General Principles Table of Contents

Updates & Revisions

Definition of a Patient

Table of Contents

A patient shall be considered any person who meets ANY of the following:

- Requests medical attention or medical assistance of any kind (includes lift assist that are a result of a fall)
- In obvious need of medical attention or medical assistance
- Likely to have sustained an injury from an incident or accident
- A caretaker/family member requests medical attention or assistance on their behalf

ALL PATIENTS SHALL BE OFFERED EVALUATION, TREATMENT, AND TRANSPORT

Pediatric Patients

- Trauma Protocols: 15 years, 364 days and younger
- Medical Emergencies Transport: 17 years, 364 days and younger
- EMS Treatment: Once a child reaches puberty, use the indicated adult protocol (Puberty= breast development, underarm/ chest/facial hair)
- Medication dosing: Pediatrics= less than 50 kg (exceeds length based tape)

Implied Consent

- A patient at any age who is unable to communicate because of an injury, accident, illness or found to be unconscious and is suffering from what reasonably appears to be a life-threatening injury or illness shall be treated and transported based on implied consent

- The principle of implied consent presumes that if the individual were conscious and able to communicate, he or she would consent to emergency treatment

- In these situations, patients may be transported without their consent. Law enforcement, physical restraint, and/or chemical restraint may be required.

FLORIDA INCAPACITATED PERSONS ACT (STATUTE 401.445)

- (1) No recovery shall be allowed in any court in this state against any emergency medical technician, paramedic, or physician as defined in this chapter, any advanced practice registered nurse licensed under s. 464.012, or any physician assistant licensed under s. 458.347 or s. 459.022, or any person acting under the direct medical supervision of a physician, in an action brought for examining or treating a patient without his or her informed consent if:
  (a) The patient at the time of examination or treatment is intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent as provided in s. 766.103;
  (b) The patient at the time of examination or treatment is experiencing an emergency medical condition; and
  (c) The patient would reasonably, under all the surrounding circumstances, undergo such examination, treatment, or procedure if he or she were advised by the emergency medical technician, paramedic, physician, advanced practice registered nurse, or physician assistant in accordance with s. 766.103

Examination and treatment provided under this subsection shall be limited to reasonable examination of the patient to determine the medical condition of the patient and treatment reasonably necessary to alleviate the emergency medical condition or to stabilize the patient.

- (2) In examining and treating a person who is apparently intoxicated, under the influence of drugs, or otherwise incapable of providing informed consent, the emergency medical technician, paramedic, physician, advanced practice registered nurse, or physician assistant, or any person acting under the direct medical supervision of a physician, shall proceed wherever possible with the consent of the person. If the person reasonably appears to be incapacitated and refuses his or her consent, the person may be examined, treated, or taken to a hospital or other appropriate treatment resource if he or she is in need of emergency attention, without his or her consent, but unreasonable force shall not be used.

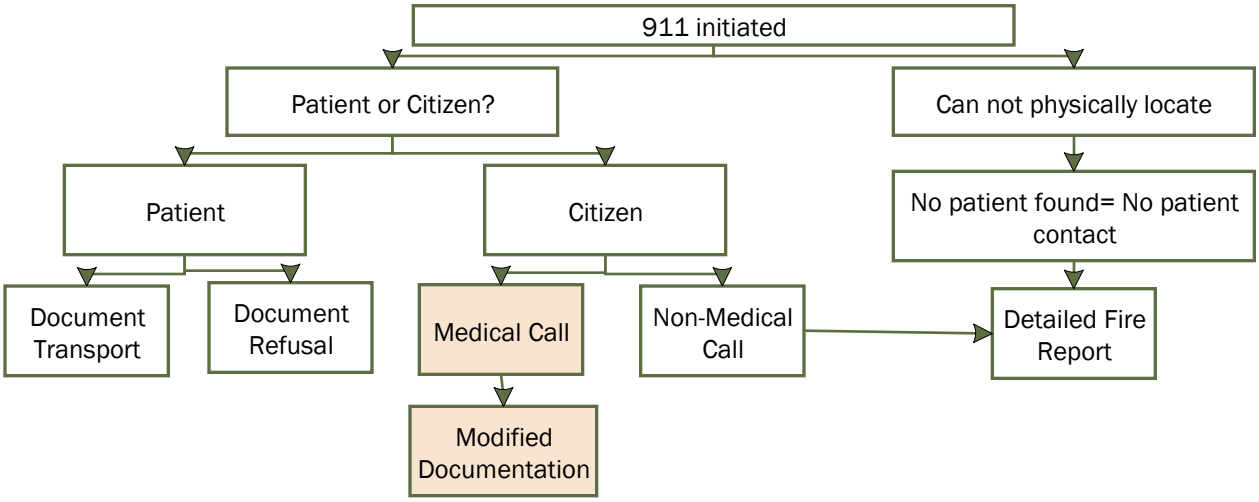
Definition of a Patient

Table of Contents

Patient Care Report

- A patient encounter shall occur with each patient as defined in protocol. If the person does not meet the criteria, you must follow your agency·s documentation guidelines, which may include a Public Assist Report or Occupant Refusal Form.

