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Craven County Standards Policy

Obtaining & Maintaining Privileges

Policy:

Anyone requesting or renewing privileges shall follow the procedure below.

Purpose:

- To ensure the appropriate orientation and acclimation into the Craven, Jones & Pamlico County ems system plan.
- To ensure an organized renewal process.

Procedure:

1. All personnel requesting new or renewed privileges must show affiliation with a service in the Craven, Jones & Pamlico County systems. The individual can only be credentialed to the highest level offered by this service.

2. Applications for new providers should be made through the county emergency services office or directly with the medical director.

3. Paramedics are highly encouraged to have a letter of good standing from their prior medical director. If unable to obtain a letter or if returning from a long period of inactivity, a written explanation detailing why they are unable to do so.

4. Recent paramedic/intermediate graduates and providers new to the system must precept a minimum of six paramedic/intermediate level calls with a county approved preceptor. The calls must be paramedic level and be a good mixture of call types. The PCR will be completed by the new provider. A preceptor evaluation form will be attached to the PCR and submitted to the medical director for review. The medical director reserves the right to extend the providers precepting period and number of call required.

5. Providers already credentialed in the system must perform a professional evaluation (scope / skills assessment) yearly.

6. Continuing education must follow the requirements in the county education plan.

7. Certification renewal paperwork must be submitted to the local community college no less than 90 days prior to expiration. Failure to do so may bring disciplinary action or failure to renew your certification. Individual who choose to recertify outside the system will be treated as new providers

Craven County Standards Policy

Preceptor Qualifications

Policy:

- Establish minimum qualifications for field preceptors.

Purpose:

To ensure the appropriate orientation and acclimation into the Craven, Jones & Pamlico County System Plan.
To ensure qualified field supervision for new providers.

Qualifications:

1. Minimum of two years as a paramedic
2. Minimum of two years active in the Craven, Jones & Pamlico County system
3. Preceptor class once every 3 years
4. Approval by Medical Director
5. RSI Credentialed
6. AMLS, ILTS, ACLS, PALS certified highly recommended
7. EMT-Intermediates required two years active in the Craven, Jones & Pamlico county system.

Procedure:

1. Orient and Instruct new personnel/students to the system plan.
2. Students and/or New Providers are granted the privilege to function under preceptor's direct supervision.
3. Guide new providers/students in writing PCR's to appropriate documentation standards.
4. Evaluate New personnel and report to the medical director.

Craven County Standards Policy

Drug Assisted Intubation Qualifications

Policy:

- Establish minimum qualifications for drug assisted intubation privilege.

Purpose:

To ensure the most experienced and skill personnel perform this high risk skill.

Qualifications:

1. Minimum of two years as a paramedic
2. Minimum of two years active in the Craven, Jones & Pamlico county system
3. Medical Director Approved Drug Assisted Intubation class once every 2 years
4. Approval by Medical Director
5. AMLS, ILTS, ACLS, PALS highly recommended.
6. Must document minimum of four live intubations per year.

Procedure:

1. All Drug Assisted Intubations must have a minimum of two credentialed personnel for the procedure.
2. Drug Assisted Intubation Protocol must be followed EXACTLY. The only exception is orders by online medical control allowing deviation.
3. The North Carolina EMS Airway Evaluation Form must be filled out This includes signature of receiving physician confirming tube placement. The original must be forwarded to the medical director for review.

Quick Response Services (QRS)

Policy:

Fire Departments, municipalities, and/or corporate entities may provide Quick Response Services to aid in an medical emergency till the transporting services arrives.

Purpose:

To provide:

- Rapid emergency care when transport is distant or delayed
  Appropriate medical stabilization and treatment at the scene when necessary
  Package and prepare patient for transport.

Procedure:

1. Requirements and Application are outlined in the Quick Response Service Recognition packet which can be obtained from the county office of emergency services.

2. The current QRS operating levels offered in the Craven, Jones & Pamlico county system are: Medical Responder, EMT-Basic, and EMT-Intermediate levels.

3. If the organization chooses basic or intermediate levels, they must comply with NC OEMS electronic documentation standards and will be issued a provider number.

4. Medical treatment by QRS Service follows regional protocols to the level certified by the provider and the QRS service operating certification.

5. As outlined Quick Response Service Recognition packet, EMT-Basic and EMT-Intermediate QRS must maintain minimum equipment standards.

