

**4101****Universal Patient
Care****Treatment Protocol**Last Reviewed: **July 1, 2025**Last Revised: **July 1, 2026****PURPOSE**

Facilitate appropriate initial assessment and management of any EMS patient and link to appropriate specific treatment protocols as directed by the findings within the Universal Patient Care Protocol. Perform assessments and interventions as noted below within the providers scope of practice.

Patient/Scene Management

1. Assess scene safety
 - a. Evaluate for hazards to EMS personnel, patient, bystanders
 - b. Safely remove patient from hazards prior to beginning medical care
 - c. Determine the number of patients
 - d. Determine mechanism of injury or potential source of illness
 - e. Request additional resources if needed. Cancel, reduce, or increase priority of responding equipment as clinically indicated and operationally required
 - i. Request air ambulance as clinically indicated and operationally required
 - ii. Consider declaring an/a EMS Surge/Mass Casualty Incident (MCI), go to REMSA Protocol 3305 *EMS Surge/Multiple Patient Incident (MCI) Management*
2. Use appropriate personal protective equipment (PPE)
 - a. Consider suspected or confirmed hazards on scene
 - b. Consider suspected or confirmed highly contagious infectious disease (i.e. contact, droplet, or airborne)
3. Consider cervical spine stabilization and/or spinal precautions if traumatic injury is suspected

Primary Survey

Airway, breathing, circulation should be assessed; however, there may be circumstances to reprioritize and evaluate circulation, airway, breathing when significant hemorrhage is recognized. As clinically indicated, obtain the patients age and weight (reported by written document, patient/parent, or EMS estimation). Classify patient as pediatric if appearing or known to be 14 years of age or less.

1. Airway: assess for patency and open airway as clinically indicated
 - a. Head tilt/chin lift
 - b. Jaw thrust
 - c. Suction as clinically indicated
 - d. Consider the need for an airway adjunct or definitive airway (i.e. OPA, NPA, iGel, orotracheal intubation)
 - e. Patients with laryngectomies or tracheostomies, remove all objects or clothing that may be obstructing the opening, suction as clinically indicated, maintain the flow of the prescribed oxygen and reposition the head and/or neck
2. Breathing:
 - a. Evaluate rate, breath sounds, accessory muscle use, retractions, patient positioning, oxygen saturation
 - b. Provide supplemental oxygen as clinically indicated for target O2 of 94-98% SPO2 and based on clinical presentation
 - c. Evaluate ETCO2 as clinically indicated and per treatment policy requirements
3. Circulation:
 - a. Control any major external hemorrhage (i.e. direct pressure, hemostatic gauze, tourniquet placement)
 - b. Assess for pulse
 - i. If none – go to REMSA Protocol 4405/4903 *Adult/Pediatric Medical Cardiac Arrest* or REMSA Protocol 4301/4902 *Adult/Pediatric Traumatic Shock/Injury/Arrest* treatment protocols as applicable
 - ii. Assess rate and quality of radial, brachial, and/or carotid as clinically indicated
 - iii. Evaluate perfusion – skin color, temperature, moisture, and capillary refill

4. Disability:
 - a. Evaluate patient responsiveness: Glasgow Coma Scale (GCS) or AVPU (Alertness, Verbal, Pain, Unresponsive). mLAPSS as clinically indicated.
 - b. Evaluate gross motor and sensory function in all extremities
 - c. For found/reported altered mental status or suspected stroke, obtain blood glucose level and treat as clinically indicated
 - d. If acute stroke suspected – go to REMSA Protocol 4502 *Suspected Stroke*
5. Expose: removal of clothing and/or obstructions on patient as appropriate to complaint and physical exam requirements
 - a. Be considerate of patient modesty
 - b. Consider warming/cooling measures as appropriate and clinically indicated
6. Assess for urgency of transport if any critical injuries or illnesses are discovered during the primary survey
 - a. Prior to transport: Consider need for specialty care destinations (i.e. Stroke, STEMI, Trauma) and contact REMSA authorized base hospital as required by REMSA protocols.
 - b. Contact Level I/II Trauma base for any instances where multiple patients are present (EMS Surge/MCI) for early notification and patient distribution.

Insert treatment protocols for emergency stabilization of the patient when indicated early in the assessment. Follow clinically indicated treatment protocols when the patient requires emergency interventions within the providers scope of practice.

