

MN Metro Region EMS System Pandemic Response Matrix

Approved March 12, 2020 EMS TOC Executive Committee



PANDEMIC CRISIS CONDITIONS TRANSPORT GUIDANCE






Policy context

These standing orders will be used to provide the best pre-hospital care to the greatest number of people during an extreme situation. They will only be put into place on approval from the EMS medical directors under conditions in which EMS services are pending or not answering calls for which there is a significant risk of death for the patient. They do not supersede other protocols. You will be notified when this status is in effect.

Our ethical commitments are:

- A. **Proportionality:** All individuals should receive the highest level of care given the resources available at the time.
- B. **Transparency:** Governments and institutions have an ethical obligation to plan allocation through a process that is transparent, open, and publicly debated.
- C. **Fairness:** The proposed triage process relies on the principle of maximization of benefit to the population served. The triage process treats patients equally based on objective, physiologic criteria, and when these criteria do not clearly favor a particular patient, “first come, first serve” rules will apply...
- D. **Assurance:** In order to ensure “procedural justice,” EMS triage processes will be regularly evaluated to assure that the process has been followed fairly and consistently.
- E. **Documentation:** Patient records will include notation that crisis care transport rules were in effect.

When an ambulance arrives on scene during crisis conditions, instead of automatically offering transport to an emergency department, as under normal practice, you will assess the patient’s objective condition and triage him/her into the following categories:


	<input type="radio"/> provide homecare information
	<input type="radio"/> refer to a clinic or other medical destination
	<input type="radio"/> refer to use of alternate transportation to a hospital, clinic or other medical destination
	<input type="radio"/> transport by (and at the discretion of) law enforcement
	<input type="radio"/> transport by ambulance to a hospital or other medical destination







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Standing Orders

- A. If the patient’s complaint or symptoms are not listed in this Appendix, Paramedic’s discretion is advised if the decision is not in conflict with SOP.
- B. During crisis care conditions **automatically offer to transport**  patients with the following presentations:





	1. Paramedic discretion – suspicion of critical illness/injury
	2. Altered vital signs (or age-specific abnormal vital signs), including any one of these: <ul style="list-style-type: none"> ○ SBP < 90 ○ SpO2 < 92% ○ RR > 30 (or respiratory distress) ○ HR > 120, or delayed capillary refill
	3. Breathing: <ul style="list-style-type: none"> ○ Respiratory distress ○ Cyanosis, or pallor/ashen skin
	4. Circulation/Shock: <ul style="list-style-type: none"> ○ Signs or symptoms of shock ○ Severe/uncontrollable bleeding ○ Large amounts of blood (or suspected blood) in emesis or stool
	5. Neurologic: <ul style="list-style-type: none"> ○ Unconscious or altered level of consciousness ○ New focal neurologic signs (CVA, etc.) ○ Status, multiple or first-time seizure ○ Severe headaches – especially sudden onset or accompanied with neck pain/stiffness ○ Head injuries with more than brief loss of consciousness or continued neck pain, dizziness, vision disturbances, ongoing amnesia or headache, and/or nausea and vomiting
	6. Trauma: <ul style="list-style-type: none"> ○ Significant trauma with chest/spinal/abdominal/neurologic injury deemed unstable or potentially unstable ○ Suspected fractures or dislocations that cannot be safely transported by private vehicle

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C. When resources are at crisis care levels **consider patients with the following presentations for:**

- **Transportation by ambulance**  - Note that many ‘transport by ambulance’ patients will not require emergency transport to the hospital – in which case, the crew may answer additional calls until the ambulance is full, or a critical patient is picked up, depending on system call volumes.
- **Transportation by alternate means:**
 - private vehicle**  **or first responder transport**  **to clinic, hospital, or alternate care site.** Except in very limited cases, the patient should NOT self-transport to the hospital/clinic but could be driven by someone else.
- **Homecare**  Give patient the Homecare form for their complaint and advise to contact PMD if symptoms persist or worsen. The form will have information pertaining to their complaint and list ways of caring for themselves, as well as what to look for that would prompt self-transport to a clinic or hospital, or transport via ambulance to the hospital. Advise the patient that this does not restrict them from seeking care at a clinic or hospital on their own, should they desire.

