



SUBJECT: **HOSPITAL GUIDELINES FOR INTERFACILITY TRANSFERS VIA AMBULANCE**

APPROVED BY:

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I. PURPOSE

To assure that all ambulance transfers between acute care hospitals and other facilities as approved by the EMS Medical Director are arranged in a manner that maximizes patient safety.

A. Requests for ambulance service from all other facilities, e.g., physician's offices, urgent care centers, clinics (except for those approved by the EMS Medical Director), nursing homes, convalescent hospitals, or other facilities not equipped or licensed to provide acute inpatient care are considered either "emergency" or "routine transport" calls rather than interfacility transfers

1. The 911 system should be activated by these other (non-acute care) facilities for patients requiring emergency transport and care.
2. Private ambulance service providers should be contacted for routine transport needs.

II. RESPONSIBILITY

The sending facility is responsible for assuring safe interfacility patient transfer. This means that the sending facility is responsible for selecting the appropriately staffed ambulance for each patient.

III. AMBULANCE PERSONNEL

Four transport options are available for transfers of patients between acute care facilities:

- EMT-I
- Interfacility Transfer Paramedic (CCT-P)
- Emergency Paramedic
- Critical Care (Includes RN or Physician staff)

The scopes of practice of EMT-I's, CCT-Paramedics and Emergency Paramedics are limited and regulated by state regulation and local EMS guidelines. Please refer to page 5 of this policy for a comprehensive listing of scope of practice.

IV. TRANSFER TYPES

A. EMT-I AMBULANCE TRANSFER

For transfer of a stable patient requiring en route care within the EMT-I scope of practice, or for the transfer of any patient when accompanied by hospital personnel and equipment to provide care beyond the EMT-I scope of practice.

1. Ambulance staffed with two (2) EMT-I's.
2. Care provided includes patient observation and basic life support skills.
3. **If patient may require care beyond EMT-I scope of practice, transferring facility must send appropriate personnel supplied with necessary equipment/medications for transfer.**

4. Procedure for Obtaining: Contact private ambulance provider to arrange for transfer.
5. Medical Oversight: Transferring physician is responsible.
6. Several private ambulance services offer EMT-I staffed ambulances for patient transfers. These ambulance services are not provided under the auspices of the County Emergency Medical Services Agency.

Note: EMT-I's are generally utilized for routine (scheduled or unscheduled) transfers. In some cases, EMT-I ambulance may represent the only promptly available level of care based on 911-system activity.

B. INTERFACILITY TRANSFER PARAMEDICS (CCT-P's).

For transfer of any patient for whom sending physician/hospital determines CCT-P level of care is appropriate. This level of service is appropriate for stable patients requiring cardiac monitoring, advanced life support (ALS) care, or care within the CCT-Paramedic expanded scope of practice. Sending physician should keep in mind that the minimum staffing level of a CCT-P unit is one paramedic and one EMT-I driver. This level of transport may not be appropriate for patients with complex monitoring or treatment requirements.

1. Staffing levels and standards are regulated and overseen by the local EMS Agency.
2. Procedure for Obtaining: Contact private ambulance provider offering CCT-P level service to arrange for transfer.
3. Medical Oversight: CCT-Paramedics function under standing orders written by sending facility physicians. Transferring physician is responsible for specifying orders within parameters of the CCT-P scope of practice.
4. Some private ambulance services may offer CCT-P ambulances for transfer.

C. EMERGENCY PARAMEDIC AMBULANCE TRANSFER

For IMMEDIATE transfer of a patient requiring emergency care not available at sending facility.

1. May be requested when patient requires care not available at the sending facility, and time to definitive care is critical.
2. A nearby paramedic ambulance can usually be sent, but due to increased demands on the EMS system, a paramedic ambulance may not always be available. If requested in those situations, the closest available EMT-I unit can be sent.
3. The patient generally will be transported to the nearest **appropriate** emergency medical facility. The nearest **appropriate** facility may not be the closest basic emergency department.

Ambulance personnel should consider arrangements that have been made by the sending facility/physician for the timely care of the patient at a hospital that, although not the closest, is equipped, staffed, and prepared to administer care to the patient being transferred.

4. Procedure for Obtaining:
 - a. Telephone County-designated emergency ambulance provider dispatch center directly and request an immediate response paramedic ambulance for an emergency transfer.
 - b. Prepare to send appropriate personnel and equipment if patient care required enroute is beyond the scope of practice of ambulance personnel who respond.
 - c. Prepare copies of medical records, x-rays, etc., for transfer.

