

# **Patient Resolution Guide (PRG)**

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## I. INTRODUCTION

The information contained in this Training Bulletin is designed to provide a comprehensive description of each element listed in the current Patient Resolution Guide (PRG) and its underlying principles to assist all members in providing the highest possible level of service and quality patient care.

The PRG is used as a quick reference by Basic Life Support (BLS) and Advanced Life Support (ALS) units in determining appropriate Emergency Medical Service (EMS) patient care and disposition.

The PRG format is divided into two sections: *Section I*, referred to as “**ALS Unit Required/Base Contact**,” lists those medical and trauma conditions that require ALS response, and either base station contact or use of SFTP’s where appropriate. *Section II*, referred to as “**BLS or ALS Transport Required**,” lists those medical and trauma conditions that require either BLS or ALS transport.

Included are six (6) *Principles* to assist members in making prudent patient care decisions, based upon all factors pertaining to the incident. Members are reminded that when doubt exists regarding a patient’s care and/or disposition, always act in the best interest of the patient.

The paramedic is the highest medical authority on scene and is responsible for both the welfare of the patient and the quality of care given by all team members. The Incident Commander is responsible for the incident as a whole and for scene management. This includes: scene safety, resource allocation, and communications.

To effectively manage EMS incidents and assure for quality patient care and personnel safety, field personnel are expected to have a clear understanding of the policies and procedures contained in LAFD Book 35, *EMS Field Manual*.

The following information was compiled from the Department of Health Services (DHS), *Pre-hospital Care Policy Manual* (LAFD Book 33); *EMS Updates*; *Brady’s, Pre-hospital Emergency Care*; Department of Transportation (DOT) *North American Emergency Response Guidebook*; *Jane’s Chem-Bio Handbook*; and The American Heart Association.

Note: “>” means greater than and “<” means less than.

*Training Bulletin No.18* is subject to revisions as policy and/or procedures change.

## II. SECTION I - ALS UNIT REQUIRED/BASE CONTACT

### ◆ ALTE (Apparent Life Threatening Event):

DHS REF. NO.: 510

#### COMMENTS:

- An Apparent Life Threatening Event (ALTE) in a pediatric patient (12 months and under) is described as an episode that is frightening to the observer and characterized by a combination of these symptoms: transient apnea, color change (usually cyanosis or pallor, but occasionally erythema), marked change in muscle tone (usually limpness), and choking or gagging.
- For ALTE patients, base hospital contact and transport to a PCCC is required. This condition was previously called "Near-missed SIDS."

**NOTE:** These are considered critical patients with the potential for rapid decompensation. Obtain a careful history of current complaint from the person who witnessed the events. ALTE may occur during sleep, wakefulness, or feeding and may be a symptom of many specific disorders including, but not limited to: infection, seizures, metabolic disorders, and gastrointestinal problems. These patients usually appear entirely normal by the time they reach the emergency department.

### ◆ ALOC (Altered Level of Consciousness):

DHS REF. NOS.: 808, 809, AND 510

#### COMMENTS:

- *Altered level of consciousness* is defined as: < A & O x 3 and a GCS < 15.
- All patients shall have an assessment of level of consciousness and shall include:
  1. Orientation Assessment
  2. Glasgow Coma Scale
- Patient assessment of orientation shall be performed by having the patient provide information such as:
  1. Name
  2. Day of week/year/time of the day
  3. Where he/she lives and where they are

\* **Patients that are amnesic to the event are no longer considered altered.**

*Patients unable to reasonably answer one or more of the above questions shall be considered to have ALOC.*

- ALOC presents in a variety of forms including confusion, lethargy, disorientation, impaired cognition, or coma. Inappropriate aggressiveness or hostility should alert pre-hospital care personnel to the possibility that the patient may have a serious underlying condition.
- Patients who are normally altered (e.g., those with Alzheimer's Disease, Organic Brain Syndrome, history of stroke, or being mentally challenged, etc.), do not necessarily require an ALS unit provided they have no other priority symptoms and their mental status at the time of your exam is normal for them.
- Basic assessment followed by focused assessment:
  - ✓ ABC's, LOC, GCS
  - ✓ Neurological status, pupils, presence of nystagmus
  - ✓ Complete head to toe exam for signs of trauma or self-inflicted injury
  - ✓ Respiratory status (effort, symmetry, stridor, wheezing, tidal volume, rate, pattern)
  - ✓ Skin signs (color, temperature, moisture, rash)

**NOTE:** Documentation is necessary in the F-902M *Comments* section, if the GCS score is <15, and normal for the patient. No GCS is required for infants < 12 months of age.

- *Persistent altered mental status* has been added to the PCCC transport guidelines. Persistent altered mental status is an altered mental status (GCS  $\leq$  14) that is not improving on EMT-1 or paramedic arrival. Unresponsive patients have a high incidence of airway compromise.

#### **AMA (Against Medical Advice):**

**DHS REF. NOS.: 808 AND 834**

#### **COMMENTS:**

- EMT-1s are not permitted to handle patient refusals whose conditions meet any of the criteria listed in the LAFD PRG or DHS Ref. 808.

