CLINICAL OPERATIONS PROCEDURES - TABLE OF CONTENTS

PATIENT'S BILL OF RIGHTS

The Patient and/or Patient's Family has the right to expect and receive the following from Sumner County Emergency Medical Services personnel:

1. A clean, well-maintained, well-equipped, climate-controlled ambulance.

2. The closest available ambulance and first responder (when needed) dispatched to their call for help with no unusual delays for any reason.

3. All responding personnel to be clean, neat, dressed in the appropriate uniforms, and looking professional.

4. All responding personnel to be polite, compassionate, considerate, empathetic, soft-spoken, respectful and well-mannered.

5. Transportation to the clinically-appropriate medical facility of their choice without questions being raised regarding their ability to go by some other means, or any other method of discouraging transport.

6. A clean stretcher with fresh sheets, blankets and a pillow and the appropriate medical equipment brought immediately to their location; carried or wheeled as smoothly as possible while the patient is secured with safety straps and covered with a sheet or blanket to protect the patient's modesty; and wheeled smoothly into the Emergency Department.

7. To have their vital signs checked and documented in both transport and non-transport situations.

8. To have all valuables and medications in their possession documented on the patient care report at the time they are transported, and clearly document to whom in the Emergency Department those valuables and medications were given.

9. To have their pertinent history, injuries, illness, vital signs, treatment, interventions and medications adequately, thoroughly, and truthfully documented on the patient care report.

10. To have the specifics about patient history, current situation and nature of their injury or illness kept confidential in all respects.

COMMUNICATIONS

- Patients, family members, and other persons on scene or in a facility shall be regarded with respect and professionalism. The use of advanced medical terminology should be reserved for those who also possess an understanding of such language and meanings. However, care should also be applied to not speak in a manner that can be perceived as condescending or insulting to ones intelligence.

- When EMS personnel are taking report from others directly involved in the care of the patient, such as care givers, family, or other healthcare providers, this shall be done in a manner that promotes teamwork, mutual respect, and closed loop communication. Vital signs, and other pertinent information given by nursing staff, physicians, or first responders should be recorded in writing when possible.

- It is the responsibility of the most qualified Paramedic caring for the patient to ensure transmission of all aspects of the patient assessment and care to the responding Emergency Unit or Medical Control.

- When reporting a disposition to Medical Control or the responding unit, provide the following minimum information:
    a. Identify as Sumner County Medic or Unit with number
    b. Patient's age and chief complaint
    c. Is the patient stable or unstable, including complete V/S and LOC
    d. Interventions performed
    e. Provide other information as requested.

<u>If a BLS unit is transporting and requests on-line medical control, it is necessary to identify as a BLS unit with no paramedic on board. This will prevent initial confusion from hospital personnel in this rare circumstance</u>

- For each and every call, the first directives are scene safety and body substance isolation precautions.

- For any drug administration of procedures outside these Guidelines, the EMS Provider must receive authorization from Medical Control. Paramedics en-route to the scene are not authorized to issue orders.

- Any confirmed information regarding infectious disease history, or other concerns for contamination to EMS or hospital personnel should be shared between team members involved in the care of the patient as early as possible. (to include known findings of bed bugs, etc)

- EMS personnel should advise the receiving facility ASAP when transporting a patient with a known **haz-mat exposure**, in order to facilitate early arrangements for proper decontamination without risking any danger to others. EMS **should <u>NOT</u> proceed into an ER** with any such patient until direction has been given by ER staff.

- When transporting patients with a suspected acute coronary syndrome / STEMI, EMS personnel should advise the facility of a **"STEMI Alert"** as early as possible.

- When transporting patients with a suspected stroke / CVA, EMS personnel should advise the facility of a **"Stroke Alert"** as early as possible.

- When transporting patients who are critically injured and/or unstable, EMS personnel should advise the facility of a **"Trauma Alert"** as early as possible.

USE OF LIGHTS AND SIRENS

No emergency response is so urgent that we cannot respond in a safe manner so as to protect the lives of the public and ourselves. To do otherwise could compound an already urgent situation and result in additional emergency patients.

The safety of individuals proceeding to the scene as well as the public through which they are traveling is of high priority.

The driver of any authorized emergency vehicle shall not be relieved from the duty to drive with due regard for the safety of all persons, nor shall it protect the driver from the consequences of his reckless disregard for the safety of others.

THE LAW

Tennessee Code
Title 55 - Motor and Other Vehicles
Chapter 8 - Operation of Vehicles Rules of the Road
55-8-108 - Authorized emergency vehicles.

55-8-108. Authorized emergency vehicles.

(a) The driver of an authorized emergency vehicle, when responding to an emergency call, or when in the pursuit of an actual or suspected violator of the law, or when responding to but not upon returning from a fire alarm, may exercise the privileges set forth in this section, but subject to the conditions stated in this section.

(b) (1) A driver of an authorized emergency vehicle operating the vehicle in accordance with subsection (a) may:

(A) Park or stand, notwithstanding other provisions of this chapter that regulate parking or standing;

(B) Proceed past a red or stop signal or stop sign, but only after slowing down as may be necessary for safe operation;

(C) Exceed the speed limits so long as life or property is not thereby endangered; and

(D) Disregard regulations governing direction of movement or turning in specified directions.

(2) Subdivision (b)(1) shall not relieve the driver of an authorized emergency vehicle from the duty to drive with due regard for the safety of all persons, nor shall subdivision (b)(1) protect the driver from the consequences of the driver's own reckless disregard for the safety of others.

(c) (1) The exemptions granted under subsection (b) to a driver of an authorized emergency vehicle shall only apply when the vehicle is making use of audible and visual signals meeting the requirements of the applicable laws of this state, except that while parked or standing, an authorized emergency vehicle shall only be required to make use of visual signals meeting the requirements of the applicable laws of this state.

(2) Nothing in this section shall be construed to prohibit the driver of an authorized emergency vehicle, while parked or standing, from making use of both audible and visual signals meeting the requirements of the applicable laws of this state, in the discretion of the driver.

(d) An authorized emergency vehicle operated as a police vehicle may be equipped with or display a red light only in combination with a blue light visible from in front of the vehicle.

[Acts 1955, ch. 329, § 7; T.C.A., § 59-808; Acts 1986, ch. 822, § 1; 1989, ch. 173, § 1; 2001, ch. 60, § 1.]

USE OF LIGHTS AND SIRENS - GUIDING PRINCIPLES

The driver of the ambulance should be advised by the attending medic, as outlined by ambulance protocol, whether it is necessary to respond lights and sirens. If a question arises concerning the response mode or mode of transport of any patient, shift command and/or medical control should be contacted.

The driver should be advised by the attending medic if the patient's condition changes while in transport, and the method of operating as an authorized emergency vehicle can be altered as appropriate.

When operating a vehicle as "an authorized emergency vehicle", both the warning lights and siren (minimum 100 watt) must be in use. Operating a vehicle with only one of these warning devices in use does not satisfy the requirements of the law / state rules and regulations, and SCEMS SOG's.

There are certain medical conditions that may require the rapid transport of the patient, but without the use of an audible warning device due to the patient's condition (i.e. acute MI, pre-eclampsia, use of stethoscope, or other times in which siren noise distracts patient assessment, increases patient anxiety, etc.). In circumstances where lights only are used for transport, the driver should be advised that the vehicle **cannot** proceed as "an authorized emergency vehicle". This may apply when operating on interstates, and other roadways where cross street traffic is not a factor, and/or during hours where other motorists are not present. This would be considered to alert law officers, concerned citizens, etc that the ambulance is indeed in transport of an unstable patient.

Despite the existence of an emergency situation, there are times when it may be more appropriate to approach a scene or transport the patient to a medical facility without the use of lights and sirens, or 'non-emergency". Similarly, there may be environmental conditions (i.e. traffic, weather, etc.) in which operating as an emergency vehicle or "emergency" introduces unreasonable risk and/or disruption and provides minimal opportunity to arrive at the scene early. In any case, remember ambulance charges and third party payment rates do not correspond directly with the use of warning lights and siren. **The term "emergency transport", shall mean "without delay", and does not necessarily mandate the use of lights and sirens.**

When transporting a patient, either "emergency" or "non-emergency", the driver of the ambulance should be especially aware of the physical danger inherent and the operation of an emergency vehicle, and drive in a manner to minimize turbulence to passengers resulting from quick and/or sudden stops, acceleration, and turning movements.

Realizing all contingency cannot be considered and a hard and fast rule established, the practice of returning to "The County" or to a station quarters "emergency" for any reason other than an emergency is discouraged and not allowed. In context with this, responding "emergency" to a hospital to transport a patient to another hospital is also discouraged and not allowed, unless a physician order is given to do so based on the direct needs of the patient in question.

CALLS ORIGINATING ON HOSPITAL PROPERTY

- EMS will still respond no matter where the call originates from. This must be done to ensure all patients get appropriate emergency care either from EMS providing transport, or to confirm that a hospital based rapid response team has made patient contact and no further assistance is required of EMS.

- If a patient calls EMS from within the emergency department of a hospital, then they fall under EMTALA laws and must be appropriately transferred by an attending ER physician. Supervisors would need to collaborate with the emergency department physician to ensure EMTALA laws are being upheld while EMS is still offering an appropriate service. These are laws and law enforcement agencies may also need to be involved in cases where persons requesting EMS refuse to comply with hospital staff yet still demand services of EMS.

There is much information on EMTALA. As the industry evolves with increasing call volumes, there are situations arising that create unique circumstances in which the EMS system is abused at times. It is the goal of Sumner EMS to provide good customer service and quality pre-hospital care. This must be done if good coordination with our hospital based colleagues in compliance with all laws and regulations.

