



Yolo County Health and Human Services



Kristin Weivoda
EMS Administrator

John S. Rose, MD, FACEP
Medical Director

DATE: July 15, 2019

TO: Yolo County Providers and Agencies

FROM: Yolo County EMS Agency

SUBJECT: August 1, 2019 EMS Protocol & Policy Revisions Release

MEMORANDUM

Effective August 1, 2019 the listed Protocols and Policies will go into effect for all Yolo County Providers. The protocol App and website will be updated. It is the responsibility of each agency to ensure that their personnel receive this information.

As a reminder, policies and protocols are updated two (2) times a year; February 1st and August 1st.

Protocol Updates

Agitated and/or Combative Patients

UPDATED: Removed from Policy and put into Protocol format.

Post Resuscitation Care

NEW: Added push Epinephrine 0.5 mL (5 mcg) slow IV push, every three (3) minutes, titrate to SBP > 90

Shock

NEW: Added push Epinephrine 0.5 mL (5 mcg) slow IV push, every three (3) minutes, titrate to SBP > 90

Symptomatic Bradycardia

NEW: Added push Epinephrine 0.5 mL (5 mcg) slow IV push, every three (3) minutes, titrate to SBP > 90

Trauma Patient Care

UPDATED: Added TXA to the protocol, all trauma patient care now in a single protocol

Quick Reference Updates

Grief Support

NEW: Grief Support

Tracheostomy Emergencies

NEW: Reference guide for tracheostomy care and trouble shooting.

Policy Updates

Prehospital Documentation

Updated: Revised language



Yolo County Emergency Medical Services Agency

Protocols

Revised Date: July 15, 2019

AGITATED AND/OR COMBATIVE PATIENTS	
Adult	Pediatric
Indication	
<ol style="list-style-type: none"> 1. The safety of the patient, community, and responding personnel is of paramount concern when following this policy. 2. Many situations that result in agitated patients can be resolved by simple conversation and de-escalation techniques. 3. Prehospital personnel must consider that combative or violent behavior may be a symptom of medical conditions such as head trauma, hypoxia, alcohol, drug related problems, hypoglycemia and other metabolic disorders, dementia, stress, and psychiatric disorders. 4. Restraint mechanisms are to be used only when necessary in situations where the patient is potentially violent or is exhibiting behavior that is dangerous to self or others. 5. Only the minimum amount of restraint necessary to protect providers and the patient should be used. 6. This policy is not intended to negate the need for law enforcement personnel to use appropriate restraint equipment that is approved by their respective agency to establish scene management. 	
BLS	
Assess vital signs O ₂ , titrate SpO ₂ to \geq 94%	
Agitated Patients	
<p>De-Escalation Techniques:</p> <ul style="list-style-type: none"> • Remain Calm • Position yourself at the patient's level • Listen • Acknowledge their feelings • Avoid giving orders • Offer options • Ask what they need • Do not threaten • Use only the required responders, ask others to step out <p>Physical Restraint:</p> <ul style="list-style-type: none"> • Use only padded soft restraints that will allow for quick release. • Restrained extremities should be evaluated for pulse quality, capillary refill, color, temperature, nerve and motor function immediately following application and every 10 minutes thereafter. • Restraints shall be applied in such a manner that they do not cause vascular, neurological or respiratory compromise. 	



Interfacility Transport (IFT) of Psychiatric Patients

- Transport personnel must be provided with the written restraint order from the transferring Physician or their designee as part of the transfer record.
- Padded soft restraints are the preferred method of restraint for IFT Psychiatric Patients.
- A two-point, locking, padded cuff and belt restraint and/or two-point locking, padded ankle restraints may be used only in the IFT of psychiatric patients on a 5150 hold. Transport personnel must have immediate access to the restraint key at all times.
- Restrained extremities should be evaluated for pulse quality, capillary refill, color, temperature, nerve and motor function immediately following application and every 10 minutes thereafter.

ALS

Consider: Blood Glucose, Temperature, Cardiac Monitor, Waveform EtCO₂

Patients in Law Enforcement Custody

- Restraint devices applied by law enforcement must provide sufficient slack in the restraint device to allow the patient to straighten the abdomen and chest and to take full tidal volume breaths.
- Restraint devices applied by law enforcement require the officer's continued presence to ensure patient and scene management safety. The officer should accompany the patient in the ambulance.
- In the unusual event that this is not possible, the officer should follow by driving in tandem with the ambulance on a pre-determined route. A method to alert the officer of any problems that may develop during transport should be discussed prior to leaving the scene. Patients in custody/arrest remain the responsibility of law enforcement.

