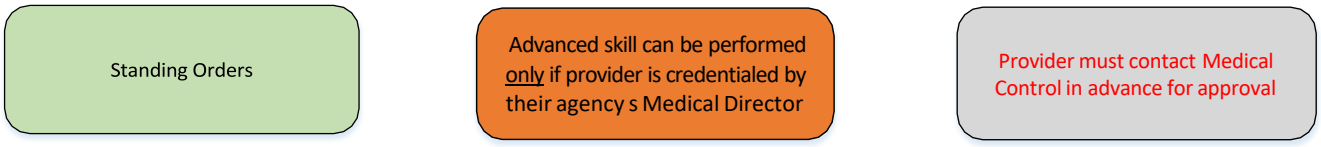
JPASD Protocol Introduction

All licensed EMS practitioners are expected to provide prehospital care under the direction of the highest skilled level EMS practitioner and Medical Control. This may be accomplished by voice communication established with a physician and under the physician's order or through utilization of standing order outlined in an approved protocol.

Standing Orders

Standing orders are designed for EMS providers to initiate care without having to contact Medical Control. Additionally, certain treatments and procedures must be credentialed by the agency's Medical Director before they can be performed within our service area. Education, training, and medical oversight for these advanced skills is the responsibility of the agency's Medical Director.

The following colors are utilized within the JPASD Protocols to clarify provider orders:



Additional colors utilized within the JPASD Protocols include:

Medical Control

Online medical control – via radio or telephone – can be used whenever desired by the EMT or paramedic. When contacting Medical Control, providers should begin their report stating the reason or request for which they are calling. The provider report should then follow the format outlined in the appendix.

Listed below are reasons for which Medical Control **MUST** be contacted:

- as clinically indicated and in accordance with the operating procedures of your employer
- as indicated in the On-Scene Physician policy
- at any point as directed within the following JPASD Protocols
- prior to administration of medications that are not standing orders
- if a line of treatment is in question or patient care becomes unclear
- prior to performance of an advanced skill(s) as specifically stated in the appropriate protocol
- to request/receive orders to terminate

In the event that primary Medical Control cannot be reached, the responsibility of Medical Control will belong to either the receiving facility or the agency's EMS Medical Director. Physicians serving as Medical Control are expected to be familiar with JPASD Protocols and to use them as a guide for providing prehospital orders and/ or consultation.

A Medical Control physician should notify an agency's EMS director in writing or by email whenever prehospital care has been rendered that they believe does not comply with the protocol as outlined by JPASD. They may also notify the JPASD EMS Director if there are protocols that a Medical Control physician needs to be revised in order to maintain quality prehospital patient care.

On-Scene Physician

If a licensed physician other than an agency's EMS medical director is first to arrive on-scene of an emergency, protection from liability applies as outlined in the Good Samaritan Statute[1]. Upon arrival of the EMS practitioner, the physician has three options:

a) *Allow the EMS practitioner to assume full authority for directing the care of the patient.* In this instance, the physician will not have any risks of liability for patient abandonment.

b) *Assist the EMS practitioner in the care of the patient without assuming authority over patient care.* In this instance the EMS practitioner must articulate that state law requires EMS personnel to comply with standing orders and/or verbal orders from a pre-established Medical Control.

c) *Assume full authority for directing patient care*. The primary purpose of this option is to support a previously well-established physician-patient relationship; however, it may be utilized under other less anticipated circumstances. In this instance, the physician must state their intent to assume responsibility for any patient care given and must accompany the patient to the hospital. EMS providers should manage this situation based on the following process.