Guideline for Appropriate Documentation of Encounter



Refusal Documentation

Meets Refusal/Non-transport Criteria: **See Refusal Protocol**

Document evidence of decision making capacity such as:

- The patient is alert, oriented and understands and answers questions appropriately
- The physical assessment with any specific findings
- The specific potential consequences told to the patient of not receiving medical care/evaluation
- The alternatives to care (contacting private physician immediately, POV, alternate hospital destination, etc.)
- The patient·s own words why they refused

Obtain a witness signature (preferably someone on scene besides a crew member)

Suspected Child/Elder Abuse Reporting

Table of Contents

All health care clinicians are obliged by law to report cases of suspected child or vulnerable adult abuse and/or neglect to local police or adult/child protective service agencies.
Please call DCFS (1-800-25-ABUSE) (1-800-252-2873) and also report suspicions to the ED physician & ED charge nurse

1-800-25-ABUSE 1-800-252-2873

- Assess the scene closely, make mental notes, and document thoroughly.
- Upon arrival at the Emergency Department (ED), a verbal report summarizing your findings should be given to the responsible medical personnel.
- Do not make accusatory, confrontational, angry, or threatening statements to any parties present
- Lieutenant or Paramedic should report information to the Department of Children and Families (DCF) directly, as well as to the hospital staff.
- If we can report exactly what we saw at the home, DCF and the hospital can be more accurate in their reports and serve the patient better.
- For any non-transported patient, if you have concerns about the possible abuse, it will need to be reported to the appropriate local or state agency (Department of Children and Families or LEA)

Freestandings

Freestanding ED·s are licensed emergency departments that accept patients as an extension to an affiliated hospital. Although freestanding emergency departments must follow the same regulatory requirements as an emergency department on the main hospital premises, there are some patients that may be better served with transport directly to the appropriate facility. The following patients **should not** be transported to a freestanding emergency department unless there is an unstable airway or Traumatic Arrest and the closest ED is a freestanding:

- Any alert defined within the EMS Protocols (STEMI, Stroke, Sepsis, Trauma, Safety, Cardiac, CPAP, Hazmat)
- Post-ROSC
- Pregnant women at or greater than 20 weeks
- LVAD patients
- Baker acts
- Violent patients
- Altered mental status or Glasgow score < 13
- Concern for pulseless/ischemic extremity
- Peds < 18 years old with unstable vital signs and/or requiring oxygen
- Medical Cardiac Arrest

Patients with an unstable airway or those suffering from a traumatic cause of arrest should be transported to a Freestanding if it is the closest ED.

Unstable Airway

- Inability to maintain adequate SpO2 after 2 failed intubation attempts
- Unable to successfully oxygenate/ventilate via supraglottic device or BVM
- Unable to maintain SpO2 >88% with airway adjuncts (NPA, OPA) and BVM techniques by the most experienced provider on scene
- Advanced airway immediately required to prevent death

Paramedic discretion can be used in deciding between a freestanding emergency department and a hospital, except for the conditions specified above. Consider transport to main hospital if it·s likely the patient will require admission.

General Approach to Pit Crew for Critical Care

Table of Contents

Approach

Utilize the ABCDE method as a checklist and a means to assign roles during critical care calls.
Purpose: Allows for cognitive offloading and the ability to multi-task to ensure high quality care for complex and critical calls.

- For calls where there is only 1 paramedic, the team leader (paramedic) may need to assign specific tasks under each category to the EMT(s) rather than assign the entire category, as some tasks within the category may not be within the EMT scope of practice. However, many times more than one paramedic will be dispatched to a critical call, therefore you can assign the entire category to those individuals that are paramedics.

Procedure

- Team leader verbalizes the category and the associated tasks for the specific call. At that time, the team leader will also delegate the tasks to the individuals on scene.
- Crew should be addressing the category verbalized and reporting back as needed. Team leader advises of the intervention.
- Team leader will continue with assessment and move on to the next category, as long as preceding categories have been addressed or are being addressed simultaneously.

