TFRD

MEDIC UNIT

OPERATIONS

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Tab 100 Medic Transport Operations N-4 08/2018

Toledo Fire & Rescue Department has a **Driving Procedure** (C Manual - Emergency Procedures, C-26) and a **Backing of Apparatus Procedure** (B Manual - Non-Emergency Procedures, B-2). These procedures shall be followed at all times when not transporting a patient. However, while transporting a patient, following all criteria in these procedures may not be possible. Therefore, every effort shall be made as feasibly as possible to adhere to these policies.

1. All members shall have a valid driver's license.

2. Drivers of all vehicles when not responding to an emergency shall comply with all state traffic regulations.

3. All members shall be seated and wear seat belts while vehicles are in motion. During transport, the EMT delivering patient care in the back of the medic transport may encounter situations requiring him/her to be unbuckled. The unbuckled EMT should complete the necessary task(s) as efficiently as possible. Immediately upon completion of the task(s) the EMT shall reapply his/her seat belt. This provision **does not** relieve the driver from wearing his/her seat belt at all times while the medic transport is in motion.

4. A driver of any emergency vehicle when responding to an emergency upon approaching a red or stop signal, or any stop sign, shall slow down as necessary for safety to traffic, but may proceed cautiously past such red or stop sign or signal with due regard for the safety of all persons using the street or highway. (O.R.C. - 4511.03)

5. O.R.C. 4511.24 states that "speed limits do not apply to emergency or public safety vehicles when they are responding to emergency calls and are equipped with and operating flashing, oscillating or rotating lights, and sound audible signals by bell, whistle or siren." Departmental policy requires drivers not to exceed 10 mph over the posted limit. (School zones – no more than 20 mph during restricted hours.)

NOTE: This section does not relieve the driver from the duty to drive with due regard for the safety for all persons using the street or highway.

During Code-3 response (emergency lights and siren operating), a driver shall operate the vehicle with **due regard for safety**. Slower response speeds shall be affected by factors including, but not limited to:

- **a.** Slippery/wet roads
- **b.** Inclement weather
- **c.** Poor visibility
- **d.** Heavy or congested traffic conditions
- **e.** Road design or characteristics

f. School zones
g. Residential areas

6. Traversing one-way streets opposite of the prescribed direction shall be attempted only when the distance to be traveled is no more than one block or when there is no other direct route available. But, in either case, extreme caution shall be exercised and speed reduced accordingly. (O.R.C. 4511.03)

7. Passing of emergency vehicles when responding to emergencies shall NOT be permitted unless a signal is given by the driver of the lead vehicle.

8. When two emergency units approach an intersection at the same time and there is a traffic signal, the emergency unit with the green light has the right of way. At unmarked intersections, the vehicle on the right has the right of way. If at all in doubt, TFRD drivers shall slow down and give signal to or take signal from the other vehicle.

9. Generally, TFRD apparatus are not designed for off-road use. TFRD department policy prohibits taking vehicles off-road unless the benefit of doing so outweighs the risk of demobilizing the unit. The Incident Commander shall be responsible for this decision.

10. Siren and air horn use shall be restricted to emergency response or where traffic conditions warrant an audible warning to other drivers. They are not to be used frivolously. Decibel levels sirens and air horns produce can cause physical harm to TFRD members and passersby on the street. Members shall exercise discretion in the use of these devices.

Code-2 Response: Medic Transports may be dispatched to a scene Code-2. Response is considered to be immediate without emergency lights and siren operating. All traffic laws must be obeyed just as if operating a private vehicle.

Code-3 Response: Code-3 response (emergency lights and siren operating) **must be made with due regard for safety of all persons**.

Backing at the Hospital: When backing a medic transport at the hospital with a patient onboard, the following guidelines shall be followed:

a. If you can avoid backing, don't back.
b. Never be in a hurry when backing.
c. Do not start to back when unsure of the area.
d. Do not put the vehicle into reverse before coming to a complete stop.
e. Lower the driver's window down completely.
f. Attempt to elicit the services of a spotter to stand behind the vehicle while you are backing.
g. Make visual and verbal contact if someone is behind the vehicle assisting you.

h. The vehicle reverse alarm must be used when backing.

i. The EMT in the back shall open the back doors, step out of the medic transport, and have portable radio on correct channel. This allows the EMT to maintain visual of patient while assisting driver with backing up.

