

Archer City Ambulance Service

Policies and Procedures

Table of Contents

Consent and Refusal of Treatment and / or Transport	4
Elements of Consent to Treatment / Transport	4
Refusal of Treatment / Transport	5
Refusal of Care	5
Documentation of Refusal of Care	6
Signature of an Authorized Refusal Form	6
Transport to Hospitals other than Hamilton Hospital or URHCS	7
Medical Direction Policy and Procedures	7
Offline Medical Direction	8
Online Medical Direction	9
ALS Procedures by BLS Personnel	9
Reporting Abuse of Children, Elderly or Dependent Adults	9
Definition	9
Elderly / Dependant Abuse	10
Child Abuse	10
Equipment and Vehicle Operations	10
Vehicle Operations	10
Utilizing a Non-Archer City Ambulance Service Driver	11
Accidents	12
Accidents, Review and Action	13
Vehicle Breakdown	13
Vehicle Maintenance	14
Vehicle Maintenance Schedule	14
Inventory Control	15
Drug Inventory / Replacement	15
Obtaining / Replacing Medications	15
Confidentiality / Release of Patient Information	16
Crime Scene	22
Injured Patient	22
Dead on Scene	23
Guidelines Regarding Resuscitation	23
Initiation of CPR	23
CPR in Progress	23
Obvious Death	24
Discontinuing CPR	25
Search for Donor Card	25
EMS Personnel and the Justice of the Peace	26
Do-Not Resuscitate Orders / OOHDR	26
Purpose	26
Definitions	27
Procedure	27
Transportation of Hospice Patients (with DNR Orders)	29
Palliative Care	29
Pregnant Persons	29

Table of Contents Continued

EMS Dispatch Procedures	29
911 EMS Calls	29
Archer County Sheriff's Department Notifications of EMS Response	29
Radio / Phone Communications	30
Forced Entry	30
Hazardous / Flammable Materials	31
Helicopter Evacuation	32
Incident Report Form	33
Jail Responses	33
Transportation of Prisoners	33
On-Scene Roles	34
Primary Paramedic	34
On-Scene Physician	34
Additional EMS Personnel	34
Nurses and Other Allied Health Personnel	34
Fire Department Personnel	35
Law Enforcement Personnel	35
Other EMS Services On-Scene	35
Personal Physician	35
Prohibited Activities	36
Ambulance Run Reports	36
Patient Restraint	37
Self-Protection	38
Sexual Assault	38
Third-Out Riders in EMS	39
Third-Out Riders Rules and Regulations	39
Guidelines for Facility to Facility Transfers	41
Transfer of Care in the Field	42
Handling of Valuables	43
Transportation of Belligerent / Violent Patients	43
Weapons Policy	43
EMS Stand-By During Fire, Rescue and Other Operations	44
QI Plan	44
QI-QA Sheets	45
Infection Control	47
Alcohol and Drug Policies	50
Contact List	51
Archer City Ambulance Service Personnel	51
Regularly Used Numbers	51
City Structure Flow Chart	52

CONSENT AND REFUSAL OF TREATMENT AND / OR TRANSPORT

Elements of Consent to Treatment / Transport

EMS personnel must obtain informed, legal consent prior to treatment and / or transportation.

- A. All adult patients who are in possession of their faculties (conscious and alert to person, place, time and event) must give EMS permission for treatment and transportation (verbal consent is sufficient).
- B. Adult patients who are in possession of their faculties (conscious and alert to person, place, time and event) have the Legal Right to refuse treatment and/or transportation, even if that refusal will result in serious harm or death.
 1. It shall be policy to encourage all persons needing medical help or transportation to make use of the services offered. However, if they choose to refuse service after being informed of the possible consequences of their refusal, they should be allowed to do so.
 2. Thorough documentation of the patient's refusal and the crews efforts to persuade them to seek help are necessary. Anytime patient contact is made a Refusal of Service statement must be signed by the patient and witnessed.
- C. Adult patients who are unconscious may be treated under the implied consent laws.
- D. Patients with an altered mental status will be treated under implied consent.
- E. Minors (persons under the age of 18 and who have not been married) are unable to consent or refuse treatment and therefore present special legal problems. Every effort shall be made to obtain legal consent for the treatment of minors.
 1. Under circumstances of serious medical conditions that are *life threatening* or have the *potential for permanent disability* the rules of implied consent are used.
 2. In situations to which EMS is called that involve minors that do not have a life-threatening condition, every reasonable effort to contact the minor's parent or legal guardian should be made.
 3. If consent cannot be obtained because of lack of contact, the Texas Family Code, Sections 35.01 and 35.02 provide limited consent powers to certain others in particular circumstances. Certain relatives of the child can give consent. They are:
 - A grandparent.
 - An adult brother or sister.
 - An adult aunt or uncle.
 - The parent or guardian may also leave written authorization for consent to treatment with an educational institution or day care center in which the minor is enrolled. The parent or guardian may also leave written authorization for consent to treatment with an individual.
 4. The minor may consent to their own treatment under the following circumstances:
 - The minor is on active duty with the Armed Services of the United States of America.
 - The minor is 16 years of age or older and resides separate from their parents or guardians (regardless of the duration of such residence) and is managing their own financial affairs, regardless of source of income.

- The minor is unmarried and pregnant and consents to hospital, medical or surgical treatment related to the pregnancy.
 - The consent to examination and treatment is for drug addiction, dependency or any other condition related directly to drug use.
5. Consent is to the diagnosis and treatment of infectious, contagious, or communicable disease which is required by law or regulation to be reported by a licensed physician to a local health officer.

Refusal of Treatment / Transport

When a patient refuses treatment and / or transport by a responding EMS unit for whatever reason, the following steps should be taken:

- A. Assess the physical and neurological status of the patient to the best of your ability, as the patient permits.
- B. If deemed an emergency situation, explain to the patient the necessity of seeking further medical help.
- C. When possible have your partner, a family member, or law enforcement officer explain the same concerns to the patient.
- D. Contact Medical Control and offer the refusing party the option of talking directly to a physician, or if possible, their personal physician.
- E. If all reasonable options have been exercised, try again to convince the patient of the need for further care.
- F. If the patient still refuses to be transported have them sign a statement of refusal. When possible have a law enforcement officer witness the refusal form.
- G. If the patient will not sign the refusal form document, document the refusal and get substantiating witness signatures, preferably law enforcement if possible.
- H. The refusal form should be signed and witnessed in the appropriate area, with printed names beneath the signatures.

Regarding Witnesses:

- EMS personnel may sign as a witness, as a last resort, on a refusal form.
- On any unusual or questionable refusal law enforcement, fire department personnel or a credible bystander should sign as a witness.
- It should be made clear that the co-signer is witnessing only the refusal and not making a comment on any medical situation.

Refusal of Care

- A. The following must be present to allow refusal of care:
 - 1. Competence
 - 2. Be an adult patient, this is defined as:
 - A person at least 18 years old.
 - A legally married minor (under 18 years old).

- A minor on active duty with the Armed Services of the United States of America.
 - A self-sufficient minor at least 15 years of age, living apart from parents and managing his / her own affairs.
 - An emancipated minor (must show proof).
3. The parent of a minor child or a legal representative of the patient. Spouses or relatives cannot consent to the refusal of care for the patient unless they are a legally designated representative.
- B. Patients who meet one or more of the following conditions are considered potentially incapable of making competent decisions regarding their medical care:
1. Patients who present with an altered level of consciousness from any cause including altered vital signs and those who are suspected to be under the influence of drugs and or alcohol.
 2. Patients who have attempted suicide or verbalized a suicidal intent.
 3. Patients making irrational decisions and not acting like a “reasonable person”.
 4. Patients under arrest may refuse prehospital treatment but may not refuse transport to the nearest appropriate receiving hospital.
- C. Field personnel should make contact with a hospital physician if the patient requires prehospital treatment but appears to be incompetent, and therefore incapable of refusing treatment which is felt to be necessary by those field personnel. Whenever hospital contact is made it becomes the responsibility of the hospital physician to determine the patient’s need for further evaluation and / or treatment.

Documentation of Refusal of Care

- A. Whenever a competent adult refuses emergency medical evaluation or treatment, prehospital personnel shall utilize the following steps to document the circumstances of the refusal:
1. Evaluate the patient as much as capable or allowed.
 2. Document the history and physical assessment on the patient care report, charting as much information as is available, including refusal of any portion of the evaluation.
 3. Determine the appropriate plan of action for the patient, including field treatment and hospital destination.
 4. Clearly describe the plan of action to the patient in easily understandable terms, along with the need for further hospital evaluation.

Signature of an Authorized Refusal Form

The patient, parent or legal representative should sign a refusal form. If the patient, parent or legal representative refuses to sign, that should be clearly documented. At no time should prehospital personnel put themselves in danger by attempting to treat or transport patients who refuse care. Prehospital personnel should use good judgment and the appropriate support agencies for assistance under these circumstances.

Transport to Facilities other than URHCS or Hamilton Hospital

Policy-- A medically *stable* patient has the right to request care at the hospital facility or his or her choice. Medically *unstable* patients should be transported to the nearest appropriate medical facility for initiation of a higher level of care as quickly as possible. It shall be assumed that any hospital is capable of offering a higher level of care than which can be provided in the field or on an ambulance, regardless of its certification level.

When a patient requests transportation to a medical facility other than those listed above, the following guidelines should be followed:

1. Assess the patient for their emergency needs and offer to transport the patient to URHCS or Hamilton Hospital based on the medical needs of the patient.
2. If the patient is stable and requests transport to another facility within the accepted range of 50 miles, transport the patient to the desired medical facility.
3. If the patient's medical stability is in question, and transport to URHCS or Hamilton Hospital refused, contact the Medical Director or physician on call to determine whether the patient can be appropriately transported to another facility.
4. If unstable and refusing transportation to the nearest appropriate medical facility, the patient or a family member should sign a refusal form to release the crew from liability. The consequences of not transporting to the closest medical facility should be clearly stated to the patient and / or family and documented specifically on the run sheet.
5. Authorization to transport to a facility outside of Wichita or Young counties will be determined by the Medical Director or physician on call.

Medical Direction Policy and Procedures

- A. The provision of invasive emergency medical care is considered by Texas statute to be a "delegated medical practice". The Medical Director of any ambulance service is therefore considered to be "responsible for all aspects of the operation of an EMS system concerning provision of medical care". (Title 22, Part IX, Chapter 197.2)
- B. Medical Director's Authority: The Medical Director of Archer City Ambulance Service has control over the ability of EMS personnel to use advanced field skills, since EMS personnel work under the auspices of the Medical Director's license. The Medical Director may therefore grant or deny the right to use advanced skills at any time.
- C. Granting of Basic and / or Advanced Privileges: The provision of emergency medical care involves a unique and varied set of skills, both mental and physical, and requires continuing education and reevaluation of invasive and noninvasive techniques, fitness and knowledge of protocols and procedures. The Medical Director may develop criteria and testing in the following areas:
 1. Medical procedural knowledge and skills.
 2. Physical fitness and physical capabilities.
 3. EMS protocols.

4. Local geography.

Personnel may be tested in the above areas as a condition of beginning and continuing employment within this EMS system.

- D. Disciplinary Actions: The EMS Medical Director may take the following disciplinary regarding EMS personnel:

1. Counseling.
2. A report documenting a medical error.
3. Probation.
4. Denial of use of advanced skills.

He may also require the individual to take appropriate remedial or corrective measures which may include, but are not limited to, retraining, testing, and /or field and / or hospital preceptors.

Depending on the severity of the medical or procedural error, or physical limitations making EMS personnel unable to perform their regular duties, the Medical Director may skip any step (counseling, documentation or probation) and deny the use of Basic and / or Advanced skills. He may also recommend disciplinary action to the Texas Department of State Health Services, including the revocation of certification. He may also make recommendations to EMS administration staff regarding continued employment within the EMS system.