Category	Tasks	Role
A- Airway	Activate airway assistance (BVM, Supraglottic or ETT) if GCS <8, refractory hypoxia or other indication C-collar	Paramedic
B- Breathing	Monitor O2 Monitor respirations Monitor Capnography O2 supplementation as needed BVM(OPA/NPA) as needed Pre-oxygenate (NRB, CPAP, BVM) in preparation for intubation Set up apneic oxygenation for intubation	EMT can be assigned all tasks in this category (EMT to alert paramedic of abnormalities)
C- Circulatory	Monitor BP frequently IV/IO Fluids Meds EKG	Paramedic
D- Diagnostic & Destination	Check Glucose Review specific protocol Recommended meds based on protocol Review if any specific destination requirements	EMT can be assigned all tasks in this category (open protocol book/app & call out to team leader)
E- Exposure	Look for hives DCAP BTLS Decon as needed	Paramedic

Interfacility transport requires unique skills and capabilities, both in clinical care and operational coordination. Adhere t o the following standards for all interfacility transports:

- Interfacility transport decisions (including staffing, equipment and transport destination) should be made based on the patient·s medical needs
- Coordination between hospitals and interfacility transport agencies is essential, before transports are initiated, to ensure that patient care requirements do not exceed the capabilities of the patient attendant
- When a hospital is requesting interfacility transport please contact communications.
- If EMS crew members are not capable of managing devices or medications that must be continued during transport, an adequately trained care provider (critical care paramedic or RN) from the transferring facility, must accompany the patient during transport.
- If an EMS crew is contacted regarding an interfacility transfer or a non-time critical patient, the crew should contact their Supervisor for guidance regarding how to proceed

Emergency Interfacility Transports

EMS may be called upon for the immediate transfer of patients requiring emergency care not available at the sending facility, where time to definitive care is critical.

The patient will be transported to the facility at which a physician has accepted the patient unless:

- Operationally unfeasible
- There is no accepting physician
- During transport, the patient experiences unforeseen life threatening events requiring immediate intervention (i.e. cardiac arrest, unstable airway)
- It is a time sensitive condition such as a trauma alert, STEMI alert, or Stroke alert and there is a closer facility capable of definitive care

Online Medical Control

The Medical Control Base Station (MCBS) will provide online radio) medical control to EMS personnel operating under the medical oversight of the EMS Medical Directors.

Medical Control Physicians

Senior level Emergency Medicine Resident Physicians in collaboration with and under supervision of an Emergency Medicine attending will be available for medical control consultations. Medical Control physicians will:

- Participate in MCBS training as provided by the Medical Directors
- Participate in EMS related continuous quality improvement efforts
- Maintain knowledge of local EMS protocols and operational guidelines
- Respond to EMS calls in a timely manner when operationally feasible

EMS Personnel

Medical Control contact required:

? EMS unsure of patient's capacity
? ALS treatment administered (excludes Rehab protocol, Asthma & hypoglycemia when guidelines met)
? Meets alert criteria and patient refuses transport
? Abnormal vital signs, clinical factors, or EMS judgement that indicates it is a high risk refusal (potential for poor outcome)
? Children under 12 months of age except when 911 activated by an outside party and there are no complaints injuries in any of the passengers and the infant has a normal assessment (Parental/guardian capacity required)

Consultation Procedure:

- Hail Medical Control via the appropriate radio channel (Kiss/SCFR med control)
  In the event Medical Control is unable to answer the radio, EMS personnel should contact Dispatch for them to contact HCA Florida Osceola Regional by phone 407-518-3801. In the event of a life-threatening, time-sensitive condition or Online Medical Control is unavailable, Dispatch should contact the Medical Directors.
- EMS Personnel should provide the call details, **ensuring numbers 1-9 are obtained before the call** and are verbalized during the consultation (see next page)
- If orders conflict with local EMS protocols, politely state your concerns
- If orders are outside of the EMS protocols and would endanger the patient, contact the Medical Directors
- Under no circumstances shall EMS personnel perform procedures or give medications that are outside their scope of practice and/or credential

#6 and #7 are objective findings to assess for alcohol intoxication

Medical Decision Makers

Table of Contents

It is appropriate to identify the patient·s medical decision maker only when the patient is deemed incapacitated or the court has appointed legal guardianship to make decisions for the patient.

Degree of Authority (Florida)

Florida Statute 765.401

1. Legal Guardian- if court appointed
2. Durable Power of Attorney (POA)- if includes healthcare
3. Healthcare Surrogate- if designated and no Durable Power of Attorney (POA) exists
4. Next of Kin (Proxy)- if no legal document exists
   - Spouse → Children (Adult) → Parents → Siblings (Adult) → Others

Pediatric Considerations (Minors < 18 y/o)

Order of Authority:
1. Parent or Step-parent
2. Grandparent
3. Adult Sibling
4.Adult aunt or uncle

Emancipated Minors
- Married
- Pregnant when decision relates to pregnancy
- Legally emancipated

Medication Administration (The ´µ Rights)

- RIGHT: Patient
- RIGHT: Medication
- RIGHT: Time
- RIGHT: Dose
- RIGHT: Route

Monitoring Vehicle/Equipment

- Follow Agency·s Standard Operating Guidelines/Procedures
- Notify the EMS Supervisor of any equipment malfunctions at the conclusion of patient care activities

