Oakland County EMS Medical Control Authority, Inc.
Medical Treatment and Operational Policies & Protocols

Contents of the Oakland County manual were approved by the Department of Consumer & Industry Services, EMS Section, on September 25, 1996, except where indicated otherwise.

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Patient Triage

All persons examined will be assigned a priority rating by the EMS person in charge, i.e., the highest trained licensed EMS personnel. For multiple patient encounters, refer to "MCI Disaster Protocol". As with all triage decisions, the priority assigned may change depending on further assessment, communication with online medical control or overt change in patient condition.

Priority 1: Critically ill or injured person who needs immediate attention. Delay in care will threaten life or limb.

Priority 2: An urgent situation where the person's condition could deteriorate into a priority 1 before arriving at a medical facility.

Priority 3: Illness or injury not meeting the criteria for priority 1,2, or 4.

Priority 4: Dead on scene (DOS), according to Protocols.

State approved: July 10, 2007

Patient Dead on Scene

Medical reasons <u>not to start</u> CPR include the following:

A. Patient without vital signs, plus

B. Any one of the following are present:
   1. decapitation
   2. gross dismemberment of the body
   3. full thickness, total body burns
   4. body decay and putrefaction
   5. body frozen solid
   6. rigor mortis
   7. lividity
   8. head trauma with brain matter exposed
   9. underwater submersion greater than two hours

C. Physician or registered nurse on the scene pronounces patient legally dead.

Medical reasons to discontinue ACLS include:

A. Establishment of cardiovascular unresponsiveness, plus

B. Patient without vital signs.

C. Asystole, pulseless electrical activity, ventricular fibrillation or non-responsive to standard resuscitative therapy, plus

D. Determination by on-line medical control physician that further therapy is not indicated.

NOTE:	**If family members, bystanders or others present object to the order or physical confrontation appears likely, notify the medical control physician and continue resuscitation efforts.**

Procedure for obtaining a pronouncement of death, due to cardiovascular unresponsiveness include the following:

A. Present to the medical control physician results of the physical examination, including vital signs.

B. Present results of cardiac monitoring or use of AED (if applicable).

C. Present summary of the patient's condition in regards to the following:
   1. present problem
   2. past medical history, especially as this relates to any terminal illness that may be present
   3. applicability of advance directives
   4. presence of durable power of attorney, physician and/or family members and their agreement in limiting life support.

D. Medical control physician will then do one of the following:
   1. pronounce death
   2. request initiation or continuance of basic/advanced life support permit comfort-care-only procedures (e.g. oxygen, suction, medications, transport, etc.)

3. permit comfort-care-only procedures (e.g. oxygen, suction, medications, transport, etc.)
4. request further information to clarify issues.

Documentation

A. Record time of pronouncement of death and names of medical control physician and hospital.
B. Notify local police authority.
C. Notify medical examiner's office.
D. Body or bodies will not be moved until the medical examiner's office and police authority approves removal.
E. Medical examiner's office will determine destination of the body (county morgue or funeral home).
F. Personal belongings shall not be removed from the body.
G. Leave endotracheal tubes and IV's in place.

Updated Protocol: State approved July 10, 2007

Do Not Resuscitate Policy

Purpose

The purpose of this policy is to provide a guideline to prehospital providers who under certain circumstances, may accommodate those patients who do not wish to receive and/or may not benefit from cardiopulmonary resuscitation. This policy is drafted in accordance with Act 368, Public Acts of 1978, as amended by Act No. 179 of the Public Acts of 1990, as well as Act No. 193 of the Public Acts of 1996. This policy is intended to facilitate kind, humane and compassionate service for those patients who have executed a valid "Do Not Resuscitate Order" under the aforementioned Acts.

Definitions

A. **Attending Physician** – means the physician who has primary responsibility for the treatment and care of a declarant.

B. **Declarant** – means a person who has executed a do-not-resuscitate order or on whose behalf a do-not-resuscitate order has been executed pursuant to applicable laws.

C. **Do-Not-Resuscitate Order** – means a document executed pursuant to the Act directing that in the event that a patient suffers cessation of both spontaneous respiration and circulation in a setting outside of a hospital, a nursing home, or a mental health facility owned or operated by the department of community health, no resuscitation will be initiated.

D. **Do-Not-Resuscitate Identification Bracelet or Identification Bracelet** – means a wrist bracelet that meets the requirements of the Act and is worn by the declarant while a do-not-resuscitate order is in effect. A Do-Not-Resuscitate identification bracelet shall possess features that make it clearly recognizable as a Do-Not-Resuscitate identification bracelet including, but not limited to, all of the following:

   1. Bracelet shall be imprinted with the words **"DO NOT RESUSCITATE ORDER"**, the name and address of the declarant and the name and telephone number of the declarant's attending physician, if any. The words required above shall be printed in a type size and style that is as easily read as practicable, given the size of the identification bracelet.

E. **Order** – means a do-not-resuscitate order.

F. **Patient Advocate** – means an individual designated to make medical treatment decisions for a patient under Section 496 of the revised probate code, Act No. 642 of the Public Acts of 1978, being section 400.496 of the Michigan Compiled Laws.

G. **Vital Sign** – means a pulse or evidence of respiration.

Procedure

A. When a medical first responder, emergency medical technician, emergency medical technician specialist, or a paramedic (hereafter collectively referred to as "EMS Tech") arrives at a declarant's location, the EMS Tech shall determine if the declarant has one or more vital signs, whether or not the EMS Tech views or is provided with an order as described in the Act.

B. If the EMS Tech determines that the declarant has **<u>no vital signs</u>** and if the EMS Tech determines that the declarant is wearing a do-not-resuscitate bracelet as outlined in the

Act or the EMS Tech is provided with a do-not-resuscitate order for the declarant, the EMS Tech shall not attempt to resuscitate the declarant.

Civil or Criminal Liability

In accordance with the Act, a person or organization is not subject to civil or criminal liability for either of the following:

A. Attempting to resuscitate an individual who has executed a do-not-resuscitate order or on whose behalf an order has been executed, if the person or organization has no actual notice of the order.

B. Failing to resuscitate an individual who has revoked a do-not-resuscitate order or on whose behalf a do-not-resuscitate order has been revoked, if the person or organization does not receive actual notice of the revocation.

Do-not-resuscitate order form / identification bracelet

A. In accordance with the Act, a "Do-Not-Resuscitate Form" shall be completed by the declarant who shall have same in their possession and accessible within his or her place of residence.

1. A "Do-Not-Resuscitate Form" for a declarant whose heart and breathing stop, shall be in substantially the form as outlined in The Do Not Resuscitate (DNR) requiring physician's signature.
2. A "Do-Not-Resuscitate Form" for a declarant who based on religious purposes whose heart and breathing stop, shall be in substantially the form as outlined in the DNR order for the Adherent of a Church or Religious Denomination.
3. A Do-Not-Resuscitate identification bracelet shall possess features that make it clearly recognizable as a Do-Not-Resuscitate identification bracelet including, but not limited to all of the following:
   - Bracelet shall be imprinted with the words **"DO NOT RESUSCITATE ORDER"**, the name and address of the declarant and the name and telephone number of the declarant's attending physician, if any.
   - The words required above shall be printed in a type size and style that is as easily read as practicable, given the size of the identification bracelet.

Revocation of do-not-resuscitate order

A. In accordance with Act 193, a declarant or patient advocate who executes an order on behalf of the declarant may revoke an order at any time, and in any manner by which he or she is able to communicate an intent to revoke the order. Upon revocation, the declarant, patient advocate, attending physician or a delegatee of the attending physician who has actual notice of the revocation shall destroy the order and remove the declarant's do-not-resuscitate identification bracelet, if applicable.

B. A physician or physician's delegatee who receives notice of a revocation of an order shall include the revocation as part of revoking declarant's permanent medical record.

C. A declarant's or patient advocate's revocation of an order is binding upon another person at the time that other person receives actual notice of revocation.

State Approved Protocol: July 10, 2007

Alternative EMS Response Team

Purpose:
The purpose of the policy is to provide a protocol for the use of alternative EMS response, which includes but is not limited to bicycles, golf carts, and other non-traditional response modes in the Oakland County Medical Control Authority (OCMCA) zone during events that their presence would be advantageous.

Procedure:
Any agency that wants to utilize an alternative EMS response team (Team) will carry at least all the equipment listed in this protocol. Staffing of the alternative EMS response team will not exceed the agency's Oakland County licensing level.

When responding to an emergency, the Team will respond along with a transport capable unit to assure appropriate transport of the patient. The Team will give a complete report of patient condition and treatments to the transporting unit, and will follow the OCMCA protocols. Mandatory communication capabilities include allowing the Team to reach their agency's dispatch and to reach an OCMCA approved hospital for medical control.

Equipment List:
MFR/BLS/Paramedic
- AED
- Jump Kit
- Oxygen/Oxygen supplies
- Airway management supplies
- Suction
- Communication device

Paramedic
- ECG Monitor/Defibrillator
- IV Kit
- Drug Box

Drug Box (Paramedic only)

Any ALS agency wanting to obtain a drug box for use on an Alternative EMS Response Team vehicle will take a device that can be sealed and is capable of carrying all of the medications listed on the contents list to the agency's Base Hospital to be filled. The agency must also provide a device that can carry all controlled substances that can be attached to one of the paramedic's person. Only one set of boxes (two) may be filled for each paramedic Team an ALS agency deploys. Both boxes will be inventoried and sealed with expiration date labeled on the box. The boxes will be kept in a secured area when not in use.

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Drug Box Contents:

Drug/Item	Concentration	Packaging/Quantity
Adenosine	6 mg/2 ml	5 vials
Albuterol	2.5 mg/3 ml	2 vials with 1 nebulizer
Amiodarone	150 mg/3 ml	2 amps
Aspirin	82 mg/tablet	minimum 4 chewable tabs
Atropine	1 mg/10 ml	2 pre-filled syringes
Dextrose 50%	25 gm/50 ml	2 pre-filled syringes
Diphenhydramine	50 mg/1 ml	1 vial
Epinephrine 1:1000	30 mg/30 ml	1 vial
Epinephrine 1:10,000	1 mg/10 ml	2 pre-filled syringes
Naloxone	2 mg/2 ml	2 vials
Nitroglycerin	0.4 mg/tab	1 bottle
Sodium Chloride	20 ml	1 vial
Alcohol Pads		12
Needle	21 g - 1.5 inch	4
Needle	18 g - 1.5 inch	4
Syringe	10 ml	4
Syringe	1 ml	4

Controlled Substances Drug Box Contents		
Diazepam	10 mg/2 ml	1 vial
Morphine	10 mg/1 ml	2 ampules

<u>Drug Box Exchange</u>:

1. A county approved ALS unit will transport all patients the paramedic Team treats. During an event, all medications used by the bicycle paramedic team will be replaced from the responding ALS unit's drug box.

