YAKIMA
County Operating Procedures (COPs)

Approved Date: 03/2023

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COUNTY OPERATING PROCEDURE #5.1: TRAUMA SYSTEM ACTIVATION

Effective Date: 03/2023

1. **PURPOSE:**
   A. Implement local policies and procedures for patients who meet the criteria for trauma system activation as described in the State of Washington Prehospital Triage (Destination) Procedures.

   B. Ensure:
      I. Patients are transported to the most appropriate hospital facility in accordance with South Central Region EMS & Trauma Care Council, Patient Care Procedure #5.1, Trauma Triage and Destination Procedure.

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:**
   A. Upon receipt of a potential trauma call, the applicable dispatch center will alert responding units of the ETA of the closest, available air medical transport agency in appropriate critical trauma cases if paramedic response is greater than 20 minutes.

   B. The first certified EMS provider (or agency) to determine that a patient meets the trauma triage criteria (TTC), in accordance with the *Field Triage Decision Scheme: The National Trauma Triage Protocol,* shall contact MultiCare Yakima Memorial Hospital (MCYM), as soon as possible, and provide the following information:
      I. Identification of EMS agency.
      II. Number of patients (if more than one)
      III. Approximate Patient(s) age.
      IV. Mechanism (cause) of injury.
      V. Trauma triage criteria (qualifying factor(s)
      VI. This must be done immediately upon determining the patient's condition via the H.E.A.R. frequency, cellular phone, or through the applicable dispatch center.

   C. Radio contact with Medical Control will be preceded with the phrase: "This is a trauma alert."

   D. While enroute to the hospital, the transporting agency should provide a patient status report, via radio or other means, to the receiving facility. This report should include:
      I. Identification of EMS agency
      II. Number of patients (if more than one)
      III. Patient(s) age
      IV. Mechanism (cause) of the injury
      V. Chief complaint/description of the injury

VI. GCS (PRIOR TO INTUBATION and/or SEDATION)
VII. Vital signs
VIII. Co-morbid factors

E. If contact with medical control is impossible due to the incident location or other problems, the first EMS agency to determine that the patient(s) meets the trauma activation criteria may transmit patient information to the applicable dispatch center, who should notify medical control.

F. In the event of a mass casualty incident, see COP MCI.

G. MCYM is the designated trauma hospital for Yakima County.

H. If a patient meets trauma activation criteria and the patient or patient's guardian, requests transport to a facility other than MCYM, that is a lower-level trauma hospital, inform the patient/guardian of the potential consequences, obtain signature on appropriate form and transport as requested.

I. The highest-level facility may divert the patient(s) to the next closest designated trauma facility in the event there is a lack of resources to care for the patient(s).

J. If the incident is gang related, and safety concerns are raised regarding the destination of a patient, contact Medical Control for direction.

K. In areas of Yakima County where transport time from the scene to MCYM would be 30 minutes or less, despite proximity to Astria Sunnyside Hospital or Astria Toppenish Hospital, for the conditions described below, patient destination should be MCYM.
I. Pregnant patients
II. Pediatric patients known or estimated to be less than 15 years of age.

L. Consider ambulance rendezvous where ambulance arrival times may be delayed.

COUNTY OPERATING PROCEDURE #5.2: CARDIAC TRIAGE AND DESTINATION

Effective Date: 03/2023

1. **PURPOSE:**
   A. Implement local policies and procedures for patients who meet the criteria for cardiac related system activation as described in the State of Washington Prehospital Triage (Destination) Procedures.

   B. Ensure:
      I. Patients are transported to the most appropriate hospital facility in accordance with South Central Region EMS & Trauma Care Council, Patient Care Procedure #5.2, Cardiac Triage and Destination Procedure.
      II. Hospital preparedness when receiving a cardiac related alert.

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:**
   A. A patient meeting criteria listed under the State of WA Prehospital Cardiac Triage Destination Procedure listed under "assess Applicability for Triage" should be transported and triaged according to the following local guidelines:

   B. Upon receipt of an acute coronary syndrome patient, the first arriving agency should determine the following in accordance with the State of Washington Prehospital Cardiac Triage Destination Procedure:
      I. Post cardiac arrest with ROSC, -or-
      II. Age > 21, with symptoms lasting more than 10 minutes but less than 12 hours suspected to be caused by coronary artery disease.

