and Utilization

1. **PURPOSE:**

   Air Medical Service activation and utilization provides expeditious transport of critically ill or injured patients to the appropriate hospital including designated/categorized receiving facilities.

2. **SCOPE**:

   Licensed and trauma verified aid and/or ambulance services utilize the county protocols and county operating procedures (COPs) consistent with current "WA Statewide Recommendations for EMS Use Air Medical" (within the WA State Air Medical Plan) to identify and direct activation and utilization of air medical services.

3. **GENERAL PROCEDURES:**

   a. For scene transport to be efficacious and optimize patient outcome, the air medical response should take significantly less time (greater than 20 minutes time savings) than it takes to travel by ground to the closest appropriate facility. If this is not the case, strong consideration should be given to activating the helicopter from the scene, and meeting at the local hospital. This decision should be made in conjunction with local medical control. This is particularly important for head injured and hypotensive patients.
   b. Responders should involve dispatch to contact and activate air medical response to maintain system safety and integrity. The dispatching agency will provide the helicopter with the correct radio frequency to use for contacting EMS ground units.
   c. Responding EMS service may activate air medical service prior to arrival on scene based on dispatch information or upon arrival on scene based on initial assessment.
   d. Air medical Service will provide ETA of available fully staffed closest air ambulance.
   e. The final patient transport and destination decisions will be made on the scene.
   f. Air medical service will notify PSAP/dispatch when activated by a mechanism outside the emergency dispatch system.

   Air Medical transport is recommended for the following:

   Trauma:

   a. Head injured patients with one of the following:
      i. Revised Trauma score <12 or deteriorating

ii. Pediatric Revised Trauma score <10 or deteriorating
iii. Change in LOC and/or neurological deficits
iv. Significant penetrating injury above mid-thigh, torso, or head.

b. Patients with the following chest injuries:
    i. Possible tension pneumothorax
    j. Major chest wall injury
    k. Potential cardiac injury
    l. Penetrating chest wound
c. Patients with unstable vital signs including hypotension, tachypnea, severe respiratory failure.
d. Patient with burns of greater than 10% BSA or major burns of face, hands, feet, or perineum.
e. Major electrical or chemical burns.
f. Patients with spine injuries with neurologic involvement and potential airway/breathing compromise.
g. Amputation or near amputation.
h. Two or more long bone fractures or a major pelvic fracture.
i. Patients with scalping injury or “degloving” injury.
j. Patients with a significant mechanism of injury, hemodynamic instability, and associated signs and symptoms including:
    i. MVA with significant structural intrusion into victim’s space.
    ii. Speed of vehicle >55 mph.
    iii. MVA with extrication time >15 minutes or prolonged entrapment time.
    iv. MVA with patient ejected.
    v. MVA with associated fatalities.
    vi. Motorcycle victim ejected at >20 mph.
    vii. Pedestrian struck and thrown >15 feet.
    viii. Fall from a height of 20 feet or greater.
    ix. Crushing injuries to the abdomen, chest, or head.
    x. Near-drowning injuries, with or without existing hypothermia.
    xi. Trauma patients <12 or >55 years old.

Non-trauma:

a. Any patient airway that cannot be maintained.
b. Patient with cardiac disease and is experiencing a progressively deteriorating course, is unstable, and/or requires measures not available en route (e.g. ALS level care, cardiac catheterization, thrombolytic therapy.)

c. Patient is experiencing a severe neurological illness requiring neurosurgical or other intervention that is not available en route. (CVA, uncontrolled seizures, etc.)

EXCEPTIONS

Some patients that do not meet the above indications for air transport may still be candidates for air transport under the following circumstances:

a. Long distance transport of critical patients (more than 2 hours by ground)
b. Remote locations with isolated injury patients that could create a prolonged painful transport (i.e. logging injury).
c. Situations where a ground CCT unit will not be available for an extended time period.
d. Situations where resources at the sending facility and/or scene are severely limited.
e. Mass casualty situations
f. Lack of availability of ground transport
g. Lack of availability of specialty care personnel (with a minimum of one registered nurse) to accompany patient
h. Road conditions which may extend ground transport times (e.g. icy roads, flooding, remote locations, bridge openings, heavy traffic, etc.)
i. Land transport would deplete the local community of vital EMS services for an extended period of time.
j. EMS regional or state-approved protocol identifies need for on-scene air transport.

