Carnegie Mellon University
Emergency Medical Services

Crew Chief Training Manual

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Introduction

Welcome to the CMU EMS Crew Chief (CC) Training Manual. This manual has been designed as a comprehensive resource for the Crew Chief-in-training (CCIT), as well as a reference for current CCs. Its reading is required didactic training for the CCIT program, and CCITs should feel comfortable with the material in order to function effectively on scene.

The material is organized logically such that it can be read coherently from start to finish, but is also arranged such that individual facts can be looked up easily. While there is a large amount of information to master, don't feel overwhelmed! You will soon learn that a majority of the knowledge is used on a day-to-day basis and quickly becomes instinctive.

Why do we have the Crew Chief?

The CC serves many purposes within CMU EMS. The foremost of the CC's functions is, as the name explains, to oversee all aspects of a crew. Regardless of the medical training of a crew, it is important to have a single person who is taking responsibility for a particular shift. This person needs to coordinate all aspects of a shift, from scheduling, to running calls, to special issues with certain crew members. For CMU EMS this person is the Crew Chief.

On scene, the CC is the CMU EMS member who is ultimately in charge of the patient. It is his or her responsibility to assure that appropriate exam, treatment, and transport of the patient are provided, although under ideal circumstances, active patient interaction should be mostly performed by other members of the responding crew. The CC also has the role of evaluator for any in-training members who are participating in the call. If a refusal of treatment and/or transport is required for the patient, the CC ensures that it is appropriately filled out and signed. Medical Command is contacted by the CC as well, if necessary, and as such the CC must be able to give a clear and coherent medical command report. The CC is also the member that should be coordinating communications and interactions with any other responding agencies, including but not limited to CMPD and City of Pittsburgh Department of Public Safety.

It is important to understand that while the Crew Chief may be the most medically trained member on a scene, **the purpose of the Crew Chief is to coordinate**, as opposed to directly provide care. A Crew Chief must be on every call to ensure everything goes right.

After the completion of a call, the CC is responsible for reviewing the call with its members and completing evaluations for in-training members. The CC assures that soiled equipment is decontaminated or replaced, and that CMU EMS is ready to respond to subsequent calls. Dispatch/On-scene/Clear times are obtained from the CMPD dispatcher, and the call information is logged. The CC makes sure that appropriate Pennsylvania state documentation is completed in a timely manner, either by themselves or by an appropriately trained other member.

A Short History

The command structure of CMU EMS has undergone several large changes that bring us to where we are today. Originally, the on-duty crew was segregated into "medical" and "trauma" teams, with each

responding only to their representative classes of calls. An EMT was required to respond to all calls, although at times an "experienced" first responder was allowed to be the responsible crewmember during times of short staffing. No specific training was required of EMTs to be crew leaders.

The next alteration to occur rearranged the on-duty members into one crew, as we have currently, still with an EMT as the required member to respond. As staffing became more predictable, the use of non-EMTs as "crew chiefs" diminished. Three- and four-day continuous shifts eventually were reduced to the 24-hour shifts that we continue to implement.

The last major reorganization brings us to the current state of operations. With the institution of medical command protocols that were only available to EMTs, first responders could no longer act as Crew Chiefs. In addition, training sessions with the medical director to become "on orders" for protocols were required, now allowing only *trained* EMTs to sign off on calls. Realizing that there was now quite a bit of experience and knowledge to be gained once someone's EMT certification was obtained, the CCIT program was instituted. Today the program is even more involved, allowing us to provide the highest level of care to students, faculty, staff, and visitors.

Operating Policies

In addition to our medical command protocols, CMU EMS has day-to-day policies that help the Operations Manager maintain the operational status of the service. Most of the topics covered in this manual also have associated policies that should be reviewed frequently. These policies are written by the Operations Manager and approved by the QAB are constantly reviewed and revised for clarity and relevance. These policies are available together in the CMU EMS Operating Policies section of the documentation manual.

Crewmembers & You

There are five different types of active members in the organization who might show up to any given call. As a CC, it is imperative that you know who is coming and what to expect of them. A short summary of each classification is given below.

Precepting Member

Because of their ranges in experience, the precepting members' role in the call is largely dependant on their confidence. As they near completion of their medical member training standards, the precepting members should be able to perform most, if not all exams, as well as provide any treatments in which they are trained. They are not allowed on scene by themselves (except for extenuating circumstances such as cardiac arrest) and should coordinate with the nearest responding medical member on where to meet. Precepting members should be evaluated on all calls and provided with encouragement and education as they proceed to medical membership.

Medical Member

The CMU EMS medical member is the workhorse of the organization. He or she can proceed on scene by themselves, provide a complete exam, and render all treatments encompassed by their level of certified training. For most calls, he or she should be allowed to do as much as possible, freeing up the CC to deal with their duties on a call. Should the CC not be the first member to reach the patient, medical members should give a brief report to the CC when he or she arrives. Medical members may also assist in evaluating precepting members, as the CC may not be able to observe all of the actions.

Crew Chief-in-Training (CCIT)

After completion of appropriate didactic training and a medical command protocol review, CCITs may begin their field training. Like precepting members, the level at which the CCIT functions may be dependent on their experience. Ideally, the CCIT functions exactly as the CC, taking dispatches, organizing call response, equipment replacement, etc. The CC however should be aware that the CCIT is still very much in training and must be supervised to correct any errors as needed. This being said, a CC should only make corrections on-scene when they directly affect patient care. A CCIT may not, except in extreme circumstances, operate independently from a CC. In situations where there is both a CC and a CCIT, the CC is still ultimately responsible for the patient and the call.

Crew Chief (CC)

As described in the *Introduction*, the CC has a variety of roles while on scene. Other duties required of the CC include checking the CMPD car bags/AEDs on prescheduled dates, ensuring the crew's equipment is signed out appropriately, reviewing tripsheets, and various other tasks that are described throughout this and other training manuals. The CC is an EMT that has medical command authorization to administer of specific medications, is certified in CPR and AED use, and can appropriately treat and secure transport for any medical emergency they are presented with. This represents the highest level of medical training in CMU EMS.

Supervisor

As defined, the Supervisor is a member of CMU EMS that has been designated to represent the Executive Director and Operations Manager when they are not present. A Supervisor is generally a CC who has been involved with the organization for a long period of time, and is appointed by those who he or she represents. While there is no stated further medical training past the CC level, the Supervisor should have the appropriate interpersonal and organization skills to deal with a variety of complicated circumstances that are not necessarily taught as part of CC training. Such events include interaction with the press, University officials, certain "serious" calls, and disputes among crewmembers. Further information about situations that warrant a supervisor response can be found in the CMU EMS *Staffing Policy*.

Leadership – setting the example for you crew

As the Crew Chief, it is your role to ensure the appropriate treatment and transport of your patients. While you may occasionally be the only responding EMS provider, it is most frequently the case that you will be orchestrating the involvement of two or three other CMU EMS members, as well as CMPD; City of Pittsburgh public safety officers; and friends, family, and coworkers of the patient. It is accordingly important that Crew Chiefs become confident in their actions and function as leaders both on and off the scene of a call.

Setting the Example

From the moment the tones go out until the call is over, the Crew Chief sets the tone of the call. New members, as well as those who have been involved with EMS for quite some time, will pick up on your "style." It is necessary then that you are setting an appropriate example for your crew when you are representing the organization. Some of the best training and scene control measures are not active, but passively demonstrated through your own actions. The easiest way to avoid bad habits in your crew is to avoid them yourself!

Face-to-Face Communication

Whenever possible, communications with your fellow EMS members should be made face-to-face. CMU EMS is a close-knit family, and face-to-face communication is highly encouraged. This provides the most effective discussions of issues with your crewmembers and allows for them to feel open to talk to you as well. It is very important to praise publicly and criticize privately but always doing so in a face-to-face manner. Even though e-mail is very pervasive here, avoid using it as a replacement for person to person interactions.

Morale

At this point in your training as a Crew Chief, you should be well aware that crew morale is not always at its highest. EMS as a profession requires long hours, frequent arousal from sleep, dealing with illness and injury on a constant basis, and oftentimes a complete lack of appreciation from those we serve and those we work with. As a leader and role model for your crew, you, as a Crew Chief, have a valuable opportunity to keep spirits high. Foster conversation with your crew as an outlet for stress and offer suggestions for coping. CMU EMS members have historically gotten together outside of the EMS setting and it is hoped that this trend does continue.

Giving Orders

Giving orders is a necessary skill for the Crew Chief in charge of patient care and the incident scene. In general your crewmembers will follow your orders without incident, but there are a few points to keep in mind. Firstly remember to be courteous; "please" and "thank you" will get you far. Keep calm and do not yell, a practice that will quickly produce a lowering in morale and respect as well as a general disregard for what you are saying. Finally for those times when someone from your crew disagrees with you, it is important to keep in mind that patient care comes first. When the call is not serious, you may quickly discuss the issue with the member, out of earshot of the patient at best. Again remember

to be respectful of the other person's point of view – often times they may be correct! A Supervisor can also be called to the scene to help mitigate the issue, but this is a route that can hopefully be avoided by good interaction with your crew. When time is of the essence, it may be necessary to ask the member to "step aside" from the patient such that you or another member can perform a needed exam or treatment. Again tact is of utmost importance, and this should not be a situation that you will see with any regularity.

Giving Praise

Praise of a job well done can never be expressed too often. It is the practice of CMU EMS to announce all organizational rank increases on the public electronic bulletin boards. It is nice to thank your crew after each call, and especially after the more trying ones. Exemplary actions should be announced to the organization. A far too uncommon use of the incident reporting system is just for this purpose. Please take advantage of it. If you would like some other ideas, please contact a Supervisor or an Executive Board member.

Giving Comments/Criticism

If you have suggestions, be direct, and try to preface them with the things the member did correctly. Try to save all comments and criticisms until after the call. A post-call wrap-up can happen with the full crew, and should include "what was wrong with this person, and what could we do for them" but sometimes may include comments about the performance of the crew. Some of these comments should be done in private. Be sure to tactfully ask to speak with a crew member in a private setting and try to avoid situations where you are announcing what that member did wrong.

Giving Punishment

Administering a reprimand is one of the most difficult aspects of crew management. It is often seen as a personal attack, however should ideally never be so. Punishment is generally left up to Supervisors and QAB members. The Crew Chief role in punishment often consists of its reporting via an incident report, as well as enforcement should it involve restrictions while on duty. General crew interaction techniques as discussed in this section should still apply.

Equipment -

Almost all calls require some type of equipment to be used. The severity and type of call will dictate which of the following pieces of equipment you may require.

Jumpkits

Every member of the CMU EMS duty crew carries a jump kit of some type. This kit allows a member to treat a wide variety of situations without requesting additional equipment. It also allows a member to have ready access to soft tissue supplies which are used on a majority of our calls. The jump kit contents are standardized however the layout may be slightly different from bag to bag. There is a list of what goes in a jump kit hanging in the front office near the battery chargers.

Crew Chief Bag

The CC bag (or in reality, backpack) contains additional items for the CC or their designee to use and is essentially an overgrown jump kit. This bag must be checked at the beginning of each shift by the CC or CCIT. In the main compartment is the CC jump kit which is composed of exactly the same items as the standard jump kits but also contains a spacer (for use with a metered dose inhaler) and a set of nasal airways.

The second compartment contains the pulse-ox, digital thermometer, extra gloves, and O2 wrench. You must always check the pulse-ox to be sure it works at the beginning of every shift. The CC key ring contains keys to some of the off campus residence halls and the crew quarters, AED locations, equipment cabinet. CCs should each have their own supervisor key that will allow them entrance to all card accessed dorms.

The front compartment contains the clipboard with refusals, on-scene forms, hospital information, important phone numbers, pediatric conversion charts and protocol information. Make sure this is stocked and ready to use at the start of the shift.

Car Bags

Inside four of the marked Campus Police car there is a car bag which contains additional equipment. In general, these bags must be requested either through dispatch or through an officer and will be brought to the scene. The two front compartments of the car bag contain soft-tissue and irrigation supplies which closely resemble the contents of a standard jump kit. The main compartment contains a D size O2 cylinder, O2 administration supplies, activated charcoal, clipboard and a flashlight. The top compartment contains airway equipment, PPE, and a pediatric BVM. The side pockets contain stethoscopes and BP cuffs. The rear compartment contains an OB kit, HazMat book, rain blanket, trauma dressings, burn sheets, rain blanket, SAM splints, C-collars and cravats. *Appendix I* provides a complete list of all items and their locations within the various car bags.

AED, Suction, Backboard, Splint Bag & Blankets

All CMPD cars have a splint bag, folding backboard, and AED. One car includes a stair chair. There is an additional stair chair in the basement of 300 S Craig St. The splint bag contains a set of disposable air splints as well as standard splinting materials including SAM splints, cravats, etc. C-Collars, head-wedges and other splint supplies are also included in the splint bag. The AEDs in the cars should be moved from the trunk to the passenger compartment of any car when the outside temperature drops below 40 degrees, mid October, and can be returned to the trucks in mid April .

