

INTRODUCTION TO PROTOCOLS 12/03/2013

These protocols were written in joint effort by the Medical Control Board of Lane County. The Medical Control Board is a volunteer organization consisting of Medical Directors and EMS Professionals from the City of Eugene Fire & EMS Department, Lane Fire Authority, South Lane Fire/Rescue, Springfield Fire & Life Safety, Western Lane Ambulance as well as those in surrounding jurisdictions within the Lane County Ambulance Services Areas.

The Board meets monthly with the objective of coordinating the delivery of emergency medical care. Where evidence is available, the Board has diligently evaluated the material and drafted protocols that will assist EMS Personnel in providing excellent patient care. Where evidence is lacking, the Board has relied on best practices, expert advice and consensus to guide the development of the protocol or procedure. These protocols are reviewed on a regular basis and updated when necessary to reflect advances in the art and science pertaining to the care of the acutely ill and injured.

EMS is performed in a stressful environment with time-critical decisions and no specific patient care matrix can be developed that will cover every type of injury, illness, and complicating circumstance that EMS Professionals will encounter while providing on-scene care. It is the Board's expectation that providers will use these protocols in conjunction with their training and experience to do what is best for each patient. From time to time, it is expected that circumstances will arise that are not covered within these protocols. In such instances, providers should function within their scope of practice and use all available resources (including Physician Consultation at the receiving facility) to provide the best possible patient care. Any protocol deviations should be documented and sent to your EMS agency's EMS Office and the Medical Director for review.

The Board attempts to achieve, by consensus, a high level of cooperation in developing, purchasing, maintaining and standardizing EMS equipment and protocols. Individual agencies and their Medical Directors can act independently of the Board; however the coordination of medical equipment and practices within the county is an obvious community benefit. Agency-specific protocols may be appended to these protocols when signed by their respective Medical Directors.

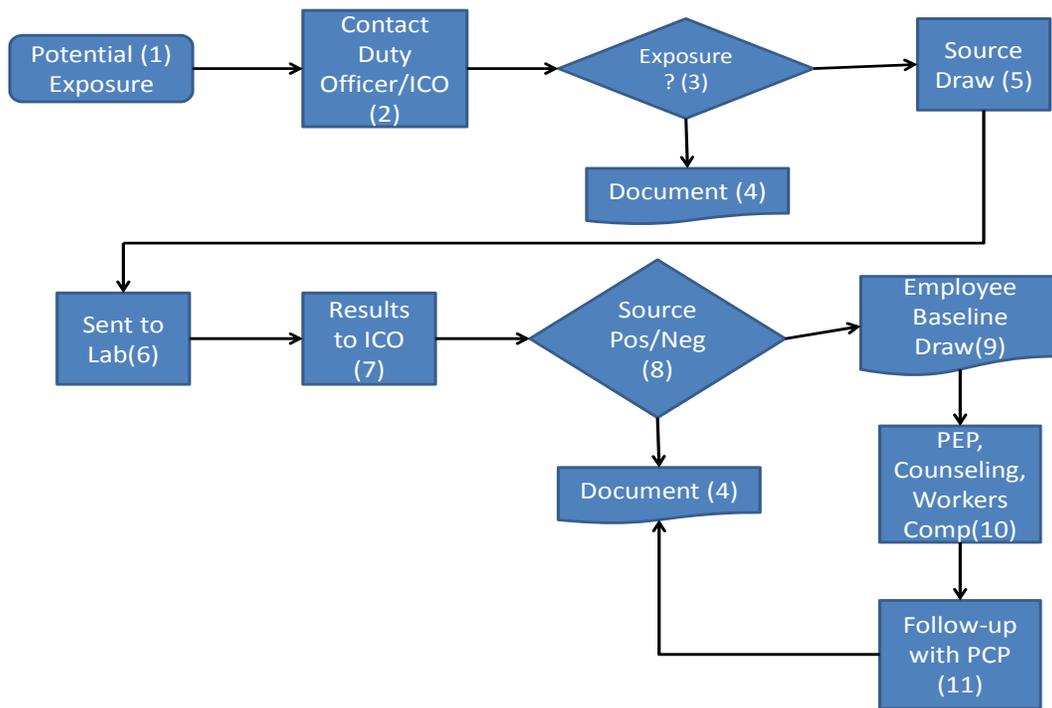
Thanks to everyone who has provided assistance in protocol development and review. Anything that is complex and includes detail is prone to errors. Please review these protocols carefully and route any potential errors, unclear directions, or suggestions for improvement to your agency's EMS Office.