For more on this visit: http://www.emtala.com/faq.htm

http://www.emtala.com/250yard.htm

RESPONSE - STAGING ON LAW ENFORCEMENT SCENES

Scenes in which EMS may be directed to stage and await clearance of law enforcement personnel often include:

- Domestics
- Assaults
- Known weapons involved
- Active Shooter or Suspect with a Gun
- Psychiatric, Dangerous Person(s)

EMS personnel responding to these scenes should adhere to the follow guidelines:

1. Maintain situation awareness at all times.

2. A non-emergency response is acceptable unless there are confirmed patients with potential life threats. This decision may be left up to the unit commander or command personnel in charge.

3. Position/Stage in a location that keeps you out of the flow of traffic as best possible and at an appropriate distance from the immediate scene. *(For example, do not stage within seeing distance of a home where a subject is known to be armed with a rifle...)*

4. Personnel should remain with the ambulance and ready to move. In the event that the scene expands and a danger is presented before being made secure by law enforcement, personnel shall make all attempts to escape and evade with all due regard possible for the safety of others. YOUR safety is the most important.

5. Maintain communications with dispatch per the appropriate radio channel. Avoid the use of cell phones unless necessary for operational purposes. This can distract personnel from what is going on around them and can draw attention to your immediate position in the dark.

6. When responding to a scene known, or suspected, to involve the potential for violence, personnel should don their body armor **before arriving on scene** if at all possible.

7. Sumner EMS personnel should don their assigned body armor anytime they are responding to a scene known, or suspected, to involve the potential for violence.

RESPONSE - STAGING ON FIRE SCENES

EMS commonly responds with Fire Departments to scenes where patients are not yet confirmed, but likely to present. Some of these scenes include:

- Structure Fires
- Investigations to odors, smoke, or possible hazardous materials
- Fire Alarms at places of multiple family dwellings (apartments, hotels)
- Fire Alarms at residential institutions (nursing facilities, etc)

EMS personnel staging on the scene of a working fire should follow these guidelines:

1. Maintain situation awareness at all times.

2. A non-emergency response is acceptable unless there are confirmed patients with potential life threats. This decision may be left up to the unit commander or command personnel in charge.

3. Position the ambulance in a location that keeps you out of the flow of traffic

4. Be aware to not position the ambulance where it interfere with fire scene operations due to the layout of large diameter hose, handlines, outriggers on aerial apparatus, etc. To avoid this, it is best practice to position the ambulance slightly away from the immediate scene.

5. This following equipment should be taken to the definitive staging area:

    - EMS stretcher with mounted portable O2 (min. PSI @ 1000)
    - Cardiac Monitor / Defibrillator (AED is BLS unit)
    - Long Spine Board, consider C-collar and head immobilizer
    - EMS Bag with necessary equipment ready to deliver ACLS/PALS

6. Report to the Incident Commander and establish communications as best possible. The best location to position the EMS cot with equipment is sideways (to stay out of the way) in front of the primary/first-in pumper apparatus. This is the fire engine with the hoses coming off of it. Even if we cannot hear the radio traffic for the FD at the time, the engineer of this apparatus will be able to. Also, let the Incident Commander know where to find you in the event that a patient is found or a fire fighter has a medical emergency.

7. **DO NOT freelance on scene** and **STAY TOGETHER**. You could be needed at any moment and need to be at a high readiness level. Treatment and transport of a patient that presents unexpectedly cannot happen without both personnel ready to respond.

8. It will not be routine practice for EMS personnel to assist in fire suppression efforts. This is discouraged as it distracts EMS crews from their primary objective. Furthermore, operating in any role outside of the specified job functions of EMS provider may create liabilities, limitations to worker's compensation coverage, or increase injury potential.

This plan applies to most working fires, where FD operations are in play and the potential for patient presentation via rescued occupants or injured/ill firefighters is likely. If scene conditions or other factors increase a risk toward EMS personnel safety, then it is acceptable to alter this.

USE OF SAFETY GEAR (Personal Protective Equipment / PPE)

Purpose

Certain scenes will involve increased risks of danger to personnel. This is to emphasize the need to utilize safety gear designed to minimize or prevent injury to EMS personnel.

Plan

In taking a proactive response to the real potentials of danger facing EMS personnel today, Sumner EMS has made attempts to provide effective safety gear specific to certain missions. The following personal protective equipment (PPE) items shall be used when indicated by the mission environment:

BSI protection gear - Shall be donned as appropriate for the condition of the patient and required interventions at that time.

ANSI Traffic Safety Vests - Shall be worn at all times by personnel on scene of any roadway incident. The vest should be worn on the outside of other clothing to provide high visibility.

Ballistic Vests - Sumner EMS personnel should don their assigned body armor anytime they are responding to a scene that is known, or suspected, to involve the potential for violence.

Universal Ballistic Trauma Plate/Carriers - To be worn outside / over ballistic vests to provide additional protection against larger caliber firearms. To be used in situations where shots are being fired, or there is an otherwise known threat of firearm assault.

Extrication Gear - Shall be worn when personnel are actively involved in the rescue or treatment of patients entrapped in a motor vehicle accident. This gear is not designed for structural firefighting and only provides flash protection against vehicle fires to give rescuers time to get to safety in the event fire erupts while attempting to rescue/treat entrapped patients.

Fire/Rescue Helmets - To be worn along with extrication gear when personnel are actively involved in patient care during extrication of a patient entrapped in a motor vehicle accident. Fire/Rescue helmets should also be worn when in or around scenes involving hazards of structural collapse, or otherwise anytime there is risk to head injury from falling debris.

Personal Floatation Devices (PFD) - Shall be worn anytime personnel are in the immediate vicinity of water deep enough to cause drowning in the event of accidental fall into water. This will include anytime personnel are aboard a boat or other marine rescue / swift water operations.

Goggles / Eye Protection / Helmet face shields - Should be applied when there is risk of glass breaking, flying debris, or when hydraulic rescue tools are being used (due to the risk of lines busting and spraying into the eyes).

BALLISTIC VESTS / BODY ARMOR

Policy:

In accordance with NFPA 1500, Sumner County Emergency Medical Services shall provide each full-time field employee with protective equipment that is designed to provide protection from the hazards to which the employee is likely to be exposed and is suitable for the tasks that the employee is expected to perform. Body armor has been proven to provide an effective means to protect the wearer from blunt force trauma, sharp objects as well as gunshot wounds. Protective body armor, shall be utilized only by members who are trained and qualified to use such equipment.

Purpose:

The purpose of this policy is to establish procedures for the care, use, and maintenance of protective body armor. Furthermore, to maximize personnel safety through the use of body armor in combination with prescribed safety procedures and to provide personnel with a procedure for proper use and care.

While the use of body armor provides a significant level of protection, it is no substitute for proper safety procedures, or the use of common sense.

Issuing of Body Armor

- All full-time personnel will be issued SCEMS approved body armor when possible.
- All users of the provided body armor will sign a negligent use contract for use prior to wearing.
- Body armor will be replaced if it is damaged or worn out by SCEMS as described later in this document.
- Body armor that is found to be damaged and that needs to be replaced due to misuse or abuse by an employee, will be replaced at the expense of that employee.

Use of Body Armor

- Personnel should wear body armor anytime they feel it is necessary.
- Body armor shall be worn when dispatched to the following incidents:

  - Any incident where it is reported that shots have been fired, persons have been shot or stabbed, or a weapon is involved
  - Any civil disturbance
  - Any reported suicide where the means involve the use of a weapon or are unknown
  - Any SWAT standby or police situation involving violence
  - Any domestic violence, family dispute or address that has been identified as a concern for such
  - Any incident that may potentially involve an explosive device, including a suspicious package, bomb threat, etc.
  - Any time deemed necessary by the IC or officer in charge of unit responding

Note: This list is not intended to be all inclusive.

- Personnel dispatched to the above types of incidents shall don protective body armor prior to entering the affected area and shall wear said PPE until all potential threats have been mitigated by law enforcement.

- The wearing of protective body armor shall not relieve personnel from the requirement that they stage or remain in a secure area of the incident scene until informed by law enforcement that the scene is secure.

- When not in use protective body armor shall be properly secured to prevent theft.

- Body armor will be worn in accordance with manufactures guidelines and recommendations.

- Personnel will adjust the body armor at the beginning if the shift to ensure proper fit.

- SCEMS owned body armor will not be used outside of shift duty or outside of SCEMS sponsored events.

NOTE: *Please be advised of wearing body armor in extreme heat does require frequent hydration and any attempts to stay cool at all times*

Body armor can be removed under the following circumstances:

- Motor Vehicle Accidents where personnel have to enter a vehicle.
  *(NOTE) Intent on entering the vehicle for medical/treatment purposes.

- Water Rescues where the employee is:

  - Standing or moving along the shoreline within five (5) feet of the water's edge.
  - When boarding any boat to travel to, or assess a patient.
  - When the responder DONs a personal floatation device (PFD)
  - Anytime the OIC (Officer in Charge) of the incident advises the career staff/member to remove.

Inspection of Body Armor

- ALL members of command staff will be responsible for ensuring that the body armor is worn and maintained as required by this policy through routine observation and periodic documented inspection at in-services or spot checks in the field.

- Daily inspection of body armor will be conducted for cleanliness, and signs of damage, abuse and wear. This will be done by personnel at the start and end of their shift for their assigned body armor.

- Personnel will report any damage to their chain of command officer, AND the Deputy Chief of Logistics should be notified ASAP.

- Regular inspection of body armor will be completed by command staff or designees.