Safe Following Distance: Rear-end collisions are one of the leading causes of accidents. These types of accidents are preventable. There are a number of guidelines which can be followed to avoid this type of accident:

a. Practice the four (4) second rule for following the vehicle ahead. As the vehicle ahead of you passes an object, your vehicle should pass the same object no less than four (4) seconds later.

b. Increase following distances for adverse weather conditions or with a patient on board:

i. Add one (1) second for reduced visibility.
ii. Add one (1) second for having patient on-board.
iii. Add two (2) seconds for snow covered roads.
iv. Add three (3) seconds for ice covered roads.

c. Know the gross vehicle weight of the vehicle and understand the concepts of reaction time and the stopping distance needed at various speeds. Reaction time is the time when a situation arises until the time the operator identifies the hazard and decides on an appropriate response. Stopping distance is the time when the brakes are applied until the time the vehicle comes to a complete stop.

d. Look ahead:

i. Scan ahead of the vehicle so that potential hazards can be identified.
ii. Scan 12-20 seconds ahead.
iii. Maintain an escape route so that hazards identified or unexpected maneuvers by others won't cause you to slam on the brakes.
iv. Ease off the accelerator and cover the brakes if hazards are clearly recognized.
v. Change the pitch of the siren when the vehicle is within 100 feet of the vehicle ahead.
vi. If available, utilize a signal requesting vehicles ahead to pull to the right.

Intersection Crossing: Intersections provide a location for high frequency and severity of accidents. Restricted visibility, assumptions of other driver's actions, and confused or startled drivers are reasons for these accidents. Listed below are special considerations for proceeding through an intersection:

a. Proceeding through a green light:

i. Slow down.
ii. Take foot off accelerator.

iii. Look in all directions. Be aware of oncoming vehicles which may turn in front of you.
iv. Proceed with caution.

b. Proceeding through a yellow or red light:
i. Come to a complete stop.
ii. Establish eye contact with drivers of other vehicles.
iii. Wait for at least two (2) seconds.
iv. Proceed with caution one lane at a time.
v. Make eye contact with any vehicle driver that is approaching. You do not have the right of way. You are asking to have the right of way.

c. Right or left turns across stopped traffic:
i. Come to a complete stop next to vehicle.
ii. Establish eye contact with vehicle's driver.
iii. Beware of vehicles approaching from behind.
iv. Proceed with caution.

d. Special precautions:
i. Be aware of all surroundings as they change rapidly.
ii. Avoid startling motorists.
iii. Do not pass school buses with their red lights and / or stop sign activated.
iv. Obey school zone speed limits.
v. Do not cross double yellow lines.
vi. Use all emergency lights when responding Code-3.
vii. Do not try to outrun trains.
viii. Use varied or different siren tones.
ix. Be courteous and patient.
x. Avoid passing on the right unless as a last resort.
xi. Sirens must be used during Code-3 responses.

Tab 100 Medic Transport Status Times - MDT O-2 08/2018

RCOG Dispatch (Fire dispatch) must be notified of any change in medic transport status (i.e., in-service, out-of-service, out of district, etc.). This notification is necessary to ensure timely emergency response to the citizens of the City of Toledo and to assist dispatchers with system status management should an emergency response be required.

Any medic transport activity, other than an assigned emergency response, must be communicated to Fire Dispatch. Medic transport travel outside of the first due response

district, other than emergency response, shall be coordinated with Fire Dispatch to ensure adequate response coverage within the City of Toledo.

Following is a list of examples intended to provide a guideline for medic transport activity where TFRD EMS Dispatch should be notified:

a. **A medic transport leaves its designated quarters and is "*available on radio*":** Destination, arrival, departure and next destination shall be communicated to Fire Dispatch.

b. **A medic transport is leaving a hospital after transport and not returning to quarters:** Destination, arrival, departure and next destination shall be communicated to Fire Dispatch.

c. **A medic transport is refueling or replenishing oxygen supply at a station other than their assigned quarters:** Destination, arrival, departure and next destination shall be communicated to Fire Dispatch.

d. **Any change in medic transport location that is not initiated by Fire Dispatch:** Destination, arrival, departure and next destination shall be communicated to Fire Dispatch.

Recording Emergency Response Times

Dispatch time: The time a medic transport is dispatched by Fire Dispatch.

Enroute time: The time a medic transport leaves its present location in response to an emergency incident.

Transport time: The time a medic transport leaves the scene and begins transport to a designated emergency department.

Transport Complete time: The time a medic transport arrives at the destination hospital emergency department.

In-Service time: The time a medic transport is available for another emergency response (NOTE: Hospital out-of-service times are limited to 30 minutes unless extraordinary circumstances).

Note: Double check MDT times coincide with ESO times

In Quarters time: The time a medic transport has arrived back at their designated quarters.

A complete list of accurate emergency response times can be accessed from the MDT or by contacting Fire Dispatch at 419-720-0270.

MDT Procedures

1. Incident Processing: Incidents for emergency response will be received via the station base radio/speaker system, or while "on the air," the vehicle mobile radio and mobile data terminal (MDT). Incident information will be displayed on the MDT along with any additional text or premise information.

