Chapter 4

Communications and Documentation

Unit Summary

After students complete this chapter presentation and the related course work, they will have an understanding of therapeutic communication; means to communicate effectively with special populations such as children, geriatric patients, and hearing- and visually impaired patients; methods and procedures for effective communication; components of effective written reports, types of written reports, and ways to correct errors found within written reports; documentation of refusal of care; special reporting situations; use of medical terminology; communications systems and equipment; regulations and protocols governing radio communications; and communication with medical control and hospitals.

National EMS Education Standard Competencies

Preparatory

Applies fundamental knowledge of the emergency medical services (EMS) system, safety/well-being of the emergency medical technician (EMT), medical/legal, and ethical issues to the provision of emergency care.

Therapeutic Communication

Principles of communicating with patients in a manner that achieves a positive relationship

• Interviewing techniques (pp 122–126)

• Adjusting communication strategies for age, stage of development, patients with special needs, and differing cultures (pp 120, 127–131)

• Verbal defusing strategies (pp 120–123)

• Family presence issues (pp 123–126)

EMS System Communication

Communication needed to

• Call for resources (pp 151–153)

• Transfer care of the patient (pp 153–156)

• Interact within the team structure (pp 151–153)

• EMS communication system (pp 146–151)

• Communication with other health care professionals (pp 153–156)

• Team communication and dynamics (pp 131–133, 153–156)

Documentation

• Recording patient findings (pp 134–146)

• Principles of medical documentation and report writing (pp 134–136)

Medical Terminology

Uses foundational anatomical and medical terms and abbreviations in written and oral communication with colleagues and other health care professionals.

Knowledge Objectives

1.Describe the factors and strategies to consider for therapeutic communication with patients. (pp 119–133)

2. Discuss the techniques of effective verbal communication. (pp 122–133)

3. Explain the skills that should be used to communicate with family members, bystanders, people from other agencies, and hospital personnel. (pp 122–133)

4. Discuss special considerations in communicating with older people, children, patients who are hard of hearing, visually impaired patients, and non–English-speaking patients. (pp 127–131)

5. Describe the use of written communications and documentation. (pp 133–146)

6. State the purpose of a patient care report (PCR) and the information required to complete it. (pp 134–143)

7. Explain the legal implications of the PCR. (pp 142–143)

8. Describe how to document refusal of care, including the legal implications. (pp 143–146)

9. Discuss state and/or local special reporting requirements, such as for gunshot wounds, dog bites, and abuse. (p 146)

10. Describe the basic principles of the various types of communications equipment used in EMS. (pp 146–150)

11. Describe the use of radio communications, including the proper methods of initiating and terminating a radio call. (pp 150–151)

12. List the correct radio procedures in the following phases of a typical call: initial receipt of call, en route to call, on scene, arrival at hospital (or point of transfer), and return to service. (pp 151–153)

13. List the proper sequence of information to communicate in radio delivery of a patient report. (p 153–156)

Skills Objectives

1. Demonstrate the techniques of successful cross-cultural communication. (p 120)

2. Demonstrate completion of a PCR. (pp 134–143)

3**.** Demonstrate how to make a simulated, concise radio transmission with dispatch. (pp 150–153)

Readings and Preparation

Review all instructional materials including ***Emergency Care and Transportation of the Sick and Injured***, **Twelfth Edition**, Chapter 4, and all related presentation support materials.

• Review local radio protocols and procedures for conducting both dispatch and medical communications.

• Review local protocols and procedures for operating radio/telephonic communication equipment, including procedures for equipment failure.

Support Materials

• Lecture PowerPoint presentation

• Case Study PowerPoint presentation

• Copies of locally approved prehospital care report forms and refusal of treatment forms (minimum of one per student)

• Display of radio/telephonic equipment used in the local area

Enhancements

• Direct students to visit Navigate.

• Contact the local 9-1-1, or public safety access point (PSAP), communication center for information on correct radio/communication designs used in the area. If possible, arrange for students to visit the center for an observation shift.

• Contact the local base station hospital to arrange for students to visit the base for an observation shift.

• **Content connections:** Students should be able to relate the information found in this chapter to every chapter presented in the text. This chapter sets the stage for proper communication skills that the students will need when working with patients. Therapeutic communication should be reinforced throughout the course.