***AN ALS RESOURCE SHALL BE REQUESTED TO DOCUMENT A PATIENT'S REFUSAL AGAINST MEDICAL ADVICE (AMA). A PARAMEDIC WORKING ON A BLS RESOURCE MAY NOT HANDLE AMA'S IN LIEU OF AN ALS RESOURCE.***

**NOTE:** It is always within the rights of a competent patient to refuse care, even if such refusal might jeopardize his/her health. Complete and accurate documentation is a key factor in decreasing liability when a patient refuses treatment or transportation.

### **COMPETENT PATIENT (AMA)**

A patient is considered to be competent if he/she is alert and oriented and has the capacity to understand the circumstances surrounding his/her illness, injury, or impairment and the risks associated with refusing treatment and/or transport to an emergency department. When a competent patient has been informed of the need for care and possible risks and/or consequences of refusal, and still declines medical treatment/transport, ALS personnel shall provide the following:

#### **AMA REFUSAL**

- Determine whether the patient (or legal representative) is competent to refuse care and sign AMA. Advise the patient of the risks associated with refusal. Establish base hospital contact (base contact shall be made while the ALS unit is with the patient). Advise the base hospital of all circumstances of the incident, including indicated care or need for transport, reasons for the refusal, and the patient's plan for follow-up care.
- After complete documentation (which includes patient assessments; initial, focused, pertinent negatives, complete detailed physical assessment including history, and competency assessment), have patient or legal guardian sign the *Patient Release* (back of the F-902M white copy). When possible, the signature shall be witnessed, preferably by a family member. Advise patient to seek alternative medical care immediately or reactivate 9-1-1 as needed. Be specific about their condition and associated symptoms.

#### **If the patient refuses to sign, document this in the F-902M Comments section.**

- If the basis for the patient's refusal is due to his/her choice of hospital and the base hospital concurs that transportation to the desired hospital should be provided and the patient is stable enough to be transported the additional distance; then efforts to accommodate the patient request should be made.
- If the desired hospital transport time exceeds 30 minutes, the transporting unit shall request an EMS Battalion Captain to be attached to the incident. The EMS Battalion Captain, in concert with the OCD Floor Captain, shall make the final determination regarding patient transport and destination.  
(*Patient accommodations should be made consistent with the Department's current Patient Destination Guidelines Book 35 and Customer Service Guidelines.*)
- If paramedics are uncomfortable with any aspect of an AMA or requested destination, an EMS Battalion Captain shall be requested to respond to the incident.

### **COMPETENT PATIENT (RELEASE AT SCENE)**

A release at scene may be made for patients who do not meet the criteria listed on the LAFD PRG or DHS Ref. 808, and do not have a medical problem that requires immediate treatment and/or transportation.

### **RELEASE AT SCENE**

- **All patients (excluding those with minor trauma), shall be offered transport to a hospital via Department ambulance.**
- If the patient does not meet the provisions of the PRG and declines transportation, this offer of transportation shall be documented in the *Comments* section of the F-902M by noting "Patient declined offer of transportation to hospital" along with any pertinent negatives in terms of the patient's signs and symptoms. If the patient declines transportation via LAFD ambulance, alternative transportation options should be explored (e.g., private vehicle or private ambulance) and alternatives to hospital transport should be considered (private physician's office, local health clinic, etc.). The patient should sign the Patient Release form on the back of the white copy of the F-902M that they are declining treatment or transportation, have been advised of potential consequences of this section, and have been provided with aftercare instructions.
- All patients left at scene ("Release at Scene" and "AMA") are given the F-902M pink copy (*Patient After Care Instructions*) and are requested to sign in the space provided on the front of the F-902M, indicating that they have received these instructions.
- In cases where the patient refuses to sign the *Patient Release*, a notation shall be made to that effect on the patient signature line.
- If the patient does not meet Sections I or II of the PRG, an ALS resource does not need to be present to document that transportation was declined. However, good judgement shall be used to determine whether paramedic assessment and base station contact may be helpful.
- It is vital to recognize the limitations of pre-hospital evaluation. Appropriate effort should be made to encourage patients to be transported, especially when there are risk factors for serious disease.

### **INCOMPETENT PATIENT**

In relation to AMA's and treatment/transport refusals, the incompetent patient is defined as the patient who is not alert and/or oriented, OR a patient who is unable to comprehend the risks and/or consequences associated with any delay or refusal of treatment. Competency may be impaired by mental illness, intoxication, physical and/or mental impairment.

- If the incompetent patient requires transport and the patient is resistant/combatative,

EMS personnel should consider assistance from law enforcement for a possible 72-hour treatment and evaluation hold, (5150 California Welfare and Institutions Code).

- When the incompetent patient is refusing treatment/transport, the patient may be transported to an appropriate facility under implied consent (in this instance, a 5150 hold is not necessary).
- Patients should not be regarded as competent if they have attempted suicide, verbalized suicidal intent, or when other factors lead EMS personnel to suspect suicidal intent (danger to self or others).
- At no time are field personnel to place themselves in danger by attempting to transport or treat a patient who refuses. At all times, utilize good judgment coupled with the appropriate assistance.

