TRANSPORT POLICIES

Definition of "Patient"

It is important to remember that the definition of patient requires the input of both the individual and the healthcare provider, and an assessment of the circumstances that led to the 9-1-1 call. The definition of a patient is a separate question from whether or not the patient gets evaluated and/or treated. The definition of a patient is any human being that:

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

All individuals meeting any of the above criteria are considered "patients" under this protocol. These criteria are intended to be considered in the widest sense. If there are any questions or doubts, the individual should be considered a patient.

Anyone that fits the definition of a patient must be properly evaluated and/or appropriate treatment options taken (including informed refusal if the competent patient absolutely does not wish medical care or transport despite our suggestions that they do). Similarly, anyone that does not fit the definition of a patient as defined here does not require an evaluation or completion of a Patient Care Record. If there is any doubt, an individual should be deemed a patient and appropriate evaluation should take place.

CONSENT

A. **Expressed Consent** must be obtained from a conscious, oriented (to person, place, time, and circumstance) and competent adult (> 18 years old) patient ,parent, legal guardian, or individual less than 18 years old who is either married, in the military or declared emancipated by the court for treatment and transport
    1. This consent may be in the form of a nod, verbal consent, or gesture.

B. **Implied Consent** occurs when a patient is incapable of giving permission for treatment due to being unconscious and/or incompetent. It is assumed that their permission would be given for any life-saving treatments. This also applies to minors who require life-saving interventions and the parent or legal guardian is not present to provide consent.

C. **Minor** may receive diagnosis and treatment for STDs *without* parental consent.
Minors may also consent to the evaluation and treatment of a minor who is a victim of a sexual offense *without* parental consent, but written notification to the parent or guardian that such an examination has taken place is *required.*

D. **Contraception:** Minors in Ohio have the right to recieve contraceptives (including emergency contraception) *without* parental consent if they are at a clinic that recieves federal funding through title X (most EDs)

A. Transport Destination

1. Stable patients should be transported to the facility of choice whenever possible. There may be EMS calls where the EMS unit is unable to transport the patient to their destination of choice. If the competent patient insists on transport to that specific facility, and is in stable condition, a private ambulance may be called to take the patient. The responding EMS unit must stand by until the private EMS providers arrive and assume care of the patient.
2. Unstable patient should be transported to the closest, most appropriate facility, taking into consideration Ohio's trauma triage rules and the facility's capabilities. (i.e., Cardiac catheterization lab, stroke care, burn center, etc.)

B. Mode of Transport

1. Ground transport – BLS units should transport unstable patients immediately unless an ALS unit is en route with an ETA of < 5 minutes. Consider ALS intercept when necessary.

2. **ALS vs BLS Care** - How to handle calls that are staffed by different levels of pre-hospital providers:

A). In general, a patient should be cared for by the highest -trained person available in the ambulance If a Paramedic and an EMT-B staff a given squad, the medic should be handling the vast majority of those calls, and certainly all calls in which any ALS is required.
When the medic downgrades a call to an A-EMT or EMT-B level, they must be extremely confident that the patient will not deteriorate or require any advanced interventions en-route. The provider they have put in charge of the patient's care may not be in a position to intervene if the patient decompensates. If the patient suffers harm as a result of the downgrade and subsequent unavailability of ALS interventions during transport, in that case such calls will be subject to investigation and review by medical direction

B) There may be RARE cases in which the paramedic may feel it is appropriate to downgrade a call to an A-EMT or EMT-B level of care, but this should be a rare occurrence, performed with caution, and only if the following criteria have been met:

1. The paramedic has performed a complete assessment and has a high degree of confidence that the patient would not benefit from advanced life support measures on the scene or during the transport.
2. No ALS intervention or medication has been initiated (even if the patient improves or if the EKG is normal)
3. The paramedic and lower-level care ambulance crew both agree on a plan for subsequent patient care If the patient's condition deteriorates during transport, the BLS resource shall transport the patient to the closest, most appropriate hospital and make the proper notifications.
4. The patient is alert, oriented, and acting appropriately for their age.
5. There are no signs of significant impairment due to drugs, alcohol, organic causes, or mental illness
6. If any doubt of appropriateness of downgrade contact Medical Control.

C) No specialty team activation calls (Stroke, Trauma, STEMI, Sepsis, Cardiac Arrest) shall be downgraded. The highest-trained person in the ambulance shall be in charge of these patients.

