TURNOVER OF PATIENT CARE REDLINE CHANGES

EFFECTIVE DATE: 12-01-2016
REVISED DATE: 12-01-2016

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: Health and Safety Code, Division 2.5, Sections 1798 & 1798.6. California Code of Regulations, Title 22, Division 9, Section 100169 100175

4008.1 POLICY and INTENT

The purpose of this policy is to define the process for the transfer of care between prehospital care providers.

~~a. Responsibility for patient care in the prehospital setting may be transferred between prehospital care providers according to established procedures. **These procedures are applicable between transport units and between ALS First Response and transport units only**.~~

4008.2 DEFINITIONS

a. **BLS**: EMT level of care

b. **ALS:** Paramedic level of care

c. **First Response:** Non-ambulance EMS response

d. **Transport**: EMS ambulance

e. **IC**: Incident Commander

~~a. **BLS** - EMT~~

~~b. **LALS** - AEMT~~

~~c. **ALS First Response** - Paramedic level response. Usually a single paramedic in a non-transport vehicle.~~

~~d. **ALS Transport** - Paramedic staffed transport unit~~

~~e. **IC** - Incident Command~~

4008.3 TRANSFER OF RESPONSIBILITY - PATIENT TURNOVERS

a. Patients under the care of a First Responder or transport provider may be transferred to another provider or transport unit, if the level of care is appropriate for the patient's condition.

~~a. Patient turnovers occurring between an ALS First Response and transport provider or two transport provider agencies may be transferred to an equal or higher level of care. Any patient being cared for within standing orders (i.e. protocol does not require Base Hospital Consultation). Base Hospital advice/approval should be sought for patients under care directed by the Base Hospital.~~

b. Providers transferring care ~~The ALS First Response provider~~ will provide the transport care

provider with a complete report on the patient's condition, treatment provided and properly document the transfer of responsibility and care per *Administrative Guideline #6001 ePCR Completion*

c. Transition of patient care may be affected by scene hazards such as SWAT operations, heavy rescue, crash-fire-rescue, confined space rescue or hazardous materials incidents. In such hazardous situations, the Incident Commander (IC) shall determine when the patient can be safely accessed by transport care providers.

d. The care provider with patient health care authority shall comply with all IC decisions regarding scene safety. The care provider with patient health care authority shall keep IC informed of resource needs and medical decisions.

e. ALS First Response or ALS transport personnel may transfer care of patients to BLS transport units if an assessment on scene has been completed, the patient is deemed stable, and does not meet the following BLS Exclusion Criteria:

~~e. ALS First Response or ALS transport units may transfer care of BLS patients to BLS transport units within the following guidelines, if:~~

~~1. There is a need to conserve ALS resource availability; and,~~

~~2. A BLS unit can **safely** transport and care for the patient.~~

BLS Exclusion Criteria:

1. Airway emergencies
2. Respiratory distress that has received any ALS intervention
3. Unresolved hypotension for any reason
4. Cardiac-related working primary impression
5. Suspected stroke, regardless of time of onset
6. Acute change in mental status
7. Severe **acute** pain where complaints of pain and physical exam are consistent
8. Anaphylaxis. This is defined as systemic symptoms characterized by respiratory findings and shock, usually within 30 minutes of exposure. This does not include localized swelling and itching at site of exposure.
9. Obstetric complaint with reported gestational age of 20 weeks or later
10. Hypoglycemia when the patient cannot safely take oral glucose during transport
11. Paramedic Discretion: Any condition where the complaint, or extent of a known problem is unclear. Examples include multiple trauma, severe abdominal pain in a patient with co-morbid conditions of age and complex medical history, etc.
12. Meets Specialty Care destination/activation/alert criteria

~~***Unsafe* conditions are defined as:**~~

~~1. Any condition where the problem, or extent of a known problem is unclear. Examples include multiple trauma, or severe abdominal pain in a patient with co-morbid conditions of age and complex medical history, altered mental status, trauma triage criteria, etc.~~

~~2. Cardiac related working primary impression~~

~~3. Strokes or TIA, regardless of time last seen normal~~

~~4. Airway emergencies~~

~~5. Asthma that has received any ALS intervention~~

~~6. Unresolved hypotension for any reason~~

~~7. Severe **acute** pain where complaints of pain and physical exam are consistent~~

~~8. Anaphylaxis. This is defined as systemic symptoms characterized by respiratory findings and shock, usually within 30 minutes of exposure. This does not include localized swelling and itching at site of exposure.~~

~~9. Obstetric conditions~~

~~10. Hypoglycemia when the patient cannot safely take oral glucose during transport~~

f. The process to ensure patient transport ***safety*** will include:

1. Patients must be stable with medical complaints that can be cared for at the BLS level. Before transferring care to the BLS transport unit, the examining paramedic will reasonably determine that there are no anticipated changes in the patients' present condition.
2. ALS assessment tools may be utilized (such as EKG monitoring and blood glucose determination) in order to fully assess the patient and determine eligibility for turnover to BLS. Saline locks are permissible.~~EMT scope of practice limitations for monitoring IV must be met for administration and adjustments without foreseeable complications~~.
3. All administration of ALS medications requires the patient to remain under the care of ALS personnel with the **exception of ~~ZOFRAN~~Ondansetron-PO~~, given prospectively for anticipated motion sickness due to ambulance transportation only~~.**
4. Except during a declared MCI or when no other ALS transport alternative exists, patients meeting trauma criteria will be considered ALS patients and treated accordingly.
5. The EMT who will be in attendance is comfortable with the patients' condition and fully accepts responsibility for the patient and ongoing care.

4008.4 TRANSFER BETWEEN SPECIALTY UNITS AND CIRCUMSTANCES

a. Flight nurses may turn patients over to paramedics. These patients must not have or require any medications or therapies that are outside the paramedic scope of practice, and the transporting paramedic must agree to accept responsibility for the patient.

b. These same procedures should be utilized for turnovers from, or to, specialized transport

vehicles or other modality as long as the delay caused by the turnover is offset by a safer or more rapid transport overall.

c. These procedures will also apply when providers caring for patients in a standby capacity at a special event or mass gathering and require another unit to transport from the event location.

4008.5 MEASURABLE INDICATORS

a. A patient status change resulting in the BLS transport unit upgrading to an emergent transport or requesting emergent ALS assistance or intercept will be a sentinel event requiring investigation. All transfer of care occurrences will be reviewed by the provider Medical Director.

b. Medical decisions or actions of the care provider, at the time of occurrence, that seem to be non-compliant with LEMSA policies and procedures should be brought to the attention of the IC, when present. The IC **may** intervene by advising the involved medical care provider of such concerns. If concerns persist after consultation and communication with the care provider, the Base Hospital should be contacted. The Base Hospital Physician has final authority over patient care decisions. The IC will submit a written incident report detailing the concerns via the LEMSA Event Reporting system per *Administrative Guideline #6003 EMS Event Reporting*.

c. Any significant problem which poses a potential or actual threat to patient care or public health and safety that requires immediate attention should be brought to the attention of the IC, or Incident Safety Officer, if one is appointed. Care providers should follow up by preparing an incident report which provides a factual summary of the incident, actions, results and incident outcome. Incident reports shall be submitted through the organization, agency or department chain of command, with referral to the LEMSA.