Montana Inter-Facility Transport Guidance Document 2019

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Introduction

The Montana Board of Medical Examiners has approved the following scope of practice for licensed Montana Emergency Medical Technicians thru Paramedics (including all endorsements) who provide inter-facility transfers. **Patient condition and anticipated course should always be considered when choosing the appropriate provider for transfer/transport.**

These protocols are intended to be used to assist the local medical director, transferring physician and individual ECP licensee in understanding the established scope of practice regarding inter-facility transport and care provided by the individual licensed ECP given responsibility for that care. The medical director is responsible for appropriate training for an ECP utilizing these guidelines and should provide authorization before a provider undertakes interfacility transfers.

ECPs may transfer patients between medical facilities if they possess the knowledge and skills necessary to manage the needs of the patient. Consultation with the transferring physician is required to assure the potential needs of the patient are met while conducting the transfer. The ECPs scope of practice may not be expanded to meet the needs of the patient; appropriate personnel must be obtained to assure continuity of patient care.

As with the Emergency Care Protocols, the Board authorizes the medical director to limit the service or individual EMT providers function / practice where appropriate and in accordance with provider's abilities or needs of the community they serve. **However**, the local medical director may not significantly alter or expand approved Board protocols without first seeking Board of Medical Examiners approval. (See ARM 24.156. 2140 for Board Protocol Request/Approval Procedures) A submission for approval form is available on http://www.emt.mt.gov/.

Emergency Medical Personnel may not function/practice beyond their individual licensure level and scope of practice authorized by the state-wide protocols or transfer protocols.

It is always the responsibility of the Montana Emergency Medical Provider to know/recognize their SCOPE OF PRACTICE and operate within their scope.

Those levels which have no additional scope identified specifically for intra-facility transfers may only operate under the scope of practice as they would when responding to an emergency response. However, the scope of education provided to assure a competent emergency response may not be adequate to maintain patient care established by a facility and continued during a lengthy transport. The depth and breadth of knowledge necessary to function safely and protect the patient entrusted to that provider may not be present.

EMT (Emergency Medical Technician):

GENERAL GUIDANCE:

If the patient has active medications running in an IV drip, has recently been administered sedating medications, has active airway or circulation issues or has undergone advanced procedures (beyond simple IV starts, for example) this suggests that the patient falls outside the scope of the **EMT** for transfer and a higher-level provider or other means of transport should be considered. Status and care required for each patient must be evaluated individually to assess if the EMT is the correct provider for interfacility transport.

Nothing specific to interfacility transfers

EMT (Emergency Medical Technician) with airway endorsement:
The **EMT with the airway endorsement** may initiate a King airway during an interfacility transport.

EMT (Emergency Medical Technician) with IV/IO maintenance endorsement:
The **EMT with the IV/IO maintenance endorsement** may monitor intravenous administration of clear fluids during an interfacility transport.

EMT (Emergency Medical Technician) with IV/IO initiation endorsement:
The **EMT with the IV/IO initiation endorsement** may initiate/monitor intravenous administration of clear fluids during an interfacility transport.

EMT (Emergency Medical Technician) with medication endorsement:
Nothing specific to interfacility transfers

EMT (Emergency Medical Technician) with Narcan endorsement:
Nothing specific to interfacility transfers

AEMT (Advanced Emergency Medical Technician):

GENERAL GUIDANCE:

If the patient is being ventilated, requires continuous EKG monitoring, has cardiac rhythm disturbances or active ischemia, has active medications running in an IV drip, has recently been administered sedating medications, has active airway or circulation issues or has undergone advanced procedures, this suggests that the patient falls outside the scope of the **AEMT** for transfer and a higher level provider or other means of transport should be considered. Status and care required for each patient must be evaluated individually to assess if the AEMT is the correct provider for interfacility transport.

The **AEMT** may initiate a King or I-Gel airway during an interfacility transport.

AEMT (Advanced Emergency Medical Technician) with medications endorsement:
Nothing specific to interfacility transfers

AEMT (Advanced Emergency Medical Technician with I99 Endorsement):
The **AEMT with I99 Endorsement** may initiate/monitor an intubated patient during an interfacility transport.

The **AEMT with I99 Endorsement** may utilize a ECG monitor during an interfacility transport.

PARAMEDIC:

GENERAL GUIDANCE:

If the patient is being transferred from an ICU or inpatient unit, has multiple IV medications or infusions, or has labile condition or vital signs, this suggests that the patient falls outside the scope of the **Paramedic** for transfer and **Paramedic(s) with the Critical Care endorsement** or other means of transport should be considered. Status and care required for each patient must be evaluated individually to assess if the Paramedic is the correct provider for interfacility transport.

The **Paramedic** may continue administration, without titration (except Heparin and Nitroglycerin), of medications initiated in the emergency department such as antibiotics, steroids, ACLS drugs, vitamins, non-OB magnesium, fractionated heparin, etc. via subcutaneous, intramuscular, intraosseous, and/or intravenous routes. The Paramedic may utilize central venous lines if previously trained and authorized by the medical director.