Medic transports will notify Fire Dispatch of their following status:

~~**F1**~~ – Enroute
~~**F2**~~ – On Scene
~~**F3**~~ – Trans (Transport)
~~**(Pressing this function key requires a specific hospital selection).**~~
Contact LCEMS Dispatch on EMS channel 2 to request a Med-channel with the destination hospital. ~~**Enter the beginning mileage in "tenths" of a mile (i.e. 0.0).**~~
~~**F4**~~ – TransC (Transport Complete)
~~**(The time of transport should be verbalized to TFRD Dispatch by radio). Enter the ending mileage in "tenths" of a mile.**~~

2. In-Service: To place the medic transport back in service from an emergency run, use MDT buttons as communication with Fire Dispatch to give disposition of incident.

~~**F5**~~ – AOR (Available on Radio)
~~Use the F5 function key for returning medic transport "in-service" status following an emergency response.~~

~~**F6**~~ – AIQ (Available in Quarters)
~~**F7** – GD (Give Disposition) – **DO NOT USE** the F7 function key~~

3. Incident Times: Incidents can be viewed by entering the proper commands into the MDT.

~~**F8 –** CAD CMD (CAD Command) – this allows the medic transport to enter commands into the CAD system to view incidents.~~
~~**After receiving the CAD Command line – type in the following commands for incident viewing:**~~

~~**IH** - Incident History of most recent rescue transport activity.~~
~~**UH** - Unit History will display list of incidents for which the rescue transport has been assigned.~~

~~**IH#** – (incident number) – will display specific incidents identified by number.~~

~~4. Messages: Messaging by MDT should not be used for delivery/receipt of "incident information." Pertinent incident information should be voiced by radio communication to TFRD Dispatch or other TFRD units.~~

~~**WHO ALL –** Shows all terminal names in the system.~~
~~**TO/TERMINAL NAME/MESSAGE –** Command to send a message~~

~~5. Other Function Keys:~~

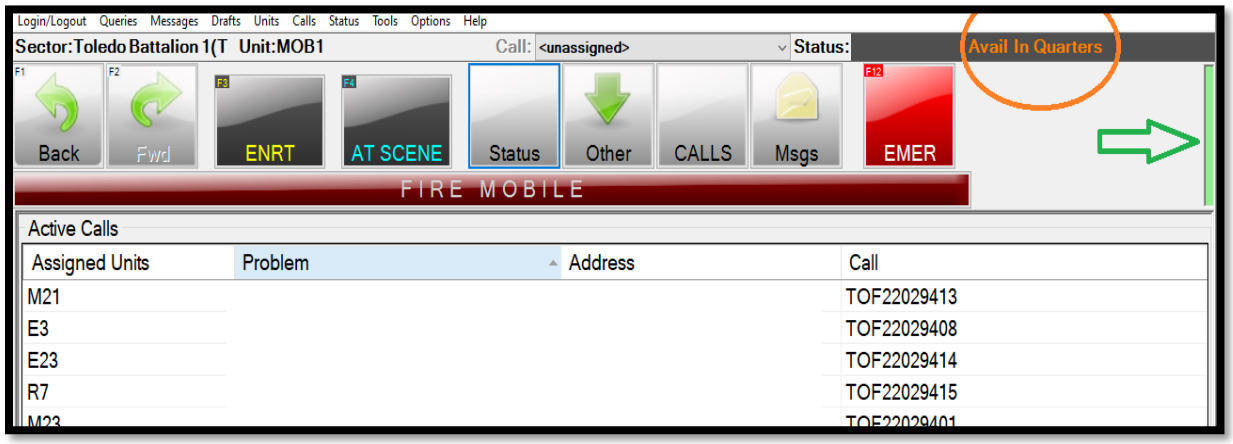
~~**F9 –** Onview **– DO NOT USE**~~
~~**F10** – Chg Pwd – (This function allows individuals to change passwords)~~

If MDT is not functioning, Notify Fire Dispatch immediately (during business hours (0700-1600) contact communications bureau).

Current (4/23)- Methods of Practice.

When you are not driving the medic unit, you are considered to be "writing". While the driver assesses the vehicles status (ie. Tires, fuel/fluid levels, operating lights) the member "writing", will log the crew into the CAD system (VisiNet Mobile) and set the shift into the EHR software (currently: ESO Suite). The images to the right are how you should find the MDT screen at the start of your shift.

