Mission

To promote high-quality, consistent pre-hospital care in the region

Philosophy of Protocols

Medical protocols in the pre-hospital setting are established to ensure safe, efficient and effective interventions during the pre-hospital phase of patient care. Provider safety, coupled with the patient's best interests, should be the final determinants for all decisions. The goals of the EMS Regional Medical Protocols are:

- To establish minimum expectations for appropriate patient care
- To relieve pain and suffering, improve patient outcomes and do no harm
- To ensure a structure of accountability for operational medical directors, facilities, agencies and providers

These protocols represent a consolidation of national, state and local sources of information, and will serve as the ideal standard of care for all pre-hospital patient care providers within the EMS region, as directed by the Operational Medical Directors committee. ***In situations where an approved medical protocol conflicts with other recognized care standards, the care provider shall adhere to the EMS Regional Medical Protocol***. It is acknowledged that there are situations in which deviation from the protocols may be needed in the interest of patient care. In those situations, when possible, EMS personnel should obtain permission from on-line medical direction to deviate from established protocols. All instances of protocol deviation must be thoroughly documented in the patient care report, noting the deviation which occurred and the specific circumstances and reasoning that led to that deviation.

It is expected that providers will use the protocols in conjunction with each other as necessary. Providers should use the Airway/Oxygenation/Ventilation protocol on each patient, and may implement two or more protocols simultaneously as the patient condition warrants.

Expectations

Ongoing review of protocols is required to remain current with interventions known to be effective in pre-hospital care and should be the responsibility of each provider of the EMS region. ***It is expected that each provider maintain a functional knowledge of these protocols***, and apply them appropriately during all patient interactions, so the continuum of care may be effectively achieved.

The protocols should be used to direct appropriate treatments, both through standing orders and with online medical control, to the patients we encounter. At each patient encounter it is expected that an initial assessment will be completed, regardless of whether the patient is transported. The initial assessment must be completed before proceeding to the appropriate protocol. The initial assessment should include, at a minimum:

Scene size-up: Is the scene safe? Do you have enough resources? If not, how can you get them? What is the mechanism of injury / nature of illness?
Airway: Is the airway open? If not, correct any airway problems immediately. If you cannot correct an airway problem, transport the patient immediately to the closest hospital.
Breathing: Is the patient breathing? Is it adequate? If respirations are absent or inadequate, ensure an open airway and assist the patient's ventilations as needed.
Circulation: Assess the patient's pulse and note the skin color and temperature. The initial blood pressure reading should be obtained manually, by auscultation (preferred) or palpation.
Disability: Assess the patient's level of consciousness and mental status. A simple AVPU exam and/or Glasgow Coma Scale should be completed and documented on each patient as appropriate.

BLS providers are expected to request ALS assistance if the patient has any deficiencies in the initial assessment. Additional ALS providers may be needed for critically sick or injured patients.

All providers are expected to reassess patients throughout the EMS encounter. Stable patients should be reassessed at least every 15 minutes, and unstable patients should be reassessed at least every 5 minutes. Vital signs should be obtained and documented on every patient, including those who ultimately refuse transportation.

These protocols are not intended to prolong the treatment of patients on scene or delay transport. These protocols exist to provide prompt, quality pre-hospital medicine to the sick and injured patients in our community.

It is expected that providers will make early contact with the receiving facility to advise them about incoming patients. Waiting to contact the facility until you are just a few minutes out provides little benefit to patient care. Providers should persist in their attempts to contact medical control, using radio, cellular phone or relay through dispatch as needed. In situations where providers are truly unable to make contact with medical control, providers may implement life saving procedures as standing orders not to exceed their scope of practice. The provider must notify their agency and thoroughly document the incident, utilizing the patient care report and the regional quality improvement form.

Authority

Regional medical protocols are developed by consensus of participating agencies, under Emergency Medical Services Regulations 12VAC 31-2730 (Performance standards). Each agency OMD must approve the protocols and has the authority to limit or expand implementation of protocols within their agency. Emergency Medical Services Regulations 12VAC5-31-1890 (responsibilities of operational medical directors) grants authority to establish and enforce protocols, policies and procedures. All prehospital medical care is carried out with the express written authority of the Operational Medical Directors and under their supervision. Emergency Medical Services Regulations 12VAC 5-31-1040 (Operational medical director authorization to practice) states “EMS personnel may only provide emergency medical care while acting under authority of the operational medical director for the EMS agency for which they are affiliated and within the scope of the EMS agency license.”