14G – PATIENT PRIORITIZATION

EMERGENCY MEDICAL RESPONDER

EMT

EMT-INTERMEDIATE 85

ADVANCED EMT

PARAMEDIC

While each patient will receive the best possible EMS care in a humane and ethical manner, proper patient prioritization ensures that patients most dependent upon rapid and critical medical interventions receive expeditious field treatment and that destination hospitals receive early notification.

Red/Priority I: Patient condition expected to require immediate intervention upon Emergency Department arrival. Examples include:

- Inability to successfully oxygenate and/or ventilate;
- Acute dyspnea in adults requiring NIPPV (use of red lights & sirens at paramedic discretion based upon patient stability and if markedly improving on NIPPV);
- Acute Myocardial Infarction with ST elevation on 12-Lead ECG;
- Acute Congestive Heart Failure with hypotension (Cardiogenic Shock);
- Acute Stroke with positive LAPSS with symptom onset < 23 hours in duration;
- Status epilepticus;
- Deep penetrating trauma (e.g. gunshot wound) to head, neck, or trunk;
- Trauma in adults with systolic blood pressure <90 mmHg;
- Trauma in pediatrics with systolic blood pressure < (70 + 2 X age in years) mmHg.

Red/Priority I patients are typically transported to the Emergency Department with red lights and sirens.

Yellow/Priority II: Patient condition expected to require intervention within 15 minutes upon Emergency Department arrival. Yellow/Priority II patients have potential time sensitive problems, are currently stable, but at risk for sudden deterioration. Examples include:

- Acute dyspnea in adults and pediatrics with normalizing vital signs;
- Acute non-traumatic chest pain in adults improving with protocol specified treatment;
- High force traumatic injuries with normal and stable vital signs.

Yellow/Priority II patients may be transported to the hospital red lights and sirens if time of transport would otherwise create marked risk to patient recovery. In most situations, though, the safety risk of red lights and sirens transport of these patients is unwarranted.

PROTOCOL 14G: Patient Prioritization, cont.

Green/Priority III: Patient condition expected to require routine timeliness of intervention upon Emergency Department arrival. Green/Priority III patients do not appear to require further emergent medical intervention and do not appear to have life/organ threatening conditions. Examples include:

- Asthma exacerbation dyspnea resolved with bronchodilator nebulization;
- Nausea/non-bloody vomiting with normal and stable vital signs;
- Isolated orthopedic injury with intact neurovascular function.

Green/Priority III patients should be transported to the hospital without red lights and without sirens. The safety risk of red lights and sirens transport of these patients is unwarranted.

Black or Blue: Obvious death or illness/injury severity incompatible with successful resuscitation given concurrent system demands (such as in multiple casualty responses).

Adult trauma patients are determined to be **Red/Priority I** by either vital signs and level of consciousness (systolic BP < 90 mmHg, sustained tachycardia, respiratory rate <10 or >29 breaths per minute, GCS ≤ 13, cool, diaphoretic skin) or any of the following anatomical injury:

- Penetrating injury of head, neck, torso, extremities proximal to elbow or knee;
- Amputation proximal to the wrist or ankle;
- Paralysis or suspected spinal fracture with neurological deficit;
- Flail chest;
- Two or more suspected proximal long - bone fractures;
- Open or suspected depressed skull fracture;
- Unstable pelvis or suspected pelvic fracture;
- Tender and/or distended abdomen;
- Burns associated with other Priority I Trauma;
- Crushed, degloved, or mangled extremity, proximal to the wrist or ankle;
- Pulseless extremity.

Adult trauma patients are determined to be **Yellow/Priority II** from events with risk of severe injury despite normal and stable vital signs without change in usual mentation or usual neurologic function, or respiratory distress. Adult trauma patients may also be determined to be Yellow/Priority II if exhibiting a single system injury as noted:

- High risk auto crash (intrusion > 12 inches in occupant site; intrusion > 18 inches in any site; ejection (partial or complete) from automobile; death in same passenger compartment);
- Auto v. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact;
- Motorcycle crash > 20 mph;
- Falls > 20 feet in height (one building story is 10 feet in height);
- Significant force alleged assault;
- Isolated closed head trauma with resolved altered mental status (Neuro System);
- Positive seatbelt sign or handlebar mark;
- Fractures/dislocation; lacerations/avulsions with extensive tissue damage;
- High voltage electrical injury;
- Pregnancy > 20 weeks.

