Yale
NewHaven
Health
Yale New Haven
Hospital

YNHH CENTER FOR EMS

EMS POLICY & PROCEDURE MANUAL

Table of Contents

Purpose

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 for continuous quality improvement.

Guidelines

A. 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.

B. Without direct medical oversight (DMO), EMS providers shall not deviate from these protocols. Licensed independent practitioners (defined by state regulations as physicians, PAs, and APRNs) may deviate from protocols in accordance with their clinical judgment but must document and be prepared to justify such deviations.

C. There may be situations where more than one clinical impression exists. The provider should initiate routine care and may contact the DMO physician to help differentiate the most emergent clinical problem and select the most suitable therapy or therapies. Two sets of standing orders for two different possible medical conditions should not be implemented on the same call without contacting DMO.

D. 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.

E. 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. In the case of controlled substances, unused portions of vials or medication remaining in syringes must be wasted in the ED, with wasting witnessed and documented by a registered nurse, physician assistant, or attending physician there.

Professional Conduct

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 (both in the field and in the ED) must be courteous and respectful, regardless of circumstances or provocation.

B. 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.

C. It is recognized that there are circumstances, particularly involving traumatic mechanisms of injury (as in the case of motor vehicle crashes or industrial accidents), when it is extremely helpful to the Emergency Department clinicians to see what the scene looked like. Photographs can become a part of the patient's hospital medical record. Whenever possible, no persons should be visible in the photograph. Other identifying information, such as license plates, should also be excluded if possible. Patient care and/or transport should not be delayed to obtain photographs. State law strictly limits taking and distributing photographs by public safety and/or medical emergency responders:

Sec. 53-341c. Unauthorized taking or transmission by first responders of images of crime or accident victims. Any peace officer or firefighter, as those terms are defined in section 53a-3, or any ambulance driver, emergency medical responder, emergency medical technician or paramedic, as those terms are defined in section 19a-175, who responds to a request to provide medical or other assistance to a person and, other than in the performance of his or her duties, knowingly (1) takes a photographic or digital image of such person without the consent of such person or a member of such person's immediate family, or (2) transmits, disseminates or otherwise makes available to a third person a photographic or digital image of such person without the consent of such person or a member of such person's immediate family, shall be fined not more than two thousand dollars or imprisoned not more than one year, or both.

EMS providers should not share photographs or other potentially identifiable information (either privately or on public forums such as social media) that could result in the disclosure of a patients protected health information. Providers are encouraged to remain aware of the public nature of social media and should avoid any posting that disparages patients or otherwise could negatively reflect upon the provider-patient relationship. Additionally, EMS providers should not share scene photographs or other potentially identifiable information (either privately or on public forums such as social media) outside of the transmission of necessary medical information during the transfer of care.

D. To avoid on-scene confusion, only paramedics who have current YNHH CEMS medical authorization should wear "paramedic" rockers and/or other items identifying themselves as paramedics during emergency responses on behalf of a CEMS sponsored agency.

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

Covered Agencies

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 Student 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 Student EMS

Medical Authority at the Scene

A. On advanced life support (ALS) calls, the first paramedic to initiate patient care shall assume responsibility for the patient at the scene unless that paramedic decides to transfer patient care responsibility to another appropriately trained EMS provider. If a first-responder paramedic wishes to maintain responsibility for patient care after the transporting paramedic has assessed the patient and begun to assist with care, the first-responder paramedic must accompany the patient to the ED in the ambulance. In the absence of a YNHH CEMS-authorized paramedic, the YNHH CEMS-authorized provider with the highest level of state EMS certification shall assume responsibility for patient care.

B. EMS personnel may accept DMO from an on-scene physician only after:
    a. The physician has been identified as a Connecticut licensed physician (MD or DO) and has offered some form of identification, such as a copy of the physician license or a hospital ID tag, which confirms the 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 a SHARP 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.

C. SHARP Team

On-scene medical oversight may be provided by a 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 twelve-town greater New Haven area. The team is a state-certified ALS agency, and operates two licensed response vehicles.

The SHARP Team is available to respond to any type of emergency incident. Team members can assist with triage, treatment, logistics, communications, and rehabilitation, as the needs of the incident dictate. A primary purpose of the team is to provide for the safety and medical needs of emergency personnel operating at incident scenes.

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.

SHARP Team members periodically audit field operations through unannounced observation for the purposes of continuous quality improvement, education, and research.

Communications

Timely and appropriate communications can allow field EMS personnel to obtain direct medical oversight (DMO) from sponsor hospital-based clinicians and can allow 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.

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

C. In complex incidents or those involving one or more critical patients, early notification to receiving facilities with limited pertinent information is more important than a complete report just prior to arrival at the hospital.

D. Any incident involving two or more response vehicles should be handled on scene through an Incident Management System (IMS). Where multiple patients are involved, communication to the hospital(s) should be coordinated by one person.

