

Administrative Protocols Introduction	Lorain County EMS Protocols Revised 6/29/2006
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Members of the Lorain County EMS Council Protocol Committee have revised the Lorain County Protocols 2003. Lorain County EMS Council has adopted the following Protocols for use in Lorain County. If you have any questions about the use of these Protocols, please refer them to your Medical Director. If any Protocol errors are noted, please forward them to Lorain County EMS Council, 322 N. Gateway Blvd., Elyria, OH 44035. Any errors in grammar should be forwarded to Lorain County EMS Council in writing via mail or e-mail at lthanmer@alltel.net.

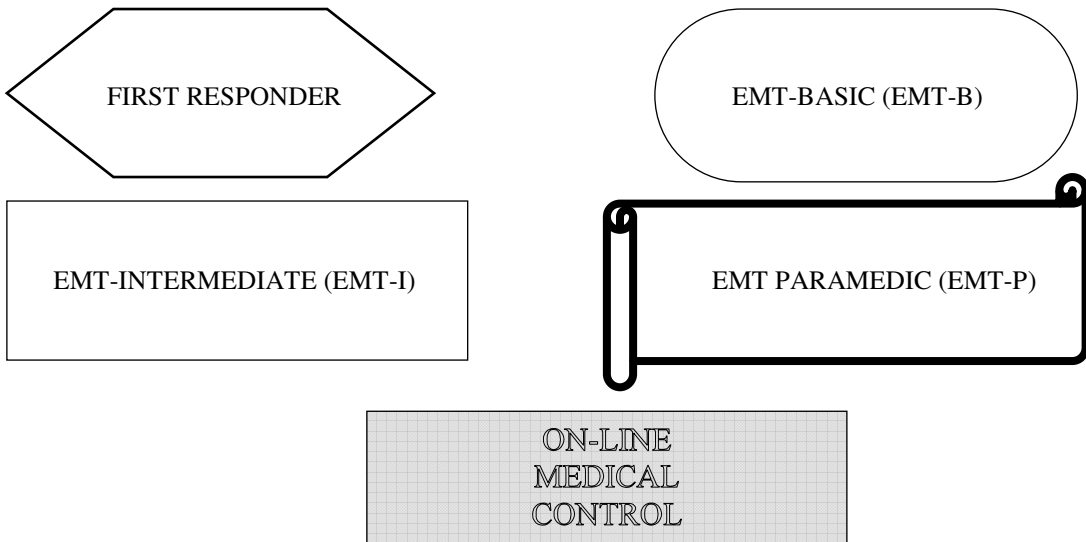
Although not identical, these Protocols are derived from the Ohio State EMS guidelines. **These Protocols must be readily accessible to all EMS providers whom belong to an EMS Agency.** A copy of the protocols can be purchased from Moos Printing. Moos Printing is aware of the styles of protocol books and a simple phone call is all that is needed. The protocols will be delivered by Moos Printing to your station. All billing will be handled between the EMS Agency and Moos Printing. Other printing companies may be used. You will need to take your CD-Rom to your own individual printing company of your choice.

The bottom of the page shows when the current version was printed. Older versions are obsolete with the following exception; EMT-Intermediates whom have not completed the Intermediate Transitional Course to the State of Ohio EMT-Intermediate '99 must use the Lorain County Protocols 2003.

All algorithms are shape coded to denote procedures, which may be performed by each level of certification. To perform shaded procedures, Medical Control must be contacted.

Higher levels of certification will perform lower level evaluations and procedures when interpreting the algorithms.

KEY TO ALGORITHMS



Administrative Protocols
Air Ambulance Transport

Lorain County EMS Protocols
Administrative Protocol 1
Revised 11/15/2005

1. PURPOSE

- 1.1. To define how the on-scene Incident Command (IC) should request an Air Ambulance to the scene of an emergency incident. With the mixture of public fire, EMS and private EMS systems in Lorain County, this procedure will identify a countywide standard operating guideline.

2. DIVISIONS AFFECTED

- 2.1. All Lorain County Fire Departments
- 2.2. All Public and Private EMS Agencies
- 2.3. All Law Enforcement Agencies
- 2.4. Lorain County 9-1-1
- 2.5. Lorain County EMA

3. RESPONSIBILITY

- 3.1. First responsibility is that the proper ICS/IMS has been established on scene of the emergency incident.
- 3.2. Each fire and EMS department (public or private) must ensure that their personnel are adequately trained and comply with this guideline.

4. PROCEDURE

- 4.1. The authority having jurisdiction (AHJ) shall establish Command.
- 4.2. Fire/EMS department shall evaluate patient(s) condition to determine if an air ambulance(s) is required and level of care. Ultimately the patient care decisions will be the responsibility of the most qualified, highest trained EMS provider.
- 4.3. Suspected serious trauma with any the following conditions to a patient who will require an extrication time of longer than 15-20 minutes: unsecured airway, unconsciousness, hypotension with tachycardia, unable to obtain venous access.
 - 4.3.1. *Serious injury or illness in a patient who is not easily accessible to land vehicles, but where an adequate clearing for helicopter landing is nearby.*
 - 4.3.2. *Scenes of numerous seriously-injured patients*
- 4.4. The Incident Commander shall be responsible for requesting all air ambulance(s). This request shall include:
 - 4.4.1. Identification of safe landing zones (LZ).
 - 4.4.2. Determination of the on-scene radio frequency to be used.
 - 4.4.3. Determination of how the air ambulance(s) will be dispatched.
 - 4.4.4. Obtaining an ETA for the air ambulance.
- 4.5. If there will be a long delay (at the discretion of the most qualified, highest trained EMS provider) before an air ambulance can arrive on scene, it is recommended that the

patient(s) be ground transported to the nearest hospital. The air ambulance should then be diverted to the receiving hospital through incident command.

4.6. Transfer of care.

4.6.1. Until the patient becomes the full responsibility of the flight crew and/or flight physician, the on-line physician is responsible.

4.6.2. Once care of the patient is turned over to the air ambulance team, patient care responsibility rests with the flight crew and their Medical Control and/or flight physician.

4.6.3. When transferring care to the air ambulance, the EMT in charge of patient care has the option to request a destination facility through Incident Command.

Administrative Protocols
Trauma Triage Rules
(As written in the O.R.C.)

Lorain County EMS Protocols
Administrative Protocol 2
Revised 11/15/2005

4765-14-1 Definitions.

- (A) *As used in this chapter and section 4765.01 of the Revised Code, "trauma" or "traumatic injury" means severe damage to or destruction of tissue that satisfies both of the following conditions:*
- (1) It creates a significant risk of any of the following:
 - (a) Loss of life;
 - (b) Loss of a limb; Significant, permanent disfigurement;
 - (c) Significant, permanent disability; and
 - (2) It is caused by any of the following:
 - (a) Blunt or penetrating injury;
 - (b) Exposure to electromagnetic, chemical, or radioactive energy
 - (c) Drowning, suffocation, or strangulation;
 - (d) A deficit or excess of heat.
- (B) "Evidence of poor perfusion" means physiologic indicators of hemorrhage or decreased cardiovascular function, which may include any of the following symptoms:
- (1) Weak distal pulse;
 - (2) Pallor;
 - (3) Cyanosis;
 - (4) Delayed capillary refill;
 - (5) Tachycardia.
- (C) "Evidence of respiratory distress or failure" means physiologic indicators of decreased ventilatory function, which may include any of the following symptoms:
- (1) Stridor;
 - (2) Grunting;
 - (3) Retractions;
 - (4) Cyanosis;
 - (5) Hoarseness
 - (6) Difficulty speaking.
- (D) "Evidence of hemorrhagic shock" means physiologic indicators of blood loss that may include any of the following symptoms:
- (1) Delayed capillary refill;
 - (2) Cool, pale, diaphoretic skin
 - (3) Decreased systolic blood pressure with narrowing pulse pressure;
 - (4) Altered level of consciousness.
- (E) "Seatbelt sign" means abdominal or thoracic contusions and abrasions resulting from the use of a seatbelt during a motor vehicle collision.
- (F) "Signs or symptoms of spinal cord injury" means physiologic indicators that the spinal cord is damaged, including, but not limited to, paralysis, weakness, numbness, or tingling of one or more extremities.

- (G) “Evidence of neurovascular compromise” means physiologic indicators of injury to blood vessels or nerves including, but not limited to, pallor, loss of palpable pulses, paralysis, paresthesia, or severe pain.

4765-14-2 Determination of a trauma victim.

Emergency medical service personnel shall use the criteria in this rule, consistent with their certification, to evaluate whether an injured person qualifies as an adult trauma victim or pediatric trauma victim, in conjunction with the definition of trauma in section 4765.01 of the Revised Code and this chapter.

- (A) An adult trauma victim is a person sixteen years of age or older exhibiting one or more of the following physiologic or anatomic conditions:
- (1) Physiologic conditions
 - (a) Glasgow coma scale less than or equal to thirteen;
 - (b) Loss of consciousness greater than five minutes;
 - (c) Deterioration in level of consciousness at the scene or during transport;
 - (d) Failure to localize to pain;
 - (e) Respiratory rate less than ten or greater than twenty-nine;
 - (f) Requires endotracheal intubation;
 - (g) Requires relief of tension pneumothorax;
 - (h) Pulse greater than one hundred twenty in combination with evidence of hemorrhagic shock;
 - (i) Systolic blood pressure less than ninety, or absent radial pulse with carotid pulse present;
 - (2) Anatomic conditions
 - (a) Penetrating trauma to the head, neck, or torso;
 - (b) Significant, penetrating trauma to extremities proximal to the knee or elbow with evidence of neurovascular compromise;
 - (c) Injuries to the head, neck, or torso where the following physical findings are present:
 - (i) Visible crush injury;
 - (ii) Abdominal tenderness, distention, or seat belt sign;
 - (iii) Pelvic fracture;
 - (iv) Flail chest;
 - (d) Injuries to the extremities where the following physical findings are present:
 - (i) Amputations proximal to the wrist or ankle;
 - (ii) Visible crush injury;
 - (iii) Fractures of two or more proximal long bones;
 - (iv) Evidence of neurovascular compromise.
 - (e) Signs or symptoms of spinal cord injury;
 - (f) Second degree or third degree burns greater than ten per cent total body surface area, or other significant burns involving the face, feet, hands, genitalia, or airway.
- (B) A pediatric trauma victim is a person under sixteen years of age exhibiting one or more of the following physiologic or anatomic conditions:
- (1) Physiologic conditions
 - (a) Glasgow coma scale less than or equal to thirteen;
 - (b) Loss of consciousness greater than five minutes;
 - (c) Deterioration in level of consciousness at the scene or during transport;
 - (d) Failure to localize to pain;
 - (e) Evidence of poor perfusion, or evidence of respiratory distress or failure.
 - (2) Anatomic conditions
 - (a) Penetrating trauma to the head, neck, or torso;
 - (b) Significant, penetrating trauma to extremities proximal to the knee or elbow with evidence of neurovascular compromise;
 - (c) Injuries to the head, neck, or torso where the following physical findings are present:

- (i) Visible crush injury;
- (ii) Abdominal tenderness, distention, or seat belt sign;
- (iii) Pelvic fracture;
- (iv) Flail chest;

(d) Injuries to the extremities where the following physical findings are present:

- (i) Amputations proximal to the wrist or ankle;
- (ii) Visible crush injury;
- (iii) Fractures of two or more proximal long bones;
- (iv) Evidence of neurovascular compromise.