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BLOODBORNE PATHOGEN EXPOSURE 05/06/2014

INDICATIONS	<p>This protocol is intended to be used when there is a bloodborne pathogen exposure to a First Responder or an EMS worker.</p> <p>According to the Ryan White Act, First Responders and EMS personnel have a right to a sample of the patient's blood for testing if there has been an exposure. If patients do not consent; it may be necessary to contact law enforcement to get a court order for source patient testing.</p> <p>**If the source patient is not being transported and there are not personnel on-scene qualified to obtain a blood draw, agencies may contact Med Express to do the draw at (541) 228-3111. Personnel will need to be able to provide a call-back number to Med-Express Dispatch.</p>
EMR/EMT	<p>Provide basic first aid to the worker</p> <ul style="list-style-type: none"> • Wash or irrigate the area that was affected. • Bandage the wound. • Get the Occupation Exposure Packet from the apparatus. • Explain to the patient that there has been an exposure and have the patient sign the consent for blood specimen collection.
A-EMT, EMT-I, PARAMEDIC	<ul style="list-style-type: none"> • If patient is not being transported, obtain blood draw from source patient – See Blood Specimen Collection protocol

BBP EXPOSURE FLOW CHART 01/15/2014



This flowchart is not intended to replace individual agency bloodborne pathogens policies. It is intended to provide guidance to agencies and personnel that may need additional information during an exposure event.

1. Provide First Aid to employee. Relieve the employee of duties when possible. An exposure or incident form should be completed addressing circumstances surrounding potential exposure per agency policy. If able determine if patient has high-risk lifestyle, IV drug use, known HIV positive.
2. The potential exposure shall be reported immediately to the employee's supervisor or as directed by agency policy. Contact the agency Infection Control Officer (ICO).
3. The ICO shall determine if the incident is an exposure. Elements necessary for transmission include: presence of infectious agent (consider dosage and virulence), means of transmission and host resistance (consider PPE used, skin integrity, recipient health etc). Other considerations include: depth (deep or superficial) of percutaneous injury, visible fresh blood, prolonged mucous membrane or skin contact (compromised skin integrity). If no exposure, proceed to step 4 of the flowchart, process terminated. If determined an exposure proceed to step 5 of the flowchart with the assistance of the ICO.
4. Document incident per agency policy. Documentation shall be placed in employee's confidential health record. Provide counseling as necessary.

BBP EXPOSURE FLOW CHART

01/15/2014

5. Patient Transported: If the source patient is transported to the hospital contact the emergency room charge nurse and advise of need for source blood draw.

PeaceHealth: charge nurse shall follow the Employee Body Fluid Exposure protocol. Provide employee's name, date of birth and first six digits of social security number for tracking. Request the lab contact the agency ICO with results ASAP within 24 hours. Request the results are faxed to Cascade Health Solutions.

McKenzie Willamette: advise the charge nurse of the exposure. Once the patient is accepted as a patient and the hospital has consent, the lab will draw the source patient. Request the lab contact the agency ICO with results ASAP within 24 hours. McKenzie is also able to send results to Cascade Health Solutions.

6. Patient Not Transported: Obtain source patient blood draw according to Lane County EMS protocols. If needed, the transport agency can provide an approved lab draw kit. MedExpress (541-228-3111) can provide lab draw services if needed.

Deliver the source blood specimen to the PeaceHealth Lab located at the RiverBend Annex. If needed, MedExpress (541-228-3111) can deliver source blood specimen.