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

F. 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.

G. When requesting DMO, verify that the physician is on the line prior to initiating report. Begin the patch with the question you have or the information you need. This will help the physician know what to listen for. When you receive an order from DMO, repeat the order to verify its accuracy. Do not hesitate to ask the physician to repeat or clarify an order if there is any doubt. In those instances where a request for medication or other intervention is denied by a medical oversight physician, the paramedic is to document the fact that the request was denied, along with the physician's name and facility. Under no circumstances are paramedics allowed to contact an alternate facility or another medical oversight physician with the same request.

Hospital Notifications

Hospital Notifications are made through MedCom/Valley Shore by radio or phone:

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

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

Priority 1 patients:

Provide a patient report that includes the following:

- age and gender of patient
- immediate pertinent history
- current chief complaint (in the patient's own words if appropriate)
- medications and medication allergies **only** if pertinent to this event
- vital signs and pertinent positive and negative physical exam findings
- treatment provided and patient response
- estimated time of arrival
- any specific needs (e.g. security) or problems (e.g. hazmat)

Priority 2 patients:

No notification patch is required to YNHH facilities (York Street campus, Saint Raphael campus, Yale Pediatric ED and Yale-Guilford), but may be made if deemed necessary by the transporting unit. Priority 2 patches are still required to the West Haven VA ED. Priority 2 patches should take no more than 15 seconds. Provide only the following:

- age and gender of patient
- chief complaint or summary of problem (e.g. "ankle sprain")
- vital signs
- estimated time of arrival
- any specific needs (e.g. security) or problems (e.g. hazmat).

Documentation and Record Keeping

A. An approved electronic patient care report (ePCR) will be used to document each time any EMS unit makes contact with a patient, including lift assists. No ePCR is required by YNHH CEMS if a unit is cancelled while responding, or if no patient contact of any type is made, if appropriate response information (e.g. times and unit identifiers) is captured and stored by the unit's agency (e.g. dispatch/telecommunications records).

B. Emergency patients may be defined as any person for whom the EMS system has been activated and:
    a. Has a physical or mental complaint, or suspected injury or illness.
    b. Requires or requests treatment or transport.
    c. Any person who is not alert and oriented.
    d. Any minor less than 12 years old without a parent or guardian present.

C. Individuals who do not meet the definition of an emergency patient do not require completion of a full patient care report/RMA documentation. Emergency personnel may document basic demographic information (name, age) on an alternative record such as an NFIRS report, police report or MCI documentation.

D. Crews that transport a patient to the hospital will complete an ePCR at the time the patient is delivered to the receiving facility and will either leave a paper copy or transmit an electronic copy to that facility. If the ePCR or authorized equivalent cannot be completed prior to the unit being dispatched to another call, the run form will be completed and delivered as soon as possible, always before the end of the crew's shift.

E. EMS providers for services utilizing the ESO Health Data Exchange are required to enter a patient CSN (contact serial number) from the hospital ID bracelet into the ePCR for all patients transported to a YNHH facility, including non-emergency transfers. This information is required to upload the EMS ePCR directly into the patient hospital record. It is preferable that this be performed using a barcode scanner, but it may also be entered manually if the scanner is not available.

F. Units that do not accompany the patient to the hospital must complete an ePCR or an authorized equivalent (paper PCR) prior to completion of the shift but are not required to submit it to the hospital. 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.

G. An ECG rhythm strip should be obtained on all patients who are monitored, and this strip or a photocopy should be attached to the hospital copy. If a 12-lead ECG is performed, the ECG or a photocopy should be attached to the hospital's printed copy of the ePCR. All ECGs should be uploaded to the ePCR as part of the overall patient care record.

H. Documentation on the patient care report for each intubated patient (ETT or approved rescue airway) 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. Patient care documentation shall assure that all data points have been included on the ePCR.

I. 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 authorizing implementation (if applicable).

J. If a paramedic performs a patient assessment and then releases the patient to a BLS unit, that paramedic must document his or her assessment on an ePCR.

Triage and Transport Guidelines

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 regular ED, and is staffed by the same attending emergency physicians, physician assistants, and nurses that staff the YNHH Emergency Department. The facility is equipped and staffed to offer the full range of emergency medicine for patients of all ages.

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

a. Trauma: Patients meeting the state's physiologic, anatomic, or mechanism of injury trauma triage criteria shall be transported directly to a designated trauma center. Patients with major burns and amputations should be transported directly to a trauma center.

b. Myocardial Infarction: Patients whose 12-lead ECG shows an acute ST-segment elevation myocardial infarction (STEMI) should generally 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 being cared for under the Focal Neurological Deficit protocol who meet the EMS Stroke Screen criteria should generally 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 generally 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 incapacitation: 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), – i.e., 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.

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. Transport of Behavioral Health, Corrections and Police Custody Patients

a. Adult PEC
   i. All adult patients on a PEC (emergency certificate signed by a physician, psychologist, licensed clinical social worker or advanced practice RN) should be brought to the York St Campus ED that has full-time psychiatrist staffing.
b. Altercation, assault or other person-on- person violence
   i. 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, 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.
   ii. 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. The decision of the direct medical oversight physician carries the same authority as the EMS protocols.

