Purpose:

Emotional pains, such as, fear, anger, anxiety, grief, or confusion are frequently left untreated due to prioritization of medical treatment. Just as physical pain is treated in the field, we should also be treating emotional pain. A calm scene can be created with the use of the right words and body language. Left untreated, the physiologic effects of increased sympathetic nervous system response compound other comorbid presentations.

General:

Emergency situations vary greatly. What someone may call an emergency might not necessarily be viewed as an emergency by the medic. It is important to understand, as a paramedic, you are exposed to life's extremes routinely where patients are typically not. This often causes a disconnect in understanding the person(s) level of urgency. Remember that their situation, no matter how minor it may seem, was concerning enough for them to dial 911. With lights, sirens, and the stress of the situation at hand, some people may not be able to process what is happening effectively nor be able to handle the situation in what we may deem as an "appropriate manner". It is up to you as a trained medical professional to enter these high stress situations and create a calm environment for the patient, family, and bystanders. Every emergency and every person is unique. Use of the following guideline as a proven tool to help structure the medic's approach to creating the calm scene in almost any situation in which your patient, family member, or bystander is experiencing emotional pain. Understand that each patient/scene is dynamic and just like dealing with 5 stages of death/dying, we must be just as fluid with routine calls.

Gain Rapport with Adults: Without rapport, effective communication is simply not possible.

1) <u>Get Centered:</u> Despite seeming obvious, this step is often over looked. It has been proven by taking 1-3 deep breaths before entering any scene focuses and levels the professional in high stress situations. Law enforcement, military, physicians, etc. all use this technique to help them interact with people better and to promote an internal calm which allows them to evaluate the scene/situation better and make better decisions faster. You must also accept that humans naturally have internal assumptions, preconceived notions, and judgements. Accepting this allows you to recognize and control how you approach your scene and people as a healthcare professional; objectively approaching people individually with a level of calm is the most important start point.
2) <u>Establish an Alliance</u>: Alliance is empathy in action. You are establishing a connection between yourself and the person experiencing pain, illness, or emotional distress as a medical professional and fellow human being, not as a "robotic doc in a box". Once you have approached the scene calmly, then getting the person to center on your calmness will naturally cause the person to calm as well. This can be one of the most challenging moments. Just as we can project calm and our patients absorb it, we can just as easily absorb our patient's anxiety. You may use the following verbiage to help you in establishing an alliance;
   a) "It's ok, you can take comfort in knowing the worst is over and we are here to help"
   b) "My name is _______, I'm a paramedic/EMT and I am here to help you."
   c) "You're safe now, the worst is over, and we are here to help you"
3) <u>Get a Contract:</u> By establishing a verbal contract you are able to make a further connection and facilitate cooperation. This may sound formal, but by doing so you are giving the person an agreement to accept your authority and work with you toward their care. By allowing them to work with you, it also reduces the feeling of being simply a victim. The person will instead be empowered as a co-rescuer. You may use the following verbiage or create your own;
   a) "Will you let me help you feel better?"
   b) "Will you come with me?"
   c) "We have a lot of things to get done to help you; will you help me with them?"
4) <u>Be Realistic:</u> When responding to a call remember that the emergency has *already happened*. **The worst is over.** Credibility can easily be lost when you use template statements such as "everything is going to be fine/ok" or "just relax" or "I'm not freaking out so you can't freak out". In the person's mind everything is *not* fine and they are in a (their) terrible situation. Using "…the worst is over…," you are establishing that some horrible incident *did* occur but they are now in the right place; with the right people; to move forward in their healing; and "we are going to do everything we can to care for you/make you comfortable." If you feel that the worst is not over you can still claim "**the worst is over because you are not alone, we are here to care for you**." Even when the patient is experiencing an MI, the scariest moment is when their realization of mortality is being experienced <u>alone</u>. Ensure you find a balance, being overly positive can also be detrimental and cause you to loose rapport. It is of utmost importance to stick to the truth in order to lead the person into relief and cooperation of your care.
5) <u>Show Compassion:</u> Establishing rapport is easiest when you show compassion and concern. Compassion and concern are simply caring and showing empathy: our words, our gestures, our voices, everything about us that says we care and want to help. This can be hard to maintain at 3 am, at this time of night anyone can forget what to say or even *how* to say it. **Listening** is the first step in showing compassion as well as giving you a clear path to diagnosis. When speaking to the person you can repeat things that they said to reaffirm that you are listening and that you care about them. You may use the following verbiage as a guideline to creating your own; (understand it is hard to convey the emotion and non-verbal communication that comes with each of these statements)
   a) A person may say: "The wreck happened so fast, my air bag went off and I was just terrified."
      To which you may reply: "That is terrifying."
   b) A person may say: "I've been telling him all day that he could be having a heart attack but he just wouldn't listen."
      To which you may reply: "I understand. The worst is over and we are here to give him the medical help he needs."
   c) A person may say: "I can't believe I cut my arm so bad!"
      To which you may say: "That is an impressive cut. Let's get you taken care of; I'll be with you the whole way to the hospital."
6) <u>Solicit Their Help/ Shift Their Focus:</u> Soliciting help from someone in an emergency or crisis is a straightforward approach that takes the established alliance and builds on it so the person can participate in the care being rendered. Distraction from the immediate peril can result from this partnered action as well. Remember that no one wants to be excluded, especially when it is in regard to their own well-being, or the well-being of their loved one. You may use the following verbiage as a guideline to creating your own;

a) "As I put this oxygen on, you can focus on slow, deep, easy breaths so that you can get all the oxygen you need to feel better."
b) "I'm going to help you. In order to do that, I need you to ____."
c) "Will you help me out and hold this bandage right here?"
d) "I need your help in making you more comfortable. Which way is more comfortable, with your leg in this position or this one?"

Gain Rapport with Children: Without rapport, effective communication is simply not possible.

1) Get Centered: Any situation in which a child is involved can be especially difficult. You need to have a calm, centered mind in order to perform your job effectively. This is especially true in young children as they are developing their verbal communication and rely more on nonverbal cues as a primary mode of communication.
2) Establish an Alliance: While you are establishing a connection between yourself and the child who is suffering pain, illness, or emotional distress, remember to include the child's care giver in the process and reaffirm to them that the care giver will remain with them. It is extremely important that you always verbalize what you are about to do prior to doing it in order to maintain your alliance once it has been established. You may use the following verbiage to help you in establishing an alliance;
   a) "…I'm here to help you feel better. Mommy is going to be right here with us to help too. Your safe now and the worst is over"
   b) "I've got you (child's name) and I'm here to help you. Daddy is right here by your side and he's going to help us too."
   c) "Your grandma called me to come help, I'm a paramedic and that's what we do. Help people feel better."
3) Get a Contract: Keeping up to date with cartoons can be a great resource in getting a contract with children. If you are able to use reference to their favorite cartoon characters, you can instantly build a connection with them. By allowing the child to work with you it also reduces the feeling of being helpless. Instead, the child will be empowered as a co-rescuer. You may use the following verbiage or create your own;
   a) "Will you be my partner and help me so we can get this all better really fast just like Doc McStuffins?"
   b) "You can be my partner like 'Ryder' and help me to make this all better."
   c) "Remember how Dora is always helping Boots? Well I need you to help me just like Dora so we can make this all better."
4) Show Compassion: **Listening** is the first step in showing compassion as well as giving you a clear path to diagnosis. When speaking to the child you can repeat things that they said to reaffirm that you are listening and that you care about them. You may use the following verbiage as a guideline to creating your own;
   a) A child may say: "Ow!!! It hurts so bad."
      To which you may reply: "I can see the owie and that it hurts a lot, I know and it's ok that the owie hurts that bad."
   b) A child may cry and not respond.
      To which you may respond with: "I know how burns can make you cry sometimes, and it's ok to cry, sometimes crying can make it feel a little better…"
   c) A child may shy away and exhibit fear.
      To which you may respond with: "…'it' can be very scary when something like this happens, but your safe now and we are here to help make it better…"
5) Shift Their Focus: With certain suggestions, you can help separate the child from the injury, not in a literal since of amputation, but in a figurative way in order to keep them from identifying with their injury. When the focus is on their injury the child can be easily over whelmed by anxiety and pain. By simply changing their focus, you can provide some pain and stress relief. You may use the following verbiage as a guideline to creating your own;
   a) "While that leg over there continues to feel better, the rest of your body can rest and be comfy."
   b) "You can take yourself in your mind any place you want. Where did you go last summer (on vacation etc.)?"
   c) "What is your favorite cartoon (sport, game etc.)?"
   d) Tell a story about a similar situation "My little boy broke his leg when he was 6 years old. He went to the doctor and was taken care of just like you are being taken care of. Now he's all better and is playing football."
6) Solicit Their Help: Soliciting help from a child in an emergency or crisis is a straightforward approach that takes the established alliance and builds on it so the person can participate in the care being rendered. Remember, including a child can empower them as well as distract them from the immediate peril. Once again the use of their favorite cartoon characters can help. You may use the following verbiage as a guideline to creating your own;
   a) "Remember how Chase helped Ryder to save the baby dolphin? I'm going to put the bandage on your owie. You can be my partner just like Chase and help me by holding your arm just like this. Good job!"
   b) "I'm going to put this splint on your leg. It helps to keep it still so it can feel better. You can be my partner and help me out just like Dora and Boots."
   c) "This can be scary but remember how brave Larry was when Bob needed his help? You to be brave just like Larry and help me too so you can start feeling better."