Patient Care

- Respond to all 911 activations
- Complete a proper assessment on all patients as much as allowed
- Check all equipment and ensure working in proper order
- Bring all necessary equipment to the patient
- Utilize appropriate PPE
- Manage life-threatening injuries immediately on scene (unless safety is a concern)
- Call for and utilize additional resources as needed
- Select the appropriate transport destination according to protocol and patient condition
- Ensure proper notification and hand-off to the receiving facility
- See Sentinel Event Reporting Protocol for required near miss and error notifications

Refusals/Non-Transports

Table of Contents

Patient requests Non-Transport

Caution:

*This is one of the highest risk encounters in EMS. The only indication for this protocol is when the **patient initiates** the non-transport request. Providers are not allowed to initiate this protocol outside of patient·s request

To avoid difficulties, ask the patient **WHICH** hospital they prefer (protocol dependent & operationally feasible) rather than **IF** they would like to go to the hospital

First assess capacity then assess risk

Capacity Assessment

? AAO x 4 AND GCS 15
? Has Insight and judgement
? No psychiatric decompensation or suicidal thoughts
? No signs of intoxication

If yes to ALL OF THE ABOVE, patient may refuse treatment and transport

Assess Risk of Refusal

Full ALS Assessment as allowed

Medical Control contact required:

? EMS unsure of patient·s capacity
? ALS treatment administered (excludes Rehab protocol, Asthma & hypoglycemia when guidelines met)
? Meets alert criteria
? Abnormal vital signs, clinical factors, or EMS judgement that indicates it is a high risk refusal (potential for poor outcome)

Meets Refusal/Non-transport Criteria:

Document evidence of decision making capacity such as:

- The patient is alert, oriented and understands and answers questions appropriately
- The physical assessment with any specific findings
- The specific potential consequences told to the patient of not receiving medical care/evaluation
- The alternatives to care (contacting private physician immediately, POV, alternate hospital destination, etc.)
- The patient·s own words why they refused

Does NOT meet Refusal/Non-transport Criteria: Proceed with Transport

- Utilize caregivers/family members for assistance if available
- Contact medical control & LEO for assistance as needed
- If patient becomes agitated/aggressive, proceed to Behavioral Protocol

PEARLS

- See infographic above for important elements to include in medical control consultation
- Utilize caregivers/family members to convince the patient to allow transport for further evaluation and treatment
- Communicate that EMS Personnel are not trained nor equipped to definitively diagnose or ´Medically Clearµ any patient of any condition
- Utilize medical control to assist in determining patient·s capacity if unsure, to assist with convincing the patient to allow transport, and to assist with documentation of a high risk refusal in the event of a poor outcome

Refusals/Non-Transports

Patient requests Non-Transport after ALS interventions:

Some patients may request non-transport after the resolution of symptoms due to EMS administered treatment. In the instances below, Medical control contact is not required prior to authorizing the refusal if all of the criteria below are met.

Hypoglycemia

- ☐ Patient with known hx of Diabetes
- ☐ Patient is on Insulin only & not on any oral diabetic agents (excludes Metformin)
- ☐ Baseline mental status and no new neurological deficits
- ☐ BGL >80 plus ability to eat & availability of food on scene
- ☐ Patient has the capacity to make informed health decisions

Bronchospasm resolved after Nebulizer Treatment

- ☐ Presentation is consistent with mild asthma
- ☐ No severe dyspnea at onset
- ☐ Not initially hypoxic (02 sat < 90%)
- ☐ No pain, fever or hemoptysis
- ☐ Significant improvement after a single nebulizer treatment with complete resolution of symptoms
- ☐ Vital signs within normal limits after treatment given (includes 02 > 96%)
- ☐ Patient has the capacity to make informed health decisions

On-Scene Rehab

This scenario is worth highlighting, as typically, any response where ALS treatment is provided, medical control contact is required. On-scene Rehab is an exception.

- ☐ See protocol for complete guidelines

Pediatric- Refusals/Non-Transports

Table of Contents

Parent/legal guardian requests non-transport

Full ALS Assessment as allowed

Life or limb threatening

YES

NO

A parent or legal guardian can refuse treatment of the minor if they demonstrate capacity AND there is no life-theatening immediate danger

Capacity Assessment

? AAO x 4, GCS 15
? Insight and judgement
? No psychiatric decompensation
? No signs of intoxication

Lacks capacity

Has capacity

Assess Risk of Refusal

High Risk or < 12 months of age

Low risk & > 12 months of age

Contact Medical Control

Contact LEO for assistance (temporary custody under neglect or abuse)

Allow refusal/non-transport & document evidence of decision making capacity such as:

- The legal Guardian is alert, oriented and understands and answers questions appropriately
- The physical assessment with any specific findings
- The specific potential consequences told to the Legal Guardian of not receiving medical care/ evaluation
- The alternatives to care (contacting private physician immediately, POV, etc.)

