Advisory 16-07 MLREMS Policies and Formulary

To: All MLREMS Paramedic Providers, ALS Chiefs, and Agency Leadership

From: Jeremy T. Cushman, MD, MS, EMT-P
Regional Medical Director

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Please find the attached revised MLREMS Policies and Formulary in preparation for the Collaborative Protocol release later this month. The MLREMS Policies have been reviewed, with some policies transforming into educational documents (available here), while similar policies have been condensed.

The MLREMS Policies are effective as of October 1, 2016, while the MLREMS Formulary will be effective starting November 1, 2016.

These policies are also available on line here, and the formulary is available here. As a reminder, optional formulary items must be approved by the Agency Medical Director who must also oversee the training on their indications and use.

If you have any questions upon reviewing these materials, please don't hesitate to contact the Program Agency office.

EMT'S ASSISTING ON ADVANCED PROCEDURES

PURPOSE

To outline duties that a Paramedic may delegate to an EMT during patient care.

POLICY

1. An EMT may set up the following equipment after successful completion of a training program as approved by the Agency Medical Director:

    a. Assembly of IV/IO fluid administration sets to include:
        - Saline lock
        - Fluids and drop sets

    b. Application of ALS monitoring equipment to include:
        - Monitoring leads
        - 12-Lead Electrocardiogram
        - Noninvasive automatic blood pressure devices
        - Continuous pulse oximetry devices
        - Continuous waveform capnography devices

2. An EMT may use a Paramedic's blood glucose monitor to determine a patient's blood glucose if so trained. EMTs may independently determine blood glucose only if so trained and the agency for which they are practicing under has approval to carry and use point-of-care blood glucose testing equipment.

3. Under no circumstances shall a BLS provider perform IV cannulation or diagnose electrocardiograms.

4. Even after the completion of any "ALS assistant" program (also known as Assist-A-Tech), the EMT is not certified to practice beyond the scope of the NYS BLS curriculum, and at all times is operating under the delegated practice of the ALS provider.

5. EMTs shall have the responsibility to decline requests for assistance if they have not been trained or are not comfortable providing the assistance.

CANCELLATION OF PARAMEDICS BY EMTS

PURPOSE

To outline the procedure by which Paramedics are cancelled appropriately.

POLICY

1. Any individual certified at the First Responder or higher level shall have the authority to request the response of a Paramedic unit if it has not been dispatched.

2. A responding Paramedic may be canceled by an EMT or higher on scene under the following circumstances:

    a. The provider has personally assessed the patient, and;

    b. The patient does not require evaluation or management by a Paramedic based on potential injury, medical condition, or complaint, and;

    c. The Paramedic is not the only responding transporting unit if the patient will need to be transported.

3. The provider canceling the Paramedic will be responsible for completing appropriate Prehospital documentation, including documenting the cancellation of the Paramedic.

4. Paramedics providing service with a non-transport/non-ALS service shall have the authority to supersede the EMT's decision to cancel a responding ALS unit.

5. Once the Paramedic has made visual contact with a patient, he/she shall follow the "Paramedic Release to EMT" policy.

6. The transporting EMT is ultimately responsible for patient care and may call back a canceled Paramedic if they are uncomfortable caring for the patient, regardless of who canceled the Paramedic.

7. A Paramedic may not be cancelled if the patient has received epinephrine, aspirin, albuterol, or naloxone.

PARAMEDIC RELEASE TO EMT

PURPOSE

This policy applies to all patients where patient contact has been made and the Paramedic desires to release the patient to an EMT or the EMT feels a Paramedic is not indicated. Patient contact is defined by the provider's visual contact with the patient.

POLICY

An ALS unit (i.e. an ambulance or first response unit staffed by a Paramedic and certified to operate at the ALS level) who makes patient contact may transfer care of a patient to a BLS unit according to the following procedure:

1. The Paramedic will complete a focused assessment on the patient. This will include:

    a. Focused subjective assessment including the history of the problem.

    b. Complete medical history including current medications, allergies, and recent hospitalizations.

    c. Assessment of all pertinent systems.

    d. A complete set of vital signs including blood pressure, pulse, respirations, level of consciousness, and skin color/temperature.

2. The Paramedic will assure that the patient's condition does not currently, and will likely not in the near future, warrant paramedic care (to include pain control).

3. The Paramedic will assure through verbal conference with the EMT that they are comfortable assuming care of the patient.

4. The Paramedic will complete a PCR which includes full documentation of the assessment performed, physical findings, pertinent negatives, and vital signs. In cases where both the EMT and Paramedic are from the same agency, it is acceptable for the ALS assessment to be completed as an addendum on the transporting provider's PCR.

CONSIDERATIONS

1. The Paramedic must accompany the patient to the hospital if the EMT expresses any discomfort with assuming care for the patient. This is regardless of whether or not the Paramedic believes any ALS procedures are warranted. However, it is the obligation of the EMT to state if they are not comfortable with managing the patient.

2. The Paramedic may not use tests to exclude pathology. For example, a normal 3- or 12-lead EKG does not rule out the presence of a myocardial infarction or other cardiac emergency. Acquisition of an EKG should not be used as a determining factor for whether a patient may be released to BLS care. Similarly, a normal SPO_2 or $EtCO_2$ do not rule out respiratory disorders.

3. It is the responsibility of the Paramedic on scene to contact Medical Control if there is any debate as to the appropriateness of the release to BLS.

MANAGEMENT OF PSYCHIATRIC & VIOLENT OR POTENTIALLY VIOLENT PATIENTS

PURPOSE

This guideline is intended to define standards to assure that both the psychiatric patient and the caregiver are safe during transport to the hospital. This will also outline techniques that may be used for the management of violent and potentially violent patients.

NOTE: This policy applies to patients not presenting with a primary medical or traumatic condition.

- If the patient has a presenting medical or traumatic condition requiring immediate treatment, follow the appropriate regional protocol.
- In all cases clinical continuity and safety for patients and providers should be considered.
- Transport the person to the destination noted on the transport papers, regardless of the patient's preference.
- In the absence of written transport papers, transport the person to the Article 9.39 hospital where current psychiatric treatment is being provided.
- If the person is not in a current treatment program (at a 9.39 facility), they should be taken to the nearest Article 9.39 hospital.
- Strong Memorial Hospital is the only local 9.39 facility with pediatric inpatient psychiatric beds.
- Article 9.39 Hospitals in the Monroe-Livingston area include:

  Monroe County
  - Rochester General Hospital
  - University of Rochester Medical Center - Strong Memorial Hospital
  - Unity - St. Mary's Campus

  Surrounding Counties
  - Clifton Springs Hospital
  - Newark-Wayne Community Hospital
  - Olean General Hospital
  - St. Joseph's Hospital Health Center
  - Wyoming County Community Hospital

DEFINITIONS

A psychiatric patient is defined as a person encountered by EMS personnel with an actual or potential psychiatric problem.

Mental Illness: A disorder in which individuals experience periodic problems with feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment, and

rehabilitation. Mental illness may be acute, time limited, chronic, lifelong and may occur at any time in an individual's life.

Emotionally Disturbed Person: An individual who is in severe crisis, displaying behavior that may include irrational behavior, suicidal ideation, or other bizarre behavior that may be brought on by depression, intense anger, or anxiety.

9.39 Hospital: A hospital licensed pursuant to NYS Mental Hygiene Law (NYSMHL), section 9.39 that maintains adequate staff and facilities for the observation, examination, care, and treatment of person(s) alleged to be mentally ill. 9.39 hospitals in Monroe and Livingston Counties include Strong, Rochester General, Unity and St. Mary's.

GENERALIZED SIGNS & SYMPTOMS

The following guidelines are generalized signs and symptoms of behavior that may suggest mental illness, although EMT's and Paramedics should consider other potential causes, such as underlying medical conditions (diabetes); reactions to narcotics/alcohol; or temporary emotional disturbances that are situationally motivated. The EMT or Paramedic should evaluate the following related symptomatic behavior in the total context of the situation when making judgments about an individual's mental state and need for intervention.

Mentally ill and/or emotionally disturbed persons may show signs of:

1. Strong and unrelenting fear of persons, places, or things. The fear of people or crowds (agoraphobia), for example may make the individual extremely reclusive or aggressive without apparent provocation.

2. Demonstration of extremely inappropriate behavior(s) for a given context. For example, people who are observed yelling to themselves in a public place.

3. Becoming easily frustrated in new or unforeseen circumstances and the demonstration of inappropriate or aggressive behavior(s) in dealing with the situation.

4. In addition to the aforementioned, a mentally ill/emotionally disturbed person, may exhibit one or more of the following characteristics:

a. Abnormal memory loss related to such common facts as name, home address (although these may be signs of other physical ailments such as brain injury or Alzheimer's disease).

b. Delusions: the belief in thoughts or ideas that are false, such as delusions of grandeur ("I am God"), paranoid delusions ("Everyone is out to get me"), or somatic delusions: the belief that one suffers from extraordinary physical maladies that are not possible.

c. EMS personnel should be alert to the fact that just because a patient appears to suffer from somatic delusions (e.g., believing their heart was stolen), does not mean that there is not serious physical symptoms worthy of assessment, such as cardiac arrhythmias.

d. Hallucinations of any of the five senses (e.g., hearing voices commanding the person to act, feeling ones skin crawl, etc.)

e. Extreme fright, anxiety, or depression

See the Agitated Patient protocol for patients where environmental modification and verbal de-escalation is not successful or not possible and/or the Excited Delirium Protocol for additional details about identifying and handling individuals displaying extreme behavior.

THE MENTAL HYGIENE LAW

Section 9.41 of the NYS MHL allows a *law enforcement officer* to place in custody and transport to a 9.39 hospital, any person who appears to be mentally ill for evaluation if:

1. The individual displays a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior, by which others are placed in reasonable fear of serious physical harm.

2. The individual displays a substantial risk of physical harm to him/herself as manifested by threats or attempts at suicide or serious bodily harm.

3. The individual exhibits other conduct demonstrating that he/she is dangerous to him/herself. They may include, but are not limited to: the person's refusal or inability to meet his/her essential need for food, shelter, clothing, or health care, provided that such refusal or inability is likely to result in serious harm if there is not immediate hospitalization.

Pursuant to section 22.09 of the NYS MHL, an individual who is intoxicated or impaired because of known or suspected alcohol and/or substances in their body, may be placed in the custody of a police officer and brought to a hospital facility under the NYS MHL, for immediate treatment, observation and care if the individual appears to be incapacitated by alcohol and/or substances to the degree that they are unconscious, incapable of making a rational decision with the respect to the need for emergency treatment, or there is a likelihood to result in harm to the person or to others.

EMS RESPONSE GUIDELINES

When dispatched to a psychiatric emergency, the EMS crew must always consider their safety first. The following are response guidelines to psychiatric-type calls:

- Based on dispatch information, a crew may always exercise the option to stage near the scene or in quarters. (Notify the respective dispatcher of your staging location).

- The general response to all staging areas is non-emergent. Response may be upgraded if you receive information that you are cleared into the scene and the reported patients' condition warrants an emergent response.

- The responding unit should consider requesting a paramedic, if not already available, to reports of a "violent medical", to allow chemical restraint to be applied as per protocol. If the patient does not need chemical restraint and has no other indications for advanced interventions, that patient may be released to BLS for transport, following all applicable protocols.

    1. Responders should apply the following techniques on every call to promote their safety and the safety of those around them:
        a. Have two means of communication with the respective dispatch center at all times
        b. Ensure that location changes are reported to the respective dispatch center
        c. Be aware of an exit route from the scene
        d. Have a plan for an alternate source of cover or concealment
        e. Request that dogs and other potentially hostile animals be secured
        f. Scan the scene for improvised weapons
        g. Be alert to the body language of all persons on the scene

    2. Scene Safety: Often law enforcement will enter the scene first to assess the scene safety prior to the ambulance crew arriving. However, there may be situations whereby staging may not be prudent. This may include a situation where the psychiatric patient is reported to be unresponsive.

Patient contact may be delayed if the responders believe the scene may be unsafe, based on either dispatch information or a scene size-up. EMS units should stage out of sight from any potentially hostile incident and notify their respective dispatch center of their staging location.

If patient contact is delayed due to a potentially dangerous environment, it should be reported to their respective dispatch center and documented on the PCR with both the reason and the time.

If EMS providers are already on scene and the situation becomes hostile, the providers should exit the situation to a safe area, until law enforcement can establish a safe scene.

3. In order to execute an involuntary transport, a sworn law enforcement officer must place the patient under Mental Hygiene Arrest (MHA), as outlined above. There is no middle ground: either the patient is under arrest or they are not. A "voluntary" MHA is a misnomer.

   If a patient with a psychiatric condition wishes to voluntarily go to the hospital:

   a. A patient may go to the hospital voluntarily and request a psychiatric evaluation. They can revoke their decision to go to the hospital at any time during the transport.

   b. If the patient changes their mind and cannot be convinced to continue to the hospital, the crew is obligated to allow the patient out of the ambulance as soon as it is safe to do so. Notify law enforcement to your location so that a determination can be made as to the disposition of the patient. At no time is the crew to attempt to restrain the patient who is not under MHA.

4. Responders are reminded that verbal statements made to the patient can help deescalate the situation. The following are some standard approaches that should be used in all situations with distressed individuals:

   a. Use the phrase, "slow down" to encourage the individual to calm down. Using the phrase "calm down" can often have a paradoxical effect. For example, "could you please slow down a bit? I want to understand what you are saying and it's hard to understand you when you are talking so fast."

b. Use empathy as much as possible. Empathetic statements let the patient know you understand what is upsetting them. Once a patient feels “heard”, there will be better rapport and more cooperation. To be empathetic:
   - Listen carefully to what the patient is saying
   - Pay particular attention to the emotion(s) he/she is experiencing
   - Communicate with the patient. For example: “I can understand how angry that makes you,” “That really is painful, isn’t it?” or “That’s a lot to deal with.”
   - Rather than confronting the delusions (e.g., “you can’t possibly be living without a heart”) or feeding into them (e.g.; “yes, we’ve seen other individuals who have had their heart stolen”), an empathetic approach will be much more effective. For example: "It sounds like your chest feels empty to you” and/or “that must really be scary.”

5. If the patient is under MHA, apply the following guidelines:

   a. If the patient is not already handcuffed upon arrival of EMS:
      - The provider and arresting officer must evaluate the potential for the patient to become violent and determine the need for restraints.

      - If the patient has displayed any acts of violence, threatened violence, displayed any violent tendencies, or the arresting officer requires the patient be in handcuffs during transport, the patient should be restrained using the standard restraint procedure, as outlined in section 6, (Patient Restraint Guidelines) below.

      - If both the provider and arresting officer agree that no restraints are warranted, the patient may be transported on the gurney using the standard gurney straps only (restraints are not required). All straps must be used.

      - If the arresting officer requires what is often called a “courtesy cuff” (one cuff on the patients wrist, one cuff on the gurney), the patient should be fully restrained using the standard restraint procedure outlined in section 6, (Patient Restraint Guidelines), below.

   b. If the patient is already handcuffed behind the back upon arrival of EMS:
      - Evaluate the patient for violence potential.

- Engage the arresting officer(s), discussing their assessment of the patients' mental condition.

- There may be rare instances whereby removing the handcuffs of a patient already cuffed would not be in everyone's best interest. Should that be the case, the arresting officer and the provider should have a discussion regarding options:

  i. The use of chemical restraint may be considered following protocol.

  ii. Removal of the cuffs and restraining after the patient has been adequately sedated.

  iii. Transport with handcuffs left in place.
  iv. Transport using a means other than EMS.

6. Patient Restraint Guidelines
   a. When practical, and prior to restraining a patient, explain to the patient and patient's significant other(s) the reason for restraint use. Maintain constant, direct supervision of the restrained patient.

   b. Patients should be restrained on a backboard or gurney in a supine position. Patients should be restrained using a soft restraint (such as a cravat, spiral gauze, or commercial soft restraint). Place a webbed belt or strap around the patients' thighs and chest; however, these belts must not restrict chest expansion. One hand is to be secured to the backboard slot or head of gurney (on the same side as the limb being restrained), above the patients' head. The other hand will be secured to the backboard slot or gurney rail at the patients' side (on the same side as the limb being restrained). All limbs should be restrained.

