Introduction

It is evident over the last decade that emergency medical care has greatly decreased the mortality rate of acutely ill or injured patients. It is imperative that emergency medicine not only be delivered in an educated and professional matter, but also as expeditiously as possible. The following protocols were set up to increase the educational standpoint and also to decrease the time between patient interaction and delivery to the medical facility. These protocols were also set up to provide a written outline of systematic patient assessment and management in the pre-hospital setting. These protocols will also develop a written standard of care for all medics working in the system to follow. It is imperative that these protocols are used and controlled in the field by the medics. The medical director is assuming an active roll in this system and will work in the direction of pre-hospital emergency care in this region. The protocols are set up for each level of education, with the primary emphasis on the Emergency Care Attendant, EMT-Basic, Intermediate and Paramedic. It must be understood that these protocols are guidelines to follow and not every patient will fall under these specific areas. If you come across one of these areas that may not be specifically covered under these protocols, then medical direction must be sought. These protocols are also strictly for the medics that are certified under this medical director and it should not be assumed that if you live in this region and you are a certified medic through Texas Department of State Health Services that you can automatically work under these protocols. The Medics will perform all maneuvers and skills that they have been certified in. These protocols are not a license or certification to deviate from those duties. Each medic will receive a copy of these protocols and changes as soon as possible after the change. A copy of these protocols shall be in each unit for quick reference and the TDSHS license shall be in plain view on each unit also.

Patients will be transported to the closest, most appropriate facility by the most expeditious method possible. The determination of facility and transport method will be determined by the highest level of medic involved in the patient care or in the case of mass/multi casualties, as determined by the incident commander or his designee.

HEART OF TEXAS MEMORIAL HOSPITAL

June 21, 2011 Medical Staff meeting with Dr. Vickers, Dr. McDonough, Justin Harrison, PA-C, Jim Patterson, PA-C, Pam Wigginton, RN, Tina Shunk, RN, Tim Jones, Tonya Weatherman and Dr. Benham, Shannon Emergency Department.

The HOTHS Medical Staff, along with Dr. Benham, agreed on the following related to our emergency department and the City of Brady EMS:

All trauma will be diverted from HOTHS emergency department.

City based stemi's will be treated by HOTHS emergency department. Out of city proximity stemi's will be transported direct to Shannon or nearest appropriate emergency department. (ST segment elevation myocardial infarction/heart attack)

Stroke patients will be treated by HOTHS emergency department.

HOTHS emergency department providers will be notified, same day, if a hospital initiated ground transfer deviates to air.

Tim Jones
6/21/11

2008 Nine Road, Box 1150, Brady, Texas 76825 • 915/597-2901 • Fax 915/597-2280

June 24, 2011

Eddie Sayles
Brady Fire/EMS Department
Brady, Texas

Re: EMS diversion/Transport policy

Eddie,

As a follow up to our meeting on June 21, 2011 I would like you to work with your staff in implementing the follow policy on the transport and diversion of certain patients to Heart of Texas Memorial Hospital.

All major trauma should be diverted to the closest trauma center.

The Heart of Texas Memorial Hospital now has teleneurology capabilities and as such should be able to offer stroke patients timely thrombolytic therapy. Therefore all patients with CVA symptoms should be transported to The Heart of Texas Memorial Hospital.

Patients with chest pain and a 12 lead EKG consistent with an Acute ST Segment Elevation Myocardial Infarction (STEMI) should be transported to The Heart of Texas Memorial Hospital if their location is inside the city limits of Brady. If outside the city limits of Brady the patient should be transported to the closest medical center with the capabilities for definitive care. (i.e. Heart Cath Lab with diagnostic and therapeutic capabilities)

If Brady EMS is providing ground transportation from The Heart of Texas Memorial Hospital to another facility and the patients condition changes such that air transportation is required, then the transferring provider should be notified of that change as soon as possible.

As always I appreciate the excellent care your and your staff provide the citizens of Brady and McCulloch county. We should plan to follow those patients who are affected by this policy to ensure that they are receiving the best care possible and modify this policy if we identify areas for improvement.

