

**POLICY
Crime Scene Preservation**

Criteria: Any EMS encounter with a location that is the suspected site of a crime.

Exclusion Criteria:

1. The safety of the EMS personnel is of paramount importance, and these guidelines do not come before the principles outlined in general scene safety.
2. These guidelines provide general information related to crime scene preservation.
3. These guidelines do not comprehensively cover all possible situations, and EMS provider judgment should be used when there is no clear direction.

Procedure:

1. Provide live saving measures: ^{1,2}
 - a. Never cut through holes in clothing created by bullets or knives.
 - b. Retain all clothing, place in a paper bag.
 - c. When transporting a patient who may be dying, ascertain name and/or description of the assailant, if possible.
2. Wear protective equipment (i.e. gloves) for all patient care and other activities within the crime scene.
3. If a camera is available, take a picture of the scene/victim prior to touching/moving the patient and or other objects present. This, however, should not delay care of a viable patient.
4. In cases of obvious death, DO NOT move the body:
 - a. Leave the scene the same way you entered.
 - b. Leave the scene in the same condition as when you entered.
 - c. Do not allow anyone to enter the scene until police arrive.
5. Notify the investigating law enforcement office of any alteration of the crime scene by EMS personnel including:
 - a. Any movement of furniture, tables, etc., by providers.
 - b. The original position of the items.
 - c. If you turned on lights.
 - d. What you touched, moved, etc.
6. At an outdoor crime scene, do not disturb shoe prints; tire marks, shell casings, etc.
 - a. Limit movement at the crime scene.
 - b. Attempt to keep others out of the area.
7. Firearms/Weapons:
 - a. Do not move firearms (loaded or unloaded) unless it poses a potential immediate threat.
 - b. Secure any weapon that can be used against you or the crew out of the reach of the patient and bystanders.
 - c. Guns should be handed over to a law enforcement officer if possible or placed in a locked space, when available.
 - d. Place two fingers on the barrel of the gun and place in a secure area.

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- e. Do not unload a gun.
 - f. Knives should be placed in a locked place, when available.
 - g. Do not clean or disturb a patient's hands (when involved with a firearm). Consider covering a patient's hands with a paper bag during treatment/transport.
8. Listen for conversations overheard at the crime scene. Report any conversations to law enforcement officials.

Notes:

- 1. Your first duty is to provide emergency medical care at the scene of an illness/injury.
- 2. Certain measures can be taken to assist law enforcement personnel in preserving a crime scene without jeopardy to the patient.

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**PROTOCOL
Domestic or Elder Abuse / Neglect**

Overview: Wisconsin law establishes requirements that any person licensed, certified or otherwise authorized to provide health care shall offer immediate and adequate information regarding services available to abuse and neglect victims. Abuse is defined as physical, mental or sexual injury to a child or an eligible adult. An eligible elder is a person 60 years of age or older who resides with another individual suspected of abuse, neglect or financial exploitation. An eligible domestic partner is defined as a spouse or person who resides in a domestic living situation with another individual suspected of abuse. EMS personnel should not rely on another mandated reporter to file a report on the victims' behalf.

First Responder Care should be focused on assessing the situation, initiating care and assure scene and personal safety.

1. Render initial care in accordance with the Routine Patient Care Protocol. Treat obvious injuries or illnesses.
2. Maintain control of the scene. Call law enforcement personnel to scene.
3. Survey scene for evidence of factors that could adversely affect the patient's welfare:
4. Environmental
5. Interaction with family members
6. Discrepancies in history of events
7. Injury patterns that do not correlate with the history of patient use and mobility
8. Signs of intentional injury or emotional harm.

BLS/ ILS/ ALS Care should be directed at directed at conducting a thorough patient assessment, initiating Routine Patient Care Protocol and determining medical and mental health needs.

1. Render initial care in accordance with the Routine Patient Care Protocol and BLS care as above.
2. Initiate transport as soon as possible.

Critical Thinking Elements:

- If offender is present and interferes with transportation of the patient or is influencing the patient's acceptance of medical care, contact police and Medical Control for consultation on appropriate action.
- Upon arrival, notify the receiving physician or nurse of the suspected abuse.
- Thoroughly document the history and physical exam findings on the Prehospital Report.

