CENTRAL REGION PATIENT CARE PROCEDURES

Approved date: 3/21/2023

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Department of Health, Emergency Care System

REGULATIONS

The following regulations provide guidance on 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.

1.1 REVISED CODE OF WASHINGTON (RCW):

- **RCW 18.73** – Emergency medical care and transportation services
  - RCW 18.73.030 - Definitions
- **RCW Chapter 70.168** – Statewide Trauma Care System
  - RCW 70.168.015 – Definitions
  - RCW 70.168.100 – Regional Emergency medical Services and Trauma Care Councils
  - RCW 70.168.170 – Ambulance services – Work Group – Patient transportation – Mental health or chemical dependency services

1.2 WASHINGTON ADMINISTRATIVE CODE (WAC):

- **WAC Chapter 246-976** – Emergency Medical Services and Trauma Care Systems
  - WAC 246-976-920 – Medical Program Director
  - WAC 246-976-960 – Regional emergency medical services and trauma care councils
  - WAC 246-976-970 – Local emergency medical services and trauma care councils

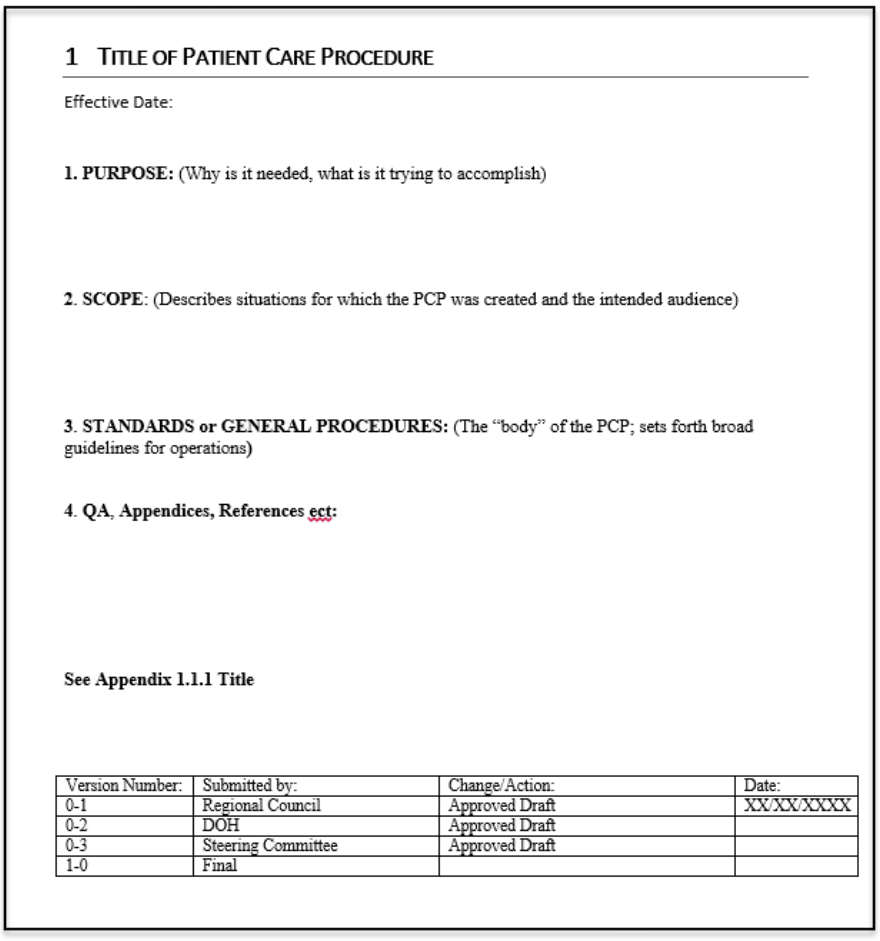
ANATOMY OF A PCP

RCW 18.73.030 – Defines a "Patient Care Procedure".

Other helpful definitions when building the anatomy of the PCP:

- **Purpose:** The purpose explains why it is needed and what it is trying to accomplish
- **Scope:** Describes the situations for which the PCP was created and the intended audience
- **Standards or General Procedures**: The "body" of the PCP, it sets forth broad guidelines for operations

Example:



1 TITLE OF PATIENT CARE PROCEDURE

Effective Date:

1. PURPOSE: (Why is it needed, what is it trying to accomplish)

2. SCOPE: (Describes situations for which the PCP was created and the intended audience)

3. STANDARDS or GENERAL PROCEDURES: (The "body" of the PCP; sets forth broad guidelines for operations)

4. QA, Appendices, References ect:

See Appendix 1.1.1 Title

Version Number:	Submitted by:	Change/Action:	Date:
0-1	Regional Council	Approved Draft	XX/XX/XXXX
0-2	DOH	Approved Draft	
0-3	Steering Committee	Approved Draft	
1-0	Final		

1 LEVEL OF MEDICAL CARE PERSONNEL TO BE DISPATCHED TO AN EMERGENCY SCENE

Effective Date: 2009

1. PURPOSE: To define guidelines for triage of trauma patients in the region.

2. **SCOPE**: This PCP applies to all 911 calls and EMS and trauma patients in the region.

3. **GENERAL PROCEDURES:**

Dispatch

Dispatch centers are accessed through the enhanced 911 system. Regional dispatch centers dispatch EMS units in accordance with King County Criteria Based Dispatch Guidelines. Seattle dispatchers use Seattle Fire Department Dispatch Guidelines. Dispatchers provide bystander emergency medical instructions while EMS units are in route to the scene.

The Central Region EMS Trauma Committee requires that emergency dispatching protocols be based on medical criteria. All EMS dispatching guidelines and protocols must be approved by the Program Medical Director of King County EMS in consultation with the Medical Program Directors of the paramedic programs within the County

Basic Life Support

Basic Life Support response is provided by city and county fire department units staffed by EMTs or private ambulance services staffed by EMTs. The nearest unit to an emergency scene will be dispatched following established dispatch guidelines.

BLS Code Red Response and Transport

Note: Primary responding EMS personnel refers to fire department EMT personnel or paramedics response originating as part of the 911 EMS system. Emergency response refers to travel with light and sirens. The following procedures are intended to maximize patient safety and minimize risk to life and limb. Common sense and good judgment must be used at all times.

1) The response mode from primary BLS response (fire department EMT personnel) shall be based on information made available to the EMS dispatchers and the decision for mode of travel made according to dispatch guidelines.
2) The default mode for travel to the scene for non-primary BLS responders shall be by non-emergency response unless a specific response for code-red (emergency response) is

made by primary responding EMS personnel at the scene or specific protocols

3) The default mode for BLS transport from scene to hospital shall be by non-emergency response unless a specific response for code-red transport is made by primary responding EMS personnel at the scene.
4) If a patient undergoing BLS transport to hospital deteriorates, the BLS personnel should contact the EMS dispatcher and ask for paramedic assistance, unless documentary evidence exists to travel code-red to hospital (such as travel to hospital can occur faster than waiting for paramedic assistance).

Advanced Life Support

The paramedic unit nearest the emergency scene is simultaneously dispatched consistent with dispatch guidelines. Paramedic units provide advanced life support transport.

Wilderness

Wilderness response is directed by the King County Sheriff Search and Rescue Coordinator. EMS units may be dispatched to a staging area depending on the nature and location of the incident. Transportation of trauma patients from wilderness areas is primarily accomplished by helicopter. The Level I trauma center should be the primary destination of these patients.

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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			☐ Major ☐ Minor
			☐ Major ☐ Minor

2 GUIDELINES FOR RENDEZVOUS WITH AGENCIES THAT OFFER HIGHER LEVEL OF CARE

The Central Region EMS and Trauma Care Council does not currently have this patient care procedure.

3 AIR MEDICAL SERVICES - ACTIVATION AND UTILIZATION

Effective Date: 2019

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 State of Washington Emergency Care Systems Air Ambulance Service Plan to identify and direct activation and utilization of air medical services.

3. **GENERAL PROCEDURES:** (content based on State Air Medical Procedure)
   a. For scene transport to be efficacious and optimize patient outcome, the air medical response should take significantly less time than it takes to travel by ground to the closest appropriate facility. Another strong consideration should be given to activating the helicopter from the scene, and rendezvous at the local hospital. This decision should be made as per local COPS in conjunction with local medical control.
   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 – patient condition identified as a major trauma per the trauma triage tool. (see link to the WA Trauma Triage Destination Procedure in appendix)

   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.)

Follow local COPs for exception and exclusion criteria.

