REDUCING THE RISK IN EMS: A STUDY OF NO TRANSPORT LIABILITY ISSUES IN FIRE BASED EMS AND THEIR APPLICATION TO GARLAND FIRE DEPARTMENT EMS, GARLAND, TEXAS

ADVANCED LEADERSHIP ISSUES IN EMERGENCY MEDICAL SERVICES

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ABSTRACT

Garland Fire Department Emergency Medical Services (EMS) has been identified as having a significant patient no transport rate. The problem identified was that an uncertain degree of liability exists in no transports due to the fact that no policy exists to govern those decisions. The purpose of the research was to gather data about the types of patients not transported by Garland Fire Department (GFD) EMS, to explore the liability issues by looking at policies in other departments, and to explore solutions for minimizing liability with the involvement of medical direction.

Descriptive research was used to examine similar situations in other departments, accomplished by a literature review. Evaluative research was used to look at no transport scenarios in other departments and the perception of liability that existed in other departments.

The first question, what types of patients, based on chief complaint, are not transported by GFD EMS, identified patients in four categories. The second question, is there liability associated with no transports after assessment or is the decision to not transport within the scope of practice of GFD paramedics was researched by an external survey that addressed liability, revealing that liability is perceived to be real in no transports in this large system. The third question, what specific actions can be taken by GFD paramedics to minimize liability was addressed by a literature review to look at providers and their solutions, which was directed toward physician involvement and documentation, along with a no transport policy

The procedures consisted of doing surveys that addressed pertinent data, and a literature review. The results were recognition of the liability issues, the need for

more medical direction, and quality monitoring.

The recommendations were to involve the medical community, to improve assessment and documentation skills, and to develop quality feedback loops.

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INTRODUCTION

In order to address the United States Fire Administrations operational objective related to risk reduction in communities that is lead by the Fire Service within those communities, it is necessary to examine the effectiveness of some specific risk reduction efforts in the Fire Service. This research was directed at EMS transports as provided by the Fire Service in Garland, Texas. More specifically, the research was directed at EMS no transports. Garland Fire Department (GFD) personnel are culturally and racially diverse, and they serve a population of 210,000 that is equally culturally and racially diverse.

The problem is that the Garland Fire Department Paramedics face an uncertain degree of liability due to conflicts in patient care policy and actual practice with regard to transporting or not transporting patients in the 911 system.

The purpose of this research project was to identify the types of patients that are not transported and why, to explore the potential liability associated with those no transports, and to recommend action for correcting the disparity that currently exists between practice and protocol.

Descriptive and evaluative research methods were used to answer the following questions:

1. What types of patients, based on chief complaint, are not transported by Garland Fire Department EMS?

2. Is there liability associated with no transports after assessment or is the decision to not transport within the scope of practice of Garland Fire Department Paramedics?
3. What specific actions can be taken by Garland Fire Department Paramedics to minimize liability as it relates to transporting or not transporting a patient that has called 911?

BACKGROUND AND SIGNIFICANCE

The City of Garland, Texas has a diverse population of 210,000. The City is one of the ten largest cities in Texas and the Fire Department is one of the ten largest with 240 employees. Although the Fire Department provides many services to the community, EMS is the largest service, being at least 75% of the alarms each month. The Department provides seven full time ambulances divided into districts, two peak load ambulances, two reserve ambulances, and paramedic engines. The ambulances and engines, including the reserve ambulances are always staffed with two paramedics fully trained in all aspects of pre hospital advanced life support. There are 18,000 EMS alarms each year.

In 1972, when local departments began to take over the ambulance service from the funeral homes, it was common practice to take everyone to the hospital; There was no such thing as a refusal. However, as populations and systems grew, and especially with the advent of the 911 system in this part of Texas, it was identified that people were not calling 911 to go the hospital necessarily, but were, in many cases, just trying to access health care or health care advice in what they perceived to be a quick and efficient manner.

