SUBJECT: DECLINING EMERGENCY MEDICAL CARE AND/OR TRANSPORT

I. PURPOSE

To provide guidance to prehospital personnel in situations where the patient, or their legal representative, declines medical care or transport when care is recommended and felt to be necessary by the prehospital personnel attending that patient. All qualified persons are permitted to make decisions affecting their care, including the ability to decline care.

II. DEFINITIONS

A. Patient: Any person encountered by EMS personnel who demonstrates any known or suspected illness or injury OR who requests care or evaluation shall be considered a patient.

B. Competency: The ability to understand and to demonstrate an understanding of the nature of the illness/injury and the consequence of declining medical care.

C. Qualified Person: A competent person making a decision for him/herself or another who is qualified by one of the following:

1. An adult patient, defined as a person who is at least 18 years old;
2. A minor (under 18 years old) who qualifies based on one of the following conditions:
   ♦ A legally married minor;
   ♦ a minor on active duty with the armed forces;
   ♦ a minor seeking prevention or treatment of pregnancy or treatment related to sexual assault;
   ♦ a minor 12 years of age or older, seeking treatment of contact with an infectious, contagious or communicable disease or sexually transmitted disease;
   ♦ a self-sufficient minor at least 15 years of age, living apart from parents and managing his/her own financial affairs;
   ♦ an emancipated minor (must show proof); OR,
3. The parent of a minor child or a legal representative of the patient (of any age). Spouses or relatives cannot consent to, or decline care for the patient unless they are legally designated representatives.

III. PATIENT EVALUATION

A. All potential patients at the scene of an EMS system call must be offered medical care/transport.
B. Patients should be evaluated as much as capable and allowed.
C. Qualified persons as defined above have the legal right to decline EMS care or transportation.
D. Qualified persons may limit the scope of their consent (e.g. may consent to transportation but not treatment, or consent only to certain treatments).
E. Every reasonable attempt should be made to convince a patient or legal representative of the need for further medical evaluation and treatment, and should be informed clearly of the risks and consequences of declining care. Resources to aid in the effort include family members and friends, law enforcement, and base hospital personnel.
F. Prehospital personnel should not put themselves in danger by attempting to treat or transport patients who do not meet qualifications to decline care (not competent to decline care or not qualified to decline). Assistance from support agencies in appropriate circumstances should be utilized.

IV. BASE CONTACT REQUIREMENTS

A. Base contact is required:
   • If ALS care is initiated and then the patient declines further treatment or transport;
   • When, in the field personnel’s opinion, the patient’s decision to decline care poses a threat to his/her well-being;
   • If the patient’s competency status is unclear (neither competent nor clearly incompetent) and involuntary treatment or transport is deemed appropriate.
B. Patients in law enforcement custody or under 5150 hold do not require consent for transportation. Base contact is not required in these circumstances. Consent for treatment is not affected by custody or 5150 status.

V. DOCUMENTATION

A. It is essential to carefully document instances in which care is declined.
B. Items required for documentation include:
   • History and physical examination findings to the extent available;
   • Statement that the patient was alert and oriented to person, place, time and situation;
   • Statement that the patient appeared competent to decline care and did not show evidence of significant impairment due to drugs, alcohol, organic (medical) causes, or mental illness;
• Statement that the patient was provided information about the nature of the medical condition, and planned treatment/transportation that was offered;
• Statement that the patient was provided specific risks and consequences of refusing care and that s/he acknowledged or verbalized understanding of those risks and consequences;
• Specific comments the patient made concerning refusal of care (use quote marks as appropriate);
• Whether base contact was made and the name of the base physician involved;
• Advisory to the patient to call 911 or seek further medical care if s/he should change their mind;
• Disposition—whether the patient was released in care of self, in custody of law enforcement, in care or custody of parent or guardian, or other person;
• Signature of the patient, parent, or legal representative, or documentation of refusal to sign;
• Name and signature of witness if available;
• Name of interpreter if used.
• Any other statements that are felt appropriate to document the situation or events.