   C. If a patient is suffering from an acute coronary syndrome (cardiac event), according to the State of Washington Prehospital Cardiac Triage Destination Procedure, transporting agency would transport according to these guidelines:
      I. A BLS/ILS transporting unit should go to the nearest Level 1 Cardiac Center within 30 minutes transport time.
         a. If the Level 1 Cardiac Center(s) are greater than 30 minutes away the BLS/ILS transporting unit should go to the nearest Level 2 Cardiac Center.
      II. An ALS unit should go to the nearest Level 1 Cardiac Center within 60 minutes transport time.
         a. If the Level 1 Cardiac Center(s) are greater than 60 minutes away the ALS unit should go to the nearest Level 2 Cardiac Center.

D. If there are two or more of the same level facilities to choose from within the transport times, patient preference, insurance, physician practice patterns, and local rotation agreements may be considered.

E. Consider ambulance air-medical transport, if ambulance arrival and/or transport times may cause a delay.

F. Consider rendezvous with ambulance if ambulance arrival times may be delayed.

COUNTY OPERATING PROCEDURE #5.3: STROKE TRIAGE DESTINATION PROCEDURE

Effective Date: 03/2023

1. **PURPOSE:**
   A. Implement local policies and procedures for patients who meet the criteria for stroke alert activation as described in the State of Washington Prehospital Triage (Destination) Procedures.

   B. Ensure:
      I. Patients are transported to the most appropriate hospital facility in accordance with South Central Region EMS & Trauma Care Council, Patient Care Procedure #5.3, Stroke Triage and Destination Procedure, and any other applicable local, state and Region requirements.
      II. Hospital preparedness when receiving a patient that meets stroke criteria.

2. **SCOPE**:
   Licensed and trauma verified aid and/or ambulance services utilize the most current State of WA 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:**
   A. Transport the patient to the nearest Level I, II, or III Stroke Center.

   B. If the nearest center is a Level III, and there is a Level I or II available with no more than 15 minutes increase in transport time, transport to the nearest Level I or II Stroke Center.

   C. Assess availability of air-medical transport if it can help get the patient to a Stroke Center in time for intervention.

   D. If unable to manage airway, consider rendezvous with a medic or intermediate unit, or stop at nearest facility capable of definitive airway management.

   E. If there are two or more Stroke Centers of the same level to choose from within the transport time frame, patient preference, insurance, physician practice patterns, and local rotation agreements may be considered.

   F. Consider ambulance rendezvous or air-medical transport, if ambulance arrival and/or transport times may be delayed.

COUNTY OPERATING PROCEDURE #6: MEDICAL CONTROL COMMUNICATIONS

Effective Date: 03/2023

1. **PURPOSE:**
   A. The primary purposes for prehospital-to-hospital communications are to notify the hospital of information concerning the patient they are about to receive; to obtain verbal orders or advice on a treatment or problem occurring in the field (on-line medical control); to activate cardiac or stroke systems for related events and to activate the trauma system in cases of major trauma.

   B. Define Direct Medical Control and the responsibilities of the Medical Control Facility and the Medical Program Director (MPD).

   C. Provide a policy for standardized, preplanned communication methods to be used for interagency radio communication during emergency medical incidents.

   D. Enable agencies to meet the requirements of South-Central Region EMS & Trauma Care Council Patient Care Procedure #6, EMS/Medical Control Communications.

2. **SCOPE**:
   Communications between prehospital personnel, base station hospital (on-line 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. The designated Medical Control Facility (MCF) for Yakima County is MultiCare Yakima Memorial Hospital, and will be responsible for the following:
      I. Provide on-line medical control and consultation to prehospital care providers for patients they are about to receive via an EMS unit or in cases where the receiving hospital's physician cannot be contacted
      II. Resolve and/or provide advice on cases of disparity regarding treatment and/or transport between prehospital care providers or other medical professionals at the scene; or other incidents or disputes concerning patient care in the field.
      III. Based on availability of resources, direct or divert patients to the most appropriate clinical facility.
         a. Patients should be transported to the closest appropriate emergency facility, unless otherwise directed by the Medical Control Facility or the patient's or family's preference.
         b. Obtain daily bed status of all hospitals in Yakima County.
      IV. Physicians participating in the emergency departments at MultiCare Yakima Memorial Hospital, Astria Toppenish Hospital, and Astria Sunnyside Hospital are authorized to provide

on-line medical control (verbal orders) to certified prehospital care providers practicing under the authority of the Yakima County Medical Program Director. (MPD)

a. Non-physicians are not authorized to provide on-line medical control to prehospital care providers.
b. Physicians not delegated by the MPD are not authorized to direct prehospital care providers.

