Yale NewHaven Health
Yale New Haven Hospital

EMS POLICY & PROCEDURE MANUAL

YALE NEW HAVEN HOSPITAL CENTER FOR EMS

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Definitions

Direct Medical Oversight (DMO): physician orders to EMS providers related to medical care. This may be on scene or via radio/phone through the receiving emergency department or hospital unit campus.

EMS Medical Director: The EMS Physician responsible for EMS medical direction for EMS agencies/personnel, including but not limited to credentialing to practice, scope of clinical responsibilities while operating as an EMS clinician, medical oversight, peer review, and continuing medical education. The EMS medical director is accountable to Yale New Haven Health System (YNHHS) through the Chief Clinical Officer and Clinical Operations, the EMS Section Chief/YNHHS EMS Chief, and, in the case of Sponsor Hospitals, the hospital president, or any of the aforementioned individuals' designee(s). Examples of EMS medical directors include, but are not limited to: critical care transport EMS medical director, Sponsor Hospital EMS medical director, and SHARP Team EMS medical director.

Deputy EMS Medical Director: an EMS physician designated by the system's EMS Chief or EMS Section Chief who can act on behalf of the EMS medical director (above) when needed.

EMS Section Chief/YNHHS Chief of EMS: EMS physician overseeing EMS medical directors as well as EMS clinical operations at YNHHS and concurrently authorized as deputy EMS medical director.

EMS Service/Agency*:* An organization or entity (a) licensed under applicable state and local laws and regulations to provide emergency medical services, and (b) under the medical oversight of an EMS medical director.

Medical Authorization/Credentialing (also known as 'medical control')*:* Permission to perform medical care treatments (a) to the extent permitted by the CT Office of Emergency Medical Services; and (b) according to EMS medical director-approved protocols.

Sponsor Hospital: A hospital that has agreed to maintain staff for the provision of medical oversight, supervision and direction to an emergency medical service organization and its personnel and has been approved for such activity by the Department of Public Health.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS**
	Policy & Procedure Manual 1.1 – Medical Control Overview
Effective Date: 6-2-2023	**Revised Date:** 09-02-2025

The following are protocols to be used by all EMS personnel holding medical authorization from Yale New Haven Hospital Center for EMS, to ensure quality and standardized medical care, and to establish standards by which prehospital care may be audited.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS**
	Policy & Procedure Manual 1.2 – Covered Agencies
Effective Date: 6-2-2023	**Revised Date:** 09-02-2025

The Yale New Haven Hospital Center for EMS is the Sponsor Hospital for:

- Allied Universal Security Services (Medtronic)
- American Medical Response of CT - New Haven
- Bethany Volunteer Fire Department Ambulance Corps
- Branford Fire Department
- East Haven Fire Department
- Guilford Fire Department
- Hamden Fire Department
- Madison Emergency Medical Services
- Madison Hose Company No. 1
- Madison Police Department
- Nelson Ambulance Service
- New Haven Fire Department
- Yale New Haven Sponsor Hospital Area Response Physician (SHARP) Team
- North Branford Police Department
- North Branford Volunteer Fire Department
- North Haven Fire Department
- North Madison Volunteer Fire Company
- Orange Police Department
- Quinnipiac University EMS
- University of New Haven Student EMS
- West Haven Fire Department
- West Haven Fire Department - Allingtown
- West Shore Fire Department
- Woodbridge Police Department
- Woodbridge Volunteer Fire Department
- Yale University EMS

A. EMS clinicians should follow Connecticut State EMS Protocols for any situations not specifically covered under this policy. Clinicians are expected to be familiar with all applicable protocols and any current updates.

B. Treatment provided during transport such as oxygen and cardiac monitoring must be continued during the transfer from the ambulance into the emergency department (ED). Exceptions will be clearly communicated to services.

C. Providers have the right to refuse to carry out orders or perform procedures that are outside of the protocol, inappropriate for the patient's condition, or exceed the provider's scope of practice.

D. With the exception of intravenous fluids and drips that are already infusing, medications are not to be transferred from field personnel to emergency department personnel, even when only a single dose has been drawn out of a multi-dose vial. Incompletely used multi-dose vials are to be discarded in appropriate waste containers in the ED.

E. Any opened but unused portion of the controlled medications must be destroyed in the presence of the Emergency Department charge nurse (or designee) at the receiving facility and documented on the Proof of Use sheet. Signatures of the paramedic and the appropriate witness are required. The pharmacy will not accept partially returned medications.

F. EMS agencies must be in compliance with all Yale Center for EMS (YCEMS) policies, procedures, and directives for applicants to be considered for medical authorization.

G. The following resources are approved for EMS clinicians to use under standing orders when determining pediatric medication dosages and equipment sizing:

- CT Statewide EMS Protocols
- CT Pediatric Color Coded Medication Reference
- Broselow Pediatric Emergency Tape
- Pedi STAT EMS

A. As medical professionals, it is expected that all EMS personnel will perform in a professional manner at all times. Interactions with patients, family members, bystanders, other emergency responders, and other medical professionals must be courteous and respectful, regardless of circumstances or provocation.

B. EMS clinicians must abide by all local, state, and federal regulations regarding patient privacy and protected health information. Under no circumstances shall EMS Clinicians contact patients or family members using information obtained during the course of their clinical interaction, unless specifically necessary for patient care and safety.

C. All EMS clinicians must abide by healthcare facility safety and privacy policies while on their premises.

D. It is expected that field personnel shall manage their work schedules in order to allow adequate time off and rest. Excessive fatigue jeopardizes the safety of field personnel (e.g., driving emergency vehicles) and patients (e.g., clinical decision making and procedural skills). Working sequential shifts at one agency or working a shift for one agency immediately after a shift at another agency without adequate rest, is strongly discouraged. Work hours may be examined when complaints or continuous quality improvement (CQI) efforts result in case investigation.

E. As medical professionals, it is expected that all EMS providers shall provide complete and accurate information during discussions with other providers, including with YCEMS medical oversight personnel (both online and off-line). Intentional misrepresentation or omission of information may result in potential withholding/withdrawal of medical authorization.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 1.5 – Medical Authority at the Scene	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

A. In accordance with CT EMS Regulation 19a-179-13, EMS personnel may accept DMO from an on-scene physician who is not a part of the SHARP Team only after:
    a. The physician has been identified as a Connecticut licensed physician (MD or DO) and has offered some form of valid identification, such as a copy of the physician license, which confirms the identity and credentials.
    b. Obtaining from the physician a commitment to accompany the patient to the hospital in the vehicle transporting the patient.
    c. Having the physician speak directly to a physician responsible for DMO (DMO in the ED, or Medical Direction Team Physician) and receiving authority to provide on-scene medical oversight.
    d. Unless all the above criteria are met, care will continue as if no physician were on the scene.

B. SHARP Team
    a. On-scene medical oversight may be provided by a physician member of the SHARP Team without securing permission from the DMO physician in the ED. The SHARP Team provides immediate EMS physician field response to support emergency responders throughout the entire state of Connecticut.
    b. The SHARP Team is available to respond to any type of emergency incident. Team members can assist as authorized by the incident commander. A primary purpose of the team is to provide for the safety and medical needs of emergency personnel operating at incident scenes.
    c. The team is dispatched by MedCom/Valley Shore. Contact MedCom/Valley Shore via radio or by phone to request a response. MedCom/Valley Shore policy requires that the Incident Commander authorize the request. The responding team member(s) will report to the IC upon arrival for assignment, accountability, and reporting responsibility, and will remain available at the scene until released through the command structure. Unless specifically requested by the paramedic in charge, SHARP Team members will not assume responsibility for patient care.
    d. SHARP Team members have the authority to audit and respond to field operations through response and observation of scene calls.
    e. Licensed independent practitioners (defined by state regulations as physicians, PAs, and APRNs) on the SHARP team may deviate from protocols in accordance with their clinical judgment but must document and be prepared to justify such deviations.

A. An electronic patient care report (ePCR) will be used to document every call a unit is dispatched to, including lift assists. An ePCR is required by YCEMS unless the unit is cancelled prior to arrival at scene and appropriate response information (e.g., times and unit identifiers) is captured and stored by the unit's agency (e.g., dispatch/telecommunications records). If there are multiple patients, an ePCR must be completed for each patient. Documenting the care for multiple patients in a single ePCR is not sufficient. All ePCRs must be documented thoroughly. Simply documenting "refer to ___'s ePCR" is not sufficient.

B. Emergency patients may be defined as any person for whom the EMS system has been activated and one of the following is present:
    a. Has a physical or mental complaint, or suspected injury or illness.
    b. Requires or requests evaluation, assistance, treatment, or transport.
    c. Any person who is not alert and oriented, including untimely death.
    d. Any minor less than 12 years old without a parent or guardian present.
    e. Any individual for whom help could reasonably be assumed to have been requested or expected of EMS personnel interacting with the individual. For patients who are unable to communicate or otherwise non-communicative, such as patients who are unresponsive, such a request is assumed to be implied.

C. Crews that transport a patient to the hospital will complete an ePCR at the time the patient is delivered to the receiving facility. If the ePCR cannot be completed prior to the unit being dispatched to another call, the run form must be completed as soon as possible, **always before the end of the crew's shift**.

D. Units that do not accompany the patient to the hospital must complete an ePCR as soon as possible, always before the end of the crew's shift, and select the hospital that the patient was transported to in the destination field of the ePCR. The transporting crew must include the name of the first responder service and any relevant information received when they took over care of the patient on their ePCR. Transporting crews (including paramedic intercept units) shall select the hospital that the patient was transported to in the destination field of the ePCR.

E. YCEMS shall set the minimum configurations for ePCR software. All ePCR software used by YCEMS -sponsored agencies must be configured to transmit all ePCRs to the YNHH ESO HDE system and YCEMS ESO umbrella account. The EMS Coordinator, Associate

EMS Coordinator(s), and EMS Operations Coordinator shall be given access to all agency ePCR software. Exceptions and/or deviations from the above may be granted by the EMS Section Chief upon request for valid reasons that do not unnecessarily compromise patient or community safety depending on the circumstances.

F. ePCR software shall be capable of including all trend data, events, and ECGs uploaded from the cardiac monitor in the PDF version of the ePCR and shall be transmitted to the YNHH ESO HDE and YCEMS ESO umbrella accounts. ePCR software shall also be capable of generating a PCO file from the cardiac monitor upload which must be readily available in the ePCR attachments.

G. All cardiac monitor data and ECGs must be transmitted and uploaded to the ePCR. A photo of the code summary or ECGs does not meet this requirement. If a 12-lead ECG is performed, the 12-lead ECG printout or a photocopy shall be left with the hospital clinical team. If a clinically relevant ECG strip is obtained then it should be printed and given to hospital staff (e.g., run of A-Fib, VT, etc.).
    a. Cardiac monitor data transmitted and uploaded to the ePCR must contain continuous data from all channels. When transmitting cardiac monitor data to the ePCR, the clinician shall always utilize the "All" report type.
    b. If an AED is utilized, the AED data file for the incident must be uploaded to the ePCR.

H. After administration of any medication, the following must be documented on the ePCR:
    a. Dose, route, and time of administration.
    b. Effect of medication on patient's condition.
    c. DMO facility and physician name authorizing administration (if applicable).

I. If a paramedic performs a patient assessment and then releases the patient to a BLS unit, that paramedic must document their own assessment on an ePCR.

