

# SECTION III

# ADMINISTRATION

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# AEROMEDICAL TRANSPORT

## GENERAL CONSIDERATIONS

Control of a medical emergency scene should be the responsibility of the individual in attendance who is most appropriately trained and knowledgeable in providing prehospital emergency stabilization and transport. When an EMS unit is requested and dispatched to the scene of an emergency, a doctor/patient relationship has been established between the patient and the physician providing medical direction for the EMS unit. Where on-line medical direction exists, treatment and transport of the patient are the ultimate responsibility of the on-line physician. Where on-line medical direction does not exist, treatment and transport of the patient is the ultimate responsibility of the off-line physician or physician committee.

Activation of an EMS air ambulance is a MEDICAL CONTROL DECISION. A request for an air ambulance should be made by adequately trained pre-hospital care providers (either BLS or ALS).

## PROCEDURE FOR SUMMONING AEROMEDICAL TRANSPORT

- A. Assess patient and/or scene.
- B. Institute appropriate treatment and/or extrication (follow Trauma or Medical protocols).
- C. CONTACT MEDICAL CONTROL.
- D. Contact appropriate Aeromedical transport.

## SUMMONING AEROMEDICAL TRANSPORT BEFORE NOTIFICATION OF MEDICAL CONTROL

If, under extraordinary circumstances and/or an EMT is unable to contact Medical Control and they feel Aeromedical transport is essential, they may initiate the direct request of a helicopter for transport or assistance.

The EMT must document that Medical Control could not be contacted and the circumstances of the incident.

The following circumstances would lend themselves well to helicopter evacuation. Calling the air ambulance should be considered, in the interest of time, before calling Medical Control:

1. Suspected serious trauma with any the following conditions to a patient who will require an extrication time of longer than 15-20 minutes: Unsecured airway, unconsciousness, hypotension with tachycardia, or unable to obtain venous access.

## AEROMEDICAL TRANSPORT (cont)

2. Serious injury or illness in a patient who is not easily accessible to land vehicles, but where an adequate clearing for helicopter landing is nearby.
3. Scenes of numerous seriously-injured patients.

Except for situations cited above, Aeromedical transport should be requested only after scene and/or victim has been assessed and on-line Medical Control has been established.

<b>EMS UNIT HAS ON-LINE MEDICAL DIRECTION AND THE AEROMEDICAL TEAM HAS A PHYSICIAN PRESENT:</b>
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- A. Until the patient becomes the full responsibility of the flight crew, the on-line physician is responsible. If there is any disagreement between the flight physician and the on-line physician, the EMS personnel must only take orders from the on-line physician and place the flight physician in radio or telephone contact with the on-line physician.
- B. Once care of the patient is turned over to the Aeromedical team, patient care responsibility rests with the flight physician.
- C. The receiving hospital should be determined in consultation between the on-line physician and the flight physician.

## COMMUNICATIONS

A member of the prehospital care team must contact Medical Control at the earliest time conducive to good patient care. This may mean that the hospital is contacted from the scene if assistance is needed in the patient's immediate care or permission is required for part of the patient care deemed necessary by the paramedic or EMT in charge.

When possible, the member of the team most knowledgeable about the patient should be the one calling in the report.

Although all EMTs and paramedics have been trained to give a full, complete report, this is often not necessary and may interfere with the physician's duties in the Emergency Department. Reports should be as complete but concise as possible to allow the physician to understand the patient's condition. It is not an insult for the physician to ask questions after the report is given. This is often more efficient than giving a thorough report consisting mostly of irrelevant information.

If multiple victims are present on the scene, it is advisable to contact Medical Control with a preliminary report. This should be an overview of the scene, including the number of victims, seriousness of the injuries, estimated on-scene and transport times to the control hospital or possible other nearby facilities. This allows preparation for receiving the victims and facilitates good patient care.

When calling in a report it should begin by identification of the squad calling, and the level of care which is able to be provided to the patient (i.e., basic, advanced or medic).

### CODE THREE PATIENTS

This category is for the most seriously ill or injured patients.

1. Type of Squad: Basic, Intermediate, Paramedic
2. Age and Sex of Patient:
3. Type of Situation: Injury and/or Illness
4. Specific Complaint: Short and to the point (i.e., chest pain, skull fracture)
5. Mechanism: MVA / MCA / fall
6. Vital Signs: B/P / Pulse / Resp. / LOC / EKG
7. Patient Care: Airway Management, Circulatory Support, Drug Therapy
8. General Impression: Stable / Unstable
9. ETA to Medical Facility

### CODE TWO PATIENTS

This category is for individuals who have significant signs or symptoms of illness or injury, and at this time are stable.

1. Type of Squad: Basic, Intermediate, Paramedic
2. Age and Sex of Patient:
3. Type of Situation: Injury and/or Illness
4. Specific Complaint: Short and to the point (i.e., 10% 2nd degree burn to leg)
5. Mechanism: MVA / MCA / fall
6. Vital Signs: B/P / Pulse / Resp. / LOC / EKG
7. ETA to Medical Facility

## COMMUNICATIONS (cont)

### CODE ONE PATIENTS

This category covers all minor illness or injury circumstances and the patient is in no danger of developing any significant signs or symptoms.