PROTOCOL 14G: Patient Prioritization, cont.

Adult Priority II Determining Criteria, cont.

Adult trauma patients are determined to be **Yellow/Priority II** from events with risk of severe injury despite normal and stable vital signs without change in usual mentation or usual neurologic function, or respiratory distress. Adult trauma patients may also be determined to be Yellow/Priority II if exhibiting a single system injury as noted:

- Facial lacerations; fractured facial bones; avulsed teeth (Maxillofacial/Dental);
- Select & isolated hand injuries ("isolated" defined by the level of suspected injury involvement being no further proximal than the elbow).
  - Only certain hand injuries require rapid treatment to avoid unfavorable outcomes. These "select" Priority II injuries include:
    - Vascular injuries that involve significant arterial hemorrhage;
    - Nerve injuries that cause loss of motor function;
    - Amputations;
    - High-pressure injection injuries;
    - Flexor tendon injuries of hand.

Adult trauma patients may be determined to be **Discretionary Red/Priority I or Yellow/Priority II** if clinical suspicion of significant injury and heightened by any single or particularly a combination of the following patient attributes:

- Age > 55;
- Anticoagulation, bleeding disorders and/or significant comorbidities;
- Time sensitive extremity injury.

Discretionary Red/Priority I or Yellow/Priority II adult trauma patient radio and care reports should clearly indicate to the receiving Trauma Center personnel the rationale for the Discretionary Red/Priority I or Yellow/Priority II assignment.

Level III Trauma Centers are intended to receive adult patients at risk for severe injury with normal, stable vital signs or patients with no significant anatomical injuries.

Adult trauma patients are determined to be **Green/Priority III** from events with normal and stable vital signs, without change in usual mentation or usual neurologic function, and without new or significant organ system dysfunction. Green/Priority III adult trauma may include:

- Single proximal or distal long bone fractures without dislocation;
- Minor puncture wounds/lacerations/abrasions;
- Isolated neck pain without new neurological deficit;
- Isolated extremity pain;
- Isolated abdominal pain.

PROTOCOL 14G: Patient Prioritization, cont.

Level IV Trauma Centers may receive adult patients without physiologic instability, altered mentation, neurological deficit or significant anatomical injuries and have also not been involved in a significant mechanism of injury incident for expected care at that facility. Patients in other categories (eg. with physiologic instability) should be expected to be transferred to a higher level trauma center after immediate care needs are addressed (eg. invasive airway management).

Pediatric trauma patients are prioritized **Red/Priority I** by either physiological criteria (systolic BP < (70 + 2 x age of patient in years) mmHg, sustained tachycardia >160 bpm, respiratory rate <12 or >40, pulse oximetry<95% without supplemental oxygen, or GCS ≤ 12)

- Penetrating injury of head, neck, torso, extremities proximal to elbow or knee;
- Amputation proximal to the wrist or ankle;
- Paralysis or suspected spinal fracture with neurological deficit;
- Flail chest;
- Unstable pelvis or suspected pelvic fracture;
- Crushed, degloved, or mangled extremity, proximal to the wrist or ankle;
- Pulseless extremity;
- Two or more open fractures.

Pediatric trauma patients are prioritized **Yellow/Priority II** from "high-energy" events with risk of severe injury despite normal and stable vital signs without change in usual mentation or usual neurologic function, or respiratory distress. Pediatric trauma patients may also be determined to be Yellow/Priority II if exhibiting any of the adult trauma priority II single system injury criteria.