- d. An emergency paramedic ambulance should not be expected to wait at the hospital for more than 10 minutes while a patient is being prepared for transport, and after 10 minutes, the crew may contact their dispatch and return to 911 EMS service. (Patient records not available within the 10-minute time frame may be faxed to the receiving hospital.

8. Medical Oversight:

Paramedics function under EMS Field Treatment Guidelines, and will contact their base hospital if necessary to obtain additional patient orders. By law, paramedics may not accept advanced life support medical direction from physicians or RN's assisting with transfers.

D. **CRITICAL CARE AMBULANCE (CCT)** with RN or MD staffing.

For transfer of any patient for whom the sending physician/hospital determines CCT level of care is appropriate. RN/Physician-staffed CCT units are the appropriate mode for unstable patients requiring advanced life support level care.

1. Equipped/staffed to transfer critically ill patients.
2. Staffing levels, standards, quality activities are NOT regulated or overseen by the County.
3. Procedure for Obtaining: Contact private ambulance provider offering CCT level service to arrange for transfer.
4. Medical Oversight: Transferring physician is responsible.
5. Some private ambulance services provide CCT ambulances for transfer. These services are not provided under the auspices of the County Emergency Medical Services Agency.

- E. *Interfacility Transfer Matrix* (attached) outlines the various types and capabilities of ambulances that may be available for patient transfer.

V. DOCUMENTATION AND REVIEW

- A. ALL interfacility transfers involving paramedics are subject to EMS system quality improvement review.
- B. The base hospital will also review any emergency paramedic interfacility transfers for which there was base hospital contact.

Contra Costa Health Services
Emergency Medical Services Agency

Patient Name: _____ Date: _____ Time: _____

Cardiac monitoring standard unless indicated. _____ No Cardiac Monitor required

Vital Signs: Every 15 minutes, more frequently by treatment guideline or MD order: q _____ min.

_____ Oxygen: Rate: _____ L/min _____ NC _____ Mask _____ ETT _____ Trach Collar

_____ IV: Solution: _____ Rate: _____ Saline Lock only _____

_____ IV with KCl: (if >20 mEq/L or < or = 40 mEq/L must run on pump—max rate: 10 mEq/hr)

Solution: _____ Rate: _____ KCl: _____ mEq/L

_____ Morphine: Dose _____ mg IV, Frequency: _____ (Maximum 20 mg)

_____ IV NTG: Concentration: _____ Half-strength (25 mg/250 ml) Starting rate _____ ml/hr (max 30 ml/hr)

_____ Full-strength (50 mg/250 ml) Starting rate _____ ml/hr (max 15 ml/hr)

Note: NTG sublingual should not be co-administered with IV NTG

_____ Sublingual NTG: Dose 0.4 mg Frequency _____ Maximum 6 doses

Note: Sublingual NTG should not be co-administered with IV NTG

_____ IV Heparin: Concentration 100 units/ml (25,000 units/250 ml or 50,000 units/500 ml)

Rate: _____ units/hour _____ ml/hour (maximum rate 1600 units/hr or 16 ml/hour)

_____ IV Lidocaine infusion _____ mg/minute (maximum rate 4 mg/minute) Rate: _____ ml/hour

_____ IV Dopamine infusion _____ mcg/kg/minute Concentration: _____ mg/ml Rate: _____ ml/hour

_____ Nebulized Albuterol: Dose: _____ 2.5 mg/3 ml _____ 5 mg/6 ml Frequency _____

Note: maximum standing order dose 10 mg for children age 14 and under

_____ NG or Gastric Tube: _____ Gravity Drainage _____ Clamped _____ Suction @ _____

_____ Chest Tube: _____ Water Seal _____ Suction @ _____

_____ Other indwelling devices _____ Foley _____ Other: _____

_____ Other (within CCT-P scope): _____

STANDING ORDERS:

Cardiopulmonary arrest or impending arrest: Follows County EMS Treatment Guidelines

Other medical issues (e.g. anaphylaxis, seizure): Follows County EMS Treatment Guidelines