◆ **BURNS:** Facial, neck, or electrical

Extensive Burns:   √ > 20% Body surface area (BSA) in an Adult  
                                   √ > 15% BSA in a Child  
                                   √ > 10% BSA in an Infant

Critical Burns:     Facial/Respiratory tract  
                                   Hands and/or Feet  
                                   Joint surfaces  
                                   Perineum  
                                   Electrical  
                                   Burns associated with fractures or other injuries

**DHS REF. NOS.: 808, 510**

**COMMENTS:**

- When determining the severity of burns, consider these factors: degree, percentage, site, age, medical history, and associated injuries.
- Burn patients who are under 5 and over 55 years of age, or who have a history of chronic illness, shall be considered to have a significant burn injury.
- Electrical burns are frequently associated with significantly greater internal injuries. The most frequent arrhythmias seen are ventricular.
- Avoid prolonged cooling measures that may produce hypothermia.
- Initial assessment, focused assessment for singed nasal hair, hoarseness, or sooty sputum.

To estimate the burned body surface area (BSA) use

**The Rule of Nines**

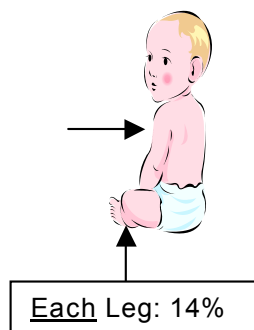
ADULT

Head & Neck:	9%
<u>Each</u> Upper Extremity:	9%
Posterior Trunk:	18%
Anterior Trunk:	18%

Head: 18%

Each Arm: 9%

Posterior Trunk: 18%  
 Anterior Trunk: 18%



◆ **CARDIOPULMONARY ARREST (excluding DHS Ref. Nos. 814, 815 and 818):**

**DHS REF. NOS.: 808, 510, 814, 815**

**COMMENTS:**

- Ref. Nos. 814 (determination/pronouncement of death), 815 (honoring valid DNR orders) and 818 (honoring advanced health care directives) patients do not require ALS. **In the absence of the DNR and/or physician's written instructions, or when in doubt, you are obligated to begin full resuscitation immediately.**
- All cardiac arrests require base hospital contact (include the following in the report: estimated patient down time, witnessed or unwitnessed arrest, bystander CPR, pulses present with CPR, and time pulses are restored). Follow the Department's cardiac arrest routing procedures.

◆ **CHEST PAIN OR DISCOMFORT:**

**DHS REF. NO.: 808**

**COMMENTS:**

- All patients complaining of chest pain or discomfort require an ALS assessment.
- When using the Standing Field Treatment Protocol (SFTP) M4 (chest pain), base hospital contact is required for dysrhythmias, poor perfusion, and suspected cardiac chest pain in patients < 30 years of age.
- Include OPQRST, patient history, allergies, medications, pertinent negatives, the patient's response to treatment, and reassessment after medication including vital signs.
- Patients who require a cardiac monitor require continuous cardiac monitoring (with documentation identifying rhythm) until transfer of care in the emergency department. This same principal applies to patients who require supplemental

oxygen.

Geriatric patients and diabetics may experience what is known as a silent “MI (heart attack)” due to depressed pain perception. One-third of elderly MI patients never experience pain, but aching shoulders and indigestion are common complaints. The elderly may present with very general complaints such as weakness and fatigue. Difficulty breathing is also a common initial complaint. *For these reasons, it is recommended to always place geriatric patients on a cardiac monitor.*

◆ **DIFFUSE ABDOMINAL TENDERNESS (resulting from trauma):**

**DHS REF. NOS.: 808, 506, 510**

**COMMENTS:**

- “Diffuse abdominal tenderness” is defined as pain/tenderness in two or more quadrants and requires immediate transport to a designated trauma hospital, if transport time does not exceed 30 minutes. To assess for rigidity and guarding, palpate each of the 4 quadrants one time only (using the first three finger pads). Further palpation does not add to examination findings and results in needless pain for the patient.
- Transport pediatric trauma patients to the most accessible pediatric trauma center (PTC). If transport to a PTC is greater than 30 minutes, transport to the most accessible trauma center. If a trauma center is can not be accessed with in 30 minutes, then transport to the most accessible EDAP.

**NOTE:** This extended transport time is for trauma patients only. Pediatric patients not meeting trauma criteria/guidelines shall be transported to a PCCC.

◆ **EXPOSURE (to hazardous material) - symptomatic:**

**DHS REF. NOS.: 807, 808**

**COMMENTS:**

- As first responders, be aware of the potential for your own safety and use your personal protective equipment. Recognition is the key, we will not always have the ability to identify the hazard. Exercise extreme caution on scene approach, wearing your personal protective equipment (PPE) where there are indicators of a hazardous or unstable environment.
- Utilize the DOT, *North American Emergency Response Guidebook*, as a primary guide to quickly identify the hazard and the precautions to use during the initial response phase. Assess hazards, number of patients, and determine additional resources (remember “secondary devices”).
- Ensure measures for proper decontamination prior to transport and provide appropriate pre-hospital care consistent with certification. Consider Haz-Mat

exposure (duration of exposure, type of material, inhaled/ingestion/skin absorption).

