NOTICE: THIS IS A RAPIDLY EVOLVING SITUATION.
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UPDATED 03.19.20

PURPOSE

This policy statement addresses emergency medical services (EMS) as related to response to patients with respiratory issues including but not limited to fever, cough and respiratory distress.

SUMMARY:

While some patients can be recognized as meeting FC (fever cough) call-type, not all patients will have visible signs/symptoms for immediate identification and precautions should be taken whenever possible.

APPROPRIATE PPE:

EMS Providers must don proper PPE (N95 respirator, eye-shield or goggles, gloves and gown) while a nebulizer treatment is administered and appropriately disinfect the ambulance after the transport has concluded.

PPE (gloves, gowns, N95 respirator, and eye protection) MUST be donned prior to any procedure with potential for aerosolization. This includes nebulization, intubation procedures and CPAP, particularly when administering nebulized medications. Even when using the alternative devices and procedures below to limit misting into the environment, use of full PPE, including N95 respirator is required.

- This applies to all patients, not just those identified/suspected as FC call type.
- An N95 mask shall never be applied to a patient during a treatment.

NEBULIZED MEDICATIONS:

Effective immediately, ALL patients requiring nebulized medication, inclusive of those identified/suspicious for the FC call-type, should have nebulized medication administered using a delivery device that limits misting into the environment, if available. These devices may be available under the term, breath actuated nebulizers (BAN).
METERED DOSE INHALER:

If mist limiting nebulizers are not available and treatment is indicated, and the patient has a metered dose inhaler, instruct the patient to use the inhaler. If the inhaler is not effective AND the patient status requires medication urgently, provide nebulized medication using available device.

INTUBATION:

When appropriate and in line with local guidance, consider the use of alternative airways in order to decrease the possible risk of exposure.

MEDICAL CONTROL:

EMS Providers should contact Medical Control with any difficult or unclear situations.
NOTICE: THIS IS A RAPIDLY EVOLVING SITUATION. PLEASE CHECK BACK DAILY FOR ANY UPDATES TO THIS POLICY. UPDATED 02.14.2020

Background:

Emergency medical services (EMS) play a vital role in responding to requests for assistance, triaging patients, and providing emergency medical treatment and transport for persons with various illnesses. However, unlike patient care in the controlled environment of a healthcare facility, care and transports by EMS present unique challenges because of the nature of the setting, enclosed space during transport, frequent need for rapid medical decision-making, interventions with limited information, and a varying range of patient acuity and jurisdictional healthcare resources.

This document is designed to provide County Emergency Managers, County EMS Coordinators, and Public Safety Answering Points (PSAPs) with interim guidance regarding the outbreak of 2019 Novel Coronavirus (COVID-19) that began in Wuhan City, Hubei Province, China in December 2019.

This guidance does not constitute a response protocol but serves as a reference for general considerations and the protection of responders.

For questions regarding information in this advisory or information you’ve received about this outbreak from other sources, please contact the Bureau of Emergency Medical Services and Trauma Systems. For updates and additional information regarding this COVID-19 outbreak, please visit the following web pages:

- New York State Department of Health (DOH), 2019 Novel Coronavirus site at: https://www.health.ny.gov/diseases/communicable/coronavirus/

Regional Approach

Many regions may find it appropriate to develop a regional approach for emergency medical response and inter-facility transportation to meet local needs, maximize the efficacy of locally available resources and ensure the safety of EMS providers in response to a Person Under Investigation (PUI) or confirmed case of COVID-19. For the purpose of this document, the term “region” may include New York State EMS regions, counties, multiple counties, or multiple municipalities.

Policy 20-03 - COVID-19 County Emergency Managers, County EMS Coordinators, and PSAP Guidance (V1.0)
If a region chooses to develop a regional approach, depending upon the resources and needs of the region, one or more lead agency must be identified and asked to staff or otherwise operationally support a regional team. This process should include support from all EMS agencies and medical directors in the region. County EMS Coordinators should provide any regional response plan to the Bureau of EMS for review.

The core mission of any regional approach developed should be:

1) To protect the health and safety of our EMS providers.

2) To provide PUIs, or patients with diagnosed COVID-19, with appropriate care while limiting the possibility of further contagion.

The development of a regional approach should be a collaborative process involving all local stakeholders and, at a minimum, should include:

| Regional EMS Advisory Committees (REMACs) | County EMS Coordinators |
| Regional EMS Councils (REMSCOs) | County Fire Coordinators |
| Regional Program Agencies | Local EMS Agencies |
| Agency Medical Directors | Local Public Safety Answering Points (PSAPs) |
| Regional and Local Hospitals | Local Health Departments (LHDs) |
| State / County / Local law enforcement |

**Coordination with Local Health Departments (LHDs):**

County Emergency Managers, County EMS Coordinators, and LHDs are encouraged to develop local policies and procedures for coordination between first responders and LHDs. When developing local policies and procedures, the following should be considered:

1) Local guidance for first responders encountering a patient who is ill and who may have risk factors for exposure to COVID-19 and who has not been previously identified as a PUI.

2) Procedures for first responders to contact emergency management officials and/or LHDs for consultation and coordination when encountering a patient who is ill and who may have risk factors for exposure to COVID-19 and who has not previously been identified as a PUI. This should include after-hours, weekend, and holiday contact information.

3) LHD reporting requirements and procedures for EMS agencies regarding monitoring of health care personnel with potential exposure in a health care setting to patients with COVID-19.

**9-1-1 Public Safety Answering Points (PSAPs):**

PSAPs or Emergency Medical Dispatch (EMD) centers (as appropriate) should question callers and determine the possibility that this call concerns a person who may have signs or symptoms and risk factors associated with the COVID-19. PSAPs should establish policies and procedures for the management of these calls. In developing policies and procedures, PSAPs should consider the following:

1) The query process should never supersede the provision of pre-arrival instructions to the caller when immediate life-saving interventions (e.g., CPR or the Heimlich maneuver) are indicated.

2) Patients who meet the appropriate criteria should be evaluated and transported as a PUI.

Information on COVID-19 will be updated as the public health response proceeds.

**Policy 20-03 - COVID-19 County Emergency Managers, County EMS Coordinators, and PSAP Guidance (V1.0)**
3) Information on a possible PUI should be communicated immediately to EMS clinicians before arrival on scene in order to allow use of appropriate personal protective equipment (PPE) and to limit non-essential responders from having close contact with a PUI.

4) PSAPs should utilize medical dispatch procedures that are coordinated with their EMS medical director and with the local or state public health department.

5) PSAPs and EMS units that respond to ill travelers at US international airports or other ports of entry to the United States (maritime ports or border crossings) should be in contact with the CDC quarantine station of jurisdiction for the port of entry for planning guidance. They should notify the quarantine station when responding to that location if a communicable disease is suspected in a traveler.


**Personal Protective Equipment (PPE) Supply Shortage**

Shortages of PPE supplies may occur. The Department asks all EMS agencies to compare their existing inventories of PPE, such as face shields, gowns, gloves, masks, N95 respirators, against the expected rate of use of these items under a surge situation, to determine the quantities needed to be on hand. EMS agencies that identify a shortage of PPE, should use existing plans and vendor agreements to procure additional assets, by taking the following steps:

1) Use existing vendor agreements and procurement plans to place orders for quantities needed by type and size of PPE.

2) Notify County Office of Emergency Management (OEM) when all existing agreements are exhausted and supply needs exceed those available from these sources.

3) Coordinate with County OEM to identify and utilize other existing county resources.

4) Notify the respective DOH Regional Office of ongoing need.

5) If all local resources have been exhausted, submit a request, via your County OEM, to the NYS OEM. The request should include as much detail as available, but include at a minimum the following elements:
   a) Type and Quantity of PPE by size
   b) Point of Contact at the requesting facility or system
   c) Delivery location
   d) Date request is needed to be filled by
   e) Record of pending orders

6) Upon receipt of a request submitted to NYS OEM, the Department will be notified and will use the information provided to validate the request and its ability to meet the identified need. EMS agencies should expect that the identified Point of Contact listed in the request will be contacted by the Department for clarification and coordination. Please note that in order to assure adequate time to process and fill a request (as resources are available), a request should be submitted via your County OEM no later than 10 days before an item is out of stock at the requesting EMS agency.

**Policy 20-03 - COVID-19 County Emergency Managers, County EMS Coordinators, and PSAP Guidance (V1.0)**
7) It is critical the EMS agency work in advance to prepare for anticipated shortages and to proactively work with all available sources of critical resources. It is also critical that EMS agencies put controls in place to safeguard these resources and monitor their usage.

**Expanding EMS System Capacity During Medical Surge:**

County Emergency Managers, County EMS Coordinators, and community planners should evaluate the role of EMS in medical surge planning and examine the need to supplement existing guidance on integrating EMS into community preparedness plans. Plans should address the partnerships, resources, and planning needed to implement four strategies for expanding EMS system capacity during an emergency resulting in medical surge:

1) Tiered Dispatch: Strategies to preserve EMS resources, including caller screening to determine acuity and referral of non-life-threatening calls.

2) Modified Treatment and Transport Strategies: Strategies to modify routine treatment and transport protocols to allow EMS personnel to assess, treat, release, and refer patients without transport and, when needed, to transport patients away from a hospital.

3) Coordinated Transport to Alternate Destinations: Strategies to transport patients to facilities that do not traditionally receive 9-1-1 patients (e.g., clinics, urgent care, surgery centers, and alternate care sites) by establishing surge protocols.

4) Support for Rapid Implementation of Patient Interventions: Strategies to allow EMS personnel to assist larger community and public health response efforts by delivering vaccines, pharmaceuticals, non-pharmaceuticals, and personal protective equipment (PPE) to both patients and caregivers at home.

County EMS Coordinators and community planners are encouraged to review the CDC Framework for Expanding EMS System Capacity During Medical Surge tool for community planners to help explore the role of EMS in medical surge planning and to examine the need to supplement existing guidance on integrating EMS into community preparedness plans. The CDC tool can be found at: https://www.cdc.gov/cpr/readiness/healthcare/Expanding-EMS-Systems.htm.

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Purpose:

This document is designed to provide Emergency Medical Services (EMS) practitioners, agencies and systems with interim guidance regarding the outbreak of 2019 Novel Coronavirus (2019-nCoV) that began in Wuhan City, Hubei Province, China on December 2019.

This guidance should be considered for the development of response plans and is not intended to supersede any infectious disease response plan that has been developed and approved by local, State or Federal authorities legally charged to do so. This guidance does not constitute a response protocol but serves as a reference for general considerations and the protection of responders.

EMS agencies are encouraged to adopt policies and procedures regarding response and treatment of all patients with communicable diseases. EMS agencies should assure that all personnel are provided with information regarding the outbreak of 2019-nCoV and any necessary personal protective equipment (PPE), such as N95 respirators, including guidelines for the use of such PPE.

For updates and additional information regarding this 2019-nCoV outbreak, please visit the following web pages:


For questions regarding information in this advisory or information you've received about this outbreak from other sources, please contact the Bureau of Emergency Medical Services and Trauma Systems.

Epidemiology:

This is a rapidly evolving situation. EMS practitioners, agencies and systems should visit the CDC website for the most up to date information at https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html.

Assessment & Screening:

The CDC clinical criteria for a 2019-nCoV Patient Under Investigation (PUI) have been developed based on what is known about the MERS-CoV and the SARS-CoV and are subject to change as additional information becomes available. EMS practitioners, agencies and systems should visit the Policy 20-02 2019-nCoV “Wuhan Coronavirus” (v2.0)
Infection Control:

To expedite public health containment strategies, EMS providers should implement appropriate infection control measures, including airborne precautions when 2019-nCoV is suspected.

- EMS providers should institute Standard, Contact, Airborne Precautions, and eye protection including the use of an N95 respirator and goggles or face shield.
- 2019-nCoV PUIs should don a surgical mask and, when transporting a patient through the hospital or other common areas, the patient should remain masked. Transport through the hospital should be minimized.
- The receiving facility must be notified prior to arrival so that appropriate infection prevention and control precautions can be implemented, as the preferred placement for patients being evaluated for 2019-nCoV is in an airborne infection isolation room (AIIR).

Personal Protective Equipment (PPE):

PPE carried by EMS agencies shall be utilized to provide protection from a patient suspected to have 2019-nCoV. EMS practitioners should use PPE appropriately, and for all interactions involving contact with the patient or the patient’s environment. EMS practitioners should don PPE prior to patient contact and properly discard PPE immediately after patient contact to contain pathogens.

In addition to these considerations, EMS providers are required to follow their local infectious disease emergency response plan. The following PPE is recommended for use by EMS when treating a patient with suspected 2019-nCoV infection:

- Standard Precautions;
- Contact Precautions, including gown and gloves;
- Eye protection (goggles or face shield);
- Disposable NIOSH-approved, fit-tested N95 respirator;
  - EMS agencies may use PAPRs with full hood and high efficiency particulate air (HEPA) filter for Airborne Precautions for employees that cannot safely fit test on N95 respirators due to facial hair, facial structure, etc.
- Provide a surgical mask (N95 is not recommended) for all suspected 2019-nCoV patients;
  - Patients who are intubated should be ventilated with a bag-valve device or ventilator equipped with a HEPA filter on exhalation port
- Provide tissues to patients for secretion control and encourage patient hand hygiene and cough etiquette practices.


Transport Considerations:

- Standard transportation to appropriate hospital receiving facility.
- It is recommended to have the patient compartment exhaust vent on high and to isolate the driver compartment from the patient compartment. It is also recommended to have the driver compartment ventilation fan set to high without recirculation.
- If driver/pilot compartment is not isolated from the patient compartment, the vehicle operator should don a NIOSH-approved, fit-tested N95 respirator or a PAPR.
- The receiving facility must be notified prior to arrival so that appropriate infection prevention and control precautions can be implemented.

Policy 20-02 2019-nCoV “Wuhan Coronavirus” (v2.0)
• When providing hospital notification, please indicate if any family or support persons are accompanying the patient, as they too may need to be isolated. EMS agencies should have a plan for family members wishing to accompany the patient that prevents crew exposures.

EMS personnel must notify the receiving hospital before arrival if they are transporting a patient with suspected 2019-nCoV, to their facility.

Agency officers should speak with hospital personnel in advance to discuss what procedures are in place for accepting such patients. Hospitals may request EMS personnel deliver such patient(s) through a separate secure entrance.

A hospital may not refuse patients with suspected coronavirus infection unless a municipal response plan designed to do so has been activated.

Decontamination Considerations:

At this time, routine disinfection procedures for rooms, equipment and ambulances are recommended. Any waste generated is not considered Category A waste. Use disposable or dedicated patient-care equipment (e.g., blood pressure cuffs). If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient according to the equipment and disinfectant manufacturers’ instructions for use.

• Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients. Don clean PPE to handle the patient at the transport location.
• Any visibly soiled surface must first be decontaminated using an Environmental Protection Agency (EPA)-registered hospital disinfectant according to directions on the label.
• Disinfect all potentially contaminated/high touch surfaces including the stretcher with an EPA-registered hospital disinfectant according to directions on the label. More information about disinfectants can be found on CDC’s infection control web page: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html.
• Medical equipment (stethoscope, blood pressure (BP) cuff, etc.) making patient contact should be disposable or cleaned and disinfected before use on another patient according to the equipment and disinfectant manufacturers’ instructions for use.
• It is not known how long 2019-nCoV remains infectious in the air. Therefore, the current recommendation is to use a time period consistent with airborne pathogens such as measles or tuberculosis. This means that the ambulance used to transport a patient with suspected 2019-nCoV infection should not be used for a period of two (2) hours after the patient exits the vehicle. Additional factors may be considered in the development of decontamination policies and procedures to reduce vehicle downtime. EMS agencies are encouraged to consult with the ambulance manufacturer to determine the vehicle’s passenger compartment air changes per hour (ACH) for 99.9% removal of airborne contaminants to establish a safe time period for reintroduction of the vehicle less than the 2-hour recommendation.¹

If an EMS agency is using less than 2-hour recommendation after speaking with the ambulance manufacturer, documentation from the ambulance manufacturer and the agency policy and procedure should be maintained on file.

¹ Table B1 “Air changes/hour (ACH) and time required for airborne-contaminant removal by efficiency” from the 2003 Guidelines for Environmental Infection Control in Health-Care Facilities (https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1)
This document is designed to provide guidance to Emergency Medical Services (EMS) providers, agencies and systems responding to a patient with suspected measles. This guidance should be considered for the development of measles response plans and is not intended to supersede any infectious disease response plan that has been developed and approved by local, State or Federal authorities legally charged to do so. This guidance does not constitute a response protocol but serves as a reference for general considerations and the protection of responders.

EMS agencies are encouraged to adopt policies and procedures regarding response and treatment of all patients with communicable diseases. EMS agencies should assure that all personnel are provided with factual information regarding the measles virus and any necessary personal protective equipment (PPE), such as N95 respirators, including guidelines for the use of such PPE.

**Measles Epidemiology**

Measles can be severe and is highly contagious; following exposure, up to 90% of susceptible persons develop measles. The virus is transmitted by direct contact with infectious droplets or by airborne spread when an infected person breathes, coughs, or sneezes.

Measles virus can remain infectious in the air for up to 2 hours after an infected person leaves the ambulance, room, or area. The time from exposure to the onset of a rash averages 14 days with a range of 7 to 21 days. Persons with measles are infectious from 4 days before the onset of rash to 4 days after rash onset.

**Clinical Features**

Symptoms of measles include a prodrome of:
- Fever (up to 101-105 degrees F)
- Runny nose (coryza)
- Cough
- Red, watery eyes (conjunctivitis)
- Koplik Spots (blue-white spots on the bright red background of the buccal mucosa may be present, often before the rash develops, but are often not seen and are not required for the diagnosis of measles)
A red, blotchy rash presents 3-7 days after the prodrome begins and lasts 4-7 days. It usually starts on the face and proceeds down the body to involve the extremities last and may include the palms and soles. The rash is usually discrete but may become confluent on the upper body; it resolves in the same order that it appeared.

Anyone with measles can have serious complications but those under 5 years old and those older than 20 are at greatest risk, along with pregnant women and any immunocompromised individuals. Complications may include: ear infections; diarrhea; pneumonia; encephalitis; pre-term labor; deafness; or death.

**EMS personnel**
EMS providers are at increased risk of exposure to measles and there is increased risk for transmission from EMS personnel to high risk individuals. It is recommended that all agencies have documented evidence of immunity against measles on file for all First responders, including EMS personnel, to protect personnel and prevent any potential spread to other susceptible patients.

Presumptive evidence of measles immunity for healthcare providers includes any of the following:

- Written documentation of vaccination with 2 doses of live measles or MMR vaccine administered at least 28 days apart\(^1\)
- Laboratory evidence of immunity
- Laboratory confirmation of disease, or
- Birth before 1957\(^2\)

For healthcare personnel who have had two documented doses of MMR vaccine, serologic testing for immunity is not recommended. In the event that a HCP who has two documented doses of MMR vaccine is tested serologically and determined to have negative or equivocal measles titer results, it is not recommended that the person receive an additional dose of MMR vaccine. Such persons should be considered to have presumptive evidence of measles immunity. Documented age-appropriate vaccination supersedes the results of subsequent serologic testing.

**Assessment & Screening**
EMS providers should suspect measles in clinically compatible cases, especially those individuals who reside in or have spent time in the geographic areas experiencing measles outbreaks, have recently traveled internationally, or who were exposed to a person with febrile

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\(^1\)The first dose of measles-containing vaccine should be administered on or after the first birthday; a second dose should be administered no earlier than 28 days after the first dose.

\(^2\)For healthcare personnel born before 1957 who lack other evidence of immunity, consider administering two doses of MMR outside of the outbreak areas. Whereas, for healthcare personnel born before 1957 who are in outbreak areas or caring for persons from outbreak areas, recommend two documented doses of MMR. Alternatively, assess serologic testing for evidence of immunity.
rash illness. This is particularly important in those who report that they are not fully vaccinated. It is important to remember that individuals who were exposed and not immune to measles could develop signs and symptoms of measles 7-21 days after the initial exposure. To identify areas where measles outbreaks may be occurring, please visit the local health department webpage where the patient resides or regularly spends time.

- Only those with known immunity should approach patients who are suspected to have measles.
- Evaluate relevant information from dispatch for clinical indicators consistent with measles.
- Consider restricting entry of unnecessary EMS personnel to the scene and ambulance if no life-threatening symptoms are present in order to decrease first responder exposure.
- Conduct a “doorway evaluation” if possible. If stable and verbal, minimize contact with the patient until appropriate PPE is donned.
- The level of PPE required should be based on the patient’s history, along with any signs and symptoms. Change to standard precautions if there is no suspicion of measles.
- Perform hand hygiene before and after all patient care activities.

Infection Control

To expedite public health containment strategies, EMS providers should implement appropriate infection control measures, including airborne precautions when measles is suspected.

Providers should remain vigilant for persons presenting with febrile rash illness particularly among people who reside in or have spent time in geographic areas experiencing measles outbreaks, have recently traveled internationally, or who were exposed to a person with febrile rash illness.

- Measles is spread via airborne transmission and direct contact with infectious droplets.
- EMS providers should institute standard and airborne precautions using an N95 respirator.³
- Patients presenting with febrile rash illness should immediately be placed in a surgical mask and, when transporting a patient through the hospital or other common areas, the patient should remain masked. Transport through the hospital should be minimized.
- The receiving facility must be notified prior to arrival so that appropriate infection control precautions can be implemented, as the preferred placement for patients who require airborne precautions is in a single-patient airborne infection isolation room (AIIR).

Personal Protective Equipment

PPE carried by EMS agencies shall be utilized to provide protection from a suspected measles patient. In addition to these considerations, EMS providers are required to follow their local infectious disease emergency response plan. The following PPE is recommended for use by EMS when treating a patient with suspected measles infection:

³ Regardless of presumptive immunity status, all healthcare staff should use respiratory protection consistent with airborne infection control precautions (use of an N95 respirator or a respirator with similar effectiveness in preventing airborne transmission). Because of the possibility, albeit low, of MMR vaccine failure in healthcare providers exposed to infected patients, they should all observe airborne precautions in caring for patients with measles.
• Standard Precautions and
• Disposable NIOSH-approved, fit-tested N95 respirator.
  o EMS agencies may use powered air purifying respirators (PAPRs) with full hood
    and high efficiency particulate air (HEPA) filter for airborne precautions for
    employees that cannot safely fit test on N95 respirators due to facial hair, facial
    structure, etc.
• Provide a surgical mask (N95 is not recommended) for all patients with febrile rash
  illness.
  o Patients who are intubated should be ventilated with a bag-valve device or
    ventilator equipped with a HEPA filter on exhalation port
• Provide tissues to patients for secretion control and encourage patient hand hygiene
  and cough etiquette practices.

Transport Considerations

• Standard transportation to appropriate hospital receiving facility.
• It is recommended to have the patient compartment exhaust vent on high and to isolate
  the driver compartment from the patient compartment. It is also recommended to have
  the driver compartment ventilation fan set to high without recirculation.
• If driver/pilot compartment is not isolated from the patient compartment, the vehicle
  operator should don a NIOSH-approved, fit-tested N95 respirator.
• The receiving facility must be notified prior to arrival so that appropriate infection control
  precautions can be implemented.
• When providing notification, please indicate if any family or supports are accompanying
  the patient, as they too may need to be isolated. EMS agencies should have a plan for
  family members wishing to accompany the patient that prevents crew exposures.
• Complete the Measles Contact Form for any suspected measles-related ambulance
  transport and fax to NYS DOH EMS.

EMS personnel must notify the receiving hospital before arrival if they are transporting a patient
with fever and a rash, to their facility.

Agency officers should speak with hospital personnel in advance to discuss what procedures
are in place for accepting such patients. Hospitals may request EMS personnel deliver such
patient(s) through a separate secure entrance.

A hospital may not refuse patients with suspected measles infection unless a municipal
response plan designed to do so has been activated.

Decontamination Considerations

• Any visibly soiled surface must first be decontaminated using an Environmental
  Protection Agency (EPA)-registered hospital disinfectant according to directions on the
  label.
• Disinfect all potentially contaminated/high touch surfaces including the stretcher with an
  EPA-registered hospital disinfectant according to directions on the label.
• Medical equipment (stethoscope, blood pressure (BP) cuff, etc.) making patient contact
  should be disposable or cleaned and disinfected before use on another patient.
• Consideration should be given, when feasible, to place the transporting vehicle out of service for that period to protect EMS personnel and subsequent patients.
• Measles has been reported to survive in the air for up to two hours, therefore, the ambulance used to transport a patient with suspected measles infection should not be used for a period of two (2) hours after the patient exits the vehicle. Additional factors may be considered in the development of decontamination policies and procedures to reduce vehicle downtime. EMS agencies are encouraged to consult with the ambulance manufacturer to determine the vehicle's passenger compartment airchanges per hour (ACH) for 99.9% removal of airborne contaminants to establish a safe time period for reintroduction of the vehicle less than the 2 hour recommendation.4

If an EMS agency is using less than 2 hour recommendation after speaking with the ambulance manufacturer, documentation from the ambulance manufacturer and the agency policy and procedure should be maintained on file.

Post Exposure Follow-up

Confirm EMS personnel immunity status and, if unsure, consult with designated Infection Control Officer, Medical Director, and/or personal health care provider for guidance. If potentially exposed, notify the appropriate agency contact per your agency policies and procedures. Even those with evidence of immunity should watch for signs/symptoms of measles for 21 days following an exposure and should report immediately if they become ill.

EMS personnel exposed to measles without presumptive evidence of immunity should receive the MMR vaccine within 72 hours, or immunoglobulin (IG) should be administered within 6 days. Exclude from duty all EMS personnel without evidence of immunity to measles, from Day 5, even if PEP of MMR vaccine or IG was given. Such personnel must be excluded for 21 days, if MMR is received, or for 28 days if IG is received.

4 Table B1 “Air changes/hour (ACH) and time required for airborne-contaminant removal by efficiency” from the 2003 Guidelines for Environmental Infection Control in Health-Care Facilities
https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1
References

New York State Department of Health. Health Advisory: Measles Exposures in New York State, 2018


EMS PROVIDER GUIDANCE FOR SUSPECTED MEASLES PATIENTS

Measles Epidemiology
Measles can be severe and is highly contagious. The virus is transmitted by direct contact with infectious droplets or by airborne spread when an infected person breathes, coughs, or sneezes.

Measles virus can remain active and contagious for up to 2 hours in the air or on surfaces. The time from exposure to the onset of a rash averages 14 days. Persons with measles are infectious from 4 days before the onset of symptoms to 4 days after rash onset.

Clinical Features
Symptoms of measles include a prodrome of:
- Fever (101-105 degrees F)
- Runny Nose
- Cough
- Red, watery eyes
- Koplik Spots - blue-white spots on the bright red background of the buccal mucosa may be present, often before the rash develops, but are often not seen and are not required for the diagnosis of measles

A red, blotchy rash presents 3-7 days later and lasts 4-7 days. It usually starts on the face and proceeds down the body to involve the extremities last and may include the palms and soles. The rash resolves in the same order that it appeared.

Infection Control
Providers should remain vigilant for persons presenting with febrile and rash illness particularly among people who reside in or have spent time in geographic areas experiencing measles outbreaks, have recently traveled internationally, or who were exposed to a person with febrile rash illness.

- Measles is spread via airborne transmission and direct contact with infectious droplets.
- EMS providers should take respiratory precautions using an N95 respirator mask.
- Patients presenting with febrile rash illness should immediately be placed in a surgical mask and, when transporting a patient through the hospital, the patient should remain masked.
- The ambulance used to transport a patient with suspected measles infection should not be used for a period of 2 hours after the patient exits the vehicle and the number of people entering and leaving the vehicle should be minimized.

Personal Protective Equipment
EMS providers are required to follow their local infectious disease emergency response plan. The following PPE is recommended for use by EMS when treating a patient with suspected measles infection:
- Disposable exam gloves
- Goggles or face shield
- Disposable NIOSH-approved, fit-tested N95 respirator or PAPR.
- Disposable fluid-resistant gown that extends to at least mid-calf or disposable fluid-resistant coveralls.

Patient Care Considerations
Anyone with measles can have serious complications but those under 5 years old and those older than 20 are at greatest risk, along with pregnant women, and any immunocompromised individuals. Complications may include: ear infections; diarrhea; pneumonia; encephalitis; deafness or cognitive disability.

- Provide a surgical mask (N95 is not recommended) for all patients with febrile rash illness.
- Provide tissues to patients for secretion control and encourage patient hand hygiene and cough etiquette practices.
- The performance of aerosol generating procedures, such as endotracheal intubation and open suctioning of the respiratory tract should be avoided unless medically indicated.
- Patients who are intubated should be ventilated with a bag-valve device or ventilator equipped with a HEPA filter on exhalation port.

Transport Considerations
- Standard transportation to appropriate hospital receiving facility.
- It is recommended to have the patient compartment exhaust vent on high and isolating the driver compartment from the patient compartment. It is also recommended to have the driver compartment ventilation fan set to high without recirculation.
- When providing hospital pre-notification, please indicate if any family or supports are accompanying the patient, as they too may need to be isolated and follow agency plan.

Hospital Notification
EMS personnel must notify the receiving hospital before arrival if they are transporting a patient with febrile and rash illness, with or without a rash, to their facility.

Decontamination Considerations
Follow agency decontamination procedures after transfer of patient.

DOH Bureau of EMS Notification
Complete the Measles Contact Form for any suspected measles related ambulance transport and fax to NYS DOH EMS at (518)402-0985
**Name of Agency:** [ ]

**Agency Code:** [ ]

**Incident County:** [ ]

**Incident City:** [ ]

**Incident Zip Code:** [ ]

**Patient Age:** [ ]

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**Destination Hospital:** [ ]

**Pre-notification made to:** [ ]

(Provide name of person notification was given to)

**Provider Information**

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**Instructions:**

Complete this form for any suspected measles related ambulance transport and fax to the NYS Bureau of EMS at (518) 402-0985.
EMS PROVIDER GUIDANCE FOR SUSPECTED MEASLES PATIENTS

Measles Epidemiology
Measles can be severe and is highly contagious. The virus is transmitted by direct contact with infectious droplets or by airborne spread when an infected person breathes, coughs, or sneezes.

Measles virus can remain active and contagious for up to 2 hours in the air or on surfaces. The time from exposure to the onset of a rash averages 14 days. Persons with measles are infectious from 4 days before the onset of symptoms to 4 days after rash onset.

Clinical Features
Symptoms of measles include a prodrome of:
- Fever (101-105 degrees F)
- Runny Nose
- Cough
- Red, watery eyes
- Koplik Spots - blue-white spots on the bright red background of the buccal mucosa may be present, often before the rash develops, but are often not seen and are not required for the diagnosis of measles

A red, blotchy rash presents 3-7 days later and lasts 4-7 days. It usually starts on the face and proceeds down the body to involve the extremities last and may include the palms and soles. The rash resolves in the same order that it appeared.

Infection Control
Providers should remain vigilant for persons presenting with febrile and rash illness particularly among people who reside in or have spent time in geographic areas experiencing measles outbreaks, have recently traveled internationally, or who were exposed to a person with febrile rash illness.

Personal Protective Equipment
EMS providers are required to follow their local infectious disease emergency response plan. The following PPE is recommended for use by EMS when treating a patient with suspected measles infection:
- Disposable exam gloves
- Goggles or face shield
- Disposable NIOSH-approved, fit-tested N95 respirator or PAPR.
- Disposable fluid-resistant gown that extends to at least mid-calf or disposable fluid-resistant coveralls.

Patient Care Considerations
Anyone with measles can have serious complications but those under 5 years old and those older than 20 are at greatest risk, along with pregnant women, and any immunocompromised individuals. Complications may include: ear infections; diarrhea; pneumonia; encephalitis; deafness or cognitive disability.
- Provide a surgical mask (N95 is not recommended) for all patients with febrile rash illness.
- Measles is spread via airborne transmission and direct contact with infectious droplets.
- EMS providers should take respiratory precautions using an N95 respirator mask.
- Patients presenting with febrile rash illness should immediately be placed in a surgical mask and, when transporting a patient through the hospital, the patient should remain masked.
- The ambulance used to transport a patient with suspected measles infection should not be used for a period of 2 hours after the patient exits the vehicle and the number of people entering and leaving the vehicle should be minimized.

Transport Considerations
- Standard transportation to appropriate hospital receiving facility.
- It is recommended to have the patient compartment exhaust vent on high and isolating the driver compartment from the patient compartment. It is also recommended to have the driver compartment ventilation fan set to high without recirculation.
- When providing hospital pre-notification, please indicate if any family or supports are accompanying the patient, as they too may need to be isolated and follow agency plan.

Hospital Notification
EMS personnel must notify the receiving hospital before arrival if they are transporting a patient with febrile and rash illness, with or without a rash, to their facility.

Decontamination Considerations
Follow agency decontamination procedures after transfer of patient.

DOH Bureau of EMS Notification
Complete the Measles Contact Form for any suspected measles related ambulance transport and fax to NYS DOH EMS at (518)402-0985.
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Destination Hospital: 
Pre-notification made to: *(Provide name of person notification was given to)*

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**Instructions:**

Complete this form for any suspected measles related ambulance transport and fax to the NYS Bureau of EMS at (518) 402-0985.
Purpose

The purpose of this policy is to define the New York State (NYS) Department of Health (DOH) Bureau of EMS Certified Laboratory Instructor (CLI) and Certified Instructor Coordinator (CIC):

- prerequisite requirements;
- examination and certification requirements;
- processing; and
- re-certification requirements.

Definitions

The following definitions are found in Chapter VI Title 10 NYCRR Part 800.3 of the New York State Official Compilation of Codes Rules and Regulations:

- (t) A Certified Laboratory Instructor means a person certified pursuant to these regulations to instruct, in psychomotor skills, candidates in courses leading to certification as certified first responder, emergency medical technician, advanced emergency medical technician and Paramedic.

- (s) A Certified Instructor Coordinator means a person certified pursuant to these regulations to serve as the lead instructor for courses leading to certification. Certified instructor coordinators must be certified, pursuant to these regulations, at or above the level at which they seek to instruct.

Instructor Certification

This process consists of successfully completing the NYS sanctioned CLI or CIC course, the internship requirements and successfully passing, with at least 70% on the CLI or CIC written certification exam. The instructor examinations were adopted by SEMSCO and written by EMS educators and peers to confirm instructor’s knowledge of teaching theory, methodology and learning domains.

Instructor candidates will have two attempts to pass the written certification examination. If unsuccessful after two attempts, the candidate must contact BEMS for a remediation plan.
Upon completion of the remediation plan, instructor candidates will have two additional attempts to pass the instructor exam. If after four attempts a passing grade is not achieved, the instructor candidate will be required to complete the appropriate CLI or CIC course again.

The written examination consists of materials from the NYS DOH BEMS website and includes, but is not limited to: policy statements, Administration Manual for EMS Education Programs, Classroom and Exam Location Standards Manual, CIC Quick Reference Guide, Practical Skills Manual, and the CLI/CIC course curriculums.

Additional exam content includes material from the National Association of EMS Educators 2nd Edition, Foundations of Education; An EMS Approach. ISB-10; 1-111-13488-X

Policy

Certified Laboratory Instructor:

CLI Prerequisites for Certification
The candidate must:
1. Complete an Application for Instructor Certification (DOH-2260).
2. Hold current certification as a NYS EMT or higher.
3. Must have provided direct, hands-on, pre-hospital patient care with a NYS Certified EMS agency, at the EMT level or higher for at least one year within the last three years. This will be documented by assuring that the candidate’s name is listed on the agencies roster and patient care reports.
4. Have no open clinical or criminal investigations on a local, regional, or state level prior to or during the CLI course or internship period.

CLI Certification Requirements
The candidate must:
1. Completion of all prerequisite requirements as stated above.
2. Attend and successfully complete all modules of the NYS CLI course.
3. Serve as a CLI intern under the supervision of a currently certified NYS CIC Instructor in a BEMS approved certification course at the EMT level or higher. The internship must meet the objectives outlined in Bureau of EMS Policy Statement entitled “Internship Requirements for Instructor Certification”.
4. Instruct the minimum lab sessions, as dictated on CLI Internship Tracking Form, DOH-4451.
5. Maintain NYS EMT or higher level of certification throughout the CLI certification process.
6. Successfully pass the NYS BEMS CLI written instructor examination. To register for an instructor exam, visit the NYS DOH website: www.health.ny.gov/professionals/ems/emsforms.htm and submit DOH-4245, the Registration for Emergency Medical Technician’s Test Scheduling Request. Follow the directions on the form for submission.
7. Submit the following items, as one single packet, to the Bureau of EMS Central Office within 18 months of CLI course completion:
   a) The completed and signed Application for Instructor Certification (DOH 2260).
   b) The CLI Internship Completion Report (DOH-3378) completed and signed by the supervising CIC instructor.
   c) The completed and signed CLI Internship Tracking Worksheet (DOH-4451)
   d) At least one Lab Instruction Audit Report (DOH-2423) conducted by the supervising CIC instructor.
e) At least one Lab Instruction Audit Report (DOH-2423) conducted by an additional CIC or CLI, Regional faulty member or BEMS staff. This audit must be from someone other than the supervising CIC instructor.

Note: Individuals with whom the CLI candidate has a close personal relationship may not serve as the candidate’s supervising CIC and/or auditor during the instructor internship. Clarifications regarding this exclusion must be directed to the Bureau of EMS Central Office, prior to the start of the instructor certification process.

8. As an intern and/or practicing CLI, comply with:
   a) All applicable state and federal laws and regulations including, but not limited to NYS Public Health Law;
   b) Chapter VI Title 10 Part 800 of the Official Compilation of Codes, Rules, and Regulations, and;
   c) Policies as issued by the Bureau of EMS.
   d) Violations of 8a, 8b, or 8c of this section may result in denial of instructor certification, suspension or revocation of current instructor certification based upon a review by the Bureau of EMS.

Certified Instructor Coordinator:

CIC Prerequisites for Certification
The candidate must:
1. Complete an Application for Instructor Certification (DOH-2260).
2. Hold current certification as a NYS EMT or higher.
3. Hold current certification as a NYS CLI (unless registered in the CIC “fast track” program utilizing the NAEMSE Instructor I certification) and maintain the CLI certification during the CIC certification process.
4. Must have provided direct, hands-on, pre-hospital patient care at the EMT level or higher, with an NYS Certified EMS agency for at least one year within the last three years. This will be documented by assuring that the candidate’s name is listed on the agencies roster and patient care reports.
5. Have no open clinical or criminal investigations on a local, regional, or state level prior to or during the CIC course or internship period.

CIC Certification Requirements
The candidate must:
1. Attend and successfully complete all modules of the CIC course.
2. A candidate may substitute completing a NYS CIC course with successful completion of the National Association of EMS Educator’s (NAEMSE) level 1 Instructor Course within the last 5 years.

If utilizing the NAEMSE course in lieu of the NYS CIC course, the candidate must contact the BEMS Central Office to register into the program prior to beginning the internship or certification process.

The candidate will be required to complete a CLI internship, a CIC internship, complete the NYS Instructor Addendum webinar, and pass the written instructor certification exam once proof of NAEMSE course completion has been accepted by the BEMS Central Office.
NOTE: CLI and CIC internships cannot be completed concurrently, without the pre-approval of the Central office.

Completion of the NAEMSE Instructor course cannot be utilized towards CLI certification.

3. Successfully complete an instructor internship under the supervision of a currently certified CIC in a BEMS approved original or refresher course at the EMT level or higher. The candidate, under the mentorship of a single course sponsor and one CIC of record, must:
   a) Prepare and deliver the required hours of didactic material, within a NYS EMS certification course as found on the CIC Tracking form DOH-4452, and
   b) Directly plan, coordinate and implement lab sessions, observe CLI performance, and debrief staff with the supervising CIC, and organize the final practical skills exam with PSE exam coordinator.
   c) The internship must meet the objectives outlined in the CIC curriculum and Bureau of EMS Policy Statement entitled “Internship Requirements for Instructor Certification”.

4. Maintain NYS EMT or higher level certification throughout the CIC certification process.

5. Successfully pass the NYS BEMS CIC written Instructor examination. To register for an upcoming Instructor exam, visit the NYS DOH website: www.health.ny.gov/professionals/emsforms.htm and submit DOH 4245, the Registration for Emergency Medical Technician’s Test Scheduling Request. Follow the instructions on the form for submitting.

6. Must maintain CLI certification during the CIC internship (if not utilizing the “fast track”).

7. Submit the following items, as one single packet, to the Bureau of EMS Central Office within 18 months of NYS CIC course completion:
   a) The completed and signed Application for Instructor Certification (DOH 2260)
   b) The CIC Internship Completion Report (DOH-3377) completed and signed by the supervising CIC.
   c) The completed and signed CIC Internship Tracking Worksheet (DOH-4452).
   d) At least one Didactic Presentation Audit Report (DOH-2424) conducted by the supervising CIC.
   e) At least one Didactic Presentation Audit Report (DOH-2424) conducted by a Regional Faculty member or Bureau of EMS Representative.

   Note: Individuals with whom the CIC candidate has a close interpersonal relationship (real or perceived) may not serve as the candidate’s supervising CIC and/or auditor during the instructor internship. Clarifications concerning this exclusion must be directed to the Bureau of EMS, prior to the start of the instructor certification process.

8. As an intern and/or practicing CIC, comply with:
   a) All applicable state and federal laws and regulations including, but not limited to NYS Public Health Law;
   b) Chapter VI Title 10 Part 800 of the Official Compilation of Codes, Rules, and Regulations, and;
   c) Policies as issued by the Bureau of EMS.
   d) Violations of 8a, 8b, or 8c of this section may result in denial of instructor certification or suspension or revocation of current instructor certification based upon a review by the Bureau of EMS.
Instructor Recertification

CLI Recertification Requirements

The CLI must:
1. Hold current certification as a NYS EMT or higher.
2. Be certified as a NYS BEMS provider at or above the desired teaching level.
3. Must have successfully passed the NYS BEMS CLI written Instructor exam since their original CLI course completion date. To register for an upcoming instructor exam, visit www.health.ny.gov/professionals/ems and submit DOH-4245 Registration for Emergency Medical Technician’s Test Scheduling Request.
4. Must complete and submit the Application for Instructor Recertification (DOH-3508) to the Bureau of EMS Central Office.
   a) Must be actively providing on-going, direct, hands-on, pre-hospital patient care, at the EMT level or higher with a NYS certified EMS agency for at least one year within the last three years.
   b) Provide evidence of participation as a CLI in at least one BEMS approved course at the EMT level or higher, within the past three years. If the candidate has not participated as a CLI in at least one BEMS approved course, the candidate must receive a minimum of 2 favorable Lab Instruction Audit Reports (DOH-2423). Both reports must be within 3 months of applying for recertification with one completed by a currently certified CIC, the other by a currently certified CLI or additional CIC.
   c) Provide evidence of participation in at least eight (8) hours of instructor level training approved by the Bureau of EMS Central Office.
      i. 3 hours must be from an official BEMS instructor update with a state provided course number.
      ii. 5 hours must be from any BEMS approved educational continuing instructor education OR BEMS instructor update with a course number (educational CE must be related back to adult learning, EMS education instruction, etc. When in doubt, contact BEMS Central Office for clarification). Examples of courses acceptable, but not limited to, the 5 hour continuing education are:
         a. AHA Instructor Updates with verification certificates
         b. PHTLS Instructor Updates with verification certificates
         c. PEPP Instructor Updates with verification certificates
         d. NAEMSE Instructor I and II with verification certificates (if not already used for the “fast track” program)
         e. NYS Fire Instructor I and II with verification certificates
         f. AHA Instructor original courses with verification certificates, NOT certification cards.
5. If CLI certification has been expired for more than 2 years, the applicant must comply with all items above as well as:
   a) Complete a minimum of 2 Lab Instruction Audit Reports (DOH-2423). One must be completed by a CIC, the second by a different CIC or a CLI. Both reports must be completed within 3 months of application for recertification.
   b) Must have successfully passed the CLI written Instructor exam since last expired. To register for an upcoming instructor exam, visit www.health.ny.gov/professionals/ems and submit DOH-4245 Registration for Emergency Medical Technician’s Exam Test Scheduling Request.
   c) CLI certification that has been expired for more than 5 years may be required to repeat the CLI course and internship. Contact the BEMS Central office prior to any CLI activity.
6. Must comply with:
   a) All applicable state and federal laws and regulations including, but not limited to NYS Public Health Law;
   b) Chapter VI Title 10 Part 800 of the Official Compilation of Codes, Rules, and Regulations and;
   c) Policies as issued by the Bureau of EMS.
   d) Violations of 6a, 6b, or 6c of this section may result in denial of instructor recertification or suspension or revocation of current instructor certification based upon a review by the Bureau of EMS.

CIC Recertification Requirements

The candidate must:
1. Hold current certification as a NYS EMT or higher.
2. Have successfully passed the NYS BEMS CIC written Instructor Exam once since their original CIC course completion date. To register for an upcoming Instructor exam, visit the NYS DOH website: www.health.ny.gov/professionals/ems and submit DOH-4245, the Registration for Emergency Medical Technician’s Exam Test Scheduling Request.
3. Must complete and submit an Application for Instructor Recertification (DOH-3508) to the Bureau of EMS Central Office.
   a) Must have served as the CIC of record for at least one BEMS approved course within the past three years and/or since the last renewal date. If the candidate has not served as the CIC of record for at least one BEMS approved course, then he/she will be required to successfully complete a minimum of 2 favorable Didactic Presentation Audit Reports. One conducted by a Regional Faculty member or Bureau of EMS Representative, the other by a current CIC. Both reports must be within 3 months of applying for recertification.
   b) Provide evidence of participation in at least eight (8) hours of instructor-level training approved by the Bureau of EMS Central Office:
      i. 3 hours must be from an official BEMS instructor update with a state provided course number.
      ii. 5 hours must be from any BEMS approved educational continuing instructor education OR BEMS instructor update with a course number (educational CE must be related back to adult learning, EMS education instruction, etc. When in doubt, contact BEMS Center Office for clarification). Examples of courses acceptable, but not limited to, the 5 hour continuing education are:
         a. AHA Instructor Updates with verification certificates
         b. PHTLS Instructor Updates with verification certificates
         c. PEPP Instructor Updates with verification certificates
         d. NAEMSE Instructor I and II with verification certificates (if not already used for the “fast track” program)
         e. NYS Fire Instructor I and II with verification certificates
         f. AHA Instructor original courses with verification certificates, NOT certification cards.
4. If CIC certification has been expired for **more than 2 years**, the applicant must comply with all items above as well as:
   a) Submit a minimum of 2 favorable Didactic Presentation Audit Reports. One conducted by a Regional Faculty member or Bureau of EMS Representative, the other by a current CIC. Both reports must be within 3 months of applying for recertification.
   b) Complete CIC Internship Completion Report (DOH-3377), completed by the CIC of record for the course.
   c) Complete the BEMS Update webinar and submit the completion certificate with your recertification information. Contact the Central Office for the webinar link address.
   d) Must be actively providing on-going, direct, hands-on, pre-hospital patient care, at the EMT level or higher with a NYS certified EMS agency for at least one year within the last three years.
   e) **CIC certification that has been expired for more than 5 years may be required to repeat the CIC course and internship. Contact the BEMS Central office prior to any CIC activity.**

5. Comply with:
   a) All applicable state and federal laws and regulations including, but not limited to NYS Public Health Law;
   b) Chapter VI Title 10 Part 800 of the Official Compilation of Codes, Rules, and Regulations, and;
   c) Policies as issued by the Bureau of EMS.
   d) Violations of 5a, 5b, or 5c of this section may result in denial of instructor recertification or suspension or revocation of current instructor certification based upon a review by the Bureau of EMS.

**Bureau of EMS Instructor Processing**

It is the responsibility of the individual seeking instructor certification, with the assistance of their course sponsor and preceptor, to meet all certification requirements and submit all completed documentation electronically to the Bureau of EMS **Central Office**. The completed file will be reviewed by the BEMS representative who will do one of the following:

1. Issue certification to the individual with an instructor number and expiration date that is three years after the date of issuance and notify the individual of the recertification requirements, **or**
2. Extend the internship period for a specific amount of time and arrange for appropriate remediation by notifying the candidate in writing, **or**
3. Deny instructor certification by notifying the candidate in writing.
ADDITIONAL INFORMATION

• Basic or Advanced Level Instructor Certification
All CLI Instructor certifications will be given at the current level of candidate certification.

CIC instructor certifications will be granted at the BASIC EMT level. If advanced level CIC instructor certification is sought, the CIC candidate must complete seven additional lectors at the ALS level. These lectors can be completed during their initial CIC internship or at a later time. **Candidates may not instruct above the level of their current certification.**

• Instructor Advanced Standing
CLIs holding a permanent or provisional teaching certificate from the New York State Education Department (NYSED) may be eligible for advanced standing in a CIC course. The CIC candidate will be required to provide a copy of the NYSED teaching certificate and a copy of the CLI certificate to the Bureau of EMS Central Office. If approved, the candidate will be notified of the modules of the course he or she will be required to attend, as well as any additional items required.

• Instructor Reciprocity
Instructor reciprocity from other states, in compliance with regulations, will be handled by the Bureau of EMS Central Office on a case-by-case basis.

• CIC Interning CLI/CIC candidates
A CIC is required to be certified at least one year and have been the CIC of record for one complete original course that was not cancelled, prior to interning new CLI or CIC candidates.

• CIC Signing CME Content
A CIC must have been a CIC of record for one complete original course prior to teaching core content or approving content in the NYS CME recertification program.

• NAEMSE Instructor I Course
The National Association of EMS Educators Instructor I course may be utilized in place of the NYS CIC course for those candidates pursuing CIC certification only. After completing the NAEMSE program, candidates will be required to submit an Instructor Application (DOH-2260) with a copy of the NAEMSE completion certificate to the BEMS Central Office. Upon approval of the application, candidates will be provided instructions pertaining to the completion of a CLI internship, a CIC internship, the instructor webinar, and the NYS EMS CIC written examination.

Issued and authorized by Bureau of EMS Office of the Director
BACKGROUND AND PURPOSE

Under Section 3066 of the Public Health Law and Part 405.45 of the Health Code, the Department may designate a hospital as a trauma center so long as the hospital attains verification from the American College of Surgeons Committee on Trauma (ACS-COT) or other entity determined by the Department. To assist hospitals in meeting initial verification requirements, the Department shall implement this policy of designating provisional trauma centers.

PROCEDURE

A hospital seeking provisional trauma center designation should submit the following electronically to the New York State Bureau of EMS and Trauma Systems, Trauma Program Manager.

Section 1 – Commitment Letter
Written commitment from the hospital’s governing body and medical staff indicating support for the trauma program and commitment to maintaining the high standards required to provide optimal care to all trauma patients.

Section 2 – Creation of a Trauma Service
Documentation reflecting the creation of a Trauma Service with a description of the organizational structure detailing the reporting hierarchy of the Service.

Section 3 – Trauma Medical Director (Adult and/or Pediatric)
Documentation indicating that the Trauma Medical Director, as defined by the American College of Surgeons – Committee on Trauma (ACS-COT*), has been hired, and who has designated authority over the Trauma Service. Because the care of trauma patients crosses many hospital specialties, the trauma program must be empowered to address issues that involve multiple disciplines and services.

Section 4 – Trauma Program Manager (Adult and/or Pediatric)
Documentation indicating a Trauma Program Manager, as defined by ACS-COT*, has been hired and is dedicated to the Trauma Program.

Section 5 – Trauma Registry
Documentation indicating a Trauma Registrar has been hired, trauma registry software has been purchased and trauma registry training has been received; and the hospital’s plan for submitting trauma data to the New York State Trauma Registry (NYSTR), National Trauma Data Bank (NTDB), and (if applicable) the Trauma Quality Improvement Program (TQIP).
Section 6 – Performance Improvement
Documentation of the hospital’s performance improvement process as it pertains to trauma, even if this is not yet fully developed. The goal will be to have a performance improvement process in keeping with the principles outlined in the Society of Trauma Nurses’ *Trauma Outcomes & Performance Improvement Course***.

Section 7 – State Trauma Advisory Committee and Regional Trauma Advisory Committee
Documentation of the hospital’s participation in the Regional Trauma Advisory Committee (RTAC) and (as often as practicable) attendance at State Trauma Advisory Committee (STAC) meetings.

Section 8 – Timeline for American College of Surgeons verification
Documentation of the timeline and plan for the hospital’s successful verification by the ACS-COT.

After review of the above documentation, the Department may request clarifications or further documents from the hospital.

Upon completion of the Department’s review and determination that the facility has submitted all required documentation, the Department will issue a letter designating the facility as a Provisional Trauma Center.

*Every six months* from the date a hospital is designated by the Department as a provisional trauma center, the hospital shall submit a written progress report and timeline updating the Department on the hospital’s progress toward an ACS-COT consultative visit or verification visit.

The progress report shall include documentation of the following:
- number of trauma patients treated
- trauma data uploaded to the New York State Trauma Registry
- performance improvement project description(s) and status
- participation in the Regional and State Trauma Advisory Committees
- other required documents as assigned by DOH in writing during provisional status

*One year* from the date a hospital is designated by the Department, the hospital shall submit documentation that an official request has been made to the ACS-COT for a consultative visit.

*Two years* from the date the hospital receives the ACS-COT consultative report, the hospital shall submit documentation to the Department that an official request has been made to the ACS-COT for a verification visit.

Provisional designation will be rescinded for failure to provide the Department with progress reports, documentation of official requests for consultative or verification visits or if visits have not been scheduled as outlined above.

Once the hospital receives provisional designation from the Department, the Department will notify EMS agencies through the appropriate Regional EMS Councils so that the hospital may begin preferentially receiving trauma patients.

The Department may conduct a site inspection to determine compliance with the provisional designation requirements.
*The ACS-COT guidelines called the Resources for Optimal Care of the Injured Patient, 2014 can be found at: https://www.facs.org/quality-programs/trauma/vrc/resources. This contains the standards the facility needs to be working towards at the time of their consultative visit.

**Society of Trauma Nurses Trauma Outcomes & Performance Improvement Course can be found at: https://www.traumanurses.org/education/stn-topic
On May 6, 2015 Title 10 of the New York Codes, Rules and Regulations Part 800 were amended as they relate to certification, recertification and continuing medical education recertification requirements. These sections reflect New York State’s policy of removing barriers to the licensure and employment of persons previously convicted of one or more criminal offenses and incorporate Article 23-A of the Corrections Law into the review of an applicants’ prior criminal offenses.

The following provisions are contained in Part 800:

...if the applicant has been convicted of one or more criminal offenses, as defined in §800.3(ak), be found eligible after a balancing of the factors set out in Article 23-A of Corrections Law. In accordance with that Article, no application for a license shall be denied by reason of the applicant having been previously convicted of one or more criminal offenses unless (i) there is a direct relationship between one or more of the previous criminal offenses and duties required of this certificate or (ii) certifying the applicant would involve an unreasonable risk to property or the safety or welfare of a specific individual or the general public. In determining these questions, the agency will look at the eight factors listed under New York State Corrections Law Section 753.

...not have been found guilty or in violation, in any jurisdiction, of any other non-criminal offense or statutory and/or regulatory violation, as those terms are defined in Section 800.3 of this Part, relating to patient safety unless the department determines such applicant would not involve an unreasonable risk to property or the safety or welfare of a specific individual or the general public.

Purpose:

This policy specifies the process for the review of applicants seeking Emergency Medical Services (EMS) certification with a history of criminal convictions. It also describes the responsibilities of the applicant, the Certified Instructor Coordinator (CIC) and the Department of Health.

Applications for Original EMS Certification or Recertification:

In accordance with the provisions of the State Emergency Medical Services Code, 10 NYCRR Part 800, applicants for EMS certification or recertification must not have been convicted of certain misdemeanors or felonies. The Department will review all criminal convictions from any federal, military, state and/or local jurisdiction to determine if such convictions fall within the scope of those specified in Part 800. If the applicant has been convicted of one or more criminal offenses, the Department will consider the eight factors listed under New York State Corrections Law Section 753, to determine if the applicant represents an unreasonable risk to property or the safety or welfare of the general public.

Certain Family Court or other designated governmental agency findings are also subject to review by the Department. If an applicant is unsure as to the status of any court proceeding, he/she SHOULD NOT sign the Application for Emergency Medical Services Certification (DOH-65).

10 NYCRR Part 800 does not prevent an applicant with a criminal conviction from attending and completing all of the training requirements of an EMS certification course. However, it may prevent the applicant from
becoming certified in New York State until the Department has conducted a review and investigation of the circumstances of the conviction(s) and made a determination that the applicant does not represent an unreasonable risk to property or the safety or welfare of the general public.

If the Department makes a determination allowing certification, the applicant will be eligible to take the applicable New York State practical and written certification examinations, if otherwise qualified. All applicants must be fully informed of these requirements by the Certified Instructor Coordinator (CIC) at the beginning of a course.

Applicants will not be permitted to take the NYS practical or written certification examination until the background review and investigation is completed and a final written determination is received by the applicant.

The Certification Application:

All applicants applying for NYS EMS certification at any level must complete the Application for Emergency Medical Services Certification (DOH-65). The bottom of the application contains an affirmation that states "Do not sign this if you have any convictions". Under no circumstances should an applicant sign this application if he or she has a criminal conviction of any type.

The CIC must identify all unsigned applications and send them with the course memorandum and all other applications to the Department immediately after the second class session. The CIC should include a separate memorandum or note identifying each unsigned application. The applicant(s) will be listed on the class list but will not be issued an examination ticket until cleared in writing by Department. It is the responsibility of the applicant to understand this policy, gather the required documentation and provide it to the Department. An EMS representative from the Department may conduct an interview. This may take the form of a personal meeting or telephone interview. In an effort to permit a timely review and determination, the applicant must provide all the required documentation within 30 days of the initial Department contact. If the applicant does not provide the documentation, the investigatory review will be closed and the applicant will not be able to seek EMS certification.

The applicant should not contact the Bureau of EMS (BEMS) directly. Upon the receipt and processing of the unsigned DOH-65 application form, the applicant will be sent a package of information outlining the investigative process, the required information to be supplied and the contact name and telephone number of the Bureau of EMS Representative reviewing their case.

The Department will only discuss issues related to criminal convictions with the applicant or their legal representative. There is no requirement or need for the applicant to disclose the circumstances of any conviction(s) with the CIC.

The Review Process:

All applicants entered in the review process will need to provide the following written documentation concerning all convictions. This information must be sent directly to the Department regional office as detailed in the letter sent to the applicant.

1. A notarized sworn affidavit stating that the applicant has not had any conviction(s) for a crime or crimes other than those currently identified.

2. If the applicant is recertifying and has signed previous certification applications, he/she must provide an explanation as to why these applications were signed.

3. A signed and dated statement describing the reason that they are seeking EMS certification.
4. A signed and dated written narrative description of the circumstances leading to and surrounding each conviction.

5. An original or certified copy of the certificate of disposition from the court. A Certificate of Relief from Disabilities does not fulfill this documentation requirement. If these items are not available, an original letter from the court must be supplied attesting that the documentation does not exist or is no longer available. Please note that the applicant may be responsible for the cost of obtaining these documents.

6. A letter from the applicant's probation/parole officer (if applicable) documenting compliance with their probation/parole. A copy of the final probation/parole report must also be included.

7. If the applicant's conviction resulted in any court ordered therapy, clinical evaluations or counseling, a letter or report from the organization or individual who provided the evaluation, counseling or therapy is required. The letter or report should indicate if treatment is ongoing or if it has been completed and whether or not it was considered to have been successful. The letter should also indicate that the counselor/therapist believes that the applicant is suitable to perform patient care in a prehospital setting.

8. The applicant is required to submit letters from the administration of each EMS agency with whom they are affiliated. These letters must be on official letterhead and presented to the Department EMS Representative in a sealed and signed envelope. These letters must describe any involvement in EMS or other health care settings, the length of the affiliation with the agency, an awareness of the specific conviction(s), the circumstances and the agency's willingness to monitor the individual during the performance of his/her EMS duties.

9. The applicant should submit other letters of recommendation. These letters must also be presented to the EMS Representative in a sealed and signed envelope. These recommendations must include a description of the relationship with the applicant, have knowledge of the conviction, an understanding of the EMS environment, and can attest to the applicant's good character. The letters may include, but not be limited to:
   1. current employers;
   2. health care professionals;
   3. community leaders (i.e. clergy, law enforcement or educators)

10. Each applicant may have a personal interview with a Department EMS Representative after all the documentation requirements have been met. A telephone interview may be conducted in the place of a personal meeting. Upon completion of the investigation and review, the applicant will be notified in writing of the Department's decision.

While the investigation and review is ongoing, an applicant may attend all classes. However, the applicant will be prevented from taking any NYS certifying examination, including the challenge practical skills examination at the beginning of the refresher program, the practical examination at the conclusion of the training program and the final written certification examination, until all course requirements are completed and a favorable determination is made in writing by the Department.

Applicants possessing current NYS EMS certification will be afforded a hearing in accordance with the provisions of Section 12-a of the Public Health Law if the Department seeks suspension, revocation or any other legal action.
Background

A Technical Advisory Group (TAG) was established by the New York State Emergency Medical Services Council (SEMSCO) at its September 2016 meeting. The TAG was established to examine ongoing concerns about the future viability of the EMT-Critical Care (CC) level of certification in New York State. The TAG was charged with examining the past and present operation of the CC program with the goal of making recommendations on the CC going forward.

The TAG reviewed CC utilization in each region, the curriculum, administrative burden and costs of sustaining CC education curriculum and exam development and maintenance, original course participation, refresher course attendance, use of CME refreshers and the comparative scope of practice and availability of AEMT educational programs. In the final analysis, the TAG concluded:

- The CC provider numbers have been steadily declining since 1997 and continue to trend downward.
- The number of CC original and refresher courses offered has also declined while the number of course sponsors has remained stable. The decline in course offerings is likely related to declining enrollments.
- Simultaneously, the CC program would require extensive curriculum, practical skills and written examination extensive revisions.
- The CC has no national equivalent from which curriculum and test items can be drawn.

The TAG proposed to SEMAC and SEMSCO a number of actions to gradually end the CC level of certification in NYS. These actions would allow continued CC certification renewals, affording REMSCO and REMAC a prolonged period in which to sustain or reconfigure their systems, based on regional needs. These were approved by the SEMSCO at its May 10, 2017 meeting.

Transition Implementation Process

The following actions are being implemented to gradually end the CC level of certification:

1. Current CCs may continue refreshing their certification through the Continuing Medical Education (CME) refresher program.
2. The Department will no longer approve original CC courses with a start date after January 1, 2018.
3. The Department will no longer approve CC refresher or rapid refresher courses whose written examination would take place after August of 2019.
4. The development and release of an advanced standing/bridge program from CC to Paramedic. This will be open to any NYS CC with 3 years of documented continuous practice1. This program will include, but not be limited to, on-line didactic content with availability of skills and testing by local course sponsors.

1 The term “continuous practice” is defined by 10 NYCRR Part 800.3(w)
Based on the results of a State Emergency Medical Advisory Committee (SEMAC) demonstration project, the New York State Emergency Medical Service Advisory Council (SEMSCO) approved Syringe Epinephrine for Emergency Medical Technicians (Check & Inject NY) at the September 14, 2016 meeting. The project established that EMTs, with the appropriate training may administer the proper dose of epinephrine for a patient experiencing a severe anaphylactic reaction using a specific 1cc syringe. Additionally, the project realized a significant cost saving over maintaining epinephrine auto-injectors.

The Commissioner of Health has approved the addition of Syringe Epinephrine and at the request of the SEMAC, this approval includes the intramuscular administration of 1:1000 epinephrine using a 1cc syringe, a 23 gauge, 1 inch intramuscular safety needle and a single dose 1:1000 epinephrine packaged in a 1mg/ml vial as an addition to the scope of practice for an EMT.

Policy

- **Education:**

  *Every EMT original, refresher and continuing medical education (CME) certification training program must include the didactic content and psychomotor skills for the administration of 1:1000 epinephrine using a syringe for treating a patient with severe anaphylaxis.*

  The NYS EMS Instructional Guidelines have been updated and an Intramuscular Injection Psychomotor Evaluation Tool (practical skills sheet) has been developed to assist EMS course sponsors, Certified Instructor Coordinators (CIC) and EMS agencies in providing initial and ongoing training. An instructor update can be found at [http://vitalsignsconference.com/server/moodle/login/index.php](http://vitalsignsconference.com/server/moodle/login/index.php) under “All Courses” in “Instructors” section. The course is entitled “2017 Instructor Update – Epi for EMTs”. The education resources are available at: [http://www.health.ny.gov/professionals/ems/national_education_standards_transition/index.htm](http://www.health.ny.gov/professionals/ems/national_education_standards_transition/index.htm) on pages 2 through 4.

- **BLS EMS Agencies**

  EMS Agencies intending to implement a Syringe Epinephrine program, in consultation with their medical director, should develop written policies and procedures for the use of Syringe Epinephrine that are consistent with regional policies and protocols. This should include, but not be limited to the following:
Written policies and procedures requiring an approved training program, requirements for continuing education, maintenance of competencies and the documentation for authorized providers;

Written policies and procedures requiring for the use of a 1cc syringe, a 23 gauge, 1 inch intra-muscular safety needle and single dose 1:1000 epinephrine packaged in a 1mg/ml vial;

A description of how the syringes, needles and medication will be kept secure in the vehicles and the station(s);

A plan for appropriate and safe disposal of medical waste;

A description of how the medication will be maintained within manufacturer’s approved temperature and light ranges; and

Documentation of an administration and the medical director’s plan for quality assurance and appropriateness review of utilization.

Once the EMS service has decided to implement a syringe epinephrine program, the EMS Service must provide the Department with an updated Medical Director Verification Form (DOH-4362).

- **Resources**

Medical Director Verification Form (DOH-4362) – fill-in-able  

Check & Inject NY  

Anaphylactic Reaction with Respiratory Distress and Hypoperfusion Protocol – M-3  

Emergency Medical Technician Instructional Guidelines – Intramuscular Injections and Psychomotor Evaluation Tool (pages 2 – 4)  
PURPOSE:

The purpose of this policy statement is to provide EMS providers knowledge and understanding of the role, responsibility and capabilities of Certified Athletic Trainers so that when EMS is called to a sporting event, the patient will benefit from positive communication and consistent prehospital emergency medical care.

BACKGROUND:

EMS often responds to sporting events where Certified Athletic Trainers are employed, such as public schools, sports leagues and college sporting events. In many instances, a Certified Athletic Trainer may be the highest trained healthcare provider available when an athlete has sustained an injury or has become ill. It is important that EMS providers and Certified Athletic Trainers work together.

Certified Athletic Trainers are certified under NYS Education Law, Article 162. Section 8351 defines an Athletic Trainer as:

“...any person who is duly certified in accordance with this article to perform athletic training under the supervision of a physician and limits his or her practice to secondary schools, institutions of postsecondary education, professional athletic organizations, or a person who, under the supervision of a physician, carries out comparable functions on orthopedic athletic injuries, excluding spinal cord injuries, in a health care organization. Supervision of an athletic trainer by a physician shall be continuous but shall not be construed as requiring the physical presence of the supervising physician at the time and place where such services are performed.”

Certified Athletic Trainers manage athletic injuries and illnesses such as sprains, strains, contusions, and postsurgical reconditioning. Their responsibilities include:

- Identification of factors that may contribute to athletic injury and eliminate them before an injury occurs;
- conduct pre-participation screenings;
- develop appropriate fitness and training programs;
- apply protective or injury preventative devices, such as tape, bandages, or braces;
- maintain CPR and AED training;
- recognition and evaluation of potentially serious, life threatening injuries; and
- administering appropriate first aid and emergency care to the injured athlete.
At athletic events, Certified Athletic Trainers provide emergency care and first aid to individuals who have sustained an athletic injury, evaluate the injury(s), and make referrals to appropriate medical personnel. Through individual consultation and lectures, Certified Athletic Trainers also instruct coaches, athletes, parents, medical personnel, and the community in the care and prevention of athletic injuries.

Additional information regarding Certified Athletic Trainers can be found at: http://www.op.nysed.gov/prof/at/

RECOMMENDATIONS:

EMS agencies should be aware of those facilities, both public and private, that may have Athletic Trainers working with teams at their sporting events. Meeting with Certified Athletic Trainers and discussing the EMS agency resources, scope of practice and protocols, will assist developing an understanding of the roles and responsibilities, improve relationships and should it become necessary, the prehospital care provided at the scene of a medical emergency. As a part of the planning process the agency medical director should be contacted to discuss specific issues and treatment plans.
This policy is an update regarding fentanyl for prehospital Emergency Medical Services agencies. Please take the time to read and understand this Policy Statement. Each individual EMS agency, its controlled substances agent and the medical director are responsible for adhering to all applicable laws, regulations and policies.

History:
At the request of the State Emergency Medical Advisory Committee (SEMAC) and a number of air medical service physician medical directors, the Department was approached requesting that fentanyl be added to the formulary authorized by the Class 3C controlled substance license. This request was reviewed by the Department’s Division of Legal Affairs and the Bureau of Narcotic Enforcement (BNE).

Based on the potency of fentanyl and the serious issues of diversion and abuse, the Department initially approved its use by New York States air medical service providers under specific conditions. At the May 2007 meeting of the SEMAC, the use of fentanyl was approved for all advanced life support (ALS) EMS agencies possessing a current Department of Health EMS Agency Certification and Prehospital Controlled Substance License.

At present, the SEMAC and the Department approve regional ALS protocols that allow for the administration of fentanyl on standing orders for specific prehospital conditions in both adult and pediatric patients. In order for an ALS level EMS agency to possess and administer fentanyl, all of the following conditions must be met and the agency must receive Department approval.

This policy addresses the following:

- Approval Process
- Reporting Process
- Required Conditions
**Approval Process:**
In order for the Department to approve the addition of fentanyl to an EMS agency with a current Class 3C controlled substance license, the following conditions must be met and the Department must review and issue written approval.

1. The Regional Medical Advisory Committee (REMAC) must provide protocols for the administration of fentanyl and a periodic evaluation of its use on the regional level.

2. The protocols must be approved by the SEMAC and the Department.

3. The service medical director must approve, in writing, fentanyl for use by the EMS agency.

4. Only those individuals certified at the EMT - Critical Care or Paramedic level may participate in the Operational Plan and administer a controlled substance medication to aprehospital patient.

5. The EMS agency must submit an amendment to their Controlled Substance Operations Plan to include, but not be limited to the following:
   - A detailed description of the procurement; inventory process and security of fentanyl.
   - A program for routine quality assurance by the service medical director for instances where fentanyl has been administered.
   - The training program used to in-service all appropriate staff on the inventory, security and administration of fentanyl.
   - Policies for submitting the Quarterly Report (attached) for fentanyl stock and administrations. This must be received by the Department within 30 days of the end each quarter.

6. **Prior** to including fentanyl in the EMS agency’s controlled substance formulary, the medical director and the agent must receive written approval from the Department.

7. Each substock may have a maximum of 400mcg of fentanyl.

**Reporting Requirements:**

1. A separate Quarterly Report for fentanyl stock and administrations. This form is available on line at [http://www.health.state.ny.us/forms/doh-4352.pdf](http://www.health.state.ny.us/forms/doh-4352.pdf). This must be received by the Department within 30 days of the end each quarter.

2. As a part of the reporting process, the agency medical director is required to provide a written report of the service’s use of fentanyl in the prior year no later than **January 31st of each year**. The report should include, but not be limited to the following items:
   - The total number of administrations, amount or medication used and dose.
   - The amount of fentanyl wasted.
   - A summary of the patient presenting problems.
   - A narrative summary highlighting the Quality Assurance reviews conducted for each fentanyl administration.
Please note that failure to submit the quarterly and/or the annual reports may result in the suspension of the agency’s authority to possess and administer controlled substance medications.

3. All instances where a theft, loss or diversion, are suspected **MUST BE REPORTED TO THE DEPARTMENT IMMEDIATELY.** This report must be made to the BEMS Central Office using the *Loss of Controlled Substances Report* form (DOH-2094). This form is available on line at [http://www.health.ny.gov/forms/doh-2094.pdf](http://www.health.ny.gov/forms/doh-2094.pdf)

4. **Prior** to including fentanyl in the EMS agency’s formulary, the medical director and the agent must receive written approval from the Department.

5. If the agency makes any changes or updates to the Controlled Substance Operations Plan, it must provide the specific changes to the Department in writing **prior** to implementation.

**Required Conditions:**

1. Fentanyl may only be stocked in 2ml vials or ampules containing 50mcg/ml.

2. The Department must approve the sub-stock inventory that exceeds 400mcg of fentanyl.

3. The agency operation plan and the medical director must insure that the formulary includes an appropriate antagonist **in an amount proportional to the amount of fentanyl carried,** necessary to reverse the effects of a fentanyl administration.

4. Fentanyl may only be administered on standing orders for adult patients as delineated in the approved regional ALS protocols. **Other administrations will require direct medical control consultation.**

The Department continues to closely monitor the EMS agencies that maintain a Class 3C controlled substance license to insure that there is the strictest compliance with all of the applicable sections of Public Health Law, the Codes, Rules and Regulations – Part 800 and Section 80.136 of the Part 80 Rules and Regulations on Controlled Substances in New York State, as well as the EMS service’s approved Controlled Substance Operations Plan.

Issued and authorized by Bureau of EMS Office of the Director
This Policy Statement establishes the State Emergency Medical Advisory Committee (SEMAC) and the Department’s criteria for including ketamine in an EMS agency’s controlled substance formulary. Please take the time to read and understand this Policy Statement. Each individual EMS agency, its controlled substances agent and the medical director are responsible for adhering to all applicable laws, regulations and policies.

**History:**
In June of 2009, the SEMAC approved ketamine to be added to the State EMS Drug Formulary. This change required the Department to review and approve the medication, the process for inventory, security and training. This updated version reflects changes allowed by the Bureau of Narcotics Enforcement (BNE) and based on SEMAC approved advanced life support protocols.

Based on the potency of ketamine and the potential for serious issues of diversion and abuse, the Department remains extremely concerned about its applications in the prehospital environment.

**Conditions for Approval:**
In order for the Department to approve the addition of ketamine to an EMS agency with a current Class 3C controlled substance license, the following conditions must be met and the Department must review and issue written approvals.

1. The Regional Medical Advisory Committee (REMAC) must develop protocols for the administration of ketamine and a quarterly evaluation of its use on the regional level.

2. The protocols must also be approved by the SEMAC and then by the Department.

3. The service medical director must approve, in writing, ketamine for use by the EMS service.

4. Only those individuals certified at the paramedic level may administer ketamine.

5. The EMS agency must submit an amendment to their Controlled Substance Operations Plan to include, but not be limited to the following:

   - A detailed description of the procurement; inventory process and security of ketamine.
   - A program for 100% quality assurance by the service medical director for instances where ketamine has been administered.
   - A separate Quarterly Report (attached) for ketamine stock and administrations. This must be received by the Department within 30 days of the end each quarter.
6. The EMS agency must submit for review and approval by the Department, the training program developed to in-service personnel. The program must include, but not be limited to training on the updated controlled substance plan, inventory, security, patient administration and reporting policies and procedures. The curriculum format must follow the BEMS required curriculum addition format.

7. Each substock (the controlled substance medications carried on each vehicle) is limited to a **MAXIMUM of 1,000 mg**.

8. There are two (2) components of the reporting process:
   
   
   b. The EMS agency medical director is required to provide a written report of the service’s use of ketamine in the prior year no later than **January 31st of each year**. It must include, but not be limited to the following items:
      < The total number of administrations, amount or medication used and dose.
      < The amount of ketamine wasted.
      < A summary of the patient presenting problems.
      < A narrative summary highlighting the Quality Assurance reviews conducted for each ketamine administration.

9. All instances where a theft, loss or diversion, are suspected **MUST BE REPORTED TO THE DEPARTMENT IMMEDIATELY**. This report must be made to the BEMS Central Office using the *Loss of Controlled Substances Report* form (DOH-2094). This form is available on line at [http://www.health.ny.gov/forms/doh-2094.pdf](http://www.health.ny.gov/forms/doh-2094.pdf).

10. **Prior** to including ketamine in the EMS agency’s formulary, the medical director and the agent must receive written approval from the Department.

11. If the agency makes any changes or updates to the Controlled Substance Operations Plan, it must provide the specific changes to the Department in writing **prior** to implementation.

The Department continues to closely monitor the EMS agencies that maintain a Class 3C controlled substance license to insure that there is the strictest compliance with all of the applicable sections of Public Health Law, the Codes, Rules and Regulations – Part 800 and Section 80.136 of the Part 80 Rules and Regulations on Controlled Substances in New York State, as well as the EMS service’s approved Controlled Substance Operations Plan.
**Drug Formulary**

**KETAMINE**

**Class**

Anesthetic Induction

**Description**

Ketamine is a controlled substance medication that is a rapid-acting general anesthetic producing an anesthetic state characterized by profound analgesia, normal pharyngeal-laryngeal reflexes, normal or slightly enhanced skeletal muscle tone, cardiovascular and respiratory stimulation, and occasionally a transient and minimal respiratory depression.

**Onset & Duration**

- **Onset:** Rapid – IV within 30 seconds half life 10-15 min.; IM within 3-4 minutes
- **Duration:** IV 2 mg/kg lasts 5-10 minutes; IM 9 to 13 mg/kg lasts 12-25 minutes

**Indications**

1. Ketamine is indicated as the sole anesthetic induction agent for management of trauma patients in extreme pain requiring proper immobilization and/or extrication.

**Contraindications**

1. Ketamine is contraindicated in those in whom a significant elevation of blood pressure would constitute a serious hazard and in those who have shown hypersensitivity to the drug.

**Adverse Reactions**

1. Cardiovascular - blood pressure and pulse rate are frequently elevated following administration of Ketamine alone. However, hypotension and bradycardia have been observed. Arrhythmia has also occurred.
2. Respiration - Although respiration is frequently stimulated, severe depression of respiration or apnea may occur following rapid intravenous administration of high doses of Ketamine.
Laryngospasms and other forms of airway obstruction have occurred during Ketamine anesthesia.

3. Eye - Diplopia and nystagmus have been noted following Ketamine administration. It also may cause a slight elevation in intraocular pressure measurement.

4. Neurological - In some patients, enhanced skeletal muscle tone may be manifested by tonic and clonic movements sometimes resembling seizures.

5. Gastrointestinal - Anorexia, nausea and vomiting have been observed; however, this is not usually severe and allows the great majority of patients to take liquids by mouth shortly after regaining consciousness.

6. General: Anaphylaxis, local pain and exanthema at the injection site have infrequently been reported. Transient erythema and/or morbilliform rash have also been reported.

**Ketamine continued...**

**Drug Interactions**

Prolonged recovery time may occur if barbiturates and/or narcotics are used concurrently with Ketamine.

**How Supplied**

Injection: IM or IV 15 mg (15 mg/mL) and 30 mg (30 mg/mL)

Ketamine Hydrochloride Injection, USP is supplied as the hydrochloride in concentrations equivalent to Ketamine base.

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<thead>
<tr>
<th>Container</th>
<th>Concentration</th>
<th>Fill Quantity</th>
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<tbody>
<tr>
<td>Fliptop Vial</td>
<td>100 mg/mL</td>
<td>5 mL</td>
</tr>
<tr>
<td>Fliptop Vial</td>
<td>50 mg/mL</td>
<td>10 mL</td>
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</table>

Color of solution may vary from colorless to very slightly yellowish and may darken upon prolonged exposure to light. This darkening does not affect potency. Do not use if a precipitate appears.

Store at 20 to 25°C (68 to 77°F).

Protect from light.

**Dosing**

Adult IV 1-4.5 mg/kg IV over 1 min.

Adult IM 6.5-13 mg/kg IM one dose
Pediatric IV  >3 months 1.5 mg/kg IV over 1 min.
Pediatric IM  >3 months 4-5 mg/kg one dose

Protocol

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<tr>
<th>MA XX</th>
<th>Adult Pain Management</th>
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<tr>
<td>MA XX</td>
<td>Pediatric Pain Management</td>
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Special Considerations

1. Elevation of blood pressure begins shortly after injection, reaches a maximum within a few minutes and usually returns to preanesthetic values within 15 minutes after injection.
2. Because pharyngeal and laryngeal reflexes are usually active, Ketamine can not be used alone for advanced airway management such as intubation. Mechanical stimulation of the pharynx should be avoided, whenever possible, if Ketamine is used alone.
3. The incidence of emergence reactions may be reduced if verbal and tactile stimulation of the patient is minimized during the recovery period. This does not preclude the monitoring of vital signs.
4. The intravenous dose should be administered over a period of 60 seconds. More rapid administration may result in respiratory depression or apnea and enhanced pressor response.
5. Use with caution in the chronic alcoholic and the acutely alcohol-intoxicated patient.
6. This medication is a Class III controlled substance medication approved for prehospital use by the SEMAC and the Department.
The purpose of this policy is to assist eligible entities defined by Article 30, section 3000-c of the Public Health Law (PHL) in understanding the notification process for utilizing epinephrine auto-injectors (i.e. EpiPen®). An epinephrine auto-injector program is designed to encourage greater acquisition, deployment and use of epinephrine auto-injectors in an effort to reduce the number of deaths associated with anaphylaxis.

An "epinephrine auto-injector device" is defined as a single-use device used for the automatic injection of a premeasured dose of epinephrine into the human body, approved by the U.S. Food and Drug Administration for the purpose of emergency treatment of a person appearing to experience anaphylactic symptoms.

Eligible entities are defined as:

1. An ambulance service or advanced life support first response service; a certified first responder, emergency medical technician, advanced emergency medical technician or paramedic, who is employed by or an enrolled member of any such service;

2. A children's overnight camp as defined in subdivision one of section thirteen hundred ninety-two PHL, a summer day camp as defined in subdivision two of section thirteen hundred ninety-two of PHL, a traveling summer day camp as defined in subdivision three of section thirteen hundred ninety-two of PHL or a person employed by such a camp;

3. School districts, boards of cooperative educational services, county vocational education and extension boards, charter schools, and non-public elementary and secondary schools in this state or any person employed by any such entity;

4. A sports, entertainment, amusement, education, government, day care or retail facility; an educational institution, youth organization or sports league; an establishment that serves food; or a person employed by such entity; and

5. Any other person or entity designated or approved, or in a category designated or approved pursuant to regulations of the commissioner in consultation with other appropriate agencies.

New York State EMS agencies with a Department issued agency code; children’s camps as defined by subpart 7-2 of the New York State Sanitary Code; and schools are strongly encouraged to participate in the epinephrine auto-injector program.
**Epinephrine Auto-Injector Program**

To initiate an epinephrine auto-injector program, the following steps should be considered:

- A health care practitioner or pharmacist authorized to prescribe medications may prescribe, dispense or provide an epinephrine auto-injector device to or for an eligible person or entity by a non-patient-specific prescription.


Any training program submitted for approval must include, but may not be limited to the following objectives and competencies:

1. identify common causes of allergic reactions;
2. identify the signs and symptoms of a mild and severe allergic reaction (anaphylaxis);
3. identify how signs and symptoms of anaphylaxis differ from other medical conditions;
4. demonstrate knowing when epinephrine should be administered and when it should not be administered;
5. demonstrate determining the correct dose of auto-injector, adult or pediatric, to administer;
6. demonstrate the steps for administering epinephrine by an auto-injector;
7. describe the methods for safely storing and handling epinephrine and appropriately disposing of the auto-injector after use;
8. demonstrate the steps for providing for on-going care of the patient until Emergency Medical Services (EMS) arrives;
9. demonstrate knowledge of appropriate documentation and reporting of an event in which an epinephrine auto-injector was administered; and
10. understand the NYS laws that allow an individual to possess and use an epinephrine auto-injector in a life-threatening situation.

Prior to initiating the training program, please submit proposed training programs for approval to:

New York State Department of Health  
Bureau of Emergency Medical Services and Trauma Systems  
875 Central Avenue  
Albany, NY  12206  
518-402-0996  
518-402-0985 (fax)

- **Suggested policies and procedures:**
  - Written policies and procedures for the acquisition, storage, accounting, and proper disposal of used auto-injectors.
  - Written policies and procedures for the training of authorized users;
  - Written practice protocols for the use of the epinephrine auto-injector;
  - A method of making notification of the use of the epinephrine auto-injector;
  - A method for documentation of the use of the epinephrine auto-injector; and
  - A process for quality assurance.
**Reporting an Epinephrine Auto-Injector Use**

In the event that an epinephrine auto-injector is administered to a patient experiencing anaphylaxis, the entity should report the incident. At a minimum, the following should be provided as part of this written notification:

- The name of the epinephrine auto-injector entity;
- Location of the incident;
- The date and time of the incident;
- The age and gender of the patient;
- The number and dose of epinephrine auto-injectors administered to the patient;
- The name of the ambulance service that transported the patient, and
- The name of the hospital to which the patient was transported.

In the case of an EMS agency, the report must be written and submitted on a Prehospital Care Report (PCR/e-PCR) and shared with the agency’s physician medical director.

In addition, Subpart 7-2 of the State Sanitary code requires children's camp operators to report in writing any epinephrine administration to the permit-issuing official within 24 hours of the administration.

**Resources**

New York State Public Health Law, Article 30, section 3000-c  
[http://www.health.ny.gov/professionals/ems/art30.htm#BM3000c](http://www.health.ny.gov/professionals/ems/art30.htm#BM3000c)

Epinephrine by Auto-Injector Training Guidelines for Unlicensed or Uncertified Personnel  

EMT original curriculum Lesson 4-5 on Allergies  

American Academy of Pediatrics  
[http://www.aap.org](http://www.aap.org)

American Red Cross - Anaphylaxis and Epinephrine Auto-Injector - Online Course  
[http://www.redcross.org/take-a-class/course-dowbt000000000011096](http://www.redcross.org/take-a-class/course-dowbt000000000011096)

American College of Allergy, Asthma & Immunology  

Food Allergy Research and Education  
[https://www.foodallergy.org/treating-an-allergic-reaction/epinephrine](https://www.foodallergy.org/treating-an-allergic-reaction/epinephrine)

Asthma and Allergy Foundation  

Regional EMS Council Listing  

Chapter 373 of the Laws of 2016 - effective March 28, 2017
I. Purpose

The purpose of this Policy Statement is to delineate procedures for granting Advanced Standing in Emergency Medical Services certification courses (Basic EMT, Advanced EMT, EMT-Critical Care and EMT-Paramedic), excluding Certified First Responder.

EMS course sponsors may need to recognize the experience and expertise that medical professionals bring to their courses. This will require tailoring programs to avoid redundancy and repetition and recognize an individual's education and experience. When appropriate, course sponsors, in consultation with their Medical Director and Certified Instructor Coordinator (CIC), are encouraged to review and evaluate the experience and education of a student and grant "advanced standing." This should be based on competency based evaluations and take the form of waived attendance of specific class sessions for the individual or a modified course schedule for the class.

The sponsor, Medical Director and CIC must evaluate a candidate’s prior experience and education with the understanding of the specific course objectives for each certification level. While some candidates may be competent in a particular objective, others may need review or may not have covered the objective at all in their original course. Even a professional license does not guarantee a candidate's competency in all of the specific objectives of an EMS certification course. As an example, a Registered Nurse (RN) who is a Certified Emergency Nurse (CEN), and has ACLS and ATLS or equivalent training with work experience in an emergency department, may not need to complete a small portion of a paramedic program and a field internship in order to complete all of the objectives. While an RN with long term care experience may need to attend the majority of the paramedic course in order to complete all of the objectives.

In order to determine an individual's educational needs it will require a review the student's prior education and experience, as well as an assessment of current knowledge and skills.

II. Who Can Offer Advanced Standing?

In order to award advanced standing to medical professionals, the course sponsor must first have completed two (2) or more full-original certification courses at the certification level for which advanced standing is being sought. Any candidate seeking advanced standing must be registered in an EMS original certification course.
III. Candidate Eligibility Requirements

Each candidate must meet the eligibility requirements as set forth in Title 10 NYCRR Part 800.6 as well as for the course in which they are enrolled. Candidates seeking advanced EMS certification (AEMT, EMT-CC or EMT-P), must have a NYS EMT certification that remains valid throughout the entire training program. Further, to be eligible for advanced standing in an EMS certification course, the candidate must have current certification or license in New York State, in one of the professions listed below:

- Certified First Responder
- Emergency Medical Technician
- Advanced EMT
- EMT-Critical Care
- Registered Nurse
- Nurse Midwife
- Nurse Anesthetist
- Nurse Practitioner
- Physician Assistant
- Physician

Specific class sessions may be waived for Licensed Practical Nurses (LPN), Respiratory Therapist and other medical and allied health professionals when appropriate and with approval of the Bureau of EMS (BEMS) Central Office.

IV. Procedures

1. The candidate must be enrolled in an original EMS certification course.

2. The Medical Director and CIC must review and verify the candidate’s credentials. This includes, but may not be limited to obtaining copies of the following:
   a) Professional license(s);
   b) Certification(s);
   c) College transcripts;
   d) Course completion records from relevant continuing education programs (e.g., CPR, ACLS, PALS or equivalent, clinical training and experience).

3. The candidate’s cognitive knowledge, psychomotor skills and clinical proficiency must be assessed. The level of proficiency required to "waive" session attendance or to modify the class schedule must be equal to or greater than the entry-level proficiency of a graduate from the course.
   a. Cognitive objectives must be evaluated through a formal written examination, which adequately reflects each section of the current Educational Standards and curriculum. In many instances, the exam make-up may be similar to the make-up of a "challenge" written exam that is administered at the start of a refresher course. A blueprint of this exam must be developed, approved by the course sponsor Medical Director and CIC, and kept on-file with all other course related paperwork.
   b. Psychomotor objectives must be evaluated through a formal practical skills examination, which adequately reflects the objectives in the current Educational Standards and curriculum. The course sponsor is encouraged to develop scenario type evaluations that encompass multiple objectives in lieu of evaluating each objective separately. A blueprint of this exam must be developed, approved by the course sponsor Medical Director and CIC, and kept on-file with all other course related paperwork.
c. Individuals currently holding a NYS EMS certification (at the start of the first class session), may be granted advanced standing, up to their current level of certification, without additional cognitive or psychomotor testing. For example, a currently certified EMT- Critical Care who enrolls in a Paramedic original course, may be given advanced standing for those components of the Paramedic curriculum that are contained in the NYS EMT - Critical Care curriculum. Prior to approval, the Paramedic course sponsor’s Medical Director may decide to conduct a portion, or all of the required cognitive and psychomotor testing. Advanced standing must be approved by the Paramedic course sponsor Medical Director.

4. The course Medical Director may grant advanced standing for some or all of the objectives of the hospital clinical and Field Internship for a candidate who can document prior hospital or prehospital care experience relevant to specific objectives. The candidate must also demonstrate the ability to serve as a team leader in a variety of prehospital emergency situations. These requirements should not be more, or less than those required of all other students, as approved by BEMS in the course sponsor's policies and procedures.

5. Once the decision is made by the course Medical Director to grant approval for advanced standing, the candidate and CIC must sign a written agreement outlining the candidate’s course requirements.

6. Once a candidate has successfully completed all course requirements to the satisfaction of the course Medical Director, he/she is eligible to take the state certifying practical skills and written examinations.

7. If the course is conducted exclusively for students seeking advanced standing (i.e., a paramedic course exclusively for EMT-CC's or a course exclusively for experienced emergency nurses), after the assessment and evaluation of all of the candidates has been completed, the sponsor needs to file a modified course schedule with the Department.

8. The course sponsor must maintain, individual candidate files (student record) which includes a copy of the student-sponsor agreement, all of the candidate's credentials, records of performance on assessment exams (written and practical), field internship evaluation and documentation of completion of all course requirements. If a Course Sponsor plans to offer advanced standing they must develop written advanced standing policies and procedures as part of their sponsorship agreement with BEMS.

V. Resources

For additional information refer to the following:

National EMS Education Guidelines
http://www.health.ny.gov/professionals/ems/national_education_standards_transition/

Educational Standards for each level of EMS certification

EMS Certification Practical Skills Matrix
The purpose of this policy is to assist eligible entities defined by Article 30, section 3000-c of the Public Health Law (PHL) in understanding the notification process for utilizing epinephrine auto-injectors (i.e. EpiPen®). An epinephrine auto-injector program is designed to encourage greater acquisition, deployment and use of epinephrine auto-injectors in an effort to reduce the number of deaths associated with anaphylaxis.

An "epinephrine auto-injector device" is defined as a single-use device used for the automatic injection of a premeasured dose of epinephrine into the human body, approved by the U.S. Food and Drug Administration for the purpose of emergency treatment of a person appearing to experience anaphylactic symptoms.

Eligible entities are defined as:

1. An ambulance service or advanced life support first response service; a certified first responder, emergency medical technician, advanced emergency medical technician or paramedic, who is employed by or an enrolled member of any such service;

2. A children's overnight camp as defined in subdivision one of section thirteen hundred ninety-two PHL, a summer day camp as defined in subdivision two of section thirteen hundred ninety-two of PHL, a traveling summer day camp as defined in subdivision three of section thirteen hundred ninety-two of PHL or a person employed by such a camp;

3. School districts, boards of cooperative educational services, county vocational education and extension boards, charter schools, and non-public elementary and secondary schools in this state or any person employed by any such entity;

4. A sports, entertainment, amusement, education, government, day care or retail facility; an educational institution, youth organization or sports league; an establishment that serves food; or a person employed by such entity; and

5. Any other person or entity designated or approved, or in a category designated or approved pursuant to regulations of the commissioner in consultation with other appropriate agencies.

New York State EMS agencies with a Department issued agency code; children’s camps as defined by subpart 7-2 of the New York State Sanitary Code; and schools are strongly encouraged to participate in the epinephrine auto-injector program.
**Epinephrine Auto-Injector Program**

To initiate an epinephrine auto-injector program, the following steps should be considered:

- A health care practitioner or pharmacist authorized to prescribe medications may prescribe, dispense or provide an epinephrine auto-injector device to or for an eligible person or entity by a non-patient-specific prescription.


Any training program submitted for approval must include, but may not be limited to the following objectives and competencies:

1. identify common causes of allergic reactions;
2. identify the signs and symptoms of a mild and severe allergic reaction (anaphylaxis);
3. identify how signs and symptoms of anaphylaxis differ from other medical conditions;
4. demonstrate knowing when epinephrine should be administered and when it should not be administered;
5. demonstrate determining the correct dose of auto-injector, adult or pediatric, to administer;
6. demonstrate the steps for administering epinephrine by an auto-injector;
7. describe the methods for safely storing and handling epinephrine and appropriately disposing of the auto-injector after use;
8. demonstrate the steps for providing for on-going care of the patient until Emergency Medical Services (EMS) arrives;
9. demonstrate knowledge of appropriate documentation and reporting of an event in which an epinephrine auto-injector was administered; and
10. understand the NYS laws that allow an individual to possess and use an epinephrine auto-injector in a life-threatening situation.

Prior to initiating the training program, please submit proposed training programs for approval to:

New York State Department of Health  
Bureau of Emergency Medical Services and Trauma Systems  
875 Central Avenue  
Albany, NY 12206

518-402-0996  
518-402-0985 (fax)

- Suggested policies and procedures:
  - Written policies and procedures for the acquisition, storage, accounting, and proper disposal of used auto-injectors.
  - Written policies and procedures for the training of authorized users;
  - Written practice protocols for the use of the epinephrine auto-injector;
  - A method of making notification of the use of the epinephrine auto-injector;
  - A method for documentation of the use of the epinephrine auto-injector; and
  - A process for quality assurance.
Reporting an Epinephrine Auto-Injector Use

In the event that an epinephrine auto-injector is administered to a patient experiencing anaphylaxis, the entity should report the incident. At a minimum, the following should be provided as part of this written notification:

- The name of the epinephrine auto-injector entity;
- Location of the incident;
- The date and time of the incident;
- The age and gender of the patient;
- The number and dose of epinephrine auto-injectors administered to the patient;
- The name of the ambulance service that transported the patient, and
- The name of the hospital to which the patient was transported.

In the case of an EMS agency, the report must be written and submitted on a Prehospital Care Report (PCR/e-PCR) and shared with the agency’s physician medical director.

In addition, Subpart 7-2 of the State Sanitary code requires children's camp operators to report in writing any epinephrine administration to the permit-issuing official within 24 hours of the administration.

Resources

New York State Public Health Law, Article 30, section 3000-c
http://www.health.ny.gov/professionals/ems/art30.htm#BM3000c

Epinephrine by Auto-Injector Training Guidelines for Unlicensed or Uncertified Personnel

EMT original curriculum Lesson 4-5 on Allergies

American Academy of Pediatrics
http://www.aap.org

American Red Cross - Anaphylaxis and Epinephrine Auto-Injector - Online Course
http://www.redcross.org/take-a-class/course-dowbt000000000011096

American College of Allergy, Asthma & Immunology
http://acaai.org/

Food Allergy Research and Education
https://www.foodallergy.org/treating-an-allergic-reaction/epinephrine

Asthma and Allergy Foundation
http://www.aafa.org/

Regional EMS Council Listing
http://www.health.ny.gov/professionals/ems/regional.htm

Chapter 373 of the Laws of 2016 - effective March 28, 2017
This Policy Statement establishes the State Emergency Medical Advisory Committee (SEMAC) and the Department’s criteria for including ketamine in an EMS agency’s controlled substance formulary. Please take the time to read and understand this Policy Statement. Each individual EMS agency, its controlled substances agent and the medical director are responsible for adhering to all applicable laws, regulations and policies.

History:
In June of 2009, the SEMAC approved ketamine to be added to the State EMS Drug Formulary. This change required the Department to review and approve the medication, the process for inventory, security and training. This updated version reflects changes allowed by the Bureau of Narcotics Enforcement (BNE) and based on SEMAC approved advanced life support protocols.

Based on the potency of ketamine and the potential for serious issues of diversion and abuse, the Department remains extremely concerned about its applications in the prehospital environment.

Conditions for Approval:
In order for the Department to approve the addition of ketamine to an EMS agency with a current Class 3C controlled substance license, the following conditions must be met and the Department must review and issue written approvals.

1. The Regional Medical Advisory Committee (REMAC) must develop protocols for the administration of ketamine and a quarterly evaluation of its use on the regional level.

2. The protocols must also be approved by the SEMAC and then by the Department.

3. The service medical director must approve, in writing, ketamine for use by the EMS service.

4. Only those individuals certified at the paramedic level may administer ketamine.

5. The EMS agency must submit an amendment to their Controlled Substance Operations Plan to include, but not be limited to the following:

   - A detailed description of the procurement; inventory process and security of ketamine.
   - A program for 100% quality assurance by the service medical director for instances where ketamine has been administered.
   - A separate Quarterly Report (attached) for ketamine stock and administrations. This must be received by the Department within 30 days of the end each quarter.
6. The EMS agency must submit for review and approval by the Department, the training program developed to in-service personnel. The program must include, but not be limited to training on the updated controlled substance plan, inventory, security, patient administration and reporting policies and procedures. The curriculum format must follow the BEMS required curriculum addition format.

7. Each substock (the controlled substance medications carried on each vehicle) is limited to a **MAXIMUM of 1,000 mg.**

8. There are two (2) components of the reporting process:
   
   
   b. The EMS agency medical director is required to provide a written report of the service’s use of ketamine in the prior year no later than **January 31st of each year.** It must include, but not be limited to the following items:
      
      - The total number of administrations, amount or medication used and dose.
      - The amount of ketamine wasted.
      - A summary of the patient presenting problems.
      - A narrative summary highlighting the Quality Assurance reviews conducted for each ketamine administration.

9. All instances where a theft, loss or diversion, are suspected **MUST BE REPORTED TO THE DEPARTMENT IMMEDIATELY.** This report must be made to the BEMS Central Office using the Loss of Controlled Substances Report form (DOH-2094). This form is available on line at [http://www.health.ny.gov/forms/doh-2094.pdf](http://www.health.ny.gov/forms/doh-2094.pdf).

10. **Prior** to including ketamine in the EMS agency’s formulary, the medical director and the agent must receive written approval from the Department.

11. If the agency makes any changes or updates to the Controlled Substance Operations Plan, it must provide the specific changes to the Department in writing **prior** to implementation.

The Department continues to closely monitor the EMS agencies that maintain a Class 3C controlled substance license to insure that there is the strictest compliance with all of the applicable sections of Public Health Law, the Codes, Rules and Regulations – Part 800 and Section 80.136 of the Part 80 Rules and Regulations on Controlled Substances in New York State, as well as the EMS service’s approved Controlled Substance Operations Plan.
Drug Formulary

KETAMINE

Class
Anesthetic Induction

Description
Ketamine is a controlled substance medication that is a rapid-acting general anesthetic producing an anesthetic state characterized by profound analgesia, normal pharyngeal-laryngeal reflexes, normal or slightly enhanced skeletal muscle tone, cardiovascular and respiratory stimulation, and occasionally a transient and minimal respiratory depression.

Onset & Duration
Onset: Rapid – IV within 30 seconds half life 10-15 min.; IM within 3-4 minutes
Duration: IV 2 mg/kg lasts 5-10 minutes; IM 9 to 13 mg/kg lasts 12-25 minutes

Indications
1. Ketamine is indicated as the sole anesthetic induction agent for management of trauma patients in extreme pain requiring proper immobilization and/or extrication.

Contraindications
1. Ketamine is contraindicated in those in whom a significant elevation of blood pressure would constitute a serious hazard and in those who have shown hypersensitivity to the drug.

Adverse Reactions
1. Cardiovascular - blood pressure and pulse rate are frequently elevated following administration of Ketamine alone. However, hypotension and bradycardia have been observed. Arrhythmia has also occurred.
2. Respiration - Although respiration is frequently stimulated, severe depression of respiration or apnea may occur following rapid intravenous administration of high doses of Ketamine.
Laryngospasms and other forms of airway obstruction have occurred during Ketamine anesthesia.

3. Eye - Diplopia and nystagmus have been noted following Ketamine administration. It also may cause a slight elevation in intraocular pressure measurement.

4. Neurological - In some patients, enhanced skeletal muscle tone may be manifested by tonic and clonic movements sometimes resembling seizures.

5. Gastrointestinal - Anorexia, nausea and vomiting have been observed; however, this is not usually severe and allows the great majority of patients to take liquids by mouth shortly after regaining consciousness.

6. General: Anaphylaxis, local pain and exanthema at the injection site have infrequently been reported. Transient erythema and/or morbilliform rash have also been reported.

Ketamine continued...

Drug Interactions

Prolonged recovery time may occur if barbiturates and/or narcotics are used concurrently with Ketamine.

How Supplied

Injection: IM or IV 15 mg (15 mg/mL) and 30 mg (30 mg/mL)

Ketamine Hydrochloride Injection, USP is supplied as the hydrochloride in concentrations equivalent to Ketamine base.

<table>
<thead>
<tr>
<th>Container Concentration</th>
<th>Fill Quantity</th>
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<tbody>
<tr>
<td>Fliptop 100 mg/mL</td>
<td>5 mL</td>
</tr>
<tr>
<td>Fliptop 50 mg/mL</td>
<td>10 mL</td>
</tr>
<tr>
<td>Vial</td>
<td>10 mL</td>
</tr>
</tbody>
</table>

Color of solution may vary from colorless to very slightly yellowish and may darken upon prolonged exposure to light. This darkening does not affect potency. Do not use if a precipitate appears.

Store at 20 to 25°C (68 to 77°F).

Protect from light.

Dosing

Adult IV  1-4.5 mg/kg IV over 1 min.
Adult IM  6.5-13 mg/kg IM one dose
Pediatric IV  >3 months 1.5 mg/kg IV over 1 min.
Pediatric IM  >3 months 4-5 mg/kg one dose

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**Protocol**

<table>
<thead>
<tr>
<th>MA</th>
<th>Adult Pain Management</th>
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<tbody>
<tr>
<td>MA</td>
<td>Pediatric Pain Management</td>
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</table>

**Special Considerations**

1. Elevation of blood pressure begins shortly after injection, reaches a maximum within a few minutes and usually returns to preanesthetic values within 15 minutes after injection.

2. Because pharyngeal and laryngeal reflexes are usually active, Ketamine can not be used alone for advanced airway management such as intubation. Mechanical stimulation of the pharynx should be avoided, whenever possible, if Ketamine is used alone.

3. The incidence of emergence reactions may be reduced if verbal and tactile stimulation of the patient is minimized during the recovery period. This does not preclude the monitoring of vital signs.

4. The intravenous dose should be administered over a period of 60 seconds. More rapid administration may result in respiratory depression or apnea and enhanced pressor response.

5. Use with caution in the chronic alcoholic and the acutely alcohol-intoxicated patient.

6. This medication is a Class III controlled substance medication approved for prehospital use by the SEMAC and the Department.
This policy is an update regarding fentanyl for prehospital Emergency Medical Services agencies. Please take the time to read and understand this Policy Statement. Each individual EMS agency, its controlled substances agent and the medical director are responsible for adhering to all applicable laws, regulations and policies.

**History:**
At the request of the State Emergency Medical Advisory Committee (SEMAC) and a number of air medical service physician medical directors, the Department was approached requesting that fentanyl be added to the formulary authorized by the Class 3C controlled substance license. This request was reviewed by the Department’s Division of Legal Affairs and the Bureau of Narcotic Enforcement (BNE).

Based on the potency of fentanyl and the serious issues of diversion and abuse, the Department initially approved its use by New York States air medical service providers under specific conditions. At the May 2007 meeting of the SEMAC, the use of fentanyl was approved for all advanced life support (ALS) EMS agencies possessing a current Department of Health EMS Agency Certification and Prehospital Controlled Substance License.

At present, the SEMAC and the Department approve regional ALS protocols that allow for the administration of fentanyl on standing orders for specific prehospital conditions in both adult and pediatric patients. In order for an ALS level EMS agency to possess and administer fentanyl, all of the following conditions must be met and the agency must receive Department approval.

This policy addresses the following:

- **Approval Process**
- **Reporting Process**
- **Required Conditions**
**Approval Process:**
In order for the Department to approve the addition of fentanyl to an EMS agency with a current Class 3C controlled substance license, the following conditions must be met and the Department must review and issue written approval.

1. The Regional Medical Advisory Committee (REMAC) must provide protocols for the administration of fentanyl and a periodic evaluation of its use on the regional level.

2. The protocols must be approved by the SEMAC and the Department.

3. The service medical director must approve, in writing, fentanyl for use by the EMS agency.

4. Only those individuals certified at the EMT - Critical Care or Paramedic level may participate in the Operational Plan and administer a controlled substance medication to a prehospital patient.

5. The EMS agency must submit an amendment to their Controlled Substance Operations Plan to include, but not be limited to the following:
   - A detailed description of the procurement; inventory process and security of fentanyl.
   - A program for routine quality assurance by the service medical director for instances where fentanyl has been administered.
   - The training program used to in-service all appropriate staff on the inventory, security and administration of fentanyl.
   - Policies for submitting the Quarterly Report (attached) for fentanyl stock and administrations. This must be received by the Department within 30 days of the end each quarter.

6. **Prior** to including fentanyl in the EMS agency’s controlled substance formulary, the medical director and the agent must receive written approval from the Department.

7. Each substock may have a maximum of 400mcg of fentanyl.

**Reporting Requirements:**

1. A separate Quarterly Report for fentanyl stock and administrations. This form is available online at [http://www.health.state.ny.us/forms/doh-4352.pdf](http://www.health.state.ny.us/forms/doh-4352.pdf). This must be received by the Department within 30 days of the end each quarter.

2. As a part of the reporting process, the agency medical director is required to provide a written report of the service’s use of fentanyl in the prior year no later than **January 31st of each year**. The report should include, but not be limited to the following items:
   - The total number of administrations, amount or medication used and dose.
   - The amount of fentanyl wasted.
   - A summary of the patient presenting problems.
   - A narrative summary highlighting the Quality Assurance reviews conducted for each fentanyl administration.
Please note that failure to submit the quarterly and/or the annual reports may result in the suspension of the agency’s authority to possess and administer controlled substance medications.

3. All instances where a theft, loss or diversion, are suspected **MUST BE REPORTED TO THE DEPARTMENT IMMEDIATELY**. This report must be made to the BEMS Central Office using the Loss of Controlled Substances Report form (DOH-2094). This form is available on line at [http://www.health.ny.gov/forms/doh-2094.pdf](http://www.health.ny.gov/forms/doh-2094.pdf)

4. **Prior** to including fentanyl in the EMS agency’s formulary, the medical director and the agent must receive written approval from the Department.

5. If the agency makes any changes or updates to the Controlled Substance Operations Plan, it must provide the specific changes to the Department in writing **prior** to implementation.

**Required Conditions:**

1. Fentanyl may only be stocked in 2ml vials or ampules containing 50mcg/ml.

2. The Department must approve the sub-stock inventory that exceeds 400mcg of fentanyl.

3. The agency operation plan and the medical director must insure that the formulary includes an appropriate antagonist in an amount proportional to the amount of fentanyl carried, necessary to reverse the effects of a fentanyl administration.

4. Fentanyl may only be administered on standing orders for adult patients as delineated in the approved regional ALS protocols. **Other administrations will require direct medical control consultation.**

The Department continues to closely monitor the EMS agencies that maintain a Class 3C controlled substance license to insure that there is the strictest compliance with all of the applicable sections of Public Health Law, the Codes, Rules and Regulations – Part 800 and Section 80.136 of the Part 80 Rules and Regulations on Controlled Substances in New York State, as well as the EMS service’s approved Controlled Substance Operations Plan.

Issued and authorized by Bureau of EMS Office of the Director
PURPOSE:

The purpose of this policy statement is to provide EMS providers knowledge and understanding of the role, responsibility and capabilities of Certified Athletic Trainers so that when EMS is called to a sporting event, the patient will benefit from positive communication and consistent prehospital emergency medical care.

BACKGROUND:

EMS often responds to sporting events where Certified Athletic Trainers are employed, such as public schools, sports leagues and college sporting events. In many instances, a Certified Athletic Trainer may be the highest trained healthcare provider available when an athlete has sustained an injury or has become ill. It is important that EMS providers and Certified Athletic Trainers work together.

Certified Athletic Trainers are certified under NYS Education Law, Article 162. Section 8351 defines an Athletic Trainer as:

"... any person who is duly certified in accordance with this article to perform athletic training under the supervision of a physician and limits his or her practice to secondary schools, institutions of postsecondary education, professional athletic organizations, or a person who, under the supervision of a physician, carries out comparable functions on orthopedic athletic injuries, excluding spinal cord injuries, in a health care organization. Supervision of an athletic trainer by a physician shall be continuous but shall not be construed as requiring the physical presence of the supervising physician at the time and place where such services are performed."

Certified Athletic Trainers manage athletic injuries and illnesses such as sprains, strains, contusions, and postsurgical reconditioning. Their responsibilities include:

- Identification of factors that may contribute to athletic injury and eliminate them before an injury occurs;
- conduct pre-participation screenings;
- develop appropriate fitness and training programs;
- apply protective or injury preventative devices, such as tape, bandages, or braces;
- maintain CPR and AED training;
- recognition and evaluation of potentially serious, life threatening injuries; and
- administering appropriate first aid and emergency care to the injured athlete.
At athletic events, Certified Athletic Trainers provide emergency care and first aid to individuals who have sustained an athletic injury, evaluate the injury(s), and make referrals to appropriate medical personnel. Through individual consultation and lectures, Certified Athletic Trainers also instruct coaches, athletes, parents, medical personnel, and the community in the care and prevention of athletic injuries.

Additional information regarding Certified Athletic Trainers can be found at: http://www.op.nysed.gov/prof/at/

RECOMMENDATIONS:

EMS agencies should be aware of those facilities, both public and private, that may have Athletic Trainers working with teams at their sporting events. Meeting with Certified Athletic Trainers and discussing the EMS agency resources, scope of practice and protocols, will assist developing an understanding of the roles and responsibilities, improve relationships and should it become necessary, the prehospital care provided at the scene of a medical emergency. As a part of the planning process the agency medical director should be contacted to discuss specific issues and treatment plans.
Based on the results of a State Emergency Medical Advisory Committee (SEMAC) demonstration project, the New York State Emergency Medical Service Advisory Council (SEMSCO) approved Syringe Epinephrine for Emergency Medical Technicians (Check & Inject NY) at the September 14, 2016 meeting. The project established that EMTs, with the appropriate training may administer the proper dose of epinephrine for a patient experiencing a severe anaphylactic reaction using a specific 1cc syringe. Additionally, the project realized a significant cost saving over maintaining epinephrine auto-injectors.

The Commissioner of Health has approved the addition of Syringe Epinephrine and at the request of the SEMAC, this approval includes the intramuscular administration of 1:1000 epinephrine using a 1cc syringe, a 23 gauge, 1 inch intramuscular safety needle and a single dose 1:1000 epinephrine packaged in a 1mg/ml vial as an addition to the scope of practice for an EMT.

Policy

- **Education:**

  *Every EMT original, refresher and continuing medical education (CME) certification training program must include the didactic content and psychomotor skills for the administration of 1:1000 epinephrine using a syringe for treating a patient with severe anaphylaxis.*

  The NYS EMS Instructional Guidelines have been updated and an Intramuscular Injection Psychomotor Evaluation Tool (practical skills sheet) has been developed to assist EMS course sponsors, Certified Instructor Coordinators (CIC) and EMS agencies in providing initial and ongoing training. An instructor update can be found at [http://vitalsignsconference.com](http://vitalsignsconference.com) under “All Courses” in “Instructors” section. The course is entitled “2017 Instructor Update – Epi for EMTs”. The education resources are available at: [http://www.health.ny.gov/professionals/ems/national_education_standards_transition/index.htm](http://www.health.ny.gov/professionals/ems/national_education_standards_transition/index.htm) on pages 2 through 4.

- **BLS EMS Agencies**

  EMS Agencies intending to implement a Syringe Epinephrine program, in consultation with their medical director, should develop written policies and procedures for the use of Syringe Epinephrine that are consistent with regional policies and protocols. This should include, but not be limited to the following:
• Written policies and procedures requiring an approved training program, requirements for continuing education, maintenance of competencies and the documentation for authorized providers;

• Written policies and procedures requiring for the use of a 1cc syringe, a 23 gauge, 1 inch intra-muscular safety needle and single dose 1:1000 epinephrine packaged in a 1mg/ml vial;

• A description of how the syringes, needles and medication will be kept secure in the vehicles and the station(s);

• A plan for appropriate and safe disposal of medical waste;

• A description of how the medication will be maintained within manufacturer’s approved temperature and light ranges; and

• Documentation of an administration and the medical director’s plan for quality assurance and appropriateness review of utilization.

Once the EMS service has decided to implement a syringe epinephrine program, the EMS Service must provide the Department with an updated **Medical Director Verification Form (DOH-4362)**.

### Resources

**Medical Director Verification Form (DOH-4362)** – fill-in-able

**Check & Inject NY**

**Anaphylactic Reaction with Respiratory Distress and Hypoperfusion Protocol** – M-3

**Emergency Medical Technician Instructional Guidelines** – Intramuscular Injections and Psychomotor Evaluation Tool (pages 2 – 4)
Background

A Technical Advisory Group (TAG) was established the New York State Emergency Medical Services Council (SEMSCO) at their September 2016 meeting. The TAG was established to examine ongoing concerns about the future viability of the EMT-Critical Care (CC) level of certification in New York State. The TAG was charged with examining the past and present operation of the CC program with the goal of making recommendations on the CC going forward.

The TAG reviewed CC utilization in each region, the curriculum, administrative burden and costs of sustaining CC education curriculum and exam development and maintenance, original course participation, refresher course attendance, use of CME refreshers and the comparative scope of practice and availability of AEMT educational programs. In the final analysis, the TAG concluded:

- The CC provider numbers have been steadily declining since 1997 and continue to trend downward;
- The number of CC original and refresher courses offered has also declined while the number of course sponsors have remained stable. The decline in course offerings is likely related to declining enrollments.
- Simultaneously, the CC program would require extensive curriculum, practical skills and written examination extensive revisions.
- The CC has no national equivalent from which curriculum and test items can be drawn.

The TAG proposed to SEMAC and SEMSCO a number of actions to gradually end the CC level of certification in NYS. These actions would allow continued CC certification renewals, affording REMSCOs and REMACs a prolonged period in which to sustain or reconfigure their systems, based on regional needs. These were approved by the SEMSCO at their May 10, 2017 meeting.

Transition Implementation Process

The following actions are being implemented to gradually end the CC level of certification.

1. Continue the CC Continuing Medical Education (CME) refresher program.

2. The Department will no longer approve original CC courses with a start date after January 1, 2018.

3. The Department will no longer approve CC refresher or rapid refresher courses whose written examination would that place after August of 2019.

4. The development and release of an advanced standing/bridge program from CC to Paramedic. This will be open to any NYS CC with 3 years of documented continuous practice¹. This program will include, but not be limited to on-line didactic content with availability of skills and testing by local course sponsors.

¹ The term “continuous practice” is defined by 10 NYCRR Part 800.3(w)
At the March, 2016 meetings of the State Emergency Medical Advisory Committee (SEMAC) and the State EMS Council (SEMSCO), the acquisition and transmission of 12 lead electrocardiograms (ECG) by Basic Life Support (BLS) and Advanced Emergency Medical Technician (AEMT) level providers was approved for use by New York State’s EMS agencies. This decision was based on the results of a demonstration project, which established that BLS providers acquiring and transmitting a 12-lead ECG from the field to physicians in hospitals may substantially improve the timeliness of identification and intervention in patients suffering from an ST Elevation Myocardial Infarction (STEMI).

The SEMAC approved BLS/AEMT 12 lead ECG acquisition as a regional option. Should an EMS agency wish to implement a 12 lead ECG program at the BLS/AEMT level, the EMS agency must be granted approval by their Regional Emergency Medical Advisory Committee (REMAC) and each certified EMS provider must complete a REMAC approved training program. The acquisition and transmission of 12 lead ECG will be an option in the NYS BLS Protocols, but training will not be included in the state approved original or refresher curricula/courses.

In systems heavily reliant on BLS providers, acquiring and transmitting 12-lead ECG from the field to physicians in hospitals can substantially improve the timeliness of identification and intervention in patients suffering from STEMI. This may also improve care in two-tiered systems where BLS is likely to be on scene and working in conjunction with, or intercepting with Advanced Life Support (ALS) providers.

Policy

REMACs may choose, but are not required, to allow the BLS/AEMT acquisition and transmission of 12 lead ECGs into their systems. If approved, the REMAC may develop a policy for which devices may be used and how they will integrate into the existing systems for STEMI care. Any device approved must be capable of transmitting 12 lead ECG data to the receiving hospital.

EMS Agencies wishing to implement a BLS/AEMT 12 lead acquisition and transmission program must make a written request to their REMAC. The request should include, but may not be limited to the following:
A letter from the agency medical director supporting the implementation of the 12 lead program, including the physician’s plan for training, quality assurance and appropriateness review.

A letter from the receiving hospital(s) advising that they are capable of receiving the 12 lead data and providing it to the appropriate hospital personnel.

Agency policies and procedures for the 12 lead program that are consistent with state and regional policies and protocols. This should include, but may not be limited to, the following:

- Use of the approved training program, requirements for continuing education, maintenance of competencies and the documentation for authorized providers;
- A description of how the agency will follow the NYS Statewide Adult and Pediatric Protocols – Adult Cardiac Related Problem (M-5) [http://www.health.ny.gov/professionals/ems/protocol.htm](http://www.health.ny.gov/professionals/ems/protocol.htm);
- A description of the 12 lead device proposed to be utilized by the EMS agency; and
- Assurance that 12 lead ECGs obtained while caring for a patient will be subject to physician review.

Once the EMS agency has received written approval from the REMAC, the EMS Service must provide the Department with an updated Medical Director Verification Form (DOH-4362) [http://www.health.ny.gov/forms/doh-4362.pdf](http://www.health.ny.gov/forms/doh-4362.pdf) indicating approval to participate in the 12 lead acquisition program.
Bureau of Emergency Medical Services and Trauma Systems

POLICY STATEMENT

Supersedes/Updates: New

The Department of Health’s Bureau of Emergency Medical Services and Trauma Systems and the Blood and Tissue Resources Program have collaborated on a process to allow advanced life support ambulance services that have been approved as Ambulance Transfusion Services (ATS), to provide inter-facility transports for patients who are receiving blood or blood products.

In order for an ambulance service to transport a patient receiving blood/blood products from one hospital to another, the ambulance service must be approved by the Department as an Ambulance Transfusion Service (ATS). An ATS is defined in Section 58-2.16(h) as:

…an ambulance service certified by the department that administers blood components during transport from one hospital to another hospital.

A new Section 58-2.16(h) adds provisions to permit Emergency Medical Technician (EMT) - Critical Care and EMT-Paramedics (EMT-CC/EMT-P) with specialized training to monitor transfusions and initiate additional units during inter-facility transport to facilitate expeditious transport of patients requiring transfusion during transport.

Notification Process:

In order for an ambulance service to be an ATS for the administration of blood/blood products to a patient being transported between hospitals, the ambulance agency must have the following in place and receive written acknowledgement from the Department:

- The ambulance service medical director must approve the personnel training and quality assurance programs for the EMS service, as well as all personnel who will be involved in administering of blood/blood products.

- The ambulance service should make written notification to the REMAC.

- Only those individuals certified at the EMT-CC/EMT-P level may administer blood/blood products and monitor the medical status of those patients.

- Each EMT-CC/EMT-P must complete the training requirements required by the Department. The training must be conducted by the agency medical director, a NYS EMT-P Certified Instructor Coordinator in conjunction with the blood bank physician with whom the agency has an agreement. Additionally, each EMT-CC/EMT-P will be required to receive updated training on an annual basis.
• In order to obtain permission from the Department to be an ATS, the ambulance service must submit a complete Notice of Intent to Provide Ambulance Transfusion Services (ATS) to the Bureau of EMS. The Notice must be accompanied by the following documentation:
  
  o A letter from the medical director accepting full responsibility for training staff, as well as oversight and quality assurance for the administration of blood/blood products.
  o A copy of the ambulance service’s policies, procedures, and protocol for the transport of patients receiving blood/blood products.
  o A list of all advanced EMS providers approved and trained to administer/monitor patients receiving blood/blood products. The list must include EMT-CC/P certification numbers and current expiration dates.
  o A written agreement with a hospital blood bank must specify roles and responsibilities for assuring compliance with all applicable DOH regulations. The written agreement must include, but not be limited to the following:
    ▪ Description and information on storage and transportation devices;
    ▪ emergency protocols and procedures for adverse reactions;
    ▪ process for providing the blood bank with appropriate patient records; and
    ▪ participation in quality improvement programs.

  The written agreement must be approved and signed by the hospital’s transfusion service director, ambulance agency medical director and chief executive officer.

• The ambulance service must be able to do the following:
  
  o Transport blood/blood products in a cooler provided and tested by the hospital transfusion center.
  o Purchase and utilize an appropriate electronic patient thermometer.
  o Monitor and document the condition of the patient receiving a transfusion, which will include, but not be limited to, physical assessments, and vital signs, including temperature.
  o Recognize and treat adverse transfusion reactions in accordance with regional protocols and/or medical control.

• The ambulance service must submit to the Department, policies and procedures for the administration and monitoring of blood/blood products with each Notice of Intent. The policies and procedures must include, but not be limited to, the following:
  
  o A detailed description of the process for the procurement of blood and maintaining the temperature and integrity as required by the hospital transfusion center.
  o A program of 100% quality assurance case review by the service medical director for all patients transported with blood/blood products having been administered.
  o The training program used to in-service all EMT-CC/P staff.

• In the event of an adverse reaction, the ambulance service medical director is required to submit a report to the Department within 24 hours. The report shall include, but not be limited to, the following items:
  
  o A copy of the patient record.
  o A summary of the patient’s presenting problems.
  o A narrative summary highlighting the Quality Assurance reviews conducted for each blood/blood product administration.
  o A copy of the medical director’s review and comments.
  o The report should be sent to the following address:

  Bureau of Emergency Medical Services and Trauma Systems
  NYS Department of Health
  875 Central Avenue
  Albany, NY 12206
• Mail the completed packet, with the signed agreement, standard operating procedures, and other relevant documents to:

  Bureau of Emergency Medical Services and Trauma Systems
  NYS Department of Health
  875 Central Avenue
  Albany, NY 12206

• After the Department’s review of the ambulance service’s Notice of Intent, policies and procedures, training program and implementation plans, the Department will issue a written approval to operate as an ATS. The ambulance service may not transport a patient receiving blood/blood products until it has received the written notification.

• Every ambulance service approved to operate as an ATS will be required to submit a renewal Notice to the Department along with the agency’s biennial certification renewal application.

• The Department will closely monitor all ambulance agencies that transport patients with blood/blood products being infused to insure that there is strict compliance with all of the applicable sections of Public Health Law, the Codes, Rules and Regulations. The Department, in accordance with 10 NYCRR Part 800, Subpart 58-2, and Article 30 of the NYS Public Health Law, may conduct a site inspection, including required documents, without prior notice of an applicant or approved Ambulance Transfusion Service. Failure to comply with any of the applicable regulations and policies may result in the revocation of the ambulance service’s ATS designation.
Background

The New York State Department of Health (Department), Bureau of Emergency Medical Services and Trauma Systems (BEMS) administers certification examinations to persons who meet the minimum requirements for NYS certification in accordance with Chapter VI of Title 10 (HEALTH) of the Official Compilation of Codes, Rules and Regulations, Part 800.

Purpose

This policy is intended to provide guidance to persons with documented disabilities who request reasonable accommodations to take the NYS DOH BEMS certification examination. The Department, in accordance with the requirements of Title II of the Americans with Disabilities Act (ADA), as amended, will not discriminate on the basis of disability.

Procedures

The Department offers reasonable and appropriate accommodations for its certification examinations for those persons with documented disabilities, as required by the Americans with Disabilities Act (ADA).

The Department will review each request on an individual basis and make its decisions relative to appropriate accommodations based on the following guidelines:

1. An individual requesting an accommodation under ADA must present adequate documentation demonstrating that his/her condition substantially limits one or more major life activities.

2. Requested accommodations must be reasonable and appropriate for the documented disability and must not fundamentally alter the examination’s effectiveness in assessing the essential functions of pre-hospital care, which the examinations are designed to measure.

3. Professionals conducting assessments, rendering diagnoses of specific disabilities and/or making recommendations for appropriate accommodations, must be qualified to do so.
4. All documentation submitted in support of a requested accommodation will be kept in confidence and will be disclosed to Department staff and consultants only to the extent necessary to evaluate and/or provide the accommodation. No information concerning an accommodation request will be released to third parties without written permission from the candidate.

In order for an individual to be eligible to take a NYS DOH BEMS certification examination, the individual must:

1. Enroll in a NYS DOH BEMS approved course offered through an approved educational entity (course sponsor).

2. Complete and submit, through the EMS course sponsor, an Application for Emergency Medical Services Certification, form number DOH-65.

3. Persons requesting an accommodation must submit their request in writing to the Department via fax to 518-402-0985 or to:

   New York State Department of Health
   Bureau of EMS – Certification Unit
   875 Central Avenue
   Albany, New York 12206

Requests should include the following information:

   a. Individual’s first and last name.
   b. Individual’s mailing address.
   c. Individual’s telephone number and email address.
   d. Course number the individual is enrolled in (obtain from instructor).
   e. What accommodations the individual is requesting, if known.
   f. Any documentation from professionals who have conducted assessments or who have rendered diagnoses to support the accommodation request.
   g. In many cases, this can be in the form of an Individualized Education Program (IEP), a formal psycho-educational evaluation.

All requests for reasonable accommodations must be received by the Department no later than 8 weeks prior to the date of the certification examination scheduled for the class in which the individual is enrolled. Ideally, the request should be made at the start of the course or as soon as possible.
Individuals requesting an accommodation will be notified in writing of the Department’s decision to either grant, deny or modify the requested accommodation.

In the event the individual does not agree with the Department’s decision, the individual requesting the accommodation may file an appeal by contacting:

Designated Reasonable Accommodation Coordinator
New York State Department of Health
Empire State Plaza, Corning Tower, Room 2284
Albany, NY 12237
(518) 474-4398

4. Meet all requirements for Initial Certification Requirements in Part 800.6 or Recertification Requirements in Part 800.7.

5. Complete all requirements for course completion through a course sponsor.
Emergency Medical Services (EMS) providers care for patients of all ages, who present with a wide variety of illnesses or injuries. Nationally and in New York State, 9-10% of all EMS responses are for pediatric patients; in New York that amounts to approximately 270,000-300,000 pediatric patients annually who are treated by EMS. The enclosed guidance is intended to ensure that ambulance services in New York State are properly equipped to provide appropriate care to pediatric patients.

In an effort to better care for pediatric patients, the federal Emergency Medical Services for Children (EMSC), in collaboration with the American Academy of Pediatrics (AAP), American College of Surgeons Committee on Trauma (ACS-COT), American College of Emergency Physicians (ACEP), National Association of EMS Physicians (NAEMSP), Emergency Nurses Association (ENA), and the National Association of State EMS Officials (NASEMSO) have jointly developed a list of standardized equipment for emergency ground ambulances. All seven organizations adhere to the principle that EMS providers at all levels must have the appropriate equipment and supplies to optimize prehospital delivery of care.

This recently updated list of Equipment for Ground Ambulances (2014) has been approved and endorsed by New York’s State EMS Council (SEMSCO), State Emergency Medical Advisory Committee (SEMAC) and the EMS for Children Advisory Committee (EMSCAC) for certified EMS agencies in New York.

Equipment for Ground Ambulances - Online Version:

(Publisher Name: American Academy of Pediatrics & Journal of Prehospital Care).
This link references the complete document/equipment list for both BLS and ALS ambulances.

The chart found below lists pediatric BLS items required in New York State Part 800 regulations, and also includes the national Equipment for Ground Ambulances recommendations. The additional recommended equipment to current Part 800 regulations are shaded on the list. Adult-sized equipment is included with pediatric sizes as many children are the size of small adults. The SEMSCO and SEMAC recommend that Regional Medical Advisory Committees (REMAC) should consult the national Equipment for Ground Ambulances list when updating the regional ALS equipment requirements.
### BLS Equipment

<table>
<thead>
<tr>
<th>Equipment</th>
<th># Pieces of Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suction catheters</strong></td>
<td></td>
</tr>
<tr>
<td>Rigid tonsil tip</td>
<td>2</td>
</tr>
<tr>
<td>Flexible between 6-10 French</td>
<td>2 each</td>
</tr>
<tr>
<td><em>Flexible between 12-16 French</em></td>
<td>1</td>
</tr>
<tr>
<td><strong>Oxygen delivery</strong></td>
<td></td>
</tr>
<tr>
<td>Nasal cannula- Adult</td>
<td>4</td>
</tr>
<tr>
<td>Nasal cannula- Child</td>
<td>2</td>
</tr>
<tr>
<td>Non-rebreather masks- Adult</td>
<td>4</td>
</tr>
<tr>
<td>Non-rebreather masks- Child</td>
<td>2</td>
</tr>
<tr>
<td><strong>Bag valve mask</strong></td>
<td></td>
</tr>
<tr>
<td>Hand operated self-expanding bags child 450-750 ml</td>
<td>1</td>
</tr>
<tr>
<td>Hand operated self-expanding bags adult &gt;1000 ml</td>
<td>1</td>
</tr>
<tr>
<td><strong>Masks for BVM</strong></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>1</td>
</tr>
<tr>
<td>Child</td>
<td>1</td>
</tr>
<tr>
<td>Infant</td>
<td>1</td>
</tr>
<tr>
<td>*Neonate</td>
<td>1</td>
</tr>
<tr>
<td><strong>Airways</strong></td>
<td></td>
</tr>
<tr>
<td>*Nasal Airways 1 size between 16-24 Fr</td>
<td>1</td>
</tr>
<tr>
<td>*Nasal Airways 1 size between 26-34 Fr</td>
<td>1</td>
</tr>
<tr>
<td>Oral airways size 0-1</td>
<td>2</td>
</tr>
<tr>
<td>Oral airways size 2-3</td>
<td>2</td>
</tr>
<tr>
<td>Oral airways size 4-5</td>
<td>4</td>
</tr>
<tr>
<td>*Pulse oximeter</td>
<td>1</td>
</tr>
<tr>
<td>*with pediatric probe</td>
<td>1</td>
</tr>
<tr>
<td>*with adult probe</td>
<td>1</td>
</tr>
<tr>
<td>*AED that includes pediatric capability</td>
<td>1</td>
</tr>
<tr>
<td>*adult pads</td>
<td>1</td>
</tr>
<tr>
<td>*child pads or dose attenuator with adult pads</td>
<td>1</td>
</tr>
<tr>
<td><strong>Immobilization devices</strong></td>
<td></td>
</tr>
<tr>
<td>Rigid cervical collar - small</td>
<td>1</td>
</tr>
<tr>
<td>Rigid cervical collar - medium</td>
<td>1</td>
</tr>
<tr>
<td>Rigid cervical collar - large</td>
<td>1</td>
</tr>
<tr>
<td>Lower extremity traction - adult</td>
<td>1</td>
</tr>
<tr>
<td>Extremity immobilization - small</td>
<td>1</td>
</tr>
<tr>
<td>Extremity immobilization - medium</td>
<td>2</td>
</tr>
<tr>
<td>Extremity immobilization - large</td>
<td>2</td>
</tr>
<tr>
<td>OB Sterile Kit (Commercial or locally packed)</td>
<td>1</td>
</tr>
<tr>
<td>Receiving blanket</td>
<td>1</td>
</tr>
<tr>
<td>*Head cover</td>
<td>1</td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
<td></td>
</tr>
<tr>
<td>Sphygmomanometer adult cuff</td>
<td>1</td>
</tr>
<tr>
<td>Sphygmomanometer pediatric cuff</td>
<td>1</td>
</tr>
<tr>
<td>*Length-based resuscitation tape or reference material that provides appropriate guidance based on length or age</td>
<td>1</td>
</tr>
<tr>
<td>*Age/size appropriate restraint systems for all passengers and patients transporting in ground ambulances. (For children, this should be according to the National Highway Traffic Administration’s document; Safe Transport of Children in Emergency Ground Ambulances)</td>
<td>Various</td>
</tr>
<tr>
<td>*Access to pediatric and adult patient care protocols</td>
<td>1</td>
</tr>
</tbody>
</table>

*Shading* indicates recommended equipment in addition to Part 800.
Based on the results of a demonstration project, at the September 9, 2014 meeting of the New York State Emergency Medical Service Advisory Council (SEMSCO), the use of Continuous Positive Airway Pressure (CPAP) by Emergency Medical Technicians (EMT) in Basic Life Support (BLS) EMS agencies was approved. The SEMAC approval was granted with the specific condition that an EMS service wishing to use a CPAP device at the BLS level, be granted approval by their Regional Emergency Medical Advisory Committee (REMAC) and that each EMT complete an approved training program. The Commissioner of Health has approved the addition of CPAP as a part of the scope of practice for certified EMTs in New York State.

Policy

The SEMAC has approved a statewide protocol for the use of CPAP devices by EMT personnel for patients in respiratory distress. The REMAC must also adopt a single standardized training program, approved by the Department, which will be used by all agencies electing to utilize CPAP at the EMT level.

EMS Agencies wishing to be authorized to use CPAP devices must make a written request to their REMAC. The request should include, but may not be limited to the following:

- A letter from the agency medical director supporting the request for use of CPAP, including the physician’s plan for quality assurance and appropriateness review of each utilization.

- Written policies and procedures for the use of CPAP that are consistent with regional policies and protocols. This shall include the following:
  - Written policies and procedures requiring the approved training program, requirements for continuing education, maintenance of competencies and the documentation for authorized providers;
  - A description of the CPAP device being utilized by the EMS agency.

Once the EMS service has received written approval from the REMAC, the EMS Service must provide the Department with an updated Medical Director Verification Form (DOH-4362) indicating CPAP approval.
Background

The New York State Department of Health (Department), Bureau of Emergency Medical Services (EMS) is responsible for the oversight of New York State (NYS) EMS education and training programs, leading to NYS EMS certification. Courses leading to certification at all levels of Emergency Medical Technician, are required to contain learning objectives, which are to be completed through field observation, hospital observation, field clinical, and/or hospital clinical methods.

Purpose

This policy is intended to provide guidance to NYS EMS agencies, course sponsors, hospitals, and other affiliated institutions who may be accepting EMS students for the purpose of completing field and clinical educational objectives that lead to NYS EMS certification.

Procedures

1. NYS EMS Education Programs - In order for an individual to begin and complete any of the field and/or clinical learning objectives, individuals must be enrolled in a NYS Department of Health approved EMS certification course. In order to be considered a student, the following conditions must be met:
   
a. A Department approved Course Sponsor must oversee all educational components;
b. An affiliation agreement between the Course Sponsor and the clinical or field EMS agency and/or institution must be approved and on file with the Department;
c. Form DOH-782, Course Application must be approved and on file with the Department; Form DOH-65, Application for Emergency Medical Services Certification must be completed by all students and on file with the Department;
d. Student must have met all Course Sponsor educational requirements to begin aforementioned learning objectives as approved by the Department;
e. A Course Sponsor approved preceptor must oversee all aspects of the clinical and/or field objectives that are completed outside of the classroom;
f. Department and Course Sponsor approved student and preceptor documentation must be complete; and,
g. Only those skills, previously and successfully completed in the classroom environment and approved by the Certified Instructor Coordinator (CIC) for the course, may be performed by the student, and under the direct supervision of their assigned preceptor outside the classroom.

2. Out-of-state EMS Education Programs - Individuals who are students in courses held outside of NYS and are not enrolled in a NYS Department of Health approved EMS
certification course must have the following:

a. An affiliation agreement between the NYS EMS agency and/or medical institution and the out-of-state educational institution that is approved and on file with the Department;

b. A NYS EMS certified provider must act as a preceptor for any student completing their objectives at a NYS EMS agency. The preceptor must be currently certified at or above the level of training the student is seeking and approved by the agency Medical Director, or in the case of hospitals and/or other medical institutions, in accordance with their policies;

c. Objectives completed at a hospital or other non-EMS agency medical institution, must follow the policies and procedures of that medical institution as outlined in the affiliation agreement;

d. Students who are completing learning objectives for a national Emergency Medical Responder (EMR) or EMT course may only observe; they may not provide direct patient care;

e. Students who are completing learning objectives for any EMS course above the level of EMT that include advanced level skills, must be certified as a NYS EMS EMT prior to beginning any learning objectives or skills in NYS;

f. Students may apply for and must be granted NYS EMS Reciprocity prior to beginning clinical and/or field rotations;

g. Documented behavioral and learning objectives for each student must be provided by the out-of-state educational institution and maintained on file with the preceptor’s EMS agency and/or institution;

h. Students may only perform those ALS skills, for which their lead instructor documented successful demonstration in the classroom environment and under the direct supervision of their assigned preceptor; and,

i. All aspects of the student’s learning experience must be documented by the preceptor and kept on file at the agency or medical institution.

3. Affiliation Agreements Requirements – All of these agreements must include, but not be limited to the following:

a. The contact information, including names, addresses, telephone numbers, e-mail addresses and other demographic information for each of the entities involved in the agreement;

b. The start and expiration date of the agreement. The duration of the agreement may not be more than four (4) years and must be reviewed and approved by the Department annually.

c. The written responsibilities for the preceptor, student and agency/institution;

d. Liability and malpractice insurance requirements for all parties; and

e. The process that the preceptor, student and educational institution utilize to correspond regarding student progress.

Adherence to this policy will insure patient safety, appropriate prehospital care, completion of the field and/or clinical education goals and objectives, as well as protect the EMS community. For further questions, please contact:

Education Unit
New York State Department of Health
Bureau of Emergency Medical Services and Trauma Systems
518-402-0996
PURPOSE:

The purpose of this policy statement is to provide clarification of the requirements pertaining to the labeling and signage of NYS Certified ambulances and emergency ambulance service vehicles (EASVs). The applicable governing regulations are 10 NYCRR Part 800.21(e), which defines the requirements for the exterior labeling of all ambulances and emergency ambulance service vehicles (EASVs) and 10 NYCRR Part 800.4(a), which restricts the display of the word “Ambulance” to only motor vehicles, aircraft, and boats certified by the Department.

BACKGROUND:

These regulations, 800.21(e) and 800.4(a), were adopted to protect the public. They were respectively intended to clearly identify the DOH certificate holder operating a certified EMS vehicle, and to prohibit the display of the word “ambulance” on all land, air, and water vehicles, other than Department of Health certified ambulances.

For contract, marketing and other reasons, some agencies may have placed the names and logos of organizations other than the DOH certificate holder on vehicles as part of the signage or labeling displayed. Other services may have used modern design technology to create striking vehicle graphics for their EMS vehicles. In certain situations, either of these actions may have the unintended consequence of violating Part 800.21(e) or Part 800.4(a).

REGULATION:

- **All certified ambulance services must:** “Display on the exterior of both sides and the back of all ambulances and emergency ambulance service vehicles the name of the service in letters not less than 3 inches in height and clearly legible. The logo provided by the department shall also be displayed on both sides and the back of every ambulance and shall be removed upon sale or transfer of the vehicle.” [10 NYCRR Part 800.21(e)]

- **“The word “ambulance” may not be displayed on a vehicle, aircraft, or boat except on a vehicle, aircraft, or boat registered with the department as an ambulance except to comply with 800.21 (e).”** [10 NYCRR Part 800.4(a)]
POLICY

- It is the Department’s duty to protect the public’s right to easily identify the DOH certified provider of an EMS service, and to protect the public from labeling and signage that may be misleading, or in the worst case, blatantly fraudulent.

- The name (or DBA) of the certified entity, as it appears on the DOH Ambulance Service Certificate, must be displayed predominately, larger than any other name, and in a manner that does not confuse the identity of the actual DOH certified operator. Any other name or lettering displayed (hospital, industrial corporation, etc.) must be smaller in size and secondary in relationship to the name of the DOH certified entity.

- The statement ‘Operated for’ may be used, as appropriate, to indicate a relationship to the second entity.

- Any labeling design which includes a second name is subject to the approval of the Department. Services are required to submit actual or conceptual designs to the Bureau of EMS & Trauma Systems for prior approval.

- If a certified EMS agency’s name contains the word “ambulance”, the word “ambulance” may be displayed on an EASV operated by the agency, but only to the extent necessary to comply with Part 800.21(e), and only as part of the agency’s complete and entire name. Additionally, the word “ambulance” must be of the same size, or smaller than, other labeling that identifies the DOH certified operator.

- If a vehicle is marked with “advanced life support”, “paramedics” or with any similar level of care identification, the service operator must ensure that the vehicle is staffed by personnel at the advertised level of care, at all times when the vehicle is in service.

- Labeling a certified EMS vehicle in any manner that constitutes “false advertising”, as declared unlawful and defined by Article 22-A of NYS General Business Law, is also a violation of 10 NYCRR Part 800.2 [“Applicability of Other Laws, Codes, Rules, and Regulations”].

MUNICIPAL CONTRACTUAL IDENTIFICATION

The name of the service requirement does not apply to an agency when operating a service for a municipality under the provisions of PHL 3008.7a. In these cases all operations are the responsibility of the licensed entity and since the service is operated by the municipality, all vehicles must bear the name of the entity. The specifics of any such arrangement should be discussed with the Department prior to implementation.
This policy was developed in conjunction with the State Emergency Medical Services Council (SEMSCO) and State Emergency Medical Advisory Committee (SEMAC). It is intended to provide guidance to EMS Agency Medical Directors, Regional Medical Directors, and Regional Emergency Medical Advisory Committees (REMACs) to promote an ongoing EMS patient care performance monitoring and quality improvement relationship between EMS providers and the Physician Medical Directors ultimately responsible for authorizing EMS provider practice.

**Purpose**

1. To protect EMS patients by providing the means for remediating and if necessary restricting the practice of an EMS provider when a Physician Medical Director has concern about the EMS provider’s ability to competently provide medical care.
2. To provide fair and consistent due process for the EMS provider in resolving and/or appealing a patient care restriction.
3. To ensure that patient care restrictions are enacted fairly and in accordance with an EMS agency’s or region’s quality improvement (QI) program.
4. To ensure that the QI process is not used in a punitive fashion.
5. To promote interagency and interregional QI initiatives in cases where EMS providers operate in multiple regions.

**Definitions**

1. “Agency Medical Director (AMD)” means a physician identified by an EMS agency as providing medical oversight for the agency.

2. “Regional Medical Director (RMD)” means a physician identified by a REMAC as providing medical oversight for the region.

3. “Patient care restriction” means any restriction placed on an EMS provider by an AMD, RMD, or REMAC that limits an EMS provider’s ability to perform, in whole or in part, to the EMS provider’s level of certification and/or regional authorization.

A patient care restriction may restrict all care (the provider may not practice either basic or advanced level care), restrict only advanced level care (the provider may still practice basic level care), restrict an individual skill or procedure, and/or remove standing orders.
(the provider would have to contact Medical Control and receive specific on-line orders to perform procedures, treatments, and therapies).

Patient care restrictions should be considered separate from and in addition to any non-patient care related restrictions that may be placed on a provider by an EMS agency (i.e., violation of agency rules and procedures, lateness, uniform issues, drivers’ license restriction, etc.).

4. “Medical Case Review (MCR)” means a confidential review of a patient care restriction performed under the auspices of the regional QI program.

5. “Medical Review Board (MRB)” means a board of physicians convened by the REMAC to perform a medical case review and/or to hear an appeal of a patient care restriction.

Procedure for Enacting/Remediating a Restriction

The care administered by EMS providers is authorized and overseen by physicians. In some cases, these physicians may be AMDs, while in other cases these physicians may be RMDs and/or a REMAC.

1. An AMD may place an EMS provider on a patient care restriction when there is concern regarding the provider’s ability to render appropriate EMS care. The AMD must provide appropriate immediate notification to the affected provider, followed by written notification to the provider within five (5) business days. For any restriction lasting more than 30 calendar days, the AMD must notify the REMAC in writing within five (5) business days of it being known that the duration will surpass 30 days. The AMD may, at any time, notify other respective AMDs, the RMD, the REMAC, and/or the Bureau of EMS and Trauma Systems of any matter felt serious enough to warrant such notification(s) and possible further action.

2. A RMD may (independent of the AMDs) place a provider on a patient care restriction when there is concern regarding the provider’s ability to render appropriate EMS care. The RMD must provide appropriate immediate notification to the affected provider, followed by written notification to the provider within five (5) business days. Such restriction may be concurrent with or in addition to restrictions enacted by an AMD. The RMD must report any such restrictions to the respective AMDs and REMAC in a timely manner and may, at any time, notify the Bureau of EMS and Trauma Systems of any matter felt serious enough to warrant such notification and possible further action.

3. A REMAC may (independent of the AMDs or RMD) place a provider on a patient care restriction when there is concern regarding the provider’s ability to render appropriate EMS care. The REMAC must provide appropriate immediate notification to the effected provider, followed by written notification to the affected provider within five (5) business days. Such restriction may be concurrent with or in addition to restrictions enacted by an AMD or RMD. The REMAC must report any such restriction to the RMD and respective AMDs in a timely manner and may, at any time, notify the Bureau of EMS and Trauma Systems of any matter felt serious enough to warrant such notification and possible further action.
4. When notified of a patient care restriction enacted by an AMD or RMD, the REMAC may enact a greater patient care restriction further limiting the care a provider may render within the region. The REMAC must provide appropriate immediate notification to the affected provider, followed by written notification to the provider within five (5) business days.

5. For any restriction coming before the REMAC, the REMAC is responsible to make timely written notification of such restriction to all EMS agencies, and the respective AMDs, where the provider is listed as practicing. If appropriate, the REMAC will notify in writing all other affected REMACs and the Bureau of EMS and Trauma Systems for possible further action. All patient care restrictions coming before the REMAC will be reviewed by the Regional QI Program committee.

6. The respective AMDs, RMDs, and REMACs will be responsible for ensuring that any patient care restriction is honored.

7. Any patient care restriction should be followed by a definitive course of provider remediation, including a timeframe for the restriction/remediation, developed in partnership with the provider, AMD, RMD, REMAC, EMS agency, local EMS training center, and/or local hospital as appropriate and allowable. Once the provider has successfully completed remediation and the restriction removed, written notification must be provided to the appropriate persons and entities. If it is determined that the issue cannot be corrected through remediation or the provider is no longer affiliated with the respective EMS agency or REMAC region, the matter will come before the REMAC (in consultation with the Bureau of EMS and Trauma Systems as necessary) for appropriate further action.

**Procedure for an Appealing a Restriction**

1. A provider may appeal any patient care restriction by an AMD or RMD in writing to the REMAC.

2. Within 30 days of receipt of an appeal, the REMAC must convene a MRB to conduct a MCR under the auspices of the Regional QI Program.

3. The MRB may request relevant documentation including pre-hospital patient care reports, hospital records, training records, QI records, and written statements from patients, providers, bystanders, etc. The MRB may invite the provider, AMD, RMD, patient, other providers, EMS agency officials, or other parties who may be able to provide relevant information.
4. As the MRB is a committee of the REMAC, after hearing the appeal the MRB must make a recommendation to the REMAC, which in turn shall make the determination on the appeal. The MRB may recommend to the REMAC:
   
   a. that the REMAC remove all or part of the restriction;
   
   b. that the provider successfully complete appropriate remediation before the REMAC removes all or part of the restriction;
   
   c. that the REMAC revoke the provider’s credentials/authorization to practice; and/or
   
   d. that the REMAC refer the matter to the Bureau of EMS and Trauma Systems for investigation/enforcement action.

5. After an appeal is determined, the REMAC must provide follow up notification of the determination to all those originally notified of the restriction.

6. In accordance with Public Health Law Article 30, Section 3004-A:

   4. Any decision of a regional emergency medical advisory committee regarding provision of a level of care, including staffing requirements, may be appealed to the state emergency medical advisory committee by any regional EMS council, ambulance service, advanced life support service, certified first responder, emergency medical technician, or advanced emergency medical technician adversely affected. . . . Any decision of the state emergency medical advisory committee may be appealed pursuant to subdivision two-a f section three thousand two-a of this article.

Issued and Authorized by
Lee Burns, Director - Bureau of EMS
At the October, 2013 meeting of the New York State Emergency Medical Advisory Committee (SEMAC), the administration of naloxone (Narcan®) using a mucosal atomizer device (MAD) for patients experiencing opioid overdoses was approved for use by certified Basic Life Support EMS providers in Basic Life Support (BLS) EMS agencies. The Commissioner of Health has approved the administration of intranasal naloxone as a part of the scope of practice for certified Basic Life Support EMS providers in New York State.

The purpose of this policy is to explain the process for agencies wishing to implement an intranasal naloxone program. The addition of administration of intranasal naloxone is intended to provide prompt emergency medical care to patients with symptomatic acute opioid overdoses as described in prehospital protocol.

In order to participate in the BLS intranasal naloxone program, the EMS agency must have approval from its medical director, complete the approved training program which includes watching a video, reviewing written materials and a brief supervised practice session and make notification to the local Regional Emergency Medical Advisory Committee (REMAC).

BLS INTRANASAL NALOXONE PROGRAM

The SEMAC has approved an amendment to the Altered Mental Status protocol in the New York State CFR and EMT/AEMT BLS Protocols which will enable EMS agencies and certified Basic Life Support EMS providers to administer intranasal naloxone to patients experiencing an acute opioid overdose. A NYS EMS Lesson Plan Guide has been developed for use by EMS course sponsors. Additionally, the REMAC may approve training programs and determine the type and level of record keeping and quality assurance requirements for this procedure.

PARTICIPATION

EMS agencies intending to participate in the intranasal naloxone program, must:

1. Notify the local REMAC in writing;
2. Utilize an intranasal naloxone kit that contains the following:
   a. Two (2)- naloxone hydrochloride pre-filled Luer-Lock (needleless) syringes containing 2mg/2ml
   b. Two (2)- mucosal atomization devices (MAD): and
   c. One (1)- container for security/storage
Additionally EMS agencies must do the following as a minimum:

1. Develop written policies and procedures for the intranasal naloxone program that are consistent with state and local protocol. This shall include, but not be limited to the following:
   - policies and procedures for the EMS training, credentialing and continuing education;
   - documentation of credentialed users;
   - appropriate patient documentation;
   - a defined quality assurance program, including appropriateness review by the medical director;
   - policies and procedures for:
     - inventory;
     - storage, including environmental considerations;
     - security; and
     - proper disposal of medication and administration devices.

2. Perform quality assurance evaluations on each administration for the initial six (6) months of the program, or longer at the request of the medical director.

3. Provide data to the REMAC upon request.

CONCLUSION

With a growing number of prehospital opioid overdoses throughout the NYS, all EMS agencies are encouraged to train their certified BLS providers in the administration of intranasal naloxone and stock the medication and mucosal atomizer devices (MAD) on their certified EMS response vehicles. The addition of intranasal naloxone has life-saving benefits in reversing opioid overdoses in the prehospital setting. EMS providers are frequently the first to arrive at the scene of an overdose putting them in the best position to administer this time-sensitive, life-saving intervention. The use of a nasal atomizer device reduces the potential for occupational exposure to needle stick injuries. Widely available evidence exists to indicate that the medication is equally effective when administered intra-nasally and suggests no negative health outcomes.

The New York State EMS Demonstration Project concluded with the following:

- 2,035 EMTs trained;
- 223 opioid overdose reversals;
- No adverse events;
- No significant hazards to EMS personnel; and
- 10% of contacted reversals entered rehabilitation programs.
RESOURCES

- CFR/BLS Altered Mental Status Protocol (attached)
- BLS Drug Formulary – Naloxone (attached)
- NYS EMS Lesson Plan Guide
- Reversing Opioid Overdose: Training for EMS and Public Safety Personnel

Course Link: http://hivtrainingny.org/Account/LogOn?crs=821

This link will take you to the DOH website which hosts the training video and associated materials. To access the materials, you must establish an account which is free and takes only a couple of minutes. Once you establish an account, you will be directed to the training materials.

- “Substance Abuse and Mental Health Administration - Opioid Overdose Prevention Toolkit.”

http://store.samhsa.gov/product/SMA13-4742

Issued and Authorized by
Lee Burns, Director - Bureau of EMS
Recommendation on CBRNE AWARENESS
This policy was developed to assist EMS providers and agencies in adopting policies and procedures that will address all-hazards awareness to incidents that include acts of terrorism involving Weapons of Mass Destruction (WMD) specifically chemical & biological agents, radiological, nuclear and explosive (CBRNE) incidents. The intention is for responders to have a keen understanding on how to recognize the unfamiliar risks they may encounter at the scene of a CBRNE event.

Background
The use of terrorism is not a new phenomenon; however, since the early 1970’s terrorist attacks on U.S. interests and citizens has grown in popularity as a strategy or tactic to elicit change. There are many definitions for terrorism, but all contain factors that use force or fear to further an objective.

Terrorism is about the fear of violence. The availability of CBRNE elements allows for a variety of weapons. Additionally, there is increased concern that arson and firearms may also be used as a tactic. History shows that explosives are overwhelmingly the weapon of choice, yet all forms of terrorism have the potential to impact all responders. Although the probability of a significant CBRNE incident is low, the consequences are too severe to ignore. A CBRNE incident can happen anywhere, anytime! EMS providers must be alert and recognize what they may confront when responding to an act of terrorism involving CBRNE.

FBI Definition of Domestic Terrorism
Activities that involve acts dangerous to human life that are a violation of criminal laws of the United States or of any state; appear to be intended to intimidate or coerce a civilian population; to influence the policy of a government by mass destruction, assassination, or kidnapping; and occur primarily within the territorial jurisdiction of the United States. (U.S. Congress, par. 3)

Policy
EMS responders will operate within the Incident Command System (ICS). ICS is one element of the National Incident Management System (NIMS). During a CBRNE response, EMS shall follow ICS as the New York State standard for command and management system.

Department of Homeland Security maintains a two tiered terrorism alert, non-credible & credible threat. EMS agencies should maintain a working relationship with other local and regional responding agencies i.e. law
enforcement, fire, county emergency management office, local & county elected officials. When a credible threat has been determined, these disciplines, including EMS, should meet to be briefed and discuss a mitigation strategy. Consideration should also be given to information and intelligence products which are available to the emergency services community. Maintaining an awareness of events which may impact your community, such as severe weather or mass-gatherings, is a good way to be better prepared for potential incidents.

EMS responders must play a role in the prevention and anticipation of a terrorist attack. The threat of a terrorist attack is real and responders need to understand what makes up the components of such aggression. These factors include:

- Element of surprise. Few people may have prior knowledge of the attack. The suddenness of an attack has much shock value.
- Means of the attack. Attacks can be conducted using a range of CBRNE elements, with improvised explosive devices (IEDs) being the most common. Arson and firearms may be used as well.
- Foreknowledge of a response. Terrorists will gather intelligence by conducting surveillance of potential targets to understand first responder’s response and resource capabilities.
- EMS is in a unique position to observe things. We are invited into areas to provide care. During this response we may see things that are not right. Be observant when doing the Scene Safety Survey. “IF YOU SEE SOMETHING, SAY SOMETHING”, report any suspicious activity to the NYS Terrorism Tips Line at 1-866-SAFE-NYS (866 723-3697). Or call your dispatch; do not transmit over the radio.
- Significant dates. Terrorist attacks may occur on noteworthy dates i.e. April 19th, September 11th.
- Target of the attack. Targets can include: responders (secondary device/ambush), the public, critical infrastructures and other potential targets such as schools, sports arenas, malls, places of worship and mass gathering special events.

**Scene Awareness:**
Scene awareness begins well before any response to a CBRNE incident. Each community should conduct a collaborative effort among emergency responder disciplines and their regional Office of Emergency Management to conduct a threat and vulnerability analysis. Pre planning and preparedness should include assessing resource capabilities, potential terrorist targets, training and exercising together, and knowing each agency’s roles and responsibilities. Responders need to be familiar with their community, existing violence from gangs, protests, union/labor/political issues, nearby military bases, nuclear plants, VIP visits, pharmaceutical plants, interstate commerce, railways, federal buildings and mass gathering events.

Terrorists will plan their impending attacks by acquiring CBRNE materials necessary for their attacks. As responders, we need to maintain a situational awareness when approaching and on scenes. Are there suspicious materials or supplies that indicate preparation of a weapon? For example:

- nitrogen-based fertilizer
- fuel containers/drums
- bomb making materials
- pipes with caps
• propane tanks
• strong chemical smells
• large quantities of fire strike match books
• unknown powder
• castor beans or plants, which could be used to make Ricin
• bottles of hydrogen peroxide
• containers filled with urine
• fireworks, gun powder
• spraying equipment for dissemination
• blueprints of a facility to gain illicit entry
• books or literature on bombing making, etc.
• extremist materials, such as flags, posters, literature, and websites
• the presence of potentially hazardous materials (especially high concentrations are present)
• the unusual presence of equipment which could be used to manufacture CBRNE materials (such as grinders, blenders, mixers, glassware, ice bath, distillers, filters, hot plates, and/or safety equipment to provide protection from hazardous materials)
• quantities of an item, which is unusual for the context in which it is found (such as the presence of several GPS devices, cell phones, backpacks, or other items which could be used to construct an explosive device or aid in an attack)

Be aware of:

• suspicious persons who exhibit apprehensive behavior, improperly dressed for the location or season
• vehicles abandoned with multiple parking tickets, unattended or appear to be out of place
• abandoned packages, luggage or mail left unattended in a crowded place
• mail packages with excessive postage and signage alerts i.e. fragile or handle with care, no return address, oil stains and wires protruding
• chemical fires or toxic odors
• unusual explosions in rural or wooded areas
• the theft or attempted theft of gear, equipment, or vehicles, which could be used to gain access into
secure areas, or aid in criminal or terrorist activity

• statements by individuals that they may engage in violent acts

• individual(s) posing unusual questions related to staffing levels, security, and response plans related to your facility or a location where you may respond

• any unusual activity or circumstance in your community or workplace.

A CBRNE incident can be violent. While enroute, listen to the radio traffic and ask for informational updates. The scene will be the hot zone, and may include CBRNE hazards, weapons being fired, secondary devices, partially exploded devices, booby traps, blood from arterial bleeds, body parts, debris, collapsed structures, fire, smoke, and injured victims screaming for assistance. Know your wind direction!

Responders need to recognize the hazard/threat and make a mental assessment. Avoid the hazard by not getting contaminated or injured. Stay away from liquids, unknown powders, clouds or vapors. Remain alert for suspicious objects/packages/vehicles, and persons who appear to be acting unusual for the circumstances (such as not panicked or surprised by an explosion). If a hazard is detected, isolate or remove yourself from the threat, remove others from the contaminated zone and keep civilians/people from going into the contaminated zone. Encourage anyone within the danger zone to self-evacuate if possible. Notify your dispatch. Ask or find the command post (CP) or establish a CP. Identify the kill zone. Practice the concept of time, distance and shielding. Keep victims within the CBRNE hot zone.

General scene precautions to protect providers include:

• Take protective actions to preserve health and safety i.e. retreat. Have a verbal (code) phrase with your partner to initiate retreat. Understand the first in responders may be in the hot zone and become a victim of the attack. At this time, the exposed responder can still be a resource in providing intelligence i.e. description of the firearm, signs & symptoms, etc.

• Stage in an area upwind, uphill and upstream from the incident.

• Isolation involves preventing others from entering the affected area.

• Shelter in place if evacuation is not possible or is not appropriate i.e. when evacuation would put others at greater risk. This means shelter inside a building and remain there until the danger passes.

• If providers have exited their vehicles and are ambushed, hide behind your wheels to prevent being struck by ricochet bullets fired under your vehicle.

• Try to recognize by sight the following: visible corrosion, chemical reactions, pooling of liquids, condensation on pressure tanks, dead animal, insects, plants, fire or vapor clouds, injured victims or casualties. Multiple victims with same signs & symptoms may indicate a WMD release i.e. seizures, excess salivation, lacrimation, loss of bladder (urination) & bowel control (defecation), gastro-intestinal cramping, emesis, mitosis, better known as SLUDGEM of an organophosphate poisoning/nerve agent.

• Listen for sounds i.e. hissing indicative of a pressure release.

• **BE AWARE AND SUSPECT SECONDARY EXPLOSIVE SCENE DEVICES.**

• Smell is a good initial indicator, but the sense of smell can be overwhelmed and cause the responder to think the odor has gone away, for the presence of hazardous materials. If an odor is smelled, you are too close.

• Do not touch or taste any substance that has not been identified!
• Use PPE that includes: gloves, goggles/face shields, masks/positive pressure, full tyvek suits with hoods & booties.
• Taking note of the appearance of smoke, sounds, odors at the scene and on patients, and the image of the scene in general can aid law enforcement in the investigation.

Use your Emergency Response Guidebook (ERG). This is an aid to identify a hazardous material and should be used during the initial phase of arriving on an incident. Refer to guide 111 of the orange pages if the hazard is unknown.

**Chemical Agents:**
Terrorists may use a toxic warfare chemical i.e. choking, blood, blister or nerve agent, but more likely a more readily available source for WMD will be a toxic industrial chemical (TIC). TICs are within many communities i.e. chlorine, hydrogen cyanide and anhydrous ammonia. Chemical agents can exist in a solid, liquid or gaseous state. Chemical incidents have a rapid onset of symptoms (minutes to hours) and reveal easily seen observations i.e. dead foliage, pungent odor, dead animals/insects and colored residue.

**Biological Agents:**
A biological agent includes: bacteria, virus or a toxin. These agents cause the same symptoms as a naturally occurring disease. Exposures to a biological agent will begin with flu-like symptoms. There may be delayed onset of symptoms (incubation period) making the initial diagnosis difficult and the actual location of infection difficult to determine. Diseases from a biological attack may be contagious. Public health will be the first to detect such an outbreak.

**Radiological Materials and Nuclear Weapons:**
Radiological materials emit invisible, unstable energy in the forms of: alpha particles, beta particles, gamma rays and/or neutrons. All forms of radiation are odorless and colorless, thus radiation detectors must be utilized to detect decaying radioactive isotopes. Dependent on the type and dose of energy, radiation can travel in all directions exposing or penetrating individuals causing radiation sickness (ARS). ARS includes: nausea, diarrhea, burns and possible death. Like biological attacks, radiation incidents will take several days to weeks to appear.

A nuclear weapon incident has a low probability of use, but if detonated can produce devastating large scale damage, much larger than a conventional high explosive. A nuclear weapon detonation may not have a mushroom shaped cloud. Remember time, distance and shielding.

**Explosives Devices:**
Explosive materials have two categories: low and high. Seventy percent of all terrorist incidents involve explosives and can present as an Improvised Explosive Device (IED). IEDs can be deployed in any shape, form or size including: package-type, vehicle-type or suicide (human-borne). When responding, think secondary device!

**References:**
[www.FirstResponderTraining.gov](http://www.FirstResponderTraining.gov) - FEMA /DHS funded training courses
www.cdp.dhs.gov - Center of Domestic Preparedness, Alabama
- National Center for Biomedical Research & Training, Louisiana
www.teex.com/nerrtc - National Emergency Response & Rescue Center, Texas
www.emrtc.nmt.edu - Energetic Materials Research & Testing Center, New Mexico
www.dhses.ny.gov/oct/safeguardNY/ - NYS Division of Homeland Security and Emergency Services
Understanding Terrorism and Managing the Consequences, Paul Maniscalco, and Hank Christen
Introduction:

This policy was updated in consultation with NYS Department of Health (DOH) Bureau of Communicable Disease Control, NYS DOH Occupational Health and Safety, and NYS Department of Labor Public Employee Safety and Health. It is the intention of this policy statement to provide information and recommendations for the transport of patients with potentially infectious respiratory illnesses, such as influenza and tuberculosis (TB). This policy will also provide updated guidelines for “respiratory etiquette” and the use of Personal Protection Equipment (PPE) as well as recommendations for preventive health care measures for EMS providers.

The Bureau of Emergency Medical Services (BEMS) strongly recommends that all EMS agencies review this guidance document, along with other State and county public health recommendations, to prepare your EMS agency response to a patient with a potentially infectious respiratory illness.

EMS providers should be aware of the signs and symptoms of infectious respiratory diseases and the procedures necessary for protecting themselves. Not all respiratory infections are transmitted in the same way. Transmission can occur from direct or indirect contact, large droplets, or small droplet nuclei. The mode of transmission will depend on the etiological agent. When encountering patients with symptoms of potentially infectious respiratory illness, the CDC recommends the use of surgical masks. Certain procedures can also impact transmission of infectious agents by producing aerosols. These are deemed “high risk respiratory procedures” and include intubation, extubation, deep tracheal suctioning, nebulized respiratory treatments and bronchoscopy. When performing these high risk procedures, the CDC recommends the use of appropriate and/or adequate "NIOSH APPROVED / RATED" respirators. The use of NIOSH approved respiratory protection may be required under pandemic influenza or other emerging disease alerts issued by CDC.

More often in the field of emergency medicine, the etiologic agents of infections are unknown. Given this, it is paramount that good infection control practices be followed for contact with all patients.

<table>
<thead>
<tr>
<th>Respiratory Etiquette Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement the use of surgical masks by healthcare personnel, during the evaluation of patients with respiratory symptoms.</td>
</tr>
<tr>
<td>Provide surgical masks to all patients with symptoms of a respiratory illness. Provide instructions on the proper use and disposal of masks.</td>
</tr>
<tr>
<td>For patients who cannot wear a surgical mask in addition to any medical treatment being provided, provide tissues and instructions on when to use them (i.e., when coughing, sneezing, or controlling nasal secretions), how and where to dispose of them, and the importance of hand hygiene after handling this material.</td>
</tr>
</tbody>
</table>
Recommendations:

1. Personal Protection

When assessing a patient with symptoms of a febrile respiratory illness, the use of a surgical mask is recommended. When performing high risk aerosolizing procedures the use of a NIOSH approved/rated respirator is recommended. When directed by a BEMS Advisory, the REMAC or the EMS agency medical director, use the highest level of respiratory protection available. The employer is responsible for ensuring the proper PPE is utilized and when respirators are used, conforming with requirements (i.e. medical screening, fit testing, training, user seal checks, respiratory protection plan, etc.) as prescribed by the OSHA Respiratory Protection standard. In all cases, adhere to Standard Precautions - the use of gown, gloves and eye protection if contact with bodily secretions or a contaminated environment is anticipated. Additionally, EMS providers must be familiar with PPE application (donning) and removal (doffing) procedures. The routine use of Standard Precautions will allow EMS providers to protect themselves and their patients against known infectious diseases or other new emerging diseases.

- Place a surgical mask on the patient if not medically contraindicated.
- Prior to transporting a patient with an infectious respiratory symptom, the door between the driver and the patient compartment should be closed. If the vehicle does not have a barrier between the cab and the patient compartment, the driver and front seat passenger should wear a surgical mask, if the patient cannot wear one.
- Practice good hand hygiene. Hands must be properly washed before donning and after removal of gloves with warm soapy water or disinfected with a waterless hand sanitizer if a sink is not immediately available. **Do not wait until you return to the ambulance station to practice hand hygiene.**
- Assure adequate cleaning of the equipment and vehicles between transports. This cleaning should minimally include:
  a. Use of Environmental Protection Agency (EPA) approved disinfectant;
  b. Disinfecting any reusable equipment used on the patient as per the manufacturer’s instructions;
  c. Frequently touched surfaces of the vehicle;
  d. Visibly soiled surfaces.

2. Medical Procedures

Medical procedures, such as nebulized respiratory treatments, that may re-aerosolize infectious material should only be done if medically necessary. It is recommended that mechanical ventilators, including BVM devices and suction equipment, should be fitted with a HEPA filter, if available, to prevent re-aerosolization. EMS agencies should contact equipment manufacturers for recommendations on a HEPA filter. When performing these high risk procedures, the CDC recommends the use of appropriate and/or adequate "NIOSH APPROVED/RATED" respirators.

3. Tuberculosis

Although the overall risk is low, there has been documented transmission of *M. tuberculosis* in EMS occupational settings. EMS personnel should be included in comprehensive training, education, and testing programs for TB infection, and follow-up testing as indicated by the risk classification of the setting. Drivers, HCWs, and other staff transporting patients with suspected or confirmed TB should wear an N95 respirator, and the patient should wear a surgical mask. In addition, ambulances should allow for the maximum amount of outdoor air to be circulated in the vehicle.
EMS Provider Health Precautions

1. BEMS strongly recommends providing the following to EMS agencies and providers:

   a. Enforce the use of surgical masks and/or adequate "NIOSH APPROVED/RATED" respirators when assessing or performing aerosolizing procedures. When respirators are used, the employer shall conform with requirements (i.e. medical screening, fit testing, training, seal checks, respiratory protection plan, etc.) as prescribed by the OSHA Respiratory Protection standard.

   b. Frequent and on-going education including, but not limited to infection control measures, PPE as well as proper personal/hand hygiene.

   c. Annual flu vaccinations and other preventive health measures.

2. EMS agencies should monitor their crews for any type of infectious illness. EMS management should monitor any provider that presents with signs and symptoms of a febrile respiratory illness. Agencies should consider the following (in order of preference):

   ➢ Release staff from duty until they have sought medical attention and have sufficiently recovered.
   ➢ Assigning staff to non-patient care related duties for the duration of their illness.
   ➢ Require EMS providers to don surgical masks to protect their patients while providing care.
   ➢ The EMS agency medical director and the County Public Health Office should be advised of any EMS healthcare provider who is hospitalized with pneumonia.

Conclusion:

Adherence to the above respiratory protection guidance will allow the EMS community to protect itself when assessing and treating patients with a potentially infectious respiratory disease. The routine use of standard precautions will protect against other types of infectious diseases.

For Additional Resources:

Please review the information provided at the following web sites:

➢ www.health.state.ny.us
➢ http://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm
➢ http://www.labor.state.ny.us/workerprotection/safetyhealth/dosh_pesh.shtm

Issued by:
Lee Burns, Director
Bureau of EMS
BACKGROUND

Drug shortages, including controlled substances, are occurring frequently. Drug shortages can adversely affect patient care and may result in medication errors. According to the American Society of Health-System Pharmacists (ASHP) Guidelines on Managing Drug Product Shortages in Hospitals and Health Systems (8/1/09), pharmacy departments must take a leadership role in efforts to develop and implement appropriate strategies and processes for informing practitioners of shortages and ensuring the safe and effective use of therapeutic alternatives. EMS agencies that have contracts or MOUs with a hospital pharmacy, are considered “practitioners” and therefore should be notified by the pharmacy.

The main sources to use for the most up to date information should be your pharmacy or medication vendor as well as the Federal Drug Administration (FDA). The FDA has a web site that contains the most current information on national drug shortages. The web site is: http://www.fda.gov/Drugs/DrugSafety/DrugShortages/default.htm

Planning for any type of drug shortage can be divided into three phases: identification and assessment, preparation, and contingency.

1. Identification and Assessment

Assessment requires a critical evaluation of the current situation and the potential effect the shortage may have on the healthcare system. For patients whose treatment depends on the unavailable drug product, alternative therapies must be identified. EMS agencies should review their past patient data to assess the projected needs for their community.

2. Preparation

EMS agencies should first review their current medication inventory policies to determine if changes to those policies need to be made. For example, a new policy that may allow for only stocking first line EMS response units with medications that may be on the shortage list, while assuring those units that are out-of-service or not used for primary emergency response are not carrying any medications that may be in short supply. Additionally EMS agencies should review their medication stock to determine the usage trends, current supplies, expiration dates and replacement availability or the need to order alternative medications.
3. Compliance

At no time can an EMS agency borrow, supply or sell any medication to another entity unless they possess a distributor’s license. The movement of medications is strictly regulated by the Food and Drug Administration (FDA) and the Drug Enforcement Agency (DEA).

10 NYCRR §80.136 - Controlled substances for emergency medical services: purchasing, possessing, delivering, administering and safeguarding of controlled substances authorizes a certified advanced life support EMS agency to possess the following controlled substances approved by the Department and BEMS Policies; ketamine, midazolam, diazepam, morphine and fentanyl.

The Department has changed the Controlled Substance (CS) licenses for all EMS agencies to include Schedules II, III and IV. This will allow EMS agencies to possess and administer medications that are approved by Department to address drug shortage issues and changes in prehospital protocols.

Medication Expiration Dates

All medications have expiration dates that are developed by each specific manufacturer and reviewed by the FDA. When a drug shortage occurs, the FDA is able to review data from manufacturers pertaining to using a drug past its expiration date. The FDA may determine if they will approve extended expiration dating to increase supplies until new productions are available. If the FDA does allow this, it will be posted on the aforementioned FDA web site. Please be advised, that the Department must also approve the extension of medication expiration dates. Therefore, no expired medications may be administered to patients without the approval of the FDA and the NYS Department of Health.

Commissioner’s Ruling Exempt Distribution

A hospital pharmacy may purchase or transfer controlled substances from another hospital or retail pharmacy for their immediate, legitimate medical needs.

Definition of an immediate need exists when the facility or retail pharmacy is not capable of preparing a controlled substance medication or does not have a controlled substance in stock and immediate administration or dispensing of the drug is necessary for proper treatment.
Procedures

DOH - Bureau of EMS

- Will establish a state-wide medication formulary for alternative medications. This formulary will allow REMACs to better prepare for, and initiate changes to regional protocols to meet the changing needs of a region.
- Continue its work with the State Emergency Medical Advisory Committee (SEMAC) to make additions and subtractions to the alternative formulary as necessary.

REMAC

- Will open communication with hospital systems within their region to identify and share information regarding drug shortage issues.
- Establish communication with all EMS agencies within the region to monitor potential local drug shortage issues.
- When a region-wide drug shortage issue has developed, submit a letter of request to BEMS advising that a portion of the state-wide alternative medication formulary is being utilized. Specific medications and protocol changes must accompany this letter of request. BEMS will review the request and issue a determination.
- The alternative medication formulary (attached) was developed to include up to four (4) alternative medications. Alternate A should be the first consideration, followed by alternate B, alternate C and then finally alternate D. Each REMAC needs to evaluate which of the alternative medications is best for their region.
- Will coordinate provider education for all new medications or uses of medications using the provided educational template.
- Every 30 days after approval of the alternative formulary, the REMAC must evaluate the need to continue the use of the alternative formulary.
- Every 6 months after approval of the alternative formulary, the REMAC must submit a written request for extension to BEMS.

EMS Agencies

- Must continue to evaluate potential drug shortages within their operating territory.
- Notify the REMAC of any potential or current drug shortages.
- If any changes are made to the controlled substances inventory at an agency, an updated CS plan must be submitted and approved by the Department.
- Assure education of certified providers within the agency follows the BEMS educational template.
- If a specific medication is no longer available, and there is no BEMS approved alternative, the EMS agency must still continue to provide care to the best of its ability. The lack of a medication should not prohibit any response and care of patients in your area. EMS agencies must follow their regionally approved protocols to the best of their ability with the medications available to them.

Issued and authorized by the Bureau of EMS Director
Requirements for any New Medication added to the Prehospital Formulary
by any Region or EMS Agency

Background:

During the course of initial certification at the EMT-Critical Care and Paramedic levels, medications are introduced in a systematic fashion. This provides for extensive and detailed information on each medication they are authorized to use according to the NYS curriculum.

Issue:

After the providers are certified and are using their skills in the field, the education modalities used to introduce new medications or medications specific to a region have no uniformity or standardized educational methodology. Many times it is up to the individual certified provider to learn about medications.

Solution:

In consultation with the SEMAC, the Bureau of EMS has established a required outline to be used by all agencies, regions and course sponsors as a minimum requirement of objectives for any new medication added to the scope of practice, protocols or regional and state medication formulary.

Completion of all educational requirements must be kept on file for all personnel.
LESSON PLAN GUIDE

Cognitive Objectives

At the completion of this session, the advanced EMT student will be able to:

1. Describe mechanisms of drug action.
2. List and differentiate the phases of drug activity, including the pharmaceutical, pharmacokinetic, and pharmacodynamic phases.
5. Discuss considerations for storing and securing medications.
6. List the component of the drug profile by classification.
7. Integrate pathophysiological principles of pharmacology with patient assessment.
8. Synthesize patient history information and assessment findings to form a field impression.
9. Synthesize a field impression to implement a pharmacologic management plan.

Components of a drug profile

A. Drug names
B. Classification
C. Mechanisms of action
D. Indications
E. Pharmacokinetics
F. Side/adverse effects
G. Routes of administration
H. How supplied
I. Dosages
J. Contraindications
K. Considerations for pediatric patients, geriatric patients, pregnant patients, and other special patient groups
L. Other profile components

Educational Resources:

A. New York State EMS certification curriculum
B. Physician’s Desk Reference
C. Drug manufacture’s information
D. Federal Food and Drug Administration
E. Paramedic text books
F. Additional resources as necessary
## New York State EMS Alternative Medication Formulary

**Valid Through December 31, 2013**

<table>
<thead>
<tr>
<th>Current Medication</th>
<th>Alternate A</th>
<th>Alternate B</th>
<th>Alternate C</th>
<th>Alternate D</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ondansetron (Zofran)</td>
<td>Promethazine 12.5 mg IM</td>
<td>Droperidol 0.625 mg IV/IM</td>
<td>Metoclopramide (Reglan) 10mg IV/IM</td>
<td>Diphenhydramine 25-50 mg IV/IM</td>
<td>ADULT ONLY Anti-emetic Ondansetron 4 mg ODT also an option</td>
</tr>
<tr>
<td>Etomidate</td>
<td>Midazolam C(_{IV}) (Versed) 5 mg IV</td>
<td>Lorazepam C(_{IV}) (Ativan) 2 mg IV</td>
<td>Ketamine C(_{III}) 1 mg/kg IV <strong>OR</strong> 3 mg/kg IM</td>
<td>Propofol 2 mg/kg IV</td>
<td>Induction <strong>Ativan (Lorazepam) must be refrigerated following manufacturers guidelines</strong></td>
</tr>
<tr>
<td>Morphine C(_{II})</td>
<td>Fentanyl C(_{II}) 50 mcg IV (Inventory 400 mcg)</td>
<td>Ketorolac (Toradol) 30 mg IV or IM</td>
<td>Remifentanil C(_{II}) 0.5 mcg/kg or 50 mcg IV</td>
<td>Hydromorphone C(_{II}) (Dilaudid) 0.5 mg</td>
<td>Pain Management Protocol Only</td>
</tr>
<tr>
<td>Fentanyl C(_{II})</td>
<td>Morphine C(_{II}) 4-6 mg IV</td>
<td>Ketorolac (Toradol) 30 mg IV or IM</td>
<td>Remifentanil C(_{II}) 0.5 mcg/kg or 50 mcg IV</td>
<td>Hydromorphone C(_{II}) (Dilaudid) 0.5 mg</td>
<td>Pain Management Protocol Only</td>
</tr>
<tr>
<td>Fentanyl C(_{II})</td>
<td>Remifentanil C(_{II}) 0.5 mcg/kg or 50 mcg IV</td>
<td></td>
<td></td>
<td></td>
<td>ROSC Protocol Only (shivering)</td>
</tr>
<tr>
<td>Midazolam C(_{IV}) (Versed)</td>
<td>Lorazepam C(_{IV}) 2 mg or 0.05 mg/kg IV</td>
<td>Diazepam C(_{IV}) 5 mg IV</td>
<td></td>
<td></td>
<td>Seizure management</td>
</tr>
<tr>
<td>Diazepam C(_{IV}) (Valium)</td>
<td>Midazolam C(_{IV}) 5 mg IV</td>
<td>Lorazepam C(_{IV}) 2mg IV</td>
<td></td>
<td></td>
<td>Seizure management</td>
</tr>
<tr>
<td>New York State EMS Alternative Medication Formulary</td>
<td></td>
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<tr>
<td>---------------------------------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lorazepam CIV</strong> <em>(Ativan)</em></td>
<td>Midazolam CIV</td>
<td>Diazepam CIV</td>
<td>Seizure management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lorazepam CIV</td>
<td>Midazolam CIV</td>
<td>Diazepam CIV</td>
<td>Seizure management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 mg IV</td>
<td>5 mg IV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ketorolac</td>
<td>Ibuprofen <em>(Caldolor)</em></td>
<td>400-800 mg IV</td>
<td>NSAID pain management <em>(not mandatory substitution because of cost)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ketamine CIII</td>
<td>Etomidate</td>
<td>Midazolam CIV</td>
<td>Patient disentanglement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ketamine CIII</td>
<td>Etomidate</td>
<td>Midazolam CIV</td>
<td>Patient disentanglement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.1 mg/kg IV</td>
<td>2-5 mg IV and/or Fentanyl</td>
<td>50 mcg IV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sodium Bicarbonate</td>
<td></td>
<td></td>
<td>No substitution available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midazolam CIV <em>(Versed)</em></td>
<td>Droperidol</td>
<td>Haloperidol</td>
<td>Ketamine 1-3 mg/kg IM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midazolam CIV <em>(Versed)</em></td>
<td>Droperidol</td>
<td>Haloperidol</td>
<td>Ketamine 1-3 mg/kg IM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5 mg IM</td>
<td>5 mg IM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epinephrine 1:10,000</td>
<td>Epinephrine 1:1,000 30mL Vial</td>
<td>Epinephrine 1:1,000 1mg/ml Ampule</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epinephrine 1:10,000</td>
<td>Epinephrine 1:1,000 30mL Vial</td>
<td>Epinephrine 1:1,000 1mg/ml Ampule</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Expel 1mL of normal saline from a 10mL syringe (pre-filled)</td>
<td>1. Expel 1mL of normal saline from a 10mL syringe (pre-filled)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Instill 1mg(mL) of Epinephrine 1:1,000 from 30 mL vial in to pre-filled syringe</td>
<td>2. Instill 1mg(mL) of Epinephrine 1:1,000 from ampule in to pre-filled syringe</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. 30mL vials are to be single patient use only</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Suggestion:
Make medication substitutions that will allow minimal formulary changes when possible, even when this means moving into secondary alternates to allow for maximum safety. Example: if adding Droperidol for nausea, consider adding an option for patient restraint.
This policy was created by the Safety subcommittee of New York State Emergency Medical Services Council. The subcommittee recommends that each agency establish the position of Health and Safety Officer (HSO) to develop, implement and maintain a system to address the potential health and safety hazards encountered by their EMS providers and patients. Additionally, it is suggested that agencies appoint a committee to support the HSO position. This policy is intended to improve EMS health and safety practices for the provider, the patient and the public as well as ensure regulatory compliance and to further promote a strong safety culture.

Background
EMS works in a very challenging environment in which providers face a multitude of inherent risks to themselves, their patients, their families and the public. The risk of injury, infection, vehicle crashes, emotional stress, physical violence, medical error, serious harm or even death is very real. Safety standards and procedures are learned and reinforced through education, annual training, lessons learned, best practices and responses experienced. Though many EMS providers understand the risks and how to reduce them, preventable incidents causing injury and death still occur.

Policy
An EMS agency manager/administrator may designate an HSO as well as the supporting safety committee, to work jointly to oversee the development and sustainment of a health and safety program. The HSO should hold, at a minimum, a current NYS EMT certification and maintain this certification throughout their appointment.

An HSO’s Roles and Responsibilities may include, but not be limited to:

- Being an advocate for safe practices and procedures to better protect providers, the patient and the public. The HSO will be accountable for continual attention to safety issues and trends involving safety and wellness.

- Being familiar with regulatory standards that apply to EMS. The HSO should be well versed with infection control practices and knowledgeable on the hazards of diseases and illness. An HSO can provide information about workplace hazards and what protective practices and equipment are available to reduce preventable incidents from occurring. The HSO can assist in sponsoring health and wellness programs to address issues related to weight, diet, fitness and psychological stress.
• The role may include tracking safety organizations’ principles and be aware of current safety products that reduce unsafe practices. An HSO can investigate accidents, injuries and near misses. The HSO should have the authority to track and monitor workplace safety, identify hazards as well as to correct them.

• The responsibility of ensuring that all incidents i.e. medical equipment malfunction or a vehicle crash with serious injury are reported in accordance with the appropriate authority's mandates. This reported data is important to identifying safety issues within the EMS system. This will allow the state to compile measurements on EMS related injuries, illnesses, medical adverse events and fatalities. This data driven information will promote procedures and initiatives to improve our EMS system.

**Conclusion**

EMS agencies must consciously understand the risks involved that are related to its responders and patient safety. The objective is to lower unfortunate, preventable incidents and to ensure our providers, patients and the public have a safe outcome. A designated HSO may assist with promoting a healthy and safe work environment within an EMS organization. An HSO contributes to a positive safety culture that will improve the health and safety awareness of EMS providers.

**Key Responsibilities for an HSO:**
Bloodborne Pathogens Exposure Control Plan
Driver Safety, Emergency Vehicle Operations, Investigations
Scene Safety, Scene Operations, Violent Scenes, Workplace Violence
Patient Handling, Stretcher Operations, Severe Weather
HazMat/WMD Awareness, Emergency Response Guide
Personal Health, Wellness, Ergonomics
Annual/Training, Records, Reported Data

**Reference Sites for Health & Safety**

- [www.cdc.gov](http://www.cdc.gov)
- [www.osha.gov/dts/oom/clinicians](http://www.osha.gov/dts/oom/clinicians)
- [www.health.ny.gov](http://www.health.ny.gov)
- [www.labor.ny.gov/workerprotection/safetyhealth/DOSH_INDEX.shtm](http://www.labor.ny.gov/workerprotection/safetyhealth/DOSH_INDEX.shtm)
- [www.nsc.org](http://www.nsc.org)
- [www.naemt.org](http://www.naemt.org)
This policy was developed in conjunction with the New York State Emergency Medical Services Council (SEMSCO) and an appointed Technical Advisory Group (TAG) comprised of various representatives of the State’s EMS community. In addition to the guidance policy, included this policy is an updated definition of Mutual Aid and a tool kit (Appendix A) intended to be a resource to EMS agencies, County EMS Coordinators and Regional EMS Councils (REMSCO) when developing, evaluating and reviewing EMS Mutual Aid plans.

PURPOSE:
The purpose of this policy is to update and clarify the appropriate uses of EMS Mutual Aid and to address issues faced by many New York State EMS agencies as a result of frequent shortages of certified personnel available to respond to requests for emergency medical assistance.

This policy is based on these previous policy statements which remain in effect: 89-02 – EMS Mutual Aid Planning Guidelines; 95-04 – EMS Mutual Aid; 95-09 – Developing EMS Agency Policies and Procedures; 01-02 – EMS use of the Incident Command System; 01-04 – EMT Staffing Standard for Voluntary Ambulance Services; and PHL Article 30, and Part 800 - The State EMS Code.

All of the above policy statements, laws, and regulations are available on the Bureau of EMS website: www.health.state.ny.us/nysdoh/ems/main.htm. All EMS agency leadership and staff are encouraged to review each of these documents.

OBJECTIVES:
1. To provide a clear, comprehensive definition of EMS Mutual Aid, and how mutual aid should be used appropriately;
2. To reaffirm the role of the Regional EMS Councils (REMSCO) and EMS Program Agencies in developing, reviewing and approving mutual aid plans;
3. To provide guidelines for mutual aid plans that EMS agencies, 911 Communication Centers and County EMS Coordinators can follow that adhere to Article 30 requirements with respect to Primary Operating Territory, and the concept of closest appropriate EMS agency:
4. To encourage collaboration and cooperation between REMSCOs, County EMS Coordinators, 911 Communication Centers, and all EMS agencies in the development, review and approval of EMS mutual aid plans.
5. To delineate different types of mutual aid plans according to the scale of the required response.
DEFINITION OF MUTUAL AID:

- Article 30 of Public Health Law does not directly define mutual aid, but rather it identifies and defines Mutual Aid Agreements in Section 3001.20 as follows:

  “‘Mutual aid agreement’ means a written agreement, entered into by two or more ambulance services or advanced life support first response services possessing valid ambulance service or advanced life support first response service certificates or statements of registration, for the organized, coordinated, and cooperative reciprocal mobilization of personnel, equipment, services, or facilities for back-up or support upon request as required pursuant to a written mutual aid plan. An ambulance service and advanced life support first response service may participate in one or more mutual aid agreements.”

- Article 5 of County Law, section 223-B (3) EMS Training and Mutual Aid Programs states:

  “If the office of county EMS coordinator is created in any county, a county EMS coordinator shall be appointed. It shall be his or her duty to administer the county programs for EMS training and mutual aid in cases of emergencies in which the services of EMS providers would be used...”

- Policy Statement 89-02 defines Mutual Aid in the following manner:

  “MUTUAL AID – means the pre-planned and organized response of emergency medical services, and other emergency personnel and equipment, to a request for assistance, in an emergency, when local resources have been expended. The response is predicated on formal agreements among participating agencies or jurisdictions.”

- Policy 95-04 mentions the use of EMS mutual aid in this way:

  o "From time to time, to meet peak demand or extraordinary resource utilization, it may be necessary to request assistance to answer a call or provide additional resources. This is the concept and intent of EMS mutual aid.”
  o "EMS mutual aid requests must be made with the intent of having the closest (usually means the unit with the shortest response time to the patient) available EMS unit respond to a patient’s medical need, at a time when the resources of the requesting agency are temporarily unavailable or have been expended.”
  o "Mutual aid plans and agreements for normal day to day requests are the responsibility of the individual EMS service.”
  o "Service type (eg. volunteer, fire, hospital, commercial) must not be a consideration in any plan or to any request.”

With consideration of the aforementioned documents, a combined and updated five part definition of EMS mutual aid that supersedes previous definitions and reflects the current state of EMS operational coverage, is stated as:

1. A preplanned, organized and coordinated response of EMS agencies to a request for assistance when local EMS resources are either temporarily unavailable, or have already been expended;

2. The elements of any response under a mutual aid request will be determined by a formal written mutual aid plan or agreement among participating EMS agencies and/or jurisdictions, and approved by the REMSCO having jurisdiction for the geographic area in question. EMS agencies may participate in more than one mutual aid plan;
3. Mutual aid plans or agreements must be designed to address all possible applications of mutual aid, whether for large scale multiple casualty incidents, or for the needs of EMS operational assistance for neighboring EMS agencies. However, mutual aid plans are not intended substitute for the following:
   a. An EMS agency’s continued, routine, ongoing or frequent inability to provide EMS response when requested or dispatched due to staffing and/or equipment shortages
   b. A determination of need for an expansion of operation territory for routine, frequent or ongoing response outside of an agencies primary operating authority.
   c. Contracting with an appropriately authorized EMS agency.

4. The plan or agreement must also be designed to utilize the EMS agency having the appropriate resources with the shortest response time to the scene of the call. For the purposes of this section, response time is defined as time of dispatch to time on scene.

5. The provisions of Article 30 with respect to the Primary Operating Territory of an EMS agency must be considered when designing the EMS mutual aid plan.

ROLE OF REGIONAL EMS COUNCILS

• Article 30, Section 3003.3 (f), states that REMSCO have the power to: “undertake, or cause to be undertaken plans, surveys, analyses and studies necessary, convenient, or desirable for the effectuation of its purposes and powers, and to prepare recommendations and reports in regard thereto;”
• Article 30, Section 3003.4 state that “Each regional council shall have the responsibility to coordinate emergency medical service programs within its region...”
• Under Article 30, section 3003-A-1, EMS Program Agencies: “....may be responsible for facilitating quality improvement of emergency medical care within its region... and other activities to support and facilitate regional emergency medical systems.”
• Article 30 section 3010.1(b) states: “...An ambulance service shall receive patients only within the primary territory specified on its ambulance service certificate or statement of registration, except: (b) as required for the fulfillment of a mutual aid agreement authorized by the regional council;”
• Additionally, Part 800.21(p) requires every EMS service to have a written mutual aid plan.

REMSCOs have a responsibility to participate in the development, review and authorization of mutual aid plans of all types. By virtue of their statutory authority, REMSCOs, with assistance from EMS Program Agencies, are expected to initiate efforts with 911 Communication Centers, County EMS Coordinators and all EMS agencies, to develop, review and authorize EMS mutual aid plans that reflect the needs and resources of their particular region of the state.

TYPES OF MUTUAL AID PLANS

The types of mutual aid plans can range from complex statewide plans to simple interagency agreements. Examples of mutual aid plans, in descending order of complexity, include:

• The Statewide Mobilization Plan;

• Multiple casualty incidents, and other large events that require single or multiple jurisdictional response plans within or between regions;

• Countywide plans that cover the geography of particular primary operating territories within a county in the event resources are expended or unavailable;
• Individual, or multiple, interagency plans, that are in compliance with all applicable laws, that provide coverage assistance to neighboring agencies in the event resources are expended or otherwise unavailable.

In order to provide the closest appropriate EMS unit, and to foster ease of implementation by 911 Communication Centers and County EMS Coordinators, these plans shall designate the following:

• Those services having appropriately staffed, readily available units in closest proximity and with direct access to the district involved, thereby being capable of providing an optimal response time;

• Beginning first with services possessing operating authority for the requesting district;

• In cases where no service with operating authority exists or is willing/able to participate, proceeding next to those services without operating authority for the requesting district;

• Additional mutual aid plan participants shall be based on the next closest, appropriately staffed and readily available services.

All listed EMS agencies should agree, by positive affirmation in the plan, their commitment and willingness to participate and respond to the service areas identified on the list.

CONCLUSION

The New York State EMS Council Technical Advisory Group (TAG), with whom this policy was developed, have prepared a Mutual Aid Planning Tool Kit. This tool kit (Appendix A) is intended to be a resource to EMS agencies, County EMS Coordinators and Regional EMS Councils (REMSCO) when developing, evaluating and reviewing EMS Mutual Aid plans.

It is imperative, for the efficient and timely operation of EMS systems across the state that all REMSCOs, County EMS Coordinators, 911 Communication Centers, and all EMS agencies collaborate and cooperate in the development, review and authorization of EMS mutual aid plans.

Again, mutual aid plans are not intended substitute for an EMS agency’s continued, routine, ongoing or frequent inability to provide EMS response when requested or dispatched due to staffing and/or equipment shortages; a determination of need for an expansion of operation territory for routine, frequent or ongoing response outside of an agencies primary operating authority and contracting with an appropriately authorized EMS agency. But rather to address all possible applications of mutual aid, whether for large scale multiple casualty incidents, or for the needs of EMS operational assistance for neighboring EMS agencies
Appendix A
New York State EMS Agency Mutual Aid Planning Worksheet

The following Mutual Aid worksheets are intended to give EMS agencies, County EMS/Emergency Services Coordinators, and Regional EMS Councils a logical and objective pathway to evaluate, formulate, and approve EMS Mutual Aid plans. They attempt to gather the most pertinent information for mutual aid decision making. However, additional information that is unique to a given area may also need to be considered. This information should be documented on additional sheets, along with any information requested that does not fit in the space provided.

Section 1: EMS Agency instructions:

This worksheet is intended to identify all EMS agencies that should be considered to respond as mutual aid to a requesting EMS agency. Please list all EMS agencies that are willing to respond as mutual aid to all or a portion of the requesting agency’s service area, and what minimum response time is expected. When considering which agency should be first call for mutual aid, any agency that has overlapping operating authority with the requesting agency should, in most cases, be the first call agency. However, there may be geographic or operational reasons to utilize an adjacent agency that has separate operating authority from the requesting agency. As a result, agencies with overlapping operating authority may be designated to participate as secondary mutual aid coverage if needed. In all cases, adequately document the reasons for all choices.

Section 2: EMS Coordinator instructions:

By completing this form you are affirming the choices for EMS mutual aid made by the agencies in your jurisdiction. Please attach any supporting documentation or narrative comments that will substantiate your determination. During this process it is expected that you will confer with your Regional Council to clarify any of the information you have been given by your agencies, and to discuss the broad outline of the plan you will submit for approval.

Section 3: Regional Council instructions:

It is expected that Regional Councils will collaborate with County EMS Coordinators to either initiate a review and revision to existing EMS mutual aid plans, or develop EMS mutual aid plans that meet the standards of this policy. During that process there should be cooperation and collaboration with County EMS Coordinators, agencies, and concerned governmental bodies to affirm the validity of the plans submitted. This form is designed to facilitate that process. Please attach any additional supporting documentation not included by EMS Coordinators, and/or attach a brief narrative substantiating your approval.
**Section 1: EMS Agency Review**

1. Name of EMS Agency: 

2. Ambulance Operating Territory: 

3. Does another EMS Agency possess a valid NYS DOH operating certificate for this area?  [ ] YES [ ] NO

4. Please list all current EMS Agencies possessing valid operating certificates:

<table>
<thead>
<tr>
<th>Name</th>
<th>Is this EMS Agency able to provide Mutual Aid to you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>[ ] YES, [ ] NO Reason:_____________________________</td>
</tr>
<tr>
<td>b.</td>
<td>[ ] YES, [ ] NO Reason:_____________________________</td>
</tr>
<tr>
<td>c.</td>
<td>[ ] YES, [ ] NO Reason:_____________________________</td>
</tr>
<tr>
<td>d.</td>
<td>[ ] YES, [ ] NO Reason:_____________________________</td>
</tr>
</tbody>
</table>

5. Other than current valid operating certificate holders for your area, are there other EMS Agencies that, while not possessing a valid operating certificate for your area, can respond in a more timely and reliable manner to your mutual aid requests?  [ ] YES  [ ] NO

If “YES”, please identify these EMS agencies:

| a.   | ____________________________ |
| b.   | ____________________________ |
| c.   | ____________________________ |
| d.   | ____________________________ |

6. Please provide the time criteria (in minutes), that you utilize to determine what constitutes a “reasonable response time” for the geographical service area in question (For the purposes of this section, response time is defined as time of dispatch to time on scene): ___________ minutes.
7. Please indicate below the EMS Agency and the specific portion(s) of your certified area of operations you designate for Mutual Aid coverage (please attach any written agreements and maps or territorial descriptions necessary):

<table>
<thead>
<tr>
<th>EMS Agency</th>
<th>Designated to Cover:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. _____________</td>
<td>[ ] Entirety of area, [ ] Specific Portion: __________________________</td>
</tr>
<tr>
<td>b. _____________</td>
<td>[ ] Entirety of area, [ ] Specific Portion: __________________________</td>
</tr>
<tr>
<td>c. _____________</td>
<td>[ ] Entirety of area, [ ] Specific Portion: __________________________</td>
</tr>
<tr>
<td>d. _____________</td>
<td>[ ] Entirety of area, [ ] Specific Portion: __________________________</td>
</tr>
</tbody>
</table>

**Affirmation:** I, the undersigned, verify that I represent and am duly authorized by the EMS Agency identified above to designate the EMS Agencies identified to provide Mutual Aid assistance to our organization consistent with all applicable laws and regulations.

Print Name: __________________________
Signature: __________________________
Title: __________________________
Date: __________
Section 2: County EMS Coordinator Review

1. Name of County EMS Coordinator:  

2. County of Jurisdiction:  

3. After your review of the information submitted by this EMS Agency designating their choices for other EMS Agencies to provide Mutual Aid assistance to their area of operations in accordance with all existing regulations, do you find:
   
a. That the primary EMS Agencies designated are the most technically capable with meeting initial medical requests to respond?  [ ] YES  [ ] No  
   
b. If any of the designated EMS Agencies do not possess a valid operating certificate from the DOH, have you verified in collaboration with the local Regional EMS Council that all existing EMS agencies identified by the NYSDOH, Bureau of EMS (BEMS) as having valid operating certificates for this area either cannot, or will not have the capability to respond in a reasonable response time?  [ ] YES  [ ] NO  
   
c. Please provide the time criteria (in minutes), that you utilize to determine what constitutes a “reasonable response time” for the geographical service area in question (For the purposes of this section, response time is defined as time of dispatch to time on scene):  ___________ minutes.  

To support your determination, please provide supporting documentation such as BEMS service lists, levels of care provided, municipal preference lists, alternative mutual aid coordination processes utilized (i.e., system status management, GPS tracking, or other technologies), or any other verifiable method that substantiates a history of local mutual aid.
4. Do you have any special considerations or concerns associated with any element of the aforementioned EMS Agencies designated to respond under this Mutual Aid agreement? [ ] NO, [ ] Yes: Please describe: ___

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Affirmation:**

I, ____________, the County EMS Coordinator for ________County, have reviewed the aforementioned elements of this Mutual Aid Agreement for: (EMS Agency)__________

__________, and find it to be both reasonable and compliant with all applicable regulations.

Print Name: __________________________

Signature: __________________________

Date: _______________
**Section 3: Regional EMS Council Review**

1. Name of Regional EMS Council: _____________________________________________
2. Name of Reviewer: _______________________________________________________
3. Title: ___________________________________________________________________

4. After your review of the information submitted by this EMS Agency designating their choices for other EMS Agencies to provide Mutual Aid assistance to their area of operations in accordance with all existing regulations, do you find:
   a. That the primary EMS Agencies designated are the most technically capable with meeting initial medical requests to respond?  [ ] YES  [ ] No
   b. If any of the designated EMS Agencies do not possess a valid operating authority, have you verified in collaboration with the local County EMS Coordinator that all existing EMS agencies identified by the NYSDOH, Bureau of EMS (BEMS) as having valid operating authority for this area either cannot, or will not have the capability to respond in a reasonable response time?  [ ] YES  [ ] NO
   c. Please provide the time criteria (in minutes), that you utilize to determine what constitutes a “reasonable response time” for the geographical service area in question (For the purposes of this section, response time is defined as time of dispatch to time on scene): ___________ minutes.

   To support your determination, please provide supporting documentation such as BEMS service lists, levels of care provided, municipal preference lists, alternative mutual aid coordination processes utilized (i.e., system status management, GPS tracking, or other technologies), or any other verifiable method that substantiates a history of local mutual aid.
5. Do you have any special considerations or concerns associated with any element of the aforementioned EMS Agencies designated to respond under this Mutual Aid agreement? [ ] NO, [ ] Yes: Please describe: 
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

Affirmation:

I, _____________, the authorized reviewer for the _____________Regional EMS Council, have reviewed the aforementioned elements of this Mutual Aid Agreement for: (EMS Agency) ________________, and find it to be both reasonable and compliant with all applicable regulations.

Print Name: ____________________
Signature: _____________________
Title: _________________________
Date: ______________
BACKGROUND:
This policy statement is intended to provide clear direction to EMS providers, EMS agencies and the emergency service community regarding the requirements for the possession and production of NYS Department of Health issued EMS certification. This policy statement also addresses the certification period, security and alteration of DOH issued certificates.

CERTIFICATION PERIOD:
EMS certificates issued by the Department are valid for 37 months from the date of issue and expire at 11:59 p.m. on the date indicated on the document. The following are the only exceptions to this certification period:

1. The provider is a participant in an approved pilot re-certification program that allows for certification for a period different than three years and such provider has received a certification from the Department with an expiration date more than 37 months in the future.
2. The provider has been approved for extended certification as allowed for by Public Health Law.

CERTIFICATION EXPIRING AFTER STATE EXAMS:
The New York State Administrative Procedures Act (SAPA), Article 4, (401.2) allows EMS provider’s certifications to remain valid after it has expired under certain circumstances.

If a certified provider’s expiration date occurs after he/she has completed a recertification course, has taken the NYS Written Certification Examination, but has not yet received their examination results, their certification will remain valid until such time as he/she receives their official examination results. Official examination results are considered to mean an official failure letter from BEMS, certification renewal certificate from BEMS, or on-site scoring results.

If a certified provider’s expiration date occurs prior to taking the NYS Written Certification Examination, their certification is not eligible to remain valid under SAPA.

In order to comply with SAPA the provider must provide proof that he/she completed the NYS Written Certification Examination. This proof will usually be in the form of the signed examination ticket received at BEMS within 1 week of completing the NYS Written Examination. If written documentation of current
certification is required under SAPA, the individual must call BEMS and make a formal request. BEMS will not provide additional documentation under SAPA until such time as we receive the signed examination ticket.

CERTIFICATION DOCUMENTS:
Pursuant to provisions of 10 NYCRR Part 800 the Department issues an original certificate to persons whom:

- Successfully complete the requirements set forth for obtaining an original certification as a Certified First Responder (CFR), Emergency Medical Technician (EMT) or Advanced Emergency Medical Technician (AEMT).

- Successfully completes the requirements set forth for obtaining re-certification as a CFR, EMT or AEMT.

- Obtains certification as an EMT or AEMT through the reciprocity process by having such certification issued by another state or approved military program.

- Have no legal barrier to the issuance of such certificates.

ALTERATION OR FORGERY OF DOH ISSUED EMS CERTIFICATES:
Department certificates are printed in a unique font on security paper that will show the word “VOID” when the card is photocopied.

Upon receipt of the certificate from the Department the holder should sign and immediately laminate the card for its protection.

Any adulteration of a certificate issued by the Department or any production of a document that is offered to be a certificate issued by the Department shall be prosecuted to the fullest extent the law allows and may bar the individual from any future certification by the Department.

SERVICE REQUIREMENTS:
EMS services are required by 10 NYCRR Part 800.21(k)(1) to maintain personnel files for all members/employees. The file must include a copy of the member’s/employee’s state issued EMS certificate.

The certified provider should be required to provide the original certification to the agency for the agency to inspect and copy. If there are any questions regarding the validity of the certification, notify the Bureau of EMS immediately.

An agency shall be held responsible for the outcomes and actions of any provider whom they allow to practice without positive proof that the certification offered by that individual is valid.

PROVIDER IDENTIFICATION:
Agencies/systems are encouraged to have a policy that governs the proper identification of members/employees while providing care or while responding. Such identification is particularly useful when members of an agency respond beyond their local area when participating in mutual aid responses.
While there is no statutory or regulatory requirement to do so, all EMS agencies or systems should consider the issuance of identification to members/employees. Such identification may include, but not be limited to:

- Agency name
- Provider name
- Provider photograph
- Provider level of certification
- DOH certification number
- Level of care authorized by agency and/or REMAC
- Agency and/or REMAC identification number
- Date of Birth
- Blood Type
- Expiration date of identification card.

Certified providers are discouraged from using their laminated, Department issued certification card as a displayed form of identification.

Although it is not a requirement of 10 NYCRR Part 800 that Department issued certificates be carried by individuals while providing care, it is strongly encouraged.

LOST OR DESTROYED CERTIFICATES:
Should the certificate issued by the Department be lost, destroyed or if it becomes unreadable you may request a replacement certificate. Requests must be submitted using the form DOH – 4453, which can be found on our web site. The EMT must sign the request. **No verbal requests will be processed.**

VERIFICATION OF CERTIFICATION:
Any individual or entity, who is seeking to verify current or past BEMS certification for an individual, may do so by completing the official request form found on our web site under the Verification Information section.

EMS agencies may also utilize the NYS DOH Health Commerce System (HCS) to obtain current provider verifications. To obtain an HCS account, please go to: [http://www.health.ny.gov/prevention/immunization/information_system/providers/hpn_account_instructions.htm](http://www.health.ny.gov/prevention/immunization/information_system/providers/hpn_account_instructions.htm).

INSIGNIA & PATCHES:
The NYS Department of Health does not issue any type of patch, shield or other worn insignia. In accordance with PHL §3003(4) a Regional Emergency Medical Services Council (REMSCO) may issue, “uniform emergency medical technician insignia and certificates”.

A person who chooses to wear a patch, shield or other insignia may only indicate the level of care at which the Department certifies them. To do otherwise would be indicating certification not held by the provider. This may constitute a criminal offense.
This policy was developed to assist EMS providers and agencies in adopting policies and procedures that will address issues of improved and appropriate personal safety while treating and transporting patients in the patient care compartment of the ambulance. Additionally, this policy is intended to articulate the need for provider, patient and equipment restraint in the patient compartment. It is also intended to improve the EMS agency’s awareness of the inherent risks to unrestrained personnel and encourage agencies to be proactive in making this aspect of the prehospital environment safer for their personnel and patients.

**Background**

The patient care compartments of ambulances are not generally designed to protect people in the event of a motor vehicle crash (MVC). Most fatalities and serious injuries in ambulance crashes involve unrestrained or poorly restrained passengers in the patient care compartment. The use of seatbelts and patient care device restraints have been recommended by numerous emergency vehicle crash safety experts as a method of reducing injuries in ambulance crashes. However, many EMS providers still do not use seatbelts or restrain their equipment properly. One motivation for failing to follow this simple safety technique is the belief that EMS providers should be unrestrained in order to provide appropriate patient care. Only a very few prehospitul care interventions are so essential they should be performed regardless of an EMS providers ability to restrain themselves.

**Policy**

Whenever possible, EMS providers should perform patient care skills when they are appropriately restrained in a moving vehicle or done when the vehicle is stopped. As long as it is safe and appropriate to do so, the ambulance should be pulled off the road and stopped for the duration of necessary interventions and procedures. As a matter of safety, EMS providers should plan their patient care so that essential interventions are performed prior to beginning transport and have ready access to patient care equipment that might be expected to be used during a transport while maintaining provider safety restraints.

Agencies should strongly consider technological adjuncts such as automated vital signs monitors and multiple control panels that will allow providers to continue to perform essential aspects of patient care while seat belted. As an agency considers the purchase of new vehicles, or is retrofitting current vehicles, design considerations such as access to sharps containers, the ability to secure equipment, rounded corners, radio access, and padded head strike zones should be considered and adopted as appropriate. Additionally, new technology such as ventilators and automatic chest compression devices should be evaluated for use in required situations.

**Conclusion**

Very few patient care interventions are so essential to the preservation of a patient’s life or limb that they should be performed regardless of the EMS provider’s ability to restrain themselves. EMS providers should attempt to perform all patient interventions while they are appropriately restrained in a vehicle that is in motion. As with all protocols, there will be exceptions, however it should be a very rare occasion where an EMS provider is unrestrained in the back of a moving ambulance for any reason.
The New York State Department of Health, Bureau of Emergency Medical Services is responsible, pursuant to Article 30 of the Public Health Law (PHL) for the collection of prehospital patient documentation data. The paper Prehospital Care Report (PCR) has been the primary instrument used for patient care and EMS event documentation. The primary purpose of the PCR/ePCR is to document all prehospital care and pertinent patient information for medical and legal purposes, as well as serving as a data collection tool for local and statewide quality improvement, protocol development and when approved, research.

The Department collects and compiles raw data into quantitative and summary data as a retrospective review of EMS activity throughout the state. Recently, links were made to match out-of-hospital PCR/ePCR data with in-hospital data from the NYS Trauma Registry and the Statewide Planning and Research Cooperative System (SPARCS) Emergency Department data sets to create a more complete and inclusive patient care record. The PCR information is provided to the State and Regional EMS Councils and the State and Regional Emergency Medical Advisory Committees.

PHL Article 30 requires that all ambulance and advanced life support first response services (ALS-FR) submit all call reporting documentation to the Department, in a format approved by the Department. The NYS EMS Code, 10NYCRR Part 800.15, requires that every person certified as an EMS provider, at any level, must complete a PCR/ePCR for each request for EMS response received by his/her agency, in accordance with the Department’s established policy.

**Article 30 § 3053 Reporting**

Advance life support first response services and ambulance services registered or certified pursuant to article thirty of this chapter shall submit detailed individual call reports on a form to be provided by the department, or may submit data electronically in a format approved by the department. The state emergency medical services council, with the approval of the commissioner, may adopt rules and regulations permitting or requiring ambulance services whose volume exceeds twenty thousand calls per year to submit call report data electronically. Such rules shall define the data elements to be submitted, and may include requirements that assure availability of data to the regional emergency medical advisory committee.

**Part 800.15 Required Conduct**

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 except:

(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;
As more regions and EMS agencies look toward the implementation of an electronic patient documentation platform, it is the Department’s intention to continue to collect patient care data through regionally based systems and/or through the State EMS Bridge.

The National EMS Information System (NEMSIS)
NEMSIS is a national effort to standardize the prehospital data collected by EMS agencies. NEMSIS is the national repository that will be used to potentially store EMS data from every state in the nation. Since the 1970s, the need for EMS information systems and databases has been well established, and many statewide data systems have been created. However, these EMS systems vary in their ability to collect patient and systems data and allow analysis at a local, state, and national level.

For this reason, the NEMSIS project was developed to help states collect more standardized elements and eventually submit the data to a national EMS database.

Electronic Data Submission in New York State
As the federal government continues coordinating the national EMS data set, called National EMS Information System (NEMSIS), New York State has updated its method for collecting the prehospital patient care data. In consultation with the NYS EMS Council, the Department has published a NEMSIS compliant data dictionary. The additional information will provide a vast new look at the EMS picture in NYS and allow for an improved evaluation of the system at the local, regional and state levels. The New York State EMS Data Dictionary is available at the following URL:

http://www.health.ny.gov/nysdoh/ems/electronic_data_submission.htm

Policy
The Department works with Regional EMS Councils, ambulance and first response services in an effort to facilitate the submission of the required data elements through an electronic medium. In an effort to insure an acceptable format, prior to implementing an electronic data collection product for the submission of ePCR data, the EMS agency MUST RECEIVE WRITTEN APPROVAL FROM THE DEPARTMENT and the applicable Regional EMS Council(s). This policy statement is intended to define the criteria necessary for an EMS Agency to convert its paper PCR system to the electronic submission of patient care report data.

In order to be considered for approval by the Department to submit PCR data electronically, EMS agencies MUST adhere to all of the following:

1. Be in compliance with all applicable sections of Article 30 and Part 800.
2. Be submitting paper PCRs to the Regional Program Agency on a routine and on-going basis.
3. Contact the Department, in writing, to determine electronic reporting requirements and request approval for electronic submission.
4. For EMS services that receive one-time, start up funding (i.e., grant funds) to purchase ePCR software/hardware, the written request for approval will need to include a plan of funding sustainability of the software/hardware after the initial funding stream has been depleted.
5. If the software being considered for purchase is not currently mapped and submitting to the NY state data repository, testing of the data compliance must occur to insure proper format and electronic transmission to the satisfaction of the Department and the Regional Program Agency.
6. Submit PCR data to the Department in the specified data file format at predetermined and scheduled intervals.
7. Receive approval from the appropriate Regional Emergency Medical Services Council(s) (REMSCO) and Regional Emergency Medical Advisory Committee(s) (REMAC) in writing.
8. All EMS services must submit the standard NYS data file to the Regional Program Agency in a compatible format on a regular and routine schedule determined by the program agency.
9. Apply for, and receive an account with the Department’s Health Commerce System (HCS). This may be done with assistance from the Regional Program Agency.

10. If any changes or interruptions are made to the electronic patient record system that may affect data submission, the EMS service must notify the Department, in writing, ten (10) business days in advance of implementation. It is the Department’s expectation that once a service converts to an electronic data collection (ePCR) system, that service will maintain the electronic system and NOT revert back to a paper-based system.

**Additional Requirements**

EMS agencies considering the submittal of patient care data through an electronic medium are also required to maintain records in accordance with established policies, laws and regulations. This must include, but may not be limited to:

- Strict written confidentiality policies, including a written statement, addressing the electronic transmission, storage and security.
- Be in compliance with the Federal Regulations pertaining to the transfer of electronic patient information and HIPPA.
- Use an electronic data collection product that meets or exceeds the National EMS Information System (NEMSIS) data set and includes minimum statewide required data fields.
- Records retention policies which must include, but not be limited to:
  - If maintaining original records, they must be secured and available for retrieval within 24 hours of request.
  - Patient records may be stored electronically, however a hardcopy of the like image must be readily available upon appropriate request.
  - Federal Law (HIPPA) requires that medical records be retained for six years (6). If the call involves the treatment of persons under age 18, the PCR must be retained for three years after the child reaches age 18.
- Records must be made available for review by the Department upon request as required by regulation.
- Provide the REMAC or its designee, with additional data elements as requested for use with quality improvement programs, specific studies or approved research projects.
- The maintenance of patient records in a readable format and be capable, upon request by patient or designee, of providing the patient record.
- The patient records have to be provided to the receiving hospital at the time the patient care is transferred or a predetermined written plan with the hospital must be in place.
- EMS services are required to leave a paper copy or transfer the electronic PCR information to the hospital prior to the EMS service leaving the hospital. This document must minimally include, patient demographics, presenting problem, assessment findings, vital signs, and treatment rendered.
- Failure to leave patient information with the emergency department upon the delivery of the patient may compromise medical treatment and interrupt the continuity of patient care.
- All electronic patient records should be completed and closed prior to the end of the shift during which the patient was treated. There should be no access to patient records on personally owned computers. Agencies should have policies restricting the use of personally owned computers for completing ePCRs.

**Other Important Considerations**

There are many details surrounding electronic patient record systems. It is the Department’s expectation that every EMS agency choosing to implement an electronic patient documentation system will carefully examine these details and while this list may not be comprehensive, consider the following issues:

- Understand and adhere to the applicable HIPAA regulations.
- Have an appropriate secure method of data transmission.
- Have the necessary technical staff support to the electronic program.
- Have appropriate infrastructure, security and back up for the system.
- Have the funding available to maintain the hardware and software associated with the system.
- Researched the product and vendor to ensure that all of the state, local and legal requirements are met by the product to be utilized.

**The Review Process**

Once the Department receives a written request to submit patient data electronically, it will review the request, and require the EMS service through a Memorandum of Understanding, to agree to the conditions set forth by the Department.

The conditions may include, but not be limited to:

1. The provision of a confidentiality statement.
2. Description of system infrastructure.
3. Proof of system back up or redundancy.
4. Proof of contracts for technical support, maintenance, upgrading and trouble-shooting.
5. Information about the hardware and software products chosen for the system.
7. Proof of continuous transmission of data to the Department, REMSCO/REMAC and the EMS service(s).
8. Proof that patient care records are provided to the receiving hospital, long term care facility or alternative destination, as appropriate, at the time the patient is delivered or a written agreement with the hospital for the delivery of the patient record at an alternative time or method.
9. Proof of compliance with PHL Article 30 requirements for service level Quality Improvement Committee.
10. Proof that there is a regular and routine process for providing data to the applicable REMSCOs, REMACs and Program Agencies.
11. The Department has the ability to amend the data collection method or elements as may be required by any future changes to the New York State data set.

**Notice**

In accordance with section 3053 of the PHL, the Department may immediately revoke the authority to submit data electronically from an agency or regional program upon written notice. If the authority is revoked, the agency will be mandated to submit paper PCRs through the Regional Program Agency.
Documentation is an essential part of all prehospital medical care. It must include, but not be limited to the documentation of the event or incident, the medical condition, treatment provided and the patient’s medical history. The primary purpose of the Patient Care Report (PCR) is to document all care and pertinent patient information as well as serving as a data collection tool.

Article 30, section 3053 of the Public Health Law requires all certified EMS agencies to submit PCR/ePCRs to the Department. The completion of a PCR is a requirement for all certified EMS providers in accordance with Title 10 NYCRR Part 800.15. This also includes all of the electronic PCR (ePCR) programs. While Basic Life Support – First Response (BLS-FR) agencies are not specifically required to submit PCR/ePCR data, their participation in the EMS system, quality assurance and data collection are critical to system management and patient care. All BLS-FR agencies are encouraged to submit EMS data through the Regional Program Agencies.

The documentation included on the PCR/e-PCR provides vital information, which is necessary for continued care at the hospital. As part of transferring the patient to the Emergency Department Staff the agency must provide an appropriate medical record that includes the demographic, event/incident, assessment findings and treatment details upon delivery of the patient.

PCR/ePCR Use:

A PCR/ePCR should be completed each time the EMS agency is dispatched for any type response. This includes (but is not limited to):

- Patients transported to any location,
- Patients who refuse care and/or transport,
- Patients treated by one agency and transported by another,
- Calls where no patient contact is made, such as
  - Calls cancelled before reaching the scene
  - Calls where no patient is located
  - When dispatched for a stand by
  - Events

If an agency is dispatched to a stand-by and while there they treat a patient, two PCRs should be completed. One as a record of the event and one for the patient care provided.
Information Entry:

All information written on the paper PCR should be legible and printed in blue or black ink.

Any member of the crew may enter information on the PCR/ePCR. The individual indicated as "In Charge" should be the person who provided or directed the care to the patient. There is no requirement that the person in charge be certified as the highest level of care present. However, the individual indicated as in charge is responsible for the care provided and documented. The provider listed as “In Charge” must be at least an EMT. If any advanced life support care was provided to the patient, the provider listed as “In Charge” must be an advanced EMT at the level appropriate for the care provided.

A complete PCR/e-PCR must include the fields required by the New York State Data Dictionary. The complete data dictionary can be found at the following URL:

http://www.health.ny.gov/nysdoh/ems/electronic_data_submission.htm

Distribution of Paper PCRs:

Pink (Hospital Patient Record) Copy:
- Ambulance Service: Leave the “pink” copy at the hospital prior to the agency leaving the hospital. In instances where this is not possible, all attempts should be made to provide the completed document to the receiving hospital as soon as reasonably possible. However, the ambulance crew must provide an appropriate medical record that includes the demographic, event/incident, assessment findings and treatment details upon delivery of the patient to the receiving facility.

- Advanced Life Support First Response (ALS FR) Agency: If no representative of the ALS agency will be accompanying the patient to the hospital, the transporting agency must be provided with an appropriate medical record that includes the demographic, event/incident, assessment findings and treatment details, if possible prior to leaving the scene. If an ALS provider is accompanying the patient than they must provide the completed medical record to the receiving facility prior to leaving (as above).


Yellow (Research) Copy:
- Ambulance Service: Yellow copy shall be submitted by the service to the Regional EMS Program Agency as designated by the Department. PCRs shall be submitted at least monthly, or more often if so indicated by the program agency.

- Advanced Life Support First Response (ALS FR) Agency: Yellow copy shall be submitted by the service to the Regional EMS Program Agency as designated by the Department. PCRs shall be submitted at least monthly, or more often if so indicated by the program agency.

- Basic Life Support First Response (BLS FR) Agency: While not required by statute, the yellow copy shall be submitted by the service to the Regional EMS Program Agency
as designated by the Department. PCRs shall be submitted at least monthly, or more often if so indicated by the program agency.

White (Agency) Copy:

- **All Agencies:** The original white copy should be retained in a secure location at the service’s permanent office as designated to the Department for the following time periods:

  **NOTE:** Federal Law (HIPAA) requires that medical records be retained for Six Years. If the call involves the treatment of persons under age 18, the PCR must be retained for three years after the child reaches age 18.

Electronic PCRs (ePCR):

- EMS services are required to leave a paper copy or transfer the electronic PCR information to the hospital prior to the EMS service leaving the hospital. This document must minimally include, patient demographics, presenting problem, assessment findings, vital signs, and treatment rendered.

- Failure to leave patient information with the emergency department upon the delivery of the patient may compromise medical treatment and interrupt the continuity of patient care.

- All electronic patient records should be completed and closed prior to the end of the shift during which the patient was treated. There should be no access to patient records on personally owned computers. Agencies should have policies restricting the use of personally owned computers for completing ePCRs.

**Confidentiality & Disclosure of PCRs/Personal Healthcare Information:**

Maintaining confidentiality is an essential part of all health 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.

**Title 10 NYCRR Part 800.15:**

*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 except:

(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;

**Title 10 NYCRR Part 800.21:**

*An ambulance/ALS-FR service shall:*

(l) maintain a record of each ambulance call…
Health Insurance Portability & Accountability Act of 1996 (HIPAA):

Federal Law (HIPAA) requires all healthcare providers to have a written policy on protecting Personal Health Information (PHI), including PCRs.

Such a policy should include (but not be limited to):
- Indicate that requests from patients for PCR/ePCR copies be in writing;
- That the agency will maintain a copy of the written request with the original PCR/ePCR;
- Maintaining the confidentiality of the information contained on a PCR/ePCR as well as the actual PCR/ePCR;
- Conducting security training for all employees/members in proper security procedures to protect personal health information; and
- Documenting security training of employees/members.

Providing PCR/ePCR copies to the receiving hospital, other providers giving care in a tiered system and to the EMS program agency for QI does not constitute a violation of the HIPAA regulations. For additional agency specific questions regarding HIPAA agencies should contact their legal counsel and/or the U.S. Department of Health and Human Services.

Other PCR/ePCR Disclosures:

The PCR/ePCR may also serve as a document called upon in legal proceedings relating to a person or an incident. No EMS agency is obligated to provide a copy of the PCR/ePCR simply at the request of a law enforcement or other agency. If a copy of the PCR/ePCR is being requested as part of an official investigation the requestor must produce either a subpoena, from a court having competent jurisdiction, or a signed release from the patient. PCR/ePCR must be made available for inspection to properly identified employees of the NYS Department of Health.

A person may request a copy of a PCR/ePCR completed for themselves as the patient or the parent or legal guardian of a patient may obtain a copy of a PCR/ePCR completed for that patient. In cases where the patient is now deceased the person who is the court appointed legal representative of the patient’s estate may request a copy of the PCR/ePCR.

An agency may provide a copy of a PCR/ePCR to those entities that represent that agency either for the purpose of collection of fees from the patient or their insurance carrier or as part of any legal proceedings relating to the agency. In such situations those representative are also responsible for protecting the personal health information contained within the document.
Disposition Codes:

All hospitals in New York State have a three digit code indicating the hospital. In addition the name of the hospital must be indicated.

<table>
<thead>
<tr>
<th>Non Hospital Disposition Codes</th>
<th>Meaning</th>
<th>Example (See Note)</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Nursing Home</td>
<td>Any nursing home, rehabilitation center, respite home or extended care facility not listed with a hospital disposition code.</td>
</tr>
<tr>
<td>002</td>
<td>Other Medical Facility</td>
<td>Includes outpatient and specialty clinics, doctor’s offices, diagnostic and testing facilities.</td>
</tr>
<tr>
<td>003</td>
<td>Residence</td>
<td>When a patient is transported to a private residence.</td>
</tr>
<tr>
<td>004</td>
<td>Treated By This Unit &amp; Transported By Another Unit</td>
<td>In a multi-tiered response system, this disposition would be used by any BLS FR or ALS FR agency. This code would also be used if one ambulance service provides ALS interface for another ambulance. It would not be used by multiple vehicles from the same agency i.e., two ambulances are dispatched to the same call.</td>
</tr>
<tr>
<td>005</td>
<td>Refused Medical Aid and Or Transport</td>
<td>Any time contact is made and a person is evaluated, to include such procedures as vital signs being taken, or any treatment is provided. The documentation included on the PCR must indicate that the patient was advised of the need for care and the patient was competent to make an informed refusal of such care.</td>
</tr>
<tr>
<td>006</td>
<td>Call Cancelled</td>
<td>Any time a call is canceled prior to the arrival of the EMS agency this disposition code should be used. When possible the crew should document what other agency canceled the response or the reason for the cancellation.</td>
</tr>
<tr>
<td>007</td>
<td>Stand By Only (No Patient)</td>
<td>Used if a service is dispatched for a call such as to stand by during a fire or other incident. If any person is treated at the scene an additional PCR should be completed for them.</td>
</tr>
<tr>
<td>008</td>
<td>No Patient Found</td>
<td>If a service arrives at a scene and there is no one there with any complaint or injury, this code should be used. This would include being dispatched to a motor vehicle crash at which there are no persons who require any evaluation or care to. Document completely under Comments</td>
</tr>
<tr>
<td>010</td>
<td>Other</td>
<td>Any instance not indicated or explained above. This might include a lift assistance call for a person who has fallen. Document completely under Comments</td>
</tr>
</tbody>
</table>

NOTE: It is impossible to include every possible scenario an effort is made to provide guidance on many common occurrences.
BACKGROUND
The New York State Emergency Medical Advisory Committee (SEMAC) has approved the use of glucometers and nebulized albuterol by Emergency Medical Technicians (EMT) who are employees/volunteers of an EMS agency (i.e. ambulance service, ALS-FR, BLS-FR). The SEMAC approval was granted with the specific condition that the EMS agency wishing to use a glucometer or nebulized albuterol, be granted approval by the Regional Emergency Medical Advisory Committee (REMAC), that each EMT from that EMS agency complete a REMAC approved training program, and that the EMS agency be granted a Limited Service Laboratory Registration (for blood glucometry only).

The purpose of this policy is to explain the approval process for EMS agencies wishing to implement a nebulized albuterol and/or blood glucometry program.

- Prehospital blood sugar evaluation is intended to assist in the recognition of hypoglycemia and improve the speed with which proper treatment is received.

- Nebulized albuterol, when administered under the Statewide BLS Adult and Pediatric Treatment Protocols has been shown to decrease respiratory distress in patients between one and sixty-five years of age who are experiencing an exacerbation of their previously diagnosed asthma.

AUTHORIZATION FOR BLOOD GLUCOMETRY AND/OR NEBULIZED ALBUTEROL
Each REMAC will adopt protocols which will allow an EMT to obtain a blood sample, using a lancet device or equivalent, and test the blood sample in a commercially manufactured electronic glucometer. The REMAC will determine the type and level of record keeping and quality assurance required for both blood glucometry and/or nebulized albuterol. Please note that a protocol for nebulized albuterol has been approved by SEMAC and is included in the Statewide BLS Adult and Pediatric Treatment Protocols for EMT-B and AEMT.

To be authorized to use an electronic glucometer or nebulized albuterol, the EMS agency must make written request to the appropriate REMAC. The request must include, but not necessarily be limited to, the following items:

- A letter from the EMS agency physician medical director supporting the request and indicating an understanding of their role in the Clinical Laboratory requirements (blood glucometry only) and quality assurance process.
A completed NYS Department of Health Clinical Laboratory Evaluation Program Limited Service Laboratory Registration Application (form DOH-4081) for blood testing licensure (blood glucometry only).

Written policies and procedures for the operation of the glucometer and storage and maintenance of nebulized albuterol that are consistent with applicable Regional and State protocols. These policies and procedures shall include, but not necessarily be limited to the following:

- didactic and psychomotor objectives for training of authorized users including who will be authorized to conduct this training;
- documentation and attendance records of the training of authorized users;
- a defined quality assurance program, including appropriateness review by the EMS agency physician medical director;
- documentation of control testing process (blood glucometry only);
- written policies and procedures for storage of the glucometer and/or nebulized albuterol, and proper disposal of sharps devices (blood glucometry only);
- notice to the EMS agency physician medical director of the use of the glucometer and/or nebulized albuterol, and;
- requirements for documentation when the glucometer and/or nebulized albuterol is used for patient care.

LIMITED LABORATORY REGISTRATION FOR BLOOD GLUCOMETRY
New York State Public Health Law requires that any EMS agency testing blood glucose, whether by electronic glucometer or chemstrip, be required to possess a Limited Service Laboratory Registration. In order to obtain the Registration, EMS agencies must complete and submit the following document:

- Limited Service Laboratory Registration Application (form DOH-4081)

Information and application materials are available at:

http://www.wadsworth.org/labcert/limited/index.htm

No EMS agency may engage in the testing of blood glucose without a Limited Service Laboratory Registration Certificate.

NOTIFICATION
Once the EMS agency has received written approval for blood glucometry and/or nebulized albuterol from the REMAC, the EMS agency must provide BEMS with an updated and signed Medical Director Verification Form (form DOH-4362), indicating the Limited Laboratory Registration permit number (if applicable) and authorization by the EMS agency physician medical director.

Issued and authorized by the Bureau of EMS Acting Director
The purpose of this policy is to assist a children’s camp or EMS agency in understanding the notification process for utilizing epinephrine auto-injectors under the provisions of Article 30, section 3003 of the Public Health Law authorizing the use of an epinephrine auto-injector (epi-pen). An epinephrine auto-injector program is designed to encourage greater acquisition, deployment and use of epinephrine auto-injectors at children’s camps and EMS agencies around the State in an effort to reduce the number of deaths associated with anaphylaxis [hypersensitivity (as to foreign proteins or drugs) resulting from sensitization following prior contact with the causative agent].

At present, only New York State Department of Health Bureau of Emergency Medical Services (BEMS) certified ambulance services are required to have epinephrine auto-injectors and trained providers available when in-service. The exception to this rule is when the ambulance is staffed at the time of the call with an EMT –Critical Care or EMT-Paramedic authorized by the appropriate Regional Emergency Medical Advisory Committee (REMAC) to administer epinephrine via subcutaneous or intramuscular injection. All other recognized EMS agencies such as certified Advanced Life Support First Responder (ALSFR) agencies, Basic Life Support First Responder (BLSFR) agencies with a BEMS issued agency code and children’s camps as defined by subpart 7-2 of the New York State Sanitary Code are strongly encouraged to participate in the epinephrine auto-injector program.

To be authorized to purchase, acquire, possess and use an epinephrine auto-injector under this statute, the entity is required to file a completed and signed Notice of Intent to Provide Epinephrine Auto-Injector (NOI) DOH-4188 and collaborative agreement with the appropriate Regional Emergency Medical Services Council (REMSCO) who will then forward a copy of the NOI to BEMS.

There are no approvals or certifications issued by REMSCO/REMAC/BEMS

Epinephrine Auto-Injector Program Requirements

Original Notification Process
To be authorized to purchase, acquire, possess and utilize an epinephrine auto-injector, the following steps must be completed:

- Identify a New York State licensed physician or New York State based hospital knowledgeable and experienced in emergency cardiac care to serve as Emergency Health Care Provider (EHCP) and participate in a collaborative agreement;

- Select and utilize the appropriate New York State Emergency Medical Services Council (SEMSCO)/BEMS approved epinephrine auto-injector training course curricula for epinephrine auto-injector providers. At present, the two (2) approved curricula are as follows (see attached):
  - NYS DOH BEMS EMT-Basic original curriculum (EMT/AEMT providers)
  - NYS DOH BEMS Training Program Outline for unlicensed/uncertified personnel (children’s camp)
  - Other curricula as approved on a case to case basis by NYS DOH Bureau of Community Environmental Health & Food Protection

- Develop with the EHCP, a written collaborative agreement which must include, but not be limited to the following:
  - written policy and procedure for acquisition, storage, accounting, and proper disposal of used auto-injectors.
  - written policies and procedures for the training of authorized users;
  - written practice protocols for the use of the epinephrine auto injector;
  - a method of notifying the EHCP of the use of the epinephrine auto injector;
  - documentation of the use of the epinephrine auto injector;

- Provide written notice to the 911 public safety answering point (PSAP) or equivalent ambulance dispatch entity of the availability of epinephrine auto-injectors at your location

Policy Statement 11-08
• File with the appropriate REMSCO a completed and signed original of the NOI along with a completed and signed original of the Collaborative Agreement

• File a new NOI and Collaborative Agreement with the REMSCO if the EHCP changes or with a change in content of the Collaborative Agreement

**REMSCO Responsibility With Regard To Epinephrine Auto-Injector Programs**

Each REMSCO is responsible for receiving and maintaining notification and utilization documentation submitted by the epinephrine auto-injector program. The REMSCO shall develop and implement the following policies and procedures:

• Ensure that a copy of each original or updated NOI is forwarded to BEMS;
• Maintain the original of the NOI and the Collaborative Agreement;
• Collect utilization documentation and information;
• Provide detailed quarterly reports to BEMS regarding epinephrine auto-injector programs in the region, and;
• Develop Continuous Quality Improvement (CQI) participation, data submission and documentation requirements for participating entities.

**Data Collection Requirements**

The following minimum data shall be developed and collected as a part of the REMSCO epinephrine auto-injector CQI process:

• Name of entity providing the epinephrine auto-injector;
• Date of incident;
• Time of Incident;
• Patient age;
• Patient gender;
• Number of epinephrine auto-injections administered to the patient;
• Name of the transporting ambulance service, and
• Patient status at time of transport

A copy of the data set shall be provided quarterly to BEMS by the REMSCO.

**Reporting an Epinephrine Auto-Injector Use**

In the event that an epinephrine auto-injector is administered to a patient experiencing anaphylaxis, the entity must report the incident to their EHCP. While it is not required by Article 30 of Public Health Law (PHL), BEMS policy dictates that epinephrine auto-injector entities provide written notification to the REMSCO within 48 hours of the epinephrine auto-injector use. At a minimum, the following should be provided as part of this written notification:

• The name of the epinephrine auto-injector entity;
• Location of the incident;
• The date and time of the incident;
• The age and gender of the patient;
• The number of epinephrine auto-injectors administered to the patient;
• The name of the ambulance service that transported the patient, and
• The name of the hospital to which the patient was transported.

A copy of the above written notification shall also be provided to the EHCP.

In addition, Subpart 7-2 of the State Sanitary code requires children's camp operators to report in writing any epinephrine administration to the permit-issuing official within 24 hours of the administration.

**Attachments**

1. EMT-Basic original curriculum Lesson 4-5 on Allergies
2. Training Program Outline for Unlicensed/Uncertified Personnel to Administer Epinephrine by Auto-Injector In Life Threatening Situations
3. REMSCO Listing

Policy Statement 11-08
Purpose:
To create a method for certified EMS agencies to have their operating certificate territory description changed to reflect the actual area served, without adding new territory. Rewording may be desirable when an existing description is either vague, imprecise, or uses descriptors that may no longer be an accurate representation of the geography served. This policy may also serve as a guideline for the Regional EMS Council to use when reviewing and considering a Clarification of Operating Territory request.

Incorrect territory descriptors may exist for a number of reasons, for example:

- The original description used vague language - vicinity of, surrounding area, adjacent to, etc.
- The description is no longer a valid municipal entity – city, town or village restructured or geography legally changed.
- The description was never a valid naming convention – for example, municipal subdivisions described by north, south, east or west when there is no such legal name.
- Service to a district, such as a fire district, where no valid geographical boundaries were ever documented to define its boarders. This descriptor variance may apply to entities that provided services under contracts that changed over time. The most frequent instance of such variations has been observed due to changes in fire protection districts.
- Entities serving an area that has an “excluded” portion of geography, the exclusion descriptors being imprecise, or using descriptors based on vague local terminology.

While the most common reason for an agency to request a COT may be financially motivated, there is merit to evaluating the areas served in each county to insure that no geography is left without authorized ambulance service coverage. Also, it is difficult for agencies to create effective mutual aid agreements if a given EMS agency’s territory is not accurately described.

County EMS Coordinators and Public Safety Answering Points (PSAPs) are encouraged to evaluate the territory of each EMS agency operating within their jurisdiction to insure that ambulance service coverage legally exists throughout the entirety of each county.

Clarification of Operating Territory Process:
Each REMSCO should develop a consistent methodology and written policies to process COT requests. Copies of the adopted process and policy should be made available to EMS agencies upon request.

It is important to note that Article 30 of Public Health Law (A30 PHL) specifically describes the statutory authority of the Regional EMS Councils (REMSCOs) regarding the creation of new emergency medical services or the expansion of territory of existing services. The processes to fulfill such actions may be found in DOH Policy Statement #06-06 EMS Operating Certificate Application Process (CON). Because the COT process does not create new authority, or expand existing certified EMS agency operating territory, the traditional CON process is not
required. REMSCOs may adopt a simplified version of the CON process with several specific exceptions.

- No public hearing is required because proof of “public need” is not in question.
- Once the policy is established, it is recommended that the REMSCO place a deadline for receiving COT requests. This will allow the REMSCO to entertain COTs for a limited period of time, after which, EMS agencies must make application as described in the current EMS Operating Certificate Application Process (CON) Policy Statement.

The following items need to be included in any COT process:

- A written request for a Clarification of Operating Territory submitted to the REMSCO(s) having jurisdiction. If more than one REMSCO has jurisdiction then simultaneous and identical requests must be made to all REMSCOs having jurisdiction.
- A historical account, including supporting documents, explaining why the applicant’s territory qualifies for the COT.
- A copy of the applicant’s current, and if relevant prior, Department issued service operating certificates (DOH-4005 for ALSFR Services or DOH-3414 for Ambulance Services)
- A statement from the applicant indicating if the service has ever been instructed by NYS DOH to apply to a REMSCO for a traditional CON to correct the service’s operating territory.
- Statements of concurrence or support, from impacted municipalities, adjoining certified services, services holding overlapping EMS operating authority and all PSAPs or dispatch systems having jurisdiction. The statements must be no more than 6 months old and be signed by the executive officers or elected officials of the represented concerned parties.

Supporting documents should include, but are not limited to:

- DOH issued service Operating Certificates or service records;
- Contracts;
- Maps;
- Copies of Patient Care Reports (with patient identification removed but geographical information included to substantiate location);
- Dispatch records or call logs;
- Correspondence and/or communications with municipalities, other EMS agencies, REMSCO or Program Agency, or the Department relating to the territory needing clarification;
- Media documentation and historical records.

The following steps need to be included in any COT process:

- Submission of a formal request for COT, with all supporting documents to the REMSCO.
- Written acknowledgment by the REMSCO to the applicant and the Department of receipt of the COT application. The Department will verify if the applicant’s territory concerns are eligible for the COT process.
- Review of the application and supporting documents by the REMSCO’s committee / COT workgroup.
- Opportunity for follow up to complete or clarify any information under consideration by the reviewing committee.
- Presentation of the COT by the reviewing committee to the REMSCO at any regular or special meeting that has a quorum to conduct REMSCO business.
- Motion, second and vote by the REMSCO to accept, modify or deny the rewording of the applicant’s operating territory.
- Written notification to the Department of the REMSCO’s motion and vote, including a copy of the application and supporting documents. Note that the format of the notice to the Department to change the applicant’s territory descriptor is an “Endorsement of the need for clarification and a recommendation of the terminology and wording that will most accurately describe the applicant’s existing operating territory without expansion.”
After receipt by the Department of the REMSCO’s notification, a concurrence review will be conducted. Upon establishing concurrence with the REMSCO’s recommendation the Department will issue an “amended” DOH-4005 or DOH-3414 certificate to the applicant with copies to all REMSCOs having jurisdiction.

Additional Considerations:
- An applicant that has previously been directed by the Department or the REMSCO to apply for an expansion of operating territory for the geography at issue will not be considered for the COT process.
- If upon review by a REMSCO an application is deemed to constitute an expansion of operating territory and not a clarification of operating territory, the application must be returned to the applicant, with a copy to the Department, directing the applicant to make application for an expansion of operating territory.
- A COT is not a CON process and is therefore not subject to the statutory time frames specified in A30 PHL or DOH Policy #06-06. However the council must process and come to a determination as expeditiously as is feasible to best serve the public interest. The Department is also not bound to statutory time frames, but will make reasonable efforts to conclude concurrence reviews in a timely manner.
- The Department reserves the right to approve or deny final concurrence and issuance of an amended territory on any applicant’s service operating certificate. In the event of denial the Department will provide an explanation for the denial and any alternative course of action available to the applicant.
- A COT is not subject to appeal within the statutory definitions established by A30 PHL. Should a COT recommendation that is concurred by the Department be appealed within 120 days, by any party having standing to appeal, the amended wording will be vacated and the applicant referred to apply for a traditional CON.

Frequently Asked Questions:
Q: Can a COT be used as a means to “grandfather” geography that has been traditionally served by a certified EMS agency, but where such geography has never been identified by the territory descriptor currently on the agency’s DOH operating certificate?
A: No. The COT process is not a substitute for “grandfathering” territory. If a certified EMS agency is providing service outside the boundaries listed on its current DOH certificate, the agency must apply for an Expansion of Operating Territory (EOT) to the Regional EMS Council(s) having jurisdiction. It is important to note that Article 30, section 3009 - Continuation of Existing Services is no longer applicable.

Q: May a service that is currently applying for an expansion of operating territory, request a COT for another portion of its territory that is not subject to “demonstration of need”?
A: Because a COT is not subject to A30 PHL statutory processes, a council is not barred from considering an application at any time convenient to its review committee and general membership. However, the Department does not recommend conducting a CON and COT for the same applicant concurrently if the workload or territory issues under consideration could confuse or complicate fair evaluation of the statutorily mandated CON action.

Q: May a REMSCO charge fees to conduct a COT?
A: Yes. However, because there is no public hearing and all documentation requirements may be assigned to the applicant, in practice there should be minimal if any additional expenses beyond the normal course of business for a REMSCO. Therefore, the Department recommends REMSCOs keep any fees minimal and refund any unused funds to the applicant. Nominal expenses for a COT would be anticipated to apply primarily to document copying and postage and/or information exchange expenses.
PURPOSE:
This policy was developed by the State Emergency Medical Advisory Committee (SEMAC) and the Department to better define the statutory authority, roles and responsibilities, the development of treatment protocols, credentialing, provision of medical control and oversight to the prehospital community. It was approved by the State EMS Council at its March, 2011 meeting and is authorized by the Department.

DEFINITIONS:
1. "State Emergency Medical Advisory Committee" (SEMAC) means the New York State Emergency Medical Advisory Committee formed pursuant to Public Health Law Section 3002-a.

2. "Regional Emergency Medical Advisory Committee" (REMAC) As defined in section 3001.16 means a group of five or more physicians, and one or more non-voting individuals representative of each of the following: hospitals, basic life support providers, advanced life support providers and emergency medical services training sponsor medical directors approved by the affected regional emergency medical services councils.

3. "Medical control" (3001.15) means:
   (a) advice and direction provided by a physician or under the direction of a physician to certified first responders, emergency medical technicians or advanced emergency medical technicians who are providing medical care at the scene of an emergency or en route to a health care facility and
   (b) indirect medical control including the written policies, procedures, and protocols for prehospital emergency medical care and transportation developed by the state emergency medical advisory committee, approved by the state council, the commissioner and implemented by regional medical advisory committees.

4. "Under the direction of a physician" shall mean a Physician, Physician Assistant, Nurse Practitioner, or Registered Professional Nurse that meets or exceeds those requirements as established in NYCRR Title 10, Section 405.19 – Emergency Services. Registered Professional Nurses must have completed the educational requirements within one year as stated in Section 405.19. Per Section 405.19 the following education requirements are:
   i. Physician ACLS and ATLS
   ii. Physician Assistant ACLS and ATLS
   iii. Nurse Practitioner ACLS and ATLS
   iv. Registered Professional Nurse ACLS
5. "Course sponsor medical director" means a physician licensed in the State of New York, identified by an approved training course sponsor and approved by the Department as having sufficient knowledge and experience required by the Department to fulfill the educational needs of Department certification courses.

6. "On-line (direct) medical control" means the advice and direction provided by a physician or under the direction of a physician, operating under guidelines approved by a REMAC, to certified EMS personnel who are providing medical care at the scene of an emergency or en route to a health care facility.

On-line medical control must be made directly between the on-line medical control personnel (Physician, Physician Assistant, Nurse Practitioner or Registered Professional Nurse¹) and certified EMS field personnel and be in real time. Physician and Non-physician on-line medical control personnel must successfully complete a REMAC approved on-line medical control program. The physician on-line medical director or the REMAC will be responsible for conducting quality assurance review of the hospital or regional on-line medical control programs and personnel.

7. "Medical control location" means a place which has been approved by one or more REMAC(s) as having met their policies and procedures to provide on-line medical control.

8. "Regional EMS system" means the provision of emergency medical service, in an organized manner, by one or more EMS services or EMS systems, utilizing certified EMS personnel, in accordance with the medical control policies of the REMAC.

9. "EMS system" means one or more EMS services organized to provide emergency medical service in an area served by one or more Regional EMS Councils. An EMS system must have a system medical director and have been approved by each REMAC as having met the medical standards of the REMAC in each Region within which the system will provide care.

10. "Regional medical director" means a physician member of a REMAC, who has been approved by the REMAC as having met its credentialing policies and procedures and who may be appointed by a REMAC with specific duties and responsibilities.

11. "System medical director" means a physician identified by an EMS system who has been approved by one or more REMAC(s) as having met their credentialing policies and procedures and who oversees the medical care provided by all EMS services within the EMS System.

12. "Service medical director" means a physician identified by an EMS service who has been approved by one or more REMAC(s) as having met their credentialing policies and procedures, who is directly responsible for the medical care provided by the certified EMS personnel of that EMS service, and who provides and participates in the EMS service’s quality improvement program. No physician may act as service medical director for more than 10 EMS Services. A ratio of physician to certified EMS personnel

¹ Meeting the requirements of Title 10 NYCRR Part 405.19 (d) Staffing, sections (1) Emergency Service Physician and (3) Registered Physicians Assistants, Nurse Practitioners and Registered Professional Nurses.
supervision must be provided as follows; a) 500:1 for certified EMS personnel who provide Automated External Defibrillation, b) 100:1 for certified EMS personnel who provide advanced life support; provided that the maximum number of personnel to be supervised by an individual physician may not exceed 500 AED or 100 ALS personnel.

13. "Certified EMS personnel" means certified first responders, emergency medical technicians or advanced emergency medical technicians currently certified by the Department.

MEDICAL CONTROL
Medical control is accomplished through physician participation and direction at the state, regional, system and service levels.

State Emergency Medical Advisory Committee (SEMAC)
The state emergency medical advisory committee (SEMAC) shall:

1) develop minimum standards for:
   - medical control,
   - triage, treatment, and transportation protocols,
   - protocols for invasive procedures,
   - protocols for infection control,
   - the administration of drugs, by certified EMS personnel,
   - the use of regulated medical devices by certified EMS personnel,
   - equipment, staffing and documentation requirements for medical control locations,
   - the approval of EMS systems,
   - qualifications and responsibilities for regional, system, service and course sponsor medical directors,
   - operational aspects of the provision of EMS related to improving patient care or outcome.

2) issue, with the consent of the Commissioner, statewide advisory guidelines that include, but are not limited to:
   - medical standards for the establishment and approval of EMS services,
   - criteria for regional approval of dispatch, triage, treatment and transportation protocols,
   - criteria for statewide, regional, system and service quality improvement programs,
   - responsibilities of service medical directors,
   - inter regional ALS protocol coordination and use,
   - patient destination protocols,
   - policies to be utilized when no patient is found and/or a patient refuses services,
   - criteria for transfer of patient care between non-physician providers,
   - criteria for appropriate utilization of air medical transportation resources,
   - medical aspects of disaster and multiple casualty incidents and mutual aid,
   - any subject in section 1.

3) issue minimum statewide guidelines, in compliance with all Federal and State rules, for inter-facility transfers including:
   - acceptance of any patient by the transferring crew,
   - authorization and responsibility of the sending hospital and physician,
   - required documentation, by the transferring physician, of the level of care to be provided during the transfer,

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2 10 NYCRR Part 80.136 (a)(2) ...The medical director of any advanced life support system with 10 or more advanced life support agencies and/or 100 or more advanced emergency medical technicians (AEMTS) shall designate associate physicians...
• responsibilities of the receiving facility,
• use of prehospital protocols and medical control intervention,
• use of medical modalities outside the regional prehospital protocol set that require special or additional training,
• documentation and transmission of medical orders.

4) review and approve protocols developed and/or implemented by REMAC's;

5) review and make recommendations to the SEMSCO and the Commissioner regarding demonstration projects developed pursuant to 10 NYCRR Part 800.19;

6) develop procedures for the review and approval of prehospital EMS research/evaluation activities;

7) report to the SEMSCO on all issues brought before it.

Regional Emergency Medical Advisory Committee (REMAC)
Although by law a REMAC is given independent authority to decide EMS medical issues within its region, it must work cooperatively and with one common purpose with its Regional EMS Council (REMSCO) and the EMS community so that the system operates smoothly and effectively. For that to happen, the REMAC and the REMSCO need to establish joint operating procedures to ensure effective communications that produces a partnership of shared responsibilities that assures the provision of quality EMS services within the region. Toward this common objective the following goals for a REMAC are:

• To establish prehospital medical standards for a region consistent with the current practice of emergency medicine.

• To provide medical leadership, education, guidance, quality assurance and appropriate remediation to all participants in the regional EMS system

• To ensure and participate in regional and agency level quality assurance activities.

• To educate and credential physicians to provide on-line medical control.

• To educate and credential NYS certified EMS prehospital care providers.

• To ensure the availability and quality of educational programs for all pre-hospital care providers.

• To coordinate the development of the regional medical control system.

• To define roles and responsibilities of the REMAC physicians within the Regional EMS System.

• To encourage broad medical participation and a diverse representative constituency in the development of medical control policies and procedures, as well as dispatch, triage, treatment, and transportation protocols which are consistent with the standards of the SEMAC and which address specific local conditions.

• To develop a methodology by which both the REMSCO and REMAC will review, approve/disapprove, and forward recommendations to the appropriate regional and State committees regarding pre-hospital demonstration projects.
To receive patient outcome information from hospitals and pre-hospital EMS services and coordinate quality assurance/improvement activities for the purpose of assessing pre-hospital care concerns.

To encourage and review pre-hospital research/evaluation.

Each REMAC, within the standards and guidelines established by the SEMAC:

1) shall develop, review and/or implement dispatch, treatment, triage and transportation protocols, specific to the needs of its region(s). Such protocols shall delineate care to be provided under standing orders and/or on-line medical control,

2) may develop protocols, including but not limited to the following:
   - determining patient destination;
   - procedures to be followed when a patient refuses and/or no transport of a patient occurs;
   - circumstances under which care may be transferred from one level of non-physician provider to another;
   - utilization of air medical transportation resources.

3) may develop policies and procedures, to optimize medical control of all pre-hospital patient care activities for all EMS services providing care within its region. Such policies and procedures shall include, but are not limited to,
   - the initial and continuing qualifications for physicians providing on-line medical control,
   - minimum staffing, equipment and documentation requirements for medical control locations,
   - qualifications and responsibilities for the regional, system, service and course sponsor medical directors,
   - approval of EMS services, indicating they have met the requirements of the REMAC to provide a level of care, upon initial application and any subsequent changes in the level of service offered;
   - guidelines for inter-facility transfers,
   - the initial credentialing and continuing medical and educational qualifications of all pre-hospital care providers in the region;
   - process for disciplinary action against EMS providers;
   - medical requirements for and approval of EMS systems and services,
   - approval and use of inter-regional protocols,
   - operational aspects of the provision of EMS related to improving patient care or outcome,

4) may develop, implement and shall participate in a region wide quality improvement plan which addresses regional and system wide issues, and which facilitates the integration of emergency medical service with hospital quality improvement activities,

5) shall review and make recommendations to the REMSCO for any demonstration projects developed pursuant to Section 800.19 of this Part.

6) may designate, if appropriate, a member to act as regional medical director, who if appointed shall have written duties, authorities and responsibilities defined by the REMAC.

7) may develop procedures for the review and approval of prehospital EMS research/evaluation activities.
8) shall address all issues brought before it by the REMSCO or any provider or other interested party.

RESOURCE INFORMATION

11-03 Providing Medical Direction  
http://www.health.state.ny.us/nysdoh/ems/policy/11-03.htm

American College of Emergency Physicians  
http://www.acep.org

National Association of EMS Physicians  
http://www.naemsp.org
I Purpose

This policy is intended to provide assistance to Emergency Medical Service (EMS) agencies and physician medical directors so that they may better understand medical direction for patients of all ages at the agency level. The policy should clarify and expand upon the definitions contained in Policy Statement 95-01, Medical Control, issued May 31, 1995. It is also the intent of this policy to define the roles and responsibilities of the service, the service medical director the Regional EMS Council (REMSCO) and the Regional Emergency Medical Advisory Committee (REMAC) in relation to this topic. While the Department recommends that every agency providing pre-hospital emergency medical care have a physician medical director, it is a requirement for those agencies described below;

- All Ambulance Services providing Defibrillation.
- All Ambulance Services providing any level of Advanced Life Support (ALS).
- All Advanced Life Support First Response Agencies.
- All Basic Life Support First Response agencies providing Defibrillation and/or possessing a DOH issued EMS Agency ID code number that also have REMAC issued authority to provide any adjunct level of BLS care such as Albuterol or Blood Glucometry.1.
- All entities authorized to provide Public Access Defibrillation under § 3000-b of Public Health Law (PHL) shall have an Emergency Health Care Provider (EHCP).
- All entities authorized to provide Epinephrine Auto Injectors under § 3000-c of Public Health Law (PHL) must have an Emergency Health Care Provider (EHCP).

An EMS Service Medical Director shall mean a physician, licensed by New York State and approved by the local REMAC with whom the agency has a professional relationship.

An Emergency Health Care Provider (EHCP) means: (I) a physician with knowledge and experience in the delivery of emergency medical care; or (II) a hospital licensed under article twenty-eight of the NYS Public Health Law that provides emergency medical care and with whom the Public Access Defibrillation or Epinephrine Auto Injector program provider entity has a written collaborative agreement.

1 While Basic Life Support First Response agencies are encouraged to interact with a physician medical director for all patient care responses, these agencies are only required to have a medical director involved in training, use and quality improvement of the public access defibrillation and/or epinephrine auto-injector program. If such agency holds a DOH issued EMS Agency ID# and has also been granted REMAC authority to provide adjunct levels of BLS care (eg: Albuterol and/or Blood Glucometry) then the agency is required to have a REMAC approved physician service medical director as an eligibility requirement for the EMS Agency ID.
II Selecting an EMS Agency Medical Director

- For Basic Life Support (BLS) and Advanced Life Support (ALS) ambulance services or Advanced Life Support First Response Services (ALS-FR), the provisions of Policy Statement 95-01 regarding service medical director states that the physician must be approved by the REMAC as having met their credentialing policies and procedures.

The Responsibilities of the EMS Service Medical Director

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

1) Assure that service certified EMS personnel are oriented to the protocols promulgated by the SEMAC and the REMAC(s) for the area(s) of operation of the service,

2) Interact with REMAC in the development of protocols, the regional Quality Improvement (QI) process and in disciplinary issues,

3) Active development, review and participation in the Quality Improvement program developed by the service as part of the Regional Council’s Quality Improvement program, as required in PHL §3006, or §3004-a,

4) Working with the service’s providers on issues and questions regarding all ages of patient care,

5) Participate/interact in other activities that relate to the provision of medical care or affect the patient care provided by the EMS service,

6) Participate, as necessary, with the service’s certified EMS personnel in Continuing Education Programs and the re-certification process,

7) Verify, by affirmation provided by the department (DOH-4362 Medical Director Verification form), that he/she serves as the medical director for the EMS service, providing medical oversight inclusive of the levels of care and/or BLS adjunct treatment protocols specified on the form,

8) In accordance with NYS law, regulation or department policy submit any documentation required for additional level of care approvals obtained by the EMS agency represented.

Immunity from Liability for Medical Direction

Article 30 § 3013 (5), of PHL: Notwithstanding any inconsistent provision of any general, special or local law, any physician who voluntarily and without the expectation of monetary compensation provides indirect medical control, shall not be liable for damages for injuries or death alleged to have been sustained by any person as a result of such medical direction unless it is established that such injuries or death were caused by gross negligence on the part of such physician.

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2 PHL Article 30 § 3001 (15) "Medical control" means: (a) advice and direction provided by a physician or under the direction of a physician to certified first responders, emergency medical technicians or advanced emergency medical technicians who are providing medical care at the scene of an emergency or en route to a health care facility and (b) indirect medical control including the written policies, procedures, and protocols for prehospital emergency medical care and transportation developed by the state emergency medical advisory committee, approved by the state emergency medical services council and the commissioner, and implemented by regional medical advisory committees.
III  Selecting an Emergency Health Care Provider for Public Access Defibrillation or Epinephrine Auto Injector Programs

- For organizations engaged in the PAD program, PHL §3000-b 1 (B) requires the selection of an Emergency Health Care Provider (EHCP). An EHCP is defined as “(I) a physician with knowledge and experience in the delivery of emergency cardiac care; or (II) a hospital licensed under article twenty-eight of this chapter that provides emergency cardiac care.”
- For organizations engaged in the epi-pen program PHL §3000-c 1(B) requires the selection of an Emergency Health Care Provider (EHCP). An EHCP is defined as (i) a physician with knowledge and experience in the delivery of emergency care; or (ii) a hospital licensed under article twenty-eight of this chapter that provides emergency care.

IV  Responsibilities of a Public Access Defibrillation Program EHCP

1) §3000-b.1(E) states that, “The Emergency Health Care Provider (EHCP) shall participate in the regional quality improvement program pursuant to subdivision one of section three thousand four-A of this article.”

2) §3000-b.1(D) requires every use of the defibrillator to be reported promptly to the agency’s EHCP. It will be the EHCP’s responsibility to receive and review these reports of use. They must also communicate any concerns relating to the use of the device to the provider.

3) Serve as the physician of record for the purposes of purchasing the AED by the PAD program.

V  Responsibilities of an Epinephrine Auto-Injector Program EHCP

1) §3000-c.3(c) requires every use of an epinephrine auto injector to be reported to the agency’s EHCP. It will be the EHCP’s responsibility to receive and review these reports of use. They must also communicate any concerns relating to the use of the device to the provider.

2) It will be the responsibility of the EHCP to oversee the acquisition and deployment of the devices and to assure the quality control standards implemented by the manufacturer are maintained.

3) Serve as the physician of record for the purposes of purchasing or issuing a prescription for the program to obtain epinephrine auto injectors.

VI  Immunity from Liability for EHCP

3000-B (4) Application of other laws.
   a. Operation of an automated external defibrillator pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability.
   b. Operation of an automated external defibrillator pursuant to this section shall not constitute the unlawful practice of a profession under title VIII of the education law.

3000-C (4) Application of other laws.
   a. Use of an epinephrine auto-injector device pursuant to this section shall be considered first aid or emergency treatment for the purpose of any statute relating to liability.
   b. Purchase, acquisition, possession or use of an epinephrine auto-injector device pursuant to this section shall not constitute the unlawful practice of a profession or other violation under title eight of the education law or article thirty-three of this chapter.
c. Any person otherwise authorized to sell or provide an epinephrine auto-injector device may sell or provide it to a person authorized to possess it pursuant to this section.

VII Implementation:

- All EMS agencies should immediately identify a physician medical director that meets the criteria set forth by the REMAC.

- All EMS agencies should carry a copy of off-line written protocols either on-person and/or on the responding vehicle(s); off-line written protocols need to be available to the provider from the time of dispatch through patient transport to a definitive care facility.

- REMSCOs, when receiving a Notice of Intent to provide Public Access Defibrillation or Epinephrine auto-injectors, shall assure the Emergency Health Care Provider meets the requirements detailed in the applicable laws.

REMACs shall establish, maintain and make available, annually, the policies and procedures established for the credentialling of physicians as service medical directors in the region. They shall also maintain and make available, annually, the list of physicians who have met those credentialling policies and procedures and are serving as medical directors. REMACs shall only grant ALS, and/or BLS adjunct levels of care, authority to agencies that are either certified or recognized by the Department and are under the medical direction of a physician credentialed by the REMAC. REMACs are encouraged to collaborate with adjoining region REMACs to promote availability of medical oversight to agencies routinely operating in more than one region.

Physicians asked to serve as EMS agency Medical Directors of BLS Ambulance or First Response services shall maintain a ratio of physician to certified providers that is no greater than 500:1. An Advanced Life Support Ambulance or First Response service must maintain a physician to certified provider ratio of no greater than 100:1. However, physician may not be the medical director for more than 10 services, unless approved by the local REMAC. These ratios were developed and approved by the SEMAC as part of Policy Statement 95-01.

Issued and Authorized
Lee Burns, Acting Director - Bureau of EMS
Purpose

This policy updates all EMS providers and agencies of changes in the laws regarding Do Not Resuscitate (DNR) orders and Medical Orders for Life-Sustaining Treatment (MOLST). The Department now has an approved MOLST form, DOH-5003 Medical Orders for Life-Sustaining Treatment. This form does not replace the Nonhospital Order Not to Resuscitate in either the English or the Spanish version (DOH-3474, DOH-3474es), but rather provides an alternative. Nonhospital DNR orders are now governed by Public Health Law Article 29-CCC.

Additionally, this policy will provide an introduction to the Family Health Care Decisions Act (FHCDA). FHCDA allows family members or certain other individuals to make health care decisions, including decisions about the withholding or withdrawing of life-sustaining treatment, on behalf of patients who lose their ability to make such decisions and have not prepared advance directives regarding their wishes. **FHCDA went into effect on June 1, 2010.**

Nonhospital Order Not to Resuscitate

The New York State Department of Health has an approved standard **Out of Hospital DNR** form (DOH-3474) that is legally recognized statewide for DNR requests occurring outside of Article 28 licensed facilities. This form is intended for patients not originating from a hospital or nursing home.

For patients with a valid Nonhospital DNR or MOLST form with a DNR order, the Public Health Law allows a standard metal bracelet to be worn by the patient, which includes a caduceus and the words “DO NOT Resuscitate.” EMS providers should assume that there is a valid DNR in place when a DNR bracelet is identified on a patient.

Medical Orders for Life-Sustaining Treatment (MOLST)

MOLST is an alternative form for patients to document their end-of-life care preferences and to assure that those preferences are made known to health care providers across the health care delivery system. Unlike the Nonhospital Order Not to Resuscitate, the MOLST form documents DNI orders and orders regarding other life-sustaining treatment, in addition to DNR orders. MOLST should be honored by EMS agencies, hospitals, nursing homes, adult homes, hospices and other health care facilities and their health care provider staff. MOLST has been approved by the Office of Mental Health and the Office for People With Developmental Disabilities for use as a nonhospital DNR/DNI form for persons with developmental disabilities, or persons with mental illness, who are incapable of making their own health care decisions or who have a guardian of the person appointed pursuant to Article 81 of the Mental Hygiene Law or Article 17-A of the Surrogate’s Court Procedure Act.

Chapter 197 of the Laws of 2008 authorized the MOLST form to be used statewide as an alternative form for nonhospital DNR and/or DNI and allowed EMS providers to honor this form in all counties in New York State.

Both the Nonhospital Order Not to Resuscitate form (DOH-3474) and the MOLST form (DOH-5003) are New York State Department of Health forms. The MOLST form was updated in June 2010 to make it more user-friendly and to align the form with the recently enacted Family Health Care Decisions Act. The MOLST form is currently utilized by many health care systems. **If a patient has a prior version of the MOLST in place and signed by a physician, the form is still considered VALID, and the patient care orders should be honored, unless it is known that the patient’s form has been revoked.**
What are the DNR/DNI rules that affect EMS agencies and providers now?

1. Effective July 7, 2008, the MOLST form is approved for use statewide without the need for a standard one-page Nonhospital Order Not to Resuscitate form.
2. EMS agencies must still honor the standard one-page nonhospital DNR form or bracelet.
3. When a patient wears a DNR bracelet, it refers ONLY to the do not resuscitate rules that apply to the nonhospital DNR order. At present there are no nonhospital DNI bracelets.
4. The MOLST form also provides the patient and his/her physician with the ability to give a Do Not Intubate (DNI) order to health care providers including EMS. Refer to Section E on the MOLST form to review DNI information.
5. Occasionally EMS providers may encounter a patient who has a newly completed MOLST that does not have the authorizing physician's signature. While the unsigned MOLST form may provide the EMS provider with information about the patient's treatment preferences, it is not a valid DNR or other order. In the case of an unsigned MOLST form EMS providers should:
   1. Initiate resuscitation following applicable state and/or regional protocols;
   2. Obtain clinical information on status of the patient;
   3. Confirm the MOLST form is specific to the patient;
   4. Consult with local medical control and relay the above information; and
   5. Follow the direction of the medical control physician.

What are the differences and similarities between the standard one-page nonhospital DNR order and the MOLST form?

1. The MOLST form ([DOH-5003](#)) is a bright pink multi-page form; however, a photocopy or facsimile of the original form is acceptable and legal. A Nonhospital Order Not to Resuscitate form ([DOH-3474](#)) is a single-page form on white paper with black ink.
2. The MOLST form is meant to be utilized by health care providers across the health care system. It is not limited to EMS agencies; it travels with the patient to different care settings. The Nonhospital Order Not to Resuscitate form is not intended for use in facilities.
3. MOLST provides for end-of-life orders concerning resuscitation and intubation for Advanced EMTs when the patient is in full cardio-pulmonary arrest or has progressive or impending pulmonary failure without acute cardiopulmonary arrest. The Nonhospital Order Not to Resuscitate form ([DOH-3474](#)) only applies to patients in full cardio or pulmonary arrest.
4. Both forms, the MOLST form and the Nonhospital Order Not to Resuscitate form ([DOH-3474](#)) must be authorized by a physician.
5. Unlike the Nonhospital Order Not to Resuscitate form, there are multiple patient orders contained on the MOLST form that are intended for other health care providers to follow in other health care settings such as the hospital or nursing home.
6. The MOLST form gives prehospital care providers and agencies direction regarding the patient's end-of-life treatment orders in Section A (page 1) and Section E (page 2). See below.

**Orientation to the MOLST Form, DOH-5003 (June 2010)**

**Section A – Resuscitation Instructions When Patient has No Pulse and/or is Not Breathing**

Section A is titled Resuscitation Instructions When a Patient Has No Pulse and/or Is Not Breathing. It provides two boxes, only one of which will be checked. The first box, “CPR Order: Attempt Cardio-Pulmonary Resuscitation,” indicates that the patient wants all resuscitation efforts to be made, including defibrillation and intubation, if they are found in cardiac and/or respiratory arrest.

The second box, “DNR Order: Do Not Attempt Resuscitation (Allow Natural Death),” indicates the patient does not want any resuscitation efforts made, and the patient wishes to be allowed a natural death. This does not prevent treatment up to the point of resuscitation.
Section B - Consent for Resuscitation Instructions

This section **MUST** be filled out in accordance with New York State law. A box should always be checked to indicate who consented to the decision, and the name of the decision-maker should be printed. If the signature line is left blank, the box for verbal consent should be checked. If the box for verbal consent is checked, the attending physician who signed the order should have witnessed the consent or two other adult witnesses should be indicated.

Section C – Physician Signature for Sections A and B and for section E

A licensed physician must always sign the orders. If the physician is licensed in a border state, the physician must insert the abbreviation for the state in which he/she is licensed, along with the license number.

As with the Nonhospital Order Not to Resuscitate form (DOH-3474), the MOLST form is required to be reviewed by the physician periodically. However, both forms should be considered valid unless it is known that the medical order has been revoked.

Section D – Advance Directives

This section contains multiple check boxes listing advanced directives for the patient.

Section E – Orders for Other Life-Sustaining Treatment and Future Hospitalization

When the Patient has a Pulse and the Patient is Still Breathing

This section contains several parts containing treatment options that must be reviewed by prehospital care providers and includes:

**Treatment Guidelines**
- Comfort measures only
- Limited medical interventions
- No limitations

**Instructions for Intubation and Mechanical Ventilation**
- Do Not Intubate (DNI)
- A trial period
  - Intubation and mechanical ventilation
  - Non-invasive ventilation (e.g. BIPAP)
- Intubation and long-term mechanical ventilation

**Future Hospitalization/Transfer**
- Do not send to hospital unless pain or severe symptoms cannot otherwise be controlled
- Send to hospital if necessary, based on MOLST orders.

**Artificially Administered Fluids and Nutrition**
- No feeding tube
- A trial period of feeding tube
- Long-term feeding tube
- No IV fluids
- A trial period of IV fluids

**Antibiotics**
- Do not use antibiotics
- Limited use of antibiotics
- Use antibiotics

**Other Instructions (e.g. dialysis, transfusions)**
If any part of Section E is completed, additional consent and a physician signature, similar to Section B, must be documented at the end of this section. Sometimes two boxes will be checked in Section E. If the form was completed in the community (as opposed to a hospital or nursing home), a Public Health Law Surrogate may consent to a nonhospital DNR and/or DNI order, but may not consent to withholding other life-sustaining treatment unless the consent is based on clear and convincing evidence of the patient’s wishes. For that reason, the
box for “based on clear and convincing evidence of the patient’s wishes” may be checked in addition to the box for “Public Health Law Surrogate.”

Liability Protection

PHL § 2994-gg provides: "No person shall be subjected to criminal prosecution or civil liability, or be deemed to have engaged in unprofessional conduct, for honoring reasonably and in good faith pursuant to this section a nonhospital order not to resuscitate, for disregarding a nonhospital order pursuant to section twenty-nine hundred ninety-four-ee of this article, or for other actions taken reasonably and in good faith pursuant to this section."

Frequently Asked Questions

What should I do if I am uncertain how to proceed?
Contact Medical Control.

What do I do if the patient has both a nonhospital DNR order and a MOLST form? Which do I honor?
If the forms have different orders, you should follow the form that has the most recently dated authorization. In all instances you should follow the DNI instructions on the MOLST form if the form is signed by a physician, as the nonhospital DNR order does not provide this advice.

What if the old MOLST form was signed prior to June 1, 2010, the date the Family Health Care Decisions Act became effective?
You may honor the previous versions of the form as if it were authorized after the statutory effective date.

Does the MOLST law allow EMS to honor other advance directives?
The law does not expand the ability of EMS personnel to honor advance directives such as a Health Care Proxy or Living Will.

What procedures are, and are not, performed if the patient presents a DNR?
Do not resuscitate (DNR) means, for the patient in cardiac or respiratory arrest (i.e., when the patient has no pulse and/or is not breathing), NO chest compressions, ventilation, defibrillation, endotracheal intubation, or medications. If the patient is NOT in cardiac or respiratory arrest, full treatment for all injuries, pain, difficult or insufficient breathing, hemorrhage and/or other medical conditions must be provided, unless Section E of the MOLST form provides different instructions. Relief of choking caused by a foreign body is usually appropriate, although if breathing has stopped, ventilation should not be assisted.

CPR must be initiated if no Out of Hospital or facility DNR is presented. If a DNR order is presented after CPR has been started, stop CPR.

What documentation is required for a patient with a DNR order?
Prehospital care providers should attach a copy of the Out of Hospital DNR form, MOLST form, hospital DNR order and/or copy of the patient’s chart to the patient care report, along with all other usual documentation. It should be noted on the patient care report that a written DNR order was present including the name of the physician, date signed and other appropriate information.

If the cardiac/respiratory arrest occurred during transport, the DNR form should accompany the patient so that it may be incorporated into the medical record at the receiving facility.

Patients who are identified as dead at the scene need not be transported by ambulance; however, local EMS agencies should consider transportation for DNR patients who collapse in public locations. In these cases it may be necessary to transport the individual to a hospital without resuscitative measures in order to move the body to a location that provides privacy. Local policies need to be coordinated with the Medical Examiner/Coroner and law enforcement.
**MOLST Training**

EMS providers and agencies who are interested in more specific training regarding the MOLST form and process may go to [http://www.compassionandsupport.org](http://www.compassionandsupport.org). This site has a specific training program for EMS providers. The site contains frequently asked questions and a training video that would be useful to better understand the MOLST form and process.

If you have other questions about this policy guidance please contact your DOH Regional EMS office or you may call 518-402-0996.

**Resources**

New York State Department of Health MOLST Information:

MOLST Forms
[http://www.health.state.ny.us/forms/doh-5003.pdf](http://www.health.state.ny.us/forms/doh-5003.pdf)

Compassion and Support Website:
[http://www.compassionandsupport.org](http://www.compassionandsupport.org)

MOLST Training Center:

MOLST EMS Training Page:

Issued and authorized by Lee Burns, Acting Director of the Bureau of EMS
In 2010, the New York State Vehicle and Traffic Law (VTL) was amended to authorize an advanced emergency medical technician (AEMT) to draw evidentiary blood samples for the purpose of determining alcohol or drug content solely at the request of a police officer. The law no longer requires the procedure to be performed by AEMT’s under the supervision and at the direction of a physician. VTL section 1194(4)(a)(1) states:

(1) At the request of a police officer, the following persons may withdraw blood for the purpose of determining the alcoholic or drug content therein: (i) a physician, a registered professional nurse, a registered physician assistant, a certified nurse practitioner, or an advanced emergency medical technician as certified by the department of health…

Preface
Please note that VTL §1194 is permissive. This means that an AEMT (Intermediate, Critical Care and Paramedic), is authorized to legally obtain a blood sample at the request of a police officer for the purpose of alcohol/drug screening, but the AEMT is not mandated to perform the procedure.

When the AEMT is acting pursuant to a request by a police officer relying on VTL §1194, the AEMT is acting independent of physician or medical control oversight. A patient/care-provider relationship between the AEMT and the person from whom the blood sample is to be taken does not exist. Consequently, it is important for AEMTs intending to act pursuant to VTL §1194 to prepare for such law enforcement requests. This policy is intended to assist AEMTs and EMS agencies in planning with respect to this law, but should not be considered complete and exclusive guidance.

Policy
1. VTL §1194 is permissive to all "AEMT" levels regardless of whether or not a particular level is authorized or utilized within a particular agency and/or region.

2. VTL §1194 permits, but does not require, an AEMT to draw blood for the purposes of blood alcohol and/or drug content analysis upon request of a police officer. Physician authorization is no longer required in order to comply with the request.

3. EMS agencies, employers, and other entities that could possibly place the AEMT in the position of receiving a request for blood draw pursuant to VTL §1194 should work with the AEMT to prepare for dealing with such requests. AEMTs, agency heads, medical directors, legal advisors, and local police agencies should all be consulted regarding the following:
   a. adequate AEMT training,
   b. how requests will be made/received,
   c. the proper handling of the blood specimen evidence,
   d. appropriate documentation of the event.

Even though VTL 1194 does not provide for a physician oversight role, medical directors still have a role in blood draw training and infection control procedures, and may be able to offer insight as to medical/legal documentation and consistency with procedures used in local emergency departments.
4. Patient care should not be compromised or delayed for the purpose of drawing a blood sample for law enforcement. Unstable patients should not have evidentiary blood samples drawn if the AEMT believes it will compromise prehospital medical care; instead, the patient should be transported to the hospital where a blood draw can be performed, as may be appropriate.

5. If an AEMT has been summoned only for the purpose of obtaining a blood sample pursuant to VTL §1194 and no obvious medical care is needed, the person submitting to the blood draw should not be offered medical care and transport.

6. The AEMT will make a determination of the need to provide medical care and transportation for the person from whom the blood draw is requested. If there is any uncertainty, the AEMT should contact a medical control physician and put the physician in contact with the ranking police officer present.

7. To document the chain of custody, any blood draw performed by an AEMT pursuant to VTL §1194 should be performed in the physical presence of the police officer who will be taking immediate custody of the blood sample.

8. The AEMT must confirm with the person from whom the blood sample is being requested and the supervising police officer that the person is consenting to the blood draw.

9. There are a number of different alcohol/drug blood sampling kits on the market and being used by police agencies. The AEMT should only use the kit supplied by the police officer at the time of the event and follow the specific instructions indicated within that kit. AEMTs and/or EMS agencies should not supply or stock their own kits.

10. General considerations when drawing evidentiary blood samples are:
    a. Do not use alcohol on the person's skin prior to drawing blood samples.
    b. If the person requires vascular access for medical purposes, draw the blood tubes from the police supplied testing kit prior to attaching intravenous lines or administering intravenous medications.
    c. If the person does not require vascular access for medical purposes, draw only the blood tubes from the police supplied testing kit.

11. Although an AEMT may be asked to draw blood from a person who is not considered a patient, the details of the event and venipuncture of any blood draw performed by an AEMT pursuant to VTL §1194 should be documented on a standard paper or electronic Prehospital Care Report (PCR) consistent with current practice.

**Conclusion**
Although VTL §1194 authorizes the AEMT to function independent of the physician medical director, medical control, and the local EMS system, AEMTs, EMS agencies, medical directors, legal advisors, and police agencies should cooperatively work together to facilitate VTL §1194 blood draws at the local level. This policy is intended only as a guide to assist AEMTs, EMS and police agencies in planning for the police requests. It is not intended to be all inclusive and complete guidance. Agencies should proactively work together to address VTL §1194 issues unique to the local circumstances.
KETAMINE

Class
Anesthetic Induction

Description
Ketamine is a controlled substance medication that is a rapid-acting general anesthetic producing an anesthetic state characterized by profound analgesia, normal pharyngeal-laryngeal reflexes, normal or slightly enhanced skeletal muscle tone, cardiovascular and respiratory stimulation, and occasionally a transient and minimal respiratory depression.

Onset & Duration
Onset: Rapid – IV within 30 seconds half life 10-15 min.; IM within 3-4 minutes
Duration: IV 2 mg/kg lasts 5-10 minutes; IM 9 to 13 mg/kg lasts 12-25 minutes

Indications
1. Ketamine is indicated as the sole anesthetic induction agent for management of trauma patients in extreme pain requiring proper immobilization and/or extrication.

Contraindications
1. Ketamine is contraindicated in those in whom a significant elevation of blood pressure would constitute a serious hazard and in those who have shown hypersensitivity to the drug.

Adverse Reactions
1. Cardiovascular - blood pressure and pulse rate are frequently elevated following administration of Ketamine alone. However, hypotension and bradycardia have been observed. Arrhythmia has also occurred.
2. Respiration - Although respiration is frequently stimulated, severe depression of respiration or apnea may occur following rapid intravenous administration of high doses of Ketamine.
Laryngospasms and other forms of airway obstruction have occurred during Ketamine anesthesia.

3. Eye - Diplopia and nystagmus have been noted following Ketamine administration. It also may cause a slight elevation in intraocular pressure measurement.

4. Neurological - In some patients, enhanced skeletal muscle tone may be manifested by tonic and clonic movements sometimes resembling seizures.

5. Gastrointestinal - Anorexia, nausea and vomiting have been observed; however, this is not usually severe and allows the great majority of patients to take liquids by mouth shortly after regaining consciousness.

6. General: Anaphylaxis, local pain and exanthema at the injection site have infrequently been reported. Transient erythema and/or morbilliform rash have also been reported.

*Ketamine continued...*

**Drug Interactions**

Prolonged recovery time may occur if barbiturates and/or narcotics are used concurrently with Ketamine.

**How Supplied**

Injection: IM or IV 15 mg (15 mg/mL) and 30 mg (30 mg/mL) Ketamine Hydrochloride Injection, USP is supplied as the hydrochloride in concentrations equivalent to Ketamine base.

<table>
<thead>
<tr>
<th>Container</th>
<th>Concentration</th>
<th>Fill Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fliptop Vial</td>
<td>100 mg/mL</td>
<td>5 mL, Box of 10</td>
</tr>
<tr>
<td>Fliptop Vial</td>
<td>50 mg/mL</td>
<td>10 mL, Box of 10</td>
</tr>
</tbody>
</table>

Color of solution may vary from colorless to very slightly yellowish and may darken upon prolonged exposure to light. This darkening does not affect potency. Do not use if a precipitate appears.

Store at 20 to 25°C (68 to 77°F).

Protect from light.

**Dosing**

Adult IV 1-4.5 mg/kg IV over 1 min.

Adult IM 6.5-13 mg/kg IM one dose
Pediatric IV >3 months 1.5 mg/kg IV over 1 min.
Pediatric IM >3 months 4-5 mg/kg one dose

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**Protocol**

<table>
<thead>
<tr>
<th>MA XX</th>
<th>Adult Pain Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA XX</td>
<td>Pediatric Pain Management</td>
</tr>
</tbody>
</table>

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**Special Considerations**

1. Elevation of blood pressure begins shortly after injection, reaches a maximum within a few minutes and usually returns to preanesthetic values within 15 minutes after injection.

2. Because pharyngeal and laryngeal reflexes are usually active, Ketamine can not be used alone for advanced airway management such as intubation. Mechanical stimulation of the pharynx should be avoided, whenever possible, if Ketamine is used alone.

3. The incidence of emergence reactions may be reduced if verbal and tactile stimulation of the patient is minimized during the recovery period. This does not preclude the monitoring of vital signs.

4. The intravenous dose should be administered over a period of 60 seconds. More rapid administration may result in respiratory depression or apnea and enhanced pressor response.

5. Use with caution in the chronic alcoholic and the acutely alcohol-intoxicated patient.

6. This medication is a Class III controlled substance medication approved for prehospital use by the SEMAC and the Department.
I) Introduction
In an effort to ensure compliance with New York State Public Health Law and the associated Codes, Rules and Regulations and Policy Statements, the Department of Health is authorized to conduct full service inspections/surveys as well as individual vehicle inspections. The Department may inquire into the operation of ambulance services and advanced life support first response services and conduct periodic inspections of facilities, communication services, vehicles, methods, procedures, materials, staff and equipment.

II) Full Service Inspections:

a) Department of Health Bureau of EMS Surveillance:
The Purpose of a full service inspection is to ensure that an ambulance service or Advanced Life Support First Response (ALSFR) agency is in compliance with all the applicable laws, regulations and department policies regarding the safe and efficient operation of the EMS agency. In conducting these inspections department representatives assist agencies in achieving the goal of not only overall compliance but also improved quality of care delivered to patients.

b) Ambulance Services;
Ambulance services are required to comply with the provisions set forth in Part 800 of Title 10 NYCRR. This includes Part 800.21 General Requirements.

During a full ambulance agency inspection, representatives from the Department may inspect any of the items outlined in Part 800.21 including, but not limited to:

- Personnel files
- Training records
- Incident reports
- Prehospital Care Reports
- Agency Policies (Including all policies required in Part 800.21(p))
- Mutual Aid Plans
- Hazardous Materials Plans
- Multiple Casualty Incident Plans
- Ambulances
- Emergency Ambulance Service Vehicles (EASV) including personally owned vehicles operated as EASVs as authorized by the agency
- Buildings and facilities for such items as the proper storage of supplies and equipment and the proper disposal of regulated materials
- Equipment (including all requirements listed in Part 800.22-800.25)
- Vehicle check sheets and maintenance records
- Personnel Rosters.
c) Advanced Life Support – First Response Agencies:
Advanced Life Support First Response (ALS FR) agencies are required to comply with the provisions set forth in Part 800 of Title 10 NYCRR and applicable Department of Health, Bureau of Emergency Medical Services Policy Statements.

During an ALS FR agency inspection, representatives from the Department may inspect any of the items outlined in that policy statement including but not limited to:
- Personnel files
- Training records
- Incident reports
- Prehospital Care Reports
- Agency Policies
- Mutual Aid Plans
- Hazardous Materials Plans
- Multiple Casualty Incident Plans
- All vehicles operated as emergency vehicles by the agency
- Buildings and facilities for such items as the proper storage of supplies and equipment and the proper disposal of regulated materials.

d) Controlled Substances Licensees:
Any service granted a license to possess and administer controlled substances in accordance with Article 33 and Part 80 of Title 10 NYCRR, shall be subject to inspection of all records, stock, sub-stock, security standards and for compliance with the operations plan submitted by the agency and approved by the Department.

e) Quality Improvement Program:
Inspections of either an ambulance service or ALS FR agency may also include records pertaining to the establishment of, or participation in, a Quality Improvement Program as required in §3006 of the Public Health Law.

III) Vehicle Inspections:
Inspections of emergency medical services vehicles may be conducted by representatives of the Department of Health anytime the vehicles are in service. For a vehicle to be considered “Out of Service” it should be in compliance with Department of Health Bureau of Emergency Medical Services Policy.

a) Spot/Quick Check;
Vehicle inspections may, at the discretion of the Department representative, consist of a “Quick Check” or a full vehicle inspection.

The "Quick Check" attempts to verify twenty-four (24) items of the required equipment and supplies found in Part 800 of the State Health Code. These items are generally used to treat patients suffering from life threatening illness or injury. Any ambulance found missing these minimum standards may be removed from service, and a full vehicle inspection conducted.

b) Complete Vehicle Inspection;
Any vehicle operated by an ambulance service as an ambulance shall be required to be in complete compliance with the applicable sections of 10 NYCRR Part 800, unless otherwise authorized by the Commissioner pursuant to Part 800.25 or 800.27.
Any vehicle operated by an ambulance service as an Emergency Ambulance Service Vehicle (EASV) must be in compliance with Parts 800.21, 800.23 and 800.26. This includes personally owned vehicles authorized as EASVs by the agency.

Any vehicle operated by an Advanced Life Support First Response Service as a first response vehicle must be in complete compliance with Parts 800.21, 800.23, 800.26 and Department of Health Bureau of Emergency Medical Services policies.

All vehicles operated as emergency vehicles must be in compliance with the applicable sections of the NYS Vehicle and Traffic Law.

Any vehicle that fails an inspection may be placed out of service by the Department representative conducting the inspection. The failure may result in the issuance of a Notice of Violation or a Statement of Deficiencies. In both cases, the service will be required to submit plans in writing that address the deficiencies and steps taken to correct the identified violations.

In an effort to provide the most effective care in the prehospital environment, the Bureau of EMS encourages agencies to operate with more than the minimally required supplies and equipment.

The items required by Part 800 and Bureau of EMS policy statements are the minimum requirements for the operation of an EMS service. There are many additional policies that agencies may implement for productive operation. There are additional supplies and equipment that a service may wish to utilize to enhance patient care. Each agency is encouraged to evaluate their operation to determine whether additional equipment and supplies would be appropriate for use in their EMS system. However, medical equipment and supplies should be in accordance with state and regional treatment protocols, the scope of practice of the service and all applicable federal, state and regional guidelines. Should items inappropriate for the authorized level of care be found in agency vehicles, the agency may be subject to enforcement action.

IV) Additional information:

In addition to the Bureau of EMS Policy statements already listed, EMS agency operators are encouraged to refer to the Bureau of EMS Policy Statement page at: http://www.health.state.ny.us/nysdoh/ems/policy/policy.htm for policies that include items subject to inspection by the Department.

Issued and Authorized by:
Lee Burns, Acting Director
Bureau of Emergency Medical Services
At their December 2009 meetings, the New York State Emergency Medical Services Council (SEMSCO) and the State Medical Advisory Committee (SEMAC) voted to amend Title 10 of the New York Codes, Rules and Regulations – Part 800 to require that all patients transported by EMS in the State of New York, have access to certain life saving equipment. The amendment will require that all in service ambulances be equipped with defibrillators and epinephrine.

During the regulatory approval process, the SEMSCO and SEMAC are strongly encouraging all ambulance agencies to comply with the following:

1. All in-service transporting ambulances must have the ability to defibrillate patients of all age groups.

   This requirement may be met with either an Automated External Defibrillator (AED) or through Advanced Life Support (ALS) treatment modalities, manual defibrillation.

2. Epinephrine auto-injectors must be on all in-service transporting ambulances that do not already have the ability to administer epinephrine through ALS modalities at the time of interaction with the patient.

   This requirement is for adult and pediatric patients. It may be met by stocking both adult and pediatric epinephrine auto-injectors that are carried on the ambulance or through the use of ALS modalities that are already in-place on the ambulance. The storage and safe guarding must be maintained in compliance with BEMS policy statement 09-11 entitled, “Storage and safe guarding of medications administered by the EMT-Bs”.

   Every agency that utilizes auto injectors must be in compliance with policy statement 00-01 Use of Epinephrine Auto Injectors by EMS Agencies.

   http://www.health.state.ny.us/nysdoh/ems/policy/09-11.htm
   http://www.health.state.ny.us/nysdoh/ems/pdf/00-01.pdf

This policy for providing defibrillation and epinephrine administration capabilities will take effect on May 1, 2010. However, all EMS agencies are encouraged to implement this policy prior to May 1, 2010. The intent of this policy statement is to promote rapid initiation of defibrillation and epinephrine to those patients who are in need of these life saving modalities.
Purpose
Due to the unique nature of the prehospital environment, medications and intravenous fluids that are stored and used in the prehospital setting are subjected to extreme environmental changes. This may have a negative impact on the stability, strength, quality and purity of these medications. As a result, medications may become less effective or may negatively impact the patients. Programs should be implemented with regards to how medications and intravenous solutions are stored in the EMS stations and vehicles. This policy applies to all BLS and ALS agencies that carry medications and/or intravenous fluids.

Policy
In an effort to assist agencies in maintaining the integrity of prehospital medications and intravenous fluids, the following should be the minimum requirements implemented by each service authorized to carry prehospital medications and intravenous fluids.

- All EMS services authorized by the Regional Emergency Medical Advisory Committee (REMAC) to carry medications and intravenous fluids must develop policies to define the appropriate storage and maintenance of all medications and intravenous fluids. These policies should also be incorporated in to the agency’s policies and procedures as well as the QI program.

- All medications and intravenous fluids must be stored in an environment that protects them from extreme temperature changes and light according to each medication manufacturer’s guidelines. This includes all vehicles, stationary cabinets or any other storage facilities where medications and intravenous fluids are stored. According to manufacturer’s guidelines, most medications must be stored at temperatures that range from 59 degrees to 77 degrees Fahrenheit. However, the temperature ranges may differ for many medications.

- Agencies must have policies related to the recognition, destruction and replacement of medication that have been exposed to conditions outside or have surpassed the printed expiration date as required by the manufacture’s guidelines.

- Agencies must routinely monitor and record the temperatures for all locations where medications and intravenous solutions are stored.

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¹ New Jersey – Drug Adulteration Study, October, 1995
Purpose
The medications approved for use by Emergency Medical Technician - Basics (EMT-B) are considered to be lifesaving measures. As such, care should be taken to allow for immediate access, while safe guarding the medications when not caring for a patient. This policy is developed to address concerns regarding the storage and safe-guarding of medications that may be administered in accordance with state and regional BLS protocols by EMT-Bs.

Policy
Prior to implementing prehospital medication administration, each agency must receive approval from their Regional Emergency Medical Advisory Committee (REMAC). All EMS agencies carrying medications for use by EMT-Bs, prior to placing them in service, must develop policies and procedures that include, but may not be limited to the following items; inventory control, storage, expiration and replacement of these items and the process for provider education.

In an effort to assist agencies in maintaining control of the medications that may be administered by EMT-Bs, the following should be the minimum requirements implemented by each service providing this level of care.

- The medications must be stored in an environment that protects them from extreme temperature changes and light. According to most medication manufacturer’s guidelines, medications must be stored at temperatures that range from 59 degrees to 77 degrees\(^1\).

- All medications must be secured in a container or location capable of being secured with a lock or numbered tear-away-type inventory control tag when not being used for patient care.

- The medication must be placed in either a closed ambulance compartment or inside a bag or box that is taken to the patient’s side.

- It is strongly recommended that BLS medications not be placed in the same locked cabinet with medications, syringes or needles used by Advanced Life Support Providers.

- The EMS agency must provide safe disposal for medical waste/sharps on EMS vehicles.

\(^1\) New Jersey – Drug Adulteration Study, October, 1995
The provision of prehospital emergency medical services inherently involves risk to the safety and health of providers, patients and the general public. All too frequently an EMS crew is involved in a “near miss” event or sustains actual injury. Because EMS providers are the most valuable part of the EMS system, the New York State Emergency Medical Services Council (SEMSCO), the State Emergency Medical Advisory Committee (SEMAC) and the Department’s Bureau of Emergency Medical Services (BEMS) have undertaken an examination of the practice of EMS response and prehospital care. This ongoing project is intended to promote a safe working environment and a “culture of safety”.

Title 10 New York State Codes, Rules and Regulations – Part 800.21(q) require the EMS service to report certain types of incidents to the Department within 24 hours of the event and within five (5) business days. These incidents include:

- A patient death or injury due to the actions of the EMS provider
- A response vehicle crash
- Injuries to an on-duty\(^1\) EMS provider requiring medical treatment
- The death of an EMS provider while on-duty.
- Patient care equipment failures that occur while being used to treat a patient and known to have caused harm to the patient or crew.
- It is alleged that any member of the ambulance service has responded to an incident or treated a patient while under the influence of alcohol or drugs while on duty.

In addition to the above mentioned circumstances, reportable incidents also include EMS response or on-duty related illnesses and exposures to infectious diseases or hazardous materials.

**REPORTABLE INCIDENT FORM**

In an effort to better capture detailed information on EMS related injuries, illnesses and reportable events, the Department, with the assistance of the SEMSCO’s “Safety” Technical Advisory Group (TAG) have developed the attached Reportable Incident Form (DOH-4461).

This form must be completed for any incident in which serious injury, illness or death of an EMS provider, patient or other individual (for example, a bystander, driver of another vehicle) occurred in the course of their EMS response and/or duties. The form must be completed and returned to the appropriate BEMS Regional EMS Office within five (5) business days of the incident. A current list of regional office and EMS staff is available at [http://www.health.state.ny.us/nysdoh/ems/emsrep.htm](http://www.health.state.ny.us/nysdoh/ems/emsrep.htm). This form does not take the place of any other local, state, federal or insurance required reporting form.

The form does not require the inclusion of individual identification or protected medical information and such materials should not be included when submitted to the Department. The information obtained on

\(^1\) For the purposes of this Policy Statement, the term “on-duty” is defined as responding to a patient, treating and/or transporting a patient, assigned stand-bys and returning to service, the EMS station or residence.
the form will be collected in a database to be used to study events, incidents and injury trends with the intention to identify issues and solutions for change in order to make the EMS environment safer for its participants, the patients and the citizens of local communities. Additionally, the completed forms will maintained by the Department.

As an important reminder, the Part 800.21(q) also requires that an EMS agency report any situation in which it is alleged that a member/staff of the EMS agency has responded to an incident or treated a patient while under the influence of alcohol or drugs while on duty must also be reported to the Department. This must be done in writing and sent to the appropriate BEMS Regional EMS Office within five (5) business days of the incident.

FORM DIRECTIONS

The form is comprised of six (6) pages. It is only necessary to complete the pages that pertain to the specific incident being reported. If the incident requires additional description, use the appropriate supplemental pages provided. The pages of the form may be photocopied and attached as necessary. Additional copies of the form are available on the Department’s web site at http://www.health.state.ny.us/nysdoh/ems/emsforms.htm.

Only complete and return sections that pertain to the incident being reported.

1. Please attach copies of any agency specific Incident Reports. Individual and/or protected medical information may be redacted.
2. If the type of injury, illness, or any other necessary information is not listed, Section 6 on page 6 must be completed. If multiple pages are necessary, this page can be photocopied.
3. Section 1 is for general information relating to the incident only and must be completed for all reporting. Only complete items in this section that pertain to the incident. Example: If no vehicle involved, do not complete that part.
4. Section 2 must be completed if an EMS crew member is injured or otherwise meets the reporting criteria.
5. Section 3 must be completed if a patient is injured or otherwise meets the reporting criteria.
6. Section 4 must be completed if another emergency responder (outside of your agency) or civilian is injured or otherwise meets the reporting criteria.
7. Section 5 must be completed if one or more vehicles were involved in the incident.
8. Section 6 must be completed only if additional documentation is necessary to describe this incident. Photocopies of this sheet can be utilized for additional documentation.
9. Supplemental Page 1 is only to be used to document additional EMS crew members injured or otherwise meets the reporting criteria.
10. Supplemental Page 2 is only to be used to document additional patients injured or otherwise meet the reporting criteria.
11. Supplemental Page 3 is only to be used if additional emergency responders (other than your crew), or civilians are injured or otherwise meet the reporting criteria.
12. Supplemental Page 4 is to be used as necessary to document additional vehicles involved with this incident.

CONCLUSION

The submission of the Reportable Incident form is required should there be any serious injury, illness or death of an EMS provider, patient or other individual (for example, a bystander, driver of another vehicle) occurring in the course of their EMS response and/or duties. If there is a question as to whether a specific event meets the regulatory criteria, please complete and submit the form and documentation. It is the SEMSCO and Department’s goal to be able to study the information gathered so that the EMS community has a better understanding of the risks it faces and is able to work to build a safer EMS and patient care environment.

Approved by Edward Wronski, Director
This form must be completed for any serious injury, illness or death of an EMS provider, patient or other individual in accordance with Part 800.21(q) and 800.21(r). The completed form must be submitted to the New York State Department of Health’s Bureau of Emergency Medical Services within 5 business days for every incident.

Name of EMS Service ____________________________________________ NYS EMS Agency Code ________________

Address __________________________________________________________________________________________

City_______________________________ State ______ ZIP ___________ County ______________________________

Name of Contact Person and Title _________________________________________________________________

Business Phone (_________ ) _______________________ Other Phone (_________ ) ______________________

FORM DIRECTIONS

Only complete and return sections that pertain to the incident being reported.

1. Please attach copies of any agency specific Incident Reports.

2. If the type of injury, illness, or any other necessary information is not listed, Section 6 on page 6 must be completed. **If multiple pages are necessary, this page can be photocopied.**

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11. Supplemental Page 3 is only to be used if additional emergency responders (other than your crew), or civilians are injured or otherwise meet the reporting criteria.

12. Supplemental Page 4 is to be used as necessary to document additional vehicles involved with this incident.

This form does not replace any incident reporting forms required by a regional council, state or federal laws and regulation, and/or insurance policies.
# General Incident Information

<table>
<thead>
<tr>
<th>Date of Incident</th>
<th>Time (24 Hour)</th>
<th>Day of Week</th>
</tr>
</thead>
</table>

**Your Agency Type** *(Check only one.)*
- Commercial
- College
- Fire Department
- Independent
- Industrial
- Not-for-Profit
- Municipal
- Hospital

**Type of Incident**
- Illness
- Injury
- Injury During Response/Scene Operations
- Injury During Training Operations
- Other

**Location**
- Roadway
- Residence
- Commercial Site
- Other

**Agency Status at Time of Incident**
- Available
- On Scene
- Parked (Staffed)
- Responding
- En-route to Hospital
- Parked (Unstaffed)

**Weather Conditions at the Time of the Incident** *(Check all that apply.)*
- Daylight
- Night
- Dawn/Dusk
- Clear
- Fog
- Rain
- Snow
- Ice
- Other

**Motor Vehicle Involved**
- Yes
- No

**EMS Vehicle Involved**
- Ambulance
- ALS-FR
- EASV
- Other

**Other Vehicle Involved**
- Car
- Truck
- Other

**Law Enforcement Response**
- Yes
- No

If Incident Occurred During Response, What Was the Patient Condition Based on Dispatch Information?
- Minor
- Moderate
- Serious
- Critical

**If Roadway**
- Number of Lanes _____

**Road Conditions**
- Dry
- Wet
- Ice
- Snow
- Other

**Contributing Factors**
- Mechanical Failure
- Drug/Alcohol Impaired (EMS Provider)
- Broken Traffic Control Device
- Drug/Alcohol Impaired (Other Party)
- Other

**Number of Persons Involved**
- EMS Crew Member
- Patient
- Other Emergency Service
- Civilian

**Number of Persons Injured**
- EMS Crew Member
- Patient
- Other Emergency Service
- Civilian
## SECTION 2  Injured EMS Crew Member Information

*Complete this section for each injured EMS crew member. If more than one EMS crew member, use Supplemental Page 1.*

**Age** _______  □ Male  □ Female  
- □ CFR  
- □ EMT  
- □ EMT I  
- □ EMT CC  
- □ EMT P  
- □ EMS Supervisor  
- □ Driver/Helper  
- □ Volunteer  
- □ Paid  

**Vehicle Operator**  
- □ EVOC/CEVO Trained (Year _________ )  
- □ Restricted  
- □ Working Outside Environment  
- □ Unrestricted  
- □ Working Inside Building (Non-vehicle)  

**Vehicle Occupant**  
- □ Restricted  
- □ Working Outside Environment  
- □ Unrestricted  
- □ Working Inside Building (Non-vehicle)  

**Mechanism of Injury**  
- □ Animal Bite  
- □ Assault  
- □ No Weapon  
- □ With Weapon (Type __________________________ )  
- □ Carrying Equipment  
- □ Moving Patient  
- □ Transfer Onto/Off Stretcher  
- □ During Stretcher Transport  
- □ Electrical Injury  
- □ Explosion  
- □ Fire  
- □ Hazardous Materials Exposure (Specify Product __________________________ )  
- □ Lifting/Bending  
- □ Needle Stick  
- □ Pedestrian Struck  
- □ Slip/Fall  
- □ Structural Collapse  
- □ Toxic Inhalation  
- □ Other ______________________________________________________________________

**Injury/Illness Description**  
- □ Respiratory  
- □ Death  
- □ Head Injury  
- □ Exposure  
- □ Cardiac  
- □ Fracture/Dislocation  
- □ Spinal Injury  
- □ Heat  
- □ Cardiac Arrest  
- □ Laceration  
- □ Sprain/Strain  
- □ Cold  
- □ Stroke  
- □ Burn  
- □ Trauma Penetrating  
- □ Exposure Hazmat  
- □ Seizure  
- □ Amputation  

**Specify Body Part Affected**  
- □ Head  
- □ Back  
- □ Leg (□ Left / □ Right)  
- □ Neck  
- □ Abdomen  
- □ Hand (□ Left / □ Right)  
- □ Chest  
- □ Arm (□ Left / □ Right)  
- □ Foot (□ Left / □ Right)  
- □ Internal Organ/System ______________________________________________________________________

**Disposition: Admission**  
- □ Emergency Department Only  
- □ Critical Care Admission  
- □ Personal Physician  
- □ Hospital General Admission  
- □ Deceased  
- □ None  
- □ Time Lost __________ (Days)
SECTION 3  Patient Information

If more than one patient, use Supplemental Page 2.

Age ______  □ Male  □ Female

Pre-event Condition  □ Stable  □ Unstable  □ Critical

Post Event Injury Condition  □ Stable  □ Unstable  □ Critical

Injury/Illness Description

□ Respiratory  □ Death  □ Head Injury  □ Exposure
□ Cardiac  □ Fracture/Dislocation  □ Spinal Injury  □ Heat
□ Cardiac Arrest  □ Laceration  □ Sprain/Strain  □ Cold
□ Stroke  □ Burn  □ Trauma Penetrating  □ Exposure Hazmat
□ Seizure  □ Amputation  □ Possible Cause ________________________________

Specify Body Part Affected

□ Head  □ Back  □ Leg ( □ Left / □ Right )
□ Neck  □ Abdomen  □ Hand ( □ Left / □ Right )
□ Chest  □ Arm ( □ Left / □ Right )  □ Foot ( □ Left / □ Right )
□ Internal Organ/System ________________________________

Disposition: Admission

□ Emergency Department Only  □ Critical Care Admission  □ Personal Physician
□ Hospital General Admission  □ Deceased  □ None  □ Time Lost _________ (Days)

SECTION 4  Other Emergency Service Personnel (Firefighter, Police) or Civilian Information

If more than one other emergency service personnel or civilian, use Supplemental Page 3.

Age ______  □ Male  □ Female

Injury/Illness Description

□ Respiratory  □ Death  □ Head Injury  □ Exposure
□ Cardiac  □ Fracture/Dislocation  □ Spinal Injury  □ Heat
□ Cardiac Arrest  □ Laceration  □ Sprain/Strain  □ Cold
□ Stroke  □ Burn  □ Trauma Penetrating  □ Exposure Hazmat
□ Seizure  □ Amputation

Specify Body Part Affected

□ Head  □ Back  □ Leg ( □ Left / □ Right )
□ Neck  □ Abdomen  □ Hand ( □ Left / □ Right )
□ Chest  □ Arm ( □ Left / □ Right )  □ Foot ( □ Left / □ Right )
□ Internal Organ/System ________________________________

Disposition: Admission

□ Emergency Department Only  □ Critical Care Admission  □ Personal Physician
□ Hospital General Admission  □ Deceased  □ None  □ Time Lost _________ (Days)
### Vehicle #1 (Ambulance) Information

**Type of Vehicle**

- □ Type I
- □ Type II
- □ Other

**Amount of Damage**

- □ Minor
- □ Severe
- □ Moderate
- □ Personal Injury
- □ Entrapment
- □ Airbag Deployment

**Vehicle Information**

- Vehicle Make _____________________________
- Vehicle Year __________
- License Plate Number _____________
- Insurance Code ___________________________
- Last Maintenance Date _____________
- Emergency Lights at Time of Collision? □ Yes □ No
- Siren at Time of Collision? □ Yes □ No

**Ambulance Operator**

- Driver’s Name _____________________________
- NYS EMT Number _____________
- Age ________ □ Male □ Female □ Hours on Duty _________
- □ CFR
- □ EMT
- □ EMT I
- □ EMT CC
- □ EMT P
- □ EMS Supervisor
- □ Volunteer
- □ Driver/Helper

**Reported to Duty From**  
(Rested equals 8 hours of sleep.)

- □ Home Rested
- □ Other Work Location Rested
- □ Home Unrested
- □ Other Work Location Unrested

**Investigating Agency/Precinct**

- □ State Police
- □ Local Police Department
- □ Sheriff
- □ Other _____________________________
- Law Enforcement Name, Barracks or Precinct _____________________________
- Report Number _____________
- Total Accident Damage Estimate ($) _____________

### Vehicle #2 Information

*If more than one vehicle, use Supplemental Page 4.*

**Type of Vehicle**

- □ Sedan
- □ Truck (Semi)
- □ Other
- □ SUV
- □ Truck (Straight)
- □ Other Emergency Vehicle
- □ Pickup

**Amount of Damage**

- □ Minor
- □ Severe
- □ Moderate
- □ Personal Injury
- □ Entrapment
- □ Airbag Deployment
**Supplemental Page 1**

Additional Injured EMS Crew Member Information

This page is intended to be used for documenting additional injured EMS crew members. Photocopy as necessary.

### Age

- [ ] Male
- [ ] Female

### Position

- [ ] CFR
- [ ] EMT
- [ ] EMT I
- [ ] Driver/Helper
- [ ] EMT CC
- [ ] EMT P
- [ ] Volunteer
- [ ] EMS Supervisor
- [ ] Paid

### Vehicle Operator

- [ ] EVO/CEVO Trained (Year ____________ )

### Mechanism of Injury

- [ ] Animal Bite
- [ ] Assault
- [ ] No Weapon
- [ ] With Weapon (Type ________________________ )
- [ ] Carrying Equipment
- [ ] Moving Patient
- [ ] Transfer Onto/Off Stretcher
- [ ] During Stretcher Transport
- [ ] Electrical Injury
- [ ] Explosion

### Injury/Illness Description

- [ ] Respiratory
- [ ] Cardiac
- [ ] Cardiac Arrest
- [ ] Stroke
- [ ] Seizure
- [ ] Death
- [ ] Fracture/Dislocation
- [ ] Laceration
- [ ] Burn
- [ ] Head Injury
- [ ] Spinal Injury
- [ ] Sprain/Strain
- [ ] Trauma Penetrating
- [ ] Exposure
- [ ] Head
- [ ] Heat
- [ ] Cold
- [ ] Exposure Hazmat

### Specify Body Part Affected

- [ ] Head
- [ ] Back
- [ ] Leg ( [ ] Left / [ ] Right )
- [ ] Neck
- [ ] Abdomen
- [ ] Hand ( [ ] Left / [ ] Right )
- [ ] Chest
- [ ] Arm ( [ ] Left / [ ] Right )
- [ ] Foot ( [ ] Left / [ ] Right )
- [ ] Internal Organ/System

### Disposition: Admission

- [ ] Emergency Department Only
- [ ] Critical Care Admission
- [ ] Personal Physician
- [ ] Hospital General Admission
- [ ] Deceased
- [ ] None
- [ ] Time Lost ____________ (Days)
### Patient #2 Information

**Age**

□ Male  □ Female

**Pre-event Condition**

□ Stable  □ Unstable  □ Critical

**Post Event Injury Condition**

□ Stable  □ Unstable  □ Critical

**Injury/Illness Description**

- □ Respiratory
- □ Cardiac
- □ Cardiac Arrest
- □ Stroke
- □ Seizure
- □ Death
- □ Fracture/Dislocation
- □ Laceration
- □ Burn
- □ Amputation
- □ Head Injury
- □ Spinal Injury
- □ Laceration
- □ Trauma Penetrating
- □ Possible Cause

**Specify Body Part Affected**

- □ Head
- □ Back
- □ Leg (□ Left / □ Right)
- □ Neck
- □ Abdomen
- □ Hand (□ Left / □ Right)
- □ Chest
- □ Arm (□ Left / □ Right)
- □ Foot (□ Left / □ Right)
- □ Internal Organ/System

**Disposition: Admission**

□ Emergency Department Only  □ Critical Care Admission  □ Personal Physician

□ Hospital General Admission  □ Deceased  □ None  □ Time Lost _________ (Days)

### Patient #3 Information

**Age**

□ Male  □ Female

**Pre-event Condition**

□ Stable  □ Unstable  □ Critical

**Post Event Injury Condition**

□ Stable  □ Unstable  □ Critical

**Injury/Illness Description**

- □ Respiratory
- □ Cardiac
- □ Cardiac Arrest
- □ Stroke
- □ Seizure
- □ Death
- □ Fracture/Dislocation
- □ Laceration
- □ Burn
- □ Amputation
- □ Head Injury
- □ Spinal Injury
- □ Laceration
- □ Trauma Penetrating
- □ Possible Cause

**Specify Body Part Affected**

- □ Head
- □ Back
- □ Leg (□ Left / □ Right)
- □ Neck
- □ Abdomen
- □ Hand (□ Left / □ Right)
- □ Chest
- □ Arm (□ Left / □ Right)
- □ Foot (□ Left / □ Right)
- □ Internal Organ/System

**Disposition: Admission**

□ Emergency Department Only  □ Critical Care Admission  □ Personal Physician

□ Hospital General Admission  □ Deceased  □ None  □ Time Lost _________ (Days)
This page is intended to be used for documenting additional personnel or civilians. Photocopy as necessary.

<table>
<thead>
<tr>
<th>Other Emergency Service Personnel or Civilian #2 Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age _______  □ Male  □ Female</td>
</tr>
<tr>
<td>Injury/Illness Description</td>
</tr>
<tr>
<td>□ Respiratory □ Death □ Head Injury □ Exposure</td>
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<tr>
<td>□ Cardiac □ Fracture/Dislocation □ Spinal Injury □ Heat</td>
</tr>
<tr>
<td>□ Cardiac Arrest □ Laceration □ Sprain/Strain □ Cold</td>
</tr>
<tr>
<td>□ Stroke □ Burn □ Trauma Penetrating □ Exposure Hazmat</td>
</tr>
<tr>
<td>Specify Body Part Affected</td>
</tr>
<tr>
<td>□ Head □ Back □ Leg ( □ Left / □ Right)</td>
</tr>
<tr>
<td>□ Neck □ Abdomen □ Hand ( □ Left / □ Right)</td>
</tr>
<tr>
<td>□ Chest □ Arm ( □ Left / □ Right) □ Foot ( □ Left / □ Right)</td>
</tr>
<tr>
<td>Disposition: Admission</td>
</tr>
<tr>
<td>□ Emergency Department Only □ Critical Care Admission □ Personal Physician</td>
</tr>
<tr>
<td>□ Hospital General Admission □ Deceased □ None □ Time Lost ________ (Days)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Emergency Service Personnel or Civilian #3 Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age _______  □ Male  □ Female</td>
</tr>
<tr>
<td>Injury/Illness Description</td>
</tr>
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<td>□ Respiratory □ Death □ Head Injury □ Exposure</td>
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<tr>
<td>□ Cardiac □ Fracture/Dislocation □ Spinal Injury □ Heat</td>
</tr>
<tr>
<td>□ Cardiac Arrest □ Laceration □ Sprain/Strain □ Cold</td>
</tr>
<tr>
<td>□ Stroke □ Burn □ Trauma Penetrating □ Exposure Hazmat</td>
</tr>
<tr>
<td>Specify Body Part Affected</td>
</tr>
<tr>
<td>□ Head □ Back □ Leg ( □ Left / □ Right)</td>
</tr>
<tr>
<td>□ Neck □ Abdomen □ Hand ( □ Left / □ Right)</td>
</tr>
<tr>
<td>□ Chest □ Arm ( □ Left / □ Right) □ Foot ( □ Left / □ Right)</td>
</tr>
<tr>
<td>Disposition: Admission</td>
</tr>
<tr>
<td>□ Emergency Department Only □ Critical Care Admission □ Personal Physician</td>
</tr>
<tr>
<td>□ Hospital General Admission □ Deceased □ None □ Time Lost ________ (Days)</td>
</tr>
</tbody>
</table>
### Vehicle #3 Information

**Type of Vehicle**
- [ ] Sedan
- [ ] Truck (Semi)
- [ ] Other
- [ ] SUV
- [ ] Truck (Straight)
- [ ] Other Emergency Vehicle
- [ ] Pickup

**Amount of Damage**
- [ ] Minor
- [ ] Severe
- [ ] Entrapment
- [ ] Moderate
- [ ] Personal Injury
- [ ] Airbag Deployment

### Vehicle #4 Information

**Type of Vehicle**
- [ ] Sedan
- [ ] Truck (Semi)
- [ ] Other
- [ ] SUV
- [ ] Truck (Straight)
- [ ] Other Emergency Vehicle
- [ ] Pickup

**Amount of Damage**
- [ ] Minor
- [ ] Severe
- [ ] Entrapment
- [ ] Moderate
- [ ] Personal Injury
- [ ] Airbag Deployment

### Vehicle #5 Information

**Type of Vehicle**
- [ ] Sedan
- [ ] Truck (Semi)
- [ ] Other
- [ ] SUV
- [ ] Truck (Straight)
- [ ] Other Emergency Vehicle
- [ ] Pickup

**Amount of Damage**
- [ ] Minor
- [ ] Severe
- [ ] Entrapment
- [ ] Moderate
- [ ] Personal Injury
- [ ] Airbag Deployment
BACKGROUND
Each year there are approximately 3 million EMS responses in New York State. Occasionally, across the country EMS vehicles are stolen and damaged. A study titled, “Ambulance Snatching: How Vulnerable Are We” identifies a sampling of 151 ambulance arrivals observed at emergency departments in several states. The average time present at the Emergency Department was 21.5 minutes, 23.2% of the vehicles were left with the engine running, 26.5% were left with doors or compartments open, 90.1% were left unattended and 84.1% were left unlocked.

Occasionally the Department receives a report that an unattended EMS vehicle has been stolen from the scene of a call or from the parking lot of a hospital. Additionally, there has been information distributed internationally indicating that stolen ambulances may be used to gain access to critical areas in a terrorist attack.

EMS operations create many potential exposures for loss or theft of equipment. In many cases, responding EMS vehicles are staffed with two EMS providers. The ambulance or non-transporting response car arrives on the scene and the providers go to the patient, leaving the EMS vehicle unattended. Additionally, vehicles are frequently left unattended with doors unlocked or open, cabinets unlocked, and possibly the engine running while its’ left outside of business establishments; left outside of the Emergency Department; or on the scene of an emergency response. EMS vehicles are also often stored in an unsecured station or other location.

PURPOSE
This policy is intended to encourage EMS agencies to develop policies and procedures that will improve the security and safety of their response vehicles and minimize the possibility of unauthorized use or theft.

Some examples of common best practices, if appropriate for the situation, would include, but not be limited to the following:

- Leaving a crew member with the vehicle,
- Shutting off the engine and removing the ignition key from any EMS vehicle,
- Locking the vehicle and its exterior storage compartments when left unattended,
- The installation of a commercial anti theft device,
- Securing of vehicles and contents when not in service or being repaired,
- The routine inspection and prompt reporting of missing equipment,
There will be times, such as during weather extremes that may require the EMS vehicle to remain running in order to keep the patient compartment warm or cool and maintain medications within their safe temperature range. With these considerations in mind, EMS agencies should have in place, and implement policies for securing the vehicle.

Each agency should perform a risk analysis to evaluate their risks and vulnerabilities of vehicle security. Policies and procedures should be developed for the identified risks that in turn, will reduce the opportunity for their vehicles to be stolen or misused.

Should an agency experience the theft of an emergency response vehicle, after the appropriate law enforcement and insurance notifications have been made, notification must be made to the Department of Health, Bureau of EMS in accordance with 10 NYCRR Part 800.21(p)(11)(i).

Issued by: Operations/Disaster Preparedness Units
Approval: Bureau of EMS Director

The purpose of this policy is to assist a person, firm, organization or other entity in understanding the notification process for operating an automated external defibrillator pursuant to a collaborative agreement under the provisions of Chapter 552 of the Laws of 1998 authorizing Public Access Defibrillation. A Public Access Defibrillation (PAD) program is designed to encourage greater acquisition, deployment and use of automatic external defibrillators (AED) in communities around the state in an effort to reduce the numbers of deaths associated with sudden cardiac arrest. Since the enabling legislation’s inception, there have been 4,889 PAD programs established, with over 156,167 people trained and 21,692 AED machines in public sites across the state. This program has been successful in saving many lives all across New York State.

At present, the following facilities or organizations must have trained providers and an AED on site:

- Public schools (§ 1 of the Education Law);
- State owned public buildings (Title 9 of Executive Law Subtitle G§ 303.1);
- Health clubs with a membership of greater than 500 people (General Business Law § 627-A);
- Public gathering locations (PHL § 225–5(b)), and
- Public surf beaches with lifeguards (PHL § 225–5(c)).

To be authorized to use an AED under this statute an individual or organization needs to make specific notification of intent to establish a PAD program to the appropriate Regional Emergency Medical Services Council (REMSCO) and the New York State Department of Health (DOH).

There are no approvals or certifications required.

**Public Access Defibrillation Program Requirements**

**Original Notification Process**

To be authorized to have a PAD program and utilize an AED, the following steps must be completed:

- Identify a New York State licensed physician or New York State based hospital knowledgeable and experienced in emergency cardiac care to serve as Emergency Health Care Provider (EHCP) to participate in a collaborative agreement;
- Select an AED that is in compliance with the Article 30, section 3000-B (1)(A). The AED must be programmed to the current Emergency Cardiovascular Care (ECC) Guidelines, capable of defibrillating both adult and pediatric patients. Please check the shaded box on the Notice of Intent to Provide PAD (DOH-4135) if the machine is approved for pediatric use;
- Select and use a SEMAC/DOH approved PAD training course for AED users. At present, the 12 approved programs are as follows:
  - American Heart Association
  - American Red Cross
  - American Safety & Health Institute
  - Emergency Care and Safety Institute
  - Emergency First Response
  - Emergency Services Institute
  - EMS Safety Service, Inc
  - Emergency University
  - Medic First Aid International
  - National Safety Council
  - REMSCO of NYC, Inc
  - State University of NY
  - Wilderness Medical Associates
• Develop with the EHCP, a written collaborative agreement which shall include, but not be limited to the following items:
  
  - Written practice protocols for the use of the AED;
  - Written policies and procedures which include:
    - Training requirements for AED users;
    - A process for the immediate notification of EMS by calling of 911;
    - A process for identification of the location of the AED units;
    - A process for routine inspection of the AED unit(s) as well as regular maintenance and which meet or exceed manufacturers recommendations;
    - Incident documentation requirements, and
    - Participation in a regionally approved quality improvement program.
  
• Provide written notice to the 911 and/or the community equivalent ambulance dispatch entity of the availability of AED service at the organization’s location;

• File the Notice of Intent (NOI) to Provide PAD (DOH 4135) and a signed Collaborative Agreement with the appropriate Regional Emergency Medical Services Council (REMSCO), and

• File a new NOI and Collaborative Agreement with the REMSCO if the EHCP changes.

**Reporting a PAD AED Use**

In the event that the PAD program uses the AED to defibrillate a person, the program must report the incident to the appropriate REMSCO. The REMSCO may request additional information regarding the incident, but the PAD must report, at a minimum, the following information:

- Provide written notification of AED usage to the REMSCO within 48 hours of the incident;
- The name of the PAD program;
- Location of the incident;
- The date and time of the incident;
- The age and gender of the patient;
- Estimated time from arrest to CPR and the 1st AED shock;
- The number of shocks administered to the patient;
- The name of the EMS agency that responded, and
- The hospital to which the patient was transported.

A copy of the usage report should also be provided to the EHCP.

**Regional EMS Council Responsibility in Public Access Defibrillation**

Each REMSCO is responsible for receiving and maintaining notification and utilization documentation. The REMSCOs must develop and implement the following policies and procedures:

- Insure that a copy of each new or updated Notice of Intent (DOH 4135) is forwarded to the Bureau of EMS;
- Maintain a copy of the Notice of Intent and the Collaborative Agreement;
- Collect utilization documentation and information;
- Provide detailed quarterly reports to the DOH on PAD programs in the region, and
- Develop Quality Assurance participation, data submission and documentation requirements for participating organizations.

**Data Collection Requirements**

REMSCO quality improvement programs are encouraged to use the data elements from the Utstein Guidelines for Prehospital Cardiac Arrest Research (Cumming RO, Chamberlain DA, Abramson NS, et al, Circulation 1991; 84:960-975).
The following minimum data set is to be developed and collected as a part of the regional PAD QI process. A copy of the data set is to be provided by each region to the DOH Bureau of EMS quarterly:

- Name of organization providing PAD;
- Date of incident;
- Time of Incident;
- Patient age;
- Patient gender;
- Estimated time from arrest to 1st AED shock;
- Estimated Time from arrest to CPR;
- Number of shocks administered to the patient;
- Transport ambulance service, and
- Patient outcome at incident site (remained unresponsive, became responsive, etc).

**Ambulance and ALS First Response Services**

Ambulance or ALSFR services may not participate in PAD programs for emergency response. Certified EMS agencies must apply for authority to equip and utilize AEDs through their local Regional Emergency Medical Advisory Committee (REMAC).

Please note that the Prehospital Care Report (PCR) has a check box for EMS providers to indicate that a patient has been defibrillated prior to EMS arrival by a community or by-stander PAD provider. Documenting this information is required so that the DOH may monitor the effectiveness of these community based programs

**Attachments**

1. Notice of Intent to Provide Public Access Defibrillation
2. Regional EMS Council Listing
## New York State Department of Health

**Bureau of Emergency Medical Services**

**Notice of Intent to Provide**

**Public Access Defibrillation**

Original Notification [ ] Update [ ]

### Entity Providing PAD

<table>
<thead>
<tr>
<th>Name of Organization</th>
<th>( ) Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Primary Contact Person</td>
<td>E-Mail Address</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Fax Number</td>
<td></td>
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</tbody>
</table>

### Type of Entity (please check the appropriate boxes)

<table>
<thead>
<tr>
<th>Business</th>
<th>Fire Department/District</th>
<th>Private School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction Company</td>
<td>Police Department</td>
<td>College/University</td>
</tr>
<tr>
<td>Health Club/Gym</td>
<td>Local Municipal Government</td>
<td>Physician’s Office</td>
</tr>
<tr>
<td>Recreational Facility</td>
<td>County Government</td>
<td>Dental Office or Clinic</td>
</tr>
<tr>
<td>Industrial Setting</td>
<td>State Government</td>
<td>Adult Care Facility</td>
</tr>
<tr>
<td>Retail Setting</td>
<td>Public Utilities</td>
<td>Mental Health Office or Clinic</td>
</tr>
<tr>
<td>Transportation Hub</td>
<td>Public School K – 6</td>
<td>Other Medical Facility (specify)</td>
</tr>
<tr>
<td>Restaurant</td>
<td>Public School 6 - 12</td>
<td>Other (specify)</td>
</tr>
</tbody>
</table>

### PAD Training Program (Indicate the training program chosen. Only the approved programs may be used. Please see Policy Statement 09-03 [http://www.health.state.ny.us/nysdoh/ems/policy/09-03.htm])

### Automated External Defibrillator

<table>
<thead>
<tr>
<th>Manufacturer of AED Unit</th>
<th>Model of AED Pediatric Capable</th>
<th>Number of Trained PAD Providers</th>
<th>Number of AEDs</th>
</tr>
</thead>
</table>

### Emergency Health Care Provider

<table>
<thead>
<tr>
<th>Name of Emergency Health Care Provider (Hospital or Physician)</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Fax Number</td>
<td></td>
</tr>
</tbody>
</table>

### Name of Ambulance Service and 911 Dispatch Center

<table>
<thead>
<tr>
<th>Name of Ambulance Service and Contact Person</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of 911 Dispatch Center and Contact Person</td>
<td>County</td>
</tr>
</tbody>
</table>

### Authorization Names and Signatures

<table>
<thead>
<tr>
<th>CEO or Designee (Please print)</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician or Hospital Representative (Please print)</td>
<td>Signature</td>
<td>Date</td>
</tr>
</tbody>
</table>

---

**Complete this form and send it with your completed Collaborative Agreement to the REMSCO for your area**

Policy Statement 09-03

Page 4 of 5
Adirondack-Appalachian REMSCO
Main St. PO Box 212
Speculator, NY 12164
(518) 548-5911
(518) 548-7605 fax

Counties: Delaware, Fulton, Hamilton, Montgomery, Otsego, Schoharie

Big Lakes Regional EMS Council
534 Main Street  Suite 19
Medina, NY 14103
(585) 798-1620

Counties: Genesee, Niagara, Orleans

Central NY Regional EMS Council
Jefferson Tower - Suite LL1
50 Presidential Plaza
Syracuse, NY 13202
(315) 701-5707
(315) 701-5709 – fax

Counties: Cayuga, Cortland, Onondaga, Oswego, Tompkins

Finger Lakes Regional EMS Council
FLCC Geneva Ext. Ctr.
63 Pulteney Street
Geneva, NY 14456
(315) 789-0108
(315) 789-5638 fax

Counties: Ontario, Seneca, Wayne, Yates

Hudson-Mohawk Regional EMS Council
C/O REMO
1653 Central Avenue
Albany, NY 12205
(518) 464-5097
(518) 464-5099 fax

Counties: Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady

Hudson Valley Regional EMS Council
45 Academy Avenue
Cornwall on Hudson, NY 12520
(845) 534-2430
(845) 534-3070 fax

Counties: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster,

Mid-State Regional EMS Council
2521 Sunset Avenue
Utica, NY 13502
(315) 738-8351
(315) 738-8981 fax
(888) 225-6642

Counties: Herkimer, Madison, Oneida

Monroe-Livingston Reg EMS Council
Office of Prehospital Care
Strong Memorial Hospital
601 Elmwood Ave.  Box 4-9200
Rochester, NY  14692
585-275-3098 or
585-273-3961

Counties: Livingston, Monroe

Mountains Lakes Regional EMS Council
365 Aviation Road
Queensbury, NY  12804
(518) 793-8200
(518) 793-6647 fax

Counties: Clinton, Essex, Franklin, Warren, Washington

Nassau Regional EMS Council
2201 Hempstead Turnpike
Bldg. A - 4th Floor
Box 78
East Meadow, NY 11554
(516) 542-0025
(516) 542-0049 fax

Counties: Nassau

North Country Regional EMS Council
SUNY Canton College of Technology
34 Cornell Drive
Canton, NY 13617
866-475-3977
315-379-3977
(315) 379-3979 fax

Counties: Jefferson, Lewis, St. Lawrence

Regional EMS Council of NYC
475 Riverside Drive, Suite 1929
New York, NY 10115
(212) 870-2301
(212) 870-2302 fax

Counties: Bronx, Kings, New York, Queens, Richmond

Southern Tier Regional EMS Council
PO Box 3492
Elmira, NY 14905-0492
(607) 732-2354
(607) 732-2661 fax
800-343-1311

Counties: Chemung, Schuyler, Steuben

Southwestern Regional EMS Council
PO Box 544
Olean, NY 14760
(716) 373-2612

Counties: Allegany, Cattaraugus, Chautauqua

Suffolk Regional EMS Council
Suffolk County Dept. of Hlth. Svrcs. Div. of Emergency Medical Services
Dennison Building, 1st Floor
100 Veterans Memorial Highway
Hauppauge, NY 11788-5401
(631) 853-5800
(631) 853-8307 fax

Counties: Suffolk

Susquehanna Regional EMS Council
Public Safety Building
153 Lt. Van Winkle Drive
Binghamton, NY 13905-1559
(607) 778-1178

Counties: Broome, Chenango, Tioga

Westchester Regional EMS Council
4 Dana Road
Valhalla, NY 10595
(914) 231-1616
(914) 813-4161 fax

Counties: Westchester

Wyoming-Erie Regional EMS Council
PO Box 630
Clarence, NY 14031
(716) 668-9184
(716) 668-2754 fax

Counties: Erie, Wyoming

Listing Revised:  March 12, 2009
Purpose and Background:
It is the purpose of this policy statement to outline the procedure for military personnel being released from active duty to have their CFR/EMT/AEMT certification extended under the provisions of Chapter 206 of the Laws of 2008 signed by Governor Paterson on July 7, 2008 and Section 3011 of Article 30 of Public Health Law:

The text of this law as it pertains to this policy statement is as follows:

“The commissioner is hereby authorized and empowered to extend the certification for emergency medical technicians, advanced emergency medical technicians or certified first responders who have been ordered to active military duty, other than for training, on or after the eleventh day of September, two thousand one and whose certification will expire during their military duty or within the six months immediately following separation from military service. The extended certification shall be for the period of military duty and for twelve months after they have been released from active military duty.”

If the CFR/EMT/AEMT’s certification expires more than six (6) months following separation from active military duty, the individual is not eligible for extension of certification under the provisions of this law. In this case, the CFR/EMT/AEMT remains eligible for a refresher course. The maximum certification extension granted will be for the period of military duty and for 12 months effective from the date of release from active military duty as evidenced by official military separation documentation (i.e. DD-214 or DA Form 2-A Statement of Release from Active Duty).

Procedure:
Upon release from active military duty, the applicant for extension of certification must:

1. Complete form DOH-4281 entitled “Certification Extension for Military Personnel.” This form is also available in downloadable PDF format on the NYS EMS website at www.health.state.ny.us/forms/doh-4281.pdf. Additionally, it can be obtained by contacting the Bureau of EMS at 518-402-0996 ext 1 prompt 4.

2. Return the completed form DOH-4281 and a copy of your official military separation documentation (i.e. DD-214 or DA Form 2-A Statement of Release from Active Duty) to:

   NYS DOH Bureau of EMS
   Certification Unit
   875 Central Avenue
   Albany NY 12206

Within two weeks of receipt of the above documentation and after review and approval of same, the Bureau of EMS will issue a new certification card bearing the extended expiration date.

Issued and authorized by Bureau of EMS Office of the Director
Under the provisions of New York State Public Health Law Article 30, section 3008(7)a, a municipality, as defined by Article 1 of the General Municipal Law, may determine that need exists to establish an ambulance or advanced life support service (ALS-FR). Before the municipality may begin operation, it must make notification to the State Emergency Medical Services Council (SEMSCO) and possess an EMS Operating Certificate. In order to obtain an EMS operating certificate, the municipality must complete the following steps:

1- The municipality must file a written request with the State Emergency Medical Services Council (SEMSCO). The request must be sent to the SEMSCO in care of the Bureau of Emergency Medical Services (BEMS). The written request must include the following items:

   a) A certified copy of the local law, ordinance or resolution from the municipal legislative body empowering the municipality to establish and operate a certified EMS service. The local law, ordinance or resolution should include, but not be limited to, the following:

      • A statement of need;
      • A statement establishing the type of service (ie. ALS-FR or Ambulance);
      • A statement declaring the area to be served; and
      • The date the resolution is to take effect.

   b) A letter from the chief executive officer of the municipality requesting Public Health Law Operating Authority as a certified ALS-FR or ambulance service.

   c) A complete Application for EMS Operating Certificate, a map identifying the area of operation (geography to be served may not exceed the boundaries of the applying municipality) and evidence that the service meets or exceeds all New York State Department of Health applicable standards.

   d) If the municipality intends on providing Advanced Life Support, it must apply to the appropriate Regional Emergency Medical Services Advisory Council (REMAC) and be approved to provide advanced life support care. The approval letter from the REMAC, stating the actual level of care approved, must be included in the submission.

   e) If the municipality intends to contract with another EMS provider for service, the filing should include copies of signed contracts or agreements.

   f) If the municipality intends to operate an ALS-FR, the filing must include a transport agreement with an appropriately authorized NYS certified ambulance service.

   g) The filing for a municipal service must be sent to the following address by certified mail or other return receipt delivery:

   New York State EMS Council
   c/o Bureau of Emergency Medical Services - Operations Unit
   New York State Department of Health
   875 Central Avenue
   Albany, New York 12206-1388

   New York State EMS Council
   c/o Bureau of Emergency Medical Services - Operations Unit
   New York State Department of Health
   875 Central Avenue
   Albany, New York 12206-1388
2- Prior to the issuance of a Certificate of Operating Authority, the ALS-FR or ambulance service must complete and submit the following to the appropriate DOH EMS Regional Office:

- The Application for EMS Operating Certificate (DOH-206) packet.
- If intending to provide adjunct Basic Life Support (BLS) and ALS levels of care, include written REMAC authorization.
- Identify a physician medical director using the Medical Director Verification Form (DOH-4362).

3- A full service inspection will then be conducted by the Department’s appropriate regional EMS staff. The full service inspection may not take place before the filing is complete, received and reviewed by the Bureau of EMS. The inspection establishes that the EMS service meets or exceeds the appropriate training, staffing and equipment standards as set forth by 10NYCRR Part 800.

4- Upon successful completion of the inspection and receipt of the NYS DOH Operating Certificate, the service may begin operation. The municipality shall be granted operating authority for a period of two years starting on the date the request is received by the Bureau of EMS.

5- In order to convert the municipal declaration to a permanent operating authority, the ALS-FR or ambulance service must receive a determination of public need from the Regional EMS Council (REMSCO). Prior to the expiration of the municipal ALS-FR or ambulance service (two years from the date of the original filing with SEMSCO) a complete application for New ALS-FR or ambulance service must be received by the REMSCO. The REMSCO must render a determination of need pursuant to PHL 3008. The application process, filing information and required documentation may be found in DOH Policy Statement 06-06. The policy may be found at www.health.state.ny.us/nysdoh/ems/pdf/06-06.pdf. It is strongly recommended that the municipality file the application for a new service at least 90 days prior to the expiration of the original certificate.

6- Should the municipality make notification to the SEMSCO that it wishes to operate an ALS-FR or ambulance service and then, prior to beginning service or anytime during the two year period, determine that it is not in the best interest of the local government and/or community, it may rescind the declaration. As with the original declaration, this must be done by local law, ordinance or resolution rescinding the original local law, ordinance or resolution. This must be accompanied by a cover letter and submitted to the SEMSCO, in care of the Department by certified mail or other return receipt delivery.

Additional Information

< The municipality is responsible for this EMS agency, even if they enter into contracts with another organization to provide the EMS response.

< An operating certificate obtained under the provisions of 3008 section 7(a) for the original two year authority and the subsequent permanent authority may not be transferred.

< If the municipality fails to become operational during the initial two years and does not rescind the declaration, it may not file another municipal declaration to establish an EMS service under the provisions of 3008 section 7(a).

< With the exception of an entire county, a municipality may only declare operating authority for the geography over which it has direct jurisdiction (e.g. an incorporated village contained within the borders of a town would not be included within the authority of an EMS agency established by the town {Also see next item}).
Multiple municipalities, under written inter-municipal agreements, may collaborate to operate a single EMS service to serve several municipalities as long as each participating municipality submits a declaration to the SEMSCO.

A municipality that intends to collect fees for the provision of EMS services (patient billing) will need to apply for provider status in accordance with Federal and State Medicare/Medicaid regulations. While the municipality may contract for billing services, it must be the billing entity.

The failure to initiate EMS operation in a timely manner (within 60 days of notification to the SEMSCO) may contradict the declaration of need and may work against the municipality’s ability to transition to a permanent operating authority after the two year period.

Available Web Based Resources

Prior to filing for a Muni-CON with the SEMSCO/Department, the following documentation may provide additional information.

- Municipal Certificate of Need (Muni-CON): An Overview
  www.health.state.ny.us/nysdoh/ems/operational_authority/municipal_certificate_of_need.htm

- Public Health Law, Article 30, section 3008
  www.health.state.ny.us/nysdoh/ems/art30.htm#BM3008

- Title 10 of the NYS Codes, Rules and Regulations related to EMS
  www.health.state.ny.us/nysdoh/ems/publaw.htm

- GML - Article 1, Section 2 - Definitions
  http://public.leginfo.state.ny.us/menugetf.cgi

- 06-06 EMS Operating Certificate Application Process (CON)
  www.health.state.ny.us/nysdoh/ems/pdf/06-06.pdf

- Application for Ambulance and ALS-FR Operating Authority
  www.health.state.ny.us/nysdoh/ems/operational_authority/certified/application_instructions.htm

- DOH Regional Offices – EMS Representatives
  www.health.state.ny.us/nysdoh/ems/emsrep.htm

- Regional EMS Council (REMSCO) Contact Information
  www.health.state.ny.us/nysdoh/ems/regional.htm

Please direct requests for applications, additional information or questions to the Bureau of EMS, Operations Unit at 518-402-0996 x2.
EMS providers, police, firefighters and all other responders will be required to wear American National Standards Institute (ANSI) International Safety Equipment Association (ISEA) approved High Visibility Vests effective no later than November 24, 2008. This new federal rule (attached) requires individuals working on or near highways to wear the high visibility vests while conducting operations on roadways supported by federal dollars.

The purpose of the regulation is to decrease the likelihood of worker fatalities or injuries caused by motor vehicles, construction vehicles and equipment while working within the right-of-way on Federal-aid highways. The federal regulation contains the following definitions:

- **Close proximity** means within the highway right-of-way on Federal-aid highways.

- **High-visibility safety apparel** means personal protective safety clothing that is intended to provide conspicuity during both daytime and nighttime usage, and that meets the Performance Class 2 or 3 requirements of the ANSI/ISEA 107-2004.

- **Workers** means people on foot whose duties place them within the right-of-way of a Federal-aid highway, such as highway construction and maintenance forces, survey crews, utility crews, responders to incidents within the highway right-of-way, and law enforcement personnel when directing traffic, investigating crashes, and handling lane closures, obstructed roadways, and disasters within the right-of-way of a Federal-aid highway.

The ANSI/ISEA 107-2004 Classes are as follows:

- **Class 1 Garments**: Intended for use in activities that permit the wearer's full and undivided attention to approaching traffic. There should be separation of the worker from the traffic, which should be traveling no faster than 25 miles per hour.

- **Class 2 Garments**: Intended for use in activities where greater visibility is necessary during inclement weather conditions or in work environment with risks that exceed those for Class1 Garments. This class also covers workers who perform tasks that divert their attention from approaching traffic, or that put them in close proximity to passing vehicles traveling at 25 miles per hour or higher.

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1 The standard requires that the background fabrics must be fluorescent yellow-green, fluorescent orange-red or fluorescent red. Apparel must provide 360° of visibility; the retro-reflective striping must encircle the torso. It must also be at least 2" above the hem. If there are multiple bands, they have to be separated by at least the width of the band.
• **Class 3 Garments:** Provides the highest level of visibility, and are intended for workers who face serious hazards and often have high task loads that require attention away from their work. Garments for these workers should provide enhanced visibility to more of the body, such as the arms and legs.

In an effort to better insure the safety of EMS providers on the scene of an emergency response, it is **strongly recommended** that every EMS agency do, but not limited to the following:

- Develop policies and procedures that require the use of high visibility/retro-reflective\(^2\) safety apparel for all EMS providers while working on, or near local, state or interstate roadways.

- Make available high visibility/retro-reflective safety apparel for EMS providers for use while working on or near local, state or interstate roadways.

Additional information maybe obtained at the following web sites:

- International Safety Equipment Association (ISEA)  
  [www.safetyequipment.org](http://www.safetyequipment.org)

- American National Standards Institute (ANSI)  
  [www.ansi.org](http://www.ansi.org)

- Burns, David M. & Dr. Lee Pavelka. 3M® website: How Fluorescence Improves Roadway Safety. [www.3m.com/us/safety/tcm/research/fluorescence.jhtml](http://www.3m.com/us/safety/tcm/research/fluorescence.jhtml)

- The CDC’s NIOSH website Death in the line of duty…: [www.cdc.gov/niosh](http://www.cdc.gov/niosh)

- Schertz, Greg (Safety Engineer, FHWA). Roadway Safety Foundation: The Importance of Retroreflectivity

- 3M Corporation website: [www.scotchlite.com](http://www.scotchlite.com)


- Oriole, Kim (JEMS InfoMail Reporter). JEMS: Journal of Emergency Medical Services: Fatality Study: EMS Is a Dangerous Profession,

\(^2\)Retro-reflection occurs when light rays are returned in the direction from which they came. A large amount of reflected light is returned directly to the original light source, causing retro-reflective materials to appear brightest to an observer located near the light source.
PART 634—WORKER VISIBILITY

Sec.
634.1 Purpose.
634.2 Definitions.
634.3 Rule.
634.4 Compliance date.

AUTHORITY: 23 U.S.C. 101(a), 109(d), 114(a), 315, and 402(a); Sec. 1402 of Pub. L. 109–59; 23 CFR 1.32; and 49 CFR 1–48(b). SOURCE: 71 FR 67800, Nov. 24, 2006, unless otherwise noted.

EFFECTIVE DATE NOTE: At 71 FR 67800, Nov. 24, 2006, part 634 was added, effective Nov. 24, 2008.

§ 634.1 Purpose.
The purpose of the regulations in this part is to decrease the likelihood of worker fatalities or injuries caused by motor vehicles and construction vehicles and equipment while working within the right-of-way on Federal-aid highways.

§ 634.2 Definitions.
Close proximity means within the highway right-of-way on Federal-aid highways.

High-visibility safety apparel means personal protective safety clothing that is intended to provide conspicuity during both daytime and nighttime usage, and that meets the Performance Class 2 or 3 requirements of the ANSI/ISEA 107–2004 publication entitled “American National Standard for High-Visibility Safety Apparel and Headwear.” This publication is incorporated by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51 and is on file at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call (202) 741–6030, or go to http://www.archives.gov/federalregister/codeoffederalregulations/ibrlocations.html. It is available for inspection and copying at the Federal Highway Administration, 400 Seventh Street, SW., Room 4232, Washington, DC, 20590, as provided in 49 CFR Part 7. This publication is available for purchase from the International Safety Equipment Association (ISEA) at 1901 N. Moore Street, Suite 808, Arlington, VA 22209, http://www.safetyequipment.org.

Workers means people on foot whose duties place them within the right-of-way of a Federal-aid highway, such as highway construction and maintenance forces, survey crews, utility crews, responders to incidents within the highway right-of-way, and law enforcement personnel when directing traffic, investigating crashes, and handling lane closures, obstructed roadways, and disasters within the right-of-way of a Federal-aid highway.

§ 634.3 Rule.
All workers within the right-of-way of a Federal-aid highway who are exposed either to traffic (vehicles using the highway for purposes of travel) or to construction equipment within the work area shall wear high-visibility safety apparel.

§ 634.4 Compliance date.
States and other agencies shall comply with the provisions of this Part no later than November 24, 2008.
For the previous five (5) years, the New York State Department of Motor Vehicles reported an annual average of 489 ambulance vehicle crashes. A growing number of these crashes have cost the lives or seriously injured EMS providers, patients and the general public. The NYS Vehicle & Traffic Law requires drivers and all front seat passengers in motor vehicles to be restrained in safety seats or by safety belts. While an exemption in the law specifically excludes those vehicles defined as an “authorized emergency vehicle (V&T section 101)” which includes ambulances, it is vitally important that seatbelts are used at all times by every occupant of an emergency vehicle.

National Highway Traffic Safety Administration (NHTSA) data shows that when lap/shoulder seat belts are used properly, they reduce the risk of fatal injury to front-seat passenger car occupants by 45 percent and the risk of moderate-to-critical injury by 50 percent. For light-truck front-seat occupants, seat belts reduce the risk of fatal injury by 60 percent and the risk of moderate-to-critical injury by 65 percent. (Light trucks, weighing less than 10,000 lbs., also include truck-based station wagons.)

The New York State Department of Motor Vehicles 2006 data reported a total of 506 ambulance crashes. The data indicated that 1,427 individuals were involved, of that 876 (61.4%) were wearing a lap and harness seatbelt. The injury severity is reported as follows:

- 16 serious injuries
- 19 moderate injuries
- 257 minor injuries
- 584 reported no injuries

PURPOSE

It is the purpose of this policy to strongly remind EMS agencies and individual providers to evaluate their overall operations and develop practices or internal controls that lead to a safe working environment and a culture of safety in all aspects of the agency. This policy also assists EMS agencies in reviewing or developing policies and practices that insure safe driving habits, the appropriate use of seat belts by all crew members,

1 Excerpted from the NHTSA – Crash Outcome Data Evaluation System (CODES).
passengers and patients as well as a review of practices in the patient care compartment to improve safety.

RECOMMENDATIONS

New York State Emergency Medical Services Council (SEMSCO) and the Bureau of EMS strongly recommend that all EMS agencies develop and periodically review, service specific policies for their personnel that include the provision of appropriate emergency driver training programs, proper driving skills and behaviors. The policies should also include, but are not limited to the following:

- All drivers and front seat passengers of ambulances must use seat belts at all times when the vehicle is in motion.
- All operators & passengers of non-ambulance response vehicle (EASV, ALSFR, etc.) must use seat belts at all times when the vehicle is in motion.
- All patients not located on a patient carrying device - stretcher, as well as any passengers riding in the patient compartment must use seat belts at all times when the vehicle is in motion.
- All EMS personnel in the patient compartment must use seat belts when they are not attending to a patient and the vehicle is in motion. In as much as possible, EMS personnel should perform patient care activities while restrained by a seatbelt. Only if it becomes necessary to care for the patient, should the seat belt be removed. Examples of necessary care are CPR, artificial ventilation, medication administration, or reassessment of unstable patients.
- All patients on the stretcher must be secured at all times when the vehicle is in motion or the stretcher is being carried or moved. Manufacturer recommendations often include the use of shoulder harnesses and those restraints should be used at all times.
- Any child transported to the hospital should be in the child’s own protective restraining device – child safety seat - when available. He/she should be placed in the device and the device should be belted to an ambulance seat. If the child actually is the patient, he/she should be secured onto the stretcher and if appropriate, kept in the child safety seat.
- If the ambulance service does not have an ambulance equipped with child safety seats, it is recommended that the agency purchase an approved child safety seat for each ambulance.
- Agencies should consider the acquisition of patient monitoring devices (such as automated blood pressure cuffs) and positioning of equipment in the patient care area that would allow for personnel to remain restrained while providing patient care.

CONCLUSION

Whether paid or volunteer, commercial, municipal, independent or fire based, the EMS community can not afford to lose EMS providers because of death, injury or disability when the circumstances can be prevented through education and policy improvements. It is the responsibility of every EMS agency and prehospital care provider to establish and/or continue the culture of safety in the emergency medical services.
RESOURCE INFORMATION

Below is a small selection of web sites that may provide additional resource information:

National Highway Traffic Safety Administration
http://www.nhtsa.gov

Emergency Vehicle Operators Course (EVOC) Information

United State Fire Administration

National Safety Council – Coaching Emergency Vehicle Operators (CEVO)
http://www2.nsc.org/onlinetraining/driving/cevo.cfm

Volunteer Fireman’s Insurance Service, Inc. (VFIS)
http://www.vfis.com/education_training.htm

International Association of Fire Chiefs
http://www.iafc.org/displaycommon.cfm?an=1&subarticlenbr=413

New York State Department of Motor Vehicles – 2006 Crash Summary Data
http://www.nydmv.state.ny.us/Statistics/2006_NYS_Accident_Summary_Final.pdf
Introduction:

This policy is intended to assist EMS agencies in developing a record retention policy. It must be noted that records retention requirements differ depending upon the ownership of the EMS service. Agencies owned by local governments are required by law to maintain records as defined in the General Retention and Disposition Schedule (GRDS). At present there are no state laws or regulations that define how long private organizations must maintain their patient care records and other related EMS documents. However federal regulations do require providers being paid through Medicaid and Medicare to retain appropriate documentation in compliance with applicable regulations. Similarly, commercial and third party payers may have their own requirements for record retention.

It is the intention of this policy statement to provide a guideline for the retention of records by all types of EMS Services. This policy was prepared in conjunction with the GRDS for use by miscellaneous local governments in New York State (Section 185.14, 8NYCRR (Appendix K). The GRDS is prepared and issued by the State Archives, within the New York State Education Department and indicates the minimum length of time that officials must retain their records before they may be disposed of legally.

Unless otherwise required by regulation or policy: EMS Agencies, Course Sponsors and individual provider’s are not required to create and/or use all of the following forms of documentation. However, if the documents are created and/or used they must be retained according to the following schedule.

It is recommended that all EMS Agencies and Course Sponsors develop a policy that describes how they will comply with all record retention requirements. This policy should include, but not be limited to:

- 800.21(k) - personnel files;
- 800.21(l) - a record of each ambulance call;
- 800.21(p) - written policies; and
- 800.21(r) - all unexpected authorized EMS response vehicle and patient care equipment failures.

Retention Schedule:

***All documents should be appraised for historical value and considered for permanent retention.***

Agency:

- Administrative documents, such as meeting minutes and financial records must be retained for 7.5 years.
- Patient Care Reports (electronic or hardcopy), must be retained for 6 years or 3 years past the patients eighteenth birthday, whichever is longer.
- Patient care data files containing medical treatment and/or billing information must be retained for 6 years or 3 years past the patients eighteenth birthday, whichever is longer.
- Summary record of all patients treated and/or transported must be retained for 3 years.
- Ambulance run chronological log must be retained for 6 years after the last entry.
- Monthly or periodic reports or listings must be retained for 3 years.
Reports containing information on subjects (not patient specific) such as types of medical emergencies, types and amounts of supplies used, call frequency etc. must be retained for:
- Reports containing billing information – 7 years.
- Reports not containing billing information – 1 year.
- All records pertaining to controlled substances must be retained for 5 years.
- Rescue and Disaster Response Reports and related records, covering specific incidents must be retained for 3 years.

Course Sponsor:
- Documents containing information on individuals and course files must be retained for 5 years.
- Documents containing information on instructors must be retained for 5 years after working association ends.

Provider Training Records:
- Application for training or certification must be retained for 6 months.
- Training and course materials must be retained for 7 years after the course completion.

HIPAA
- All written policies and procedures as required by the Health Insurance Portability and Accountability Act of 1996 are required to be maintained in writing for at least six years from the date of its creation, or the date when the document was last in effect, which ever is later.
- Section § 164.530(j), states that “written” includes electronic storage. Paper records are not required.

Conclusion:
EMS agencies should have a policy in place describing their procedures to comply with the retention of all required records. This policy must describe the length of time each document will be retained. Additionally, the policy should describe where the documents will be stored, how they will be protected, and procedures for obtaining a stored record if necessary.

Other regulatory agencies such as the IRS, OSHA / PESH etc., have regulations for document retention. It is beyond the scope of this document to address every regulation. Therefore, it is incumbent upon each responsible party to research and maintain compliance with all document regulations.

Resources:
- New York State Archives:
- 10 NYCRR Part 800 State Emergency Medical Services Code
  - [http://www.nyhealth.gov/nysdoh/ems/part800.htm](http://www.nyhealth.gov/nysdoh/ems/part800.htm)
- Health Insurance Portability & Accountability Act of 1996 - HIPAA
  - Website: [http://www.hhs.gov/ocr/hipaa/](http://www.hhs.gov/ocr/hipaa/)
- New York State Department of Labor
  - Website: [http://www.labor.state.ny.us/](http://www.labor.state.ny.us/)
  - Division of Safety and Health
    - [http://www.labor.state.ny.us/workerprotection/safetyhealth/DOSH_PESH.shtm](http://www.labor.state.ny.us/workerprotection/safetyhealth/DOSH_PESH.shtm)
- US Department of Labor - OSHA
- Internal Revenue Service
Background:

The New York State Department of Health, in accordance with State and Federal Laws, ensures that all health care providers protect the confidentiality of those patients for whom they are caring. It is the responsibility of each EMS provider to maintain the confidentiality of privileged information that they may have been exposed to in the course of their duties as a health care provider.

All agencies and/or systems are encouraged to have policies that require and include:

1. Initial and as necessary, refresher training of staff regarding the importance of patient confidentiality; and
2. Procedures for maintaining patient confidentiality.

To better understand what the role of the EMS provider is with reference to patient confidentiality, we must first define the term. The Encyclopedia of Surgery defines confidentiality as:

> “Confidentiality is the right of an individual to have personal, identifiable medical information kept private. Such information should be available only to the physician of record and other health care and insurance personnel as necessary. As of 2003, patient confidentiality was protected by federal statute.”

Laws and Regulations:

The New York State (NYS) Public Health Law (PHL) Article 30 section 3006 and Title 10NYCRR Part 800.15 require any information that may disclose patient identity to be kept confidential. The Health Insurance Portability & Accountability Act of 1996, (HIPAA) is a federal law that protects patient confidentiality and privacy.

PHL Article 30, Section 3006:

§ 3006. Quality Improvement Program.

2. The information required to be collected and maintained, including information from the prehospital care reporting system which identifies an individual, shall be kept confidential and shall not be released except to the department or pursuant to section three thousand four-a of this article.
3. Notwithstanding any other provisions of law, none of the records, documentation, or committee actions or records required pursuant to this section shall be subject to disclosure under article six of the public officers law or article thirty-one of the civil practice law and rules, except as hereinafter provided or as provided in any other provision of law. No person in attendance at a meeting of any such committee shall be required to testify as to what transpired there at. The prohibition related to disclosure of testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject of which was reviewed at the meeting. The prohibition of disclosure of information from the prehospital care reporting system shall not apply to information which does not identify a particular ambulance service or individual.

4. Any person who in good faith and without malice provides information to further the purpose of this section or who, in good faith and without malice, participates on the quality improvement committee shall not be subject to any action for civil damages or other relief as a result of such activity.

Title 10NYCRR Part 800; section 800.15 REQUIRED CONDUCT:

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 except:

(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;
(2) to the extent necessary and authorized by the patient or his or her representative in order to collect insurance payments due;
(3) to the extent otherwise authorized by law;

The Health Insurance Portability & Accountability Act of 2003 (HIPAA):

In April 2003, HIPAA established a set of Federal regulations regarding confidentiality and privacy. Though, the department does not enforce HIPAA regulations, the law does affect EMS in NYS. It specifically relates to electronic patient billing and access to a patient’s health records. The NYS Department of Health has information regarding HIPAA and how it affects NYS PHL. See References.

HIPAA and state laws do not necessarily preclude sharing of patient information among and between EMS providers and other health care providers, law enforcement, regional and state quality assurance systems, and other users of public health data. However, in the exchange of such information, EMS providers and systems are to be vigilant in ensuring the protection of data for the purpose it is being released.

Summary:

It is beyond the scope of this policy statement to identify all of the laws or regulations that require confidentiality. This policy statement only identifies the most common items that pertain to the emergency medical services. Every EMS agency and/or provider must maintain compliance with the patient’s needs of confidentiality.

All EMS providers and other necessary agency personnel are routinely exposed to confidential patient information. The Agency and all personnel exposed to confidential information is required to maintain confidentiality throughout every aspect of emergency medical service operations. It is required in but not limited to:

• training and education;
• every patient contact;
• communication:
Resources:

EMS services are encouraged to review the HIPAA act and the NYS PHL to determine which law will take precedence over the other when there are similar topics and how they will affect your service and procedures. The Department has a chart that breaks down each section and discusses which law will take precedence. It can be found at
http://www.health.state.ny.us/nysdoh/hipaa/pdf/hipaa_preemption_charts.pdf

Below are several links for further reference to confidentiality.

Certification – Student Reference Guide

NYS PHL Article 30 Section 3006:
http://www.health.state.ny.us/nysdoh/ems/art30.htm#BM3006

Part 800 section 800.15:
http://www.health.state.ny.us/nysdoh/ems/part800.htm#800.15

NYS Dept. of Health HIPAA advisory links:
http://www.health.state.ny.us/nysdoh/hipaa/hipaa.htm
http://www.health.state.ny.us/nysdoh/hipaa/pdf/hipaa_preemption_charts.pdf

US Dept. of Health and Human Services Office for Civil Rights – HIPAA
http://www.hhs.gov/ocr/hipaa

Surgery Encyclopedia web link:
http://www.surgeryencyclopedia.com/Pa-St/Patient-Confidentiality.html
This policy is intended to provide information to EMS personnel about the rights of patients and their service animals as well as several of the laws concerning service animals under the Americans with Disabilities Act (ADA). This policy will assist ambulance agencies in understanding the rights of patients who utilize service dogs/animals, how these animals should be transported and that these animals have rights under the law that are not granted to domestic pets.

In the United States, the idea of a service dog started with a woman named Dorothy Harrison Eustis. 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.

Definitions of Service Animals

- The U.S. Department of Justice defines any guide dog, signal dog, or other animal 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.

- New York State Agriculture and Markets Article 7 section 108 defines the following:
  9. "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.
  22. "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.
  23. "Person with a disability" means any person with a disability as that term is defined in subdivision twenty-one of section two hundred ninety-two of the executive law.
Identifying a Service Dog/Animal
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.

Transporting the Patient and the Service Animal
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. 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 devises may include:

- Crates, cages, specialty carriers.
- 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 that case every effort should be made to insure safe care and transportation of the animal by alternative means (animal control personnel, family members, etc).
- EMS should notify the receiving facility of the presence of a service animal accompanying the patient.

Additional Information and Resources
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.

NYS has developed the Empire State Animal Response Team (ESART) and is working with counties across the state to develop individual County Animal Response Teams (CART’s) to assist with coordination of evacuation, shelter, and transportation of household pets and service animals per the state and federal "P.E.T.S. Act of 2006." The following web site provides additional information about these resources:
http://www.empiresart.com/

The following sites offer resources and Frequently Asked Questions (FAQ’s) with regard to Service Animals:
http://www.usdoj.gov/crt/ada/archive/qasrvc.htm/
http://www.deltasociety.org/
http://www.aspca.org/site/PageServer
http://www.hsus.org/
http://www.seeingeye.org/
http://www.guidingeyes.org/
INTRODUCTION

This Policy Statement describes the application and consideration process, in accordance with Article 30 of the New York State Public Health Law (PHL), when applying for the following:

- A new ambulance or advanced life support first response service operating certificate,
- A transfer of EMS service ownership,
- An expansion of operating territory, and/or
- A transition from a municipal declaration to permanent operating certificate at the end of the two year initial operating period.

This policy was written in consultation with the State EMS Council’s Systems Subcommittee and supported by the State EMS Council (SEMSCO). This document, along with its appendices, will assist the applicant in insuring that the application conforms to and contains the information required in the rules and regulations promulgated pursuant to PHL.

This document, along with its appendices, defines a systematic and logical approach and establishes a framework for Regional Emergency Medical Service Councils (REMSCO) to use when processing EMS Service applications in accordance with PHL.

Article 30 Section 3003 of Public Health Law states:

§ 5. The REMSCO shall have the responsibility to make determinations of public need for the establishment of additional emergency medical services and ambulance services and to make the determinations of public need as provided in section three thousand eight.
Article 30 Section 3005 of Public Health Law states:
§ 5. No initial certificate (except initial certificates issued pursuant to subdivision two of this section) shall be issued unless the commissioner finds that the proposed operator or operators are competent and fit to operate the service and that the ambulance service or advanced life support first response service is staffed and equipped in accordance with rules and regulations promulgated pursuant to this article.

§ 6. No ambulance service or advanced life support first response service shall begin operation without prior approval of the appropriate REMSCO, or if there is no appropriate REMSCO established such ambulance service or advanced life support first response service shall apply for approval from the state council as to the public need for the establishment of additional ambulance service or advanced life support first response service, pursuant to section three thousand eight of this article.

Article 30 Section 3008 of Public Health Law states:
§ 1. Every application for a determination of public need shall be made in writing to the appropriate REMSCO, shall specify the primary territory within which the applicant requests to operate, be verified under oath, and shall be in such form and contain such information as required by the rules and regulations promulgated pursuant to this article.

§ 2. Notice of the application shall be forwarded by registered or certified mail by the appropriate REMSCO to the chief executive officers of all general hospitals, ambulance services, and municipalities operating within the same county or counties where the service seeks to operate. The notice shall provide opportunity for comment.

§ 3. Notice pursuant to this section shall be deemed filed with the ambulance service and municipality upon being mailed by the appropriate regional or state council by registered or certified mail.

§ 4. The appropriate REMSCO or the state council shall make its determination of public need within sixty days after receipt of the application.

§ 5. The applicant or any concerned party may appeal the determination of the appropriate REMSCO to the state council within thirty days after the REMSCO makes its determination.
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A. PUBLIC NEED

The State EMS Council and the Department of Health defined public need as:

THE DEMONSTRATED ABSENCE, REDUCED AVAILABILITY OR AN INADEQUATE LEVEL OF CARE IN AMBULANCE OR EMERGENCY MEDICAL SERVICE AVAILABLE TO A GEOGRAPHICAL AREA WHICH IS NOT READILY CORRECTABLE THROUGH THE REALLOCATION OR IMPROVEMENT OF EXISTING RESOURCES.

Variables in considering “Public Need”

- Geography
- Population (size, density, projections)
- Level of care (existing, available)
- Quality, reliability, and response patterns of existing services
- Type of service (emergency, non-emergency)
- Special need (i.e. Air, Industrial or Facility)
- Service effectiveness, cost, and operation
- Other local factors

Each REMSCO shall prepare a statement, which is reviewed annually and is made available to each applicant that provides regional definitions and or minimum standards, alone or in combination, for these variables and any other local criteria that are appropriate to the development and review of an application.

The REMSCO has an obligation to determine if the issues identified are truly ones of public need/necessity or, as an alternative, if any improvement in existing resource allocation or coordination within a specific time frame can resolve the problem. Inherent in this review is a determination as to why appropriate measures were not taken by existing providers prior to the submission of a new application.

Every new EMS service or any service seeking to expand its primary territory must, by statute, receive the approval of the appropriate REMSCO prior to the issuance of an operating certificate.

Six distinctive steps are identified in the Article 30 process for determining public need for a proposed ambulance or ALS-FR service. These steps are:

1. Application
2. Public Notice
3. The Public Hearing
4. REMSCO Determination
5. A 30 day appeal period for new, municipal and expansion applications
6. Certificate of Issuance or Appeal

Each step must be successfully completed in order to move to the next step.
B. THE APPLICATION

A completed application for new EMS Service, including a transition from municipal declaration after two years in operation, Expansion of Primary Operating Territory or Transfer of Ownership (DOH 3777) must be submitted to the appropriate REMSCO.

- At least two (2) original applications shall be provided to the REMSCO. All applications shall be considered complete when submitted on the prescribed form, be notarized and affirmed, be accompanied by all required attachments, endorsements, evidence and other supporting and explanatory material the applicant wishes the REMSCO to consider and any necessary fees.

- It is the applicant's responsibility to verify that, prior to submission, the application is properly completed and that all necessary attachments and fees, if applicable, are submitted in accordance with all policies, rules and/or regulations.

- The application and narrative shall describe the following:
  - proposed area of service;
  - vehicles, equipment and supplies;
  - level of service;
  - hours of operation;
  - service location;
  - dispatch;
  - Other pertinent operational aspects of the proposed service to allow for a reasonable and comprehensive review.

- The application shall describe the initial source of funds, the adequacy of sources of future revenue and shall provide a first year budget for the proposed service in enough detail to allow a reasonable assessment of the financial stability of the applicant to provide the proposed service and the financial feasibility of the proposal.

- All applications shall focus on how the proposed service will meet the definition of public need. The narrative and endorsements shall respond to and document issues related to this definition. Statements of want, desire, feeling or other unsubstantiated sentiments are not acceptable.

- The complete application is the basis for the demonstration of need. In the public hearing the applicant may be restricted to corroborating and/or explaining the data therein.

- The applicant bears the burden of proof for the demonstration of public need.

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An original may be a first generation copy in original format with original signatures.
REQUIRED ATTACHMENTS:

The attachments to the application should include, but not be limited to, the following items:

1. Detailed narrative to support the demonstration of need, or statement of purpose and intent for transfer, or expansion.
   - The applicant, including municipalities, shall demonstrate sufficient knowledge of the EMS system in the area to be able to describe the positive and negative impact the proposed agency shall have on the area and providers. The applicant shall submit a narrative to be appended to the application detailing this impact on the following:

   1. All existing ambulance and or emergency medical services within the proposed area in terms of but not limited to:
      - response time (time the call was received to time on the scene);
      - staffing;
      - level of service;
      - call volume for the past 12 months and the anticipated call volume for first 12 months of operation;
      - mutual aid;
      - quality assurance;
      - medical direction;
      - protocols;
      - ability and quality of existing services, and;
      - Financial impact, and any adverse impact the proposed service will have on existing services.

   2. The EMS system in the area – Provide a description of the EMS system, all existing EMS agencies, hospitals and other institutions that generate an EMS response. Additionally, include participation agreements, mutual aid, and actual and projected response times for the proposed agency and the existing agencies for the past and next 12 months. The description must also include communications system interface, medical direction and control, proposed services impact, positive & negative on the community, including on patient care and recruitment & retention of EMS personnel and any possible economies and improvements in service to be anticipated from the applicants operation.

   3. Additionally, municipal EMS services, at the time of transition, may be required to provide documentation regarding the impact their declaration has had on the existing EMS community for the first two (2) years of operation.

   - The applicant shall demonstrate the ability to meet the definition of public need within the variables and any other standards defined by the REMSCO. In addition, the fourteen items of evaluation, found in Appendix 1, shall be addressed in the application, and or any attachments.

   - It is the intent of the public application and hearing process to obtain input from all whom may use, provide, pay for or participate in the EMS system. Therefore, applicants, including municipal services shall solicit letters of endorsement from, but not limited to, the following agencies or
organizations within the proposed service area and those with service areas or influence areas (i.e. adjacent ambulance primary service areas or hospitals with bordering patient catchment areas, etc.):

- All EMS and ALSFR agencies licensed to provide service in the area, county and contiguous counties in the region;
- EMS Medical Director(s) in the region;
- The chairperson of any County EMS organization and county EMS Coordinator;
- All hospital CEO's and emergency department directors, and;
- The CEOs of all municipalities.

- All letters of solicitation shall include a general description of the new service, the type and level of service to be provided, the demonstration of public need, how the proposed service plans to impact public need and a request for response by a specified date.

- All letters in response to the applicant’s solicitation shall be signed by the CEO of the organization or authorized designee, can be no more than six (6) months old and shall include an acknowledgement of receipt of the definition of public need.

- The application shall include a copy or sample of the letter of solicitation, a list of the agencies/individuals to which it was sent and all responses received.

- Applicants shall provide copies of the application accepted by the REMSCO for each member, unless otherwise defined by local REMSCO policy.

3. Affirmation of Fitness and Competence (DOH 3778)

- The application shall attest to the competency and fitness of the applicant(s) and/or officers of the corporation. An affirmation of Competency and Fitness (DOH 3778) shall be provided.

- For the purposes of fitness and competency review, the applicant must include personal information to include, but not be limited to current resume/curriculum vitae, home address, and date of birth and social security number. This information will not be maintained in any files or be discoverable and will be destroyed once the determination has been made.

4. Certificate of Incorporation

- The applicant shall include the Certificates of Incorporation, d.b.a’s and ownership from the issuing government.

- The application must include a complete listing of all shareholders, principal owners and operators of the EMS service.
5. Financial Information

- The application shall describe the initial source of funds, the adequacy of sources of future revenue and shall provide a first year budget for the proposed service in enough detail to allow a reasonable assessment of the financial stability of the applicant to provide the proposed service and the financial feasibility of the proposal.

- The applicant shall provide taxpayer federal identification number issued to the organization.

6. Primary Operating Territory Map

- The applicant shall include a written description of the desired territory described within geo-political boundaries.

- A detailed map of the primary operating area.

7. Fees

- The REMSCO may establish a **uniform and non-waivable** fee to be received with each application that reflects the direct and real costs of the application review, the process of public notice and the hearing. The fee shall be reviewed and re-approved annually by the REMSCO and be made available at the official place of business. The fee must accompany the completed application when submitted to the REMSCO. Within sixty (60) days of the determination, the REMSCO shall provide the applicant with a detailed expenditure report.

8. Application Worksheet

- Attached as Appendix 2, is an **Application for Public Need Work Sheet**. This Work Sheet is intended to assist the applicant and the REMSCO in completing the application process.

9. Submission of the Application

- Once the application and required attachments have been completed, the completed package must be delivered to the REMSCO at their official business address, by certified mail or personal service.
C. REMSCO RESPONSIBILITY

Upon receipt, the application shall be reviewed for completeness by the designated REMSCO sub-committee or program staff.

- The application shall be accepted if it is deemed to be complete in accordance with these policies. The acceptance date must be documented in the shaded section on the second page of the application form (DOH-3777).

- When determined to be complete by the REMSCO, the time frame for processing established by Article 30, 3008 begins.

- If found to be incomplete, it shall be returned by certified mail or personal service to the applicant within ten (10) business days with a written explanation of the grounds for the rejection.

- If requested, the applicant shall provide copies of the accepted application and attachments for each REMSCO member.

- The designated REMSCO shall begin action immediately upon receipt and acceptance of a complete application. This action shall include the following:
  1. scheduling a hearing date;
  2. send public notice, and;
  3. establish a REMSCO meeting date at which a determination will be made so as to comply with the 60-day time limit established in PHL. Appendix 4 delineates the time line that is to be followed in order to comply with Public Health Law, Section 3008.

1. Fitness and Competency

One responsibility of the application process is to insure a high quality of ownership and management of an ambulance or ALS-FR service to the degree of attempting to identify any issues of character that would be detrimental to this highly personal service. With this as a purpose, the REMSCO shall address issues relative to the competency and fitness of the applicant and/or officers of the corporation as prescribed in PHL 3005(5).

The REMSCO may request the Department to conduct the detailed review. The review shall include multiple factors such as the individual or group of individuals standing in the community, an evaluation of the applicants prior record as an ambulance service operator or health care provider, and if applicable, a statement of experience in the industry, or related industries. The REMSCO may augment the fitness and competency review, however it must have a documented process.

The review will also include an evaluation of past history, including computer searches of legal filings and judgements, business ownership as well as any convictions for a crime or crimes involving moral turpitude including, but not
limited to, murder, manslaughter, assault, sexual abuse, theft, robbery, drug abuse, the sale of drugs or fraud. The fitness and competency review will also include an applicant’s history with both Medicaid and Medicare programs.

In addition to original applications and municipal applications, a fitness and competency (F&C) determination must be made by the REMSCO for all transfers of ownership.

The applicant shall submit a completed Affirmation of Fitness and Competency (DOH 3778) for each principal owner and/or operator. The REMSCO or upon request, the Department shall conduct a review of the applicant's fitness and competency in accordance with the provisions of PHL Section 3005. A current resume for each principal owner and/or operator must be attached for each affirmation submitted.

2. Public Notice

- The REMSCO shall establish a date, time and location for a public hearing(s) to review the application and receive all comments.

- The hearing(s) shall be held within 30 calendar days of accepting a complete application and the notice shall be postmarked at least 14 calendar days prior to the hearing date.

- The hearing(s) shall be established at a time and place(s) logical to the application, preferably in the county or central to the proposed service area. Considerations for public access must be included.

- More than one public hearing may be held if it is in the best interest of the application and so long as the same application and information is presented by the applicant at each hearing and they are held within the appropriate time frames.

- One public hearing can be held to serve the needs of several REMSCOs, if it is in the best interest of each REMSCO and applicant.

- Letters of notice shall be sent in accordance with PHL 3008, by certified mail to:

  "The chief executive officers of all general hospitals, ambulance services, and municipalities operating within the same county or counties where the service seeks to operate...."

- Hospitals adjoining the proposed service area and ambulance agencies with adjoining primary service areas and the local health systems agency shall also be included in the notice.
The letter of notice shall include the date, time and location of the hearing session, the definition of public need, a solicitation of response to the application by a specific date and provide a mechanism for any interested party to obtain and/or review the application.

The REMSCO shall maintain a copy of the letter of notice, a list of recipients, and all postal receipts until final disposition of the application is made.

The information contained in the letter of notice shall be published in the newspaper designated by the REMSCO to receive legal notices. As necessary this shall include newspapers designated by the REMSCO.

3. The Public Hearing

The REMSCO shall establish a committee to hear each application. The Committee will **usually** consist of five members. Normally one member shall be from the county or area the applicant proposes to serve, and one member shall represent the majority of the ambulance constituency in the proposed service area.

The REMSCO must use a hearing officer designated by the REMSCO and charged with finding fact and preparing a report for the REMSCO. REMSCOs can utilize individuals who are authorized by various state agencies (DEC, State, etc.) to act as hearing officers or other individuals with similar training and experience. Ideally, a hearing officer should be familiar with Public Health Law and the administrative hearing process. The hearing officer will moderate and insure the hearing process follows generally accepted procedures.

The purpose of the hearing is to provide a technical review and objective evaluation of the applicant's statement of need as well as any other testimony presented.

The committee may hear witnesses, receive written statements, ask questions and accept testimony in any form that will lend credibility to the hearing and the ultimate determination.

The REMSCO shall complete and maintain a record of the proceedings of any and all hearings. This shall be in stenographic or tape form. The record must be transcribed and considered along with all other evidence in making the determination, especially pertinent are all discussions relating to public need.

A written summary of the hearing shall be prepared that includes a finding of fact and a recommendation to support or deny the motion to approve the application and detailed justification for the recommendation made. Any other pertinent findings for presentation to the REMSCO must also be included. If a hearing officer's report is the principle process, the
committee should review the report and prepare the recommendation for the REMSCO following a similar outline. It is recommended that the committee meet at a time other than immediately prior to the REMSCO meeting for its deliberations.

4. Determination of Need

- At the designated REMSCO meeting, the chairperson of the hearing committee shall present the application, committee report, including the summary, any technical review, finding of fact and a specific recommendation.

- The recommendation of the hearing committee comes to the floor of the REMSCO as a seconded motion for debate.

- Opportunity shall be provided for REMSCO members present to make inquiry and ask questions prior to making a determination. As the application and the public hearing(s) constitute the appropriate forum to introduce/provide new information, this is not an opportunity for REMSCO members or non-REMSCO members to introduce/provide new information.

- The REMSCO may place binding contingencies on the approval of an application as long as the conditions are in the best interest of the EMS system and are not in conflict with any State law or regulation. The applicant may amend the application so long as it is occurs prior to the public hearing.

- Each REMSCO may establish a policy within the framework mandated by NYS Ethics Rules and established by the State EMS Council regarding members abstaining from voting in cases of conflict of interest.

  This policy shall address members who have a pecuniary (financial) interest in a competing service and those who serve as an officer in an organization deemed to be in direct competition with the applicant.

- Each REMSCO has the obligation to discuss and record in the record, all pertinent points and issues of the application relating to need, the definition of public need, and specific reasons and rationale for and against the application based on the application, evidence presented and testimony from the public hearing.

- It is proper format for a motion to approve the application. The motion is supported by a recommendation from the committee for or against the application and shall contain rationale and justification, positive and negative, for the recommendation presented.

- The REMSCO shall make its determination by a roll call ballot of the members present to accept or reject the recommendation of the
committee. The motion must be made in the form of an approval of the application. Based on the Department’s Bureau of House Counsel opinion (Appendix 3), in order to make a determination, it must be passed by not less than a majority of the entire members authorized to vote, not those members present for the meeting.

- A statement shall be entered into the stenographic record that clearly defines the authority of alternates to vote in the procedure and a statement of the needed majority to pass the motion. A written record of the roll call vote shall list all voting members of the REMSCO and include at least the following information:
  - Member name, affiliation and status as member or alternate;
  - Present or absent for ballot;
  - Voting for, against or abstaining;
  - Declarations and/or decisions of conflict of interest;

D. ISSUANCE OF OPERATING AUTHORITY

- The REMSCO shall provide written notice of its determination to the applicant within seven (7) business days by receipted mail or delivery method.

- The REMSCO shall provide to the Department with written notice of the determination within seven (7) business days by receipted mail or delivery method. Notice shall include:
  - An original copy of the complete, accepted application and attachments;
  - A written copy of the seconded motion to approve the application on which the REMSCO vote is based;
  - Documentation of the roll call vote;
  - A copy of the document or checklist the REMSCO used to determined the application to be complete.

- If the REMSCO(s) determination is to grant operating authority, and no notice of appeal is filed within the 30 business days, the Department's Regional EMS representative shall obtain additional required paperwork, and conduct any necessary inspections.

- The Department will issue the EMS Operating Certificate.

- The REMSCO must retain all documentation and stenographic minutes in the event of an appeal to the determination.

E. THE APPEAL PROCESS

The applicant or any other party directly involved has the right to appeal by filing notice with the Executive Secretary of the State EMS Council at the Department. This notice must be received by the Department, using receipted delivery, within thirty (30) calendar days of the date of the REMSCO's determination.
- After the REMSCO’s determination a notice of appeal may be filed within the 30 days. The Department shall not issue the EMS operating certificate. This shall stand until the conclusion of all appeal processes.

- In the event of an appeal the Department shall request the assignment of an Administrative Law Judge (ALJ) to hear the appeal and make a finding of fact and recommendation to the State EMS Council.

- SEMSCO meetings and considerations of service application appeals are not de novo (consideration of new material or information) hearings of the application, therefore discussion will be limited to State EMS Council members and the record.

- The State EMS Council’s Systems Committee shall review any appeal and the recommendation of the ALJ and shall make a recommendation to the State EMS Council. The complete application and pertinent record and the ALJs report shall be provided to the Council prior to their consideration of the appeal and a decision in accordance with PHL 3002(3).

- The SEMSCO meeting notice will serve to provide a date by which any opposition to the application from certificate holders in the territory to be served or any receiving hospital or municipality for the proposed service must be declared.

- If no opposition is heard/received, the SEMSCO may make a determination following an open discussion period at the next scheduled meeting.

- If significant opposition is received, as determined by council reviewers/staff, a public hearing should be scheduled at least two (2) weeks prior to the scheduled SEMSCO meeting.
F. TRANSFER OF EMS SERVICE OPERATING AUTHORITY

Article 30, Section 3010 permits EMS services to transfer operating authority to a new owner(s) or operator(s) following a review of the competency and fitness of the new operator and with the approval of the appropriate REMSCO(s) and the Department.

This approval process assumes that the original holder of certificate has been in continuous operation and will surrender all rights to operate an EMS service under this certificate without application and approval of the appropriate REMSCO.

1. Allowable Transfer Circumstances

Transfers of operating authority are allowable in the following circumstances with approval of the appropriate REMSCO and the Department:

a) Any change in the individual who is the sole proprietor (3010.2(a));

b) Any change that results in adding new partners (3010.2(b));

c) Any transfer, assignment or other disposition of ten percent (10%) or more of a corporation's stock (3010.2(c));

d) Any transfer of all or substantially all of the assets of a corporation to a new corporation or owner (3010.2(d));

e) A municipality that has transitioned to a permanent operating authority.

Examples: the change in an operator without changing the territory of a sole proprietor, a sole proprietor incorporating for the first time or a fire department service and assets being assumed by a volunteer ambulance corp.

2. The Application Procedure

The applicant shall submit to the appropriate REMSCO at least two (2) original versions of the application, including fees as appropriate and the number of copies as requested by the REMSCO of the following documents:

- A completed Application for New EMS Service, Expansion of Primary Territory or Transfer of Ownership (DOH 3777).

- Completed, notarized and sworn Affirmation of Competency and Fitness (DOH 3778) and a current resume for each proposed owner and/or operator (example: CEO, managing partner, executive board member, operations manager). A statement of purpose and intent, signed by both parties that explains in common terms what is being proposed and including the end effect on both individuals, partnerships or corporations.

- A complete resume for the new owner(s)/operator(s) that includes all health related licenses, social security number (which will be kept confidential) and a history of all employment and/or activities in any regulated health care facility or activity for the past 10 years.
A list and/or copy of orders or deficiency notices issued within the past 10 years from any NYS Department or equivalent out of state agency listed that have deficiencies identified (singular or repetitive) that did or could have caused patient harm or were repetitive and uncorrected.

A list of any malpractice actions within the past 10 years that relate to patient care or harm and the outcome of each.

A copy of any stock sale and/or transfer agreement or other contract or legal agreement.

A listing of all capital, property, plant, equipment, receivables and stock owned by the certificate holder or involved in the transfer. Note: Disclosure of the financial values of each is not required.

A complete listing of the final owner(s).

3. Fitness and Competency

One responsibility of the application process is to insure a high quality of ownership and management of an ambulance service to the degree of attempting to identify any issues of character that would be detrimental to this highly personal service. With this as a purpose, the REMSCO shall address issues relative to the competency and fitness of the applicant and/or officers of the corporation as prescribed in PHL 3005(5).

The REMSCO may request the Department to conduct the detailed review. The review will include an evaluation of past history, including computer searches of public documents including legal filings and judgements and business ownership. Additionally any charges or convictions for a crime or crimes involving moral turpitude including, but not limited to, murder, manslaughter, assault, sexual abuse, theft, robbery, drug abuse, the sale of drugs or fraud are considered. The fitness and competency review will also include an applicant’s history with both Medicaid and Medicare programs.

In addition to original applications and municipal transition, a fitness and competency (F&C) determination must be made by the REMSCO for all transfers of ownership.

The applicant shall submit a completed Affirmation of Fitness and Competency (DOH 3778). The REMSCO shall conduct a review of the applicant’s fitness and competency in accordance with the provisions of PHL Section 3005. A current resume for each applicant/owner/operator must be attached for each affirmation submitted.
4. Review and Approval Process

- REMSCO receives the application and insures that all requirements are met and that all documents are complete. REMSCO contacts the applicant to acknowledge receipt, obtain any missing items, clarify any information and inform the applicant when the application is complete and the date the application will be considered.

- If the new owner meets any of the criteria stated in 3005(8), REMSCO contacts the DOH Central Office for review of any history of patient harm or uncorrected deficiencies in any regulated facility specified in the statute. If the new owner(s) has no involvement in a specified area, such will be noted to the REMSCO.

- REMSCO staff will forward a copy of the application and affirmations to the DOH Central Office within five (5) working days of the application being deemed complete. The DOH and REMSCO staff may jointly develop the information required to determine if a new operator has provided a consistently high level of care and therefore is competent to operate the service. Since approval of both the REMSCO and Department are required, joint development of all required information is essential to expedite the process.

- A new operator may not be found to be competent if there have been multiple, repeated or uncorrected violations of the State EMS Code or other applicable rules and regulations that have directly threatened the health, safety or welfare of a patient.

- Definitions for substantially consistent high level of care will be developed and codified by the State EMS Council. In the absence of these regulations, an operator cannot be found to have provided this level of care if the/any Department has/had instituted license revocation proceedings for a service the operator was a principle in within the last 10 years.

- The REMSCO and the Department have an obligation to act expeditiously to review and act on an application to prevent unnecessary hardship to individuals or corporations. The REMSCO shall render a decision at its next scheduled meeting or no later than sixty (60) days following receipt of a complete application and all fitness and competency review information. The Department will make every effort to have their information available to the REMSCO at least two (2) weeks prior to the scheduled REMSCO meeting.

- There are NO mailing, notice, hearing or time requirements imposed by the statute. If a REMSCO sub-committee review is conducted, the committee shall focus on reviewing fitness and competency only. There is no intent for a hearing and a committee review to delay the process.
The REMSCO meeting is an open meeting and the vote for the review of fitness and competency shall be conducted by roll call vote, using the definition of majority from the REMSCO’s by-laws.

The REMSCO shall forward to the Department within seven (7) business days, one complete original application and competency affirmation and the written REMSCO decision. A complete record of the proceedings will be maintained including the meeting's minutes and a record of the roll call vote and any committee recommendations and vote record. The REMSCO needs to include a detailed rationale and explanation for any negative decision.

The Department will review the application and REMSCO decision and within ten (10) business days of receiving the decision, confirm or deny the REMSCO decision and notify the applicant and REMSCO accordingly.

Approval of the application, receipt of final transaction closures and the transfer of operating authority will be granted only upon approval of both the REMSCO and the Department.

Following approval of both the REMSCO and the Department an application for EMS Operating Certificate will be completed and a site inspection scheduled with the appropriate DOH Area Office.

5. Transferring Operating Authority to Publicly Held Entities

This section defines additional requirements needed to transfer the operating authority of an EMS service where the new owner/operator will be a publicly traded corporation, typically with ownership widely distributed among numerous and constantly changing stockholders.

I. The requirements for fitness and competency reviews will apply to:

- The Corporate entity and any parent or health related subsidiaries;
- Any/All Directors of the Corporation;
- Any/All Officers of the Corporation, and/or;
- Any/All stockholder(s) holding ten (10) or more percent of the stock of the corporate applicant as of the filing date of the application to transfer.

The review will include any operations in other states where the service is licensed to conduct EMS or health care related business.

II. The Application to transfer EMS Service Operating Authority shall include, but not be limited to:

- A photocopy of the executed existing or proposed applicable corporate certificate which shall, in all respects conform to the applicable provisions of the New York Business law.'

- If the applicant is a foreign corporation, it shall include a photocopy of the executed existing or proposed Application for Authority to do business in NY as a Foreign Corporation, which in all respects conforms to the requirements for filing with the NY Secretary of State.
III. The proposed new owner/operator agrees to:

- Identify and maintain current a principal location of the business within the state;
- Provide the name of the individual empowered to conduct business;
- Implement NYS DOH statutes, rules & regulations and policies relating to the conduct of its EMS business in the state;
- Empower the individual to make routine decisions on behalf of the owner/operator with regard to the conduct of its EMS business.
Many states have specific guidelines that they use to evaluate ambulance-service license applications. Although some states license the service to operate in any part of the state, others require separate authorization for each specific service area. The following information was adapted from regulations, which guide Missouri's Department of Health in granting ambulance licenses. EMS managers throughout the nation should find this information helpful in considering the viability of any new service area.

When considering a request for licensure of an ambulance service, the Missouri Bureau of Emergency Medical Services employs the following 14-factor analysis in making the difficult decision on whether or not a new service should be licensed. Typically, a convenience and necessity hearing is held to evaluate the 14 criteria. Following the hearing, and upon further review, a formal determination is made on the need for the service.

1. What is the population of the jurisdiction requesting the ambulance service, including tourism and traffic flow through the area? Does the area have a large enough population base to support a new ambulance service?

2. How many calls for service and how many emergency calls are made in the proposed area? What is the average daily rate of calls for this area? Would the area have a large enough demand to maintain a full-time service?

3. What is the average response time for all calls and emergency calls during a recent time period? Is the average response time reasonably prompt or under response-time specifications?

4. What is the quality of existing services and how do the present conditions affect public convenience? Do the nearby ambulance services adequately cover the emergency medical needs of the area? Would a newly licensed ambulance service be an improvement to public convenience?

5. Do mutual-aid ambulance agreements exist among the area under consideration and the nearby ambulance, police, and fire units? Are these agreements necessary for adequate coverage of this particular area?

6. Would the employees of the proposed ambulance service have a sufficient level of clinical experience for maintaining emergency care?
7. Would opportunities exist for personnel to maintain their level of skill? If an additional ambulance service were added, would the dilution of service calls between the ambulance services cause decay in skills due to inactivity?

8. Are the existing communications capabilities adequate for maintaining medical control and directing paramedics? Would the proposed facilities by an improvement?

9. How will the ambulance service be financed? Are the financial resources available to the proposed ambulance service sufficient for maintaining a full-time service?

10. How will the ambulance service be organized and administered? Does management seem willing to support an ambulance service and is management capable of performing its duties?

11. What will be the total cost of the new ambulance service? Are the benefits that the proposed area would receive worth the expense?

12. Does public opinion in the proposed area favor the establishment of a new ambulance service?

13. Do the local government planning agencies favor establishment of a new ambulance service?

14. Are there any viable alternatives other than licensing a new ambulance service? For example, in some cases volunteer EMTs or fire fighters can respond in a non-licensed vehicle and call in an existing service for transport.

Before embarking on a program of licensure, an EMS leader should review the above questions and then objectively decide if there’s a legitimate need for an ambulance service in the area.

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1 Excerpt taken from *EMS Management: Beyond The Street, 2ed*; written by Joseph J. Fitch, © 1993 by JEMS Publishing Co., Inc.
APPENDIX 2

APPLICATION FOR PUBLIC NEED WORK SHEET

To be completed and a made part of the record.

1. Required DOH Applications

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- DOH Form 3777, *Application for New EMS Service, Expansion of Primary Operating Territory or Transfer of Ownership*, completed and notarized.
- DOH Form 3778, *Affirmation of Fitness and Competency*, competed and notarized for *each person* identified as an officer, director holder of greater than 10% of companies stock.

2. Narrative which includes the following operational aspects of the proposed service:

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- Proposed Area of Service
- Proposed level of care of the service
- Proposed hours of operation
- Proposed physical location(s) of the service
- Proposed number of employees/members.
- Number of ambulances/ALS FR vehicles.

3. The applicant has included financial information including:

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- Source of initial funds
- First/next year’s proposed operating budget.
- Proof of adequacy of funding sources/future revenue.
- Documentation to support that the applicant has financial resources capable of support proposed service/expansion.
4. The narrative shall include documentation of the positive and negative impact of the proposed new/expanded service to include (but not be limited to):

Impact on all existing ambulance/EMS relating to:

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>Response times</td>
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<tr>
<td>Staffing</td>
<td></td>
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<td>Level of service</td>
<td></td>
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<tr>
<td>Call volume of last 12 month/proposed first 12 months of operation</td>
<td></td>
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<tr>
<td>Mutual Aid</td>
<td></td>
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<tr>
<td>Medical direction</td>
<td></td>
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<tr>
<td>Quality assurance</td>
<td></td>
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<tr>
<td>Financial impact on any existing service(s)</td>
<td></td>
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<tr>
<td>Any adverse impact the proposed service will have on any existing service(s)</td>
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<tr>
<td>Prehospital care protocols</td>
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5. Narrative addendum of the application lists all segments of the EMS system in the proposed new/expanded operating territory including:

<table>
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<tr>
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<tbody>
<tr>
<td>All existing EMS agencies</td>
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<tr>
<td>All hospitals and other institutions generating calls (nursing homes, adult homes, centers for independent living, community residences for the disabled, etc)</td>
<td></td>
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<td>Any/all mutual aid agreements</td>
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<td>Actual &amp; projected response times for past and next 12 months</td>
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<tr>
<td>Communications system and the impact additional/expanded service will have on the existing communications system.</td>
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<tr>
<td>Medical direction/control of system and impact additional/expanded service will have on existing system.</td>
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<tr>
<td>Any anticipated improvements the new/expanded service intends to make in the communications system if approved.</td>
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</table>
6. The applicant shall include copies of letters showing they have advised various entities of their proposal and solicit letters of support.

The letters sent by the applicant must:

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<thead>
<tr>
<th>YES</th>
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<tbody>
<tr>
<td></td>
<td>Include a definition of public need</td>
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<td>Include a general description of the new/expanded service.</td>
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<td>Include the type and level of service proposed.</td>
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<td></td>
<td>Request a response by a specific date and that the request be signed by the CEO of the entity.</td>
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<td>Letters received back in support or opposition are not more than six months old.</td>
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7. Applicant documents letters have been sent to:

<table>
<thead>
<tr>
<th>YES</th>
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<tbody>
<tr>
<td></td>
<td>All Ambulance and Advanced Life First Response services within proposed operating territory.</td>
</tr>
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<td>All EMS Medical Directors in Region</td>
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<td>The Chairperson(s) of any county(ies) EMS organization(s) County EMS coordinator(s)</td>
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<td>All Hospital CEOs</td>
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<td></td>
<td>All Hospital Emergency Department Directors</td>
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<td></td>
<td>The CEOs of all municipalities</td>
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<td></td>
<td>All ambulance services in areas adjacent to the proposed operating territory</td>
</tr>
<tr>
<td></td>
<td>All hospitals in areas adjacent to the proposed operating territory</td>
</tr>
<tr>
<td></td>
<td>The applicant submitted proof of receipt by entity letter was sent to (copies of registered mail receipts signed by agency letter was sent to)</td>
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8. Required Fees

<table>
<thead>
<tr>
<th>YES</th>
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<tr>
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<td>Applicant has submitted required REMSCO application fee.</td>
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9. Application Deemed Complete:

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<th>YES</th>
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<tr>
<td>Regional Council/Program Agency Staff</td>
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<tr>
<td>Transportation/Ambulance Committee</td>
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<tr>
<td>Full Regional EMS Council</td>
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<tr>
<td>Provide Written Notification to Applicant indicating Complete Submission</td>
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10. Dates of Action:

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<th>YES</th>
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<td></td>
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<tr>
<td>Request for F&amp;C review from DOH</td>
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<tr>
<td>Received results of F&amp;C review from DOH</td>
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<tr>
<td>Public Hearing Officer Assigned</td>
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<tr>
<td>Public Hearing Scheduled</td>
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<tr>
<td>Transportation/Ambulance Committee/REMSCO Meeting</td>
<td></td>
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<tr>
<td>Copy of Complete Application and Determination sent to DOH</td>
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11. Regional Council Decisions:

<table>
<thead>
<tr>
<th>Agree</th>
<th>Deny</th>
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<tr>
<td>Transportation/Ambulance Committee</td>
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<tr>
<td>Public Hearing Officer</td>
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<td>REMSCO Determination</td>
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NEW YORK STATE DEPARTMENT OF HEALTH
INTEROFFICE MEMORANDUM

TO: New York State EMS Council
    State Emergency Medical Advisory Committee
    All Regional EMS Councils

FROM: Edward G. Wronska, Director
      Bureau of Emergency Medical Services

DATE: September 11, 2001

SUBJECT: Voting Requirements for Regional EMS Council

The State EMS Council has requested a clarification of the voting requirements of Section 3003 (5) which outlines the Certificate of Need process for Regional EMS Councils. The following opinion was provided and/or approved by the Bureau of House Counsel:

1. A quorum is defined as a majority of the whole number of voting members of the council who must be present at a meeting in order to conduct business in which a vote is required for statutorily authorized business, such as a CON. If the council has 30 voting members, than 16 would need to be present at the meeting in order to have a quorum.

2. Any voting member who “abstains” from casting a vote is still counted as a voting member in attendance at the meeting to determine if a quorum is present. Therefore, if 16 voting members were present at a meeting for a council of 30, and one member indicated they would abstain from voting, you would still have a quorum.

3. In order for a motion or resolution to be passed it must be approved by “not less than a majority” of whole number of members authorized to vote, not just those members present at the meeting. GCL Section 41. Thus, if a board is authorized to contain thirty (30) members and sixteen (16) are actually present, there is sufficient attendance to constitute a quorum and business may be conducted at that meeting. However, any issue which did not receive the vote of every one of those 16 members would fail, because the minimum vote needed to pass a resolution or motion is sixteen, the majority of the body’s total authorized membership. Members who abstain from voting, or who are disqualified from voting, still count as making up part of a quorum. But for an official action of
a board or council, actual affirmative votes constituting a majority of the body’s authorized membership must be cast. Also note, that in determining a majority, the whole number of members includes all those positions authorized to vote, including vacant positions and those who may be disqualified, absent or abstaining.

I hope this helps to clarify the issue of quorum and majority for voting in a CON or other statutorily mandated function of a regional EMS council that requires a vote.
DEFINITION OF TERMS/GLOSSARY

**Advanced life support first response service:** "Advanced life support first responder (ALSFR) service" means any person or organization that provides advanced life support care, but does not transport patients.

**Ambulance Service:** "Ambulance service" means an individual, partnership, association, corporation, municipality or any legal or public entity or subdivision thereof engaged in providing emergency medical care and the transportation of sick or injured persons by motor vehicle, aircraft or other forms of transportation to, from, or between general hospitals or other health care facilities.

**Article 30:** Is the New York State Public Health Law that specifically addresses the Emergency Medical Services (EMS) and pre-hospital care. It is the purpose of this article to promote the public health, safety and welfare by providing for certification of all advanced life support first response services and ambulance services; the creation of regional emergency medical services REMSCOs; and a New York state emergency medical services REMSCO to develop minimum training standards for certified first responders, emergency medical technicians and advanced emergency medical technicians and minimum equipment and communication standards for advanced life support first response services and ambulance services.

**De Novo:** A new, afresh. Considering the matter anew, the same as if it had not been heard before and as if no decision previously had been rendered.

**The Department:** Department means the New York State Department of Health, Bureau of Emergency Medical Services (BEMS).

**Primary Operating Territory:** "Primary operating territory" means the geographic area or subdivisions listed on an EMS certificate or within which the EMS service may receive patients for transport.

**Part 800:** Part 800 is the section of Title 10 of the New York State Codes, Rules and Regulations (10NYCRR) that pertain to EMS systems, services, providers, course sponsors and vehicle requirements. This Chapter is known and may be cited as the State Emergency Medical Services Code.

**Public Need:** Public Need means the demonstrated absence, reduced availability or an inadequate level of care in ambulance or emergency medical service available to a geographical area which is not readily correctable through the reallocation or improvement of existing resources.

**Regional Emergency Medical Services Council:** Regional Emergency Medical Services Council (REMSCO) means a regional emergency medical services council established pursuant to section 3003 of article 30 of the Public Health Law.

**Fitness and Competence:** *fit* means that the operator or proposed operator (a) has not been convicted of a crime or pleaded nolo contendere to a felony charge involving murder, manslaughter, assault, sexual abuse, theft, robbery, fraud, embezzlement, drug abuse, or sale of drugs and (b) is not or was not subject to a state or federal administrative order relating to fraud or embezzlement, unless the commissioner finds that such conviction or such order does not demonstrate a present risk or danger to patients or the public… *competent* means that any proposed operator of any ambulance service or advanced life support first response service who is already or had been within the last ten years an incorporator, director, sponsor, principal stockholder, or operator of any ambulance service…

**Municipal Operating Authority:** …any municipality… or fire district acting on behalf of any such municipality, and acting through its local legislative body, … authorized and empowered to adopt
and amend local laws, ordinances or resolutions to establish and operate advanced life support first responder services or municipal ambulance services within the municipality, upon meeting or exceeding all standards set by the department for appropriate training, staffing and equipment, and upon filing with the New York State Emergency Medical Services Council, a written request for such authorization.
The National Incident Management System – NIMS

Introduction:
Under Homeland Security Presidential Directive #5 (February 2003), the Federal government has created the National Incident Management System (NIMS). This system directs the creation of a comprehensive, national approach to incident management by federal, state, territorial, Tribal and local responders. The Presidential Directive also makes NIMS compliance a requirement for any of these entities wishing to receive Federal funds starting with Federal fiscal year 2007.

Federal and State response agencies and any agencies receiving Federal monies, have been given compliance guidance and are working towards educating and training their respective organizations in becoming NIMS compliant. The Federal government has expanded the definitions of "first responder" agencies beyond the traditional Fire, HAZMAT, Police, EMS to include public works, public health, emergency communications, emergency management, and other agencies involved in disaster preparedness, prevention, response and recovery activities.

This integrated system establishes a uniform set of processes, protocols, and procedures that all emergency responders, at every level of government will use to conduct response actions.

There are six (6) components included in NIMS:

- Command and Management
- Preparedness
- Resource Management
- Communications and Information Management
- Supporting Technologies
- Ongoing Management and Maintenance

Additionally, NIMS identifies a variety of Federal Preparedness programs that are available to responders.

This policy will review the components of NIMS and some of the available guidance and requirements. It also provides a list of resources that should be checked frequently for updated information.
Background:
New York State (NYS) Perspective

On March 5, 1996, Governor George Pataki signed Executive Order No. 26 establishing the National Incident Management System (NIMS) - Incident Command System (ICS) as the State standard command and control system that will be utilized during emergency operations. Since that time, NYS agencies have used ICS in every response or pre-planned event operation and have trained tens of thousands of individuals in the Incident Command System.

State response agencies have been advised that the following training requirements will need to be completed by the basic responder:

IS 700
ICS 100
ICS 200

Effects on New York State’s EMS System:

All future preparedness grants and funding will be contingent upon NIMS compliance by the end of fiscal year 06. Additionally, any first response agency that is independent and not part of a municipality, yet receives funding from a municipality that is mandated to be compliant, must also be compliant. For more information: www.fema.gov/nims/

HSPD-5 Requirements for Local governments in order to be in compliance with NIMS by September 30, 2006 include:

- Institutionalizing the use of the Incident Command System (ICS). (Encourage adoption of local resolutions that require ICS for incident management);
- Formally recognizing the NIMS and adopting NIMS principals and policies. (Local resolution);
- Establishing a NIMS baseline by determining which NIMS requirements are already met using the NIMS Capability Assessment Support Tool. (NIMCAST); and
- Establishing a timeframe and developing a strategy for full NIMS implementation using the NIMS Implementation Template.

TRAINING REQUIREMENTS:

- Complete the NIMS Awareness Course "IS-700 National Incident Management System (NIMS), An Introduction." (All entry level First Responders and disaster workers);
- Complete ICS 100: Introduction to ICS. (All entry level First Responders and disaster workers);
- Complete ICS 200: Basic ICS. (All personnel listed above plus single resource leaders, first line supervisors, field supervisors and other emergency management/response personnel that require a higher level of ICS/NIMS Training);
- Complete the National Response Plan Course IS-800 NRP: An Introduction. (All personnel listed above plus middle management including strike team leaders, task force leaders, unit leaders, division/group supervisors, branch directors and multi-agency coordination system/emergency operations center staff);
- Complete ICS 300: Intermediate ICS. (All personnel listed above plus middle management including strike team leaders, task force leaders, unit leaders, division/group supervisors, branch directors and multi-agency coordination system/emergency operations center staff); and
- Complete ICS 400: Advanced ICS. (All personnel listed above plus Command and general staff, select department heads with multi-agency coordination system responsibilities, area commanders, emergency managers and multi-agency coordination system/emergency operations center managers).
Training Resources:

The IS-700, IS-800, ICS-100 and ICS200 are all available as self study courses on-line. Additionally, the ICS-200, ICS-300 and ICS-400 are available at various times throughout New York State. Contact your county Emergency Manager or check the training calendar on the SEMO website, http://www.nysemo.state.ny.us, for course dates and locations. Please routinely check this calendar as it is frequently updated.

Steps to NIMS Compliance:

1. Adopt NIMS through executive order, proclamation, resolution, policy statement or legislation as the jurisdiction’s official all-hazards, incident response system;

2. Manage all incidents and preplanned events using the Incident Command System;


4. Begin the process of identifying individuals who will take the required training;

5. Have appropriate employees, (defined above), take the training’s IS-700, IS-800, ICS-100, ICS-200, ICS-300 (FFY07) and ICS-400 (FFY07): http://www.security.state.ny.us/training/index.html;

6. Start to identify plans and procedures that require updating to include NIMS and determine who will be responsible to update them;

7. Have the individual(s) that were identified in bullet 6 above begin to make the necessary adjustments;

8. Ensure exercise programs include NIMS principles;

9. Inventory assets using Resource typing; http://www.fema.gov/pdf/emergency/nims/508-3_emergency_medica_%20services_%20resources.pdf

10. Coordinate and support emergency incident and planned event management through the development and use of integrated Multi-Agency Coordination Systems – (develop and maintain communications between local Incident Command Posts (ICPs), local 911 centers, local Emergency Operating Centers (EOCs) and the state EOC); and

11. Implement processes, procedures and plans to communicate timely, accurate information to the public during an incident using a Joint Information System and Joint Information Center.

Summary:

NIMS is still an evolving plan and process. This policy is intended to introduce NIMS and list basic requirements. It is not all inclusive, nor will it be capable of always being a complete document. Agencies and Municipalities are strongly encouraged to use the additional resources and review updates, as they are available.
Additional Resources

1. **Training:**
   - [http://www.security.state.ny.us/training/nims_documents.html](http://www.security.state.ny.us/training/nims_documents.html)
   - [http://www.security.state.ny.us/training/training_calendar.html](http://www.security.state.ny.us/training/training_calendar.html)
   - [http://www.nysemo.state.ny.us/training/semotraining.asp](http://www.nysemo.state.ny.us/training/semotraining.asp)
   - [http://training.fema.gov/EMIWeb/](http://training.fema.gov/EMIWeb/)

2. **NYS Office of Homeland Security NIMS Information Center:**
   - [http://www.security.state.ny.us/training/nims_documents.html](http://www.security.state.ny.us/training/nims_documents.html)
   - [http://www.security.state.ny.us/training/training_calendar.html](http://www.security.state.ny.us/training/training_calendar.html)

   - **NYS Point of Contact**
   - **NYS Office of Homeland Security NIMS Information Coordinator (NIC) Training Guidance:**
     - Telephone: (866) 837-9133
     - Email questions: NIMS@security.state.ny.us

3. **NYS Emergency Management Office (SEMO):**
   - **SEMO Training Guidance/Assistance**
     - [http://www.nysemo.state.ny.us/training/semotraining.asp](http://www.nysemo.state.ny.us/training/semotraining.asp)

4. **FEMA**

   - **NIMS Integration Center (NIC):**
     - [http://www.fema.gov/nims/](http://www.fema.gov/nims/)

   - **NIMS Mutual Aid Ambulance Typing:**
     - [http://www.fema.gov/pdf/emergency/nims/508-3_emergency_medica_%20services_%20resources.pdf](http://www.fema.gov/pdf/emergency/nims/508-3_emergency_medica_%20services_%20resources.pdf)

   - **NIMS Glossary:**

   - **NIMSCAST Access:**
     - [http://www.fema.gov/nimcast/index.jsp](http://www.fema.gov/nimcast/index.jsp)
The following policy for Basic Life Support First Response (BLS-FR) agencies was developed by the Bureau of Emergency Medical Services (BEMS), in cooperation with the New York State EMS Council’s EMS Systems committee. This policy is intended to provide guidance to the managers of agencies that provide BLS first response service to their community. While BLS-FR services are not defined or regulated by Public Health Law, it is vitally important that BLS-FR agencies are integrated into the local EMS systems.

Purpose
The overall intent of providing BLSFR is to ensure adequate, or where possible enhance, the delivery of emergency medical care to the community. This may include, but not be limited to the following:

- Improve overall response times to medical emergencies;
- The delivery of quality prehospital patient care;
- Provide additional BLS treatments such as Public Access Defibrillation (PAD);
- Provide personnel support to transporting agencies by supplementing availability of drivers and care providers;
- Increase availability of personnel for large scale incidents, and
- Improve public awareness of EMS issues in the community and the value of personnel trained in First Aid, CPR and PAD

NYS EMS Agency Code
In order for a BLS-FR agency participating in a local EMS system to obtain an agency code number, the agency needs to provide documentation indicating the following:

- Support from the Executive of the municipality (village, city, town, county) for the territory covered. This may be a mayor, supervisor, board of commissioners or the chairman of a fire district and must be documented in writing.

  AND

- Document being publicly dispatched and providing primary EMS response on a regular and ongoing basis to public emergency medical needs, as defined by 3001(l) of the Public Health Law.
EMS System Participation
The following information must be documented by the BLSFR agency as part of its participation in the local EMS system:

- Description of response plan, including territory served,
- Method of dispatch / activation / radio communications resources used,
- Adherence to state and regional BLS patient treatment protocols,
- A written participation agreement with transporting service(s) to include, but not limited to:
  - Appropriate transfer of patient to insure continuity of care;
  - Agreement with the local ambulance service to transport patients received from the BLSFR agency;
  - Appropriate, timely documentation of patient care (i.e. PCR or equivalent, see NYS-EMS Policy 02-05);
  - Participation in unified incident command;
  - Participation in QA/QI activities;
  - Adherence to State and Regional BLS Treatment protocols, and
  - Management of supply, resupply/retrieval of medical equipment and supplies used, and
- Identify resources to be used:
  - Number and type of vehicle(s);
  - Number and level of EMS certification of the personnel, and
  - Medical equipment and supplies used to deliver patient care. (i.e.: equipment, and supplies such as identified in Part 800.26) coordinated with the transporting ambulance service.

Agencies making application to NYS DOH for recognition as a BLS-FR agency will be required to submit proof of local EMS system participation to their Regional Emergency Medical Services Council for evaluation and written endorsement.

Operations
Operational issues for BLS-FR agencies to consider should include, but not be limited to:

- Written Standard Operating Policies-Guidelines (SOPs / SOGs) that ensure use of state / regional BLS treatment protocols;
- Policies to insure the use of appropriately trained personnel to render patient care. Appropriately trained personnel include Certified First Responder, Emergency Medical Technician\(^1\), Nationally recognized First Aid and/or CPR and Public Access Defibrillation (PAD);

\(^1\) Personnel certified at Advanced EMT levels may **NOT** render care beyond the scope of practice of an EMT when providing care for a BLS-FR service. Defibrillation may only be provided by agencies with either PAD authority or BLS-Defibrillation authority as granted by a Regional Emergency Medical Advisory Committee.
• Policies that insure patient care rendered is by the individuals with the highest present level of EMS training/certification;
• Documentation of patient care rendered and secure storage of medical records;
• Training and Continuing Education;
• Policies regarding infection control, confidentiality, liability, minors, psychiatric patients, mandatory reporting of child abuse or Methamphetamine Laboratories, refusal of medical aid (RMA) and other special situations;
• Mutual Aid / MCI / Haz-Mat planning;
• Periodic review and renewal of participation agreements with transporting agency(s);
• Communications method used to talk to both dispatch and the arriving ambulance to report patient status and scene information. Such communications needs to include ability to contact medical control if required;
• A detailed list of equipment provided by the BLSFR agency. All equipment needs to be compatible with the equipment and vehicles used by the ambulance service(s). The attached list from Part 800.26 is a reasonable reference for developing an equipment list; and
• Incident management training / National Incident Management System (NIMS) Compliance.

Defibrillation
BLSFR agencies are encouraged to provide defibrillation by being a Public Access provider. Contact your Regional EMS Council or the Bureau of EMS for current information on providing PAD or see DOH Policy Statement #06-03, Public Access Defibrillation.

Additional Resources
Additional resource information may be found at the NYS DOH web site.

www.health.state.ny.us/nysdoh/ems/main.htm
800.26 EMERGENCY AMBULANCE SERVICE VEHICLE EQUIPMENT REQUIREMENTS

The governing authority of any ambulance service, which, as a part of its response system, utilizes emergency ambulance service vehicles, other than an ambulance to bring personnel and equipment to the scene, must have policies in effect for equipment, staffing, individual authorization, dispatch and response criteria and appropriate insurance.

(a) A waiver of the equipment for emergency ambulance service vehicles may be considered when the service provides an acceptable plan to the Department demonstrating how appropriate staff, equipment and vehicles will respond to a call for emergency medical assistance. The Regional EMS Councils will be solicited for comment.

(b) Any emergency ambulance service vehicle shall be equipped and supplied with emergency care equipment consisting of:

(1) 12 sterile 4 inches x 4 inches gauze pads;
(2) adhesive tape, three rolls assorted sizes;
(3) six rolls conforming gauge bandage, assorted sizes;
(4) two universal dressings, minimum 10 inches x 30 inches;
(5) six 5 inches x 9 inches (minimum size) sterile dressings or equivalent;
(6) one pair of bandage shears;
(7) six triangular bandages;
(8) sterile normal saline in plastic container (1/2 liter minimum) within the manufacturer's expiration date;
(9) one air occlusive dressing;
(10) one liquid glucose or equivalent;
(11) disposable sterile burn sheet;
(12) sterile obstetric [O.B.] kit;
(13) blood pressure sphygmomanometers cuff in adult and pediatric sizes and stethoscope;
(14) three rigid extrication collars capable of limiting movement of the cervical spine. These collars shall include small, medium and large adult sizes; and
(15) carrying case for essential equipment and supplies.

(c) Oxygen and resuscitation equipment consisting of:

(1) portable oxygen with a minimum 350 liter capacity with pressure gauge, regulator and flow meter medical "D" size or larger. The oxygen cylinder must contain a minimum of 1000 pounds per square inch.
(2) manually operated self-refilling bag valve mask ventilation devices in pediatric and adult sizes with a system capable of operating with oxygen enrichment and clear adult, and clear pediatric size masks with air cushion;
(3) four individually wrapped or boxed oropharyngeal airways in a range of sizes.
(d) For pediatric and adult patients;
(4) two each: disposable non-rebreather oxygen masks, and disposable nasal cannula individually wrapped;
(5) portable suction equipment capable, according to the manufacturer's specifications, of producing a vacuum of over 300 mmHg when the suction tube is clamped and including two plastic large bore rigid pharyngeal suction tips, individually wrapped; and
(6) pen light or flashlight.

(d) A two-way voice communications enabling direct communication with the agency dispatcher and the responding ambulance vehicle on frequencies other than citizens band.

(e) Safety equipment consisting of:
   (1) six flares or three U.S. Department of Transportation approved reflective road triangles;
   (2) one battery lantern in operable condition; and
   (3) one Underwriters' Laboratory rated five-pound ABC fire extinguisher or any extinguisher having a UL rating of 10BC.

(f) Extrication equipment consisting of:
   (1) one short backboard or equivalent capable of immobilizing the cervical spine of a [sitting] seated patient. The short backboard shall have at least two 2 inches x 9 foot long web straps with fasteners unless straps are affixed to the device; and
   (2) one blanket.
As prehospital care becomes more sophisticated and hospital care more specialized, it is important to clarify the responsibilities of ambulance services to transport their patients to the appropriate medical facility destination. EMS services are required by either state or regional EMS medical advisory committees to transport patients to hospitals with special designations.

**BACKGROUND**

While Article 30 of the New York State Public Health Law defines ambulance service, it does not require ambulances to transport patients to specific hospital destinations. However, the New York State Emergency Medical Services Council has made the following statements concerning the transport of emergency patients:

- All ambulance patients can expect to be informed of the need to be taken to a medical facility capable of providing appropriate emergency medical care.  

- The triage and transport of out of hospital patients must be based upon established principles of emergency medical practice, including pre-established state and regional medical protocols and guidelines. For any given patient, the appropriateness of the receiving facility to provide emergency care is a medical decision. Therefore, the direction or redirection of a transporting vehicle cannot be made without medical approval based upon established Regional Emergency Medical Services System protocols.

Also, the NYS Basic Life Support Protocols, which Part 800 regulations require all Emergency Medical Technicians to comply with specify:

- Major Trauma Protocols – If the patient meets any one of the criteria delineated in the protocols, they must be transported to a regional trauma center.

- Suspected Stroke – A. Transport the patient to the closest New York State Department of Health designated Stroke Center if the total prehospital time is less than two hours.

Additionally, a Regional Medical Advisory Committee (REMAC) may have developed treatment and transport protocols that address local conditions and require that patients be transported to specific facilities in certain situations.
POLICY

Based on the mechanism of injury, assessment findings, treatment, state and local protocol, a patient, in need of emergency medical care must be taken to the nearest appropriate health care facility capable of treating the illness, disability or injury of the patient. Ambulance services are under no obligation to transport patients to medical facilities not licensed under Article 28 of the Public Health Law. It is expected that the EMS provider will consult with a medical control physician, should there be questions of protocol, policies, procedures and transport destinations.

In non-emergency situations, ambulance services may make transports to facilities such as physician’s offices, diagnostic and treatment centers (DT&C), free standing emergency clinics or other destinations. However, the ambulance crew must be aware of the emergency care capabilities of such facilities at the time of the patient request.

A patient's choice of hospital or other facility should be complied with unless contraindicated by state, regional or system/service protocol or the assessment by a certified EMS provider shows that complying with the patient's request would be injurious or cause further harm to the patient. Patient transfer can be arranged following emergency care and stabilization. In such cases, the EMT should fully document the patient's request and the reasons for the alternate destination decision, including any medical control consultation.

HOSPITAL DIVERSION REQUESTS

A hospital may notify the EMS system of a temporary inability to provide care in the emergency department (ED) and request ambulances divert patients to an alternate hospital facility. A request to divert to another facility may be honored by EMS providers. A diversion request does not mean the hospital ED is closed, but usually means the current emergency patient load exceeds the Emergency Department's ability to treat additional patients promptly. If the patient's condition is unstable and the hospital requesting diversion is the closest appropriate hospital, ambulance service personnel should notify the hospital of the patient's condition and to expect the patient's arrival. This procedure should also be followed when a patient demands transport to a facility on diversion. The hospital may not refuse care for a patient presented. Should an issue arise, the EMS provider should consult with a medical control physician.

Endnote:

1. Ambulance Patient's Bill of Rights, NYSEMS Council, 1998 Emergency Medical Services Plan
2. Access to Emergency Care in a Managed Care Environment, NYSEMS Council, 1998 Emergency Medical Services Plan
3. Adult and Pediatric Major Trauma Protocols, T-6, T-7, May, 2004
4. Suspected Stroke Protocol, M-17, January, 2005
Purpose:

Air Medical Services (AMS) are a valuable, yet limited resource in New York State. It is important that Emergency Medical Service Personnel utilize consistent and appropriate criteria when requesting an air medical service for assistance with patient care and transport. The following represents a combination of the current criteria in use throughout the state. These criteria are consistent with national AMS utilization criteria. It is important that review of appropriate helicopter utilization be a part of EMS training, as well as a component of the agency and regional level retrospective quality assurance process.

Criteria:

1. The helicopter is an air ambulance and an essential part of the EMS system. It may be considered in situations wherein:
   - The use of the helicopter would speed a patient’s arrival to the hospital capable of providing definitive care and this is felt to be significant to the patient’s condition, or;
   - If specialized services offered by the air medical service would benefit the patient prior to arrival at the hospital.

2. The following criteria should be used when considering use of an air medical service:
   - The patient’s condition is a “life or limb” threatening situation demanding intensive multidisciplinary treatment and care. This may include but not be limited to:
     - Patients with physical findings defined in the adult and pediatric major trauma protocols (see attached)
     - Critical burn patients (see attached)
     - Critically ill medical patients requiring care at a specialized center to include, but not be limited to: acute stroke or ST elevation MI as defined by NYS protocol (see attached); and/or
     - Patients in cardiac arrest who are not hypothermic should be excluded from these criteria

3. Dispatch, Police, Fire or EMS will evaluate the situation/condition and if necessary, may place the helicopter on standby.
4. The helicopter may be requested to respond to the scene when:
   - ALS personnel request the helicopter.
   - BLS personnel request the helicopter, when ALS is delayed or unavailable.
   - In the absence of an EMS agency, any emergency service may request the helicopter, if it is felt to be medically necessary.

5. When EMS arrive, they should assess the situation. If the MOST HIGHLY TRAINED EMS PERSONNEL ON THE SCENE determine, that the helicopter is not needed, it should be cancelled as soon as possible.

6. When use of air medical services is not specifically defined by the protocol, the on scene EMS provider should establish communication with medical control to discuss the situation with the on line physician.

7. Air medical services may be considered in situations where the patient is inaccessible by other means or, if utilization of existing ground transport services threatens to overwhelm the local EMS system.

8. The destination facility will be determined by the AMS crew based upon medical appropriateness with consideration for patient preference and on line medical direction, in compliance with regional protocols.

9. An EMS service should not wait on the scene or delay transport waiting for the helicopter to arrive. If the patient is packaged and ready for transport, the EMS service should initiate transport to the hospital and reassign the landing zone. The helicopter may intercept with an ambulance during transport at an alternate-landing site.

Transfer of Patient Care, Documentation and Quality Assurance:
   - As with other instances where care of a patient is transferred, it is expected that all patient related information, assessment findings and treatment will be communicated to the flight crew.
   - At the completion of the EMS call, all of the details of the response, including, but not limited to all patient related information, assessment findings and treatment must be documented on a Department approved Patient Care Report (PCR).
   - As with all EMS responses, helicopter utilization, the treatment and transportation of patients will be reviewed as a part of a Quality Assurance process.
**ADULT MAJOR TRAUMA**

1. GCS less than or equal to 13
2. Respiratory Rate less than 10 or more than 29 breaths per minute
3. Pulse rate is less than 50 or more than 120 beats per minute
4. Systolic blood pressure is less than 90mmHg
5. Penetrating injuries to head, neck, torso or proximal extremities
6. Two or more suspected proximal long bone fractures
7. Suspected flail chest
8. Suspected spinal cord injury or limb paralysis
9. Amputation (except digits)
10. Suspected pelvic fracture
11. Open or depressed skull fracture

**PEDIATRIC MAJOR TRAUMA**

1. Pulse greater than normal range for patient’s age
2. Systolic blood pressure below normal range
3. Respiratory status inadequate (central cyanosis, respiratory rate low for the child’s age, capillary refill time greater than two seconds)
4. Glasgow coma scale less than 14
5. Penetrating injuries of the trunk, head, neck, chest, abdomen or groin.
6. Two or more proximal long bone fractures
7. Flail chest
8. Combined system trauma that involves two or more body systems, injuries or major blunt trauma to the chest or abdomen
9. Spinal cord injury or limb paralysis
10. Amputation (except digits)

**CRITICAL BURNS**

1. Greater than 20% Body Surface Area (BSA) second or third degree burns
2. Evidence of airway/facial burns
3. Circumferential extremity burns

**CRITICAL MEDICAL CONDITIONS**

1. Suspected acute stroke
   - Positive Cincinnati Pre-hospital Stroke Scale
   - Total prehospital time (time from when the patient’s symptoms and/or signs first began to when the patient is expected to arrive at the Stroke Center) is less than two (2) hours.
2. Suspected Acute Myocardial Infarction
   - Chest pain, Shortness of breath or other symptoms typical of a cardiac event
   - EKG findings of
     - ST elevation 1mm or more in 2 or more contiguous leads
     OR
     - LBBB (QRS duration >.12msec and Q wave in V1 or V2)

**Note that for patients with burns and coexisting trauma, the traumatic injury should be considered the first priority and the patient should be triaged to the closest appropriate trauma center for initial stabilization.**
BACKGROUND

At the January, 2005 meeting of the New York State Emergency Medical Advisory Committee (SEMAC), the use of glucometers by Emergency Medical Technicians (EMT) in Basic Life Support (BLS) EMS agencies was approved. The SEMAC approval was granted with the specific condition that the EMS service wishing to use a glucometer at the BLS level, be granted approval by the local Regional Emergency Medical Advisory Committee (REMAC), each EMT complete an approved training program and the service apply and be granted a Limited Laboratory Registration.

The purpose of this policy is to explain the approval process for agencies wishing to implement a glucometry program. The addition of prehospital blood sugar evaluation is intended to assist in the recognition of hypoglycemia and improve the speed with which proper treatment is received.

AUTHORIZATION

Each REMAC, interested in allowing their BLS EMS agencies to participate, will adopt protocols which will allow a basic EMT to obtain a blood sample, using a lancet device, or equivalent and test the blood sample in a commercially manufactured electronic glucometer. The REMAC will also determine the type and level of record keeping and quality assurance required for this procedure.

To be authorized to use an electronic glucometer, the EMS agency must make written request to the local Regional Emergency Medical Advisory Committee (REMAC). The request must include, but not be limited to the following items and possess the necessary Clinical Laboratory authorizations required by Public Health Law.

- Include a letter from the service medical director supporting the request and indicating an understanding of their role in the quality assurance process.
• Complete the NYS Department of Health Clinical Laboratory Limited Laboratory Registration application (DOH-4081) for blood testing licensure.

• Develop written policies and procedures for the operation of the glucometer that are consistent with local protocol. This shall include at least the following:
  • written policies and procedures for the training and documentation of authorized users;
  • a defined quality assurance program, including appropriateness review by the medical director;
  • documentation of control testing process; and
  • written policies and procedures for storage of electronic glucometer, and proper disposal of sharps devices.

**LIMITED LABORATORY REGISTRATION**

The law requires that any EMS service testing blood glucose, whether by electronic glucometer or chemstrip, be required to possess a **Limited Laboratory Registration**. In order to obtain the Registration, EMS agencies must complete and submit the following documents:

• **Limited Service Laboratory Registration (DOH-4081)**

• **Disclosure of Ownership and Controlling Interest Statement (DOH-3486)**

The information and appropriate application paperwork is available at:

http://www.wadsworth.org/labcert/clep/Administrative/ChangeForms.htm

*No EMS service may engage in the testing of blood glucose without a registration permit.*

**NOTIFICATION**

Once the EMS service has received written approval from the REMAC, the EMS Service must provide the Bureau of EMS with a new **Medical Director Verification Form (DOH-4362)**, indicating the Limited Laboratory Registration permit number and authorization by the service medical director.
10NYCRR Part 800.26 – Emergency Ambulance Service Vehicles

In November of 2004, amendments to the Part 800.26, which address Emergency Ambulance Service Vehicles (EASV) went into effect. The proposed amendments are intended to allow local EMS systems and agencies an increased flexibility in determining the best and most appropriate configuration for assigning vehicles to emergency response in order to meet system, local EMS personnel, deployment and patient needs.

The new sections of the regulation are as follows:

The governing authority of any ambulance service, which, as a part of its response system, utilizes emergency ambulance service vehicles, other than an ambulance to bring personnel and equipment to the scene, must have policies in effect for equipment, staffing, individual authorization, dispatch and response criteria and appropriate insurance.

(a) A waiver of the equipment for emergency ambulance service vehicles may be considered when the service provides an acceptable plan to the Department demonstrating how appropriate staff, equipment and vehicles will respond to a call for emergency medical assistance. The Regional EMS Councils will be solicited for comment. . . .

Policy

The purpose of an EASV, which remains unchanged by this amendment and policy, is to deliver personnel and/or equipment to the scene of a medical emergency. Ambulance services must still address and document how this purpose is met whenever an EASV equipment waiver is requested.

Part 800.26(b) is the list of equipment required for all EASVs. This list represents the minimum amount of equipment and supplies necessary for an EMS provider to respond to a scene to care for a sick or injured patient. The amendment to the regulation specifically allows for an ambulance service to request that the Department of Health, Bureau of EMS (BEMS), in consultation with the Regional EMS Council (REMSCO), waive some, or all of the equipment requirements listed in Part 800.26(b). In order for a waiver to be considered, the
following criteria must be met.

- A request for an equipment waiver must be made in writing to BEMS.
  - The letter must be on the EMS agency’s official letterhead.
  - The letter must detail what specific equipment and/or supplies are to be waived.
  - The letter must include the reason the waiver is being requested.
  - The letter must include the agency’s EASV policies and procedures addressing equipment, staffing, individual authorizations, dispatch, response criteria and appropriate insurance.
  - The letter must be signed by the agency’s chief executive officer (CEO), or the head of the governing body (i.e. Chairman of the board of commissioners, president or mayor)
  - The ambulance service must submit a complete and executed Affirmation of Compliance (DOH-1881) identifying each EASV.

- A copy must be provided to the REMSCO(s).

The complete regulation, including the equipment list is available on the Department’s web site at [www.health.state.ny.us/nysdoh/ems/part800.htm#800.26](http://www.health.state.ny.us/nysdoh/ems/part800.htm#800.26)

**Important Notes**

In addition to the Part 800 requirements, the operation of any EASV must be in compliance with all applicable New York State Vehicle and Traffic Laws. Additionally, when equipped with red lights and siren, the EASV must be insured with the appropriate coverage as an emergency vehicle. No waivers for appropriate policies and procedures or vehicle insurance will be granted.

This policy statement **DOES NOT SUPERCEDE** DOH EMS Policy Statement 01-01. Policy Statement 01-01 is intended to clarify the requirements and procedures for authorization of Emergency Ambulance Service Vehicles (EASV).

Authorization as an EASV involves more than just the use of red lights and a siren on a vehicle. It is expected that every EASV be in compliance with all of the provisions of 10 NYCRR Part 800.21 & .26. This includes proper agency identification; vehicle marking and patient care equipment. All vehicles authorized by the service as EASVs may be subject to inspection. In the event violations to the code are found, the violations will be charged against the service authorizing the vehicle.
In an effort to improve response times, provide the correct resources to patients, Emergency Medical Services agencies are more frequently posting their vehicles in designated locations within their response areas. As a result, many emergency vehicles engines sit idling for extended periods of time to facilitate proper climate controls. Because of the associated health and environmental risks, excessive idling of trucks and buses is a violation of Federal, New York State and New York City environmental laws.

Based on these laws, it is expected that EMS agencies will examine their general operating procedures regarding posting EMS vehicles and system status management and develop polices that will insure proper compliance. While ambulances are considered emergency vehicles under the Vehicle and Traffic Law, allowing these vehicles to idle for excessive periods of time in non-emergency operation is not permitted.

The Department of Health, Bureau of EMS considers on-scene operations, or the positioning of an ambulance/EMS response vehicle in designated locations within a community, as a component of a planned emergency response system, to be emergency operation. However, when EMS agencies position vehicles, consideration must be given to the impact on the community. The EMS agency must be flexible in re-positioning vehicles to limit the environmental impact on the community.

The New York State and New York City laws limit the amount of time a truck or bus may idle. Vehicle owners and operators, and in some cases people who control buildings or land, are subject to fines and legal actions for violations. All truck and bus drivers should insure that vehicle idling is minimized, and that engine idling times are within the legal limits prescribed by law.
The following are sections of both the State law as well as the New York City law.

**Under New York State Environmental Conservation Law, heavy duty trucks and buses may not idle for more than five (5) consecutive minutes.**

The exceptions to the law include:

- When the engine is powering an auxiliary function, such as loading or unloading cargo, or mixing concrete;
- When running the engine is required for maintenance; or
- When fire, police, utility or other vehicles are performing emergency services.

**Under New York City Environmental Protection Law, trucks and buses may not idle for more than 3 consecutive minutes.**

The law provides for two exceptions:

- When the engine is powering a loading, unloading, or processing device; or
- When the vehicle is a legally authorized emergency vehicle.

Unless in emergency operation, ambulances and first response vehicles ARE NOT exempt from the provisions of these environment conservation laws. The penalties for violation of these laws may include fines ranging from $250 to $15,000.

For more information:

- New York State’s idling regulation is found at 6 NYCRR § 217-3.2.
- New York City’s idling regulation is found at NYC Administrative Code § 24-163.
- The American Lung Association - [www.alanys.org](http://www.alanys.org)
- The US Environmental Protection Agency – [www.epa.gov/otaq](http://www.epa.gov/otaq)
- The NYS Attorney General – [www.oag.state.ny.us](http://www.oag.state.ny.us)
- The NYS Department of Environmental Conservation – [www.dec.state.ny.us](http://www.dec.state.ny.us)
EMT-Basic Assisted Medication Administration

This policy is intended to delineate the role of the EMT-B in assisting a patient in taking his or her own pre-prescribed medication(s). The only medications included in the training curriculum and protocols are Nitroglycerin (tablet or spray), Bronchodilator (metered dose inhaler) and epinephrine in an auto-injector.

Definitions:

1. Pre-prescribed medications are those medications that are prescribed by a physician for a specific patient prior to an emergency and are present at the scene of the emergency.

2. "Assisting" means delivering a patient's pre-prescribed medication, regardless of who delivers the medication.

3. “Contraindication” or “contraindicated” means that the condition of the patient does not require, or may be dangerous to the patient if administered or the patient does not meet the criteria set forth by the published protocols.

Procedure:

1. A certified EMT-B should deliver pre-prescribed nitroglycerin or a bronchodilator to a patient if the patient indicates (verbally, by gesture, etc.) their desire to take their medication and the delivery of such medication is not contraindicated by protocol or the EMT-B's training. If there is any question, contact Medical Control.

**NOTE:** There is no circumstance when it would be proper to deliver either nitroglycerin or a bronchodilator to a patient who can not indicate their desire to take their pre-prescribed medication.
NOTE: As stated, this procedure prevents an EMT-B from delivering either of these medications to an unconscious or unwilling patient. The contraindication statement is added for cases where the patient indicates their desire to take their medication but it is contraindicated by the patient’s presentation or condition.

2. A certified EMT-B should deliver pre-prescribed epinephrine by auto-injector to a patient who exhibits signs/symptoms consistent with the indications for the medication and protocol or the EMT-B’s training does not contraindicate the medication. If there is any question, contact Medical Control.

NOTE: There are many scenarios in which the patient may not be able to indicate their desire to take their pre-prescribed epinephrine and the EMT-B must make the decision to do so. The EMT-B is trained to recognize the signs and symptoms of anaphylaxis and the contraindications for epinephrine. In cases of an allergic reaction, where the patient is conscious and alert, the patient should be able to participate in the decision and the delivery of the epinephrine auto-injector.

Special Circumstances:

Experience has shown that "assisted medications" may not be labeled with the patient's name on the container, inhaler or auto-injector carried by the patient. In this circumstance, if the patient indicates a desire to take the medication, the following should be considered:

- The medication has been identified as being the patient's pre-prescribed medication by a claim (the patient or family member states that it belongs to the patient) or an appearance (is in the patient's pocket or purse, etc).
- The patient exhibits signs/symptoms consistent with the indications for the medication.
- Protocol or the EMT-B's training does not contraindicate the medication.

Only then should the EMT-B assist in delivering the medication. In addition, the container, inhaler or auto-injector may not be labeled with the name of the medication.

- In no case should an EMT-B assist in the delivery of a medication from a container, inhaler, or auto-injector that is not labeled with the name of the medication.
- In cases where the label indicates that the medication is outdated, the EMT-B must contact Medical Control for direction. If there is any question, contact Medical Control.

NOTE: Signs/symptoms and indications for the assisted medication are included in the New York State EMT-B curricula.
MAINTENANCE OF IVs BY EMERGENCY MEDICAL TECHNICIANS - BASICS

This policy is intended to clarify that an Emergency Medical Technician–Basic (EMT-B) may not transport a patient with an intravenous line (IV) in place. The Department of Health, Bureau of Emergency Medical Services (BEMS) at the request of the State Emergency Medical Advisory Council (SEMAC) was asked to clarify the role of an EMT-B in providing care to patients who require IV therapy.

This issue has been addressed previously by the Department of Health and the SEMAC. A former opinion provided by the Bureau of Emergency Medical Services (EMS) in September 1991, indicated that a non-medicated IV could be maintained and discontinued by a basic EMT if special training were provided to the EMT, and the training was documented by the ambulance service. This opinion is now rescinded in part due to the changing composition of pre-hospital care providers. In the mid-1980s, there were a minimal number of advanced EMS providers who were able to respond to the demands of facilities requiring the transportation of patients requiring IV maintenance. Currently, there are significantly more ALS providers who can appropriately care for patients that require advanced EMS care and IV therapy.

Policy

The SEMAC has determined that it is no longer permissible 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:
1. Intravenous lines with fluid.
2. Intravenous lines with medication.
3. 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 secured and dressed prior to leaving the health care facility.
Summary

Hospitals and long term care facilities are responsible under state and federal regulations to assure a patient is transported with the appropriate level of medical care necessary to the patient’s medical condition. The transport of a patient with an IV, medicated or non-medicated, requires the presence of an advanced emergency medical technician or a licensed health care provider with the appropriate skills. A basic level ambulance may transport a patient with an IV only if the hospital or nursing home provides appropriate medical staff to accompany the patient to maintain the IV. If the hospital or nursing home cannot provide medical staff during the transport of the patient, then an advanced life support ambulance service must provide the service. In order for an EMT-B to care for the patient, the IV must be discontinued or secured with a non-medicated saline lock device during transport.

Issued By:
Edward G. Wronski, Bureau Director
In conjunction with the SEMAC
Introduction:
This policy was prepared in conjunction with the Department’s Planning Work Group for Disease Prevention. The Bureau of Emergency Medical Services (BEMS) strongly recommends that all EMS services review this guidance document, along with other state and county public health recommendations to prepare your EMS agency’s response to a patient with an infectious respiratory illness suspected of being SARS. BEMS is sharing this Policy Statement with County EMS Coordinators, Public Health Directors, REMACs, Regional EMS Councils, Program Agencies and Dispatch Centers.

EMS providers should be aware of the signs and symptoms of infectious respiratory diseases, SARS-CoV (SARS) and the procedures necessary for protecting themselves. Not all respiratory infections are transmitted in the same way. Transmission can occur from direct or indirect contact, large droplets, or small droplet nuclei. The mode of transmission will depend on the etiological agent. Certain procedures can also impact transmission of infectious agents by producing aerosols. These are deemed “high risk respiratory procedures” and include intubation, extubation, deep tracheal suctioning, nebulized respiratory treatments and bronchoscopy. More often in the field of emergency medicine, the etiologic agents of infections are unknown. Given this, it is paramount that good infection control practices be followed for contact with all patients.

SARS – Background:
A new emerging infection, Severe Acute Respiratory Syndrome (SARS), has heightened awareness of the importance of utilizing good infection control practices to prevent the transmission of respiratory diseases. Information from the SARS outbreaks worldwide during the spring of 2003 suggests that SARS is transmitted through close contact with infected persons. SARS is most likely spread by droplet transmission, however, the possibility of airborne transmission and spread through inanimate objects cannot be ruled out. Healthcare procedures that produce aerosols (e.g. nebulized respiratory treatments, intubation/extubation and deep tracheal suctioning) appear to have an impact on the transmissibility of SARS.

In discussion with Ontario EMS recently we learned about the dramatic effect a SARS outbreak can have on a community and specifically its prehospital health care community. However, we also learned from our Canadian EMS neighbors that three prehospital care providers acquired the disease with their first SARS contact at the beginning of the outbreak. The infected EMS providers were those who did not use PPE (i.e. N95 mask) or used it late. Once the infective nature of the disease was realized, all EMS personnel were required to don PPE including an N95 mask, eye protection, gowns, gloves and practice good hand hygiene. There were no additional infections of EMS personnel after this policy was implemented. NYS EMS should learn from this, follow appropriate protective procedures and prevent the spread of infection.

In the absence of identified SARS cases in the world, implementing the infection control strategies of Standard and Droplet Precautions for respiratory infections of unknown etiology with the additional incorporation of Respiratory Etiquette principles will control transmission without overburdening the healthcare system. Implementation of this strategy will likely impact the transmission of seasonal circulating infections that are transmitted by respiratory spread (e.g. influenza, adenovirus, respiratory syncytial virus, and Mycoplasma pneumoniae).
Purpose:
Guidance for infection control and prevention for SARS will be dependant on the emergence of SARS worldwide, nationwide, statewide, and/or locally. Approaching infection control measures according to the level of known SARS activity will enable healthcare programs to maintain an environment that is safe for the prevention of communicable disease outbreaks, while not overtaxing the healthcare system with intensive isolation procedures and public health notifications. The intention of this document is to assist EMS Agencies in the planning for SARS cases and to provide specific infection control guidance for the following scenarios: no SARS transmission has been identified in the world; SARS transmission identified in the world, but no transmission locally; and SARS transmission identified locally.

Infection Control Guidance
Preparedness Planning for the Re-emergence of SARS:
1. BEMS strongly recommends the following for EMS services and providers:
   a) Fit testing for an N-95 or higher respirator mask
   b) Education on performing a “fit check” (conforming the mask to the face and checking for air leaks) after donning N95 respirators
   c) Frequent and on-going education including, but not limited to infection control measures, PPE as well as proper personal/hand hygiene.
   d) Routine flu vaccinations and other preventative health measures
2. EMS services should monitor their crews for any type of infectious illness:
   a) EMS management should monitor any provider that presents with signs and symptoms of a respiratory illness. Services should consider the following (in order of preference):
      - Release staff from duty until they have sought medical attention and have sufficiently recovered.
      - Assigning staff to non-patient care related duties for the duration of their illness.
      - Require EMS providers to don surgical masks to protect their patients while providing care.
      - The EMS medical director and the County Public Health Office should be advised of any EMS healthcare provider who is hospitalized with pneumonia.

No SARS Identified Worldwide:
1. Practice Body Substance Isolation (BSI) or Standard Precautions. Utilize personal protective equipment (PPE -e.g. use of gown, gloves and eye protection/face shield) based on the contact with bodily substances that is anticipated. More information on Standard Precautions can be found on the following Centers for disease Control and Prevention (CDC) Website: http://www.cdc.gov/ncidod/hip/ISOLAT/Isolat.htm.
2. Utilize the Standard Respiratory Precautions below for all patients presenting with respiratory symptoms. This includes wearing a surgical mask within 3 feet of the patient.
3. Prior to transporting a patient with respiratory symptoms, the door between the driver and the patient compartment should be closed. If the vehicle does not have a barrier between the cab and the patient compartment, the driver and front seat passenger should also wear surgical masks.
4. Hands must be properly washed or disinfected with a waterless hand sanitizer immediately after removal of gloves. Do not wait until you return to the ambulance station to practice hand hygiene.
5. Assure adequate cleaning of the equipment and vehicles between transports. This cleaning should minimally include:
   a. Use of an Environmental Protection Agency (EPA) approved disinfectant;
   b. Disinfection of any reusable equipment used on the patient as per the manufacturer’s instructions;
   c. Frequently touched surfaces of the vehicle;
   d. Visibly soiled surfaces.
6. Medical procedures, such as nebulized respiratory treatments, that may re-aerosolize infectious material should only be done if medically necessary. It is recommended that mechanical ventilators, including BVM devices and suction equipment, should be fitted with a HEPA filter, if available, to prevent re-aerosolization. EMS services should contact equipment manufacturers for recommendations on a HEPA filter.

7. Humidified oxygen use should be suspended for the treatment of a suspected SARS patient unless otherwise directed by medical control.

<table>
<thead>
<tr>
<th>Standard Respiratory Precautions</th>
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<tbody>
<tr>
<td>➢ Provide surgical masks to all patients with symptoms of a respiratory illness. Provide instructions on the proper use and disposal of masks.</td>
</tr>
<tr>
<td>➢ For patients who cannot wear a surgical mask, provide tissues and instructions on when to use them (i.e., when coughing, sneezing, or controlling nasal secretions), how and where to dispose of them, and the importance of hand hygiene after handling this material.</td>
</tr>
<tr>
<td>➢ Implement use of surgical or procedure masks by healthcare personnel during the evaluation of patients with respiratory symptoms.</td>
</tr>
<tr>
<td>➢ Continue to use droplet precautions to manage patients with respiratory symptoms until it is determined that the cause of symptoms is not an infectious agent that requires precautions beyond standard precautions.</td>
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</table>

SARS Re-emerges in the World without Local Transmission:

1. Follow the recommendations in Specific Infection Control Guidance – No SARS Transmission Identified Worldwide.

2. Assign a point person to regularly access CDC Website http://www.cdc.gov/ncidod/sars/ to obtain updated information on the epidemiology of SARS, and to share the up to date case definition with EMS personnel.

3. Screen all patients for fever, respiratory symptoms, and SARS risk factors.

   SARS risk factors include:
   - Travel within 10 days of illness onset to a foreign or domestic location with documented or suspected recent local transmission of SARS, or
   - Persons who had close contact within the last 10 days of illness onset with an ill traveler who had recently returned from an area with documented or suspected recent local transmission of SARS, or
   - Employment as a healthcare worker, or
   - Close contact within 10 days of illness onset, with a person with confirmed or probable SARS or SARS report under investigation.

3. For Patients meeting the established SARS case definition, Temperature of >100.4°F (>38°C) and one or more clinical findings of respiratory illness (e.g., cough, shortness of breath, difficulty breathing, or hypoxia):
   a. Utilize Airborne, Contact, and Standard Precautions, including a fit-tested N95 respirator, gloves, gown and approved eye protection (e.g. face shield or goggles).
   b. Prior to transporting the patient, the door between the driver and the patient compartment should be closed. If the vehicle does not have a barrier between the cab and the patient compartment, the driver and front seat passenger should also wear fit-tested N95 respirators. Do not use any air-recirculating mechanisms in the vehicle, and consider opening a window for fresh air exchanges.
   c. Perform high-risk procedures that increase aerosolization (nebulized treatments, deep tracheal suctioning, intubation/extubation), only if medically necessary; do not use humidified oxygen.
   d. After treating and transporting any patient with a infectious respiratory illness or a suspected SARS case, decontamination and waste disposal procedures should be followed:
The ambulance patient compartment, including stretchers, railings, medical equipment, control panels and adjacent flooring, counter tops should be cleaned using a recommended EPA approved disinfectant in accordance with manufacturer’s specifications.

- All PPE as well as disposable equipment and supplies used while treating patients should be disposed as regulated medical waste.
- Spills of body fluids should be cleaned by placing absorbent material over the spill and collecting the material in a biohazard bag for disposal.
- Personnel cleaning the vehicles should be appropriately protected.

e. If treating and transporting a patient suspected to have SARS, the EMS service must immediately notify:

- The destination hospital prior to arrival of the suspected case of SARS and the possible need for an airborne infection isolation room and proper precautions. Do not identify the patient as a suspected SARS patient over the radio. Please utilize either a cellular or landline telephone.
- The County Public Health Officer

**SARS Re-emerges in the World with Local Transmission:**

1. Follow the recommendations above for Specific Infection Control Guidance – No SARS Transmission Identified Worldwide and SARS Re-emerges in the World without Local Transmission.

2. Actively screen all patients for fever or respiratory symptoms.

3. Utilize Airborne, Contact, and Standard Precautions, including a fit-tested N95 respirator, gloves, gown and approved eye protection (e.g. face shield or goggles) for all patients presenting with respiratory symptoms.

4. Notify the receiving hospital of the need for an Airborne Isolation room or SARS designated unit.

**Conclusion:**

It is vitally important that the EMS community regularly utilize Standard Precautions and Personal Protective Equipment when treating all patients with a suspected infectious disease. Changing routine habits to include these measures will allow EMS providers to protect themselves against known infectious diseases as well as SARS - CoV or other new emerging diseases.

In addition to changing habits, providing initial and on going education on disease prevention, personal hygiene and hand washing techniques, equipment and vehicle cleaning will allow the EMS community to protect patients and itself against all types of infectious diseases.

For Additional Resources:

Please review the information provided at the following web sites;

1. www.health.state.ny.us
2. www.cdc.gov

**References:**

1. CDC Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS), IV - Infection Control for Prehospital Emergency Medical Services, January 8, 2004
2. Policy Statement 03-11, Respiratory Disease Precautions

Issued By: Edward Wronski, Bureau Director
With the participation of the DOH Infectious Disease Clinical Workgroup
Introduction:
It is the intention of this Policy Statement to provide information and recommendations for the transport of patients with potentially infectious respiratory illnesses. This policy will also provide updated guidelines for “respiratory etiquette” and the use of Personal Protection Equipment (PPE) as well as recommendations for preventive health care measures for EMS providers.

This policy was prepared in conjunction with the Department’s Planning Work Group for Disease Prevention. The Bureau of Emergency Medical Services (BEMS) strongly recommends that all EMS agencies review this guidance document, along with other state and county public health recommendations to prepare your EMS agency response to a patient with an infectious respiratory illness. BEMS is sharing this Policy Statement with County EMS Coordinators, Public Health Directors, REMAC, Regional EMS Councils, Program Agencies and Dispatch Centers.

A new emerging infection, Severe Acute Respiratory Syndrome (SARS), has heightened awareness of the importance of utilizing good infection control practices to prevent the transmission of respiratory diseases. Information from the SARS outbreaks worldwide during the spring of 2003 suggests that SARS is transmitted through close contact with infected persons. SARS is most likely spread by droplet transmission. However, the possibility of airborne transmission and spread through contaminated or inanimate objects has not been ruled out. Healthcare procedures that produce aerosols (e.g. nebulized respiratory treatments, intubation/extubation and deep tracheal suctioning) appear to have an impact on the transmissibility of SARS.

EMS providers should be aware of the signs and symptoms of infectious respiratory diseases and the procedures necessary for protecting themselves. Not all respiratory infections are transmitted in the same way. Transmission can occur from direct or indirect contact, large droplets, or small droplet nuclei. The mode of transmission will depend on the etiological agent. Certain procedures can also impact transmission of infectious agents by producing aerosols. These are deemed “high risk respiratory procedures” and include intubation, extubation, deep tracheal suctioning, nebulized respiratory treatments and bronchoscopy. More often in the field of emergency medicine, the etiologic agents of infections are unknown. Given this, it is paramount that good infection control practices be followed for contact with all patients.
Respiratory Etiquette Strategy

- Implement the use of surgical masks by healthcare personnel, during the evaluation of patients with respiratory symptoms.
- Provide surgical masks to all patients with symptoms of a respiratory illness. Provide instructions on the proper use and disposal of masks.
- For patients who cannot wear a surgical mask in addition to any medical treatment being provided, provide tissues and instructions on when to use them (i.e., when coughing, sneezing, or controlling nasal secretions), how and where to dispose of them, and the importance of hand hygiene after handling this material.
- Continue to use droplet precautions to manage patients with respiratory symptoms until it is determined that the cause of symptoms is not an infectious agent that requires precautions beyond standard precautions.

Recommendations:

1. Personal Protection
   - When assessing a patient with symptoms of a febrile respiratory illness, a surgical mask is usually adequate protection. When directed by a BEMS Advisory, the REMAC or the service medical director, use the highest level of respiratory protection available. A fit-tested N-95 respirator or higher is preferred.
   - Adhere to Standard Precautions - the use of gown, gloves and eye protection if contact with bodily secretions or a contaminated environment is anticipated. Additionally, EMS providers must be familiar with PPE application (donning) and removal (doffing) procedures.
   - Place a surgical mask on the patient if not medically contraindicated.
   - Prior to transporting a patient with an infectious respiratory symptom, the door between the driver and the patient compartment should be closed. If the vehicle does not have a barrier between the cab and the patient compartment, the driver and front seat passenger should, if so directed, wear a surgical mask or higher.
   - Practice good hand hygiene. Hands must be properly washed before and after removal of gloves with warm soapy water or disinfected with a waterless hand sanitizer if a sink is not immediately available. **Do not wait until you return to the ambulance station to practice hand hygiene.**
   - Assure adequate cleaning of the equipment and vehicles between transports. This cleaning should minimally include:
     a. Use of Environmental Protection Agency (EPA) approved disinfectant;
     b. Disinfecting any reusable equipment used on the patient as per the manufacturer's instructions;
     c. Frequently touched surfaces of the vehicle;
     d. Visibly soiled surfaces.

2. Medical procedures, such as nebulized respiratory treatments, that may re-aerosolize infectious material should only be done if medically necessary. It is recommended that mechanical ventilators, including BVM devices and suction equipment, should be fitted with a HEPA filter, if available, to prevent re-aerosolization. EMS agencies should contact equipment manufacturers for recommendations on a HEPA filter. The highest level of respiratory protection should be worn during these procedures.

EMS Provider Health Precautions

1. BEMS strongly recommends providing the following to EMS agencies and providers:
   a. Fit testing for an N-95 or higher respirator masks and insuring that each provider knows the manufacturer and model of the N-95 mask for which they were fit tested.
   b. Education on performing a “fit check” (conforming the mask to the face and checking for air leaks) after donning N95 respirators.
   c. Frequent and on-going education including, but not limited to infection control measures, PPE as well as proper personal/hand hygiene.
   d. Annual flu vaccinations and other preventive health measures.
2. EMS agencies should monitor their crews for any type of infectious illness. EMS management should monitor any provider that presents with signs and symptoms of a febrile respiratory illness. Agencies should consider the following (in order of preference):

- Release staff from duty until they have sought medical attention and have sufficiently recovered.
- Assigning staff to non-patient care related duties for the duration of their illness.
- Require EMS providers to don surgical masks to protect their patients while providing care.
- The EMS agency medical director and the County Public Health Office should be advised of any EMS healthcare provider who is hospitalized with pneumonia.

**Conclusion:**

It is vitally important that the EMS community get in the habit of using Standard Precautions, such as donning Personal Protective Equipment and placing a surgical mask on the patient when appropriate, while treating all patients with a suspected infectious disease. Changing routine habits to include these measures will allow EMS providers to protect themselves and their patients against known infectious diseases as well as SARS or other new emerging diseases.

In addition to changing habits, providing initial and on going education on disease prevention, proper donning and removing of PPE, hand hygiene and hand washing techniques as well as equipment and vehicle cleaning will allow the EMS community to protect patients and itself against all types of infectious diseases.

For Additional Resources:
Please review the information provided at the following web sites;

- [www.health.state.ny.us](http://www.health.state.ny.us)
- [www.cdc.gov/ncidod/hip/ISOLAT/Isolat.htm](http://www.cdc.gov/ncidod/hip/ISOLAT/Isolat.htm)

**References:**
1. CDC Interim Guidance: Ground Emergency Medical Transport for Severe Acute Respiratory Syndrome Patients
2. CDC Updated Interim Guidance - Pre-Hospital Emergency Medical Care and Ground Transport of suspected Severe Acute Respiratory Syndrome Patients.
3. NYS DOH - ADVISORY AND UPDATE SUBJECT: Severe Acute Respiratory Syndrome (SARS) - EMS Update

Issued by:
Edward G. Wronski, Director
Bureau of EMS
Introduction:

The New York State Department of Health distributed the *Radiological Terrorism Rapid Response Card* to all organizations involved in emergency response. The card is designed to serve as a quick reference to providers when faced with a potential act of radiological terrorism.

Emergency Medical Services (EMS) agencies are encouraged to have all responders review this document and understand what capabilities exist within their agency in complying with the recommendations.

These guidelines are provided to give you basic information to manage care at the scene of a possible radiologically contaminated patient or patients, who received a large dose of radiation while protecting yourself as well. The guidelines are applicable to any incident where a person may have been exposed to a radiological hazard including acts of terrorism.

The attached pages of this policy statement contain the *Radiological Terrorism Rapid Response Card* in its entirety. Should you desire additional copies, it is available in several electronic formats on the Bureau of EMS’ WMD and Disaster Preparedness Website, which can be located at:

http://www.health.state.ny.us/nysdoh/ems/main.htm
RADIOLOGICAL TERRORISM

Rapid Response Card for EMS Personnel
This guide provides Emergency Medical Services (EMS) staff and other health care providers with basic information to manage radiologically contaminated patients, or patients who received a large dose of radiation from an external radiation source. This guidance is applicable in all radiological incidents, including terrorism. The format is designed to be a quick reference guide for use during emergencies, but it is important to become familiar with the information in advance. While this rapid response card is directed at those who would provide medical management, the concepts discussed will be of practical use by all first responders.

PHONE NUMBERS:
New York State Department of Health (NYSDOH)
Bureau of Environmental Radiation Protection 518-402-7550
Wadsworth Center Laboratory 518-473-4854
After hours: NYSDOH Duty Officer 1-866-881-2809
After hours: SEMO State Warning Point 518-457-2200
(SEMO – State Emergency Management Office)

New York City Department of Health
Bureau of Radiological Health 212-676-1572
After hours: 212-764-7667

Your County Health Department
Consult phone book blue pages under “County Offices”

Poison Control Centers 1-800-222-1222

MEDICAL PREPAREDNESS REFERENCES AND RESOURCES
http://www.orau.gov/reacts/guidance.htm
http://www.afrri.usuhs.mil/

EXPOSURE VS. CONTAMINATION

External Radiation Exposure: Radiation exposure occurs when a person is near a radiation source. Persons exposed to a radiation source do not become
radioactive. For example, an x-ray machine is a source of radiation exposure. However, you do not become radioactive when you have an x-ray taken.

**Contamination:** Radioactive contamination results when loose particles of radioactive material settle on surfaces, skin, or clothing. Internal contamination may result if these loose particles are inhaled, ingested, or lodged in an open wound. Contaminated people are radioactive and should be decontaminated as quickly as possible. However, the level of radioactive contamination is unlikely to cause a health risk to another individual.

**RADIATION EXPOSURE AND CONTAMINATION EVENTS**

There are four types of radiation accident victims:

1. **A person who has received a significant dose from an external source(s).**
   This includes an exposure to a large radiation source over a short period of time or exposure to a smaller radioactive source over a longer time frame. Such exposure will cause symptoms that depend on the amount of exposure. This includes nausea, reddening of the skin and fatigue. An extremely high exposure may result in death of the victim. These symptoms may not appear immediately; it may take several days or weeks before symptoms are observed. (See Recognizing Radiation-Related Illnesses) **Externally exposed patients do not become radioactive and therefore they do not pose a risk to EMS or other first responders. Do not delay medical attention.**

2. **Internal contamination from inhalation and/or ingestion of radioactive material.**
   Patients are not likely to exhibit any symptoms related to radiological contamination. Internal contamination needs to be assessed and treated in a clinical setting (emergency department). It is extremely unlikely that the level of internal contamination would be sufficient to cause an external exposure hazard from the patient to EMS and other first responders. A person who has inhaled and/or ingested radioactive material is very likely to also have external contamination (see the next item).

3. **External contamination of the body surface and/or clothing by liquids or particles.**
   Patients are not likely to exhibit any symptoms related to radiological contamination. A person who is externally contaminated is likely to also have internal contamination from breathing contaminated dust/dirt/air. (Internal contamination needs to be assessed and treated in a clinical setting). The amount of radioactive material expected to be on the surface of the victim is not likely to cause a radiation hazard to EMS or any first responder. In most
cases, external skin contamination is not life threatening and can be removed with soap and water.

**Use of Universal Precautions will help prevent the spread of contamination to emergency responders. Emergency responders should not delay treatment of victims due to fear of becoming contaminated with radioactive materials.**

The victim should be handled in a manner that will reduce the potential spread of contamination to other individuals and medical equipment (e.g., stretcher, ambulance). External contamination is likely in the situation with a radiological dispersal device – a so-called “dirty bomb.” In a dirty bomb event, the major hazard to health and safety is the explosion itself and/or injury from shrapnel. An exception would be when a fragment of a high activity radiation source pierces the victim. In that situation, an external exposure hazard may exist.

4. A combination of the above.
In this situation, using the guidance for external contamination is warranted.

**PRECAUTIONS**

**Contamination: UNIVERSAL PRECAUTIONS** should be used in any situation where the presence of radioactive materials is suspected. Persons entering a radiological area, sometimes referred to as a “Hot Zone”, may be directed to wear overshoes and a dust mask. Rescuers (i.e., fire department) should move victims out of the hazard area (for example a fire, compromised structure or vehicle) to a location where EMS can attend to the victim’s medical needs.

**External Radiation Exposure:** The three cardinal rules of radiation protection for external radiation exposure (not contamination) from a radiation source are time, distance and shielding.

• **TIME** – The less time you spend near the radiation source, the lower your exposure will be.

• **DISTANCE** – The greater your distance from the source, the less your exposure will be. Radiation exposure decreases with distance according to the inverse-square law. That is, if you triple your distance from the radiation source, your exposure will decrease by a factor of 9 (three squared).

• **SHIELDING** – External exposure to radiation can be partially blocked by the use of shielding. Traditionally, shielding is made of lead or concrete. However, staying behind vehicles, buildings, or other objects will also decrease exposure.

**HEALTH AND SAFETY RISK TO EMS**
It is important to understand that a person who has been exposed to radiation is unlikely to pose a radiological health risk to any other person. However, if a relatively high activity gamma source (external exposure) is present at the emergency site, it is possible for an individual to receive a radiation dose that could pose a health risk. It is anticipated that hazardous materials (HAZMAT) personnel will have made an initial radiological assessment, and specific safety precautions will be given.

RADIOLOGICAL ASSESSMENT
First responders, fire fighters, or HAZMAT, may have performed an initial assessment or screening for the involvement of radioactive materials. Ask the incident commander (IC), or fire/HAZMAT Chief, if radioactive materials have been identified or are suspected. If contamination is identified or suspected, assume that the victim has external contamination. The IC will likely have set up a “Hot Zone” to limit access to a contaminated area. Responders working in the hot zone should limit their time in this zone to what is necessary to assist victims. The incident commander should position EMS outside of the hot zone so that patient triage/treatment can be done safely. Patients should be decontaminated prior to delivery to EMS, if possible.

RECOGNIZING RADIATION-RELATED ILLNESSES
Determining that someone has been exposed to radiation can be difficult in situations other than catastrophic events (nuclear detonations and severe nuclear power plant accidents). Effects of exposure and/or contamination will not appear immediately following exposure. It can take days or weeks to see symptoms. Some symptoms can be similar to those for chemical exposure. In most cases, there will be no immediate symptoms of radiation exposure or contamination. The following clinical clues suggest a possible radiological terrorist event:

- The acute radiation syndrome follows a predictable pattern that unfolds over several days or weeks after substantial exposure or catastrophic events. See below for specific symptom clusters.

- Victims may present individually over a longer period of time after exposure to unknown radiation sources.

- Specific symptoms of concern, especially following a 2-3 week period with nausea and vomiting, are:
  - thermal burn-like skin lesions without documented heat exposure;
  - a tendency to bleed (nosebleeds, gingival (gum) bleeding, bruising);
  - hair loss.

- Symptom clusters as delayed effects after radiation exposure:
  - Headache, fatigue, weakness
  - Partial and full thickness skin damage, epilation (hair loss), ulceration
  - Anorexia, nausea, vomiting, diarrhea
GUIDELINES FOR EMERGENCY MEDICAL MANAGEMENT

1. **USE UNIVERSAL PRECAUTIONS** to help prevent the spread of contamination from injured victims to emergency personnel.

2. **Assess and treat life-threatening injuries immediately.** Treatment of such patients takes priority over all other activities, including decontamination. Do not delay advanced life support if victims cannot be moved, or to assess contamination status. Perform routine emergency care during extrication procedures. Do not delay medical attention for victims with life-threatening injuries.

3. **Move victims away from the radiation hazard area, using proper patient transfer techniques to prevent further injury.** Stay within the controlled zone if contamination is suspected.

4. **Expose wounds and cover with sterile dressings.** Priority efforts should be directed to decontamination of open wounds.

5. **Victims should be monitored at the control line for possible contamination only after they are medically stable.** Radiation levels above background indicate the presence of contamination. Remove the contaminated person’s clothing, provided removal can be accomplished without causing further injury.

6. **Contaminated patients who do not have life-threatening or serious injuries may be decontaminated on site.** Removal of the patient’s clothing may reduce the contamination by up to 90%. Place such items in a plastic bag (double bag if possible) and label with the person’s name and location (incident site). These items may be analyzed later to determine the specific isotope and extent of contamination. These items may also be legal evidence.

7. **Flush eyes with water or sterile saline. Irrigation or washing of skin with tepid water and a mild soap is effective for initial decontamination.** Do not use irritants or methods that may abrade the skin, as this could cause internal contamination. It is not necessary to collect the water that was used for decontamination. However, do not let that water contaminate other persons or equipment.

8. **Move the ambulance cot to the clean side of the control line and unfold a clean sheet or blanket over it.** Place the victim on the covered cot and package for transport. Do not remove the victim from the backboard if one was used.
9. **Package the victim by folding the stretcher sheet over and securing the patient in the appropriate manner.** This prevents spread of contamination to the ambulance.

10. **Before leaving the controlled area, rescuers should remove protective clothing at the control line.** If possible, the victim should be transported by personnel who have not entered the controlled area. Ambulance personnel attending victims should wear gloves.

11. **Notify proper authorities and hospital.** Let the hospital know that you are dealing with radiological victims, and provide an estimate of how many persons, their medical conditions, any known radiological information and an estimate of your arrival time. Ask for any special instructions the hospital may have. You may be directed to an entrance other than the routine emergency department entrance for the purposes of radiological contamination control.

12. **Transport the victim to the hospital.** Follow the hospital’s radiological protocol upon arrival. Hand-off patients in a manner which reduces the likelihood of spreading contamination. Wrap the patient in a second clean sheet for transfer at the hospital.

13. **The ambulance is considered contaminated until proven otherwise or decontaminated.** However, you may be directed to use the same ambulance for additional trips to the same event site prior to being “clean-released.”

14. **Have yourself surveyed and decontaminated as necessary.**

**DECONTAMINATION GUIDELINES**
Proper decontamination of patients is important to prevent contamination of facilities and equipment and to prevent exposure to other individuals. Immediate removal of the patient’s clothing can remove up to 90% of the contaminant. Removed clothing, bagged and sealed to prevent spread of contamination, should be retained as possible evidence. After clothing is removed, the patient’s skin and eyes may need to be decontaminated. In most cases, decontamination of the skin can be accomplished by gently washing with soap and water followed by a thorough water rinse. It is important not to abrade the skin during washing or rinsing, as this can lead to internal radioactive contamination of the patient. For eyes, flush with plenty of water.

**TREATMENT AND DECONTAMINATION RULES**
- Patient with life-threatening condition: treat, then decontaminate.
- Patient with non-life-threatening condition: decontaminate, then treat.
- Uninjured contaminated persons should **NOT** be directed to medical facility; they should be decontaminated on site.
• Externally irradiated patients are not contaminated.

• Exposure without contamination requires no decontamination.

• Treating contaminated patients before decontamination may contaminate equipment, vehicles and the facility. Plan for patient decontamination before arrival if not medically contraindicated.

• For contaminated patients, use Universal Precautions, remove patient’s clothing, and decontaminate with soap and water.

• For internal contamination, contact the Radiation Safety Officer and/or a Nuclear Medicine Physician at the hospital. Internal contamination will have to be assessed and treated at a hospital.

USE OF POTASSIM IODIDE
In the event of a severe nuclear power plant accident, health officials may direct the use of potassium iodide (KI) tablets to protect the thyroid from exposure to radioactive iodine. KI saturates the thyroid with non-radioactive iodine to minimize the uptake of radioactive iodine isotopes. It must be taken within the first few hours after exposure to be effective. Persons allergic to iodine or shellfish should not take KI.

Note: KI is only effective for protecting the thyroid gland from radioiodine exposure.
Use of “Mark I Kits” (AtroPen® Auto-Injector & Pralidoxime Chloride Injector)

Purpose:

To provide EMS agencies with guidelines on the appropriate use of “Mark I Kits”. The “Mark I Kit” contains antidotes to be used in instances of exposure to a nerve or organophosphate agent. The Mark I kit consists of two autoinjectors containing Atropine Sulfate and Pralidoxime Chloride.

Key Provision:

Only those EMS services that are part of the Metropolitan Medical Response Systems (MMRS) and/or a Municipal response Plans are authorized to purchase and utilize the specialized equipment and medications needed in WMD incidents. This includes “Mark I Kits”.

Guidelines:

The initial guidelines for the use of the “Mark I Kits” were developed by the Bio-Terrorism sub-committee of the State Emergency Medical Advisory Committee (SEMAC). They were then adopted by the SEMAC as well as the State Emergency Medical Services Council (SEMSCO), to provide guidance to EMS agencies who are a part of the Metropolitan Medical Response System (MMRS) and/or a Municipal Response Plan. This updated edition is to provide additional guidance on the use of the Mark I kits.

There are five provisions in the guidelines:

1. An EMS agency must be participating in an MMRS or Municipal Response Plan for WMD incidents.

2. The decision to utilize the “Mark I” antidote must be done under the authority of medical control.

3. At a minimum, an EMS provider must be trained to the WMD awareness level. The
awareness program should be a national training program or modeled after one of the training programs developed by the Department of Defense (DOD), Department of Justice (DOJ) or Federal Emergency Management Agency (FEMA).

An online WMD awareness course is offered through the Domestic Preparedness Campus of Texas A&M University’s web site at:

http://www.teexwmdcampus.com

4. The “Mark I Kit” is not to be used for self-administration or prophylaxis.

5. Use of the “Mark I Kit” is to be based on signs and symptoms of the patient. The Suspicion or identified presence of a nerve agent is not sufficient reason to administer these medications.

Antidote Mechanism of Action:

1. The nervous system controls body functions by secreting chemical transmitters which act as “instructions” to nerves, muscles and glands at the nerve endings.

2. These neurological instructions come in two forms:
   1) **stimulate** (move or work)
   2) **relax** (stop or rest).

3. When a nerve agent is present, it interferes with the normal instructions of chemical transmitters that direct the muscle or gland to return to an un-stimulated, relaxed state.

4. By interfering with the normal chemical checks and balances, the action of toxic nerve agents is to over-stimulate the nerve endings and central nervous system.

5. Over-stimulation of the nervous system causes muscles and certain glands to over-react and cause the symptoms of: SLUDGEM + Respirations and Agitation.

6. The initial treatment for a nerve agent exposure consists of a two part antidote:
   1) Atropine, and
   2) 2-PAM Chloride.

**NOTE:** ATROPINE IS THE PRIMARY DRUG FOR TREATMENT OF NERVE AGENT EXPOSURE!
7. Atropine stops the effect of the nerve agent by blocking the effects of over-stimulation. It effectively counters the actions of the nerve agent at nerve receptors.

8. Atropine relieves the smooth muscle constriction in the lungs (wheezing, respiratory distress) and gastrointestinal (diarrhea, cramps) tract, and also dries up respiratory tract secretions.

9. The companion drug to Atropine is 2-PAM CL; this drug complements the action of Atropine. 2-Pam Chloride acts to restore normal functions at the nerve ending by removing the nerve agent and affecting toxin irreversibility. This antidote is effective at re-establishing normal skeletal muscle contraction (relieves twitching and paralysis of respiratory muscles).

RECOMMENDED ANTIDOTE DOSING SCHEDULE FOR EXPOSURE TO NERVE AGENT

1. If severe signs and symptoms are present, three (3) Atropine auto-injectors and three (3) 2-PAM CL injectors should be administered in rapid succession.

2. If the patient exhibits SLUDGEM but no central nervous system (CNS) findings are present, then two (2) Atropine auto-injectors and one (1) 2-PAM CL injector should be given.

3. In either case, remove secretions, maintain patient’s airway and, if necessary and the situation permits, use artificial ventilation.

4. Repeat dosages will be given as specified in the Extended Re-evaluation and Treatment Schedule (Table 2).

5. If symptoms resolve, then only monitoring is necessary.

6. Pre-measured doses of auto-injectors should be safe in most adults. It should be noted, however that auto-injectors were designed for a military profile: approximate age 18-35, weight 70 kg. Or 154 lbs., healthy and with no preexisting medical conditions.

7. Pralidoxime (2-PAM CL) is most effective if administered immediately after poisoning and following but not before Atropine, especially for severe exposures.

8. When the nerve agent has been ingested exposure may continue for some time due to slow absorption from the lower bowel. Fatal relapses have been reported after initial improvement. Continued medical monitoring and transport is mandatory.
9. If dermal exposure has occurred, decontamination is critical and should be done with standard decontamination procedures. Patient monitoring should be directed to the same signs and symptoms as with all nerve agent exposures.

10. Diazepam (Valium) may be given cautiously if convulsions are not controlled.

**Antidote Dosing Schedules:**

**Initial Treatment (Table 1)**

<table>
<thead>
<tr>
<th>Signs &amp; Symptoms</th>
<th>Atropine Dose Monitor Interval</th>
<th>2-Pam Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe Respiratory Distress, Agitation, <strong>SLUDGEM</strong></td>
<td>3 Auto-injectors (6 mg) Monitor every 5 minutes</td>
<td>3 Auto-injectors (1.8 gms)</td>
</tr>
<tr>
<td>Respiratory Distress, <strong>SLUDGEM</strong></td>
<td>2 Auto-injectors (4 mg) Monitor every 10 minutes</td>
<td>1 Auto-injector (600 mg)</td>
</tr>
<tr>
<td>Asymptomatic, None</td>
<td>Monitor for signs &amp; symptoms every 15 minutes</td>
<td>None</td>
</tr>
</tbody>
</table>

In the initial phase, triage will be initiated in the Hot Zone, continued in the warm zone, and performed only by trained personnel who are wearing appropriate Personal Protective Equipment (as determined by the Incident Commander). Patient decontamination will be simultaneous with and/or prior to treatment. Children should be decontaminated and have expedited transport off scene especially if they are demonstrating any signs and symptoms of exposure.

**Extended Re-Evaluation & Treatment Phase:**

This phase is reached once patients have been initially managed and patient volume allows for more protracted patient assessments.

**Extended Re-evaluation and Treatment Schedule (Table 2)**

<table>
<thead>
<tr>
<th>Signs &amp; Symptoms</th>
<th>Atropine Dose Monitor Interval</th>
<th>2 Pam Dose</th>
<th>Atropine Repeat Dosing Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe Respiratory Distress, Agitation, <strong>SLUDGEM</strong></td>
<td>2 mg Monitor every 5 minutes</td>
<td>Up to a maximum of 1.8 gms. (3 auto-injectors)</td>
<td>Atropine 3-5 minutes as needed</td>
</tr>
<tr>
<td>Respiratory Distress <strong>SLUDGEM</strong></td>
<td>2 mg Monitor every 5 to 15 minutes</td>
<td>Up to a maximum of 600 mg. (1 auto-injector)</td>
<td>Atropine 5-10 minutes as needed</td>
</tr>
<tr>
<td>Asymptomatic</td>
<td>None Monitor every 15 minutes</td>
<td>None</td>
<td>Atropine 5-15 minutes as needed</td>
</tr>
</tbody>
</table>
Note: Personnel operating in this phase should be aware of the potential for “off-gassing”. Off-gassing is the process by which vapors are given off by chemically contaminated clothing.

Cautions For Use Of Auto-Injectors:

1. Every potential exposure in the immediate vicinity of the incident must be medically evaluated and monitored. Delayed symptoms may present anytime post incident.

   Any patient ill enough to receive even one dose of atropine must be evaluated at an appropriate facility (e.g. casualty collection point, hospital, etc.).

2. Signs or symptoms of nerve agent poisoning may reappear. Serial observations are a critical part of the management process.

3. Auto injectors have been developed for use in the adult population. Safety and effectiveness of 2-PAM CL in children has not been established. The atropine and 2-PAM CL antidote auto injectors should not be used in children 9 years of age or younger.

   For additional information on the treatment of pediatric patients contact medical control or refer to local REMAC developed protocols.

Adverse Reactions:

Note: Adverse reactions may occur but there are no contraindications to treating systematic patients.

1. Atropine may cause chest pain. It may also exacerbate angina or induce a myocardial infarction.

2. Up to one hour after intramuscular injection of 2-PAM CL some pain may be experienced at the site of injection.

3. 2-PAM CL may cause blurred vision, double vision (diplopia), dizziness, headache, drowsiness, nausea, rapid heart rate (tachycardia), increased blood pressure, and hyperventilation.

4. Both (Atropine and 2-Pam CL) should be used with caution (but not withheld) in patients with preexisting cardiac disease, high blood pressure, or strokes, particularly in the Extended Re-evaluation and Treatment Phase.

Auto-Injectors – General:

Note: Use of antidotes will not protect responders from anticipated exposures.
1. Auto-injectors are self-contained, simple, compact injection systems that come equipped with a pre-measured dose (normal adult dose) of antidote.

2. An antidote relieves, counteracts, or reverses the effects of poisons or drugs such as nerve agents.

3. The Mark I kit must be kept at room temperature (about 25°C 77°F) and must be protected from freezing.

4. **Mark 1 antidote kits are to be used only:**
   
   1) when specific signs and symptoms of exposure are present
   
   AND

   2) the scene has been declared the site of a nerve agent release by a local competent authority

   AND

   3) Following consultation with Medical Control and in compliance with any local REMAC Nerve Agent Protocol.

   a. The Mark 1 injectors are not to be used as a prophylaxis for personal protection.
   
   b. There is to be no self-administration of antidote.

5. Auto-injectors permit rapid administration of antidote, prevent needle cross-contamination between patients, and enable rapid and accurate administration to a large number of patients (even if the emergency provider and the patient are in chemical protective clothing).

6. Auto-injectors facilitate treatment by providing simple, accurate, drug administration of a pre-measured, controlled dose.

7. Auto-injectors administer a predictable drug dose that is not operator dependent.

8. Auto-injectors contain pre-measured doses of the nerve agent antidotes:
   
   1) Atropine
   
   2) 2-PAM Chloride (2-PAM CL; pralidoxime chloride)

9. Each auto-injector contains pre-measured amounts of Atropine (2 mg total dose per injection) and 2-PAM CL (600 mg total dose per injection).

10. Mark 1 antidote kits are available and are only to be used under the direction of medical control in accordance with a local REMAC approved
Nerve Agent Exposure protocol. EMS agencies must be identified as a participant in a municipal response plan involving nerve agents.

**Directions For Use Of Auto-Injector**

1. When auto-injector use is indicated, the recommended procedure is to inject the contents of the auto-injector into the muscles of an anterolateral (front and side) thigh (through the pocket).

2. Procedure:

   1) Remove safety cap (yellow on Atropine; gray on 2-PAM CL). Do not touch the colored end of the injector after removing the safety cap.

   2) **Caution**: The injector can and will inject into the fingers or hand if any pressure is applied to either end of the injector.

   3) Hold injector as you would a pen. Place colored end (green on Atropine, Gray on 2-PAM CL) on thickest part of thigh and press hard until injector is activated.

   4) Pressure automatically activates the spring, which plunges the needle into the muscle and simultaneously forces fluid (Atropine or 2-Pam CL) through it into the muscle tissues.

   5) **Hold firmly in place for ten seconds then remove**. Massage the area of injection.

   6) After each auto-injector has been activated, the empty container should be disposed of properly. It cannot be refilled nor can the protruding needle be retracted.

**IMPORTANT:** Physicians and/or other medical personnel and emergency responders assisting evacuated victims of nerve agent exposure should avoid exposing themselves to cross-contamination by ensuring that they do not come into direct contact with the patient’s clothing.

**Documentation:**

- When a patient has received treatment with the use of a Mark I kit(s) there must be a method to record such information so persons providing subsequent care are aware of that treatment and the amount of medication given.

- If the resources are present it is recommended that a triage tag be placed on each patient and that any treatment given be recorded on that tag.
• If the patient is provided with care prior to decontamination than replace that triage tag following decontamination with a new (dry) tag and copy over any information regarding treatments already provided.

• In the event triage tags are not available, documentation might be provided by affixing a piece of medical tape on the patient indicating what care has been provided. Be sure that if such a system is used that any tape applied prior to decontamination is removed as part of decontamination and the information is exactly copied on any new documents pertaining to the patient.

Sample Protocol:

Attached to this policy and guideline is a model “Mark I PROTOCOL” based upon existing metropolitan response system protocols and various federal agency recommendations for administration. This protocol is not mandated and was not specifically approved by the SEMAC. This protocol is provided to assist a Regional Medical Advisory Committee (REMAC) or municipal system Medical Director in developing a local protocol. This model is not intended for independent use by an EMS agency. It may be used only with medical authorization and participation of the agency in a municipal or MMRS plan.

There are currently five metropolitan areas that are part of the MMRS program in New York State:

- New York City
- Yonkers
- Buffalo
- Rochester
- Syracuse

If your agency is included in an MMRS or municipal response plan you may have received training and formal protocols for WMD response, including the use of the “Mark I Kits”. This guideline, if different from the plan in which you participate, is not meant to supercede your local protocol, medical control or policy.

This policy has been distributed to your REMAC, Regional EMS Councils and County Emergency Management authorities.

Issued and Authorized by:
Edward G. Wronski, Director
Bureau of EMS
MODEL PROTOCOL FOR THE USE OF MARK I KITS

Purpose: These are antidotes to be used in instances of exposure to a nerve or organophosphate agent.

Use: The Mark I is to be used only if you are part of the MMRS and or a Municipal Response Plan.

Contents: (1) Atropine Auto-Injector (2 mg total dose per injection)
(2) 2-PAM (2-PAM CL; pralidoxime chloride) 600 mgs. total dose per injection.

- NOTE: These injectors are not to be used as a prophylactic modality. There is to be no self-administration of the antidote.

I: Mark I Kit

(a) To be used only in a disaster situation and only if you are a part of the MMRS and or a Municipal Response system.
(b) The Mark I Kit is only to be utilized under direct authority of Medical Control.

II: Auto Injector Use

(a) Pre measured doses in auto-injectors should be safe for most adults.
(b) Atropine auto-injector and Pralidoxime (2 PAM CL) may be administered by qualified emergency personnel and designated emergency responders who have had adequate training in on-site recognition and treatment of nerve and or organophosphate agent intoxication in the event of a chemical release. This is specific to the disaster setting.
(c) Medical treatment is directed to relieving respiratory distress and alleviating seizures.

III: Indications for use of the Auto Injectors

(a) It is a concern that the use of auto-injectors could lead to administration of inappropriate and harmful doses during a non-chemical agent or minimal exposure situations. The auto-injectors are to be used only if the patient presents with SLUDGEM + RESPIRATIONS and AGITATION.
(b) The Atropine and 2-PAM CL auto injectors should be used by qualified emergency medical personnel and designated emergency responders only after the following events have occurred:

1) The recognition of the existence of a potential chemical or organophosphate agent release in an area.
2) Some or all of the symptoms of the nerve agent poisoning cited below are present:
SLUDGEM + RESPIRATION and AGITATION

S – salivation (excessive drooling)
L – lacrimation (tearing)
U – urination
D – defecation / diarrhea
G – GI upset (cramps)
E – emesis (vomiting)
M – muscle (twitching, spasm, “bag of worms”)

+ RESPIRATION – difficulty breathing / distress (sob, wheezing)

+ AGITATION + CNS SIGNS – confusion, agitation, seizures, coma.

3) Atropine must be given first, do not give anything else until the effects of atropine become apparent. Only when the effects of the atropine have been seen can you then give 2 – PAM CL.
4) If symptoms resolve, then only monitoring is necessary.
5) If severe signs and symptoms are present; three (3) Atropine auto-injectors and three (3) 2-PAM CL injectors should be administered in rapid succession (stacked).

1. Remove secretions
2. Maintain an open airway
3. Use artificial ventilation in necessary and possible
4. Repeat Atropine immediately as directed

6) Pralidoxime (2-PAM CL) is most effective if administered immediately after the poisoning but not before Atropine, especially for severe exposures.
7) If available Diazepam (Valium) may be cautiously given, under direct medical control, if convulsions are not controlled.
8) When the nerve agent has been ingested, exposure may continue for some time due to slow absorption from the lower bowel, and fatal relapses have been reported after initial improvement. Continued medical monitoring and transport is mandatory.
9) If dermal exposure has occurred, decontamination is critical and should be done with standard decontamination procedures. Patient monitoring should be directed to the same signs and symptoms as with all nerve or organophosphate exposures.

7/2/2002
Introduction:

The New York State Department of Health distributed the *Chemical Terrorism Preparedness and Response Card* to all organizations involved in emergency response. The card is designed to serve as a quick reference to providers when faced with a potential act of chemical terrorism.

Emergency Medical Services agencies are encouraged to have all responders review this document and understand what capabilities exist within their agency in complying with the recommendations. All agencies are advised that the directions and recommendations regarding antidote use should only be performed in accordance with established medical protocols for your agency. The use of personal protective equipment including the use of Self Contained Breathing Apparatus (SCBA), should only occur after providers have received proper training on the use and fitting of such equipment.

The Bureau of EMS and the State Emergency Medical Advisory Committee (SEMAC) believe that EMS personnel should not be providing patient care in an environment that requires the use of SCBA. It is not the role of EMS personnel to enter a “hot zone” in an identified WMD incident. EMS crews should operate in the “cold zone” and HazMat or other specially equipped teams should bring patients out of the hot zone to be treated and transported.

These guidelines are provided to assist you in providing care at the scene of a possible Chemical Terrorism incident and not becoming a victim of one.

The attached pages of this policy statement contain the Chemical Terrorism Preparedness and Response Card in its entirety. Should you desire additional copies, it is available in several electronic formats on the Bureau of EMS’ WMD and Disaster Preparedness Website, which can be located at:

http://www.health.state.ny.us/nysdoh/ems/main.htm
RECOGNIZING CHEMICAL TERRORISM-RELATED ILLNESSES

Adequate planning and regular training are the key to preparedness for terrorism-related events. Healthcare providers should be alert to illness patterns and reports of chemical exposure that might signal an act of terrorism. The following clinical, epidemiological and circumstantial clues may suggest a possible chemical terrorist event:

- An unusual increase in the number of people seeking care, especially with respiratory, neurological or gastrointestinal symptoms
- Any clustering of symptoms or unusual age distribution (e.g., chemical exposure in children)
- Location of release not consistent with a chemical’s use
- Simultaneous impact to human, animal and plant populations
- Any unusual clustering of patients in time or location (e.g., persons who attended the same public event)

Any unusual symptoms, illnesses or clusters of these should be reported immediately. EMS personnel should call their medical control facility and dispatching agency. The county health department and local Poison Control Center should also be notified.

PHONE NUMBERS

New York State Department of Health (NYSDOH)  
Bureau of Toxic Substance Assessment 518-402-7800  
Wadsworth Center Laboratories 518-474-7161  
After hours: NYSDOH Duty Officer 1-866-881-2809  
After hours: SEMO State Warning Point 518-457-2200  
(SEMO - State Emergency Management Office)

New York City Department of Health  
Poison Control Center 212-764-7667

Your County Health Department  
Consult phone book blue pages under “County Offices”

Poison Control Centers 1-800-222-1222

MEDICAL PREPAREDNESS REFERENCES AND RESOURCES

This response card is only a summary of important information. For more detail for preparedness planning, review the following resources and those at the end of Table 2:
*Textbook of Military Medicine – Medical Aspects of Chemical and Biological Warfare  
*Centers for Disease Control and Prevention Public Health Emergency Preparedness and Response  
http://www.bt.cdc.gov/Agent/AgentlistChem.asp

TABLE 1  
RECOGNIZING AND DIAGNOSING HEALTH EFFECTS OF CHEMICAL TERRORISM

<table>
<thead>
<tr>
<th>Agent Type</th>
<th>Agent Names</th>
<th>Any Unique Characteristics</th>
<th>Initial Effects</th>
</tr>
</thead>
</table>
| Nerve      | - Cyclohexyl sarin (GF)  
- Sarin (GB)  
- Soman (GD)  
- Tabun (GA)  
- VX         | - Miosis (pinpoint pupils)  
- Copious secretions  
- Muscle twitching/ fasciculations | - Miosis (pinpoint pupils)  
- Blurred/ dim vision  
- Headache  
- Nausea, vomiting, diarrhea  
- Copious secretions/ sweating  
- Muscle twitching/ fasciculations  
- Breathing difficulty  
- Seizures |
| Asphyxiant/ Blood | - Arsine  
- Cyanogen chloride  
- Hydrogen cyanide | - Possible cherry red skin  
- Possible cyanosis  
- Possible frostbite* | - Confusion  
- Nausea  
- Patients may gasp for air, similar to |
**TABLE 2  DECONTAMINATION AND TREATMENT**

<table>
<thead>
<tr>
<th>Agent Type</th>
<th>Decontamination</th>
<th>First Aid Assess ABCs</th>
<th>Other Patient Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nerve</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Remove clothing immediately</td>
<td>Atropine before other measures</td>
<td>Onset of symptoms from dermal contact with liquid forms may be delayed</td>
</tr>
<tr>
<td></td>
<td>Gently wash skin with soap and water</td>
<td>Prazidoxime (2-PAM) chlorate</td>
<td>Repeated antidote administration may be necessary</td>
</tr>
<tr>
<td></td>
<td>Do not abrade skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For eyes, flush with plenty of water or normal saline</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Asphyxiant/ Blood</strong></td>
<td>Remove clothing immediately if no frostbite*</td>
<td>Rapid treatment with oxygen</td>
<td>Artine and cyanogen chloride may cause delayed pulmonary edema</td>
</tr>
<tr>
<td></td>
<td>Gently wash skin with soap and water</td>
<td>For cyanide, use antidotes (sodium nitrite and then sodium thiocyanate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do not abrade skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For eyes, flush with plenty of water or normal saline</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Choking/ Pulmonary-damaging</strong></td>
<td>Remove clothing immediately if no frostbite*</td>
<td>Fresh air, forced rest</td>
<td>May cause delayed pulmonary edema, even following a symptom-free period that varies in duration with the amount inhaled</td>
</tr>
<tr>
<td></td>
<td>Gently wash skin with soap and water</td>
<td>Semi-upright position</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do not abrade skin</td>
<td>If signs of respiratory distress are present, oxygen with or without positive airway pressure may be needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For eyes, flush with plenty of water or normal saline</td>
<td>Other supportive therapy, as needed</td>
<td></td>
</tr>
<tr>
<td><strong>Blistering/ Viscant</strong></td>
<td>Immediate decontamination is essential to minimize damage</td>
<td>Immediately decontaminate skin</td>
<td>Possible pulmonary edema</td>
</tr>
<tr>
<td></td>
<td>Remove clothing immediately</td>
<td>Flush eyes with water or normal saline for 10-15 minutes</td>
<td>Mustard has an asymptomatic latent period</td>
</tr>
<tr>
<td></td>
<td>Gently wash skin with soap and water</td>
<td>If breathing difficulty, give oxygen</td>
<td>There is no antidote or treatment for mustard</td>
</tr>
<tr>
<td></td>
<td>Do not abrade skin</td>
<td>Supportive care</td>
<td>Lewisite has immediate burning pain, blister later</td>
</tr>
<tr>
<td></td>
<td>For eyes, flush with plenty of water or normal saline</td>
<td></td>
<td>Specific antidote British Anti-Lewisite (BAL) may decrease systemic effects of Lewisite</td>
</tr>
<tr>
<td><strong>Incapacitating/ Behavior-altering</strong></td>
<td>Remove clothing immediately</td>
<td>Remove heavy clothing</td>
<td>Possible pulmonary edema</td>
</tr>
<tr>
<td></td>
<td>Gently wash skin with water or soap and water</td>
<td>Evaluate mental status</td>
<td>Mustard has an asymptomatic latent period</td>
</tr>
<tr>
<td></td>
<td>Do not abrade skin</td>
<td>Use restraints as needed</td>
<td>There is no antidote or treatment for mustard</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitor core temperature carefully</td>
<td>Lewisite has immediate burning pain, blister later</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supportive care</td>
<td>Specific antidote British Anti-Lewisite (BAL) may decrease systemic effects of Lewisite</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Phosgene oxime causes immediate pain</td>
</tr>
</tbody>
</table>

*For frostbite areas, do NOT remove any adhering clothing. Wash area with plenty of warm water to release clothing.

References for Preparedness and Response Card:

### TABLE 3
**ANTIDOTE RECOMMENDATIONS FOLLOWING EXPOSURE TO CYANIDE**

**Note** - Victims whose clothing or skin is contaminated with hydrogen cyanide liquid or solution can secondarily contaminate response personnel by direct contact or through off-gassing vapors. Avoid dermal contact with cyanide-contaminated victims or with gastric contents of victims who may have ingested cyanide-containing materials. Victims exposed only to hydrogen cyanide gas do not pose contamination risks to rescuers. **If the patient is a victim of recent smoke inhalation (may have high carboxyhemoglobin levels), administer only sodium thiosulfate.**

<table>
<thead>
<tr>
<th>Patient</th>
<th>Mild (conscious)</th>
<th>Severe (unconscious)</th>
<th>Other Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td>If patient is conscious and has no other signs or symptoms, antidotes may not be necessary.</td>
<td>Sodium nitrite: 0.12 - 0.33 ml/kg, not to exceed 10 ml of 3% solution slow IV over no less than 5 minutes, or slower if hypotension develops and Sodium thiosulfate: 1.65 ml/kg of 25% solution IV over 10 - 20 minutes</td>
<td>For sodium nitrite-induced orthostatic hypotension, normal saline infusion and supine position are recommended. If still apneic after antidote administration, consider sodium bicarbonate for severe acidosis.</td>
</tr>
<tr>
<td>Adult</td>
<td>If patient is conscious and has no other signs or symptoms, antidotes may not be necessary.</td>
<td>Sodium nitrite: 10 - 20 ml of 3% solution slow IV over no less than 5 minutes, or slower if hypotension develops and Sodium thiosulfate: 50 ml of 25% solution IV over 10 - 20 minutes</td>
<td></td>
</tr>
</tbody>
</table>

1. If sodium nitrite is unavailable, administer amyl nitrite by inhalation from crushable ampules.
2. Available in Pasadena Cyanide Antidote Kit, formerly Lilly Cyanide Kit.
**TABLE 4**

ANTIDOTE RECOMMENDATIONS FOLLOWING EXPOSURE TO NERVE AGENTS

<table>
<thead>
<tr>
<th>Patient Age</th>
<th>Mild/ Moderate Effects¹</th>
<th>Severe Effects²</th>
<th>Other Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infants (0-2 yrs)</strong></td>
<td>Atropine: 0.05 mg/kg IM, or 0.02 mg/kg IV; and 2-PAM Chloride: 15 mg/kg IM or IV slowly</td>
<td>Atropine: 0.1 mg/kg IM, or 0.02 mg/kg IV; and 2-PAM Chloride: 25 mg/kg IM, or 15 mg/kg IV slowly</td>
<td>Assisted ventilation after antidotes for severe exposure. Repeat atropine (2 mg IM, or 1 mg IM for infants) at 5 - 10 minute intervals until secretions have diminished and breathing is comfortable or airway resistance has returned to near normal.</td>
</tr>
<tr>
<td><strong>Child (2-10 yrs)</strong></td>
<td>Atropine: 1 mg IM, or 0.02 mg/kg IV; and 2-PAM Chloride³: 15 mg/kg IM or IV slowly</td>
<td>Atropine: 2 mg IM, or 0.02 mg/kg IV; and 2-PAM Chloride³: 25 mg/kg IM, or 15 mg/kg IV slowly</td>
<td>Phentolamine for 2-PAM-induced hypertension: (5 mg IV for adults; 1 mg IV for children). Diazepam for convulsions: (0.2 to 0.5 mg IV for infants less than 5 years; 1 mg IV for children 5 years and older; 5 mg IV for adults).</td>
</tr>
<tr>
<td><strong>Adolescent (&gt;10 yrs)</strong></td>
<td>Atropine: 2 mg IM, or 0.02 mg/kg IV; and 2-PAM Chloride³: 15 mg/kg IM or IV slowly</td>
<td>Atropine: 4 mg IM, or 0.02 mg/kg IV; and 2-PAM Chloride³: 25 mg/kg IM, or 15 mg/kg IV slowly</td>
<td>-</td>
</tr>
<tr>
<td><strong>Adult</strong></td>
<td>Atropine: 2 to 4 mg IM or IV; and 2-PAM Chloride: 600 mg IM, or 15 mg/kg IV slowly</td>
<td>Atropine: 6 mg IM; and 2-PAM Chloride: 1,800 mg IM, or 15 mg/kg IV slowly</td>
<td>-</td>
</tr>
<tr>
<td><strong>Elderly, frail</strong></td>
<td>Atropine: 1 mg IM; and 2-PAM Chloride: 10 mg/kg IM, or 5 to 10 mg/kg IV slowly</td>
<td>Atropine: 2 to 4 mg IM; and 2-PAM Chloride: 25 mg/kg IM, or 5 to 10 mg/kg IV slowly</td>
<td>-</td>
</tr>
</tbody>
</table>

1. **Mild/Moderate effects** include localized sweating, muscle fasciculations, nausea, vomiting, weakness, dyspnea.
2. **Severe effects** include unconsciousness, convulsions, apnea, flaccid paralysis.
3. If calculated dose exceeds the adult IM dose, adjust accordingly.

**NOTE:** 2-PAM Chloride is Pralidoxime Chloride or Protopam Chloride.

**PERSONAL PROTECTIVE EQUIPMENT (PPE)**

**DO NOT BECOME A CASUALTY!**

First responders face the greatest exposure potential, often to unidentified agents. To protect yourself:

- Be alert
- Keep an appropriate distance
- Stay upwind
• Wait for assessment by a HAZMAT team before entering

Ideally, responders in an unknown situation should wear Level A PPE. Exposure can occur from inhalation of vapors, dermal contact or eye contact. The following is a general discussion to help responders/healthcare providers determine appropriate PPE.

PPE to Prevent Inhalation Exposure:

Protection from both vapors and particulates may be required when the chemical agent is being released. After release, protection from vapors is most important. Surgical and N-95 masks will not protect against inhalation of vapors. Half-face and full-face respirators, with the appropriate canister, will provide good protection from vapors. These operate by negative pressure and must be fit tested for optimal protection. Powered, air-purifying respirators (PAPR) and self-contained breathing apparatus (SCBA) provide even greater protection and operate under positive pressure so that fit characteristics are less important.

PPE to Prevent Dermal Exposure:

Latex examination gloves provide very little protection from most chemical agents and can cause allergies. Gloves made of Viton, nitrile, butyl or neoprene provide more protection and, in some styles, allow adequate dexterity. However, the resistance of these materials to different chemicals varies and it is best to have a variety of gloves available. Double gloving may provide additional protection. Chemical-resistant aprons or suits can also prevent dermal exposure.

PPE to Prevent Eye Exposure:

Full-face respirators, PAPR and SCBA will provide protection from both splashes and vapors. Protective eyewear, such as goggles or a face shield, will not provide protection from chemical vapors. Protective eyewear is required during decontamination to prevent splashing into eyes.

DECONTAMINATION GUIDELINES

Proper decontamination is often the most important first step in treating a patient exposed to chemical agents. Immediate removal of patient clothing can remove up to 90 percent of the contaminant. Removed clothing should be bagged, sealed and retained as possible evidence.

After the clothing is removed, the patient’s skin and eyes may need to be decontaminated. In most cases, decontamination of skin can be accomplished by gentle and thorough washing with soap and water followed by a thorough water rinse. For eyes, flush with plenty of water or normal saline. Decontamination water may need to be contained.

Bleach solutions, concentrated or dilute, should not be used on people. Diluted bleach (1 part household bleach to 9 parts water) can be used on equipment and other hard surfaces. Because bleach solutions irritate the eyes, skin and respiratory tract, they must be handled with caution and used with adequate ventilation.

It is important not to abrade the skin during washing or rinsing. This is especially true after exposure to blistering/vesicant agents which bind to skin. These agents may leave the skin compromised and susceptible to further damage. For choking/pulmonary-damaging agents or incapacitating/behavior-altering agents, a rinse in water alone may be adequate.
ODORS

Some chemical agents are accompanied by a characteristic odor that may provide a warning. However, after a while, people may become used to the chemical and no longer detect the smell. The chemical may still be present even if there is no detectable odor.

DISCLAIMER

The information on this card is meant to be a quick guide and is not intended to be comprehensive. This information or the web sites and references listed in this card are not a substitute for professional medical advice, diagnosis, or treatment of the individual. Please consult other references, Poison Control Center, and check antidote dosages, particularly for children and pregnant women.
Introduction:

In 2003 the Bureau of Emergency Medical Services will introduce the fifth version (Version-5) of the New York State Prehospital Care Report (PCR)(DOH 3283) (sample attached). The primary purpose of the PCR remains a form used to document all prehospital care and pertinent patient information. The secondary purpose of the PCR is that of a data collection tool.

The Department of Health maintains a data system that tracks all inpatient care in hospitals by linking some of the data, Version-5 of the PCR will allow for the collection of additional data. That will allow linking prehospital patient care and the care provided by the emergency department and if admitted the hospital through to discharge. The linkage is obtained by certain identifying factors such as digits of the social security number and several of the characters in the patient’s last name. This will permit the EMS system to better determine the effectiveness of the care given in a prehospital setting for quality assurance purposes.

Version-5 also includes characteristics necessary to utilize this form as a scannable instrument. Optical Character Recognition (OCR) will permit the form to be scanned and have the data extracted from it into useable tables. The only way this will be accomplished is if the person completing the form prints legibly. This will allow agencies, counties or regions to consider scannable systems locally.

Completing a Version-5 PCR:

While the form looks different, all of the previous items contained in a PCR are continued on the Version-5. Several items have been added and the format that information is entered has also been changed. Added to the Version-5 are:

- Boxes for providing the patient’s social security number (SS#)
- An indication if the patient was defibrillated by a Public Access Defibrillation (PAD) Provider.
• The patient’s Date of Birth is now an 8-character entry requiring the century to be included. This field is located on the bottom line of the patient information box between the box for the patient’s age and the circles for the patient’s gender.

The other differences between Version-5 and the previous versions include:

• Boxes are now provided for each character of agency and patient identifying information.
  ➢ Please place one character in each box.
  ➢ Do not draw lines through boxes that are not relevant to the patient.
  ➢ **Print carefully and legibly.**

• The **Presenting Problem, Treatment Given** and several other “Boxes” are now **circles.**
  ➢ Please completely darken each circle that is applicable.
  ➢ The *Presenting Problems* and *Treatment Given* sections are now printed with red ink. This red ink will not be recognized when the form is scanned. This feature is essential when the scanning process is implemented.
  ➢ **Do not use X or √ to indicate a selection.**

There are no special tools required to complete the PCR, however it must be completed using black ink to be read by a scanner.

If you have any questions about completing a PCR please refer to DOH Policy Statement 02-05 (or any subsequent replacement of that document).

Issued and Authorized by:
Edward G. Wronski, Director
Bureau of Emergency Medical Services
SUBJECT: Ambulance and ALS FR Service Certificates

INTRODUCTION:

Operating certificates are documents issued by the Department to Ambulance Services and Advanced Life Support First Response Services. The certificate defines the services operating territory and contains the name under which the agency is required to operate.

Certificates are valid for two years. The certificate’s expiration date is printed in the upper right hand corner of the document. **It is the certified service’s responsibility to insure that their certification is maintained continuously.**

RENEWAL PROCESS:

Renewal of operating authority applications are mailed to certified services sixty to ninety days prior to expiration of their certificates. These mailings are sent to the last official address filed with the Department by the agency. It is the agency’s responsibility to provide the Bureau of Emergency Medical Services of their current mailing address and to advise the Bureau of EMS of any address changes.

Failure to receive this mailing is not justification for lapsed certification. Services that do not receive renewal applications by mail or which need assistance may find copies of the application and other needed forms in the **DOH Bureau of EMS Operations Resource Guide** or on the Bureau’s site on the World Wide Web: [www.health.state.ny.us/nysdoh/ems/main.htm](http://www.health.state.ny.us/nysdoh/ems/main.htm)

It is the responsibility of operators of certified services to file complete recertification applications with the Department at least thirty days prior to the expiration date of their current certificate. **Completed applications shall be filed with the Department’s regional office as indicated in the application packet or on the web site.**
Completed recertification applications received by the Department prior to the expiration of the current certificate, will result in a new certificate issued with an expiration date two years from the current expiration date. This assures no lapse in certification. However, at the Department's option, window stickers for vehicles may be withheld pending an inspection of the agency, its records and vehicles.

Applications filed after the expiration date or which are submitted incomplete will be issued an expiration date two (2) years from the end of the month in which the application is received and approved by the Department. Failure to file complete recertification applications on time may result in periods of lapsed certification. Additionally the Department may report lapses of certification to Medicaid, Medicare, insurance carriers or other interested parties upon request. Services may also be subject to disciplinary procedures if they operate without certification.

The Regional Medical Advisory Committee (REMAC) will be advised of any lapse of certification of an ALS agency as advanced life support may not be provided by a service that is not currently certified by the Department. The authority to possess and administer controlled substances held by any EMS service will be considered suspended during any lapse in certification by the service.

All current operating certificates issued by the Department must be posted conspicuously, as indicated on the certificate.

If there are any errors on the certificate that is issued to an agency it is the agency’s responsibility to notify the Department to have a new certificate issued.

Certificates may not be transferred and remain the property of the NYS Department of Health. Certificates must be surrendered to the Department upon any termination of operation by a certified EMS agency.

Authorized and Issued by;
Edward G. Wronski, Director
Bureau of Emergency Medical Services
PURPOSE:

This policy statement is intended to provide EMS agencies with guidance to assist them in meeting their requirement to have policies regarding preventive maintenance for all EMS vehicles and equipment pursuant to 10 NYCRR Part 800.21(p)(8).

EMS VEHICLES:

The most effective source of information regarding the preventive maintenance program for an EMS vehicle comes from the manufacturer’s “Operating Instructions” or “Owner’s Manual” that was provided with the vehicle at the time of delivery. If your agency does not have a copy of this type of information than it should be obtained from the manufacturer.

An agency policy developed to comply with 800.21(p)(8) should include (but not be limited to):

- Annual DMV Inspection
- Fluid and filter change intervals
- Tire rotation intervals
- Fluid level check schedule
- Battery check intervals
- Inspection of lights and the electrical system
- Inspection of belts, hoses and clamps
- Inspection of doors and gaskets
- Brake service intervals
- Evaluation of the heating and cooling system
- Schedule of other maintenance procedures particular to vehicle
- Procedures for daily/weekly inspections to be performed by members/employees
- Procedures employees/members should follow in the event a malfunction occurs

As important as the performance of these procedures, of equal importance is their documentation. Services are urged to maintain complete maintenance records on all their vehicles. Such records should include inspection reports as well as records of services...
performed by either the agency’s employees/members, outside vendors or representatives of the vehicle manufacturer. This record might also contain any service bulletins or recall notices issued by the manufacture and records of compliance with their recommendations.

Personally owned vehicles operated as Emergency Ambulance Service Vehicles (EASV) should also be covered by the agency’s policy to assure that the owner/operator of the vehicle is maintaining the vehicle and it is capable of emergency response and safe operation.

**EMS EQUIPMENT:**

Nearly all pieces of EMS equipment come with some form of an “Owner’s Manual” or “Operator’s Guide”. These documents need to be retained and reviewed by appropriate agency staff and the procedures for care and maintenance should be followed.

Each agency’s policy on preventive maintenance of equipment should include, but not be limited to, provisions to:

- Perform manufacture’s recommended calibrations/inspections
- Perform manufacture’s recommended service (including lubrications) and the proper materials to use in performing recommended service
- Replace and service batteries (if applicable)
- Proper inspection of all equipment available to provider
- Proper cleaning and disinfecting procedures
- Procedures for removing equipment from service
- Procedures to be followed in the event of equipment failures

The following types of equipment should be covered by any preventive maintenance or biometric service policy developed by an agency:

- Radios and other communications equipment
- Stretchers and stretcher mounting hardware
- AEDs
- ECG/Manual Defibrillator equipment
- Pulse oximeters
- Suction devices
- Rechargeable battery powered lights
- BP Cuffs; manual and automatic
- Patient stabilization/transportation/immobilization devices
- Oxygen regulators and delivery systems
- Ventilators
- Infusion devices
- Specialized pieces of equipment owned or operated by the service
As with vehicles EMS agencies should have a record or log (paper or electronic) for each piece of equipment that contains:

- When and where the equipment was purchased/obtained
- Documentation pertaining to repairs of the piece of equipment
- Equipment maintenance schedule per the manufacturers instructions
- Documentation pertaining to all maintenance performed on the equipment

All agencies are reminded that they must “maintain a record of all unexpected authorized EMS response vehicle and patient care equipment failures that could have resulted in harm to a patient and the corrective actions taken. A copy of this record shall be submitted to the Department with the EMS service's biennial recertification application” ¹

The development of clear and concise policies provide EMS service employees/members with an understanding as to what each member of the organizations roles and responsibilities are relating to maintaining, servicing and repairing agency equipment and vehicles. These policies also serve to allow providers to have functioning vehicles and equipment to provide the best possible patient care.

Issued and Authorized by:
Edward G. Wronski, Director
Bureau of EMS

¹ 10 NYCRR part 800.21(r)
This policy provides advanced life support (ALS) EMS agencies with a brief explanation of the recent revisions to the United States Department of Labor, Occupational Health and Safety Administration (OSHA) regulations and the Needlestick Safety and Prevention Act. This policy does not supercede or take precedence over any guidance that OSHA or New York State Public Employee Safety and Health (PESH) may provide.

In 1992 the OSHA issued the Bloodborne Pathogen regulations (29 CFR 1910). In November of 2000, the Needlestick Safety and Prevention Act was signed into law and took effect on April 18th, 2001. This new act required that OSHA revise the Bloodborne Pathogen standard to add the following components:

- Provide new examples in the definition of engineering controls.
- Require that exposure control plans reflect how employers implement a needleless/safety and needle stick prevention program.
- Requires the employer to solicit input from direct patient care employees in the identification, evaluation and selection of safer needle devices and work practices.
- Require employers to establish and maintain a log of sharps related injuries.

This new section of the OSHA regulations requires that EMS services use sharps, such as syringes and intravenous catheters that are engineered with built-in safety features or mechanisms that will reduce the risk of a blood or body fluid exposure by a needlestick injury.

In July of 2002 OSHA further clarified their position on the removal of needles from blood tube holders in order to reuse the blood tube holder. OSHA stated that “Contaminated needles and other contaminated sharps shall not be bent, recapped, or removed, unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical or dental procedure.” More specifically, OSHA’s new compliance directive, CPL 2-2.69 at XIII.D.5 states, “removing the needle from a used blood-drawing/phlebotomy device is rarely, if ever, required by a medical procedure. Because such devices involve the use of a double-ended needle, such removal clearly exposes employees to additional risk, as does the increased manipulation of a contaminated device.” In order to prevent potential worker exposure to the contaminated hollow bore needle at both the front and back ends, blood tube holders, with needles attached, must be immediately discarded into an accessible sharps container after the safety feature has been activated.
Engineering Controls
The revised definition of engineering controls means “controls (e.g. sharps, disposal containers, self sheathing needles, safer medical devices such as sharps with engineered injury protections and needleless systems) that isolate or remove the bloodborne pathogens hazard from the work place”. Sharps with engineered injury protections are defined as non-needle or a needle with a built in safety feature or mechanism that will effectively reduce the risk of a blood or body fluid exposure.

Revision to the Exposure Control Plan (ECP)
EMS agencies must update their existing ECP to include changes in technology that will reduce or eliminate exposure to blood or body fluids. The ECP must include the consideration and implementation of safer medical devices and the solicitation of input from non-managerial employees.

Sharps Injury Log
The revision of the OSHA regulations now requires that EMS services maintain a sharps injury log. The log must include information regarding the type and brand of device involved, the department or area the incident occurred and a description of the incident for each needlestick injury.

Selection of Safer Medical Devices
In deciding what type of safety device to choose, the EMS agency should select an appropriate device based on the agency’s exposure determination and one, which will not compromise patient care. The service must identify any worker exposure to blood and body fluids, review all processes and procedures that have a risk of exposure and re-evaluate any new processes or procedures that are implemented. The OSHA regulation requires the agency to involve employees in the testing and choosing of the devices that will be used in the field.

The process of choosing an appropriate safety device should be made in consultation with the agency medical director. The Regional Emergency Medical Advisory Committee (REMAC) may also be able to provide further guidance in determining an appropriate safe needle device.

Training and Education on the Use of Safer Devices
Recent studies have shown that health care providers that use safer needle devices, without the proper in service training, may be at a greater risk of a needlestick injury than when using unprotected needle devices. Additionally, poor or no training on new safer needle devices may be attributed to a decrease in IV cannulation success rates. Therefore, it is imperative that agencies provide a comprehensive training program with the safe needle devices, which have been chosen, for use by the EMS agency. Each provider must have the opportunity to practice using training manikins with the safe device. If possible, the provider should also be able to use the safe devices under supervision in field practice.

Further Information
For further information please refer to the following web sites:

- NYS Department of Labor, Public Employees Health and Safety
  www.labor.ny.us (Business in New York)
- US Department of Labor, Occupational Health and Safety
  www.osha.gov (Bloodborne Pathogens)
On November 13th, 2001 § 413 of the Social Services Law was amended, in relation to persons and officials who are required to report cases of suspected child abuse or maltreatment. Effective February 1st, 2002 the law will require Emergency Medical Technicians to report suspected child abuse they come across while performing their jobs. The Bureau of EMS will not require EMTs to attend a specialized course for child abuse. The current EMS course curricula include sections on child abuse. However, the Bureau does reserve the right to amend the curricula in the future. Therefore, this Policy Statement and attached fact sheet are intended to be used by New York State EMTs to help them better understand their obligations as well as the signs and symptoms of possible child abuse or maltreatment.

Reporting Procedures:

§ 415 of the Social Services Law states that, “Reports of suspected child abuse or maltreatment made pursuant to this title shall be made immediately by telephone or by telephone facsimile machine on a form supplied by the commissioner. Oral reports shall be followed by a report in writing within forty-eight hours after such oral report. Oral reports shall be made to the statewide central 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 service.”

Oral Reports of suspected child abuse or maltreatment shall be made by calling the NYS Child Abuse and Maltreatment Register at:

1-800-635-1522

NOTE: This phone number is for mandated reporters ONLY and should NOT be provided to the general public.

- All oral reports must be followed up with a written report within 48 hours using Form DSS-2221-A, “Report of Suspected Child Abuse or Maltreatment” (Attached).

- A copy of the completed and submitted Form DSS-2221-A should be attached to the agency copy of the Prehospital Care Report retained by the agency.

Agency Policies

10 NYCRR Part 800.21(p)(11)(ii) requires all ambulance services to have and enforce a written policy regarding the reporting of child abuse. Based on the addition to §413 of Social Services Law all services should ensure that the policy developed regarding this requirement includes the mandatory reporting requirement and the process required by Social Services Law § 415. The agency policy needs to address areas such as Prehospital Care Report documentation, notifying the Emergency Room staff, calling the above 800 telephone number, and the completion of form DSS-2221-A.
Immunity From Liability

Immunity from liability for reporting cases of suspected child abuse or maltreatment is provided to those individuals required to report such cases under § 419 of the Social Services Law so long as the individual was acting in, “good faith”.

Failure To Report

§ 420 Of the Social Services Law states:

1. Any person, official or institution required by this title to report a case of suspected child abuse or maltreatment who willfully fails to do so shall be guilty of a class A misdemeanor.

2. Any person, official or institution required by this title to report a case of suspected child abuse or maltreatment who knowingly and willfully fails to do so shall be civilly liable for the damages proximately caused by such failure.

Attachments:

Child Abuse/Maltreatment Fact Sheet
Form DSS-2221-A

Issued and Authorized by:
Edward G. Wronski, Director
Bureau of Emergency Medical Services

\(^1\) Pertains to Onondaga and Monroe Counties Only
Child Abuse and Maltreatment Fact Sheet

This fact sheet is intended to be used by New York State EMTs as a learning tool and guide to help them better understand the signs and symptoms of possible child abuse or maltreatment. The signs and indicators listed in this document are not conclusive proof of child abuse or maltreatment. There can be other, reasonable explanations for what you observe.

Definition of Child Abuse:

An “abused child” is a child less than eighteen (18) years of age whose parent or other person legally responsible for his/her care:
1. Inflicts or allows to be inflicted upon the child serious physical injury, or
2. Creates or allows to be created a substantial risk of physical injury, or
3. Commits or allows to be committed against the child a sexual offense as defined in the penal law.

Definition of Child Maltreatment:

A “maltreated child” is a child under eighteen (18) years of age who has had serious physical injury inflicted upon him/her by other than accidental means.

A “maltreated child” is also a child under eighteen (18) years of age whose physical, mental or emotional condition has been impaired or is in danger of becoming impaired as a result of the failure of his/her parent or other person legally responsible for his/her care to exercise a minimum degree of care:

1. In supplying the child with adequate food, clothing, shelter, education, medical or surgical care, though financially able to do so or offered financial or other reasonable means to do so; or
2. In providing the child with proper supervision or guardianship; or
3. By unreasonable inflicting, or allowing to be inflicted, harm or substantial risk thereof, including the infliction of excessive corporal punishment; or
4. By using a drug or drugs; or
5. By using alcoholic beverages to the extent that he/she loses self-control of his/her actions; or
6. By any other acts of a similarly serious nature requiring the aid of the Family Court.

Some of the physical indicators of possible child abuse:

- Bruises in different stages of healing, welts, or bite marks on face, lips, mouth, neck, wrist, thighs, ankles, or torso, or on several area of the body such as:
  - Injuries to both eyes or both cheeks (usually only one side of the face is injured in an accident)
  - Marks that are clustered, that form regular patterns, that reflect the shape of such articles as an electrical cord, belt buckle, fork tines, or human teeth.
  - Grab marks on the arms or shoulders; and/or
  - Bizarre marks, such as permanent tattoos

- Lacerations or abrasions to mouth, lips, gums, eyes, external genitalia, arms, legs, or torso.

- Burns:
  - From cigars or cigarettes, especially on soles, palms, back, or buttocks.
  - From immersion in scalding water (socklike or glovelike on feet or on hands, doughnut-shaped on buttocks or genitalia)
  - That are patterned like an object, such as an iron or electric burner; burns from ropes on arms, legs, neck, or torso.
Any fractures:
- Multiple or spiral, of the long bones, to skull, nose, or facial structure.
- Other injuries, such as dislocation.

Head Injuries:
- Absence of hair or hemorrhage beneath the scalp from hairpulling.
- Subdural hematomas
- Retinal hemorrhage or detachment, from shaking
- Eye injuries
- Jaw and nasal fractures
- Tooth or frenulum injury

Symptoms that suggest fabricated or induced illness, sometimes known as Munchausen Syndrome by Proxy (MSP); for example, a parent might be repeatedly feeding a child quantities of laxatives sufficient to cause diarrhea, dehydration, or hospitalization, without revealing the child has been medicated.

Some of the emotional and behavioral signs of possible child abuse:
- Apprehension when other children cry
- Aggressiveness
- Withdrawal
- Fear of going home
- Fear of parents and other adults
- Extreme mood swings
- Inappropriate mood
- Habit disorder, such as nail-biting
- Low self-esteem
- Neuroses, such as hypochondria, obsessions
- Refusal to remove outer garments
- Attempted suicide

Some of the physical signs of possible child neglect:
- Newborn with positive toxicology for drugs
- Lags in physical development
- Constant hunger
- Speech disorder
- Poor hygiene
- Inappropriate dress for the season
- Lack of medical care
- Inadequate supervision

Some of the emotional and behavioral indicators of possible child neglect:
- Chronic fatigue
- Habit disorder, such as thumb-sucking by a ten-year-old, rocking, biting
- Reports no caregiver at home
- Frequent absences from school or lateness
- Hypochondria
- Shifts from complaint to aggressive behavior
- Age-inappropriate behavior
- Begging for food
- Lags in emotional or mental development
- Use of alcohol or drugs
Some of the signs of possible child sexual abuse:

- Difficulty in walking and sitting
- Pain or itching in the genital area
- Torn, stained, or bloody underclothing
- Bruises or bleeding of external genitalia or vaginal or anal areas
- Bruises to the hard or soft palate
- Sexually transmitted diseases, especially in preteens
- Painful discharge of urine or repeated urinary infections
- Foreign bodies in the vagina or the rectum
- Pregnancy, especially in early adolescence

Some emotional and behavioral signs of possible child sexual abuse:

Many of the following indicators may also reflect problems unrelated to sexual abuse. Moreover, no one child will show all of these signs.

Particularly in children who are less than eight years of age look for:

- Eating disorders
- Fear of sleeping alone
- Enuresis (bed wetting at night or daytime accidents)
- Separation anxiety
- Thumb or object sucking
- Encopresis (soiling)
- Language regression
- Sexual talk
- Excessive masturbation
- Sexual acting out, posturing
- Crying spells
- Hyperactivity
- Change in school behavior (fear of school, drop in grades, trouble concentrating)
- Regular tantrums
- Excessive fear (including of men or women)
- Nightmares or night terrors
- Sadness or depression
- Suicidal thoughts
- Extreme nervousness
- Hypochondria

In children over eight through adolescence:

- Fear of being alone
- Peer problems
- Frequent fights with family members
- Poor self-esteem
- Excessive nervousness
- Emotional numbness (out-of-body experiences, or feelings of unreality)
- Substance Abuse
- Excessive guilt or shame
- Mood swings
- Sexual concerns or preoccupations
- Withdrawn, isolated behavior
- Overly compliant behavior
- Suicidal thoughts or gestures
- Self-mutilation
- Hyperalertness
- Sexual acting out
- Avoidant, phobic behavior, including sexual topics
- Unwillingness to change into gym clothes
- Violent fantasies
- Memory problems
- Fear of future abuse
- Intrusive, recurrent thoughts, or flashbacks
REPORT OF SUSPECTED CHILD ABUSE OR MALTREATMENT

New York State Office of Children and Family Services

SUBJECTS OF REPORT

<table>
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<th>Line #</th>
<th>Last Name</th>
<th>First Name</th>
<th>Aliases</th>
<th>Sex (M, F, Unk)</th>
<th>Birthday or Age Mo/ Day/ Yr</th>
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<th>Relation Code</th>
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List Addresses and Telephone Numbers (Using Line Numbers From Above)

BASIS OF SUSPICIONS

Alleged suspicions of abuse or maltreatment. Give child(ren)’s line number(s). If all children, write "ALL".

- DOA/Fatality
- Fractures
- Internal Injuries (i.e. Subdural Hematoma)
- Lacerations/Bruises/Welts
- Burns/Scalding
- Excessive Corporal Punishment
- Inappropriate Isolation/Restraint(Institutional Abuse Only)
- Inappropriate Custodial Conduct(Institutional Abuse Only)
- Child’s Drug/Alcohol Use
- Poisoning/Noxious Substances
- Choking/Twisting/Shaking
- Lack of Medical Care
- Malnutrition/Failure to Thrive
- Sexual Abuse
- Inadequate Guardianship
- Swelling/Dislocation/Sprains
- Educational Neglect
- Emotional Neglect
- Inadequate Medical Care/Therapy
- Abandonment
- Parent’s Drug/Alcohol Misuse
- Other specify
- Inappropriate Isolation/Restraint (Institutional Abuse Only)
- Inadequate Guardianship
- Other specify
- Swelling/Dislocation/Sprains

State reasons for suspicion, including the nature and extent of each child’s injuries, abuse or maltreatment, past and present, and any evidence or suspicions of “Parental” behavior contributing to the problem. (If known, give time/date of alleged incident) _____ / _____ / _____ Time ______(AM/PM)

The Mandated Reporter Requests Finding of Investigation YES ☐ NO ☐

CONFIDENTIAL SOURCES OF REPORT CONFIDENTIAL

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AGENCY/INSTITUTION

RELATIONSHIP ( ☑ = REPORTER, X = SOURCE)

☐ Med. Exam/Coroner ☐ Physician ☐ Hosp. Staff ☐ Law Enforcement ☐ Neighbor ☐ Relative ☐ Inst. Staff
☐ Social Services ☐ Public Health ☐ Mental Health ☐ School Staff ☐ Other Specify

For Use By Physicians Only

Medical Diagnosis on Child

Hospitalization Required: ☐ None ☐ Under 1 week ☐ 1-2 weeks ☐ Over 2 weeks

Actions Taken Or ☐ Medical Exam ☐ X-Ray ☐ Removal/Keeping ☐ Not. Med Exam/Coroner
About To Be Taken ☐ Photographs ☐ Hospitalization ☐ Returning Home ☐ Notified DA

Signature of Person Making This Report Title Date Submitted Mo. Day Yr.

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About To Be Taken ☐ Photographs ☐ Hospitalization ☐ Returning Home ☐ Notified DA

Signature of Person Making This Report Title Date Submitted Mo. Day Yr.
Abstract Sections from Article 6, Title 6, Social Services Law

Section 412. Definitions

1. **Definition of Child Abuse** (see N.Y.S. Family Court Act Section 1012(e))
   
   An “abused child” is a child less than eighteen years of age whose parent or other person legally responsible for his care:
   
   1) Inflicts or allows to be inflicted upon the child serious physical injury, or
   2) Creates or allows to be created a substantial risk of physical injury, or
   3) Commits or allows to committed against the child a sexual offense as defined in the penal law.

2. **Definition of Child Maltreatment** (see N.Y.S. Family Court Act, Section 1012(f))

   A “maltreated child” is a child under eighteen years of age whose physical, mental or emotional condition has been impaired or is in danger of becoming impaired as a result of the failure of his parent or other person legally responsible for his care to exercise a minimum degree of care:
   
   1) in supplying the child with adequate food, clothing, shelter, education, medical or surgical care, though financially able to do so or offered financial or other reasonable means to do so; or
   2) in providing the child with proper supervision or guardianship; or
   3) by unreasonable inflicting, or allowing to be inflicted, harm or a substantial risk thereof, including the infliction of excessive corporal punishment; or
   4) by using a drug or drugs; or
   5) by using alcoholic beverages to the extent that he loses self-control of his actions; or
   6) by any other acts of a similarly serious nature requiring the aid of the Family Court.

Section 415. Reporting Procedure.

Reports of suspected child abuse or maltreatment shall be made immediately by telephone* and in writing within 48 hours after such oral report…written reports shall be made to the appropriate local child protective services on this form (Report of Suspected Child Abuse and Maltreatment, DSS-2221-A). Submit the written DSS-2221-A form for Residential Institutional abuse reports directly to the State Central Register 40 N. Pearl St. Albany, N.Y. 12243.

Section 419. Immunity from Liability.

Any person, official or institution participating in good faith in the making of a report, the taking of photographs, or the removal or keeping of a child pursuant to this title shall have immunity from any liability, civil or of any person required to report cases of child abuse or maltreatment shall be presumed.

Section 420. Penalties for Failure to Report.

1. Any person, official, or institution required by this title to report a case of suspected child abuse or maltreatment who willfully fails to do so shall be guilty of a class A misdemeanor.
2. Any person, official, or institution required by this title to report a case of suspected child abuse or maltreatment who knowingly and willfully fails to do so shall be civilly liable for the damages proximately caused by such failure.

*NYS CHILD ABUSE AND MALTREATMENT REGISTER: 1-800-635-1522 (FOR MANDATED REPORTERS ONLY)
1-800-342-3720 (FOR PUBLIC CALLERS)
March 6, 2002

Dear EMS Agency:

In an earlier letter we shared that effective February 1, 2002, emergency medical technicians (EMTs) are required to report suspected cases of child abuse or maltreatment to the New York State central child abuse registry. We had also provided a copy of the Department of Health’s Policy Statement # 02-01, which describes how EMTs and ambulance services are to comply with this new reporting requirement.

At this time we would like to clarify a few issues that have come to our attention concerning the reporting of suspected child abuse cases by EMTs. Listed below is a summary of these issues:

1. EMTs are not required to take a course on how to comply with the reporting requirements. However, Regional EMS Councils, EMS services, EMS Course Sponsors and other interested parties may offer an overview of the legislation and guidelines on how best to achieve the desired results within their community or EMS agency. Such a course may be designed to meet the continuing medical education requirements of the Pilot Project.

2. For the time being, EMTs are required to be the reporter of record for suspected cases even if the child is transported and admitted to a hospital. EMTs can not and should not transfer the responsibility for reporting a suspected case to hospital personnel or any other health provider.

3. If there are multiple EMTs responding to a call from the same EMS agency, it is only necessary for the EMT of record (in-charge of patient care) from that agency to submit the required form. This may be confusing when there are multiple agencies responding, treating, and transporting the same patient. The EMT of record from each agency must file a separate report.

4. Reporting Procedures: An oral report must be made immediately to the NYS Child Abuse and Maltreatment Register at 1-800-635-1522. This must be followed by a written report, using Form DSS-2221-A, within 48 hours to the local child protective services for where the child resides. The only time Form DSS-2221-A is to be sent directly to the NYS Central Register is when the child resides in a Residential Institution.

5. EMS agencies are reminded that they must update their policies and procedures with regards to their personnel reporting child abuse and/or neglect. These policies and procedures need to reflect the guidelines in BEMS policy statement #02-01 as well as the required local reporting procedures for their area.

6. It is understood that EMTs will need to complete the DSS-2221-A form after an emergency situation. EMTs are not expected to have the form filled out in its entirety. EMTs should fill out as much information as possible, with the limited information they have and submit the form to their local child protective service who will obtain the rest of the information on the form.
7. The Bureau of EMS encourages EMS agencies to continue to have open dialogue with their local Child Protective Service to better understand issues at the local level.

For assistance on how best EMTs and/or ambulance services can meet the new reporting requirements, please contact the Bureau of EMS at 518-402-0996 Ext. 1, 4 (Education Unit). EMTs should refrain from contacting the NYS Central Register. The Requirement to Report Instances of Suspected Child Abuse or Maltreatment Policy Statement is accessible at www.health.state.ny.us (click on providers for EMS webpage). If you have questions about the mandatory reporter program, please visit the New York State Office of Children and Family Services at http://www.ocfs.state.ny.us or contact them at 518-474-4670.

Thank you for your cooperation with this important reporting initiative.

Sincerely,

Edward G. Wronski
Director
Bureau of Emergency Medical Services

cc: Regional EMS Councils
Regional Emergency Medical Advisory Committees
EMS Course Sponsors
ADVISORY FOR RESPONSE TO PATIENTS EXPOSED TO UNKNOWN SUBSTANCES

PLEASE DISTRIBUTE IMMEDIATELY

This advisory is being sent to you to assist when responding to an emergency call involving a package, envelope or substance suspected of being Anthrax. Also attached are Anthrax advisories/protocols developed by the Department of Health to assist you in understanding what Anthrax is, mail handling protocols, recommended patient/equipment, decontamination guidelines, specimen handling and criteria for lab testing.

There are some primary things to understand about responding to an emergency medical response which involves a call site alleged to contain Anthrax or involving an unknown powder/substance:

1. Confirm scene safety and type of incident. Responding EMS agencies are NOT advised to enter an affected area until a competent authority has determined the scene to be safe.

2. If your arrive on the scene first, notify competent authority.

3. If an unknown substance has been found in the air handling system, evacuate the premises immediately and notify the competent authority.

4. Anthrax is NOT contagious. Person to person transmission has never been reported.

5. There will be little or no need for prehospital medical care. Do not transport the individual to a hospital, unless other medical conditions need to be addressed (i.e., chest pain, severe anxiety). Patients should not be transported to a hospital.

6. If patient insists on being transported to the hospital, contact medical control for physician consultation.
7. If you transport to the hospital, notify the receiving hospital that you are bringing a patient who has been exposed to a powder/unknown substance and request the hospital to have staff meet you outside of the Emergency Department.

8. Create a list of individuals who were in area of exposure to be given to the incident commander or local police and shared with local public health officials. All, or most individuals, should be released home with the self-monitoring instructions attached.

9. The need for testing of the substance will be determined by appropriate authorities following risk assessment.

10. Unless a lab test confirms the nature of the powder substance, there is no need to immediately initiate prehospital medical treatment. These lab tests take at least 24 hours to complete. There is no harm to an individual waiting for lab results before beginning appropriate medical treatment.

11. The Centers for Disease Control (CDC) has advised that no treatment is necessary for Anthrax in an otherwise healthy person exposed to an unknown powder/substance.

12. If you arrive at the scene and patient(s) have been decontaminated, you should follow the above guidelines, but assist in addressing individual concerns about infection and treatment.

13. If you enter a scene and the patient has not been decontaminated and there is an observable substance, contact a competent authority and perform the following:

   X If the patient has a powder or other substance on their skin or clothing, ask the patient to remove their outer clothing. If the patient is not able to undress themselves, put on PPE\(^1\) and remove the patients outer or exposed clothing.
   X Provide the patient with a disposable garment or a sheet.
   X The patient's clothing should be secured by the patient (if possible), in a clear plastic bag and left with the competent authorities on the scene.
   X See attached Decontamination Advisory. This should be followed by the appropriate local agency responsible for decontamination. EMS is not generally responsible for decontamination.

14. Remember you are considered health care providers who the public expects will be knowledgeable about Anthrax. Often, you will be the highest medical authority at the scene. Please review the attached materials and be prepared to work with local or state public health officials in calming public fears regarding these incidents.

**NOTE:** This guideline is being provided to your local REMAC for incorporation into local protocol.

\(^1\)Personal Protective Equipment (PPE) - Gloves, mask and eye protection. These may not be necessary on every call. Use the appropriate PPE based on the patient assessment and the presence of blood or body fluids and pertinent past medical history.
Attachments

X DOH Anthrax Fact Sheet
X Protocol for Mail Handling
X Decontamination Advisory
X Patient Self-monitoring Instructions
X Criteria For Wadsworth Laboratory Testing
X Protocol for Submitting Environmental Samples for Laboratory Testing

cc: Regional Emergency Medical Advisory Committees
    County EMS Coordinators
    Regional DOH Offices
    State Emergency Management Office
    County Emergency Managers
    County Fire Coordinators
    County Hazmat Teams
    County/City Health Departments
    New York State Police
    Sheriffs Association
    Hospital Emergency Departments
SUBJECT: Sample Standard Operating Procedure to Follow in Case of an EMS Vehicle Collision

In response to concerns of EMS service operators on how to handle an EMS vehicle accident the following guidelines have been prepared for inclusion into each service’s standard operating procedures.

If A Collision Occurs With An EMS Vehicle

1) Protect the scene with warning lights or flares. If the vehicles are in a hazardous location or blocking traffic, they may be moved to the side of the street.

2) Notify the dispatcher immediately to request the following:
   a) The supervisor
   b) The appropriate police agency.
   c) Any other necessary services such as Fire Department or towing service etc.

3) If the EMS vehicle was enroute to the scene of a call notify the dispatcher to immediately dispatch another EMS unit to that assignment.

4) If a patient was being transported and the ambulance has been rendered inoperable, have the dispatcher send an ambulance to transport the patient.

5) If the patient being transported is unstable and the ambulance is not rendered inoperable, and there are no other unstable patients on the scene, then instruct the other vehicle operator to remain at the scene until police arrive and provide them with:
   • Service name;
   • Vehicle identifier; and
   • The ambulance operator’s name
• Record the name, vehicle type, make, and license number of the other vehicle before leaving the scene with your patient.
• If the crew has an extra person, leave him/her at the scene to begin the paperwork.

6) If a stable patient is being transported assure that care is being provided to the patient by an EMT while awaiting the arrival of the police, if waiting will not cause excessive delay. While waiting for police to arrive exchange information then continue transport to the original destination upon arrival of the police. Return to the scene after delivering the patient to their destination.

7) Administer patient care to any injured persons.

8) If there is no patient exchange necessary, obtain information with other involved person (license, registration and insurance card). Record the police officer’s name, shield number, department; if any tickets are issued, and make a rough sketch of the pertinent aspects of the scene.

9) Obtain name, address, telephone number and a brief statement from any witness.

10) Make sure even the minor injuries are well-documented and receive appropriate emergency department follow-up as needed.

11) Per 10 NYCRR Part 800.21, report to the Department of Health EMS Bureau Representative for your region, within 24 hours, any accident involving personal injury and/or any accident that results in an ambulance being placed out of service.

12) New York State Vehicle and Traffic Law also requires the owner of any vehicle involved in an accident resulting in any personal injury, death and/or damage exceeding $1,000 (to any one vehicle) to file a report with the Department of Motor Vehicles within 10 days. The required MV-104 form may be obtained at any police station or DMV office.

13) Individual EMS agencies should contact their insurance carriers to determine if there are any additional requirements they may have regarding this topic.

Issued and Authorized by
Edward G. Wronski, Director
Bureau of Emergency Medical Services
Background Information

The Abandoned Infant Protection Act was created in Chapter 156 of the Laws of 2000. Under this provision a parent, guardian or other legally responsible person may leave their infant (who must be five days old or less) at a safe place. The law requires that an adult must intend that the child be safe from physical injury, cared for in an appropriate manner, with an appropriate person, in a suitable location and promptly notify an appropriate person of the child’s location. People leaving an infant in compliance with this law are not required to provide their names. Such individuals will not be prosecuted as a class E felony of Abandonment of a Child and class A misdemeanor of Endangering the Welfare of a Child.

The governing legislation did not specify or define what is an acceptable safe location. Instead, local district attorneys are to determine whether the parent left the child in an appropriate location. Individuals who give up their infants do not automatically surrender their parental rights; and may later seek to reclaim the child. It is important to note that this legislation does not amend provisions of the Social Services law which make abandonment of an infant reportable to the New York State Central Register for Child Abuse and Maltreatment.

The New York State Office of Children and Family Services has released several Public Service Announcements and brochures about this program. In these materials; the public is provided with the intent of the new law; including a listing of suggested safe places where infants may be brought. The sites include hospitals, police stations, fire stations and other safe places. Some county district attorneys have already defined what constitutes a safe place within their county. Other counties have not yet done so.
Role of Emergency Medical Services Agencies

In the event a parent or legal guardian chooses to relinquish care of their newborn infant to an emergency medical service agency; the following guidelines should be considered:

1. In keeping with the intent of the governing legislation; parents are not required to provide their names to the safe location or staff. In a non-judgmental manner, EMS staff may ask the presenting adult if there is any medical information that is important to know in the care of the infant.

2. EMS services and systems may want to contact their county Office of the District Attorney to determine what if any locations have been identified as “safe places” by the District Attorney for the purposes of this legislation.

3. Infants received by an EMS service agency should be transported to the nearest hospital for medical assessment/care. EMS agencies should not be expected to interact with local child protection service agencies unless directed to do so.

4. If a parent seeks follow up information about the child they relinquished to the care of the EMS service agency; a referral should be made to the hospital where the infant was transported or the local office of social services.

Further Information

Information about this program may be obtained by contacting:

New York State Office of Children and Family Services
Capital View Office Park
52 Washington Street
Rensselaer, New York 12144

1-800-345-SAFE
http://www.dfa.state.ny.us

Issued by
Edward Wronski, Director
Bureau of Emergency Medical Services
There have been issues raised about the EMT staffing standard that became effective January 1, 2001 for voluntary ambulance services. Article 30 of the Public Health Law states that “the minimum staffing standard for a voluntary ambulance service shall be an Emergency Medical Technician with the patient.” The following is intended to help clarify the meaning of the law. This policy is written for ambulance service operation. It does not address first response service operation.

1. A voluntary ambulance service must have an Emergency Medical Technician (EMT) or higher, attending to the patient at the scene and in the ambulance while transporting the patient to the hospital.

2. If a voluntary ambulance service has a written response policy in place in which an EMT is allowed to respond directly to the scene from home or work, the ambulance may respond to the scene of the emergency even if an EMT is not on board.

3. If the EMT responding directly to the scene is delayed and the only other ambulance crew available are Certified First Responders (CFR), the CFR may begin care. It is acceptable to have a CFR as a part of an ambulance crew. The EMT assumes responsibility for care upon arriving at the scene.

4. If the EMT does not arrive at the scene and another service is immediately available with appropriate staffing, the patient should be transported by that service. If no other service is immediately available the patient should be transported. While this is a violation of Public Health Law, it is in the best interest of the patient to transport to a hospital where appropriate care is available, only as a last resort option.

Continual and repeated failure of a service to assure an EMT arrives at the scene to provide care may result in the Department taking disciplinary action against the service and/or the individual. It is recommended that any service unable to routinely provide an EMT to an emergency, whether on the ambulance or arriving independently, file for an exemption to the staffing standard with the local Regional EMS Council.
5. An ambulance should NOT respond to the scene of an emergency if it is known that an EMT is not available. It is recommended that all ambulance services preplan for the lack of staffing by written mutual aid agreements with neighboring ambulance services and by alerting the local Public Safety Answering Point (PSAP) or dispatch authority as early as possible. An ambulance service that responds to the scene of an emergency when called without an EMT should consult with an attorney regarding civil liability for not providing the statutory standard of care to a patient.

6. A service may send an ambulance and equipment to the scene of an emergency if they know another service will provide the EMT staff necessary to perform patient care. The service sending the ambulance would share responsibility for the care being provided. These types of mutual agreements to share the staff and equipment must be done in writing in advance.

7. The staffing standard requires one (1) EMT with a patient. Therefore, an ambulance must be staffed with at least one EMT. While it is preferable to have more than one EMT if there are multiple patients, the law does not require it. In the event of a multiple patient situation, the EMT would assume supervision of the care being provided to the patients being treated and transported.

**NOTE:** In a multiple casualty incident (MCI), local or regional protocols should be followed.

Please remember that there has always been a public expectation to be treated by a trained Emergency Medical Technician when they call 9-1-1 in a medical emergency. The law now requires this. Please work with us to assure that this standard of care is provided to all of our patients. Thank you.

Issued by:
Edward Wronski, Director
Bureau of Emergency Medical Services
Introduction:

Governor’s Executive Order Number 26, issued on March 5, 1996, established the Incident Command System (ICS). It states that ICS shall be used in New York State, "as the standard command and control system during emergency operations."

ICS is the model tool for command, control, and coordination of a response. It provides a means to coordinate the efforts of individual agencies as they work toward the common goal of stabilizing the incident and protecting life, property, and the environment. ICS uses principles that have been proven to improve efficiency and effectiveness in a business setting and applies the principles to emergency response.

ICS Overview:

ICS was developed in the 1970s in response to a series of major wild-land fires in southern California. At that time, municipal, county, State, and Federal fire authorities collaborated to form the Firefighting Resources of California Organized for Potential Emergencies (FIRESCOPE). Although originally developed in response to wildfires, ICS has evolved into an all-risk system that is appropriate for all types of fire and non-fire emergencies.

Many incidents, whether major accidents (such as Haz Mat spills), minor incidents (such as house fires and utility outages), or disasters (such as tornadoes, hurricanes, and earthquakes), require a response from a number of different agencies. Regardless of the size of the incident or the number of agencies involved in the response, all incidents require a coordinated effort to ensure an effective response and the efficient, safe use of resources. In Hazardous Materials incidents the use of the ICS is required by Federal Labor Law.
The ICS organization is built around five major components:

- Command
- Operations
- Finance/Administration
- Planning
- Logistics

These five major components are the foundation of the ICS. In small-scale incidents, all of the components may be managed by one person, the Incident Commander. Large-scale incidents usually require that each component, or section, be set up separately. Each of the primary ICS sections may be divided into smaller functions as needed.

**INCIDENT COMMAND:**

The ICS organization has the capability to expand or contract to meet the needs of the incident, but all incidents, regardless of size or complexity, will have an Incident Commander. A basic ICS operating guideline is that the Incident Commander is responsible for on-scene management. The person who initially assumes the command of an incident retains it until command authority is transferred to another person, who then becomes the Incident Commander.

As New York is a “Home Rule State” there are numerous New York State, County and Local Statutes that define the roles and responsibilities of Law Enforcement, Fire Service Personnel, County Emergency Management Personnel, as well as State, County and Local Government Officials. It is to the service’s advantage to find out who is responsible for what in your service’s location prior to an event occurring.

Based on the ICS system and the scope of the incident, EMS providers may be assigned or responsible for any number of roles. These roles may range from incident commander on a strictly medical situation to that of an operational or support unit member in a large multiple agency response to a major incident.

**OPERATIONS:**

Patient care is the primary operational function of EMS personnel. It is the responsibility of those certified EMS providers who are employees/members of Basic Life Support First Response (BLS FR) agencies, certified ALS First Response (ALS FR) and Ambulance Services to provide care in accordance with all established standards and protocols.

Individuals who are not functioning as part of an EMS systems have no patient care responsibility. Such a duty to act only arises from participation with an agency having jurisdiction.

**REMAC Responsibility:**

The Regional Medical Emergency Medical Advisory Committee (REMAC) has the statutory authority for the development of prehospital polices, procedures, triage, treatment and transportation protocols. These protocols should address concerns when multiple EMS providers, of various levels of certification, from one or more agencies are operating at the same scene. The protocols developed by the REMAC should also include
a provision regarding the transfer of patient care from one prehospital care provider or agency to another when needed. In addition the protocols should include a method for requesting additional and/or specialized resources and the coordination of these resources.

**Access To Patients:**

There are situations where circumstances may delay contact by EMS providers to the patient. This may occur when a patient must be dis-entangled from an automobile crash, extricated from a confined space or when the patient’s placement in an environment that causes an immediate danger to life and health (IDLH) requires Self Contained Breathing Apparatus for access such as a hazardous materials incident.

These situations require the use of specialized tools, equipment and personnel to bring the patient to the EMS providers. In these situations the EMS personnel should serve as advisers to the incident commander or operational staff who have the expertise and equipment to approach the patient safely. This should occur while EMS providers remain at a safe location, waiting for the patient to be brought to them.

EMS providers must be cognizant of the fact that they can provide no benefit to patients if they become victims themselves.

**Other Roles of EMS providers:**

EMS providers may also be requested to participate in emergency operations that do not directly involve an injury or illness. These involve providing EMS support to responder monitoring or rehabilitation efforts at incidents such as a release of a hazardous material. In these situations the command structure calls for EMS to support the operational mission of the responders. In such incidents EMS command becomes subordinate to the operations officer of the Incident Command System.

**PRE-INCIDENT PLANNING:**

Prior to the need to implement the Incident Command System all EMS agencies should prepare a written plan outlining their agency’s operating guidelines including (but not limited to):

- When the ICS plan should be implemented.
- Who in the agency may implement the ICS plan.
- Transition of command.
- Medical control notification.
- Personnel accountability system.
- Roles and responsibilities for all responders.
- Notification that the plan has been implemented.
- Releasing information to the media.
- Communications procedures.
• Written agreements with other agencies that will function as part of the agency’s ICS plan. These should include;
  • Other EMS agencies;
  • Fire service agencies;
  • Law enforcement agencies;
  • Disaster response agencies;
  • Transportation providers;
  • Any government agencies affected i.e. dispatch centers, public health depts.; and
  • Receiving hospitals.

Any plan developed should include a provision for incidents the agency has been brought into as a support agency or as part of another agency’s ICS Plan.

**FINANCE AND ADMINISTRATION:**

As part of the planning process the aspect of financing and administration can be reviewed. This includes the issue of the costs associated with an incident and how these costs will be covered.

An agency that is called to stand by or provide rehabilitative services at an incident may incur expenses that it wishes to have reimbursed. Having an arrangement about such issues prior to an event may eliminate problems at or after an incident.

There is also the possibility that funds may be available for agency reimbursement from various government entities depending on the scope and magnitude of the incident and if a disaster declaration is made. Services should investigate funding sources when they are involved in a large scale response; including documentation required to support such reimbursement.

**LOGISTICS:**

As part of the logistics of a large incident EMS agencies should give consideration to several areas. These include, but are not limited to:

• Communications capabilities with other responding agencies;
• Access to the stockpiles of supplies and equipment needed in an emergency;
• Availability to contact members/employees and advise them additional human resources are needed;
• Personnel accountability;
• Equipment tracking; and
• Availability of Personnel Protective Equipment (PPE) for responding employees/members.

**Statutory Requirements:**
In addition to the requirement set forth by Executive Order #26 requiring use of the Incident Command System, 10 NYCRR Part 800.21 requires ambulance services to have and enforce polices on:

- Mutual aid;
- A response plan for Hazardous Materials Incidents; and
- A response plan for Multiple Casualty Incidents

Each of these policies should address the agency’s use of the Incident Command System.

Training:

Upon implementation of a plan, an agency should conduct exercises using the plan to both educate members/employees and determine its effectiveness. These exercises may include participation in incident drills conducted by local hospitals, participation with other local emergency service agencies conducting exercises or an independent exercise within the agency. It is recommended that the agency conduct these exercises utilizing the plan as needed to assure all personnel are familiar with the plan and to assure those who may have a specific duty within the plan are aware of their roles and responsibilities.

Training in the Incident Command System can be obtained by contacting:

**The Federal Emergency Management Agency**
National Emergency Training Center
16825 South Seton Avenue
Emmitsburg, MD 21727

www.fema.gov

A CD-ROM based ICS Self study course is available free from FEMA at: http://www.usfa.fema.gov/nfa/tr_ertss4.htm

**New York State Department of State**
Office of Fire Prevention and Control
41 State Street
Albany, NY 12231-0001
(518) 474-6746

Local County Fire Coordinator

Issued and Authorized by:
Edward G. Wronski, Director
Bureau of Emergency Medical Services
Introduction:

This policy is intended to clarify the requirements and procedures for utilizing personally owned vehicles (POV) as Emergency Ambulance Service Vehicles (EASV).

Authorization as an EASV involves more than just the use of red lights and a siren on a vehicle. It is expected that every EASV is in compliance with all of the provisions of 10 NYCRR Part 800.21 & .26. This includes proper agency identification, vehicle marking and patient care equipment. All vehicles authorized by the service as EASVs may be subject to inspection. In the event violations to the code are found, the violations will be charged against the service authorizing the vehicle.

Legal Basis for Use of Red Lights and Sirens in Private Vehicles

The New York State Vehicle and Traffic Law, § 115-c states:

“An emergency ambulance service vehicle shall be defined as an appropriately equipped motor vehicle owned or operated by an ambulance service as defined in section three thousand one of the public health law and used for purposes of transporting emergency medical personnel and equipment to sick and injured persons.”

The Attorney General has issued an opinion (dated May 4, 1995) interpreting this section of the law as follows:

“…‘owned or operated by’ includes an appropriately equipped privately-owned vehicle operated by an agent of an ambulance service and used in transporting emergency medical personnel and equipment to sick and injured persons.”

The Counsel to the Commissioner of Motor Vehicles previously rendered an opinion that states:

“An emergency medical technician, whether a paid employee or a volunteer, performing duties for an ambulance service may equip his private vehicle with red lights and sirens and may use these red lights and sirens, in accordance with the above quoted section 115-c, to arrive at the scene of an emergency faster.”
Authorization

An ambulance service shall issue written authorization using the Emergency Vehicle Authorization Card (DOH-4136). The authorization card shall be signed by both the Chief Executive Officer of the service and the EMT to whom it is issued. A copy of the authorization card and a record of it being issued shall be maintained by the service.

Authorization expires on the expiration date of the individual’s EMT certification. The ambulance service may impose a shorter authorization period (e.g. annual) and has the authority, without department approval, to remove the authorization at anytime for cause.

The EASV authorization shall be considered invalid for the following reasons:

- The individual is no longer an active member or employee of the authorizing ambulance service.
- The individual is not currently certified by the New York State Department of Health as an Emergency Medical Technician or Advanced Emergency Medical Technician.
- The service is no longer certified by the New York State Department of Health as an ambulance service.

An ambulance service is not required to issue any EASV authorization to a member or employee if the service feels it is not necessary for the operation of the service. The Commissioner of the New York State Department of Motor Vehicles has stated in an opinion:

“Because the law allows an emergency medical technician to use red flashing lights does not mean that an ambulance service has to allow it. Due to the fear of liability, or for other reasons, an ambulance service may prohibit some or all of its members from using red flashing lights.”

Agency Policies and Procedures:

Any service wishing to authorize its employees/members to use their personal vehicles as EASVs must develop and implement an agency policy and procedures for the issuance of EASV authorization. It is recommended these include, but may not be limited to, the following:

- The issuance of such authorization.
- Training requirements prior to the issuance of the authorization.
- Maintaining authorization.
- Equipment, maintenance, and inventory requirements.
- Documentation requirements for the routine inventory of equipment and supplies.
f) Insurance coverage.
g) Maintaining a copy of the members EMT certification, Driver’s License, Vehicle Registration and verification of DMV Inspection.
h) Vehicle operations, response etc.
i) Procedures for revoking the authorization.

Training:

Prior to the issuance of authorization for an EASV the organization should assure the member/employee is appropriately trained in the operation of an emergency vehicle. It is recommended that the member/employee have completed at least one of the following courses:

- Emergency Vehicle Operators Course (NYS Office of Fire Prevention and Control)
- Coaching the Emergency Vehicle Operator – Ambulance (National Safety Council)
- Ambulance Accident Prevention Seminar (NYS DOH)
- Emergency Vehicle Operators Course – Ambulance (US DOT NHTSA)

Accountability:

A personal vehicle authorized as an EASV must meet all the requirements of the NYS Vehicle and Traffic Law, Article 30 of the Public Health Law, 10 NYCRR Part 800 and all applicable EMS Policy Statements.

The inappropriate use of red lights and sirens and/or the unsafe operation of any EASV may subject the EMT to violations of the Vehicle and Traffic Law.

Procedure for obtaining EASV authorization cards:

Only agencies certified as ambulance services by the Department of Health may apply for authorization of personally owned EASVs.

1) Prior to issuance of authorization as an EASV the Chief Executive, or their designee, shall complete a copy of the Affirmation of Compliance (DOH - 1881) that indicates each vehicle is in compliance with 10 NYCRR part 800 and have it notarized.

2) Any time a vehicle is added to the list of authorized vehicles an Affirmation of Compliance must be completed and notarized for the added vehicle. In the event a vehicle is removed, the department must be notified in writing.

3) The completed Affirmation of Compliance shall be sent to the DOH regional office for the service’s operating area. The regional office will issue the appropriate window decal(s) and NYS Certification “logo” stickers for the vehicle(s).
4) A copy of the completed and executed Affirmation of Compliance shall be sent, along with a cover memo on agency letterhead, to the Bureau of EMS’s Central Office. The Central Office will issue the numbered Emergency Vehicle Authorization Cards (DOH - 4136) to the service.

Authorized & Issued By
Edward G. Wronski, Director
Bureau of Emergency Medical Services
The Operation of Ambulances and Other EMS Response Vehicles
Including a Model Standard Operating Procedure for EMS Agencies

PURPOSES

1. To describe the legal requirements in New York State for driving ambulances and other EMS response vehicles.

2. To establish a standard in New York State for EMS response vehicle emergency operations.

3. To create a climate to help reduce the number of crashes and accidents and thereby reduce the injuries and property damage associated with EMS response vehicle emergency operations.

4. To provide information to develop educational programs for EMS emergency vehicle operators.

BACKGROUND

The epidemic of ambulance vehicle crashes and accidents that had been identified has continued and has involved the loss of civilian life and injury to civilians and EMS personnel. The magnitude of the problem requires that every NYS EMS agency be made aware of the problem and take immediate steps to reduce the potential for these accidents.

New York State Department of Motor Vehicle statistics illustrate a consistent yearly frequency of over 400 ambulance accidents or crashes, injuring almost 2 persons per day. These statistics also show that most of these accidents are avoidable. Based on these statistics, if each EMS response vehicle were able to stop at every controlled intersection, 75% of all of these accidents could be prevented.

EMS emergency response vehicles must be operated in a manner that provides for due regard and the safety of all persons and property. Safe arrival and patient welfare shall always have priority over unnecessary speed or hazardous driving practices while enroute to an incident or to the hospital. The NYS Vehicle and Traffic Law (V&T) authorizes privileges that ambulance and other emergency vehicle drivers may use...
during an emergency operation. Modern EMS practices,\textsuperscript{1,2,3} including the use of Emergency Medical Dispatch (EMD), EMT and Advanced EMS training and the patient treatment modalities available today, dramatically reduce the need for emergency operations.

**LEGAL BACKGROUND**

The NYS Vehicle and Traffic (V&T) Law states the following \textsuperscript{4}:

\textsuperscript{1} 114-b. Emergency Operations – the operation, or parking, of an authorized emergency vehicle, when such vehicle is engaged in transporting a sick or injured person… Emergency operation shall not include returning from such service.

\textsuperscript{2} 101. Authorized emergency vehicles – every ambulance, … emergency ambulance service vehicle.

\textsuperscript{3} 1104 Authorized Emergency Vehicles –

(a) The driver of an authorized emergency vehicle, when involved in an emergency operation, may exercise the privileges set forth in this section, but subject to the conditions herein stated.

(b) The driver of an authorized emergency vehicle may:

1. Stop, stand or park irrespective of the provisions of this title;
2. Proceed past a steady red signal, a flashing red signal or a stop sign, but only after slowing down as may be necessary for safe operations;
3. Exceed the maximum speed limits so long as he does not endanger life or property;
4. Disregard the regulations governing directions of movement or turning in specified directions.

(c) Except for an authorized emergency vehicle operated as a police vehicle, the exemptions herein granted to an authorized emergency vehicle shall apply only when audible signals are sounded from any said vehicle while in motion by bell, horn, siren, electronic device or exhaust whistle as may be reasonably necessary, and when the vehicle is equipped with at least one lighted lamp so that from any direction, under normal atmospheric conditions from a distance of five hundred feet from such vehicle, at least one red light will be displayed and visible.

(e) THE FOREGOING PROVISIONS SHALL NOT RELIEVE THE DRIVER OF AN AUTHORIZED EMERGENCY VEHICLE FROM THE DUTY TO DRIVE WITH DUE REGARD \textsuperscript{5} FOR THE SAFETY OF ALL PERSONS, NOR SHALL SUCH PROVISIONS PROTECT THE DRIVER FROM THE CONSEQUENCES OF HIS RECKLESS DISREGARD FOR THE SAFETY

\textsuperscript{1} Use of Warning Lights and Siren in Emergency Medical Vehicle Response and Patient Transport, NAEMSP & NASEMSD, Prehospital and Disaster Medicine, April-June 1994.
\textsuperscript{3} National Fire Protection Association (NFPA) Part 1500, section 4-2
\textsuperscript{4} NYS MV&T Law, italics provided to indicate direct quotation
\textsuperscript{5} A principle of legal accountability in which a review of the specific circumstances of a crash or accident will determine if a reasonably careful person, performing similar duties and under similar circumstances would act in the same manner. This legal concept is analogous to the prudent man in ordinary liability cases.
OF OTHERS.

DISCUSSION

It is important to note that the V&T law does not define specific operations permitted by the various types of emergency vehicles, such as police, fire or EMS. Generally personal opinion and tradition, not statute or regulation have defined the perception of requirements for ambulance emergency operations. An example is the mistaken belief that an ambulance’s red lights must be on if a patient is on board. This historical precedent must change. There is no requirement that emergency operations be used for any EMS response.

Emergency operations in EMS are always an affirmative decision that is made at the time of each response. Today, EMD, industry data, EMS educational materials, legal case precedents, and other industry practices set a standard of care for emergency vehicle operation which is binding on all EMS providers. Drivers of emergency vehicles are reminded that they solely bear the responsibility for driving safely and with due regard. There is no immunity from liability provided in NYS law for driving.

Operating a vehicle in emergency mode is one of the most dangerous activities that an EMS provider is routinely involved in. Careful consideration must always be given for the lives and safety of the driver, the crew, the patient and for the safety of every other person that the vehicle will encounter during the call.

NYS – EMS POLICY

- Every EMS response vehicle must be driven safely at all times, operating at a speed commensurate with the needs of the patient and the safety of all involved. Drivers exercising any of the V&T Law privileges must do so cautiously and with due regard for the safety of all others.

- Types of Responses -
  
  - Non-emergency Operations - anytime an EMS response vehicle is out of the station on an assignment other than an emergency run, shall be considered to be a non-emergency operation. All non-emergency operations shall be made using headlights only - no light bars, beacons, corner or grill flashers or sirens shall be used. During a non-emergency operation, the EMS response vehicle shall be driven in a safe manner and is not authorized to use any emergency vehicle privileges as provided for in the V&T Law.
  
  - Emergency Operations - shall be limited to any response to the scene where the driver of the emergency vehicle actually perceives, based on instructions received or information available to him or her, the call to be a true emergency. EMD dispatch classifications ⁶, indicating a true or potentially true emergency

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⁶ i.e. Emergency Medical Dispatch, U.S. Dept. of Transportation, Feb. 1996
should be used to determine the initial response type. **Patient assessments made by a certified care provider, should determine the response type to the hospital.** In order for a response to be a true or potentially true emergency, the operator or EMT/AEMT must have an articulable reason to believe that emergency operations may make a difference in patient outcome. **During an emergency operation headlights and all emergency lights shall be illuminated and the siren used as required in the vehicle and traffic law.**

- Each EMS response vehicle operator must recognize that the emergency vehicle has no absolute right of way, it is qualified and cannot be taken forcefully.

- During emergency operations every EMS response vehicle must be operated in such a manner and at such a speed upon approaching an intersection, controlled by a traffic control device so as to permit safe passage through the intersection. Before entering the intersection the operator must reduce the speed of the vehicle to be able to stop the vehicle if necessary to permit such safe passage. **They should come to a complete stop if they have a red signal or stop sign.**

- **Every EMS response vehicle must stop upon encountering a stopped school bus with red lights flashing; any non controlled railroad crossing or railroad crossing at which safety gates and/or warning lights are activated or if requested by a police officer.**

- EMS response vehicles are discouraged from using escorts or traveling in convoys due to the extreme dangers associated with multiple emergency vehicles operating in close proximity to each other. For the purpose of this policy statement and any developed from it emergency vehicles should maintain a spacing of at least 300 – 400 feet between them in ideal driving conditions and more when visibility is limited or road conditions are less than ideal.

- At emergency scenes the use of emergency warning lights must be governed by the need to protect the safety of all personnel, patients and the public. In some cases the use of emergency lights should be minimized.

- **Per Part 800.21 of NYCRR, every NYS ambulance or ALSFR service must have and enforce a written policy which describes the authorized practices for driving EMS response vehicles by their members or employees.** The service policy must be consistent with this policy and must include the following:
  - A definition of emergency and non-emergency call types, including dispatch criteria for determining the type of call,
  - A description of the authorization required to use emergency operations on dispatch and enroute to the hospital, including call types, dispatcher and crew chief authority and other criteria.

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9 NFPA 1500 4-2.7(b)(c)
10 U.S. DOT, NHTSA Emergency Vehicle Operator Course, Ambulance
- A statement regarding exceeding the posted speed limit,
- A statement regarding the speed permitted and stopping requirements through intersections which are uncontrolled or controlled,
- Frequency and content of driver screening and training requirements for individuals authorized by the service to drive an EMS response vehicle. and
- Insurance company driver screening including age, driving record, training, and other requirements.

- Every NYS-EMS agency shall have a training program\textsuperscript{11} for all individuals authorized by the service to drive an EMS emergency response vehicle. The program shall include a curriculum, approved instructors, and frequency of training and documentation.

- Every NYS EMS agency shall have a notification policy in the event of an accident or crash. This shall be consistent with Part 800.21(p).

- A prompt, safe response can be attained by:
  
  - Knowing where you are going.
  
  - Having all personnel on board, seated with seat belts secured unless actively performing necessary emergency medical care.\textsuperscript{12}
  
  - Leaving the station in a safe and standard manner:
    - quickly boarding the vehicle
    - opening station doors fully
  
  - Using warning devices to move with and around traffic and to request the right-of-way.
  
  - Driving defensively, at reasonable speeds, slowing or stopping at all intersections and giving approaching traffic adequate time to recognize the vehicle and yield the right of way.
  
  - Using pre-planned response routes which take into account hazards, construction, traffic density, etc.

\textsuperscript{11} NYS-EMS Ambulance Accident Prevention Seminar, DOT EVOC, National Safety Council, programs provided by Insurance Carrier, etc.

\textsuperscript{12} NFPA 1500 4-3.1.1
MODEL SERVICE SPECIFIC POLICY

The following model policy may be easily adopted by any EMS service to be included as a part of the service’s policies and standard operating procedures.

<Service Name>
Policy and Standard Operating Procedure for Emergency Vehicle Operations

Purpose - There shall be established a system for the safe operation of all EMS emergency response vehicles.

Scope - These policies are binding on every driver and certified care provider in charge of patient care.

Types of Responses -

Non – emergency Operations - anytime an EMS response vehicle is out of the station on an assignment other than an emergency run shall be considered to be a non-emergency operation.

Emergency Operations - shall be limited to any response to a scene, which is perceived to be a true emergency situation. True emergencies are defined by EMD and dispatch policy for a response to any situation in which there is a high probability of death or life threatening illness or injury. The risk of emergency operations must be demonstrably able to make a difference in patient outcome.

Emergency Vehicle Operations

First and Foremost - DO NO Harm!

1. Emergency operations are authorized only to responses deemed by dispatch protocol to be emergency in nature where the risks associated with emergency operations demonstrably make a difference in patient outcome.

2. Upon dispatch, emergency operations are only authorized when the dispatch call type justifies an emergency response.

3. All operations considered non-emergency shall be made using headlights only - no light bars, beacons, corner or grill flashers or sirens shall be used. During a non-emergency operation, the EMS response vehicle should be driven in a safe manner and is not authorized to use any emergency vehicle privileges as
4. Emergency operations are authorized at a scene when it is necessary to protect the safety of EMS personnel, patients or the public.

5. EMS response vehicles do not have an absolute right of way, it is qualified and cannot be taken forcefully.

6. During an emergency operation the vehicle’s headlights and all emergency lights shall be illuminated and the siren used as required in the vehicle and traffic law.

7. Once on the scene, the decision for determining the type of response for additional EMS vehicles responding to the scene shall be made by a NYS certified provider following assessment of the scene and all patients. It will be the responsibility of that certified responder to notify the dispatcher or other responding units of the type of response that is warranted, emergency or non-emergency.

8. The EMT/AEMT in charge of patient care, following assessment of the patient, shall be responsible for determining the response type enroute to the hospital.

9. EMS response vehicles shall not exceed posted speed limits by more than ten (10) miles per hour.

10. EMS response vehicles shall not exceed posted speed limits when proceeding through intersections with a green signal or no control device.

11. When an EMS response vehicle approaches an intersection, with or without a control device, the vehicle must be operated in such a manner as to permit the driver to make a safe controlled stop if necessary.

12. When an EMS response vehicle approaches a red light, stop sign, stopped school bus or a non controlled railroad crossing, the vehicle must come to a complete stop.

13. The driver of an EMS response vehicle must account for all lanes of traffic prior to proceeding through an intersection and should treat each lane of traffic as a separate intersection.

14. When an EMS response vehicle uses the median (turning lane) or an oncoming traffic lane to approach intersections, they must come to a complete stop before proceeding through the intersection with caution.

15. When traffic conditions require an EMS response vehicle to travel in the oncoming traffic lanes, the maximum speed is twenty (20) miles per hour.

16. The use of escorts and convoys is discouraged. Emergency vehicles should maintain a minimum distance of 300 – 400 feet when traveling in emergency mode in ideal conditions. This distance should be increased when conditions are limited.
Purpose:

The intent of this policy is to advise individuals participating in Department of Health (DOH) approved courses and those working in the Emergency Medical Services field that they are entitled to an environment that is free from sexual harassment.

Policy:

DOH requires all course sponsors to develop and implement a policy on sexual harassment. DOH also encourages all EMS provider agencies to develop their own agency policy on sexual harassment.

Sexual harassment is not merely offensive but it is a form of discrimination in violation of Federal and State Law.¹

Definitions:

Employer: Includes any Emergency Medical Services provider agency, including but not limited to municipal entities, volunteer fire departments, volunteer ambulance corps, commercial, industrial and hospital provider agencies.

Employee: Any person, compensated or not, that is employed by or a volunteer for any EMS provider agency or course sponsor.

Workplace: Any location or vehicle that an employee is at in the course of their duties for the employer.

Student: Any person enrolled in a DOH approved EMS training course.

Educational Setting: Includes any location being used for EMS education. This definition extends to locations used for clinical and field training of EMS providers.

Sexual Harassment: Any unwanted verbal or physical advances, sexually explicit derogatory statements, or sexually discriminatory remarks made by someone in a workplace or educational setting which are offensive or objectionable to the recipient, cause the recipient discomfort or humiliation, or interfere with the recipient’s job performance or educational progress.

¹ Title VII of the Civil Rights Act of 1964
Executive Order No. 19 Issued 5/31/83
It may include: Visual harassment; posters, magazines, calendars etc
Verbal harassment or abuse: repeated requests for dates, lewd comments
sexually explicit jokes, whistling etc.
Written Harassment: Love poems, letters, graffiti
Offensive gestures
Subtle pressure for sexual activities
Unnecessary touching, patting, pinching or kissing.
Leering or ogling
Brushing up against another’s body.
Promise of promotions, favorable performance evaluations or grades, etc in return for sexual favors
Demanding sexual favors accompanied by implied or overt threats to a person’s job, promotion, performance evaluation, grade, etc.
Physical assault, rape.

Implementation:

All course sponsors shall, and all EMS provider agencies are encouraged to, develop a policy to address sexual harassment in their location.

These policies should include a notification to all employees and students that sexual harassment is a violation of law and is intolerable in either the educational or employment setting.

The policy statement should state that sexual harassment is considered a form of employee and/or student misconduct and that sanctions will be enforced against individuals engaging in sexual harassment and against supervisory, administrative or managerial personnel who knowingly allow such behavior to continue.

Policies should also include a procedure for the following:
- making a complaint of sexual harassment;
- to whom complaints are to be made;
- in what form the complaint should be filed, and
- the procedure the sponsor/employer will follow in investigating the complaint.

The policy should provide for a subsequent review to determine if sexual harassment has been effectively stopped.

In addition to filing a complaint within the procedure of the workplace or course sponsor’s policy or for agencies that do not have policies, individuals are also entitled to seek relief by filing a complaint with:

- New York State Division of Human Rights
- Federal Equal Employment Opportunity Commission
- U.S. Labor Department – Office of Civil Rights
- A court having appropriate jurisdiction

Once developed, the policy should be widely distributed by providing a copy of it to all employees, it should be included in all new employee and student orientations and publicized within the workplace or educational setting.

All employers developing polices should conduct appropriate training to instruct and sensitize all employees to the policy.
Functional Position Description
Emergency Medical Technician – Basic (EMT-B)
Advanced Emergency Medical Technician (AEMT)

Purpose:
Provide a guide for those who are interested in understanding what qualifications, competencies and tasks are expected of the EMT-B and/or the AEMT.

Qualifications:
• Complete the Application for Emergency Medical Services Certification (DOH-65), including affirmation regarding criminal convictions
• Successfully complete an approved New York State EMT-B or AEMT course
• Achieve a passing score on the practical and written certification examinations
• Must be at least 18 years of age prior to the last day of the month in which they are scheduled to take the written certification examination
• Knowledge and Skills required show need for high school or equivalent education
• Ability to communicate effectively via telephone and radio equipment
• Ability to lift, carry and balance up to 125 pounds (250 pounds with assistance)
• Ability to interpret oral, written and diagnostic form instructions
• Ability to use good judgement and remain calm in high stress situations
• Ability to be unaffected by loud noises and flashing lights
• Ability to function efficiently without interruption throughout an entire work shift
• Ability to calculate weight and volume ratios
• Ability to read English language, manuals and road maps
• Ability to accurately discern street signs and addresses
• Ability to interview patients, patient family members and bystanders
• Ability to document, in writing, all relevant information in prescribed format in light of legal ramifications of such
• Ability to converse, in English, with coworkers and hospital staff with regard to the status of the patient
• Possesses good manual dexterity with ability to perform all tasks related to the highest quality patient care
• Ability to bend, stoop and crawl on uneven terrain
• Ability to withstand varied environmental conditions such as extreme heat, cold and moisture
• Ability to work in low light situations and confined spaces
• Ability to work with other providers to make appropriate patient care decisions
Competency Areas:

The EMT-B
Must demonstrate competency in assessment of a patient, handling emergencies using Basic Life Support equipment and techniques. Must be able to perform CPR, control bleeding, provide non-invasive treatment of hypoperfusion, stabilize / immobilize injured bones and the spine, manage environmental emergencies and emergency childbirth. Must be able to use a semi-automatic defibrillator. Must be able to assist patients with self-administration or administer emergency medications as described in state and local protocol.

The AEMT-Intermediate
Must demonstrate competency in all EMT-B skills and equipment usage. Must be able to provide Advanced Life Support using intravenous therapy, defibrillator and advanced airway adjuncts to control the airway in cases of respiratory and cardiac arrest.

The AEMT-Critical Care
Must demonstrate competency in all EMT-B skills and equipment usage. Must be able to provide Advanced Life Support using the AEMT-Intermediate skills and equipment. Must be able to administer appropriate medications.

The EMT-Paramedic
Must be capable of utilizing all EMT-B and AEMT-intermediate skills and equipment. Must be able to perform under Advanced cardiac Life Support (ACLS) and Basic Trauma Life Support (BTLS) standards. Must be knowledgeable and competent in the use of a cardiac monitor/defibrillator and intravenous drugs and fluids. The EMT-Paramedic has reached the highest level of pre-hospital care certification.

Description of Tasks:
Responds to calls when dispatched. Reads maps, may drive ambulance to emergency site using most expeditious route permitted by weather and road conditions. Observes all traffic ordinances and regulations.
Uses appropriate body substance isolation procedures. Assesses the safety of the scene, gains access to the patient, assesses extent of injury or illness. Extricates patient from entrapment. Communicates with dispatcher requesting additional assistance or services as necessary. Determines nature of illness or injury. Visually inspects for medical identification emblems to aid in care (medical bracelet, charm, etc.) Uses prescribed techniques and equipment to provide patient care. Provides additional emergency care following established protocols. Assesses and monitors vital signs and general appearance of patient for change. Makes determination regarding patient status and priority for emergency care using established criteria. Reassures patient, family members and bystanders.
Assists with lifting, carrying and properly loading patient into the ambulance. Avoids mishandling patient and undue haste. Determines appropriate medical facility to which patient will be transported. Transports patient to medical facility providing ongoing medical care as necessary enroute. Reports nature of injury or illness to receiving facility. Asks for medical direction from medical control physician and carries
out medical control orders as appropriate. Assists in moving patient from ambulance into medical facility. Reports verbally and in writing observations of the patient’s emergency and care provided (including written report(s) and care provided by Certified First Responders prior to EMT-B/AEMT arrival on scene) to emergency department staff and assists staff as required.

Complies with regulations in handling deceased, notifies authorities and arranges for protection of property and evidence at scene.

Replaces supplies, properly disposes of medical waste. Properly cleans contaminated equipment according to established guidelines. Checks all equipment for future readiness. Maintains ambulance in operable condition. Ensures cleanliness and organization of ambulance, its equipment and supplies. Determines vehicle readiness by checking operator maintainable fluid, fuel and air pressure levels. Maintains familiarity with all specialized equipment.
Functional Position Description
Certified First responder (CFR)

**Purpose:**
Provide a guide for anyone who is interested in understanding what qualifications, competencies and tasks are expected of the CFR.

**Qualifications:**
- Complete the *Application for Emergency Medical Services Certification* (DOH-65), including affirmation regarding criminal convictions
- Successfully complete an approved New York State CFR course
- Achieve a passing score on the practical and written certification examinations
- Must be at least 16 years of age prior to the last day of the month in which they are scheduled to take the written certification examination
- Knowledge and Skills required show a need for high school or equivalent education
- Ability to communicate effectively via telephone and radio equipment
- Ability to lift, carry and balance up to 125 pounds (250 pounds with assistance)
- Ability to interpret oral, written and diagnostic form instructions
- Ability to use good judgement and remain calm in high stress situations
- Ability to be unaffected by loud noises and flashing lights
- Ability to function efficiently without interruption throughout an entire work shift
- Ability to read English language, manuals and road maps
- Ability to accurately discern street signs and addresses
- Ability to interview patients, patient family members and bystanders
- Ability to document, in writing, all relevant information in prescribed format in light of legal ramifications of such
- Ability to converse in English with coworkers and hospital staff with regard to the status of the patient
- Possesses good manual dexterity with ability to perform all tasks related to the highest quality patient care
- Ability to bend, stoop and crawl on uneven terrain
- Ability to withstand varied environmental conditions such as extreme heat, cold and moisture
- Ability to work in low light situations and confined spaces
- Ability to work with other providers to make appropriate patient care decisions
**Competency Areas:**
- Patient Assessment
- Use of Basic Life Support Equipment within the scope of practice for the CFR
- Ability to perform Cardio-Pulmonary Resuscitation (CPR)
- Control Bleeding
- Provide non-invasive treatment for hypoperfusion
- Manage environmental emergencies
- Provide initial care in medical and trauma emergencies, and emergency childbirth

**Description of Tasks:**
Responds to calls when dispatched. Reads maps, may drive emergency response vehicle to emergency site using most expeditious route permitted by weather and road conditions. Observes all traffic ordinances and regulations.

Uses appropriate body substance isolation procedures. Assesses the safety of the scene, gains access to the patient, assesses extent of injury or illness. Communicates with dispatcher requesting additional assistance or services as necessary. Determines nature of illness or injury. Visually inspects for medical identification emblems to aid in care (medical bracelet, charm, etc.) Uses prescribed techniques and equipment to provide patient care. Provides additional emergency care following established protocols. Assesses and monitors vital signs and general appearance of patient for change. Makes determination regarding patient status and priority for emergency care using established criteria. Reassures patient, family members and bystanders. Avoids mishandling patient and undue haste. Reports verbally and in writing, information gathered about patient’s emergency and care rendered to EMT or AEMT in charge of ambulance crew on scene.

Assists with lifting, carrying and properly loading patient into the ambulance.

Complies with regulations in handling deceased, notifies authorities and arranges for protection of property and evidence at scene.

Replaces supplies, properly disposes of medical waste. Properly cleans contaminated equipment according to established guidelines. Checks all equipment for future readiness. Maintains emergency vehicle in operable condition. Ensures cleanliness and organization of emergency response vehicle, its equipment and supplies. Determines vehicle readiness by checking operator maintainable fluids, fuel and air pressure levels. Maintains familiarity with all specialized equipment.
Introduction:

Bicycles provide rapid access to areas not always accessible by motorized vehicles. Many EMS agencies use mountain bikes as Emergency Ambulance Service Vehicles (EASVs) in order to provide rapid first response capabilities at mass gatherings, sporting events, special events and in remote areas.

In addition to transporting an EMS provider, bicycles can carry a moderate amount of equipment allowing a provider to initiate care until the arrival of a more traditional first response vehicle or ambulance. Bicycles provide a way to transport a provider amongst large crowds with minimal disturbance and with lessened risk of injury to event participants and spectators.

Some agencies may choose to utilize bicycles for responses to areas where motor vehicle access is difficult or limited on a regular basis while others may only utilize them on selected occasions.

In addition to the obvious response advantages there is also a public relations advantage seeing EMS providers in the community in a manner other than inside an ambulance.

Policy Development:

Every agency that intends to utilize bicycles as EASVs to provide first response EMS should develop policies and procedures to include:

- Staffing patterns
- When bicycles will be used
- Equipment to be utilized, requirements and location
- Inventory control
- Communications equipment requirements and procedures
- Procedures for obtaining/simultaneous dispatch of an ambulance or other patient transport vehicle when required
- Medical Direction
**Equipment Selection:**

In selecting a bicycle for use in EMS, the agency should choose a medium to heavy duty mountain bike equipped in compliance with NYS V&TL §1236. (This section includes the minimum requirement for lights, reflectors and audible warning devices on bicycles.)

Bicycles should be fit to the person riding them. Each bike or rider should be equipped with a water bottle to provide the rider with adequate hydration. Bikes should also be equipped with a kickstand that will support the bike and all equipment attached to it.

Bike pedals should have cages and straps. Handle bars with bar ends will offer riders additional hand placements and help reduce rider fatigue.

It is strongly urged that all EMS agencies using bicycle units develop a policy that requires all persons wear an ANSI or SNELL Foundation approved bicycle helmet.

All riders should also wear eye protection and well padded cycling gloves.

Equipment racks and packs should be securely mounted to prevent equipment from shifting while riding and additional padding may be required to prevent damage to equipment and supplies. Depending on the amount of equipment and supplies being carried by the bike, panniers may or may not be used.

Additional equipment may include emergency warning lights, horns and sirens as the service chooses.

In addition to EMS supplies it is imperative that the bicycle carry minimal maintenance and repair equipment, ie. patch kit, portable pump and a tool kit/multi tool.

The agency should develop and implement a check sheet to be completed on a regular basis to require routine checks on tires (inflation/tread), brakes, shifters, chain lubrication, lights, communications equipment and any emergency warning equipment used.

Ideally, EMS providers should utilize teams of two providers working together as one first response unit. This will allow for a distribution of the equipment and the weight associated with it.

**For a BLS first response using a bicycle, the equipment required by Part 800.26 shall be carried. Services may request waivers through the normal process.**

EMS bike units may also carry a defibrillator, either manual or automatic, depending on the level of care to be provided by the bicycle rider and per medical director approval.
ALS services may also carry ALS equipment with the approval of their medical director and REMAC.

Bags of IV solutions, drip sets and related materials may be carried on the bicycles. However, syringes, needles, IV catheters and any medications should be carried on the person of the certified AEMT. These items should be carried in a fanny or back pack to protect them from theft. It should also be considered, depending on the type of event, whether to carry these items at all if doing so might put the provider in harms way from someone who might be attempting to forcibly take these items.

**Communications:**

As per DOH Bureau of EMS policy statement 98-02, *Radio Communications Systems for EMS Services*, bike units should be equipped with communications equipment that allows for communication with dispatch, other responding EMS units and medical control for the event or activity.

It is not advisable to depend solely on portable cellular telephones for any phase of the bike unit communications needs. This is particularly true in remote areas or at mass gatherings where local cell site capabilities might be overwhelmed by an influx of cellular users.

**Rider Selection:**

In choosing employees/members to staff a bike unit consideration should be given to the fact that it takes a considerable amount of stamina to operate a bike that is weighted down with EMS equipment for the duration of a special event or a tour of duty.

Also to be considered is the physical exertion of pedaling to a scene and then finding a situation that requires additional strenuous physical activity, i.e. doing CPR.

Prior to assigning employees/members to a bike unit consideration should be given to providing a comprehensive medical assessment of the employee/member by a physician. It is advisable to consider the creation of an agency policy requiring such an examination prior to assignment to a bike unit.

**Training:**

Since there are no specific training programs to prepare a person to provide EMS while on a bike, it is advisable to open up communications with local bike clubs or police bike units who might provide technical support on bike selection and riding technique.

Any training should include proper bike fitting, rider safety, an understanding of NYS Vehicle and Traffic laws relating to operating a bicycle, understanding cadence and gearing, proper nutrition for a rider and basic bicycle maintenance.
POLICY STATEMENT ON SMOKING

Background:

This policy replaces Policy Number 89-10 (No Smoking in Ambulances), the Department of Health policy statement that encouraged all EMS agencies to adopt a strict policy banning cigarette smoking in ambulance vehicles at any time.

Since that time the Occupational Safety and Health Administration has issued guidelines concerning this topic as it relates to the Blood Borne Pathogen Standard (OSHA 1910). The Environmental Protection Agency has also issued a statement concerning the exposure to Environmental Tobacco Smoke.

As a reminder, smoking has been proven to be a health hazard and known to cause cancer and cardio-pulmonary disease. It should be noted that smoking and exposing others to second hand smoke are both recognized as health hazards. The presence of cigarette smoke in an enclosed compartment, such as an ambulance, causes damage to disposable supplies and is prohibited.

OSHA regulations state that there shall be no smoking within 20 feet of any compressed cylinder including oxygen (29 CFR 1910.101b). This rules out smoking in any ambulance or EMS response vehicle as well as within most garages or apparatus bays where EMS vehicles are housed. This sentiment is echoed by the National Fire Protection Association (NFPA) in their standards. In accordance with the New York State Clean Indoor Air Act, smoking is not permitted in most public and government owned buildings.

In addition to all of the known health and safety related aspects of smoking, the public relations perspective must also be examined. The health care community has repeatedly indicated the hazards of smoking. As a professional representative of the healthcare community, EMS providers must support the public health warnings and not permit smoking in the health care environment. Disregarding this may lessen the public confidence and understanding of EMS professionals as health care providers.

Policy:

It is the policy of the Bureau of EMS that there should be no smoking in or around any ambulance or EMS response vehicle at any time. This includes vehicle garages and apparatus bays, as well as during an EMS response in which patients are being treated. Smoking should be restricted to defined areas. It is recommended that smoking and/or loitering be prohibited in stairwells, vestibules, entrances and exits.

All provider agencies need to develop and institute policies consistent with this Policy Statement.
This policy is designed to clarify the minimum requirements of the NYS Codes, Rules and Regulations specific to the security of medications and authorized controlled substances as well as needles and syringes utilized in the (EMS) environment. Local REMACs may have additional requirements in place. It is each agency and individuals responsibility to become familiar with all appropriate requirements within the state and their region.

Part 800.23 (f) of the New York State Emergency Medical Services Code states that for each ambulance carrying controlled substances, drugs or needles, there shall be a securely locked cabinet in which these items are stored when not in use. Additionally, 80.136 (4) (i ) (ii) requires that controlled substances be locked in a box within a locked stationary cabinet under a two-lock system using different keys.

These laws, rules and regulations will be interpreted as follows for ambulance, EASV or ALS first response vehicles carrying these materials:

1. Drug boxes or bags holding syringes or needles (used or unused), IV starter sets containing syringes and/or needles, non-controlled drugs, (items not found in Article 33 PHL) shall be kept in a key-locked compartment within the ambulance vehicle at all times when not being used for patient care purposes. The drug box or bag need not be locked inside the compartment.

Agencies using sharps disposal bins will be considered to be in compliance with the security requirements so long as the disposal container is secured in the vehicle and the manufacturer’s original security/safety barrier is intact. Agencies which carry smaller disposal bins such as the ones carried in “first-in bags”, are reminded that these types of disposal bins still need to be stored within the locked cabinet.

Non-medicated IV solutions and oxygen do not need to be locked, but do need to be secured within the vehicle.
2. Drug boxes or bags holding authorized controlled substances (items found in Article 33 PHL, ie: morphine and/or diazapam) must be double locked at all times using a two different key lock system, when not being used for patient care purposes. This means that the container holding the controlled substances must be locked and stored inside a key locked compartment within the ambulance, EASV or ALS first response vehicle in accordance with the approved agency controlled substance plan.

If a soft style first in bag is to be used in conjunction with controlled substances, the container holding the controlled substances must be constructed of a hard rigid plastic or metal and must be able to be locked with a key.

The requirement for securing of controlled substances may also be accomplished by having the approved certified and authorized personnel maintain direct possession of controlled substances while on duty. Individuals are not allowed to carry controlled substances on their person while “on call”.

3. For the purpose of this policy, a locked ambulance, EASV or ALS first response vehicle will be considered a locked cabinet so long as all compartments and doors are able to be secured and are fully operational.

An ALS ambulance, EASV or ALS first response vehicle not carrying controlled substances may keep an unlocked drug box outside a compartment so long as the vehicle is locked at all times. In this instance the vehicle is the cabinet.

If controlled substances are a part of the medication formulary, a two key locking system is required. One of these systems may be the locked ambulance, EASV or ALS first response vehicle.

4. Access to drugs, controlled substances and needles must be carefully monitored. In most cases, only properly certified and authorized personnel should have access to or possess keys which allow access to these items. Each agency needs to develop policies addressing these issues in accordance with regional and state guidelines. Agency administrators are advised to contact their local Department of Health office for further assistance.
Transition of Care

With the passage of Chapter 552 of the Laws of 1998 (Public Access Defibrillation) and more recently, Chapter 578 of the Laws of 1999 (Epinephrine Auto-Injector), EMS Providers will increasingly encounter situations where a patient has been defibrillated or administered epinephrine, prior to the arrival of EMS, by a non-license/non-certified "first responder." It is important that there be a smooth and orderly "transition of care" between civilians and EMS providers as well as between EMS providers of different levels. This includes the transfer of information and continuation of appropriate care.

Public Access Defibrillation

When arriving at a call where a patient is being treated by a "first responder" with an AED, the EMS Provider should immediately confirm the patient's status (responsive, unresponsive, apneic, pulseless, etc..), and determine if a "shock" is indicated. Treat the patient appropriately, request ALS if available and prepare for immediate transport. The "first responder's" AED should remain on the patient until a full cycle of the AED has been completed. The AED and/or pads are usually changed when the patient is ready for transport or upon treatment by an ALS provider.

For patients where "no shock" is indicated, the EMS Provider should continue CPR (verify that CPR is being performed correctly) and prepare for immediate transport.

For patients where a "shock" is indicated, the EMS Provider should administer a complete set of 3 "shocks" and prepare for immediate transport.

If the EMS unit does not have a defibrillator/AED, the "first responder" should accompany the patient to the hospital, follow regional protocols and provide CPR as indicated (the ambulance should pull over and stop when analyzing and shocking the patient).

The EMS Provider should attempt to gather the following information:

1. how long the patient has been down,
2. when CPR began,
3. when was the patient first "shocked,"
4. how many "shocks" the patient has received, and
5. any pertinent patient history that is available.
Epinephrine Auto-Injector for Anaphylactic Reactions with Respiratory Distress or Shock

When arriving on the scene of a patient experiencing an anaphylactic reaction, if the patient is being treated by a "first responder" who has administered epinephrine by an auto-injector, the EMS Provider should immediately confirm the patient's status. The EMS Provider should pay close attention to the patient's airway, respiratory distress and any signs or symptoms of hypoperfusion (shock). Treat the patient appropriately, request ALS if available and prepare for immediate transport.

The EMS Provider should attempt to gather the following information:

1. determine the substance the patient was exposed to,
2. how long ago the exposure occurred,
3. the initial symptoms the patient reported,
4. the time and dosage of the epinephrine administered,
5. the name of the individual who administered it, and
6. the patient's response to the treatment.

Medical Control must be contacted prior to administering a second epinephrine injection.
EMS Response to School Incidents and Bus Accidents

The purpose of this policy statement is to furnish information to EMS providers and agencies concerning responses to schools and the management of school bus accidents.

Background

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.

Legal Responsibilities

Several citations in Education Law place responsibility for student health and safety on the local school board/district:

State Education Law §912 places responsibility on the school board for the health and welfare of all children including the administration of emergency care programs for all ill or injured pupils.

Formal Opinion of Counsel No. 213(1967) the State Education Department cites several authorities for schools to provide health and safety and pupil transportation for children in their jurisdiction.

In Decision 10,587(1981) the State Education Commissioner found that the responsibility for pupil safety shifts from the parent at the point of pick up by the school bus.

These citations clearly identify the roles and jurisdiction for a school’s health services and administrative employees and its agent provider of transportation. These
responsibilities include student health and safety and pupil guardianship. The exact nature of the responsibility is left to local district policy, procedure and practice.

No specific statute clearly defines responsibility in the case of a school bus crash. As in most other prehospital situations more than one agency has a role and jurisdiction. In the case of a school bus accident the school district, law enforcement and EMS each have specific and unique roles. As in many field situations the use of well established plans and a unified incident command structure provides the means to define whom is in charge of the incident.

Emergency Planning with Schools

Utilizing long established practice of pre planning for responses to known situations, EMS agencies need to establish the necessary dialog with school administrators and health services personnel to develop, implement, periodically drill, and review response plans to school incidents including bus accidents.

The State Education Department in guidelines\(^2\) provided to local school districts identifies a requirement\(^3\) to develop comprehensive emergency plans for all contingencies. It specifies that all community resources be identified and policies and action plans be developed and coordinated with local emergency services. Additionally, the emergency procedure guidelines require training in the response to catastrophic emergencies and conducting periodic instruction in disaster, fire and bus drills.

Recommendations

EMS agencies need to communicate with the administrators of all school districts in their response areas and develop, implement and/or review specific emergency response plans to school emergencies, including bus crashes. It is helpful if this planning is done in a coordinated environment, which would include law enforcement, fire, and the local office of emergency service/management.

The authority, jurisdiction and responsibilities of the school and each response agency must be included in the plan.

Assessment and triage protocols need to take into account the behavior of children in such incidents. The protocols also must recognize that passengers may be injured, act as if they are injured or may not be injured at all. The objective for EMS providers is to render appropriate care and/or transportation for passengers who require emergency medical care and/or transportation.

Any student presenting injury or a sign or symptom suggesting injury should be properly assessed, triaged and transported in accordance with state and local treatment protocols.
Any student presenting with no complaint or injury can be released to school health services personnel or administrator on the scene for further evaluation and transportation. Once the student has been released to the school district, its personnel assume responsibility for the student and any further assessment, treatment or transportation to a hospital as needed.

All persons on the bus need to be identified and recorded as being involved in the crash. Treatments provided and passenger disposition may be documented via log, triage tag or PCR if treated and/or transported. A copy of all documentation should be made available to the school upon request. Schools and EMS agencies should develop a tracking system for use in such situations.

School bus crashes are difficult and emotional incidents for all involved. Each one is different and a well-developed and rehearsed plan conducted using a unified incident command management system will facilitate the most effective outcome for the patients, schools, EMS services and other responsible local authorities.

Endnotes:

1 will be referred to as schools

2 Emergency procedures in the School Setting, State Education Department, 1993.

3 State Education Commissioner's Regulations § 155.13
PURPOSE

The purpose of this statement and the frequently asked questions (FAQ) is to provide prehospital providers with clarification and information on accepting non-hospital and hospital Do Not Resuscitate Orders (DNR). Readers are referred to PHL § 29-B and DOH Memo 92-32, DNR Orders that are the governing documents for detailed discussions on the subject. This policy does not supercede any other DOH document.

These guidelines are intended to assist local emergency medical services (EMS) agencies in developing DNR policies. EMS agencies should develop policies that instruct crews how to properly respond to patients who have a DNR. DNR policies allowing patients to refuse resuscitation ensure that patient’s legal rights are honored and are a critical part of the healthcare and EMS systems. Patients must be provided their legal and ethical rights to consent to or refuse medical care in the prehospital setting.

DNR patients are generally, although not always, victims of terminal illnesses, and are encountered in skilled nursing facilities, private residences and other settings. They may or may not be clients of hospices. In some cases, patients use the EMS system solely to obtain medical transportation. In other cases accident victims may present a DNR order.

Despite instructions not to perform resuscitation or call an ambulance, family members and employees of nursing facilities frequently activate 9-1-1 when death is imminent.

In addition to providing palliative care for patients, prehospital care providers may benefit families by assisting in determining when death has occurred. This may be an appropriate role for the EMS system although it should be restricted to private residences and not to licensed facilities which are expected to have policies for determining death by house medical staff.

EMS agencies are encouraged to meet with all components (hospitals, nursing facilities, hospices, etc.) of the health care system in their community in order to develop common understandings and policies to mutually manage patients with DNRs in emergency situations.
What is an "Out of Hospital" DNR?

The New York State Department of Health has an approved standard Out of Hospital DNR form that is legally recognized statewide for DNR requests occurring outside of Article 28 licensed facilities. This form is intended for patients not originating from a hospital or nursing home. The form (DOH-3474) is available on the Department’s web site (www.health.state.ny.us) or from your local DOH EMS Office or health department. There are NO other approved Out of Hospital DNR forms. Copies can be kept on ambulances and made available to patients, facilities or physicians as a part of their community education program.

What is a recognized DNR Bracelet?

A standard DOH approved metal bracelet, worn by the patient, which includes a caduceus and the words "Do Not Resuscitate". EMT’s should assume that a DNR order is in place authorizing the bracelet. It is not necessary to locate the written DNR order.

Where/When is an Out of Hospital DNR Order Valid?

For any patient NOT originating from a hospital or nursing facility including but not limited to:

- The patient’s home
- A hospice
- A clinic

What determines the validity of the Out of Hospital DNR?

- Merely the presentation of a signed Out of Hospital DNR form (or a copy) or a DNR bracelet to the EMT.
- A good faith attempt to identify the patient. A witness who can reliably identify the patient is useful.
- Out of hospital DNRs do not expire.
- The Out of Hospital DNR form and/or bracelet should be taken with the patient.

Hospital & Nursing Home DNR orders

All Article 28 licensed facilities are required to issue, review and maintain DNR orders. EMS providers will honor hospital DNR orders for patient transports originating from the facility. The DNR can not be expired. The facility staff must provide a copy of the order.
and/or patient's chart with the recorded DNR order to the ambulance crew. Facilities, other than hospitals or nursing homes, are encouraged to use the NYS-DOH approved non-hospital DNR Form as supplemental documentation to avoid confusion and potentially unwanted resuscitation.

**May EMS providers accept living wills or health care proxies?**

A living will or health care proxy is NOT valid in the prehospital setting.

**Under what circumstances may an EMS provider disregard an Out of Hospital DNR order?**

Any case where there is reasonable evidence to suggest that the DNR order has been revoked or cancelled.

If the patient is conscious and states that they wish resuscitative measures, the DNR Form should be ignored.

If the patient is unable to state his or her desire and a family member is present and requests resuscitative measures for the patient and a confrontational situation is likely to result, if the request is denied.

A physician directs that the order be disregarded.

**What procedures are and are not preformed if the patient presents a DNR?**

Do not resuscitate (DNR) means, for the patient in cardiac or respiratory arrest, NO chest compressions, ventilation, defibrillation, endotracheal intubation, or medications.

If the patient is NOT in cardiac or respiratory arrest, full treatment for all injuries, pain, difficult or insufficient breathing, hemorrhage and/or other medical conditions must be provided.

Relief of choking caused by a foreign body is usually appropriate, although if breathing has stopped, ventilation should not be assisted.

CPR must be initiated if no Out of Hospital or facility DNR is presented. If a DNR order is presented after CPR has been started, stop CPR.

For unusual situations or questions on individual patient circumstances, contact medical control.

**What documentation is required for a patient with a DNR order?**

Emergency medical technicians/paramedics should attach a copy of the Out of Hospital DNR form, hospital DNR order and/or copy of the patient’s chart to the patient
care report, along with all other usual documentation. It should be noted on the patient care report that a written DNR order was present including the name of the physician, date signed and other appropriate information.

If the cardiac/respiratory arrest occurred during transport, the DNR Form should accompany the patient so that it may be incorporated into the medical record at the receiving facility.

Patients who are identified as dead at the scene need not be transported by ambulance, however, local EMS agencies should consider transportation for DNR patients who collapse in public locations. In these cases it may be necessary to transport the individual to a hospital without resuscitative measures in order to move the body to a location that provides privacy. Local policies need to be coordinated with the Medical Examiner/Coroner and law enforcement.

**Liability Protections**

PHL§2977.12 "No person shall be subjected to criminal prosecution or civil liability, or be deemed to have engaged in unprofessional conduct, for honoring reasonably and in good faith pursuant to this section a non hospital order not to resuscitate, for disregarding a non hospital order pursuant to section ten of this section, or for other actions taken reasonably and in good faith pursuant to this section".
It is the purpose of this policy to clarify the legal issues surrounding consent to medical care and/or the refusal of care by minors in the pre-hospital EMS setting.

Emergency Medical Services (EMS) providers are often presented with patients who are considered by law to be minors. The issue of providing care and/or the patient’s right to refuse care becomes a complex circumstance EMS providers must address. In the prehospital situation the issue at hand is not usually providing care but rather the failure to treat.

Legal Background

A minor, in New York State, is defined as a person who is under eighteen (18) years of age.

This is defined by the General Obligations Law §1-202, Domestic Relations Law §2 and Public Health Law §2504. Under this section of Public Health Law, a person who is eighteen or older may give effective consent for health care.

Public Health Law § 2504

Enabling certain persons to consent for certain medical, dental, health and hospital services.

1. Any person who is eighteen years of age or older, or is the parent of a child or has married, may give effective consent for medical, dental, health and hospital services for himself or herself, and the consent of no other person shall be necessary.
2. Any person who has been married or who has borne a child may give effective consent for medical, dental, health and hospital services for his or her child.

3. Any person who is pregnant may give effective consent for medical, dental, health and hospital services relating to prenatal care.

4. Medical, dental, health and hospital services may be rendered to persons of any age without the consent of a parent or legal guardian when, in the physician's judgment an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment which would increase the risk to the person's life or health.

5. Anyone who acts in good faith based on the representation by a person that he is eligible to consent pursuant to the terms of this section shall be deemed to have received effective consent.

In addition to these provisions for health care consent by 'emancipated' individuals, there are other statutory provisions for minors who are in military service or are seeking treatment for AIDS (PHL §2781) and other sexually transmitted diseases (PHL §2305). So long as the individual is a minor, the presumption is that he or she is not emancipated and the burden of proof rests on the individual asserting it.

The Mental Hygiene Law also addresses consent but for situations not usually within the scope of EMS. Additionally in §9.41 it permits peace and police officers to ‘direct the removal of any person to a hospital who is conducting himself in such a manner which is likely to result in serious harm to himself or others’.

Other governmental agencies, such as law enforcement, mental health or corrections, may have legal definitions for individuals under eighteen that describe specific rights or responsibilities. Unfortunately, these do not impact health care decisions including the ability to consent or refuse care in the prehospital setting.

Refusal of Medical Assistance (RMA)

An individual who is legally a minor cannot give effective legal/informed consent to treatment and therefore, conversely, cannot legally refuse treatment.
Documentation

Complete an assessment of the patient. Fully document all circumstances including subjective and objective findings, attempts to contact parents, note any objections or refusals by the patient and all other pertinent situational facts. Include witness statements. Always consider contacting medical control for assistance.

Collaboration with other Agencies

EMS agencies are advised to work with hospital administrators, local law enforcement agencies, school administrators and community youth group leaders to develop policies and procedures to best serve the medical needs of minors in time of an emergency.

There are alternatives to EMS and hospitals for custody and supervision of minors. An uninjured child may be supervised by law enforcement personnel or a school or activity (soccer, etc.) supervisor until a parent is contacted. In some situations, a responsible adult (grandparent, aunt, brother, etc.) with the child can assist in the decisions making.

EMS agencies should work with local youth activities to ensure they have made plans to contact parents, have provided consent to treatment forms or have other permissions in place for the children in their supervision.

EMS agencies also need to work and plan with all police agencies for those situations involving minors, particularly those who are not injured and do not require hospitalization. Local and state police have broad powers which can be used to protect minors and facilitate custody.

However, all else failing, the EMS provider may remain responsible for providing care and/or transportation of a minor to a hospital.

EMS Agency Protocols

Agency policies and regional BLS and ALS protocol sets can contain guidance for treating minors in the prehospital setting. Contacting medical control is always an acceptable option for EMS providers faced with uncertain situations. Medical control may be able to influence the situation, even if it can’t change the consent options.

Recommendations

EMS providers may find themselves responsible for minors, in situations they have been called to when there is no parent or guardian present or reachable.

Although it is easy to determine a legal definition of a minor, the responsibility to treat or
release is a much more complex legal, ethical, social and public relations problem. The nature of children and their special needs coupled with their inability to legally give informed consent, present special and unique matters for EMS personnel to consider and evaluate. Careful assessment, decision making and documentation are key as is discussion and planning with other agencies.

Act in the best interest of the patient – EMS providers must strike a balance between abandoning the patient and forcing care. There may be instances in which a minor appears mature enough to make an independent judgment, however legally, the minor is unable to make a decision. Always contact medical control for assistance if there is any question!

Common sense, prior agreements, sufficient documentation, and acting in the best interest of the patient must prevail.
The purpose of this policy is to clarify the appropriate use of the various types of medical transportation available for non-emergency patient transports to, from, or between medical facilities. This policy refers to the patient care and operational aspects of ambulance and other forms of medical transportation, it does not address medical necessity for reimbursement by third party payers.

Many factors are involved when deciding on which type of medically related transportation is to be used for a specific patient. Included are patient condition at the time of transport, the specific level and type of care (ALS, BLS) or medical monitoring needed, personal preference, contracts and economics.

Ambulance service and patient care during transport are governed by Article 30 of the New York State Public Health Law. Patient care and or medical monitoring may only be provided by certified or licensed healthcare providers in an ambulance.

In the medical transportation industry there are ambulance, “ambulette”\(^1\) and livery forms of transportation. Each has an appropriate use. In each situation the patient’s medical condition and the type and level of care required to treat the patient’s condition must be the first consideration when deciding on which type of transportation to use for the transfer.

\(^{1}\) A.k.a.: Para-transit, wheelchair, invalid coach
POLICY

Transportation by ambulance is required if the patient requires medical care or medical monitoring as directed by a physician during the transport. Examples include, but are not limited to, administering oxygen to a patient who does not normally use it, assessment, maintaining IV’s, cardiac (EKG) monitoring, or the periodic monitoring of pulse, respiration, blood pressure or other vital signs and documenting changes in a patient’s condition. Medical care and/or patient monitoring can only be provided by a certified or licensed health care provider and can only be provided in an ambulance.

Ambulette or livery transportation is appropriate for patients who DO NOT need medical care or medical monitoring during the trip. Ambulette's may carry a patient's individually prescribed and provided oxygen (as if the patient is in a private vehicle). An ambulette service MAY NOT provide oxygen or oxygen delivery equipment and ambulette personnel MAY NOT monitor or deliver oxygen or adjust flow rates.

A service not licensed as an ambulance may not advertise the ability to provide medical care during transport. Services should exercise caution using medically trained staff on any vehicle that is not an ambulance. Such advertising and staffing only serves to confuse the public or health care institution regarding the actual levels of medical care and capabilities available.

Issued: John J. Clair
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Authorized: Edward G. Wronski
Director
GUIDELINES FOR EXPOSURE TO BLOOD AND/OR BODY SECRETIONS

BACKGROUND

The New York State Department of Health receives many requests for guidance in the area of infection control from emergency medical service (EMS) personnel who may be exposed to contaminated or potentially contaminated blood or body secretions.

For many years the medical community has been aware of problems caused by human immunodeficiency virus (HIV) and has more recently identified the hepatitis C (HVC) virus as a potential problem.

This policy statement, developed with the assistance of the Department’s Wadsworth Center for Laboratories and Research, updates the information published in previous versions of this policy.

UNIVERSAL PRECAUTIONS

These guidelines are intended to prevent or minimize exposure to the transmission of bloodborne infectious diseases, particularly HIV and viral hepatitis, to employees whose duties put them at risk. All emergency medical services organizations should ensure full implementation of universal precautions and body substance isolation\(^1\) (BSI) techniques, and require immunization of all employees\(^2\) who are identified as being at risk.

According to the U.S. Department of Labor, Occupational Safety and Health Administration, “universal precautions” refers to the method of infection control in which all human blood and certain human blood fluids are treated as if known to be infectious for bloodborne pathogens. Universal precautions are to be observed in all situations where there is a potential for contact with blood or other potentially infectious material. In emergency situations, differentiating between body fluid types is difficult or

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\(^1\) Body substance isolation – an infection control concept and practice that assumes that all body fluids are potentially infectious. Emergency Care and Transportation of the Sick and Injured. AAOS 7th Edition 1998

\(^2\) For these purposes, employee means volunteer and paid individuals who act on behalf of the EMS service.
impossible, and all body fluids are to be considered potentially infectious. Universal precautions and BSI techniques must be applied correctly and consistently, to provide a very low incidence of worker exposure to HIV and various hepatitis viruses.

**BLOODBORNE PATHOGENS EXPOSURE CONTROL PLAN**

EMS services are encouraged to review, with their medical director, the service exposure control plan and the federal Bloodborne Pathogen Regulations, 29CFR Part 1910.1030, to ensure that all appropriate and required actions are taken with regard to EMS personnel education and training, personal protective equipment, the use of new safer equipment, particularly for sharps, pre-exposure vaccination and post-exposure follow-up.

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SAMPLE OPERATING PROCEDURE
The Department recommends these sample operating procedures be included in EMS service exposure control plans.

What to Report
EMS personnel should immediately report to their supervisor all percutaneous, nonintact skin or mucous membrane contact with blood or body secretions; and supervisors should refer exposed employees for immediate medical attention.

Initial Response

- Thoroughly cleanse area of exposure. (See below for cleansing instructions.)
- Seek immediate attention and exposure evaluation.
- Review the exposed employee’s immunization history.
- Refer the exposed employee for appropriate medical evaluation, care and any necessary post exposure follow up treatment.
- Have the exposed employee’s supervisor complete necessary documentation and required reports. (See below for administrative responsibilities).

Testing

- Have service designated officer (DO) seek any existing information on the source.
- Inform the patient of applicable laws and regulations concerning disclosing the identity and infectious status of the source individual.
- Have the source individual’s blood tested for HIV and the various forms of hepatitis as soon as consent has been obtained.
- Test the exposed employee for HIV and the various forms of hepatitis.

Notification and Counseling

Share test results with the exposed employee, who should also be counseled about his or her health status and, if necessary, treatment options.
Wound Cleansing

- For a puncture cleanse with betadine immediately and follow up by soaking the site for five minutes in a solution of betadine and sterile water.
- For skin contact, first wash the area with soap and water. Then, clean it with betadine.
- For mucous membranes: if in mouth, rinse out mouth with large quantity of tap water; if eyes, flush with water from eyewash. If eyewash is not available, use tap water.

Administrative Responsibilities

Once the area of contact has been cleansed, and the exposed employee referred for further medical treatment, the supervisor should do all paperwork needed to document the incident. He or she should:

- Direct the member/employee to the appropriate location for evaluation and immediate medical treatment.
- Prepare an incident report and note the incident on the prehospital care report for the call in which the exposure took place.
- Advise the employee to initiate a Workers' Compensation claim.
- Verify that appropriate employee health records have been updated.
- Follow-up on the employee's medical care, and confirm that appropriate medical care has been given.

Testing Guidelines

Supervisors should arrange to have the source individual's blood tested for HIV and various forms of hepatitis as soon as possible after consent has been obtained. If the source individual is unable or unwilling to give consent, the EMS organization should consider seeking the legal authority to act without his or her consent. If it is impossible to draw blood from the source individual, but some other sample of his or her blood is available, this should be used. (If the source individual is already known to be infected with one or more bloodborne pathogens, the test for that pathogen may be omitted.)

Supervisors should ask the exposed employee for his or her permission to begin baseline blood tests for HIV and various forms of hepatitis. This should be done as soon as possible after exposure. Follow-up testing for HIV should take place at six weeks, 12 weeks, 26 weeks and 52 weeks after exposure.
Treatment Possibilities

HIV prophylaxis may include the administration of antiretroviral treatment. Highly active retroviral therapy (HAART) should be initiated as soon as possible, preferably within one hour following exposure, particularly if the EMS provider is HIV negative and the source is HIV positive or at risk.

The risk of transmission of hepatitis B (HBV) or hepatitis C (HCV) is significantly greater than the risk of transmission of HIV. Chronic HBV infection can be prevented in the nonimmune employee by administration of prophylactic hepatitis B immune globulin (HBIG) and the hepatitis B vaccine series. There is no known effective prophylaxis for HCV. The exposed employee should be referred for medical management to a specialist knowledgeable in this area. Obtained baseline HCV serology should be repeated in four to six months.

In cases of possible HBV infection, use the attached treatment protocol, developed and recommended by the Wadsworth Center.

Because the treatment of pregnant woman can present special medical problems, medical personnel treating women who may be pregnant should implement appropriate additional safeguards.
Recent ambulance inspections and reports from manufacturer’s representatives have identified several areas of concern regarding equipment on ambulances and emergency ambulance service vehicles (EASV) that are in need of clarification and in some cases service attention. Service managers need to review the following areas to identify any items relevant to their individual service.

**Equipment Storage**

Section 800.23 (d) intends that all equipment within the vehicle must be secured whenever the vehicle is in motion or an item is not directly being used for patient care. One of the purposes of this requirement is to prevent loose items from injuring members of the crew. This would include any equipment on open side shelves or storage racks where cardiac monitors, portable suction units and the like are usually kept. A manufacturer’s supplied restraining device or light duty strap holding these items in place is acceptable.

Each piece of equipment placed in service on an ambulance or EASV must have an identified storage location. The vehicle’s floor is not acceptable. Equipment bags may be kept on the vehicle’s stretcher so long as they are strapped to the stretcher with the head of the stretcher in the raised position.

**Pediatric Equipment**

Part 800.24 (h) lists the pediatric equipment that must be maintained on each ambulance vehicle. Due to the relatively low use of this equipment, it is recommended that services devise specific storage methods to locate all pediatric equipment in one common area or kit separate from adult items. Common storage facilitates locating specific pediatric items when they are needed and lessens loss.

It is acceptable to have a sealed pediatric kit so long as there is a visible list of the contents outside of the kit. The kit’s contents need to be inventoried at regular intervals and at any time the seal is broken.

**Bag Valve (BVM) and Masks**

Agencies are reminded that 800.24 (b) (1) requires each vehicle to have an adult-sized bag valve mask ventilation device with at least two (2) clear adult masks in different sizes. Additionally, 800.24 (h) (2) requires a total of three (3) pediatric masks in newborn, infant, and child sizes. Because of infection control policies and procedures, many services now use a disposable BVM and mask system with BVMs and masks commonly replaced by the receiving hospital as a single unit. However, we are finding that the exchange BVMs, as well as other prepackaged BVMs, do not contain the required number of differently sized masks. Services who have exchange programs must insure that proper sizes and quantities, as called for by Part 800, are available and accessible at all times.
Equipment Items with Batteries

Part 800.23 (a) requires that all equipment be clean and operable. In the case of portable equipment, operable means functioning at full capacity while away from the vehicle. Several reports have been received where patient care equipment, powered by a battery, has failed while in use. Agencies usually leave equipment such as portable battery operated suction units and defibrillators permanently attached to a shore line or direct AC source inside the vehicle to maintain a full charge. To insure proper performance and operating condition, all equipment which has a battery power source should be removed from its charger or charging power source, (e.g., shore line ) and be fully tested as it would be if it were being used for patient care.

Providers need to be familiar with manufacturer’s instructions and recommendations pertaining to battery charging indicators, as well as other lights or signals pertaining to each items maintenance, testing and operation.

Linen

Section 800.24 (f) (1,2) requires one (1) set of linen on the cot and one (1) spare set. Often we find anywhere from several to dozens of extra pieces of linen stored under the cot mattresses, under the bench seat and other odd locations within the ambulance. These storage methods allow linen to become entangled in the cot or it’s securing mechanisms and frequently is not clean enough to be used.

It is recommended that only the required spare linen, or if needed, enough linen for the duty shift, be stored in one cabinet.

Padded Splints

800.24 (c) (4) requires six (6) padded board splints. Due to infection control concerns, every effort should be made to insure that these splints are covered with a non permeable covering to prevent contamination from body fluids. Routine maintenance and cleaning in accordance with individual manufacturer’s and agency policy will prolong the usefulness of these items. It is further recommended that any padded splint with a rip or tear in its protective covering be repaired or replaced immediately.

Long Spine Boards (Wooden)

Many agencies continue to use wooden spine boards for spinal immobilization. Services need to maintain wooden spine boards in such a way as to insure that the board has a non permeable waterproof finish on its entire surface that is able to be cleaned (scrubbed) and insure that the board is not splintered. Wooden boards with a damaged or worn finish are easily contaminated and are not able to be cleaned properly. Wooden spine boards which are splintered or where the surface is no longer able to be cleaned must be repaired or replaced immediately.

Storage of Drugs and Needles

800.23 (f) requires all drugs and needles to be stored in a locked compartment. Services should refer to NYS EMS Policy Statement 86-19 for specific guidelines. Service managers need to insure that ALS crews routinely comply with the locking requirement to maintain security and accountability.

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Purpose

The purpose of this policy statement is to provide clarification to the requirements of Section 21.q of Part 800 which specifies incident reporting responsibilities and requirements for EMS services. Reports must be made for incidents in which a patient under the charge and care of the service was injured or harmed by actions or omissions of a service employee as well as for on duty death or injury of a service member/employee.

Notification Requirements

The chief executive officer of an EMS service is required to notify the DOH Area Office of the occurrence of any incident or circumstance in which a patient, or member/employee is harmed, injured or killed in any of the circumstances listed below. Questionable situations should be referred to the area office for resolution.

Notification must be made to the Department's Area office by telephone by the close of business the day following the incident and in writing within five days.

Types of Reportable Events

The following types of situations must be reported to the DOH:

- a patient dies, is injured, killed or otherwise harmed due to actions of commission or omission by a member of the ambulance service;

- an EMS response vehicle operated by the service is involved in a motor vehicle crash in which a patient, member of the crew or other person is killed or injured to the extent requiring hospitalization or care by a physician;

- any member of the ambulance service, while on duty, is killed or injured to the extent requiring hospitalization or care by a physician;

- patient care equipment fails while in use, causing patient harm;

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1 State EMS Code, Part 800, Section 21(q) 1-5 and Section 21(r)
• it is alleged that any member of the ambulance service has responded to an incident or treated a patient while under the influence of alcohol or drugs;

The definitions of the type of events listed above are very general in nature as EMS services and crews have broad and varying operating conditions and situations. The Department’s interest is in those events in which a patient, under the charge and care of the service, is injured or harmed by acts of commission or omission by a service member/employee. Examples might include failure to maintain an airway, failure to resuscitate, not honoring a properly executed DNR order, dropping a patient, etc. The situations described here are not to be considered an all inclusive list.

Additionally, to meet the requirements of Part 800.21(q)2 & 3 the DOH does require the reporting of any line of duty death or serious injury of a member or employee. This means that if a member of the service is killed or seriously injured in a sudden or unexpected circumstance (not a chronic situation) a report to the Area Office needs to be made.

The written report to the Area Office needs to describe the circumstances, outcomes and injuries or deaths of all involved. A copy of any motor vehicle accident report should be included. The Department will in each instance review the report and information submitted and determine what follow up action(s) or additional documentation will be required by the service.

*Having the incident identified and/or reviewed by the service or regional Quality Improvement process does not relieve the service from these reporting requirements.*

**Equipment Failures**

Services are to notify the Bureau of EMS in writing, of all unexpected authorized EMS response vehicle and/or patient care equipment failures that could have resulted in harm to a patient. One example is a defibrillator failing to discharge. Any corrective actions taken by the service should be included. The intent of this section is to track trends in vehicle or equipment failures so that reports may be made to manufacturers and other appropriate agencies.

The reporting of equipment failure to the Department does not relieve the agency from any requirements of the US Food and Drug Administration’s (FDA) mandatory medical device reporting. A copy of any FDA report filed will meet the intent of this requirement.

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INTRODUCTION

Advanced Life Support (ALS) is an essential level of out-of-hospital medical care. Various predictors indicate that under ordinary situations 5 to 25 percent of all calls in a system will be for patients in need of ALS care. It is important that every prehospital patient needing ALS care receive it without delay and that all are transported to definitive care at a hospital in a timely fashion.

The policy serves to:

- Define ALS intercepts.
- Define parameters for the utilization of ALS as well as to provide objectives every intercept should meet
  - Minimize delay in transporting patients to definitive care at a hospital.
  - Enhance the provision of patient care by maximizing the availability of ALS for those patients identified as being in need of ALS care.
  - Provide guidelines to assist in identifying and accessing the most appropriate ALS service at the time of request.
- Encourage REMACs to develop regional specific guidelines and protocols that enhance the availability of ALS and the appropriate use of ALS intercepts in the region.

New York State Statewide BLS Protocol

In 1996, the NYS BLS protocols were changed to introduce the concept of ALS intercepts and their use as the principal method of providing ALS care to patients needing this level of care when the initial EMS system contact is a BLS ambulance.

The provision of ALS by intercept permits the appropriate utilization of ALS resources
by identifying a hospital or ALS service as the nearest ALS provider at the time of need. Call location, staffed ALS unit availability and/or direction of travel will effect the decision.

**Excerpt from NYS BLS Protocol:**

The goal of prehospital emergency medical care is DEFINITIVE CARE for the patient as rapidly and safely as the situation indicates with no deterioration of his/her condition and, when possible, in an improved condition. BLS units shall deliver their patients who will benefit from ALS care to this higher level of care as soon as possible. This may be accomplished either by intercepting with an ALS unit or by transport to an appropriate hospital, which ever can be effected more quickly.

A system of ALS intercept (when available within a given area) shall be pre-arranged. Formal written agreements for the request of ALS shall be developed in advance by those agencies not able to provide ALS.

A request for ALS intercept shall occur as noted in specific treatment protocols.

Initiation of patient transport shall not be delayed to await the arrival of an ALS unit, unless an on-line medical control physician otherwise directs.

**Immediate Transport Decision:**

Determine patient status (CUPS):
- Critical or Unstable --- Immediate transport
- Potentially Unstable -- Secondary survey and transport

If the patient’s condition dictates immediate transport, the vital signs, secondary assessment, and treatment should be completed en route to the nearest appropriate hospital (as defined below in Section VII, Transport).

Intercept with an ALS unit (if available) en route to the nearest appropriate hospital as noted in specific treatment protocols.

*Note: Do Not delay patient transport to await the arrival of an ALS unit.*

**ALS Intercepts**

- An intercept is an authorized and staffed ALS unit, dispatched by request or protocol, meeting a BLS unit while it is en route to the nearest appropriate hospital.
- A BLS unit assesses the patient, determines the need for and requests ALS,
packages and begins patient transport. The BLS unit shall not wait on the scene for the ALS unit’s arrival. The request for ALS should be made as soon as the the patient’s condition is recognized as needing ALS.

- A hospital emergency department (ED) is the highest level of ALS medical care. Patients should be transported without delay to the nearest appropriate ED by the BLS unit. Definitive medical care can only be provided at a hospital ED.

- **ALS mutual aid is a misnomer and does not exist.** The statutory definition of mutual aid\(^1\) as well as the need for priority transport makes the use of the term “mutual aid” inappropriate in these circumstances.

- BLS services should identify ALS services in advance which are staffed and readily available to provide ALS intercept. More than one service may need to be identified if the BLS service regularly transports to more than one hospital. All formal response agreement needs to be established in advance. Dispatch entities should monitor actual staffing and operational status of ALS resources to insure their availability at the time of the call and minimize any potential delay. The use of the “closest unit” concept is appropriate to dispatch ALS units.

- All ALS patients should be transported to the hospital without delay by a BLS ambulance, particularly when the arrival of the ALS unit to the scene is estimated to be longer than the transport time to the hospital.

- In developing ALS intercept relationships, REMACs must consider the patient’s and ALS unit’s proximity to the hospital. Patient transport to an emergency department should not be delayed. BLS/ALS care should ideally be administered en route.

- Simultaneous dispatch of BLS and ALS resources should only be provided under the direction of dispatchers trained in the principals of emergency medical dispatch for those calls identified by a recognized dispatch algorithm.

- REMACs should develop protocols that permit a certified provider who arrives on the scene after the time of dispatch, to cancel initially dispatched ALS resources when, after assessment, it is determined that ALS care is not needed.

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\(^1\) Reference NYS-EMS Policy 95-04, “EMS Mutual Aid”
This policy updates a number of previously issued policy statements and memorandums sent to services over the last several years detailing use and safety concerns for oxygen delivery equipment. This policy supersedes all previously issued statements.

**AMBULANCE OXYGEN SYSTEMS**

Oxygen delivery systems in ambulances are a potential source of hazard if the distribution system and cylinders are not properly installed and maintained. Oxygen systems in ambulance vehicles need to be maintained in accordance with the original equipment manufacturer’s (OEM) specifications and inspected periodically for leaks, cleanliness and system integrity. Any unexplained noise or loss of oxygen gas should be investigated thoroughly. Caution should be exercised when replacing any component in the system to avoid installing an incompatible or incorrect piece of equipment (eg. liter flow regulator to replace a pressure reduction valve). *At no time should adhesive tape or similar materials, or petroleum products be used to seal connections or repair leaks.*

**OXYGEN CYLINDERS**

Poorly maintained or the incorrect handling of oxygen cylinders can be hazardous to staff and/or patients. The Department recommends that all providers become familiar with the applicable Federal US DOT regulations (CFR-49-100/199) pertaining to the maintenance of oxygen cylinders.

Services should take all necessary measures to ensure cylinder integrity. Specific attention should be given to the following areas concerning oxygen cylinders.

- Cylinder leaks, abnormal bulging, defective or inoperative valves or safety devices.
b. Physical presence of rust or corrosion on a cylinder or cylinder neck.

c. Any foreign substances or residues, such as from adhesive tape around the cylinder neck, oxygen valve or regulator assembly. The presence of these materials may hamper the ability of the oxygen delivery equipment to work properly and in some cases may have the potential to cause fire or explosion.

d. All oxygen cylinders must have proper hydrostatic testing and be marked appropriately. Services need to be aware of the specific requirements for the testing requirements of steel and aluminum tanks (eg. ten (10) years initial testing for steel cylinders and five (5) years for aluminum cylinders). Figure A identifies the proper definitions and markings for pressurized gas cylinders.

Any cylinder placed in service by an EMS service, whether or not it is currently on a vehicle, must be within test requirements as evidenced by a valid hydrostatic test date imprinted on the cylinder.

Paper labels on a cylinder usually indicate a gas expiration date and are not a valid cylinder test date.
MINIMUM SUPPLY/CYLINDER PRESSURE

An adequate supply of oxygen must be available at the beginning and at all times during a shift or ambulance call. To meet the requirements of 800.24.b, the Department will accept a minimum of 2,000 psi in any combination of portable cylinders (e.g., 1 @ 1700 and 1 @ 700) on a vehicle at the beginning of the shift. Oxygen used during a shift must be documented on a PCR. One portable cylinder must contain at least 500 psi at any time. A vehicle with less than 500 psi in one portable cylinder must be considered out of service until restocked.

An ‘installed’ cylinder (H, K, Q, etc.) must contain at least 500 psi.

Services must develop policies and procedures to address cylinder replacement when there is a low volume (e.g., 500, 700 psi) and such replacement needs to be based on the number of cylinders carried, resupply capability, shift length, etc.

INSTALLED OXYGEN SYSTEMS WITH HUMIDIFIERS

The Department recommends that disposable type oxygen humidifiers be the unit of choice. Services that continue to use non-disposable humidifiers must take steps to ensure the sanitary condition of the system at all times including a separate supply of sterile water, as required by 800.23(a). At no time is water to be stored in a ‘refillable’ humidifier. Any refillable system must be dry unless it is currently in patient use, as open sterile water can quickly become contaminated with microorganisms.

OXYGEN CYLINDER SECURING DEVICES

Part 800.23 (e) requires that each pressurized gas cylinder in any ambulance be mechanically secured. For installed oxygen systems, this must be accomplished by using the OEM supplied securing system or a similar replacement system that is maintained in proper condition. Portable and spare cylinders, must be mechanically fixed in place using a cup & yoke or equivalent device.

Portable cylinders may be packaged in a rigid or padded protective case and then stored in a cabinet or strapped to the ambulance cot with the head of the cot in the elevated position. In all situations the cylinder head and regulator are to be protected. At no time are oxygen cylinders to be stored in a cabinet or under the squad bench held in place by other items of equipment.
LIQUID OXYGEN SYSTEMS

Liquid oxygen systems are beginning to be used in ambulance vehicles as a “bulk” source. Each service is advised to fully research the feasibility of using a liquid oxygen system prior to making a decision to use this type of system. Issues concerning the use of liquid oxygen systems include but are not limited to:

a. Liquid oxygen systems bleed off almost constantly, and may waste a lot of oxygen making these systems unsuitable for low volume ambulance vehicles where more oxygen will be exhausted than used.

b. Liquid oxygen systems may be classified as a hazardous material in certain quantities, and in some jurisdictions are prohibited on thoroughfares, bridges and/or tunnels.

c. Source and ability to refill the unit.

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This policy is another in a continuing series published in an effort to help keep EMS services informed of changes in equipment and answer common questions pertaining to equipment requirements of the State EMS Code, Part 800.

**Item 1 - Battery Lantern (800.24.g.2 & 800.26.d.2)**
A battery lantern is considered to be a device capable of providing a sufficient amount of light to provide limited patient care when lighting or electrical failures occur in a vehicle and also capable of providing light remotely at a scene. One two “D” cell or larger hand held or free standing light with a halogen or krypton light source is acceptable and will meet the requirements of the code.

**Item 2 - Penlight/Flashlight (800.24.f.15 & 800.26.b.6)**
A flashlight may be a reusable or disposable pen size or mini flashlight generally used while performing patient assessment duties such as pupillary response. A battery lantern meeting the requirements of item one (1) of this policy does not meet the requirement for this item.

**Item 3 - Adult Extrication Collars (800.24.c.5 & 800.26.a.14)**
Each certified ambulance or ALS-FR service must have adult rigid extrication collars available in three (3) different sizes which provide access to the patients anterior neck. The Department has determined that, when used according to manufactures specifications, one adjustable style collar is equivalent to the three (3) individual adult sizes required. Therefore, one (1) adjustable rigid collar may replace the three (3) adult sized collars. One adjustable collar does not however, replace the need for a pediatric collar. Services are advised to discuss the choice of adjustable cervical collars with their service medical director and insure that all personnel are fully trained in the application, sizing and use of any cervical collar.

*It is recommended, that enough collars, of the same style and manufacture be available to provide for the possibility of two (2) or more patients. It is also recommended that collars not be carried or stored on a vehicle handrail as they may become easily soiled or contaminated.*
Item 4 - Blood Pressure Cuffs (800.24.f.5 & 800.26.a.13)
Many vehicles have fixed blood pressure cuffs in the patient compartment. Thus, a provider cannot perform an adequate assessment for a patient away from the vehicle. Therefore, at least one blood pressure cuff needs to be available to permit adequate patient assessment away from the vehicle. Any blood pressure cuff which is currently on a certified vehicle must be in good working order, including proper calibration of the gauge to zero.

Item 5 - Adult Bag Valve Mask (B.V.M.) (800.24.b.1 & 800.26.b.2)
Each certified vehicle is required to have a manually operated self-refilling adult size B.V.M. with two (2) different sized adult masks. Masks must be clear and have an inflatable air cushion. One (1) clear adult Blob type mask may replace the two (2) different sized adult masks. Merely having two (2) similar sized adult masks does not meet the requirements of 800.24.b.1.

*It is recommended that the two (2) different sized adult masks be stored in the same container as the adult B.V.M.*

Item 6 - Pediatric Bag Valve Mask (B.V.M.) (800.24.h.1&.2 & 800.26.b.2)
Each certified vehicle is required to have a pediatric size B.V.M. with three (3) different sized clear pediatric masks with an inflatable rim. These sizes will include child, infant, and neonate. One (1) pediatric Blob mask does not replace the need for three (3) pediatric masks.

*It is recommended that the three (3) pediatric masks be stored in the same container as the pediatric B.V.M.*

Item 7 - Adult and Pediatric Oral Airways (800.24.b.2&h.4 & 800.26.b.3)
A total of ten (10) oral airways are required and need to include four (4) adult airways in various sizes and 2 sets of three (3) pediatric airways in child, infant, and neonate sizes. Oral airways must be kept clean and sanitary, and are not required to be sterile or individually wrapped. **Do not wrap individual oral airways in foil or plastic wrap.**
Pediatric airways may be stored separately if there is a separate pediatric kit or cabinet routinely maintained on the vehicle.

*It is recommended that one complete set of seven (7) airways be stored in a box or plastic bag that is easily accessible to the care giver. Do not store bulk quantities of multiple sized airways in one container.*

Item 8 - Secured Equipment (800.23.d)
It is the intent of this requirement to minimize possible injury to crew members or patients, and damage to the vehicle or the equipment itself, that may result from equipment not being properly secured. All equipment in each vehicle will be secured, as far as is practical, except when the equipment is being used to provide patient care. All items of equipment, such as defibrillator units, jump kits, and portable oxygen units need to have a secure storage area. These items may be stored strapped to the ambulance...
stretcher so long as the head of the stretcher is in the raised position. Cabinet doors and other coverings must be functional and unbroken. It is recommended that ,whenever possible, every effort be made to secure all equipment during patient transport.

Item 9 - Sealed Pre-inventoried Equipment Bags and Cabinets
Services may use pre-inventoried kits or cabinets for equipment or supplies, and may seal or secure them to guarantee the contents. Any such seal must be easily broken to ensure availability and access for use. Furthermore, the attendant must be able to readily locate, identify and access any equipment that is contained in a sealed kit or cabinet. Services must have policies in effect which call for the routine opening, cleaning, and re-inventory of these sealed areas. Each kit or cabinet must have an inventory list visible or available in the vehicle. Items considered to be “lifesaving” in nature, such as suction catheters or tubing and oxygen delivery devices, must have at least one item located outside of any sealed cabinet.

Item 10- Sharps Containers
Part 800 does not directly address the issue of sharps containers. Each service will have a policy addressing the storage and disposal of used/contaminated sharps. It is not required that a sharps container be locked in a cabinet, but it is required that the container be properly secured. Caution should be taken when using these containers to prevent over filling and accidental exposure. Never break, bend, cut, or recap any needles prior to disposing of them. Never forcefully push a needle into a container. Smaller volume agencies should make provisions to empty small containers at the end of each day. Similar practices of maintenance and cleaning should pertain to all other trash containers.

*It is recommended that a service use the smallest size collection bin reasonable for the daily needs of the service.*
Objective

The objective of this policy is to identify the responsibilities of EMS services and individuals in regards to equipment required by Part 800 that may be considered by a service to be personal issue.

Background

Part 800 of the New York State EMS Code defines what equipment must be available and operational on each certified emergency response vehicle (Ambulance, EASV or ALSFR vehicle). Services may issue their members/employees certain items of EMS equipment such as penlights, stethoscopes, and blood pressure cuffs, or may permit members/employees to carry their own similar equipment.

Policy

Any service which issues or permits the use of personal equipment by its members/employees must have written policies in effect which clearly define which items of equipment are personal issue, and the responsibility of each member/employee for the availability, cleanliness and operational condition of each item when on duty. The service may limit what equipment members/employees may carry. Individual members/employees should receive a copy of the policy and acknowledge its receipt. The service's daily vehicle inspection report should identify any items of equipment considered to be personnel issue.

As with any item of equipment required by Part 800, the EMS service is held responsible for the availability, cleanliness and operating condition of any personal issue equipment.

Issued by: John J. Clair
Associate Director-Operations

Authorized by: Edward G. Wronski
Director

Thomas Fortune
Sr. EMS Representative-Operations
Statement of Purpose:

Radio communications resources for EMS services need to be capable of providing:

> Initial dispatch of the service including, equipment and/or personnel.

> The ability for the vehicle dispatched, while en route to a location within a designated response area, to be reached by the dispatching point and conduct 2-way communications.

> Within a reasonable distance and at least 10 minutes prior to arrival, contact a destination Hospital ED to provide patient status and time of arrival information.

> The ability for a destination hospital or Medical Control Physician to reach and converse with EMS personnel, prior to arrival, if needed.

> Medical Control activities, as required by the region’s Medical Advisory Committee (REMAC), at all points within the service area.

> Participation in local/regional interagency routine EMS activities (mutual aid, intercepts, etc)

> Participation in local/regional interagency MCI/Disaster activities in accordance with local or regional preplans.

> Other agency or local communications needs as identified by individual services or systems.
Policy:

Each EMS agency shall have available 2-way radio communications capability and a back up or redundant capability for each Emergency Response vehicle and/or its personnel to meet the needs as stated above.

Examples of the types of EMS services that shall have this capability include:

- ALS First Response
- BLS Ambulance
- ALS Ambulance

Any certified ambulance must have operational communications equipment in accordance with part 800.22(e) which states, "ALL AMBULANCES SHALL: have two-way voice communication equipment to provide communication with hospital emergency departments directly or through a dispatcher, throughout the duration of an ambulance call within their primary operating area. It shall be licensed by the Federal Communications Commission in other than the Citizens Band. Alternative Communication systems are subject to the approval of the department as being equivalent in capability."

Any vehicle identified as an Emergency Ambulance Service Vehicle (EASV) must have operational communications equipment in accordance with part 800.26(c) which states, "Any emergency ambulance service vehicle (other than an ambulance) shall be equipped and supplied with: A two-way voice communications enabling direct communication with the agency dispatcher and the responding ambulance vehicle on frequencies other than citizens band."

800.22(e) means, any service (Ambulance or ALS First Response) which is authorized by a REMAC to provide Advanced Life Support (ALS) care shall have communications capability to access and use a REMAC approved communications system for the purpose of establishing On Line Medical Control and conversing directly with an approved Medical Control point at any location where a patient is to be received within the service’s authorized territory.

800.26(c) means, any EASV or ALS First Response Vehicle shall have communications capability to; communicate directly with Medical Control to insure appropriate patient care, maintain communications with the incident dispatch point, and communicate with any ambulance or personnel to which it is responding to provide additional EMS assistance including ALS intercept. These communications capabilities need to be operable throughout the service’s authorized territory.

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1 A cellular phone type communications capability may not be used to provide redundancy to another cellular phone type system. A cellular phone may be used however to provide communications redundancy to a standard two-way radio system and vice versa. A Separate two-way radio system may be used to provide redundancy to any primary two-way radio system.

2 This applies to territory within the constraints of each REMAC region or system within which the service has authority and actually provides ALS patient care. Some services may operate under multiple communications systems depending on the ALS systems within which they have REMAC approval.
Any service which is a participant in a local or regional preplan or contract for mutual aid, ALS Intercept, MCI or Disaster Response, shall have communications capability to; contact or be contacted by the dispatch control point, incident site, field command, county or regional control center and/or other services in accordance with the provisions of said plan.

Each agency or service shall hold a valid FCC issued license for the operation of communications equipment on frequencies used by the service OR hold a valid “Letter of Authority” from an appropriately licensed entity to operate communications equipment on frequencies used by the authorizing service.

For the purposes of this policy, communication systems include land mobile two-way, trunked, commercial and public safety systems under Part 90 of the FCC Rules and Regulations and cellular phone systems authorized by the Federal Communications Commission. Specifically excluded from use are CB, GMRS, Marine, all FCC designated “unlicensed” radio services and other non Part 90 Radio Services.

Additional Notes:

In areas where communications are not reliable due to geographic and topographic considerations, it is the responsibility of the REMAC of each system to evaluate communications systems proposed to be used for Medical Control and endorse specific communications methods to be used. Alternative communications systems (e.g.: Cellular Telephone) may be recommended by a REMAC for either redundancy or replacement of conventional systems where deemed appropriate. This may be the case for example where REMAC protocols reflect actual communications capabilities, conventional systems have been demonstrated to provide inadequate coverage, or to provide for medical control in the event of communications failure. (NOTE: Communications failure is the sudden and unexpected loss of communications capability. It is NOT characterized by an inability to communicate reliably under normal conditions.)

In instances where hand carried devices are used to provide communications for an EMS service, the device should be capable of being connected to an antenna system affixed to the exterior of the vehicle and the device should also be capable of being operated using the vehicles fixed electrical power system. Such devices may serve as back up communications to an alternate communications service.

In all cases, hand held communications devices should be kept at least three (3) feet from patients with pacemaker implants, or any electronic medical device, while the communications device is in use.

Issued By:
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Dana L. Jonas
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Authorized by:
Edward G. Wronski
Director, Bureau of Emergency Medical Services
The following interim policy statement on AED training is effective immediately. As a new AED course curriculum is adopted and our data processing system upgraded, we will update this policy.

Introduction

Since January 1991, a number of first responder agencies have participated in a demonstration study to consider moving Automated External Defibrillation (AED) to the basic life support (CFR & EMT) level. Based on the data from this study, several other national studies and the recommendations of the 1992 National Conference on Cardiopulmonary Resuscitation and Emergency Cardiac Care, the State EMS Council has recommended and the Commissioner of Health adopted regulatory changes to the State EMS Code (10NYCRR-800) which defines AED as a basic life support skill. Non-transporting first response EMS agencies are no longer required to obtain Certificate of Need (CON) approval in order to provide AED level care. However, all services are required to have Regional Medical Advisory Committee (REMAC) approval, be part of an Emergency Medical Services System, and have medical control.

Specific questions from agencies wishing to provide AED level care should be directed to their Regional Emergency Medical Advisory Committee (REMAC).

AED Training

To use the Automated External Defibrillator the CFR/EMT/AEMT must successfully complete training which meets or exceeds the State approved AED Standard Curriculum [800.15(d)(4)]. The curriculum which should be used until the revised AED curriculum is published should be the currently published EMT-Defibrillation curriculum.

A. Who can conduct AED Courses?

Any BLS or ALS Course Sponsor, currently approved by the Department of Health, may conduct AED original training, in accordance with the State approved AED Standard Curriculum. The Course Sponsor must file a Course Application (DOH-782) and course schedule at least 30 days prior to the start of the AED course. Attached to the application should be a copy of the course schedule covering the objectives of the curriculum. Please check the box Basic EMT-D Original to indicate this is a stand-alone AED course.

B. Who can teach AED Courses?
The AED instructor must be a currently Certified Instructor Coordinator (CIC) and hold current certification at or above the EMT-Defibrillation level, as outlined in Policy Statement 93-8. It is the responsibility of the Medical Director to assure that quality of medical instruction.

C. **End of Course Documentation**
Within 10 days of course completion the sponsor must submit a *Course Memorandum (DOH-263)*, a *Final Practical Skills Examination Summary Sheet (DOH-2733)*, and an *Application for EMT-Defibrillation Certification (DOH-3306)* for each candidate (CFR or EMT) which have successfully completed the course.

D. **Retraining and Reauthorization**
Periodic "retraining" is the responsibility of the Service Medical Director. In low call volume areas the Medical Director may wish to conduct AED drills or in-service training as frequently as every 90 days.

E. **Who maintains course completion records?**

1. **Course Sponsor**
The State EMS Code (10NYCRR-800) Section 800.20(9) requires that Course Sponsors maintain individual course and student records for a period of 5 years. These records should include attendance, learning contract, practical skills and written examinations.

2. **EMS Agency**
Section 800.21(k) of the State EMS Code requires that all EMS agencies maintain current and accurate personnel files on all CFR/EMT/AEMT personnel. Training records must include:
   a. copies of state issued certification;
   b. record of additional or specialized training; and
   c. in-service training and continuing education programs.

Verification of original AED training must be maintained as a record of specialized training. AED "retraining" approved by the Service Medical Director must be maintained as a record of in-service training.

**Certified First Responder**

A Certified First Responder is eligible for AED training. However, it needs to be clearly understood that the current regulations do not include a level of certification called "CFR-Defibrillation". Within the limitations of the 51 hour CFR course, AED training is not included. The department will not be issuing a certification for this level.

There are future plans to issue a certificate of course completion for AED Training.

**Funding**

The current budget allows for reimbursement of $50 per eligible student who completes the "stand alone" EMT-D original or "stand alone" AED course. See Course Funding policy statement for details.
The purpose of this policy is to provide EMS services with guidance as mutual aid plans and policies are developed. This policy statement discusses the concept, history and legal basis for EMS mutual aid in New York State.

EMS services have the responsibility to routinely provide the type and level of service authorized and/or expected by the community, in a timely and reliable manner.

From time to time, to meet peak demand or extraordinary resource utilization, it may be necessary to request assistance to answer a call or provide additional resources. This is the concept of and intent of EMS mutual aid.

EMS mutual aid requests must be made with the intent of having the closest available EMS unit respond to a patient's medical need, at a time when the resources of the requesting agency are temporarily unavailable or have been expended.

The response to multiple casualty incidents (MCI's) and other large scale events are usually conducted in accordance with a county or other pre-determined resource allocation and management plan. These may require mutual aid responses but are developed independently due to the special planning needs required.

EMS services are required by the State EMS Code (800.21.p) to have a written mutual aid plan. Regional EMS Councils are encouraged to coordinate the development of agency and/or county mutual aid plans and the Councils have the authority to approve an EMS service operating beyond its primary operating territory for purposes of fulfilling the provisions of a mutual aid agreement (PHL3010.1.b).

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Authorized by: Edward G. Wronski
Deputy Director

Background:
The provision of mutual aid by fire departments is provided for in several sections
of the General Municipal Law (GML) however, without definition, terms or conditions. The GML does specify that the requesting fire department is responsible for responding equipment and the responding fire service retains responsibility for personnel. The GML does not address mutual aid with non fire agencies - eg. volunteer or commercial.

For EMS mutual aid, the provisions of Article 30 with regard to primary operating territory must prevail, all other circumstances being the same - eg. response time, location, staffing, etc.

There is no statutory or regulatory definition requiring, presuming or defining who may, or must or who can not request mutual aid. In other words, there is no definition or prohibition regarding what type of agency a requesting agency must call. Therefore any service type may request the assistance of any other EMS service:

• FD <= > VAC
• VAC <= > Commercial
• FD <= > Commercial

Insurance policies are available to cover the assets and liabilities of any agency requesting or responding to a request for EMS assistance. There is no restriction with regard to who may obtain or provide such coverage.

Conclusion:

It may be concluded that mutual aid in New York State may be easily achieved within the current regulatory and statutory definitions if:

• Services providing an EMS response to a request for EMS assistance maintain responsibility for their own liability - specifically; vehicles, equipment and personnel.

• EMS mutual aid is requested from the closest, available, appropriate agency capable of responding at the time of the request.

Mutual Aid Plans:

EMS agencies need to develop and maintain written mutual aid plans (800.21.p). These plans, while agency specific, should be developed in conjunction and cooperation with counties and Regional EMS Councils.

For assistance in developing mutual aid plans, refer to NYS-EMS policy 89.2 Mutual Aid Planning Guidelines.

Mutual aid plans must insure that any request is made with the intent of having the closest [usually means the unit with the shortest response time to the patient] available EMS unit respond to a patient's medical need, at the time the resources of
the requesting service are temporarily unavailable or have been expended.

Mutual aid plans and agreements for normal day to day requests are the responsibility of the individual EMS service. Typically such agreements identify the closest EMS unit that is to be requested. Frequently, an EMS service's area of operation is divided, within a plan, to facilitate a timely response based on the location of the neighboring service. Service type (eg. volunteer, fire, hospital, commercial) must not be a consideration in any plan or to any request. Staffing, unit availability, response time and primary operating territory are the primary concerns to be addressed. The specific agency to be requested for a mutual aid response may vary with day or time based on availability.

Mutual aid plans for multiple patients are usually developed and coordinated at a county level to insure an adequate response as well as to provide coverage of all affected areas.

The statutory definition of mutual aid excludes inter-facility transfers and ALS intercepts.

Counties providing coordinated dispatch, (911, fire control, etc.) will need to monitor crew status and service availability, to assist in implementing agency mutual aid plans - particularly when they act as the service's dispatch.

1 - usually means the unit with the shortest response time to the patient
REQUIREMENTS FOR
ADVANCED LIFE SUPPORT FIRST RESPONSE (ALSFR) SERVICES

I. Introduction

The 1993 amendments to Article 30 of the Public Health Law require that First Responder (non-transport) EMS services, which provide ALS, be certified by the Department (PHL 3005). To enable the certification of ALSFR services, this policy sets forth the requirements that an ALSFR service must meet. Each ALSFR service must have an operational plan (Section II a), specific BLS and ALS equipment (Section V), policies and procedures relating to operations, dispatch, and documentation (Section III), and reporting certain incidents (Section IV). These requirements have been designed to compliment the typical requirements that REMAC’s and local medical directors have required of ALSFR services.

This policy statement will serve as interim direction for the minimum requirements, conduct and competency in the operation of ALSFR services under the provisions of Section 3012 of the Public Health Law, until final regulations are adopted by the Department.

II. General Requirements
An ALSFR service shall:

a. develop and submit to the Department, for review and/or modification and approval, a plan which demonstrates the manner in which the ALSFR service will provide ALS care. This plan shall include but not necessarily be limited to:
   1. staffing patterns and level(s) of care;
   2. vehicle configuration, type and use;
   3. access, safeguarding, security and secure storage, including environmental protection from temperature and other damage, of all ALS equipment and supplies while in use and storage;
   4. dispatch, ambulance and ALS communications;
   5. ALS protocols and on-line medical control; and
   6. Written approval of medical control for participation in the plan,

b. identify to the department all vehicles or other conveyances which will be used as ALSFR vehicles;
c. display on each ALSFR vehicle when in service a valid Department of Health certificate of inspection;

d. have and maintain each ALSFR vehicle in compliance with all applicable federal or state agency (DMV, DOT, FAA, USCG, etc.) registration and applicable requirements;

e. have for each ALSFR vehicle or conveyance any appropriate safety inspection certificate from a federal or state agency (DMV, DOT, FAA, USCG, etc.), unless specifically exempted by statute;

f. notify the department in writing when any designated ALSFR vehicle is permanently removed from service as an ALSFR vehicle. Any department certificate of inspection shall be removed at such time;

g. display on the exterior of both sides on any ALSFR vehicle the name of the service in clearly legible letters not less than 3 inches in height;

h. equip any ALSFR vehicle placed in service with the minimum equipment set forth in this part;

i. have on each call when providing ALS care at least one individual who is a certified advanced emergency medical technician attending the patient at all times;

j. provide ALS care only at a level and in a manner authorized by medical control;

k. only permit ALSFR conveyances to be operated by a duly licensed individual;

l. make available for inspection, with or without notice, to representatives of the department all vehicles, conveyances, materials, equipment, records, procedures, and facilities;

m. maintain current and accurate personnel files for all certified first responders and emergency medical technicians, showing qualifications, training and certifications and health records including immunization status. Employee health records shall be maintained separately and in compliance with all applicable requirements. Information contained in such personnel files shall be reviewed no less frequently than annually, and may be disclosed only to authorized individuals;

n. maintain a record of each EMS call in compliance with the requirements of 800.32 of this part;

o. maintain adequate, secure and safe storage facilities for all equipment, supplies and oxygen. Separate storage and disposal shall be maintained for soiled supplies and waste in accordance with applicable requirements;
p. maintain all equipment and supplies in a clean and sanitary condition, secure and environmentally protected;

q. have a written agreement with one or more ambulance services which describes dispatch criteria and procedures and which requires the ambulance service to transport any patients in the care of the ALSFR service and ALSFR service personnel, to a hospital;

r. operate only within its primary territory except:
   1. in response to a request for mutual aid in accordance with the service’s written mutual aid plan; or
   2. in response to a mutual aid plan implemented by a central dispatch agency on behalf of an ambulance or ALSFR service or on behalf of a county or city emergency management office; or
   3. by approval of the department and the appropriate regional emergency medical services council for up to 60 days if the expansion of territory is necessary to meet an emergency need;

III. Required Policies

a. have and enforce written policies concerning:
   1. mutual aid, including any required authorizations and agreements, to request the response of the nearest, appropriate, available EMS service(s). The written plan shall consider the incident location and access to it, location of the mutual aid agency, primary service area, level of service, staff availability and any other pertinent information when identifying the mutual aid agency;
   2. coverage of the service’s response area when it is unable to respond to emergency calls for assistance;
   3. the maximum call receipt interval for all emergency calls for assistance, except for MCI or disaster situations;
   4. actions to be taken if the maximum call receipt interval determined in (3) is exceeded and an ALSFR vehicle has not yet started toward the incident location;
   5. authorization and protocols for a central dispatch agency to send a mutual aid service when the service does not or cannot respond;
   6. minimum qualifications and job descriptions for all patient care providers, drivers and EMS dispatchers;
   7. physical, health and immunization requirements for all patient care providers and drivers, including provisions for biennial review and updating of such requirements;
   8. preventive maintenance requirements for all authorized EMS response vehicles and patient care equipment;
   9. cleaning and decontamination of authorized EMS response vehicles and equipment, in accordance with currently accepted practices;
   10. equipping and inspection of all authorized EMS response vehicles;
   11. reporting by the agency of suspected:
      i. crimes;
      ii. child abuse;
ii. patient abuse; and/or
iv. domestic violence, including any directed toward elderly persons;

12. responsibilities of patient care providers when:
   i. a patient cannot be located
   ii. entry cannot be gained to the scene of an incident
   iii. a patient judged to be in need of medical assistance refuses treatment and/or transportation;
   iv. patients seek transportation to a hospital outside the area in which the service ordinarily transports patients;
   v. a receiving hospital requests that a patient be transported to another facility before arrival at the hospital;
   vi. treating minors;
   vii. treating or transporting patients with reported psychiatric problems; and
   viii. confronted with an unattended death.

13. infection control practices and a system for reporting, managing and tracking exposures and ensuring the confidentiality of all information that is in compliance with all applicable requirements;

14. by July 1, 1995, have an EMS response plan for hazardous material incidents. Participation in a county or regional plan will meet this requirement.

15. By July 1, 1996, have a response plan for multiple casualty incidents. Participation in a county or regional MCI plan will meet this requirement.

IV. Required Reporting

a. upon discovery by or report to the governing authority of the service, report to the Department’s Area Office by telephone no later than the following business day and in writing within 5 working days every instance in which:
   1. a patient dies, is injured or otherwise harmed due to actions of commission or omission by a member of the ALSFR service;
   2. an authorized EMS response vehicle operated by the service is involved in a motor vehicle crash in which a patient, member of the crew or other person is killed or injured to the extent requiring hospitalization or care by a physician;
   3. EMS personnel are killed or injured to the extent requiring hospitalization or care by a physician while on duty;
   4. patient care equipment fails while in use, causing patient harm;
   5. it is alleged that any member of the service has responded to an incident or treated a patient while under the influence of alcohol or drugs;

b. On or in a form approved by the Department, maintain a record of all unexpected authorized EMS response vehicle and patient care equipment failures that could have resulted in harm to a patient and the corrective actions taken. A copy of this record shall be submitted to the Department with the EMS service’s biennial recertification application.
V. ALS First Response Vehicle Equipment Requirements

Every ALS first response vehicle shall be equipped, meeting all requirements of 800.23 and shall be supplied as follows:

a. Emergency care equipment and supplies consisting of:
   1. twelve sterile 4"x4" gauze pads;
   2. adhesive tape, 2 rolls assorted sizes;
   3. six rolls conforming gauze bandage, assorted sizes;
   4. two universal dressings, minimum 10 by 30 inches;
   5. six 5"x9" (minimum size) sterile dressings or equivalent;
   6. one pair of bandage shears;
   7. six triangular bandages;
   8. sterile normal saline in plastic container (1/2 liter minimum) within the manufacturer's expiration date;
   9. one air-occlusive dressing;
   10. one liquid glucose or equivalent;
   11. disposable sterile burn sheet;
   12. one emergency childbirth kit, with sterile supplies;
   13. blood pressure cuff(s) in adult and pediatric sizes;
   14. one stethoscope
   15. rigid extrication collars capable of limiting movement of the cervical spine. These collars shall include one each pediatric and small, medium and large adult sizes;
   16. carrying case for essential equipment and supplies;
   17. one set or personal protective mask and goggles or equivalent for each crew person;
   18. four pairs of disposable gloves in two sizes;
   19. one pen light or flashlight; and
   20. one blanket.

b. Oxygen and resuscitation equipment consisting of:
   1. portable oxygen with a minimum 360 liter capacity with pressure gauge, regulator and flow meter (medical "D" size or larger) and one spare cylinder. The oxygen cylinders must contain a minimum of 2,000 psi between them, and each cylinder shall contain a minimum of 500 psi;
   2. manually operated self-refilling bag valve mask ventilation devices in pediatric and adult sizes, each with a system capable of operating with oxygen enrichment and, as appropriate, two sizes each of clean adult and pediatric masks with air cushion;
   3. six oropharyngeal airways, one each in a range of sizes child through adult, packaged so as to be individually identifiable and maintained sanitary;
   4. two each: disposable non-rebreather oxygen masks, and disposable nasal cannula individually wrapped;
   5. one each, pediatric non-rebreather mask and nasal cannula;
6. portable electric suction equipment capable, according to the manufacturer’s specifications, of producing a vacuum of over 300 mm Hg when the suction tube is clamped, including one wrapped plastic Yankauer pharyngeal suction tip, one 8 fr. Catheter and one pediatric suction device;
7. one pen light or flashlight; and
8. one blanket.

c. Two-way voice communications by radio or equivalent enabling reliable, direct communication with the ALSFR service dispatcher, the responding ambulance vehicle and, as required, on line medical control throughout the duration of the call on frequencies other than citizens band.

d. Safety equipment consisting of:
   1. six flares or three U.S. Department of Transportation approved reflective road triangles;
   2. one battery lantern in operable condition; and
   3. one Underwrites’ Laboratory rated five-pound ABC fire extinguisher or any extinguisher having a UL rating of 10BC.

e. Provide one or more of the following categories of advanced life support equipment as defined by medical control for the level of ALS care authorized:
   1. fluid administration equipment and supplies;
   2. airway management equipment and supplies;
   3. a defibrillator and supplies;
   4. medication administration equipment and supplies;
   5. other equipment and supplies to provide ALS care as authorized by medical control, the Commissioner and the State EMS Council.

f. Maintain all equipment and supplies in such a manner as to:
   i. prevent damage or deterioration from environmental changes;
   ii. limit access and maintain security at all times; and
   iii. be secure and packaged so as to prevent physical damage.

g. An ALSFR service may make application to the Commissioner for modification or exceptions to the vehicle or equipment requirements of this part if the nature of the EMS operation justifies such modification. Such application must clearly demonstrate that the ALSFR service plan meets the requirements as set forth in section 800.30(a) of this part, and provide specific justification for any exemptions requested.
The incidence of tuberculosis (TB) has increased substantially in the last few years. EMS providers should be aware of this infectious disease and the procedures for protecting themselves.

As with all infectious diseases, no precaution is 100% effective; rather, these precautions are designed to reduce the probability that the disease can be transmitted from person to person.

TB is spread when small droplets from the respiratory tract of an infected person enter the air and are inhaled by another person. Precautions can be taken in three areas to reduce the danger.

First, the patient's mouth should be covered with a mask. A disposable micron surgical mask (#M "Aseptix" sub-micron molded surgical mask, Catalog #1812; or equivalent) is best, but a standard surgical mask or even an oxygen mask is helpful. The nature of the medical treatment required by the patient should determine which mask is used.

Second, a disposable micron mask or disposable particulate respirator (PR), should be worn by the provider. It should fit snugly on the face. A beard or mustache will markedly reduce the effectiveness of such protection.

Third, the number of infectious droplets in the air can be reduced by ensuring good ventilation in the patient compartment of the ambulance. Thus, the ventilation system should be maximized and/or side windows opened to provide a steady source of clean air.

Which patients should receive respiratory precautions?

Patients with respiratory symptoms of more than 2 weeks duration or any patient with a respiratory symptom of any duration who is a member of a higher risk group. The CDC defines high risk groups as follows:*  

- Alcoholics
- IV drug users
- Contacts of patients known to have active TB
- Low income populations
- Prisoners
- HIV infected persons
- Nursing home residents
- Refugees
Persons with other pre-existing medical conditions which compromise the ability to fight infection are also at increased risk. Such conditions include:

- Chemotherapy
- Diabetes
- Steroid Therapy
- Renal failure
- Some cancers

(source: CDC)

Clearly, TB patients receiving nebulized aerosols of Beta-agonists are likely to spread infectious droplets. In such patients, as well as those presenting with respiratory symptoms such as a persistent cough, special attention should be given to these precautions by EMS providers.

Since air-borne droplet spread is the only means of TB transmission, there is no need to decontaminate or disinfect the ambulance or equipment. The following sections from the CDC Mortality and Morbidity Weekly Report (December 7, 1990) summarize the CDC recommendations for control of TB in pre-hospital settings:

1. Other source-control methods
   A simple but important source-control technique is for infectious patients to cover all coughs and sneezes with a tissue, thus containing most liquid drops and droplets before evaporation can occur. A patient's use of a properly fitted surgical mask or disposable, valveless particulate respirator (PR) (see below) also may reduce the spread of infectious particles. However since the device would need to be worn constantly for the protection of others, it would be practical in only very limited circumstances (e.g., when a patient is being transported within a medical facility or between facilities).

2. For persons exposed to tuberculosis patients.
   Appropriate masks, when worn by health-care providers or other persons who must share air space with a patient who has infectious tuberculosis, may provide additional protection against tuberculosis transmission. Standard surgical masks may not be effective in preventing inhalation of dropley nuclei, because some are not designed to provide a tight face seal and to filter out particulates in the droplet nucles size range (1-5 microns). A better alternative is the disposable PR. PRs were originally developed for industrial use to protect workers. Although the appearance and comfort of PRs may be similar to that of cup-shaped surgical masks, they provide a better facial fit and better filtration capability. However, the efficacy of PRs in protecting susceptible persons from infection with tuberculosis has not been demonstrated.
PRs may be most beneficial in the following situations:

a) when appropriate ventilation is not available and the patient's signs and symptoms suggest a high potential for infectiousness, b) when the patient is potentially infectious and is undergoing a procedure that is likely to produce bursts of aerosolized infectious particles or to result in copious coughing or sputum production, regardless of whether appropriate ventilation is in place, and c) when the patient is potentially infectious, has a productive cough, and is unable or unwilling to cover cough.

Comfort influences the acceptability of PRs. Generally, the more efficient the PRs, the greater is the work of breathing through them and the greater the perceived discomfort. A proper fit is vital to protect against inhaling droplet nuclei. When gaps are present, air will preferentially flow through the gaps, allowing the PR to function more like a funnel than a filter, thus providing virtually no protection.

3. For tuberculosis patients.

Masks or PRs worn by patients with suspected or confirmed tuberculosis may be useful in selected circumstances (see below). PRs used by patients should be valveless. Some PRs have valves to release expired air, and these would not be appropriate for patients to use.

4. Emergency medical services

When emergency-medical-response personnel or others must transport patients with confirmed or suspected active tuberculosis, a mask or valveless PR should be fitted on the patient. If this is not possible, the worker should wear a PR (see above). If feasible, the rear windows of the vehicle should be kept open and the heating and air conditioning system be set on a nonrecirculating cycle.

Emergency-response personnel should be routinely screened for tuberculosis at regular intervals. They should also be included in the follow-up of contacts of a patient with infectious tuberculosis.

(End of CDC recommendations).

**Treatment of Exposed Providers**

PPD testing should be conducted for pre-hospital providers who are exposed to TB patients for whom adequate infection control measures (outlined above) were not taken. Unless a negative skin test has been documented within the preceding three months, each exposed worker (except those who are already known to be positive reactors) should receive a PPD (Mantoux) skin test as soon as possible.

If the skin test is negative, the test should be repeated within twelve weeks after the exposure ended.

Persons with skin test reaction of 5mm induration (swelling) or greater, or with symptoms suggestive of active TB, should receive chest x-ray examinations.
Persons with previously known positive skin test reactions who have been exposed to an infectious patient should be evaluated for active TB, but do not require a repeat skin test or a chest x-ray examination, unless they have symptoms suggestive of active TB.

Optimally, arrangements for treatment should be made by each agency in advance of an exposure. Possible sources of care include: personal physician, receiving hospitals or County Health Departments.

*Core Curriculum on Tuberculosis; Centers for Disease Control, April 1991: p. 11

Issued by: J. Lawrence Mottley, M.D.
Senior Medical Advisor
SUBJECT: Out-of Service Vehicles

Once the Emergency Medical Services Program has been notified that an ambulance has been placed in service and the appropriate sticker is affixed, it is considered in service unless removed from service. An ambulance is removed from service either temporarily or permanently. The following procedure must be followed in either case. The procedure to follow when returning to service an ambulance which had been temporarily removed from service is also included.

TEMPORARY REMOVAL FROM SERVICE

A. When an ambulance is removed from service, whether for vehicle maintenance reasons or lack of patient care equipment, and it is believed that this removal will be temporary, the following procedure is to be used:

1. Place on the outside of the windshield, over the State Certification sticker, a State "Out of Service" sticker.

RETURN TO SERVICE OF AN AMBULANCE TEMPORARILY REMOVED FROM SERVICE

A. When an ambulance that has been temporarily removed from service is returned to service, the ambulance service operator will perform the following:

1. Assure that the vehicle is in compliance with Part 800 of the codes of the New York State Department of Health.

2. Remove the "Out of Service" sticker from the vehicle windshield.

AMBULANCE PERMANENTLY REMOVED FROM SERVICE

A. When an ambulance is permanently removed from service the ambulance service operator will perform the following:

1. Notify in writing, on official letterhead, the appropriate State EMS Representative of the following information:
• Make
• Year
• Vehicle/Radio ID
• License Plate Number

2. Remove ALL New York State EMS logos from the sides and rear of the vehicle.

3. Remove the Department of Health Certificate of Inspection sticker from the windshield.

If there are any questions concerning this policy, please contact the appropriate EMS Representative or Associate Director of Operations at (518) 402-0996.

Approved by: Michael Gilbertson, Director
SUBJECT: Part 18

Part 18 of the New York State Sanitary Code requires specific emergency medical services (EMS) planning and coverage for all events likely to attract 5,000 persons or more, at any given time. It is the Department’s position that such coverage must provide for care of participants as well as spectators.

All Applications for a Permit for a Public Gathering (DOH-44) must include a plan which encompasses EMS protection for the participants (including athletes) as well as spectators. Following are methods by which this coverage may be addressed.

When a physician, trainer, or coach is responsible for care of the participants (generally athletes), the EMS plan must include an interface between the responsible person and the EMS system. This interface must include a written understanding, protocols, and two-way communication via radio or telephone. For high risk events, the permit issuing official may require additional EMS personnel and equipment dedicated to care of the participants.

For other events, EMS coverage for participants may be included with the general coverage for spectators.

Issued by: George L. Johnson, Associate Emergency Medical Care Representative
Authorized by: Michael Gilbertson, Director
SUBJECT: Sample Standard Operating Procedure to Follow in Respect to Backing and Parking the Ambulance

Policy

In response to the often questioned concerns of ambulance operators on procedures for backing and parking ambulances and in preparation for the Ambulance Accident Prevention Seminar (AAPS), the following guidelines have been prepared so they could easily be adapted into each service’s standard operating procedures.

Backing the Ambulance

1. Backing of the ambulance should be avoided whenever possible. Where backing is unavoidable, a spotter or an assistant outside the vehicle should be used.

2. In addition, a spotter should be used when vehicles must negotiate forward turns with restrictive side clearances and where height clearances are uncertain. The purpose of the spotter is to expand the driver’s sense for the right, left, front and rear space cushions.

3. Under circumstances where the ambulance is staffed by only the driver (e.g., all other personnel are inside the residence with the patient), the driver should attempt to utilize any available emergency services personnel to act as spotters. Where no personnel are available to assist, the driver shall park the vehicle, get out, and make a complete survey of the space cushion around all four sides of the vehicle to determine if any obstructions are present before proceeding to back the ambulance.

4. Spotters are never permitted to ride the tailboard or running boards while the vehicle is in motion. The spotter should be in a visible safe zone positioning him/herself ten (10) to fifteen (15) feet at the left rear of the ambulance.
5. The vehicle should not be backed until the spotter is in position in the safe zone and has communicated his/her approval to begin backing by way of a hand signal, and voice, when possible. Spotters should remain visible to the driver in the safe zone. Anytime the driver loses sight of the spotter, the vehicle should be stopped immediately until the spotter is again visible and the communication to continue backing is processed. This is definitely not a high-speed maneuver. It should be done very slowly and cautiously.

**Parking the Ambulance**

1. Always park the ambulance in a hazard-free area to protect the crew, patient and the ambulance (e.g., at a motor vehicle accident pull past the accident, avoiding fuel spills, and park the vehicle off the road on the shoulder).

2. When parking to the driver’s blind side a spotter should be used.

3. When parking in a parking space or driveway, back into the parking area so that you have a safe and efficient exit.

**General Rules for Drivers and Spotters**

1. Never be in a rush when backing or parking!

2. Do not start to back or park when unsure of the area.

3. Do not put the ambulance into reverse gear until it has come to a complete stop.

4. When it is dark outside use the side and rear spotlights when backing to light the area.

5. If the vehicle has a backup alarm that can be disengaged, it should always be in the on position before backing the vehicle.

**Standard Signals for Spotters**

1. Straight Back – One hand above the head with palm toward face, waving back. Other hand at your side.

2. Turn – Both arms pointing the same direction with index fingers extended.

3. Stop – Both arms crossed with hands in fists. Be sure to reinforce the signal by yelling the stop order loud enough so the driver can hear.

4. Night Backing – Signals are the same. The spotter should assure that the spotlights on the rear of the ambulance are turned on before allowing the vehicle to be backed. A flashlight, wand type is useful, maybe carried but at no time will it be directed towards the mirrors.
On March 1, 1989, the New York State EMS Council approved these Guidelines for the Development of EMS Mutual Aid Plans. This planning guide is a voluntary, educational document designed to assist local communities as EMS Mutual Aid Plans are developed, reviewed or refined.

PURPOSE:

To establish a guideline for the development of uniform agreements between ambulance and other emergency medical response agencies, making available a methodology to obtain the resources needed to manage medical emergency incidents in a defined and reliable way.

Mutual aid plans for Emergency Medical Services should be incorporated in, or appended to, county and local public safety emergency planning documents.

OBJECTIVE:

To create an interest in, and foster, a climate to encourage development of EMS mutual aid plans in all communities, particularly where no such plans currently exist. All EMS agencies, regardless of sponsorship or type, need written plans that are individual or a part of a fire mutual aid plan to facilitate EMS operations and to provide a logical extension into major operations. Pre-planned EMS mutual aid will facilitate daily dispatch and improve the response to all patients. These plans can be written in most jurisdictions within the current legislative structure and with existing authorities.

DEFINITIONS:

"*" indicates definition referenced from NYS Public Health Law, Article 30 or Part 800, The State EMS Code.

* AMBULANCE – means a motor vehicle, airplane, or boat or other form of transport especially designed and equipped to provide emergency medical care during transit.

* AMBULANCE SERVICE – means an agency engaged in providing emergency medical services and the transportation of sick, disabled or injured persons by motor vehicle, aircraft or other form of transportation to or from facilities providing
hospital services. (As used here "PERSON" means an individual, partnership, association, corporation or any other entity.)

* EMERGENCY MEDICAL SERVICE – means a service engaged in providing initial emergency medial assistance including but not limited to rescue & extrication, the treatment of trauma, burns, respiratory, circulatory and obstetrical emergencies.

MULTIPLE CASUALTY INCIDENT (MCI) – means any incident which produces a number of casualties necessitating assistance from outside the normal jurisdiction. This may be in the form of simple mutual aid for a localized incident or a more extensive response involving county or regional resources in the case of large scale incidents.

MUTUAL AID – means the preplanned and organized response of emergency medical services, and other emergency personnel and equipment, to a request for assistance in an emergency when local resources have been expended. The response is predicated upon formal agreements among participating agencies or jurisdictions.

MUTUAL AID PLAN – means a written agreement between two or more jurisdictions which lists responding agencies, personnel and equipment, and delineates command responsibilities. The plan must define the primary role(s) of all responding agencies and personnel.

* PRIMARY OPERATING TERRITORY – means that geographic area stated on a DOH ambulance service certificate or certificate of registration which defines the usual or normal operating area of an ambulance service.

EMERGENCY RESPONSE AREA – means geographic boundaries used to define emergency medical services response capability by one or more EMS agencies. This can be an EMS district, fire district, village, town, city, an area defined by local statute or contract or any combination thereof.

PRIMARY RESPONSE AGENCY(S) - means the initial EMS agency(s) responsible for answering calls for service in a specific emergency response area.

CONSIDERATIONS FOR THE DEVELOPMENT OF MUTUAL AID PLANS

When EMS agencies or other local groups begin to develop or review mutual aid plans, a coordinated approach to the process is necessary. The process must involve all possible organizations, take into account local needs and resources and then follow a systematic approach to create a response concept and a written plan.

In the following two sections, plan development and review considerations are presented. The first section contains those elements which a local or county EMS plan should consider in the development phase. In the second section are factors
which a county or regional review body can assess to insure that local plans are
developed with a regional consistency.

All plans need to be common in concept and in a form that allows integration into
a regional approach that crosses geo-political boundaries.

While no specific EMS legislation currently exists to mandate plan development
locally, SARA Title 3 and Executive Law 2-B are examples of existing authorities
and initiatives which involve emergency medical services and therefore EMS
mutual aid plans.

EMS MUTUAL AID PLAN DEVELOPMENT:

All plans shall:

- Be consistent with the Incident Command System and the NYS-EMS MCI Management Model.
- Include a system for training all participating agencies to carry out
  their designated role as defined in the plan.
- Include a scheduled annual review of the plan and the supporting
  resources as well as providing a method for updating the plan and
  familiarizing all participants with any changes.
- Take into account geography, demographics, medical resources,
  emergency response personnel, any identified hazards or other
  unique local needs.
- Include for each EMS agency the provision of day to day back-up
  from one or more agencies as needed. This daily response plan will
  usually provide the basis for the larger MCI response. Agency
  location, level of care, staffing, actual response time and usual
  number of vehicles must be considered. This daily mutual aid plan
  may vary by day, time, or season.
- Provide for mutual aid services to be furnished first by agencies
  serving the same emergency response area. Additional
  ambulances or other EMS resources are obtained from adjacent
  service areas as needed.
- Insure that during mutual aid operations, emergency response
  areas or other defined areas are not left without EMS or ambulance
  coverage for routine needs. EMS resources must remain in zone or
  be brought in by the plan. Methods of coverage, local personnel
  and agencies to be utilized shall be detailed in the plan.
- Be designed to expand and contract the resources on site or on call
  as the nature and size of an incident changes.
• Include participation by non-EMS agencies which may have a function in certain EMS emergency operations. Such agencies may include: police, fire, rescue, haz-mat teams, utility companies, Red Cross, church groups, heavy construction equipment operators, amateur radio groups, etc.

• Insure that EMS operations and mutual aid plans are provided for in all local emergency response plans. This must include command as well as resource management concerns.

• Insure that EMS operations and mutual aid plans are appropriately included in county fire mutual aid plans to facilitate specific EMS responses.

• Address the communication needs of response agencies including command interface between agencies. Regional EMS Councils in their planning and review function should insure that a coordinated interagency radio network is available to facilitate command and tactical operations.

• Include a comprehensive system for organized mobilization and deployment of manpower and equipment.

• Include mandatory considerations for the safety and protection of all personnel at all times during any emergency operation. The designation of a safety officer and mandatory use of personnel and equipment staging areas are strongly recommended. This is normally the responsibility of the Incident Commander and must be provided for by EMS operations if not otherwise provided for.

• Provide for on-scene administration, coordination, record keeping and retrospective evaluation of the operation, including providing the on-scene personnel and documents necessary to implement the system.

• Address liability protection and compensation coverage for all participants.

• Address medical issues such as triage, the use of BLS vs. ALS in large scale operations, disaster protocols that differ from day to day, protocols, hospital capability and capacity, hospital and medical communication capability, etc.

• Address post-incident critical stress management to be utilized as needed.

• Include an incident critique for all participants and a plan review.

SEE APPENDED BIBLIOGRAPHY FOR REFERENCES TO FACILITATE
PLANNING

EMS MUTUAL AID PLAN REVIEW:

** Pursuant to PHL Article 30 each Regional EMS Council has "the responsibility to coordinate Emergency Medical Services programs within its region". Therefore every Regional EMS Council should take a leadership role to ensure the development, coordination and maintenance of EMS mutual aid plans within its region.

** Any plan developed by a county or local EMS council or other official should be submitted to the appropriate Regional EMS Council for review of content and for coordination with existing plans and planning objectives.

** Each Regional Council should develop objectives to ensure that plans developed in the region are consistent and capable of being integrated with adjacent plans. Regional Councils need to coordinate planning objectives with those of adjacent agencies.

** Where county government has the planning responsibility for emergency response plans, the county should include Emergency Medical Services mutual aid as one component. Plans developed and administered by county government should be submitted to the appropriate Regional EMS Council for review.

** Each Regional EMS Council should develop objectives to ensure annual review of all plans developed in its area.

LIABILITY CONSIDERATIONS IN MUTUAL AID PLANNING:

The issues of liability and associated responsibility for coverage must be addressed completely for the protection of all jurisdictions and participants.

As a rule, an assumption is made that if you respond on a mutual aid call, as part of a mutual aid plan, you assume full responsibility for your equipment, personnel and their actions in the very same manner as in day to day operations. This rule stands unless some other liability coverage can be documented.

Under some circumstances, state or local statutes or agreements may modify the assumption of liability.

As plans are developed or refined a detailed review of all applicable Federal, State and local statutes must be undertaken with the assistance of expert legal counsel.

In certain circumstances the following may apply: Executive Law Section 2-B, General Municipal Law, NYS County, Town and Village Law, Public Health Law and local laws or policies.

A contract with a municipality may provide certain protections when acting on behalf of that municipality.
Additionally, liability insurance policies, self-insurance coverage and other locally implemented liability plans, including each individual's personal liability coverage, should be reviewed.

Plans must address liability protection, the assumption, transfer or carry over of coverage including all those provided for by statute. All participants, equipment and supplies that will be utilized damaged or otherwise requiring replacement in any mutual aid plan must be taken into account.

In addition to operational reviews, all mutual aid agreements should be reviewed by the appropriate legal counsel and insurance underwriters.

**Ambulance/EMS Unit Mutual Aid Dispatch Pre-plan**

Adopted from the NYS-EMS MCI Management Model

<table>
<thead>
<tr>
<th>AMBULANCE AGENCY</th>
<th>NUMBER OF PATIENTS</th>
<th>FIRST CALL AMBULANCES</th>
<th>SECOND CALL AMBULANCES</th>
<th>COVER/RELOCATION AGENCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amb A</td>
<td>Daily</td>
<td>Amb B</td>
<td>Amb C</td>
<td>Amb B</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Amb B</td>
<td>Amb F</td>
<td>Amb H</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>Amb C</td>
<td>Amb G</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30</td>
<td>Amb D</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>40</td>
<td>Amb E</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amb B</td>
<td>Daily</td>
<td>Amb A</td>
<td>Amb B</td>
<td>Amb B</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A preplanned mutual aid response system is established to insure an appropriate and orderly response of resources to an incident. The use of the increasing diameter (concentric circle) or ring approach to define the response allows a plan to be developed with realistic response times. Revisions can easily be made either to the plan or an operation as the need, situation size, availability of resources, or back-up coverage changes. Participants' familiarity with local geography makes this concept easily implemented.

Each EMS agency needs to establish a plan for an incident in its primary service area based on incident type, immediate response needs, types and levels of service needed and/or available (i.e. BLS, ALS, etc.), neighboring agencies availability to respond, and the need to cover the primary service area for other calls.

The agency mutual aid plan needs to be reviewed and coordinated at county and
regional levels to insure overall consistency and integration with adjacent plans.

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Issued by:

John J. Clair
Senior EMS Representative
Andrew W. Stern
Associate Director

Authorized by:

Michael Gilbertson
Director
SUBJECT: Barrier Precautions and Reprocessing Recommendations for Prehospital Providers

The New York State Emergency Medical Services Program has received numerous requests for guidance on the topic of infection control for EMS personnel, specifically dealing with the issues of proper barrier protections and reprocessing of equipment or supplies commonly used in the field. Following are recommendations developed with the assistance of the New York State Department of Health’s Division of Epidemiology.

RECOMMENDATIONS FOR REPROCESSING MEDICAL EQUIPMENT USED IN THE PREHOSPITAL HEALTH CARE SETTING

<table>
<thead>
<tr>
<th>TYPE OF EQUIPMENT</th>
<th>STERILIZATION</th>
<th>HIGH LEVEL DISINFECTION</th>
<th>GENERAL DISINFECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reusable devices that contact mucous membranes: (e.g., laryngoscope, EOA mask and tube, ET stylette)</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>thermometers*</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Reusable, noninvasive equipment that contacts intact skin: (e.g., splints, stethoscopes)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Reusable materials which may be laundered: blood pressure cuffs, linen, MAST (with bladders removed)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

(Follow recommended laundry procedures for the material being washed and the detergent being used)
Other ambulance equipment:
stretchers, stairchair, head immobilizers, etc.

*Clean, then soak in alcohol or tincture of iodine.

SPECIAL NOTE: Dispose of all disposable equipment after single use, e.g., oral and nasal airways, suction catheters and tubing, bite sticks, oxygen masks and cannulae, disposable pocket masks and bag valve masks.

**Sterilization**
- **Destroys:** All forms of microbial life.
- **Methods:** Steam (autoclave), gas (ethylene oxide), dry heat, immersion in EPA approved chemical "sterilant" for period specified by product manufacturer (e.g. 10-18 hours).
- **Use:** Disposable invasive equipment eliminates need to sterilize many items in EMS setting. When indicated, arrangements should be made with a health facility for this level of reprocessing.

**High Level Disinfection**
- **Destroys:** Most forms of microbial life, some spores may not be eliminated by this method.
- **Method:** Immersion in an EPA approved chemical "sterilant" (e.g., 2% activated glutaraldehyde) for the shorter contact time specified by the product manufacturer (e.g., 30-45 minutes).
- **Use:** Reusable devices that contact mucous membranes.

**General Disinfection**
- **Destroys:** Most viruses, bacteria, and fungi; may not be as effective against M. tuberculosis and does not kill spores.
- **Methods:** Application of or immersion in any of the following:
  - 1:10 to 1:100 dilution of sodium hypochlorite (bleach)
  - phenol products
  - quaternary ammonium chlorides
  - 2% gluteraldehyde (10 minutes)

**Environmental Disinfection**
- Environmental surfaces which have become soiled should be cleaned and disinfected using any cleaner/disinfectant agent which is intended for environmental use.* Such surfaces include floors, woodwork, ambulance seats, countertops, etc.

*Do not use 1:10 dilution on plexiglass, i.e., cabinet doors or EKG monitor screens. It will fog them permanently. Use a 1:100 solution or preferably another disinfectant recommended by the manufacturer.

**RECOMMENDED BARRIER PRECAUTIONS FOR INFECTION CONTROL IN THE PREHOSPITAL HEALTH CARE SETTING**

<table>
<thead>
<tr>
<th>PROCEDURE OR TYPE OF CONTACT</th>
<th>DISPOSABLE GOWN</th>
<th>MASK</th>
<th>PROTECTIVE EYEWEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GLOVES</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedure</td>
<td>Yes</td>
<td>No</td>
<td>** Yes**</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>-----</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td>Artificial respiration</td>
<td>Yes</td>
<td>No</td>
<td>**</td>
</tr>
<tr>
<td>Blood drawing or starting an IV</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>For direct contact with feces or urine</td>
<td>Yes</td>
<td>Yes, if soiling is likely</td>
<td>No</td>
</tr>
<tr>
<td>Endotracheal intubation, EOA, EGTA</td>
<td>Yes</td>
<td>No</td>
<td>Yes, if splashing is likely</td>
</tr>
<tr>
<td>Bleeding control procedures with spurting blood/emergency childbirth</td>
<td>Yes</td>
<td>Yes, if soiling is likely</td>
<td>Yes</td>
</tr>
<tr>
<td>Bleeding control procedures with minimal bleeding</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Oral/nasal suctioning, manually cleaning airway</td>
<td>Yes</td>
<td>No</td>
<td>Yes, if splashing is likely</td>
</tr>
<tr>
<td>Taking a temperature</td>
<td>No*</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Giving an injection</td>
<td>No*</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Handling and cleaning soiled instruments (utility)</td>
<td>Yes</td>
<td>Yes, if soiling is likely</td>
<td>No</td>
</tr>
<tr>
<td>Taking a blood pressure</td>
<td>No*</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

*While gloves are not necessary for these procedures, it is likely they will be worn because of other activities which require their use.

**Ambulance and first response agencies should use either bag valve mask, resuscitators or a pocket mask with a one-way valve on all patients.

Issued by: Robert Elling, Assistant Director for Program Development
Authorized by: Michael Gilbertson, Director
SUBJECT: Patient Carrying Devices

There are many patient carrying devices in the EMS inventory, including orthopedic stretchers, stair chairs, canvas slings, spine boards, soft or rigid stretchers (such as the Reeves and the SKED) and single or multiple level ambulance cots.

Each of these carrying devices has been designed by the manufacturer for a specific use. The orthopedic stretcher to lift or move patients with orthopedic injuries; the long spine board to immobilize patients with potential spinal column injuries; the stair chair to move on stairs and around narrow hallways; the "Reeves" to facilitate moving individuals in a semi-rigid but flat position. There are overlaps in the capabilities of many of these devices. However, it is important to recognize that each of these devices has specific limitations which restricts its use in certain circumstances. In other words, no device can be used all of the time on all patients.

The State Emergency Medical Services Program recently investigated several circumstances where patient carrying devices were inappropriately used. It appears that the reason for the use is that the ambulance crew uses a particular device for every patient. Examples of inappropriate uses of devices include transporting a non-traumatized chest pain patient on an orthopedic or Reeves stretcher, thus preventing the patient from sitting up, and attempting to immobilize the spine of an injured patient on a Reeves or other soft stretcher. While there are sometimes extenuating circumstances in the field, routine use of these devices for the purposes given is clearly inappropriate.

EMTs have an obligation to weigh carefully the decision to use a specific piece of EMS equipment, including carrying devices, in order to assure that the equipment is appropriate for the patient, the problem, and the situation.

All providers should assure that patients transported by ambulance are strapped to the stretcher or crew bench. No patient should ever be transported strapped to a Reeves or long backboard but not to the stretcher. Strapping to the stretcher is the only way to prevent movement of the initial carrying device in the event the ambulance comes to a sudden stop. Patients should never be transported within the ambulance in a chair since these can not be secured. Children, however,
may be transported in their car seats if strapped to the stretcher or crew bench, assuming that their injuries do not require them to lay flat.

Your attention to these issues is expected in the interest of improving patient care.

Issued and Authorized by: Michael Gilbertson, Director
New York State Emergency Medical Services Program

OPERATIONAL UPDATE

Supersedes/Updates: 87-41 Reissued

NYS-EMS

MULTIPLE CASUALTY INCIDENT
M.C.I. RESPONSE KIT

IMPORTANT IMPORTANT IMPORTANT

- Do not respond to the incident, unless directed to.
- Be sure to load all disaster supplies to take to the site.
- Open this kit, review the field manual and your local response plan for specific responsibilities.
- Contact EMS COMMAND by radio prior to arriving on site for assignment.

DRIVER ALWAYS STAY WITH THE AMBULANCE. DO NOT LEAVE IT UNATTENDED.

NEW YORK STATE DEPARTMENT OF HEALTH
EMERGENCY MEDICAL SERVICES PROGRAM

* New York State Emergency Medical Services has supplied Mass Casualty Incident (MCI) response kits to all ambulance agencies, many EMS first response units, course sponsors and county EMS program offices. These kits are designed for one time use at any real incident and it is suggested that use of the kit be so restricted. The field kit should be stored in your emergency response vehicle in a location that keeps it from being damaged, yet is accessible. * Distributed in 1987

Several EMS vendors supply the kits, their components and other items related to MCI management.

Some kits that were previously distributed by EMS agencies may have components which are compatible with the new standard contained in the new NYS kits, which uses the Incident Command System as its base. Old kits should be replaced and used for training (with inappropriate components discarded).
The NYS-EMS MCI Field Management Kit contains the following items:

- Field Manuals
- Command Officer Identification Vests
- Command Post & Area I.D. Signs
- Plastic Ribbon for Triage & Area Marking
- Armbands for ancillary personnel
- Pencils (#2) & grease pencil

There are other items that may be useful resources for your agency’s response plan. You need to consider the following:

**Equipment and Supplies**

1. **Equipment**
   
   All equipment must be boldly marked identifying the agency of ownership.

   All cots/stretchers should be boldly marked to identify the agency and specific vehicle assigned to.

2. **Agency Disaster Supplies:**
   
   Additional medical patient handling and administrative supplies need to be stored and made available. Typically these supplies include:

   - 10 - 6’ x 16” wooden spineboards
   - Bandages, dressings
   - Splints
   - Oxygen & resuscitation equipment
   - Pencils, clipboards & felt tips or indelible markers
   - Flashlights & lanterns
   - Blankets
   - Ground cover/tarps (conveniently colored red/yellow/green)
   - Tape
   - ALS equipment
   - Plastic ziploc bags
   - Masking or duct tape
   - Pylons
   - Stapler
   - Morgue bag
   - Boundary marking tape
   - Rope or perimeter

3. **Replenishment of Supplies:**
   
   - At scene
   - After incident
   - Special supplies (ALS)

Although the kit provided is intended for one time use, the intentional use of individual components in training can enhance MCI preparation and education. Using Triage tags on specific days, patient types or multiple accident patients will familiarize ambulance personnel and hospitals with them. Staging, patient prioritizing and patient handling are good drills for the education of all agency members. Management and incident command concepts should be applied at many incidents and events occurring almost daily.
How to Use the NYS-EMS Triage Tag

Serial #: Use as tag identity not supplied in order or with any security. May be used to identify patients.

Tag #: Use to record patients in a specific incident. Serially assign each patient a number at 2nd stage triage point.

Site retains top copy (yellow). Keep with dispatch log.

Hospital admission copy (pink). Begins chart process.

Card copy (white) attaches to and remains on patient.

Tag attached to patient at prominent point (i.e., around neck, upper arm)

Serial #: 30075

NYS EMS TRIAGE TAG

NAME
ADDRESS OTHER IDENTIFICATION INFORMATION
CATEGORIES MAJOR INJURIES
AIRWAY/RESPIRATORY
HEAD/NECK/SPINE
CHEST/ABDOMEN
BURNS
FRACTURES
MEDICAL

HOSPITAL SENT TO
TIME
AMBULANCE AGENCY ID
1 2 3 0
PRIORITY
TIME
RECORD ALL DIAGNOSIS AND TREATMENT

P-0 DECEASED
P-1 IMMEDIATE
P-2 DELAYED
P-3 HOLD

Black
Red
Yellow
Green

TREATMENT RECORD
TIME
RECORD ALL DIAGNOSIS AND TREATMENT

P-0 DECEASED
Expired
Non-survivor

P-1 IMMEDIATE
Airway-respiratory, cardiac problems
Uncontrolled hemorrhage, open chest-abdomen severe head injury, shock, burns or medical

P-2 DELAYED
Moderate burns, uncomplicated head injury

P-3 HOLD
All minor & uncomplicated fractures, wounds, other injuries, burns & psychological problems
New York State Department of Health Bureau of Emergency Medical Services MCI Drills & Exercises

Simulated exercises are held to test the components of the MCI Model independently and the local MCI Plan in its entirety. These exercises are the learning experiences that train emergency personnel in the community. Drills should be conducted with this purpose in mind and planned to achieve the maximum possible learning for all participants.

Considerations in Planning Drills:

1) Purpose of Drill — Predefine the purposes the drill is to accomplish. Is it to test patient transportation, vehicle staging, triage, communications, medical treatment, command functions, the hospital ED or the system, etc.? Keep your goals practical and within the capability and experience of all participants.

2) Pre-announced or unannounced ("Surprise") drills — For most purposes, pre-announced drills function better than unannounced ones. You can plan for personnel shortages and other problems that frequently occur in training. Any "Surprise" drill must be preceded by many announced component drills so all participants are totally familiar with the entire model and plan. Everyone involved must also be familiar with all administrative aspects before beginning with patient care problems.

3) Victims — After deciding on the purpose and scope of the drill, determine the scenario, the type and number of injuries, and select groups from which to recruit possible victims. Experiences have been good with boy/girl scouts, nursing schools, senior citizen groups, EMT candidates, ambulance squad members and junior corps and school groups including teachers. However, remember the victims need to match the situation.

4) Timing — Weekday, week night, weekend. What do the participating operations need to test or try. What groups have not had the experience of participation and what groups are available.

5) Moulage — It is effective only if field medical treatment is part of the scenario. If the exercise is transport only, communications, hospital flow, etc., and no patient care is included, moulage is not necessary. Use tags with injuries, vital signs and priority predetermined. If you use moulage, consider setting up a tracking system by numerically or alphabetically identifying each victim so a later critique can be provided to evaluate planned vs. recognized injuries, treatment, patient flow, times, etc.

6) Scenario — A realistic story and detailed script needs to be prepared to adequately run the exercise. A time line should also be developed as a guideline for later evaluation. Do not become trapped by the usual bus or airplane accident, look at your community or other events for examples. Amusement rides, grandstands, buildings, trains, mass sickness, gas leaks, smoke conditions are all examples.

7) Staging — For drills to be effective, realistic response times need to be provided. Estimate real response times (including crew response) and plan each unit's entry accordingly. In this manner, full crews can be in station or at a nearby staging area and dispatched accordingly. Similar dispatch timing procedures can be used from a simulated site for hospital drills where only a traffic or patient flow needs to be evaluated.

8) Emergency operating conditions (lights and sirens) — is never justifiable in a drill situation. Speed does not contribute to a drill's effectiveness. The confusion to the public and risk to all participants is unwarranted. Safety must be first and foremost always.

9) Evaluation - Recruit qualified observers to evaluate the exercise. Provide them with goals, objectives, injury set-up, time lines and evaluation forms. Attempt not to use local agency officers, crew chiefs, etc. Those persons who would normally be available and expected to be at a real exercise should participate in the EMS leadership roles. Provide evaluation checklists for each drill to identify the items being tested.

Issued by: John J. Clair, Senior EMS Representative

Authorized by: Michael Gilbertson, Director, Emergency Medical Services Development Program

Distribution: Regional EMS Councils; Regional EMS Programs; Course Sponsors; Ambulance Services; First Responder Agencies; Disaster Coordinators; County EMS Coordinators; Hospital Emergency Department Directors.
Policy Update: CHANGES TO DEFINITION OF "SCHOOL"

The regulations to the Commissioner of Motor Vehicles were amended October 26, 1987, to expand the definition of the term "school" as it relates to junior operator (Class 6 and 8) driving restrictions. The term "school" now includes:

1. Classes conducted or approved by the New York State Office of Fire Prevention and Control for the purpose of training volunteer firefighters.

2. Classes conducted by the New York State Department of Health for the purpose of training emergency medical technicians, advanced emergency medical technicians and paramedics.

3. Classes conducted or approved by the New York State Department of Health for the purpose of providing training in any ancillary emergency medical services (e.g. emergency medical first responder training.)

The term "school" also includes classes conducted by the National Guard, or any other active reserve group of the U.S. Armed Forces, for the purpose of training members of such groups.

A junior operator who is driving to or from such classes should carry a letter from the class administrator or instructor stating the name, date of birth and motorist identification number of the student, the hours, location and duration of the course, and an address and phone number at which the administrator or instructor may be contacted by a police officer to verify information.

The specific regulation of the Department of Motor Vehicles has been attached to this policy update.

Issued by: Robert Elling, Assistant Director for Program Development
Authorized by: Michael Gilbertson, Director
SUBJECT: Infection Control – CPR Manikins

(The following recommendations for decontaminating manikins used in CPR training were furnished to the Emergency Medical Services Program by the United States Center for Disease Control, Atlanta, Georgia.)

1. The manufacturer’s recommendations and provision for sanitary practices should be thoroughly examined.

2. Students should be told in advance that the training sessions will involve "close physical contact" with their fellow students.

3. Students should not actively participate in training sessions if they have dermatologic lesions on the hands or in oral or circumoral areas; are known to be hepatitis B carriers; have upper-respiratory-traction infections or AIDS (or evidence of HTLV III/LAV infection); or the student has reason to believe that he or she has been exposed to or is in the active stage of any infectious process.

4. If more than one CPR manikin is used in a class, students should be assigned in pairs, with each pair having contact with only one manikin. This limits possible exposures.

5. All persons responsible for CPR training should be thoroughly familiar with hygienic concepts, as well as the procedures for cleaning and maintaining manikins and accessories. Manikins should be inspected routinely for signs of physical deterioration, such as cracks or tears in plastic surfaces, which prevent thorough cleaning. Manikin’s clothes and hair should be washed periodically or whenever visibly soiled.

6. In order to limit the potential for disease transmission during the two-rescuer "switching procedure", the second student taking over ventilation should simulate it instead of blowing into the manikin.

7. When practicing the "obstructed airway procedure", the finger sweep should either be simulated or done on a manikin whose airway was
decontaminated before the procedure and will be decontaminated afterwards.

8. Each time a different student uses the manikin, the individual protective face shield, if used, should be changed. After a potentially contaminating procedure, the manikin face and inside the mouth should be wiped vigorously with clean absorbent material (e.g., 4” X 4” gauze pad) wetted with hypochlorite solution or with 70% isopropanol, or ethanol. The surfaces should remain wet for at least 30 seconds before they are wiped dry with a second piece of clean absorbent material. Although highly bactericidal, alcohols are not broad-spectrum agents; their use here is recommended primarily as an aid in mechanical cleaning and because some persons find the odor or hypochlorite objectionable. Little viable microbial contamination is likely after the cleaning procedure.

9. At the end of class, the procedures listed below should be followed to avoid drying of contamination on manikin surfaces:

   - Disassemble the manikin as directed by manufacturer.

   - As indicated, thoroughly wash all external surfaces (also reusable protective face shields) with warm soapy water and brushes.

   - Rinse all surfaces with fresh water.

   - Wet all surfaces with a sodium hypochlorite solution having at least 500 ppm free available chlorite (e.g., ¼ cup (approximately 60 ml) liquid household bleach (approximately 5% sodium hypochlorite) per gallon (approximately 4 liters) of tap water) for 10 minutes. This solution must be made fresh at each class and discarded after each use.

   - Rinse with fresh water and immediately dry all external and internal surfaces.

10. Persons responsible for the use and maintenance of CPR manikins should not totally rely on disinfectants for protection from cross-infection. Emphasis should be placed on thorough cleaning (scrubbing, wiping). Microbial contamination is easily removed from smooth, nonporous surfaces by using disposable cleaning cloths moistened with a detergent solution. There is no evidence that a soaking procedure alone in any liquid is as effective as the same procedure accompanied by vigorous scrubbing.