(e) Signs or symptoms of spinal cord injury;

(f) Second or third degree burns greater than ten per cent total body surface area, or other significant burns involving the face, feet, hands, genitalia, or airway.

(C) Emergency medical service personnel shall also consider mechanism of injury and special considerations, as taught in the EMT-basic, EMT-intermediate, or EMT-paramedic curriculum, when evaluating whether an injured person qualifies as a trauma victim.

4765-14-03 Enforcement of state or regional trauma triage protocols.

- (A) EMS medical directors shall be responsible for enforcing state or regional trauma triage protocols for EMS personnel under their medical direction through a performance improvement or peer review process.
- (B) The EMS medical directors may request assistance from the RPABs to address issues related to quality improvement and peer review of state or regional trauma triage protocols.
- (C) The board shall investigate all complaints regarding violations of state or regional trauma triage protocols consistent with their current procedures for investigations.

4765-14-04 Education of state and regional trauma triage protocols.

The board shall consult with the state trauma committee, emergency medical service organizations and personnel, regional directors and regional physician advisory boards, emergency medical service instructors, and persons who regularly provide medical direction to emergency medical service personnel in this state for assistance in developing and implementing educational opportunities regarding state and regional trauma triage protocols. The board may also enlist the assistance of the division of EMS or direct the division of EMS to participate in developing and implementing educational opportunities regarding state and regional trauma triage protocols in a manner to be determined by the board.

4765-14-05 Exceptions to mandatory transport .

(A) Emergency medical service personnel shall transport a trauma victim, as defined in section 4765.01 of the Revised Code and this chapter, directly to an adult or pediatric trauma center that is qualified to provide appropriate adult or pediatric care, unless one or more of the following exceptions apply:

- (1) It is medically necessary to transport the victim to another hospital for initial assessment and stabilization before transfer to an adult or pediatric trauma center;
- (2) It is unsafe or medically inappropriate to transport the victim directly to an adult or pediatric trauma center due to adverse weather or ground conditions or excessive transport time;
- (3) Transporting the victim to an adult or pediatric trauma center would cause a shortage of local emergency medical service resources;

(4) No appropriate adult or pediatric trauma center is able to receive and provide adult or pediatric trauma care to the trauma victim without undue delay;

(5) Before transport of a patient begins, the patient requests to be taken to a particular hospital that is not a trauma center or, if the patient is less than eighteen years of age or is not able to communicate, such a request is made by an adult member of the patient's family or a legal representative of the patient.

Administrative Protocols Communications	Lorain County EMS Protocols Administrative Protocol 3 Revised 6/29/2006
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1. PURPOSE

- 1.1. Communication should be established early and clearly. Good communication is key to good patient care and running a smooth incident.

2. DIVISIONS AFFECTED

- 2.1. All Public and Private EMS Agencies

3. RESPONSIBILITY

- 3.1. A member of the pre-hospital care team must contact Medical Control at the earliest time conducive to good patient care. This may mean that the hospital is contacted from the scene if assistance is needed in the patient's immediate care or permission is required for part of the patient care deemed necessary by the paramedic or EMT in charge.
- 3.2. EMT's and paramedics have been trained to give a full, complete report, this is often not necessary and may interfere with the physician's duties in the Emergency Department

4. PROCEDURE

- 4.1. Reports should be as complete but concise as possible to allow the physician to understand the patient's condition. It is not an insult for the physician to ask questions after the report is given. This is often more efficient than giving a thorough report consisting mostly of irrelevant information.
- 4.2. If multiple victims are present on the scene, it is advisable to contact Medical Control with a preliminary report. This should be an overview of the scene, including the number of victims, seriousness of the injuries, estimated on-scene and transport times to the control hospital or possible other nearby facilities. This allows preparation for receiving the victims and facilitates good patient care.
- 4.3. When calling in a report it should begin by identification of the squad calling, and the level of care, which can be provided to the patient (i.e., basic, advanced or medic), and the nature of the call (who you need to talk with, physician or nurse).
- 4.4. Categorizing patients

4.4.1. **RED (IMMEDIATE) PATIENTS -- MOST SERIOUSLY ILL This category is for the most seriously ill or injured patients.**

1. Type of Squad: Basic, Intermediate, Paramedic
2. Age and Sex of Patient:
3. Type of Situation: Injury and/or Illness
4. Specific Complaint: Short and to the point (i.e., chest pain)
5. Mechanism: MVA / MCA / fall
6. Vital Signs: B/P / Pulse / Resp. / LOC / EKG
7. Patient Care: Airway Management, Circulatory Support, and Drugs
8. General Impression: Stable / Unstable
9. ETA to Medical Facility

4.4.2. **YELLOW (DELAYED) PATIENTS -- SIGNIFICANTLY ILL. This category is for individuals who have significant signs or symptoms of illness or injury, and at this time are stable.**

1. Type of Squad: Basic, Intermediate, Paramedic
2. Age and Sex of Patient:
3. Type of Situation: Injury and/or Illness
4. Specific Complaint: Short, to the point (i.e., 10% 2nd degree leg burn)
5. Mechanism: MVA / MCA / fall
6. Vital Signs: B/P / Pulse / Resp. / LOC / EKG
7. ETA to Medical Facility

4.4.3. **GREEN (MINOR) PATIENTS -- MINOR PATIENTS. This category covers all minor illness or injury circumstances and the patient is in no danger of developing any significant signs or symptoms.**

1. Type of Squad: Basic, Intermediate, Paramedic
2. Age and Sex of Patient:
3. Type of Situation: Injury and/or Illness
4. Specific Complaint: Short and to the point (i.e., ABD pain for 2 weeks)

4.5. Code I (non transport) for minors

4.5.1. If after evaluation of a minor, the EMT and medical control agree that the patient is a Code I, that minor can be left in the care of a responsible adult that is not the parent or legal guardian. The responsible adult may be a family friend, neighbor, school bus driver, teacher, school official, police officer, social worker, or other person at the discretion of medical control and the EMT.

4.5.2. Once the above information is given, wait for further requests and/or orders from Medical Control.

4.5.3. If the patient requires special care; (i.e., security; interpreter; additional people for lifting, isolation for infection, vermin infestation, or hazardous material) this information should also be relayed.

TYPES OF PATIENTS ACCORDING TO TRIAGE PRIORITY
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IMMEDIATE PATIENTS

Airway and/or Breathing Difficulty
Cardiac Arrest
Circulation Difficulty (Bleeding and/or Shock)
Open Chest and Abdominal Injury
Complicated Childbirth
Chest Pain

Unconsciousness
Severe Head Injury
Severe Burns
Severe Poisoning
Status Epilepticus
Altered LOC
Multiple Fractures

DELAYED PATIENTS

C-spine Injury
Acute ABD Pain
Moderate Burns

Normal Childbirth
Violent or Combative Patient
Psychiatric

MINOR PATIENTS

Minor Injury
Minor Illness

Administrative Protocols
Dead on Arrival (DOA)

Lorain County EMS Protocols
Administrative Protocol 4
Revised 11/15/2005

1. PURPOSE

- 1.1. When a DOA is encountered, the squad members should not disturb the scene or the body as much as possible, unless it is necessary to do so in order to care for and assist other victims. Once it is determined that the victim is, in fact, dead the squad members should move as rapidly as possible to transfer responsibility or management of the scene to the Police Department and/or Coroner's Office. It is the squad member's responsibility to notify the Coroner's Office directly or to ensure that the Coroner's Office has been notified by a police officer on the scene.

2. DIVISIONS AFFECTED

- 2.1. All Public and Private EMS Agencies

3. RESPONSIBILITY

- 3.1. A determination that the victim is dead rests with the squad members.

4. PROCEDURE

- 4.1. Any of the following may be used as guidelines to support the determination that a victim is deceased:
- 4.1.1. There is an injury, which is incompatible with life (i.e., decapitated, or burned beyond recognition).
 - 4.1.2. Cardiac arrest, secondary to massive blunt trauma without signs of exsanguinating hemorrhage (i.e. limb amputation).
 - 4.1.3. The victim shows signs of decomposition, rigor mortis, or extremely dependent lividity.
 - 4.1.4. If the patient is an adult with an unwitnessed cardiac arrest, has a history of an absence of vital signs for greater than 20 minutes, and is found in Asystole, not secondary to hypothermia or cold water drowning.
 - 4.1.5. If the patient is an infant or child with an unwitnessed cardiac arrest and is found in Asystole, except in hypothermic patients with a downtime of less than 30 minutes.
- 4.2. In cold water drowning if recovered if less than 1 hour.
- 4.2.1. If there are valid DNR (Do Not Resuscitate) orders, see DNR Protocol.
 - 4.2.2. If the patient has a history of terminal disease, the family refuses resuscitation and permission to pronounce the patient dead is given by Medical Control.

CAUTION: IF ANY DOUBT EXISTS THAT THE VICTIM IS DEAD AT THE TIME OF ARRIVAL OF THE SQUAD, RESUSCITATIVE MEASURES SHOULD BE INSTITUTED IMMEDIATELY. WHENEVER RESUSCITATIVE MEASURES ARE INSTITUTED, THEY MUST BE CONTINUED UNTIL ARRIVAL AT A HOSPITAL OR UNTIL A PHYSICIAN HAS PRONOUNCED THE VICTIM DEAD OR A VALID DNR IS PRONOUNCED

Administrative Protocols Do Not Resuscitate (DNR) Comfort Care Guidelines	Lorain County EMS Protocols Administrative Protocol 5 Revised 11/15/2005
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1. PURPOSE

- 1.1. Pre-hospital (out of hospital) providers are called to care for patients who are known to have incurable or terminal illnesses on an ever-increasing basis. Examples of such patients include those with metastatic cancer, AIDS, or severe CVA's. Many patients and/or their families have intelligently and consciously altered their consent for treatment, made out a living will, or entered into Hospice care arrangements.
- 1.2. EMS providers and medical control physicians often find these encounters confusing, frustrating, and charged with emotion. This is especially true when there is no prearranged document or consistent, rational or standardized approach by which to care for these patients and their families.

2. DIVISIONS AFFECTED

- 2.1. All Public and Private EMS Agencies

3. RESPONSIBILITY

- 3.1. Living Will & Durable Power of Attorney Does NOT Mean DNR !
- 3.2. DNR does NOT mean "do not treat"!
- 3.3. Patients can be either DNR Comfort Care patients or DNR Comfort Care - Arrest patients. The difference is that for a DNR Comfort Care patient, the State of Ohio DNR Protocol is activated immediately when a DNR order is issued or when a living will requesting no CPR becomes effective, but for a DNR Comfort Care -- Arrest patient, the protocol is activated only when the patient experiences a cardiac arrest or a respiratory arrest. Be careful to check the patient's DNR order or DNR identification to determine which applies.

