



Wake County EMS System

Standards Procedure



Request for Alternative Destination

Purpose:

The purpose of this policy is to:

- Provide world class patient care and EMS service to the citizens of Wake County.
- Give direction for providers who encounter patients with mental health and substance abuse crisis that may be better served by a receiving facility other than an emergency department.
- Establish an orderly method by which clinical issues can be rapidly addressed.

Policy:

1. If a patient presents with primary substance abuse and/or mental health crisis (e.g., suicidal ideation without actual attempt), they should be evaluated on both the "Behavioral" and the "Well Person" protocols. If the patient is non-combative (and thus does not require medication from the Behavioral protocol) and successfully passes the Well Person screen, an Advanced Practice Paramedic (APP) on duty may be contacted; otherwise, the patient should be transported as per the usual and customary procedures.
2. After contact with the APP, the originally responding EMS crew will maintain appropriate clinical contact and monitoring of the patient until the APP arrives. If response of the APP is delayed, the EMS crew and APP will communicate via phone or radio and determine the most appropriate treatment plan and destination for the patient.
3. Until an appropriate destination for the patient has been determined, the patient will not be left unattended by EMS personnel.
4. Once the screening exam by the APP is complete, the patient may be referred to Wake County Human Services Crisis Assessment and/or Alcohol Treatment Center via appropriate transportation. At no point will patients be transported in an NCOEMS permitted vehicle to a destination other than a receiving emergency department.
5. If the patient's condition is determined not to be appropriate for transport to a destination other than an emergency department, or the patient refuses the recommended alternative destination, transportation to a receiving hospital emergency department by a Wake County EMS System ambulance shall be offered.
6. Where transportation to a non-emergency department destination is deemed to be appropriate and the patient accepts that destination, the APP will be responsible for primary documentation of the patient encounter in accordance with the "documentation with multiple providers" policy.



Wake County EMS System

Standards Procedure



Documentation with Multiple Providers

Purpose:

The purpose of this policy is to:

- Provide world class patient care and EMS service to the citizens of Wake County.
- Provide a consistent method for documenting patient care encounters that include multiple providers, particularly when an Advanced Practice Paramedic is involved.

Policy:

1. All providers involved in the patient care activity are responsible for ensuring accurate patient care documentation. The lead provider (listed as "primary attendant") on the ECR is ultimately responsible and should read the entire report once all documentation is complete.
2. In the situation where all providers are present during the documentation, then the care team may coordinate and a single provider document the patient care encounter with review by all care providers.
3. In the situation where all providers are not present during the final documentation (e.g., an APP provided some patient care on-scene but did not accompany the crew to the hospital, an APP provided on-line medical direction, etc.), the following shall be accomplished:
 - a. The APP will begin the patient care report- record patient name, date of birth, and the name of the primary provider.
 - b. The APP will document their portion of the patient care encounter as rapidly as possible and upload this information so that it will be available to the primary provider.
 - c. In the case of a transported patient, the primary provider shall wait to begin any documentation until they have accessed the network, appropriately identified the patient care record, and then selected the record to begin documentation.
 - d. In the case of a non-transported, the APP and primary provider will coordinate the appropriate order of documentation.
 - e. If there is any dispute over documentation, the first attempt to reconcile will be accomplished via conversation between the APP and the primary provider. Corrections will be placed in an addendum. If the dispute cannot be resolved in this manner, the district chief shall be contacted for mediation.



Wake County EMS System Standards Policy



Atypical Protocol Utilization and On-Line Medical Direction

Purpose:

The purpose of this policy is to:

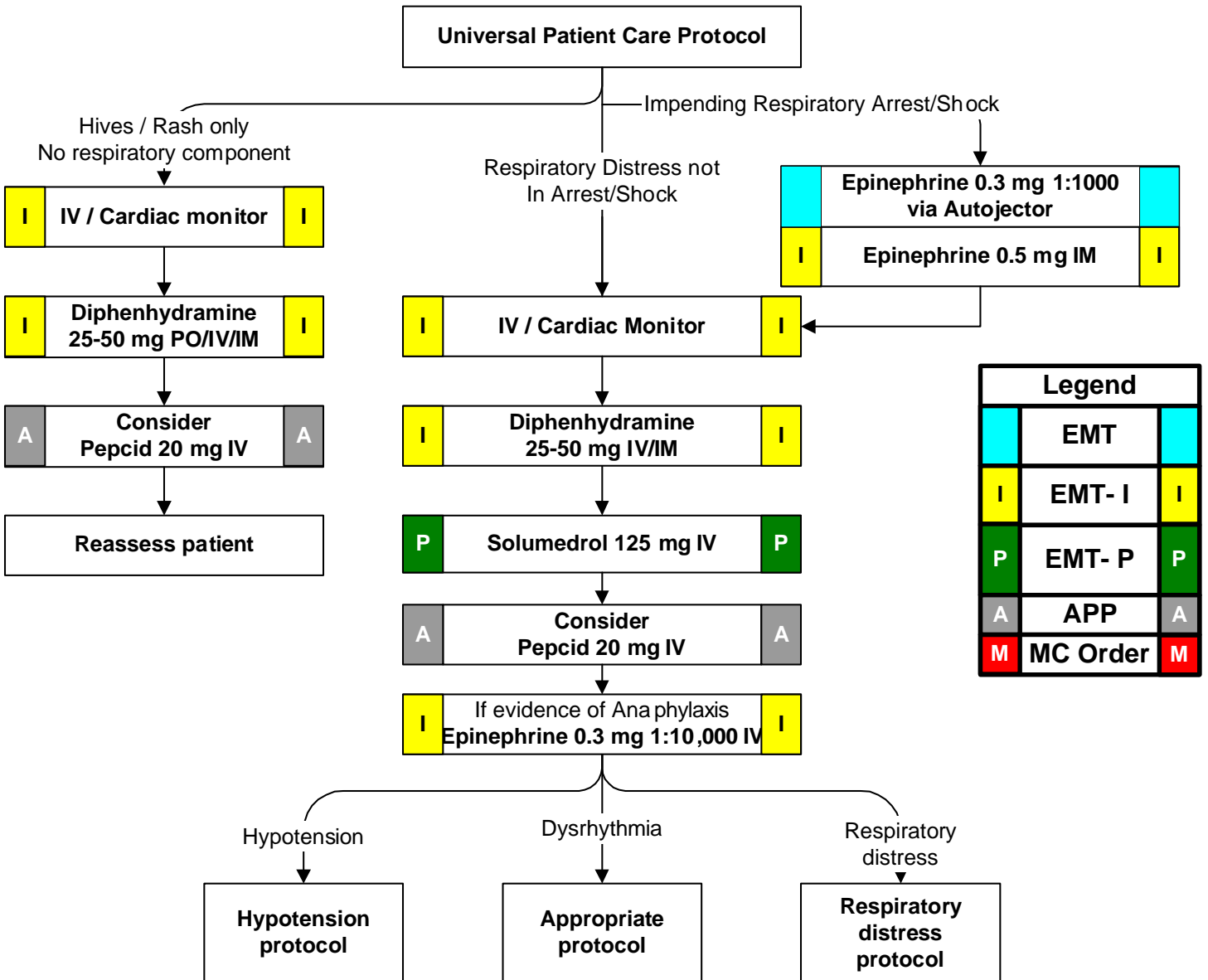
- Provide world-class patient care and EMS service to the citizens of Wake County.
- Give direction for providers who encounter complicated, unusual, and atypical patient encounters.
- Establish an orderly method by which clinical issues can be rapidly addressed.
- This policy does not affect administrative issues related to employee/employer relationships (sick outs, injuries, narcotic replacements, etc.)

