Z-05 BLS ATTENDING/ ALS INTERCEPT		

NOTE: Individual agencies may elect to have Paramedic (ALS) attend on <u>all</u> patients.

- This is at the discretion of the Operations Director/Manager and Medical Director.
- The agency's policy supersedes this guideline except in Mass Casualty Incidents.

ALS Response & Evaluation

- A Paramedic (ALS resource) will be dispatched to every 911 request for EMS service for any High-Priority (i.e. Priority 1 or Priority 2 call).
- A BLS resource may be dispatched to lower priority (i.e. Priority 3) calls if:
  - An ALS resource is not immediately available and the EMS System and EMS Medical Director have agreed to dispatch a BLS resource to these calls.
  - <u>AND</u> an ALS resource (or process for dispatching an ALS resource) is available to intercept the BLS crew should the patient not meet criteria for EMT/AEMT Attending either on initial evaluation or if deterioration occurs during transport.
- The Paramedic will complete and document a thorough detailed assessment prior to making the decision to transfer care (attending responsibility) to a lower credentialed provider.

Transfer of Care

If the higher-leveled provider determines that the patient's condition is stable and ALL patient care needs can be managed by a provider with a lower level credential, patient care may be transferred to a provider of lower certification for care while en route to the hospital.

- The determination of who attends should be based upon:
  - The patient's immediate treatment needs, and
  - Any reasonably anticipated treatment needs while en-route to the hospital.
- The highest-credentialed provider is responsible for making the decision for which patients can be safely transported by a provider with lower credentials.
  - The highest-credentialed provider on scene retains the right to attend to any patient transported based on his/her impression of the patient's clinical condition or needs.
  - If the lower-credentialed provider is not comfortable assuming the attending role, the paramedic (or highest credentialed provider) should attend during transport.
  - As a general rule, if providers are questioning or do not agree on who should attend

the patient, the highest-credentialed provider should attend the patient.

The care of the following patients <u>cannot</u> be transferred to a lower-credentialed provider (i.e. Paramedic to an EMT/AEMT) :

- Any **unstable or potentially unstable patient** should always be attended by the highest credentialed EMS provider on scene (generally Paramedic) .
- Any patient who is requiring or might reasonably require additional or ongoing medications, procedures and/or monitoring beyond the scope of practice of the lower-credentialed provider.
- Any patient with significantly **abnormal vital signs**:
  - Hypotension (SBP <90 mmHg in adults) at *any time* during evaluation.
  - Any of the following that do not improve with basic comfort/calming measures:
    - Heart Rate >120 <u>or</u>
    - Respiratory Rate >20 <u>or</u>
    - Systolic Blood Pressure >220 (with no symptoms of stroke, chest pain or SOB).
  - Any patient with *new/increased oxygen demand* (oxygen saturation <94% on room air/baseline home oxygen).
    - <u>NOTE</u>: Any EMS provider may attend patients with O_2 given by nasal cannula when it is used as a *comfort measure only*, and not used for hypoxia as above.
  - Any patient not at their baseline mental status (e.g postictal seizure patients).
    - EXCEPT when there is definitive evidence of mild to moderate substance abuse/ intoxication that can be verified, wholey explains the altered LOC, and the patient is otherwise stable.
- Any patient that received interventions (medications or treatments) prior to transport beyond the EMS Provider's scope of practice, EXCEPT:
  - A patient who has received a **single dose** of non-opioid pain medication and/or an antiemetic as the only medication/fluid outside of the EMS provider's formulary.
  - Assessment tools that do not have significantly abnormal findings that have been performed by a higher-credentialed provider (i.e. Continuous/12-lead ECG).

Z-05 BLS ATTENDING/ ALS INTERCEPT		

ALS Intercept

Indication: An ALS resource (paramedic) will be dispatched if a BLS Provider (EMT/AEMT) is attending a patient and IF:

- The patient's status changes (deteriorates) and they meet any of the criteria noted in the "Cannot be Transferred" section above, OR
- There is any other change in patient condition that is concerning to the EMT/AEMT, and the EMT/AEMT does not feel comfortable in their ability to assess and/or treat a patient for any reason.

ALS Intercept Procedure:

- *BLS Provider attending with paramedic driving*:
  - The paramedic will drive to the nearest safe area and assume the attending role/care of the patient.
- *BLS Provider attending with other driver:*
  - The nearest/most appropriate ALS resource, including mutual aid resources when needed, will be dispatched to rendezvous with the BLS crew.
  - The BLS crew will **not remain on scene unless** the ALS resource has a response time of **less than 5 minutes.**
  - The BLS crew will begin transport as quickly as possible to the nearest appropriate emergency department, and **if transport time is less than 10 minutes, the ALS intercept will be aborted** or may occur at the destination facility.
  - If transport time is expected to be >10 minutes, the BLS crew will communicate directly with the ALS resource to arrange a rendezvous point.
  - A delay of >10 minutes waiting on scene or at a rendezvous point is not acceptable. This is from the time of arrival to the time of the ALS crew beginning transport (i.e. wheels rolling).

Z-05 BLS ATTENDING/ ALS INTERCEPT		First Responder EMT AEMT Paramedic

Documentation

- All providers are responsible for the documentation of their evaluations and treatments.
- The content of the report is ultimately the responsibility of the highest-credentialed provider evaluating/treating the patient.
- The ePCR should always reflect the decision making process to determine which provider attends in the back of the ambulance.

ATTENTION:
EMT/AEMT Attending with Continuous ECG Monitoring:

- Any patient transported by an EMT or AEMT with Continuous ECG monitoring WILL HAVE a 12-Lead ECG performed and interpreted by the Paramedic prior to transport.
- The patient may remain on continuous ECG monitoring while transported by a provider not trained on rhythm strip interpretation, BUT it may only be used as a surrogate for monitoring heart rate, AND **treatment decisions** based on the rhythm strip **may only be made by Paramedics**.
- The patient's rhythm MUST be their baseline rhythm (normal sinus rhythm or atrial fibrillation), and must be within vital sign parameters listed above.
- If during transport the EMT/AEMT notes ANY Heart Rate >120 or <50:
    - Immediately print a rhythm strip.
    - Notify the paramedic of the change in rate and any change in patient status.
    - Document the rate and any additional evaluations or interventions performed.
- Attach or scan ALL rhythm strips to the chart.

Z-05 BLS ATTENDING/ ALS INTERCEPT		

ATTENTION:
Concerning Chief Complaints:

- In general, an *actively* unstable patient should be quickly and easily determined during the initial ALS assessment and should ALWAYS be attended by the most experienced provider on scene.
- The ultimate decision of whether a patient has signs or symptoms that may indicate a potentially unstable patient who may deteriorate or require ALS interventions en route is always the responsibility of the Paramedic.
- The following complaints may often appear stable, BUT should be considered potentially unstable and should always be attended by the Paramedic:
    - **As noted above**: any abnormalities in vital signs or mental status.
    - Acute chest pain, dyspnea or other anginal-equivalent symptoms that are consistent with a potential cardiac cause.
    - Unexplained syncope in patients >35 years old.
    - Acute neurologic symptoms (including those that have that resolved, i.e. TIA) that are concerning for stroke.
    - Acute and severe sudden-onset headache concerning for aneurysm rupture.
    - Overdose of any medication that has cardiac effects (slowing heart rate or lowering blood pressure) or potential sedative effects, regardless of quantity or timing of ingestion.