

LANE COUNTY MEDICAL CONTROL BOARD
INTERMEDIATE PROTOCOLS: INTRODUCTION

REQUEST CHANGE TO MEDICAL PROTOCOLS

Page 1 of 1
12/00

BASIC Protocol Intermediate Protocol ALS Protocol

Request to change existing protocol named: _____

Request to add new protocol titled: _____

Describe proposed changes (or attach copy of current protocol with suggested changes indicated):

Describe rationale for change or addition:

Sign your name and return this form to your EMS Instructor, supervising physician or designee who will route a copy to EMS Training Coordinator at Eugene Fire & EMS Training, 1705 W. 2nd Avenue, Eugene, Oregon 97402. This request will be reviewed by M.C.B. (Medical Control Board, formerly called Medical Advisory Board) at the next regularly scheduled meeting unless the agenda is already full.

Your Name: _____ Date: _____

Mail/Pony address:

RESPONSE FROM M.C.B:

This page purposely left blank

- I. Purposes of History-taking and Patient Examination
 - A. To gain the patient's confidence and thereby alleviate some anxiety contributing to the patient's discomfort.
 - B. To identify the patient's problem(s) rapidly, and which problems require immediate care in the field.
 - C. To obtain information that may not be readily available to those caring for the patient later; for example, thorough observations of the environment in which the patient was found.

- II. Patient Assessment Guidelines
 - A. Patient assessment must be **SYSTEMATIC** with gathering of subjective (reported by patient, family bystanders etc.) and objective (observed or measured by EMT) information. A hasty approach inevitably leads to omissions.
 - B. Both history and physical examination must be orderly and thorough.
 - C. Communication with the patient should continue during the physical examination.
 - D. Infection control precautions against communicable disease should be used when appropriate.
 - E. Traumatic injuries require a specific approach based on current trauma principles from PHTLS/BTLS and Oregon Trauma System guidelines. Refer to Trauma Activation protocol, section C.

- III. Scene Assessment
 - A. Observations of the Environment
 - 1. Hazards to EMT or patient.
 - a. Hazardous materials.
 - b. Weapons.
 - c. Sharps or biohazards.
 - 2. Hysterical or hostile public.
 - 3. Unsanitary surroundings.
 - 4. Weather conditions.
 - 5. Poor lighting.

These conditions may be alleviated by rapid, but careful, movement of the patient to an EMS vehicle, if available, for initial treatment.

- B. Mechanisms of Injury (this is one of the most important aspects of trauma assessment)
 - 1. What caused the injury.
 - 2. Position of autos, guns, etc.
 - 3. Speed of vehicles.
 - C. Quick Scene Assessment
 - 1. Provide for patient safety or remove from danger.
 - 2. Mechanism of injury.
 - 3. Number of patients, critical and noncritical.
 - 4. Need for additional medic units.
 - 5. Need for extrication.
 - 6. Need for more fire apparatus.
 - 7. Police.
 - 8. Utility company.
 - 9. Trauma activation of hospital if appropriate.
- IV. The Physical Examination
- Physical assessment begins with the PRIMARY SURVEY.
- A. Primary Survey (ABCs)
 - 1. Mental status.
 - 2. Airway.
 - 3. Breathing.
 - 4. Circulation.
 - B. Secondary Survey
 - 1. Establish why help was requested (try to identify a chief complaint). If appropriate use **PQRST** format to analyze a complaint of pain:
 - a. **P**recipitation or palliation of the chief complaint (has anything ie position made the pain better or worse?).
 - b. **Q**uality of the pain (dull, sharp, stabbing, burning etc).
 - c. **R**adiation of the pain.
 - d. **S**everity of the pain (on a scale of 1-10).
 - e. **T**ime of onset and has the pain been continuous or intermittent.