Paramedic students in the Dallas area, which includes Garland, have always been trained at The University Of Texas Health Science Center in Dallas, under the direction, for the last thirty years, of Doctor James Atkins. Although considered to be an excellent educational process for paramedic students, the Health Science Center has not changed its educational approach dramatically in the last thirty years. Students have been taught to react but not to think, and their protocols for patient care have been simple and very conservative. For many years that proved to be a very practical approach, but as the system and population grew, so did their needs. The advent of Doctor Paul Pepe into the system about one year ago has caused significant changes in the system. Dr. Pepe has asked that each city look at the service it is providing from the perspective of the provision of quality care and has asked that we extend that into the realm of patients who are contacting us but we are not taking them to the hospital. He has asked us to evaluate the risk and to determine if one exists and if so, what to do about minimizing or eliminating that risk.

Jack Ayres (1996) in his lecture to paramedic students consistently suggests to them that the easiest way to face litigation is to fail to either treat or transport. He suggests further that 95% of the litigation brought against paramedics comes from the failure to treat or transport (Ayres, 2001). That information, coupled with our legal definition of abandonment causes significant concern on the part of Administration and the Medical Director.

Types of patients that were not transported by GFD were unknown before this research was done, and it was also unknown whether or not those no transports were GFD refusals or informed patient refusals. Only generic data has existed until now.

The scope of practice of paramedics has been an issue in the State of Texas for the last two years. The advent of licensure for paramedics has increased the scope of practice dialogue in Texas. Clearly the organizational impact of transporting everyone to the hospital could be devastating, and there is no point in beginning such a practice if it is not necessary.

In Advanced Leadership Issues in Emergency Medical Services, Module 5 of the Student Manual discusses risk management and how the process of effectively evaluating risk should evolve. The module discusses the identification and measurement of risk, the development of strategies to reduce risk and implementation of those strategies, and the monitoring for success that needs to take place. Risk identification and reduction is the key factor in the no transport issue, with the potential liability being the primary concern.

LITERATURE REVIEW

Before analyzing the potential for risk reduction, it is important to have a clear understanding of what risk management in EMS is, and to define what risks actually exist. Harkins (2001) defines risk management in part as a dangerous element or factor that contributes to the probability of loss. He identifies three key factors that are used to determine risk: The probability of the occurrence of an undesired event, second, the occurrence of an undesired consequence, and third, the severity of the harm that could occur. This is a process where the risk is identified, the impact is evaluated, and then methods are chosen to reduce or eliminate the risk (FEMA, 1996).

In addressing the priorities for risk reduction, there are several factors to be evaluated, including the potential for risk taking behaviors within a defined group (Mitchell & Everly, 1997). Another factor is the cultural basis for taking risks (Durbin, 2000), in which he stresses that Americans and Canadians are inherently risk takers. That information, coupled with the information that Mitchell and Everly (1997) provide about EMS personnel identifies this group as having high risk taking potential. Baron et al (2000), suggest that worry becomes a factor in assessing risk reduction because of the concern about consequences.

In EMS patient care is paramount and is the most predominant area in which EMS personnel face high risk and the potential for liability. Since the late 1970's and ongoing today, attorneys have been talking to EMS personnel about the issue that they perceive to be the harbinger of the greatest EMS liability, refusals of transport (Page, 1978). As recently as four months ago, Jack Ayres (2001) made the statement that he has made consistently since the late 1970's, that the refusal of transport by paramedics contributes to 95% of the litigation against paramedics.

Certainly the dialogue about transport refusals has experienced some evolution. In 2001 a position paper was issued that suggested some guidelines for no transports (ACEP, 2001). This position allows for transport refusals within certain guidelines, including adequate assessment. A study published in 2000 evaluated the efficacy of no transport or refusal of transport policies that have been established using criteria such as orientation, lack of intoxication, lack of head trauma, and age appropriate behavior (Weaver et al, 2000). While this study reinforces the fact that

the right of refusal of treatment by patients in this country is well established, it also reinforces that the patient must be mentally competent to accept or refuse treatment. This study suggests therefore, that patients who do not meet the stated criteria must then be transported.