Chemical Restraint

Early chemical restraint should be considered for patients with signs of Excited Delirium

Midazolam 2 mg SIVP

- Titrate to desired degree of sedation
- May repeat at 1 – 2 mg increments every 3 minutes
- Total max dose 6 mg

Or

Midazolam 5 mg IM

- No repeat

Or

Midazolam 10 mg IN

- ½ dose each nare
- No repeat

Midazolam 0.1 mg/kg SIVP

- Titrate to desired degree of sedation
- May repeat x 2 every 5 -10 minutes
- Max single dose 2 mg
- Total max dose 4 mg

**Use a 1 mL syringe for Midazolam administration in pediatric patients*

Or

Midazolam 0.1 mg/kg IM

- Max dose 4 mg
- No repeat

Or

Midazolam 0.2 mg/kg IN

- ½ dose each nare
- Max dose 5 mg
- No repeat



Yolo County Emergency Medical Services Agency

Protocols

Revised Date: July 15, 2019

Consider

- Consider any potential cause of the abnormal or combative behavior such as, but not limited to, head trauma, hypoxia, drug and alcohol related problems, hypoglycemia and other metabolic disorders, stress, excited delirium, or psychiatric disorders and treat according to the appropriate protocol.
- It is recognized that a full assessment requires patient cooperation, and thus may be difficult or impossible to perform.

Direction

- The receiving hospital shall be informed as soon as possible with the time and type of restraint.
- Patients shall not be transported in a prone position.
- Prehospital personnel must ensure that the patient's position does not compromise their respiratory/circulatory systems, and does not preclude any necessary medical interventions to protect or manage the airway should vomiting occur.
- The following forms of restraint shall NOT be applied by prehospital care personnel:
 - Hard plastic ties
 - Any restraint device requiring a key to remove. (EXCEPTION: IFT of Psychiatric Patients)
 - Restraining hands and feet behind the patient.
 - "Sandwich" restraints, using backboard, scoop-stretcher or flats.
 - Restraints shall not be attached to movable side rails of a gurney.
- Contact Receiving ED Physician for additional treatment.



Yolo County Emergency Medical Services Agency

Protocols

Revised Date: July 15, 2019

POST RESUSCITATION CARE	
Adult	Pediatric
BLS	
Assess vital signs O ₂ , titrate SpO ₂ to ≥ 94% Assist ventilations as needed Avoid hyperventilation Temperature	
BLS Local Scope	
Blood Glucose Check	
ALS	
Cardiac Monitor, Waveform EtCO ₂ , Vascular Access 12-Lead ECG (required on all ROSC patients)	
<p style="text-align: center;"><u>BP < 90 & HR > 50 BPM</u></p> <p>Fluid Bolus NS 250 mL IV/IO</p> <ul style="list-style-type: none"> • May repeat as needed <p style="text-align: center;"><u>BP < 90 & HR < 60 BPM</u></p> <p>Atropine 0.5 mg IV/IO</p> <ul style="list-style-type: none"> • May repeat every 3 - 5 minutes • Max dose 3 mg <p style="text-align: center;"><u>If no response, consider</u></p> <p>Epinephrine 0.5 mL (5 mcg) slow IV push</p> <ul style="list-style-type: none"> • every 3 minutes • titrate to SBP > 90 <p>Transcutaneous Pacing</p> <p style="text-align: center;"><u>VF/VT ROSC</u></p> <p style="text-align: center;"><i>* Only give Amiodarone if not previously administered during initial resuscitation</i></p> <p>Amiodarone Drip 150 mg in D5W 100 mL IV/IO (100 gtts/min with 10 gtts/mL set)</p> <ul style="list-style-type: none"> • Give over 10 minutes • No repeat 	<p style="text-align: center;"><u>Signs of hypoperfusion</u></p> <p>Fluid Bolus NS 20 mL/kg IV/IO</p> <ul style="list-style-type: none"> • Titrate to age appropriate SBP <p style="text-align: center;"><i>* Sustain normothermia</i></p>



Yolo County Emergency Medical Services Agency

Protocols

Revised Date: July 15, 2019

Direction

- Transport to a STEMI Receiving Center
- Transmit 12-Lead ECG to Receiving ED
- Consider sedation if the patient is combative
- Contact Receiving ED Physician for additional treatment