2. The transporting ALS unit will use their opened drug box for any additional treatment the patient might need during the transport. The ALS unit will be responsible for documentation of drug use. Upon arrival at the hospital the ALS unit will follow the usual box exchange procedure for an ALS unit.

3. The paramedic Team will keep a daily log of all patients treated, drugs used and replaced from an ALS drug box.

4. At the end of the paramedic Team's event, the drug box must be returned to the hospital

pharmacy for update of its contents, seal and expiration date.

<u>IV Kits and Fluids</u>:

1. The paramedic Team will carry two county approved IV kits and two 1000ml bags of normal saline.

2. The paramedic Team will replace the used kits and bags of IV fluids with the transporting ALS unit, or at the hospital. The ALS unit will obtain a new IV kit at the receiving hospital following the normal IV exchange policy.

3. All remaining and used IV equipment will be given to the transporting unit for proper disposal.

State approved: July 10, 2007

Bloodborne Pathogen Exposure Policy

Police, Fire or EMS personnel who, in the performance of their duty, sustain a needle stick, mucous membrane or open wound exposure to blood or other potentially infectious material (OPIM) may request, under Public Act 368 and 419, that the patient be tested for HIV/Hepatitis B and C surface antigen. The exposed individual shall make the request on a Michigan Department of Community Health Form J427 (**MDCH Form J427**).

The health facility that receives an exposure request from Police, Fire or EMS personnel shall accept as fact the description of their exposure to the patient's blood or OPIM, unless the health care facility has a reasonable cause to believe otherwise. The health care facility shall make the determination as to whether or not an exposure was a needle stick, mucous membrane or open wound pursuant to the Michigan Administrative Codes. Determination may occur in person, by phone or by appropriate personnel according to MIOSHA standards.

Categories for Exposure Testing:

Patient and Exposed Individual are at the **SAME** Hospital

A. An exposure sticker will be placed on the patient's EMS Medical Report form and verbal notification given to the physician caring for the source patient.

B. A health care professional determines an exposure has occurred. A health care professional is defined as a (n):
   1. Paramedic
   2. Emergency Medical Technician (EMT)
   3. EMT Specialist
   4. Physician
   5. Nurse
   6. Medical First Responder

C. A MDCH Form J427 must be completed and given to the hospital attending emergency physician.

D. The hospital will test the patient for HIV/ Hepatitis B and C surface antigen. The test results will be disseminated to Police, Fire or EMS personnel within 1 hour for HIV and 48 hours for Hepatitis B and C after notification of the health facility. Notification will be released on positive or negative results to the individual specified on Form MDCH J427.

E. The exposed individual will be referred to their respective department and MIOSHA Exposure Control Plan for follow-up, testing, logistics and counseling.

Patient and Exposed Individual are at Different Hospitals

A. An exposure sticker will be placed on the patient's EMS Medical Report form and verbal notification given to the physician caring for the source patient.

B. A health care professional has determined an exposure has occurred. A health care professional is defined in B 1. above.

C. A Michigan Department of Community Health Form J427 must be completed. The health care professional will contact the source patient's receiving hospital and indicate an exposure has

occurred. The health care professional will fax a copy of the MDCH Form J427 to the source patient's receiving hospital.

D. The source patient's receiving hospital will test the patient for HIV/ Hepatitis B and C surface antigen. The test results will be disseminated to Police, Fire or EMS personnel within 1 hour for HIV and 48 hours for Hepatitis B and C after notification of the health facility.

E. Notification will be released on positive or negative results to the individual specified on the MDCH Form J427.

F. The exposed individual will be referred to their respective department and MIOSHA Exposure Control Plan for follow-up, testing, logistics and counseling.

Exposures Where There is No patient (unknown Source Patient, Death, Patient left hospital priorto testing, or refused testing)

A. An exposure sticker will be placed on the patient's EMS Medical report form and verbal
notification given to the physician caring for the source patient (if known).

B. A health care professional determines whether an exposure has occurred. A health care professional is defined in section B 1.

C. MDCH Form J427 is completed and faxed or given to the source patient's emergency department (if known).

D. If the patient left prior to testing, the receiving hospital will attempt to contact the patient to initiate testing for HIV/ Hepatitis B and C surface antigen. If the patient agrees to be tested, refer to this policy, section "Categories for Exposure Testing".

E. If the patient is unavailable for testing, the exposed individual may undergo testing outlined in their department's MIOSHA Exposure Control Plan. The exposed individual's department and designated testing facility shall be responsible for testing, logistic and counseling of their employee.

In all cases, follow-up testing, logistics and counseling will be at the expense discretion of the exposed individual's department and respective exposure control plans.

Treatment

All treatment will be provided to exposed individuals according the current Center for Disease Control (CDC) recommendations.

State Approved: March 12, 2001

Communications

On-line Medical Control will be available from the Oakland County EMS Medical Control Authority designated receiving and base hospitals.

Receiving Facility
EMS personnel should contact the receiving Emergency Facility on patients who receive emergency care or evaluation. EMS units should contact the receiving Emergency Facility prior to or at time of leaving the scene.

Base Hospital
EMS personnel should contact the Base Hospital for on-line medical direction involving exceptional circumstances (see special considerations).

Freestanding Facilities
Freestanding Facilities, approved by the Oakland County EMS Medical Control Authority to provide medical direction, shall do so for cases in which the Freestanding Facility is the anticipated receiving facility. On-line medical direction, in consultation with the transporting EMS personnel, shall be responsible for identifying whether the Freestanding Facility is an appropriate receiving.

Unstable patients are not appropriate for freestanding facilities unless, in the opinion of the EMS personnel or on – line medical control physician, transporting the patient to a further facility could have an adverse effect on the patient's outcome.

Priority 1 and 2 Communications Requests for Medical Direction

1. EMS personnel must begin radio report stating "requesting a physician to the radio" (i.e. POH this is alpha 123 priority 2 traffic requesting a physician to the radio)
2. Initial report will contain only the following information
    - Age
    - Sex
    - Chief complaint
    - Vital signs if outside of normal limits, including significant EKG changes
    - Field treatment (i.e. IV, O2, Meds given)
    - ETA
    - Request for orders or medical direction

Priority 1,2,3 Communications Notification Only

Unless the incident/patient involves special consideration (see below), priority 3 communications will be notification only.

1. EMS personnel must begin their radio contact stating "notification only" (i.e. POH, this is Alpha 123, priority 2 traffic for notification only)
2. Report will contain only the following information:
    - Age
    - Sex
    - Chief complaint
    - ETA

For Priority 1 and 2 only

- Vital signs if outside of normal limits, including significant EKG changes
- Field treatment (i.e. IV, O2, Meds given) (priority 1 and 2 only)

3. For priority 3 notification contact, the hospital emergency administrative radio (HEAR), data burst, 800 Mhz, CAD, cell phone, or Alphanumeric page (beeper) may be utilized to notify the receiving emergency facility.

Special Considerations

In the following situations, EMS personnel will contact their Base Hospital or receiving facility, whichever is appropriate for medical direction from a physician or for documentation purposes.

1. Pronouncement of death on scene.
2. Patient refusing treatment/transport against EMS personnel's' advice.
3. Elopement (patient leaves scene).
4. Incidents involving minors with possible legal implications.
5. Deviations from transportation protocol.
6. Any situation where EMS personnel feel medical direction from a physician is indicated.

State Approved: May 23, 2001

Disaster & MCI Protocols with Incident Command

Definition of a Disaster
An unanticipated event that exceeds the routine response expectations of an EMS System.

Duties of the First Responding Agency
Establish Incident Command, Command Post (display green light or leave lights on), and assign MCI number (first responding agencies incident number).

NOTE:	First responding unit should remain on scene and will not treat or transport patients.

Notify other responding agencies of MCI, approx. # of patients, & location of staging area via:
A. Your agency's dispatch.
B. Frequency 155.400.

Incident Commander duties:
A. Will appoint EMS Officer.
B. Incident Commander may request, if necessary and available, a site medical team for special situations.

EMS Officer's duties:
A. Designate a Triage Officer, Communications Officer, Staging Officer, and location of the EMS Staging Area.
B. Assign duties of establishing secondary triage to an ALS unit.
C. Coordinating available EMS resources with dispatch and Incident Commander.

Triage Officer's duties: (identified by triage vest or white tape on back in cross pattern)
A. Assesses scene for:
   1. Number of injured
   2. Resources needed (i.e. additional units, special rescue teams, site medical teams, etc.)
   3. Potential hazards, and convey findings to the EMS Officer.
   4. Assigns triage teams for tagging, retrieval, and treatment.

Communication Officer's duties: (Paramedic)
A. Establish Medical Control with a Disaster Control Hospital via 800 MHz Radio System. Only the communication officer will be in contact with the Disaster Control Hospital regarding this incident.

Disaster Control Hospitals:

BOTSFORD	**NORTH OAKLAND**
POH REGIONAL MEDICAL CENTER	**PROVIDENCE-SOUTHFIELD**
ST. JOSEPH MERCY – PONTIAC	**BEAUMONT – ROYAL OAK**

Communication Officer's Duties (Paramedic) – continued:

1. Communicates to Medical Control:
   - Initial information: Type of incident, approximate number of patients, types of injuries
   - For all patients will be the agency incident number of the first responding agency
   - Patient information & destination for all patients being transported from scene:
     a) Number of patients
     b) Priorities
     c) Body Area Affected
     d) Adult or Ped.
     e) ETA

Staging Office will coordinate available resources moving into the disaster scene.

