Appendix 1

Administrative Policies

Baker Act

A psychiatric patient may be involuntarily hospitalized by law enforcement under authority of the Baker Act. The Baker act applies to persons who may suffer from neglect without care or treatment or if the patient presents an imminent threat of bodily harm to himself or another. This removes the patient's right to refuse treatment. A provider who questions the patient's ability to make informed refusal should summon law enforcement to implement the Baker Act. A physician may also initiate a Baker Act hospitalization.

All persons treated under the Baker Act will be transported to the nearest appropriate facility.

A. Law enforcement will search the patient when the medical situation permits.

B. Restraints will be used only when the patient is likely to harm himself or others. The restraints should secure all extremities, the torso and the pelvic region. Continue restraining the patient throughout the transport.

C. Ambulatory psychiatric patients shall be escorted by at least two personnel, one on each side of the patient. Each provider should keep one hand in contact with the patient. A provider should sit within arm's reach during transport.

D. Law enforcement will provide a completed Baker Act form, (HRS-MH Form 3052A) to the EMS provider. The original form will be taken by the provider and be left with the patient at the receiving facility. The crew shall inspect this form before initiating transport. Do not transport the patient if the form is not completed with the name of receiving facility, patients name, time and date, criteria checked off, observations, and a signature.

E. A patient may voluntarily sign a Baker Act Form 40 as a self committal to a mental facility. Once this form is signed, the patient gives up legal rights and can be involuntarily transported.

F. Voluntary patients should have prior authorization for transport from the receiving facility. Notify law enforcement immediately of any patients who are a threat to themselves or others. Detain, if you can do so safely without using force, the patient under the authority of Florida Statute 401.445. Do not use force to detain any patient.

G. Nonemergency substance abuse patients should have prior authorization for transport from the receiving facility.

H. Intoxicated patients may be involuntarily transported under the authority of the Marchman Act. Law enforcement personnel must authorize treatment and transportation. The intoxicated patient who refuses to be transported will be the responsibility of law enforcement.

I. Any patient requiring medical treatment shall be taken to the nearest receiving facility.

Community Vaccinations

Rationale:
This information pertains to community vaccinations and the three manufactures or the COVID-19 vaccine collectively.

Background: In the case of viral pandemics such as the H1N1 influenza pandemic and the present SARS-Cov-2 (COVID-19) pandemic when rapid wide scale immunization is necessary, Paramedics, while serving at EMS agency community outreach events, are authorized under Florida statute 401, rule 64J to administer vaccinations to their agency personnel and the community. EMTs have been authorized by the Florida Department of Health and the Governor of the state of Florida to administer vaccinations with appropriate training and under the supervision of a paramedic but not to draw-up vaccines in a syringe.

INDICATIONS:

The COVID-19 vaccine may be administered to an individual who:

- Is 18 years of age or older until clinical trials of vaccines for children have been shown to be effective.

The seasonal INFLUENZA vaccine may be administrated to an individual who:

  - Is 12 years of age or older.
  - Has not been previously vaccinated with the current seasonal influenza vaccine.

CONTRAINDICATIONS:

- Hx of severe allergic reaction to the vaccine or its ingredients; Polyethylene glycol
- Hx of Epi-Pen use for anaphylaxis.
- COVID-19 positive test within the last 2 weeks (if moderate to severe symptoms including fever > 103F, respiratory distress, Emergency Department or hospital care) then it is advisable to wait from 60 to 90 days from the start of the infection before receiving a COVID- 19 vaccination influenza positive test.
- Symptoms of COVID-19 or influenza within the last 10 days," sick" today with or without fever.

Vaccine guidance questions:

- Hx of Allergies to Food, Medicine, Latex, Insect Envenomation + if yes close monitoring post vaccination for a minimum of 30 minutes Immunocompromised or on medicines that affect the immune system + if yes advise that the vaccine may offer lower chance of protection.

- Hx of Bleeding Disorder or on Blood Thinner + If yes worn and monitor for Signs/Sx of hematoma at injection site.
- Hx of Prior COVID-19 Vaccine Injection + if a second injection is required by the vaccine manufacture, the second Injection of vaccine must be from the same vaccine manufacturer + if a second injection is required by the vaccine manufacturers and the vaccine recipient developed a moderate to severe COVID-19 infection after the first vaccination then it is advisable to wait 60 to 90 days after the start of the COVID-19 infection before receiving the second vaccination + if the second injection is required by the vaccine manufacturer and the vaccine recipient developed significant side effects from the first vaccine injection (including fever greater than 103 F, severe/debilitating muscle and joint pain or urticaria covering most of the skin surface > 4 hours after the vaccine was administered) then it is advisable to wait 60 to 90 days before receiving the second vaccination.

