

Determination of Death in the Field

Purpose:

This policy outlines the process by which field personnel (ALS & BLS) may determine death. Field personnel need not initiate or continue resuscitative efforts when death has been determined, respective to their scope of practice, using the following criteria outlined below. Only physicians and coroners are allowed to make a pronouncement of death. This guideline applies to both adult and pediatric patients.

In all cases where determination of death is considered, it is assumed that the patient has no pulse or respirations. If there is any doubt, initiate CPR and resuscitative efforts, then contact Medical Control as soon as reasonably possible.

In order to determine a patient dead at least one or more of the following criteria below must be applicable. Patients may be treated and transported, if in the judgment of the lead medic, the scene dictates that this would be beneficial for field personnel, bystanders, family members, personnel safety or other causes not outlined in this policy. In addition, Medical Control contact is expected for any patients or situations that do not specifically meet the following criteria. In those cases where Medical Control contact is made, the Emergency Department physician will have final authority as to what course of action shall be taken.

If the patient clearly meets one or more of the following criteria the patient may be determined to be dead with no Medical Control contact necessary. In all cases where death has been determined, notify the appropriate law enforcement agency through dispatch. Law enforcement then has the responsibility of contacting the Coroner's Office (or investigating agency) with jurisdictional authority.

Causes for Determination of Death (BLS/ALS)

- A. Decapitation
- B. Incineration
- C. Rigor Mortis
- D. Livor Mortis (Lividity)
- E. Decomposition
- F. Total separation of vital organs from body, or total destruction of organs with absence of life signs.
- G. Absence of life signs when there are multiple victims, and resuscitation would hinder care of more viable patients.
- H. Valid DNR, Living Will and/or situation where Durable Power of Attorney is applicable.
- I. Extended submersion
- J. Massive head trauma

Causes for Determination of Death (ALS Only)

All cases described below require contact with a medical control physician to approve termination of treatment.

- A. Medical:
 - 1. Patient is asystolic in at least three (3) leads after treatment per protocol and medical Control is consulted.
- B. Blunt Trauma: Resuscitative efforts may be withheld or terminated in patients found apneic and pulseless with:
 - 1. Blunt trauma to the head, neck or torso; **and**
 - 2. No spontaneous pulse or respiration following appropriate medical interventions, which include, for example: ensuring a patent airway or chest decompression. (The majority of injuries sustained by these patients are not compatible with life. "Appropriate" interventions will vary and should be dictated by guidance from the **medical control**.)

C. Penetrating Trauma: Resuscitation and rapid transport to a hospital facility should be initiated on all patients found in full arrest secondary to penetrating trauma. Exceptions may exist in the following circumstance:

1. Patients found pulseless and apneic with penetrating trauma **if** the provision of ALS has been unavailable for **at least 20 minutes** from the time EMS personnel initiate on-scene assessment. (Appropriate"

interventions at this point will vary and should be dictated by guidance from the Medical Control.)

2. However, if there is any doubt about duration of the arrest, then resuscitation and rapid transport should be initiated.

Definitions:

- A. Absence of life signs—the physical examination of the patient, including palpating pulse for minimum of sixty (60) seconds and assessing absence of respirations for minimum of sixty (60) seconds.
- B. Asystole is determined by the use of cardiac monitor, attaching leads, and observing and recording asystole in three (3) leads for a minimum of sixty (60) seconds.
- C. Rigor Mortis—the stiffness seen in corpses. Rigor mortis begins with the muscles of mastication and progresses from the head down the body affecting the legs and feet last. Generally manifested in 1 to 6 hours and a maximum of 6 to 24 hours.
- D. Livor Mortis (Lividity) - Cutaneous dark spots on dependant portions of a corpse. Generally manifested within 1/2 to 2 hours. Reaches maximum presentation in 8 to 12 hours.

Do Not Resuscitate and CPR Directives

General Principles

- A. This protocol is for the prehospital management of the statutory "CPR Directive," which refers to a specifically identifiable, numbered form that is printed on security paper. The form must be signed by the patient or the patient's authorized agent. The form must also be signed by the patient's attending physician.
- B. In addition to the written CPR Directive form, the patient or authorized agent may obtain a CPR Directive necklace or bracelet to be worn by the patient. This bracelet or necklace will have imprinted on it the same number as the form.
- C. CPR shall be withheld or terminated if the original CPR Directive form is readily accessible with an original signature, or if the necklace or bracelet is worn by the patient.
- D. A CPR Directive may be implemented for a minor only after a physician issues a "Do Not Resuscitate" order and the parents of the minor (if married and living together), custodial parent, or legal guardian execute(s) a CPR Directive for the minor.
- E. A CPR Directive does not only apply to patients in full cardiac arrest, but should also be honored by withholding resuscitation in patients who are seriously ill or near arrest.

Procedure

- A. Upon finding a patient with a CPR Directive (form, bracelet, or necklace):
- B. Perform initial patient assessment.
- C. Verify that the CPR Directive form is one of the original copies (it should be light blue color below the title portion of document) and is unaltered (not defaced or altered physically in some way).
- D. Verify that the information on the form or, if present, on the back of necklace or bracelet, appears to be appropriate for the patient (look at race, sex, date of birth, eye and hair color). If possible, try to verify identity of patient by an additional source (e.g., family member, driver's license or other readily available sources).
- E. Upon verification of the CPR Directive, withhold CPR. If CPR has been started, it should be stopped.
- F. If there is any question of the validity of the document or the identity of the patient, initiate full resuscitation measures and contact the base for guidance. Be sure to inform the base of the CPR Directive form, bracelet, or necklace, and the condition and history of the patient.
- G. Complete documentation, including attaching a copy of monitor strips on each copy of the run report (EMT-P or EMT-I).
- H. Provide appropriate emotional support to family if possible.
- I. If the death occurs outside of a health care facility or if tissue donation has been declared, then the coroner is to be immediately contacted via law enforcement. If the declarant has indicated on the CPR Directives form a desire to donate any tissues, appropriate authorities should be notified.
- J. The following resuscitation measures are to be withdrawn or withheld from a person who has a valid CPR Directive:
 - 1. CPR and chest compressions
 - 2. Endotracheal intubation or other advanced airway management
 - 3. Artificial ventilation
 - 4. Defibrillation
 - 5. Cardiac resuscitation measures and medications.
- K. The following interventions may be administered or provided:

1. Assist in maintenance of airway (non-advanced airway management, such as positioning)
 2. Suctioning
 3. Oxygen
 4. Pain medication
 5. Control bleeding
 6. Ambulance transportation
- L. In addition to the standard documentation, the following information should be documented when possible by the prehospital provider on the run report:
1. Patient's status (e.g. condition found, medical history obtained)
 2. Type of "CPR Directive" found (document, bracelet or necklace)
 3. CPR Directive number
 4. Name of attending physician, if known
 5. Special circumstances which justify initiating resuscitation if this was done despite the presence of the CPR Directive
 6. Monitor strips in at least two leads (EMT-P and EMT-I)