Duties Of All Other Units

A. All units responding to the incident **shall report** to the **staging area**.
B. Upon arrival, turn emergency lights off, and report to Staging Officer for assignment.
C. EMS unit leaving the scene, will only return to the scene if instructed to do so.
D. Record MCI# on all documents.
E. Render patient care as assigned by Triage Officer.

Disaster Control Hospital

A. Medical control duties will be assumed by one of the Disaster Control Hospitals (see above).
B. All patient care will be by **SOPs**. Additional treatment per medical direction only.
C. Document all vital information regarding incident.
D. Will notify hospitals of disaster situation via 800 MHz Hospital All Call Radio, and request hospital capabilities.
E. Coordinate Hospital capability information, and convey it to the Communications Officer.
F. Notify receiving hospitals of their impending arrivals via 800 MHz Hospital All Call Radio.

Receiving Hospital

A. Report their hospital capabilities to the Disaster Control Hospital.
B. Will be notified only of the # of patients, priorities, body area affected, adult/ped., & ETA by the Disaster Control Hospital.
C. Compile log of incident and forward it to the EMS Medical Director.

Communicable Disease Protocol

The EMS provider must recognize any patient that presents with one of the following:

- a skin rash
- open wounds
- blood or other body fluids
- a respiratory illness that produces cough and/or sputum may be potentially infectious, and EMS personnel must take the necessary precautions to avoid exposure. These precautions include following this protocol.

<u>Exposure Defined:</u>
An exposure is determined to be any breach of the skin by cut, needle stick, absorption or open wound, splash to the eyes, nose or mouth, inhaled, and any other parenteral route.

<u>Reporting Exposures:</u>
Police, Fire or EMS personnel who, in the performance of their duty, sustain a needle stick, mucous membrane or open wound exposure to blood or other potentially infectious material (OPIM) may request, under Public Act 368 and 419, that the patient be tested for HIV/Hepatitis B and C surface antigen. The exposed individual shall make the request on a Michigan Department of Community Health Form. The exposed individual should also report the exposure in accordance with their employer's policies and procedures.

The health facility that receives an exposure request from Police, Fire or EMS personnel shall accept as fact the description of their exposure to the patient's blood or OPIM, unless the health care facility has a reasonable cause to believe otherwise. The health care facility shall make the determination as to whether or not an exposure was a needle stick, mucous membrane or open wound pursuant to the Michigan Administrative Codes. Determination may occur in person, by phone or by appropriate personnel according to MIOSHA standards.

<u>Pre-Radio</u>
MFR/EMT/SPECIALIST/PARMEDIC

1. If a patient presents with one of the following symptom complexes, follow the remainder of this protocol.
   a. Fever > 100.5 F **AND** headache or malaise or myalgia, **AND** cough or shortness of breath or difficulty breathing.
   b. Pustular, papular or vesicular rash distributed over the body in the same stage of development(trunk, face, arms or legs) preceded by fever **AND** rash progressing over days (not weeks or months) **AND** patient appears ill.
2. Consider the patient to be both airborne and contact contagious. Crew will don the following PPE:
   a. N95 or higher protective mask/respiratory protection
   b. Gloves
   c. Goggles or face shield

   DO NOT REMOVE protective equipment during patient transport.

3. Follow General Pre-Hospital Care Protocols
   (Oxygen delivery with non-rebreather facemasks may be used for patient, however, nebulizer use should be avoided if possible because of increase spread of disease)

4. Positive pressure ventilation should be performed using a resuscitation bag-valve mask. If available, one equipped to provide HEPA or equivalent filtration of expired air should be used. Also see the section in this protocol "Mechanically Ventilated Patients".
5. Patient should wear a paper surgical mask to reduce droplet production, if tolerated.
6. Notify the receiving facility, prior to transport, of the patient's condition to facilitate preparation of the facility and institution of appropriate infection control procedures.
7. Hands must be washed or disinfected with a waterless hand sanitizer immediately after removal of gloves. Hand hygiene is of primary importance for all personnel working with patients.
8. Vehicles that have separate driver and patient compartments and can provide separate ventilation to these areas are preferred for transportation of patient. If a vehicle without separate compartments and ventilation must be used, the outside air vents in the driver compartment should be turned to the highest setting during transport of patient to provide relative negative pressure in the patient care compartment.
9. Patients should also be encouraged to use hand sanitizers.
10. Unless critical, do not allow additional passengers to travel with the patient in the ambulance.
11. All PPE and linens will be placed in an impervious biohazard plastic bag upon arrival at destination and disposed of in accordance with the direction from the hospital personnel.

MECHANICALLY VENTILATED PATIENTS

1. Mechanical ventilators for potentially contagious patient transports must provide HEPA filtration of airflow exhaust.
2. EMS providers should consult their ventilator equipment manufacturer to confirm appropriate filtration capability and the effect of filtration on positive pressure ventilation.
3. BIPAP, CPAP and nebulizers should be avoided if possible because of increased spread of disease when used.

CLEANING AND DISINFECTION

Cleaning and Disinfection after transporting a potentially contagious patient must be done immediately and prior to transporting additional patients. Contaminated non-reusable equipment should be placed in biohazard bags and disposed of at hospital. Contaminated reusable patient care equipment should be placed in biohazard bags and labeled for cleaning and disinfection. Reusable equipment should be cleaned and disinfected according to manufacturer's instruction.

INTERFACILITY TRANSFERS

1. Follow the above precautions for inter-facility transfers.

2. Prior to transporting the patient the receiving facility should be notified and given an ETA for patient arrival allowing them time to prepare to receive this patient.
3. Clarify with receiving facility the appropriate entrance and route inside the hospital to be used once crew has arrived at the receiving facility.
4. All unnecessary items should be removed from the vehicle to avoid contamination.
5. All transport personnel will wear the following PPE:
   a. N-95 (or higher) protective mask/ respiratory protection
   b. Gloves
   c. Goggles or face shield
   d. Gown
   e. Shoe Covers

   DO NOT REMOVE protective equipment during patient transport.
6. Drape/Cover interior of patient compartment and stretcher (utilizing plastic or disposable sheets with plastic backing)
7. Isolate patient:
   a. Place disposable surgical mask on patient
   b. Cover patient with linen sheet to reduce chance of contaminating objects in area.
8. All PPE and linens will be placed in an impervious biohazard plastic bag upon arrival at the receiving destination and disposed of in accordance with the direction from the hospital personnel
9. The ambulance(s)/transport vehicle will not be used to transport other patients (or for any other use) until it is decontaminated using the current CDC guidelines for decontamination.
10. Patient cohorting may occur if resources are exhausted and patients are grouped with the same disease. Cohorting should only be utilized as a last resort.

NOTE: When applicable, all non-vaccinated EMS personnel should be vaccinated within 24 hours following potential exposure.

Regional Protocol Approved by MDCH: May 3, 2005

Contaminated Patient

Purpose: This protocol is intended to protect responding EMS providers, hospital personnel and the community from the possibility of contamination.

Identification of the Contaminated Patient

Use all your senses. Suspect hazardous material situation if you:

- **See** containers, labels or placards, or a location suggesting a hazardous substance
- **Hear** explosions, or reports of possible contamination, pre-arrival or on scene
- **Smell** unusual odors – be suspicious

Protocol

1. If contamination of a patient is suspected, the local fire or public safety department must be informed of the hazardous material situation.
2. The responding EMS agencies must prevent further contamination to themselves or others. Determine if any contaminated patients have already left the scene and promptly notify the hospital(s).
3. The responding EMS agency must not spread any contamination outside the response area until the responding fire or public safety department incident commander, or appropriate designee, has confirmed that decontamination is complete. Contaminated patients will not be transported out of the decontamination area until field decontamination is complete.
4. EMS responders will not enter a known contaminated area without proper personal protective equipment, training, and direction by incident command.
5. Invasive patient care procedures (IV, OPA, NPA, ET, Combitube) should not begin until decontamination of the patient is confirmed or until personal protective equipment is in place.
6. Prior to transport of a decontaminated patient, on-line medical control will be contacted to assure the patient is transported to a facility equipped to handle the specific needs of the patient.
7. Once the scene Incident Commander, or the appropriate designee, has confirmed that the patient is decontaminated, the responding EMS agency may transport the patient to the designated facility.

State approved protocol
Approved by MCC: January 23, 2003

General WMD Protocol

This protocol is intended to provide general pre-arrival information for suspected HAZMAT and WMD incidents.

NOTE: This information is designed to augment other established protocols. A single medical control order in a mass casualty incident may be applied to all symptomatic patients.

I. MEDICAL RESPONSE

A. First responding units must approach with caution.
B. Approach upwind, uphill and upstream, as appropriate.
C. Utilize resource materials such as the Emergency Response Guidebook or Emergency Care for Hazardous Materials Exposure.
D. Utilize appropriate PPE.
E. Be aware of contaminated terrain and contaminated objects.
F. Hazmat response protocols must be initiated, as well as unified incident command.
G. Maintain a safe distance.
H. Attempt to identify the nature of the exposure by looking for placards, mode of dispersal (vehicle explosion, bomb, aerosolized gas, etc.).
I. Estimate number and viability of victims.
J. Victims and potential victims must be evacuated rapidly from the contaminated area and decontaminated as quickly as possible, if appropriate. In certain situations, treatment may be initiated within the hot and/or warm zones of an incident by properly trained, protected and equipped personnel.
K. Be alert for secondary devices.
L. Assure patients are adequately decontaminated *prior* to transport, per standard decontamination procedure.
M. Alert hospital(s) as early as possible.
N. For a large scale event, consider contacting the following:
EOC activation: Oakland County Emergency Response and Preparedness: 248-858-5300
Oakland County Medical Control Authority: 248-975-9704
MEDRUN activation via Survival Flight: 800-822-2233.

II. PERSONAL PROTECTION

A. Don appropriate PPE, as directed.
B. Assure EMS personnel are operating outside of Hot Zone unless trained and equipped to operate in the Hot Zone.
C. Avoid contact with body fluids – “off-gassing” possible.

III. NERVE AGENT EXPOSURE PROTOCOL

Pre-Radio

MFR/EMT/SPECIALIST/PARMEDIC

1. Patient Management (After Evacuation and Decontamination)
   A. Follow General Pre-Hospital Care Protocols
   B. Administer Mark I Kit(s), if available.

