Paramedic Committee
Meeting Minutes
February 13, 2012

PRESENT	REPRESENTING
Chief Daryl McNutt	Whitehouse Fire
EMC Chief Martin Fuller	Whitehouse Fire
Chief Mark Mullins	Oregon Fire Dept.
Chief Rick Helminski	Springfield Twp. Fire
Chief Jeff Kowalski	Sylvania Twp. Fire
Captain Allison Armstrong	Toledo Fire EMS Bureau
Lt Mark Benadum	Toledo Fire EMS Bureau
Rod Standiford	Sylvania Twp. Fire – LS6
Kim Hood	Toledo Fire – LS5
Barb Aldrich	Toledo Fire
Gregory May	Springfield Twp. Fire –LS10
Jim Fenn	Flower Hospital
Dr. Greg Hymel	St. Vincent Mercy Hospital/TFD
Chad Premo	ProMedica
Dr. Daniel Schwerin	St. Vincent Mercy Hospital/TFD
Tony Santiago	Toledo Fire – LS4
Nicole Knight	Toledo Fire – Training
Craig Koperski	Sylvania Fire – LS6 & LCEMS Annex
Brian Lisowski	Sylvania Fire – LS6 & LCEMS Annex
Rod Standiford	Sylvania Fire – LS6
Tim Treadaway	Toledo Fire
Jim Fenn	Flower Hospital
Rich Ellett	Maumee Fire – LS7

STAFF	
Dennis Cole	Emergency Services Director
Brent Parquette	QA/QI
Pat Moomey	Communications Manager
Al Moenter	Annex Supervisor

ABSENT	
	Toledo Fire – LS1
	Toledo Fire – LS2
	Toledo Fire - LS3
Chief Charles Flack	Jerusalem Twp. Fire

Call to Order

The meeting was called to order at 9:00 am by Chief McNutt

Minute Approval

The minutes from January 9, 2012 meeting were available for review. Chief Mullins made a motion to approve the minutes which was seconded by Chief Kowalski. The minutes were approved as written.

Training

Brent reported CE comments were available for review. Brent said the topic for January was geriatrics with hands on. The comments were positive. February's CE will be on pediatrics to stay in line with recertification. March will be finishing up with pediatrics and OB. Also, the King Vision will be built in March's CE.

QA

Nothing to report.

Old Business

Drug Shortage – Brent reported Fentanyl continues to be in shortage and possibly we may be able to obtain some in mid-March. There is also a shortage of Mag Sulfate and the drug was pulled off the First Responders to be put on the life squads.

Brent reported we found out we were not eligible to obtain drugs through HHS. You have to be a federal agency.

Craig reported Bound Tree has a list of the medications that are on a National back order. LCEMS will put a list in the lockers of what LCEMS is out of and the shortages.

Brent reported 15 King Visions have been delivered. Our intent is to teach the instructors in the next 3 days and present it in March's CE with implementation in April. They will only be on the life squads.

Open Discussion

Brent reported he was at a meeting at Flower Hospital and they offered to fax over face sheets if we give them a dedicated fax number.

Protocols – Rich reported the protocols are not accessible on the ePCR. Brent reported we no longer do protocols on disks. They are on the web and link onto the tablet. With all the changes being made, it is easier to keep them updated on the web. Also if there is a change, it is reported at CE.

Versed – Rod asked if Versed will be placed back on the First responders. Brent reported once our stock is back-up.

Cardiac arrests – Tony Santiago asked if the paramedics initiate ICE on cardiac arrest patients are they to go to an ICE hospital. The response was yes.

Collaboration of Entities – Captain Armstrong reported on an incident where they responded to a 9-1-1 call to a facility where a private ambulance was called in first. He asked who is in charge. Dennis reported if 91-1-1 is activated, we assume the scene. Paramedics are to use good judgment as to what is best for the patient. A discussion ensued on the subject.

Decreased LOC – Craig Koperski asked if decreased LOC is a reason to send a life squad on a run. Pat Moomey reported there is no card on Decreased LOC, the go by the cards Sick Person, or Unconscious. Dispatch follows the cards the Medical Director tells us. (cards attached)

St. Anne – Barb Aldrich reported St. Anne is promoting their EC as a geriatric center and asked if this is something we should filter down. Brent reported not at this time.

Stroke Hospitals – Dennis reported that at the last Medical Committee there was discussion regarding Stoke Hospital designation. We are not moving forward with this at this time.

Brent reported when he was at the meeting at Flower, they told him when paramedics say they have a stroke patient, they want the patient to go straight to CT and pass up the EC. They are not there yet, it will start in April. LCEMS does not have a stroke diversion. Rich Ellett mentioned they are challenged at times from UTMC because they are a "Stroke Center"

Hospital designation – Tony brought up the issue of patients transported to the various hospitals and designation and the travel times. Brent reported paramedics should communicate before the start of the transport. The issue of AMA was brought up and when Medical Control is to be contacted. (Protocol 100, R – Refusal Treatment/Transport/Treat/Release attached) A lengthy discussion ensued.