V. Procedures listed in the Yakima County Prehospital Care Protocols as "Verbal Orders" (highlighted in bold/italic) may be performed only after consultation and approval of the on-duty emergency physician at the hospital to which the patient will be transported.
   a. If unable to contact the receiving hospital's physician, then contact the designated Medical Control Facility for consultation and orders.
   b. The Yakima County MPD, if available, may be used as a resource if neither the receiving hospital nor Medical Control Facility physicians can be contacted for direction. MPD directives supersede any instructions from the receiving hospital, medical control physician, or protocols.

VI. If all reasonable attempts to contact a physician have been unsuccessful, and failure to perform a procedure requiring a verbal order could adversely impact the patient's outcome, such a procedure may be performed as a standing order. The reason for not making contact must be documented on the medical incident report.

VII. During an event that has exceeded the MCI Level I (i.e., 11 patients or more) it is appropriate for the Medical Control Facility to track each patient by their START triage tag number and document their destination, be it to local or out-of-county hospitals.

B. Direct (on-line) medical control allows the MPD to influence the clinical care being delivered by an EMS system on a minute-by-minute basis. This can be done while the MPD (or his/her delegate) is either at the scene, or by radio, telephone, or cellular phone. Because this must be provided twenty-four hours a day, direct medical control is a medical oversight activity that is delegated by the MPD to the emergency physicians at the hospitals in Yakima County. An MPD directive supersedes any instructions from the receiving hospital, medical control facility, or protocols.

C. Prehospital-to-hospital communications may be conducted via radio frequency (HEAR frequency), using standard telephone lines, or by cellular phone.

D. Requests to speak to a physician should be preceded by agency and unit identification, and brief description of the incident (e.g., "We are at the scene of a cardiac arrest and would like to speak with the physician.").

E. Once contact has been made with the emergency physician, provide a brief description of the situation and the nature of the request. Repeat all verbal orders back to the physician.

F. Only a physician or nurse may receive reports from prehospital care providers. A nurse may relay a physician's orders but may not provide orders to prehospital personnel.

G. For incidents of a more sensitive nature in which a patient's name must be transmitted, or situations involving some type of dispute in the field, communications should be done via standard telephone or cellular phone.

H. For coordination during EMS incidents, communication between responding fire departments, transport agencies, emergency dispatch centers and hospitals, shall be done by utilizing a mutually agreed upon method that best meets the needs of the agencies.
   I. Emergency Dispatch Center to/from/between Responding Units: Communication from or to the Emergency Dispatch Center and the Responding Units shall primarily utilize the appropriate Upper Valley or Lower Valley Main Dispatch channel.
   II. Transport Agencies to/from Hospitals: Communications between the Transport Agencies and the Hospitals shall use the best communication method possible depending on circumstances; primarily these methods shall be HEAR radio frequency, cellular phone to designated line at the emergency room (as available) or relay through the appropriate Dispatch Center.
   III. On-scene communications should go through Incident Command.
   IV. Ambulance agencies requesting additional transport resources regarding a 911 call will do so through the proper on-scene incident command or via the appropriate fire dispatch.

COUNTY OPERATING PROCEDURE #10.1: MASS CASUALTY INCIDENT

Effective Date: 03/2023

1. **PURPOSE:**
   A. Implement local policies and procedures for mass casualty incidents in accordance with South Central Region EMS & Trauma Care Council, Patient Care Procedure #10.1, MCI.

   B. Ensure that patients involved in a mass casualty incident are transported to the most appropriate hospital facility in a timely manner and with swift efficiency and effective communication.

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. Dispatch
      I. Upon receipt of a potential mass casualty incident (MCI) call, the applicable fire dispatch center should advise responding fire district/department units of which designated facility will be Medical Control for the incident (in Yakima County it is MultiCare Yakima Memorial Hospital; Out of County then advise) and at this time, it is recommended that the dispatch center notify Medical Control of the "potential" situation.