Off Line Medical Direction

- A. Introduction: The Medical Director of Archer City Ambulance Service shall develop a set of treatment protocols (defined by state statute as “Off Line medical direction” to guide care in most situations that will present themselves in the field. While the presence of protocol should guide the provision of medical care, *they should not take the place of training or general good sense.*
- B. Limitations of Protocols: Separate procedural and treatment protocols shall be established for each certification level, but clearance to perform any invasive procedure or administer any therapy shall be granted by the Medical Director on an individual basis, not solely based on level of certification.
- C. Protocol Levels: Separate treatment protocols shall be established for the following levels of provider:
1. ECA
 2. EMT-B
 3. EMT-I
 4. EMT-P / LP
- D. Deviation From Protocol: Any deviation from written treatment protocol should have well-documented, medically sound and defensible justification written on the run sheet. If doubt about the need to deviate from a protocol exists contact On Line Medical Control prior to deviating, if possible.
- E. Deviation by Medical Control: Any order from medical control which deviates from the treatment protocol may (and should) be brought to the attention of Medical Control at that time, if appropriate. The decision of

Medical Control on this issue is final, since EMS personnel are operating under the scope of the physician's license.

On Line Medical Control

- A. Introduction: Situations will invariably arise which are not covered in standing treatment protocols. Situations will also arise in which standing protocols may not seem to apply adequately to the individual needs of the given patient. In these situations direct contact with a physician is necessary in order to provide the best care to the patient.
- B Procedure: Primary responsibility for the medical care of the EMS patient falls to the Medical Director, and every effort should be made to contact that individual if available. This contact may be made by radio, cellular phone or relayed through the hospital RN on duty. Direct contact is always preferable so that important patient information is not incorrectly communicated in the relay.

If the Medical Director is unavailable, his / her designee should be contacted.

If the designated interim Medical Director is unavailable, the physician on call for the Emergency Department at the receiving hospital may be contacted.

- C. Authority: Orders of On Line Medical Control shall be followed to the letter, unless they are deemed detrimental to the patient or in obvious departure from the standard of care. Any departure from direct orders could cause the EMS provider to be subject to reprimand or even termination of employment.

ALS Procedures by BLS Personnel

ECA's or EMT's who are asked by a physician to perform ALS procedures at the scene (i.e. IV therapy, medications, etc.) should adhere to the following guidelines:

1. Tell the physician that BLS training does not cover ALS procedures and that you must respectfully decline to perform the procedure.
2. Document the procedure requested, by whom and the outcome of the refusal.

Note: One should never perform any skill that he or she has not been trained to perform.

Reporting Abuse of Children, Elderly or Dependent Adults

Definitions:

- A. "Child Abuse" means any of the following:
1. A physical injury which is inflicted by other than accidental means on a child by another person.
 2. The sexual assault of a child.
 3. Willful cruelty or unjustifiable punishment of a child.
 4. Corporal punishment of a child (a situation where any person willfully inflicts upon any child any cruel or inhumane corporal punishment or injury resulting in a traumatic condition).
 5. The neglect of a child (the negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter or supervision where no physical injury has occurred).

6. Abuse in out-of-home care (any of the above definitions occur when the person responsible for the child's welfare is a foster parent, administrator or the employee of a public or private residential home, school or other institution or agency).
- B. "Elderly" means any person who is 65 years of age or older.
- C. "Dependant Adult" means any person between the ages of 18 and 64 who has physical or mental limitations which restrict his or her ability to perform normal activities or is unable to protect his or her rights. These patients include, but are not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age.
- D. "Abuse of the Elderly or a Dependant Adult" means physical abuse, neglect, intimidation, cruel punishment, fiduciary abuse, abandonment, isolation or other treatment which results in physical harm, pain, mental suffering or deprivation. This includes, but is not limited to, deprivation by a care custodian of goods and services which are necessary to avoid physical harm or mental suffering.

Child Abuse

EMS personnel who know of or observe a child within their professional capacities that they reasonably suspect is a victim of child abuse *must* report this to a child protective agency or local law enforcement. One member of the EMS team may make the call reporting an incident to a child protective agency or local law enforcement *all members are responsible to see that it has been done*. Any healthcare professional who knowingly fails to report child abuse *is guilty of a criminal offense*.

Elderly / Dependent Abuse

EMS personnel *are required to* report physical abuse of elders or dependent adults under the following circumstances:

- A. When EMS personnel have observed an incident that reasonably appears to be physical abuse.
- B. When EMS personnel have observed a physical injury where the nature of the injury clearly indicates that physical abuse has occurred.
- C. When EMS personnel are told by an elderly or dependant adult that he or she has experienced behavior constituting physical abuse.

EMS personnel are to make reasonable efforts to transport victims of elderly or adult dependant abuse to a hospital and are to give a report of their suspicions to the receiving physician or nurse. Hospital personnel may then have additional reporting responsibilities; however, EMS personnel are not relieved of their own obligations to report. All reporting should first be done to the local law enforcement agency in whose jurisdiction the incident occurred.

Equipment and Vehicle Operations

Vehicle Operations

- A. Code 1 designates the operation of the ambulance without the use of emergency lighting and siren. Employees will drive the vehicle under routine driving procedures in accordance with the Texas Uniform Traffic Act.

B. Code 3 designates the operation of the ambulance using emergency lighting, siren and / or air horn. Employees will not operate an ambulance under Code 3 unless the patient's need is sufficient to justify Code 3. Employees are authorized to run the ambulance Code 3 when:

1. Enroute to a designated emergency call.
2. The EMS crew determines the patient's condition is unstable.
3. The Police / Sheriff Officer Dispatcher or Medical Control gives expressed authorization.

Employees operating an ambulance under Code 3 conditions may exercise privileges set forth in Article 2, Section 24 of the Texas Uniform Traffic Act. They may:

1. Park or stand in restricted areas.
2. Exceed the maximum speed limits so long as life and property are not endangered. No person shall drive on a roadway at a speed greater than is reasonable under the conditions presented.
3. Disregard regulations governing direction of movement or turning in a specified direction. (Employees are not to drive against traffic flow on a one-way street unless it is the only prudent way to get to an emergency scene.)

Note: The above provisions DO NOT relieve the driver from the duty to drive with regard for the safety of all persons and DOES NOT protect the driver from the consequences of reckless operation of the ambulance. The driver should always consider the environment when exercising these rights, including weather conditions, traffic conditions, pedestrian traffic, existing hazards, etc.

All persons driving Code 3 will be required to come to a complete stop before entering a controlled intersection. A controlled intersection is defined as one where the right-of-way is controlled by a STOP sign or a traffic signal displaying a steady red or flashing red light. Signal controlled intersections will be treated with the usual caution.

- C. All EMS employees will utilize the practices and principles of safe emergency driving at all times.
- D. Upon arrival at a call the EMS employee will park the vehicle in such a manner that the vehicle protects the patients and employees while not unnecessarily posing a hazard or impeding traffic.
- E. Unless necessary for safety reasons, all emergency lighting and non-essential systems on the vehicle will be turned off upon arrival at the call.
- F. When backing an ambulance one person should station himself or herself at the rear of the ambulance to spot for the driver. If the ambulance is involved in a collision when utilizing a spotter both the the spotter and the driver can be held responsible for the accident.

In the event a patient needs to be transported Code 3 and no spotter is available the driver should make a 360 degree walk around the ambulance to be sure there is adequate clearance to back the unit safely.

Utilizing A Non-Archer City Ambulance Service Driver

In the event that a patient's condition dictates additional EMS personnel in the box to assist with that patient's needs or in the event of multiple patients requiring additional EMS assistance in the box employees of Archer City may be utilized to drive the ambulance. These employees include, but are not limited to, members of the Archer City Fire Department and Archer City Police Department Officers.

Note: Two EMS certifications are required to be on an ambulance for it to operate. This policy DOES NOT allow the ambulance to be operated without two Archer City Ambulance Service employees on board.

Accidents

A. Accidents Witnessed By, But Not Involving EMS Units:

1. An EMS vehicle not responding to an emergency call:
 - Minor accidents, *with no injuries*, will be reported to the Sheriff Department Dispatcher.
 - Major accidents, *with injuries*, will be reported to the Sheriff Department Dispatcher. The EMS crew will stop, assess, treat and transport as necessary.
2. An EMS vehicle responding to an emergency call:
 - Minor accidents, *with no injuries*, will be reported to the Sheriff Department Dispatcher.
 - Major accidents, *with injuries*, will be reported to the Sheriff Department Dispatcher. The crew must exercise judgment as to the severity of the collision and the nature of the initial call in determining whether to request authorization to stop. The final decision will be based upon the location and the availability of an additional ambulance. Authorization should be obtained from medical control.

B. Accidents Involving EMS Vehicles:

1. General Guidelines:
 - All accidents involving EMS vehicles will be reported immediately to the Sheriff Department Dispatcher and the EMS Director. The situation should be assessed and law enforcement and additional back-up should be requested as needed.
 - As soon as possible a written report from the driver of the EMS vehicle involved will be submitted to the EMS Director and the Archer City, City Manager. A separate written report from each crew member telling what they heard and saw will also be required.
 - All EMS personnel will document any injuries as required.
 - EMS personnel shall cooperate with law enforcement agencies in investigating the incident.
2. Accidents occurring en route to an emergency call:
 - Immediately notify the Sheriff Department Dispatcher and then stop to assess damage to the ambulance and possible injuries.
 - If *there are injuries*, or if unable to continue due to damage to the ambulance, notify the Sheriff, Office Dispatcher and EMS Director so that appropriate units may be sent to the accident location and to the initial call.
 - Notify the EMS Director after completion of the call, check with the Sheriff Department Dispatcher as to whether or not to return to the scene of the accident.
3. Accidents occurring en route to the hospital with a patient:
 - If the *patient is stable and no injuries are incurred*, notify the Sheriff Officer Dispatcher, then advise the other party involved in the accident that law enforcement is en route and then proceed to the hospital.

- If the *patient is unstable and no serious injuries are incurred*, advise the Sheriff Office Dispatcher, then advise the other party involved that law enforcement and another ambulance (if necessary) are en route, then proceed to the hospital.
- In situations where the *patient is stable and serious injuries are incurred*, advise the Sheriff Office Dispatcher to send an additional ambulance, remain on scene until that unit arrives, then proceed to the hospital.
- In situations where there is an *unstable patient and serious injuries are incurred*, the crew should exercise their best judgment and request appropriate assistance.

Accidents, Review and Action

All accidents will be reviewed in order to determine the preventability of the accident according to Emergency Vehicles Operator's Course standards. These investigations will serve to prevent future accidents involving EMS vehicles.

All EMS vehicular accidents will be reviewed by the EMS Director and the City Manager to present the facts of the case.

The EMS Director, City Manager and the Archer City Council, with consultation from appropriate law enforcement authorities, will make a ruling on the preventability of the accident. The employee will be notified of the ruling within seven days.

All preventable accidents within a twenty-four month period will subject the employee to the following disciplinary actions:

1. Non-preventable accident:
 - No action.
2. First preventable accident:
 - Written reprimand.
 - Up to 24 hours suspension, without pay, depending on the severity of the accident.
 - Mandatory enrollment in a Defensive Driving Course.
3. Second preventable accident:
 - Up to 3 shifts suspension, without pay.
4. Third preventable accident:
 - Employee is subject to termination.

Vehicle Breakdown

If the ambulance breaks down, notify the Sheriff Office Dispatcher immediately via radio or telephone. Whether en route to the scene or to the hospital:

1. Stop the vehicle immediately.
2. Call for a second unit if a patient is on board.
3. Attempt to safely mark your vehicle with proper warning devices.

4. Communicate with the EMS Director, City Manager or City Secretary to develop a plan to have the unit returned into service as quickly as possible.

Vehicle Maintenance

At the beginning of each shift the oncoming crew will be responsible for verifying the on-board presence of all items on the supply list and for verifying the working condition of all medical equipment, as well as aspects of the ambulance itself. Supplies will immediately be restocked and any mechanical problem will be reported to the EMS Director and dealt with as soon as possible.

UNDER NO CIRCUMSTANCE should a vehicle be placed in service, which has:

1. Supplies insufficient to meet EMS licensing requirements.
2. Supplies are insufficient to render reasonable patient care.
3. Mechanical deficiencies great enough to compromise patient care.
4. Mechanical deficiencies great enough to endanger the patient, the crew or the public.

If any one or a combination of the above occurs, the vehicle should be placed out of service until appropriate measures to resolve the problem have been taken.

