Montgomery Fire/Rescue Department Leads the Way

The Office of Emergency Medical Services would like to take this opportunity to recognize the Montgomery Fire/Rescue Department for its professional leadership and example setting performance.

At the time of this writing the Montgomery Fire/Rescue Department protects 162 square miles of territory for both fire suppression and provision of ALS Emergency Medical Services first response. It does so out of 15 fire stations located strategically throughout its response area, and with over 300 licensed EMS personnel. The Department maintains an ISO class rating of 1, granting Montgomery the privilege of fire protection quality only provided by 0.2% of the nation’s fire departments. The Firefighter Combat Challenge team of the Department also has set two world records for Combat Challenge performance and competing against teams from fire departments around the country and around the world.

How does a fire department from Montgomery, Alabama achieve such impressive performance benchmarks and awards? Attention to detail - which did not go unnoticed in the Office of Emergency Medical Services’ licensing section earlier this year.

Everyone in EMS is aware of the March 31st biennial deadline for licensure renewal, which mirrors that of certification renewal of the National Registry of Emergency Medical Technicians. During the first quarter of each year the workload in the OEMS licensure section increases exponentially. Alabama licenses over 12,000 EMS providers consistently. Paper applications often arrive late in the cycle, are sometimes only partially complete for attached documentation and signatures, and frequently must be returned to the applicant so that the problems can be corrected. Large departments and services regularly send the paperwork of their entire staff for renewal and it is not unprecedented for the entire bundle of applications to be returned for correction before they can be successfully processed.
Enter this year the Montgomery Fire/Rescue Department, carrying a large container of hanging folders containing 318 license applications. As the staff began disassembling the package (which was delivered early enough in the process cycle that it could be quickly reviewed and data entered) each application was complete in its content, signatures, attached documentation (which included proof of citizenship) and was provided neatly in folders in the same orientation and in alphabetical order. What that accomplished was expedition of a large batch of files through an arduous review and entry process. The clerks performing the process were so impressed (as compared to the quality of the average license renewal application package) they reported the quality standard to their supervisors and to our staff in general.

The Office of Emergency Medical Services would like to thanks the Montgomery Fire/Rescue Department for their extraordinary standards of quality, protecting our homes and offices, our lives; and making an otherwise tedious and time consuming task for our personnel much smoother than it could have otherwise been. Keep up the good work!
Birmingham Fire Rescue Department’s Culture of Excellence

Birmingham Fire Rescue Department has a great history and a very important job. The City of Birmingham consists of 146 square miles of the most densely packed streets in Alabama. It is composed of a variety of terrain, mostly hilly, with densely populated streets many of which are multistory buildings and houses. In addition, the conditions are often icy, many residents are factually homeless, and about 30% of registered citizens are living at or below the poverty level. The city is a matrix of major highways, interstates and heavily traveled streets and roads, through which some of the heaviest traffic in the southeast travels and rush hour is a thing of legend. Whereas Montgomery may hold the title of the legislative center of Alabama, Birmingham is both the economic and the education center of Alabama; hosting one of the premier medical and research based universities in the country and the world, the University of Alabama in Birmingham, among many other hallowed centers of learning. Because of the nature of its commerce and endeavors the population surges in the city to untold levels during every work day of every week and on weekends due to the many attractions found on the hilly landscape. Meeting these and other challenges every day is the Birmingham Fire Rescue Department.

Birmingham Fire Rescue provides its services out of 31 fire stations scattered deliberately throughout the rolling terrain of its response area. It is a massive organization with a brilliant history. The organization was one of the first in Alabama to initiate paramedic-level EMS service to its citizens, taking advantage of UAB’s location within its territory. Dr. Alan Dimick, the BFRD’s medical director is considered by most Alabama EMS historians to be one of the grandfathers of Alabama EMS. Dr. Dimick became the medical director of the federal grant that trained the first 33 paramedics in Alabama in 1972. A renowned surgeon and founder of the UAB Burn Center, he went on to be the medical director of the UAB Regional Technical Institute from 1973 to 1985 and oversaw the education of hundreds of EMS providers in the Birmingham area and the state of Alabama at large.

