Transportation Protocol

Purpose: To define the decision-making process to be followed by EMS personnel in order to ensure patients are transported to a facility appropriate for their condition.

I. Transportation Procedure
   A. Priority 3 patients (medical or trauma): Shall be transported to an appropriate Emergency Facility of the patient’s or patient’s family choice, or closest if no preference.
      • Patient Priority is defined in the Patient Prioritization Protocol 8.24 for criteria.
      • For psychiatric emergencies, transport patient to the closest facility per the Psychiatric Emergencies Protocol 1-8.

   B. Priority 1 and 2 (medical) Patients: shall be transported to the closest appropriate Emergency Facility, unless one of the following conditions exist:
      1. ST Elevation Myocardial Infarction (STEMI) - Acute
         Patients with presumed acute myocardial infarction shall be transported to an interventional cardiac facility. Notify receiving hospital, as soon as possible, of impending arrival of a “STEMI ALERT” patient and give ETA.
         • See Chest Pain/Acute Coronary Syndrome Protocol 5.5 for STEMI criteria.
      2. Return of Spontaneous Circulation (ROSC)
         Patients with ROSC, in most circumstances will be transported to an interventional cardiac facility. Notify receiving hospital, as soon as possible, of impending arrival of the patient and give ETA.
      3. Burns
         After receiving approval from the medical control hospital, transport to the closest appropriate facility. Notify destination hospital as soon as possible of impending arrival of the patient and give ETA.
         • See Burns Protocol 2.3 for criteria.
      4. Stroke
         If Cincinnati Stroke Scale is abnormal, notify receiving hospital as soon as possible of impending arrival of a “STROKE ALERT” patient, with the time the patient was “last seen normal” and give ETA. Transport to closest appropriate stroke facility.
         • See Stroke Protocol 3.2 for criteria.
      5. Obstetrical
         Pregnancy greater than 20 weeks, transport to an OB facility. Notify receiving hospital, as soon as possible, of impending arrival of the patient and give ETA.
         • See Obstetrical Emergencies Protocol 4.2 for criteria.
      6. Pediatrics (medical)
         Transport after receiving approval from the closest appropriate facility. Notify hospital as soon as possible of impending arrival of the patient and give ETA.
         • See associated pediatric protocols for criteria.
C. **Priority 1 and 2 (trauma) Patients:** Patients meeting any of the trauma criteria listed below, should be transported to a trauma center.

- Pediatric trauma patients should be transported to a Pediatric Trauma Center (age ≤ 14 yrs.).
- OB trauma patients should be transported to a trauma center with OB capabilities.

II. **Trauma Criteria**

**Criteria for Transport to Level 1 and 2 Trauma Centers Only:**

**Vital Signs**

- Glasgow coma scale ≤13
- Systolic blood pressure < 90 mmHg
- Respiratory rate < 10 or > 29 breaths per minute: Infant < 20; aged < 1 year, or need for ventilatory support

**Anatomy of Injury**

- All penetrating injuries to head, neck, torso and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g., flail chest)
- Two or more proximal long bone fractures
- Crushed, degloved or mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fractures
- Paralysis

**Criteria for Transport to a Level 1, 2 or 3 Trauma Center**

**Mechanism of Injury**

- Falls
  - Adults >20 feet (one story is equal to 10 feet)
  - Children >10 feet or two to three times the height of the child
- High-risk auto crash
  - Intrusion, including roof: >12 inches occupant site; >18 inches on any site
  - Ejection (partial or complete) from the automobile
  - Death in the same passenger compartment
  - Vehicle telemetry data consistent with a high risk of injury
- Auto vs. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact
- Motorcycle crash >20 mph

**Special Considerations**

- Older adults:
  - Risk of injury/death increases after 55 years
  - SBP <110 might represent shock after age 65 years
  - Low impact mechanisms (e.g. ground level falls) might result in severe injury.
• Children:
  Should be triaged preferentially to pediatric-capable trauma centers

• Anti-coagulation and bleeding disorders
  Patients with head injury are at high risk for rapid deterioration

• Burns
  Without other trauma mechanism: triage to a burn facility
  With trauma mechanism: triage to a trauma center

• Pregnancy >20 weeks (with OB/Neonatal Capabilities)

• EMS provider judgment

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.

Note: Requests for transport to hospitals outside of the OCMCA, based on provider discretion and when medically appropriate, may be honored. For questions, contact online Medical Control.

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
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 operate under their home MCA protocols.