SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

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FIELD TO HOSPITAL COMMUNICATIONS

I. PURPOSE

To establish standards for field to hospital notifications and reporting for in-coming ambulance patients from the 911 system and communications with the Base Hospital.

II. POLICY

A. Communications between field personnel, Receiving Hospital personnel, Field Supervisors, and Base Hospital Physicians shall adhere to the standards presented within this policy. Any operational reporting guidelines required by an ambulance provider shall be consistent with the guidelines noted in this policy.

B. No patient names or other personal identifying information may be given to the Receiving Hospital except at the request of the physician and with the patient's approval.

C. Under no circumstances shall the Receiving Hospital physician or nursing personnel provide medical direction to field personnel or refuse to accept an EMS ambulance patient.

D. Interfacility transfers pre-arranged with a physician and hospital are excluded from advance notification except in situations where the patient has unexpectedly deteriorated and requires immediate care in the emergency department.

E. Refer to EMS Agency Policy #8000 EMS MCI Plan for suspension of Receiving Hospital or Base Hospital contact in the event of a multi-casualty incident (MCI).

III. CRITICAL ALERTS

A. Critical Alerts are brief alert notifications for shock trauma, STEMI, stroke, critical pediatric or compromised airway patients intended to alert Emergency Department staff and other in-patient services (trauma, cardiology, neurology, anesthesia, respiratory therapy) about time sensitive conditions where definitive treatment is beyond the Emergency Department. Critical alerts are not subject to interrogation by the receiving facility; acknowledgement of receipt is all that is required. Full patient report is to be done after ED arrival. The format for critical alerts is in Attachment A.

B. Field personnel must make a reasonable effort to do critical alerts prior to the ambulance departing the scene. The transporting paramedic may do the alert or may designate another field responder to do it. It is within the scope of EMTs to make these calls.

C. Provide early critical alerts to Emergency Departments for the following:

1. **Shock Trauma Alert:** To Zuckerberg San Francisco General Hospital (ZSFG) for any patient with a major mechanism of injury from blunt or penetrating trauma as determined by the paramedic AND severe hemorrhagic shock with either SBP < 90 or absent peripheral pulses.

2. **STEMI Alerts:** To STAR Centers for patients meeting STEMI (STAR) Center destination criteria (per Policy 5000 Ambulance Destination). EKG transmission to STAR centers shall precede STEMI Alerts.

3. **Stroke Alerts:** To Stroke Centers for patients meeting Stroke Center destination criteria (per Policy 5000 Ambulance Destination).

4. **Critical Pediatric Alert:** to Pediatric Critical Care Centers for patients meeting the Pediatric Critical Care destination criteria (per Policy 5000 Ambulance Destination)

5. **Compromised Airway Alert:** to a Receiving Hospital when transporting a patient with an acutely compromised airway needing further immediate care.

IV. HOSPITAL NOTIFICATION PATIENT REPORTS

A. Field personnel shall provide hospital notification patient reports for ALL patient transports to an Emergency Department except Zuckerberg San Francisco General Hospital that have not required a Critical Alert per IIIC above. The format for Hospital Notification Patient Reports is in Appendix B.

B. Hospital notification patient reports to Zuckerberg San Francisco General Hospital are limited to the following:
   1. Shock Trauma Alerts
   2. STEMIs/Post Arrest ROSC
   3. Stroke
   4. Other patients trauma meeting trauma triage criteria
   5. Other critical medical or special circumstances (e.g. hazmat, etc.) at paramedic discretion

V. BASE HOSPITAL PHYSICIAN CONTACT

A. Field personnel shall document contacts with Base Hospital Physicians on the prehospital care record (PCR).

B. Prehospital personnel shall contact the Base Hospital Physician for treatment authorization or medical consultation for any of the following circumstances:
   1. Prior to administering any drug or initiating any treatment that requires Base Hospital Physician contact according to the EMS Agency Protocol Manual.
   2. Any questions or clarifications regarding the appropriate destination or specialty care receiving facility for a patient.
   3. Any patient whose care requires deviation from the EMS Agency Treatment Protocols.
   4. Any patient in which an on-scene physician wishes to assume total responsibility for medical care.
   5. Any patient refusal that requires Base Hospital contact in accordance with Policy #4040 Procedure and Documentation for Non-Transported Patients.
   6. Any patient, who in the paramedic's judgement, would benefit from a Base Hospital physician medical consultation.
   7. The format for Base Hospital Physician consultation is in Attachment C: (Full) Report Elements for In-Coming EMS Patients or Base Hospital Contact, per Policy 4040 Procedure and Documentation for Non Transported Patients.