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 Draft		☐ Major ☐ Minor
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4 ON SCENE COMMAND

The Central Region EMS and Trauma Care Council does not currently have this patient care procedure.

5 PREHOSPITAL TRIAGE AND DESTINATION PROCEDURE

Effective Date: 2009

1. PURPOSE: This patient care procedure provides guidance for patient triage and determination of the appropriate hospital destination.

2. **SCOPE**: This procedure applies to prehospital personnel in the field.

3. **GENERAL PROCEDURES:**

l. Prehospital care providers respect the right of the patient to choose a hospital destination and will make reasonable efforts to assure that choice is observed. Alternately and under ADAPT guidelines, fire department-based BLS providers may transport or suggest transport of patients to non-hospital settings such as stand alone emergency rooms and clinics. Reference Appendix II – ADAPT Guidelines

Factors including patient's choices may be:

1. Personal Preference
2. Personal physician's affiliation
3. HMO or preferred provider

Modifying factors which may influence the prehospital provider's response:

1. Patient unable to communicate choice
2. Unstable patient who would benefit from transportation to nearest hospital or to hospital providing specialized services.
3. Transport to patient's choice of hospital would put medic unit or aid car out of service for extended period and alternative transport is not appropriate or available.

II. Prehospital providers should transport unstable patients, i.e. compromised airway, post arrest, shock from non-traumatic causes, etc. to the nearest hospital able to accept the patient.

II. Emergency patients requiring specialized care such as hyperbaric treatment, neonatal ICU, or high-risk OB care should be transported to the nearest hospital able to provide such care.

IV. When in doubt, prehospital care providers should contact online medical control.

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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			☐ Major ☐ Minor

5.1 TRAUMA TRIAGE AND DESTINATION PROCEDURE

Effective Date: 2009

1. PURPOSE: These procedures are intended to provide guidance to prehospital care providers and their medical control physicians in determining which trauma center will receive the patient.

2. **SCOPE**: This procedure is for prehospital care providers and their medical control physicians.

3. **GENERAL PROCEDURES:**

1. For patients meeting the inclusion criteria of the State of Washington Prehospital Trauma Triage (Destination) Procedure, prehospital providers will contact online medical control of the closest trauma center or Harborview Medical Center (Reference: Designated Trauma Centers in King County/Paramedic Response Area). Medical Control or Harborview Medical Center will determine patient destination consistent with the State of Washington Prehospital Trauma Triage (Destination) Procedure.

2. The primary destination of pediatric patients meeting the inclusion criteria of the State of Washington Prehospital Trauma Triage (Destination) Procedure is the Level I trauma center.

3. Unstable trauma patients should be managed consistent with the State of Washington Prehospital Trauma Triage (Destination) Procedure. Unstable trauma patients are those needing a patent airway or who may benefit from the initiation of fluid resuscitation. EMS providers who are unable to secure an airway or establish an intravenous line should consider these factors in the following order:

a. time to arrival of responding medic unit
b. time to rendezvous with responding medic unit
c. time to nearest trauma center
d. time to arrival of Air Medical Transport.
e. time to nearest hospital with 24 hr emergency room
f. unusual events such as earthquakes and other natural disasters

4. Patient destination decisions will be monitored by the Regional Quality Assurance Committee.

The goal in treating the unstable trauma patient is to provide potential life saving intervention and transportation to the highest-level trauma center able to provide definitive treatment. Ideally these interventions will be performed in a manner that does not unduly delay transport of a patient to the appropriate level of trauma center. This may require EMS providers to stop at a local hospital to stabilize and then transfer the patient to the trauma center.

Consistent with inter-facility transfer agreements, trauma patients stabilized at non-designated hospitals should be transferred to a trauma center as soon as possible. Patients stabilized at Level III or IV trauma centers and meeting the criteria for triage to the Level I trauma center should be transferred as necessary. The State's Level I trauma center is:

Harborview Medical Center
325 Ninth Avenue
Seattle, WA 98104

All Central Region Trauma Care Facilities are as follows as of March 2023:

Level I Trauma Center (Pediatric and Adult)
Harborview Medical Center

Level III Trauma Centers
MultiCare Auburn Medical Center
EvergreenHealth
Overlake Hospital Medical Center
Valley Medical Center

Level IV Trauma Centers
St. Anne Hospital
UW Medical Center - Northwest
St. Francis Hospital

Level V Trauma Center
St. Elizabeth Hospital
Snoqualmie Valley Hospital

4. **APPENDICES:**

DOH guidance document: Prehospital Trauma Triage and Destination Procedure.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
Regional Council	Update facility Names	9/12/2022	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.2 CARDIAC TRIAGE AND DESTINATION PROCEDURE

Effective Date: 2018

1. PURPOSE: Provides guidance for the prehospital care and transport of cardiac patients in Central Region.

2. **SCOPE**: This procedure applies to prehospital providers caring for cardiac patients.

3. **GENERAL PROCEDURES:**
These procedures are intended to provide guidance to prehospital care providers and their medical control physicians in determining which Cardiac Center will receive the patient.

1. Prehospital providers will contact established medical control. Medical Control will determine patient destination consistent with Washington State Cardiac Patient Care Triage Destination Procedure.

2. Patients shall be managed consistent with the State of Washington Prehospital Cardiac Triage Destination Procedure.

3. Patient destination decisions and patient outcome will be monitored by the Regional Quality Assurance Committee

Current Approved Cardiac Care Centers, as of March 2023

Level I	MultiCare Auburn Medical Center
	EvergreenHealth
	Harborview Medical Center
	St. Anne Hospital
	UW Medical Center - Northwest
	Overlake Hospital Medical Center
	St. Francis Hospital
	Swedish Cherry Hill
	UW Medical Center - Montlake
	Valley Medical Center
	Virginia Mason Medical Center
	Swedish- Issaquah
Level II	Swedish First Hill
	Snoqualmie Valley Medical Center
	St. Elizabeth Hospital
	Swedish Ballard

4. **APPENDICES:** DOH guidance document on prehospital cardiac care.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
Regional Council	Update Facility Names	9/12/2022	☐ Major ☒ Minor
			☐ Major ☐ Minor
			☐ Major ☐ Minor

5.3 STROKE TRIAGE AND DESTINATION PROCEDURE

Effective Date: 2018

1. PURPOSE: To provide prehospital guidance on the transport and care of stroke patients.

2. **SCOPE**: This procedure is appropriate for prehospital providers who are caring for stroke patients.

3. **GENERAL PROCEDURES:** Stroke Patient Triage and Destination

These procedures are intended to provide guidance to prehospital care providers and their medical control physicians in determining which Stroke Center will receive the patient.
EMTs shall transport patient to the closest appropriate level Stroke Center consistent with the Washington State Stroke Patient Care Triage Destination Procedure and with regard to the patient or family preference. "

1. For all patients with suspected stroke, EMS personnel will contact the closest Level I or II or III stroke center and describe the situation. The hospital will advise EMS of appropriate patient destination consistent with the Washington State Patient Care Triage Destination Procedure.

2. For unstable stroke patients, EMTs shall request Paramedic assistance

3. Paramedics shall contact established medical control. Medical Control will determine patient destination consistent with Washington State Stroke Patient Care Triage Destination Procedure.

4. Patients should be managed consistent with the King County ALS Protocols and State of Washington Prehospital Stroke Triage Destination Procedure.

5. Patients should be managed consistent with the King County ALS Protocols and State of Washington Prehospital Stroke Triage Destination Procedure.

