NORTH CENTRAL REGION EMS & TRAUMA CARE COUNCIL

REGION PATIENT CARE PROCEDURES

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REGULATIONS

The following regulations provide guidance on subject matter contained in this document. Please note, that this is not an inclusive list. For more information, please contact a Department of Health Emergency Care System representative.

1.1 REVISED CODE OF WASHINGTON (RCW):

- **RCW 18.73** – Emergency medical care and transportation services
  - RCW 18.73.030 - Definitions
- **RCW Chapter 70.168** – Statewide Trauma Care System
  - RCW 70.168.015 – Definitions
  - RCW 70.168.100 – Regional Emergency medical Services and Trauma Care Councils
  - RCW 70.168.170 – Ambulance services – Work Group – Patient transportation – Mental health or chemical dependency services

1.2 WASHINGTON ADMINISTRATIVE CODE (WAC):

- **WAC Chapter 246-976** – Emergency Medical Services and Trauma Care Systems
  - WAC 246-976-920 – Medical Program Director
  - WAC 246-976-960 – Regional emergency medical services and trauma care councils
  - WAC 246-976-970 – Local emergency medical services and trauma care councils

1.1 DISPATCH OF AGENCIES

Effective Date: 4/4/2001
Revised: 5/2008

1. PURPOSE:

A. To provide timely & appropriate care to all emergency medical & trauma patients as identified in WAC 246-976-390.
B. To minimize "response time" in order to get appropriately trained EMS personnel to the scene as quickly as possible.
C. To establish uniform & appropriate dispatch of response agencies.
D. To utilize criteria-based EMD trained dispatchers to identify potential major trauma incidents & activate the Trauma System by dispatching the appropriate services.

3. GENERAL PROCEDURES:

A. The nearest appropriate aid and/or ambulance service shall be dispatched as identified in the North Central Region EMS/Trauma Care response area maps, or as defined in local and/or county operating procedures.
B. Licensed aid and/or licensed ambulance services shall be dispatched by trained dispatchers to all emergency medical incidents.
C. Verified aid and/or verified ambulance services shall be dispatched by trained dispatchers to all known injury incidents which meet Trauma Registry Inclusion Criteria.
D. All Communication/Dispatch Centers charged with the responsibility of receiving calls for Emergency Medical Services shall develop or adopt an EMD (Emergency Medical Dispatch) Program that meets the Washington EMD Program and Implementation Guidelines.

4. DEFINITIONS:

- ***"Response Time"*** per WAC 246-976-010, is defined as "the time from agency notification until the time of first EMS personnel arrive at the scene."
- ***"Appropriate"*** is defined as "the verified or licensed service that normally responds within an identified service area."

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council			☐ Major ☐ Minor
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*Reformatted 11/5/2020 with no changes

1.2 TIMELY & APPROPRIATE EMS RESPONSE

Effective Date: 4/4/2001
Revised: 5/2008

1. PURPOSE:

To ensure that emergency medical and trauma patients who live in an area that is serviced by two or more ambulance providers, which have the same level of licensure, receive the timeliest & highest level of care that is available.

2. **SCOPE**:

If available, the highest-level "appropriately staffed" ambulance within the designated area shall be dispatched to emergency medical & trauma incidents.

3. **GENERAL PROCEDURES:**

A. Except when "extraordinary circumstances" exist, the highest-level "appropriately staffed" licensed ambulance shall respond to all emergency medical & trauma incidents.
B. When a licensed ambulance provider is unable to immediately respond an "appropriately staffed" ambulance to an emergency medical or trauma incident, and there exists another ambulance which is "appropriately staffed" and capable of responding to the incident in a timely manner, then the service that was originally dispatched shall transfer the call to the second ambulance for response.
C. This procedure shall only apply to emergency calls received through the county 911dispatch center.

4. DEFINITIONS:

- ***"Extraordinary Circumstances"*** shall be defined as situations out-of-the-usual when all available ambulances from local licensed ambulance providers are committed to calls for service.
- ***"Appropriately staffed"*** shall be defined as an ambulance which immediately initiates its response to an emergency medical or trauma incident staffed with at least two crew members which are certified to a level that is commensurate with the standard of care that has been set in the local area (i.e., Paramedic/EMT, ILS-EMT/EMT, EMT.EMT or EMT/1st Responder).
- ***"Highest- Level"*** shall be defined as the service within the response area that has the highest level of certified personnel available, at the time of the call.

