



# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DIVISION OF HEALTH SERVICES  
**EMERGENCY MEDICAL SERVICES**  
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**Date:** July 3, 2006  
**To:** Holders of Policy and Procedure Manuals  
**From:** Diane Claytor RN MS  
EMS Program Administrator  
**Subject:** **Update to Policy Manual, Change Notice #25**

Enclosed please find Update # 25 to the EMS Policy and Procedure Manual. Please add the new signature page and replace the Table of Contents. Log the Change Notice on the appropriate page.

If any change was made in the policy, the complete policy is included in the packet. This is to decrease the potential for error that might be caused by replacing single pages.

The packet includes the following policies:

- 4613 – Trauma Triage and Destination Guideline Policy
- 8104\* – Refusal of Care Against Medical Advise (AMA) and Release at Scene (RAS) – includes AMA/RAS form
- 8413\* – 12 Lead Electrocardiogram Policy and Procedure

Items contained in the **Patient Care Manual** are indicated with a (\*), should you choose to update those manuals.

If you have not received training on these changes, please contact your CQI Liaison or Training Officer. Please assure that the changes are made in your manual.

Thank you.

**MARIN COUNTY**  
**EMS Program Policies and Procedures**  
**DISTRIBUTION LIST**  
**July, 2006**

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Marin County Fire Department, Batt. Chief Brian Meuser	one
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San Rafael Fire Department, Chief. Jon Montenero	one
SMEMPS, Chief, Richard Pearce	one
Ross Valley Paramedic Authority, Chief Robert Sinnott	one
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CalStar - Hayward, Ross J. Fay, RN	one
CHP - Helicopter Unit.(Napa Airport), Sgt. Brad Elder	one
Life Flight - Stanford	one
REACH - Santa Rosa, Sean Russell, EMT-P	one
<b><i>OTHER AGENCIES:</i></b>	
Corte Madera Fire Department, Chief Bob Fox	one
Stinson Beach Fire Protection District, Chief Kenny Stevens	one
American Medical Response, (AMR) Galand Chapman, EMT-P	one
Sonoma Life Support (AMR), Eric Polan, EMT-P	one
St. Joseph's Ambulance Service, Richard Angotti, CEO	one
Marinwood Fire Department, John Bagala, EMT-P	one
Southern Marin Fire Protection District, Chief Michael Stone	one
Bolinas Fire Protection District, Chief Anita Brown	one
<b>Total</b>	<b>29</b>

***COUNTY OF MARIN***

***DEPARTMENT OF HEALTH AND HUMAN SERVICES***

Division of Health Services

*Emergency Medical Services Program*

**Policy and Procedure Manual**

**July, 2006**

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*Diane Claytor, RN, MS, EMS Program Administrator*

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*Frima Stewart, Director of Health Services*

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*William L. Teufel, MD, EMS Program, Medical Director*

**EMS Program Policy & Procedure Manual**

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# *EMS Policy & Procedures Manual*

## *Record of Change*

**Keep your policy manual current.** After receiving and filing additional or revised policies/protocols, initial and date the block following the appropriate change.

There should not be any blank boxes between initialed blocks; this means you either failed to record the CHANGE NOTICE or have not received it. Notify the Marin County EMS Office if you did not receive a CHANGE NOTICE.

<b>No.</b>	<b>Initial</b>	<b>Date</b>	<b>No.</b>	<b>Initial</b>	<b>Date</b>	<b>No.</b>	<b>Initial</b>	<b>Date</b>
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**TRAUMA TRIAGE and DESTINATION GUIDELINE POLICY**

**I. PURPOSE**

To provide further explanation and guidance beyond the Marin County Trauma Triage Criteria Tool that will help identify trauma patients in the field and, based upon their injuries, direct their transport to an appropriate level of trauma care facility.

**II. RELATED POLICIES**

- A. Service Area for Hospitals, #4603
- B. EMS Aircraft, #5100
- C. Hospital Diversion Policy, #5400
- D. Destination Guidelines, #8106
- E. Multi-Casualty Incident, #8212

**III. DEFINITIONS**

- A. *Designated trauma center* refers to an acute care facility holding designation as a Level I, Level II, Level III, or EDAT.
- B. *“Provide Trauma Notification”* means that field personnel will advise the trauma center as soon as possible of their impending arrival by providing a Trauma Notification (see Trauma Triage Tool).
- C. *Time closest facility* is that facility which can be reached in the shortest amount of time (see section VI.D)

**IV. GENERAL POLICY**

- A. It is the overall goal of the Marin County Trauma System to provide treatment of injured patients at Marin County hospitals.
- B. The following policy statements pertain to use of the Trauma Triage Tool attached as Appendix A:
  - 1. Patients shall be determined to meet criteria for transport to a designated trauma center if they meet the criteria listed in the Trauma Triage Tool (see Appendix A).