6. Medical Responders not wishing to operate at the basic or intermediate level are not bound by the above policy.

7. The medical director and the county office of emergency services have the final determination on certification and renewal of QRS programs. A QRS program may be suspended or revoked at anytime.

Peer Review Policy

Policy:

All service providers are required to attend the Peer Review Subcommittee meetings as outlined in the Craven, Jones & Pamlico System Plan. The meeting will meet quarterly and will be announced by the county office of emergency services.

Attendance Policy:

Each department will designate a training / quality assurance officer to attend. Smaller departments may send their captain.

Failure to attend the quarterly meetings will result in the following ramifications

One meeting missed – Training officer / Captain placed on probation.

Two Meetings missed – Training Officer and/or Captain of department – medical privileges suspended. Must meet with peer review committee / medical director for corrective action.

Craven, Jones & Pamlico / Four Meetings Missed – Emergency Meeting with EMS System Administrator, NC OEMS, department board/president, Appropriate government official (Mayor, Commissioners) to discuss future of department and/or revocation of franchise.

Exceptions:

In the event of an emergency, if the Training / QA Officer / Captain cannot attend only the chair of the peer review committee / subcommittee, County Office of Emergency Services, and/or the medical director can excuse a department from the above meetings. Excused Absences do not count against the department. All excusal must be made in writing and filed with the county office of emergency services.

Paramedic Assist Policy

Policy:

Basic or Intermediate Providers may request a paramedic assist on any patient with an illness or injury exceeding their scope of practice or comfort level.

Purpose:

To provide:

- The most advanced care available prehospital..

Procedure:

1. Request for assistance should be made early before transport initiated.

2. The closest paramedic unit to the scene should be requested for assistance.

3. The patient should be transported expeditiously and the basic unit should NOT wait on scene for paramedic assist. The Paramedic unit will rendezvous while enroute to the hospital.

4. Roadside transfers of patients are forbidden. This is an extremely dangerous practice which risks patient and crew safety.

   Exception:

   If all providers are in agreement and a safe area off the roadway is secured. If any provider feels this is unsafe in anyway then the transfer is forbidden. All patient transfer prehospital must be reported in the PCR and directly to the medical director or county office for review.

5. Paramedic Services who routinely do assists should streamline their gear for this practice.

6. Grievances should be made to the county office or the medical director after the call in disagreements in procedure or patient care. At the time of the call, the highest trained individual is in charge of patient care.

7. Paramedics should not attempt to BLS Release a call made by a basic or intermediate service. In extreme cases, medical control may be contacted for permission to release.

FIT FOR DUTY

Craven County contracts with many municipal and private providers to supply our emergency medical services. While each employer has their own employee requirements, the county office of emergency services and medical director require that an ems provider be fit for duty when responding too and providing emergency care in Craven County.

1. The Ems provider must be drug free. Employers are encouraged to practice random drug testing. The County Office of Emergency Services and/or EMS Medical Director shall request employers perform drug testing in response to external and internal complaints. Irregularities in patient care noticed by the Craven County Peer Review Committee and/or EMS Medical Director. Inaccuracies of the providers DEA Narcotic checklists and inventories.

2. Ems provider should be of sound mind to provide the best of care in the highest stress environments. Providers with suspected early signs of decompensating mental illness will be subjected to a mental health evaluation.

3. EMS Provider shall be of good physical condition. New or unstabilized chronic medical disorders that impact the provider's physical capabilities to physically perform their duties will need medical clearance by a specialist or primary doctor before return to work. The EMS Medical Director will review each situation and may request additional subspecialty clearance before reinstatement of privileges.

Evaluations/drug testing will be requested through the individuals employer. All results and summary of evaluations will be reviewed by the medical director for further recommendations.

Craven County Standards Policy
Suspected abuse of Children, the Elderly and the Disabled

Policy:

Set forth for EMS providers the reporting procedure for the suspected abuse, neglect or exploitation of children, the Elderly and the disabled.

Purpose:

Duty to report- N.C.G.S. §7B-301,

- Anyone who suspects child abuse, neglect, or dependency must report their concerns
- Reports must be made to the county DSS where the patient resides and/or local law enforcement
- May be made orally, by telephone or in writing
- Reporter must give their name, address and telephone number
- Protect the life of patient from harm, as well as that of the EMS team from liability
- Collect as much information as possible, especially information
- Class 1 misdemeanor for knowingly or wantonly failing to report

Procedure:

1. Assess for and document psychological characteristics of abuse, including excessive passivity, compliant or fearful behavior, excessive aggression, violent tendencies, excessive crying, fussy behavior, hyperactivity, or other behavioral disorders.

