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DIVERSION

1. GENERAL RULES OF DIVERSION

- a. No two contiguous hospitals may be on diversion at any given time.
- b. Chart "A" illustrates contiguous hospitals in the Pioneer Valley.
- c. In Berkshire County only one hospital may be on diversion at any given time.
- d. Diversion periods are limited to two hours; a second consecutive two-hour period for the same hospital is allowed only under the circumstances listed below:
- e. After a hospital has been on diversion, it must be off diversion for an equivalent period of time. (In other words, two hours on diversion requires two hours off diversion; four hours on diversion requires four hours off diversion.)

2. PATIENTS WHO MAY NOT BE DIVERTED

- a. Designated Trauma Centers (Level 1 or 2) may not divert patients meeting trauma criteria.
- b. Designated Primary Stroke Service Hospitals may not divert patients meeting stroke criteria unless CT Scan capability is unavailable.
- c. Cardiac/Respiratory arrests may not be diverted.
- d. Unstable critical patients may not be diverted. EMT's should make the determination if the patient is critical/unstable, with medical control consultation if necessary.
- e. Baystate Medical Center may not divert pediatric patients, **recent Baystate Medical Center Bariatric Surgery patients with potential surgical complications, Acute ST Elevation MI (STEMI) patients or patients being transported directly from Baystate Health clinics (3300 Main St, 140 High St, Mason Square (NHC) and Brightwood).** *

3. PROCEDURE FOR DECLARING A DIVERSION

- a. Hospitals in the Springfield CMED network will call Springfield CMED (*at least 15 minutes prior to declaring a Diversion*) and state that the hospital needs to go on diversion. If no other contiguous hospital is on diversion, the requesting hospital is then on diversion for the next two hours.
- b. Hospitals outside the CMED network will notify their appropriate Dispatch agencies, however CMED must also be contacted (413-846-6226) so they can log the event.
- c. If there is a contiguous hospital already on diversion, the requesting hospital may reserve the next available slot.
- d. If two or more hospitals desire the same slot, they must negotiate between themselves and come to an agreement based on their respective needs.
 - i. When agreement is achieved both hospitals shall contact CMED with the decision.
 - ii. The CMED Operator will record the decision.

4. NOTIFYING PARTIES OF A DECLARED DIVERSION

- a. Springfield CMED will notify the appropriate ambulance services and Dispatch agencies.
- b. CMED will also notify appropriate ED's of the neighboring hospital's diversion status.
- c. CMED must be notified of a diversion even if the hospital is not a participant in the CMED network.
- d. At the end of the two-hour period, the hospital will be off diversion (unless an extension has been granted, see Section 5). CMED will notify all pertinent parties of the status change.
Note: CMED requires 15 minutes to make such notifications.

DIVERSION POLICY Continued

5. EXTENDING DIVERSION PERIODS

- a. Diversion may be extended only under the following circumstances:
 - i. If no other hospital has reserved the next time period, the hospital on diversion may stay on diversion for one more two-hour period.
 - ii. If another hospital has reserved the next time period, the hospital on diversion may stay on diversion if the second hospital agrees. Arrangements must be made between the two hospitals and the hospital holding the reservation must contact CMED and make the change.
 - iii. *No hospital may be on diversion for more than four hours consecutively.*

6. CONTACTS AND RESPONSIBLE PERSONS

- a. The hospital contact person for each hospital will be the ED Charge Nurse.
- b. The CMED contact person will be the CMED Operator.
- c. CMED will log the diversions on the MDPH Diversion website. A copy of the information will be maintained at CMED and the WMEMS Office.

7. *If a hospital attempts to go on diversion outside of this policy, the CMED Operator will tell the Charge Nurse that the hospital may not go on diversion, and that he/she will not make notifications to EMS or Dispatch. If there is a continuing problem, CMED will contact WMEMS staff.*

8. Issues will be resolved by the Regional Medical Director and Executive Director. *The Executive Director can be contacted at 413-586-6065.*

9. **DISASTER CONDITIONS**

- a. If a “Disaster” is declared in any of the 12 municipalities in the Metropolitan Medical Response System (MMRS) area, any Diversion underway in the MMRS area will be cancelled. We will then be operating under the MMRS Surge Plan until the disaster is declared under control.
- b. If a hospital has activated their internal “Disaster Plan”, and that condition impacts their patient intake capability, they should communicate with CMED who will cancel active diversion status of contiguous hospitals.

Diversion Chart A

| | BSMC | BMC | CDH | FH | FMC | HMC | MLH | MMC | NH | NAR H | WH |
|-----------------------------|------|-----|-----|----|-----|-----|-----|-----|----|----------|----|
| BAYSTATE MC (BSMC) | ■ | | | | | ■ | | ■ | ■ | | |
| BERKSHIRE MC (BMC) | | ■ | | ■ | | | | | | ■ | |
| COOLEY DICKINSON HOSP (CDH) | | | ■ | | ■ | ■ | | | | | |
| FAIRVIEW HOSP (FH) | | ■ | | ■ | | | | | | ■ | |
| FRANKLIN MC (FMC) | | | ■ | | ■ | | | | | | |
| HOLYOKE MC (HMC) | ■ | | ■ | | | ■ | | ■ | ■ | | |
| MARY LANE HOSP (MLH) | | | | | | | ■ | | | | ■ |
| MERCY MC (MMC) | ■ | | | | | ■ | | ■ | ■ | | |
| NOBLE HOSP (NH) | ■ | | | | | ■ | | ■ | ■ | | |
| N.ADAMS RGL (NARH) | | ■ | | ■ | | | | | | ■ | |
| WING HOSP (WH) | | | | | | | ■ | | | | ■ |