1. Type of Squad: Basic, Intermediate, Paramedic
2. Age and Sex of Patient:
3. Type of Situation: Injury and/or Illness
4. Specific Complaint: Short and to the point (i.e., ABD pain for the last two weeks)

Code I (non transport) for minors.

If after evaluation of a minor, the EMT and medical control agree that the patient is a Code I, that minor can be left in the care of a responsible adult that is not the parent or legal guardian. The responsible adult may be a family friend, neighbor, school bus driver, teacher, school official, police officer, social worker, or other person at the discretion of medical control and the EMT.

Once the above information is given, wait for further requests and/or orders from Medical Control.

If the patient requires special care; (i.e., security; interpreter; additional people for lifting, isolation for infection, vermin infestation, or hazardous material) this information should also be relayed.

### TYPES OF PATIENTS ACCORDING TO TRIAGE PRIORITY

#### CODE THREE PATIENTS

Airway and/or Breathing Difficulty  
Cardiac Arrest  
Circulation Difficulty (Bleeding and/or Shock)  
Open Chest and Abdominal Injury  
Complicated Childbirth  
Chest Pain

Unconsciousness  
Severe Head Injury  
Severe Burns  
Severe Poisoning  
Status Epilepticus  
Altered LOC  
Multiple Fractures

#### CODE TWO PATIENTS

C-spine Injury  
Acute ABD Pain  
Moderate Burns

Normal Childbirth  
Violent and/or Combative Patient  
Psychiatric

#### CODE ONE PATIENTS

Minor Injury  
Minor Illness

# PROTOCOL FOR DOA

## GENERAL STATEMENT

- A. When a DOA is encountered, the squad members should avoid disturbing the scene or the body as much as possible, unless it is necessary to do so in order to care for and assist other victims. Once it is determined that the victim is, in fact, dead, the squad members should make contact with local law enforcement officials and/or Medical Examiner's Office to determine if there will be a transfer of responsibility or management of the scene to either agency. It is the squad member's responsibility to notify the Medical Examiner's office directly or to ensure that the Medical Examiner's office has been notified by a police officer on the scene.

A determination that the victim is dead rests with the squad members. Any of the following may be used as guidelines to support the determination that a victim is deceased:

1. There is an injury that is incompatible with life (i.e., decapitated, or burned beyond recognition).
  - a. Cardiac arrest, secondary to massive blunt trauma without signs of exsanguinating hemorrhage (i.e. limb amputation).
2. The victim shows signs of decomposition, rigor mortis, or extremely dependent lividity.
3. If the patient is an adult with an un-witnessed cardiac arrest, has a history of an absence of vital signs for greater than 20 minutes, and is found in asystole, not secondary to hypothermia or cold water drowning.
4. If the patient is an infant or child with an un-witnessed cardiac arrest and is found in asystole, except:
  - a. In hypothermic patients with a downtime of less than 30 minutes.
  - b. In cold water drowning if recovered in less than 1 hour.
5. If there are valid DNR (Do Not Resuscitate) orders, see DNR Protocol.
6. If the patient has a history of terminal disease, the family refuses resuscitation, and permission to pronounce the patient dead is given by Medical Control.

**CAUTION: IF ANY DOUBT EXISTS THAT THE VICTIM IS DEAD AT THE TIME OF ARRIVAL OF THE SQUAD, RESUSCITATIVE MEASURES SHOULD BE INSTITUTED IMMEDIATELY. WHENEVER RESUSCITATIVE MEASURES ARE INSTITUTED, THEY MUST BE CONTINUED UNTIL ARRIVAL AT A HOSPITAL OR UNTIL A PHYSICIAN HAS PRONOUNCED THE VICTIM DEAD.**

- B. If the Medical Examiner's office accepts jurisdiction, a representative from the Medical Examiner's office will make arrangements for transportation of the body. If local law enforcement officials accept jurisdiction, they will take over control of the crime scene and assume the responsibility for transportation of the body. A copy of the DOA checklist should be left with the agency claiming jurisdiction.
- C. If the Medical Examiner's office and local law enforcement officials both decline jurisdiction, EMS will determine if the family has selected a funeral home. If a funeral home has been selected, Med Control will be contacted for pronouncement.

## DOA PROTOCOL (cont)

- D. If the medical control physician will pronounce the deceased, the physician's name and time of death will be recorded and contact should be made with the patient's family physician to determine if he will sign the death certificate.
- E. If the medical control physician will not pronounce, if a funeral home cannot be determined, or the next of kin cannot be reached to determine the desired disposition, the deceased will be transported to the closest most appropriate facility.
- F. EMS will then contact the funeral home and make arrangements for the removal of the deceased.
- G. It is not necessary for EMS to remain on the scene once either local law enforcement or the Medical Examiner's office has claimed jurisdiction over the deceased or once the deceased has been pronounced and arrangements have been made for the removal. The yellow copy of the DOA checklist should be left with the body for the transporting agency.

