PURPOSE

The decision to request ALS intercept must weigh the potential benefits against any delays in delivering the patient to definitive care.

This guideline is intended for services that provide BLS transport. It defines which patients may benefit from ALS intercept and/or transport. For the purposes of this policy, BLS is defined as EMT-Basic, while ALS is defined as Intermediate Technician, EMT-Intermediate, and EMT-Paramedic.

Patients presenting with the following conditions should be assessed for the potential benefit of receiving ALS care through an ALS intercept from the closest available ALS service.

GUIDELINE

I. Patients with the following presentations should be considered for ALS intercept:

A. Accident/assault victim with multiple trauma or significant mechanism of injury, including but not limited to:

1. Falls from a distance of > 20 feet
2. Ejection from a vehicle
3. Death in the same passenger compartment
4. Extrication time > 20 minutes
5. Rollover
6. High speed auto crash with:
   a. Initial speed > 40 mph,
   b. Major auto deformity > 20 inches,
   c. Passenger compartment intrusion > 12 inches,
   d. Or steering wheel deformity
7. Auto-pedestrian/auto-bicycle injury with significant (> 5mph) impact
8. Pedestrian thrown or run over
9. Motorcycle crash > 20mph or with separation of rider

B. Airway compromise

C. Altered level of consciousness: persistent, alternating, unknown etiology, or GCS < 13

D. Anaphylaxis

E. Breathing distress

F. Burns: major partial or full thickness, hydrofluoric acid or fluorine gas exposure, respiratory or facial, or when pain control is indicated

G. Chest pain and/or heart problems

H. Cardiac or respiratory arrest

I. Cerebrovascular accident or stroke symptoms

J. Near drowning

K. Electrical injury

L. Fractures: bilateral femur, pelvic, or open fractures (suspected or known), or when pain control is indicated

M. Heatstroke with altered level of consciousness

N. Hemorrhage: internal or external, with evidence of shock

O. Obstetrical: known or suspected complications, including, but not limited to, breech, prematurity, multiple births, or pre-eclampsia

P. Overdoses, drug reactions, and poisonings associated with GCS <13

Q. Penetrating trauma to head, neck, or torso

R. Seizures: prolonged or repetitive, initial episode or unknown etiology

S. Paramedic, EMT, or physician discretion

T. Any patient whose vital signs fall within these ranges should be considered for ALS intercept:

Age	Blood Pressure	Pulse	Respirations
>11 Yrs	<90 or >200 systolic or >120 diastolic	<50 or >150	<10 or >30
3-11 Yrs	<80 systolic	<60 or >150	<15 or >30
3mo-2Yrs	<70 systolic	<80 or >160	<20 or >40
Birth-2 Mos	<50 systolic	<100 or >180	<30 or >50

II. Patients with the following presentations may be transported BLS as long as they do not fit any of the above criteria:

A. Accident/assault victims with minor trauma

B. Altered level of consciousness: brief and improving, and GCS of 14 or 15

C. Burns: minor (<20% total body surface area (TBSA) in adults, <10% TBSA if <12 or >60 years)

D. Fractures: simple

E. Lacerations: minor

F. Obstetrical: uncomplicated

G. Psychiatric or suicidal patients

H. Seizure: febrile or with known history and improving LOC

I. Uncomplicated diabetic emergencies responding rapidly to oral glucose or Glucagon

The State of Wisconsin requires the medical director or his/her designee to attest to the competency of all Emergency Medical Responders (EMR) with Advanced Skills and all Emergency Medical Technicians (EMT), Advanced EMTs, Intermediates and Paramedics. To facilitate this service for the providers receiving medical direction through the Bayfield-Ashland Counties EMS Council the following will occur:

Emergency Medical Responders (EMR) / First Responders:
The Service training officer shall be responsible for verifying all Emergency Medical Responders annually in CPR/AED use and attest to their completion of bi-annual refresher training.

EMT:
All EMTs shall demonstrate competency in CPR/AED in the presence of the medical director or his/her designee annually. The Service training officer may act as the medical director's designee and shall be responsible for attesting to their competency in all other advanced skills and successful completion of required bi-annual refresher training.

General:

It is the belief of the Services that individual patients and their families have the right to request the hospital destination of their choice when being transported by ambulance during an emergency.

Policy:

I. All patients will be asked their preference of hospital destination.

   A. If protocol specifies that the patient should be transported to a different facility, the EMT will:

      1. Explain to the patient that service protocol indicates that a particular hospital is designated to receive them. Obtain informed refusal from the patient. This informed refusal should be the result of a professional attempt to educate the patient and not coerce their decision. It should include the potential adverse outcomes from not going to the designated facility.

      2. Transport the patient to the hospital of their choice.

      3. Document any disagreement in writing using the AMA form and have it signed by the patient or their representative.

   B. If the patient has no choice, the EMT will:

      1. Transport to the nearest appropriate facility.

II. The only exception to the above is the following:

   A. The requested hospital is on by-pass for the patient's condition. In this instance the patient will be transported to the next nearest available hospital.

III. No attempt shall be made to unduly influence patient choice of hospitals except where that influence is objectively in the best interest of the patient.

IV. The service has no responsibility to transport a patient to a hospital not included in its operational plan as a primary receiving hospital unless so approved by the service director.

I. FOUNDATION FOR POLICY

A. It is the responsibility of the EMS Medical Director to:

1. Assure that the EMTs initial training meets the standards established by the State of Wisconsin and the EMS medical community.
2. Provide continuing education to maintain knowledge and the skill levels of the EMS provider.
3. Establish Standards of Care, Medical Procedures, Standards for Practical Skills, and Administrative Policies to define and guide professional practice.
4. Supervise and evaluate individuals licensed with the EMS service.
5. Provide access to additional training or other support services as needed.
6. Actively seek solutions to issues identified through the Quality Improvement process.
7. Take appropriate corrective actions upon identification of activities by an EMT that negatively impact the EMS service and/or patient care.

B. It is the responsibility of the individual EMT to:

1. Attain and maintain knowledge and skills necessary to safely practice as a licensed EMT in the EMS Service.
2. Provide medical care within their scope of practice with the needs of the patient as the primary concern.
3. Accept personal responsibility for maintenance of professional standards.
4. Provide emergency medical services as outlined in Standards of Care, Medical Protocols, Standards for Practical Skills, and Administrative Policies of the EMS Service.
5. Conduct his/her practice in a manner that reflects positively on self, peers, and the EMS Service.

II. PURPOSE OF POLICY

A. Upon identification of a potential problem or upon receipt of a complaint regarding provision of pre-hospital care or the action of any individual(s) licensed within the EMS Service, it is the responsibility of the Medical Director and/or his/her designee to investigate the allegations impartially and completely. Such investigation will adhere to due process and consist of the following phases:

1. FACT FINDING PHASE

a. All complaints or allegations must involve a specific incident or series of incidences and may be lodged by any individual or organization. Any individual named in a complaint has the right to all information obtained by the Medical Director, including the source of the complaint.

b. Fact finding activities will begin within two (2) working days of the receipt of the complaint and should be complete within 14 days of the initial notification of the incident. The Medical Director or his/her designee is responsible for the initial contacts and collection of information.

c. Fact finding activities will include contact with the complainant for additional information as necessary and telephone or personal contact with the EMT involved.

d. The EMT will be informed of the specific complaint and the individual or organization that brought the problem to the attention of the Medical Director.

e. The EMT will respond verbally, providing such information as necessary to clarify or resolve the issues. Written replies may be requested by the Medical Director or his/her designee and must be completed and submitted within 9 calendar days.

f. The Medical Director or his/her designee will then review the information and generate a report.

g. All reports will be classified as either an **Educational** or **Disciplinary** issue.