6. Patient destination decisions and patient outcome will be monitored by the Regional Quality Assurance Committee

Current Approved Stroke Centers

Level 1	Harborview Medical Center
	Swedish Cherry Hill
	UW Medical Center- Northwest
	Virginia Mason Medical Center
Level II	MultiCare Auburn Medical Center

EvergreenHealth
Overlake Hospital Medical Center
St. Anne Hospital
Swedish First Hill
Swedish Issaquah
Valley Medical Center

Level III Snoqualmie Valley Hospital
St. Elizabeth Hospital
St. Francis Hospital
Swedish – Ballard
UW Medical Center - Montlake

4. **APPENDICES:** See stroke triage tool on the next page.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
Regional Council	Update facility names	9/12/22	☐ Major ☒ Minor
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2019 King County Prehospital Stroke Triage Procedure

STEP 1: Assess Likelihood of Stroke

- Numbness or weakness of the face, arm, or leg, especially on one side of the body
- Confusion, trouble speaking, or understanding
- Trouble seeing in one or both eyes
- Trouble walking, dizziness, loss of balance, or coordination
- Severe headache with no known cause

If any of above, proceed to STEP 2, otherwise, transport per regional/county operating procedures

STEP 2: Perform F.A.S.T. Assessment (positive if any of Face/Arms/Speech abnormal)

- **Face**: Unilateral facial droop
- **Arms**: Unilateral arm drift or weakness
- **Speech**: Abnormal or slurred
- **Time**: Best estimate of Time Last Known Well =_____

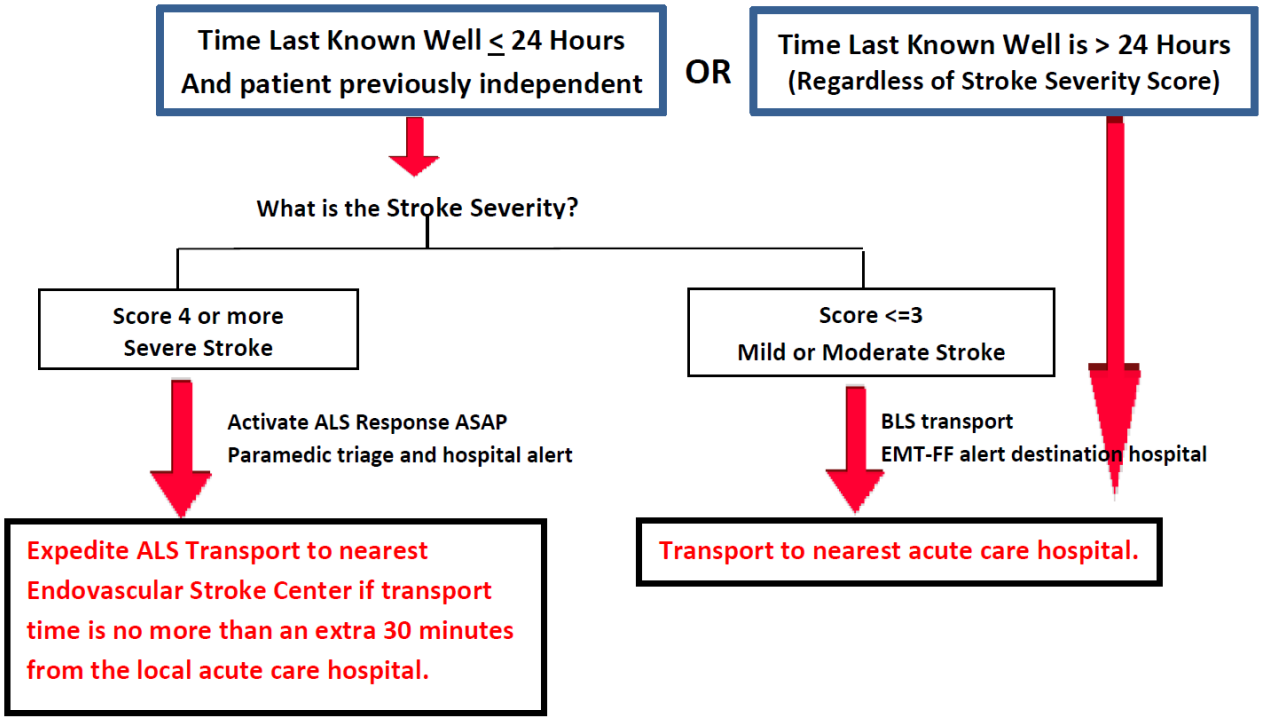
If FAST negative transport per regional operating procedures

STEP 3: If F.A.S.T Positive - Calculate Stroke Severity Score

Facial Droop:	Absent 0	Present 1			
Arm Drift:	Absent 0	Drifts 1	Falls Rapidly 2		
Grip Strength:	Normal 0	Weak 1	No Grip 2		

Total Stroke Severity Score = _____ (max. 5 points)

STEP 4: Determine Destination: Time Last Known Well & Stroke Severity Score



Exclude persons with chronic illness that makes them bedbound – for example those with advanced dementia or longstanding medical illness who require substantial assistance for basic life activities. These patients should proceed to local hospital regardless of stroke severity or last known well status.

5.4 MENTAL HEALTH AND CHEMICAL DEPENDENCY DESTINATION PROCEDURE

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

5.5 PREHOSPITAL TRIAGE AND DESTINATION PROCEDURE - OTHER

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

6 EMS/MEDICAL CONTROL COMMUNICATIONS

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

7 HOSPITAL DIVERSION

Effective Date: 2009

1. PURPOSE: This procedure outlines Central Region's no-divert policy.

2. **SCOPE**: This procedure is appropriate for times of high patient census, and is meant for hospital and prehospital personnel.

3. **GENERAL PROCEDURES:**
Ambulance diversion is defined as an active statement by a hospital, whether verbal or via WATrac ED Status, that patients arriving by ambulance will not be accepted. King County hospitals have unanimously adopted a No Diversion Policy for all medical and surgical patients effective May 31, 2011.

Hospitals may close their emergency departments only in an internal emergency such as facility damage or lockdown. There may be circumstances where an advisory to prehospital agencies will allow ambulance services to make transport destination decisions in the best interest of their patient; for example when a hospital reports "CT down" or "specialty care unavailable." Prehospital service may use this information to make an appropriate transport decision. The decision on where to transport a patient will remain at the discretion of the prehospital provider unless directed to a specific facility by medical control.

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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			☐ Major ☐ Minor

8 CROSS BORDER TRANSPORT

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

9 INTER-FACILITY TRANSPORT PROCEDURE

Effective Date: 2009

1. PURPOSE: To establish guidelines for the transport of patients between facilities within Central Region.

2. **SCOPE**: This procedure is relevant for hospital emergency department personnel and EMS agencies who may transfer a patient from one facility to another within the region.

3. **GENERAL PROCEDURES:**

Private ALS and BLS agencies provide interfacility patient transfers at the direction of the hospital initiating the transfer. All interfacility patient transfers shall be consistent with the transfer procedures in WAC 246-976-890.

Level III, Level IV, and Level V trauma centers will transfer patients to the State Level I trauma center when appropriate. The State's Level I trauma center is:

Harborview Medical Center
325 Ninth Avenue
Seattle, WA 98104

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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10 PROCEDURES TO HANDLE TYPES AND VOLUMES OF PATIENTS THAT EXCEED REGIONAL RESOURCES

10.1 MCI

Effective Date: 2009

1. PURPOSE: To establish procedures for patient transport in the event of a mass casualty incident.

2. **SCOPE**: This procedure is relevant to EMS and hospital personnel in the region in the event of a mass casualty incident.

3. **GENERAL PROCEDURES:**
The Central Region has adequate resources to meet normal trauma patient volumes. The Quality Assurance Committee monitors mechanism of injury and patient volumes.

Large Multiple Casualty Incidents may require the triage of patients to non-designated King County hospitals or to trauma centers in adjacent counties.

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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			☐ Major ☐ Minor
			☐ Major ☐ Minor

10.2 ALL HAZARDS- MCI AND SEVERE BURNS

Effective Date: 2009

1. PURPOSE: Provides guidance for transport and care of patients in an MCI who may have suffered severe burns and need specialized care.

2. **SCOPE**: This procedure is appropriate for EMS teams in an MCI in which many patients suffer severe burns.

3. **GENERAL PROCEDURES:**

STANDARD: During a mass casualty incident (MCI) with severely burned adult and pediatric patients,

1. All verified ambulance and verified aid services shall respond to an MCI per the King County Fire Chief's MCI Plan
2. All licensed ambulance and licensed aid services shall assist during an MCI per King County Fire Chief's MCI Plan when activated by incident command through dispatch in support of the King County Fire Chief's MCI Plan and/or in support of verified EMS services
3. All EMS certified personnel shall assist during an MCI per King County Fire Chief's MCI Plans when requested by incident command through dispatch in support of the King County Fire Chief's MCI Plan and/or in support of verified EMS services
4. Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.
5. All EMS agencies working during an MCI event shall operate within the Incident Command System as identified in local protocol and MCI plan.

PURPOSE:

1. To develop and communicate the information of regional trauma plan section VII prior to an MCI.
2. To implement King County Fire Chief's MCI Plan during an MCI.
3. To provide trauma and burn care to at least 50 severely injured adult and pediatric patients per region.
4. To provide safe mass transportation with pre-identified medical staff, equipment, and supplies per mass transport vehicle.