4. PROCEDURE

- 4.1. A DNR Comfort Care or DNR Comfort Care - Arrest patient's status is confirmed when the patient has one of the following:
 - 4.1.1. A DNR Comfort Care card or form completed for the patient.
 - 4.1.2. A completed State of Ohio living will (declaration) form that states that the patient does not want CPR (in the case of a patient who has been determined by two doctors to be in a terminal or permanently unconscious state).
 - 4.1.3. A DNR Comfort Care necklace or bracelet bearing the DNR Comfort Care official logo.
 - 4.1.4. A DNR order signed by the patient's attending physician or, when authorized by section 2133.211 of the Ohio Revised Code, a certified nurse practitioner (CNP) or clinical nurse specialist (CNS).
 - 4.1.5. A verbal DNR order is issued by the patient's attending physician, CNP, or CNS.
 - 4.1.6. Copies of these items are sufficient.
- 4.2. EMS workers are not required to search a person to see if they have DNR Identification.

- 4.3. If an EMS or other health care worker discovers one of these items in the possession of a patient, the worker must make a reasonable effort to identify DNR patients in appropriate circumstances. Examples of ways to verify identity are:
 - 4.3.1. The patient or a family member, caregiver, or friend gives the patient's name.
 - 4.3.2. The health care worker knows the patient personally.
 - 4.3.3. Institution identification band.
 - 4.3.4. Driver's license, passport, or other picture ID.
 - 4.3.5. Look on the patient's cell phone for ICE, In Case of Emergency for a contact.
- 4.4. If you cannot verify the identity of a patient with DNR Identification after reasonable efforts, you still should follow this protocol.
- 4.5. Verification of identity is not required for patients or residents of health care facilities when a DNR order is present on the person's chart.
- 4.6. EMS personnel who receive a verbal DNR order from a doctor or CNP/CNS must verify the identity of the person issuing the order. Some examples of verification are:
 - 4.6.1. Personal knowledge of the doctor/CNP/CNS.
 - 4.6.2. List of practitioners with other identifying information such as addresses.
 - 4.6.3. A return telephone call to verify information provided.
- 4.7. Activation
 - 4.7.1. When this protocol is activated for a given DNR Comfort Care patient depends on whether the patient is a DNR Comfort Care patient or a DNR Comfort Care - Arrest patient. For a DNR Comfort Care patient, this protocol is activated when the DNR order is issued or the living will specifying no CPR becomes effective. For a DNR Comfort Care - Arrest patient, the protocol is activated when the patient experiences a cardiac arrest or a respiratory arrest.
 - 4.7.2. "Cardiac arrest" means absence of a palpable pulse. "Respiratory arrest" means absence of spontaneous respirations or presence of agonal breathing.
- 4.8. Actions
 - 4.8.1. For patients for whom the DNR Comfort Care protocol is activated, you will:
 - Suction the airway
 - Administer oxygen
 - Position for comfort
 - Splint or immobilize
 - Control bleeding
 - Provide pain medication
 - Provide emotional support
 - Contact other appropriate health care providers such as hospice, home health, attending physician/CNP/CNS
 - 4.8.2. For patients for whom DNR Comfort Care protocol is activated, you **will not**:
 - Administer chest compressions
 - Insert artificial airway
 - Administer resuscitative drugs

- Defibrillate or cardiovert
- Provide respiratory assistance (other than that listed above)
- Initiate resuscitative IV
- Initiate cardiac monitoring

4.8.3. If you have responded to an emergency situation by initiating any of the "will not" actions prior to confirming that the DNR Comfort Care Protocol must be activated, discontinue them when you activate the protocol. You may continue respiratory assistance, IV medications, etc., that have been part of the patient's ongoing course of treatment for an underlying disease.

4.9. Interaction with the Patient, Family, and Bystanders

4.9.1. The patient always may request resuscitation even if he or she is a DNR Comfort Care patient and this protocol has been activated. The request for resuscitation amounts to a revocation of DNR Comfort Care status.

4.9.2. If family or bystanders request or demand resuscitation for a person for whom the DNR Comfort Care Protocol has been activated, do not proceed with resuscitation. Provide comfort measures as outlined above and try to help the family understand the dying process and the patient's choice not to be resuscitated.

4.10. Documentation

4.10.1. EMS or other health care personnel who implement the DNR Protocol for a DNR Comfort Care patient should document in their records, in accordance with the policy of their agency or facility:

4.10.1.1. The item that identified the person as DNR Comfort Care (as listed in the Identification portion of this protocol).

4.10.1.2. The method of verifying the person's identity, if any was found through reasonable efforts.

4.10.1.3. Whether the person was a DNR Comfort Care or DNR Comfort Care - Arrest patient.

4.10.1.4. The actions taken to implement the DNR Protocol.

4.10.2. The following minimum data should be recorded on the run Sheet:

- Name, age, gender
- Attending/ Hospice physician's named
- Date, time, location
- Event, description, history
- Assessment
- Treatment, if applicable
- Revocation, if applicable

4.11. When a DNR Order is Current

4.11.1. A DNR order for a patient of a health care facility shall be considered current in accordance with the facility's policy. A DNR order for a patient outside a health care facility shall be considered current unless discontinued by the patient's attending physician/CNP/CNS, or revoked by the patient. EMS personnel are not required to research whether a DNR order that appears to be current has been discontinued.

- 4.11.2. It is imperative that a copy of, or the original DNR/Comfort Care order and identification accompany the patient wherever the patient goes. This will help to alleviate any confusion between health care givers at multiple sites.



DNR IDENTIFICATION FORM

DNRCC

(If this box is checked the DNR Comfort Care Protocol is activated immediately.)

DNRCC – Arrest

(If this box is checked the DNR Comfort Care Protocol is implemented in the event of a cardiac arrest or a respiratory arrest.)

Patient Name: _____

Address: _____

City _____ State _____ Zip _____

Birthdate _____ Gender M F

Signature _____ (optional)

Certification of DNR Comfort Care Status (to be completed by the physician)*

(Check only one box)

Do-Not-Resuscitate Order – My signature below constitutes and confirms a formal order to emergency medical services and other health care personnel that the person identified above is to be treated under the State of Ohio DNR Protocol. I affirm that this order is not contrary to reasonable medical standards or, to the best of my knowledge, contrary to the wishes of the person or of another person who is lawfully authorized to make informed medical decisions on the person's behalf. I also affirm that I have documented the grounds for this order in the person's medical record.

Living Will (Declaration) and Qualifying Condition – The person identified above has a valid Ohio Living will (declaration) and has been certified by two physicians in accordance with Ohio law as being terminal or in a permanent unconscious state, or both.

Printed Name of physician*: _____

Signature _____ Date _____

Address: _____ Phone _____

City/State _____ Zip _____

* A DNR order may be issued by a certified nurse practitioner or clinical nurse specialist when authorized by section 2133.211 of the Ohio Revised Code.

See reverse side for DNR Protocol



DO NOT RESUSCITATE COMFORT CARE PROTOCOL

After the State of Ohio DNR Protocol has been activated for a specific DNR Comfort Care patient, the Protocol specifies that emergency medical services and other health care workers are to do the following:

WILL:

- Suction the airway
- Administer oxygen
- Position for comfort
- Splint or immobilize
- Control bleeding
- Provide pain medication
- Provide emotional support
- Contact other appropriate health care providers such as hospice, home health, attending physician/CNS/CNP

WILL NOT:

- Administer chest compressions
- Insert artificial airway
- Administer resuscitative drugs
- Defibrillate or cardiovert
- Provide respiratory assistance (other than that listed above)
- Initiate resuscitative IV
- Initiate cardiac monitoring

If you have responded to an emergency situation by initiating any of the **WILL NOT** actions prior to confirming that the DNR Comfort Care Protocol should be activated, discontinue them when you activate the Protocol. You may continue respiratory assistance, IV medications, etc., that have been part of the patient's ongoing course of treatment for an underlying disease.

Administrative Protocols Mass Casualty Operating Guidelines	Lorain County EMS Protocols Administrative Protocol 6 Revised 11/2005, 6/29/2006
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1. PURPOSE

- 1.1. Fire/EMS/rescue agencies respond to a wide range of emergency incidents. Although the possibility of a Mass Casualty Incident (MCI) occurring in Lorain County may seem remote, it will occur. As an MCI incident unfolds, additional organizational support will be required. The Incident Command System (ICS) provides for the effective management of personnel and resources and provides for their accountability, safety, and welfare. It also establishes procedures for the implementation of all ICS components required for a Mass Casualty Incident.

2. DIVISIONS AFFECTED

- 2.1. All public and private fire, rescue, and EMS personnel.
- 2.2. Lorain County Emergency Management Agency
- 2.3. Lorain County 9-1-1 Agency
- 2.4. Lorain County Hospitals and Coroner's Office

3. RESPONSIBILITY

- 3.1. All officers/supervisors are responsible to comply with and ensure that personnel under their command are adequately trained, fully understand, and comply with this guideline.
- 3.2. All personnel have the responsibility to learn and follow this guideline.
- 3.3. The *Incident Command System* must be initiated by the first-arriving resource. ICS allows the *Incident Commander* to escalate and expand the command organization as needed. Only the positions needed should be implemented, based on the number of tasks to be performed or availability of resource
- 3.4. The responsibility of the first-arriving fire unit will include the functions of *Command*. The *Incident Commander* is responsible for the development of an action plan that takes into account the EMS aspects of the incident and provide for:
- 3.4.1. SAFETY hazard assessment (existing or potential) and/or life-threatening situations.
- 3.4.2. SURVEY the scene to approximate the number and severity of patients.
- 3.4.3. SET UP the scene for emergency medical functions.
- 3.4.4. START (simple triage and rapid treatment of patients).

4. DEFINITIONS

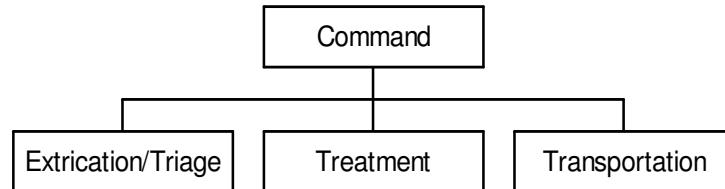
- 4.1. Mass casualty incident (MCI): An emergency or disaster involving multiple victims exceeding the capability of responding personnel, requiring patient stabilization at the same time and location.
- 4.2. **START** system: A simple system used at the scene of mass casualty incidents to quickly assess and prioritize care according to three conditions: breathing, circulation, and level of consciousness.

