

Prehospital
Patient Care Protocols

Section III
Administrative



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Prehospital Patient Care Protocols

III. Administrative

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1. INTERFACILITY TRANSFER OF ACUTELY ILL / INJURED PATIENTS

A. Indications: A physician requests an interfacility transport of a patient upon whom procedures and/or medications have been initiated that are beyond the scope of the EMS agency's protocols of practice.

B. Protocol for management:

1. The interfacility transport should be performed by an ALS-equipped and ALS-staffed ambulance and should take place only after receiving physician has conferred with the ordering physician.
2. The ordering physician/institution will provide the EMS agency, prior to dispatch, a patient report that includes the patient's condition and any special treatment the patient is receiving.
3. If the treatment is outside the provider's normal scope of practice, the agency's Operational Medical Director (OMD) should be contacted for approval and to determine if other appropriate personnel (i.e. Registered Nurse, Respiratory Therapist, Physician) should accompany the patient.
4. The Attendant in Charge (AIC) should request a brief patient report from the health care personnel on scene, and should obtain the pertinent paperwork to go with the patient (i.e. face sheet, transport sheet, lab work, x-rays, etc.). If the patient is a "No Code" or has a valid Do Not Resuscitate order, a written order (including a Prehospital DNR order) must accompany the patient. Assessment by the AIC should be kept to a minimum and should not delay transport. Also, the AIC will have access to information necessary to provide appropriate care during transport.
5. If the ambulance crew arrives and the patient's condition has deteriorated to a life-threatening situation where immediate intervention is necessary, the AIC will consult with the attending physician if she/he is available. If the attending physician is not immediately available, the AIC should contact the agency OMD or on-line Medical Control for additional instructions.
6. An ALS provider may monitor and administer nonstandard medications prescribed by the patient's transferring physician with on-line Medical Control as needed during transfer.
7. The administration of any medications not covered by protocol will be recorded on the Prehospital Patient Care Report, noting the name of the transferring physician, time that Medical Control was contacted, and dosage of the medication and route administered.

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2. PATIENT AND SCENE MANAGEMENT

A. Indications: An orderly management of the emergency scene will improve any level of Prehospital patient care. Although questions concerning authority (i.e. on-scene physician and response by more than one EMS agency) can arise, they should be settled quickly and quietly.

B. Protocol for management:

1. The senior certified prehospital provider will have authority for patient care and management at the scene of an emergency. In the case of equal certification, the first on-scene provider will retain patient control.**
2. Authority for management of the emergency scene, exclusive of medical control over the patient, will rest with the appropriate on-scene public safety officials (i.e. police, fire, rescue). It is recommended that scene management be negotiated in advance of emergencies by local agreements and written protocols.
3. If other medical professionals at the emergency scene offer or provide assistance in patient care, the following will apply:
 - a. Medical professionals who offer their assistance at the scene should be asked to identify themselves and their level of training. The prehospital provider should request that the medical professional provide proof of her/his identity if that person wants to continue to assist with patient care after the ambulance has arrived.
 - b. Physicians are the only medical professional who may assume **CONTROL** of the patient's care. Prehospital providers should recognize the knowledge and expertise of other medical professionals and use them for the best patient care possible. **All medical professionals who assist or offer assistance should be treated with courtesy and respect.**
 - c. The authority for Medical Control of the prehospital provider's procedures rests in these Prehospital Patient Care Protocols adopted by the EMS agency and the agency Operational Medical Director (OMD).
 - d. A physician at the scene who renders care for the patient prior to arrival of an EMS unit may retain Advanced Life Support medical authority for the patient if the physician desires. The prehospital provider will tell the physician who wants to supervise or to direct patient care that the physician **MUST** accompany the patient to the receiving hospital to maintain continuity of patient care. If requested, the physician will have made available to her/him their services and equipment of the ambulance and/or EMS agency.

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- e. Documentation of these events will be complete and will include the physician's name.
- f. If there is a conflict about patient care or treatment protocols, the prehospital provider will contact on-line medical control or, if practical, the agency OMD for further instructions. Under no circumstances should this conflict interfere with prudent patient care.

** The five levels of Prehospital EMS certification, recognized at this time by the Commonwealth of Virginia, are:

- 1) **First Responder**, whose authority is superseded by the:
- 2) **Emergency Medical Technician–Basic**, whose authority is superseded by the:
- 3) **Emergency Medical Technician–Enhanced**, whose authority is superseded by the:
- 4) **Emergency Medical Technician–Intermediate**, whose authority is superseded by the:
- 5) **Emergency Medical Technician–Paramedic** .

3. DOCUMENTATION AND CONFIDENTIALITY

A. Indications: Under the existing Virginia law, all licensed emergency medical services agencies are required to “participate in the prehospital patient care reporting procedures by making available ... the minimum data set on forms.” Licensed EMS agencies, prehospital providers and the Commonwealth of Virginia are required to keep patient information confidential.

B. Protocol for management: Each EMS agency should, in consultation with the agency’s legal counsel, develop a procedure dealing with how and when patient information will be released to the patient, the patient’s family, law enforcement officials, the news media and/or any other parties requesting the information. The procedures should include development of a release form which will be signed by a responsible person. Documentation of patient care should, at a minimum, meet the following requirements:

1. A patient care report will be written for each patient who is seen, treated or transported by an ambulance or rescue squad. The report should be completed on the prehospital patient care report in use in the area/region.
2. In addition to information required by the Commonwealth of Virginia, documentation also should include:
 - a. The patient’s chief complaint.
 - b. Vital signs with times.
 - c. Treatment provided and times.
 - d. ECG strip(s), if monitored.
 - e. Changes in patient condition.
 - f. Contact with Medical Control.
 - g. Any deviation from protocol.
3. If a patient refuses treatment or transport, documentation should include:
 - a. The patient’s full name.
 - b. The reason for response.
 - c. Reason for the patient’s refusal.
 - d. Vital signs and times.
 - e. Any other physical signs or symptoms.

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- f. Perceived competency of the patient.
 - g. Patient's level of consciousness.
 - h. Names and signatures of witness.
 - i. Signature of patient.
 - j. Any additional refusal forms.
4. When a patient is transported, a copy of the report should be left at the receiving hospital.
- C EMS agencies are urged to develop, in consultation with legal counsel, an incident report form for quality assurance purposes to document any additional information relevant to the treatment and transport of patients.

4. TREATMENT OF MINORS

A. Indications: Prehospital providers are called to treat a young patient and there is no parent or other person responsible for the minor.

B. Protocol for management:

1. In the case of a minor 14 years of age or older who is physically capable of giving consent, such consent shall be obtained prior to treatment and/or transportation by qualified EMS personnel at the scene of an accident, fire or other emergency prior to hospital admission.
2. The prehospital provider may treat and/or transport, under the doctrine of implied consent, any minor who requires immediate care to save a life or prevent serious injury.
3. If a minor refuses care but, in the provider's judgment, needs that care, the provider should contact on-line Medical Control for additional instructions.
4. If a minor is injured or ill and no parent contact is possible, the provider should contact on-line Medical Control for additional instructions.
5. The provider should ALWAYS act on the side of appropriate patient care. Careful and complete documentation ALWAYS is important.
6. If the ill or injured patient is a young child and the parent is present, the Prehospital provider should refer to the appropriate Pediatric Protocol sections and consider the following in regard to transport:
 - a. Transport conscious children with a parent unless it interferes with proper patient care.
 - b. In cases of major trauma or cardiopulmonary arrest, exercise judgement in allowing parents to accompany the child in the ambulance.
 - c. Allow the parent to hold and/or touch the child whenever possible and safe to do so.
 - d. Both parent and child will respond best to open and honest dialogue.

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5. PATIENT REFUSAL

A. Indications: If a patient (or the person responsible for a minor patient) refuses secondary care and/or ambulance transport to a hospital after prehospital providers have been called to the scene, the following procedures should be carried out:

B. Protocol for management:

1. Complete an Initial Assessment and Vital Signs of the patient, with particular attention to the patient's neurological status.
2. Determine if the patient is competent to make a valid judgement concerning the extent of the patients' illness or injury. If the provider has doubts about whether the patient is competent to refuse, the provider should contact on-line Medical Control.
3. Clearly explain to the patient and all responsible parties the possible risks and/or overall concerns with to refusing care.
4. Do not perform continued Advanced Life Support procedures on a patient who refuses prehospital care.
5. Complete the PPCR form, clearly document the Initial Assessment findings and the discussions with all involved persons regarding the possible consequences of refusing additional Prehospital care and/or transportation, The form and discussion should be witnessed by a second EMS provider.
6. After the form has been completed, have the patient or the person responsible for a minor patient sign the refusal form provided on the Virginia PPCR form and an additional refusal form if provided. This procedure should be witnessed by at least one other individual (i.e. fire, medical, law enforcement, security personnel, or an immediate family member).

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6. DO NOT RESUSCITATE (DNR)

A. Indications: Prehospital providers should initiate cardiopulmonary resuscitation (CPR) on all patients without vital signs UNLESS the patient presents one or more of the following conditions:

1. Decapitation.
2. 100% full thickness burn (incineration).
3. Putrefied, decayed or decomposed body.
4. Advanced lividity.
5. Rigor mortis.
6. Obvious mortal wounds, i.e. crushing injuries to head and/or chest.
7. A valid state of Virginia Durable Do Not Resuscitate (DDNR) order.
8. Asystole as a presenting rhythm in an unwitnessed arrest.

B. Protocol for management:

1. The responsible prehospital provider should perform routine patient assessment, resuscitation and/or intervention efforts until the DDNR or other alternate form of DNR status is confirmed.
Alternate DNR orders:
 - a. EMS-DNR order (old format) written after July 1, 1999.
 - b. DNR order written for a patient currently admitted to a licensed health care facility. EMS personnel may recognize these orders only while the patient is in the facility. DNR may appear in different forms including prescription forms, facility DNR forms, and patient records. All DNR formats must contain: Patient name, physician name, DNR determination, and date of issue.
 - c. DNR order written for the purpose of patient transfer. EMS personnel may recognize these orders during transport. DNR may appear in different forms including prescription forms, facility DNR forms, and patient records. All DNR formats must contain: Patient name, physician name, DNR determination, and date of issue.

****NOTE:** Many times prehospital providers are presented with a Living Will. Living Wills are NOT recognized in the prehospital setting due to the fact that it is not a physician ordered DNR and therefore does not fit into the accepted "alternate DNR order".