Definition of Abbreviations

Medical Oversight

Medical Director: Benjamin Oei, MD

Austin County
EMS Protocol & Guideline

Version:	1.0
Date:	04/2019

@	At
Δ	Change
ABC's	Airway, Breathing, Circulation
ABD	Abdomen
AC	Antecubital
AED	Automated External Defibrillator
AFIB	Atrial Fibrillation
ALS	Advanced Life Support
AMA	Against Medical Advice
AOS	Arrived On Scene
APAP	Acetaminophen
ASA	Aspirin
BBB	Bundle Branch Block
BG	Blood Glucose
BLS	Basic Life Support
BM	Bowel Movement
BP	Blood Pressure
BSA	Body Surface Area
BVM	Bag Valve Mask
C/O	Complaining Of
CA	Cancer
CABG	Coronary Artery Bypass Graft
CAD	Coronary Artery Disease
CAO	Conscious And Alert
CC	Chief Complaint
CHF	Congestive Heart Failure
CIT	Crisis Interventions Team
CNS	Central Nervous System
CO	Carbon Monoxide
CO2	Carbon Dioxide
COPD	Chronic Obstructive Pulmonary Disease
CP	Chest Pain
CPR	Cardiopulmonary Resuscitation
CQI	Continuous Quality Improvement
CR	Capillary Refill
CSF	Cerebral Spinal Fluid
CT scan	Computerized axial Tomography
CVA	Cerebral Vascular Attack
D/C	Discontinue
D5W	Dextrose 5% in Water
DCAP-BTLS	Deformities, Contusions, Punctures, Burns, Tenderness, Lacerations
DNR	Do Not Resuscitate
DOA	Dead On Arrival

DOS	Dead On Scene
DVT	Deep Vein Thrombosis
Dx	Diagnosis
ECG	Electrocardiogram
EDD	Estimated Due Date
EJ	External Jugular
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
ERG	Emergency Response Guide
ET	Endotracheal Tube
ETA	Estimated Time of Arrival
ETC02	End Tidal Carbon Dioxide
ETOH	Ethyl Alcohol
F	Female
FD	Fire Department
FTO	Field Training Officer
Fx	Fracture
g	gram
GCS	Glasgow Coma Scale
GI	Gastrointestinal
GOA	Gone On Arrival
GSW	Gun Shot Wound
gtts	drops
GYN	Gynecology
HR	Heart Rate
HTN	Hypertension
Hx	History
hyper	high or above
hypo	low or below
ICP	Intracranial Pressure
IM	Intramuscular
IN	Intranasal
IO	Intraosseous
IV	Intravenous
IVP	Intravenous Push
J	Joules
JVD	Jugular Vein Distension
kg	Kilogram
KVO	Keep Vein Open
L	Left
L&D	Labor & Delivery
lb	pound

LBBB	Left Bundle Branch Block
LLQ	Left Lower Quadrant
LMP	Last Menstrual Period
LOC	Loss Of Consciousness
LUQ	Left Upper Quadrant
M	Male
mcg or µg	micrograms
MCI	Mass Casualty Incident
MDI	Metered Dose Inhaler
MED	Medication
mEq	millequivalent
mg	milligram
MI	Myocardial Infarction
min	minute
MOI	Mechanism Of Injury
MRI	Magnetic Resonance Imaging
MVA	Motor Vehicle Accident
N/V	Nausea/Vomiting
NaCl	sodium chloride
NC	Nasal Cannula
NEB	Nebulizer
NKA	No Known Allergies
NKDA	No Known Drug Allergies
NPA	Nasopharyngeal Airway
NRB	Non-Rebreather mask
NS	Normal Saline
NSR	Normal Sinus Rhythm
NTG	Nitroglycerin
O2	Oxygen
OB	Obstetrics
OD	Overdose
OOH-DNR	Out Of Hospital - Do Not Resuscitate
OPA	Oropharyngeal Airway
OPQRST	Onset, Provocation, Quality, Radiation, Severity, Time
OTC	Over The Counter
PAC	Premature Atrial Contraction
PCN	Penicillin
PD	Police Department

PEA	Pulseless Electrical Activity
PERRL	Pupils Equal, Round & Reactive to Light
PJC	Premature Junctional Contractions
PO	Orally
POV	Privately Owned Vehicle
prn	as needed
PT	Patient
PTA	Prior To Arrival
PVC	Premature Ventricular Contractions
q	Every
R	Right
R/O	Rule Out
RBBB	Right Bundle Branch Block
RLQ	Right Lower Quadrant
ROM	Range Of Motion
RUQ	Right Upper Quadrant
RVR	Rapid Ventricular Response
Rx	Prescription therapy
SL	Sublingual
SMR	Spinal Motion Restriction
SO	Sheriff Officer
SOB	Shortness Of Breath
SpO2	Oxygen Saturation by pulse oximeter
SQ	Subcutaneous
SVT	Supraventricular Tachycardia
Sx	Symptom
TCP	Transcutaneous Pacing
TIA	Transient Ischemic Attack
TKO	To Keep Open
Tx	Treatment
UTI	Urinary Tract Infection
V/S	Vital Signs
VF or VFIB	Ventricular Fibrillation
VS	Vital Signs
VT or VTACH	Ventricular Tachycardia
WNL	Within Normal Limits
Y/O	Years Old

Term	Definition
ABC's	- Establishment and maintenance of an open and patent airway, including the use of oral/nasal airways, suctioning, and endotracheal intubation. - Establishment and maintenance of adequate respiratory rate and volume including the use of artificial ventilation, ventilatory assistance, bag-valve mask device, endotracheal intubation, and the demand valve device. - Assessment of perfusion and hemorrhage, and circulatory support through external manual/mechanical chest compression and control of major external bleeding.
ALS	- Therapies and procedures beyond basic life support, including: IV's, IO, medication administration by any route other than nebulizer, intubation of the trachea and esophagus, ECG monitoring, defibrillation/cardioversion, surgical airway, chest decompression, external cardiac pacing,endotracheal and/or gastric suctioning.
AFIB	- Atrial Fibrillation
	- A hospital, not necessarily the nearest hospital, with the resources and capability to care for a patient based upon the patient's medical need.
APAP	- Acetaminophen
	- Protocol designation by the Medical Director allowing practice as indicated by the individual Paramedic's delegation of practice letter.
BP	- blood pressure
BLS	- Therapies and procedures including: vital signs, oxygen administration, airway maintenance, oral/nasal suctioning, bleeding control, bandaging, fracture care and splinting, spinal immobilization, patient assessment, semi-automatic defibrillation (AED), CPR, nebulized bronchodilator treatments, and blood glucose level evaluation (glucometer use).
BSA	- Body Surface Area
	- Intentional movement of a patient from the scene to a specific hospital, not necessarily the nearest hospital, based upon the patient's medical need
COPD	- Chronic Obstructive Pulmonary Disease
CR	- Capillary Refill time
	- Any patient with one or more of the following: - Second degree > 30% BSA - Third degree > 10% BSA - Circumferential Burns - Burns with associated significant injuries - Burns with associated inhalation injury - Any burns of the face, feet, hands, or genitalia
SMR	- Motion restriction and protection of the spinal column/cord including manual techniques, cervical collars, extrication techniques and devices, backboards, cervical motion restriction devices, and strapping.
DOS	- Death on Scene
	- A point of care, diagnostic device to measure blood glucose levels.
ECG	- Electrocardiogram
ETCO2	- End Tidal Carbon Dioxide
G	- Grams
GCS	- Glasgow Coma Scale
	- Blood-sugar > 200 mg/dl
HTN	- Systolic > 180 mmHg **OR** diastolic > 110 mmHg **with** end-organ compromise
	- Blood-sugar < 60 mg/dl
ICP	- In-Charge Paramedic. Protocol designation by the Medical Director allowing practice **up to** that designated for approved Paramedics (see Delegation).
IM	- Intramuscular Medication Administration Route
IN	- Intranasal medication administration route.
IO	- Intraosseous fluid/medication administration route.
IV	- Intravenous fluid/medication administration route.
IVP	- IV push medication administration route.
J or j	- Joule
kg	- Kilograms
mcg or μg	- Micrograms
mEq	- Milliequivalent
mg	- Milligrams

min. or mins	- Minutes
N/V	- Nausea and/or vomiting
NTG	- Nitroglycerin
O_2	- Oxygen (administration)
OOH-DNR	- Out-of-Hospital Do Not Resuscitate order
PEDI	- A patient < 16 years of age **OR** weighing < 60 kg
PO	- Oral medication administration route.
PR	- Rectal medication administration route.
EDD	- A delivery occurring prior to the end of the 37th week of gestation
prn	- As needed
q	- Every
RVR	- Rapid ventricular response
SL	- Sublingual medication administration route
IVP	- Administration of an IV medication over the span of 60 seconds, or more
SQ	- Subcutaneous medication administration route
	- Any individual who experiences blunt or penetrating single or multiple organ system injury resulting in potential morbidity and/or mortality
	- The classification of patients according to medical needs
VF or VFIB	- Ventricular fibrillation
V/S	- Respiratory rate, blood pressure, pulse rate, pulse oximetry, temperature, and breath sounds
VT or VTach	- Ventricular Tachycardia
Δ	- Change

State Licensure: ACEMS recognizes the following state licensing levels for prehospital care providers that fall under the medical direction by employment or official association via contract/memorandum of understanding (i.e. Fire Department responders, etc).

- Emergency Care Attendant (ECA)/ Emergency Medical Responder (EMR)
- Emergency Medical Technician (EMT-Basic)
- Advanced EMT (EMT-Intermediate)
- Paramedic (EMT-Paramedic) or Licensed Paramedic (LP)

Each level of licensure is only valid when in good standing with Texas Department of State Health Services and is not expired. Expired licensure requires immediate cessation of all duties and activities as a medical care provider and notification to 1st line supervisor.

ACEMS Credentialing: ACEMS utilizes an internal credentialing process. Below are the credentials with description.

- **LEVEL A (EMT Basic)** – Administration of BLS medication and procedures
    - Application of electrodes for ECG or 12-lead acquisition. The 12 lead must be interpreted by a Paramedic or Physician
      (The Cardiac monitor can be applied as a tool to rule out underlying cardiac issues. Once it is applied a paramedic will review the EKG to determine if the patient needs to continue to be on the monitor or if they can be removed. If they need to continue on the monitor then a paramedic will ride the call to the hospital. If the patient is removed from the monitor and a lower level of certification rides the call to the hospital then they will document the following.
      Cardiac monitor applied for diagnostic purposes only and no abnormalities noted by paramedic (name here).
      This will allow for more comprehensive patient assessments and do so without locking a paramedic into riding a call that does not require their specific level of certification. This should alleviate the concerns over applying the monitor.)
    - Blood glucose determination
    - Nebulized albuterol / ipratropium administration
    - Oral acetaminophen administration
    - Oral dextrose administration
    - Oral Ibuprofen administration
    - King LT placement
    - IM injection EPI 1:1000
    - IM injection Glucagon
    - Those designated as Basic may provide patient care enroute to receiving facility providing no interventions above Level A were performed prior to transport and/or anticipated to need intervention and monitoring above a Level A during transport.
- **LEVEL B (EMT Intermediate)** – Includes Level A skills with addition of:
    - Endotracheal intubation,
    - venipuncture procedures
    - Intraosseous insertion/infusion
    - Non-narcotic medication administration under direct authorization & supervision of Level D.
- **LEVEL C – (Paramedic I)** Includes Level A & B skills with addition of
    - All Paramedic level skills outlined in this protocol.
    - Level C can **only** operate at Level C under the authority of a Level D.
    - Some new and/or advanced procedures may be individually excluded from the Level C.
- **LEVEL D – (Paramedic II)** Full comprehensive and unrestricted off-line medical privileges.
- CREDENTIALING PROCESS:
    - Level A, B and C are credentialed by the Clinical Coordinator and/or Medical Director. This process includes:
        - Internal training structure/training academy
        - Protocol based test passing with a minimum score of 80%.
    - Level D is credentialed only by the Medical Director. This process includes:
        - Protocol based test passing with a minimum score of 80%
        - Scenario preparation time with Clinical Division including high acuity call training
        - Oral interview and/or scenario based performance with the Medical Director
    - Employee has a total of 3 attempts to be successful on the credentialing process. If the employee is unsuccessful the employee cannot reattempt for a minimum time of 6 months. A PIP will be constructed for each employee who is unsuccessful in this process. Failure to be successful after 3 attempts will result in referral to the Administrative Team for further action.