   B. First Responder/EMS
      I. The first EMS provider (or agency), certified in ICS, determines that an MCI exists should immediately establish incident command, per local agency procedures utilizing National Incident Management System (NIMS) guidelines.
         a. This should be done immediately upon the determination that the number of patients may overload local EMS and/or hospital resources.
         b. The following levels will be relayed from the first EMS provider on-scene to the applicable fire dispatch center:

            - <u>MCI Level I:</u> 5-10 patients are critically injured in a single incident. Initial response may include:
               i. UPPER VALLEY: Confirm with Incident Command for an EMS Level 2 transport
               ii. LOWER VALLEY: Request additional resources.
               iii. Four additional ambulances.
               iv. One helicopter to the scene or airport.

- MCI Level II: 11-20 patients are involved in a single incident. Initial response may include:
    i. UPPER VALLEY: Confirm with Incident Command for an EMS Level 2 & 3 transport.
    ii. LOWER VALLEY: Request for additional resources, notify Yakima Valley Office of Emergency Management.
    iii. All available transport resources.
        a) Notification from ambulance supervisors to Incident Command of available call-back crews is recommended.
    iv. Two helicopters to the scene or airport.
    v. Public transit.
    vi. For areas on the outer edges of the county consider requesting nearby/neighboring county resources.

- MCI Level III: Greater than 20 patients all involved in a single incident. Initial response may include:
    i. UPPER VALLEY: Confirm with Incident Command for an EMS Level 4 Transport.
    ii. LOWER VALLEY: Request for additional resources, notify Yakima Valley office of Emergency Management.
    iii. All available transport resources.
        a) Notification from ambulance supervisors to Incident Command of available call-back crews is recommended.
    iv. For assistance with the incident for back-filling coverage of daily 911 calls, consider requests for assistance from neighboring agencies
    v. Two helicopters to the scene or airport.
    vi. Notification given to all available helicopter agencies of the situation with notification to Incident Commander on number of available helicopters.
    vii. Public Transit

C. Radio or 'verbal responses' to receiving hospitals from transporting units are not necessary, unless the attendant feels it is in the best interest of the patient (s) that contact be made.
    I. If the transporting EMS agency determines contact with the receiving facility is necessary, they will provide them with following information:
        a. Identification of EMS agency
        b. Patients' identification numbers (located on START triage tag)
        c. Patients' START category (Green, Yellow, Red, or Black)

D. Simple Triage and Rapid Transport (START) criteria will be utilized at Mass Casualty Incidents.

E. If contact with Medical Control is impossible due to the incident location or other complications, EMS agencies may transmit patient information to the applicable fire dispatch center, who shall notify the Medical Control center.

F. Patients involved in a confirmed MCI may not make a transport destination request or determine the destination of any ground or air transport vehicle.

G. Radio contact with Medical Control should be preceded with the phrase: “This is an MCI transmission.”

H. Transport Officer (typically a Fire Department/District representative)

I. The Transport Officer is responsible for providing Medical Control with all necessary patient information. This may include:
   I. Updates on the total number of patients known, as available.
   II. Updates on the total number of patients per color category, as available.
   III. Updates on the total number of patients ready for transport.
   IV. The transporting unit agency name and number.
   V. The number of patients on board.
   VI. The number of each color category on board.

J. Medical Control
   The designated Medical Control Facility for Yakima County is MultiCare Yakima Memorial Hospital and in the event of a mass casualty incident and/or disaster, the Medical Control Facility will:
   I. Ascertain the staffing and availability of other resources from local hospitals in Yakima County.
   II. Determine patient transport destination.
   III. Communicate patient transport destinations with prehospital providers (on scene Transport Officer or their delegate) in accordance with the Yakima County Operating Procedure for MCIs. “*Medical Control should determine the transport destination for each ground-transporting agency. Destination assignments should be relayed from Medical Control to the Transport Officer and then to the transporting unit. It should not be via direct contact between the transporting unit and Medical Control as is done on a single patient incident.”*
   IV. Medical Control Facility will notify each receiving facility of the incoming unit, its patient load, and each of the patient’s “START” triage color classification (Green, Yellow, Red, or Black).
   V. In the event the Medical Control Facility determines a shortage of hospital resources within the county exists, the Medical Control Facility should begin contacting out-of-county hospitals. It is recommended that any large ground transport vehicle (i.e., public transit), carrying no red patients, be considered for an out-of-county transport destination. In addition, all air transport agencies should consider both in and out-of-county transport destinations.

