I. PURPOSE
This policy establishes the minimum qualifications for Ambulance Strike Team (AST) and Medical Task Force (MTF) Leader, herein referred to as Ambulance Strike Team Leader (ASTL) qualifications card. This policy also establishes the duties and responsibilities of an ASTL to promote consistency and competency in the management of prehospital care operations during multi-patient events.

II. INITIAL QUALIFICATIONS
A. An individual must satisfy all the following requirements prior to serving as an ASTL:
   1. Minimum of three (3) years field experience in the provision of emergency medical/prehospital care services.
   2. Must be a field supervisor for their EMS employer or employed by the EMS Agency.
   3. Valid and unrestricted paramedic license or EMT certificate.
   4. No pending disciplinary actions against accreditation, licensure, or employment.
   5. Applicants must meet the ASTL training perquisites set forth in the ASTL system manual at the time of the approved ASTL course.

III. ASTL QUALIFICATION CARD
A. Applicants for an ASTL qualification card in Contra Costa County must meet the following requirements:
   1. Successful completion of an approved Contra Costa County ASTL course or equivalent course approved by the LEMSA. For equivalent courses that have been approved by THE LEMSA, applicants will be required to attend a Contra Costa County ASTL bridge course within six months.
   2. Complete an ASTL position task book. The tasks must be critically evaluated and accurately recorded by each evaluator. The evaluator must document the applicant’s performance on the evaluation record in compliance with the ASTL system manual. The tasks and evaluations must be completed within 12 months of completion of an approved ASTL course.
   3. An ASTL qualification card is valid for five years. An applicant for renewal of an ASTL card must have performed as an ASTL for no less than two events in the past five years.

IV. DUTIES AND RESPONSIBILITIES
A. The ASTL is responsible for:
   1. Overseeing the safety and condition of the AST or MTF, personnel and equipment.
   2. Coordinating the movement of the team traveling to and returning from the incident.
   3. Communicating and reporting assignments, work progress, resources status, and situation updates with the LEMSA duty officer.
   4. Supervising the operational deployment of the team at the incident, as directed by the on-scene incident command system (ICS) Division/Group Supervisor, or other member of the incident management team.
5. Maintaining familiarity with team operations, including assembling, responding, and direction the actions of the assigned units, keeping the team accounted for at all times.

6. Contacting the appropriate incident personnel with problems encountered on the incident, including mechanical, operational, and/or logistical.

7. Ensuring vehicles have adequate communications capability.

8. Maintaining positive public relations during the incident (in coordination with the public information officer).

9. Prior to deployment, determining mission duration, special circumstances, staging area and contact information.

10. Collaborating with the incident commander to ensure, when able, patients evacuated from hospital and medical facilities are transported with necessary medical equipment, medications and medical records before leaving the scene.

11. Ensuring completion and submission of ICS documents.

12. Compliance with the AST/MTF system manual.
I. PURPOSE
This policy defines the requirements for patients with decision making capacity to decline medical care/transport. This policy is applicable to all EMS providers.

Providers should recognize these situations as high risk. When patients insist on refusing care/ambulance transport or insist on leaving the scene; careful discussion with the patient and specific documentation may improve outcomes. In addition, this policy is intended to empower providers to ensure appropriate utilization of transportation resources.

Against Medical Advice (AMA): To provide a procedure for ALS personnel to follow when an individual identified as a “patient” refuses medical treatment/ambulance transportation or when a parent(s) or legal guardian refuses medical treatment/ambulance transport for a minor identified as a patient. Only ALS personnel may complete an AMA.

Release at Scene (RAS): To provide a procedure for BLS and ALS personnel to follow when both a person with decision making capacity AND the provider feel that no further EMS treatment and/or ambulance transport is warranted. The individual must meet all criteria set forth in Section 4007.VII.

II. AMA CRITERIA AND ACTIONS
Against Medical Advice (AMA)
A. AMA applies to patients who refuse medical care or ambulance transport. Only ALS personnel may complete an AMA.

B. In order to refuse care, a patient must be legally and mentally capable of doing so by meeting the following criteria:
   1. Is an adult (> 18 years of age), or if a minor meets the criteria set forth in Section 4007.V; and
   2. Understands the nature of the medical condition or injury and the risks and consequences of refusing care;
   3. Exhibits no evidence of altered mental status, including suspected alcohol or drug ingestion that impairs one’s ability to make a sound decision regarding medical care/transport.