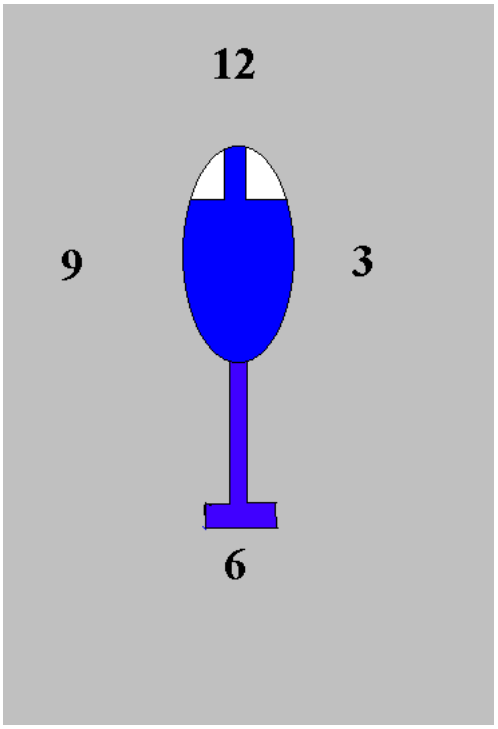
D) Use your team to divide and conquer - patient care responsibilities should be split up during the call such that every provider on the team can function to the limits of their license and contribute to optimal patient care. No provider shall function outside of their scope of practice, nor shall they be ordered by a superior officer to do so. A lower-level care provider may begin the patient care report; however, the highest-level provider must review the patient care report and is ultimately responsible for its content.

E) Downgrade documentation requirements:

1. All cases in which the patients are released to a lower level of care must be thoroughly documented.
2. The patient care report must document all assessment findings, treatment rendered, and the clinical decision-making factors that played a role in the patient's release to a lower-level ambulance crew.

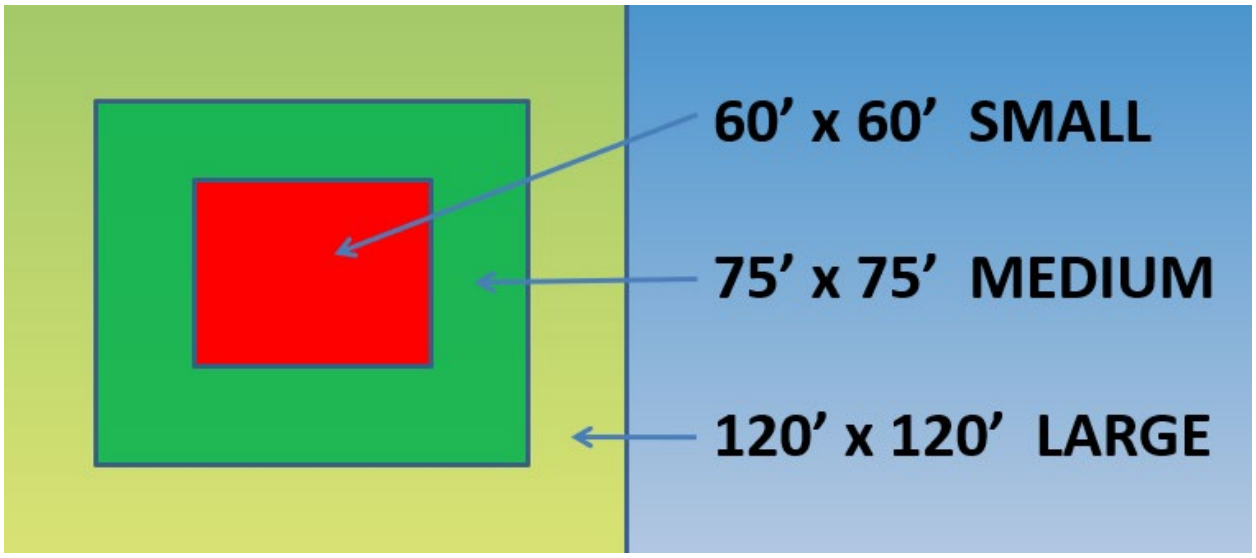
3. Rotary Wing Aeromedical Transport/Helicopter EMS/HEMS:

   A. A request for helicopter transport should come from the highest-trained EMS personnel on the scene, and should be made as early as possible to minimize delays in transport to definitive care
   B. In general, HEMS transport should be considered for the **4T's: Time, Terrain, Training and Traffic:**
      Time – prolonged extrication, technical rescue, prolonged transport time, remote region, multiple seriously injured patients being triaged
      Terrain – patients trapped in difficult to access areas (e.g. ravine, cliff, deep valley, poor road conditions)
      Training – you anticipate that blood transfusion, chest tube insertion, rapid sequence intubation/RSI (that cannot otherwise be accomplished using your Advanced Airway Management procedures), or amputation will be required
      Traffic: severe traffic jam, accident that shuts down the highway
   C. EMS providers are to follow routine patient care protocols until care is transferred to the aeromedical unit
   D. Helicopter safety: Be warned that the main rotor disc tilts and can impose a lethal ceiling. Most helicopter loads & offloads are performed "cold". If you *must* approach the helicopter "hot"/while the blades are turning, stay low and approach from the front (12 o'clock) so the pilot can see you, until you receive further instruction:

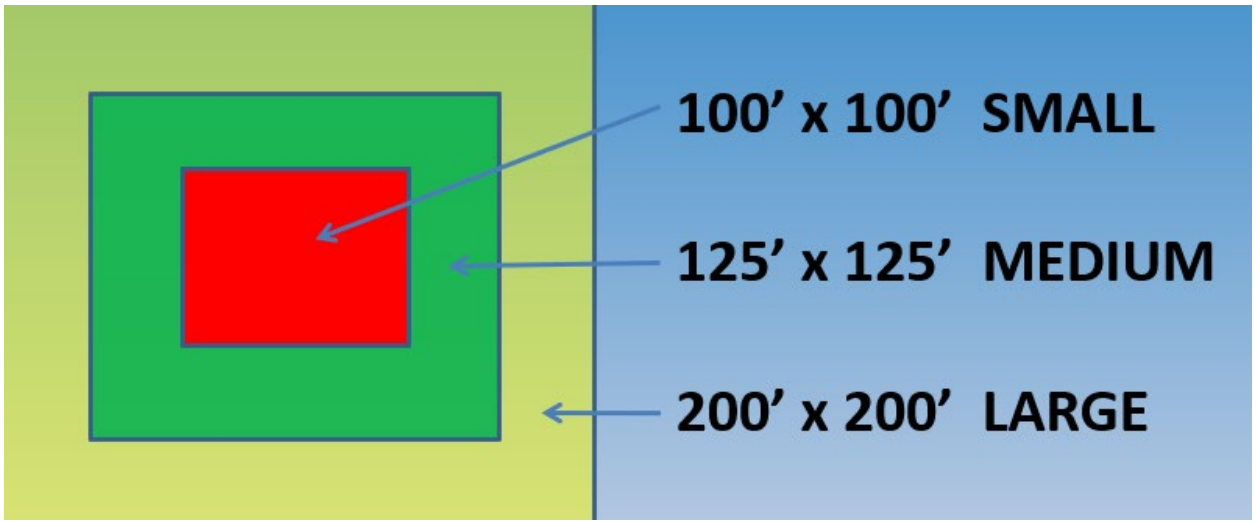


      Not all tail rotors are shielded. Stay well clear of an actively spinning tail rotor at the rear (6 o'clock) position of the aircraft