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2. "Physician consultation" is **REQUIRED** in the following circumstances:
    - a. The paramedic is unable to transport the patient to the indicated facility in an expedient manner;
    - b. The paramedic assesses the patient and scene conditions and believes transport to a different level of care is indicated;
    - c. Patient requests a facility not indicated by the Trauma Triage Criteria Tool;
    - d. Field and/or flight crew assesses the patient, scene conditions and heliport availability and believes an emergency transport to a Marin County facility via helicopter is indicated.
  3. "Physician consultation" is **RECOMMENDED** whenever assistance in resolving treatment decisions or transport destinations is desired.
  4. Unmanageable airway: Patients with airway compromise, unmanageable by BLS or ALS adjuncts, will be transported to the closest receiving facility.
  5. Traumatic Arrest in the Field Prior to Paramedic Arrival: Patients found in cardiopulmonary arrest due to blunt or penetrating trauma will be determined dead at the scene and not transported. Exceptions may be made at paramedic discretion in socially appropriate cases, i.e., personnel safety at the scene, high public visibility, or pediatric patients.
  6. Traumatic Arrest in the Presence of Paramedics
    - a. Traumatic arrest with paramedics on scene – transport patient to closest basic emergency department.
    - b. Traumatic arrest while enroute to trauma center – continue to trauma center unless travel time to an alternate facility is ten minutes less than travel time to the trauma center.
- C. Evaluate all transportation issues. Consider all time elements involved when choosing a destination. For patients who meet Physiologic or Anatomic Criteria:
1. Determine the estimated ground transport time to the Level III, considering traffic conditions, weather, and other relevant factors. Estimated ground transport time is evaluated from the time the patient is packaged and ready for transport.
  2. Determine the estimated air transport time to the Level II: air transport time includes: minutes until arrival (if helicopter is not already on the ground); scene and load time of flight crew (typically 10"); flight time to trauma center; and off-load time (typically 7-10 minutes). If helicopter is on the ground at the time the patient is ready for transport, then air transport time is evaluated as time to load, flight time to trauma center and time to off-load to the ED.
  3. Choose the method of transport that will deliver the patient to definitive care in the shortest time (air transport to Level II versus ground transport to Level III).

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- D. It is the overall goal of the Marin County trauma system to transport pediatric patients who meet anatomic or physiologic criteria on the tool directly to Children's Hospital Oakland (see Trauma Triage Tool). If ETA (transfer time) is anticipated to be >30 minutes, physician consultation should be obtained with the Level III Trauma Center if direct transport to Children's Hospital Oakland is desirable.
- E. Incidents involving multiple trauma victims (3 or more) will be handled in the following manner:
1. Prehospital providers should obtain a physician consultation from Marin General Hospital Level III Trauma Center, regarding destinations anytime there are 3 or more patients meeting trauma triage criteria. If an incident is deemed to be an MCI, prehospital providers will refer to the MCI/EMR policy for destination guidelines.
  2. Prehospital providers do NOT need to obtain a physician consultation for a multiple trauma victim incident when the patients' injury levels are such that a natural division of the patients between trauma centers would occur.
  3. Helicopter dispatch should be initiated anytime in which 3 or more patients meet A&P criteria.
  4. Kaiser Terra Linda (EDAT) will be used for patients meeting mechanism of injury trauma triage criteria that MGH Level III trauma center is unable to accept.
  5. Helicopter transport to an out-of-county Level I or II trauma center should be used to transport patients meeting anatomic and physiologic trauma triage criteria that Marin General Hospital Level III cannot accept.

**REFUSAL OF CARE AGAINST MEDICAL ADVICE (AMA)  
And  
RELEASE AT SCENE (RAS)**

**I. PURPOSE**

To provide guidelines for prehospital personnel dealing with patients refusing care Against Medical Advice (AMA) or patients requesting a Release at Scene (RAS)

