General Guidelines For All Patients

Primary Assessment: Done initially on every patient and repeated every few minutes as indicated.

- ✓ Check responsiveness
- ✓ Airway: Is it patent? Identify and correct any obstruction
- ✓ Breathing: Rate and quality. Identify and correct any compromising factors
- ✓ Circulation: Pulse, rate, quality, and location.
- ✓ Control external bleeding
- ✓ Check for shock, if present, treat

Secondary Assessment: Complete as indicated by patient condition

1. Level of consciousness (**see Glasgow Coma Scale**).
2. Reassure patient. Inform patient about exam and treatment.
3. Obtain a brief history of illness or injury from patient, family, or bystanders. Check for medical identification.
4. Perform a head to toe assessment. Record vital signs, to include pulse, blood pressure, respirations, skin color, pupils, etc.

Field Treatment:

1. Triage problems according to severity (see **Mass Casualty Incident protocols**).
2. Provide treatment, using appropriate protocols.
3. Transport:
   A. Use of lights and sirens should be limited to the emergency transportation of critical patients.
   B. Destination determined by:
      a. Patients meeting major trauma triage criteria, as defined by **State of Washington Prehospital Trauma Triage Destination Procedures**, will be transported to the Level II facility, as the

primary receiving facility as determined by the annual schedule of weekly rotation provided by our Regional Level II Trauma centers.

b. MD to MD arrangement*

c. Patient request*

d. Senior Medical Officer judgment

C. If the intended receiving hospital ER is on divert (Red), the patient destination should rely upon the same factors as they relate to the available receiving facilities.†

COMMUNICATIONS:

1. **H.E.A.R. Radio during transport:** All users of the H.E.A.R. system are urged to transmit essential communications and keep air times as short as possible. The following format for communications should be used. If Medical Control feels additional communications are necessary, they may contact the transporting unit via the H.E.A.R. system.

2. **Emergency Prehospital H.E.A.R. Report Format:**

✓ Unit identification

✓ Category of emergency:

A. Code Red - Critical

B. Code Yellow - Urgent

C. Code Green - Stable

D. Code 99 - EMS Personnel Endangerment

E. Hazmat Code

a. Code Red

b. Code Yellow

c. Code Green

✓ Age and sex of patient

✓ Chief complaint or reason for transport

✓ Very brief pertinent medical history (one sentence, if possible)

- ✓ Vital signs and level of consciousness
- ✓ Pertinent treatment rendered and results, if any
- ✓ Request for additional information or treatment
- ✓ Estimated time of arrival

The H.E.A.R. report should be provided as soon as practical, once transport has begun. All reports should be given in this order and should be a maximum of 30 seconds. The H.E.A.R. report is not meant to be a full patient record and should relay only pertinent patient care information. Patient identification information is inappropriate to be given on the H.E.A.R. frequency. Advise Medical Control or receiving emergency department of changes in patient's condition en route, and request direction for further treatment.

3. **Verbal report to emergency department:** The verbal report to emergency department physician and/or triage nurse should contain more detail than the radio report. The emergency care provider now has the time to present thorough details of the scene, complete assessment of the patient, and complete report on patient care and result of efforts.

   - ✓ Name, age, sex, and patient's physician
   - ✓ Chief complaint of injuries
   - ✓ If trauma, describe the trauma scene/mechanism of injury
   - ✓ Pertinent medical history
   - ✓ Vital signs and level of consciousness
   - ✓ Condition changes or trends in vital signs or level of consciousness during transport
   - ✓ Explain patient treatments and results

4. **Written Report:** Complete an EMS Medical Incident Report (MIR) on all patient encounters. The **C.H.A.R.T.E.D.** method (see figure 1.1) has been adopted as the standard for report writing in Spokane County. The MIR is a LEGAL record and may be called upon as evidence in any court of law. An MIR should be formatted on a

triplicate copy paper document. Each individual using this format should clearly identify their name and agency in association with the information that they have contributed to the effort. The color coded copies should be used in the following manner:

White Copy:	First responding EMS agency
Yellow Copy:	Transporting EMS agency
Pink Copy:	Receiving hospital

SEE NEXT PAGE FOR C.H.A.R.T.E.D TABLE

*Patient requests and physician to physician referrals must, in general, be respected. However, if in the judgment of the Senior Medical Officer a critical patient requires transport to a nearer hospital for stabilization, it is the Senior Medical Officer's responsibility to explain this to the patient or physician. If a conscious patient or physician who, in the judgment of the Senior Medical Officer, is capable of making a rational decision persists in requesting transport to a different facility, the patient and/or physician request should be followed (see **Patient Treatment Rights**). Attempt to obtain a signature on a medical release form.

† In spite of ER divert (Red status) Sacred Heart Medical Center will receive pediatric and adult major trauma patients. In spite of ER divert (Red status) Deaconess Medical Center, Holy Family Hospital, and Sacred Heart Medical Center will still receive Level I STEMI patients.

Fig. 1.1: C.H.A.R.T.E.D Method

C **Chief Complaint:** The major problem with the patient. May include significant associated symptoms

Hx **History:** Will include subjective information which the patient, family, bystanders, or other witnesses tell you.

- **S** **Symptoms:** What you are told associated with the problem at hand. Should include pertinent negatives.
- **A** **Allergies:** Known drug allergies.
- **M** **Medications:** Medications the patient has or should have taken. Bring medication bottles to hospital.
- **P** **Past Medical History:** Pertinent or possibly pertinent problem of the past. Name of patient's physician. History of smoking, if known.
- **L** **Last Food/Beverage:** Anything the patient ate or drank prior to the incident
- **E** **Events Prior:** What the patient was doing prior to the incident.
- **D** **Description of PT:** Age, gender, race, size, etc.

Ax **Assessment:** Physical findings of primary and secondary survey, as well as vital signs.

R **Rendered Treatment:** What you did for the patient and any change as a result of treatment.

Tx **Transport/Transfer:** Who, where, and how the PT was transported, patient care transferred to, and any changes while transporting

Ex **Evaluation:** Was the *Trauma Triage Tool* used for destination decision?

Dx **Destination:** Name of destination hospital and reason(s) selected:

A. Highest designated facility within 30 minutes (Step 1 or Step 2)

B. Nearest designated facility within 30 minutes (Step 3)

C. Per documented online Medical Control

D. Patient/family request

E. Physician request

F. Other (must be documented)