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Regional Council			☐ Major ☐ Minor
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*Reformatted 11/5/2020 with no changes

1.3 RESPONSE TIMES

Effective Date: 4/4/2001
Revised: 5/2008

1. PURPOSE:

A. To define prehospital response times for emergency medical & trauma incidents to urban, suburban, rural and wilderness areas in the North Central Region.
B. To define urban, suburban, rural and wilderness response areas.
C. To provide trauma patients with appropriate & timely care.

2. **SCOPE**:

All verified ambulance & aid services shall respond to emergency medical & trauma incidents in a timely manner in accordance with WAC 246-976-390. All licensed ambulance & aid services shall respond to emergency medical incidents in a timely manner.

3. **GENERAL PROCEDURES:**

A. The Regional Council, with input from prehospital providers and Local Councils, shall identify response areas & times as urban, suburban, rural and wilderness.
B. Verified/licensed ambulance & verified/licensed aid services shall collect & submit documentation to ensure the following response times are met or exceeded as established by PCP, COP or WAC 246-976-430.

	Aid Vehicle	**Ambulance**
Urban	8 minutes	10 minutes
Suburban	15 minutes	20 minutes
Rural	45 minutes	45 minutes
Wilderness	ASAP	ASAP

C. Verified aid & ambulance services shall provide documentation on major trauma cases to show the above response times are met 80% of the time.
D. County Operating Procedures must meet or exceed the above standards.

E. Verified/licensed ambulance & verified/licensed aid are encouraged to set the "Golden Hour" as a goal for wilderness response times.

4. DEFINITIONS:

An agency response area or portion thereof:

- ***"Urban"*** an incorporated area over 30,000; or an incorporated or unincorporated area of at least 10,000 & a population density over 2,000 per square mile.
- ***"Suburban"*** an incorporated or unincorporated area with a population of 10,000 to 29,999 or any area with a population density of 1,000 to 2,000 per square mile.
- ***"Rural"*** an incorporated or unincorporated area with a total population less than 10,000 or with a population density of less than 1,000 per square mile.
- ***"Wilderness"*** any rural area not readily accessible by public or private road
- ***"Agency Response Time"*** is defined as the time from agency notification until the time of first EMS personnel arrive at the scene. (This is defined in WAC and constitutes "activation time" plus "en route time.")

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3 AIR AMBULANCE SERVICES – ACTIVATION AND UTILIZATION

Effective Date: 9/1/ 2020

1. PURPOSE:

Provide guidelines for those initiating the request for air ambulance services to the scene.

2. **SCOPE**:

Air ambulance services activation and response that provides safe and expeditious transport of critically ill or injured patients to the appropriate designated and/or categorized receiving facilities.

3. **GENERAL PROCEDURES:**

A. Air ambulance services should be used when it will reduce the total out-of-hospital time for a critical trauma, cardiac, or stroke patient by 15 minutes or more; or provide for the patient to arrive at a higher-level trauma, cardiac, or stroke hospital within 30 minutes or less even if a lower level hospital is closer.
B. Prehospital personnel enroute to the scene make the request for early activation of the closest available air ambulance service resource to the location of the scene, or place them on standby for an on-scene response.
C. When appropriate; the call should be initiated through the emergency dispatching system. Notify dispatch of request for air ambulance services if the call has been initiated through a mobile device application.
D. The air ambulance service communications staff will give as accurate of an ETA possible from the closest fully staffed and readily available resource to the dispatch center requesting a scene response. This ETA will include the total time for air ambulance to arrive on scene. If ETA of closest fully staffed resource for that agency is extended, call should go to the next closest fully staffed resource, even if it is another service.
E. The responding air ambulance service will make radio contact with the receiving facility.
F. An air ambulance service that has been launched or placed on standby can only be cancelled by the highest level of certified prehospital personnel dispatched to the scene. Responding personnel may communicate and coordinate whether cancellation is appropriate with the highest-level personnel dispatched prior to their arrival on scene.
G. Scene flights; the air ambulance service responding to the scene will have contact with an agency on scene based on each county's established air to ground frequency.