Equipment Restocking

Soft tissue supplies are available for restocking from the shelf in the office. Any additional supplies are located in the equipment cabinet that is in the back office. Supplies can be found by referencing the cabinet guide which is on the inside of the right door. Any issues should be brought to both the Operations Manager and the Equipment Director. Do not throw anything that is damaged away, instead replace it and leave it for the equipment director to handle – it may be useful for training or to take parts from.

If you use a car bag during the course of a call, please replace any used items, reseal the bag and return it to Campus Police for placement back into the proper car. Do not put it back and expect someone else to deal with it.

Care, Cleaning and Decontamination

Please take care to treat our equipment with respect. Most of this equipment needs to last many years and with the proper care it will do just that. All equipment should be clean and in good working order when you use it. Some equipment also will come in a sterilized package. Any sterile package which is opened (therefore no longer sterile) should be replaced.

If any equipment comes in contact with bodily fluids or becomes excessively dirty, please follow the posted cleaning and decontamination procedures as outlined in the CMU EMS Documentation binder or posted on the main office bulletin board. When in doubt, use a 1 to 10 solution of bleach and water or an alcohol based disinfectant.

Car Bag Checks

Twice a week, (Historically on Monday and Thursday nights at 23:00 hours) the car bags must be checked. This involves going to 300 S Craig St and requesting keys for all four marked police cars from the dispatcher. Open each trunk and ensure that the proper equipment is located in it (note: the AED might be in the passenger area) and that the two front, main and rear pockets of the bags are sealed. In the event that a bag is not sealed, please take it to the office and complete a car bag checklist which is located on a clipboard above the chargers on the office wall. Compartments that require seals should be resealed after checking. See *Appendix I* for a sample checklist.

Radios & Communication Devices

This section contains a description of important radio terms, which you will need to understand in order to understand the CMU EMS radio system.

Channels and Radio Functions

Motorola HT-750 Channels (UHF)

Channel	Function	Channel	Function
1	CMU EMS Dispatch 1	9	DISP MED 1 (City Ch #9)
2	CMU EMS Dispatch 1 (TONE)	10	DISP MED 2 (City Ch #10)
3	CMU EMS Talkaround	11	PGH PD 5 & 6 - (City Ch #3)
4	CMU Police Dispatch	12	Medical Command Channel 4
5	CMU EMS Dispatch 2	13	Medical Command Channel 8
6	CMU EMS Repeater Bypass	14	PEMA
7	PGH FIRE 1 (City Ch #5)	15	Scan Channel: 1, 5, 9
8	PGH FIRE 2 (City Ch #6)	16	Scan Channel: 1, 4, 5, 9

Top Button: Volume Check

Middle Side Button: Squelch Break & Reset after tones

Scan Button: CMU EMS Primary Dispatch, CMU EMS T/A 1, CMU Police Dispatch, and CMU EMS T/A 2 (i.e. channels 1, 3, 4, 5)

Battery Level: holding the orange button on the top of the radio will display the current battery level in the top light. Green means high, yellow means medium, red means low.

Basic Radio Problems & How to Fix Them

> <u>Tones do not work</u> – If the tones are not set off by dispatch, it is probably human error. This should be corrected by explaining the procedure to the dispatcher after the call. Since you should be on channel 1, you will not miss a call if this happens; usually you will have enough people also monitoring channel 1 to handle the call, but if enough people do not call in, you can ask dispatch to put the tones out and repeat the dispatch. If the tones do not set off your radio and sound wrong, you should go to the dispatch center (after the call) and check the radio console. The radio console is a large device with a large number of buttons, including a telephone keypad. One of the buttons is labeled "EMS Tones". After pressing that button you must press the "Page Send" button, which is a safety to prevent the tones from being sent out accidentally. If you follow the procedure to send the tones and still do not hear them, have CMPD contact the radio repair company.

The repeater is not working – The repeater can go down for a variety of reasons including device failure and power outage[1]. It is likely that you will not know if the repeater is down until you try to use it, so you should test it frequently during storms and power outages. If the repeater is down, it will not have the familiar "tail" of empty noise that is usually heard after you transmit. If you find that the repeater goes down, you should follow this procedure:

1. Your priority is delivering emergency medical service to the campus. You should contact campus police by any means available and notify them of the repeater outage. You should notify them how to contact you for the time being – the best thing to do is proceed to the EMS office.

2. Once CMPD knows of the situation, you can begin to notify the rest of your crew as to the backup procedure. The crew can be contacted by telephone, or over the air; if necessary, you can put together another crew. The procedure is to switch to the "Dispatch 2." Dispatchers should know how to switch. The CMPD base radio is more powerful than the portables, so even on channel 5 you may be able to hear them even when they cannot hear you. To rectify this, you can try to obtain permission from the on-duty CMPD Supervisor to use their channel for communications with the dispatch center. If this agreement is set, you should advise all members that CMPD communications will have to go through you.

All other radio problems probably require a service technician. If in doubt, or if you are unable to fix the system yourself, contact the on duty Supervisor or Operations Manager for more assistance.

Radio Terms

Repeater – A radio repeater is a device that receives radio signals on one frequency and simultaneously retransmits them on another frequency. It allows an individual with a small, low powered radio to have their signal broadcast with much higher power from a higher location – giving significant increase in range. The frequency is listens on is called the *input* frequency; the frequency it rebroadcasts on is called the *output*. These frequencies together make up a single *channel*. Our repeater is located on the roof of Morewood E-Tower. On channel 1, our portable radios are setup to automatically transmit on the input of the repeater and receive on the output of the repeater, so that the repeater function is practically unknown to the user. CMPD also uses a repeater for their operations.

Simplex – A repeater is known as a half-duplex system because it uses 2 frequencies but only allows 1 person to talk at once. Another type of radio system is simplex. Simplex communications occur directly between two radios. The communication is limited by the power and antenna of each radio. The benefit is that there are fewer links to break in the communications chain. An example of a simplex channel is our "dispatch 2," channel 5.

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[1] At the time of this writing, the repeater may or may not be connected to the backup power system. The CMPD repeater is under the backup power system.

<u>Talk around</u> – a good combination of repeater and simplex operations is talk around. Our talk around (channel 3) is set up to transmit and receive on the output of the repeater. This allows the user to be able to monitor the repeater, but have a conversation that is not rebroadcast at high power to all the users of a radio system. Another type of talk around (which we refer to as *repeater bypass*) is set on channel 6 of our portable radios. This channel transmits on the output of the repeater **with** a code squelch (see below), allowing anyone within range of the radio who is on channel 1 to receive your signal, without going through the repeater. In addition, repeater bypass mode makes the radio **receive** on the input frequency – so, you can still talk to another person who is within range but is **not** on repeater bypass mode. (They transmit on the input which you are listening to; you transmit on the output, which they are listening to). This is useful if the repeater goes down and you need to get a message to the duty crew who may not know that the repeater is down.

<u>Squelch</u> – The squelch setting on a radio is the threshold that blocks out low powered signals and static. This *carrier squelch* is a pre-programmed level in the radio. Another type of squelch, *code squelch*[2], uses a coded signal to tell the receiving radio that the signal it is receiving should not be ignored, but rather should be played through the radio's speaker. We use a code squelch on all of our channels except for talk around channel 3. Transmitting with code squelch on channel 3 would allow nearby users to hear the talkaround signal, even while they are on channel 1 (this what repeater bypass does). The unfortunate side-effect of not using a code squelch on channel 3 is that strong signals not intended for us but using the same frequency are played through the radio's speaker. Now that you understand about code squelch, read about the PL Break feature above.

<u>Tones</u> – Another type of squelch is called *signaling squelch*. This squelch keeps has the radio ignore all received signals unless it first hears certain audible signaling tones. An example of signaling squelch is our channel 2. Depending on the settings of the radio, signaling squelch "opens up the radio" for a certain period of time, or until manually reset. On our radios, the tones cause the radio to turn off code squelch for receiving – in other words, once the tones go out, the radio receives all signals that are more powerful than static until being reset.

<u>VHF/UHF</u> – VHF stands for *very high frequency*; UHF stands for *ultra high frequency*. VHF is further divided into VHF-high and VHF-low. Most VHF-high public service frequencies are around 150 megahertz. Most UHF public service frequencies are around 460 megahertz. The typical distinction between VHF and UHF is that a VHF signal tends to travel farther than a UHF signal of equal power, however UHF is known for its ability to better penetrate buildings and the ground.[3] All of our radios are UHF, with the exception of the two radios we keep to communicate with the Carnival Committee – the entire city of Pittsburgh is based on a UHF system. For a UHF system to be able to cover the entire city, it is necessary to have multiple repeater sites connected together. CMPD also uses a UHF system with one repeated channel and multiple simplex channels.

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[2] There are two types of code squelch – tone and digital. Tone squelch is known by different names (depending on which company is manufacturing the radio): CTCSS (continuous tone code squelch system) and PL (private line). Digital squelch is known as DCS and DPL; we will leave it as an exercise to the reader to figure out what those mean.

[3] A good comparison involves AM and FM broadcast radio. AM broadcast uses lower frequencies than FM, and tends to have a much larger range. On the other hand, AM is more easily blocked by man-made and natural structures.

Other Radio Frequencies

The primary purpose of these frequencies is to be able to communicate directly with CMPD dispatch and officers, as well as with Pittsburgh EMS dispatch and units. In most cases, alternative means of contacting CMPD and the city should be used first, however there are a few cases where you should use the City Radio to do more than listen.

If you are unable to contact CMPD on the EMS channel multiple times, and you have an urgent situation that cannot wait, you may try to contact CMPD dispatch or responding units directly on their channel. This should truly be reserved for dire circumstances, as many CMPD personnel may not agree with your use of this channel. For example, CMPD occasionally maintains radio silence when an officer may be in a dangerous situation. If you were to break this silence with a non-emergent issue, CMPD may not be very happy. When using the channel, you should make sure to identify yourself as "EMT xx" or just "CMU EMS" and indicate that you are using the CMPD channel, to avoid confusion. For example: "Radio from EMT 80, on CMPD dispatch."

Requesting an ambulance should primarily be done via telephone to 911, or via CMPD dispatch, however in dire circumstances, you may use the city EMS channel to do this. The radio is also a very important tool to use whenever Pittsburgh EMS is responding to a call. By turning on the radio to their channel (channel 9 = dispatch 1), you can find out which unit is responding to your call and from where. Listening to the channel is the main use of the city radio, but in some situations you may also need to talk on it. If you do talk on it, you should continue to monitor the channel in case you are called back. Channel 16 will scan the main CMU EMS frequency, the CMPD frequency and the Pittsburgh EMS Dispatch frequency. Channel 15 will scan the same frequencies, with the exception of the CMPD frequency, and is handy is situations where you need to listen to the City and our frequency, but don't care that someone locked themselves out of their room. Both frequencies will only, however, transmit on the CMU EMS frequency.

Pittsburgh EMS uses the call sign "base" to refer to the dispatch center. For example: "Carnegie Mellon EMS to base", "Carnegie Mellon EMS to EMS dispatch", or replace "Carnegie Mellon EMS" with "CMU EMS". Many units do not say "base" but merely shout out their unit number to notify dispatch that they are calling in – dispatch may shout out the unit number to tell that unit they are being called. In some cases, where you have critical information updates for responding units (e.g. the patient has stopped breathing), they are definitely lost, or Medic Dispatch has given them the wrong address, you may contact a Pittsburgh EMS unit directly. For the most part, however, there is little information you really need to give or get from Pittsburgh EMS via the radio. Asking for an ETA is an improper use of the radio – they are coming as fast as they can (in most cases), and you will merely aggravate the responding units by asking.

If you know which unit, you can call them directly; if not, you can contact dispatch to find out which unit is responding. Asking the responding unit to switch to "Channel 10" (their secondary dispatch) can be used if a long or complicated conversation is required.

Pittsburgh EMS units are identified as such:

- 50x = Supervisor
- Engine X = Fire Engine First Responder x
- "51xx" or "Medic xx" = Paramedic Unit xx
- "520x" or "Rescue x" = Rescue Unit
- "530x" = Training Unit

CMPD uses the call numbers 390x (where x is 5-9) to identify themselves on city channels. CMPD officers may also be of assistance by monitoring the channel or contacting units for you. You should listen to the Pittsburgh EMS channel to familiarize yourself with how they use the channel.

Start of the Shift and From Dispatch to AOS

Start of the Shift

Equipment check is 21:00 hours every night while CMU EMS is in service. This involves the Crew Chief examining the crew for the shift, ensuring everyone has appropriate equipment and checking the CC bag. Additional responsibilities during equipment check include administering scenarios to precepts, assisting new members in completing their qualification standards, decontaminating equipment, and checking car bags.