The subject of no transport is multi-faceted in nature. There are ethical issues to consider (Bamonti et al, 2001), and in the absence of specific guidance there exists the consideration of the potential for negligence and even criminal charges (Hail, 1998). In Charlottesville, Virginia a position paper cites that paramedics should not enter into a no transport decision without the involvement of medical direction (MMB, 2001). This opinion brings forward another critical issue, the one of scope of practice for paramedics in this country who practice in the pre hospital environment. Given the fact that paramedics have some advanced capability in assessment, there have been some studies that support their ability to triage patients based on their findings (Richards & Ferrall, 1999), although this particular study cites a percentage of patients who were under triaged with altered mental status. Some specific obvious findings met with strong results (Hale & Sipprell, 2000), in which paramedics consistently identified wounds that required transport versus those that did not. Incorporated into the pre hospital environment is, of course, the process of Emergency Medical Dispatch (EMD). In some systems studied, those with an effective EMD process were able to reduce the number of inappropriate calls made by advanced life support units, although it was noted that this was more effective in two tiered systems (Bailey et al, 2000).

The concept of scope of practice changes is not new. In *Emergency Medical Services: Agenda for the Future* (NHTSA, 1998), the role of the future pre hospital care provider was scheduled to become more home care centered, to include care that would be rendered in the home with no discussion of transport. While that has not happened, at least not on a wide scale, the discussions that followed have continued to include ideas of more assessment, the addition of skills, the potential for wound care, catheter care, and medication administration as originally suggested. There is support in the medical community for such a move, if for no other reason than survival (Garza, 1998). She suggests further that public education is an integral part of this process.

In the discussion of scope of practice changes and no transports, the most important issue is patient care and safety. Experience counts, regardless of the quality of initial education (Pointer, 2001), and experienced street paramedics make better decisions based on that experience. The experienced pre hospital provider is more likely to heed the input of family surrounding the patient (Boyd, 1980), which will lessen the likelihood of errors or poor judgment in patient care.

Providing the pre hospital caregiver with all of the information and tools that they need to do the job will enhance patient safety as well. This is best achieved through good communication to employees (Burton & Nivens, 1997). In the discussion of no transport issues, it is important to have a clear understanding on the part of employees of what abandonment means (Maggiore, 2002), and probably the most important concern of all, how to effectively document all incidents (Graham, 1996).

The last concern is how to measure the practice standards once they are understood by the providers. Rudy et al (2001), suggests that benchmarking patient outcomes outside of the environment of pre-hospital care is an option. This program provides the pre-hospital provider with a measure of hospital outcomes as a result of pre-hospital care. Monitoring of routine data, such as response times and times on scene also provide effective feedback (Crawford, 1999). Above all, the development of an effective quality improvement program within the system (Polsky, 1992), and the provisions of ownership, good training, and teamwork (Cockburn, 1998), are the best insurance for patient safety.

In summary, the first phase of the literature review looked at determining the risks in Emergency Medical Services (EMS), and reviewed alternatives for reducing those risks. The second phase of the literature review looked at no transport decisions as being a specific risk, explored the no transport policies that exist, and looked at some of the determinants that are used to make no transport decisions. The third phase of the literature review looked at the most important aspect of this process, the safety of patient care and how to evaluate the effectiveness of that safety. Types of reporting data were explored, along with quality improvement programs, and the benefits of employee enhancement programs. Significant to this research is the critical need for risk reduction programs within both fire and EMS systems, and the fact that specific issues need to be addressed for risk reduction, especially the topic being studied in this project, the liability imposed upon EMS by non transport of patients.