NOT CONTIGUOUS = □

CONTIGUOUS = ■

HAZARDOUS MATERIALS INCIDENTS**A. MECHANISM**

1. Transportation accident
2. Storage tank leaks
3. Industrial accidents
4. Nuclear or biological accidents
5. Terrorist incidents

B. HAZARD IDENTIFICATION

1. Solid, liquid, or gas
2. How exposed?
3. Hazard type:
 - a. Flammable
 - b. Toxic
 - c. Corrosive
 - d. Radioactive
 - e. Reactive
 - f. Infectious (etiologic)
4. Hazard effects:
 - a. Thermal
 - b. Blast
 - c. Pulmonary
 - d. Mechanical
 - e. Contamination
 - f. Asphyxiation

C. SITUATION STRATEGY

1. Size up - DO NOT RUN IN!
2. Call for help/back up
3. Identify HAZ-MAT present and communicate to incoming units
4. Identify what is threatened and how
5. Identify who is in charge of the scene
6. Determine needs and tactics for:
 - a. Rescue/extrication
 - b. Evacuation
 - c. Medical Control
 - d. Decontamination and triage
 - e. Determine protective equipment needs
 - f. Need for morgue
 - g. Transportation of victims

D. DECONTAMINATION AREA NEEDS

1. Layout decontamination/triage area with people flow in mind
2. Keep victims and workers isolated by levels of contamination
3. Use plastic sheets and double gloves

(HAZARDOUS MATERIALS INCIDENTS CONTINUED)

4. Minimize water use and collect as a hazardous waste
5. Keep up hill/up wind
6. Keep near water supply/near road
7. Plan location for safety from incident vs. transportation time from incident
8. Shelter victims from rain, wind, temperature, and public view

E. POST INCIDENT CONSIDERATIONS

1. Decontamination of ambulance and ambulance equipment
2. Decontamination of morgue
3. Disposal of contaminated clothing, supplies, and equipment
NOTE: Contaminated items must be disposed of in accordance with EPA/DEQE procedures
4. Medical follow-up on EMS personnel involved in case of latent effects
5. Review with EPA/Public Health personnel for environmental health concerns

HISTORY TAKING

1. Introduce yourself and identify your position.
2. Address your patient by his/her last name if he/she has reached the age of majority.
3. Assessment (Medical or Trauma)
 - **Onset:** when did the symptoms begin and what was the patient doing at the time?
 - **Provocation:** activities that change the pain / complaint
 - **Quality:** sharp, dull, throbbing, crushing, constant vs. intermittent
 - **Radiation:** yes/no and to where?
 - **Severity:** rate on a scale of 1 to 10
 - **Time:** how long has pain / complaint lasted?

Detailed Trauma Assessment: Check for presence of:

- **Deformities**
- **Contusions**
- **Abrasions**
- **Punctures / penetrations**
- **Burns**
- **Tenderness**
- **Lacerations**
- **Swelling**

4. History
 - **Signs and symptoms:** of present illness/injury
 - a. nature of complaint
 - b. mechanism of injury or illness
 - c. chronology of illness
 - d. location of pain
 - **Allergies:** medications and environmental
 - **Medications:** prescribed, over the counter, and illicit
 - a. when last taken
 - b. did it alleviate the present problem
 - c. dosage and frequency
 - **Past Medical History:**
 - **Last Oral Intake:**
 - **Events Leading to the current illness / injury:**
 - a. position of patient-has patient moved or been moved
 - b. loss of consciousness
5. Physician (patient's primary care MD)

ISOLATION AND HANDLING CONTAGIOUS DISEASE

- A Standard Precautions, as recommended by the Center for Disease Control, should be followed when dealing with any patient. (Bloodborne Pathogens Standards, 1991; TB Standards, 1994; CDC Isolation Guidelines, 1996)
1. EMTs should wear gloves when dealing with blood, any bodily fluids, secretions or excretions (except sweat), non-intact skin, mucous membranes or contaminated items.
 2. Hands must be washed immediately after patient contact and removal of gloves. If water is not available, a waterless hand cleansing solution may be used, followed by thorough hand washing with soap and water as soon as possible.
 3. Mask, eye protection, face shields and/or gowns should be worn whenever patient care activities are likely to generate splashes or sprays of blood or other bodily fluids.
 4. Handle used patient care equipment so as not to contaminate skin, clothing or other equipment. Ensure that disposable equipment is discarded properly, and reusable equipment is cleaned with the appropriate solutions.
 5. Puncture resistant containers must be available for immediate disposal of needles, scalpels or other sharp instruments used during field procedures.
 6. Biohazardous waste should be bagged, removed from the scene and disposed of properly.
- B Transmission-based Precautions, as recommended by the Center for Disease Control, should be followed when dealing with patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond Standard Precautions are needed. (CDC Isolation Guidelines, 1996)
1. Airborne Precautions/Droplet Precautions - In addition to Standard Precautions, use Airborne Precautions or Droplet Precautions for patients known or suspected to have serious illnesses transmitted by airborne droplet nuclei (small-particle residue) or airborne droplet (large-particle droplets). Examples of such illnesses are measles and tuberculosis (small-particle) and meningitis (large-particle).
 - a. Wear respiratory protection when dealing with a patient with known or suspected pulmonary tuberculosis.
 - b. When dealing with a patient with known measles or varicella, wear respiratory protection if you are not immune.
 - c. When dealing with a patient with a rash and a fever, or symptoms such as persistent cough, night sweats and fever, use respiratory protection.
 - d. Mask the patient during movement, if possible.
 2. Contact Precautions - In addition to Standard Precautions, use Contact Precautions for specified patients known or suspected to be infected with epidemiologically important microorganisms that can be transmitted by direct contact with the patient or indirect contact with environmental surfaces or patient-care items in the patient environment. Examples are patients with diarrhea, patients with abscesses or draining wounds that cannot be covered, patients with *Staphylococcus aureus*, or streptococcus.
 - a. In addition to wearing gloves as outlined under Standard Precautions, change gloves after having contact with highly infectious material.