2. Asses for and document physical signs of abuse, including especially any injuries that are inconsistent with the reported mechanism of injury.

3. Asses and document sign and symptoms of neglect, including inappropriate level of clothing for weather, inadequate hygiene, absence of attentive caregiver(s), or physical signs of malnutrition.

4. Reporting suspected abuse or neglect makes it possible for a family to get help.

5. Immediately report any suspicious finding to both the receiving hospital (if transported) and to agency responsible for Social Services in the county. After hours, the child/adult protective services worker on call can be contacted by the EMS system's 911 communications center. While law enforcement may also be notified, North Carolina law requires the EMS provider to report the suspicion of abuse to DSS. EMS should not accuse or challenge the suspected abuser.

6. This is a legal requirement to report, not an accusation. In the event of child fatality, law enforcement must be notified.

7. Failure to report could mean difference of life and death for the patient.

Criteria for Death / Withholding Resuscitation

Policy:

CPR, BLS and ALS treatment are to be withheld only if the patient is obviously dead (see procedure section) or a valid (*properly completed, signed, dated, and unexpired*) **North Carolina Do Not Resuscitate (DNR)** form and/or **Medical Orders for Scope of Treatment (MOST)** form is present (Disposition Policy 5).

EMS personnel shall also honor a valid **POLST (Physician Orders for Life Sustaining Treatment), POST (Physician Orders for Scope of Treatment), MOST and/or DNR** (*properly completed, signed, dated, and unexpired*) from another state or US military form. NCGS Article 23: 90-320.

Purpose:

The purpose of this policy is to:

- Honor those who have obviously expired prior to EMS arrival.
- To honor the terminal wishes of the patient
- To prevent the initiation of unwanted resuscitation

Procedure:

1. If a patient is in complete cardiopulmonary arrest (clinically dead) and meets one or more of the criteria below, CPR and ALS therapy need not be initiated:

    - Body decomposition
    - Rigor mortis
    - Dependent lividity
    - Injury not compatible with life (i.e., decapitation, burned beyond recognition, massive open or penetrating trauma to the head or chest with obvious organ destruction)
    - Extended downtime (> 15 minutes) with Asystole on ECG or no shock advised on AED
    - Meets criteria established in AC 12 Termination of CPR Protocol
    - Meets criteria established in TB 10 Traumatic Arrest Protocol

2. If a bystander or first responder has initiated CPR or automated defibrillation prior to ALS personnel (Paramedic or AEMT) arrival and any of the above criteria (signs of obvious death) are present, the ALS provider may discontinue CPR / resuscitation efforts. All other EMS personnel levels must communicate with medical control prior to discontinuation of the resuscitative efforts unless specifically addressed in AC 12 Termination of CPR Protocol and/ or TB 10 Traumatic Arrest Protocol.

3. If doubt exists, start resuscitation immediately. Once resuscitation is initiated, continue resuscitation efforts until either:
    a) Resuscitation efforts meet the criteria for implementing the **Discontinuation of Prehospital Resuscitation Policy** (Disposition Policy 3).
    b) Patient care responsibilities are transferred to the destination hospital staff.

Deceased Subjects

Policy:

EMS will handle the disposition of deceased subjects in a uniform, professional, and timely manner.

Purpose:

The purpose of this policy is to:

- Organize and provide for a timely disposition of any deceased subject
- Maintain respect for the deceased and family
- Allow EMS to return to service in a timely manner.

Procedure:

1. Do not remove lines or tubes from unsuccessful cardiac arrests/codes unless directed below.

2. Notify the law enforcement agency with jurisdiction if applicable.

3. If subject was found deceased by EMS, the scene is turned over to law enforcement.

4. If EMS has attempted to resuscitate the patient and then terminated the resuscitative efforts, EMS personnel should contact the primary care provider (medical cases) or medical examiner (traumatic cases or primary care provider unavailable) to provide information about the resuscitative efforts.

