

**Suffolk County Department of Health Services
Division of Emergency Medical Services**

**BASIC LIFE SUPPORT
SUFFOLK COUNTY EMS POLICIES**



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INTRODUCTION

The Suffolk County Emergency Medical Services System (EMS System) is an organized and integrated system consisting of ambulance services, first responder services, emergency physicians, hospitals, other support services and personnel providing patient care through approved patient care protocols under the supervision of a designated EMS Medical Director.

Within the EMS System, out-of-hospital emergency medical care is the delegated practice of medicine, whereby non-physicians, with the appropriate certifications and authorizations, are credentialed by the Medical Director to provide patient care under the direction and control of a licensed physician. Direction may be provided “on-line” (direct radio or telephone contact) with a supervising physician, or “off-line” pursuant to standing orders and protocols. This care may be provided at the scene of a medical emergency and/or during transportation of the ill or injured to a hospital.

The System’s **Policies and Protocols Manual (the “Manual”)** serves as the reference for patient care within the System. It is intended to:

- Define the standard of care and establish quality assurance and quality improvement procedures for the EMS System;
- Guide personnel in delivering the highest standard of emergency medical care; and,
- Encourage the interdisciplinary approach to emergency medical care.

The **Manual** is divided into the two sections identified below:

A. GENERAL ADMINISTRATIVE POLICIES: This Section contains the administrative and operating policies and procedures for the EMS System.

B. APPENDICES

It is important to note that while protection from liability is afforded by Article 30 of the New York State Public Health Law, and financial protection is provided by various forms of insurance written for participants in the EMS System, such protection is not intended to extend to an individual who, or agency which, fails to adhere to the standard of care specified in this **Manual**.

While an attempt has been made to provide policies and guidelines for most eventualities, situations may arise which have not been addressed in this **Manual**. In such cases, field personnel and Medical Control physicians must use their training and good judgment to provide interventions which meet the accepted standard of care and which is within the scope of their certification or licensure.

GENERAL ADMINISTRATIVE POLICIES

I. MEDICAL CONTROL

A. DEFINITION:

Responsibility for all aspects of out-of hospital patient care provided within the Suffolk County EMS System rests with the EMS System Medical Director. All such patient care is provided as an extension of the Medical Director's license to practice medicine. Ambulance Service-level Medical Directors are responsible for quality improvement and educational initiatives on a local level with each of his/her respective ambulance services. Pre-hospital emergency medical care at the Basic Life Support (BLS) level generally does not involve on-line physician intervention. BLS protocols and policies do contain Medical Control Options in certain specific circumstances, requiring Medical Control contact when directed:

- High Risk RMA; or
- On the completion of a call in which they administered Albuterol via medical nebulizer or used the EPI Pen; or
- Administered Naloxone and used CPAP * (agency and provider in pilot program); or
- Transport of a trauma patient to non trauma center; or
- Use of the AED; or
- Poison Control consultation; or
- Questions concerning pre-hospital administration of BLS medications.

BLS personnel are also encouraged to contact Medical Control for on-line physician assistance whenever questions arise regarding treatment and/or transport options.

An **on-line medical control physician** is a physician authorized by the Medical Director to provide advice and direction to EMTs providing out-of-hospital medical care. A **designated EMS field physician** is a physician authorized by the Medical Director to provide advice and direction when such physician is present at the scene of an out-of-hospital medical emergency.

Medical Control may be reached by cellular or landline telephone at 689-1430, or by using the 800 MHz radio system by "hailing" Medical Control on the talk group identified as "ALS CALL." Medical Control will direct the caller to the available talk group, MEDCONTROL 1 or MEDCONTROL 2, where technician-to-physician conversation can take place. (MEDCONTROL 3 and 4 are reserved for future use). In the event that contact cannot be made by cellular telephone **OR** 800 MHz radio, pre-hospital personnel may contact Medical Control via channel 4 (155.175MHz) on the VHF Hi-Band radio. **NOTE: Refusal of Medical Assistance (RMA) consults, as more fully described in Section V, must take place on the telephone.**

B. MEDICAL CONTROL AS A RESOURCE

Medical Control may be accessed by any pre-hospital provider personnel **at any time** for consultation and advice regarding patient care including, but not limited to, questions about triage, treatment, selection of destination hospital, appropriateness of medevac utilization, and cases involving refusal of medical assistance.

C. ROLE OF ON-SCENE PHYSICIANS

1. Designated EMS Field Physicians: On occasion, a physician may be present at the scene of an out-of-hospital emergency. The EMS Medical Director, a Medical Control Physician, or a Designated EMS Field Physician may provide on-scene medical control in accordance with System protocols. These physicians may accompany the patient to the hospital but **are not obligated** to do so. A list of Designated EMS Field Physicians is listed in the appendices section of this manual.

2. Other Physicians: In the event that a non-designated physician is at the scene and wishes to assume responsibility for the care of a patient, the physician must be properly identified. Acceptable forms of identification include, but are not limited to, a medical society card, professional organization membership card, or vehicle registration. Until proper identification has been established, the EMT shall render care to the patient per state and local protocol, policies and procedures.

To assume responsibility for the care of a patient, an on-scene physician must agree to assume all responsibility for the patient, document the assumption of responsibility on the Prehospital Care Report (PCR), and agree to accompany the patient to the hospital **in the ambulance**. If the on-scene physician agrees to these terms, the physician's orders may be carried out. However, such orders must conform to the level of training of the field personnel and to the protocols established in the **Manual**. Any out-of-protocol procedures initiated by a non-designated physician remain the responsibility of that physician at the scene and during transport. Medical Control need not be contacted until the post-event telephone report if the above conditions are met, unless the EMT is uncomfortable with the non-designated physician's actions. EMS providers should always maintain a professional approach to other health care professionals during the transition of care phase of the alarm. If the on-scene physician is reluctant to agree to these terms, or orders an out-of-protocol procedure, the EMT must contact Medical Control. The Medical Control Physician will make a judgment concerning the on-scene physician's participation and responsibility. If the on-scene physician refuses to communicate with the Medical Control Physician, the EMT must inform the on-scene physician that the EMT may only accept the orders of the Medical Control Physician.

3. Physicians at the site of a disaster: Once a scene has been declared a disaster by a County official, the orders of any properly identified on-scene physician may be followed and documented on the PCR or triage tag.

D. ROLE OF "PHYSICIAN-EXTENDERS" AT THE SCENE

If a "Physician Extender" (**Physician Assistant or Nurse Practitioner**), is present at an emergency **in their usual employment setting**, and requests to assume responsibility for the care of the **patient, under the license of their absentee supervising physician**, the "physician extender" may do so, provided that the individual has been properly identified. Acceptable forms of identification include, but are not limited to, a state registration certificate, professional medical society card or hospital identification card. Until proper identification has been established the EMT shall render care to the patient in the usual manner. The "physician extender" must abide by the terms and conditions defined for "other physicians" (see section C-2 above).

A "physician extender" outside the normal setting of his/her usual place of employment may not provide on-scene medical direction, and EMS providers may only take medical direction from a physician.

E. OTHER HEALTH CARE PROFESSIONALS AT THE SCENE

In any event where a health care professional other than a physician or physician extender, as specified above, is at the scene, the EMT is to maintain responsibility for patient care.

II. EMS PROVIDERS

The Suffolk County EMS System recognizes two (2) levels of care:

A. Basic Life Support: BLS is provided by those certified as New York State First Responders (CFR) or Emergency Medical Technician-Basics (EMT-B) in compliance with New York State BLS Protocols and Policies.

B. Advanced Life Support: ALS is provided by those certified as New York State Emergency Medical Technician-Critical Cares (EMT-CC) or Emergency Medical Technician-Paramedics (EMT-P) in compliance with the policies and protocols set forth in the Advanced Life Support Manual.

All ALS providers must complete the Regional Emergency Medical Advisory Committee (REMAC) approved credentialing process and receive the prior authorization of the EMS Medical Director before they are allowed to function in the System. The ALS provider must be a member, employee or authorized representative of an agency that has an ALS agreement with the Suffolk County Department of Health Services, and may only operate in the System when acting as a member of such agency or when specifically requested to assist another agency that has an ALS agreement with the Suffolk County Department of Health Services. An AEMT who is no longer a member of an authorized ALS agency MAY NOT continue to function as an AEMT in the System. In order to maintain operating privileges, an AEMT must complete all EMS System/REMAC-authorized protocol or policy updates.

C. Policy and Procedure In-Service Requirements: All providers receive in-service training on policies and procedures specific for the region through original and recurrent training. Providers that attend and receive initial EMT training outside of Suffolk County approved course sponsorships are required to receive county in-service training prior to operating within the Suffolk County System.

D. Standard of Care: All Basic Life Support (BLS) functions and treatment modalities shall follow the New York State Department of Health (NYS-DOH) BLS Protocols consistent with NYS-DOH approved training curricula.

III. SELECTION OF DESTINATION HOSPITAL

NY State DOH policy for ambulances requires that patients be transported to the closest appropriate hospital Emergency Department. When a patient's condition requires **ADVANCED LEVEL CARE OR INTERVENTIONS, OR IS CONSIDERED TO BE LIFE THREATNING**, the ambulance service is obligated to transport the patient to the nearest appropriate hospital Emergency Department, unless directed to another facility by state or regional protocols, or by a Medical Control Physician or Designated EMS Field Physician.

- Appropriateness is defined as the hospital most appropriate by NY State DOH designation (i.e.: Trauma Center, Stroke Center, Burn Center, PCI-Capable Center, Pediatric Capability), where an admitting physician has privileges into a recognized specialty care area (i.e.: pediatrics), or in cases where there are no specific services at a particular hospital (i.e.: OB/GYN and Labor & Delivery).
- Psychiatric Emergencies should be transported to the closest emergency department for medical evaluation and clearance for secondary transfer, as indicated by additional diagnostic testing.
- Patients that may require hyperbaric therapy should be transported to the closest emergency department for evaluation and clearance for secondary transfer, as indicated by additional diagnostic testing.
- Patients that are victims of sexual assault should be transported to a hospital that maintains a Sexual Assault Nurse Examiner (SANE) Program, unless the assault is compounded by an unstable illness or injury. SANE Centers are identified in the appendices section of the manual.

In many instances the patient's illness or injury is not immediately life threatening. In such situations, the following factors should be considered when selecting the destination hospital, provided that the drive time to the alternative receiving hospital does not exceed more than twenty (>20) minutes additional time than it would have taken to get to the original facility, per NY State BLS policy:

- NY State or Regional injury/illness specific protocols;
- The patient's or family's request to be transported to a more distant hospital;
- The hospital affiliation of the patient's private physician;
- Travel time and road conditions; and
- The ambulance agency's internal policy for the selection of a destination.

A decision to transport a patient to a facility other than the nearest hospital implies that a judgment has been made that the risks of prolonged transport are outweighed by the potential benefits to the patient. Medical Control should be contacted for assistance in transport decisions when questions regarding the appropriateness of by-passing a hospital arise.

An ambulance service's duty to act is to the patient in their presence, not the "patient they might get," therefore, agency internal policies should reflect care that is most appropriate and safe for the patient, not convenience of returning back to the district. In the event that EMS providers are unsure as to the appropriate destination hospital, they should contact Medical Control for physician advice.

IV. HOSPITAL DIVERSION

Section 405.19 (e) (4) of the NYS Hospital Code authorizes hospitals to request diversion of ambulances to other facilities when the acceptance of another critical patient might endanger the life of that, or another, patient. **A request for diversion does not require that the ambulance divert from that facility.** *EMS personnel are not obligated to honor such a request if they believe that a critically ill or injured patient's condition warrants transport to the closest hospital.* However, if it is determined that the patient is stable, the diversion request may be honored. Medical Control may be contacted to assist in the transport decision. EMS personnel **should fully document** the reason(s) for their decision on the PCR.

Hospital diversion is a dynamic process, and may be the result of general overcrowding during seasonal variances, or the result of the loss of specific diagnostic and/or treatment equipment. Each hospital's decision to request diversion is made based upon different thresholds, in turn, based on each hospital's specific resources. Hospitals must take aggressive action within the institution to decompress patient load prior to requesting diversion. In cases of general overcrowding, where a particular hospital is overwhelmed with a full census and extenuating circumstances in the emergency department, it may be acceptable to temporarily divert patients to allow the hospital to decompress. However, in cases where hospitals with contiguous catchments areas are requesting diversion, it may not be appropriate to honor such requests.

In cases where a hospital-specific event of magnitude, or a loss of critical infrastructure or diagnostic equipment negatively affects a hospital's ability to receive patients, and the hospital makes an affirmative decision to temporarily place its emergency department out-of service, every effort will be made to effectively communicate information to ambulances and to redirect patients. Personnel should expect to receive information via Suffolk County FRES Communications, and should fully document the reason(s) for their decision on the PCR.

V. REFUSAL OF MEDICAL ASSISTANCE (RMA)

In the event that an ambulance service responds to a reported medical emergency where both the individuals at the scene and EMS personnel believe that no injuries or illnesses exist and that there are no individuals requiring or requesting EMS assistance, a PCR shall be prepared using the following Disposition Codes: 008 [Gone on Arrival (patient removed prior to arrival)] or 009 [Unfounded (false alarm) (no patient found)]. A thorough assessment of the scene is required to rule out mechanism of injury criteria. A physical assessment may also be necessary to make the determination that there are no patients at the scene. Consider the High Risk Criteria identified below before determining that there are no patients at the scene. Refer to the "No Patient Found" policy in the appendices section of the manual for guidance on determining patients from individuals.

If in the judgment of EMS personnel there is a patient at the scene that requires treatment and/or ambulance transport, but who refuses such services, Medical Control must be contacted in an attempt to convince the patient to consent to appropriate care.