# DO NOT RESUSCITATE/SUPPORT CARE GUIDELINES

## BACKGROUND

- A. Prehospital (out of hospital) providers are called to care for patients who are known to have incurable or terminal illnesses on an ever-increasing basis. Examples of such patients include those with metastatic cancer, AIDS, severe CVA. Many patients, and/or their families have intelligently and consciously altered their consent for treatment, made out a living will, or entered into Hospice care agreements.

EMS providers and medical control physicians often find these encounters confusing, frustrating, and charged with emotion. This is especially true when there is no prearranged document or consistent, rational or standardized approach by which to care for these patients and their families.

These guidelines are designed to help EMS providers and medical control physicians determine how, when, and to what level of resuscitation a patient desires or requires. A newer “pro-active” approach is to refer to DNR as **SUPPORT** Care. Ohio ACEP and EMS Board are actively working to develop and pass into law a State of Ohio **SUPPORT** Care (DNR) policy.

## DEFINITION

- A. DNR orders are defined to withhold CPR and Advanced Life Support from patients suffering from terminal illness.

A DNR order may be written with specific guidelines such as Comfort Care only or Full Medical Management with various “check list” treatment modalities (e.g., medications, blood products, tube feedings), but if not otherwise noted implies not initiating or continuing the following: CPR, intubation, advanced airway management, manual or mechanical ventilatory support, electrical monitoring or therapy, administering ACLS drugs.

**DNR orders do not mean, “DO NOT TREAT!”**

Prehospital providers and medical control physicians must be sensitive to and actively involved with the administration of other palliative and supportive care interventions, such as to make the patient comfortable, relieve their pain, allay both the patients’ and families’ fear and apprehension.

Other interventions may, but not necessarily include: oxygen administration; suctioning the airway; IV fluids; control bleeding; splinting; position for comfort; contacting a private/hospice physician or nurse; transport of the patient to a hospital or hospice.

## ACTION / IDENTIFICATION

- A. The procedure or action by which a healthcare provider identifies a patient with a DNR/Support Care order is usually by one of three (3) methods:
1. A valid DNR/Support Care document is present.

## DNR (cont)

2. The patient, guardian or family refuses care.
3. The patient is wearing a DNR/Support Care bracelet/ID.

### B. Valid DNR/Support Care orders are characterized by:

1. A properly signed, witnessed, and written document.
2. It is written by a physician or nurse.
  - a. If written by a nurse and not countersigned by a physician:
    1. The order must include the physician's name.
    2. It must state that it is a verbal or telephone order.
    3. The order must be less than two (2) weeks old.
    4. The patient must be a nursing home or Hospice patient.
  - b. If there is no written order, but a physician requests the patient be made DNR, the physician should directly contact Medical Control.

### C. The following minimum data should be included on the EMS Run Sheet:

1. Name, gender, age.
2. Attending/Hospice physician's names.
3. Date, time, location of run.
4. Event, description, history.
5. Assessment: vital signs; physical exam.
6. Treatment, if applicable.
7. Revocation, if applicable.

## REVOCATION

### A. A DNR/Support Care patient may revoke their status at any time by:

1. Direct communication with the prehospital provider.
2. The private physician is directed by the patient, guardian or family to revoke the order. This must be either by written or direct verbal order. This scenario may occur when the patient cannot communicate with the EMS provider.

## ACCOMPANIMENT

- A. It is imperative that a copy of, or the original DNR/Support Care order accompany the patient wherever the patient goes. This policy will help prevent confusion about, or inappropriate initiation of advanced care modalities for any terminally ill patient.

# PROTOCOL FOR PATIENT REFUSAL

## GENERAL STATEMENT

- A. Permission not to treat or transport a patient must come from the base station physician. The EMT may not accept a refusal unless it is authorized by the base station. This decreases the EMTs and Paramedic's liability. Direct communication between the physician and the patient may resolve many questions and often convinces the patient of the importance of treatment and transport. The following is an outline of legal principles which may help the EMT to understand patient refusal.
1. Consent
    - a. The patient has the responsibility and right to consent to or refuse treatment. If he or she is unable to do so, a legal guardian has this right.
    - b. A durable power of attorney is an authorization that allows a patient's wishes to be followed even when he or she becomes incompetent.
    - c. When waiting to obtain lawful consent from the person authorized to make such consent would present a serious risk of death, serious impairment of health or would prolong severe pain or suffering of the patient, treatment may be undertaken to avoid those risks without consent. In no event should legal consent procedures be allowed to delay immediately required treatment.
    - d. In non-emergency cases involving minors, consent should be obtained from the parent or legal guardian prior to undertaking any *treatment*. All children must be evaluated for acuity of illness, regardless of obtaining parental consent.
    - e. AGE: Patient must be over 18 years of age or "emancipated" to be permitted to consent or refuse treatment. A child under 18 years of age who is married or is living away from home and is financially independent of his/her parents, may consent for their own care and may consent to medical or surgical care for his/her child.
    - f. If the patient is under age, consent should be from:
      1. Legal guardian
      2. Natural parent
      3. Adopted parent
    - g. NOTE: There has not been a single reported decision that held a physician liable where beneficial care was provided to a minor without obtaining consent.
  2. Mental Competence - Decision Making Capability
    - a. A person is mentally competent if he:
      1. Is capable of understanding the nature and consequences of the proposed treatment.
      2. Has sufficient emotional control, judgment, and discretion to manage their own affairs.
    - b. Ascertaining that the patient is oriented, has an understanding of what happened and may possibly happen if treated or not treated, and a plan of action - such as whom he will call for transportation home - should be adequate for these determinations.