For the transport medication the Paramedic should be familiar with pharmacology & indications as well as signs, symptoms and treatment of any major adverse drug reactions. Infusion may be discontinued if significant adverse reaction is noted and should be reported as soon as possible.

1. Collect all transfer documentation: transfer sheet, EKG's, lab, other pertinent information.
2. Contact the online medical director (medical control), document indication and order for drug during transport
3. Maintain oxygen flow rate for an oxygen saturation of greater than or equal to 94%.
4. Attach cardiac monitor.
5. Assess and record vital signs, to include temperature, prior to transfer and every 5 to 10 minutes enroute.
6. Reassess patient frequently during transport and document findings.
7. Document dose and route at beginning of transport and patient response.

The **Paramedic** may initiate or continue the administration of blood products.

1. Maintain oxygen flow rate for an oxygen saturation of greater than or equal to 94%.
2. Attach cardiac monitor.
3. Assess and record vital signs, to include temperature, prior to transfer and every 5 to 10 minutes enroute.
4. Reassess patient frequently during transport and document findings.
5. Collect all transfer documentation: transfer sheet, EKGs, lab, other pertinent information.
6. Contact the online medical director (medical control), document order, indication, and rate of administration for blood product.
7. Document the unit blood bank number of all units to be transferred with the patient.
8. Instruct patient to report onset of any unusual symptoms that might indicate a transfusion reaction:

chills	dizziness	back pain
restlessness	nausea	chest pain
headache	anxiety	dyspnea

9. Watch for signs of a transfusion reaction:

temperature elevation		rash
facial flushing	cyanosis	sweating

bradycardia tachycardia hypotension
distended neck veins

10. If a transfusion reaction is suspected:
    a. Discontinue the transfusion, save the remaining blood, bag and tubing.
    b. Document and report reaction and treatment to receiving facility
    c. Maintain IV with normal saline
    d. Notify online medical director
    e. Draw a blue top tube from a site other than the transfusion site
    f. Treat hypotension with normal saline infusion

The **Paramedic** may initiate or continue the administration of Heparin.

1. Maintain oxygen flow rate for an oxygen saturation of greater than or equal to 94%.
2. Attach cardiac monitor.
3. Assess and record vital signs, to include temperature, prior to transfer and every 5 to 10 minutes enroute.
4. Reassess patient frequently during transport and document findings.
5. Collect all transfer documentation: transfer sheet, EKGs, lab, other pertinent information.
6. Contact the online medical director (medical control), document indication and order for drug during transport.
7. Document drip rate at beginning of transport and patient response.
8. Drip rate change during transport:
    a. If patient develops an unexplained decrease in blood pressure, discontinue drip and contact the online medical director (medical control).
    b. If patient develops unexplained neurological symptoms such as headache, numbness, weakness, seizure, etc., discontinue drip and contact the online medical director (medical control).

The **Paramedic** may initiate or continue the administration of Nitroglycerin (50mg/250ml D5: 200 mcg/ml).

1. Maintain oxygen flow rate for an oxygen saturation of greater than or equal to 94%.
2. Attach cardiac monitor.
3. Assess and record vital signs, to include temperature, prior to transfer and every 5 to 10 minutes enroute.
4. Reassess patient frequently during transport and document findings.
5. Collect all transfer documentation: transfer sheet, EKGs, lab, other pertinent information.
6. Contact the online medical director (medical control), document indication and order for drug during transport.
7. Document drip rate at the beginning of transport and patient's response.
8. Drip rate changes during transport:
    a. If chest pain present, increase the nitroglycerin drip 5 mcg/min (1.5 ml/hr) or 3.3 mcg/min (1.0 ml/hr) depending on your pump, every five minutes until the chest pain resolves or systolic blood pressure drops below 100. If more than an additional 10 mcg/min required, contact the online medical director (medical control).
    b. If systolic blood pressure drops below 100, decrease the nitroglycerin

by 5 mcg/min (1.5 ml/hr) or 3.3 mcg/min (1.0 ml/hr) depending on your pump and contact the online medical director (medical control).

c. If systolic blood pressure drops below 90, stop the nitroglycerin drip, place patient in Trendelenburg, consider a fluid bolus and contact the online medical director (medical control).

The **Paramedic** may initiate or continue the administration of Potassium (K).