- 4.3. Triage: The process of sorting and providing care to multiple victims according to the severity of their injuries or illnesses.
5. INITIAL RESPONSE
 - 5.1. An MCI incident exists if any one of the following conditions are present:
 - 5.1.1. Lack of one paramedic for each critical patient.
 - 5.1.2. Lack of one EMT for every three (3) non-critical patients.
 - 5.1.3. An incident that involves more than 15 patients regardless of level of injuries.
 - 5.2. The following branches/groups shall be routinely established as necessary at fires, vehicular accidents, hazardous materials incidents, or any other emergency incident that produces injuries or medical emergencies.
 - 5.2.1. Medical: Sector or Branch established to direct the activities and assume the management of all medical sectors, including triage, treatment, and transportation.
 - 5.2.2. Triage: Organizational sector responsible for completion of a rapid assessment of victims and establishing a prioritization for emergency medical care.
 - 5.2.3. Treatment: Organizational sector responsible for complete field triage and patient stabilization. This sector offers continuing care for victims until they can be transported to a medical facility.
 - 5.2.4. Transportation: Organizational sector responsible for the management and provision of ground and air transport for victims and coordination with medical facilities.
6. MEDICAL OPERATIONS
 - 6.1. The responsibilities assigned to the *Medical* operations officer will vary to some degree in each situation. These responsibilities generally include:
 - 6.1.1. Taking control of *Medical* operations.
 - 6.1.2. Maintaining initial and continuing situation evaluation with reports to *Command*.
 - 6.1.3. Triage of victims or coordination with *Triage* and/or *Extrication* officers.
 - 6.1.4. Field treatment, stabilization and preparation of victims for transportation or coordination with *Treatment* officer.
 - 6.1.5. Provisions for transportation of victims and distribution of patients to medical facilities or coordination with *Transportation* officer.
 - 6.1.6. Notification and coordination with Coroner for establishment of morgue facilities and handling of deceased victims.
 - 6.2. Assignments of scene personnel to specific functions will be made by either the *Medical* officer or *Command*. Personnel assigned as sector officers shall wear appropriate identification vests.
 - 6.3. The initial and continuing progress reports from the sector officers will include the following information:
 - Type of situation
 - Number of victims
 - Condition, type of injuries of victims (as a group)
 - Resource requirements
 - Need for special equipment, supplies, etc.

- Fire or accident site stability
- Hospital notification
- Consideration to active emergency operations plan

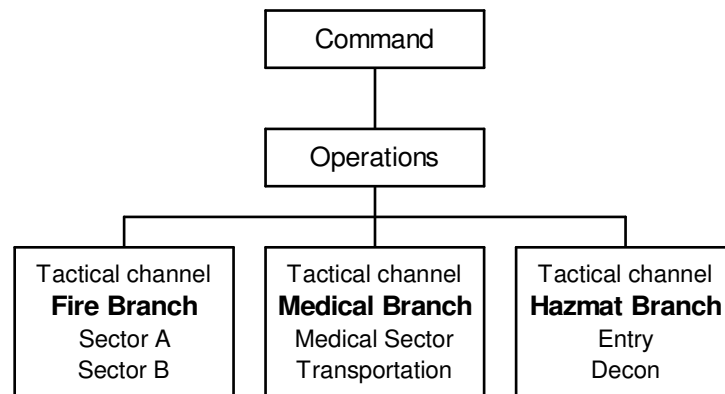
6.4. The type and complexity of various situations suggest different, but similar organizational structures.

6.4.1. VEHICULAR ACCIDENT - several victims

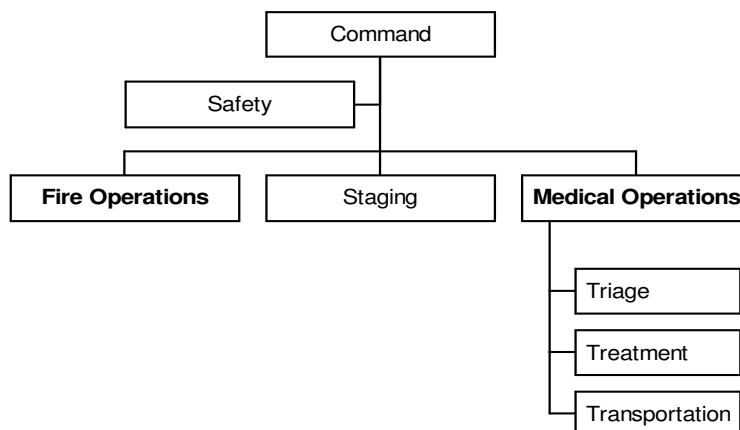


In this situation, Command would assign each company the responsibility for a specific function. This incident is entirely of an EMS nature and, unless delegated or assigned, *Command* is responsible for coordination.

6.4.2. AIRCRAFT CRASH WITH VICTIMS



6.4.3. MAJOR MEDICAL EMERGENCY (with or without fire)



In the case of a major disaster, the structure above should be instituted. When fire is involved, it will probably be wise to split *Fire* operations and *Medical* operations, each under an operations officer who reports to *Command*. The *Medical* operations officer is responsible for the entire medical function and

assigns units and sectors that report to him/her. If there is no fire, *Command* may elect to omit the *Medical* operations level and personally command this function.

6.5. The radio designation for the *Medical* operations or group officer is "**MEDICAL**".

7. TRIAGE

7.1. The Triage group is responsible for victim management (**START** triage) at the actual incident site and for any extrication effort before the victims are moved to the Treatment area. This includes the moving of these patients from the actual site, unless an *Extrication* group officer has been assigned.

7.2. *Command* or, if designated, the *Safety* officer shall decide if the area is safe or potentially hazardous. If safe, triage shall be accomplished before removal to the treatment area. If hazardous, the operations shall proceed to a "rescue" mode, i.e., victims shall be moved rapidly to a safer area where triage shall then be completed.

7.3. The *Triage* officer responsibilities shall include the following:

- Determinations whether triage and treatment is to be conducted on site or at a separate treatment area.
- Evaluation of resources needed for extrication of trapped victims and removal of victims to treatment area.
- Evaluation of resources needed for triage and primary treatment of patients.
- Communication of resource requirements to *Command* (or *Medical*).
- Resource allocation within sector.
- Supervision of assigned personnel and units.
- Progress reports to *Command* (or *Medical*) and "All Clear" when all victims have been removed.
- Coordination with other sectors as required.

8. TRIAGE GUIDELINES

8.1. The *Triage* officer should assign crews or aides to help size up the situation and report resource needs to him.

8.2. If the victims are spread out in a safe area allowing for "on the spot" triage, personnel should be assigned to a specific area or group of victims. Personnel assigned to a triage area must determine the needs of those victims and ask for assistance if necessary. Personnel have responsibility for all victims in their area until they are delivered to treatment area, to transportation area, or handed over to another company. Personnel completing triage assignments will become available for reassignment by *Triage* or *Command*.

8.3. Triage will be accomplished by using the **START** (Simple Triage And Rapid Treatment) system, which is a simple way to quickly assess and prioritize victims. The **START** system only requires the assessment of three items: breathing, circulation and level of consciousness.

8.4. Using the **START** system, each victim is classified into one of four categories:

- 8.4.1. **IMMEDIATE (Red Tag):** Immediate victims are those persons that require immediate assistance at the paramedic level and/or immediate transport to a medical facility (severe airway/breathing problems, uncontrolled bleeding, shock, severe burns, etc.).

- 8.4.2. DELAYED (Yellow Tag): Categorization of victim who is breathing and has pulse and level of consciousness within normal limits, but who may not be able to move because of an incapacitating injury (burns, fractures, back injury, etc.).
- 8.4.3. MINOR (Green Tag): Minor victims who are able to walk to treatment area, and will minimal treatment or be uninjured (minor burns, cuts, minor injuries, etc.).
- 8.4.4. NON-SALVAGEABLE (Black Tag): These victims are those persons with obvious mortal injuries where death appears reasonably certain or victim is already dead. Obvious dead bodies must not be moved unless necessary to provide treatment for other victims.
- 8.5. Using the **START** system requires that the first arriving personnel clear the area of all those victims with only minor injuries. If a person is able to walk to a designated area for evaluation by medical personnel (IMMEDIATE), allow them to do so. Movement of these victims enables personnel:
 - 8.5.1. To move people to a safer area.
 - 8.5.2. To ensure higher-level medical care.
 - 8.5.3. To reduce the number of remaining victims that must be triaged.
- 8.6. Designated triage personnel shall move quickly among the remaining victims, assessing the severity of injuries. Each victim will be classified into one the four categories for care. Classification of victims will be based on the following assessment:
 - 8.6.1. Check breathing: Assess whether the victim is breathing or not. If not breathing, attempt to clear and open the airway. If the victim does not begin breathing on their own with the airway open, classify as DECEASED and move on to the next victim.
 - If victim does begin to breathe on their own when airway is opened, classify as IMMEDIATE and move on to the next victim.
 - Check breathing rate: Greater than 30 times a minute, classify as IMMEDIATE and move on.
 - Less than 30 times a minute, evaluate circulation.
 - 8.6.2. Check circulation: Check for presence of the radial pulse. If you cannot find the radial pulse, the blood pressure is low. Control any severe bleeding by using direct pressure, elevation or pressure bandage. Classify the victim as IMMEDIATE and move on the next victim.
 - If the pulse is present and no severe bleeding is evident, check the level of consciousness.
 - 8.6.3. Check level of consciousness: At this point you know that 1) breathing is normal (less than 30 per minute) and radial pulse is present. Determine the victim's level of consciousness by using AVPU scale. Classify each victim according to the following:
 - 8.6.4. Victim is alert and responds to verbal stimuli. Classify as MINOR.
 - 8.6.5. Victim who has some injury that prevents them from moving to safety, but their condition is not life threatening; or, a victim who remains unconscious, responds only to painful stimuli, or responds inappropriately to verbal stimuli is classified as IMMEDIATE.
- 8.7. Once classified, each victim shall be appropriately marked or tagged with the METTAG. All victims should be moved to the appropriate treatment area and monitored for

changing conditions that would affect triage classification. If a change in condition occurs, the victim must be reclassified and retagged.

8.8. Triage should not be interrupted at any time to start CPR on any victim.

9. TREATMENT

9.1. The *Treatment* group is responsible for establishment and operation of a treatment area in a suitable location. The proximity of this area must be determined by the circumstances; it must be in a readily accessible area, but away from any dangerous conditions associated with the incident.

9.2. The treatment group should prepare an area for the arrival of patients from the triage or extrication area and shall report when ready. The treatment group shall first establish an "Immediate" treatment area where advanced level treatment will be given. A "delayed" treatment area, where basic treatment and supervision is available, shall be established if there is a need to hold non-critical patients. An "Assembly area" for "Minor" level patients will be established where minimum treatment will be given before transportation.

9.3. Treatment group will determine priorities for patients to be transported to medical facilities and will consult with the transportation group on the allocation of patients to facilities.

9.4. The *Treatment* officer is responsible for the following:

- Evaluation of resources required for treatment and reporting needs to Command.
- Identification of suitable treatment areas for Immediate, Delayed, and Minor victims.
- Assignment and coordination of personnel to provide suitable treatment for all patients.
- Coordination with other sectors.