1) An **Educational Issue** is one in which it is determined that the complaint/problem was created by a lack of understanding of academic foundation, Standard of Care, Medical Protocol(s), or System Policy(ies).

2) A **Disciplinary Issue** is one in which there is willful or repeated violation of a Standard of Care, Medical Protocol, or System Policy where the EMT has the appropriate academic foundation and/or has received remedial education regarding the Standard, Protocol, or Policy.

2. RECONCILIATION PHASE

a. For **Educational Issues**, the EMT involved will be notified by letter of the results of the fact-finding.

1) The letter will be sent to the home address of the EMT.

2) The EMT will be instructed to contact the Medical Director to arrange a meeting date and time.

3) If the EMT fails to contact the Medical Director or his/her designee within five (5) days from the date the letter was mailed, the EMT will be contacted by phone to verify receipt of the letter and to schedule the educational session.

4) The Medical Director or his/her designee will conduct the educational session within five days of the call.

5) Failure to respond to the letter and telephone contact or refusal to attend a scheduled educational session will be reported, verbally and in writing, to the EMT's EMS Service Director accompanied by a request for formal action by the EMS Service. This report will contain the details of the complaint, the results of the fact-finding, and the documentation of contact with the EMT.

b. In **Disciplinary Issues**, the EMT involved will be notified by letter of the results of the fact-finding.

1) The letter will be sent to the EMT's home address. A copy of that letter will be sent to the EMT's EMS Service Director with a cover letter from the Medical Director requesting disciplinary action.

2) If a potential risk to public safety is alleged, the Medical Director retains the right to impose sanctions on the practice of any individual EMT including limits on patient contact from the start of the fact-finding phase through the disciplinary action of the EMS Service.

c. Actions requested of the EMS Service Administrative Officer by the Medical Director may include but are not limited to:

1) No disciplinary action indicated.
2) Monitoring of performance for a specified period of time including specifics of who will do the monitoring and the evaluation tools that will be employed to monitor progress.
3) Counseling, including specific issues of concern, improvement expected and the evaluation process to be used to determine progress.
4) Written reprimand to the individual with copies to the EMS Service and the EMT's file.
5) Probation with the specifics of the conditional terms under which the EMT may continue to practice, the time of reviews, and the behavioral changes expected along with the evaluation tools to be used to monitor progress.
6) Suspension of particular EMS duties, the period of time suspension is to be enforced and the conditions for removal of suspension.
7) Withdrawal of Medical Control with notification to the EMS Service and the State of Wisconsin Department of Health Services EMS Systems Section that the Medical Director will no longer accept any medical responsibility for the actions of the individual.

3. CONSEQUENCES AND CONFIDENTIALITY

a. No action by the Medical Director and/or his/her designee is to be construed, implied, or meant to affect the individual EMT's employment status, hourly wage, or future employability. The results of all phases are limited to the extent to which medical control will be extended to the EMT. The consequences, as they relate to the EMT's employment status are to be handled by the EMT's employer through established policy.

b. The Medical Director, maintaining the confidentiality of patient information and that of the EMT, will retain on file, records of complaints, results of the investigations, and the actions taken.

4. RIGHT TO APPEAL

a. The decision of the Medical Director is final as far as his/her rights are concerned regarding provision of Medical Control to the EMT. However, appeal of any decision may be handled through local policy and protocol if such procedures are established.

In the event that a physician, other than a Medical Control Physician, should be present at the scene, he or she may direct the EMT provided he or she accepts the following restrictions:

A. He or she must be a physician licensed to practice in the State of WI.

B. He or she must be willing to accept responsibility for the care of the patient until arrival at the hospital (i.e., must accompany the patient in the ambulance to the hospital).

C. He or she must be willing to accept the limitations of interventions which EMTs may perform, as outlined in Wisconsin Administrative Code, EMT-B Chapter HSS 110, EMT-1 Chapter HSS 111EMT-P Chapter HSS 112, and HSS 113 as modified by local protocols.

If these criteria are not acceptable to the physician on the scene, the EMT must seek on-line medical control from the potential receiving hospital.

In the specific case of the patient who is being cared for by a specific physician in a nursing home, the EMT may accept orders conveyed to him or her directly by that physician via a telephone, again provided the physician is willing to accept the restrictions listed above, with the exception of provision in number B (i.e., must accompany the patient in the ambulance to the ER). These orders may cover directives regarding destinations on transfer and may also include orders to discontinue or withhold resuscitation. Any other orders that cover the spectrum of activities preformed by the EMT may only be given or approved by on-line medical control. Such incidents must be carefully documented in the ambulance run report form by the EMT, and all orders should subsequently be signed by that physician.

Further medical control may be obtained, if needed, from the Medical Control Physician at the receiving hospital.

GENERAL:

In the event that the service responds to the scene of a multiple casualty incident (MCI) (more than the service is able to care for, or as the result of a mutual aid response to another services request during an MCI event) each responding squad shall follow these general guidelines. Because every MCI event is unique, flexibility is required but overall the Incident Command System (ICS) structure will be the guiding force behind deployment and patient care.

All protocols become standing orders.

I. First on scene: Park vehicle and position yourself and other responders upwind/ upgrade and at a safe distance/location.

II. First-In Report (Size up incident)

- A. Identify yourself and your unit via radio to Dispatch
- B. Describe the incident including exact location
- C. Describe the type or types of structures/vehicles involved
- D. Estimate the number of injuries or casualties
- E. Determine safety hazards
- F. Advise of the need for evacuation of the public

III. Establish Command

- A. State you are assuming command by identifying yourself and naming command (example: "...and I will be Hwy 13 Command."
- B. Give exact location of command post. Stay there.
- C. Request additional resources needed immediately (ambulances, helicopter medical, law enforcement, traffic control, hazmat, etc.)
- D. Identify route of approach for other responders (i.e. wind direction, traffic congestion, etc.)
- E. Identify staging area location.
- F. Request responding units report to staging area for assignment and maintain radio silence.
- G. Request initial notification of closest hospital or medical control facility.
- H. Designate radio frequencies for use on scene.