J. All information, including but not limited to all successful and unsuccessful intervention attempts (12-Lead ECG, Intubation, DMO Consult, IV Attempt, Field Presumption Time of Death, Stroke Alert, etc.) and assessment findings shall be documented in the appropriate data field. Solely documenting information in the narrative is not sufficient.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 2.1 – EMT Medical Authorization	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

***Purpose*:**

To provide a mechanism by which the State of Connecticut-certified or licensed EMS personnel can become medically authorized by a Sponsor Hospital. Only employees of EMS services sponsored by YCEMS, or personnel functioning in an EMS role with YNHHS who otherwise meet the requirements of this policy are eligible to obtain medical authorization.

***Eligibility*:**

To be eligible for consideration for temporary medical authorization at the EMT level, an applicant must:

1. Meet all applicable state licensure and certification requirements;
2. Be employed by and in good standing with a Connecticut licensed EMS service or YNHH hospital entity;
3. Complete local EMS area onboarding/familiarity training for destination determination and operational standards consistent with Sponsor Hospital approved policy.
4. Adhere ongoing continuing medical education requirements and tracking as stipulated by the EMS medical director and Sponsor Hospital.

Process:

To be considered for medical authorization, agencies must submit an updated roster no less than quarterly. Agencies must ensure that applicants have ALL of the following:

1. A copy of a current State of Connecticut EMT certification card
2. A copy of a current Basic Life Support for Healthcare Provider (BLS-HCP) card from the AHA, Red Cross and/or the Military Training Network.
3. A current driver's license.

YCEMS staff may audit this documentation at any time.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 2.2 – Initial Paramedic Medical Authorization	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

***Purpose*:**

To provide a mechanism by which the State of Connecticut-certified or licensed EMS personnel can become medically authorized by a Sponsor Hospital and obtain medical authorization/credentialing eligibility.

Eligibility:

To be eligible for consideration for medical authorization, an applicant must;

1. Meet all applicable state licensure and certification requirements;
2. Be employed by and in good standing with a Connecticut EMS agency with YNHH sponsor hospital affiliation and/or a YNHH hospital;

Process:

Application Package (All)

To be considered for medical authorization, an agency must provide a completed application for each applicant with the following documentation to the Sponsor Hospital office:

1. A letter of recommendation from the EMS agency verifying employment at the level for which medical authorization is being sought.
2. A copy of a current State of Connecticut Paramedic license card.
3. A copy of a current driver's license.
4. A copy of the following current certifications:
    a. Basic Life Support for Healthcare Providers (BLS-HCP) card from the AHA, Red Cross and/or the Military Training Network.
    b. ACLS
    c. PALS

Additional Requirements

1. **For new paramedics** (i.e., without previous employment as a paramedic), they must have completed a CoAEMSP-accredited paramedic program and have passed the

NREMT paramedic exam (or verification of passing equivalent testing as determined by the YCEMS staff).

a. See 'Precepting' & 'Protocol Exam' below

2. **For applicants with current medical authorization/credentialing as a paramedic in Connecticut in another system**:
    a. A signed and dated letter of attestation from the applicant's last active Connecticut agency EMS medical director and EMS coordinator verifying good standing and that the paramedic is able and credentialed to practice within the scope of a paramedic in the state of Connecticut in addition to meeting all the regulatory standards implicit therein.
    b. See 'Protocol Exam', 'Agency Authorization Letter', 'EMS Coordinator Interview' below

3. For all other scenarios, to be determined by YCEMS staff based on context and local/state/national/industry standards.

Protocol Exam (All)

Upon review and approval of the required application materials by the YCEMS staff, the applicant will schedule a written protocol exam with the YCEMS team, to be completed within 30 days. If the applicant fails (grade < 70%) the protocol exam, they may schedule a time to take the exam no sooner than seven days from the initial attempt. If the applicant fails the exam a second time, they must re-start the application process not less than 90 days after the second failure.

Precepting

1. **New graduate paramedic applicants**
2. New graduate paramedic applicants must complete a minimum of ten (10) advanced life support calls under the supervision of their agency-approved paramedic field preceptor or field training officer -AND- whatever additional requirements the Agency Chief, or designee, designates as necessary for the new paramedic to function safely and effectively as an ALS provider.
3. The definition of an ALS call is any call where the paramedic completes a full assessment and provides or directs any 2 of the following:
    i. 4-lead cardiac monitoring
    ii. 12-lead cardiac monitoring
    iii. IV/IO access attempt
    iv. Medication administration other than oxygen
    v. Advanced airway management
4. The precepting paramedic should accompany the patient to the hospital. However, YCEMS acknowledges that it may be appropriate to transfer care to another transporting paramedic.
5. Following completion of the above minimum requirements, when the Agency

Chief, or their designee, feels the applicant is ready for final evaluation, they will notify the EMS Coordinator, or designee, that the applicant is ready for final evaluation. Arrangements will then be made for final evaluation through the YCEMS office. **This also applies to individuals without ongoing medical authorization in Connecticut.**

i. The final evaluation shall consist of an EMS medical director-prescribed competency evaluation.
ii. If the applicant does not pass their first attempt, the agency will be notified and advised of next steps and recommendations. Feedback will also be provided directly to the applicant. Applicants may return for repeat evaluation after sign-off by the individual agency training officer.
iii. If an applicant fails a second attempt, a meeting will be required between the applicant, their Agency/Service chief or training officer, and a member of the YCEMS team to discuss a focused learning plan. Additionally, the applicant will be required to be cleared again by a YCEMS-approved preceptor before re-challenging the final assessment.
iv. If an applicant fails a 3rd attempt, they may not challenge again for a minimum of 6 months. The YCEMS team will advise the agency on additional recommendations for remediation. If a paramedic takes 3 or more attempts to gain medical authorization, the YCEMS CQI committee will do random review of ePCRs from that individual for the following 6 months. This may range from all charts to any number of randomly selected charts at the discretion of the medical direction team.

Agency Authorization Letter (All)

For paramedics with valid Connecticut paramedic licensure, the paramedic must complete the Agency's service chief, or said entity's designee's, prescribed and attested to onboarding process, including, but not limited to, local EMS area onboarding/familiarity training for destination determination and operational standards consistent with YCEMS approved policy. The Agency's service chief or designee will then submit a letter attesting to the paramedic's successful completion of appropriate onboarding, skills verification, EMS Operational training, appropriate professionalism standards, and ability to perform adequately and safely within the paramedic scope of practice in the state of Connecticut.

EMS Coordinator Interview (Paramedics with current CT Medical Control in another system)

Upon completion of the above the EMS Coordinator or designee will meet with the applicant and Agency Leadership for an interview. Applicants who meet professional expectations will be granted medical control. Otherwise, the applicant will be provided with feedback and professional expectations for further development or remediation.

Medical Control Authorization (All)

Upon successful completion of the applicable above requirements, the YCEMS Staff will grant medical authorization to the applicant for a period of up to the completion of the paramedic's current Connecticut licensing cycle.

Should a medically authorized paramedic wish to function at the EMT level only, but maintain paramedic licensing, written notification of such must be submitted to the YCEMS Operations Coordinator one of the following must occur:

1. The paramedic must continue to complete the requirements of the YCEMS Continuing Education Policy for paramedics, or;

2. The paramedic must successfully complete 40 hours of approved EMT continuing education every two years in accordance with CT DPH guidelines.

3. Paramedics practicing at the EMT level wishing to return to practice as a paramedic must ensure that their CME requirements are up to date as set forth in this policy manual.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 2.4 – EMS Instructor Medical Authorization	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

Eligibility:

To be eligible for consideration for medical authorization, an applicant must;

1. Meet all applicable state licensure and certification requirements;
2. Be employed by and in good standing with a YCEMS-sponsored EMS service or YNHH agency;
3. Meet all other requirements specified in this policy.

Process:

To be considered for medical authorization, applicants must provide the following documentation to the YCEMS office:

1. A copy of a current State of Connecticut EMS Instructor certification
2. A letter of recommendation from the applicant's EMS service
3. A completed YCEMS Medical Authorization Application.

EMS Instructors who receive medical authorization from YCEMS shall provide the EMS coordinator and EMS medical director with an email copy of all EMS training application forms submitted to OEMS at the time of submission for course approval. Additionally, at that time the instructor is expected to provide the EMS coordinator and EMS medical director with a course syllabus and expected enrollment numbers. After course completion, the instructor must submit data on course outcomes including student evaluations and pass rates (when applicable) to the EMS coordinator and EMS medical director.

Mandatory Continuing Medical Education

All providers shall be required to complete ten (10) hours of EMS medical director, or authorized designee, led case reviews/didactics every two-year renewal cycle unless granted an exception in writing by the YCEMS/Sponsor Hospital Manager.

Continuing Education Requirements:

EMT

- State of CT EMT certification
- BLS-HCP certification (from the AHA, Red Cross and/or the Military Training Network).

Paramedic

- State of CT paramedic
- NREMT or verification of equivalent CME.
    - For individuals who do not maintain NREMT certification, the providers agency will be responsible for providing a packet with documentation and attestation of CME that meet NREMT minimum standards.
- BLS-HCP certification (from the AHA, Red Cross and/or the Military Training Network)
- AHA ACLS
- AHA PALS

Any paramedic with current medical authorization but functioning in a non-clinical position or at the BLS level for longer than twelve months will be required to the new paramedic process as outlined above. Once the final evaluation is complete, full privileges will be restored.

EMS Medical Director Authority

DEFINITIONS

A. Patient – Any person that presents with an apparent or stated need for medical assistance or care to an EMS clinician.

B. Protocol – The set of standards approved by the EMS Medical Director (or either respective entity's applicable and authorized designee) outlining the parameters and guidelines

for delivery of patient assessment and care.

C. EMS Medical Director: EMS leadership physician team member or the Medical Director's authorized designee performing the roles and overseeing the responsibilities outlined in this job description -or- as directed by the Connecticut Department of Public Health Office of EMS in addition to any other related guidelines/regulations.

D. EMS clinician: any EMS team member or participant providing clinical care for EMS patients. This includes, but is not limited to, physicians, advanced practice providers, nurses, respiratory therapists, paramedics, emergency medical technicians (EMTs), and EMT-advanced clinicians. For the purposes of this document, any references to 'clinician' or 'clinicians' will be assumed to refer to the definition pertaining to 'EMS clinician' given in this document unless otherwise stated.

E. Scope of practice: tasks/roles that an EMS clinician can be reasonably expected and legally authorized to perform based on:
- The clinician's assigned clinical role at the EMS agency that is under the sponsor hospital's oversight and/or jurisdiction.
- The level of training, expertise, and capabilities that can be reasonably assumed from the clinician's licensure that enables the clinician to practice in the clinician's currently assigned clinical role at the EMS agency that is under the sponsor hospital's oversight and/or jurisdiction.

F. Credentialed clinician: an EMS clinician authorized by EMS Medical Director (or either respective entity's applicable and authorized designee) to perform the duties and responsibilities that can reasonably be expected of the clinician within the associated scope of practice and at a level that is commensurate with the clinician's assigned role as an EMS clinician -AND- who possesses the required up-to-date licensures and certifications required for that assigned role.

G. EMS agency – any EMS entity providing clinical care under the supervisory responsibility of the sponsor hospital.

I. Guidelines

A. Credentialled EMS clinicians with assigned roles at an EMS AGENCY involving clinical care of patients must maintain the following or risk losing their credentials to practice as an EMS clinician at an EMS agency that is under the sponsor hospital's oversight and/or jurisdiction:
    a. Current licensures and certifications applicable to the clinician's level of training and the clinician's assumed scope of practice based on the clinician's assigned role. This includes compliance with any other applicable policies or regulatory standards not stated within this document.
    b. Good standing within the EMS agency and the Connecticut Department of Public Health and any applicable policies and/or regulatory standards.
    c. Professional standards commensurate with the individual's assigned role as an EMS clinician at the EMS agency including an understanding of just culture, and including at-risk and reckless behavior.