PROCEDURES

Descriptive research was used to review and describe the type of patients that are not transported by GFD. All of the no transport incidents for the year 2001 were reviewed one by one. Each incident was evaluated on the basis of completeness of documentation related to the no transport decision, whether by the patient or the paramedic. In addition, and in order to answer the first question, a list was compiled that established the types of patients that were not transported, along with patterns that developed related to shifts, stations and specific personnel that routinely are involved in no transport decisions (Appendix A). Specific patterns among personnel did evolve as noted in the Appendix, and a very specific but small list of types of incidents evolved as well.

A literature review was conducted to address the second question. It was conducted in three phases. The first phase identified the importance of risk reduction programs specific to both fire and EMS systems which served to develop the background for specific liability issues, such as no transport decisions. The second phase reviewed no transport policies, the effectiveness of no transport decisions by pre hospital care providers, and scope of practice issues. The third phase of the literature review tracked the purpose of the third question as it explored potential resolutions such as quality improvement, better communication, and better documentation.

Evaluative research was used in the form of surveys that were sent out to all participating cities in the Dallas County system (Appendix B). The purpose of the survey was to measure the concern that exists in the local area by administrative

entities in the fire based EMS services related to no transport decisions. 20 surveys were sent out and the response was 100%. 50% of the respondents cite a no transport rate of 20%-40% and 50% of the respondents cite a no transport rate of 41%-60%. In reviewing the statistical data for the system, the average no transport rate is 43% (Appendix C). 90% of the respondents believe that decisions for no transport are within the scope of practice of pre hospital care providers, although 100% of the respondents have had to counsel with at least one paramedic related to his/her no transport decision. Reaction was mixed on the rationale behind those decisions, but 80% responded that the rationale was correct but the supporting documentation was not sufficient. All of the respondents (100%), identified liability associated with no transport decisions.

Once the survey was collected and tabulated, it was mailed to ten other cities in Texas of varying sizes that had no association with the Dallas County system. The response was 100%. Those cities were identified because of the fire based nature of their EMS systems and the similarity of their tax structure and Medicare base to Garland. The return on the surveys was 100%, and the results were identical in their responses, except that the no transport rates averaged only 27% (Appendix C).

The last part of data gathering was to survey the pre hospital care providers of GFD about recommendations for risk reduction in no transport incidents. Fifty paramedics were interviewed personally for their responses (Appendix D). A personal interview option was selected to maximize the return. Their responses range from doing nothing to calling for medical direction for every no transport. 100% agree that liability exists and are concerned for their own as well as the liability of GFD. 100%

also agree that they have no desire to make a decision that would jeopardize patient care.

This research was limited only by the fact that the Dallas County system has not had a firm direction related to no transport incidents for the last thirty years. The surveys and the literature support that a firm stance on this subject is long overdue.

RESULTS

Answers to Research Questions

Research Question 1. In order to determine what types of patients are not transported by GFD EMS, it was necessary to review 100% of the no transport incidents for the year 2001. Of the 18,000 EMS alarms in 2001, the no transport rate was 40%, or 7200 incidents. 15%, or 1080 incidents were classified as having no patient upon arrival, leaving the remainder to be classified by chief complaint (Appendix A). All of the chief complaints were specific in nature with breathing difficulty being the most common with 52%, and chest pain the second at 28%. Minor trauma constituted 3%, and the remaining 2% was a series of isolated events, such as a possible seizure and a racing heart.

In reviewing the data collected on these incidents and the documentation, it was often necessary to access the hard copy of the run report to obtain a clear picture of the patient and his/her condition. The information provided created items of interest from two primary perspectives. The first is system abuse by repeat patients, leading to possible inadequate assessment (Boyd, 1980), and the second is insufficient documentation to support no transport decisions, even when initiated by the patient. Weiss, et al (2002) suggest that high utilization and repeat calls are common in the elderly population. That trend contributes to an increased perception on the part of EMS providers that transport is

not needed, especially when the chief complaint is essentially the same each time (Boyd, 1980). However, the mere fact that the chief complaint is the same may be giving the paramedic the opportunity to have a limited focus, therefore failing to assess other significant signs and symptoms (NIH, 1996).