IV. Initial Actions – Establish the following groups (it may be only one individual until arrival of additional personnel) and assign personnel to each or report to the appropriate group if previously established:

- A. TRIAGE GROUP – sort and categorize all patients.
  1. Triage Group SUPERVISOR is responsible for initiating and directing the Triage Group.
  2. The Triage Group Supervisor receives direction from the EMS Branch Director or IC until EMS Branch established. Responsibilities include:
     a. Implement START, Simple Triage and Rapid Treatment

b. Estimate number and severity of patients and inform the EMS Branch Director

c. Establish triage and extrication teams

d. Report progress & needs to EMS Branch Director

e. Move patients by priority to treatment sector

B. TREATMENT GROUP – provide on-scene treatment of patients

1. Treatment Group SUPERVISOR is responsible for initiating and directing the Treatment Group.

2. The Treatment Group Supervisor receives direction from the EMS Branch Director or IC until the EMS Branch is established. Responsibilities include:

a. Establish treatment area close to incident - if possible

b. Limit access of non-essential personnel

c. Triage patient on arrival to treatment area

d. Group patients by priority (immediate and delayed)

e. Limits medical care to urgent needs

C. TRANSPORTATION GROUP – ensure all patients are transported to the appropriate facility.

1. Transportation Group SUPERVISOR is responsible for initiating and directing the Transportation Group.

2. The Transportation Group Supervisor receives direction from the EMS Branch Director or IC until the EMS Branch is established. Responsibilities include:

a. Establish patient loading zone

b. Establish and operate a helicopter landing zone

c. Request personnel to function as a Medical Resource with the hospitals for the purpose of:

1) Ongoing identification of receiving hospitals' available resources

2) Assigning patients in treatment areas to transporting units by priority

3) Directing transporting units to the appropriate hospital based on available resource information

4) Communicate with the receiving hospital a brief description of transporting units, numbers of patients, brief patient report, and ETA

5) Maintain a patient log and tracking patients

6) Maintain a communications link with receiving hospitals

d. Communicates with Medical Resource to identify receiving hospitals and tracks status

e. Reports to EMS Branch Director or IC and hospitals when last patient has been transported

D. STAGING OFFICER

1. Establishes staging location at a site remote from the incident to avoid "gridlocking" units
2. Coordinates with police to block streets and other access routes
3. Maintains log of units and inventory of all specialized equipment and medical supplies

V. Transfer of command

A. As the incident progresses it may become prudent for command to be transferred to another responder. This is a normal occurrence in the ICS and should not be considered a reflection on the abilities of the current IC.

B. Transfer of Command occurs for any of the reasons listed below:

1. A person of equal of higher rank arrives on scene
2. At the end of a shift or operational period
3. As appropriate for predominant technical needs (fire, law enforcement, medical)
4. IC defined by ordinance or preplanning

C. Criteria for Transfer of Command

1. Must be accomplished face to face
2. Must include a briefing that includes the following (minimum):
   a. Current situation
   b. Incident goals
   c. Summary of current actions
   d. Resources and actions needed to resolve the incident
3. Transfer of command must be announced (preferably via radio_ so all responders are aware of the transfer

D. Once relieved, the new IC may assign the outgoing IC to other duties as needed.

PURPOSE

The EMS Protocols under which the Ambulance Service operates require regular review and modification to maintain currency with accepted standards of practice and to improve patient care. The following policy and procedure addresses the manner in which protocol changess are reviewed and changes implemented.

POLICY

The patient care protocols will be reviewed at regular intervals. The Medical Director Advisory Committee (MDAC) to the Bayfield-Ashland Counties EMS Council will serve as the reviewing entity. The MDAC, defined in the EMS Council bylaws, is comprised of five elected representatives from the EMT Services, the Medical Director of those Services, an ALS representative, a representative from the local training center and a representative from MMC/Ashland.

PROCEDURE

1. Any person may request a protocol review and suggest changes to it.
2. Protocol review requests will be made by submitting a written request for such review to the MDAC or the medical director.
3. The protocol will be reviewed by the Medical Director who will submit a recommendation(s) to the MDAC.
4. The protocol will then be reviewed at the next scheduled MDAC and/or EMS Council meeting where any changes, deletions, or modifications will become recommendations.
5. The protocol will then be given to the Medical Director for review and approval.
6. If the protocol is not approved by the Medical Director it will return to the MDAC for further review.
7. If the protocol is approved by the Medical Director it will be forwarded by the EMS Council to the state EMS office for review and approval.
    a. If it is determined that dissemination of the new protocol is time critical it will be made available to all EMTs upon approval by the state EMS office. The protocol will be reviewed at the next regularly scheduled in-house training session. The protocol will become effective on the date of the in-house training session.
    b. If dissemination is not time critical it may be kept on file until the next protocol update publication. It will become effective at the time of publication.

POLICY RECOMMENDATION

The emergency medical services (EMS) crew is responsible for the safe operation of an ambulance. There is a documented risk of crashes involving emergency vehicles resulting in excess injury and death to emergency personnel, patients, and bystanders. Because of this increased risk, it is recommended that the use of red lights and siren during transport should be minimized. Use of lights and siren transport (also referred to as "Code 3" or "Hot response") should be reserved for unstable medical conditions.

PATIENT CARE GOALS

- Identify patients for whom use of emergency lights and siren during transport can potentially reduce patient morbidity and mortality.
- Eliminate unnecessary use of emergency lights and siren during transport.

PROCEDURE

1. **Lights and Siren transport does <u>not</u> mandate traveling at dangerous or excessive speeds, or speeds above the legal posted speed limit.**
2. **Road type, traffic conditions, and weather conditions all must be considered when using lights and siren.** (For example, when driving on a highway, it may be safer to drive with the flow of traffic at normal highway speeds without lights and siren, instead of stimulating possibly erratic lane changes by using lights and siren.).
3. When using lights and siren extreme caution must be taken when approaching an intersection even if a priority light control system is being used. **Ambulance must come to complete stop** before proceeding through an intersection when there is a possibility that cross traffic has a green light.
4. At the discretion of the ambulance crew, driving with lights and siren **<u>may be considered</u>** if the following clinical conditions or circumstances exist **if such use will significantly shorten delays associated in delivering the patient to definitive care**.
   a. Difficulty in sustaining the ABC's including (but not limited to):
      - Inability to establish an adequate airway or ventilation.
      - Severe respiratory distress or respiratory injury not responsive to available field treatment.
      - Acute coronary syndrome, impending or progressing cardiac event or a cardiac dysrhythmia which are unresponsive to available field treatment.
      - Severe, uncontrolled hemorrhage.
      - Shock with altered mental status

   b. Severe trauma including (but not limited to):
      - Penetrating wounds to head, neck, and torso.
      - Two or more proximal long bone fractures.
      - Major amputations (proximal to wrist or ankle).
      - Neurovascular compromise of an extremity.
      - Multi-system trauma.

   c. Severe neurological conditions including (but not limited to):

- Status epilepticus.
- Substantial or rapidly deteriorating level of consciousness.
- Rapid deterioration due to a suspected life threatening cerebral vascular accident (CVA/stroke).
- For a suspected CVA where a significant reduction of time to receive thrombolytic therapy can be achieved and the patient meets treatment inclusion criteria.

d. Obstetrical emergencies including (but not limited to):

- Prolapsed cord.
- Labor complications that threaten survival of the mother or fetus.
- Breech presentation.
- Arrested delivery (inability to complete delivery of a baby that is partially born).
- Suspected ruptured ectopic pregnancy.

e. Patients who pose a safety threat to themselves or the crew after reasonable attempts to control the situation have failed.