Secondary Survey

The performance of the secondary survey should not delay patient transport in critical patients. Secondary surveys should be tailored to the patient's presentation and chief complaint. Secondary survey should be completed after the primary survey has ruled out any immediate interventions that need to be performed on the patient based on assessment finding.

1. Head
 - a. Pupils
 - b. Ears
 - c. Naso-oropharynx
 - d. Skull and scalp
2. Neck
 - a. Jugular venous distention
 - b. Tracheal position
 - c. Spinal tenderness
3. Chest
 - a. Retractions
 - b. Breath sounds
 - c. Chest wall tenderness, deformity, crepitus, and excursion
4. Abdomen/Back
 - a. Tenderness or bruising
 - b. Abdominal distention, rebound, or guarding
 - c. Spinal tenderness, crepitus, or step-offs
 - d. Pelvic stability or tenderness
5. Extremities: evaluate all four extremities as indicated
 - a. Pulses
 - b. Edema
 - c. Deformity/crepitus
6. Neurologic
 - a. Mental status/orientation (if the patient has a history of an altered mental status, document if they are at baseline or not)
 - b. Motor/sensory
7. Evaluate for medical equipment the patient may have (e.g. pacemaker/defibrillator, LVAD, insulin pump, dialysis fistula)

Insert treatment protocols for patient disposition. If during either the primary or secondary survey, critical findings are discovered, appropriate interventions should be performed within providers scope of practice as indicated in the appropriate treatment protocol. Follow operationally indicated treatment protocols when required for patient disposition and transport destination decisions.

Vital Signs/History

Obtain baseline vital signs (an initial full set of vital signs is required: pulse, blood pressure, respiratory rate, neurologic status assessment, pulse oximetry as indicated, waveform capnography as indicated)

1. Stable patients will have at least two sets of pertinent vital signs. Vital signs are taken 10 to 15 minutes apart and, if transported, taken shortly before arrival at the receiving facility. Vital signs may be taken more often as clinically indicated.
2. Critical patients will have vital signs taken every 5 minutes. Vital signs may be taken more often as clinically indicated.
3. Neurologic status assessment involves establishing baseline and then trending any change in patient neurologic status
 - a. Glasgow Coma Scale (GCS) should be used to gather baseline and trending changes in the patient.
 - b. If the patient is a suspected Stroke, mLAPSS is to be utilized and go to REMSA Protocol 4502 *Suspected Stroke*
4. Patients with cardiac or respiratory complaints:
 - a. Pulse oximetry
 - b. 12-Lead electrocardiogram (EKG) should be obtained promptly in patients with cardiac or suspected cardiac complaints when paramedic present
 - c. Continuous cardiac monitoring on scene and throughout transport
 - d. Waveform capnography to be used for patients with respiratory complaints (mandatory use on critical patients and those patients who require invasive airway management)
5. Patients with altered mental status:
 - a. Check blood glucose. If low, go to REMSA Protocol 4201/4901 *Adult/Pediatric Symptomatic Hypoglycemia*
 - b. Consider waveform capnography (mandatory use on critical patients and those patients who require invasive airway management)
6. Obtain **OPQRST** history:
 - a. **O**nsset of symptoms
 - b. **P**rovocation: location; any exacerbating or alleviating factors
 - c. **Q**uality of pain
 - d. **R**adiation of pain
 - e. **S**everity of symptoms: appropriate pain scale for age and patient's presentation
 - f. **T**ime of onset and circumstances around onset
7. Obtain **SAMPLE** history:
 - a. **S**ymptoms
 - b. **A**llergies: medication, environmental, and foods
 - c. **M**edications: prescription and over the counter; bring containers to ED if possible
 - d. **P**ast medical history
 - i. Look for medical alert tags, portable medical records, advanced directives
 - ii. Look for medical devices/implants (e.g. dialysis shunts, insulin pumps, pacemaker, central venous access port, gastric tubes, urinary catheter)
 - iii. For females of childbearing age, inquire about potential or recent pregnancy when applicable
 - e. **L**ast oral intake
 - f. **E**vents leading up to the 911 encounter
 - i. In patients with syncope, seizure, altered mental status, or acute stroke, consider bringing the witness to the hospital or obtain their contact phone number to provide the receiving facility

Treatment and Interventions

Insert treatment protocols for patient disposition.