H. Air ambulance services must be appropriately utilized during an MCI. If such request is made, the requesting prehospital agency should clearly communicate the need for either on scene or rendezvous location to respond to. Air ambulance services will determine most appropriate aircraft for transport based on patient status, weather, and location of incident.

4. TRANSPORT CONSIDERATIONS:

A. Mechanism of Injury – considerations utilizing the *"Prehospital Trauma Triage Destination Procedure"*
    a. Death in the same vehicle
    b. Ejected from vehicle
    c. Anticipated prolonged extrication: greater than 20 minutes with significant injury
    d. Long fall: greater than 30 feet for adults, 15 feet for children
    e. Sudden or severe deceleration
    f. Multiple casualty incidents

B. Patient characteristics – considerations utilizing the *"Prehospital Trauma Triage Destination Procedure"*
    a. Glasgow Coma Scale (GCS) less than or equal to 13
    b. Patient was unconscious and not yet returned to GCS of 15
    c. Respiratory rate less than a 10 or greater than 29 breaths per minute
    d. BP less than 90 mmHg or clinical signs of shock
    e. Penetrating injury to the chest, neck, head, abdomen, groin or proximal extremity
    f. Flail chest/unstable chest wall structures
    g. Major amputation of extremity
    h. Burns second-degree >20 percent
    i. Burns third-degree >10 percent
    j. Burns third-degree involving the eyes, neck, hands, feet, or groin
    k. Burns, high voltage-electrical
    l. Facial or airway burns with or without inhalation injury
    m. Paralysis/spinal cord injury with deficits
    n. Suspected pelvic fracture
    o. Multi-system trauma (three or more anatomic body regions injured)

C. Acute Coronary Syndrome – considerations utilizing the *"Prehospital Cardiac Triage Destination Procedure"*
    a. Post CPA – ROSC
    b. Hypotension and/or Pulmonary edema
    c. ST elevation myocardial infarction
    d. High Risk Score > 4

D. Stroke – considerations utilizing the *"Prehospital Stroke Triage Destination Procedure"*
    a. F.A.S.T. and L.A.M.S. > 4
    Note: (With the extended window for thrombectomy, particularly for patients outside the window for tPA it is important that direct transport to a

thrombectomy capable center be considered if the LAMS is > 4 and time of symptom onset is within 24 hours.

5. CONSIDERATIONS FOR AIR AMBULANCE TRANSPORT:

In general, prehospital providers must communicate to air ambulance any of the following circumstances that could affect ability to transport:

a. Hazardous materials exposure
b. Highly infectious disease (such as Ebola)
c. Inclement weather
d. Patient weight and size

If any of the conditions above are present:

a. Consider initiating ground transport and identifying a rendezvous location if air ambulance confirms the ability to transport.
b. Consider utilization of air ambulance personnel assistance if additional manpower is necessary

6. SAFETY OF GROUND CREWS AROUND AIRCRAFT

To promote safety of all personnel, ground crews must:

a. NOT approach the aircraft until directed to do so by the flight crews.
b. NOT approach the tail of the aircraft.
c. Use situational awareness while operating around aircraft.

7. LANDING ZONE CONSIDERATIONS:

All situations for safety and consideration of landing zones are at the pilot's discretion.

To promote safe consistent practices for EMS and air ambulance services in managing landing zones for helicopters. EMS MUST:

A. Select a location for the landing zone that is at least:
    b. Night; 100 ft. x 100 ft.
    c. Daytime: 75 ft. x 75 ft.
B. Assure the landing zone location is free of loose debris.
C. Assure the approach and departure paths are free of obstructions, and identify to the pilot hazards such as wires, poles, antennae, trees, wind speed and direction, etc.
D. Provide air ambulance services with the latitude and longitude of the landing zone. Avoid using nomenclature such as "Zone 1."
E. Mark night landing zones with lights. Cones may be used if secured or held down. Do not use flares.
F. Establish security for the landing zone for safety and privacy.