4. For any long distance transport (greater than 25 miles), where reducing time to definitive care is clinically indicated, consider options other than emergent driving. In these cases, an alternative mode of transportation or higher level of care (such as air-medical or critical care transfer) should be considered, if available, appropriate, and if it will not delay the arrival of the patient.

5. **Critical-care level interfacility patient transports should <u>not</u> automatically be handled as lights and siren events**. Clinical judgment and the patient criteria listed above should be applied on transfers to determine the level of urgency and transport mode.

6. When a physician or nurse attempts to order lights and siren transport for a patient, when it is believed by the crew to be contraindicated, attempt to resolve the issue with the ordering physician/nurse. Contact medical control to assist in resolving the issue is necessary.

7. Transport with lights and siren should be **<u>avoided</u>** in the following circumstances:

   a. Patients who present with a written and valid "Do Not Resuscitate" (DNR) order, confirmed by the patient's wishes and/or medical authority orders to withhold treatment.

   b. Interfacility transfers when the patient is being transported to a lower level of care.

   c. Transport of human organs, blood, or organ transplant teams. The possible exception would be a long distance inter-city transport of an organ or organ recipient, where the time frame for successful reimplantation is in jeopardy, and use of lights and siren would save a significant amount of time.

   d. Transport of an unsalvageable patient (including cardio-pulmonary arrests) even if treatment procedures are continued en route.

   e. Situations where the crew is requested to respond to another call while currently transporting a patient who does not warrant emergent transport.

8. **Use of lights and sirens during transport must be documented in the patient care report and must include the patient's condition, case circumstances, and the rationale for choosing emergent transport.**

PURPOSE:

The guiding philosophy by the service is that all calls for assistance will have as their basic goal to provide immediate life saving care, stabilization, treatment, and transport of the patient. In the event that a patient refuses this care the following procedure will be followed. Such refusal may occur in one of three manners

1. Refusal of care/transport in which the EMT and patient believe that a life threatening condition does **not** exist. This is known as refusal of care. (ROC)
2. Refusal of care/transport in which the EMT believes that a significant potential exists for a life threatening condition. This is known as refusing against medical advice (AMA).
3. Refusal of transport after treatment has been rendered in which both patient and EMT believe that a life threat does **not** exist and that the patient does **not** require transport. This is known as treat and release (T&R)

Note: Never advise against seeking medical evaluation

PROCEDURE:

1. All patients will be approached and offered EMS assistance.
2. In the event that the patient refuses treatment the following information must be documented
   a. Name and basic demographic information (DOB, address) regarding the patient
   b. The mechanism of injury or nature of the patient's complaint (if any)
   c. Any form of treatment that has been rendered.
   d. One set of Vital Signs to include BP, pulse, RR, Oxygen saturations, LOC (or documentation of patient's refusal to allow such evaluation).

Refusal of Care (ROC)

1. The Refusal of Care form will be used to document the refusal of care of the patient who is felt by the EMT and the patient not to have a life threatening condition or need for transport.
2. The patient must sign the ROC form and it must be witnessed and signed by the EMT.
3. A copy of the form must be provided to the patient.

Against Medical Advice (AMA)

1. Any patient whom the EMT suspects may have a potentially life threatening condition for which the patient refuses care must be determined to have the capacity to make such a decision.
2. The AMA medical clearance form must be completed.
3. Medical Control must be contacted for consultation regarding any patient who is deemed not competent to refuse care. Medical control may give permission to release the patient or request Law Enforcement intervention.
4. Any patient for whom any of the following apply who refuses care must have law enforcement involved.
   a. Danger to self or others.
   b. Deranged thought processes leading to letter (a) above.
   c. All suicide gestures or attempts.

d. Any minor who has suffered a battery.

5. Informed refusal must be accomplished. This means the EMT or on-line medical control physician has outlined the possible risks and consequences of refusing further treatment or transport
6. The AMA form must be signed and witnessed by the signature of any of the following (in order or preference) and a copy of the form provided to the patient.
   a. A Law Enforcement Officer.
   b. A family member.
   c. Crew member.
7. The patient care report must be completed and the AMA form attached to it. Documentation must be made regarding all facets of the patient's condition including suspected injury/illness, reasons given for signing AMA, determination of competency, details of informed refusal and possible consequences of such refusal, offer of further assistance if desired, disposition of patient (into who's custody).

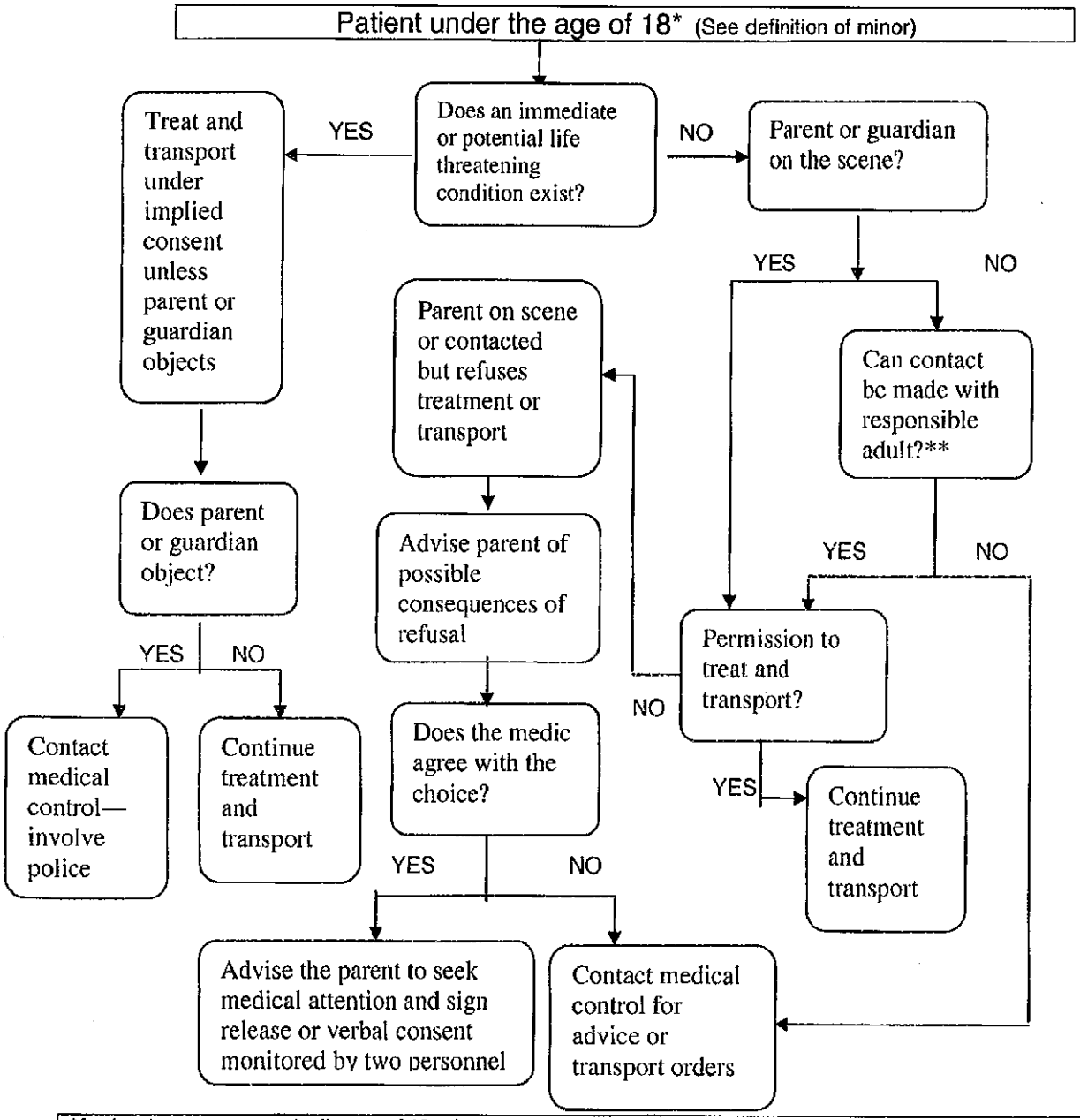
Treat and Release (T&R)