Birmingham Fire Rescue Department has always had a great deal to live up to. They are one of the premier EMS sites in the state and the southeast, their run volume is intense for both EMS and fire calls, and they are a transport EMS service with the Grandfather of Alabama EMS as their medical director. They demonstrated their ability to maintain their position on the forefront this month at the Office of Emergency Medical Services.
Many of our readers are already aware of the issues our Office encounters during the EMS license renewal period every year. Individual license applications often arrive incomplete and without complete documentation and must be returned to the applicant. Alabama has over 12,000 licensed EMS providers at several levels and all must renew every two years. This process is all facilitated by the hands of our office staff and on paper applications. Birmingham Fire Rescue sent 379 applications to our office, all of which were complete in every aspect; signatures, documentation, copies of identification, etc. All were oriented, alphabetized, and contained in a manner that made the process of review and data entry as seamless as humanly possible and the completion of the process as quick as humanly possible. Our Office would like to commend the BFRD for their efforts and commitment to excellence in both their paperwork and their operations. Outstanding job.
<table>
<thead>
<tr>
<th>Name</th>
<th>Rule/Protocol</th>
<th>Complaint</th>
<th>Action Taken</th>
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<tbody>
<tr>
<td>Danny Cornelius</td>
<td>420-2-1-.25</td>
<td>Scope of Practice</td>
<td>Remediation</td>
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<td>Under Triaging Patients</td>
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<td>Equipment Failures</td>
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<td>ALS Transport Service</td>
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<td>Inappropriate Transport</td>
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Provider Service Inspections

The inspection reports for the following services can be found on Compliance Issues page of the Office of EMS webpage. These inspections were completed January-March, 2018.

Abbeville Fire Rescue
AirEvac EMS-Colbert County
AirEvac EMS-Jackson County
Alabama Fire College
Albertville Fire and Rescue
AmServ EMS-Bibb County
A-Med Ambulance Service-Marshall County
AmStar EMS-Sumter County
Anniston EMS
Ariton Rescue
Ashford Ambulance
Bessemer Fire Department
Boaz Fire Rescue
Brantley Rescue
Brookwood Volunteer Fire Department
Cahaba Valley Fire
Care Ambulance-Chilton County
Care Ambulance-Montgomery County
Care Ambulance-Russell County
Cherokee Rescue Squad
City of Lanett Fire and EMS
Clanton Fire Department
Clay County Rescue Squad
Coffee County EMS
Collins Chapel Volunteer Fire Department
Columbia Fire Rescue
Cottonwood Ambulance
Crawford Volunteer Fire Department
Daleville Police Volunteer Rescue
Dekalb Ambulance Service
Desoto Rescue Squad
East Alabama EMS
Echo EMS
Provider Service Inspections

continued

Eclectic Fire Department
EMS Care-Russell County
Enterprise Fire
Enterprise Rescue
Excelsior Ambulance-Montgomery County
Fairview Fire Rescue
Green Pond Fire Rescue
Greene County EMS
Guntersville Fire Rescue
Haleburg Rescue
Haynes Ambulance-Autauga County
Haynes Ambulance-Elmore County
Haynes Ambulance-Montgomery County
Haynes LifeFlight
Headland Fire Rescue
Helena Fire Department
Highland Medical Center Ambulance Service
Indian Ford Fire District
Jacksonville Fire Department
Jefferson County Sheriff’s Office Tactical Team
Jemison Fire Rescue
Keller EMS-Colbert County
Keller EMS-Franklin County
Lafayette Fire and EMS
Leeds Fire Rescue
Lifecare-Tuscaloosa County
Lifesaver 3-Chambers County
Littlerville Fire Rescue
Livingston Fire Rescue
Locust Fork Fire Rescue
Luverne Rescue
Midland City Fire Rescue
Millbrook Fire Department
Montgomery Fire Department
Moody Fire Rescue
Nectar Fire Department
Nixon Chapel Volunteer Fire Department
Provider Service Inspections continued