• **Cultural considerations:** People communicate in a variety of ways, such as through eye contact, body position, and facial expressions. Many factors need to be taken into consideration during communication. Patients with special needs may require you to consider alternative forms of communication. For example, if the patient is deaf and you cannot communicate using sign language, you may need to communicate by having the patient write down his or her feelings. Ask students to form groups and practice simple phrases in sign language. See Figure 4-7 in the text for examples.

Teaching Tips

• For many students, an opportunity to visit and learn about the local EMS dispatch center will be their first glimpse at the “behind the scenes” components of the EMS system. You should make every effort to arrange observation time at both the dispatch center and the base hospital.

• Stress that basic effective communication processes are a key factor in ensuring a successful incident. EMTs must focus on verbal and interpersonal communication skills with all types of patients—including children, older or impaired patients, non–English-speaking patients, and other groups that may require special communication needs.

• Stress that written documents become a part of the incident record and the patient’s medical records. Students must understand the importance of legible, thorough, and accurate reporting. This can be illustrated through use of locally approved forms during simulations conducted throughout the remainder of the course.

• Review local medical communications and procedures with the students, including procedures for equipment failure, reporting of errors, and methods for processing written reports.

• During the skills lab, have students use “family” radios to give radio reports.

• Incorporate devices that will allow students to “feel” what it is like to be elderly, such as earplugs to simulate hearing loss, reading glasses covered with plastic wrap to simulate visual problems, and so forth.

• Divide students into small groups for a role-playing exercise focusing on communication. Have one student portray a patient, one act as an EMT, and one remain as an observer or assume the role of a family member or bystander. Ask all of the EMTs to leave the room, and create a scenario for the patients to act out. Allow each EMT 3 to 5 minutes to interact with the patient. Observe each group and at the end of the allotted time, debrief the class using the input from different group members.

• Invite an attorney who works with cases involving patient care to speak with the class about the importance of precise and accurate documentation. Ask the attorney to share examples of narratives to illustrate this component of patient care. If possible, have the attorney review and critique narratives written by the students and share this feedback with the class.

• Invite a member of the community who relies on a guide dog or a person who trains guide dogs to speak with the students.

• Pair the students up. Place a blindfold on the first student, and have the second student guide the first through the building. If possible, have the students go up and down a flight of stairs.

• Create scenarios in the classroom and ask the students to create a verbal report and a written report. Choose students to read their reports to the class and then allow the other students to provide feedback.

Unit Activities

**Writing assignments:** Assign each student a research paper on the topic of aging and the challenges he or she may face as an EMT when responding to calls involving older patients.

**Student presentations:** Have each student make a presentation to the class regarding appropriate ways to communicate with an elderly patient or a non–English-speaking patient who is in distress.

**Group activities:** Ask each student to prepare scenarios for patients of various ages, with various complaints. In small groups, ask students to play out the scenario, reinforcing the importance of communication.

**Visual thinking:** Provide the students with a sketch of Figure 4-1 of the text. Do not include the text/labels that are within the figure. Ask the students to fill in the text:

- Sender

- Receiver

- Encoding

- Message

- Decoding

- Noise

- Feedback

Pre-Lecture

### You Are the Provider

“You Are the Provider” is a progressive case study that encourages critical thinking skills.

### Instructor Directions

**1.** Direct students to read the “You Are the Provider” scenario found throughout Chapter 4.

**2.** You may wish to assign students to a partner or a group. Direct them to review the discussion questions at the end of the scenario and prepare a response to each question. Facilitate a class dialogue centered on the discussion questions and the Patient Care Report.

**3.** You may also use this as an individual activity and ask students to turn in their comments on a separate piece of paper.

Lecture

I. Introduction

A. Communication is the transmission of information to another person, whether it is verbal or through body language (nonverbal).