Process for On-Scene Physician Assuming Patient Care

1. The EMS practitioner should ask the physician to show his/her Louisiana State Board of Medical Examiners license as verification of his/her identity as a physician.
2. The EMS practitioner should confirm (and reaffirm) that the on-scene physician is agreeing to:
    a. Full medicolegal responsibility of patient care
    b. Remain physically present during the duration of prehospital care, including riding in the back of the ambulance with patient and performing handoff to a clinician at the receiving facility.
    c. Sign the EMS patient care report (i.e. prehospital medical record) indicating that they have accepted full responsibility for medical care and all medical orders given.
3. The EMS practitioner should establish contact with the base hospital physician serving as Medical Control. After advising the Medical Control Physician (MCP) of useful patient information, the EMS practitioner should inform them that a physician is present and wishing to assume patient care responsibility. The on-scene and Medical Control physician should discuss the appropriate patient treatment and determine who will have authority over patient care.
4. EMS personnel will accept orders from the on-scene physician only after the base hospital physician serving as Medical Control has stated that care is being transferred to the on-scene physician. EMS practitioners may only execute orders and perform duties that are within their scope of practice.
5. If at any time the on-scene physician's orders become questionable, are contrary to established JPASD protocols, or appear to interfere with quality patient care, the EMS practitioner should

[1] Louisiana State Legislature RS 37:1731. http://legis.la.gov/legis/Law.aspx?d=93432

immediately re-establish contact with the base hospital physician for guidance before executing the orders. In any case of conflict, the orders of the online Medical Control physician take priority.

EMS practitioners shall treat all on-scene physicians with respect and shall endeavor to work in cooperation with an on-scene physician for the patient's best interest. The EMS practitioners should make their services, equipment, supplies and ambulance available to the on-scene physician as much as feasible.

Patient Refusal of On-Scene Physician Care

In the event that a patient refused the care of the on-scene physician but accepts the care of the EMS practitioner, the online Medical Control physician will be responsible for directing the EMS practitioner, regardless of whom the two physicians originally decided would have patient care authority.

A patient (or a patient/guardian, in the case of a minor) who is lucid and understands the medical risks and consequences of their decisions has the legal right to refuse care by the EMS practitioner, on-scene physician, and Medical Control physician after such risks and consequences have been explained to him/her.

In the event that a patient wishes for the on-scene physician to have authority over care, but the online Medical Control physician does not feel that this is in the patient's best interest, the EMS team on-scene should attempt to have the patient sign a refusal of service form before leaving the scene (as is standard practice). The on-scene physician is then responsible for further patient care and for arranging transport of the patient to an appropriate hospital or facility.

Provider Responsibilities

EMS practitioners are authorized to perform services, treatments, and procedures authorized by JPASD and within the provider's Louisiana Bureau of EMS scope of practice matrix guidelines to the extent that he/she has been trained to perform such services. EMS agencies are responsible for module education and documentation of skill proficiency and education. All skills, procedures, interventions, and medications must be included in agency protocols as approved by the agency's medical director. Ambulance services are responsible for ensuring compliance with applicable protocols by their personnel.

In the event of a basic level ambulance response to an emergency within Parish of Jackson (unless an MCI or disaster is declared) EMRs, EMTs and Advanced EMTs are permitted to administer the medications as specified within this document that are also in accordance with the Louisiana Bureau of EMS approved scope of practice matrix for licensed EMS practitioners.

The scope of practice for each EMS practitioner level is determined by the LA EMS Certification Commission. The most up to date matrix is available at https://ldh.la.gov/index.cfm/page/1754.

Ambulance Requirements

Patients in the need of transport to a hospital will be transported in an ambulance or an approved vehicle that meets the requirements of the regulatory agencies of JPASD and the state of Louisiana.

In addition to state requirements, JPASD mandates all EMS services and systems licensed to operate in the region carry the following equipment:

- 12-lead EKG
- AED (Automatic External Defibrillator); biphasic (for BLS units)

- All medications listed within these guidelines, unless stated “if available”
- Biphasic defibrillation
- Quantitative end tidal CO_2 ($EtCO_2$) capnography
- Glucometer
- Intraosseous vascular access (adult and pediatric)
- SpO2
- Transcutaneous pacing
- Continuous Positive Airway Pressure (CPAP)

Operating without the above equipment violates certain parish ordinances and could jeopardize licensure.