B. EMS medical direction and sponsor hospital leadership/council ***may*** remove a clinician's credentials, and therefore the clinician from active duty as an EMS clinician, to ensure patient safety and/or professional standards are met as described below.
    a. The EMS coordinator and EMS Medical Director (or either respective entity's applicable and authorized designee) have an ethical and legal responsibility to:
        i. ensure that the clinician can safely practice within his/her scope of practice and at a level that is commensurate with his/her assigned role as an EMS clinician.

-AND-

        ii. remove from service any EMS clinician who has demonstrated an inability to safely perform within the EMS clinician's assigned scope of practice at a level that is commensurate with EMS clinician's assigned role as an EMS clinician. Examples *may* include, but are not limited to:
            1. Repeated instances of at-risk and/or reckless behavior despite previous coaching and/or remediation.
            2. Reasonable concern that the clinician is unable to perform within the expected scope of practice at a level that is commensurate with the clinician's assigned role as an EMS clinician.
                a. Examples include:
                    i. Clinicians demonstrating inability to perform life-saving maneuvers related to managing airways, assisting ventilation/breathing, or supporting circulation/preventing hemorrhage.
                    ii. Clinicians demonstrating inability to perform life support maneuvers that would be reasonably expected of them based on certifications required certifications for their assigned role.
            3. Clinicians who disregard and/or do not comply with the following expectations and duties:
                a. Clinicians are expected to only perform procedures that they have been:
                    i. specifically trained through a curriculum sanctioned by the EMS Medical Director – OR – procedures that the clinician can reasonably be expected to safely conduct based on the EMS clinician's training/certifications
                    ii. approved by the EMS Medical Director to perform
                    iii. certified as competent to perform
                    iv. licensed to perform
                b. Clinicians must not act negligently, recklessly, or in such a manner that endangers the health or safety of

emergency patients, team members, other public safety personnel, or members of the general public.

c. Clinicians must comply with state and federal laws governing the confidentiality of patient privacy.
d. Clinicians must comply with the protocols, guidelines, and policies, whenever applicable, as established by:
    i. The Connecticut Department of Public Health
    ii. The EMS agency
    iii. The sponsor hospital EMS Medical Director

References:

Kuzel AR, Kuhl EA. EMS Medical Director Legal Issues and Liability. [Updated 2023 Nov 2]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK597344/

Cone, D. C., Brice, J. H., Delbridge, T. R., & Brent Myers, J. (2015). Emergency Medical Services: Clinical Practice and Systems Oversight: Second Edition. Volume 2: Medical Oversight of EMS. Wiley. DOI: 10.1002/9781118990810

(2017) Clinical Credentialing of EMS Providers, Prehospital Emergency Care, 21:3, 397-398, DOI: 10.1080/10903127.2017.1282565

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 2.6 – Precepting of Paramedic Applicants	
Effective Date: 09-02-2025		**Revised Date:**

Approval of Paramedics

Service chiefs and/or training officers may assign preceptors for agency preceptees. Agencies must provide a list of all currently endorsed preceptors to the YCEMS Operations Coordinator. Preceptors must meet the following requirements:

1) Must hold current, unrestricted medical authorization, and be in good standing, as a Paramedic through YCEMS.
2) Must have a minimum of: at least two years recent field experience as a Paramedic in the YNHH region, or, at least one year in the YNHH region and an additional year in a similar system.
3) Must have no open QI cases or patient complaints against them including significant documented deviations of protocol or need for remediation for at least one year prior to the application.
4) Must be familiar with CT EMS Protocols and YCEMS Policies and Procedures.
5) All members must complete the annual protocol exam with a passing score of 80%
6) Must have experience and/or interest in teaching.

The application will be reviewed by the Operations Coordinator and Medical Director for final approval.

Preceptors and the agency training officer or service chief must attest to an applicant's readiness for independent practice at the paramedic level prior to requesting final medical authorization evaluation (aka: final simulation evaluation).

Patterns of multiple failures of applicants to pass the final simulation evaluation after recommendation by an agency will result in a formal review of agency preceptors and evaluation forms by the YCEMS and EMS Medical Director or assigned designees. This may result in revocation or modification of an individual's status as a preceptor.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 2.7 – Criminal Arrest/Conviction Policy	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

(Note: This policy is modeled, with permission, on the National Registry of EMT's felony policy.)

EMS practitioners, pursuant to their state licensure, certification, or national registration, have unsupervised contact with patients, as well as unsupervised access to patients' personal property, at a time when patients are at maximum physical and emotional vulnerability. In this capacity, EMS practitioners are placed in a position of the highest public trust, even above that granted to the other public safety professionals and most other health care providers. While police officers require warrants to enter private property and are subject to substantial oversight when carrying out duties of an intrusive nature, such as "strip searches." EMS practitioners are afforded free access to the homes and bodies of patients who, because of their need for medical attention, are extremely vulnerable and often unable to voice objections to offensive actions, provide an accurate account of events at a later time, or otherwise defend or protect themselves.

Citizens in need of EMS services rely on the EMS system and state licensure, certification, or national registration requirements to assure that those who respond to calls for aid and provide the necessary medical and/or transportation services are worthy of this extraordinary trust. Federal law prohibits persons convicted of criminal conduct from serving as police officers, and in the YCEMS staff's view, EMS providers should be held to a similar, if not higher, standard. YCEMS is empowered to grant medical authorization to individual EMS practitioners who meet the applicable criteria, and therefore must ensure that individuals who are granted medical authorization do not present an unreasonable risk to public safety and are otherwise worthy of the high degree of public trust that is placed in them.

1. **General Denial:**

    a. Medical authorization of individuals convicted of certain crimes presents an unreasonable risk to public health and/or safety. Thus, individuals who have been convicted of any of the following types of crimes are not eligible for medical authorization at any level, and shall have their applications denied or their authorization revoked, as applicable:

        i. A felony involving sexual misconduct where the victim's failure to affirmatively consent is an element of the crime (e.g., forcible rape).

ii. A felony involving the sexual or physical abuse or assault of children, the elderly or the infirm, including but not limited to sexual misconduct with a child, making or distributing child pornography or using a child in a sexual display, incest involving a child or assault on an elderly or infirm person.

iii. Any crime in which the victim is a person whose care is entrusted to YCEMS (e.g., an out-of-hospital patient or a patient or resident of a health care facility), including but not limited to abuse, neglect, theft or financial exploitation.

b. Revocation of medical authorization shall be effective immediately upon documentation or determination of conviction of any of the above.

2. **Presumptive Denial**

a. Medical authorization of the following individuals will be denied or revoked except in extraordinary circumstances, and then will be granted only if EMS Medical Director determines, based on clear and convincing evidence, that such authorization will not pose an unreasonable risk to public health and/or safety:

i. Individuals who have been convicted of any crime that can raise an issue of public trust and who are currently incarcerated, on work release, or on probation or parole.

ii. Individuals convicted of any of the following crimes, unless at least five years have passed since the conviction OR at least five years have passed since release from custodial confinement, whichever occurs later:

1. A serious crime of violence against any person, including but not limited to assault or battery with a dangerous weapon, aggravated assault and battery, murder or attempted murder, voluntary manslaughter, kidnapping, robbery of any degree or arson.

2. A crime involving any controlled substance, including but not limited to unlawful possession or distribution, or intent to distribute unlawfully, any Schedule 1 through V drug as determined by the Uniform Controlled Dangerous Substances Act.

3. A serious crime against property, including but not limited to grand larceny, burglary, embezzlement, or insurance fraud.

4. Any crime involving sexual misconduct.

b. The EMS Medical Director's decision shall be final.

3. **Discretionary Denial**

   Notwithstanding any other provisions of this policy, the EMS Medical Director may, in their discretion, deny an individual's application for medical authorization where such individual has been convicted of any other crime (not including minor traffic violations) not specified in this policy. In determining whether denial of such individual's application is appropriate, the EMS Medical Director may consider the following factors:

   a. The seriousness of the crime;
   b. Whether the crime relates directly to the delivery of patient care;
   c. The period of time that has elapsed since the crime was committed;
   d. Whether the crime involved violence to, or abuse of, another person;
   e. Whether the victim of the crime was a minor or a person of diminished capacity;
   f. Whether the applicant's actions and conduct since the crime occurred are consistent with the holding of a person of public trust.

The EMS Medical Director may consider additional factors as are appropriate under the circumstances.

4. **Denial, Suspension, or Withdrawal of Medical Authorization in Cases of Criminal Arrest**

   a. This applies to clinicians following a criminal arrest, issuance of a criminal summons or criminal arrest warrant, or those released pending trial on bond or bail.
   b. Any instance of arrest being made for a significant crime as defined above or that can cause an issue of public trust can result in suspension pending completion of the criminal investigation.
   c. The EMS Medical Director or the medical direction team will determine if a criminal arrest would create an issue of public trust.
   d. All parties remain innocent until proven guilty, however in the instance of serious claims and arrests that constitute an issue of public trust or potential patient harm, the EMS Medical Director may suspend the authorization until the completion of the investigation.
   e. If the EMS clinician is found guilty of the crime, then full withdrawal of medical authorization is warranted as defined above.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 3.1 – Patient Assessment and Downgrade	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

All patients must be evaluated by the highest-level EMS provider present on scene, regardless of initial dispatch complaint or EMD classification. A paramedic on scene may only delegate care to the BLS provider after they have performed their own assessment and determined that the patient does not require further ALS management.

BLS providers may only cancel responding paramedics in certain situations pursuant to the ALS cancellation policy (3.2).

Any paramedic on any ALS first response unit must make patient contact whenever dispatched to an ALS call, unless cancelled by a BLS unit, in accordance with the ALS cancellation policy, or by another ALS unit on scene. Clinical decision making is the legal responsibility of the CT OEMS Primary Service Area Responder at the Paramedic Level until formally handed off to another provider, or to the transport paramedic who must then agree that the first responder paramedic is not needed, or if cancelled by a BLS unit in accordance with the ALS cancellation policy.

After evaluation and with documentation, paramedics may downgrade level of care to BLS if appropriate. This requires an appropriate physical examination, vital signs, additional testing when appropriate, and written documentation of these assessments in the patient record by the paramedic. ALS assessment or interventions do not in and of itself preclude a paramedic from downgrading the patient to the BLS level of care. All clinicians on scene must be in agreement that downgrading the patient is appropriate. All clinicians have a duty to express disagreement to the downgrade of a patient, when not clinically appropriate.

Paramedics who are not part of the transport crew are responsible for completion of a full PCR on every patient contact. Inappropriate downgrades of patients requiring further ALS interventions to BLS, or inviting inappropriate refusals of transport, can be considered a form of patient abandonment.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 3.2 – BLS Cancellation of ALS	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

PURPOSE

To clarify when BLS (EMTs) with Yale New Haven Hospital medical authorization may cancel Advanced Life Support (ALS) that has been dispatched per EMD guidelines but has not yet established direct patient contact. The purpose of this protocol is to allow for efficient use of resources and minimize paramedic response times for true life-threatening emergencies. BLS EMTs employing this protocol must have current YNHH Medical Authorization and must have completed YCEMS EMT orientation and relevant refresher training.

If an ALS unit has been dispatched to a call, the response may be cancelled by the BLS unit if considered appropriate by the most senior EMT on scene or supervising EMT.

ELIGIBILITY – patients must meet at least one of the two criteria below.

1. Patients with stable vital signs (see below) for whom there is no reasonable foreseeable need for ALS level care. All EMTs on scene must agree that ALS care is not warranted.
   - Patients must have vital signs within these parameters:
     - HR 60-100
     - RR 12 – 20
     - Systolic Blood Pressure (100-180)
     - O2 Saturation (94-100%)
2. Scenarios in which the patient can be transported to an appropriate health care facility in less time than it would take ALS to arrive on scene or intercept with BLS.