2. Request the original DDNR form.
3. Determine that the DDNR order is intact and not defaced.
4. The provider should verify the identity of the DDNR patient through the family members or friends at the scene, or with appropriate photo identification (e.g. driver's license)
5. Once validity is verified, resuscitation efforts may be ceased or withheld.
6. Document information on PPCR form
 - a. DDNR form number.
 - b. Patient name.

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- c. Physician Name.
- d. Date of issue
- e. Method of identification

C. Resuscitation measures the provider should avoid:

- 1. Cardiopulmonary Resuscitation (CPR).
- 2. Endotracheal intubation or other advanced airway management.
- 3. Artificial ventilation.
- 4. Defibrillation.
- 5. Cardiac resuscitation medications.

D. These comfort measures are encouraged:

- 1. Airway (excluding intubation or advanced airway management).
- 2. Suction.
- 3. Supplemental oxygen delivery devices.
- 4. Pain medications or intravenous fluids.
- 5. Bleeding control.
- 6. Patient positioning.
- 7. Other therapies deemed necessary to provide comfort care or to alleviate pain.

E. DDNR forms may be located:

- 1. At the patient's bedside.
- 2. On the back of the patient's bedroom door.
- 3. On the refrigerator.
- 4. In the patient's wallet.

F. DDNR orders may be revoked by:

- 1. The patient, by destroying the EMS-DDNR form or alternate DNR form or by verbally withdrawing consent to the order.
- 2. The authorized decision-maker for the patient.

G. Revisions in the Virginia DDNR vs. EMS DNR:

- 1. DDNR program, adopted by the Virginia State Board of Health, became effective on January 3, 2000.
- 2. Once issued, the DDNR orders do not expire.
- 3. DDNR forms may be honored in any facility, program or organization operated or licensed by the State Board of Health or by the Department of Mental Health, Mental Retardation and Substance Abuse Services, or operated, licensed or owned by another state agency.

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NOTE: DDNR orders can now be written for anyone, regardless of health condition or age. Inclusion of minors is a significant change in the emergency DDNR order.

H. Alternate forms of identification for DDNR:

1. DDNR bracelets and necklaces are available and can be honored in place of the Virginia Durable DNR Order form by emergency medical services providers. Only approved necklaces or bracelets can be honored. These alternative forms of identification must have the following information:
 - a. Patient's full legal name.
 - b. Durable DNR number from the Virginia DDNR form or a unique to the patient number that the vendor has assigned.
 - c. The words "Virginia Durable Do Not Resuscitate".
 - d. The vendor's 24 hour phone number.
 - e. The physician's name and phone number.

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7. CEASE RESUSCITATION

A. Indications: Under existing Virginia EMS practice standards, prehospital providers should initiate cardiopulmonary resuscitation (CPR) on all patients without vital signs UNLESS the patient presents one or more of the following conditions:

1. Decapitation.
2. 100% full thickness burn (incineration).
3. Putrefied, decayed or decomposed body.
4. Advanced lividity.
5. Rigor mortis.
6. Obvious mortal wounds, i.e. crushing injuries to head and/or chest.
7. A valid state of Virginia EMS-DDNR order.
8. Asystole as a presenting rhythm in an unwitnessed arrest.

B. Protocol for management:

1. If CPR has been initiated and circumstances arise where the prehospital ALS provider believes resuscitative efforts may not be indicated, the provider should confirm that the patient is pulseless and apneic and note the rhythm. The provider then should contact Medical Control so that the on-line physician can decide to continue or stop resuscitative efforts.
2. Providers should begin contact with Medical Control with the statement: "This is a potential cease-resuscitation call." The provider should review why resuscitative efforts may not be indicated (i.e. end-stage cancer). The provider then should report the rhythm and interventions and, if directed by on-line Medical Control, stop resuscitative efforts.

NOTE: Patients who are hypothermic or who are victims of cold water drownings should receive appropriate resuscitative efforts. Patients with electrical injuries, including those struck by lightning, may initially be tetanic, or stiff, and should receive appropriate resuscitative efforts.

3. If a patient is determined to be dead on the scene (DOA) or if the cessation of resuscitative efforts is authorized by on-line Medical Control, follow local protocols concerning notification of the proper law enforcement authorities and/or medical examiner.
4. Document specific findings, such as signs of death, on the PPCR form. Include name of physician who ordered resuscitation efforts ended and log the time of the order.
5. Be attentive to the emotional needs of the patient's survivors when dealing with them. If possible, leave survivors in the care of family and/or friends.

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8. TRAUMATIC CEASE RESUSCITATION

A. Indications: The primary purpose of a traumatic cease resuscitation protocol is to reduce the likelihood of injuring prehospital providers and to prevent injury to the public who we serve while transporting non-viable patients to receiving facilities. If a trauma patient presents with one or more of the following conditions, then the prehospital provider should consider termination of treatment or do not resuscitate. In cases of hypothermia or submersion, follow the appropriate protocol. The conditions are:

1. Decapitation.
2. 100% full thickness burns without signs/symptoms of life.
3. Obvious mortal wounds (i.e. crushing injuries to the head or chest, gunshot wounds to the head or chest with massive tissue destruction or loss) without signs/symptoms of life.
4. Blunt or penetrating trauma with no signs of life when first responders arrive.
5. Greater than 30-minute transport time to any receiving facility with a pediatric cardiac arrest.

B. Protocol for Management-Adult:

1. ***WHEN IN DOUBT, RESUSCITATE!!!!!!!***
2. The responding prehospital provider should perform a routine patient assessment.
3. Once the provider determines that the patient is without life (no pulse, no respirations), the provider will verify the patient's condition with another prehospital provider.
4. If both providers agree, they will note the time of death and follow local protocols concerning notification of law enforcement or the medical examiner.
5. At no time during the assessment phase should ALS procedures/treatments be started. **DO NOT initiate IV lines**, intubate, etc. ALS procedures indicate that a patient needs to be transported to the closest appropriate hospital.
6. **At the provider's discretion, the cardiac monitor may be attached for the purpose of printing a rhythm strip to document a non-perfusing rhythm.**

C. Protocol for Management-Pediatric:

1. **Almost all pediatric cardiac arrest patients should have the benefit of full resuscitative efforts, including transport.**
2. ***WHEN IN DOUBT, RESUSCITATE!!!!!!!***
3. If the pediatric patient presents with any of the indications for Traumatic Cease Resuscitation **and** the pediatric patient remains in cardiac arrest after initial **BLS** resuscitative efforts, contact the receiving facility and establish on-line medical control for orders to cease resuscitation.
4. Note the time of death and follow the local protocols for notification of law enforcement or the medical examiner.

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D. Special Circumstances:

1. Remember that there are several special circumstances (hypothermia, electrocution, etc.) that deem that the patient needs to be transported to a medical facility. ***It is important to remember that any patient who may benefit from advanced life support, must receive it.*** Follow the ODEMSA protocols for treatment of said patients.

9. INFECTION CONTROL

A. Indications: In order to protect patients, healthcare providers, and their families, Prehospital providers must be familiar with, and act in accordance with, effective infection control measures for airborne and bloodborne pathogens. Infection control can only be achieved if all members of the EMS system participate. The ultimate goal is a safe environment for patients and everyone else involved in the healthcare system.

B. Standard Precautions:

1. Standard Precautions should be observed with every patient. This includes, but is not limited to, starting IVs, intubation, suctioning, caring for trauma patients, nebulizer treatments, OB emergencies.
2. Body fluids include: blood, saliva, sputum, vomitus or other gastric secretions, urine, feces, cerebrospinal fluids, breast milk, serosanguinous fluid, semen and/or bodily drainage.

C. Protocol for Management:

1. Wear appropriate protective gloves on every patient. Change gloves between patients or if gloves become contaminated or torn.
2. Wash hands after any patient contact, even when gloves have been used.
3. Wear gown if soiling of clothing or of exposed skin with blood or body fluids is likely. Gowns must be impervious to fluids.
4. Wear appropriate mask and eye protection if aerosolization or spattering of body fluids is likely to occur, e.g. during suctioning, nebulizer treatments, insertion of endotracheal tubes and other invasive procedures, or when a patient displays signs and symptoms suggestive of an infection with an airborne or respiratory route of transmission, or if the provider has been told the patient has an infection with a respiratory component.
5. Use airway adjuncts whenever respiratory assistance is indicated. Adjuncts include pocket masks with one-way valves, shields and Bag-Valve Masks (BVM). BVMs should be the first choice when ventilating a patient.
6. Contaminated equipment:
 - a. Place contaminated disposable equipment in an appropriately marked biohazard bag. Dispose in a location approved for biohazard waste or served by an agency licensed to haul biohazard waste.
 - b. Render non-disposable equipment safe for handling before putting it back in service. Follow manufacturers' recommendations for proper cleaning and decontamination procedures. CDC may also provide information on current decontamination of equipment.

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- c Use a high-level disinfecting solution on non-disposable equipment, e.g. laryngoscope blades, before re-using the items.
7. In the field, place linens soiled with body fluids in appropriately marked bio-hazard bags. In the hospital, ask and determine the appropriate container and place soiled linens in it. Remove linen from biohazard bag before placing in linen container. Always wear appropriate protective gloves when handling soiled linens.
8. Dispose of needles, syringes and sharp items in a rigid, puncture-resistant container, red in color or bearing the universal biohazard symbol. Do not bend or shear needles. Recapping contaminated needles is only permitted by a single-handed method and is **NOT** recommended.
9. Do not leave sharps or any contaminated items in any Drug Box.
10. Place any specimen to be left at the hospital in double-bagged, zip-lock-type bags with the universal biohazard label attached to the outer bag. Attach a specimen label to the outer bag. When in doubt, check with the Charge Nurse.
11. Wipe up body fluid spills promptly. Wear gloves when cleaning up spills. Decontaminate with a disinfectant approved by the Environmental Protection Agency (EPA) and CDC. Dispose of gloves and cleaning items in an appropriately marked biohazard bag.
12. Regularly clean and disinfect the interior of emergency vehicles and any on-board equipment. Follow agency procedures for cleaning and disinfecting solutions in accordance with manufacturers' guidelines and Center for Disease Control (CDC) recommendations.
13. Discard unused articles, medications and equipment **only** when those items have been opened or in some way have been contaminated with blood and/or body fluids.