ISOLATION AND HANDLING CONTAGIOUS DISEASE continued

- b. In addition to wearing a gown as outlined in Standard Precautions, wear a gown when dealing with a patient if you anticipate that your clothing will have substantial contact with the patient or environmental surfaces, or if the patient has diarrhea or is incontinent.

- C Each ambulance service should establish and maintain standard operating procedures including but not limited to such areas as infection control, decontamination and unprotected exposure.

- D Unprotected Exposure
 - 1. Each ambulance service should appoint an infection control officer.
 - 2. The appropriate unprotected exposure forms should be made readily available to EMTs and first responders working with/for the service.
 - 3. In the event of an unprotected exposure as defined by 105 CMR 172.001, the appropriate forms should be filed with the hospital receiving the patient within 24 hours.

MAST - (MEDICAL ANTI-SHOCK TROUSERS)

The State has removed from the Pre Hospital Treatment Protocols references to the utilization of MAST/PASG for the treatment of shock.

Services in Region one who choose to continue to carry the MAST/PASG on their ambulance may utilize the device as a splint for pelvic fractures under medical direction.

A. ABSOLUTE CONTRAINDICATIONS:

1. Pulmonary Edema
2. Penetrating Thoracic Injury

B. RELATIVE CONTRAINDICATIONS:

1. Advanced pregnancy (unless absolutely necessary to save the mother's life)
2. Evisceration
3. Impaled object in the abdomen

C. PROCEDURE FOR APPLICATION:

1. Medical Control approval must be received before inflation.
2. Unfold MAST pants and lay flat on long board.
3. Ensure there are no sharp objects between the patient and the garment.
4. Place the patient on MAST pants face up so that the top of the garment will be just below the lowest rib.
5. The leg sections should be applied one at a time, followed by the abdominal section.
6. Attach foot pump.
7. Inflate the to approximately 60 mm Hg or until an indentation can be created with the thumb.
NOTE: MED CON may elect a different inflation procedure in place of the above method.
8. Vital signs should be checked frequently (every 3-5 minutes) thereafter.
9. MAST PANTS SHOULD NEVER BE DEFLATED IN THE FIELD UNLESS SPECIFICALLY ORDERED BY MEDICAL CONTROL.

MEDICAL COMMUNICATIONS**A. RADIO PRIORITIES**

1. Priority 1--Severe life threatening injury/illness
2. Priority 2--Possible life-threatening conditions
3. Priority 3--Non life-threatening condition
4. Priority 4--Administrative or informational use

B. RADIO REPORTING FORMAT

The following format is to be used when transmitting a report to Medical Control. Although situations will vary, this is the minimum acceptable data set. Reports should be limited to between thirty seconds and a minute of radio time.

1. When you contact a CMED, identify yourself by service and technician number and state the priority of your patient's condition. When you are patched through to the hospital, again identify yourself as above; if you are going to request a Signal 300, 400 or 600 do so now.
2. When you have permission to give your report, do so in the following order:
 - a. age
 - b. sex
 - c. chief complaint (if trauma, state the mechanism of injury)
 - d. level of consciousness - ALERT or Responds to - VOICE, PAIN or UNRESPONSIVE
 - e. stop your report and ask "Do you copy? When you receive an affirmative reply, resume your report.
 - f. vital signs: pulse, respirations, blood pressure
 - g. brief report of pertinent physical findings from your secondary survey.
 - h. brief patient history where applicable
 - i. treatment rendered en route to hospital
 - j. estimated time of arrival

When an EMT wishes to contact Medical Control, the following procedure should be followed: (signal 300-Basic EMT, 400-Intermediate EMT or 600-Paramedic EMT)

1. The Technician requesting the Signal 400 should contact the hospital in the usual manner, identifying him/herself both by Ambulance Company and TEK number (for example; "General Hospital, this is the Medic One Ambulance Company, TEK I-6 requesting a Signal 400).
2. The hospital personnel answering the radio will ask the Technician to 'stand by', and will summon a Medical Control physician or his/her designee.
3. The physician (or designee) will call back the Technician, identifying both him/herself and the Technician by number (for instance, "TEK I-6, this is General Hospital Med-Con 2, go ahead.")
4. The Technician will then transmit the results of his/her patient assessment. In most cases this will be both primary and secondary assessment. However, in some cases the Signal 300, 400 or 600 call may be initiated before the secondary survey has been accomplished.
5. If the Technician has in mind any particular treatment plan that is in keeping with the medical care protocols the Technician may request permission to perform a particular procedure.

(MEDICAL COMMUNICATIONS CONTINUED)

6. Whether or not a particular procedure is requested by the Technician, the Medical Control physician has the responsibility for making treatment decisions.
7. In the event that a Technician wishes to request the rationale for an order given by a Medical Control physician which deviates from established protocol, the following procedure should be observed:
 - a. The Technician should request that the order be repeated, to eliminate the possibility of confusion in communications.
 - b. The Medical Control physician will repeat the order (or change it, if appropriate).
 - c. If the Technician still desires clarification, he/she should request 'CODE ZEBRA'.
 - d. It is at the discretion of the Medical Control physician whether this requested clarification will be given briefly over the radio, or upon arrival of the ambulance at the Emergency Department.
8. Unless a protocol is specifically designated as one that may be carried out without a prior Medical Control order, no advanced level procedure is to be carried out without direct Medical Control. (For communication system failure see #9.)
9. In case of communication system failure*, in life threatening situations* procedures for which an EMT is trained and permission is usually required from Medical Control may be performed.