Additional Considerations

- A. The patient may revoke the CPR Directive at any time by oral expression of revocation or by destruction of the CPR Directive form, bracelet or necklace. If a guardian, agent or proxy decision-maker executed the CPR Directive, then the guardian, agent or proxy decision-maker may revoke the CPR Directive.
- B. CPR is to be initiated if the original CPR Directive form, necklace or bracelet is not readily available, (i.e., being worn by or physically present with the patient). The bracelet or necklace is only available to the patient after the form has been properly executed. Removal of the bracelet or necklace may be construed as revocation. Therefore, if the bracelet or necklace is readily accessible but not on the patient, any question as to whether or not the Directive has been revoked should result in resuscitation until the situation is clarified.
- C. Consult with Medical Control if you have questions about terminating CPR and transport. If not in full arrest, patients with CPR Directives may still be transported to provide comfort measures.
- D. In the absence of the existence of a CPR Directive, a person's consent to CPR shall be presumed. The statutorily authorized CPR Directive is only one manner for a patient to document resuscitation preferences. Other "Do Not Resuscitate" forms and advance directives may be honored but base contact is required.
- E. Under Colorado Law, refraining from performing CPR, when there is a CPR Directive, does not constitute assisting a suicide, and caregivers who honor a CPR Directive by withholding CPR are protected from legal liability.

Hazardous Materials

Purpose

This is to establish a standard operating procedure which deals with the health of team members and victims of hazardous material incidents. It is designed to minimize all health effects from the exposure to hazardous materials. The practices contained herein are congruent with the recommended practices from OSHA, NFPA and medical control. This document is not to be considered all inclusive; it is to represent a guideline only.

Policy

These protocols are designed to act only in designated hazardous material incidents, in addition to our medical care protocols, with exposure to specific chemical compounds.

The possibility of secondary contamination shall be recognized and measures taken to reduce the chance of such contamination. Appropriate protective gear shall be worn at all applicable times during treatment procedures. Leave the contamination at the scene of the emergency; NEVER take it with you to the emergency department.

In all operations involving victims or the possibility thereof, the closest appropriate medical facility must be notified early in the incident. The facility must be informed of the possibility of walking wounded, the type of chemical(s), the routes of exposure, the number of patients, the type of decon done in the field, and if possible all associated medical algorithms.

Procedure

The following medical care guidelines are specifically designed for use during the treatment and transport of victims of an exposure to a "known" chemical. However, general considerations for patient care as described in the general "Medical Care Protocols", shall be used as the foundation for appropriate quality patient care on all exposures from "unknown" substances.

Site Safety is of paramount concern for all responders. No entry into the Hot or Warm Zones without proper personnel protective equipment shall be allowed.

Specific Medical Care Protocols

The following specific treatment guidelines are approved for use during the treatment of victim(s) of chemical exposure. Quick access cards are located within the drug box.

1. Carbon Monoxide Poisoning
2. Aniline Dyes, Nitrites, Nitrates, Nitrobenzine, and Nitrogen Dioxide
3. Cyanide and Hydrogen Sulfide (Blood Agents)
4. Organophosphate Insecticide Poisoning and Carbamate Poisoning (Nerve Agents)
5. Hydrofluoric Acid Burns and Poisoning
6. Phenol
7. Chemical Burns to the Eye
8. Bronchospasms Secondary to Toxic Inhalation
9. Tachydysrhythmias
10. Chloramine and Chlorine
11. Biological Agents
12. Blister Agents

1. **Carbon Monoxide Poisoning**
(Includes all cases of altered mental status in the context of hazardous materials)

Description:

Colorless, odorless, tasteless, non-irritating gas. Converts hemoglobin into carboxyhemoglobin, a non-oxygen carrying compound causing chemical asphyxiation. Pulse oximetry will indicate an incorrect, unusually high oxygen saturation.

S/S:

Mild exposure (20 to 30% saturation)-Headache, nausea, dizziness, and tachycardia
Moderate exposure (30 to 50% saturation)-Syncope and dyspnea
Severe exposure (>50% saturation) - Seizure, coma, and death

Treatment:

- 1 Scene safety, monitor environment for changing levels of CO.
- 2 ABC's, remove from hazard, ECG monitoring
- 3 Immediately administer 100% oxygen if conscious, if unconscious and not arousable perform endotracheal intubation to deliver 100% oxygen.
- 4 Start IV 1000cc Normal Saline
- 5 Treat unconscious patients per standard medical protocols, to include glucose check and correction if needed, administer Narcan, and checking body temperature.

2. Aniline Dyes, Nitrites, Nitrates, Nitrobenzene, and Nitrogen Dioxide

Description:

Commonly found in fertilizers, paints, inks, and dyes. Changes hemoglobin into a non-carrying compound methemoglobin. Blood color changes from red to a chocolate brown color. Pulse oximetry will indicate an inaccurately low reading due to the opaqueness of the compound.

S/S:

Cyanosis, unresponsive to oxygenation and good minute volume, Headache, Nausea, Vomiting, Tachycardia, Arrhythmia, Syncope, Dyspnea, Seizure, Coma, Death.

Treatment:

- 1 Decon, ABC's, 2 large bore IV's, cardiac monitoring, treat cardiac changes per ACLS guidelines, treat seizures per protocol
- 2 Immediately administer 100% oxygen, if unconscious and not arousable perform endotracheal intubation to deliver 100% oxygen.
- 3 Start IV 1000cc Normal Saline
- 4 If hypotensive, position patient, increase IV flow, if severe consider Dopamine.
- 5 If symptomatic and no clinic suspicion of exposure to Carbon Monoxide, then:
 - a. Administer Methylene Blue, 1-2 mg/kg SIVP over 5 minutes.

3. Cyanide and Hydrogen Sulfide (Blood Agents)

Description:

Cyanide:

One of the most rapid acting poisons. Bitter almond smell to those without sensory deficit. Interferes with the uptake of oxygen into the cells and halts cellular respiration causing chemical asphyxiation. Pulse oximetry will accurately indicate an unusually high saturation due to the cell's inability to pick up oxygen from the blood stream.

S/S:

Tachypnea, tachycardia, headache, ECG tracings indicative of myocardial ischemia / infarct, nausea, vomiting, seizure, and coma.

Hydrogen Sulfide:

Also known as sewer gas. Has a distinctive smell of rotten eggs but most dangerous when it can't be smelled. Formed naturally by the decomposition of organic substances. Heavier than air. Interferes with cellular respiration.