Care, Maintenance, and Replacement of Body Armor

- Personnel will disassemble the outer shell of the vest , wash and dry the outer shell every two (2) weeks in accordance with manufacturer's instructions or as needed daily and then reassemble. ***The Kevlar portion of the vest does not get washed with any chemicals, other than wiped down with disinfectant wipes.***

- Personnel are responsible for proper storage of their assigned body armor.

Research and Development for Future Vest Replacement

- It will be the responsibility of Sumner County EMS to replace the body armor as needed but no more than every five (5) years, or before the manufacturer's expiration date.

- The Deputy Chief of Logistics will be responsible for:

  - Monitoring technological advances in the body armor industry that may necessitate a change in body armor.
  - Assessing weapons and ammunition currently in use in our area, and the suitability of approved body armor to protect against those threats.
  - Working with other administrators to coordinate training that emphasizes safe and proper use of SCEMS purchased body armor.

Guidelines for the Care, Use and Maintenance of the Protective Body Armor

- The care, use and maintenance of protective body armor shall be in accordance with the manufacturer's recommendations.

- All protective body armor shall meet or exceed National Institute of Justice NIF 0101.06 requirements.

- Body armor shall be correctly fitted to each member using such PPE following the manufacturer's recommendations and shall not be used beyond the manufacturer's warranty period.

- As with any type of personal protective equipment, personnel shall not utilize body armor or bullet proof vests if they have not been trained in its use and limitations.

- Personnel shall not wear improperly sized, ill-fitting, or damaged protective body armor.

- Personnel without body armor are strictly prohibited from exposing themselves to situations where its use is required, and are required to remain in secure areas at incident scenes, including in staging areas and/or in vehicles.

- All questions on the care, use and maintenance of protective body armor shall be referred to the Deputy Chief of Logistics.

BODY SUBSTANCE ISOLATION / BSI PROTOCOL

Purpose

To emphasis the need to use appropriate protection against communicable diseases when delivering emergency assessment and treatments to the sick and injured.

Plan

Sumner County EMS personnel, including designated first responder agencies, will provide responders with appropriate protective equipment for body substance isolation. This equipment shall include the following, along with the applications for donning the BSI apparel:

Non-Latex Examination Gloves - Shall be used when making physical contact with sick or injured persons. This is not only to protect the provider, but also the patient... especially those who may have compromised immune systems.

Goggles / Eye Protection / Face shields - Shall be used when assessing or treating patients where there is a likely risk for splash contact into eyes or otherwise onto the provider. Examples include:

- Arterial bleeding
- Airway Management (suctioning, intubation, cricothyrotomy)
- OB/childbirth
- Blood draw / usage of Vacutainer vials or other pressurized containers
- Consider when assessing blood glucose due to risk of accidental splash exposure.

N95 Filtration Mask - Shall be used when assessing or treating patients known or suspected to have airborne communicable diseases. Examples of this include:

- Respiratory MRSA (in the lungs)
- Pneumonia , Influenza, or Tuberculosis

Surgical Mask - May be used to put onto the patients to control the spread of communicable illness through exhalation (TB, respiratory MRSA, etc)

Gown / Shoe Covers - Shall be worn when indicated to protect EMS personnel from body fluids or other pathogens when assessing and treating situations such as:

- OB/childbirth
- Trauma Calls
- Transport of patients with known infectious disease process

Biohazard Bags (Red Bags) - Shall be utilized when disposing of materials saturated or heavily soiled with potentially infectious waste such as body fluids.

Approved Sharps Containers - Shall be utilized when disposing of needles, scalpels, or otherwise sharp objects that pose a danger of puncture or penetration to the skin.

RESPONDING IN INCLEMENT WEATHER CONDITONS

- If there are winter weather conditions that make response dangerous, then personnel should consider avoiding the use of lights and sirens. Emergency response often requires the ability of EMS units and other vehicles to come to unexpected stops or slowing down. In the due regard for the safety of other motorists, consideration of responding without lights and sirens is acceptable if personnel feel it may increase accident potential.

- EMS supervisors and personnel should avoid non-emergency response or transport during active severe weather, such as tornado warnings. When dangerous storms are approaching our area or anticipated routes of travel, only emergency response or necessary emergency transports should be made. At any time that personnel aboard the unit feel that themselves or the patient may be in imminent danger, then it is acceptable to await in the safest location possible.

  THE DECISION TO LIMIT RESPONSE OR TRANSPORT OPERATIONS DUE TO WEATHER WILL COME FROM SHIFT COMMAND AND REMAINS IN EFFECT UNTIL NOTIFIED BY SHIFT COMMAND TO RESUME NORMAL OPERATIONS

- At no time should personnel drive an ambulance through moving or still water of unknown depth. Flooding can make travel and response extremely dangerous. It takes only 12 inches of flowing water to move a small vehicle. It takes 18-24 inches of flowing water to move larger vehicles. Do not underestimate the power of water. Avoid driving through water and find an alternate route. Request additional resources as needed, but please **do not** risk your safety or the patients by driving through potentially dangerous water on the roadway.

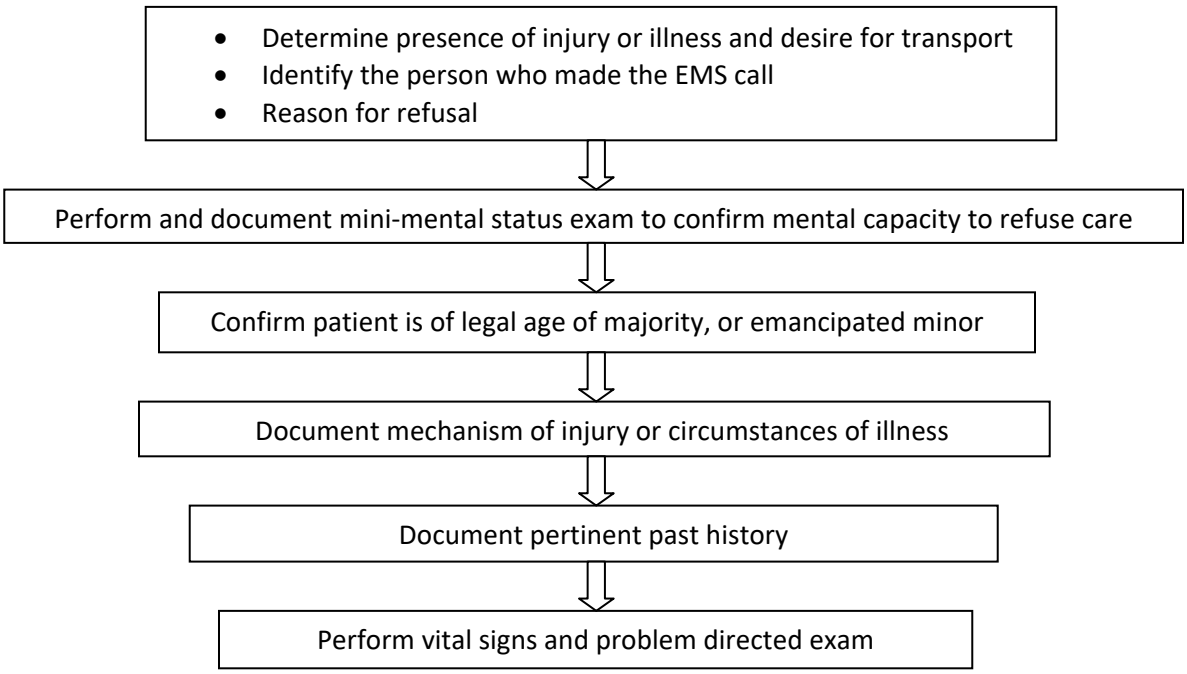
MEDICAL CONTROL DETERMINATION

Medical Control

Definition: The instructions and advice provided by a physician, and the orders by a physician that define the treatment of the patient.

- **TRANSPORT** - To access Medical Control, contact the Emergency Department physician on duty of the destination as determined by either patient choice or destination guidelines.
- **NON-TRANSPORT OR ASSISTANCE WITH FIELD DETERMINATION OF DEATH –** To access Medical Control, contact the on-duty ER physician at **Sumner Regional Medical Center.**

PATIENT REFUSAL OF TRANSPORT (AMA)



The following may not refuse transport:

1. Patients with impaired judgment and decreased mental status
2. Minors (less than 18 years of age or older unless they are emancipated by the courts)
3. All minors must have refusal from parent or guardian, not older sibling or other relative, unless every effort has been made to contact parent/guardian and was not successful
4. Do not release minor on the scene without parent/guardian consent

CONTINUED ON NEXT PAGE...

PATIENT REFUSAL OF TRANSPORT (continued)

Reasons for Non-Transport

Minor illness or injury and acceptable alternative transportation available

No Patient Found on the Scene

Definition: No person found to have any complaint of injury/illness of any type or degree

- PCR is to be completed in detail as to why no patient was found, i.e.: no person found on scene, person located with no complaint of injury/illness and denies needing medical assistance.

In order to refuse transport, a patient must be ALERT, ORIENTED, and:

- The patient cannot be somnolent (sleepy, altered mental status)
- Patient must be oriented to time, place, and familiar persons (family, friends on scene)
- Patient should be able to stand and ambulate without deficits or falling
- Able to understand / comprehend the risks of refusing transport when choosing NOT to allow further care by EMS personnel due to a medical complaint or injury.

