POLICY
Off-line Medical Control, Standing Medical Orders and Protocols

POLICY STATEMENT:
This Prehospital Care Manual, developed by the EMS Medical Director(s), reflects current, nationally recommended treatment modalities for providing patient care in the Prehospital setting.

GOAL/PURPOSE:
This Prehospital Care Manual, containing Standing Medical Orders, Protocols, Policies and Procedures, is intended to establish the standard of care which is expected of the MCEMS System provider.

POLICY/PROCEDURE:

Standing Medical Orders, Protocols, Policies and Procedures contained in this Prehospital Care Manual are the written, established standard of care to be followed by all members of the MCEMS System for treatment of the acutely ill or injured patient. Variance from these established treatment guidelines is a quality assurance indicator.

The EMS provider will initiate patient care under these guidelines and contact Medical Control in a timely manner for those treatments which require on-line physician's order. Diligent effort must be made to contact Medical Control in a timely manner via cellular phone, VHF radio or land line as a last resort. Delay or failure to contact Medical Control for required on-line orders is a quality assurance indicator.

These Standing Medical Orders/Protocols will be utilized as Off-Line Medical Control under the following circumstances:

- In the event communications cannot be established or communication is disrupted or lost between the Prehospital provider and Medical Control.
- In the event that establishing communications would cause an inadvisable delay in care that would increase life threat to the patient.
- In the event the Medical Control Physician is not immediately available for communication.
- In the event of a disaster situation, where an immediate action to preserve and save lives supersedes the need to communicate with hospital based personnel.

Inability to contact Medical Control should not delay patient transport or the provision of life-saving therapies. Patient destination and transport decisions are set forth in these Standing Medical Orders/Protocols.

Patients, family, DPOA or a physician may request transfer to their facility of choice if patient is stable. Unstable or Critical patients will be transported to the closet appropriate facility. If patient or patient's family absolutely refuse transport to the closest appropriate facility, they must be informed that by doing so may result in death or significant morbidity. If they still refuse transport to the closest appropriate facility (and it is deemed they are able to make this decision—i.e. not under the influence of alcohol, drugs, etc.) proceed as requested and contact the facility. Appropriate paperwork needs to be filed per each EMS agencies SOG's. See Patient Destination Policy.

POLICY
On-line (Voice) Medical Control

POLICY STATEMENT:
Medical Control is designed to provide immediate medical direction and consultation to the Prehospital EMS providers in accordance with established patient treatment guidelines.

GOAL/PURPOSE:
On-line (voice) Medical Control is utilized to involve the expertise of an Emergency Medicine Physician in the treatment plans and decisions involving patient care in the Prehospital setting.

POLICY/PROCEDURE:

A. On-line Medical Control

EMS communications shall be conducted using cellular phone or VHF Radio.

AMC ED……..920-794-8562
HFM ED……..920-684-4285
HFM ED……..920-684-4595

Ambulances shall contact the closest hospital via radio when they are dispatched to a known multiple patients incident, severe illness, child birth, or significant trauma scene.

B. Refusals and False Calls

1. Refusals shall be categorized as High Risk and Low Risk patient contacts.

High-risk refusals require On-line Medical Control consultation prior to securing and accepting the refusal and terminating patient contact. High-risk refusals involve cases when the patient's condition may warrant delivery of care in to prevent loss of life or permanent impairment.

High Risk - Head injury (signs, symptoms or mechanism)
Presence of alcohol or drugs
Significant mechanism of injury
Altered level of consciousness or impaired judgment
Minors (patient's 17 years-old or younger)
Situations involving by-passing a closer hospital when a life-threatening injury/illness has been identified
Diabetics having a hypoglycemic reaction

- If the patient is felt not to be competent, EMS personnel should initiate Detention procedures. The nearest law enforcement agency should be contacted for law enforcement ordered detention.

Low risk refusals do not require On-line Medical Control consultation if the EMS provider determines the patient meets the low risk criteria and there is no doubt the patient understands the risk of refusal and is able (not impaired) to consent to the refusal. If the EMS provider has any questions or concerns about the patient's ability to refuse, Medical Control should be contacted.