1. Effective communication is an essential component of prehospital care.

2. It is necessary to achieve a positive relationship with patients and coworkers.

B. Verbal communication skills are important for EMTs.

1. Enables you to gather information from the patient and bystanders

2. Makes it possible for you to coordinate all the responders who are often present at the scene

3. An integral part of transferring the patient’s care to the nurses and physicians at the hospital

C. Documentation

1. The written or electronically recorded part of the patient’s permanent medical record

2. Demonstrates that appropriate care was delivered

3. Communicates the patient’s story to others who may participate in the patient’s future care

4. Adequate reporting and accurate records ensure the continuity of patient care.

5. Complete patient records

a. Guarantee proper transfer of responsibility

b. Comply with requirements of health departments and law enforcement agencies

c. Fulfill your organization’s administrative needs

6. Drives funding and research for EMS

D. Computer, radio, and telephone communications

1. Link you to other members of the EMS, fire department, and law enforcement communities

2. You must know:

a. What your system can and cannot do

b. How to use the system efficiently and effectively

II. Therapeutic Communication

A. Therapeutic communication uses various communication techniques and strategies.

1. Both verbal and nonverbal

2. Encourages patients to express how they feel and achieves a positive relationship with patients

B. The Shannon-Weaver communication model was developed to assist in the mathematical theory of communication for Bell Telephone Labs in the late 1940s. The model remains a valuable tool in understanding human communications:

1. Sender takes a thought

2. Encodes it into a message

3. Sends the message to the receiver

4. Receiver decodes the message

5. Sends feedback to the sender

C. Age, culture, and personal experience

1. Influences how a person communicates

2. Body language and eye contact are greatly affected by culture.

a. In some cultures, people are encouraged to express emotion, while others view it as a sign of weakness.

b. In some cultures, it is impolite to look away while speaking.

3. Tone, pace, and volume of the language

a. Reflect the mood of the person communicating

b. Provide insight into the perceived importance of the message

4. Ethnocentrism: considering your own cultural values more important than those of others

a. People tend to translate messages they receive using their own worldview.

5. Cultural imposition: forcing your values onto others

a. Health care providers may consciously or subconsciously force their cultural values onto their patients because they believe their values are better.

D. Nonverbal communication

1. Body language provides more information than words alone.

a. Even without exchanging any words, you should be able to ascertain the patient’s mood.

E. Facial expressions, body language, and eye contact

1. Eye contact and body language are powerful communication tools.

2. Pay attention to body language, both your own and that of your patients.

3. Physical cues will help you and your patient to truly understand the message being sent.

4. When you are treating a potentially hostile patient, understand and be aware of your own body language. Stay calm and try to defuse the situation:

a. Assess the safety of the scene.

b. Do not assume an aggressive posture.

c. Make good eye contact, but do not stare.

d. Speak calmly, confidently, and slowly.

e. Never threaten the patient, either verbally or physically.

F. Physical factors

1. Noise: anything that dampens or obscures the true meaning of a message

a. Literal noise, or sounds in the environment, lighting, distance, or physical obstacles may affect your communication.

2. Cultural norms often dictate the amount of space, or proximity, between people when communicating.

a. As a person gets closer, a greater sense of trust must be established.

3. Your gestures, body movements, and attitude toward the patient are critically important in gaining the trust of both the patient and the family.

G. Verbal communication

1. One of the most fundamental functions of EMTs is to ask patients questions.

2. Open-ended questions require some level of detail in the response.

a. Use whenever possible

b. Example: “What seems to be bothering you?”

3. Closed-ended questions can be answered in very short responses.

a. The response is sometimes a single word like yes or no.

b. Use if patients cannot provide long answers. Example: “Are you having trouble breathing?”

c. May miss important issues if pertinent questions are not asked

4. You can use many powerful communication tools when trying to obtain information from patients:

a. Facilitation: encouraging the patient to talk more or provide more information

b. Pause: gives the patient space and time to think and respond

c. Reflection: restating a patient’s statement made to you to confirm your understanding

d. Empathy: being sensitive to the patient’s feelings and thoughts

e. Clarification: asking the patient to explain what he or she meant by an answer

f. Confrontation: making the patient who is in denial or in a mental state of shock focus on urgent and life-critical issues

g. Interpretation: restating the patient’s complaint to confirm your understanding

h. Explanation: providing factual information to support a conversation

i. Summary: providing the patient with an overview of the conversation and the steps you will be taking

5. When interviewing a patient, consider the careful use of touchto show caring and compassion.

a. Touch is a powerful tool.

b. Use it consciously and sparingly.

c. If you are going to touch the patient, approach slowly and touch the patient’s shoulder or arm respectfully or consider holding the patient’s hand.

d. Avoid touching the patient’s torso, chest, or face simply as a means of communication, because these areas are often viewed as intimate.