Call types where refusals are discouraged, and on-line medical control consult is recommended:

- Pediatric patients - traumas with considerable mechanism of injury
- Pregnant patients with blunt abdominal trauma - high risk for abruptio placentae
- Anaphylaxis/allergic reaction calls - rebound anaphylaxis can occur up to 30 mins later
- Falls with potential head injuries, especially when patients are on anticoagulants
- Apparent Life Threatening Events (ALTE), especially in infant/pediatric patients
- Any patient with concerns of shock, who presents with unstable V/S

If a pediatric patient / minor appears to need transport for physician assessment, however the guardian / caregiver is refusing to allow transport, contact the on-duty supervisor and involve law enforcement as needed. Avoid threatening anyone with pursuing these actions and do your due diligence to inform people the best you can of why you feel transport is needed at the time. Promote mutual respect and professionalism at all times.

If needed, reference the pediatric refusal protocol and follow the guidelines under requirements to be met.

DOCUMENTATION OF MVAS WITH NO INJURIES/ NO COMPLAINTS

Upon assessment of persons involved in a motor vehicle accident, if it is determined that the person assessed has NO complaints of injury or illness, and NO signs or symptoms noted by EMS personnel, then a refusal of transport is not required, and this is "No patient found". It is "no patient found" because the person involved is refusing medical assistance due to not having any reason to need it, therefore they are not a patient (as stated in State Protocols). **This shall only be applicable for patients who are their own legal guardian.**

SCEMS personnel should make attempts to acquire the person's name and birth date if the person is willing to give this information. DO NOT ask for social security numbers, as this is not necessary. The person is not being transported and they, nor their insurance will be billed, therefore we do not need social security number information.

Apply the information to the EPCR for the MVA, and return to service when appropriate.

Do NOT include the names or dates of birth for uninjured persons in the narrative of any transported patients. **The information for the uninjured persons goes in its own run number / run ticket.**

In extremis type situations, it is not mandatory to acquire information if the persons involved DO NOT have any complaints of injury or illness and no obvious signs are present. The following are examples of situations in which EMS personnel may forego acquiring specifics on persons who deny injury that are involved in MVAs:

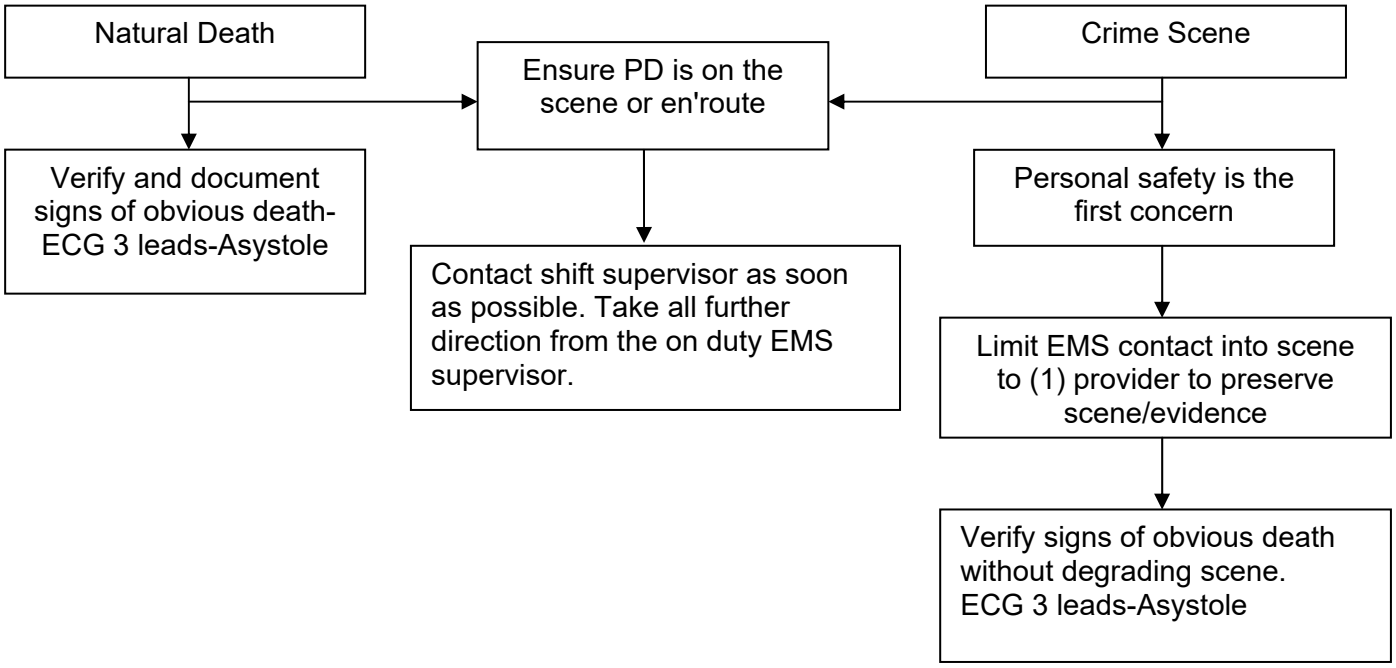
- **Mass Casualty Incidents** that overwhelm immediate scene resources
- **Severe weather** events that pose risk to personnel on scene
- If persons on scene are hostile or uncooperative, **do not risk conflict**
- If there are patients from the MVA who **require immediate transport** due to their condition, DO NOT delay transport to acquire information on non-injured persons involved. Notify supervisor as appropriate.
- If **traffic is posing extreme hazards** to personnel safety, we should not delay clearing the scene to gather information on non-injured persons who have already denied the need for EMS care.

NATURAL DEATH/CRIME SCENE MANAGEMENT

Assessment:

Devastating Injuries/Signs of obvious death

- i.e. Decapitation, exsanguinations of body fluids, pupils dilated. lividity, rigor mortis, pupils fixed
- Identify time when last seen alive, cause, pmhx, medications, and recent hx of illness or complaints



- **Do not withhold resuscitative efforts if care is indicated and signs of obvious death are not present.**
- **Avoid crime scene degradation if care is not indicated.**
- **Only Paramedics will document DOA reports when partnered w/ an AEMT.**

ECG strips confirming asystole are NOT required when there is obvious signs of death such as:

- Decapitation
- Incineration
- Body decomposition
- Lividity And rigor mortis

If there is any question to whether or not there are any signs of life, acquire the ecg 3 lead.

PHYSICIAN ON SCENE

PURPOSE:

To establish guidelines for determining patient care responsibility at the scene of a medical emergency when a physician is on the scene. The physician must be a licensed health care professional medically qualified to render emergency care in the State on Tennessee who specializes in the care that is needed. It is recognized that a qualified physician on scene may facilitate patient care.

PROCEDURE

1. AEMTs or Paramedics shall:

   - Inform the physician that the AEMT or Paramedics must contact their Medical Control.
   - Inform Medical Control of the presence of the physician on scene.

2. Medical Control may:

   - Ask to speak to the physician to determine qualifications.
   - Request that AEMTs or Paramedics verify the licensure of the physician.

3. Any Physician may offer assistance, but:

   - Must provide proof that he/she is a licensed physician with a background in emergency care.
   - Allow the AEMT/Paramedic to remain under Medical Control Direction or,
   - Request to talk to the base hospital to offer medical advice and assistance or,
   - Take **total responsibility** for care given by the AEMT/Paramedic and **physically accompany** the patient until such time that the patient arrives at a hospital and responsibility is assumed by the receiving physician, and shall,

     - Sign for all instructions given to the AEMT/Paramedic
     - Maintain Medical Control contact whenever possible.

4. If the patient's private physician is on the scene:

   - Inform the patient's private physician that the AEMT/Paramedic must make contact with Medical Control.
   - May request that the patient's physician contact Medical Control.
   - At no time will the AEMT/Paramedic take any Verbal orders over the phone unless they are coming from Medical Control. The **exception** to this rule is if the physician is known by the AEMT/Paramedic and has rapport with EMS Medical Directors.

HANDLING OF PATIENT'S VALUABLES/PERSONAL PROPERTY

GENERAL STATEMENT

- A medic's first responsibility is to treat the patient. Handling a patient's valuables or personal property is secondary to proper pre-hospital emergency care. However, special attention needs to be paid to how a patient's personal property is handled by EMS personnel (when handling it cannot be avoided) to minimize potential problems for EMS later on. In "load-and-go" situations, do not waste time handling patient's valuables.
- Proper procedure under this protocol is determined by location of the patient (at home, accident scene, etc.), whether family members or friends of the patient are present, whether law enforcement personnel are present and several other factors. **Every situation cannot be described here, but the following is to serve as a guideline.**
- Patient's personal property could include but not be limited to: glasses, dentures, wallets, money, watches, jewelry, expensive clothing, medications, and keys.

PATIENT AT HOME OR A RESIDENCE

- Advise and encourage the patient to leave all unnecessary personal items and valuables at home or with a family member or friend.
- A patient's medication in most cases would need to go to the hospital either with the patient or be carried by a family member. If it is necessary for the medic to handle these medications they should be treated like any other patient valuables.
- Do not remove a watch, jewelry, or wallet from a patient unless it is necessary to treat the patient, (IV, etc...)
- If it is necessary to do so tell the patient you are removing the item. Then try to give it to the patient if conscious and alert or to a family member if present and document this on the ambulance trip report. If possible have another medic or law enforcement officer witness what you did with the patient's personal property.
- If the patient insists on taking personal items with they, they must be alert enough to keep possession of the items.
- If you are uncomfortable about the security of the premises you are leaving, notify law enforcement.

