EMS

Communications & Documentation

Off-Line Medical Control, Standing Medical Orders & Protocols Policy

The Prehospital Care Manual, as developed by the EMS Medical Director, reflects nationally recommended treatment modalities for providing patient care in the prehospital setting. This Prehospital Care Manual, containing Standing Medical Orders, Protocols, Policies & Procedures, is intended to establish the standard of care which is expected of the Memorial EMS System provider.

1. Standing Medical Orders, Protocols, Policies & Procedures contained in this Prehospital Care Manual are the written, established standard of care to be followed by all members of the Memorial EMS System for treatment of the acutely ill or injured patient.

2. The EMS provider will initiate patient care under these guidelines and contact Base Station Medical Control in a timely manner for consultation regarding treatment not specifically covered by standing orders, in addition to those protocols that specify on-line physician's order. Diligent effort must be made to contact Medical Control in a timely manner via Twiage, cellular telemetry, landline phone, or VHF MERCI radio. Delay or failure to contact Medical Control for required on-line orders is a quality assurance indicator.

3. These Standing Medical Orders will be utilized as Off-Line Medical Control under the following circumstances:

    - For conditions covered by this protocol manual.

    - In the event communication cannot be established or is disrupted between the Prehospital provider and Medical Control.

    - In the event that establishing communications would cause an inadvisable delay in care that would increase life threat to the patient.

    - In the event the Medical Control physician is not immediately available for communication.

    - In the event of a disaster situation, where an immediate action to preserve and save lives supersedes the need to communicate with hospital-based personnel, or where such communication is not required by the disaster protocol.

4. Inability to contact Medical Control should not delay patient transport or the provision of life-saving therapies. Patient destination and transport decisions are set forth in these Standing Medical Orders / Protocols.

On-Line Medical Control Policy

On-Line Medical Control

The TWIAGE App is the preferred method of communications with all participating area hospitals except in cases where on-line medical control is required. On-line Medical Control is designed to provide immediate medical direction and consultation to the Prehospital EMS provider in accordance with established patient treatment guidelines and policies in this manual.

On-line Medical Control is utilized to involve the expertise of an Emergency Medical Physician in the treatment plans and decisions involving patient care in the Prehospital setting.

1. EMS communications requiring on-line contact with a base station physician shall be conducted using **cellular telemetry**. **Note*: When calling Memorial for Medical Control and when calling in patient reports, the individual answering the call will identify themselves as "Memorial Base Control."
2. Incoming telemetry calls will usually be answered by an Emergency Communications Registered Nurse (ECRN). The ECRN may request Medical Control from a Base Station Physician if orders or consultation are needed. The ECRN, as an agent of the EMS Medical Director, may initiate the order for any treatment included within EMS protocol. A Medical Control physician is required any time an order outside of protocol is requested or issued.
3. *Pre-hospital personnel in need of on-line Medical Control identify the need for orders at the beginning of the report. A licensed ECRN can give orders for anything within protocol requiring Medical Control approval.*
4. ***Memorial EMS agencies and providers can only accept Medical Control orders from a Memorial affiliated hospital. If a provider feels the order is incorrect and for the safety of the patient requests override, the request will go the senior most physician and Springfield Memorial Emergency Department. CQI will be required.***
5. Use of **telemetry** is required for patient care requiring interventions beyond the *Routine BLS, ILS or ALS* standing medical orders. Situations requiring Medical Control contact include, but are not limited to:
    - Any time an order is specifically required for BLS, ILS or ALS medications as outlined in the protocol.
    - Any time orders are needed for certain defined *procedures*.
    - Any instance an EMS provider desires *physician involvement*.
    - Any situation that involves *bypassing* a closer hospital.
    - Anytime an EMS provider feels a *deferral* is warranted.
    - Anytime a Field Training Instructor (FTI) feels a student needs to further develop communication skills.
    - **When a pre-hospital 12-Lead EKG is acquired that shows wide-complex tachycardia, consultation is requested, or to activate STEMI protocol.**
    - Circumstances involving a Death on Scene (DOS) or cases involving advanced directives (DNR et al).
    - High risk refusals (*see next pages*).

On-Line Medical Control Policy

On-Line Medical Control (Continued)

- *First Responder* low risk refusals (*see item #10 of this policy*).

6. **"Telemetry" calls** include all medical complaints requiring Medical Control contact, refusals, traumas and consultations.

7. **"MERCI" calls** are made via MERCI radio and called directly to the receiving hospital (or in cases where telemetry communication is not possible and consult with a physician is necessary). MERCI communication is adequate for patient care that does not require interventions beyond *Routine BLS, ILS or ALS Care*. Specifically, patients that have received only oxygen, monitor, IV and/or medications without the need for additional orders or in cases where Medical Control contact is not required.