**II. DEFINITIONS**

- A. Against Medical Advice (AMA) – The refusal of treatment or transport, by an emergency patient or his/her designated decision maker, against the advice of the medical personnel on scene or of the receiving hospital.
- B. Release at Scene (RAS) – A call outcome that occurs when the patient and the EMS personnel agree that the illness/injury does not require immediate treatment/transport via emergency/911 services and the patient does not require the services of the prehospital system.
- C. Patient – Any person who seeks medical attention from 911/ EMS.
- D. Patients who may legally give consent for medical treatment are:
1. At least 18 years of age
  2. A minor (<18) who is lawfully married or divorced
  3. A minor on active duty with the armed forces
  4. A minor who seeks prevention or treatment of pregnancy or sexual assault
  5. A minor who is 12 years of age or older, who seeks treatment of rape, contagious diseases, alcohol or drug abuse
  6. A self sufficient minor, 15 years or older, caring for themselves
  7. A legally emancipated minor
- E. Designated Decision Maker (DDM) – An individual to whom a person or court has legally given the authority to make medical decisions concerning the person's health care (a parent or a Durable Power of Attorney for Health Care).
- F. Competency – the ability to understand and to demonstrate an understanding of the nature and consequences of refusing medical care.
- G. Emergency Medical Personnel:
- EMT – P (Paramedics) – providing ALS or BLS service
  - EMT - 1 (Emergency Medical Technicians) – providing only BLS service

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### **III. AGAINST MEDICAL ADVICE (AMA) POLICY**

- A. All emergency patients will be offered treatment and/or transport following a complete assessment.
- B. Adults have the right to accept or refuse any and all prehospital care and transportation, provided that the decision to accept or refuse these treatments and transportation is made on an informed basis and provided that these adults have the mental capacity to make and understand the implications of such a decision. To meet the standard of “meaningful understanding” the patient must be informed and must understand (best demonstrated by the patient’s ability to restate) the nature and consequences of the consent or refusal at the time the care and/or treatment is being offered. The following information must be provided to the patient or DDM by the Emergency Medical Personnel:

1. The nature of the recommended treatment
2. The risks involved including any possible complications
3. The benefits of the treatment
4. The consequences for not seeking care and treatment - these must be reasonable for the presenting condition.

C. High-Risk Patient Complaints:

Some patient complaints may represent more concerning and potentially higher risk (for the patient and medical provider) clinical conditions. These patients may warrant (but not require) receiving hospital and/or physician contact before completing an AMA with a patient of DDM. Every effort should be made to transport patients with the following complaints:

1. Patients  $\geq$  65 years of age who are requesting AMA.
2. Chest Pain
3. SOB/Dyspnea
4. Syncope
5. Headache (new onset)
6. Seizure (new onset)
7. TIA/Resolving Stroke Symptoms
8. Traumatic Injuries
9. Pediatric Complaints
10. Pregnancy-related Issues

- D. If the patient refuses transport to the recommended destination and the patient's refusal of transport would create a life-threatening or high-risk situation, obtain a Receiving Hospital Physician Consult, document the AMA, and transport the patient to the requested facility within Marin County. If this patient requests an out of county transport, a Physician Consult from the recommended destination hospital in Marin County is required.
- E. If the patient cannot legally refuse care or is mentally incapable of refusing care:
  - 1. Document on the PCR that the patient required immediate treatment and/or transport, and lacked the mental capacity to understand the risks/consequences of the refusal (implied consent), and transport accordingly.
  - 2. Do not request a 5150 hold unless the patient requires a psychiatric evaluation
  - 3. Treat as necessary to prevent death or serious disability and transport.
  - 4. Consider involvement of law enforcement early if there is a threat to self, others or grave disability.

#### **IV. RELEASE AT SCENE (RAS) POLICY**

- A. After evaluation by the EMS personnel, and the patient/DDM is deemed a competent adult, EMS personnel may release at scene the patient as long as both the EMS personnel and the patient/DDM concur that the illness/injury does not require immediate treatment/transport via emergency/911 services and the patient does not require the services of the prehospital system.
- B. EMS personnel shall advise patients of alternative care and transport options, which may include, but not be limited to:
  - 1. Private transport to a clinic, a physician's office, or an ER.
  - 2. Telephone consultation with a physician.
- C. EMS personnel are encouraged to obtain a Receiving Hospital Physician Consult if there are any questions or concerns regarding the patient's disposition.
- D. The patient or DDM shall sign the AMA/RAS Form.
- E. Patients that do not have a DDM physically present may be released at scene after telephone consent is obtained. This would most often occur with a minor when the parent is not at the scene.