EXCLUSION - BLS personnel should not cancel responding ALS resources for 'high risk' patients, including but not limited to:

- Cardiac arrest with active CPR
- Cardiac symptoms
- Difficulty breathing
- Acute altered mental status
- Attempted suicide by overdose or a combative patient

- Seizures
- Near drowning
- Active significant hemorrhage
- Pediatric patients <13 years old
- Patients who meet Trauma Triage Criteria

PROCEDURE:

BLS Personnel must:

1. Complete an appropriate patient assessment and provide treatment according to Connecticut Statewide EMS protocols.
2. If BLS determines that patient meets eligibility as defined above, they may cancel the ALS responding unit.
3. BLS must document their assessment and treatment of the patient on their electronic patient care report (ePCR) and document the cancellation as well as reason(s) for cancellation on the ePCR.
4. A completed ePCR is required by the cancelling BLS unit regardless of whether they are ultimately the transporting unit.

* YCEMS reserves the right to rescind or restrict this protocol at any time if significant patient safety concerns are identified.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS**
	Policy & Procedure Manual 3.3 – Paramedic Airway Policy
Effective Date: 6-2-2023	**Revised Date:** 09-02-2025

YCEMS paramedic shall utilize this policy during all attempts at advanced airway management, or when assuming responsibility for an airway already established by a non-YCEMS agency. The term "advanced airway" shall be applied to both the endotracheal tube and any other approved supraglottic airway. A properly secured airway is a lifesaving measure that has the potential for devastating harm if not performed or maintained correctly. The availability of objective methods of tube placement confirmation (quantitative electronic waveform capnography) has given the paramedic a tool to continuously ensure that an advanced airway is positioned correctly. The following steps are designed to assist the paramedic in verifying initial airway placement, and to maintain a correctly positioned airway device until the Emergency Department staff assumes patient care.

A. The paramedic who initially establishes an advanced airway (endotracheal tube or supraglottic) shall assume the role of airway paramedic. The airway paramedic shall take responsibility for airway monitoring until the patient is transferred to the emergency department staff. While ventilation after an airway placement may be delegated to another clinician (including a BLS provider) after appropriate securing of the ETT or SGA, the airway paramedic shall be responsible for all aspects of airway placement (lung sounds, capnography, pulse oximetry, etc.). The airway paramedic may transfer responsibility of the airway to another paramedic in certain circumstances, such as in a cardiac arrest with return of spontaneous circulation in which another paramedic is the code leader and is transporting the patient. In these circumstances, the paramedic assuming the responsibility of airway paramedic must independently confirm appropriate placement of the airway to their satisfaction (using an appropriate assessment such as direct visualization, end-tidal CO2 tracing, and presence of bilateral breath sounds). The paramedic who assumes the role of airway paramedic is then fully responsible for that airway, and any issues that are identified will be assumed to have occurred after the transfer.

B. Waveform end-tidal CO_2 confirmation and continuous monitoring is required for all field airway management. Waveform end-tidal CO_2 shall be used to both confirm initial tube placement, and to continuously monitor tube placement until patient care is transferred to the ED staff or care is otherwise terminated including during patient transfer to and from the ambulance. Quantitative capnography must include continuous display of the $ETCO_2$ waveform. Mechanical esophageal detector devices (bulb or syringe types) may also be used to supplement end-tidal CO_2 in

equivocal cases, but some form of end-tidal CO_2 detection is mandatory. Should the patient lose their $ETCO_2$ reading, the paramedic should immediately search for an explanation. Possible reasons include:

a. Lack of perfusion
b. Equipment sensor contamination due to body fluids
c. Other equipment malfunction.
d. Inadvertent tube dislodgement due to tube movement

C. The paramedic should seek to correct the problem resulting in the loss of capnography reading. If after 30 seconds there is no return of $ETCO_2$ measurement, the patient should be extubated and ventilated with SGA or a BVM and airway adjunct. The patient may be re-intubated, however the airway device will only be left in place as long as an $ETCO_2$ reading is measurable.

D. Upon Emergency Department arrival, the Airway Paramedic shall record a quantitative capnography reading. The Airway Paramedic shall request confirmation of airway placement by an Emergency Department physician **before** the patient is physically transferred from ambulance stretcher to hospital bed. The name of the confirming physician must be documented in the ePCR.

E. In the event that a YCEMS paramedic is questioned regarding correct airway placement, an airway debriefing shall be initiated immediately. The paramedic shall contact MedCom/Valley Shore and request notification of the YCEMS EMS Coordinator. If the coordinator cannot be contacted, a Medical Direction Team member shall be contacted through MedCom/Valley Shore. The YCEMS representative performing the debriefing shall either respond directly to the Emergency Department or speak with the involved parties by telephone. All cardiac monitor data will be electronically transmitted to the ePCR and provided to the YCEMS personnel performing the debriefing. If system status allows, the involved crew should remain at the hospital until the debriefing is complete. If possible, the cardiac monitor should be pulled from service in order to ensure data remains retrievable by YCEMS staff.

F. Documentation on the patient care report for each intubated patient (ETT or approved SGA) shall include the methods used to confirm placement, presence of an acceptable ETCO2 waveform, the initial ETCO2 value, and a repeat ETCO2 value documented each time repeat vital signs are taken, the patient is moved, and prior to transferring care at the ED. Patient care documentation shall assure that all data points have been included on the ePCR.

G. Documentation is a key component in protecting a paramedic against claims of a misplaced airway device. The documentation will include initial and final assessment of airway placement, regardless of transportation decision (hospital transport or field termination). Documentation will also reflect a re-assessment performed after each patient movement.

A. Yale New Haven Shoreline Medical Center ED

The Yale-New Haven Shoreline Medical Center ED, known by its MedCom/Valley Shore designation as "Yale Guilford," operates as a free-standing ED, and is staffed by the same attending emergency physicians, APPs, and nurses that staff the YNHH Emergency Department.

There are several general categories of patients who typically should not be transported to the Yale Guilford ED:

a. Trauma: Clinicians should refer to the state Trauma Triage Protocol. Patients who are in the high risk (red) category should not be transported to Shoreline. Patients who are in the moderate risk (yellow) category should generally be transported to a trauma center.
b. Myocardial Infarction: Patients whose 12-lead ECG shows an acute ST-segment elevation myocardial infarction (STEMI) should be transported to a facility offering 24-hour percutaneous coronary intervention, and the cardiac cath lab activated from the field. These cases should be discussed with the YNHH York St Campus DMO physician if there are any destination issues.
c. Acute Stroke: Patients who are suspected of acute stroke should be transported to a facility capable of rapid screening and treatment of stroke. The Yale Guilford ED is unable to provide this level of rapid treatment.
d. Active Labor: Women in active labor should be transported to a facility with labor and delivery facilities. The Guilford ED is staffed and equipped to deliver babies, and if delivery is imminent, is an acceptable destination.
e. Psychiatric Emergencies, including alcohol or drug intoxication: The Yale Guilford ED does not have the resources for prolonged monitoring of restrained patients. Patients who will need an evaluation by a psychiatrist or prolonged observation for substance intoxication should be transported to a hospital-based ED.
f. ROSC (Return of Spontaneous Circulation): Cardiac arrest patients who have been successfully resuscitated in the field should be transported directly to a facility capable of providing the full spectrum of post-arrest care (e.g., PCI, induced hypothermia), – e.g., to the YNHH York Street Campus or YNHH St. Raphael Campus.
g. Complex Medical Devices: All patients with implanted medical devices (other than pacemakers and/or defibrillators) such as left ventricular assist devices (LVAD) or with continuous medication pumps (other than insulin) such as prostacyclin pumps

for pulmonary hypertension should be transported to the York Street Campus.

h. For certain patients undergoing complex medical care such as phase I clinical trials, may require evaluation at the facility where they are undergoing care.
i. In the event a critical patient is in need of emergent intervention that requires an ER Physician (e.g., RSI), EMS may transport to Yale Guilford for the emergent intervention, however, must patch to Yale Guilford as early as possible.

B. Patients with Suspected Hip Fractures

Patients aged greater than 65 years with a ground level fall and **not** meeting *state trauma triage protocols but* presenting with signs of hip fracture shall be transported to ***YNHH – Saint Raphael Campus*** for evaluation and treatment, rather than either Yale Guilford or YNHH-York St Campus. Signs of a suspected hip fracture include severe pain, shortening of the leg, with or without inward or outward rotation of the leg, typically after a fall. Other indicators include inability to bear weight on the leg, and/or stiffness, swelling or bruising in the area of the hip immediately after a fall.

C. Altercation, assault or other person-on-person violence

a. If patients representing both sides of an altercation, assault, or person-on-person violence are injured, they should NOT both be brought to the same ED unless both of the individuals involved meet the state trauma criteria for mandatory transport to a trauma center. Otherwise, they should be transported to separate emergency departments. This is for their own protection and for the safety of EMS providers, hospital staff and other patients.
b. If the patients or law enforcement officers demand transport to the same facility, the transporting provider or incident commander should call direct medical oversight at the York St. campus for permission to transport to the same facility, or confirmation that they should go to separate ED's.

D. Pediatric Transport Destination Guidelines

a. Pediatric patients should be transported to YNHH Children's ED. Patients aged 15 years or younger will not be transported by EMS to the St Raphael campus ED. The SRC ED will continue to accept walk-in pediatric patients.
b. Patients aged 15 years or younger with an acute behavioral health issue and a history of same, or in custody of law enforcement or Department of Corrections should be transported to the Yale Children's ED. All such patients 16 years or older should be transported to an ADULT emergency department.

E. Pediatric Refusal of Care/Transport

a. For minors (below 18 years of age) with no parent/legal guardian as defined by CT State Protocol, the providers must call DMO at the Yale Children's ED prior to obtaining the refusal.

b. Providers may obtain refusals without contacting DMO for minors 12 years or older WITH a parent/legal guardian, as defined by CT State Protocol, AND the provider agrees that the refusal is reasonable and appropriate. DMO should still be contacted for all children under 12.

F. Obstetrics and Gynecology Destination Guidelines:

a. Provided it is safe to do so, all OB/GYN patients with a gestational age of 16 weeks or greater should be transported only to the York Street campus and bypass Yale New Haven Shoreline Medical Center ED and YNHH Saint Raphael Campuses, regardless of complaint,
b. Patients < 50 years of age with gynecologic complaints such as vaginal bleeding or vaginal discharge who are not known to be pregnant but have abnormal vital signs (HR greater than 110, systolic blood pressure less than 90) or who have other signs of shock or critical illness should be transported only to the York Street campus and bypass Yale New Haven Shoreline Medical Center ED and YNHH Saint Raphael Campuses provided it is safe to do so.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 3.5 – Cardiac Cath Lab Activation	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

Inclusion Criteria:

A. 12-lead ECG of good quality showing a STEMI (MUST MEET ALL THREE CRITERIA):
   - ST elevation 2mm or greater in leads V2-V3, or 1mm or greater in at least two other anatomically contiguous leads
   - No left bundle branch block (LBBB) or wide-complex paced rhythm
   - *** ACUTE MI SUSPECTED***, *** MEETS ST ELEVATION MI CRITERIA***, or other device specific STEMI interpretation prints on 12 lead ECG AND paramedic agrees with interpretation

B. Active chest pain or equivalent symptoms (e.g., nausea, dyspnea)

C. No major active bleeding (e.g., Vomiting frank blood)

D. No significant trauma

E. If there is significant concern for STEMI based on paramedic interpretation of ECG that does not meet above criteria due to poor ECG quality, the paramedic cannot activate the cardiac cath lab; however, should transport to a STEMI capable destination. The clinician should notify the receiving hospital of this concern via patch/Twiage **AND** on arrival ensure the receiving triage staff member is notified.