North Chilton Volunteer Fire Department
Northflight-Tuscaloosa County
Northport Fire Rescue
Northstar Paramedic Services-Tuscaloosa County
Odenville Fire Rescue
Oneonta Fire Rescue
Opelika Fire Rescue
Oxford EMS
Phil Campbell Rescue Squad
Pickens County Ambulance Service
Piedmont Rescue Squad
Pine Mountain Volunteer Fire and EMS District
Pintlala Volunteer Fire Department
Progressive Health
Rainsville Fire Rescue
Regional Air Medical Services-Walker County
Rosa Volunteer Fire Rescue
Scottsboro Fire Department
Shoals Ambulance-Colbert County
Shoals Ambulance-Jefferson County
Shoals Ambulance-Lauderdale County
Skipperville Volunteer Rescue
Smiths Station Fire Rescue
Steele Fire Rescue
Thorsby Fire Department
Tuscaloosa County Sheriff’s Office
Tuscaloosa Fire Rescue
Valley EMS
Vines Ambulance Service
West Blount Fire District
Culture of Excellence

Air Evac-Colbert County
Air Evac-Jackson County
Dekalb Ambulance Service
Eclectic Fire Department
Enterprise Rescue
Moody Fire and Rescue
Nectar Fire Department
Nixon Chapel Volunteer Fire Department
Pine Mountain Fire Department
Rainsville Fire and Rescue
Steele Fire and Rescue
Be the Star of Life
"...so others may live..."

Your job in EMS isn't easy and only a few can do it. It can definitely be the most rewarding job of all for there is no greater feeling of accomplishment than that of saving a life. We know you don't do it for the money and you don't do it for the glory. You do it because it is what you were meant to do. You do what you have to and you do it every day, hoping and praying that you made a difference in someone's life.

You do all these things and definitely do not get the recognition you deserve. Always remember that you are more than "just an Ambulance Driver", or "just a Paramedic", or "just an "EMT", and you are even more than just an "everyday" worker. You are sent to help the wounded and to help the sick and you can be the difference between life and death. You are the reason that this woman is able to see her son graduate high school. You saved that man's life so that he can walk his daughter down the aisle at her wedding. You see the young man working at the store and know that you brought him back when he overdosed last year. You were there when he gave up on himself and now he is changing his life because of the second chance that you helped him achieve.

Always remember that the care you provide to EVERY patient should be to the best of your ability. We, in EMS, tend to let the “non-sense” calls and frequent patients influence how we care for everyone we meet throughout the shift. We have all done it. Keep in mind that we come to them where they are, meet them as they are, and should always give them the best that we have to offer. You are the face of EMS in Alabama so be the "Star of Life", and every day, you shine through in someone, brighter than ever.

Thank you for what you do and for the service you provide. Thank you for being compassionate and being there for others in their worst moments and thank you for what you do for EMS in Alabama.

Jamie Gray
Compliance Coordinator
The Alabama Opioid Assistance Project

Drug overdose deaths are increasing at an alarming rate nationwide. According to the CDC, there was a 137% increase in the number of deaths due to drug overdoses between 2000 and 2014. Also, during this period, the rate of overdose deaths involving opioids increased by 200%. Drug overdose deaths now exceed deaths due to vehicle crashes.

The Alabama Department of Mental Health indicates that 4.71% of Alabama’s population over the age of 17 (175,000+ individuals) are estimated to have used pain relievers for nonmedical purposes in the past year. In reviewing the statistics for nonmedical use of pain relievers between 2006-2012, the rate of nonmedical use in Alabama was higher than the rate of nonmedical use in the U.S. as a whole. Alabama has one of the highest opioid user rates in the world. With only 5% of the U.S. population, Alabama uses approximately 80% of all the opioid drugs in the nation. In addition, ADMH states that nearly 30,000 Alabamians over the age of 17 are estimated to be dependent upon heroin and/or prescription painkillers. Furthermore, in 2015, for the first time ever, admissions to substance abuse treatment for opioid use disorders exceeded those for alcohol use disorders in Alabama.