2. **AMPLE** history.
 - a. **Allergies.**
 - b. **Medications** patient is on (have any of them been started, adjusted or stopped recently).
 - c. **Past medical history.**
 - 1) Major underlying medical problems (heart, lungs, diabetes etc).
 - 2) Doctor/hospital.
 - d. **Last** time patient was well (when was onset of this event).
 - 1) Why was EMS called?
 - 2) When did illness/injury start?
 - 3) If illness has been going on for a while, did it worsen and when?
 - e. **Event** that triggered an EMS response (any other details about the event).
3. Vital signs
 - a. Mental status in more detail and CNS status.
 - b. Pulse rate.
 - c. Blood pressure.
 - d. Respirations.
 - e. Skin signs.
 - f. Temperature (if appropriate).
 - g. Pulse oximetry
4. Past medical history
 - a. Major underlying medical problem and chronic problems (heart, COPD, diabetes, etc.).
 - b. Medications.
 - c. Allergies.
 - d. Doctor/hospital.
5. Physical exam of patient (head to toe exam).

This page purposely left blank

NOTE: In the event voice communication cannot be established or maintained to request an order or consultation, and a delay in treatment may jeopardize the life of a patient, initiate treatment approved by the Medical Control Board. Attempt to reestablish communications as soon as possible. Upon arrival of Medic Unit, report the situation to the Paramedic technician. An agency incident report shall be filled out on any procedure or medication that would ordinarily require a verbal order.

These incidents will be reviewed by the Medical Control Board, Physician Advisor or Physician Advisor designee for the involved agency. It is the responsibility of agency personnel to bring these incidents to the attention of the supervising physician or designee.

This page purposely left blank

-
- I. Withholding Resuscitative Efforts:
- A. Determining death in the field without initiating resuscitative efforts should be considered in the following conditions^a:
1. Patient qualifies as a "DNR" patient (with an MD order).
 2. A pulseless, apneic patient in a mass casualty incident or multiple patient scene where the resources of the system are required for the stabilization of living patients.
 3. Decapitation
 4. Separation of torso
 5. Cremation
 6. Rigor Mortis in a warm environment
 7. Decomposition
 8. Venous pooling in dependent body parts (dependent lividity).
 9. Penetrating head wound with no vital signs.
 10. Pulseless, apneic drowning patient with confirmed underwater time of an hour or more.
 11. **Pulseless, apneic, asystolic patient with prolonged downtime.**
- B. Traumatic Cardiac Arrest
1. In addition to the conditions listed above under Withholding Resuscitative Efforts, a victim of trauma should be determined to be dead at the scene if there is evidence of major trauma (blunt or penetrating) and there are no signs of life.
 - a. If there is evidence of major trauma to the patient and or the patient is trapped, a monitor is not needed to pronounce death.
 - b. If however, the amount of body trauma does not appear to account for death, apply the defibrillator and analyze. If the patient is in a shockable rhythm, proceed with appropriate **cardiac arrest ACLS** algorithm and trauma resuscitation unless the patient is trapped. If the patient is in nonviable rhythm (asystole or agonal) the patient should be pronounced dead.
 2. See trauma algorithm under E in additional information section at end of this protocol.

^aIf BLS has been started by a bystander, family or first responder, these conditions may still be used to determine Death in Field without M.D. contact.

II. Determining Death in Medical Cardiac Arrest (if patient does not fall under criteria listed under section I, Withholding Resuscitative Efforts):

- A. The victim of a medical (non-traumatic) cardiac arrest, who does not meet the criteria listed above under section I, Withholding Resuscitative Efforts, should have the following:
 - 1. Begin BLS procedures.
 - 2. Apply Cardiac Monitor if available.
 - a. If shockable rhythm proceed with defibrillation as per Cardiac Arrest Shockable Rhythm (Section A).
 - b. If no shock indicated, continue CPR and proceed with Cardiac Arrest Non-Shockable Rhythm (Section A) until Paramedic arrives or if appropriate, contact MD with available patient history, current condition, and with a request to discontinue resuscitation.
- B. A patient who does not respond to ALS/ACLS procedures performed by paramedics is unlikely to benefit from transport to the hospital. Research indicates that a patient who remains in asystole or pulseless agonal rhythm in spite of full ACLS resuscitation measures will not respond to the same measures after transport to the hospital. Therefore, in usual circumstances, EMS personnel may anticipate that the code will be run at the scene and if unsuccessful, the resuscitation will be terminated with MD order, and the patient will not be transported.