* communication system failure = three attempts at direct communication with Emergency Department within two minutes (no more than two attempts with same device) to include at least one attempt with a mobile unit. Attempts, including times must be documented on the run report.

* life threatening situations = those illnesses or injuries in which the patient is likely to die prior to arrival at the hospital without intervention.

10. While ambulance radio is the normal means of communication between Medical Control Physician and Technician, the telephone or other means of communication may occasionally be used.

MEDICAL CONTROL AND BYSTANDER INTERVENTION

From time to time in the prehospital care setting, a bystander physician, nurse, or Advanced EMT may be present at the scene of an emergency. In such situations, the following procedure should be followed:

1. Ask the physician for identification and thank him/her for his/her offer of assistance.
2. Inform the physician that you are an EMT functioning under direct Medical Control with an on-line Medical Control physician via two-way radio and that all treatment orders must come from that source.
3. If necessary or appropriate, contact Medical Control and ask the bystander physician to confer with him/her.
NOTE: When U. Mass. Lifeflight arrives on a scene, Medical Control will automatically be turned over to the physician on board the helicopter. This occurs when the helicopter has landed, not while the helicopter is still in the air.
4. Continue to follow the orders of Medical Control. You MAY NOT follow the directions of the on-scene physician UNLESS that physician has been given permission by Medical Control to so function. In such circumstances, the bystander physician will be asked to accompany the patient to the hospital. At all such times, document all orders given by the bystander physician. In addition, document all procedures performed by the bystander physician. The bystander physician should sign the run form after all orders and procedures have been documented.
5. If the bystander physician refuses to speak to Medical Control, the EMT should continue to provide patient care at the direction of Medical Control and according to standard protocol.
6. If the bystander physician becomes obstructive, you may ask law enforcement personnel to intervene. This is to be seen as a last resort, and must be reported to Medical Control.
7. If the scene of the emergency is a physician's office, the EMT should neither interfere with nor participate in care being provided by the physician or his/her staff prior to the transfer of care to the EMT. However, once the EMT is asked to begin care of the patient, all further care should be under the direction of Medical Control as outlined above.

For the purpose of simplicity, the specific wording of this policy mentions only physician-bystanders. However, the principles described above also apply to other providers of emergency care such as advanced EMTs or nurses.

MEDICATIONS

(Addendum to Statewide Treatment Protocols Appendix A - Medications List)

Additional required medications in Region I:

Amiodarone, Metoprolol (Lopressor)

Additional medications which may be carried with Service Medical Director approval:

ALS Medical Director Option: Lorazepam (Ativan)

BLS Medical Director Option: Albuterol

Nerve Agent Antidote Kit

Note: Region I paramedic level ambulance services are required to carry the medications listed in “Appendix A - Medications List” of the Statewide Treatment Protocols under “Required Medications.” In addition to those medications, Region I paramedic level ambulance services must also carry the above additional meds. These drugs have been approved from the “Optional Medications” list found in “Appendix A” by the Region I Physicians’ Council.

AUTHORIZED MEDICATIONS FOR USE BY PARAMEDIC LEVEL PERSONNEL

The form supplied and minimum stock level are recommendations. Each paramedic vehicle should have enough medications on hand to treat two patients. The form of the medication carried is that provided by the pharmacy of the hospital with which your service is affiliated. Medication dosages are dictated by protocol.

| MEDICATION (GENERIC) | MEDICATION (TRADE/COMMON) | HOW SUPPLIED | MINIMUM STOCK LEVEL |
|---------------------------------|--------------------------------------|---------------------------------------|--------------------------------|
| Activated Charcoal | | 25 gm bottle (sorbitol) | 1 |
| | | 25 gm bottle (water) | 1 |
| Adenosine | Adenocard | 6 mg/2mL unit dose vial | 5 |
| Albuterol Sulfate | Proventil or Ventolin | Unit dose, 3mL (0.083% sol) | 3 |
| Amiodarone | | 150mg/3ml vial | 2 |
| ASA | Asprin | 81 mg tablets | 1 bottle |
| Atropine Sulfate | | 0.5 – 1.0 mg prefilled syringe | 5 |
| Atrovent Solution | | Unit dose, 2.5mL (0.02 % sol) | 2 |
| Calcium Chloride | | 10 ml prefilled syringe (100mg/ml) | 2 |

WMEMS REGION ONE GUIDELINES

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| | | | |
|--------------------------|---------------------|--|--------|
| *Cetacaine Spray | | 56 gm bottle | 1 |
| Dextrose 25% Inject | D25 | infant prefilled syringe | 2 |
| Dextrose 50% Inject | D50 | 25 gm prefilled syringe | 2 |
| Diltiazem | Cardizem | 5ml prefilled syringe (5mg/ml) | 2 |
| Diphenhydramine HCl | Benadryl | 50 mg/ml – ampule or prefilled syringe | 2 |
| Epinephrine 1:1000 | Adrenalin | 1mg (1mL) ampule | 6 |
| Epinephrine | EpiPen Autoinjector | Junior – 0.15 mg (1:2000) Adult – 0.3 mg (1:1000) | 2 2 |
| Epinephrine 1:10,000 | Adrenaline | 1 mg prefilled syringe | 10 |
| Furosemide | Lasix | 40 mg (4mL) vial | 4 |
| Oral Glucose | Glucose | 25 gm unit dose | 2 |
| Glucagon | | 1 mg vial (w/ 1 mL diluting sol) | 2 |
| Lidocaine HCl | Xylocaine | 100 mg prefilled syringe | 4 |
| *Lidocaine HCl 2% Jelly | Xylocaine | multi-use tube | 1 |
| Magnesium Sulfate | | 10% 50 mL vial | 1 |
| Metoprolol | Lopressor | 5 mg vial | 2 |
| Naloxone HCl | Narcan | 2.0 mg (2mL) | 4 |
| *NeoSynephrine Spray | | .5 mL bottle | 1 |
| Nerve Agent Antidote Kit | MARK I | pre-packaged kits | 2 |
| Nitroglycerine | | 0.4 mg (1/150 grain) | 1 |
| Nitroglycerine Paste | Nitropaste | multi-use tube | 1 |
| Normal Saline | | 2.5 mL unit dose | 5 |
| Oxygen | | | |
| Sodium Bicarbonate | | 50 mEq prefilled syringe | 2 |

| | | | |
|-------------|----------|----------------------------------|---|
| Terbutaline | Brethine | 1mg/mL ampule | 2 |
| Thiamine | | 100 mg/mL 2 mL prefilled syringe | 2 |