D. Pediatric Transport Destination Guidelines

a. 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, but those who are transported by EMS are likely to require consult or other services not readily available at the SRC ED.
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 present, 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 present, 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. All OB/GYN patients with a gestational age of 20 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, provided it is safe to do so.
b. Patients 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 New Haven Hospital Capacity Coordination Center

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. They can be reached on SC MED 10 or on the phone at 203-688-1337

If the patient's condition dictates transport to a specific facility, C3 **does not need to be contacted**. These patients will still require a patch to the ED if YNHH CEMS policies and procedures mandate the patch.

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)
- Transports from Yale Health Plan not meeting other destination criteria (YSC)
- Unstable GYN patients (YSC)
- 20+ 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)

Categories that DO require C3 contact:

- Cardiac arrest
- STEMI/Cath lab activations between 0800-1700 Monday-Friday
- Stroke alerts
- Psychiatric and substance abuse patients
- Law enforcement preference

If there is not a protocol related destination, please follow below:

Contact the ED Navigator Nurse using the following steps:

- Identify unit and call C3 on SC MED 10 (Example: 2C2 to C3).
- If you cannot access SC MED 10, use the C3 phone number: 203-688-1337
- State the patient age and chief complaint (do not request a specific destination)
- C3 will recommend a destination, based on optimal ability to care for that patient.
- If the patient is strongly opposed to that destination, notify C3. C3 may ask crews to inform patients of extended wait times or overcrowded conditions at a specific campus to allow the patient to make an informed decision.

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.

C3 is available as a resource to all EMS providers. Mandatory use of the system will be determined at the individual agency level in collaboration with YNHH leadership.

Mass Casualty Incident Communication

***Purpose**:* To assist agencies operating under Yale CEMS 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 his/her designee such as a transport officer) should 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 his/her designee) should 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 en route rather than each individual inbound medic performing detailed patches to the ED.

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

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

Trauma Destination Guidelines

Patients meeting 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 meet the following criteria may be transported to other ED's, at their request.

Patients meeting the following state trauma criteria shall be transported to a Level I or Level II trauma center.

- Physiologic findings of:
    - Glasgow Coma Scale of 12 or less, OR
    - Systolic blood pressure of less than 90 mm Hg, OR
    - Respiratory rate of less than 10 or more than 29 breaths per minute
- Anatomy of the Injury:
    - Gunshot wound to chest, head, neck, abdomen or groin, OR
    - Third degree burns covering more than 15% of the body, or third degree burns of face, or airway involvement, OR
    - Evidence of spinal cord injury, OR
    - Amputation other than digits, OR
    - Two or more obvious proximal long bone fractures
- Mechanism of Injury:
    - Fall from over 20 feet
    - Apparent high-speed impact
    - Ejection of patient from vehicle
    - Death of same car occupant
    - Pedestrian hit by car going faster than 20 MPH
    - Vehicle rollover
    - Significant vehicle deformity, especially steering wheel
- Other factors to consider in addition to anatomy, physiology and mechanism, when deciding whether an injured patient should be transported to a trauma center:
    - Age less than 5 or greater than 55 years
    - Known cardiac or respiratory disease
    - Penetrating injury to thorax, abdomen, neck, or groin other than gunshot wound

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.

- If field personnel need help deciding whether a patient meets trauma criteria, they should contact DMO at YSC for additional guidance. EMS personnel should NOT call the Saint Raphael Campus or Yale-Guilford to ask permission to bring a patient, nor should ED staff divert an incoming patient based on the patch from EMS personnel.
- If a patient meeting trauma criteria refuses transport to a trauma center, and/or demands transport to the St Raphael Campus or the Yale Guilford ED, contact medical oversight at the York Street Campus through MedCom/Valley Shore for assistance dealing with the refusal.

YNHH Pediatric Trauma Destination Guideline

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. All other patients
   a. <18 years old – any pediatric ED
   b. 21 years old or greater – any adult ED
   c. 18- 20 years old- Pediatric OR adult ED, per patient request

Lights and Siren Policy

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 en route).

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)

Medication Formulary

The following medications are approved for use by EMS services receiving medical oversight from YNHH CEMS, 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
- **Dexamethasone**
- Dextrose
- Diltiazem
- Diphenhydramine
- Epinephrine (1:1,000)
- Epinephrine (1:10,000)
- Fentanyl
- Glucagon
- Glucose (oral)
- Haloperidol
- **Hydroxocobalamin**
- Ipratropium Bromide
- Ketorolac
- Lidocaine
- Magnesium Sulfate
- Methylprednisolone
- Metoclopramide
- Metoprolol
- Midazolam
- Morphine Sulfate
- Naloxone
- Nitroglycerin (SL and IV)
- Norepinephrine
- Ondansetron
- Oxygen
- Sodium Bicarbonate
- Tetracaine

Transport Medications

Any YNHH CEMS-authorized paramedic may transport any patient who is already on an intravenous infusion of any of the following medications, under written orders from the transferring physician. The paramedic is not authorized to alter the dose of any medication not included in the Connecticut Statewide EMS Protocols Drug Formulary once transport has begun without contacting Direct Medical Oversight. Paramedics may in rare circumstances turn off an infusion if they are concerned for life-threatening medication complications such as allergic reaction or hypotension while they attempt to call Direct Medical Oversight.