DOSAGE:

- Moderna- 0.5ml IM in the deltoid muscle to be repeated x 1 in 28 days.
- Pfizer- 0.5 ml IM in the deltoid muscle to be repeated x 1 in 21 days.
- Johnson and Johnson- 0.5 ml IM in the deltoid muscle; no repeat injection necessary.

SEVERE ADVERSE REACTION:

- If Anaphylaxis or severe Angioedema of the upper airway treat with Epinephrine (See Anaphylaxis Protocol) and transport to the nearest emergency department.
- inform the medical director, infectious disease officer within 24 hours.
- If generalized urticaria-offer antihistamines, H2 blocker and steroids and transport to the nearest emergency department.

Critical Care Transports

Coastal Health Systems of Brevard Inc. will provide Interfacility transportation for Critical Care patients. A critical care transport team, trained and capable of transporting patients, will be available 24 hours per day for both adult and pediatric patients.

1. CHSB medics will understand the critical care environment to include patient types and technology involved.
2. CHSB medics will understand his or her role with critical care transports. To include both medical and legal issues.
3. CHSB medics will understand the equipment used by CHSB for critical care transports.
4. CHSB medics will have the organizational skills necessary for transporting the critical care patient.
   A. Formulating a transport plan.
   B. Implementing the transport plan.
   C. Evaluating the transport plan.

Formulating the transport plan: The transport plan begins with understanding Intensive care and develops with the patient's caregivers. CHSB medics use a modular approach to airway and circulation monitoring and management, medication administration, and general ICU monitoring skills. Focus on the patient first, and then the technology. Don't become technologically blinded, but allow technology to assist in meeting the patient's needs.

1. Know what type of intensive care unit to which you are inroute and gather appropriate equipment.
A. Cardiac surgical and medical
B. General surgical and medical
C. Neurological
D. Orthopedics
E. Pediatric
F. Burns

2. Prepare for transport
A. Assemble all equipment necessary for transport.
B. Have backup equipment ready.
C. Insure protocols and written orders are in place.
D. Obtain the telephone numbers of the receiving physician and facility.
E. Familiarize yourself with the patient's drainage systems (chest tubes, Foley catheters, nasogastric tubes and surgical drains.
F. Double check infusion sites to assure patency (mediports and central lines).
G. Obtain the patient's records and review them with the RN to fully understand the patient's needs.

3. Patient care enroute
A. Provide care and monitor patient based on protocol and patient class.
B. Insure crew members have the competencies to meet the patient's specific needs.
C. Monitor patient care equipment to insure it is working properly.
D. Establish radio and or cellular phone contacts as needed.
E. Document patient care needs, responses to treatments, and changes in condition.

4. Deliver the patient on arrival at the receiving hospital.
A. Deliver the report and records with the patient.
B. Evaluate the transport.

5. Work with facility staff if they are required to accompany patient during transport.
A. An RN will assume all patient care and responsibility.
B. Respiratory Therapist will assume all patient airway care and responsibility.
C. Physicians will assume all patient care and responsibility.
D. The paramedic will assume patient care for cardiac arrest or other acute conditions.

Destination Decisions

Definitions:

State Approved Trauma Center (SATC, Level 1 or 2):
Those hospitals having the facilities and personnel appropriate for the care of the major trauma patient.

Basic Treatment Facility (BTF):
A hospital's emergency department that can provide care to most emergency patients, excluding major trauma.

Patient Choice:
The hospital chosen independently by the patient. This definition specifically excludes a decision derived by paramedic prompting or recommendation.