   - If MERCI traffic prevents contact with the receiving hospital, the Resource Hospital (Springfield Memorial Hospital) may be contacted for assistance in proper routing of communications.
   - If the receiving hospital deems that further care is necessary or requests additional interventions be performed, the EMS provider should contact Medical Control. Only Medical Control (ED Physician or ECRN) at the resource hospital (SMH) or affiliate hospitals (LMH, JMH, TMH, or DMH) may give orders.
   - If the receiving hospital requests discontinuation of treatment established by the prehospital provider, Medical Control contact should be established.

8. **High Risk Refusals** require Medical Control consultation prior to securing and accepting the refusal and terminating patient contact. High risk refusals involve cases where the patient's condition may warrant delivery of care in accordance with implied consent of the *Emergency Doctrine* or other statutory provision. **High risk refusals** include, but are not limited to:

   - Head injury (based on mechanism or signs & symptoms)
   - Presence of alcohol/ drugs resulting in questionable loss of decisional capacity
   - Anytime medications are given and patient refuses transport (Dextrose is the only exception to this)
   - Significant mechanism of injury (e.g. rollover MVA)
   - Altered level of consciousness or impaired judgment
   - Unaccompanied minors (≤17 yrs old, when guardian cannot be contacted)
   - Situations that involve bypassing a closer hospital

On-Line Medical Control Policy

On-Line Medical Control (Continued)

9. **Low Risk Refusals** do not require Medical Control consultation (for BLS, ILS & ALS levels) if the prehospital provider determines that the patient meets the *Low Risk Criteria* and there is no doubt that the patient understands the risk of refusal. The patient cannot be impaired and must be able to consent to the refusal. Medical Control should be contacted if there are any concerns about the patient's ability to refuse. **Low risk** refusals may include:

    - Slow speed auto accidents with no intrusion into patient compartment, low mechanism of injury, and no patient injury beyond minor scrapes and bruises.
    - Fall from standing without other medical conditions and no extreme of age.
    - Isolated injuries not related to an auto accident or other significant mechanism of injury
    - False calls or "third party" calls where no illness, injury or mechanism of injury is apparent.
    - Lifting assistance or "public assist" calls (for which EMS is called for assistance in moving a patient from chair to bed, floor to bed, car to home, etc.). This assumes the EMS agency is routinely called to assist this patient, the patient is assessed to ensure there is no complaint or injury and there has been no significant change in the patient's condition. EMS crews must complete a patient care report indicating all assessment findings and assistance rendered.

10. **If the EMS provider has not been able to contact Medical Control** via cellular telemetry, telephone or MERCI radio, the EMS provider will initiate the appropriate protocol(s). Upon arrival at the receiving hospital, an incident report must be completed and forwarded to the EMS Office within 24 hours of the occurrence. This report should document all aspects of the run with specific details of the radio/communications failure and initiation of the Memorial EMS System *Standing Medical Orders and Standard Operating Procedures*.

11. First Responders may handle **low risk** refusals only (as defined above). **Under no circumstance should a First Responder take a *high risk* refusal**.

12. When EMS is requested, but the patient identified, from the initial request call that mobility assistance only is all that is requested, documentation at the agency level is allowed. If any question exists about the patient's needs or condition an informed refusal should be completed and signed by the patient.

Radio/ MICU Communications Protocol

Radio communications is a vital component of prehospital care. Information reported should be concise and provide an accurate description of the patient's condition as well as treatment rendered. Therefore, **a complete patient assessment and set of vital signs should be completed prior to contacting Medical Control or the receiving hospital.**

Regardless of the destination, **early** and **timely** notification of Medical Control or the receiving hospital is essential for prompt care to be delivered by all involved.

Components of the Patient Report

1. Unit identification
2. Destination & ETA
3. Age/sex
4. Chief complaint
5. Assessment (General appearance, degree of distress & level of consciousness)
6. Vital signs
7. Pertinent physical examination and negative findings, history
8. Treatment rendered and patient response to treatment

If Medical Control contact is necessary to obtain orders (where indicated by protocol), diligent attempts must be made to establish communication with local and/ or receiving facility capable of providing Medical Control.

Radio/ MICU Communications Protocol

EMS Alert Patient Report

Certain patient populations benefit from activation of specialty teams, protocols, providers and other resources that the majority of patients do not require. As such, including in the notification for such patients the specific need as soon as possible in the EMS communication can aid both the EMS provider giving report and the Emergency Department receiving the communication to obtain specific critical elements of information specific to that patient complaint. Specific treatment protocols include reference to identifying a patient as an "EMS Alert Patient Report" and identifying the specific suspected complaint in the initial seconds of the radio report.

