

JERSEY  
COMMUNITY  
HOSPITAL  
EMS  
SYSTEM  
SOG'S

2016

## **Introduction**

These Standard Operating Guidelines (SOGs) have been designed as patient care directives for Jersey Community Hospital Ems System prehospital care providers. Providers should rely on these guidelines to guide a patient's treatment prior to arrival in the emergency department.

At all times, providers should evaluate each patient, make an assessment, and treat as directed by the appropriate SOG(s). A patient may require utilization of more than one SOG. The prehospital care provider should always keep the best interests of the patient in mind.

The medical director of Jersey Community Hospital Ems System understand that varying and exceptional circumstances do occur. Indeed, it may be necessary, at times, to make reasonable deviations from these SOGs. However, it should be noted that the SOGs do NOT replace contact with Medical Control, particularly when deviation from the SOGs is deemed necessary by the prehospital care provider.

The Jersey Community Hospital Ems System SOGs are divided by category. Each patient shall undergo a general medical or trauma exam, the breadth of which shall be dictated by the time allowed and the nature of the patient's illness or injury. Next, the Circulation, Airway, and Breathing of each patient shall be assessed without exception. While evaluation of each is often conducted simultaneously, these "Basic Concepts" are delineated in separate chapters, along with specific emergencies pertinent to each.

Following evaluation of a patient's Circulation, Airway, and Breathing, each patient shall be assessed for Disability.

Next, the Jersey Community Hospital Ems System SOGs include separate chapters for pain control, medical emergencies, obstetric emergencies, etc.

## **ALS ASSIST GUIDELINES FOR BLS UNITS IN-FIELD SERVICE UPGRADES**

1. Any BLS unit may request ALS assistance to render a higher level of patient care for any patient.
2. A request for ALS assistance shall be implemented in route to the call when a call is received for a potentially critically ill or injured patient, i.e. a patient in cardiac arrest. Most commonly, the request for ALS assistance will occur at the end of the scene size-up.
3. Suggested criteria for requesting ALS assistance include, but are not limited to:
  - a. Patients with compromised or obstructed airways.
  - b. Respiratory distress or arrest.
  - c. Cardiac arrest.
  - d. Symptoms of acute coronary syndrome: chest pain, SOB, etc.
  - e. Altered level of consciousness.
  - f. Diabetic emergency.
  - g. Seizure or postictal state.
  - h. Pregnancy with imminent delivery.
  - i. Poisoning/overdose.
  - j. Major Trauma including, but not limited to:
    - Multiple injuries or isolated severe injuries or pain.
    - Trauma patients with entrapment.
    - Major burns or those with potential respiratory involvement.
  - k. Medical or trauma patients exhibiting signs of shock (altered mental status, hypotension, diaphoresis, and tachypnea).
  - l. Any patient meeting criteria in Region IV Appendix A, B, or D.
  - m. Any case deemed by the responding agency or Medical Control as beneficial to patient outcome.
4. If there is uncertainty regarding the need for ALS assistance, request ALS! Err on the side of the patient.
5. Consideration should be given to the following:
  - a. Transport time to hospital.
  - b. Rendezvous site.
  - c. Availability of resources.
  - d. Interventions needed (defibrillation, airway, and drugs).
6. If, at any time, the BLS unit has the ability to arrive at the hospital within five minutes, ALS assist can be canceled UNLESS the patient has a compromised airway. (This

includes unresponsive patients, patients in respiratory or cardiac arrest, or in whom impending respiratory or cardiac arrest is suspected.)

a. All other cases require request for ALS intercept. The BLS unit shall call for ALS assist as soon as it is evident that ALS care is needed. The BLS unit will NOT delay transportation to the ED to await ALS assist. Rendezvous in route is appropriate in these circumstances.

7. BLS ambulance personnel at the scene of an emergency shall allow ALS ambulance personnel at the scene access to the patient for the purpose of assessing whether ALS care is warranted.

8. ALS personnel will have control of the scene.

9. If the ALS personnel determine that the patient requires advanced life support care, the BLS personnel shall transfer the care of that patient to the ALS personnel. Higher level personnel shall assume in-field responsibility for the patient during the remainder of a prehospital transport.