1. The Treat and Release form must be completed for all patients provided care/treatment at the scene and felt by both the patient and the EMT not to require transportation to the hospital. It must include
   a. Summary of the event, injury, illness
   b. Treatment rendered
   c. Aftercare instructions, if any, given to the patient
2. Any vital signs which fall outside the normal range require Medical Control contact for consultation.
3. The Treat and Release form must be signed by the patient or their representative and witnessed by the EMT. A copy of the form may be given to the patient.

Minors

1. Strictly speaking, persons under the age of 18 are not considered legally capable, and therefore cannot refuse care. Clear legal exception include;
   a. Minor is emancipated
   b. Minor is married
   c. Minor is in armed forces
2. However, common sense must be used when dealing with minors who appear to be reasonable and competent.
3. The minor encounter decision tree will be used to determine whether it is prudent to release the minor from care.
4. It is reasonable to make contact by phone with the minor's legal guardian to obtain permission to release the minor. The name, phone number, and address of the person contacted must be documented in the Refusal of Care, Treat and Release, and/or Patient Care report.

DECISION TREE FOR THE TRANSPORT OF MINORS BY EMS



*A minor is any person under the age of 18 unless:

1. Minor is married.
2. The minor has been legally emancipated by the court and can provide documentation of such.
3. Minor is in the armed forces.
4. The above circumstances are a simplification of the laws concerning emancipated minors. When in doubt concerning the ability of a minor to consent for care, contact a medical control physician.

**A babysitter or relative can consent for emergency medical care if he/she was entrusted with the minor's care by the parent or guardian.	For any doubt about the refusal or permission to transport, contact medical control for advice.

Approved: April 2014
Reviewed:
Revised:

PURPOSE:

To provide guidance and criteria for the use of physical restraint of patients during care and transport.

DEFINITION:

Any mechanism used to physically confine a patient. This includes, but is not limited to: soft composite dressing, tape, leathers or hand cuffs wrapped and secured at the wrist and/or ankles and/or chest or lower extremities.

POLICY / PROCEDURE

A. If EMS personnel judge it necessary to restrain a patient to protect him/her self from injury, or to protect others (bystanders or EMS personnel) from injury:

   1. Document the events leading up to the need for restraint use in the patient record.
   2. Document the method of restraint and the position of restraint in the patient record.
   3. Document the reason for restraining the patient.
   4. In the event that the patient spits, the rescuer may place over the patient's mouth and nose a surgical mask or an oxygen mask that is connected to high flow oxygen.

B. Inform patient of the reason for restraint.

C. Restrain patients in a manner that does not impair circulation or cause choking or aspiration. **DO NOT restrain patients in the prone position (face down)**. Prone restraint has the potential to impair the patient's ability to breathe adequately. Police officers are trained in restraining violent individuals safely. Utilize the police on the scene in deciding the appropriate restraint technique to maximize the safety of the rescuers and the patient.

D. As soon as possible, attempt to remove any potentially dangerous items (belts, shoes, sharp objects, weapons) prior to restraint. Any weapons or contraband (drugs, drug paraphernalia) shall be turned over to a Law Enforcement Officer.

E. Assess the patient's circulation (checking pulses in the feet and wrists) every 5-10 minutes while the patient is restrained. If circulation is impaired, adjust or loosen restraints as needed. Document the presence of pulses in each extremity and the patient's ability to breathe after restraint is accomplished. Be prepared to turn the patient to facilitate clearance of the airway while also having suction devices readily available.

F. Inform hospital personnel who assume responsibility for the patient's care at the hospital of the reason for restraining the patient.

G. The EMT at his discretion may request that law enforcement accompany and or follow the patient to the hospital. **Any patient restrained in handcuffs shall have law enforcement accompany the patient in the patient compartment or follow the ambulance.**

PURPOSE

Cardio-respiratory arrest has a low survival rate in the best of circumstances. This policy provides guidance for termination of or withholding resuscitation.

GUIDELINES

1. Most pulseless nonbreathing patients should have full resuscitative efforts, consisting of CPR, defibrillation when applicable, Advanced Life Support, and transport to the hospital.
2.. Emergency Medical Technicians will not withhold or terminate resuscitation without a direct order from a Medical Control physician, the patient's private physician, or other recognized physician. The ordering physician must assume responsibility for this order.
3. Situations when withholding or discontinuing resuscitation should be considered are listed below:
   A. The patient's personal physician is available in person or by telephone, and personally directs the rescuers to withhold or terminate resuscitation, based on his or her knowledge of the patient's medical condition.
   B The patient has an unwitnessed cardiac arrest with suspected downtime >15 minutes, and the presenting rhythm is asystole, regardless of presence of CPR or air management.
   C. Patients who after an airway has been established and have received a full round of ACLS therapy remain in asystole regardless of the presenting rhythm.
   D. The patient has cardiac arrest due to severe blunt trauma and has no clinical signs of life.
   E. Other conditions as determined by a Medical Control physician.
   F. Circumstances during which performance of CPR is not physically possible or could result in injury to rescuers.
4. Resuscitation attempts may be withheld (or discontinued if started) without direct communication with a physician in any of the following situations:
   A. A patient with obvious signs of death such as rigor mortis, dependent lividity, decomposition, decapitation, or a transected torso.
   B. Provision of written documentation, by either the family, guardian, or attendant staff, that the patient, or his or her appropriate legal representative, has indicated that the patient does not wish to be resuscitated in the event of cardiopulmonary arrest. Such documentation may include:
      1) A signed order from a physician.
      2) A properly executed "Living Will".
      3) A properly executed "Durable Power of Attorney for Health Care". In this case, only the individual named as holding Power of Attorney may request discontinuation of resuscitation.
      4) Any other form or device for conveying the patient's advance directive that has been recognized by the State of Wisconsin and that has been properly executed.

PROCEDURE

1. Upon arrival at the scene of a patient in cardiac arrest, the crew should begin CPR. (This is not necessary in cases of obvious death such as decomposition, decapitation, or transected

torso.)