E. NEMSPA landing zone/LZ recommendations: DAY



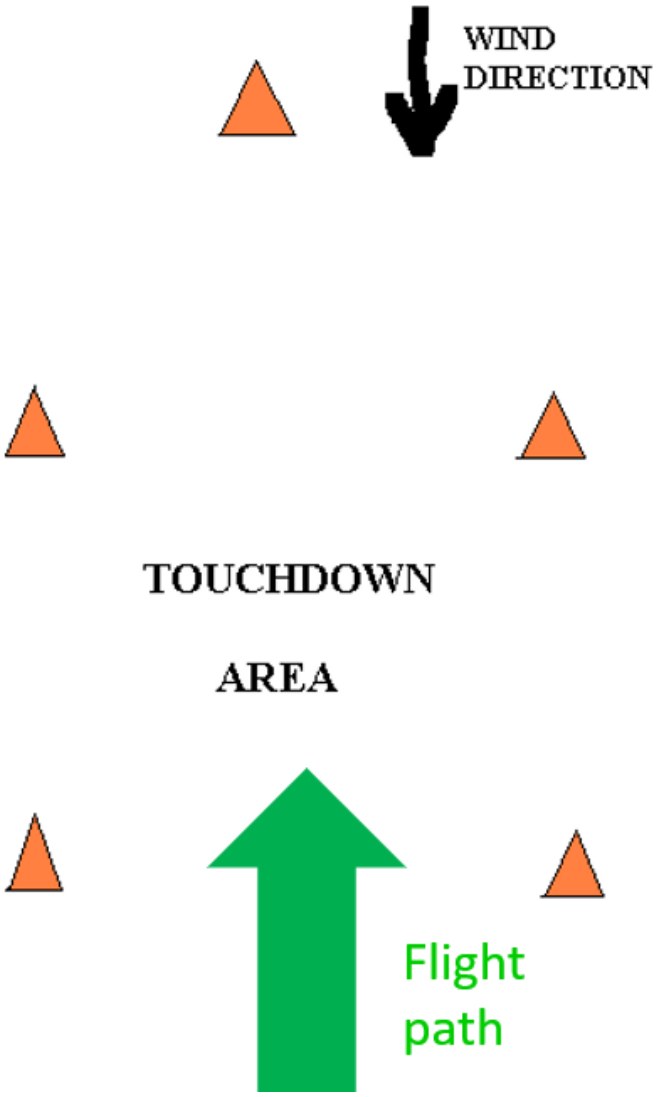
F. NEMSPA landing zone/LZ recommendations: NIGHT



G. Final approach and landing are the most dangerous part of any flight, responsible for 49% of fatal aviation accidents – you must reconnoiter your LZ in 360 degrees – searching for hazards in all directions, before you inform the pilot that they are cleared to land. Pay special attention to:
- WIRES, WIRES, WIRES
- Telephone poles, antennas
- Trash, debris
- Your equipment, bags, tools
- Mailboxes, street signs, vehicles/open vehicle doors

- Stumps, rocks, logs, tall grass (with hidden obstacles)
- Drones
- Rotor wash can create gale or even hurricane force winds!

H. Ideal approach/landing and takeoff vectors are both INTO the wind. This should be balanced against the risk of nearby power lines, tall buildings, fences and other obstacles



I. Observe “sterile cockpit” during final approach and takeoff by staying off the radio to minimize pilot distraction. Only ONE person on the ground should use clear, concise, plain-language to communicate approach vector, wind direction and ground hazards to the pilot, but ANYONE can call a no-fault, no-hesitation “Abort!” in case of a last-second hazard detection or other safety issue

C. Communication

A member of the prehospital care team must contact the receiving facility at the earliest time conducive to good patient care. Frequently, this means the call should be made from the scene.

1. When possible, the member of the team most knowledgeable about the patient should be the one to call report.
2. Although EMTs have been trained to give a full, complete report, this is often not necessary when a more detailed report can be given at the bedside when patient care is transferred to the hospital staff. Telephone reports should be complete but concise as possible to allow the receiving facility to understand the patient's condition.
3. When calling in a report, it should begin by identification of the squad and level of care which is able to be provided to the patient (i.e., Basic EMT, Advanced EMT, or Paramedic). The report should include:
    a. Age and sex of patient
    b. Specific complaint
    c. Mechanism of injury
    d. Vital signs (to include pulse oximetry, EKG, capnography as indicated)
    e. Patient care provided
    f. ETA to facility
4. Once the above information is given, wait for further requests and/or orders from Medical Control
5. If the patient requires special care (i.e., security, interpreter, isolation, additional people for lifting, etc) this information should also be relayed.
6. If multiple victims are present on scene, it is advisable to contact Medical Control with a preliminary report.

D. Selected Diversion

Is a situation in which a particular hospital is forced to limit the number and/or type of patients they are capable of accepting. For example, there are no available critical care beds, CT scan is down, etc. This recognizes that often a hospital/ED may be capable of treating many types of emergencies, even when they are temporarily unable to accept others.

1. With Selective Diversion, a hospital is requesting that EMS transport a specific type of patient to another facility that may be able to provide the necessary treatments. EMS needs to consider what is best for the patient.