If there is any doubt about whether life support should be commenced or if there is a disagreement among EMS personnel, then life support measures will be continued.

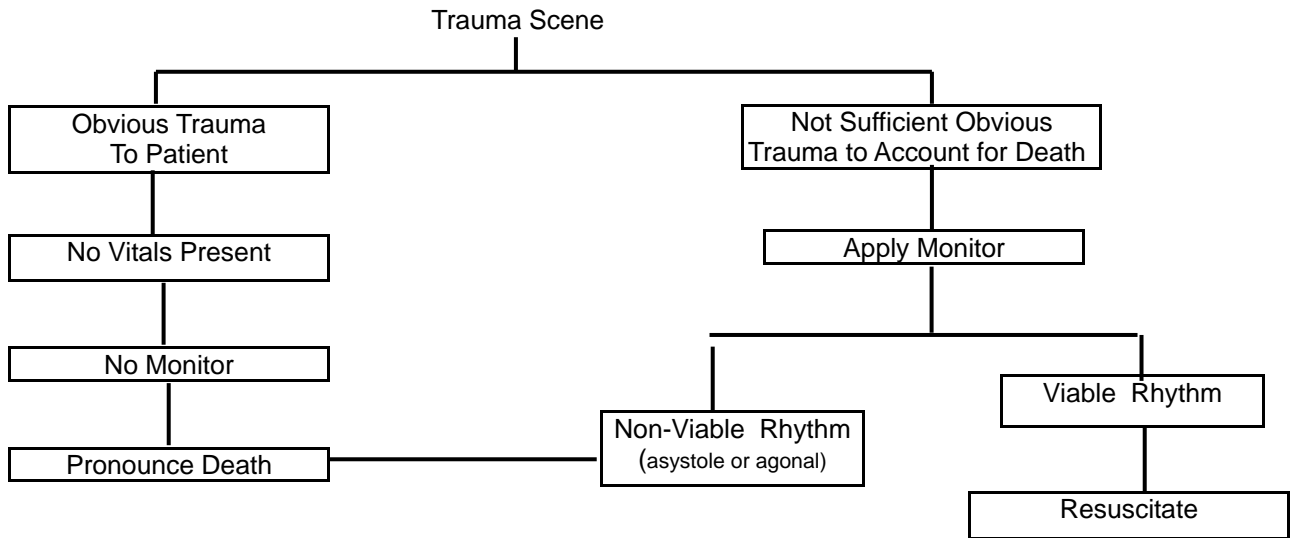
III. Additional Information:

- A. DNR (do not resuscitate) orders, also known as "No Code" orders are a legal document with a physician signature. (DNR orders apply only if the patient is pulseless and apneic.) ~~The document must be present to withhold resuscitation if the situation would otherwise warrant full measures.~~ If no signed orders are present but the family states that signed orders do exist, and there is evidence of terminal disease, the EMT may follow family direction.
- B. Living wills, also known as advance directives, are documents signed by the patient which indicate their wish not to be resuscitated with heroic lifesaving measures. If the patient does not meet death in field criteria listed under I (Withholding Resuscitative Efforts), start BLS and call private MD or Emergency Physician to consult regarding discontinuation of resuscitation. It

is essential to recognize that living wills are meant for catastrophic events such as end stage cancer or full cardiac arrest and are not meant for temporary, potentially reversible situations such as choking on food. Furthermore, neither DNR orders or living wills are intended to withhold simple comfort measures such as suctioning or oxygen if the patient is not in full cardiac arrest.