D. Exposure -- Provider Responsibilities:

1. Wash any skin and irrigate any mucous membranes that are exposed to blood and/or body fluids as soon as possible after the exposure. Change contaminated clothing promptly and inspect skin for signs of openings and contamination.
2. Upon arrival at the hospital Emergency Department, or as soon as possible thereafter, notify a hospital official/representative (Emergency Department physician, ED nurse manager, charge nurse) of any possible exposure. Notify

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the EMS agency official/supervisor as soon as possible of any possible exposure and for non-emergency or follow-up care.

3. Obtain and complete before leaving the hospital an ODEMSA Infectious Disease Exposure Report, which are available in the Emergency Department. Use one Exposure Report form for each provider. Distribute copies as indicated on the Report.

E. Exposure – Hospital’s Responsibilities:

1. When a patient transported by its providers is determined to have an airborne or bloodborne infectious disease, notify the EMS agency's Infectious Disease Liaison Officer or Operational Medical Director (OMD), as listed in the ODEMSA Infectious Disease Registry.
2. Furnish the prehospital provider(s) with ODEMSA's Infectious Disease Exposure Report(s).
3. After receiving the completed Exposure Report, perform the appropriate testing on the source patient and render appropriate initial treatment to the exposed provider (if requested) as determined by the Emergency Department physician.
4. Furnish test results to the exposed provider, or the prehospital agency's Liaison Officer(s) or OMD, as listed in the ODEMSA Infectious Disease Control Registry, as soon as practical after determination of an airborne pathogen and/or exposure has been made. This will be done during business hours, Monday through Friday, 8 a.m. to 4:30 p.m. In the case of a holiday, the notification will be done the next working day.
5. Notify the EMS agency's Liaison Officer in writing of an exposure.
6. Ensure that providers get any emergency treatment indicated and that all appropriate hospital reports are completed. Providers must contact their agency official/supervisor for non-emergency or follow-up care.

F. Exposure – Agency’s Responsibilities:

1. Appoint and educate by July 1 of every year three individuals to serve as Infectious Disease Control Liaison Officers (or EMS agency contact persons) for hospitals, and familiarize them with the agency's Infectious Disease Control Plan, ODEMSA's Infectious Disease Exposure Report and this Protocol. Furnish those names, and that of the agency's OMD, each year to ODEMSA. ODEMSA will print them in a registry for hospitals.
2. Ensure that decontamination procedures, according to the agency's Infectious Disease Control Plan, are completed as soon as possible after the incident.

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3. Notify the prehospital agency's Operational Medical Director, or the OMD's representative, of the exposure or possible exposure and the actions that have been taken.
4. Notify personnel from any other agency who may have been exposed during the incident, or the appropriate official of that agency.
5. Respond to the receiving hospital's Infection Control Professional within 10 days of receipt of written notification of an exposure.
6. Work with the agency OMD or other designated physician, and the receiving hospital, to ensure that the provider has received appropriate follow-up care, that all appropriate reports have been completed and filed, and that the incident has been brought to closure.

G. Recommended Protective Equipment for Infectious disease control:

Task / Activity	Disposable Gloves	Gown	Mask	Protective Eyewear
Bleeding control with spurting blood	YES	YES	YES	YES
Bleeding control with minimal bleeding	YES	NO	NO	NO
Childbirth	YES	YES	YES	YES
Blood Drawing	YES	NO	NO	NO
Starting an IV	YES	NO	NO	NO
Airway Management	YES	NO	YES	YES
Oral / Nasal Suctioning	YES	NO	YES	YES
Decontamination of equipment	YES	NO	NO	NO
Measuring blood pressure	NO	NO	NO	NO
Measuring temperature	NO	NO	NO	NO
Giving injections (IM, SQ)	YES	NO	NO	NO

H. GLOSSARY OF TERMS:

Clean - Free of any obvious debris.

Contamination - Introduction of disease germs or infectious materials into or on normally sterile objects.

Decontamination - Completely removing disease-causing agents.

Exposure - Coming into contact with, but not necessarily being infected by, a disease-causing agent.

Infection - A condition or state of the body in which a disease-causing agent, or pathogen, has entered it.

Pathogen - A disease-causing substance or agent.

Sterilization – Destruction of all microbial life by steam, gas, or liquid agents.



Old Dominion EMS Alliance Infectious Disease Exposure Report

Please Print All Information; Use ball-point Pen

DATE _____

Provider's Name _____ AGENCY _____

Contact Phone _____ Other Agency Involved _____

Date of Incident _____ Time of Incident _____ PPCR No. _____

Patient's Name _____ SS No. _____

Patient's DOB _____ Patient's Blood Drawn? Yes No Unknown

Receiving Hospital _____ Arrival Time _____

Name of Physician/Nurse Notified _____

Brief Description of Incident _____

SAMPLE

Source of Exposure:

- Spit/Saliva
- Vomitus
- Respiratory Secretions
- Blood
- Pus
- Rash
- Urine
- Feces
- Other _____

Type of Exposure: _____ Location on Provider's Body _____

- | | | |
|--|--|--|
| <input type="checkbox"/> Skin | <input type="checkbox"/> Percutaneous | <input type="checkbox"/> Mucous Membrane |
| <input type="checkbox"/> Intact | <input type="checkbox"/> Puncture | <input type="checkbox"/> Eye |
| <input type="checkbox"/> Non-intact | <input type="checkbox"/> Incision/Laceration | <input type="checkbox"/> Mouth |
| e.g. eczema, pierced ears, open sores, hangnail, cut, abrasion | <input type="checkbox"/> Needle Stick | <input type="checkbox"/> Nose (nares) |
| | <input type="checkbox"/> Bite/Avulsion | |
| <input type="checkbox"/> Clothing | <input type="checkbox"/> Airborne | |
| <input type="checkbox"/> Soaked | <input type="checkbox"/> Spitting | <input type="checkbox"/> Intubation |
| <input type="checkbox"/> Drop(s) | <input type="checkbox"/> Productive Cough | <input type="checkbox"/> Suctioning |
| <input type="checkbox"/> Diluted | <input type="checkbox"/> Talking, Laughing | <input type="checkbox"/> Aerosol TX |
| <input type="checkbox"/> Dried | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Mouth to Mouth (unshielded) |
- NOTE: If blood soaked through clothing, check skin exposure box and complete appropriately.

If Needle Stick Exposure:

Brand of Needle _____ Type of Needle _____

Duration of Exposure:

Hours, indicate total hours: _____ Minutes, indicate total minutes: _____

Personal Protective Equipment Used During Exposure:

- Mask/Shield Combination
- Mask
- Respirator
- Goggles
- Gown
- BVM
- Gloves
- Tyvek Suit
- Resuscitation Shield

Steps Taken To Minimize Exposure:

- Washed Off Skin
- Masked Patient
- Irrigated Eyes
- Changed Contaminated Clothing
- Rinsed Mouth
- Other: _____

I request that appropriate tests be conducted on the patient on my behalf.

Provider's Signature _____ Date _____

ICP Follow-up Completed By (signature) _____ Date _____

HOSPITAL COPY – Please Forward Copy of Completed Report to the Provider's OMD.

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10. PATIENT DIRECT ADMISSIONS

A. Indications: Ambulance crews involved in transporting direct admission patients to hospitals should be able to return to service as quickly as possible. This especially is true with volunteer agencies and fire and municipal services whose personnel and equipment may be limited at any given time. It also is important that direct admission patients be properly treated and spared unnecessary costs.

B. Prehospital Goal: For those EMS agencies which choose to transport direct admission patients, the overall goal will be to work closely within this protocol with the receiving hospital. This cooperation will ensure that appropriate actions are taken so that the patient can be delivered to the proper hospital destination with minimum delay and the EMS unit returned to service in a timely manner.

C. Protocol for Management:

1. Responding to a direct admission call, ambulance crews should notify the receiving hospital's emergency department as early as possible to allow the department staff to follow up with hospital admissions.
2. Upon arrival at the hospital, the ambulance crew's attendant in charge (AIC) should talk directly with the emergency department charge nurse.
3. The charge nurse and AIC will determine the following:
 - a. If the direct admission patient's room is ready.
 - b. If the ambulance crew is needed to take the patient to the room.
 - c. If the crew is available to take the patient to the room.
4. If the answer to any of those questions is NO, the AIC will turn over care of the patient to the emergency department staff. The crew then will complete its regular duties and return to service as soon as possible.
5. If the answer to each of those questions is YES, the crew will assist the hospital by taking the patient to her/his designated room. The crew then will complete its regular duties and return to service promptly.
6. When possible and if requested by the AIC, the hospital will provide a guide and/or directions to the patient's room.
7. Any complaint or problem involving a direct admission patient at any hospital will be resolved at a later time through direct discussion between the emergency department nurse manager and the chief operating officer of the Prehospital agency, or persons designated by those individuals.

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11. ALS Drug Box Policies and Procedures **Current January 2006**

1. INTRODUCTION:

The Advanced Life Support Drug Box of the Old Dominion EMS Alliance (ODEMSA) is a critical component of the Central Virginia emergency medical services (EMS) system for the treatment of sick or injured persons. The basis of restocking these ALS Drug Boxes, also known as Cardiac Drug Boxes, is contained in the Ambulance/ALS Drug Box Regional Restocking Agreement and Policies signed by participating acute care hospitals and out-of-hospital agencies. That agreement and the Restocking Policy are annexes of this document.

2. PURPOSE AND SCOPE:

The purpose of this document is to delineate the policies and procedures for the management of ODEMSA's ALS Drug Box system, to establish mechanisms of control and accountability, and to establish a means of orienting new Advanced Life Support (ALS) providers and Operational Medical Directors (OMDs) in the ODEMSA region.

The ODEMSA Drug Box system reflects systems in use in other Regional EMS Councils in Virginia. It is meant to coincide with, and work within, rules and regulations promulgated by the Virginia Board of Pharmacy and the Virginia Department of Health's Office of EMS. It operates in coordination with provisions of the Ambulance/ALS Drug Box Regional Restocking Agreement and Policies which have been approved by all 17 acute care hospitals and all eligible out-of-hospitals EMS agencies in the ODEMSA region, and which are appended to this document.

All 17 acute care hospitals in the ODEMSA region are signatories to the Regional Restocking Agreement and Policies. Only those licensed EMS agencies within Planning Districts 13, 14, 15 and 19 that have signed that agreement and policies are entitled to participate in the ALS Drug Box Exchange and, therefore, come under these Policies and Procedures. A dated list of signatories is attached to this document.