Hospital Selection

1. The choice of hospital destination should preferentially be based on the patient’s medical need. If, in the opinion of the highest skilled level EMS practitioner or Medical Control, the patient’s condition is unstable the patient will be transported to the closest appropriate hospital emergency department.

2. In patients who are stable, hospital diversion should next be considered by EMS practitioners when choosing hospital destination. Providers should maintain awareness of local hospital status and encourage local ED staff to regularly update hospital status within the LERN Portal. Providers may be required to override hospital diversion to transport patients to facilities with specialized patient care capabilities (e.g. trauma, stroke, STEMI).

3. In stable patients where hospital diversion is not a factor, patients (or an authorized guardian) will be allowed to select the hospital destination of choice within the EMS service area. EMS providers should consider factors such as travel time and weather when determining hospital destination and make selections in the patient’s best interest. If a patient’s hospital choice cannot be honored, providers should make every effort to transport the patient to a hospital within their preferred healthcare system. Hospital destination should not be determined by a provider’s unsubstantiated perception of hospital capability.

4. Patients who have sustained rabid animal bites, venomous snake bites, or any other poisonous bites or stings should be transported to an ED that has antivenin and rabies treatment. Providers should contact Medical Control for assistance identifying the appropriate receiving ED.

Hospital Diversion

JPASD providers will make every attempt to honor hospital diversion and acknowledge patient off-load times of receiving facilities. A diversion request usually means the hospital’s current patient load exceeds the ED’s ability to treat additional patients promptly. If one ED is overcrowded and another is available, diversion helps ensure that a patient is treated in a timely manner.

Diversion status indicates an area of the hospital (e.g. ICU, psychiatric) is without further available resources. This may include “ED Saturation.” EMS providers should make every effort possible to avoid transporting patients to hospitals on ED saturation. Limited Diversion Status does not apply to patients who are critically ill requiring immediate stabilization.

Patient/Call Disposition

All 911 calls received by EMS will be given one of the following dispositions:

1. Cancelled prior to arrival on scene
   - This disposition is provided by the Communications Center (i.e. dispatch).
   - Dispatcher must obtain a name of the canceling party, documenting it on a recorded line as they relay the name to the EMS crew for agency-specific documentation.
2. Unfounded
   - This is reserved for instances when an EMS crew (or first responding agency) arrives at a location and is unable to locate a patient. Every attempt will be made by the responding crew to locate the patient.
3. Patient "Gone on Arrival" (GOA)
   - This is reserved for instances when an EMS crew (or first responding agency) arrives on a scene and a bystander reports that the patient has left the scene.
   - Every effort should be made to obtain information regarding how and when the patient left and the party relaying that the patient is gone should be documented over the radio.
4. Cancelled on Scene
   - This is reserved for when an EMS unit arrives on the scene of a 911 call and finds **NO individual on scene with injuries, no complaints, and no request(s) for medical assistance.**
   - Should the medic render ANY type of assessment or treatment, this disposition should not be utilized. This disposition generally does not apply if a unit is on scene for an extended period of time.
   - EMS providers must obtain the name of the canceling party (whether it is law enforcement, fire department or the people involved in the incident).
5. Patient Refusal
   - This is reserved for a low acuity call in which neither the patient/guardian nor the provider feels that the patient's condition warrants transport via an ambulance.
   - It is recommended that providers obtain a patient refusal – not "cancelled on scene" disposition – when choosing not to care for individuals involved in trauma with a concerning mechanism of injury.
   - A patient refusal on a patient care report will be signed by the patient/guardian and witnessed by another party on the scene. Providers should seek to obtain witness signature from an individual accompanying the patient or a first responder from an outside agency (e.g. police, fire).
   - Providers may obtain the signature of their EMS partner as a last resort if no third party is present.