Policy:

1. Clinical encounters requiring use of this protocol may be divided into two types:
 - a. those whose clinical situation is covered by existing protocol but who are presenting an operational/administrative challenge (e.g., patient refusals, non-intubated post-ROSC patients) and require non-medical control guidance or
 - b. those whose clinical situation is not covered by existing protocol (e.g., modification of drug dosage, termination of resuscitation not covered in current policy) and thus require medical control orders via on-line medical direction (OLM).
2. Patients (b) requiring OLM shall contact medical control via as described in steps 4 and 5 below. The provider requesting OLM must be at the scene with the patient.
3. The first call for operational/administrative issues related to an individual patient or patients will be placed to the Advanced Practice Paramedic (APP) on duty for the region. If possible, the call should be placed directly to the "Medic xx" cell phone. If this is not practical, the APP may be contacted on Dispatch 1 and then move to the appropriate "Admin" talk group.
4. If the request is for OLM or if there are no APPs immediately available for administrative/operational issues, the next call will be placed to a member of the Office of Medical Affairs (MD-1, MD-2, MD-20 (NOTE: MD-20 for administrative/operational calls only)).
5. If neither APP nor members of OMA are available, request OLM from a physician at the most appropriate receiving hospital via radio. Please note that only physicians at receiving hospitals can provide medical direction; other staff, including nurses, may not provide on-line medical direction.
6. In the electronic call report, the name of the individual (and unit number if applicable) providing OLM/APU will be documented in the narrative section. The APP will add a note confirming the advice provided as stated in the "APP Documentation" Policy.
7. Additionally, the APP for the region can take any calls from the Foundations of Practice document where immediate notification of the medical director is required.

Allergic Reaction

History <ul style="list-style-type: none"> Onset and location Insect sting or bite Food allergy / exposure Medication allergy / exposure New clothing, soap, detergent Past history of reactions Past medical history Medication history 	Signs and Symptoms: <ul style="list-style-type: none"> Itching or hives Coughing / wheezing or respiratory distress Chest or throat constriction Difficulty swallowing Hypotension or shock Edema 	Differential: <ul style="list-style-type: none"> Urticaria (rash only) Anaphylaxis (systemic effect) Shock (vascular effect) Angioedema (drug induced) Aspiration / Airway obstruction Vasovagal event Asthma or COPD CHF
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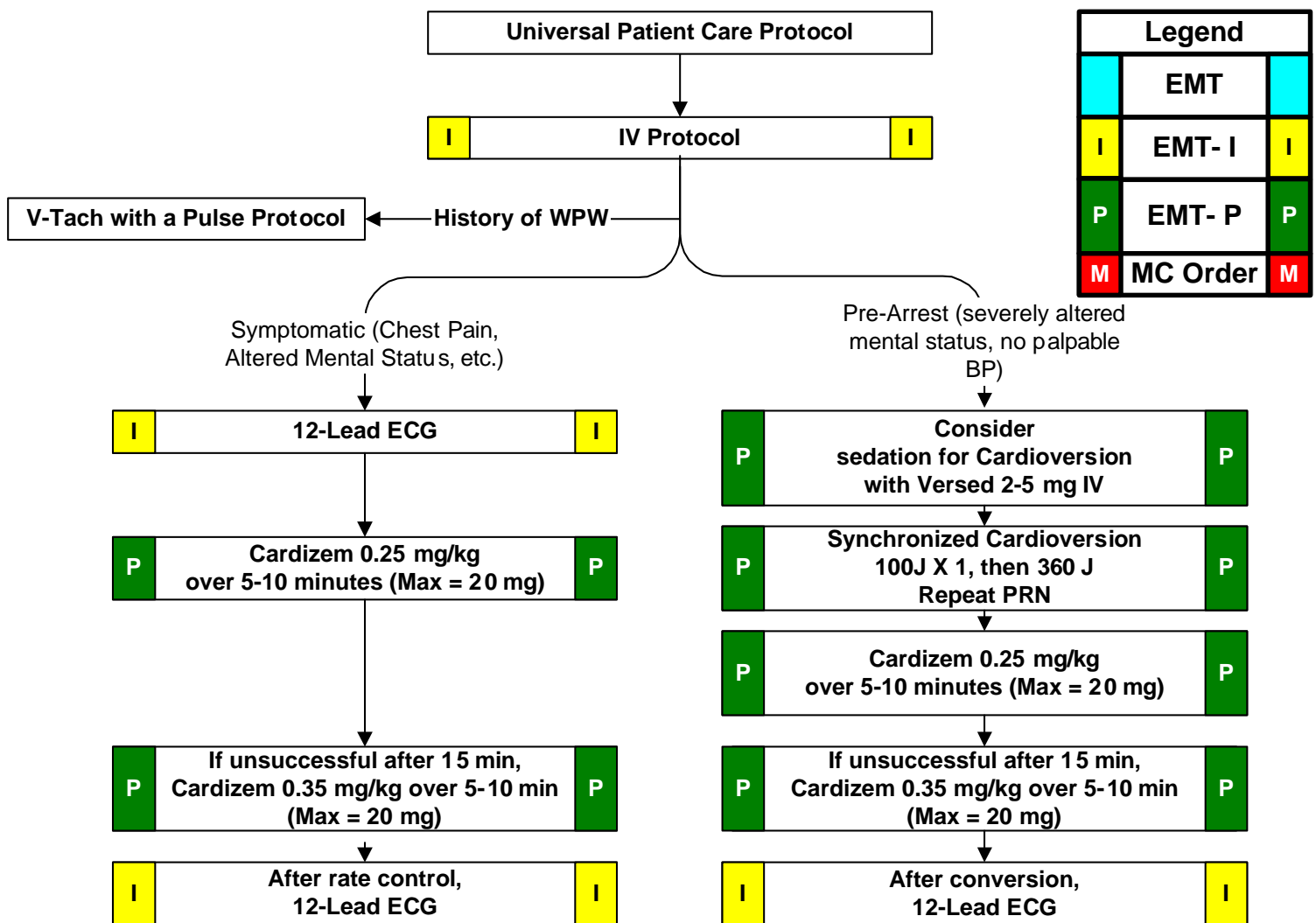