In 2013, ADMH indicates that students in 9th-12th grade in Alabama report more than a 200% higher rate of having used heroin in their lifetime, compared with their counterparts across the nation:

5.9% of male youth in Alabama used heroin compared to 2.8% in the nation
3.8% of female youth in Alabama used heroin compared to 1.6% in the nation
5.3% of both male and female youth in Alabama used heroin compared to 2.2% in the nation

The rates for Alabama’s youth utilizing prescription drugs for nonmedical purposes is also higher than those of youth in the nation:

21.2% of male youth in Alabama used prescription drugs without a prescription compared to 18.3% in the nation
17.9% of male youth in Alabama used prescription drugs without a prescription compared to 17.2% in the nation
19.7% of both male and female youth in Alabama used prescription drugs without a prescription compared to 17.8% in the nation
Prescription pain relievers and heroin are the primary drugs associated with overdose deaths in Alabama. The CDC reported that, in 2012, Alabama ranked first in the number of opioid pain reliever prescriptions written per 100 persons. Alabama also ranked fourth in the number of high dose opioid pain reliever prescriptions. The 2015 National Drug Control Strategy Data Supplement estimated that 218,000 Alabamians used a pain reliever for nonmedical use in 2013 and, according to the CDC, 598 Alabamians died in 2013 from a drug overdose which increased to 723 in 2014.

In efforts to combat this problem head on, the Alabama Office of EMS has been awarded a $3.2M grant over the next 4 years to aid our efforts in the opioid crisis here in Alabama. This grant has many components and will be used to help supply naloxone to all licensed providers in the state. The grant will also be used to assist overdose victims in locating recovery information and support services including treatment facilities. The Office of EMS will be collaborating with the Alabama Council on Substance Abuse to better fill the needs of our patients and to supply real time support services to those in need. Prevention and education will be a component available to patients and well as our licensed personnel in the state. Continuing education classes will be offered for a number of topics to include subjects such as street drug recognition, stress management, dealing with trauma, and many others. The OEMS will also be utilizing this project to help educate the public on what constitutes a need for activating the 911 system so to better the efficiency of our EMS system and response capabilities.

As stated before, there are many components to this project so please be patient in the implementation process so that we may implement this process as seamlessly as possible.
Thrombolytic Checklist for Stroke

Emergency medical services personnel (EMSP) are a critical component in stroke care. Early recognition and treatment of stroke offers more opportunity for treatment, which may save lives and reduce the long-term effects of stroke. Treatment for acute ischemic stroke, the most common type of stroke, may include tPA (tissue plasminogen activator) administration and/or mechanical thrombectomy, if certain criteria are met.

The Stroke Thrombolytic Checklist in the Emergency Medical Service (EMS) Protocols was revised in the recent protocol update. The changes were made based on suggestions from stroke care professionals and EMS Regional Directors. The checklist should be completed for any patient suspect of, or presenting with, acute stroke symptoms. A copy of the completed form should be left with the patient at the stroke center.

The Alabama Trauma Communications Center (ATCC) needs specific information to enter the patient into the Alabama Stroke System. As the EMSP completes the Thrombolytic Checklist for Stroke, the information for ATCC is documented which allows for a rapid report and Stroke System entry.

Stroke centers are trying to reduce door-to-needle times for tPA administration; therefore, time is critical and EMSP can help. A very important section of the thrombolytic checklist for hospital staff is the “Historian Cell Phone #.” If possible, the EMSP should collect the cell phone or historian contact information before leaving the scene. Current contact information provides a mechanism for stroke center staff to verify or collect additional information if needed.

For convenience, the Office of OEMS printed note pads of the revised Thrombolytic Checklist for Stroke and provided them to the EMS Regional Offices for further distribution. Providers may print their own copies from the EMS Protocols Ninth Edition 2018 (Page 132) instead of using the pre-printed notepads.

Alice Floyd, BSN, RN
Acute Health System Manager
Update from the Education Coordinator

In the last several months, I have begun the process of reuniting with old friends in the world of Alabama EMS and making new ones. As you know, this is a small world in which we all operate, so the reunion has been nice. I have met many of you at conferences, meetings, or just as I travel throughout the state on business. For instance, I was in the northern portion of the state last month when I had the pleasure of dropping by Lawrence County EMS, Helen Keller EMS, Northwest-Shoals Community College, HEMSI, and Calhoun Community College. For the most part, this was merely to introduce myself as the new EMS Education Coordinator for the OEMS. We had a great time getting to know one another, and I hope to get around to many more of you soon.

I would like to introduce a new member of the OEMS staff, Mr. Kent Wilson. Kent was hired as an EMS Specialist and will be working with me on educational aspects of our office. Kent is also working with the Compliance division to help bring all ambulance inspections up to date.