7. The lab or hospital employee health should contact the Infection Control Officer with results ASAP within 24 hours post exposure.
8. ***Negative Results:*** Proceed to step 4. Process terminated

Positive Results: Contact employee and provide information on continuance of process. If HIV positive, begin Post Exposure Prophylaxis (PEP). PEP available M-F 8-5 Cascade Health Solutions Clinic 541-228-3000 or after hours at Peacehealth or McKenzie Willamette Emergency Department. For other positive results employee shall report to Cascade Health Solutions the next business day.

9. Employee shall report to Cascade Health Solutions the next business day. Baseline blood testing of an expose employee is a series of initial, 6 weeks, 3-month and 6-month draws.
10. Employee will be provided PEP as directed by occupational health. Post-exposure counseling shall be provided by a qualified counselor to evaluate the potential risks, process and outcomes. Dr Kovacevic, Board Certified Occupational/Environmental medicine, can provide counseling. Cascade Health will provide initial treatment using an educational and treatment script developed by Dr Kovacevic (541-228-3093). Workman's Compensation documentation shall be processed.
11. Employee should follow-up with primary care physician.

**BBP EXPOSURE FLOW CHART
01/15/2014**

12. Proceed to step 4 of the flowchart. Process terminated.

All agencies must ensure annual bloodborne pathogen training is accomplished.

**Further guidance from the Oregon OSHA BloodBorne Pathogens guidance:
http://www.orosha.org/subjects/bloodborne_pathogens.html**

Contact numbers:

Cascade Health Solutions

**(Brandon Mattix): 541-228-3000
Cascade Health Solutions Fax: 541-228-3185
MedExpress: 541-228-3111**

PeaceHealth

**RiverBend: ER Charge Nurse: 541-222-6929
House Charge Nurse: 541-222-2060
University: ER Charge Nurse: 541-686-6929
Employee Health: 541-222-2535
Risk Management: 541-222-2485
Lab: 541-341-8010
(123 International Way, lobby open 8-5, call box inside double
doors after hrs to contact lab)
EMS Liaison: 541-222-1794**

McKenzie Willamette

**Charge Nurse: 541-726-4444 (ask for charge nurse)
Lab: 541-726-4429 (2nd floor above the ER)**

**CONFIRMED DEATH
09/10/2013**

INDICATIONS	This procedure is used once a patient is pronounced dead.
PROCEDURE	<ol style="list-style-type: none"> 1. Notify Dispatch that the patient is deceased. Dispatch will notify the appropriate law enforcement agency. 2. Determine/evaluate if this appears to be the natural death of someone under the care of a local physician versus a case falling under medical examiner jurisdiction (see below). If any doubt exists, treat this as a medical examiner case and avoid altering the scene until police investigation is complete. 3. In medical examiner cases the body will not be removed from scene until law enforcement personnel arrive. 4. Fire/EMS personnel may be committed to the scene for care of the family. 5. If a patient is under hospice care, contact hospice agency regarding disposition of the body. 6. Document pertinent information in a PCR
DEATHS REQUIRING INVESTIGATION	<ol style="list-style-type: none"> 1. Violent or unnatural death (accident, suicide, homicide, or undetermined manner of traumatic death) 2. Unattended death (not under the care of a physician during the period immediately prior to death) 3. Unanticipated death within 24 hours of discharge from the hospital 4. Substance abuse related deaths 5. Law enforcement custody deaths 6. Deaths relating to employment 7. Communicable diseases
RESOURCES FOR REFERRAL OR BEREAVEMENT	<ol style="list-style-type: none"> 1. McKenzie-Willamette Pastoral Care 541-726-4478 2. Sacred Heart Pastoral Care 541-686-7102 3. Senior & Disabled Services 541-682-4038 4. Chaplain – contact dispatch