It was noted in the Garland data that many patients classified as having breathing difficulty breathing were assessed, treated, and then not transported because their breathing improved post treatment (Appendix A). The patients complaining of chest pain were assessed well enough that cardiac chest pain was ruled out (Appendix A). Other patients experienced minor trauma which could be effectively triaged (Hale & Sipprell, 2000) and not transported, and other isolated incidents which were self-resolving in nature.

In order to approach risk reduction in no transports, documentation is critical. Not only must handwriting be legible, but also descriptions must be clear and concise (King, 1983). The obvious data must be documented, such as demographics, chief complaint, and assessment. Unusual circumstances must also be documented and thoroughly explained, especially in the case of no transports (King, 1983). Graham (1996) stresses the value of documentation as well. He states that documentation helps EMS prove the fact that their job was done within the correct parameters.

GFD paramedics are well informed on the issue of abandonment and the reasons why adults can refuse transport (Ayres, 1996). That does not stop the no transport of patients, but it does suggest that all paramedics need follow up on patient outcomes (Rudy et al, 2001) in an effort to be proactive. Safety initiatives in EMS that address the

reduction of risk and concern about liability are based on the recognition of the human factor and the importance of providing follow up (Robinson, 2002).

Research Question 2. Is there liability associated with no transports after assessment or is the decision to not transport within the scope of practice of GFD paramedics? Establishing the existence of liability associated with no transports was based primarily on an examination of no transport policies, abandonment and negligence issues, and scope of practice issues. Also important for review were fire and EMS specific risk reduction programs. No transport policies describe the parameters in which EMS personnel can effectively no transport patients (Weaver et al, 2000). The primary concern is the issue of competence and orientation of patients, and the fact that competence is a legal determination as opposed to a medical one (Weaver et al, 2000). This study also raises the issue of lack of physician consultation, which is supported by a bulletin from Charlottesville, Virginia (MMB, 2001), which states that physician involvement is paramount and should always be part of the no transport decision.

Maggiore (2002) reinforces the concern over pre hospital personnel and their abandonment issues, which is now recognized as at least partially manifested as no transport predicaments. Documentation is also a subject of concern and should include but not be limited to demographics, assessment, physical examination findings, factors related to competence and orientation, and a detailed account of care rendered by EMS (Weaver et al, 2000). Hafter (2002) stresses again the value of documentation that is legible and without errors.

The scope of practice issue is one that is critical to making a determination about the ability of paramedics to make no transport decisions. Dallas County EMS providers

were surveyed related to no transport decisions by their field personnel (Appendix C). The issue is a current concern, indicated by the fact the 50% of the respondents cite a no transport rate of 41% to 60%. The average no transport rate in the Dallas County system is 43% (Appendix B). Although 90% of the respondents believe that the decisions for no transport are within the scope of practice for their providers, 100% of the respondents have had to counsel with at least one of their paramedics about his/her no transport decisions. 80% responded that the rationale was most often correct, the supporting documentation was not sufficient. 100% of the respondents agreed that there was personal and departmental liability associated with no transport decisions (Appendix B & C).

In San Diego paramedic initiated refusals of transport are prohibited by protocol (Seltzer et al, 2001). As cited earlier, this study also reflects on lack of physician involvement in the no transport decision, although it is noted that physician involvement might change the outcome of the decision. The National Association of EMS Physicians (ACEP, 2001) stress the importance of effective documentation, good instructional materials, following protocols when they exist, and most importantly, consider treat, release, and referral options, which is one of the tenets of *EMS: Agenda for the Future* (NHTSA, 1998).