- Amiodarone
- Antibiotics
- Beta blockers (all: e.g., esmolol, metoprolol, propranolol)
- Blood products (e.g. PRBCs, platelets, KCentra)
- Calcium channel blockers (all: e.g., nicardipine, clevidipine, diltiazem)
- Dopamine
- Fentanyl
- Heparin (only after the initial bolus is completed)
- Insulin
- Lidocaine
- Magnesium Sulfate
- Midazolam
- Morphine
- Naloxone
- Nitroglycerin
- Propofol (after approved CEMS training)
- tPA (only after the initial bolus has been completed)

BLS/ALS Assessment

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 ALS management.

BLS providers may only cancel responding paramedics in certain limited situations.

Responding paramedic units may not be cancelled on calls requiring ALS response during EMD (e.g. Echo, Delta, or Charlie calls), or calls in which a paramedic is requested by a BLS provider on scene.
For calls in which ALS is not automatically dispatched per EMD guidelines (e.g. Bravo/Alpha calls, Priority 2 calls) the patient may be managed by BLS personnel. If an ALS unit has been dispatched to a Bravo or Alpha call, the response may be cancelled by BLS on scene if considered appropriate by the most senior EMT on scene.

The paramedic on any ALS first response units must make contact with the patient whenever dispatched to a medical call that meets ALS criteria as above. If there is already a transport paramedic on scene, that paramedic has evaluated the patient, and indicates there is no need for additional help, then the first responder paramedic can clear.

In cases where the paramedics arrive simultaneously, the ALS first responder must make contact and evaluate the patient. The patient is a responsibility of the CT OEMS Primary Service Area Responder at the Paramedic Level until formally handed off to either a BLS unit if appropriate, or to the transport paramedic who must then agree that the first responder paramedic is not needed.

After evaluation and with documentation, paramedics may downgrade level of care to BLS if appropriate. This requires an appropriate physical examination, additional testing when appropriate, and written documentation of these assessments in the patient record by the paramedic. Inappropriate downgrades of patients requiring ALS interventions to BLS, or inviting inappropriate refusals of transport, can be considered a form of patient abandonment. In cases in which the call is appropriately given to the BLS provider after a paramedic assessment, the EMT may write the documentation, but the paramedic must also sign the chart and include his or her assessment and justification for BLS only care. Paramedics who are not part of the transport crew are responsible for completion of a full PCR on every patient contact.

Airway Paramedic Policy

YNHH CEMS paramedic shall utilize this policy during all attempts at advanced airway management, or when assuming responsibility for an airway already established by a non-YNHH CEMS 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), 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 his or her 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 intubations (adult and pediatric, oral and nasal, endotracheal tube and supraglottic airway). 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 extubating 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 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 the appropriate Emergency Department staff member, before the patient is physically transferred from ambulance stretcher to hospital bed. YNHH CEMS shall encourage local Emergency Department personnel to cooperate with this request.

E. In the event that a YNHH CEMS 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 hospital EMS Coordinator. If the coordinator cannot be contacted, the on-call SHARP Team member shall be contacted through MedCom/Valley Shore. The YNHH CEMS representative performing the debriefing shall either respond directly to the Emergency Department, or speak with the involved parties by telephone. A Code Summary should be printed for the call in question and provided to the YNHH CEMS personnel performing the debriefing. If system status allows, the involved crew should remain at the hospital until the debriefing is complete.

F. Documentation is a key component in protecting a paramedic against claims of a misplaced airway device. The documentation should include initial and final assessment of airway placement, regardless of transportation decision (hospital transport or field termination). Documentation should also reflect a re- assessment performed after each patient movement. The mnemonic "EMS BREATH" may be used as a memory aid for the components of airway verification. The components are:

- E= End Tidal CO2 reading
- M= Measure (size/depth of tube)
- S= SaO2 reading
- B= Bilateral breath sounds
- R= Rise/fall of chest
- E= Esophageal detection
- A= Absent gastric sounds
- T= Tube misting
- H= Hospital confirmation

Documentation should be made on the ePCR. Copies should be left in the Emergency Department prior to leaving the hospital.

Cardiac Cath Lab Activation

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*** (LP 12), *** MEETS ST ELEVATION MI CRITERIA*** (LP 15), 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 major surgery within the past six weeks (e.g., abdominal, neurosurgical)

E. No significant trauma

Activation Process:

1. If your service utilizes C3, contact C3 for destination between 0800.- 1700. Monday-Friday. Otherwise, proceed to York Street campus.

2. Notify the receiving hospital as soon as the patient has met activation criteria. Contact MedCom/ Valley Shore and advise them of the /destination facility and request cath lab activation.

3. Follow treatment protocols as outlined in ACS protocol (3.0)

4. Initiate transport

5. After stabilization of patient, establish communications with the receiving hospital to provide a full report and ETA. Clearly state that the patient has a STEMI and that the cath lab should be activated.