   <u>Cases that require notification of the Medical Examiner when death results from:</u>

   Accident
   Homicide
   Violence
   Poisoning
   Suicide
   Occurring in jail, prison, correctional institution, or in LEO custody
   Occurring under suspicious, unusual, or unnatural circumstances
   Sudden unexpected death when in otherwise good health
   No current primary care or specialty physician care

5. Transport arrangements should be made in concert with law enforcement and the family's wishes.

6. If the deceased subject's death is not under the jurisdiction of the medical examiner, any line(s) or tube(s) placed by EMS should be removed prior to transport.

7. Document the situation, name of primary care provider or Medical Examiner contacted, the patient care report form (PCR).

8. Physician Assistants and/or Nurse Practitioners may sign a North Carolina death certificate when specially authorized by their supervising physician.

9. Follow Disposition Policy 9 Organ Procurement Agency Notification

Discontinuation of Prehospital Resuscitation

Policy:

Unsuccessful cardiopulmonary resuscitation (CPR), basic life support (BLS), and other advanced life support (ALS) interventions may be discontinued prior to transport or arrival at the hospital when this policy is followed.

Purpose:

The purpose of this policy is to:

- Allow for discontinuation of prehospital resuscitation after the delivery of adequate and appropriate BLS and/or ALS therapy.

Procedure:

1. Discontinuation of CPR, BLS, and ALS intervention may be implemented **prior to contact with Medical Control if <u>ALL</u>** of the following criteria have been met:

    - Patient must be ≥ 18 years of age
    - High quality CPR administered
    - Airway successfully managed:
        Acceptable airway management techniques include orotracheal intubation, Blind Insertion Airway Device (BIAD) placement, or cricothyrotomy
        EtCO2 monitoring for airway confirmation utilized if available
    - IV or IO access has been achieved
    - No hypothermia (body temperature ≥ 93.2°F or 32°C)
    - Protocol AC 12 On Scene Resuscitation Termination of CPR or TB 10 Traumatic Arrest utilized as applicable
    - All EMS BLS and ALS personnel involved in the patient's care agree that discontinuation of the resuscitation is appropriate

2. If all of the above criteria are not met and discontinuation of prehospital resuscitation is desired, **contact Medical Control**.

3. The **Deceased Subjects Policy** should be followed.

Document all patient care and interactions with the patient's family, personal physician, medical examiner, law enforcement, and medical control in the EMS patient care report (PCR).

EXCLUSION: If CPR is started by bystanders and/or first responders, a paramedic may discontinue resuscitation if there are obvious signs of death not initially recognized.

Disposition (Patient Instructions)

Policy:

All patient encounters responded to by EMS will result in the accurate and timely completion of:

- The Patient Care Report (PCR) for all patients transported by EMS
- The Patient Disposition Form for all patients not transported by EMS

Purpose:

To provide for the documentation of:

- The evaluation and care of the patient
- The patient's refusal of the evaluation, treatment, and/or transportation
- The patient's disposition instructions
- The patient's EMS encounter to protect the local EMS system and its personnel from undue risk and liability.

Procedure:

1. All patient encounters, which result in some component of an evaluation, must have a Patient Care Report completed.

2. All patients who refuse any component of the evaluation or treatment, based on the complaint, must have a Disposition Form completed.

3. All patients who are NOT transported by EMS must have a Disposition (patient instruction) Form completed including the Patient Instruction Section.

4. A copy of the Patient Disposition Form should be maintained with the official Patient Care Report (PCR)

North Carolina Do Not Resuscitate and MOST Form

Policy:

CPR, BLS and ALS treatment are to be withheld only if the patient is obviously dead (see procedure section) or a valid (*properly completed, signed, dated, and unexpired*) **North Carolina Do Not Resuscitate (DNR)** form and/or **Medical Orders for Scope of Treatment (MOST)** form is present (Disposition Policy 5).

EMS personnel shall also honor a valid **POLST (Physician Orders for Life Sustaining Treatment), POST (Physician Orders for Scope of Treatment), MOST and/or DNR** (*properly completed, signed, dated, and unexpired*) from another state or US military form. NCGS Article 23: 90-320.

Purpose:

- Honor those who have obviously expired prior to EMS arrival.
- To honor the terminal wishes of the patient
- To prevent the initiation of unwanted resuscitation

Procedure:

1. When confronted with a patient or situation involving the NC DNR and/or MOST form(s), the following form content must be verified before honoring the form(s) request.

    - The form(s) must be either an original North Carolina DNR or North Carolina MOST form
    - The effective date and expiration date must be completed and current
    - The DNR and/or MOST Form must be signed by a physician, physician's assistant, or nurse practitioner.
    - <u>Out-of-state or US military form:</u>
        Must be an original MOST, DNR, POLST (Physician Orders for Life Sustaining Treatment) or POST (Physician Orders for Scope of Treatment).
        The effective date and expiration date must be completed and current
        The DNR and/or MOST Form must be signed by a physician, physician's assistant, or nurse practitioner
2. A valid DNR or MOST form may be overridden by the request of (N.C.G.S. 90-21.13):
    Court appointed guardian
    Health care power of attorney
    Spouse
    Majority of patient's reasonably available parents and/or children who are ≥ 18 years old
    Majority of patient's reasonably available siblings who are ≥ 18 years old
    Patient's attending physician
    *EMS personnel should contact **Medical Control** to obtain assistance and direction if clarification is necessary.*
3. A living will (other legal document) that identifies the patient's desire to withhold CPR or other medical care may be honored with the approval of **Medical Control**. Ideally, consultation with patient's family and personal physician is suggested as time allows.

Patient Without a Protocol

Policy:

Anyone requesting EMS services will receive a professional evaluation, treatment, and transportation (if needed) in a systematic, orderly fashion regardless of the patient's problem or condition.

Purpose:

- To ensure the provision of appropriate medical care for every patient regardless of the patient's problem or condition.

Procedure:

1. Treatment and medical direction for all patient encounters, which can be triaged into an EMS patient care protocol, is to be initiated by protocol.

2. When confronted with an emergency or situation that does not fit into an existing EMS patient care protocol, the patient should be treated by the **Universal Patient Care Protocol** and a **Medical Control Physician** should be contacted for further instructions.

Physician on Scene

Policy:

The medical direction of prehospital care at the scene of an emergency is the responsibility of those most appropriately trained in providing such care. All care should be provided within the rules and regulations of the state of North Carolina.

Purpose:

- To identify a chain of command to allow field personnel to adequately care for the patient
- To assure the patient receives the maximum benefit from prehospital care
- To minimize the liability of the EMS system as well as the on-scene physician

Procedure:

1. When a non medical-control physician offers assistance to EMS or the patient is being attended by a physician with whom they do not have an ongoing patient relationship, EMS personnel must review the On-Scene Physician Form with the physician. All requisite documentation must be verified and the physician must be approved by on-line medical control.

2. When the patient is being attended by a physician with whom they have an ongoing patient relationship, EMS personnel may follow orders given by the physician if the orders conform to current EMS guidelines, and if the physician signs the PCR. Notify medical control at the earliest opportunity. Any deviation from local EMS protocols requires the physician to accompany the patient to the hospital.

3. EMS personnel may accept orders from the patient's physician over the phone with the approval of medical control. The paramedic should obtain the specific order and the physician's phone number for relay to medical control so that medical control can discuss any concerns with the physician directly.

Opioid Overdose/Misuse (Optional)

Policy:
Patients who have experienced an opioid overdose/misuse should be offered a variety of options to more appropriately manage their care where available in the community. All care should be provided within the rules and regulations of the state of North Carolina.

Purpose:
- To ensure patients are offered options for treatment of opioid misuse where available.
- Provide harm reduction measures related to opioid misuse.

Procedure:
1. Patients must be over 18 years of age and experienced unintentional overdose or misuse of an opioid medication(s) only. Patients must NOT have experienced cardiac arrest defined as administration of chest compressions by first responders or EMS during the incident.

2. The patient must regain a normal mental status and respiratory effort after the administration of naloxone, NOT have suicidal or homicidal ideations/intentions, and NOT ingested substance(s) for intentional self-harm.

3. Patients who have co-ingested other substances should be treated based on appropriate protocol. Consult Carolina Poison Center at 1-800-222-1222 for advice if needed.

4. Transport to an Emergency Department should be offered to all patients. For patients who decline transport to an Emergency Department, alternative destinations should be offered if available in the community. Options may include assistance with accessing inpatient treatment centers, outpatient facilities, mobile crisis solutions, addiction specialists, and/or other local treatment options.

5. In order to decline transport, the patient must meet the following criteria:
   a) Be 18 years or older
   b) Maintain a GCS of 15 (alert, and oriented to time, place, person, and situation)
   c) Demonstrate decision-making capacity as outlined in Universal Protocol (UP 1) Pearls.