PROTOCOL

Behavioral Emergencies

Overview: Behavioral episodes may range from despondent and withdrawn behavior to aggressive and violent behavior. Behavioral changes may be a symptom of a number of medical conditions including head injury, trauma, substance abuse, metabolic disorders, stress and psychiatric disorders. Patient assessment and evaluation of the situation is crucial in differentiating medical intervention needs from psychological support needs.

First Responder Care should be focused on assessing the situation, initiating care and assure scene and personal safety.

1. Render initial care in accordance with the Routine Patient Care Protocol
2. Determine if the patient is a threat to self or others, or if patient is unable to care or provide for self.
3. Protect patient from harm to self or others. Call law enforcement personnel to scene, if needed.
4. Maintain control of the scene.

BLS/ ILS/ ALS Care should be directed at conducting a thorough patient assessment, initiating Routine Patient Care Protocol and determining medical and mental health needs.

1. Render initial care in accordance with the Routine Patient Care Protocol and FRLS care as above.
2. Determine if the patient is a threat to self or others, or if patient is unable to care or provide for himself.
3. CONTACT MEDICAL CONTROL as early as possible if restraints or force is needed.
4. Initiate transport as soon as possible.
5. All stable patients presenting with psychiatric conditions should be transported to Holy Family Memorial Emergency Department. Those with unstable emergencies (i.e. significant overdose) should be transported to the closest facility for stabilization.

Critical Thinking Elements:

- Document patient behavior, statements, actions or surroundings that substantiates threatening behavior, if witnessed.
- Do not touch a patient with a mental illness without telling them your intent in advance.
- Verbally attempt to calm and reorient the patient to reality. Do not participate in a patient's delusions or hallucinations.
- Consider medical etiologies of behavioral disorder and treat according to appropriate SOP; hypoxia, substance abuse/overdose, neurologic disease (CVA, intracerebral bleed, etc.), metabolic derangement (hypoglycemia, thyroid disease, etc.).
- Consult Medical Control from the scene in ALL instances where a refusal of transport is being considered or the patient is to be restrained.
- If restraints are used, document reason for restraints, time of application, condition of the patient before and after restraints are applied, method of restraint and law enforcement involvement (including law enforcement equipment used). Patient and restraints should be reassessed every 5 minutes.

POLICY

Petitioning an Emotionally Disturbed Patient

POLICY STATEMENT: EMS providers should consider the mental health needs of a patient who appears emotionally or mentally incapacitated. This involves cases that the EMS provider has reasonable cause or evidence to suspect a patient may intentionally or unintentionally physically injure himself/herself or other persons, or is unable to care for his/her own physical needs and is in need of mental health treatment against his/her will. This does not include a person whose mental processes have merely been weakened or impaired by reason of advanced years and the patient is under the supervision of family or another healthcare provider, unless the family or healthcare provider has activated EMS for a specific behavioral emergency.

GOALS/PURPOSE: To facilitate patient care of the emotionally disturbed patient.

POLICY/PROCEDURE:

1. Attempt to persuade the patient of the need for evaluation and to compel patient to be transported to the hospital so that a physician can evaluate him/her.
2. If persuasion is unsuccessful, contact Medical Control and relay the history of the event, clearly indicating your suspicions and/or evidence. Have the Base Station physician discuss the patient's needs with the parties involved in the situation.
3. The EMS crew will then follow the direction of the Base Station physician when determining the disposition of the patient or termination of patient contact. Another agency's or party's opinion should not influence the EMS provider's assistance to a mental health need.
4. Whether the patient is transported against his/her will or voluntarily, under no circumstances does this mean that the EMS providers are committing the patient to a hospital admission. It simply enables the EMS providers to transport a person suspected to be in need of mental health treatment to a hospital so that a physician may evaluate said patient.
5. If patient is combative or may harm self or others, call police for assistance and follow restraint policy.

EMS Personnel may not transport a patient against their will. EMS MUST involve police who will place the patient under temporary custody to facilitate transport.

POLICY

Do Not Resuscitate (DNR)

POLICY STATEMENT/PURPOSE: A Do Not Resuscitate Policy is a tool to be used in the pre-hospital setting to set forth guidelines for providing CPR / resuscitation or for withholding resuscitation efforts. The purpose of this policy is to specify requirements for valid DNR orders and to establish a procedure for field management of these situations.

