TO: All MCFRS EMS Providers DATE: July 15, 2013

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SUBJECT: The patient's needs do not change based on where the medic is coming from

When Chief Tom Carr released Directive 04-16, the "Safe Driving Action Plan" in 2004 pertaining to safety in the operation of apparatus, I saw an analogy much in common between the goals he outlined in the driving arena, and our goals in the medical arena. Similarly, Chief Lohr has just outlined disapproval of any lapses in vigilance and judgment that can result in preventable outcomes in the wake of another cluster of events. I hope to use the same tools to instill an analogous sense of caution for patient safety.

The MCFRS has recurrently debated the deployment model to best serve the population, to include chase vehicles versus transport models, 1+1 staffing and now the AFRA. In 2005, we had only one "chase unit" in the old Car 293, but we have now morphed into a system with essentially numerous 40,000+ pound equivalents to the single medic utility. Although most medics in the K293 did a great job, we began a newer recurring "question posed" of what threshold was required to "compel the medic to leave his unit" and upgrade the transport BLS ambulance. In a recent 2013 tally of Office data, **20%-40% of the QA cases making it to review involve downgrade decisions**. Our medics even testify that temptation to have a different threshold for care exists in decision-making when on the ALS fire engine. This educational memo **unambiguously warns against allowing anything else but the patient's needs to dictate that threshold, your actions or your habitual practice approach**.

- ALS First Response Apparatus provide an excellent opportunity to deliver crossed trained ALS-level responders as soon as possible to our patients' side

- Patients who give complaints via 911 that justify an ALS dispatch should receive such level of assessment that establishes the need for subsequent care, and the benefit of engagement by the ALS provider when she/he reaches the scene

- The fact that a medic arrives on an AFRA, however, does not alter the level of assessment, fact finding, skills, and then appropriate disposition of the patient.

- Irrespective of fire service rank, the highest trained dispatched provider on the scene has the ultimate responsibility of determining the level of care that each patient requires, in compliance with Maryland Protocols, and subject to an IC/Officer's absolute authority and discretion over scene safety and management

- ALS care includes not just skills, but assessment, monitoring or may be simply the decision to remain with the patient during the entire encounter

- Officers on the scene should support ALS upgrades with few exceptions; often the borderline cases are the ones likely to need monitoring for deterioration

- The ALS provider should assess in an intimidation-free zone that follows the needs of patients; If the medic feels coming off an AFRA is prudent, this decision should be fully supported by the entire crew without hesitation

- A patient's complaint drives an ALS-level assessment, which should be performed and their encounter documented in the ePCR or the "ALS to BLS Downgrade Tab" if appropriate, per FCGO-13-01; Simply handing-off the task of full ALS documentation to the transporting BLS provider is insufficient

- The BLS provider should assess in a worry-free zone that follows the needs of patients; Although ALS wave-offs by BLS are justifiable when there is good faith assessment then evidence of an over dispatch, there should be no pre-emptive coercion or discussion that encourages BLS providers to "always cancel the AFRA before we get there if you think it may be BLS", because that it a set-up for a later catastrophe, notwithstanding daily stress to the BLS providers; it is also a set-up for a complaint or worse still a legal proceeding that accuses the medic of avoiding the job, or bad faith omissions

- BLS providers who feel sincerely uncomfortable transporting a patient alone should explain to arriving ALS the rationale, without fear of calling for or taking the medic from an engine company, or suffering any implicit later adverse consequences

- Finally, ALS and BLS Officers who feel that the medic should not downgrade a patient should feel free to question the downgrade or advise the medics to upgrade

- ALL factors being considered that are distractions -such as "we'll miss the box", "middle of night", "we have to chase you to the hospital", or "we are so close to the hospital"- are medically irrelevant and deeply frowned upon by the Office of Medical Oversight; In short, **a patient's needs dictate <u>how</u> the medic is engaged and <u>determine</u> where the patient should go ; but needs do not change depending on where the medic is coming from, or where the patient is going**