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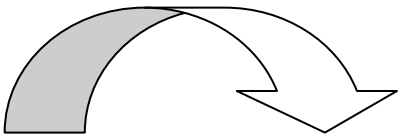

HANDLING OF PATIENT'S VALUABLES/PERSONAL PROPERTY

(***Continued***)

PATIENT AT ACCIDENT SCENE OR NOT AT HOME

- If the patient is conscious encourage the patient to give personal property and valuables to a responsible person of his choice. If you have to remove any item from the patient (e.g., watch, jewelry, etc.) to treat the patient, return the items to the patient, and if possible, have someone witness this and document it on the trip report.
- If law enforcement presents you with a patient's personal items, request that they (law enforcement) present the items to the patient (if conscious and alert) or to the patient's family, or present them to the hospital staff.
- If personal items or valuables are handled by first responders or bystanders before they were presented to you, document this on the trip report.
- If personal items or valuables are destroyed in order to gain access to the patient, this should be documented and the items kept.
- If patient is disoriented or unconscious give the patient's personal items to a family member or law enforcement officer if possible. Document any incident involving valuables on the trip report and obtain signature from the person receiving valuables. If family or law enforcement are unavailable, transport valuables with patient.

TAKING CHARGE OF PATIENT'S PERSONAL ITEMS

When EMS personnel finds themselves in possession of a patient's personal items and valuables, he/she should carefully document what was done with the items.

- Place the items in a container provided for that purpose – zip lock bags for small items and plastic garbage bags for larger items.
- Make a list of the items placed in each bag and place the list on the bag or in the bag. Medications should be listed separately. Currency should be listed by amount.
- Have your partner or law enforcement officer verify (sign) the list of items included in the bag.
- When you arrive at the hospital, turn the bag(s) over to the appropriate hospital staff (depending on hospital protocol) and have them sign for the items.
- Retain a copy of this signed list to be attached to the EMS copy of the trip report.

SECURING OF WEAPON FOUND ON SCENE / PATIENT

Purpose

To comply with Tennessee legislation in regards to concealed carry laws while providing a safe environment for EMS personnel, patients, family members, and members of the public.

Emergency responders and healthcare providers are likely to encounter an increasing number of persons carrying firearms. In most cases, this will be legal carry of concealed firearms, however it is very possible to encounter patients who are illegally in possession of a firearm, yet in emergent need of medical attention. The potential for inadvertent harm to emergency responders as they care for these patients is a concern. Appropriate guidelines and training should be followed to reduce the risk of harm, most significantly, the accidental discharge of a firearm.

Most hospitals are declared “no carry zones” as individuals not exempt (Law Enforcement) are prohibited from bringing firearms into the structure. (T.C.A. 39-17-1359.).

Response Guideline

EMS Providers who are licensed to carry a concealed firearm and are doing so at the time of a call, should secure their firearm either at home or in their personal vehicle, prior to entering their station, apparatus, or scene.

Training

All agencies should obtain appropriate firearm awareness training. This training may be available through their EMS System. Agencies should work with local law enforcement or other appropriate agency to facilitate training their members on basic firearm safety and handling instructions.

Preferred Practice

EMS providers should make any and all attempts, within reason, to not handle or transport any firearms. If patient condition and safety concerns allow, the patient should secure the firearm at home or in their personal vehicle prior to transport. Law enforcement should be utilized as needed.

Transporting Agencies

Sumner EMS will need to purchase an appropriate container that can secure a firearm if found. Containers must be in a secure, locked compartment or safe, that ensures the firearm will not have the barrel pointed in the direction of any individuals in the apparatus. We must develop a guideline or policy that outlines how they plan on securing and transporting a firearm if found on a patient. This guideline or policy must be approved by our respective EMS Administrators.

Patient Care During the Initial Assessment of a Patient

EMS Providers will need to inquire about any concealed firearms. If the patient has a firearm, all legal efforts should be utilized to avoid having to transport a firearm to the Emergency Department. However, if the patient’s condition requires immediate transportation, then transportation should not be delayed unless there is an imminent threat to the providers. If the patient is deemed stable and police are en route, transportation may be delayed to relinquish the firearm to the police.

SECURING OF WEAPON FOUND ON SCENE / PATIENT

(CONTINUED FROM PAGE 26)

Conscious Patients

EMS Providers should approach an alert and oriented patient in calm discussion regarding the need to secure a firearm prior to transport. The ideal situation would include the patient leaving the firearm secured at their residence or in their personal vehicle. Simple explanations should be given including current law, as well as this Guideline, if questions arise. If, after this explanation, the patient refuses to secure or relinquish the firearm, EMS Providers may immediately stop their assessment and refuse transportation until Law Enforcement can intervene.

Patients with Altered Levels of Consciousness

If a firearm is found on an awake patient with an altered level of consciousness, EMS providers should not attempt to have the patient hand over the firearm on their own. EMS providers should not attempt to disarm a patient who they feel would potentially use the firearm against them. Law enforcement should be notified and they should secure the firearm.

Unresponsive Patients

If a firearm is found on an unresponsive patient requiring immediate care, and law enforcement is not on scene, EMS Providers will need to carefully separate the firearm from the patient prior to transport. If the firearm is in a holster, the entire holster should be removed from the patient. If it is physically impossible to remove the holster with the firearm inside, the firearm will need to be removed from the holster if the provider has received proper training to do so. Once removed, the firearm should be secured in appropriate container that houses firearm that will point away from EMS Providers and the patient.

Transporting Family, Friends, etc.

All firearm guidelines also apply to anyone requesting to accompany patient(s) to the hospital. EMS personnel will need to inquire about a concealed firearm prior to transport. If the individual refuses to secure the firearm, they should not be allowed to ride in the ambulance.

Safety

Scene safety remains the top priority for EMS responders. If the EMS Providers feel that there is a valid life threat to them, then retreat to a safe area is indicated. Law Enforcement should be notified and EMS should stage in a safe area until the scene is deemed safe by Law Enforcement.

Notification of the Emergency Department

If a firearm is being transported to the Emergency Department, EMS Providers should advise, during their radio report that a secured firearm is on board. EMS providers should advise the facility ahead of time that a firearm is on board, and request appropriate security or law enforcement personnel to be on hand to secure the firearm upon arrival. Emergency Departments will follow internal policies on having that firearm secured by appropriate Security personnel or Law Enforcement.

Arrival at Hospital

Upon arrival, relinquish the secured firearm to appropriate designee as soon as possible. A firearm should not be left unattended at any time.

AIR AMBULANCE TRANSPORT

(This page adopted from State of TN EMS Protocols)

Request for an Air Ambulance must be in accordance with approved service policy.

A scene flight by air ambulance MAY be indicated IF:

- The level I trauma patient's condition warrants immediate and extreme action **and** the extrication **and/or** transport time is greater than 30 minutes **and** if the patient **is not** in trauma full arrest.
- Transport time is defined as the length of time beginning when the emergency unit would leave the scene transporting until time of arrival at the trauma center.

The on-scene Paramedic or EMS Supervisory Personnel shall have the authority to disregard the response of an air ambulance in accordance with approved service policy.

Additional Criteria:

- Multi-system blunt or penetrating trauma with unstable vital signs
- Greater than 25% TBSA burns
- Paralysis or spinal injury
- Amputation proximal to wrist or ankle
- Flail or crushed chest

Situational Criteria:

- High energy mechanisms
- Prolonged entrapment
- Multiple casualty incident

Patients will be categorized according to the current Tennessee Trauma Destination Determinates.

- **DO NOT** request an air ambulance transport if patient is in traumatic cardiopulmonary arrest. If the patient has no vital signs, they are in trauma full-arrest.
- The Paramedic in charge of the patient shall have the authority **through** the Incident Commander to disregard the response of the air ambulance.
- The Paramedic will coordinate with the Incident Commander to insure the helicopter receives patient information and landing zone location.

NOTE: Medical responsibility will be assumed by the medical flight crew personnel upon arrival at the scene.

The following may impact transport by helicopter:

a. Adults who have traction splint(s) applied
b. Patients over 6'4"
c. Patients whose girth exceeds 27"
d. Any splint or device that exceeds the boundary of the long spine board

SUMNER EMS - USE OF AEROMEDICAL TRANSPORT

- Strong consideration should be used when deciding to facilitate transport using aeromedical services. While teaming with our colleagues from aeromedical services can provide benefits, it may also inadvertently create delay. It is not good practice for an EMS unit to wait on scene for a helicopter when that time frame would also permit for ground transport. Aside from infusing blood products, Sumner County EMS has the same therapeutic capabilities with our protocols and training that can be given by aeromedical crews.

- An appropriate rapid trauma assessment should be done on trauma patients to justify the use of aeromedical transport. This should be compared to the geographical location, expected traffic conditions, and time frame given for aeromedical rendezvous. In many cases, it is best practice to initiate ground transport without delay, especially in the western part of Sumner County. This also applies for high acuity or otherwise unstable medical patients in rural areas.

- If a physician has ordered emergency transfer of a patient from the emergency department, EMS personnel should transport by ground without delay. If aeromedical services are considered, this should be approved by the transferring physician, otherwise this typically causes unnecessary delay. When aeromedical services have been arranged by the hospital personnel, EMS will continue to provide transport between the airport and hospital.

- TIKI MAST is not routinely used for individual scene or patient needs. This resource provides medical / evac in disaster situations and requesting this resource comes from State EMS. For routine operations requiring aeromedical support, services such as LifeFlight, Air-Evac, etc. should be contacted.

- Personnel should be advised that if using TIKI MAST on a disaster response/MCI operation, an attending paramedic /AEMT will be needed to accompany the patient in flight. Also, certain medical equipment will have to be sent as well depending on patient condition. These include:
    - Cardiac Monitor
    - Advanced Airway Equipment
    - Controlled Substances
    - Other specialized medications

(A) SUMNER COUNTY EMS TRANSPORT SERVICE AREA:

Our service area is all hospital emergency departments in Sumner County and adjacent counties. That may be altered with the order of an Emergency Physician needing to transfer a patient for a specialty intervention. In such case, any direct order from that physician to transport a patient needs to be carried out without delay.