Pearls:

- Exam: Mental Status, Skin, Heart, Lungs
- Contact Medical Control** prior to administering IV epinephrine in patients who are >50 years of age, have a history of cardiac disease, or if the patient's heart rate is >150. Epinephrine may precipitate cardiac ischemia. These patients should receive a 12-lead ECG.
- Any patient with respiratory symptoms or extensive reaction should receive IV or IM diphenhydramine.
- The shorter the onset of symptoms from contact, the more severe the reaction.

Atrial Fibrillation

History: <ul style="list-style-type: none"> • Medications (Aminophylline, Diet pills, Thyroid supplements, Decongestants, Digoxin) • Diet (caffeine, chocolate) • Drugs (nicotine, cocaine) • Past medical history • History of palpitations / heart racing • Syncope / near syncope 	Signs and Symptoms: <ul style="list-style-type: none"> • HR > 130/Min • QRS < .12 Sec • Dizziness, CP, SOB • Potential presenting rhythm Sinus tachycardia Atrial fibrillation / flutter Multifocal atrial tachycardia 	Differential: <ul style="list-style-type: none"> • Heart disease (WPW, Valvular) • Sick sinus syndrome • Myocardial infarction • Electrolyte imbalance • Exertion, Pain, Emotional stress • Fever • Hypoxia • Hypovolemia or Anemia • Drug effect / Overdose (see HX) • Hyperthyroidism • Pulmonary embolus
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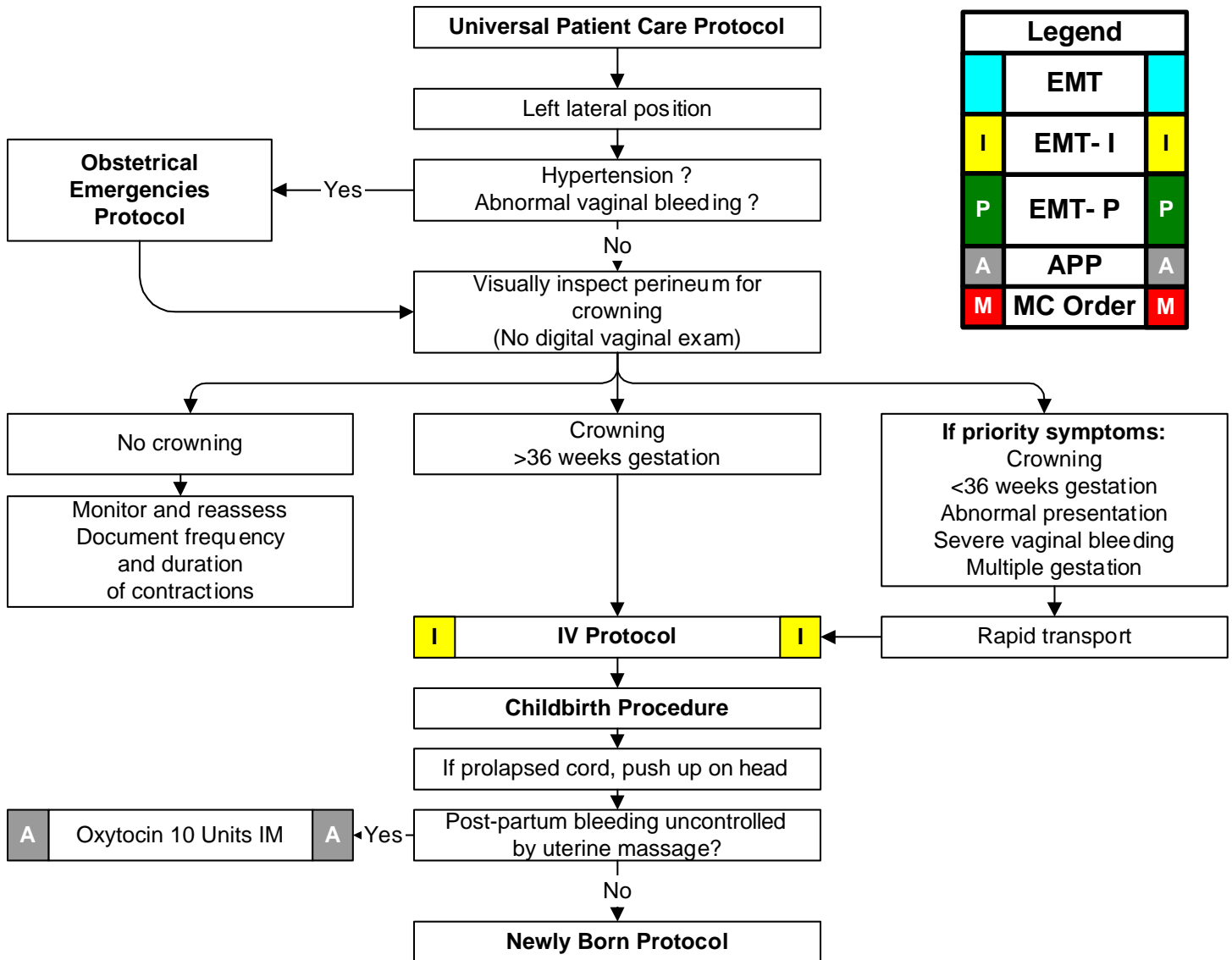