Field Application:

- Level B and C can only perform at their credentialed level in the presence of a Level D. In the absence of a Level D, the credentialed individual can only perform at Level A.
- In specific instances, the Level D is not required for personnel to perform at the B and C levels. These include, but are not limited to

approved programs/situations:

  - Fire Department ALS first responders
  - Disaster situations
  - Prolonged MCI situations
  - Extenuating circumstances with approval from Clinical Division.

- A Level D waiver or specialized protocol is only issued by the Medical Director and disseminated by Clinical Division. Documentation of this will be done either through signed standing memorandum for sustained operations or with an internal signed memorandum and communicated via email, radio, or verbal direction by supervising staff (Lieutenant and above).

Purpose:

Define and provide a guideline for documentation of the narrative in patient care reporting. This guideline should reflect the ePCR narrative format and contain relevant information. Unique calls that are specialized or have additional considerations should have the findings documented in the appropriate location below. (i.e. RSI will have a detailed airway assessment, refusals, etc...)

This guideline also defines that all fields within the ePCR but is outside of the narrative is primarily for data collection, state reporting, federal reporting and research purposes. The data collection area does not provide a descriptive picture of how the patient presented. The only place within the ePCR that achieves this is documented in the narrative; however, both sections are equally important and must correlate and reflect one another.

General:

EMS documentation is a professional - legal document that requires structure and attention to detail. This document provides a general guideline for the medic on where to document information. The medic must pay close attention to ensuring conflicting documentation does not exist. A majority of all the below information should apply to all patients, however, few isolated items may not apply to individual patients. Do NOT type in all capital letters. Spelling and punctuation is inherent to human writing, however, all efforts to minimize errors is imperative.

The Professional EMS Document:

The professional EMS document is a document that is objectively written with facts and findings. When fact and finding is not present, the description is concluded based on surrounding events in a non-prejudice approach. Subjective information from the observing chart writer reflects more of an objective evaluation describing things such as “look of grimace”, “patient presents stoic” and “patient rested uncomfortably…” The document is free of derogatory phrases or words such as “drunk”, “high”, etc., unless appropriately documented as statements, with validity, were made to EMS and add pertinent information to the scene (i.e. patient states “I’m drunk”). The document reflects that of a medical investigator who “rules out” life threats based on assessment of the scene, patient and presentation in its totality without bias to age, race, religion or creed.

DATA COLLECTION: This section of the PCR is designed to collect data that is mandated by Federal, State, Local authorities as well as internal data tracking for clinical reasoning.

INCIDENT TAB - DATA COLLECTION:

- **Date –** The correct date of the call
- **Run Number –** The EMS incident number assigned for the call according to dispatch records.
- **Priority-** How the unit responded to the call (e.g. Lights and sirens)
- **Location –** The location in which an incident occurred or patient was located.
- **Providers –** All of ACEMS personal that were on scene and assisted with patient care.
- **Disposition-** Documentation of transport of a patient, refusal with supporting documentation of the refusal in the drop down menu (AMA, POV, etc.), DOA, transfer of care (e.g Lifeflight), etc.
- **Destination –** Documentation of where the patient was transported.
- **Times –** Received, Dispatched, Location, Patient Contact, Etc. This information is provided by Austin County Sheriff’s Department – Dispatch. Inaccurate times or information should be relayed to the EMS office and the Shift Supervisor.
- **Additional Agencies:** This section should document other agencies that were associated with the call (e.g. Fire Department, Police Department, etc.

PATIENT TAB - DATA COLLECTION:

- **Patient:** Patient name and spelling MUST be correct. Confirm with the patient and/or family for correct spelling and DOB when appropriate to. Avoid using “John/Jane Doe” at all possibility, however, it is understood that there are times there is no other option.
- **NOK:** In the instance that the patient is a minor, altered, potentially life threatening situation, etc., providing NOK is highly important. Otherwise, if the patient is a competent adult and the above does not exist, then NOK is not required.
- **History:** Fill in all history. Add elapsed time for procedures applicable to presentation (i.e. Heart Stent 3 weeks ago)
- **Medications:** Document the patient medication WITH dosages when available. Medications should not routinely be taken to the hospital unless patient presentation or condition takes priority/dictates and obtaining medication information on scene would delay transport.
- **Allergies:** If not “true allergies” and more classified as reactions, then document the type of reaction (i.e. Morphine – “makes me vomit”)

ASSESSMENT TAB – DATA COLLECTION:

- **Assessment:** Patient Assessment “check box” is much different than the patient assessment that will be documented in the narrative. This section is to collect data on injuries/complaints. This documentation required is the presence of an injury/complaint and only requires the box to be checked with no further description. The description will be documented in the narrative. Pertinent negatives are require in the assessment tab of the report

- **Differential Diagnosis:** This only requires a check-box and must mimic what is documented in the narrative.
- **Trauma:** This is required for all trauma patients, fill out as applicable.

VITAL SIGNS TAB – DATA COLLECTION:

- **Vital Signs:** Each "patient" **will** receive a minimum of 2 sets of vital signs, except in DOS patients. If vital signs are unable to be obtained and were warranted, the vitals will be left blank with reasoning documented in the narrative. A manual blood pressure should be performed if an automatic pressure is unable to be obtained, and/or if the automatic blood pressure reading is or appears to be inaccurate. If the monitor reports inaccurate data (i.e. inconsistent BP, HR high due to artifact, etc.) then the medic may elect to either delete the individual vital sign or modify the values to reflect an accurate reading.
- **Scores:** Certain patient's require scores; fill out the appropriate-applicable score (Stroke, C-Spine, etc.).
- **LifePak/AED:** Any time the 4 lead is placed on the patient, the data MUST be uploaded to the primary/transport ePCR. If a second monitor was applied to the patient (i.e. first responder, squad) the data MUST be uploaded for the high acuity calls (i.e. STEMI, SVT, V-Tach, Defibrillation, instances where the 2nd monitor collected significant events). The primary/transport ePCR cannot be closed until this is complete. In the instance that the 2nd monitor did not collect data of a significant event and is a routine patient, the data should routinely be uploaded, but is not absolute. BLS calls are encouraged to upload data, but not necessary. Data lost, corrupt or accidentally deleted must be documented in the end of the narrative as "Administrative" and the on duty supervisor must be contacted.

FLOWCHART TAB – DATA COLLECTION:

- **Interventions:** Interventions will be filled out accurately according to the qualifying fields. Accuracy of time is highly important. Times should be estimated (when not time stamped) as close as possible to real time to ensure accuracy in documentation and data tracking.
- **Quick Log:** Quick Log should be used in high acuity calls such as cardiac arrest and RSI. This helps to ease the documentation demands after the call and ensure a high rate of accuracy to real time documentation.
- **Outcome:** Complete the applicable and required fields
- **Times:** All times documented as accurately as possible. Most times are provided from Dispatch, however, if there is ever a discrepancy, it is the responsibility of the chart writer to ensure accuracy of reported times.

SIGNATURE TAB: All applicable signatures must be obtained. Most of these are self-explanatory. Here is clarification on some high risk topics

- **Who Signs:**
  - If the patient is physically able to sign, the patient **MUST** sign, despite any other reasoning. It may be difficult in situations when the spouse "signs everything". This is often best explained to the patient that the signature is validating services rendered and for HIPPA.
  - If the patient is actually – physically/mentally NOT able to sign, then a family or guardian of the patient may sign for the patient.
  - If the patient is actually – physically/mentally not able to sign AND there is NOT a family or guardian present, then the chart writer signs for the patient services rendered.
- All signatures required for the ePCR **must** be obtained electronically. Non-electronic signatures may be obtained only in the presence of a technology failure.
- Both providers must sign the ePCR

- Nurse or Physician at the receiving facility must sign the ePCR where it indicates a facility signature**.**

NARRATIVE TAB:

- **Clinical Impression:** This information is based on the providers clinical impression of the patient presentation, and should indicate medical/trauma or both
- **Supporting Signs & Symptoms:** Documentation to support the clinical impression.

******The narrative section should be a PROFESSIONAL, stand-alone document with correlating and supporting data and details from the above sections******

THE NARRATIVE: Narrative must paint a general picture with standard information and pertinent negatives. Information contained elsewhere in the report does not substitute for needing to be documented in the narrative. Administrative information such as patient's name, DOB, address, etc. should not be included.

Subjective: This is the information about the incident and /or patient obtained outside of what EMS personnel witness (i.e. what patient, family and bystanders report to EMS).

1. Age of the patient & gender male / female
2. Events / incidents that produced chief complaint i.e. MOI or NOI
3. SAMPLE-AR / O, P, Q, R, S, T
4. RELEVANT TO CURRENT PATIENT STATUS: Past medical history, Medications, allergies

Objective: This is the "Physical Exam". Each patient will have an evaluation of the primary assessment systematically unless extenuating circumstances did not allow for this. After the primary assessment is documented, extending the physical exam to the focused/detail exam according to the current patient presentation/situation. Pertinent negatives relevant to the current patient presentation/situation must be utilized in this section. All of the below Objective sub-headings must be documented in the ePCR narrative.

1. SCENE SIZE UP
   - Location description (not address), Brief comment on position found
   - Surroundings / environment
2. GROSS CIRCULATION
   - Level of consciousness (LOC - AVPU) / Gross Circulation
   - CPR needed / Bleeding control needed
   - Overt need for C-Spine can be placed here or assessed later
3. PATIENT AFFECT (reactive patient's only)
   - Patient's general presentation (i.e. Look of grimace, agitated, stoic, pleasant, obvious distress, etc.)
4. AIRWAY
   - Airway patency & Any considerations for impending airway issues
   - Overt need for C-Spine control (may be modified later as more details are collected)
5. BREATHING
   - General Rate & Tidal Volume adequacy / Chest Excursion
   - Breath Sounds
6. CIRCULATION
   - Distal Pulses (+0 to +4 scale)
   - Skin Temp / Color / Condition / Capillary Refill
   - Internal Bleeding (CHARTS: Chest, Abdomen, Retroperitoneal/Pelvis, Thigh/Femur, Severity)
7. DISABILITY
   - C-Spine control need or not
   - Glasgow Coma Score (GCS)
   - Appropriate conversation in addition to; oriented to Person, Place, Time, and Events (A & O x 4)
   - Motor: Gross and Fine
   - Pupils
   - Stroke/NIH Assessment
8. EXPOSE
   - Physical exam - detailed.
   - Initial Vital Signs – only required to note specific VS that are significant findings or pertinent negative findings relevant to the patient presentation / situation. Otherwise may state "VS otherwise unremarkable" or "as charted above".
     - Consideration of medication inhibiting factors to "normal" findings must be noted.
     - "Normal" is only reserved for the medical – general values, not what is "normal" for the patient.
   - Verbal interview details – document in quotes what is stated by the patient, family members, and/or bystanders.
   - Cognitive Status (i.e. is the patient adequately comprehending the situation, making good conversation and/or able to work through semi-complex problems). Any findings should be compared to patient's "normal" status.

