UCONN HEALTH

Emergency Medical Services Partners

February 2018, Issue 93

health.uconn.edu/ems

UConn JDH EMS Radio Patches

UConn John Dempsey Hospital requires a radio patch on all incoming EMS transports to the ED.

We would like to share with you our ideal radio patches in each of the following categories;

1. General Notification
2. General Priority One
3. Stroke Alert
4. Medical Control
5. STEMI ALERT
6. Trauma Acceptance
7. Presumption
8. High Risk Refusal
9. Treatment Decision

Priority Patches

When bringing in a patient lights and sirens who will need immediate treatment on arrival, please include **relevant history of event**, any abnormal vitals signs and treatment rendered.

"*331, five minutes out, 52-year-old male with history of CHF with sudden respiratory distress. Pale, diaphoretic. On CPAP, given NTG, SAT was in 80s, now is up to 95. 12-lead shows sinus tack. Any questions?"*

"11 Unit 1, ten minutes out with 72-year-old male witnessed cardiac arrest, defibrillated X 2, given 3 epis, now in PEA, CPR in progress, patient is intubated. Any questions?"

If we have questions, we will ask.

General Notification

For general notification patches, please call from 3-5 minutes out. Along with your ETA, please include your unit number, patient age, sex and general complaint. **Please be brief**. If we have questions, we will ask.

Examples:

"AMR 911, five minutes out with 37-year-old male with history of seizure, non compliant with meds, had witnessed seizure, is now alert and oriented with stable vitals."

"Unit 23, four minutes out with 85-year-old female with dementia, tripped and fell, leg is shortened and rotated. No LOC, stable vitals, given fentanyl for pain."

A brief patch is all that is needed to allow us to prepare for the patient's arrival. The full report can be given at patient bedside during handover.

Stroke ALERT

When transporting stroke patients to **UConn John Dempsey Hospital**, please state you are calling with a **STROKE ALERT.** Clearly describe the patient's symptoms. Include the following key points in your radio patches.

1. Last Known Time Without Symptoms
2. Cincinnati Stroke Scale
3. Blood Glucose Tested

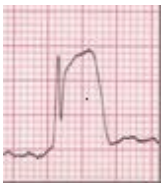
Call from the scene if possible.

You <u>do not need</u> Medical Control for a Stroke Alert.

If you are uncertain if the patient is having a stroke, but stroke is in your differential diagnosis, state you are calling with a **Possible Stroke Alert**.

"929 with 155, calling with a stroke alert, 15 minutes out with 63-year-old female with aphasia, left sided facial droop and pronator drift, Last seen normal at 12:45, Cincinnati—3, Blood sugar 120. Any questions?"

STEMI ALERT Patch



At **UConn John Dempsey Hospital** we will activate the cardiac cath lab based on the EMS radio patch. *(ECG transmission is encouraged).* This is important for those cases where transmission fails or is delayed. Here are six points to remember when patching in.

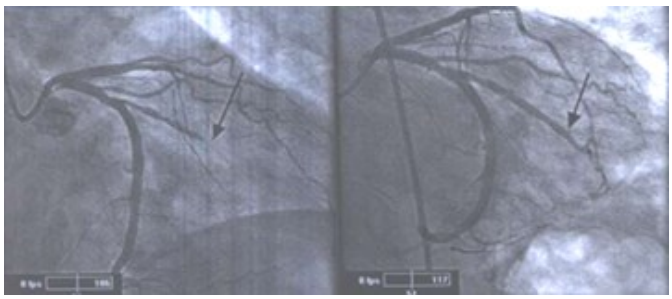
1. Call from the scene. 20 minutes lead time can be equal to 20 minutes heart muscle saved as it enables our team to prepare for the patient's arrival.
2. Ask CMED for a **STEMI ALERT <u>with Medical Control.</u>** Only the Emergency MD can activate the cardiac cath lab. Failing to ask for medical control will force you to repeat your patch after a physician is finally brought to the phone.
3. Briefly describe the main symptoms and presentation.
4. Describe the ECG. State the leads the elevation is present in and whether or not there are any reciprocal changes.
5. Patient History. Briefly describe the patient's significant history
6. Request Cath Lab Activation. If you are convinced this is a STEMI, tell the MD what you want — the cath lab activated.