PROCEDURES:

1. Incident Command shall follow the King County Fire Chief's MCI Plan and will notify Disaster Medical Control Center (DMCC) when an MCI condition exists, including factors identifying severe burn injuries and number of adult/pediatric patients.
2. Medical program directors agree that protocols being used by responding agencies shall continue to be used throughout transport of patients regardless of county, state or country.
3. EMS personnel may use the "Prehospital Mass Casualty Incident (MCI) general Algorithm during the MCI incident.

A. The “SAMPLE ONLY” algorithm is intended as a boilerplate or skeleton outline only. It is not intended as a state directed requirement.
B. the DRAFT-SAMPLE Algorithm is attached on the next page.

4. APPENDICES:

Prehospital Mass Causality Incident (MCI) General Algorithm

1. Receive dispatch
2. Respond as directed
3. Arrive at scene
4. Determine mass causality conditions exist
5. Establish Incident Command (IC)
6. Scene assessment and size-up

CBRNE	NON-CBRNE
1) Notify the DMCC and IC of CBRNE situation 2) Standby for HazMat/LE to clear scene 3) Don PPE if needed 4) Establish hot, warm, and cold zones 5) Begin Initial Triage of Patients 6) Notify medical control and IC of patients conditions 7) Decontaminate patients as needed 8) Begin initial treatment 9) Follow PCPs and MCI Plans 10) Request additional resources that may include activating MAA 11) Initiate patient transport to medical centers as directed by medical control and/or the DMCC 12) Upon arrival at Medical Center, transfer care of patients to medical centers staff (medical center should activate their respective MCI Plan as necessary)	Notify medical control and/or the DMCC and local Emergency Management Office 1) Ensure scene is safe 2) Begin Initial Triage and Treatment of Critically Injured Patients 3) Establish a staging area 4) Follow EMS patient care procedures (PCPs) and MCI Plans 5) Request additional resources that may include activating MAA 6) Initiate patient transport to medical centers as directed by medical control and/or the DMCC 7) Upon arrival at Medical Center, transfer care of patients to medical centers staff (medical center should activate their respective MCI Plan as necessary)

Prepare transport vehicle to return to service

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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			☐ Major ☐ Minor

10.3 OTHER

The Central Region EMS and Trauma Care Council does not have this specific patient care procedure.

A) REGION SPECIFIC PATIENT CARE PROCEDURES: ACTIVATION OF TRAUMA TEAM

Effective Date: 2009

1. PURPOSE: To provide a general guideline for hospital facilities' activation of their trauma team for incoming patients.

2. **SCOPE**: Applies to hospital personnel.

3. **GENERAL PROCEDURES:**
Trauma team activation is accomplished at the time of contact with Medical Control. Online medical control at the receiving trauma center will activate the trauma team upon notification of the transporting agency or dispatcher. All designated trauma centers will activate their trauma team per WAC 246-976-870.

4. **APPENDICES:** N/A

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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B) REGION SPECIFIC PATIENT CARE PROCEDURES: ADAPT CLINIC AND URGENT CARE CLINIC TRANSPORTATION POLICY

Effective Date: 2009

1. PURPOSE: To provide guidance about patient transport to urgent care clinics.

2. **SCOPE**: This procedure applies to prehospital personnel.

3. **GENERAL PROCEDURES:**
Selected patients may be transported to a clinic, urgent care clinic, free standing emergency department, or hospital-based emergency department via BLS transport if the patient meets the criteria listed below. These policies apply to non-primary (private) BLS ambulance when EMS personnel request private BLS ambulance to transport the patient.

1) The fire department based (primary) EMT provider considers a taxi to be an appropriate and safe method of transportation for the particular clinical problem.
2) Paramedic care is NOT required
3) Patient is ambulatory
4) Patient has a non-urgent condition (clinically stable) including
   a) Low index of suspicion for:
      a. Cardiac problem
      b. Stroke
      c. Abdominal aortic aneurysm
      d. GI bleed problems
   b) Low index of suspicion for major mechanism of injury
5) Patient must not have
      a. Need for a backboard
      b. Uncontrolled bleeding
      c. Uncontrolled pain
      d. Need for oxygen (except patient self administered oxygen)
6) Patient should be masked if there are respiratory symptoms

For guidance regarding transport decisions EMTs may consult with paramedics or with emergency department personnel at the medical control hospital.
The EMT must notify the destination facility of the clinical problem and the facility must agree to accept the patient.

ADAPT Taxi Voucher Transportation Policy

Selected patients may be transported to a clinic, urgent care clinic, free standing emergency department, or hospital-based emergency department via taxi if the following conditions listed above are met and the fire department-based EMT considers a taxi to be an appropriate and safe method of transportation for the particular clinical problem.

4. **APPENDICES:**

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft		☐ Major ☐ Minor
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C) Region Specific Patient Care Procedures: Paramedic Training and Changes in Service Levels

Effective Date: 2009

1. PURPOSE: To provide information about paramedic training and service levels in the region.

2. **SCOPE**: Applies to prehospital agencies and leadership.

3. **GENERAL PROCEDURES:**
In order to maintain the highest quality care for prehospital emergencies it shall be required that:

1. The standard level response of ALS service shall be two paramedics. Exceptions may be authorized by the King County MPD for outlying districts and when split crews are required to respond to mass casualties.
2. King County paramedics shall be trained through and satisfy the educational requirements of the Paramedic Training program at the University of Washington/Harborview Medical Center.
3. Requests to expand or reduce service to a trauma response area, to change the level of EMS service provided, and new applications for EMS agencies seeking trauma verification must be reviewed and receive a recommendation by the Regional EMS Council in accordance with WAC 246-976-395(4).

4. **APPENDICES:** N/A

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			☐ Major ☐ Minor
			☐ Major ☐ Minor

DOH GUIDANCE DOCUMENTS

State of Washington
Prehospital Trauma Triage (Destination) Procedure

Purpose

The Trauma Triage Procedure was developed by the Centers for Disease Control in partnership with the American College of Surgeons, Committee on Trauma. The guidelines have been adopted by the Department of Health (DOH) based on the recommendation of the State EMS and Trauma Steering Committee.

The procedure is described in the attached algorithm. The guidelines represent the current best practice for the triage of trauma patients. The algorithm allows EMS and Trauma Responders to quickly and accurately determine if the patient is a major trauma patient. Major trauma patients must be taken to the highest appropriate level trauma facility in the defined system within 30 minutes transport time (Air or Ground).

The "defined system" is the trauma system that exists within an EMS and Trauma Care Region.

Explanation of Procedure

Any certified EMS and Trauma responder can identify a major trauma patient and activate the trauma system. This may include asking for Advanced Life Support response or air medical evacuation.

Step (1) Assess the patient's vital signs and level of consciousness using the Glasgow Coma Scale. Step 1 findings require activation of the trauma system. They also require rapid transport to the highest, most appropriate trauma center within 30 minutes transport time (ground or air). If unable to manage the patient's airway, consider meeting up with an ALS unit or transporting to the nearest facility capable of definitive airway management.