Clinical Impression: Differential Diagnosis(s) (DD) based on patient presentation and protocol the patient is being treating according to. This includes "possible" and "rule out" listings.

Performed:

1. Chronological order of events, treatments and patient reaction throughout care. This is also the "FOCUSED" exam on the patient assessment.
2. Interventions should be restated, however, unless the details are not impacting to patient or painting the picture, then it can be generalized. Standardized dosages (such as NTG spray) does not need to be re-documented, however, other dosages such as pain control helps to identify dose to patient response. When in doubt, dosages can be documented. Time should be documented in a "time lapsed" format.

a. Example of too much data
   i. *…At 1845, four 81mg (total of 324mg) chewable baby ASA administered PO. At 1846 0.4mg NTG administered sublingual spray and again at 1851 with no change in complaint or status…*
   ii. **Instead**: *…Administered 324mg baby ASA PO and 2 SL NTG reducing patient pain from 8/10 to 2/10. Patient observed presentation improved with reduction of anxiousness and generally resting comfortably…*

b. Example of pertinent dosages information (any medication that has a variable dose)
   i. *4mg Morphine administered with pain reduced to 4/10 but still noticeably restless and look of grimace. Patient redosed with 4mg Morphine with complete resolution of pain and resting comfortably.*

3. **ONGOING EXAM:**
   a. Trending vital signs that are notable. If not notable or primarily unchanged, document as such.
   b. Patient's response (+ / - / =) to therapies (i.e. pain was relieved, symptoms worsened, no change, etc.)
   c. Patient's affect throughout care and status upon arrival to the receiving facility or transport.
   d. A generalized "once over" of the patient's presentation/symptoms upon arrival to hospital

4. ****APPENDED NARRATIVE****: Located below the narrative portion of the report
   a. In the event of unique events relevant to the patient, but not to patient care, this is where you document it. Situations including but not limited to:
      i. Monitor Data loss
      ii. Why patient did not sign
      iii. Any other specific and unique events

5. **REVIEW**:
   The chart writer MUST do a "spell check" once the narrative is complete. Spell check is not very comprehensive when it comes to medical words and terminology, so close attention is needed to ensure not to change correct words to "auto correct" words that are incorrect for the document.

EXAMPLE:

SUBJECTIVE: Called to middle apartment complex for 65 y/o Male patient c/o R wrist pain. Patient reported that he was walking to the bathroom and tripped on rug without presence of dizziness. Patient fell forward and put his right arm out to stop his decent and felt a "snap" when his hand impacted. Patient denies striking his head, any other complaints or LOC. Patient ambulated without difficulty to his phone, called 911 and sat in his recliner until EMS arrival. SAMPLE-AR: Patient has relevant history of osteoporosis and right radial Fx approx. 10 years ago with no deficits. Patient takes ASA 81mg daily and denies any allergies. Patient denies any recent changes in medications, sleep habits, or daily activities. Patient states he does "blead easily" because of the ASA. Pain is 8/10 and constant to R wrist with no radiation.

OBJECTIVE: Scene is a well-kept apartment and a generally healthy appearing patient found in the recliner who welcomed EMS into scene without hesitation. Patient is Alert, no frank bleeding is noted, obvious painful presentation with a look of grimace. Airway is intact without obstruction. Breathing rate 22 with adequate tidal volume, good chest excursion and no audible noises. Lung sounds are clear all 4 lung fields. Circulation, Pulse 110, radial pulses +2 bilaterally, skin is pink, warm and dry with capillary refill < 2 seconds. Abdomen soft and pliable, pelvis stable and femurs intact. Disability, patient is fully awake, alert and oriented and providing good, appropriate conversation. Patient denies any drug or ETOH. Based on presentation throughout assessment pain is appropriate to the injury and perceived as bearable and not distracting to other potential injuries. C-spine assessed with no midline or lateral tenderness to the cervical area. NEXUS criteria is met and C-Spine is cleared. Gross and fine motor intact x3 with deficit to injured R wrist. Pupils are 4mm and PEARL.

Expose, detailed exam shows obvious deformity to the R wrist with lateral rotation and no significant swelling. Skin is warm distally to injury, but capillary refill 3 seconds. Neurologically sensation is intact distally and motor function is present, but ROM is decreased with significant increased pain upon movement. Patient is complaint free otherwise. No skin lesions, abrasions, or frank concerns noted during assessment. VS: HR 104 and RR 20, otherwise VS are unremarkable.

ASSESSMENT: Possible Fx to the R wrist due to MOI, patient hearing a "snap" and frank angulation to the R wrist. All other applicable differential diagnosis of C-Spine injury, arrhythmia, and hypotension are preliminarily ruled out based on assessment findings.

PERFORMED: Patient was manually holding/splinting R wrist. IV was initiated, 20g L hand. Fentanyl 75 mcg slow IVP with reduction of pain from 8/10 to 4/10 and patient presented relaxed. Splint placed on R wrist with arm board and ACE wrap. Gauze roll placed in patient's hand for position of function. PMS reassessed distally to injury with no change and remains intact. Patient stood in position with assistance as stretcher was brought to patient and placed in fowler's position. Pt. moved to ambulance and transport initiated. During transport pain increased to 6/10 and observed increasing grimace. Re-dose 75mcg of Fentanyl slow IVP with reduction of pain to 2/10 and observed to primarily be relieved of pain. Patient rested comfortably throughout transport after Fentanyl. VS improved with HR decreasing to 88 and RR to 16. VS otherwise unremarkable. Upon arrival to the hospital patient pain control still adequate at 3/10 and PMS distal to the R wrist unchanged. Care and report given to RN (MD, etc.) and patient placed in ER room XX. End of report.

DNR Exists:

GENERAL:

It is acceptable, under the following circumstances, for ACEMS personnel to elect to withhold resuscitative measures from an apneic/pulseless patient or discontinue any attempts initiated by the public and/or first responders:

1) Visible trauma to the head or trunk clearly incompatible with life (examples):
   - Decapitation
   - Total incineration
2) Rigor Mortis
3) Decomposition
4) Dependent lividity
5) Mass casualty incident where triage principles preclude CPR from being initiated
6) Valid Do Not Resuscitate directive executed by the patient's physician through the following mechanism:
   - Direct phone contact with the patient's physician
   - Current, written, "DNR" Texas DNR-OOH order signed by the patient's physician
   - A valid State of Texas OOH-DNR (Photo copies are acceptable) or other official, valid out of state DNR.
   - An intact, unaltered, identifiable **plastic** identification OOH DNR bracelet, with the word "Texas" (or a representation of the geographical shape of Texas and the word "STOP" imposed over the shape) and the words "Do Not Resuscitate", **shall** be honored by qualified EMS personnel in lieu of an OOH DNR Order form.

7) An intact, unaltered, easily identifiable **metal** bracelet or necklace inscribed with the words, "Texas Do Not Resuscitate - OOH" **shall** be honored by qualified EMS personnel in lieu of an OOH DNR Order form.

8) Family member(s)/guardian(s) are against any attempts to resuscitate, they appear to be of sound mind, and malicious intent is not apparent. This should especially be considered if the patient has signed a "Directive to Physicians" and that document is present, claimed DNR but not present, or DNR present but not filled out fully/expired.

PEARL:

- BLS care must be initiated until resuscitation decision is determined.
- NEVER withhold supportive care or comfort care.
- Consideration and documentation of the situation in its totality is essential to ensure an appropriate decision.
- Including other supervisory staff in questionable situations is key to making the appropriate decision.
- DNR Tattoos are not acceptable documentation to withhold resuscitation, but can be considered in reviewing the totality of the scene/situation.

DNR Does NOT Exist:

PURPOSE

Termination or withholding of life support efforts in the pre-hospital setting will apply to situations in which adult patients experience a primary cardiac arrest due to medical causes and in the absence of a DNR. The Paramedic should utilize this guideline set forth below to ensure making the appropriate decision.

PROCEDURE

Pre-Determination

1) Resuscitation efforts will **not be terminated or withheld** in patients presenting with:
   - The patient whose cardiac arrest may be secondary to some other correctable reason
   - The patient who has persistent/unresolved ventricular fibrillation or ventricular tachycardia
   - The patient who has had a return of a spontaneous pulse at any time during resuscitation
   - The patient who demonstrates any neurological signs
   - The patient who has suffered cardiac arrest while in the care of ACEMS personnel or First Responder Organizations (witnessed)
   - The patient who does not have a confirmed-secure airway (endotracheal tube, King LT, BVM Face-mask → Confirmed by constant ETCO2 wave form) and IV/IO access if ALS resuscitation was initiated.
2) Resuscitation efforts **may be terminated or withheld** in patients meeting the following criteria:
   - The patient must be greater than 18 years of age and;
   - The patient presents with cardiac arrest in the absence of the above criteria (paragraph 1).

3) ALS resuscitative efforts by ACEMS personnel shall be **at least** 20 minutes regardless of previous CPR time and arrest interval, with a documented and consistent ETCO2 < 10 mmHg.

Post-Determination

1) If the patient meets criteria for termination, the medic should approach the family or responsible party about termination of the resuscitative efforts.
    a. End of Life considerations must be discussed with family. Key points of **what was/is the patient's wishes** and **what is in the best interest of the patient** (with considerations to quality of life, terminal illness, etc.) are essential in making a decision.
    b. The In Charge Paramedic will then contact Oak Bend Medical Center for on-line medical direction. The crew member must provide the On-line medical control Dr. with all the information available about the patient's current condition, family wishes, and patient's past medical history. The ACEMS Paramedic must document the name of the physician and time of death provided.
2) **CONTINUE RESUSCITATION**: In the event any family member or responsible party indicates their sustained objection to the concept of termination of resuscitation, the resuscitation efforts shall continue until care is assumed by the receiving emergency room physician.
    a. **Transport:** Should transport be initiated and is obvious resuscitation efforts will be discontinued upon arriving to the hospital, transporting NON-EMERGENCY is the appropriate transport priority.
3) **STOP RESUSCITATION**: Once the decision to terminate the resuscitation efforts is acknowledged by the family or responsible party, the crew will advise over the radio "Medic XX, out with a DOS". The crew shall tie off all IV lines close to the insertion site and remove the IV fluid bag and any other supplies external to the patient. The monitoring pads, IV/IO catheters and airway devices shall remain in place.
4) Law enforcement must be notified and arrive on scene before crew may leave/go in service unless for scene safety reasons.
5) At all times, ACEMS personnel shall be attentive to the psychological needs of the "survivors" and provide support as needed
6) In the absence of an official care giver or guardian (in person or by phone), ACEMS is expected to make a decision in the best interest of the patient. Contacting the on duty supervisor, Clinical Coordinator, Deputy Director, Director and/or Medical Direction is encouraged if decision is unclear.