G. Avoid pointing spotlights and high beams towards the aircraft. Bright lights should be dimmed as the aircraft approaches.
H. Do not approach an aircraft unless escorted by an aircrew member.
I. Consult with aircrew members before loading and unloading. Loading and unloading procedures will be conducted under the direction of the flight crew.

8. DEFINITIONS:

- ***"Standby"*** Upon receiving the request, dispatch will notify the pilot and crew of the possible flight. The crew will respond to the aircraft and ensure they are in a flight ready status. The crew will then remain at or near the aircraft until such time as they are launched or released from standby.
- ***"Launch time"*** launch time is the time the skids lift the helipad en route to the scene location.
- ***"Early activation"*** Departing for a requested scene prior to arrival of the first responders, based on a high index of suspicion that specialty services will be necessary.

9. APPENDICES

Prehospital Trauma Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/530143.pdf

Prehospital Cardiac Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/346050.pdf

Prehospital Stroke Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/530182.pdf

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Regional Council	New	6/3/2020	☐ Major ☒ Minor
			☐ Major ☐ Minor
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5.2 CARDIAC TRIAGE AND DESTINATION PROCEDURE

Effective Date: 11/1/2018

1. PURPOSE:

A. To implement regional policies and procedures for all cardiac patients who meet criteria for cardiac triage activation as described in the State of Washington Prehospital Cardiac Triage Destination Procedure.
B. To ensure that all cardiac patients are transported to the most appropriate categorized facility as described in RCW 70.168.150
C. To allow the receiving facilities adequate time to activate their Cardiac response team.

2. **SCOPE**:

A. All ambulance and aid services shall comply with the State of Washington Prehospital Cardiac Triage Destination Procedure.
B. All ambulance services shall transport patients to the most appropriate categorized cardiac facility as identified in the County Operating Procedures (COPs).
C. All categorized receiving facilities will determine when it is appropriate to divert ambulances to another categorized facility.
D. All ambulance and aid services shall consider ALS rendezvous or Air Medical services if beyond the designated time requirements in the Triage Destination Procedure.

3. **GENERAL PROCEDURES:**

The first certified EMS provider determines that a patient:

A. Presents with signs, symptoms, or past medical history suggesting a cardiac event (in accordance with the State of Washington Prehospital Cardiac Triage Destination Procedure).
B. Meets the cardiac triage criteria.
C. The provider shall care for the patient as described in the Medical Program Director's (MPD) patient care protocol for cardiac patients.
D. The provider then determines destination based upon the criteria identified and the following:
    a. For patients meeting Cardiac Triage criteria, transport destinations will comply with the triage tool and COPs.
    b. Agencies unable to meet the transport destination criteria will utilize Online Medical Control for determination of transport mode.
    c. Online medical control for all counties shall be accessed per County Operating Procedures (COPs).
E. The EMS provider will initiate communication with the receiving facility as soon as possible, to allow the receiving facility adequate time to activate their cardiac response teams.

F. The receiving facility will notify the transporting ambulance service about diversion in accordance with COPs.
G. Medical Control and/or the receiving facility shall be provided with patient information, as outlined in the Prehospital Destination Tool and COPs.
H. All information shall be documented on an appropriate medical incident report (MIR) form approved by the County MPD.

4. APPENDICES:

Appendix 1. State of Washington Prehospital Cardiac Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/346050.pdf

Appendix 2. State of Washington Emergency Cardiac and Stroke Categorized Facilities
https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/EmergencyCardiacandStrokeSystem/ForMPDsandEMS

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	02/07/2018	☐ Major ☒ Minor
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5.3 STROKE TRIAGE AND DESTINATION PROCEDURE

Effective Date: 11/1/2018

1. PURPOSE:

A. To implement regional policies and procedures for all stroke patients who meet criteria for stroke triage activation as described in the State of Washington Prehospital Stroke Triage Destination Procedure.
B. To ensure that all stroke patients are transported to the most appropriate categorized facility as described in RCW 70.168.150
C. To allow the receiving facilities adequate time to activate their stroke response team.