- C. Power of attorney in health care matters is for the purpose of designating another person to make decisions regarding health care issues for a patient. Generally this is not appropriate for withholding resuscitation if the current event appears to be a reversible situation such as choking on food.
- D. All of above (DNR, Living Wills and Durable Power of Attorney for Health Care Matters) can be used as information to aid, usually in consultation with MD, in the decision about whether to continue resuscitation.
- E. Physician Orders for Life-Sustaining Treatment (POLST); the POLST is a voluntary form, which was developed to document and communicate patient treatment preferences across treatment settings.
 - 1. It includes a section for documentation of DNR orders and a section communicating patient preferences for EMS care.
 - 2. While these forms are most often used to limit care, they may also indicate that the patient wants everything medically appropriate done-**read the form carefully.**
 - 3. When signed by a physician, nurse practitioner or physician's assistant, the POLST is a medical order and EMTs are directed to honor it in their Scope of Practice.
 - 4. When arriving on the scene of a patient who may have a POLST form but it is not immediately found, call 1-888-476-5787 (888-4-POLSTS). A communication specialist from the OHSU Emergency Communication Center will answer the phone and ask for the following information to identify the patient: name, birth date, address, last 4 numbers of social security, gender, Registry ID# and, if a POLST form is in the Registry, will provide the POLST orders to EMS. (The communication center can also then fax a copy of the form to the receiving hospital if the patient is being transported.)

F. Algorithm for pronouncing death at trauma scene:



LANE COUNTY MEDICAL CONTROL BOARD
INTERMEDIATE PROTOCOLS: INTRODUCTION

GENERAL INFORMATION REGARDING INTERMEDIATE PROTOCOLS Page 1 of 4
12/10

These protocols are intended for EMT Intermediates who work with the rural and metro Fire Departments in Lane County, Oregon. Each department must have their own Physician Advisor who has approved these protocols and has agreed to be supervising physician for each EMT within that department. This Physician Advisor must be in good standing with the Lane County Medical Control Board, OHD-EMS and Board of Medical Examiners and will be personally responsible for authorization and review of these protocols.

The EMT Intermediate is expected to be familiar with Oregon Scope of Practice for all levels of EMT in Oregon. No procedure may be done that is outside the scope of practice of the individual EMT. Each EMT is responsible for meeting current certification and recertification requirements at state and department levels, and for maintaining proficiency in authorized skills.

Priorities in patient care always start with the basic life support procedures such as airway maintenance, CPR and stemming blood loss. In the following Intermediate Protocols, most care is done by standing order within your scope of practice (the Physician Advisor has authorized you to give the described care without calling for a verbal order). There are several exceptions which are noted within the protocols.

To consult with Medical Control or to obtain an order for any care not specified in protocols by standing order:

1. Obtain order from base station (emergency department physician) by phone or radio.

RiverBend Hospital – 541-222-1581
McKenzie Willamette Hospital – 541-726-4470
University District Hospital ED – 541-686-7341

2. Attempt to contact the approaching medic unit and the Paramedic may give the order.

In the event that an emergency physician cannot be contacted for urgent orders and the medic unit is not available for orders, refer to the protocols and give the care you judge necessary (see page 5-1 for authorization in the event of communication failure). The following general guidelines will apply:

1. **CARDIAC CARE:** With suspected cardiac patients, initiate oxygen therapy and an IV line with a microdrip or saline lock (EMT I, P). If an IV infusion is started it is usually kept at a keep open rate (approximately 25 ml/hour). Monitor ECG. Consider the administration of nitro and analgesia per the Acute Pain Management Protocol.