## Patient Refusal (cont)

- c. Patients with impaired cerebral perfusion, in shock, postictal, or under the influence of drugs will be unlikely to fulfill these criteria.
  - d. If the patient is not mentally competent under these guidelines, consent should be obtained from another responsible party - who must also be mentally competent and must be 21 years of age - in the following order of preference:
    - 1. Legal guardian
    - 2. Spouse
    - 3. Adult son or daughter
    - 4. Parent
    - 5. Adult brother or sister
  - e. If the patient is not mentally competent and none of the above persons can be reached, the person should be treated and transported to a medical facility. It is preferable under such circumstances to obtain concurrence of a police officer in this course of action.
  - f. If the patient himself is not competent to consent and a legal guardian as defined under "d" is present, and if that person is competent, he or she has the same right to consent or refuse treatment as the patient himself. Those wishes cannot be ignored in a non-life-threatening situation.
3. Code I (non transport) for minors
- a. If after evaluation of a minor, the EMT and medical control agree that the patient is a Code I, that minor can be left in the care of a responsible adult that is not the parent or legal guardian. The responsible adult may be a family friend, neighbor, school bus driver, teacher, school official, police officer, social worker, or other person at the discretion of medical control and the EMT.

### PROCEDURE FOR REFUSAL

- A. If a patient wishes to refuse treatment, examination or transportation, the following steps will be taken.
- 1. The EMT will complete a Patient Refusal Checklist (see enclosed example) prior to contacting medical control.
  - 2. Medical control will be contacted and the refusal check list reviewed. This contact and the orders that were given must be documented. If unable to contact medical control, document why.
  - 3. The patient must be advised of the benefits of treatment and transport as well as the specific risks of refusing treatment and transport.
  - 4. The patient must be able to relate to the EMT in his or her own words what these risks and benefits are.
  - 5. The patient will be provided with a refusal information sheet, also attached. A copy of this refusal information sheet or the refusal section of the check list will be signed by the patient, dated, and both will be kept with the patient's file.

## EMS PATIENT REFUSAL CHECKLIST

1. ASSESSMENT OF PATIENT (CIRCLE APPROPRIATE RESPONSE)

ALCOHOL / DRUGS INGESTION PER HISTORY OR EXAM	Y / N
ALTERED LEVEL OF CONSCIOUSNESS	Y / N
HEAD INJURY	Y / N
ORIENTED TO:	
PERSON	PLACE
TIME	SITUATION

2. MEDICAL CONTROL

CONTACTED VIA:      PHONE                                      RADIO                      TIME \_\_\_\_\_  
 UNABLE TO CONTACT ( )                      MEDICAL CONTROL PHYSICIAN \_\_\_\_\_

If medical control not able to be contacted, explain in comment section of checklist ORDERS:

- ( ) INDICATED TREATMENT / TRANSPORT MAY BE REFUSED BY PATIENT
- ( ) USE REASONABLE FORCE / RESTRAINT TO PROVIDE TREATMENT
- ( ) USE REASONABLE FORCE AND / OR RESTRAINT TO TRANSPORT

OTHER \_\_\_\_\_

3. PATIENT ADVISED                      (CIRCLE APPROPRIATE RESPONSE)

- \* MEDICAL TREATMENT / EVALUATION NEEDED                      Y / N
- \* AMBULANCE TRANSPORT NEEDED                      Y / N
- \* FURTHER HARM MAY RESULT WITHOUT MEDICAL TREATMENT OR EVALUATION                      Y / N
- \* TRANSPORT BY MEANS OTHER THAN AMBULANCE COULD BE HAZARDOUS IN LIGHT OF THE PATIENT'S PRESENT ILLNESS OR INJURY                      Y / N
- \* PATIENT PROVIDED WITH REFUSAL ADVICE SHEET                      Y / N
- \* PATIENT WOULD NOT ACCEPT REFUSAL SHEET                      Y / N

