

Appendix A

RELATED POLICIES AND PROCEDURES

The following are policies, procedures and directives relating to patient care approved by the Operational Medical Directors Committee:

1. It is the responsibility of EMS personnel to ensure that **any contaminated materials and used supplies, particularly needles, have been removed from IV and drug boxes** prior to presentation to the pharmacy for exchange. It is to be understood that the ALS provider who returns the boxes to the pharmacy is responsible for their cleanliness.

Approved: August, 1991

2. Disposal of Unused Controlled Medications - Partial doses of controlled medications

(i.e. morphine and Valium) that are not administered to the patient will be discarded (wasted) in the hospital by disposal down a sink drain. *An EMT-C, EMT-I, EMT-P, licensed registered nurse or pharmacist must witness that action.* The individual witnessing the disposal must sign the PPCR on a line where the AIC has clearly indicated the medication and dose that was wasted. The AIC may use the narrative section or the "...agency's use" section to document wastage of controlled medications.

Approved: December 10, 1996

Revised: March 20, 2003

3. All EMS agencies within the TEMS region are to complete a **Prehospital Patient Care Report (PPCR)** on all patients transported within the following categories:

- Advanced Life Support Calls
- Inter Hospital Calls
- Any transport to a hospital

The appropriate copy of the PPCR is to be left at the receiving facility at the time of transport. In cases of call overload, the PPCR should be completed as soon as possible (within 24 hours) and returned to the receiving facility for inclusion in the patient's record.

Approved: February, 1991

4. The use of any **circumferential pneumatic device, (MAST, PSAG, air splints)** should not be used as a primary splint for lower extremity fractures in the absence of hypotension. It has been shown that the use of the MAST garment as a splint can precipitate compartment syndrome in lower extremities.

Approved: August, 1990

5. Notification of transport to receiving hospitals:

- Each local EMS agency and hospital should establish its own routine policy on whether or not EMS should call (notify) the receiving hospital on BLS cases.
- All ALS cases should be called in to the receiving hospital using the following format:
 - Identification of caller, EMS Agency and ambulance number
 - Age and sex of patient
 - Statement of primary problem, medical history and results of physical Examination
 - Level of distress of patient (e.g. none, moderate, or severe)
 - Treatment already rendered
 - Request for further treatment
 - Acknowledgment of additional orders received
 - Statement of destination and estimated time of arrival
 - A brief summary and update on the patient should be communicated directly to personnel at the receiving medical facility.
- The following practices should be avoided:
 - Stating patient's name
 - Use of personal identification numbers.
 - Stating patient's race or ethnic origin (unless pertinent)
- When transporting BLS patients the proper format for calling in the radio report will be as follows:
 - Agency/Unit identification
 - Chief Complaint
 - ETA (estimated time of arrival)

Technicians need not report any other information unless specifically requested by the receiving facility.

Note: Sentara Norfolk General Hospital has requested that technicians not call in reports on BLS patients.

When an EMS agency transports to a hospital outside their normal catchment area, all cases including BLS should be called into the receiving hospital.

Approved: December 1, 1998

Revised: March 20, 2003

Revised: September 2, 2009

6. The use of the **14 gauge angiocath IV catheters** is restricted for chest decompression use only (suggested length 2 1/4 inches).

Approved: May, 1992 Revised: December, 1998

7. **Red lights and sirens (RLS)** are a tool to be used for the benefit of patient care. The benefits for the use of this tool should outweigh the risks. Risk assessment must consider the patient, EMS crew and public. Specifically, the Attendant-in-Charge (AIC) must consider the condition of the patient being treated and if there is a need for rapid transport to a medical facility. If more expeditious arrival at the hospital will immediately benefit the patient, then RLS use may be instituted. Discussion with on-line medical control may be utilized to assist in determining the need for RLS. However, the ultimate decision for RLS use rests with the AIC. The safe, prudent and legal operation of the vehicle remains the responsibility of the vehicle operator.

Specific situations in which individual EMS agencies will or will not require RLS may be enacted under policy of the agency Operational Medical Director.

Approved: March, 1995 Revised: December 1998

8. EMS Coverage During Standby Events

- Local governments should regulate EMS care provided within a jurisdiction so that all patients, even at special events, are able to receive a level of care usually available in that jurisdiction.
- Agencies intending to standby in an area outside their jurisdiction should notify the “home” agency of the standby;
- 911 agencies doing standbys in their own jurisdiction may standby with BLS, even if ALS is normally provided, as long as ALS is readily available;
- A “home” agency, when notified that an outside agency will conduct a standby, should remind the standby agency of the appropriate level of care to be provided.

Approved May 20, 1998