EMS Alert Patient Report categories include

- STEMI
- Stroke
- Trauma
- Cardiac/ Respiratory Arrest/ Impending Arrest
- Sepsis

Specific information for each patient type is included in the protocols. Information listed in those protocols is to aid is determining severity, as well as needs of the inbound patient with the goal of activating resources prior to patient arrival.

While all patients in the above categories are critical, the EMS provider must understand the process and needs of those patients to assist in getting the patient the most appropriate service in the timeliest fashion. While expedited transport is appropriate in most situations, assessment and communication could improve the time to definitive treatment if care is provided in a different order for different patient times.

All EMS Alert Patient Report situations qualify for continuous QI (CQI).

Patient Right of Refusal Policy

A patient may refuse medical help and/or transportation. Once the patient has received treatment, he/she may refuse to be transported if he/she does not appear to be a threat to themselves or others. ***Any person refusing treatment must be informed of the risks of not receiving emergency medical care and/or transportation***. NOTE: Family members cannot refuse transportation of a patient to a hospital unless they can produce a copy of a *Durable Power of Attorney for Healthcare*.

Refusal Process

1. Assure an accurate assessment has been conducted that includes the patient's chief complaint, history, objective findings and the patient's ability to make **sound** decisions.

2. Explain to the patient the risk associated with his/her decision to refuse treatment and transportation.

3. Secure Medical Control approval of **high risk refusals** (low risk refusals for First Responders) in accordance with the *Online Medical Control Policy*.

4. Complete the *Against Medical Advice/Refusal Form* and have the patient sign the form. If the patient is a minor, this form should be signed by a legal guardian or *Durable Power of Attorney for Healthcare*. **NOTE**: Parental refusals may be accepted by voice contact with the parent (i.e. by telephone) if the EMS provider has made reasonable effort to confirm the identity of the parent and the form may be signed by an adult witness on scene. This should be clearly documented on the refusal form and in the patient care report.

5. If available, it is preferable to have a police officer at the scene act as the witness. If a police officer is not present, any other bystander may act as a witness. However, his/her name, address & telephone number should be obtained and documented.

6. If the patient refuses medical help and/or transportation after having been informed of the risks of not receiving emergency medical care and refuses to sign the release, clearly document the patient's refusal to sign the report. Also, have the entire crew witness the statement and have an additional witness sign your statement, preferably a police officer. Include the officer's badge number and contact Medical Control.

7. If an agency uses the MEMS provided physical triplicate refusal form- The top (white) original of the *AMA/Refusal Form* is maintained by the agency securing the refusal. The yellow copy is forwarded to the EMS Office with the appropriate copies of the patient care report. The patient is provided with the pink copy of the *AMA/Refusal Form*. If an agency utilizes electronic documentation, they must have a process to provide the patient with a copy of the acknowledgement and signatures for the release of liability.

Patient Right of Refusal Policy

Memorial EMS

MEMORIAL EMS SYSTEM—PATIENT REFUSAL FORM

Date _____ Agency incident # _____

Patient name _____
Home address _____
City _____ State _____ Zip _____
Phone # _____
DOB _____ Age _____ Sex _____

Agency _____
Unit ID _____
Location of call _____
_____
City _____

Call Times (24-hour)

Call received _____
Dispatched _____
En route _____
Arrive on scene _____
minutes—enr. to scene _____
Depart scene _____
minutes—time on scene _____

Dispatched for _____

Patient complaint _____

Did the patient request EMS? Y N

Did the patient agree to assessment and vital signs? Y N

Was the patient conscious and alert with decision-making capability when refusal was signed? Y N

(If no, contact Medical Control and include in narrative.)

Recent medical events or changes _____

Time	B/P	HR	RR	SPO2	B.G.	EKG	Lung sounds	Pupils	Skin

Narrative _____

Crew #1 _____ # _____
Crew #2 _____ # _____

❑ **Option 1** **ACKNOWLEDGMENT AND RELEASE OF LIABILITY FOR ALL HEALTHCARE PROVIDERS**

I, _____, hereby acknowledge and release the above-mentioned emergency service provider and its personnel, Memorial Medical Center, and all EMS system physicians, nurses, agents and personnel of any liability for my refusal to accept further treatment. I acknowledge that I have been advised of and understand the risks of not accepting emergency treatment and/ or transportation to the nearest hospital facility, which I am refusing.