Pearls:

- Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extre mities, Neuro
- Adenosine may not be effective in identifiable atrial flutter/fibrillation, yet is not harmful.
- Monitor for hypotension after administration of Cardizem.
- Monitor for respiratory depression and hypotension associated with Versed.
- Continuous pulse oximetry is required for all Atrial Fibrillation Patients.
- Document all rhythm changes with monitor strips and obtain monitor strips with each therapeutic intervention.

Childbirth / Labor

History: <ul style="list-style-type: none"> • Due date • Time contractions started / how often • Rupture of membranes • Time / amount of any vaginal bleeding • Sensation of fetal activity • Past medical and delivery history • Medications • Drug use • Gravida/Para status • High Risk pregnancy 	Signs and Symptoms: <ul style="list-style-type: none"> • Spasmodic pain • Vaginal discharge or bleeding • Crowning or urge to push • Meconium 	Differential: <ul style="list-style-type: none"> • Abnormal presentation Buttock Foot Hand • Prolapsed cord • Placenta previa • Abruptio placenta
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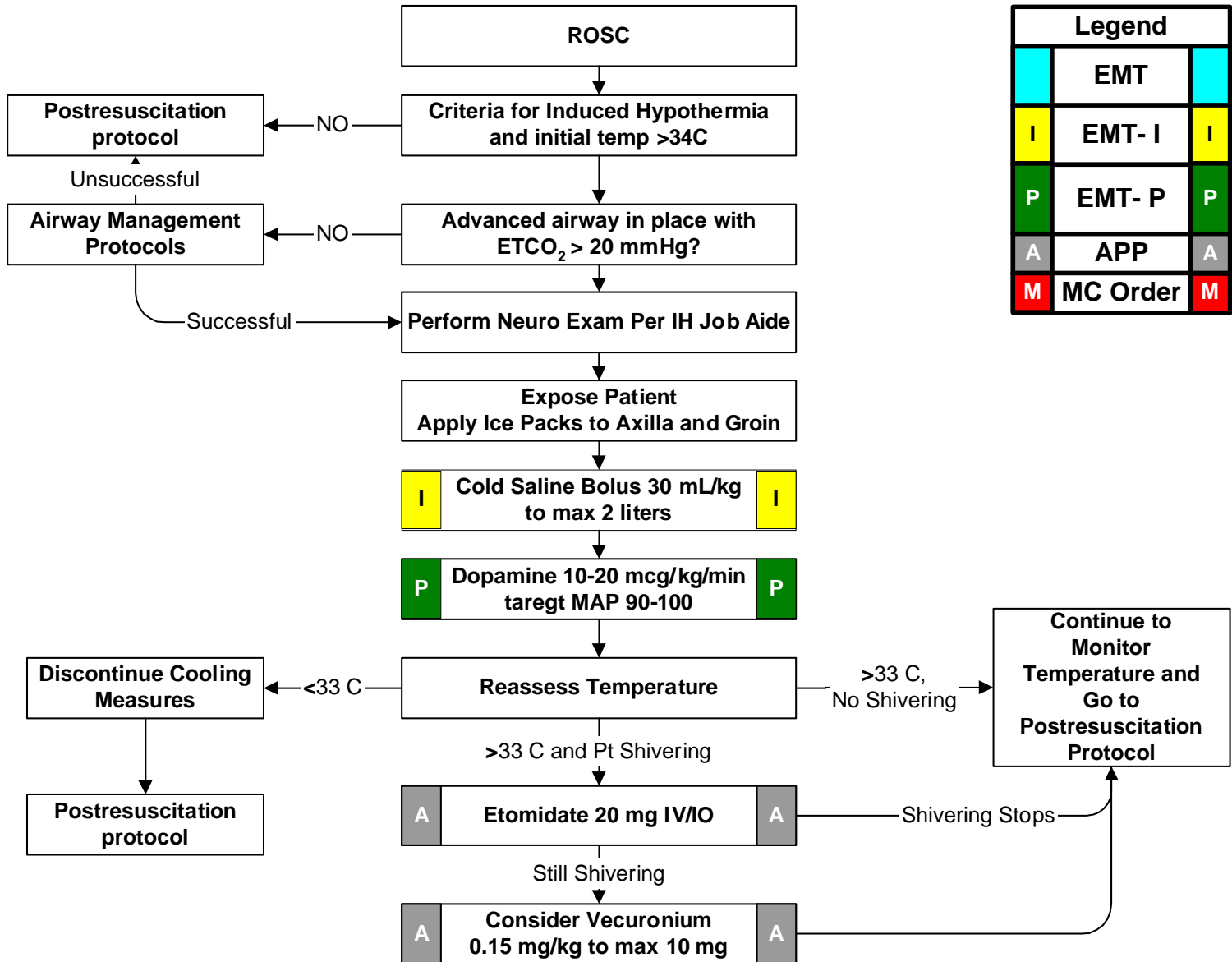


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Pearls: <ul style="list-style-type: none"> • Exam (of Mother): Mental Status, Heart, Lungs, Abdomen, Neu ro • Document all times (delivery, contraction frequency, and length). • If maternal seizures occur, refer to the Obstetrical Emergencies Protocol. • After delivery, massaging the uterus (lower abdomen) will promote uterine contraction and help to control post-partum bleeding. • Some perineal bleeding is normal with any childbirth. Large quantities of blood or free bleeding are abnormal. • Record APGAR at 1 minute and 5 minutes after birth.