Vehicle Maintenance Schedule

6,000 Miles

- Oil Change

15,000 Miles

- Transmission (Fluid and Filter)
- Fuel Filter
- Air Filters
- Wiper Blades
- Check Radiator Cap
- Front and Rear Brakes Checked

30,000 Miles

- Replace Serpentine Belts

60,000 Miles

- Change Gear Oil
- Replace U Joints
- Replace Front and Rear Shocks
- Replace Belt Tensioner and Pulley

90,000 Miles

- Replace Water Pump
- Replace Clutch Fan

- Replace Hose
- Replace Thermostat
- Flush Radiator
- Replace Cap

Inventory Control

Each employee is responsible for the care, accountability and cleaning of all equipment on the unit which are designed for use by EMS. Care includes inventory and inspection of equipment to ensure it is available for use and is functioning properly when needed, securing all equipment from unauthorized access or use and maintaining a working knowledge of all equipment. Investigations of lost or missing equipment determined to be the result of negligence will result in disciplinary action.

- A. All equipment should be cleaned and tested weekly. Any missing or damaged equipment will be reported to the EMS Director. Equipment and supplies will be ordered according to Archer City Ambulance Service purchasing procedures.
 1. The crew should check the ambulance using the Approved Inventory List. If there is a deficiency found, the deficiency should be corrected and it should be brought to the attention of the EMS Director.
 2. Any damaged equipment will be reported to the EMS Director. Any missing or damaged equipment will be noted and replaced.
- B. All equipment should be cleaned after each use.
- C. Monitor / defibrillator batteries will be rotated on a regular basis. The batteries should be placed on the charger in the storage room after they are replaced with charged batteries replaced on the ambulance.
- D. Any time an ambulance is parked and left unattended in public (other than at a call or at the E.R.) all doors should be locked to prevent theft.
- E. All narcotics, benzodiazepines, pain relief and antiemetic drugs will be stored in the drug lock box. The drug box should be locked with both locks when not in use.
- F. All supplies used are to be replaced from the EMS storage room. Drugs secured in the lock box require a full-time paramedic to replace them.

Drug Inventory / Replacement

- A. All drugs and IV solutions will be inventoried daily during morning truck checks and stocked at levels indicated on the Approved Inventory List.
- B. Expiration dates will be checked daily on all drugs and solutions.
- C. All drugs and solutions will be checked daily as to appearance and color.
- D. Expired drugs should be turned in and replaced. Drugs are to be replaced on a one-for-one basis from the EMS stock and recorded.

Obtaining or Replacing Medications

This policy outlines the process used by ALS personnel to obtain and replace medications.

- A. The initial inventory of medications will be obtained from Archer City Ambulance Service. Archer City Ambulance Service will maintain records containing the following information:
- The date of issue.
 - The unit ID the medication is being replaced on.
 - The signature of the EMS person obtaining the medication.
- B. Controlled substances will be secured in the ambulances with adequate precautions to prevent loss. The paramedic personnel are responsible for insuring that this security occurs.
- C. All narcotics, benzodiazepines, pain relief and antiemetic drugs will be stored in the drug lock box. The drug box should be locked with both locks when not in use.
- D. A narcotics log will be kept which includes the number of each controlled substance assigned to each ambulance. A check shall be performed and signed off at least once per month to insure that the current amounts of controlled substances are present on each ambulance.
- E. Restock of Medications
1. All medications shall be re-stocked from the Archer City Ambulance Service supply room.
 2. If a medication container is discovered to be broken it shall be returned to the EMS Director. The paramedic on duty should complete a report describing the circumstances of the breakage. This report will should be submitted to the EMS Director.
 3. The paramedic on duty shall be responsible for replacing any used narcotics and filling out the appropriate paperwork logging use and waste of the narcotics.

Confidentiality / Release of Patient Information

SECTION: EMERGENCY MEDICAL SERVICE

TOPIC: COMPLIANCE WITH HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) and TEXAS HEALTH RECORDS PRIVACY ACT, TEXAS HEALTH AND SAFETY CODE CHAPTER 181.

REFERENCE: Public Law 104-191, 42 U.S.C. 1301 et seq; 45 C.F.R. 160.001 et seq. and Texas Health and Safety Code Chapter 181.001 et seq.

- A. **PURPOSE:** The purpose of this policy is to set forth guidelines for compliance with the Health Insurance Portability and Accountability Act of 1966, hereafter called "HIPAA," and The Texas Health Records Privacy Act, by Archer City EMS, hereinafter referred to for all purposes as EMS.
- B. **POLICY:** It is the policy of Archer City EMS to comply with the provisions of HIPAA and to protect Individually Identifiable Health Information (IIHI), also herein referred to as Protected Health Information (PHI) gathered in the course of providing Emergency Medical Services; all employees and agents of the Archer City EMS shall at all times maintain the highest level of confidentiality and information and protected health information gained from patients in the course of EMS assessment and treatment and kept in any form by the Archer City EMS.
- C. **DEFINITIONS**

1. Employee – Any person employed by the Archer City EMS including those employed full-time, part-time or on a seasonal or event basis.
2. Individual – Any person using the services of Archer City EMS.
3. Individually Identifiable Health Information (IIHI) – Is information that is a subset of health information, including demographic information collected from an individual, and:
 - Is created or received by a health care provider
 - Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
 - That identifies the individual; or
 - With respect to which there is a reasonable basis to believe the information can be used to identify the individual.
 - Individually Identifiable Health Information is also referred to herein as Protected Health Information (PHI) and the two terms shall have the same meaning.
4. Business Associate - One who uses individually identifiable health information for:
 - Claims processing for Archer City EMS
 - Medical direction
 - Education in an affiliated EMS education program
 - A Citizens Fire Academy experience
 - Utilization review
 - Quality assurance or improvement
 - Billing
 - Benefit management
 - Legal advice
 - Accounting and auditing
 - Consulting
 - Data aggregation
 - Data management
 - Accreditation
 - Financial services
 - Collection agency
5. Health Care – Emergency or non-emergency assessment, treatment, or procedures with respect to physical or mental condition or functional status of an individual or that affects the structure or function of the body; use or dispensing of a drug, device, supply item, equipment or other item from a prescription or under medical protocols.
6. Information -- Any information, recorded in any way whatsoever that is
 - Created or received by a provider
 - Relates to past, present or future physical mental health or condition
 - Related to provision of health care
 - Related to payment for services

7. Standard --A rule or requirement which employs IIHI for describing information for the classification of components, specification of materials, performance, or operations, or a description of procedures.
8. Designated Record – A set of one patient’s records which include medical records and billing.
9. Disclosure -Release, transfer, divulging, or providing access to IIHI and PHI to anyone other than the Archer City EMS for the purposes of billing, conducting quality assessment and improvement activities, outcome evaluations, legal consultations, developing clinical guidelines, protocol development, unit and personnel deployment strategies, case management and care coordination, student and employee education, and release of information to law enforcement, governmental agencies, and media as permitted or required by law, customer service, auditing, fraud and abuse studies, complaint resolution, employee discipline, transfer to another entity if such entity replaces Archer City EMS as an ambulance provider, and all other like disclosures.
10. EMS –Archer City EMS
11. Minimum Necessary Standard - The minimum necessary amount of IIHI or PHI that is needed by an individual to carry out that individual's job function.
12. Protected Health Information (PHI) -Any individually identifiable health information (IIHI) or other information in the possession of Archer City EMS which is protected by HIPAA; or Texas Health and Safety Code Chapter 181, called The Texas Health Records Privacy Act; or Texas Health and Safety Code Chapter 773, called the Texas Emergency Medical Service Act; or by any other pertinent statute or regulation.
13. Designated Record Set (DRS) -A designated record set means all records containing protected health information (PHI) which relates to a patient. DRS should include the patient care report and all its parts, including billing documents, ECG monitor strips, medication records, treatment records, physician statements of medical necessity, transfer records, photographs, x-rays, or any other materials or data which are a part of the patient care record. Similarly, records of claims, whether paper or electronic, all correspondence and documents from or with insurance payers, and amendments of patient records, statements of disagreement by the patient requesting amendment when patient request for amendment is denied, summaries of patient records, and copies of patient request forms and EMS responses to them. DRS should also include copies of records created by and received from other health care providers.

DRS should not include quality assurance/quality improvement data, accident reports, incident reports, or peer review documents or materials.

D. General Provisions

1. Privacy Officer -- Archer City EMS will maintain a designated Privacy Officer to oversee all confidentiality issues and to serve as a contact point for patients and their families to voice concerns, complaints, to access records, or to request that amendments be made to their patient records. All requests for patient information/records should be referred to the Privacy Officer. The Privacy officer will: monitor employee and company (or department) compliance with all state and federal privacy standards:

- investigate complaints regarding privacy issues.
 - follow company (or department) procedures in resolving complaints.
 - implement appropriate sanctions for violation of policies and procedures.
 - provide initial and ongoing training on privacy issues to all personnel who have direct or indirect access to PHI.
 - keep custody of and maintain the security of patient records.
 - maintain administrative, electronic, and physical barriers to access to PHI
 - enforce the minimum necessary standard.
 - identify all employees and classes of employees, and all others and classes of others who have or may have access to PHI.
 - identify the level of information needed by each employee and class of employees necessary to carry out job function according to the minimum necessary standard concept
 - insure that all employees and others have signed a Confidentiality Agreement and have attended appropriate training sessions.
 - review all requests for disclosure and make determinations as to whether or not to grant such requests, and if granted, to what extent information shall be disclosed.
 - receive and act on requests for access and copying of records, amendment of records, restrictions on uses and disclosures of records, and for confidential communications.
 - resolve conflicts between members of the workforce as to uses and disclosures of PHI and act as a liaison between members of the workforce and others who may have questions and issues regarding PHI.
2. Confidentiality Agreement --All personnel, including but not limited to riders, students, first responders, office managers, billing personnel, billing agencies, administrators, legal advisors, consultants, auditors, or any other individual who may have direct or inadvertent access to patient records shall sign a confidentiality agreement that will remain in effect permanently.
 3. Patient Consent Form Signatures – Each adult patient who is, in the opinion of the medical crew responding to such patient, possessive of the present mental capacity to execute a healthcare document, shall be asked to sign a consent to use PHI and a billing authorization/financial responsibility form.

A parent, legal guardian, or other person authorized by the Texas Family Code to make healthcare decisions for minors, shall sign a consent for a minor patient.

A legal guardian, managing conservator, or one holding a power of attorney to make healthcare decisions shall sign a consent for a patient which is legally incompetent.

Other next of kin may be allowed to sign a consent if the patient is unable to sign and has not expressed a prior desire not to sign a consent.

4. Patient Unable to Sign Consent --When a patient or other authorized person has not signed a consent, the reason shall be documented on the consent form. A follow up letter with a consent form attached will be sent to the patient by United States Mail within a reasonable time after the incident, and the patient asked to sign and return it. A notation will be made in the Follow-Up Consent/Authorization Log showing the date and address to which the follow up letter is sent. Reasonable efforts must be documented showing that attempts to gain the patient's signature were made.

5. Crew Responsibility to Obtain Consent --Each crew member shall ensure that consents are obtained whenever possible and shall be responsible for correct documentation of failed efforts to obtain consent at the time of service.
6. Patient Authorization Form Signatures --Each adult patient who is, in the opinion of the medical crew responding to such patient, possessive of the present mental capacity to execute a healthcare document, may be asked to sign an authorization for disclosure of PHI.

A parent, legal guardian, or other person authorized by the Texas Family Code to make healthcare decisions for minors, shall sign an authorization for a minor patient.

A legal guardian, managing conservator, or one holding a power of attorney to make healthcare decisions shall sign an authorization for a patient which is legally incompetent.

Other next of kin may be allowed to sign an authorization if the patient is unable to sign and has not expressed a prior desire not to sign a consent.

7. Patient Unable to Sign Authorization -- When a patient or other authorized person has not signed an authorization, the reason shall be documented on the authorization form. A follow up letter with an authorization form attached will be sent to the patient by United States Mail within a reasonable time after the incident, and the patient asked to sign and return it. A notation will be made in the Follow Up Consent/Authorization Log showing the date and address to which the follow up letter is sent. Reasonable efforts must be documented showing that attempts to gain the patient's signature were made.
8. Crew Responsibility to Obtain Authorization -- Each crew member shall ensure that authorizations are obtained whenever possible and shall be responsible for correct documentation of failed efforts to obtain authorization at the time of service. The authorization form may be deferred according to standing orders issued by appropriate supervisory personnel.
9. Patient Care Record Security – All patient charts and associated paperwork are to be treated as highly confidential and administrative, electronic and physical security must be maintained at all times to ensure that PHI is neither intentionally nor inadvertently disclosed to those who DO NOT have the right to such information.
10. Verbal, Written, and Electronic Information Necessary for Treatment -All PHI obtained in the course of patient assessment and treatment which is necessary for continued treatment shall be disclosed only to those persons engaged in treatment who have a need to know such information, but no PHI shall be withheld which is necessary for continued treatment of a patient.
11. Maintaining Confidentiality of Verbal and Written PHI at the Scene and During Treatment – Archer City EMS personnel should make every effort to minimize information that can be heard or read by those who do NOT have a “need to know” or “right to know” such information to carry out treatment. This includes bystanders, law enforcement officers, and even some family members. Because it is difficult at times to determine quickly who has a right to know PHI, Archer City EMS personnel should not share information with anyone unless it is necessary to continue treatment and care for the patient. If in doubt, tactfully decline the information until proper lines of authority have been established. The Privacy Officer shall be notified of any conflicts that arise under this section.