2. Obtain history from the family or bystanders.
3. Perform physical assessment of the patient including the documentation of asystole. This step may be omitted in cases of obvious death as listed in step 1.
4. The EMT in charge of the case should contact Medical Control, describing the facts of the case and the cardiac rhythm. After evaluating the patient's history and assessment information, the physician may decide to order the resuscitation stopped.
5. If resuscitative efforts are stopped, request the Communications Center to notify law enforcement and/or the Coroner. At least one crew member should remain at the scene until relieved by a law enforcement officer or the Coroner.
6. Leave all supplies used, electrodes, and airway devices on patient unless instructed by coroner to do otherwise.
7. Provide support to family members as needed until law enforcement or others can assume this role.
8. Document fully in the Patient Care Record the events leading to the decision to withhold or terminate resuscitation.

SERVICE MUST HAVE OPERATIONAL PLAN AMENDMENT TO PERFORM INTERFACILITY TRANSPORTS

PURPOSE

This policy sets the scope of practice for interfacility transports provided by the service. It also sets the crewmember composition for various anticipated patient scenarios. It is ultimately the responsibility of the referring and receiving physicians, in consultation with the service medical director (when appropriate), to assess the transport needs of each patient and utilize the most appropriate means available to provide quality patient care..

GUIDELINES

1. The inter-facility transport of an acutely ill or injured patient is the ultimate responsibility of the transferring physician and facility.
2. They must assure that the transporting staffs are well informed as to the procedures, dosages of medications and precautions necessary for each patient they are transporting.
3. It must be assured that the transporting staff is not being asked to exceed their capabilities, scope of practice or put into a transfer situation in which they do not feel comfortable or lack the training to handle.
4. The transport staff has the right to decline any such transport so that more appropriate staffing methods can be arranged.
5. There is no responsibility by EMS to affect an interfacility transport if in so doing their primary coverage area would suffer from lack of resources.

PATIENT CARE

1. Each patent should receive special attention to their comfort issues such as sensitivity to hot/cold, extremity support, torso support, privacy and other issues as they might arise.
2. Each patient should be treated with the utmost respect and accommodation. Patients often request something to drink; beverages such as water or soft drink may be administered to the patient but only with the prior approval of the transferring facility.
3. If any situation were to occur that does not fit the specified procedures or the standard protocols, contact will be made with the transferring facility/physician or the medical director
4. Each patient shall have a full assessment made prior to initiating transport. This assessment shall include
    a. The reason for transport
    b. Pertinent history and physical including vital signs
    c. Standing orders provided by the transferring physician
    d. Repeat vital signs at regular intervals dependent on the patient's conditions
5. Medications and therapies may only be performed that are within the scope of practice of the attendant EMTs as prescribed by the state of Wisconsin.
6. In the event that the patient is receiving a medication not listed in these protocols appropriate education regarding this medication must be obtained prior to transport.
7. The Medical Director or his designee will provide this education and documentation of the same provided to DHFS upon their request and the Medical Director made aware of the

occurrence.

8. Crews should have the pertinent information as to dosage, indications, contra-indications and action clearly specified.

MEDICAL CONTROL

1. All transfers must establish the physician who is accepting medical control for each transferred patient prior to transport.
2. If the transferring physician is unwilling to be readily available during the duration of the transport, then the transferring physician may agree to transfer this responsibility to the receiving physician. If this occurs the receiving physician shall be contacted prior to commencing the transport.
3. Documentation of medical control authority will be made in the Patient Care Record.

SCOPE OF PRACTICE

Once a request is made of the service to provide an interfacility transport a checklist will be used to determine the patient's condition, medications being administered, medical equipment required, and anticipated needs of the patient. The crew will then use the following scope of practice to determine;

1. Can care of the patient be provided by service within this scope of practice?

2. What crew composition is required to facilitate this transport?

In addition to the standard scope of practice of each provider as approved by state statute the following skills and medications may be provided for the given providers upon approval of the service medical director, the successful completion of additional training and education, and the approval of the state.

Prohibited Procedures and Patients

- Intracranial monitoring device
- Fibrinolytic initiation
- Intra-aortic balloon pumps or other ventricular assist device
- Neonates requiring isolet transport – unless neonatal resuscitation team is in patient compartment.
- Barriatric patients who can not be safely restrained in the patient compartment
- Orthopedic hardware which prohibits safely restraining the patient during transport
- High Risk OB patients where breech presentation is suspected

Section 1: Basic Life Support Interfacility Transport

I. Required minimum staffing is 1 EMT in patient compartment.

- All patients with stable vital signs. The need for advanced life support is not anticipated.
- Patient is breathing spontaneously with airway management limited to supplemental oxygen and suctioning.
- May have saline lock but no running I.V. fluids

Section 2: Advanced Life Support Interfacility Transport

I. Required minimum staffing is **1 Paramedic in patient compartment**.

- CPAP
- Patient on home ventilator
- Any of the following medications begun at the transferring facility
  - Insulin infusion
  - Heparin infusion
  - Manitol infusion
  - Blood, blood products, Hetastarch, albumin, or other volume expanders (may only continue what is hanging. May NOT hang new blood or products)
  - PCA pumps
  - Antibiotics
  - Potassium infusion
- Central line maintenance and fluid administration
- Arterial line maintenance with pressure bag (no monitoring)
- No more than 1 vasoactive drip medication*

II. Required minimum staffing **2 Paramedics in patient compartment** (a CCEN or TNCC certified nurse may be substituted for 1 EMT-Paramedic by the transferring facility and upon approval of the service medical director).

- Intubated patient (includes non-visualized airways)
  - If hospital ventilator used then respiratory therapist must accompany patient
- External pacing
- Chest tube maintenance
- ACLS medications anticipated (high risk for arrest)
- TPA administration or administered within 1 hour of transport
- 2 or more vasoactive drip medications*

*Vasoactive medications include but are not limited to the following

- Nitroglycerin
- Nitroprusside
- Dopamine
- Dobutamine
- Isoproterenol
- Procainamide
- Magnesium Sulfate

III. Required minimum staffing is **1 Paramedic and OB Nurse (from transferring facility with capability to perform constant fetal monitoring).** The transferring physician must be of the opinion that fetal delivery is not imminent.

- High Risk OB. This includes but is not limited to OB patients greater than 20 weeks gestation with
  - Eclampsia
  - Pre-eclampsia
  - Placenta abruption
  - Placenta previa (with bleeding).
- Fetal Monitoring
- Administration of Tocolytics (to prevent labor)

PURPOSE:

To establish minimum documentation requirements so that each run report accurately reflects a patient's assessment, history, and the emergency medical care given to that patient.

POLICY:

Every run report will contain the following information:

1. **General Information**: Name of the provider, responding unit, call number, crew members' last names, call date, reason for call, location, destination, first responding units, monitoring MD/medical control operator, receiving RN/MD signature, patient (or parent/guardian) signature if treatment or transportation is refused.
2. **Patient Information**: Patient name, address, age, birth date, sex, and personal physician
3. **Times**: Initial call, enroute, at scene, leave scene, and at destination.
4. **Chief Complaint**: Ideally in the patient's own words, what is their primary complaint? If the patient has none, write "none". If patient cannot give one, describe what the major problem appears to be, such as "unresponsive" or "cardiac arrest."
5. **History of Present Illness**: What events led up to the request for assistance? When did symptoms begin? What was the patient doing when they began? Has anything the patient taken or done changed the complaint? If pain, describe severity, location, type, and radiation. Have there been any previous episodes? Has there been any loss of consciousness? If pregnant, include pregnancy number and due date. Use direct quotes when documenting drug or alcohol use.