C. Actions:
   1. If the patient is legally and mentally capable of refusing care:
      a. Honor the patients request and complete the refusal;
      b. Document the Electronic Health Record (EHR) thoroughly; and
      c. Complete an “AMA/Release at Scene” (AMA/RAS-Form 4007) Form Section II.
   2. If the patient cannot legally refuse care or is mentally incapable of refusing care AND requires medical care/transport:
      a. Document in the EHR to reflect that the patient required immediate treatment/transport and lacked the mental capacity to understand the risks/consequences of refusal (implied consent). Assessment findings should also be documented to support a decision to treat/transport.
      b. Treat and transport only as necessary to prevent death or serious disability.
c. The law presumes that an individual is competent to consent or refuse care. The party alleging a lack of capacity has the legal burden of proving it. Document accordingly; anyone forcing treatment on an unwilling patient must be able to prove both the necessity of the treatment and the incapacity of the patient.

III. BASE HOSPITAL CONTACT

A. For patients with acute conditions that pose a threat to the life or health of the patient, every effort should be made to convince the patient to be transported. Be persuasive – get help from family members, friends, or a Base Hospital MICN/Physician.

B. Paramedics must contact the Base Hospital:
   1. For any patient determined to require involuntary treatment or transport;
   2. Whenever the refusal of care or transport poses a threat to the patient's well-being;
   3. In trauma triage when criteria is met for base contact and the patient wishes to AMA; or
   4. Any other situation in which, in the prehospital personnel's opinion, Base Hospital contact would be beneficial in resolving treatment or transport issues.
   5. When required by field treatment guideline (e.g., Syncope, BRUE, etc.).

IV. REQUIRED DOCUMENTATION FOR THE PATIENT REFUSING CARE:

A. Document thoroughly as outlined in LEMSA Administrative Policy 6001 (Documentation of the Electronic Health Record).

B. The phrase “decision making capacity” shall be documented in the EHR narrative to reflect that the patient had the mental capacity to make a sound decision when refusing care/transport. This phrase is a quality assurance marker used for auditing purposes.

C. Specific AMA documentation may include:
   1. Indications that there were no signs of impairment due to drugs, alcohol, organic causes, or mental illness that affected the patient’s ability to make a sound decision regarding medical care/transport.
   2. Anything that caused the prehospital provider to believe the patient was mentally capable.
   3. The indications that the patient understood the risks.
   4. What the patient specifically said about why he/she is refusing treatment/transport (use “quotes” as appropriate).
   5. The prehospital provider’s efforts to encourage the patient to seek care.
   6. The person(s), if any, who agreed to look after the patient.
V. MINORS
A. Minors who may consent include:
   1. A legally married minor;
   2. A minor on active duty with the U.S. military;
   3. A minor seeking prevention or treatment of pregnancy or treatment related to sexual assault;
   4. A minor seeking treatment of contact with an infectious, contagious or communicable disease or sexually transmitted disease;
   5. A self-sufficient minor of at least 15 years of age, living apart from parents and managing his/her own financial affairs;
   6. An emancipated minor (must provide proof); or
   7. The parent of a minor child or a legal representative of the patient (of any age)
B. If the parent/guardian or conservator is not at the scene, consent/refusal of care may be obtained over the telephone. Document exactly as if the parent/guardian or conservator was present on scene. Verify the name and relationship of the individual to the patient. Attempt to have another person validate the consent/refusal with the parent/guardian or conservator. Document exactly what was said (use “quotes” as appropriate).
   1. Do not release the child to the custody of a relative or friend unless the individual has been authorized by the parent/guardian or conservator to make medical decisions for the child.
C. If the patient is 18 years of age or older, but there is a reason to suspect that the patient has been judged incompetent by a court and placed under a legal conservatorship, seek consent from the designated guardian.
D. If the parent/guardian or conservator is unavailable and treatment can be safely delayed:
   1. Document thoroughly.
   2. Attempt to reach the parent/guardian or conservator by telephone. Do not release the child to the custody of a relative or friend unless the individual has been authorized by the parent/guardian or conservator to make medical decisions for the child.
E. If the parent/guardian or conservator is unavailable and treatment cannot be safely delayed:
   1. Treat and transport as necessary to prevent death or serious disability (implied consent).
F. If the parent/guardian or conservator is available but refuses to consent for necessary, emergency treatment:
   1. Explain the risks of refusal;
   2. Be persuasive – get help from family members, friends, or a Base Hospital MICN/Physician.
   3. Involve law enforcement.

VI. ARREST AND 5150
An individual under arrest, incarcerated, or on a 5150 is legally capable of consenting or refusing medical care.