12. Maintaining Confidentiality when Charting and Working with Patient Care Records/Medical Charts --When working on Patient Care Records/Medical Charts all personnel shall take extra care to ensure that no PHI or records are left where they can be seen by those who have no “need to know” nor “right to know” such information.

13. Filing of Completed Records/Charts --Completed Patient Care Records/Medical Charts shall be placed in a locked container/area provided. No record shall be left lying on a desk or in any other place where it can be read by an unauthorized person.

All personnel having a need to access to records shall at all times maintain the highest security of patient records and PHI.

14. Release of Records and PHI – All requests for PHI or any medical records will be made to the Privacy Officer. The Privacy Officer will review all requests prior to approval or denial. Requests other than routine disclosures, state or federally mandated information releases, or other releases mandated by law will require authorization by the patient or the patient’s legal representative.

All other information release, requests for amendment, restrictions, confidential communications, or accounting shall be made utilizing the proper forms as provided by the privacy officer.

Approvals or denials for release of records or amendments to records will be made within 30 business days of the original written request. If the request cannot be acted upon within the 30 day period, the requesting person shall be so notified, the reason given for failure to provide the service requested, and the date when the request will be acted upon stated, which date shall be not later than 60 days from the date of original receipt of the request. If the request is denied, the requestor shall be so notified using the appropriate letter form, the reasons for denial given and the requestor’s rights to review or appeal, if any, stated.

The Privacy Officer shall determine all matters regarding release of information, amendments to patient care records, restrictions on release, confidential communications, and access to records, based upon accepted interpretation of the HIPAA rule. The Privacy Officer shall consult the attorney for the system when necessary before making such determinations.

All documents released shall be in designated record sets as the same are defined above.

15. Policy on Student Riders --All education programs affiliated with the Archer City EMS shall complete a Business Agreement with the City, which shall require that the education program and its students comply with all the City’s policies and procedures regarding HIPAA. Each student, prior to riding out on an ambulance or fire apparatus shall complete a confidentiality agreement. It shall be the responsibility of the EMS or fire crew to which the student is assigned to adequately orient the student to HIPAA requirement and to the City’s policies and procedures.
16. Policy on Other Riders --All other riders on City ambulances and fire apparatus shall complete a confidentiality agreement prior to riding out. It shall be the responsibility of the EMS or fire crew to adequately orient the rider to HIPAA requirements and to the City’s policies and procedures.
17. Policy on Peer Review and Performance Improvement --All PHI and records used in performance improvement and/or peer review shall be de-identified to the extent possible while still carrying out the purposes of the peer review or performance improvement. All such records shall be kept

separate and apart from all other patient records and shall be subject to the same administrative, electronic, and physical barriers to information leakage as are other records and PHI. If de-identified records cannot reasonably be used, only the persons having an actual need to know the PHI involved in the peer review or performance improvement shall have access to such information.

18. **Minimum Necessary Disclosure** --The Privacy Officer shall determine in each case the minimum necessary disclosure that shall be made when a request for disclosure is made. When the request is from a law enforcement agency, a governmental agency or other entity entitled by law to receive information, that entity's request shall be deemed the minimum necessary information needed by such entity.
19. **Requests from Attorneys** – The Privacy Officer shall insure that all requests from attorneys for records are accompanied by the proper authorizations if the patient has not previously executed an authorization permitting disclosure to the attorney. The Privacy Officer may require that authorizations with original signatures are provided prior to releasing information.
20. **Search Warrants, Court Subpoenas, and Grand Jury Subpoenas** -- The Privacy Officer shall determine the validity of all Court and Grand Jury processes before release of information, and shall seek the advice of the City's attorney whenever necessary before complying with such process.
21. **Requests from the Secretary of Health and Human Services** – The Privacy Officer shall comply with all requests for information from The Secretary of Health and Human Services.
22. **Complaints** --The Privacy Officer shall receive all complaints received under HIPAA and shall take the following steps upon receipt of a complaint:
 - Evaluate the complaint to determine its validity.
 - If the complaint is valid institute the necessary steps to correct the problem.
 - Notify the complainant of the action taken.
 - If the complaint is deemed invalid, notify the complainant of such determination and advise the complainant of his rights to file a complaint with The Secretary of Health and Human Services.
 - Document all actions on complaints in the patient's files.
23. **Disclosure Log** – All disclosures except for treatment, payment, operations, shall be logged in the disclosure log kept in each patient's records in order to comply with the requirements for accounting for disclosures.

Crime Scene

- A. **Crime Scene** -- The first priority of EMS personnel is treatment of the patient. It is emphasized that while care is to be taken in minimizing patient and / or object movement, this is a secondary consideration and should not hinder resuscitative efforts. Any conflict between EMS personnel and law enforcement should be reported immediately to the Medical Director for resolution of the conflict.
- B. **Injured Patient** – If resuscitative are begun, the following guidelines should apply:

1. Utilize the same route in and out of the crime scene, disturbing as little of the surroundings as possible.
 2. Note the position of the body and other pertinent objects, weapons, medications, etc.
 3. Avoid cutting through or tearing apparent bullet or knife holes. Clothing should be cut (if necessary) along seams or in areas which would not compromise entrance or exit wound markings on the clothing.
 4. Place any clothing or materials in the patients possession in paper bags and do not discard, these items should be given to the investigator.
 5. Give the law enforcement officer on the scene a detailed, accurate description of the body position, location of weapons, and objects left or touched by EMS personnel. If the scene or patient is disturbed in any fashion in order to perform patient care, document the “pre-disturbed” position of things on the reporting forms, if at all possible, and report to the investigator.
- C. Dead on Scene – If the patient is obviously dead and death appears to be due to other than natural causes, the following procedures are to be used:
1. Do not touch or move the body.
 2. Immediately request the appropriate law enforcement agency, if not already on scene.
 3. Do not touch or move any weapons, medication containers, suicide notes or any other items that may be pertinent to the incident investigation.
 4. Avoid touching doors, windows, light switches, etc.
 5. Use of the telephone should be approved by the senior law enforcement officer.

Guidelines Regarding CPR

- A. Initiation of CPR – The purpose of this policy is to provide criteria to aid field personnel in the determination of death in the field. This policy also outlines the procedures to be followed whenever CPR is to be withheld or discontinued in the pre-hospital setting.
- B. CPR in Progress – If CPR is in progress (by first responders, family members, etc) upon arrival at the scene, the EMS crew should continue resuscitative efforts until one of the following occurs:
 1. Spontaneous respirations and / or pulse returns.
 2. Patient care is transferred to other persons with the same or higher certification.
 3. Patient care is formally transferred to appropriately certified licensed personnel at a receiving hospital.
 4. The patient is pronounced dead by a physician.

In cases where continuance of resuscitation is questionable, contact the Medical Director, Emergency Room Physician or the patient's personal Physician for direction.

Field personnel do not need to initiate CPR when death has been determined using the criteria outlined below, or when an approved Do-Not-Resuscitate order is present. At no time shall EMS personnel direct the discontinuation of CPR unless a licensed physician accepts responsibility for the decision via direct voice communication, a physician at the scene directs discontinuation of CPR. EMS may declare death apparent death but may NOT pronounce death in any instance. EMS personnel may use a cardiac monitor to assist in their determination of death without initiation of other ALS procedures **if allowed by the investigating law enforcement agency or the JP on scene.**

C. Obvious Death – Pulseless, apnic patients with any of the following:

1. Decapitation.
2. Total incineration.
3. Decomposition.
4. Total destruction of the heart, lungs, brain or separation any of these organs from the body.
5. Rigor mortis or post-mortem lividity without evidence of hypothermia, drug ingestion or poisoning.
6. Cardiac arrest victims in Mass Casualty Incidents.

Procedure:

1. Do not initiate CPR.
2. Notify the Sheriff Department, JP and any other appropriate investigative agencies if not already done.
3. Complete a Transfer of Patient Care report with written documentation, cardiac strips, etc.

D. Probable Death – Non-Witnessed Medical Arrest or Non-Witnessed Trauma Arrest without CPR in Progress

1. Total absence of observers or witness information.
2. Situations where witness information states that incident occurred greater than 15 minutes prior to initiation of ALS care.
3. The patient is in cardiac arrest due to blunt trauma.
4. The patient is in cardiac arrest throughout a prolonged extrication, >15 minutes, and no resuscitative measures can be carried out prior to extrication.

Procedure:

1. Do not initiate CPR.
2. Auscultate the chest for apical heart sounds or breathe sounds for at least one minute.
3. Notify Medical Control of all findings and await instructions.
4. Notify the Sheriff Department, JP and any other appropriate investigative agencies if not already done.
5. Complete a Transfer of Patient Care report with written documentation, cardiac strips, etc.

E. Discontinuing Adult CPR

CPR may not be discontinued without physician contact by EMS personnel in patients where an approved Do-Not-Resuscitate Order is produced after initiation or resuscitative measures have begun.

The Medical Director, physician on call or a patient's personal physician may consider discontinuing CPR in the prehospital setting and pronouncing a patient dead at scene provided certain conditions are met. These include, but are not limited to:

1. There is no evidence of hypothermia, drug ingestion or poisoning.
2. Upon initial assessment it is determined that there are mortal injuries.
3. There is a confirmed diagnosis of terminal illness.
4. Initial resuscitation efforts have been unsuccessful.

Procedure:

1. Contact the Medical Director or appropriate physician to relay all facts and findings.
2. Complete a Transfer of Patient Care report with written documentation, cardiac strips, etc. Include the physician's name and time of death as pronounced by the physician.
3. Notify the Sheriff Department, JP and any other appropriate investigative agencies if not already done.

F. Search for Donor Card

EMS personnel should make a reasonable search for a document of anatomical gift or other information identifying the bearer as a donor or as individual who has refused to make an anatomical gift when it appears that death of the individual may be imminent.

If a document of anatomical gift or evidence of refusal to make an anatomical gift is located by EMS personnel, and the individual is taken to the hospital, the hospital shall be provided with the documentation.

In situations where an investigating law enforcement officer has requested the documentation, verbal notification of the documentation at the hospital will meet this requirement.

If a purse or wallet is searched by EMS personnel the search must be done in the presence of a witness. The name of the witness, details of the search, what was found and who was notified shall be documented in the Transfer of Patient Care report.

No search may be made by EMS personnel after a patient has expired.

- G. EMS Personnel and the Justice of the Peace -- EMS personnel are not to move a dead body from the position or place of death.

EMS personnel may take steps as dictated by the Justice of the Peace for purposes of ascertaining whether medical care might be needed or in determining death. When it is apparent that medical attention would be of no avail, as previously defined, and when this can be clearly determined by simple inspection, the body shall not be disturbed nor shall any of the surroundings be disturbed. Furthermore, EMS personnel shall not search the body, clothing or premises. It is not the responsibility of EMS personnel to notify the next-of-kin or seek any other information.

EMS shall remain on scene until the Justice of the Peace arrives and takes possession / custody of the body.

It is imperative that the body and its surroundings be left untouched. If necessary, the family may be excluded from the room where the body lies until the JP arrives.

Do-Not-Resuscitate Orders

- A. Purpose

This policy sets forth the procedures for establishing and carrying out orders to withhold resuscitative measures for patients who have documented the desire to not be resuscitated. This policy is based on Health and Safety Code, Title 8, chapter 674 and Texas Administrative Code 157.25. Specifically this policy addresses:

1. The proper method for establishing Do-Not-Resuscitate Order for use in the prehospital setting.
2. The procedures for EMS personnel to follow in the field when a DNR Order is presented.
3. The procedures for EMS personnel to follow in the field when a DNR order is presented to them, but family members on scene contradict the Order, or there is a question about the validity of the DNR order.
4. The procedures which allow patients in Hospice programs that do not have DNR orders to receive non-emergency ambulance transport services.
5. Palliative care to terminally ill patients.