** service may choose one of these for assistance with nasotracheal intubation*

PRE-MIXED INFUSIONS

| MEDICATION (GENERIC) | MEDICATION (TRADE/COMMON) | HOW SUPPLIED | MINIMUM STOCK LEVEL |
|-------------------------|------------------------------|------------------------|------------------------|
| Dopamine | Intropin | Pre-mixed bag – 500 cc | 1 |
| Lidocaine HCl (20%) | Xylocaine | Pre-mixed bag – 500cc | 1 |

NARCOTIC KIT

| MEDICATION (GENERIC) | MEDICATION (TRADE/COMMON) | HOW SUPPLIED | MINIMUM STOCK LEVEL |
|--|------------------------------|-------------------------------|------------------------|
| Lorazepam (Service Medical Director Option) | Ativan | 2 or 4 mg/ml vials | 2 |
| Morphine Sulfate | | 4 mg Tubex or Interlink | 3 |
| Diazepam | Valium | 10 mg (2mL) prefilled syringe | 2 |
| Midazolam | Versed | 10 mg (2 ml) vial | 2 |

IV SOLUTIONS

| MEDICATION (GENERIC) | MEDICATION (TRADE/COMMON) | HOW SUPPLIED | MINIMUM STOCK LEVEL |
|-------------------------|------------------------------|--------------|------------------------|
| 0.9% Sodium Chloride | Normal Saline | 100 cc bags | 2 |
| | | 250 cc bags | 2 |

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| | |
|--------------|---|
| 500 cc bags | 2 |
| 1000 cc bags | 6 |

| | | | |
|-----------------------|-----|-------------|---|
| Dextrose 10% Solution | D10 | 250 cc bags | 1 |
|-----------------------|-----|-------------|---|

AUTHORIZED MEDICATIONS FOR USE BY INTERMEDIATE LEVEL PERSONNEL

| MEDICATION (GENERIC) | MEDICATION HOW SUPPLIED (TRADE/COMMON) | MINIMUM STOCK LEVEL | |
|---------------------------------|---|--------------------------------|----------|
| Activated Charcoal | 25 gm bottle | 1 | |
| | 25 gm bottle (water) | 1 | |
| **Albuterol Sulfate | Proventil or Ventolin | Unit dose, 3mL (0.083% sol) | 3 |
| ASA | Asprin | 81 mg tablets | 1 bottle |
| Epinephrine | EpiPen Autoinjector | Junior – 0.15 mg (1:2000) | 2 |
| | | Adult – 0.3 mg (1:1000) | 2 |
| Nerve Agent Antidote Kit | MARK I | pre-packaged kits | 2 |
| Oral Glucose | Glucose | 25 gm unit dose | 2 |
| Oxygen | | | |
| 0.9% Sodium Chloride | Normal Saline | 250 cc bags | 2 |
| | | 500 cc bags | 2 |
| | | 1000 cc bags | 6 |

**** Only if authorized by Ambulance Service Medical Director**

AUTHORIZED MEDICATIONS FOR USE BY BASIC LEVEL PERSONNEL

| MEDICATION (GENERIC) | MEDICATION HOW SUPPLIED (TRADE/COMMON) | MINIMUM STOCK LEVEL | |
|---------------------------------|---|--------------------------------|----------|
| Activated Charcoal | 25 gm bottle | 1 | |
| | 25 gm bottle (water) | 1 | |
| **Albuterol Sulfate | Proventil or Ventolin | Unit dose, 3mL (0.083% sol) | 3 |
| ASA | Asprin | 81 mg tablets | 1 bottle |

| | | | |
|--------------------------|---------------------|---------------------------|---|
| Epinephrine | EpiPen Autoinjector | Junior – 0.15 mg (1:2000) | 2 |
| | | Adult – 0.3 mg (1:1000) | 2 |
| Nerve Agent Antidote Kit | MARK I | pre-packaged kits | 2 |
| Oral Glucose | Glucose | 25 gm unit dose | 2 |
| Oxygen | | | |