(B) BASIC LIFE SUPPORT TRANSPORT GUIDELINE

This reference is directed to interfacility or discharge transports of patients where there may be concern over the physiological stability of the patient. This does not mandate that personnel cannot or should not use sound clinical judgment to determine stability of the patient. Furthermore, on-hand or on-line medical control through a physician may override this.

Vital Signs Parameters

Many of the patients transported by Sumner EMS are often unstable, or their condition is subject to change at any given time. These patients fall under the need for Advanced Life Support personnel to transport. For non-emergency/BLS transports, the following assessment parameters should be used as a guide to determine with immediate intervention or consult by the physician attending to the patient is suggested.

Consult with the physician attending to the patient prior to transporting if you have:

- Blood Pressure: >180 systolic
- Pulse: <60 and symptomatic, > 120 in adults, >150 in children, or > 180 in infants
- **Any question of airway stability or respiratory compromise**
- Blood Glucose: < 50, or > 400 mg/dl **and symptomatic**

- **A Basic Life Support unit should not await ALS intercept when in close proximity to a hospital / emergency room.** It is acceptable to initiate ALS intercept, otherwise a BLS crew should NOT delay transport to await an ALS unit to arrive.

- As patient's condition presents, BLS personnel may initiate all appropriate therapies per protocol/standing orders up to their scope of practice only.

- A report shall be called to the receiving facility as soon as possible.

- If On-Line Medical Control is required, the attending AEMT shall notify the physician that the unit is BLS before consulting for further orders. This lets the physician be aware of the capabilities during transport ahead of further considerations into patient treatments.

(A) PATIENT'S RIGHT TO CHOSE DESTINATION:

- Regardless of insurance, established physician or not, and so forth, the patient, guardian, or POA has the right to chose what hospital we transport to. We should function as a patient care advocate and let a patient know if a facility they chose is on diversion, however if they continue to adamantly request that destination, then that is where they should go.

- There have been some transports where patients requested transport to a Nashville area facility and crew members have advised patient's or families that due to diversion, EMS could not go there. This is not true. "Diversion" should not be used as justification to transport locally when a patient is requesting transport to a Nashville hospital.

(B) WHEN EMS MAY OVERRIDE THE PATIENT'S OR FAMILY'S CHOICE OF DESTINATION:

Patient Condition -

- When a patient is unstable the EMS crew may feel it is justified to go to the closest **appropriate** facility. Your documentation would need to reflect your justification for making that choice based on the condition of the patient.

Inclement Weather / Safety Issues -

- When transport dangers are increased due to weather conditions, EMS personnel should transport to the closest appropriate facility. We wouldn't want to transport to one hospital, only to do a continuity of care transfer later, possibly after road conditions had worsened. It would be safest for everyone involved to transport the patient one time to the facility that can ultimately meet their needs. You can always contact on-line medical control if you are unsure.

(C) CHOICE OF DESTINATION AGAINST MEDICAL ADVICE

- We do not want patients to refuse transport because of transport destination issues. If a patient is well oriented, and has stable vital signs that indicate physiologic stability, they may still chose to be transported to a farther away hospital even when it is against medical advice. Document these situations appropriately, contact a supervisor as needed, but know that we must function not only as good clinicians, but also as good customer service representatives. We must avoid situations where a ***symptomatic*** patient refuses our care, especially over transport destination liberties.

(D) DEFINITION OF "CLOSEST APPROPRIATE FACILITY" :

- Closest appropriate facility references the hospital closest to your location that can provide what interventions your patient will need. For example, if the patient is unstable and requiring immediate physician care, then the closest appropriate facility would be any hospital emergency department. If the patient was stable, however suffering a stroke or AMI, then they need to be transported to a facility that can provide rapid CT or cath lab (PCI) intervention. This is the same for trauma, OB care, etc.. This is an overall judgment call on the paramedic treating the patient based on the patient's condition.

(A) WHEN EMS MUST HONOR FACILITY DIVERSION STATUS:

- If a hospital is on "CT diversion", then that means they cannot effectively assess and/or treat a CVA patient there without CT scanner capability. Those patients would for sure need to be transported elsewhere. If you are unsure, it may be a good idea to call ahead and consult with on-line medical control to make sure the physician(s) at the hospital you are transporting to can manage the patient at that facility.

- Any time a physician gives the order to divert to another facility, EMS must honor that order. Document the name of the physician in the report.

- If a facility is on diversion due to "decon", it is possible that they have experienced a biological threat or hazardous materials incident. In such case, they are on definitive diversion and you absolutely should transport elsewhere.

** Veterans Administration (VA) Hospitals may divert patients if they cannot be found in their records. When calling report to these facilities they often ask for the patients initials and last four digits of the social security number to verify that they will accept that patient. Providing this information is NOT prohibited per HIPPA laws. This should be done in advance whenever possible.**

(B) WHEN EMS CAN CONTINUE TO A FACILITY ON "DIVERSION" :

- EMS should relay to the patient when a facility is on "E.D." diversion due to overcrowding. The patient may still be transported there if they continue to make that choice when stable. If a facility is on "med-surg" diversion, it means that the surgical capabilities or admission rooms for post-op care are full and they may require transfer to another facility if surgery is needed. Again, the patient may request transport to the initial choice hospital against medical advice. "Med-surg" diversion will not apply to all patients, use good judgment and consult on-line medical control as needed.

- If the patient is stable and understands the conditions of diversion, yet they still request that facility, EMS should provide transport to that facility. If any problems are encountered due to bringing a patient to a facility in this situation, those should be documented separate from the patient care report and notify your supervisor as soon as possible.

Diversion does not routinely mean that patients cannot be transported to certain facilities. Even complete diversion does not mandate that EMS cannot transport patients do a choice destination, or if that destination is the closest appropriate facility.

IF THERE ARE MECHANICAL ISSUES DURING TRANSPORT

- Safety of personnel and the patient is first and foremost. If a unit has mechanical issues and goes stationary on the side of the roadway, personnel should carefully maneuver the unit to the right side of the roadway. Warning lights should be activated if functioning. If personnel need to exit the unit, traffic safety vests should be worn.

- Local law enforcement or TDOT Help Units can be summoned through our dispatch to respond to the location to help divert traffic if needed.

- Response should be based on the condition of the patient and traffic dangers that are imposed if the initial unit was forced to go stationary in a dangerous traffic location. In this case, the back-up unit should respond without delay. This may need to be definitively relayed when requesting aid from other services.

- Personnel and supervisors should make all attempts to avoid swapping into another unit on the side of the public roadway. The unit should be re-located to a safe position away from moving traffic if possible. This applies when moving the patient into another ambulance or if putting a unit back in service by swapping into a reserve.

TRANSPORT OF PATIENTS KNOWN TO ABUSE THE EMS SYSTEM

Whereas our goal is to provide excellence in care and good customer services to persons requesting our services, there are individuals in every community who develop a redundant reliance on the EMS system. Issues known to be associated with abuse and/or overuse of the EMS system quickly consume 911 EMS resources. Developed EMS systems must preserve and manage resources such as 911 ALS units for everyone in the community. In order to best manage resources, and stay ready to respond to life threatening medical emergencies; Sumner EMS shall not make it routine practice to accommodate persons requesting transport to any facility beyond LOCAL Emergency Departments for:

- complaints related to pharmaceutical dependency.
- patients who are known to EMS, with repeat 911 response for non-emergency complaints of on-going conditions (unless ordered by a physician)
- on-going, non-acute psychiatric illness / disturbance (patients known to EMS)

It is determined that these patients should have an established physician to address their ongoing healthcare needs, especially if their condition is so acute that the patient must request EMS on a regular basis. The patient should be encouraged to establish care through a primary care physician. EMS personnel should transport to local facilities only in these cases.

NOTE: If patients who fall within these circumstances indeed show signs of acute medical necessity, such as in trauma, stroke, MI cases, then they shall be treated and transported without delay according to the appropriate protocol.

If no acute medical emergency potential exists, yet the patient still requests transport, a BLS unit may respond to the call and facilitate transport. Sound judgment is required in this decision.

---Information regarding persons suspected of overusing / abusing the EMS system should be relayed through the chain of command up to the Office of Clinical Issues for follow up---

- **At any time that a patient becomes unstable and requires immediate physician care, EMS should proceed to the closest designated hospital emergency department.**

- **Otherwise, attempts should be made to accommodate the transportation requests of our patients while using sound judgment that reflects best clinical standards and good customer service.**

EMS TRANSPORT OF SERVICE ANIMALS WITH PATIENTS

This policy is intended to provide information to EMS personnel about the rights of patients and their service animals as well as several of the laws concerning service animals under the Americans with Disabilities Act (ADA). This policy will assist in understanding the rights of patients who utilize service dogs/animals, how these animals should be transported and that these animals have rights under the law that are not granted to domestic pets.

Definitions of Service Animals

The U.S. Department of Justice defines any guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability. If the animal meets this definition, it is considered a service animal under the Americans with Disabilities Act (ADA) regardless of whether it has been licensed or certified by a state or local government.

"Guide dog" means any dog that is trained to aid a person who is blind and is actually used for such purpose, or any dog owned by a recognized guide dog training center located within the state during the period such dog is being trained or bred for such purpose.