1. ABDOMINAL PAIN:



	<ul style="list-style-type: none"> ○ AAA history or suspected ○ Marked tenderness/guarding ○ Pain radiating into back and/or groin/inner thighs ○ Recurrent severe vomiting not associated with diarrhea
 	<ul style="list-style-type: none"> ○ Recurrent severe vomiting associated with diarrhea – to emergency if associated with signs/symptoms of dehydration, to urgent care or clinic if no dizziness nor vital sign changes and normal exam
	<ul style="list-style-type: none"> ○ Intermittent vomiting and/or diarrhea without blood or evidence of dehydration

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2. ANAPHYLAXIS/STINGS:

	<ul style="list-style-type: none"> ○ Patients who have had epinephrine administered for symptoms ○ Patients experiencing airway, hypotension, or respiratory symptoms, after an allergy exposure ○ Vomiting with a history of anaphylaxis in the past
	<p>Patients with itching after exposure – if rapid onset of symptoms, may require EMS transport; if delayed > 1hour, safe for private transport. All patients with history of anaphylaxis should be seen in emergency room if possible. Others may be seen in clinic or urgent care. EMS may administer diphenhydramine prior to clearing scene, up to 1mg/kg.</p>

3. BACK PAIN:

	<ul style="list-style-type: none"> ○ Acute trauma with midline bony spinal tenderness ○ New onset of extremity weakness, sensory deficits, other neurological changes, incontinence of urine or bowel, urinary retention, or bloody urine ○ Concern for abdominal aortic aneurysm ○ Pain radiating into abdomen, or groin/inner thighs ○ Fever and back pain
	<ul style="list-style-type: none"> ○ Inability to ambulate/care for self ○ Concern for kidney stone, bloody urine
	<ul style="list-style-type: none"> ○ Muscular back pain without neuro changes, fever, or trauma

4. BEHAVIORAL:


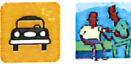

	<ul style="list-style-type: none"> ○ Uncontrolled agitation requiring sedation by EMS
 OR 	<ul style="list-style-type: none"> ○ Suicidal ideation – must be left with a responsible party
 OR 	<ul style="list-style-type: none"> ○ Other emotionally disturbed patients may be transported at law enforcement's discretion or by other means

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5. BLEEDING (LACERATIONS, ABRASIONS OR AVULSIONS):

	<ul style="list-style-type: none"> ○ Patient is on anticoagulant with significant ongoing bleeding or large hematoma
	<ul style="list-style-type: none"> ○ Significant lacerations after bandaging – heavily contaminated, bite-related, likely to involve foreign body, deep structure injury, sensory/motor deficit – to emergency room ○ Lacerations requiring simple repair – consider self-transport to physician’s office or urgent care center (however, some offices do not do procedures; patient will need to call ahead)
	<ul style="list-style-type: none"> ○ Abrasions or avulsions not requiring suturing or repair, no significant contamination. ○ Minor lacerations that do not require sutures

6. BURNS:

	<ul style="list-style-type: none"> ○ All chemical or electrical burns ○ Suspected inhalant burn ○ Significant third degree burns ○ Second degree burns to $\geq 5\%$ of body area ○ Second degree burns to face, mouth ○ Severe pain
	<ul style="list-style-type: none"> ○ Second degree burns to hands or feet, or to other location 1%-5% body surface area (size of patient’s palmar surface)
	<ul style="list-style-type: none"> ○ Second degree burns $< 1\%$ body surface area, non-critical location ○ First degree burns

7. CARDIAC ARREST:

	<ul style="list-style-type: none"> ○ Witnessed down time ≤ 10 minutes – follow usual resuscitation protocols
	<ul style="list-style-type: none"> ○ All others – report death to dispatch and return to service; do not wait for law enforcement or medical examiner arrival



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8. CHEST PAIN:

	<ul style="list-style-type: none"> ○ Chest pain or other signs or symptoms suspicious for cardiac ischemia, pulmonary embolus, or other life threat
	<ul style="list-style-type: none"> ○ Chest pain ongoing for >12 hours and a normal ECG ○ Pleuritic chest pain without hypoxia ○ Chest pain reproducible on physical exam to palpation is generally NOT concerning; unless ECG changes or known cardiac disease, unlikely to require treatment for acute coronary syndrome

9. DIABETIC:

 OR 	<ul style="list-style-type: none"> ○ Any patient on oral diabetes medications with low blood glucose – if transported by private vehicle must NOT drive self ○ Critical high glucose or signs of Diabetic Ketoacidosis/dehydration ○ By EMS for any Kussmaul respirations, tachypnea, or hypotension
	<ul style="list-style-type: none"> ○ Patients with typical hypoglycemia due to insulin and explanation for low sugar (did not eat, etc.) can be left without medical control contact as long as family/friend is present and patient is eating

10. ENVIRONMENTAL:




	<ul style="list-style-type: none"> ○ Heat-related illness with any alteration in mental status (confusion, decreased LOC) ○ Frozen extremity ○ Hypothermia with AMS
 OR 	<ul style="list-style-type: none"> ○ Frostbite to face, hands, feet, other location suspected deeper injury, blisters
	<ul style="list-style-type: none"> ○ Heat-related illness without alteration in mental status – initiate external cooling at home under supervision of friends/family ○ Minor frostbite with tissues now soft, pink, no blisters, and NOT involving digits