Treatment:

- 1 Scene safety. If rescue is needed, assume the worse, use Level A PPE.
- 2 Decon, ABC's, ECG monitoring, 2 large bore IV's, treat cardiac changes per ACLS guidelines, and treat seizures per protocol.

- 3 Amyl Nitrite pearls – Broken and held on a gauze pad under the patient’s nose. Allow the patient to inhale for 15 to 30 seconds of every minute. Change pearls every 3 minutes. During the interval, the patient should breath 100% oxygen. If the patient is not breathing, place the “pearls” into a BVM and ventilate the patient. (This is temporary measure; it should not delay IV treatment.)
- 4 As soon as possible, start an IV of normal saline and immediately give:
 - a. Adult - Sodium Nitrite 10 ml of a 3% solution IV over 2 minutes (300mg). 1 amp in > 5 mins. Monitor BP, as hypotension may occur.
 - b. Children - .33ml/kg of 3% solution over 10 minutes.
 - c. Administer 100% (NRBM) oxygen after Sodium Nitrite

In cases of smoke inhalation or carbon monoxide poisoning, administer the following with 100% oxygen. Not to be administered in Hydrogen Sulfide poisonings.

- a. Sodium Thiosulfate 50 ml of a 25% solution over 10 minutes. Monitor BP.
- b. Children – 1.65 ml/kg up to 50 ml over 10 minutes.

4. **Organophosphate Insecticide Poisoning (OIP) and Carbamate Poisoning (Nerve Agents)**

Description:

Pesticide can be inhaled, ingested, injected or absorbed. Once in the body it binds with the acetylcholinesterase causing initially excitation of the nervous conduction then paralysis. Common seen signs are Salivation, Lacrimation, Urination, Defecation (SLUD). Can be lethal in less than 5 mg dose.

S/S:

Headache, nausea, vomiting, muscle twitching, incoordination, abdominal cramping, diarrhea, and hypersecretions, blurred vision, wheezing, productive cough (possible pulmonary edema), bradycardia (may precede tachycardia), unconsciousness, and seizures (large quantities can cause isolated paralysis).

Treatment:

- 1 Decon, ABC’s, IV, cardiac monitoring with 12 lead, treat cardiac changes per ACLS guidelines, treat seizures per protocol
- 2 Immediately give 100% oxygen to insure tissue oxygenation. Consider intubation w/ possible need for sedation.
- 3 Start IV with Normal Saline (TKO)and give:
 - a. If symptomatic give Atropine 2-4mg IVP at 5 minute intervals until Atropinization (mouth dries) occurs. (There is no max dose. Use extreme caution in a hypoxic patient, may cause V-fib)
- 4 If ingestion, consider activated charcoal with sorbitol 1 to 2 g/kg in 500ml PO or NG.

5. **Hydrofluoric Acid Burns and Poisonings**

Description:

The strongest inorganic acid known. Injury is twofold; causes corrosive burning of the skin and deep underlying tissue, also binds with calcium and magnesium of the nerve pathways, bone, and blood stream. The results are spontaneous depolarization producing excruciating pain, and cardiac dysrhythmias degenerating to cardiac arrest. Symptoms may be delayed up to 24 hours.

Treatment:

Skin Burns:

- 1 Decon, ECG monitor w/ 12 lead, IV Normal Saline (TKO), 100% O2 by mask, Pulse OX
- 2 Immediately flush exposed area with large amounts of water.

- 3 Apply Calcium Gluconate Gel to burned area (mix 10cc of a 10 % Calcium Gluconate solution into a 2oz tube of water soluble jelly).
 - 4 Massage into burned area.
- Eye Injuries:
- 1 Immediately flush eyes with any means possible.
 - 2 Mix 50cc of a 10% solution Calcium Gluconate into 500cc of Normal Saline for irrigation.
 - 3 Connect bag and tubing to a Morgan Irrigation Lens and run wide open.
- Inhalation Injury:
- 1 Scene safety, take respiratory precautions (SCBA).
 - 2 Mix 6cc of sterile water into a 3cc of a 10% Calcium Gluconate
 - 3 Place solution in nebulizer and connect to oxygen to provide effective fog
- Gastrointestinal Exposure:
- 1 Immediate dilution with large volumes milk or water.
 - 2 Be careful not to contact the effluent as it is caustic. (Charcoal is not indicated)

6. Phenol

Description:

Also known as Carboic Acid. Found in many household items and is commonly used as a disinfectant, germicide, antiseptic, and as a wood preservative. It causes injury much the same as other acids by coagulating proteins found in the skin. Systemic effects are seen throughout the central nervous system. Evidenced by CNS depression including respiratory arrest.

Treatment:

- 1 Decontaminate initially with large volumes of water, and then irrigate burned areas with isopropyl alcohol. (Small amounts of water will increase absorption)
- 2 Support respirations possible need for intubation, control seizures (Valium, Ativan) as per protocol, and ventricular ectopy as per ACLS guidelines.
- 3 100% O2 by mask, IV Normal Saline (TKO), ECG monitoring with 12 lead.

7. Chemical Burns to the Eyes

Note:

Watch run off to prevent further contamination.

Treatment:

- 1 Immediately start eye irrigation by whatever means possible.
- 2 Insure all particulate matter or contact lenses are out of the eye by digitally opening the lids and pouring irrigating fluid across the globe.
- 3 Prepare the Morgan Lens by attaching an IV solution of Normal Saline; insure that fluid continues to flow at steady rate.
- 4 Apply 1-2 drops of Ponticaine Tetracaine Ophthalmic drops into the injured eye.
- 5 Insert the lens
- 6 Continue irrigation throughout transport.

8. Bronchospasms Secondary to Toxic Inhalation

Description:

Wheezing due to exposure of the respiratory system to an irritant.

Treatment:

- 1 Decon, ABC's, 2 large bore IV's, cardiac monitoring, treat cardiac changes per ACLS guidelines, treat seizures per protocol
- 2 Immediately give 100% humidified oxygen. Apply pulse OX

- 3 Issue an albuterol / atrovent nebulizer.
- 4 If wheezing continues consider Epinephrine 1:1000 at a dose of .03 to .05 mg SQ

9. Tachydysrhythmias

Description:

Super ventricular tachycardia due to sensation of a toxic exposure and CNS stimulants.

Treatment:

- 1 Decon, ABC's, 2 large bore IV's, cardiac monitoring with 12 lead, treat cardiac changes per ACLS guidelines, treat seizures per protocol
- 2 Establish an IV of normal saline (AC is preferable)
 - a. Administer Adenocard 6mg rapid IV push with saline push behind it.
 - b. Administer Adenocard 12mg rapid IV push with saline push behind it.
 - c. Administer Adenocard 12mg rapid IV push with saline push behind it.
 - d. Contact medical control

10. Chloramine and Chlorine

Description:

Chloramine is the mixture of "over the counter (OTC)" bleach and ammonia. Forms an irritating gas that converts to hydrochloric acid in the lining of the upper air passages. The mixture is toxic and flammable. The patient will typically complain of a burning sensation to the upper respiratory system, coughing and hoarseness.

