Indications for 12-lead:
- Any patient experiencing symptoms of possible cardiac origin.
- Symptoms may include, but are not limited to:
  - chest pain
  - arrhythmia
  - palpitations
  - Patients with history of cardiac disease
  - CHF
  - difficulty breathing
  - syncope
  - altered mental status
  - dizziness
  - unexplained weakness
  - diaphoresis
  - unexplained nausea in patients over 40
  - ROSC

Patient assessment warrants acquisition of 12-lead:
Acquire, interpret and document results of single lead ECG

Refer to appropriate standard or protocol for treatment/monitoring/transport directions

Patient meets any criteria for ALS transport?

Yes:
Transport ALS to appropriate facility
Reacquire 12-lead if patient has changes in clinical presentation
Update EMSCOM of any significant findings
Transport BLS or ILS to appropriate facility

No:
Print copy of 12-lead and turn over to transport unit (transmission not required)

Criteria for consideration of BLS or ILS transport (ALL CRITERIA MUST BE MET)
- Absence of ST elevation or depression
- patient’s vital signs are within normal limits
- all responders agree with turn down

Notes:
- Leads (electrodes) should not be removed; wires can be removed if necessary but prefer to simply unplug cable from monitor and reconnect in rig so serial 12-leads can be done (with the electrodes in the same place).
POLICY: Adverse medical events will be reported to the OEM EMS division in the established timeline for the type of event.

<table>
<thead>
<tr>
<th>Event Type</th>
<th>Sentinel Event / Serious Safety Event</th>
<th>Precursor Safety Event</th>
<th>Serious Circumstances that may impact medical practice within the OEM EMS system</th>
</tr>
</thead>
</table>
| Definition | A patient safety event (not primarily related to the natural course of the patient’s illness or underlying condition) that reaches a patient and results in any of the following:  
> Death  
> Permanent harm  
> Severe temporary harm | Any deviation from the OEM EMS standards that reached a patient and had either minimal harm or no harm | Any significant EMS related event report to the fire department’s risk manager or other regulatory agency including, but not limited to, the jurisdictional Fire/Police or Public Safety Commission, Occupational Safety and Health Administration, or Wisconsin Department of Health. |

Examples include but not limited to:

- Any deviation from an EMS policy or treatment protocol with patient harm
- Medication or procedural errors with harm

- Any of the occurrences defined by DHS 110.54 Reasons for Enforcement Actions, Wisconsin State Statue Chapter 256 or other related Statute, Administrative Rule or local ordinance. Examples include but not limited to:
  - The person made a false statement on an application for, or otherwise obtained a permit, certificate or license through fraud or error.
  - The licensing examination for the person was completed through error or fraud.
  - The person violated a court order pertaining to emergency medical services.
  - The person's license or certification was revoked within the past two years.
  - The person has an arrest or conviction history substantially related to the performance of duties as an EMS professional, as determined by the department.
  - The person committed or permitted, aided or abetted the commission of an unlawful act that substantially relates to performance of EMS duties, as determined by the department.
  - The person failed to a violation of the rules of DHS 110 by a licensee, certificate holder or permit holder.
  - The person failed to maintain certification in CPR for health care professionals by completing a course approved by the department and has performed as a first responder or EMT.
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
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<td>The person practiced beyond the scope of practice for his or her license or certificate.</td>
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<td>The person practiced or attempted to practice when unable to do so with reasonable skill and safety.</td>
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<td>The person practiced or attempted to practice while impaired by alcohol or other drugs.</td>
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<td>The person engaged in conduct that was dangerous or detrimental to the health or safety of a patient or to members of the general public while performing EMS duties.</td>
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<td>The person administered, supplied, obtained or possessed any drug other than in the course of legitimate EMS practice or as otherwise permitted by law.</td>
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<td>The individual engaged in inappropriate sexual contact, exposure, gratification, or other sexual behavior with or in the presence of a patient.</td>
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<td>The person abused a patient by any act of nonconsensual force, violence, harassment, deprivation, nonconsensual sexual contact or neglect.</td>
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<td>The person obtained or attempted to obtain anything of value from a patient for the benefit of self or a person other than the patient unless authorized by law.</td>
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<td>The person falsified or inappropriately altered patient care reports.</td>
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<td>The person revealed to another person not engaged in the care of the patient information about a patient's medical condition when release of the information was not authorized by the patient, authorized by law, or requested by the department in the investigation of complaints.</td>
</tr>
<tr>
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<td>The person failed or refused to provide emergency medical care to a patient because of the patient's race, color, sex, age, beliefs, national origin, handicap, medical condition, or sexual orientation.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>The person abandoned a patient.</td>
</tr>
</tbody>
</table>
**Event Type** | **Sentinel Event / Serious Safety Event** | **Precursor Safety Event** | **Serious Circumstances that may impact medical practice within the OEM EMS system**
--- | --- | --- | ---
**Note** | Any event that has patient harm, implicates OEM EMS or partnering fire departments and is likely to be a news/media story within 24 hours. |  |  |
**Timing** | Immediate | Within next business day | Within next business day |
**Whom to contact** | Medical Director  
AND  
OEM EMS Division Director  
24/7 via EMSCOM at 414.278.4343 | qualityems@milwaukeecountywi.gov  
AND  
Fire Department EMS Liaison |  |
Universal Care:

ALERTS: ISOLATION, OPIOID, SEPSIS

CODE: STEMI, STROKE LVO POSITIVE/NEGATIVE

Practice Guideline

Providers will assess patients per routine practice guidelines to determine working assessment.

**Code - STEMI**

- Providers will notify EMSCOM of a Code STEMI immediately of patient presentation of acute coronary syndrome & 12-lead diagnostic of STEMI (or paramedic judgment).

- Provider will report:
  - Patient case number
  - Initial vital signs
  - Receiving hospital & ETA
  - Transmit 12-lead with pt ID#, initials, age, gender


- Provider will complete assessment and provide full report to EMSCOM prior to transport.

**Code Stroke - LVO Negative**

- Providers will notify EMSCOM of a Code Stroke-LVO Positive/Negative immediately of patient presentation with positive BEFAST and LVO Snow scale, as applicable, less than 24 hours.

- Provider will report:
  - Patient case number
  - Initial vital signs
  - Receiving hospital and ETA
  - Positive LVO Finding

- EMSCOM will include Isolation Alert, Sepsis Alert, Opioid Alert with above information in normal paging process.

**Code Stroke - LVO Positive**

- Providers will notify EMSCOM of an “Isolation Alert” with positive history/symptoms of potential infectious process requiring additional personal protective agent and/or isolation measures.

- Provider will report:
  - Patient case number
  - Initial vital signs
  - Receiving hospital and ETA
  - Suspected infectious agent

- Providers will notify EMSCOM of an “Opioid Alert” if treating a patient with a positive history / symptoms of opioid overdose or if Naloxone was administered.

- Provider will report:
  - Patient case number
  - Initial vital signs
  - Receiving hospital and ETA
  - Primary Working Assessment Overdose
  - Name of opioid taken

- Providers will notify EMSCOM of a “Sepsis Alert” if patient presentation with 2 or more positive Systemic Inflammatory Response Syndrome criteria.

- Provider will report:
  - Patient case number
  - Initial vital signs
  - Receiving hospital and ETA
  - Primary Working Assessment is Sepsis

Initiated: 11/04/2013
Reviewed/Revised: 03/01/2018
Revision 5

Approved: M. Riccardo Colella, DO, MPH, FACEP
Reviewed: EMS Division Director Kenneth Sternig, RN
WI DHS ES Approval: 03/01/2018
POLICY: Milwaukee County EMS Communications will provide early notification of the impending arrival of patients with the following working assessments:

- Suspected STEMI as identified by patient presentation of acute coronary syndrome and a 12 lead diagnostic for STEMI (or paramedic judgment)
- Suspected STROKE LVO NEGATIVE as identified by a positive BEFAST, negative LVO, and last known well (LKW) time less than 24 hours
- Suspected STROKE LVO POSITIVE as identified by a positive BEFAST, positive LVO, and last known well (LKW) time less than 24 hours
- Suspected infectious process requiring additional personal protective equipment or isolation measures
- Suspected sepsis
- Suspected opioid use

Notes:

- **Code STEMI, Code Stroke LVO Negative, and Code Stroke LVO Positive are pre-arrival notifications.** The intention is to provide the receiving hospital with as much pre-arrival notification as possible to allow the hospital to gather resources not readily available in the emergency department.

- **Isolation Alert, Opioid Alert and Sepsis Alert:** are designed to increase awareness on the behalf of the receiving emergency department to allow for focused approaches to managing patients needing isolation, experienced an opioid overdose or may be septic.
POLICY: If the first responding EMS unit determines after patient assessment that ALS evaluation, treatment, and transport are not required, the responding ALS or ILS unit may be cancelled.

BLS and ILS units must request a Milwaukee County paramedic evaluation for patients meeting the following criteria.  
Note: This does not exclude any other patient from assessment by a Milwaukee County paramedic.

1. **An EMT, physician, physician’s assistant, or nurse on scene requests ALS/paramedic transport.** This does not include transports that meet established criteria for interfacility transports.  
2. **Mechanism of injury includes a motor vehicle crash in which (these patients should be transported to Level I/Level II trauma center):**
   a. Estimated crash impact speed was 40 mph or greater  
   b. Prolonged or complicated extrication was required  
   c. Passenger compartment intrusion is greater than 12 inches  
   d. Another occupant in the same vehicle was killed  
   e. The patient was ejected from the vehicle  
   f. The vehicle rolled over onto the roof  
   g. The patient was on a motorcycle or bicycle with impact speed over 20 mph  
   h. A motorcycle or bicycle rider was thrown from the cycle  
   i. A pedestrian was struck by a motor vehicle  
3. The adult patient (12 years or older) fell 20 feet or more OR a pediatric patient (less than 12 years old) fell 10 feet or more. These patients should be transported to Level I/Level II trauma center.  
4. **Injuries that include (these patients should be transported to Level I/Level II trauma center):**
   a. Penetrating injury to the head, neck, chest, axilla, proximal extremities, abdomen, back, buttocks, pelvis or groin  
   b. Flail chest  
   c. Two or more long bone fractures (femur, humerus)  
   d. Amputation above the wrist or ankle  
   e. New-onset paralysis of traumatic origin  
5. Burn injuries to the face, airway, or body surface area greater than 18%  
6. Glasgow Coma Scale of 13 or less  
7. Patient experiencing status or recurrent seizures  
8. Suspected tricyclic overdose, regardless of the number taken or present signs/symptoms  
9. Pregnant patient at 24 or more weeks gestation with vaginal bleeding  
10. Experiencing complicated childbirth with any of the following:
    a. Excessive bleeding  
    b. Amniotic fluid contaminated by fecal material  
    c. Multiple births  
    d. Premature imminent delivery  
    e. Abnormal fetal presentation (breech)  
    f. Prolapsed umbilical cord  
    g. Newborn with a pulse less than 140  
    h. Newborn flaccid or poor cry
11. Chief complaint of non-traumatic chest pain with any of the following:
   a. Cardiac history - MI, angina, coronary bypass surgery, angioplasty or valve replacement, arrhythmia, pacemaker, automatic implanted cardiac defibrillator (AICD), bradycardia, tachycardia, heart surgery
   b. Taking/prescribed two or more cardiac medications
   c. Diabetes
   d. Renal failure/dialysis
   e. Cocaine use within the past 24 hours
   f. Pain radiation to the neck, jaw or arm
   g. Diaphoresis
   h. Nausea/vomiting
   i. Age 40 and older
12. Age 50 or older with non-traumatic pain to the neck, jaw or arm and accompanied with any of the following:
   a. Diaphoresis
   b. Nausea/vomiting
13. Respiratory distress – Any patient with abnormal respiratory rate or pulse oximetry and any of the following:
   a. Inability to speak in full sentences (if normally verbal)
   b. Retractions
   c. Cyanosis
   d. Poor aeration
   e. Accessory muscle use
   f. Wheezing
   g. Grunting
14. Abnormal vital signs with associated symptoms
15. History or physical examination reveals a potentially life-threatening situation
16. The BLS, ILS, or ALS private provider has initiated an EMT-Basic advanced procedure and interfacility criteria are not met.
17. Patients in which EMT-Basic advanced skills were initiated; these patients also require ALS transport:
   a. Administration of albuterol without complete relief of symptoms (examples: wheezing, dyspnea)
   b. Administration of aspirin
   c. Administration of epinephrine for allergic reactions
   d. Assistance in self-administration of nitroglycerin
   e. Administration of dextrose without complete relief of symptoms (example: altered level of consciousness after second dose of dextrose)
18. Known blood glucose level greater than 400 mg/dL with symptoms of DKA (polyuria, polydipsia, nausea/vomiting, abdominal pain, weakness, dizziness, altered mental status, fruity-scented breath). BLS providers must request ALS unit for known blood sugar less than 60 mg/dL. ILS may treat blood sugar less than 60 mg/dL.
19. Any infant less than 90 days old with a reported incident of an Apparent Life Threatening Event (ALTE), regardless of the infant’s current status.
20. Vital signs requiring ALS evaluation:

<table>
<thead>
<tr>
<th>AGE</th>
<th>RESPIRATIONS</th>
<th>PULSE</th>
<th>BLOOD PRESSURE</th>
<th>Room Air Pulse Oximetry</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn</td>
<td>Poor cry</td>
<td>&lt;140</td>
<td>CRT &gt; 3 sec</td>
<td>&lt; 94%</td>
</tr>
<tr>
<td>&lt;1 year</td>
<td>&lt;30 or &gt;44</td>
<td>&lt;100 or 160</td>
<td>CRT &gt; 3 sec</td>
<td>&lt; 94%</td>
</tr>
<tr>
<td>1 – 4 years</td>
<td>&lt;20 or &gt;40</td>
<td>&lt;90 or 140</td>
<td>&lt;80 or &gt;110 systolic</td>
<td>&lt; 94%</td>
</tr>
<tr>
<td>5 – 11 years</td>
<td>&lt;16 or &gt;26</td>
<td>&lt;60 or 120</td>
<td>&lt;80 or &gt;130 systolic</td>
<td>&lt; 94%</td>
</tr>
<tr>
<td>12 – 15 years</td>
<td>&lt;10 or &gt;28</td>
<td>&lt;60 or 130</td>
<td>&lt;90 or &gt;140 systolic</td>
<td>&lt; 94%</td>
</tr>
<tr>
<td>Adults 16 years and older</td>
<td>&lt;10 or &gt;28</td>
<td>&lt;51 or &gt;130</td>
<td>&lt;90 or &gt;220 systolic OR &lt;140 diastolic</td>
<td>&lt; 94%</td>
</tr>
</tbody>
</table>

< means less than    > means greater than    CRT = capillary refill time
POLICY: Milwaukee County EMS providers will apply usual Standards of Care, Medical Protocols, Standards for Practical Skills, and Operational Policies set forth by Milwaukee County EMS to patients who have been subjected to the use of a conducted energy devices (also known variably as “conducted energy weapon”, “electric control device”, “electronic restraint”, “tazer”, “taser”, or “stun gun”).