VII. RELEASE AT SCENE (RAS)
A. Release at scene applies to all individuals. Both BLS AND ALS personnel may complete a RAS.
   1. The individual must meet ALL of the following criteria:
a. Exhibits no evidence of altered mental status, including suspected alcohol or drug ingestion that impairs one’s ability to make a sound decision regarding medical care/transport;

b. Does not have a complaint suggestive of potential illness or injury that indicates a need for EMS treatment/transport;

c. Does not have obvious evidence of illness or injury that indicates a need for EMS treatment/transport;

d. Has not experienced an acute event that could reasonably lead to illness or injury; and

e. Is not in a circumstance or situation that could reasonably lead to illness or injury that indicates a need for EMS treatment/transport.

B. Actions:
1. Complete the release;
   a. Enter the individual’s name on the “AMA/Release at Scene” (AMA/RAS-Form 4007) Form Section I and obtain a signature; and

2. Complete a narrative detailing the circumstances of the RAS.

3. In an event where multiple people sign a “Multi-Person/Pt. Release at Scene” (RAS-Log 4007) Log, complete one narrative detailing the circumstances of that event (*not one for each individual*).
I. PURPOSE
This policy establishes standards for transfer of patient care for 9-1-1 ambulance personnel to Emergency Department (ED) staff in Contra Costa County. These standards are essential to public safety.

II. POLICY
Hospitals designated as an EMS receiving hospital in Contra Costa County shall be prepared to receive patients transported by 9-1-1 ambulance providers and accept these patients upon arrival. The patient transfer process performance expectations for the EMS System is twenty (20) minutes or less 90% of the time.

III. EMS AMBULANCE PROVIDER RESPONSIBILITIES
A. Prehospital personnel will notify ED staff of their estimated time of arrival as soon as practical, once patient destination has been established.

B. Prehospital personnel shall provide continuity in their treatments upon arrival at the hospital, which typically may involve oxygen, IV fluids and nebulizer treatments, which have been started prior to patient arrival in the ED.

C. During periods of unusual level of demand, prehospital personnel may provide the stable patient with information on hospital delays to assist the patient in their choice of destination.

D. Prehospital personnel will promptly notify ED supervisory staff of ambulance parking, stacking conditions and “Never Events” when they occur. Ambulance supervisory personnel will assist with the resolution of parking and stacking issues and follow up with the Contra Costa County EMS Agency (LEMSA) and hospital.

E. Notification of the need to release ambulance resources shall be communicated by the ambulance supervisor using the following chain of command:
   1. ED charge nurse and physician in charge
   2. Hospital House Nursing Supervisor

F. “Never Events” must be reported as an EMS Event.

IV. RECEIVING HOSPITAL RESPONSIBILITIES
A. The hospital responsibility for the care of a patient begins when the patient or ambulance arrives on hospital grounds and requires an initial assessment and triage of the patient without delay. *

B. Hospital staff shall provide ongoing care beyond oxygen and IV fluids once the patient has arrived in the ED.

C. ED staff will work with ambulance personnel to ensure optimal patient care handoff and resolve any instances or delayed patient care handoff.

D. During periods of unusual level of demand, hospitals shall activate internal protocols for ED saturation using the hospital incident command system.

E. Predictable seasonal high utilization periods are considered normal EMS System operations that should be included in hospital planning and are not considered unusual level of demand episodes.
F. Hospital staff will work with LEMSA staff to ensure internal policies and procedures are in place to prioritize patients arriving by EMS ambulance and effectively manage ambulance parking and stacking issues. Examples include:
   1. Rapid response teams to support ED patient care flow.
   2. Communication protocols with appropriate personnel to support rapid patient transfer of care decisions (e.g., Hospital Nurse Supervisor, Hospital Administrator on call, the EMS Duty Officer, etc.)

V. EMS AGENCY RESPONSIBILITIES
   A. Provide hospitals and ED leadership with reliable patient handoff performance reports.
   B. Post countywide EMS-hospital offload reports including “Never Events” on the LEMSA website at appropriate intervals.
   C. All “Never Events” will be referred to the hospital patient safety manager and will be subject to appropriate action upon review.

*Emergency Medical Treatment and Labor Act (EMTALA)*
I. PURPOSE
A. To establish a system of patient safety and EMS response-related reporting requirements for the purposes of review, data analysis, patient safety and EMS system performance;
B. To define reporting requirements for events which may have the potential to cause community concern or represent a threat to public health and safety;
C. To define the reporting and monitoring responsibilities of all EMS system participants; and
D. To recognize exemplary prehospital care in the EMS system.