PARAMEDIC

1. Establish vascular access
2. Administer Atropine 2-6 mg IV/IM per Mark I Kit, if available.
3. Treat seizures per Seizure Protocol.
4. Monitor EKG

Post-Radio

PARAMEDIC

1. Additional Atropine 2 mg IV/IM for continued secretions (0.05 mg/kg for pediatrics).
2. Anticipate additional Valium for patients with severe signs.

IV. CHEMICAL EXPOSURE PROTOCOL

Note: If there is a confirmation of, or symptoms indicative of a chemical incident, utilize appropriate PPE as outlined in the General section.

Pre-Radio

MFR/EMT/SPECIALIST/PARMEDIC

1. Nerve Agents & Cyanide Compounds – refer to appropriate protocol.
2. Choking Agents
   A. If difficulty breathing, see Asthma/Wheezing Protocol.
   B. Respiratory chemical PPE (if available).
   C. Eye irrigation
      1. Remove contact lenses
      2. Continuous flush through transport with NS, each eye.
3. Vesicant (Blister)/Lacrimator Agents
   A. Lacrimator agent: use eye irrigation, as noted above.
   B. Respiratory treatment per protocol.

V. CYANIDE EXPOSURE PROTOCOL

This Protocol is intended for EMS personnel at all levels to assess and treat patients exposed to cyanide. The protocol includes the use of inhaled amyl nitrite by trained personnel who are authorized by their local medical control authority. Additionally, the protocol allows trained and authorized paramedics to administer sodium nitrite and sodium thiosulfate when these medications are available. Contact local HAZMAT Team immediately.

Pre-Radio
MFR/EMT/SPECIALIST/PARMEDIC

1. Patient Management (After Evacuation)
   A. Follow General Pre-Hospital Care Protocols
   B. Evaluate and maintain the airway, provide oxygenation and support ventilation as needed.
   C. Patients in respiratory arrest, but still having a pulse, should receive positive pressure ventilation when operationally feasible.

Post-Radio
PARAMEDIC

1. Amyl Nitrite per Cyanide Antidote Kit.
2. Sodium Nitrite 10 ml (300 mg) IV over 5 minutes, if available, cyanide exposure confirmed, and with medical control order for critical patients.
   A. For pediatric patients: 0.15 ml/kg IV >5 minutes.
   B. Monitor BP carefully and slow administration for hypotension.
3. Sodium Thiosulfate 50 ml (12.5 g) IV over 10 minutes, if available, cyanide exposure confirmed, and with medical control order for critical patients.
   A. For pediatric patients: 1.65 ml/kg (12.5 g/50 ml solution) IV over 10 minutes.
   B. Generally administered after sodium nitrite.
   C. If cyanide exposure not confirmed, may receive order for Sodium Thiosulfate without Sodium Nitrite.

State approved: August 10, 2006

Mark I Auto Injector Kit Procedure

Applicability: This protocol shall encompass the storage, training, acquisition, deployment and use of the Nerve Agent Antidote Kit, "Mark I", manufactured by the Meridian Medical Technology Corporation.

Oversight: An OCMCA representative shall be placed in charge with compliance to this protocol and shall designate an agency representative to verify compliance with this protocol.

Licensure and OCMCA Membership: Any licensed EMS agency participating with the OCMCA shall be availed of the benefits of this protocol. Participation with this protocol shall require compliance with all applicable sections.

Participation: Department participation in this protocol (personnel and department kit acquisition) is voluntary.

Training: A designated OCMCA physician shall provide Train the Trainer (TtT) courses as required. These courses shall be presented to agency program representatives or EMS Instructor Coordinators for dissemination to their personnel. Training shall consist of an overview of the central nervous system, nerve agent weapons and their effects on the human body. In addition, Mark I auto injectors shall be presented and reviewed to attendees.

The purchase of Mark I training kits shall be required for agency representatives to instruct their own personnel.

Lastly, the training presented may be done in the form of a PowerPoint presentation, of which copies shall be distributed to each participating agency. Training records shall be maintained by each agency and refresher training shall be made available based on the needs of the system.

Purchase, Storage and Deployment of Kits: Individual kits may be purchased by an agency for use in conjunction with their response needs. While the cost of these kits will be the responsibility of the agency, medical oversight shall be done in accordance with the provisions of the protocol.

Kits owned by individual agencies are pre-designated for responding personnel of that jurisdiction (e.g. police, fire, EMS, etc.). In addition, civilian needs may be considered if quantities are available as determined by the individual jurisdiction.

Kits must be stored in appropriate containers for protection from the elements as well as to provide a mechanism for the securing of the kits in accordance with State law. A master list of quantities, lot numbers, expiration dates, and locations of kits is to be kept on file with the OCMCA program coordinator.

Deployment of kits is to be done with the authorization of the Incident Commander.

Deployment of agency kits to trained agency personnel may be ordered pre-incident for responses and/or events that have a potential to develop into nerve agent attacks/exposures. Note: Kits may only be deployed to personnel that are members of an OCMCA participating agency and have completed orientation training to the Mark I kit.

Use of Mark I Kits: Usage of the Mark I auto injector kit is to be based upon the medical need of the exposed individual after a nerve agent attack. Kits may be administered by any medically licensed EMS provider operating in a participating OCMCA agency that has received training in the use of Mark I kits.

Replenishment/Replacement of Supplies: Kits used in the conjunction with responses and those destroyed as a result of expiration or otherwise shall be replaced under the same auspices of the original purchase. Upon the determination of the need to replace kits, agency and OCMCA program representatives shall be made aware of the replacement, lot numbers, expiration date or the new kit, and location of the kit.

Should kits be opened for training and/or inspection, a new medication seal shall be installed and the details of this replacement shall be conveyed to the agency and OCMCA representative.

Disposal of Kits: Kits shall be disposed of in accordance with similar medical items in accordance with federal and state law.

Oakland County Protocol Approved by MDCH: May 3, 2005

Oakland County Medical Control Authority Mark I Kit Inventory

Agency: ___________________________________

Designation	Location	Quantity	Lot Number(s)	Expiration Date(s)	Verified By:
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

Violent/Chemical/Hazardous Scene

Purpose: To ensure safety of EMS personnel when faced with known or potentially violent/hazardous situations.

Note: This policy applies to any situation, which may expose EMS personnel to known or potentially violent (e.g., shooting, stabbing, assault, other violent crimes) or other known or potentially hazardous (e.g., hazardous material, chemical, biological) situations.
The medical component of the response to a violent or hazardous incident will operate under the Incident Command System.

Procedure

I. Upon notification of a known or potentially violent situation, the EMS personnel will determine through dispatch, the nature and location of incident and:
   A. Violent Situations
      1. Is assailant/weapon present?
      2. Assure law enforcement notification?
      3. Is scene secure?
   B. Hazardous materials situation
      1. Is scene secure?
      2. Nature and identification of material?
      3. Assure FD/Hazmat Team notification?

   NOTE: The above information should be communicated to responding crews.

II. In any situation in which the scene is not secured, EMS personnel ARE NOT TO ENTER THE SCENE until it has been secured by the appropriate agency.

   When responding to an unsecured scene, EMS personnel will stage an appropriate distance away from the scene to protect themselves from danger.

III. Once on the scene, if the situation changes posing an immediate life or limb threat to EMS personnel:
   1. Attempt to safely exit scene.
      a. Exit scene with patient, if possible.
      b. Medical treatment protocols may be limited or deferred to assure safety of EMS personnel and/or patient.
   2. Notify the dispatcher of the assistance needed.
   3. Provide any additional information available – e.g., number of assailants, weapons present/involved, any additional information.

IV. **Special Considerations:** For those patients, who have been contaminated in a hazardous material incident, refer to Contaminated Patient Protocol.

State approved protocol: Approved by MCC on January 23, 2003

TRIAGE / PRIORITY RATING SYSTEM
RED (1) YELLOW (2) GREEN (3) BLACK (4)

START TRIAGE

All Walking Wounded
MINOR
GREEN

RESPIRATIONS

- **NO**
  - **POSITION AIRWAY**
    - **NO** → Deceased **BLACK**
    - **YES** → Immediate **RED**
- **YES**
  - Over 30 Min. → Immediate **RED**
  - Under 30 Min. → **ASSESS PERFUSION**
    - No Radial Pulse → Control Bleeding → Immediate **RED**
    - Radial Pulse Present → **ASSESS MENTAL STATUS**
      - Can't Follow Simple Commands → Immediate **RED**
      - Follow Simple Commands → Delayed **YELLOW**

OAKLAND COUNTY EMS DISASTER MULTICASUALTY INCIDENT NOTIFICATION SHEET

OAKLAND COUNTY MEDICAL CONTROL AUTHORITY
Office: (248) 975-9704

Bonnie Kincaid	Trina Basaj
Cell: (248) 321-9320	Cell: (586) 855-8858
Home: (248) 793-3087	Home: (586) 329-3077

EMS Medical Director
Steve McGraw, D.O.
Office: (248) 849-3015 Pager: (248) 367-6391
Home: (313) 881-7071 Cell: (313) 930-5481

Medical Control Committee Chairperson
Rami Khoury, MD
Office: (248) 849-3331 Home(248) 960-6524

Medical Control Committee Vice Chairperson
Tressa Gardner, DO
Office: (248) 338-5339 Cell: (248) 310-4140
Pager: (248) 407-0686

Operations Committee Chairperson
Leo Chartier, Chief
Office: (248) 433-7745 Pager: (248) 312-2543
Home: (248) 681-4686

Criteria:
The Medical Control Board's primary concern is medical issues. For this reason:

1. The decision to activate the EMS Notification sheet will be determined by the online medical control physician. If the sheet is activated, the medical control physician or designee will proceed down the sheet until contact is made.

2. During an Oakland County disaster, when the Emergency Operating Center has been activated, the EMS Disaster Notification Sheet **must** be activated.

3. During any multi-casualty incident, when deemed necessary, the EMS Notification Sheet **may** be activated.

Dispatch Protocol

Background

As mandated under Public Act 179 of 1990, Section 20919 (1)(b): "A local medical control authority shall establish written protocols for the practice of life support agencies and licensed emergency medical services personnel within its region. The protocols shall be developed and adopted in accordance with procedures established by the department and shall include medical protocols to ensure the appropriate dispatching of a life support agency based upon medical need and the capability of the emergency medical services system."