POLICY/PROCEDURE:

1. Any FR, EMT-B, EMT-IT, EMT-I, EMT-P who is actively participating in a Department approved EMS System may honor, follow and respect a valid DNR order. Medical Control will be contacted in all cases involving DNRs.
2. DNR refers to the withholding of life sustaining treatment such as: cardiopulmonary resuscitation (CPR); electrical therapy to include pacing, cardioversion and defibrillation; tracheal intubation and manually or mechanically assisted ventilation, unless otherwise stated on the DNR order.
3. By itself, a DNR order does not mean that any other life prolonging therapy, hospitalization or use of the Emergency Medical System is to be withheld. On-line Medical Control must be consulted in cases involving DNR orders. DNR orders do not affect treatment of patients not in full arrest (pulseless and breathless).
4. A DNR order may be invalidated if the immediate cause of a respiratory / cardiac arrest is related to trauma or mechanical airway obstruction.
5. When EMS personnel arrive on scene and discover the patient is pulseless and breathless and CPR is not in progress, resuscitation (at minimum CPR) must be initiated unless one or more of the following conditions exist:
 - a. Obvious signs of biological death are present.
 - b. Decapitation.
 - c. Rigor mortis without profound hypothermia.
 - d. Dependent lividity.
 - e. Obvious mortal wounds with no signs of life.
 - f. Decomposition
 - g. The patient has been declared dead by the patient's physician or a coroner.
 - h. A valid DNR Bracelet is present and the EMS provider has made reasonable effort to verify the identity of the patient named in a valid DNR order (i.e., identification by another person, ID band, Photo ID or facility or home-care / hospice nursing staff).
6. If the above signs of death are recognized, EMS personnel must contact Medical Control to confirm the decision not to attempt resuscitation (cease effort or do not resuscitate orders) prior to notifying the coroner.
7. If the EMS provider has concerns regarding the validity of the DNR orders, the degree of life sustaining treatment to be withheld or the status of the patient's condition the provider should immediately institute BLS measures and contact Medical Control for further directions.
8. When EMS personnel arrive on scene and discover CPR is in progress, the EMS provider should:
 - a. Assess pulse and breathing and analysis EKG activity.
 - b. Determine if signs of death are present or a valid DNR exist.
 - c. Continue resuscitation if signs of death are not obvious and a valid DNR is not available.
 - d. Contact Medical Control for orders, including possible cease effort orders.

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9. If the patient's primary care physician is at the scene or on the telephone and requesting specific resuscitation or DNR procedures, EMS personnel should verify the physician's identity (if not known to the EMT) and notify Medical Control of the request of the on-scene physician. The physician on scene shall sign the ambulance report form if Medical Control approves his request(s).
10. Any other advance directives or "living will" cannot be honored, followed and respected by pre-hospital care providers. EMS personnel must contact Medical Control for direction regarding any other type of advanced directive. Resuscitation should not be withheld during the process of contacting or discussing the situation with Medical Control.
11. A Durable Power of Attorney for Health Care is an agent who has been delegated by the patient to make any health care decisions (including the withholding or withdrawal of life sustaining treatment) which the patient is unable to make. When a patient's surrogate decision maker is present or has been contacted by pre-hospital personnel and they direct that resuscitative efforts not be instituted:
12. The EMT is required to ask the durable power of attorney for health care agent to provide positive identification (i.e., driver's license, picture ID, etc.), see the document and ask the agent to point out the language that confirms that the 'power' is in effect and that it covers the situation at hand (i.e., assure the scope of authority the durable power of attorney for health care has, and that the patient's medical or mental condition complies with the document designating the DPAH).
13. A durable power of attorney for health care agent or a surrogate decision maker can provide consent to a DNR order, but the order itself must be written by a physician.
14. An EMT cannot honor a verbal or written DNR request or order made directly by a durable power of attorney for health care agent or a surrogate decision maker or any other person, other than a physician. If such a situation is encountered, contact Medical Control for direction in interpreting the validity of the order or request.
15. Revocation of a written DNR order is accomplished when the DNR order is physically destroyed or verbally rescinded by the physician who signed the order and/or the person who gave written consent to the order.
16. Pre-hospital care providers have a duty to act and provide care in the best interest of the patient. This requires the provision of full medical and resuscitative interventions when medically indicated and not contraindicated by the wishes of the patient. All patients should have access to emergency medical services and may refuse treatment including CPR.
17. When managing a patient that is apparently non-viable, but desired and/or approved medical measures appear unclear (i.e., upset family situation, no agreement on DNR, etc.), EMS personnel should provide assessment, initiate resuscitative measures and contact Medical Control for further directions.
18. If EMS personnel are transporting a patient with a valid DNR order to or from home and the patient arrest enroute, contact Medical Control for orders regarding the transport. Do not initiate resuscitative measures unless otherwise directed by Medical Control.
19. If EMS personnel are transporting a patient with a valid DNR order during an inter-hospital transfer and the patient arrest enroute, continue transport to the hospital and contact Medical Control for orders. Do not initiate resuscitative measures unless otherwise directed by Medical Control.
20. If System personnel are transporting a patient with a valid DNR order from a long-term care facility and the patient arrest enroute, continue transport to the hospital and contact Medical Control. Do not initiate resuscitative measures unless otherwise directed by Medical Control.
21. If System personnel arrive at the scene and the family states that the patient is a hospice patient with a valid DNR order, do not initiate resuscitative measures and contact Medical Control for further orders.