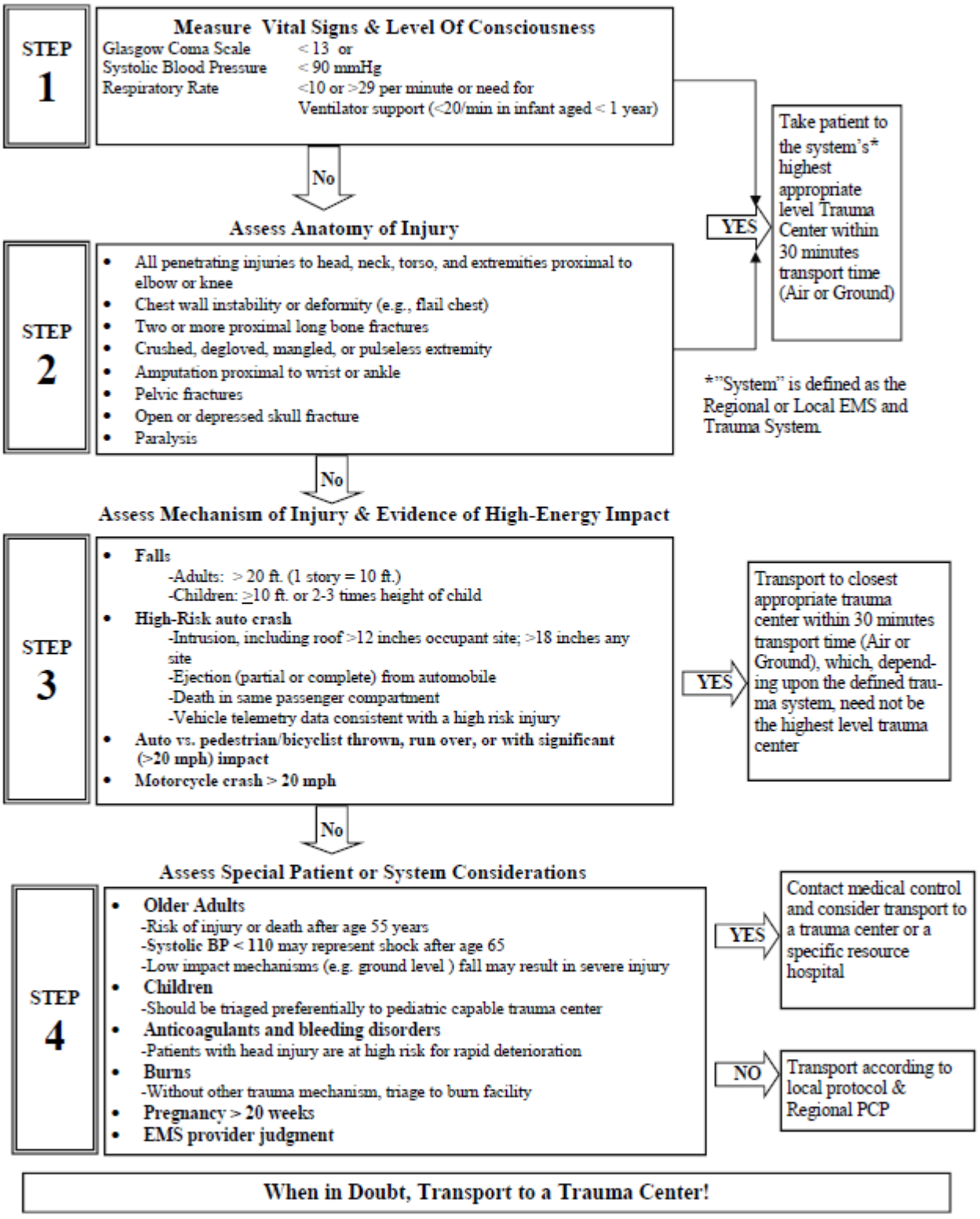
Step (2) Assess the anatomy of injury. Step 2 findings require activation of the trauma system. They also require rapid transport to the highest, most appropriate trauma center within 30 minutes transport time (ground or air). The presence of the specific anatomical injuries even with normal vital signs, lack of pain or normal levels of consciousness still require calling medical control and activating the trauma system.

Step (3) Assess biomechanics of the injury and address other risk factors. The conditions identified are reasons for the provider to transport to a trauma center. The destination trauma center need not be the highest level trauma center. Medical control should be contacted as soon as possible.

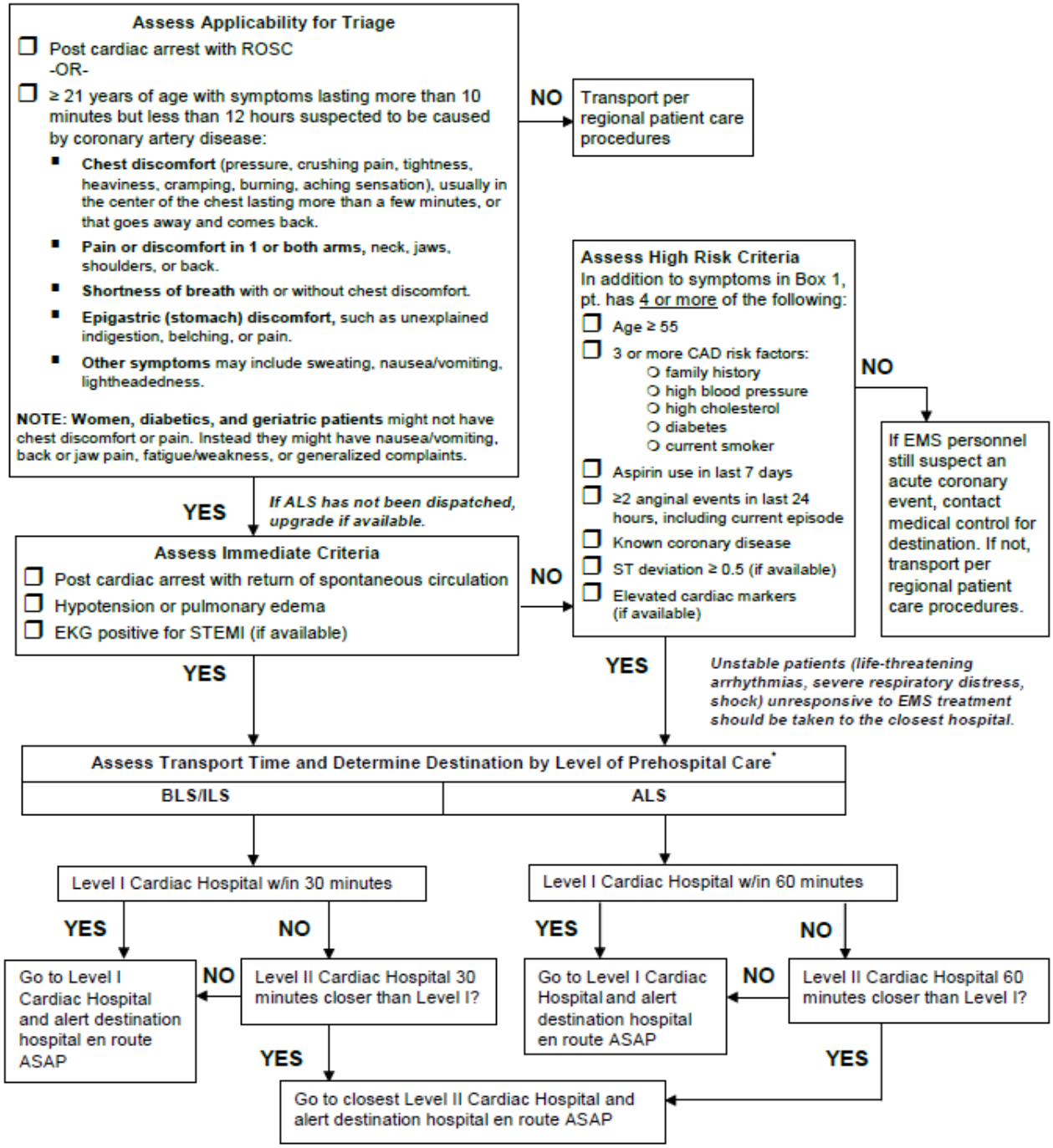
Step (4) has been added to assess special patients or system considerations. Risk factors coupled with "Provider Judgment" are reasons for the provider to contact Medical Control and discuss appropriate transport for these patients. In some cases, the decision may be to transport to the nearest trauma center.

Regional Patient Care Procedures (PCP's) and Local County Operating Procedures (COPS) provide additional detail about the appropriate hospital destination. PCP's and COP's are intended to further define how the system operates. The Prehospital Trauma Triage procedure and the Regional Patient Care Procedures work in a "hand in glove" fashion to address trauma patient care needs.

Washington State Trauma Triage Destination Procedures



State of Washington
Prehospital Cardiac Triage Destination Procedure



State of Washington
Prehospital Cardiac Triage Destination Procedure

Why triage cardiac patients?

The faster a patient having a heart attack or who's been resuscitated gets treatment, the less likely he or she will die or be permanently disabled. Patients with unstable angina and non-ST elevation acute coronary syndromes (UA/NSTE) are included in the triage procedure because they often need immediate specialized cardiac care. This triage procedure is intended to be part of a coordinated regional system of care that includes dispatch, EMS, and both Level I and Level II Cardiac Hospitals.

How do I use the Cardiac Triage Destination Procedure?

A. **Assess applicability for triage** – If a patient is post cardiac arrest with ROSC, or is over 21 and has any of the symptoms listed, the triage tool is applicable to the patient. Go to the "Assess Immediate Criteria" box. **NOTE**: Women, diabetics, and geriatric patients often have symptoms other than chest pain/discomfort so review all symptoms with the patient.

B. **Assess immediate criteria** – If the patient meets any one of these criteria, he or she is very likely experiencing a heart attack or other heart emergency needing immediate specialized cardiac care. Go to "Assess Transport Time and Determine Destination" box. If the patient does not meet immediate criteria, or you can't do an ECG, go to the "Assess High Risk Criteria" box.