6. Interview techniques to avoid

a. Providing false assurance or reassurance

b. Giving unsolicited advice

c. Asking leading or biased questions

d. Talking too much

e. Interrupting

f. Using “why” questions

g. Using authoritative language

h. Speaking in professional jargon

7. Presence of family, friends, and bystanders

a. They may be valuable during the patient interview process.

b. Allow the patient to answer if he or she is able to and wants to, even if well-meaning family members attempt to answer for the individual.

c. Do not be afraid to ask others to step aside for a moment while you talk to the patient.

d. You may need to decide if having family and friends nearby will help or hinder care.

8. Golden Rules to help calm and reassure a patient:

a. Make and keep eye contact at all times.

b. Provide your name and use the patient’s proper name.

c. Tell the patient the truth.

d. Use language the patient can understand.

e. Be careful what you say about the patient to others.

f. Be aware of your body language.

g. Speak slowly, clearly, and distinctly.

h. If the patient is hard of hearing, face the patient so he or she can read your lips.

i. Allow the patient time to answer or respond.

j. Act and speak in a calm, confident manner.

H. Emotional intelligence (people skills)

1. The ability to understand and manage your own emotions and properly respond to others’ emotions

2. Helps defuse conflict, build a rapport, communicate more effectively, and manage difficult situations

3. Attributes of emotional intelligence

a. Self-awareness: the ability to recognize your emotions and how they affect your thoughts and behavior

b. Self-regulation: the ability to control impulsive emotions and behaviors and to manage emotions in a positive way

c. Motivation: the ability to motivate yourself and others in a positive direction

d. Empathy: the ability to understand the concerns, emotions, and needs of others by picking up on communication and social cues and clues

e. Social skills: the ability to develop and maintain positive rapport and relationships through effective communications

4. Understanding and improving your own emotional intelligence

a. Assess how you react to a stressful situation. Manage your frustration, and work on staying calm and in control when faced with minor irritations.

b. Practice mindfulness: focus your attention on the present moment, without blame and judgment of yourself and others.

c. Take responsibility for your actions.

d. Consider how your actions will affect others.

5. Behavioral change stairway model

a. Developed by the Federal Bureau of Investigation to manage hostage situations and adapted for most crisis situations:

i. Employ active listening.

ii. Display empathy.

iii. Build a rapport.

iv. Exert influence.

v. Initiate behavior change.

I. Communicating with older patients

1. Identify yourself.

2. Present yourself as competent, confident, and caring.

3. Do not assume that an older patient is senile or confused.

4. You may encounter hostility, irritability, and some confusion.

a. Do not assume this is normal behavior.

b. Assess for signs of hypoxia, CVA, drug overdose, infection, hypoglycemia, hyperglycemia, or insufficient perfusion.

5. Approach an older patient slowly and calmly.

6. Allow plenty of time for the patient to respond to your questions.

7. Watch for signs of confusion, anxiety, or impaired hearing or vision.

8. The patient should feel confident that you are in charge and that everything possible is being done for him or her.

9. Be patient!

10. Older patients:

a. Often do not feel much pain

b. May not be fully aware of important changes in their body systems

c. You must be especially vigilant for objective changes.

11. When possible, give the patient time to pack a few personal items before leaving for the hospital.

12. Locate any hearing aids, eyeglasses, and dentures before departure.

13. Older patients are often worried about the safety of their home, valuable items, and pets.

a. Share these concerns with the person assuming care of the patient at the hospital.

J. Communicating with children

1. Fear is most obvious and severe in children.

2. Children may be frightened by:

a. Your uniform

b. The ambulance

c. A crowd of people gathered around them

3. Let a child keep a favorite toy, doll, or security blanket.

4. If possible, have a family member or friend nearby.

a. If practical, let the parent or guardian hold the child during evaluation and treatment.

5. Be honest. Children easily see through lies or deception.

6. Tell the child ahead of time if something will hurt.

7. Respect the child’s modesty.

8. Speak in a professional, yet friendly way.

9. Use an appropriate tone and vocabulary.

10. Maintain eye contact.

11. Position yourself at the child’s level.

a. Do not tower over a child.

K. Communicating with patients who are hard of hearing

1. Most people who are hard of hearing have normal intelligence and are not embarrassed by their disability.

2. Position yourself so that the patient can see your lips.

3. Hearing aids

a. Be careful that these devices are not lost during an accident or fall.

b. They may be forgotten if the patient is confused.

c. Ask the family about use of a hearing aid.