The scope of practice of paramedics is one of the considerations in determining their ability to make or influence effective no transport decisions. The ability of emergency dispatch personnel and protocols (Bailey et al, 2000) may serve to complicate the decision because of inappropriate Advanced Life Support (ALS) responses. Basic life support (BLS) personnel may help or hinder the response of ALS personnel because of

their potential to over and under triage (Cone &Wydro, 2001). Other studies cite under triage in several categories, but especially in dementia and psychiatric disorders by Emergency Medical Technicians (EMT) (Schmidt et al, 2001). Richards and Ferrall (1999) believe that EMS personnel can predict patient disposition and outcome with reasonable success. These findings suggest that the benefit of an increase in scope of practice of paramedics is not definitive. Further, the issue is probably best addressed by Bissell et al (1999), who state that, in the realm of evidence based medicine, EMS personnel do not have the pathophysiology background to do effective decision making or disposition, indicating that an enhanced scope of practice would not be of particular benefit.

Research Question 3. What specific actions can be taken by GFD paramedics to minimize liability as it relates to transporting or not transporting 911 patients?

Fifty paramedics surveyed in GFD both recognize and are concerned about the liability associated with no transports (Appendix D), both for themselves and for GFD. Each person surveyed cited options for no transport decisions that range from doing nothing differently to calling for medical direction for every no transport. Although calling for medical direction is certainly supported by current literature (MMB, 2001), it is not practical overall. Relying on medical direction is one option and should be at least a part of other changes. One of the most important actions to consider is improved documentation (Graham, 1996). Documentation needs to include clear, concise, legible information especially in the incidents where the patient is not transported to the hospital by EMS (Ayres, 1996).

Quality feedback loops are necessary to allow the paramedic to learn retrospectively about their clinical judgment (Persse et al, 2002). Quality management for the entire system is also an important step to show practitioners the effects of clinical decisions, and to enhance current training to stay abreast of new technological issues. Although an enhanced scope of practice is still nebulous in the literature (Kamper et al, 2001), good assessment and triage skills are always integral parts of good service and good practice (Fitch, 2000).

As GFD looks to the future and the impetus for community health care continues (NHTSA, 1998), it will be necessary to involve the local medical community in the creation of firm guidelines for no transports. It will also be necessary to enhance documentation efforts, hone assessment skills, and to participate actively in quality improvement activities to minimize liability (Fitch, 2000).

DISCUSSION

EMS experts and leaders are in agreement with local services that no transport issues are of concern and do represent potential liability. Specific concerns noted and ear marked for improvement were documentation (Ayres, 1996), and the involvement of the medical community in no transport discussions (MMB, 2001). An enhanced scope of practice is not supported wholly by the literature, giving forth the thought that even enhanced assessment skills may fall short of providing the needed data for informed no transport decisions (Kamper et al, 2001). This is contrary to the information solicited by surveys from local service providers who believe that local practitioners are functioning within their current scope of practice by making no transport decisions (Appendix B). Hale and Sipprell (2002) believe that it is within the scope of practice of paramedics to

triage and refer minor trauma. Other researchers place more emphasis on decision making within levels of practice. Cone and Wydro (2001) believe, for example, that basic life support practitioners cannot make effective decisions about disregarding advanced life support practitioners. GFD providers are confident of their skills, but demonstrate concern about liability for themselves and the department (Appendix D). Each paramedic surveyed expressed concern over the potential of making an incorrect no transport decision that could do harm to a patient. A no transport policy would provide additional support as the one delineated by Weaver et al (2000). The primary thrust in no transport policies is the determination of competence and orientation (Weaver et al, 2000). While the experts may not agree on how to best make that determination, it is better than no policy at all, which is what GFD paramedics recognize as the biggest gap in their no transport decisions.

Overall, the literature favors limiting the ability of paramedics to make no transport decisions. Some researchers state that reasonable success is attainable by paramedics (Richards & Ferrall, 1999), but Bissell et al (1999) make an argument for the fact that pathophysiology knowledge is not strong enough on the paramedic level, and that there are not enough teaching cases available for effective inclusion into the paramedic curriculum.