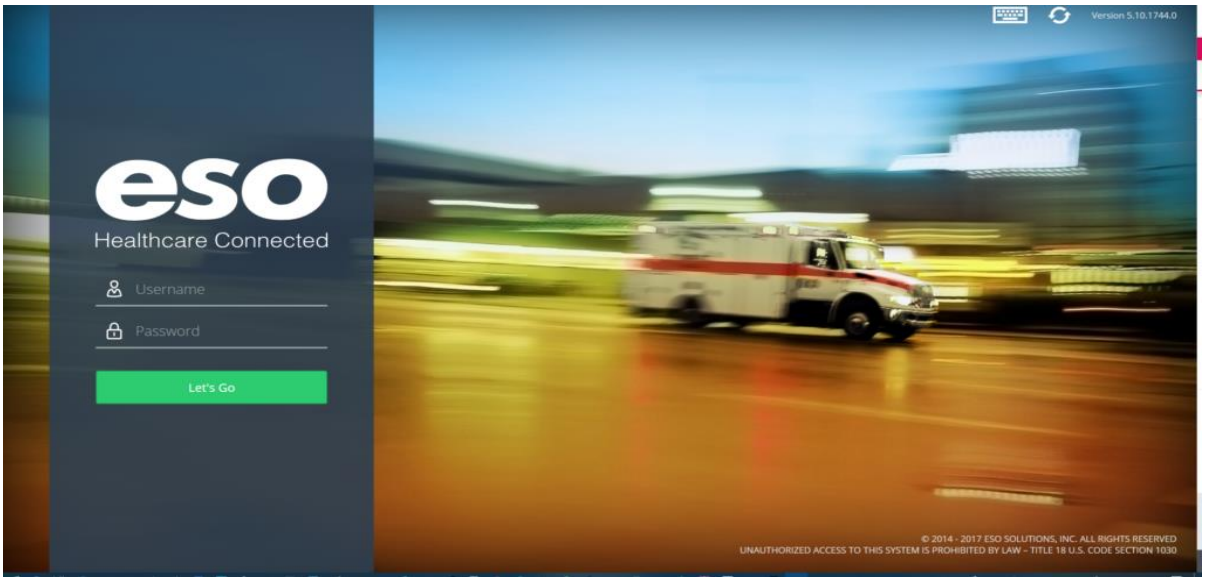
The MDT (VisiNet Mobile)



Status: , Connection: Green/Connected

Available in Quarters

The EHR (ESO)



Username: _____

Password: _____

Agency code: ___tfrdems_____ **(for outside the desktop app)**

***Refresh app once password changed in browser to update on app version.**

STEPS to setting the "SEAT" (aka Lead)

****0700- Immediately following rollcall****

1. Fire Run Ready:

1.1. All gear on rig
1.2. SCBA (0700)
1.3. Portable Radios accounted for

2. Wake Computer:

2.1. Tap- "enter" (on keyboard)
2.2. Username= **MDT**
Password= **pass**

3. Assign Crew (MDT):

3.1. Update if shortcut is Orange
3.2. Tap- "Other" (GREEN DOWN ARROW)
3.3. Tap- "Change Crew"
3.4. ADD members to the window.
3.5. Tap- "submit"

4. Set Shift (ESO):

4.1. Add personal Log-in info then refresh desk top app.
4.2. Tap- "Let's Go"
4.3. Tap- "Set Shift" (information added now will auto populate into the runs that you import from CAD)

Repeat Steps 3 & 4 every time a member is moved from your unit

5. Inventory:

5.1. Account for all equipment
5.2. Inspect all equipment
5.3. Maintain/clean/replace

All Equipment assigned to you during a tour may be required for any operational tactic of duty. It is every individual's responsibility to maintain those resources required to perform said duty at this level of professionalism and civil service

6. Journal:

6.1. Note all required fields
6.2. Note missing/ broken equipment
6.3. Keep full detailed records

liability of missing equipment often falls to the last member(s) whom <u>did not note</u> equipment was misplaced

7. Take Runs:

7.1. Stay Alert
7.2. Do No Harm
7.3. Advocate for the Patient
7.4. Utilize Med control for help
7.5. Document. Document. Document

Repeat Steps 5, 6 & 7 as needed

100-03 Fire Station Journals

I. <u>PURPOSE</u>

A Fire Station Journal is maintained in each fire station to record all specific activities for each unit and personnel assigned to them for any period of time. Any events or occurrences pertaining to Department personnel, property, equipment, or programs, which may need to be referenced in the future, shall be recorded in the Fire Station Journal. The Fire Station Journal should contain the significant details of any entry. A primary benefit of maintaining a Fire Station Journal is a standard communication medium between shifts and companies, where significant occurrences from preceding shifts, etc., can be referenced.

