Division 05 Emergency Medical

Chapter 01 – Emergency Medical Service Operations

October 2011

POLICY

This General Order establishes procedures and rules governing the operation of all emergency medical service units operated under the authority of the Emergency Medical Services Operational Program managed by the Prince George's County Fire/EMS Department.

DEFINITIONS

Appropriate Facility – a healthcare facility that receives patients to deliver emergency medical or specialty medical care. (i.e. trauma facilities, labor and delivery, burn facility, etc.)

Emergency Medical Service Crew – personnel that administer patient care that are trained and currently certified/licensed as an emergency medical services provider by MIEMSS.

Emergency Medical Service Unit – any apparatus authorized to respond to an emergency medical incident.

Priority 1 – a person that is critically ill or injured, requiring immediate attention; an unstable patient with life-threatening injury or illness. As outlined in the Maryland Medical Protocols for EMS Providers.

Priority 2 – a person with a less serious condition, yet potentially life threatening injury or illness, requiring emergency medical attention, but not immediately endangering the patient's life. As outlined in the Maryland Medical Protocols for EMS Providers.

Priority 3 – a person with a non-emergent condition, requiring medical attention, but not on an emergency basis. As outlined in the Maryland Medical Protocols for EMS Providers.

Priority 4 – a person that does not require medical attention. As outlined in the Maryland Medical Protocols for EMS Providers.

CRT-99 – Maryland's equivalent to a National Registry EMT – I

PROCEDURES

General Provisions

The goal of all Fire/EMS Department emergency medical service units is to provide the best possible pre-hospital medical care to any person that requires it by expressed or implied request. All care provided shall always be in the best interest of the patient.

Each EMS response consists of several phases:

1) Preparedness
2) System Access
3) Incident Prioritization
4) Response Configuration
5) Response Deployment
6) Pre-Arrival
7) On-Scene Care
8) Disposition
9) Notification/Consultation
10) Transportation
11) Transfer of Care
12) Documentation/Data Collection
13) Return to Service

Phase 1 - Preparedness

Staffing

An emergency medical service unit has a minimum staffing of two (2) providers.

Basic Life Support

The primary provider attending to a patient must maintain affiliation with Prince George's County Fire/EMS Department or any of its volunteer organizations with certification as an EMT-Basic (EMT-B) or a higher certification/license.

Unit Drivers or Support Providers on the unit must be currently County certified as a First Responder or a higher certification/license.

Advanced Life Support

The primary provider attending to a patient must maintain affiliation with Prince George's County Fire/EMS Department or any of its volunteer organizations with certification as a CRT-99 or a higher certification/license.

Support Providers on the unit must be currently County certified as an EMT-Basic (EMT-B) ALS Assist Program is preferred, be a student of an approved ALS training program, or maintain a higher certification/license.

Any operational providers must:

- Maintain all current EMS Provider certifications or licensures
  - MIEMSS continuing education
  - American Heart Association (AHA) cardiopulmonary resuscitation (CPR) training for healthcare providers
  - Maintain current automated external defibrillator (AED) training.
- Maintain clinical affiliation by meeting all county requirements

EMS Students may participate only if they are current volunteer members or are enrolled in an approved emergency medical training program.

Observers are subject to the requirements of the Ride-Along Observer General Order.

Equipment

The emergency medical service crew must ensure operational readiness of the vehicle. Equipment requirements are described in General Order 05-06 – EMS Equipment Standardization.

Vehicle

The emergency medical service crew must ensure that the vehicle and all of its systems are functional and properly maintained at all times.

Phase 2 – System Access

System access is managed by the Prince George's County Public Safety Communications (PSC) using an Enhanced 911 System.

Phase 3 – Prioritization

Prince George's County Public Safety Communications (PSC) uses a Medical Priority Dispatch System (MPDS). This uses a nationally recognized model to query 911 callers for the most appropriate information necessary to make proper resource assignments and provide pre-arrival instructions.

Three factors in combination create the determinant code identified by the MPDS system. The following three factors are identified by the MPDS system:

- Chief Complaint
- Severity of Complaint
- Incident Description

The resulting determinant code will be formatted as outlined in General Order 05-20, EMS Performance Measurement

This information is used by EMS Providers to understand the nature of the incident they are responding to.