Activation Process:

1. Between 0800 - 1700. Monday-Friday (other than federal holidays), contact C3 for destination. Otherwise, proceed to York Street campus.

2. Notify the receiving hospital via radio patch, phone, or Twiage as soon as the patient has met activation criteria and advise them of the destination facility and clearly state that the patient has a STEMI and that this is a cath lab activation.

3. Follow treatment protocols as outlined in CT State EMS Protocol - ACS (3.0)

4. Initiate transport

A. Determine an accurate time of last known well. If possible, obtain contact information from a witness on-scene.

B. If symptoms began **within the last 24 hours**, the patient is not hypoglycemic (< 60 mg/dL) AND the stroke screen is positive:

   a. Contact C3 for destination assignment.

   b. Notify the receiving facility of a Stroke Alert as soon as possible via phone, radio, or Twiage.

   c. Initiate rapid transport to the Stroke Center (Yale New Haven Hospital-York Street Campus OR Saint Raphael Campus).

   d. Patients < 18 years old should be transported to Yale Children's Hospital ED.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 3.7 – Trauma Destination Guidelines	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

Patients meeting state trauma triage criteria shall be transported to a designated trauma center, as per state regulations. The Emergency Department at YNHH York Street is the designated trauma facility for major trauma patients. Injured patients who do NOT state trauma criteria may be transported to other EDs, at their request. Patients meeting state trauma criteria shall be transported to a Level I or Level II trauma center.

Prehospital notification is required for all patients meeting trauma criteria.

The only exception to these destination guidelines shall be a trauma patient in whom airway control cannot be established or external bleeding cannot be controlled by the EMS providers. EMS units coming from East or North of the Yale Guilford ED can stop there for assistance securing the airway or controlling bleeding site(s) and will then continue transport of the patient to the trauma center.

- Field personnel should communicate the nature of the injuries and mechanism and should NOT request a specific type of trauma activation (modified vs. full). Communicating the nature of the injuries and the mechanism of injury (paying close attention to those criteria triggering a trauma response such as height of the fall, or the amount of MVC interior intrusion) will allow the ED staff to activate the trauma team according to that facility's criteria.

Adult Burns: A patient meeting the following criteria shall be transported directly to Bridgeport Hospital unless **the clinician suspects impending airway compromise requiring advanced airway management**

- Partial thickness burns greater than 10% total body surface area (TBSA).
- Burns that involve the face, hands, feet, genitalia, perineum, or major joints.
- Third degree burns in any age group.
- Electrical burns, including lightning injury.
- Chemical burns.

A. For patients meeting the state trauma triage criteria
   a. <16 years old– YNHH Pediatric ED
   b. 16 years old or greater – YNHH York St Campus Adult ED

B. Pediatric Burns:
   a. IF the patient has no airway involvement, need for orthopedic or neurosurgical intervention, AND the injury is an isolated burn to the hands, feet, face, or genitals, or if the TBSA is ≥ 15%, transport to Bridgeport Hospital for the burn center.
   b. IF the patient has airway involvement, needs surgery intervention other than burn management, or if the burn is < 15%, and doesn't involve the named regions above, the patient should come to the Pediatric ED at YNHH.
   c. If there is traumatic mechanism (blunt, penetrating, etc.) the patient should go to the closest pediatric trauma center.

C. All other patients under 18 years old should be transported to any pediatric ED.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 3.9 – Lights and Siren Policy	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

The highest level certified/licensed EMS provider responsible for the patient's care will advise the driver of the appropriate mode of transportation based upon the medical condition of the patient.

When transporting the patient utilizing lights and sirens, the need for immediate medical intervention should be beyond the capabilities of the ambulance crew using available supplies and equipment and the reasons must be documented on the patient care report.

Such conditions include, but are not limited to:

1. Unstable airway or severe respiratory distress
2. Shock without vascular access.
3. Patient with anatomic or physiologic criteria for field triage to a trauma center
4. Status epilepticus that persists after administration of benzodiazepines.
5. Cardiac arrest with persistent ventricular fibrillation, hypothermia, overdose, or poisoning.

However, should traffic be so congested that significant delays in transport may occur, L&S transport may be considered for emergent conditions other than the above.

The mode of transport for emergency interfacility transfers should be based upon the judgment of the paramedic and directions of the referring physician or direct medical oversight physician who provides the orders for patient care during the transport. Generally, emergency interfacility transport patients have been stabilized to a point where the minimal time saved by L&S transport is not of importance to patient outcome (unless the patient's condition has deteriorated enroute).

Lights and sirens use should be documented and justified on the patient care report (e.g., "flail chest", "systolic BP<90", etc.).

Exceptions to these policies can be made under extraordinary circumstances (e.g., disaster conditions or a back log of high priority calls where the demand for EMS ambulances exceeds available resources).

(From the guidelines approved by the state by the Connecticut EMS Advisory Council) Response Guidelines for Authorized Emergency Medical Vehicles (Including Lights and Siren Use)

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 4.1 – Communications	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

Timely and appropriate communications can alenableield EMS personnel to obtain direct medical oversight (DMO) from Sponsor Hospital-based clinicians, allowing hospital staff to plan for appropriate resource availability, activate clinical response protocols, and improve overall management of hospital patient flow.

A. All requests for DMO should be addressed through MedCom/Valley Shore to the YNHH York Street Campus (adult or pediatric as appropriate), regardless of the patient's location or destination.

- If the DMO physician and EMS clinician disagree on the appropriate course of action, the call should be escalated to the EMS Medical Director or designee, which can be facilitated by the MedCom or Valley Shore dispatcher.

B. Patches, Stroke Alerts, and cardiac cath lab activations, when required, will be made to the destination ED through MedCom/Valley Shore or Twiage.

C. Units should evaluate the scene for possible multiple casualties, hazardous materials, or other special incidents, and follow appropriate medical communication procedures through MedCom/Valley Shore.

D. Identifying information such as patient names, dates of birth, full Social Security Numbers, and other protected health information may not be transmitted by radio. It is acceptable to provide the last four digits of the patient's Social Security Number and the first letter of the patient's last name (NOT the entire last name) when patching to the West Haven VA ED.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 4.2 –C3 and Hospital Communication	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

The YNHH Capacity Coordination Center (C3) provides real-time recommendations to EMS providers about the most appropriate destination for patients being transported to YNHH. The ED Navigator Nurse has access to the status of all the YNHH Emergency Departments and the overall capabilities, including bed capacity of each campus.

YNHH C3 can be reached via Twiage, radio, or by direct phone communication:

- Radio: SC MED 10
- Phone: 203-688-1337

C3 must be contacted for all patients arriving to a YNHH facility unless the patient's condition dictates transport to a specific facility pursuant to this policy.

Twiage is the preferred method for C3 and hospital notification. Radio patching or phone notifications may be used if Twiage is unavailable.

C3 must be contacted for all patients through radio, phone, or Twiage unless the patient's condition dictates transport to a specific facility pursuant to this policy. **Patients who are being transported Priority 1 will still require a direct hospital notification.**

Categories that DO NOT require a C3 notification:

- Patients < 18 years old (YSC Pediatric ED)
- Suspected or confirmed hip fractures (SRC)
- Patients that meet state trauma criteria (YSC)
- Unstable GYN patients (YSC)
- 16+ weeks pregnant with any complaint (YSC)
- Patients with implanted medical devices (other than pacemakers and/or defibrillators) such as left ventricular assist devices (YSC)
- Patients with any medication pump (other than insulin) such as prostacyclin pumps for pulmonary hypertension (YSC)

In rare circumstances (eg: extreme census, major incidents), C3 may divert an ambulance to a specific campus. C3 cannot override a patient's refusal to be transported to a specific campus unless that campus is on diversion. In the event a patient has a strong preference to a specific campus and is unwilling to be transported unless it is to that campus, advise C3. Please do not make destination decisions or advise patients without first consulting C3.

Priority 1 patients:

Clinicians must notifiy the receiving hospital for ALL Priority 1 patients. Twiage is the preferred method of hospital communication. Please provide a concise patient report that includes the following:

- Age and gender of patient.
- Clinical impression (e.g. GSW to head).
- Vital signs and pertinent physical exam findings.
- Treatment provided and patient response.
- Estimated time of arrival.
- Any specific needs (e.g., security, OB, respiratory, etc.) or problems (e.g., hazmat).

Radio patching or phone notification may be used if Twiage is unavailable.

Priority 2 patients:

Radio patches are discouraged for Priority two patients, however Twiage notification is strongly encouraged for all patients being transported into the YNHH delivery network. Commercial ambulance services under YNHH Medical Oversight must pre-notify for all patients through TWIAE unless the service is temporarily unavailable. Priority 2 patches are still required to the West Haven VA ED. Twiage notification should include the following:

- Age and gender of patient
- Clinical impression
- Vital signs
- Estimated time of arrival
- Any specific needs (e.g., security) or problems (e.g., hazmat).

MEDCOM/Valley Shore

MedCom: 203-499-5607 or MED 10 SC
Valley Shore: 860-399-7981 or MED 22 SC

- Identify the hospital by name.
- Request a patch or DMO patch.
- Use special case identification as indicated (e.g., trauma, pediatrics, cardiac cath lab activation, stroke alert, hazmat).

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 4.3 – Mass Casualty Incident Communication	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

Purpose*:* To assist agencies operating under YCEMS Operations in the setting of a mass casualty incident with communicating with the hospital, distributing patients among hospital campuses, and activating hospital resources.

Policy*:* Once a mass casualty incident has been identified and an incident command structure established, the incident commander (or their designee such as a transport officer) will contact the YNHH Capacity Coordination Center (C3) to serve as the primary point of contact with the hospital. C3 staff will then notify the receiving emergency departments, activate internal hospital protocols as needed, and give guidance on distributing the patients to YNHH campuses.

The incident commander (or their designee) will re-contact C3 as needed throughout the event to provide updates and get further guidance on patient transport destinations. C3 will serve as the primary point of contact for EMS and will distribute information to hospital staff in real-time.

This should not take the place of activating the YNHH SHARP team if physician presence on scene is desired. The SHARP team is dispatched by MedCom/Valley Shore. Contact MedCom/Valley Shore via radio or by phone to request a response.

During large scale events with high numbers of patients, in order to avoid heavy radio traffic and obstruction of radio communication, the Incident Commander's designee should perform abbreviated hospital notifications regarding patients enroute rather than each individual inbound medic performing detailed patches to the ED.

Incident command or designee should prioritize notification to C3 of incidents involving:

- Three or more ambulances to any incident,
- three or more critical (red) victims,
- and/or seven or more patients for transport.

YNHH C3 can be reached via Twiage, radio, or by direct phone communication:

- Radio: SC MED 10
- Phone: 203-688-1337

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 5.1 – Interfacility Transport Ventilator	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

Mechanical ventilators should be used during the interfacility transfer of patients with advanced airways (endotracheal tube/tracheostomy) who are on existing mechanical ventilation. These transports should only be performed by paramedics who have completed YCEMS-approved ventilator training.

Exclusion criteria:

1) Patients with high potential for clinical instability (ED to ICU, ICU to ICU transfers).
2) Patients with anticipated need for ventilator adjustments during transport.
3) Patients < 18 years old.
4) Patients requiring specialized ventilator modes not available on transport ventilator.
5) Patients without adequate sedation/analgesia.
6) Intubated patients with a known pneumothorax and without a chest tube.