C. Use of a standardized form (example provided on the following page) that includes many of the above elements can aid in documentation.

(DRAFT OF STANDARDIZED FORM TO BE DEVELOPED)
SUBJECT: DRAFT - EMS SYSTEM MEDICAL DIRECTION AND OVERSIGHT

APPROVED BY: Art Lathrop, EMS Director, and Joseph A. Barger, M.D., EMS Medical Director

I. PURPOSE
Emergency medical services rendered by Contra Costa County EMS system provider agencies are accomplished under the medical direction of the EMS Medical Director. This policy defines the scope of medical direction and oversight provided in the EMS system.

II. SCOPE OF DIRECTION AND OVERSIGHT
Medical direction applies to all events involving emergency medical care for patients from the outset of 911 system activation to the delivery of patients to receiving facilities. Dispatch, first response, transport provider care, and base hospital direction fall under the direction of the EMS Medical Director or his/her designee. In addition to emergency responses, medical direction also applies to paramedic (and in some situations to EMT-I) interfacility transports.

Medical direction is provided prospectively through written policies and procedures, approved by the EMS Medical Director, and immediately through on-line communications with the base hospital. Oversight is also provided retrospectively through quality improvement activities and continuing education of providers.

Medical direction also includes oversight of EMS personnel credentialed by the county. These include EMT-I’s, paramedics, and base station MICN’s.

III. PROSPECTIVE, IMMEDIATE, AND RETROSPECTIVE MEDICAL DIRECTION AND OVERSIGHT
Below is a listing of examples that describe individual facets of prospective, immediate, and retrospective medical direction and oversight. This list is not all-inclusive.

Prospective medical direction and oversight:
- Credentialing of EMT-I, paramedic and MICN personnel;
- Designation of continuing education and prehospital training program providers;
- Designation of base hospitals and trauma center;
- Review and approval of medical dispatch protocols, including pre-arrival and post-dispatch instructions;
- Provision of the Prehospital Care Manual, which guides EMT-I’s, paramedics, and MICN’s in the care provided in the field;
- Continuing education activities;
- Provision of the Multicasualty and Multi-Victim Incident Plans;
- EMS Agency policies.
Immediate (concurrent) medical direction and oversight:
- Provision of guidance by MICN's following treatment guidelines from the Prehospital Care Manual;
- Provision of guidance by base hospital physicians (including situations defined in the Prehospital Care Manual);
- Provision of guidance by base MICN’s and physicians concerning interfacility transfers with regard to scope issues for EMT-I and paramedic personnel.

Retrospective medical direction and oversight:
- Quality assurance and improvement activities, coordinated at the EMS Agency level;
- Specific incident review and action by base station and EMS Agency personnel;
- Continuing education prompted by QI data review.

IV. INPUT AND MODIFICATION OF MEDICAL DIRECTION

System participants, including provider agencies and personnel, participate in regular meetings of the Medical Advisory Committee (MAC). This committee is open to the public for input. Requests for changes in treatment guidelines or policy and procedure changes that impact medical care are discussed and recommendations are made. The recommendations of MAC are advisory to the EMS Medical Director and the EMS Director. Formal requests for changes are to be made in writing to the EMS Medical Director.

Proposals for utilization of paramedic personnel in settings other than 911 ground response (e.g. bicycle-based units, aircraft-based paramedics) must be submitted to the EMS Medical Director and EMS Director for review and authorization. Any approval must include policies and procedures that maintain prospective, immediate, and retrospective medical direction and oversight of paramedic personnel.
4 ALS Procedures

**Oral Endotracheal Intubation**

In adults, oral endotracheal intubation is the optimal method of advanced airway control. Intubation allows for protection of the airway and decreases the chance of aspiration.