4. Steps to take to efficiently communicate with patients who are hard of hearing:

a. Have paper and pen available.

b. If the patient can read lips, face the patient and speak slowly and distinctly.

c. Never shout.

d. Listen carefully, ask short questions, and give short answers.

e. Learn some simple phrases in sign language.

L. Communicating with visually impaired patients

1. Ask the patient if he or she can see at all.

a. Visually impaired patients are not necessarily completely blind. Many can perceive light and dark or can see shadows or movement.

b. Expect the patient to have normal intelligence.

2. Explain everything that you are doing as you are doing it.

3. Stay in physical contact with the patient as you begin your care.

4. If the patient can walk to the ambulance, place his or her hand on your arm.

5. Transport mobility aids such as a cane with the patient to the hospital.

6. Guide dogs

a. Easily identified by their special harnesses

b. If possible, transport the dog with the patient.

i. This alleviates stress for both the patient and the dog. Guide dogs are trained not to leave their masters.

c. Otherwise, arrange for care of the dog. A conscious patient can tell you about the dog and give instructions for its care.

M. Communicating with non­–English-speaking patients

1. You must obtain a medical history even though the patient does not speak English. You cannot skip this step.

2. Find out if the patient knows a few English words or phrases.

3. Use short, simple questions.

4. Point to parts of the body.

5. Have a family member or friend interpret until a professional interpreter is available.

6. Consider learning some common phrases in another language that is used in your area.

a. Pocket cards that show the pronunciation of terms are available.

b. Use a smartphone app or website to help you translate.

7. Request a translator at the hospital.

N. Mission-critical communications

1. Mission-critical communications are any communications where disruption will result in the failure of the task at hand.

2. Shared mental model

a. A mental model is the picture individuals have in their head of “what’s going on.”

b. For any team to work effectively together, all members must share a mental model.

c. To build a mental model, the following questions must be answered:

i. What is the focused priority for the patient? (What is the crux of the problem?)

ii. What is the history of prior care? (What got us to this point?)

iii. What is the patient’s current state? (Where are we now?)

iv. What is the patient’s immediate need? (What is the very next thing that needs to happen?)

d. Answering the four questions quickly and efficiently will help avoid errors and misunderstandings.

O. Patient care hand-over

1. Effective communication between EMS providers and other health care professionals in the receiving facility is essential to efficient, effective, and appropriate patient care.

2. Patient care hand-over is the transfer of pertinent patient information and the responsibility for patient care.

a. Communication failures between reporting providers and receiving providers are a source of medical liability for provider and organizations.

3. Giving the hand-over report

a. Initiate eye contact

i. Make eye contact with the person with whom the patient is being transferred.

b. Manage the environment

i. Whenever possible, try to minimize noise, interruptions, and distractions.

c. Ensure the ABCs

i. If there is priority critical care that must be initiated or continued, it must be immediately conveyed and addressed by the receiving clinician or team.

d. Provide a structured report

i. SBAR (situation, background, assessment, and recap/treatment)

ii. SBAT (situation, background, assessment, and treatment)

e. Provide documentation

i. The verbal report should consist of the patient’s priority condition, prior care, current state, and immediate needs.

4. Receiving the hand-over report

a. Maintain eye contact

b. Manage the environment

c. Ensure understanding

d. Summarize

e. Gather supplementary patient documentation

III. Written Communications and Documentation

A. Patient care report (PCR)

1. Also known as the prehospital care report

2. A legal document used to record all aspects of the care your patient received from initial dispatch to hospital arrival

3. Two types of PCRs: written and electronic

4. The PCR serves six functions:

a. Continuity of care

b. Compliance and legal documentation

c. Administrative information

d. Reimbursement

e. Education

f. Data collection for continuous quality improvement and research

B. Examples of information collected on a PCR:

1. Chief complaint

2. Mechanism of injury or illness

3. Level of consciousness (using AVPU) or mental status

4. Vital signs

5. Initial and ongoing assessment

6. Patient demographics (age, gender, ethnic background)

7. Transport information (how the patient was moved and reason for destination choice)

C. Administrative information gathered from a PCR, including when:

1. The incident was reported.

2. The EMS unit was notified.

3. The EMS unit arrived at the scene.

4. The EMS unit left the scene.

5. The EMS unit arrived at the receiving facility.

6. Patient care was transferred.

7. The unit is back in service.

D. Types of forms

1. Most PCRs are completed in an electronic format referred to as an ePCR.

a. Virtually all are designed to comply with NEMSIS data collection requirements.

b. ePCRs allow patient information to be transmitted directly to hospital computers and may be integrated with the patient’s electronic medical record.