Guidelines:

1) Confirm correct airway placement in accordance with CT Statewide EMS Protocols
2) Verify ventilator settings from the sending facility. Standard ventilator settings for EMS transports are:

    a) Ventilator mode: Assist Control (AC)
    b) Tidal volume: 6-8 ml/kg (ideal body weight)
    c) Rate: 10-20 breaths/minute
    d) FiO_2: 21-100% (titrate to SpO_2 > 92%)
    e) PEEP: 2-10 cm H_2O

    Patients with ventilator settings other than those listed above require the approval of DMO prior to the initiation of transport.

3) Connect patient to EMS monitor (including capnography) and pulse oximetry prior to switching ventilators.
4) Patients must be observed, by the sending facility, for a minimum of 20 minutes after any adjustment in ventilator settings.
5) Patient should be stable on the transport ventilator for 20 minutes prior to departure.
6) Ensure the availability of a BVM, suction, and sufficient portable oxygen supply prior to switching ventilators.

7) Transfer patient to transport ventilator and monitor for any clinical signs of distress. Once the patient has become comfortable on the transport ventilator and has no signs of distress, they may be moved to the EMS stretcher.
8) During transport, repeat vital signs every 5 minutes, including pulse oximetry and capnography. The repeat assessment should also include an assessment of patient lung sounds, and evaluation for any signs of respiratory distress.
9) After arrival at the receiving facility, follow the steps above when transferring from the EMS stretcher to the facility stretcher.
10) All ventilator transports should be submitted for CQI review.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 5.2 – Interfacility Transport to Hospice	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

***Purpose**:*

To assist agencies operating under YCEMS operations with patient care of patients enrolled in hospice and requiring transport to home or hospice facilities. These patients are near the end-of-life and their treatment should prioritize relief and pain from distressing symptoms, affirmation of dying as a natural process and emotional support to family and patients.

Assessment, Treatment, and Interventions:

1. Prior to transportation from sending facility:
    - **a.** Review and confirm approved advance care planning documents including valid DNR and Medical Order for Life Sustaining Treatment (MOLST) forms.
        - **i.** If the patient can communicate and has capacity to make medical decisions, consult with them directly before treatment.
        - **ii.** If the patient lacks capacity to make decisions regarding treatment, identify the guardian, power of attorney or other accepted healthcare proxy.
    - **b.** Confirm a plan in writing and signed by sending Physician/Advanced Practice Provider (APP) that outlines (a) contingency planning, (b) paramedic orders for infusing medications not included in the CT Statewide EMS protocols drug formulary and (c) hospice contact information. Contingency plan should mention, in the event the patient decompensates (e.g., becomes pulseless) during transport, whether the patient should be diverted to the nearest Emergency Department, or whether they should proceed to the receiving facility. If no plan is outlined, the default will be to transport to the closest Emergency Department.
2. For intubated hospice patients, paramedics may not extubate. Any de-escalation of patient care should be performed by the receiving medical team (e.g., hospice physicians and nurses).
3. If hospice patients and their families have non-emergent concerns, please encourage them to call hospice.

- Where a patient has a medical condition that cannot be appropriately treated under the existing protocols and has provided the provider with a written treatment plan prepared by the patient's sending physician and approved by the provider's direct medical oversight, the provider may perform the treatments prescribed in the treatment plan provided they are within their level and scope of practice. This specific instance would not require contact with direct medical oversight.

- All non-titratable infusions can be continued per sending physician orders. In the instance of pump failure, stop infusion and hold until arrival at destination or call DMO for instruction if infusion falls outside of Connecticut Statewide EMS Protocol.

- All sending physician orders should be in writing or printed and documented or uploaded in the ePCR.

- All medications without a specific protocol should be given in accordance with Connecticut Statewide EMS Protocol or YCEMS Policy and Procedure Manual.
    - If there is a medication out of scope or of question that is not included in SCT protocol, state protocol or YCEMS Policy and Procedure Manual call DMO.

- Interfacility Transport DMO
    - Contact EMS Physician via MedCom. Specify this is not for the Red Phone but rather the EMS Physician for Interfacility or Specialty Care Transport.

SCT Medication Protocols

Blood Continuation Protocol

- Confirm blood has been cross matched with standard hospital protocol
    - Note: have a higher level of suspicion for reactions with uncrossed blood
- Continue blood transfusion per sending physician orders
- Repeat vitals and exam of patient at least every 20 minutes while blood is running and for at least 1 hour post transfusion is complete
- For any suspected transfusion reaction
    - STOP the infusion if any of the above symptoms are discovered!
    - Start infusion of normal saline
    - Treat hypotension and anaphylactic reaction with CT EMS Statewide Protocol
    - Contact DMO
    - If minor allergic reaction (urticaria) administer **diphenhydramine**, 50 mg IV
    - If SpO2 is below 92% or patient experiences wheezing / rales, administer high-flow supplemental oxygen and consider positive pressure ventilation per Statewide CT EMS Protocol. If significant signs of volume overload, consider furosemide, 40 mg IV if available.
    - Notify issuing hospital's blood bank of any suspected reaction.
        - GH: 863-3080, BH: 384-3062, SRC: 789-4010, YNH: 688-2443, LMH: 860-444-5110, WH: 401-348-3305

D25 (Adult)

- **Rare to be used, call DMO for infusion**
- Obtain an order from the sending provider for a D25 bolus or infusion and reasoning for high concentration, dose, rate, titration parameters with glucose goals
- Central line infusion only
- ****serum glucose levels must be monitored every 30 minutes (q30 min) while on an D25 infusion****

Dexmedetomidine

- This is a poor choice for transport due to the stimulation during transport compared to the ICU. Please discuss with sending physician on dexmedetomidine as only sedative, first ask for alternatives and significant PRN boluses of other medications for emergent sedation.
    - If denied call DMO for discussion with sending physician
    - Keep patient in soft wrist restraints for duration of transport given **high risk of self-extubating**
- Infusion: 0.2 – 0.7 mcg/kg/hr
- Titration: 0.1 mcg/kg/hr q30min for RASS -1 to +1 or sending physician RASS goal order
- No bolus dosing of Dexmedetomidine
- Adjunct Emergent Sedation:
    - Midazolam 2.5 mg IV q5min max of 5 mg **OR**

- Fentanyl 100mcg IV q5min max 300mcg

Esmolol (infusion, titration)

- Obtain HR/BP goal orders from sending physician
  - Note – Esmolol is better at controlling HR than BP
  - Ask for 2nd agent if being used for BP control
- Dose range: 50-200 mcg/kg/min
- Titrate by: 50mcg/kg/min every 4 minutes as needed for HR goal
- Hold with HR < 60 beat/min, MAP <65, SBP <90, or any contraindications

Fentanyl (Infusion, titration)

- Indication: Sedation and Analgesia in the Intubated Patient
  - Infusion: 0.5 mcg/kg/hr
  - Titrate by: 0.25 mcg/kg/hr q2 minutes
  - Maximum dose range: 10 mcg/kg/hr
  - Goal RASS -1 to +1 or sending physician RASS goal order
  - Hold for SBP < 100mmHg or HR < 60bpm, oversedation, or any contraindications
- Emergent bolus with infusion
  - Fentanyl 1 mcg/kg slowly IV/IO/IM
    - Maximum 100mcg per dose
    - May repeat every 5 minutes x 3 doses
    - Hold with SBP < 100mmHg or with any contraindication
    - Contact Medical Control if additional doses are required

Hydromorphone (infusion, titration)

- Infusion: 0.2 to 5 mg/hr
- Titration should be avoided but if necessary, should be a stable infusion: 0.2 mg/hr every 30 min for RASS -1 to +1 or sending physician RASS goal order
- Rarely used infusion, obtain indication from sending physician rather than more common alternatives

Insulin (Infusion)

- Do not bolus insulin, up titration orders need to be discussed with DMO prior to transport
- ****serum glucose levels must be monitored every 30 minutes (q30 min) while on an insulin infusion****
- Obtain an order from the sending provider for an insulin drip, dose, rate
  - Including when to decrease and add dextrose containing fluids in DKA
    - Default option if no sending orders

        - When BGL 250 mg/dL or less in DKA
            - STOP the insulin infusion and obtain BGL every 15 minutes
            - Contact DMO if glucose is over 350 mg/dL and ask about re-initiation and dosing of insulin infusion
    - **SCT can only down titrate insulin by sending physician orders, for any up titration contact DMO**
- Discuss regular insulin drip rate with the sending provider
    - Standard Initiation dose – 0.1 units/kg/hr or less
    - Maximum dose 15 units/hr
- With decrease in serum blood glucose by more than 100 mg/dL/hr
    - STOP the insulin infusion
- With hypoglycemia < 70 mg/dL
    - STOP the insulin infusion
    - Dextrose 50% (D50) OR Dextrose 10% infusion (D10), 25g IV bolus
        - Glucagon 1mg SQ/IM if no IV access
    - Repeat BGL every 15 minutes and continue until stabilized above 150 mg/dL

Lorazepam (infusion)

- Infusion: 1-20mg/hr
- Titration: 0.5mg/hr q15min for RASS -1 to +1
- Emergent Bolus: 1 mg q30 min
    - Use CT State Protocol dosing for breakthrough seizure and contact DMO

Midazolam (Infusion, titration)

- Infusion: 0.5 mg/hr
- Titrate by: 0.5 mg/hr q5 minutes
- Maximum dose: 20 mg/hr
- Goal RASS -1 to +1 or sending physician RASS goal order
- RASS less than -1: Decreased to prior effective dose or by half
- Hold with hemodynamic instability, or any contraindications
- Emergent Bolus: 1 mg IV over 1 minute (bolus from infusion bag or EMS Narcotics)
    - Use CT State Protocol dosing for breakthrough seizure and contact DMO

Nicardipine (infusion, titration)

- Obtain BP goal orders from sending physician
- Infusion: 5-15mg/hr
- Titrate by 2.5mg/hr q10minutes
- Maximum dose: 15mg/hr
- Hold with HR < 60 beat/min or any contraindications

Phenylephrine (infusion, titration)

- Obtain BP goal orders from sending physician, if patient is stable on dose, this dose can be continued as starting infusion dose.
- Starting infusion: 0.25-9 mcg/kg/min for a goal of MAP >65 or SBP >90
- Infusion range for PIV: 0.25- 4.5 mcg/kg/min
- Titrate by 0.25 mcg/kg/min every 1-2 minutes
- Max Dose: 9 mcg/kg/min

Propofol

- Starting infusion: 5mcg/kg/min, if patient is stable on dose of less than 80mcg/kg/min this dose can be continued as starting infusion dose.
- Titrate by: 5mcg/kg/min q5 minutes to a RASS -1 to +1 or sending physician RASS goal order
- Reduce dose by half OR 10 mcg/kg/min for any SBP of less than 90mmHg or MAP less than 65 and start pressors.
- Maximum dose range: 80mcg/kg/min.
    - Note: contraindicated in patients with allergies to eggs, egg products, soybean, or soy products.
    - Note: avoid in patients with pancreatitis