Treatment:

After the patient is removed from the atmosphere and appropriate decontamination is completed, give:

- 1 100% oxygen via NRB mask.
- 2 Assemble nebulizer and administer 5 cc of sterile water.
- 3 If burning persists titrate half strength adult bicarb (3.75 % or 4.2%) and administer 5 cc through a nebulizer.

11. Biological Agent

- 1 Tularemia (Bacterium)
 - A. Route of Infection – Vector, Respiratory, and Digestive
 - B. Incubation Period / Onset Time – 2 to 10 days
 - C. Transmission to Humans – No
 - D. Signs & Symptoms – Ulcer glandular (local ulcer and regional lymphadenopathy), fever, chills, headache, and malaise. Typhoidal or septicemic-fever, headache, malaise, substernal discomfort, weight loss, non-productive cough.
 - E. Decontamination or infection control procedures – Secretions and lesion precautions, strict isolation not required, use of heat or disinfectants renders organism harmless
 - F. Prehospital care – Supportive care
- 2 Q-Fever (Bacterium)
 - A. Route of Infection – Vector, and Respiratory
 - B. Incubation Period / Onset Time – 2 to 10 days
 - C. Transmission to Humans – Rare
 - D. Signs & Symptoms – Fever, cough, and pleuritic chest pain
 - E. Decontamination or infection control procedures – Use of soap and water or a weak 0.5 percent hypochlorite solution.
 - F. Prehospital care – Supportive care

- 3 Smallpox (Virus)
 - A. Route of Infection – Respiratory, Skin, Direct human to human contact
 - B. Incubation Period / Onset Time – 10 to 12 days
 - C. Transmission to Humans – High
 - D. Signs & Symptoms – Malaise, fever, rigors, vomiting, headache, backache; 2 to 3 days later, lesions which develop into pustular vesicles, more abundant on face and extremities, developing synchronously.
 - E. Decontamination or infection control procedures – Strict quarantine with respiratory isolation for a minimum of 16 to 17 days following exposure for all contacts. Patients are infectious until all scabs heal.
 - F. Prehospital care – Supportive care
- 4 Venezuelan Equine Encephalitis (Virus)
 - A. Route of Infection – Respiratory, and Vector
 - B. Incubation Period / Onset Time – 2 to 6 days
 - C. Transmission to Humans – Low
 - D. Signs & Symptoms – Sudden onset, with malaise, spiking fever, rigors, sever headache, photophobia, and myalgias. Nausea, vomiting, cough, sore throat, and diarrhea may follow.
 - E. Decontamination or infection control procedures – Body substance isolation; infectious through mosquito bites.
 - F. Prehospital care – Analgesics for headache and myalgia, anticonvulsants and respiratory support.
- 5 Viral Hemorrhagic Fever (Virus)
 - A. Route of Infection – Respiratory (?), Direct Human to Human contact, and Vector
 - B. Incubation Period / Onset Time – 3 to 21 days
 - C. Transmission to Humans – Moderate
 - D. Signs & Symptoms – Fever, easy bleeding, petechiae, hypotension, shock, edema, malaise, myalgia, headache, vomiting, and diarrhea.
 - E. Decontamination or infection control procedures – Decontamination with hypochlorite or phenolic disinfectants. Body substance isolation required.
 - F. Prehospital care – Supportive care directed at respiratory and circulatory support.
- 6 Botulinum Toxin (Toxin)
 - A. Route of Infection – Respiratory, and Digestive
 - B. Incubation Period / Onset Time – 24 hours to several days
 - C. Transmission to Humans – No
 - D. Signs & Symptoms – Ptosis, weakness, dizziness, dry mouth and throat, blurred vision and diplopia, dysarthria, dysphonia, dysphagia, followed by symmetrical descending paralysis and respiratory failure.
 - E. Decontamination or infection control procedures – 0.5 % hypochlorite solution and/or soap and water
 - F. Prehospital care – Aggressive respiratory support, and supportive care for other symptoms
- 7 Staphylococcal Enterotoxin B (SEB) (Toxin)
 - A. Route of Infection – Respiratory, and Digestive
 - B. Incubation Period / Onset Time – 4 to 6 hours
 - C. Transmission to Humans – No
 - D. Signs & Symptoms – Sudden onset, with fever, chills, headache, myalgia, and nonproductive cough. Some may develop respiratory distress and retrosternal pain. If ingested, nausea, vomiting, and diarrhea.
 - E. Decontamination or infection control procedures – 0.5 % hypochlorite solution and/or soap and water
 - F. Prehospital care – Supportive care directed at respiratory support.
- 8 Ricin (Toxin)
 - A. Route of Infection – Respiratory, and Digestive
 - B. Incubation Period / Onset Time – 24 to 72 hours
 - C. Transmission to Humans – No

- D. Signs & Symptoms – Weakness, fever, cough, and pulmonary edema 18 to 24 hours post exposure, followed by severe respiratory distress and death from hypoxemia in 36 to 72 hours.
 - E. Decontamination or infection control procedures – 0.5 % hypochlorite solution and/or soap and water
 - F. Prehospital care – Supportive care with aggressive airway management. Volume replacement of GI fluid loss.
- 9 Trichothecene Mycotoxins (T2) (Toxin)
- A. Route of Infection – Respiratory, Skin, Direct Human to Human Contact, and Digestive
 - B. Incubation Period / Onset Time –minutes to hours
 - C. Transmission to Humans – No
 - D. Signs & Symptoms – Skin pain, pruritus, redness, vesicles, necrosis; nose and throat pain, nasal discharge, itching and sneezing, cough, dyspnea, wheezing, chest pain, and hemoptysis, ataxia, shock, and death.
 - E. Decontamination or infection control procedures – Soap and water, after clothing has been removed. Eye exposure—copious saline irrigation.
 - F. Prehospital care – Supportive care directed at respiratory and circulatory support.
- 10 Anthrax (Bacterium)
- A. Route of Infection – Respiratory, Skin and Digestive
 - B. Incubation Period / Onset Time – 1 to 6 days
 - C. Transmission to Humans – No except for cutaneous type
 - D. Signs & Symptoms – Fever, malaise, fatigue, cough, and mild chest discomfort, followed by severe respiratory distress with dyspnea, diaphoresis, stridor, and cyanosis; shock and death within 24 to 36 hours of severe symptoms.
 - E. Decontamination or infection control procedures – Universal body fluid precautions, decontamination with low pressure soap and water wash, the .05 hypochlorite solution, then 2nd soap and water wash.
 - F. Prehospital care – Supportive care.
- 11 Cholera (Bacterium)
- A. Route of Infection –Digestive, and Direct human to human contact
 - B. Incubation Period / Onset Time – 1 to 5 days
 - C. Transmission to Humans – Rare
 - D. Signs & Symptoms – Asymptomatic to severe with sudden onset, vomiting, abdominal distension and pain with little or no fever followed rapidly by diarrhea. Fluid loss can exceed 5 to 10 liters per day.
 - E. Decontamination or infection control procedures – Enteric precautions, soap and water washes, and a hypochlorite solution for equipment. Personal contact rarely causes infection.
 - F. Prehospital care – Supportive care directed at rapid fluid replacement.
- 12 Pneumonic Plague (Bacterium)
- A. Route of Infection – Respiratory, and Vector
 - B. Incubation Period / Onset Time – 2 to 3 days
 - C. Transmission to Humans – High
 - D. Signs & Symptoms – High fever, chills, headache, hemoptysis, and toxemia, with rapid progression to dyspnea, stridor, and cyanosis; death is due to respiratory failure, circulatory collapse.
 - E. Decontamination or infection control procedures – Strict isolation precautions. Use of soap and water for personnel decon, heat, UV rays, and disinfectants for equipment.
 - F. Prehospital care – Supportive care directed at respiratory and circulatory support.
- 13 Bubonic Plague (Bacterium)
- A. Route of Infection – Respiratory, and Vector
 - B. Incubation Period / Onset Time – 2 to 10 days
 - C. Transmission to Humans – High