PEARLS

- See Care of Unaccompanied Minor Protocol as needed
- Laws regarding informed consent are state specific. It is important to be familiar with your state·s regulations.
- See infographic above for important elements to include in medical control consultation
- Medical control contact not required for a minor MVC in <12 months of age where 911 was activated by an outside party and the re are no complaints or injuries in any of the passengers and the infant has a normal assessment and is without injury.

Physician/Nurse on Scene

Physician Responsiblities

Occasions will arise when a physician on the scene physically or via telephone will attempt to direct or assist prehospital care. The physician must be willing to accept the following conditions:

- Provide documentation of her/his status as a physician (copy of medical license or medical license #)
- Assume responsibility for outcomes related to his/her oversight of patient care
- Agree to accompany the patient during transport if accompaniment is deemed necessary
- The Medical Control physician must relinquish the responsibility of patient care to the physician on scene for the scene physician to take control

EMS Responsibilities

- All interactions with physicians on the scene must be well documented in the Patient Care Report, including the physicians name and contact information
- Orders provided by the physician should be followed as long as they do not, in the judgment of the paramedic, endanger patient well being. The paramedic may request the physician to attend the patient during transport if the suggested treatment varies significantly from standing orders.
- Under no circumstances shall EMS personnel perform procedures or give medications that are outside their scope of practice and/or credential
- If the physician·s care is judged by the paramedic to be potentially harmful: Politely voice his or her concerns and immediately contact Medical Control
- If the conflict remains unresolved, follow the directives of the Medical Control Physician
- If the physician on scene continues to carry out the intervention in question, offer no assistance and enlist aid from law enforcement

Licensed Nurses present at an emergency scene who wish to participate in administering care must function in accordance with Florida law (F.S. 401 and F.S. Chapter 464)

Physician on Scene Card

"Orange Card" to be given to physician on scene offering assistance:

Kissimmee, Florida
Office of the Medical Director

Thank you for your offer of assistance. Be advised these Emergency Medical technicians and Paramedics are operating under the authority of Florida Law and City of Kissimmee and St. Cloud Fire Resue & EMS Protocols developed by the Medical Director. No physician or any other person may intercede in patient care without the Medical Command physician on duty relinquishing responsibility for patient care/treatment via radio or telephone. If responsibility is given to a physi cian at the scene, that physician is responsible for any and all care given at the scene, and may be asked to accompany the patient(s) to the hospital. Furthermore, the physician accepting the above responsibilities must sign the patient·s prehospital medical record.

Thank You.

Contact Medical Control for Additional Orders if Needed

Police Custody

Assessment

- When called to a scene to assess a person in police custody perform all assessments and treatment consistent with the standards set for the typical, non-detained patient. **EMS personnel are not equipped to perform formal medical clearance for patients in police custody prior to jail transport.** Paramedics are also not authorized to conduct blood draws for Law Enforcement in the field. If the subject is determined to be in need of medical attention and/or treatment, then transport shall be provided in accordance with the appropriate protocol.
- After assessing the patient, and treating any obvious conditions, transport to the ED should be offered in a manner consistent with the General Approach Protocol and a patient care report will be generated for all such encounters.
- All patients who receive either phyical or chemical restraint must be continuously observed by ALS personnel

Patient Initiated Refusal

- If the detained patient refuses transport, execute a standard refusal process as detailed in protocol
- Advise the Law Enforcement Officer (LEO) of the patient·s decision, and if all criteria are met, release the patient to the LEO
- If the LEO requests EMS transport in a scenario where the patient has refused, comply with the LEO·s request and transport the patient to the nearest appropriate ED
- If the patient does not meet refusal criteria, advise the LEO that transport is indicated and coordinate a safe transport of the detained patient.
- In scenarios where a LEO is unwilling to allow transport of a detained patient after EMS personnel have determined transport is indicated (i.e. requested transport, obvious medical necessity or not a candidate for refusal) adhere to the following:
  - -Assure that the LEO understands transport is indicated and that medical clearance prior to incarceration is not a process performed by EMS
  - -Contact the on shift Supervisor and advise of the situation
  - -Contact Medical Control for further input and assistance as needed
  - -If unable to resolve the issue, defer to the officer·s legal authority to retain custody of the patient
  - -Document the interaction well, including the law enforcement agency and officer involved

Safe Transport

- Patients restrained by law enforcement devices (i.e. handcuffs) must be transported accompanied by a law enforcement officer in the patient compartment who is capable of removing the device.
- Do not transport any restrained patient in a prone position

Clinical Feedback Rating

EMS QA Personnel will review charts and assign a Clinical Feedback Rating based on Table 1.
Feedback will be provided to the crew if any opportunities are found based on chart review and hospital outcomes.

In addition to the routine Quality Assurance performed by Medical Direction, reports categorized as POOR will also be assigned to the medical directors for additional review in ESO.

a. QA Personnel should provide EMS Personnel a notification of all fair protocol adherence ratings. Fair rated reports are viewed as ´near-missesµ and serve as opportunities to encourage continuing education and review system processes.