II. REPORTING RESPONSIBILITY
A. The reporting requirements established by this policy apply to prehospital care providers, EMS service providers, and hospitals.
B. Providers shall directly report to the Contra Costa EMS Agency (LEMSA) any event that is “required to be reported” by this policy.

III. IMMEDIATE POLICY REPORTING REQUIREMENTS
The following EMS events shall be reported immediately to the LEMSA by telephone to the EMS Duty Officer at (925) 570-9708. The telephone report shall be followed by the submission of a written EMS event report:
A. Any event that has resulted in or has the potential to lead to an adverse patient outcome;
B. Any deviation from a LEMSA policy or protocol that resulted in patient harm or a threat to public safety;
C. Medication, treatment or clinical errors that resulted in patient harm;
D. Equipment failure or malfunction that resulted in patient harm;
E. Technology or communications systems errors or malfunctions that resulted in patient harm;
F. The on-duty death of any prehospital personnel;
G. The on-duty arrest of any prehospital personnel either working in Contra Costa County or certified or accredited through the LEMSA; or
H. The collision of any ambulance or EMS response vehicle that results in injury.

IV. URGENT POLICY REPORTING REQUIREMENTS
A. The following EMS events shall be reported to the LEMSA within twenty-four (24) hours:
   1. Any unusual event/occurrence (e.g., MCI, abnormal patient condition, Base Hospital communication failure);
   2. Any deviation from LEMSA policy or treatment guideline that had the potential to result in patient harm;
   3. Medication, treatment or clinical errors that had the potential to result in patient harm;
   4. Equipment failure or malfunction that had the potential to result in patient harm;
5. Any event or circumstance that is or shall be reported to another regulatory or enforcement agency, including but not limited to any law enforcement agency, the California Emergency Medical Services Authority (EMSA), California Occupational Health and Safety Administration (Cal-OSHA), the State or County Department of Public Health (CDPH), or the Centers for Disease Control and Prevention;

6. Whenever the operator of an interfacility basic life support (BLS) or critical care transport (CCT) ambulance operates with lights and siren whether responding to or from a location in Contra Costa County or upgrades mode of transport to lights and siren;

7. Knowledge of or the commission of any event or circumstance that represents a threat to public health and safety as defined by Health and Safety Code Section 1798.200(c)(1) through 11:
   a. Fraud in the procurement of any certificate or license under this division;
   b. Gross negligence;
   c. Repeated negligent acts;
   d. Incompetence;
   e. The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of prehospital personnel;
   f. Conviction of any crime which is substantially related to the qualifications, functions, and duties of prehospital personnel;
   g. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel;
   h. Violating or attempting to violate any federal or state statute or regulation that regulates narcotics, dangerous drugs, or controlled substances;
   i. Addiction to, the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances;
   j. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification;
   k. Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired;
   l. Unprofessional conduct exhibited by any of the following:
      i. The mistreatment or physical abuse of any patient resulting from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties would use if confronted with a similar circumstance. Nothing in this section shall be deemed to prohibit an EMT or paramedic from assisting a peace officer, or a peace officer who is acting in the dual capacity of peace officer and EMT or paramedic, from using that force that is reasonably necessary to affect a lawful arrest or detention.
ii. The failure to maintain confidentiality of patient medical information, except as disclosure is otherwise permitted or required by law in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

iii. The commission of any sexually related offense specified under Section 290 of the Penal Code.

V. GENERAL POLICY REPORTING REQUIREMENT
Timely reporting of the following types of events is strongly encouraged:
A. Great Catches: Events that are recognized and prevented before they actually occur. A “great catch” includes recognition of provider action that contributes to the prevention of negative or adverse patient outcomes. Near miss events are included in this category.
B. Community events that may cause public concern, either positive or negative (e.g., bomb threats, multi casualty incidents and EMS system operational issues).
C. Exemplary care in the field deserving of recognition and/or commendation.
D. Any event in which the provider agency determines a case review would be beneficial (e.g., educational component; unusual/abnormal component).

VI. PARAMEDIC REPORTING REQUIREMENTS
A. The employer or supervisor of a paramedic shall report the commission of any event or circumstance described in Section IV(A)(7)(a) through (l) herein, involving a paramedic to EMSA within 72 hours of the discovery of such circumstance or event. The report shall be made to EMSA on the Paramedic Complaint Investigation Request form no later than the following business day and shall include any applicable supporting documents (e.g., internal investigation report, witness statements, EHR).
B. The employer or supervisor of a paramedic who makes a report to EMSA under this section must provide the LEMSA with a copy of the completed paramedic investigation request form and supporting documents and attachments no later than the following business day.