Low Risk - Slow speed auto accidents without injury
Isolated injuries not related to an auto accident or other non-significant mechanism of injury.

2. False calls are "third-party" calls where no illness, injury or mechanism of injury is apparent.

3. Lifting assistance or "assist only" calls (EMS is called for assistance in moving a patient from chair to bed, floor to bed, car to home, etc.) do not require a refusal form. This assumes the patient is assessed to ensure there is no complaint or injury and there has been no significant change in the patient's condition. EMS crews must complete their services appropriate incident report.

C. Documentation of Inability to contact Medical Control and Utilization of Protocol

- If the EMS provider has not been able to contact Medical Control via cellular telephone, VHF radio, or land line (only as last effort), the EMS provider will initiate the appropriate protocol(s). Upon arrival at the receiving hospital, a written report (i.e. Incident Report) will be completed by the EMS provider and forwarded to the EMS Medical Director within 24 hours of the occurrence. This report should document all aspects of the run, with specific details of the radio/communications failure and initiation of the MCEMS System Standing Medical Orders and Standard Operating Procedures.

D. Quality Assurance

Discrepancies should be documented on an incident report and forwarded to the service's medical director. Quality Assurance indicators include:

- Delays or failures in contacting On-line Medical Control for interventions requiring On-line communication.
- Patient arriving in the Emergency Department with a complaint or condition that is different than the Prehospital report given.
- All helicopter requests.
- Orders requested by EMS provider but refused by Medical Control.
- All patient transport refusals (high and low risk).
- All cases involved advanced airway care (CPAP, Combitube, ETT).
- QA indicators established by the medical directors for the specific agencies.

PROTOCOL
Hospital Communications

Components of the Patient Report:

Patient name and date of birth
ETA
Age/sex
Chief complaint
Assessment
General appearance, degree of distress, and level of consciousness (AVPU).
Vital signs
Pertinent physical examination findings
Glasgow Coma Score for trauma patients

SAMPLE HISTORY:
- S: associated signs and symptoms.
- A: allergies.
- M: medications patient is presently taking.
- P: past medical history.
- L: last oral intake.
- E: any other pertinent physical or environmental observations

Any treatment initiated and results.

Format: Patient assessment and set of vital signs should be completed prior to contacting Medical Control or the receiving hospital.

The order of data transmitted will depend on circumstances; however, the preceeding information should be transmitted without delay:*

> *NOTE: Regardless of destination, early and timely notification of Medical Control or the receiving hospital is essential for prompt care to be delivered by all involved.

Modes of Transmission:

If Medical Control contact is necessary to obtain physician orders, as indicated by the protocols, diligent attempts must be made to establish base station contact via:

1. Cellular—AMC (794-8562) , HFM (684-4285; 684-4595); if unable to establish contact via cellular,
2. VHF RADIO, If unable to contact via Cellular,
3. Landline—AMC (794-5125), HFM (684-2603), if unable to contact follow established protocols.

POLICY
Patient Right of Refusal

POLICY STATEMENT: A patient may refuse medical help and/or transportation, or once he has received treatment, refuse to be transported if he/she does not appear to be a threat to himself or others. Any person refusing treatment must be informed of the risks of not receiving emergency medical care and/or transportation. NOTE: Family members cannot refuse transportation of a patient to a hospital, UNLESS they have Durable Power of Attorney for Healthcare.

GOAL/PURPOSE: To clarify the EMS provider's responsibility when a patient refuses treatment/transport.

POLICY/PROCEDURE:

- Assure an accurate patient assessment has been conducted to include: patient's complaint, history and objective findings, and patient's ability to make sound decisions.

- Complete the Patient Refusal Checklist.

- Explain to the patient the risk associated with their decision to refuse treatment and transportation.

- Secure Medical Control approval of high-risk refusals in accordance with the On-line (voice) Medical Control policy.