9.5. The treatment area shall have a readily identifiable entrance. Traffic cones or markers shall be used to make this entrance obvious and the location shall be announced. Personnel shall be assigned to meet and direct arriving litter bearers on the placement of patients in "Immediate", "Delayed" or "Minor" areas.

9.6. Patients arriving at the treatment area must be re-triaged at the entrance and retagged if necessary.

9.7. Patients in the treatment areas should be arranged in rows with five feet between patients and heads toward the aisles to provide working room.

9.8. Advanced medical functions will only be given in "Immediate" treatment area. Less intensive patient monitoring and treatment will be administered in the "Minor" treatment area by fewer personnel. "Assembly" or Minor treatment will be of a minor injury treatment only.

9.9. If the condition of a patient changes significantly (better or worse), it may be necessary to transfer the patient to a higher or lower priority area.

10. TRANSPORTATION

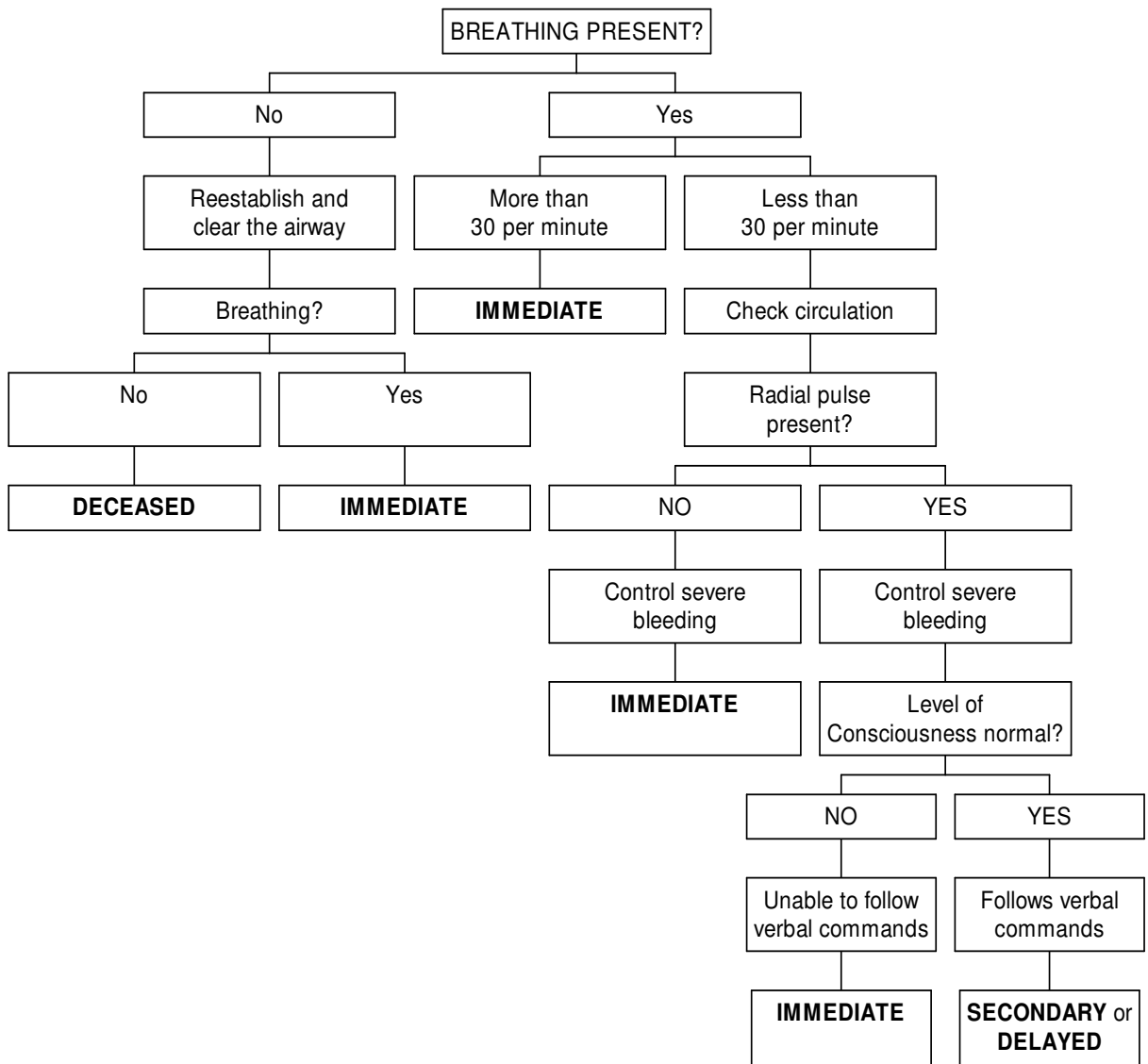
10.1. The *Transportation* group is responsible for the provision of patient transportation to appropriate medical facilities and the provision of medical supplies needed at the scene. The transportation group also maintains hospital capacity status and uses this to allocate patients to appropriate facilities in consultation with the Treatment group.

10.2. *Transportation* officer responsibilities include:

- Determination of patient transportation requirements and availability of ambulances and other transportation.

- Identification of ambulance staging and loading areas and coordinate with helicopter landing zones.
 - Communication with the hospital(s) to maintain the Hospital Capability status and Transportation Log for routing of patients.
 - Procurement of supplies needed at scene.
 - Coordination of patient transportation and allocation with treatment group.
 - Progress reports to *Command*.
 - Coordination with other sectors.
- 10.3. The *Transportation* officer, after conferring with the *Treatment* officer, shall report to the hospital(s) the estimated number of injured persons, the severity and type of injuries.
- 10.4. The *Transportation* officer shall station close to the treatment area, since frequent coordination and communication is necessary between these sectors.
- 10.5. Ambulances shall be initially staged at a regular staging area, and brought in one at a time to load. Each ambulance shall be loaded with patients for one hospital only. Paramedics units are to transport patients with advanced care given and EMT units are to transport patients with basic care given.
- 10.6. To reduce congestion at the MCI scene, responding EMS units may be requested to report to a designated *Staging* officer. The location of staging area shall be coordinated with *Command* and the *Medical* officer. The area shall be readily accessible, easy to locate, and in proximity to the loading zone in the treatment area. EMS units in the staging area shall be divided by personnel/squad capabilities:
- Basic life support
 - Intermediate life support
 - Advanced life support
- 10.7. If necessary, the *Medical* officer shall assign an *EMS Staging* officer. The *EMS Staging* officer shall record all pertinent information on a Unit Staging Log as EMS units arrive at staging, including person in charge, capabilities, and supplies. Units will not be dispatched from EMS staging to transportation until requested.
- 10.8. The *Transportation* officer shall complete the transport section of the triage tag, tear it off, and retain it.
- 10.9. If helicopters are to be used, a landing area must be identified, using GPS if available, at a safe distance from the scene. Coordinators must be assigned to track patient allocation and to maintain safety in the area. Radio communications with these coordinators is necessary.
- 10.10. Communications with *air medical transport* shall be established on a separate frequency than that used by other sectors.
- 10.11. It may be necessary to use ambulances or other vehicles to move personnel and equipment between the helicopter and treatment area, and to carry patients to the landing zone.
- 10.12. Ambulance personnel may be requested to bring back needed material supplies from hospitals. Personnel shall be assigned to set up a supply pool and gather equipment that may be needed from parked apparatus. The supply pool should be close to the treatment and triage areas.

START System



MEDICAL OPERATIONS

(Medical)

DEFINITION

The Medical operations (officer) shall be designated by the Incident Commander and shall be responsible for the direction and control of all medical efforts, shall manage all personnel, equipment and support materials needed for the provision of emergency medical care, and shall be responsible for the management of Triage, Treatment and Transportation groups in the absence of designated officer(s). The Incident Commander shall act as the *Medical* (or any other operations officer) in the absence of any designated group officer(s).

DUTIES AND RESPONSIBILITIES

- Maintaining initial and continuing situation evaluation with reports to *Command*.
- Supervise all medical operations.
- Check with *Command* to determine if safe to begin operations.
- Coordinate with *Command* on areas of medical operations to prevent space conflicts with fire operations.

TRIAGE OFFICER

(Triage)

DEFINITION

The *Triage* group (officer) shall be responsible for the sorting and prioritizing of victims for treatment, tagging, and movement into the patient collection area. *Triage* officer will be assigned based on the EMS certification level available at the incident.

DUTIES AND RESPONSIBILITIES

- Reports to *Medical* operations officer.
- Determinations whether triage and treatment is to be conducted on site or at a separate treatment area. Have all patients triaged and tagged.
- Evaluation of resources needed for triage and primary treatment of patients.
- Communication of resource requirements to *Command* (or *Medical*).
- Coordinate with *Treatment* on location of patient collection and temporary morgue areas.
- Move all patients on backboards into patient collection area by color priority:

RED: Most urgent; salvageable if treated and transported immediately, or any injured emergency worker.

YELLOW: Urgent; salvageable if treated and transported soon, or massive injury, probably not salvageable.

GREEN: Non-urgent; treatment can be delayed.

BLACK: DOA or full arrest; leave all black victims in position found unless they must be moved to assist viable patients.

- Keep *Medical* and *Transportation* informed of number of casualties.
- When all victims RED through GREEN have been moved to collection point, have all personnel report back to *Medical* for reassignment.
- Makes progress reports to *Medical* officer and "All Clear" when all victims have been removed

TREATMENT OFFICER

(Treatment)

DEFINITION

The *Treatment* group (officer) is the person responsible for the actual stabilization and treatment of all victims.

DUTIES AND RESPONSIBILITIES

- Reports to the *Medical* operations officer
- Identification of suitable treatment areas for Immediate, Delayed, and Minor victims.
- Coordinate with *Triage* officer on locations of triage/treatment areas and their organization. Include casualty flow.
- Evaluation of resources required for treatment and reporting needs to *Medical* officer.
- Re-triage patients as they come into collection area.
- Place victims in color areas (R-Y-G) with worst victims of each color group, nearest to the "Transport" end of area.
- Supervise stabilization/treatment of all casualties after they have been triaged.
- Coordinate transportation priorities with *Transport* Group. Do not transport DOA's.
- Provide periodic reports to *Medical* and *Transportation*.
- Begin reducing, shifting or relieving treatment personnel, as necessary.

To prevent distraction, any injured emergency worker must be transported away from the scene immediately.

TRANSPORTATION OFFICER (Transportation)

DEFINITION

The *Transportation* group (officer) shall be responsible for the organized movement or transport of all casualties from the collection area to receiving hospitals or specialty treatment centers, including transportation by both ground and air vehicles.