**** Only if authorized by Ambulance Service Medical Director**

Updated May 1998, June 2001, January 2004, September 2006

POINT OF ENTRY PLAN

1. Patients have the right to make decisions regarding their health care, including, but not limited to, the right to choose who provides that care and where it is provided.
2. In accordance with 105 CMR 170.330(A)(3) ambulance services in Massachusetts shall have written policies and procedures addressing "...delivery of patients to appropriate health care facilities;" 105 CMR 170.020 defines "Appropriate Health Care Facility means an emergency department, either physically located within an acute care hospital licensed by the Department pursuant to 105 CMR 130.000 to provide emergency services, or in a satellite emergency facility approved by the Department pursuant to 105 CMR 130.821, that is closest geographically or conforms to a Department-approved point-of-entry plan." Also, in accordance with 105 CMR 170.355(A) "No service, or agent thereof, including but not limited to its EMS personnel, shall refuse in the case of an emergency to dispatch an available EMS vehicle... within the service's regular operating area...or to transport a patient to an appropriate health care facility..." Finally, in accordance with 105 CMR 170.357 "Each ambulance service shall ensure that its EMTs deliver patients in accordance with regional point-of-entry plans approved by the Department. No ambulance service shall develop a point-of-entry plan independent of a Department-approved regional point-of-entry plan."
3. With the exception of patients falling into the following categories, emergent patients should be transported to the nearest appropriate emergency department. Patients requesting transport to an emergency department/hospital farther away may be transported to that hospital provided no more than 20 minutes will be added to the transport time if the crew is BLS or no more than 30 minutes will be added to the transport time if the crew is ALS.
 - A. Patients with trauma, pediatric trauma, burns or amputations who meet the statewide trauma triage guidelines should be transported according to those guidelines.
 - B. Obstetric patients should be transported to a facility with a labor and delivery unit. Unless the patient is in active labor, emergent patients who are pregnant should always be transported to the emergency department, not the labor and delivery area, unless so directed by Medical Control.
 - C. EMS operational definition of acute stroke:
Presence of symptoms < 2 hr duration (or since last seen at baseline) according to the Boston Stroke Scale (BOSS) **or** other concerning neurologic signs consistent with stroke. Other neurologic signs include:
 - sudden onset dizziness with inability to walk
 - double vision and eye movement abnormalities
 - weakness affecting the leg
 - a) Following the Mass EMS Pre-hospital Treatment Protocols for Acute Stroke, establish a diagnosis of possible stroke based on BOSS scale (Protocols Appendix Q)
 - b) Establish time of onset and last time seen at baseline
 - c) If stroke symptoms present and time of onset of symptoms to hospital arrival will be \leq 2 hours, transport patient to nearest appropriate DPH designated Primary Stroke Service (PSS)*
 - d) Notify receiving facility as early as possible
4. The categories of patients referred to in #3 are: Trauma, Pediatric Trauma, Burns, Amputation, Obstetrics and Stroke (see Appendix for current list of designated hospitals in Region One).

*** Determining most appropriate transport:**

- I. The goal is to transport the patient to a PSS within 2 hours of symptom onset. Choose the most appropriate mode of transport (air, ground, etc.) and destination to achieve this.
 - II. If the patient has depressed level of consciousness, compromised airway control, known hypoglycemia, suspected severe hypoglycemia (diaphoretic and a known diabetic), or is hemodynamically unstable, it may be more appropriate to transfer to nearest receiving hospital for acute stabilization.
 - III. If CT Scan capability is unavailable at the nearest PSS, the patient should be transported to the next appropriate PSS as per above guidelines.
 - IV. If the patient will arrive at the PSS more than 2 hours after symptom onset, transport should be to the nearest hospital. This time-guideline may be revised in the future as new therapies extend the stroke treatment time-window.
5. If the nearest appropriate facility is on diversion, the patient should be transported to the next nearest emergency department, as directed. No patient meeting trauma triage guidelines will be diverted from a Level 1 Trauma Center, nor will priority 1 patients be diverted. No PSS may divert a patient meeting stroke criteria (except if CT Scan capability is unavailable) .
 6. Patients in the Berkshire Medical Center catchments area should consult their Medical Control. High risk trauma patients should be transported to Berkshire Medical Center for initial treatment and stabilization when the transport time to a Level One Trauma Center exceeds 20 minutes for BLS and 30 minutes for ALS services.

POINT OF ENTRY PLAN (APPENDIX)

As of March 6, 2006 the following is a list of designated hospitals in Region One:

Level One Trauma Center (ACS Verified for Adult and Pediatric Trauma):

Baystate Medical Center

Level Two Trauma Center (ACS Verified for Adult and Pediatric Trauma):

Berkshire Medical Center

DPH Designated Primary Stroke Service:

Baystate Medical Center
 Berkshire Medical Center
 Cooley Dickinson Hospital
 Fairview Hospital
 Franklin Medical Center
 Holyoke Medical Center
 Mary Lane Hospital
 Mercy Medical Center
 Noble Hospital
 North Adams Regional Hospital
 Wing Memorial

RAPE, ASSAULT, ABUSE

- A. Preserve any evidence including the patient's clothing. Clothing should be placed in paper bags only. Chain of custody of evidence must be traceable.
- B. Treat any injuries.
- C. Document anything that the patient says to you.
- D. Do not comment on anything other than the injuries that you are treating.
- E. If the patient wishes to talk, be receptive but **DO NOT** make any verbal conclusions. **KEEP YOUR OPINION TO YOURSELF.**
- F. Do not ask leading questions.

TRAUMA TRIAGE PLAN**I. SYSTEM ENTRY – TYPE OF PATIENT**

- A. High risk trauma patients will be routed according to these protocols.
- B. Patients not in the high risk group are routed according to the patient's choice of hospital or closest appropriate hospital, following the Regional Point of Entry Plan.

II. FIELD TRIAGE PROTOCOL FOR HIGH RISK PATIENTS

- A. All prehospital providers must notify their Medical Control regarding the destination of a high risk patient.
- B. Early notification to the receiving facility is strongly encouraged, even from the scene, as it enhances patient care.
- C. Medical Control will direct field care and patient transport by protocol.
- D. BLS and ALS Service may bypass the closest hospital in order to transport to a Trauma Center if the added transport time is no longer than 20 minutes.
- E. Medical Control will allow transport of patients according to the protocols **unless it is not in the patient's best interest**. In these cases, Medical Control will advise otherwise.
- F. High risk patients who request transportation to an alternative hospital will be transported to the appropriate facility according to the Regional Point of Entry Plan and in consultation with Medical Control.
- G. All cases with an alteration of or a deviation from protocol will be reviewed.

III. INTERFACILITY TRANSFERS

- A. Within the region, transfer of the high risk patient should be from a system hospital to a Trauma Center or to a higher level Trauma Center.
- B. Transfers to a specialty center may be done when deemed to be medically necessary.
- C. Transfers that deviate from the protocol will be reviewed.