The goal of EMS is to reduce death and disability arising from medical emergencies by providing rapid response by trained emergency medical personnel who can give stabilizing or definitive medical care to the patient at the scene of the emergency. The effectiveness of an EMS system depends upon the speed at which appropriate medical care can be provided to the patient. An Emergency Medical Dispatch program (EMD), which prioritizes EMS calls and provides pre-arrival instructions, can enhance the effectiveness of the EMS system. Additionally, the use of an EMD program will reduce the use of lights and sirens used by EMS personnel, which may reduce the risk to response crews and citizens.

The dispatcher plays a critical role within the EMS system. As the primary point of contact with the public, the dispatcher provides a channel for communications between the caller reporting the emergency and EMS. By communicating effectively with the use of an EMD program, the dispatcher may be able to reduce the frequency of death or the severity of disability.

Local municipalities shall determine, in accordance with the rules and regulations of their local Medical Control Authority, the level of agency licensure as well as who will provide ALS service in their area.

Protocol

A. 911 shall be utilized and will dispatch the closest appropriate vehicle.

B. Since ALS can provide optimal medical care and its delay can negatively impact patient outcome, in areas where ALS is available it shall be **simultaneously dispatched** to certain medical emergencies including, but not limited to:

   1. cardiac arrest
   2. chest pain
   3. drug overdose / poison
   4. altered mental status / unconscious
   5. allergic reaction
   6. difficulty breathing
   7. drowning or near drowning
   8. injury with bleeding or immobility
   9. seizures / convulsions
   10. diabetic reactions
   11. child birth
   12. burns

13. or as determined through prioritized dispatch developed through an approved EMD program by the American Society for Testing and Materials (ASTM).

C. All citizens shall have access to pre-arrival instructions through an Emergency Medical Dispatch program approved by the American Society for Testing and Materials (ASTM) by January 1, 2000. Examples of approved programs include, but are not limited to APCO's program or the Clawson / Medical Priority program.

Domestic Violence Screening Policy and Procedure

Purpose:
Domestic violence is a major healthcare issue. EMS, as the frontline of emergency care, is in a unique position to evaluate the scene and screen patients for domestic violence.

Policy:
Patients transported by EMS, over the age 14, will be screened for domestic violence by the EMS provider. Exceptions may be made for non-communicative, unstable patients and those applicable under category C. below (signals from patient / partner). Providers should consider relevance of Adult / Elder Abuse or Neglect and Child Abuse Protocols first in applying this protocol.

Screening Procedure:

A. Criteria for screening:
1. Patient must be alone, ideally in the back of the EMS vehicle (absolutely no family or friends present).
2. Question the patient in a nonjudgmental and supportive manner.
3. Because often there are no outward clues, routinely ask the screening question.

B. Screening Question:
"We are concerned with our patients' health and safety so we ask our patients this question: Are you in a relationship or situation in which you are being hurt—verbally, emotionally, sexually, or physically?"

If the patient answers yes, state: "We will let the hospital staff know to help you with the resources you need to end the violence."

If the patient answers no, state: "If you know of anyone in this situation, please let them know resources are available to help them."

C. Signals from patient/partner
1. Patient may minimize the extent of the violence by the partner.
2. Patient may seem inappropriately unconcerned about the nature and extent of injuries.
3. Patient may seem frightened, ashamed, evasive or embarrassed, and may avoid eye contact or close her eyes during the interview.
4. Patient may not speak when the partner is in the room.
5. Patient may not give a history that is consistent with injuries or there is a time delay between injuries and presentation.
6. When you ask a question of the patient, the partner may answer.
7. The batterer may exhibit outward hostility at you or the patient.
8. The batterer may insist on riding in the ambulance.

D. Documentation:

1. Document on the EMS run form the following:
    - Answer to screening question.
    - Anything suspicious at scene or with family/guardian*, including any signals from the patient/partner*.
    - Multiple runs on same patient.

E. Intervention/Reporting

1. Follow medical treatment protocols.
2. Report to emergency department staff upon arrival with written and verbal communication.

EMERGENCY FACILITY TELEPHONE NUMBERS

Hospital	Telephone #	Fax #	Recorded Line #
Botsford General Hospital	(248) 471-8566	(248) 615-7390	(248) 471-7273
Crittenton Hospital	(248) 652-5311	(248) 601-6025	(248) 601-6060
Genesys Regional Medical Center	(810) 606-5933	(810) 606-6381	(810) 606-6922
Henry Ford Medical Center-West Bloomfield	(248) 661-7150	(248) 661-6447	(248) 661-6450
Huron Valley-Sinai	(248) 937-4400	(248) 937-3306	(248) 937-4555
Michigan Orthopaedic Specialty	(248) 733-2303	(248) 733-2255	
North Oakland Medical Center	(248) 857-7257	(248) 857-6723	(248) 857-6719
POH Regional Medical Center	(248) 338-5332	(248) 338-5340	(248) 338-5369
Providence Hospital-Novi	(248) 465-4210	(248) 465-4889	
Providence Hospital-Southfield	(248) 849-4160	(248) 849-5431	(248) 849-5431
St John-Oakland	(248) 967-7661	(248) 967-7876	(248) 967-7656
St Joseph Mercy-Oakland	(248) 758-7000	(248) 858-3650	(248) 858-6660
William Beaumont-RO	(248) 898-7808	(248) 898-4671	(248) 898-4566
William Beaumont-Troy	(248) 964-8787	(248) 964-5068	(248) 964-5486

Updated: July 2008

Equipment

The patient-care equipment carried on BLS or ALS vehicles shall not exceed the state-approved minimum, without MCB authorization. The following equipment list must be carried unless stated otherwise. Each agency must choose a device type with their Base Hospital.

1. An ET detection device is mandatory equipment.
2. Kendrich-Type Extrication Device (KED).
3. Disposable ET Holder (ALS only).
4. Anterior-Posterior/Defibrillator Paddles (may be used in the Oakland County EMS System with the base hospital's approval, but usage must be reported to the MCB.
5. Broslow Pediatric Tape, or similar device.
6. Each life support vehicle that is dispatched and responding to provide medical first response life support, basic life support, or limited advanced life support shall be equipped with an automated external defibrillator.
7. The brand of automated defibrillators to be utilized must be approved by the FDA. Type approved by the State EMS Division.
8. Supraglottic Airway Device (SAD) as approved by local MCA protocol include:
   a. Combitube
   b. King LTS-D

State approved: December 10, 2007

Evidentiary Blood Draw Protocol (optional)

Purpose
OCMCA has provisions to allow Paramedics working for a licensed OCMCA agency, when requested by a law enforcement officer, who is in the possession of a search warrant duly signed by a magistrate or judge, and under the supervision and at the direction of medical control, to draw blood for the purposes of determining the presence of alcohol and/or drugs. If a patient presents with a medical condition, the General Prehospital Care protocol will be initiated.

Post-Radio
PARAMEDIC

1. Obtain blood draw kit from law enforcement officer and only use the provided contents within the kit for collection.
2. Sample shall be obtained in the presence of a law enforcement officer.
3. Do not use alcohol or alcoholic solutions to sterilize skin surface, needle or syringe.
4. Draw two tubes of venous blood from subject in presence of law enforcement officer, and tell the subject IN THE PRESENCE OF LAW ENFORCEMENT OFFICER that no alcohol was used in sterilizing the skin surface, needle, or syringe. Slowly invert blood collection tube(s) several times to distribute the sodium fluoride/potassium oxalate preservative.
5. Complete blood specimen label(s) by entering name of subject, date and time of blood collection, and your name in ink.
6. In the presence of subject, hand tube(s) of blood and label(s) to law enforcement officer for signing, packaging, and transfer to the laboratory.

State approved: December 10, 2007

Helicopter Transportation

Indications

To be used only if it will benefit the patient.

A. The speed of the transport from the scene to definitive care may have an impact on outcome.

B. When special equipment on-board the aircraft is needed.

C. When special skills and expertise of the flight crew is needed.

D. When search, rescue and transport of victims inaccessible by ground transport systems.

Contraindications

A. Unsafe weather conditions as determined by helicopter agency
   1. If the flight has been turned down for weather reasons by one agency a second agency will not be called

B. Any patient who represents a threat to the crew or operation of the aircraft:
   1. Radioactive exposure;
   2. Combative and unable to be restrained;
   3. Psychiatric disorder (suicidal ideation) that cannot be chemically restrained; or
   4. Non intubated prisoner

C. Patients who can be safely transported by an alternate method.

General Guidelines

A. Only Oakland County Medical Control Board approved air medical services can operate in Oakland County and may be requested.

B. Only Oakland County EMS and dispatch personnel, may request air medical transport.

C. Requesting Agency must have training in helicopter landing zone preparation and safety.

D. The Base Hospital Medical Control Physician (MCP) in concurrence with the on-scene ALS provider may cancel air medical transport at any time.

E. All requests for air medical transport will be reviewed by the PSRO Committee.

Procedure for Activation of Helicopter Transport

To be utilized **only** if it will benefit the patient.

A. Ground transportation will be dispatched simultaneously with the helicopter.

B. Advise on-line MCP as soon as possible, of helicopter request.

C. The patient will be transported to the nearest appropriate Emergency Facility according to the OCMCA transportation policy.

D. The helicopter's medical personnel must abide by the Medical Control Transport and Destination Protocols of the system requesting helicopter transport.

State Approved: May 3, 2005

Incident Investigation Procedure

Any altercations between EMS companies, EMT-P's or EMT-B's at the scene of a medical emergency will result in immediate investigation and possible suspension of EMS privileges by the EMS Medical Director.

Introduction
This policy presents the guidelines for documenting the circumstances involved in any "incident" occurring in pre-hospital care in Oakland County. The MCB has developed and implemented a QI Plan designed to reduce morbidity and mortality and improve the quality and appropriateness of the care provided its patients. Prompt and proper reporting of incidents is necessary for the MCB to accomplish the objectives set forth in its QI Plan.

Definitions
Incident: any occurrence not consistent with the policies and procedures established by the MCB and any dispute among participants of the EMS system.

