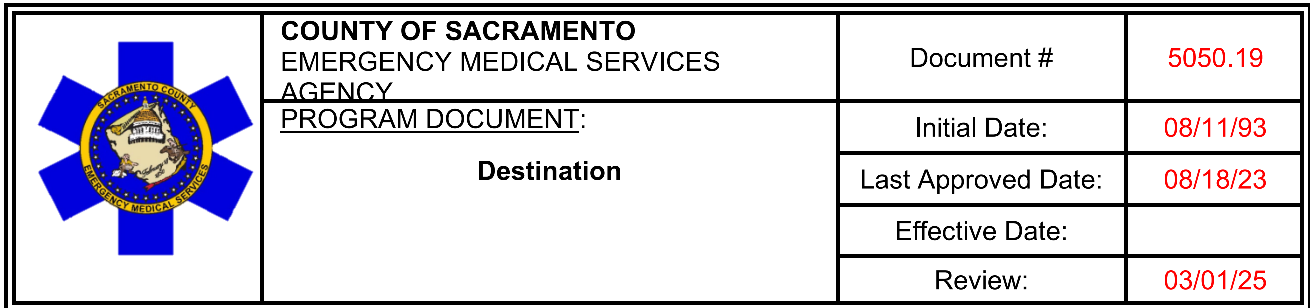

	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	5050.19
	PROGRAM DOCUMENT: **Destination**	Initial Date:	08/11/93
		Last Approved Date:	08/18/23
		Effective Date:	
		Review:	03/01/25

Signature on File — EMS Medical Director

Signature on File — EMS Administrator

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Purpose:

A. To guide prehospital care personnel in arriving at a destination decision.

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9

Definitions:

A. Time Closest Facility: The time closest Hospital, taking into consideration traffic and weather conditions or other factors which clearly affect transport time.
B. Most Appropriate Facility: The nearest receiving facility having specialized services likely to be required by a patient.
C. Receiving Hospital: An acute care hospital licensed under Division 2, Chapter 2, Article 1 (commencing with § 1250) of the CA Health and Safety Code, with a permit for basic emergency service, as determined by the Local EMS Agency (LEMSA), which is utilizing the Hospital in the emergency medical services system[1].

Policy:

Transport destination decisions shall be based on the following priority rank order:

A. Patients meeting special triage criteria for Critical Trauma, Burn, STEMI, or Stroke shall be transported to the most appropriate facility designated by the Sacramento County EMS Agency (SCEMSA).
B. Patients likely to require specialized services as identified in treatment protocol will be transported to the most appropriate receiving facility ~~(i.e., Labor & Delivery, Ventricular Assist Devices, Cardiopulmonary Arrest with Return of Spontaneous Circulation~~). Refer to PD # 2060 – Hospital Services.
C. If prehospital personnel do not believe the patient has a medical condition that would render them unstable for transport, and no Special Triage Criteria apply (see Considerations for Destination Selection, subd. (C)(2), the patient SHALL be transported to a facility that most closely matches the following rank-order criteria:
   1. A facility within the Patient's Preferred Health Plans {HSC § 1797.106(b)] or the Patient's existing in-plan hospital system affiliation[1];
   2. The facility that the Patient/Family/Guardian requests at the time of transport;
   3. The facility requested by the Patient's private Physician;
   4. The facility requested by Law Enforcement; and
   5. The facility that most closely meets EMS System resource availability, as determined by SCEMSA in coordination with the EMS provider management.

Considerations for Destination Selection

A. The Sacramento Veterans Administration Medical Center shall receive only the following patients[2].
   1. Veteran patients requesting to be transported to the VA Medical Center under Policy C.1 above.
   2. Adult patients (>14 years) under Cardio-Pulmonary Resuscitation (CPR) when the VA is the time closest facility.
   3. Adult patients (>14 years) with unstable airways when the VA is the time closest facility.

B. Law enforcement agencies retain primary responsibility for the safe transport of patients under arrest.
   1. Patients under arrest or in psychiatric detention shall be searched thoroughly by law enforcement for weapons and contraband prior to placement in the ambulance.
   2. Patients under arrest, if handcuffed, must always be accompanied in the ambulance by law enforcement personnel.
   3. Prehospital personnel and law enforcement officers should mutually agree on the need for law enforcement assistance during the transport of patients in psychiatric detention.

C. Direct medical oversight shall be utilized to aid in arriving at a destination decision in the following situations:
   1. Patient's condition is determined to be unstable by the prehospital personnel's assessment, and the destination is not the most accessible facility.
   2. Special Triage Criteria dictate a different destination from the destination based on patients, family/guardian, private physicians, or law enforcement's request.
   3. Control facility makes all destination decisions for a Mass Casualty Incident (MCI) or during a countywide level II, III or IV expanded emergency.
   4. Direct medical oversight, when utilized, shall be the overriding decisive factor in determining the destination.

D. Non-trauma patients under Cardiopulmonary Resuscitation (CPR) shall be taken to the most accessible receiving Hospital.
   1. Any patient with an initial shockable rhythm (Ventricular Tachycardia or Ventricular Fibrillation or shocked by an AED) who has a Return of Spontaneous Circulation (ROSC) during any part of the resuscitation and who is transported shall be transported to a STEMI Percutaneous Coronary Intervention (PCI) center.

E. Trauma patients with unstable or obstructed airways or tension pneumothorax(s) that cannot be stabilized, cleared, or relieved in the field shall be taken to the most accessible receiving Hospital.

F. Any ambulance presenting at an emergency department carrying more than one patient will offload all patients at that emergency department, except as directed by the control facility during a declared MCI or area-wide emergency.