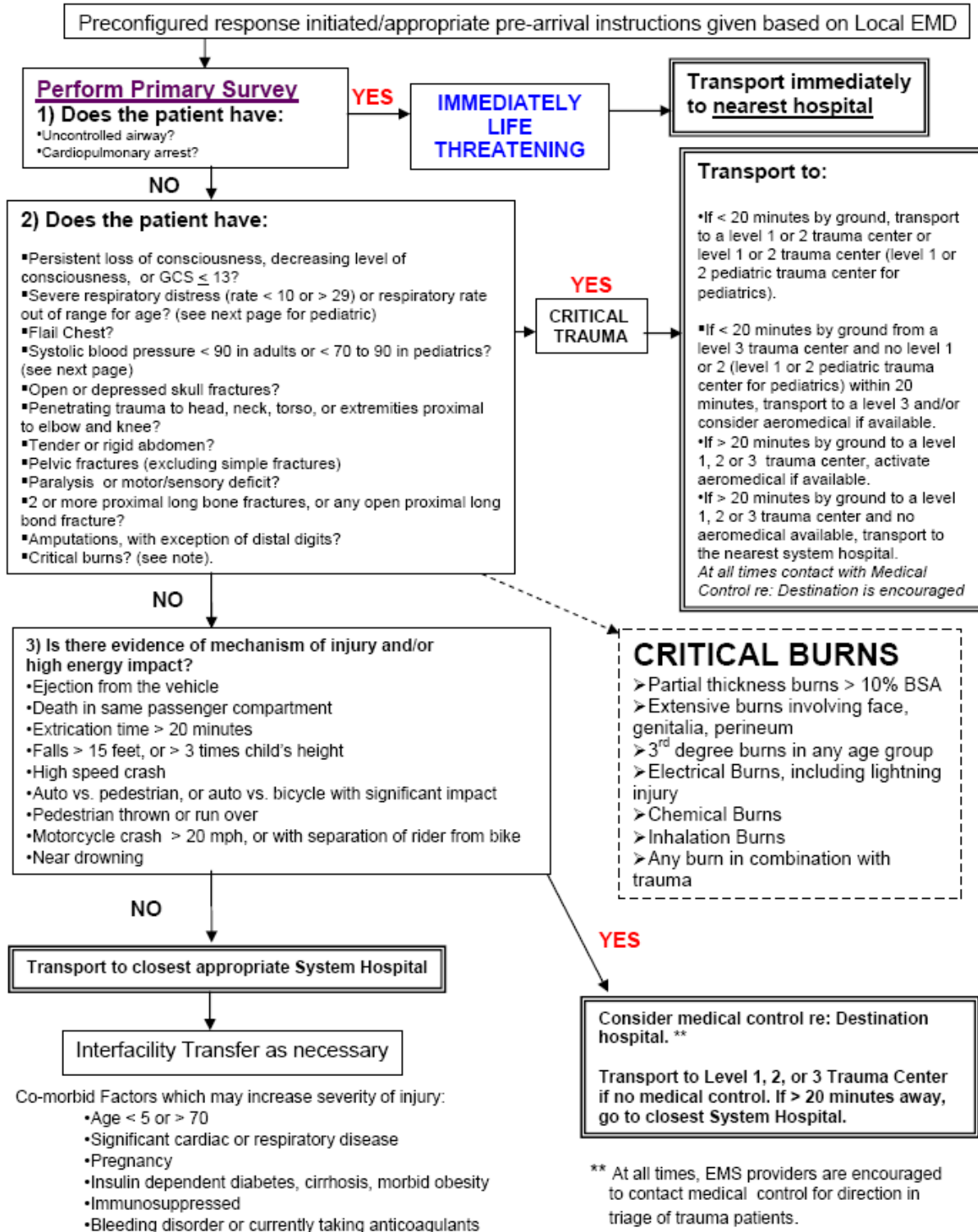
IV. TRAUMA SYSTEM EVALUATION

The Trauma Systems Committee will establish and maintain a mechanism to evaluate the trauma system in Western Massachusetts through ongoing review of:

- A. System performance- effectiveness/appropriateness of triage and transport protocols
- B. Resource utilization (personnel, transportation, communications and hospitals)
- C. Transport efficiency measures-scene times, transport times, method/type of transport and length of stay in hospital
- D. Patient outcome measures-injury patterns, mechanisms, nature and severity of injuries

Statewide Trauma Field Triage Criteria and Point-of-Entry Plan for Adult and Pediatric Patients

NOTE: Additional pediatric-specific information can be found below.
Early notification of the receiving facility, even from the scene, will enhance patient care.



VII. AERO MEDICAL TRANSPORT GUIDELINES

The use of aero medical services may be an option for transport of critically ill or injured patients who require specialized medical facilities such as Trauma Centers.

Aero medical support and ground ALS (paramedics) should be considered when the following operational conditions exist and the patient meets Trauma Triage Criteria.

- A. When the estimated scene & transportation time (including extrication) to the nearest appropriate hospital, exceeds 30 minutes.
- B. Patient location, weather, or road conditions precludes use of standard ground ambulance.
- C. Multiple casualties/patients will exceed the capabilities of local hospital and ground agencies.

Patients in cardiac arrest secondary to blunt trauma should be taken by ground ambulance to the closest facility after consultation with Medical Control.

It is appropriate to place an aero medical service on standby until EMS or first responders arrive on the scene to render a qualified assessment. The decision to activate aero medical transport in the absence of the above criteria should be made in conjunction with the local Medical Control physician.

The judgments of the professionals at the scene are the most important element in making decisions about the use of aero medical transport.