YNHH Cath Lab Hours:

The cardiac catheterization lab at the Saint Raphael Campus is open from 0800-1700, Monday-Friday. All cath lab activations falling outside of those hours should be transported to the York Street Campus.

Stroke Alert

A. Initiate patient care in accordance with current CT State EMS Protocols.

B. Determine an accurate time of symptom onset.

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

   a. If your service utilizes C3, contact C3 for destination.

   b. Notify the receiving facility of a Stroke Alert as soon as possible

   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

Medical Authorization Policy

PURPOSE:

To provide a mechanism by which State of Connecticut certified or licensed EMS personnel can become medically authorized by Yale-New Haven Hospital Center for EMS (YNHHCEMS) MIC Medical Director. Only employees of EMS services sponsored by YNHHCEMS, or personnel functioning in an EMS role with YNHHS who otherwise meet the requirements of this policy are eligible to obtain medical authorization.

A. DEFINITIONS:

The following definitions apply to this Policy;

Applicant: An employee of an EMS service who has applied to YNHHCEMS for medical authorization.

ALS calls: Those calls requiring advanced life support services in which the applicant for medical authorization is responsible for assessment of the patient, formulation of an appropriate treatment plan, and performance of appropriate ALS skills under the supervision of an approved Paramedic Field Instructor (PFI) or SHARP Team member.

Medical Authorization: Permission to perform medical care treatments (a) to the extent permitted by the CT Office of Emergency Medical Services; and (b) according to YNHHCEMS protocol under the medical oversight and direction of YNHHCEMS as provided by law.

EMS Service: An organization or entity that is (a) authorized under applicable state and local laws and regulations to provide emergency medical services, and (b) sponsored by YNHHCEMS.

B. 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 an EMS service or YNHH agency;
3. Meet all other requirements specified in this Policy.

C. PROCESS:

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

1. A copy of a current State of Connecticut certification card or license at the level for which medical authorization is being sought.
2. A copy of current BLS-HCP card.
3. A letter from the EMS service verifying employment at the MIC level for which medical authorization is being sought.
4. A completed YNHHCEMS MIC Personnel application.

D. PARAMEDICS:

In addition to the above (C1-4), the following must be submitted by the paramedics seeking medical authorization.

1. A current, valid National Registry of EMTs paramedic card, current State of Connecticut paramedic license, and current ACLS, PALS, PHTLS, CPR and EPC cards. Paramedic applicants may apply and begin precepting without current EPC certification on the condition that they will complete course prior to attaining YNHHCEMS medical authorization. NREMT paramedic registration is mandatory for all paramedic applicants for YNHHCEMS medical oversight. ***TECC or TCCC certification may be used as a substitute for PHTLS.***

2. A letter of recommendation is required from the applicant's last MIC medical director who provided medical authorization, verifying that the applicant is eligible for on-going medical authorization and attesting to his/her professionalism; or, if the applicant is a new graduate, a letter of recommendation from the Course Medical Director or Course Coordinator verifying that the applicant graduated in good standing and attesting to his/her professionalism.

3. A copy of a current driver's license.

4. Upon review and approval of the required application materials by the YNHHCEMS Director, the applicant will schedule a written protocol exam with the YNHHCEMS office, to be completed within 30 days. If the applicant fails (grade<70%) the protocol exam, he/she may schedule a time to take the exam within an additional 30 days. If the applicant fails the exam a second time, he/she must re-start the application process not less than 90 days after the second failure.

5. Upon successful completion of the protocol exam, the MIC Director will grant probationary medical authorization to the applicant for a period of up to, but not exceeding ninety (90) days. During this probationary period, applicants for medical authorization at the paramedic level must provide pre-hospital patient care under the supervision of a YNHHCEMS-approved Paramedic Field Instructor (PFI). If the applicant is unable to complete the required number of ALS calls set forth in a. or b.

below in the 90-day period, he/she must apply to the YNHHCEMS office in writing for an extension of the probationary period.

6. New graduate paramedic applicants must complete a minimum of thirty (30) advanced life support (ALS) calls, each to the satisfaction of the YNHHCEMS PFI. This must include a full ALS assessment, defined as the administration of a medication other than oxygen OR an EKG AND an IV/IO attempt. In certain circumstances and at the discretion of the PFI, it may be appropriate for care to then be transferred to another paramedic unit without riding in the call to the hospital.

7. Paramedic applicants with prior field experience under the auspices of another medical director must complete a minimum of fifteen (15) ALS calls, each to the satisfaction of the YNHHCEMS PFI. This must include a full ALS assessment, defined as the administration of a medication other than oxygen OR an EKG AND an IV/IO attempt. In certain circumstances and at the discretion of the PFI, it may be appropriate for care to then be transferred to another paramedic unit without riding in the call to the hospital.