C. **Assess high risk criteria** – If, in addition to meeting criteria in box 1, the patient meets four or more of these high risk criteria, he or she is considered high risk for a heart attack or other heart emergency needing immediate specialized cardiac care. These criteria are based on the TIMI risk assessment for unstable angina/non-STEMI. If the patient does not meet the high risk criteria in this box, but you believe the patient is having an acute coronary event based on presentation and history, consult with medical control to determine appropriate destination. High risk criteria definitions:

- ☐ 3 or more CAD (coronary artery disease) risk factors:
  - Age ≥ 55: epidemiological data for WA show that incidence of heart attack increases at this age
  - Family history: father or brother with heart disease before 55, or mother or sister before 65
  - High blood pressure: ≥140/90, or patient/family report, or patient on blood pressure medication
  - High cholesterol: patient/family report or patient on cholesterol medication
  - Diabetes: patient/family report
  - Current smoker: patient/family report.
- ☐ Aspirin use in last 7 days: any aspirin use in last 7 days.
- ☐ ≥2 anginal events in last 24 hours: 2 or more episodes of symptoms described in box 1 of the triage tool, including the current event.
- ☐ Known coronary disease: history of angina, heart attack, cardiac arrest, congestive heart failure, balloon angioplasty, stent, or bypass surgery.
- ☐ ST deviation ≥ 0.5 mm (if available): ST depression ≥ 0.5 mm is significant; transient ST elevation ≥ 0.5 mm for < 20 minutes is treated as ST-segment depression and is high risk; ST elevation >1 mm for more than 20 minutes places these patients in the STEMI treatment category.
- ☐ Elevated cardiac markers (if available): CK-MB or Troponin I in the "high probability" range of the device used. Only definitely positive results should be used in triage decisions.

D. **Determine destination** – The general guideline is to take a patient meeting the triage criteria directly to a Level I Cardiac Hospital within reasonable transport times. For BLS, this is generally within 30 minutes transport time, and for ALS, generally 60 minutes transport time. See below for further guidance. Regional patient care procedures and county operating procedures may provide additional guidance.

E. **Inform the hospital en route so staff can activate the cath lab and call in staff if necessary.**

What if a Level I Cardiac Hospital is just a little farther down the road than a Level II?

You can make slight changes to the 30/60 minute timeframe. The benefits of opening an artery faster at a Level I can outweigh the extra transport time. To determine whether to transport beyond the 30 or 60 minutes, figure the difference in transport time between the Level I Cardiac Hospital and the Level II Cardiac Hospital. For BLS, if the difference is more than 30 minutes, go to the Level II Cardiac Hospital. For ALS, if the difference is more than 60 minutes, go to the level II Cardiac Hospital.

BLS examples: A) minutes to Level I minus minutes to Level II = 29: go to Level I
B) Minutes to Level I minus minutes to Level II = 35: go to Level II

ALS examples: A) minutes to Level I minus minutes to Level II = 45: go to Level I
B) Minutes to Level I minus minutes to Level II = 68: go to Level II

NOTE: We recommend ALS use a fibrinolytic checklist to determine if a patient is ineligible for fibrinolysis. If ineligible, transport to closest Level I hospital even if it's greater than 60 minutes or rendezvous with air transport.

What if there are two or more Level I or II facilities to choose from?

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

DOH 346-050 April 2011

State of Washington
Prehospital Stroke Triage Destination Procedure

STEP 1: Assess Likelihood of Stroke

- Numbness or weakness of the face, arm, or leg, especially on one side of the body
- Confusion, trouble speaking, or understanding
- Trouble seeing in one or both eyes
- Trouble walking, dizziness, loss of balance, or coordination
- Severe headache with no known cause

If any of above, proceed to STEP 2, if none, transport per regional PCP/county operating procedures

STEP 2: Perform F.A.S.T. Assessment *(positive if any of Face/Arms/Speech abnormal)*

- **Face**: Unilateral facial droop
- **Arms**: Unilateral arm drift or weakness
- **Speech**: Abnormal or slurred
- **Time**: Best estimate of Time Last Known Well =_____

If FAST negative, transport per regional/county operating procedures

STEP 3: If F.A.S.T. Positive - Calculate Stroke Severity Score (LAMS)

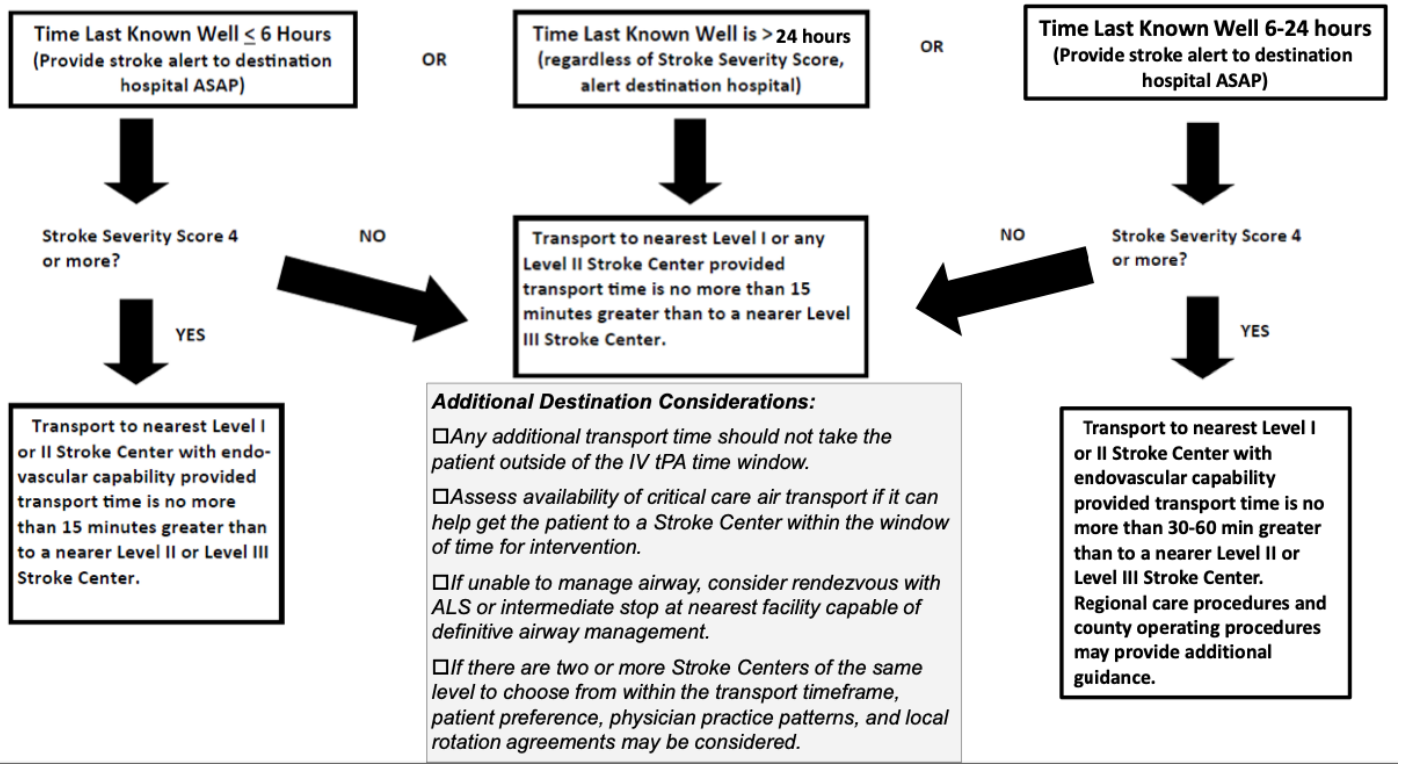
Facial Droop:	Absent	0	Present	1		
Arm Drift:	Absent	0	Drifts	1	Falls Rapidly	2
Grip Strength:	Normal	0	Weak	1	No Grip	2

Total Stroke Severity Score = **(max. 5 points)**

STEP 4: Determine Destination: Time Last Known Well + Stroke Severity Score - *See Back Page*

DOH 530-182 February 2019

STEP 4: Determine Destination: Time Last Known Well + Stroke Severity Score



The purpose of the Prehospital Stroke Triage and Destination Procedure is to identify stroke patients in the field and take them to the most appropriate hospital, which might not be the nearest hospital. Stroke treatment is time-critical – the sooner patients are treated, the better their chances of survival and recovering function.

For strokes caused by a blocked blood vessel in the brain (ischemic, the majority of strokes), clot-busting medication (tPA) must be administered within 4.5 hours from the time the patient was last known well, a treatment that can be given at WA DOH Level 1, 2 or 3 stroke centers (for a list of categorized hospitals, please click here).