3. OVERSIGHT AND OWNERSHIP:

Oversight of the ALS Drug Box Policies and Procedures will rest with the Pharmacy Committee, a standing committee of ODEMSA, and the ODEMSA Board of Directors through the ODEMSA staff. The Pharmacy Committee, representing hospital and prehospital components, will be nominated by those components and appointed by the ODEMSA Board. The Pharmacy Committee will meet regularly and have separate Policies and Procedures. The medications contained in the ALS Drug Box are the property of the hospitals' pharmacies and are controlled by state regulations. Boxes are the property of ODEMSA.

4. POLICY GOALS:

The goals and objectives of these policies and procedures are:

- A. To provide a safe and effective method for the distribution of medications by prehospital EMS providers in cooperation with hospital pharmacies.
- B. To enhance communications and cooperation between hospital pharmacies and emergency department staffs and prehospital EMS providers.
- C. To maintain a system that allows a safe, rapid, effective and accountable exchange of used Cardiac Drug Boxes for restocked Cardiac Drug Boxes on a one-for-one basis.
- D. To maintain a system of evaluation and education so that the Central Virginia EMS system is consistent with current local, state and national standards of care and protocols, and in compliance with state and federal regulations.

5. THE SYSTEM AND BOX DESCRIBED:

The ODEMSA Cardiac Drug Box system involves a one-for-one exchange between acute care hospitals in the ODEMSA region and ALS agencies licensed by the Virginia Health Department and is provided for in the Regional Restocking Agreement and Policies.

The Drug Box contains medications designated by physicians for the treatment of emergent patients under the ODEMSA Prehospital Patient Care Protocols as most recently revised. The list of contents – the ALS Drug Box

Contents of the ODEMSA Prehospital Patient Care Protocols -- is determined by the Old Dominion Medical Control Committee in coordination with hospital pharmacy Directors through the ODEMSA Pharmacy Committee.

The ALS Drug Box is carried on licensed ALS emergency vehicles in the ODEMSA region as outlined in the Rules and Regulations of the Board of Health Governing EMS and consistent with the regulations and requirements of the Virginia Board of Pharmacy.

The standardized Drug Box approved by the Medical Control Committee for use in this region is a Flambeau PM1872 case, orange in color. It is marked "CARDIAC" in bold letters on the top, lower left corner. It carries the letters "ODEMSA" in the upper left corner. An individual number is located on top and on at least three sides of the lid. The Drug Boxes also contain a clear plastic sleeve on the top, at right, which contains a yellow Control/Report Form and at least one standardized ODEMSA Discrepancy Form. Each box when filled is locked with a numbered seal with the letters "ODEMSA" engraved.

PLEASE NOTE: While ALS Drug Boxes are the property of ODEMSA, the contents of the boxes are owned by participating hospital pharmacies in the region.

Unless otherwise specified, medication expirations dates will be based on the final day of the month indicated.

Medications are dispensed in the field by certified prehospital ALS providers under the license of the ALS agency's OMD according to the ODEMSA Prehospital Patient Care Protocols and/or under the direction of on-line medical control. Used ALS Drug Boxes will be exchanged only with the appropriate forms containing patient information and with authorized signatures. Exchanges will be in compliance with the Ambulance/ALS Drug Box Restocking Agreement and Ambulance Restocking Policies as signed by hospitals and EMS agencies (effective Jan. 1, 2000).

6: DRUG BOX ACQUISITION:

Only EMS agencies licensed at the Advanced Life Support level and which have signed the regional Ambulance/ALS Drug Box Regional Restocking Agreement or, in the case of for-profit agencies, have a separate agreement of compliance with ODEMSA will be qualified to apply for and receive a new ALS Drug Box from ODEMSA.

Applications for a Drug Box will consist of a request letter from the EMS agency signed by the agency's president or chief officer and the agency's Operational Medical Director. The letter will briefly state the reason for acquiring the Drug Box.

Agencies will be responsible for paying a set-up fee charged by ODEMSA to prepare a Box for service, and for paying any fee imposed to replace a damaged or destroyed Box.

It is the responsibility of the applying agency to make arrangements with a pharmacy to have the Drug Box filled in accordance with the ALS Drug Box Contents of ODEMSA's Prehospital Patient Care Protocols, which is attached to this document.

Only boxes meeting ODEMSA's standards, as described above and endorsed by the ODEMSA Pharmacy Committee, will be filled by the hospital Pharmacy and used by out-of-hospital agencies and providers.

The Pharmacy Committee will review all requests at its regular meetings.

7. DRUG BOX RETURNS:

In the event that a licensed EMS agency loses its ALS license, ceases operations or moves outside the ODEMSA region, the agency will notify ODEMSA in writing within 30 days. It then will return any and all ALS Drug Boxes that were in its possession to the hospital Pharmacy that last restocked the box(es).

The Pharmacy will confirm to ODEMSA in writing that the Drug Box(es) has (have) been returned. When so notified, ODEMSA then will issue to the agency a receipt for the box(es).

The receiving pharmacy will add the Drug Box(es) to its reserves and place it (them) back into general circulation within the Restocking program.

8. DRUG BOX ACCOUNTABILITY:

ALS Drug Boxes are filled by hospital Pharmacies and sealed until used by an out-of-hospital provider. The Pharmacy is responsible for the filled box until it is exchanged with a prehospital ALS provider for a used box.

The prehospital EMS agency is responsible for the storage and security of the box outside the hospital, including and after it has been opened in the field by an ALS provider. Once the box is opened, the ALS provider

is responsible for the contents of the box and its condition until it is returned and accepted for exchange at an appropriate hospital.

Only clean boxes that are safe to handle will be accepted for exchange.

The seal used for ALS Drug Boxes is supplied to the hospital pharmacies by ODEMSA and is a standardized type that can provide security for the contents. Seals are individually numbered and marked with the letters "ODEMSA" to signify the Old Dominion EMS Alliance. When ODEMSA seals are not available, a pharmacy may use a hospital seal that it deems as appropriate for the purpose until such time as the ODEMSA seals are available.

The means of accounting for the ALS Drug Box contents is the Commonwealth of Virginia Prehospital Patient Care Report (PPCR) as most recently revised or its equivalent as approved by the Virginia Office of EMS. All medications administered to patients must be recorded on the PPCR, which is a legal document and a medical record.

Information and documentation should include: IV procedures, a recording of the used Drug Box and the new Drug Box issued for each call, the Medical Control physician's signature when controlled drugs are ordered, and the signature of a pharmacist or other licensed professional to indicate that all controlled drugs have been accounted for by EMS personnel and the receiving hospital. The drug section of the PPCR is used to document the administration of drugs specified in local protocols, including dose, route and times.

The following procedure is to be followed insofar as it does not otherwise conflict with established policies and procedures of the receiving hospital's Pharmacy Department or Virginia Board of Pharmacy regulations:

The ALS provider, using the PPCR, is responsible for accounting for all medications in the Box, including narcotics, whether or not they were used.

The ALS provider will count narcotics in the Drug Box in the presence of a licensed professional (i.e. pharmacist, nurse, physician).

If narcotics have been used, any remaining narcotic should be wasted in the hospital emergency department in the presence of a licensed professional in conformance with State Board of Pharmacy regulations.

The amount of narcotic administered and the amount (if any) wasted should be recorded by the licensed professional and recorded in an appropriate location on the PPCR.

Instances when there has been a significant discrepancy in accounting for medications – e.g. involving two or more Drug Boxes or involving Schedule 2 or 4 medications (morphine or valium) -- will be reported as soon as possible to ODEMSA. ODEMSA, in turn, will promptly notify the Virginia Board of Pharmacy, the Virginia Office of EMS, the last-filling hospital and, if appropriate, local and/or state law enforcement officials.

ODEMSA will ensure that all Discrepancy Reports it receives are audited not less than every six months and that a written report is made available to the Pharmacy Committee.

9. HOSPITAL PHARMACY RESPONSIBILITIES:

Each participating hospital Pharmacy in the ODEMSA region agrees to the following:

- A. To purchase, store, control and dispense all pharmaceuticals and related paraphernalia contained in the ALS Drug Boxes and in quantity sufficient to meet the needs of the Drug Box Program.
- B. To ensure that all drug and paraphernalia contained or replaced in the Drug Boxes are generically equivalent to those approved by the Medical Control Committee.
- C. To ensure in-hospital compliance with all Virginia Board of Pharmacy rules and regulations regarding prehospital Drug Boxes.
- D. To ensure that only a Pharmacist, or authorized personnel under the direction of a Pharmacist, restocks or exchanges the ALS Drug Boxes.
- E. To ensure that all packaging of medication and paraphernalia is identical to that approved.
- F. To ensure that all pharmaceuticals and paraphernalia are within expirations dates, that the earliest expiration date is beyond three months as practical, and that the yellow Control/Report Form has been filled out.
- G. To ensure that a sufficient quantity of ALS Drug Boxes are available for exchange on a 24-hour basis.

- H. To ensure that each Drug Box is restocked according to the ALS Drug Box Contents list, as most recently revised, and that each box contains a copy of that list as supplied to the Hospital Pharmacy by ODEMSA.
- I. To ensure that any discrepancy has been reported on an ODEMSA Drug Box Discrepancy Form and forwarded to ODEMSA in a timely manner.
- J. To ensure that all ALS Drug Boxes have been locked with an appropriate security seal.
- K. To ensure that when a system-wide shortage of a medication occurs, or when ALS Drug Boxes have short dated drugs, the ALS Drug Boxes' exteriors will be so-marked.