**V. PATIENTS TRANSPORTED AGAINST WILL:**

- A. Implied Consent – If the patient is not a danger to him/herself or others, yet not competent to refuse evaluation or transport, the patient should be transported to the appropriate facility under implied consent. In this case, a 5150 hold is not necessary. However, if the providers believe the patient will resist (and that it is medically necessary to transport the patient against his/her will), the providers should request police assistance in transporting the patient. The police may consider the placement of a 5150 hold on the patient, but this is not required for transport.
- B. 5150 - When a patient exhibits signs of being a danger to him/herself or others, or is gravely disabled and cannot simply be treated and/or transported, the provider should notify the proper authorities to obtain a 5150, and remain with the patient until authorities have made such a determination. Patients on a 5150 hold cannot be released at the scene.
- C. At no time are field personnel to put themselves in danger by attempting to transport or treat a patient who refuses. At all times, good judgment should be used, appropriate assistance obtained, and supporting documentation completed.

**VI. Documentation Requirements (PCR):**

The following items shall be included for adherence to protocol:

- 1. Who activated 911 and the reason for the call
- 2. All medical care provided including the chief complaint and level of distress of the patient, level of consciousness, and a Glasgow Coma Scale.
- 3. The apparent competency of the patient to sign out AMA or RAS
- 4. The ability of the patient/DDM to verbalize an understanding of his/her illness or injury
- 5. The patient/DDM has had the risks and potential outcome of non-treatment and/or non-transport explained fully by the provider, such that the patient/DDM can verbalize understanding of this information
- 6. The presence or absence of any impairment of the patient/DDM such as by alcohol or drugs
- 7. Reasons given by the patient/DDM for refusing offered care and transport. Include patient's/DDM's alternate plan if one has been stated.
- 8. That the patient/DDM has been informed that they may re-access 911 if necessary
- 9. Signature of the patient/DDM on the AMA/RAS Form, or reason why signature was not obtained

**MARIN COUNTY EMS  
AGAINST MEDICAL ADVICE (AMA)–RELEASE AT SCENE (RAS) FORM**

**CRITERIA FOR REFUSING CARE**

The patient meets all of the following:

1. Is an adult (18 or over), or if < 18 meets the criteria stated in the AMA/RAS policy
2. Exhibits no evidence of:
  - Altered level of consciousness
  - Alcohol or drug ingestion that impairs judgment
3. Understands the nature of the medical condition, as well as the risks and consequences refusing care

**1. ACKNOWLEDGMENT OF INFORMATION:**

**A.  AMA:** I have been advised that medical assistance on my behalf is necessary, and that refusal of said assistance could be hazardous to my health, and under certain circumstances, including disability and/or death. I have been advised to discuss my medical complaints with my regular health care provider as soon as possible. Nevertheless, I refuse to accept treatment or transport to a medical facility and assume all risks and consequences of any decision.

**or**

**B.  RAS:** I acknowledge that I may have a medical problem, which may require additional medical attention, and that an ambulance is available to transport me to the hospital. Instead, I elect to seek alternative medical care and refuse further treatment and/or transport.

**2. RELEASE OF LIABILITY:** By signing this form, I am releasing the County of Marin, the responding Provider Agency(ies), and the Receiving Hospital (if contacted) of any liability or medical claims resulting from my decision to refuse the medical care/transport offered.

**I have read and understand the “Acknowledgment of Information” and “Release of Liability”. I also acknowledge that I have received a Notice of Privacy Practices.**

**Signature:** \_\_\_\_\_  **Refused to sign, Reason:** \_\_\_\_\_  
Relationship (if not the patient): Lawful: parent guardian conservator (pertains to a child/dependent only)  
 Physician Consulted: \_\_\_\_\_  
 Telephone consent/refusal obtained. Witnessed by: \_\_\_\_\_  
 Interpreter used: \_\_\_\_\_

<b>DISPOSITION:</b>  <input type="checkbox"/> Released in care or custody of self.  <input type="checkbox"/> Released in custody of law enforcement Agency: _____ Badge #: _____ Released in care or custody of: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____
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<b>Instructions</b>  1. If you change your mind or your condition changes, call 9-1-1 (in an emergency), go to an emergency department in your area, or call your private doctor (if appropriate). 2. _____ 3. _____ _____
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Completed by (Print) \_\_\_\_\_ Signature \_\_\_\_\_ Unit #/Agency # \_\_\_\_\_

<b>Witness Information</b>
Signature: _____ Name Printed: _____
Address: _____ City: _____
State: _____ Zip: _____ Phone: ( ) _____ Driver's License #: _____

Patient Name: \_\_\_\_\_ AO#: \_\_\_\_\_

DDM: \_\_\_\_\_ Date: \_\_\_\_\_

## **12 LEAD ELECTROCARDIOGRAM POLICY AND PROCEDURE**

### **I. PURPOSE**

The purpose of this policy and procedure is to direct use of the 12-lead ECG in order to identify ST elevation myocardial infarction (STEMI) in the field, with the goal to reduce the time to open the occluded coronary artery by direct angioplasty in appropriate STEMI patients.