1. Administer oxygen as appropriate with a target of achieving 94-98% saturation and select the appropriate method of oxygen delivery to mitigate or treat hypercarbia associated with hypoventilation.
2. Place appropriate monitoring equipment as dictated by assessment findings; these may include:
 - a. Continuous pulse oximetry
 - b. Cardiac rhythm monitoring
 - c. Waveform capnography or digital capnometry
3. Establish vascular access if indicated or in patients who are at risk for clinical deterioration (IO if unable to obtain IV access in two attempts). Consider the need for additional sites.
4. Monitor pain scale if appropriate
5. Reassess patient after any treatment or intervention and/or as clinically indicated

Insert treatment protocols for patient management. Follow clinically indicated treatment protocols and interventions when required for patient management within the providers scope of practice. If a Medical or Trauma patient doesn't fit a specific treatment protocol, make base station contact for further direction.

Transfer of Care

The content and quality of information provided during the transfer of patient care to another party is critical for seamless patient care and maintenance of patient safety. Ideally, a complete electronic medical record should be provided to the next caregiver at the time of transfer of care. If provision of the completed medical record is not possible at the time of transfer of care, a detailed verbal report should be provided to the next caregiver.

1. The information provided during the transfer of care should include, but not limited to:
 - a. Patient's full name
 - b. Age
 - c. Chief complaint
 - d. History of present illness/Mechanism of injury
 - e. Past medical history
 - f. Medications
 - g. Allergies
 - h. Vital signs with documented times
 - i. Patient assessment, interventions, medications given by provider along with the timing and patient's response to such medications and interventions
2. The detailed verbal report provided at the time of transfer of care does not take the place of or negate the requirement for the provision of a complete electronic or written medical record of the care provided by the EMS personnel.

Patient Safety Considerations

1. Be aware of legal issues and patient rights as they pertain to and impact patient care (e.g. patients with functional needs or children with special healthcare needs)
2. Be aware of potential need to adjust management based on patient age and comorbidities, including medication dosages
3. The maximum weight-based dose of medication administration to a pediatric patient should not exceed the maximum adult dose
4. Consider air medical transport, if available, for patients with time-critical conditions where ground transport time exceeds 30 minutes

Performance Measures

1. Abnormal vital signs should be addressed and reassessed
2. Response to treatments and medication therapy should be documented including pain scale when applicable and reassessment if appropriate
3. Limit scene time for patients with time-critical illness or injury unless clinically indicated
4. Blood glucose level obtained when indicated
5. Compliance with provision of critical information during patient transfer of care
6. Appropriate utilization of air medical services

Documentation Elements

1. At least two sets of vital signs should be documented for every patient
2. All patient interventions and responses to care should be documented in the ePCR Actions Panel of the agency that provided the care (i.e., improved, not improved)
3. If a 4-Lead and/or 12-Lead is placed on the patient, the findings (i.e. rhythm strip, 12-Lead) **MUST** be uploaded or attached to the ePCR documentation
4. All major changes in clinical status including, but not limited to, vital signs and data from monitoring equipment, should be documented
5. Unification of ePCR, between/within agencies is highly encouraged

Key Considerations

1. **Pediatrics:** a patient appearing or known to be older than 29 days but less than or equal to 14 years of age. If the age is unknown, any patient weighing less than 36 kg/79.2 lbs **AND** whose length (measured from crown to heel) falls within the range of any commercially available, standardized length-based pediatric resuscitation tape.
 - a. Use a weight-based assessment tool (length-based tape or other system) to estimate patient weight and guide medication therapy and adjunct choices.
 - b. Consider using the pediatric assessment triangle (appearance, work of breathing, circulation) when first approaching a child to help with assessment.
2. **Geriatrics:** a patient appearing or known to be 65 years of age or more
 - a. In these patients, medications can have prolonged effects if there is preexisting renal disease (i.e., on dialysis or a diagnosis of chronic renal insufficiency) or hepatic disease (i.e., severe cirrhosis or end-stage liver disease).
3. **Secondary Survey:** if the patient has critical primary survey problems, it may not be possible to complete. Every effort should be made to complete in route to the receiving facility.
4. **Critical Patients:** proactive patient management should occur simultaneously with assessment.
 - a. Ideally, one provider should be assigned to exclusively monitor and facilitate patient-focused care
 - b. Other than lifesaving interventions that prevent deterioration enroute, treatment and interventions should be initiated as soon as practical but should not impede extrication or delay transport to definitive care.