II. <u>GENERAL GUIDELINES</u>

a) Fire Station Journal entries shall be legibly printed in standard journals.

b) All entries shall be made in ink. They shall be made in chronological order, with the time entered in 24- hour notation.

c) **<u>Day and Date</u>**

a. Day and date and headings shall be noted in red ink.
b. Names, ~~watches~~, absences, and other acknowledgements should be noted in black ink.
c. The day, date, and titles shall be entered at the top center of each page. A new page should be utilized for each new date.

d) **Routine Activities**

a. Routine activities shall be noted in black ink.
b. These are to include certain types of routine and non-emergency activity shall be entered in the Fire Station Journal. This includes any repairs, changes of location, or modification to apparatus equipment or facilities, and out-of-service times due to mechanical problems or similar occurrences. Any problems or unusual situations shall also be noted. Such as equipment sent for repair.

e) **Emergency Runs**

a. Emergency runs shall be noted in green ink.
b. The first line of these entries shall include the incident number, dispatch time, In-service time and address.
c. The second line shall designate the hospital transported to and the method of transport.

f) **Fire Runs**

a. Fire runs shall be noted in red ink
b. The first line of these entries shall include the incident number, dispatch time, on-scene time, in-service time, and address.
c. The second line designates type of fire incident (still, regular, or second), owner's name, duties assigned, and equipment used.

g) **Injuries to Fire Department Personnel**

a. Injuries to Fire Department personnel shall be noted in black ink.
b. Any injury sustained by Fire Department personnel shall be completely described in the journal. This shall include time, person injured, a brief description of the injury, and medical treatment necessary.

h) **Accidents involving Fire Department Personnel**

a. Accidents involving Fire Department Personnel shall be noted in black ink.
b. Any accidents involving fire department personnel shall be completely described in the Fire Station Journal. This shall include time, person driving, a brief description of the accident, and any medical treatment necessary. Information should also be obtained about the vehicle or property involved in the accident. This shall include owner's name, address, phone number, license number, and brief description of property damaged.

i) **Unusual Circumstances or Incidents**

a. Unusual circumstances or incidents shall be noted in black ink.
b. The details of any unusual situation such a damage or loss of City equipment, encounters with hostile civilians, or any other similar activities shall be documented in detail in the Fire Journal.

j) **Responsibility**

a. Responsibility notations shall be made in black ink.
b. The responsibility for the Journal maintenance shall rest solely with the company officer. At the conclusion of each shift is the company officer's responsibility to make a Last entry for the shift, noting that the log is complete, followed by his/her signature.

Thursday, November 30, 2005			
Platoon "D" @ 0700		~~Watch~~	Absent/Reason
Lt. Smith		~~0700-100~~	J Donovan- KD
J Case D/E		1100-1500N/W	M Cole- V
M Jones A/O		~~1500-1900~~	
B Kidd		~~1900-2300~~	
ROLL CALL	ok @ 0700	INSP	ok @ 0700
~~GONG~~	ok @ 0700	FUEL	15 gal @ 18's
INV	ok @ 0700	SICK	none @ 0700
SCBA	ok @ 0700	DUTIES	Apparatus floor

NOTE: J Case 5 minutes late this a.m.; this is his first late

NOTE: Missing/broken Vacuum Splint -reported to officer Lt. Smith @time of observation

2.0 #56798 @ 845 I/S 920 1010 Swan Lane
Toledo Hospital via Medic 11

DRILL Mobile data computers

5 #57,689 @ 1045 O/S 1146 I/S 101 Crane Lane
4.0 Regular Alarm- Berri Sanders Owner- Attack- 1 % line & 3 SCBA's

6 #57710 @ 1245 O/S I/S 12571011 Ostrich Lane
1.0 Still Alarm- James Duncan Owner- Illegal burning

NOTE: Driver J. Case struck a fence pole at corner of Cherry and Erie @ 1300
Fence on property of A Smith, 1234 Cherry St., (419) 345-6789
Damage to fence- small dent; No damage to E916. TPD 43 on scene and took report.

Green Airway Bag Inventory

Item	Quantity
Airways-Nasal Pharyngeal 20,22,24,26,28,30,32,34	1 each
Lubricant	5
Airways - Oral-Non-Sterile 50,60,80,90,100,110	1 each
Tongue Depressors	2
V-Vac Adapter	1
V-Vac Disposable Cartridge	1
V-Vac Suction Catheters	2
Emesis Bags	2
Contamination Bags	2
Sharps - Shuttle (Box of 24)	1
Sharps - Quart	1
Masks-N95 S - M - L (TFD use)	4
BP Cuff/Gauge (1 unit) PEDS	1
BP Cuff/Gauge (1 unit) Adult	1
BP Cuff/Gauge (1 unit) XL	1
Stethoscopes	1
Emergency Blankets - Yellow	1
Penlights	2
Scissors - Trauma	1
Mask - Ped	1
Mask - Adult	2
Nasal Cannula - Adult	2
Nasal Cannula - Peds	1
O2 Wrench - plastic	1
Pulse Ox	1
Glucometer - Complete	1
Oxygen “D” Cylinder	1
Aspirin 81 mg multi-dose bottle	1
Oral Glucose 15 gm tube	3