Phase 4 – Response Configuration

EMS resources are assigned to each MPDS determinant by the EMS System Manager, Jurisdictional Medical Director, and Public Safety Communications. The goal of these resource assignments is to maximize system effectiveness and efficiency.

Provider concerns or comments regarding response configurations should be referred to the EMS Operational Program Manager through the chain of command.

Phase 5 – Response Deployment

Units are deployed to incidents by PSC via radio, alerting system, pager, and CAD printer. Once a unit is notified of an incident, there shall be no hesitancy in providing prompt response. EMS units should notify PSC when they are en route to the dispatched location no later than 60 seconds from the initial notification.

- Select "Sts" on radio

Select "RESPONDING" on radio

Phase 6 – Pre Arrival Considerations

EMS Units must consider all of the following when responding to and approaching the scene of an incident:

Safety – Provider and patient safety are of paramount importance. This must be considered prior to any action.

Situation – Use all information available to formulate a plan of action prior to arrival. Contingency plans must also be considered.

Staging – Consider staging at a safe distance for any reports of violence and query law enforcement officials for clearance to approach the scene.

Standard Precautions – Comply with all components of infection control practices and standard precautions.

Size – Determine the number of patients. Initiate multiple casualty (triage) procedures, if necessary.

Staffing – Request additional resources, if necessary. Providers must anticipate the evolution of an incident to determine resource needs.

System – Consider establishing the Incident Command System for escalating incidents or coordinating multiple resources.

Phase 7 – On Scene Care

When an EMS unit arrives on scene, the following notification is made:

- Select "Sts" on radio

- Select "STAGING" or "ON SCENE" as appropriate

When an EMS unit arrives at the patient's side, the following may be utilized to assist with documentation of incident times:

- Select "Sts" on radio
- Select "AT PATIENT"

Patient/Provider Relationship

Providers must determine which persons they encounter are indeed patients and give anyone they encounter the opportunity for obtain emergency medical care. Providers must always consider these factors:

- Provider Safety – A patient/provider relationship cannot exist if there is a threat to the provider.

- Request for Care
  - Expressed
  - Implied

- Legal Mandates
  - Legal Capacity- When a person is a non-emancipated minor, unconscious, intoxicated/impaired, or their judgment or ability to respond is compromised; the concept of implied consent applies.
  - Mental Capacity- Patients that are oriented to person, place, and time, they cannot be forced to accept treatment or transportation.
  - Fully Informed of treatment options and the anticipated risks of non-treatment

Patient Refusals

Patients may refuse medical care and treatment only after informed of the foreseeable risks associated with that decision. Patients must be awake, alert, and capable to understand the risks associated with making an informed refusal of care.

Those patients that refuse medical care and treatment after requesting services from the Fire/EMS Department must have a completed physical exam and vital signs documented on an electronic patient care report (ePCR).

The patient or patient's legal guardian must sign the pertinent section of the Patient Refusal documentation.

Providers are not permitted to initiate a refusal of service for any person that has requested medical care.

Patient Care

EMS providers shall perform treatment of injuries and conditions consistent with their level of certification. The "standard of care" is described in the current edition of the Maryland Medical Protocols for Emergency Medical Services Providers.

ALS/BLS Interface

The EMS System functions using both BLS and ALS units to provide care and transportation of patients. The interface between these levels of providers is critical to delivering the best possible care.

In all cases, these providers must collaborate professionally to ensure the best possible care is provided to the patient.

Providers must consider the need for ALS resources once they have completed their initial assessment and completed a set of vital signs.

Phase 8 – Disposition

Patient Transportation Destination

Providers shall base transportation destination decisions using the following factors:

First Factor - Patient's Clinical Needs – As described by Maryland Medical Protocols for Emergency Medical Services Providers

- Patient priority
- Capability of local healthcare facilities
- Referral to specialty center

Second Factor - System Requirements

- Facility Diversion Status
- Anticipated time to return to service
  - Anticipated transport time
  - Anticipated patient transfer time
  - Number of EMS Units currently waiting
  - Number of transports to a facility within the previous hour
- Approved special transport policies

Third Factor – Patient's Medical Request

- Continued care at specific facility
- Physician relationship
- Personal preference

Fourth Factor – Provider Preference

- Proximity to the station
- Equipment replenishment
- Other considerations

Fifth Factor – Patients in the custody of the Department of Corrections shall be handled as outlined in General Order 05-08, EMS Transportation from the Department of Corrections.