I. Need for Medical Evaluation
A. Available scientific evidence suggests that not all patients subjected to a conducted energy device will require an EMS evaluation.
B. If requested/called by law enforcement, EMS providers will conduct a patient evaluation applying usual standards of care, protocols, skills, and policies.

II. Need for Transport to Receiving Hospital
A. Available scientific evidence suggests that not all patients subjected to a conducted energy device will require hospital evaluation.
B. Patients will be transported if any of the following situations apply:
   1. Any patient age 12 years or younger
   2. Pregnant patients greater than or equal to 20 weeks in gestation
   3. Any abnormality of vital signs (see Standard of Care – Normal Vital Signs, with the exception that adult blood pressure of over 160/100 or below 100/70 is considered abnormal in these circumstances)
   4. Use of more than 3 device shocks on a patient
   5. Barbs that have hit in the following areas
      a. Eyes/Orbits
      b. Neck
      c. Genitalia
   6. Significant trauma or mechanism of injury related to events before, during, or after device application (e.g. falls, MVC)
   7. Burns, if greater than mild reddening of the skin between the barbs
   8. Barbs that cannot be removed using usual methods (refer to Standards of Care – Conducted Energy Device Barb Removal)
   9. Persistent agitated behavior that is not responsive to verbal de-escalation
   10. History of coronary disease, CHF, cardiac arrhythmias, or AICD/pacer
   11. Other abnormal or unusual signs or symptoms persisting after shock (for example, numbness, paralysis, shortness of breath, chest pain, dizziness, loss of consciousness, profuse sweating, or others)
C. Patients will also be transported if, in the judgment of EMS or law enforcement, further evaluation is warranted.
D. Transport can occur at the level deemed appropriate by on-scene EMS personnel (follow usual protocols for BLS versus ALS level transport).
POLICY: Administration of controlled substances will be uniformly documented to accurately reflect usage. Controlled substances will be visually inspected for seal damage and volume discrepancies.

Perform visual inspection of controlled substance vials for seal integrity and appropriate volume

Any volume discrepancy?

Yes

Check medication for seal integrity and expiration date during the daily count

Any seal damage?

No

Yes

Any expired controlled substances?

No

Yes

Log daily count in Controlled Substance Monitoring System

Empty contents of drug vial into sharps container 2 paramedics required to complete this

Document on Controlled substance administration record: Vial #, date, time why drug was wasted (expired, broken seal, not used, etc.), amount given 0 and amount wasted (total dose in vial) Both paramedics must sign the record

Any volume discrepancy?

No

Notify Department Administration immediately for further instructions

Department Administration will notify EMS Administration of discrepancy

Open screen for study kit logging

Enter kit number, study name, fit for use, and save

Any study kits to be logged?

Yes

Administer controlled substance as ordered by protocol or medical control physician

Continue patient care and transport

Document on the controlled substance administration record: date, time of administration, patient name, amount of medication administered, and amount of medication wasted

Sign and have the controlled substance sheet co-signed by another member of the paramedic team

Return the controlled substance administration sheet to the Milwaukee County EMS offices after all medication vials have been accounted for
NOTES:

- MC EMS will perform routine visual checks as well as auditing each MED unit to assure documentation is complete and accurate.
- Records will also be reconciled with the FMLH pharmacy at the end of the year.
POLICY: Management of controlled substances within the Milwaukee County EMS system is a collaborative effort of several system stakeholders to ensure compliance with system and federal standards.
**Policy:** If the EMTs on scene determine that a patient may expire on scene if ALS treatment is delayed, the EMTs may opt to Load & Go transport the patient to the closest appropriate open medical facility.

- Routine medical care for all patients
- Determine patient requires ALS assessment and/or transport
- Determine patient may expire at scene if ALS treatment is delayed
- Request ALS unit and information regarding location from where unit is responding
- Initiate appropriate treatment, consistent with Milwaukee County EMS Policies & Procedures
- Prepare patient for transport
- Transfer patient care to MED unit
- MED unit on scene?
  - Yes
  - No
- Contact dispatch center for ETA of MED unit
- Wait for MED unit to transfer patient care
- Response time longer than transport time?
  - Yes
  - Consider ALS intercept
  - Transport to closest appropriate medical facility

**Notes:**
- Potential Load & Go situations exist if:
  - The patient has an uncontrolled airway
  - The patient is bleeding to death
  - The patient has penetrating trauma to the thorax or abdomen
  - The patient is experiencing complications of childbirth
- Documentation on the run report must support Load & Go transport decision
POLICY:

- All patients evaluated by the paramedic team will be monitored in accordance with the standards of care, policies and protocols of Milwaukee County EMS.

- Standard Lead II configuration will be used for initial evaluation and continuous monitoring of the ECG. A 12-lead ECG will be obtained and transmitted for any patient experiencing symptoms of suspected cardiac origin.

- A six inch or longer strip will accompany the patient to the hospital.

- ECG monitoring of a patient under the care of a paramedic team must be done by a licensed paramedic. BLS and other non-paramedic personnel may not be assigned nor assume responsibility to perform continuous ECG monitoring.

- Any change in rhythm will be documented on the run report and an attempt will be made to obtain a six inch strip of the new rhythm to be left with the patient at the hospital.

- The paramedic team will transmit an ECG “burst” to the Communications Base at the request of the medical control physician, and at least prior to:
  - Requesting a medical control physician for the call
  - Patient care intervention
  - Patient re-assessment (e.g. stop CPR)
  - Request to stop resuscitation efforts

- This policy does not exclude any patient from ECG monitoring or the paramedic team from transmitting an ECG burst to the Communications Base. Medical control should be contacted for medical orders when appropriate for symptomatic patients.
POLICY: Upon dispatch, a unit staffed as a dedicated ALS or as an ALS/BLS unit will contact the Milwaukee County EMS Communications Center by radio. Contact with medical control is to be made for medical orders not covered by protocol.

Paramedics may request medical control for advice in unusual circumstances e.g. refusal of care/transport, or when uncomfortable with or unsure of treatment options. ALS or ALS/BLS units transporting a patient without on-line medical control will provide appropriate medical information about the patient to the Communications Center for relay to the receiving facility. When paramedics need medical control or are ready to provide a report during transport, a frequency should be requested.

The ALS or ALS/BLS unit will notify the Communications Center of the disposition of the call, the patient’s report number and primary working assessment for every patient assessed, regardless of transport disposition.

ALS or ALS/BLS units responding to a fire call or potential mass casualty incident will notify the Communications Center and remain on the call-in channel unless otherwise directed by a communicator. If three or more ALS or ALS/BLS units are dispatched to a single event, one of the paramedics on scene will be designated to contact EMS Communications with the following information:

- Type of incident
- Location of incident
- # and severity of injuries
- ALS or ALS/BLS units on scene
- The designated unit personnel will provide updates at regular 15-minutes intervals, if only to report no change in situation status.
Universal Care:
EMS COMMUNICATIONS NOTIFICATION
Operational Policy

1. Notify EMS Comm by radio at time of response
2. Notify EMS Comm of arrival on scene
3. Fire or potential MCI call with at least 3 ALS/BLS units?
   - Yes: Designate a paramedic to remain in radio contact with EMS Comm
   - No: Report to EMS Comm: incident type, location, # and severity of injuries, EMS units on scene
4. Medical control requested?
   - Yes: Provide regular 15-minute updates if only to report no change in situation status
   - No:
5. If possible, provide case # and PWA while waiting for physician response
6. ALS transport?
   - Yes: Provide patient report, including case # and PWA, on assigned channel ASAP to allow communicator to provide adequate hospital notification
   - No: Notify EMS Comm of hospital arrival
7. Call back with patient name for medical control calls
Determine equipment failed/ needs repair

- Medical/radio equipment failure (Radio, monitor/defibrillator, glucometer)
  - Did failure affect patient care?
    - No
    - Can MED unit function without equipment?
      - No
        - Take unit out of service immediately after call and contact EMS Supervisor or Stores clerk for exchange and repair. If failure occurs after business hours or on weekends, call the Communications Center and request they contact the EMS Supervisor to arrange for exchange and repair.
      - Yes
        - Follow fire department procedures for exchange/repair
    - Yes
      - Notify the EMS Supervisor or Stores Clerk ASAP during business hours to arrange for exchange and repair

- Vehicle failure (engine, lights, siren, tires, etc.)
  - Follow fire department procedures for exchange/repair

NOTES:
- If it becomes necessary to change to a back-up vehicle, test all radios prior to changing to the new vehicle. Test radios again when returning to the repaired vehicle.
- The MED unit personnel are responsible for notifying the fire department that repairs or vehicle changeovers are being made.
- Equipment that is out of service or fails on a call should be documented on the run report in the appropriate section.
- Notify the Quality Manager with details of failures affecting patient care. The Quality Manager will file the necessary FDA reports.
Each paramedic unit is responsible for labeling all hardware (radios, monitors, splints, kits, etc.) in their inventory with their department and unit designation.

A current log of items which must be left with a patient at a hospital will be maintained by the paramedic unit and those items retrieved as soon as possible. The log should include the type of equipment, quantity, hospital location, date left, patient or run number and date retrieved.

When items are missing from the inventory, they are to be reported immediately to the appropriate fire department officer and to OEM-EMS Division as soon as possible but no later than the next regular business day.

Approved inventory lists for equipment and supplies are available from Milwaukee County EMS. A copy of the kit setup is required to be submitted and kept on file with Milwaukee County EMS on an annual basis. Any piece of equipment or supply not specifically included cannot be present on the vehicle or used by paramedics without the written permission of the Medical Director. Proposals to add new equipment must include in-service, evaluation and continuing education information and a fiscal impact statement.

Essential equipment must be on the paramedic unit and operational in order for the unit to be in service and respond to requests for emergency medical services. This essential equipment includes:

- Airway Kit
- Medication Kit
- Suction
- Oxygen Kit
- Stretcher
- Communications equipment (the cellular telephone on the 12 Lead may be used for emergency communications if the radio system fails)
- Monitor-defibrillator
POLICY: Milwaukee County Emergency Medical Services will request air ambulance transport utilizing the Wisconsin Helicopter Emergency Medical Services (HEMS) Guidelines:

A. HEMS utilization is a medical decision requiring appropriate oversight and should be integrated within regional systems of care.

B. HEMS may provide a time savings benefit to patients with time sensitive emergencies\(^1\) in reaching hospitals that can provide interventions IF the patient can be delivered during an interventional window\(^2\) and Ground Emergency Medical Services (GEMS) are not able to appropriately deliver the patient to definitive care within that interventional window.
   1. Examples include: Injured patients meeting the State of Wisconsin Field Trauma Triage Guidelines Category 2 or 3 who are more than 30 minutes of ground travel to the closest American College of Surgeons (ACS) verified Level I or Level II trauma center.
      a. HEMS utilization for mechanism of injury or special population alone (Category 4 or 5) lacks clear evidence of benefit. Since these patients may not need the resources of the highest trauma level facility in a region, use of HEMS should be carefully considered. Standing protocols or online medical consultation may offer individual guidance.
   2. Patients with acute STEMI needing transportation to a regional percutaneous coronary intervention (PCI) capable hospital where ground transportation exceeds an interventional window.

C. HEMS may provide clinical resources to patients needing critical care services if unable to obtain critical care services by ground emergency medical services (GEMS) (e.g., inter-facility transfer).

D. HEMS may provide a mode of transport for geographically isolated, remote patients independent of emergency medical urgency (e.g., from an island) although this mode should be carefully considered.

E. HEMS may provide a resource to local GEMS systems during disasters and times of low community resources.

F. HEMS have unique risks of transport, including economic.

G. Hospital destination and mode of transport are two separate and distinct clinical issues.

H. Mode of transport decisions pose unique challenges in developing evidence-based transport guidelines.

\(^1\)A time-sensitive emergency can be defined as an acute, life-threatening medical or traumatic event that requires a time-critical intervention to reduce mortality and/or morbidity. Examples include major systems trauma, ST elevation myocardial infarction (STEMI) and stroke.

\(^2\)An interventional window can be defined as the period of time during which mortality or morbidity is likely to be reduced by the administration of pharmaceutical agents, medical procedures or interventions. An interventional window should be based on available national consensus guidelines such as the American Heart Association’s first medical contact or door to balloon time. The “Golden Hour” of trauma refers to the core principle of rapid intervention in trauma cases, rather than the narrow meaning of a critical one-hour time period. There is no evidence to suggest that survival rates drop off after 60 minutes.
Universal Care: HELICOPTER EMS – STATE POLICY
Operational Policy

Assess scene and patient

Refer to WI HEMS Utilization Guidelines to frame the discussion about HEMS utilization

Ground transport to appropriate facility at appropriate provider level

Yes

Patient extricated prior to helicopter arrival?

Ground transport time more than 30 minutes?

No

Consider requesting air ambulance through fire department dispatch

Yes

PT requires critical care/ skill unavailable at scene?

