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Division: Emergency Medical	
Chapter: Emergency Medical Service Operations	
By Order of the County Fire Chief: Tiffany D. Green	**Prior Revision:** December 3, 2020

POLICY

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

DEFINITIONS

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

CRT-I – A Maryland intermediate advanced life support (ALS) Clinician.

Direct to Triage Protocol (DTT) – A state-approved protocol where priority three patients meeting specific criteria may proceed directly to the receiving facility's waiting room.

Emergency Medical Service Crew – Personnel that are certified/licensed by MIEMSS to administer patient care as an Emergency Medical Services Clinician.

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

EMS Operational Program Manager – Appointed by the Fire Chief to manage the Emergency Medical Services system within Prince George's County. The appointee is typically an Assistant Fire Chief or Civilian Manager and serves in the role of EMS Commander.

Hospital Bed Delay – The period exceeding the established patient off-load interval of 20 minutes.

Priority 1 – A person that is critically ill or injured, requiring immediate attention, an unstable patient with life-threatening injury or illness. As outlined in the Maryland Medical Protocols for EMS.

Priority 2 – A person with a less serious condition, yet potentially life-threatening injury or illness, requiring emergency medical attention, but not immediately endangering the patient's life. As outlined in the Maryland Medical Protocols for EMS.

Priority 3 – A person with a non-emergent condition, requiring medical attention, but not on an emergency basis. As outlined in the Maryland Medical Protocols for EMS.

Priority 4 – A person that does not require medical attention. As outlined in the Maryland Medical Protocols for EMS.

SCOPE

This General Order is intended for all Prince George's County-affiliated EMS Clinicians through MIEMSS (e.g., 1600XX).

PROCEDURES / RESPONSIBILITIES

I. General Provisions

A. The goal of all Fire/EMS Department Emergency Medical Service Clinicians is to provide the best possible pre-hospital medical care to any person that requires it by expressed or implied request. All care provided will always be in the best interest of the patient.

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

II. Phase 1 - Preparedness

A. Staffing

1. An emergency medical service unit has a minimum staffing of two (2) EMS Clinicians.
2. Basic Life Support:
   a) The primary EMS Clinician attending to a patient must be a County credentialed BLS Clinician as approved by the Jurisdictional Medical Director and maintain affiliation with Prince George's County Fire/EMS Department or any of its volunteer organizations.
   b) The driver on the unit must be currently County credentialed as an Emergency Medical Responder or a higher certification/license.
   c) Any support Clinicians must be County credentialed as an EMT or be a student of

an approved BLS training program.

3. Advanced Life Support:
   a) The primary EMS Clinician attending to a patient must be a County credentialed ALS Clinician as approved by the Jurisdictional Medical Director and maintain affiliation with Prince George's County Fire/EMS Department or any of its volunteer organizations.
   b) The driver must be County credentialed as an EMT, preferably with the ALS Assist Program training, be a student of an approved ALS training program, or maintain an ALS certification/license.
   c) Any support Clinicians must be County credentialed as an EMT or be a student of an approved ALS or BLS training program.
4. Any Operational Clinicians Must:
   a) Maintain all current EMS Clinician certifications or licenses:
      (1) MIEMSS continuing education.
      (2) American Heart Association (AHA) cardiopulmonary resuscitation (CPR) training for healthcare providers or equivalent (American Safety and Health Institute).
      (3) Automated external defibrillator (AED) training.
   b) Stay current with requirements to maintain their affiliation with the Prince George's County EMS Operational Program.
5. EMS students may participate only if they are current volunteer members or are enrolled in an approved emergency medical training program.
6. Observers are subject to the requirements of General Order 13-02, *Ride-Along Observer Program*.

B. Equipment

1. Supervisors are responsible for ensuring operational readiness of the vehicle and all equipment is present and accounted for by crews at the beginning of each "tour of duty." Equipment requirements are described in General Order 05-06, *EMS Equipment Standardization*.
   a) If any equipment is missing, the crew member must notify the immediate supervisor, complete a Loss Damage Report, and contact an EMS Duty Officer (EMSDO) for replacement.

C. Vehicle
1. Supervisors are responsible for ensuring that the vehicle and all of its systems are functional and properly maintained at all times by crews at the beginning of each "tour of duty."