Patient Classifications & Destination Decision:

1. Class 1/Red Unstable

   A. Medical- To closest appropriate hospital.
   B. Trauma- Refer to Trauma Transport Protocols

2. Class 2/Yellow Stable, but at risk of deterioration

   A. Medical
      1. Hospital of patient's choice within zone., unless paramedic decides such a transport would be detrimental to patient's clinical condition, then transport to closest appropriate hospital.
      2. Unassigned: Closest hospital
   B. Trauma- Refer to Trauma Transport Protocols

3. Class 3/Green Stable

   A. Medical- Hospital of patient's choice within the County including Sebastian Medical Center (system status allowing)
   B. Trauma- Refer to Trauma Transport Protocols

4. Class 4/Black Meets Death Scene Criteria. Notify Law Enforcement & Do NOT Transport.

Use of Helicopter Ambulance Service:

1. Patients should be transported by ground ambulance except when:

   A. Patients meet the criteria for air transport under the Trauma Transport Protocol.
   B. Road conditions will cause delays for patients requiring rapid transport.
   C. There are multiple victims of a serious nature requiring rapid transport.

2. Helicopters will **NOT** be used for adult cardiac arrest patients unless initial resuscitation measures have been successful and rapid transport by ground is not available.

EMT IV (Intravenous)

- Pursuant to the rules of the Florida Department of Health Chapter 64E-2.008, Florida Administrative Code, an Emergency Medical Technician (EMT) who has successfully completed training equivalent to the 1999 U.S.D.O.T. EMT-Intermediate National Standard Curriculum related to intravenous (IV) therapy shall be allowed to initiate a non-medicated peripheral IV.

- An EMT shall only be allowed to initiate a non-medicated IV under the direct supervision of a Florida certified Paramedic (of the same licensed agency) who has directed EMT to do so.

- All IV's initiated by an EMT shall follow the guidelines established in the Double Lumen Catheter Protocol as outlined in the Procedures Manual of the Brevard County EMS Standing Orders.

- No EMT shall be permitted to initiate an intraosseous infusion or access a patient's external jugular vein.

Incapacitated Patients

Florida Statute 401.445 provides authority for EMS Providers to examine and treat patients who are incapacitated and cannot make decisions for themselves.

Patients are incapacitated if they are unable to make informed consent for treatment due to intoxication by drugs or alcohol or by their medical emergency (such as decreased mental status).

The provider has a legal ability to treat a patient experiencing a medical emergency. Make every attempt to get consent from the patient. If the patient is incapacitated, he may be treated and transported without his consent.

Request law enforcement to restrain any patient who requires it. Unreasonable force shall not be used.

A patient who has been treated as an incapacitated patient must be transported until a physician determines that he is no longer incapacitated.

Interfacility Transfer

A patient transported to the closest hospital or Trauma Center may be transferred to another hospital if the patient or physician requests it or if the closest hospital is on diversion. Each hospital agrees to transfer (regardless of financial status) any competent patient who requests it. Transfers will be arranged between physicians. Emergency and attending physicians are authorized to arrange transfers.

Paramedics will prior to accepting a patient for transfer, receive a summary of the patient's condition, transfer documents (summary, lab work, x-rays, etc.) current treatment, treatment orders, possible complications, and pertinent medical information. A paramedic who is asked to transfer a patient with special needs that exceed his scope of practice will not make the transfer without being accompanied in the unit by an appropriately trained provider (RN, RT, MD, etc.).

Patients who receive emergency transfers must have at least one IV in place prior to transfer. Orders for IV composition and rate should be provided.

Interagency Agency Coordination

1. Transport of the patient should begin as soon as possible
2. Always work together cooperatively in the best interest of the patient
3. Disagreements in patient care shall be resolved by medical control

Mass Gathering Events

Purpose:

To establish minimum standards for Emergency Medical Services at Mass Gatherings and special events.

Ensure adequate medical-health resources are provided to protect the health and welfare of the general public at public and private events that may have an impact on emergency services.

Authority:

Based Upon FEMA Guideline FA-197
https://www.usfa.fema.gov/downloads/pdf/publications/templates_guidance_ems_mass_incident_deployment.pdf and

Policy:

A. Mass Gathering or Special Event medical plans requiring review by the EMS Coordinator shall meet the minimum standards for the size and type of event, as recommended in this policy. The recommended standards are summarized in Appendix A.