2. **SCOPE**:

A. All ambulance and aid services shall comply with the State of Washington Prehospital Stroke Triage Destination Procedure.
B. All ambulance services shall transport patients to the most appropriate categorized stroke facility as identified in the County Operating Procedures (COPs).
C. All categorized receiving facilities will determine when it is appropriate to divert ambulances to another categorized facility.
D. All ambulance and aid services shall consider ALS rendezvous or Air Medical services if beyond the designated time requirements in the Triage Destination Procedure.

3. **GENERAL PROCEDURES:**

The first certified EMS provider determines that a patient:

A. Presents with signs, symptoms, or past medical history suggesting a stroke event (in accordance with the State of Washington Prehospital Cardiac Triage Destination Procedure).
B. Meets the stroke triage criteria.
C. The provider shall care for the patient as described in the Medical Program Director's (MPD) patient care protocol for stroke patients.
D. The provider then determines destination based upon the criteria identified and the following:
    a. For patients meeting Stroke Triage criteria, transport destinations will comply with the triage tool and COPs.
    b. Agencies unable to meet the transport destination criteria will utilize Online Medical Control for determination of transport mode.
    c. Online medical control for all counties shall be accessed per County Operating Procedures (COPs).
E. The EMS provider will initiate communication with the receiving facility as soon as possible, to allow the receiving facility adequate time to activate their stroke response teams.

F. The receiving facility will notify the transporting ambulance service about diversion in accordance with COPs.
G. Medical Control and/or the receiving facility shall be provided with patient information, as outlined in the Prehospital Destination Tool and COPs.
H. All information shall be documented on an appropriate medical incident report (MIR) form approved by the County MPD.

4. APPENDICES:

Appendix 1. State of Washington Prehospital Stroke Triage Destination Procedure
https://www.doh.wa.gov/Portals/1/Documents/Pubs/530182.pdf

Appendix 2. State of Washington Emergency Cardiac and Stroke Categorized Facilities
https://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyMedicalServicesEMSSystems/EmergencyCardiacandStrokeSystem/ForMPDsandEMS

Submitted by:	Change/Action:	Date:	Type of Change
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			☐ Major ☐ Minor

5.4 MENTAL HEALTH AND CHEMICAL DEPENDENCY DESTINATION PROCEDURE

Effective Date: 11/1/2018

1. PURPOSE:

To operational licensed EMS aid and/or ambulance services who may transport patients from the field to mental health or chemical dependency services in accordance with WA State legislation HB 1721.

2. **SCOPE**:

In 2015, the WA State Legislature passed HB 1721 allowing Emergency Medical Services (EMS) licensed ambulance and aid services to transport patients from the field to mental health or chemical dependency services. In the North Central Region, licensed EMS ambulance services may transport patients from the field to mental health or chemical dependency services in accordance with RCW 70.168.170, if approved by their county Medical Program Director (MPD).

3. **GENERAL PROCEDURES:**

A. Prehospital EMS agency and receiving mental health and/or chemical dependency facility participation is voluntary.
B. Participating agencies and facilities will adhere to the WA State Department of Health Guideline for Implementation of HB 1721 (see attached appendices)
C. Facilities that participate will work with county Medical Program Director (MPD) and EMS agencies to establish criteria that all participating facilities and EMS agencies will follow for accepting patients.
D. MPD and the Local EMS and Trauma Care Council must develop a county operating procedure (COP). The COP must be consistent with the WA State Department of Health Guideline for Implementation of HB 1721 and this PCP.
E. Prior to implementing and during ongoing operation of transport to alternate receiving facilities the following must be in place with DOH approval:
    a) County operating procedure
    b) MPD patient care protocol
    c) Ensure EMS providers receive training in accordance with WA State Department of Health Guideline for Implementation of HB 1721
    d) Facilities that accept referrals directly from prehospital providers

4. **APPENDICES:**

Appendix 1. WA State Department of Health Guideline for Implementation of HB 1721

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council	Approved Draft	02/07/2018	☒ Major ☐ Minor
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			☐ Major ☐ Minor

5.5 IDENTIFICATION OF MAJOR TRAUMA & EMERGENCY MEDICAL PATIENTS

Effective Date: 10/23/1998
Revised: 5/2008

1. PURPOSE:

A. To implement regional policies and procedures for all emergency medical patients and all trauma patients who meet the criteria for trauma system activation as described in the Washington Prehospital Trauma Triage Procedures.
B. To ensure that all emergency medical patients are transported to the closest most appropriate facility in the shortest time possible.
C. To ensure that all major trauma patients are transported to the most appropriate facility capable of meeting the patient's need in accordance with WAC 246-976-390
D. To allow the designated facility sufficient time to activate their emergency medical and/or trauma resuscitation team. (See WA 246-976-550 (d).