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22. On occasion, EMS Personnel may encounter an out-of- town patient with a valid DNR order visiting in the EMS System area. If the DNR order appears to be valid (signed by the patient and physician and has a current date), contact Medical Control for orders.
23. The coroner will be notified of any patient or family wishes that there is to be tissue donation and the patient is not transported to the hospital.
24. The on-line Medical Control physician's responsibility is to make reasonable effort to confirm the DNR order is valid and order resuscitative measures within the directives of the DNR order. If the DNR order can not be validated, EMS personnel should be ordered to initiate or continue resuscitative measures.
25. All EMS System personnel will receive a copy of the policy and education will be conducted initially, annually and on an 'as needed' basis.
26. All associate and participating hospitals, area physicians and Medical Society staff, extended care facilities, hospice and home health agencies, coroners, dispatchers and private duty nursing agencies within the service area of the EMS System will also receive copies of the policy, as appropriate. The policy may be reviewed with these parties as requested or warranted by quality assurance activities.
27. Education shall include, at a minimum, the following information:
 - a. An overview of the System DNR policy.
 - b. Approved forms and/or the required components of a valid DNR order.
 - c. Expectations healthcare staff in obvious death and DNR situations.
 - d. Instructions on System access.
28. Appropriate pre-hospital care reports will be completed on all patients who are not resuscitated in the pre-hospital setting. A copy of the DNR form should be retained and attached as supporting documentation to the prehospital care report form.
29. Continuous monitoring and evaluation will be conducted on all charts involving DNR orders.
30. All System personnel are to submit an incident report regarding difficulties experienced with DNR situations. These will be evaluated on an individual basis and summarized quarterly. Any quality issues identified will be reported to the EMS Medical Director, as well as any corrective action necessary.
31. Follow the System's coroner notification policy.

POLICY

Resuscitation vs. Cease Efforts

POLICY STATEMENT: The EMS provider is responsible to make every effort to preserve life. In absence of an advanced directive, resuscitative measures shall be attempted if there is any chance that life exists. There are times when death is obvious and no resuscitation is indicated.

POLICY/PROCEDURE:

1. When EMS personnel arrive on scene and discover the patient is pulseless and breathless and CPR is not in progress, resuscitation (at minimum CPR) must be initiated unless one or more of the following conditions exist:
 - a. Obvious signs of biological death are present.
 - b. Decapitation.
 - c. Rigor mortis without profound hypothermia.
 - d. Dependent lividity.
 - e. Obvious mortal wounds with no signs of life.
 - f. Decomposition
 - g. The patient has been declared dead by the patient's physician or a coroner.
 - h. A valid DNR order is present and the EMS provider has made reasonable effort to verify the identity of the patient named in the DNR order (i.e., identification by another person, ID band, Photo ID or facility or home-care / hospice nursing staff.).
2. If the above signs of death are recognized, EMS personnel must contact Medical Control to confirm the decision not to attempt resuscitation (cease effort or do not resuscitate orders) prior to notifying the coroner.
3. If the EMS provider has concerns regarding the validity of a DNR orders, the degree of life sustaining treatment to be withheld or the status of the patient's condition the provider should immediately initiate resuscitative measures and contact Medical Control for further directions.
4. When EMS personnel arrive on scene and discover CPR is in progress, the EMS provider should:
 - a. Assess pulse and breathing and analysis EKG activity.
 - b. Determine if signs of death are present or a valid DNR exist.
 - c. Continue resuscitation if signs of death are not obvious and a valid DNR is not available.
 - d. Contact Medical Control for orders, including possible cease effort orders.
5. Cease effort orders may be considered and the Medical Control physician may order resuscitation efforts to be discontinued (or not initiated) if the following conditions exist:
 - a. No signs of life are present, (i.e., pulse, no respirations), patient "down time" is unknown, EKG is Asystole or PEA and on-site resuscitation efforts have been unsuccessful.
 - b. Injuries inconsistent with life, even if the patient's body temperature is warm.
 - c. Triage or patient prioritization deems resuscitative resources would be more beneficial for use on other victims.