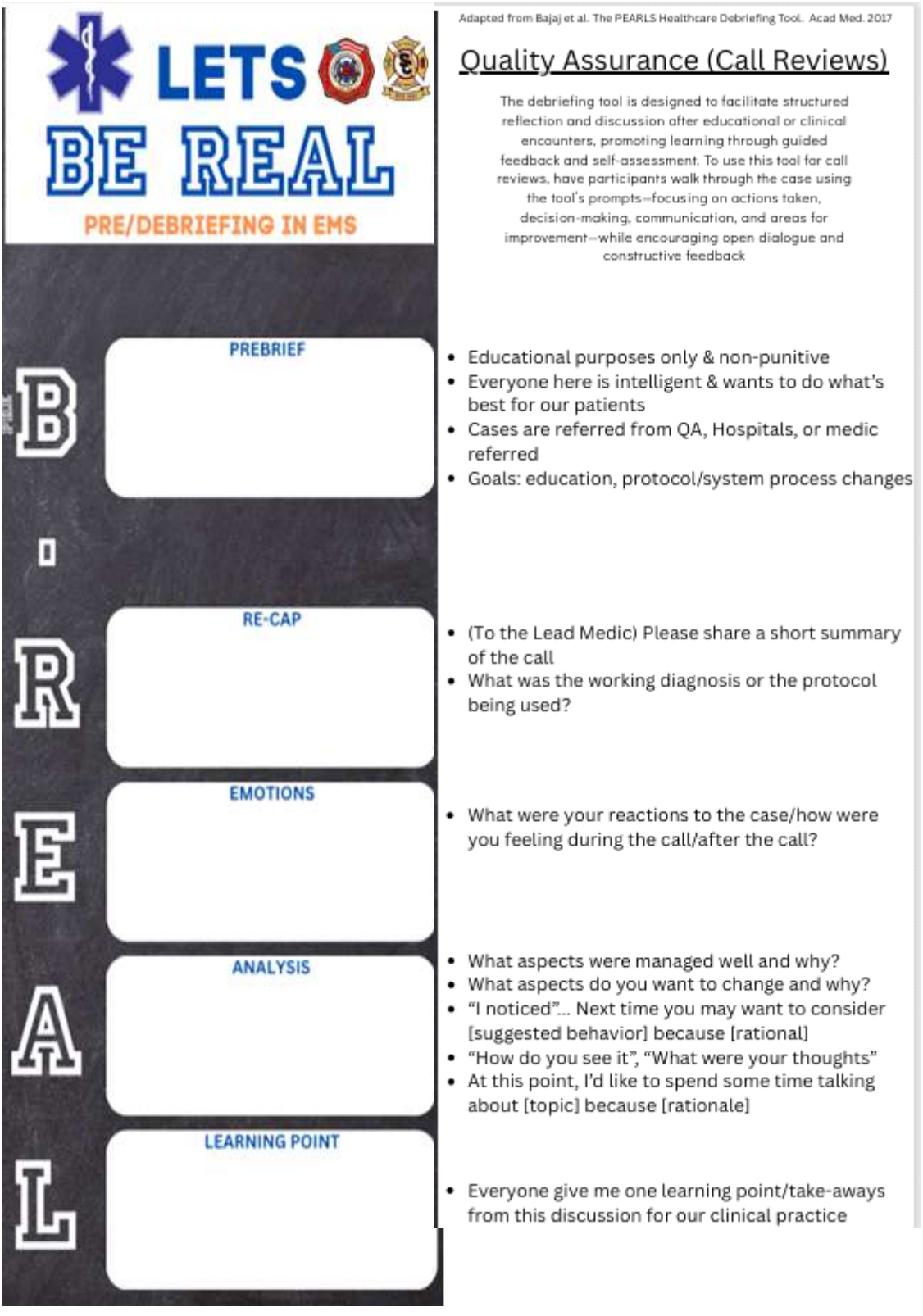
b. A biennial report of ´clinical feedback rating by medicµ will be run to identify trends in EMS personnel protocol adherence.

Table 1

Clinical Feedback Rating	Examples
EXCELLENT: • Exceeds expectations	• Ex. Protocol lacks guidance or protocol not established for specific patient presentation
GOOD: • Typical call, no deviation from protocol	
FAIR: • Deviation from protocol without patient compromise (also without Medical Control justification) • Improper documentation of refusals	• Ex. Administering Nitroglycerin to an Inferior MI without subsequent hypotension or patient complication
POOR: • Incorrect medications/dosages • Incorrect treatment • Deviation from protocol with patient compromise • Refusal without medical control contact or justification when required • Missing ´alertµ notification	• Ex. Administering Adenosine to a patient in Atrial Fibrillation • Ex. Inappropriate dosage as a result of dosing based on age rather than weight for Pediatrics

MD Call Reviews

Call Reviews will be conducted, routinely, with EMS crews to gain deeper insights into patient encounters, discuss notable cases, identify opportunities for system improvement, reinforce protocol adherence, and provide targeted education and training. The ´B-REAL format will be utilized for all in-person call reviews to ensure standardization and a non-punitive environment that promotes self-reflection and continued education.