   (or)

   History of Present Injury: What events led up to the request for assistance? What is the mechanism of injury? When did it occur? Include information on speed, accident type, vehicle damage, ejection, entrapment or loss of consciousness. Was safety equipment such as seatbelts, helmets, air bags, or car seats used? Attach photo if available.
6. **Past Medical History**: List pertinent history, especially heart and lung disease, diabetes, stroke, seizures, recent surgeries, psychological problems, communicable diseases, and DNR/DNI status.
7. **Allergies**: List allergies; especially drug, and food or insect if pertinent to call.
8. **Medications**: Document all current medications and when last taken, if pertinent. *If patient denies any of the above, write "none" or if unknown, write "unknown".* It is permissible to document "see list" if the list of medications is attached to the chart and contains a patient identifier.
9. **Physical Exam**: How was the patient found (positioning/obvious distress)? What was initial level of consciousness (AVPU)? Was patient oriented to person, place, and time? Document assessment of airway, breathing (dyspnea, lung sounds, JVD, 02 sats), and circulation (pulses, skin color/temp, bleeding, capillary refill). Document findings of head-to-toe exam, including wounds, deformity, tenderness, edema, pupils, incontinence, and CMS findings before and after treatment. Include pertinent negatives. Include Glasgow Coma Scale (GCS). If chart is not on form, then document: GCS=12 (E-3, V-4, M-5). If newborn, include one and five-minute APGARs.
10. **Treatment**: Document all treatment administered. The following treatments/assessments have specific documentation requirements:

    A Oxygen: liter flow and route. Example: "NRB mask at 15 lpm".

B. I.V.: time, fluid type and size, needle gauge, location, drip rate, amount infused. Example: "16:04 - IV 500 cc NS, 18 g. to ® antecubital, 250 cc fluid challenge, then TKO".

C. ECG -3 and 12 lead (ALS): rhythm interpretation, rate, ectopy, and injury patterns. Example: "ECG - sinus tach at 120/min w/ 1-2 unifocal PVCs/min. with inferior injury". Attach ECG sample to run report and leave with patient in ER. ECG -3 and 12 lead (BLS): attach strip only, do not interpret rhythms.

D. Medications: time, name, dosage, route, initials of person who administered, and SO (standing order) or VO (verbal order). Example: "15:48 - lidocaine 75 mg IV SO

E. Advanced airway: type, size, and evaluation. Example: "Intubated with Combitube, ventilated through #1 port, good bilateral chest rise/lung sounds, absent stomach sounds, passed NG tube through port #2 with release of stomach air". Confirm and document airway placement before entering ED.

F. Defibrillation: time and joules. Example: "18:10 - Defib at 200 J."

G. MAST: time and sections inflated. Example: "4:26 – MAST applied, both legs inflated".

H. For signs/symptoms suggestive of stroke, complete the Cincinnati Prehospital Stroke Scale and document the findings and time of onset on the run sheet.

11. **Response/Transport**: How did the patient respond to any treatment given? Were there any changes in the patient's condition enroute? How was the patient transported to the hospital (routinely or red lights and siren [RLS], and whether stretcher was used)?

12. **Vital signs**: One complete set of vital signs every 15 minutes on each patient, including time, BP, pulse, respirations, and O2 sats. More are required if patient is unstable (every. 5 min.), or receives medication or treatment that indicates the need to reassess more frequently. Most patients should have two complete sets of vital signs obtained on them before arrival to the hospital unless patient contact is < 10 min. If unable to obtain, document why.

13. **Rationale for allowing the patient to be transported BLS, if first evaluated by ALS.**

14. **Impression**: What is the provider's impression of what is wrong with the patient?

15. **Signatures**: Each run report must be signed by the person who wrote it. An EMT or paramedic may write BLS run reports. A Paramedic or Intermediate must write ALS run reports. If the patient is transported, the receiving RN or MD must sign the form. If the patient refuses treatment or transport, they must sign a refusal statement. Document any instructions given to the patient. If patient is a minor, a parent or guardian must sign the form. If the patient refuses treatment/transport and also refuses to sign, then write "refused" in the box and have someone who witnessed the refusal co-sign the form.

SPECIAL NOTES:

1. All information obtained during the course of patient care delivery is confidential.
2. A run report must be filled out each time an EMS provider offers or provides service to a patient. The only exception to this is a mass casualty incident.
3. Complete one run report for each patient; e.g. mothers and newborns must each have separate run reports.
4. In severe trauma, where scene times are delayed longer than 10 minutes, document reasons for extended scene times, i.e. extrication or unsecured scene.
5. All reports should be written in black or typed/printed.

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Reviewed:
Revised:

6. Correct errors by drawing one line through the incorrect item and initialing by it. Example: "Administered 4 mg ~~morphine~~TG Narcan IV push."
7. Any suspicious situation regarding child/elder neglect/abuse must be reported, according to Wisconsin State Law, to a licensed peace officer or child protection officer.

PURPOSE:

To provide consistent radio communications with communications centers and other response agencies.

POLICY:

UNIT COMMUNICATIONS WITH DISPATCH

A. Units calling Dispatch should identify themselves with the appropriate department name and then address the communications center as DISPATCH. (Example: Washburn Fire to Dispatch.) If a department's radio transmission may change from tower to tower, the radio unit should also identify the tower on which they are transmitting. (Example: South Shore Ambulance to Dispatch/Port Wing.)

B. If you need a response from Dispatch, then address Dispatch. (Example: South Shore EMT Hofman to Dispatch). If you are transmitting on the radio for the benefit of other responders, do not address Dispatch and do not expect Dispatch to acknowledge your transmission. (Iron River EMT Victorson to the scene.)

C. The use of plain text (versus 10-codes) is the standard operating procedure for radio communications.

D. An Ambulance Department should transmit the following to Dispatch:
   1. Department – Acknowledge the page [Iron River Ambulance to Dispatch. Acknowledge the page.]
   2. Ambulance en route
   3. Ambulance at the scene
   4. Ambulance en route to hospital
   5. Ambulance arrived at hospital
   6. Ambulance returning to hall

E. The ambulance should also transmit the following information to Dispatch during Intercept calls:
   1. Intercept request
   2. Making intercept
   3. Action following intercept (Example: patient transferred to ground ambulance or helicopter and returning to hall, back en route to hospital, etc.).

F. If you are not receiving clear transmission from Dispatch, please inform the dispatcher with a suggested change of tower in order to receive a better signal.

DISPATCH PROCEDURES

A. The order of dispatch by radio pager:
   1. Select appropriate fire/ambulance department(s) button(s).
   2. Activate pager(s).
   1. Announce Department(s) that are to respond.
   2. Announce type of emergency.
   3. Announce name of residence, if appropriate.
   4. Announce location of the emergency by address, both number and road name, including the town/village/city.
   5. Announce additional information needed to respond appropriately.