2. **Exceptions to Selective Diversion Status:** EMS personnel may disregard a hospital being on Selective Diversion under the following circumstances.
    a. The patient is unstable including, but not limited to:
        - having an unmanageable airway;
        - being given CPR;
        - having uncontrolled internal or external hemorrhaging;
        - major trauma.
    b. The patient is in active labor.
    c. The patient has major burns.
    d. It is unsafe or inappropriate due to excessive ground transport time or adverse weather.
    e. It would cause a shortage of local EMS resources.
    f. No other trauma centers are available to accept patient due to bed saturation or resource availability.
    g. The patient or guardian request transport to a specific hospital prior to the initiation of the transport itself even after EMS personnel have advised the patient or guardian the institution is on Selective Diversion.

3. **Patients with Special Needs:**

A) Dangerously morbidly obese patients:

- Do not transport patients who are dangerously morbidly obese to Free-Standing EDs. These facilities do not have adequate staffing or hardware to safely move and treat the patient. It is unsafe for the patient and the ED team. Such patients should be transferred to full-service hospital instead.

- The exception to this rule is if the patient is too ill/too unstable to be safely transported to a full-service hospital. In a truly life-threatening emergency, transport to a Free-Standing ED is acceptable, but the EMS crew is expected to REMAIN in the ED and assist the ED team (which will likely be significantly understaffed to care for this patient) in stabilizing and treating the patient (e.g. transfer, repositioning, intubation, CPR)

- Barberton ED and Akron City ED have roughly equal hardware when it comes to caring for this patient population. Equipment weight limitations are as follows:

  Barberton ED CT: 650 pounds max
  Barberton Hoyer Lift: 1,000 pounds max
  Akron City ED CT: 600 pounds max
  Akron City Hoyer Lift: 1,000 pounds max

- EMS should call the receiving ED **well in advance** of their arrival to the ED so that the ED team has time to secure the equipment and staffing necessary to care for the patient. If there is any doubt as to where the patient should be transported, EMS should discuss this with online medical control.

E. Interfacility Transfer

1 The transferring physician is ultimately responsible for the patient until accepted by the receiving facility.

2. The EMS provider will be responsible for following the transferring physician's orders. The EMT must check, be completely familiarized with, and understand the transfer orders. Any questions or concerns, for example DNR status or medications ordered, must be answered and clarified before the EMT accepts the patient for transport and assumes patient care.
3. If unanticipated problems arise, follow written EMS protocols and contact the transferring physician.

NON-TRANSPORTS

If an individual is not transported by EMS, one of the following MUST apply:

1. Invalid Assist
2. Patient Refusal

Patient Refusal – the patient or responsible person (parent, legal guardian, durable power of attorney) has the responsibility and right to consent to or refuse any and all treatment, to include transport.

1. The individual must be 18 years of age or older or if less than 18 years of age must be married, in the military or declared emancipated by the court.
2. The individual must have medical capacity
   a. Awake;
   b. Alert and oriented to person, place, time and circumstance;
   c. Non-intoxicated; **- (*See #5. Specific for Opiate Overdose)**
   d. Capable of understanding the nature and consequences of the proposed treatment and refusal of treatment; AND
   e. Has sufficient emotional control, judgment, and discretion to manage his own affairs
3. If a patient / responsible person wishes to refuse examination, treatment, or transport, the following steps will be taken:
   a. The patient must be advised of the **RISKS, BENEFITS** and **ALTERNATIVES** (RBA) of refusing treatment and transport.
   b. The patient must be able to relate to the EMT in his/her own words what these risks and benefits are;
   c. Being alert and oriented x 3 is important to document, but is, on its own, insufficient to make an informed decision.
   d. The EMT must document that the patient has medical capacity as identified;
   e. The patient is asked to print and sign the EMS Non-Transport form, Patient Refusing EMS Transport section. A witness and the EMT will also print and sign their names;
   f. The patient will be provided with a copy of the refusal information sheet.
4. Medical Control **does not** need to be contacted unless the EMT is:
   a. Unsure of the patient's legal competence, or medical capacity
   b. Would like assistance convincing the patient to accept treatment / transport.
5. ***A presumptive opiate overdose** (e.g. heroin) [1,2,3] may chose to refuse EMS transport to the emergency department and be released by EMS after being treated with naloxone (Narcan). The naloxone reverses the influence of the opiate, so they are no longer under the influence when they are making their choice. Caution must be exercised if longer acting opiates are used/suspected:
   a. An opiate overdose refusal is permissible if the following additional conditions are met:
      1. Vital signs are stable x 2 - 15 minutes apart
      2. Pulse ox is > 93% x 2 readings 15 minutes apart
      3. Lungs sounds are clear
      4. **The patient consents to receive an additional 2 mg naloxone IM**
   b. The opiate overdose patient must be transported if
      1. They were apneic and/or pulseless on EMS/Police arrival and CPR had to be performed.
      2. They want to get help
      3. They have injuries or conditions that require assessment & treatment
      4. They have already received naloxone in the preceding 12 hours
      5. The EMS provider is uncomfortable with nontransport or individual department policy precludes this
   c. The patient should be encouraged:
      1. To get help
      2. To call if there is a problem