Orange First Aid Box Inventory

Item	Quantity
Tape, Cloth - 2"	1
Tape, Plastic - 2"	1
Tape, Plastic - 1"	1
Antimicrobial Hand Wipes	10
Contamination Bags	2
Sharps - Shuttle	1
Band-aids	12
Burn Sheets	1
Butterflies Med (Box of 100)	12
Butterflies Large (Box of 100)	12
Dressings 4x4 (Box of 25)	12
Emergency Blankets - Yellow	1
Eye Pads	4
Eye Shield - metal	2
Eye Wash	1
Ice Packs	3
O.B. Kit	3
O.B. Pads	1
Penlights	4
Restraints	1
Ring Cutter	2
Ring Cutter Blades	1
Roller Gauze - 2" (Box of 12)	1
Roller Gauze - 4" (Box of 12)	6
Scissors - Trauma	6
Sodium Chloride 250ml Bottle	1
Sting Ease (Box of 10)	1
Trauma Dressing	1
Triangular Bandages	2
Vaseline Dressing	2
Pliers	3

Red C-Collar Bag Inventory

Item	Quantity
Cervical Collar - Infant	1
Cervical Collar - Pediatric	1
Cervical Collar - Neckless	4
Cervical Collar - Short	1
Cervical Collar - Regular	1
Cervical Collar - Tall	1
Tape, Duct (Rolls)	1
Tape, Cloth - 2" (Box of 6)	2
Towel Rolls or equivalent	2
Scissors - Trauma	1
Emergency Blankets - Yellow	1
Cardboard Splint - Large	1
Cardboard Splint - Small	1
Mega Mover	1
Smith cot	1

Radio Methods-

A county dispatch system recently changed TFRD operational procedures. MDT status buttons are encouraged to reduce radio traffic.

Use the following **MDT Status buttons**:

- AIQ
- En-route
- On Scene **(single unit response only)**
- Transport
- Transport complete/miles

Verbalize over **the radio**:

- AOR after completing an incident
- Always verbalize STAGED (violent type codes, fires, etc.)
- Verbalize ON SCENE **for multi-unit response (structure fires, accidents, etc. due to IC needs)**
- Actions not in CAD
- Traveling out of District (shop, supplies, etc.)
- IF your MDT is not functioning contact Fire dispatch Immediately

Radio Channels:

TYPE	ZONE	CHANNEL
ALL (AOR)	1	1
EMS (assigned to run)	1	3
STILL (illegal burn)	1	6
FIRE (fire ground Ops)	1	7
COUNTY (ask for Med)	2	1
MED (hospital)	2	Assigned by Dispatch

When making radio contact-

1. Select the correct zone and channel
2. Listen briefly, as to not interrupt another emergency's traffic
3. Announce- first who you are directly speaking to, then your unit ID.

Example- "Lucas County, Medic Thirteen"

If a longer statement or a question is to follow, allow the dispatcher to focus their attention and return to your traffic and when they are able.

If a short statement, give the whole request at once.

Example- "Lucas County, Medic Thirteen- requesting a med channel to St. Charles"

S.O.A.P.P. – helps you organize your thoughts

- S= subjective – the story of what happened
- O= objective – things you can see and measure (VS, mental status, general impression)
- A= assessment
- P= plan/procedures
- P= prehospital course- how patient responded

Radio Operation Example (w/report):

Dispatched Medic 9 to an ILL from quarters;

Lead hits "Enroute" upon entering rig.

MOVE to **CHAN 3**.

Lead hits "Onscene" while arriving at address- Lead notes a duplex.

"Dispatch, Medic nine, can I have an address check?"

Dispatch- "Medic Nine, 916 ½ 14th Street"

"Ok 916 and a ½ 14th Street"

Medic 9 decides transportation is necessary;

"Dispatch, Medic 9 is transporting to St. V's"

Dispatch- "Ok, M9 Transporting at 0740"

MOVE to **ZONE 2 (toggle B) -CHAN 1-**

"Lucas County, Medic Nine, Med channel to St. V's"

LC- "Speak to V's on 8"

MOVE to **CHAN 8-**

"St. V's, Medic Nine"

St. Vs- "Go ahead Medic Nine"

'St. Vs, we are enroute with a 25-year-old female, who is alert and oriented x4. Her chief complaint is an ingrown toenail that has become infected. Pt states she has been on an antibiotic for a week and it seems to be getting worse. Vitals are as follows..., HR is 106 and regular, BP is 128/78, Respirations are 12 and unlabored. SpO2 is 98% on room air. Pt states she doesn't have any significant medical history nor allergies to medications. Our ETA is about 10 mins, do you have any questions or orders?'

St. V's- "Nope, see you in room 4"

"Ok room 4"

MOVE TO **CHAN 1-**

"Medic Nine's clear the med"

LC- "clear the med 0741"

MOVE to **ZONE 1 (toggle A) -CHAN 3-**

"Medic Nine, Transport Complete"

Dispatch- "Transport complete, 0746"

Once ready to return to service.

