Communications

Purpose: Provide specific requirements for succinct and expeditious radio reports to receiving medical facilities when transporting stable patients, and describe expectations for communication when transporting critical patients.

Currently EMS providers transmit a patient report for all emergent and non- emergent transports. The limited literature supports little process improvement measures or improvement in patent care outcomes for non-emergent patients and their subsequent radio reports. In an effort to reduce field staff work redundancy and dispatch task saturation, the MCB has developed new radio reduction report guidelines for non-emergent transports on low acuity patients. This guideline is designed to improve efficiency for non- emergent transports while still giving the EDs an appropriate amount of lead-time for safe patient placement, reinforcing our Emergency Department Patient Turnover guidelines. Radio reports should be limited to 30 seconds for the majority of patients.

1. Radio reports are still required for:
- All emergent patient transports (Any code 3 return to the ED)
- All hospital alert transports—STEMI, Stroke, Sepsis, and Trauma/Burns
- Patients that may require additional staff and security due to hostile/aggressive actions/jails/detention centers/ in custody or any suicidal/homicidal patients
- Active labor with imminent delivery , post-delivery or contractions less than 2 minutes apart or any patient pregnant with active abd pain/ cramping or vaginal bleeding > or < 20 weeks
- All Bannered MCI patients

2. At the paramedic/ EMTs discretion, based on patient presentation and active treatment, any patient that will most likely meet ED triage criteria will not require a radio transport. ED triage should take EMS patients prior to stable walk-in patients.

3. All other non-priority transports will require a radio report in an effort to allow the ED enough time for bed placement. Examples may include:
- CPAP use on asthma/ COPD/ CHF exacerbation
- Active respiratory treatment—multiple nebs, epi administration, magnesium, nitro
- Limbs with vascular compromise
- Extremity fractures with obvious deformity or vascular compromise
- Patients that are bed bound, unable to sit in chair or triage area. Including morbidly obese, hemi/paraplegia, fractured extremities,hips dislocations, or any additional medical devices or equipment
- Patients from skilled nursing facilities or rehab hospitals
- Patients with concern for infectious disease—ex. C diff, MRSA, bed bugs, lice
- Patients receiving benzo’s or opiates that require closer airway observation
- Opiate OD’s that require more than single dose of Naloxone for reversal (whether 0.4 IM/IV or 2 IN) or require closer airway andETCO2 monitoring
- Anaphylactic reactions
- Any toxic ingestion/polypharmacy overdose
- Hypotensive/tachycardic patients requiring frequent or large fluid boluses
- Arrhythmias—SVT, narrow/wide complex tachycardia, Stable V- Tac
- Geriatric patients 80 and older with extensive medication lists and complex medical history

Communications Continued

Routine requirements for radio reports are as follows:

- Age and gender
- Chief complaint / mechanism of injury (relevant clinical conditions)
- Current status (stable, unstable, suitable for triage)
- ETA
- When required by acuity or complexity, more information may be relayed, including vital signs and treatment rendered.

When transporting a critical patient it is important to provide a “picture” of the patient and their condition. Brevity is still important. It is not important at this stage to include everything about the patient’s recent or past medical history unless something in that history is important in obtaining a medication order.

Patient name, medical record number, or other patient identifiers cannot be given over the radio because these are open channels and the patient’s right to privacy would be violated.

If patient is unstable, contact the ED or Albuquerque Base ASAP from scene to provide early notification (age, chief complaint, and ETA).

Activate UNMH trauma team using Trauma Alert Protocol (TAP) criteria when appropriate.

Advise dispatch and activate MCI protocol when appropriate.

MCEP Consult

When requesting to speak to the MCEP, state the reason or need for direct MCEP, for example, forced transport, medication orders, termination of resuscitation or withholding resuscitation. This allows the MCEP to prepare for your call and prioritize it in relation to other patients in the emergency department. Per state statute, nurse practioners and PAs are not to give on line medical direction nor may thay dictate care on scene.

UNM EMS Consortioum

This is a group of board certified EM and EMS physicians in conjuction with EMS fellows that are available 24 hours a day. These physicians have the experience and capacity to understand unique and complicated patient/ scene circumstances. They are also available for scene response given their EMS expertise. Contact is made through Albuquerque Base on a recorded line at 505-449-5710. These physicians have the final decision making authority in the system as EMS trained physicians and medical directors for the respective programs. If a hospital destination MD and EMS Consortium MD are both contacted, the final decision lies with the Consortium physician.

Hospital MCEP

These are Emergency Medicine Physicians based in the emergency department that may/may not have any EMS experience. Hospital based MCEP calls are appropriate for standard medication orders, simple/straight forward termination of cardiac arrest and hospital destination advice based on the patient’s illness or injury.