B. Definition -- Do-Not-Resuscitate Order (DNR) means that none of the following will be used:

- CPR
- Defibrillation
- Cardiac Resuscitation Medications
- Advanced Airway Management
- Artificial Ventilation
- Transcutaneous Cardiac Pacing

C. Procedure

Establishing a Do-Not-Resuscitate Order

1. The patient or the patient's representative is responsible for contacting their physician or health care provider for assistance in executing this order.
2. The attending physician is required to complete section D and sign the bottom of the form. This doctor will document the existence of a DNR order in the patient's medical record.
3. If the attending physician refuses to execute or comply with the DNR order, the physician must inform the patient or the patient's representative and make a reasonable attempt to transfer the care of the patient to a physician who is willing to execute or comply with the order.
4. The appropriate section must be completed by the patient, legal guardian, agent, proxy, qualified relative, parent of a minor or managing proxy and witnessed by two qualified witness's. New DNR Orders may also require a Notary's signature and seal. Any signature on the order should also be in the bottom section of the order.
5. The "Instructions" for the completion of the OOH DNR Order should be referenced during execution of the order. The instructions for a Texas DNR can be found on the back of the order.
6. The patient may choose to wear an official OOH DNR identification device:
 - An intact, unaltered, easily identifiable plastic identification OOH DNR bracelet, with the word "**TEXAS**" (or a representation of the geographical shape of Texas and the word "**STOP**" imposed over the shape) and the words "**DO NOT RESUSCITATE**", shall be honored by qualified EMS personnel in lieu of an original OOH DNR Order form.
 - An intact, unaltered, easily identifiable metal bracelet inscribed with the words, "**Texas Do Not Resuscitate – OOH**" shall be honored by qualified EMS personnel in lieu of an OOH DNR Order form.
 - The person or entity who provides an OOH DNR identification device to an individual shall send with the identification device a statement with the words, "Pursuant to Health and Safety Code, 166.090, this identification device may only be worn by a person who has executed a valid out-of-hospital DNR order."

Emergency Medical Personnel At The Scene Of A Medical Emergency Shall Respond As Follows Under The Following Conditions:

1. An approved DNR order is presented upon arrival: EMS personnel identify the patient as having an approved DNR order when the:
 - Original form or a *copy of the original form* is present and appears to be valid. It would be difficult for EMS personnel to validate a DNR order, therefore; if the order appears to have original signatures in the required areas then the document shall be considered valid.
 - The patient is wearing an approved ID device.

EMS personnel may accept an OOH DNR order or device that has been executed in any other state, if there is no reason to question the authenticity of the order or device.

2. If an OOH DNR order is presented, but relatives at the scene object to, or contradict the DNR Order, or the validity of the DNR Order is in question:
 - EMS personnel shall provide all appropriate care and resuscitative measures for the patient. Although the patient's wishes or instructions should remain paramount, resuscitation is to be provided until the situation is clarified. Resuscitation efforts should continue until a direct order is given by Medical Control or the attending physician.
3. CPR is initiated prior to the presentation of an approved DNR Order:
 - CPR may be discontinued, without contacting Medical Control when the DNR is presented and the patient is identified as the person for whom the form is intended. EMS personnel shall document all relevant information and facts on the run report.
 - Medical Control may order discontinuation of resuscitate measures with oral verification from ambulance personnel of a valid and complete DNR Order and verification of the patients identity in any other appropriate situation, including those where an approved DNR order is not an approved form. EMS personnel shall document all relevant information and facts on the run report.
4. No DNR is presented:
 - EMS personnel shall provide all appropriate interventions and resuscitative measures for the patient and transport to the nearest appropriate facility.
 - If a Durable Power of Attorney for Health Care Form is presented (without a DNR Order) by the Attorney in Fact, and the Attorney in Fact does not want resuscitative measures, upon arrival EMS personnel shall contact Medical Control. Hospital physicians retain full responsibility and authority for determining the appropriateness and extent of prehospital resuscitative decisions.
5. If the patient is being transported:
 - If a valid DNR is discovered while transporting a patient, withhold or withdraw life sustaining efforts upon discovery of the order and continue to transport to the hospital where hospital personnel will complete body disposition.

D. Transportation of Hospice Patients

1. If service for terminally ill patients is requested through the 911 system, this procedure does not apply, except for patients with approved DNR orders.
2. Upon response to a privately received call from Hospice, patients may be transported without lights or sirens. If the patient becomes pulseless or apnic in route to the hospital EMS personnel should continue transport without initiation of resuscitative efforts and without lights or sirens.
3. If a patient becomes pulseless or apnic upon arrival at a scene EMS personnel may advise family and Hospice of the apparent death and that ambulance transport will not be made. Unless requested otherwise by Hospice, ambulance personnel may leave the scene after receiving clearance from Medical Control.

E. Palliative Care

It is appropriate that at the moment of death, although the cessation of spontaneous respirations or pulse may have not yet occurred (but it is obvious this is the moment of death) and the health care provider has identified a valid DNR Order, only palliative care should be initiated.

Patients should not be transferred to hospitals simply to die unless specifically requested by the family. Patients should be allowed to die with dignity and comfort within their own home. This includes surrogate homes, such as long-term care facilities.

F. Pregnant Persons

EMS personnel may not withhold the designated treatments listed in subsection B from a person known by responding EMS personnel to be pregnant.

EMS Dispatch Procedures

A. Emergent 911 EMS dispatching will follow the following procedure:

Any 911 call will be dispatched to the proper location directly from the Archer County Sheriff's Department. The information obtained by the dispatcher shall include:

- A telephone number of the requestor ("call back" number).
- Address and specific directions to the location requested.
- Nature of the injury or medical illness.

Once "toned out", the EMS crew on duty shall respond to the dispatcher for confirmation of reception and destination.

A record of all times associated with the 911 call shall be maintained with the dispatchers at the Archer County Sheriff's Office.

B. Archer County Sheriff's Department Notification of EMS Response:

Whenever a call for emergency assistance is received from any other source, the Archer County Sheriff's Office dispatcher will be notified immediately of the response. The dispatcher will also be notified of the location of the emergency.

Radio / Phone Communications

EMS should attempt to follow a consistent protocol when communicating patient information to other medical personnel via phone or radio.

A. The following procedure will be used when communicating with the hospital:

- Agency, Unit Number, Attendant
- Priority: 1 2 3 4
- ETA
- Age
- M or F
- Mechanism of Injury and / or Chief Complaint
- Assessment Findings
- Vitals: BP, Pulse, Respirations, O2 SAT, BBG, Rhythm, GCS
- Treatment / Interventions

B. Every aspect of radio communications is to be conducted in a uniform manner by all EMS employees. Avoid using phrases and language that is not easily understood by all persons involved in the communication.

Forced Entry

Occasionally, EMS responders may be faced with a situation where the unit has been called to a residence and no one appears to be present at the residence. In situations where the patient is believed to be alone and is now medically unable to unlock a door or verbally respond, EMS personnel may consider using forced entry.

Forcible entry will be used only in cases where other means to obtain access are unsuccessful. The following procedures are to be used:

1. If there is no answer at the residence, request the Sheriff's Office dispatcher to try the "call back" number.
2. If the "call back" number is ineffective, without endangering themselves, EMS personnel should try all doors and windows.
3. If no unlocked openings are found and available information does not verify that an emergency situation exists, then the EMS unit may return to service.

4. If an emergency is found to exist, or available information suggests an emergency exists, then the following procedures are to be followed:
 - Law enforcement assistance is to be requested.
 - Forcible entry locations should be sought that will minimize damage to the structure. However, reasonable efforts to gain access should be made regardless of damage estimations.
 - All personnel will use extreme caution in providing for their own safety.
5. All pertinent facts of the situation shall be documented in the narrative portion of the run report.
6. The EMS crew will submit a detailed incident report to the EMS Director no later than 24 hours following the incident.

Law enforcement is normally empowered in such situations to gain immediate entry when necessary. If possible, entry should be left to law enforcement personnel. However, do not compromise patient care to await the arrival of law enforcement personnel if an emergency is known to exist.

Hazardous / Flammable Materials

Emergency incidents that are suspected to involve hazardous materials will be treated as such until proven otherwise. Suspect hazardous materials in any spill, leak or rupture of containers (boxes, cans, barrels, etc.) whose contents are not immediately identifiable.

Other locations to be considered hazardous are:

- Chemical plants or warehouses.
 - Train derailments.
 - Accidents involving tankers.
 - Storage facilities.
 - Gas line ruptures.
- A. Any vehicle displaying placards with an ID number (or an orange panel on tank trucks) is carrying a hazardous material. The ID number may be on the sides or on the ends of the vehicle, tank, truck or rail car.
 - B. Park your vehicle in a strategic location and safe area upwind and upslope of the scene or the suggested distance from the scene as noted in the HAZMAT Guidebook, located in the ambulance. If the material is unknown, a minimum distance of 1,500 feet will be utilized.
 - C. Attempt to identify the material. Refer to the HAZMAT Guidebook for information.
 - D. No rescue or entrance into the rescue area will be performed until the material is identified and appropriate protective clothing and equipment has been acquired for EMS personnel. This will most likely be obtained from the Fire Department. Obvious dead patients in a hazardous material scene will not be rescued unless there is no risk to the EMS personnel.
 - E. EMS should not be involved in extrication or rescue of victims at a HAZMAT scene unless trained to the appropriate level as required by S.A.R.A. Title 1, and they have the appropriate protective gear.

F. Procedure

- Notify the Sheriff's Office dispatcher of the need for appropriate assistance.
- If the material can be identified as harmless, proceed into the incident area and attend to patient care.
- If the material cannot be identified or is identified as harmful, DO NOT go into the incident area without protective gear and backup.

Regardless of the distress of the patient(s), DO NOT jeopardize yourself, your crew or your unit. Stay out of the incident area until adequate assistance arrives.

Helicopter Evacuation

A. Dispatching

After assessing the need and feasibility of air transport, contact the the Sheriff's Department dispatcher and request air transport or call air transport services directly. Provide the dispatcher or air service with the following information:

- Patient information.
- Exact location of the patient, GPS coordinates if available.
- Weather conditions at your location.
- Any unusual circumstances.

B. Packaging

If possible a patient should be placed and secured to a long spine board, with C-spine precautions if a trauma patient and any applicable interventions performed prior to air ambulance arrival. Make sure the patient is as compact as possible, but be sure you can still provide the care needed.

C. Landing Site Preparation

1. The helicopter landing zone should be at least 100'x100', as level as possible and preferably on a firm surface. Areas with a slope are discouraged to prevent the possibility of a main rotor blade striking the slope or aircraft slippage upon landing.
2. Be sure the area is clear of debris. The helicopter can generate winds up to 60 mph and kick up debris from the ground. Usually, part of the roadway is preferred. The area must be kept clear as the aircraft prepares to land. DO NOT let people wander through the area. Close all doors and windows of your EMS unit at the landing site. EMS personnel, law enforcement, bystanders, etc. should remove any caps they may be wearing.
3. The landing zone should be clearly identified. During the day, hand signals are adequate to direct the pilot to safety. At night lights should be placed at the four corners of the landing zone. Flashlights or automobile lights positioned at each corner and focused toward the center of the 100'x100' landing zone work well. Do not focus lights toward the aircraft. Do Not use flares.

D. Safety Considerations

1. The pilot of the helicopter is responsible for all safety considerations and all operations of the aircraft. The pilot will determine if the weather permits safe flight, if the landing zone is secure, and if the patient is properly prepared for flight.
2. Once the helicopter lands do not approach it until the pilot signals you to do so. Always approach the helicopter from the front and NEVER from the tail section for any reason.
3. Do not assist the crew with opening and closing the doors or loading and unloading equipment. Flight crews will direct the loading and unloading of patients and let you know how you may help them.
4. Bystanders should be kept at least 100' from the aircraft at all times.

Incident Report Form

This document is used to document unusual circumstances of all types. All incidents which may require administrative follow-up or which have the potential for problems arising at a later date. The use of this form is for the protection, both medically and legally, of the EMS Provider as well as the employee involved in the incident. These forms are located in the second office at the station.