Yolo County Emergency Medical Services Agency

Protocols

Revised Date: July 15, 2019

SHOCK	
Adult	Pediatric
Compensated Shock	
<ul style="list-style-type: none"> Tachycardia Cool Extremities Capillary refill time > 2 seconds Weak peripheral pulses compared to central pulses Normal BP 	
Decompensated Shock	
<ul style="list-style-type: none"> Hypotension and/or bradycardia (late finding in pediatric patients) Decreased mental status Decreased urine output Tachypnea Non-detectable distal pulses with weak central pulses Pale/cool/diaphoretic skin signs 	
BLS	
Assess vital signs O ₂ , titrate SpO ₂ to ≥ 94% Temperature	
ALS	
Cardiac Monitor, 12-Lead ECG, Waveform EtCO ₂ , Vascular Access	
<p style="text-align: center;"><u>SBP < 90</u></p> <p>Fluid Bolus NS 250 mL IV/IO</p> <ul style="list-style-type: none"> May repeat as needed <p style="text-align: center;"><u>SBP < 90 and Pulse < 60</u></p> <p><u>If patient continues to have signs and symptoms of shock after fluid dose; consider</u></p> <p>Epinephrine 0.5 mL (5 mcg) slow IV push</p> <ul style="list-style-type: none"> every 3 minutes titrate to a SBP >90 <p>Establish second large bore IV, if possible</p>	<p>Fluid Bolus NS 20 mL/kg IV/IO</p> <ul style="list-style-type: none"> Titrate to age appropriate SBP
Consider	
Shock in children may be subtle and difficult to recognize; tachycardia may be the only sign	
Direction	
<ul style="list-style-type: none"> Contact Receiving ED Physician for additional treatment 	



Yolo County Emergency Medical Services Agency

Protocols

Revised Date: July 15, 2019

SYMPTOMATIC BRADYCARDIA	
Adult	Pediatric
Signs & Symptoms	
<ul style="list-style-type: none"> • Hypotension • Acute altered mental status • Chest pain • Seizures • Syncope/near syncope • Shortness of breath • Pallor or cyanosis 	
BLS	
Assess vital signs O ₂ , titrate SpO ₂ to ≥ 94% Assist ventilations as needed	
ALS	
Cardiac Monitor, 12-Lead ECG, Waveform EtCO ₂ , Vascular Access	
HR < 50	HR < 60
<p>Atropine 0.5 mg IV/IO</p> <ul style="list-style-type: none"> • May repeat every 3 - 5 minutes • Max total dose 3 mg <p style="text-align: center;"><u>and/or</u></p> <p>Transcutaneous Pacing</p> <p style="text-align: center;"><u>SBP < 90</u></p> <p>Fluid Bolus NS 250 mL IV/IO</p> <ul style="list-style-type: none"> • May repeat as needed <p style="text-align: center;"><u>Consider:</u></p> <p>Epinephrine 0.5 mL (5 mcg) slow IV push</p> <ul style="list-style-type: none"> • every 3 minutes • titrate to a SBP > 90 <p style="text-align: center;"><i>(continued next page)</i></p>	<p style="text-align: center;"><i>*Assure adequate oxygenation and ventilation</i></p> <p style="text-align: center;"><u>If HR remains < 60 despite oxygenation and ventilation</u></p> <p>CPR (for patients without signs of puberty)</p> <p>Epinephrine (1:10,000) 0.01 mg/kg IV/IO</p> <ul style="list-style-type: none"> • May repeat every 3 - 5 minutes <p style="text-align: center;"><u>Increased vagal tone</u></p> <p>Atropine 0.02 mg/kg IV/IO</p> <ul style="list-style-type: none"> • Minimum dose 0.1 mg • Max single dose 0.5 mg • Total max dose 3 mg



Yolo County Emergency Medical Services Agency

Protocols

Revised Date: July 15, 2019

HR < 50	HR < 60
<p><u>If no response and patient on Beta Blockers</u></p> <p>Glucagon 1 mg IV/IO</p> <ul style="list-style-type: none">Given over 1 minuteNo repeat <p style="text-align: center;"><u>Or</u></p> <p>Glucagon 1 mg IM/IN No repeat</p>	
Consider	
<ul style="list-style-type: none">H's and T'sConsider sedation with pacingThe majority of pediatric bradycardia is due to respiratory problems	
Direction	
<ul style="list-style-type: none">Transmit ECG to Receiving EDContact Receiving ED Physician for additional treatment	