6. Repeat steps 1 – 5.
7. Announce time of Dispatch.
8. If there is no response within two (2) minutes of the initial call, repeat steps 1 – 5.
9. If there is no response within two (2) minutes (either by telephone or radio) the Dispatcher will automatically dispatch the next appropriate department(s).

B. Any acknowledgement of the page means the service is responsible for the call. This includes requesting additional pages, mutual aid, or other resources. (Dispatch should not be expected to keep track of those who have responded on the radio.)

C. Ambulance Departments will be notified as a Fire Department is dispatched in the ambulance response area. If a Fire Department is en route to an emergency, the Dispatcher will automatically notify the appropriate ambulance department.

D. Fire Departments will be notified as an Ambulance Department is dispatched to a motor vehicle accident in the fire department response area. If the fire department in that jurisdiction does not have extrication equipment they may request the closest department with the appropriate equipment also be notified/put on standby until it is known that extrication will not be necessary. If an ambulance is en route to a motor vehicle accident, the Dispatcher will automatically notify the appropriate fire department.

MUTUAL AID REQUESTS

A. AMBULANCE/EMS – A department shall request specific equipment and/or personnel when requesting mutual aid. Examples include, but are not limited to: ambulance, EMTs, extrication equipment, law enforcement, etc..

B. GROUND INTERCEPT – A department shall request the specific ambulance agency, state the basic reason for the request and specify the route of travel to the hospital when requesting a ground intercept. Communication with the intercepting ambulance will take place on a non-repeater frequency when possible and include specific information as needed.

C. MEDICAL HELICOPTER – Requests for the medical helicopter may be made by any emergency agency. Please provide:
   1. Requesting agency name.
   2. General location of the incident and/or landing zone.
   3. Type of incident
      a. Auto accident – multiple patients/with fatality/extended extrication time
      b. Amputations
      c. Severe burns
      d. Remote or difficult road access
      e. Search in conjunction with a medical emergency
   4. Radio frequency to communicate on – EMS A.
   5. It is highly recommended that a mobile radio be used for all radio communications with the helicopter.

D. In anticipation of an expanding emergency, departments may request notification of a neighboring department as follows:

   1. ALERT – No action required.
      Department notified that assistance may be needed as local resources are depleted or inoperable.
      Example: Barnes Ambulance down for the week for repairs. EMTs would be available to respond to a scene. Both Iron River and Great Divide may be

notified that the need to respond into Barnes service area to transport a patient may be requested.

Notification should be done from department to department by telephone when possible. Dispatch is to be contacted if they are expected to make any changes in established procedures.

2. STANDBY – Personnel and equipment at the hall ready to respond.

   Example: Barnes and Iron River Fire Departments are responding to a working fire with all personnel and equipment. Brule and Drummond may be requested to standby at their hall. The expectation is that personnel would be in turnout gear with trucks and equipment ready to respond.

   Notification would be paged through the communications center.

3. MOVE-UP – Department personnel and equipment are moved to a designated location.

   Example: Great Divide and Mason EMS have responded to a multi-casualty accident with all units and personnel. Barnes EMS may be requested to move-up to a location allowing coverage of both areas, perhaps near A and N. Iron River would be requested to move a unit to a location allowing coverage toward Mason, perhaps Ino. Move-up locations are designated by the requesting department.

   Notification would be paged through the communications center.

PURPOSE:

The purpose of this policy is to establish a standardized procedure to follow when an EMS response is cancelled while the ambulance/personnel are en route to a scene.

POLICY:

The ambulance service and personnel will cancel a response when notified to do so based upon the following:

- A call back from the original caller requesting cancellation of the ambulance
- Report from on-scene responders (law enforcement, fire, ems)
    - That no patient has been found
    - That no treatment is needed
- Dispatched to the wrong location and/or response area

If an EMS provider affiliated with the service renders any care to a potential patient – including a visual assessment – and a determination is made that the ambulance is not required, the responder will ensure that proper refusal of care documentation is completed. This may require that the ambulance continue to the scene non-emergent if the EMS provider on scene does not have proper documentation/paperwork.

Downgrade to a non-emergent response will be based upon a report from/advice of an on-scene responder.

PURPOSE:

The purpose of this policy is to assure the efficient response of personnel and emergency vehicles to the scene of an emergency while minimizing risk to persons and property.

POLICY:

State and local laws may exempt ambulances from regular traffic laws when the vehicle is responding to an emergency. However, neither state nor local laws absolve the driver from the responsibility of driving with due regard (Wis. Stat. 346.03 (5) and 346.19 (2)) for the safety of others on the road. The driver bears full responsibility for the safety of patient and staff as well as the public and remains fully accountable for his/her actions.

DRIVER TRAINING – Only personnel who have completed the service's driver training program and are listed by the Service Director as approved drivers, may operate service vehicles, unless a person operates the ambulance under supervision as part of the driver training program.

All emergency vehicle operators shall undergo specific training prior to driving an emergency vehicle. A formal training course, such as the Emergency Vehicle Operations Course (EVOC) or Coaching the Emergency Vehicle Operator (CEVO) shall be used whenever possible. If such a formal training course is not continually or readily available, the service may create its own in-house course based on the principles of EVOC, CEVO or other standardized emergency vehicle operator courses. Training shall include both classroom and behind the wheel education. EMS personnel shall successfully complete a final evaluation conducted by a local service official other than one who has provided the training before operating a service vehicle other than during driver training.

DRIVER BACKGROUND – All ambulance operators shall have an acceptable driving record as established by local service policy. Driving records shall be routinely and regularly checked.

SEAT BELTS – All personnel and passengers shall use the ambulance safety belt restraining systems.

All personnel in charge of a service emergency vehicle will insure that all passengers use safety belts whenever the vehicle is in motion. All personnel in the patient case area shall be seat-belted at all times unless this interferes with essential patient care.

EXITING STATION – On leaving the station the driver shall be aware of other emergency vehicles leaving at the same time. On leaving the station the driver shall gently apply the brakes to assure their operation prior to entering the street. Vehicles leaving the same location should respond using the same route when practical. Emergency vehicles shall not travel closer than 500 feet of each other and they shall utilize different audible warning devices.

WARNING DEVICES – All audible and visual warning devices shall be in operation when making an emergency response. Headlamps should be turned on whenever the ambulance is moving for added safety.

SPEED – The maximum speed of any responding vehicle shall be reasonable and prudent with consideration of the posted speed limit. The driver shall always maintain a speed consistent with safe operation of the vehicle under the prevailing conditions.

INTERSECTIONS – Intersections are the most dangerous areas to approach during an emergency response/transport. The driver shall maintain the ability to come to a complete stop until all other traffic in the intersection has yielded.

DRIVING LEFT OF CENTER – Driving in the center turning lane or left of center is extremely dangerous and shall be avoided whenever possible. If it is necessary to drive in the center turning lane or left of center, the maximum permissible speed shall be prudent and reasonable, considering the increase possibility for the need to stop suddenly.

PASSING ON THE RIGHT – Passing vehicles on the right is a potentially dangerous maneuver that shall be avoided whenever possible.