CAD – The question was asked when was the new CAD going to be available. Dennis reported this has been slid back to the fall. Dennis said Automatic Mutual Aid bound them up for a while. Also, jurisdictions did not want to go live in June due to vacations. No specific date at this time.

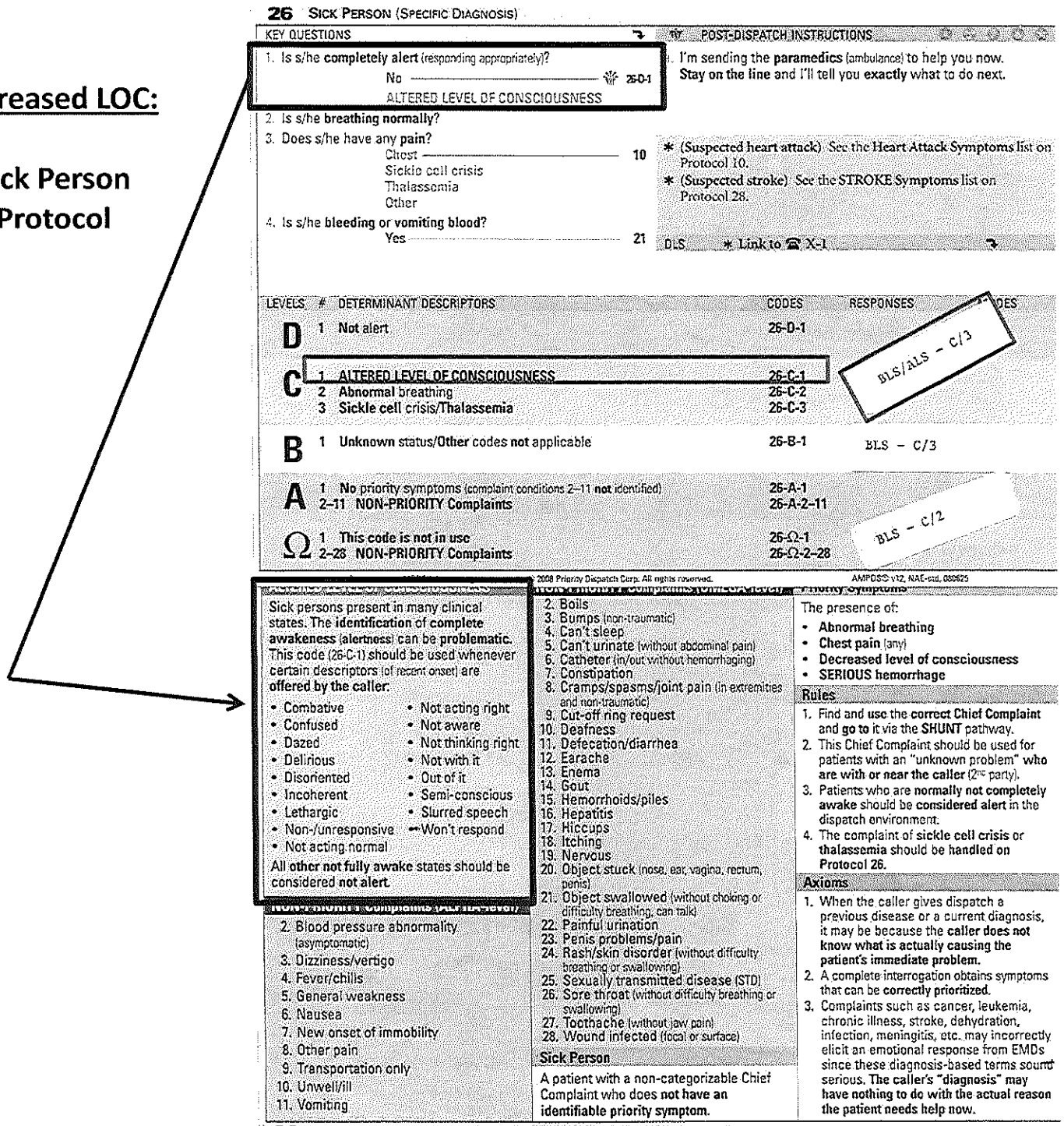
Patient signatures – Mark Benadum mentioned that if there is an issue with capturing signatures, that the "out-of-service" time could be moved up to 30 minutes. Dennis reported the signatures problem is the attention to detail.

Next Meeting and Adjournment

With no further business, the meeting was adjourned at 9:42 a.m. The next meeting will be Monday, **March 12th** at 9:00 a.m.

Decreased LOC:

Sick Person Protocol



26 SICK PERSON (SPECIFIC DIAGNOSIS)

KEY QUESTIONS

1. Is s/he **completely alert** (responding appropriately)?
   No — 26-D-1
   ALTERED LEVEL OF CONSCIOUSNESS
2. Is s/he **breathing normally**?
3. Does s/he have any **pain**?
   Chest — 10
   Sickle cell crisis
   Thalassemia
   Other
4. Is s/he **bleeding** or **vomiting blood**?
   Yes — 21

POST-DISPATCH INSTRUCTIONS

I'm sending the **paramedics** (ambulance) to help you now. **Stay on the line** and I'll tell you **exactly** what to do next.