4. DISPOSITION

- ( ) REFUSED ALL EMS SERVICES
- ( ) REFUSED TRANSPORT, ACCEPTED FIELD TREATMENT
- ( ) REFUSED FIELD TREATMENT, ACCEPTED TRANSPORT
- ( ) RELEASED IN CARE OR CUSTODY OF SELF
- ( ) RELEASED IN CUSTODY OF LAW ENFORCEMENT AGENCY  
     AGENCY \_\_\_\_\_  
     OFFICER \_\_\_\_\_
- ( ) RELEASED IN CARE OR CUSTODY OF RELATIVE OR FRIEND  
     NAME \_\_\_\_\_  
     RELATION \_\_\_\_\_

5. COMMENTS

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

EMT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_

OFFICER \_\_\_\_\_ DATE \_\_\_\_\_ TIME \_\_\_\_\_

# REFUSAL INFORMATION SHEET

## PLEASE READ AND KEEP THIS FORM

This form has been given to you because you have refused treatment and/or transport by the Emergency Medical Service. Your health and safety are our primary concern, so even though you have decided not to accept our advice, please remember the following:

1. The evaluation and/or treatment provided to you by the EMS squad is not a substitute for medical evaluation and treatment by a doctor. We advise you to get medical evaluation and treatment.
2. Your condition may not seem as bad to you as it actually is. Without treatment your condition or problem could become worse. If you are planning to get medical treatment, a decision to refuse treatment or transport by the EMS may result in a delay which could make your condition or problem worse.
3. Medical evaluation and/or treatment may be obtained by calling your doctor, if you have one, or by going to any hospital Emergency Department in this area, all of which are staffed 24 hours a day by Emergency physicians. You may be seen at these Emergency Departments without an appointment.
4. If you change your mind or your condition becomes worse and you decide to accept treatment and transport by the Emergency Medical Service, please do not hesitate to call us back. We will do our best to help you.
5. [ ] **If the box at the left has been checked**, it means that your problem or condition has been discussed with an Emergency physician at the medical control hospital by radio or telephone, and the advice given to you by the Emergency Medical Service has been issued or approved by the Emergency physician.

\*\*\*I have been informed of the dangers of my not being treated and/or transported by the Emergency Medical Services, for my condition, for treatment by an emergency department or private physician. I release \_\_\_\_\_ and consulting hospital, their employees and officers from all liability for any adverse results caused by my decision.

I have received a copy of this information sheet.

Signature: \_\_\_\_\_

Circle one:          Patient                  Spouse                  Parent                  Guardian

Print Name: \_\_\_\_\_

EMT Signature: \_\_\_\_\_ Witness: \_\_\_\_\_

Print Name: \_\_\_\_\_

Report Number: \_\_\_\_\_ Date: \_\_\_\_\_

## **NON-TRANSPORTS**

A number of EMS calls result in non-transport of the patient or victim. If an individual is not transported by the squad, the following guidelines will apply:

1. EMS may receive a call only to assist a patient. These calls may involve moving or lifting a patient at a home who has limited ability and resources to do so for themselves. First priority on these calls is to ensure the patient is not injured or ill. Once patient contact has been established and there are no visible signs of injury or illness and the patient does not complain of any injury or illness then these types of calls can be considered service calls. Therefore, no formal EMS report or consult with medical control is required. However, at any time during the course of the call the patient complains of injury or illness, then proper protocol and procedures must be followed.
2. If the patient refuses treatment or transport, the patient refusal procedure should be followed.
3. Non transport for minors.

If after evaluation of a minor, the EMT and medical control agree that the patient does not need transport, that minor can be left in the care of a responsible adult that is not the parent or legal guardian. The responsible adult may be a family friend, neighbor, school bus driver, teacher, school official, police officer, social worker, or other person at the discretion of medical control and the EMT.

## **INVALID / PATIENT ASSIST**

This protocol is to clarify what constitutes the proper and complete documentation of an invalid assist call. There is some inconsistency throughout Region VIII on whether such a call is documented as an EMS alarm with an EMS report or as a service call documented on a fire report. Regardless of the format of your department's documentation, there are three specific components you must be sure to include in your documentation of these alarms.

You must document the following three areas of concern:

1. That you asked about the presence of any acute illness / injury and the patient / caregiver denied acute illness / injury.
2. That you did not find any obvious signs or symptoms of any acute illness / injury.
3. That you offered treatment / transport and the patient / caregiver declined treatment / transport.

These components must be included in your handling of the alarm and must be documented in your written report for the alarm to ensure that we are providing the best EMS care for our patients and covering our bases medical-legally.

# HEAVY PATIENTS

## GENERAL CONSIDERATIONS

There is an increasing percentage of the population that has a weight in excess of 300 lbs. As patients, these individuals are frequently classed as high risk because of the increased medical complications associated with their excess weight. In the EMS system they present the additional problem of movement and transportation. These individuals have the right to expect prompt and expert emergency medical care. Therefore, in order to facilitate the care of these individuals without risking the health of EMS workers, the following protocol is established.