C. The Base Hospital physician shall provide medical consultation for prehospital personnel in accordance with EMS Agency Policy 5011 Base Hospital Standards and all other applicable EMS Agency policies and protocols.

D. After the prehospital personnel have made Base Hospital physician contact, the personnel shall then notify the Receiving Hospital of any patient enroute to that facility. In rare circumstances the prehospital personnel's respective dispatch center shall relay this information if they are unable to do so.

VI. HOSPITAL AND FIELD RADIO GUIDELINES FOR CALLS

1. Use plain English during radio communications.
2. Make reasonable efforts to minimize voice radio traffic.
   - Receiving Hospital personnel and Base Hospital Physicians should avoid requesting information from Field Personnel that is not essential.
   - Receiving Hospital personnel and Base Hospital physicians shall repeat reports only when the transmission is unclear.

VII. FIELD RADIO COMMUNICATION FAILURE

In the event of radio communication failure in the field, the field personnel's respective dispatch center shall relay information from the field personnel to the Receiving Hospital as needed according to the approved reporting guidelines.

VIII. AUTHORITY

California Health and Safety Code 1797.204 and 1797.220.
California Code of Regulations, Title 22, Sections 100173-100175.

ATTACHMENT A: (BRIEF) CRITICAL ALERT GUIDELINES

CRITICAL ALERT

Critical Alert Elements:

1. Confirm hospital
2. Ambulance provider and unit number.
3. Reason for the critical alert (definition listed below):
   A. Shock trauma
   B. STEMI
   C. Stroke
   D. Critical Pediatric
   E. Compromised airway
4. Patient age and gender
5. Alert Criteria (definition listed below):
   A. **Shock trauma**: MOI plus signs of hemorrhagic shock, e.g. SBP<90 or absent peripheral pulses
   B. **STEMI criteria**: EKG with evidence of acute STEMI
   C. **Stroke**: Cincinnati stroke scale result and time last seen normal
   D. **Critical Pediatric**: post cardiac arrest, status epilepticus, hypotension with shock, or acute deteriorating level of consciousness without trauma
   E. Compromised airway: critical need for further treatment to secure airway
6. Estimated time of arrival (ETA)
7. Confirm message reception

Shock Trauma Alert: To ZSFG for patients with a major mechanism of injury from blunt or penetrating trauma as determined by the paramedic AND severe hemorrhagic shock with either SBP < 90 or absent peripheral pulses.

STEMI Alert: To STAR Centers for patients meeting STAR Center destination criteria. Must include EKG transmissions prior to STEMI alert notification.

Stroke Alert: To Stroke Centers for patients meeting Stroke destination criteria.

Critical Pediatric: To Pediatric Critical Care Centers for patients meeting PCCC destination criteria.

Compromised Airway: To a Receiving Hospital for patients with a critical airway need per ambulance destination policy

NOTE: *Full reports at given at the bedside after arrival.*

ATTACHMENT B: HOSPITAL REPORT GUIDELINES FOR OTHER EMS PATIENTS *(Not Shock Trauma/STEMI/Stroke/Critical Pediatric or Compromised Airway)*

All Reports:

1. **Start** with name of hospital you are trying to contact.
2. Name of ambulance company and unit number.
3. Patient age and gender.
4. Go to MIVT formats below for trauma or medical calls:

   Trauma MIVT Format:

   - **M**echanism of injury (MOI)
   - **I**njuries sustained (Sign and symptoms; pertinent positive/negative physical findings/special consideration e.g. hazmat, violent, etc.)
   - **V**ital signs
   - **T**reatment rendered including response to treatment. (Estimated) **T**ime of Arrival

   Medical MIVT Format:

   - **M**edical Condition (Patient chief complaint)
   - **I**llness (Sign and symptoms; pertinent positive/negative physical findings/special consideration e.g. hazmat, violent, etc.)
   - **V**ital signs
   - **T**reatment rendered including response to treatment. (Estimated) **T**ime of Arrival

5. ETA
6. Confirm receipt

ATTACHMENT C: REPORT GUIDELINES FOR BASE HOSPITAL PHYSICIAN CONSULATION

All Base Calls:

1. Ambulance Company name and unit ID number
2. Prehospital provider ID
3. Incident number
4. Purpose of the consultation
5. Patient age and gender
6. Location found
7. Patient chief complaint
8. Vital signs
9. Blood glucose and ECG findings if relevant
10. Patient assessment, pertinent physical exam
11. Pertinent past medical history
12. Capacity assessment findings
13. Patient's plan for care if any
14. Prehospital provider's opinion for disposition