In pediatric patients, BLS maneuvers are the preferred method for initial airway management and are frequently sufficient to maintain the airway. If BLS maneuvers appear ineffective or are unable to be maintained, intubation should be considered. Gastric distention is common with use of BLS maneuvers, but aspiration frequency is similar in intubated and non-intubated patients. The elder (demand) valve is not to be used when ventilating pediatric patients. Because training and experience with pediatric intubation is variable, only paramedics who have completed the Contra Costa County advanced airway certification requirements may perform this skill.

Nasotracheal intubation is not an approved skill in Contra Costa County.

No more than three attempts at endotracheal intubation should be done. Unsuccessful intubations should be managed either with an EDTLA (Combitube) or via BLS maneuvers.

Base hospital physician consultation is recommended if there is any question concerning the need to intubate a patient. The Base Hospital physician may also approve extubation of a patient in the field (aside from extubation for meconium aspiration of newborns).

**Indications**

- Patient in cardiopulmonary or respiratory arrest
- Patient with severe respiratory distress (adults)
- Patient with a respiratory rate of 6 or less, or with ineffective respiratory effort

**Contraindications**

- Isolated medical respiratory arrest with suspected hypoglycemia or narcotic overdose
- Maxillo-facial trauma with unrecognizable facial landmarks
- Patients experiencing seizures
- Patients with an active gag reflex

**Equipment**

- OPA: sizes 000-6
- Laryngoscope handle
- Laryngoscope blades: 2 each
  - #2, 3, 4 MacIntosh blade
  - #0, 1, 2, 3, 4 Miller blade
- 1" Waterproof Tape/Tube Holder
- Esophageal intubation detection bulb
- Water Soluble Lubricant
- Magill Forceps (pedi/adult)
- ET Tubes: 3 each, sizes 2.5-9.0
- Extra Batteries
- Extra Bulbs
- Bag-Valve-Mask
- 12 cc Syringe
- Stylets (pedi/adult)
- Suction
- Stethoscope
**Procedure**

1) Assure an adequate BLS airway.

2) Hyperventilate with 100% oxygen using a bag-valve-mask or demand valve.

3) Select appropriate ET tube. If appropriate tube has a cuff, check cuff to ensure that it does not leak; note the amount of air needed to inflate. Deflate tube cuff. Leave syringe attached.
   
   a) Insert appropriate stylet, making sure that it is recessed at least one cm. from the distal opening of the ET tube. Lubricate the tip of the tube.

4) Assure c-spine immobilization with suspected trauma.

5) Insert laryngoscope and visualize the vocal cords.

6) Suction if necessary and remove any loose or obstructing foreign bodies.

7) CAREFULLY pass the endotracheal tube tip past the vocal cords; remove the stylet; advance the ET tube until the cuff is just beyond the vocal cords; then inflate the cuff with 5-7cc of air. In uncuffed pediatric tubes, advance tube no more than 2.5 cm beyond vocal cords (use vocal cord marker line if present on tube);
   
   a) Attach the compressed esophageal intubation detector bulb to the end of the ET tube and release the bulb. If the bulb does not fully re-inflate, extubate the patient and repeat steps 2 through 7.
   
   b) If the patient is not in cardiac arrest, attach end-tidal CO₂ detection device to the ET tube. Observe for presence or absence of color change in device after several ventilations. If there is no color change, extubate and repeat steps 2 - 7.
   
   c) Auscultate the chest for air entry on the right and left sides equally. Look for symmetric chest wall rise.

8) Immediately assess tube placement with colorimetric end-tidal CO₂ indicator:
   
   a) If the end-tidal CO₂ indicator indicates exhaled carbon dioxide (changes from purple to yellow color), the tube should be secured.

   b) If the end-tidal CO₂ indicator does not change color (remains purple), no carbon dioxide is being exhaled.

   C In a patient with pulses, no color change indicates incorrect endotracheal tube placement (esophageal). The tube should be removed and reintubation attempted.

   C In a patient without pulses, this may represent correct placement but requires further confirmation with esophageal detector bulb.
        
        < If the esophageal detector bulb rapidly inflates, this indicates tracheal placement, and the tube should be secured.
        