      - When placing the patient on a backboard:
        i. Apply thigh strap above the knees
        ii. Apply soft restraints to both wrists
        iii. Remove one hand from handcuffs
        iv. Ideally, secure the right arm to the backboard/gurney above the patient's head, secure the left arm to the backboard/gurney
        v. Apply chest strap as high up on the chest as possible

vi. Re-tighten all straps, check all limb restraints
vii. Assure breathing is not compromised with strap placement

- If necessary, the patients' ankles can be secured with cravats or gauze to the lower slots of the backboard or gurney frame. Handcuffs or plastic bands should be replaced with gauze or cravats if feasible. Handcuffing to a backboard is favored over handcuffing to a gurney to allow for patient movement should their condition deteriorate.

- If handcuffs are requested by law enforcement, a means for removal should be readily available at all times to allow rapid access to the patient for medical management.

c. Once restraints are applied, the EMS provider must regularly reassess vital signs, and circulatory, motor, and sensory status distal to the restraints. Restrained extremities must be monitored for constriction, ischemia, or other signs of injury. The patients' medical status must be continuously monitored. **The patient may never be transported in the prone position and must never be left alone.**

d. If the patient is restrained using the accepted restraint guideline and the EMS provider feels comfortable with transporting the patient, the arresting officer may follow the ambulance to the hospital. If the provider is not comfortable transporting the patient alone, the arresting officer should be requested to ride along in the patient compartment. Note that the officer may at their discretion decide to ride in the ambulance even if the EMS provider does not request it.

e. If there is disagreement the EMS Provider and arresting officer with regard to the proper method of safe transport in the ambulance, or the request of the officer to ride along, the EMS provider should request their superior, as well as the appropriate law enforcement supervisor.

f. If the patient is spitting, it is appropriate to apply a "Spit Sock" or surgical mask. The EMS provider must constantly monitor the patient's airway, respiratory status, and level of consciousness.

g. Documentation is expected to include the following:

i. Steps taken to control patient prior to use of physical restraints, including the reasons restraints were needed and why less restrictive measures were unable to be utilized.

ii. Baseline skin color and integrity prior to application of restraints.

iii. The time restraints were applied.

iv. Pertinent observations, including vital signs, and any changes in behavior.

v. Name of police agency, and if possible, name of police officer.

vi. A patient evaluation should be documented every 5 minutes for restrained patients, or every 15 minutes for stable, non-restrained patients.

RAPID SEQUENCE INDUCTION PROGRAM

PURPOSE

The Monroe-Livingston Region's Rapid Sequence Induction Program (RSI Program) provides advanced airway capabilities, specifically rapid sequence induction and intubation, to properly identified patients requiring such definitive airway management.

OVERVIEW

Rapid Sequence Induction has been used in the hospital setting for years to help provide the highest possible intubation success rate for patients undergoing emergent intubation. Its use in the Prehospital setting has been the subject of significant research and this program was established after a review of the medical literature and best practices existing in other parts of the country. The RSI Program exists to provide RSI services to Monroe and Livingston counties in a careful, safe, and controlled fashion. *It is important to recognize that the successful performance of an RSI procedure does not imply appropriateness of the procedure.*

AUTHORIZATION

The program is authorized by the Monroe-Livingston REMAC and overseen by the Regional EMS Medical Director. As such, the RSI Program is a regional program, not one implemented at the agency level. The Regional EMS Medical Director may designate additional physicians to supervise the implementation, quality assurance, and continuing education requirements for the RSI Program.

Individuals and agencies providing RSI do so as an added service under the oversight of the REMAC and the Regional EMS Medical Director. Failure to follow these regulations will lead to the penalties described in this policy including revocation of RSI credentials for the paramedic and/or the agency.

MEDICAL CARE

This policy does not define the manner in which the RSI procedure is performed. The "RSI Protocol" as defined in the most recent protocols, shall be the sole authority on how such a procedure is performed in the Prehospital setting. Both the RSI Protocol and RSI Policy and Procedure here are to be used ONLY by individuals currently credentialed as an RSI-Paramedic while working for an RSI authorized agency. They are not to be used for routine Advanced Life Support Care.

CREDENTIALING REQUIREMENTS

RSI AGENCY

A RSI Agency is one that maintains the following:

1. Has unrestricted authorization from the New York State Department of Health and the Monroe-Livingston County REMAC to provide Advanced Life Support care.

2. Has unrestricted authorization from the New York State Department of Health and Bureau of Narcotics Enforcement to carry and administer controlled substances to patients.

3. Has agreed to abide by the RSI Protocol and the RSI Policies and Procedures approved by the Monroe-Livingston REMAC, including agreeing to provide the RSI Paramedic the proper medications and equipment as detailed in the protocol and following all QA requirements as detailed in this policy.

4. Has agreed to make RSI Paramedics available to all EMS agencies in the region when RSI skills may be required.

5. Has been approved by the Regional Medical Director to provide RSI.

RSI PARAMEDIC

A RSI Paramedic is an individual who is credentialed to provide RSI services to patients in the Monroe-Livingston EMS Region. RSI Agencies can and are encouraged to create their own clearance process for RSI Paramedics. However, no paramedics can provide RSI services at any agency if they are not credentialed at the regional level. To act as a RSI Paramedic, the individual must practice with an agency authorized to provide RSI care. *Thus, a RSI Paramedic practicing with an agency that does not provide RSI services cannot perform RSI on a patient.*

The RSI Paramedic or RSI Agency is responsible for any costs required for maintaining their credentialing.

CREDENTIALING PROCESS

The following are required to be considered for practice as a RSI Paramedic:

1. Active practice as a paramedic for a minimum of two years; at least one of which in the Monroe - Livingston System;
2. Be in good standing with the REMAC Patient Safety Committee;
3. Have recommendations from the Agency ALS Chief and Medical Director;
4. Have a current NY State Paramedic certification;
5. Have a current ACLS certification;
6. Have a current PALS/PEPP certification;
7. Successfully complete competency training as determined by the Regional Medical Director.

Providers will be considered for credentialing based on their quality of clinical care, the thoroughness and accuracy of their documentation, and their procedural and clinical competency. The Regional EMS Medical Director may request documentation from the sponsoring agency to substantiate the provider's documentation and clinical skills. RSI providers will be added to the system in a quantity and at a time dictated by the Regional EMS Medical Director to ensure the most appropriate distribution of providers within the Monroe-Livingston Region.

Maintenance of Credentials

RSI Paramedics must meet all credentialing requirements at all times. It is the responsibility of the RSI Paramedic and the RSI Agency for whom they operate to report noncompliance with these criteria or clinical care concerns that could impact the provider's ability to provide RSI services. Failure to meet any of these criteria at any time immediately revokes the RSI Paramedic's credentials to provide RSI services to the community. This change must immediately (within one business day) be reported in writing to the RSI Agency ALS Chief, the Agency Medical Director, and the Regional EMS Medical Director.

RSI Paramedics will be continuously reviewed and may be suspended from the program at any time for not meeting the documentation, clinical, or procedural expectations of the Regional EMS Medical Director. Suspension of RSI privileges can be appealed to the Regional Patient Safety Committee. Reinstatement to the program will be considered on a case-by-case basis.

CONTINUING EDUCATION

Continuing education is a key component to the maintenance of RSI proficiency. It must include both practical and didactic education. It is the responsibility of the RSI Paramedic to ensure that he/she attends sufficient continuing education opportunities in order to meet annual didactic and procedural competencies.

OPERATIONS

Requesting RSI Paramedic Assistance

Any level provider may request assistance from a RSI Paramedic via their agency dispatch or via the Monroe or Livingston County 911 Center. All dispatch centers should establish a protocol to identify and send the nearest RSI Paramedic in a safe and efficient manner.

Actions on Arrival

All RSI Paramedics should thoroughly evaluate the setting and patient upon arrival at the patient's side. He/she must consider all issues as detailed in the RSI Protocol.

Considerations of note include:

1. Consideration of BLS and ALS airway options – The RSI Paramedic must evaluate and ensure that all BLS airway options and ALS airway options have been considered. These considerations must be documented on the PCR.

2. Proximity to the hospital ED – If avoidable, transport to the ED should not be significantly delayed to RSI the patient with the understanding that a compromised airway is immediately life threatening and must be managed in a timely fashion.

3. Indications have been met and contraindications have been excluded.

4. Anticipated difficulty of RSI – the need for RSI in patients expected to be very difficult intubations should receive particular consideration.

5. Medical control authorization as appropriate – on-line medical control exists to assist the RSI paramedic in determining the best options for the patient.

If the patient is not felt to need RSI, the RSI Paramedic must transport with the patient to monitor for further deterioration of the patient's respiratory status.

After-Call Actions

After-call actions include a combination of detailed documentation and verbal debriefing with a designated physician. The intent of this process is to ensure that quality patient care is delivered, any RSI Paramedic issues are immediately noted, and detailed, clinical information is obtained. As detailed below, some debriefing will occur immediately after care is provided, while other debriefing will occur when possible after care is provided.

1. Patients Receiving RSI.

After completing the RSI, whether the procedure is successful or not, and transferring care to the ED, the RSI Paramedic is responsible for the following:

a. PCR – A thorough and complete PCR must be completed immediately. The PCR must include the reasoning behind performing the RSI, response to the BLS and ALS airway options, and medical control authorization as appropriate.

b. RSI Quality Assurance Form – The Monroe-Livingston Region RSI QA Data Form must be completed and submitted with a copy of the PCR to the Regional EMS Medical Director within two business days for RSI agencies not using emsCharts. For agencies using emsCharts, agencies shall participate in the QA process by utilizing a quality assurance research module designed specifically for the RSI program. For agencies using emsCharts, completion of a separate Quality Assurance form will not be required.

c. Debriefing – After transfer of care, the On-Call EMS Medical Director must be paged via either the agency dispatcher or the 911 Dispatch Center. A debriefing will be immediately performed by the available medical director.

2. Patients for whom RSI was not performed.

In some cases, either the RSI Paramedic or Medical Control will decide that RSI was not indicated. In the event that this occurs, the RSI Paramedic is responsible for the following:

a. PCR – A thorough and complete PCR must be completed immediately. The PCR must include the reasoning behind not performing the RSI, response to the BLS and ALS airway options, and medical control discussion (if applicable).

b. RSI Quality Assurance Form – The Monroe-Livingston Region RSI QA Data Form must be completed and submitted with a copy of the PCR to the Regional EMS Medical

Director within two business days for RSI Agencies not using emsCharts. For agencies using emsCharts, agencies shall participate in the QA process by utilizing a quality assurance research module designed specifically for the RSI program. For agencies using emsCharts, completion of a separate Quality Assurance form will not be required.

c. Should the RSI Paramedic wish to discuss the call, they can contact the On-Call EMS Medical Director through the appropriate communication center. Although mandatory post-call debriefing is not required, the medical directors would be happy to discuss any RSI situation with the involved paramedics as they see fit.

QUALITY ASSURANCE

The Monroe-Livingston Regional RSI Quality Assurance Program includes immediate debriefing of the RSI Paramedic with an On-Call EMS Medical Director after successful or unsuccessful RSI. It further includes reporting and debriefing of requests for RSI in which an RSI was not performed. A detailed Quality Improvement Tool (the Monroe-Livingston Region RSI QA Data Form or emsCharts Research Module) is to be completed by a RSI Paramedic immediately after the transfer of patient care, and is to be included with a copy of the PCR to the Regional EMS Medical Director.

The Regional EMS Medical Director will review all calls in which both successful and unsuccessful RSI's were performed, as well as all calls where a RSI Paramedic was requested but the patient did not meet RSI criteria. The Regional EMS Medical Director will advise the REMAC Patient Safety Committee of any patient care concerns or trends observed system-wide that may benefit by additional training or modification to existing medical care protocol.

The Regional EMS Medical Director has the responsibility and authority to advise the REMAC Patient Safety Committee of any RSI paramedic that should be restricted from participating in the RSI program. Furthermore, the On-Call Medical Director that debriefs the RSI Paramedic at the time of the procedure has the authority to immediately suspend an individual's RSI privileges should it be required. Doing so requires immediate notification of the Regional EMS Medical Director, Agency Medical Director, and Agency Operations Director, as well as written documentation submitted to the Regional Program Agency for distribution to the above parties within three business days.

Changes to this policy and the RSI Protocol will be done in accordance with the available literature, best standards and intensive continuing review of all RSI procedures performed in the Monroe-Livingston region.

REFUSAL OF TREATMENT/TRANSPORT POLICY

PURPOSE

This policy outlines the evaluation of a patient refusing treatment or transport and the documentation expected when obtaining such a refusal.

OVERVIEW

A patient is defined as a person encountered by EMS personnel with an actual or potential injury or medical problem. "Encountered" refers to visual contact with the patient. These persons may have requested an EMS response or may have had an EMS response requested for them. Due to the hidden nature of some illnesses or injuries, an assessment should be performed on all patients. For patients initially refusing care, an attempt to evaluate the individual, even if only by visual assessment is expected and must be documented.

EVALUATION

The evaluation of any patient refusing medical treatment or transport should include the following:

1. Visual Assessment – To include responsiveness, level of consciousness, orientation, obvious injuries, respiratory distress, and gait.

2. Initial Assessment – Airway, breathing, circulation, and disability.

3. Vital Signs – Pulse, blood pressure, respiratory rate and effort. Pulse oximetry and/or blood glucose when clinically indicated.

4. Focused Exam – As dictated by the patient's complaint (if any).

5. Medical Decision Making Capacity Determination – As defined below.

Patients at the scene of an emergency who demonstrate capacity for medical decision making shall be allowed to make decisions regarding their medical care, including refusal of evaluation, treatment, or transport. In order to ensure that a patient exhibits the capacity for medical decision making, **the patient must have the ability to understand the nature and consequences of their medical care decision**. A patient, who is evaluated and found to have any one of the following conditions, shall be considered incapable to making medical decisions regarding care and/or transport and should be transported to the closest appropriate medical facility under implied consent:

1. Altered mental status from any cause including altered vital signs, intoxication from drugs and/or alcohol, presumed metabolic causes (ingestion, hypoglycemia, stroke, etc), head trauma, or dementia.

2. Age less than 18 unless an emancipated minor or with legal guardian consent.

3. Attempted suicide, danger to self or others, or verbalizing suicidal intent.

4. Acting in an irrational manner, to the extent that a reasonable person would believe that the capacity to make medical decisions is impaired.

5. Severe illness or injury to the extent that a reasonable and medically capable person (or, for a pediatric patient, the parent/guardian) would seek further medical care.

6. When appropriate documents are signed and patient is placed under involuntary commitment pursuant to Article 9 of the New York State Mental Hygiene Law.

Patient consent in these circumstances is implied, meaning that a reasonable and medically capable adult would allow appropriate medical treatment and transport under similar conditions. Providers who identify a patient requiring transport under implied consent and are refusing to do so may require Medical Control consultation and/or Law Enforcement involvement to ensure the patient is transported to an appropriate emergency facility for evaluation. Medical care should be provided according to protocol.

Once a patient assessed to lack decisional capacity is transported under implied consent to the appropriate emergency facility, another determination of decisional capacity may be required for continued involuntary care and treatment. Patients exhibiting the following at risk criteria should receive particular attention to an appropriate evaluation and risk/benefit discussion prior to not transporting and the EMS provider may consider medical control consultation prior to obtaining a refusal:

1. Age greater than 65 years or less than 1 year.
2. Pulse >120 or <50.
3. Systolic blood pressure >200 or <90.
4. Respirations >29 or <10.
5. Serious chief complaint (chest pain, SOB, syncope).
6. Significant mechanism of injury.

A patient exhibiting medical decision making capacity and wishing to refuse care/transport may do so after the provider has assured the following have been completed:

1. Determined the patient exhibits decisional capacity to refuse care/transport.
2. Offered transport to a hospital.
3. Explained the risks of refusing care/transport.
4. Explained that by refusing care/transport, the possibility of serious illness of death may increase.
5. Advised the patient to seek medical attention and provided instructions for follow-up care.
6. Confirmed that the patient understands these directions.
7. Ensured that the patient signed a Refusal of Treatment/Transport Form or documented why it was not signed.
8. Left the patient in the care of a responsible adult when possible.
9. Advised the patient to call 911 with any return of symptoms or if they wish to be re-evaluated and transported to the hospital.

MEDICAL CONTROL

The EMS provider may consider consulting Medical Control if the patient does not wish transport. The purpose of the consultation is to obtain a "second opinion" with the goal of helping the patient realize the seriousness of their condition and accept transportation. Medical consultation is highly recommended for the following:

1. The provider is unsure if the patient is medically capable to refuse treatment and/or transport.

2. The provider disagrees with the patient's decision to transport due to unstable vital signs, clinical factors uncovered by the assessment, or the provider's judgment that the patient is likely to have a poor outcome if not transported (see at risk criteria, above).