    - High-risk refusals involve cases when the patient's condition may warrant delivery of care in accordance with implied consent of the Emergency Doctrine or other statutory provision. High risk refusals include, but are not limited to:

        High Risk - Head injury (signs, symptoms or mechanism)
        Presence of alcohol or drugs
        Significant mechanism of injury
        Altered level of consciousness or impaired judgment
        Minors (patient's 17 years-old or younger)
        Situations involving by-passing a closer hospital when a life-threatening injury/illness has been identified
        Diabetics having a hypoglycemic reaction

- Complete the Against Medical Advice/Refusal Form and have the patient sign the form. If a minor, this form must be signed by a legal guardian, or Durable Power of Attorney for healthcare. (Parental refuses may be accepted by voice contact with the parent (i.e. telephone) if the EMS provider has made reasonable effort to confirm the identity of the parent.)

- A witness to the patient's release of services must also sign the AMA/Refusal form. If available, it is preferable to have a police officer at the scene act as the witness. If police are not present, any other bystander may act as witness. However, his/her name, address, and telephone number should be obtained and written on the back of the report.

- If the patient refuses medical help and/or transportation after having been informed of the risks of not receiving emergency medical care and also refuses to sign the release, clearly document the patient's refusal to sign the report, and have the entire crew witness the statement. Have an additional witness sign your statement also, preferably a police officer. Include the officer's badge number. Establish voice contact via cellular telemetry with Medical Control and state that the patient refuses treatment and/or transport, and also refuses to sign the release.

- AMA/Refusal forms are maintained by the agency securing the refusal.

POLICY
Incident Reporting

POLICY STATEMENT: Prehospital care providers shall complete a MCEMS Review and Comment Report Form (attached) or Agency Incident Report whenever a System related issue occurs. In order to properly assess the situation and determine a solution to the issue, the following information needs to be provided on the form:

- Date the incident occurred.
- Time the incident occurred
- CAD incident number if available
- Location of the incident
- Events leading to and contributing to the incident
- Personnel Involved
- Agency and/or institution involved
- Brief description of the occurrence
- Copy of Prehospital Care Report or any other related documentation

GOAL/PURPOSE:
To properly communicate and address issues and concerns that may arise in the EMS program.

PROCEDURE:

- All review and comment report forms shall be given to Service Director who will assess the incident and if necessary forward report to EMS Medical Director.
- The EMS Medical Director and/or Service Director will determine the appropriate course of action/resolution.
- The EMS provider originating the report will be notified of the resolution.
- Situations requiring EMS Medical Director and Service Director notification include:
    - "Any situation which is not consistent with routine operations, System procedures or routine care of a particular patient. It may be any situation, condition or event that could adversely affect the patient, co-worker or System."

- Situations that require reporting to the EMS Medical Director(s) include:
    - Any deviation from MCEMS policies, procedures or protocols.
    - Medication or treatment error
    - Delays in patient care, scene response times or involving base station physician contact
    - Operating on protocol when (Medical Control) is indicated
    - Violence towards EMS providers that results in injury or prevents the provider from providing appropriate care.
    - Failure of equipment (i.e. monitors)
    - Inappropriate Medical Control orders
    - Repetitive concerns and/or conflicts between agencies or hospital-agency conflicts
    - Patterns of job performance that indicate skill decay or knowledge deficiencies

- Situations subject to review and resolution at the agency level include:
    - Personal conflicts between employees
    - Personal conflicts between agencies (that do not impact patient care)
    - Operational errors (that do not impact patient care)
    - Behavioral issues (that do not impact patient care)
    - Patterns of job performance that indicate skill decay or knowledge deficiencies

Manitowoc County Incident Report

Reason for Report:

( ) Constructive ( ) Medical Direction Related ( ) Other (Explained below)
( ) Complimentary ( ) Patient Related ( ) EMS provider Related

Occurrence Date: / / Occurrence Time: a.m./p.m. Run#: _____

CAD Incident Number: _____

Patient Name:

Name of EMS Service:

EMS Team Members:

Hospital: Nurse:

Physician (Hospital): Other(s):

Description of occurrence or events (use additional paper if necessary)

Follow-up/Corrective Action by medical director and service director:

Person initiating report: _____ Date Submitted: / /

Medical Director:_____ Date: / /

Report shall be turned into service director or medical director within 24 hours of event!!

POLICY
EMS Report Forms
(Documenting Patient Care)

POLICY STATEMENT: Documentation of patient contacts and care is a vital aspect of assuring good continuity of care, providing a means of quality assurance and historical documentation of the event.

