System Medical Advisory

June 19, 2018

Lift Assist

Background of the Problem:

- Lift assists represent a population at greater risk for illness or injury than previously thought. By nature of their situation and due to the presence of any number of underlying conditions, these individuals carry significant risk for decompensating illness and/or injury.
- The risks associated with "lift assists" have been well-documented in the medical literature for more than 20 years. Most recently, a study reported up to 20 percent of these patients end up in the emergency department within two weeks.
- The current Medical Priority Dispatch System is not capable of adequately triaging these individuals to significantly reduce these risks.
- For lift assists, identification of the true cause of the person's event (fall or otherwise) and/or reasons for heightened risk of injury is essential but often cannot be identified without a thorough assessment and history.
- These lift-assist patients may not fully grasp the risks associated with a limited assessment and/or refusing transport even when providers attempt to communicate these risks to the patient.
- Without addressing the true cause(s) of the event, a significant percentage of these individuals will have an increased likelihood of subsequent calls for 9-1-1 assistance.

Solution:

- All individual calls categorized as "lift assists" are considered patients. As such, these patients require a full history, assessment and patient care record.
- In particular, these patients carry a greater risk for a decompensating/worsening underlying medical condition and/or potential fracture (including but not limited to cervical spine and pelvis fractures).
- A lift-assist patient may meet the "high risk" patient category based on their age, condition, or any "yes" answer to the criteria highlighted in the Lift Assist History checklist.
- If a lift assist patient meets criteria for "high risk," then the patient must be offered an evaluation by a system-credentialed Advanced Level Provider (future Provider Level 5 or above). Any offer should include the risks and benefits of a more thorough evaluation and an explanation that this will not necessarily require the patient be transported to an emergency department. If the patient refuses to accept an ALS-credentialed Provider evaluation, the first responder must complete a full assessment and physical exam (including a full set of vital signs).

This must also include evaluation of full mental capacity and documentation of the Lift Assist History checklist.

- The first responder on scene must contact the On-Call System Medical Director for further recommendations if the patient meets the "high risk" patient category but refuses ALS evaluation. Following communication with the On Call System Medical Director, the first responder may proceed with the refusal form.

Lift Assist History Checklist:

1. Have you had any recent falls or illness that include fever, chills, nausea, vomiting, diarrhea, shortness of breath, chest pain, dizziness or other illness?
2. Did you faint or pass out?
3. Have you had any new or worsening weakness?
4. Is the reason you called us today a new problem for you?

Risk-Benefit Disclosure to be explained to all patients refusing further evaluation or transport:

There is the potential that you have a serious underlying medical condition that resulted in your inability to move yourself. You have received a basic screening exam only and we are unable to fully evaluate for a large number of potential illnesses or injuries. Despite this, you are refusing a more advanced assessment by one of our advanced level providers.

As promised, here is the YouTube link to the full quality video. https://youtu.be/IjCJ_TwbKIU

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Refusal of Care and Capacity Checklists CR-29

Refusal of Care/Treatment Checklist:

- ❑ Pt is ≥ 18 or emancipated minor
- ❑ Pt is not suicidal/homicidal
- ❑ Pt demonstrates capacity
- ❑ Pt understands evaluation is incomplete
- ❑ Solutions to obstacles have been sought
- ❑ Pt instructed to seek medical attention
- ❑ Pt instructed to call back at any time
- ❑ Above documented fully in PCR
- ❑ The following are considered **high risk** patient/situations:
    - *Age greater than 65 or Less than 3?*
    - *Pulse greater than 110 or less than 60?*
    - *Systolic BP greater than 200 or less than 90?*
    - *Respirations greater than 30 or less than 12?*
    - *Serious chief complaint (chest pain, SOB, syncope)*
    - *Significant MOI or high suspicion of injury (CR-30 Steps 1, 2, 3)?*

Any "High Risk" patient as defined above **must** be assessed by an ALS-credentialed Provider or Responder.

EXCEPTION: If an ALS-credentialed Provider or Responder has not been dispatched to the scene and the primary complaint is ambulatory dysfunction i.e. "lift assist," then there **must** be an offer for an ALS evaluation. If the patient subsequently refuses ALS evaluation, the On-Call System Medical Director (OCSMD) **must** be contacted. Following contact with the OCSMD, the first responder may complete the refusal form based on OCSMD recommendations.

Even when an ALS-credentialed Provider or Responder completes a full evaluation, consultation with the On Call System Medical Director is recommended for all "high risk" refusals.

Lift Assist History Checklist for BLS and ILS Providers/Responders:

- ❑ Have you had any recent falls or illness that include fever, chills, nausea, vomiting, diarrhea, shortness of breath, chest pain, dizziness or other illness?
- ❑ Did you faint or pass out?
- ❑ Have you had any new or worsening weakness?
- ❑ Is the reason you called us today a new problem for you?