12-lead ECGs can and should be used with a number of patient care policies (e.g. Coma/ALOC, Chest Pain/Acute Coronary Syndrome, Acute Pulmonary Edema). Treatment under these policies should proceed in conjunction with the application of the 12-lead ECG.

### **II. POLICY**

- A. This procedure is indicated in Acute Coronary Syndrome (ACS) patients to determine the presence of acute ST-elevation MI (STEMI).
- B. If the 12-lead ECG is positive for acute STEMI, patients should be transported directly to a STEMI Receiving Center (SRC) which has a cardiac catheterization lab with PCI capabilities (see Destination Guidelines Policy, #8106).
- C. The use of 12-lead ECGs in Marin County is optional; however, agencies opting to use 12-lead ECGs must utilize this procedure consistently.

### **III. INDICATIONS**

Indicated for patients with medical history and/or presenting complaints consistent with acute coronary syndrome. Patients will have one or more of the following:

- A. Chest or upper abdominal pain, described as pressure or tightness.
- B. Chest pain/tightness with radiation to jaw, neck, left shoulder, or left arm
- C. Nausea or Vomiting
- D. Diaphoresis
- E. Shortness of breath and/or difficulty with ventilation
- F. Anxiety, feeling of "doom"
- G. Syncope or dizziness
- H. Other signs or symptoms suggestive of acute coronary syndrome.

### **IV. CONTRAINDICATIONS (RELATIVE)**

- A. Life-threatening conditions including presence of ventricular tachycardia, ventricular fibrillation, or 3<sup>rd</sup> degree AV block.
- B. Any situation in which a delay to obtain ECG would compromise care of the patient.
- C. Uncooperative patient.

## V. PROCEDURE

- A. Follow appropriate policies regarding the patient's clinical assessment (chest pain/ACS, acute pulmonary edema, etc.)
- B. Attach ECG leads to the patient
  1. Attach limb leads to the upper arms and ankles
  2. Attach chest leads as follows:
    - a. V1: Right 4<sup>th</sup> intercostal space
    - b. V2: Left 4<sup>th</sup> intercostal space
    - c. V3: Halfway between V2 and V4
    - d. V4: Left 5<sup>th</sup> intercostal space, mid-clavicular line
    - e. V5: Horizontal to V4, anterior axillary line
    - f. V6: Horizontal to V5, mid-axillary line
    - g. V4R: right 5<sup>th</sup> intercostals space, mid-clavicular line (use in all suspected inferior MIs at physician request).
- C. If the 12-lead ECG shows ST elevation in 2 or more contiguous leads with a computer interpretation of suspected acute myocardial infarction, immediately contact the appropriate SRC (see VI). If computer interpretation is inconclusive and ST segment elevation is present, seek immediate consultation with the appropriate SRC.
- D. Retain a copy of the 12-lead ECG for CQI purposes.

## VI. HOSPITAL COMMUNICATION / TRANSPORTATION

- A. If 12-lead impression is STEMI and paramedic assessment indicates hemodynamic instability, transport to nearest SRC. Examples of hemodynamic instability include:
  1. Systolic BP<100 (prior to Nitroglycerin and Morphine Sulfate administration)
  2. Signs of acute pulmonary edema such as rales and/or shortness of breath/dyspnea with measured hypoxia
  3. Refractory Ventricular tachyarrhythmias (ventricular tachycardia or fibrillation requiring defibrillation or Antiarrhythmic therapy enroute to nearest SRC)
  4. The paramedic may direct a patient to the nearest SRC whenever they feel that the patient's condition requires more immediate evaluation and treatment.
- B. As soon as possible, provide intended SRC with verbal report. If intended SRC is unavailable, transport to the nearest available SRC.
- C. Verbal report to the SRC will include:
  1. Age and gender of patient
  2. Symptoms, including presence or absence of chest pain
  3. 12-lead findings
- D. If 12-lead impression is STEMI, and patient is hemodynamically stable, transport the patient to the preferred SRC. Preferred is defined as:
  1. Patient preferred
  2. If a treating cardiologist is identified, the SRC used by the cardiologist
- E. If the preferred SRC is more than 10 minutes further than the nearest SRC, transport the patient to the nearest SRC.
- F. The patient will be transported to the nearest SRC if no preference is determined.