DUTIES AND RESPONSIBILITIES

- Reports to the *Medical* operations officer
- Determination of patient transportation requirements and availability of ambulances and other transportation.
- Communication with the hospital(s) to keep medical facility status and routing information of patients.
- Identification of ambulance staging and loading areas and helicopter landing zones.
- Obtain reports on number of casualties by type (RED-YELLOW-GREEN) from Triage. Update periodically as needed.
- Inform *EMS Staging* of manpower/equipment/supply needs.
- Procurement of supplies needed at scene through the *Medical* officer.
- For each victim, contact the hospital and report the following:
 - Ambulance name
 - Tag color(s)
 - Chief problem
 - Keep record of casualties sent to each facility.
 - Insure each ambulance driver knows location of hospital dispatched to.
- Provide reports to *Medical* on location of transportation command post, entry/exit flow of ambulances, and any other pertinent information. Keep updated as necessary.
- Begin relieving, shifting or reducing staff as necessary.

MCI COMMAND TACTICAL WORKSHEET

Confirm Mass Casualty Incident

Determine location, number and condition of victim(s)

Immediate (Red) _____

Delayed (Yellow) _____

Minor (Green) _____

Dead (Black) _____

Notification of hospital(s)

Rescue or recovery mode

Establish Command Post

Emergency Operations Center needed?

Communication channel designated

Hazard(s) to rescuers [hazmat, structural, hot/cold]

Activate Lorain County EMA - mutual aid

Assess need for more personnel

Assess need for additional equipment

Establish Branches/Groups

Safety Officer

Triage Officer

Extrication Officer

Treatment Officer

Medical Operations

Staging Officer

Fire Operations

Transportation Officer

PIO, Liaison

EMS Staging

MCI Operations

Make general area safe

Identify Group operation areas

Extrication area

Triage area

Treatment area(s)

Transportation area

Staging area

Extrication personnel

Medical personnel

Personal protective equipment

Air supply (SCBA, SAR)

Communications and lighting

Victim removal equipment

Decontamination

Termination

Personnel accountability

Removal of equipment

Decontamination

CISD and debriefing

CHECKLISTS

Treatment Sector Log

Medical Equipment Checklist

Hospital Capability & Patient Tally Sheet

Hospital Transportation Log

EMS Unit Staging Log

Post-Incident Analysis Report

Post-Incident Patient Analysis Report

Administrative Protocols Patient Refusal of Treatment or Transport	Lorain County EMS Protocols Administrative Protocol 7 Revised 11/2005, 9/6/2006
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1. PURPOSE

- 1.1. Permission not to treat or transport a patient must come from the base station physician.

The EMT may not accept a refusal unless the base station authorizes it. This decreases the EMT's and Paramedic's liability. Direct communication between the physician and the patient may resolve many questions and often convinces the patient of the importance of treatment and transport. The following is an outline of legal principles, which may help the EMT to understand patient refusal.

2. DIVISIONS AFFECTED

- 2.1. All Public and Private EMS Agencies

3. DEFINITIONS

3.1. Consent

- 3.1.1. The patient has the responsibility and right to consent to or refuse treatment. If he or she is unable to do so, a legal guardian has this right.
- 3.1.2. A durable power of attorney is an authorization that allows a patient's wishes to be followed even when he or she becomes incompetent.
- 3.1.3. When waiting to obtain lawful consent from the person authorized to make such consent would present a serious risk of death, serious impairment of health or would prolong severe pain or suffering of the patient, treatment may be undertaken to avoid those risks without consent. In no event should legal consent procedures be allowed to delay immediately required treatment.
- 3.1.4. In non-emergency cases involving minors, consent should be obtained from the parent or legal guardian prior to undertaking any *treatment*. All children must be evaluated for acuity of illness, regardless of obtaining parental consent.
- 3.1.5. AGE: Patient must be over 18 years of age or "emancipated" to be permitted to consent or refuse treatment. A child under 18 years of age who is married or is living away from home and is financially independent of his/her parents, may consent for their own care and may consent to medical or surgical care for his/her child.
- 3.1.6. If the patient is under age, consent should be from:
- Legal guardian
 - Natural parent
 - Adopted parent
- 3.1.7. NOTE: There has not been a single reported decision that held a physician liable where beneficial care was provided to a minor without obtaining consent.

3.2. Mental Competence - Decision Making Capability

- 3.2.1. A person is mentally competent if he:

- Is capable of understanding the nature and consequences of the proposed treatment.
 - Has sufficient emotional control, judgment, and discretion to manage his own affairs.
- 3.2.2. Ascertaining that the patient is oriented, has an understanding of what happened and may possibly happen if treated or not treated, and a plan of action - such as whom he will call for transportation home - should be adequate for these determinations.
- 3.2.3. Patients with impaired cerebral perfusion, in shock, post-ictal, or under the influence of drugs will be unlikely to fulfill these criteria.
- 3.2.4. If the patient is not mentally competent under these guidelines, consent should be obtained from another responsible party - who must also be mentally competent and must be 21 years of age - in the following order of preference:
- Legal guardian
 - Spouse
 - Adult son or daughter
 - Parent
 - Adult brother or sister
- 3.2.5. If the patient is not mentally competent and none of the above persons can be reached, the person should be treated and transported to a medical facility. It is preferable under such circumstances to obtain concurrence of a police officer in this course of action.
- 3.2.6. If the patient himself is not competent to consent and a legal guardian as defined under 3.2.4 above is present, and if that person is competent, he or she has the same right to consent or refuse treatment as the patient himself. Those wishes cannot be ignored in a non-life-threatening situation.
- 3.3. Code I (non transport) for minors
- 3.3.1. If after evaluation of a minor, the EMT and medical control agree that the patient is a Code I, that minor can be left in the care of a responsible adult that is not the parent or legal guardian. The responsible adult may be a family friend, neighbor, school bus driver, teacher, school official, police officer, social worker, or other person at the discretion of medical control and the EMT.

4. PROCEDURE

- 4.1. If a patient wishes to refuse either treatment, examination or transportation, the following steps will be taken.
- 4.1.1. The EMT will complete a Patient Refusal Checklist (see enclosed example) prior to contacting medical control.
- 4.1.2. Medical control must be contacted and the refusal checklist reviewed. This contact and the orders that were given must be documented. If unable to contact medical control, document why.
- 4.1.3. The patient must be advised of the benefits of treatment and transport as well as the specific risks of refusing treatment and transport.
- 4.1.4. The patient must be able to relate to the EMT in his or her own words what these risks and benefits are.

- 4.1.5. The patient will be provided with a refusal information sheet, also attached. A copy of this refusal information sheet or the refusal section of the checklist will be signed by the patient, dated, and both will be kept with the patient's file.
- 4.1.6. If this is from a traumatic incident, make sure you refer to the Procedure Protocol 05, Cervical Spine Clearing in the Field.

EMS PATIENT REFUSAL CHECKLIST

1. ASSESSMENT OF PATIENT (CIRCLE APPROPRIATE RESPONSE)

ALCOHOL / DRUGS INGESTION PER HISTORY OR EXAM Y / N
ALTERED LEVEL OF CONSCIOUSNESS Y / N
HEAD INJURY Y / N
ORIENTED TO: PERSON PLACE TIME SITUATION

2. MEDICAL CONTROL

CONTACTED VIA: PHONE RADIO TIME _____
UNABLE TO CONTACT () MEDICAL CONTROL PHYSICIAN _____

If medical control not able to be contacted, explain in comment section of checklist
ORDERS:

- () INDICATED TREATMENT / TRANSPORT MAY BE REFUSED BY PATIENT
- () USE REASONABLE FORCE / RESTRAINT TO PROVIDE TREATMENT
- () USE REASONABLE FORCE AND / OR RESTRAINT TO TRANSPORT

OTHER _____

3. PATIENT ADVISED (CIRCLE APPROPRIATE RESPONSE)

* MEDICAL TREATMENT / EVALUATION NEEDED Y / N
* AMBULANCE TRANSPORT NEEDED Y / N
* FURTHER HARM MAY RESULT WITHOUT MEDICAL Y / N
TREATMENT OR EVALUATION
* TRANSPORT BY MEANS OTHER THAN AMBULANCE COULD BE
HAZARDOUS IN LIGHT OF THE PATIENT'S PRESENT ILLNESS OR INJURY Y / N
* PATIENT PROVIDED WITH REFUSAL ADVICE SHEET Y / N
* PATIENT WOULD NOT ACCEPT REFUSAL SHEET Y / N

4. DISPOSITION

- () REFUSED ALL EMS SERVICES
- () REFUSED TRANSPORT, ACCEPTED FIELD TREATMENT
- () REFUSED FIELD TREATMENT, ACCEPTED TRANSPORT
- () RELEASED IN CARE OR CUSTODY OF SELF
- () RELEASED IN CUSTODY OF LAW ENFORCEMENT AGENCY
AGENCY _____
OFFICER _____
- () RELEASED IN CARE OR CUSTODY OF RELATIVE OR FRIEND
NAME _____
RELATION _____

5. COMMENTS

EMT SIGNATURE _____ DATE _____ TIME _____

OFFICER _____ DATE _____ TIME _____

REFUSAL INFORMATION SHEET

PLEASE READ AND KEEP THIS FORM

This form has been given to you because you have refused treatment and/or transport by the Emergency Medical Service. Your health and safety are our primary concern, so even though you have decided not to accept our advice, please remember the following:

1. The evaluation and/or treatment provided to you by the EMS squad is not a substitute for medical evaluation and treatment by a doctor. We advise you to get medical evaluation and treatment.
2. Your condition may not seem as bad to you as it actually is. Without treatment your condition or problem could become worse. If you are planning to get medical treatment, a decision to refuse treatment or transport by the EMS may result in a delay, which could make your condition or problem worse.
3. Medical evaluation and/or treatment may be obtained by calling your doctor, if you have one, or by going to any hospital Emergency Department in this area, all of which are staffed 24 hours a day by Emergency physicians. You may be seen at these Emergency Departments without an appointment.
4. If you change your mind or your condition becomes worse and you decide to accept treatment and transport by the Emergency Medical Service, please do not hesitate to call us back. We will do our best to help you.
5. [] **If the box at the left has been checked**, it means that your problem or condition has been discussed with an Emergency physician at the medical control hospital by radio or telephone, and the advise given to you by the Emergency Medical Service has been issued or approved by the Emergency physician.

*** I have been informed of the dangers of my not being treated and/or transported by the Emergency Medical Services, for my condition, for treatment by an emergency department or private physician.
I release _____ and consulting hospital their employees and officers from all liability for any adverse results caused by my decision.

I have received a copy of this information sheet.

Signature: _____

Circle one: Patient Spouse Parent Guardian

Print Name: _____

EMT Signature: _____ Witness: _____

Print Name: _____

Report Number: _____ Date: _____

Administrative Protocols Non-Transports	Lorain County EMS Protocols Administrative Protocol 8 Revised 11/15/2005
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1. PURPOSE

- 1.1. A number of EMS calls result in non-transport of the patient or victim.