I have been advised as follows:

- That I should receive emergency medical treatment and transportation to a hospital, which I am refusing.
- That having received emergency medical treatment, I am refusing further aid or transport to a medical facility.
- I am refusing all medical assessment, treatment and transport.
- That my failure to seek treatment and transport could result in permanent injury, impairment, disability and could lead to my death.
- I certify that I have the ability and appreciate the consequences of making decisions regarding my medical treatment and the ability to reach an informed decision.
- I have been made aware and understand that I can call 9–1–1 again and at any time.

Signature of patient or authorized representative _____ Date _____ Time _____

❑ **Option 2** **REFUSAL TO SIGN RELEASE STATEMENT**

The above patient was informed and read the above release from medical responsibility clause and was asked to sign due to his/her refusal of Emergency Medical Services. The above patient was informed of the risks of not receiving emergency medical assessment, treatment and/or transportation to the nearest medical facility, and still stated his/her refusal to sign the above. The above-described patient has the ability to understand and appreciate the consequences of making decisions regarding medical treatment and the ability to reach an informed decision and sufficient understanding to make responsible decisions concerning the medical care of his/her person.

Signature of witness #1 _____ Date/time _____ Printed _____ Phone _____
Signature of witness #2 _____ Date/time _____ Printed _____ Phone _____

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Patient Right of Refusal Policy

Notice of EMS Response and Refusal Document Practices

- A Memorial EMS System—Patient Refusal Form has been generated as a result of this encounter.
- This record is kept on file at:

  _____

  _____

  _____
- It can be accessed (in person) by the patient or whomever has legal guardianship of said patient.
- To request a copy of this record, please call:

  _____

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Incident Reporting Policy

Prehospital care providers shall complete a Memorial EMS System (or the individual agency) *Incident Report Form* whenever a System related issue occurs. In order to properly assess the situation and determine a solution to the issue, the following information needs to be provided on the form:

1. Date of occurrence
2. Time the incident occurred
3. Location of the incident
4. Description of the events
5. Personnel involved
6. Agency and/or institution involved
7. Copy of the patient care record and/or any other related documents

Incident Report Process

1. All incident report forms shall be given to the EMS provider's immediate supervisor, training officer, or quality assurance coordinator who will assess the incident and will forward the report to the Memorial EMS System Quality Assurance Coordinator.

2. The EMS QA Coordinator will review the incident and notify the EMS Medical Director and the appropriate course of action will be determined.

3. The EMS provider originating the report will be notified of the resolution.

Incident Report Indicators

Situations requiring EMS Office notification include: (see attached form)

- "Any situation which is not consistent with routine operations, System procedures or routine care of a particular patient. It may be any situation, condition or event that could adversely affect the patient, co-worker or the System."
- Any deviation from Memorial EMS System policies, procedures or protocols.
- **Medication errors**
- **Treatment errors**
- Delays in patient care or scene response
- Operating on protocol when Medical Control contact was indicated but unavailable

Incident Reporting Policy

Incident Report Indicators (continued)

- Violence toward EMS providers that results in injury or prevents the provider from delivering appropriate patient care
- Equipment failure (e.g. cardiac monitor, glucometer)
- Inappropriate Medical Control orders
- Repeated concerns/conflicts between agencies, provider/physician or provider/hospital conflicts
- Patterns of job performance that indicate skill decay or knowledge deficiencies affecting patient care
- Every time an EMS provider is not able to complete their paperwork within the two hour IDPH requirement.

Situations subject to review and resolution at the agency level include:

- Conflicts between employees
- Conflicts between agencies (that do not impact patient care)
- Operational errors (that do not impact patient care)
- Behavioral issues (that do not impact patient care)

Memorial EMS

Unusual Occurrence/ Incident Report

Patient Name or MRN	Equipment Involved	Event Date	Event Time	Report Date	Report Time	Incident Location

Dispatch Info	Additional Agencies/ Departments/ Units Involved

Description of Unusual Occurrence or Incident

Agency Printed name Signature

Possible way in which situation could have been avoided

Witness: ☐ Completing Additional Report	Witness: ☐ Completing Additional Report	Witness: ☐ Completing Additional Report

EMS Office Date Report Received:	Initial Actions Taken by EMS Office
☐ Follow-Up Needed Completed by:	

Additional Notes ☐ EMS Medical Director ☐ Other:

EMS Patient Care Reports Policy

Documentation of patient contacts and care is a vital aspect of assuring continuity of care, providing a means of quality assurance and historical documentation of the event. It is just as important as the care itself and should be an accurate reflection of the events that transpired. **It is imperative to patient care that receiving facilities have the EMS Patient Care Report available to review.**

Patient Care Reports

1. All EMS providers/agencies involved must complete a patient care report for each patient contact or *request* for response (*e.g.* agency is cancelled enroute to a call then a "cancelled call" chart must be completed).