Yolo County Emergency Medical Services Agency

Protocols

Revised Date: July 15, 2019

TRAUMA PATIENT CARE	
Adult	Pediatric
Purpose	
<p>To identify trauma patients who are at the greatest risk for serious injury and determine the most appropriate destination.</p> <ul style="list-style-type: none"> Trauma Centers improve outcomes for patients with significant traumatic injuries. Patients with significant traumatic injuries requiring an operating room within the first 4 hours benefit from being transported immediately to an appropriate trauma center. Level I and Level II trauma centers are able to provide emergent neurosurgical interventions. Patients requiring neurosurgical interventions should go directly to a level I or level II trauma center. Mechanism of Injury (MOI) does not directly indicate trauma criteria. MOI plus physical signs and symptoms indicate a high suspicion of critical injuries requiring a Level I or Level II Trauma Center. 	
Physiological Criteria (Level I, II)	
<ul style="list-style-type: none"> Hypotension – Systolic Blood Pressure < 90 mmHg Sustained tachycardia – Heart Rate > 120 beats per minute Respiratory Rate < 10 or > 29 breaths per minute Altered Mental Status – Glasgow Coma Scale (GCS) < 14 	
Neurosurgical Criteria (Level I, II)	
<ul style="list-style-type: none"> Penetrating trauma to head, excluding facial injuries Suspected open or depressed skull fracture Paralysis GCS < 12 	
Anatomical Criteria (Level I, II)	
<ul style="list-style-type: none"> Penetrating injury to neck, torso, buttocks, groin, or extremities proximal to knee or elbow Flail chest 2 or more proximal long bone fractures Crushed, de-gloved, or mangled extremity (excluding digits) Amputation proximal to wrist and ankle Pelvic instability or crepitus with a possible fracture from major trauma 	
Mechanism of Injury Criteria (Level I, II, III)	
<ul style="list-style-type: none"> Intrusion into the passenger compartment: occupant side > 12 inches, any side > 18 inches Death of a patient in the same compartment Vehicle striking pedestrian or bicyclist with speed at impact > 20 MPH or involving torso run over Motorcycle crash with estimated speed of ≥ 20 MPH with a stationary object Ejection from vehicle (partial or complete) When available, vehicle telemetry data is consistent with high risk of injury 	



Yolo County Emergency Medical Services Agency

Protocols

Revised Date: July 15, 2019

Adult	Pediatric
Special Considerations	
<p>Patients with either high energy or low energy mechanism are more prone to serious injury if they have one or more of the following risk factors:</p> <ul style="list-style-type: none"> • Patients 55 years or older • Anticoagulant use or bleeding disorder • Time sensitive extremity injury • End stage renal disease requiring dialysis • Pregnant patients > 20 weeks <p>These patients may have injuries that exceed the capabilities of the receiving hospital and should be considered for transport to a trauma center. Contact Closest Trauma Hospital Physician if there is any concern about appropriate destination.</p>	
BLS	
<p>Open and position the airway Airway Adjuncts: OPA/NPA as needed to control the airway O₂, titrate SpO₂ to ≥ 94% SMR if indicated Identify and treat life threatening conditions Control external bleeding Prevent hypothermia Treat suspected shock</p>	
ALS	
Cardiac Monitor, Waveform EtCO ₂ , Vascular Access	
<p>Fluid Bolus NS 250 mL IV/IO</p> <ul style="list-style-type: none"> • Titrate SBP ≥ 90 mmHg <p>Initiate second large bore IV</p>	<p style="text-align: center;"><u>If poor perfusion or suspected shock</u></p> <p>Fluid Bolus NS 20 mL/kg IV/IO</p> <ul style="list-style-type: none"> • Titrate to age appropriate SBP <p>Initiate second large bore IV</p>



Yolo County Emergency Medical Services Agency

Protocols

Revised Date: July 15, 2019

ALS

Adult

Trauma patients with signs and symptoms of hemorrhagic shock meeting all of the following criteria:

1. Blunt or penetrating trauma to the chest, abdomen, or pelvis
2. Transport time > 30 minutes from a trauma center
3. Within 3 hours of injury
4. SBP < 90