10. EMT-P/PHRN personnel may, on an ALS assist, temporarily transfer the ALS equipment to the BLS vehicle. A vehicle upgraded as per protocol will be recognized by IDPH as approved for the higher level of service during the remainder of the patient transport.

11. Medical Control should be contacted for clarification should patient care issues or concerns arise.

12. The BLS unit will complete a State run record to include all assessments and treatments carried out while the patient was in their care. The BLS unit should conclude their report indicating they relinquished care to the appropriate ALS unit. A copy of the PCR shall be given to the ALS unit to include with their documentation,

13. The ALS unit will complete a State run record to include all assessments and treatments carried out while the patient was in their care. Making sure to include a copy of the Basic PCR in their documentation.

14. The highest standards of patient care and professionalism at the scene will be maintained at all times. The care and safety of the patient is the highest priority. Should any conflict arise, submit an Incident Report to the EMS Coordinator.

## **CONSIDERATIONS FOR CHILDREN WITH SPECIAL HEALTHCARE NEEDS**

1. Track Children with Special Healthcare Needs in your service community, and become familiar with both the child and his/her anticipated emergency care needs.
2. Refer to the child's emergency care plan formulated by his/her medical providers, if available. Understanding the child's baseline will assist in determining the significance of altered physical findings. Parents/caregivers are the best source of information on: medications, baseline vitals, functional level/normal mentation, likely medical complications, equipment operation and troubleshooting, emergency procedures.
3. Regardless of underlying condition, assess in a systematic and thorough manner. Use parents/caregivers/home health nurses as medical resources.
4. Be prepared for differences in airway anatomy, physical development, cognitive development and possibly existing surgical alterations or mechanical adjuncts. Common home therapies include: respiratory support (oxygen, apnea monitors, pulse oximeters, tracheostomies, and mechanical ventilators), nutrition therapy (nasogastric or gastrostomy feeding tubes), intravenous therapy (central venous catheters), urinary catheterization or dialysis (continuous ambulatory peritoneal dialysis), biotelemetry, ostomy care, orthotic devices, communication or mobility devices, or hospice care.
5. Communicate with the child in an age-appropriate manner. Maintain communication with and remain sensitive to the parents/ caregivers and the child.
6. The most common emergency encountered with these patients is respiratory-related, and, so, familiarity with respiratory emergency interventions, adjuncts, and treatment is appropriate

# GERIATRIC EMERGENCIES

Geriatric patients are generally considered to be persons older than 65 years. A decline in body systems starts in our late 20s and progresses slowly throughout our lifespan. The reality is that we all age, and older persons are becoming a larger percentage of the population.

1. Recall that the geriatric patient may present atypically due to numerous bodily changes as he/she ages. For example:

- a. Alterations in neurotransmitters decrease reaction time and slow complex mental functions.
- b. Increased peripheral vascular resistance, leading to hypertension.
- c. Muscles become less flexible, and strength declines. Progressive bone loss increases risk of fracture.
- d. There is a decreased ability to maintain normal body temperature.
- e. Oxygen and carbon dioxide exchange in the lungs and at the cellular level declines. The body fatigues at a faster rate than when younger.
- f. Metabolism decreases. As a result, weight gain may be present.
- g. Collagen production decreases; skin is wrinkled, thinner and more susceptible to bruising.
- h. Visual changes occur due to cataracts, macular degeneration, and the eyes' inability to handle light changes.
- i. Changes in hearing, taste, touch and smell place them at risk for injury.
- j. The major body systems such as the cardiovascular, renal, musculoskeletal and immune systems all begin to age and function less efficiently.

2. The geriatric patient assessment is the same as all other age groups. However, do not make assumptions about an older person's level of consciousness. Never assume that an altered level of consciousness or confusion is normal.

3. Dizziness or weakness is often difficult to assess for an older patient. This complaint can be caused by a cardiac problem, infections in the inner ear or hypertension. You must consider the potential for a wide range of medical problems, including cardiac disease.