- A. In managing a patient with weight over 300 lbs., at no time should the patient be moved without at least 4 individuals to assist. At the scene, as many EMS personnel as can be mobilized may be supplemented by police or other safety personnel as appropriate. If 4 individuals are not available, mutual aid will be required.
- B. It may be necessary to remove doors, walls or windows. The situation is no different than extrication from a vehicle, although property damage may be higher. At all times the patient's life must be the first priority.
- C. The patient is to be placed on at least 2 (double) backboards or other adequate transfer device for support.
- D. The patient is to be loaded on a cot that is in the down position, and the cot is to be kept in the down position at all times.
- E. Three (3) EMS personnel are to accompany the patient during transport. If additional personnel are available they are to travel in a separate vehicle.
- F. The patient will be loaded directly from the squad onto a special hospital bed for this type of patient, which will be brought to the ED entrance.
- G. It is **NECESSARY TO NOTIFY THE HOSPITAL WELL IN ADVANCE** of arrival so that preparations can be completed in a timely fashion.
- H. If individuals in the community are known to fall within this special category it is appropriate to inform them in advance of the type of assistance they can expect from the EMS system, and help them make plans well in advance to assist you. When calling for the squad, and if they identify themselves and their special needs, it will promote the timeliness of your efforts.

## **ON SCENE EMT INTERVENER**

On an EMS run where an unknown EMT from outside the responding EMS agency wishes to intervene in the care of patients, the following steps should be initiated:

1. Ideally, if no further assistance is needed, the offer should be declined.
2. If the intervener's assistance is needed or may contribute to the care of the patient:
  - a. An attempt should be made to obtain proper identification of a valid Ohio EMT card. Acceptance of borderline states' EMT cards is at the discretion of individual EMS services. Notation of intervener name, address and certification numbers must be documented on the run report.
3. Significant involvement with patient care or variance from protocols will require the intervener to accompany the patient to the hospital.

## PHYSICIAN AT THE SCENE

### GOOD SAMARITAN PHYSICIAN

This is a physician with no previous relationship to the patient, who is not the patient's private physician, but is offering assistance in caring for the patient. The following criteria must be met for this physician to assume any responsibility for the care of the patient:

1. Medical Control must be informed and give approval.
2. The physician must have proof they are a physician. They should be able to show you their medical license. Notation of physician name, address and certification numbers must be documented on the run report.
3. The physician must be willing to assume responsibility for the patient until relieved by another physician, usually at the emergency department.
4. The physician must not require the EMT to perform any procedures or institute any treatment that would vary from protocol and/or procedure.

If the physician is not willing or able to comply with all the above requirements, his assistance must be courteously declined.

### PHYSICIAN IN HIS/HER OFFICE, OR URGENT CARE CENTER

1. EMS should perform its duties as usual under the supervision of Medical Control or by protocol.
2. The physician may elect to treat the patient in his office.
3. The EMT should not provide any treatment under the physician's direction that varies from protocol. If asked, the EMT should decline until contact is made with Medical Control.
4. Once the patient has been transferred into the squad, the patient's care comes under Medical Control.