2. Per IDPH 515.310 **Agencies must complete their ePCR within 2 hours of patient delivery to destination hospital**. Returning the unit to service ready condition should not be delayed for paperwork completion. In all situations the ePCR must be completed and submitted prior to the end of shift. If a crew is unable to complete and submit their report within 2 hours, an incident report should be submitted to the EMS Office also before end of shift. Memorial EMS will notify IDPH any time an ePCR is not complete within the 2 hour requirement.

3. Memorial EMS does not have a short form for handoff at the ED. The verbal report and Twiage report can assist in communicating handoff information, however a full ePCR must be completed per IDPH.

4. Documentation must be completed on System approved forms and/or System approved electronic reporting systems. For transporting agencies, the electronic reporting system must be NEMSIS compliant and up to date with IDPH requirements. **Any PCR software changes must be discussed with MEMS (prior to purchase).**

5. Non-transport agencies must complete patient care documentation immediately following the call**.**

6. Copies of all patient care reports must be provided to the EMS Office. This can be completed by bunching quarterly and can be the original hand written report or an electronic copy of all reports. This includes every transport and refusal.

Patient Confidentiality & Release of Information Policy

All Memorial EMS System personnel are exposed to or engaged in the collection, handling, documentation or distribution of patient information. Therefore, all EMS personnel are responsible for the protection of this information. Patient specific information, even amongst providers directly involved in patient care, should not be discussed in locations where non-involved parties can hear the conversation.

Unnecessary sharing of confidential information will not be tolerated. EMS personnel must understand that breach of confidentiality is a serious issue that carries legal implications due to laws governing privacy (HIPAA). Corrective action **will** be taken including System suspension or termination.

Confidential Information Guidelines

1. **Written and Electronic Documentation**

   a) Confidentiality is governed by the "*need to know*" concept.

   b) Any audiovisual documentation collected involving a patient or scene encounter shall be performed exclusively through the Twiage App. No copying, posting, or sharing outside the Twiage App is allowed.

   c) Only Memorial EMS System personnel and hospital medical staff **directly involved** in a patient's care or personnel involved in the quality assurance process are allowed access to the patient's medical records and reports. Authorized medical records and billing personnel are allowed access to the patient's medical records and reports in accordance with hospital and EMS provider policies.

   d) Requests for release of patient care related information (from third party payers, law enforcement personnel, the coroner, fire department or other agencies) should be directed to the EMS agency's medical records department.

2. **Verbal Reports**

   a) Memorial EMS System personnel are **not** to discuss specific patients in public areas.

   b) EMS providers should not discuss any confidential information regarding patient care with friends and relatives or friends and relatives of the patient. This includes hospitalization of a patient and/or the patient's condition.

   c) Information gained from case reviews for the purpose of education, research, quality improvement, or quality assurance is considered confidential.

Patient Confidentiality & Release of Information Policy

Confidential Information Guidelines (continued)

3. **Radio Communications**

   a) No patient name will be mentioned in the process of prehospital radio transmissions utilizing MERCI radio.

   b) Customarily, when calling in a "direct admit" the patient's initials can be included in the radio report. This is necessary for identification and is acceptable to transmit.

   c) Sensitive patient information regarding diagnosis or prognosis not necessary for direct care of the current patient condition should not be discussed during radio transmissions.

   d) MERCI capabilities are required on all IDPH licensed vehicles. Cellular telemetry to the MICU line is the preferred mechanism of communication. Regardless of mechanism, transport units should their uniquely identifiable MERCI moniker for communications. Local jurisdiction identifiers are not acceptable.

   e) If utilizing cellular telemetry, patient specific identifiers may be requested for the advance notification of specialty teams. See complaint specific protocols for such items.

4. **Communication at the Scene**

   a) Every effort should be made to maintain the patient's auditory and visual privacy during treatment at the scene and enroute.

   b) EMS personnel should limit bystanders at the scene of an emergency. Law enforcement personnel may be called upon to assist in maintaining bystanders at a reasonable distance.

5. **Information Regarding Patient Outcomes**

   a) For the purposes on quality improvement a certain degree of patient outcome information needs to be available for EMS providers. Every effort will be made to ensure what information allowed by law is available.

      1. These requests should be forwarded to the Assistance EMS Coordinator for Quality Improvement.