Talking Points

1) Approaching family may be difficult and must be done so in a calm and reassuring manor. Instilling confidence in not only the procedures that have been done but also the perceived competence of the care providers is important. This helps set the tone.
2) Getting the family to level with the medic on a reasonable emotional level is the priority to ensure they are mentally ready to receive the discussion and understand the situation. Many techniques can be used to achieve this; however, composing yourself calm and confident is the primary start to this. Using plain (but professional) English is important.
3) Family members at times may become or already be unreasonable and emotionally impaired to the situation. These are challenging and at times impossible requiring law enforcement to ensure the safety of the crew and the family member.
4) "Isn't there anything else you can do for him?" An appropriate response would be "Ma'am/Sir; we have been doing continuous CPR helping to keep his blood flowing, we have been breathing for your father, and we have been giving him all of the appropriate medications. There has not been any positive response to any treatments. We have done all of the same treatments that the hospital would do and there are no other treatments to provide. I know this is very difficult right now, but we need to consider discontinuing our efforts to revive him…"
    a. If there are any other presenting factors that are identified to support termination such as rigor, pooling, etc., then present these findings to the family as well.
5) Often family members will ask difficult questions such as "why". Avoid using the phrase, "I understand…" An appropriate response would be "I am sorry for your loss. This is a difficult time and it will be even more difficult without any answers. Today there will most likely not be any answers to why. There is always the possibility of a heart attack, stroke, or (situation appropriate…..) but that determination will come another day. Right now the focus is gathering family and friends…. "
6) When applicable, considering "what the patient would want" can help direct the family's thoughts to understanding the situation better. Patient's previous discussions/documents with the family about quality of life and wishes will help support the discussion.

Austin County Emergency Medical Service providers may utilize the standing orders in this document while responding to incidents within the following geographical area:

- Within the geographical boundaries of Austin County, Texas
- While responding to requests for mutual aid in counties adjacent to Austin County, Texas
- While responding to requests for assistance by any City, County, State or Federal agency with authority to request EMS aid for actual or potential incidents within the confines of the State of Texas or United States of America.
- Other incidents as deemed appropriate and authorized by the Medical Director and/or EMS Director.

Purpose: To provide guidelines for the management of situations where 911 EMS services are requested and the patient (or legal patient representative) either declines/refuses EMS evaluation, treatment, and/or transportation to a hospital OR when there is a No Patient/ No Need for EMS situation.

General Statement: Although Emergency Medical Services are requested for a variety of reasons, not all requests for EMS result in transportation. Determining who may safely refuse EMS evaluation, treatment, and/or transportation is the responsibility of the PII.

Definition of a PATIENT:

A person that…

- Has a complaint suggestive of potential illness or injury
- Requests evaluation for potential illness or injury
- Has obvious evidence of illness or injury **Including DOS
- Has experienced an acute event that could reasonably lead to illness or injury
- Is in a circumstance or situation that could reasonably lead to illness or injury

Absolute Exclusions for No Injury/No Medical Emergency Scenarios:

- Significant MOI/HPI
- Altered Mental Status
- Visible Injury
- Actively suicidal/homicidal
- Law Enforcement Custody or Detained

1. **CANCELLED/DISREGARD:** May be used when the medic unit is cancelled by dispatch **for any reason prior to their arrival on scene OR**:
   i. Fire Department on scene may disregard/cancel a unit while en route or upon arrival to the scene if EMS is not needed
   ii. Law Enforcement on scene may disregard/cancel a unit while en route or upon arrival to the scene if EMS is not needed
   iii. Supervisor or higher rank on scene may disregard/cancel a unit while en route or upon arrival to the scene if EMS is not needed
   iv. First Responder on scene may disregard/cancel a unit while en route or upon arrival to the scene if EMS is not needed
   v. Automatic Medical Alarm- an EMS unit may be disregarded either prior to arrival to a scene or on scene when medical alarm activation was accidental per the homeowner, the alarm company, or the medic alert owner that states that EMS is otherwise not needed.

2. **GOA/UNFOUNDED:** May be used when medic unit cannot locate a patient or calling party after reasonable efforts to locate the incident have failed OR when a person that has requested EMS has left the scene prior to EMS arrival.

3. **NO INJURY/NO MEDICAL EMERGENCY:** The following qualifiers may be used to denote situations when EMS was not needed after arrival to the scene:
   a. **MVI-**motor vehicle incident with no reported or visible injuries. It must be clearly documented in the narrative the circumstances of the initial call for EMS and why EMS was determined not to be needed by any parties on scene. If any involved persons have a visible injury then this outcome determinant may not be used and a "patient" exists. NO DEMOGRAPHIC FIELDS ARE REQUIRED TO COMPLETE THIS RECORD.
   b. **Public Assist / Child Locked in Vehicle**-a call for assistance where the person does not require evaluation, treatment, or transportation by EMS. The person that EMS that has been called for does not meet the "patient" definition. Consideration of secondary injuries such as heat exposure and 2nd injury from the event leading to needed a lift assist, should be considered and documented. Typically, these calls are for lift assistance only or assistance with activities of daily living (ADLs). DEMOGRAPHIC FIELDS ARE REQUIRED TO COMPLETE THIS RECORD.
   c. **Fire/EMS Standby**-to be used when EMS is called to the scene of a fire or other special event where no persons presented for the duration of the event with a patient related complaint or request. NO DEMOGRAPHIC FIELDS ARE REQUIRED TO COMPLETE THIS RECORD.
   d. **Law Enforcement Support**-EMS is often times called to a law enforcement scene when it is not clearly known at the time of police and EMS dispatch if EMS is needed for any reason. If EMS arrives on a scene and law enforcement personnel state that there is no need for medical evaluation, treatment, or transportation or otherwise disregards EMS while on scene then the medic may document a "no patient" scenario in the narrative. DEMOGRAPHIC FIELDS ARE REQUIRED TO COMPLETE THIS RECORD.
   e. **Third Party Welfare Check**- numerous calls for EMS are made by concerned third party callers. Many times the person that had EMS called on their behalf do not know that EMS was contacted for them and state that they do not require EMS evaluation, treatment, or transportation. The medic must make careful assessment of the scene, circumstances, mentation and current state of the person and ultimately make a decision if this 911 call for assistance meets criteria for a possible "patient" scenario. All narrative fields in the ePCR must reflect this evaluation and DEMOGRAPHIC FIELDS ARE REQUIRED TO COMPLETE THIS RECORD.

REFUSALS

1) Minor patients shall not be permitted to decline/refuse medical care or EMS transportation. Consent or a refusal must be obtained from the parent or legal guardian. A parent or legal guardian cannot refuse emergent life-saving medical care for their children.
2) Any patient (or legal patient representative) who is impaired (by alcohol, illicit drug, prescribed medication, or any other reason) or who has altered mental status should not be permitted to decline/refuse medical care or EMS transportation. Thorough evaluation and documentation of a patient's cognitive status is imperative in situations where drugs or alcohol are a factor or consideration. When competence is questionable err on the side of providing medical care for the patient by treating and transporting him/her.
3) Any patient (or legal patient representative) should not be permitted to decline/refuse EMS transportation if invasive treatment was rendered by Austin County EMS personnel excluding diabetic patients treated with IV D50% and /or glucagon IM. It is strongly recommended that a supervisor be contacted in cases where invasive care was rendered and a patient (or caregiver) does not wish to be transported to the hospital (i.e. IV therapy, medication administration, etc.).
4) At any time, Austin County EMS personnel may enlist the assistance of the Field Supervisor, the patient's physician, or law enforcement officials to encourage a patient to accept EMS transport to the hospital.
5) Patients who present with the following signs/symptoms shall be strongly discouraged from declining/refusing EMS transport:
   - chest pain or other symptoms suspicious of cardiac ischemia
   - shortness of breath / respiratory distress
   - hypertension (systolic b/p ≥ 200 mmHg and/or diastolic b/p ≥ 110 mmHg)
   - abdominal pain with significant findings (orthostasis, guarding, rigidity, hematemesis, rebound tenderness, abdominal surgery within last year)
   - overdose
   - seizure
   - altered mental status or neurological deficit
   - Any complaint or abnormal finding that could be related to a known or suspected pregnancy including abdominal pain of unknown etiology in a female of childbearing potential
   - evidence of possible injury to the head, spine, chest, abdomen, or pelvis
   - known or suspected abuse victims

Required Refusal Documentation

In all cases where patient contact is established and the patient (or legal patient representative) refuses EMS transport, the following shall be thoroughly documented:

1) Patient's complaint and why EMS was activated
2) Level of consciousness (oriented to person, place, time, & situation); the provider must document facts sufficient to demonstrate the patient's present mental capacity and understanding of his/her condition and the consequences of refusing treatment and/or transport
3) Physical findings
4) Vital Signs (B/P, pulse, respiratory rate & quality) - preferably 2 complete sets
5) Other diagnostic findings (ECG, Glucometer, Pulse Oximetry, Temperature)
6) Attempts at encouraging and offering EMS transportation including law enforcement and/or supervisor involvement
7) Condition of patient upon arrival and departure
8) Reason patient is refusing and understanding the risks of such a refusal
9) Patient's plans for seeking physician evaluation (hospital, emergency clinic, personal physician, etc.)
10) Names of other people present who witnessed patient's refusal and attempts at encouraging patient to seek further care
11) The patient or legal guardian signature on the PCR (refusal and Notices of Privacy Practice screens), or if a patient refuses to sign the Refusal form, the provider should document the circumstances under which the patient refused to sign.
12) Any treatment rendered by EMS.

PEARLS for Refusals

- The patient should be made aware that evaluation/treatment is incomplete due to limitations of the pre-hospital care environment; diagnostic tests used in the field are not indicative of all underlying etiology or pathology
- The patient should be advised that they may call 911 again at <u>any</u> time if they wish to be transported to the hospital or if their condition changes or worsens.
- A descriptive narrative that illustrates the circumstances of the call for EMS and any pertinent dialogue between EMS and the patient or other parties on scene.
- USE EXTREME CAUTION when utilizing the PATIENT REFUSAL for any psychiatric complaints. A comprehensive narrative and assessments are vital to describe incidents where EMS was called for a psychiatric related complaint and the patient opted to decline EMS evaluation, treatment, or transportation.