8. Paramedics who have current medical authorization in Connecticut from a Yale New Haven Health System sponsor hospital are eligible for an expedited medical authorization process:

    a. After successful completion of the written protocol exam, the applicant must complete a minimum of 20 hours ride time under the supervision of a YNHH CEMS PFI. During this ride time, the applicant must transport a patient to or otherwise visit both campuses of Yale New Haven Hospital to become familiar with local ED operations, including controlled substance exchanges and the ESO HDE system.
    b. Upon completion of this ride time, the applicant will be eligible to complete the final check ride.
    c. Should the Paramedic applicant fail to successfully complete the check ride process, they must complete 15 advanced life support calls as explained in this section.

9. The supervising PFI will evaluate and document each call on a YNHHCEMS MIC Preceptor Field Evaluation form and/or online Fisdap eval. A completed patient care report must be attached to the evaluation form for each call. These forms will be compiled for review at the time of the final field evaluation.

10. The minimum requirements set forth in this section may be modified at the sole discretion of the MIC Medical Director, e.g. for paramedics with substantial prior field and teaching experience.

11. When, as determined by the PFI(s) and the EMS Coordinator(s), the MIC applicant has demonstrated sufficient clinical competence and professionalism such that medical authorization is appropriate and in the best interest of the public health and safety, a written or verbal recommendation for final field evaluation will be made to the MIC

Medical Director. In the event the PFI(s), EMS Coordinator(s), and/or YNHHCEMS Director determine the MIC applicant has not demonstrated sufficient clinical competence and professionalism to warrant final field evaluation, the MIC Medical Director will review the applicant's file, discuss the applicant's performance with the PFI(s) and/or EMS Coordinator(s), and determine the appropriate course of action, which may include additional precepting.

12. Following completion of the minimum requirements (and/or such other requirements as the MIC Medical Director may prescribe pursuant to Section D.6 above) and recommendation as above, the supervising PFI, as applicable, will submit the applicant's field evaluation documentation to the YNHHCEMS office for review. Arrangements will then be made for final field evaluation through the YNHH CEMS office. This field evaluation shall consist of a minimum of four hours of direct field observation by a member of the YNHH CEMS medical oversight group OR a high-fidelity simulation-based assessment. If the medical oversight group does not recommend medical authorization, they shall advise the MIC Medical Director how to proceed. Feedback will also be provided directly to the applicant. Typically, additional precepted ALS calls will be required before the applicant is granted another final field evaluation. If an applicant fails two attempts, a meeting will be required between the applicant, his or her service chief or training officer, and a member of the medical oversight team in order to discuss a focused learning plan. Additionally, the applicant will be required to be cleared again by a paramedic field instructor before re-challenging the final assessment after a minimum of 3 months of remediation. If the applicant fails a 3rd attempt, he or she may not challenge again for a minimum of 6 months.

E. MODIFICATION OF MEDICAL AUTHORIZATION FOR PARAMEDICS

Should a medically authorized paramedic wish to function at the EMT-B level only, but maintain paramedic licensing, written notification of such must be submitted to the YNHHCEMS Director and one of the following must occur:

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

2. The paramedic must successfully complete 40 hours of approved EMT continuing education within six months of relinquishing medical authorization, and every two years thereafter.

   Note: For reasons of liability. YNHHCEMS strongly recommends against YNHHCEMS-authorized paramedics serving as paramedics at one YNHHCEMS-sponsored ALS agency, but as an EMT-B at another YNHHCEMS-sponsored ALS agency.

3. Any paramedic with current medical authorization but functioning in a non-clinical position for longer than six months, or unable to function in a clinical position for longer than six months will be required to precept for a minimum of 15 calls and

complete a final field evaluation by a member of the YNHHCEMS Operations Committee. Once the final evaluation is complete, full privileges will be restored.

F. CRIMINAL CONVICTION POLICY

(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 YNHHCEMS' view, EMS providers should be held to a similar, if not higher, standard. YNHHCEMS 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 YNHHCEMS (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 MIC 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 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 MIC Medical Director's decision shall be final.

3. **Discretionary Denial**

Notwithstanding any other provisions of this policy, the MIC Medical Director may, in his or her sole 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 MIC 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 MIC Medical Director may consider additional factors as are appropriate under the circumstances.

EMS Provider Remediation Policy

The following policy statement outlines an escalating remediation program for EMS providers whose patient care involves protocol, policy, or procedure violations. These violations include but are not limited to protocol violations, inappropriate downgrades to basic life support (BLS) care, inappropriate invitations or acceptance of patient refusals, failure to recognize a critical condition (stroke, STEMI, etc.), and any other negligent or inappropriate care of patients that resulted or could reasonably have resulted in poor patient outcomes.

This policy is not designed to apply to cases of professional misconduct (drug diversion, assault, etc.) but is reserved for clinical errors.

If YNHH CEMS medical direction establishes through a QA/QI investigation that an EMS provider has provided inadequate or negligent medical care of a patient as outlined above, the following steps will be taken in sequence:

A. For the initial violation, the EMS provider will be subject to remediation in protocols, policies and procedures. This may include but is not restricted to a formal course, informal didactics, or shadowing experience. A written warning will be given to the paramedic, that service's EMS Chief, and a copy placed in the provider's QA file.

