	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	5011.04
	PROGRAM DOCUMENT: **Paramedic/AEMT to EMT Transfer of Care**	Initial Date:	05/07/24
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Signature on File	Signature on File
EMS Medical Director	EMS Administrator

Purpose:

A. To establish a guideline for the transfer of care from an Advanced Life Support (ALS) services to a Basic Life Support (BLS) services
B. To ensure seamless transition of patient care while maintaining the highest standard of safety, efficiency, and continuity of medical treatment.

Authority

A. California Health and Safety Code, Division 2.5 §1797.220, §1798.

Policy:

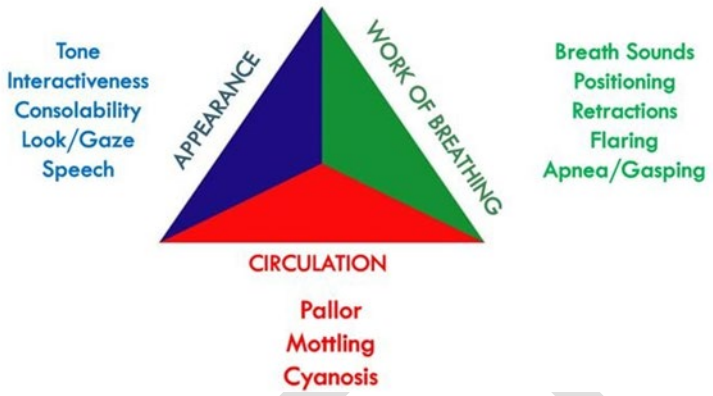
A. Paramedics can transfer care to an EMT for stable ~~low-acuity~~ patients meeting all of the following criteria:
   1. ~~Oriented to person, place, time with a GCS of 15 and must exhibit decision-making capacity, unless there is a history of dementia with caregiver verification of baseline mental status.~~ Patient GCS ≥ 14 or at baseline mentation if the baseline is less than 14.
   2. ~~Exhibit no evidence of altered level of consciousness or be under the influence of drugs, alcohol, or other substances.~~
   3. No new focal weakness, dizziness/vertigo or seizure activity.
   4. Systolic blood pressure: sBP > 90 mmHg or < 200 mmHg.
   5. Diastolic blood pressure: dBP < 120 mm Hg.
   6. Heart rate: HR > 50 or < 120.
   7. Respiratory rate: RR > 10 or < 24.
   8. O2 saturation ≥ 94%. O2 saturation for COPD patients ≥ 88% or patient stable on home oxygen level.

B. Paramedics **CAN NOT** transfer care to an EMT for any patient meeting the following criteria:
   1. Any patient meeting trauma criteria per PD # 5053 – Trauma Triage Criteria.
   2. ~~Have syncope, or~~ Brief resolved unexplained event (BRUE)
   3. ~~Active chest pain or meet~~ Anyone with an EKG reading STEMI criteria per PD# 8030 – Discomfort/Pain of Suspected Cardiac Origin.
   4. Positive stroke assessment per PD# 8060 - Stroke.
   5. Combative or currently under chemical and/or physical restraint.
   6. Suspicion for ingestion or overdose and unable to maintain airway.
   7. Airway support (BVM, NIV).

C. BLS units may transport patients who have been medicated with Zofran, Toradol, Acetaminophen or Dextrose/oral glucose.

1. Any other medication administration will require ALS transport.
2. May transport patients with an IV which has been saline locked.

D. Pediatric patients must meet stability criteria through assessment using the Pediatric Assessment Tool (PAT) per PD# 2003 -BLS Tiered Response System.



E. All transfers of care between a Paramedic and EMT shall be documented with a clear statement in the narrative that transfer of care occurred, the name of the transferring paramedic, and that all parameters were met to transfer care to the EMT.

F. If a Paramedic from the **first response unit** retains care for transport with a BLS medic unit, this should be documented with a clear statement in the narrative including the employee names and roles of all transporting crew members. The BLS unit may be added as a crew member in the EMS documentation system if necessary. The Paramedic retaining care of the patient will complete the PCR.

G. Patient assessment and refusal of EMS care shall be performed by ALS personnel whenever possible. BLS personnel may only complete the refusal of EMS care procedures if ALS personnel are not on scene and do not meet criteria as listed in PD# 2101 – Patient Initiated Refusal of EMS Assessment, Treatment and/or Transport.

H. Patient deterioration during transport:
   1. If deterioration occurs, the Paramedic shall assume responsibility for the ongoing care of the patient.
      a. If a Paramedic is not immediately available, the BLS provider shall consider the following two options:
         - Facilitate prompt transport of the patient to the closest, most appropriate Emergency Department (ED).
         - Request for an ALS unit where a Paramedic shall assume responsibility for the ongoing care of the patient.

I. Patient ED Consolidation:

NOTE: All patients that are not immediately off-loaded in the Emergency Department shall be deemed to require a BLS level of care until they are transitioned to an ED bed and hand off to ED medical personnel is completed.

1. Patients that are being held in Emergency Departments with an ambulance patient offload delay (APOD) may be transitioned to Wall Decompression (WD) personnel for supervision. WD personnel may include paramedics or EMT staff to be determined by EMS leadership. It is the position of SCEMSA that all patients who

are delayed in transferring to an ED bed may be supervised, at a minimum, by EMT trained personnel. Per PD# 5050 – Destination, a patient shall be moved to the waiting room if they meet stability criteria initially, OR if after two consecutive 15-minute vital sign assessments (30 minutes minimum) they are stable. Patients who do not meet stability criteria for waiting room placement are candidates for decompression consolidation.

a. **RATIO –** A crew of two may accept up to four (4) patients. This ratio may be extended to six (6) at supervisor discretion.
b. **TRIAGE to WAITING –** Wall decompression personnel shall utilize SCEMSA PD# 5050 – Destination, when applicable, to transfer patients to the emergency department waiting room.
c. **MONITORING** – Patients being supervised by wall decompression personnel shall have vital signs and GCS re-assessment every 15 minutes to identify patients who are clinically deteriorating. Any abnormal vital sign or mental status change shall be communicated to the triage nurse. This communication shall be documented in the patient ePCR.
d. **PATIENT HAND OFF** – It is the responsibility of the transport provider to provide an accurate patient hand off to incoming wall decompression personnel.
    - This hand off will, at a minimum, contain:
        - PT: chief complaint, vital sign history and details of care already rendered.
        - ED triage staff will be informed of the patient hand off as a courtesy.
e. **ED TRANSFER SIGNATURE** – A signature will be obtained from ED medical personnel at the time when the patient is physically moved from the EMS equipment to the ED gurney if no consolidation has occurred.
    - If consolidation has occurred with an outside agency that cannot capture the ED medical personnel signature in the EPCR, then a ED medical personnel signature shall be obtained at the time of transfer to wall decompression personnel. The wall decompression personnel will complete a short form to accurately capture APOT time once the patient is off their gurney.
f. **DOCUMENTATION** – Continuous documentation of vital signs assessment every 15 minutes, all patient events, as well as accurate ambulance patient offload time (APOT) – transfer of the patient from EMS equipment to ED care – shall be documented. This information may be captured on the transferred ePCR, or on a wall decompression summary report.

Cross References: PD# 5050 – Destination
PD# 5053 – Trauma Triage Criteria
PD# 8030 – Discomfort-Pain of Suspected Cardiac Origin
PD# 8060 – Stroke