MD Signature: _____ Date: _____

Paramedic Signature: _____ Date: _____

Ambulance Service: _____ Unit: _____

COMPARISON OF EMT-I AND PARAMEDIC SCOPE OF PRACTICE - CONTRA COSTA COUNTY

SKILL	EMT-I SCOPE OF PRACTICE	EMERGENCY AMBULANCE PARAMEDIC SCOPE OF PRACTICE (Includes EMT-I scope)	INTERFACILITY TRANSFER PARAMEDIC SCOPE OF PRACTICE
LIFE SUPPORT	CPR	CPR plus ACLS within scope	CPR plus ACLS within scope
AIRWAY MANAGEMENT	Oropharyngeal airway Nasopharyngeal airway Suction devices Oxygen delivery via nasal cannula or simple mask only Bag-valve-mask	Endotracheal intubation Esophageal/tracheal airway Airway visualization with laryngoscope and foreign body removal with forceps	Same as emergency ambulance paramedic
IV FLUIDS AND MANAGEMENT	May monitor peripheral lines containing plain isotonic or glucose solutions with no medications added.. EMT-I's are restricted to monitoring, maintaining present rate, or turning off flow of IV fluid	Administer and adjust rate of glucose or isotonic balanced saline solutions. May monitor and adjust IV solutions containing potassium (20 mEq/L or less).	Administer and adjust rate of glucose or isotonic balanced saline solutions May monitor and adjust IV solutions containing potassium, heparin, and/or NTG May use an infusion pump to administer the above
MONITORING	Cannot provide cardiac monitoring. May monitor NG and gastrostomy tubes, saline or heparin locks, foley catheters or established tracheostomy tubes. Central venous access lines may be present but no infusions except if via patient-controlled device. Cannot transport patients with arterial lines or chest tubes	Continuous ECG monitoring Chest tube monitoring Pulse oximetry IV line monitoring, not including arterial lines	Continuous ECG monitoring Chest tube monitoring Pulse oximetry IV line monitoring, not including arterial lines Tubes monitoring including foleys, suprapubic catheters, and other indwelling GI tubes
BASIC PROCEDURES	First aid CPR Obtain vital signs, pupillary status, assess level of consciousness Use stretchers and immobilization devices May assist patient in use of patient-operated, physician prescribed devices	Defibrillation Synchronized cardioversion Valsalva maneuver Cardiac pacing Venous blood sample draws Blood glucose monitoring	Same as emergency ambulance paramedic
INVASIVE PROCEDURES	None	Needle thoracostomy Needle cricothyrotomy	Same as emergency ambulance paramedic
MEDICATIONS	Glucose paste only	Activated Charcoal Adenosine Albuterol Atropine Calcium Chloride Dextrose (25% or 50%) Diazepam Diphenhydramine Dopamine Epinephrine	Furosemide Glucagon Glucose paste Lidocaine Midazolam Morphine sulfate Naloxone Nitroglycerin (sublingual) Sodium Bicarbonate
			Same as emergency ambulance paramedic, plus: IV heparin IV NTG IV KCl

INTERFACILITY TRANSFER MATRIX (4/29/02)

TRANSFER TYPE	EMT-I AMBULANCE*	EMERGENCY PARAMEDIC AMBULANCE*	INTERFACILITY TRANSFER PARAMEDICS (CCT-P)*	RN - CRITICAL CARE AMBULANCE
REASON FOR TRANSFER	Scheduled or routine transfer for med/surg admission or diagnostic procedure. In some instances, may be only available ambulance in emergent situation.	Time sensitive transfer to nearest appropriate higher level of care.	Transfer of patient requiring advanced life support (ALS). Staffed and equipped to transfer stable patients.	Transfer of patients requiring advanced life support; in particular, unstable patients.
TYPES OF PATIENTS	Stable med/surg admits from ED and in-pt. transfers. In some instances, may transfer in emergent situation.	Examples: critical trauma, neurosurgical, pediatric, or time sensitive cardiac cath patients.	Examples: cardiac cath patients, stable patients requiring cardiac monitoring and or receiving heparin, KCl and NTG.	Unstable
MEDICAL CONTROL	Sending MD	Base hospital	Sending physician specifies orders; EMS Medical Director provides oversight.	Sending MD
HOW OBTAINED/ PHONE NUMBERS (Individual hospital to complete)	Call:	Call local emergency ambulance provider dispatch center (NOT 911) directly at: Request paramedic ambulance for immediate transfer to nearest higher level of care.	Call:	Call: Children's Transport Team: Available 24 hrs/day. All staff and equipment provided. Call Children's Hospital at: 1-800-428-5437

* EMT-I's, emergency paramedics and CCT-paramedics may only perform those treatments/skills identified in their Scopes of Practice.