As you know, we just released the new 9th Edition of the Alabama EMS Protocols. They will go into effect May 1, 2018 and can be found on our website under Rules and Protocols. Please take a look at them and familiarize yourself with them. We would like to also emphasize that the protocols should be treated me as a guideline rather than as a bible. You were trained to perform these duties and you passed the test. We want you to use those skills, but keep your scope of practice in mind as you practice your profession.

We are also updating the rules to include EMS education regulation. Many of you who have been around for a while probably remember that this was removed from the OEMS and given to the Alabama Community College System around 2006. Recently, we have been asked to take up this torch again. To assist us with ensuring we include all that is vital to teaching all EMS Personnel, we have created a committee of experts to write an updated version of these rules. The committee includes representatives from the OEMS, community colleges, the Alabama Fire College, the four year universities, the private universities, and the EMS regions. We are confident that a set of very good working rules can be drafted.

I am very pleased to be working in the OEMS again and with all of you as we continue to make EMS in Alabama stronger, safer, and unified.

Chris Hutto, MBA, NRP
Education Coordinator
“To Transport… Or Not to Transport…THAT is the question...”

By Gary L. Varner

NATIONAL REGISTRY SCENARIO:
You are the lead paramedic on an Alabama licensed rural emergency response ambulance. Your partner is an Advanced EMT. At 13:45 hours you are dispatched to a general illness call at a nearby familiar address. When you arrive on the scene you find a 65-year-old male sitting on the patio in an aluminum yard chair underneath a blooming crape myrtle tree. The temperature is neither hot nor cold, but just pleasant. The patient does not appear to be in a great deal of distress. His wife of 45 years is holding an ancient cordless telephone receiver and is seated in an identical chair and both are pushed up to a metal patio table. Both subjects have obviously been drinking from cold sweating glasses full of what appears to be iced tea. A small Chihuahua is bristled up under the table. As you approach the patient, the Chihuahua (who you recognize from your many interactions with this couple and know by the name “PePe”) begins his expected outburst of incessant, shrill barking. The couple (let’s call them “the McGillicuddys”) then begins their own outburst of bickering, which was also expected. Between the dog and the couple, you and your partner cannot understand the basis of the conversation between the two and the tirade between all three begins to resemble pandemonium. You and your partner approach the couple and when in hearing distance you both smile, you extend your hand to the man, and say “Mr. McGillicuddy...How can we help you today? What seems to be the problem?” Before Mr. McGillicuddy, yourself, your partner, or PePe can utter another sound, Mrs. McGillicuddy (a rather rotund woman of remarkable girth and shorter-than-average height, wearing a tie-died moo-moo, pink curlers and fuzzy bedroom slippers) states loudly in a shrill scratchy voice and thick Southern country accent; “Weeeeeeelll I’ma gonna tell you smart-alecky boys this right NOW.... He’s A goin-to-go to the HOSPITAL NOOOO MATTER WHUT!!” To which a gruff and apparently exhausted Mr. McGillicuddy replies “I... ain’t-a... goin’.”

REVIEW:
Could it be that you actually tried to analyze the scenario for the first 6-to-8 lines? Questions you formulated may include; Was it a rural type of medical complaint (toxicology, heat) and possibly farm related? Was the dispatch time being past lunch part of the mechanism of illness? If the address is known to you, what is the nature of chronic illness? Could the patient be allergic to the flowering of the tree, or to the bees that are drawn to them, or to the pollen? As the story unfolds from there, and you realize the situation (that you have probably personally encountered to a point) you may have become LESS clinically minded and MORE (what’s a nice term for it?) annoyed.
Continued from page 15

The fact of the matter is - people make bad decisions when they are annoyed. We draw conclusions without reviewing all of the facts. We stick to our preferences rather than anticipating potential outcomes and analyzing the situation to avoid poor outcomes. Factors in this scenario that could possibly influence improper decisions include, but are not limited to:

1. The fact that historically the family calls 9-1-1 frequently.
2. Possible history of difficult interaction between EMS and one or both McGillicuddys (and maybe even Pepe).
3. Territoriality of Mrs. McGillicuddy’s control over Mr. McGillicuddy’s healthcare choices.
4. Territoriality of Mr. McGillicuddy’s control over his own healthcare and destiny.
5. Disquieting stimulus of bickering couple amplified by loud incessant barking of the dog.
6. Ego-driven infuriation at the fact that two highly trained and educated (and perhaps experienced) registered and licensed EMS providers can be dressed down by a family member without similar sacrifice or attributes and whose mind cannot be changed by God or man; and were in fact challenged without the availability of reasonable response or recourse.
7. The professional duty and responsibility to protect Mr. McGillicuddy’s civil rights while also protecting his health.