* (Suspected heart attack) See the Heart Attack Symptoms list on Protocol 10.
* (Suspected stroke) See the STROKE Symptoms list on Protocol 28.

DLS * Link to X-1

LEVELS	#	DETERMINANT DESCRIPTORS	CODES	RESPONSES
D	1	**Not** alert	26-D-1	
C	1	**ALTERED LEVEL OF CONSCIOUSNESS**	26-C-1	BLS/ALS – C/3
	2	**Abnormal** breathing	26-C-2	
	3	**Sickle cell crisis/Thalassemia**	26-C-3	
B	1	**Unknown** status/**Other** codes **not** applicable	26-B-1	BLS – C/3
A	1	**No** priority symptoms (complaint conditions 2–11 **not** identified)	26-A-1	
	2–11	**NON-PRIORITY Complaints**	26-A-2–11	BLS – C/2
Ω	1	**This code is not in use**	26-Ω-1	
	2–28	**NON-PRIORITY Complaints**	26-Ω-2–28	

Sick persons present in many clinical states. The **identification** of **complete awakeness** (**alertness**) can be **problematic.** This code (26-C-1) should be used whenever certain descriptors (of recent onset) are **offered by the caller:**

- Combative
- Confused
- Dazed
- Delirious
- Disoriented
- Incoherent
- Lethargic
- Non-/unresponsive
- Not acting normal
- Not acting right
- Not aware
- Not thinking right
- Not with it
- Out of it
- Semi-conscious
- Slurred speech
- Won't respond

All **other not fully awake** states should be considered **not alert.**

NON-PRIORITY Complaints (ALPHA level)

2. Blood pressure abnormality (asymptomatic)
3. Dizziness/vertigo
4. Fever/chills
5. General weakness
6. Nausea
7. New onset of immobility
8. Other pain
9. Transportation only
10. Unwell/ill
11. Vomiting

NON-PRIORITY Complaints (NUMERIC level)

2. Boils
3. Bumps (non-traumatic)
4. Can't sleep
5. Can't urinate (without abdominal pain)
6. Catheter (in/out without hemorrhaging)
7. Constipation
8. Cramps/spasms/joint pain (in extremities and non-traumatic)
9. Cut-off ring request
10. Deafness
11. Defecation/diarrhea
12. Earache
13. Enema
14. Gout
15. Hemorrhoids/piles
16. Hepatitis
17. Hiccups
18. Itching
19. Nervous
20. Object stuck (nose, ear, vagina, rectum, penis)
21. Object swallowed (without choking or difficulty breathing, can talk)
22. Painful urination
23. Penis problems/pain
24. Rash/skin disorder (without difficulty breathing or swallowing)
25. Sexually transmitted disease (STD)
26. Sore throat (without difficulty breathing or swallowing)
27. Toothache (without jaw pain)
28. Wound infected (local or surface)

Sick Person

A patient with a non-categorizable Chief Complaint who does **not have an identifiable priority symptom.**

Priority Symptoms

The presence of:

- **Abnormal breathing**
- **Chest pain** (any)
- **Decreased level of consciousness**
- **SERIOUS hemorrhage**

Rules

1. Find and **use** the **correct Chief Complaint** and **go to** it via the **SHUNT** pathway.
2. This Chief Complaint should be used for patients with an "unknown problem" who are **with or near the caller** (2nd party).
3. Patients who are **normally not completely awake** should be **considered alert** in the dispatch environment.
4. The complaint of **sickle cell crisis** or **thalassemia** should be **handled on Protocol 26.**

Axioms

1. When the caller gives dispatch a previous disease or a current diagnosis, it may be because the **caller does not know what is actually causing the patient's immediate problem.**
2. A complete interrogation obtains symptoms that can be **correctly prioritized.**
3. Complaints such as cancer, leukemia, chronic illness, stroke, dehydration, infection, meningitis, etc. may incorrectly elicit an emotional response from EMDs since these diagnosis-based terms sound serious. **The caller's "diagnosis" may have nothing to do with the actual reason the patient needs help now.**