Other important tasks to do during this time are to make sure that all of your crew members have no outstanding tripsheets and that you know any hours which they might be out of service. Sleeping locations as well as any special preferences that your crew might have are also good to note. Another important thing to do is to make sure all of the crew has signed out their equipment on the sign-out sheet (including crew quarters keys, if applicable). Any member not signing out their equipment will be subject to the current policy set forth by the Operations Manager.

Dispatching

The "dispatch" function of a Crew Chief is not very difficult. As a member for many months, you are already familiar with the basic order of a dispatch. There are a few other parts that you must consider as a Crew Chief.

1. As a Crew Chief you must always keep your radio on channel 1; this allows CMPD and members of your crew to reach you without having the tones set off.

2. When a dispatch goes out, you must remember the location and problem (this is made easier by repeating it to yourself).

3. **Before** deciding which CMU EMS members to send to the call, you must decide if additional equipment or resources are needed and notify CMPD of this. Within a few seconds of a dispatch, CMPD may stop paying attention to us. You can request information or equipment at any time, but doing so immediately will go much smoother than waiting. It is recommended that you wait for CMPD to acknowledge your request before dispatching personnel.

4. Personnel – We already know that a Crew Chief must attend every call, but just because you are handling the dispatch does not mean that you have to go. If another Crew Chief calls in, you can disregard yourself. Obviously, you want to send the closest personnel to each call, but you must also account for other considerations. Do you want to send a precept to this call so he can get more experience? Even if he is a little farther away, on a minor call it may be worth it. On certain calls, some members may be better equipped to respond – for example, it may be useful to have a female member on an OB call. If the call's nature warrants, you may authorize a precept to go on scene without a Medical member to explore the situation. **For all serious calls, think speed of response before people to send.**

When to Request City Medics

Depending on the dispatch, the Crew Chief may decide to start an ambulance as backup or for transport ahead of arriving on scene. If a patient is going to need an ambulance anyway, start one as soon as you can. For example, anyone with chest pain (over 30 yrs old), any diabetic emergency, pregnancy problems, severe shortness of breath, loss of consciousness (LOC), altered level of consciousness (ALOC), major trauma, etc. will need an ambulance. Start them ahead of time to minimize their time to patient. Also keep in mind that Medic 7 is not always available so an early start will allow extra time for an ambulance from another area to get to Carnegie Mellon. Another important point: always confirm with CMPD and monitor the Pittsburgh EMS channel to determine that the city has been dispatched.

If you arrive on scene and determine that the patient needs an ambulance, you may request an ambulance via radio to CMPD or by calling 911 (in that order of preference). If you are unable to contact the EOC over the phone, another option is to have CMPD contact them. In some circumstances it may be necessary to contact the EOC on the EMS dispatch frequency to request an ambulance. If you do that, you will need the following information: street address (CMPD can be contacted to obtain the street address for a campus building or the information can be found on the inside of the clipboards) or intersection where the medics are needed, age and sex of the patient, chief complaint, and whether the patient is conscious and breathing.

After the ambulance has been requested and the medics have been dispatched, the Crew Chief should listen to the EMS frequency to stay apprised of the incoming unit. If necessary (and rarely is it necessary, see radio section above), contact the incoming medic unit and give them a brief report on the patient's condition. This report should include much of the same information that is on the on-scene form, and the same information you would give to medical command: patient's age, sex, and chief complaint, whether he is conscious and breathing, and information about what interventions have already been performed (e.g. splinting, backboarding, etc.). The report should not include details such as vital signs or medical history, since those will not often change the response level or the equipment that the medics need. If the patient's condition changes significantly (e.g. they lose consciousness or stop breathing) or you need additional assistance, such as medical backup or rescue, you should update the medics and the city's dispatch center (Emergency Operations Center – EOC). The medics should also be advised of any hazards present on or near the scene.

Responding

While responding the CC must coordinate response of precepts and Medical members, as well as thinking ahead to scene safety (declaring Code Red and a staging area if necessary) and patient transport options. It is useful listen to channel 16 (scan Pgh EMS and CMPD) so that you can hear CMPD and Pittsburgh EMS while responding. Be aware that channel 16 on the CC radio transmits to the CMU EMS 1 frequency. Switch to channel 4 to speak directly to CMPD or channel 9 for Pittsburgh EMS.

In most cases the officers will beat us to a call (they have cars, sirens, master keycards, etc…) and when they arrive on scene they may update the dispatch center. Do not assume that the dispatch center will update you. Instead, put your radio into scan to be sure to catch any important information. Thanks

to priority scan, you will always bounce back to channel 1 if there is anything being said. In addition, any transmissions you make while on scan will also be on channel 1.

In the event that you need to speak with the dispatch center and they are not answering you directly you may contact them on their channel. See the Radio section for more specific information regarding this.

Responding Off-Campus

Often we will be dispatched to an off-campus dorm or building to provide medical services. Campus Police will always offer transport to that location from a staging point. Almost always we will meet in the UC Turnaround. Instruct your crew to stage at that location and let the CMPD dispatchers know to have a car pick you up there. Remember that response to an off-campus building in a personally owned vehicle (POV) is not condoned.

Delayed Responses

There are times when it is not possible to respond to a scene in a timely fashion. In these situations, a CC should request that Pittsburgh EMS be dispatched to that location to render care, especially if the call is of a serious nature. A CC **may not refuse any dispatch** unless the scene is unsafe or there is a higher priority call currently in progress. Even if either of these are true, a Pittsburgh EMS unit must be dispatched if CMU EMS is requested and unable to go. Please see the CMU EMS Operational Policies for more information. In many cases, a CC can direct another member to respond to a second call while a first call is in progress. Alternatively, a CC can respond to a second call if he feels confident that a member he or she will be leaving on scene can properly wrap up the current call. For the most part, care should only be left to another EMT unless a refusal has already been signed, due to abandonment issues.

Getting disregarded & No Patient Found

Sometimes when the CMPD officer arrives on the scene, a patient does not wish to see EMS. In this case, the Officer will radio the dispatch center and they will cancel our response. Other times, both CMPD and CMU EMS will arrive on scene and we will not be able to find a patient. After conducting a thorough search of the area, a CC may make the decision that the patient cannot be found and return the CMU EMS crew. Both of these calls must still be logged into PONS and a tripsheet must still be written for both types.

Arriving to a scene after Pittsburgh EMS

Situations may arise where Pittsburgh EMS arrives on scene of a medical incident before you do. In these situations, it is a courtesy for the CC (and only the CC) to check with the unit to make sure they don't require any help or equipment. If not, then you and your crew should clear the scene immediately. The call must still be logged and a tripsheet written.

Scene Safety

As the Crew Chief you are responsible for all of the crew on a call and making sure that dispatch knows you are there. You are also responsible for the environment that they are working in. You must be aware of all potential hazards including but not limited to:

- Crowds
- Vomit
- Bloodborne pathogens
- Debris
- Spilled chemicals in labs
- HazMat
- Weapons

The CC's number one priority is scene control. It is the CC's job to make sure that all aspects of scene safety are being taken care of. In addition the CC should make sure that the members treating the patient have all of the equipment they need. The CC should also coordinate the transfer of care to Pittsburgh EMS and any other issues that arise. Finally, the CC should already have an idea of how he or she wants to steer the patient outcome (e.g. ambulance tx, CMPD -> H, refusal, etc…)

In the event of a motor vehicle collision (MVC), the Crew Chief should pay special attention to hazards relating to cars (fuel, fluids, air bags, etc…) and should be sure that the appropriate personnel are coming to the scene. When in doubt, request a Rescue truck and also the fire department. Disabled vehicles should be turned off, placed in park (or in gear for a manual transmission), and the parking brake set. It is common to tunnel-in on the patient while forgetting that you are standing in the middle of a road – make sure you have police assistance to direct traffic and always remember to constantly observe your surroundings whenever you move in the roadway. Further ideas for managing a vehicle collision are discussed elsewhere.

The Crew Chief is also responsible for coordinating a mass casualty incident (MCI). More information about special hazards and situations is listed in the *Special Operations* section of this manual.

As always, **your safety is** first even though the CC is ultimately responsible for the safety of everyone on a given scene. Never put yourself, your crew or your patient (in that order) in an unsafe situation. Never be afraid to take yourself or your crew out of a situation that is not safe.

Taking CMU EMS In and Out Of Service

CCs and Supervisors are authorized to take CMU EMS out of service. We usually go out of service when school is out of session for extended periods of time, such as Thanksgiving and Winter breaks. Sometimes we are required to be out of service due to staffing shortages (i.e. every CC has an important class for that period). It is vitally important that Dispatch knows when we are in or out of service, so that they do not waste time calling us when nobody is listening, and so they can dispatch us when we are in service.

There are two procedures for taking CMU EMS out of service. If we are going to be out of service for less than 12 hours, you can take us out of service by calling Dispatch, stating that you are from EMS, and that you are taking us out of service. Make sure you (or the person putting us back in service) call Dispatch to put us back in service. Announce over the radio that you are taking EMS out of service, and again when you put EMS back in service.

If CMU EMS will be out of service for more than 12 hours, the following procedure must be done:

1. Call the CMPD Dispatcher
2. Tell dispatcher that you are taking CMU EMS out of service.
3. Announce over CMU EMS Dispatch 1 that CMU EMS is out of service and give current radio time.
4. Mark us as Out of Service in the In/Out of Service screen in PONS

To put us back in service, follow the same procedure, replacing “out” with “in”.

Scene Control

Just like in EMT class, a scene size-up must be performed when arriving on any scene. The first 30 seconds on scene will set the tone for the call. It is the CC's responsibility to ensure the safety of the crew as well as the patient or patients. It is important to take a firm grasp of the scene and actively maintain control over it until the call is over.

The Scene & Your Crew

Whether you like it or not, the less experienced members of the crew will look up to you as the senior member of the crew. Often, they assume you have the all the answers and look to your actions as a guide for their own. It is, therefore, very important to stay calm in even the most hectic situations.

You should always be looking out for the safety of your crew. You should also do your best to be managing patient care. Often times, CC's feel that since they are the most medically experienced personnel on a scene, they should be the one performing the assessments of the patient. While this is very true for minor medical situations, where there is plenty of time for a precept or new medical member to practice skills, often times it is necessary for a CC to jump in and perform EMT level tasks in order to care for the patient.

Let the other members of the crew do as much as possible. Sure, you can probably take a BP and get a history better than the others, but how are they going to get experience if you don't let them? But be sure to pay attention with what is happening and always ensure good call progression. If a crewmember seems particularly hesitant, you may explain to the patient that your crewmember is a trainee and ask permission to have him perform whatever you are asking.

The Scene & CMPD

By the time you get to be a CC, at least a few officers should know you by name. Many will look at you as a peer, so be professional. We enjoy a very good relationship with the officers, which has been built up over time; try your best not to give them a reason to change their view. Good rules of thumb to follow are to always be polite and ask for help when you need it. They are willing to get things for you and help with patient care if asked, but otherwise will stay out of your way.

CMPD used to have EMTs, but almost all have let their certifications expire, or maintain a certification with little or no practice. In the event that an officer is an EMT, he or she has the option of contributing to patient care. If they do this, you must still document the call and get their certification information for later inclusion in the narrative. CMPD has control over all non-medical aspects of a scene. Some CMPD officers are very proactive in helping, when they see that you need help; others shy away very quickly from medical calls.

The most frequent problem we run into is with CMPD dispatchers. It can sometimes be difficult to confirm the city has been started or trying to raise them on the air after you have been dispatched. Remember that this is not entirely their fault, as they trying to juggle the phone, the computers, the CMPD radio and a bunch of other things. The best ways to keep communications smooth are to ask for anything (Pittsburgh EMS, equipment, etc…) as the first thing after the dispatch. They have heard

"you can show EMS enroute" a million times; they have a much easier time if you say, "please start the city" as soon as they are done talking after instead of the standard phrases. Also, don't forget to speak slowly and clearly.

Scene Command Hierarchy

A scene is controlled by the most medically qualified person on scene. Usually, even if the Fire Department is on scene, a CC as an EMT is in charge of the medical care of the patient once he or she arrives since most of the firefighters are only FR's. Any paramedic or MD automatically has scene control unless otherwise delegated to another unit. In short, always defer control to anyone who you know has equal or higher certification and wishes to control the scene and/or patient care.

Scene Hazards/ Code Red Scene

A Code Red scene is a scene nobody should be on until it is cleared by CMPD or the fire department. These scenes are unsafe and could potentially present a danger to the welfare of you and your crew. With that in mind, it is your job to recognize dangers which would warrant a code red scene and to make sure you and your crew are out of harms way. Often the CC must assume that a scene is unsafe and assemble their crew at a safe staging location. When in doubt, wait for an all-clear from CMPD before entering any potentially unsafe area. Any scenes which involve fights, assaults, weapons, fires or similar hazards should be assumed to be "Red" until otherwise notified. Once a scene is declared Red, the following items should be taken into account:

> Staging Area – Once you call a scene Code Red, it is your job to set up a place for you and your crew to wait until the scene is secured by CMPD. When picking your staging area employ common sense. If there is a fire or volatile chemical hazard, be upwind of it. If there is a fluid/flood hazard, be uphill. Common sense is your ally, use it well. If CMPD is staging in a certain area, it makes sense to be located at the same place.