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DEATH IN THE FIELD

09/10/2013

<p>PURPOSE</p>	<p>Used to determining death in the field without initiating resuscitative efforts. Withholding resuscitation efforts should be considered by EMS professionals in the following conditions regardless of whether BLS has been initiated prior to EMS arrival. MD contact is not necessary:</p> <ol style="list-style-type: none"> 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; 3. Decapitation/Separation of torso; 4. Cremation, Rigor Mortis in a warm environment; Decomposition, Venous pooling in dependent body parts (dependent lividity); 5. Penetrating head wound with no vital sign; 6. Pulseless, apneic drowning patient with confirmed underwater time of ≥ 1 hour; 7. Pulseless, apneic, patient with evidence of prolonged downtime. <p>If no signed orders are present but the family states that signed orders do exist, and there is evidence of terminal disease, the EMS Personnel may follow family direction.</p>
<p>TRAUMATIC CARDIAC ARREST</p>	<p>Trauma victims 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.</p> <ul style="list-style-type: none"> • If there is evidence of major trauma to the patient and/or the patient is trapped, a monitor is not needed to pronounce death. • If 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, follow Pulseless Arrest Protocol
<p>MEDICAL CARDIAC ARREST</p>	<p>For the victim of a medical cardiac arrest who does not meet the criteria listed above under Withholding Resuscitative Efforts, follow the Pulseless Arrest Protocol. If appropriate, contact MD with patient history and current condition to request to discontinue resuscitation efforts. First responders may also wait until a paramedic is on-scene to facilitate this decision.</p>

DEATH IN THE FIELD

09/10/2013

POLST Physician Order for Life Sustaining Treatment

The POLST registry is voluntary and most often is used to limit care. It may also indicate that the patient wants everything medically appropriate done for them. These forms may be kept by patients or electronically stored by OHSU. Usually there is some indication on-scene that there is POLST documentation.

1. Forms: Must be signed by a Physician.
2. Electronic Access: **Call 1-888-476-5787 (888-4-POLSTS)**. OHSU Emergency Communication Center will answer the phone and will provide the POLST orders to EMS. They will ask for the name and date of birth.

END OF LIFE ORDERS

These orders may also be useful in consultation with MD, in the decision about whether to continue resuscitation:

- **DO NOT RESUSCITATE ORDERS (DNR):** Also known as a "No Code" order, this is a legal document with a physician signature. These should be honored.
- **LIVING WILL:** also known as an Advance Directive, is a document signed by the patient. This may indicate the patient's wish not to be resuscitated with heroic lifesaving measures. If the patient does not meet death in field criteria listed under (Withholding Resuscitative Efforts), start BLS and call private MD or Emergency Physician to consult regarding discontinuation of resuscitation.
- **DURABLE POWER OF ATTORNEY:** Power of attorney is not sufficient for withholding resuscitation if the current event appears to be a reversible situation such as choking on food.

HEALTHCARE PROFESSIONALS ON SCENE 09/10/2013

A Physician (M.D/D.O.) is the highest licensed healthcare provider and therefore has authority to direct the healthcare team in the care of a patient. There are two main types of situations in which EMS personnel will interact with a physician on scene.

CLINIC/OFFICE FACILITY:

EMS Personnel should follow the direction of the physician unless, in your opinion, the care ordered is contrary to reasonable patient care. At that time:

1. Explain that you are operating under protocols authorized by your Medical Director;
2. Contact medical control and request that the ED physician speak to the on scene physician;
3. Follow on scene physician orders when authorized by ED physician.

ON SCENE:

When a medical doctor is on the scene of an emergency and that physician wants to assist with, or assume responsibility and direct patient care, EMS Personnel shall follow the listed guidelines:

1. Explain to the doctor that you are operating under treatment protocols authorized by your Medical Director and that policy requires that you follow those treatment guidelines unless:
 - a. Contact is made with Medical Control and the ED physician specifically advises the medic to follow whatever the on-scene physician feels is required in the way of patient care.
 - b. The on-scene physician chooses to take full responsibility for any and all care given at the scene of the incident and en-route to the hospital. They must also accompany the patient to the hospital and sign the pre-hospital care chart.
2. If at any time, the on-scene medical doctor orders become questionable, re-establish communication with the receiving hospital ED physician and explain before any questionable orders are completed.
3. If there is a problem with a physician or other healthcare provider, and he/she continues to interfere with reasonable patient care, request police assistance to identify the person and have him/her removed from the scene.
4. Documentation involving physician direction at the scene should include:
 - a. The physician's name on the patient care report.
 - b. Any unusual/conflicting conditions at the scene.
 - c. A detailed agency incident report shall be completed and turned in to the EMS Office and the Medical Director.