On Scene Physician Intervention

On occasion, system members may be approached by a physician who, after properly identifying himself, wishes to assist with care for the patient through providing direction to the on-scene medical personnel. Though often well intentioned, this intervention may create a distraction to the personnel providing care for the patient. The following guidelines should be followed in this case:

- Explain to the physician that all medical procedures are being performed per written protocol or per on-line medical direction and that these are according to the System Medical Director's wishes. If the physician still insists on providing direction,
- Explain that the physician will have to take complete charge for the care of the patient including accompanying the patient to the hospital and documentation of all activities during transport. If the physician still insists on providing direction,
- System personnel should document all direction given and care provided. If the on-scene medical personnel do not agree with the care proposed by the intervening physician, they may refuse to participate in that specific care. In this event, they shall immediately contact on line medical direction.

On Scene Non EMS Certified or Licensed Medical Practitioner Intervention

On occasion, System members may be approached by a Non EMS Certified or Licensed Medical Personnel who after properly identifying himself, wishes to assist with care for the patient through providing direction or assistance to the on-scene medical personnel. (i.e., Pediatric Nurse) Though often well intentioned, this intervention may create a distraction to the personnel providing care for the patient. The following guidelines should be followed in this case:

- Explain to the bystander that all medical procedures are being performed per written protocol or per on-line medical direction and that these are according to the System Medical Director's orders.
- These bystanders will not participate in any care without the approval of an EMS Supervisor.
- System personnel should document all direction given and care provided.

ACEMS Patient Assessment

PRIMARY ASSESSMENT

Circulation and Initial Impression

Gross-Visible Bleeding / Open Chest / Cardiac Arrest / Gross Perfusion Intact

Level of Consciousness AVPU (AV / PU)

- AV: Manage secretions and airway if needed
- P: Cannot manage own airway: Place NPA
- U: Cannot manage own airway: Place OPA and/or NPA

**Overt Need for C-Spine control (may be modified later as more details are collected)

Airway

Look in: patent, moist, pink
Look Externally: BVM considerations / Intubation considerations / LEMON

Breathing

Rate & Tidal Volume –**Adequate** Minute Volume
Breath Sounds **Normal**
Feel Chest Excursion **Normal**

Circulation

Distally

Pulse: Quality **+0** to **+4**
Skin: Temp / Color / Condition
Perfusion: Capillary Refill

Internal Bleeding

CARTS: Chest, Abdomen, Retroperitoneal/Pelvis, Thigh/Femur, Severity

Pulse Quality

+4 Unable to Occlude
+3 Occludes with Significant Pressure
+2 Occludes with Moderate Pressure
+1 Occludes Easily
+0 Absent

Disability

Cognition / Glasgow Coma Scale
Motor: Gross & Fine (x4 extremities)
Pupils – PERRL
Stroke/NIH Assessment as needed
C-Spine Assessment as needed

Patient Acuity: Sick / Not Sick / Not Sick Yet

Toxic Vital Signs

AGE	PULSE	RR	SBP
<2m	180	50	60
2m-2y	160	40	70
2y-7y	140	20	90
>8y	110	20	90

ETC02 <30 & >50
SPO2 < 92%

SECONDARY ASSESSMENT

Expose

Physically: Detailed as needed in area of complaint, suspicion and/or rule out
Verbally: with SAMPLE-AR and OPQRST
Toxic Vital Signs (lowest BP, Highest HR, room air SPO2) **Explainable** vs **Dangerous**

Focused Exam

Trending of vital signs (BP, HR, RR, Lung Sounds, SPO2, ETC02, BGL, ECG, 12-Lead, Temperature)
Trending of Patient Presentation / symptoms
Patient responses to therapies performed

PEARLS

- Document according to the assessment performed above and the results of interventions performed. Utilize a narrative based format (See Documentation Guideline).
- Focused assessments should be performed according to the complaint. Ensure to assess the patient in a “Rule Out” approach.
- A comprehensive patient exam requires a balance of 3 major factors; good physical & verbal exams, adequate & effective use of diagnostic tools, and the “gut” feeling based on experience to ensure discovery and potential treatment for obvious and obscure conditions.

Purpose:

Define what ACEMS considers to be a patient, no-patient, and public assist and the applicable required actions for each.

General:

Typically it is obvious when a patient exists, however, there are scenarios that can be difficult to define if a patient exists or not. Utilize the following guidelines and examples to help guide your decision on which category your scene fits in. Close call rules and documentation is driven off the below information and will help define the actions/assessments that are required. Generally speaking, obtaining vital signs and performing a patient assessment in any instance is good practice when unclear if a patient exists. All events/findings must be documented in the ePCR according to the Documentation Guideline.

Patient:

A patient exists if any of the following are present/exist:

1. Any person with a complaint and/or visible injury/illness
2. Any person who has a reported OR reasonably suspected injury and/or illness exists.
3. Any person who is unconscious (refer to patient right's and refusal)
4. Any person who is intoxicated/altered and unable to make own decisions (refer to patient's rights and refusal)
5. Any incident that has a significant MOI (mechanism of injury)

If a patient exists, then a full ePCR must be completed. A minimum of 2 vital signs and a full assessment must be completed in addition to the required basic information for each ePCR. REFUSAL IS REQUIRED

Assistance Only:

A person(s) requesting public assist would exist in the following examples as long as any of the above does not exist:

1. Lift Assist – Person needing assistance getting back into bed/chair/etc. The person did not claim any injury sustained from the event NOR did the person report any illness that lead up to the event.
2. Blood Pressure Check – Person who requests a BP check after a home machine reports a concerning value or like scenario. This does NOT include any person who reports any associated symptoms or concerns.
3. Person/Child Locked in Vehicle – Person who is locked inside a vehicle (or like scenario) and is freed within a reasonable amount of time in consideration to current weather conditions and/or potential medical condition(s).
4. Welfare Check with absence of any of the above.

Any person who is defined as a Public Assist should have a minimum of 1 vital sign set and an assessment completed in addition to the required basic information for each ePCR. After performing an assessment and ruling out any instances of a patient, then a REFUSAL IS NOT REQUIRED for public assist.

No Patient / No Medical Emergency:

Any Person(s) whom 911 have been activated for by a 2nd, 3rd, 4th, etc. party where an injury or illness was suspected, but was not substantiated. Examples of this would be:

1. MVA's where a witness activated 911 and once on scene all persons on scene lack any of the above.
2. Family member/friend activated 911 who are not on scene and concerns/reports were not substantiated.
3. A patient DOES exist if:
   a. At any time (reasonable to the event) the person did confirm or is reasonable that an event/symptom did exist, despite any resolution of symptoms prior to arriving on scene and/or lack of presentation upon arrival.

Any instance that a No Patient scenario exists then the ePCR needs to be completed in the following:

1. If a single person, then only 1 ePCR needs to be completed and no vital signs and/or assessments required.
2. If multiple persons involved, but No Patients, 1 ePCR needs to be completed describing the entire scene.
3. If Multiple persons involved and 1 or more patients in addition to No Patients, 1 ePCR per patient and a notation of the number of individuals involved and their status.

Purpose:

Define the outline for patient rights and refusal and how to approach these situations.

General:

Once we have begun collecting information regarding a patient encounter, it is important to take every precaution to protect patient confidentiality. While HIPAA issues are to be considered, we also have ethical obligations to protect a patient's confidential information. This applies not only to the sharing of written information but also requires us to monitor our speech so as not to inadvertently share patient information in casual conversation. Formal communication in essence of educational purposes, after call reviews and incident reporting to superiors is acceptable. ***Patients of legal age with intact cognitive function retain the right to accept or refuse medical care, even if the consequences of the refusal of care may potentially be harmful for the patient***. In the event a patient attempts to refuse medical care, it is important to recall that we should:

1) Be courteous and professional
2) Offer transport or treatment without some (or all) of the recommended treatment(s) if that is what the patient will allow (document discussion that lead to the elected course of treatment, obtain refusal documentation including patient signature).
3) Clearly advise the patient of the possible complications of their decision. ***not just general concepts*
4) Advise the patient to call back if they subsequently desire treatment and transport
5) Accurately document all components of the patient encounter.

Types of Consent:

1) Expressed/informed consent: Most patients ACEMS is called to will fall under this. Expressed consent is presented in 2 ways; 1, the medic requests the opportunity to assess, treat and transport the patient and 2, the medic inherently initiates assessment, treatment and transport and the abled-informed patient does not express wishes otherwise.
2) Implied consent: Situations exist where the patient is either unconscious requiring life sustaining interventions or the patient is in an altered/impaired cognitive state (i.e. drugs, ETOH, Alzheimer's). Under the doctrine of implied consent, in these situations the patient does not have the right to refuse and is treated based on the assumption that a "normal" person would consent to treatment. Ensure that adequate assessment of the patient, scene and situation is conducted before determining adequate or inadequate cognitive state.
3) Involuntary Consent: Situations where it has been lawfully determined by an empowered representative of the state (i.e. Judge, Law Enforcement Officer, EMS) that a person be treated and transported without the right to refuse. This includes, but not limited to;
   a) Threat to themselves or others: may be initiated by EMS and LE must be advised.
   b) Court ordered / In custody: Initiated by LE and must be accompanied by LE or other LE official
   c) Lawful representative of the state dictates reasonable cause for issuance of involuntary consent: must be accompanied by LE or other LE official.

Special Consideration: **Minors**

1) In general, patients under the age of 18 may not consent to medical treatment or transport. The following groups may consent for the treatment of a minor:
   a) Mother or Father or a Legal Guardian (i.e. grandparent, adult brother, adult sister, etc.)
   b) An individual standing in loco parentis. A person stands in loco parentis when he or she takes on the responsibilities of a parent of the child (e.g., a step-parent)
   c) The leader of a group of children in possession of written permission from the parent authorizing emergency medical treatment (e.g., a school field trip, a child at school where the parent is not present).
2) In the following circumstances, **no consent is required** prior to initiating treatment:
   a) The parent, guardian, or person standing in loco parentis cannot be reached and the minor needs to receive medical treatment
   b) The identity of the child is unknown and a delay in giving treatment would endanger the life of the child
   c) The effort to contact the child's parents, guardian, or a person standing in loco parentis would result in a delay that would seriously worsen the condition of the child
3) Under the following circumstances, a **minor** may consent to treatment without the knowledge of the parent/guardian:
   a) On active duty with armed services.
   b) 16 years old or older and residing apart from parents, managing conservator or guardian and managing his or her own financial affairs.
   c) Unmarried and pregnant and consenting to treatment related to pregnancy other than abortion.
   d) Unmarried and the parent of a child and has actual custody of that child and consents for him or her.
   e) Consenting to diagnosis or treatment of an infectious, contagious, or communicable disease that is reportable to the Texas Department of State Health Services (DSHS).
   f) Consenting to examination /treatment for chemical addiction, dependency, or any other condition directly related to chemical use.
   g) Consenting for counseling for suicide prevention, chemical addiction or dependency

Life-threatening situations without ability to communicate

1) A patient of any age who is unable to communicate because of an injury, accident, illness, or unconsciousness – AND- is suffering from what reasonably appears to be a life-threatening injury or illness. This patient is treated on the principle of implied consent.
2) The principle of implied consent presumes that if the individual with the illness or injury were conscious and able to communicate, he or she would consent to emergency treatment
3) In these situations, patients may be transported without their consent. Law enforcement, physical restraint, and/or chemical restraint may be required