EMS Non-Transport Form

(Check which one applies)

□ Release for Patient Alternative Transport

An EMS Provider has evaluated you in communication with a physician by phone. It has been determined that your condition is stable and you **do not require medically supervised transport by ambulance** at this time, and thus are being released for private vehicle transport to a medical facility. **THIS DOES NOT MEAN THAT YOU DO NOT NEED TO SEE A PHYSICIAN!** You have received only a basic screening assessment and are advised to see a physician for complete evaluation and care. If you choose NOT to get further medical evaluation and treatment at this time, your condition may worsen leading to more serious ongoing health problems, complications, delayed or prolonged healing, permanent disabilities or impairments. If your condition changes/worsens, please call back EMS (911) at any time.

EMS Personnel: describe the minor/focal nature of the patient's injury/illness, and confirm that no evidence (through history, mechanism, exam) was found to suggest risk of a more serious/acute condition that would prevent safe, private transport.

_____

_____

Med Control Physician consulted:_____Time: _____

□ Patient Refusing EMS Transport

EMS Personnel: confirm that the patient/guardian has medical capacity to decline EMS care/transport (must check all 3):

□ Awake, A&O to person, place, time, circumstance
□ Expresses understanding of the RBA
□ Non-intoxicated

Patient Advised and Understands the Following (Check all that apply):

□ An EMS provider has evaluated you. This is a basic screening assessment to determine the severity of your condition and initiate stabilizing preliminary care. **THIS IS NOT A SUBSTITUE FOR EVALUATION AND TREATMENT BY A PHYSICIAN!**

□ Your condition/ complaint may be **POTENTIALLY UNSTABLE, SERIOUS, OR POSSIBLY EVEN LIFE-THREATENING**. Even if you feel fine now, you could have a serious underlying health problem or hidden injury that cannot be detected on screening exam alone and that could rapidly worsen or recur leading to delayed/prolonged healing, serious disability or even death without proper medical evaluation and treatment.

□ Transport by means other than ambulance could be hazardous in light of your current condition or complaint, or if your condition were to suddenly recur or worsen.

□ If you change your mind or if your condition worsens, please feel free to call back EMS (911) at any time.

□ **You have been offered/advised to have ambulance transport to the hospital for immediate further medical evaluation and treatment by a physician as your condition/complaint may be potentially unstable and you are choosing to reject this advise and decline this service.**

_____	X _____	
Patient/Guardian Printed Name	Signature	Date
_____	_____	_____
EMT Printed Name	Signature	Date
_____	_____	_____
Witness Printed Name for Refusal ONLY	Signature	Date

Invalid Assist Checklist

Incident #	Time of call	En route	On scene	In service	In quarters

Name:_____DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone number: _____

Contact person:_____ Relation to patient: _____

Reason for call: _____

Is person complaining of any injuries or illnesses? □ YES □ NO
If answered “yes”, complete Patient Care Report (PCR)

Were there any stroke-like symptoms or dizziness? □ YES □ NO
If answered “yes”, complete PCR

Is person at base-line mental function? □ YES □ NO
If answered “no”, complete PCR

If the call was for a fall, is person on a blood thinner? □ YES □ NO □ N/A
If answered “yes”, complete PCR

Has your EMS agency been called for this person in the last 48 hours? □ YES □ NO
If answered “yes”, complete PCR

NOTE: If at anytime the EMS agency is completing a Patient Care Report (PCR), the “Invalid Assist” category is no longer applicable to this person. (i.e., the person has met the definition of a patient). One of the following now applies to this patient:

- Treat and transport per protocol
- Patient Refusal
- Patient Alternative Transport

EMT Signature:_____ Date: _____

Station call Back by_____@_____on_____