        < If the esophageal detector bulb inflates slowly or there is no air return, the patient should have the tube removed and reintubation should be attempted.

9) Following successful confirmation of intubation, auscultation of lungs, epigastrium, and observation of chest rise should be done. If chest does not rise, extubate and reintubate.

10) Secure the tube with tape or ET holder and ventilate. Mark the TUBE at the level of the lips.

11) Continued monitoring includes both physical exam findings and use of a colorimetric end-tidal CO₂ indicator or capnometer. Reassessment should occur after any patient movement, and should include esophageal detector bulb in pulseless patients who are not exhaling carbon dioxide.

If the chest DOES NOT RISE, extubate and repeat steps 2-7.

—— 8) Auscultate the left upper quadrant of the abdomen. If air entry is heard, extubate and repeat steps 2 -7.

—— 9) Secure the tube with tape or ET holder and ventilate. Mark the TUBE at the level of the lips.

—— 10) Re-auscultate the lung fields and the left upper quadrant to assure correct placement of the tube.

—— 11) Continue to monitor the patient for proper tube placement throughout prehospital treatment and transport. ET tube placement is to be reassessed with the esophageal intubation detector bulb after any patient movement.

—— 12) Document time of intubation, landmarks used to verify tube placement, and times and results of
tube placement checks performed throughout the resuscitation and transport.

! If there is continued slow air return with the esophageal indicator bulb on the second attempt, the vocal chords and tube placement should be assessed by direct visualization. False results can occasionally occur when patients have CHF or obesity (the bulb will not inflate despite being in the trachea).

! Positive end-tidal CO2 readings (color change from purple to yellow) can occasionally occur with a tube that is dislodged with the tip of the tube is lying just above the vocal cords. Capnometers will show a different waveform in these instances, but a colorimetric device will not. Consistent observation of the patient's perfusion, vital signs, and chest rise, along with monitoring of the end-tidal CO2 indicator or capnometer is essential.

STOMAL INTUBATION

For patients with existing tracheostomy without tube (mature stoma):

1) Assure an adequate BLS airway.
2) Hyperventilate with 100% oxygen using a bag-valve-mask. Do not use demand valve.
3) Select the largest endotracheal tube that will fit through the stoma without force (it should not be necessary to lubricate the tube).
4) Check cuff, if applicable.
5) Do not use a stylet.
6) Pass endotracheal tube until the cuff is just past the stoma. Right mainstem bronchus intubation may occur if the tube is placed further since the distance from tracheostomy to carina is less than 10 cm. The tube will protrude from the neck by several inches.
7) Inflate the cuff
8) If the patient is not in cardiac arrest, attach end-tidal CO2 detection device to the ET tube. Observe for presence or absence of color change in device after several ventilations. If there is no color change, extubate and repeat steps 2-7.
8) Immediately assess tube placement with colorimetric end-tidal CO2 indicator:
   a) If the end-tidal CO2 indicator indicates exhaled carbon dioxide (changes from purple to yellow color), the tube should be secured.
   b) If the end-tidal CO2 indicator does not change color (remains purple), no carbon dioxide is being exhaled.
      C In a patient with pulses, no color change indicates incorrect endotracheal tube placement (esophageal). The tube should be removed and reintubation attempted.
      C In a patient without pulses, this may represent correct placement but requires further confirmation with esophageal detector bulb.
         < If the esophageal detector bulb rapidly inflates, this indicates tracheal placement, and the tube should be secured.
         < If the esophageal detector bulb inflates slowly or there is no air return, the patient should have the tube removed and reintubation should be attempted.
9) Auscultate the chest for air entry on the right and left sides equally. Look for symmetric chest wall rise. Check neck for subcutaneous emphysema, which indicates false passage of tube. If the chest DOES NOT RISE, extubate and repeat steps 2-7.
10) Secure the tube with tape and ventilate.

Note: Do not attempt to reinsert a dislodged pre-existing tracheostomy tube