Special Considerations:

- Patients with hypothermia and children may have no signs of life but still be viable. Prolonged resuscitation efforts are indicated for patients with hypothermia and/or if the victim is a pediatric patient.

POLICY

Coroner Notifications

POLICY STATEMENT: This procedure has been developed to provide guidelines for the EMS crews to follow when they come in contact with death in the Prehospital setting.

GOAL/PURPOSE: To assure Prehospital personnel are aware of and adhere to coroner and System policies involving death cases.

POLICY/PROCEDURE:

1. Deaths that are subject to coroner investigation include:
 - a. Accidental deaths of any type or cause.
 - b. Homicidal deaths.
 - c. Suicidal deaths.
 - d. Abortions – Criminal or self induced maternal or fetal deaths.
 - e. Sudden deaths – When in apparent good health or in any suspicious or unusual manner including sudden death on the street, at home, in a public place, at place of employment, or any deaths under unknown circumstances, that may ultimately be the subject of investigation.
2. The coroner, or his designee, should be provided the following information:
 - a. Your name
 - b. Your EMS service
 - c. Location of the body or death
 - d. Phone number and/or radio frequency you are available on.
 - e. Brief explanation the situation
3. Once this information has been provided, wait for the coroner or his designee to arrive or for further instructions. EMS crews may clear the scene if law enforcement is on scene and no other emergency exists.
4. Law enforcement personnel are responsible for death scenes once the determination of death is established with Medical Control and the coroner has been notified.
5. If a patient is determined to be dead (cease effort orders) during EMS, note time and location and record this information on the Prehospital care report. Immediately contact the coroner to discuss death jurisdiction. Do not cross county jurisdiction with a patient that has been determined to be dead.

POLICY

Healthcare (Physician) On Scene

POLICY STATEMENT: Only personnel licensed to perform in the prehospital setting and in the Manitowoc County Area EMS System are allowed to perform advanced patient care (i.e., IV, intubation, medication, pacing) at the scene unless approved by Medical Control. An on scene healthcare provider (physician) does not automatically supersede the EMS provider's authority. Patient care shall not be relinquished to another person or provider unless approved by the EMS Medical Director or Medical Control.

GOAL/PURPOSE:

To clarify the EMS provider's responsibility to a patient at those infrequent situations when a healthcare provider, physician or nurse is at the scene of the incident, and wishes or attempts to get involved with the patient's care.

POLICY:

1. If a professed, duly licensed medical professional (physician/dentist/nurse – hereinafter collectively referred to as physician) wishes to participate in and/or direct patient care on-scene, the EMS provider should contact Medical Control and inform the on-duty physician of the situation.
2. If the on-scene physician (including the patient's primary care physician) has properly identified himself/herself and wishes to direct patient care, the Medical Control physician must give approval prior to acting on the on-scene physician's request. If care is relinquished to the on-scene physician, he/she must sign the ambulance report form and accompany the patient to the hospital. This procedure should be explained to the on-scene physician prior to seeking Medical Control approval.
3. If the physician orders, while on scene or enroute, procedures or treatments that the EMS provider believes unreasonable, medically inaccurate, and/or outside the EMS provider's standard of care, the EMT should refuse to follow such orders and reestablish contact Medical Control. In all circumstances the EMS provider shall avoid any order or procedures that would be harmful to the patient.
4. If an on-scene physician (or person claiming to be a healthcare provider) is obstructing EMS efforts or substantially compromising patient care, the EMS provider should distract or redirect the interfering healthcare provider, request police assistance if necessary and communicate the situation to Medical Control.
5. If EMS personnel or nursing staff from another System or jurisdiction (other than a requested intercept or mutual aid) are at the scene and request to provide or assist with patient care and their assistance is not needed, excuse them from the scene. If assistance is needed, these personnel may provide assistance with the supervision of the agency having jurisdiction of the scene. Manitowoc County EMS System policies, procedures and protocols must be followed regardless of the assisting EMS personnel's authorized level of care.