2. **TRAUMA:** When significant blood loss has been observed or can be reasonably expected, oxygen therapy and an IV line (EMT I, P) should be initiated using standard tubing and a large bore catheter (14 or 16 gauge preferred). Trauma patients should be prepared for immediate transport and if indicated have full spine immobilization. If in doubt as to the cause of shock, treat for hypovolemic shock. If patient(s) meet trauma activation criteria this should be communicated at earliest opportunity. Refer to guidelines in Trauma Activation Protocol, Section C.
3. **LIFE THREATENING EMERGENCIES:** Those patients who are unconscious or in shock from an unknown cause, such as possible poisoning or overdose, should have oxygen therapy and an IV line (EMT I, P) using standard tubing and a large bore catheter (14 or 16 gauge preferred). This IV should be run at a rate titrated to the patient's status. Patient's with altered consciousness from unknown cause should receive naloxone (Narcan ®) and have blood sugar checked.
4. **RESPIRATORY DISTRESS:** The respiratory distress patient should be placed on oxygen and evaluated for upper or lower airway problem. If lower airway bronchospasm is a predominant feature and the cause of respiratory distress can be determined to be allergic reaction, epinephrine should be given according to Allergic Reaction protocol, Section A. When possible obtain an order for epinephrine.
5. **OXYGEN THERAPY:** All sick patients should receive oxygen therapy according to the guidelines in the Oxygen Therapy Protocol, Section C
6. **IV THERAPY:** IV therapy should be started by the EMT I, P on any patient who is severely ill or has likelihood of deteriorating. Attempts to start an IV should be reasonable (weigh benefit vs risk) . Do not delay transport to start an IV in a critical patient, especially a trauma patient. Do not start an IV in an awake pediatric patient in respiratory distress in whom increased agitation while you start the IV may worsen the respiratory situation. Refer to the guidelines in the Intravenous Therapy Protocol, Section C. Intraosseous may be initiated by standing order.
7. **DEFIBRILLATION:** EMT B, I, P personnel may operate SAD or AED defibrillators. Refer to guidelines under Cardiac Algorithms and Cardiac Arrest, both in Section A. Also refer to the procedure Defibrillation in Section C in more detail.

8. **COMMUNICABLE DISEASE PRECAUTIONS:** All EMS providers should wear appropriate PPE (personal protective equipment) to protect them from exposure to bloodborne and airborne pathogens etc. Use your agency guidelines on bloodborne and airborne pathogens.

9. **PATIENT CARE REPORTS:** The Medical Control Board requires that a patient care report must be filled out on every patient whether transported or not. One copy of the first response unit report must be given to the transporting Medic Unit and will be taken to the hospital with the patient. If the first responding unit works for the same agency as the transporting Medic Unit, the information may be transcribed onto the Paramedic report and the BLS report used as a work sheet and thrown away. If the first response unit is not from the transporting agency, then the first response record must be maintained as a separate document with one copy left at hospital and one copy to EMS office. The Medical Control Board requires that a PCR be completed while in the emergency department prior to departure. When a medic crew is dispatched to another emergency prior to completion of the PCR, the crew may depart if sufficient patient information to support safe and timely continuation of patient care has been relayed in an oral report to the receiving Registered Nurse. In all cases, a completed PCR must be left at the hospital within 12 hours of the time the crew departs the hospital or prior to the crew going off duty, whichever occurs first.

10. **PROTOCOL DEVIATIONS:** It should be noted that there may be protocol deviations that occur. Each agency may have additional policies regarding these deviations, however; it will be the general policy of the Medical Control Board that all protocol deviations shall be documented on the pre-hospital care report form. Understand that the PCR should only be a factual report of the deviation. The details surrounding the deviation should be documented in an incident report forwarded to the EMS office of the individual agency for review by the EMS Administrator and Physician Advisor.

11. **MEDICAL DEVICE FAILURE:** The FDA Medical Device Reporting (MDR) regulations require user facilities to report the following:
 - Device-related deaths to the FDA and the device manufacturer;
 - Device-related serious injuries to the manufacturer, or the FDA if the manufacturer is not known; and
 - Submit to the FDA on an annual basis a summary of all reports submitted during that period.

In order to comply with these regulations it is necessary that any time there is a device failure that results in a death or serious injury this must be reported to the FDA within 24 hours.

12. **SPECIAL PATIENTS/PLAN OF CARE:** Occasionally there are patients that are identified by agencies that need a specific protocol written for their medical condition/circumstance. These "Plans of Care" will be written by the physician advisor of the agency where the patient resides with input from the patient's primary care physician, if available. These Plans of Care will be kept on file at the EMS Agency and will also be kept on file at the area hospitals. If appropriate for quick reference, the patient will also receive a copy to have on file.