- D. Signs & Symptoms – High fever, chills, malaise, tender lymph nodes (buboes), may progress to septicemic form, with spread to the CNS, lungs, and elsewhere.
- E. Decontamination or infection control procedures – Isolation precautions, secretions and lesion precautions. Use of soap and water for personnel decon; use heat, UV rays, or disinfectants for equipment.
- F. Prehospital care – Supportive care directed at respiratory and circulatory support.

12 Blister Agents

- 1 Sulfur Mustard (HD)
 - A. Means of Exposure – Skin contact and/or inhalation
 - B. Lethal Dosage – Via inhalation 1500 LCt50. Via skin exposure 4500 LD50
 - C. Rate of Action – Delayed (tissue damage occurs within minutes of contact, but clinical effects are not immediately evident). Effects manifested 2 to 24 hours after exposure.
 - D. Effects – Pain is not immediate. Topical effects occur on the skin (blisters), in airways (coughing, lesions, in rare cases resulting in respiratory failure) and in the eyes (itching, burning sensation, possible cornea damage). Nausea and vomiting can also result.
 - E. Antidotes / Methods of Treatment - Thorough decontamination using water. Prevention of effects using antibiotics. Application of lotions / ointments to soothe blisters. Mustard has no known antidote.
- 2 Lewisite (L)
 - A. Means of Exposure – Skin contact and/or inhalation
 - B. Lethal Dosage – Via inhalation 1300 LCt50. Via skin exposure greater than 4500 LD50
 - C. Rate of Action – Rapid pain and irritation occur immediately.
 - D. Effects – Effects are similar to mustard: Skin blistering, burning / watery / swollen eyes, upper airway irritation, and systemic blood poisoning.
 - E. Antidotes / Methods of Treatment - Thorough decontamination using water. Prevention of effects using antibiotics. Application of lotions / ointments to soothe blisters. British – Anti-Lewisite can mitigate some systemic effects of Lewisite, though it can itself cause some toxicity.
- 3 Nitrogen Mustard (HN3)
 - A. Means of Exposure – Skin contact and/or inhalation
 - B. Lethal Dosage – Via inhalation 1500 LCt50. Via skin exposure 4500 LD50
 - C. Rate of Action – Rapid. Rash occurs within one hour; blistering occurs between 6 to 12 hours after exposure
 - D. Effects – Skin blistering, respiratory tract damage.
 - E. Antidotes / Methods of Treatment - Thorough decontamination using water. Prevention of effects using antibiotics. Application of lotions / ointments to soothe blisters. Mustard has no known antidote.
- 4 Mustard – Lewisite
 - A. Means of Exposure – Skin contact and/or inhalation
 - B. Lethal Dosage – Via inhalation 1500 LCt50. Via skin exposure 10000 LD50
 - C. Rate of Action – Rapid. Stinging sensation occurs immediately; blisters follow hours later
 - D. Effects – Skin blistering, burning in the eyes, inflammation of respiratory tract
 - E. Antidotes / Methods of Treatment - Thorough decontamination using water. Prevention of effects using antibiotics. Application of lotions / ointments to soothe blisters. Mustard has no known antidote.
- 5 Phosgene – oxime (CX)
 - A. Means of Exposure – Skin contact and/or inhalation

- B. Lethal Dosage – Via inhalation 3200 LCt50. Via skin exposure 25 LD50
- C. Rate of Action – Rapid
- D. Effects – Extremely irritating to eyes, skin, and upper respiratory system
- E. Antidotes / Methods of Treatment - Thorough decontamination using water. Prevention of effects using antibiotics. Application of lotions / ointments to soothe blisters.

Helicopter Protocols

These protocols are written to be used as a guide when requesting helicopter service. The protocols should be followed unless there are reasons to deviate from them. The choice of which service you request should be based on providing the patient and the scene with the most appropriate care as quickly and safely possible.

The existing process will allow you to “one stop shop”. You will ALWAYS call Central Dispatch and request the helicopter. Unless they know that Care Flight is out of service they will dispatch them, as they are the closest and most appropriate.

The first question that Dispatch will ask the helicopter service is “Are you available?” If Care Flight is unable to provide service, Dispatch will then immediately initiate a request for Air Care or another service.

During this process you will receive updates to the status of your requested flight and an E.T.A. from dispatch and or the responding service.

➤ When requesting helicopter response Central Dispatch shall or with approval of Central the requesting agency shall:

- Provide the scene location
 - Physical location by land marks, road numbers and distances from known geographical locations
 - GPS coordinates and elevation
- Provide frequency / channel information
- Provide responding units numbers or designation (Fire-police-EMS)
- Provide any other information as requested
- Provide communication assistance as needed, even if the response is not specific to La Plata County.
- Central Dispatch shall provide flight following as requested
 - Document / log all position reports

➤ Helicopter operating in La Plata County shall:

- For all situations, except Search and Rescue, utilize Durango Fire and Rescue Channel 153.770TX and 154.445RX - PL 131.8. S&R will use the Brown Frequency of 155.595TX and 154.785RX PL 131.8.
- Central Dispatch or the person requesting will notify the helicopter of the LZ frequency as chosen by the LZ manager. (FERN-1, TX/RX 154.280 PL CSQ) If FERN is being used Air to Ground will be chosen, TX/RX 172.275 (PL CSQ)

➤ On-scene command

- Assign LZ Manager
- Assist in LZ selection as needed
- Communicate with Central Dispatch as needed regarding aircraft status and advise them of the LZ frequency.
 - LZ frequencies, FERN-1, if FERN is unavailable, use Air to Ground or as assigned.