Potentially life-threatening situations

1) Patients in this category generally fall into one of two groups: the alert patient who has a concerning presentation and refuses treatment and/or transport (e.g., the patient with chest pain and EKG changes=STEMI) or the patient who may be intoxicated but does not have what reasonably appears to be a life-threatening injury (e.g., the patient who has consumed alcohol with a small laceration). In these situations, the following steps should be taken:
   a. Determine orientation to person, place, time and event. This evaluates gross mental status and does not determine cognitive status.
   b. Engage the patient with conversation and determine if the cognition is appropriate and intact. Document findings.
   c. Determine what factor(s) is/are influencing the patient to refuse medical care. Resolve the ones in your power (e.g., patient does not want an IV – offer transport without an IV).
   d. Attempt communication with spouse/significant other/other family members if available.
   e. If patient continues to refuse, clearly explain risks of refusal and have the patient repeat these concerns back to you. Document your results in the patient care report.
   f. In a courteous manner, assure the patient they can call back for treatment and transport at any time

Refusal of the Informed Patient:

Situations exist that ACEMS will be called to a scene where the patient does not wish to be treated or transported. It is acceptable that these patients wish to refuse when ACEMS conducts an appropriate refusal. Use the below guidelines to ensure a professional, appropriate refusal of the informed patient. Before the medic engages the patient in discussion of refusal, the medic must first complete a full assessment of the patient, scene and situation. The patient may initiate this conversation, but it is the medic's responsibility to put the discussion about the refusal off until properly prepared to discuss with the patient.

1) Patient does not wish to be treated:
   a. All attempts need to be made to ensure the patient has been FULLY assessed before making any determination. The patient cannot make an informed decision until all diagnostic data has been collected and the medic presents the findings objectively to the patient.
   b. Once the patient is properly assessed (with respect of the patient's right to refuse assessment), then the medic will objectively present the findings and include "worst and best case scenario" based on realistic differential diagnosis. This approach provides the patient good and medical professional reasoning to the risks and why treatment and transport is recommended. This should also include friends, family, etc. when appropriate and not counterproductive.
   c. Medic must ensure the patient has been offered treatment and transport.
   d. If the patient continues to refuse, discussion about alternatives in seeking medical attention should be discussed. These include, but not limited to: Community Paramedicine, free standing ER's, Health Clinic's, family physician and specialty physician.
   e. If the patient continues to refuse, then a final recap of situation and efforts to encourage patient to treatment and transport should be made before having the patient/guardian sign the refusal.
2) Patient does not wish to be transported, but treatment on scene is consented.
   a. The above efforts should be made in addition to the below considerations.
   b. Life sustaining treatments should never be withheld from a patient.
   c. Diabetic emergencies involving hypoglycemia is the most common instance for this. Even if considered routine, every effort to evaluate underlying indications of metabolic changes and causes needs to be done.
   d. Patients may request simple, BLS assistance such as a splint or bandaging but requesting to go POV to hospital. It is acceptable to treat the patient and allow refusal when appropriate.
   e. The medic may be presented unique situations where treatment is administered, but then transport is then denied. These situations are **<u>not</u>** common and every effort should be made to transport the patient, however, when appropriate it is permitted to allow the patient to refuse when mentally intact. In these rare cases, the Shift Supervisor and/or Clinical Coordinator should be advised and a unified decision made (ultimately the medic on scene has authority). If they are not available, then contacting medical control is the next step.
      i. Example: Patient is out of albuterol treatments at home or has the medication but not with them. After the first treatment the patient's symptoms resolve. The patient has initiated a plan or currently has a plan to follow up with family physician, obtain/pickup prescription or able to gain access to own medication supply. In this case, refusal is acceptable as long as above refusal criteria have been met.
      ii. Instances where narcotics were given, then the patient must be transported. If this becomes problematic, then supervisory staff needs to be notified and involved.
      iii. Instances where significant medical interventions were performed, the patient must be transported (i.e. IO, Pt. was unable to protect own airway at any time, ALTE, etc.). If this becomes problematic, then supervisory staff needs to be notified and involved.
3) Patient does not wish to receive treatment but is requesting transport.
   a. The above efforts should be made in addition to the below considerations.
   b. If the treatment is related to a life sustaining situation, considerations to patient's wishes, religion, etc. will be made. Description of the potential life threats/negatives of not accepting treatment should be presented to the patient professionally and objectively. Effort to encourage this should be in direct proportion to the situation:
      i. Patient IV (or other relevant interventions) which the medic wishes to start for "precautionary" reasoning VS.
      ii. Patient presenting with STEMI and refusing IV (or other relevant interventions)

Purpose:

To identify the need for a performance improvement plan (PIP), initiate recommendations and provide clear parameters for the medic on how to improve and be successful. This process will be a result of action or inaction that impacted the patient care provided post call. Ultimately the PIP goal is to provide a team effort to setting up the medic for success and ultimately improving professionalism and quality of care ACEMS provides.

This process is not intended for events where the medic performed appropriately outside of the protocol and was dictated by a unique presenting situation/patient. The PIP is not disciplinary. In the instance of significant infractions, the Medical Director and/or EMS Director can initiate a separate disciplinary action.

General:

This protocol applies to any employee or first responder who operates under ACEMS protocols and medical direction. If, in the opinion of the Clinical Coordinator, the medic was inappropriate in treatment(s) and/or in providing/withholding care outlined in these protocols, then a PIP may be initiated. The PIP is developed by the Clinical Coordinator (including the Medical Director when appropriate) with input from Deputy Directors, Director, and/or any other department member that is applicable to the situation.

The PIP should be:

1) Written Objectively and non-threatening and based on fact and/or investigative findings
2) Clear outline of the events that took place
3) The standards and expectations relevant to the situation
4) Clear outline and direction on how to improve future performance. This may include additional tasks to be completed.
5) Appropriate timeline with identified review way-points
6) Reviewed with the medic, adjusted/changed as needed during the review, and signed by both the medic, Clinical Coordinator, and Director
7) Timely with adequate review (not hasty) and not put off.

Additional tasks: Additional tasks may be assigned to the medic to facilitate knowledge base expansion, experience and/or validation of skills. This can be done in a multitude of ways. This may include, but not limited to, the following:

1) Research paper relevant to the situation
2) 1:1 training and review time with Clinical Coordinator and/or Clinical Division staff
3) Skills reverification process
4) Attendance to nationally or locally recognized courses (i.e. AMLS, PALS, ACLS, etc.) relevant to situation
5) Clinical review of calls/documentation with Clinical Division staff and the medic

Modifications: Modifications can be made for the medic temporarily (not to exceed a time period of 90 days) to help ensure success in improving the medic's performance. These may include, but not limited to, the following:

1) Scheduling modifications
2) Partner/station modifications
3) FTO assignments
4) Specific requirements based on call or procedure type (i.e. refusals, RSI, etc.).

Recommendations: Recommendations are reserved for serious infractions, repetitive infractions, and malicious activity relevant to patient care and/or failure of the medic to improve to an acceptable level within PIP time frames. Recommendations may be made to Deputy Directors, the Medical Director and/or the ACEMS Director based on the situation. The recommendations should be appropriate to the situation. This may include, but not limited to, the following:

1) Credentialing modifications (Medical Director approval only)
2) Permanent partner/station modification (Director of ACEMS, Deputy Directors and Clinical Coordinator)
3) Termination (Director only)

Non-Punitive Medication Error / Significant Event Reporting (MESE): This is designed to provide the medic a pathway to report incidental errors that are inherently a fact of providing medicine to patients, but is never acceptable when it happens. Every attempt needs to be made to reduce instances of MESE's, such as failure to sedate a paralyzed patient. MESE does not apply to actions determined to be malicious.

- The medic or partner has the responsibility to inform the receiving facility staff of the MESE.
- The MESE must be immediately reported (without delay to patient care/immediate duties to patient) to the on Duty Supervisor and/or Clinical Coordinator by verbal communication first and then a written Email describing the situation and incident in detail.
- The on Duty Supervisor and/or Clinical Coordinator will initiate any immediate corrective action(s) that are appropriate in concerns to the patient, receiving facility, staff and/or crew.
- The incident will be reviewed by the Clinical Coordinator and Administrative Team and a PIP will be developed according to the above process.
- *****Termination is <u>NOT</u> authorized.***
- Failure of the medic to meet the PIP standards and expectations and after exhausting, within a reasonable effort, all potential of the PIP may result in disciplinary action up to and including termination. Termination will not be from the MESE, but for failure to meet a performance standard after being given adequate opportunity within the PIP.

PEARLS

- The medic has the right to request further review of situation and/or a meeting with senior leadership with proper notification.
- All parties will approach the situation as a team effort to improve the medic's performance in a positive, non-threatening way.

Policy:

The medical direction of pre-hospital care at the scene of an emergency is the responsibility of those most appropriately trained in providing such care. All care should be provided within the rules and regulations of the state of Texas.

Purpose:

Identify a chain of command to allow field personnel to adequately care for the patient. Assure the patient receives the maximum benefit from pre-hospital care. Minimize liability of the ACEMS as well as any on-scene physician.

Procedure:

1. For the purposes of this policy, a physician may be considered "on scene" according to the below instances and therefore able to take medical-legal responsibility for the patient and therefore issue orders. Orders received from an authorized (as determined by this policy) physician may be followed, even if they conflict with existing local protocols and are appropriate. Under no circumstances shall ACEMS personnel perform procedures or give medications that are outside their scope of practice and/or credential. ACEMS personnel may aid and assist the physician.
   - **a. Non-medical-control physician**
     - i. When a non-medical-control physician offers assistance to ACEMS or a patient is being attended to by a physician with whom they do not have an ongoing patient relationship, ACEMS personnel must identify the physician's name, phone number, area of specialty/practice and sign the "physician on scene" acceptance of responsibility in PCR.
   - **b. Attending Physician**
     - i. When a patient is being attended to by a physician with whom they have an ongoing patient provider relationship (i.e. doctor's office), ACEMS personnel may follow orders given by and/or sustain treatments the physician has initiated. ACEMS personnel must identify the physician's name, phone number, area of specialty/practice and sign the "physician on scene" acceptance of responsibility in PCR only IF specific treatments that are not routine for ACEMS are requested. The paramedic crew must assess for appropriateness in considerations of the physician's expertise and patient's presentation. Involving the Battalion and/or Lieutenant is recommended.
       1. For example; in a case where a therapy has already been initiated by a stand-alone clinic, such as Nitroglycerine infusion, Propofol, Integrilin, etc., then the infusion may be continued for transport. If specialized equipment, such as IV pumps, vents, etc. is required to facilitate maintenance of the therapy, then utilizing the originating facility's equipment is acceptable.
       2. If staff members would be beneficial in maintaining/sustaining care or equipment, request for the staff members to be transported with the patient.
   - **c. On-line patient's physician**
     - i. ACEMS personnel may accept orders from a patient's physician over the phone that extends beyond routine treatments. The medic should obtain the specific order and the physician's name, area of specialty/practice and phone number. Final decision to follow through with the order lies in the Paramedic on scene as they must assess for appropriateness of the treatment according to the patient's presentation. Documentation of this must be reflected in the ePCR.