Ground transport to appropriate facility at appropriate provider level

No

Universal Care: HELICOPTER EMS – STATE POLICY
Operational Policy

Monitor FD’s designated frequency for notification estimated time of arrival

Designate and set up landing zone in a smooth area, as level as possible with < 5 degree slope, clear of wires, trees, debris and other obstacles

Helicopter landing at night or when strong winds are a factor?

Yes

Consider illuminating landing zone, taking care to keep lights out of pilot’s eyes

No

Designate landing zone of 150 x 150 feet

Keep crowds at least 150 ft away from helicopter at all times

Anticipate request for a tail rotor guard assignment

No personnel running or smoking and no vehicles within 50 feet of aircraft

When signaling where to land, stand with your back to the wind and depart when helicopter is on final approach

NOTE: Rotor wash can produce high winds - PROTECT YOUR EYES!

Air medical personnel will coordinate all loading and unloading of patients and equipment

Approach aircraft from the front and downhill side only after signaled to do so by air medical crewmember; do not assist with opening or closing doors; carry all equipment below the waist

Transfer patient care to air medical crew

Clear area and return to quarters

NOTES: FFL response time is approximately 20 minutes from request to arrival at scene within Milwaukee County.
POLICY: Federal legislation and Wisconsin “confidentiality” laws rigorously protect patient health information. Both federal and State regulations must be followed to ensure patient privacy protection.

All EMS Provider agencies that are considered covered entities under the federal Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. parts 160 & 164) are required to become and maintain compliance with the HIPAA Privacy Rule, Security Rule and Electronic Data Exchange regulations. All Fire Departments in Milwaukee County and Milwaukee County EMS are considered covered entities.

As outlined by HIPAA guidelines, covered entity agencies will appoint a designated Privacy Officer and Security Officer to develop, distribute, and enforce policies and procedures for their staff on agency specific privacy and security practices and provide formal HIPAA training for all their staff.

Milwaukee County EMS endorses and expects all EMS Providers working under Milwaukee County Medical Direction to follow their Agency’s internal policies and procedures for privacy and security practices and receive HIPAA training. Any inadvertent, unintentional or negligent act which violates a patient privacy policy must be reported to their Agency’s Privacy Officer.

STEPS to ACHIEVING HIPAA COMPLIANCE:
1. Appoint and Document a HIPAA Compliance Officer
2. Conduct a Risk Analysis
3. Develop/Implement HIPAA Policies and Procedures
4. Train & Appropriately Sanction Workforce
5. Identify Your Business Associates & Enter into Agreements
6. Grant Patients their HIPAA Rights and Distribute Your Notice of Privacy Practices
7. Implement Administrative, Physical and Technical Safeguards
8. Respond Appropriately to HIPAA Violations & Breaches
9. Have a Complaint-Resolution Process
10. Comply with HIPAA Recordkeeping Requirements

HIPAA Resources for Agencies:
Free:
www.hhs.gov/ocr/privacy (U.S. Department of Health & Human Services)
http://hipaacow.org (Health Insurance Portability and Accountability Act Collaborative of Wisconsin)
Numerous Documents for Privacy, Security, Risk Toolkit
Privacy 101 Webinar
HIPAA Education ppt slides

Fee based:
Complete guide to compliance
Forms and Numerous Policy & Procedure Templates
HIPAA Training DVD
POLICY: This policy provides principles and decision-making guidance for patients, EMS providers and hospitals within the MCEMS system.

Guiding Principles

- EMS and health care systems will partner to ensure access to safe and high quality care.
- Patients have the right to make informed health choices including hospital destination within the Milwaukee County EMS System; care outside of an informed patient care choice may impact safety, quality and economic risks.

- *EMS System definition of Internal Disaster: Facility is closed due to internal disaster situation such as physical plant deficiency. In this case, an alternate destination is required.
- Internal Disaster is EMS System designation recognized by MCEMS as “closing” a hospital to ambulance transport.
**Scope of Practice** **may** include:
- Patients paralyzed and intubated
- Pre-administration of pain medication and/or antibiotics
- Blood products already administered

**Scope of Practice** **does not** include:
- Managing chest tubes
- Administration of blood products
- IV pumps
- Management of other medical devices

**POLICY:** Upon request, Milwaukee County ALS units will transport a patient from one emergency department (ED) or outpatient health care facility (OHCF) to another receiving emergency department within the Milwaukee County EMS System in accordance with System policies and procedures.

**NOTES:**
- Even though the patient appears stable and transport is for urgent continuing care (STEMI > Cath lab, trauma > Trauma Surgery, etc.):
  - Attempt to meet 10-minute door-in-door-out (DIDO) time standard, documenting any cause for delay in transport
- Milwaukee County Paramedics may not provide care outside the policies and procedures of Milwaukee County EMS Plan. Pertinent records that usually accompany the patient may include, but are not limited to lab and/or x-ray reports, ED treatment, and nursing notes.
POLICY:
The decision to utilize warning lights and siren transport with a patient on-board is a medical decision and will be determined by the judgment of the highest level provider attending the patient.

Warning lights and siren transport may be appropriate with time sensitive conditions (such as Code Stroke, Code STEMI, or patients meeting physiologic or anatomic criteria for Level I/II trauma center transport), impending or obstructed airway concerns not responding to EMS intervention, or other conditions where EMS intervention is unable to manage the patient condition with resources available based on clinical judgment.

Warning lights and siren transport should not be used for patients not described above.

Use of warning lights and sirens will be documented on the patient care record.

- Use of warning lights and siren is a medical decision.
- Use of warning lights and siren has safety implications to patients, providers and the public.
- Use of warning lights and siren transport to the hospital has little impact on patient care outcome.
- Use of warning lights and siren saves very little time based on scientific literature.
- The provision of ALS care and mode of transport are independent; one does not necessarily determine the other.
- Traffic conditions should not be a determining factor in absence of a truly life-saving or time sensitive emergency.
- Mode of transport is an important tool in developing a culture of patient safety.
POLICY: Deceased patients will be managed in a professional and respectful manner, to meet the needs of the community, under the guidelines developed in conjunction with the Milwaukee County Medical Examiner’s Office.

DEFINITIONS:
Resuscitation attempt: Initiation of basic or advanced life support procedures in an attempt to reverse cardiac arrest of medical or traumatic origin. These procedures include, but are not limited to, CPR, placement of an advanced airway, cardiac monitoring/defibrillation.

Suspicious death: Patient’s death is considered to be from other than natural causes, including suspected sudden infant death syndrome (SIDS), crimes, suicide, and accidental death.

Non-suspicious death: Patient’s death is apparently due to natural causes.

Potential crime scene: A location where any part of a criminal act occurred, where evidence relating to a crime may be found, or suspicions of a criminal act may have occurred.

PROCEDURE:
Resuscitation will be initiated on all patients in cardiac arrest, unless one of the following conditions is met:

- Decapitation
- Rigor mortis
- Tissue decomposition
- Dependent lividity
- Valid State of Wisconsin Do-Not-Resuscitate order or Physician Orders for Life-Sustaining Treatment
- Fire victim with full-thickness burns to 90% or greater body surface area

A patient may be pronounced en route to a hospital if condition warrants. In such case, the destination should be changed to the Medical Examiner’s Office. 

EMS unit should notify the Medical Examiner prior to redirecting transport.

The EMS unit (ALS or BLS) responsible for assessing (no resuscitation attempted) or treating (resuscitation attempted) shall call the Medical Examiner’s Office to provide a firsthand account of the scene and patient history before leaving the scene.

If the Medical Examiner’s Office cannot be reached, the ME has requested that at a minimum the following information should be left on the ME phone message:

- Date
- Name of EMS provider calling
- EMS vehicle number
- Patient’s name
- Patient’s age
- Pronouncing physician name (OLMC or EMS Medical Director’s name) if resuscitation was attempted
- Time patient was pronounced if resuscitation was attempted
For a potential crime scene:

- Notify law enforcement if not already involved.
- Include potential crime information in report to Medical Examiner’s Office.
- Observe, document and report to law enforcement anything unusual at the scene.
- Protect potential evidence
  - Do not “clean up” the body
  - Leave holes in clothing from bullet or stab wounds intact
  - Do not touch or move items at the scene
  - Observe, document and report to law enforcement and the Medical Examiner’s Office any items disturbed by EMS at the scene
- Turn the body over to law enforcement
- Law enforcement has the legal responsibility to maintain scene integrity

For all other patients:

- Do not remove lines or tubes from the deceased
- Do not “clean up” the body
- Do not disturb the scene
- If covering the body, use only a clean, disposable blanket

Disposition of the body:

- Do not leave the body unattended
- The body may be turned over to law enforcement, which has the legal responsibility to maintain scene integrity
- If approval is granted by the Medical Examiner’s Office, the body may be turned over to a funeral home
- If the resuscitation attempt took place in the ambulance, include the information in your report and transport to the Medical Examiner’s Office at 933 West Highland Avenue
  - Do not transfer the body to another transport vehicle unless the municipality would be left with no available responding ALS unit; refer to individual municipal policy
  - If the death is considered suspicious, a police officer or detective may accompany the body in the ambulance to the Medical Examiner’s Office to maintain integrity of evidence
- Transport to a funeral home shall be determined by individual municipal policy

Documentation:

A patient care record will be completed for all deceased patients. Documentation will include:

- Pertinent information regarding patient’s known medical history.
- Treatment provided; if no treatment was provided, the reason for not initiating a resuscitation attempt.
- The time of determination not to initiate resuscitative measures, or the time CPR was discontinued

A copy of the patient care record is to be forwarded to the Medical Examiner’s Office.
Universal Care: MASS CASUALTY TRIAGE Practice Guideline

Determine patient needs outnumber readily available resources

If possible, estimate total number of Immediate/Red, Delayed/Yellow, and Minimal/Green patients and relay information to the EMS Communications Center

1st ALS unit on scene?

- Yes
  - Establish EMS Branch (as directed by Incident Commander)
  - Paramedic Officer or Team Leader?
    - Yes
      - Take assignment as Triage Officer
    - No
      - Most senior paramedic?
        - Yes
          - Assist Triage Officer or other team as assigned
        - No
          - Contact EMS Communications and Incident Command with following data:
            - # and severity of injuries
            - exact location and type of incident

- No
  - Report to Staging

EMS Communications will request area hospitals update bed availability on WiTrac

Contact EMS Communications and Incident Command with following data:
- # and severity of injuries
- exact location and type of incident

Assign as needed:
- Triage Officer
- Transport Officer
- Staging Officer
- Minimal/Green Team officer

Report initial hospital bed count to transport officer

Maintain communications with and report to Incident Commander as necessary

Maintain communications with the EMS Communications Center to update hospital bed availability

Initiate triage protocol

Attach severity ID tag to wrist or ankle of each patient and move to appropriate zone

Re-triage as necessary if patient condition changes

Package for transport

NOTES:
- Utilization order of EMS resources is:
  - Local EMS agency and mutual aid units (including air ambulances)
  - Zone resources (MABAS)
  - Activation of Milwaukee County Disaster Plan (Annex H-3) may be requested by Incident Commander through Milwaukee County Emergency Management
  - Refer to individual fire department disaster/multi-casualty incident position descriptions for further specific duties.
  - Refer to the S.A.L.T. Triage standard of care for patient assessment.
  - BLS transport units should use MCI ambulance to hospital communication protocol.
  - EMS units should report back to staging after transport until released by the Incident Commander.
The MACC must be completed prior to the administration of any medication.

If a discrepancy, disagreement, or need for clarification is encountered at any step in the process, it MUST be resolved prior to continuing the cross-check.

If there is an interruption or change in patient condition of any kind, the process must be re-initiated by Provider 1.

**Contraindications** include:
- Expiration date
- Known patient allergies
- Verification of appropriate vital signs

Avoid ambiguous statements of confirmations like ‘okay.’

Essentially only Provider 2 can authorize the administration of the medication.

**RED RULE of Medication Administration**

(A Duty to Avoid Causing UNJUSTIFIABLE Harm)

NEVER give the contents of a syringe that is not labeled or without visualizing the vial or ampule from which it was immediately drawn!
POLICY: The patient care record narrative will provide a complete picture of the patient presentation, pertinent findings, pertinent negatives, ongoing development of the patient care event, care and treatment provided and condition at end of call.

GUIDELINES: The intent of writing a narrative documentation is to tell a story that can be completely understood by people who were not present at the scene. Narrative documentation should provide a clear and concise, yet thorough explanation of what occurred at the scene of the call. Document an unbiased and factual description of the call. Make sure all check boxes or electronic screen choices match documentation made in the narrative section of the PCR. Use a systematic approach, a good PCR should be written with the same systematic approach that is used for the patient assessment. Include critical information and document care chronologically.

Sample guideline for Narrative Documentation:
1. Found (age & sex of patient) in (position) complaining of____________.
2. Since (duration).
3. States chief complaint began (time).
4. Precipitating factors
5. List interventions by patient/family & results
6. Describe signs & symptoms and assessments which are not mentioned previously in record.
7. Describe treatments not already mentioned in record: patient treated with ______ or treated as above.
8. List responses to treatments if not already mentioned.
10. List any problems which may have occurred as a result of your interventions.
11. Patient transported in (position) to what hospital and with/without lights/siren, if not already mentioned.
13. Document status of patient upon admission to emergency department. Include comments of any "significant findings" which the patient was treated for, ex: Upon admission to ED, patient ________.
14. After narrative is written it – READ IT. Check for accuracy AND consistency.

A narrative in conjunction with other data fields in the PCR should clearly provide the patient assessment information below:

Guidelines for Assessment/Interview:
1. Name:
2. Age:
3. Chief Complaint:
4. Onset/Duration:
5. Precipitating Factors:
6. Interventions by Patient:
7. Associated Symptoms:
8. Medical History:
9. Allergies/what kind:
10. Vital Signs - Blood Pressure, Pulse and Respirations:
11. Breath Sounds:
12. Pupils:
13. Skin:
14. Neck Veins:
15. Mental status:
16. Initial Physical Exam:
17. Decide on what Primary Impression is and how the patient will be treated.
Universal Care: 
NEW PRODUCT EVALUATION 
Operational Policy

This guideline is intended to provide EMS personnel of the Milwaukee County EMS System with a mechanism for objective evaluation of contemporary EMS equipment proposed for addition to the inventory of the paramedic unit:

Only two (2) product evaluations may be in progress at a given time.