III. Phase 2 – System Access

A. System access is managed by Prince George's County Public Safety Communications (PSC) using an Enhanced 911 System.

IV. Phase 3 – Prioritization

A. PSC uses a Medical Priority Dispatch System (MPDS). This uses a nationally recognized model to query 911 callers for the most appropriate information necessary to make proper resource assignments and provide pre-arrival instructions.

B. Three (3) factors in combination create the determinant code identified by the MPDS system. The following three factors are identified by the MPDS system:
   1. Chief Complaint
   2. Severity of Complaint
   3. Incident Description

C. The resulting determinant code will be formatted as outlined in General Order 05-20, *EMS Performance Measurement – Disposition Codes*.

D. This information is used by EMS Clinicians to understand the nature of the incident they are responding to.

V. Phase 4 – Response Configuration

A. EMS resources are assigned to each MPDS determinant by the EMS Operational Program Manager or designee, Jurisdictional Medical Director, and PSC. The goal of these resource assignments is to maximize system effectiveness and efficiency.

B. EMS Clinicians concerns or comments regarding response configurations should be referred to the EMS Operational Program Manager through the chain-of-command.

VI. Phase 5 – Response Deployment

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

VII. Phase 6 – Pre-Arrival Considerations

A. EMS units must consider all of the following when responding to and approaching the scene of an incident:
   1. Safety – EMS Clinician and patient safety are of paramount importance. This must be considered prior to any action.
   2. Situation – Use all information available to formulate a plan of action prior to arrival. Contingency plans must also be considered.
   3. Staging – Consider staging at a safe distance for any reports of violence and query law enforcement officials for clearance to approach the scene.

4. Staging Location – An Officer or senior EMS provider will identify a staging location. The staging location will be at or within one (1) mile of the incident unless it is determined to be unsafe by the unit officer. Staging in the station will only occur if the incident at or within a one (1) mile radius of the station.
5. Standard Precautions – Comply with all components of infection control practices and standard precautions.
6. Size – Determine the number of patients. Initiate multiple casualty (triage) procedures, if necessary.
7. Staffing – Request additional resources, if necessary. EMS Clinicians must anticipate the evolution of an incident to determine resource needs.
8. System – Consider establishing the Incident Command System for escalating incidents or coordinating multiple resources.

VIII. Phase 7 – On Scene Care

A. When an EMS unit arrives on scene or to staging, the following notification is made:
   1. Select "STS" on radio.
   2. Select "ON SCENE."

B. Patient/EMS Clinician Relationship
   1. EMS Clinicians must determine which persons they encounter are indeed patients and give anyone they encounter the opportunity to obtain emergency medical care. Clinicians must always consider these factors:
      a) EMS Clinician Safety – A patient/EMS Clinician relationship cannot exist if there is a threat to the Clinician.
      b) Request for Care
         (1) Expressed
         (2) Implied
      c) Legal Mandates
         (1) Legal Capacity – When a person is a non-emancipated minor, unconscious, intoxicated/impaired, or their judgment or ability to respond is compromised, the concept of implied consent applies.
         (2) Mental Capacity – Patients that are oriented to person, place, and time cannot be forced to accept treatment or transportation.
         (3) Patient must be fully informed of treatment options and understand the situation and anticipated risks of non-treatment.

C. Patient Refusals
   1. Patients may refuse medical care and treatment only after informed of the foreseeable risks associated with that decision. Patients must be awake, alert, and capable to understand the risks associated with making an informed refusal of care.
   2. Those patients that refuse medical care and treatment after requesting services from the Fire/EMS Department must have a completed physical exam and vital signs documented in an electronic patient care report (ePCR).
   3. The patient or patient's legal guardian must sign the pertinent section of the Patient Refusal documentation.

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

D. Patient Care
1. EMS Clinicians shall perform treatment of injuries and conditions consistent with their level of certification. The "standard of care" is described in the current edition of the Maryland Medical Protocols for EMS.

E. ALS/BLS Interface
1. The EMS system functions using both BLS and ALS units to provide care and transportation of patients. The interface between these levels of EMS Clinicians is critical to delivering the best possible care.
2. In all cases, these EMS Clinicians must collaborate professionally to ensure the best possible care is provided to the patient.
3. EMS Clinicians must consider the need for ALS resources once they have completed their initial assessment and completed a set of vital signs.