- Initiate interventions as necessary and remember “no one who is able to walk and talk is in immediate danger of loss of life,” START (Simple Triage and Rapid Treatment).
- Base hospital contact is required on all patients exposed to hazardous materials with a medical complaint. Symptoms may include headache, vertigo (dizziness), nausea, vomiting, coughing, hoarseness, burning sensations, redness, etc.

◆ **EXTREMITY INJURY (with neurological and/or vascular compromise):**

**DHS REF. NO.: 808**

**COMMENTS:**

- Injuries may include lacerations, fractures, or gunshot wounds that present with compromised sensory (feeling), motor (movement), and/or circulation (cool/cold, pale skin or delayed capillary refill/absent or intermittent distal pulse) in affected extremity.
- Extremity injuries with neuro-vascular compromise now meet trauma center criteria. Therefore, these patients should be transported to the nearest trauma center if it is accessible within 30 minutes transport time.

**NOTE:** Use proper body substance isolation (BSI) techniques. Assess the pulse, motor function, and sensation distal (PMS) to the injury before and after all interventions, e.g., applying splints (reassessments performed every 5 minutes). STAT immobilization and patient transport is indicated for patients presenting with pulselessness and cyanosis distal to an injured extremity and life threatening injuries (e.g., severe blood loss, shock, internal injuries).

◆ **FALL: >15 Feet**

**DHS REF. NOS.: 808, 506, 510**

**COMMENTS:**

- Patients surviving falls from heights > 15 feet meet trauma center criteria.
- Trauma patients with chest injuries, difficulty breathing, and/or signs of shock should be assessed for bilateral breath sounds after the initial assessment has been completed to determine possible tension pneumothorax.
- Breath sounds are assessed at the 5<sup>th</sup> and 6<sup>th</sup> intercostal space, mid-axillary line for presence, and equality.

- Repeat initial and focused examination every **5 minutes for priority patients** and every **15 minutes for stable patients**.

◆ **FLAIL CHEST (blunt injury to chest with unstable chest wall):**

**DHS REF. NOS.: 808, 506, 510**

**COMMENTS:**

- “Flail Chest” is defined as two or more adjacent ribs broken in two or more places, creating a segment that is unattached. This flail segment will move in the direction opposite to the rest of the rib cage. This contrary movement is called “paradoxical.”
- High flow O<sub>2</sub> assessment for other major injuries and rapid transport to the trauma center are recommended field treatments. Because lung contusion and collapse are associated with a flail segment, assist ventilations with BVM as needed.

**NOTE:** This is a life threatening chest injury that is associated with severe pulmonary contusions, interferes with proper chest expansion causing intrathoracic pressure changes, and severe respiratory distress or inadequate respiration and rapid patient deterioration. A blow to the chest can be forceful enough to cause a spinal injury.

◆ **FRACTURE (pelvis or femur) - suspected:**

**DHS REF. NO.: 808**

**COMMENTS:**

- Assess PMS (distal pulses, motor, and sensory function) before and after all interventions, i.e., mechanical traction (for femur fracture).

**NOTE:** Femur fractures may lead to serious internal bleeding.

- Pelvic injury should be assessed during the rapid trauma assessment because of the potential seriousness of associated bleeding. If the patient does not complain of pain or is unresponsive, gently compress the pelvis to determine instability. Pelvic injuries are considered to be critical. Rapid assessment and transport are indicated for a painful/unstable pelvis. Lateral motor vehicle collision impacts and auto versus pedestrians are noted for creating pelvis and upper femur fractures.

Immobilize/stabilize the pelvis (pneumatic anti-shock garment), place the patient on a backboard, and consider prompt transport when critical findings (tender, deformed, or unstable pelvis) are suspected.

◆ **HYPERTENSION (symptomatic):**

**(REMOVED 2003)**

**DHS REF. NO.: Medical Control Guidelines**

**COMMENTS:**

- Hypertension is a common disorder characterized by a persistent elevation of the systolic blood pressure above 140 mmHg and a diastolic blood pressure above 90 mmHg. No emergency treatment is indicated for patients with isolated high blood pressure readings in the field, in the absence of other priority symptoms (*Brady Paramedic Care, Third Edition, 1997*; basic field care treatment, includes: Basic airway, oxygen, Fowler's position, and cardiac monitor).
- Remember, in a pregnant patient, an elevated systolic blood pressure of >140 and/or a diastolic blood pressure of > 90 is very serious.
- "Symptomatic" is defined as any symptom that may be secondary to hypertension. Symptoms related to hypertension may include headache, vertigo, epistaxis (bloody nose), nausea, vomiting, visual disturbances (blurred vision), tinnitus (ringing or tinkling sound in the ear), and altered mental status. Symptoms, which may be related to hypertension that are treatable in the field, include chest pain or discomfort, dyspnea (shortness of breath), tachypnea, and/or altered level of consciousness. Symptomatic blood pressure parameters are: systolic blood pressure greater than 140 mmHg and/or diastolic pressure greater than 90 mmHg.
- Although deleted from the PRG, consideration must be given for other medical conditions that may have caused the patient to call 911 such as acute neurological symptoms (i.e., blurred vision, weak and dizzy, numbness, etc.).
- These symptoms now fall under **SYNCOPE**, Section I of the PRG that will require ALS transportation.