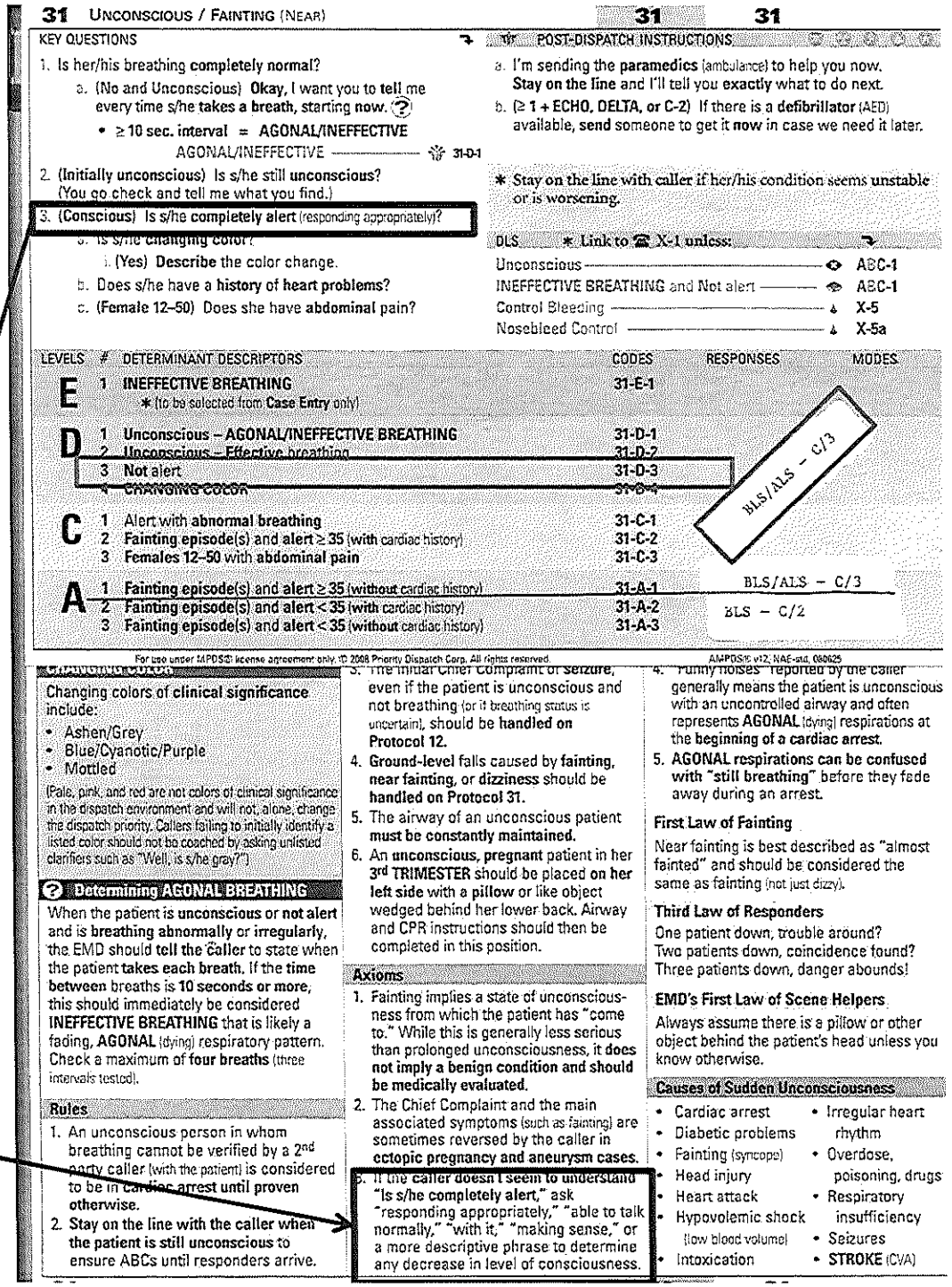
National Academy of Emergency Medical Dispatchers

EMD v12 Protocol Cards

Card 26:
Sick Person

Decreased LOC:

Unconscious Protocol



31 UNCONSCIOUS / FAINTING (NEAR) — 31 — 31

KEY QUESTIONS

1. Is her/his breathing **completely normal?**
   a. (No and Unconscious) **Okay,** I want you to **tell** me every time s/he **takes a breath,** starting **now.** (?)
   - **≥ 10 sec. interval = AGONAL/INEFFECTIVE**

   AGONAL/INEFFECTIVE ——— 31-D-1
2. **(Initially unconscious)** Is s/he still **unconscious?** (You go check and tell me what you find.)
3. **(Conscious)** Is s/he **completely alert** (responding appropriately)?
   a. Is s/he **changing color?**
      i. (Yes) **Describe** the color change.
   b. Does s/he have a **history of heart problems?**
   c. **(Female 12–50)** Does she have **abdominal pain?**

POST-DISPATCH INSTRUCTIONS

a. I'm sending the **paramedics** (ambulance) to help you now. **Stay on the line** and I'll tell you **exactly** what to do next.
b. **(≥ 1 + ECHO, DELTA, or C-2)** If there is a **defibrillator** (AED) available, **send** someone to get it **now** in case we need it later.

* Stay on the line with caller if her/his condition seems unstable or is worsening.

DLS * Link to ☎ X-1 unless:

Unconscious	ABC-1
INEFFECTIVE BREATHING and Not alert	ABC-1
Control Bleeding	X-5
Nosebleed Control	X-5a

LEVELS	#	DETERMINANT DESCRIPTORS	CODES	RESPONSES	MODES
E	1	**INEFFECTIVE BREATHING** * (to be selected from **Case Entry** only)	31-E-1		
D	1	**Unconscious – AGONAL/INEFFECTIVE BREATHING**	31-D-1		
	2	**Unconscious – Effective breathing**	31-D-2		
	3	**Not alert**	31-D-3		
	4	**CHANGING COLOR**	31-D-4		
C	1	Alert with **abnormal breathing**	31-C-1		
	2	**Fainting episode(s)** and **alert ≥ 35** (with cardiac history)	31-C-2		
	3	**Females 12–50** with **abdominal pain**	31-C-3		
A	1	**Fainting episode(s)** and **alert ≥ 35** (without cardiac history)	31-A-1	BLS/ALS – C/3	
	2	**Fainting episode(s)** and **alert < 35** (with cardiac history)	31-A-2	BLS – C/2	
	3	**Fainting episode(s)** and **alert < 35** (without cardiac history)	31-A-3		

BLS/ALS – C/3

AMPDS® v12, NAE-std, 080625

CAUTION-CODES

Changing colors of **clinical significance** include:
- Ashen/Grey
- Blue/Cyanotic/Purple
- Mottled

(Pale, pink, and red are not colors of clinical significance in the dispatch environment and will not, alone, change the dispatch priority. Callers failing to initially identify a listed color should not be coached by asking unlisted clarifiers such as "Well, is s/he gray?")