2. DIVISIONS AFFECTED

- 2.1. All Public and Private EMS Agencies

3. PROCEDURE

- 3.1. If the squad does not transport an individual, the following guidelines will apply:
- 3.1.1. In the event of a patient assist call and no Emergency Medical Services are rendered, a report should be made but Medical Control need not be contacted.
 - 3.1.2. If the patient refuses treatment or transport, the patient refusal procedure should be followed.
 - 3.1.3. If the patient is requesting transport and the EMT in charge does not feel it is necessary to transport the patient, Medical Control must be contacted and approve the EMS refusal. This includes any case that might be transported by car or private ambulance.
 - 3.1.4. A Code I Advisory Sheet should be initiated and given to the patient. (See Code I Advisory Sheet)
 - 3.1.5. Code I (non transport) for minors
- 3.2. If after evaluation of a minor, the EMT and medical control agree that the patient is a Code I, that minor can be left in the care of a responsible adult that is not the parent or legal guardian. The responsible adult may be a family friend, neighbor, school bus driver, teacher, school official, police officer, social worker, or other person at the discretion of medical control and the EMT.

CODE I ADVISORY SHEET For Minors Only

An EMS provider has evaluated you. It has been determined that you do not need an ambulance at this time. THIS DOES NOT MEAN THAT A PHYSICIAN SHOULD NOT SEE YOU. THE EVALUATION AND TREATMENT YOU RECEIVED WAS TO DETERMINE THE SEVERITY OF YOUR PROBLEM AND WHETHER OR NOT YOU NEEDED AN AMBULANCE; IT IS NOT A SUBSTITUTE FOR FINAL EVALUATION AND TREATMENT BY A PHYSICIAN.

We advise you to see a physician at this time. You may decide that you don't need to see a physician now, but if you don't then you must take the risk that you will not receive treatment that you need and that this may cause problems for you later on. The following may help you decide:

1. If you have a cut, only a physician should decide whether or not you need stitches. Most physicians recommend stitches within 8 hours because after that the risk of an infection becomes much greater.
2. If you have a cut, scrape or burn and have not had a tetanus (lockjaw) shot within 5 years, you may need one. You do not need to get a tetanus shot immediately, but you should not delay this more than 24 hours.
3. Many burns do not appear to be as bad as they really are. Also, serious problems can develop from some burns, which may be prevented by early medical treatment.
4. If the pain or other discomfort you had has gone away, it does not necessarily mean the problem that caused it has gone away.
5. If you decide you don't need to see a physician and then change your mind, don't wait. The longer you wait, the more problems you may have.

USE COMMON SENSE!!!

"IF I DON'T HAVE A PHYSICIAN, OR CAN'T SEE MY PHYSICIAN NOW, WHAT CAN I DO?"

**GO TO THE NEAREST EMERGENCY DEPARTMENT OR CALL BACK EMERGENCY
MEDICAL SERVICES.**

Patient Signature _____ Date _____

EMT Signature _____

Report # _____

Administrative Protocols Heavy Patients	Lorain County EMS Protocols Administrative Protocol 9 Revised 11/15/2005
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1. PURPOSE

- 1.1. Less than one percent of the population has a weight in excess of 300 lbs. This means that in any community there may be one or more individuals who fall into this extreme. As patients, these individuals are frequently classed as high risk because of the increased medical complications associated with their excess weight. In the EMS system they present the additional problem of movement and transportation. These individuals have the right to expect prompt and expert emergency medical care. Therefore, in order to facilitate the care of these individuals without risking the health of EMS workers, the following protocol is established.

2. DIVISIONS AFFECTED

- 2.1. All Public and Private EMS Agencies

3. PROCEDURE

- 3.1. In managing a patient with weight over 300 lbs., but less than 500 LBS, consider moving the patient with at least 6 individuals. At the scene, as many EMS personnel as can be mobilized may be supplemented by police or other safety personnel as appropriate. Consider Mutual Aid if necessary.
- 3.2. Make sure the transfer devices are adequate for the job. Two backboards can be used. Cots should be kept in the DOWN position during the entire transfer
- 3.3. In managing a patient with weight over 500 lbs., engineering a safe transfer to the ED becomes as important as medical care. Tugging on the limbs of a truly obese patient causes dislocations , fractures and tears. These patients may require a vehicle other than an ambulance for transfer. The primary receiving facility may also not be able to handle a patient of that size, requiring further transfer. It may be necessary to remove doors, walls or windows. Consider asking for help from people experienced in the transfer of obese patients. Bringing an ED physician to the scene may be an option if the extrication time is extended or if the medic feels that the patient will not require admission to a hospital
- 3.4. It is NECESSARY TO NOTIFY THE HOSPITAL WELL IN ADVANCE of arrival so that preparations can be completed.
- 3.5. If individuals in the community are known to fall within this special category it is appropriate to inform them in advance of the type of assistance they can expect from the EMS system, and help them make plans well in advance to assist you. When calling for the squad, and if they identify themselves and their special needs, it will promote the timeliness of your efforts.
- 3.6. Truly obese people often live a very private life. Please do not forget to treat these people with the same dignity and respect your other patients receive.

Administrative Protocols
On Scene EMT Intervener

Lorain County EMS Protocols
Administrative Protocol 10
Revised 11/15/2005

1. PURPOSE

- 1.1. On a EMS run where an unknown EMT from outside the responding EMS agency wishes to intervene in the care of patients.

2. DIVISIONS AFFECTED

- 2.1. All Public and Private EMS Agencies

3. PROCEDURE

- 3.1. Ideally, if no further assistance is needed, the offer should be declined.
- 3.2. If the intervener's assistance is required or may significantly contribute to the care of the patient:
- Obtain proper identification of a valid Ohio EMT card. Acceptance of borderline states' EMT cards are at the discretion of individual EMS services. Notation of intervener name, address and certification numbers must be documented on the run report.
- 3.3. Significant involvement with patient care or variance from protocols will require the intervener to accompany the patient to the hospital.

Administrative Protocols Physician at the Scene	Lorain County EMS Protocols Administrative Protocol 11 Revised 11/15/2005
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1. PURPOSE

1.1. GOOD SAMARITAN PHYSICIAN

1.1.1. This is a physician with no previous relationship to the patient, who is not the patient's private physician, but is offering assistance in caring for the patient.

1.2. PHYSICIAN IN HIS/HER OFFICE, OR URGENT CARE CENTER

1.2.1. This is for the call in the physician's office

2. DIVISIONS AFFECTED

2.1. All Public and Private EMS Agencies

3. PROCEDURE

3.1. GOOD SAMARITAN PHYSICIAN

3.1.1. The following criteria must be met for this physician to assume any responsibility for the care of the patient:

- Medical Control must be informed and give approval.
- The physician must have proof that he/she is a physician. They should be able to show you their medical license. Notation of physician name, address and certification numbers must be documented on the run report.
- The physician must be willing to assume responsibility for the patient until relieved by another physician, usually at the emergency department.
- The physician must not require the EMT to perform any procedures or institute any treatment that would vary from protocol and/or procedure.

3.1.2. If the physician is not willing or able to comply with all the above requirements, his assistance must be courteously declined.

3.2. PHYSICIAN IN HIS/HER OFFICE, OR URGENT CARE CENTER

3.2.1. EMS should perform its duties as usual under the supervision of Medical Control or by protocol.

3.2.2. The physician may elect to treat the patient in his office.

3.2.3. The EMT should not provide any treatment under the physician's direction that varies from protocol. If asked, the EMT should decline until contact is made with Medical Control.

3.2.4. Once the patient has been transferred into the squad, the patient's care comes under Medical Control.

Administrative Protocols Restraint Policy	Lorain County EMS Protocols Administrative Protocol 12 Revised 11/2006, 7/17/2006
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1. PURPOSE

- 1.1. Soft restraints are to be used only when necessary in situations where the patient is potentially violent and may be of danger to themselves or others. EMS providers must remember that aggressive violent behavior may be a symptom of medical conditions such as but not limited to:
- Head Trauma
 - Alcohol/Drug related problems
 - Metabolic disorders (i.e., hypoglycemia, hypoxia, etc.)
 - Psychiatric/Stress related disorders

2. DIVISIONS AFFECTED

- 2.1. All Public and Private EMS Agencies

3. RESPONSIBILITIES

- 3.1. Patient health care management remains the responsibility of the EMS provider. The method of restraint shall not restrict the adequate monitoring of vital signs, ability to protect the patient's airway, compromise peripheral neurovascular status or otherwise prevent appropriate and necessary therapeutic measures.
- 3.2. It is recognized that evaluation of many patient parameters requires patient cooperation and thus may be difficult or impossible.
- 3.3. All restraints should have the ability to be quickly released, if necessary.

4. PROCEDURES

- 4.1. Restraints applied by law enforcement (i.e., handcuffs) require a law enforcement officer to remain immediately available to adjust restraints as necessary for the patient's safety. This policy is not intended to negate the need for law enforcement personnel to use appropriate restraint equipment to establish scene control.
- 4.2. Patients shall not be transported in a face down prone position to ensure adequate respiratory and circulatory monitoring and management.
- 4.3. Restrained extremities should be monitored for color, nerve and motor function, pulse quality and capillary refill at the time of application and every 15 minutes thereafter.
- 4.4. Restraint documentation on the EMS report shall include:
- Reason for restraint
 - Agency responsible for restraint application (i.e., EMS, Police.)
- 4.5. Documentation of cardio-respiratory status and peripheral neurovascular status.

Administrative Protocols
Free Standing Urgent Care Center

Lorain County EMS Protocols
Administrative Protocol 13
Revised 11/2005, 7/17/2006

1. PURPOSE

- 1.1. EMS units should not transport patients to freestanding urgent care center (or private physicians' offices) in response to emergency calls. This is not to be confused with a free standing emergency department which has a board certified or board eligible emergency medical specialist with 24-hours a day stat laboratories, X-Ray, CT scanner and ultrasound capabilities.

2. DIVISIONS AFFECTED

- 2.1. All Public and Private EMS Agencies

3. PROCEDURE

- 3.1. A patient can be transported to a free standing urgent care center if the following conditions exist:
 - 3.1.1. When directed by Medical Control.
 - 3.1.2. If specifically authorized by on-line medical direction.
 - 3.1.3. When the EMS unit is following protocols approved by Medical Control that authorize such transports under certain circumstances.
 - 3.1.4. When the EMS unit is a private service responding to a call in which the patient and/or the family requests transport to such facility and the patient is clearly in stable condition.
- 3.2. From the perspective of an EMS system, free standing urgent care centers are no different, and no more appropriate as an EMS transport destination, than any private physician's office.
- 3.3. Community Health Partners, East Campus is a full service, free standing emergency room. Transport to the East Campus by direction of Medical Control at West Campus, or if patient's condition warrants a closer ER.
- 3.4. Avon Emergency Care Center is a full service, free standing emergency room. This is a part of the EMH Regional Healthcare System.

Administrative Protocols Non-Hospital Transfer Policy	Lorain County EMS Protocols Administrative Protocol 14 Revised 11/15/2005
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1. PURPOSE

- 1.1. On occasion, the out of hospital provider(s) will be called upon to transport a patient from a non-hospital location to another non-hospital facility such as Hospice Center or from Hospice to home or a doctor's office.