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➤ **LZ Manager**

- Select LZ
- Establish communication with helicopter on the appropriate DFRA or Brown channel.
- Once communication is established on DFRA or Brown, LZ operations will be conducted on FERN-1 or Air to Ground or other designated channel.
- Advise responding aircraft of the LZ location.
- Advise on weather, hazards; wind (speed / direction) any other LZ specifics.

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➤ **Helicopter**

- Once airborne initiate radio contact with Central Dispatch and provide them a status, and an E.T.A. on DFRA or Brown.
 - Notify dispatch when landing and departing the scene.
- Establish communication with command or LZ Manager on the appropriate DFRA or Brown channel.
- Notify Mercy Medical Center (MMC) on Regional Medical frequency (155.430 Tx & Rx PL CSQ) inform them of pt destination and condition.
- Patient reporting or status with the E.R. If radio communication cannot be established with MMC, on regional meds, they should try the Mercy "green" frequency 155.385 Tx & Rx PL CSQ. If still unsuccessful, Central Dispatch may take the information via DFRA or Brown channel and contact MMC or the helicopter may attempt to raise MMC ER on, DFRA primary channel.

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If radio communication cannot be established with MMC, Central Dispatch will take the information via DFRA or Brown channel and contact MMC.

NOTE: This procedure applies to all agencies involved in helicopter operations within La Plata County or while providing mutual aid out side the County.

LA PLATA COUNTY



HELICOPTER

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Initiate radio contact with Central Dispatch

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will be used 172.275 (PL CSQ) assigned by command or Central Dispatch.

Medical Helicopter Activation

Purpose:

To provide a standard for the activation of medical helicopter resources providing emergency medical care in the prehospital setting within La Plata County.

General Principles:

- A. Consider use of medical helicopter scene response when:
 - 1. Patient(s) with life-threatening trauma and prolonged extrication and/or transport time (i.e. using Medical helicopter will reduce "scene to hospital" time).
 - 2. Multiple casualty incidents and inability of ground transport units to manage and transport all patients in a timely manner.
 - 3. Inability or difficulty in transporting patient using conventional means.
- B. Highest level EMS provider on-scene or the Incident Commander should make the decision to mobilize a Medical Helicopter.
- C. Decision may be made to launch medical helicopter prior to arrival on scene. Pre-arrival information from bystanders or first responders indicating the possible need for helicopter resources may be deemed sufficient for activation without delay.

Procedure:

NOTE: The closest available Air Ambulance will be dispatched via Central Dispatch. (See La Plata County Helicopter Protocols for activation procedure)

Cancellation of Air Ambulance:

- A. Only the on-scene Incident Commander, *in collaboration* with the on-scene medical authority, may cancel a medical helicopter en route.
- B. Medical Control may be used as a resource to assist with cancellation decisions.
- C. Medical helicopter services retain final authority to cancel the mission for any reason, such as weather or other safety concerns.

Destination Hospital:

- A. Once care is transferred, medical helicopter crews function under separate operational protocols and retain all decisional authority for patient destinations.

Quality Assessment:

- A. All agencies providing prehospital emergency medical services in La Plata County and activating medical helicopters may request quality assessment information from the helicopter services for the purpose of reviewing system procedures, performance and assuring timely, high quality services. Agencies providing such medical helicopter services are to maintain and provide this information as requested.

Multiple Agency Responses

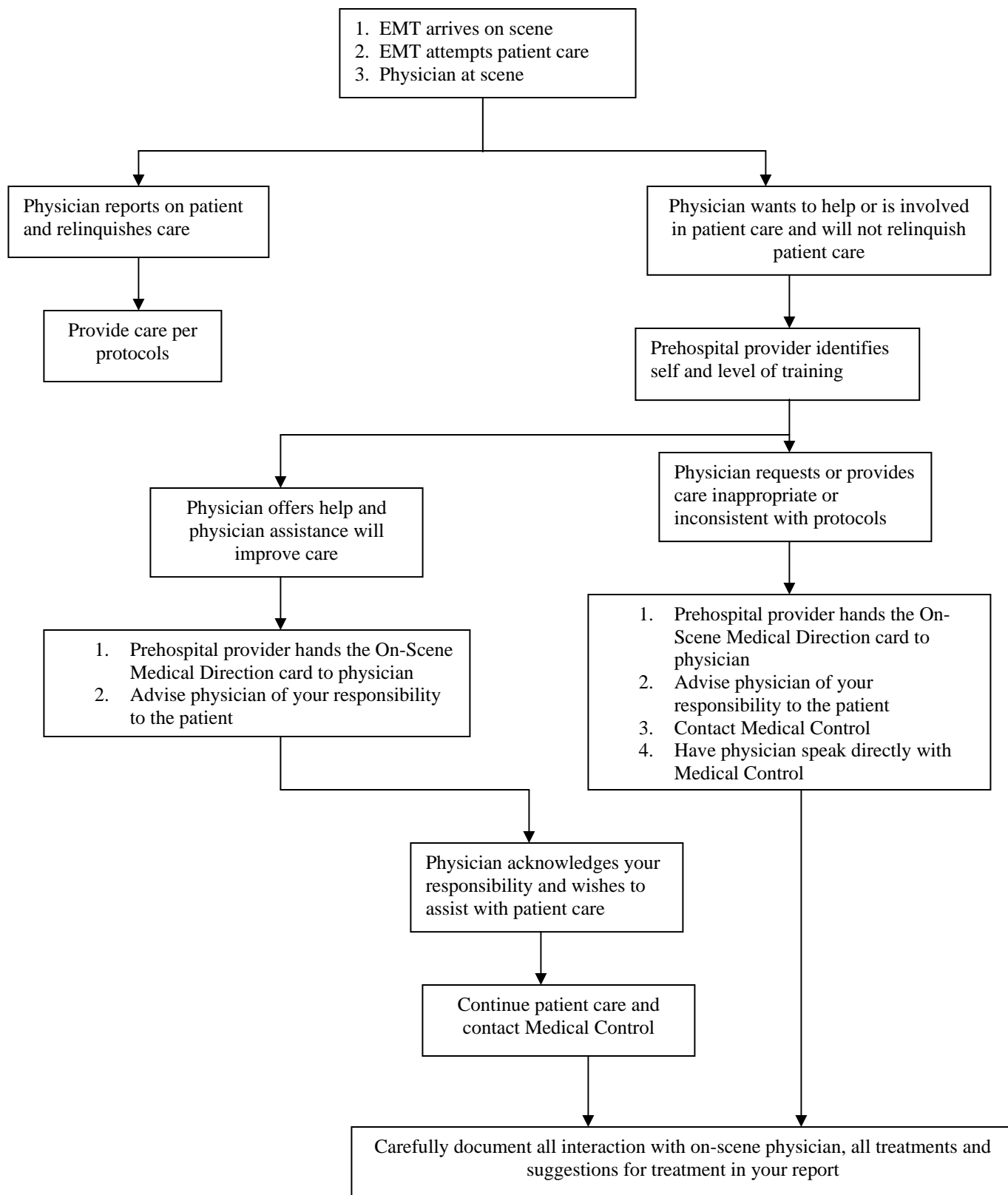
Purpose:

Multiple agencies in La Plata County routinely respond together on calls for emergency medical service. These responses may be mutual aid, automatic aid or direct requests for higher a level service, such as en route intercepts. While each agency is committed to assisting with quality emergency medical services to its neighbors, we must also recognize the associated legal and ethical liabilities. For this reason, decisional authority must be defined. The following guidelines exist to provide optimal patient care while avoiding conflict during critical events:

Guidelines:

1. Upon dispatch for a higher level of care the requested agency immediately becomes the lead agency for the purposes of patient care transport. Direct patient care remains the responsibility of on-scene personnel until direct on-scene transfer of care occurs.
2. The lead agency when dispatched may make resource determinations prior to arrival (e.g. helicopter). This should be accomplished through direct, clear communications with on-scene personnel, when possible.
3. Upon arrival to the patient, lead agency personnel shall assume immediate medical authority. This includes all patient care decisions, as well as determining personnel and additional resources needs.
4. Transition of care to lead agency personnel shall begin as soon as reasonably possible upon arrival. This means a face to face with the medic or fire fighter in charge to the lead medic assuming care. This transition will be done with respect and professionalism.
5. Mode of transport, including transporting agency shall be at the discretion of the lead agency. Such decisions may be made prior to arrival based on available information.
6. Intercept shall be completed at the earliest reasonable location and without undue delay. When the transition occurs on a roadway i.e. meeting en-route, the lead agency/medic will still make the determination for the mode of transportation i.e. which ambulance, helicopter etc...will be used.
7. To smooth transitions and avoid confusion, the first responding agency shall inform the patient and/or family—as soon as reasonably possible—that additional medical crews are responding and will assume responsibility for their care upon arrival.
8. If there is ever an issue on the above IT SHALL NOT BE BREECHED on the scene unless it is critical to the patients well being. The issue will be discussed and a determination made at a later time.

Physician at the Scene/ Medical Direction Algorithm



On-Scene Interveners

Purpose

To provide guidelines for prehospital personnel who encounter a physician or other medical interveners at the scene of an emergency.

General Principles

- A. The prehospital provider generally has a duty to respond to an emergency, initiate treatment and conduct an assessment of the patient to the extent possible.
- B. EMTs of all certification levels provide legal patient care under the medical license of the Medical Director.
- C. A physician who voluntarily offers or renders medical assistance at an emergency scene is generally considered a "Good Samaritan." However, once a physician initiates treatment, he/she may feel a physician-patient relationship has been established.
- D. Bystander nurses and EMTs of all levels have no legal authority, but should be treated respectfully.
- E. Good patient care should be the focus of any interaction between prehospital care providers and the on-scene intervener.

Procedure

- A. Physician Interveners
 1. See algorithm
- B. All Other Medical Providers

Continue procedure until success

 1. Introduce yourself and state your level of certification.
 2. Politely and respectfully begin transition of care by requesting patient care information.
 3. Inform provider that you function under established protocols, have responsibility for the patient and intend to render care according to your protocols.
 4. Contact Medical Control and have them speak with the physician to clarify responsibility
 5. Request law enforcement assistance.

Notes:

- A. Every situation may be different; on-scene medically trained bystanders can often be helpful, but occasionally hinder patient care.
- B. Always remain respectful and in control of emotions. The best way to remain in control of the situation is to not let it escalate.
- C. On-scene medical providers may also be family members.
- D. **Contact Medical Control** for assistance when any question arises.

On Scene Physician Information

Thank you for your offer of assistance. Please be advised that these Emergency Medical Technicians are operating under the authority of a Medical Director through standing medical orders in the La Plata County emergency medical system.

To avoid confusion and expedite patient care, no individual should intervene in the care of this patient unless the individual is:

1. requested to do so by the emergency medical services personnel
2. authorized by the medical oversight physician
3. is legally capable of providing more extensive emergency medical care at the scene

IF YOU ASSUME PATIENT MANAGEMENT, YOU ACCEPT FULL RESPONSIBILITY FOR PATIENT CARE UNTIL THE ATTENDING EMERGENCY MEDICAL SERVICES PERSONNEL OR MEDICAL OVERSIGHT PHYSICIAN ACCEPTS THAT PATIENT RESPONSIBILITY. THIS WILL REQUIRE THAT YOU ACCOMPANY THE PATIENT TO THE EMERGENCY DEPARTMENT.

Refusal of Care

General Principles

When mentally competent patients refuse or revoke consent, they are exercising their right to terminate the medical relationship with prehospital providers. Patients who are thinking clearly, acting rationally and have minimal illness or injury must be allowed to refuse all or part of the care offered and/or transport. Complete documentation and contact with medical control are critical once a medical relationship has been established and the patient elects to refuse or revoke consent.

Because an oriented patient may not necessarily possess the ability to process information effectively, patient assessment must also include the patient's comprehension abilities if refusing transport. The patient should be able to demonstrate a capability to understand:

1. The nature of the condition;
2. The risks and benefits of the proposed treatment; and
3. The risks and benefits of refusing care.

If a reasonable person would consent to transport given similar circumstances, the patient should be transported if at all possible. With mentally incompetent patients, use law enforcement assistance when necessary. Both EMS providers and law enforcement are protected by the "good faith" rule in the state of Colorado.

A. Termination of the Medical Relationship:

Non-licensed medical providers (such as emergency medical technicians of all levels and registered nurses working in the prehospital setting under a physician license) do not have the authority to terminate the medical relationship once established. Base contact with an emergency department physician is an absolute requirement when terminating the medical relationship.