4. Altered Mental Status is a similarly elusive diagnosis. Altered Mental Status may present as very subtle changes in cognition, but may represent a potentially serious illness. The causes of altered mental status in the elderly may range from trauma to Acute Coronary Syndrome to urinary tract infections.

5. Be aware that the sensation of pain may be diminished in an older patient, leading you to underestimate the severity of his or her condition. This diminished sensation is associated with the aging nervous system. In addition, fear of hospitalization often causes the patient to either understate or minimize their symptoms.

# INITIAL MEDICAL CARE

## FR/EMR/BLS

1. Conduct a **General Medical Assessment**.
2. Support Circulation, Airway, and Breathing as outlined in the Basic Concepts within the individual provider's scope of practice.
  - a. Keep NPO.
  - b. Keep warm.
  - c. Position the patient appropriately.
  - d. Place the conscious patient in a semi-Fowler's position or position of comfort unless contraindicated, e.g. trauma or hypotension.
  - e. FR/EMR should place the patient with decreased mental status in the High Arm IN Endangered Spine (HAINES) (<https://youtu.be/x3Wzp8b5hfw>) position while awaiting EMS unless contra-indicated, e.g. trauma or respiratory insufficiency.
  - i. Extend one of the victim's arms above the head and roll the body to the side so the victim's head rests on the extended arm. Bend both legs to stabilize the victim.
  - f. If evidence of shock, lie supine. If no evidence of trauma or injury, raise the feet about 6 to 12 inches.
3. If, in the judgment of the provider, the patient is at risk of cardiac or respiratory compromise, administer **OXYGEN**: Adult: Pediatric:  
**Stable:** 2-6 LPM by nasal cannula. Stable: blow-by oxygen as tolerated.  
**Unstable:** 100% oxygen by non-rebreather mask.
4. Follow the appropriate SOG(s). If none apply, contact Medical Control for further direction.
5. Obtain ALS intercept, as necessary.
6. Contact Medical Control.
7. Complete all documentation as required. Justification for on-scene time:
  - >20 minutes for medical patients should be included in the narrative.
  - >10 minutes for trauma patients should be included in the narrative.

**ALS:** Same as above with the following included:

8. If, in the judgment of the provider, the patient is at risk of cardiac or respiratory compromise:
  - a. Establish an IV lock or IV of **NORMAL SALINE** at a TKO rate:
    - 30 ml/hr for adult patients
    - 20ml/hr for pediatric patients
9. If, in the judgment of the provider, the patient is at risk of **cardiac / respiratory** compromise:
  - a. Monitor cardiac rhythm, 12-lead, and pulse oximetry.
  - b. Utilize capnography, if available, on any patient at risk for developing hypoventilation

As the Medical Director for the Jersey Community Hospital EMS System, I hereby approve the follow Standard Operating Guidelines (SOGs).

All system personnel shall follow the SOGs until Medical control is contacted. Once Medical Control is in contact with the EMS personnel – they shall direct the treatment plan.

No treatment of any patient shall be delayed to contact Medical Control. SOGs will be followed until contact is made.

The JCH Medical Director will recognize and elect to use Region 3 and Region 4 SOGs as part of the Jersey Community Hospital EMS System SOGs.

The current SOGs used by Jersey Community Hospital EMS System will be placed on JCH WEB page for easy access by all System personnel.

The EMS Coordinator will be the designee for the Medical Director.

All decisions shall be final with Medical Director.

Medical Director:

Date:

\_\_\_\_\_ John Palcheff, DO

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EMS Coordinator:

Date:

\_\_\_\_\_ Modell Renken, NAEMTP

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As the Medical Director for the Jersey Community Hospital EMS System, I hereby approve the follow Standard Operating Guidelines (SOGs).

Medical Director:

Date:

\_\_\_\_\_ John Palcheff, DO

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As the EMS Coordinator for the Jersey Community Hospital EMS System, I will be responsible for making the Standard Operating Guidelines (SOGs) available to all system personnel and will oversee the following of the approved SOGs under the authority of the EMS Medical Director.

EMS Coordinator:

Date:

\_\_\_\_\_ Modell Renken, NAEMTP

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