Now we all know that this scenario has a “textbook answer.” If ten different EMTs read this article, then ten different (but perhaps similar) answers may brew on the other side of the digital screen. Because of rigorous training, we all know what to do:

1. Assure safety of the scene after donning BSI. Gain control of the conversation, calmly and reassuringly, and communicate with the parties involved. Note mechanism of illness and number of patients (which one or both) is ill.
2. Consider additional resources (animal control, police, other, none).
3. Form general impression of patient, and so on.

Now, put yourself realistically into the situation. If you read it carefully you should already feel a little bit of stress. Now instead of a daytime call (13:45 or 1:45 p.m.) let’s make it 01:45 or 1:45 a.m. on a 24-hour shift where you finally went to bed at midnight after a long day of running. Can you feel an increase in stress? For me; I do. For me, throughout my field career, knowing my station pillow was getting cool on my bunk in the middle of the night for “a basic services call” (real or perceived) scaled my frustration levels up a bit.
TAKE HOME LESSONS SO FAR
Aside from the tongue-in-cheek familiarity that almost all of us have with this scenario. What else can we learn from it?

Here are a few ideas:
Your index of suspicion for a true medical emergency should elevate with the level of confusion in any given call. The weirder the call is – the harder you should look for a true emergency. Often calls can be like icebergs where most of the important factors may not be relatively obvious.

Even though untrained citizens often over-react, they also know and understand the physical and mental condition of their family members better than anyone and fearfully react to unexpected changes in them. The rescuer must remain calm and often the family member will likewise calm down, however, family members often exasperate rescuers when they refuse, or are unable, to calm down in a patient care situation. As the EMS professional we must remember that (a) fear multiplied by (b) a lack of understanding often results in anger, frustration and even violence.

ANY patient can refuse care if they have the “capacity” to refuse care. Determining capacity is sometimes not easy but is something we deal with on every call. If the patient is not cooperative (with EMS and/or family on scene) what are the possible causes? The laundry list of causation may include a closed head injury or other neurological process, such as stroke, etc. It may also include blood glucose variation (low or high), hypoxia, hypotension, severe pain, hormone imbalances, electrolyte imbalances, drugs, alcohol or other toxicology, acute mental health changes or even good old stubbornness.
According to Dr. Christopher Colwell in his article “Know When Uncooperative Patients Can Refuse Care and Transport” in the August 1, 2016 issue of the Journal of Emergency Medical Services (JEMS) a patient must possess the following four abilities to have the capacity to make healthcare choices:

- To communicate a choice;
- To understand relevant information as it is communicated;
- To appreciate the significance of the information to their own individual circumstances; and
- To use reasoning to arrive at a specific choice.

Dr. Colwell offers the following five questions to ask patients in order to help determine their capacity:

- Have you decided what you want to do?
- What are the risks of the options we have discussed?
- What could happen if you choose to do nothing at this time?
- Why do you think this is the best option for you at this time?
- Why have you chosen the option that you did?

**DOCUMENTATION**

Even if you “do everything right” on a call – documentation will always be what protects you if your actions are ever called into question. Our best recommendation is that you describe the fact that you asked questions (the same as above or similar) of the patient and that you document his answers. You should always include a description of persons on scene and witnessing your interaction with the patient, most preferably law enforcement or fire personnel, but at least a friend or relative. In his March 14, 2015 JEMS article “Pro Bono: Documenting Patient Refusals”, EMS Attorney Douglas Wolfberg advocates that documenting a refusal is more than simply obtaining a signature. The patient must be INFORMED of the possible risks of refusing care. Mr. Wolfberg states that as a defense attorney for EMS he would rather have a narrative detailing the risks and consequences that were disclosed to the refusing patient than a simple signature with no documentation of the risks discussed. He strongly advises that EMS providers do both, but his example illustrates the importance of good documentation.