Every attempt will be made for product evaluation to rotate through all paramedic units on a cyclical basis.

Whenever possible there will be at least one (1) suburban paramedic unit and one (1) Milwaukee paramedic unit evaluating a product for each evaluation period.

Paramedic units will have the proposed equipment for at least one calendar month to evaluate the product.

The product being evaluated should not replace an existing item on the ambulance. If a problem arises, the previous existing item should be immediately available.

Each shift of paramedics will complete the short evaluation form at the end of the evaluation period.

At the end of the evaluation period, the paramedic units will return the product and evaluation forms to the OEM-EMS Division.

The units involved will make every effort to safeguard the item being evaluated.

The results of the evaluation will be reported to all personnel at the next regularly scheduled Continuing Education Conference.

If a paramedic unit would like a product evaluated, a Request of Product Review will be submitted to Milwaukee County EMS.

The paramedic unit requesting the product evaluation should be one of the units participating in the evaluation.
POLICY:

Milwaukee County EMS Advanced Life Support providers will establish on-line medical control whenever:

- Directed by the MCEMS Standards and Practice (S&P) Manual
- Special circumstances not specifically outlined in the S&P manual arise, requiring emergent medical advice, opinion, or orders
- Deteriorating patient conditions do not improve with protocols

Circumstances may arise where there is an inability to carry out an OLMC order, e.g. the provider feels the administration of an ordered medication would endanger the patient, a medication is not available, or a physician’s order is outside the protocol:

- The prehospital provider must immediately notify the consulting physician why the order cannot be carried out
- The prehospital provider must initiate the MCEMS Quality Assurance process as soon as practical following the call (same shift) by calling the EMS Incident Line at (414) 257-6660.

Circumstances may arise where the OLMC physician provides orders for extraordinary care. In rare cases, a physician providing on-line medical consultation may direct a prehospital provider to render care that is truly life-saving, not explicitly listed within the protocols, but within the Wisconsin EMS Scope of Practice guidelines for the provider’s level of EMS licensure:

- During the consultation, the physician and prehospital provider must acknowledge and agree that the patient’s condition and extraordinary care are not addressed elsewhere within these medical protocols and the order is absolutely necessary to maintain the life of the patient.
- The prehospital provider must feel capable of correctly performing the care directed by the consulting physician, based on the instructions given by the consulting physician.
- The prehospital provider must inform the consulting physician of the effect of the treatment and notify the receiving physician of the treatment upon arrival at the hospital.
- The prehospital provider must initiate the MCEMS Quality Assurance process as soon as practical following the call (same shift) by calling the EMS Incident Line at (414) 257-6660.

Circumstances may arise where the prehospital provider may not be able to contact an OLMC physician because of a radio or other communication failure:

- The prehospital provider must attempt to contact the MCEMS EMSCOM center by direct telephone.
- The prehospital provider must provide care as outlined in the S&P manual.
- The prehospital provider must not provide care exceeding the training certification or scope of care of the EMS provider as outlined by the MCEMS Operational Plan or State of Wisconsin EMS guidelines.

Care under exceptional circumstances (mass casualty or other disaster) will be addressed in a separate policy/guideline.
POLICY:

- EMS providers may only provide care within their approved scope of practice regardless of an on-scene physician directive; care beyond scope of practice must be performed by the physician.
- Telephone directives from a personal physician are not valid. The physician is welcome to call EMSCOM and speak to an on-line medical control physician.
- A valid Wisconsin State approved DNR or POLST form may be followed provided it is within the scope of practice for the EMS provider.

The on-scene physician MUST:

- Provide valid WI medical license or other valid physician identification
- Agree to assume complete responsibility and liability for care
- Agree to accompany patient to the hospital and transfer patient to a receiving physician
- Perform any orders not within the scope of training for the EMS provider
- Sign all orders on the EMS patient care record

If physician refuses any of the above, call on-line medical control for assistance at 414-278-4343

Speak to MCEMS on-line medical control to discuss additional care requests by calling 414-278-4343
**POLICY:** Milwaukee County EMS is responsible for maintaining accountability and will document any and all discrepancies in tracking controlled substances.

1. Fire department identifies out-of-balance controlled substance.
2. Conduct internal search in attempt to locate missing drug.
3. Missing drug found?
   - **NO**
     - Notify EMS Supervisor, Program Director, and Medical Director immediately of discrepancy.
     - Remove remaining vials and corresponding control sheet from drug box.
     - Complete Controlled Substance Out-Of-Balance Form and forward with remaining vials and control sheet to MC EMS offices.
     - Begin collection of written documentation including:
       - Who noticed drug missing; when it was noticed missing; when last count balanced; results of interviews of all staff working since last balanced count.
     - Complete a conclusion report with process and findings of the investigation; remediation plan including how to prevent future occurrences.
     - Forward copies of all documentation to MC EMS offices.

   - **YES**
     - Notify appropriate law enforcement agency and follow additional instructions provided.

4. Missing more than 1 dose from 1 incident?
   - **NO**
     - MC EMS will attach a copy of the Out-Of-Balance report to the controlled substance tracking sheet and forward to the pharmacy.
     - Forward a copy of the documentation to the Quality Manager for incident logging purposes.
     - All documentation will be filed by the Stores Clerk in the Controlled Substance Tracking File.

   - **YES**
     - The Medical Director or Program Director may request reporting to the appropriate law enforcement agency.

**NOTE:**
- The Medical Director or Program Director may request reporting to the appropriate law enforcement agency.
Purpose:
- To standardize the mechanism by which individuals from EMS systems outside Milwaukee County can request clinical experience within the Milwaukee County EMS System
- To define the procedure for in-field observation by eligible parties

Eligibility: (any of the following)
- Employees/members in good standing with a licensed Ambulance Service Provider who delivers Advanced Life Support prehospital care within a State or regional approved plan in a political subdivision outside Milwaukee County. Applications are accepted only from a state licensed EMS Provider or state certified EMS Education Center on behalf of the individual (individuals may not independently apply for training).
- Licensed physicians and medical students involved in emergency medical care and/or medical control.
- Other medical professionals, including but not necessarily limited to registered nurses and physician assistants, who have an active role in the delivery of emergency medical care.
- Individuals engaged in current research in emergency medical care.

Experiences available:
- Initial instruction (didactic and clinical experience) for Emergency Medical Technician--Paramedic or -- Advanced
- Refresher (continuing education) course for licensed paramedics
- Customized educational programs with content developed as requested by the employing agency
- Supervised field experience with operational EMS unit
- Ride-along (non-participatory) with operational EMS unit

Prerequisites:
- Approval by the Milwaukee County EMS System Program and/or Medical Directors.
- Valid Wisconsin license or training permit as EMT-B, EMT-A, or EMT-P for participatory experiences.
- Contractual agreement between parent organization and Milwaukee County for participatory experience.
- Transfer of Medical Control to Milwaukee County System for the duration of the participatory experience.
- Signed waivers from parent organization and participants.
- Release of academic information waivers from participants for educational programs.
- Proof of injury and liability insurance (Worker's Compensation and malpractice).
- Agreement that non-instructional expenses (i.e., books, personal educational materials, travel, lodging and meal costs) are the responsibility of the participant/parent organization.
- Proof of meeting clinical sites’ communicable disease requirements.

Application process for participatory experiences
- Written request for experience sent to the Milwaukee County EMS System Program Director by authorized administrative officer of parent organization.
Universal Care:

OUTSIDE EMS STUDENT PARTICIPATION:

Operational Policy

Agreement on the terms of the experience, including:
- Dates and times of the experience
- Type of experience (didactic, clinical, field)
- Cost to the parent organization. Milwaukee County Statutes require that outside educational offerings must be financially self-supporting.
- Development of appropriate objectives and content of the experience.
- Agreement of participation from the Chief of the hosting Milwaukee County Fire Department, including any costs to the Education Center/student.
- Signed contract returned to Milwaukee County EMS Program Director.
- Receipt of documentation of prerequisites.

Educational sessions
- Assignment of appropriate instructors and support personnel.
- Orientation of the participant(s), including baseline evaluation as needed (e.g. pretest, IV skill station, etc.). Cost of any orientation session must be included in the original negotiated price with the employing department.
- Presentation of the content.
- Evaluation of the participant(s).
- Evaluation/feedback by the participant(s) of the presentation.

Completion of the educational session
- Notification of completion sent to the parent organization.
- Submission of student evaluations to the parent organization.
- Final bill forwarded to the parent organization.
- Receipt and deposit of tuition payment.

Ride-along observations:
- Individuals who wish to ride with operational paramedic units on an observation-only (non-participatory) basis should submit a request to the Program Director of the Milwaukee County EMS System.
- Ride-along observations are for educational purposes only. Applicants should state clearly in their request the objectives of their experience.
- Ride-along observations by students from a course charging tuition will be assessed a fee, proportional to the total hours of the course. The actual fee will be negotiated (prior to the start of the experience) by the Program Director or his/her designee.
- Permission must be granted by the Chief of the hosting Fire Department.
- All requirements of the hosting fire department must be met:
  - Proof of Worker’s Compensation and liability insurance.
  - Signed waivers from the individual and his/her employer.
- Date, time and unit assignments are coordinated through the Milwaukee County EMS Education Center. Priorities are assigned based on the educational need(s) of the observer and the constraints of the EMS system.
An intern must serve a minimum of 6 months on an ALS transport unit to be eligible for Full Practice Status. At 5 months, the intern paramedic report will be created to give the Fire Department and OEM an overview of the intern’s status and performance within the system.

**Meaningful Evaluations:**
- Detailed comments to include:
  1. Types of runs
  2. Performance as Team Lead
  3. Strengths/Weaknesses
  4. Goals for next shift
  5. Equipment competency
  6. Documentation

**Individual vs. System Performance Report**
- Call Types
- Skills Performance
- Run Volume

**Quality Assurance:**
- Protocol Deviations
- Kudos/Complaints
- High Profile / High Risk Run

**FD Recommended Action Plan**
- Suggestions to make intern successful

**Simulation:**
- Intern must act as Team Lead:
  1. Hands on assessment
  2. Develop working assessment
  3. Directs all team members
  4. Develop treatment plan
  5. Perform treatment interventions
  6. Provide radio report
  7. Choose appropriate destination
  8. Provide hand off report
- Intern Paramedic Report drives simulation type
- May use any reference material normally available

**Portfolio:**
- Evaluations
- System Performance Report
- Attestation Letter
- Simulation Performance

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Initiated: 02/07/2018
Reviewed/Revised:
Revision

Approved: M. Riccardo Colella, DO, MPH, FACEP
Approved: EMS Division Director Kenneth Sternig, RN

Page 1 of 1
Initial onboarding request may be emailed from FD Admin to OEM EMS Education manager

Onboarding Files:
1. All necessary documents
2. Competency evaluations
3. Attestation letter(s) from EMS liaison
4. Competency evaluation
5. Medical Dir recommendation

Intern Target Solutions Assignments
- Protocols
- Last CE review
- Recent OEM Numbered Notices

Competency Evaluations:
- Scenario Simulation
- Protocol Review Exam
- Medical Director Interview

FD Responsibility
- Initiate onboarding request
- Submit registration form
- Review & readiness for evaluation
- Schedule evaluation
- Attestation letter(s)
  - FD member in good standing
  - Positioned to succeed
  - Studied, trained, prepared
  - FD supports member
- Facilitates remediation plan
- Confirm intern status in ePCR
- OPIQ account/fingerprinting

OEM:
- Creates TS account and files
- Confirms all documents in TS folder
- Notifies RRC
- Confirms TS assignment completion
- Notifies Medical Director of onboarding request
- Confirms evaluation scheduling
- Completes evaluation results
- Assists with remediation plan
- Completes affiliation in e-licensing
- Creates paramedic number
- Mails credential letter confirming Intern Paramedic Status

*NOTE: Applicants must obtain NREMT-Paramedic certification within 6 months of establishing OEM-EMS Paramedic Intern status.
POLICY: Prior to the application of restraints – physical and/or chemical - a patient must meet the following criteria:

- Excited delirium/agitation
- Immediate threat of harm to self or others

1. Protect patient, family, bystanders and EMS personnel from potential harm
2. Evaluate situation to determine the need for police presence; obtain additional help as necessary
3. Routine medical care for all patients
4. Attempt to rule out medical cause for patient's abnormal behavior (AEIOU-TIPS V)
5. Evaluate for and document suicide potential
6. Maintain non-threatening attitude toward patient
7. Attempt verbal de-escalation prior to restraining patient
8. Apply restraints as necessary without causing vascular or neurological compromise
9. Assess respiratory status frequently
10. Assess pulse quality, CRT, color, and CMS of restrained extremities at least every 15 minutes
11. Transport patient in left lateral lying position to appropriate facility
12. Rapid restraint criteria met?
13. Physical
14. Chemical
15. Yes
16. Contact medical control for additional doses as needed
17. Monitor respiratory status
18. Transport to appropriate facility
19. No
20. Routine care and transport to appropriate facility

AEIOU-TIPS V
A - Airway, alcohol, arrest
E - Epilepsy, electrolytes, endocrine
I - Insulin
O – Overdose, oxygen depletion, opiates
U – Uremia (chronic renal failure)
T - Trauma, tumors, temp
I - Infection
P - Psych, pseudoseizures
S - Syncope, shock, stroke, sickle cell crisis
V - Vascular, inadequate blood flow

Ketamine
1mg/kg IV; dilute 1:1 with NS; max dose 100 mg
3mg/kg IM; do not dilute; max dose 300 mg

Midazolam
1 - 2 mg IV, IM, IN;
May repeat one additional dose of Midazolam 1 - 2 mg IV, IM, IN
NOTES:

- Intranasal administration of Ketamine is not an option
- Use the least restrictive or invasive method of restraint necessary
- Chemical restraint may be less restrictive and more appropriate than physical restraint in some situations
- Documentation of need for restraint must include:
  - Description of the circumstances/behavior which precipitated the use of restraint
  - A statement indicating that patient/significant others were informed of the reasons for the restraint and that its use was for the safety of the patient/bystanders
  - A statement that no other less restrictive measures were appropriate and/or successful
  - The time of application of the physical restraint device
  - The position in which the patient was restrained and transported
  - The type of restraint used
- Physical restraint equipment applied by EMS personnel must be padded, soft, allow for quick release, and may not interfere with necessary medical treatment
- Spider and 9-foot straps may be used to restrain a patient in addition to the padded soft restraints.
- Restrained patients may NOT be transported in the prone position
- EMS providers may NOT use:
  - Hard plastic ties or any restraint device which requires a key to remove
  - Backboard or scoop stretcher to "sandwich" the patient
  - Restraints that secure the patient's hands and feet behind the back ("hog-tie")
  - Restraints that interfere with assessment of the patient's airway.
- For physical restraint devices applied by law enforcement officers:
  - The restraints and position must provide sufficient slack in the device to allow the patient to straighten the abdomen and chest to take full tidal volume.
  - Restraint devices may not interfere with patient care.
  - An officer must be present with the patient AT ALL TIMES at the scene as well as in the patient compartment of the transport vehicle during transport
- Side effects of Midazolam may include respiratory depression, apnea, and hypotension.
- Side effects of Ketamine may include excessive salivation, hypertension, tachycardia, hallucination
PURPOSE:  Body-worn cameras (BWC) will be used by the Milwaukee Police Department and the Milwaukee County Sheriff’s Office beginning September 2015. Additional law enforcement agencies will likely add these devices in the future. They are used to assist Officers in the performance of their duties by providing an accurate and unbiased recording of interactions between police members and the public.