Purpose
The documentation of incidents provides:

A. A complete, accurate and timely record of the circumstances involved in any incident.
B. A quality improvement tool to identify and evaluate the causative factors of each incident so that similar instance may be prevented or reduced to their lowest probability of occurrence.
C. The identification and evaluation of actual or potential life or health hazards, and facilitates implementation of corrective measures wherever indicated.

Format and Reporting Procedure

A. Incidents shall be reported to the Base Hospital EMS Physician, and a copy sent to the EMS Medical Director (via the MCA office).
B. Incidents may be reported verbally, but shall be submitted in written form within 72 hours.
C. The written incident report shall include the:
    1. complaintee;
    2. individual or agency registering the complaint;
    3. a narrative of the event(s) which precipitated the report; and
    4. identification of the policy or procedure believed to have been violated.
D. The EMS Medical Director may be contacted directly (via the MCA office) if:
    1. there is no base hospital; or
    2. the base hospital is the complaintee.
E. The EMS Medical Director, at his/her discretion, may entertain incident reports, which do not conform to the above formatting, or reporting procedure.
F. The MCA office will assign an incident report number.

<u>Serious</u> Incident Investigation and Resolution Procedure

If an incident is of such a serious nature that continued participation in the EMS system by the involved individuals or organization poses a significant risk to patient safety, and/or is otherwise covered in the definition of the EMS Medical Director responsibilities, and there is reasonable evidence that the complaint has merit:

A. The EMS Medical Director may order the immediate temporary suspension of the privilege to participate in the EMS System of the accused hospital, EMS operator and/or EMS personnel.
   1. The EMS Medical Director must notify the EMS Division of revoked privileges in accordance with PA179.

B. The EMS Medical Director then immediately appoints a panel as described above which:
   1. Conducts any necessary further investigation to obtain any information required before a hearing.
   2. Conducts a hearing.

C. The panel concludes the hearing with a decision:
   1. Suspension terminated and organization or individual reinstated.
   2. Suspension terminated and organization or individual reinstated with appropriate conditions imposed.
   3. Suspension continued and appropriate further action ordered.

D. The EMS Medical Director initiates the action ordered by the panel.

<u>Standard</u> Incident Investigation and Resolution Procedure

The Base Hospital EMS Physician or EMS Medical Director shall conduct a preliminary investigation to determine validity of complaints, and dismiss any found to be without merit within ten business days. If the complaint warrants further investigation or action, the Base Hospital EMS Physician or EMS Medical Director shall follow one of two courses, except in those instances outlined in the "Serious Incident Investigation and Resolution Procedure" section.

A. The Base Hospital EMS Physician or EMS Medical Director refers the matter;
   1. to the hospital's administrative representative and/or E.F. Director, as appropriate, if complaintee is a hospital; or
   2. to the agency's administrative head and to the E.F. Director of the agency's base hospital, if complaintee is an EMS agency or personnel.

B. The agency or hospital investigates the matter and reports back to the Base Hospital EMS Physician with a copy sent to the EMS Medical Director.
   1. The report will:
      - Be in writing;
      - Outline the steps taken in conducting the investigation;
      - Detail the conclusions drawn from the investigation; and
      - Outline action planned for the resolution of any problems revealed by the investigation.

C. The EMS Medical Director retains the right to remain personally involved in the investigation process.

D. Corrective action is taken by the hospital or EMS agency according to its own internal policy, and with the EMS Medical Director, and the Base Hospital EMS Physicians concurrence.

E. A follow-up report must be submitted to the Base Hospital EMS Physician and the EMS Medical Director when a resolution has been decided and when the proposed action has occurred.

F. If a report received from the investigating agency or hospital is unacceptable, and discussion with the hospital or agency fails to resolve the conflict, the EMS Medical Director may:

1. elect to resolve the issue; or
2. appoint a panel to further investigate the matter. The EMS Medical Director will notify the involved agency, hospital, or individuals of his/her decision before proceeding.
   - The panel is to consist of four persons:

     a. a Base Hospital EMS Physician of a base hospital not involved in the incident;
     b. a second EP from a different hospital as selected by complaintee, from the MCB;
     c. a third member, as appropriate and determined by the professional category of the complaintee and chosen from another organization; and
     d. the administrative head, or his/her designee, of that service or hospital against whom the complaint has been made (non-voting).
3. The EMS Medical Director sets the date by which the case is to be reviewed and a report submitted. Maximum of ten business days.
4. The panel investigates the incident utilizing, as appropriate:
   - Review of records
     a. EMS Reporting Forms
     b. Emergency Facility EMS Records
     c. Emergency Facility Chart
     d. Tapes
   - Interview of any personnel involved
5. The subjects of the investigation shall be invited to attend meetings of the panel.
6. Panel develops a conclusion regarding the incident and reports to the EMS Medical Director in writing.

Whenever deemed appropriate, actions taken as a result of an investigation will be carried out according to the following process:

A. If complaintee is hospital or hospital personnel.

1. If a problem is with personnel, corrective action is taken by the hospital according to the hospital's personnel policies/procedures.
   - EMS Medical Director is notified of action intended.
   - EMS Medical Director is notified when action has been completed.

2. If problem is with the performance or policy of the hospital or its Emergency Department, notification is made in writing to the EMS Medical Director of the steps planned to correct the problem.
   - A follow up report is made to the EMS Medical Director when the problem has been corrected. The EMS Medical Director sets the date by which this must be done.

B. If compliantee is an EMT or EMS agency.
   1. If the problem is with EMS personnel:
      - Corrective action is taken by the employer according to the policies/procedures of the agency (employer).
        a. EMS Medical Director is notified of action intended.
        b. EMS Medical Director is notified when action has been completed.

C. If the EMS Medical Director disagrees with the intended action, he/she retains the right to discuss it with the administrative representative of the EMS agency or hospital.

D. Appeals
   1. Appeal of decisions made by the EMS Medical Director may be made by any party in an incident to the QI Committee. Further appeals may be made to the MCB. Such appeals must be in writing, must be sent to the EMS Medical Director in addition to the Chairperson of the MCB.

   2. Appeals must be heard within one month of the decision of the EMS Medical Director and/or panel.

Incident Review Procedure

A. Incidents, once investigated and resolved, will be reviewed by the QI Committee and presented by the EMS Medical Director.

B. Incidents will be reported to the MCB in a blinded format for information.

IV Policy

Southeastern Michigan (SEM) Regional ALS Intravenous Solutions and Supply Exchange and Replacement Procedure (For: Oakland, Western Wayne, Washtenaw, Livingston, Lapeer and Genesee Counties)

Vehicle Stock

A. Each approved ALS unit will be initially provided with three (3) IV start kits by their base hospital pharmacy. (See Appendix 1 for contents) Once initially stocked, kits assembled according to the approved contents list in any participating zone may be utilized in other participating zones.

B. Each EMS provider will be responsible for providing any additional equipment required by Michigan Department of Consumer and Industry Services (MDCIS) – EMS division.

C. All IV solutions, needles, syringes, and supplies will be stored in a securely locked; temperature controlled location on each approved ALS unit. IV kits will remain sealed at all times except when in use.

D. IV start kits are to be inspected daily by the crew of the unit for evidence of loss, theft, discrepancy, and expiration date. It is recommended that this inspection be included in a standard documented vehicle checklist.

Use / Replacement / Exchange

A. IV start kits will only be opened by a paramedic when presented with a patient requiring advanced life support care and/or IV therapy and then only when acting on written or transmitted orders from a physician at an appropriate on-line medical control facility or pre-contact provisions of approved treatment protocols.

B. All participating facilities will supply IV kits with contents as approved by the participating medical control authorities, available for replacement of supplies used by approved ALS providers. Replacement IV kits will be available within the hospital pharmacy or emergency centers of the participating hospital. (24 hrs/day, 7 days/wk) Appropriate record keeping and security measures are required at each exchange site to ensure that only appropriately licensed and authorized personnel have access to IV solutions, and other related supplies.

C. Oakland County provides an IV Ancillary Supply Exchange List. All items used and on the list may be picked up in the emergency center for all OCMCA participating facilities.

D. IV kits used by the approved EMS units for patients transported will be replaced, at the time of the run, by the receiving hospital according to established procedure. If the receiving facility
does not participate in the regional EMS medication system and medications / IV supplies are expended for the patient who is transported, the unit will then proceed to the regional participating hospital which initiated care to complete replacement.

E. Use of any IV fluids contained in the IV start kits will be documented on the EMS run report of the patient for whom the supplies were used. (This includes any medications / IV solutions prepared for use but not actually administered to the patient, such as failed IV attempts, etc.)

F. All empty containers and packaging and used materials will be properly disposed of by the EMS crew which used the IV start kit.
   1. If there is blood or body fluid contamination to any unused materials or packaging, the EMS crew will clean and dispose of contaminated material per protocol.
   2. All unused, un-contaminated supplies will be returned to the IV kit package.

G. The EMS crew will complete the approved IV Ancillary Supply Exchange List provided for any IV solutions used. That form, accompanied by a copy of the EMS run report, shall serve as a permanent medical record of IV solutions administered.

H. The EMS crew is responsible for proper distribution of the completed forms.

Expiration of Solutions

A. All items in an IV kit will have expiration dates not less than 90 days after the kit is prepared.

B. Any unused items bearing expiration dates less than 90 days shall be removed from the kit and replaced with new stock as described in (A) above.

C. IV kit will have a label securely attached to the outside containing the following information:
   1. The name of the participating hospital pharmacy that assembled the IV kit.
   2. The date the kit was restocked.
   3. The printed name and initial of the pharmacist who checked the kit.
   4. The expiration date is the last day of the month of the earliest expiring medication. The label will include the month/day/year.

   IV KITS: When completely stocked and assembled, the label (as described on prior page) will be attached to the outer plastic bag in a tamper evident manner.

Discrepancies

A. For purpose of this policy an "discrepancy" is any breakage, expiration, shortage, theft, or diversion of an IV start kit, or any contents thereof.

B. A standard "medication incident report" will be completed each time a discrepancy occurs. The form should be initiated by the person(s) who discovered the discrepancy and investigated to the fullest capacity by that person(s). EMS personnel or hospital staff may fill out this form.