If a patient presents to EMS with a severe stroke, they are more likely to have blockage of a large vessel and can benefit from mechanical clot retrieval (thrombectomy). Thrombectomy must begin by 24 hours since last known well, and is a more complex intervention, only available in Level I and a small number of Level II stroke centers.

There are 3 key elements to determine the appropriate destination hospital:

FAST stroke screen to identify a patient with a high probability of stroke.

Stroke Severity Score to determine if a patient meets criteria for "severe" stroke.

Time since Last Known Well (LKW) which helps determine eligibility for tPA and thrombectomy.

STEPS to determine destination:

Do a FAST Stroke Screen Assessment: (**F**acial droop, **A**rm drift, **S**peech changes, **T**ime since LKW) is a simple way to tell if someone might be having a stroke. If FAST is negative, stroke is less likely, and standard destination procedures apply. If FAST is positive (face or arms or speech is abnormal), it's likely the patient is having a stroke and the EMS provider moves on to assessing stroke severity.

Assess severity: The stroke severity assessment scores the FAST stroke screen. Patients get points for deficits:

Facial droop gets 1 point if present, 0 points if absent;

Arm drift (have patient hold arms up in air) gets 2 points if an arm falls rapidly, 1 point if slowly drifts down and 0 points if the arms stay steady;

Grip strength gets 2 points if no real effort can be made, 1 point if grip is clearly there but weak, and 0 points if grips seem of full strength.

Add up the points: A score $\geq$ 4 is interpreted as "severe."

Determine time since LKW: It is important to use the LKW time as opposed to when symptoms were first noticed. If a patient woke up in the morning with symptoms and was well when they went to bed, time LKW is the time they went to bed. If stroke symptoms occur when the patient is awake, LKW could be the same time the symptoms started if the patient or a bystander noticed the onset. LKW time could also be prior to symptoms starting if a patient delays reporting symptoms or, for example, someone discovers a patient with symptoms but saw them well 2 hours prior.

Determine Destination:

Time since LKW $\leq$ 6 hours and "Severe" (score $\geq$ 4): This group benefits from preferential transport to a thrombectomy stroke center. The patient should be taken directly to the nearest thrombectomy stroke center provided it is no more than 15 extra minutes travel compared to the nearest stroke center.

Time since LKW is > 24 hours (regardless of severity score): These patients should be taken to nearest Level I or II stroke center provided it is no more than 15 minutes greater than to a nearer Level III stroke center.

Time since LKW 6-24 hours but NOT "Severe": These patients should be taken directly to the nearest Level I or Level II stroke center provided it is no more than 15 extra minutes travel compared to a nearer Level 3 stroke center.

Time since LKW 6-24 hours AND "Severe": Transport to nearest Level I or II Stroke Center with endovascular capability provided transport time is no more than 30-60 min greater than to a nearer Level II or Level III Stroke Center. Regional care procedures and county operating procedures may provide additional guidance.

Notification: Immediately notify the destination hospital of incoming stroke. If the patient is within 6 hours LKW, call a stroke alert according to county operating procedures or locally determined protocol.

Document: key medical history, medication list and next of kin phone contacts; time on scene; FAST assessment and results (or reason why not); blood glucose level; LKW time (including unknown); and whether the hospital was notified from the field and if it was a stroke alert.

Washington State Department of Health
Guideline for Implementing SHB 1721
July 2016

Background

In 2015 the Washington State Legislature passed legislation (SHB 1721) allowing emergency medical services ambulance and aid services to transport patients from the field to mental health or chemical dependency services. Participation is voluntary.

The Legislation

SHB 1721 section one calls for the Department of Health (department) in consultation, with the Department of Social and Health Services, to convene a workgroup comprising members of the steering committee and representatives of ambulance services, firefighters, mental health providers, and chemical dependency treatment programs. The workgroup was to establish alternative facility guidelines for developing protocols, procedures, and applicable training appropriate to the level of emergency medical service provider.

The guidelines shall consider when to transport to a mental health facility or chemical dependency treatment program to include:

- The presence of a medical emergency that requires immediate medical care;
- The severity of the mental health or substance use disorder needs of the patient;
- The training of emergency medical service personnel to respond to a patient experiencing emergency mental health or substance abuse disorders; and
- The risk the patient presents to the patient's self, the public, and the emergency medical service personnel.

By July 1, 2016, the department shall make the guidelines available to all regional emergency medical services and trauma care councils for incorporation into the patient care procedures of regional emergency medical services and trauma care plans.

Please forward questions about this document to:

Department of Health
Office of Community Health Systems
EMS and Trauma Section
P.O. Box 47853
Olympia, WA 98504
360-236-2841
HSQA.EMS@doh.wa.gov

What this means for regional EMS and trauma care councils
Regional EMS and trauma care councils shall develop a patient care procedure (PCP) that provides guidance to medical program directors and EMS agencies to operationalize transport of patients to a mental health or chemical dependency treatment facility. The PCP must:

- Direct participating facilities and agencies to adhere to the Washington State Department of Health Guideline for the Implementing SHB 1721 (guideline);
- Identify health care representatives and interested parties to be included in collaborative workgroups for designing and monitoring programs;
- Direct facilities that participate in the program to work with the medical program director (MPD) and EMS entities to reach consensus on criteria that all facilities and EMS entities participating in the program will follow for accepting patients.
- Include a statement that the facility participation is voluntary;
- Direct the local EMS council and MPD to establish a quality assurance process to monitor programs;
- Direct the local EMS council and MPD to develop and establish a county operating procedure (COP) inclusive of the standards recommended by the guideline and PCP, to include dispatch criteria, response parameters and other local nuances to operationalize the program;
- Direct the EMS MPD to establish a patient care protocol (protocol) inclusive of the standards and screening criteria recommended by the guideline and PCP;
- Direct the MPD to develop and implement department-approved education for emergency medical service personnel in accordance with the training requirements of the guideline. Educational programs must be approved by the department.

What this means for Local EMS and Trauma Care Councils
Local EMS and trauma care councils must collaborate with the MPD to develop a COP inclusive of the standards in the guideline. The COP must be consistent with state standards and the PCP.

The COP must include:

- A list of approved mental health and chemical dependency facilities participating in the program;
- Destination determination criteria including considerations for transports that may take the EMS service out of its county of origin;
- A list of options for methods of transport and any pertinent timelines for transport to occur;
- Guidance to EMS providers on when to contact law enforcement, and any procedures that must be considered during EMS and law enforcement interactions;
- Guidance to EMS providers on when to contact the designated mental health professional (DMHP) and any procedures to be considered during an involuntary hold.

Washington State Department of Health

What this means for medical program directors
MPDs must develop a patient care protocol inclusive of the standards and screening criteria in the guideline and PCP. The protocol must be consistent with state standards, PCP, and COP. The protocol should assist EMS providers in:

- Determining medical emergency that requires immediate care;
- Assessing the risk the patient presents to the patient's self, the public, and the emergency medical service personnel;
- Determining the severity of mental health or substance use disorder.

MPDs must develop and implement department-approved education for emergency medical service personnel who will respond and transport patients to mental health and chemical dependency facilities. Training must include content that meets the outlined criteria in **Appendix C** of this document.

Washington State Department of Health

Appendix A

EMS Screening Criteria for Transport to Mental Health Services

Inclusion criteria:

Facility:

Reference:

RCW 71.05.020 - Definitions
RCW 71.05.153 - Emergent detention of persons with mental disorders – Procedure

Mental health services authorized to receive patients include; crisis stabilization units, evaluation and treatment facilities and triage facilities.

Mental health services who have elected to operate as an involuntary facility may receive patients referred by a peace officer or a patient in involuntary status by a DMHP.

Patient:

- Voluntary with a mental health chief complaint willing to go to an alternative destination.
- Patients with a mental health chief complaint referred by a peace officer.
- Patients with a mental health chief complaint detained under the Involuntary Treatment Act (ITA) by a DMHP. The proper documents must be completed and signed by a DMHP for reimbursement.
- Patients with mental health complaints must have a clear history of mental health problems. No new onset mental health problems.
- The patient's current condition cannot be explained by another medical issue and traumatic injury is not suspected.
- The EMS agency was dispatched via 911.
- Age 18-55 is recommended based on a review of research during the development of the Department of Health guideline. MPDs may adjust this parameter.
- Cooperative and non-combative.
- Normal level of consciousness, no medical issues suspected.
- Suicidal patients may accept voluntary care, or may be detained by a peace officer or DMHP.
- HR 50-110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- BP systolic 100-190, diastolic less than 110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.