Medical Control consultation **is required** for the parent or legal guardian refusing transport of a child being evaluated for a Brief Resolved Unexplained Event (BRUE).

DOCUMENTATION

Patient refusals are the highest risk encounters in clinical EMS. Careful assessment, patient counseling, and appropriate Medical Control consultation can decrease non-transport of high-risk refusals. Paramount to the decision-making involved in a patient refusal of treatment and/or transport is the documentation of that refusal.

Documentation is expected to include:

1. In the prehospital care report the provider's assessment, treatment provided, reasons for refusal, determination of medical decision making capacity, and Medical Control consultation as appropriate.

2. Completion of a refusal of treatment/transport form that is in some form attached to the prehospital care report, to include at a minimum, the following:

    a. Agency Name
    b. Date of Incident
    c. PCR associated with the refusal
    d. Patient's signature, date and time of refusal
    e. Witness signature, date and time of refusal

Associated Documents for Optional Use by Agencies:

1. MLREMS Refusal of Treatment/Transport Form
2. MLREMS Refusal of Treatment/Transport Information Card.

EMERGENCY MEDICAL DISPATCH

PURPOSE

To establish the standard by which emergency requests for emergency medical service are processed.

POLICY

1. All telephone requests for emergency medical care received in Monroe or Livingston counties must be processed using an Emergency Medical Dispatch (EMD) program. Such a program must assure the following:

    a. EMD is used as an integral part of every EMS call receipt and dispatch process.

    b. Emergency Medical Dispatchers handle all calls and are trained in the principles and procedures of EMD following the standards of a recognized curriculum.

    c. A nationally recognized EMD reference system is used which includes standardized caller interrogation and pre-arrival instructions.

    d. There are written policies and procedures for call receipt, call processing, and dispatch of resources based on the identified patient need. This should include the time frames for call processing, a priority assignment of resources based on need and availability, simultaneous dispatch of resources, ALS intercept, mutual aid, Mass Casualty Incidents, etc.

    e. There are written policies for maintaining documentation including voice and text records compliant with any local, state, or federal requirements.

    f. There are written policies and procedures for variance investigation and an EMD quality improvement program.

    g. There is an identified physician Medical Director who is an active participant in the local EMS system and is familiar with EMD dispatch principles and the local EMS system. This physician shall also be responsible for the medical component and quality improvement of the EMD program.

h. Emergency Medical Dispatch should be used to determine the level of response and that level should balance the need of the patient and risk to the community.

2. Any public safety agency (law enforcement, fire and emergency medical service) that does not refer calls for emergency medical care to an EMD-enabled Public Safety Answering Point must have in place a written policy outlining the process used to handle telephone requests for emergency medical care and providing pre-arrival instructions. This policy must be written with and approved by the agency Medical Director.

CARE AND TRANSPORT OF MINORS

PURPOSE

EMS providers are occasionally called to treat and transport minors. New York State does not allow a person under age 18, unless emancipated, to assume responsibility for their medical care. This policy defines an emancipated minor and outlines the treatment expectations of minors and emancipated minors.

POLICY

1. Definition of emancipation shall be a person between the ages of 16 and 18 who:
    a. Live separate and apart from their parents
    b. Do not receive any financial support from them
    c. Live beyond the parent's custody and control
    d. Are not in foster care
2. An emancipating event includes:
    a. Marriage
    b. Pregnancy (only for prenatal care)
    c. Parenthood
    d. Degree/Diploma
    e. Military Service
3. If a minor is ill or injured in any way, they should be transported to a medical facility.
4. If a minor is between the ages of 16 and 18 and relates an emancipating event, they may make their own decisions regarding treatment and transport to include refusing such care.
5. If a minor is not injured use the following guidelines:

a. A law enforcement officer has the legal authority to assume responsibility for a minor who is not injured until a parent/guardian can be located. If willing, the officer must sign the refusal form in the area for guardian.

b. Make reasonable efforts to contact parent/guardian. Document who you spoke with and their treatment decision for the minor. Care and treatment should never be delayed to accomplish this.

c. If contact with a parent/guardian cannot be made, contact Medical Control.

EMERGENCY INCIDENT REHABILITATION

PURPOSE

To ensure the physical and mental condition of responders operating at the scene of an emergency or training exercise does not deteriorate to a point that affects the safety and health of the responder, fellow responders, or the safety and integrity of the operation.

Agency leadership are strongly encouraged to review the United States Fire Administration guide to Emergency Incident Rehabilitation (February 2008 revision) and the National Fire Protection Association Standard 1584 to assist in placing this policy into context. Regardless of how rehabilitation is implemented, it is absolutely crucial that all responders follow this policy. No one, including officers, should be allowed to skip the rehabilitation process as enforcement of this policy will have a measureable effect on the long-term well-being of all responders.

POLICY

The following policy is strongly recommended for events, including training, fireground operations, hazardous materials incidents, prolonged extrication, and any other event where emergency response personnel are engaged in activities that pose a risk of exceeding a safe level of physical or mental endurance. This policy defines the minimum expectations of Emergency Incident Rehabilitation in the Monroe-Livingston Region, however agencies may, upon approval of their Medical Director, choose to implement additional criteria for rest, re-hydration, or physiologic measures provided they are not less than the minimum expectations set forth herein.

EXPECTATIONS

1. It is the responsibility of all responders at the scene to monitor themselves and their personnel to ensure the safety, health and welfare of all responders by ensuring adequate rest and hydration following the recommendations as set forth in this policy.

2. All providers are encouraged to participate in self-rehabilitation. This should ideally include 10 minutes between work periods and/or SCBA exchanges whereby the provider is allowed to rest and consume appropriate fluids while awaiting reassignment.

3. The Incident Commander shall consider the circumstances of each incident or training exercise early in the evolution of the incident or exercise, and make adequate provisions for the rest and rehabilitation for all personnel operating at the scene.

4. For any event where emergency response personnel are engaged in activities that pose a risk of exceeding a safe level of physical or mental endurance, it is recommended that the Incident Commander or their designee (Incident Safety Officer or Logistics Section Chief) establish the following minimum:

    a. Rehabilitation Area
        - Ample space with preference to seating for responders
        - Protection from the elements, fumes, or hazards
        - Accessible by EMS
        - Clearly identified
        - Temperature control including active cooling and re-warming of responders as indicated by environmental conditions
        - Re-hydration to include water and electrolyte replacement
        - Nutrition (as appropriate for the duration of the incident)
        - Staffing should include at least one Rehabilitation Officer/Manager with training of at least EMT, and BLS equipment to include oxygen, blood pressure cuff and pulse oximeter. Availability of an AED and Pulse-CO-Oximetry in proximity to the Rehabilitation Area is strongly encouraged.

    b. Treatment Area
        - Separate from the rehabilitation area
        - In close proximity to a transporting ALS ambulance and the rehabilitation area
        - Staffing should include a fully-staffed ALS transporting ambulance

5. There should be at least one rehabilitation staff member for every 5 responders in the Rehabilitation Area.

6. For large incidents, it may be advisable to have more than one Rehabilitation and/or Treatment Area established. This decision should be made by the Incident Commander or their designee.

7. For incidents greater than a single alarm, it is recommended that a minimum of one fully staffed ALS transporting ambulance is available per alarm assignment. Additional transporting ambulances may be required depending on the type of operation, environmental conditions, and number of responders involved.

8. No personnel should enter the warm or hot zone of a declared Hazardous Materials Incident unless the Rehabilitation and Treatment areas have been established and staffed according to

the policies and procedures of the respective Hazardous Materials Team. This must include an ALS transporting ambulance.

9. It is advised that the pre-hydration, when possible, occurs to include a minimum of 16 ounces of non-caffeinated fluids over the two hours prior to scheduled events, such as training exercises.

PROCEDURE

1. Responders should be detailed to the Rehabilitation Area by the Incident Commander or their designee after every 45 minutes of continuous hard labor, one 45 minute or 60 minute rated SCBA cylinder, two, thirty-minute rated SCBA cylinders, or after being decontaminated. The Incident Commander or Incident Safety Officer may direct personnel to the Rehabilitation Area at any time for reasons not mentioned above.

2. All responders must be decontaminated (if necessary) and remove personal protective equipment prior to entering the Rehabilitation Area.

3. All responders must follow their agencies accountability system when entering/departing the Rehabilitation and/or Treatment Areas.

4. Upon entering the Rehabilitation Area, the responder is expected to do the following:
    a. Drink at least 16 ounces of fluid (water first, then half-strength electrolyte solution if available).
    b. Refrain from tobacco use (smoked, smokeless, or electronic) in the Rehabilitation or Treatment Areas.
    c. Heed the directives of the Rehabilitation Officer/Manager with regards to their disposition to the manpower/staging or the treatment areas.

5. The responder will be assessed by the Rehabilitation Officer/Manager or other medically trained personnel.

6. Any responder entering the rehabilitation area with complaints of chest pain, shortness of breath (beyond normal exertion), or altered mental status will be immediately moved to the Treatment Area and may not return to duty for the duration of the incident. This shall be immediately reported to the individual(s) responsible for scene safety, accountability, and/or command.

7. Every responder will be assessed for presence of other symptoms to include dizziness, weakness, nausea, headache, cramps, aches or pain, changes in gait, speech or behavior,

mental/physical stress, exhaustion, and symptoms of heat or cold-related stress. These symptoms do not require immediate removal to the Treatment Area, but must resolve prior to returning to manpower/staging.

8. Every responder will have vital signs assessed to include Pulse, Respiratory Rate, Blood Pressure, and Pulse-Oximetry over a thirty-second period and recorded on the Incident Rehabilitation Log. Use of pulse co-oximetry is optional, but encouraged.

9. Abnormal Vital Signs are considered any one of the following:

    a. Pulse >110 per minute
    b. Respirations >20 per minute
    c. Systolic Blood Pressure >160
    d. Diastolic Blood Pressure <100
    e. SPO_2 <96% in ambient air
    f. Pulse co-oximetry >5% (if measured)

10. If on any vital sign exam an irregular pulse is identified that is not previously known to the responder, the responder should be moved to the Treatment Area for further evaluation. This shall be immediately reported to the individual(s) responsible for scene safety, accountability and/or command.

11. If the vital signs are within normal limits (as defined above) the responder is encouraged to drink at least 16 ounces of fluid and may return to manpower/staging after a minimum of 10 minutes rest.

12. If vital signs are abnormal (as defined above), the responder will be monitored for 10 minutes and encouraged to rest and consume appropriate fluids.

13. After 10 minutes from time of entry to the Rehabilitation Area, the responder will be re-assessed and all vital signs retaken.

    a. If vital signs are within normal limits, the responder may return to manpower/staging.
    b. If vital signs continue to remain abnormal (as defined above), the responder will be observed for another 10 minutes and encouraged to rest and consume appropriate fluids.

14. After 20 minutes from time of entry to the Rehabilitation Area, the responder will be re-assessed and all vital signs retaken.

    a. If vital signs are within normal limits, the responder may return to manpower/staging.
    b. If vital signs continue to remain abnormal (as defined above), the responder will be referred to the Treatment Area. This shall be immediately reported to the individual(s) responsible for scene safety, accountability and/or command.

15. If the responder exhibits any symptoms of chest pain, shortness of breath, or altered mental status during their time in the Rehabilitation Area, they should be moved to the treatment Area immediately and may not return to duty. This shall be immediately reported to the individual(s) responsible for scene safety, accountability and/or command.

16. No responder may return to the manpower/staging unless they fulfill the following:

    a. No symptoms of dizziness, weakness, nausea, headache, cramps, aches or pain, changes in gait, speech or behavior, and symptoms of heat or cold-related stress.
    b. Pulse less than or equal to 110 per minute
    c. Respirations less than or equal to 20 per minute
    d. Systolic Blood Pressure less than or equal to 160
    e. Diastolic Blood Pressure less than or equal to 100
    f. Pulse oximetry greater than or equal to 96% in ambient air
    g. Pulse co-oximetry less than or equal to 5% (if measured)

17. Any responder moved to the Treatment Area should have care provided according to the most recent edition of the regional protocols.

18. All personnel should be encouraged to hydrate with at least 36 ounces of appropriate fluids over two hours after the conclusion of the incident.

INTERPRETING CO VALUES DURING INCIDENT REHABILITATION

1. The use of hand-held pulse co-oximetry devises is optional, and not required for Incident Rehabilitation.

2. The SpCO reading is to be used as a screening measure. Definitive carboxyhemoglobin determinations are performed via blood draw in the hospital setting. Any patient with complaints

of chest pain, shortness of breath, or altered mental status should receive oxygen by a non-rebreather mask and moved to the Treatment Area, regardless of SpCO reading.

3. The following CO treatment guidelines will pertain to the asymptomatic emergency responder on entry to the Rehabilitation Area.

    a. If SpCo<5% and vital signs are within normal limits, the provider is encouraged to drink at least 16 ounces of fluid and may return to manpower/staging after a minimum of 10 minutes rest.

    b. If SpCO is greater than or equal to 5% and <12% , the responder may breathe ambient air and may not leave the rehabilitation area until their CO level is below 5%.

    c. If SpCO is greater than or equal to 12%, the responder should be moved to the Treatment Area and receive high-flow oxygen until the SpCO is <5%.

    d. If SpCO is greater than or equal to 25%, the responder will be moved to the Treatment Area and transported with high-flow oxygen to an emergency department.

DOCUMENTATION

1. All responders entering the Rehabilitation Area should have their name, vital signs, and disposition recorded on the Rehabilitation Log (Attached). This Log should be attached and stored with the stand-by PCR associated with the incident and a copy given to the Incident Commander or Incident Safety Officer.

2. A separate PCR must be completed for any responder referred to the Treatment Area, regardless of whether the responder was transported by EMS. Should the responder not wish transport, an informal refusal must be completed and the individual(s) responsible for scene safety, accountability and/or command shall be notified.

Incident Rehabilitation Log

Rehabilitation Officer:______________________________ Incident Date: ____________

Incident Commander:______________________________

Incident Location:______________________________ Page: _____ of _____

Name	Time In	Time	Pulse Rate	Pulse Regularity	Respiratory Rate	Blood Pressure	Pulse Oximetry	Pulse CO-Oximetry	Symptoms	Time Out	Disposition
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Abnormal Vital Signs: >110/min Irregular >20/min >160 Systolic <96% >5%

>100 Diastolic

FIRE DEPARTMENT BLS FIRST RESPONSE DOCUMENTATION REQUIREMENTS

PURPOSE

To define the minimum documentation expectations of Fire Department Basic Life Support First Response agencies who respond to requests for emergency medical services. This policy does not apply to transporting or non-transporting ALS agencies that must complete a Prehospital Care Report for every incident to which they are dispatched.

POLICY

Fire Department Basic Life Support First Response (BLSFR) agencies must record all requests for emergency medical services using either a PCR or a written or electronic fire service log, hereafter referred to as a Fire Record Management System (FireRMS).

For every request for emergency medical services, the following must be included in the FireRMS:

1. Date and time of incident
2. Incident location
3. EMD Code associated with the incident
4. The disposition of the incident

A Prehospital Care Report (PCR) must be completed when patient care is provided independently by a member of the BLSFR agency at any point during the response. "Independent patient care" refers to a member of the BLSFR agency who is in charge of patient care to their level of certification prior to the arrival of a transport unit or an advanced provider who assumes responsibility for that patient's care. Should the BLSFR agency not provide independent patient care during that incident, then a PCR is not required and the FireRMS may be used to document the service type provided.

The FireRMS incident dispositions and documentation requirements are:

1. Canceled
    a. The BLSFR agency is cancelled en-route or on-scene by a law enforcement, fire or EMS agency and makes no patient contact. Patient contact is defined as visual contact with the patient. No PCR is required and the disposition is recorded in FireRMS.

    b. NFIRS Equivalent:
        - 611 – Dispatched and canceled en route. Incident cleared or canceled prior to arrival of the responding unit.

2. No Patient Found
    a. The BLSFR agency arrives on scene and finds no patient. A patient is defined as a person encountered by EMS personnel with actual or potential injury or medical problem. No PCR is required and the disposition is recorded in FireRMS.

    b. NFIRS Equivalents:
        - 324 – Motor vehicle accident with no injuries
        - 621 – Wrong location, excludes malicious false alarms (710 series).
        - 622 – No incident found on arrival at dispatch address
        - 661 – EMS call where injured party has been transported by a non-fire service agency or left the scene prior to arrival.
        - 600 – Good intent call, other.