> Safety of Precepts – The CC needs to be especially wary of the location of precepts responding to an unsafe scene. They have the least experience and are most likely to be somewhere they should not be. Always have their safety in mind, and make sure you have a good handle on their location and their actions.

> Establish Communication – Create an open line of communications with CMPD so they know where you are in case they need you. This is also important in case the hazard moves and additional areas need to be evacuated.

Scene hazards often but do not always have to present themselves in a human form. Specific call types lend themselves to potential hazardous conditions and experience will teach you many of these. Some special situations to keep in mind are listed below – most are discussed in much further depth elsewhere in this manual.

> Roads – Roads have cars, and cars can hurt you. Keep in mind, every time you are near a road way (even if you are crossing one to respond to a call) that the potential for being hit exists. Always let CMPD control traffic in a busy intersection before trying to attend to a patient. If

CMPD is not available, designate at least one crew member to manage the traffic patterns and ensure crew and patient safety.

<u>Fights & Violent Patients</u> – Never enter an unsecured fight scene. If dispatched to a fight, you should stage until CMPD notifies you that they have secured the scene.

<u>Fraternities</u> – Fraternities on campus are not by definition dangerous, but it is important to keep certain factors in mind. Alcohol is common during weekend events and there is always the potential for your actions to be interpreted incorrectly. Never enter a crowded enclosed area (fraternity or otherwise) unless it has already been secured by CMPD. Never be afraid to leave a scene and return if conditions become unsafe. Remember from your EMT training: never allow an obstruction to exist between you and a safe exit.

<u>Suicide Attempts</u> – Any person who threatens to hurt him or herself should be assumed to be a threat to you and your crew as well. This is not to say that this person is violent, but they can be erratic in behavior. Anytime you interact with a suicidal patient, keep a safe distance and ensure that CMPD has cleared the patient of any weapons before you approach him/her. At the same time, you should not act afraid of the patient. You can explain to him that there are certain questions that you need to ask, and make sure that is ok with them. Then you can calmly ask him if he or she has any weapons, and is currently thinking about hurting himself or anyone else. Without making the patient feel uncomfortable, you should discretely ensure that CMPD is always present.

<u>Chemical/electrical burns</u> – These types of calls can normally assure a hazard present. You want to make sure whatever caused the chemical/electrical burn has been mitigated by the time you arrive on scene. If in doubt, request a HazMat team or electrician response. A non-conductive pole (such as a board of wood) can be used to separate a patient from an electrical source. If possible, request a copy of the MSDS sheet for the chemical in question so you can better determine how to handle the situation.

<u>Hazardous Materials</u> – By definition these substances are dangerous. If you perceive a potential hazmat clear the scene immediately. Do your best to contain the hazard and evacuate people without putting yourself in harms way.

<u>Bloodborne Pathogens</u> – Bloodborne pathogens pose one of the greatest risks to any public safety worker. It is important that we never assume that just because a patient looks healthy he or she is. Many diseases (such as HIV) often present with no symptoms. It is therefore necessary to get into the habit of using Body Substance Isolation (BSI) for all calls.

Pittsburgh EMS

The City of Pittsburgh Paramedic/Rescue provides ALS and patient transportation for all members of the City of Pittsburgh community. We use them as a resource when a patient is too sick to go to a hospital in a campus police car as well as when major incidents happen on campus. They are contacted (in order of preference) by CMU EMS via 911,by Campus Police via 911, by CMU EMS via radio, or by Campus Police via radio.

Remember, no matter what attitude they show up with, it is important to treat them with the utmost respect and courtesy.

Overview

Pittsburgh EMS is dispatched in 4 priority system. A priority number 0, 1, 2 or 3 classifies the call. The breakdown of the priorities is as follows:

> Priority 0 – Serious Emergency; ambulance, First Responder Fire Truck both sent lights and sirens. Extra manpower can also be sent via Rescue or extra medic units on these types of calls.
>
> Priority 1 – Serious Emergency; ambulance sent lights and sirens.
>
> Priority 2 – Emergency; ambulance sent lights and sirens however more caution is used when coming to the scene.
>
> Priority 3 – Non-Emergency; ALS or BLS ambulance sent without lights or sirens.

As a reminder, all ALS units are designated 51XX (e.g. 5107 is Medic 7). All BLS units are designated as EMT-X (e.g. EMT-1). All rescue units are 52XX (e.g. 5201 is Rescue 1 and 5221 is River Rescue). All Supervisors are 50X (e.g. 502). First Responder fire trucks are generally Engine or Truck XX (e.g. Engine 11).

Calling 9-1-1

The first step in requesting Pittsburgh EMS is contacting them through their dispatch center, 911. As discussed above, there are multiple ways of having them dispatched. For the purposes of this example, let's assume that you are calling 911 from a cell phone .

When you call 911, you are contacting the emergency operations center for the County of Allegheny. The center is run by the County Department of Emergency Services and is responsible for managing the dispatch operations of Police, Fire, and EMS. A call taker, who is completely different from the dispatcher, will answer your call. They will enter the information into their dispatch system at which point it will be routed to the dispatcher who will put it out over the air. A typical conversation will go something like this:

> *Dispatcher*: Pittsburgh 911, what is your emergency?
> *You*: This is EMT Smith with CMU EMS. We have a 30 y/o F, unconscious, breathing.

Dispatcher: Sir, what is your address?
You: 4902 Forbes Ave on the Carnegie Mellon Campus. Police will meet you on Forbes Ave. and direct you into the building.

Dispatcher: What is your call back number?
You: You can contact us through our dispatch center at 268-2323

Dispatcher: Do you have any more information about the patient?
You: No
Dispatcher: Someone will be there shortly. Thank you.

The basics of calling 911 are as follows:

1. Identify self as "EMT whatever" with CMU EMS.
2. Give the age, sex and chief complaint of the patient along with any other important information (not breathing, seizure, cardiac arrest, AED on scene, etc…)
3. Give the address of the building you are in (or the closest one if you are outside)
4. When they ask for a call back number, give them dispatch at 268-2323
5. Tell them that the campus police will meet them on some street to guide them into the location.

Note: 911 Call Takers may not understand many EMT terms, so speak simply and clearly. Don't use acronyms. They will translate 'semi-conscious' into 'unconscious'.

Radio Dispatch

For the purposes of this example let's assume that there is no way to contact Pittsburgh EMS via phone and they must be contacted via radio (This almost never happens). When this happens the dispatcher is listening to the information and then relaying it to a call taker who is entering it into the system and then sending it back to the dispatcher to be dispatched. This works against the flow of the system so it should only be used when absolutely necessary.

If you have to use Campus Police to dispatch the medics, they will give the entire dialog on the city police channel. This will then have to be relayed to the medical dispatch area where it is entered as a call and then dispatched.

A typical radio dispatch from CMU EMS will go something like this:

You: CMU EMS
Dispatcher: Last unit?
You: Carnegie Mellon University EMS
Dispatcher: CMU go ahead

You: We're requesting a medic unit to 4902 Forbes Ave. We're on scene here with 3909 and a 20 year old intoxicated male who is semi-conscious. He is breathing; we have him on oxygen at this time. We'll have the police meet you out on Forbes Ave.

Dispatcher: That's copied. Standby.

The basics of a radio dispatch are as follows:

1. Select channel 9 (medic dispatch 1 = “channel 9”) on the radio
2. Say, “dispatch from CMU”, or “base from CMU EMS”, or “CMU EMS” when the air is clear
3. Wait for them to acknowledge you
4. Advise them of the situation: “yes sir/ma’am, we’re requesting an < ambulance, rescue unit, don’t specify> to <address>. We’re on scene here with 3909 and a <XX year old, male/female, CHIEF COMPLAINT> who is <conscious/semi-conscious/unconscious>. <He/She> is <breathing/not breathing>. We’ll have the police meet you outside <address>.”
    a. Note: They usually won’t hear your report entirely, so you may have to repeat portions

Updating the Medics

If, while listening to the city channel, you discover a major error has been made in the dispatch information you can contact the medic unit responding and give them a **brief** amount of information to help them with their response. In the course of listening you may also discover that the medic unit is lost or has questions about the scene. It is our practice to help out over the radio in those situations as well. Keep in mind that updates can also be given by calling back 911 so always consider that as an option.

Key points about updating/contacting the medics:

1. If you were smart, you were listening to medic dispatch after you requested the medics, so you know which truck was dispatched (nearby trucks, 1, 11, 5, 6, and 7).
    a. If you don’t know, and you need to call them, contact dispatch first and ask them which unit is responding to <address>

2. You can call them just like calling someone from your own crew (except use CMU EMS instead of your unit number). Example: “Medic 7 from CMU EMS.”

3. **DO NOT ASK FOR AN ETA**. If there is a reason for them to come faster, tell them the reason; such as: “the patient is in respiratory arrest”

4. If a first responder fire engine (“eleven engine”) is also sent then you will hear them sign on “on channel 9” and dispatch will tell them that they are responding with medic whoever. Generally we don’t need the first responder, but you don’t want to give an order to the engine or to dispatch, so what you can do is call the responding unit and tell them that we have EMTs on scene, maybe a **QUICK** report (“conscious, alert, vitals stable”) and then say “it’s up to you if you want to disregard the first responders.”

5. In the event that you need to cancel the city from responding to a location, you can do it either by calling 911 or over the radio and telling their dispatcher that they “can take a disregard.” Depending on the call, the medics may not want to accept a disregard from

you. Telling them that the patient is refusing care or will transport by POV is useful in helping them understand.

The First Responders

When a call is dispatched as Priority-0, a First Responder unit will respond to the scene in advance of the Pittsburgh EMS unit. These units have certified First Responders onboard only, no EMTs. This means that as long as an EMT is on scene, they do not have medical control of the scene. You are not allowed to get on the radio and disregard fire. You may, however, call the CMPD dispatcher or the 911 dispatcher and inform them that CMU EMS is on scene. To avoid this situation, when you call 911, make it abundantly clear that there are EMTs on scene.

If you have the resources, send a member to give them a short report, tell them EMTs are on-scene, and offer to lead them up to the scene if they want to go. You can give as detailed a report as you want, but they aren't going to hear anything beyond "patient is conscious and alert". The person to be giving the report to is the captain, who usually sits in the front passenger seat of the engine. Try and be as nice as you can to these guys, they did just come all the way out to do absolutely nothing. As the EMT, you are the one who is responsible for the standard of care; legally as well, so do not let them steal your patient.

Meeting the Medics

While some paramedics may ignore your report, it is your responsibility in transferring patient care to verbally report all pertinent information to whomever you are transferring care to. If you feel your report was definitely ignored, you should document this. In your report, give them your name, that you are an EMT with CMU EMS, a copy of the on-scene form, and let them know what is going on (patient's condition, chief complaint, assessment, treatment, last vitals, etc…). Tell them stuff like "we might need the stretcher on this, patient says he can't walk." In general, hinting like this, as opposed to telling them specifically that the stretcher is needed, is more professional.

If you treat Pittsburgh EMS with respect, stay out of their way and let them do their jobs they will usually return the favor. No matter what unit arrives on scene, wait until **after** they have gotten a chance to grab their bags and start heading inside before you approach them and give them a verbal report. Offer a copy of the on-scene to them but first check to make sure the copy you give them is legible (sometimes the pink copies of on-scene forms don't turn out well). After you give a verbal and/or written report to the medics and show them to the patient, you have transferred care. Unless you feel welcome (e.g. the medics are asking you questions, or it is obvious that they need extra man-power) clear the scene and return into service. If you used any replaceable equipment like oxygen masks or C-collars you can ask if the medics have a spare to trade out with you. If they don't or you forget, it isn't a big deal just replace the equipment from the EMS office.

Keep in mind that Pittsburgh EMS medics are doing a job and they want to be in and out as fast as they can. If the crewmembers request your assistance **and you know how to operate the equipment**, you are welcome to help (document in tripsheet: assisted Medic 7 w/ ____) otherwise it is time to clear the

scene and return to service. If you are asked to do something that you do not know how to do, simply state that you don't know how – this is a much better solution than setting up a piece of equipment improperly.

There have been times where verbal altercations have occurred. In this case, make a swift transfer of care and clear the scene. Don't return any insults and don't stand around the scene. After you have cleared the scene contact the on-duty CMU EMS supervisor. If need be, speak with the on-duty CMPD supervisor. If a situation is truly urgent (it rarely is), the CMU EMS supervisor may contact the on duty Pittsburgh EMS supervisor by telephone, however a verbal argument rarely merits immediate action. You also need to document the facts in an incident report.