This form should be completed immediately after the incident so that facts are fresh on your mind. This should include all pertinent details, be limited to the actual facts and be void of personal impressions and / or bias.

Jail Responses

- A. When responding to the jail, the stretcher and all appropriate equipment should be removed from the vehicle and taken to the patient.
- B. All doors and windows to the unit are to be closed and locked if left unattended.
- C. Any equipment brought into the jail must not be left unattended in prisoner access areas.
- D. If a prisoner is transported, law enforcement personnel should accompany or closely follow the ambulance to the receiving facility. If the patient is to be handcuffed, law enforcement MUST accompany the patient in the back of the ambulance.

Transportation of Prisoners

Persons requiring treatment and / or transport by EMS who are under arrest shall be accompanied by an on-duty enforcement agent to the receiving medical facility whenever possible. If an agent is unavailable, the crew may, at their discretion transport without one, making clear to the responsible agency that no attempt to restrict the prisoner's exit from the vehicle will be made by EMS personnel. In no case will a prisoner be transported while handcuffed without a law enforcement officer in the back of the unit.

On-Scene Rolls

- A. Primary Paramedic -- The primary paramedic on the first EMS unit on the scene assumes overall control and direction of the other crews.
1. Scene control may be taken over only by previously designated personnel with supervisory responsibility.
 2. Scene control may be relinquished in deference to the patient's need for advanced care.
- B. On-Scene Physician – In some cases where a physician, who is not the patient's personal physician, appears on scene and elects to direct the care of the patient, thus assuming medical control of the scene, the following guidelines should be used:
1. This physician should identify his or herself and identify their specialty to the senior EMS crew member.
 2. After identification, contact should be made with Medical Control to secure a transfer of medical direction.
 3. If approved by Medical Control, the on-scene physician should then sign a document identifying themselves and their willingness to accept responsibility for the patient.
 4. The physician then **MUST** accompany the patient to the hospital and fill out documentation required by the receiving hospital, including the patient care report form. The signatures should be complete and legible with all forms dated and witnessed.
 5. Nothing in this policy shall be construed so as to be in conflict with Rule 197.5 of the Texas State Board of Medical Examiners.
- C. Additional EMS Personnel – At times, individuals with EMS certification, but from outside an organization's service area, will coincidentally be passing through the service area at the time of an emergency and will offer assistance. These individuals should not be allowed to participate in patient care before showing written verification that their certification is valid. Regardless of the certification of these individuals, scene control will remain with the primary medic of the first crew.
- Persons with advanced certification will not be permitted to administer invasive treatment unless:
1. Medical Control in direct voice delegates such treatment.
 2. The assisting paramedic can be identified as being on a list with permission to use local protocols. If this verification cannot be immediately obtained through Medical Control, the assisting paramedic will function only at discretion of the on-scene control paramedic and will be allowed to operate only at the BLS level.
- D. Nurses and Other Allied Healthcare Professionals – These persons **ARE NOT** trained in pre-hospital care and are **NOT CERTIFIED** or licensed to administer it. Before allowing these persons to assist in patient care their certification / license should be verified. The extent to which they participate in patient care is solely determined by the on-scene control paramedic.

E. Fire Department Personnel

Fire Department personnel are responsible for all fire suppression, hazard control and heavy extrication.

In all rescue and extrication operations, the role of EMS personnel will be to direct patient care and advise rescue teams on phases of the operation which might compromise the patient's condition. Unless specifically trained, EMS personnel will not direct the technical aspects of extrication.

Fire Department personnel may be utilized as drivers of the ambulance if both EMS personnel on the ambulance are being utilized in the back of the ambulance. In the event of a full code Fire Department personnel with a minimum of current AHA CPR certification may be utilized for the purposes of providing compressions, under the direction of the paramedic providing primary patient care, in route to the hospital.

F. Law Enforcement Personnel

Law Enforcement officers are responsible for traffic control and control of disruptive bystanders.

Law Enforcement personnel with the Archer City Police Department may be utilized as drivers of the ambulance if both EMS personnel on the ambulance are being utilized in the back of the ambulance.

G. Other EMS Services On Scene – These situations arise when a call involves mutual aid or when the exact location of the emergency is unknown and two or more services are dispatched to the general area where the emergency is thought to be. In the following it is assumed that all parties are acting in a good faith manner solely in the best interest of the patient.

1. When approaching the scene of an obvious emergency, which is out of the prescribed jurisdictional service area, the crew should continue their response and initiate patient care as required with usual protocol.
2. If a crew from the area of jurisdiction does arrive prior to the point in patient care when transport is needed, the crew should transport to their usual facility.
3. If a crew from the area of jurisdiction does arrive prior to patient transport, then both crews should negotiate further patient treatment and cooperatively determine transport destination based on the patient's further medical needs (considering patient's condition, BLS vs. ALS capabilities of the services, distance and capability of medical centers, etc.). If there is any delay or conflict in making these decisions, Medical Control should be contacted for assistance.
4. If a crew arrives at a scene within their jurisdiction and finds that another service from outside that jurisdiction has already initiated patient care, the arriving crew should not attempt to take charge of patient care, but should expeditiously negotiate with the attending crew as to who will continue patient care and to what medical facility the patient will be transported. If delay or conflicts arise in making these decisions, Medical Control should be contacted for assistance.

H. Personal Physician

1. When EMS personnel are in direct contact with a patient's personal physician (either by phone, radio, or in person at the scene), that physician is to be respected as the senior medical person on the scene and their orders are to be followed without question.

2. When the physician elects to accompany their patient to the hospital, EMS personnel should respect the physician's wishes in the management of the patient during the entire course of care for the patient. When the patient requests that the patient should be transported immediately, this should be done with all reasonable haste, after obtaining patient consent.
3. It is not appropriate to evaluate a patient previously evaluated by a physician prior to transporting that patient. However, it is reasonable to expect a physician or their representatives to give an adequate report regarding the patient to EMS personnel and physicians will be continually encouraged by the Medical Director to give such a report.
4. If EMS personnel disagree with the physician's management or with the appropriateness of their use of the EMS system, this subject shall not be discussed with the physician, but rather their requests should be respected and EMS's questions should be discussed with the Medical Director.
5. Once direct contact ends with a patient's personal physician, EMS personnel will give a progress report to the receiving Emergency Department by radio or phone. The Emergency Department physician may then give additional orders or change previous orders depending upon the patient's condition.

Prohibited Activities

EMS employees will not solicit or accept any gifts, gratuities, loans, fees or anything of value, whether directly or indirectly related to services provided by Archer City Ambulance Service.

Any attempts at solicitation should be relayed to the EMS Director.

Ambulance Run Reports

Ambulance run reports must be completed on all patients transported by EMS crews or where aid is rendered. Patients who refuse treatment will have a Refusal of Medical Treatment and/or Transport form.

Once a copy of the run report has been placed with the patient's chart it becomes an official document to that chart and is subject to subpoena. The form, therefore, will not be altered or rewritten at a later time for any reason. If for any reason a late entry addendum or special circumstance prohibits a complete report be handed in at the time the patient is transferred to a facility the report should be faxed to the receiving facility as soon as it is completed.

A. General guidelines will be as follows:

1. Complete all areas / boxes on the form. Writing should be legible. Errors should have a single line drawn through the word(s) followed by the initials of the person completing the form.
2. These forms, and any personal information contained in them, are confidential and should not be released by EMS personnel.
3. The primary care attendant will be responsible for completion of the patient care report. This should be done as soon as possible after the patient is delivered to the Emergency Room.

4. An incomplete PCR will in no way delay the crew from being available for call once the ambulance has been restocked and is ready for service.
5. Indicate the incident number on the run report.
6. Document the illness or injury indicating the necessity of the ambulance.
7. Obtain a face sheet from the receiving facility that shows patients insurance information or responsibility party prior to departing the receiving facility.
8. Acquire patient, patient's authorized representative or receiving facility representative signature on the Billing / HIPPA form.
9. If a patient has Medicaid, acquire a signature on the Medicaid Signature form.

B. Review

All EMS run reports will be reviewed by the EMS Director or personnel assigned to do so. At least 25% of all calls will be reviewed for Quality Assurance / Quality Improvement. Runs that are deemed significant shall be reviewed by the Medical Director. Any deficiencies in documentation may necessitate a conference with the EMS Director or Medical Director.

Patient Restraint

Under normal circumstances EMS personnel should not attempt to restrain a violent patient. Law enforcement personnel should be called for assistance. However, any patient who presents a significant threat to himself or herself or others may be physically restrained by EMS personnel. When patient restraint becomes necessary, the following procedure should be followed:

1. Soft wrist and ankle restraints, along with folded sheets, are the only authorized restraining materials.
2. Use techniques which will cause no injury to the patient, i.e., the minimum amount of force possible will be used to secure the restraints.
3. Restraints shall allow for a small amount of movement in each extremity. In no case shall they be so secure as to prevent all movement.
4. Pulses and other measures to assure distal circulation will be checked frequently following the application of restraints.
5. Contact Medical Control as soon as possible and advise them of the specifics of the situation and the reason for the restraints.
6. Get assistance from a law enforcement officer when possible and, if available, get the officer to accompany the patient in the back of the ambulance.
7. At the termination of the call, fully document all pertinent details including signatures of witnesses if possible.

Self Protection

- A. In all cases where the threat of physical harm is possible EMS personnel should contact law enforcement through the Sheriff's Office dispatcher before entering the area. The EMS crew should NOT enter the area until law enforcement advises that the scene is secure. At no time should personnel attempt to manage the situation without aid. Primary emphasis should be the safety of the crew.
- B. If already on the scene EMS personnel, when threatened with bodily harm either by serious verbal threat or weapon(s), should make every effort to avoid confrontation by leaving the premises / scene and requesting law enforcement assistance.
- C. In situations where EMS personnel are exposed to serious verbal threat or threat by weapon(s) where efforts to avoid confrontation are unsuccessful and personal injury seems imminent, EMS personnel may use any measure reasonable and prudent to protect themselves from injury or death. Immediately notify law enforcement through the Sheriff's Office dispatcher.

Sexual Assault

In the event a patient reports that he or she has been sexually assaulted, the following procedure should be followed:

- A. With the patient's permission, notify the Sheriff's Office dispatcher immediately. If a weapon is involved, the Sheriff's Office dispatcher must be notified. To maintain patient confidentiality, avoid using the patient's name or the nature of injury over monitored radio frequencies.
- B. History taking should be limited to information pertinent to the patient's injuries and subsequent treatment. Any detailed description of the assault is unnecessary and may be psychologically injurious to the patient.
- C. Injuries should be treated following standard triage conditions. Wounds containing debris should not be cleansed at the scene unless they are life-threatening. The site of the sexual assault should not be examined by EMS personnel unless obvious bleeding needs to be controlled.
- D. In addition to the treatment of physical injury, particular attention should be paid to the psychological injury. Referral to a sexual assault program might be helpful. A non-judgmental attitude must be maintained by the EMS crew.
- E. The patient should be advised not to wash, shower, brush their teeth, use a mouthwash, douche, urinate or defecate prior to examination in an Emergency Department. If the assault was oral, they should also be advised not to drink or smoke to help preserve physical evidence.
- F. The scene should be treated as any other crime scene with special attention given to the preservation of evidence.
- G. Any clothing that must be removed should be handled as little as possible and given to law enforcement.
 - 1. Each garment should be placed separately in its' own paper bag. It is preferable that each piece of clothing be folded inward, placing a piece of paper against any stain, so that stains are not in contact with the bag or other parts of the clothing.

2. If moisture of any kind is on the clothing and might leak through the paper bag, should be placed inside a larger paper bag with the top of the second bag left open.
- H. If it is necessary to cut off items of clothing, be sure not to cut through existing rips, tears or stains if possible.
- I. Circumstances and time permitting, recommend that a change of clothing be brought to the hospital.
- J. Be aware that the patient has the right to refuse treatment and / or transportation, either initially or at any point thereafter. However, you should stress to the patient the importance of seeking an immediate examination, since injuries can go or unnoticed or appear at a later time.