EXCLUSIONS

Patients for whom air medical transport is contraindicated include:

a. Patients who have been pronounced dead. (The need for or potential for cardiopulmonary resuscitation is not a contraindication for air transport.)
b. Obstetrical patients in advanced active labor and in whom an imminent and /or precipitous delivery can be expected.
c. Patients with actual or potential for violent or self-destructive behavior that cannot be adequately and safely restrained or controlled using chemical or physical restraints.
d. A patient in traumatic full arrest if another critically injured patient requires air transport and is determined to have a greater chance of surviving with rapid transport by air.

e. HAZMAT victims not appropriately decontaminated that pose a risk to the crew or could potentially contaminate the aircraft.

4. **APPENDICES:**

Link to DOH website:

WA State Air Medical Plan

https://www.doh.wa.gov/portals/1/Documents/Pubs/530129.pdf

WA Trauma Triage Destination Procedure:

https://www.doh.wa.gov/Portals/1/Documents/Pubs/530143.pdf

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4. On Scene Command

1. **PURPOSE:**
   Provide coordinated and systematic delivery of patient centric emergency medical care and transport services at all incidents, to include single EMS agency, multi-agency, and multi-jurisdictional responses.

2. **SCOPE**:
   The National Incident Management System (NIMS) Incident Command System (ICS) will be used when establishing on scene command.

3. **GENERAL PROCEDURES:**
   a. Agencies are responsible for ensuring responders are trained in NIMS ICS per FEMA guidelines at the appropriate level.
   b. ICS guidelines will be followed when establishing command and assigning other roles based on incident needs.
   c. The Medical Group Supervisor should be an individual trained in the ICS, familiar with both the local EMS resources and the county Mass Casualty Incident and Disaster Plan, and capable of coordinating the medical component of a multiple patient incident.
   d. Unified Command: An application of ICS used when there is more than one agency with incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the Unified Command, often the senior person from agencies and/or disciplines participating in the Unified Command, to establish a common set of objectives and strategies and a single Incident Action Plan.

4. **APPENDICES: None**

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5. Prehospital Triage and Destination Procedure

1. **PURPOSE:**
   Provide guidance for transport destination decisions for Trauma, Cardiac, Stroke, Mental Health and Chemical Dependence patients from the emergency medical scene to the appropriate receiving facility.

2. **SCOPE**:
   Coordinated system of care which identifies hospital levels of services available for specific categories of patient need. The triage destination procedures inform EMS providers of patient triage criteria algorithm to identify the transport destination to the appropriate designated/categorized hospital receiving facilities.

3. **GENERAL PROCEDURES:**
   EMS providers use the statewide triage destination procedures to identify transport of critically ill or injured patients to the appropriate designated/categorized hospital receiving facilities for definitive care.

4. **APPENDICES: None**

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5.1 Trauma Triage and Destination Procedure

1. **PURPOSE:**
   Trauma patients are identified and transported to the most appropriate trauma designated hospital receiving facility to reduce death and disability.

2. **SCOPE**:
   Licensed and trauma verified aid and/or ambulance services utilize the most current State of WA Prehospital Trauma Triage (Destination) Procedure to identify and direct transport of patients to the appropriate trauma designated hospital.

3. **GENERAL PROCEDURES:**
   Prehospital providers will utilize the most current State of WA Prehospital Trauma Triage (Destination) Procedure, local COPs, and MPD protocols to direct prehospital providers to transport patients to an appropriate WA State trauma designated hospital receiving facility.

4. **APPENDICES:**
   Link to DOH website: WA Trauma Triage Destination Procedure:
   https://www.doh.wa.gov/Portals/1/Documents/Pubs/530143.pdf

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5.2 Cardiac Triage and Destination Procedure

1. **PURPOSE:**
   Patients presenting with signs and symptoms of acute cardiac distress are identified and transported to appropriate categorized WA State Emergency Cardiac System participating hospital to reduce death and disability.