10. PREHOSPITAL AGENCY/PROVIDER RESPONSIBILITIES:

Each participating licensed prehospital agency and/or Provider in the ODEMSA region agrees to the following:

- A. When acquiring a new ALS Drug Box, to make prior appropriate arrangements with a hospital pharmacy to have the box filled in accordance with the ALS Drug Box Contents of ODEMSA's Prehospital Patient Care Protocols.
- B. To store and secure ALS Drug Boxes and related supplies in licensed ALS vehicles according to Virginia EMS Regulations (effective 1/15/2003), i.e. Section 12 VAC 5-31-520, and the Virginia Board of Pharmacy.
- C. To otherwise comply with all Virginia Board of Pharmacy rules and regulations regarding Drug Boxes.
- D. When more than one ALS Drug Box is carried on a vehicle, to rotate the boxes in use to minimize long term drug expiration.
- E. To allow only Virginia certified ALS providers or licensed medical personnel to handle or administer medications contained in Drug Boxes. Certified ALS providers include: EMT- Enhanced/EMT-Shock Trauma; EMT-Cardiac/EMT-Intermediate; and EMT-Paramedic. Licensed medical personnel include hospital pharmacists, registered nurses and physicians.
- F. To ensure that ALS providers, at the beginning of a duty shift, will check Drug Boxes in the possession of their respective agencies for the security seal and for drug expiration dates.
- G. To ensure that any Drug Box with a broken seal or expired medications is reported to the appropriate EMS officer, as designated by the agency, and taken to a participating Hospital Pharmacy to be inspected and, if appropriate, re-sealed or restocked.
- H. To ensure that the administering ALS provider fills out and files a PPCR when the contents of a Drug Box are used during an emergency call.
- I. To notify the Virginia office of EMS and the Old Dominion EMS Alliance when any ALS Drug Box's controlled substance(s) or regulated medical devices appear to have been diverted, in compliance with Virginia EMS Regulations (12 VAC 5-31-520 D). Such notification will involve use of the Virginia Office of EMS Drug Diversion Report Form (EMS-6023F as attached to this document), a copy of which will be sent to ODEMSA.
- J. To ensure that the ALS Drug Box used on a call is cleaned and free of any dirt, blood or other fluids or biohazards, and is otherwise safe to handle before it is returned to the Hospital Pharmacy for replacement.
- K. To ensure that the ALS provider disposes on appropriate containers all trash, including paraphernalia, from the use of the Drug Box during a call.
- L. To participate from time to time as needed in an inventory report to ODEMSA of Drug Boxes in the agency's possession.

11. O.D.E.M.S.A.'S RESPONSIBILITIES:

The Old Dominion EMS Alliance agrees to the following:

- A. To properly prepare and mark ALS Drug Boxes for entry into the system.
- B. To maintain, repair or replace Drug Boxes in a timely fashion as needed and requested by hospital pharmacies.
- C. To provide locks, forms and other documentation as needed and requested by hospital pharmacies.

- D. To forward Discrepancy Forms to the last-filling hospital in a timely manner after such reports are filed by hospitals or individuals.
- E. To coordinate the reporting process when there has been a significant discrepancy – as defined by the Committee -- in accounting for drugs, e.g. involving two or more Boxes or Schedule 2 or 4 drugs (See Section 8-E).
- F. To ensure that drug audits and drug box inventory results and other appropriate reports are available to the Pharmacy Committee.
- G. To respond to complaints or problems from hospital or out-of-hospital and provide needed immediate assistance to mitigate until such time as the Committee can take appropriate action.
- H. To communicate with the Virginia Office of EMS to ensure that office has received the original of any state Drug Diversion Report Form it receives.
- I. To coordinate between the Pharmacy Committee and other standing committees -- i.e. Medical Control or Manpower and Training -- as to proposed changes in the ALS Drug Box Contents.
- J. To staff meetings of the ODEMSA Pharmacy Committee and ensure that meeting notices and meeting minutes are distributed in a timely fashion.

12. COMPLIANCE AND MODIFICATION:

Compliance with these policies will be monitored by ODEMSA and reported regularly to the ODEMSA Pharmacy Committee, a standing committee of ODEMSA. That Committee will decide on monitoring policies and on appropriate corrective action in the event of non-compliance.

The Pharmacy Committee will review recommended revisions and updates to these ALS Drug Box Policies and Procedures. Recommendations approved by the Pharmacy Committee will be forwarded to the Medical Control Committee or other appropriate Committee for endorsement, and ultimately to the ODEMSA Board of Directors for its action.

Approved by ODEMSA Pharmacy Committee 03-04-02
Approved by Old Dominion Medical Control Committee 03-20-02
Reviewed by Virginia Board of Pharmacy 03-20-02
Approved by ODEMSA Board of Directors 03-21-02
Endorsed by South Central EMS Council 06-17-02
Endorsed by Metro Richmond EMS Council 07-23-02
Reviewed, Revised and Endorsed by ODEMSA Pharmacy Committee 8-12-03
Approved by ODEMSA Board of Directors 10-30-02
Reviewed and Revised by ODEMSA Pharmacy Committee 10/2004
 Reviewed by ODEMSA Pharmacy Committee 10/2004
 Reviewed by ODEMSA Pharmacy Committee 10/2005
 Reviewed by ODEMSA Pharmacy Committee 1/2006

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12. Patient Destination Policy

SCOPE: This policy pertains to all licensed EMS Agencies providing Class B (Basic Life Support), C (Advanced Life Support) and D (Specialized Life Support) ambulance transportation.

PURPOSE: To provide for a defined, consistent policy for the destination of ambulance patients consistent with quality patient care and regional medical protocols within the Old Dominion EMS Alliance (ODEMSA) region which includes Planning Districts 13, 14, 15 and 19.

POLICY ELEMENTS:

1. All ambulance patients (resulting from requests for emergency assistance which result in transport) normally will be transported to the closest appropriate hospital emergency department unless redirected by the on-line Medical Control Physician or by Medical Control during a declared Diversion. The closest appropriate hospital is defined as the hospital closest to the location of the patient that can provide the level of care needed by the patient. The Medical Control Physician is defined as the attending emergency department physician at the hospital contacted by the ambulance Attendant-in-Charge (AIC) or a person designated by the AIC. Medical Control is defined as that hospital designated to direct ambulance movements in line with ODEMSA's Hospital Diversion Policy as most recently revised.
2. Stable patients may be transported to the patient's hospital of choice if allowed by local EMS agency policies and by available resources.
3. Patients who meet certain criteria as severe trauma patients, as defined in the Old Dominion EMS Alliance Trauma Care System Plan, usually will be transported directly to a Trauma Center unless redirected by the Medical Control Physician in accordance with the Trauma Care System Plan.
4. Individual EMS agencies and/or EMS systems are responsible for determining operational policies related to the most effective ambulance deployment and utilization patterns. This may include policies allowing transport of stable patients to hospitals of the patients' choice.
5. In mass casualty incident (MCI) situations, the current Central Virginia Mass Casualty Incident Plan and its EMS Mutual Aid Response Guide, as most recently revised, will govern patient transportation and hospital destination(s).
6. Other policies and protocols related to patient transport and ambulance-to-hospital communications are defined in the ODEMSA Prehospital Patient Care Protocols and the Hospital Diversion Policy as most recently revised.

1/1/2000
Reviewed and Revised 2/2004
Reviewed 2/2005

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13. Hospital Diversion Policy For Emergency Patients **Current January 2006**

A. PURPOSE: To maintain an orderly, systematic and appropriate distribution of emergency patients transported by ambulances during a single or multiple hospital diversion situation within the Old Dominion EMS Alliance region.

B. SCOPE: This policy pertains to all acute care hospitals and all licensed EMS agencies providing ground ambulance transportation as defined in Virginia Department of Health regulations. It will be Annex B to the Central Virginia Mass Casualty Incident Plan, as most recently revised, of which all 16 hospitals are signatories.

This Policy will have the highest level of impact on the 12 acute care hospitals in the Richmond/Tri-Cities area (PD 15 and 19). However, it also is recognized that the diversion status of those 12 hospitals can have a significant impact on the four remaining acute care hospitals located in Emporia, Farmville, South Boston and South Hill (PD 13, 14 and 19).

NOTE: Early contact and notification by the EMS ambulance crew to the intended hospital is essential for optimal patient care. It is highly recommended that the ambulance Attendant in Charge (AIC) use the regional MIVT Report format when providing the hospital with pre-arrival information on the patient. Once an EMS unit has marked on route and a report has been given to the receiving hospital, any later change in diversion status of the receiving hospital will not affect that ambulance.

1. CONTRAINDICATIONS: Patients with airway obstruction, uncontrollable airway, uncontrollable bleeding, who are in extremis, or with CPR in progress should be taken immediately to the closest appropriate hospital, without regard to the hospital's diversion status.

Level 1 Trauma Centers are never on diversion for major or multi-system trauma patients except in extraordinary circumstances.

2. DIVERSION OVERRULE: Prehospital EMS providers may overrule diversion if a patient is in extremis, or for significant weather/traffic delays, mechanical problems, etc. An EMS provider who believes an acute decompensation is likely to occur if the patient is diverted to a more distant hospital **ALWAYS** has the option to take that patient to the closest Emergency Department regardless of the diversion status. The Attendant-in-Charge also has the option to ask via radio or phone to speak directly to an Emergency Department physician. Good clinical sense and optimal patient care are the ultimate considerations.

NOTE: Such decisions to overrule a hospital's diversion status may be referred for review to the Old Dominion Medical Control Committee and the provider's agency by the receiving hospital.

3. CONSIDERATIONS: When there are questions about hospital destination in an out-of-hospital situation, the prehospital attendant-in-charge should contact the local hospital as early as possible by radio or phone for destination guidance.

NOTE: Decisions by on-line Medical Control and prehospital EMS providers about patient destination must always be in the best interest of the patient.

4. Refer to ODEMSA's complete Hospital Diversion Policy for further information.

Acute Care Hospitals in the ODEMSA Region

CJW Medical Center-Chippenham (2)

7101 Jahnke Road
Richmond, VA 23225

CJW Medical Center-Johnston-Willis (2)

1401 Johnston-Willis Drive
Richmond, VA 23235

Community Memorial Healthcenter

125 Buena Vista Circle
South Hill, VA 23970

Halifax Regional Hospital

2204 Wilborn Avenue
South Boston, VA 24592

Henrico Doctors' Hospital - Forest

1602 Skipwith Road
Richmond, VA 23229

Henrico Doctors' Hospital - Parham

7700 Parham Road
Richmond, VA 23294

John Randolph Medical Center

411 W. Randolph Road
Hopewell, VA 23860

McGuire VA Medical Center

1201 Broad Rock Road
Richmond, VA 23249

Memorial Regional Medical Center

8260 Atlee Road
Mechanicsville, VA 23116

Retreat Hospital

2621 Grove Avenue
Richmond, VA 23220

Richmond Community Hospital

1500 N. 28th Street
Richmond, VA 23228

St. Mary's Hospital

5801 Bremo Road
Richmond, VA 23226

Southern Va. Regional Medical Center

727 N. Main Street
Emporia, VA 23847

Southside Community Hospital

800 Oak Street
Farmville, VA 23901

Southside Regional Medical Center (2)

801 S. Adams Street
Petersburg, VA 23803

St. Francis Medical Center

13700 St. Francis Boulevard
Midlothian, VA 23114

VCU Medical Center (1)

401 N. 12th Street
Richmond, VA 23298

NOTE: (1) Level 1 Trauma Center
(2) Level 3 Trauma Center

Policy and Protocol **For Use of the Nerve Agent Antidote Auto-Injector (Mark 1 Kit)**

Scope:

The use of the MARK 1 auto-injector is intended for any event, including Weapons of Mass Destruction (WMD incidents), when it has been determined that a poisoning by a chemical nerve agent/ organophosphate has occurred. Use of the kits is limited to this purpose. The use of this antidote for any other class of agents is contraindicated and may be a life-threatening hazard. It is particularly geared to the use of Mark 1 kits that are carried on licensed EMS vehicles in the Old Dominion EMS Alliance region.