Capturing Ambulance Patient Offload Times [APOT] (Refer to SCEMSA

PD# 2521 – Ambulance Patient Offload Time (APOT), Data Collection and Reporting).

A. APOT times are measured and then reported using two separate yet equally important steps: Clock Start and Clock Stop.
   1. Clock Start: The time the ambulance arrives at the ED and stops at the location outside the hospital ED where the patient will be unloaded from the ambulance. Typically this time is captured in dispatch as “Transport Arrived” by button push or voiced over radio.
   2. Clock Stop: The time ED medical staff has:
      - Accepted a verbal patient report.

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- The patient has been transferred to a hospital bed/chair.
- A signature has been applied by the hospital staff in the EMS record. Most ePCR platforms have a “lock” or “transfer complete” button, which captures the “clock stop.”

Transport of ALS and BLS Patients to the Emergency Department Waiting Room:

A. If an offload delay of greater than 20 minutes is expected, a patient meeting the waiting room criteria outlined below may be moved to the waiting room:
   1. GCS = 15, or at baseline with caregiver in attendance.
   2. Exhibits decision-making capacity or has a caregiver in attendance.
   3. Can stand or maintain a sitting position.
   4. Adult Vital Sign Parameters:
      a. Systolic Blood Pressure ≥ 100 mmHg and ≤ 200 mmHg.
      b. Diastolic Blood Pressure < 120 mmHg.
      c. Pulse > 50 bpm and < 110 bpm.
      d. Respiratory Rate > 10 and < 20.
      e. O_2 Saturation ≥ 94% room air.
   5. Pediatric Vitals Parameters:
      a. Within normal age-appropriate parameters.

B. If, after two consecutive 15-minute vital sign assessments (30 minutes minimum) **AND** the patient now meets the criteria outlined in Section A (above) in BOTH assessment cycles, the patient may be moved to the waiting room. EMS shall remove any IV in place prior to placing the patient in the waiting room.

C. Patients with **ANY** of the following **CAN NOT** go to the waiting room:
   1. Meets Stroke, STEMI, Sepsis, or Trauma criteria.
   2. Has Spinal Motion Restriction (collar +/- backboard).

   NOTE: If removed by ED staff, this criteria does not apply.

   3. Has focal weakness, dizziness/vertigo, and recent seizure activity.
   4. Has active chest pain of suspected cardiac origin.
   5. Has complaint of syncope.
   6. Brief Resolved Unexplained Event (Pediatric).
   7. Has received Naloxone from EMS, law enforcement, or a bystander.
   8. Has received a narcotic analgesic.
   9. Has expressed Suicidal/Homicidal thoughts or intentionally ingested a toxin or medication with the intent of self-harm, **AND a sitter, law enforcement, or responsible adult IS NOT present.**
   10. On a 5150 hold **AND a sitter or law enforcement IS NOT present.**
   11. Patients with a known communicable disease such as C. Diff, TB, or other need for isolation.

D. EMS personnel must make every effort to complete an in-person transfer of care to a hospital employee authorized to triage the patient and make an effort to obtain a signature for the transfer of patient care. If a detailed report is declined, this shall be documented. The nurses’ signature should be obtained, when possible, but is not required for patient offload if all criteria are met to offload the patient to the ED waiting room. If a triage nurse is unavailable to accept the transfer of care, the radio report that was provided before arrival at the hospital will be considered equivalent to a notification to the hospital staff.

E. Documentation (ePCR): For any patients transported to the ED waiting room, the following shall be documented:
   1. That PD# 5050 criterion was met to offload the patient to the ED waiting room.
   2. Obtain the name of the person to whom the notification was provided.
   3. Under “Procedures,” document:
      - Hospital Waiting Room.

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F. It is the responsibility of the provider to QI 100% of **ALL** calls where it is determined by the paramedic that the patient is stable for the ED waiting room per this policy with a monthly summary report to SCEMSA.

Patients intend to elope on hospital grounds – reference PD# 2105

[1]If it is determined, by hospital identification armband or from patient verbalization, they were transported, treated, released, refused care, or departed against medical advice from the identified Hospital within the past twelve (12) hours, and there exists no medical condition that the prehospital personnel believes is unstable, and no Special Triage Policy applies, the patient can be transported back to the identified Hospital. (HSC § 1797.106(b))

[2]The Sacramento VA Medical Center is authorized to provide care to individuals responding to, involved in, or otherwise affected by a disaster or emergency, as described in 38 U.S.C. 1785 and 38 CFR 17.86, the NRF, and other guidance. VA has additional authority to furnish hospital care and medical services as a humanitarian service in emergency cases but is required to charge for such care (see 38 U.S.C. 1784 and 38 CFR 17.102).

For the purposes of determining the destination, Kaiser Hospital South Sacramento and Methodist Hospital shall be considered equidistant.

Cross Reference: PD# 2060 – Hospital Services
PD# 2200 – Medical Oversight
PD# 2525 – Prehospital Notification
PD# 5052 – Trauma Destination
PD# 5053 – Trauma Triage Criteria
PD# 8025 – Burns
PD# 8030 – Discomfort – Pain of Suspected Cardiac Origin
PD# 8031 – Non-Truamatic Cardiac Arrest
PD# 8042 – Childbirth
PD# 8044 – Spinal Motion Restriction (SMR)
PD# 8060 – Stroke
PD# 8833 – Ventricular Assist Device (VAD)
PD# 7501 – Multi-Casualty Critique
PD# 9016 – Pediatric Parameters
PD# 9019 – Brief Resolved Unexplained Event (BRUE)

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