3. Assist Ambulance
    a. The BLS agency assists the transporting ambulance or a higher level of care (in the case of a non-transporting ALS unit) with patient care (lifting, packaging, obtaining vital signs, riding with the transporting crew, etc) at the direction of the provider in charge. No PCR is required and the disposition is recorded in FireRMS.

    b. NFIRS Equivalent:
        - 311 – Medical assist. Includes incidents where medical assistance is provided to another group/agency that has primary EMS responsibility.

4. Patient Care Provided
    a. The BLSFR agency is in charge of providing independent patient care to the level of their certification at any time during the incident. A PCR is required and the disposition is recorded in FireRMS. This includes when an agency provider:

        i. Administers aspirin, albuterol, naloxone, or epi-pen.

        ii. Utilizes an AED or blood glucometer.

iii. Performs any procedure, including: cardiopulmonary resuscitation or assisted ventilation; spinal motion restriction using a cervical immobilization device and/or backboard; or immobilization of a suspected fracture using a splint or other immobilization device.

b. Generally, any time the BLSFR agency is at the patient's side before the transporting provider, a PCR is expected as an evaluation and "independent patient care" has been performed. Other instances such as mandated reporter conditions (abuse, neglect) should result in the generation of a PCR. When in doubt, complete a PCR.

c. NFIRS Equivalents:
   - 321 – EMS call. Includes calls when the patient refuses treatment. Excludes vehicle accident with injury (322) and pedestrian struck (323)
   - 322 – Motor vehicle accident with injuries. Includes collision with other vehicle, fixed objects, or loss of control resulting in leaving the roadway.
   - 323 – Motor vehicle/pedestrian accident (MV Ped). Includes any motor vehicle accident involving a pedestrian injury.

5. Standby
   a. The BLSFR agency provides EMS standby services for hazardous conditions with the intent to provide emergency medical aid or assessment should it be required. This includes emergency incident rehabilitation. No PCR is required and the disposition is recorded in FireRMS. If a patient is assessed or treated beyond that which is specified in emergency incident rehabilitation policy, a PCR is required.

   b. NFIRS Equivalent:
      - 381 – Rescue or EMS standby for hazardous conditions. Excludes aircraft standby (462).

It is expected that the BLSFR agency monitor compliance with these documentation expectations.

ON-LINE MEDICAL CONTROL REQUIREMENTS

PURPOSE

To define the requirements of facilities and physicians providing on-line medical control to EMS providers in the Monroe-Livingston Region.

DEFINITION

On-Line Medical Control (OLMC) is the advice and direction through a direct, live communication link (two-way radio or telephone) from a physician to emergency medical responders, emergency medical technicians or paramedics who are providing medical care at the scene of an emergency.

FACILITY REQUIREMENTS

To be considered an OLMC facility in the Monroe-Livingston Region, the facility must:

1. Have an emergency department meeting all standards for emergency department/service as defined in Section 405 of the NYS Hospital Code.

2. Have a physician staff member physically present in the emergency department and immediately available 24 hours a day that is credentialed by the Monroe-Livingston REMAC to provide OLMC.

3. Provide on-line medical direction for BLS and ALS agencies that transport patients to their facility and to facilities not able to provide OLMC.

4. Accept patients requiring BLS and/or ALS services who may have received EMS care under physician direction originating from another medical control hospital.

5. Maintain direct two-way radio and/or compatible telephones available to communicate with BLS and ALS units and medical control hospitals.

6. Use only Monroe-Livingston REMAC approved medical control logs and maintain them for a minimum of 7 years.

7. Record all audio from direct two-way radio and/or compatible telephones providing OLMC and maintain them for a minimum of 7 years.

8. Assume the responsibility for the care and maintenance of necessary communications equipment within the institution.

9. Familiarize staff members with approved regional and state protocols.

10. Participate in local and or regional EMS planning activities as appropriate.

11. Participate in quality improvement activities as defined in Part 405.19 item (f) of the NYS Hospital Code.

12. Participate in quality improvement activities as requested by the Monroe-Livingston REMAC or System Medical Director as they relate to the provision of OLMC.

13. Designate a Hospital Medical Control Director to be in charge of overall coordination of medical control in that facility.

PHYSICIAN REQUIREMENTS

To be credentialed as an On-Line Medical Control Physician in the Monroe-Livingston Region, the physician must:

1. Be licensed to practice medicine or osteopathy in New York.

2. Be Board Certified/Board Eligible by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine **or** be credentialed in basic and advanced cardiac life support, and Advanced Trauma Life Support, or equivalent.

3. Physicians-in-training must be credentialed in basic and advanced cardiac life support and Advanced Trauma Life Support.

4. Be trained in and thoroughly familiar with the following:
    a. Regional and state BLS and ALS protocols
    b. Communication systems
    c. EMS levels of training and responsibilities
    d. Medical control system and responsibilities of a medical control physician

5. Successfully complete (80% or better) a written OLMC Test administered by the Monroe-Livingston REMAC.

6. Review, and as directed, complete re-training regarding the provision of OLMC as regional protocols and policies are updated.

CONTINUOUS INFUSIONS

PURPOSE

This policy outlines the use of continuous infusions in the Prehospital and interfacility environment.

POLICY

Certain continuous infusions may be maintained by a paramedic provider during Prehospital interfacility transport and do not require the use of a Specialty Care Transport provider. Specific medications may require the use of a Continuous Electronic Infusion Device (commonly referred to as a medication pump). Paramedics using a Continuous Electronic Infusion Device must be trained in its use according to manufacturer's guidelines and as approved by the Agency Medical Director. The agency using such a device must have a written policy outlining the training requirements, eligibility, quality assurance program, and parameters for use of the specific device being used by the agency. Medical Control is not required for use of the device, but is required for any deviation from agency policy on its use.

INDICATIONS

The following continuous infusions may be maintained by a paramedic provider. Medications that require use of a Continuous Electronic Infusion Device are indicated by an asterisk(*):

- Abciximab*
- Any Antibiotic
- Amiodarone*
- Dextrose 5% in Water (D5W)
- Diltiazem*
- Eptifibatide*
- Fentanyl*
- Insulin*
- Heparin*
- Hydromorphone*
- Lactated Ringer's
- Lidocaine*
- Magnesium*
- Morphine*
- Nitroglycerin*
- Normal Saline
- Pantoprazole*
- Sodium Bicarbonate
- Tissue Plasminogen Activator*
- Total Parenteral Nutrition+/- Lipids

CONTRAINDICATIONS

1. The paramedic provider may transport no more than three continuous medication infusions; no more than one of which may be vasoactive.

2. Contraindications are otherwise related to the specific medication or solution being infused.

PROCEDURE

1. The patient requires continuous infusion of an indicated medication or crystalloid.

2. A reliable source of intravenous access (large bore peripheral IV or central venous catheter) exists.

3. If required, adjust infusion device to appropriate administration rate per manufacturers instructions.

4. The patient must be constantly monitored throughout the transport including:
    a. Continuous pulse oximetry.
    b. Continuous ECG monitoring.
    c. Frequent blood pressure monitoring.
    d. Frequent examination of the infusion site.

5. During interfacility transports, an order for the infusion rate must be given by the sending physician and this rate entered and double-checked prior to departing the sending facility. The compatibility of more than one infusion must be verified with the sending facility prior to departure.

6. Any adjustment to the infusion rate during transport may only be done with Absolute On-Line Medical Control. The only exceptions are for medications (antibiotics, etc) that are completed during the transport or for medications that have infiltrated their access site. Specialty Care Transport Paramedics should follow their specific protocols.

7. A paramedic provider with access to a Continuous Electronic Infusion Device may use such device for administering any medication included in the regional protocols.

TRAINING CONSIDERATIONS

Implementation of a Continuous Electronic Infusion Device Program requires additional training and review above and beyond the standard New York State Paramedic Curriculum. The training for the use of any Continuous Electronic Infusion Device should include a didactic module presented by the Agency Medical Director or their designee. This didactic module should, at a minimum, include: an overview of the pharmacology, indications, contraindications, and side effects of common medications to be used under this protocol; familiarization with central access devices and proper technique to access and maintain them; and a detailed understanding of the infusion device being used. To supplement the didactic information, a practical application module utilizing scenario 0based training is expected to ensure device familiarity and clinical decision-making. The purchase, training, continuing education, authorization, and use of a Continuous Electronic Infusion Device must be approved by the Agency Medical Director.

web www.mlrems.org
phone (585) 463-2900
fax (585) 473-3516

office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
601 Elmwood Avenue, Box 655
Rochester, NY 14642

USE OF TRANSPORT VENTILATORS

PURPOSE

This policy outlines the minimum equipment, training, and quality assurance requirements for the use of transport ventilators in the Prehospital environment.

POLICY

This policy does not define the circumstances of transport ventilator use. Regional protocols shall be the sole authority on how such a device is utilized in the Prehospital setting. This policy defines who are credentialed by their agency and authorized by their Agency Medical Director to use such equipment.

Transport ventilators may be used when available by paramedic providers trained in its use according to manufacturer's guidelines and as approved by the Agency Medical Director. The agency using such a device must have a written policy outlining how they will implement the prescribed MLREMS training requirements, eligibility, quality assurance program, and parameters for use of the specific device being used by the agency.

DEVICE REQUIREMENTS

Devices must be FDA approved. Additionally, the transport ventilator must, at a minimum, possess:

- Adjustable ventilator rates between 8 and 20 breaths per minute
- Adjustable tidal volumes between 200 and 1000ml
- High pressure alarm

TRAINING CONSIDERATIONS

Implementation of a transport ventilator program requires additional training and review above and beyond the standard New York State Paramedic Curriculum. The training for the use of any transport ventilator program should include a didactic/competency module presented by the Agency Medical Director or their designee. This didactic/competency module should, at a minimum, include:

- An overview of the use of positive pressure ventilation
- Control of ventilation using a mechanical ventilator, including modes of cycling, pressure limits, alarm meanings and standard settings
- Pulmonary/ventilator mechanics
- Assessment of ventilator status, including respiratory and ventilator failure
- Hemodynamic effects of positive pressure ventilation and PEEP
- Barotrauma
- Monitoring of patient ventilator status while on a ventilator
- Troubleshooting ventilator failure and alarms
- Competency-based evaluation of proper set-up, use and troubleshooting of the equipment, including scenario-based problems.

CONTINUING EDUCATION

Any paramedic who maintains credentials at the SCT level has met the above criteria for continuing education in ventilator use. Paramedics who are not credentialed as SCT providers must successfully

complete 6 hours of didactic continuing education and pass a competency based evaluation for proper set-up, use, and troubleshooting of their ventilator on an annual basis. The agency is responsible for maintaining records regarding currency of credentials.

QUALITY ASSURANCE

A written Quality Assurance plan approved by the Agency Medical Director must exist for monitoring the appropriate use of transport ventilators. It is expected that any use of the transport ventilator will be reviewed by the Agency Medical Director.

web www.mlrems.org
phone (585) 463-2900
fax (585) 473-3516

office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
601 Elmwood Avenue, Box 655
Rochester, NY 14642

USE OF INVASIVE TEMPERATURE PROBES

PURPOSE

This policy outlines the indications for use of invasive temperature probes in the Prehospital environment.

POLICY

Invasive temperature probes (defined herein as thermometers placed in the esophageal and rectal space) may be used when available by paramedics trained in its use according to the manufacturer's guidelines, the following procedure, and as approved by the Agency Medical Director.

INDICATIONS

1. Accurate core temperature measurements are necessary to optimize patient care in the following circumstances:

    a. Concern for significant hyperthermia
    b. Concern for significant hypothermia

2. Patient is 16 years of age or greater

3. Patient is unconscious

CONTRAINDICATIONS

1. Caustic ingestion for esophageal placement

2. Active upper GI hemorrhage for esophageal and rectal placement

3. Active lower GI hemorrhage for rectal placement

4. Known esophageal disease (varices, esophageal cancer, etc) for esophageal placement

CONSIDERATIONS

1. In intubated non-trauma patients, preference is given to insertion of the esophageal probe.

2. In intubated trauma patients, preference is given to insertion of the rectal probe.

3. In unconscious but non-intubated patients, preference is given to insertion of the rectal probe.

4. Insert device according to manufacturer's instructions. Attempts should be limited to three.

5. Follow the appropriate regional protocols for continued treatment of underlying condition (Hyperthermia or Hypothermia).

SPECIALTY CARE TRANSPORT PARAMEDIC

PURPOSE

This policy outlines the initial training, credentialing, and continuing education requirements of the Specialty Care Transport Paramedic.

POLICY

GLOSSARY OF TERMS

CCEMT-P: Critical Care Emergency Medical Technician. Paramedic as certified through the University of Maryland-Baltimore Critical Care Transport curriculum.

CCP-C: Critical Care Paramedic – Certified

CICP: Certified Intensive Care Paramedic. Paramedic as certified through the Cleveland Clinic Certified Intensive Care Paramedic curriculum.

FP-C: Flight Paramedic – Certified

Medical Director: The physician at the Agency or system level authorizing practice at the SCT level.

MICP: Mobile intensive Care Paramedic certification as issued by Monroe Community College.

Specialty Care Medical Control: On-line medical control provided specifically for the Specialty Care Transport team by the Agency Medical Director.

Specialty Care Transport Intern: SCT certified (CCEMT-P, CCP-C, CICP, FP-C, MICP) individual undergoing internship and not credentialed to practice at the SCT level without peer supervision.

Specialty Care Transport Paramedic: Has completed the SCT internship program, and is credentialed by the Regional EMS Medical Director to provide Specialty Care Transports in the Monroe-Livingston EMS Region. This individual has the ultimate responsibility for the care of the patient and the well being of the transport crew. He/She must maintain contact with the patient from the hand-off of care at the sending facility to the hand-off of care at the receiving facility. He/She is responsible for communication with medical control, transport reports and documentation.

Specialty Care Transport Preceptor: Individual credentialed to evaluate and document the performance of an SCT Intern.

Specialty Care Transport Chief Paramedic: Individual designated by an agency to represent that organization's Specialty Care Transport program to the Medical Director and to the REMAC.

Standard Medical Control: On-line medical control provided for all field providers by designated hospitals.

CHANGE OF STATUS/ROLE

ACHIEVING ACTIVE STATUS

Requirements – Current EMT-P with 2 years experience and a recommendation from the agency SCT Chief. SCT Paramedic must be a current RSI technician or in the process of completing RSI training. SCT paramedic will need to take and pass the SCT protocol test. All documents and credentials must be submitted for review to the SCT committee. All SCT paramedics must complete an approved internship with their respective agencies. All SCT Paramedics will need to have a certification through CCP-C or FP-C within a year of starting as an SCT Paramedic and maintaining it for the duration.

CLEARANCE OF THE SCT PARAMEDIC

The clearance process will include agency specific training and attendance to the SCT Regional Training. The clearance process for the individual paramedics will take place through their respective agencies and will include successful completion of an internship that is approved by the SCT committee as detailed later in this policy.

PROBATIONARY STATUS OF THE SCT PARAMEDIC

All SCT Paramedics will be on a probationary period for at least a year after clearance by their respective agencies. The probationary period can be extended at the discretion of the SCT Chief, Agency Medical Director, or Regional Medical Director.

MAINTENANCE OF ACTIVE STATUS

An SCT Paramedic must complete a minimum of 3 Specialty Care Transports (1 actual transport and at least 2 simulations) in any 12-month period. In the event that this quota is not reached, the SCT Paramedic must complete a Specialty Care Transport under the supervision of a Specialty Care Transport Preceptor and must re-credential with the Specialty Care Transport agency medical director. SCT Paramedics will need to have attendance at 4 yearly in-services and one regional meeting with attendance reported to the SCT Committee yearly.

All SCT Paramedics must be reviewed and re-credentialed yearly by the Agency Medical Director with appropriate documentation submitted yearly. This review must t least take the form of QA and medical director review. SCT paramedics will be regionally credentialed paramedics in accordance with the REMAC ALS Credentialing Requirements.

All SCT Paramedics must complete annual continuing education requirements as detailed later in this policy.

SUSPENSION

The SCT Paramedic will be suspended from his/her role in the event any of the above listed requirements are not met. Immediate reinstatement to his/her role will occur if the specialist recredentials within three months from the suspension date. If the specialist fails to re-credential within the given time period, he/she will be required the repeat the internship period.

NOTIFICATION OF STATUS

The Regional EMS Medical Director must be notified immediately in the event that the status of an SCT Paramedic changes.