Communications Center / Dispatch

JPASD does not operate a Communication Center currently. (Dispatch is by JPSO 911). Communication Centers play a vital role in the EMS system; they can begin treating patients first. Communication's *call takers* begin care with triaging, whether triaging one patient or triaging for an MCI; from there they determine what resources are needed. Another key role of Communication Centers is to facilitate street crews in whatever means realistically possible. As the EMS system evolves, Communication Centers will soon be accommodating the needs of the streets crew in several different ways.

Dispatchers and *call takers* will now be able to treat patients pharmacologically with aspirin. Through minimal training EMS *dispatchers* and *call takers* should recognize the symptoms of an *Acute Coronary Syndrome* (ACS). ACS includes unstable and stable angina and acute myocardial infarction. Patients with a chief complaint of chest pain who are NOT allergic to aspirin and do not have active or recent gastrointestinal (GI) bleeding should be instructed to chew an aspirin (160 to 325 mg). Patients who are already on a daily aspirin regimen and have taken an aspirin with in the past 24 hours should not be instructed to take an aspirin.

When EMS dispatchers are aware of a "significant traumatic incident" (when scene time is critical) they should transmit a solid tone for no less than 3 -5 seconds when 8 minutes has elapsed, if available. The transmission of this tone will stand as a reminder to the crew(s) on scene that they are approaching a 10 minute scene time. After the tone is transmitted a verbal notification will be broadcasted. "Unit #" or "All units on Main St. this is your 8 minute notification," (repeat once) end the broadcast with "no notification response is needed."

Using the same concepts as previously listed; if available, the Communication Center should transmit a solid tone once scene times have reached 30 minutes on all cardiac arrests. When units arrive on scene of calls that need notification, they will advise communications "patient contact" along with "8 minute (or 30 minute) notification needed." As an example "unit 1 patient contact, 8 minute notification please."

For calls involving poisonings and/or overdoses where the substance can be verified, communication centers will contact the Poison Control Center at (800) 222-1222. The information from poison control will then be relayed to the responding crews. Hospital Emergency Departments also call the Poison Control Center for poisoning; they are the recognized authority. All calls to and from the Poison Control Center are recorded and they often will tell the pre-hospital providers patients do not need to be transported. These procedures will take place as the communication center has the manpower. Dispatching units and answering the emergency lines will always take priority.

6. Patient AMA
    - This is reserved for a more acute call in which the provider believes – based on their clinical assessment – that the patient needs EMS treatment and transport, yet the patient/guardian is declining treatment and transport.
    - AMA requires refusal on a patient care report and signature by patient and witness as described above.
    - Providers may offer and provide stabilizing care to the patient on-scene prior to completing the call with the direction of Med Control.
7. Patient Deceased on Scene
    - Death may be medical or traumatic in etiology; providers should follow the appropriate clinical guideline.
    - Providers must contact Medical Control to obtain orders to withhold or terminate resuscitation.
    - Providers must report the Time of Termination (TOT) in the patient care report.
    - Local law enforcement and/or the parish Coroner's Office must be contacted.
8. Patient Transported to an appropriate ED or pre-established alternate destination of care.

Regional Mass Casualty Response

For any mass casualty incident (MCI) within Parish of Jackson, the primary 911 provider for the parish in which the incident occurred is expected to serve as lead EMS agency and assume control of the incident upon their arrival. The National Incident Management System (NIMS) will be utilized to manage all MCI events.

Any non-lead EMS agency present on-scene will defer to the leadership of the primary 911 provider – this includes relinquishing command/control of the incident to a representative of equal or higher skill level within the lead EMS agency.

It is the responsibility of the highest skilled provider within the lead agency to serve as Incident Commander (or designate another incident commander) and to request additional resources as needed. Additional EMS agencies may provide mutual aid as designated/requested by the Incident Commander.