TXA Bolus drip 1gm in NS 50 - 100 mL IV/IO over 10 minutes

- No repeat

Fluid Bolus NS 250 mL IV/IO

- Repeat as needed to maintain SBP \geq 90

*** Place the approved neon green wristband on patient**

TXA Contraindications

- Active thromboembolic event (within the last 24 hours); i.e., active stroke, myocardial infarction, pulmonary embolism or DVT
- Hypersensitivity or anaphylactic reaction to TXA
- Traumatic arrest with > 5 minutes of CPR without return of vital signs
- Suspected traumatic brain injury
- Drowning or hanging victims
- Cervical cord injury with motor deficits

Consider

Consider advanced airway if GCS is \leq 8 and BLS airway is ineffective

- IV/IO access should be initiated en route
- Consider pain management
- **Pregnant patients** meeting criteria should be taken to a **Trauma Center** with **obstetric** services.
- Air ambulances should only be used when they offer a measurable advantage to ground transport. Air ambulances may benefit patients injured in locations distant from a trauma center, and/or those in need of immediate procedures available to a Flight Nurse but outside the scope of practice of Paramedics.
- Patients with an uncontrolled airway may be considered for transport to the closest hospital.
- For trauma meeting burn criteria - refer to burn triage criteria
- This policy does not apply to Multi-Casualty Incidents

Direction

- If patient meets trauma triage criteria transport to a designated Trauma Receiving Center
- Contact the Trauma Center and advise them of a **“TRAUMA ALERT”** (preferably from the scene)
- If TXA administered advise the Trauma Hospital of **“TRAUMA ALERT TXA”**
- On scene time should be \leq 10 minutes
- Contact the closest Trauma Center Physician for additional treatment or **transport decisions**
- When in doubt, transport to the closest Trauma Center



TRACHEOSTOMY EMERGENCIES

Adult	Pediatric
--------------	------------------

Definitions

- **DOPE Pneumonic:** Displaced, Obstructed, Pneumothorax, and Equipment failure.
- **Tracheotomy:** Incision made below the cricoid cartilage through the 2nd-4th tracheal rings.
- **Tracheostomy:** The opening or stoma made by this incision.
- **Tracheostomy Tube:** Artificial airway inserted into the trachea through the tracheostomy.
- **Laryngectomy:** The removal of the larynx and separation of the airway from the mouth, nose, and esophagus.



Purpose

The majority of adults and children with tracheostomies are dependent on the tube as their primary airway. Cardio-respiratory arrest most commonly results from tracheostomy obstructions. Obstruction may be due to thick secretions, mucous plug, blood clot, foreign body, or kinking or dislodgement of the tube. Early warning signs of obstruction include tachypnea, tachycardia, and desaturation. Cyanosis, bradycardia, and apnea are late signs. **DO NOT** wait for these to develop before intervening.

BLS

- Position of comfort
- Open and position the airway
- Evaluate RR
- Apply O₂ to both the face and tracheostomy
- Titrate SpO₂ to ≥ 94%
- Airway Adjuncts: OPA/NPA as needed to control the airway
- Ventilate via BVM either mouth or tracheostomy tube
- Reassess often
- Oral pharyngeal suctioning as needed
- Suction around the tracheostomy opening as needed (do not enter the stoma)
- Avoid hyperventilation

ALS

Cardiac Monitor, Continuous Waveform EtCO₂, Suction, Vascular Access



Yolo County Emergency Medical Services Agency

Quick References

Revised Date: July 15, 2019

ALS (cont)

Severe Respiratory Distress or Respiratory Arrest

- Assess the patient using the DOPE mnemonic
- Remove speaking valve if present
- Remove T-tube if on humidified oxygen
- If the patient is on a ventilator remove from the ventilator and provide manual ventilation with a BVM to tracheostomy tube
- Provide suction (see below)

If unable to ventilate or pass a suction catheter

- If the caregiver is available, have them remove and replace the tracheostomy tube
- If the caregiver is not available, deflate the tracheostomy tube cuff (if present) and remove the tube
- Ventilate via a BVM to face with airway adjuncts while blocking the stoma with a finger
- If unable to ventilate via BVM to face, attempt ventilation via stoma with pediatric BVM mask
- If unable to ventilate via BVM to stoma, attempt oral intubation using a bougie (see Airway Management procedure)
- If unable to orally intubate after 2 attempts, attempt to intubate the Stoma (see procedure below)

Tracheostomy Suctioning

Indications

- Audible or visual signs of secretions in the tube
- Signs of respiratory distress
- Suspicious or blocked or partially blocked tube
- Inability to clear the tube with coughing
- Request by patient