Lead hits "Available on Radio"

MOVE to **ZONE 1 (toggle A) -CHAN 1-**

Tab 100 Closest Hospital Transport S-2 08/2018

TFRD has determined that patients requiring medically necessary treatment shall be transported to the nearest appropriate facility. The goal is for TFRD Medic Units to transport medically emergent patients to the appropriate facility where definitive stabilizing care can be rendered in a timelier manner.

If the patient's insurance will only allow that patient to be treated at a particular hospital system (i.e. Mercy or ProMedica) then the patient will be offered transport to the nearest facility within their NETWORK.

In the event that a patient insists on being transported to a hospital that is not the nearest appropriate facility, it shall be explained to them that to maintain their health and safety, we require that they be transported to the nearest hospital. Furthermore, it is likely they will be responsible for the costs because their insurance company will not cover the transportation costs to a facility that is not the closest. If the patient insists, capture an AMA for transport to a facility that is not the nearest to their current location.

Tab 100 Refusal Treatment/Transport - Treat/Release M-2 08/2018

-Refusal of Aid Procedure (C Manual - Emergency Procedures, C-84)

Patients refusing treatment and/or transportation should be made fully aware of the nature of their existing problem and the possible consequences of their refusal. The patient must be considered alert/oriented and not under the influence of alcohol, drugs, or a medical condition that could impede his/her decision-making ability.

If no relatives are present, witness of the refusal by two (2) persons (preferably not the EMS crew) and clear documentation of all information must be contained within the electronic health record (EHR)

The patient who has attempted suicide or who has suicidal ideation may not refuse treatment or transport. Law enforcement assistance and/or transport to the hospital are to be considered if necessary.

Best Practices (AMA)

1. Explain in comprehensible terms the need for treatment and the consequences to the patient of declining treatment, (i.e., worsening condition, seizure, brain damage, stroke, heart attack, death, etc.). Explain to the patient what treatment is to be done per protocol (such as Oxygen, cardiac monitoring, IVs, etc.). Also explain to the patient what treatment may be done at the hospital such as x-rays, ECG, blood test and physician evaluation.

2. If the patient still declines care, meticulously document what you advised the patient and all indications of the patient's alertness, full orientation and capacity to repeat back the explanation given. Have the patient do this in front of another person, preferably in the presence of another family member, police officer, or ambulance crew personnel. Document the results and the name of the person who witnessed the event of the refusal.

3. It may be appropriate to have the patient communicate directly with On-Line Medical Control via radio to reinforce the consequences of the patient's decision.

4. On-Line Medical Control contact must be made while at the scene with the patient. A full radio report including any assessments, vital signs, interventions, and request for refusal must be given to On-Line Medical Control for approval.

5. Before securing a patient's signature, the refusal statement should be read aloud for a complete understanding of the consequences of signing.

6. Upon completion of the incident, an EHR must be completed detailing patient demographic information, response times, assessments, vital signs, interventions and outcome information.

7. Patients / family should be encouraged to call 911 if patient deteriorates; we will return to the scene and provide care.

Patients who accept transport but refuse a procedure we want to perform? Ex.) Cervical collar, 12-lead etc. – Should sign an AMA in these circumstances as well.

Tab 200 Medical Legal Considerations E-1

Consent:

a) A mentally competent patient has the right to consider or refuse treatment and/or transport.

b) Consent is considered “implied” when a patient is unable to consent to treatment due to:
   I. Age
   II. Altered mental status
   III. Medical condition

c) Time delays in obtaining lawful consent from an authorized person should not delay patient treatment in the following areas:
   I. Serious risk of death
   II. Serious impairment of health
   III. Prolongation of pain and/or suffering

d) Medical consent can be given by individuals ≥ 18 years of age.
   A minor (< 18) shall be considered "emancipated" if he or she has married, entered the armed services, becomes employed and self-subsisting, or has become independent from the care and control of his/her parent, guardian, or custodian.

e) If the patient is a minor, consent can be authorized by a:
   I. Competent biological parent
   II. Adopted parent
   III. Legal guardian

Mental Competence:

a) A patient is considered mentally competent if he/she:
   I. Is able to understand the nature and consequences of his/her illness or injury.
   II. Is able to understand the nature and consequences of the proposed treatment.

III. Has sufficient emotional control, judgment and discretion to manage his/her own affairs. Patients should be continually assessed for mental orientation and ability to understand surrounding events. They must also understand the consequences of refusing aide and/or transport and have a plan of action.

b) If a patient is not mentally competent under these guidelines, consent should be obtained from another mentally competent, responsible party such as a:
   I. Spouse
   II. Adult son or daughter
   III. Parent
   IV. Adult brother or sister

c) Legal guardian If a patient is found to be not mentally competent, and efforts to seek out another responsible party have failed, the person should be treated and/or transported to the hospital. Assistance from the local police agency may be required.