Induced Hypothermia

History <ul style="list-style-type: none"> Non-traumatic cardiac arrest (drowning and hanging are permissible in this protocol) 	Signs and Symptoms: <ul style="list-style-type: none"> Return of pulse 	Differential: <ul style="list-style-type: none"> Continue to address specific differentials associated with the original dysrhythmia
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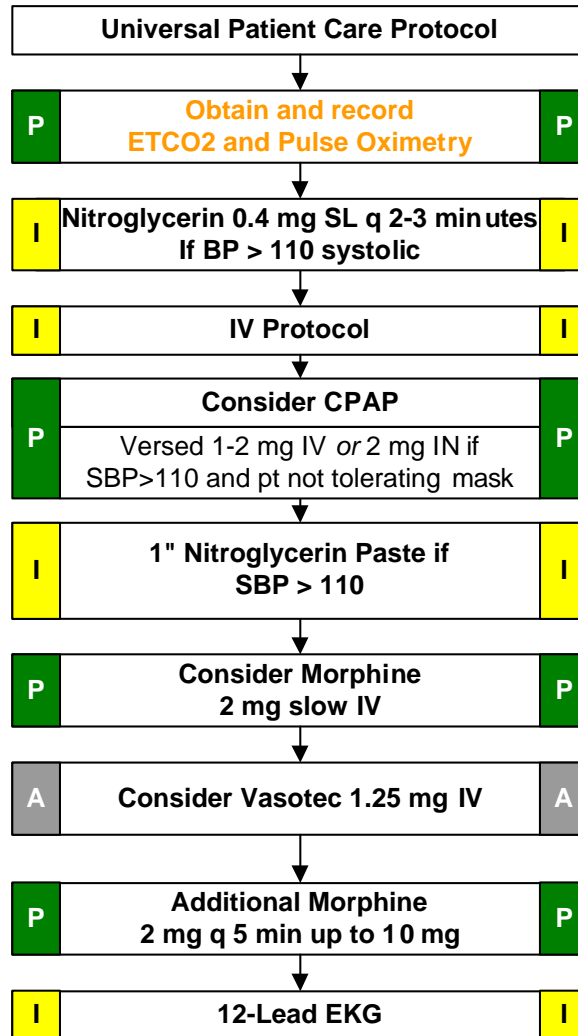


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Pearls: <ul style="list-style-type: none"> Criteria for Induced Hypothermia ROSC not related to blunt/penetrating trauma or hemorrhage Age 12 or older with adult body habitus Temperature after ROSC greater than 34 C degrees Advanced airway in place with no purposeful response to pain If no advanced airway can be obtained, cooling may only be initiated on order from online medical control Take care to protect patient modesty. Undergarments may remain in place during cooling Do not delay transport to cool Frequently monitor airway, especially after each patient move Patients may develop metabolic alkalosis with cooling. Do not hyperventilate
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Pulmonary Edema

History: <ul style="list-style-type: none"> • Congestive heart failure • Past medical history • Medications (digoxin, lasix) • Viagra, Levitra, Cialis • Cardiac history --past myocardial infarction 	Signs/Symptoms: <ul style="list-style-type: none"> • Respiratory distress, bilateral rales • Apprehension, orthopnea • Jugular vein distention • Pink, frothy sputum • Peripheral edema, diaphoresis • Hypotension, shock • Chest pain 	Differential: <ul style="list-style-type: none"> • Myocardial infarction • Congestive heart failure • Asthma • Anaphylaxis • Aspiration • COPD • Pleural effusion • Pneumonia • Pulmonary embolus • Pericardial tamponade • Toxic Exposure
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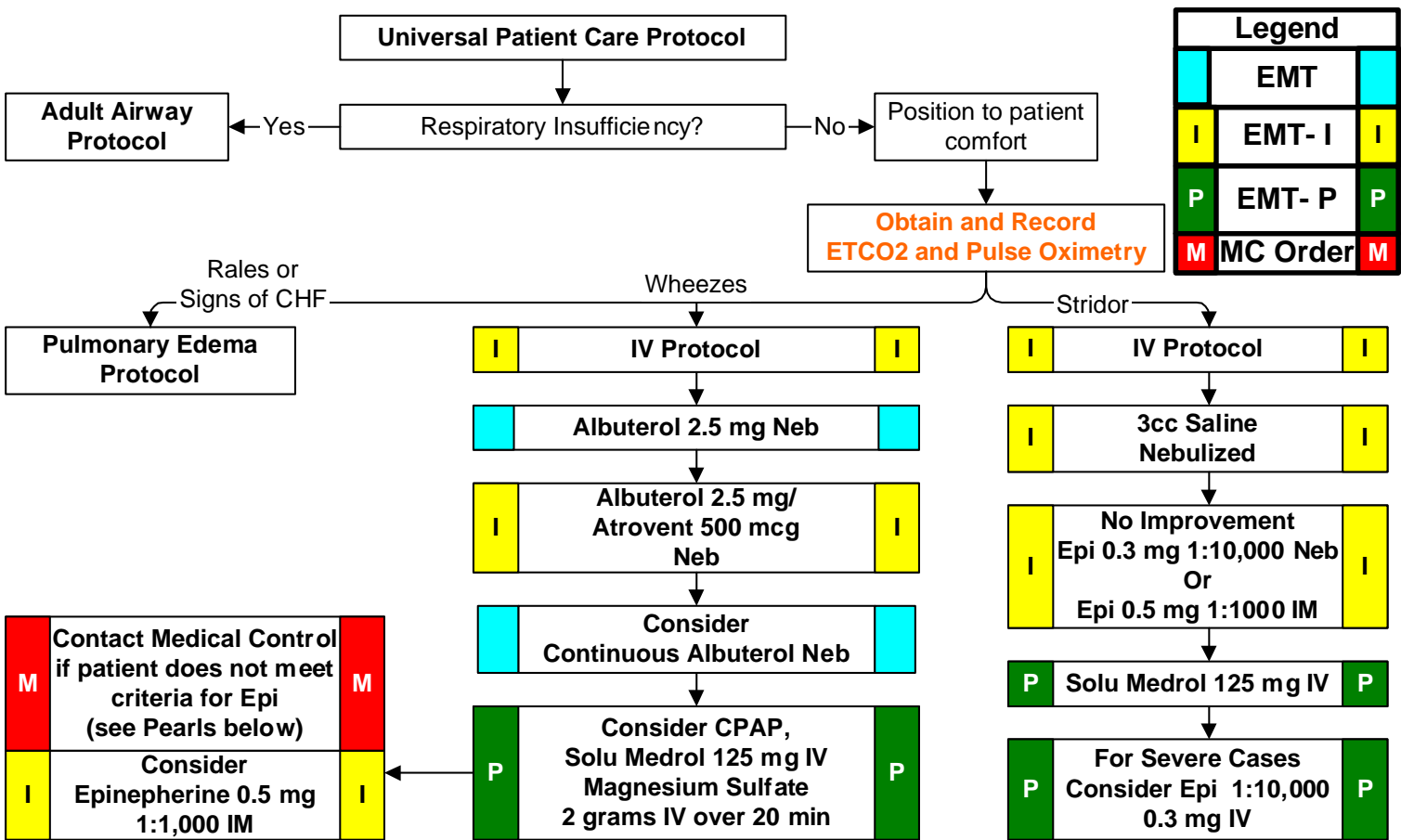
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Pearls:

- **Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extremities, Neuro**
- **Avoid Nitroglycerin in any patient who's used Viagra or Levitra in the past 24 hours or Cialis in the past 36 hours due to possible severe hypotension.**
- If patient has taken nitroglycerin without relief, consider potency of the medication.
- Consider myocardial infarction in all these patients.
- Diabetics and geriatric patients often have atypical pain, or only generalized complaints.
- **Careful monitoring of level of consciousness, BP, and respiratory status with above interventions is essential.**
- Allow the patient to be in their position of comfort to maximize their breathing effort.
- If patient condition precludes use of indicated NTG spray, proceed to NTG paste.
- If Nitro Paste is used, do not continue to use Nitro Spray.
- Document CPAP application using the "CPAP" procedure in the call reporting system. Document 12-lead with "12-lead EKG" procedure

Respiratory Distress

History: <ul style="list-style-type: none"> Asthma; COPD -- chronic bronchitis, emphysema, congestive heart failure Home treatment (oxygen, nebulizer) Medications (theophylline, steroids, inhalers) Toxic exposure, smoke inhalation 	Signs and Symptoms: <ul style="list-style-type: none"> Shortness of breath Pursed lip breathing Decreased ability to speak Increased respiratory rate and effort Wheezing, rhonchi, rales, stridor Use of accessory muscles Fever, cough Tachycardia 	Differential: <ul style="list-style-type: none"> Asthma Anaphylaxis Aspiration COPD (Emphysema, Bronchitis) Pleural effusion Pneumonia Pulmonary embolus Pneumothorax Cardiac (MI or CHF) Pericardial tamponade Hyperventilation Inhaled toxin (Carbon monoxide, etc.)
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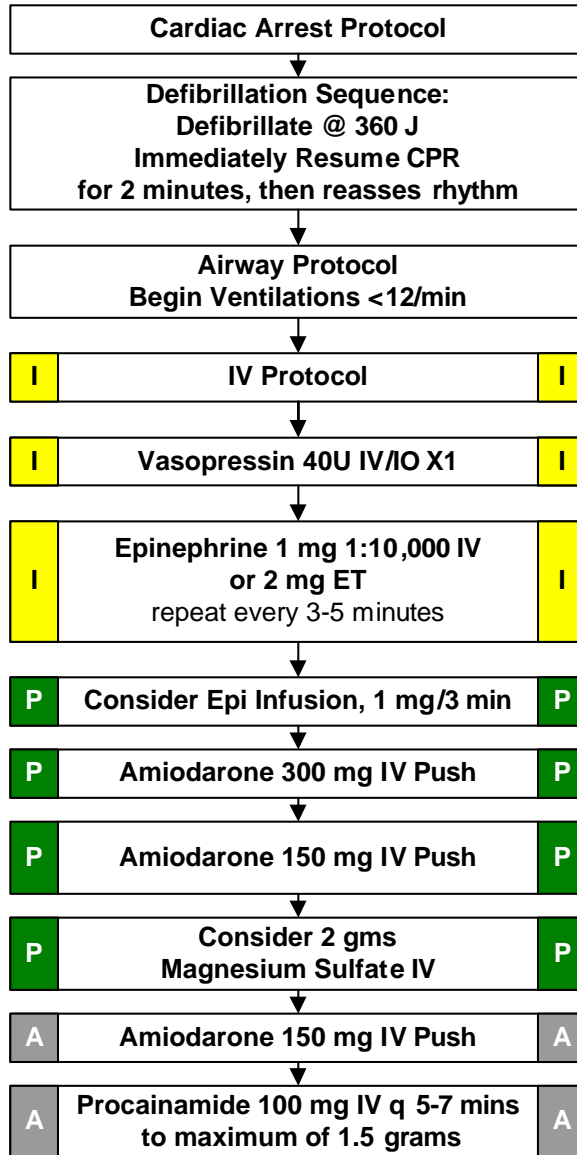
- Pearls:**
- EMT administration of albuterol is restricted only to patients who are under doctor's orders/prescription for albuterol. Any EMT wishing to provide albuterol must complete in-service training prior to administration.
 - Pulse oximetry should be monitored continuously if initial saturation is < or = 96%, or there is patient deterioration.
 - CPAP may be considered in asthma/COPD patients not responding to bronchodilators. This requires continuous monitoring for hypotension, changes in mental status.
 - Contact Medical Control** prior to administering IV epinephrine in patients who are >50 years of age, have a history of cardiac disease, or if the patient's heart rate is >150. Epinephrine may precipitate cardiac ischemia. A 12-lead ECG should be performed on these patients.
 - A silent chest in respiratory distress is a pre-respiratory arrest sign.
 - ETCO2 should be recorded for patients who require CPAP, solumedrol, magnesium sulfate, or epinephrine.**
 - Xopenex may be substituted for Albuterol and mixed with Atrovent. Use patient current dose (0.31-1.25 mg) and meds.