Sincerely,

CB

Charles Benham, M.D.
Medical Director
Brady Fire/EMS Department

BRADY FIRE/EMS
216 W. Commerce
Brady, TX 76825
Ph. (325) 597-2311

City of Brady
PO Box 351
Brady, Texas 76825
Ph. (325) 597-2152

FACILITY REQUEST FORM

Patient: _____ Date: _____ Time: _____

I _____, voluntarily request medical transportation by

Brady Fire/EMS, for the purpose of obtaining medical care at _____ (the receiving facility). I understand that Brady Fire/EMS is operated by the City of Brady.

I further consent to the provision of all medical treatment that, in the judgment of the attending medical personnel, may become necessary or advisable during transportation. I have been informed of and understand the nature of the risks involved in the transportation and understand that risks may be involved in the provision of any medical care that might become necessary or advisable during transportation to the above noted receiving facility. I also understand that risks may be involved that may not have been discussed due to the potential urgent nature of my transportation, either with respect to my medical care and/or the transportation itself.

I agree that all rights and liabilities of each party, with respect to my transportation and medical care, are to be governed by the substantive laws of the State of Texas.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the results of said medical care.

I authorize any physician, hospital, or other health care entity to release any medical or other information necessary to process third party payment, or claims for services, rendered by Brady Fire/EMS. I understand and agree that payments for transportation, treatment, and other goods and services provided by Brady Fire/EMS, which are covered in whole or in part by third party payers, will be made directly to Brady Fire/EMs. I further transfer and assign any and all rights, title, and interest in such payments for such services to Brady Fire/EMS, or the receiving facility, as appropriate. I understand and agree that I am personally responsible for all charges incurred during this transport.

I certify that this form has been fully explained to me, that I understand its contents, and that all blanks or statements requiring completion were filled in before I signed my name. I have had the opportunity to ask questions about the transport, and this form, and have had them answered to my satisfaction.

_____ / _____ _____ / _____

Signature **Date** **Witness** **Date**

This patient is unable to give informed consent because _____ _____. Therefore, I, the surrogate decision maker, give consent and authorization, and make all representations, as stated above, on behalf of the patient.

_____ / _____ _____ / _____

Signature **Date** **Witness** **Date**

_____

Relationship to Patient

TRAUMA

The highest priority for major trauma is rapid transport, with the urgency of transport being greater the more unstable or seriously injured the patient. Other priorities are spinal immobilization, oxygenation and fluid resuscitation. Treatment should be done enroute to the hospital as much as possible.
Consider bypass protocols.
The following patients are candidates for rapid transport with minimal scene times:

BLUNT- INJURY MECHANISM:
*High speed (over *25* MPH) motor vehicle collisions.
* Significant damage to vehicle (Violation of the passenger compartment, shell of vehicle, dashboard, windshield or steering column damage likely to be caused by the patient).
* Motor vehicle vs. Pedestrian accidents.
* Ejected patients.
* Falls over 10 feet.
* Motorcycle accidents.

BLUNT-INJURY LOCATION:
*Significant involvement of the head, neck, chest, abdomen or the pelvis region.
* Femur fractures or any two proximal long bone fractures.
* Pregnancy.

PENETRATING INJURY:
* GSW or SW to the head, neck, groin, chest, abdomen or pelvis region.

PHYSICAL SIGNS:
* Trauma score of 9 or less or Glasgow Coma score of 10 or less.
* Suspected spinal cord injury (See spinal cord injury protocol pg 40).
* Amputation or de-gloving injuries.

TREATMENT:

ECA/ BASIC:
ABC's, control bleeding, splint fractures, high flow 02 w/non-rebreather or BVM at 12 lpm or higher. Spinal motion restriction, Oxygen Sat.
Vital signs every 5 minutes

INTERMEDIATE:
IV NS. If Hypotensive, run to maintain blood pressure of 70 and consider MAST(PASG)
IV's x2 if manpower and supplies allow

PARAMEDIC:
Cardiac monitor.
Rapid Sequence Intubation if necessary.

