



## Division 05

## Emergency Medical

# Chapter 01 –Emergency Medical Service Operations

March 2009

### POLICY

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

### DEFINITIONS

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

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

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

**Priority 1** – a person that is critically ill or injured, requiring immediate attention; an unstable patient with life-threatening injury or illness.

**Priority 2** – a person with a less serious condition, yet potentially life threatening injury or illness, requiring emergency medical attention, but not immediately endangering the patient's life.

**Priority 3** – a person with a non-emergent

condition, requiring medical attention, but not on an emergency basis.

Priority 4 – a person that does not require medical attention.

### PROCEDURES

#### General Provisions

The primary objective of all Fire/EMS Department emergency medical service units is to provide the best pre-hospital care possible to any person who requests or needs care. Any care provided shall always be in the best interest of the patient.

Each EMS response consists of several phases:

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

#### Phase 1 - Preparedness

#### Staffing

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



Any provider attending to a patient must be certified as a MIEMSS EMT-Basic (EMT-B) or hold a higher certification/license.

Other providers on the unit must be currently certified as a First Responder or hold a higher certification/license.

All providers operating on the unit must:

- Maintain current American Heart Association cardiopulmonary resuscitation training for healthcare providers
- Maintain current automated external defibrillator (AED) training.

Other providers may function on the unit as an observer/trainee, provided he/she is enrolled in a formal emergency medical training program. Observers are subject to the requirements of the Ride-Along Observer General Order.

**Equipment**

The emergency medical service crew must ensure operational readiness of the vehicle.

**Vehicle**

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

**Phase 2 – System Access**

System access is managed by the Prince George's County Public Safety Communication using an Enhanced 911 System.

**Phase 3 – Prioritization**

Prince George's County Public Safety Communications (PSC) uses a Priority Emergency Medical Dispatch system. This uses a nationally recognized model to query 911 callers for the most appropriate information necessary to make proper resource assignments.

**Phase 4 – Response Configuration**

Resources are assigned to emergency medical service calls using the information developed by the EMD process. Response configurations for each EMD determinant code are designated by Medical Director and EMS System Manager.

**Phase 5 – Response Deployment**

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

**Phase 6 – Pre Arrival Considerations**

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

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

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

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



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

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

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

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

**Phase 7 – On Scene Care**

**Patient-Provider Relationship**

Providers must determine which persons they encounter are seeking or requiring medical care. When a person is a non-emancipated minor, unconscious, intoxicated/impaired, or their judgment or ability to respond is compromised; the concept of implied consent applies. If the person is alert to person, place, and time, they cannot be forced to accept treatment or transportation.

**Patient Refusals**

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

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

The patient or patient legal guardian then needs to sign the pertinent section of the refusal form.

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

**Patient Care**

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

**ALS/BLS Interface**

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

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

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

**Phase 8 – Disposition**

**Patient Transportation Destination**

Providers base transportation destination decisions using the following factors:

**First Factor** - Patient's Clinical Needs

- a. Patient priority
- b. Capability of local healthcare facilities
- c. Referral to specialty center



Second Factor - System Considerations

- a. Anticipated transport time
- b. Diversion Status
- c. Pre-arranged transport policies
- d. Anticipated time to return to service

Third Factor - Patient's Medical Request

- a. Continued care at specific facility
- b. Physician relationship
- c. Personal preference

Fourth Factor - Provider Preference

- a. Proximity to the station
- b. Other considerations

**Hospital Diversion**

Hospitals have the ability to go on diversion status whenever their facility/staff does not have the capability to adequately care for any additional patients. Patients should be transported in accordance with Alert Status System of MIEMSS Region V.

**Phase 9 - Notification and Consultation**

When any patient is transported from a scene by an EMS unit, the following notifications are made:

1. PSC
  - a. Time transport started
  - b. Patient Information
    - i. Age(s)
    - ii. Sex(s)
    - iii. Chief Complaint(s)
    - iv. Priority(s)
  - c. Medical Facility Destination
  - d. Estimated Time of Arrival
  - e. Starting Mileage (Optional)
2. Receiving Facility
  - a. Patient information should be conveyed to the receiving facility for all transports through EMRC.
  - b. For notifications only, the receiving facility does not need to provide a base station

trained provider.

**Consultation**

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

**Phase 10 - Transportation**

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

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

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

Priority 4 patients generally do not require transportation.

**Phase 11 - Transfer of Care**

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

1. PSC
  - a. Time unit arrived at the facility
  - b. Ending Mileage (optional)

All emergency warning devices and the vehicle engine are to be turned off and the ignition keys removed while the vehicle is



unattended. All equipment and supplies should be secured within the unit.

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

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

**Phase 12 – Documentation/Data Collection**

An electronic patient care report (ePCR) shall be completed any time an EMS unit is dispatched on an incident. It is the responsibility of the providers to ensure this is completed. Station Officers and Volunteer Chiefs must ensure this documentation is completed and accurate.

For most patient transports, units will complete the ePCR while at the receiving medical facility. If the facility is not equipped, the ePCR can be completed at the station. In either case, a copy of the ePCR is to be given to the receiving facility staff for inclusion in the patient's records.

**Phase 13 – Return to Service**

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

**Replenish Supplies**

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

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

**REFERENCES**

Maryland Medical Protocols for Emergency Medical Services Providers

Alert Status System of MIEMSS Region V

**FORMS/ATTACHMENTS**

N/A