"Service dog" means any dog that has been or is being individually trained to do work or perform tasks for the benefit of a person with a disability, provided that the dog is or will be owned by such person or that person's parent, guardian or other legal representative

"Person with a disability" as defined by Federal laws, means "Any **person** who has a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment."

The EMS provider may ask the following types of questions when presented with a service animal:

- "Is this a service dog?" or "Does your animal have legal allowances?"
- "Is the service animal required because of a disability?"

The EMS provider may NOT ask about the extent of the patient's disability except as it relates to patient care.

Transporting the Patient and the Service Animal

When transporting a patient with a service animal, every effort should be made to do so in a safe manner for the patient, the animal and the crew members. If possible, the animal should be secured in some manner in order to prevent injury to either the animal or the crew during transport. Safe transport devises may include:

- Crates, cages, specialty carriers.
- Seatbelts or passenger restraints using a specialized harness or seat belt attachments.
- In certain situations it may not be possible for the animal to be transported with the patient. In that case every effort should be made to insure safe care and transportation of the animal by alternative means (animal control personnel, family members, etc).
- EMS should notify the receiving facility of the presence of a service animal accompanying the patient. Additional Information and Resources Regardless of the purpose of the animal, if the animal is a potential threat to health or safety of anyone involved in response, the animal may be excluded from transport.

The following sites offer resources and Frequently Asked Questions (FAQ's) with regard to Service Animals:
http://www.usdoj.gov/crt/ada/archive/qasrvc.htm/ http://www.deltasociety.org/
http://www.aspca.org/site/PageServer http://www.hsus.org/ http://www.seeingeye.org/
http://www.guidingeyes.org

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(A) HEALTH CARE POWER OF ATTORNEYS

Patients who have a Health Care Power of Attorney retain the right to make healthcare decisions as long as they are mentally capable of doing so. No treatment can be provided or withdrawn against the patient's will unless they become mentally incapable of making decisions.

(B) EMANCIPATED MINORS

Any non-emancipated minor who is between their sixteenth and eighteenth birthday may consent to health services, but may not refuse. A minor who is married, pregnant (or has been pregnant), or independently living away from home may refuse treatment and/or transport.
Refusals of care and/or transport should be well documented in the patient care report (PCR).

DNR, POST, and Advanced Directives

Policy:

Any patient presenting to any component of the EMS system with a completed Tennessee ***Do Not Resuscitate*** **(DNR)** form shall have the form honored. Treatment will be limited as documented on the DNR form. A living will or other legal document that identifies the patient's desire to withhold CPR or other medical care should be provided in the official forms from the State of Tennessee, otherwise EMS does not have standing orders to honor the document. These official documents for this purpose should be arranged when possible in consultation with the patient's family and personal physician.

Purpose:

To honor the terminal wishes of the patient and to prevent the initiation of unwanted resuscitation.

Procedure:

1. When confronted with a cardiac arrest patient, the following conditions must be present in order to honor the DNR request and withhold CPR and ALS therapy:
    a. The form(s) must be a Tennessee DNR form , or DNR box is checked in section A of the POST form.
    b. The effective date and expiration date must be completed and current.
    c. The DNR form must be signed by a physician, physician's assistant, or nurse practitioner.
2. A valid DNR form may be overridden by the request of the patient, the guardian of the patient or an on-scene physician.
3. If the patient or anyone associated with the patient requests that a TN DNR form not be honored, EMS personnel should contact supervisors to obtain assistance and direction.
4. When confronted with a seriously ill patient who is not in cardiac arrest and has a POST form, the **POST form Section B** shall be utilized as follows:
    a. Full Scope of Treatment box is checked: Use all appropriate measures included in Sumner County EMS protocols to stabilize/resuscitate the patient.
    b. Limited Scope of Treatment box is checked: The maximum airway intervention is non-rebreather mask and airway suctioning. All appropriate IV medications may be utilized. No electrical therapies are to be provided.
    c. Comfort Measures box is checked: The maximum airway intervention is non-rebreather mask and airway suctioning. IV pain medications may be administered. Medical Control may be contacted to reference appropriate treatment.
5. If family members are present and ask that resuscitative efforts be withheld in the absence of an advanced directive, determine their relationship to the patient and the patient's history. If the patient has an obvious life-limiting illness (terminal cancer, advanced neurological disease, advanced age, etc.), resuscitative efforts may be withheld. If there is no obvious life-limiting illness, begin resuscitation based on appropriate protocol(s) and contact Medical Control for further guidance.
6. Living wills or other documents indicating the patient's desire to withhold CPR or other medical care may be honored only in consultation with the patient's family and Medical Control approval to not resuscitate.
7. **When in doubt – contact supervisors immediately**. On-line medical control may be consulted for decisions regarding medical aspects of a pending resuscitation, however they are not responsible to provide legal consultation toward certain medical-legal aspects of documentation, family disagreement, or other legalities.

Resuscitative Measures to be withheld:

- CPR
- Advanced airway management to include intubation
- Artificial ventilations
- Defibrillation
- Cardiac resuscitation medications (Epinephrine, etc.)

Approved procedures include:

- Suctioning
- Basic Cardiac Monitoring
- Oxygen and Basic Airway (OPA, NPA)
- CPAP
- Control Bleeding
- Comfort Care
- Non-Cardiac resuscitation medications
- Pain Management

POST form 1, left blank intentionally

Directions for use of TN POST form, left blank intentionally

COMMUNICATING DEATH WITH FAMILY

Policy:

To aid in the notification and grieving process for family and friends after the immediate death of a loved one.

Purpose:

1. Death notification can be very complex and will have lasting impact on family and friends. Understanding the basics of human emotion and the normal reactions to traumatic events can help guide a proper notification.
2. Everyone reacts differently to death notifications; some will appear catatonic with little to no outward emotion while others will become angry and irrational.
3. The five basic stages of grief are:
    1. Denial and isolation
    2. Anger
    3. Bargaining
    4. Depression
    5. Acceptance
4. **In the pre-hospital environment, it is likely that family will express all five stages of grief rapidly and while EMS is on-scene**.
5. Each individual processes a death notification in their own unique manner. Be patient and courteous and allow the family member to find peace in their own way.

Procedure:

1. Delivery matters:
    a. Introduce yourself by name and get on eye level with the family member.
    b. Confirm the identity and relationship of the family member.
    c. Use a very simple one line sentence to break the news, “I am very sorry to tell you but (use the victim’s name) has died. Do not use “passed”, “expired”, or “moved on”. Also, refrain from referring to the body as a victim, patient, son, etc.
    d. Immediately inform the family member that they will be helped through the entire process.
    e. Pause and allow the family member time to process the information and ask questions.
    f. Demonstrate empathy and understanding.
    g. Ask if other family members or friends should be notified.
2. **Statements to <u>avoid:</u>**
    a. I know how you feel.
    b. You need to be strong.
    c. Calm down.
    d. God must have needed him/her more than you.
    e. Now that you know, I need to know what funeral home you would like.
    f. It could have been worse.
3. Helpful Statements:
    a. I am sorry.
    b. This is harder than most people think.
    c. Is there anyone I can contact for you?
    d. I wish I could give you an answer that could help, but I just cannot.
    e. I can't imagine how you must feel, and I am willing to do what I can to help.
4. Listen; allow the family to speak and grieve. Many times they just want to be heard.

FIREFIGHTER REHABILITATION

Policy:

Upon arrival on the scene of a working fire, EMS personnel shall report to the Incident Commander and prepare to provide medical assessment, necessary treatments, and be ready for transport if needed.

Purpose:

To provide parameters for normal vital signs and Identify individuals requiring treatment and transport.

Procedure:

1. If safe to do so, position the EMS cot with ALS bag and cardiac monitor sideways in front of the primary pumper apparatus. Notify command of your location and try to establish communications.
2. As firefighter's exit the structure for rehab needs, encourage the removal of all PPE (including bunker pants), rest, cooling, and oral hydration.
3. Assess pulse rate. If greater than 85 percent maximum for age (see note below) perform orthostatic vitals. If pulse rate increases greater than 20 bpm or a systolic B/P drop more than 20 strongly suggest immediate IV hydration and transport.
4. **Assess firefighters' exhaled CO2 levels, especially if they have depleted 2 or more SCBA bottles.** This may pose increased risks of re-breathing their own CO2 during high CO2 output due to increased aerobic metabolism. ***Any ETCO2 less than 35 mmHg or over 45 mmHg suggests risks of anoxia! This should be considered abnormal and emergency transport should be made.*** This can be done by allowing the firefighter to exhale through a mainstream capnography device, or if supplemental O2 is needed, sampling may be acquired through a side stream ETCO2 nasal cannula.
5. Assessment of vital signs after the responder has rested for 10 minutes after their last exertion. Abnormal vital signs include:
    1. Blood pressure: systolic greater than 200 or diastolic greater than 110.
    2. Heart rate greater than 110.
    3. Respirations less than 8 or greater than 40 per minute.
    4. Temperature greater than 101.
    5. Pulse oximetry less than 90%.
    6. CO greater than 10%.
6. If any abnormal vital signs, strongly suggest rest, rehydration, and active cooling. Re-evaluate in 10 minutes and strongly suggest transport with no improvement in total rehab time of 30 minutes. Report all abnormal vital signs to the on-scene fire incident commander or rehab officer.
7. Fire personnel should not be medically cleared to return to full duty with abnormal vital signs.
8. Any person with abnormal vital signs who refuse intervention or return to full duty against medical advice will sign a refusal.
9. Transport will be encouraged automatically for the following:
    a. Chest pain.
    b. Shortness of breath unresolved by 10 minutes of high flow O_2.
    c. Heart rhythm other than normal sinus or sinus tach.
    d. Syncope, disorientation, or confusion.
    e. Abnormal vital signs include:
    f. Vital signs that have not returned to normal limits after 30 minutes of rehabilitation.
    g. Inability to hold fluids down or vomiting.