Mr. Wolfberg explains that a patient experiencing a symptom which is reasonably suggestive of a serious problem, and who refuses treatment and transport, should be advised of the worst case scenario. For example, a patient experiencing chest pain should be warned that it could actually be a heart attack and that it could possibly result in death if left untreated.
He calls this “the duty to terrify.” If the patient has a possible fractured toe, however, using the risk of death to discourage refusal would be unreasonable. A good refusal narrative should document that multiple alternatives were given, such as traveling to the E.D., or physician’s office by private vehicle. The report writer should always document the measures that EMS employed to exercise due diligence in consideration of the patient’s health.

FUNCTIONAL APPROACH
My personal suggestion is that IF you allow a patient to refuse treatment and transport and you end up doing LESS documentation than if the patient accepted treatment and transport, you are NOT documenting correctly. Even with a good refusal form (the link to Mr. Wolfberg’s is included below) is utilized; more than adequate narrative documentation is necessary for optimum protection.

Our office advocates that when EMS providers write narratives and complete documentation – they should do so as though they were writing it for a plaintiff’s attorney and as if it would be scrutinized in a court of law. It is not unreasonable to anticipate that it may (that is MY duty to terrify).

CONCLUSION
EMS is never completely straightforward. Many times people must be diagnosed with technology only available to physicians and in hospitals. EMS providers must “always expect the worst” in order to adequately protect and support our patients.

Visit Mr. Wolfberg’s site, www.pwwemslaw.com. Resources include free attorney reviewed forms and a free EMS law library access.

As America continues its decades-long increasing trend towards greater obesity, ambulance EMS personnel often find themselves calling fire departments for lifting assistance. The great thing about firefighters is that they always find a way to lift the patient, no matter how heavy.
Some e-PCR Points of Clarification:

1. It is a requirement to complete a patient care report on every response. This office is already monitoring submission rates and comparative data suggests that many agencies are not reporting all runs as required. Please submit all required runs to avoid noncompliance.

2. Each record must be submitted electronically within 72 hours or less. The goal is to eventually narrow that down to within 24 hours. The 24 hour reporting allows Public Health to monitor surveillance trends as required by the Federal emergency preparedness guidelines.

3. Our IT staff is always available to assist you with your e-PCR needs. If you need assistance, you may call Chris or Lori at 334-206-5383. You may get a voice recording depending on the call volume. They will eventually get back to you. If you do not hear from them within a reasonable time, you may wish to email them.

4. Collecting and importing data is paramount only to reporting reliable data. Reliable data is accurate and contains no errors. When one looks for shortcuts and/or skips data entry in areas that has been discovered to have no validation rules, it dilutes the integrity of the data, not to mention falsifies a legal document. Please make sure you enter data accurately.

5. As of January 1, 2017, Alabama began transitioning to NEMSIS version 3.x data. We will also continue to accept NEMSIS version 2.0 data until December 31, 2017. Alabama will be a NEMSIS version 3.4 compliant state beginning January 1, 2018.
General Information

Do You Have Questions for OEMS Staff?

This is another reminder to those of you calling our office (334) 206-5383:

Complaints, Investigations, and Inspections — Call Jamie Gray
Licensure — Call Stephanie Smith, Kembley Thomas, or Vickie Turner
Individual Training or Testing — Call Chris Hutto
EMS for Children, Website, and Social Media — Call Katherine Dixon Hert
EMS Data/NEMSIS — Call Gary Varner

Requests for Information from Regional Offices

The Office of EMS would like to request that you comply with any request for information from your regional office. Some Directors are still having issues receiving information and data as requested by the State office. We would greatly appreciate your cooperation and compliance.

Reporting Requirements

Please be reminded that, according to Rule 420-2-1-.07 (6h), All licensed provider services shall provide notification and written documentation within three working days to the OEMS regarding any protocol or rule violation, which includes but not limited to, according to 420-2-1-.30 (8), anyone guilty of misconduct or has committed a serious and material violation of these rules; has been convicted of a crime.

Also be reminded that, according to Rule 420-2-1-.29 (7), All licensed provider services shall provide notification and written documentation about any individual who meets the definition of an impaired EMSP.