Sentinel Events

Table of Contents

Sentinel Event: Any unexpected event/ occurrence involving death or serious physical or psychological injury, or the risk thereof. The phrase ´or the risk thereofµ includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

The following requires an immediate notification to the Chief Medical Officer/ System Medical Director and a Sentinel Event Report Form from the involved crew member(s) (within 24 hours):

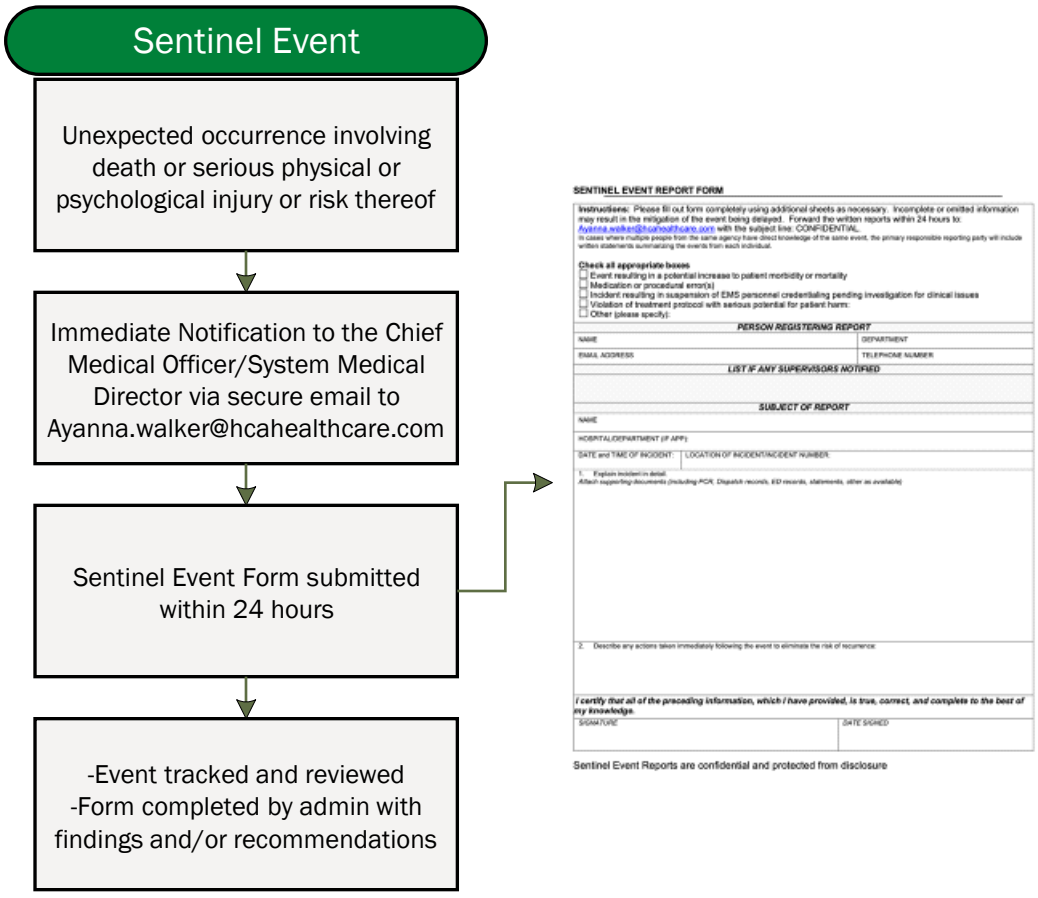
- Any event that has caused or has the potential to cause harm to a patient (i.e. unrecognized esophageal intubation)
- Any deviation from agency policy, protocol, or field procedure that resulted in patient harm or a threat to public safety;
- Medication, treatment, or clinical errors that has caused or has the potential to cause harm to a patient
- Controlled substance inventory discrepancies and/ or loss, theft, or suspected diversion of a controlled substance(s)
- Equipment failure or malfunction that resulted in patient harm
- Technology or communications systems errors or malfunctions that resulted in patient harm
- Any auto accident with an ALS transport unit where a patient is inside and there is a delay in patient transport and definitive care

Sentinel Event Reporting

Immediate Notification to the Chief Medical Officer/System Medical Director via secure email to Ayanna.walker@hcahealthcare.com and/or phone call. If voicemail reached, please leave a message specifying you need to discuss a sentinel event. Do not leave patient information on the voicemail but please include your name and call back information.