This document contains protocols based on the principles of prehospital medical care. The EMT is expected to use common sense when making decisions regarding the application of these principles. DO NO FURTHER HARM. When in doubt, consult with Medical Control, or if unable to establish contact with ED physician, consult with responding Medic Unit.

I. Purpose

- A. Interhospital transfers are a common occurrence for ambulance agencies. This protocol and algorithm clarify the level of service required to complete all interfacility transports.

II. Guidelines

- A. The Paramedic should request a full report on the patient to include medications, and the parameters for their use on this patient, as well as orientation to any hospital equipment to be used on the transfer.
- B. If the Paramedic is uncomfortable with a transfer situation (e.g. unfamiliar with medications and equipment), or if the patient is critically ill or unstable and critical care transport team is not an option, the Paramedic should request additional personnel with specialty or critical care training to accompany the patient to the receiving hospital.
 - 1. Critical Care personnel may include: ICU or Critical Care Nurse, ED Nurse, Paramedic with Critical Care Training (CCEMTP).
 - 2. Specialty Personnel may include: Labor and Delivery Nurse for obstetric patients or Respiratory Therapist (RT) on intubated medically stable patients.
- C. When receiving an aeromedical transfer patient at the airport, the Paramedic may request the transfer personnel accompany the patient all the way to the hospital.
 - 1. If the transferring personnel refuse, the Paramedic should contact their supervisor and the on duty ED physician at the receiving hospital for further direction.
- D. When weather conditions or other factors prohibit safe transport of the patient to the receiving facility, the transfer will be postponed until other safe transport can be arranged.

III. Specific Information:


- A. Transfer patients should have the following information with them and the Paramedic must ensure that this paperwork arrives with the patient at the destination facility:
 - 1. Transfer orders which indicate receiving hospital and MD
 - 2. Medication and care orders (in writing) for use during transfer
 - 3. Patient care report from hospital to include vital signs, medications and treatments given
 - 4. Relevant diagnostic information (Lab, X-ray and CT or MRI) when needed

- B. Patients being transferred on medication that is being self administered via a pump may continue to be administered by the patient en route. Examples of these pumps include: PCA (Patient Controlled Analgesic) pump, Insulin pump. Medics should be familiar with the medication and potential side effects of the medication. They should be prepared to treat the potential side effects, which may include stopping the infusion.
- C. Patients that have an antibiotic infusion running may be transported at the ILS, ALS or Critical Care level. If the patient develops any signs of an allergic reaction to the antibiotic being infused, the infusion should be stopped and treatment initiated per the Allergic Reaction Protocol.