2. The narrative section of the PCR may be the most important.

**E. Standardized narrative formats:**

1. The two most common narrative formats used in health care are CHART and SOAP.
2. CHART method

a. Stands for chief complaint, history and physical examination, assessment, treatment and transport

i. Begin with the dispatch information.

b. Chief complaint or chief concern

i. States the condition most urgently requiring EMS intervention

c. History

i. Includes details relating to the current event and the patient’s medical history prior to this event

ii. Details come from the patient or others on scene, from dispatch or from the patient record.

d. Assessments

i. Describe all assessments you perform on the patient, including vital signs and the physical examination.

e. Treatment (Rx)

i. Detail all interventions that were performed.

f. Transport

i. Explain how the patient was moved to the ambulance.

ii. How the patient was transported (positioned and secure)

iii. Whether emergency lights and sirens were used

iv. Where the patient was taken, including the room number

v. The name of the person to whom the report was given and care was transferred

3. SOAP method

a. Subjective

i. Include information by the patient or others on the scene, such as the chief complaint, events leading up tot the incident, mechanism of injury and past medical history.

b. Objective

i. Include details you gather primarily through patient assessment, such as vital signs, physical exam findings, and other measurements, such as blood glucose or oxygen saturation.

c. Assessment

i. Summarize key findings. If appropriate, provide your impression of what the patient’s problem might be (eg, possible fractured lower leg or possible stroke).

d. Plan

i. Document treatment provided for the patient.

4. Once complete, distribute copies to the appropriate location.

F. Documenting medical necessity

1. Medicare and Medicaid payers will reimburse for ambulance transport only if the services are medically necessary.

2. Medically necessary means it would have been unsafe or impossible to transport the patient by any other means.

3. Example of scenarios constituting medical necessity:

a. The patient was transported in an emergency situation and could not be transported by other means.

b. The patient needed to be restrained to prevent injury to prevent injury to self or others.

c. The patient required oxygen or other emergency treatment during transport to the nearest appropriate facility.

d. The patient was unconscious or in shock.

e. The patient exhibited signs and symptoms of acute respiratory distress or cardiac distress.

f. The patient needed to remain immobile because of a fracture that had not been stabilized or the possibility of a fracture.

g. The patient experienced severe hemorrhage.

h. The patient was confined to a bed before and after the ambulance trip.

4. Medical necessity also applies to the level of care provided for the patient.

5. Signatures from the patient or guardian are also required for appropriate reimbursement.

G. Health information exchanges (HIEs)

1. Improves the sharing of data between EMS and other health care providers

2. Allow EMS providers to access relevant health data, avoid unnecessary duplication of effort in data entry, and view patient outcomes related to hospital care

3. Allow EMTs to contribute to and access electronic health information on both a regular basis and during times of disaster

4. Most HIEs follow the SAFR framework:

a. Search

i. EMS providers can search for hospital and other records that will help make treatment and transport decisions.

b. Alert

i. Hospitals are notified of incoming EMS patients with automated systems that populate ED dashboards with information entered by EMS in the field.

c. File

i. Data in the EMS electronic patient care reports are incorporated directly into patient’s longitudinal health records.

d. Reconcile

i. Feedback on outcomes and other hospital data are provided to EMS agencies for billing and quality improvement.

H. Reporting errors

1. If you leave something out or record it incorrectly, do not try to cover it up.

2. Falsification:

a. Results in poor patient care

b. May result in suspension and/or legal action

3. If you discover an error as you are writing your report, draw a single horizontal line through the error, initial it, and write the correct information next to it.

a. Do not try to erase or cover the error with correction fluid.

4. If an error is discovered after you submit your report, follow the same process.

a. Add a note with the correct information.

b. If information was accidentally omitted, begin the new section with the word “addendum,” add the new information, then add the date and your initials.

I. Documenting refusal of care

1. Refusal of care is a common source of lawsuits.

a. Thorough documentation is crucial.