IX. Phase 8 – Disposition

A. Patient Transportation Destination
1. EMS Clinicians shall base transportation destination decisions on the following factors:
   a) First Factor – Patient's Clinical Needs – as described by Maryland Medical Protocols for EMS
      (1) Patient priority
      (2) Capability of local healthcare facilities
      (3) Referral to specialty center
   b) Second Factor – System Requirements
      (1) Facility diversion status
      (2) Anticipated time to return to service
         (a) Anticipated transport time
         (b) Anticipated patient transfer time
         (c) Number of EMS units currently waiting
         (d) Number of transports to a facility within the previous hour
      (3) Approved special transport policies
   c) Third Factor – Patient's Medical Request
      (1) Continued care at specific facility
      (2) Physician relationship
      (3) Personal preference
   d) Fourth Factor – As Directed by EMS Supervisor
      (1) Proximity to the station
      (2) Equipment replenishment
      (3) Other considerations
   e) There are no geographic restrictions for patient transportation as long as these factors are considered.

B. Hospital Diversion
   1. Hospitals have the ability to go on diversion status whenever the facility/staff does not have the capability to adequately care for any additional patients. Patients should be transported in accordance with General Order 05-09, *Hospital Diversion*.

X. Phase 9 – Notification and Consultation

A. When any patient is transported from a scene by an EMS unit, the following notifications must be made at the time when transport is initiated:
   1. PSC – via voice on appropriate talk group:
      a) Patient Information
         (1) Priority(s)
         (2) Trauma Decision Tree Category (trauma center transports only)
      b) Medical Facility Destination
      c) Estimated Time of Arrival
      d) Starting Mileage (Optional)
   2. Receiving Facility:
      a) Patient information should be conveyed to the receiving facility for all Priority 1 and 2 patients through EMRC on the appropriate talk group.
      b) For notifications only, the receiving facility does not need to provide a base station trained Clinician.

B. Medical Consultation
   1. Medical consultation must be obtained from an approved base station Clinician in accordance with the Maryland Medical Protocols for EMS.

XI. Phase 10 – Transportation

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

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

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

D. Priority 4 patients generally do not require transportation.

XII. Phase 11 – Transfer of Care

A. When an EMS unit arrives at the destination medical facility, the following notifications will be made:
   1. Select "STS" on radio.
   2. Select "TRNSPRT CMPLT."
   3. Ending mileage (optional).

B. All emergency warning devices and the vehicle engine are to be turned off and the ignition keys removed while the vehicle is unattended. All equipment and supplies should be secured within the unit.

C. The hospital's responsibility for patient care begins when the patient or transport unit arrives on hospital grounds and requires an initial assessment and triage of the patient by hospital Emergency Department (ED) personnel without delay. The ED personnel should off-load the patient to a hospital bed or other suitable sitting or reclining device at the earliest possible time, not to exceed 20 minutes after arrival at the ED. The ED staff will work with Clinicians to ensure optimal patient transfer of care and resolve any instances of delay past the time standard.
   1. The patient is the responsibility of the hospital upon arrival of the patient on the hospital's property, as defined in 42 CFR § 489.24(b). At such point in time, the patient has become a hospital patient.
   2. Patient information should be conveyed to the receiving facility for all Priority 1 and 2 patients transports through EMRC on the appropriate talk group.

D. EMS Clinician Responsibilities
   1. Clinicians shall continue to maintain patient care until the patient is transferred to a designated area in the receiving hospital ED.
   2. In all cases, prior to departure, the EMS crew shall provide a verbal report, and Maryland Institute of Emergency Medical Services Systems (MIEMSS) approved "short form" or completed Maryland Electronic Patient Care Report (ePCR) to a representative of the facility summarizing the condition of the hospital patient, the location in the facility of where the hospital patient is being left, any treatments and/or interventions provided prior to departure. In the discretion of the EMS crew, this verbal or preliminary written report can be given to any hospital representative, whether in a clinical or ED administrative capacity.
   3. EMS crew members shall use their best efforts to obtain a handoff of care signature, but if no hospital representative is available or willing to sign, the crew shall document within the ePCR the unavailability and/or refusal of hospital representatives to sign and proceed with departure from the hospital in accordance with this policy.
   4. During triage by ED medical personnel, Clinicians will provide a complete verbal patient report containing any pertinent information necessary for the patient's ongoing care. Transfer of patient care is complete once ED medical personnel have received a verbal patient report, and the patient is off-loaded from the transport unit stretcher to an acceptable location.

5. The "PT Transfer" button must be pushed on your portable radio as soon as the patient transfer process occurs.
6. Clinicians are responsible for immediately returning to a response-ready status once patient care has been transferred to ED medical personnel, the patient has been moved from the transport unit stretcher, and all required documentation is complete.