GENERAL STATEMENT

"Do No Harm, Do Know Harm". The ACEMS Protocols are designed to serve as a guideline in assessing, treating and transporting patients. Every treatment and interaction that we as healthcare professionals elect to do or not to do, has both an effect and affect on our patient. The treatment not only includes the medicine we administer, but the emotional impact we have on the patient's experience; including family and friends.

It is impossible to outline treatment sequences for every situation; therefore, in addition to these protocols and guidelines, each patient should be treated individually and appropriately. The clinician should utilize sound judgement, and conduct a comprehensive patient assessment in addition to timely notification of the receiving hospital. Ultimately, as a professional healthcare organization, ACEMS protocols reflect the mission to provide the best patient care and experience to our patients/customers.

GENERAL RULES FOR FOLLOWING PROTOCOL AND GUIDELINE

1. ACEMS views their patients as customers. A majority of patients in the prehospital setting are primarily in need of comfort type care and not necessarily life sustaining or resuscitation procedures. If our patients have a bad experience based on our performance, then we have not successfully performed our mission. Some key things that must be considered as a professional prehospital care provider are:
   a) The patient/customer defines the emergency
   b) Patients typically desire 3 things: get there quickly, take their pain away and be nice to them.
   c) Ensure good, appropriate, effective care and communication with the patient/customer, family, etc.

2. If a dysrhythmia is to be treated, do so in the following order:
   First: Treat Rate
   Second: Treat Rhythm
   Third: Treat Blood Pressure

3. Protocols and guidelines may overlap with one another. The clinician must utilize sound judgement and evaluate the effects of treatment to identify the best course of action with integrating multiple treatments. Do not start the protocol over when transiting between protocols. Generally speaking, "pick up where you left off" while ensuring the maximum total dosage of medication for the patient is not exceeded.

4. The emergency patient benefits from early appropriate medical interventions. Withholding treatments in relation to close proximity of the hospital is detrimental to the patient in most instances. The clinician must evaluate the patient's need for definitive care (STEMI, CVA, and Trauma) to what treatment options are available as to minimize the immediate impact of the emergency to the patient physiologically and psychologically.

5. Some protocols and drug dosages are taught as absolutes; however, sound medical judgement based on a good patient assessment and consideration of risk vs benefit to the patient must be used. Documentation of situations such as this must be thorough and objective.

6. In general, the protocols are divided into Adult and Pediatric sections, as well as medical, trauma, and other special groupings. For pediatric patients, the appropriate pediatric-specific protocol should be utilized if one exists. If there is not a pediatric-specific protocol for a given pediatric patient situation, utilize the adult protocol for care guidance, but always use pediatric weight-based dosages for medications. Never exceed adult dosages of medication for a pediatric patient. Using official reference materials (i.e., Broselow tape, pocket guides, smart phone apps, Handtevy) are an acceptable means of providing guidance. However, contacting the Clinical Coordinator, Shift Supervisor, and/or Medical Control can be utilized.

7. The Medical Director, Administrative Team, and Clinical Division have extensively reviewed the included elements. These represent proven practices which are the foundation of this profession and the ongoing mission for ACEMS in efforts to provide the best possible care. Changes will occasionally be made to adhere with current practices and to improve clarity. Any changes will be overtly trained and distributed before being placed as an "active protocol".

8. It is impossible to condense and explain all of the information for each protocol. It is important to understand that the expectation is for the clinician to apply the knowledge, experience, and initial training they received; along with individual professional development, and their "gut feeling" to not only identify the etiology of the patient's presentation but also to formulate the best treatment plan for the individual patient.

9. *As a physician licensed to practice medicine in the State of Texas, and as the authorized Medical Director for Austin County EMS (ACEMS), I hereby authorize this page and all subsequent pages within this protocol and guideline:*

____ ____________________

Benjamin Oei, MD, FACEP — Date
Medical Director
Austin County EMS

# Storage of Medication	**Austin County** EMS Protocol & Guideline	
Medical Director: Benjamin Oei, M.D.	**Version:**	**1.0**
	Date:	**04/2019**

All medications will be maintained within the ranges listed below. Highlighted medications will be secured by pad lock or other appropriate controlled access device.		
Medication	Recommended Minimum Temperature	Recommended Maximum Temperature
Acetaminophen	59°F	86°F
Adenosine (Adenocard)	59°F	86°F
Albuterol Sulfate (Proventil)	59°F	86°F
Amiodarone HCL (Cordarone)	59°F	86°F
Aspirin	59°F	86°F
Atropine Sulfate	59°F	86°F
Atrovent (Ipratropium)	59°F	86°F
Calcium Chloride	59°F	86°F
Dextrose 50 %	59°F	86°F
Diltiazem (Cardizem)	36°F	46°F
Diazepam	59°F	86°F
Diphenhydramine (Benadryl)	59°F	86°F
Epinephrine HCL (Adrenalin)	59°F	86°F
Famotidine (Pepcid)	59°F	86°F
Fentanyl Citrate (Sublimaze)	36°F	86°F
Glucagon	59°F	86°F
Heparin Sodium	36°F	86°F
Hydroxocobalamin	36°F	86°F
Ketamine	59°F	86°F
Ketorolac	36°F	86°F
Labetalol (Normodyne)	59°F	86°F
Lidocaine HCL (Xylocaine)	59°F	86°F
Magnesium Sulfate	59°F	86°F
Methylprednisolone (Solu – Medrol)	59°F	86°F
Metoprolol	36°F	86°F
Midazolam (Versed)	36°F	86°F
Morphine Sulfate	36°F	86°F
Naloxone (Narcan)	59°F	86°F
Nitro Paste	59°F	86°F
Nitroglycerin Spray	59°F	86°F
Ondansteron Hydrochloride (Zofran)	59°F	86°F
Rocuronium	36* F	86°F
Sodium Bicarbonate	59°F	86°F
Succinylcholine (Anectine)	36°F	46°F
Tetracaine Ophthalmic Solution	59°F	86°F
Terbutaline	59°F	86°F
Thiamine	59°F	86°F
Tranxamine Acid (TXA)	59°F	86°F
Vasopressin (Pitressin)	59°F	86°F
Vecuronium (Norcuron)	36°F	86°F

Medical Director Austin County EMS
Benjamin Oei M.D

Transport Determination

Medical Oversight

Medical Director: Benjamin Oei, MD

Austin County EMS Protocol & Guideline	
Version:	**1.0**
Date:	**04/2019**

Purpose: To establish a guideline for the transportation of ACEMS Patients.

Procedure: All sick or injured persons requesting transport shall be transported to an appropriate local emergency department of the patient's preference. The only exceptions to this rule are found below.

1. An "appropriate local emergency department" includes all Texas DSHS approved Emergency Departments and Emergency Departments at hospitals in contiguous counties. The ability to pay or insurance status if known SHALL NOT BE A FACTOR. If the unit availability is limited (system status), contact your supervisor prior to a patient-requested non-routine out-of-county transport .

2. All sick or injured persons requesting transport who do not express a preference will be transported to the closest appropriate local hospital or ED.

3. Patients whose conditions are covered by a formal Destination Plan (Pediatric, Post-Resuscitation, STEMI, Stroke, Trauma, etc.) shall be transported in accordance with those specialty algorithms to the appropriate destination. All other patients should be transported per this policy.

4. In unusual circumstances, transport in other vehicles may be appropriate when directed under the authority of the Clinical Coordinator, Administrative Team and/or Operations Division. This is primarily for disaster situations. Acute situations requiring remote medicine, such as using a fire truck or pickup truck to move patient to the ambulance, do not require any approval. However, safety in utilizing this alternative mode is required.

5. Select patients who may or may not be frequent utilizers of the EMS System may have a preexisting specialty care plan / pre-existing healthcare relationships. These situations include, but are not limited to, Cancer treatments, Obstetric care, and LVAD patients. These patients should be transported to their respective specialty hospitals in consideration of risk-benefit. Risk-Benefit would include taking the patient to closest hospital to stabilize issues associated with eminent failure to Airway, Breathing, and Circulation. Consideration to the requirements in #3 must also be considered. If #3 exists, then it overrides the transport decision.

6. In the event of **multiple patients** needing transport the medic should load as many as safely possible before offloading to other transport units. Below are some considerations that will dictate loading multiple patients vs loading to other units:

    a. A second unit may be called if the stability of the patient is anticipated to require significant manpower and/or interventions during transport.
    b. A second unit may be called in the instance of emotional upset between the two or more patients.
    c. Two patients can be transported together as long as they both require the same facility and/or agree on the destination.
    d. In the event that two patients require a monitor, but are stable patients, the Shift Supervisor may provide a second monitor to facilitate this.
    e. Patients (typically 3 or more patients) who are stable and not requiring a backboard/supine position may be transported in another seat belted location in the back of the ambulance.
    f. Ultimately, maximizing the ambulance utilization without causing any undue risk to the patient is the directive in selecting multiple patient load vs calling multiple units.
    g. Total number of patients able to be transported is directly dependent on the ability to safely secure them during transport.

Use of Air Medical Asset(s) should be considered according to the following:

1. Rapid transport to the specialty facility is warranted and Air Medical will have a positive impact to transport time. Air Medical is NOT reserved for Trauma patients only.
2. Traffic and/or construction consideration for impacting transport time for Trauma, STEMI, Stroke, etc. patients.
3. In the event of MCI and/or local resources are exhausted, Air Medical transport can be utilized for patients classified in triage order as "Red", or when appropriate "Yellow".
4. Transport destination is directed as the above transport decision guidelines. Patients will be transported to the appropriate facility based on accrediting credentials (Trauma, STEMI, Comprehensive Stroke, etc.). There is no existing reason to refuse or miss-direct transport to an adequately credentialed facility other than patient refusing.

Transport Mode (Emergency / Non-Emergency)

1. Emergency transport is reserved for patients who will directly benefit from early arrival to the hospital. Examples of these patients primarily are: STEMI, Stroke, Level 1 Trauma criteria, cardiac arrest/respiratory arrest and patients whose Airway, Breathing and Circulation is compromised and/or not responding to treatments by field staff.
2. All other patients who do not fit in the above category will be transported non-emergency to the hospital
3. Consideration of risk, benefit MUST be weighed. Transporting emergency traffic for a patient that would not directly benefit from early arrival to the hospital causes undue risk to the patient, crew and public.