Indications for Use:

In the event of exposure to a known or a suspected organophosphate chemical agent, responders should withdraw immediately from the area if possible. Withdrawal should be made with the realization that the responder may be contaminated and should be limited to the nearest fresh-air site avoiding contamination of bystanders or other responders.

- A. In general, pinpoint pupils, increased secretions, and muscle fasciculation are the most reliable signs of nerve agent exposure.
- B. Nerve agents are either vaporous or liquid agents belonging to the classification of drugs known as organophosphates. Tabun (GA), Sarin (GB), Soman (GC) and VX are the most commonly stockpiled agents. The first three, though transported as liquids, are weaponized by vaporization and are inhaled. VX stays in a heavy liquid form, much like motor oil, and is spread by the droplet route.

Mild Vapor Exposure:

Signs and symptoms following a vapor exposure occur within seconds to minutes, and include:

- A. Miosis – constriction of the pupil. Characteristically occurs from a nerve agent vapor exposure to the eye, or from direct liquid contact with the eye. Miosis is usually accompanied by eye pain, described often as a dull ache in the front of the forehead or as pain about the orbit

- B. Headache.**
- C. Dim vision.**
- D. Increased salivation, lacrimation, and rhinorrhea (rhinorrhea may be the first indicator of exposure, aside from eye findings, in a vapor exposure).**
- E. Mild respiratory distress.**
- F. Mild muscle weakness and/or mild, localized muscle twitching.**

Management:

- A. Most symptoms resolve spontaneously within 15-30 minutes.**
- B. No specific treatment is indicated.**

Treatment:

- A. If airway effects are noted (chest tightness, shortness of breath, airway secretions), and/or if other symptoms are not improving over time, administer one MARK I auto-injector kit.**
- B. Monitor progress, noting that MARK I auto-injectors will not reverse miosis. Supplemental oxygen is required in those personnel with pulmonary manifestations, or with a history of cardiac disease.**

Moderate Exposure:

Signs and symptoms for a moderate exposure include:

- A. Those occurring in mild exposures.**
- B. More respiratory distress.**
- C. Muscular weakness and fasciculation – twitching can be localized, as in the case of mild to moderate liquid exposure, or generalized, as in large liquid and moderate to large vaporous exposures.**
- D. Gastrointestinal effects (vomiting and diarrhea) – these are generally the first systemic signs of skin exposure (liquid agent) to a nerve agent**
- E. Sweating – may be localized for a mild to moderate liquid exposure, or generalized for a vapor or large liquid exposure.**
- F. Tachycardia, hypertension.**

Management and Treatment:

- A. Administer one or two MARK I kits, and titrate to symptomatology (up to a maximum of three MARK I kits).**
- B. Respiratory management – supplemental oxygen, assistance in secretion management.**
- C. Decontaminate and transport.**

Severe Exposure:

Signs and symptoms for a severe exposure include:

- A. Miosis.
- B. Copious respiratory secretions impairing a patent airway.
- C. Severe respiratory distress or apnea.
- D. Possible cyanosis.
- E. Muscle twitching which progresses to muscle rigidity and flaccid paralysis.
- F. Altered level of consciousness – patient may be unconscious or seizing.
- G. Incontinence of bowel and bladder.

The onset of symptoms for a severe exposure usually is rapid -- from seconds to minutes for a vapor exposure -- but may take up to 30 minutes for a VX or liquid exposure.

Management and Treatment

- A. Aggressive airway control, including BVM, intubation, Combitube© insertion, and vigilant suctioning.
- B. Administer three MARK I kits in rapid succession.
- C. Anticonvulsant medications probably will be required, even in the absence of seizure activity. Administer one Diazepam auto-injector if available. If not, consider administration of Valium IV.
- D. Decontaminate and transport.

Special Considerations:

- A. Riot control agents, i.e. mace, tear gas, pepper spray, are irritants to mucous membranes.
 - 1. Excessive tearing and rhinorrhea will be present.
 - 2. Shortness of breath may be present.
 - 3. Miosis is never present.
 - 4. Atropine and Pralidoxime are not indicated.
- B. Pesticides, such as malathion, chlorpyrifos, and diazinon are also organophosphates. They are not as potent.
 - 1. Treatment is usually limited to Atropine alone.
 - 2. Pralidosime is not indicated for pesticides containing carbamates.
- C. Industrial gases, such as chlorine and phosgene, have similar presentations to nerve agents.
 - 1. Shortness of breath.
 - 2. Skin or mucous membrane irritation.
 - 3. Cough may be present.
 - 4. Muscle fasciculation and miosis are not present.

Recommended Procedure for Administration of MARK 1 Kits

Note: Two administration protocols are outlined: the sequential protocol allows the two components of the MARK I kit to be given one at a time; the simultaneous protocol allows for both auto-injectors to be administered at the same time. There are no therapeutic advantages of one over the other, and either may be employed with the same effect. Refer to the photograph and information on Page 8.

A. Self-Administration: Sequential Protocol

- 1. The MARK 1 kit contains two auto-injectors: the larger black-tipped Pralidoxime, labeled #2, containing 600mg of medication in 2ml; and the smaller green-tipped Atropine, labeled #1, containing 2mg in 0.7ml.**
- 2. Hold the kit in the non-dominant hand with the larger (#2) auto-injector on top.**
- 3. Grasp the smaller (#1) auto-injector in the dominant hand with a pencil-type grip, pull and remove the smaller green-tipped #1 Atropine injector from its clips.**
- 4. The Atropine auto-injector now is “armed.”**
- 5. Select a large muscle mass – the anterolateral thigh is the preferred site.**
- 6. The upper outer quadrant of the buttocks is permissible, particularly for thin casualties .**
- 7. Remove any objects (coins, keys, buttons) that may be obstructing the path of the spring-loaded needle; do not inject directly onto or in close proximity to the thigh, hip, or knee bone.**
- 8. The auto-injectors are designed to be used through clothing and turnout gear.**
- 9. Place the colored end (needle side) against the selected site and apply firm, even, stabbing pressure to the auto-injector.**
- 10. Hold in place for 10 seconds.**
- 11. Massage the site if possible.**
- 12. Repeat, using the black-colored Pralidoxime injector labeled #2.**
- 13. Make every effort to dispose of used needles carefully, either by utilizing a sharps container/ bucket, and/or by bending the tips of the non-retracting needles against a hard surface (ground).**
- 14. Monitor for improvement in symptoms – remember, miosis or pupillary constriction will not improve unless topical Atropine is given.**
- 15. Multiple or repeated doses may be given according to signs and symptoms up to a maximum of three (3) Mark 1 kits.**

B. Self-Administration: Simultaneous Protocol

- 1. Prepare both Mark 1 auto-injectors, as described above.**
- 2. Select two muscle sites, one in each thigh or buttock .**
- 3. Simultaneously, inject both auto-injectors into the desired sites, holding firm pressure for 10 seconds until both auto-injectors are fully discharged.**
- 4. Massage, dispose of sharps, and monitor effects and symptoms as above.**

C. Buddy Administration

- 1. If conscious, have the recipient squat and not kneel to receive antidote administration.**
- 2. If unconscious, position the recipient on his/her side in a lateral position.**
- 3. Select the thigh or upper outer quadrant of the buttocks as the site of injection (the thigh is preferable).**
- 4. Administer per injection protocols.**
- 5. Monitor for improvement or need for additional MARK 1 injections.**
- 6. In order to determine that a responder has received treatment with antidote kit[s], each kit shall include a marking pen. The pen is to be used to signify that a responder has received treatment with MARK 1 kits and/or Diazepam.**
- 7. In order to determine that a responder has received treatment with antidote kit[s], each kit shall include a marking pen. The pen is to be used to signify that a responder has received treatment with MARK 1 kits and/or Diazepam.**
- 8. A single vertical line shall be drawn upon the forehead of the responder for every MARK 1 kit received, and a “V” added when needed to signify the administration of the Diazepam component.**

Post-Treatment Actions

- A. Once egress is made and self-treatment has been performed, the responder shall notify other personnel on scene of the danger inside and shall await decontamination before advancing for further medical evaluation.**
- B. Once treated with antidote kit[s], the responder shall be taken off-line immediately and, after at least gross decontamination, will be transported to the nearest emergency department for further medical evaluation.**
- C. A Triage Tag will be attached to the responder indicating the use of MARK 1 auto injector(s), and adding any information regarding the exposure [liquid or vapor, signs and symptoms, and especially if the responder has been decontaminated].**

Mark 1 Auto-Injector Kit Described



This is a photo of the Mark 1 auto-injector kit that will be used to treat persons exposed to nerve agents and/or pesticides in the ODEMSA region. It contains two medications that provide an antidote for nerve agent victims. Victims would include citizens and emergency responders such as firefighters, law enforcement officers, and emergency medical services (EMS) providers in the 9,000-square-mile Central Virginia area. The auto-injectors are simple to use and can be self-administered or administered by EMS personnel.

Under the ODEMSA plan, each licensed EMS vehicle in Planning Districts 13, 14, 15 and 19 will carry up to 25 auto-injectors in locked compartments. This will allow crews to respond directly to an incident, saving critical time in treating people exposed to pesticides or other lethal nerve agents.

In partnership with local governments, ODEMSA has obtained two matching state Rescue Squad Assistance Fund grants to equip 229 licensed EMS vehicles in Planning Districts 13, 14 and 19. Plans are being developed to similarly equip all EMS vehicles in Planning District 15 also.

Adapted by Old Dominion EMS Alliance
Source: Virginia Department of Health
Office of Emergency Medical Services

MARK 1 KIT UTILIZATION PROTOCOL

Introduction

The primary intent of using MARK I Kits is to allow first responders to self-treat or to treat other first responders in the event of a chemical nerve agent exposure. However, the Office of EMS/VDH realizes that, in the event of a mass public exposure to a nerve agent, the first responders may possess the resources to treat other members of the public safety response team. Accordingly, OEMS endorses the following protocol for on-scene administration of the MARK 1 Kits. This protocol is intended as an interim document pending publication of the updated ODEMSA Prehospital Patient Care Protocols.