***

Doctor, This is a STEMI ALERT, I am on scene with a 56-year-old male with 10 of 10 crushing chest pain of sudden onset. He is pale, cool and diaphoretic. The ECG shows ST elevation in II, III, and aVF with reciprocal change in I, aVL, and V1-V3. He has a history of a prior MI. I am requesting cath lab activation. Our ETA is 20 minutes.

***

Note: If you are not certain it is a STEMI, it is okay to call in and say "I have a possible STEMI."



Trauma Acceptance Patch

When considering patient destination with trauma patients, if you have any doubt, do not hesitate to **contact medical control at UConn John Dempsey Hospital to confirm patient acceptance.** Provide a description of patient's injuries, mechanism, vital signs, and any relevant history.

Trauma patients with the following physiological signs should be brought to a Level I or II Trauma Center:

(A) Glasgow Coma Scale of twelve (12) or less; or
(B) systolic blood pressure of less than ninety (90) mm Hg; or
(C) respiratory rate of less than ten (10) or more than twenty-nine (29) breaths per minute.

And/or patients with the following injuries should also be taken directly to a Level I or Level II trauma center:

(A) gunshot wound to chest, head, neck, abdomen or groin;
(B) third degree burns covering more than fifteen (15) per cent of the body, or third degree burns of face, or airway involvement;
(C) evidence of spinal cord injury;
(D) amputation, other than digits; or
(E) two (2) or more obvious proximal long bone fractures.
And severely injured patients less than thirteen (13) years of age.

All other trauma patients, including those with significant mechanism of injury, may be transported to non Level I/Level II hospitals based on consultation with medical control.

"930, requesting medical control for a trauma acceptance."

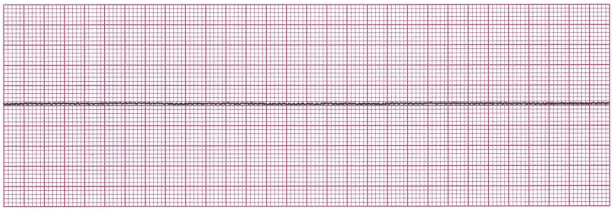
Confirm medical control is on.

"330, on scene with a 19-year-old male restrained driver of car that rolled over. Patient is alert and oriented, self-extricated. No loss of consciousness. Patient has an obvious deformity to his right forearm. BP—130/70, pulse-88, respirations-18. Will you accept this patient?"

Note: We routinely accept patients on blood thinners who have suffered ground level falls. You do not need to call medical control for these patients.

Death Presumption

According to state treatment guidelines:
Once CPR has been started, medical control must be contacted should the responders wish to terminate resuscitation in the field.
When calling medical control state:
"332 requesting medical control for a death presumption."
Confirm medical control.
"332, on scene with a 95-year-old female found apneic and pulseless in her bed. Last seen alive yesterday. Asystole on our arrival. Patient is intubated and has received four rounds of epinephrine to no effect. After 20 minutes of ACLS, she is still asystole with an ETCO2 of 10. Requesting permission to terminate resuscitation."



Note: In cases of dependent lividity with rigor mortis and in cases of injuries incompatible with life, the condition of clinical death must be confirmed by observation of the following:
a. Reposition the airway and look, listen, and feel for at least 30 seconds for spontaneous respirations; respiration is absent.
b. Palpate the carotid pulse for at least 30 seconds; pulse is absent.
c. Examine the pupils of both eyes with a light; both pupils are non-reactive.
d. Absence of a shockable rhythm with an AED for 30 seconds or lack of cardiac activity with a cardiac monitor [paramedic] (in at least 2 leads) for 30 seconds.
If all the components above are confirmed, no CPR is required. **Medical Control does not need to be contacted in these circumstances.**

Physician Names

At UConn John Dempsey Hospital, we do not use physician numbers. Please request the physician name if they do not provide it. Document all encounters with direct medical control in your PCRs.