B. Mass Gathering or Special Event medical plans shall include, but not be limited to, the following considerations:
   1. Event description, including date(s), time(s) and location of event
   2. Expected number of event personnel, participants and spectators
   3. Availability of alcohol at the event
   4. Site map
      a. indicting entrances/exits, seating and isles/walkways
      b. Ingress/egress route(s) for emergency vehicles
      c. Landing Zone(s) should be identified for air ambulance

   5. EMS/911 Communications
      a. Activation of 911 system
      b. Direct communication between on-site personnel
         A. Between venue staff and/or security personnel, event coordinator, and medical personnel.
         B. Between medical personnel located at a First Aid Station and mobile teams
         C. Between medical personnel and SCR911
         D. Between medical personnel and ambulances, and
         E. Between medical staff and receiving hospitals

6. Medical/EMS Services to be utilized:
    a. Name(s) of EMS/Fire organization(s) providing service
    b. Level of coverage & Location
        A. CPR, rapid access to AEDs, and 911 access
        B. First Aid stations (if indicated; see Appendix A)
        C. Ambulances (if indicated; see Appendix A)
        D. Mobile medical teams (if indicated; see Appendix A)

7. Patient Care Documentation
    a. Complete Daily Patient Care Log
    b. Provide total number of patients transported daily
    c. PCR required for each patient transported

        A. Mass Gathering or Special Events requiring medical personnel or ambulances may enter into a separate agreement with an approved and permitted provider for operations EMS Agency.

Procedure:

A. First Aid treatment would be administered to people in need of First Aid only. A daily First Aid Contact Log will be filled out for every person requesting First Aid only.

B. If the person requires a higher level of care up to and including BLS/ALS, then a PCR would be completed which may also include AMA (Against Medical Advice) or RAS (Released at Scene) documentation. A report run number will be generated for all documented PCRs. All patients requiring transport will be transported by the County's contracted 911 provider.

C. First Aid Supplies may include:

- Band Aids
- Antibiotic Ointment
- Suntan Lotion
- Bee Sting Swabs
- Sterile Water
- Feminine Hygiene Products
- Viricidal Wipes
- Bottled Drinking Water
- Ice Packs
- Acetaminophen
- Ibuprofen
- Aspirin

D. The EMS Agency Coordinator shall review the medical plan within 10 days and respond to both the event sponsor and the permitting agency.

APPENDIX A

MINIMUM RESOURCE GUIDELINES

Event Type	Crowd Size (anticipated)	CPR & 911 Access	1st Aid Station with min. of EMT	Ambulance	Mobile Teams
Concert / Music Festival / Fair / Rodeo	<2,500	X	*		
	2,500-15,000	X	X	*	*
	15,000-50,000	X	X	X	X
	>50,000	X	X	X	X
Athletic / Sporting Event	<2,500	X	*	*	
	2,500-15,000	X	X	X	
	15,000-50,000	X	X	X	
	>50,000	X	X	X	
Parade / Street Fair / Outside Venue	<2,500	X			
	2,500-15,000	X	*		
	15,000-50,000	X	X	*	*
	>50,000	X	X	X	X

X = Required

* = Recommended

= Multiple Units May Be Required depending on history and size of event. A reasonable planning guide is 1 unit per 10,000 participants or spectators.

CPR & 911 Access: Event staff and/or safety personnel have the capability to notify 911 of any medical emergencies and to provide CPR/AED access.

First Aid Stations with minimum of one EMT: A fixed facility with the ability to provide First Aid level care staffed by at least one Emergency Medical Technician or higher skill level personnel. First Aid level care is identified as treatment of minor medical conditions or injuries by care providers that have received training in First Aid. Examples of First Aid care are cleaning, bandaging, and referring simple wounds such as scrapes and shallow cuts, providing cold packs for musculo-skeletal strains and bruises, and giving drinking water and a place to rest for patients who are mildly dehydrated. Examples of a First Aid Station are a tent, a clinic, an ambulance or a vehicle or some type. The First Aid Station must have 911 communications capability.

Ambulance: An ambulance staffed by at least one Paramedic and one EMT.

Mobile Teams: Mobile Teams consist of two or more personnel, one of whom must be an EMT or higher-level provider, with treatment supplies necessary for the provider's skill level, and communications capability with 911 and the First Aid Station.

Fire Agency Emergency Medical Services - FIRST AID CONTACT LOG: For use in the field a template is attached.

Fire Agency Emergency Medical Services

FIRST AID CONTACT LOG

Date _____ Event _____

Name _____ Name _____
(EMT/Paramedic) (EMT/Paramedic)

Name	Age	Complaint	Type of 1st Aid Provided

On-Line Medical Control

The on-duty emergency department physicians serve as the 24 hour on-line (by radio or phone) medical control authority

The paramedic may contact medical control for consultation as desired but must contact medical control for authorization for level III orders, any deviation from protocol, when a patient refusal may endanger the patient or provider, when bystander physicians or other providers try to participate in patient care, and any situation where there is conflict between providers, hospitals, or other health care agencies.