2. **SCOPE**:

A. Major trauma patients will be identified in the initial EMS field assessment using the most current State of Washington Prehospital Trauma Triage (Destination) Procedures as published by the Department of Health.
B. Major trauma patients will be identified by the region's prehospital services and hospitals for the purposes of state trauma registry inclusion, using the trauma registry inclusion criteria as outlined in WAC 246-976-430.
C. Major trauma patients will be identified for the purposes of regional quality improvement as patients who meet the Trauma System Activation criteria of the most current version of the State of Washington Prehospital Triage Procedures, and the patients who activate hospital resource teams and those who meet the hospital trauma patient registry criteria.
D. Patients not meeting the criteria to activate the trauma system will be transported to the closest most appropriate local facility as outlined in local procedures.

3. **GENERAL PROCEDURES:**

A. The first certified EMS/TC provider to determine that a patient:

    a. Meets the trauma triage criteria *and/or*

b. Presents with factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure)
c. Needs definitive medical care, should contact the nearest/appropriate highest/ designated facility via the H.E.A.R. frequency (or other means as conditions dictate).

B. Radio contact with the receiving facility should be preceded with the phrase: "This is a major trauma or major heart alert."
C. The receiving facility shall be provided with the following information, as outlined in the Prehospital Destination Tool:

a. Identification of EMS agency.
b. Patient's age
c. Patient's chief complaint or problem.
d. If injury, identification of the biomechanics of anatomy of the injury.
e. Vital signs
f. Level of consciousness
g. Other factors that require consultation with medical control
h. Number of patients (if more than one)
i. Amount of time it would take to transport the patient from scene to the nearest appropriate hospital (transport time)

D. When determined that a patient meets the trauma triage criteria, a Washington State Trauma Registry Band should be attached to the patient's wrist or ankle as soon as appropriate.
E. Whenever possible, ILS or ALS service should be dispatched to the scene by ground or air as appropriate. If unavailable, rendezvous will be arranged with the highest possible level of care.
F. While enroute to the receiving facility the transporting agency shall provide complete report to the receiving hospital regarding the patient's status.
G. All information shall be documented on an appropriate medical incident report (MIR) form approved by the county medical program director.

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7 DESIGNATED TRAUMA CENTER DIVERSION

Effective Date: 10/23/1998
Revised: 5/2008

1. PURPOSE:

A. To define implications for initiation of trauma center diversion (bypass) status in the Region.
B. To define the methods for notification of initiation of trauma canter diversion.
C. To identify situations when a facility must consider diverting major trauma patients to another designated trauma center.

2. **SCOPE**:

Designated trauma centers in the North Central Region will go on diversion for receiving major trauma patients based on the facilities' ability to provide initial resuscitation, diagnostic procedures, and operative intervention at the designated level of care.

3. **GENERAL PROCEDURES:**

A. Diversion will be categorized as partial or total based on the inability of the facility to manage specific types of major trauma or all major traumas at the time. Hospitals must consider diversion when:

    a. Surgeon is unavailable
    b. OR is unavailable
    c. CT is down if Level II
    d. ER unable to manage more major trauma
    e. Beds are unavailable
    f. Shortage of needed staff

B. Each designated trauma center will have a hospital-approved policy to divert patients to other designated facilities on the ability to manage each patient at a particular time.
C. A diversion log will be kept indicating the time of diversion and the reason for partial or total diversion.
D. All facilities initiating diversion must provide notification to other designated trauma centers in Region.