IV. Figure 1 Algorithm (See Following Page)

LANE COUNTY MEDICAL CONTROL BOARD
 INTERMEDIATE PROTOCOLS: INTRODUCTION

INTERHOSPITAL TRANSFERS

Stretcher Car	Basic Life Support (BLS)	Intermediate Life Support (ILS)	Advanced Life Support (ALS)	**Critical Care Transport (CCT) Requires a Paramedic and Additional Trained Specialty Personnel
No EMT/Attendant Required with Patient	EMT-Basic 1 Driver/1 EMT in back	EMT-Intermediate 1 EMT Driver/1 EMT-I in back	EMT-Paramedic 1 EMT Driver/1 EMT P in back	1 EMT Driver/1 EMT P in back with RT, ICU, ED, L&D Nurse, CCT Paramedic, Etc.
STABLE PATIENTS	STABLE PATIENTS	STABLE PATIENTS	STABLE/UNSTABLE PATIENTS	CRITICAL PATIENTS
Patient to remain supine or reclined	IV: SL only NO hanging IVs	IV: May start/maintain saline drip	IV: May start/maintain saline drip	IV: May start/maintain saline drip
Patient may maintain own oxygen				
	Basic Airway: May Administer O2 NO Intubation May perform Tracheal Suctioning	Basic Airway: May Administer O2 NO Intubation May perform Tracheal Suctioning	Advanced Airway Management: May Administer O ₂ NO Intubated Patients May Perform Tracheal Suctioning NO Acute onset resp distress patients on CPAP/BiPAP NO Vent Patients	Advanced Airway Management: May Administer O ₂ Intubated Patients May Perform Tracheal Suctioning Acute onset resp distress patients on CPAP/BiPAP Patients on Ventilator
These transports can be handled by a private vendor	MEDS: NO MEDS	MEDS: May bolus meds <u>only</u> within Agency protocol/standing orders Patients with PCA pump	MEDS: May drip or bolus meds <u>only</u> within Agency protocol/standing orders Patients with PCA pump	MEDS: May maintain med drips and bolus meds outside Agency protocol/standing orders Patients with PCA pump
	Cardiac Monitoring: NO cardiac monitoring	Cardiac Monitoring: Stable rhythms <u>only</u>	Cardiac Monitoring: Stable/unstable rhythms Read and interpret 12 Lead	Cardiac Monitoring: Stable/unstable rhythms Read and interpret 12 Lead
				STEMI
				Active Chest Pain with Ongoing Dynamic ECG Changes
	May Defibrillate with AED NO Cardioversion NO External Pacing	May Manually Defibrillate NO Cardioversion NO External Pacing	May Manually Defibrillate Cardiovert External Pace (Stable)	May Manually Defibrillate Cardiovert External Pace (Stable)
	OB Transfer (Stable) Patient not in labor/delivery not imminent	OB Transfer (Stable) Patient not in labor/delivery not imminent	OB Transfers (Stable) Acute Low Risk/In labor/delivery not imminent	OB Transfers (Stable/Unstable) Acute High Risk/In labor/delivery may be imminent

**Critical patients that have a time sensitive condition need to be transported immediately. Only when critical care transport is not available should these patients go by alternative means. Sending facilities with patients meeting critical care criteria should use CCT transport for these patients. Out of hospital time should be minimized for all critical patients.

This page purposely left blank

**LANE COUNTY MEDICAL CONTROL BOARD
INTERMEDIATE PROTOCOLS: INTRODUCTION**

PATIENT REFUSALS & NON TRANSPORTS

Page 1 of 3
5/09

I. Purpose:

The refusal of medical care and transport is a difficult problem for the pre-hospital EMS system. In terms of liability, the patient that is not transported poses a very high risk. This protocol is designed to help define situations in which it is appropriate to obtain a signed refusal, what to do when transport is needed and care is refused, and also to help determine possible alternatives to transport.

II. Guidelines & Definitions

- A. Decision Making Capacity: The ability to make an informed decision about the need for medical care is based on the following:
 - 1. Accurate information given the patient regarding potential risks associated with refusing treatment and/or transport.
 - 2. The person's perceived ability to understand and verbalize these risks back to the medic.
- B. Impaired Decision Making Capacity: The inability to understand the nature of the illness or injuries, or the risks and consequences of refusing care.
- C. Emergency Rule: EMTs may treat and/or transport under the doctrine of implied consent a person who requires immediate care to save a life or prevent further injury. Minors may be treated and transported without parental consent if a good faith effort has been made to contact the parents or guardians regarding care and transport to a hospital, and the patient, in the opinion of EMTs needs transport to a hospital. When in doubt, contact Medical Control.

III. Procedure (EMT P):

- A. Determine if there is an "Identified Patient":
 - 1. There is an "Patient Identified" if the person meets ANY of the following criteria:
 - a. Significant mechanism of injury.
 - b. Signs or symptoms of traumatic injury.
 - c. Acute, or recent change in, medical condition.
 - d. Behavior problems that place the patient or others at risk.
 - e. Person is less than 16 years of age and meets one of the other criteria referenced.
 - f. Person is the 911 caller.
 - g. In the medic's judgement the patient requires medical treatment.

**LANE COUNTY MEDICAL CONTROL BOARD
INTERMEDIATE PROTOCOLS: INTRODUCTION**

PATIENT REFUSALS & NON TRANSPORTS

Page 2 of 3
5/09

- B. Identified Patient who is refusing medical care and transport:
 - 1. Determine if the patient appears to have impaired decision making capacity. Consider conditions that may be complicating the patient's ability to make a decision:
 - Head injury.
 - Drug or alcohol intoxication.
 - Toxic exposure.
 - Psychiatric problems.
 - Language barriers (consider translator).
 - Serious medical conditions.