ON-SCENE PROTOCOL

An Incident Involving a Nerve Agent Occurs



Self-Treat and Treat Your Crew



Provide Treatment to Other Public Safety Responders



EMT-Ps or EMT-Is May Administer the MARK 1 Kits

If sufficient resources are not available then:



EMT-Basics May Administer the MARK 1 Kits

If sufficient resources are not available then:



Trained First Responders May Administer the MARK 1 Kits



Transport After at Least Gross Decontamination

**For patients requiring continued administration of the MARK 1 Kit, the EMS provider is authorized to adhere to the following transportation protocol
(in order of preference):**



EMT-P/EMT-I Accompanies the Patients

If sufficient resources are not available then:



EMT-Basic Accompanies the Patients

If sufficient resources are not available then:



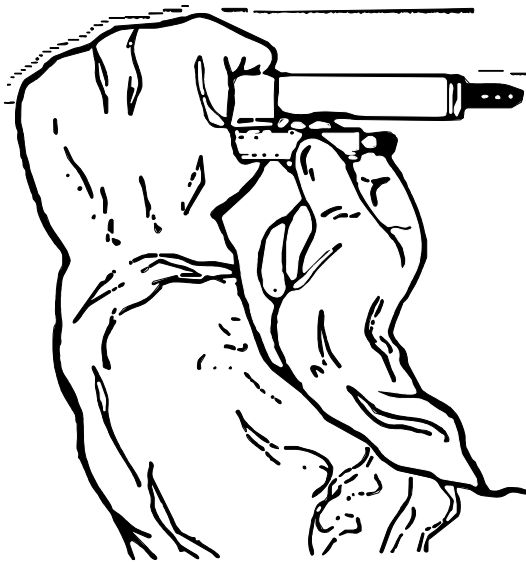
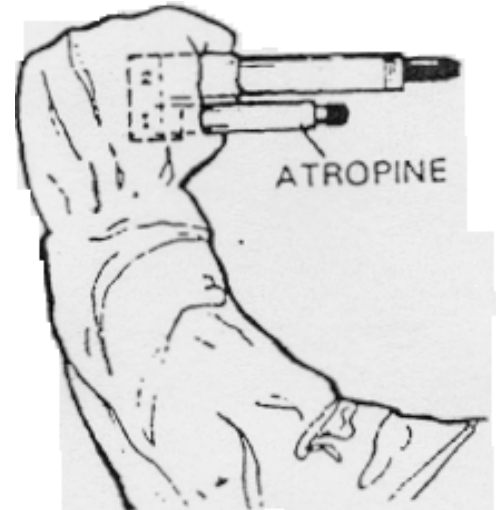
MARK 1 kits may be given to transporting medical personnel, including air medical crews, to facilitate continued patient care.



MARK I INSTRUCTIONS

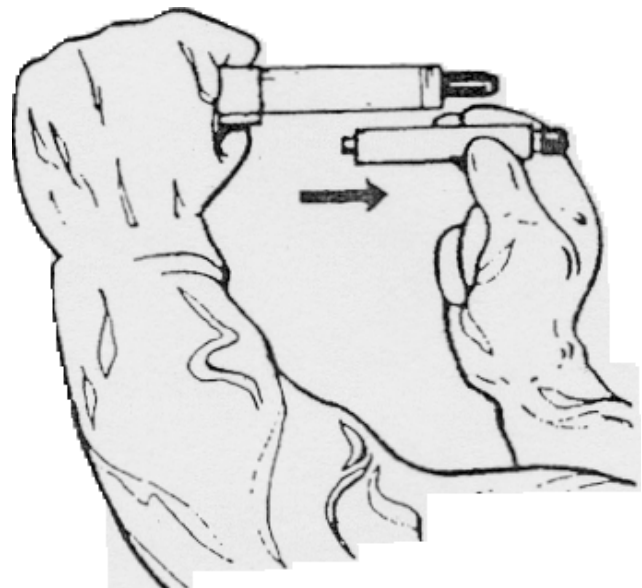


1. Remove the Nerve Agent Antidote Kit {MARKI kit} from its storage location.
2. With your non-dominant hand, hold the autoinjectors by the plastic clip so that the larger autoinjector is on top and both are positioned in front of you at eye level.

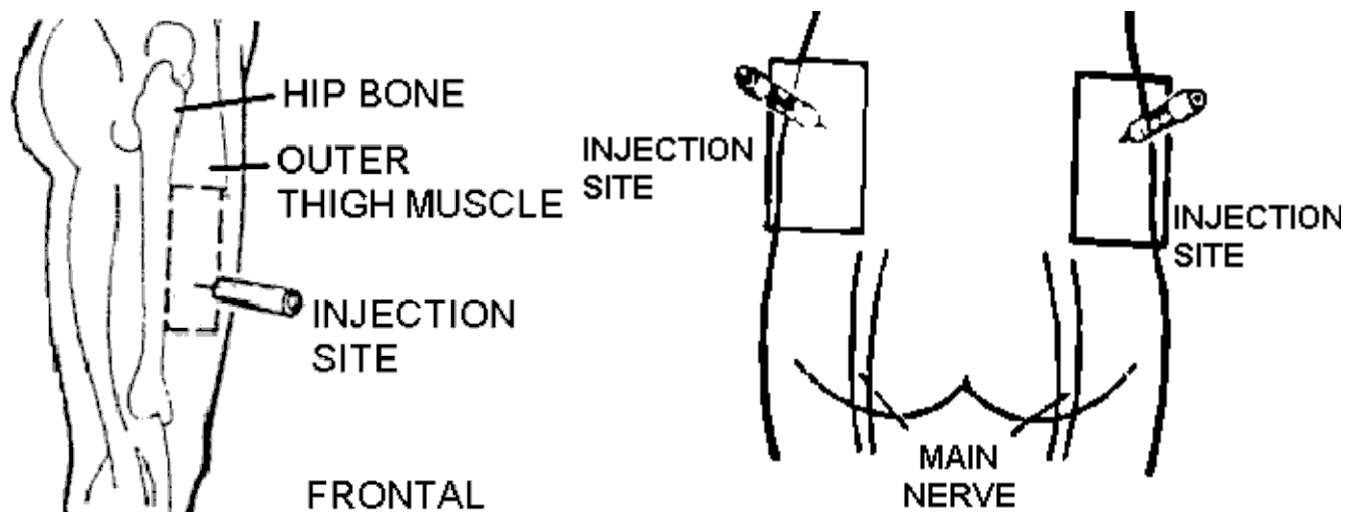


3. With the other hand, check the injection site (thigh or buttocks) for buttons or objects in pockets which may interfere with the injections.
4. Grasp the atropine (green-tipped) autoinjector with the thumb and first two fingers.

5. Pull the injector out of the clip with a smooth motion.



6. Hold the autoinjector like a pen or pencil, between the thumb and first two fingers.
7. Position the green tip of the autoinjector against the injection site (thigh or buttocks).



8. Apply firm, even pressure (not a jabbing motion) to the injector until it pushes the needle into the thigh or buttock.
9. Hold the injector firmly in place for at least 10 seconds. The seconds can be estimated by counting "one one thousand, two one thousand," and so forth.
10. Carefully remove the autoinjector.
- 11. Place the used autoinjector into a sharps container.**
12. Pull the 2-PAMCI autoinjector (black-tipped) out of the clip and inject using the procedures outlined in steps 4 through 11.
13. Annotate the number of autoinjectors administered on an ambulance prehospital patient care report (PPCR) or, in a mass casualty incident situation, in the Treatment Record section on the reverse side of the Virginia Triage Tag.

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15. Treat and Release Policy at Mass Gathering Events

Patient Care Policy **Treat and Release for Minor Injuries** **At Mass Gathering Events**

Current January 2006

I. Scope:

This policy and its related protocol are intended for use only in gatherings of large numbers of persons such as races, concerts and rallies, and in those circumstances/ situations approved by the EMS Agency's operational medical director (OMD). It is designed to give clear patient care guidelines to EMS providers in the ODEMSA region and allow them the option of treating patients with minor injuries and/or medical complaints without transporting the patients to a medical facility. The OMD must approve this policy before it is implemented.

It is intended for use only in when the number of anticipated patients could quickly overwhelm existing EMS or hospital resources to provide appropriate patient care. This policy will apply to any patient that meets the patient profile (below) that requires basic first aid only.

EMS providers are expected to use good clinical judgment and complete documentation. Providers may transport any patient to a medical facility regardless of the patient's chief complaint, presenting symptoms or clinical assessment according to ODEMSA Prehospital Patient Care Protocols.

Any patient who asks to be transported to a medical facility, even if the EMS provider feels that the patient could be treated and released under this policy, will be transported.

Any patient for whom the E911 System has been appropriately activated may be transported to the hospital for further evaluation.

II. Patient Profile (Those patients who may be treated with this protocol):

A. Patient history and examination will be reliable:

1. Alert and oriented X3.
2. **No** suggestion of drug, alcohol or other substance usage/abuse.
3. **No** suggestion of psychological/psychiatric problems.
4. **No** head injury (including loss of consciousness or altered mental status).
5. Patient is able to communicate adequately and to understand what is being communicated to him/her.

B. Injuries sustained where mechanism of injury is very low risk for significant injury.

D. Patient has no spinal injury, pain, tenderness or deformity on exam, and has a normal sensory/ motor exam.

- E. Patient does not exhibit any signs of chest pain or shortness of breath.
- F. Patient will have vital signs within age specific normal limits.

III. General Exclusion Criteria:

- A. Any patient with a pain scale assessment higher than a "5" on a 1 to 10 scale.
- B. Any patient who does not meet all requirements in the Patient Profile section.
- C. Any patient who requests transportation to a medical facility.
- D. Any patient for whom the E911 System has been appropriately activated.

IV. Indications and Treatments:

Minor complaints/injuries may include the following, but are not limited to:

A. Any minor injury requiring simple wound disinfection and bandage application:

1. **Treatment:** After completion of the primary exam, clean abrasions, simple avulsions, and small lacerations not requiring suturing with normal saline. Apply antibiotic ointment (Bacitracin or Neosporin) and sterile bandage. Ensure that the patient has had Tetanus Toxoid immunization within the last five (5) years. **NOTE:** If not current with Tetanus immunization, the patient must be referred within 72 hours from the incident to his/her own physician.