LEAVE OF ABSENCE

An SCT Paramedic may request a leave of absence of up to 1 year from SCT transports. The request must be done in writing and sent to the Agency Medical Director. The Medical Director may reinstate the paramedic without any formal retraining or reclearing, if in the opinion of the Medical Director the paramedic provided appropriate care before requesting a leave. If concerns exist regarding the paramedic's skills due to the leave of absence, the Medical Director can require any of the following – specific remediation, demonstration of skill proficiencies, performance of transport(s) with an SCT Paramedic Preceptor, or full reclearing.

LEAVE OF ABSENCE GREATER THAN ONE YEAR

For a leave of absence greater than 1 year, the SCT Paramedic will be required to complete a full reclearance and internship. If the leave of absence includes a leave from all ALS activities entirely, the Specialty Care Transport Paramedic will also be required to fully reclear at the ALS level prior to reclearing at the SCT level. There are no exceptions.

ADVANCED STANDING

Any individual who wishes to apply for advanced standing as an SCT provider in the MLREMS region may apply to the SCT agency for advanced standing. After review, the Specialty Care Transport Chief Paramedic will ensure that the Advanced Standing Candidate meets the following requirements:

1. Demonstration of knowledge and skills competency as submitted and reviewed by the SCT Committee.

2. Demonstrated knowledge of the Monroe-Livingston Regional SCT Protocols will successful passing of the protocol test.

3. Participate as lead SCT Paramedic on at least one SCT transport and three agency based simulations one of which is trouble shooting mechanical ventilation.

4. Agency SCT Chief Paramedic and Agency Medical Director approval.

5. Regional EMS Medical Director approval.

6. Probationary period of one year. The probationary period can be extended at the discretion of the SCT Chief, Agency Medical Director, or Regional Medical Director.

The CME hourly requirements may be pro-rated, depending on the date of clearance by the Regional EMS Medical Director. Additionally, the Regional EMS Medical Director may elect to accept CME training from another agency, after review. Subsequent CME requirements after the end of the first calendar year must been ALL MLREMS SCT requirements.

SCT PARAMEDIC INTERNSHIP

The SCT Paramedic Internship is a structured program used to evaluate and document the performance of an individual who has completed required didactic coursework to operate as an SCT Paramedic. Internship is required for newly certified SCT Paramedics and for those who have been absent from the specialty care setting for an extended period of time.

The internship period should be used for familiarization with equipment, procedures, and documentation requirements. Orientation to an individual organization's policies, procedures, and equipment shall be done according to that organization's procedures and will not be included in the scope of this document.

The following are the *minimum* expectations for authorization to provide Specialty Care Transport in the Monroe-Livingston Regional EMS System, and may be exceeded by individual organizations.

INTERNSHIP PERIOD

Entry to an SCT Paramedic Internship is open to all currently certified NYS EMT-Paramedics with two years of experience who hold a current CCEMT-P, CICP, MICP, OR FP-C certification, and can produce verification of all other requirements. The SCT Chief Paramedic or his/her designee shall complete the SCT Internship Registry Form and present it to the Regional EMS Medical Director. The intern has six months to complete the internship. If after six months, the Intern has not successfully completed the program, the SCT Chief Paramedic may request a three month extension from the Agency Medical Director. Approval will be based on the SCT Chief Paramedic's recommendation.

FAILURE TO COMPLETE INTERNSHIP

If the internship is not completed after the three month extension, the Intern and his/her SCT Chief Paramedic shall communicate with the Agency Medical Director to review progress, discuss alternatives, and determine the viability of the SCT Paramedic Intern as an SCT provider. With agreement of the Regional EMS Medical Director, an additional three month extension may be granted.

If the Intern violates the terms of the agreement or fails to complete the requirements of the Internship, the agency can terminate the internship. The Intern and Regional EMS Medical Director shall be notified of the termination. If an Intern fails to complete his/her internship at one agency, then he/she can attempt internship at another agency with the agreement of the new agency's SCT Chief Paramedic and Medical Director.

INTERNSHIP REQUIREMENTS

1. Demonstration of knowledge and skills competency
2. Demonstrated knowledge of the Monroe-Livingston Regional SCT Protocols
3. Completion of at least hours in various ICU or SCT clinical settings as approved by the Agency Medical Director
4. A *minimum* of nine transports including at least one acute mechanical ventilation transport. There will also need to be at least six other simulated transports, two of which will involve trouble shooting mechanical ventilation. The SCT Chief Paramedic should assure that the transports reflect a varied set of patients
5. Clearance recommendations from two SCT Paramedic Preceptors (based on observed patient transports) to practice as an SCT Paramedic. Agency SCT Chief Paramedic and Agency Medical Director approval.
6. Regional EMS Medical Director approval

DOCUMENTATION

All SCT training shifts will be documented on the *Specialty Care Transport Evaluation Form* or an acceptable equivalent. All positive and constructive commentary shall be discussed, documented and the appropriate forms should be signed by both Preceptor and Intern. These sheets will be retained by the organization for use in the clearance decision and as part of the Specialty Care Transport Paramedic's permanent record.

All documentation regarding the SCT Paramedic's training and internship will be retained by the Agency as specified in the approved SCT QA/QI plan.

INTERNSHIP CONTENT

An Intern may practice only under the direct supervision of a credentialed Monroe-Livingston Regional EMS System SCT Preceptor that is approved to precept for that agency.

The Intern must be able to competently demonstrate:

1. Knowledge of regional and SCT Protocols with successful passing of the SCT protocol test.
2. Knowledge and proper use of SCT specific equipment
3. Proper and aseptic technique for all parenteral skills
4. Proper patient assessment, diagnosis, and appropriate treatment decisions
5. Skill in interpretation of patient ECG's and lab values
6. Proper airway management skills including suctioning of the patient with airway adjuncts
7. Knowledge and proper use of mechanical ventilation and troubleshooting ventilators
8. Knowledge and proper use of pharmacological interventions
9. Documentation skills

CLEARANCE

Only calls taken during the official internship period may be counted toward clearance of the Intern. Once the internship requirements have been completed, the SCT Chief Paramedic and the Agency Medical Director should review all documentation and determine if the Intern is ready to be cleared. Clinical training requirements may be completed prior to the start of the official internship.

The Intern must express agreement to be cleared before the SCT Chief Paramedic can proceed. If after review, the SCT Chief Paramedic and Agency Medical Director are not completely satisfied with the performance of the Intern, he/she may recommend continued training with periodic reviews. The sCT Chief Paramedic should document said reasons and discuss them with the Intern. This documentation should include any recommendations for remediation.

INTERNSHIP COMPLETION

Upon successful completion of the prescribed internship program, the SCT Chief Paramedic shall do the following:

1. Complete the SCT Registry Form. The Registry Form shall be forwarded to the Monroe-Livingston Regional Program Agency for addition of the new provider to the SCT Registry.

2. Complete and sign the SCT Internship Completion Form and forward to the Monroe-Livingston Regional Program Agency for inclusion in the regional provider database.

APPEALS

Appeals to this procedure shall be directed to the SCT Committee and if needed to the Regional EMS Medical Director as needed.

AGENCY REQUIREMENTS

QUALITY ASSURANCE/QUALITY IMPROVEMENT

Due to the critical nature of the patients transported by the Specialty Care Transport teams, each agency must devise and implement a 100% QA/QI program and upon request submit the program to the REMAC for review.

Each Agency providing SCT Level transports within the MLREMS region shall submit, yearly, a summary of their QA/QI program to the REMAC for review. This review is due by July 30th of each year.

CONTINUING EDUCATION

Continuing education requirements for Specialty Care Transport Paramedics include: didactic, interactive skills labs and independent, self-study totaling a minimum of 24 hours per year. This shall include the following:

1. SCT Paramedics must obtain at least four hours of clinical CME with up to (no more than) 12 hours counting toward the 24 hour goal with at least 4 hours of respiratory clinical CME

2. SCT Paramedics must obtain at least 12 hours of didactic CME with up to (no more than) 20 hours counting toward the 24 hour goal
    a. Up to 6 hours of Self Study
    b. No more than 8 hours of MLREMS Program Agency sponsored/approved lectures
    c. No more than 8 hours of Agency Sponsored Lectures
    d. No more than 6 hours of Hospital sponsored events/vendor events/conferences

The SCT Paramedic must attend four quarterly in-service trainings (one hour CME each) as given by their respective agencies or other SCT agencies in the region. The SCT paramedic will be required to attend at least one of the two Regional Training Conferences that will be given bi-annually (six hours CME).

The training year for SCT Paramedic Continuing Education is July 1 through June 30. The Agency SCT Medical Director must sign off on each SCT Paramedic's Continuing Medical Education requirements at the end of each year.

SCT PARAMEDIC PRECEPTOR

An SCT Preceptor is a knowledgeable person, credentialed to practice as an SCT Paramedic in the MLREMS region, who meets the qualifications listed below. The Preceptor serves as an evaluator who identifies areas of excellence and areas of required improvement on the performance of an SCT Intern. The Preceptor should "refrain from acting" unless patient care may be compromised. The Preceptor is a teacher to the student/Intern.

For consideration, a candidate must inform the SCT Chief Paramedic of his/her intent to become a preceptor. The preceptor candidate must be a Regional Preceptor. The candidate may then be

recommended by the SCT Chief Paramedic and Agency Medical Director, and appointed by the regional EMS Medical Director in accordance with the following guidelines:

1. Preceptor Qualifications

   The Preceptor Candidate must have served as a Specialty Care Transport Paramedic for a minimum of one year and be a regional preceptor.

   The following qualifications are subjective in nature and are to be assessed by the SCT Chief Paramedic and Agency Medical Director:

   - Demonstrates ability for instruction and guidance of those persons training under them
   - Demonstrates exceptional initiative and competency in knowledge and skills
   - Excellent communication skills
   - Excellent documentation skills

2. Preceptor Approval

   The SCT Chief Paramedic must submit a completed preceptor recommendation form to the Regional EMS Medical Director for final approval. The SCT Paramedic's status as a Preceptor will be updated in the regional provider database.

3. Maintenance of Preceptor Status

   The SCT Chief Paramedic will review preceptor status for all SCT Preceptors annually. Review criteria will consist of:

   - Preceptor is actively participating as an SCT provider
   - Compliance with established Continuing Medical Education (CME) requirements
   - Record in good standing as a preceptor
   - Teaching Continuing Education courses each year

ALS PRECEPTOR POLICY

PURPOSE

To outline the requirements for designation as an ALS Preceptor.

POLICY

1. Although a preceptor must be recognized by the region in order to meet the requirements of credentialing as outlined in this policy, an agency is not obligated to use that provider as a preceptor. However, agencies must only use MLREMS preceptors to provide ALS skills field education to students and interns.

2. The Monroe-Livingston Region desires to develop and foster a cadre of experienced paramedics to precept new paramedics in the MLREMS region. As such, desired qualities of a regional preceptor include:
    a. An understanding of the educational process for the various levels of care.

    b. Excellent interpersonal skills with a specific emphasis on coaching and mentoring.

    c. The ability to apply an evaluation rubric in an objective manner to assist in learning.

    d. Demonstrated professionalism include high ethical standards, appropriate administrative ability, continuous development, consistent adherence to standards of car, and knowledge of quality assurance.

3. Preceptor Eligibility
    a. Certified paramedic actively practicing for a minimum of three years prior to the date of application.

        i. Agencies may submit for consideration preceptor candidates whom do not meet the three year active practice certification requirement with support of the Agency Medical Director.

    b. System-cleared as a paramedic actively practicing in the Monroe-Livingston system for one year prior to the date of application.

    c. Score of 85% or greater on the MLREMS protocol exam taken within six months prior to the date of application.

    d. Completion of any required regional training as outlined by MLREMS.

    e. Recommendation from an agency ALS supervisor and Agency Medical Director.

4. Preceptor Selection
    a. Preceptor applications will be reviewed by the REMAC Patient Safety Committee.

b. Preceptors will be appointed by the Regional Medical Director following the recommendation of the REMAC Patient Safety Committee.

c. Preceptor candidates who do not receive appointment as a preceptor may appeal to the REMAC for review of their application.

5. Preceptor Training
    a. Preceptor candidates will receive the following minimum initial training to obtain System Preceptor status (may be waived with prior Patient Safety Committee Approval:
        i. Skill development and evaluation of adult learners
        ii. Coaching and providing appropriate feedback
        iii. Interpersonal communications skills
        iv. Curriculum familiarity and stages of development
        v. Administration of the learning process
        vi. Use of evaluation forms
        vii. Confidential feedback to educational institute or employee
        viii. Professional behavior discussion

    b. Once designated as a preceptor, preceptors must meet the following:
        i. Meet all required regional training as outlined by MLREMS.
        ii. Have no outstanding agency, or regional quality assurance concerns.
        iii. Complete any preceptor continuing education made available by the Region that may include highlights and updates of the preceptor program, common concerns, and case studies.

6. It is strongly encouraged that agencies do not overburden their preceptors by limiting their preceptor time to a maximum of 2/3 of their scheduled road time.

7. A preceptor may have their system preceptor status suspended or revoked by the Regional Medical Director independent of their ability to practice. Appeals of this decision can be made to the Regional Patient Safety committee.

8. A preceptor may request a Leave of Absence and voluntarily suspend their privileges for personal reasons (e.g. maternity leave, military deployment, temporary disability, etc) by providing such a request in writing to the Regional Program Agency. The Regional Medical Director will confidentially review this request and determine an appropriate plan to allow the preceptor to be reinstated once the preceptor elects to return to active practice.

LONG DISTANCE TRANSPORT POLICY

PURPOSE

This policy outlines policies required by agencies that engage in long distance transport (LDT) and shares best practices when considering staffing models for long distance transport of patients and out of and into the Monroe-Livingston EMS Region, by the Monroe-Livingston EMS provider services.

DEFINITIONS

Ambulance - Any vehicle which meets the motor vehicle, airplane or boat outlined in Chapter VI Title 10 of the New York State Emergency Medical Services Code Part 800.3.e or 800.3.i

Crew Configuration – Any combination of emergency medical technician, Paramedic, Specialty Care Transport Paramedic or Hospital Specialty provider (Physician, Registered Nurse, Respiratory Therapist, Perfusionist, etc.)

Driver – Any person who operates an ambulance. This includes, but is not limited to full time, part time, per diem or contracted operators.

Long Distance Transport – Any transport that involves driving, one way, over three hours with a patient onboard.

POLICY

Long distance transport of patients places a demonstrated strain on the crew members tasked with the transport. Crew fatigue and potential adverse weather are likely to promote potentially unsafe conditions for proper vehicle operation and patient care. Agencies are encouraged to develop internal policies governing long distance transport. While no specific Department of Transportation (DOT) or NYS Department of Health (DOH) regulation(s) define or regulate long distance EMS transport, DOT Motor Carrier Rules do place limitations on length of time while driving.

Each agency which provides long distance transport shall establish policies that deal with long distance transport. Such policies should include, but not be limited to:

1. Limitations of long distance/time in which personnel may operate ambulances or act as the medical provider during a long distance transport.

2. Standard Operating Guidelines which outlines standardized checklist or other device to ensure that sufficient planning and resources are available to ensure the safety of transport of the patient and the crew.

3. Actions when vehicle/equipment failure delay or endanger patient transport
    a. Vehicle failure
    b. Medical equipment failure
    c. Communications failure
    d. Diversion to appropriate facilities
    e. Emergency resupply during transport

web www.mlrems.org
phone (585) 463-2900
fax (585) 473-3516

office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
601 Elmwood Avenue, Box 655
Rochester, NY 14642

The following matrix should be considered when staffing for long distance transports:

Parameter	Crew Configuration	Comments
BLS <3 hours	EMT, EMT	
BLS >3 hours	EMT, EMT	Driver change every 3 hours
ALS <3 hours	EMT, ALS	
ALS >3 hours	EMT, EMT, ALS	Driver change every 3 hours
SCT <3 hours	EMT, SCT	Add crew as needs/complexity dictate
SCT, Vent >3 hours	EMT, EMT, SCT, SCT	Driver change every 3 hours, 2nd SCT for pt care
Any transport >10 hours	As above	Mandated crew rest (overnight) or sufficient crew replacement (complete)

web www.mlrems.org
phone (585) 463-2900
fax (585) 473-3516

office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
601 Elmwood Avenue, Box 655
Rochester, NY 14642

AGENCY MEDICAL DIRECTOR CREDENTIALING

PURPOSE

The primary role of the medical director is to ensure quality patient care. Responsibilities include involvement with the ongoing design, operation, evaluation and revision of the agency's care for patients from initial patient access to definitive patient care and from basic first response through advanced level care (as indicated by the service type). Each EMS agency should ensure that the medical director has ultimate authority over patient care including authority to limit the patient care activities of those who deviate from established standards or do not meet training expectations, and the responsibility and authority to develop and implement medical policies and procedures. The EMS medical director's qualifications, responsibilities, and authority must be delineated in writing within each EMS agency. The EMS agency has an obligation to provide the EMS medical director with the resources, authority, indemnification, and compensation commensurate with these responsibilities. The following outlines the essential and desired qualifications of a physician providing EMS Medical Direction for an Agency in the Monroe-Livingston Region along with the credentialing requirements and expected responsibilities of the agency EMS Medical Director.