INFORMATIONAL:  During the course of activation, these recordings may also capture EMS patient activities. The recordings are owned by the law enforcement agency and therefore are subject to the Wisconsin Open Records Law. Law enforcement agencies are not considered covered entities under HIPAA or covered by Wisconsin patient health care confidentiality laws. Milwaukee County Corporation Counsel’s opinion was requested concerning EMS rights and police body-worn cameras. Their opinion is outlined below.

1. EMS may not impede law enforcement duties by activation of BWC by citing HIPAA or other concerns.
2. By necessity, confidentiality issues must be addressed after the fact for those occurrences.
3. Where a patient is receiving medical care and does not pose a likelihood of immediate law enforcement intervention, EMS could request that the officer de-activate the BWC. However, this is dependent upon the severity of patient’s medical condition and the officer’s judgement of whether circumstances merit activation of the BWC, including the potential that the person may abscond.
4. If the patient is in custody and being investigated, EMS cannot and should not intervene in law enforcement duties regarding activation of the BWC.
5. Both MPD and MC Sheriff’s Office have policies in place to address privacy issues. MPD states BWC’s will not be activated “in a place where a reasonable expectation of privacy exists...” and accidental recording may be deleted before the retention period expires at the Chief’s discretion. The MC Sheriff’s Office policy contains a provision for deletion requests as well.

RECOMMENDATIONS:
1. Perform EMS business as usual.
2. Apply safety precautions first.
3. Protect the patient’s privacy, if able. Currently if sensitive patient healthcare issues need to be discussed, EMS may ask the Officer to step away for privacy. Continue to do so, however, the Officer always has the discretion to comply or not.
4. Any EMS event may potentially be recorded by the public as well, necessitating professionalism at all times.
5. Quality documentation is more important than ever in caring for your patient as well as protecting yourself.
POLICY: A potential crime scene is defined as a location where any part of a criminal act occurred, where evidence relating to a crime may be found, or suspicions that a criminal act may have occurred.

Assure scene safety before entering

Care for the patient(s) as necessary to sustain life, disturbing the scene as little as possible

Notify law enforcement if not already involved

Observe, document and report to law enforcement anything unusual at the scene

**Protect potential evidence:**
- leave holes in clothing from bullet or stab wounds intact
- do not touch or move items at the scene unless necessary in the delivery of care

Observe, document and report to law enforcement any items disturbed by EMS at the scene

Observe, document and report to law enforcement any items disturbed by others at the scene

If a death occurs as a result of a crime, turn responsibility for the body over to law enforcement as soon as the death is declared

Do not “clean up” the body after resuscitation attempts have failed

Document patient care provided or reason for not rendering care

NOTES:
- Cooperate with police for information gathering at scene, such as:
  - Disruption of scene by EMS personnel or others
  - Names of responding EMS personnel
  - Medical care provided to the patient
- All documentation is to be noted in objective terms
- Patient's or bystanders' statements are to be put in quotes
- Avoid documentation not relevant to patient care
- The patient care record is a legal document and will be used in court
- The patient care record is confidential and protected by state statutes
Policy: All EMS patient care providers receiving medical oversight by and contracted to operate in the Milwaukee County EMS system must request and be granted practice status and privileges by the Milwaukee County EMS Medical Director.

I. Minimum qualifications
   A. Be an active member in good standing of an agency under contract to provide EMS services
      1. Candidates may not have a current or pending disciplinary action or suspension
      2. Candidates are required to sign waivers permitting the EMS Medical Director to review employment and disciplinary files
      3. Provide verification of an acceptable Caregiver’s Background check
      4. Provide documentation of the lack of potentially communicable disease (i.e. up to date recommended immunizations; see new student policy)
   B. Have a current State of Wisconsin EMT-P, EMT-A, or EMT-B license and meet all applicable State rules and regulations.
   C. After September 1, 2010, all Paramedics new to the system must have and maintain NREMT certification.
   D. ALS providers must present a certification of completion for the Human Participants Protection Education for Research Teams online course, sponsored by the National Institutes of Health.

II. Minimum competency
   A. Clinical Evaluation
      1. Produce documentation that meets or exceeds Milwaukee County EMS Education Center level-appropriate course work and skill competencies
      2. Successfully complete an ALS content evaluation by a member of the Milwaukee County EMS Education Center faculty.
      3. Demonstrate competent level-appropriate, scope of practice during observation by a member of the Milwaukee County EMS Education Center
   B. Demonstrate competent level-appropriate EMS patient care knowledge and safe patient management during a verbal examination by the Milwaukee County EMS Medical Director

Graduation from the Milwaukee County EMS Education Center satisfies all minimum qualifications and competencies

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FOR THE FULL PRACTICE EMS PROVIDER

The full-practice EMS provider is defined as: An EMS provider who routinely provides patient care in the Milwaukee County System. An example of full-practice is the full-time municipal fire department paramedic.

Full Practice ALS Providers

- Demonstrate skill proficiency by meeting or exceeding yearly psychomotor skills competencies established by the Medical Director. Individuals with inadequate experience opportunities to maintain skill proficiency (as determined by the Medical Director) may be required to obtain additional educational experience in a manner prescribed by the Medical Director.

- While assigned to an active paramedic unit, all paramedics must rotate through all patient care assignments on a regular basis, spending an equivalent amount of time in each position. Assignment to the positions is designated by Fire Department administration and monitored by Milwaukee County EMS.

Non-practicing ALS Providers

The non-practicing paramedic is defined as: A paramedic who does not provide ALS care in the Milwaukee County EMS system but whose work contributes directly to the benefit of the system. An example of a special reserve paramedic is one who has attained a supervisory or administrative position. The Non-practicing Paramedic:

- Must have attained at least 2 years of full-practice status or its equivalent.

- Receives prior authorization from the medical director prior to providing ALS care.
Intern ALS, EMT-A, and EMT-B Providers
The Intern EMS Provider is defined as: A provider who has not previously had full practice status in the Milwaukee County EMS system. Examples would be new Milwaukee County EMS Education Center graduates and transfer paramedics, regardless of years of experience. “Transfer EMS provider” is defined as any individual whose initial training did not occur at the Milwaukee County EMS Education Center.

An ALS provider will be referred to as an “Intern Paramedic” until he or she has met both of the following criteria:

- Completed 12 months with a minimum of 2400 shift work hours on a transporting MED Unit AND
- Achieved 50% of the 2-year skill and performance benchmarks.

The Intern Paramedic may only provide ALS patient care if accompanied by a full-practice paramedic.

An EMT-Advanced provider will be considered an intern until performance benchmarks are achieved.

An EMT-Basis provider will be considered an intern until successfully completing their probationary period with the employing EMS agency.

FOR THE GRADUATE PARAMEDIC

A Graduate Paramedic is defined as: An individual who has successfully completed a paramedic education course, has taken the NREMT-P certification examination, and is awaiting the results of the examination.

A graduate paramedic has privileges consistent with a paramedic student. The Graduate Paramedic may perform ALS procedures when accompanied by two licensed paramedics, one of whom must have full practice privileges AND at least two years of experience.
INTERRUPTED OR CHANGE IN PRACTICE PRIVILEGE

Any interruption or change in work schedule that may affect a paramedic's practice status must be reported immediately to the Program Director of Milwaukee County EMS. Examples include but are not limited to: injury, illness, family leave, retirement, or change of employer.

Paramedics who have not been active within their classification for a period of more than 90 calendar days must contact the Education Manager at the Milwaukee County EMS Education Center prior to returning to patient care duties to evaluate content EMS provider may have missed and to discuss meeting to remediate on missed content/ new policies/new equipment etc..

Paramedics who have not been active within their classification for more than 1 calendar year must successfully complete an ALS content evaluation including an infield observation by a member of the Milwaukee County EMS Education staff.

If the interruption from service was due to injury or illness, the paramedic must present documentation that he or she has been medically approved to return to active duty prior to any evaluation by Milwaukee County EMS.

REINSTATEMENT OF PRACTICE PRIVILEGE

Paramedics who have not been active on a paramedic unit for a period of more than ninety (90) calendar days must be re-evaluated by the Milwaukee County EMS Education Center. The medical director will determine the individual's status and practice privilege prior to reassignment to a paramedic unit. For individuals who have not been assigned to the paramedic unit secondary to illness or injury, the paramedic must also present documentation that he/she has been medically approved to return to active duty prior to any evaluation by Milwaukee County EMS.

Paramedics who have not been active on a paramedic unit for a period of more than one (1) calendar year must successfully complete an ALS Content evaluation including an infield observation by a member of the Milwaukee County EMS Education staff and satisfy any State requirements regarding licensure prior to reassignment to a paramedic unit. For individuals who have not been assigned to the paramedic unit secondary to illness or injury, the paramedic must also present documentation that he/she has been medically approved to return to active duty prior to any evaluation by Milwaukee County EMS.

The medical director reserves the right to assign the practice privilege.
- **WI Statute Chapter 51** (State alcohol, drug abuse, developmental disabilities and mental health act) provides legal procedures for voluntary and involuntary admission, treatment and rehabilitation of individuals (adults and minor children) afflicted with mental illness, developmental disability, drug dependency, or alcoholism.

- **WI Statute Chapter 55** (Protective services system) provides legal procedures for emergency protective placements if it is probable that an individual is incapable of providing for his or her own care or custody so as to create a substantial risk of physical harm to himself, herself or others if protective intervention is not immediately taken.
  - In Milwaukee County on an authorized Emergency Assistant (EA) or a Milwaukee County Adult Protective Services (APS) worker may detain the person at an appropriate facility and initiate an emergency protective placement.
  - Milwaukee County EA/APS will contact EMS or the local police department to transport as needed under authority of Chapter 55 Emergency Detention Process

```
Yes

Transport patient as directed by authorities

No

Patient under Chapter 51 custody or detention?

Yes

Obtain and thoroughly document informed consent for refusal of transport

No

Request police response for possible Chapter 51 custody or detention

Patient under Chapter 55 custody or detention?

Yes

EA / APS worker will show identification and identify patient is under Chapter 55 custody or detention

No

Immediate concern for patient’s / other’s safety?

Yes

Transport patient as directed by authorities (EA/APS worker will accompany patient to hospital)

No

Obtain and thoroughly document informed consent for refusal of transport
```

**Notes:**
- For patients 60 years and older, contact Milwaukee County Department on Aging at 414-289-6874
- For patients under 60 years of age, contact Milwaukee County Disability Services Division at 414-289-6660
Patient Care Goals:
1. Protect patient autonomy while ensuring safety.

Patient Presentation:
Inclusion Criteria
Decision-Making Capacity:
An individual who is alert, oriented, and has the capacity to understand the circumstances surrounding his/her illness or impairment, as well as the possible risks associated with refusing treatment and/or transport, typically is considered to have decision-making capacity.

The individual’s judgment must also not be significantly impaired by illness, injury or drugs/alcohol intoxication.

Individuals who have attempted suicide, verbalized suicidal intent, or have other factors that lead EMS providers to suspect suicidal intent, should not be regarded as having decision-making capacity and may not decline transport to a medical facility.

Adult Patient: For this guideline, someone who is 18.
Emancipated minors can make decisions regarding their healthcare. An emancipated minor means a minor who is or has been married; a minor who has previously given birth; or a minor who has been legally freed from the care, custody and control of her parents, with little likelihood of returning to the care, custody and control prior to marriage or prior to reaching the age of majority.

Quality Improvement:
Key Documentation Elements
1. Capacity for decision-making
2. Elements of refusal/transport checklist are captured in documentation and signed by patient or their guardian.

Patient Safety Considerations:
EMS should not be endangered by attempting to treat/transport an individual who refuses care; ensure police, chemical and physical restraint as needed.

Refusal of Care/Transport Checklist:
___ EMS explained the risks, benefits and alternatives to treatment and transport
___ Patient understands and can explain the risks, benefits and alternatives to treatment and transport
___ Patient is left in a safe environment
___ Patient is encouraged to seek medical attention or recall 911 PNN
If any one member of the EMS team, regardless of their team assignment, feels it is in the best interest of a patient to be evaluated and/or transported, the EMS unit will evaluate and/or transport the patient. The level of transport will be determined by patient assessment needs and treatment provided.