◆ **INGESTION (of toxic or poisonous substance) - suspected:**

**DHS REF. NO.: 808**

- A "Potentially Poisonous Substance" includes any "potentially harmful" substance, both natural and synthetic, which may accidentally or deliberately be introduced into the human body. Typically, these incidents involve the misuse/abuse or overdose of a drug/medication or toxic substance ingestion. For example:
  - ✓ Illicit (illegal) drug
  - ✓ Prescribed medication
  - ✓ Over-the-counter (OTC) medication
  - ✓ Petroleum product
  - ✓ Household cleaning product
  - ✓ Poison
  - ✓ ETOH

- It may also include the inappropriate combination of prescribed/OTC medication and/or the mixing of alcohol and medication. Depending on the chemical involved, immediate or delayed effects may occur, resulting in a wide variation of signs/symptoms. Always assume that an overdose patient will present with delayed symptoms.

◆ **MULTIPLE PATIENTS (five or more requiring transport):**

**DHS REF. NO.: 808, 519**

**COMMENTS:**

In general, contact the medical alert center for 10 or more patients and the Base Hospital for less than 10 patients. A BLS unit may provide transport. Contact the nearest Trauma Center Base Station if the patient's complaints are the result of trauma.

◆ **PENETRATING INJURY (to the skull, neck, or trunk):**

**DHS REF. NOS.: 808, 506, 510**

**COMMENTS:**

Penetrating injuries are caused by objects that can penetrate the surface of the body, such as bullets, darts, and other impaled objects.

- ◆ **PREGNANCY:**    ✓ Abdominal Pain with (suspected) pregnancy  
                             ✓ Childbirth or Signs of Labor

**DHS REF. NO.: 808**

**COMMENTS:**

- Pregnancy is a normal process that is usually event-free. However, a pregnant patient may be experiencing a pre-delivery emergency if she presents with one or more of the following: abdominal pain, nausea, vomiting, vaginal bleeding, passage of tissue, weakness, dizziness, altered mental status, hypertension, seizures, excessive swelling of the face and/or extremities, abdominal trauma, or shock (hypoperfusion).

- Perform initial and focused assessment.

**Vital signs:** Systolic blood pressure may be 10-15 mmHg lower than normal in the second trimester, and HR may be 15-20 points higher than in the third trimester. For BP > 140/90: Assess for edema, seizure activity, visual disturbances, rales (pre-eclampsia, eclampsia).

- General guidelines for care include: Performing ongoing assessments enroute to the appropriate receiving facility; ensuring adequate airway, breathing, and circulation (administer oxygen at 15/L via mask); transporting patient in left lateral

position (if on a backboard tilt the board to the left); treating for shock, if indicated; and providing emergency medical care as you would for the non-pregnant patient based on any other signs and/or symptoms.

- Indications that delivery is imminent include contractions that are less than 2 minutes apart, they are intense and last from 30 to 90 seconds, the patient feels the infant's head moving down the birth canal (sensation of bowel movement), crowning (the patient has a strong urge to push), and the patient's abdomen is rigid.
- Take all appropriate body substance isolation (BSI) and precautions, including gloves and eye protection. As the infant's head is delivered, assess the position of the umbilical cord, remove fluids from infant's airway (suction mouth and nostrils), and maintain body warmth.
- The APGAR scoring system is used to perform a thorough assessment of the infant at 1 and 5 minutes post delivery. This includes appearance, pulse, grimace, activity, and respiration.
- Transport to the most accessible perinatal center, patients who appear to be in active labor (whether or not delivery appears imminent), patients whose chief complaint appears to be related to the pregnancy (e.g., abdominal pain, discharge, non-traumatic shoulder pain), patients who appear to be having perinatal complications, and injured patients who do not meet trauma criteria or guidelines.
- Transport to the most accessible receiving facility, patients in acute respiratory distress; patients in full arrest, and patients whose chief complaint is clearly not related to the pregnancy.
- Base hospital may direct patients who are < or equal to 34 weeks gestation (with a chief complaint directly related to labor or delivery) to a perinatal receiving facility with a NICU.
- Patient destination request may be honored if the condition of the patient permits and transport to the requested OB facility would not exceed 20 minutes.
- Perinatal patients meeting trauma criteria and/or guidelines shall be transported to a trauma center.

◆ **SEIZURE**, in cases of:

- ✓ Pregnancy
- ✓ Post-Trauma
- ✓ Continuous Seizure
- ✓ Multiple Seizures

**DHS REF. NOS.: 808, 506, 510, 809**

**COMMENTS:**

- “Continuous” or “Multiple” seizures are defined as:
  - 1 seizure lasting 10 minutes or more
  - 2 seizures without regaining consciousness in between
  - 3 or more seizures within one hour
- Exercise good clinical judgment when determining whether or not an ALS unit may be required to ensure appropriate patient care and destination involving the “first-time” seizure patient.
- Seizure patients (with a history of seizures) who are A & O x 3, with a GCS of 15, may be transported by a BLS unit providing he/she has no other priority symptoms.