2. DIVISIONS AFFECTED

- 2.1. All Public and Private EMS Agencies

3. PROCEDURE

- 3.1. The provider(s) will follow the written or pre-existing orders of the patient's physician or physician approved Hospice Center orders for the transport. At times, a Hospice nurse may arrive or already be at the scene. He/she should be able to help review orders and/or care directives such as DNR or "Support Care" orders to enable transport in accordance with the wishes of the patient and his/her family. A Hospice patient by definition is DNR.
- 3.2. Medical Control does not need to be contacted unless the DNR is revoked. However, if the provider(s) feels the need to contact Medical Control for advice or direction, the provider(s) will clearly advise Medical Control of the patient's terminal condition and DNR status.
- 3.3. If medication(s) needs to be "wasted", e.g., Morphine, Valium, then the receiving Hospice supervisor, nurse or EMS supervisor may witness and document appropriate disposal of the said medication(s) and administration equipment, e.g., needle(s), syringe(s), IV catheter(s), Heparin or saline lock(s) or IV lines and/or solutions. Medications or equipment should never be transported to an Emergency Department to be disposed of or wasted. Any and all waste materials will be disposed of into approved and appropriately labeled containers.

Administrative Protocols Inter-Facility Patient Transport Guidelines	Lorain County EMS Protocols Administrative Protocol 15 Revised 11/15/2005
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1. PURPOSE

- 1.1. The transportation of patients from one healthcare facility to another should be carried out in an orderly and expeditious manner.

2. DIVISIONS AFFECTED

- 2.1. All Public and Private EMS Agencies that provide for inter-facility transports.

3. PROCEDURE

- 3.1. Regardless of origin or destination, patients remain the responsibility of the transferring physician until received by the accepting physician or his/her agent. The transfer papers and accompanying record must document the reason for transfer as well as the time of contact and the name of the receiving facility; physician and/or accepting agent in accordance with nationally recognized standards and federal regulations.
- 3.2. The decision regarding the level and scope of practice of the out-of-hospital transporting agency and the individual providers should be made in consultation with the receiving physician and must be appropriate to the stability of the patient and their medical and equipment needs. The provider will be responsible for carrying out the orders of the transferring physician during the transfer unless acting as the agent of the receiving facility with superseding medical control, or if a physician accompanies the patient. Any questions or concerns regarding those orders, including but not limited to Do Not Resuscitate (DNR) orders, medications or treatments, must be answered or clarified prior to departure. The route(s) of travel, possible diversionary medical facilities and their phone or radio call numbers should also be determined.
- 3.3. If unanticipated problems or concerns arise during transport, direct, on-line medical control will be obtained. If for technical or logistical reasons this is not possible, the transporting agent should follow written protocols or standing orders until the transferring, receiving or nearest diversionary facility can be contacted on-line.

Administrative Protocols
Termination of Resuscitation Efforts

Lorain County EMS Protocols
Administrative Protocol 16
Revised 11/15/2005

1. PURPOSE

- 1.1. "Resuscitation may be discontinued in the pre-hospital setting when the patient is unable to be resuscitated after an adequate trial of ACLS."

2. DIVISIONS AFFECTED

- 2.1. All Public and Private EMS.

3. PROCEDURE

- 3.1. In accordance with the Journal of American Medical Association's guidelines for cardiopulmonary resuscitation and emergency cardiac care, the above statement encourages local medical directors to develop guidelines for pre-hospital care providers to terminate resuscitation efforts when the patient's survivability is questionable.

- 3.2. A trial of ACLS, according to the guidelines, occurs when:

- adequate BLS has been provided for a reasonable length of time;
- endotracheal intubation has been successfully accomplished;
- intravenous access has been achieved and rhythm-appropriate medications and counter shocks for ventricular fibrillation have been administered according to protocol; and
- persistent Asystole or agonal electrocardiographic patterns are present and no reversible causes are identified.
- The State of Ohio Regional Physician Advisory Board has adopted the following criteria for termination of resuscitation efforts at the scene following unmonitored, out of hospital, adult, primary cardiac arrest.

- 3.3. Paramedic personnel under local medical control authority may terminate resuscitation when:

- adult cardiopulmonary arrest (not associated with trauma, body temperature aberration, respiratory etiology, or drug overdose);
- standard ACLS in accordance with American Heart Association guidelines has been carried out for over 20 minutes;
- no restoration of circulation (spontaneous pulse rate of greater than 60 beats per minute for at least a 5 minute period); and
- absence of persistent, recurring, or refractory ventricular fibrillation/Tachycardia or any continuous neurological activity (e.g., spontaneous respirations, eye opening or motor response).

- 3.3.1. When the above conditions have been met, the paramedic should contact medical control and request termination of resuscitation.

- 3.4. Documentation should be completed and forwarded to the appropriate Medical Control Authority within 24 hours of the run.

Administrative Protocols Triage Tuesdays	Lorain County EMS Protocols Administrative Protocol 17 Revised 11/2006, 6/29/2006
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1. PURPOSE

- 1.1. Designed to be used every Tuesday to familiarize and keep familiar on a regular basis the START triage system and using the Triage tags. The more we use these on a regular basis, the more likely we will use it and the more proficient EMT's and Firefighters will become at using the START system.

2. DIVISIONS AFFECTED

- 2.1. All Public and Private EMS providers.
- 2.2. All Public and Private Firefighters.

3. PROCEDURE

- 3.1. This procedure will be used each and every Tuesday for the entire year. It will begin at your EMS or Fire Department's shift change. So if your shifts start at 7:00 a.m. that is when your EMS or Fire Department will start using the tags for Tuesday. This will end the next morning at the end of that shift. So if A shift comes in at 8:00 Tuesday morning, they will use the Triage Tags until 8:00 Wednesday morning.
- 3.2. You will follow the guidelines used in the START system.
 - 3.2.1. IMMEDIATE (Red Tag): Immediate victims are those persons that require immediate assistance at the paramedic level and/or immediate transport to a medical facility (severe airway/breathing problems, uncontrolled bleeding, shock, severe burns, etc.).
 - 3.2.2. DELAYED (Yellow Tag): Categorization of victim who is breathing and has pulse and level of consciousness within normal limits, but who may not be able to move because of an incapacitating injury (burns, fractures, back injury, etc.).
 - 3.2.3. MINOR (Green Tag): Delayed victims who are able to walk to treatment area, and will minimal treatment or be uninjured (minor burns, cuts, minor injuries, etc.).
 - 3.2.4. NON-SALVAGEABLE (Black Tag): These victims are those persons with obvious mortal injuries where death appears reasonably certain or victim is already dead. Obvious dead bodies must not be moved unless necessary to provide treatment for other victims.

- 3.3. Designated triage personnel shall move quickly among the remaining victims, assessing the severity of injuries. Each victim will be classified into one the four categories for care. Classification of victims will be based on the following assessment:
- 3.3.1. Check breathing: Assess whether the victim is breathing or not. If not breathing, attempt to clear and open the airway. If the victim does not begin breathing on their own with the airway open, classify as NON-SALVAGEABLE and move on to the next victim.
- If victim does begin to breathe on their own when airway is opened, classify as IMMEDIATE and move on to the next victim. Check breathing rate: Greater than 30 times a minute, classify as IMMEDIATE and move on. Less than 30 times a minute, evaluate circulation.
- 3.3.2. Check circulation: Check for presence of the radial pulse. If you cannot find the radial pulse, the blood pressure is low. Control any severe bleeding by using direct pressure, elevation or pressure bandage. Classify the victim as IMMEDIATE and move on the next victim.
- If the pulse is present and no severe bleeding is evident, check the level of consciousness.
- 3.3.3. Check level of consciousness: At this point you know that 1) breathing is normal (less than 30 per minute) and radial pulse is present. Determine the victim's level of consciousness by using AVPU scale. Classify each victim according to the following:
- Victim is alert and responds to verbal stimuli. Classify as DELAYED.
 - Victim who has some injury that prevents them from moving to safety, but their condition is not life threatening; or, a victim who remains unconscious and responds only to painful stimuli, or responds inappropriately to verbal stimuli is classified as IMMEDIATE.
- 3.4. You will use the new Lorain County Triage Tags for each patient.
- 3.5. When you call your report into the hospital, you will simply give the number of patients and their tag status. For instance, "This is XYZ Ambulance Service; we are enroute to your facility with 1 yellow patient."
- 3.5.1. The reason we are giving such a short non-descriptive report is so that the hospital also becomes familiar with the START system.
- 3.5.2. You will give your normal face-to-face report once you arrive at the hospital.

3.5.3. The Triage tags will be filled out and given to the staff with the patient.

3.6. EMS Services, document the Triage Tag number.

3.6.1. Place the Treatment sticker on your face sheet. If you are using electronic reporting and are not using any paper report; make sure you enter the Triage Tag number into your comments.

3.6.2. Also take the Transport Record sticker. You can place this sticker on the run report as well. Again, if you are using electronic reporting, just document the Triage Tag number in your comments. You do not have to take this sticker if you are not using a paper run report.

3.7. Hospitals, document the Triage Tag number.

3.7.1. Hospitals should take the Hospital bar code sticker from the Triage Tag and place it somewhere on the patient care record.

4. QUALITY ASSURANCE

4.1. EMS Units should give the Triage Tags to the hospital. The hospitals will do the QA on the tags and report back to EMS Council and the individual departments. The EMS crew will make a copy of the tag and take it back with them to the station. They should be collected and the EMS Coordinator from the EMS department should QA/QI these tags to ensure that they are being used correctly.

4.2. The EMS Coordinator for the hospitals will then report on the activity of the use of the Triage Tags.

Administrative Protocols
12-Lead EKG

Lorain County EMS Protocols
Administrative Protocol 18
Revised 6/29/2006

1. PURPOSE

- 1.1. A 12 lead EKG is important in any patient with chest pain of suspected cardiac origin and in patients with perfusing arrhythmias. Since paramedic treatment may mask any underlying signs visible on later 12-leads, it is important to get one at the earliest opportunity.

2. DIVISIONS AFFECTED

- 2.1. All Public and Private EMS providers.

3. PROCEDURE

- 3.1. Follow the Chest Pain protocols
- 3.2. Although care should never be delayed, it is imperative to obtain a 12-lead EKG as soon as possible prior to administration of ASA or NTG, especially if the patient condition allows for it.
- 3.3. With the patient in a semi-recumbant position apply the limb and chest leads
- 3.4. Obtain EKG
- 3.5. Interpret EKG for:
 - signs of Myocardial infarction including Q waves, ST segment elevation and T-wave inversion
 - Lead II, III aVF represent the inferior leads
 - Lead V1 – V4 represent the anterior leads
 - Lead I and aVL represent the lateral leads
 - Arrhythmias
- 3.6. Attempt to transmit the EKG to the receiving Hospital before arrival, especially if discrepancies are noted
- 3.7. Give copy of EKG to the Nurse or Physician taking care of the patient

4. QUALITY ASSURANCE

- 4.1. EMS agencies should have regular review of EMS calls, especially focusing on the 12-lead EKGs if your agency performs such a service.