? Determining AGONAL BREATHING

When the patient is **unconscious** or **not alert** and is **breathing abnormally** or **irregularly,** the EMD should **tell the caller** to state when the patient **takes each breath.** If the **time between** breaths is **10 seconds or more,** this should immediately be considered **INEFFECTIVE BREATHING** that is likely a fading, **AGONAL** (dying) respiratory pattern. Check a maximum of **four breaths** (three intervals tested).

Rules

1. An unconscious person in whom breathing cannot be verified by a 2nd party caller (with the patient) is considered to be in **cardiac arrest until proven otherwise.**
2. **Stay on the line with the caller when the patient is still unconscious** to ensure ABCs until responders arrive.
3. The initial Chief Complaint of **seizure,** even if the patient is unconscious and not breathing (or if breathing status is uncertain), should be **handled on Protocol 12.**
4. **Ground-level** falls caused by **fainting, near fainting,** or **dizziness** should be **handled on Protocol 31.**
5. The airway of an unconscious patient **must be constantly maintained.**
6. An **unconscious, pregnant** patient in her **3rd TRIMESTER** should be placed **on her left side** with a **pillow** or like object wedged behind her lower back. Airway and CPR instructions should then be completed in this position.

Axioms

1. Fainting implies a state of unconsciousness from which the patient has "come to." While this is generally less serious than prolonged unconsciousness, it **does not imply a benign condition and should be medically evaluated.**
2. The Chief Complaint and the main associated symptoms (such as fainting) are sometimes reversed by the caller in **ectopic pregnancy and aneurysm cases.**
3. **If the caller doesn't seem to understand "Is s/he completely alert,"** ask "responding appropriately," "able to talk normally," "with it," "making sense," or a more descriptive phrase to determine any decrease in level of consciousness.
4. "Funny noises" reported by the caller generally means the patient is unconscious with an uncontrolled airway and often represents **AGONAL** (dying) respirations at the **beginning of a cardiac arrest.**
5. **AGONAL respirations can be confused with "still breathing"** before they fade away during an arrest.

First Law of Fainting

Near fainting is best described as "almost fainted" and should be considered the same as fainting (not just dizzy).

Third Law of Responders

One patient down, trouble around?
Two patients down, coincidence found?
Three patients down, danger abounds!

EMD's First Law of Scene Helpers

Always assume there is a pillow or other object behind the patient's head unless you know otherwise.

Causes of Sudden Unconsciousness

- Cardiac arrest
- Diabetic problems
- Fainting (syncope)
- Head injury
- Heart attack
- Hypovolemic shock (low blood volume)
- Intoxication
- Irregular heart rhythm
- Overdose, poisoning, drugs
- Respiratory insufficiency
- Seizures
- **STROKE** (CVA)

National Academy of Emergency Medical Dispatchers

EMD v12 Protocol Cards

Card 31:
Unconscious / Near Fainting

LUCAS COUNTY

R
Refusal Treatment/Transport
Treat / Release

Refusal of Treatment or Transport
Patients refusing treatment and/or transportation should be made fully aware of the nature of their existing problem and the possible consequences of their refusal. The patient must be considered alert/oriented and not under the influence of alcohol, drugs, or a medical condition that could impede his/her decision-making ability. When diligent, repeated efforts to reason with the patient fail, a refusal statement (AMA) should be signed and witnessed.

In the event the patient refuses to sign the AMA statement, a family member's signature is acceptable as witness of the refusal as long as the family member is aware of the consequences of the patient's action. If no relatives are present, witness of the refusal by two (2) persons (preferably not the EMS crew) and clear documentation of all information must be contained within the electronic patient care reporting form.

If the patient is under the influence of alcohol, drugs, or a medical condition that can impede his/her decision-making ability, neither the patient nor family member can refuse treatment. The patient must be treated and transported as medically appropriate. Law enforcement assistance and/or transport to the hospital are to be considered if necessary.

The patient who has attempted suicide or who has suicidal ideation may not refuse treatment or transport. Law enforcement assistance and/or transport to the hospital are to be considered if necessary.

Special Notes:

A. Explain in comprehensible terms the need for treatment and the consequences to the patient of declining treatment, (i.e., worsening condition, seizure, brain damage, stroke, heart attack, death, etc). Explain to the patient what treatment is to be done per protocol (such as Oxygen, cardiac monitoring, IVs, etc.). Also explain to the patient what treatment may be done at the hospital such as x-rays, ECG, blood test and physician evaluation.