There are no geographic restrictions for patient transportation as long as these factors are considered.

Hospital Diversion

Hospitals have the ability to go on diversion status whenever the facility/staff does not have the capability to adequately care for any additional patients. Patients should be transported in accordance with General Order 05-09 - Hospital Diversion

Phase 9 – Notification and Consultation

When any patient is transported from a scene by an EMS unit, the following notifications made at the time when transport is initiated:

PSC – via voice on appropriate talkgroup

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- Patient Information
  - Age(s)
  - Sex(s)
  - Chief Complaint(s)
  - Priority(s)
- Medical Facility Destination
- Estimated Time of Arrival
- Starting Mileage (Optional)

Receiving Facility

- Patient information should be conveyed to the receiving facility for all transports through EMRC on the appropriate talkgroup.
- For notifications only, the receiving facility does not need to provide a base station trained provider.

Medical Consultation

Medical consultation must be obtained from an approved base station provider in accordance with the Maryland Medical Protocols for EMS Providers.

Phase 10 – Transportation

Priority 1 patients are transported using visible and audible emergency warning devices to the nearest hospital/medical facility having the capabilities and facilities to stabilize/treat the patient unless otherwise directed by Medical Consultation.

Priority 2 patients are transported using emergency warning devices to the most appropriate area hospital. At the discretion of the EMS crew, considering the best interest of the patient, the transport may be accomplished without the use of emergency warning devices.

Priority 3 patients are transported without the use of emergency warning devices to an appropriate area hospital.

Priority 4 patients generally do not require transportation.

Phase 11 – Transfer of Care

When an EMS unit arrives at the destination medical facility, the following notifications made:

PSC

- Select "Sts" on Radio
- Select "TRNSPRT CMPLT"
- Ending Mileage (optional)

All emergency warning devices and the vehicle engine are to be turned off and the ignition keys removed while the vehicle is unattended. All equipment and supplies should be secured within the unit.

An EMS provider must remain with the patient at all times to provide care until the patient is transferred to care under the direct supervision of facility staff.

Patients are generally accepted into the facility through the emergency department. However, in some cases the patient may be directly admitted to a more appropriate medical care unit. This should be coordinated with the medical facility staff prior to arrival through EMRC.

Phase 12 – Documentation/Data Collection

An electronic patient care report (ePCR) shall be completed any time an EMS unit is dispatched on an incident. It is the responsibility of the providers to ensure this is completed. Station Officers and Volunteer Chiefs must ensure this documentation is completed and accurate.
For most patient transports, units will complete the ePCR prior to leaving the receiving medical facility. If the facility or unit is not equipped, the ePCR can be completed at the station. In either case, a copy of the ePCR is to be given to the receiving facility staff for inclusion in the patient's records.

Phase 13 – Return to Service

Units must minimize the amount of time they are out of service at a medical facility. As soon as the unit is ready for service, PSC shall be notified. This will generally occur as the unit leaves the medical facility.

- EMS units shall follow General Order 5-20, EMS Performance Measurement - Determinant /Disposition Codes when returning to service.
  - Via voice on the appropriate talkgroup
- If a Determinant/Disposition Code is not necessary
  - Select "Sts" on radio
  - Select "AVAIL / ON AIR"

Public Safety Communications will inquire about an EMS unit's status after 60 minutes at the receiving facility.

Replenish Supplies

EMS units should replenish medications, supplies, and equipment used on the currently transported patient from receiving facility stock on a one-for-one exchange basis. If necessary, coordinate with hospital staff to receive appropriate materials. If replenishing of supplies is not possible at receiving facility, EMS units will replenish from station stores.

When a patient is suspected to or is known to be suffering from a potentially contagious disease, providers are to utilize appropriate protective measures as described by current Infection Control practices. The ambulance equipment and patient compartment shall be thoroughly decontaminated.

REFERENCES

Maryland Medical Protocols for Emergency Medical Services Providers

Alert Status System of MIEMSS Region V

FORMS/ATTACHMENTS

N/A