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9.0 INTERFACILITY TRANSFER

Effective Date: 10/23/1998
Revised: 2/3/2010

1. PURPOSE:

A. To ensure that trauma patients receive treatment in facilities that have made a commitment to the provision of designated trauma service.
B. To define the referral resources for inter-facility transfers of patients requiring a higher level of care or transfer, due to situational inability to provide care.
C. To recommend criteria for inter-facility transfer of major trauma patients from receiving facility to a higher level of care.

2. SCOPE:

A. Written transfer agreements will be in place among all facilities in the region and tertiary care facilities commonly referred to which are out of the region.
B. All inter-facility transfers shall be compliant with current OBRA/COBRA regulations and consistent with RCW 70.170.060(02).
C. Level IV and V facilities will transfer the following adult and pediatric patients to a Level III or higher facility for post resuscitation care:

   a. Central Nervous System Injury Dx
   b. Head injury with any one of the following:
   c. Open, penetrating, or depressed skull fracture
   d. Severe coma (Glasgow Coma Score <10)
   e. Deterioration in Coma Score of 2 or more points
   f. Lateralizing signs
   g. Unstable spine
   h. Spinal cord injury (any level)
   i. Chest Injury Dx
   j. Suspected great vessel or cardiac injuries
   k. Major chest wall injury
   l. Patients who may require protracted ventilation
   m. Pelvis Injury Dx
   n. Pelvic ring disruption with shock requirement more than 5 units of blood transfusion
   o. Evidence of continued hemorrhage
   p. Compounded/open pelvic fracture or pelvic visceral injury
   q. Multiple System Injury Dx

r. Severe facial injury with head injury
s. Chest injury with head injury
t. Abdominal or pelvic injury with head injury
u. Burns with head injury
v. Specialized Problems
w. Burns > 20% BSA or involving airway
x. Carbon Monoxide poisoning
y. Barotrauma
z. Secondary Deterioration (Late Sequelae)
aa. Patients requiring mechanical ventilation
bb. Sepsis
cc. Organ system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal or coagulation systems)

D. All pediatric patients less than 15 years triaged under Step I or II of the Prehospital triage tool; or are unstable after ED resuscitation or emergent observation intervention at hospital with general designations should be considered for immediate transfer to a higher level designated pediatric trauma center.
E. For inter-facility transfer of critical major trauma patients, air or ground ALS transport is the standard. Trauma verified services shall be used for all inter-facility transfers of major trauma patients.
F. Transport of patients out of region shall be consistent with these standards.

3. **GENERAL PROCEDURES:**

A. The General and Pediatric Trauma Transfer Criteria established by the Department of Health should be followed. Each designated trauma facility is required to develop procedures, protocols, and criteria defining which patients they keep or transfer.
B. The transferring facility must arrange for the appropriate level of care during transport.
C. The receiving facility must accept the transfer prior to the patient leaving the sending facility.
D. All appropriate documentation must accompany the patient to the receiving facility.
E. The transferring physician's order shall be followed during transport as allowed by MPD protocols. Should the patient's condition change during the transport, the transferring/sending physician, if readily available, should be contacted for further orders.
F. The receiving facility will be given the following information:

a. Brief history
b. Pertinent physical findings
c. Summary of treatment
d. Response to therapy and current condition.

G. MPD approved Prehospital Protocols will be followed during transport, unless direct medical orders are given to the contrary.
H. Level IV and V trauma facilities should consider having trauma patients transferred by either ground or air according to the facility's interfacility transport plan.
I. Air transport should be considered for interfacility transfer in the North Central Region based on patient acuity and consideration of total out of hospital time, in consultation with the receiving physician.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council			☐ Major ☐ Minor
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10.1 MASS CASUALTY INCIDENT (MCI)

Effective Date: 12/06/2006
Revised: 5/2008

1. PURPOSE:

A. To develop and communicate information for response, prior to an MCI.
B. To implement county MCI plans during an MCI.
C. Severe Burns: To provide trauma and burn care to severely injured adults and pediatric patients per region.
D. To provide safe mass transportation with pre-identified EMS personnel, equipment, and supplies per the approved County Disaster Plan and/or the Hazardous Mitigation Plan.