C. Copies should be sent to the hospital pharmacy involved, (if applicable), the Medical Control Authority in which the discrepancy occurred, and the chair of the MCA pharmacy committee.

D. A copy of the EMS run form, for which the discrepancy occurred, is to be attached to each copy of the discrepancy report where applicable.

State Approved Protocol: March 9, 1999

APPENDIX 1
Oakland County

IV Start Kit Contents:

One (1) 0.9% Sodium Chloride 1000ml
One (1) IV tubing set with Y site pre-pierced and reseal Macro-drip tubing

**All other IV ancillary supplies and equipment will be provided by Oakland County EMS agencies and exchanged item for item as needed to replenish stock. (See attached list)

OAKLAND COUNTY EMS MEDICAL CONTROL AUTHORITY
IV Ancillary Supply Exchange List

Agency: ______________________ Unit #: ______________________

Incident #: ______________________ Hospital: ______________________

IV ANCILLARY SUPPLIES	QUANTITY USED
NaCl 1000ml	
Macrodrip tubing (with y site pre-pierced reseal)	
Mini-drip tubing (10-20 gtt/ml) (with y site prepierced reseal).	
Extension Set (with y site prepierced reseal).	
14g angiocath	
16g angiocath	
18g x 1 ¼″ angiocath	
20g x 1 ¼″ angiocath	
22g x 1″ angiocath	
24g x ¾″ angiocath	
IO Needle (upon request only)	
18g x 1 ½″ needle	
21g x 1 ½″ needle	
Syringe 1cc w 25g x 5/8″ needle	
Syringe 3cc w 22g x 1 ½″ needle	
Syringe 5cc without needle	
Syringe 10cc without needle	
Saline Lock	
Saline Flush	
Red top blood tube	

Complete ALL Information

Date: ______________________ Patient's Name: ______________________

Patient's Address: ______________________

Paramedic's Name: ______________________
Please Print Clearly

Updated: October 31, 2007

Physician On Scene Policy

By law, unless there is an existing doctor/patient relationship, the **Medical Control Physician** is responsible for the care of the patient.

A. A physician on the scene may assist in the management of the patient at the paramedic's discretion.

B. The medical control physician should be contacted when:
   1. The patient's immediate needs are addressed or
   2. When the paramedics become uncomfortable with the scene physician's assistance.

C. The conversation with the medical control physician should include the scene physician when:
   1. The scene physician would like to talk with the medical control physician **and/or**
   2. The paramedics are uncomfortable with patient management desired by the scene physician.

D. Depending on the conversation, patient care management may be transferred to the scene physician or maintained by the medical control physician at his or her discretion.

E. If the on-scene physician assumes responsibility, he should accompany the patient to Emergency Facility, unless cleared by medical control, and sign the EMS Medical Report Form (Run Sheet).

Refusal Of Care/Transportation Policy

This policy is to be utilized if a patient, or minor patient's responsible party, refuses emergency care at the scene or ambulance transportation to the hospital from the scene. If order to refuse, the patient, or the minor's parent or guardian, must appear competent ** to medical personnel at the scene.

A. Clearly explain to all concerned the nature of the illness/injury.
B. Explain indications for emergency care or transport.
C. Explain possible complications that could arise without proper care or transport.
D. Request that the responsible individual signs a statement that service is refused on the EMS Refusal of Care/Transportation Form and witness the document. If the individual refuses to sign the refusal form, document and witness the refusal to sign form.
E. Record assessment and discussion with all concerned on the Oakland County EMS Refusal of Care/Transportation Form. Take care to note the mental status of the patient, or responsible individual, on the EMS Run Form.
F. File the EMS Refusal of Care/Transportation Form according to your agency's internal protocol.

NOTE: Medical control contact must be made in all cases in which medical care has been provided or in which the EMS provider feels that a refusal of care or transportation might compromise the patient's health or welfare or the patient meets the requirements of 1-3 on the Refusal of Care/Transportation Form.

*** A competent individual is one who is awake, alert, oriented and does not appear under the influence of alcohol, drugs or other intoxicants, does not appear to have experienced an illness/injury which may interfere with mental functioning and appears to be capable of understanding the circumstances of the current situation.

Updated Protocol: State approved June 24, 1997

Rerouting

Patients exhibiting uncontrollable problems in the field will be accepted by the closest appropriate emergency facility, regardless of the facility's rerouting status. Critical patients will be accepted by the closest appropriate emergency facility when transportation to a more distant facility could pose further significant risk to the patient. Serious but stable patients may be rerouted by an on-line medical control physician.

A. If all area emergency facilities are rerouting, then the EMS facility's rerouting status will not be honored and the patient will be transported to the closest appropriate emergency facility.

B. If the three closest facilities to the incident are all Status C, or all on similar status, the unit should contact the closest facility for transport to that facility. The on-scene EMS crew will determine the three closest facilities. Priority one patients, and patients deemed unstable by the EMS crew, will be transported to the closest appropriate facility, regardless of that facility's status.

C. It is the responsibility of the emergency facility to use the following categories to indicate rerouting status:

STATUS A: Accepting patients appropriate for that emergency facility.

STATUS B: Emergency facility's capabilities are limited. Services or resources not available should be specified, and that facility's use avoided for patients requiring them.

STATUS C: The emergency facility is so inundated with patients that it cannot adequately accept further patients.

D. Emergency facilities will accept priority 1 or 2 patients transported by BLS units, regardless of their rerouting status, unless that facility is in a declared disaster mode.

E. If the EMS personnel believe that the ordered reroute will be harmful to a patient, that patient may be transported to the contacted facility.

F. Facility
1. The decision by a hospital to reroute patients should be made by the emergency facility director, or his/her emergency physician designee. The emergency physician should consult with nursing, administrative, and/or with the directors of specialty units as individual circumstances dictate.
2. Patients will not be rerouted on the basis of ability to pay.

3. The decision to reroute a patient will not be based on a previous relationship with a particular institution, except where it would impact the patient's emergency care.

4. On-line medical control, via participating Medical Control hospitals, will remain available at all times.

G. Rerouting Communications

1. Communication with emergency facilities under **STATUS B**:
   EMS units may communicate with the closest appropriate emergency facilities, **if**:
   - Patient or family insists on a facility that would normally be an appropriate destination. In some cases, the on-line medical control physician may communicate with the patient/family.
   - BLS unit with Priority 1 or 2.
   - ALS unit with Priority 1.

2. Communication with emergency facilities under **STATUS C**:
   The Emergency facility is overburdened. It is suggested that contact with this facility not be made, except under exceptional circumstances. Transportation to and communication with, that facility may not be advisable. Other options should be considered.

3. Interhospital/Facility notification once communication has been established:
   Once communication with a facility under **STATUS B or C** is made, and a decision has been made to transport to another facility, the first facility called will communicate with the anticipated receiving facility.

Restraints Policy

The use of restraints should be reserved for patients believed to be a threat to themselves or others, and for patients who require medical treatment who are believed to be incompetent based upon the MCB Refusal of Care Policy. Restraints are not to be used as a substitute for patient surveillance. The EMS provider should seek medical direction whenever possible. If the restraining activities possess undue safety risk to EMS personnel, they should be abandoned pending assistance from law enforcement agents.

Procedure

A. Assess the scene and patient. Determine if the patient poses a risk to self, others, and/or personnel.

B. Contact on-line medical control to request further direction. The on-line physician will assist the provider in making a decision as well as in deciding the most appropriate type of restraint for the situation.

C. Request assistance and cooperation from law enforcement agencies.

D. If the situation permits, attempt to document informed consent by any significant other(s), that understand(s) and agree(s) regarding the need for restraining the patient (preferably written, but at least verbal).

E. Follow specific protocols from your agency addressing the type of restraints available.

F. Transport the patient expeditiously after being restrained. Avoid unnecessary delays.

G. Assure restraints don’t compromise the patient’s airway, breathing, or circulation.

Updated Protocol: State approved June 24, 1997

Scene Patient Management

Public Act
Authority for the management of a patient in an emergency is vested in the licensed health professional or licensed emergency medical services personnel at the scene of the emergency who has the most training specific to the provision of emergency medical care. If a licensed health professional or licensed emergency medical services personnel is not available, the authority is vested in the most appropriately trained representative of a public safety agency at the scene of the emergency.

NOTE: No other individuals (police, fire, other physician) shall be allowed to determine patient destination without prior approval from the on-line medical control physician providing medical control.

Transfer to Another LSU
A Basic Life or Advanced Life Support unit may transfer patient management or another life support unit of equal or greater qualification by mutual agreement.

Multiple Unit Response
Second responding Advanced Life Support and Basic Life Support units are responsible to assist in patient care until released by the managing Advanced Life Support Unit.

"Call Jumping" as defined by Statute, is a State and Federal violation of EMS Law and will be dealt with accordingly and reported to the appropriate agency.

Extended Care Facilities (NH)
Once an EMS unit is on the scene, management of the patient shall be according to Oakland County policy with respect to patient care, communication and transportation.

Time Synchronization Standard

Purpose: To provide accurate and uniform time information for documentation and quality improvement purposes.

Policy: The national atomic clock operated by the United States National Institute of Standards and Technology (NIST) will be used as the uniform time synchronization tool throughout the Oakland County Medical Control Authority. All agencies' and emergency departments' equipment and personnel time pieces will be synchronized to the NIST. Standard synchronization checks will be made of all agencies equipment by that agency.

Policy Detail:

1. Access to a NIST atomic clock is available via the internet at http//:www.time.gov. This site provides a snapshot time. That is, the time display is static and must be manually updated by clicking onto "update now" button. Synchronization to the NIST will be no more than 30 seconds variations.
2. Agency/facility equipment synchronization will be attempted every week at a designated time. Equipment includes, but is not limited to dispatch clocks, digital tape recorders, computers, cardiac monitors, AED, personal radios, EMS rigs, pagers wall/table/standing clocks, and cell phones.
3. Personnel watch synchronization will be the responsibility of the individual providers/workers.
4. Daylight-saving time changes will be made at 0200 on the appointed dates.