The Medical Control Physician will assess the patient's capability to refuse treatment, encourage the patient to allow appropriate care as indicated, and offer advice and guidance to EMS personnel. If the Medical Control Physician determines that the patient warrants treatment and/or transport, every effort should be made, using all available resources at the scene, to encourage the patient to consent to treatment and/or transport to the hospital. If all efforts are unsuccessful, the refusal should be thoroughly documented on the PCR, signed by the patient and witnessed, preferably by a police officer.

Documentation should also include a complete patient assessment, and a statement that the patient has received explanation of the risks associated with refusal of transport, and that there is some level of support in place for them, including an alternative plan. The use of the Suffolk County RMA Checklist, or an agency-specific checklist approved by Suffolk County EMS, must accompany PCRs or electronic report submissions for all RMA cases, whether or not Medical Control was contacted. For high risk cases, where contact with Medical Control is required, the RMA Checklist should be completed to the degree possible prior to contacting Medical Control, so that essential information is obtained and can be readily communicated. A sample RMA checklist can be found in the appendices section of the manual.

From time to time, patients may receive treatment and then refuse further treatment or transportation to the hospital. In the event that a patient receives treatment but refuses transportation by ambulance, and the EMS provider agrees that ambulance transportation is not warranted and no high-risk illness or injury exists, Medical Control need not be contacted. The patient's decision to refuse, the risks of refusal, and any recommended follow-up offered to the patient, should be noted on the PCR and the RMA signed by the patient, indicating he/she has refused transportation. If the EMS provider believes that ambulance transport is indicated, or high-risk illness or injury exists, Medical Control must be contacted. In all cases where there is no transport to a hospital, the yellow copy of the PCR must be sent to Medical Control by the ambulance service, or entered into the electronic reporting format, in the prescribed format and time frame.

The Medical Orders for Life Sustaining Treatment (MOLST) Form is an advanced directive where a patient or the surrogate decision maker has communicated end-of-life wishes extending well beyond the DNR, with implications for the ALS provider regarding limited medical interventions, pain management, fluid resuscitation and transportation to the hospital.

Patients with a valid MOLST Form may elect to determine which treatments they are willing to accept or refuse, and you are obligated to honor that request. This includes decisions to attempt treatment, withhold treatment, initiate a trial course of treatment, or elect to NOT be transported to a hospital.

In cases where there may be high-risk RMA Criteria, and an individual has expressed his/her end-of-life wishes on a MOLST Form, this is not considered an RMA and Medical Control need not be contacted.

While there are no cut and dry answers to address the many variables you may encounter in the field, there are general guidelines and principles you can apply.

IF AN ALS PROVIDER is on the scene, it is expected that the ALS provider with the highest level of certification be responsible for the assessment of the presence/absence of HIGH RISK CRITERIA and that those cases not be triaged down to a BLS provider.

A. - RMA HIGH RISK CRITERIA: An RMA should not be considered without contacting Medical Control if any of the following High Risk Criteria are present. A physical assessment may be necessary to rule out these criteria, when the patient:

- has received a medication, either by administration or self-assistance of an EMS provider, regardless of patient condition;
- has an altered mental status or a suspected head injury;
- is less than (<) eighteen (18), including situations where the legal guardian is on-scene;
- is older than (>) seventy (70) years of age for any condition;
- has neurological, cardiac, or respiratory symptoms;
- Glasgow Coma Score is less than (<) fifteen (15);
- vital signs are outside of normal limits;
- has known or suspected alcohol or drug use involved;
- has a known carbon monoxide exposure, determined by atmospheric and/or non-invasive co-oximetry monitoring; or
- attempted suicide.

EMS personnel must contact Medical Control by telephone at 631-689-1430. For confidentiality purposes, and for ease of use by patients, the radio must not be used for RMA consultations. This policy cannot address every issue or possibility regarding RMA situations, therefore questions regarding appropriate action must be directed to Medical Control.

VI. MEDEVAC SERVICE

A. GUIDELINES FOR USE OF MEDEVAC SERVICE:

The process for determining that medevac service is appropriate for a particular patient includes consideration of the patient's condition, distance from a designated specialty hospital, physical findings, mechanism of injury, contraindications for medevac service and the logistics of removing a patient unique to the given situation. In determining the appropriateness of medevac service in trauma responses, you must first evaluate the following:

EXCLUSION CRITERIA. It is inappropriate to request medevac service if the patient:

- **Is in cardiac arrest; OR**
- **Has an unmanageable airway.**

Patients who fit the exclusion criteria should be transported as promptly as possible by ground ambulance to the nearest hospital.

INCLUSION CRITERIA. It is appropriate to consider medevac request if the patient's condition:

- Requires expeditious transport to a hospital capable of providing specialized care, such as a designated Trauma Center; Stroke Center, Burn Center, STEMI Center, hospital with Obstetric (OB) services, etc.;
- Requires specialized services (medications or procedures) offered by the air medical crew not available to the ground crew prior to arrival at the hospital;
- Is a "life or limb" threatening situation demanding intensive multi-disciplinary treatment and care;
- Includes signs/symptoms/physical findings suggestive of unstable trauma patient;
- Includes critical burn patients as defined in the burn protocol; or
- Includes signs/symptoms/physical findings suggestive of an ill, unstable medical patient as defined in the medical protocols.

Per NY State DOH, if the transport time from the scene to the Trauma Center is greater than (>) thirty (30) minutes, Medical Control must be contacted for transport decision, in accordance with current NYS BLS & ALS guidelines.

Per NY State DOH, if patient will reach a Trauma Center more than (>) one (1) hour after the injury occurred, Medical Control must be contacted for a transport decision.

Medical Control should be contacted to assist with transport decisions when use of medevac services are not specifically defined by the protocols and questions as to appropriateness arise.

For specialty hospital referrals, the patient must still meet NY State or Suffolk County criteria for selection of destination hospital.

B. PHYSICAL FINDING CONSIDERATIONS

1) TRAUMA PATIENTS

NY State has adopted the National Centers for Disease Control (CDC)/American College of Surgeons Committee on Trauma (ACS-COT) Trauma Center Field Triage Decision Scheme, and Trauma Center Designation process, which preferentially sends specific patients to "the highest level of trauma care" in the region, based on regional capabilities, measurement of vital signs and level of consciousness and anatomic criteria, and per the Suffolk Regional EMS Medical Director and REMAC, the ability to reach a Level I Trauma Center within thirty (<= 30) minutes.

Therefore, trauma patients with the following abnormal vital signs or anatomic findings should preferentially be transported to a Level I Trauma Center:

- GCS < 14, or;
- Systolic BP <90, or;
- Respiratory Rate <10 or > 29;
- All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee;
- Flail Chest;
- Combination trauma with burns;
- ≥ 2 proximal long bone fractures;
- Pelvic fractures;
- Open and depressed skull fractures;
- Paralysis;
- Amputation proximal to wrist and ankle; or
- Major burns.

Trauma patients with the following mechanism of injury patterns should be transported to the closest Trauma Center (Level I or Level II):

- Ejection from automobile;
- Death in same passenger compartment;
- Heavy Extrication time > 20 minutes;
- Falls > 20 feet;
- Rollover;
- High-speed auto crash initial speed > 40 mph;
- Major auto deformity >20 inches;
- Intrusion into passenger compartment > 12 inches;
- Auto-pedestrian/auto-bicycle injury with > 5 mph impact;
- Pedestrian thrown or run over; or
- Motorcycle crash > 20 mph or with separation of rider from bike.

Consider transport to a Trauma Center (Level I or Level II), or contact Medical Control for a transport decision if trauma patient has any of the following co-morbid factors:

- Age < 5 or > 55 years;
- History of cardiac or respiratory disease;
- Insulin-dependent diabetes, cirrhosis, or morbid obesity;
- Pregnancy;
- Immunosuppressed patients; or
- Patients with bleeding disorders or on anticoagulants.

When considering the appropriateness of medevac service, the EMS provider must consider the alternative of ground ambulance transportation to the nearest appropriately designated Trauma Center. Medevac service should be requested to get the patient to the highest level of trauma care provided the patient will arrive at the Trauma Center less than (<) 60 minutes of injury, OR unless warranted by multiple critical patients. Medevac services to distribute patients to a more distant Trauma Center should be considered in cases where there are more than (>) two (2) patients perceived to require operative intervention.

Medical Control must be contacted by telephone (631-689-1430) as soon as feasible after the alarm whenever a patient who meets trauma center criteria is transported to a non-trauma center.

GROUND TRANSPORT VERSUS AIR TRANSPORT TIME CONSIDERATIONS

Ground Time Calculation

- 
- Extrication
 - Stabilization
 - Load into ambulance
 - Drive time to hospital
 - Weather
 - Road conditions
 - Traffic
 - Time of day

Air Time Calculation

- 
- helicopter preparation
 - flight time to scene
 - drive time to landing zone
 - flight time to trauma center

EQUALS GROUND TRANSPORT TIME

EQUALS AIR TRANSPORT TIME

2) MEDEVAC USE FOR NON-TRAUMA PATIENTS:

Medevac service may be required to transport patients because of circumstances that limit ground access or in cases for medical patients where ground transport times to designated specialty care hospitals is prolonged. Patients in these categories may be transported to facilities other than a designated Trauma Center.

Examples include, but are not limited to:

- the transport of a patient with a minor injury from a barrier beach or other remote areas not accessible by ground ambulance response,
- a medical patient presumed to be suffering from a stroke/CVA in an area where there are no designated stroke centers;
- a medical patient with STEMI per 12 lead EKG and the nearest PCI-capable Center is greater than sixty (>60) minutes by ground transport, AND when the mode transportation is authorized by Medical Control.

C. HOW TO REQUEST AND/OR CANCEL MEDEVAC SERVICE:

- The first responding medically certified person on-scene is responsible for making the determination that medevac service is appropriate. To avoid confusion, the decision to cancel medevac response should be made by the same person who made the original medevac service request. In certain circumstances, helicopters may be placed on stand-by, or by airborne in the vicinity of a call, based on dispatch information, pending confirmation of need, or cancellation by EMS resources on the scene.
- The primary method of requesting medevac service is through the police officer at the scene. If there is no police officer present, the medevac service can be requested through the MEDCOM or FIRECOM dispatcher. Although establishing a landing zone (LZ) is primarily the responsibility of the on-scene police, responding EMS providers should be familiar with the guidelines and safety procedures, outlined in the appendices section of this manual.
- For cases outside the Suffolk County Police District or when there is no sector car on scene, EMS providers should relay their operating frequency type (i.e. UHF, VHF, 800 MHz, other) and number through FRES MEDCOM to facilitate direct ambulance-to-helicopter communications.

D. DEFIBRILLATION ON THE MEDEVAC AIRCRAFT

Airborne defibrillation has associated risks and should never be considered a routine procedure on board a medevac aircraft. The following guidelines apply to defibrillator use on board a medevac aircraft:

- The use of a defibrillator, as well as any other equipment on board the helicopter is at the discretion of the pilot in command;
- The pilot is solely responsible for the safe operation of the aircraft and all associated equipment; and
- Only “hands free” defibrillation equipment is authorized.

The following precautions must be observed when a defibrillator is used on board the medevac aircraft:

- The patient must be on a non-conductive surface;
- The oxygen system must be off; and
- Personnel and equipment must be clear of the patient.

E. USE OF NITROUS OXIDE

The use of nitrous oxide is **PROHIBITED** on the medevac aircraft.

VII. DOCUMENTATION

A. WRITTEN DOCUMENTATION

A New York State Prehospital Care Report (PCR) or recognized accepted electronic patient care report (ePCR) must be completed for every request for ambulance response in the Suffolk County EMS System, and accounted for per NY State EMS Policy Statement 02-05 and Suffolk County EMS Operating Policy Statements 1-001 and 2-001. Each technician’s name and NYS EMT number must be included on every PCR. Departmental badge numbers are not suitable substitutes for the EMT’s name and EMT number. NY State policy requires that a written report be transferred with the patient at the receiving emergency department.

The data collected during these follow-up reports are an integral part of the System’s quality improvement and statistical documentation processes. In addition, information collected in these reports is used to credit each technician’s participation in the System and to document any skills that may have been performed.

B. TELEPHONE FOLLOW-UP

Medical Control must be contacted by telephone (444-3600) at the completion of every call when there is on-line contact with Medical Control, whenever ALS intervention(s) are provided/attempted, as well as every time an automated external defibrillator is placed on a patient, or when BLS medications are administered and therapies are initiated. Assisting a patient with his/her own prescribed medication, or administration of oral glucose does not require a follow-up telephone call to Medical Control.

The data collected during these follow-up reports are an integral part of the System’s quality improvement and statistical documentation processes. In addition, information collected in these reports is used to credit each technician’s participation in the System and to document any skills that may have been performed.

VIII. QUALITY ASSURANCE AND QUALITY IMPROVEMENT

Appropriate patient care is a medical and legal necessity. NYS BLS and Suffolk County ALS protocols define such care. EMS alarms are reviewed on a routine basis in accordance with the Suffolk County Division of EMS Quality Improvement Plan, referenced in the appendices section of the manual, and the New York State Department of Health Quality Improvement for Prehospital Providers *Workbook and Guidance Document for Service Level and Regional Level Quality Improvement Activities*.

A. MANDATORY STATE DOH NOTIFICATION OF IMPROPER ACTIVITY

The Medical Director is obligated, under New York State Department of Health EMS Policy #84-26, to report all activity that is contrary to a technician's level of certification to the State Health Department for investigation. Such action may lead to the revocation of an EMT certificate and/or the pursuit of civil or criminal action.

IX. DO NOT RESUSCITATE (DNR) ORDERS/ADVANCED DIRECTIVES

Non-hospital DNR orders and an advanced directive called the Medical Orders For Life Sustaining Treatment (MOLST) are permitted by the Family Health Care Decisions Act (FHCDCA) and governed by Public Health Law (PHL) Article 29-CCC. A DNR order is an order not to perform ventilations, compressions, defibrillation, intubation or medication administration in the event of cardiac OR respiratory arrest, including mechanical ventilation after removal of a foreign body airway obstruction if ventilations are not spontaneously restored.