Please complete 1 form per event and include information from all involved personnel. Emai the form to Ayanna.walker@hcahealthcare.com

*Continue to follow your agency·s current policies for reporting all adverse events. **The above is in addition to the current policies/SOG·s.**



Transport Destinations

Table of Contents

All patients shall be offered transport. Those requesting transport **who do not express a preference** will be transported to the closest appropriate facility. If there is a request, it may be honored when operationally feasible and it does conflict with the following:

- Unstable patients (closest appropriate facility will apply)
- Cardiac Arrest of medical etiology, VAD, Sepsis, Stroke, STEMI Alert, Third Degree Heart Block, Safety Alert, Trauma Gray and Trauma Alert, or OB (>20 weeks)- refer to appropriate protocol for specific transport destination
- Patients with an unstable and unestablished airway (closest facility including Freestanding)
  - -advanced airway immediately required to prevent death
  - -unable to successfully oxygenate/ventilate via supraglottic device/BVM/ETT
- Patients with a traumatic cause of cardiac arrest will be transported to the closest facility (including Freestanding)

Medical Home

- It is best practice to transport the patient back to their medical home for recent discharges (within 72 hours), recent (within 30 days) or recurrent surgeries, and/or condition specific occurrences where there is a pre -existing patient-provider relationship within a hospital system
- EMS Personnel should document discussion of possible risks and benefits associated with possible longer transport times

Care Plans

Select patients may have a designated Care plan as developed with the patient and his or her health care providers, the local EMS agency, and one or more local hospitals. If a patient has a formal Care plan, then the patient should be treated and transported in accordance with the Care plan, unless the patient meets criteria to be transported to a specialty receiving center

Specialty Receiving Facilities

Percutaneous Coronary Intervention (PCI)
• AdventHealth Orlando 601 E. Rollins St Orlando • AdventHealth Heart of Florida 40100 S. Highway 27 Davenport AdventHealth Celebration 400 Celebration Place Celebration • HCA Florida Osceola700 W. Oak St Kissimmee • Health First¶s Holmes Regional 1350 Hickory St Melbourne • Orlando Health Dr. Phillips 9400 Turkey Lake Rd Orlando • Orlando Health South Lake1900 Don Wickham Dr Clermont

Comprehensive Stroke Center
• AdventHealth Orlando 601 E. Rollins St Orlando • AdventHealth Celebration 400 Celebration Place Celebration • HCA Florida Osceola700 W. Oak St Kissimmee • Orlando Health Orlando Regional 29 W. Sturtevant St Orlando

Trauma Centers

- HCA Florida Osceola (LEVEL II)700 W. Oak St Kissimmee
- HCA Florida Lawnwood (LEVEL II)1700 S. 23rd StFort Pierce
- Health First¶s Holmes Regional (LEVEL II)1350 Hickory St Melbourne
- Lakeland Regional (LEVEL II)1324 Lakeland Hills Blvd Lakeland
- **Orlando Health Orlando Regional (LEVEL I) 29 W. Sturtevant St Orlando
- **Tampa General (LEVEL I)1 Tampa General Cir Tampa

** **RECONGIZED REGIONAL BURN CENTER**

Pediatric Admission Capability

- AdventHealth Celebration Pediatric ER 400 Celebration Blvd Celebration
- Nemours Children¶s Hospital 6535 Nemours Parkway Orlando (ECMO capability)
- ****Orlando Health Arnold Palmer Trauma Level 1- 92 W Miller St Orlando

****Recognized Trauma and ECMO Center for Pediatrics**

OB Receiving Facilities

- AdventHealth Celebration 400 Celebration Place Celebration
- AdventHealth Heart of Florida 40100 S. Highway 27 Davenport
- AdventHealth Orlando 601 E. Rollins St Orlando
- HCA Florida Osceola700 W. Oak St Kissimmee
- Orlando Health Winnie Palmer83 W. Miller St Orlando
- UCF Lake Nona6700 Lake Nona Blvd Lake Nona

Transport Destinations

Table of Contents

Unstable Patients	Closest appropriate facility
*Unstable and Unestablished airway	Closest facility (includes Freestanding)
Traumatic Cardiac Arrest	Closest facility (includes Freestanding)
Medical Cardiac Arrest	Refractory/Persistent Shockable rhythm or ROSC= PCI All others= closest facility (**excludes** Freestanding)
Stroke Alert	Comprehensive Stroke Center
STEMI Alert	PCI Center
Third Degree Heart Block	PCI Center
LVAD	LVAD Center (Advent Orlando, Orlando Regional)
Sepsis Alert	Closest appropriate facility (**excludes** Freestanding)
Safety Alert	Closest appropriate facility (**excludes** Freestanding)
Trauma Alert	Closest State Approved Trauma Center
Trauma Gray	State Approved Trauma Center
OB > 20 weeks	Closest OB Facility
Hazmat alert	Closest appropriate facility (**excludes** Freestanding)
*Pediatric Admits	Pediatric Comprehensive Center

Updates & Revisions