- A. Identified Patient WITH decision making capacity:
 - 1. Explain the risks and possible consequences of refusing care and/or transport.
 - 2. If a serious medical need exists, contact Medical Control for physician assistance. (Request patient speak to physician on line if necessary.)
 - 3. Enlist family, friends, or law enforcement to help convince patient to be transported.
 - 4. If patient continues to refuse, complete the Patient Refusal Information Sheet and have them sign it. Document the risks and possible consequences of refusing care and information on treatment needed that was advised to the patient.

- B. Identified Patient WITH IMPAIRED decision making capacity:
 - 1. Treat and transport any person who is incapacitated and has a medical need.
 - 2. With any medical need, make all reasonable efforts to assure that the patient receives medical care. Attempt to contact family, friends, or law enforcement to help.
 - 3. If necessary, consult with Medical Control and request a physician speak directly with the patient.
 - 4. Consider chemical or physical restraint per protocol.

**LANE COUNTY MEDICAL CONTROL BOARD
INTERMEDIATE PROTOCOLS: INTRODUCTION**

PATIENT REFUSALS & NON TRANSPORTS

Page 3 of 3
5/09

- E. Patient requesting transport, but medic determines transport is unneeded. If the patient is a frequent customer, and after a thorough assessment the patient's condition does not warrant ambulance transport, the medic should call the ED to discuss alternatives for the patient.

- F. Potential alternative means of transport ~~when~~ appropriate:
 - 1. Family members.
 - 2. CAHOOTS.
 - 3. Law enforcement

Documentation

- A. All instances of an identified patient, with or without impaired decision making capacity, must be documented on a Prehospital Care Report Form. The following is considered minimum documentation criteria:
 - General impression and level of consciousness (mental status).
 - History, vital signs, and physical exam.
 - Presence of any intoxicants.
 - Risks explained to patient.
 - Patient able to verbalize risks of non transport as explained to them by medic.
 - Communication with family, friends, police and/or Medical Control.

- A. When a patient the medic has determined needs transport and medical treatment refuses care, a Prehospital Care Report Form must be completed.

This page purposely left blank

PATIENT TREATMENT RIGHTS

The Intermediate protocols are intended for use with a conscious, consenting adult patient, or an unconscious (implied consent) patient.

If a conscious patient, who is rational, refuses treatment, you should comply with the patient's request and document the refusal.

If a conscious patient, who is irrational or may harm him/herself, refuses treatment, you should contact the police and request their assistance if the patient is a danger to self or others. The Emergency Department Physician is another important resource in difficult situations.

If a patient's family, patient's physician, or nursing home refuses treatment for a patient, attempt to establish communication between these parties. If the issue is not resolved, use your judgement to act in the best interest of the patient.

A patient has the right to select a specific hospital in Central Lane County to which to be transported if she/he is rational and if, in the Paramedic's best judgement, transport to that hospital will not cause loss of life or limb.

Age of Consent/ Treatment of Minors

If the patient is a minor the EMT should assume responsibility for the patient as if an implied contract exists. If a responsible adult parent or guardian is present who knows the child, is refusing transport, and is willing to take responsibility, and the EMT believes it is reasonable to leave the child, then act reasonably and fully document the situation.

For most purposes, Oregon law defines a minor as a child under 18 years of age. However, for medical purposes ORS 109.640 states that a minor 15 years of age or older may give consent for diagnosis, treatment and hospital care. In accordance with this statute, our policy is that a competent minor 15 years of age or older may consent to or refuse prehospital care and transport.

If a child under age 15 years has no responsible adult present, then it becomes prudent to transport the child to the hospital for follow up and safekeeping. However, if the individual under age 15 years is clearly not ill or injured and does not want transport, it is acceptable to arrange a custodial situation with a responsible adult until a parent is available.

When in doubt in any of the above situations, contact the Emergency Department Physician and fully document all of your actions.