SCT Miscellaneous and Device Protocols

BiPAP/CPAP

- **Bilevel positive airway pressure (BiPAP)**
  - Indication: hypercapnia, or hypercapnia and hypoxia
  - Continue current BiPAP settings with orders from sending physician
  - Standard initiation and minimum is IPAP 10 cmH_2O and EPAP 5 cmH_2O (**BiPAP 10/5** cmH_2O)
    - Increase the delta pressure by increasing IPAP as needed for improved ventilation
    - Titrate FiO_2 as needed for O_2 Sat >94%,
      - increase EPAP as needed for FIO_2 resistant hypoxia
    - Max Settings: **BiPAP 20/15,**
    - Minimum delta pressure (IPAP – EPAP)**: 5 cmH_2O**
    - ** Note: closely monitor hemodynamic status in patients with increasing delta pressure, as it can result in abrupt hypotension **
  - Monitor tidal volume and respiratory rate (RR), and adjust settings as needed
  - If failing BiPAP management call DMO
- **Continuous positive airway pressure (CPAP)**
  - (only if desired over BiPAP from sending physician)
  - Indication: hypoxia without hypercapnia initiate continuous positive airway pressure (CPAP)
    - Start with CPAP 5 cmH_2O
      - ** Note: closely monitor hemodynamic status in patients with increasing CPAP levels, as it can result in abrupt hypotension **
    - Titrate FiO_2 as needed for hypoxia

Ventilator – ACVC, SIMV, ACPC, PS

- Obtain the following information from the sending provider prior to transfer:
  - Reason for intubation
  - Number of days intubated
  - Ventilator settings, any recent adjustments, failed modes of ventilation
  - Patient's height and ideal body weight
  - ETT placement (<u>at the teeth</u>) and confirmatory imaging studies

- Ventilator mode: Assist Control (AC)
  - Tidal volume: 6-8 ml/kg (ideal body weight)
  - Rate: 10-20 breaths/minute
  - FiO2: 21-100% (titrate to SpO2 > 92%)
  - PEEP: 2-15 cm H2O

- Call DMO for other approved ventilator modes (SIMV, ACPC, PS) for specific settings
    - First ask if the patient can be transitioned to ACVC for transport, if not then knowing why from sending physician will be helpful for DMO physician decision making
- All intubated patients should be in soft wrist restraints
- All advanced airways need continuous ETCO2 monitoring

Tube Thoracostomy (Chest Tubes)

- Obtain orders from sending physician related to chest tube
    - Indication, position, suction status and duration it has been present
- Listen to breath sounds to get baseline before moving patient
    - Examine patient and repeat vital signs often to ensure tube is still functional
- Ensure tube is connected to the patient and re-evaluate the connections after every patient movement to ensure no leaks
- Monitor the following items after routine assessment of patient's vital signs:
    - Drainage (document the appearance and amount of fluid, at the start and at the conclusion of transport)
    - Bubbling in the water seal chamber
    - Gentle rise and fall of the water level, which corresponds with the patient's respirations is called "tidalling" and indicates that the system is functioning properly.
- Keep drain chamber lower than thorax and ensure there are no hanging loops or kinks in the tubbing
    - Keep the drainage chamber system (pleuavac, atrium, ect.) up right, ensure there is space for drainage remaining, if nearly full should be exchanged or emptied by sending facility prior to transport
        - If the system falls over: place upright without fully rotating device, see if the air leak area has fluid remaining and if it is still at marked line, if so no changes, if not call DMO for instructions.
    - If a tube becomes fully dislodged from the chest: place a 3 sided dressing, especially in spontaneously breathing patients
        - Call DMO as soon as possible
        - Closely monitor for changes in breath sounds
        - If tension pneumothorax is suspected, then proceed with needle decompression per CT Statewide EMS Protocol
    - If partially dislodged and sentinel fenestration is visible, place an occlusive dressing over the fenestration and treat as fully dislodged
    - Never clamp a chest tube that is working, if clamped at sending facility, ask to unclamp for transport, if denied call DMO
- If the chest drainage system is crushed or broken open, or the chest drain becomes detached from the chest tube
    - **Call DMO** immediately, do not reconnect; you may be instructed to place the end of the chest tube in a bottle of sterile water to create a seal.
- **Call DMO for instructions as soon as possible for any complications**

Pericardial Drain (non-traumatic indications only)

- Obtain orders from sending physician related to pericardial drain
    - Indication, position, and duration it has been present
        - Pericardial drain must be present and functional for **>24 hours** prior to SCT Transport
    - Keep the drainage bag below the level of the heart
    - Pay special attention to the drain while moving patient
- **If a complication of any type occurs call DMO**

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 5.4 – High Flow Nasal Cannula	
Effective Date: 09-02-2025		**Revised Date:**

Purpose:

Allow interfacility transfer of patients with hypoxia or respiratory distress requiring HHFNC

Exclusions:

1. HHFNC settings exceeding the availability of receiving facility
    a. E.g.:Connecticut Hospice uses AIRVO with maximum settings of 30L and 60% FiO2
2. Anticipated travel time exceeding 30 minutes from sending facility.
    a. Exceptions may be made after verbal discussion with EMS Medical Director (or designee) and confirmation of adequate ambulance O2 supply.

Guidelines:

1. At least one SCT-trained paramedic trained in HFNC with YCEMS-approval must be present and in charge for transfer.
2. The EMS Medical Director or an Associate Medical Director should be notified by phone for all HFNC transfers
3. Please refer to the YCEMS Policy & Procedure Manual, section 5.2-Interfacility Transfer to Hospice and 5.3 Specialty Care Transport Protocols for additional guidance

Procedure:

1. Ensure ambulance O2 tanks are full and operational.
2. Ensure 4-5 portable oxygen tanks available in ambulance for transfers
3. Ensure appropriate equipment brought from ambulance to bedside:
    a. Two portable oxygen tanks
    b. Hamilton T1 Vent or other approved HHFNC-compatible ventilator
    c. Heater/humidifier
    d. Connection tubing
    e. Sterile water for humidification
    f. Compatible high-flow nasal cannula
4. Obtain current high flow settings from the physician
    a. Written orders must specify starting flow rate AND FiO2

5. Confirm with nursing or care coordination that hospice staff is ready to receive patient and high flow equipment is available.
6. Place the patient on transport ventilator HHFNC at current settings and monitor for any clinical signs of distress.
    a. Patients must be observed for a minimum of 20 minutes by the sending facility after transition to portable HHFNC
7. Ensure the availability of a BVM, suction, and sufficient portable oxygen supply prior to switching ventilators.
8. Once the patient has become comfortable on the transport ventilator and has no signs of distress, he or she may be moved to the EMS stretcher.
9. Hospital Respiratory Therapy will accompany EMS crew to the ambulance with oxygen tanks.
10. Cardiac monitoring and continuous pulse oximetry are not recommended in hospice patients.
11. Titrate FiO2 for signs of respiratory distress or air hunger.

On arrival to receiving hospice facility, ensure there is an appropriately-trained staff member available to transfer patient to facility HHFNC and take over care.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 6.1 – Quality Assurance Program	
Effective Date: 09-02-2025		**Revised Date:**

Purpose:

The purpose of this policy is to provide an overview of the Yale New Haven Hospital's EMS quality assurance program. This policy is based on the principles of "just culture" and encourages self-reporting.

Retrospective Components:

- Routine review of randomly selected ePCRs for adherence to established protocols and standards of care.
- Routine review of randomly selected online phone DMO consultations.
- Focused review of high acuity cases, sentinel events, and complaints for adherence with established protocols and standards of care. This includes targeted audits of STEMIs, strokes, field deliveries, cardiac arrests, and trauma activations.
- Routine feedback to EMS clinicians based on case reviews, including recognition of excellent performance and constructive feedback for improvement.
- Continuous monitoring of clinical and operational performance trends, through data visualization dashboards that are routinely emailed to Sponsor Hospital leadership to guide future efforts.
- Standardized process for clinical investigation, including standard request for additional information form (RFAI), and standardized performance improvement plan (PIP) template (see policy 6.2).
- Continuous Quality Improvement (CQI) Committee

Concurrent Components:

- Direct field medical oversight by YCEMS-affiliated EMS physicians in the field, including involvement in on-scene debriefs and education.
- Regular meetings and safety/crisis briefings with ED and hospital staff, and monitoring of hospital status including review of real- time census data.

Prospective Components:

- Continuing medical education designed based on historical trends and identified opportunities for system improvement. These are free CME opportunities which are held at least monthly.

- Development of EMS medical direction supervised case reviews/CME that is identified through the CQI Committee and current events/threats/challenges (see policy 2.5).
- Continuous Quality Improvement (CQI) Committee

Yale Center for Emergency Medical Services (EMS) Continuous Quality Improvement (CQI) Committee Charter
Team Name: Yale Center for EMS and Sponsor Hospital
Chair/facilitator: EMS Coordinator **Medical director/team leader:** Sponsor Hospital EMS Medical Director
Team Membership: To be determined by Hospital, Health System, and EMS physician leadership
Team Status: Standing
Team mission/vision: This team will lead in the quality assurance/quality improvement (QA/QI), peer-review, and medical oversight of the Sponsor Hospital's EMS partners and area of responsibility.
Team Statement

Yale Center for EMS QA/QI Committee Objectives:

1. **Quality Improvement**: Implement continuous QA/QI processes to enhance patient care and safety, in accordance with state, federal, and industry standards/regulations.
2. **Compliance:** Ensure adherence to all relevant state and federal regulatory standards.
3. **Education and Training:** Provide ongoing education and training for EMS personnel to maintain high standards of care and professional development, following best practices for EMS education and training.
4. **Data Analysis:** Utilize data-driven approaches to monitor performance, identify areas for improvement, and measure the impact of QA/QI initiatives.
5. **Patient Safety:** Promote a culture of safety, minimizing risks and preventing harm to patients and staff, in line with applicable regulatory standards and Yale New Haven Health Core Values:
    1. **Integrity:** We do the right thing in all circumstances, ensuring transparency and honesty in our operations.
    2. **Patient-Centered:** We prioritize the needs and well-being of our patients and their families, delivering compassionate and respectful care.
    3. **Respect:** We value all individuals, fostering an inclusive environment that honors diversity and promotes dignity.
    4. **Accountability:** We take responsibility for our actions and outcomes, continuously striving for improvement and excellence.
    5. **Compassion:** We approach every interaction with empathy, understanding, and kindness.

Governance and Oversight: The Quality Assurance Program will be overseen by the EMS Quality Assurance Committee, which includes supervision by the Sponsor Hospital EMS Medical Director(s) or their designee in conjunction with EMS Coordinators, EMS Education representatives, and EMS Administration Coordinator. The committee will meet regularly to review performance metrics, discuss improvement strategies, and ensure compliance with regulatory requirements.

Operations:

- QA/QI Committee meetings are held monthly.
- Members agree to attend regularly, and when absent, send reports or a designee to the committee.
- Members participate in the ongoing identification of agenda items, follow agenda timelines, and complete follow-up activities as assigned.
- Members share information at the local level after actively participating in discussions and decisions.
- Commitment to hold each member accountable to deliverables and responsibilities.
- Meeting coordination, record keeping, attendance tracking, and assignment of agenda item follow-up will be the responsibility of the EMS Coordinator.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 6.2 – Clinical Investigation and Remediation Policy	
Effective Date: 09-02-2025		**Revised Date:**

Purpose:

This serves to define the process for clinical investigations. Clinical investigations can be opened via self-report, third-party complaint, routine chart review, or as part of a prior remediation plan. Any actions related to this policy shall respect the principles of just culture and high reliability organizations.

Procedure:

YCEMS will conduct all clinical investigations. In the event that additional information is needed it shall be requested from any relevant team members and/or supervisors through a standardized request for additional information (RFAI) form. This form will be sent to the clinician's supervisor as appropriate for each agency's chain of command. The EMS clinicians have seven (7) days to complete requested documentation of events of the call. If unable to complete documentation in this time written explanation is required to be given to YCEMS EMS Coordinator. A clinician under clinical investigation may have their medical authorization suspended at any point during an investigation if there is concern for a serious risk to patient safety, at the discretion of the EMS medical director or designee.