◆ **SHORTNESS OF BREATH (and/or tachypnea):**

DHS REF. NOS.: 808, 510

**COMMENTS:**

- In adults, tachypnea is defined as a respiratory rate of greater than 24.
- A BLS unit may transport a tachypneic patient whose respiratory rate returns to normal (less than 24) providing the patient has no complaint of shortness of breath and has no sign(s) of respiratory distress (e.g., diminished tidal volume, abnormal breath sounds, use of accessory muscles, or tracheal in-drawing, etc.). Such patients are typically those who, based on the circumstances and history, may be considered classic “emotional upset” or “panic attack” patients. Generally, these tachypneic patients are those who respond well to calming measures.

◆ **SHOCK (signs or symptoms):**

DHS REF. NOS.: 808, 506, 510

**COMMENTS:**

- Signs or symptoms of shock include two or more of the following:
  - Cool, pale, moist skin
  - Rapid, weak, thready pulses
  - Delayed capillary refill
  - Systolic BP of < 90 Adult; < 70 Child
- Consider orthostatic vital signs for non-traumatic patients.

◆ **SPINAL COLUMN INJURY (associated with sensory deficit or weakness of one or more extremities):**

**DHS REF. NOS.: 808, 809**

**COMMENTS:**

- Remove full-face helmets to allow access to the patient's airway and provide in-line immobilization stabilization of the head and neck. Custom-fitted helmets (football/hockey) should not be removed unless respiratory distress is coupled with inability to access the airway. Remove face guard.
- An athlete wearing a helmet and shoulder pads will maintain his neck in a neutral position when placed on a backboard.

◆ **STROKE (suspected) new onset of:**

- ✓ Arm Strength (Asymmetrical)
- ✓ Grip (Weak/none)
- ✓ Facial Smile/Grimace (droop)

**DHS REF. NOS.: 808**

**COMMENTS:**

- Early recognition of a stroke ("brain attack") can expedite intervention and improve timely access to hospital-based stroke therapies.
- Utilize the Los Angeles pre-hospital Stroke Screen (LAPSS) form as a convenient reference for assessment. Look for obvious asymmetry, unilateral or bilateral weakness in the face, grip, or arm. **Grimace:** facial smile droop; **Grip:** weak or none; **Gravity:** arm strength-drifts down or falls rapidly; **Hemiparesis:** paralysis of one side of the body; patient will be unable to move the arm and/or leg or facial muscles on one side of the body.
- Be sure to perform and document a blood glucose on all patients with an acute neurologic deficit.
- It is vital to ascertain and document the time of onset of symptoms for all patients with suspected stroke.

◆ **SYNCOPE (prior to EMS arrival - not resulting from trauma: (REVISED 2003)**

- Consideration is given for other medical conditions that may have caused the syncope (e.g., cardiac dysrhythmia).
- Other acute neurological symptoms (i.e., blurred vision, weak and dizzy, numbness, etc.), prior to or upon EMS arrival will require ALS transportation.

◆ **TRAUMATIC CRUSH SYNDROME:**

**DHS REF. NOS.: 506**

**COMMENTS:**

- Whenever possible, start intravenous fluid administration prior to release of compression.
- Limb amputation by MD may be necessary.
- Entrapment lasting > than 4 hours or suspicion of hyperkalemia.

◆ **VEHICLE:**

- ✓ Passenger space intrusion
- ✓ Patient ejected from vehicle
- ✓ Patient requiring extrication
- ✓ Pedestrian struck by automobile
- ✓ Survivor of a vehicular accident where a fatality occurred
- ✓ Very young and very old patients and those with precarious medical histories

**DHS REF. NOS.: 808, 506, 510**

**COMMENTS:**

- Following trauma criteria and guidelines, good clinical judgment is necessary when determining whether or not an ALS unit may be required to ensure appropriate patient care and destination involving trauma patients.
- Remember “mechanism of injury,” as it is the most effective method of recognizing potential critically injured patients before unstable vital signs develop. Also, keep in mind that the overall purpose of the trauma triage policy is “to establish criteria and standards that ensure patients requiring the care of a trauma hospital are appropriately triaged and transported.” This intent would, for example, include incidents involving a bicyclist or motorcyclist struck by an automobile.

**NOTE:** A survivor of a vehicular accident in which a fatality occurred might be so emotionally distraught that they may deny specific pain or injury. Hence, their injuries might be “masked.” These patients require an ALS assessment and may need further evaluation at a trauma center.

**III. SECTION II – BLS OR ALS TRANSPORT REQUIRED**

◆ **ABDOMINAL PAIN:**

**DHS REF. NO.: 808**

**COMMENTS:**

- In the absence of other priority symptoms (e.g., signs or symptoms of shock), a BLS unit may transport an abdominal pain patient.

**NOTE:** (Special consideration) cardiac pain may present as abdominal pain.

◆ **ALLERGIC REACTION (suspected):**

**DHS REF. NOS.: 808, 510**

**COMMENTS:**

- “Suspected” allergic reaction would include such signs or symptoms as urticaria (itching), hives, and/or rash.

**NOTE:** ALS care is required if symptoms include respiratory or circulatory involvement, e.g., shortness of breath, wheezing, or signs/symptoms of shock.