The conclusion is that documentation and assessment must be enhanced locally on the paramedic level. Medical control must be consulted on a regular basis and the local providers would benefit by a no transport policy that defines appropriate no transport parameters (Weaver et al, 2000). Once implemented, these steps must be monitored by quality feedback loops (Persse et al, 2002).

The outcomes of this study indicate that there is both perceived and real liability in encountering patients who are not transported, both on the local and national level. The most effective protection is a no transport policy that is supported by the medical director, educators, administrators and field personnel alike. The second best option for limiting or preventing liability is to refuse to allow no transport decisions by paramedics. While this would limit liability, it would cripple an already stretched system. The issue of scope of practice enhancement does not have much potential for limiting liability, because paramedics in the field do not have lab values and radiologic capability to do a definitive diagnosis regardless of the effectiveness of their assessment skills.

The organizational impacts of the results of this study are as follows:

1. A commitment of time and a philosophical change by the Medical Director.
2. A commitment of additional training time for effective documentation.
3. An enhanced understanding on the part of field paramedics in GFD to fully understand the responsibility and liability involved in no transports.
4. A willingness to buy in to feedback and constructive criticism of individual clinical practice.
5. A new initiative to develop a risk reduction program specifically for fire and EMS.

RECOMMENDATIONS

This study was undertaken because of local concern about paramedic no transport decisions and the liability that is both apparent and real involved in those decisions. The research shows that this is a complex problem. Patients often refuse transport against the wishes of paramedics and parameters have been established to allow patients that opportunity (Weaver et al, 2000). Paramedics that refuse transport are often doing so without the benefit of physician consultation and therefore without the express approval of medical direction. Clearly this creates more liability.

Since customer service is the reason for the continued existence of many EMS systems (Brunacini, 1996), the first recommendation is to re establish the mission of the service for local providers. This needs to be accomplished by redefining the mission to each provider, along with his or her role as field practitioners. The paramedics also need basic business information in an effort to give them ownership (Burton & Nivens, 1997). The second recommendation is to review the entire concept of no transports, and to create a focus group to study those types of patients that can be easily not transported because of their non-emergency status and their need for an effective referral. This process will take another collection of no transport data for review by a field based focus group.

Once this data has been collected the third recommendation is to review the pathophysiology of non-transported groups from an educational perspective to assure the medical director that a sufficient knowledge base exists among field paramedics to make certain no transport decisions. The collection of data and the evaluation of paramedics needs to be reviewed and provided as feedback for paramedics on an ongoing basis (Polsky, 1992), Documentation and assessment skills must also be enhanced as needed,

and that activity should be evaluated on a per person basis. The fourth and most important recommendation is that local paramedic representatives and the Medical Director should meet and begin a dialogue for the development of a no transport policy that will serve to protect both patient and practitioner.

The benefits of this study for GFD will be increased surveillance on no transports and more monitoring of those patients who are not transported by GFD EMS. Additional collaboration will take place between field paramedics and the Medical Director, which has been needed in this system for many years. Paramedics and educators will also be able to evaluate and provide feedback on skills competencies and knowledge base to determine where improvement is needed. Another benefit is that this effort in risk reduction for communities lead by the fire service will also be addressed.

Initiating this process in another department would include some basic steps. The first task is to look at the number and types of no transports in a fire based EMS system. The patients not transported must be from a 911 system. The second task is to evaluate through education and quality monitoring the ability of paramedics to make those decisions. The third task would be to find a solution, such as a no transport policy or a policy that does not allow anyone to refuse transport that would limit or eliminate such decisions and thus limit liability and reduce the risk.

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APPENDIX A

INCIDENT REVIEW

What types of patients are not transported by GFD EMS?

- **Breathing Difficulty – 52%**
- **Chest Pain – 28%**
- **Minor Trauma – 3%**
- **Isolated Events – 2%**
  - **Possible seizure**
  - **Racing Heart**

Paramedic A – Station 5, A Shift – 50% no transport rate every shift.