The following are aero medical services available in Region One:

| | |
|-------------------|--------------|
| Life Flight | 800-322-4354 |
| Life Star | 800-221-2569 |
| Albany Med Flight | 800-525-6663 |
| Dart Air Response | 800-650-3222 |
| Boston Med Flight | 800-233-8998 |

TRAUMA TRIAGE PLAN APPENDIX A**1. Infants:**

Approach the infant slowly and calmly, using a quiet soothing voice and perform the physical exam while the infant is on the parent or caregiver's lap.

The infant's common fears are separation from their parent or caregiver's and encounters with strangers.

Compare assessment findings with the parent or caregiver's description of the infant's normal behavior.

Use distraction techniques such as toys or familiar objects to assist with gaining the infant's cooperation.

2. Toddlers:

Toddlers have limited language skills and ability to express themselves.

They will resist any form of being restrained.

Toddlers will often react to painful and non-painful procedures the same.

Provide toddlers with limited choices, such as, "Do you want me to listen to the front of your chest or the back first?" This provides the toddler with a sense of control.

Use simple concrete terms and perform the assessment from "toe-to-head".

3. Preschool:

Preschoolers have an expanded vocabulary and are able to express themselves.

They do have difficulty distinguishing between reality and fantasy and often exhibit magical thinking.

Preschoolers may perceive pain as punishment for bad thoughts or behavior.

Explain procedures in simple terms and allow them to handle minor equipment (i.e., stethoscope).

Encourage parents to help with procedures.

4. School age:

School age children may regress to a younger state of mind when they are injured.

Body image and fear of disability are important concepts.

Provide privacy whenever possible, conduct assessment from head to toe.

School age children can localize and describe pain more accurately but may deny it for fear of painful procedures.

They have a good understanding of time and can reason events.

Parents or caregiver's are still needed for emotional support.

5. Adolescent:

Adolescence is a time of rapid growth and development. It is also a time when mental health issues such as depression, anxiety, eating disorders, substance use, risk-taking behavior and family struggles can become prominent.

Provide them with a choice of being examined and/or interviewed with or without their parent or caregiver's presence.

Avoid the use of condescending language. Be honest, nonjudgmental and provide feedback about their status.

NOTE: There are many children with special health care needs whose baselines may be considered unstable to EMS providers but are stable according to the family or caregiver. It is recommended that whenever possible, EMS providers should consult with parents or caregivers of children with special health care needs in determining the child’s deviations from his/her baseline. Enlist the parent or caregiver’s assistance in the child’s care whenever possible. Don’t assume the child with a physical disability is cognitively impaired but do approach a child with developmental delay using techniques appropriate to their developmental level, not chronological age.

TRAUMA TRIAGE PLAN APPENDIX B

GLASGOW COMA SCALE (GCS)

| INFANTS & TODDLERS | | | CHILDREN & ADULTS | | |
|----------------------------|-----------------------------|---|----------------------------|------------------------|---|
| EYE OPENING | Spontaneous | 4 | EYE OPENING | Spontaneous | 4 |
| | To voice | 3 | | To voice | 3 |
| | To pain | 2 | | To pain | 2 |
| | None | 1 | | None | 1 |
| BEST VERBAL RESPONSE | Smiles, interacts | 5 | BEST VERBAL RESPONSE | Oriented | 5 |
| | Consolable | 4 | | Confused | 4 |
| | Cries to pain | 3 | | Inappropriate words | 3 |
| | Moans to pain | 2 | | Incomprehensible words | 2 |
| | None | 1 | | None | 1 |
| BEST MOTOR RESPONSE | Normal spontaneous movement | 6 | BEST MOTOR RESPONSE | Obeys commands | 6 |
| | Localizes pain | 5 | | Localizes pain | 5 |
| | Withdraws to pain | 4 | | Withdraws (pain) | 4 |
| | Abnormal flexion | 3 | | Flexion (pain) | 3 |
| | Abnormal extension | 2 | | Extension (pain) | 2 |
| | None | 1 | | None | 1 |

TRAUMA TRIAGE PLAN APPENDIX C

PEDIATRIC VITAL SIGNS

| Age in Years | Weight in Kg | Respiratory Rate | Heart Rate | Systolic Blood Press. |
|--------------|--------------|------------------|------------|-----------------------|
| Newborn | 3-5 | 30-60 | 100-160 | 60-80 |
| 6 mos. | 7 | 25-40 | 90-120 | 80-100 |
| 1 yr. | 10 | 20-30 | 90-120 | 80-100 |
| 18 mos. | 12 | 20-30 | 80-120 | 80-110 |
| 3 yrs. | 15 | 20-30 | 80-120 | 80-110 |
| 5 yrs. | 20 | 18-24 | 70-110 | 80-110 |
| 6 yrs. | 20 | 18-24 | 80-100 | 80-110 |
| 8 yrs. | 25 | 18-24 | 70-110 | 80-110 |
| 10 yrs. | 30 | 16-20 | 70-110 | 80-110 |
| 12 yrs. | 40 | 16-20 | 60-110 | 90-120 |
| 14 yrs. | 50 | 16-20 | 60-105 | 90-120 |
| 16 yrs. | 60 | 16-20 | 60-80 | 80-120 |
| 18 yrs. | 70 | 16-20 | 60-80 | 80-120 |

TRAUMA TRIAGE PLAN APPENDIX D

ALS/BLS Interface

When ALS care is anticipated, the following issues should be taken into account:

- Proximity of the patient to a hospital
- Anticipated intercept time of responding ALS ambulance
- Pre-determining a location for intercept and the route of travel for both responding ambulances
- Radio communication difficulties due to geography
- Scene constraints (i.e., MCI, traffic backups, etc.)

Taking into consideration these issues, transportation by the BLS ambulance should be initiated as soon as possible. Communication between ambulances is essential.