B. If the patient still declines care, meticulously document what you advised the patient and all indications of the patient's alertness, full orientation and capacity to repeat back the explanation given. Have the patient do this in front of another person, preferably in the presence of another family member, police officer, or ambulance crew personnel. Document the results and the name of the person who witnessed the event of the refusal.

C. It may be appropriate to have the patient communicate directly with ***On-Line Medical Control*** via radio to reinforce the consequences of the patient's decision.

D. ***On-Line Medical Control*** contact must be made while at the scene with the patient. A full radio report including any assessments, vital signs, interventions, and request for refusal must be given to ***On-Line Medical Control.***

E. Before securing a patient's signature, the refusal statement should be read aloud for a complete understanding of the consequences of signing.

F. Upon completion of the incident, a tablet PCR must be completed detailing patient demographic information, response times, assessments, vital signs, interventions and outcome information. All ECG data acquired during patient care must be transferred to the ePCR.

Treat and Release

The LCEMS Medical Director has established criteria and reporting requirements for those scenarios where treatment without transport role is deemed appropriate by EMS (Treat and Release). In many cases patients respond favorably to treatments in the field, where in the paramedic's best judgment, transport may not be necessary (i.e., treatment of hypoglycemia Type 1 diabetics with D50).

Criteria for field "Treat and Release":

A. Perform complete/detailed medical assessment including patient interview and physical exam before and after medical treatment.

B. The patient must be considered alert/oriented and not under the influence of alcohol, drugs or a medical condition that could impede his/her decision-making ability.

C. Be certain the mentally competent patient understands the consequences of his/her condition as well as the consequences of a "treat and release" before acquiring a signature.

Refusal / Treat and Release, continued

D. ***On-Line Medical Control*** contact must be made while at the scene with the patient. A full radio report including any assessments, vital signs, interventions, and request for "treat and release" must be given to ***On-Line Medical Control***.

E. Before securing a patient's signature, the "treat and release" statement should be read aloud for a complete understanding of the consequences of signing.

F. Upon completion of the incident, a tablet PCR must be completed detailing patient demographic information, response times, assessments, vital signs, interventions and outcome information. All ECG data acquired during patient care must be transferred to the ePCR.

Lucas County EMS
Noncredit Course and Instructor Evaluation
Course: Geriatric Emergencies
Instructor: Brent Parquette
Course Dates: January 5, 10, 11, 12 17,18,19,24,25,26, 2012

COMMENTS

January 5, 2012

- Updates/announcements timely & informative – thanks. Skill stations: appropriate scenarios and questions answered effectively. Lecture was way too long & didn't involve audience participation which made it boring.
- Versed needs to be placed back on first responder rigs. Responding to a seizure call and not being able to do anything to stop a patient from seizing makes us look bad. People expect us to be able to treat them, not wait for a life squad to arrive to give a medication to stop a seizure.
- Brent, you have life squad medics that can't use a monitor or turn on the LUCAS device, so I'm sure they will fail at obtaining a signature for you! Do you know that a lot of life squad medics still insist on using the 12-lead in chest pain to determine if they are going to transport!
- Disappointed Brent did not use the work "tracing".
- Grab n go pizza's!
- Good information. Good interactive skill stations.
- Good review.

January 10, 2012

- Good review. Geezers are people too!
- As always, good review.
- Make scenarios a little more complex.
- Nice info given.

January 11, 2012

- Nice job.
- Good CE. Lecture was informative. The hands on training was good as well.
- Go over pharmacology – please!
- Good job!
- Maybe have a lawyer in to show us all the variables & curve balls of the DNR possibilities.
- Good review. Johnny Z does a great job! Maybe review of power of attorney issues could be discussed.

January 12, 2012

- Boring....zzzzz...
- Put a CVA "ci___" assessment check box's on the ZOLL.
- Excellent as usual
- Very well presented lecture

January 17, 2012

- Powerpoint handout was helpful
- Good review
- Excellent!
- Good breakout sessions

January 18, 2012

- Any more LS being added to system?
- Getting old sucks!!
- Great C.E.
- Skill stations were a great review

January 19, 2012

- Good food for thought in this C.E.
- Once again, good job
- Thanks!
- *Good stuff as always. *Put the powerpoints on-line as reference material.
- *CPAP for engines! Great job w/CE

January 24, 2012

- Good review. Need a protocol that addresses our Power of Attorney – which is correct for pt care?
- Good to be back
- Zesty!
- Nice C.E., a good refresher
- Good course. Need more time for geriatrics if it is such a large subset of pt. population. Good stations. Still confused about DNR & power of attorney.
- Nice quick and to the point. Thanks
- Good discussions esp. DNR and DNRCC
- Great refresh again
- Good lecture – good skill stations