Ventricular Fibrillation Pulseless Vent. Tachycardia



History: <ul style="list-style-type: none"> • Estimated down time • Past medical history • Medications • Events leading to arrest • Renal failure / dialysis • DNR 	Signs and Symptoms: <ul style="list-style-type: none"> • Unresponsive, apneic, pulseless • Ventricular fibrillation or ventricular tachycardia on ECG 	Differential: <ul style="list-style-type: none"> • Asystole • Artifact / Device failure • Cardiac • Endocrine / Metabolic • Drugs • Pulmonary
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AT ANY TIME

1. Rhythm Changes

Go to appropriate protocol

2. ROSC (Return of Spontaneous Circulation)

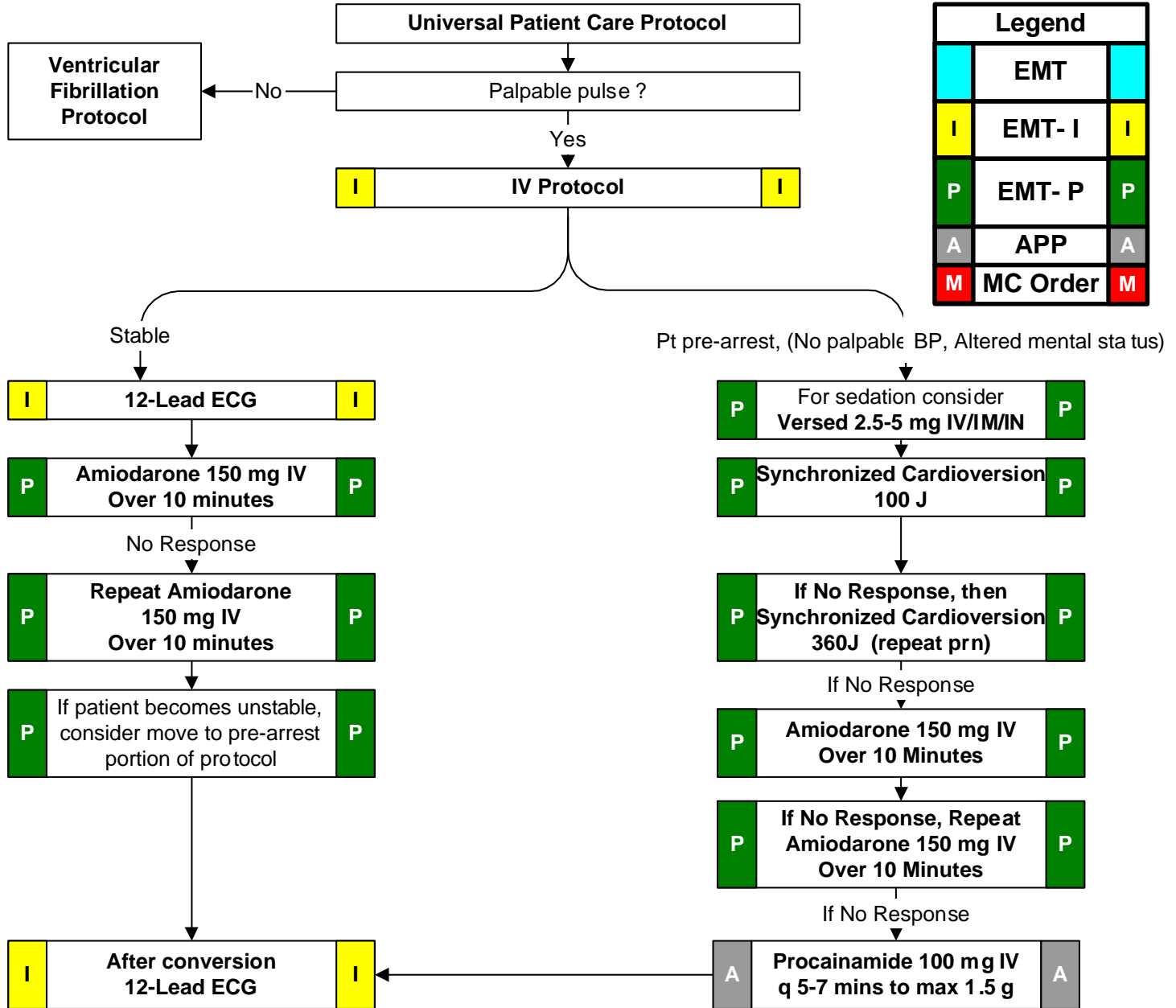
Go to Post Resuscitation Protocol

If criteria for discontinuation, cease efforts.