Procedure

- | | |
|--|---|
| <ul style="list-style-type: none"> • Select appropriately sized suction catheter (8-16 French) • Set suction to low pressure (100-120 mm/Hg) | <ul style="list-style-type: none"> • Select appropriate suction catheter (8-10 French) • Set suction to low pressure (50-100 mm/Hg) |
|--|---|
- Ventilate with 100% O₂
 - Flush catheter with saline to lubricate tip and establish patency
 - Insert the suction catheter into the stoma or tracheostomy tube with the suction off, no more than 3-6 cm
 - Do not force suction catheter
 - Apply suction by occluding the thumb hole while slowly withdrawing the catheter in a twisting motion for no longer than 10 seconds for adult patients and 5 seconds for pediatric patients
 - Suctioning can stimulate a cough reflex; allow the patient to cough. Be prepared to suction or catch secretions from the tracheal opening
 - May repeat after 1 minute or as needed



Yolo County Emergency Medical Services Agency

Quick References

Revised Date: July 15, 2019

Tracheostomy Intubation
Adult – Age 15 and older
Indication
Unable to ventilate the patient with BVM to mouth, tracheostomy tube, or tracheostomy
Procedure
<ul style="list-style-type: none"> • Prepare and position the patient • Select the largest ET tube that will fit through the stoma without force (should be the same size as the tracheostomy tube). Check the cuff for leaks • Oxygenate with 100% O₂ using a BVM to face or stoma • Do not use a stylet • Suction if necessary • Pass the ET tube and inflate the cuff (Note: Be mindful of the depth of ET Tube placement. Passing the ET tube too deep can result in mainstem bronchus placement. The pharynx has been bypassed, so the tube will protrude from the neck several inches.) • Hold the tube in place • Check the neck for subcutaneous emphysema indicating false passage • Verify placement by ALL of the following: <ol style="list-style-type: none"> 1. Rise and fall of the chest 2. Bilateral breath sounds 3. Negative epigastric sounds 4. Condensation in the tube 5. Continuous waveform EtCO₂ • Secure the tube with tape and note depth
Consider
<ul style="list-style-type: none"> • Always talk to family/caregivers as they have specific knowledge and skills. • It is important to realize that some patients have had a laryngectomy - typically cancer patients. These airways begin at the stoma. There is no connection between the patient's oropharynx and airway. Most patients, however, maintain continuity between their oropharynx and trachea. These patients usually received a tracheostomy due to prolonged respiratory failure. • Use patient's equipment if available and functioning properly. • Some patients will have uncuffed tracheostomy tubes. Air will leak around these tubes and are not sufficient for manual ventilation. If you hear air escaping from the patient's mouth and/or around the tube during ventilations and the patient is not improving, suspect an uncuffed tube. Remove the tube and ventilate via BVM to face while covering the stoma. • Continuous Waveform EtCO₂ provides information about ventilation status. EtCO₂ can be attached to both BVM mask or tracheostomy tube. • Nasal Waveform EtCO₂ should be used if the patient is not being manually ventilated. • Mucous frequently obstructs a stoma or tracheostomy tube. Patients may require repeated suctioning. • Remember that patients with stomas/tracheostomy tubes are subject to the same illnesses as anyone else.
Direction
<ul style="list-style-type: none"> • Early Base Hospital Physician Contact for difficult airway



Yolo County Emergency Medical Services Agency

Quick References

Revised Date: July 15, 2019

GRIEF SUPPORT

Purpose

The intent of this policy is to provide grief support to the families of deceased individuals who are not transported from the field. Field personnel should identify the need for grief support as soon as possible, especially for an unexpected death or if considering discontinuation of CPR in the field.

Responsibilities

- Assist the family in dealing with the death or anticipated death of the patient.
- If resuscitation is in progress, communicate with the family what you are doing and explain to them the next steps based on patients response to treatment.
- There are many different religious beliefs regarding death, respect these beliefs and do everything you can to accommodate the family and their wishes.
- Once death has been determined:
 - Contact all appropriate agencies (Police, Coroner)
 - Assist with the notification of clergy, if requested
 - Provide support until additional resources arrive

Grief Support Guidelines

Breaking the News

- Physically join the family
- Remove your gloves
- Introduce yourself and your role
- Clearly state that you have news about the deceased (use the patients name)
- Clearly state the events leading to the death. *"We found your (relation) not breathing and without a heartbeat. We did everything we could but your (relation's) condition was so severe we were unable to revive them. I am very sorry to tell you that your (relation) has died."*
- Avoid using euphemisms like "passed away" or "no longer with us"
- Avoid medical terminology
- Give the family time to react; don't leave