# RESTRAINT POLICY

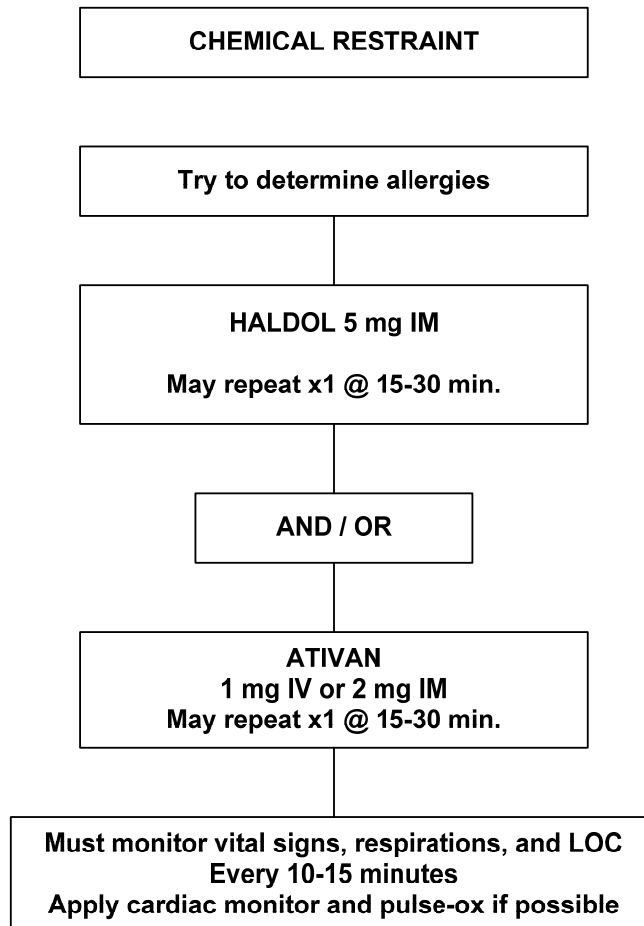
## GENERAL GUIDELINES

- A. Soft restraints are to be used only when necessary in situations where the patient is potentially violent and may be of danger to themselves or others. EMS providers must remember that aggressive violent behavior may be a symptom of medical conditions such as but not limited to:
  - 1. Head Trauma
  - 2. Alcohol/Drug related problems
  - 3. Metabolic disorders (i.e., hypoglycemia, hypoxia, etc.)
  - 4. Psychiatric/Stress related disorders
- B. Patient health care management remains the responsibility of the EMS provider. The method of restraint shall not restrict the adequate monitoring of vital signs, ability to protect the patient's airway, compromise peripheral neurovascular status or otherwise prevent appropriate and necessary therapeutic measures. It is recognized that evaluation of many patient parameters requires patient cooperation and thus may be difficult or impossible.
- C. All restraints should have the ability to be quickly released, if necessary.
- D. Restraints applied by law enforcement (i.e., handcuffs) require a law enforcement officer to remain available to adjust restraints as necessary for the patient's safety. This policy is not intended to negate the need for law enforcement personnel to use appropriate restraint equipment to establish scene control.
- E. Patients shall not be transported in a face down prone position to ensure adequate respiratory and circulatory monitoring and management.
- F. Restrained extremities should be monitored for color, nerve and motor function, pulse quality and capillary refill at the time of application and every 15 minutes thereafter.
- G. Restraint documentation on the EMS report shall include:
  - 1. Reason for restraint
  - 2. Agency responsible for restraint application (i.e., EMS, Police)
  - 3. Documentation of cardio-respiratory status and peripheral neurovascular status

# CHEMICAL RESTRAINT

## PARAMEDIC

- A. For use in conjunction with physical restraint in controlling the violent/agitated patient so as to minimize the risk of injury to themselves and/or others.
1. Attempt to determine the patient's allergies.
  2. HALDOL 5 mg, IM May repeat x1 @ 15-30 minutes
  - And / or
  3. ATIVAN 1mg IV or 2mg IM May repeat x 1 @ 15-30 minutes
  4. Precautions: Haldol may cause dystonic reactions. Treat these with Benadryl, 25mg IV or 50mg IM.
- B. All patients requiring any form of restraints must have vital signs, respirations, and LOC monitored every 10-15 minutes. Apply cardiac monitor and pulse-ox if possible.



## **TRANSPORT TO FREE-STANDING EMERGENCY / URGENT CARE CLINICS**

From the perspective of an EMS system, freestanding emergency care clinics are no different, and no more appropriate as an EMS transport destination, than any private physician's office, unless they have been through a health system agency or regional EMS review.

EMS units should not transport patients to freestanding emergency care clinics (or private physicians' offices) in response to emergency calls except:

1. When directed by Medical Control.
2. If specifically authorized by on-line medical direction.
3. When the EMS unit is following protocols approved by Medical Control that authorize such transports under certain circumstances.
4. When the EMS unit is a private service responding to a call in which the patient and/or the family requests transport to such facility and the patient is clearly in stable condition.

A freestanding emergency clinic is not automatically expected to be incorporated into the EMS system. However, in certain circumstances these facilities may be a valuable component.

## **NON-HOSPITAL TRANSFER POLICY**

### **GUIDELINES FOR TRANSFER FROM A NON-HOSPITAL LOCATION TO A NON-HOSPITAL LOCATION: HOME TO HOSPICE; HOSPICE TO HOME**

- A. On occasion, the out of hospital provider(s) will be called upon to transport a patient from a non-hospital location to another non-hospital facility such as Hospice Center or from Hospice to home or a doctor's office. The provider(s) will follow the written or pre-existing orders of the patient's physician or physician approved Hospice Center orders for the transport. At times, a Hospice nurse may arrive or already be at the scene. He/she should be able to help review orders and/or care directives such as DNR or "Support Care" orders to enable transport in accordance with the wishes of the patient and his/her family. A Hospice patient by definition is DNR.

Medical Control does not need to be contacted unless the DNR is revoked. However, if the provider(s) feels the need to contact Medical Control for advice or direction, the provider(s) will clearly advise Medical Control of the patient's terminal condition and DNR status.

If medication(s) needs to be "wasted", e.g., Morphine, Valium or Versed, then the receiving Hospice supervisor, nurse or EMS supervisor may witness and document appropriate disposal of the said medication(s) and administration equipment, e.g., needle(s), syringe(s), IV catheter(s), Heparin or saline lock(s) or IV lines and/or solutions. Medications or equipment should never be transported to an Emergency Department to be disposed of or wasted. Any and all waste materials will be disposed of into approved and appropriately labeled containers.

## INTERFACILITY PATIENT TRANSPORT GUIDELINES

The transportation of patients from one healthcare facility to another should be carried out in an orderly and expeditious manner. Regardless of origin or destination, patients remain the responsibility of the transferring physician until received by the accepting physician or his/her agent. The transfer papers and accompanying record must document the reason for transfer as well as the time of contact and the name of the receiving facility, physician and/or accepting agent in accordance with nationally recognized standards and federal regulations.