On-Scene Medical Care Provider
In the Office and In the Field

Patient Care Policy:

The issue of non-EMS system physicians on scene or in clinics and offices is a complex one. Conflicts with physicians (and other health care providers) at scenes come in many varieties. Many physicians are not well informed of the law or regulations regarding the Patient Care Policy.

The issue of non-EMS system physicians on scene or in clinics and offices is a complex one. Conflicts with physicians (and other health care providers) at scenes come in many varieties. Many physicians are not well informed of the law or regulations regarding the State EMS system and often of the abilities and skills of EMT's of all levels. Do not get into an argument with a physician at a scene. Keep in mind that your job is to care for the patient.

Office Medical Provider:

Physician caring for their patient, who subsequently calls for EMS transport.

If the physician releases the patient to you and chooses not to accompany them during transport, the following guidelines apply: (doctor's office or clinic). You are not there to re-diagnose the patient.

In essence, the licensed medical provider has transferred the physician-patient relationship to the EMS Physician Medical Director temporarily. You as the EMS provider act as the physician delegate in this regard, as you do in all patient care.

If the physician has specific orders to be carried out during transport as a matter of professional courtesy.

They should be followed if:

• The orders are consistent with your Scope of Practice.
• They seem reasonable and medically prudent for the patient.
• There is no change in the patient's condition that would warrant a deviation from the orders.

If you have any concerns, expedite transport, and contact on-line medical control for guidance.

In the Field Medical Provider:

Non-EMS System physicians may assist patient care if they:

1. Are at the scene,
2. AND identify them self (and show proof) as a Florida licensed M.D. or D.O.,
3. AND agree to assume care of the patient if the treating EMS provider requests,

4. AND if transporting, agree to accompany the patient to the receiving facility if the EMS provider requests.
5. The licensed physician may declare the patient dead if no objection by the treating EMS provider.
6. AND sign the Physician's Section of the EMS Report.

If the physician wishes to stay with the patient during transport, they may do so. However, advise the physician on Notification of Responsibility, and make sure they are clear on guidelines that apply:

• The EMT may assist in patient care only if your participation is within your Scope of Practice and based on Joint EMS Protocols.

• If any conflict over the patient's care arises it will be addressed through on-line medical control.

• The highest level EMT/Paramedic will always ride in the back with the physician and be in position to provide patient care and monitoring.

• Document the attending physician and their understanding of Patient Responsibility on the PCR and complete On-Scene Physician Form.

Patient Refusal or Non-Transport

1. Any patient refusing needed treatments and/or transportation require the completion of a Patient Refusal form. Patients who refuse part of the treatment recommended (for example, a patient may allow transport but refuse to have an IV) must also sign the Patient Refusal form.

2. The provider will communicate directly with the patient to establish his intent and inform the patient or guardian of:

   A. Their condition
   B. The potential risks of refusal
   C. Their assumption of all risks by refusal

3. The refusal form must include the patient's chief complaint, vital signs, consequences of the refusal, and paramedic assessments. Family members, law enforcement bystanders, or other crewmembers should witness the patient's signature.

4. Complete the signature lines, for patients who refuse to sign, with "patient refuses to sign", followed by your signature and have family members, law enforcement bystanders, or other crewmembers witness and sign the refusal.

Respiratory Protection

The Center for Disease Control's (CDC) and the Occupational Safety and Health Administration (OSHA) recommend employees wear particulate respirators in circumstances where providers will occupy the same space with (such as in a closed vehicle during transport) or perform procedures on individuals with suspected or confirmed infectious mycobacterium tuberculosis (TB) disease. Respirators should meet or exceed standards of the National Institute for Occupational Safety and Health (NIOSH) for high efficiency particulate air (HEPA) respirators.

Procedure:

The following procedure complies with OSHA regulations.

1. Assignment of responsibility:

   A. Each agency will delegate an Infection Control Officer who will be responsible for maintaining infection control procedures, program training of personnel, testing for disease, providing personal protective equipment, and investigating employee exposure. This individual will be appointed by the agency's medical director and the State EMS office and will have expertise in issues relevant to infection control including infectious diseases and occupational health.