Advanced procedures are defined in HFS 110 as: prehospital care consisting of basic life support procedures and invasive lifesaving procedures including the placement of advanced airway adjuncts, intravenous infusions, manual defibrillation, electrocardiogram interpretation, administration of approved drugs and other advanced skills identified in the Wisconsin scopes of practice.

Transport shall be to the closest, most appropriate open receiving hospital, taking into consideration:
- Patient's medical condition;
- Patient's request;
- Location of regular care, primary medical doctor and/or medical records;
- Insurance/HMO.

Patient needs will dictate transport to a specialty hospital. Documentation on the patient care record should support the decision to transport for specialty care.

Transport from the scene with lights and siren shall only be done when EMS providers are unable to stabilize the patient at the scene.

EMS providers shall never advise a patient that transport to a medical facility for examination by a physician is not necessary, or that the patient may drive or be driven in a private vehicle or by other medically unsupervised means. When a patient refuses ambulance transport, the standard for refusal of treatment/transport should be followed.

If a patient refuses care and/or transport and the EMS response team has doubts regarding that patient's ability to make a rational decision, the appropriate authority should be consulted (medical control, guardian, police, etc.).
Universal Care: S. A. L. T. - TRIAGE Practice Guideline

Initiate sorting

- Patient is ambulatory? No ➔ Assign to 1st priority group
  Yes ➔ Instruct patient to move independently to designated location

Assign to 3rd priority group

Assign to 2nd priority group

Assess patients beginning with 1st priority group

Initiate lifesaving intervention (See notes below)

- Respiratory effort? No ➔ Dead (color black)
  Yes ➔ Obeys commands and has peripheral pulse and no major bleeding

- Minor injury only? No ➔ Delayed (color yellow)
  Yes ➔ Minimal (color green)

- Likely to survive with current resources? No ➔ Expectant (color gray)
  Yes ➔ Immediate (color red)
NOTES:

- S.A.L.T. – Sort, Assess, Lifesaving Interventions, Treatment/Transport
- Patients should be sorted into priority groups, then receive individual assessment, beginning with the 1st priority group
- Lifesaving interventions include
  - Major hemorrhage control
  - Open airway (consider 2 rescue breaths for children)
  - Chest decompression
  - Autoinjector antidotes (MARK I Kit or DuoDote), if appropriate
- Reassess patients as frequently as possible, as patient conditions may change
Legend:
EMR = Emergency Medical Responder, EMT = Emergency Medical Technician, AEMT = Advanced EMT, INT = Intermediate, PARA = Paramedic
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(7) = No External Jugular, (8) = Bolus Only, (9) = May choose only one for seizures,
(10) = Must have one version of EPI 1:1000 available, (11) = May choose only one for pain control, (12) = Sublingual use only

<table>
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<tr>
<th>AIRWAY / VENTILATION / OXYGENATION</th>
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Universal Care:
SCOPE OF PRACTICE:
Practice Guideline:

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Initiated: 01/01/2017
Reviewed/Revised: 01/01/2017
Revision 2
Approved: M. Riccardo Colella, DO, MPH, FACEP
Approved: Program Director Sternig, RN
Total pages 6
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### IMMOBILIZATION

<table>
<thead>
<tr>
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<td><strong>X</strong></td>
</tr>
<tr>
<td>Spinal Immobilization – Seated Patient (KED, etc)</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td>Splinting – Manual</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td>Splinting – Pelvic Wrap/PASG</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
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</tr>
<tr>
<td>Splinting – Rigid</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td>Splinting – Soft</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td>Splinting – Traction</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
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<tr>
<td>Splinting – Vacuum</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
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</tr>
</tbody>
</table>

### ASSISTED PATIENT MEDICATIONS

<table>
<thead>
<tr>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>INT</th>
<th>PARA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucagon Auto-Injector</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td>Epinephrine Auto-Injector</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td>Nitroglycerin</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td>Oral Glucose</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td>Any Patient Prescribed Emergency Medication with Medical Control Approval</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
</tbody>
</table>

Initiated: 01/01/2017
Reviewed/Revised: 01/01/2017
Revision 2
Approved: M. Riccardo Colella, DO, MPH, FACEP
Approved: Program Director Sternig, RN
Total pages 6
**Legend:**

*EMR = Emergency Medical Responder, EMT = Emergency Medical Technician, AEMT = Advanced EMT, INT = Intermediate, PARA = Paramedic*

* = Optional use by a service, ** = Additional Skill requiring prior approval

1. Non-Interpretive,
2. For CPR Only,
3. May only use FiO2, rate and volume adjustments in assist control (AC) mode,
4. No add’l training req’d in code situation,
5. For Non-Medicated IV’s Only,
6. = 2 or lessMedicated IV’s per patient,
7. No External Jugular,
8. = Bolus Only,
9. May choose only one for seizures,
10. Must have one version of EPI 1:1000 available,
11. May choose only one for pain control,
12. = Sublingual use only

<table>
<thead>
<tr>
<th>MEDICATION ADMINISTRATION ROUTES</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>INT</th>
<th>PARA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aerosolized/Nebulized</td>
<td></td>
<td>X**</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Auto-Injector</td>
<td>X**</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Endotracheal Tube (ET)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intramuscular (IM)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Intranasal (IN)</td>
<td>X**</td>
<td>X**</td>
<td>X**</td>
<td>X**</td>
<td>X**</td>
</tr>
<tr>
<td>Intraosseous (IO)</td>
<td></td>
<td>X**</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Intravenous (IV)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Oral (PO)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Rectal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subcutaneous (SQ)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-Lingual (SL)</td>
<td>X**</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INITIATION / MAINTENANCE / FLUIDS</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>INT</th>
<th>PARA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maintenance – Non-Medicated IV Fluids</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>IV Pump</td>
<td>X**</td>
<td>X**</td>
<td>X</td>
<td>X(6)</td>
<td></td>
</tr>
<tr>
<td>Intraosseous</td>
<td></td>
<td>X**</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Peripheral</td>
<td>X(7)</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PICC Line – Access and Use</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saline Lock</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Legend:
**EMR** = Emergency Medical Responder, **EMT** = Emergency Medical Technician, **AEMT** = Advanced EMT, **INT** = Intermediate, **PARA** = Paramedic
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(10) = Must have one version of EPI 1:1000 available, (11) = May choose only one for pain control, (12) = Sublingual use only

<table>
<thead>
<tr>
<th>MEDICATIONS APPROVED PER PROTOCOL</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>INT</th>
<th>PARA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenosine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Albuterol</td>
<td>X**</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Amiodarone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin</td>
<td>X**</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Atropine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dextrose</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Epinephrine Auto-Injector</td>
<td>X**</td>
<td>X(10)</td>
<td>X(10)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Epinephrine 1:1000 Manually Drawn</td>
<td>X(10)</td>
<td>X(10)</td>
<td>X(10)</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Epinephrine 1:10,000</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fentanyl</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X(11)</td>
</tr>
<tr>
<td>Glucagon</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X(11)</td>
</tr>
<tr>
<td>Glucose-Oral</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X(11)</td>
</tr>
<tr>
<td>Ipratropium (Atrovent)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lidocaine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Mark I Auto-Injector (or equivalent for Self &amp; Crew)</td>
<td>X**</td>
<td>X**</td>
<td>X**</td>
<td>X**</td>
<td>X</td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td></td>
<td>X</td>
<td>X(9)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X(11)</td>
</tr>
<tr>
<td>Naloxone (Narcan)</td>
<td>X**</td>
<td>X</td>
<td>X(12)</td>
<td>X(12)</td>
<td>X</td>
</tr>
<tr>
<td>Nitroglycerin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nitrous Oxide</td>
<td></td>
<td>X</td>
<td>X**</td>
<td>X**</td>
<td>X</td>
</tr>
<tr>
<td>Ondansetron (Zofran)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Other Short-Acting Beta Agonist for Asthma</td>
<td>X**</td>
<td>X**</td>
<td>X**</td>
<td>X**</td>
<td></td>
</tr>
</tbody>
</table>
**Legend:**
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### MISCELLANEOUS

<table>
<thead>
<tr>
<th></th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>INT</th>
<th>PARA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assisted Delivery (childbirth)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Blood Glucose Monitoring</td>
<td>X**</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Blood Pressure – Automated</td>
<td>X*</td>
<td>X*</td>
<td>X*</td>
<td>X*</td>
<td>X*</td>
</tr>
<tr>
<td>Chest Tube Monitoring</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Eye Irrigation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Immunizations</td>
<td>X**</td>
<td>X**</td>
<td>X**</td>
<td>X**</td>
<td>X**</td>
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<tr>
<td>Patient Physical Restraint Application</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
The mission of Milwaukee County EMS is to provide performance excellence in prehospital care through education, communication, operations, information and quality management, and scientific discovery.

I. Medical Control: It is the responsibility of the Emergency Medical Services Medical Director to:

- Assure that initial training to Emergency Medical Technicians meets the standards established by the State of Wisconsin and the EMS medical community.
- Provide continuing education to maintain knowledge and skill levels.
- Establish General Standards of Care, Medical Protocols, Standards for Practical Skills and Operational Policies and Medical Standards for Special Operations to define and guide professional practice.
- Supervise and evaluate individuals licensed within the system.
- Provide access to additional training or other support services as needed.
- Actively seek solutions to issues identified through the Quality Improvement process.
- Take appropriate corrective actions upon identification of activities by individuals that negatively impact on the EMS system and/or patient care.

II. EMS Provider: It is the responsibility of each individual provider to:

- Attain and maintain knowledge and skills necessary to safely practice as a licensed provider in the Milwaukee County System.
- Provide medical care within the scope of practice with the needs of the patient as the primary concern.
- Accept personal responsibility for maintenance of professional standards.
- Provide emergency medical services as outlined in Standards of Care, Medical Protocols, Standards for Practical Skills Operational Policies and Medical Standards for Special Operations of the Milwaukee County EMS System.
- Conduct his/her practice in a manner that reflects positively on self, peers, the employing agency and Milwaukee County EMS.

III. Performance Improvement process and mechanisms to identify issues and seek solutions

Evaluation and assessment of the quality of care provided to the public and of the individual practitioner in the Milwaukee County EMS System will be conducted on a regular basis. This includes, but is not limited to standards of care and protocol compliance monitoring.
<table>
<thead>
<tr>
<th>GOAL</th>
<th>MECHANISM</th>
</tr>
</thead>
</table>
| To encourage communication of the strengths and weakness of the system and to search for improvements | ● Provide an accessible Suggestion Box for members to deposit comments and ideas on improving patient care  
● Advertise and encourage System feedback via the Incident line at the Milwaukee County EMS Offices. |
| To monitor the current status of the system | ● Retrospective patient care record review  
● Retrospective review of Medical Command Form  
● Retrospective peer review of tapes and patient care records  
● Development and dissemination of patient questionnaire |
| To provide feedback on system and individual performance | ● Statistical reports on patient interactions  
● Field evaluations  
● Continuing education conferences  
● Refresher courses  
● Return of peer review of tapes and patient care records to originator of the record for feedback  
● |
| To plan for and implement system improvement | ● Focused audits to identify issues  
● Continuing education conferences  
● Participation in prehospital research  
● New product evaluations |
IV. Due Process

Upon identification of a potential problem or upon receipt of a complaint regarding provision of prehospital care or the action of any individual(s) licensed within the Milwaukee County EMS System, it is the responsibility of the Medical Director and/or Program Director or his/her designee to investigate the allegations impartially and completely. Issues dealing with fire department policy need to be addressed with that fire department in accordance with their department procedures.

FACT-FINDING PHASE

All complaints or allegations must involve a specific incident(s) and may be entered by any individual or organization. Any individual named in a complaint has the right to all information obtained by Milwaukee County EMS, including the source of the complaint.

Fact-finding activities will begin within two (2) working days* of the receipt of the complaint and should be completed within 14 days from initial notification of the incident. The Quality Manager or his/her designee is responsible for the initial contacts and collection of information.

*A “working day” is defined as a normal business day of Monday through Friday exclusive of State or Federal Holidays.

Fact-finding activities will include contact with the complainant for additional information as necessary and telephone or personal contact with the EMS provider(s) involved.

The EMS provider(s) will be informed of the specific complaint and the individual or organization who brought the problem to the attention of Milwaukee County EMS.

The EMS provider(s) will respond verbally, providing such information as necessary to clarify or resolve the issues. Written replies may be requested by the Quality Manager and must be completed and submitted within 9 calendar days.

Information will be reviewed by the Medical Director and/or Program Director or his/her designee.

Any report classified as either Educational or Disciplinary will advance to the reconciliation phase.

An Education Issue is one in which it is perceived that the complaint/problem was created by a lack of understanding of academic foundation, Standard of Care, Medical Protocol(s) or System Policy(ies).

A Disciplinary Issue is one in which there is willful or repeated violation of a Standard of Practice, Medical Protocol or System Policy where the EMS provider has the appropriate academic foundation and/or has received remedial education regarding the Standard, Protocol or Policy.
RECONCILIATION PHASE

For Educational Issues, the EMS provider(s) involved will be notified by letter of the results of the fact-finding.

* The letter will be sent to the EMS provider’s home address on file at the MC EMS offices.
* If, in the judgment of the Medical Director, the facts of the situation warrant a meeting to review academic material or policies/procedures, the EMS provider(s) will be instructed in the above letter to contact the Medical Director’s office to arrange a meeting date and time.
* If the EMS provider(s) fails to contact the Medical Director within five (5) days of the date the letter was mailed, the Medical Director or designee will call the EMS provider at his/her place of employment to verify receipt of the letter and to schedule the educational session.
* The educational session will be conducted by the Medical Director or his/her designee. The time and place of the session will be established when the EMS provider calls the Medical Director but must be scheduled within five (5) working days of the call.