Paramedic B – Station 2, B Shift – 52% no transport rate every shift.

Paramedic C – Station 3, A Shift – 48% no transport rate every shift.

APPENDIX B

Karen Pickard
Garland Fire Dept.
1027A W. Austin
Garland, TX. 75040

Dear

As you are well aware, the issue of no transports in one of the biggest concerns in our system. I am doing research on this subject for the National Fire Academy Executive Fire Officer Program. Would you please take a few minutes to answer this survey and return it to me in the enclosed envelope by March 1, 2002?

Thank you so much for your time.

Sincerely,

Karen Pickard
EMS Programs Director

SURVEY

1. **What is your no transport rate in your city?**

   20-40%__10____
   41-60%_10_____
   >60%_____

2. **Do you believe that it is within the scope of practice in this area to refuse to transport patients?**

   Yes, after assessment_18__
   Yes, but probably need additional training in assessment___
   Yes___
   No_2__

3. **As an EMS Supervisor, have you ever had to question a no transport with one or more of your paramedics?**

   Yes_20__
   No___

4. **If yes, did you find that: (check all that apply)**

   Their rationale was correct___
   Their rationale was correct, but their documentation did not support the decision_16__
   Their rationale was correct, and the documentation did support their decision_4__
   Their rationale was completely inaccurate___
   Their rationale was somewhat inaccurate___

5. **Do you potential for liability of your service manifested in your no transports?**

   I see potential liability in all no transports__20_
   I see no real liability in no transports, the paramedics know what they are doing___
   I see potential liability in all no transports, but if we had firm guidelines for no transports, then the liability would be minimal___
   I see liability in some no transports, but certainly not all of them___

   Examples_____
   Additional Comments: _____

Thank you.

APPENDIX C

Karen Pickard
Garland Fire Dept.
1027A W. Austin St.
Garland, TX. 75040

Dear

In our EMS delivery system in Dallas County, one of the biggest issues confronting us is the number and types of no transports that occur in all of our cities. This survey is part of research that I am doing for a National Fire Academy Executive Officer Paper that addresses these concerns. Would you be so kind as to take a few minutes to complete this survey and mail it back to me in the enclosed envelope? I need it by March 20, 2002.

Thank you in advance.

Sincerely,

Karen Pickard
EMS Programs Director

SURVEY

1. What is your no transport rate in your city?

20-40%_18_
41-60%_2_
>60%___

2. Do you believe that it is within the scope of practice of paramedics to refuse to transport patients?

Yes, after assessment_18__
Yes, but probably need additional training in assessment___
Yes___
No_2__

3. As an EMS Supervisor, have you ever had to question a no transport with one or more of your paramedics?

Yes_20__
No___

4. If yes, did you find that: (check all that apply)

Their rationale was correct___
Their rationale was correct, but their documentation did not support the decision_16__
Their rationale was correct, and their documentation did support the decision_4__
Their rationale was completely inaccurate___
Their rationale was somewhat inaccurate___

5. Do you see potential for liability of your service manifested in your no transports?

I see potential liability in all no transports_20__
I see no real liability in no transports, the paramedics know what they are doing___
I see potential liability in all no transports, but if we had firm guidelines for no transports, then the liability would be minimal___
I see liability in some no transports, but certainly not in all of them___

Examples_____
Additional Comments_____

Thank You.

APPENDIX D

SURVEY

1. **Do you see potential liability in no transport decisions?**

   Yes_50__

   No___

2. **If yes, do you agree that the liability can be deleterious to you and to the department?**

   Yes_50__

   No___

3. **Will you take any measure necessary to protect yourself, the patient, and the department?**

   Yes_50__

   No___

RECOMMENDATIONS:

No transport policy_45__

Leave everything alone_5__

Call Biotel (Medical Control) every time there is a no transport_9__

(Numbers do not add up to 100%).