In even more rare instances there have been times where questions have been raised about the care of some patients by Pittsburgh EMS. Although frustrating, it isn't your place to try and discipline those involved. Your priority is patient care. Your best course of action is to document the incident and then have the CMU EMS supervisor notify the on duty Pittsburgh EMS supervisor.

Medical Command

On-line medical command is available through LifeFlight Command at Allegheny General Hospital. Generally, the state BLS protocols should be sufficient for treating most patients. However, if you encounter a situation that isn't covered by the standing treatment protocols or would like to do something different than the treatments prescribed in them, you may need to contact a command physician. The best way to contact medical command is by phone; their phone number is 888-354-5323. If you are unable to reach them, you will need to contact Pittsburgh EMS for transport.

Contacting Medical Command by Phone

Medical command must be contacted any time a check box in the refusal is checked "Yes" and we do not have a standing order which clears us from having to call based on that box. Medical command is a person in a room at AGH who will connect you with a doctor, record your conversation and write down relevant information, give you a record number and tell you the status of any hospital in the local area.

When you first call, you will be talking with the medical command person. This person wants to know who you are and where you are transporting your patient. Keep in mind we don't transport patients so make sure they understand this. They may also ask you for your EMT number. A typical command call will go something like this:

> *Command*: Lifeflight Command
> *You*: This is EMT Smith from CMU EMS requesting medical command consult
> *Command*: Standby

(at this point you are on hold. You will hear either a series of clicks and buzzes, or classical music. Occasionally the music will cut out, but this doesn't mean you have lost your connection)

> *Doctor*: Hello this is Dr Smith, how may I help you?

This next section is your medical report. Note that it is in the same order as the on-scene form or a tripsheet – use these as your guide as you give your report.

> *You*: Hello Sir, this is EMT Smith with CMU EMS. I'm currently on scene with a 20 y/o M who is complaining of dizziness and wishing to refuse. He called us tonight because he was having trouble focusing on objects and wanted our opinion. He is CAOx4/4 in no apparent distress. Due to the fact that he has been drinking tonight, our paperwork indicates that we need to contact medical command prior to authorizing this refusal. Patient admits to drinking 2-3 beers about an hour ago. No odor of ETOH is present on breath. Negative loss of consciousness, shortness of breath, or chest pain, patient answers all questions appropriately. No meds, no allergies, no pertinent medical history. Patient's vitals all check ok, BP: 135/85, Pulse: 72 strong/regular, Resps: 16 non-labored, Lungs: Clear/equal bi-laterally, Pupils: 3mm, equal, round, reactive. During the course of our evaluation the patient no longer felt dizzy and now wishes to refuse. He will be going back to his room with his roommate who will be with him for the rest of the night.

Doctor: That all sounds good. If the patient stays in the care of his roommates, he is ok to refuse. Make sure he knows to call back if the symptoms come back.

You: That's copy, if the patient stays in the care of his roommates, he is ok to refuse. Make sure he knows to call back if the symptoms come back. (you should be writing this down!)

Doctor: You need anything else?
You: Yes, Can I get your MCP ID?
Doctor: Sure, Its 2428
You: Thanks a lot. Can I stay on the line for a record number?
Command: Yeah, I'm here. Record #18830, Time: 03:28.

(Write this number and time down on the refusal and/or somewhere so you have it later..)

You: Thank you, goodnight.

Key Points

When talking to Medical Command always remember:

1. The command guy wants to know who you are, what you have and where you are transporting to. Make sure to explain that you are not a transport service

2. Say, "This is CMU EMS." DON'T say Carnegie, because they may confuse you with "Carnegie EMS" with is a transporting ALS service. You can also slowly say Carnegie Mellon University EMS.

3. If you have a refusal: "We have a 20 y/o intox, who wants to refuse"

4. If it's a protocol or a question, say that you'll be transferring care to the medics, just need a consult on a protocol

5. You should address the doctor as "doctor" or "sir" or "ma'am" as appropriate

6. Keep in mind that this doctor is working a shift at the hospital, which is why you have to wait

7. Repeat back any orders that the doctor gives you to confirm

8. Sometimes you get a doctor from Forbes Regional, if AGH is busy. Make sure you figure out which facility it is. You can ask the med comm. guy after the doctor hangs up. You'll also want the record number, and answer any questions he has for you.

9. If the doctor or patient wants, you can put the patient on the phone with the doctor, record it on refusal check boxes and in your narrative

10. Sometime the call disconnects before you get a chance to get a record number or time. If this happens, call command back when you get back to the EMS office. If the call disconnects before you get your orders from the doctor, call back and explain the situation.

The Command Report

Our primary reason for calling command is to get an opinion about how we should proceed with a patient. In order to have the desired outcome, a Crew Chief's command report must be polished and communicate all of the proper information. Below is a good outline for how to give a command report and things you need to know about it.

How to give the report:

1. Introduce yourself: "Hello Doctor, this is EMT <whoever> with CMU EMS, we're on scene with a <age> <sex> complaining of <chief complaint>. What happened was <HXPI>. Vitals are <vitals, indicate any trending otherwise just give the latest set>. Allergies, Meds, PMHx."

2. Don't expect the doctor to know our protocols entirely, so explain why you are calling. "I'm calling because his pressure is a little low and he wants to refuse, wanted your opinion on that."

3. The doctor will want know what YOU think "it looks like he'll be ok, he's not dizzy standing or anything like that. He's going be with a friend too" Feel free to give the Doctor this information with the report as opposed to waiting to be asked.

4. Sometimes the Doctors don't realize that you are BLS, so he might ask for a "chem strip" or to check the glucose; If this happens, explain that we are a BLS service.

5. Repeat back every order to make sure you got it right

Command Call Documentation

After talking to the Doctor, it is important to document the consult properly. Use of on-line medical command must be documented on the trip sheet, including the MD number of the physician you consulted, the orders you received, and the orders you carried out and the time of the contact. If you attempt to contact command and are unsuccessful, that should be documented on the trip sheet and also in an incident report. If you are unable to complete some or all of the orders you received, you should document that in your trip sheet, along with the reason(s) why you were unable to complete the orders. If you attempted a protocol and completed it, you must document this. If you attempted to complete a protocol but were unable to do so or you felt that a protocol was necessary but it was not performed, you must document this as well.

Key points:

1. On refusal form make sure to get the record number, orders, MD number (MCP ID).
2. On trip sheet narrative make sure to record everything the doctor said.
3. On the timeline screen in EMMA, make sure to click the Medical Command button and fill it out appropriately.
    a. Note: if you use a protocol (or the call SHOULD have a protocol but you didn't use it) you still need to fill this in.

The Refusal Form

In order to legally protect you, the service and the patient, any person who calls for our services must sign a refusal form if they are not transported to a hospital by Pittsburgh EMS. This form is to help inform patients about their rights and also allows a patient the way to legally refuse our services. A sample refusal form can be found in Appendix II of this manual.

The refusal form has three parts. The top portion of the form contains patient information such as name, address, phone, social security number, etc. This part of the form needs to be filled out to the best of your ability. It is not necessary to fill out PCP [Primary Care Physician] Name, PCP Phone. It is also not necessary to fill out Parent/Guardian Name if there is not one. The Trip number and Dispatch, Enroute, On-scene and Clear times can be left blank until after the call is over.

The middle of the form consists of the Medical command box, competency box, medical command consult information, disposition and risks. More information about these is below.

Medical Command Box

- This box contains check boxes which must be filled out during the refusal process. If any of the boxes are checked YES, then you must call command and obtain approval for the refusal.

- If a patient is a minor and you check YES, you can avoid calling command if a parent or guardian can sign the refusal form. In cases where the patient is affiliated with the university (e.g. pre-college), a CMPD officer will often agree to act as a guardian. Be sure to have them write their name and badge number by their signature. All guardians should indicate their relationship to the patient next to their name.

Competency Box

- This box allows you to evaluate the alertness and worthiness for a patient to understand the risks of refusal. Some patients who are CAO 4x4 are still not competent to refuse. Each situation is different.

- If you are concerned that a patient is not competent then you can refer to the questions on the back of the white sheet (#'s 1-8).

- If you are at all concerned about the competency of the patient, call command.

Medical Command Consulted Box

- If you contact medical command this box must be filled out.

- The Record Number can be obtained from the Command guy after you are finished with the Doctor.

- Keep in mind that PCP is not the command Doctor but rather the patients PCP.

- Facility is usually AGH however it may be Forbes Regional, make sure you check.

- As long as you get the MCP ID# (which is the Doctor's number) you don't need the name.

- Write down the orders exactly as the doctor says them. Read them back to the doctor to double check.

Disposition

- We never check "EMS personnel and patient agreed to non-transport" or "Patient illness/injury does not warrant transport by EMS" because of liability issues.

- If a patient is transported by CMPD or POV then check "Transported by other means" and indicate what those means were (ie CMPD to Shadyside).

- If you are releasing the patient to the custody of Police for transport to Allegheny County Jail (ACJ) or other place you can check the Patient Released to box. You can also use this box to release a minor to their parents.

Risks

- Check the box for whom you explain the risks to.

- Write a complete description of the risks that you have described. For example, for a bee sting one might write, "Difficulty Breathing, Swelling, Nausea, Vomiting, Dizziness and/or Death"

- Check the verbalized understanding of risks box if this happens.

- "Received instructions for" generally refers to the self-care information on the back of the pink sheet. However, since these instructions are only on the pink sheet, which is detached, you should at least give the name of the instruction set you checked on the back (e.g. write "wound care"). This spot can also be used for orders that the command physician instructs you to give to the patient.

- "Other Instructions" are for things that aren't on the back but are important (RICE is a good example of this).

Release to patient

- It is important that this warning be properly communicated to your patient. As the patient is reading the legal information or after you have read it to the patient, you can often summarize the paragraph by saying something to the effect of:
  - "You need to understand that I am not a doctor and you are refusing transport to the hospital by a trained care provider. I don't have x-ray eyes

and I can't do blood work on you. You are being released from medical care and you understand the risks as I have explained them to you (point to risks). Do you have any questions as to the risks or treatments I have explained to you?"

Signatures

- Only the EMT whose certification number is at the bottom of the patient information (on the top section of the form) may sign the refusal. Once the EMT has signed the refusal, the patient should sign the refusal as well.

Once the refusal is complete, the patient gets the pink copy. If requested, the police officer may be given the yellow copy, provided that it does not have any confidential patient information that the officer is not aware of. All white copies are to be turned in with the tripsheet.

If a person is not competent to refuse, a minor, or not mentally fit to refuse, the patient or patient's guardian should sign the refusal form, and you should have a CMPD officer or other non-EMS person on the call witness the refusal. If the patient or guardian is not able to sign the refusal form, you must have a witness sign the refusal. You should note in your trip sheet if a refusal form was signed, who signed it and witnessed it, and whether the refusal was against medical advice (AMA).

Another option when patients want to go against medical advice is to contact medical command or Pittsburgh EMS. If you contact medical command, they may be able to make a better decision as to whether the patient needs to be seen at the hospital, and sometimes knowing that a doctor wants them to go will make the patient change his mind. If you call Pittsburgh EMS, then legally, we have transferred care to a provider with a higher certification, and the patient's further care or refusal of care is Pittsburgh EMS's responsibility.

All too often, CMU EMS CC's come across a patient who should not refuse care, but wants to. The action taken is to say "ok, but I need to call a doctor first." If you are fairly confident that a patient should not refuse care, and believe the doctor will agree with you, you should attempt to gently convince the patient that they need further care without wasting time calling command. Getting the patient to agree to an ALS assessment is a good step, as once the ambulance is on scene, they will be more willing to go. Personalizing the patient's condition may also help: "if this happened to me (or my grandmother, etc), I would go to the hospital."

Hospitals

It is important to remember that CMPD offers medical transport to our patients as a courtesy, and is not required to transport the patient to any hospital of the patient's choosing. (i.e., the patient is free to choose whichever hospital they wish, but CMPD has no commitment to get them there.) CMPD is almost always willing to transport to the nearby hospitals (Presby, Magee, Children's, Shadyside) if a car is available. Transport to other hospitals, which are further from campus, is dependent on how busy CMPD is that day, how many cars they have in service, and other factors that influence their willingness to take a car off-campus for an extended period of time. CMPD will almost never transport to AGH or Mercy. If the patient wishes to go to a hospital that CMPD is not willing to transport them to, they can either refuse transport entirely and go by private means (their vehicle, a friend's vehicle, a taxicab, etc.), or you can call Pittsburgh EMS, who will transport to any hospital inside the City of Pittsburgh within reason (they will probably refuse to take unstable/seriously injured patients to a hospital further away than the closest Level I trauma center). Calling Pittsburgh EMS for minor injuries that would not otherwise require ambulance transport is discouraged.