COUNTY OPERATING PROCEDURE #10.3: INFECTIOUS DISEASE

Effective Date: 03/2023

1. **PURPOSE:**
   A. Provide a guideline for emergency medical services in the event of a local epidemic (pandemic) outbreak as recommended by the Washington State Department of Health EMS & Trauma Division.

   B. A pandemic for the purposes of this protocol will be defined as an epidemic of infectious disease that spreads through populations across a large region, for instance a continent, or even worldwide. And has the following characteristics:
      I. Emergence of a disease new to a population.
      II. Agents infect humans, causing serious illness.
      III. Agents spread easily and sustainably among humans.

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:**
   A. If an epidemic (pandemic) is declared by one or more of the listed agencies, then the following guidelines shall be implemented:
      I. Centers for Disease Control, or
      II. Washington State Department of Health
      III. Yakima County Health District, or
      IV. The Medical Control Officer

   B. Declaration of localized (Yakima County) epidemic (pandemic) alert:
      I. 911 Operations/Dispatch shall issue daily alerts to all agencies in Yakima County via the Daily Status report on the declaration of a epidemic (pandemic).
         a. This shall be a non-responsive transmission.
         b. Question callers using current guidance based on disease or procedure.
      II. And shall notify EMS agencies dispatched to priority calls of flu like symptoms.

   C. All EMS agencies shall locally appoint an Infection Control Officer (ICO) to establish a decontamination and health care screening site(s) to clear employees prior to entering the work site at the start of each shift.
      I. The established ICO for each EMS agency shall be responsible for the following:
         a. Situation Reports
            i. The ICO will provide situation reports to responders within their agencies.
               a) Shift briefings will include:
                  1) Status of outbreak including last 24-hour activity.
                  2) Hospital status

3) PPE, Infection Control
4) Status of EMS epidemic (pandemic) SOP

D. EMS provider Requirements for all EMS responses:
   I. Refer to Medical Patient Assessment Protocol

E. Flu or Covid 19 like symptoms shall be defined as any patient presenting with any of the following:
   I. High Fever
   II. Body Aches
   III. Headaches
   IV. Coughing
   V. Sore Throat
   VI. Diarrhea
   VII. Vomiting
   VIII. Fatigue and Chills

F. EMS provider requirements for contacting patients with flu like symptoms once epidemic (pandemic) has been issued shall follow enhanced PPE guidelines above the standard precautions of patient care.
   I. All Patient Contact
      a. Standard universal precautions or PPE including gloves, NIOSH approved N-95 mask and eye protection.
   II. Patients with respiratory/GI symptoms
      a. PPE outlined above, plus: disposable gown/overalls and shoe covers; (when bodily fluids are present) cover patient with surgical face mask.
   III. Patients with confirmed Covid 19 or Covid 19 symptoms:
      a. Standard universal precautions or PPE including gloves, NIOSH approved N-95 mask, eye protection, disposable gown/overalls and shoe covers: (when bodily fluids are present) cover patient with surgical face mask.

G. Patient Care and Transport to emergency department (Respiratory Distress (Flu Like) Symptoms)
   I. PPE
   II. Assess Patient for Priority Symptoms
      a. Chief Complaint
      b. Vital Signs (including check for orthostatic changes and temperature)
      c. Medical History and Travel History
   IV. Allow patient to achieve position of comfort
   V. Cover patient with surgical facemask, or administer O2 via facemask, to reduce aerosolized virus
   VI. Use proper patient isolation techniques:
      a. Close off ambulance driver's compartment
      b. Drape patient allowing airway control

i. Early EMS report to receiving facility

H. Care and No Transport:
   I. Provide explanation of the demand on limited resources and decision of no transport.
   II. Provide the most current information available from the Washington State Department of Health on preparations for a pandemic.
      a. Advise to call 911 should priority symptoms occur.
      b. Advise Home Health Care of patient condition and location for in home support and care.

South Central Region EMS & Trauma Patient Care Procedures

Table of Contents

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

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved	5/28/20	X Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

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

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved	5/28/20	X Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

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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Regional Council	Approved	5/28/20	X Major ☐ Minor
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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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Regional Council	Approved	5/28/20	X Major ☐ Minor
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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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Regional Council	Approved	5/28/20	X Major ☐ Minor
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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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Regional Council	Approved	5/28/20	X Major ☐ Minor
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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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Regional Council	Approved Draft	XX/XX/XXXX	☐ Major ☐ Minor
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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 online 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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