January 25, 2012

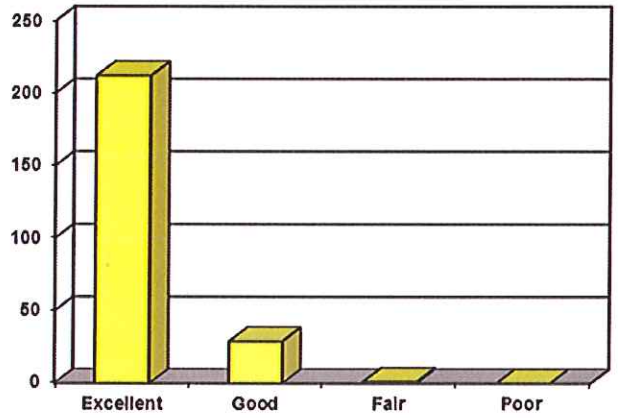
- Thanks for keeping us in the information loop regarding the research and our participation. It's nice to know we're making a difference.
- Very informational. Good anecdotal sources by all instructors. Excellent!
- Break out groups are always good.
- Need an alternative to Versed – aware of person with actual allergy to Versed. Good skills station.
- Question #26 is poor – duration of symptoms when stating SOB began "proceeding" nite is contradictory to apparent Acute Pulmonary Crisis. Peripheral Edema arguably a more significant sign. (P.S.) Don't say "Very Unique" – its grammatically poor usage. Unique in its self does not require a modifier for word usage as varying, or increase levels of uniqueness.
- Excellent info on DNR – Geriatric info very straight forward.

January 26, 2012

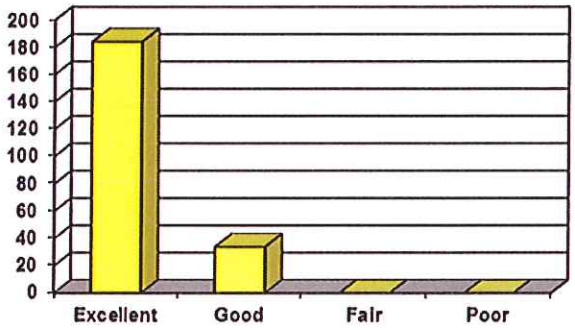
- Good CE.
- Good information. Thanks.
- Liked DNR/POA awareness
- Alarming statistics.
- Good information. More needs to be learned concerning meds and when or when not to give certain meds that interfere with conditions or patient's prescribed meds.
- Thank you

Noncredit Course and Instructor Evaluation
Geriatric Emergencies

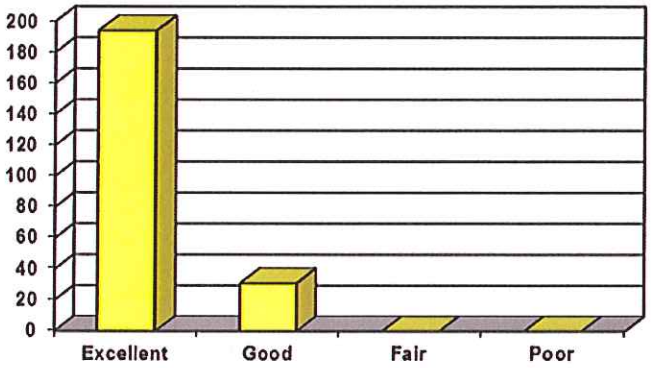
1. The course started on time



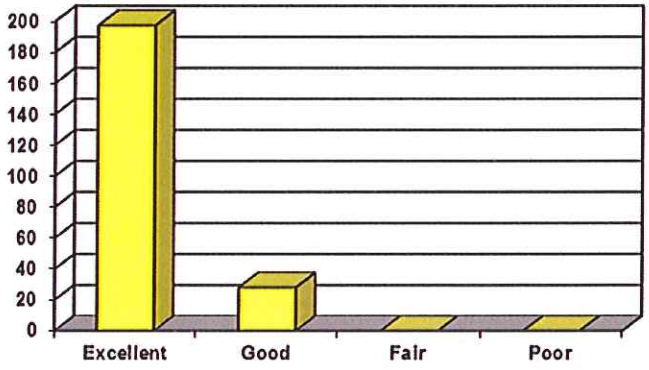
2. Course Objectives were clearly stated



3. Material was presented in an understandable manner



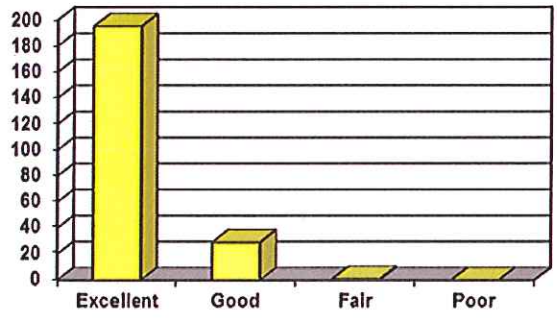
4. The instructor spoke clearly and loud enough to be heard



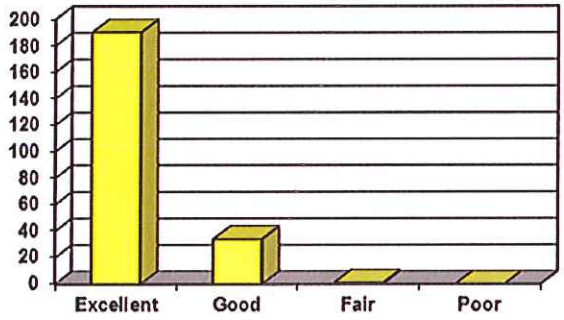
Course Dates: January 5,10,11,12,17,18,19,24,25,26, 2012
Number of evaluations: 226
Location: Lucas County EMS