Hospital/Treatment Options

If the patient requires further evaluation or treatment at a hospital or other treatment facility, they have a number of choices. CMU has a Student Health Services that can treat many of the less complicated problems we encounter. The nearby hospitals include UPMC Presbyterian, Magee-Women's Hospital of UPMC, Children's Hospital of Pittsburgh of UPMC, and UPMC Shadyside. If the patient has a preferred hospital, that preference should be taken into account; remember that the patient's decision is final, and we can only provide advice. Also keep in mind that many patients have health insurance that may restrict or specify their hospital choice. If the patient is in doubt and their condition is not life threatening, suggest that they call their health insurance provider to determine which hospital they should go to. Most health plans have a toll-free number that participants can call if they have a non-life-threatening emergency and need advice on where to seek treatment. However, many of our patients are not familiar with the local hospitals and will ask you for a recommendation. Which hospital you recommend usually depends on the nature of the incident and the patient's affiliation with the university (if any).

<u>Student Health Center/Health Service</u>

Located on the first floor of Morewood Gardens E-Tower, Health Services will treat any CMU student (undergraduate or graduate), but will not treat staff members or faculty. They are open Monday, Tuesday, and Thursday 8am-7pm, Wednesday 10am-7pm, Friday 8am-5pm, and Saturday 11am-3pm while classes are in session. During the summer, they operate on restricted hours: Monday, Tuesday, Thursday, and Friday 8:30am-5pm, and Wednesday 10am-5pm. Health Services can generally handle the following types of injuries:

- Suturing simple lacerations on extremities (i.e. lacerations that do not require deep cleaning or debridement, and not on the face, head, torso, or back)
- Evaluation of simple musculoskeletal injuries
- Non-critical OB/GYN patients who need a pelvic exam (all hemorrhaging patients should go to the nearest trauma facility or Magee)

- Evaluation of sexual assault victims that do not want to go to a hospital
- Patients with flu-like symptoms who need to be watched and rehydrated

Keep in mind when you send a patient to Health Services that if they require services that Health Services can't provide (e.g. X-rays, complex suturing, etc.) that they will have to go down to a hospital anyway, so sending them to Health Services may delay their treatment. Also keep in mind that Health Services does not have the facilities to manage a serious emergency (uncontrolled hemorrhage, respiratory compromise, etc.), so serious patients should always be sent directly to the hospital. The best analogy to use is that Health Services provides care similar to that in a family practitioner's office or urgent-care clinic. Since Health Services will likely be much less expensive than a hospital visit, the patient should be given this option if their injury is eligible for treatment there and Health Services is open. Some patients who can go to Health Services will still choose to go to the hospital, and that is a valid option; just because the patient is eligible to go to Health Services does not mean that it is their only choice.

UPMC-Presbyterian

Located on DeSoto St. off Fifth Avenue, on the University of Pittsburgh campus, Presby is a Level I trauma center/teaching hospital, and usually all major trauma and medical patients are sent here. Presby has a large Emergency Department and can accommodate large numbers of patients. Unfortunately, patients with minor or moderate ailments may be triaged to a low priority, resulting in a long wait if the ED is busy with more serious patients. Presby is reputed for transplant surgery and for the STAT MedEvac air ambulance service.

Western Psychiatric Institute and Clinic (WPIC)

Located across the street from UPMC in Oakland, WPIC treats strictly psychiatric patients. Patients that have any potential or verified medical emergency (e.g. overdose, suicide-attempt injuries, etc.) should not be transported to WPIC; instead they should be transported to a medical ER (such as Presby), where they can be transferred from to WPIC after they have been medically cleared. Due to its proximity, WPIC is usually where psychiatric patients from Carnegie Mellon go.

Magee-Womens Hospital of UPMC

Located near the intersection of Forbes Avenue and Craft Avenue, Magee's ER primarily handles OB/GYN emergencies but will accept any patient for any condition.

Children's Hospital of Pittsburgh of UPMC

Located off Penn Avenue in Lawrenceville, Children's provides services to pediatric patients and is the only Level I pediatric trauma center in this area. Most patients under 18 years of age should be sent here.

UPMC-Shadyside

Located in Shadyside near the intersection of Centre Avenue and Aiken Avenue, Shadyside is geared mainly towards primary care. If UPMC is busy, minor trauma and medical patients may

have a shorter wait here. Shadyside is reputed for its cardiac department. Shadyside is also the "comp hospital" for some CMU employees, so CMU staff and faculty who are injured while on the job may wish to go here in order to be eligible for Worker's Compensation. Furthermore, the doctors who work at Student Health Services are out of Shadyside, and this can mean easier post-hospital care for patients sent there.

WPAHS - West Penn

Located on Liberty Avenue in Friendship, West Penn specializes in neonatal emergencies and burns, however their ED is capable of treating most other medical emergencies as well.

UPMC Mercy

Located on Locust St. near the intersection of Pride St. and Boulevard of the Allies, adjacent to Duquesne University, Mercy is a Level I trauma center/teaching hospital. Trauma and medical patients can be sent here if Presby cannot be accessed. Mercy is also known for their burn center.

WPAHS - Allegheny General Hospital (AGH)

Located on the North Side near the CCAC Allegheny Campus, AGH is a Level I trauma center/teaching hospital. Any trauma and medical patients can be sent here if Presby cannot be accessed. AGH is known for its cardiac department and its LifeFlight air ambulance service. LifeFlight Command at AGH supplies on-line medical command for all CMU EMS EMTs.

Other hospitals that patients may mention, but will probably not be transported to from Carnegie Mellon, include: Butler Memorial Hospital, Jefferson Hospital, Ohio Valley General Hospital, St. Clair Hospital, Sewickley Valley Hospital, Suburban General Hospital, UPMC-Passavant, UPMC-St. Margaret (UPMC-SMMH), VA Medical Center, Westmoreland Medical Center, WPAHS - Forbes Regional, and WPAHS - Allegheny Valley Hospital (AVH). You do not have to know where all of these hospitals are, but it is good to be familiar with their names.

Finishing the Call & Post Call Items

CMU EMS has five general dispositions for our patients (uncommon ones are discussed later in this manual). They are listed below with brief descriptions:

- Refusal – Units arrive on scene and patient wants nothing to do with EMS. They refuse all treatment and transport including an ambulance.
- Treat/No Transport – CMU EMS provides treatment for some injury or illness but patient refuses transport by any means to the hospital including ambulance.
- POV Transport – CMU EMS may or may not provide treatment but the patient is refusing transport via an ambulance to the hospital. Instead, the patient wishes to be transported by a personal vehicle such as CMPD or their friend.
- Care Transferred – In this situation an ambulance is called and care is transferred to them. It does not matter whether or not the patient is actually transported, it only matters that the care (and thus the liability) was transferred to another set of care providers.

As a precept and medical member, most calls end with the termination of patient care and possibly the writing of a tripsheet. However, a variety of other tasks need to be attended to by the Crew Chief to ensure proper documentation and preparation of EMS to respond to subsequent calls.

Post-Call Wrap-Up

It is common, especially with new members and difficult calls, to do a post-call wrap-up after the crew has cleared the scene. Use this opportunity to address any problems with the way the call was run, or simply just to thank your crew for their good work. Instead of simply lecturing, trying to have less experienced members suggest problems or alternative treatments is a good learning exercise, and a great way to gauge their skills. Remember to discuss issues courteously; depending on the situation, it may be best to go over specific problems with members one-on-one. For calls that may be emotionally draining, it is important to let your crew know that they performed to the best of their ability. Especially encourage new members to discuss any troubling feelings they may have. Should they feel the need, counseling services are available and can be reached through the Operations Manager or any Supervisor. In most cases, however, this is not necessary.

Call Logging

Dispatch, on-scene, clear-of-scene, ambulance request, and ambulance arrival times should be gathered from the CMPD dispatcher at the end of each call. At this point the call can then be logged using call logging application on PONS. The use of this application should be learned as a precepting member. As the Crew Chief, you are ultimately responsible for the appropriate logging of the call and completion of the documentation, so be prepared to supervise new members in these activities.

Evaluations

All members-in-training should be evaluated on their participation on calls. Typical procedure is for the in-training member to fill out the evaluation information and leave it in the Crew Chief's mailbox to be completed. The current evaluations allow a member to be scored on multiple criteria on a Needs Improvement, Satisfactory or Excellent scale. CCIT training will allow you to become more familiar

with this process and what constitutes each type of grade. In addition to the general criteria on the front of the form, Crew Chiefs are encouraged to give specific constructive feedback whenever possible on skills both good and bad. Crew evaluations are a major data source when promoting in-training members.

Equipment Restocking

All equipment used needs to be replaced in preparation for the next call. Precept and medical members should replace any used jumpkit items at their earliest convenience, and preferably directly after the call. Any soiled, non-disposable items should be decontaminated as discussed in the CMU EMS Decontamination guidelines. If a CMPD car bag was used, it should be returned to the office for restocking. Replace any used equipment and the oxygen cylinder/regulator if necessary. (It is often possible to obtain a NRB mask from the responding ambulance free of charge. Please ask politely.) The bag should then be sealed and left for CMPD in the dispatch center to return the car. This applies for the Splint Bag as well.

If a backboard was used, it will need to be retrieved from the hospital in a timely fashion. (If they are not retrieved within 24 hr, the hospital will mail the backboard to us). The Crew Chief should inform a Supervisor or the Operations Manager of this fact to arrange the pickup. The on-coming Crew Chief should also be made aware if a particular CMPD car is missing the backboard or any other equipment.

The AED presents a special situation. The AED will need to be serviced before the unit is put back into service. Environmental Health and Safety handles servicing of all of the AEDs on campus. No matter what, a Supervisor must be notified immediately of all possible cardiac arrests on campus, and uses of an AED.

Biohazard Materials & Proper Disposal

Biohazards can range from human bodily fluids to infectious materials, such as anthrax. CMU EMS commonly deals with the former (blood, vomit, etc), while the latter is left to outside authorities. For the most part, do your best to contain and stay away from things that are suspected as chemical or biological agents. Hazardous material responses are discusses elsewhere in this manual.

Human bodily fluids are much safer and easier to deal with. For example, items that are soaked thru and thru with blood, such as a soaked 4x4 gauze pad, should be disposed of as biohazard. However, items that are merely stained with blood can generally be thrown out as regular trash, just like when you throw out a bandaid at home. Biohazard items should be placed in a red biohazard bag, and the bag should be sealed by tying it in a knot or by taping it, folding it over, and taping it again. Once bagged, biohazard bags should be brought to Student Health Services as soon as possible. If Health Services is closed, bags can be kept, separate, in the office and brought to SHS the next day. Health services will usually give you empty bags when you come in. As a rule, CMU EMS cannot store biohazard. By no means shall a biohazard bag be disposed of in regular trash.

Since the implementation of EMT-administered Epinephrine, CMU EMS has to deal with used sharps. Sharps must be placed in a sharps container, or brought directly to Health Services. Sharps should NOT be placed in a biohazard bag. In the event that a sharps container is not available, sharps can be

placed in cardboard or Styrofoam for ease of carrying. In general, sharps should not be recapped, due to the possibility of sticking yourself. As a last resort, sharps can be recapped by holding the cap between the floor and the bottom of a boot, then inserting the needle into the cap. This should not be done with cloth shoes that can be easily penetrated by a needle. Epinephrine auto-injectors (Epi-pens) should be put in a sharps container that can fit them, which can be found in the same bag as the Epi. If the Epi-pen you used came in a container with a large screw top (approx one inch long), that container can be safely used as a sharps container. The new EpiPens act as their own sharps containers, and won't fit in a sharps container. Still, exercise caution while handling a used EpiPen.

If necessary, have CMPD contact ISS to clean up any mess that you or your crew is not equipped to manage.

Special Documentation Situations

Incident Reports – An incident report should be written anytime something happens which is out of the ordinary before, during or after a call. Incident reports may also be written with reference to crew behavior or interactions between CMU EMS and CMPD or any other public safety agency. Incident Reports must also be written whenever a precept has gone on-scene by themselves, regardless of circumstance. The Incident Report form can be found as a template within MS Word on the office computer. Any available relevant personnel should sign the report, or write their own, unless the report is of negative nature and you prefer to not show the report to the member. Incident reports are not necessarily used only when something goes wrong, or when a crew member messed up. Incident Reports may also be used when a member has shown exceptional skill during an unusual or strenuous situation.

Calls Using Protocols – A list of the current CMU EMS and State BLS protocols can be found in the office as well as on our website. When writing your tripsheet, don't forget to document the fact that a protocol was used and also how far along in the protocol you got. Refer to the EMMA Users Guide or the CMU EMS Documentation Guide if you have specific questions as to how to write a tripsheet involving a protocol. In addition, calls where a protocol was indicated but not used must be documented in this way, along with a description of why the protocol was not used.

Calls Where Command Was Contacted for Orders – As a call using a protocol, the call must be logged as using a command consultation and recorded on the tripsheet. The command facility, physician contacted, and his or her orders should be recorded on a refusal sheet during the call. Our command facility reviews these tripsheets as well.

False Calls – A false call is one in which no medical assistance was ever desired or necessary. These are to be contrasted with "No patient found" calls, discussed below. A common situation would be if a bystander requested EMS for a person that looked unconscious, but was in actuality just sleeping. These calls should be logged as "False Call." A tripsheet should still be completed that documents the circumstances.