POLICY/PROCEDURE:

- All EMS providers must complete a patient care report for each patient contact or request for EMS response.
- Prior to leaving hospital an assessment form and Rhythm strip/12 lead EKG (if applicable) should be left with the patient's nurse, mounted on the hospital's paper.
- In accordance to DHS rule 110.34 provide a brief written report on arrival to the destination facility.
- Complete documentation must be provided on a System approved form or computer reporting system with in 24 hours unless specifically requested by a physician sooner.
- Routine, scheduled, interfacility transfers may be documented on a System approved interfacility transfer report form.
- Non-transporting agencies are required to complete AED QA Form and any other form dictated by the service's medical director.
- EMS providers will be notified of incomplete reports or reports with significant errors.

POLICY
Patient Confidentiality & Release of Information

POLICY STATEMENT:
All MCEMS personnel are exposed to or engaged in the collection, handling, documentation or distribution of patient information. Therefore, all EMS personnel are responsible for the protection of this information.

GOAL/PURPOSE:
To assure appropriate confidentiality of personal and sensitive information, including care and prognosis.

POLICY/PROCEDURE:

Unnecessary sharing of confidential information will not be tolerated. MCEMS personnel must understand that breach of confidentiality is a serious infraction with legal implications and may result in corrective action, including System suspension and/or termination.

1. Written and Computer Reporting System
    - Confidentiality regarding written patient care documentation is governed by the "Need to Know" concept.
    - Only MCEMS System personnel and Hospital Medical Staff directly involved in a patient's care or monitoring of the quality of care are allowed access to the patient's medical records and reports.
    - Authorized medical records and billing personnel are allowed access to the patient's medical records and reports in accordance with hospital and EMS provider policies.
    - Request for release of patient care related information (third party payers, law enforcement, coroner, fire or other agencies) should be directed to the (EMS provider's or receiving hospital's) medical records department.

2. Verbal
    - System personnel are not to discuss specific patients in public areas. Loose or "elevator talk" regarding specific patient problems and/or care is inappropriate.
    - EMS providers should not discuss any confidential information regarding patient care with friends and relatives, or the friends and relatives of patients. This includes hospitalization of a patient and/ or the patient's condition.
    - Information gained from chart or case reviews is considered confidential.

3. VHF Radio
    - Generally, no patient name will be mentioned in the process of Prehospital radio transmissions.
    - Sensitive patient information regarding diagnosis or prognosis should not be discussed during radio transmissions.

4. Scene
    - Every effort should be made to maintain the patient's auditory and visual privacy during treatment at the scene and during transport.
    - EMS personnel should limit bystanders at the scene of an emergency. Law enforcement may be called upon to assist in maintaining bystanders at a reasonable distance.

POLICY
Response to and from 911 Calls

POLICY STATEMENT:

EMS personnel are activated when the 911 system is alerted. Manitowoc County is utilizing Priority Medical Dispatch in an attempt to reduce the risk to EMS providers, patients, and the public by only responding in emergency (lights and sirens) mode when appropriate.

GOAL/PURPOSE:

To reduce the risk of injury to EMS providers, patients, and the public when responding to 911 calls and transporting patients to treatment facilities.

POLICY/PROCEDURE:

1. When the 911 call is received the dispatcher will follow the established protocols for Priority Medical Dispatch. Based on the information provided by the caller the dispatcher will dispatch the EMS personnel in an Alpha, Bravo, Charlie, Delta, Echo, Omega response. The dispatcher will obtain more information from the patient or person on scene. Each Agency will develop SOG's to appropriately determine their response as Emergency – lights and sirens, or Non-Emergency – no lights and sirens, in regards to the type of dispatch given out. All members of each agency will be trained in the methods of response. It will be the agencies responsibility to provide these guidelines to the Medical Director when requested.

2. Responding agencies may upgrade to Emergency for weather conditions if initially responding as "Non-Emergency." Examples would include: patient outside in extreme weather conditions.

3. Once departing the scene with the patient, the transporting agency should be in non-emergency mode unless the patient is in extremis or it is felt that the person is deteriorating rapidly. **Early emergency department notification is appropriate in all transports so that resources are available upon arrival.**