Duty to Act:

a) The prehospital care provider has an obligation to treat a patient in accordance with the standard of care expected from other care providers of the same training and skill level. If the provider does not act in accordance with accepted standards of care, and the patient suffers injury, the provider may be liable for negligence.

b) Once treatment has been rendered, the prehospital care provider has a duty to care or the patient until care can be transferred to a competent health care provider who accepts responsibility for the patient.

Special Considerations:

a) Failure to treat someone who needs care is a far "riskier" course than to treat in good faith with less than full legal permission. Do not let fear of legal consequences keep you from rendering such responsible and

competent care as your patient has a right to expect from your medical training.

The best defense against any legal question of consent, competence, or need for care is a well-documented emergency medical incident report (EMIR). Your documented account of patient assessment and care rendered will be invaluable if legal questions are raised

EMS Scope of Practice

The EMS provider is expected to follow local protocols regarding the overall evaluation, treatment, and transportation of this type of prehospital patient requiring EMS service. It applies to EMS provider situations where alternative transportation and care is not available or practical (prehospital, "911 scene response", or threat to a patient's life secondary to a declared disaster or emergency). It implies that the most appropriate and available level of EMS provider will respond to the request for EMS service in the prehospital setting or for emergent interfacility transfer following a declaration of a disaster or an emergency. It also implies that the patient requires the pre-existing physician-ordered medical device or drug administration and it is not feasible or appropriate to transport the patient without the pre-existing MDDA.

All emergency medical technicians (EMT's), advanced emergency medical technicians and paramedics that utilize this protocol will remain within the scope of practice for the state of Ohio as the standard. If during any point that the scope of practice changes for Emergency Medical Service providers then they will adhere to that new scope of practice. **Note: EMS Medical Directors are not permitted to expand the scope of practice for EMS providers, but may provide clarifications or limitations on services that are permitted.** Toledo Fire & Rescue Department (TFRD) EMTs are to adhere to TFRD BLS protocols.

Toledo Fire & Rescue Department BLS Protocols
Introduction and Foundations of Practice

This document describes the methods by which Toledo Fire & Rescue Department continues to provide the highest quality pre-hospital patient care. Evidence-based guidelines have been incorporated with historically proven practices to produce this document. While it is impossible to address every possible variation of disease or traumatic injury, these policies, procedures, and protocols, do provide a foundation for treating the vast majority of patients encountered in the field. Education, experience and clinical judgment will assist us as we strive to provide the highest quality pre-hospital patient care. On-Line Medical Control is available for those patient presentations that do not fall within the scope of the document.

CHEAT SHEET

	LOW			HIGH
Blood Pressure	**Systolic 90**			**Diastolic 130**
Blood Sugar	**60**			**500**
Carb. Monoxide	**3%**	**9%**	**10-19%**	**≥19%**
Capnography	**35**			**45**
Pulse Ox	**85%**	**85-90%**	**90-95%**	**95-100%**

1. BLS TAB 900 MEDICAL PROTOCOLS
    a. Section N – **HYPERTENSIVE CRISIS**
        i. Sustained or rapid rise **DIASTOLIC** pressure above **130 mmHg**

2. BLS TAB 900 MEDICAL PROTOCOLS
    a. Section P – **HYPOTENSION** (Non-Trauma)
        i. **SYSTOLIC** blood pressure below **90mmHg**.

3. BLS TAB 900 PROTOCOLS
    a. Section ZA – **ADULT HYPO – HYPERGLYCEMIA**
        i. **Hypo**: Blood sugar < **60 mg/dl**
        ii. **Hyper**: Blood sugar > **500 mg/dl**

4. BLS TAB 900 PROTOCOLS
    a. Section H - **CARBON MONOXIDE POISONING/MONITORING**
        i. No Treatment:_____**3%**
        ii. Treatment, transport pt's choice:_____**9%**
        iii. Treatment, transport closest:_____**10-19%**
        iv. Treatment, LS transport:_____**≥19%**

5. BLS TAB 500 MEDICAL PROCEDURES & EQUIPMENT
    a. Section F – **CAPNOGRAPHY ($EtCO_2$ MONITORING)**
        i. Normal $EtCO_2$: **35-45 mmHg**

6. BLS TAB 500 MEDICAL PROCEDURES & EQUIPMENT
    a. Section S - **Pulse Oximetry**
        i. Ideal range: **95% - 100%**
        ii. Mild to moderate hypoxemia: **90% - 95%**
        iii. Severe hypoxemia: **85% - 90%**
        iv. Airway and ventilate: **Below 85% if patient is symptomatic**