2. **SCOPE**:
   Licensed and trauma verified aid and/or ambulance services utilize the most current State of WA Prehospital Cardiac Triage Destination Procedure to identify patients with signs or symptoms of acute cardiac distress and transport to the appropriate categorized cardiac hospital.

3. **GENERAL PROCEDURES:**
   Prehospital providers will utilize the most current State of WA Prehospital Cardiac Triage Destination Procedure, local COPs, and MPD protocols to direct prehospital providers to transport patients to an appropriate categorized WA State Emergency Cardiac System participating hospital.

4. **APPENDICES:**
   Link to DOH website: WA Cardiac Triage Destination Procedure:
   https://www.doh.wa.gov/Portals/1/Documents/Pubs/346050.pdf
   Link to DOH website: List of WA State Emergency Cardiac and Stroke System Participating Hospitals
   https://www.doh.wa.gov/Portals/1/Documents/Pubs/345299.pdf

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5.3 Stroke Triage and Destination Procedure

1. **PURPOSE:**
   Patients presenting with signs and symptoms of acute stroke are; identified and transported to the appropriate categorized WA State Emergency Stroke System participating hospital to reduce death and disability.

2. **SCOPE**:
   Licensed and trauma verified aid and/or ambulance services utilize the most current State of Washington Prehospital Stroke Triage Destination Procedure to identify patients with signs or symptoms of acute stroke and transport to the appropriate categorized stroke hospital.

3. **GENERAL PROCEDURES:**
   Prehospital providers will utilize the most current State of WA Prehospital Stroke Triage Destination Procedure, local COPs, and MPD protocols to direct prehospital providers to transport patients to an appropriate categorized WA State Emergency Stroke System participating hospital.

4. **APPENDICES:**
   Link to DOH website: WA Stroke Triage Destination Procedure:
   https://www.doh.wa.gov/Portals/1/Documents/Pubs/346049.pdf
   Link to DOH website: List of WA State Emergency Cardiac and Stroke System Participating Hospitals
   https://www.doh.wa.gov/Portals/1/Documents/Pubs/345299.pdf

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5.4 Mental Health and Chemical Dependency Destination Procedure

1. **PURPOSE:**
   Operationalize licensed ambulance services transport of patients from the field to alternate facilities for mental health or chemical dependency services.

2. **SCOPE**:
   Licensed ambulances may transport patients from the field to mental health or chemical dependency services in accordance with RCW 70.168.170.

3. **GENERAL PROCEDURES:**
   a. Prehospital EMS agencies and receiving mental health and/or chemical dependency facility participation is voluntary.
   b. Participating agencies and facilities will adhere to the WA State Department of Health Guidelines in accordance with RCW 70.168.170.
   c. Facilities that participate will work with the MPD and EMS agencies to establish criteria for accepting patients.
   d. MPD and Local EMS and Trauma Care Council will develop county operating procedures.
   e. Upon implementation and during ongoing operation of transport to alternate receiving facilities the following will be in place with DOH approval;
      i. County Operating Procedure (COPs)
      ii. MPD patient care protocols
      iii. EMS provider education

4. **APPENDICES: none**

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6. EMS/Medical Control Communications

1. **PURPOSE:**
   Communications between prehospital personnel, base station hospital (online medical control) and all receiving healthcare facilities are interoperable to meet the system needs.

2. **SCOPE**:
   Communications between prehospital personnel, base station hospital (online medical control) and all receiving health care facilities (to include designated trauma services and categorized cardiac and stroke services) utilize effective communication to expedite patient care information exchange.

3. **GENERAL PROCEDURES:**
   a. Communication between EMS providers and healthcare facilities may be done directly or indirectly via local PSAP/dispatch.
   b. Based on geographic area communication via radio and cell phone and telephone may be used to expedite the exchange of information as needed.
   c. EMS agencies and receiving healthcare facilities will maintain communication equipment and training to communicate effectively.

4. **APPENDICES: none**

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7. Hospital Diversion

1. **PURPOSE:**
   Hospitals have diversion policies to divert trauma, cardiac, or stroke patients to other appropriate facilities based on that facility's inability to provide care and intervention.