E. Continuation of Care
1. Patient care must always be the priority and will supersede the tenants of this policy. EMS shall continue to maintain patient care until transferred to ED medical personnel, either through the timely transfer of care initiated by the hospital or EMS Duty Officer-initiated transfer of care via this policy. EMS Clinicians shall adhere to their scope of practice and applicable Maryland Medical Protocols.
   a) Unaccompanied minor children are exempt from this policy. EMS Clinicians will remain with these patients until the patient is transferred to hospital personnel.

XIII. Procedures

A. Patient Transfer – All patients who meet the Direct to Triage (DTT) shall continue to follow the current DTT process. The following procedure applies to patients who do not meet the criteria for DTT.
1. In the event Clinicians are unable to notify the receiving facility prior to transport, upon arrival at the ED, the lead Clinician will meet with the charge nurse or his/her designee, so they can provide a primary triage assessment of the patient.
2. If the 20-minute time frame from arrival at the facility elapses and the patient has not been off- loaded, the lead Clinician will politely and professionally notify the charge nurse that they have waited 20 minutes and need to complete the patient transfer process, so that the crew can return to service.
3. If the hospital cannot off-load the patient at this time, the lead Clinician is to follow the "Hospital Bed Delay" procedure.

B. Hospital Bed Delay - The Department recognizes that there are times when patient transfer delays may occur. This may be due to situations including but not limited to capacity issues in the department/hospital, multiple EMS units arriving in the ED simultaneously, and/or the acuity of patients arriving by EMS or walk-in. In the event of a delay of patient care, the following procedure will apply.
1. If the receiving ED personnel are unable to transfer the patient to a designated area within 20 minutes, the hospital triage or charge nurse may request that EMS Clinicians remain with the patient for a longer period. Please note that this is a request and not a demand. This period shall be known as "Hospital Bed Delay."
2. Upon receipt of such a request by the hospital for extended ambulance wait time, and the ED staff is still unable to transfer the patient to a designated area within 20 minutes of arrival on hospital property, the EMS crew shall notify the EMS Duty Officer. The EMS Duty Officer will consider extended ambulance wait time in light of the following factors:
   a) Is the patient an unaccompanied minor?
   b) The current condition of the patient.

c) Patient acuity and required monitoring, treatment, and interventions.
d) Availability of EMS transport units.
e) Hospital alert status (colors).

3. If, after evaluating the above-listed criteria (primarily the needs of the patient and the availability of additional transport units in the County), the lead Clinician and the EMS Duty Officer feel it is in the best interest of the patient and the Department to support this request, the Duty Officer or lead Clinician shall:
   a) Advise the charge nurse that they can accommodate a single extension of 20 minutes.
   b) Notify Public Safety Communications (PSC) of "Hospital Bed Delay" and that an extension has been approved, which should be documented in CAD notes by the TAC channel operator.
   c) Once the patient has been off-loaded:
      (1) Complete the ePCR, including the Hospital Bed Delay worksheet.
      (2) Return to service as quickly as possible.
4. If, after evaluating the above-listed criteria (primarily the needs of the patient and the availability of additional transport units in the County), the lead Clinician and EMS Duty Officer feel it is in the best interest of the patient and the Department NOT to support this request, the Duty Officer or lead Clinician shall:
   a) Advise the charge nurse that they cannot accommodate the request at this time and begin working patiently with the charge nurse to off-load the patient.
   b) Complete the ePCR, including the Hospital Bed Delay worksheet.
   c) Return to service as quickly as possible.
5. Any additional requests past the first 20-minute extension require the approval of an EMS Duty Officer or Battalion Chief. In the event the charge nurse makes such a request, the lead clinician will notify a supervisor using the following consult order:
   a) That unit's respective EMS supervisor
   b) Any other available EMS supervisor
   c) Their respective Battalion Chief
   d) Any other available Battalion Chief
6. The EMS Duty Officer/Battalion Chief will use the criteria listed above (II.B.2) to determine if a second 20-minute request should be granted.
7. If the EMS Duty Officer/Battalion Chief denies the request for a second extension the lead Clinician shall:
   a) Advise the charge nurse that they cannot accommodate the request and begin working patiently with the charge nurse to off-load the patient.
   b) Complete the ePCR, including the Hospital Bed Delay worksheet.
   c) Return to service as quickly as possible.
8. If the EMS Duty Officer/Battalion Chief approves the second 20-minute extension, the lead clinician shall:
   a) Notify the charge nurse and PSC that a second 20-minute extension has been approved, which should also be documented in CAD notes by the TAC channel operator.
   b) Advise the charge nurse that they can accommodate a single extension of 20 minutes.

c) Notify Public Safety Communications (PSC) of "Hospital Bed Delay" and that an extension has been approved, which should be documented in CAD notes by the TAC channel operator.