2. Document any assessment findings and emergency medical care given.

3. Have the patient sign a refusal form.

a. Have a family member, police officer, or bystander also sign the refusal form as a witness.

4. Depending on local requirements, the PCR might contain:

a. Complete assessment

b. Evidence that the patient is able to make a rational, informed decision

c. Discussion with the patient as to which care/transportation EMS recommends

d. Discussion with the patient as to what may happen if he or she does not allow care or transportation

e. Discussion with family, friends, or bystanders to try to encourage the patient to allow care

f. Discussion with medical direction according to local protocol

g. Providing the patient with other alternatives—for example, going to see his or her family doctor, or having a family member drive him or her to the hospital

h. Willingness of EMS to return

i. Signatures

5. Complete the PCR.

J. Special reporting situations

1. Depending on local requirements, may include:

a. Gunshot wounds

b. Dog bites

c. Certain infectious diseases

d. Suspected physical or sexual abuse

e. Multiple-casualty incident (MCI)

IV. Communications Systems and Equipment

A. Radio and telephone communications link you and your team with other members of the EMS, fire, and law enforcement communities.

1. Help the entire team to work together more effectively

2. Provide an important layer of safety and protection

B. Base station radios

1. Base station: any radio hardware containing a transmitter and a receiver that is located in a fixed place

2. Two-way radio: consists of a transmitter and a receiver

a. May also be equipped with one multichannel and several single-channel receivers.

b. A channel is an assigned frequency or frequencies used to carry voice and/or data communications.

3. A dedicated line, also known as a hotline, is used for specific point-to-point contact.

C. Mobile and portable radios

1. A mobile radio is installed in a vehicle.

2. Mobile radios are used in the ambulance to communicate with:

a. The dispatcher

b. Medical control

3. An ambulance often has more than one mobile radio.

4. Portable radios are hand-held devices.

a. Essential at the scene of an MCI.

5. When away from the ambulance, a portable radio is helpful to communicate with:

a. Dispatch

b. Another unit

c. Medical control

D. Repeater-based systems

1. A repeater is a special base station radio.

a. Receives messages and signals on one frequency

b. Automatically retransmits them on a second frequency

c. Allows two mobile or portable units that cannot reach each other directly to communicate using its greater power and antenna

E. Digital equipment

1. Telemetry converts electronic signals into coded, audible signals.

a. Signals can be transmitted by radio or telephone to a receiver with a decoder at the hospital.

b. Data from cardiac monitors can be transmitted via Bluetooth-enabled mobile devices to monitoring centers.

2. Digital signals are also used in some kinds of paging and tone-alerting systems.

F. Cellular/satellite telephones

1. EMTs often communicate with receiving facilities by cellular telephone.

2. Satellite phones (satphones) are another option.

3. A scanner is a radio receiver that searches or scans across several frequencies, stops whenever it receives a radio broadcast on that frequency, and continues once the message is complete.

a. Conversations can be easily overheard.

G. Other communications equipment

1. Ambulances usually have an external public address system.

2. EMS systems may use a variety of two-way radio hardware.

a. Simplex is push to talk, release to listen.

b. Duplex is simultaneous talk–listen.

c. Multiplex utilizes two or more frequencies, which enables more than one transmission to occur simultaneously.

3. MED channels are reserved for EMS use.

4. Trunking, or 800-MHz, assigns many frequencies allowing the computer to constantly monitor for an open frequency.

5. An interoperable communications system allows all of the agencies involved to share valuable information in real time.

6. Mobile data terminals (MDTs) inside ambulance

a. Receive data directly from dispatch center

b. Allow for expanded communication capabilities, such as maps

V. Radio Communications

A. The Federal Communications Commission (FCC) regulates all radio operations in the United States.

1. The FCC has five principal EMS-related responsibilities:

a. Allocate specific radio frequencies for use by EMS providers.

b. License base stations and assign appropriate radio call signs for those stations.

c. Establish licensing standards and operating specifications for radio equipment used by EMS providers.

d. Establish limitations for transmitter power output.

e. Monitor radio operations.