ESSENTIAL QUALIFICATIONS

1. Current and unrestricted New York State license to practice medicine.
2. Current and unrestricted DEA registration.
3. Current and active practice of emergency or acute care medicine in Monroe or Livingston County.
4. Experience or training in the out-of-hospital emergency care of the acutely ill or injured adult or pediatric patient.
5. Experience or training in on-line and off-line medical direction of out-of-hospital emergency personnel.
6. Familiarity with the design and operation of out-of-hospital personnel.
7. Experience or training in the EMS quality improvement process.
8. Knowledge of regional protocols, New York State EMS statutes and regulations, New York State Bureau of EMS Policies, and Federal EMS laws and regulations.
9. Participation in committees or subcommittees of the Regional Medical Advisory Committee.

DESIRABLE QUALIFICATIONS

1. Board Certification in Emergency Medicine or Emergency Medical Services by the American Board of Emergency Medicine or the American Board of Osteopathic Emergency Medicine.
2. EMS Fellowship training or two years of equivalent experience providing medical direction of an EMS agency or system.
3. Completion of an EMS Medical Directors training course.
4. Involvement in state or national EMS organizations.

CREDENTIALING REQUIREMENTS

In order to assure agencies in the Monroe-Livingston Region are receiving appropriate physician oversight, the individual physician wishing to serve as an Agency Medical Director must submit the following to the Regional Program Agency for review by the Monroe-Livingston REMAC:

1. Copy of NYS License and DEA.
2. Copy of current curriculum vitae indicating residency training and experience/training in the above essential expectations.

3. Satisfactory completion of the MLREMS Base Station Course.
4. Satisfactory completion of a REMAC ALS Protocol Test.
5. Completed Medical Direction Authorization Form (DOH 4362).

Physicians wishing to provide Medical Direction for more than ten transport or ALS-First Response Agencies, or more than 100 ALS providers or 500 BLS providers in one or more regions must receive REMAC approval before doing so.

With the approval of the REMAC Chair in writing, a physician may exceed the maximum thresholds described herein until the next available REMAC meeting in which a quorum is present, at which time the REMAC Chair's approval will expire. Final Agency Medical Director Credentialing is subject to REMAC Approval.

AGENCY MEDICAL DIRECTOR EXPECTATIONS

Unless otherwise provided for in statute, rule, or policy the responsibilities of an agency EMS Medical Director shall include at a minimum, but not limited to:

1. Assure that service certified EMS personnel are oriented to the protocols promulgated by the SEMAC and the REMAC(s) for the area(s) of operation of the service.
2. Interact with REMAC in the development of protocols, the regional Quality Improvement (QI) process and in disciplinary issues.
3. Active development, review and participation in the Quality Improvement program developed by the service as part of the Regional Council's Quality Improvement program, as required in PHL 3006, or 3004-a.
4. Working with the service's providers on issues and questions regarding all ages of patient care.
5. Participate/interact in other activities that relate to the provision of medical care or affect the patient care provided by the EMS service.
6. Participate, as necessary, with the service's certified EMS personnel in Continuing Education Programs and the re-certification process.
7. Verify, by affirmation provided by the department (DOH-4362 Medical Director Verification form), that he/she serves as the medical director for the EMS service, providing medical oversight inclusive of the levels of care and/or BLS adjunct treatment protocols specified on the form.
8. In accordance with NYS law, regulation or department policy submit any documentation required for additional level of care approvals obtained by the EMS agency represented.

USE OF OROGASTRIC TUBES

PURPOSE
This policy outlines the indications for placement of orogastric tubes.

POLICY
Orogastric tubes may be placed when available by paramedic providers trained in its use according to manufacturer's guidelines, the following procedure, and as approved by the Agency Medical Director. The Agency choosing to carry orogastric tubes must assure providers are trained and that the training is approved by the Agency Medical Director.

INDICATIONS
1. Patient is 12 years of age or greater
2. Patient is orotracheally intubated or a King LTS-D is in place

CONTRAINDICATIONS
1. Caustic ingestion
2. Known esophageal disease (varices, esophageal cancer, etc)

PROCEDURE
1. Size and measure patient for desired orogastric tube.
2. Adequately lubricate with water-based lubricant.
3. Insert into oropharynx and advance to appropriate measured depth.
4. If a King LTS-D is in place, the appropriately sized orogastric tube may be advanced to appropriate measured depth through the decompression port of the King LTS-D. Under no circumstances may the tube be placed around any King airway device.
5. Confirm placement by auscultation following expulsion of a large volume syringe filled with air attached to the orogastric tube.
6. Secure the orogastric tube.
7. Manually provide intermittent suction. Under no circumstances should the orogastric tube be left on continuous suction.
8. Insertion of an orogastric tube should not delay transport.
9. No medications or fluids may be administered via the OG tube without direct, on-line medical control.
10. Once placed, the tube should remain until removed by hospital personnel unless the patient self-extubates prior to hospital arrival.

web www.mlrems.org
phone (585) 463-2900
fax (585) 473-3516

office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
601 Elmwood Avenue, Box 655
Rochester, NY 14642

TRANSFER CON'S: APPROVAL TO PROVIDE ALS SERVICE

PURPOSE

This policy outlines the process by which an agency, that had been previously approved to practice at the ALS level transfers their operating certificate to another entity (e.g. name change, FD based to municipality, etc.), can apply to REMAC for approval to continue to provide service at the same level as the previous agency.

POLICY

1. The agency must provide the REMAC with the following:

    a. A letter indicating the approval of CON transfer by the Monroe-Livingston Regional EMS Council.

    b. A letter addressed to REMAC requesting approval to practice at the same level practiced at the agency prior to the CON transfer.

2. As long as there are no other changes with the transfer that would impact the provision of care, the REMAC Chair has the authority to approve the request and bring that decision to the next REMAC meeting for ratification.

3. Any REMAC ALS approval will be written as "pending" receipt of a narcotic license as agencies must carry narcotics in order to practice at the ALS level and cannot be granted the license from NYS until being recognized by REMAC as an ALS agency. Agencies will have no more than 90 days to obtain such a license. Failure to obtain a narcotics licenses will revert the agency back to the BLS level of care.

web www.mlrems.org
phone (585) 463-2900
fax (585) 473-3516

office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
601 Elmwood Avenue, Box 655
Rochester, NY 14642

APPROVAL PROCESS FOR ALS PRIVILEGES

PURPOSE

This policy outlines the process as agency must follow to apply for ALS privileges. This applies to an agency which has been operating at the BLS level of care and wishes to move to the ALS level of care OR to an ALS agency that has failed to provide service at the ALS level for longer than 90 days, for any reason.

POLICY

1. The agency must provide the REMAC with the following:
    a. A letter addressed to REMAC requesting approval to practice at the ALS level.

    b. A copy of the agency's NYSDOH operating certificate.

    c. A letter from agency's Medical Director supporting the provision of ALS services.

    d. A letter from the agency's Board of Directors supporting the provision of ALS services, including the financial resources for equipment and training.

    e. The ALS Policies and Procedures for the agency to include, at a minimum:
        i. Controlled Substance Plan
        ii. Quality Assurance Plan
        iii. Medication Storage Plan

    f. A list of the currently active members who are certified at the ALS level, including certification numbers, expiration dates, and regional clearance status.

    g. The process by which the agency will obtain regional clearance for those providers certified at the ALS level.

    h. Evidence that the agency provides BLS call coverage of at least 80%.

    i. The staffing plan to assure ALS call coverage of at least 80%.

    j. Agencies that previously provided ALS services but have not provided ALS service for greater than 90 days must submit an explanation of why they have not provided this service and how that issue will be mitigated.

2. Any REMAC ALS approval will be written as "pending" receipt of a narcotic license as agencies must carry narcotics in order to practice at the ALS level and cannot be granted the license from NYS until being recognized by REMAC as an ALS agency. Agencies will have no more than 90 days to obtain such license. Failure to obtain a narcotic license will revert the agency back to the BLS level of care.

ULTRASOUND UTILIZATION POLICY

PURPOSE
To outline the use of focused or Point-of-Care Ultrasonography.

POLICY
Ultrasound (US) is an adjunct to the assessment and treatment of patients found in the Prehospital environment. Ultrasound should not interfere with the identification and treatment of life-threatening conditions, rather it should be utilized when time and personnel are adequate and when the use of ultrasound can lead to a definitive change in patient care. Ultrasonography is not a replacement for sound medical judgment nor should it ever delay transport.

APPROVAL
Agencies that wish to utilize ultrasonography must have written approval of their Agency Medical Director. Given the nature of this modality, if the Agency Medical Director changes, the new Medical Director must give written approval for the program to continue. Without such approval the program must be terminated.

EQUIPMENT
US equipment must have FDA Medical Device Approval. The US equipment must be approved by the Agency Medical Director. The agency must have a maintenance and decontamination program. The maintenance policy must include operator and agency level maintenance, cleaning and decontamination procedures between uses. Additionally, the agency must ensure that the device undergoes routine and specific maintenance by a certified biomedical technician, including inspections as recommended by the device manufacturer. Records of all maintenance must be kept in accordance with NYSDOH Policy 08-03.

ULTRASOUND IMAGING
The Agency Medical Director is responsible for individually identifying the diagnostic assessment and invasive procedures for which ultrasound may be used.

TRAINING AND CREDENTIALING
The agency wishing to perform ultrasonography must develop policies outlining the training and credentialing of providers. The Agency Medical Director, or their physician designee, shall be responsible for approving a training program for providers in the use of ultrasonography. This training shall include both a didactic and experiential component. It shall include, but is not limited to: ultrasound anatomy and physiology, ultrasound wave propagation, characteristics, artifacts, and image interpretation. Strengths, pitfalls, and shortcomings must be covered. Ultrasound exams, including Extended Focused Assessment with Sonography for Trauma (eFAST), focused assessment for shock states, evaluation of cardiac activity, and any other examination approved by the Agency Medical Director must be included.

Prior to the use in the field, providers must be trained and demonstrate competency to their Agency Medical Director or their physician designee who is credentialed in the use of emergency ultrasound. The physician must meet one of three criteria:

1. Credentialed by their host hospital institution to perform the emergency ultrasound evaluations they are evaluating, or
2. Has met or exceeded the American College of Emergency Physicians (ACEP) Emergency Ultrasound Credentialing Criteria for each US diagnostic modality they are evaluation, or
3. Has received Registered Diagnostic Medical Sonographer (RDMS) certification

The agency will establish and ensure that all US credentialed providers demonstrate competency to the Agency Medical Director of their physician designee on a recurrent basis, at least annually. This competency must include cognitive and skill competency and can include QA review, simulation, and real-time use evaluation.

QUALITY ASSURANCE

The agency must establish a program for continuous quality assurance/quality improvement for the use of ultrasonography that is integrated into the agency QA program. Images and videos captured in the field must be retained and attached to the patient's PCR as per standard documentation requirements. The Agency Medical Director (or physician designee who is also ultrasound certified as per above) must perform 100% review of ultrasound uses and document their review. The Quality Assurance program should include a review of the training and competency of credentialed providers and a comprehensive review of each utilization of US technology in any patient interaction.

POINT OF CARE TESTING

PURPOSE
To outline the responsibilities of agencies that wish to perform Point of Care (POC) testing.

POLICY
Agencies that wish to perform any POC testing must have authorization from their Agency Medical Director. Any POC testing must be approved by the FDA as a Clinical Laboratory Improvement Amendments (CLIA) regulations "waived" test.

TRAINING
Agencies must ensure that any provider who performs POC testing has undergone a regimen of training approved by the Agency Medical Director and is able to show competency in the acquisition of biological samples for testing, and the documentation and interpretation of any data obtained from such testing.

QUALITY ASSURANCE
Any agency that proposes to provide POC testing must develop a written plan for quality assurance. The plan must include the manufacturer's suggested periodic calibration testing, records of any scheduled/periodic maintenance performed by a qualified biomedical technician, and the documentation and interpretation of such POC test results.

BLOOD GLUCOMETRY
Any agency wishing to perform blood glucometry must adhere to the guidelines established by NYSDOH BEMS Policy Statement 12-01 regarding Blood Glucometry and possess a Limited Service Laboratory Registration Certificate. In addition, the Medical Director Verification Form (DOH 4362) must be submitted to NYSDOH BEMS through the regional Program Agency.

web www.mlrems.org
phone (585) 463-2900
fax (585) 473-3516

office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
601 Elmwood Avenue, Box 655
Rochester, NY 14642

CREDENTIALING OF PARAMEDIC PROVIDERS

PURPOSE

To outline the procedure by which Paramedic providers are credentialed to practice in the Monroe-Livingston Emergency Medical Services (EMS) System.

POLICY

Candidates for Paramedic credentials will be evaluated by criteria established by the Monroe-Livingston Regional Emergency Medical Advisory Committee (REMAC) and are only eligible to obtain applicable privilege to practice at the advanced level following completion of all credentialing requirements outlined in this policy.

It is the responsibility of the Regional Medical Director to enforce this policy. Any appeal of this policy will be heard by the REMAC.

ELIGIBILITY

Paramedics must maintain ALL of the following to retrain credentials to practice at their respective level in the Monroe-Livingston Region:

1. Be certified by the New York State Department of Health Bureau of EMS at the Paramedic level.

2. Maintain active affiliation at the level of desired credential with an ALS service authorized to practice in the Monroe-Livingston Region.

3. Maintain active practice as a Paramedic provider in the Monroe-Livingston region.
    a. Active practice is defined as a minimum of thirty primary patient contacts per year as documented by being the primary care provider on the Prehospital care report at any agency in the MLREMS system.

    b. Patient contacts that are encouraged through volunteer or paid association with agencies other than Monroe-Livingston ALS agencies will not be included in the minimum requirement for evaluation of regional active status requirements.

    c. If a provider has fewer than thirty primary patient contacts, a simulation program may be used in lieu of up to fifteen primary patient contacts. The guidelines for the program are as follows:
        i. Training must be pre-approved by the Agency Medical Director.
        ii. Documentation of provider performance, objectives, and learning methods must be maintained by the agency, and available to REMAC for review.

    d. The responsible agency official/officer shall notify the Regional Program Agency of any provider who lapses in active practice for a period of greater than ninety days at their agency.

4. Within six months of being credentialed, the provider must have the following certifications, or if noted, has achieved initial certification. Any equivalencies will require prior approval of the Regional Medical Director:

Certification Requirement	PARAMEDIC
CPR	Required
ACLS	Initial only
PHTLS or ITLS or equivalent	Initial only
PALS or PEPP or equivalent	Initial only
NIMS 100, 200, & 700	Required

CREDENTIALING PROCEDURE

1. The candidate paramedic must be affiliated with an ALS agency in the Monroe-Livingston Region.

2. The candidate provider will be entered by the Regional Program Agency into the Regional Database which will be the sole repository for all individuals credentialed through this process.

3. The candidate provider must sign a waiver of consent allowing the Monroe-Livingston REMAC Patient Safety Committee the ability to confidentially inquire and review patient care concerns at any agency with which the credentialed provider practices in the Monroe-Livingston Region.

4. The candidate provider must submit copies of all required certifications to all affiliated EMS agencies prior to the start of any internship. All original certifications must be produced upon request to the Regional Program Agency within five business days.

5. The candidate paramedic must be registered with the Regional Program Agency prior to the start of any internship. The responsible agency official/officer must submit an Internship Registry Form to the Regional Program Agency. Upon receipt of this verification the Program Agency will grant access to the protocol exam to the intern.