Noncredit Course and Instructor Evaluation
Geriatric Emergencies

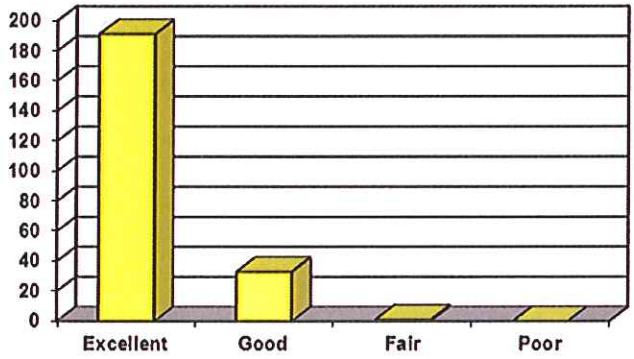
5. The instructor encouraged participation where appropriate



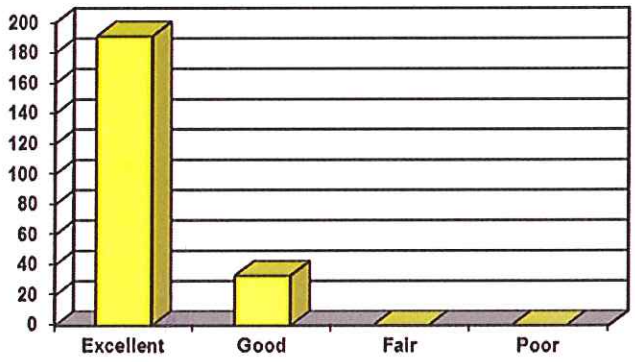
6. Handouts were easy to use and helpful



7. Rate your overall evaluation of the C.E. session



8. Did the written test reflect the objectives and course content?



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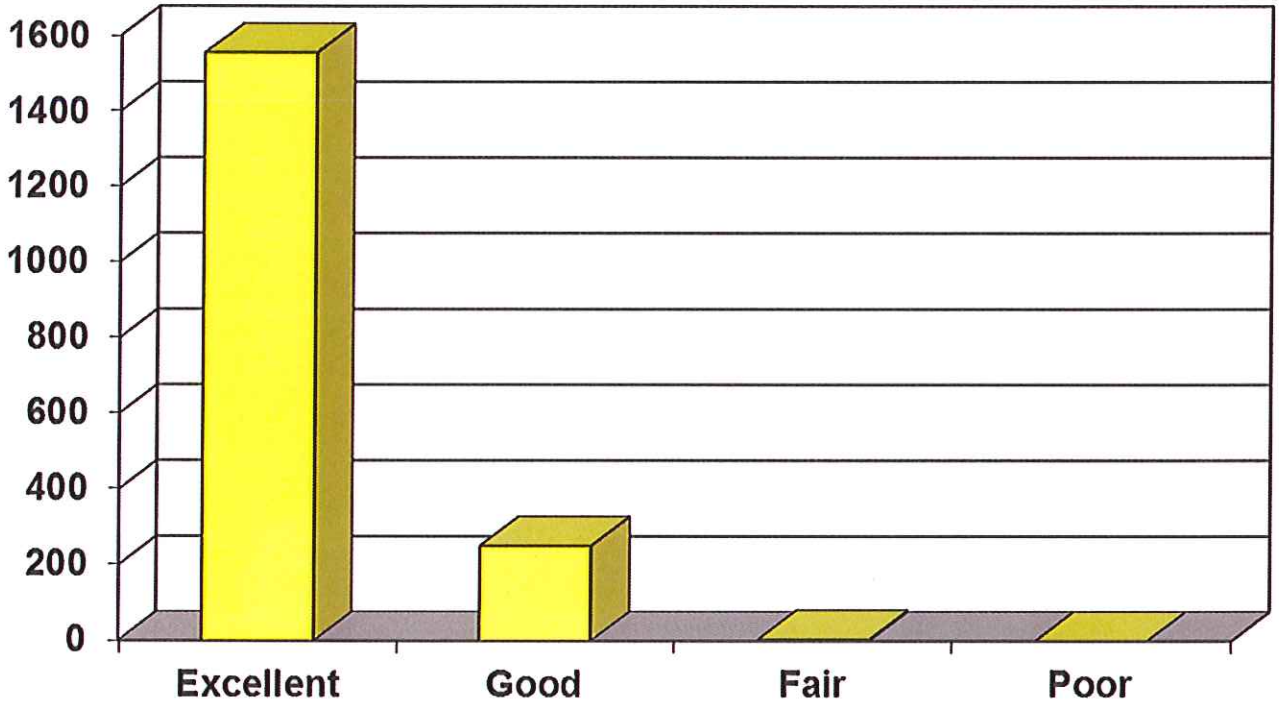
Geriatric Emergencies

Summary of All Responses to All Questions



Course Dates: January 5,10,11,12,17,18,19,24,25,26, 2012
Number of evaluations: 226
Location: Lucas County EMS