- ◆ **BLEEDING:**
- ✓ Abnormal vaginal bleeding
  - ✓ Gastrointestinal bleeding

**DHS REF. NOS.: 808, 510**

**COMMENTS:**

- Generally, a patient in the absence of other priority symptoms, e.g., signs or symptoms of shock, a gastrointestinal bleeding may be transported by a BLS unit. Patients with hematemesis (blood in vomit), or melena (blood in stool), should be considered for ALS transportation due to possible rapid decompensation.

◆ **CHILD ABUSE (suspected):**

**DHS REF. NOS.: 808, 510, 510.1, 822, 824, 826, 832**

**COMMENTS:**

- State law mandates medical professionals (this includes ALS and BLS) to report all cases of suspected abuse.
- Generally, critical child abuse patients will fall within *Section I* of this policy by presenting with some other signs and symptoms.

◆ **PATIENT WHO IS A DANGER (to self, others, or is gravely disabled):**

**DHS REF. NOS.: 808, 809, 826, 829, 829.1, 829.2, 829.3, 832, 834, 838**

**COMMENTS:**

Generally, a patient who is a danger to self/others or is gravely disabled may be transported by a BLS unit provided the patient has **no other** priority symptoms (e.g., altered level of consciousness, ingestion, or signs/symptoms of shock, etc.). A

gravely disabled person is someone who is in danger of physical harm due to the person's inability to provide for his/her basic needs of food, clothing, shelter, medical care, or safety.

(Moved to Section II)

◆ **LOSS OF CONSCIOUSNESS (LOC): Prior to EMS arrival (resulting from trauma)**

**DHS REF. NOS.: 808, 506**

**COMMENTS:**

- ALOC (amnesic to event was removed under orientation questions). The criteria for level of conscious will include *person, place, and time, not event*.
- A trauma patient with a loss of consciousness and is amnesic to event, but otherwise alert and oriented x 3 and does not meet Trauma Center Criteria or any other criteria in Section I of the PRG, will now be given a GCS score of "15." This patient can be transported by BLS or ALS ambulance of the most accessible receiving facility or EDAP as appropriate.

◆ **CHILD:**

- Age 0-12 months, transport regardless of chief complaint and/or mechanism of injury
- ALS **Base Contact** required for **ALTE**
- Age 13-36 months, requires Base Contact or Transport (except in isolated minor extremity injury)

**DHS REF. NOS.: 808, 808.1, 510, 510.1, 822, 824, 826, 832**

**COMMENTS:**

- Infants: Age 0-12 months shall be transported regardless of chief complaint and/or mechanism of injury (except for isolated minor extremity injuries). If this pediatric patient presents with a **combination** of medical complaints which include transient apnea, color change, marked muscle tone changes, choking, or gagging. They may have a more serious underlying condition (**ALTE**) and therefore require base hospital contact and transport to a PCCC.
- Children ages 1-3 require base hospital contact and/or transport.
- For **AMA** cases involving a child less than 3 years of age, **base contact is required prior to leaving the scene**.

**NOTE:** BLS unit/company members are reminded to refer to PRG, *Principle Nos. 2, 5, and 6* for guidance.

◆ **EXPOSURE (to hazardous material known to have delayed symptoms asymptomatic):**

**DHS REF. NOS.: 808, 807**

**COMMENTS:**

- Many hazardous materials are known to have delayed reactions and may initially present as asymptomatic. For patients involved in direct exposure and/or for those where there is a significant likelihood of medical complications, provide the appropriate decontamination and transportation for further evaluation.

**◆ FRACTURE (isolated fracture of spine, skull, or hip) – suspected:**

**DHS REF. NOS.: 808, 506, 510**

**COMMENTS:**

- In the absence of neurological examination findings (e.g., abnormal sensation, weakness, numbness, paresthesia (tingling), or radicular “electric” or “shooting” pain in one or more of the extremities), most patients with spine pain or tenderness may be transported by a BLS unit.
- Patients who present any of the aforementioned clinical findings, an altered mental status, or signs/symptoms of shock, require ALS care and transport to a specialty care facility.

**◆ NEAR DROWNING:**

**DHS REF. NOS.: 808, 510**

**COMMENTS:**

Generally, a near-drowning patient may be transported by a BLS unit providing they have **no other** priority symptoms (e.g., altered level of consciousness, cardiopulmonary arrest, shortness of breath or tachypnea, or signs/symptoms of shock).

**IV. PATIENT RESOLUTION GUIDE PRINCIPLES**

**1. BLS (EMTs) ARE NOT PERMITTED TO HANDLE PATIENT REFUSALS FOR PATIENTS WHOSE CONDITIONS MEET ANY OF THE CRITERIA LISTED IN THE LAFD PATIENT RESOLUTION GUIDE (PRG).**

- If treatment and/or transport is recommended or required (whether based on policy or judgment), every effort must be made to ensure that the patient is making an informed decision to refuse. To assure optimal patient care, a paramedic assessment is necessary to verify a patient’s mental competency and to make base hospital contact. **NOTE:** For AMA, base hospital contact is required while with the patient.