* Failure to respond to the letter and telephone contact or refusal to attend a scheduled educational conference will be reported, verbally and in writing, to the EMS Liaison of the employing fire department accompanied by a request for formal action by the department. That report will contain the details of the complaint, the results of the fact finding and the documentation of contact with the EMS provider(s) involved.
* A copy of the fact-finding letter and a summary of the educational session will be kept on file at the Milwaukee County EMS offices.

In Disciplinary Issues, the EMS provider(s) involved will be notified by letter of the results of the fact-finding.

* The letter will be sent to the EMS provider’s home address on file at MC EMS. A copy of that letter will be sent to the EMS Liaison of the employing fire department with a cover letter from the Medical Director requesting disciplinary action.
* The Medical Director retains the right to impose sanctions on the practice of any individual, including limits placed on patient contact from the start of the fact-finding phase through the disciplinary action of the employing fire department, if a potential risk to public safety is alleged.
Actions requested of the EMS Liaison of the employing fire department by the Medical Director may include but are not limited to:

* No disciplinary action indicated.
* Monitoring of performance for a specified time including specifics of who will do the monitoring and the evaluation tools employed to monitor progress.
* Counseling including specific issues of concern, improvement expected and the evaluation process to be used to determine progress.
* Written reprimand to the individual with copies to the employing agency and the EMS provider's file at the MC EMS offices.
* Probation with specifics of the conditional terms under which the EMS provider may continue to practice, the time of reviews and the behavioral changes expected with the evaluation tools to be used to monitor progress.
* Suspension from EMS provider duties.
* Withdrawal of Medical Control with written notification of the employing agency and the State of Wisconsin, EMS Section, that the Milwaukee County EMS System will no longer accept any medical responsibility for the actions of the individual.

Records of complaints, results of the investigations and the actions taken will be retained on file at Milwaukee County EMS. EMS provider and patient confidentiality are mandatory.
**POLICY:**
- Patient transfer of care occurs when a patient is transferred from one care provider to another.
- Realistic expectations for EMS Providers and hospital personnel are established to ensure smooth and safe transfer of care.
- Problems identified in the transfer of patient care should be reported to the Milwaukee County EMS Incident Line at (414) 257.6660 or qualityems@milwaukeecountywi.gov.

**EMS Provider Expectations of Other EMS Providers:**
- A complete patient care evaluation is performed and a transfer of care report performed.
- The patient is appropriate for transfer of care based on patient needs, provider level and EMS system guidelines.
- All EMS providers are agreeable and accountable for the transfer of care as evidence by transfer of care challenge-response (Crew A Challenge to Crew B: This is the SBAT, do you feel it is appropriate to transfer care to you and do you accept responsibility for the transfer of care? Crew B Response to Crew A: Yes/No, I think it is/is not appropriate and I will/will not accept patient transfer).

**EMS Provider Expectations of ED staff:**
- Allowance of an appropriate verbal transfer of care report in a SBAT format
- Assignment and transfer in a timely fashion by a qualified medical professional
- Assist with patient transfer from EMS transport cot to hospital bed

**ED Staff Expectations of EMS Providers:**
- Transport notification provided as early as possible utilizing system designated alerts (STEMI, Stroke, Trauma, Sepsis, Isolation, etc.) when appropriate; ECG’s as appropriate
- Verbal transfer of care report in a SBAT format
- Patient transport to area as directed (triage, trauma room, L&D, etc.)
- Make available a copy of the written report or electronic patient care record.
- Placement of medical waste in appropriate receptacle/area

Verbal Report between healthcare providers should allow for a brief, quite “time out” to convey key elements of patient care in the SBAT format:

<table>
<thead>
<tr>
<th>Situation</th>
<th>A brief concise statement of the problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>Pertinent information that provides adequate background of the situation.</td>
</tr>
<tr>
<td>Assessment</td>
<td>What is the EMS working assessment; what do you think may be the main complaint, injuries, or concerns for the patient.</td>
</tr>
<tr>
<td>Treatment</td>
<td>What treatments have been performed and how did the patient respond to the intervention.</td>
</tr>
</tbody>
</table>
**POLICY:** Patients are to be transported to the closest, most appropriate, receiving hospital, taking into consideration:

- Patient's medical condition
- Patient's request
- Location of regular care, primary medical doctor and/or medical records
- Insurance/HMO

Patients in need of specialty care should be transported to the closest appropriate receiving facility, based on the following information:

<table>
<thead>
<tr>
<th>Ascension:</th>
<th>Aurora:</th>
<th>Froedert Health:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSM Milwaukee</td>
<td>Grafton</td>
<td>Community Memorial</td>
</tr>
<tr>
<td>CSM Ozaukee</td>
<td>Sinai</td>
<td>Froedert</td>
</tr>
<tr>
<td>WF All Saints (Racine)</td>
<td>St. Luke’s – Milwaukee</td>
<td>ProHealth Care:</td>
</tr>
<tr>
<td>WF Elmbrook Memorial</td>
<td>St. Luke’s – South Shore</td>
<td>Waukesha Memorial</td>
</tr>
<tr>
<td>WF Franklin</td>
<td>West Allis Memorial/Women’s Pavilion</td>
<td></td>
</tr>
<tr>
<td>WF St. Francis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WF St. Joseph</td>
<td>Children’s Hospital and Health System</td>
<td>Zablocki VA Medical Center (VA)</td>
</tr>
</tbody>
</table>

**Patient Assessment:**

<table>
<thead>
<tr>
<th>STEMI (STEMI or Acute MI per pre-hospital ECG)</th>
<th>Specialty Hospital:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROSE</td>
<td>Transport to closest hospital: Aurora Grafton; St. Luke’s Milwaukee; Children’s Hospital of Wisconsin; CSM-Milwaukee; CSM-Ozaukee; Froedert Hospital; Waukesha Memorial; All Saints; Elmbrook Memorial; St. Francis; St. Joseph; Wheaton Franklin. If patient is stable and requests transport to medical home, transport to closest STEMI/ROSC hospital within medical system.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code Stroke - LVO Negative LKW less than 24 hours</th>
<th>Transport to closest Primary Stroke Center (PSC):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aurora Grafton; Aurora Sinai; St. Luke’s Milwaukee; West Allis Memorial; St. Luke’s South Shore; Children’s Hospital of Wisconsin; CSM-Milwaukee; CSM-Ozaukee; Community Memorial; Froedert Hospital; Waukesha Memorial; All Saints; Elmbrook Memorial; St. Francis; St. Joseph; Wheaton Franklin. If patient is stable and requests transport to medical home, transport to closest stroke hospital within medical system.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code Stroke - LVO Positive LKW less than 24 hours</th>
<th>Transport to closest Comprehensive Stroke Center (CSC) or Thrombectomy Capable Stroke Center (TCSC):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CSM-Milwaukee; Froedert; St. Luke’s Milwaukee NOTE: Direct transport to CSC or TCSC if it does not add &gt;15 min to closest PCS transport time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Need for Trauma Center evaluation Burns and/or possible CO poisoning WITH major/multiple trauma</th>
<th>Children’s Hospital of Wisconsin Froedert Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Possible CO poisoning with altered mental status, WITHOUT burns/major trauma</td>
<td>Transport to the closest: St. Luke’s - Milwaukee</td>
</tr>
<tr>
<td>Significant burns (thermal, chemical or electrical) with or without possible CO poisoning WITHOUT major trauma</td>
<td>CSM - Milwaukee</td>
</tr>
<tr>
<td>Other hyperbaric (air embolism, decompression disease, bends, SCUBA)</td>
<td>Transport to the closest: St. Luke’s - Milwaukee</td>
</tr>
<tr>
<td>Major pediatric illness/injury</td>
<td>Children’s Hospital of Wisconsin</td>
</tr>
<tr>
<td>Pediatric burns (Age &lt;12)</td>
<td>Children’s Hospital of Wisconsin</td>
</tr>
<tr>
<td>Unstable newborns</td>
<td>Transport to the closest Neonatal Intensive Care Unit: Children’s Hospital of Wisconsin St. Joseph CSM - Milwaukee All Saints - Racine</td>
</tr>
</tbody>
</table>
### Universal Care: TRANSPORT DESTINATION - HOSPITALS

**Operational Policy**

Approved: M. Riccardo Colella, DO, MPH, FACEP
Approved: EMS Division Director Kenneth Sternig, RN

**Initiated:** 12/08/1992
**Reviewed/Revised:** 03/01/2018
**Revision 44**

| OB patients in labor | 1. Facility where patient received their prenatal care is preferred. Hospitals never close to women in labor. *For gestational age less than 20 weeks, patient will be evaluated in ED.*
| | 2. For imminent delivery, transport to the closest open hospital: Aurora Grafton; Aurora Sinai; West Allis Memorial; CSM-Milwaukee; CSM-Ozaukee; Community Memorial, Froedtert Hospital, Waukesha Memorial; All Saints; Elmbrook Memorial; St. Francis; St. Joseph. |
| Psychiatric Emergencies: | Closest Emergency Department |
| Medical clearance needed | Psychiatric Crisis Service of Milwaukee County Behavioral Health Division (PCS) |
| No medical clearance needed/patient is at high risk for harm to self or others, and/or is behaviorally disruptive (should be placed on Emergency Detention) | 1. If patient is seen in the Milwaukee County Behavioral Health system (MCBHD), transport to the Psychiatric Crisis Service (PCS) center on a voluntary basis |
| No medical clearance needed/patient is at low risk for harm to self or others (police involvement not required) | 2. If not a patient of MCBHD, transport to closest ED for mental health evaluation |
| Infection Alert: Ebola | Wheaton Franciscan Healthcare - transport to St. Joseph for stable patients requesting a Wheaton Franciscan hospital |
| Ebola Virus Disease (EVD) | All other hospital systems – transport to the closest appropriate hospital |

**Notes:**
- No routine transport to a closed hospital under any circumstances
- Hospitals providing specialty services never close to their specialty
- WI Trac will post transport instructions for extenuating circumstances
## Designation by Hospital

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Stroke</th>
<th>STEMI/ROSC</th>
<th>Trauma</th>
<th>Burn</th>
<th>Unstable Newborn</th>
<th>Hyperbaric</th>
<th>Sexual Assault</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aurora Grafton</td>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aurora Sinai</td>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aurora St. Luke’s (Main)</td>
<td>Comprehensive</td>
<td>LVO</td>
<td></td>
<td></td>
<td></td>
<td>CO without burns</td>
<td></td>
</tr>
<tr>
<td>Aurora St. Luke’s – South Shore</td>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aurora West Allis</td>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s Hospital of Wisconsin</td>
<td>Primary</td>
<td></td>
<td>Under 18 years</td>
<td>Under 12 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Columbia St. Mary’s - Milwaukee</td>
<td>Primary</td>
<td></td>
<td></td>
<td>LVO</td>
<td>12 years &amp; over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Columbia St. Mary’s – Ozaukee</td>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Froedtert Community Memorial</td>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Froedtert Hospital</td>
<td>Comprehensive</td>
<td>LVO</td>
<td>18 years</td>
<td></td>
<td></td>
<td>Over 18 years</td>
<td></td>
</tr>
<tr>
<td>Waukesha Memorial</td>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheaton Franciscan All Saints (Racine)</td>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheaton Franciscan Elmbrook Memorial</td>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheaton Franciscan Franklin</td>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheaton Franciscan St. Francis</td>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheaton Franciscan St. Joseph</td>
<td>Primary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:**
- White box = hospital open to specialty services
- Gray box = hospital does not offer specialty service; no transport
Milwaukee County EMS recognizes approved Free Standing Emergency Departments (FSED) as an additional community resource and transport destination for the appropriately identified EMS patient.

FSED’s can stabilize emergencies and arrange secondary transfer for patients that need traditional acute care hospital services.

FSED’s do not have in-patient beds, surgery suites, interventional labs, or other customary support services of traditional acute care hospitals.

Secondary transfer from a FSED to an acute care hospital may have inherent delays to life or time-sensitive interventions and other immediate support needs of an acute care hospital regardless of a seamless transfer process.

Secondary transfer from a FSED to a hospital may be associated with increased costs to patients (second ambulance bill, other professional services, etc.).

MCEMS strongly recommends that the following patient types **NOT** be transported to a FSED*:

- Meeting Level I/II trauma center criteria
- Field identified STEMI
- Field identified Stroke
- Post-Cardiac Arrest Syndromes (ROSC)
- Pregnant > 20 weeks of gestational age with obstetric related concerns
- Meeting Burn Center Criteria
- Open fractures
- Major pediatric injury or illness
- With advanced airway that is adequately managed

* If a patient is experiencing a life-threatening condition that is unable to be managed by EMS providers in the field and that will likely decompensate prior to reaching an acute care hospital, EMS providers can transport such patients to a FSED if it is the closest emergency department for stabilization.

Current Free Standing Emergency Departments within the Milwaukee County EMS response area

1. Moorland Reserve Emergency Department of Froedtert and the Medical College of Wisconsin-Community Memorial Hospital; 4805 S. Moorland Road New Berlin, WI 53151

Initiated: 12/08/1992  
Reviewed/Revised: 03/31/2018  
Revision 45

Approved: M. Riccardo Colella, DO, MPH, FACEP  
Approved: EMS Division Director Kenneth Sternig, RN

Pg 1 of 1
Patient Care Goals
Facilitate appropriate initial assessment and management of any EMS patient and link to appropriate specific guidelines as dictated by the findings within the universal care guideline.

Patient Presentation

Inclusion Criteria
All patient encounters with and care delivery by EMS personnel.

Exclusion Criteria
None.