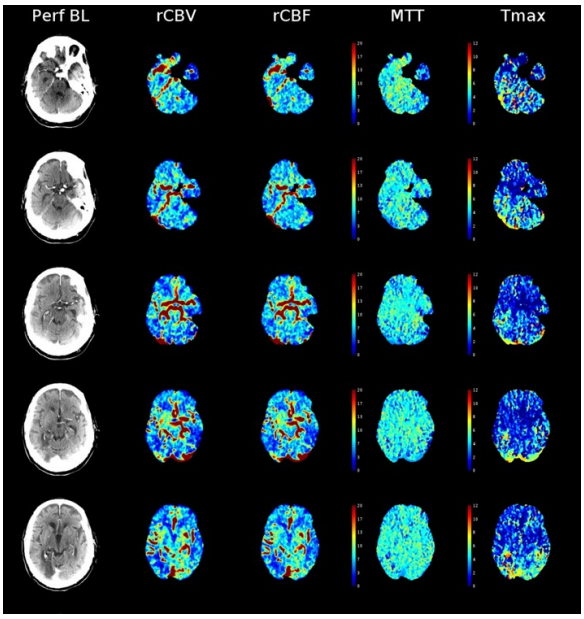
High-Risk Refusal

According to state treatment guidelines, when dealing with patients refusing care:
Consider Direct Medical Oversight for all patients who present a threat to themselves, present with an altered level of consciousness or diminished mental capacity, or have history or examination findings consistent with a high-risk refusal.
The physician is to be provided all relevant information and may need to speak directly with the patient by radio or preferably a recorded landline.
"23, calling for Medical Control for a High-Risk refusal."
Confirm medical control.
"23, on scene with a 43-year-old male who has suffered two syncopal episodes this morning, witnessed by coworkers. He hit his head in both cases. He takes Plavix. The patient's blood pressure is 88/40 with a heart rate of 48. The patient is a sinus brady, but does not take beta blockers. I have explained to the patient the nature and severity of his condition, and the risks and consequences of refusing treatment. Can you speak directly to the patient to reiterate my concerns?"
When Direct Medical Oversight is consulted for a refusal of care, obtain and document the physician's name in the patient care report.

Treatment Order

When contacting medical control to request a treatment order, state what order /intervention you are asking for and why.
"912, calling for Medical Control for a treatment order."
Confirm Medical Control.
"912, calling for orders for an additional 5 mg Versed IM to sedate a 40-year-old 140 kg male on PCP, currently being restrained by three police officers. Patient has already received 10 mg IM Versed IM in two 5 milligram aliquots five minutes apart with minor effect."
Be prepared to answer any questions the physician may have for you.
When Direct Medical Oversight is consulted for a treatment order, obtain and document the physician's name in the patient care report.

The Future is Now: Up to 24 Hour Stroke Window at UConn Health John Dempsey



Call in a Stroke Alert for any patient suspected of an acute stroke (up to 24 Hours).

STEMI Honor Role

Canton Ambulance paramedics Ryan Gonska and Ryan Kerr.
65 Minute Diagnostic ECG- to-Balloon. 81 Minute Door-to-Balloon
Bristol EMS paramedic Michael Gajdosik and his partner Ryan Sanford.
26 Minute Door- to-Balloon. 52 Minute First Medical Contact –to-Balloon
Bristol EMS paramedics Boblee Bruce, Jay Nanni and EMT Robert Klepps
35 Minute Door- to-Balloon. 64 Minute First Medical Contact –to-Balloon
American Medical Response paramedic Robert Slivinski and his partner Domingo Merced.
31 Minute Door- to-Balloon. 68 Minute First Medical Contact-to-Balloon Time.
Great work all!

Remember Early Notification Saves Lives!

UConn Health JDH EMS Website

For news, educational information, CME schedule and past copies of our newsletter *Partners*, check out our website at:

health.uconn.edu/ems

UConn EMS CONTINUING EDUCATION 2018

February – No CME
March 21, 2018
April 18, 2018
May 16, 2018
June 20, 2018
July, August – No CME
September 19, 2018
October 17, 2018
November 21, 2018
December 19, 2018

8:30-11:30 A.M.

Cell and Genome Building
400 Farmington Avenue, Farmington, CT

3 Hours CME
ALL EMS RESPONDERS WELCOME

Special CMEs Coming to UConn in 2018

In addition to our monthly CMEs, look for UConn JDH Hosted CMEs on the following topics:

STEMI and Acute MI Care
TBA

4th Annual Emergency Stroke Care Conference
Full Day Conference
June 6, 2018

2nd Annual EMS Stroke Symposium
November Evening
TBA

Geriatric Trauma
TBA

Stay tuned for dates and details.

CONTACT US:

Any questions or suggestions about EMS?
Looking for patient follow-up?

Contact EMS Coordinator Peter Canning at canning@uchc.edu or call (860) 679-3485.