Grief Support Skills

- Ask the family if there is someone they would like you to contact
- Give them permission to cry
- Tolerate silence
- Touching is okay if they request a hug or reach out
- Ask if they have any questions
- Verify their understanding
- Offer them an opportunity to view the deceased
- You cannot fix grief but you can give it an honest and safe place to exist



Yolo County Emergency Medical Services Agency

Quick References

Revised Date: July 15, 2019

Tell the family what happens next

- The coroner or mortuary must be notified
- The police will be coming to assist
- Tell them you will need to collect some information about the deceased

Knowing when to leave

- Verify they have support on scene
- Tell them it is time for you to go and ask *"Is there anything else I can do?"*
- Give them a number where they can reach you or your supervisor
- Offer your condolences, shake hands, or touch if appropriate

Useful phrases

- I can't imagine how difficult this is for you.
- I know this is very painful for you.
- I'm so sorry for your loss.
- It must be hard to accept.
- It's harder than most people think.
- You must have been very close to him/her.
- How can I help?
- Most people who go through this react just as you are.

Keys to Success: Understanding, caring, empathy, support, and advocacy.

Consider

Crime scenes or traumatic events will require additional considerations:

- Move family away from the scene before informing them of the patient's condition.
- Family notifications at a crime scene should be done with law enforcement.
- If they were injured or involved, consider their injuries before informing.
- If transporting a survivor contact the hospital to have grief counselors available when you arrive.



PREHOSPITAL DOCUMENTATION

PURPOSE

This policy defines the requirements for patient care documentation and the procedure for completion, distribution and retention of the electronic patient care reports (ePCR) applicable to all EMS transport providers, BLS first responders, and ALS first responders.

DEFINITIONS

Incident: An incident is any response involving EMS personnel to any event in which there is an actual victim or the potential for a victim, regardless of whether or not the responding unit was cancelled en route. This includes all emergency responses, nonemergency responses, walk-in contacts, responses that are cancelled before scene arrival, any pre-arranged ambulance standby and any ambulance transfers originating in region.

Patient: Any person that calls for EMS services or that EMS personnel encounter who demonstrates any known or suspected illness or injury shall be considered a patient.

Patient Contact: Patient contact has occurred if EMS personnel do **any** of the following:

- I. Offer medical assistance of any kind to a patient
- II. Visualize the patient (objective assessment)
- III. Determine the mechanism of injury
- IV. Obtain a history of present illness
- V. Witness any care rendered by other parties

POLICY

- I. ePCRs shall be completed and submitted electronically by all Advanced Life Support (ALS) and/or ambulance transport services at any level providing service within Yolo County.
- II. EMS personnel shall complete an ePCR on all EMS incidents or patient contact responses.
- III. Intentional failure to complete an ePCR when required, or fraudulent or false documentation on a written patient care report or an ePCR, may result in formal investigative action under the California Health and Safety Code, § 1798.200.
- IV. Patient care documentation management is to be compliant with HIPAA and medical record retention requirements.
- V. The Local EMS Agency (LEMSA) may request specific documentation elements related to CQI, field study or trials and other emergency management data collection requirements.

DOCUMENTATION REQUIREMENTS

- I. EMS personnel shall complete an ePCR on all EMS responses regardless of outcome. This includes responses where a unit responded and there was no patient contact.
- II. All available and relevant information shall be accurately documented in the ePCR.



Yolo County Emergency Medical Services Agency

Policy

Revised Date: July 15, 2019

- III. The first response agency's completed ePCR must be sent by facsimile transmission, or hand delivered, to the receiving facility or hospital that received the associated patient within four (4) hours.
 - A. The first responder agency shall deliver in person, verbal report or a form of field notes, to the transport provider of the assessment including vital signs, SpO₂ (if applicable), history, physical exam and all aid or treatment rendered prior to arrival of transport provider.
- IV. The ALS transporting ambulance shall leave a copy of the ePCR (electronic or printed) at the receiving hospital upon delivery of each patient. Within twenty-four (24) hours.
- V. BLS/ALS ambulances shall provide access for the Yolo County EMS Agency and receiving hospitals to patient care documentation in computer readable format and suitable for statistical analysis for all ambulance responses.
- VI. Documentation requirements may be deferred when emergency response is required but must be completed as soon as possible.