- RR 12-24 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Temperature 97-100.3 F is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Room air O2 saturation greater than 92 percent is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- If indicated check blood sugar, 70-300 is acceptable and is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Patient has the ability to care for self. MPDs may consider listing other criteria such as activities of daily living (ADLs).

Exclusion criteria:

Facility:

- Lack of bed availability
- Intake staff identifies concerns that exceed the ability of the facility to provide adequate care to the patient that requires local hospital emergency department -physician evaluation.
- Facilities may test for alcohol level and establish a cutoff level for acceptance that should not be below 300.

Patient:

- Intentional or accidental overdose
- Any acute trauma other than minor wounds not in need of treatment beyond bandaging.
- Loss of consciousness or seizure within the past 24 hours by patient history.
- Pregnancy
- Anticoagulation. MPDs may specify medications in protocols to consideration.
- Blood sugar out of control over last 24 hours by patient history. MPDs may indicate a specific range or other language to clarify.
- Indwelling tubes, lines or catheters currently being utilized that the patient cannot manage.
- New onset of mental health problems. Mental health problem is not clearly indicated in patient history.
- MPDs and participating facilities must collaborate and determine triage criteria for people with functional and access needs, including developmental delay, traumatic brain injury, organic brain syndrome, dementia, etc.
- Any evidence for acute medical or traumatic problem.

Procedure:

- Scene safety and crisis de-escalation.
- Consider contacting law enforcement to assist EMS with on-scene mitigation of suicidal patients who are not voluntary, and for agitated or combative patients.
- Ask the patients if they normally take medication for mental health and chronic medical problems. Record medications and dosages if possible.
- Obtain history regarding alcohol and illicit drug use.
- Assess for inclusion and exclusion criteria.
- For patients who meet screening criteria, contact receiving center to determine resource availability. MPDs should consider identifying and including a list of available secondary resources other than the emergency room that can be used if a primary resource is unavailable.
- Contact medical control for approval.
- Secure a safe method of transportation identified and approved by the MPD in COPs or protocols.
- Document all findings and inclusion/exclusion criteria for all person contacts on the patient care report and checklist.
- Patients who meet exclusion criteria or decline alternative destination should be transported to a local hospital emergency department using agency-specific standard operating procedures.
- At time of patient care transfer, the completed inclusion/exclusion checklist should be provided to the receiving facility.
- If at any time the receiving facility determines the patient condition has changed and emergency department evaluation is required, EMS should be re-contacted via 911 dispatch and the reason documented.

Washington State Department of Health

Appendix B

EMS Screening Guideline for Transport to Chemical Dependency Services

Inclusion criteria:

Facility:

RCW 70.96A chemical dependency centers, and treatment centers, include sobering centers, and acute and subacute detox centers.

- Facility is identified as a crisis stabilization unit, evaluation and treatment facility, or triage facility that provides chemical dependency treatment services and mental health services.

Patient:

- Voluntary patients with a chemical dependency chief complaint willing to go to an alternative destination.
- Patients with a chemical dependency chief complaint referred by a peace officer.
- Patients with a mental health and/or chemical dependency chief complaint detained under the Involuntary Treatment Act (ITA) by a designated chemical dependency specialist (DCDS). The proper documents must be completed and signed by a DCDS for reimbursement.
- The patient's current condition cannot be not explained by another medical issue.
- The EMS agency was dispatched via 911 or police request.
- Age 18-55 is recommended based on a review of research during the development of the Department of Health guideline. MPDs may adjust this parameter.
- Cooperative and non-combative.
- Normal level of consciousness, no medical issues suspected.
- HR 50-110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- BP systolic 100-190, diastolic less than 110 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- RR 12-24 is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Temperature 97-100.3 F is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Room air O2 saturation greater than 92 percent is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.

- If indicated check blood sugar, 70-300 is acceptable and is recommended based on a review of research during the development of the guideline. MPDs may adjust this parameter.
- Patient has the ability to care for self. MPDs may consider listing other criteria such as activities of daily living (ADLs).

Exclusion criteria:

Facility:

- Lack of bed availability.
- Intake staff identifies concerns that require local hospital emergency department - physician evaluation.
- Facilities may test for alcohol level and establish a cutoff level for acceptance that should not be below 300.

Patient:

- Intentional or accidental overdose.
- Any acute trauma other than minor wounds not in need of treatment beyond bandaging.
- Loss of consciousness or seizure within the past 24 hours by patient history.
- Pregnancy.
- Anticoagulation. MPDs may specify medications in protocols to consideration.
- Blood sugar out of control over past 24 hours by patient history. MPDs may indicate a specific range or other language to clarify.
- Indwelling tubes, lines or catheters currently being used.
- MPDs and participating facilities must collaborate and determine triage criteria for people with functional and access needs, including developmental delay, traumatic brain injury, organic brain syndrome, dementia, etc.
- Any evidence for acute medical or traumatic problem.

Procedure:

- Scene safety and crisis de-escalation.
- Contact law enforcement for suicidal patients who are not voluntary, and for agitated or combative patients.
- Ask the patients if they normally take medication for mental health and chronic medical problems. Record medications and dosages if possible.
- Obtain history regarding alcohol and drug use.
- Assess for inclusion and exclusion criteria.

- For patients who meet screening criteria, contact receiving center for resource availability.
- Contact medical control for approval.
- Secure safe method of transportation.
- Document all findings and inclusion/exclusion criteria for all person contacts on the patient care report and checklist.
- Patients who meet exclusion criteria or decline alternative destination should be transported to a local hospital emergency department using agency-specific standard operating procedures.
- At time of patient care transfer, provide the completed inclusion-exclusion checklist to the receiving facility.
- If at any time the receiving facility determines the patient condition has changed and emergency department evaluation is required, EMS should be re-contacted via 911 dispatch and the reason documented.

Washington State Department of Health

Appendix C

Education: The following is the minimum suggested content for department-approved MPD specialized training that shall be provided to EMS providers participating in transport programs authorized by SHB 1721 legislation and operating within the parameters of the guideline. Education programs must be approved by the department. Education must be provided on initial implementation and in an ongoing manner. MPDs may add content to the minimum recommended standards.

I. Review of the Regulatory Framework
- A. SHB 1721 Legislation and Department of Health Guideline
- B. Regional Patient Care Procedure
- C. County Operating Procedure
- D. Patient Care Protocol

II. Define Terms
- A. Receiving centers
  1. Mental Health Centers
  2. Chemical Dependency Centers
- B. Mental Health Professionals
  1. Emergency Social Worker
  2. Designated Mental Health Professional (DMHP)
- C. Involuntary referral
  1. Peace Officer
  2. DMHP
  3. Detainment Laws
  4. Mandatory reporting

III. Behavioral Health Emergencies and Crisis Response
- A. Crisis Intervention
  1. Crisis recognition and assessment
  2. Securing physical safety
     a. Withdraw from contact until scene safe
     b. Contain situation
     c. Call for adequate help
     d. Call for Law Enforcement
  3. Mitigation
  4. Destination decision making/Implementing an action plan
- B. Principles of crisis intervention
  1. Simplicity
  2. Brevity
  3. Innovation
  4. Practicality
  5. Proximity

6. Immediacy
7. Expectancy

C. SAFER-R
1. Stabilize the Situation
2. Acknowledge that something distressing has occurred
3. Facilitate the person's understanding of the situation
4. Encourage the person to make an acceptable plan of action
5. Recovery is evident

D. History/Assessment Tools
1. SAMPLE
2. OPQRST
3. SEA-3
4. MSE

F. Recognition of Increasing Rage/Risk of Violence
1. Bulging neck veins
2. Reddened face
3. Gritted Teeth
4. Muscle tension around jaw
5. Threatening Gestures
6. Threatening Posture
7. Display of a weapon
8. Clenched Fists
9. Wild or staring eyes

G. Suicide
1. Risk factors
2. Overt and covert clues
3. SADPERSONS Suicide assessment scale
4. Steps to bring a suicidal person to safety
   a. Secure the environment
   b. Develop trust and rapport
   c. Engage in a thorough risk assessment
   d. Develop a greater understanding of the person and issues that led up to the current situation
   e. Explore alternatives to suicide
   f. Select the best option for available alternatives
   g. Develop an action plan
   h. Implement the action plan
   i. Refer to appropriate facility

H. Dementia and Delirium
1. Definitions
2. Distinctions
3. Effect and association with emergent medical disorders
   a. Trauma
   b. Infection