2. **SCOPE**:

A. EMS personnel, licensed ambulance and licensed aid services shall respond to a Mass Casualty Incident (MCI) as identified in this document.
B. All verified ambulance and verified aid services shall respond to an MCI per the county MCI plans.
C. Licensed ambulance and licensed aid services shall assist during an MCI, per county MIC plans, when requested by command through dispatch in support of county MCI Plan and/or in support of verified EMS services.
D. Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.
E. All EMS agencies working during an MCI event shall operate within the National Incident Management System (NIMS) or the Incident Command System (ICS) as identified in the jurisdiction that has authority, protocol and MCI plan.

3. **GENERAL PROCEDURES:**

A. Incident Commander (IC) shall follow the county MCI Plan to inform medical control and possible appropriate medical facilities when an MCI condition exists. (Refer to county-specific Department of Emergency Management Disaster Plan).
B. Medical Program directors agree that protocols being used by the responding agency should continue to be used throughout the transport of the patient, whether it is in another county, region or state. This ensures consistent patient care will be provided by

personnel trained to use specific medicines, equipment, procedure, and/or protocols until delivery at the receiving facility has been completed.

C. EMS personnel may use the Prehospital Mass Casualty Incident General Algorithm (attached) during the MCI incident.

4. DEFINITIONS:

- ***"CBRNE"*** Chemical, Biological, Radiological, Nuclear, Explosive
- ***"County Disaster Plan"*** County Emergency Management Plan (CEMP)
- ***"Medical Control"*** MPD authority to direct medical care provided by certified EMS personnel in the prehospital system.

Submitted by:	Change/Action:	Date:	Type of Change
Regional Council			☐ Major ☐ Minor
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10.2 ALL HAZARDS

Effective Date: 12/06/2006

1. PURPOSE:

General Algorithm for response to a Prehospital Mass Casualty Incident (MCI)

2. **SCOPE**:

Major incidents/emergencies that create hazardous conditions that threaten public health that exceed local resources, and may involve multiple counties and states

3. **GENERAL PROCEDURES:**

A. Receive dispatch
B. Respond as directed
C. Arrive at scene and establish Incident Command (IC)
D. Scene assessment and size-up
E. Determine if mass casualty conditions exist
F. Implement county MCI plan
G. Request additional resources as needed
H. The dispatch center shall coordinate notification and dispatch of required agencies and resources including notification of the County Department of Emergency Management (DEM) and possible receiving facilities. The Local Health Jurisdiction (LHJ) shall be notified in events where a public health threat exists.
I. Identify hazards and determine needs to control or eliminate them. Take immediate action to isolate and deny access (Site Access Control) or mitigate the hazards as necessary to prevent additional injuries. Consider possibility of terrorist attack (WMD, secondary device)
J. Initiate START
K. Reaffirm additional resources
L. Initiate ICS 201 or similar tactical worksheet
M. Upon arrival at hospital/medical center, transfer care of patients to facility's staff (Hospital/medical center should activate their respective MCI Plan as necessary)
N. Prepare transport vehicle and return to service

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Regional Council			☐ Major ☐ Minor
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A.1 PROVIDER DESCRIBED TRENDS

Effective Date: 12/06/2006
Revised: 5/2008

1. PURPOSE:

A. To provide EMS with a mechanism to report trends/clusters or suspicions to the ED staff of infectious disease symptoms or possible trends that could be related to acts of terrorism.
B. To alert ED staff of suspicious symptoms or trends/clusters identified by EMS in the field
C. ED staff will follow established hospital procedures to notification Public Health of symptoms or trends as warranted.

2. **SCOPE**:

Emergency Medical Services (EMS) Providers, who recognize/identify trends/clusters in possible highly infectious disease or symptoms that could be related to terrorism or any unusual biological activity or event, will convey suspicions to Emergency Department (ED) staff.

3. **GENERAL PROCEDURES:**

A. Any EMS Provider who recognized a trend or clusters of patient symptoms such as, but not limited to, flu-like symptoms, respiratory symptoms, rash or unusual burns, will inform the ED staff.
B. ED staff will evaluate the EMS Provider's suspicions and follow established hospital procedures for reporting to Public Health as warranted.

4. DEFINITIONS:

"ED Staff" Emergency Department physician or nurse.

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Regional Council			☐ Major ☐ Minor
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