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INTER-HOSPITAL TRANSFERS

9/10/2013

PURPOSE	This protocol and algorithm clarify the level of service required to complete all inter-facility transports.
GUIDELINES	<ul style="list-style-type: none"> A. The paramedic should request a full report on the patient to include medications, and the parameters for their use, 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. <ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> 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.
SPECIFIC INFORMATION	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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

INTER-HOSPITAL TRANSFERS 9/10/2013

by the patient en route. Personnel 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.

INTER-HOSPITAL TRANSFERS

9/10/2013

Transfer Algorithm

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 O2 NO Intubated Patients May Perform Tracheal Suctioning NO Acute onset resp distress patients on CPAP/BIPAP NO Vent Patients	Advanced Airway Management: May Administer O2 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.

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L-VAD 12/16/2013

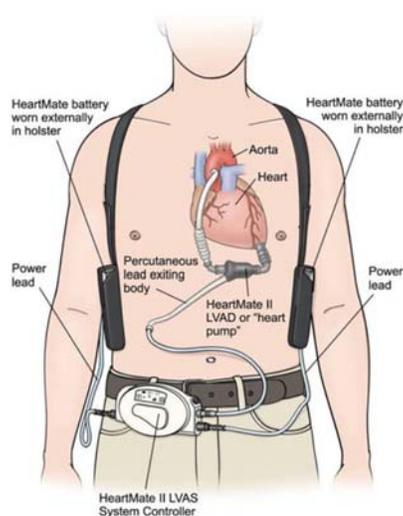
A left ventricular assist device (LVAD) is an implantable mechanical pump that helps pump blood from the lower left chamber of a heart (left ventricle) to the ascending aorta and thus the rest of the body. It is a device that is implanted in a heart failure patient while they await transplant or recovery of their hearts. It is also used in chronic heart failure patients with very poor long-term prognosis not eligible for transplant (age, malignancy, COPD, non-compliance). Patients with LVAD are dependent on these units for survival.

These devices are most commonly implanted internally below the diaphragm. However, they have several external components that must be attached for the units to function. The patient will have a conduit exiting their chest and connecting to the controller. They will also be wearing a harness with one or more batteries which also connect to the controller.

Components

- Pump
- System Controller
- Drive/Power Line
- Battery(ies) and Battery Clip
- Power Base Unit
- Power Base Unit Cable
- Display Module

***** ALWAYS TRANSPORT ALL COMPONENTS OF DEVICE WITH PATIENT *****



L-VAD 12/16/2013	
SPECIFIC INFORMATION NEEDED	<ol style="list-style-type: none"> 1. Past Medical History. <ul style="list-style-type: none"> • These patients generally have other co-morbid factors which may be the cause for acute medical care. Don't overlook these factors. 2. Device Information. <ul style="list-style-type: none"> • It is important to bring all components and information about the device, as well as the family member responsible, with the patient to the hospital.
PHYSICAL FINDINGS	<ol style="list-style-type: none"> 1. Altered cardiac physiology. <ul style="list-style-type: none"> • Due to the device, this complicates patient assessment while limiting the effectiveness of normal tools. 2. Talk to the patient to assess mentation and general status. 3. Check blood glucose. 4. The LVAD is a continuous flow device. The patient will NOT have a palpable pulse. Accordingly, <ul style="list-style-type: none"> • SpO₂ will not be accurate. • Blood pressure readings will not be obtainable. 5. Check cable connections. 6. Listen for “hum” in epigastric region to verify device function. 7. Apply ETCO₂ for monitoring of cardiorespiratory status. <ul style="list-style-type: none"> • ETCO₂ < 10 verifies death. Do not resuscitate.
TREATMENT	<ol style="list-style-type: none"> 1. Listen to concerns from the patient and family members who have received device specific training. Allow them to manage device and transport family LVAD expert if possible. 2. If patient’s primary complaint is NOT cardiopulmonary related, there MAY NOT be a need to provide ACLS care to address a status which is patient baseline. 3. Provide respiratory and ventilator assistance per standard. 4. DO NOT provide chest compressions. 5. Arrhythmias: <ul style="list-style-type: none"> • Many of these patients are in chronic VT and intermittent VF. • A patient who is awake and talking to you may not need defibrillation. • You may administer anti-arrhythmics per protocol if patient’s complaint is cardiopulmonary compromise.
PRECAUTIONS	Always transport ALL components of the device with the patient.

