

<b>REGIONS HOSPITAL EMS</b>	
POLICY/PROCEDURE: <b>Communications/Medical Control</b>	Page 1 of 4
ISSUED BY: Medical Director	No. 05-113
DATE: January 1, 2005	Supersedes: No.

**PURPOSE:**

To outline procedures to be used when contacting the East Metro Medical Resource Control Center (MRCC) for medical direction, relaying of patient medical information, estimated time of arrival, cath lab activation or other information/assistance.

**POLICY:**

1. All pre-hospital communications will be channeled through the East Metro MRCC. The MRCC is staffed 24 hours/day by specially trained paramedics or registered nurses. Emergency medicine physicians are available through MRCC at all times.
2. Medical control shall be contacted any time an ambulance is called to the scene of a medical emergency and a patient is evaluated by the ambulance crew, regardless of whether the patient is transported or not.
3. A Regions Hospital Emergency Medicine physician, at the request of the ambulance crew or the MRCC operator, may monitor any call to MRCC. Certain cases are designated as mandatory physician-monitored calls.
4. The MRCC operator or monitoring physician will relay patient information given by ambulance crews to the receiving hospital with as much advance notice as possible. Ambulance crews should give patient reports to medical control as soon as possible to allow receiving hospitals time to prepare for patient arrival or so that the crew may be notified early on of the need for diversion. Contact with MRCC should be accomplished with at least a 10 minutes ETA whenever possible.

**PROCEDURE:**

1. The East Metro MRCC shall be referred to as “East Metro Control”. Initial contact with MRCC shall be made on UHF MED channel 9, VHF EMS Statewide (National) 155.340, 800 MHz EASTMRCC or by telephone (651-254-2990) as appropriate for each service. Ambulance crews should identify their service name, unit number, ALS, EMT-I or BLS status, transport destination, and criticality or type of call and ETA. If crews have a critical patient or cath lab activation and channel 9 is busy, they may use MED channel 1 as a back up. If calling on the phone, announce immediately that they have a critical patient.
2. Contact with medical control should be made after initial evaluation of the patient. If an ambulance is responding to a confirmed critical situation or will be attending a patient a significant distance from the ambulance, contact may be made with medical control prior to arrival to arrange for on-scene communications or to alert a receiving hospital.
3. Ambulances with UHF radio capabilities may be assigned a MED channel for medical control after initial contact on MED 9 (designated as the “common calling channel”). Ramsey County EMS agencies using 800 MHz may be assigned a “Pool” talkgroup to talk with a Medical Control Physician. Assignment to an MRCC MED channel includes but is not limited to the following circumstances:
  - A. The ambulance crew intends to give a lengthy report or will be relaying information on multiple patients and does not want to “tie up” MED channel for long periods of time.
  - B. The ambulance crew will be a significant distance from the ambulance and must set portable and vehicular radios to the same channel.
  - C. The ambulance crew will be involved in the care of a critically ill or injured patient and wishes exclusive use of a radio channel for physician medical control.
  - D. During MCI events.

- E. The ambulance will be transporting a patient to St. Paul Childrens Hospital with UHF radio monitoring capabilities and the MRCC operator wishes to matrix the call to that facility for monitoring purposes only.
  - 5. If the ambulance crew wishes to consult with a physician they should state that request clearly to the medical control operator who will summon a physician to the radio. Crews are encouraged to follow written guidelines before seeking physician consultation, but no request for direct physician intervention shall be refused. Use of terms such as “Code White” and “Code Blue” can be confusing to both ambulance crews and MRCC operators and their use is discouraged.
  - 6. MRCC operators are available to state or clarify written guidelines as necessary.
  - 7. EMS personnel must be as descriptive as possible by giving *pertinent* details about the patient and scene when relaying patient information.
  - 8. Initial contact with medical control should include:
    - A. Ambulance service and unit number
    - B. Frequency
    - C. Destination
    - D. Estimated time of arrival (ETA)
- Follow-up transmission should include:
- A. Patient information
    - 1. Name (discouraged, but optional. Relay if pertinent to care or if receiving facility specifically requests.)
    - 2. Age
    - 3. Sex
    - 4. Personal physician
  - B. Chief complaint: what the patient states is wrong
  - C. History of present illness or injury: events leading up to chief complaint
  - D. Past medical history pertinent to the chief complaint
    - 1. Illnesses/injuries
    - 2. Medications
    - 3. Allergies
  - F. Physical examination (primary and secondary assessments)
    - 1. General appearance
    - 2. Level of consciousness (AVPU)
    - 3. Level of comfort/distress
    - 4. Glasgow coma score
    - 5. Pertinent initial and focused survey findings
  - G. Vital signs
    - 1. Blood pressure
    - 2. Pulse
    - 3. Respirations
    - 4. Temperature
    - 5. Pulse oximetry
  - H. ECG findings including 12-Lead when appropriate
  - I. Treatments, procedures and medications administered
  - J. Patient condition, response to treatments and/or changes in patient status
9. Paramedics give radio reports on patients receiving ALS care. Paramedics or EMTs give radio reports on patients receiving BLS care.
10. The medical control operator number (and physician name if consulted) should be recorded on the run report.
11. In addition to the radio report, a verbal report from the crew to the receiving nurse or physician who accepts care of the patient must be made prior to departure. This report must include the above information and any changes that occurred in the patient’s condition during transport. The receiving nurse or physician must sign off on the run report form.

12. When assigned a separate MED channel or talkgroup, the ambulance crew will notify medical control upon arrival at the hospital or when no further communication is anticipated, so that the channel in use may be reassigned as necessary.
13. In the following situations, consultation with a medical control physician is mandatory prior to:
  - A. Non-transport of all pediatric (< 2 years)
  - B. Non-transport of all third trimester OB patients with trauma.
  - C. Non-transport of patients who have had a hypoglycemic episode who are on oral hypoglycemic medications
  - D. Inflation of the pediatric PCT
  - E. Inflation of the abdominal section of the adult PCT
  - F. Administration of some medications for children and adults; see specific guidelines
  - G. Transport by BLS personnel without IV training once an IV has been established by ALS personnel
14. The Regions Hospital EMS On-Call Coordinator should be contacted through MRCC immediately following each run where the following procedures are attempted:
  - A. Chest decompression, needle
  - B. Pericardiocentesis
  - C. Transtracheal insufflation, needle
  - D. Rapid sequence induction
  - E. Any call/event that is newsworthy, i.e. likely to appear in the news media. Provide MRCC with a number at which the paramedic may be reached.
15. Requests to MRCC may have to be prioritized during periods of high activity. EMS personnel may be asked to “stand-by” until the MRCC operator can clear higher priority calls. The following guidelines will be used to establish priority:

Higher Priority

Units requiring medical direction  
 Units with unstable patients  
 Units utilizing ALS skills  
 Units with short ETAs  
 TTA or Cath Lab Activations

Lower Priority

Units requiring no medical direction  
 Units with stable patients  
 Units utilizing BLS skills  
 Units with long ETAs  
 Non-transports

**SPECIAL NOTES:**

1. The emergency medicine staff physician has the authority to override the medical control operator and re-prioritize requests for service.
2. In the rare event that communication difficulty, significant delay, or failure results in the inability of EMS personnel to contact medical control for treatment orders that are normally administered only after medical control or physician consultation, the EMT or paramedic may initiate those treatments that, in the opinion of the provider, are life-saving or necessary to stabilize the patient and in which they have received training. The performance of those treatments must be carried out as outlined in the guidelines and must be consistent with the provider’s level of training. Any pediatric treatments administered in this way, must be given after referring to a pediatric medication/treatment reference chart (weight-based resuscitation tape). Providers should attempt alternative communication methods (e.g. cellular phone) when difficulties arise. Treatments carried out without medical control or physician permission, due to communication failure, must be reported by the EMT or paramedic to the On Call Coordinator as soon as possible and to the medical director in writing within 24 hours using the EMS Quality Improvement Form.
3. Ambulances enroute to a hospital should contact East Metro MRCC at least 10 minutes before arrival when possible.