Third-Out Riders in EMS Units

- A. All third-out riders must sign a release form prior to riding out in any EMS unit. A new release form should be signed each time an individual rides out.
- B. Only authorized persons will be allowed to ride in an EMS vehicle.
- C. Third-out riders must be informed of all requirements and rules prior to riding in an EMS vehicle.
- D. No one under the age of 18 years of age may ride without the expressed written permission from the EMS Director and the Parent or Guardian of the third-out rider.
- E. It is the responsibility of all EMS personnel to the rider has been approved to ride and a release form has been signed.
- F. It is the responsibility of all EMS personnel to note the personnel appearance of each third-out rider when he or she reports to ride. If he or she is not dressed appropriately, they will be advised by the EMS personnel and will not be permitted to ride until he or she has complied with proper dress.

Third-Out Riders Rules and Regulations

Third-out riders fall into two groups: observers and student interns.

- A. Observers
1. These are individuals who for some personal reason may desire the experience of prehospital care by observation. Frequently this is to gain a sense of EMS roles in the community and to understand the interaction of various agencies.
 2. Observers should not be involved in the patient care process. EMS personnel will render care to the patient.
- B. Student Interns
1. Their role is to interact in the patient care process by performing duties as delegated by affiliate agreement with the training institution. The amount of involvement is to be determined by the senior medical staff on the ambulance.

2. Interns should perform skills, as determined by the crew leader, which falls within the practice for the certification the student is working toward.

Interns are “in training” and should not be left alone in the role of providing sole care for the patient. Not enough skill or training may have been obtained by the student to permit critical independent judgements. All decisions should be agreed upon by the senior EMS crew leader.

C. All EMS third-out riders are at all times to conduct themselves with proper decorum. They are to refrain from:

1. Use of alcoholic beverages prior to and during the shift.
2. Use of profane or abusive language.
3. Use of excessive conversations while riding in the unit which may interfere with radio communications.
4. Making remarks or voicing opinions to patient or family members, bystanders, law enforcement, fire personnel or first responders in any manner which would tend to provoke or degrade anyone or escalate tension or anxiety.
5. Making known to a person not authorized, any information concerning the emergency call, patient information or outcome.
6. Using information gained through the EMS third-out rider program for personal gain.
7. Wearing on their clothing any article, sign or symbol that advertises any product, business or organization.

D. EMS third-out riders are to:

1. Adhere to all policies and procedures pertaining to EMS personnel.
2. Provide personal transportation to and from the EMS bay.
3. Bring sufficient money to cover meal expenses.
4. Shall not bring any other person to the EMS bay or unit during their ride-out time.
5. Ride in designated seat with seat belt attached at all times.
6. Remain in or near the unit while on a emergency call.
7. Shall not remove any equipment from the unit unless expressly directed to do so by crew.
8. Third-out riders are not authorized to carry radios.
9. Are to observe only, unless instructed by a crew member. Exceptions are students who have clearance to perform certain procedures as part of their training program.

10. Shall not carry weapons during the ride-out.
 11. EMS third-out riders are to dress neatly and conservatively at all times. Conservative type shoes: including black athletic shoes or boots may be worn. Hair must be groomed. Sandals, tank tops or shorts are prohibited. Cleanliness and physical hygiene are required at all times.
- E. All third-out riders are subject to removal for any violation of the above rules and regulations. Additionally, due to operations or training requirements, they may be asked to leave at a moment's notice.

Guidelines for Facility to Facility Transfers

All facility to facility transfers will be arranged in a manner which will maximize patient safety. All inter-facility transfers must be arranged through the appropriate hospitals following state guidelines.

Requests for transportation from physician's offices, urgent care centers, nursing homes, convalescent hospitals or other facilities not equipped to provide acute inpatient care are considered primary transport (911) calls, rather than facility to facility transfers.

A. Responsibility

1. The responsibility for assuring safe inter-facility transfers lies with the sending facility. Archer City Ambulance Service is able to provide special critical care transport, but the sending facility is responsible for providing additional equipment and personnel necessary to assure safe transport.
2. When EMS personnel are dispatched to an inter-facility transfer, they are to evaluate the patient as they would in any patient contact. If the patient's condition has deteriorated and / or requires skills beyond the personnel's scope of training, the sending hospital is responsible for providing the necessary personnel to provide to appropriate level of care.
3. EMS personnel are to follow the standing orders of the Medical Director during the transfer. Any needed orders or information is to come from the Medical Director or hospital physician.

B. Levels of Ambulance Service Available For Transfers

1. Basic Life Support: For those transfers where no specialized patient care is needed.
2. Advanced Life Support: For those transfers where a routine monitoring of an IV may be needed.
3. Mobile Intensive Care Unit: For those transfers when the services of a paramedic are needed.

C. Paramedic Transfers and Medical Direction

1. Paramedics are utilized primarily for 9-1-1 emergency calls. Under certain circumstances when the patient requires a higher level of care and time to definitive care is critical, paramedics may be used to transfer the patient.
2. Paramedics function under the standing orders of the Medical Director. The orders of the Medical Director shall be adhered to throughout the transfer.

3. Depending on the patient's condition and medications / interventions required during the transfer, the sending hospital may need to provide an RN, or other specialized personnel, to provide care beyond the paramedic scope of practice.

D. Procedure

1. The EMS Office will be notified of the need for inter-facility transfer to determine the availability of an EMS unit. Appropriate patient information will be obtained to determine the level of unit needed for the transfer.
2. Appropriate personnel will be notified. If needed, on-call personnel will be called to the EMS station.

Transfer of Care in the Field

A. Purpose

1. To provide guidelines for the transfer of care from non-transport personnel.
2. To provide guidelines for the transfer of care from an on-scene paramedic to a BLS unit.

B. Patient Care Authority

1. The most qualified pre-hospital personnel first on-scene at a medical emergency shall have patient care management authority.
2. The individual with patient authority is responsible for the patient until care is turned over to another appropriate pre-hospital provider or responsible receiving facility staff.

C. Teamwork

1. While providing patient care, non-transport and transport personnel shall function as a team.

D. Turn Over of Patient Care Authority

1. Non-Transport to Transport Unit – First responders initiating care shall transfer care upon arrival of transport units.
2. Non-Transport ALS to Transport ALS – A non-transporting ALS unit, when first on-scene, should transfer patient care authority to the transporting ALS unit when the crew arrives on scene.
3. In those cases where a non-transport ALS unit has initiated ALS care and the transfer of authority for patient care might jeopardize patient safety, the non-transport ALS personnel may elect to maintain patient care authority during transport. Examples of such cases might include significant patient instability or complexity of advanced life support care provided prior to the arrival of transport ambulance personnel.
4. In those cases where the patient's medical condition warrant care by two ALS personnel during transport, the non-transport ALS personnel should accompany the patient during transport. The

ALS personnel with patient care authority immediately prior to transport will relinquish their authority during transport.

E. ALS to BLS Unit

1. The BLS unit is available to transport.
2. ALS care has not been initiated.
3. It does not appear that ALS care is likely to be required during transport.

An ALS crew will transport if:

1. ALS care has been started.
2. A reasonable likelihood exists that the patient may require ALS care in route.

Handling of Valuables

- A. When the patient is conscious and coherent, the handling of valuables is discouraged.
- B. If removal of patient valuables (purse, wallet, etc.) is necessary to search for medication or identification, it should be done in the presence of at least one witness from outside our EMS, such as a law enforcement officer or other official, and documented.
- C. If removal of patient valuables is justified by a need to reduce injury, this should be witnessed by a law enforcement officer or other official and the jewelry taped to a safe location on the patient or bagged and placed in a safe location.
- D. In all instances the handling of valuables (and their description) should be well documented on the PCR and the witness identified.

Transportation of Belligerent / Violent Patients

EMS personnel will on occasion have to deal with a belligerent / violent patient. The belligerent person in all probability will refuse treatment and refuse to sign a release. If possible, law enforcement should be called to witness the refusal and control the belligerent person. If the person does not need ambulance transportation, then law enforcement should assume responsibility for the patient.

Under normal circumstances EMS personnel would NOT attempt to restrain a violent patient. Law enforcement should be called for assistance. When necessary, transportation to a hospital will be made following police arrest or restraint of the patient.

Weapons Policy

No EMS employee, while on duty, is allowed to clean, carry or utilize any type of firearm or other type of weapon in violation of local, state or federal law.

EMS Standby During Fire, Rescue and Other Operations

A. Policy

Archer City Ambulance Service will provide an EMS crew and ambulance for standby services in the incident of a structural fire, wild fire, search or rescue / recovery operations which are deemed to need a medical support crew as determined by the Fire Marshal, Fire Chief or EMS Director.

B. Structure Fire

1. An EMS vehicle will be requested to be present at all structure fires in the Archer City Ambulance Service jurisdiction to provide medical care to victims and emergency personnel.
2. EMS will clear the scene when no more imminent danger is present.

C. Wild Fire

1. An EMS vehicle will respond to wild fires if requested.
2. An EMS crew will provide care and assistance responders and victims at the scene as deemed necessary.
3. EMS will clear the scene when the fire is under control or the Fire Marshal, Fire Chief or EMS Director release the EMS crew from the scene.

D. Search / Rescue / Recovery

1. An EMS crew and vehicle will respond to aid in search and rescue operations to provide care for victims and crews if necessary.
2. The EMS crew will provide on-scene standby services for special recovery operations to provide care for victims or there is risk to the recovery personnel.
3. EMS will clear the scene when all victims are found, the search is called off, the operation is completed or the crew is released by the agency in charge of the operation.

Quality Improvement Plan

A. Statement of Purpose

The purpose of this plan is to provide comprehensive, integrated, coordinated and effective program to guide the staff in its operation; to provide an objective ongoing system to monitor and evaluate patient care and clinical / technical performance while pursuing opportunities to improve patient care and to identify and resolve problems.

B. Authority and Responsibilities

The EMS Director (in conjunction with the Medical Director) shall have the authority and responsibility for identification, evaluation, resolution and monitoring of corrective actions within the scope of the departments activities. In addition the EMS Director / Medical Director shall establish critical indicators which shall be monitored on an ongoing basis for the effectiveness in identifying important problems related to patient care.

C. Reporting

The EMS Director shall submit a report of its Quality Improvement activities to the Medical Director on a quarterly basis.

D. Evaluation

The Archer City Ambulance Service Quality Improvement Program shall be reviewed and evaluated on an annual basis to determine its effectiveness.

E. Function

Essential components of the Quality Improvement Program are as follows:

1. Problem Identification
2. Problem Assessment
3. Problem Action
4. Problem Follow-up

Quality Assurance Form

<h2 style="margin: 0;">Archer City Ambulance Service</h2> <h3 style="margin: 0;">Quality Assurance Form</h3>
--

Date of Call: _____ Unit # _____ Run# _____ ARC # _____

Primary Attendant: _____ Driver: _____ Attendant: _____ Attendant: _____

Times Completed - Yes ___ No ___ Scene time > 20 min medical - Yes ___ No ___ N/A ___

Scene Time > than 10 min Trauma - Yes ___ No ___ N/A ___ If Yes was it explained - Yes ___ No ___

Pt Demographics Complete - Yes ___ No ___

PMH Complete - Yes ___ No ___ N/A ___

Pt Medications Complete - Yes ___ No ___

Pt Allergies - Yes ___ No ___

Chief Complaint - Yes ___ No ___

Injury Type and Location - Yes ___ No ___ N/A ___

Beginning GCS - Yes ___ No ___ N/A ___

Ending GCS - Yes ___ No ___ RTS - Yes ___ No ___ N/A ___

At least two sets of vitals for medical - Yes ___ No ___ N/A ___ 3+ for Trauma - Yes ___ No ___ N/A ___

If No, was it explained - Yes ___ No ___

Was treatment according to protocol - Yes ___ No ___

Was a focused physical exam performed around chief complaint - Yes ___ No ___ N/A ___

Was Narrative Legible - Yes ___ No ___

Was narrative comprehensible - Yes ___ No ___

Were medications given - Yes ___ No ___

Were vitals assessed before & after - Yes ___ No ___

Was time documented - Yes ___ No ___

Dose - Yes ___ No ___ Correct Route - Yes ___ No ___

Was Pt reassessed for change after any and all treatments - Yes ___ No ___ N/A ___

Supervisor - _____

Signature - _____ Date - _____

Comments - _____

Personnel - _____

Signature - _____ Date - _____

Comments - _____

Infection Control

A. General

1. EMS will demonstrate compliance with the OSHA Blood Borne Pathogen Rule, “29 CFR 1910.0130” as fully as possible. All EMS personnel should receive formal initial training on the Blood Borne Pathogen Rule. Refresher training is recommended to be completed by all personnel on at least an annual basis.
2. EMS personnel are strongly encouraged to document immunity to the following diseases by immunization, when applicable, by history of prior infection.
 - Rubella
 - Red Measles
 - Mumps
 - Hepatitis B
 - Tetanus Diphtheria
 - Influenza (annually)
3. It is our wish that EMS personnel be tested annually for Tuberculosis unless contraindicated. Positive reactors should be referred to the public health authorities for follow up.
4. In the unpredictable and uncontrolled pre-hospital environment, it is safest to follow body substance isolation practices which consider all body substances potentially infectious. The following should be considered as potentially infectious:
 - Amniotic Fluid
 - Blood
 - Bodily Fluids with Blood
 - Cerebrospinal Fluid
 - Feces
 - Nasal Secretions
 - Pericardial Fluid
 - Peritoneal Fluids
 - Semen
 - Sputum
 - Sweat
 - Synovial Fluid
 - Tears
 - Teeth
 - Tissue
 - Urine
 - Vaginal Secretions
 - Vomitus
5. The routine utilization of exposure control procedures and appropriate Personal Protective Equipment by the individual EMS employee, first responder or third-out rider is essential to the

safety of all involved personnel. Its use can help ensure protection from infectious materials to ambulance personnel, their family, subsequent patients and the general public.