1. Maintain oxygen flow rate for an oxygen saturation of greater than or equal to 94%.
2. Attach cardiac monitor.
3. Assess and record vital signs, to include temperature, prior to transfer and every 5 to 10 minutes enroute.
4. Reassess patient frequently during transport and document findings.
5. Collect all transfer documentation: transfer sheet, EKGs, lab, other pertinent information.
6. Contact the online medical director (medical control), document indication and order for drug during transport.
7. Document drip rate at beginning of transport and patient response.
8. Potassium must be administered via a pump at a rate not to exceed 10 milliequivalents per hour
   a. If Potassium is mixed in a fluid volume of less than 1L (1000ml), no more than 10meq of total potassium may be contained in that fluid.
   b. If the patient has no fluid restrictions, it is preferred that potassium be mixed in larger volume fluid for infusion (e.g. 10 or 20 milliequivalents in 1000ml fluid)

PARAMEDIC with Critical Care Endorsement:

GENERAL GUIDANCE:

If the patient requires intervention, care or monitoring that is beyond the scope of the Montana Critical Care Paramedic endorsement curriculum, then alternative providers and/or an alternate mode of transport should be considered. Status and care required for each patient must be evaluated individually to assess if the Critical Care paramedic is the correct provider for interfacility transport.

The **Paramedic with critical care endorsement** may initiate or continue the administration of Magnesium Sulfate (10 grams/100ml NS).

1. Maintain oxygen flow rate for an oxygen saturation of greater than or equal to 94%.
2. Attach cardiac monitor.
3. Assess and record maternal vital signs, to include temperature, patellar reflex and fetal heart rate prior to transfer and every 5 to 10 minutes enroute.
4. Reassess patient frequently during transport and document findings.
5. Collect all transfer documentation: transfer sheet, EKGs, lab, other pertinent information.
6. Contact the online medical director (medical control), document indication and order for drug during transport.
7. Transport patient on their left side.
8. Indwelling urinary catheter should be in place for patients with Pregnancy Induced Hypertension (PIH), this is optional for non-PIH patients.
9. Document urine output during transport.
10. Document pump drip rate at the beginning of transport and patient's response.
11. Drip rate changes during transport:
    a. If patient experiences a decreasing respiratory rate or other evidence of respiratory difficulty, discontinue drip, prepare to manage airway, consider calcium gluconate or calcium chloride, contact the online medical director (medical control).
    b. Decrease the drip rate by half and contact the online medical director (medical control) for any of the following:
        i. Decrease in systolic pressure of 20mm from baseline
        ii. Decrease in diastolic pressure of 10mm from baseline
        iii. Decrease in patella reflex.

The **Paramedic with critical care endorsement** may maintain mechanical ventilation.

1. Maintain oxygen flow rate for an oxygen saturation of greater than or equal to 94%.
2. Attach cardiac monitor, end-tidal CO2 monitor.
3. Assess and record vital signs, to include temperature, prior to transfer and every 5 to 10 minutes enroute.
4. Reassess patient frequently during transport and document findings.
5. Collect all transfer documentation: transfer sheet, EKGs, lab, other pertinent information.
6. Contact the online medical director (medical control), document indication and order for the mechanical ventilation during transport.
7. Document ventilator settings and patient response.
8. Document correct tracheal tube placement and secure appropriately

9. Obtain arterial blood gas prior to transport.
10. Maintain chemical paralysis if utilized pre-transport.
    a. Monitor for motor activity.
    b. Norcuron (Vecuronium) 0.1-0.15 milligram per kilogram slow IV push; duration of action is 20-30 minutes.
    c. Alternative paralytics include atracurium (Tracrium) and rocuronium (Zemuron).
11. Maintain adequate sedation
    a. Inadequate sedation may present as an unexplained increase in heart rate or blood pressure; the non-paralyzed patient may also demonstrate agitation, anxiety and/or restlessness.
    b. Midazolam (Versed) 0.035 milligram per kilogram IV over 2-3 minutes.
12. Maintain adequate analgesia
    a. Fentanyl (Sublimase) 1.0-3.0 micrograms per kilogram slow IV push; duration of action 30-60 minutes.

The **Paramedic with critical care endorsement** may maintain Thoracostomy Tube Monitoring.

1. Maintain oxygen flow rate for an oxygen saturation of greater than or equal to 94%.
2. Attach cardiac monitor.
3. Assess and record vital signs, to include temperature, prior to transfer and every 5 to 10 minutes enroute.
4. Reassess patient frequently during transport and document findings.
5. Collect all transfer documentation: transfer sheet, EKG's, lab, other pertinent information.
6. Contact the online medical director (medical control), document indication and order for the thoracostomy tube during transport.
7. Document order to maintain tube to gravity or to mechanical suction (specify amount of suction to be maintained during transport) and patient response.
8. If possible elevate head of gurney to 45 degrees.
9. Tape all tube connections securely.
10. In the event of an air leak, recheck all connections.
11. Do not pull on the tube.
12. Secure the collection chamber to the side of the gurney (do not tip over)
13. Keep the collection chamber below the level of the chest.
14. Avoid clamping or kinking of the tube and avoid dependent loops of fluid filled tubing.
15. If chest tube is partially pulled out:
    a. Do not push tube back into chest.
    b. Secure the tube in place.
16. If chest tube is pulled out, place occlusive dressing over the insertion site.
17. If patient becomes dyspneic:
    a. Assess breath sounds.
    b. Needle thoracostomy may need to be performed.