9. Once the patient has been off-loaded:
   a) Complete the ePCR, including the Hospital Bed Delay worksheet.
   b) Return to service as quickly as possible.

C. If no request is made by hospital staff for extended ambulance wait time (i.e., more than the **20-minute** window), and the ED staff is unable to transfer the patient to an ED bed within 30 minutes of arrival on hospital property, the EMS crew shall notify the EMS Duty Officer. The EMS Duty Officer may direct the EMS crew to leave the hospital and/or return to service, regardless of physical assumption of care by a hospital clinical staff member, if the EMS Duty Officer in collaboration with the EMS crew determines that the hospital patient does not clinically require continued care or monitoring by the EMS crew, in accordance with the criteria in this policy.

D. The continued working relationship between receiving hospitals and Emergency Medical Services is paramount in assuring appropriate timely care is given to the public as well as assuring resources are available and in place when time sensitive critical calls are received from the community.

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

XIV. Phase 12 – Documentation/Data Collection

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

B. EMS Clinicians will utilize all appropriate data fields to capture patient assessment/ demographics, each procedure performed, each medication administration (including medications immediately prior to the arrival of EMS), and other pertinent patient treatment information available in the data fields or drop-down boxes.

C. EMS Clinicians will utilize the "Narrative" free text section of the document to complete at minimum Subjective and Objective information. The treatment plan will be documented in the data collection fields.

D. Signatures – EMS Clinicians are required to sign in the appropriate provider field, obtain a receiving facility signature with typed name, and will capture the appropriate signatures as listed below when transporting a patient to the hospital:

1. EMS transports and the patient is able to sign – The transporting unit must obtain the patient's signature in the signature tab under "Patient Billing authorization and HIPAA Signature" and acknowledge the privacy practices.
2. EMS transports and the patient is unable to sign and has an authorized representative – The transporting unit must obtain the authorized representative's signature in the signature tab under "Authorized Representative Signature" and acknowledge the privacy practices.
3. EMS transports and the patient is unable to sign and NO authorized representative – The transporting unit must obtain a receiving facility signature under "Hospital Receiving Agent ID and Signature" and appropriately complete the EMS Clinician signature, documenting the reason the patient could not sign.

E. For most patient transports, units will complete the ePCR prior to leaving the receiving medical facility. If the Limited EMS Resources Plan is in effect, the ePCR will be completed at the station later, and a State-Approved Short Form is to be left at the facility to return the transport unit to service. In either case, a copy of the ePCR is submitted to the receiving facility electronically for inclusion in the patient's records.

XV. Phase 13 – Return to Service

A. Units must minimize the amount of time they are out of service at a medical facility. As soon as the unit is ready for service, PSC shall be notified. This will generally occur as the unit leaves the medical facility.
   1. EMS units shall follow General Order 5-20, *EMS Performance Measurement – Disposition Codes* when returning to service.
      a) Via voice on the appropriate talk group.
   2. If a Determinant/Disposition Code is not necessary:
      a) Select "STS" on radio.
      b) Select "AVAIL/ON AIR."

B. PSC will inquire about an EMS unit's status after sixty (60) minutes at the receiving facility.

C. Replenish Supplies
   1. EMS units should replenish appropriate medications, supplies, and equipment used on the currently transported patient from the appropriate Apex vending machines located at various hospitals, and in every Battalion. If the item is not available at either the hospital or Battalion Apex machine, Clinicians are still able to request a one-for-one exchange from the hospital staff. If necessary, coordinate with the hospital staff to receive appropriate supplies. If replenishing of supplies is not possible at the receiving facility, EMS units shall replenish from station stores or coordinate with an EMSDO.
   2. Units should email the EMS Logistics Office weekly and as necessary for any items not available in the Apex machines (PGFDEMSLogistics@co.pg.md.us).

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

REFERENCES

Maryland Medical Protocols for Emergency Medical Services Clinicians

Alert Status System of MIEMSS Region V

FORMS / ATTACHMENTS

N/A