The MOLST Form is an advanced directive where a patient or the surrogate decision maker has communicated end-of-life wishes extending well beyond the DNR, with implications for the ALS provider regarding limited medical interventions, pain management, fluid resuscitation and transportation to the hospital.

The approved NYS DOH NON-HOSPITAL DNR ORDER or an approved DNR bracelet OR the bright pink multi-page MOLST Form are to be honored. The DNR form must be signed and dated by the patient's attending physician. Nursing Homes and other Article 28 licensed facilities may use their own DNR form and EMS providers must honor that form. The MOLST Form also must be signed by the decision maker and the physician. Like the DNR Form, the MOLST Form is subject to periodic review with no date/time parameter attached.

Therefore, DNR Forms and MOLST Forms should be considered valid as long as they have been signed and there is no indication to suggest the order has been modified.

Absence of a valid DNR Form or MOLST Form requires that full treatment be rendered. CPR must be initiated in the absence of a Non-Hospital DNR or a facility DNR, or MOLST Form, however, CPR may be stopped once the DNR or MOLST Form is produced.

Public Health Law (PHL) 2994-gg provides immunity from liability for good faith actions concerning DNR and MOLST orders. If it is believed that a DNR order or MOLST Form is invalid, and CPR is performed, the technician will not be held liable. If a DNR order or MOLST Form is disputed, CPR may be started in order to avoid a physical confrontation.

X. DETERMINATION OF DEATH

A. **The purpose** of this policy is to assist Prehospital Care Personnel in the determination of death in the field. This policy is intended to provide Prehospital Care Personnel in Suffolk County with parameters to be used when determining whether or not to withhold resuscitative efforts.

B. Principles:

1. Prehospital Care Personnel shall determine death based on specific criteria set forth in this policy.
2. It is recognized and accepted that Prehospital Care Personnel have the discretion to initiate resuscitation in those cases where resuscitation may not be warranted by patient condition but necessary for crew safety or considered the best course of action in any given situation.
3. The determination of death of a patient in the field must be done by **strictly** following Obvious Death Criteria and Determination of Death Guidelines. If there is any doubt as to the status of the patient, life saving interventions must be started immediately. AEDs or cardiac monitors are not to be used in this decision-making process.

C. Obvious Death Criteria: A patient may be determined obviously dead by Prehospital Care Personnel if, in addition to the absence of respiration, cardiac activity, and neurological reflexes, one or more of the following physical or circumstantial conditions exist:

- Decapitation
- Massive crush injury to the head, neck, or trunk
- Penetrating or blunt injury with evisceration of the heart, lung or brain
- Decomposition
- Incineration
- Rigor Mortis
- Extreme Post-Mortem Lividity
- A valid Out-of-Hospital DNR

If CPR has been initiated by an untrained bystander in the presence of signs of obvious death, the EMS provider may elect to discontinue CPR.

D. DETERMINATION OF DEATH DOCUMENTATION GUIDELINES

1. The Patient Assessment shall, at minimum, include the following items which must be documented on the Patient Care Report (PCR):
 - a. Absence of respiration after looking, listening and feeling; and
 - b. Check for a pulse for a minimum of sixty (60) seconds.
2. Procedure:
 - a. When not to initiate CPR:
 - i. Primary assessment reveals a pulseless, non-breathing patient who has signs of prolonged lifelessness in accordance with obvious death criteria.
 - ii. A patient with an approved "NYS DOH NON-HOSPITAL Do-Not-Resuscitate ORDER" (DNR) document in accordance with NY State DOH policy.

- iii. Multiple Casualty Incidents - EMS personnel may withhold patient care from a category four (4) DEAD/EXPECTED patient (within the START Triage System) in a multiple casualty situation when patient care needs exceed resources, and for the period of time when resources are required for the stabilization and care of living patients.

Disposition of the decedent:

1. If a determination of death has occurred and the decedent has not been moved from the original place of death:
 - The decedent shall remain at scene and not be transported by EMS Personnel;
 - Resuscitation equipment, such as bag-valve-mask devices, may be removed from the decedent;
 - If public safety personnel are not present at the scene, Prehospital Care Personnel shall remain at the scene until public safety personnel or Medical Examiner arrival; and
 - Prehospital Care Personnel shall complete a PCR in accordance with existing Division/agency policy; ensuring to include the time the determination of biological death was made.

XI. INTERACTION BETWEEN LEVELS OF EMS PRACTITIONERS

If a CFR, EMT-B, or EMT-I initiated patient care prior to the arrival of an EMT-CC or EMT-P, the EMT-CC or EMT-P should allow the BLS personnel to continue to perform those Standing Orders which have been initiated. **Common sense and good patient care are to prevail in all provider interactions. When questions arise, patient care activity should be directed by the individual with the highest certification. Medical Control must be contacted to resolve any conflicts occurring during patient care activity. Once medications have been administered/assisted to any patient (by BLS or ALS technicians), or the cardiac monitor placed, or IV access has been attempted, the AEMT must assume care of that patient until arrival at the hospital.**

In cases in which a blood glucose level is the only procedure that has been obtained and the reading is greater than (>) 60dbl and less than (<) 400dbl and the patient does not have an altered level of consciousness/altered mental status, patient care may be transferred to a BLS provider for transport to the hospital

XII. PATIENT TRANSFER PROTOCOL

FROM ALS PROVIDER (EMT-CC OR EMT-P) TO BLS PROVIDER

A New York State certified EMS provider with a higher level of certification may transfer responsibility for the on-going care of a patient to a provider with a lesser New York State certification if the following conditions are met:

1. The patient does **not** have cardiac, respiratory, neurologic, or allergic signs/symptoms, and does not fit into an ALS protocol.
2. The provider with the higher level of certification must have assessed the patient and made an affirmative decision to transfer care of the patient to a provider with a lesser certification, indicating that the patient is not in need of ALS level interventions and will not likely decompensate to the point where ALS interventions may become necessary during transport to the hospital.

3. The provider with the higher level of certification must have made the determination that the patient will not require any care or skills which would be possessed by the provider with the higher level of certification and not possessed by the provider with the lesser level of certification, nor need assistance of additional advanced provider on difficult cases. **In cases where the provider of lesser certification administered or assisted with administration of a medication, the provider with the higher certification must assume care of that patient.**
4. The provider with the lesser level of certification must agree to assume responsibility for patient care. If the provider with the lesser level of certification refuses to accept that responsibility, the provider with the higher level of certification must continue to care for the patient until the transfer at the hospital is complete.
5. If either provider who is a party to the transfer has any questions concerning the appropriateness of the transfer they must contact Medical Control for a physician consultation.
6. The patient transfer must be documented on the Prehospital Care Report (PCR). The transferring of service must provide the transporting ambulance service with the pink and yellow copies of its PCR. The transporting ambulance service must leave the transferring service's pink and yellow copies of its PCR at the receiving hospital emergency department for inclusion in the patient's hospital file and the data collection system.

XIII. BLS EQUIPMENT IN PRIVATE VEHICLES

Except as provided for in the next paragraph, BLS personnel are **not** authorized to carry any item that requires a physician's prescription in their private vehicle. Such items include, but are not limited to, needles, syringes, medications, oxygen and defibrillators.

The only circumstance under which such equipment may be legitimately carried in a private vehicle is when the vehicle operator is serving as an authorized agent of an agency participating in the Suffolk County EMS System, functioning as a "BLS First-Responder." In those cases, the member's personal vehicle is considered an Emergency Ambulance Service Vehicle (EASV) and must be in compliance with all of the provisions of 10NYCRR Part 800.26 and Policy Statement 01-01

XIV. IV LINES

NYS-DOH and State Emergency Medical Advisory Committee (SEMAC) have determined that it is not appropriate for a BLS ambulance service, staffed by EMT-Bs, to transport a patient with an IV line in place.

This applies to the following situations:

- Intravenous lines with fluid.
- Intravenous lines with medication.
- Central and peripheral vascular access devices with medication.

It is allowable for an EMT-B to transport a patient with a secured saline lock device in place as long as no fluids or medication are attached to the port. However, the EMT-B must insure that the venous access site is properly secured and dressed prior to leaving the health care facility.

XV. INTERFACILITY TRANSPORT

The medical protocols in this manual are intended for use in emergency situations for care rendered in cases received through the emergency response system. These protocols are not intended for use in routine transportation or interfacility transfer situations. In cases where an emergency ambulance service vehicle may be necessary to transport a patient between home and a health care facility, or between health care facilities, or any other non-emergent situation, **PRIOR APPROVAL FROM THE SUFFOLK COUNTY EMS MEDICAL DIRECTOR, OR DESIGNEE, IS REQUIRED.**

XVI. MANDATORY REPORTING

Emergency Medical Technicians are mandated to report suspected child abuse and human animal bite victims. Reporting is required "**to report suspected abuse or maltreatment that comes to their attentions while acting in their official or professional capacity**". See Appendix for forms and policies.

XVII. PREHOSPITAL CARE REPORT (PCR)

An essential part of any prehospital medical care is the documentation of the care provided and the medical condition and history of the patient. The Prehospital Care Report (PCR), used as a requirement of Part 800, and Article 30 is the instrument developed and distributed for this documentation. The primary purpose of the PCR is to provide medical and legal documentation and pertinent patient information as well as serving as a data collection tool.

General Information

A PCR should be completed each time the agency is requested for any and all types of response. If an agency is dispatched to a stand-by and while there they treat a patient, two (2) PCRs should be completed. PCR's shall be generated from each agency involved in response to the same alarm.

Yellow (Research) Copy

Ambulance Service: The yellow copy shall be submitted by the agency to the data collection point by the twentieth (20th) of every month. PCRs shall be submitted to:

Suffolk County Medical Control
Department of Emergency Medicine
Stony Brook University Hospital
Level 4, Room 515
SUNY at Stony Brook
Stony Brook, New York 11794
Attn: PCR Inspection

White (Agency) Copy

All Agencies: The original white copy should be retained in a secure location at the agencies permanent office for the following time periods:

- Federal Law (HIPAA) requires that medical records be retained for **Six (6) Years**. If the call **does** involve the treatment of persons under age eighteen (18), the PCR must be retained for three (3) years after the child reaches age eighteen (18) or six (6) years, which ever is longer.

Pink (Medical Chart) Copy

Is to remain with the receiving institution's medical chart.

Confidentiality & Disclosure of PCRs/Personal Healthcare Information

Maintaining confidentiality is an essential part of all medical care, including prehospital care. The confidentiality of personal health information (PHI) is covered by numerous state and federal statutes, Policies, Rules and Regulations, including the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and 10 NYCRR.

10 NYCRR (Health) Part 800.21:

Every person certified at any level pursuant to these regulations shall:

(a) At all times maintain the confidentiality of information about the names, treatment, and conditions of patients treated.

(1) A prehospital care report shall be completed for each patient treated when acting as part of an organized prehospital emergency medical service, and a copy shall be provided to the hospital receiving the patient and to the authorized agent of the department for use in the State's quality assurance program;

AUDIT FORMS:

From time to time, specific audit forms are to be used to provide ancillary documentation of a particular procedure, or in response to a particular request for information. It is the responsibility of the BLS Provider to ensure the following documents are submitted to the Suffolk County EMS Division in the prescribed format. Forms may be transmitted via fax to 852-5028 or scanned and sent as a .pdf file to tom.lateulere@suffolkcountyny.gov.

- Suffolk County BLS Narcan Administration Form, with copy of the PCR (or electronic equivalent printout) and ETCO2 Waveform printout.
- Suffolk County BLS CPAP I Form, with copy of the PCR (or electronic equivalent printout).

XVIII. START TRIAGE & SMART INCIDENT COMMAND

New York State DOH has adopted Simple Triage And Rapid Treatment (START) Triage and the SMART™ triage system state wide. These methods, used concurrently are designed to assess a large number of victims rapidly and can be used by personnel with limited medical training effectively. It provides a comprehensive standardized tool for mass casualty event management across New York State.

XIX. AUTOMATIC EXTERNAL DEFIBRILLATOR (AED)

An AED event must be reported in the prescribed manner by the technician of record whenever an AED is used, regardless of whether or not the device delivers a shock. This includes cases where care is transferred to an ALS provider.

For medical-legal, quality improvement and system wide data analysis purposes, all events where the AED is used must be reported to the EMS system. The following steps outline the reporting procedure:

- Medical Control must be contacted via telephone at 444-3600, as soon as feasible after the call, to register demographic information.
- The hard copy of the ECG summary **and** a copy of the PCR are to be forwarded to the EMS Division, at the below address, within 24 hours of the call.

Suffolk County EMS Division
360 Yaphank Ave., Suite 1B
Yaphank, N.Y. 11980
Attn: AED Coordinator

Note: If the patient has been loaded into an ambulance and transport has been initiated, the patient shall be transported to the closest and most appropriate authorized Receiving Hospital with further resuscitation efforts continued.

XX. CHEMICAL AGENT ANTIDOTE KITS

The Mark I Kit contains antidote to be used in instances of exposure to a nerve agent or organophosphate-based chemicals. The Mark I kit consists of two (2) auto injectors, containing one (1) Atropine Sulfate and two (2) Pralidoxime Chloride.

In order to use Mark I Kits, EMS providers must meet the following NY State and regional criteria:

- An EMS agency must be participating in an MMRS or Municipal Response Plan for WMD incidents, such as the Suffolk County Emergency Response Plan, within Suffolk County.
- The initial decision to utilize the Mark I antidote kit must be done under the authority of Medical Control.
- At a minimum, an EMS provider must be trained to the WMD awareness level and have attended a Suffolk County in-servicing on antidote administration and patient decontamination and have appropriate PPE for the assignment.
- **The Mark I Kit is not to be used for self-administration or prophylaxis.**
- Use of the Mark I Kit is to be based on signs and symptoms of the patients. The suspicion or identified presence of a nerve agent is not sufficient reason to administer these medications. **See Appendix 8**

APPENDIX I

DESIGNATED EMS FIELD PHYSICIANS

<i>MD 1</i>	<i>Greg Pigott, MD</i>	<i>EMS System Medical Director</i>
<i>MD 103</i>	<i>Maury Greenberg, MD</i>	<i>Brookhaven Town Fire Marshall</i>
<i>MD 105</i>	<i>Michael Torelli, MD</i>	<i>Exchange VAC</i>
<i>MD 107</i>	<i>Jack Geffken, DO</i>	<i>Centerport FD</i>
<i>MD 108</i>	<i>David Kugler, MD</i>	<i>Melville FD</i>
<i>MD 109</i>	<i>Eric Cruzen, MD</i>	<i>Bay Shore VAC</i>
<i>MD 110</i>	<i>Carl Goodman, DO</i>	<i>Port Jefferson VAC</i>
<i>MD 132</i>	<i>Frank Adipietro, MD</i>	<i>Shelter Island VAC</i>
<i>MD 133</i>	<i>Edgar Borrero, MD</i>	<i>Bayport FD</i>
<i>MD 134</i>	<i>David Seres, MD</i>	<i>Ocean Beach FD</i>
<i>MD136</i>	<i>Jason Winslow, MD</i>	<i>Mastic VAC/Shirley VAC</i>
<i>MD 137</i>	<i>Augustus Mantia, MD</i>	<i>Hauppauge FD/CIHVAC</i>
<i>MD 138</i>	<i>Brian Blaustein, DO</i>	<i>Commack VAC / Sayville VAC</i>
<i>MD 139</i>	<i>Scott Coyne, MD</i>	<i>Suffolk County PD</i>
<i>MD 140</i>	<i>Richard Hindes, MD</i>	<i>Suffolk County PD</i>
<i>MD 141</i>	<i>Noah Finkel, MD</i>	<i>Suffolk County PD</i>
<i>MD 142</i>	<i>Richard Boccio, MD</i>	<i>Suffolk County PD</i>
<i>MD 143</i>	<i>Patricia Daly, MD</i>	<i>Shirley VAC</i>
<i>MD 144</i>	<i>Frank Nyberg, MD</i>	<i>Bay Shore VAC</i>
<i>MD 145</i>	<i>Chris Ng, MD</i>	<i>Selden FD</i>
<i>MD 146</i>	<i>Matthew Goldman, MD</i>	<i>Sayville VAC</i>

The physicians denoted in *italics type* are members of the Suffolk County Disaster Medical Response Team (DMRT) Medical Control Physicians employed at University Hospital Stony Brook are classified as Designated EMS Physicians outside the Medical Control setting.

EFFECTIVE: April, 1994
REVISED: July, 1999
January, 2004
October, 2004
January, 2006
October, 2007
February, 2007
July, 2010
March, 2012
August, 2014

APPENDIX II

ORAL (PO) BODY TEMPERATURE MEASUREMENT PROTOCOL

The physical and mental demands associated with firefighting and other emergency operations in hazardous situations, coupled with environmental dangers of extreme heat and humidity or extreme cold create conditions that may have an adverse impact on the safety and health of emergency response personnel. Adequate rest and rehydration activities and routine medical monitoring of emergency response personnel has become commonplace in the out-of-hospital setting. The Federal Emergency Management Agency and the United States Fire Administration have issued Emergency Incident Rehabilitation SOPs that designate a Rehabilitation Sector (Rehab) as a sector within the EMS operations component of the Incident Command System (ICS).

Routine medical monitoring and evaluation in the Rehab Sector consists of the measurement of heart rate and body temperature as primary vital signs associated with the assessment for medical problems that may result from working in extreme weather conditions. Firefighters, hazardous materials technicians and other emergency responders are routinely required to wear personal protective ensembles that inhibit the natural cooling process, thereby placing emergency responders at greater risk for succumbing to heat related emergencies.

Obtaining an oral body temperature measurement is a skill that can be performed by any certified EMS provider when engaged in emergency incident rehabilitation activities at the scene of an incident. This protocol is for the routine medical monitoring of otherwise healthy emergency response personnel and is not intended for use on patients who present to EMS with an acute onset illness or injury. Oral body temperature shall be obtained as part of the routine medical monitoring or medical evaluation of emergency response personnel engaged in activities requiring the use of personal protective equipment that inhibits the natural cooling process, placing emergency responders at greater risk for succumbing to heat related emergencies.

- Follow the manufacturer's recommendations regarding the application of a single-patient use thermometer. Oral temperature should be obtained as early in the rest phase as possible and in accordance with the FEMA/USFA Rehabilitation guidelines. The oral temperature measurement must be taken *prior to* the administration of fluids by mouth for rehydration.
- 1. Follow the event recording and disposition guidelines of the FEMA/USFA Rehabilitation SOPs or your agency's emergency incident rehabilitation plan. When performing Rehab as part of routine medical monitoring, a PCR IS NOT necessary. An Emergency Incident Rehab Log Sheet should be used to record all activity in the rehab sector and should be retained with the agency's alarm records.
- An emergency responder becomes a patient when he / she verbalizes a chief complaint. When this occurs, all applicable policies and protocols should be adhered to. A PCR IS NOW REQUIRED.

Contraindication: This protocol does not allow for the routine use of oral body temperature measurement when dealing with patients who access emergency medical services personnel following sudden onset of illness or injury.

EFFECTIVE: March, 1998
REVISED: January, 2004

APPENDIX III

USE OF THE INITIAL CASE REVIEW FIELD REPORT

As part of our expanding quality improvement initiative, the Division of Emergency Medical Services has developed a mechanism to give EMS providers an opportunity to document their concerns about issues that may arise during any phase of out-of-hospital emergency medical care. Examples may include, but are not limited to, interactions with other providers, agencies, receiving hospitals and Medical Control.

The form has been distributed to each ambulance service with recommendations to duplicate and keep available at your headquarters. The form gives you the opportunity to initiate the review of a particular concern and provides a follow-up mechanism where feedback can be used to help identify and resolve a problem. The goal is to encourage a partnership approach to patient care among the many components of our emergency medical services system.

The procedure for using the form is as follows:

- Generate the form, listing the details and your concerns about the issue.
- Mail the form to: Suffolk County EMS Division
360 Yaphank Ave., Suite 1B
Yaphank, NY 11980
Attn: Chief, Education & Training
- A review of the incident will be performed.
- The individual generating the report will receive a written summary of the review and recommendations for remedial action, should it be required.

A sample copy is provided on the next page.

March, 1998
REVIEWED: January, 2004

Continued.

*Suffolk County Emergency Medical Services System
Initial Case Review Field Report*

**QUALITY IMPROVEMENT DOCUMENT
CONFIDENTIAL INFORMATION**

Report Date: _____

Incident Date: _____

Corps: _____

Medical Control Run #: (when
applicable) _____

PCR #: (when applicable) _____

Report Submitted By: _____

Description of event:

Continue on separate sheet if necessary

APPENDIX IV

PULSE OXIMETRY

Pulse oximetry is an adjunctive measurement that may be performed by any certified EMS provider. **At no time should oxygen be withheld from a patient in respiratory distress or when a treatment protocol requires the administration of oxygen.**

Oxygen saturation (SaO₂) is a useful adjunct to supplement the physical assessment and may serve as an early warning sign of respiratory failure prior to the traditional physical indicators of hypoxia.

Most patients should have an SaO₂ level of between 97%-99%. Oxygen saturation below 90% in most patients identifies respiratory impairment and serves to quantify the effects of other therapies, including increased oxygenation, suctioning, ventilatory assistance and pharmacological agents. As with all other adjunctive tools, pulse oximetry is a supplement to patient assessment, not a replacement for it.

Users should be aware that inaccurate readings from the light-sensitive probe may be effected by:

- Decreased distal circulation (hypotension, delayed capillary refill, cool skin, pallor);
- Bright sunlight or fluorescent lights;
- Extreme patient movements;
- Moisture in the sensor;
- Loose clips;
- Dark nail polish; and
- Fake fingernails

In addition, hemoglobin saturated with compounds other than oxygen, for example, carbon monoxide, or patients predisposed to the hypoxic drive (COPD), may lead to a false high reading. Always consider mechanism of illness/injury when measuring oxygen saturation.

EFFECTIVE: March, 1998
REVISED: January, 2004

APPENDIX V

MEDEVAC INTERFACE

MEDEVAC REQUEST PROCEDURES

The EMS provider should make every effort to request medevac services from the Suffolk County Police Aviation Section through an on-scene police unit. If there is no PD unit on scene, and only if there is no PD unit on scene, you should request through Suffolk County Fire-Rescue Dispatch. You should be prepared to provide the following information:

- The agency requesting;
- The location of the potential landing zone;
- The injury or illness; and the
- Number of victims.

In certain instances, the medevac may be placed on “stand-by” by dispatch prior to your arrival. Providers should remember to confirm need, or cancel the request, as soon as feasible after arrival on-scene and assessment of the scene and the patient.

LANDING ZONE SELECTION

1. Selecting an appropriate Landing Zone should be a coordinated effort between both rescue and police personnel. **Pilots will have the final authority on the landing zone.**
 - The landing zone should be at a minimum of 100 sq. ft in a **daytime landing** and 150 sq. ft in a **nighttime landing or during windy conditions.**
2. The Landing zone should not contain snow, ice, sand, dirt, or other loose debris. Report any such conditions to the on-scene sector car.
3. Notify the pilot of any obstacles, such as overhead wires, light poles, trees, etc.

Warning lights may be placed at the corners of the landing zones. Avoid traffic cones, or other objects that are likely to be blown away by rotor wash. Headlights, spotlights, or other warning lights should *never be pointed directly at the aircraft, as this impacts the pilot's vision.*

- Secure pedestrian or vehicle traffic from the landing zone (200ft. minimum). Landing zone should be at least **100 feet** from rescue operations.

Continued.

APPENDIX V

MEDEVAC INTERFACE – Page 2.

RESCUE PERSONNEL PROCEDURES

- ✓ If the ambulance is already at the landing zone when the helicopter arrives, leave the patient in the ambulance until flight medic has examined the patient, and rendered any additional pre-flight care that is necessary prior to flight. The EMS provider caring for the patient should be prepared to give a brief patient report to the flight medic.
- The patient should be secured on a backboard with straps. Any patient care devices, such as endotracheal tubes, IVs, splints, sheets, blankets, etc. **must** be secured prior to approaching the aircraft.
- Rescue and EMS personnel should be prepared to assist with the transfer of the patient into the aircraft, MINDFUL OF ALL SAFETY PRECAUTIONS.

LANDING ZONE SAFETY POINTERS

- Never approach the aircraft until advised to do so by the flight crew.
- Approach and depart only from the front of the aircraft, in view of the pilot. ***Never approach from the rear.***
- Never approach from an uphill slope.
- Never shine any lights directly at the aircraft or use any flash bulbs during landing and lift off procedures.
- Secure all blankets and patient care equipment to the stretcher.
- Loading and unloading of patient and equipment will be under the direction of the flight crew.
- ***The flight crew will open and close the doors of the aircraft.***

EFFECTIVE: January, 2000
REVISED: January, 2004

APPENDIX VI

CERTIFIED EMS PROVIDERS AS MANDATED REPORTERS OF CHILD ABUSE

This policy applies to all certified EMS providers, while on “duty status” in NY State, as required by Section 415 of Social Services Law. The law states that:

“Reports of suspected child abuse or maltreatment made pursuant to this title shall be made immediately by telephone or facsimile machine on a form supplied by the Commissioner. Oral reports shall be made to the statewide register of child abuse and maltreatment unless the appropriate local plan for the provision of child protective services provides that oral reports should be made to the local child protective services.”

10NYCRR Part 800.21(p) (11) (ii) requires all ambulance services to have and enforce a written policy regarding the reporting of child abuse/maltreatment cases. This policy shall include at a minimum:

1. *PCR Documentation;*
2. *Emergency Department staff notification;*
3. *Placing a call to the toll-free number; and*
4. *Completion of the DSS 2221-A form.*

*Oral reports of suspected child abuse/maltreatment shall be made by calling the
NY State Child Abuse/Maltreatment Register at:*

1-800-635-1522

and by mailing the completed DSS 2221-A form to:

***CPS Register/Intake Unit
Suffolk County Department of Social Services
PO Box 18100
Hauppauge, NY 11788-8900***

The oral telephone report must be made as soon as feasible after the alarm and the written report must be submitted within forty-eight (48) hours of the alarm.

When multiple EMTs are on a call, only one (1) EMT needs to make the call and submit the report on behalf of the entire crew.

Please refer to NY State Policy Statement 02-01 for additional detailed information.

January, 2002
REVIEWED: January, 2004

APPENDIX VII

SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES DIVISION OF EMERGENCY MEDICAL SERVICES

OPERATIONS POLICY # 1-006

EFFECTIVE DATE – 9/30/98

REVISED – 1/31/01

REVISED – 10/15/12

SUFFOLK COUNTY ANIMAL BITE REGISTRY

The Suffolk County Legislature adopted Resolution 1083-1995 on November 28, 1995 establishing a registry for animal bite incidents that occur in Suffolk County. The law requires that any ambulance or rescue squad responding to an incident that involves an animal bite shall file a report using the attached forms.

The **ANIMAL BITE REGISTRY** form is used to enter the incident into the Animal Bite Registry. The **DIVISION OF PUBLIC HEALTH BITE COMPLAINTS** form provides essential information to public health officials needed for timely medical care and follow-up.

To comply with the reporting requirements of the law, the following procedures must be adhered to:

1. The **ANIMAL BITE REGISTRY** form must be completed in its entirety and distributed to the agencies listed on the form within twenty-four (24) hours of the incident.
 - A. The white (1st) copy shall be retained by the reporting agency and attached to the agency's original copy of the Pre-hospital Care Report (PCR) generated for the incident.
 - B. The yellow (2nd) copy shall be mailed to the Suffolk County Police Department Central Records Bureau, Police Headquarters, Yaphank Ave., Yaphank, NY 11980.
 - C. The pink (3rd) copy shall be mailed to the Suffolk County Department of Health, Division of Public Health at 3500 Sunrise Highway, Suite 124, PO Box 9006, Great River, NY 11739-9006. Whenever possible, this copy should also be forwarded by **fax** to the Division of Public Health (631-854-0346) as soon as possible after the incident.
 - D. The gold (4th) copy shall be mailed to the Animal Control Officer in the town in which the animal bite incident occurred (list attached).
2. The **DIVISION OF PUBLIC HEALTH BITE COMPLAINTS** form shall be completed and forwarded to the Division of Health by **fax** (631-854-0346) as soon as possible after the incident. A copy of the form should be retained by the reporting agency and attached to the agency's original copy of the Pre-hospital Care Report (PCR) generated for the incident.

APPENDIX VIII

Suffolk County Emergency Medical Services

NERVE AGENT / ORGANOPHOSPHATE POISONING PROTOCOL For BASIC & ADVANCED LIFE SUPPORT PROVIDERS

This protocol is for use with ADULT patients (≥ 15 years of age / ≥ 34 kg. body weight) **who** exhibit signs / symptoms of a nerve agent or organophosphate poisoning **and is to be used under the direction of Medical Control or on-scene EMS Field Physician** by EMS providers who have been appropriately trained and have the necessary personal protective equipment to operate in chemically contaminated environment. *In case of accidental exposure to a nerve agent or organophosphate, individuals should not administer Mark I Kits to themselves. Contact Medical Control ASAP for incident-specific orders if patients or crew member's exhibits signs / symptoms of exposure or field detection equipment identifies a nerve agent or organophosphate-based vapor or liquid.*

NOTE: Medical Control should be contacted ASAP for age/weight specific dosing for PEDIATRIC PATIENTS (< 15 / < 34 kg. body weight).

THIS MEDICAL PROTOCOL IS TO BE USED AFTER DECONTAMINATION HAS BEEN PERFORMED AND THE APPROPRIATE LEVEL OF PERSONAL PROTECTIVE EQUIPMENT HAS BEEN IDENTIFIED

- IDENTIFY SIGNS / SYMPTOMS OF ORGANOPHOSPHATE EXPOSURE

Salivation	Emesis
Lacrimation	Miosis & Muscle Contractions
Urination	Altered Mental Status
Defecation	Seizure
Gastrointestinal	

IF ANTIDOTE IS INDICATED – CONTACT SUFFOLK COUNTY MEDICAL CONTROL AT 689-1430

- ESTABLISH TRIAGE – S.T.A.R.T. Method. If NOT BREATHING / NOT RESPONSIVE, and multiple patients present, apply Noxious Stimuli Triage (NST)
 - If No Response to NST - Tag Expectant and Move to Next Patient
- ASYMPTOMATIC PATIENTS
 - Monitor for signs / symptoms q 10-15 minutes and re-triage accordingly
- FOR MILD / MODERATE EXPOSURE (runny nose, increased oral secretions, fatigue, pinpoint pupils, dim vision, sweating, chest tightness, dyspnea, nausea)
 - Provide airway support (suction, high-flow oxygen) to ensure patient is not hypoxic
 - Administer one (1) Mark I Kit. Atropine must be given first.
 - Reassess patient q 5 minutes – if secretions still present:
 - Administer a second Mark I Kit. Atropine must be given first.
 - Reassess patient q 5 minutes – if secretions still present:
 - Administer a third Mark I Kit. Atropine must be given first.
(maximum individual dose = 3 Mark I kits)
- FOR SEVERE EXPOSURE (all of the above plus severe dyspnea, loss of bowel/bladder function seizure, paralysis)
 - Provide airway support (suction, high-flow oxygen) to ensure patient is not hypoxic
 - Administer three (3) Mark I Kits. Atropine must be given first. No more than 3 doses of 2 PAM (1.8g) are to be administered in the field.
 - Establish large bore IV and give fluid bolus 250-500 cc Normal Saline
 - Reassess patient q 5 minutes – if secretions still present:
 - Atropine 2 mg. IV/IM may be repeated every five (5) minutes until secretions dry or a maximum total dose of 20 mg. is administered
 - Diazepam 10 mg. IVP, if available, as ordered by Medical Control or EMS Field Physician

APPENDIX IX

RMA CHECKLIST

Name:	Age:	Date:
Location of Call:		PCR #:

• **Assessment of Patient (Complete each item, circle appropriate response)**

Oriented to:

Person	Yes	No
Place	Yes	No
Time	Yes	No
Situation	Yes	No
Altered level of consciousness	Yes	No
Head injury	Yes	No
Alcohol or drug ingestion by exam or history	Yes	No
Medical Control		

Contacted by: ___ Phone ___ Radio at ___ hours.

_____ Unable to contact (explain in comments)

Orders:

_____ Indicated treatment and/or transport may be refused by patient.
_____ Use reasonable force and/or restraints to provide indicated treatment.
_____ Use reasonable force and/or restraint to transport.
_____ Patient refusal against medical advice.

Other: _____

Continued.

APPENDIX IX

RMA CHECKLIST – Page 2.

Patient Advised of the following: (Complete each item, circle appropriate response)

Medical treatment/evaluation recommended.....	Yes	No
Ambulance transport recommended.....	Yes	No
Further harm could result without medical treatment or evaluation.....	Yes	No

Transport by means other than ambulance could be hazardous

in light of patient’s present illness / injury.....	Yes	No
Patient provided with refusal advice sheet.....	Yes	No
Patient would not accept refusal advice sheet.....	Yes	No

Disposition

- Refused all EMS services.
- Refused transport, accepted field treatment.
- Refused field treatment, accepted transport.
- Released in care of self/relative/friend
- Released in custody of law enforcement agency:

Additional Comments, if needed:

Patient Information Sheet provided to patient. Yes No

Signature of Patient _____ Date _____

Signature of Witness _____ Date: _____

Signature of Provider _____ Date: _____

Continued.

APPENDIX IX

RMA CHECKLIST – Page 3.

Refusal of Care Information Sheet

Dear Patient; Please read and keep this form!

This form has been given to you because you have refused treatment and/or transport by the responding ambulance service. *Your health and safety are our primary concern.* Even though you have decided not to accept the advice of the EMS provider, please remember the following:

- I. The evaluation and/or treatment provided to you by the ambulance service is not a substitute for medical evaluation and treatment by a doctor. You are advised to get medical evaluation and treatment by a doctor.

- III. Your condition may not seem as bad to you as it actually is. Without treatment, your condition or problem could become worse. If you are planning to get medical treatment, a decision to refuse treatment or transport by the ambulance service may result in a delay that could make your condition or problem worse.

- III. Medical evaluation and/or treatment may be obtained by calling your doctor, if you have one, or by going to any hospital emergency department in this area, all of which are staffed 24 hours a day by emergency physicians. You may be seen at these emergency departments without an appointment.

- VI. If you change your mind or your condition becomes worse and you decide to accept treatment and transport by the ambulance service, please do not hesitate to call them back and they will do their best to help you.

Don't wait! When medical treatment is needed, it's usually better to get it right away.

I have received a copy of this information sheet.

Patient Signature_____

Date_____

APPENDIX X

EMERGENCY INCIDENT REHABILITATION (REHAB)

The physical and mental demands associated with firefighting and other emergency operations in hazardous situations, coupled with environmental dangers of extreme heat and humidity or extreme cold create conditions that may have an adverse impact on the safety and health of emergency response personnel. Additionally, in specific types of response activities, emergency responders may be exposed to Carbon Monoxide as a by-product of incomplete combustion, which places them at increased risk for occult exposure.

Adequate rest and rehydration activities and routine medical monitoring of emergency response personnel has become commonplace in the out-of-hospital setting. The Federal Emergency Management Agency and the United States Fire Administration have issued Emergency Incident Rehabilitation SOPs that designate a Rehabilitation Sector (Rehab) as a sector within the EMS operations component of the Incident Command System (ICS).

Routine medical monitoring and evaluation in the Rehab Sector consists of the measurement of heart rate and body temperature as primary vital signs associated with the assessment for medical problems that may result from working in extreme weather conditions. Firefighters, hazardous materials technicians and other emergency responders are routinely required to wear personal protective ensembles that inhibit the natural cooling process, thereby placing emergency responders at greater risk for succumbing to heat related emergencies.

Obtaining an oral body temperature measurementⁱ is a skill that can be performed by EMTs, EMT-Is, EMT-CCs and EMT-Ps when engaged in emergency incident rehabilitation activities at the scene of an incident. This protocol is for the routine medical monitoring of otherwise healthy emergency response personnel and is not intended for use on patients who present to EMS with an acute onset illness or injury.

Oral body temperature shall be obtained as part of the routine medical monitoring or medical evaluation of emergency response personnel engaged in activities requiring the use of personal protective equipment that inhibits the natural cooling process, placing emergency responders at greater risk for succumbing to heat related emergencies.ⁱⁱ

1. Follow the manufacturer's recommendations regarding the application of oral (PO) single-patient use thermometers. Oral temperature should be obtained as early in the rest phase as possible and in accordance with the FEMA/USFA Rehabilitation guidelines.ⁱⁱⁱ The oral temperature measurement must be taken *prior to* the administration of fluids by mouth for rehydration.
2. Follow the event recording and disposition guidelines of the FEMA/USFA Rehabilitation SOPs or your agency's emergency incident rehabilitation plan AND THE FOLLOWING STANDARD OPERATING PROCEDURE. When performing Rehab as part of routine medical monitoring, a PCR IS NOT necessary. An Emergency Incident Rehab Log Sheet should be used to record all activity in the rehab sector and retained with the agency fire alarm report.

Continued.

APPENDIX X

EMERGENCY INCIDENT REHABILITATION (REHAB) – Page 2.

3. If at any time, an emergency responder presents with a chief complaint, signs/symptoms, and/or abnormal vital signs, the responder becomes a patient, a PCR is required, and all applicable NY State and Suffolk County Policies and Protocols must be followed.
4. Follow the manufacturer's recommendations regarding the application of non-invasive SpCO measurement devices.

Contraindication: This protocol does not allow for the routine use of oral body temperature measurement when dealing with patients who access emergency medical services personnel following sudden onset of illness or injury or to use a SpCO measurement to facilitate a Refusal of Medical Attention on an emergency responder.

¹ Oral temperature readings with single-patient use thermometers are to be used. Other measurement devices, i.e.: tympanic or rectal are expressly prohibited by the SREMAC. Readings from tympanic thermometers are affected by the ambient temperature and may be less accurate in settings where the ambient temperature varies.

² Oral body temperature measurements is not authorized in the assessment and treatment of any patient outside the scope of Emergency Incident Rehabilitation sector operations, unless authorized and so ordered by an approved EMS Medical Control physician.

³ Emergency Incident Rehabilitation, USFA Publications, FA-114, and July, 1992: Washington, DC.

Purpose:

To serve as a monitoring standard for BLS & ALS providers operating in an Emergency Incident Rehabilitation Sector, rest, rehydration, rehab evaluation, and nutrition, are key components in supporting firefighters and other emergency responders operating in personal protective clothing for prolonged periods of time, as this activity often times impedes the body's natural cooling process. Other health hazards, such as exposure to carbon monoxide, cyanide gas, and other atmospheric hazards are common in specific types of emergency response. Carbon monoxide is a colorless, odorless tasteless toxic gas and is a product of incomplete combustion of any carbon-based material, and generally presents with vague flu-like symptoms, fatigue, or other general complaints. The addition of non-invasive CO-oximetry is an effective tool in measuring carboxyhemoglobin levels in the field.

This policy covers any event, including drills, fire-ground operations, hazardous materials incidents, technical rescues, lengthy extrications and any other event where emergency response personnel are wearing personal protective equipment and fluid loss, heat-related emergencies or exposure to carbon monoxide is a concern.

Consider the activation of a Suffolk County Disaster Medical Response Team (DMRT) physician if more than one (1) agency will be requiring incident rehab and/or operations are expected to last for long periods of time.

Continued.

APPENDIX X

EMERGENCY INCIDENT REHABILITATION (REHAB) – Page 3.

REST

Avoid going from hot directly to air conditioning. Ideally, there should be a ten (10) minute wait in ambient temperature. Firefighters should follow the “2 air bottle rule” or 45 minutes work time maximum. Typically one (1) ten (10) minute rest period is appropriate unless otherwise indicated by the results of the evaluation.

REHYDRATION STRATEGY

Rehydrate emergency responder with *at least 12 oz.* water or sports drink. Do not use carbonated beverages or caffeine. NOTE: PO Body temperature should be obtained prior to allowing the emergency responder to drink cold liquids.

EVALUATION

- Observe for behavioral changes, such as change in affect, loss of motor coordination / dexterity, or emotional decompensation.
- Measure Heart Rate and Oral (PO) Body Temperature.
- If temperature > 100.6 F, do not allow emergency responder to don PPE for the remainder of the event.
- If heart rate greater than (>) 110 bpm & temperature is less than (<) 100.6 F, one (1) additional ten (10) minute rest period is indicated.
- If heart rate does not return to normal after 20 minutes continuous rest, the emergency responder becomes a patient and is transported to the closest emergency department.

NOTE: Emergency responders should be taken out of service and treated and transported to the closest emergency department whenever:

- Signs / symptoms of heat stroke
- Altered Mental Status of any kind
- PO temp > 101 degrees F.
- Irregular heart beat
- HR > 150 bpm at any time and greater than (>) 140 bpm after rest.
- SPB > 200 at any time
- DBP > 120 at any time

Continued.

APPENDIX X

EMERGENCY INCIDENT REHABILITATION (REHAB) – Page 4.

AT ANY TIME THAT AN EMERGENCY RESPONDER COMPLAINS OF AN INJURY OR EXPRESSES ANY CHIEF COMPLAINT, OR HAS ABNORMAL VITAL SIGNS , HE/SHE BECOMES A PATIENT AND ALL APPLICABLE POLICIES AND PROTOCOLS MUST BE FOLLOWED, PARTICULARLY IF THE FOLLOWING PRESENTATIONS OCCUR:

- Chest pains
- SOB/Dyspnea
- AMS
- Headache (major sign of dehydration)
- Persistent tachycardia
- Orthostatic vital signs
- Self-monitoring of urine – reported dark color / strong smell
- Nausea/vomiting

Any EMS provider who is trained and authorized in its use may use Non-invasive CO-oxymetry in conjunction with rest and rehydration activities to determine the carboxyhemoglobin level of emergency responders.

For an SpCO greater than or equal to (\geq) 12% - TREAT with 100 % oxygen and TRANSPORT to the closest emergency department

For an SpCO less than ($<$) 12% **BUT** signs of CO exposure are present – TREAT with 100 % oxygen and TRANSPORT to the closest emergency department

For an SpCO less than ($<$) 12% and NO SIGNS OF CO EXPOSURE AND NORMAL VITAL SIGNS – no further medical monitoring is needed. An emergency incident rehabilitation log must be maintained to document rehab activities and filed with the department's fire report. Emergency responders should be instructed to seek medical attention if signs or symptoms develop over time.

ANY PATIENT WITH ASSOCIATED BURNS SHALL BE TRANSPORTED IN ACCORDANCE WITH THE BURN DESTINATION DECISION POLICY REGARDLESS OF THEIR CARBON MONOXIDE LEVEL.

REMEMBER – The use of pulse oximetry (SpO₂) in individuals exposed to CO will produce false high SpO₂ readings.

Continued.

APPENDIX X

EMERGENCY INCIDENT REHABILITATION (REHAB) – Page 5.

Patients should be transported to the closest appropriate emergency department, NOT directly to a hospital with a hyperbaric chamber, unless that hospital is in your catchment area. Hyperbaric therapy for patients with CO exposure is ordered based on failed neurological examination and laboratory confirmed blood values (>25% CoHb). In addition, hyperbaric chambers may not be readily available upon your arrival and 100% oxygen via non-rebreather facemask changes blood saturation.

The following reference table provides expected signs or symptoms that can be predicted based on percentage of CO detected in the blood. This is only a guideline, based on a variety of variables that the EMS provider may not be aware of.

<i>SpCO</i>	<i>Expected signs/symptoms</i>
0-3%	Normal non-smoker
4-10%	Mild headache, shortness of breath with exertion
10-20%	Moderate headache, fatigue, shortness of breath
20-30%	Severe headache, blurred vision, nausea, dizzy, irritable, cardiac ischemia
30-40%	Muscle weakness, vomiting, vertigo, confusion
40-50%	Arrhythmias, syncope
50-60%	Seizures, shock, apnea, coma

***WHEN IN DOUBT CONTACT MEDICAL CONTROL FOR
PHYSICIAN CONSULTATION.***

NUTRITIONAL/CARBOHYDRATE STRATEGY

During emergencies that occur over several days and include multiple operational periods, it is likely that rehab operations will be expanded to include providing snacks and/or meals concurrent with other rehab activities.

Simple carbohydrates are present in fluids and power bars and their key ingredients are rapidly available and are indicated when quick bursts of energy are needed. Complex carbohydrates are present in pastas and breads, and their key ingredients are available over longer periods of time, as they account for a more sustained release of energy.

Effective: March, 1998
Revised: March, 2007

APPENDIX XI

NON-INVASIVE CO-OXIMETRY AT CARBON MONOXIDE EMERGENCIES

Carbon Monoxide (CO) is a common by-product of incomplete combustion, present whenever fossil fuels are burned. CO is a colorless, odorless, tasteless, non-irritating gas, and is a SYSTEMIC ANHYMIANT that Interferes with oxygen transportation throughout body and interferes with oxygen utilization at the cellular level.

Because you can't see, taste, smell, or sense CO, the gas can cause irreparable harm or death before you know it is even present in your environment. CO has a Vapor Density of 0.97, which means that its weight, relative to the ambient air, is just about equal to that of the ambient air. That means that CO will not float, and seek out higher areas, nor will it sink, and collect in low lying areas. Rather, CO will be carried throughout the structure, following natural air currents and flow patterns.

Potential sources that should be sought out at an alarm include, but are not limited to:

- Blocked Chimney Opening
- Clogged Chimney
- Portable Heaters / Space Heaters
- Gas Clothes Dryers
- Wood-burning Fireplace / Stove
- Gas Stoves & Ovens
- Gas Heaters (Forced Air/Hot Water)
- Corroded or Disconnected Water Heater Vent Pipes
- Leaking Chimney Pipe or Flue
- Auto Exhaust in Garage
- Yard Equipment Exhaust in Garage
- Using Gas Grills in Enclosed Spaces
- Fire Scenes. Refer to Emergency Incident Rehab Policy for emergency responders operating at fire scenes

While fire department or hazardous materials responders conduct atmospheric monitoring activities, EMS personnel should be seeking out occupants to ensure that individuals are not patients, with the following in mind:

Everyone is at risk for CO-related illness or death; some individuals are more vulnerable, including: unborn babies of pregnant females¹; infants; children; the elderly; individuals with history of heart or lung disease; and individuals under the influence of alcohol or drugs. Severity of symptoms influenced by four (4) main factors: concentration of CO in the environment; duration of exposure; activity; and rate/work of breathing. In addition, the dose / rate / weight relationship directly proportional to progression of signs & symptoms of exposure, **therefore, signs & symptoms play a far greater role in identifying exposed people than a SpCO value. REMEMBER – The use of pulse oximetry (SpO2) in individuals exposed to CO will produce false high SpO2 readings.**

Continued.

APPENDIX XI

NON-INVASIVE CO-OXIMETRY AT CARBON MONOXIDE EMERGENCIES – Page 2.

At low levels, symptoms can include: headache/impaired judgment; dizziness/confusion/loss of memory/AMS; weakness/fatigue/sleepiness; visual disturbances; vertigo/tinnitus; nausea, vomiting; chest tightness; dyspnea; and at higher levels can progress rapidly through these signs & symptoms to loss of consciousness; seizure; coma; and death.

AT ANY TIME THAT AN INDIVIDUAL EXPRESSES ANY CHIEF COMPLAINT, OR HAS ABNORMAL VITAL SIGNS, HE/SHE BECOMES A PATIENT AND ALL APPLICABLE POLICIES AND PROTOCOLS MUST BE FOLLOWED.

EXPOSURE TO CO IS A HIGH RISK CRITERION, REQUIRING MEDICAL CONTROL CONTACT, INCLUDING CASES WHERE AN SpCO MEASUREMENT IS TAKEN AND WHEN THERE ARE ANY LEVELS OF CO IN THE ATMOSPHERE ABOVE NORMAL LEVELS.

Non-invasive CO-oxymetry may be used by any EMS provider trained and authorized in its use.

If SpCO greater than or equal to (\geq) 12% - TREAT with 100 % oxygen and TRANSPORT to the closest emergency department

If SpCO less than ($<$) 12% **BUT** signs of CO exposure are present– TREAT with 100 % oxygen and TRANSPORT to the closest emergency department

ANY PATIENT WITH ASSOCIATED BURNS SHALL BE TRANSPORTED IN ACCORDANCE WITH THE BURN DESTINATION DECISION POLICY REGARDLESS OF THEIR CARBON MONOXIDE LEVEL.

If SpCO less than ($<$) 12% and NO SIGNS OF CO EXPOSURE AND NORMAL VITAL SIGNS AND ATMOSPHERIC MONITORING LEVELS ARE WITHIN NORMAL LIMITS, no further medical monitoring is needed. Advise individuals to pay attention for the appearance of the signs & symptoms noted above and to seek medical attention if signs & symptoms develop. An emergency incident log must be established to document history, physical exam, SpCO reading and disposition.

***WHEN IN DOUBT CONTACT MEDICAL CONTROL FOR
PHYSICIAN CONSULTATION.***

Continued.

APPENDIX XI

NON-INVASIVE CO-OXIMETRY AT CARBON MONOXIDE EMERGENCIES – Page 3.

The following reference table provides expected signs or symptoms that can be predicted based on percentage of CO detected in the blood. This is only a guideline, based on a variety of variables that the EMS provider may not be aware of.

Patients should be transported to the closest appropriate emergency department, NOT directly to a hospital with a hyperbaric chamber, unless that hospital is in your catchment area. Hyperbaric therapy for patients with CO exposure is ordered based on abnormal neurological examination and laboratory confirmed blood values (>25% CoHb). In addition, hyperbaric chambers may not be readily available upon your arrival and 100% oxygen via non-rebreather facemask changes blood saturation.

<i>SpCO</i>	<i>Expected signs/symptoms</i>
0-3%	Normal non-smoker
4-10%	Mild headache, shortness of breath with exertion
10-20%	Moderate headache, fatigue, shortness of breath
20-30%	Severe headache, blurred vision, nausea, dizzy, irritable, cardiac ischemia
30-40%	Muscle weakness, vomiting, vertigo, confusion
40-50%	Arrhythmias, syncope
50-60%	Seizures, shock, apnea, coma

¹ **NOTE: Medical Control MUST BE CONTACTED for any pregnant female patient exposed or potentially exposed to CO, regardless of absence of signs/symptoms, OR an SpCO reading of 0% or higher.**

APPENDIX XII

USE OF RESTRAINT POLICY

A number of factors may contribute to a patient's abnormal behavior, including metabolic causes secondary to low blood sugar, hypoxia, or head trauma, the use of mind altering substances, or psychiatric pathology. **Signs and symptoms associated with a "behavioral emergency" should be considered of a medical nature, and patients should be transported to the closest emergency department for evaluation.** Medical Control may be contacted in cases where questions about necessity of restraint or care arise. BLS providers should consider ALS Intercept. As always, transport should not be delayed.

Patients have the right to refuse treatment and/or transport if they are of legal age and are capable of making an informed decision. A person is considered capable until proven otherwise. There are situations in which the interests of the general public outweigh an individual's right to liberty, including;

- the individual is threatening self-harm or suicide; and/or
- the individual presents a threat to third parties, including medical care-givers.

The purpose of this policy is to provide guidelines on the use of humane medical restraint in out-of-hospital situations for patients who are violent, potentially violent, or who may harm themselves or others, regardless of the underlying cause, when restraint is necessary to limit mobility or temporarily immobilize such patients. *Providers are to use the minimum and least restrictive amount of humane restraint necessary to safely accomplish patient care and transportation with regard to both patient and provider safety*, dependent on body size and strength, type of abnormal behavior, and mental state.

Indications for restraint include:

- behavior or threats that imply or create a danger to the patient and others;
- the need for safe and controlled access for medical care (medical restraint); or
- involuntary treatment/transportation of irrational or uncontrollable combative patients (behavioral restraint).

To provide care and transportation without the patient's informed consent, EMS providers must be able to document a reasonable belief that the patient would be a threat to self or others.

If, during your scene assessment, a patient is encountered who threatens the safety of your crew, retreat and await assistance from law enforcement personnel to assure scene safety. Restraints can be applied, either:

- in the presence of law enforcement personnel, and after other methods of de-escalating the patient have failed; or
- under standing orders, without law enforcement presence, in situations where crew safety is paramount, based on changes in the patient's mental/behavioral status.

Continued.

APPENDIX XII

USE OF RESTRAINT POLICY – Page 2.

Restraints should only be used in an emergency or crisis situation where the patient is non-compliant with direction, does not follow orders, or when the actions of the patient may result in physical harm to self or others. Once restraints have been applied, they should not be removed until transfer of care occurs at the hospital, under the direction of accepting hospital personnel.

Soft restraints are approved for use by EMS providers. Hard restraints, such as handcuffs, cable ties, restraints that require a key and other like restraint devices are not approved for EMS providers. When soft restraints are necessary such activity will be undertaken in a manner that protects the patient's health and safely preserves his/her dignity, rights, and well-being.

The method of restraint used shall allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway or compromise neurological or vascular status. Restrained extremities should be evaluated for the presence of circulation and motor function every five (5) minutes, with findings documented on the PCR.

In ideal circumstances, four (4) point restraints should be applied (each limb), and upper arm muscle groups should be isolated by restraining the arms in opposite directions. Once the decision to restrain is made, the team should act quickly, and four (4) persons should approach the patient, each pre-assigned to a separate limb.

EMS personnel must ensure that the patient's position does not compromise the patient's respiratory/circulatory systems, or does not preclude any necessary medical intervention to protect the patient's airway should vomiting occur.

If the patient is spitting, EMS providers should cover the patient's face with an oxygen mask, with oxygen flowing, if indicated. Alternatively, a surgical mask may be used as a personal protective barrier, if oxygen is not indicated. Under no circumstances should an EMS provider hold pillows, towels, or other objects over a patient's face.

Patients are to be transported in the supine or left lateral recumbent position. NEVER PLACE A PATIENT FACE DOWN TO RESTRAIN. Fractures, dislocations and positional asphyxia are common complications to the restraint process, and care should be taken to avoid. DO NOT transport a patient in the prone position.

- ***NEVER restrain a patient's hands and feet behind the patient, i.e. hog-tying.***
- ***NEVER "sandwich" patients between backboards, or scoop-stretchers, as a restraint.***

In situations where EMS providers encounter patients under arrest, or in cases where law enforcement personnel have applied handcuffs or plastic ties, assessment should include ensuring sufficient slack in the restraint device to allow unrestricted abdomen and chest wall movement.

Continued.

APPENDIX XII

USE OF RESTRAINT POLICY – Page 3.

NOTE: If a patient is restrained by law enforcement personnel with handcuffs or other lockable devices, law enforcement personnel must accompany the patient to the hospital in the ambulance. In other circumstances where restraints are applied by EMS providers, and the patient represents a safety risk, EMS providers should request that law enforcement personnel accompany the patient and crew to the hospital for safety purposes.

In cases where restraints are applied, complete and thorough documentation on the PCR is essential, and should include specific information as to:

- the reasons restraints were needed, and reasonable force was necessary;
- the need for treatment/transport was explained to the patient regardless of capability;
- evidence of the patient's incapability to make an informed decision;
- whether the restraints were applied by law enforcement or EMS agency and under whose orders the restraints were applied;
- failures of less restrictive measures to de-escalate the incident; and
- on-going assessment regarding the monitoring of airway, breathing and circulation, including circulation and motor function in the restrained extremities.

EFFECTIVE: July, 2010

APPENDIX XIII

REMAC ADVISORY ON EXTERNAL BLEEDING CONTROL

Changes in technology and contemporary data from the military experience have shed new light on severe bleeding control from an extremity injury. Based on standard of care established by the NY State Emergency Medical Advisory Committee (SEMAC) and the NY State Trauma Advisory Committee (STAC), and supported by the National Association of EMTs (NAEMT) Prehospital Trauma Life Support (PHTLS) curricula, the Suffolk Regional Emergency Medical Advisory Committee (REMAC) and the Suffolk Regional Trauma Advisory Committee (RTAC) are taking this opportunity to review current NY State EMS Basic Life Support (BLS) approach to the External Bleeding Protocol. Bleeding from soft tissue injury to the extremities may be associated with accompanying arterial injury. Methods to control bleeding, consistent with updated NY State BLS protocol for External Bleeding, includes:

Immediately apply direct pressure over the wound with a sterile dressing. NOTE: If available and bleeding is severe, a hemostatic gauze** dressing should be applied directly to the bleeding site simultaneously with direct pressure. If bleeding soaks through the dressing, apply additional dressings while continuing direct pressure. Do not remove dressings from the injured site! Cover the dressed site with a pressure bandage. For severe and persistent bleeding, maintain direct pressure with enough pressure to stop the bleeding, first by hand, then maintained by pressure dressing.

** If routine standard dressings were initially applied, and bleeding continues through several blood-soaked dressings, these dressings must be removed to apply a kaolin-based hemostatic dressing directly over the wound. Only kaolin-based hemostatic dressings are approved and may be used in place of simple gauze dressings, following manufacturer's recommendations for application. Kaolin-based hemostatic dressing should preferentially be used on wounds with severe bleeding, following manufacturer's recommendations. Standard dressings should be applied to simple wounds where bleeding is easily controlled.

For severe and persistent bleeding, maintain direct pressure with enough pressure to stop the bleeding, first by hand, then maintained by pressure dressing.

In cases where hemorrhage to the extremity cannot be controlled by direct pressure, pressure dressing and if applicable, hemostatic dressing, the use of tourniquets are acceptable, particularly when the wound exhibits spurting blood. The most readily available tourniquet is a blood pressure cuff. If a BP cuff is used, the cuff should be inflated to just enough pressure to stop external blood flow.

Tourniquets should be used if severe bleeding from a limb persists to control severe bleeding after all other methods have failed. The application of a tourniquet is limited to use on extremities. A second tourniquet may be applied proximal to the first if severe bleeding persists. Commercially available tourniquets, or those prepared with cravats, should be 2.5-3 inches thick. Never use wire, cord, or any material that may cut the skin. Follow manufacturers recommendations and NY State BLS External Bleeding Protocol (7/11 version).

Do not loosen or remove any tourniquet once it has been applied. The loosening of a tourniquet may dislodge clots and result in enough blood loss to cause shock and death.

Always assess for signs of hypoperfusion, keep the patient warm, and provide appropriate oxygen therapy. Ensure rapid transport to the closest appropriate hospital.

Obtain and record serial vital signs.

Record all information on the PCR.

APPENDIX XIV

LEFT VENTRICULAR ASSIST DEVICE (LVAD)

An increasing number of individuals are discharged home implanted with a left ventricular assist device or left ventricular assist system (LVAD/LVAS) to sustain life while either waiting for a heart transplant, treatment for congestive heart failure, or as destination therapy. The most common device being used in our community known to REMAC is the HeartMate II left ventricular assist system. This advisory shall provide guidance to the EMS provider when encountering a patient with such device regardless of whether the emergency is due to the device or not.

An LVAD/LVAS is a surgically implanted, battery-powered pump that helps the left ventricle pump adequate amounts of blood to the body. The LVAD/LVAS is implanted in the upper abdomen and connected to a power supply located outside the body. Blood is sent through a tube in the left ventricle into the LVAD/LVAS, which pumps the blood through another tube into the aorta and throughout the body. An LVAD/LVAS can be implanted in people who are candidates for a heart transplant as a "bridge to transplant." Some patients may experience improved heart function while the LVAD/LVAS is in place, which may make the transplant unnecessary. In patients who are ineligible for a heart transplant, the LVAD can be a "destination therapy," that is, the LVAD/LVAS is implanted permanently.

A patient may request emergency medical services for a problem that may or may not be related to the device, or cardiac in nature. The patient and family are likely to be very well trained in responding to emergencies related to the device. Defer to the expertise of the patient and family when possible. This material is not a substitute for additional education from appropriately trained individuals.

Warnings and Precautions:

- Patient will not have a palpable pulse or measurable blood pressure even when the pump is providing adequate circulation.
- An LVAD/LVAS patient's ECG heart rate will differ from the pulse rate since the LVAD/LVAS is not synchronized with the native heart rate.
- LVAD/LVAS patients should be assessed for signs of circulation as an indication of adequate perfusion (capillary refill, skin color, warmth).
- Check with family for DNR or MOLST instructions.
- The use of automated blood pressure monitoring devices may not yield accurate data. Manual auscultation with a Doppler (if available) to assess blood pressure is recommended.
- Keep the Power Module (PM)/Power Base Unit (PBU) away from water. If the PM/PBU comes in contact with water, the pump may stop, or the patient may receive a serious electrical shock.
- Connect the device to a properly tested, grounded and dedicated AC outlet when necessary. Do not use an adapter for an ungrounded wall outlet or power strip.
- Do not connect to an outlet controlled by a wall switch.

Continued.

APPENDIX XIV

LEFT VENTRICULAR ASSIST DEVICE (LVAD) – Page 2.

Warnings and Precautions – continued:

- In the event that the LVAD/LVAS stops operating, attempt to restore pump function immediately. In the event that the LVAD/LVAS stops operating and blood is stagnant in the pump for more than a few minutes, there is risk for stroke or thromboembolism.
- Disconnecting both System Controller power leads at the same time will result in a loss of pump function. One System Controller power lead must be connected to a power source at all times.
- Disconnecting the percutaneous (skin) lead from the Controller System will result in loss of pump function. The System controller must be reconnected as quickly as possible to resume pump function.
- Do not force connections. You can break a pin which will interfere with proper functioning of the device.
- At least one set of fully-charged spare batteries and back System Controller should remain with the patient at all times.
- Do not disconnect controller from patient unless instructed by Medical Control.
- For patients with LVAD/LVAS requiring CPAP by protocol, understand this is a relative contraindication. Our regional center does not believe this is a contra-indication, caution should be observed and Medical Control should be contacted.

Handling Emergencies related to the LVAD/LVAS:

An emergency condition exists whenever the device is potentially or actually unable to pump an adequate amount of blood. These conditions are signified by a HAZARD ALARM symbol and CONTINUOUS AUDIO TONE. Always defer to the patient and family if the System Controller needs to be replaced or any other emergency involving the device. Contact Medical Control if family or patient is unable to assist.

There is no back up pump. In the event that LVAD/LVAS stops operating, all attempts must be made to restore function immediately by:

- Checking the percutaneous lead connection to the System Controller;
- Switch power source, and/or
- Replacing the System Controller.

Continued.

APPENDIX XIV

LEFT VENTRICULAR ASSIST DEVICE (LVAD) – Page 3.

Emergency Scenarios

- A. **LVAD/LVAS Failure – Continuous Alarm (Red Heart) – LVAD/LVAS may have stopped:**
- The patient's own heart is intact and may provide minimal cardiac output while the LVAD/LVAS is stopped.
 - **ALS providers should place the patient on a cardiac monitor and fully assess the patient. Medical Control should be contacted for treatment orders and to assist with a destination decision.**
 - **BLS providers should request an ALS intercept, transport should not be delayed. Medical Control should be contacted for destination decision.**
- B. **LVAD/LVAS Working – “Low Flow Hazard” alarm - ECG Abnormal**
- The HeartMate II LVAD is dependent on right ventricular function. With an arrhythmia a decreased functioning right ventricle will affect LVAD /LVAS flows. The LVAD/LVAS may be able to maintain flow high enough to keep patient from going into shock.
 - **ALS providers should place the patient on a cardiac monitor and treat the underlying rhythm. Medical Control should be contacted for additional treatment orders and to assist with a destination decision.**
 - **BLS providers should request an ALS intercept, transport should not be delayed. Medical Control should be contacted for destination decision.**
- C. **LVAD /LVAS Working - “Low Flow Hazard” alarm - ECG Normal**
- Suspect internal bleeding (hypovolemia).
 - **ALS providers should initiate care for hypovolemia and contact Medical Control for additional orders for volume replacement and for destination decision.**
 - **BLS providers should request an ALS intercept, transport should not be delayed. Medical Control should be contacted for destination decision.**

BLS APPROACH: If the patient is unconscious and a pulse and respirations cannot be detected, the BLS provider **should not initiate chest compressions.** The AED should be applied and be allowed to analyze the underlying rhythm. If a shock is indicated the provider should defibrillate. The provider must contact Medical Control for further instructions.

ALS APPROACH: If the patient is unconscious and a pulse and respirations cannot be detected, the ALS provider **should not initiate chest compressions.** The cardiac monitor should be applied and the underlying rhythm analyzed. If a shock is indicated the provider should defibrillate. The provider must contact Medical Control for further instructions.

Continued.

APPENDIX XIV

LEFT VENTRICULAR ASSIST DEVICE (LVAD) – Page 4.

Emergencies unrelated to the LVAD/LVAS:

An emergency condition unrelated to the LVAD/LVAS should be handled according to the currently accepted protocol to manage that situation. However, all precautions and warnings will be followed.

Transport Decision:

When an emergency condition exists, unless the patient is in extremis, the patient should be transported to Stony Brook University Hospital (LVAD Center) if it is no more than 20 minutes past the closest hospital. Medical Control may be contacted for assistance with a transportation destination decision.

APPENDIX XV

STANDARD PATIENT PRESENTATION FORMAT FOR COMMUNICATING WITH MEDICAL CONTROL

Clear and concise verbal communication is necessary for the coordinated relay of pertinent patient information and appropriate medical orders. A standard presentation format greatly enhances the EMTs ability to quickly and effectively communicate essential information to Medical Control personnel, minimizes the chance for error, streamlines the patient care process, and reduces the amount of time that an EMT needs to spend on this function.

As a rule, the following standard presentation format should be used during routine communications with Medical Control. However, the presentation format may be adjusted based on the nature and severity of the case.

- UNIT ID / TECHNICIAN NAME / LEVEL OF CERTIFICATION
- AGE
- SEX
- CHIEF COMPLAINT
 - History of the present illness
 - Aggravating/Alleviating factors
- INITIAL VITAL SIGNS
 - Mental Status
 - Blood Pressure
 - Pulse Rate and Quality
 - Respiratory Rate, Quality and Effort
 - Lung Sounds
 - Skin Color, Condition and Temperature
 - Pupils
 - Physical Examination (including pertinent negatives)
- PAST MEDICAL HISTORY
- MEDICATIONS
- ALLERGIES
- TREATMENTS SO FAR / REPEAT VITAL SIGNS / RESPONSE TO THOSE TREATMENTS
- RECEIVING HOSPITAL AND ETA

Remember the simple **SOAPIE** formula in your approach to examining AND presenting your patient:

Subjective Interview – the patients words and description +

Objective Examination – your physical assessment +

Assessment – your prehospital impression or presumptive diagnosis (including differentials) =

Plan – your treatment(s) under standing orders or requested/ordered treatment(s)

Interventions – what's been done by patient and/or technician

APPENDIX XVI

CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP)

This skill requires separate training and credentialing for credentialed and authorized EMTs.

Indication:

Adult patients greater than or equal to (\geq) age 18 who presents with respiratory distress secondary to cardiogenic/non-cardiogenic pulmonary edema, or exacerbation of COPD AND the systolic blood pressure (BP) is greater than or equal to (\geq) 120 mmHg.

Inclusion Criteria:

- Be at least 18 years of age;
- Be alert and orientated, and able to make an informed decision;
- Be able to maintain an open and patent airway on their own;
- Have a blood pressure of at least (\geq) 120 mmHg systolic; and
- Present with moderate to severe respiratory distress accompanied with the signs and symptoms of cardiogenic or non-cardiogenic pulmonary edema or COPD.

Exclusion Criteria:

- Less than 18 years of age;
- Systolic blood pressure less than ($<$) 120 mmHg;
- Need for immediate endotracheal intubation or other methods of airway control;
- Depressed level of consciousness;
- Patients who are unable to control their own airway;
- Major Trauma, facial burns, impending respiratory or cardiac arrest;
- Uncooperative patient;
- Pregnancy;
- Pneumothorax, anaphylaxis, pulmonary embolism, or aspiration;
- Bronchospasm or wheezing, unless cardiac asthma is suspected;
- Active vomiting; or
- Less than or equal to (\leq) two (2) months status post gastric by-pass surgery.

Cautions:

CPAP is to be immediately discontinued if:

- An immediate need for advanced airway control arises;
- The patient cannot tolerate the mask for any reason; or
- Systolic BP drops to less than ($<$) 120 mmHg.

APPENDIX XVII

“NO PATIENT FOUND” POLICY

PURPOSE:

The purpose of this policy is to assist EMS personnel with clear guidance for managing situations when an individual for whom an EMS provider has been dispatched to, responds and encounters an individual, who then denies injury/illness and has no apparent injury/illness when assessed by the EMS provider. The addition of the term “Patient Encounter” refers to visual contact with an individual during an EMS response, and the term “No Patient Found” replaces the term “Unfounded,” thereby eliminating confusion.

POLICY:

1. A “Patient” is any person who is injured or ill or in need of treatment by medical personnel. This includes any person that has activated the EMS system OR for whom the EMS system has been activated for an ambulance response, OR any person that presents themselves to EMS personnel with a medically related complaint such that it could be reasonably inferred that the person is seeking or in need of medical attention. Appropriate paperwork will be completed, including a Prehospital Care Report (PCR), or electronic equivalent.
2. A “No Patient Found” is for use in the following situations:
 - No physical person found on EMS arrival after an adequate investigation of the surrounding area; or
 - Unintentional/accidental activation of an emergency medical alert system; or
 - After an adequate investigation it is reasonably certain that the person or persons on scene did not request an ambulance, in addition to those persons:
 - Denying any injury/illness complaints;
 - Not appearing to have an actual or potential injury/illness;
 - Capable of making competent decisions regarding refusal of care;
 - No mechanism of injury is present; and
 - EMS personnel on scene ascertain this information having not performed anything other than a visual assessment.
 - After following the criteria of “No Patient Found” the highest ranking EMT on scene must thoroughly document the circumstances of the alarm on the PCR. The PCR may be completed with a disposition code of 009 “No Patient Found.”
3. Any individual who is given any level of assessment or examination beyond a visual observation, such as a physical assessment/examination, vital signs, treatment or any diagnostic assessment constitutes patient care and the individual is considered a “Patient” requiring appropriate disposition.
4. Anytime the EMS provider on-scene feels that an individual has actual OR potential for an injury/illness, the individual becomes a “Patient” and the EMS provider must follow appropriate patient treatment protocol/RMA policy.
5. Lift assist is a situation that has a high potential for injury, both from the fall and from the conditions that may have precipitated the fall. An individual requiring a lift assist is considered a “Patient” and the EMS provider must follow appropriate patient treatment protocol/RMA policy.

APPENDIX XVIII

RECEIVING HOSPITALS

NY State DOH Policy requires transport to the closest appropriate hospital, based on services available and patient needs. While it is not required, it is allowable for agencies on the western-most border to transport to appropriately designated hospitals in Nassau County.

DESIGNATED 911 RECEIVING HOSPITALS

Brookhaven Memorial Hospital Medical Center
Eastern Long Island Hospital
Good Samaritan Hospital Medical Center
Huntington Hospital
John T. Mather Memorial Hospital
Peconic Bay Medical Center
Southampton Hospital
Southside Hospital
St. Catherine of Siena Hospital
St. Charles Hospital
University Medical Center Stony Brook

**Northport VA Hospital is not a regionally designated emergency receiving hospital. NVA Hospital acknowledges that hospital care has become more specialized, and neighboring hospitals have received specialty designations, and concurrently, veteran patients are increasing in numbers and medical complexities. Therefore, veteran patients who are classified by the applicable Emergency Medical Dispatch (EMD) Determinant Code, and/or present with signs/symptoms and/or chief complaint indicative of ischemic chest pain/STEMI, CVA/TIA, trauma, burns, and obstetrical/gynecological emergencies should not be transported to the NVAH hospital. Similarly, pediatric patients should not be transported to the NVAH. Patients not fitting these EMD Determinant Codes, or with signs/symptoms unrelated to these presenting problems for which there are more appropriate hospitals, may be transferred by ambulance to the NVAH. As a reminder, the NVAH does have 800 MHz radio capabilities and pre-arrival notification of inbound patients' should be made on the "Hospital North" talk group.

TRAUMA CENTERS

University Medical Center Stony Brook	Level I including pediatric capabilities
Brookhaven Memorial Hospital Medical Center	Level II
Good Samaritan Hospital Medical Center	Level II including pediatric capabilities
Huntington Hospital	Level II
Southside Hospital	Level II ACS

Continued.

APPENDIX XVIII

RECEIVING HOSPITALS – Page 2.

REGIONAL BURN CENTER

University Medical Center Stony Brook

PCI / STEMI CENTERS

Good Samaritan Hospital Medical Center

Huntington Hospital

Southside Hospital

St. Catherine of Siena Hospital

University Medical Center Stony Brook

DESIGNATED STROKE CENTERS

Brookhaven Memorial Hospital Medical Center

Good Samaritan Hospital Medical Center

Huntington Hospital

Peconic Bay Medical Center

John T. Mather Memorial Hospital

Southampton Hospital

Southside Hospital

St. Catherine of Siena Hospital

St. Charles Hospital

University Medical Center Stony Brook

HOSPITALS WITH NO OB/GYN SERVICES

Brookhaven Memorial Hospital Medical Center

Eastern Long Island

John T. Mather Hospital

HOSPITALS WITH SANE CENTER AFFILIATIONS

Good Samaritan Hospital Medical Center

Peconic Bay Medical Center

University Medical Center Stony Brook

APPENDIX XIX

EMS RESPONSE TO SCHOOL INCIDENTS AND SCHOOL BUS ACCIDENTS

The purpose of this policy statement is to provide guidance to EMS providers on their responsibilities, and the responsibilities of school district personnel during responses to school incidents and school bus accidents involving minors.

The potential number of patients, the frequent presence of uninjured children who do not require hospitalization, the jurisdiction of the school district and the responsibilities of EMS providers often raise conflicting issues of jurisdiction, consent, treatment, and transportation. The roles and responsibilities of the school district and the EMS agency must be identified in advance of any incident, by jointly developing operations plans so that a common understanding of their respective expectations and responsibilities are well defined.

EMS personnel are there to see to the physical well-being of those who may be injured or potentially injured, render appropriate emergency medical care as dictated by mechanism of illness/injury, operational policy and clinical protocol, and to remove patients from the scene to a hospital as quickly and efficiently as possible.

The New York State Education Law §912 places legal guardianship of the children involved on the school board/school district, including for the health and welfare of all children and the administration of emergency medical evaluation and care for all ill or injured pupils while in their charge. During the transportation phase, the transportation company acts as an agent of the school district during transportation and the bus driver in turn is able to make legal decisions for the children until the arrival of school board/school district/bus company representatives. In Decision 10,587 (1981), the New York State Education Commissioner ruled that the responsibility for the student's safety shifts from the parent/guardian to the school board/school district/bus company from the point of pick up by the school bus in the morning, to drop off by the school bus in the afternoon.

There is no NY State or Suffolk County EMS policy that states that all children must be taken to the hospital if an ambulance is required at the scene. Proper dispositions include one of the following:

- Transportation to the hospital;
- Refusal of Medical Assistance, per Suffolk County RMA Policy, in the presence of a legal guardian; or
- No Patient Found designation.

Continued.

APPENDIX XIX

EMS RESPONSE TO SCHOOL INCIDENTS AND SCHOOL BUS ACCIDENTS – Page 2.

Complete documentation on a PCR, or electronic equivalent, and Suffolk County RMA Checklist is required for cases where a child is a patient and is transported, or in cases where an RMA is executed.

General Guidelines:

- If a child has a complaint, or if the EMS provider observes an actual or potential physical injury/illness, or where there is a mechanism of injury, the EMS provider is permitted to render patient care and transport consistent with prehospital protocols and procedures under implied consent. If there is any doubt, always advocate for emergency department evaluation.
- EMS Providers are expected to treat school board/school district/bus company representatives as if they were the child's parent/legal guardian. Clearly state any of your findings, assessment, and treatment to them. Clearly articulate your concerns about real or potential illness/injury. If there is any doubt, always advocate for emergency department evaluation.
- If the child presents themselves without an actual or potential physical injury/illness and the EMS provider also feel that there is no actual or potential injury/illness or significant mechanism of injury, the school board/school district/bus company representative can make legal decisions for the child and can sign a Refusal of Medical Assistance (RMA) sheet as if they were the child's parent/legal guardian.
- It is acceptable to use a Prehospital Care Report (PCR), or electronic equivalent, for each child involved in the school incident or bus accident if the EMS provider chooses to do so. It is also acceptable to use a single PCR to document your assessment and actions, list the names of the children involved and obtain a single signature from the school board/school district/bus company representative.
- Accountability and the disposition of each and every child is paramount. Documentation should be shared with school board/school district/bus company representatives to ensure that your records match theirs and all children are accounted for, before the alarm is cleared.
- There are circumstances where some children may be "patients" and received treatment and transportation to a hospital, while others may not. Likewise, there may be circumstances where the occupant(s) of another vehicle are "patients" and the bus, by nature of its unique size and construction protects occupants resulting in "no patients." Accountability and disposition records should include an accounting of which children were transported to the hospital, by name, and by ambulance company, and which children remained at the scene and were turned over to their legal guardian.

Continued.

APPENDIX XIX

EMS RESPONSE TO SCHOOL INCIDENTS AND SCHOOL BUS ACCIDENTS – Page 3.

In cases where parents or other legal guardians arrive at the scene, no child should be released to his/her parent or other legal guardian without proper validation from school board/school district/bus company representatives.

This sample form may be duplicated and used to document response as an addendum to agency reports to document accountability for cases where a PCR and RMA Checklist are not required.

Alarm#: _____ **Date:** _____ **Time:** _____

Fire/EMS Agency: _____

Location of Incident: _____

School District: _____ **School Representative:** _____

Transportation Company: _____

Bus Operator: _____

Police Officer (Name/Badge #): _____

The following children were involved in a school bus incident. They have been triaged and have been found to offer no complaint, no actual or no potential injury/illness and no significant mechanism of injury. School board, school district/bus company representatives have been advised to **CALL 911 IMMEDIATELY** if there is change in any of the children that raises any suspicion of a potential injury. The appropriate School Representative has made the legal decision to assume legal responsibility for the children.

Continued.

APPENDIX XIX

EMS RESPONSE TO SCHOOL INCIDENTS AND SCHOOL BUS ACCIDENTS – Page 4.

1. Print: _____ DOB/AGE _____

2. Print: _____ DOB/AGE _____

3. Print: _____ DOB/AGE _____

4. Print: _____ DOB/AGE _____

5. Print: _____ DOB/AGE _____

6. Print: _____ DOB/AGE _____

7. Print: _____ DOB/AGE _____

8. Print: _____ DOB/AGE _____

9. Print: _____ DOB/AGE _____

APPENDIX XIX

EMS RESPONSE TO SCHOOL INCIDENTS AND SCHOOL BUS ACCIDENTS – Page 5.

School Representative:

Print Name: _____

Signature: _____ Date: _____

Highest Ranking EMS Provider on Scene:

Print Name: _____

Signature: _____ Date: _____

Witness:

Print Name: _____

Signature: _____ Date: _____

APPENDIX XX

TRANSPORTATION OF SERVICE ANIMALS

From time to time, EMS personnel in Suffolk County may encounter situations in which a patient requiring treatment and transportation to a hospital is being assisted by a service animal. Questions may arise about the proper transportation of a patient's service animal in an ambulance. According to the NYS DOH BEMS Policy Statement 07-01, *Service Animals* "in the last several decades, the concept of a service dog has expanded greatly, with dogs helping the hearing-impaired, people who use wheelchairs and those who have many other kinds of physical challenges."

The Americans with Disabilities Act made the rights of people who use service animals the law. The U.S. Department of Justice (DOJ) defines any guide dog, signal dog, or other animal as individually trained to provide assistance to an individual with a disability. If the animal meets this definition, it is considered a service animal under the Americans with Disabilities Act (ADA) regardless of whether it has been licensed or certified by a state or local government. A service animal is **NOT** considered a pet.

New York State Agriculture and Markets Article 7 §108 defines different types of Service Animals, as follows:

- **"Guide dog"** means any dog that is trained to aid a person who is blind and is actually used for such purpose, or any dog owned by a recognized guide dog training center located within the state during the period such dog is being trained or bred for such purpose; and
- **"Service dog"** means any dog that has been or is being individually trained to do work or perform tasks for the benefit of a person with a disability, provided that the dog is, or will be, owned by such person or that person's parent, guardian or other legal representative.

Service animals may include dogs of any breed or size as well as other animals including, but not limited to birds, primates and ponies. The EMS provider may ask the following types of questions when presented with a service animal:

- "Is this a service dog?" or "Does your animal have legal allowances?"
- "Is the service animal required because of a disability?"

The EMS provider may **NOT** ask about the nature or extent of the patient's disability except as it relates to patient care.

When transporting a patient with a service animal, every effort should be made to do so in a safe manner for the patient, the animal and the crew members. **Regardless of the purpose of the animal, if the animal is a potential threat to health or safety of anyone involved in response, the animal may be excluded from transport.** If possible, the animal should be secured in some manner in order to prevent injury to either the animal or the crew during transport. Safe transport devices may include:

- Crates, cages, specialty carriers; or
- Seatbelts or passenger restraints using a specialized harness or seat belt attachments.

In certain situations it may not be possible for the animal to be transported with the patient. In those situations, every effort should be made to ensure safe care and transportation of the animal by alternative means (animal control personnel, police, family members, etc.). EMS should notify the receiving facility of the presence of a service animal accompanying the patient, either in the ambulance, or by alternate transportation.

APPENDIX XXI

MUCOSAL ATOMIZATION DEVICE (MAD) / NASAL ADMINISTRATION DEVICES

Indications:

- For administration of Narcan

Contraindications:

- Epistaxis
- Nasal trauma
- Septal abnormality
- Nasal congestion
- Mucous discharge
- Destruction of nasal mucosa from surgery or past cocaine abuse

Procedure:

1. Inspect nostrils for mucus, blood or other problems that might inhibit absorption
2. Fill syringe with appropriate dose
3. Expel air from syringe
4. Attach the MAD device via luer lock
5. Briskly compress the syringe plunger to deliver half of the medication dose into the nostril.
6. Move the device over to the opposite nostril and administer the remaining medication dose.