   B. The Infection Control Officer will provide the health care worker a yearly respiratory protection program based on current information from OSHA, CDC, and NIOSH.

2. Standard operating procedures (SOPs):

   A. The Infection Control Officer will update procedures as new standards may be published. The respiratory infection program will be modified to comply with new guidelines.

   B. IMPORTANT SOP: *A patient with suspected or confirmed TB should be transported in the rear of an ambulance with the patient wearing a surgical mask over the mouth and nose (if possible) and the vent fan on (negative air pressure). Ambulance personnel should wear respiratory protection when transporting such patients. (CDC MMWR Vol.43 / RR-13, page 51)*

3. Training program:

   The respiratory protection program shall insure employees are informed of:
   1 methods of TB transmission.
   2 signs and symptoms of TB.
   3 Diagnosing employee exposure, i.e. positive skin test results, TB infection indicators, and the presence (if contacted) and treatment of the disease.
   4 procedures that may protect the employee from exposure.
   5 use of personal protective equipment, negative air pressure, etc.
   6 Respirator training, i.e. fit testing, use of, and how to recognize a malfunctioning respirator.

4 Respirator inspection, cleaning, disinfection and storage:

   A. All surfaces exposed to potentially infectious materials shall be wiped clean with a detergent and appropriately disinfected immediately after patient care. Instrument and equipment cleaning shall be done in an area separate from treatment areas. Every transport unit will be decontaminated at the end of each shift.

   B. Personal protective equipment shall be used when cleaning. This equipment, disposable cleaning materials, and the respirator, shall be disposed of in red biohazard bags.

   C. One HEPA respirator for each provider will be stored on each transport unit.

Respiratory Protection Cont.

D. Three forms of disinfecting agents may be used by each agency:
   1 Glutaraldehyde-based solutions may be used for sterilization or high level disinfection. All items must be thoroughly cleaned and rinsed following use. *Avoid skin contact and vapors.*
   2 Sodium Hypochlorite (household bleach) in a 1:100 solution (1/4 cup to one gallon of water). may be used for intermediate level disinfection on non-critical surfaces and equipment. *Irritating to skin and eyes.*
   3 Phenolics (0.5 ounce to one gallon of water) may be used for intermediate level disinfection. After cleaning, spray on surfaces and let stand for 10 minutes before wiping off. *Avoid skin or mucus membrane contact.*

E. Exposure to liquid chemical disinfectants:
   1. Decontaminate the area with copious, tepid water for a minimum of 5 minutes. Wash the area with soap and water.
   2. Follow the appropriate protocol for chemical exposures.

5. Fit testing:

A. Fit testing requires testing the seal to insure a respirator fits the provider's face with a leakage of <10%. A proper fit can usually be attained by using respirators in at three sizes.

B. Face-seal leakage compromises the ability of particulate respirators to protect employees from airborne materials. Air-born contaminants will take the path of least resistance into the respirator, bypassing the filter if it seals poorly. A proper seal between the respirator the face is essential. Face-seal leakage can result from various factors:
   1. Incorrect face piece size or shape
   2. Incorrect or defective face piece sealing-lip
   3. Beard growth
   4. Perspiration or facial oils that can cause face piece slippage
   5. Failure to use all the head straps
   6. Incorrect positioning of the face piece on the face
   7. Incorrect head strap tension or position
   8. Improper respirator maintenance
   9. Respirator damage.

C. Fit testing is the responsibility of the Infection Control Officer and must be done before the provider may make patient contact. The proper fit is confirmed by applying negative pressure in the respirator with no leakage into it.

D. Reuse of a disposable respirator is permitted only if the respirator maintains its structural and functional integrity, the interior of the respirator is not contaminated, and the initial user is the sole occupant of the respirator.

Response to Violent or Potentially Violent Scenes

1. Units dispatched to scenes where persons are potentially violent will stage. They will remain there until advised that law enforcement has secured the scene.

2. Units who are requested to stage by law enforcement will respond to a staging area in the Non-emergency mode. Units will change their response to the emergency mode after the scene is secured.

3. Units arriving in the staging area will avoid travel in corridors that can be observed from the scene.

4. The company officer or senior paramedic must evaluate the safety of the scene and withdraw if necessary until the scene is secured.

5. Providers who are present during acts of violence or the threat of violence will leave the scene and request Law Enforcement. Use clear text to describe the situation.