Pearls: <ul style="list-style-type: none"> • Precordial thump is not indicated when a defibrillator is on scene • Wait three to five minutes between antiarrhythmic doses • If no IV/IO, drugs that can be given by ET tube should have dose doubled, flush with 5cc saline. Use IV/IO if available. • Reassess and document advanced airway placement and ETCO2 frequently, after every move, and at discharge. • Calcium and sodium bicarbonate if hyperkalemia is suspected (renal failure, dialysis). • If the amplitude of the fibrillation is fine, one or two 2 minute cycles of CPR may be performed prior to defibrillation • Polymorphic V-Tach (Torsades de Pointes) may benefit from administration of magnesium sulfate. • Effective CPR and prompt defibrillation are the keys to successful resuscitation. • If BVM successful, advanced airway may be deferred 2 to 3 defibrillation sequences or until rhythm changes

Ventricular Tachycardia/ Wide Complex with Pulse

History: <ul style="list-style-type: none"> Past medical history / medications, diet, drugs. Syncope / near syncope Palpitations Pacemaker Allergies: lidocaine / novacaine 	Signs and Symptoms: <ul style="list-style-type: none"> Ventricular tachycardia on ECG (Runs or sustained) Conscious, rapid pulse Chest pain, shortness of breath Dizziness Rate usually 150 - 180 bpm for sustained V-Tach QRS > .12 Sec 	Differential: <ul style="list-style-type: none"> Artifact / Device failure Cardiac Endocrine / Metabolic Hyperkalemia Drugs Pulmonary
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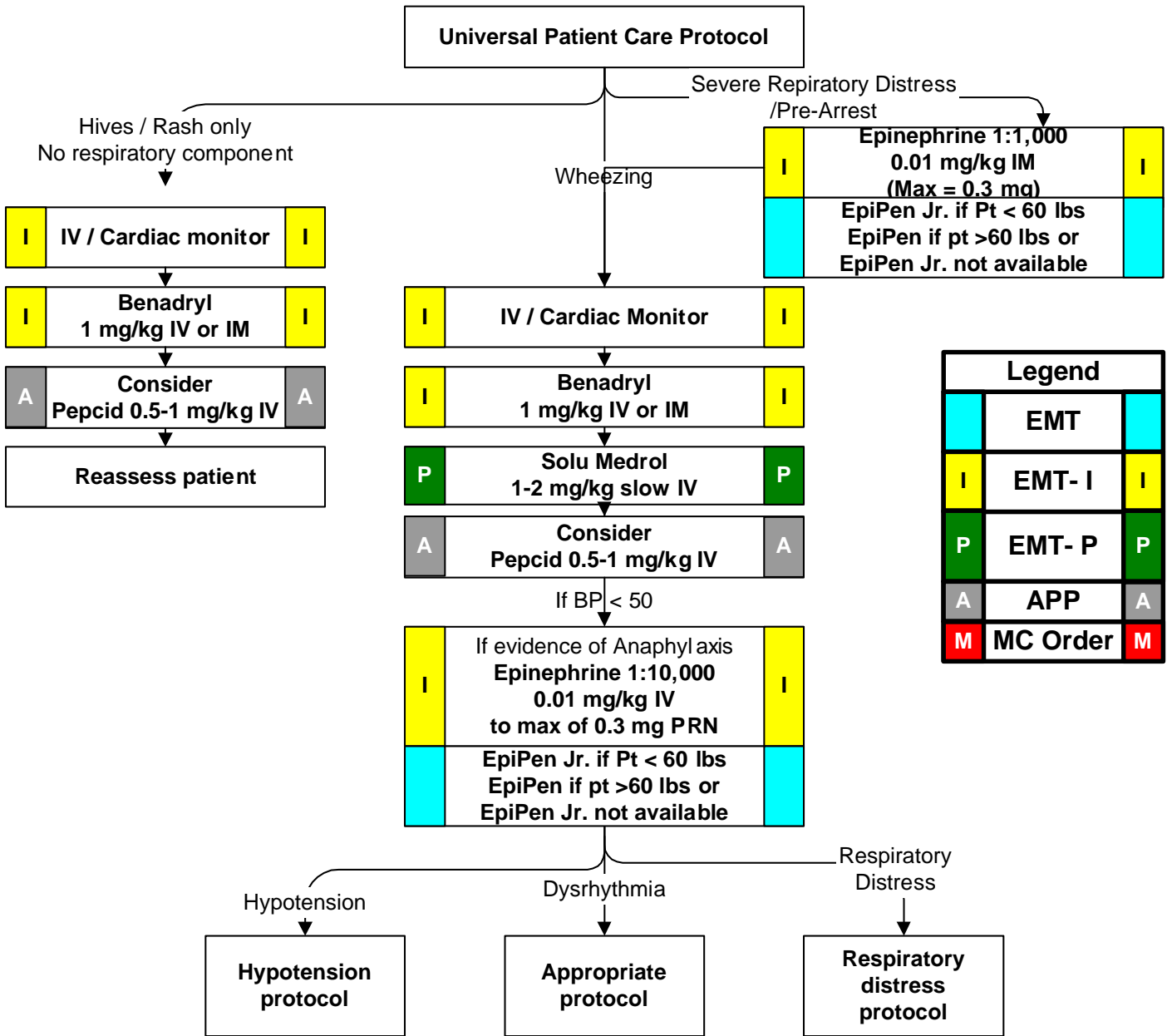


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Pearls: <ul style="list-style-type: none"> Exam: Mental Status, Skin, Neck, Lung, Heart, Abdomen, Back, Extremities, Neuro For witnessed / monitored ventricular tachycardia, try having patient cough or deliver a precordial thump. Polymorphic V-Tach (Torsades de Pointes) may benefit from the administration of magnesium sulfate 2 grams IV. If presumed hyperkalemia (end-stage renal disease, dialysis, etc), administered 1 to 2 amps of Sodium Bicarbonate Terminate procainamide if rhythm converts, QRS widens > 50%, hypotension develops, or max dose reached.

Pediatric Allergic Reaction

History <ul style="list-style-type: none"> Onset and location Insect sting or bite Food allergy / exposure Medication allergy / exposure New clothing, soap, detergent Past history of reactions Past medical history Medication history 	Signs and Symptoms: <ul style="list-style-type: none"> Itching or hives Coughing / wheezing or respiratory distress Chest or throat constriction Difficulty swallowing Hypotension or shock Edema 	Differential: <ul style="list-style-type: none"> Urticaria (rash only) Anaphylaxis (systemic effect) Shock (vascular effect) Angioedema (drug induced) Aspiration / Airway obstruction Vasovagal event Asthma or COPD CHF
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Legend		
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Pearls: <ul style="list-style-type: none"> Exam: Mental Status, Skin, Heart, Lungs Any patient with respiratory symptoms or extensive reaction should receive IV or IM Benadryl. The shorter the onset of symptoms from contact, the more severe the reaction.