2. Contraindications:

- a.) Any signs or symptoms of infection (redness, swelling, fever, drainage).
- b.) Any wound to facial area, unless it is a simple abrasion.
- c.) Any deep, jagged or gapping wound.
- d.) Any uncontrolled bleeding from the wound.
- e.) Any wound exposing subcutaneous tissue/structure.

B. Request for over the counter medications for c/o headache, or simple muscle type pain:

1. **Treatment:** After completion of the primary exam, assess patient for medication allergies. Administer Tylenol, Ibuprofen, or ASA as requested by the patient per manufacturer dosage recommendation.

2. Contraindications:

- a.) Any neurological deficits with headache.
- b.) Any history of allergies to approved medications.
- c.) Any request for ASA for complaint of chest pain (These patients must be referred to the hospital for further evaluation. ASA may be given under the ALS protocol for chest pain)
- d.) Any patient requesting ASA or ibuprofen with a history of asthma.

C. Soft tissue injury without signs or symptoms of a fracture:

1. **Treatment:** After completion of the primary exam, elevate the affected area and apply a cold/ice pack. Provide education on removal of cold pack within 20 minutes of placement.

2. **Contraindications:**

- a.) Any signs/symptoms of a fracture (deformity, excessive swelling, discoloration, any open wounds over the site, decreased range of motion).
- b.) Any neurological deficits (numbness or tingling distally, delayed capillary refill or decreased pulses distally).
- c.) Any severe pain or swelling requiring splinting.
- d.) Any injury associated with vascular deficits distal to the injury.

D. Insect stings:

1. **Treatment:** After completion of the primary exam, assess patient for previous allergies to bee stings. Monitor airway for allergic reaction/swelling. After completing history, remove the stinger by scraping with a blunt edged object. Do not remove with tweezers; squeezing may release more of the poison into the surrounding tissue. Wash the area thoroughly with soap and water. Apply ice/cold pack to relieve pain and/or swelling. Monitor airway for allergic reaction/swelling. **NOTE:** stingers not removed will continue to release venom into the tissue for as long as 20 minutes.

2. **Contraindications:**

- a.) Any patient with a history of allergies to Insect stings.
- b.) Any insect sting on the face or neck.
- c.) Any patient that exhibits signs of respiratory distress, tightness in throat or chest, dizziness, rash, fainting, nausea/vomiting, difficulty swallowing.
- d.) Any swelling of the face, lips or eyelids.
- e.) Hypotension.
- f.) Presence of hives or other obvious symptoms of a more generalized allergic reaction.

E. Tick removal:

1. **Treatment:** After completion of the primary exam, remove the tick gently by using tweezers to grasp the tick firmly at its head, next to the patient's skin. Pull firmly and steadily on the tick until it lets go. Swab the bite with alcohol. Inspect the tick to ensure that the head has been removed successfully. Educate patient on signs/symptoms of Lyme Disease (bull's eye rash, fever, headache, joint pain) and Rocky Mountain Spotted Fever (purple to red rash on trunk and extremities, fever and headache).

2. **Contraindications:**

- a.) Any tick that appears to have been embedded for longer than 24 hours.
- b.) Any signs or symptoms of infection present.

- 3.) If the tick does not appear to have been removed whole and the head remains embedded in the skin, the patient must be sent to a physician or medical facility that day.

F. Minor animal bite:

1. **Treatment:** After completion of the primary exam, wash the area of the bite carefully with soap and water. Apply antibiotic cream and a sterile dressing. Ensure that the patient has had Tetanus Toxoid immunization within the last five (5) years. **NOTE:** If not current with Tetanus immunization, the patient must be referred within 72 hours from the incident to his/her own physician.
2. Report bite (as required under State and local laws) to either local animal control or the local health department. If possible to do so without endangering anyone, detain or take steps to identify the biting animal. If the animal is deceased, the carcass should be immediately turned over to animal control.
3. Refer the patient to their primary care physician for follow up treatment because the risk of infection needs to be closely monitored.
4. **Contraindications:**
 - a.) Any facial involvement.
 - b.) Any wound that will not stop bleeding after 15 minutes of direct pressure.
 - c.) The attacking animal was wild or behaving strangely.
 - d.) Animal immunization status is unknown, or the animal cannot be found.

G. Non-traumatic nose bleeds without medical causes:

1. **Treatment:** After completion of the primary exam (rule out any medical causes), lean the patient slightly forward to avoid swallowing blood. Apply firm pressure below the bony part of the nose for 10 minutes. Reassess if bleeding continues transport to a medical facility.
2. **Contraindications:**
 - 1.) Any medical causes, i.e. hypertension, history of hemophilia.
 - 2.) Patient that is currently on any blood thinner medication.
 - 3.) Bleeding uncontrolled for longer than 10 minutes after treatment.
 - 4.) Any nosebleed caused by a direct traumatic injury.

H. 1st Degree burns (usually caused by brief skin contact with hot water, steam, hot objects, or overexposure to the sun):

1. **Treatment:** After completion of the primary exam, run cool water over the burned area or hold a cold compress on the burn. Do not use ice. Cover loosely with a sterile bandage. Offer extra fluids.
2. **Contraindications:**
 - a.) Any 2nd or 3rd degree burns.
 - b.) Any burns to the face, eyes, mouth, hands, and genital areas.

- c.) Any burn too large to cover with a bandage.
- d.) Any burn caused by electricity or an explosion.

I. Eye Irritations (sand, dirt and other “foreign bodies” on the surface of the eye):

1. Treatment: After completion of the primary exam, flush affected eye with sterile saline solution. Flush for up to 15 minutes, checking the eye every five (5) minutes to see if the foreign body has been flushed out. Encourage the patient not to touch or rub the affected eye. If the foreign material cannot be removed by flushing, or the eye remains irritated after flushing, transport to a Medical Facility.

2. Contraindications:

- a.) Any embedded foreign body.
- b.) Any eye irritation due to chemical exposure.
- c.) Any eye irritation due to trauma.

J. Splinter removal:

1. Treatment: After completion of the primary exam, remove the splinter from the skin by pulling at the same angle that it entered with a pair of tweezers. If a splinter is not easily removed, refer the patient to a physician for removal. Wash with soap and water, apply antibiotic ointment and a sterile dressing.

2. Contraindications:

- a.) If the splinter is too large or went deeply into the skin.
- b.) Any signs of infection.
- c.) If the splinter is unable to be removed.

K. Heat exhaustion/heat cramps (heat related illness):

1. Symptoms may include:

- a.) Skin: sweating, clammy, pale.
- b.) Pulse: tachycardia.
- c.) Respirations: increased.
- d.) Temperature: normal or slightly elevated.
- e.) Neurological: headache, weakness, dizziness, anxiety.
- f.) GI: nausea/vomiting.
- g.) Muscle cramps.

2. Treatment: After completion of the primary exam,

- a.) Place the patient in a cool area to rest.
- b.) Remove any excess clothing.
- c.) Sponge the skin with cool water. Consider the use of fans if available to aid in the cooling process. Air movement over moistened skin will hasten water evaporation and the cooling effects of this moisture.
- d.) Apply cold packs to the forehead and/or back of neck. Consider the application of these packs to the axillae and groin to further enhance the cooling effects in severely symptomatic patients.
- e.) Provide cold water for drinking.

- f.) Initiate IV fluid bolus for patient's with persistent symptoms despite above cooling efforts (do not initiate for any patient with a history of congestive heart disease or pulmonary edema). Bolus with 250cc-500cc over 10-20 minutes. Re-evaluate symptoms. Repeat ONCE as needed.
- g.) Reassess and appropriately document findings. Patients who show significant improvement with cessation of symptoms may be released. Provide the patient with education related to prevention of future heat related illness symptoms.

Patients will be transported to a medical facility immediately for symptoms that persist after a total of one (1) liter of normal saline.

Patients will be transported to a medical facility immediately for symptoms which persist for more than one (1) hour despite above treatment.

3. Contraindications (Patients requiring transport to a medical/facility include the following with heat related illness of any degree):

- a.) Heat stroke: (a life threatening condition where the body loses the ability to regulate its own temperature). Signs and symptoms include:
 - 1.) Hot, red, dry skin, but NOT sweaty.
 - 2.) Confusion, delirium, hallucinations.
 - 3.) Seizures.
 - 4.) Syncopal episode.
 - 5.) Frequent uncontrolled vomiting.
 - 6.) Difficulty breathing.
 - 7.) Elevated internal body temperature (>103).Patients experiencing these symptoms should be rapidly cooled, an IV of NS established and transported immediately to the closest emergency department. (See ODEMSA Protocol Hyperthermia/Heat Stroke).
- b.) Any patient with complaint of chest pain or dyspnea.
- c.) Any patient with a BP <90mmHG systolic.
- d) Any patient over the age of 70 OR under the age of 13.

V. Patient Assessment and Documentation:

Documentation is required for each patient and should be done on a PPCR, ODEMSA Treat and Release for Minor Injuries form, or other locally developed form. This form when complete will include: chief complaint, vital signs (including pain scale), primary assessment with particular attention to the patient's neurological status, clinical assessment, treatment rendered, and education on follow up care. Providers' assessment skills should be renewed and reviewed on a regular basis.

VI. Patient Referrals:

In all cases where patients are treated and released under this policy and protocol, there will be clear documentation and explanation to the patient or responsible party of the absolute need for the patient to be reevaluated by the patient's own physician or medical facility of choice for definitive medical care.

THIS POLICY AND PROTOCOL IS NOT INTENDED TO PROVIDE DEFINITIVE CARE TO ANY PATIENT. IT IS RATHER INTENDED TO PROVIDE A MECHANISM BY WHICH BASIC FIRST AID MAY BE ADMINISTERED ACUTELY, WITH PHYSICIAN FOLLOW-UP AT THE PATIENT'S EARLIEST CONVENIENCE.

VII. Quality Assurance:

It is recommended that participating agency 's quality assurance/performance improvement policy stipulate that both during and upon completion of each event where the use of the Treat and Release Patient Care Policy and Protocol has been authorized, the OMD conduct a random review of the charts generated for the appropriateness of documentation, treatment and disposition of the patient. The sample size should be large enough to assure that appropriate care by all providers is being rendered.

VIII. Reporting:

It is strongly recommended that at the conclusion of six (6) months from the date this policy is adopted, results of this project be reported back to the ODEMSA Medical Control Committee for quality assurance and quality improvement purposes.

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**Adopted by ODEMSA Board and Medical Control Committee 8/2005
Adapted by the Old Dominion EMS Alliance
Source: Henrico Division of Fire/EMS
ODEMSA T&R Policy 9-2005**