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11. ETOH/SUBSTANCE ABUSE:

	<ul style="list-style-type: none"> ○ Very decreased LOC or other confounding issues (head injury, suspicion of aspiration)
	<ul style="list-style-type: none"> ○ Otherwise may be transported at law enforcement's discretion
	<ul style="list-style-type: none"> ○ Patient may be left with a responsible individual who can assist the patient ○ Able to ambulate safely without assistance



12. EYE PAIN:

	<ul style="list-style-type: none"> ○ Impaled objects or possible penetrating injury to eye, or globe rupture ○ Chemical exposures (alkaline) – after decontamination and initial rinsing
 OR  	<ul style="list-style-type: none"> ○ Eye pain and/or acute changes to vision should receive transport for urgent evaluation to emergency department or other qualified clinic (e.g. eye clinic) ○ Chemical exposures (non-alkaline) – consult poison control for instructions; transport if symptoms / dangerous exposure
	<ul style="list-style-type: none"> ○ Chemical exposures (non-alkaline) – consult poison control for instructions; if no symptoms and limited toxicity likely, give instruction sheet

13. FEVER:

	<ul style="list-style-type: none"> ○ Fever plus altered mental status including confusion ○ Fever plus severe symptoms by paramedic assessment ○ Fever plus seizures, lethargy, stiff neck, rash, or blistering
 OR  	<ul style="list-style-type: none"> ○ ≤ 3 months with fever estimated at 100.5 degrees – to emergency room or clinic urgently ○ > 3 months with fever that does not reduce with anti-pyretics, or fever lasting more than 5 days – emergency room, urgent care, or clinic

14. HEADACHE:





	<ul style="list-style-type: none"> ○ With vision deficit, lethargy, or page 1 qualifiers (fever, etc.) ○ On anticoagulants ○ Trauma related HA worse than mild and/or with LOC
	<ul style="list-style-type: none"> ○ New headaches for patient require assessment ○ Usual headaches for patient may require treatment

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15. MUSCULOSKELETAL INJURIES (ISOLATED):

	<ul style="list-style-type: none"> ○ Loss of distal pulses ○ Unable to effectively splint the affected part ○ Neurological changes or deficits ○ Open fractures ○ Displaced fractures or pain requiring injectable narcotics
	<ul style="list-style-type: none"> ○ Suspected fractures that are stable and do not require injected analgesia may be splinted appropriately and transported by private vehicle
 OR 	<ul style="list-style-type: none"> ○ Neck pain and back pain after MVC, that is delayed in onset and not associated with midline tenderness or neurologic symptoms

16. NOSEBLEED:

	<ul style="list-style-type: none"> ○ Signs of hypovolemia or dizziness upon standing ○ Patient is on blood thinners (Coumadin, lovenox, clopidogrel, etc.) ○ Continued high blood pressure (SBP >200) in setting of nosebleed ○ Continued severe bleeding despite EMS efforts to control
	<ul style="list-style-type: none"> ○ All other

17. OB/PREGNANCY:





	<ul style="list-style-type: none"> ○ Imminent delivery ○ Pain in abdomen or back ○ Profuse vaginal bleeding ○ Third trimester (>24 weeks) bleeding ○ Pre/eclampsia – syncope, seizure, altered mental status, SBP ≥140
	<ul style="list-style-type: none"> ○ All other

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18. SYNCOPE:

	<ul style="list-style-type: none"> ○ History of coronary disease or heart failure ○ Age =>55 ○ Pregnant ○ Chest pain, headache, or shortness of breath (or other symptoms concerning to paramedics)
  	<ul style="list-style-type: none"> ○ Likely dehydration, with dizziness preceding the syncope ○ Other underlying medical conditions




19. TRAUMA

	<ul style="list-style-type: none"> ○ Elderly ○ Unable to ambulate ○ Serious mechanism ○ On blood thinners or other severe underlying disease with trauma
  	<ul style="list-style-type: none"> ○ Discretion based on degree of injury, ability to ambulate


20. TOXICOLOGIC:

   	<ul style="list-style-type: none"> ○ Overdose or other toxic exposure – contact Poison Control and/or on-line medical control ○ If intentional, see Behavioral Health in this Appendix
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21. VULNERABLE PERSON IN POTENTIAL DANGER:

  	<ul style="list-style-type: none"> ○ EMS should assure that person will not be left in dangerous environment ○ If safe disposition and transport can be arranged and the injuries do not otherwise require medical evaluation, other transport may be appropriate
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22. INTER-FACILITY TRANSFERS:

	<ul style="list-style-type: none"> ○ Requests for emergent EMS inter-facility transfers should be considered in the presence of a time-sensitive injury or diagnosis.
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