6. The selection and utilization of appropriate Personal Protective Equipment should be based upon its ability to provide an impervious barrier between any potentially contaminating body fluids and the EMS employee. Archer City Ambulance Service is responsible for the supply, repair, cleaning, replacement and safe disposal of all exposure control-related Personal Protective Equipment. All required PPE should be supplied to that departments' personnel and subsequently maintained by the individual department and at no expense to the employee or other person that may be on an Archer City Ambulance unit.

B. Vehicle Cleaning

1. All exposed surfaces in the patient compartment will be cleaned as needed with approved germicide which also has tuberculocidal properties. Gloves will be worn during cleaning.
2. All reusable hard equipment, long spine boards, cervical immobilization devices, and cervical collars will be cleaned as needed with hot soapy water, rinsed, disinfected with a germicidal agent and dried. Gloves will be worn during cleaning.
3. Stock items will be checked monthly for expiration dates. Materials with the shortest time until expiration should be used first. Expired materials will not be used and will be removed from the ambulance. Proper disposal of expired drugs will be handled by the EMS Director.
4. Disposable equipment will be used whenever possible. Used disposable items which have been contaminated with body fluids will be placed in a sealed and appropriately labeled "Biohazard" container.
5. Following each use, non-disposable equipment will be washed with hot soapy water, rinsed, disinfected with a tuberculocidal germicidal agent and dried. Gloves will be worn during cleaning. If non-disposable equipment cannot be cleaned immediately, it should be placed in a sealed and appropriately labeled "Biohazard" container until it can be properly cleaned.
6. After patient contact, priority will be given to spills of blood and other body fluids. All contaminated areas should be cleaned with an appropriate germicidal agent. Gloves should be worn during cleaning.
7. After patient contact, stretcher linens should be changed. Used linens will be placed in an impermeable bag or will be double-bagged until they can be removed from the ambulance. Used linens will be removed from the ambulance at the earliest possible time for laundering. Gloves will be worn handling linens obviously contaminated with body fluids. Bags containing contaminated linens should be labeled "Biohazard".
8. Sharp objects will be immediately placed in a puncture-proof container. Needles will not be recapped, cut, bent or removed from the syringe. The entire needle-syringe unit will be discarded. When filled, the container will be discarded in accordance with local, state and federal law.

C. Patient Care Precautions

1. Gloves will be worn on every ambulance run and should be applied before patient contact is made. However, the driver of an emergency vehicle should put on their gloves either before they depart for the emergency or immediately upon arrival. The driver should not attempt to put on gloves while driving. Nitrile gloves do not provide puncture protection.
2. Eye protection should be worn when there is a risk of splattering of body fluids. Eyeglasses with plain glass lenses may be used if safety glasses or face shields are unavailable or impractical, but safety glasses or face shields with side panels are preferred due to their added protection.
3. Mouth-to-mouth breathing should NOT be performed. The pocket mask with one-way valve or a bag-valve-mask should be used for ventilating patients.
4. Clothing soiled with blood or body fluids should be changed as soon as possible. It is recommended that a change of clothing, jump suit or surgical scrub suit be available on the ambulance for each crew member. If the crews underlying skin has been contaminated, they should be allowed to remove clothing and, if possible, shower as soon as possible.
5. Patients should be masked if a pathogenic organism should be present in their respiratory secretions. If the patient will not tolerate the mask or must receive continuous respiratory care precluding the mask, the ambulance crew should wear a mask. Also, the ambulance exhaust fan should be utilized when weather permits, the windows opened to increase the exchange of air out of the vehicle. High risk conditions indicating the wearing of masks are known mumps, measles, chicken pox, active tuberculosis, meningitis or fever accompanied by a rash, stiff neck or productive cough.
6. Known AIDS patients should be masked to protect them from infection. If the patient cannot wear a mask, the ambulance crew should wear a mask. They should notify the patient that this is being done to protect the patient from possible infectious organisms.
7. Pregnant EMS personnel should avoid providing direct care to known AIDS patients, since many of the patients excrete cytomegalovirus. CMV is known to cause birth defects.

D. Hand Washing / Hand Care

1. Vigorous scrubbing of the hands with a germicidal soap under running water for 30 seconds will remove or kill most of the pathogens. Hands should be washed at the beginning and on completion of duty and immediately following each call as soon as gloves are removed. Wearing gloves does not eliminate the need to wash your hands.
2. Lotion should be applied following hand washing to avoid chapping of the skin, but some lotions can affect the integrity of Nitrile gloves.
3. Cuts or other lesions on the hands or other exposed skin should be covered with a fluid resistant bandage. Bandaging open lesions does not eliminate the need for gloves.

E. Exposure Precautions

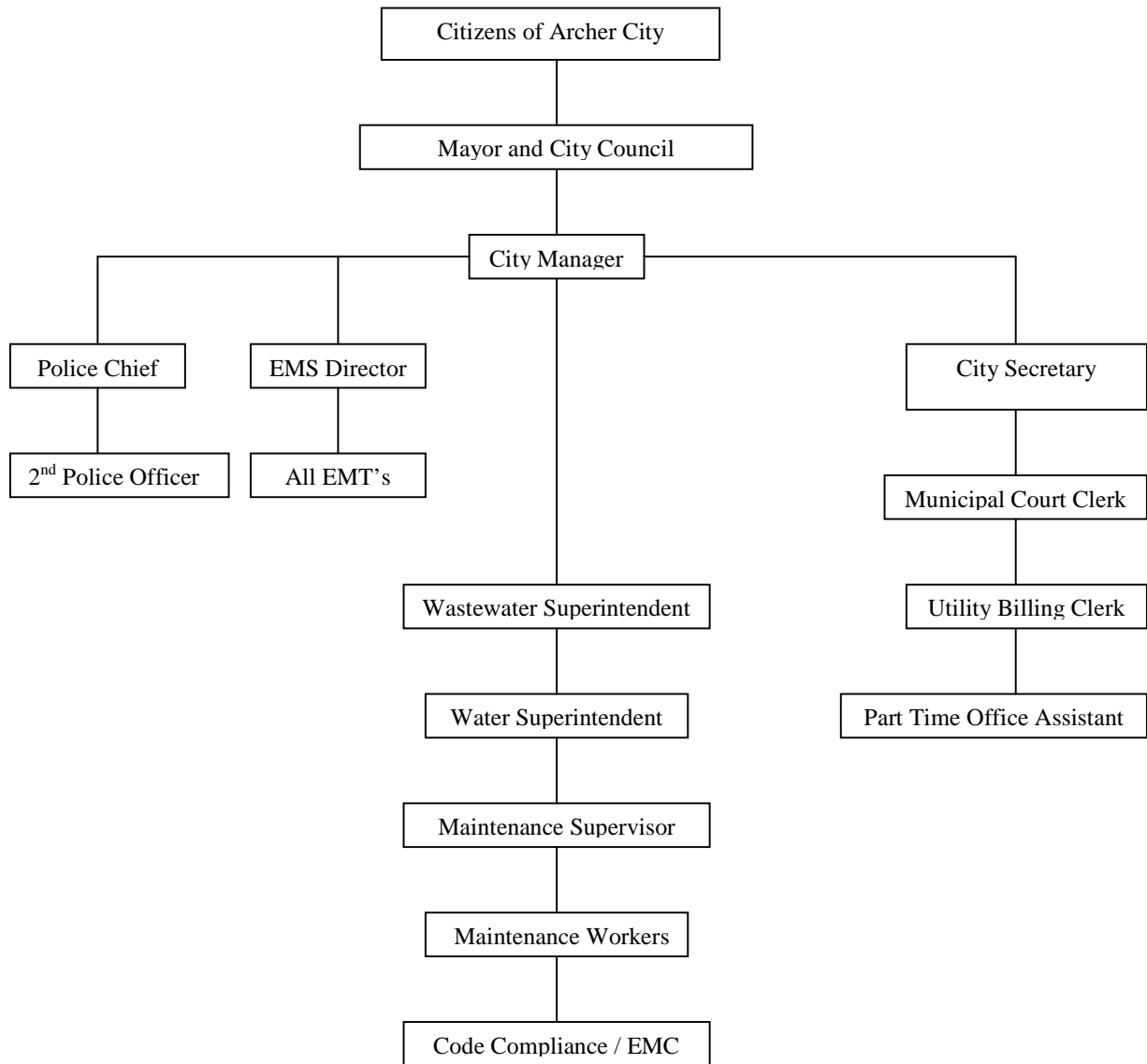
1. With routine utilization of appropriate precautions, the risk of needle stick injuries can be significantly reduced. However, in the event that a needle stick does occur, the sight should be encouraged to bleed. The sight should be cleaned immediately with alcohol foam and washed thoroughly as soon as possible.
2. All cases of possible disease exposure, including needle stick, should be reported immediately to the personnel of the receiving hospital, the Medical Director and the EMS Director. The incident should be thoroughly documented on an incident report form.
3. An Infection Control Officer will follow up on all cases of exposure of EMS personnel and will advise on appropriate procedures. State law requires this notification.

Alcohol and Drug Testing

The EMS Director or their designee shall, based on observation, require a department employee to submit to a test for alcohol or drug use while on duty. Random testing of any or all employees may be performed at any time. The results of these tests may be used in the disciplinary process and possible termination of duty. Refusal to submit to the examination will be grounds for disciplinary action and may result in the employee's termination.

1. If the employee is believed to be under the influence of alcohol, a portable breath test shall be administered. If the employee was operating a vehicle a motor vehicle in a public place, the proper police agency shall be notified as soon as it is practical.
2. If the employee has a detectable amount of alcohol in their system, or there is other competent evidence of impaired abilities to perform their duties, the employee shall be relieved of duty.
3. If the employee is believed to be the influence of self administered drugs, the employee shall be compelled to submit to a blood and / or a urine test. The test shall be administered under medical supervision where hygienic safeguards are met. If an employee refuses to submit to a blood and / or urine test the employee shall receive disciplinary action and may result in the employee's termination for insubordination.
4. If the test(s) show positive results, or there is other competent evidence of impaired abilities to perform duties, the employee shall be relieved of duty.
5. If an employee is involved in an automobile accident or an on the job accident which results in injury, the employee shall submit to a breath, blood or urine test to determine the presence of drugs and / or alcohol in his or her system. Employees who refuse to submit to a test shall be relieved from duty for failure to cooperate in an administrative investigation.

City Structure Flow Chart



Archer City Ambulance Service
Employee Acknowledgement

This is to acknowledge that I have received a copy of the Archer City Ambulance Service Policies and Procedures. I understand and agree that it is my responsibility to read and familiarize myself with the provisions of the Policies and Procedures and to abide by the policies in it. If I do not understand any Archer City Ambulance Service policy or procedure I understand that I should address any question to the Director of Archer City Ambulance Service.

Employee: _____

Date: _____

It is hereby officially found that the meeting at which the Archer City Ambulance Service Policies and Procedures were approved was open to the public and that due notice of the meeting was posted, all as required by law.

PASSED AND APPROVED at a regular meeting of the City Council of the City of Archer City, Texas, on the 19th day of January 2012.

Kim Whitsitt, City Secretary

City of Archer City