No Patient Found – A call is logged as "No Patient Found" when a person that either wanted or should have received medical attention left the scene before EMS arrival. The most frequent

manifestation of this on campus usually involves intoxicated students, or when instead of waiting for EMS to arrive, patients are transported to the hospital by other means. Again, a tripsheet should reflect all pertinent information, including all the locations where you looked for the patient.

Disregarded En Route – Occasionally EMS is disregarded while *en route* to a call. This can occur for various reasons, one of the more common being that CMPD transports the patient prior to EMS evaluation. This should be reflected in the call log and tripsheet.

Standbys – A standby is a call where EMS was on-scene prior to a medical emergency, usually to decrease the time needed to reach a patient. CMU EMS prearranges standbys for a variety of events including concerts, Buggy races, Carnival, and Commencement. A PONS entry and standby tripsheet should be written for each standby documenting when EMS was present on-scene, as well as the number and types of patients treated, and the number of the tripsheet each patient is documented in. Individual PONS entries and patient tripsheets must be completed for each patient treated at the standby in addition to the general standby tripsheet.

"Command" Tripsheets – Command tripsheets (not to be confused with tripsheets in which command was contacted) should be written in cases where an event leads to several patients being treated at the same scene (i.e. MVAs, MCIs). This trip is very similar to a standby tripsheet. It should give an overview of the situation, and give the name and type of patients treated, along with the number of the tipsheet documenting that patient. Command tripsheets should be written in timeline form (see the documentation folder for an example of a timeline).

Media

Only a Supervisor is authorized to speak on behalf of the organization to any outside entity besides CMPD. Do not provide any information to any media organizations, instead have the on-duty Supervisor contact them. In general, personal contact information should not be given out. If in doubt, always defer to a Supervisor. The Tartan should only contact the ED or OM for information.

Campus Issues

Health Services

Health Services provides basic medical services, similar to that provided by a doctor's office, for all CMU students (Undergraduate and Graduate). They are located in the First Floor of Morewood Gardens E-Tower, facing Forbes Ave. Most patients are seen by appointment, but they do accept walk-ins for urgent care. Their hours are listed in the clipboards for when classes are in session. They use a reduced schedule during breaks, and exam weeks. Health services can treat certain traumas, such as certain wounds requiring stitches (nothing on the head or face, though), and mild sprains and strains. Remember that Health Services does not have certain diagnostic equipment such as x-ray machines. Health Services is a good option for the non-emergent non-specific sick patients (i.e. "I think I have the flu"). If Health Services is open and you have doubts as to whether or not they can see a patient, you can contact them at 412-268-2157 (make sure you tell them you are calling from EMS). Remember, if you think the patient will need complex care or x-rays, etc, send them directly to the hospital to avoid delay in treatment.

Athletic trainers

CMU Athletics has several Athletic trainers on staff. These trainers are trained to provide a certain level of medical care specifically suited to an athletic environment, such as determining the level of sprains and strains. This level of training is not currently defined or regulated by the state. We occasionally get called to scenes with an athletic trainer. Per formal agreement with the Athletic Department, trainers retain control of scenes in which they are involved. If the patient refuses treatment or transport, then we treat the call as a normal refusal (i.e. fill out a refusal form).

CMPD hierarchy/organization

CMU Police Department (CMPD), consists of sworn police officers and detectives, security guards, and dispatchers. The department is headed by the Director of Security, who also serves as the Chief of Police. His duties are delegated to a Lieutenant(s), who further delegates to several Sergeants. Police Officers, Guards, Dispatchers, and other staff answer to this hierarchy. As stated above, CMPD is in charge of all non-medical aspects of EMS calls. As a Crew Chief, you must liaison with the CMPD Officers on-scene. When there is a conflict between instructions given to you by a CMPD member, the highest-ranking Officer is in charge. If there is a conflict between CMU EMS and CMPD, try and defer as much as possible to the wishes of CMPD. If instructions given by CMPD endanger you patient, make the officer aware of the situation, and remember that you are there to treat the patient. At all times, you must endeavor to preserve the good relations that exist between us and CMPD.

Response area definitions

CMU EMS responds to medical emergencies on any CMU-owned or controlled property (including off-campus CMU housing); as well as the areas immediately surrounding campus, including streets surrounding campus, and certain parts of Schenley Park. Basically, wherever CMPD responds, we respond too. You should familiarize yourself with the names of locations of off-campus buildings, such as the Software Engineering Institute (SEI), and the University Technology Development Center

(UTDC), and off-campus housing building. We occasionally respond to CMU students who live in non-CMU housing, so you should familiarize yourself with the roads near campus. Technically, our response area includes the National Robotics Engineering Consortium (NREC) is Lawerenceville, as well as the Pittsburgh Technology Center on 2nd Avenue, both of which are far off campus. CCs are reasponsible for arranging for transportation from CMPD to off-campus locations not easily reached by foot. Sometimes dispatch forgets that we need rides, so its good practice to request a ride at dispatch.. Make sure that responding crew members know where to meet for a ride (UC turnaround is usually a good choice). Remember, we cannot refuse a dispatch, so if we are dispatched to a location not mentioned above, we are still required to respond.

POV Response

Responding to calls in a privately owned vehicle is not condoned, however many Crew Chiefs use their personal cars while on duty because it allows them faster response, as well as the ability to transport their crew and equipment such as the office bag. It is important to note that a member must obey all traffic and parking laws while responding to calls. Any violations or citations incurred by a member during the response or management of a call are the member's personal responsibility and will **NOT** be covered by CMU EMS. Remember that if you get pulled over or get into an accident, there will be nobody to help your patient.

Special Circumstances – and how to deal with them

Violent Patients

On some occasions, you may come across a patient who is violent. This may be due to an altered mental status (which would be a result of an injury, illness, or intoxication) or due to other circumstances, such as the patient being upset. There are two important things to consider in this situation. First off, as always, is safety for yourself, the crew, bystanders, and your patient (in that order). Use whatever resources are available to you (police, patient's friends, etc) to help with the situation, and **always** leave yourself an escape route. If necessary, the police can restrain a patient while you provide care. Remember that the police will be looking to you for your medical opinion; although you may not feel qualified to make the "final call" on the matter, you are the highest trained medical professional on the scene at that time. You should make sure the patient understands that you are only there to help, and that you are not a police officer. You should also make sure to speak in a firm and professional manner and to never allow the patient to gain control of the situation.

As a CC, it is your job to be able to see all of these factors outside of the patient's medical condition. However, you also must be careful to ensure that the patient's mood does not distract you from any medical conditions he or she may have. For example, violence can be a sign of a head injury. Thus, it is important to document the patient's mood. Once the scene becomes safe enough to treat the patient, you should remind him that you are there for his safety and are concerned about potential injuries, and ask permission to do an exam. To a certain point, the patient has a right to refuse your exam, however this is often a judgment call. For example, if the patient seems alert and oriented, you may allow him to refuse a physical exam, if you feel it will aggravate the situation. Medical Command and Pittsburgh EMS always serve as your second line of defense. If you are confident that a patient will need to be transported, you should call for transport immediately – there is no sense arguing with the patient.

Motor Vehicle Accidents

Although there are not many roads running through campus, CMU is bordered by Forbes Avenue, with 3 major intersections nearby, and Schenley Park, where curvy roads invite drivers to drive fast. In addition, heavily traveled pedestrian crossings at Forbes and Morewood, and crossing at non-controlled points near the fraternities bring a higher risk for pedestrians to be struck.

As with all calls, scene safety is most important at an MVA. It is a common mistake for EMS providers on an MVA scene to cross a lane of traffic without looking. Since one or more lanes may be blocked, traffic may be coming from the wrong direction. As the CC, you should be making sure your crew is aware of this, and is protected as best as possible. CMPD and Pittsburgh PD will provide traffic control, but you cannot rely on this alone. You should look before crossing, establish eye contact will all drivers, and wear uniform attire whenever possible. Keep an eye on your crew to make sure they are doing the same. Furthermore, vehicle safety is very important. Vehicles that are unstable should not be approached, and all vehicles should be turned off, put in park, and the parking brake applied. Vehicles typically will not catch fire, but you should be aware of the possibility. Other problems, such as a bumper recoiling or airbag deployment, can occur after the MVA has occurred – take care when you are near these parts of a car. NEVER put yourself between a patient and an airbag until the airbag system has been made safe by the Pittsburgh Fire or EMS Rescue.

As the CC, your job goes beyond patient care. You need to make sure you have located all occupants of vehicles to make sure there are no hidden injuries – you should determine who sat in each position of a car and also note seatbelt use and airbag deployment. If there are multiple patients, multiple refusals must be obtained and a separate tripsheet written for each patient. As with any multiple patient incidents, a command tripsheet should be written which describes all of the circumstances around the incident, all of the patients treated, the transport status of each patient and any additional situational information.

If a patient seems alert and wants no exam whatsoever, you can take a verbal refusal if necessary; be sure to document that you offered medical evaluation and they refused. In addition to finding all patients, you must also be thinking about what other help is responding to you. In addition to requesting medical transportation for your patients, you may need to request Rescue for extrication or stabilization, and Fire for large spills or vehicle fires. If a vehicle or accident scene is a potential crime scene, the police will be needed to handle those aspects.

Because CMU EMT's do not typically get much MVA experience and it is impossible to write down all possibilities at an MVA, you should review EMT books often, and discuss these topics with more experienced EMT's.

Fraternities

Calls at fraternities are similar to most other calls, with a few important caveats. For the most part, fraternities are safe environments, similar to dorms. However, during parties, a fraternity can become much more dangerous. To ensure scene safety, you should be sure to know where the exits are at all times. In a room where there is loud music or a large number of people, you should try to move the patient or clear the room as best as possible. The police will help you with this, but remember that it may not always be possible or practical. If you are calling for ALS, you should determine the best place to direct the ambulance and the best route to remove the patient.

Some calls at fraternity parties involve large groups of people – for example, a fight or an incident where somebody sprays pepper spray. Use common sense and the general rules for mass casualty incidents to deal with these calls, but be sure that you are not in a dangerous position. In cases where you feel like a situation may escalate into something violent, you should wait for police to arrive and escort you before you enter.

Suicide Attempts

Patients who have attempted suicide, or purposefully harmed themselves, must be treated carefully. As always, scene safety is your priority. Explain to the patient that you have to ask them a few difficult questions. Ask them about weapons (or potential weapons) and if they feel like they want to hurt you or themselves. Always have police present, and have the police handle all weapons. Consider all threats as valid, and do not make light of the situation. Think about how bad things must have gotten for the patient to get to this point.

In the case of a patient who intentionally overdosed on medication or drugs, you should attempt to determine how much they have taken. If there is a prescription, the label on the bottle should tell you when the prescription was filled, how many pills were in the bottle, and how many should have been taken each day – this information can help you determine how many pills the patient may have taken beyond what was prescribed. Counting pill remnants in a patient's emesis is also useful.

Patients who have intentionally physically harmed themselves cannot be left alone. Typically, they will be taken to Western Psychiatric hospital for evaluation, though any injuries will require medical clearance at a regular emergency room first. The patient may be involuntarily committed to the psychiatric hospital, or "302'd" – the nickname is derived from the law allowing a person to be involuntarily committed. It is important not to lie to the patient, and to tell them that they may have to stay at the hospital for a while, but also to explain to them that it will be easiest if they cooperate. Make sure the patient knows that although it may be a long road ahead, their recovery is starting now. Many patients who have recovered from such emergencies will remember the EMS provider, as you are the first medical professional they have seen on their road to recovery. The 302 procedure is usually completed by police or somebody close to the patient (somebody must have witnessed the patient state their intentions), though your input may be required in rare cases.

It is usually CMPD's procedure to have a Student Life staff member at the hospital for patients who have attempted suicide. If the patient asks, you can call a friend or family member as well. Remember that the idea of self-inflicted harm is much more shocking to non-EMS personnel, so you should be sensitive to this.

Sexual Assaults

When called for a sexual assault victim, you should remember that the patient will most likely be very upset. In the most common case of a woman assaulted by a man, it may be best to have a female member of your crew present at all times; if this crewmember is experienced enough, it may be best to have her handle most of the patient interactions. Remember scene safety for assaults. Allow the police to respond first and secure the scene whenever possible. The scene of an assault should be treated as a crime scene – do not disturb anything more than necessary and follow police instructions. If clothing must be cut, make sure to cut around any holes, such as bullet holes. Crime scene specifics are discussed elsewhere in this manual.

You can tell the patient that he/she is a "survivor" – the assault is over now and they are in a safe place. Never refer to the patient as a "victim." In addition to requiring psychiatric first aid, the patient may be physically injured. Because the patient may be shaken up, and may not want you to examine them, it is usually acceptable to have the patient examine themselves in private for any injuries. Treat any injuries as necessary; injuries that are not life threatening can often be left for treatment at the hospital, where the patient may feel more private and safe. If a patient has vaginal bleeding, you should attempt to save any dressings used and send them to the hospital with the patient. In addition to knowing how much blood was lost, semen may be present and could be recovered from those dressings.