2. **SCOPE**:
   All designated trauma services, and categorized cardiac and stroke hospitals within the Region have written policies to divert patients to other appropriate designated or categorized facilities.

3. **GENERAL PROCEDURES:**
   a. Hospitals identify communication procedures for redirection/diversion of trauma, cardiac and stroke patients to another facility when resources are unavailable. The hospital must notify the EMS transport agencies and other designated services in their area.
   b. Exceptions to redirection/diversion:
      i. Airway compromise
      ii. Cardiac arrest
      iii. Active seizing
      iv. Persistent shock
      v. Uncontrolled hemorrhage
      vi. Urgent need for IV access, chest tube, etc.
      vii. Disaster Declaration
      viii. Paramedic Discretion

4. **APPENDICES: None**

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8. Cross International Border Transport

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1. PURPOSE:

2. **SCOPE**:

3. **GENERAL PROCEDURES:**

4. **APPENDICES:**

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9. Inter-Facility Transport Procedure

1. **PURPOSE:**
   Guidance on transferring high-risk trauma and medical patients without adverse impact to clinical outcomes.

2. **SCOPE**:
   All interfacility patient transfers via ground or air shall be provided by appropriate licensed or verified service with appropriate certified personnel and equipment to meet the patient's needs.

3. **GENERAL PROCEDURES:**
   a. Medical responsibility during transport should be arranged at the time of the initial contact between referring and receiving physicians, and transfer orders should be written after consultation between them.
   b. Immediately upon determination that a patient's needs exceed the scope of practice and/or protocols, prehospital personnel shall advise the facility that they do not have the resources to do the transfer.
   c. When on line medical control is not available, prehospital protocols shall be followed during an EMS transport in the event that an emergency situation occurs while in route that is not anticipated prior to transport.
   d. While en route, the transporting agency should communicate patient status and estimated time of arrival to the receiving health care service per MPD local protocols and COPs.

4. **APPENDICES: none**

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10. Procedures to Handle Types and Volumes of Patients That Exceed Regional Resources

1. PURPOSE:
To provide for the standardization and integration of Mass Casualty Incident (MCI) Plans between counties throughout the region.

2. **SCOPE**:
Major incidents/emergencies that create hazardous conditions that threaten public health that exceed local resources, and may involve multiple counties and states

3. **GENERAL PROCEDURES:**
All EMS agencies and Incident Commanders working during an MCI event shall operate within the National Incident Management System (NIMS).

Based on available local resources, prehospital EMS responders will use appropriate protocols and procedures consistent with the WA State DOH "Mass Casualty-All Hazard Field Protocols" during an All-Hazards-MCI incident. Prehospital EMS responders will additionally follow any other All-Hazards-MCI protocols/county operating procedures (COPs) set forth by the County Medical Program Director (MPD) and County EMS & Trauma Care Council.

The appropriate local Public Health Department will be notified where a public health threat exists. County Local Governing Officials with authority will proclaim a "state of emergency" for incidents/emergencies with health implications that threaten to overwhelm the emergency response resources and healthcare system.

4. **APPENDICES: None**

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10.1 MCI

1. PURPOSE:

To provide for the standardization and integration of Mass Casualty Incident (MCI) Plans between counties throughout the region.

2. **SCOPE**:

The following material represents a broad guideline for the common practice of our EMS providers when dealing with a mass casualty event