State approved: August 10, 2006

Transportation Protocol

I. Transportation Procedure

Patients will be transported to an Appropriate Oakland County Emergency Facility (see D.1) of the patient's or patient's family choice, unless any of the following conditions exist:

A. **Unstable Patients** – Unstable patients are not appropriate for free–standing facilities unless, in the opinion of the EMS personnel or on-line medical control physician, transporting the patient to a further facility could have an adverse effect on the patient's outcome.

1. **Unstable Medical Patients** – will be transported to the closest appropriate approved Oakland County Emergency Facility (see D.1).

2. **Unstable Trauma Patients (Adult & Pediatric)**

a. Patients meeting any of the following trauma guidelines, **but not in cardiac arrest,** in most cases should be transported to a Trauma Center (see D.2.a.). Pediatric trauma patients should be transported to a Pediatric Trauma Center (age ≤ 13 yrs) (see D.2.b.):

- Glasgow coma scale ≤ 13 with multi-system trauma
- Systolic blood pressure < 90 (pediatric = <70 + 2 times age)
- Paralysis
- Flail chest
- Two or more proximal long bone fractures
- Amputation proximal to wrist or ankle
- Crushed, degloved or mangled extremity
- Penetrating injuries to head, neck, torso and extremities proximal to elbow and knee.
- Falls > 20 feet.
- Ejection from moving vehicle.
- Death in same-passenger compartment.

b. Trauma patients that **do not** meet the trauma guidelines set above shall be transported to the closest appropriate Intermediate Level Hospital or Trauma Center (see D.2.d.).

c. In cases of isolated head trauma and a Glasgow coma scale of ≤ 13 EMS personnel must contact the closest facility for medical direction and patient destination determination.

State approved: December 10, 2007

3. **Trauma Special Considerations**
   Trauma patients meeting the following criteria should be transported directly to the appropriate specialty facility (see D.2) unless other patient condition needs supersede (e.g. unstable, ST elevation, etc.), or on-line medical direction determines otherwise:
   a. Amputations – follow trauma guidelines
   b. Burns – No divert criteria. Transport to closest appropriate facility
   c. Pregnancy – Transport to a Trauma Center with neonatal capability (see D.2.c.)
      - > 20 weeks with multisystem trauma.

B. Stable Patients –

1. **Stable Medical Patients –** If no preference, transport to the closest approved Oakland County Emergency Facility (see D.1).

2. **Stable Trauma Patients**
   a. Injured patients not requiring transportation to a trauma center will be transported to the closest appropriate Intermediate Level Hospital (see D.2.d).
   b. Only patients with minor injuries (e.g. injured ankle from stumble, injured wrist from a fall, uncomplicated elderly hip fractures, etc.) may be transported to a Treat and Transfer Facility (see D.2.e).

C. Acute ST Elevation Myocardial Infarction

Patients with presumed acute myocardial infarction based upon the following cardiac guidelines, in most circumstances will be transported to an interventional cardiac center (see D. 3).

- 12 Lead EKG with ≥ 1 mm in 2 contiguous leads.

D. Facility Designations -

1. The following approved emergency facilities are defined as **appropriate** by the Oakland County Medical Control Authority. Note: Unstable patients are not appropriate for free–standing facilities unless, in the opinion of the EMS personnel or on-line medical control physician, transporting the patient to a further facility could have an adverse effect on the patient's outcome.
   - Botsford General Hospital
   - Crittenton Hospital
   - Genesys Regional Medical Center
   - Huron Valley – Sinai Hospital
   - Michigan Orthopaedic Specialty Hospital
   - North Oakland Medical Center
   - POH Regional Medical Center
   - Providence Hospital – Southfield
   - Providence Hospital – Novi (Free Standing)

- St. John – Oakland Hospital
- Henry Ford WB (Free Standing)
- St. Joseph Mercy Hospital
- William Beaumont Hospital – Royal Oak
- William Beaumont Hospital – Troy

2. Trauma Designations -
   a. Trauma Centers (A hospital verified ACS 1 or 2)
      (i) Oakland County Trauma Center
      - Genesys Regional Medical Center
      - William Beaumont – Royal Oak
      - POH Regional Medical Center

      (ii) Out-of-County Trauma Centers
      - Hurley Hospital – Flint
      - St. Joseph – Ann Arbor
      - DMC Receiving Hospital – Detroit
      - Henry Ford Medical Center-Detroit
      - University of Michigan

   b. Pediatric Trauma Center
      (i) Oakland County
      - William Beaumont – Royal Oak

      (ii) Out-of-County
      - Hurley Hospital – Flint
      - Children's Hospital – Detroit

   c. Trauma Center with Neonatal capability
      (i) Oakland County
      - William Beaumont – Royal Oak

      (ii) Out-of-County
      - Hurley Hospital – Flint
      - Children's Hospital – Detroit
      - St. Joseph – Ann Arbor
      - UM-Mott

Note: The patient will be transported to the closest appropriate Trauma/Specialty Centers. EMS personnel, taking into account distance, weather, construction or time of day will determine destination. If destination is an out-of-county Trauma Center, contact the Base Hospital who will notify the Trauma Center.

   d. Intermediate Level Hospitals (A healthcare facility with dedicated surgical capabilities 24/7, but not recognized by ACS as a Trauma Center)
      - Botsford General
      - Crittenton

- Huron Valley Sinai
- North Oakland Medical Center
- Providence – Southfield
- St. John – Oakland
- St. Joseph Mercy – Oakland
- William Beaumont—Troy

e. Treat and Transfer Facilities (A hospital without dedicated surgical capabilities 24/7)
- Henry Ford WB
- Providence – Novi

3. Interventional Cardiac Designation
Interventional Cardiac Centers (ICC): Hospitals with 24/7 interventional cardiac catheterization labs.

a. Oakland County ICC
- Botsford General Hospital
- Crittenton Hospital
- Genesys Regional Medical Center
- Huron Valley-Sinai Hospital
- Providence Hospital-Southfield
- St. Joseph Mercy-Oakland
- William Beaumont Hospital-Royal Oak
- William Beaumont Hospital-Troy

b. Out-of-County ICC
- DMC Receiving Hospital
- Henry Ford Medical Center-Detroit
- McLaren Regional Medical Center
- St. Joseph-Ann Arbor

E. Utilization of Alternate Facilities – with approval from an Oakland County on – line medical control physician, medically stable patients may be transported to a hospital outside of Oakland County not listed in D.1.

II. ALS Intercept Procedure

When a transporting BLS Agency responds to an EMS request and subsequently initiated patient transport to a receiving Hospital, and an ALS Agency has been simultaneously dispatched to the same EMS request, ALS intercept will only occur:

1) when ALS intercept would probably result in an improved patient care outcome.
2) with Medical Control approval
3) when requested by the transporting BLS Agency.

III. Inter-County EMS Response and Transporting Procedure

A. In the pre-hospital setting, emergency medical services situations occurring in proximity to a county line are the responsibility of the Medical Control Authority in-which the situation occurred. As such, the responding EMS unit will contact and abide by that Medical Control Authority's policies and protocols.

B. Patients who access the EMS System as emergencies may be transported outside the Oakland County System, with approval of the on-line Medical Control Physician.

IV. Inter- Hospital Transfer Procedure

A. State and Federal Guidelines and laws will be followed for the transport of patients between hospitals and facilities.

B. The transferring physician is responsible for securing the acceptance of the patient by an appropriate physician at the receiving facility. In addition, the transferring physician is medically responsible for the patient until the receiving facility assumes responsibility via online medical control or receiving of patient. The name of the accepting physician must be included with the transfer orders. In addition, during transport, the transferring physician and EMS agency (within their scope of practice) are responsible for patient care unit arrival at the receiving facility.

C. The transferring physician will determine method and level of transport and what additional treatment(s), if any, will be provided during transport. Orders for treatment, including medications, ventilator settings etc., shall be provided in written form to the EMS personnel prior to initiation of the transport by the transferring physician. Ordered medications not on the Regional Drug Box list must be supplied by the transferring physician. Additional medications not used during transport shall be returned to the staff receiving facility.

D. Should the patient be unstable or require medication beyond the normal scope and training of the EMS personnel, the transferring facility shall provide appropriate staff, or discuss other appropriate means of transport.

E. In the event the patient requires medications available in the Regional Drug Box, EMS personnel may make available those medications. Drugs utilized from the Regional Drug Box will be administered by physician direction, or in accordance with the Oakland County EMS Medical Control Authority Protocol.

F. EMS prehospital on-line medical control will function as safety net for unanticipated events, which may occur during patient transport.

State approved: December 10, 2007

Use Of Lights and Sirens

Purpose
To provide a countywide policy on the appropriate use of lights and sirens.

Procedure

A. Michigan Motor Vehicle Code (Sections 257.603 and 257.653) , the Michigan Motor Vehicle Code governs the driving of emergency vehicles. All Oakland County EMS Agencies will abide by the Michigan Motor Vehicle Code.
(The appropriate sections of the code are attached as a reference for this protocol.)

B. Responding to Calls
1. EMS units may respond to requests for service with lights and sirens where there is:
   - a threat to life
   - a threat to limb
   - a threat of personal injury
   - an unknown situation
2. Where Emergency Medical Dispatchers (EMD) and/or a tiered EMS response are/is available, the EMS Agency is encouraged to develop procedures that reduce unnecessary use of lights and sirens. The procedures may include, but are not limited to, the use of established EMD call screening protocols and evaluation of the scene/patient by first responder personnel.

C. Transporting a Patient
1. EMS units may transport patients with lights and sirens when **(Please see Patient Triage, for definitions of each Priority)**:
   - the patient is determined to be a priority 1 patient.
   - the patient is determined to be a priority 2 patient **AND** their condition is unstable during the course of the transport the patient becomes violent.
   - the patient is a stable priority 2 or priority 3 when transport is initiated, but the patient's condition deteriorates en route to the hospital.
2. Priority 3 patients will **NOT** be transported with the use of lights and sirens.

D. Returning from the transport, returning to a service area.
1. EMS units may ONLY utilize lights and sirens to return to their area **IF THEY ARE RESPONDING TO AN EMERGENCY CALL** as described in B. above.
2. Lights and sirens will NOT be used to return to an area when the unit is not responding to another emergency call.

E. Agency Specific Policies
This policy does not preclude individual agencies from developing internal policies on this subject, as long as the policy include the contents of this policy as a minimum.

State approved August 19, 1997