The patient may have the urge to shower, but you should explain to them that best chances at recovering evidence are if they do not shower and instead go directly to the hospital. If a change of

clothes is available, the clothes they were wearing during the assault should be bagged in **PAPER** bags, to preserve evidence.

If sexual assault survivors wish to speak to somebody immediately, a sexual assault advisor can be called on the telephone or asked to respond to the scene. Their response time, however, may be long. SSA's are volunteers who are trained to deal with these situations. However, because they get relatively few calls, they may not be able to respond as quickly. Pamphlets regarding sexual assault should be in the crew chief clipboard. Questions you are unable to answer may be referred to an SSA, Campus Police, or medical command if necessary. If SSA is not available, the Pittsburgh Action Against Rape (PAAR) may be contacted at 1-866-END-RAPE. Patient destination will be decided between the patient and the transporting unit, however UPMC Presbyterian or Magee Woman's Hospital are ideal choices.

Pathogen Exposures

While unlikely, the chance of exposure to a Bloodborne pathogen does exist within EMS. If you believe or a crew member reports that they may have been exposed to an infectious disease, immediate action must be taken. If the exposure is via an open wound or needle stick, the site should be washed with soap and hot water for at least 10 minutes. The member should then be transported to the hospital for post-exposure treatment and possible medication. If possible, have the member go to the same hospital that the patient went to so that appropriate testing of the patient can be done. Additional information can be found in the Infection Control Policy.

Crime Scene Preservation

Some call locations may be classified as crime scenes. If you come to a scene where you suspect a crime may have been committed, or if you are directed to by a police officer, you should consider the scene a crime scene until further notice. These may include scenes of violent crime, suicide, suicide attempt, drug use, robbery or MVA.

To preserve a crime scene, you should do your best to record and report that position of any items that you need to move, including the patient. Wearing gloves will ensure that you do not add fingerprints to the scene, and limit the number of personnel at the scene, which will help reduce the possibility that something is accidentally disturbed. If clothes must be cut, be sure to cut around anything that could be part of evidence, such as bullet holes or blood spatter. If you hand over any potential evidence, such as clothing, to the police, you may be required to fill out a form or submit an affidavit regarding how you found the items, to preserve the chain of custody. Follow police instructions carefully, and defer to them for any decisions not directly regarding medical treatment of the patient.

Special Operations

Multiple Calls

We occasionally receive a call when we are already on scene of another call, or get dispatched to two calls at the same time. This presents a problem for staffing (i.e. do you have enough people to handle two calls?), as well as keeping track of personnel and equipment.

If two calls are dispatched at the same time, it is the CC's responsibility to prioritize the calls and direct members to their proper location. When possible, a member should be sent to both calls in order to give a report. If the situation calls for it (i.e. two high-priority calls), you may request to have CMPD contact Pittsburgh EMS and request mutual aid assistance.

If a call gets dispatched while you are already on the scene of another call, you have several options:

1. You can send a member to the second scene,
2. Request that CMPD hold the call (especially if you are on duty by yourself),
3. Request that Pittsburgh EMS respond to the second call,
4. If the initial call does not require a Crew Chief (for say, paperwork), you may leave the initial patient with a Medical Member with equal or higher certification than yours. Though preferably, in this situation, you would send the Medical Member onto the second call.

At no time may the Crew Chief abandon the initial patient!

Further information can be found in the Multiple Working Call Policy in the SOPs.

Triage and Mass Casualty Incidents

Like multiple working calls, mass casualty incidents present staffing and equipment problems. A mass casualty incident is technically defined as an incident with multiple patients. We generally "declare" an MCI when there are more patients than EMS personnel on-scene. It is your discretion on when to declare an MCI. A three-car pileup while you are on duty by yourself would probably be an MCI, while 3 sprained ankles when you have a full crew is probably not.

If you are declaring an MCI and are on duty by yourself or with a comparatively small crew, try and contact a Supervisor, other Crew Chiefs, Medical Members, etc. If the situation calls for it, have Dispatch contact said people.

As a Crew Chief, you will be in charge of all aspects of CMU EMS response and operations at an MCI scene. It is your responsibility to make sure that all patients are treated in an efficient manner. In order to accomplish that, patients must be triaged properly. For review, the levels of triage are found below. Once patients are triaged, proper treatment must be determined. As a single person, you are not expected to determine treatment and transport decisions for every patient. What you are expected to do is manage personnel and equipment to ensure treatment efficiency. For example, a precept can probably manage someone with a sprained ankle, while you will need and EMT to manage a patient with airway problems. You will also need to manage equipment and patient transport. If you need 3

backboards, you have to make sure they get requested and delivered. If you have five patients requiring transport, you need to make sure the city knows and is sending enough units.

MCIs must be documented with a command trip sheet, as well as a tripsheets for every patient. If a patient is refusing, make sure that all the appropriate paperwork is completed. For patients being transported, don't worry too much about the details of address, SSN, etc; just a name, sex, and age are acceptable for the tripsheet. Triage tags are available in all car bags (in the back pocket). You should familiarize yourself with these tags, which can be used in lieu of on-scene forms for patients not refusing.

The levels of triage are as follows:
Level 0 (Black): Dead or fatally injured. Examples include exposed brain, cardiac arrest of over 20 minutes (except for cold water drowning or severe hypothermia), decapitation, severed trunk, and incineration.

Level 1 (Red): *Treatable Life-Threatening Illness or Injuries*. Examples include airway and breathing difficulties, uncontrolled or severe bleeding, decreased mental status, severe medical problems, shock, and severe burns. These patients should be transported immediately.

Level 2 (Yellow): *Serious but Not Life-Threatening*. Examples include burns without airway problems, major or multiple bone or joint injuries, back injuries with or without spinal cord damage (i.e. people who got boarded). Transport of these patients can be delayed in favor of Level 1 patients.

Level 3 (Green): *Walking Wounded*. Minor musculoskeletal injuries, minor soft-tissue injuries.

Monitoring of patients is important, since they can sometimes go downhill quickly.

Standbys

One of the secondary functions of CMU EMS is to provide medical standby services for large events. As a Crew Chief, you will attend your fair share of standbys. Most standbys involve large crowds of people, which sometimes turn rowdy. It is your responsibility to ensure that your crew stays safe, and to know when to pull out or call for assistance.

There are two ways to do a standby. The most common one is to set up our equipment in a convenient place, and to have CMU EMS members walk around "patrolling". If a member is approached or comes upon someone needing help, they will then call over the radio for assistance. If you use this method, make sure someone stays with the equipment at all times, since bright orange equipment tends to sprout legs and walk away. The second method is to have us man a designated First Aid station. This method is seldom used, but may be requested by the event organizers. The only difference in this method is that somebody absolutely has to stay at the First Aid station.

As CC, you have several options as to how to communicate with your crew. If you are off-campus or on-campus and expect a lot of radio chatter, you should probably use channel 3. Otherwise, channel 1 is acceptable. If the standby is on-campus, the duty crew may be available to lend a helping hand if you need it. For concert standbys, make sure to bring earplugs for the members of your crew (they are

currently found in the grey equipment cabinet). If you are using earplugs, make sure that the volume of your radios is turned up so that you can hear them.

As far as equipment, at minimum you should bring the Office Bag, Office Splint Bag, and a backboard. You may also consider bringing the reeves stretcher.

Some standbys include a standby from either Pittsburgh EMS or a private ambulance company. It is the CC's responsibility to liaison with them as far as placement, etc. The ambulance may not be aware of our presence or existence, so make sure to introduce yourself. Having an ALS unit present can be very handy, since you can forgo refusal paperwork by transferring care to them, and letting them take the refusal. Similarly, CMPD should be made aware of where EMS personnel will be located in the event that an officer comes across a medical emergency.

All standbys require that a tripsheet get written. For standbys on campus, you should call Dispatch when you get on-scene and when you are clear. Billing must also be done so that we can get paid for the standby. We do this using the billing forms available in your office.

Carnival

Spring Carnival is the busiest week of the year for CMU EMS. When the Carnival Midway is open, CMU EMS mans a First Aid trailer. This trailer basically acts as our office for that week. There are two ways we get patients at the trailer. The first is to have patients approach the trailer. The second is for someone to either approach the trailer and lets us know, or call us using the Carnival Committee radio that is in the trailer.

There are several special considerations for Carnival. The first is that there are many people from outside of the CMU community present on the Midway and other areas of campus. There is a real possibility of having patients who are minors and away from their parents. You must take special care to ensure that any patients refusing are in fact adults. CMPD is usually willing to transport non-CMU people during Carnival, put make sure you ask first before making any promises. The second consideration is that we get a lot of requests for band-aids and ice packs from people who do not want us to treat them. People who simply request a band-aid does not count as a call, and does not require any paperwork. With this comes a fine line as to what we consider a call. Basically, if we do any treatment or evaluation of the patient, it counts as a call. When in the trailer, call it in as you would a self-dispatch.

Move-on, building week, and teardown make Midway particularly hazardous. It is up to you to make sure your scene is safe from falling debris, power tools, electrical hazards, etc. Previous years have also included the collapse of booths. Booth collapses are usually predictable, and take some time to happen. If a booth collapse is imminent, Carnival Committee will clear the Midway. It is a good idea to be as far away from the collapse as possible, while still being close enough to be able to treat people quickly. Should a booth collapse, you will most likely have a Mass Casualty Incident. You should call 911 to request EMS, Rescue, and Fire units. When you call 911 make sure you tell them it was a wooden booth that collapsed, and not a real building (wires have gotten crossed in the past).

Summer and Break Staffing

CMU EMS is usually Out of Services when school is out of session. We try to be In Service when CMU hosts Pre-college and Governor's School students as personnel allow. These students are still minors, so make sure the proper boxes are checked and Medical Command is contacted. Otherwise, staffing during the summer is exactly the same as the rest of the year, except we go out of service a lot more often due to there not being enough staff around.

Terrorism

In our day and age, terrorism is a persistent threat. While there is no public evidence showing CMU as a target, the threat does exist. As First Responders, we must be on the lookout for possible terrorist incidents.

Should there be a terrorist incident at CMU, you must treat it as an MCI. The scene must also be treated as a Code Red until cleared by Pittsburgh Fire and EMS. Recent incidents have seen First Responders being targeted. Of particular concern are secondary explosives, set to explode after an initial explosion, targeting First Responders on the scene.

Hazardous Materials

CMU and its facilities contain many hazardous materials, including chemical, biological, and nuclear. Should there be a hazardous materials incident, Pittsburgh Fire and EMS, and City and County Hazmat teams will be given control of the scene. You will also need to make sure that Environmental Health and Safety is notified.

If you know a scene is hazardous, or suspect hazardous materials, you must declare a Code Red, stage away from the scene, and await instructions from the Hazmat teams. You should scan the city frequencies, and make them aware of the situation if they are not aware of it.

Unless it is necessary to leave due to life-safety concerns, people may not leave the scene unless they have been cleared (and possibly decontaminated) by the Hazmat team. If evacuation is necessary, everyone must be evacuated to a single area to await clearance by Hazmat.

Medical, Legal and Ethical Issues

Lawsuits and Requests for Patient Information

As with any legal issue, legal proceedings regarding EMS that arise should be handled with the utmost care. University attorneys should be consulted, and all correspondence should be saved and documented. Whenever any contact is made directly to CMU EMS, correspondence should be handled through university attorneys. For example, if a lawyer calls to ask questions about procedures or a patient, you should inform him that he can contact the CMU attorney. In addition, you may want to notify the Chief of Campus Police, as CMPD oversees our operations, and our administrative liaison.

On occasion, the CMU attorneys will request medical records from us. For the most part, they are acting on our behalf, and the medical records will be handled properly. However, certain circumstances may require the patient's permission to release the records. For example, if CMU EMS is being sued for negligence, our lawyer will obviously require the patient's medical records to protect us. However, if the **university** is being sued for somebody who fell, and they are requesting medical records to see if we wrote anything about the wet floor or if the patient was truly injured, it is not CMU EMS that requires protection, but CMU. Since they are not looking out for our interests, release of patient information in this case is, for the most part, not allowed. You should use your best judgment and consult with the medical director prior to making any decisions in these situations. Also, you should express your concerns to the university attorney, and ask him to explain to you why it is acceptable to release the information under these circumstances.

All of these situations, however, are best handled by the CMU EMS Executive Director and Operations Manager. The easiest way to do this is by getting the caller's contact information and forwarding their request to the ED or OM, or by telling the caller to contact said individuals.

Appendix I – Car Bag Checklist

See attached for the most recent revision to the Car Bag Checklist.

Appendix II – Refusal Form

Due to copyright issues, a copy of the Refusal Form is only available with the printed copy of this document.