Patient Management

Assessment
1. Assess scene safety: evaluate for hazards to EMS personnel, patient, bystanders
   a. Determine number of patients
   b. Determine mechanism of injury
   c. Request additional resources if needed. Weigh the benefits of waiting for additional resources against rapid transport to definitive care
   d. Consider declaration of mass casualty incident if needed
2. Use appropriate personal protective equipment
3. Consider spine motion restriction if trauma
4. Primary Survey (Airway, Breathing, Circulation; Circulation, Airway, Breathing if major hemorrhage).
   a. Airway: assess for patency and open the airway as indicated
      i. Patient is unable to maintain airway patency—open airway
         1. Head tilt chin lift
         2. Jaw thrust
         3. Suction
         4. Consider use of the appropriate airway management adjuncts and devices: oral airway, nasal airway, supraglottic airway device (King) endotracheal tube
      ii. Obstructed airway: manage per guideline.
   b. Breathing:
      i. Evaluate rate, breath sounds, accessory muscle use, retractions, patient positioning
      ii. Administer oxygen as appropriate with a goal of > 94% oxygen saturation for most acutely ill patients
      iii. Apnea (not breathing): manage per guideline.
   c. Circulation:
      i. Assess pulse
         1. If none: manage per guideline
         2. Assess rate and quality of carotid and radial pulses
      ii. Evaluate perfusion by assessing skin color and temperature
         1. Evaluate capillary refill
         2. Control any major external bleeding.
d. Disability
   i. Evaluate patient responsiveness: Glasgow Coma Scale (see table below)
   ii. Evaluate gross motor and sensory function in all extremities
   iii. Evaluate blood glucose in patients with altered mental status
   iv. If acute stroke suspected, manage per guideline.

Expose patient as appropriate to complaint
   i. Be considerate of patient modesty
   ii. Keep patient warm

5. Secondary Survey
   The performance of the secondary survey should not delay transport in critical patients. See also secondary survey specific to individual complaints in other protocols. Secondary surveys should be tailored to patient presentation and chief complaint. The following are suggested considerations for secondary survey assessment:

   a. Head
      i. Pupils
      ii. Naso-oropharynx
      iii. Skull and scalp
   b. Neck
      i. Jugular venous distension
      ii. Tracheal position
   c. Chest
      i. Retractions
      ii. Breath sounds
      iii. Chest wall deformity
   d. Abdomen/Back
      i. Flank/abdominal tenderness or bruising
      ii. Abdominal distension
   e. Extremities
      i. Edema
      ii. Pulses
      iii. Deformity
   f. Neurologic
      i. Mental status/orientation
   g. Motor/sensory
6. Obtain baseline vital signs
   a. An initial full set of vital signs is required: pulse, blood pressure, respiratory rate, neurologic status assessment. Neurologic status assessment involves establishing a baseline and then trending any change in patient neurologic status.
   b. Patients with cardiac or respiratory complaints
      i. Pulse oximetry
      ii. 12-lead EKG should be obtained early in patients with cardiac complaints
      iii. Continuous cardiac monitoring, if available
      iv. Consider waveform capnography
   c. Patient with altered mental status
      i. Assess blood glucose
      ii. Consider waveform capnography
   d. Stable patients should have at least two sets of pertinent vital signs. Ideally, one set should be taken shortly before arrival at receiving facility
   e. Critical patients should have pertinent vital signs frequently monitored

7. Obtain OPQRST history:
   a. O: onset of symptoms
   b. P: provocation – location; any exacerbating or alleviating factors
   c. Q: quality of pain
   d. R: radiation of pain
   e. S: severity of symptoms - pain scale
   f. T: time of onset and circumstances around onset

8. Obtain SAMPLE history:
   a. S: symptoms
   b. A: allergies - medication, environmental, and foods
   c. M: medications - both prescription and over-the-counter; bring all containers to hospital if possible
   d. P: past medical history
      i. look for medical alert tags, portable medical records, advance directives
      ii. look for medical devices/implants: some common ones may be dialysis shunt, insulin pump, pacemaker, central venous access port, gastric tubes, urinary catheter
   e. L: last oral intake
   f. E: events leading up to the 911 call. In patient with syncope, seizure, altered mental status, or acute stroke, consider bringing witness to the hospital or obtain their contact phone number to provide to ED care team
Treatment and Interventions:
1. Oxygen supplementation if needed to reach target of > 94%
2. Place appropriate monitoring equipment as dictated by assessment. These may include
   a. Continuous pulse oximetry
   b. Cardiac rhythm monitoring
   c. Waveform capnography
   d. Carbon monoxide assessment
3. Establish vascular access if indicated (need for IV medication, need for fluid resuscitation) or in patients who are at risk for clinical deterioration based on paramedic judgement; routine placement of vascular access not encouraged unless indicated.
4. Monitor pain scale if appropriate
5. Reassess patient

Patient safety considerations
1. Routine use of lights and sirens is not warranted
2. Be aware of legal issues and patient rights as they pertain to and impact patient care, e.g. patients with functional needs or children with special healthcare needs
3. Be aware of potential need to adjust management based on patient age and/or comorbidities, including medication dosages
4. The maximum weight-based dose of medication administered to a pediatric patient should not exceed the maximum adult dose except where specifically stated in a patient care guideline
5. Online Medical Control should be contacted when mandated or as needed for specific consultation

Notes/Educational Pearls
Key considerations
1. Pediatrics: use a weight-based assessment tool (length-based tape or other system) to estimate patient weight and guide medication therapy and adjunct choice. Although the defined age varies by state, the pediatric population is generally defined by those patients who weigh up to 40 kg or up to 14 years of age, whichever comes first
2. Geriatrics: although the defined age varies by state, the geriatric population is generally defined as those patients who are 65 years old or more. In these patients, as well as all adult patients, reduced medication dosages may apply to patients with renal disease (i.e. on dialysis or a diagnosis of chronic renal insufficiency) or hepatic disease (i.e. severe cirrhosis or end-stage liver disease)
3. Co-morbidities: reduced medication dosages may apply to patients with renal disease (i.e. on dialysis or a diagnosis of chronic renal insufficiency) or hepatic disease (i.e. severe cirrhosis or end-stage liver disease)
4. Vital signs:
   a. Oxygen
      Goal oxygen saturation is > 94%. Supplemental oxygen administration is warranted to patients with oxygen
      saturations below this level and titrated based upon clinical condition, clinical response, and geographic location
      and altitude
   b. Normal vital signs—see chart below
      i. Hypotension is considered a systolic blood pressure less than the lower limit on the chart
      ii. Tachycardia is considered a pulse above the upper limit on the chart
      iii. Bradycardia is considered a pulse below the lower limit on the chart
      iv. Tachypnea is considered a respiratory rate above the upper limit on the chart
      v. Bradypnea is considered a respiratory rate below the lower limit on the chart

5. Secondary survey may not be completed if patient has critical primary survey problems

6. In critical patients, proactive patient management should occur simultaneously with assessment. Ideally, one provider
   should be assigned to exclusively monitor and facilitate patient-focused care. Treatment and Interventions should be
   initiated as soon as practicable, but should not impede extrication or delay transport to definitive care

Quality Improvement

Key Documentation Elements
1. At least two full sets of vital signs should be documented for every patient
2. All patient interventions should be documented

Performance Measures
1. Abnormal vital signs should be addressed and reassessed
2. Response to therapy provided should be documented including pain scale reassessment if appropriate
3. Limit scene time for patients with time-critical illness or injury unless clinically indicated

Normal Range Pediatric Vital Signs

<table>
<thead>
<tr>
<th>Heart Rate</th>
<th>Awake Rate</th>
<th>Sleeping Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn to 3 months</td>
<td>85-205</td>
<td>80-160</td>
</tr>
<tr>
<td>3 months to 2 years</td>
<td>100-190</td>
<td>75-160</td>
</tr>
<tr>
<td>2 years to 10 years</td>
<td>60-140</td>
<td>60-90</td>
</tr>
<tr>
<td>&gt;10 year</td>
<td>60-100</td>
<td>50-90</td>
</tr>
</tbody>
</table>
Respiratory Rate

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant</td>
<td>30-60</td>
</tr>
<tr>
<td>Toddler</td>
<td>24-40</td>
</tr>
<tr>
<td>Preschooler</td>
<td>22-34</td>
</tr>
<tr>
<td>School Age</td>
<td>18-30</td>
</tr>
<tr>
<td>Adolescent</td>
<td>12-16</td>
</tr>
</tbody>
</table>

Blood Pressure of **HYPOTENSION** (Minimum SBP)

<table>
<thead>
<tr>
<th>Age</th>
<th>Systolic BP mm/Hg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Term neonate (0-28 days)</td>
<td>&lt; 60 mm/Hg</td>
</tr>
<tr>
<td>Infants (1 to 12 months)</td>
<td>&lt;70 mm/Hg</td>
</tr>
<tr>
<td>Children (1 to 10 years)</td>
<td>&lt;70 + (Age in years x2) mm/Hg</td>
</tr>
<tr>
<td>Children &gt; 10 years</td>
<td>&lt;90 mm/Hg</td>
</tr>
</tbody>
</table>

**Normal Range Adult Vital Signs**

<table>
<thead>
<tr>
<th>Heart Rate</th>
<th>60-100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Rate</td>
<td>12-16</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>90-140 systolic/50-90 diastolic</td>
</tr>
</tbody>
</table>

**Temperature Range (rounded)**

<table>
<thead>
<tr>
<th>Hypothermia</th>
<th>Less than 97F/36 C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyperthermia including fever</td>
<td>Greater than 100.4 F/ 38 C</td>
</tr>
</tbody>
</table>
### Glasgow Coma Scale

#### ADULT GLASGOW COMA SCALE

<table>
<thead>
<tr>
<th></th>
<th>Adult Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Opening</td>
<td>4</td>
</tr>
<tr>
<td>Spontaneous</td>
<td>4</td>
</tr>
<tr>
<td>To Speech</td>
<td>3</td>
</tr>
<tr>
<td>To Pain</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Best Motor Response</td>
<td>6</td>
</tr>
<tr>
<td>Obey Commands</td>
<td>6</td>
</tr>
<tr>
<td>Localizes Pain</td>
<td>5</td>
</tr>
<tr>
<td>Withdraws Pain</td>
<td>4</td>
</tr>
<tr>
<td>Abnormal Flexion</td>
<td>3</td>
</tr>
<tr>
<td>Abnormal Extension</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Verbal Response</td>
<td>5</td>
</tr>
<tr>
<td>Oriented</td>
<td>5</td>
</tr>
<tr>
<td>Confused</td>
<td>4</td>
</tr>
<tr>
<td>Inappropriate</td>
<td>3</td>
</tr>
<tr>
<td>Incomprehensible</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
</tr>
</tbody>
</table>

#### PEDIATRIC GLASGOW COMA SCALE

<table>
<thead>
<tr>
<th></th>
<th>Adult Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Opening</td>
<td>4</td>
</tr>
<tr>
<td>Spontaneous</td>
<td>4</td>
</tr>
<tr>
<td>To Speech</td>
<td>3</td>
</tr>
<tr>
<td>To Pain</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Best Motor Response</td>
<td>6</td>
</tr>
<tr>
<td>Spontaneous</td>
<td>6</td>
</tr>
<tr>
<td>Movement</td>
<td>5</td>
</tr>
<tr>
<td>Withdraws to Touch</td>
<td>5</td>
</tr>
<tr>
<td>Withdraws from Pain</td>
<td>4</td>
</tr>
<tr>
<td>Abnormal Flexion</td>
<td>3</td>
</tr>
<tr>
<td>Abnormal Extension</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Verbal Response</td>
<td>5</td>
</tr>
<tr>
<td>Coos, Babble</td>
<td>5</td>
</tr>
<tr>
<td>Irritable Cry</td>
<td>4</td>
</tr>
<tr>
<td>Cries to Pain</td>
<td>3</td>
</tr>
<tr>
<td>Moans to Pain</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
</tbody>
</table>
Policy: Universal precautions are to be taken to prevent the exposure of personnel to potentially infectious body fluids.

- All EMS providers will routinely use appropriate barrier precautions to prevent skin and mucous membrane exposure when anticipating contact with patient blood or other body fluids.

- Non-latex gloves will be worn when in contact with blood or body fluids, mucous membranes or non-intact skin of all patients, for handling items or surfaces soiled with blood or body fluids and for performing venipunctures or other vascular access procedures.

- Masks and protective eye wear or face shields will be worn to prevent exposure of mucous membranes (mouth, nose and eyes) of the EMS provider during procedures likely to generate droplets of blood or other body fluids.

- Liquid-impervious gowns will be worn during procedures likely to generate droplets of blood or other body fluids (e.g. OB delivery).

- A high efficiency particulate air (HEPA) respirator will be worn when in contact in an enclosed area with a patient suspected of having pulmonary tuberculosis, meningitis, or any other communicable disease transmitted by airborne or droplet method.

Hand washing:

- A non-water-based antiseptic cleaner is to be used at the emergency scene whenever body secretions or blood soils the EMS provider’s skin. Skin surfaces will be washed with soap and water at the first opportunity.

- Liquid hand soap is preferable to bar soap for hand washing. If bar soap is used, it should be kept in a container that allows water to drain away. The bar should be changed frequently.

- Paper towels will be available to dry hands. A "community" cloth towel is not to be used.

- Hand washing is not to be done in a sink used for food preparation or clean up.

Disposal of contaminated sharps:

- Every effort is to be made to avoid injuries caused by needles and other sharp instruments contaminated with blood or body fluids. Safety-engineered sharps should be used whenever practical.

- If a contaminated needle receptacle is not readily available, the cap of the contaminated needle is to be placed on a flat surface and “scooped up” with the contaminated needle to avoid the potential of a needle stick into the hand holding the needle cap.

- Appropriately labeled bio-hazard sharps containers should be disposed of at an appropriate reception site when they are 3/4 full. Needles or other contaminated sharps should never protrude from the bio-hazard sharps container.

Any prehospital EMS provider who has reason to suspect s/he may have sustained a significant exposure shall follow their departmental procedure for reporting, testing and follow-up.
Policy: Vaccines may be administered at sites outside of municipal health department (MHD) clinics under special circumstances, as approved by the Immunization Program Manager or authorized public or occupational health representative. A municipal fire department is an approved off site location for immunization administration.

- Vaccinations will be administered only as part of an approved program in cooperation with public or occupational health services.