2. The FCC’s rules and regulations section (part 90, subpart B) deals with EMS communications issues.

B. Responding to the scene

1. The dispatcher receives the first call to 9-1-1.

2. Responsibilities of the dispatcher:

a. Properly screen and assign priority to each call (according to predetermined protocols).

b. Select and alert the appropriate EMS response unit(s).

c. Dispatch and direct EMS response unit(s) to the correct location.

d. Coordinate EMS response unit(s) with other public safety services until the incident is over.

e. Provide emergency medical instructions to the telephone caller.

3. The dispatcher assigns the appropriate EMS response unit(s) based on several criteria:

a. Nature and severity of the problem

b. Anticipated response time to the scene

c. Level of training of available EMS response unit(s)

d. The need for additional support

4. The dispatcher should give the responding unit(s) the following information:

a. Nature and severity of the injury, illness, or incident

b. Exact location of the incident

c. Number of patients

d. Responses by other public safety agencies

e. Special directions or advisories (adverse road or traffic conditions or severe weather reports)

f. Time when unit(s) are dispatched

5. EMTs should report any problems that took place during a run to the dispatcher.

6. EMTs should inform the dispatcher upon arrival at the scene.

a. The arrival report should include any obvious details observed during scene size-up.

b. Radio communications must be brief and easily understood.

c. Speak in plain English and do not use code words.

d. Report only important information.

C. Communicating with medical control and hospitals

1. The principal reason for radio communication is to facilitate communication between you and medical control (and the hospital).

2. Medical control may be located at the receiving hospital, another facility, or sometimes even in another city or state.

3. Consulting with medical control serves several purposes:

a. Notifies the hospital of an incoming patient

b. Provides an opportunity to request advice or receive orders from medical control

c. Advises the hospital of special situations

4. Plan and organize your radio communication before you transmit.

D. Giving the patient report

1. The report commonly includes the following 10 elements:

a. Your unit identification and level of services

b. Any special “alert” (trauma alert for example) indicated by the patient’s status or care

c. The receiving hospital and your estimated time of arrival

d. The patient’s age and gender

e. The patient’s chief complaint or your chief concern regarding their problem and its severity

f. A brief history of the patient’s current problem

g. A brief report of physical findings

h. A brief summary of the care given and any patient response

i. A brief description of the patient’s response to the treatment provided

j. Determine whether the receiving facility has any additional questions or orders.

E. The role of medical control

1. Medical control is either off-line (indirect) or online (direct).

2. Depending on how the protocols are written, you may need to call medical control for direct orders (permission) to conduct certain tasks:

a. Administering certain treatments

b. Determining the transport destination for patients

c. Stopping treatment and/or not transporting a patient

3. In most areas, medical control is provided by the physicians working at the receiving hospital.

4. Many variations have developed across the country.

In some areas medical direction may come from a freestanding center or from an individual physician.

F. Calling medical control

1. There are a number of ways to control access on ambulance-to-hospital channels:

a. Dispatcher monitors and assigns appropriate, clear medical control channels

b. Centralized medical emergency dispatch or resource coordination centers

2. Your report must be precise and contain only important information.

3. Never use codes when communicating with medical control, unless you are directed to do so by local protocol.

4. Once you receive an order from medical control, repeat the order back word for word and then receive confirmation.

5. Do not blindly follow an order that does not make sense to you.

G. Information regarding special situations

1. You may initiate communication with hospitals to advise them of an extraordinary call or situation.

a. A small rural hospital may be better able to respond to multiple patients from a highway crash if notified when the ambulance is first responding.

b. An entire hospital system must be notified of any disaster.

2. Other special situations:

a. Hazardous materials situations

b. Rescues in progress

c. Multiple-casualty incidents

3. When notifying the hospital of special situations, keep in mind:

a. The earlier the notification, the better.

i. Provide an estimate of the number of individuals who may need to be transported to the facility.

ii. Identify any special needs the patients might have (eg, burns or hazardous materials exposure) to assist the hospital in preparation.

4. Follow the plan for your system.

H. Maintenance of radio equipment

1. Like other EMS equipment, radio equipment must be serviced.

2. At the beginning of a shift, check the radio equipment.

3. Radio equipment may fail during a run.

a. The backup plan must then be followed.

b. Standing orders: written documents signed by the EMS systems medical director outlining specific directions, permissions, and sometimes prohibitions regarding patient care

i. When properly followed, they have the same authority and legal status as orders given over the radio.

Post-Lecture

## Assessment in Action

A. Assessment in Action is available in the Navigate course.