

EMS / ED Interface: The Need for Hospital “Inservices”

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Things you hear in the ED #1

- Cardiac arrests:
 - “Don’t you know IOs don’t work in adults?”
 - “Hyperventilate her”
 - “What do you mean you delayed the defib to do chest compressions first?”
 - “I can’t believe you brought him without out an endotracheal tube”
- Pulmonary edema:
 - “Take off the O2 so I can do an ABG on room air”
- Unconscious drunk, homeless man:
 - “Just put him back there in the corner.”

Things you hear in the ED #2

- MVC, drunk, tib-fib fx, immobilized:
"Sir, do you have neck pain? No? OK, guys, take him off the backboard for us."
- Hostile combative psych pt, fell, LOC, LBP, took 30 min to get him in the truck:
"I can't believe you didn't BB him."
- Intubated multiple trauma patient (fall), became combative in route:
"You should have just paralyzed him."
WRONG--DISLODGED TUBE!!

More things you hear in the ED

- Stable BLS MVC pt on BB:
"We can't handle that—backboards need to go to the Trauma Center"
- EMS called to ED#1 to transfer woman in labor—crowning—to ED#2:
"Just go fast."
- EMS takes critical child with airway problem to nearest "Pedi ALS capable" ED:
"Do you guys have a #3 ETT & a Broselow tape? Would you put in the IO for me?"

Things a patient shouldn't hear

- **"Why did you bring her here?"**
- **"I can't believe you gave her ____"**
- **"What idiotic Medical Director would put that in your protocol?"**
- **"The last one you brought us died."**
- **"Why'd you bring the bum here?"**

So, what can EMS crew do?

- Keep it professional.
- Always act in the best interest of the patient.
- Don't criticize in front of the patient.
- Get past the "but I'm just a paramedic and what do I know?"
- Try to communicate with the ED staff member as soon as pt's care is OK.
- If not fixed 1:1, notify ED doctor or Charge Nurse, & your EMS supervisor
- Use your QM system and Med Director

What can EMS provider do?

- **Involve your Medical Director**
- **Include hospitals as part of your QM plan**
- **Identify contacts on both sides—ask for ED “Nurse Liaison for EMS” position**
- **Open lines of communication with all ED Medical Directors and Nursing Directors in your territory**
- **Meet regularly 1:1 with each ED**
- **Set up periodic group meetings with all EDs invited**
- **Ride-along program for ED staff**

New equipment, meds, procedures

- **Notify receiving hospitals of EMS plans—need lead time**
- **Supply written info to EDs**
- **Demonstrate devices to ED doctors and/or nurses (e.g., EZ IO)**
- **Discuss efficient transfer of care (e.g., CPAP, pacing)**
- **Identify EMS contact for ED to call**

Transfer of Care

- **Assure that report is given**
- **Continue necessary care while entering ED (O2, monitor, drips, CPAP)**
- **If ED wants Rx stopped (O2, drip, BB), document, and let them do it**
- **What about ED delays??**

ED Delays in Transfer of Care

- City of Miami FR experience:
 - We accept diversion requests, but override prn and enforce the rules
 - Periodic group meetings with hospitals
 - Notify EMS captain if delay > 20 min.
 - Collegial effort with hospitals
 - Delays rare
 - Good relationship between ED and EMS

Miami-Dade County FR Experience

- Larger system and territory
- Many problems with diversion so stopped abruptly
- Then, long delays in turnaround times
- Met with EDs, sent EMTALA rules and warnings to EDs—no change
- Reported ~ 11 hospitals to CMS as potential EMTALA violations.
- Turn around times cut in half

Radio communications

- Who answers the radio?
- What training have they had?
- Do they get updates from EMS?
- Do they know your protocols?
- Does your QM program review their performance?

EMS can produce ED changes

- ED thrombolysis for acute MI
- Emergency angioplasty for acute MI
- Acute stroke intervention
- CPAP
- New BLS and ACLS changes
- Adult intraosseous access
- Hypothermia for ROSC