6. The Paramedic candidate must successfully complete a protocol exam created, maintained and verified by the Regional Program Agency, specific to the level the candidate provider wishes to credential prior to the start of any internship.
    a. Successful completion is defined as a minimum passing score of 80%.

    b. If the candidate provider does not achieve a passing score, he/she may retest after five business days of the initial exam.

    c. If the retest score is still below 80%, he/she must be remediated by an agency representative and may retest after five business days of the scored exam. Written documentation of remediation must be represented to the Regional Program Agency prior to the next exam.

    d. If the third retest is still below 80%, he/she must be counseled by the sponsoring EMS Agency Medical Director and receive an endorsement to retake the protocol exam signed by the sponsoring EMS Agency Medical Director.

e. If the fourth retest is still below 80%, and the paramedic candidate further requests credentialing in the system, that request must be forwarded to the Regional Patient Safety committee for review and recommendations.

7. Following the agency's verification that items 1-6 above are met the candidate provider may begin their internship period.

8. The intern must complete a minimum of ten patient workups with a minimum of two separate MLREMS preceptors demonstrating entry-level competence to practice independently.
    a. A patient workup is defined as patient care that involves a medication administration or invasive procedure, etc. (Cardioversion/defibrillation, CPAP, intubation, intravenous access, or fluid administration).

    b. Interns seeking credentialing should complete their patient workups at the agency with which they intend to practice whenever possible.

    c. At times it may be difficult to meet these requirements in a timely fashion due to a low call volume or limited preceptor availability. In such circumstances, the intern may ride with a separate agency in the MLREMS system, with prior approval of the intern's Agency Medical Director and the assisting agency's Medical Director. In such circumstances, it is strongly encouraged to have a written preceptor/intern agreement between these agencies.

    d. The responsible agency official/officer is responsible for maintaining all records. Records must be available upon request by the Regional Medical Director.

    e. The responsible agency official or officer must notify the program agency within two days of paramedic provider's clearance.

9. The provider must successfully complete their internship with six months of their registration with the Regional Program Agency. A three month extension may be requested by the responsible agency official/officer by submitting a written request to the Regional Medical Director. A second three month extension may be requested by the Agency Medical Director to the Regional Medical Director.

If an intern fails to complete an internship at one agency, he/she may attempt an internship at another agency with the agreement of the new agency's responsible agency official/officer. If the intern fails to complete internship with the second agency, they may not attempt internship in the Monroe-Livingston system without permission from the Agency and Regional Medical Director in writing. The results of the previous internship will be reviewed before a decision to permit a second internship is granted.

SUSPENSION AND REINSTATEMENT

1. Suspension of Privileges
    a. The responsible agency official or officer of an agency shall notify within five business days of the MLREMS Patient Safety Committee of any patient care issues leading to removal of the provider from practice at that agency.

b. Any provider who has their certification revoked or suspended by the State of NY (NYCRR Title 10 Part 800.16) must notify their Agency Medical Director and the agency retains responsibility to notify the Regional Medical Director.

c. The Regional Medical Director shall have the ability to suspend a credentialed provider's ability to provide any level care due to any patient care concerns, or failure to meet the requirements as outlined in this document including a provider's lapse in practice for a period greater than ninety days. The responsible agency official/officer and Medical Director shall be notified of such a decision within twenty four hours. Any suspension shall automatically be forwarded to the Regional Patient Safety Committee by the Regional Medical Director.

d. Should a provider be suspended for any of the above reasons, the provider's status in the Regional Database will be updated by the Regional Program Agency and other affiliated agencies will be notified.

2. Reinstatement of Privileges
   a. Providers with suspended privileges who wish to regain their regional credential must:
      i. Provide MLREMS, care of the Regional Program Agency, with a letter from the Agency Medical Director and responsible agency official or officer supporting the provider's return to active status.

      ii. If referred to the REMAC Patient Safety Committee, satisfactorily complete any performance improvement plans required by the body.

      iii. Reinstatement shall be communicated to the Regional Program Agency through the current online form for ALS providers. The form is available on the MLREMS website.

      iv. Should a provider be reinstated for any of the above reasons, the provider's status in the Regional Database will be updated by the Regional Program Agency within two business days.

Lapse of practice time	Required Workups
Greater than 90 days but less than 12 months	Three patient workups with a MLREMS preceptor
Greater than 12 months but less than 18 months	Five patient workups with a MLREMS preceptor
Greater than 18 months	Full internship is required as stated in Credentialing Procedures Section II

b. Provider reinstatement of privileges after leave of absence or lapse in practice must:

Lapse of practice time	Required Workups
Greater than 90 days but less than 12 months	Three patient workups with a MLREMS preceptor
Greater than 12 months but less than 18 months	Five patient workups with a MLREMS preceptor
Greater than 18 months	Full internship is required as stated in Credentialing Procedures Section II

AGENCY AFFILIATION

1. Every credentialed Paramedic is required to associate with an ALS agency.

2. Any ALS provider who is currently credentialed to practice with the Monroe-Livingston system may transfer their privileges to one or more Monroe-Livingston ALS agencies.
    a. The responsible agency official/officer must submit the agency add form to the Regional Program Agency. The Regional Program Agency will update the Regional Database.

    b. The agency official or officer shall, upon adding that provider to their agency, provide an agency orientation to include, but not be limited to, a review of agency specific tasks, BLS and ALS equipment, vehicle operation, quality assurance, and controlled substance policies. This is to assure that the ALS provider is familiar and comfortable with the new agency's equipment and operations under patient care situations.

    c. The ALS provider must meet each agency requirements for practicing as an ALS provider at that agency.

AGENCY RESPONSIBILITY

1. Within five business days, the agency official or officer must report to the Regional Program Agency any instance of:
    a. A provider being removed from active practice.

    b. A provider being reinstated to active practice.

2. All records regarding credentialing are to be maintained by the agency in accordance with DOH policy 08-03. These records are to be considered confidential and not available for public disclosure.

BLS PRECEPTOR PROGRAM

PURPOSE

The BLS preceptor program is available to agencies within the MLREMS system. Participation is optional and at the discretion of individual agencies.

PHILOSOPHY

The Monroe-Livingston Region desires to assist in the development and fostering of a cadre of experienced BLS providers to precept new BLS providers in the MLREMS region. As such, desired qualities of a BLS preceptor include:

1. A competent, experienced EMT dedicated to being a lifelong learner
2. Excellent interpersonal skills with a specific emphasis on coaching and mentoring
3. Demonstrated professionalism including high ethical standards, appropriate administrative ability, continuous development, consistent adherence to standards of care, and knowledge of quality assurance

RECOMMENDED PRECEPTOR ELIGIBILITY

1. Certified EMT provider actively practicing for a minimum of three years
2. Recommendation of agency training director or chief
3. Score of 85% or greater on the regional protocol exam taken no more than six months prior to the date of application
4. Completion of any required regional training as outlined by MLREMS or REMAC

PRECEPTOR TRAINING

1. Preceptor candidates will receive the following minimum initial training by attending a regional preceptor training class:
    a. Skill development and evaluation of adult learners
    b. Coaching and providing appropriate feedback
    c. Interpersonal communication skills
    d. Curriculum familiarity and stages of development
    e. Administration of the learning process
    f. Use of evaluation forms
    g. Confidential feedback to agency
    h. Professional behavior

MAINTAINING STATUS

1. Meet all required regional training as outlined by MLREMS, REMAC, or the regional medical director
2. No outstanding agency or regional quality assurance concerns

It is strongly recommended that agencies do not overburden preceptors by limiting their preceptor time to a maximum of 2/3 of their scheduled road time.

web www.mlrems.org
phone (585) 463-2900
fax (585) 473-3516

office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
601 Elmwood Avenue, Box 655
Rochester, NY 14642

BLS PRECEPTOR PROGRAM

1. Three years as a cleared EMT (date of clearance_____)
2. Approval of agency training director or chief (signature_____)
3. Score of greater than 85% on protocol test (score_____)
4. Attend a regional preceptor training class (date of training_____)

Name _____

Agency: _____

Date of Application: _____

PROVIDE THIS COMPLETED CHECKLIST TO YOUR AGENCY TRAINING DIRECTOR

web www.mlrems.org
phone (585) 463-2900
fax (585) 473-3516

office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
601 Elmwood Avenue, Box 655
Rochester, NY 14642

PREHOSPITAL DATA DICTIONARY

PURPOSE

This policy outlines the data dictionary to be used for agencies providing prehospital care in the Monroe-Livingston Region in order to standardize data reporting and comparison.

POLICY

Critical to evaluating and improving the Emergency Medical Services System is the use of patient care data. Multiple electronic Prehospital documentation platforms exist, and it results in significant variations in how critical patient data is recorded. Variations in essential fields such as how the request for service was initially dispatched, what the patient's initial presenting problem is, and the ultimate disposition of the call for service are fundamental data elements that have previously had significant variation.

In order to standardize and improve patient data reporting and ultimately patient care, three key data fields and their possible values are defined herein: Dispatched As, Patient Category, Primary Impression, and Call Outcome.

- **Dispatched As** is defined as the Emergency Medical Dispatch or Call Type code used by the respective dispatch center when dispatching an EMS resource. This data field is universal for all agency types.
- **Patient Category** is defined as the patient's initial presenting problem as identified by the EMS provider in charge. This may or may not be consistent with the "Dispatched As" data field. This data field is universal for all agency types.
- **Primary Impression** is defined as the patient's primary impression (differential diagnosis) as identified by the EMS provider in charge. This data field is universal for all agency types. This data set is more detailed than Patient Category.
- **Call Outcome** is defined as the agency's disposition of the patient. This data field is unique to the agency type, and four agency types have been defined (Basic Life Support First Response Agency, Advanced Life Support First Response Agency, Basic Life Support Transport Agency, Advanced/Basic Life Support Transport Agency).

web www.mlrems.org
phone (585) 463-2900
fax (585) 473-3516

office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
601 Elmwood Avenue, Box 655
Rochester, NY 14642

DATA FIELD: DISPATCHED AS

AGENCY TYPE: ALL

01 Abdominal Pain
02 Allergies (Reaction), Envenomations (Sting/Bite)
03 Animal Bites/Attacks
04 Assault/Sexual Assault
05 Back Pain (non-traumatic or non-recent)
06 Breathing Problems
07 Burns (Scalds/Explosions)
08 Carbon Monoxide/Inhalation/Hazmat
09 Cardiac/Respiratory Arrest/Death
10 Chest Pain
11 Choking
12 Convulsions/Seizures
13 Diabetic Problems
14 Drowning/Diving/Scuba Accidents
15 Electrocution/Lightening
16 Eye Problems/Injuries
17 Falls
18 Headaches
19 Heart Problems/AICD
20 Heat/Cold Exposure
21 Hemorrhage/Laceration
22 Inaccessible Incident/Other Entrapments
23 Overdose/Ingestion/Poisoning
24 Pregnancy/Child Birth/Miscarriage
25 Psych/Abnormal Behavior/Suicide Attempt
26 Sick Person
27 Stab/Gunshot Wound/Penetrating Trauma
28 Stroke (CVA)
29 Traffic Accident
30 Traumatic Injuries
31 Unconscious/Fainting
32 Unknown Problem
33 Interfacility/Palliative Care
36 Pandemic/Epidemic/Outbreak
Fire/Police Standby
Community Service Stand By
AIRA – Airplane Crash
ALERT – Airport Alert
BOATA – Boating Incident
DRWNA – Drowning
EMSA/EMSB
FIREA/FIREB
FUMES – Fumes
MHAA – Law Enforcement MHA
MVAPT – MVA Person Trapped
RBCST – Rebroadcast
RSI – RSI Request/Provided
SPEC – Special Operations
SUPE – Supervisor Response

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office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
601 Elmwood Avenue, Box 655
Rochester, NY 14642

DATA FIELD: PATIENT CATEGORY

AGENCY TYPE: ALL

Abdominal Pain
Alcohol Dependence/Withdrawal
Alcohol Use with Intoxication
Allergic Reaction
Allergy
Altered Mental Status
Behavioral
Bleeding
Blood Disorder
Cardiac Arrest
Cardiac Related
Dehydration
Diabetes
Diarrhea
Dizziness
Drug Use
Environmental
Fever
Foreign Body
General Illness/Malaise
Hypertension
Injury
Life Assist Only
Medical Device/Equipment Problem
Nausea or Vomiting
No Reported Patient Problem
Not Applicable
Not Available
Obvious Death
Pain
Paralysis
Poisoning
Pregnancy/Delivery
Respiratory
Respiratory Arrest
Seizures
Sepsis
Stroke or TIA
Syncope or Near Syncope
Unconscious/Unresponsive
Unknown

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Rochester, NY 14642

DATA FIELD: PRIMARY IMPRESSION

AGENCY TYPE: ALL

Abdominal Pain
Alcohol Dependence/Withdrawal
Alcohol Use with Intoxication
Allergic Reaction
Allergy – Anaphylactic Shock
Allergy – Envenomation/Sting/Insect Bite (without anaphylaxis
Altered Mental Status
Behavioral – Suicide Attempt
Behavioral – Psychiatric
Bleeding – Epistaxis
Bleeding – Life Threatening Hemorrhage
Bleeding – Hematemesis
Bleeding – Hemoptysis
Bleeding – Non-Life Threatening Hemorrhage
Bleeding – Rectal
Bleeding – Vaginal/Uterine
Blood Disorder – Anemia
Blood Disorder – Sickle Cell Crisis
Cardiac Arrest
Cardiac – AICD Activation
Cardiac – STEMI
Cardiac – Pain/Angina
Cardiac – Dysrhtyhmia
Dehydration
Diabetes – Hyperglycemia
Diabetes – Hypoglycemia
Diarrhea
Dizziness (not otherwise specified)
Drug Use – Accidental
Drug Use – Intentional
Drug Use Potential
Environmental – Hyperthermia/Heat Exposure
Environmental – Hypothermia/Cold Exposure
Exposure – Inhalation (not smoke or CO)
Exosure – Skin/Eyes
Exposure – Smooke Inhalation or CO
Fever
Foreign Body
General Illness/Malaise
Hyperkalemia
Hypertension
Injury – Abdomen
Injury - Ankle
Injury – Arm
Injury – Electrocution
Injury – Face
Injury – Foot
Injury – Head injury with loss of consciousness
Injury – Head injury without loss of consciousness
Injury – Hip
Injury – Leg
Injury – Multisystem Trauma
Injury – Neck
Injury – Other Site Not Specified
Injury – Pelvis
Injury – Upper Arm/Shoulder
Injury – Wrist/Hand/Finger
Lift Assist Only
Medical Device/Equipment Problem
Nausea or Vomiting
No Reported Patient Problem
Not Applicable
Not Available
Obvious Death
Pain – Acute – Not otherwise specified
Pain – Back Pain (non-traumatic)
Pain – Chest (suspected non-cardiac)
Pain – Chronic – Not otherwise specified
Pain – Headache
Pain – Pelvic/Perineal
Paralysis
Poisoning
Pregnancy – Complications
Pregnancy – Contractions
Pregnancy –Uncomplicated delivery
Respiratory –Airway Obstruction/Choking
Respiratory –Asthma
Respiratory –Congestive Heart Failure
Respiratory –COPD
Respiratory –Croup
Respiratory –Drowning/Near Drowning
Respiratory –Pulmonary Edema (not CHF)
Respiratory Arrest
Respiratory Distress 0 not otherwise specified
Seizures
Sepsis
Stroke or TIA
Syncope or Near Syncope
Unconscious/Unresponsive

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office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
601 Elmwood Avenue, Box 655
Rochester, NY 14642

Injury – Back
Injury – Burn
Injury - Chest

Unknown

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fax (585) 473-3516

office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
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Rochester, NY 14642

DATA FIELD: CALL OUTCOME

AGENCY TYPE: BASIC LIFE SUPPORT FIRST RESPONSE AGENCY

Call Outcome	Definition
Ambulance Assist	Defined when a BLSFR unit assists at an EMS incident, but does not provide patient care. (e.g. gather pt demographics, move equipment, assist with lifting).
Cancelled Enroute	Defined as an EMS event where the responding EMS unit is cancelled after calling enroute but prior to arrival at the scene.
Cancelled On Scene	Defined as an EMS event when the EMS unit is cancelled after calling on location, no patient contact, evaluation or treatments provided.
Cancelled Prior to Response	Defined as an EMS event where the responding EMS unit is cancelled prior to going enroute to a call.
Dead on Scene	Defined as an EMS event where the patient hass died prior to the arrival of the EMS unit. No care is provided to the patient other than documentation of the event and confirmation that the patient is dead.
No Crew Available	EMS Agency has no crew or equipment to respond to a call.
No Patient Found	Defined as an EMS event where EMS arrives at the scene but no patient is identified. No patient evaluation or care is provided.
Stand By	Used if a service is dispatched for a call, such as to stand by during a fire or other incident. If any person is treated at the scene an additional PCR should be completed for them.
Treated, Member on board Ambulance	Used by a BLSFR agency when a member rides aboard the ambulance to the hospital, and assists. (E.g. Medical 500, Unstable Patient).
Treated, Refused Transport	Any time contact is made and a person is evaluated, to include such procedures as vital signs being taken, or any treatment is provided. The documentation included on the PCR must indicate that the patient was advised of the need for care and the patient was competent to make an informed refusal of such care.
Treated, Transferred Care	In a multi-tiered response system this disposition would be used by any BLSFR or ALSFR agency and turns over a patient to an EMS transport agency.