Special Considerations:

- RN's are not licensed to perform in the prehospital setting unless they are Field RN's with Service Medical Director authorization or are functioning with a flight program requested to the scene.

POLICY

School Bus Policy

Release of Minors involved in School Bus Incidents

STATEMENT: Incidents involving school buses pose unique challenges to the EMS provider in assuring proper release of uninjured children. Once Medical Control confirms that the minor children are not injured, the custody and responsibility for these uninjured children will remain with the responding EMS provider until the children are transferred to parents, legal guardians, school officials or the hospital. If no procedure exists to have children transferred to a parent, legal guardian or school official, then these children will need to be transported to the hospital.

PURPOSE: To reduce the number of uninjured children transported to the hospital and to reduce the EMS time and resources used at the scene of school bus incidents.

PROCEDURE:

1. On arrival at the scene, EMS personnel shall determine the category of the incident and request appropriate resources. EMS must also accomplish a complete assessment of the scene to include at least: mechanism of injury, number of patients, damage to the vehicle, triage as outlined in the System Plan. Once this has been accomplished, then the patients may be assigned to one of the following categories:
2. CATEGORY A: Mechanism of injury, school bus occupancy indicates that at least one child may reasonably be expected to have significant injuries: (i.e.: roll-over, high-speed impact, intrusion into the bus etc) or significant injury is present in one or more children. All children in this incident category must be transferred to an appropriate hospital unless a System refusal form is signed by a parent or legal guardian.
3. CATEGORY B: Mechanism of injury, school bus occupancy indicates that at least one child may reasonably be expected to have minor injuries. (i.e.: speed of impact, intrusion into bus, etc) or minor injury in one or more children exists with no obvious mechanism of injury that could reasonably be expected to cause significant injuries. EMS personnel must complete the EMS multiple casualty release form and secure a signature of an appropriate school official.
4. CATEGORY C: Mechanism of injury, school bus occupancy indicates no injuries may be present and that the release of uninjured children may be the only EMS need. No injuries are present in any children and no obvious mechanism of injury exists (use approved System Multiple Patient Release School Bus Incident form).
5. CATEGORY D: If the pediatric patient (s) has special healthcare needs and/or communication difficulties, then all of these patients must be transported to the hospital for evaluation and disposition unless approval for release is received from Medical Control or parent/legal guardian has signed the approved refusal form.
6. After determining the category of the incident, EMS personnel shall determine the extent of EMS involvement and contact Medical Control. Medical Control shall approve the implementation of this policy.
7. Adults, victims 18 years and older, and occupants of other vehicles will be treated or released in accordance with routine System operating procedures.
8. If Medical Control has approved usage of this policy/plan, then each provider will implement their procedure for contacting parents, legal guardians or appropriate school officials to receive custody of uninjured children.

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9. The approved system Multiple Casualty Release form for School Bus Incidents must be utilized for all children who will not be transported.
10. Each child transported must have a completed run report.
11. One run report indicating the nature of the incident (etc.) shall be completed and must include all information regarding the incident including the number of patients released. Keep a copy of this report with the release form or with refusal forms signed by the parents.
12. Any parent or legal guardian who arrives on scene to remove and assume responsibility for their child will be requested to sign an individual refusal form.
13. EMS providers shall use reasonable means to contact the parents or school officials. This could include use of telephone, cellular phone or direct contact by police. If contacted by phone, EMS providers shall take reasonable means to confirm the identity and authority of the parent or school official.
14. Once the identity and authority of the parent or school official has been established, the EMS provider may release the child to the parent, guardian, school official or alternate transport source. School officials will follow their established program for informing parents and/or legal guardians in regard to incidents.
15. The health and safety of the child is the primary concern. It is the responsibility of the EMS provider to assure the child is returned to the parent or placed on the schools alternate transport vehicle. If the EMS provider on the scene determines a child should receive a physician evaluation or offered medical care, the child WILL BE TRANSPORTED to the hospital unless the parents are on scene and consent to refusal.
16. Each Pre-hospital provider agency in the System who may likely respond to a school bus incident, must contact the school superintendents in their district to obtain the name and title of the "appropriate school official" who may take responsibility for the children on the bus involved in the incident.
17. Utilization review (CQI) will be conducted by the EMS System of the agency(s) involved for each implementation of this procedure