The decision regarding the level and scope of practice of the out-of-hospital transporting agency and the individual providers should be made in consultation with the receiving physician and must be appropriate to the stability of the patient and their medical and equipment needs. The provider will be responsible for carrying out the orders of the transferring physician during the transfer unless acting as the agent of the receiving facility with superseding medical control, or if a physician accompanies the patient. Any questions or concerns regarding those orders, including but not limited to Do Not Resuscitate (DNR) orders, medications or treatments, must be answered or clarified prior to departure. The route(s) of travel, possible diversionary medical facilities and their phone or radio call numbers should also be determined.

If unanticipated problems or concerns arise during transport, direct, on-line medical control will be obtained. If for technical or logistical reasons this is not possible, the transporting agent should follow written protocols or standing orders until the transferring, receiving or nearest diversionary facility can be contacted on-line.

## INTERFACILITY TRANSFER POLICY

### GUIDELINES

- A. The transferring physician is ultimately responsible for the patient until accepted by the receiving physician or his/her agent, i.e., nurse, covering physician.

The out of hospital healthcare provider will be responsible in carrying out the transferring physician's orders. The provider must check, be completely familiarized with, and understand the transfer orders. Any questions or concerns, for example validity or specifics of DNR orders, medications, or treatment(s), must be answered and clarified prior to departing the transferring hospital.

If the provider does not understand or feel comfortable with the orders, then he/she must address these concerns with the physician or his/her agent, i.e., nurse or covering physician. If the concern(s) cannot be rectified, the provider should contact his/her supervisor and not proceed with the transfer until said concerns are rectified. The supervisor may need to directly, either by phone or in person, contact the physician or his/her agent to clarify or rectify any real or perceived concerns of the provider prior to initiating transfer. If the provider still has concerns, he/she should go up the chain of command until such concerns are adequately and appropriately rectified prior to proceeding with the transfer.

In order to avoid any attendant delays in care and transport, said review and clarification should and must occur prior to initiation of transfer. Thirty to sixty minutes prior to transport should usually be sufficient.

## INTERFACILITY TRANSFER (cont)

It should be documented in the transfer record that the receiving physician and hospital has been notified and has accepted the patient in transfer. Any equipment, airway management, concerns, medication(s), or special needs must also be arranged for and available prior to the immediate transfer time.

Once en route if any problem(s) arises not previously considered or covered in the transfer orders, the provider(s) will immediately contact the transferring hospital, physician or his/her agent for direct on-line medical control. If the transferring hospital cannot be accessed due to vehicle location, communication difficulties, or acts of nature, the provider will follow written protocols or standing orders until such a time that the transferring, receiving or other nearest appropriate medical facility can be contacted and act as on-line medical control for this particular concern. On occasion, for example due to patient care concerns, patient status deterioration not covered in the transfer orders, or equipment failure, the transfer may require diversion to the nearest appropriate medical facility. It is imperative that the most appropriate route(s) of travel, the locations of appropriate possible diversion medical centers and their phone or radio call numbers are made available prior to initiation of the transfer. It is the duty of the provider(s) to be familiar with this information prior to transport.

The immediate supervisor will review the above directives and ensure all is in place prior to initiating transfer.

## TERMINATION OF RESUSCITATION EFFORTS

"Resuscitation may be discontinued in the prehospital setting when the patient is non-resuscitable after an adequate trial of ACLS."

In accordance with the Journal of American Medical Association's guidelines for cardiopulmonary resuscitation and emergency cardiac care, the above statement encourages local medical directors to develop guidelines for prehospital care providers to terminate resuscitation efforts when the patient's survivability is questionable.

A trial of ACLS, according to the guidelines, occurs when:

- 1) Adequate BLS has been provided for a reasonable length of time;
- 2) Endotracheal intubation has been successfully accomplished;
- 3) Intravenous access has been achieved and rhythm-appropriate medications and counter shocks for ventricular fibrillation have been administered according to protocol; and
- 4) Persistent asystole or agonal electrocardiograph patterns are present and no reversible cause is identified.

The Region 7 & 8 EMS Medical Advisory Board has adopted the following criteria for termination of resuscitation efforts at the scene following unmonitored, out of hospital, adult, primary cardiac arrest.

Paramedic personnel under Region 7 & 8 medical control authority may terminate resuscitation when:

- 1) The patient is an adult in cardiopulmonary arrest (not associated with trauma, body temperature aberration, respiratory etiology, or drug overdose);
- 2) Standard ACLS in accordance with American Heart Association guidelines has been carried out for over 20 minutes;
- 3) No restoration of circulation (spontaneous pulse rate of greater than 60 beats per minute for at least a 5 minute period); and
- 4) Absence of persistent, recurring, or refractory ventricular fibrillation/tachycardia or any continuous neurological activity (e.g., spontaneous respirations, eye opening or motor response).

When the above conditions have been met, the paramedic should contact medical control and request termination of resuscitation.

Documentation should be completed and forwarded to the appropriate Medical Control Authority within 24 hours of the run.