DATA FIELD: CALL OUTCOME

AGENCY TYPE: ADVANCED LIFE SUPPORT FIRST RESPONSE AGENCY

Call Outcome	Definition
ALS Assist with BLS Ambulance	Use anytime an ALS unit, (fly care or ambulance) meets **another** BLS unit and the ALS Technician provides care onboard another agency's ambulance.
ALS Assist with ALS Ambulance	Use anytime an ALS unit, (fly care or ambulance) meets **another** ALS unit and the ALS Technician provides care on board another agency's ambulance.
ALS Field Termination	Used when an ALS code is initiated and the patient is **not** transported using Termination of Resuscitation Protocol.
Cancelled Enroute	Defined as an EMS event where the responding EMS unit is cancelled after calling enroute but prior to arrival at the scene.
Cancelled on Scene	Defined as an EMS event when the EMS unit is cancelled after calling on location, no patient contact, evaluation or treatments provided.
Cancelled Prior to Response	Defined as an EMS event where the responding EMS unit is cancelled prior to going enroute to a call.
Crew Share	Anytime an EMS member makes up part of a crew for another EMS agency.
Dead on Arrival <65	Defined as an EMS event where the patient has died prior to the arrival of the EMS unit. No care is provided to the patient other than documentation of the event and confirmation that the patient is dead and under 65 years old.
Dead on Arrival > or equal to 65	Defined as an EMS event where the patient has died prior to the arrival of the EMS unit. No care is provided to the patient other than documentation of the event and confirmation that the patient is dead and the patient age is greater than or equal to 65.
No Crew Available	EMS Agency has no crew or equipment to respond to a call.
No Patient Found	Defined as an EMS event where EMS arrives at the scene but no patient is identified. No patient evaluation or care is provided.
Release to BLS	An ALS provider responding on an ALS Assist/Intercept and assesses a patient and determines that patient can be released to BLS unit for transport.
Stand By	Used if a service is dispatched for a call such as to stand by during a fire or other incident. If any person is treated at the scene an additional PCR should be completed for them.
Transported to LZ for Air Transport	An EMS event where EMS arrives, evaluates, and treats the patient but then transfers the care of the patient to a Landing Zone for an Air Ambulance. Destination for these events is considered the location where the care of the patient was formally transferred.
Treated, Transferred Care	In a multi-tiered response system this disposition would be used by any BLSFR or ALSFR agency and turns over a patient to an EMS transport agency. This would be used when the level of care remains the same. (ALS release to another ALS or BLS release to BLS).
Treated, Transported BLS after ALS Assessment	This is used anytime an ALS unit is dispatched to a priority 1, 2, or 3 level call. After a paramedic has completed an assessment and no ALS interventions are required and the patient is released to a BLS agency or is transported at the BLS level.
Patient Treated/Evaluated	Defined as an EMS event, EMS arrives, evaluates and/or treats a patient with medical assistance. The patient then refuses transport. An example of this scenario would be a diabetic related call, where the patient is given care (D-50

and/or Refused Transport	treatment) or an MVA scene where a patient states they have “neck or back pain” but again after assessing the patient, they refuse transport. Patients who are able to demon state the ability to understand the nature and their consequences of their medical care decisions as per regional Protocols and Policies.
Patient Treated/Evaluated and Refused Transport ALS	Defined as an EMS event, EMS arrives, evaluates and/or treats a patient with medical assistance. The patient then refuses transport. An example of this scenario would be a diabetic related call, where the patient is given care (D-50 treatment), but again after assessing the patient, they refuse transport. Patients who are able to demonstrate the ability to understand the nature and their consequences of their medical care decisions as per the regional Protocols and Policies.
Patient Treated/Evaluated and/or Refused Transport BLS	Defined as an EMS event, EMS arrives, evaluates and/or treats a patient with medical assistance. The patient then refuses transport. An example of this scenario would be an MVA scene where a patient states they have “neck or back pain” but again after assessing the patient, they refuse transport. Patients who are able to demonstrate the ability to understand the nature and their consequences of their medical care decisions as per regional Protocols and Policies.

Note: The Patient Treated/Evaluated and Refused Transport selections are defined in three sections for agency usage depending if they also bill for that type of service.

DATA FIELD: CALL OUTCOME

AGENCY TYPE: BASIC LIFE SUPPORT TRANSPORT AGENCY

Call Outcome	Definition
Cancelled Enroute	Defined as an EMS event where the responding EMS unit is cancelled after calling enroute but prior to arrival at the scene.
Cancelled On Scene	Defined as an EMS event when the EMS unit is cancelled after calling on location, no patient contact, evaluation or treatments provided.
Cancelled Prior to Response	Defined as an EMS event where the responding EMS unit is cancelled prior to going enroute to a call.
Crew Share	Anytime an EMS member makes up part of a crew for another EMS agency.
Dead on Arrival <65	Defined as an EMS event where the patient has died prior to the arrival of the EMS unit. No care is provided to the patient other than documentation of the event and confirmation that the patient is dead and under 65 years old.
Dead on Arrival > or equal to 65	Defined as an EMS event where the patient has died prior to the arrival of the EMS unit. No care is provided to the patient other than documentation of the event and confirmation that the patient is dead and the patient age is greater than or equal to 65.
No Crew Available	EMS Agency has no crew or equipment to respond to a call.
No Patient Found	Defined as an EMS event where EMS arrives at the scene but no patient is identified. No patient evaluation or care is provided.
Stand By	Used if a service is dispatched for a call such as to stand by during a fire or other incident. If any person is treated at the scene an additional PCR should be completed for them.
Transported to LZ for Air Transport	An EMS event where EMS arrives, evaluates, and treats the patient but then transfers the care of the patient to a Landing Zone for an Air Ambulance. Destination for these events is considered the location where the care of the patient was formally transferred.
Treated, Transferred Care	In a multi-tiered response system this disposition would be used by any BLSFR or ALSFR agency and turns over a patient to an EMS transport agency. This would be used when the level of care remains the same. (ALS release to another ALS or BLS release to BLS).
Treated, Transported BLS	Defined as an EMS event where EMS unit arrives, evaluates, treats, and transports providing BLS services to the patient.
Treated, Transported ALS/Other ALS Agency on board	Defined as when a BLS level transport agency has ALS from another agency on board providing ALS care.
Treated, Transported BLS after ALS Assessment	This is used anytime an ALS unit is dispatched to a priority 1, 2, or 3 level call, a paramedic has completed an assessment, no ALS interventions are required and the patient is released to a BLS agency or is transported at the BLS level.
Patient Treated/Evaluated and/or Refused Transport	Defined as an EMS event, EMS arrives, evaluates and/or treats a patient with medical assistance. The patient then refuses transport. An example of this scenario would be a diabetic related call, where the patient is given care (D-50 treatment) or an MVA scene where a patient states they have “neck or back pain” but again after assessing the patient, they refuse and transport. Patients who are able to demonstrate the ability to understand the nature and their

	consequences of their medical care decisions as per regional Protocols and Policies.
Patient Treated/Evaluated and Refused Transport ALS	Defined as an EMS event, EMS arrives, evaluates and/or treats a patient with medical assistance. The patient then refuses transport. An example of this scenario would be a diabetic related call, where the patient is given (D-50 treatment), but again after assessing the patient, they refuse transport. Patients who are able to demonstrate the ability to understand the nature and their consequences of their medical care decisions as per regional Protocols and Policies.
Patient Treated/Evaluated and/or Refused Transport BLS	Defined as an EMS event, EMS arrives, evaluates and/or treats a patient with medical assistance. The patient then refuses transport. An example of this scenario would be an MVA scene where a patient states they have “neck or back pain” but again after assessing the patient, they refuse transport. Patients who are able to demonstrate the ability to understand the nature and their consequences of their medical care decisions as per regional Protocols and Policies.

Note: The Patient Treated/Evaluated and Refused Transport selections are defined in three selections for agency usage depending if they also bill for that type of service.

DATA FIELD: CALL OUTCOME

AGENCY TYPE: ADVANCED/BASIC LIFE SUPPORT TRANSPORT AGENCY

Call Outcome	Definition
ALS Assist with BLS Ambulance	Use anytime an ALS unit, (fly care or ambulance) meets **another** BLS unit and the ALS Technician provides care onboard another agency's ambulance.
ALS Assist with ALS Ambulance	Use anytime an ALS unit, (fly care or ambulance) meets **another** ALS unit and the ALS Technician provides care onboard another agency's ambulance.
ALS Field Termination	Used when an ALS code is initiated and the patient is **not** transported using the field termination protocol.
Cancelled Enroute	Defined as an EMS event where the responding EMS unit is cancelled after calling enroute but prior to arrival at the scene.
Cancelled On Scene	Defined as an EMS when the EMS unit is cancelled after calling on location, no patient contact, evaluation or treatments provided
Cancelled Prior to Response	Defined as an EMS event where the responding EMS unit is cancelled prior to going enroute to a call.
Crew Share	Anytime an EMS member makes up part of a crew for another EMS agency.
Dead on Arrival <65	Defined as an EMS event where the patient has died prior to the arrival of the EMS unit. No care is provided to the patient other than documentation of the event and confirmation that the patient is dead and under 65 years old.
Dead on Arrival > or equal to 65	Defined as an EMS event where the patient has died prior to the arrival of the EMS unit. No care is provided to the patient other than documentation of the event and confirmation that the patient is dead and the patient age is greater than or equal to 65.
No Crew Available	EMS Agency has no crew or equipment to respond to a call.
No Patient Found	Defined as an EMS event where EMS arrives at the scene but no patient is identified. No patient evaluation or care is provided.
Release to bLS	An ALS provider responding on an ALS Assist/Intercept and assesses a patient and determines that patient can be released to BLS unit for transport.
Stand By	Used if a service is dispatched for a call such as to stand by during a fire or other incident. If any person is treated at the scene an additional PCR should be completed for them.
Transported to LZ for Air Transport	An EMS event where EMS arrives, evaluates, and treats the patient but then transfers the care of the patient to a Landing Zone for an Air Ambulance. Destination for these events is considered the location where the care of the patient was formally transferred.
Treated, Transferred Care	In a multi-tiered response system this disposition would be used by any BLSFR or ALSFR agency and turns over a patient to an EMS transport agency. This would be used when the level of care remains the same. (ALS release to another ALS or BLS release to BLS).
Treated, Transported ALS	Defined as an EMS event where EMS unit arrives, evaluates, treats, and transports providing ALS services to the patient.
Treated, Transported BLS	Defined as an EMS event where EMS unit arrives, evaluates, treats, and transports providing BLS services to the patient.
Treated, Transported ALS/Other ALS Agency on board	Defined as when a BLS level transport agency has ALS from another agency on board providing ALS care.

web www.mlrems.org
phone (585) 463-2900
fax (585) 473-3516

office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
601 Elmwood Avenue, Box 655
Rochester, NY 14642

Treated, Transported BLS after ALS Assessment	This is used anytime an ALS unit is dispatched to a priority 1, 2, or 3 level call, a paramedic has completed an assessment, no ALS interventions are required and the patient is released to a BLS agency or is transported at the BLS level.
Patient Treated/Evaluated and/or Refused Transported	Defined as an EMS event, EMS arrives, evaluates and/or treats a patient with medical assistance. The patient then refuses transport. An example of this scenario would be a diabetic related call, where the patient is given care (D-50 treatment) or an MVA scene where a patient states they have “neck or back pain” but again after assessing the patient, they refuse transport. Patients who are able to demonstrate the ability to understand the nature and their consequences of their medical care decisions as per regional Protocols and Policies.
Patient Treated/Evaluated and/or Refused Transport ALS	Defined as an EMS event, EMS arrives, evaluates and/or treats a patient with medical assistance. The patient then refuses transport. An example of this scenario would be a diabetic related call, where the patient is given care (D-50 treatment), but again after assessing the patient, they refuse transport. Patients who are able to demonstrate the ability to understand the nature and their consequences of their medical care decisions as per regional Protocols and Policies.
Patient Treated/Evaluated and/or Refused Transport BLS	Defined as an EMS event, EMS arrives, evaluates and/or treats a patient with medical assistance. The patient then refuses transport. An example of this scenario would be an MVA scene where a patient states they have “neck or back pain” but again after assessing the patient, they refuse transport. Patients who are able to demonstrate the ability to understand the nature and their consequences of their medical care decisions as per regional Protocols and Policies.

Note: The Patient Treated/Evaluated and Refused Transport selections are defined in three selections for agency usage depending if they also bill for that type of service.

MLREMS Medication Formulary
Effective November 1, 2016

ALS Medications

Agencies/ALS units may stock more than the minimum number per ALS unit expected in this document. Total stock per ALS unit must be approved by the Agency Medical Director.

Medication	Route	Desired Unit	Minimum Number per ALS Unit
Adenosine	IV, IO	6 mg	5
Albuterol	Nebulized	2.5 mg	3
Amiodarone	IV, IO	150 mg	3
Aspirin	PO	81 mg	4
Atropine	IV, IO	1 mg	2
Ipratropium	Nebulized	0.5 mg	3†
Calcium Chloride	IV, IO	1 gram	1
Dexamethasone	IV, IO	10 mg	1
Dextrose 10%	IV, IO	25 gram	1
Diltiazem	IV, IO	25 mg	1
Diphenhydramine	IV, IO	50 mg	1
Epinephrine 1:1,000 (1 mg/mL)	IV, IO, IM, Neb	1 mg*	2*
Epinephrine 1:10,000 (0.1 mg/mL)	IV, IO	1 mg	5
Glucagon	IM	1 mg	1
Glucose, oral	PO	Varies	1
Lidocaine 2%	IV, IO	100 mg	1
Magnesium	IV, IO	5 grams	1
Metoprolol	IV, IO	5 mg	2
Naloxone	IM, IV, IO, IN	2 mg	2
Nitroglycerin	SL#	0.4 mg	1
Norepinephrine	IV, IO	4 mg	1
Ondansetron	IM, IV, IO	4 mg	1
Sodium Bicarbonate	IV, IO	50 mEq	2

† A combination unit dose (such as DuoNeb®) may be carried in place of ipratropium (Atrovent)

* ALS units must carry a minimum of 2 mg Epinephrine 1:1,000 (1 mg/mL) and this may be fulfilled by carrying two 1 mg vials or one 30 mg vial at the agency's discretion.

web www.mlrems.org
phone (585) 463-2900
fax (585) 473-3516

office
44 Celebration Drive, Suite 2100
Rochester, NY 14620

mailing
601 Elmwood Avenue, Box 655
Rochester, NY 14642

Nitroglycerin spray may be used in lieu of sublingual tablets.

Controlled Substances

Controlled substances are required of all ALS agencies in the Monroe Livingston Region. All ALS agencies must carry midazolam and must carry at a minimum either morphine or fentanyl for narcotic analgesia. The decision to carry morphine, fentanyl, or both is determined by the Agency and its Medical Director. Ketamine is an optional medication and determined by the Agency and its Medical Director. Minimum and maximum quantities are determined by the Agency and its Medical Director consistent with Bureau of EMS and Bureau of Narcotic Enforcement policy.

Medication	Route	Desired Unit
Fentanyl	IM, IV, IO, IN	100 mcg
Ketamine	IM, IV	500 mg
Midazolam	IM, IV, IO, IN	5 mg
Morphine	IM, IV	10 mg

Optional Medications

The following are optional medications and the decision to carry as well as quantities are determined by the Agency and its Medical Director.

Medication	Route	Desired Unit
Dexamethasone	PO	10 mg
Ketorolac	IM, IV	30 mg
Ondansetron	PO	4 mg

Rapid Sequence Intubation

Provision of Rapid Sequence Intubation is an optional program, however RSI-credentialed agencies must carry the minimum following medications.

Medication	Route	Desired Unit	Minimum Number per RSI Unit
Etomidate (Amidate)**	IV, IO	40 mg	1
Ketamine	IM, IV, IO	500 mg	1
Rocuronium	IV, IO	100 mg	1
Succinylcholine	IV, IO	200 mg	1

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