Transport Destination (non-ALS)

For Patients in Long Term Nursing Facilities & Skilled Nursing Facilities

1. After a completed patient assessment, if it is determined that the patient is stable, the Solo-Paramedic or Lieutenant may elect to:

    - Transport in a Brevard County Fire Rescue unit
    - Release to **Coastal Health System**

2. If the patient is to be transported by Coastal Health Systems, Brevard County Fire Rescue or the ALS first response agency personnel may remain on scene until arrival of the Coastal ambulance. A unit may clear an incident if Coastal's response time to the scene will be extended or in the event that the unit must respond to another incident. In either case, the Solo-Paramedic or Lieutenant must determine and document that the patient's condition is stable at the time of release. In these situations, the hospital copy of the report will be left with the patient or relative and given to the Coastal ambulance upon their arrival.

    - If a patient consents to alternative means of transportation, every effort will be made to ensure that this transportation can be initiated while the Brevard County Fire-Rescue unit is on the scene

3. Use the following guide to determine which patient may be transferred to Coastal Health Systems or may use another form of transportation:

    BCFR must Transport (unless patient refuses) Patient's complaining of or presenting with the following signs/symptoms:

    - Chest Pain
    - Cardiac Event
    - Shortness of Breath
    - Respiratory Event
    - AMS (Non-dementia)
    - TIA or Stroke
    - Glucose < 60mg/dL
    - Potassium > 6 mEq/L
    - Hemoglobin (<9 g/dL)
    - Seizure
    - Hypotension or Hypertension
    - Bradycardia or Tachycardia
    - Unstable Trauma
    - Dialysis (Emergent)
    - Abdominal Pain
    - Fever, Possible sepsis

BCFR must transport any patient (unless patient refuses) exhibiting a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part, or (4) with respect to a pregnant woman who is having contractions -- that there is inadequate time to effect a safe transfer to care to Coastal Health Service before delivery, or that the transfer may pose a threat to the health or safety of the woman or her unborn child.

Transport Destination (non-ALS) Cont.

Transfer of Care to Coastal Health Services may occur if the following complaints or values are present:

- Abnormal Lab Values (except for potassium > 6 mEq/L)
- No Chest pain
- No Cardiac Event
- No Shortness of Breath
- No Respiratory Event
- Hx of Dementia (but not exhibiting signs of agitation, acute distress or trauma)
- No AMS
- No Signs of TIA or Stroke
- No seizures
- No Signs of Hypo- or Hyperglycemia
- Glucose > 60mg/dL
- Hemoglobin (>9 g/dL)
- No Neurological Event
- Stable Vitals
- Direct Admit (Non-Urgent Transport)
- Follow up care management in the ED
- Lab work request

NOTE: It is imperative that a complete patient assessment is well documented to support the decision to release a patient to either an ambulance or alternate means of transportation.

Treatment and Transport of Minors

1. Units responding to a scene involving minors will notify a parent if the patient's condition allows the time.

2. Transport minors (under the age of eighteen) with injuries to the appropriate facility.

3. EMS personnel do not need parental consent for treatment or transportation of a minor.

4. Some minors such as those who are married may be emancipated. Emancipated minors are treated as adults for consent purposes.

5. Law enforcement may take a child into protective custody. The officer should then sign the Patient Refusal form.

Unit Cancellations

1. Brevard Region Transport units may accept cancellations from other agencies or units, **only under the following circumstances:**

   A. The other unit is known to be manned by paramedic personnel, or

   B. The other unit is manned by EMTs AND

      1 The nature of the call is trauma AND,

      2 The patient voluntarily signs the refusal form that indicates paralysis and death as the risk of their refusal, AND,

      3 The patient has no obvious injury AND,

      4 The patient's mental status and vital signs are stable are within normal limits.

2. BLS units may not cancel ALS units responding to medical calls unless the call is a false alarm.

3. First Response BLS units will, when they first arrive, transmit to the responding ALS units an evaluation of the scene and potential injuries. The ALS unit will, if the evaluation indicates a non-emergency call, downgrade their response from emergency to a less dangerous mode of driving. The ALS unit will continue directly to the scene and evaluate all patients.

4. Extenuating circumstances may include patient refusals, multiple calls or rescue squads responding outside their primary response area. The first response BLS unit should transmit their evaluation to the squad via the radio, such as "The patient refuses treatment and transportation." The Rescue squad may, in extenuating circumstances, cancel to remain in service or to respond to another incident.