SPECIAL CONSIDERATIONS:

1) Make sure the scene is safe before you approach. Do not become a victim. Park unit in a safe position.
2) Recognize indications of a rapid extrication and transport: Difficult respirations or apneic, decreased circulation (shock) and decreased LOC.
3) Recognize need for helicopter transport (See Helicopter Transport Protocol Pg. 39).
4) If a patient needs a c-collar, they need a backboard and head blocks also.
5) Remove clothing PRN. You cannot treat what you cannot see. Use as much tact as possible and respect patient's privacy.
6) Perform a thorough secondary survey in the back of the ambulance. Complete head-to-toe assessment and document.
7) High-flow oxygen (15 1pm) non-rebreather will be given to every pregnant trauma patient showing signs of shock. MAST can be used if not contraindicated but DO NOT inflate the abdominal section. Always try to transport a pregnant trauma patient on her left side or if spinal injury is present tilt the board slightly to left.

TRAUMA TRIAGE AND BYPASS PROTOCOLS

Patient without a pulse and respirations at scene

YES NO

Transport to closest ER

Multi-systems trauma with unstable vital signs or major anatomical injury? Significant mechanism of injury?

YES NO

Transport to closest ER

Is ALS/MICU unit available?

YES NO

Transport to closest ER
Consider transport time

Call for air transport

If air transport is not available for any reason Patient will be transported to closest available emergency department unless medic deems it necessary to transport the patient to any other emergency department (i.e.: San Angelo). If patient is transported to any other emergency department, reason for BYPASS shall be listed on pt's run report.

DEFINITIONS:

1) Multi-Systems Trauma with Unstable Vital Signs:
   Hemodynamic compromise, respiratory compromise and/or altered mental status that results in a Revised Trauma score (RTS) < 12.
2) Major Anatomical Injury:
   a) Penetrating injury of the head, neck, torso or groin.
   b) Combination of bums > 20% or involving the face, airway, hands feet or genitalia.
   c) Paralysis.
   d) Flail Chest.
   e) Two or more obvious long bone fractures.
   f) Open or suspected depressed skull fracture.
   a) Unstable pelvis or suspected pelvis fracture.
   g) Amputation above wrist or ankle.
   h) Chest Pain due to trauma
   i) Suspected closed head injury

Significant Mechanism of Injury:

a) Ejection from vehicle.
b) Death of occupant in same vehicle.
c) Extrication time >20 minutes with injury.
d) Fall >20 feet.

1) Unrestrained passenger in vehicle rollover.
2) Pedestrian, motorcyclist or pedal-cyclists thrown or run over

HELICOPTER TRANSPORT:

Indications for helicopter transport will include patients who have one of the following:

1) Glasgow coma score of 10 or less.
2) Deterioration of one point or more on the GCS.
3) Unilateral or bilateral flexor or extensor response to pain.
4) Development of unequal pupils or unresponsiveness to verbal stimuli.
5) Patients who demonstrate motor or sensory loss following trauma.
6) Any Neurological Deficits due to trauma.
7) Chest pain due to trauma
8) Suspected closed head injury
9) Any GSW to the head, neck or chest
10) Any major burn needing to go to burn center.
11) Any call that in the Paramedic's judgment should go to a Higher Level of Care. Consider transport times >20 minutes

SPINAL CORD INJURY

Priorities are protection of the patient from further injury, maintenance of the damaged spinal cord and transport of significant spinal injuries to a trauma center.

TREATMENT:

ECA/ BASIC:
1) ABCs, controlling airway with appropriate measures.
2) High-flow02.
3) Spinal motion restriction.
4) Oxygen Sat.
5) Establish baseline LOC.
6) Keep warm

INTERMEDIATE:
1) IV NS maintaining a BP of 70.

PARAMEDIC:
1) Monitor.
1) Rapid Sequence Intubation if necessary.

INDICATIONS FOR TRAUMA BYPASS: (See page 38)
* Patients who demonstrate motor or sensory loss following trauma.
* GSW to the head, neck or chest.
* Neurological deficits.