B. A second violation of protocols, policies or procedures within one year after the initial warning will result in suspension of the provider's medical authorization until:

   i. Paramedic: The paramedic must complete at least 15 PFI-supervised ALS calls. The PFI or PFIs will be assigned by YNHH CEMS. The supervising PFI will be notified of the preceptee's identified issue and is expected to maintain confidentiality as to the focus of the remediation while performing the assessment. On these calls, the precepting paramedic must provide ALS care from the scene to ED arrival. Upon completion of this remedial precepting, the paramedic must submit the PFI's evaluations for each patient encounter. These will be reviewed and approved by YNHH CEMS, following which a final ride or simulation assessment and sign-off with an EMS physician or physician assistant will be performed prior to restoration of medical authorization. Failure to be signed off by PFIs or the EMS physician/PA will require additional training and supervised ride time to be determined by YNHH CEMS. The number of supervised ALS calls during remediation is a minimum and is less important than the PFI assessment that the paramedic is competent in all domains. There will be no final physician/PA rides in the absence of that PFI assessment that the provider is competent and ready for the final ride.

   ii. EMR/EMT: The EMR/EMT must complete at least 15 calls supervised by either a PFI or a senior EMT approved by the EMS agency and YNHH CEMS (e.g. a Field Training Officer). The EMT must submit the preceptor's

evaluations for each patient encounter. These will be reviewed and approved by YNHH CEMS prior to the restoration of medical authorization. Failure to be signed off by PFIs or senior EMT will require additional training and supervised ride time.

C. Additional violations of YNHH CEMS protocols, policies or procedures within a year of remedial precepting and restoration of medical authorization will result in revocation of medical authorization.

D. CEMS reserves the right to offer or require alternative options for clinical remediation depending on specific circumstances, identified deficiencies, and previous experience.

Interfacility Transport to Hospice

Purpose:

To assist agencies operating under Yale CEMS Operations with patient care of patients requiring transport to hospice facilities. This policy is intended to cover patients being transferred for end-of-life care. Patients must have a valid DNR to qualify for this protocol. Paramedics are not authorized to de-escalate care except under direct medical oversight. They must hand over care to an equal or higher level of care at the receiving facility.

Policy:

Medications: Paramedics may transport patients on infusions of medications not included in the Connecticut Statewide EMS Protocols Drug Formulary, however they must receive an order for this medication from the sending physician and may not titrate the medication. If issues arise, they should call direct medical oversight. Paramedics may not de-escalate care on arrival to these facilities. It will be the responsibility of the receiving facility to discontinue any medications.

Ventilators: Mechanical ventilators may be used during the interfacility transfer of patients with advanced airways (endotracheal tube/tracheostomy) who are on existing mechanical ventilation as specified under the existing Interfacility Transport Ventilator protocol. Paramedics must hand off care to a physician or other care provider who is appropriately trained in management of the ventilator. It is the responsibility of the sending physician to determine appropriate level of care during transport, and he or she should be made aware of the transport team capabilities prior to initiating the transport.

Paramedics may not extubate patients, nor remove a patient from the ventilator except as needed to use a bag-valve-mask to resuscitate a patient in respiratory distress OR to transfer to the receiving facility who will either connect to their own ventilator or continue using the bag-valve-mask.

Decompensation during transport: Sending facilities must provide a plan, in-writing and signed by a physician, for contingency planning in case of decompensation in transport. It must specifically mention whether the patient should be transported to the nearest Emergency Department, or whether they should proceed to the receiving facility.

Exclusion criteria:

1) Patients with anticipated need for ventilator adjustments during transport
2) Patients < 18 years old
3) Patients requiring specialized ventilator modes not available on transport ventilator or with ventilator settings outside of existing interfacility ventilator transport protocol
4) Patients without adequate sedation/analgesia, e.g.: those who require additional doses during transport or titration of any continuous medications.
5) Intubated patients with a known pneumothorax and without a chest tube.
6) Patients needing frequent airway interventions such as those requiring frequent suctioning

Procedure:

- Verify the existence of a valid DNR and/or CMO order and obtain a copy to be kept with transfer paperwork including contingency plan form, included in the electronic record.
- Ensure the availability of a BVM, suction, and sufficient portable oxygen supply prior to switching ventilators and during patient movement into the ambulance
- Confirm correct airway placement in accordance with CT Statewide EMS Protocols
- Verify ventilator settings from the sending facility. Standard ventilator settings for EMS transports are:
    1. Ventilator mode: Assist Control (AC)
    2. Tidal volume: 6-8 ml/kg (ideal body weight)
    3. Rate: 10-16 breaths/minute
    4. FiO2: 21-100% (titrate to SpO2 > 92%)
    5. PEEP 2-5 cm H2O

  Patients with ventilator settings other than those listed above require the approval of medical oversight (medical director or associate medical director) prior to the initiation of transport
- Connect patient to EMS monitor (including continuous waveform capnography) and pulse oximetry prior to switching ventilators and maintain this throughout transport.
- Patients must be observed, by the sending facility, for a minimum of 20 minutes after any adjustment in ventilator settings.
- Patient should be stable on the transport ventilator for 20 minutes prior to departure.
- 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, he or she may be moved to the EMS stretcher.
- 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.
- If any significant change in those parameters occurs, or if the patient develops any respiratory distress, the patient must be disconnected from the ventilator, and EMS provider must ventilate by BVM for the remainder of the transport.
- All hospice transports requiring ventilatory support or IV infusions will be submitted for CQI review to Yale CEMS.
- Any requests for transport that fall outside of the established interfacility ventilator transport protocols must be approved by the CEMS Medical Director or a CEMS Associate Medical Director through the on-duty supervisor.

Interfacility Transport Ventilator

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 CEMS-approved ventilator training.

Exclusion criteria:

1) Patients with high potential for clinical instability (ED→ICU, ICU→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: 10-16 breaths/minute
    d) FiO_2: 21-100% (titrate to $SpO_2 > 92\%$)
    e) PEEP: 5 cm H_2O

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

3) Connect patient to EMS monitor (including capnography) and pulse oximetry prior to switching ventilators.
4) Ensure the availability of a BVM, suction, and sufficient portable oxygen supply prior to switching ventilators.
5) 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, he or she may be moved to the EMS stretcher.
6) 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.
7) After arrival at the receiving facility, follow the steps above when transferring from the EMS stretcher to the facility stretcher.
8) All ventilator transports should be submitted for CQI review.

YNHH CEMS Scope of Practice

Airway Management	EMR	EMT	PARAMEDIC
BVM	X	X	X
Chest Tube Maintenance			X
Cleared, Opened, Heimlich	X	X	X
Combitube			X
CPAP			X
Endotracheal Intubation			X
Endotracheal Suctioning			X
KING LT-D			X
Laryngeal Mask Airway			X
Nasogastric Tube			X
Nasopharyngeal Airway	X	X	X
Nasotracheal Intubation			X
Nebulizer Treatment			X
Needle Decompression			X
Oral Suctioning	X	X	X
Oropharyngeal Airway	X	X	X
Oxygen Administration	X	X	X
PEEP		X	X
Pulse Oximetry		X	X
Rapid Sequence Intubation			
Tracheostomy Maintenance			X
Ventilator Operation			X
Surgical & Percutaneous Cricothyrotomy			X

Medication Administration Route	EMR	EMT	PARAMEDIC
Auto Injector		X	X
Endotracheal			X
Inhalation		MDI	X
Intramuscular		X	X
Intraosseous			X
Intravenous			X
Intravenous Pump			X
Oral		X	X
Rectal		Assist Diastat	X
Subcutaneous			X

Airway Management	EMR	EMT	PARAMEDIC
BVM	X	X	X
Capnography			X
Cleared, Opened, Heimlich	X	X	X
CPAP		X	X
Endotracheal Intubation			X
Endotracheal Suctioning			X
King LT-D			X
Laryngeal Mask Airway			X
Nasogastric Tube			X
Nasopharyngeal Airway	X	X	X
Nebulizer Treatment			X
Needle Decompression			X
Oral Suctioning	X	X	X
Oropharyngeal Airway	X	X	X
Oxygen Administration	X	X	X
Percutaneous Cricothyrotomy			X
Pulse Oximetry		X	X
Tracheostomy Maintenance			X
Ventilator Operation			X

Cardiac Management	EMR	EMT	PARAMEDIC
Application of 12 Lead ECG			X
Application of 3 or 4 lead ECG			X
CPR	X	X	X
Defibrillation - AED	X	X	X
Defibrillation - Manual			X
Interpretation of 12 Lead ECG			X
Interpretation of 3 or 4 lead ECG			X
Synchronized Cardioversion			X
Transcutaneous Pacing			X

Vascular Access	EMR	EMT	PARAMEDIC
Blood Draw			X
Blood Glucose Analysis		X	X
Central Line Access			X
Intraosseous			X
Peripheral Venous Access			X

OTHER SKILLS	EMR	EMT	PARAMEDIC
Advanced Spinal Assessment		X	X
Burn Care	X	X	X
Cervical Spinal Immobilization	Manual Stabilization	X	X
Childbirth	X	X	X
Cold Pack	X	X	X
Extrication		X	X
Eye Irrigation (Morgan Lens)			X
Hot Pack	X	X	X
PEEP		X	X
Restraints - Pharmacological			X
Restraints - Physical		X	X
Spinal Immobilization - Lying (Long board)	Manual Stabilization	X	X
Spinal Immobilization - Seated (K.E.D.)	Manual Stabilization	X	X
Spinal Immobilization - Standing	Manual Stabilization	X	X
Splinting	Manual Stabilization	X	X
Splinting - Traction	Manual Stabilization	X	X
Stroke Scale		X	X
Temperature		X	X
Wound Care - Occlusive Dressing	X	X	X
Wound Care - Pressure Bandage	X	X	X
Wound Care - Tourniquet	X	X	X
Wound Care - Wound Packing	X	X	X