DOCUMENTATION PROCEDURES

- I. Personnel providing patient care are responsible for accurately documenting all available and relevant patient information on the ePCR. This requirement includes transport and first responder personnel.
- II. Use of abbreviations is not permitted in the narrative section of the record or as defined in automated ePCR pre-designated pick lists.
- III. An EMS provider's ePCR should include, at a minimum the following information:
 - A. Complete demographic information.
 - B. A clear history of the present illness with chief complaint, onset time, associated complaints, pertinent negatives, mechanism of injury, etc. The information should accurately reflect the patient's chief complaint as stated by the patient to the EMS provider and should be sufficient to refresh the clinical situation after it has faded from memory.
 - C. An appropriate physical assessment that includes all relevant portions of a head-to-toe physical exam. When appropriate, this information may be supplemented in the narrative section of the ePCR.
 - D. At least two (2) complete sets of vital signs for every patient including: pulse, respirations, blood pressure and pulse oximetry. These vital signs should be repeated and documented after drug administration, prior to patient transfer and as needed during transport. For children less than (<) three (3) years of age, blood pressure measurement is not required for all patients, but should be measured if possible, especially in critically ill patients in whom blood pressure measurement may guide treatment decisions.
 - E. A pain scale shall be documented for all patients with a GCS greater than (>) 14.
 - F. When CAD to ePCR interface embedded within the ePCR system should be used to populate all ePCR data fields it supplies. When 9-1-1 center times were improperly recorded, these may be properly edited.
 - G. When the cardiac monitor is applied, data will be transferred to the ePCR from the device. If transferred automated vital sign values do not correlate with manually obtained values or are not consistent with the patient's clinical condition, providers should manually check vitals and record manual results.



Yolo County Emergency Medical Services Agency

Policy

Revised Date: July 15, 2019

- H. For drug administrations, the drug dosage, route, administration time and response shall be documented.
 - I. A complete list of treatments in chronological order. Response to treatments should also be listed.
 - J. For patients with extremity injury, neurovascular status must be noted before and after immobilization.
 - K. For patients with spinal motion restriction, document motor function before and after motion restriction.
 - L. For IV administration or saline lock placement, the catheter size, site, number of attempts, type of fluid, and flow rate.
 - M. A cardiac monitor strip should be attached for all patients placed on the cardiac monitor. All 12-Leads should also be included. Any significant rhythm changes should be documented. For cardiac arrests, the initial strip, ending strip, pre and post defibrillation, and pacing attempts, should be attached.
 - N. Any requested medical control orders, whether approved or denied, should be documented clearly.
 - O. Any waste of controlled medications should include the quantity wasted, where wasted and name of the person who witnessed the waste. Only agency approved personnel should be utilized to witness controlled substance waste.
 - P. All personnel information, including signatures.
 - Q. ALL crewmembers are responsible for, and should review, the content of the ePCR for accuracy.
- IV. The ePCR shall be completed and distributed in accordance with this policy.
- V. Once the ePCR is completed and posted, the ePCR may not be modified for any reason. Corrections or additions should be in the form of an addendum to the ePCR.

PREHOSPITAL DATA SUBMISSION

- I. ePCR data shall be provided to YEMSA in the following manner:
 - A. Prehospital Service Providers utilizing an ePCR system shall complete a data sharing agreement with YEMSA.

ADDITIONAL PROVISIONS

- I. Multi-casualty incident:
 - A. In an MCI, every person who has signs and/or symptoms or complaint of illness or injury shall have a patient assessment completed and documented on an appropriate triage tag.
- II. Walk-ins:
 - A. Any patient, who walks into a station of an ambulance or fire department manned by EMS personnel and is assessed and/or provided treatment, shall receive a complete patient assessment and shall be reported on an ePCR.
- III. Deceased patients:
 - A. The ePCR shall be utilized to document the circumstances related to a deceased patient (no resuscitation attempt).



Yolo County Emergency Medical Services Agency

Policy

Revised Date: July 15, 2019

RECORD REVIEW

- I. Each agency/provider, receiving facilities, base hospital and the EMS Agency will review patient care records as required by the Yolo County Continuous Quality Improvement (CQI) Committee.

RECORD RETENTION

- I. Patient care records must be securely retained for at least seven (7) years or for two (2) years after the patient reaches the age of maturity, whichever is longer. Privacy will be protected by compliance with the Health Insurance Portability and Accountability Act (HIPAA).