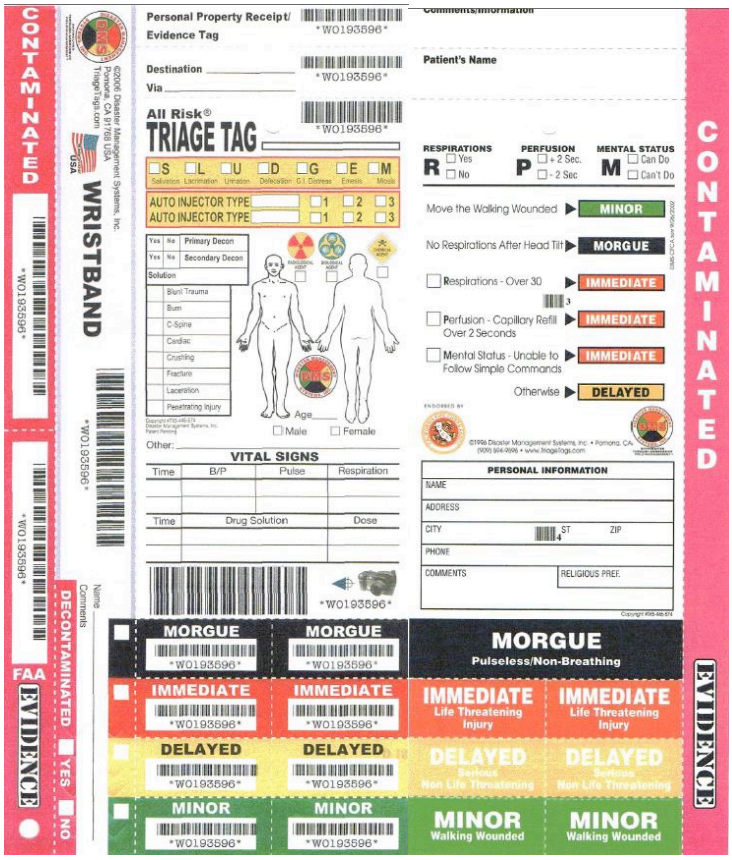
3. **GENERAL PROCEDURES:**

a. Triage System:
   i. Initial triage should be rapid with an emphasis on identifying severe but survivable injuries.
   ii. A single system should be used throughout our EMS system. START and Jump/START are simple and effective tools for initial triage.
   iii. A triage tag or identifier should be applied at the time of initial EMS contact.
   iv. Secondary triage should be applied at the scene (treatment area) with a focus on identifying patients whose outcome will depend primarily on time critical hospital-based interventions (surgery/critical care).

b. Initial Treatment after triage may include:
   i. Immediate lifesaving treatments should be done as soon as possible at the time of initial EMS contact based on available resources.
      a. Maintain open airway.
      b. Control severe bleeding.
      c. Treat open (sucking) chest wounds.
      d. Treat for shock.
   ii. Secondary treatment
      a. Spinal restriction (prior to moving the patient).
      b. Definitive airway placement and oxygen administration.
      c. Needle decompression of tension pneumothorax.

c. Transport:
   i. RED (critical) patients should be the priority for earliest transport to receiving hospitals with an emphasis on those that need immediate surgical interventions.
   ii. EMS staffed transport vehicles should be loaded to full capacity and provide ALS level EMS during transport, if possible.
   iii. When ambulance capacity is exceeded, alternate transport vehicles (buses, etc.) should be considered to move the less severely injured. EMS personnel should be assigned to the vehicles.

4. **APPENDICES:**



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10.2 All Hazards

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1. PURPOSE:

2. **SCOPE**:

3. **GENERAL PROCEDURES:**

4. **APPENDICES:**

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10.3 Highly Infectious Disease

1. PURPOSE:

To provide guidance to Medical Program Directors and EMS agencies regarding the identification, triage, treatment, transport, and post incident management of patients with suspected highly infectious diseases.

2. **SCOPE**:

The incidence and risk associated with highly infectious diseases and requires a modified level of response from Emergency Medical Services.

3. **GENERAL PROCEDURES:**

Use of the Interim Guidance for Emergency Medical Services (EMS) Systems and 9-1-1 Public Safety Answering Points (PSAPs) for Management of Patients under Investigation (PUIs) for in the United States as published by the Centers for Disease Control and Prevention (CDC) is endorsed by the Washington State Department of Health for inclusion in policies, procedures, and protocols.

EMS agencies that have self-identified as being capable of transporting patients with highly infectious diseases can be found on the WA State DOH website: EMS & Trauma GIS Resource Map. This map also identifies the hospitals capable of assessing and/or treating HID's.

4. **APPENDICES:**

Link to DOH EMS & Trauma GIS Resource Map https://fortress.wa.gov/doh/ems/index.html

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