NFPA Age-Predicted 85% maximum heart rate

Age	85 Percent
•20-25	170
•25-30	165
•30-35	160
•35-40	155
•40-45	152
•45-50	148
•50-55	140
•55-60	136
•60-65	132

INFANT ABANDONMENT

Policy:

- The Tennessee Safe Haven law allows mothers of newborns to surrender unharmed babies to designated facilities within 72 hours of birth without fear of being prosecuted. As long as the baby is unharmed and the child is surrendered within 72 hours of birth, the mother -- or parents -- will not be prosecuted and is assured of complete confidentiality.
- The law was enacted to reduce the number of unsafe abandonment of babies.
- As of April 2015, 80 children have been safely surrendered in Tennessee since the law took effect in 2001.

Note: *Sumner County EMS stations should not be listed as, or considered as, "Safe Havens" for drop off points of abandoned infants. This is only due to there being no guarantee of personnel being at the station, and likely being on a call... which would leave an infant unsheltered and uncared for.*

Purpose:

To provide protection to infants who are placed into the custody of EMS under this law and to provide guidance to personnel when confronted with this issue.

Procedure:

IF an infant is left at an EMS station (we are not acceptable Safe Haven locations due to no guarantee of personnel being at the station).

1. Follow the **General Patient Care Protocols / Pediatric General Guidelines** as needed.
2. Follow the **Neonatal Resuscitation Protocol** as appropriate.
3. *Initiate other treatment protocols as appropriate.*
4. Keep infant warm.
5. Ensure someone has called (or will call) local Department of Social Services before departing the ER
6. Transport infant to closest appropriate facility (Peds hospitals have social workers on staff)
7. Document protocols, procedures, and agency notifications in the patient care report (PCR).
8. Attempt to obtain the following:
    a. Medical information about the baby's parents.
    b. If possible, name of baby's parents (the person leaving the child does not have to reveal his or her identity).
    c. Information about the birth.

The Department of Children's Services main office is located in downtown Nashville.

UBS Tower, 10th Floor
315 Deaderick Street
Nashville, TN 37243
(615) 741-9701
email: DCS.Custsrv@tn.gov

The Secret Safe Place for Newborns of Tennessee Help Line is: 1-866-699-SAFE.

PATIENTS IN POLICE CUSTODY

Policy:

- For this policy to be used, the patient only needs to be in the care of police and does not have to be under police custody.
- All patients in police custody retain the right to request transport. This should be coordinated with law enforcement.

Purpose:

- To assure the patient receives the appropriate care following encounter with law enforcement.

Procedure:

1. Assess for evidence of traumatic injury or medical illness and follow appropriate protocol.
2. If a Taser has been used, transport to the nearest facility and treat as necessary under trauma care guidelines of "impaled object". EMS is not trained in the removal of taser probes.
3. If a chemical defense spray (FREEZE +P, Mace, Pepper/OC Spray) has been used, irrigate the face and eyes and remove contaminated clothing.
    a. Assess for dyspnea, wheezing and a history of asthma or COPD.
    b. If patient has a history of a reactive airway disease or shows any signs of dyspnea or wheezing, observe and follow the appropriate respiratory protocol as indicated based on clinical assessment findings.
    c. If an asthmatic patient is exposed to pepper spray and released to law enforcement, all parties should be advised to immediately re-contact EMS if wheezing or difficulty breathing occurs.
4. Assess patient for cardiac history, chest pain, or palpitations. If patient shows cardiac related signs or symptoms, follow appropriate cardiac protocol.
5. Continue to observe for agitated delirium syndrome.
    a. Agitated delirium is characterized by marked restlessness, irritability, and/or high fever. Patients exhibiting these signs are at high risk for sudden death and should be transported to hospital by ALS personnel.
6. If restraints are necessary, follow **Behavioral Emergencies/Chemical Restraint Protocol**.
    a. ***Patients restrained by law enforcement devices cannot be transported in the ambulance without a law enforcement officer in the patient compartment who is capable of removing the devices. (i.e. - handcuffs)***
7. If there is any doubt about the cause of the patient's alteration in mental status, transport the patient to the hospital for evaluation.
8. Coordinate disposition with patient, law enforcement and if necessary, Medical Control.
9. Never argue with law enforcement. If law enforcement interferes with the patient's ability to refuse or request care, attempt to obtain a signature verifying refusal or request of care and report the incident to a supervisor.

TRAUMA ACTIVATION

Policy:

- EMS providers shall assess each adult and pediatric trauma patient using the following criteria upon contact.
- Once a level 1 or level 2 trauma alert patient is identified in the field through assessment , a crew member must contact the receiving facility as soon as practical and provide a proper report. The words “Trauma Alert ” must be included in the report followed by the level of activation (1 or 2).
- If a patient refuses transport to a specific facility and is deemed a “Trauma Alert” by the EMS professional , documentation should include the reason for alternate transport destination after explaining the risk of “life and limb” to the patient. (The patient must be well oriented at the time).
- Upon arrival in the Trauma room EMS personnel will give a brief report to the trauma team.

Purpose:

- To ensure the patient receives the appropriate care following traumatic injuries .

Trauma Criteria Level 1:

A Level 1 (Full) Alert should be activated on any patient meeting one or more of the following criteria:

1. Glasgow coma score (GCS) ≤ 1 1
2. Injury with associated Tachycardia and **poor perfusion**
3. Systolic BP < 90 or for PEDS ≤ 70 + 2x (age in years)
4. Respiratory rate <10 or >29 or when the patient is in respiratory distress, has had a pleural decompression or is intubated .
5. Penetrating injury /wound to head, neck, torso, or extremities proximal to the elbow or knee
6. Flail chest
7. All **shotgun** wounds
8. Pelvic fracture to include hip dislocation with significant mechanism ofinjury
9. Paralysis related to trauma
10. Crushed, de -gloving, mangled, or pulseless extremity
11. Thermal injuries including 2 nd or 3rd degree burns ≥ 20% TBSA
12. Electrocution with high voltage: ≥ 220 volts or > than household current
13. Active bleeding requiring a tourniquet or continuous pressure to control
14. Discretion of any trauma team member

Evidence of Poor Perfusion

- Skin pallor, cool extremities
- Weak, distal pulses
- Cyanosis/mottling, etc.

TRAUMA ACTIVATION (CONTINUED)

Trauma Criteria Level 2:

A Level 2 (Partial) Alert should be activated on any patient meeting one or more of the following criteria after a traumatic event:

1. GCS 12 or 13
2. Ejection from automobile
3. Death of a person in the same passenger compartment
4. Falls > 15 feet or > 10 feet (for pediatrics)
5. Vehicle rollover with altered GCS
6. High-speed auto crash (collisions with speed 35 mph or greater) **with high index of suspicion**.
7. Auto-pedestrian/auto-bicycle injury with significant (5mph) impact
8. Pedestrian thrown or run over
9. Motorcycle crash > 20 mph or Crash with separation of rider from bike
10. Open or multiple fractures, excluding hands or feet
11. Thermal injuries including 2nd or 3rd burns between 10% to 20% BSA
12. Significant neurological deficit
13. Pregnancy > 20 weeks with significant mechanism of injury
14. Discretion of any trauma team member

High Index of Suspicion / Factors to Consider (For activation or upgrade in activation)

- Age > 55 years with significant mechanism of injury
- Extrication time > 20 minutes
- Cardiac or respiratory disease
- Insulin dependent diabetes
- Cirrhosis
- Morbid obesity
- Pregnancy
- Immunosuppressed patients
- Patient with bleeding disorder
- Patients on anticoagulants

AMBULANCE / CREW DECONTAMINATION GUIDELINE

Guideline:

Personnel should be familiar with the Standard Operating Guidelines (SOGs) regarding the reporting of possible exposures. Supervisors shall be contacted as soon as possible to report possible exposures or to request additional time for decontamination procedures beyond routine call types.

Purpose:

- To emphasize the use of current SOG's and the SCEMS Exposure Control Plan
- To identify a consistent process for allowing adequate time to effectively decontaminate personnel and equipment

Procedure:

In regards to call types where heavy soilage or exposure is a concern, the following process should be followed:

- Contact the on-duty supervisor to notify them of the situation.
- If there are any injuries or medical complaints of EMS personnel, any decontamination and/or treatment should be acquired as soon as possible upon arrival and delivery of the patient at the hospital.
- The receiving facility should be notified of the need for decontamination, isolation, and/or potential treatment of EMS personnel in addition to the patient report.
- EMS personnel should NOT wash out heavy soilage from the rear compartments of the ambulance in the hospital ambulance bays. Decontamination of heavily soiled rear compartments shall be done at EMS stations.
- Heavy soilage such as blood, emesis, etc should be wiped or removed as best possible with absorbent materials (towels, etc) then placed in a red bio-hazard bag if heavily soiled / saturated.
- After the bulk of heavy soilage has been properly disposed of, an appropriate germicidal disinfectant shall be applied. If additional cleaning is required with a hose to spray out the rear floors, etc, then apply disinfectant prior to flushing the area with a hose.
- If the Ultraviolet Light (UVL) is needed to properly disinfect the ambulance and equipment, supervisors should be notified and arrangements will be made to accomplish this task while minimizing risks of cross contamination.
- Appropriate time shall be allotted to afford decontamination of personnel, AND proper cleaning of the ambulance upon notification of the supervisor.
- Follow the SCEMS Exposure Control Plan and contact the Exposure Control Officer as needed.