Pediatric trauma patients may be determined to be **Discretionary Red/Priority I or Yellow/Priority II** if clinical suspicion of significant injury warrants and is heightened by any of the following patient attributes:

- GCS of 13-14;
- Extrication time > 20 mins, *death in same vehicle, speed >40 mph, rollover mechanism, vehicle external intrusion >20" or compartment intrusion >12";
- Fall criteria for pediatric trauma Red/Priority I is >10 feet or 2 – 3 times the height of the child;
- Two or more suspected proximal long - bone fractures;
- Open or suspected depressed skull fracture;
- Tender and/or distended abdomen/positive seatbelt sign or handlebar mark;
- Suspected or known Non-Accidental Trauma in pediatric patients;
- Tenderness to spine with palpation;
- Isolated open fracture (excluding hand);
- Significant laceration or soft tissue injury;
- High voltage electrical injury;
- Anticoagulation and bleeding disorders and/or significant comorbidities.

PROTOCOL 14G: Patient Prioritization, cont.

Discretionary Red/Priority I or Yellow/Priority II pediatric trauma patient radio and care reports should clearly indicate to the receiving Trauma Center personnel the rationale for the Discretionary Red/Priority I or Yellow/Priority II assignment.

Pediatric trauma patients are determined to be **Green/Priority III** from events with normal and stable vital signs, without change in usual mentation or usual neurologic function, and without new or significant organ system dysfunction. Green/Priority III pediatric trauma may include any of the adult trauma Green/Priority III injury criteria as previously listed in this protocol.

- Single bone fractures from a same level fall;
- Minor puncture wounds/lacerations/abrasions;
- Isolated extremity pain;
- Abdominal pain without bruising;
- Back pain.

SEE ALSO SECTION 19 RESOURCE: OKLAHOMA MODEL TRAUMA TRIAGE ALGORITHM

Pediatric (Age < 16 years of age) general medical patients are determined **Red/Priority I** to be if the following organ system dysfunction is evidenced by acute symptoms or physical exam signs:

Pulmonary System:

- Respiratory arrest;
- Respiratory distress and inability to maintain O_2 sat > 95% on 100% supplemental O_2;
- Stridor with inability to phonate, weak cry, altered mental status, or pallor.

Cardiovascular System:

- Cardiac arrest (or history of pre-arrival CPR) or bradycardia requiring chest compression;
- Multiple shock signs (pallor, cool, slow capillary refill, weak pulse, altered mental status);
- Persistent tachycardia > 200/min or bradycardia< 80/min (without athletic fitness level).

Neurologic System

- Status epilepticus;
- Acute sustained altered mental status without apparent etiology;
- Acute focal neurological deficits.

Metabolic System/Toxicology (Overdose);

- Ingestion of a tricyclic antidepressant;
- Ingestion, inhalation, or contact exposure causing altered mental status, respiratory distress, or shock.

PROTOCOL 14G: Patient Prioritization, cont.

Pediatric (Age ≤ 16 years of age) general medical patients are determined to be **Green/Priority III** if there does not appear to be an acute medical problem of life/organ threatening severity.

Specialized Burn Care

In Oklahoma, the following burn care specialty centers exist:

Oklahoma City:	Adult - Integris Baptist Medical Center
	Pediatric - OU Medical Center Childrens
Tulsa:	Adult/Pediatric - Hillcrest Medical Center

Patients with the following burn injuries (without additional trauma center criterion injuries) should either be transported directly to a burn care specialty center or be referred to such after initial emergency department evaluation:

- Partial thickness (second degree) burns >10% total body surface area (TBSA);
- Full thickness (third degree) burns;
- Partial or full thickness burns of the face, hands, feet, genitalia/perineum, or major joints;
- Electrical burns (includes lightning injury), inhalation burns, chemical burns;
- Burn injury in patients with preexisting medical disorders compromising healing and survival (cardiac disease, chronic respiratory illness, diabetes);
- Multisystem trauma with partial or full thickness burn as the predominant injury.

If the burn patient cannot be oxygenated or ventilated, transport the patient to the nearest appropriate emergency department for airway management.