**PATIENT REFUSAL NON-TRANSPORT
04/01/2014**

EMS Personnel 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 EMS Personnel, needs transport to a hospital. When in doubt, contact Medical Control.

Determine if there is an Identified Patient

All instances of an identified patient, with or without impaired decision making capacity, must be documented on a Pre-hospital Care Report.

<p>IDENTIFIED PATIENT</p>	<p>There is a Patient Identified if the person meets ANY of the following criteria:</p> <ol style="list-style-type: none"> 1. Significant mechanism of injury. 2. Signs or symptoms of traumatic injury. 3. Acute, or recent change in medical condition. 4. Behavior problems that place the patient or others at risk. 5. Person is less than 15 years of age and meets one of the other criteria referenced. 6. Person is the 911 caller. 7. In the medic's judgment, the patient requires medical assessment and treatment.
<p>IDENTIFIED PATIENT- REFUSING MEDICAL CARE & TRANSPORT</p>	<ol style="list-style-type: none"> 1. Determine if the patient appears to have impaired decision making capacity. 2. Consider conditions that may be complicating the patient's ability to make decisions: <ol style="list-style-type: none"> a. Head injury b. Drug or alcohol intoxication c. Toxic exposure d. Psychiatric problems e. Language barriers (consider translator) f. Serious medical conditions

PATIENT REFUSAL NON-TRANSPORT
04/01/2014

<p>IDENTIFIED PATIENT WITH DECISION MAKING CAPACITY</p>	<ol style="list-style-type: none"> 1. Explain the risks and possible consequences of refusing care and/or transport. 2. If a serious medical need exists, or any medication has been administered, contact Medical Control for physician assistance. (Request patient speak to physician if necessary.) 3. Enlist family, friends, or law enforcement to help convince patient to be transported. 4. If a patient continues to refuse, complete the Patient Refusal Information Sheet and have the patient sign it. Document in detail the risks and possible consequences of refusing care and information on treatment needed that was advised to the patient.
<p>IDENTIFIED PATIENT WITH IMPAIRED DECISION MAKING CAPACITY</p>	<ol style="list-style-type: none"> 1. Treat and transport any person who is incapacitated and has a medical need. 2. Occasionally, well intentioned friends or bystanders may refuse on the patients behalf. Only the patient can refuse care for themselves. 3. 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. 4. If necessary, consult with Medical Control and request a physician speak directly with the patient. 5. Consider chemical or physical restraint per protocol.

PATIENT TREATMENT RIGHTS

01/05/2016

These 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 assessment and treatment, comply with the patient's request and document the refusal.

If a conscious patient who is irrational or may harm him/herself refuses assessment and treatment, you should contact the police and request assistance as 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, physician, or care facility staff refuses treatment for a patient, attempt to establish communication between these parties. If the issue is not resolved, use your judgment to act in the best interest of the patient.

A patient has the right to **be transported to the closest appropriate hospital** in Central Lane County that, **in the judgement of the paramedic**, is capable of treating the patient's condition.

In the event that the desired hospital is on divert, the patient's choice of hospital may be over-ridden. The patient will be taken to the nearest appropriate hospital.

Age of Consent/Treatment of Minors:

If the patient is a minor the EMS Personnel 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 EMS Personnel 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 pre-hospital 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.

PATIENT TREATMENT RIGHTS

01/05/2016

When in doubt in any of the above situations, contact medical control and fully document all of your actions.

Customer Service

The Medical Control Board recognizes that Lane County has a very competent and professional pre-hospital EMS and medical transport system. However, there may be times when customer may have issues or are dissatisfied with the service that is rendered to them. There also may be questions that arise regarding practices or care that is received by pre-hospital providers. It is recommended that customers that have issues, are dissatisfied, or have questions contact the provider directly. If there is no resolution with the provider, customers may contact the EMS Section of the Oregon Health Authority for further resolution.