B. Refusal of Consent when Treatment/Transport is Prudent:

1. Mentally competent patients who have significant illness or injury who adamantly refuse treatment and transport are more troubling. Prehospital personnel must make every reasonable effort to inform the patient of their suspected condition and the implications of their decision. This may include time consuming deliberation, if necessary. Medics should:
 - a. Allow the provider who has established the best possible rapport with the patient to communicate with the patient.
 - b. Explain the nature of the emergency and the risks and benefits of both treatment and refusal; then ask patient to use their own words to explain what they have been told to determine if they understand all three elements.
 - c. Enlist the help of family members or friends to convince the patient, or recognize when such intervention is not helpful and manage that aspect.
 - d. Utilize the ED or medical control as a resource to help convince the patient to consent.
2. Mentally competent adults who refuse consent for treatment/transport have the right to make their own medical treatment decisions even if such refusal might result in severe deterioration or death. In this event, the following are required:
 - a. Repeated attempts to convince the patient in front of witnesses.
 - b. Consultation with the base station physician.
 - c. Have, or attempt to have patient or surrogate speak directly with the base station physician.
 - d. A reasonable attempt to have the patient sign the refusal of care document after it has been explained to them in front of at least one witness. This must also be signed by a witness, preferably not another medical provider.

- e. When the patient refuses to sign the document, the refusal form should be filled out and "refused to sign" written on it, then again witnessed.
- f. Make a reasonable attempt to have a family member or friend take responsibility for the patient.
- g. Patients in the custody of law enforcement can refuse treatment and transport providing a law enforcement official agrees to sign the Declination of Services form.

C. Refusal Documentation:

Documentation in the prehospital care report must include:

1. Patient name, address, date of birth and SSN
2. Specific information regarding the nature of the incident, assessment of the patient, explanation of the risks of refusal.
3. Documentation that the patient was able to comprehend the nature of the emergency as well as the benefit of transport vs. risks of non-transport
4. Documentation of base contact and the advice given by the physician.
5. Attached "Declination of Services" signed by patient, if possible.
6. Attached "Consent for Treatment" form when treatment has been rendered, signed by patient, if possible.
7. Patient refusals to sign documents must be noted on the form and in the PCR narrative.

D. Patient consents to transport but refuses specific treatments:

Mentally competent adults who refuse consent for treatments (i.e. IV access, medications, spinal precautions, etc) but agree to transport usually present less of an issue to EMS providers because at the very least they are being transported to the hospital. In this event the following are recommended:

- a. Explain the treatment or procedure and its benefits thoroughly.
- b. Explain the risks associated with refusing the treatment or procedure.
- c. Use tactics to convince the patient, such as enlisting family or friends and base station consultation, if necessary.
- d. Communicate the treatment refusal during the initial patient report from the field and during the bedside report.
- e. Thoroughly document all of the above in the patient report.

E. Minors:

EMS calls for minor injuries or illnesses with children also create challenges related to consent. Patients under the age of 18 years--unless emancipated--must have a legally responsible representative make the decisions regarding termination of their medical care, such as:

- a. A parent
- b. A grandparent
- c. A sibling 18 years or older
- d. A legal guardian
- e. A legal proxy, such as an adult leader or counselor, preferably with a "consent for medical treatment" form signed by a parent, if possible

With minor injuries/ illnesses requiring no medical care, a parent may be contacted by phone for consent to terminate the medical relationship. Minors requiring medical care should be transported to the ED when no parent or representative is available.

All refusal of care issues with minors, just as with adults, must be communicated to the base station physician prior to terminating the medical relationship.

F. EMS Generated Refusals:

1. In the absence of a medic safety issue, EMS personnel are expressly NOT allowed to refuse to transport a patient who is requesting to go to the hospital.

2. EMS personnel may assist in the decision making process with a patient, but must be clear that transport is always an option.
3. EMS personnel may refuse to treat and transport patients for reasons of personal safety. Any unsecured scene, such as, hazardous materials or potentially violent patient may result in the acceptable delay of medical care until which point EMS personnel are no longer at risk of personal injury.

Reporting of Suspected Abuse

Authority

A. Child Abuse:

Under Colorado State Law, medical personnel, including EMS and firefighters are required to report suspected child abuse or neglect. The law states that if the worker has reasonable cause to know or suspect that a child has been subjected to abuse or neglect or who has observed the child being subjected to circumstances or conditions which would reasonably result in abuse or neglect shall immediately report or cause a report to be made of such fact to the county department of social services or local law enforcement agency.

B. Elder and Dependant Adult Abuse:

The Colorado Protective Services for Adults at Risk of Mistreatment or Self-Neglect Act "urges" (but does not require) professionals and others who are in a position to detect abuse, neglect and financial exploitation to report suspicions to adult protective services or local law enforcement.

C. Protection from Liability

Persons who make a good faith report of abuse or neglect are immune from civil and criminal liability. Additionally, civil law provides for the protection of the identity of the reporting person(s). The criminal system usually retains identities of reporting persons in the event further information or testimony is needed.

Definitions

A. Abuse:

1. Infliction of physical pain or injury as demonstrated by, but not limited to, skin bruising, bleeding, malnutrition, dehydration, burns, bone fractures, or death.
2. Any nonconsensual sexual conduct, sexual assault or molestation, sexual exploitation, or prostitution.
3. Substantial psychological abuse, unreasonable confinement or restraint.

B. Neglect:

1. Adequate food, clothing, shelter, psychological care, physical care, medical care, or supervision is not secured for or is not provided in a timely manner and with the degree of care that a reasonable person in the same situation would exercise.
2. Any case in which the individual is in need of services because the parents, legal guardian, or custodian fails to take the same actions to provide adequate food, clothing, shelter, medical care, or supervision that a prudent guardian would take.

C. Dependent Adult

1. Adults who have physical or developmental disabilities, or failing physical or mental abilities caused by age, such that their conditions preclude them from normal activities or to protect their rights.

Reporting Procedures

- A. It is not the role of EMS to investigate suspected abuse or neglect– only to report it.
- B. It is the responsibility of each individual provider to ensure that suspected abuse is reported to proper authorities.

- C. The best method to report suspected abuse or neglect is to personally contact either La Plata County Human Services (382-6150 or after hours at 382-2879) or the appropriate law enforcement and make yourself available for interview and follow-up.
- D. If patient care is transferred, EMS personnel may also notify the caregiver receiving the patient—such as the receiving paramedic, nurse or physician—of their suspicions during the transition of care process. Follow-up contact should be made to assure a report was later made to Human Services or Law Enforcement.
- E. The reporting duties are individual and no supervisor or ranking officer should impede or inhibit the reporting duties.
- F. With multiple witnesses in the same agency, a single individual may be the reporter, but all individuals share the responsibility of assuring a report was made.
- G. Carefully document the following in the patient care report:
 - 1. All suspicions of abuse or neglect and accompanying details
 - 2. The name(s) of other witnesses
 - 3. The method used to report the suspicions
 - 4. The date, time and name(s) of persons to which the report was made

Note:

A health care worker who fails to report suspected child abuse or neglect may be charged with a class 3 misdemeanor provided in section 19-1-103(1)(A) C.R.S.