Considerations:
1) Restlessness can be a sign of cerebral hypoxia.
2) Assume cervical injury in all patients with spinal trauma.
3) Observe any changes in LOC.

HEAD TRAUMA

The priorities in head injured patients are rapid triage and helicopter transport to a trauma center for patients who are highly likely to require neuro-surgical care, maintenance of airway and circulatory status, protection of the spine, institution of measures to reduce intracranial pressure and documentation of the initial exam.

TREATMENT:

If Glasgow Coma Scale is less than 8 or those indicated for triage bypass: (See page 39).

ECA/BASIC:

1) ABC's.
2) Spinal motion restriction.
3) High-flow 02, NRB or BVM as needed.
4) Raise head of board 20 to 30 degrees.
5) Document baseline LOC.
6) Oxygen Sat

INTERMEDIATE:

1) Assure airway patency, then hyperventilate with oxygen and assisted ventilation. Provide a minute volume of 16 to 18 liters (For pedi ventilate at a rate 25% greater than normal for age). Suction should be readily available. Avoid O2 sat below 90%.
2) Initiate IV Normal Saline, KVO unless hypotensive. Do not over infuse fluid to an injured brain.

PARAMEDIC:

1) Intubation with pre-treatment of Lidocaine 1 mg/kg 1 or 2 minutes prior to attempt whenever possible. After intubation, make sure the backboard is elevated 20 to 30 degrees. Use Rapid Sequence Intubation if necessary.
2) Always assume cervical spine injury with head injury and immobilize appropriately.
3) Observe any changes in LOC.

CONTRAINDICATIONS:

Fentanyl is contraindicated for head injury.

CHEST TRAUMA

The major idea in treatment when dealing with chest trauma is getting the hole sealed off, administering high flow oxygen and rapid transport. Some chest trauma will meet the criteria for helicopter transport also. See page 39.

ECA/BASIC:

1) ABC's.
2) Vital signs and Oxygen Sat.
3) High-flow 02 (12 lpm or greater).
4) Occlude any hole with an occlusive dressing (petro gauze) and monitor for signs of tension pneumothorax.
5) Stabilize any flail sections and apply direct pressure gently to all bleeders.
6) May have to help patient breathe with a BVM with supp. 02.
7) Total spinal motion restriction.

INTERMEDIATE:

1) IV NS, titrate to BP.
2) Advanced airway as needed.
3) IV's x2 if time and/or supplies permit

PARAMEDIC:

1) Monitor. Obtain 12 lead EKG
2) Prepare for needle decompression if tension develops.
3) If patient arrests, deal more with pump and volume problems then ACLS.
   * * Major chest trauma could be an indication for trauma bypass protocols, but some chest trauma can be taken care of at HOT ER. * *

Brady Fire/EMS/Emergency Management

Complaint Awareness Policy

Any complaint against the Brady Fire/EMS/Emergency Management Departments, or individuals employed by these departments from outside the departments shall be documented and filed on the Complaint Awareness Form. If the complaint is by phone the complainant should be advised to come in to the office and fill out then submit the complaint awareness form.

All complaint awareness forms shall be submitted to the Fire Chief for review and investigation of the complaint. A copy shall be submitted to the City Manager should the complaint originate from outside the departments listed. All internal personnel complaints shall be handle according to the personnel policy in the City Personnel Handbook.

All complaints shall be kept on file by the Fire Chief according to City Policy.

Complaints not willing to be put in writing and documented shall be considered as not withholding merit. However they may be reviewed by the Fire Chief.

After review and investigation of written complaints the results shall be submitted to the City Manager by the Fire Chief in writing.

Brady Fire/EMS Department

216 W. Commerce
Brady, TX 76825
325-597-2311
www.bradyfdems.com

COMPLAINT & AWARENESS FORM

Date: _____ Time: _____

Person Filing Complaint: Person/Persons Complaint Against:

_____ _____

Ph. Number: _____

Address: _____

□ Awareness □ Informal Complaint □ Formal Complaint

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Received By: _____ Date: _____

Signature of person filing complaint: Date: