Sponsor Hospital Council of Greater Bridgeport
2022 Policy Manual

Hartford HealthCare
St. Vincent's Medical Center

Yale NewHaven Health
Bridgeport Hospital

The Mission of SHCGB

"Incorporating the values of integrity, compassion, accountability, respect, and empathy, The Sponsor Hospital Council of Greater Bridgeport is committed to the provision of high-quality pre-hospital emergency care to the citizens and visitors of the greater Bridgeport area."

This policy manual is a "living document" developed and drafted by Sponsor Hospital Council of Greater Bridgeport (SHCGB) in conjunction with the agencies it sponsors for Medical Control. At the option of SHCGB, they can be edited and updated at any time. However, they are formally reviewed, edited, and released every two years.

This document may not be amended or altered; however, it may be reproduced and distributed without permission.

DISCLAIMER: This policy manual was designed and written by SHCGB and is designed to be used in conjunction with individual service policies and procedures. EMS Providers are still required to follow all local service policies and procedures, notwithstanding this document.

Dr. Douglas Latham
EMS Medical Director
Bridgeport Hospital

Steven Valassis, MD,
EMS Medical Director
St. Vincent's Medical Center

Terence SheehanEMS Coordinator
St. Vincent's Medical Center

Wesley Young
EMS Manager
Bridgeport Hospital

TABLE OF CONTENTS

Title: General Operating Guidelines

Purpose: The purpose of this document is to guide specific Sponsor Hospital policies and procedures.

Discussion: The goal of pre-hospital emergency medical services is to administer care to the ill and injured while safely transporting patients to appropriate definitive care. Optimal patient outcomes result from a combination of thorough patient assessment, sound pre-hospital emergency medical services, and appropriate medical consultation, as needed. The following policies are to be used by EMS providers authorized to practice in the Sponsor Hospital Council of Greater Bridgeport (SHCGB) catchment area to ensure consistent and quality medical care and to establish standards by which pre-hospital emergency care may be audited for quality improvement.

Policy:

- All patients will be treated with dignity and respect.
- Anyone requesting EMS services will be offered a professional evaluation, treatment, and transportation regardless of the patient's problem or condition.
- All EMS providers will adhere to the most current version of the Connecticut Statewide EMS Protocols and treatment modalities that are SHCGB and EMS agency-specific.
- It is the responsibility of the EMS providers to be thoroughly familiar with all devices and therapies authorized for use in the Statewide EMS protocols and those specific to the SHCGB region
- All treatment and diagnostic monitoring provided during transport must be continued during the transfer from the ambulance into the Emergency Department.
- Direct medical oversight is an option at any time during the patient encounter.
- No provider shall deviate from policies or protocols without direct medical oversight (DMO).
- In the event a protocol deviation is authorized via direct medical oversight, an exception form must be completed and returned to the EMS Coordinator of the receiving hospital.
- Physician-obtained orders that seem inappropriate or outside the scope of practice of the EMS provider must be documented, and the EMS Coordinator at the receiving facility must be notified. The paramedic has the right to refuse to implement orders or procedures that are outside of the protocol, inappropriate for the patient's condition, or outside the Paramedic's level of training.

Section I: Medical Control

Title: Sponsor Hospital Authorization of Medical Control

Purpose: This policy aims to provide a structured format for EMS providers to obtain, maintain, and renew clinical authorization to practice as EMS providers in the Sponsor Hospital of Greater Bridgeport (SHCGB) catchment area.
Scope: This policy applies to all certified and licensed EMS providers currently practicing or wishing to practice in the SHCGB catchment area.

Policy:

Initial Authorization for Paramedic Providers
Any EMS agency interested in hiring a paramedic level provider is to express their interest, in writing, to each Sponsor Hospital EMS Coordinator.

- The prospective hire is required to submit a completed application for medical control to each Sponsor Hospital EMS Coordinator with supporting documentation, including but not limited to:
    - Proof of employment with a designated EMS service provider sponsored by Sponsor Hospital Council of Greater Bridgeport (SHCGB).
    - Current and unencumbered paramedic licensure.
        - Inactive applicants (defined as not functioning at the paramedic level with the full authorization granted by a sponsoring hospital or other credentialing agency for a period exceeding twelve months) will be required to show proof of completion of a state-approved paramedic refresher program if more than two years out of the field.
    - A letter from the primary or immediately previous sponsoring hospital verifying the applicant's status as a clinician at the paramedic level.
    - Current American Heart Association ACLS, PALS, and BLS healthcare provider cards.
    - Current PHTLS or ITLS certification.
    - This application must be submitted in its entirety before scheduling the initial medical control protocol test.
    - New graduate paramedics must have at least three (3) live intubations or be required to do rotations in the OR in partnership with the sponsoring service.

EMT Level Providers

- Maintain State Certification
- AHA BLS Card
- Precepting policy approved by the service provider and SHCGB

Precepting Process
Note: Medical control is agency-specific. A provider must submit a separate application for each service for which they work.

Providers who have been convicted of a crime or have had any action taken against them (censure, discipline, dismissal, termination, consent order, etc.) from any governmental agency, professional organization, sponsor hospital, or employer must provide a detailed account if requested.

SHCGB has the right to refuse medical control to any applicant based on a background check.

- After a review and verification, the medical control process may begin.
- The candidate must complete the protocol exam with 75% or higher. The test is based on the most current version of the CT Statewide Protocols, SHCGB formulary, and paramedic knowledge. The protocol test is good for six months after completion. Failure to complete the interview process within the time frame will require a new protocol test.
- Candidates failing to pass the protocol exam may retest based on the following schedule:
    - 1st attempt: The candidate may retest after seven calendar days.
    - 2d attempt: The candidate may retest after fourteen calendar days.
    - 3d attempt: The candidate may re-apply for medical control authorization and retest after ninety days.
    - Each additional failure will require a ninety-day waiting period for retests.
- Once the candidate has completed the protocol exam, the medical control interview will be scheduled with both EMS Coordinators and at least one Medical Director.
    - A National Registry oral station-type scenario and a mega code are typically offered, along with an ECG review.
    - In most cases, the interview process will be held within thirty days of completing the protocol exam.
    - Should a candidate fail to pass the interview process, candidates may request a second interview fourteen days after the initial interview, with service approval for all future interviews.
    - Should a third attempt be needed, the candidate must wait ninety days.
    - If a fourth attempt is needed, it must be after six months from the original interview date.

After successfully passing the protocol exam and interview, the candidate will be granted permission to begin precepting at the sponsoring EMS agency.

- Field Training Officers or Paramedic Field Instructors who have completed an approved two-hour training course and have been approved by Medical Control will be allowed to train paramedics.
- Graduate paramedics requesting initial medical control must have the ability to run 911 calls at the sponsoring agency.
- Precepting must begin within three months of successful completion of the protocol exam and interview process

- The precepting process must be completed within six months of passing the interview process.
- Failure to complete the process within the allotted time may result in the candidate having to begin the process over with the protocol test.
    - An extension may be considered and granted on a case-by-case basis.
- A candidate is required to complete at least thirty-five ALS calls and fifteen interventions.
    - Reciprocal medical control authorizations are considered on a case-by-case basis, depending on experience and background.
    - A minimum of five ALS calls is required for candidates seeking reciprocal medical control authorization.
- Routine paramedic care, as defined in the most current version of the CT Statewide protocols, must be performed to constitute an ALS call.
- An intervention is defined as follows:
    - Any ALS medication administration, electrical therapy (cardioversion, defibrillation, TCP), or placement of an advanced airway
    - Routine IV access, ASA, Narcan, Oxygen will not count as interventions
    - Chest needle decompression.
    - Intraosseous (IO) / External Jugular IV placement.
    - Only two interventions of different types will be counted per call regardless of the total number of interventions performed.
    - A medication may be counted three times as an intervention for a specific complaint during the precepting process.
        - For example, Nitroglycerin for chest pain or CHF can be counted three times on different calls.
    - A variety of patient encounters are required to obtain medical control at the discretion of the EMS Coordinators.
- The paramedic candidate must schedule a chart review with each EMS Coordinator at fifteen and thirty completed ALS calls. (More often if deemed necessary).
- The paramedic candidate may not be part of a two-person crew until an EMS Coordinator has signed off the first fifteen calls.
- Following the first fifteen approved calls, the preceptor and the candidate may constitute a crew and perform paramedic-level skills and interventions.
    - The candidate may be allowed to transport priority 2 level calls should the preceptor deem appropriate.
    - The candidate must have a preceptor in the patient compartment on any CMED designated priority one call until the precepting paramedic has been cleared from precepting.
- Upon completing the call requirements, the sponsoring EMS agency will request that the EMS Coordinator (s), Medical Director, or their designee monitor the candidate during a regular road shift.
- Clearing rides may be completed over a single shift or several shifts, depending on the call volume and performance of the candidate.
- If it is the opinion of the sponsoring EMS agency or the EMS Coordinator(s) that the candidate has not met the minimum competency of an entry-level paramedic, the

sponsoring EMS agency or EMS Coordinator may offer the candidate one additional round of precepting.
    - This may immediately follow the first precepting attempt.
    - This may also follow a retraining/remediation period at the discretion of the sponsoring EMS agency or EMS Coordinator(s).
    - The sponsoring EMS agency is under no obligation to re-precept a provider.
- Full medical control will be granted once the candidate has completed the precepting process and field clearance.
- Candidates completing the credentialing process with less than twelve months left in the renewal cycle will be given pro-rated CME requirements.

Maintaining Medical Control

All certified and licensed EMS providers are expected to keep current all required credentials and maintain in-service records. SHCGB has the right to request these records at any time for review.

Renewing Medical Control

- The medical control cycle in the SHCGB catchment is a two-year cycle.
- All licensed providers are responsible for acquiring and submitting the required CME hours in the appropriate categories based on current policy. (See Appendix C**)**
- Basic level providers are required to maintain current state requirements and current AHA BLS and state certification.
- If a provider was out on injury or military deployment for greater than half of the renewal cycle, medical control could modify the requirements on a case by case basis.

Lapses in SHCGB Medical Control

- Certified and licensed providers failing to submit the required credentials by stated deadlines will not be authorized to practice in the SHCGB region.
- Providers who allow a lapse in medical control for one year or less only have to submit a new application to reacquire medical control.
- Providers who allow a lapse in medical control for greater than one year but less than two years, and are not actively working as a paramedic in another region will be required to complete a new application and pass a protocol exam.
- Providers who allow a lapse in medical control for two years or more will be required to begin the precepting process as determined by medical control.

Suspension and Termination of Medical Control

Each Medical Director, in consult with at least one EMS Coordinator, is authorized to impose temporary suspensions or another temporary discipline upon EMS or Mobile Intensive Care (MIC) providers who are subject to medical control until the Medical Control Council can meet, which should be at the earliest possible date. Medical control may be terminated after the event review process.

Title: Medical Control Oversight--MICS

Purpose: For all service providers to comply with all conditions as set forth by this Sponsor Hospital for Mobile Intensive Care (MICS) and/or BLS skill authorization including, but not limited to, initial provider training and ongoing maintenance of competency, on behalf of the Sponsor Hospital Council of Greater Bridgeport (SHCGB), we agree to continue to provide medical control in accordance with Section 19a-179-12 of the Regulations of Connecticut.

Discussion: Under Section 19a-179-12 of the Regulations of Connecticut State Agencies that govern the delivery of pre-hospital emergency medical services, SHCGB has the authority to provide medical control to EMS agencies and its providers. Therefore, the SHCGB agrees to continue to provide medical control, provided the following requirements are met.

Scope: All EMS agencies currently sponsored by SHCGB or those interested in being sponsored by SHCGB.

Policy:

- Agencies must complete an agreement with the SHCGB and renew annually.
- At the time of renewal, all sponsored services agree to comply with all SHCGB policies, protocols, and procedures as part of the MICS credentialing process.
- Connecticut MICS forms and the completed state-required informational packet must be submitted to both hospital EMS Coordinators for signatures every year. The packet will also include the service's Quality Assurance policy approved by SHCGB.
- Services agree to attend quarterly Medical Control Meetings
- Each sponsored agency is responsible and accountable for maintaining the following documentation:
- Paramedics maintain at a minimum American Heart Association (AHA) ACLS, PALS, BLS, and State Licensure.
- Verification that new EMT providers hold a current AHA BLS card and have demonstrated competency in the following skills:
    - Epinephrine auto-injector administration
    - Intranasal naloxone administration
    - Automated external defibrillator
    - Assistance with nitroglycerin administration
    - Assistance with beta-agonist inhaler administration

Services that fail to meet the minimum requirements will be considered ineligible for Sponsor Hospital authorization and under no circumstances be allowed to function within SHCGB.

Title: Medication and Controlled Substances Policy

Purpose: Establish a standard for accountability and minimum requirements for drug inventory, documentation of usage, and replacement of controlled substances in accordance with Federal DEA rules and State of Connecticut Regulations. Only narcotics supplied by Bridgeport Hospital pharmacy may be carried on response vehicles as authorized by the Sponsor Hospital Council of Greater Bridgeport (SHCGB).

Scope: All SHCGB Paramedics

Policy:

1. All personnel authorized to administer drugs and all duly appointed supervisory staff responsible for inventory will always abide by this policy.
2. The sponsored agency will immediately notify the EMS Coordinator when a paramedic is no longer affiliated with their agency.
3. An authorized EMS provider shall not administer or assist with administering a drug without the verbal or written order of an authorized Emergency Department physician or as directed by written protocol.
4. Only drugs approved by the SHCGB EMS Medical Directors may be carried on ambulances. In addition, the Medical Directors and the State of Connecticut EMS Minimum Equipment List shall determine the number of drugs carried by the EMS agency.
5. Drugs may not be administered after their expiration date. All multi-drug kits will be labeled with the earliest expiration date of any product contained within, and that date shall be recorded during routine inspections. Expiration date labeling shall be the responsibility of the Bridgeport Hospital pharmacy department.
6. Paramedics are required to record all drugs administered with documentation of dosage, route, time, waste, and authorization on the ambulance run report. The paramedic will complete the run report and leave the hospital copy with the person assuming patient care.
7. Any unanticipated or undesired response directly attributable to the administration of a drug shall be reported to the receiving hospital Emergency Department physician and the EMS Coordinator and/or EMS Medical Directors.
8. Upon entering the medical control region, all paramedics must sign the narcotic agreement detailing narcotic handling. (See Appendix D)
9. All paramedics must complete a yearly narcotic signature card for signature verification.

Controlled Substances

Patient Care Responsibility and Procedure

1. Audit documentation must be generated and maintained every time a controlled substance kit is inspected or used or if direct responsibility for the kit changes hands.
2. After administration, the paramedic must record the medication, dosage, time, route, and Sponsor Hospital authorization on the narcotic administration paperwork.

Storage and Security of Controlled Substance Kits

1. Under no circumstances will controlled substances issued by any other facility other than Bridgeport Hospital be carried and stored in any vehicle.
2. All sponsored agencies and providers must provide adequate controls and procedures to guard against theft and diversion of controlled substances.
3. Controlled substance kits will be stored in a securely locked, substantially constructed vault, with at least two locks., The locks may be keyed, or a combination but must be independent of the vehicle locks. Electronic locks shall be capable of manual override when power to the vault is compromised. The on-duty shift commander shall maintain override access.
4. At no time will EMS agencies or providers store controlled medications outside of the vehicle's locked vault when not involved in the delivery of patient care. (See service agreements)
5. The sealed controlled medication kit may be removed from the vault and carried on the paramedic's person when there is a potential for the need to administer the medications at a location removed from immediate access to the paramedic vehicle.
6. The vehicle must always be locked when unattended.
7. The sealed controlled medication kit may be transferred between vehicles of the same service approved at the paramedic level. The paramedic assigned to the vehicle maintains the responsibility for the kit.
8. When a paramedic vehicle is taken out of service for no more than twenty-four hours, the controlled medication kit will remain secured in the vault. The vehicle will remain locked and placed under the direct control of the on-duty shift commander. The paramedic will inspect the controlled kit before going off-duty.
9. When a paramedic vehicle is placed back in service, the oncoming paramedic inspects the controlled kit.
10. If a unit is permanently removed from service for a period greater than twenty-four hours, the controlled medication kit assigned to that vehicle will be immediately turned in to the Bridgeport Hospital pharmacy or the hospital’s Pyxis machine for proper disposition.

Paramedic Accountability

1. The on-duty paramedic assigned to the vehicle is responsible for the controlled medication kit at all times. If the controlled substance kit is secured in an electronic vault with keypad access, the paramedic must remember their unique access codes. If the vault is key-controlled, the paramedic must always carry the keys on their person. Access to codes and/or keys that allow entry to the controlled substance vault shall be limited to the paramedic directly assigned to and responsible for the controlled substances. After the kit

is inspected, keys shall only be passed from the off-going paramedic to the oncoming paramedic.
2. Paramedics will visually inspect controlled substances every time responsibility for the kit changes hands (i.e., the beginning and end of every shift). Both the oncoming and off-going paramedic will evaluate the kit for seal damage, alterations in medication color and clarity, expired medications, and volume discrepancies. Inspections must be verifiable by audit documentation.
3. Any discrepancies in the controlled medication inventory will be documented in writing and reported immediately to the EMS Coordinator and the Bridgeport Pharmacy Department.
4. Every time a controlled substance kit is inspected, used, or direct responsibility for the kit changes hands, a complete audit documentation in the form of a signature log or other electronically generated documentation must be maintained.

Use and Disposal

1. The administration of controlled substances will be uniformly documented to reflect usage and waste accurately.
2. Opened kits will be returned to the Pyxis machine for exchange immediately after the call on which the drug(s) was used, or, if that is not possible, within that working shift.
3. Any time a controlled medication kit's seal is broken, the kit must be returned for proper exchange regardless of medication usage.
4. When exchanging kits, the completed Record of Use for Controlled Substances on Paramedic Vehicles form must be included with the following documentation:
    - Time of administration
    - Patient Name (Last name, First name)
    - Patient Home Address
    - Date of administration
    - Dosage and route of administration
    - Name and signature of authorizing Sponsor Hospital physician
    - Name of receiving facility
    - Name and signature of the paramedic who administered medication
5. Any unused amount of the opened medication must be wasted in the direct presence of an Emergency Department registered nurse or physician and its disposal documented on the Record of Use for Controlled Substances on Paramedic Vehicles form. Signatures of the paramedic and appropriate witnesses are required. Waste must be done at the hospital to which the patient was transported.. No medication in opened vials may be carried in a narcotic kit.
6. Accidental wastage, if not witnessed, must be thoroughly documented and explained by the paramedic on the Record of Use for Controlled Substances on Paramedic Vehicles form. The authorizing physician must sign the record of wastage form.

Section II: Clinical Care

Title: Clinical Authority on Scene

Purpose: This policy aims to delineate EMS provider authority and outline a process in the event of provider or inter-agency conflict regarding patient care.

Discussion: To maintain orderly scene management and allow for the rapid resolution of interprofessional conflicts, a hierarchy of clinical responsibility must be established.
In the event of disagreements regarding patient care, the focus must remain on what is in the patient's best interest. It is the responsibility of the on-scene credentialed providers to reach a consensus as to the most appropriate care for the patient(s).

Scope: All EMS agencies and providers sponsored as such in the Sponsor Hospital Council of Greater Bridgeport (SHCGB) Region.

Policy:

> ***Nothing in this statement shall be construed to limit the authority of the fire officer in charge under section 7-313e of the Connecticut General Statutes to control and direct activities at the scene of an emergency. The Fire Department within the municipality maintains responsibility for the management of the scene and the safety of all providers.***

Pursuant to the following documents:

- Public Act No. 15-223
- 2012 Sponsor Hospital Council of Greater Bridgeport (SHCGB) Medical Control Agreement with each agency.

It is the position of the SHCGB that all EMS, fire, and police personnel at the scene of an emergency work ***collaboratively*** to ensure the safe, orderly, and timely transfer of patient care and forward movement of patients.

Further, the SHCGB recognizes the following:

- ***This document is a best practice guideline. No document can be drafted that covers every variation of an emergency response.***
- A provider, as defined in Section19a-175 of the Connecticut General Statutes (CGS), holding the highest classification of licensure or certification from the Department of Public Health under chapters 368d and 384d of the CGS ***and*** is authorized to practice at the said level within the SHCGB catchment area shall be responsible for making decisions regarding patient care on the scene of an emergency.
    - Requests for Service requiring a multiagency response (i.e., EMS, fire, and/or police), the EMS organization providing transport shall assume responsibility

for making patient care decisions once they arrive on scene ***AND*** after establishing communication, ideally face to face, with the provider/fire officer in charge.
    - The provider/fire officer in charge of "boots on the ground" situational awareness may allocate resources as necessary in the interest of patient care while awaiting the arrival of EMS personnel.
    - Under routine circumstances, resources allocated to an emergency scene should not be canceled by a transporting EMS agency while en route to a scene.
        - A transporting EMS agency may cancel allocated resources with direct situational awareness regarding EMS system status ***after*** establishing direct radio communication with the provider/fire officer in charge on the scene as written in the municipality's standard operating guidelines.
    - Any requests for mutual aid resources should be coordinated as written in the municipality's standard operating guidelines.
- A provider assuming decision-making responsibility for patient care shall transfer care to a provider with a higher classification of licensure or certification upon arrival of such person on the scene of an emergency. For this statement, the order of licensure or certification from highest to lowest is:
    - Paramedic
    - Emergency Medical Technician
    - Emergency Medical Responder

- The SHCGB-credentialed paramedic on-scene has ultimate responsibility for patient care unless the care of that patient is transferred to another appropriately certified or licensed provider in accordance with Public Act No. 15-223
- In the event of unresolved conflict, the senior credentialed transport provider has final authority and responsibility for decisions regarding patient care.
- If there is a conflict involving a supervised provider, (i.e., graduate paramedic or student), the assigned Field Training Officer has the authority and should be consulted.
- All significant or unresolved conflicts are to be reported to the respective agencies involved via their chain of command, and their agency policies and procedures are to be consulted. Any such events will be reviewed in accordance with each agency's event review process.
- All providers are encouraged to report any on-scene conflicts if they feel patient care was adversely affected. The provider should reach out to the EMS Coordinator of the receiving hospital as soon as possible.
- Our collective desire is to work collaboratively with appropriately identified healthcare professionals on the scene of a medical emergency to enhance patient care. Our collective responsibility is to ensure that our patients only receive care from

appropriate, acceptable practitioners. To avoid on-scene confusion, only paramedics with current Sponsor Hospital authorization will wear clothing and other markers identifying themselves as paramedics.

For this document, the following definitions are used:

- **Emergency Medical Responder:** An individual certified to practice as an EMR under the provisions of Section 20-206ll or 20-206mm.
- **Emergency Medical Services Organization:** A public, private, or voluntary organization that offers transportation or treatment services to patients primarily under emergency conditions.
- **Emergency Medical Technician:** An individual certified to practice as an EMT under the provisions of Section 20-206ll or 20-206mm.
- **Firefighter:** A uniformed member of a paid municipal, state, or volunteer fire department.
- **Paramedic:** A person licensed to practice as a paramedic under the provisions of Section 20-206ll.
- **Patient:** An ill, injured, or physically disabled person requiring assistance and transportation.
- **Provider:** Any person, corporation, or organization, whether profit or nonprofit, whose primary purpose is to deliver medical care or services, including such medical-related care services as ambulance transportation.

Title: Patient Care Documentation Policy

Purpose: This policy is intended to outline the minimum required elements for patient care documentation for EMS agencies sponsored by the Sponsor Hospital Council of Greater Bridgeport (SHCGB). This policy applies to all levels of providers including those credentialed to provide specialty care transport.

Discussion: The primary purpose of the EMS chart review is to assure patient care adheres to treatment protocols outlined in the current version of the Connecticut EMS Statewide Protocols. Chart review is used as a basis for identifying quality improvement initiatives via data collection and analysis. As such, patient care reports must contain a minimum set of elements so that proper patient care and continuity of care is. Further, opportunities for improvement may be identified before any harm comes to a patient or provider.

Policy: The following represent the *minimum* required elements that must be included in all patient care documentation by EMS providers in the SHCGB region. EMS agencies sponsored by the SHCGB are expected to adopt these minimum requirements and encouraged to expand upon them to suit their agencies needs and interests. EMS providers who routinely fail to include these minimum requirements are subject to inquiry to identify barriers or challenges from preventing them from doing so.

General Requirements

- Run forms must be free from bias and present an objective account of the patient encounter
- Documentation of patient care shall be done immediately upon completion of patient care or transfer of care at the receiving hospital. All EPCRs must be completed before the end of a shift, preferably within eight hours (8) of arrival at the hospital.
- Providers that continually fail to complete charts in the required time are subject to loss of medical control authorization.
- Routine patient care should follow protocol 1.0 in the current version of the statewide EMS protocols.
    - ALS care includes the application of the cardiac monitor and IV access as needed.
    - IV access may be either a saline lock (as the patient condition dictates) or an IV line with normal saline or lactated ringers. Patients requiring paramedic level care and if any of these interventions are not performed, documentation must include the rationale for exclusion.
- Two sets of complete vital signs are required on all patients. On average, the “time with patient”, defined as the time from first medical contact to arrival at the receiving facility is 28 minutes. “Close proximity to the ED” and similar explanations for not assessing at least 2 sets of VS are not valid unless extenuating circumstances exist and are documented.

    - A complete set of vital signs, for the purposes of this document, is defined as blood pressure, heart rate, respiratory rate, temperature (subjective or objective), and pulse oximetry. A GCS will be included due to its ease of assessment and ubiquitous requirement on most, if not all, ePCR platforms.
- Blood glucose assessment should be reserved for patients exhibiting altered mental status with or without a history of diabetes. Routine assessment of blood glucose on patients who do not present with altered mental status is not necessary.
    - BGL's should be determined using the blood sample type for which the meter is designed. Venous blood samples should not be obtained on meters calibrated for capillary blood and vice versa unless the blood glucose monitor is calibrated for venous samples and there is manufacturer's documentation that a BGL from a venous sample is equivalent to a capillary sample and vice versa.
- The patient's weight in kilograms is required on all pediatric patients and on any patient where a weight based medication was administered.
- Medications are to be administered as outlined in the most current version of the statewide EMS protocols. Any deviation from protocol must include a rationale for administering a different dose and must be done through direct medical oversight. An EXCEPTION FORM must be completed in these instances.
- Expletives are NOT TO be included in the run form. This is, in a word, unprofessional and lends nothing to the description of the patient encounter. If, in the opinion of the documenting provider, such language must be included, statements such as "expletive deleted" or something to a similar effect are an acceptable replacement for the actual word.
- Medical abbreviations should be limited to those accepted by a reliable source. Two examples include Taber's Online (https://www.tabers.com/tabersonline/view/Tabers-Dictionary/767492/all/Medical_Abbreviations) and openMD (https://openmd.com/dictionary/medical-abbreviations). Each agency should consider identifying such a source for its own use.

Specific Requirements for sepsis, STEMI, stroke, and trauma

ACS/Non-traumatic chest pain

- Time of first medical contact
- 12 lead acquisition, interpretation, and time acquired (attach to PCR electronically)
    - Photographs of EKGs may be attached provided the ENTIRE EKG can be seen.
- Was a PAMI alert notification made and the notification time?
- Aspirin administration for appropriate patients and dose (or "catch-up" dose.)
    - Document if the patient has taken aspirin and what dosage prior to arrival

- Use of nitroglycerin prior to EMS arrival, how many tablets/sprays, and time taken
- Use of erectile dysfunction drugs within the last 48 hours and type

Stroke/CVA

- The time the patient was last known well
    - The LKW time is defined as the last time the patient can be confirmed to be at their baseline.
- Performance of and the time a Cincinnati Pre-Hospital Stroke Scale (CSS) was assessed
- Documentation of each component of CSS score
    - For example, document facial droop, slurred speech and pronator drift rather than CSS of 3.
- Blood glucose level via finger stick
- Was stroke alert notification made and the notification time?
- Contact information of a reliable family member/ witness

Sepsis

- Documentation of temperature, either subjective/tactile or through the use of a thermometer
- A complete sets of vital signs as defined in this document
- End tidal CO2 with attached values and waveforms
- Administration of a fluid bolus and total volume infused
- Was a sepsis alert notification made and the notification time?

Trauma

- Mechanism of injury and description
- Documentation of each component of the Glasgow Coma Score
    - For example, document E4, V5, M6, rather than GCS 15.
- Application of SMR.
    - If SMR was not applied/ performed documentation of c-spine clearance and the assessment used to clear the cervical spine according to protocol 4.5
- IV access if attempted.
    - If IV access was not attempted or deferred, a rationale must be documented.
- Steps taken to preserve body temperature of patient suffering from major trauma
    - Major trauma is defined using a validated scale during the PCR review process. For the purposes of this document, major trauma include, but not limited to
        - Penetrating to the head, neck, torso, proximal extremities
        - High speed MVA w/wo ejection
        - Fall from a substantial height

    - Hemodynamically unstable patients due to a traumatic cause
- Accurate location(s) of any injuries using the specific medical terminology
- Start and end times of extrication when applicable
- Was a trauma alert notification made and the notification time?

The Narrative

The narrative is the cornerstone of a patent care report (PCR). It must be clear, concise, and contain the necessary information to maintain continuity of care. It is understood that components of the narrative may be completed elsewhere in the electronic PCR. Provided the documentation accurately reflects the care provided to the patient, SHCGB does not expect a provider to repeat in the narrative what can be documented elsewhere.

Primary Assessment

The primary assessment is meant to identify and address any life threats. As such, assessment and documentation of the primary assessment addressing massive hemorrhage the airway, breathing, circulation/perfusion, and neurological disabilities/long bone deformities must be included.

History Taking

History of the Present Illness (HPI).
An as through as possible HPI must be documented including as many components of the OPQRST-AS/PN mnemonic that can be included. OPQRST AS/PN for the purposes of this document is defined as onset, provocation/palliation, quality, radiation, severity, time, associated symptoms and pertinent negatives.
SAMPLE(R) History
An as through as possible SAMPLE(R) history must be documented including as many components of this mnemonic that can be included. SAMPLE(R), for the purposes of this document is defined as signs and symptoms, allergies, medications, last oral intake, events leading up to the illness/injury, and risk factors.
Medical history, allergies, and medications:
Pertinent medical history, medications and allergies must be included. If any of these are not able to be obtained, reasons why must be documented. If a list of medications is provided and legible, it is acceptable to include a CLEAR photograph of the medications however, documenting "see list" or something to this effect without including the list is not acceptable. If no list is available, then this must be documented.

Physical Assessment

Unresponsive medical patients and patients suffering a significant mechanism of injury/trauma should have as much of a head to toe physical examination performed. Areas that are not or could not be assessed should be addressed by documenting "not assessed" and the reason why should be included.

Patients with isolated traumatic injuries or a specific chief complaint may have a focused physical examination performed.
In either case, the components of inspection, palpation, and, where appropriate, auscultation, must be addressed.

Vital Signs

Traditionally, the four primary vital signs are blood pressure, heart rate, rhythm, and quality, respiratory rate, rhythm, and quality, pulse oximetry, and temperature (either subjectively or objectively measured). For the purposes of this document a complete set of vital signs will include these vital signs and also include a GCS. When the patient condition warrants, pain ratings both before and after pain management, pulse oximetry, and end tidal CO2 must be included

The evidence for the use of pulse oximetry on healthy patients is equivocal although, like GCS, it is non-invasive, easy to assess, and readily available. Pulse oximetry may be used on all patients however, must be used on any patient suffering from a suspected cardiac or respiratory etiology. At no time should a pulse oximeter be used to assess a patient's heart rate alone. The rhythm and strength of the pulse offer meaningful insight into a patient's condition. This is something that a pulse oximeter cannot provide.

An initial *manual* blood pressure should be obtained on all patients. The literature is clear that the aneroid sphygmomanometer is more accurate and influenced less by individual patient variables. The osscilometric (automatic) blood pressure cuff may be used for assessing subsequent blood pressures provided the readings between the auscultated and osscilometric blood pressures are consistent. At any time a reading appears to be spurious, a manual blood pressure should be assessed. Palpation of blood pressures should be avoided when possible. If a blood pressure is palpated, a reason why must be included. Reasons for not obtaining a blood pressure such as "multiple layers of clothing" are not acceptable.

Case Specific and Procedural Required Elements

Airway

For BLS providers, assess the potential difficulty of ventilating a patient with a BVM using the ROMAN mnemonic:

- **R**adiation/Restrictions
- **O**bese/Obstruction/OSA
- **M**ale/Mallampati/Mask Seal
- **A**ge
- **N**eck stiffness

Difficult intubation:

The LEMON assessment should be used and documented when considering endotracheal intubation with or without the use of rapid sequence intubation.

- **Look externally:** for clues that may hamper the attempt
- **Evaluate the 3:3:2 rule:** three fingers between incisors, thyro-mental distance of three fingers, hyoid to cricoid distance of two fingers
- **Mallampati score:** Scores greater than 2 are at increased odds of a difficult intubation
- **Obstruction:** Swelling, secretions, tumors, etc.
- **Neck mobility:** Neck stiffness that would prevent optimal positioning

Intubation/advanced airway management

- Indications for choosing to intubate the patient?
- Patient's weight in kg
- Medication dosages
- Preoxygenation: What technique was used to preoxygenate the patient?
- Blade type and size: curved, straight, 0-4, video laryngoscopy
- Intubation attempts and successes
    - An intubation attempt is defined as the placement of the laryngoscope blade into the patient's mouth
- Size of the ETT and depth at the lip line and how secured (e.g.. commercial device)
- Verification of placement via:
    - Auscultation (e.g. breath sounds clear and equal bilaterally w/o sounds over the epigastrium)
    - Direct visualization (e.g. the ETT was seen passing through and resting between the vocal cords)
    - Bilaterally equal chest rise and fall
    - Waveform capnography (a description of the wave form and ETCO2 reading)
        - continuous waveform capnography must be included on all intubated patients,
- If cricoid pressure was applied
- Secondary airway device used if intubation was not elected or not successful.
- For alternate airways, document the size, type, and technique used to insert the device must be documented

Cardiac Arrest

- Approximate time of collapse if it can be determined
- Was the arrest witnessed and if so, by whom (for example bystander, family member, EMS provider)
- When was last time the patient was seen awake or at their baseline?

- Presenting rhythm. This may be documented as “shockable” or “not shockable” if an AED was applied.
- Were dispatcher CPR instructions provided and/or lay person CPR performed prior to arrival.
- Use of an AED/ prior to arrival, number of shocks delivered and time of shocks delivered if known
- Use of mechanical CPR devices such as the LUCAS device and time of application if known
- If/when CPR was terminated and why.
- Was ROSC achieved, at what time, and what physical/physiological indications?
- What was the patient’s rhythm upon arrival at the ED?
- If resuscitation was not attempted in the field, why and what indications precluded the attempt.
    - Refer to protocols 6.7 and/or 6.15.
- If direct medical oversight was consulted, what facility and physician was contacted.
- What time was the presumption made?
- All EKG tracings attached to the ePCR

Analgesia/Sedation (patient or provider administered):

- Use of age appropriate pain scale with first and last pain score, at a minimum
- Use of basic adjuncts for pain management
- Patient weight in kg
- Medications and dosages administered with times
- Documented reassessment of pain following any intervention for pain management (e.g. ice packs, splinting, positioning, padding, etc.)

CPAP

Indications for the use of CPAP including the following:

- Clinical presentation
- The patient is alert and able to follow commands
- The patient respiratory rate is greater than 10 breaths per minute
- No evidence or suspicion of pneumothorax or other injury/procedure related to the tracheobronchial tree
- No active nausea or vomiting
- Initial PEEP setting, and any changes made
- Pulse oximetry reading

IV Infusions

- IV site
- Gauge of angio-catheter used

- Medication dosage and concentration, if applicable
- Fluid type and bag size
- Rate of administration (TKO or KVO is appropriate when a fluid bolus is not being administered)

MVC

- Type of vehicles involved and type of crash
- Restraints used
- Intrusion into the passenger compartment and other damage to the passenger compartment
- Position of the patients and was there any deaths within the passenger compartment
- Speed and skid marks present

Opiate OD

- BVM ventilation prior to any naloxone administration
- Was naloxone administered prior to EMS arrival, by whom, and how much
- Naloxone only administered for patients with suspected opiate overdose exhibiting hypo-ventilation
- Lowest effective naloxone dose administered

Refusal

- Please refer to protocol 6.12

Physical or Chemical Restraint

- Reason for restraint clearly documented and appropriate for use of restraint
- Attempt made to deescalate the patient prior to administering medications
- Assessment/reassessment of distal CMS documented after application of physical restraints
- Ventilation, oxygenation and hemodynamics closely monitored following any restraint.
- Patient weight in kg

Title: Paramedic Downgrade of Care to a Basic Level Provider

Purpose: To outline the criteria necessary for a paramedic level provider's transfer of patient care to a basic level provider.

Scope: All EMS agencies authorized as such in accordance with SHCGB policy operating within the Sponsor Hospital Council of Greater Bridgeport Region.

Discussion: Basic level providers have access to more knowledge and technology than ever before. As such, patients traditionally transported by paramedic level providers may no longer require this level of care. It has been proven that basic level providers can provide the necessary level of care for specific patient types, ensuring the patient is receiving the right level of care at the right time. However, the process and criteria for safely transferring care from a paramedic level provider to a basic level provider are not without risks. Therefore, clear criteria and a transparent process are necessary to reduce the likelihood of adverse events. Basic level providers have the right to decline the transition of patient care.

Policy: A paramedic may transfer care to an EMT level provider or crew for further care and transport ***only*** if all the following criteria have been met:

- The paramedic has performed a complete and thorough documented patient assessment.
- The paramedic has a high degree of confidence that the patient would not benefit from advanced life support measures such as continuous hemodynamic monitoring, cardiac monitoring, IV placement, or medication administration.
- The paramedic and basic level provider(s) agree on a plan of care.
- The EMT level provider(s) agree to accept responsibility for subsequent patient care.
- It is the position of the SHCGB that the EMT level provider may attend to the patient and document the relevant patient management and the rationale for the triage to BLS. It is not necessary to generate two separate run forms where an EMT and paramedic are staffing the ambulance.

A paramedic ***may not*** transfer care to an EMT level provider/crew if any of the following exist:

- Interventions that have been implemented that are outside the basic level scope of practice.
    - 4 or 12 Lead ECG monitoring
    - Waveform capnography
    - ALS interventions/procedures initiated, including but not limited to vascular access and /or any medication administration, except those authorized under the basic level provider scope of practice or authorized for use in the SHCGB catchment area.

- An EMT level provider or crew is unwilling or expresses *any* concern with taking responsibility for patient care.
- The advanced level and EMT level providers cannot agree on a subsequent BLS plan of care.
- All cases in which patients are released to the care of BLS personnel must be thoroughly documented by the paramedic.
- Individual EMS agencies are responsible for ensuring all transfer of care events from ALS to BLS are documented in accordance with agency policies and procedures.

Title: STEMI Alert

Purpose: To identify patients with active ST-segment elevation MI (STEMI) as early as possible and to allow pre-hospital activation of the cardiac catheterization lab.

Scope: All EMS agencies sponsored as such in the Sponsor Hospital Council of Greater Bridgeport (SHCGB) Region.

Discussion: "Time is muscle." It has been proven that reducing the time from onset of STEMI to reperfusion improves outcomes in these patient types.

Policy: Patients exhibiting symptoms suspicious of an acute coronary syndrome will be treated per Connecticut Statewide EMS Protocol 3.0 (Acute Coronary Syndrome – Adult). Receiving hospitals should be advised of a STEMI alert for patients meeting ALL of the criteria below:

- Age of 35 or greater.
- Active chest pain or dyspnea at time of EMS primary assessment OR signs and symptoms suggestive of cardiac ischemia (nausea/vomiting, diaphoresis, dizziness, near syncope, or pain suggestive of cardiac ischemia).
- 12 Lead ECG demonstrating ST-segment (beginning at the J-point) elevations of at least 1mm in two or more contiguous leads or at least 2mm in two or more contiguous precordial leads (V1-V6).
- Patients exhibiting signs and symptoms suggestive of Acute ACS/STEMI should have a 12-lead ECG acquired as soon as possible, preferably within eight minutes from first medical contact.
- *Evidence of ST-elevation on a 4-lead rhythm strip is unreliable and should not be considered diagnostic of STEMI.*
- Absence of a paced rhythm or left bundle branch block (Supraventricular rhythm with QRS greater than 0.12 seconds in lead V1).
    - EMS should actively query/examine patient for the presence of a pacer.

The following criteria are considered supportive of STEMI diagnosis but are not required to be present when placing a receiving facility on a STEMI alert:

- Reciprocal changes, defined as ST-segment depression in opposing leads.
- Machine diagnosis of "ACUTE MI SUSPECTED."
- ECG machine diagnosis of "Acute MI" can be considered supportive of a STEMI. Furthermore, even with a computer interpretation of "Acute MI," the above criteria must be fulfilled.
- Patients exhibiting ST-segment elevations in the inferior leads should have a right-sided V4R performed to determine right ventricular involvement before Nitroglycerin (NTG) administration.
- Patients exhibiting isolated ST Depression in leads V1-V4 should have posterior leads V7-9 completed for any posterior wall involvement.

For patients exhibiting signs and symptoms consistent with acute coronary syndromes, a 12-lead ECG should be acquired within eight minutes of first medical contact (FMC).
For patients meeting the criteria above, the provider will advise CMED they have a "STEMI Alert" and request that CMED notify the receiving hospital.

This should be done from the bedside as soon as possible (preferably with 2 minutes of acquiring a 12lead ECG diagnostic for STEMI).

Once transporting, a patch must be made as early as possible requesting a STEMI alert. If the provider is unsure if the above criteria have been met, Direct Medical Oversight should be contacted for guidance.

Title: Stroke Alert

Purpose: To rapidly and reliably identify patients suffering from a cerebrovascular accident, to ensure the appropriate resources are available when the patient arrives at the receiving facility, and to facilitate rapid transfer to endovascular therapy-capable facilities when appropriate.

Scope: All Emergency Medical Services agencies sponsored as such in the Sponsor Hospital Council of Greater Bridgeport (SHCGB) Region.

Policy: Patients exhibiting signs and symptoms consistent with acute ischemic stroke (AIS) should be treated per Connecticut EMS Statewide protocol 2.25 (Stroke-Adult and Pediatric). EMS providers will place the intended receiving facility on a stroke alert for all patients demonstrating the following:

- Positive Cincinnati Prehospital Stroke Scale of 1 or greater
    - Please note:
        - Facial Droop: Ask the patient to smile and show their teeth.
            - Normal: Both sides of the face move equally well.
            - Abnormal: One or both sides do not move or move well.
        - Arm Drift: Have the patient extend his or her arms with eyes closed, holding them aloft for 10 seconds.
            - Normal: No arm drift is noted, or both arms drift equally.
            - Abnormal: One arm drifts when compared to the other.
        - Slurred Speech: Ask the patient to repeat the phrase, "You can't teach old dog new tricks."
            - Normal: No slurring is noted that is different from the patient's baseline.
            - Abnormal: Slurring of words that is not the patient's baseline.
- Blood glucose level greater than 60 mg/dL
    - If less than 60 mg/dL, treat hypoglycemia per-protocol 2.12A.
- Last known well: within 24 hours.
    - Defined as the last time the patient was observed to be at his or her baseline.
- Other considerations:
    - Balance disturbances
    - Visual disturbances

<u>Other considerations:</u>

- Package the patient, elevating the head of the bed 30 degrees.
- Keep on-scene times as short as possible, preferably less than 15 minutes.
- Obtain a 12 lead ECG if possible.
- If available, either transport a reliable witness with the patient to verify the onset of the symptoms, or secure the contact information of a family member who can confirm the LKW time.
- Reassess the patient frequently for resolution or worsening of symptoms.

Title: Adult Sepsis/Septic Shock Alert

Purpose: The purpose of this policy is to outline criteria to rapidly identify patients that are at higher risk of being septic.

Scope: All EMS agencies authorized as such operating within the SHCBG catchment area.

Discussion: Sepsis is defined as a systemic inflammatory response of the body in response to infection. The infecting pathogen triggers an overwhelming immune response causing widespread inflammation, microvascular blood clots, and fluid shifts impairing blood flow and oxygenation to critical organs such as the brain, lungs, kidneys, or liver. When sepsis is not suspected or treated promptly, hypotension, organ damage, or MODS may result.

Policy: The provider will place the receiving facility on a SEPSIS alert when a patient exhibits at least two Systemic Inflammatory Response criteria (SIRS) criteria with a suspected or confirmed infection. It is expected that all potential sepsis patients have a temperature taken by EMS as part of the standard assessment.

- Must be over 18 years old.
- SIRS Criteria
    - Temperature less than 36 degrees (C), greater than 38 degrees (C), or feels clinically febrile.
    - Heart rate higher than 90 beats per minute.
    - Respirations higher than 20 breaths per minute OR the patient is mechanically ventilated.
    - New-onset altered mental status or a change in mental status from the patient's baseline.
    - Hypoperfusion evidenced by SBP less than 90 mmHg or MAP less than 65 mmHg.
    - EtCO2 less than or equal to 25 cmH2O.

- Confirmed infection or history highly suggestive of infection including but not limited to:
    - Recent antibiotic therapy.
    - Recent medical/surgical infection or recent hospitalization.
    - Indwelling Foley catheter.
    - Tubes into body cavities (PICC, central lines, PEG tubes, etc.).
    - Immuno-compromised patients (AIDS, cancer, etc.).
    - Chemotherapy within the last six weeks.
    - A resident of a skilled nursing or rehabilitation facility.
    - Evidence of cellulitis, dysuria, cough with or without sputum production, bedsore(s) or other non-healing wounds, diarrhea, or abdominal pain.

Pre-hospital management of the septic shock patient will follow Connecticut EMS Statewide protocol 2.22 A.

Title: Trauma Alert

Purpose: This policy is intended to outline the process for activating a pre-hospital trauma alert when a patient meets the criteria listed below.

Scope: All EMS agencies authorized as such operating within the SHCBG catchment area.

Policy: Pre-hospital providers will place the intended receiving facility on a trauma alert when a patient(s) meets one or more of the following criteria. **Please note:** There are no "levels" for trauma alerts for pre-hospital providers. It is either a trauma alert, or it is not. Once alerted, the receiving facility will determine the appropriate level of alert for the patient based on the receiving facility's pre-established guidelines. Hospital-specific terminology should not be used to describe EMS trauma alert activations.

***PLEASE PLACE THE TRAUMA ALERT AS SOON AS POSSIBLE, IDEALLY WHILE STILL ON SCENE. ***

- **Physiologic Criteria**
    - SBP less than 90 mmHg in an adult or SBP less than (70+2 X age in years) in a child.
    - GCS of 13 or less or a deviation from the patient's baseline resulting from a traumatic mechanism.
    - Respiratory distress or airway compromise.
- **Anatomic Criteria**
    - Penetrating injuries to the head, neck, torso, abdomen, pelvis, or extremities excluding the hands or feet.
    - Chest wall instability, including flail chest.
    - Evidence of spinal cord injury with motor deficits (i.e., paralysis, paraplegia, quadriplegia, lateralizing signs) or sensory deficits (i.e., paresthesia or sensory changes).
    - 2d or 3d-degree burns with greater than 5% TBSA or ANY burns involving the airway.
    - Traumatic limb amputation excluding digits.
    - Multiple or open long bone fractures.
    - Injuries to one or more organ system.
    - Crushed, de-gloved, pulseless or mangled extremity.
    - Open or depressed skull fracture.
    - Pelvic fracture as evidenced by visible deformity or pelvic instability
- **Mechanism Criteria**
    - Significant vehicle deformity with at least 12 inches of intrusion into the passenger compartment, steering wheel deformity, dash deformity, or at least 18 inches of intrusion to any part of the vehicle.
    - Partial or complete ejection from a vehicle.
    - Unrestrained occupant in rollover.

- Prolonged extrication (greater than 20 minutes).
- Death of same-vehicle occupant.
- Pedestrian or bicyclist struck, run over, or thrown by an automobile traveling greater than 20mph.
- Hanging or drowning event.
- Fall from a height greater than 20 feet for an adult or greater than 10 feet for a child.
- Falls with evidence of/or history of a head injury/strike while on anticoagulation including, but not limited to, Coumadin (Warfarin), Pradaxa (Dabigatran), Eliquis (Apixaban), Xarelto (Rivaroxaban), Lovenox (Enoxaparin) or Savaysa (Edoxaban). Excludes anti-platelet drugs like aspirin, Plavix, and Brilinta.

- **Other Considerations**
  - Extremes of age: Less than 5 or greater than 55 years old.
  - 20 weeks gestation or more.
  - Provider discretion when a high index of suspicion warrants trauma alert activation.
  - Whenever possible, keep family members together.
  - Bridgeport Hospital is the designated destination for critically ill/ injured children or adult and pediatric burn victims, unless the patient is in cardiac arrest or has an unstable airway.

<u>Upon arrival at ED:</u>

- Only those EMS providers directly involved in patient care should be in the trauma room.
  - Exceptions include the need for additional manpower to assist with lifting and moving a patient.
- After observing the "EMS Time-Out," the EMS provider should give a full verbal report to the ED physician or trauma surgeon.
- The provider should remain available to answer questions from the ED physician or trauma surgeon.
- EMS crew members that are needed for another emergency response will be relieved immediately upon notification of the ED physician or trauma surgeon.
- Every attempt should be made to complete your run form before departing the receiving facility. If this is not possible, the run form must be completed as soon as possible per the SHCGB documentation policy.

Title: Patient Destination Determination

Purpose: The purpose of this policy is to provide guidance for transporting EMS agencies when determining the appropriate destination for patients who cannot identify a preferred facility or do not have a preference.

Scope: All EMS agencies authorized to operate within the SHCBG catchment area.

Discussion: Any patient requesting emergency medical services who consents to transport shall be transported to a licensed acute care hospital as defined by one that is equipped, staffed, and prepared to receive emergency cases and administer emergency medical care appropriate to the needs of the patient. (Note: this does not preclude the transport of a patient to other facilities during non-emergency interfacility transfers or scheduled non-emergency transports at the request or direction of the patient's private physician.)

Policy: A patient should be transported to their facility of choice unless one of the following circumstances exist:

- The patient does not state a preference: In this case, the patient should be transported to the closest appropriate facility within the region based on agency operating guidance approved by SHCGB.
- Every effort should be made to transport critically ill or injured patients to the appropriate closet facility regardless of the patient's preference for the management of any life threats.
- Bridgeport Hospital and St. Vincent's Medical Center are considered equivalent with regard to capabilities. With the exception of bypass, it will be considered acceptable to transport patients to either facility.
- Trauma patient destination shall be determined in accordance with the State of Connecticut Trauma Regulations.
- All current EMTLA laws should be followed
- Patients on blood-thinning medications with evidence of a head strike/injury should be transported to the closest trauma center in accordance with current SHCGB trauma alert criteria.
- EMS Crews should not bypass one hospital for another based on provider preference.
- Bridgeport Hospital is the designated destination for critically ill/injured children and/or adult and pediatric burn victims. Patients meeting these criteria may be transported to St. Vincent's Medical Center if the patient does not have a secure airway or is otherwise too unstable to be transported to Bridgeport Hospital.

Title: Field Communications / Direct Medical Oversight (DMO)

Purpose: This policy is intended to guide all levels of field providers regarding radio transmissions and requests for DMO.

Discussion: Timely and appropriate communications allow EMS personnel to obtain direct medical oversight and afford the receiving facility the ability to plan for appropriate distribution of resources, activate clinical response protocols, and improve overall hospital patient flow.

Policy:

1. All SHCGB sponsored response vehicles shall have two-way voice communication equipment to provide direct contact with hospital Emergency Departments throughout the response and patient contact.
2. To ensure a timely response, Emergency Department nurses carry portable CMED radios.
3. Any incident involving three or more patients should be considered for the implementation of an Incident Command System (ICS). Communication with the hospital(s) should be centralized through the transportation group.
4. Field-to-hospital communications should take place before leaving the scene.
   In complex cases involving high acuity or multiple patients, an early notification with limited but accurate information is more important than a detailed report made just before arriving at the hospital.

Procedure:

1. To establish contact with the hospitals, contact CMED by radio or phone and request a patch to the receiving hospital. All phone calls should be via CMED only and not directly calling the ED to ensure a recorded line.
2. Identify whether you wish to give a standard report or consult with medical direction.
3. Identify any unique circumstantial qualifiers (i.e., STEMI Alert, Stroke Alert, HazMat).
4. When consulting DMO, verify that a physician is on the line and obtain identification when possible.

For the high-acuity patient, the report should include the following:

- Unit ID and level of provider
- Age and gender
- Chief complaint
- History of the present illness
- Findings of the physical exam
- Mental status
- Vital signs
- Treatments/Interventions
- Response to treatments/interventions
- Questions
- ETA

To establish direct radio communication with Bridgeport Hospital and Hartford Healthcare St. Vincent's Medical Center:

1. Tune CMED radio/portable to Southwest Med Channel 9.
2. Request the appropriate priority "patch" to the destination facility.
3. Await acknowledgment from CMED dispatchers and direction to change over to Southwest Med Channel 3 for Bridgeport Hospital and Southwest Med Channel 8 for St. Vincent's Medical Center.
4. Await acknowledgment from charge RN.
5. Confirm your transmission is audible by stating the following:
    - "[Unit number] to [destination facility] how do you copy."
    - Await acknowledgment
    - Proceed with transmission

<u>Direct Medical Oversight (DMO)</u>

Any request for medical control orders from DMO must be relayed via a CMED-recorded MED channel or over a recorded phone line. When a provider wishes to consult with DMO for patient care/transport decisions or approval of the specific clinical treatment, direct radio communication should be established between the field provider and the physician at the intended receiving facility. The provider *must* request "direct medical oversight" when requesting a patch

To ensure continuity of care, once DMO has been established, the paramedic will follow the physician's medical orders within the scope of the current CT Statewide EMS Protocols.

- Orders relayed via DMO must be documented in the patient care report, including physician names.
- When an order is given by DMO, the provider will repeat the order to verify its accuracy.
- If DMO requests an intervention outside the scope of practice for the given provider, the provider will advise DMO.
- Verify receipt of information and wait for DMO to verify the conclusion of communications.
- ***Under no circumstances should a provider perform an intervention outside his/her scope of practice***.

Title: Interfacility Ambulance Transfer Guidelines

Purpose: To provide appropriate care for patients during interfacility transports in accordance with federal and state regulations and Sponsor Hospital guidelines.

Definition: An interfacility ambulance transfer is defined as any EMS ambulance transport from one healthcare facility to another. Examples include hospital-to-hospital, hospital-to-rehabilitation, and hospital-to-longterm care. (Guide for Interfacility Patient Transfer, NHTSA, April 2006.)

Authority:

1. COBRA regulations require all medical facilities and physicians who participate in Medicare to have a transfer organized through qualified personnel and transport equipment for each patient who must be transferred. This is the responsibility of the referring hospital.
2. Personnel should be trained to deal with the current medical condition of the patient and any reasonably foreseeable complication that could occur during transport.
3. Sponsored EMS agencies have the responsibility of notifying the EMS Coordinator of the types of transfers being requested to facilitate the assessment and training of personnel by the sponsoring hospital.
4. Patient care responsibility during transfer lies with the referring institution until the patient is received at another facility. Overlapping responsibilities with the EMS provider's Sponsor Hospital may occur if the patient deteriorates enroute, and unforeseen treatment is required.

Procedure:

1. Authorized by Level of Provider

    - Emergency Medical Technician
        - Must be a stable patient with no risk for deterioration.
        - Permitted non-contact therapies and devices, which must not be manipulated by EMS personnel.
        - Saline lock (No IV infusions).
        - Previously inserted Foley catheter, suprapubic tube, established feeding tube (NG, PEG, J-tube not connected to infusion or suction).
        - Patient-managed medication pumps (Route of administration must be through a venous catheter).
    - Paramedic
        - Transcutaneous pacing
        - Advanced airway management
        - CPAP
        - Medical monitoring devices, procedures, and medication monitoring and administration consistent with the current formulary and scope of practice. Monitoring of heparin and nitroglycerin infusions permitted.
        - Monitor central venous catheters (e.g., CVP line without active monitoring; triple lumen catheter; subclavian, internal jugular, or femoral line - but NOT

including Swan Ganz catheters), or Implantable Central Venous Catheters (e.g., Hickman or Broviac Catheter).

When the level of care required exceeds the training and/or capabilities of EMS personnel, an SCT-endorsed paramedic shall be sent, or hospital staff shall accompany the patient. Examples of conditions which may require accompaniment by hospital-provided personnel (MD, RN, RT) include:

- Medications administered are beyond the scope of paramedic/SCT training.
- Equipment/devices in use are beyond the scope of paramedic/SCT training.
- When the attending physician directs that other staff are needed.

EMS personnel will not transfer patients receiving treatments or utilizing equipment for which they have not received documented training and SHCGB endorsement without being accompanied by personnel appropriately credentialed in such treatments/devices.

2. Transfer Orders
   a. EMS personnel will receive a patient history and a patient status report from the hospital physician sending the patient and will have access to all pertinent medical information.
   b. Written orders for care during transfer will be obtained by the paramedic from the referring hospital staff.
   c. In the event of a change in patient condition during a non-physician accompanied transport, standing orders appropriate to the patient condition will be implemented, and DMO will be contacted from the referring facility for implementation of options per Sponsor Hospital guidelines.
   d. If the patient is not stabilized following these interventions and DMO is not available for consultation, the patient will be transported to the nearest appropriate facility for stabilization.

3. Communication
   a. EMS providers must follow their sponsoring hospital guidelines regarding notification of DMO before the transport of patients and regarding radio report to receiving facilities.
   b. Any unanticipated deterioration of the patient enroute should be communicated to the receiving facility or the sending facility, depending on location and radio reception availability.

4. Documentation
   a. All patient transfers will have a thorough run report completed. All assessment, care, and interventions must be documented in keeping with current standards.
   b. The name(s) of any hospital staff accompanying the patient should be documented on the EMS report.

c. A copy of the completed chart or timely access to a print out of the electronic ambulance record must be provided to the receiving facility at the time of the transfer.
d. A copy of the chart shall be submitted to the SHCGB EMS Coordinator on request for performance review.

Title: Specialty Care Transports

Purpose: To provide appropriate levels of care for patients during interfacility transports in accordance with COBRA & EMTLA regulations and responsible Sponsor Hospital guidelines.

Policy: Specific guidelines will be provided to paramedics who provide interfacility transports and wish to receive additional training to allow them to transfer patients with medications and equipment beyond those contained in this document. Only those paramedics trained and authorized by SHCGB and their service may utilize these advanced guidelines.

1. Responsibility
   a. It is the responsibility of the referring facility and physician to ensure any interfacility transport complies with all applicable COBRA regulations and is affected through qualified medical personnel using equipment appropriate for the patient encounter.
   b. Interfacility personnel should be trained to manage the current medical condition of the patient and any reasonably foreseeable complication that could occur during transport. If any personnel are not trained, authorized, and/or comfortable with the complexity of the patient, medications, medical devices, and/or equipment, they must advise the sending facility personnel and request an appropriate staff member accompany the crew for transport.
   c. Patient care responsibility during transfer lies with the referring institution until the patient is received at the destination facility. Overlapping responsibilities with the EMS provider's sponsoring hospital may occur if the patient deteriorates enroute.
   d. Sponsored EMS providers are responsible for retrospectively notifying their Medical Director of the types of transfers being requested to facilitate assessment and training of personnel by the sponsoring hospital.

2. Oversight

The Sponsor Hospital Council of Greater Bridgeport (SHCGB) will oversee interfacility transfers under these guidelines and review all transports with the transporting agency's quality assurance department. The transporting agency will forward all SCT level ePCRs to the EMS Coordinators for review monthly.

   a. All SCT level paramedics will be required to attend a refresher/recertification course on a bi-annual basis sponsored by their EMS agency. These courses will be attended by at least one member of the SHCGB Council member. These will include one lecture-based and one scenario-based review yearly.

3. Procedure
   a. Specific guidelines will be provided to paramedics who provide interfacility transports and wish to receive additional training to allow them to transfer patients with medications and equipment beyond those contained in this document. Only

those paramedics trained and authorized by SHCGB and their service may utilize these advanced guidelines.

b. Paramedics are required to attend an SHCGB approved SCT/CCT course, which consists of no less than forty hours of advanced patient care curriculum.
c. Paramedics wishing to gain credentials at the specialty care transport level must have a minimum of six months of experience before registering for an approved course. The candidate is required to have at least nine months of experience before being allowed to work at the SCT level.
d. Interfacility transport personnel will not transfer patients receiving treatments or utilizing equipment outside the scope of practice for the level of training. This may require that hospital personnel are present in the patient compartment during transport. In cases with polypharmacy and/or sophisticated equipment, either the provider or the sending facility may elect to send or request trained staff to accompany EMS.

4. Transfer Orders

a. Written orders for ALS care during the transfer on a non-physician accompanied transport will be obtained \ from the referring hospital staff by the paramedic.
b. EMS personnel will receive patient history and a patient status report from the sending facility staff and will have access to pertinent medical information. This will include consultation with respiratory for all patients needing airway support.
c. In the event of a change in patient condition during a non-physician accompanied transport, standing orders appropriate to the patient's condition will be implemented, and medical direction will be contacted for implementation of medical direction options per Sponsor Hospital guidelines.
d. If the patient is not stabilized following these interventions, and medical direction is not available for consultation, the patient will be transported to the nearest appropriate facility for stabilization.

5. Communication

a. EMS providers must follow their sponsoring hospital guidelines regarding notification of medical direction before transport of patients and regarding radio report to receiving facilities.
b. Any unanticipated deterioration of the patient enroute should be communicated to the receiving facility or the sending facility, depending on location and radio reception availability.

6. Documentation

All interfacility transfers will have an Emergency Medical Service run form or electronic Patient Care Report (ePCR) or authorized equivalent completed. All assessments, patient care, and interventions must be documented in keeping with current standards.

a. The SHCGB transport form is required to be completed and submitted with the PCR when completed. The form should be attached to the run form where possible. The form must be clear and easy to read regardless of how attached.
b. The name(s) and appropriate credentials of any hospital staff accompanying the patient should be documented on the run form.

c. At a minimum, the narrative should contain a history of the present illness, including the circumstances leading to the initial admission and reason for the transfer.
d. All medications or other equipment settings must be documented on the ePCR.
e. A copy of the completed run form and the transfer orders should be left at the receiving facility at the time of the transfer.
f. A copy of the completed run form should be retained by the service.
g. A copy of both forms should be submitted to the provider's sponsoring hospital in accordance with their guidelines for documentation.
h. The ventilator setting must be documented on the ePCR at the beginning and end of the transfer.

7. Scope of Practice

a. The Specialty Care Transport Program includes state and sponsoring hospital-specific protocols as approved by the EMS Medical Director.
b. In addition, credentialed ALS personnel, as designated in Appendix B, may monitor the following therapies **in Appendix B** during transport.
c. Patients with more than three (3) running medications will require the assistance of an additional paramedic or hospital staff member.

See Appendix B for Formulary

Section III: Quality Assurance/Continuous Quality Improvement

Title: Quality Assurance and Improvement

Purpose: To outline the SHCGB Quality Assurance and Quality Improvement program.

Scope: All EMS agencies authorized as such in the Sponsor Hospital Council of Greater Bridgeport (SHCGB) catchment area.

Policy:
The Sponsor Hospital Council of Greater Bridgeport (SHCGB) is committed to the provision of quality, outlined in the Regulations Governing the Delivery of Emergency Medical Services June 1988, Section 19a-179-12, items (6) and (7). As a sponsor to several approved Mobile Intensive Care Services within our community, SHCGB has agreed to assume the responsibilities outlined in Connecticut General Statutes and Regulations governing the delivery of Emergency Medical Services.

Both St. Vincent's Medical Center and Bridgeport Hospital appoint an EMS Medical Director, EMS Coordinator, and Emergency Department Administrator to serve on SHCGB. The EMS Coordinators work closely with the EMS Medical Directors and are responsible for monitoring the quality of care provided by pre-hospital personnel. St. Vincent's Medical Center and Bridgeport Hospital are staffed twenty-four hours a day with dedicated emergency physicians responsible for providing online medical direction to pre-hospital personnel. The Southwest CMED System links the Emergency Department physicians to pre-hospital personnel via radio and recorded phone lines.

SHCGB Program's Quality Assurance Function:

Bridgeport Hospital and St. Vincent's Medical Centers' Department of Emergency Medicine have a Quality Assurance and Risk Management plan intended to meet the following objectives:

- Assure high quality of care to all patients evaluated and treated in the Emergency Department.
- Comply with the Joint Commission and Department of Health standards and regulations.
- Early recognition of potential areas of concern and the correction of such situations.
- Provide a mechanism for evaluating and improving an individual practitioner's knowledge and skill base.

As part of the Emergency Department's Quality Assurance Program, the quality and appropriateness of patient care provided by EMS personnel are consistently monitored and evaluated.

Secure and confidential files are maintained on all pre-hospital care providers with authorization to function within the SHCGB system. Records are kept regarding medical control remediation or discipline, commendations, CME attendance, and call reviews.

The EMS Coordinators are responsible for the Quality Assurance and Improvement process as it relates to pre-hospital personnel. Emergency Department staff who have a concern regarding the EMS system or an individual provider's actions on a specific case may escalate this concern directly or through their management to the EMS Coordinator.

SHCGB, through its MIC Medical Directors, may withhold authorization from a MIC-level EMS provider or service as per state regulations.

The SHCGB maintains a planned and systematic quality management process through the following means:

1. Incident-based report of care below the expected standard.
2. EMS Coordinators will have access to all EMS services ePCR systems for QA activities.
3. A complaint or concern brought to the attention of the EMS Coordinators will initiate an investigation.
4. EMS Coordinators will review a percentage of monthly EMS ePCRs generated for all transports. The selection of ePCRs is focused on high acuity patient encounters, such as cardiac arrest, trauma, STEMI, and stroke. Reports are screened for completeness, times, and protocol adherence, along with local operating policies and procedures.
5. Additionally, each EMS Coordinator may review, on a monthly basis, all ePCRs, including IFTs, SCTs, and refusals.
6. During the advanced provider's medical control authorization renewal process, proficiency is assessed by both the number and success rate of advanced interventions (e.g., intubations, IV's, etc.), an ALS skill station review, and a potential written protocol exam. A review of CME hours is also conducted to ensure that providers meet SHCGB standards.
7. Medical Control reserves the right to conduct field observations and accompany any SHCGB provider on calls to monitor the provider or service's proficiency in rendering quality patient care. Results are forwarded directly to the MIC medical directors.
8. Each EMS Service receiving sponsorship from SHCGB must submit a written QA program for their service identifying the Quality Assurance Officer and a brief description of their internal QA process. The process must include a proactive review of agreed-upon quality metrics and must have the ability to locate review criteria. Furthermore, the EMS service must report to SHCGB any identified QA concerns, which are suspected to involve clinical care that does not meet the standard of care, including but not limited to deviations from existing protocols and policies.

Clinical Event Review Process

For any issues that are identified, regardless of how the issues are determined (i.e., whether found reactively or proactively), the process is as follows:

- EMS Coordinator initiates an investigation and determines if there is reasonable cause to proceed. If so--
- EMS Coordinator may consult with one or both EMS Medical Director(s) if needed/desired.
- EMS Coordinator will advise the other EMS Coordinator of the concern that was identified.
- If the concern is of considerable significance, one Medical Director, in consult with at least one EMS Coordinator, is authorized to impose temporary suspensions or another temporary action upon any EMS services or EMS providers who are subject to medical control until the Medical Control Council can meet, which should be at the earliest possible date.
- EMS Coordinator will forward concerns identified to the EMS service Chief or designated representative and ask for a service review of the concern before medical action, unless deemed critical intervention is needed. (See Appendix G)
- The EMS Coordinator will review the service's review and recommendations in consultation with the EMS Medical Director if needed. SHCGB may accept or modify the service's proposed remediation activities (e.g., education/consultation with a provider) at this time.
- If determined to be necessary, the EMS Coordinators may elect to conduct an additional call review with the individual(s) involved in the call, along with the service representative(s) and at least one EMS Medical Director.

Clinical Performance Review

- The EMS Coordinator will convene a Clinical Performance Review when sufficient information exists to warrant a more thorough and complete investigation before making decisions regarding a provider's credentialing privileges. All Clinical Performance Reviews will be conducted in a fair, objective, respectful, confidential, and patient-focused manner.
- Conflicts of interest may be managed by the Medical Director to ensure a fair and objective review.
- All aspects of the review, including the notes of the proceedings and documents, are considered confidential. No recordings will be allowed unless authorized explicitly by the Medical Control Council.
- All persons involved in the review follow all requirements for confidentiality, as described in the Clinical Performance Review Process document.
- Each organization and individual provider will fully participate in the Clinical Performance Review, as requested by the EMS Coordinator. Failure to do so may result in the suspension or permanent revocation of a provider's credentials by the Medical Control Council.

- The Clinical Performance Review will be conducted in an expedient manner without compromising the focus on performance improvement and thorough review. The EMS Coordinator will designate a meeting time and date, and the provider and service representative are expected to arrive on time to the designated location. The service Chief is responsible for ensuring both the provider and service representative will be present on that date unless a conflict is discussed with the EMS Coordinators before the meeting date.
- The EMS Coordinators will maintain the original Clinical Performance Review records.
- The final disposition of the investigation and recommendations for action(s) at or above the level of suspension shall require the agreement of both EMS Medical Directors, in consultation with both EMS Coordinators.

Courses of Action

1. No Action Taken / Matter Resolved - A documented review of a case determined not to have negatively impacted patient care or outcome. The EMS provider's actions were appropriate based on the results of the investigation.
2. Remediation - The review must involve a deficiency in performance and knowledge base and/or critical thinking ability. The Medical Director reserves the right to return the provider to probationary status and require clinical competency evaluations to be performed prior to the return to good standing status. The duration of the remediation program will be determined based on the findings relevant to the case.
3. Suspension - Temporary removal of Sponsor Hospital authorization based upon a clinical incident or pattern of incidents deemed significant enough by the Medical Director or designee not to allow the provider to practice until proof of remediation and clinical competency has been determined. The EMS provider will be given a list of objectives that he/she must meet to regain Sponsor Hospital authorization. Upon reinstatement of Sponsor Hospital authorization, the provider will be placed on probationary status for a minimum period of one year.
4. Revocation - Permanent removal of Sponsor Hospital authorization based on a clinical incident or pattern of incidents deemed significant enough by the Medical Control Council not to allow the provider to practice within the auspices of SHCGB.

Provider Actions

- The provider may appeal any decision by notifying SHCGB in writing within ten days of notification to the provider. The appeal letter must include new or alternative evidence not presented in the initial review process. Failure to disclose new evidence will result in an immediate appeal denial.
- The provider may request the appeal to be heard by the full Council (i.e., to include the two hospital administrative representatives). Post-appeal decisions shall require the agreement of both EMS Medical Directors, in consultation with the other Council members.

- In the case of suspension, providers may accept and complete the actions. Upon doing so, they may request a review prior to the completion of the intended suspension time, so as to appeal for earlier reinstatement.

Title: Quality Assurance Data Reporting

Scope: All agencies with current MICS sponsorship

Purpose: The Sponsor Hospital Council of Greater Bridgeport (SHCGB) recognizes that a comprehensive Quality Assurance/ Quality Improvement program begins with accurate data collection of EMS activities.

EMS Quality Metric Report

Each EMS service is required to track the minimum metrics provided by SHCGB. These metrics will be reviewed periodically, at least every two years, when this policy manual is reviewed. Metrics will be removed, added, or updated as needed. EMS agencies are required to submit a detailed report based on the current metrics to the EMS Coordinators. This report will be due by the first week of each quarter but no later than the SHCGB quarterly meeting.

See Appendix E for current Quality Metrics

Section IV: Mandatory Reporting

Title: Mandatory Reporting for EMS Providers

Scope: All EMS agencies authorized as such to operate within the Sponsor Hospital Council of Greater Bridgeport (SHCGB) catchment area.

Purpose: To outline the circumstances when and the process for EMS providers to report instances of suspected abuse of special populations and opioid overdoses.

Policy:
Licensed health care providers are legislatively mandated reporters of suspected abuse, neglect, or exploitation of particular groups of people. Legislation in June Special Session Public Act 15-5, Section 480 includes new requirements regarding mandatory reporting of impairment for certain health professionals effective October 1, 2015.

Children
Pursuant to Section 17a-101 of the Connecticut General Statutes, certain health professionals regulated by the Department of Public Health are mandated to report suspected child abuse or neglect to the Department of Children and Families (DCF), Child Abuse and Neglect Careline (1-800-842-2288), or a law enforcement agency.

Reports must be made within twelve hours of the moment the practitioner suspects the abuse/neglect has occurred. Suspected child maltreatment of any kind, regardless of the identity of the alleged perpetrator, must be reported. The Careline can answer questions regarding these laws.

Persons with Disabilities
Pursuant to Section 46a-11b of the Connecticut General Statutes, a health care provider who has reasonable cause to suspect or believe that any person with intellectual disability has been abused or neglected shall, within five calendar days, report such information or cause a report to be made in any reasonable manner to the Director of the Office of Protection and Advocacy for Persons with Disabilities or to persons the Director designates to receive such reports. Such a report shall be followed up by a written report within five additional calendar days.

Residents of Long Term Care Facilities
Pursuant to Sec. 17b-407 of the Connecticut General Statutes, a health care provider who has reasonable cause to suspect or believe that a resident in a long-term care facility has been abused, neglected, exploited or abandoned, or is in a condition that is the result of such abuse, neglect, exploitation or abandonment, shall within five calendar days report such information or cause a report to be made in any reasonable manner to the Commissioner of Social Services pursuant to chapter 319dd.

The Elderly
Pursuant to Section 17b-451 of the Connecticut General Statutes, a health care provider who has reasonable cause to suspect or believe that any elderly person has been abused, neglected, exploited or abandoned, or is in a condition which is the result of such abuse, neglect,

exploitation or abandonment, or who is in need of protective services, shall within five calendar days report such information or cause a report to be made in any reasonable manner to the Commissioner of Social Services or to the person or persons designated by the commissioner to receive such reports.

Impaired Practitioners
Effective October 1, 2015, any health care professional or hospital shall file a petition if that hospital or health care professional has any information that demonstrates that another health care professional is (or is suspected to be) unable to practice his or her profession with reasonable skill or safety.

SWORD (Statewide Opioid Reporting Directive)
Any hospital licensed pursuant to Chapter 368v of the General Statutes of emergency medical services personnel, as defined in Section 20-206jj of the General Statutes, who treats a patient for an overdose of an opioid drug, as defined in Section 20-14o of the General Statutes, shall report such overdose to the Department of Public Health in a form and manner prescribed by the Commissioner of Public Health. When multiple providers and/or services care for a patient, reporting will be the responsibility of the transporting agency.

Title: Social Services Referral Program

Scope: All EMS Providers

Purpose:
Define the indications and process for EMS providers to identify patients who may benefit from assistance provided by the hospital's Social Services Department.

Policy:
1. Emergency medical technicians and paramedics often provide emergency health care services in the homes of their patients.
2. EMS providers are, therefore, in the position to assess the living environment of their patients and those patients' ability to provide for their own care and comfort, as well as the safety of those patients' surroundings.
3. In cooperation with a multidisciplinary program through the Emergency Center, the Sponsor Hospital Programs, and the Department of Social Services, pre-hospital personnel are encouraged to identify persons who may benefit from intervention through this process.
4. Persons identified as having a risk of insufficient care and/or comfort at home will be contacted by local Social Services for follow up.
5. As required by state law and statewide protocols, mandatory reporting to appropriate agencies must be completed immediately after the transfer of care by all providers.

Procedure:
1. Timely evaluation and treatment must not be delayed or withheld.
2. Information relevant to the completion of a Social Service Referral Form must be obtained during the standard patient assessment and treatment process with information obtained from the patient, family members, and bystanders. At no time will a SHCGB - sponsored EMS provider perform an inspection of the house and surroundings outside of the assessment performed within the standards set forth by the National EMS Standards and the Connecticut Statewide Protocols.
3. Upon conclusion of patient care contact, the EMS provider may complete a Social Service Notification Form documenting the suspicions for potential intervention.
4. This form will be placed in a sealed envelope and marked "Social Services," then placed in the interdepartmental mail bin located by the Emergency Center secretary.
5. Patient confidentiality must always be respected and maintained.

Appendix A

Appendix B

Appendix C

Appendix D

Appendix E

Appendix F

Appendix G