**2. IN SITUATIONS NOT DESCRIBED IN THIS PRG, BLS RESOURCES SHALL EXERCISE THEIR CLINICAL JUDGMENT AS TO WHETHER ALS INTERVENTION AND/OR ANY TRANSPORT IS NECESSARY.**

- Decisions regarding patient care and destination are made based on knowledge, judgment, common sense, and careful attention of the patient care provider(s). The PRG is not designed nor able to cover every conceivable patient condition or circumstance encountered. If unsure of what care is best for a given patient, BLS company/unit members will not error if they always follow the two fundamental tenets of professional field EMS:
  - When in doubt, err on the side of the patient.
  - Treat all patients like a member of your family.

**3. WHEN ALS INTERVENTION OR BLS TRANSPORT IS NOT PERFORMED IN ACCORDANCE WITH THIS PRG, APPROPRIATE EXPLANATION AND DOCUMENTATION SHALL BE RECORDED ON THE F-902M (REFER TO DEPARTMENTAL TRAINING BULLETIN, NO. 98). THIS DOES NOT APPLY TO PATIENTS WHO ARE 36 MONTHS OF AGE OR LESS. WHILE ON SCENE WITH THE PATIENT, BASE HOSPITAL CONTACT SHALL BE MADE FOR PATIENTS MEETING ANY CRITERIA IN SECTIONS I AND/OR SECTION II WHO REFUSE TREATMENT/TRANSPORT (AMA). REFER TO DEPARTMENTAL BULLETIN 01-10 AND THE EMS FIELD MANUAL, BOOK 35 SECTIONS 1.5 AND 2.1.**

All members must understand that policies and procedures such as this PRG are carefully developed to provide our patients with the best care possible. Therefore, consider the PRG as a “safety net.” Its primary purpose is to protect the patient, which in turn protects the caregiver(s).

- As medical professionals, we recognize the “gray areas” involved in the practice of medicine and, as medical professionals, we have learned that the art of medicine is really the “art of caring.” When field personnel make the decision to deviate from this PRG, special care shall be exercised to ensure that everyone is safe (hence, the need to record/document thoroughly, an explanation as to the rationale for all policy deviations). Base Hospital contact is required **prior to leaving the scene.**

**4. BLS SHALL MAINTAIN A GOOD WORKING KNOWLEDGE OF THE “PATIENT DESTINATION GUIDELINES” (REFER TO SECTION 2.0 OF THE EMS FIELD MANUAL).**

- The EMS Field Manual (Book 35) contains “Patient Destination Guidelines” which may be used by field personnel when determining proper patient destination. Generally, our patients (customers) are transported to the most accessible receiving facility. There are exceptions such as a “patient request” which shall be honored, provided the patient is stable and transport does not exceed 20 minutes non-emergency (extended transport times requires EMS Battalion Captain and OCD authorization).

**5. IN SITUATIONS WHERE BLS ARRIVE ON SCENE PRIOR TO ALS, BLS SHALL NOT CANCEL**

**THE ALS RESPONSE IF A PATIENT MEETS ANY CRITERIA OUTLINED IN SECTION I OF THIS PRG. AN ALS RESOURCE SHALL BE REQUESTED IF ONE HAS NOT BEEN DISPATCHED (UNLESS PRINCIPLE NO. 6 APPLIES).**

- As patient care advocates, we must think of this principle, and the other five, as “lighthouse beacons” to safely navigate us to our intended destination while providing our patients with the best possible care.
- Medical experts and studies have indicated that critical patients need critical intervention within a critical time frame. The medical community has determined that the patient conditions listed in *Section I* of this PRG are potentially “critical” in nature. Our Department’s Medical Priority Dispatch System (MPDS) is in place for this reason. Every effort shall be made by the member in charge to facilitate rapid transport. For example, when a BLS resource and two ALS resources are dispatched to the same incident, the BLS resource shall not cancel either ALS resource for patients whose condition meets any of the criteria listed in *Section I*.

**6. IN LIFE-THREATENING SITUATIONS IN WHICH THE ESTIMATED TIME OF ARRIVAL (ETA) OF THE ALS RESOURCE EXCEEDS THE ETA TO THE MOST ACCESSIBLE RECEIVING FACILITY, BLS PERSONNEL SHALL EXERCISE THEIR CLINICAL JUDGEMENT AS TO WHETHER IT IS IN THE PATIENT’S BEST INTEREST TO BE TRANSPORTED, PRIOR TO THE ARRIVAL OF PARAMEDICS. BLS PERSONNEL SHALL MAKE EVERY EFFORT TO NOTIFY THE MOST ACCESSIBLE RECEIVING FACILITY VIA THE HEAR RADIO, TELEPHONE, DISPATCH, OR OTHER APPROPRIATE MEANS OF COMMUNICATION WHEN EXERCISING THIS PRINCIPLE.**

A “truism” in emergency medicine is that some patient conditions require immediate, rapid transport. For example, in trauma, recognizing a potentially critical “load-and-go” situation may be vital to a positive outcome. Keep in mind as always that every decision you make should be based upon the safety of all those involved (self, peers, patient, and public), applicable rules and regulations and/or policies, procedures and protocols, and public relations. The public trusts that we, as professionals, maintain the necessary knowledge (what to, why to), skills (how to), and most importantly, attitude (wanting to) which we acquired through our background, training, and experience. This trust comes from believing that if a critical situation arises, we will be prepared to make decisions using our good judgement.