

REGIONS HOSPITAL EMS	
POLICY/PROCEDURE: Communications/Medical Control	Page 1 of 3
ISSUED BY: Medical Director	No. 09-114
DATE: April 1, 2009	Supersedes: No. 05-113

PURPOSE:

To outline procedures to be used when contacting the East Metro Medical Resource Control Center (MRCC) for medical direction, guideline consultation, relaying of patient medical information, estimated time of arrival, cath lab activation, Code Grey 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. Emergency medicine physicians are available through MRCC at all times.
2. Medical control shall be contacted any time an EMS agency 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 5 minute ETA whenever possible.**

PROCEDURE:

1. The East Metro MRCC shall be referred to as “East Metro Medical Control.” Initial contact with MRCC shall be made on 800 MHz EASTMRCC or VHF EMS Statewide (National), or by telephone (651-254-2990) as appropriate for each service. During a MCI, contact should be made by radio when possible. Ambulance crews should identify their service name, unit number, transport destination, and criticality or type of call and ETA. If crews have a critical patient or cath lab activation and EASTMRCC is busy, they may use REGMD as a back up. If calling on the phone or radio, announce immediately you have a critical patient.
2. Contact with medical control should be made after initial evaluation of the patient, especially if the EMS agency will have a short ETA or if they have a critical patient (i.e. TTA, Cath Lab Activation). 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. EMS agencies using 800 MHz will be assigned to REGMD to talk with a medical control physician. Assignment to REGMD 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” EASTMRCC 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-TAC or Ramsey Pool may be more appropriate).
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 EMS agencies can consult with a physician any time they have questions concerning patient care. 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. Radio report format will vary, based on the condition of the patient:
 - A. Any report on a patient who the provider deems as **stable (see definition below)** and requires minimal interventions, does not requiring a specific transport destination, or specific alert criteria (TTA, Level 1 Trauma, Cath Lab Activation, or Code Grey Activation), the report will include: the crew, agency, chief complaint, patient age, patient gender, destination hospital, and ETA. The following will be used to define the stable patient: Systolic 120-140; Diastolic 80-100, Pulse < 110, Temp < 103 or > 95, SaO2 > 95%, no altered mental status, and provider impression of the patient
 - B. Patients who are deemed **unstable**, defined as a patient needing specific interventions or outside of the ranges listed above, the report will be inclusive of the above information and will also include vital signs, response to treatments, and any other pertinent information the crew feels they should include. In these patients, MRCC may ask for more clarifying information. If the provider is very busy with patient care, the provider should alert MRCC as early possible so MRCC can alert the receiving hospital in a timely fashion.
10. Paramedics give radio reports on patients receiving ALS care. Paramedics or EMTs give radio reports on patients receiving BLS care.
11. The medical control operator number (and physician name if consulted) should be recorded on the run report.
12. 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.

13. 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.
14. In the following situations, consultation with a medical control physician is mandatory prior to:
 - A. Non-transport of all pediatric patients < 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. Administration of some medications for children and adults; see specific guidelines
 - E. Transport by BLS personnel without IV training once an IV has been established by ALS personnel
15. The Regions Hospital EMS On-Call Clinical Supervisor should be contacted through MRCC immediately according to the EMS On-Call EMS Supervisor policy (#09-100)
16. 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:

<u>Higher Priority</u>	<u>Lower Priority</u>
Units requiring medical direction	Units requiring no medical direction
Units with unstable patients	Units with stable patients
Units utilizing ALS skills	Units utilizing BLS skills
Units with short ETAs	Units with long ETAs
TTA or Cath Lab Activations	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 Clinical Supervisor as soon as possible and to the medical director in writing within 24 hours using the EMS Quality Improvement Form.