The CQI committee will conduct clinical investigations. The case will initially be presented to the committee without identifying provider or agency information by the EMS Coordinator or designee whenever possible. Upon discussion of the case, the committee will determine appropriate next steps. In the event that more urgent evaluation is needed, the EMS coordinator and EMS medical director may expeditiously confer, take appropriate action, and report back to the CQI committee as indicated.

Each investigation can result in 3 possible outcomes:

- Unfounded complaint
- Performance improvement plan (PIP)
    - A PIP will be a customized plan for each clinician who requires performance improvement based on the investigation. The PIP can include but is not limited to any combination of modification of medical authorization, re-education (via primary agency or YCEMS, at discretion of the YCEMS CQI committee formal remediation, and precepting.

    - Re-education deemed necessary in the investigation will be targeted based on the clinician's needs and the findings of the investigation. Re-education can include but is not limited to simulation, skills training and testing, review of current research and discussion, course requirements (e.g., ACLS, TECC, paramedic curriculum modules, etc.), and/or field precepting. Additional requirements for education and/or monitoring are at the discretion of the YCEMS.
- Withdrawal of medical authorization.
    - Withdrawal of medical authorization is at the discretion of the YCEMS CQI committee and EMS Medical Director. See Section 2.5 above.

The EMS clinician has the right to give testimony during the investigation process. Labor representatives may be present at meetings between YCEMS and a clinician under investigation as an observer at the request of the EMS clinician.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 6.3 – Medication Error Policy	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

Purpose:

In the event that a YCEMS paramedic or EMT administers an incorrect medication or medication dose (either concentration, quantity or duration of infusion) the following procedure shall be initiated immediately to mitigate patient harm and initiate re-education.

Procedure:

The paramedic or EMT shall notify the receiving clinical staff (bedside nurse or charge nurse if bedside nurse unavailable AND attending physician) who are responsible for clinical care of patient in question- this notification must be documented in the ePCR and include:

1. Name of physician and nurse and time of notification.
2. Medication administered.
3. Medication dose and concentration.
4. (If applicable) duration of time medication was infused.

The medication error shall be reported to the EMS Coordinator no later than 24 hours after the incident and preferably before the end of the clinical shift.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 7.1 – Scope of Practice	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

Airway - Ventilation - Oxygenation			
Skill	**EMR**	**EMT**	**Paramedic**
Airway – nasal	✓	✓	✓
Airway – oral	✓	✓	✓
Airway – supraglottic			✓
Airway Obstruction –direct laryngoscopy			✓
Airway Obstruction – manual maneuvers	✓	✓	✓
Bag-valve-mask (BVM)	✓	✓	✓
Bilevel Positive Airway Pressure (BiPAP)			✓
Chest decompression - needle			✓
Chest tube – monitoring and management			✱
Chest tube placement – assist only			✱
Continuous Positive Airway Pressure (CPAP)		✱	✓
Cricothyrotomy			✓
End tidal CO2 w/waveform capnography			✓
Endotracheal intubation			✓
Gastric decompression – NG or OG tube			✓
Head tilt - chin lift	✓	✓	✓
Jaw-thrust	✓	✓	✓
Mouth-to-barrier	✓	✓	✓
Mouth-to-mask	✓	✓	✓
Mouth-to-mouth	✓	✓	✓
Mouth-to-nose	✓	✓	✓
Mouth-to-stoma	✓	✓	✓
Oxygen therapy – high flow nasal cannula			✓
Oxygen therapy – humidifiers		✓	✓
Oxygen therapy – nasal cannula	✓	✓	✓
Oxygen therapy – non-rebreather mask	✓	✓	✓
Oxygen therapy – partial rebreather mask		✓	✓
Oxygen therapy – simple face mask		✓	✓
Oxygen therapy – venturi mask		✓	✓
Pulse oximetry		✓	✓

Rapid sequence intubation (RSI)			✱
Suctioning – tracheobronchial of an intubated patient		✱	✓
Suctioning – upper airway	✓	✓	✓
Stable ventilator operation			

Cardiovascular – Circulation			
Skill	**EMR**	**EMT**	**Paramedic**
Cardiac monitoring 12-lead acquisition & interpretation			✓
Cardiac monitoring 12-lead acquisition & transmission		✱	✓
Cardiac monitoring – 3 or 4 lead			✓
Cardioversion - electrical			✓
CPR	✓	✓	✓
Defibrillation - AED	✓	✓	✓
Defibrillation - Manual			✓
Hemorrhage control - Direct Pressure	✓	✓	✓
Hemorrhage control - Tourniquet	✓	✓	✓
Hemorrhage control - Wound packing	✓	✓	✓
Mechanical CPR Device		✓	✓
Telemetric monitoring devices and transmission of clinical data		✓	✓
Transcutaneous pacing			✓
Transvenous pacing - monitor and maintain			✱
Vagal maneuvers			✓

Splinting – Spinal Motion Restriction – Patient Restraint			
Skill	**EMR**	**EMT**	**Paramedic**
Cervical collar		✓	✓
Emergency moves for endangered patients	✓	✓	✓
Extremity splinting		✓	✓
Extremity stabilization - Manual	✓	✓	✓
Long spine board		✓	✓
Manual cervical stabilization	✓	✓	✓
Mechanical patient restraint		✓	✓
Pelvic binder		✓	✓
Seated SMR (KED)		✓	✓
Splint - traction		✓	✓

Medication Administration – Routes			
Skill	**EMR**	**EMT**	**Paramedic**
Aerosolized/nebulized			✓
Endotracheal tube			✓
Intradermal			✓

Intramuscular *EMR limited to naloxone* *EMT limited to naloxone and epinephrine*	✱	✱	✓
Intramuscular – auto-injector	✱	✓	✓
Intranasal *EMR limited to naloxone*	✓	✓	✓
Intranasal - unit-dosed, premeasured	✓	✓	✓
Intraosseous – initiation, peds or adult			✓
Intravenous (including IV pumps)			✓
Mucosal/Sublingual		✓	✓
Nasogastric			✓
Oral		✓	✓
Rectal (*EMT/AEMT limited to patient's own diazepam*)		✓	✓
Subcutaneous			✓
Topical			✓
Transdermal			✓

Medical Director Approved Medications			
Skill	**EMR**	**EMT**	**Paramedic**
Antidote auto-injector	✓	✓	✓
Epinephrine auto-injector	✓	✓	✓
Immunizations			✱
Inhaled beta agonist/anticholinergic			✓
Patient's own metered dose inhaler		✓	✓
Intranasal opioid antagonist	✱	✱	✓
Intravenous			✓
Blood / blood products			✱
Opioid antagonist auto-injector	✱	✱	✓
Oral and topical OTC meds			✓
Oral aspirin for chest pain		✓	✓
Oral glucose for hypoglycemia		✓	✓
Parenteral analgesia for pain			✓
Patient's own sublingual nitroglycerin		✓	✓
Sublingual nitroglycerin			✓
Thrombolytic			✓

Skills - Miscellaneous			
Skill	**EMR**	**EMT**	**Paramedic**
Assisted complicated delivery		✓	✓
Assisted delivery (childbirth)	✓	✓	✓
Blood chemistry analysis			✓
Blood glucose monitoring		✱	✓
Blood pressure automated		✓	✓
Blood pressure manual	✓	✓	✓
Eye irrigation	✓	✓	✓
Eye irrigation hands free (Morgan)			✓
Ultrasound – Point of care			✱
Venous blood sampling			✓

Interfacility Transfer Medications			
Medication	**ALS**	**SCT – Adult Only (Call for Peds)**	**CCT+**
Amiodarone (bolus)	✓	✓	✓
Amiodarone (infusion)	✓	✓	✓
Antibiotics	✓	✓	✓
Bicarbonate infusion	✓	✓	✓
Blood – continuation (after 15 min)	✓	✓	✓
Blood – initiation			✓
Calcium	✓	✓	✓
D25 (Adult)		✓	✓
D5/10 (Adult)	✓	✓	✓
D50 bolus	✓	✓	✓
Dexmedetomidine		✓	✓
Diazepam	✓	✓	✓
Epinephrine	✓	✓	✓
Esmolol (infusion, no titration)	✓	✓	✓
Esmolol (infusion, titration)		✓	✓
Fentanyl (bolus)	✓	✓	✓
Fentanyl (infusion, no titration)	✓	✓	✓
Fentanyl (infusion, titration)		✓	✓
Heparin (infusion, no titration)	✓	✓	✓
Hydromorphone (infusion, titration)		✓	✓
Insulin (infusion)		✓	✓
Lidocaine	✓	✓	✓
Lorazepam (bolus)	✓	✓	✓
Lorazepam (infusion)		✓	✓
Magnesium Sulfate	✓	✓	✓
Mannitol	✓	✓	✓
Metoprolol	✓	✓	✓
Midazolam (bolus)	✓	✓	✓
Midazolam (infusion, titration)		✓	✓
Morphine (bolus)	✓	✓	✓
Morphine (infusion, no titration)	✓	✓	✓
N-acetylcysteine	✓	✓	✓
Naloxone	✓	✓	✓
Nicardipine (infusion, no titration)	✓	✓	✓
Nicardipine (infusion, titration)		✓	✓

Nitroglycerin	✓	✓	✓
Norepinephrine	✓	✓	✓
Phenylephrine (infusion)		✓	✓
Potassium	✓	✓	✓
Propofol		✓	✓
Thrombolytic Therapy (tPA, TNK)	✓	✓	✓

Interfacility Transfer Devices			
Device	**ALS**	**SCT – Adult Only (Call for Peds)**	**CCT+**
BiPAP/CPAP for Resp Failure	✓	✓	✓
Chest Tube (Water Seal)		✓	✓
Chronic Ventilator– Home Settings	✓	✓	✓
Complex or Unstable Ventilator			✓
ECMO			✓
High Flow Nasal Cannula	✱	✓	✓
IABP			✓
Impella			✓
Pericardial Drain – 24 hours or older		✓	✓
Pericardial Drain – less than 24 hours			✓
Stable Ventilator– ACVC, SIMV, ACPC, PS		✓	✓

✱ After Approved YCEMS Training

CCT^{+}: May have additional capabilities and anything outside of this outline should be discussed with Direct Medical Oversight (DMO) for scheduling transport.

Yale NewHaven Health Yale New Haven Hospital	**Yale New Haven Hospital Center for EMS** **Policy & Procedure Manual** 7.2 – Medication Formulary	
Effective Date: 6-2-2023		**Revised Date:** 09-02-2025

The following medications are approved for use by EMS services receiving medical oversight from YCEMS, in accordance with CT State EMS Guidelines. Medications in **bold** are optional and may be carried at the discretion of the EMS agency

- Acetaminophen (PO tablet/suspension mandatory, **IV optional**)
- Adenosine
- Albuterol
- Amiodarone
- Aspirin
- Atropine
- **Atropine/Pralidoxime Auto Injector**
- Calcium Chloride
- Calcium Gluconate
- **Cefazolin**
- **Dexamethasone**
- Dextrose
- Diltiazem
- Diphenhydramine
- **Droperidol**
- Epinephrine (1:1,000)
- Epinephrine (1:10,000)
- Fentanyl
- Glucagon
- Glucose (oral)
- Haloperidol
- **Hydroxocobalamin**
- Ipratropium Bromide
- Ketorolac
- **Lactated Ringers**
- Lidocaine
- Magnesium Sulfate
- Methylprednisolone
- Metoclopramide
- Metoprolol

- Midazolam
- Morphine Sulfate
- Naloxone
- Nitroglycerin (SL and IV)
- Norepinephrine
- Normal Saline
- Ondansetron
- Oral Glucose
- Oxygen
- Sodium Bicarbonate
- Normal Saline
- Tetracaine
- **Tranexamic Acid (TXA)**