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**MANITOWOC COUNTY EMS ASSOCIATION
MULTIPLE CASUALTY RELEASE FORM**

Date: _____ Time: _____ Run/Incident Number: _____

Agency: _____ Unit Number: _____

Location: _____ Number of Victims: _____

Description of Incident: _____

School District: _____ Bus Company: _____

Bus Driver: _____ School Official: _____

The following children were involved in the above school bus incident. They have been medically triaged by EMS personnel and no obvious or apparent injuries were found. The school official signing this form assumes responsibility for the children and is advised the evaluation the children received is not a substitute for medical evaluation by a doctor. The school official was instructed to CALL 911 if there is any change in any of the children that may raise any suspicion of potential injury.

Name (Print)	DOB/Age
Child #1 _____	_____
Child #2 _____	_____
Child #3 _____	_____
Child #4 _____	_____
Child #5 _____	_____
Child #6 _____	_____
Child #7 _____	_____
Child #8 _____	_____
Child #9 _____	_____
Child #10 _____	_____

Signatures

School Official: _____

EMS Crew: _____

POLICY

Patient Restraints

POLICY STATEMENT: Patients will only be restrained if clinically justified. The use of restraints is only utilized if the patient is violent and may cause bodily harm to themselves or to others. Restraints are a last resort in caring for the emotionally disturbed patient.

GOALS/PURPOSE: To identify for EMS personnel when restraints are necessary and the application procedure for restraining the violent patient. A restraint is identified as a manual or physical mechanical device that restricts the patient's freedom or movement or normal access to his/her body and cannot be easily removed.

INDICATIONS: Clinical Justification: Aggression; Behaviors out of control/combatative; Appears the patient will cause injury to themselves or others; Impulsive striking out/ throwing objects; Self abuse; Assaultive behavior/threats with weapons; Mental confusion/incompetence with aggression.

POLICY/PROCEDURE:

1. To restrain the patient, use a minimum of 4 people. Have 1-2 of those be the same sex as the patient, if possible.
2. As soon as possible contact medical control for guidance.
3. May use police protective custody if available.
4. Protect and preserve privacy and dignity of the patient.
5. Explain procedure to the family and patient if possible. One person (team leader) should communicate with the patient.
6. Do not spend time in bargaining with patient. Once the decision is made, move to restrain. For example: a patient under the influence of drugs such as PCP will not listen.
7. Remove any equipment from your person, which can be used as a weapon against you.
8. Assess the patient and area for any other types of potential weapons.
9. Approach the patient keeping the team leader near the head to continue communications.
10. Have a restrainer at 3 limbs and the team leader at the head.
11. Move patient to back board/stretchers.
12. Have patient **supine** and place **soft disposable** restraints on 3-4 limbs and fasten to **backboard**. Do not restrain prone if possible. Monitor airway frequently throughout transport.
13. The restraint is fastened to the backboard and the backboard strapped to the stretcher. This allows ease in moving the patient if necessary to their side. (May be necessary to prevent aspiration.)
14. Continue verbal contact with the patient.
15. Transport as soon as possible to nearest receiving hospital.
16. Stay with the patient at all times after restraining.
17. Document circulation checks q 15 minutes of restrained limbs, physical assessment, justifying factors for restraints, time of application of restraints, notification time of police and medical control. Document if police are on scene and accompany you to the receiving facility.

Safety:

1. Safety of yourself and the patient should be the most important factor at all times.
2. Stay with the patient.

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3. Be prepared for the unexpected.
4. Continue to monitor for weapons the patient may have access to.
5. Police to accompany you in transport if possible.
6. Do not use heavy objects or ones with metal or requiring keys to restrain.
7. Do not remove restraints until released by medical personnel at the nearest receiving hospital.