I addition to the "high risk" criterion above: If **YES** to any of these 4 checklist questions; the patient is in the "high risk" category. The patient **must** be offered an evaluation as indicated above.

Risk-Benefit Disclosure (Read to all "high risk" patients **refusing** ALS evaluation):

There is the potential that you have a serious underlying medical condition that resulted in your fall or that occurred because of your fall. You have received a basic screening exam only and we are unable to fully evaluate for a large number of potential illnesses or injuries. Despite this, you are refusing a more advanced assessment by one of our advanced level providers.

Capacity Checklist:

- ☐ Patient is able to express in their own words:
  - An understanding of the nature of their illness
  - An understanding of the risks of refusal including death
  - An understanding of alternatives to EMS treatment/transport
  - Pt can provide rationale for refusal and debate this rationale
- ☐ A patient with any of the following **MAY** lack decision making capacity and should be carefully assessed for their ability to perform the above.
  - Orientation to person, place or time that differs from baseline
  - History of drug/alcohol ingestion with appreciable impairment such as slurred speech or unsteady gait
  - Head injury with LOC, amnesia, repetitive questioning
  - Medical condition such as hypovolemia, hypoxia, metabolic emergencies (e.g., diabetic issues); hypothermia, hyperthermia, etc.
- ☐ If any question exists about their capacity contact the On Call System Medical Director

BLS Transport Decision Process CS - 14

Purpose: To define patients that cannot be transferred to a provider other than a Credentialed Paramedic.

Application:

For the purposes of this standard, “Paramedic” refers to an Austin/Travis County EMS System Credentialed Paramedic with no current restrictions on their credential to practice.

All providers on scene are expected to participate in patient care. Both providers are responsible for conducting an initial evaluation to determine a chief complaint, level of distress and initial treatment plan. Stable patients not in need of paramedic level care may be attended by another provider. The Transport Paramedic is responsible for making the decision for which patients can be safely transported by a provider with lower credentials.

The care of the following patients **cannot** be transferred to a lower level of Credential by a Transport Paramedic:

1. Any patient who requires additional or ongoing medications, intervention and/or monitoring beyond the scope of practice of the System Credentialed EMT - B provider refer to OMD Reference OMDR – 03.
2. Any patient that receives medications beyond the scope of practice of the System Credentialed EMT-B provider.
3. Postictal seizure patients who have not returned to baseline mental status.
4. Any patient with the following: Trauma Activation (steps 1 and/or 2), Stroke Alert, STEMI Alert, or Syncope.
5. Any patient for which the transporting providers **do not agree** can be safely transported without a Paramedic attending in the back of the ambulance.
6. Any “High Risk” patient as defined in Clinical Reference CR – 29 must be assessed by a Medic II.

Exceptions to the above listed items:

- Patients listed as “High Risk” in CR-29 may be transported by a Medic I provider if, the Medic II provider completes an assessment and; the patient does not require any care/monitoring beyond the scope of practice of the Medic I.
- Patients who received a **single dose** of intranasal (IN) narcotic for the purpose of pain control in a traumatic injury **not involving** the head, chest, or abdomen.
- Patients having a Syncopal episode, who are < 50 yrs. old, have a normal blood sugar, and a normal ECG.
- Monitor IV Saline Lock.
- Monitor PO route medications administered by a Medic II.
- Any hypoglycemic patient that returns to baseline mental status after treatment.
- A BLS Transport Provider may call and obtain a Termination of Resuscitation (TOR) on behalf of a Paramedic Transport Provider post ALS assessment; for patients that meet the Criteria for Death or Withholding Resuscitation, Clinical Standard CS-06. Patients who fall under the Discontinuation of Prehospital Resuscitation, Clinical Standard CS-08, and the decision for TOR must be discussed between the Medic II and the Physician.
- Refer to OMDR-3 for additional Scope of Practice.

Any “High Risk” patient as defined in CR-29 **must** be assessed by an ALS-credentialed Provider or Responder.

EXCEPTION: If an ALS-credentialed Provider or Responder has not been dispatched to the scene and the primary complaint is ambulatory dysfunction i.e. “lift assist,” then there **must** be an offer for an ALS evaluation. If the patient subsequently refuses ALS evaluation, the On-Call System Medical Director (OCSMD) **must** be contacted. Following contact with the OCSMD, the first responder may complete the refusal form based on OCSMD recommendations.

Even when an ALS-credentialed Provider or Responder completes a full evaluation, consultation with the On Call System Medical Director is recommended for all “high risk” refusals.

The ePCR should reflect the decision making process to determine which provider attends in the back of the ambulance. As with all documentation, both providers are responsible for the content of the ePCR.