6. If patient declines transport to an Emergency Department, an additional dose of naloxone should be offered by EMS if patient consents to additional treatment. IN administration is preferable to limit the possibility of provider needle stick injury. If patient has no sober and responsible party to monitor them, EMS should offer IM administration of naloxone if patient consents to treatment. If available, a naloxone kit should be left with the patient, family, and/or friends on scene. EMS should provide brief education on how to properly use these kits and refer them to read all package related material and instructions provided by the manufacturer.

7. In addition to naloxone kits, the following items should be offered where possible/available:
   a) Offer to properly dispose of any dirty needles following your agency policy
   b) Provide clean needles/syringes where possible following your agency policy
   c) Refer to a community peer support team if available
   d) Provide literature outlining resources for substance misuse treatment programs in the community

Organ Procurement Agency Notification

Policy:

When cardiopulmonary resuscitation (CPR), basic life support (BLS), and other advanced life support (ALS) interventions are withheld or discontinued on scene, EMS will report the death to the appropriate organ procurement organization servicing the county where death occurred in a timely manner. EMS will share information relevant to the donation process with the appropriate organ procurement organization.

Purpose:

To ensure an organ procurement organization is notified of deaths pronounced in the field by EMS in order to:

- Honor the decedent's registered declaration of eye and/or tissue donation.
- Preserve family's opportunity to support eye and/or tissue donation.
- Service the public health by facilitating eye and tissue donation.

Procedure:

EMS will notify the appropriate organ procurement organization of deaths pronounced outside of the hospital. Potential donors between ages of newborn – 100 years old will be referred.

Essential information to be provided to the organ procurement organization include:

- Caller name, title, and agency contact information
- Patient demographics
- Last seen alive date/time or time of death
- Circumstances of death (notify organ procurement agency even if medical examiner case)
- Medical interventions and medical history
- Next of kin name and contact information
- Who is taking custody of the decedent's body (ex: funeral home, hospital, M.E.)
- EMS **SHOULD NOT** discuss eye or tissue donation with next of kin. Coordinators specializing in family support will attempt to contact appropriate family members about organ donation.
- Document all patient care and interactions with the patient's family, personal physician, medical examiner, law enforcement, and medical control in the EMS electronic patient care report (ePCR).

Contact information for Organ Procurement Organizations:

LifeShare to the Carolinas		LifeNet Health	HonorBridge
1 (800) 932-4483		1 (800) 847-7831	1 (800) 252-2672
Anson	Jackson	Currituck	All other NC counties
Buncombe	Lincoln		
Burke	Macon		
Cabarrus	Madison		
Cherokee	Mecklenburg		
Clay	Polk		
Cleveland	Rutherford		
Gaston	Stanly		
Graham	Swain		
Haywood	Transylvania		
Henderson	Union		

EMS Offload / Facility Transition of Care

Policy:

The purpose of this policy is to:

- Ensure timely transfer of patient care to the receiving medical facility.
- Provide for the transfer of appropriate care information to the receiving facility.
- Ensure adequate number of transport units available to the community is not delayed due to prolonged Turn Around Times at receiving facilities.
- Promote teamwork and collegiality in transferring care of patients between EMS and hospital personnel with the goal of optimal patient care in focus.

Procedure:

1. EMS will provide an oral report to hospital personnel prior to EMS arrival describing patient status, mechanism of injury or illness, vital signs, therapies provided, procedures performed, and response to treatment.
2. Verbal patient report, paper transition of care/ written hand-off report, PCR copy, or ePCR transmission of patient care is provided to hospital personnel at time of transition of care.
   - Demographic information.
   - Summary of care provided.
   - Vital sign summary.
   - Procedures performed summary.
3. Assist in moving patient from EMS manner of conveyance to designated hospital area identified by hospital personnel.
4. Obtain the name and title of the receiving hospital personnel and document in the EMS PCR or ePCR.
5. Attempt to obtain the signature of the receiving hospital personnel and document in the EMS PCR or ePCR.
   - In the event hospital personnel refuse to sign acknowledging receipt of the patient, document the name and title of the hospital personnel and note hospital personnel refused to sign in the narrative portion of the PCR or ePCR or other area designated by agency.

EMS Documentation and Data Quality

Policy:

The complete EMS documentation associated with service delivery and patient care shall be electronically recorded into a Patient Care Report (PCR) within 24 hours of the completion of the EMS event, with an EMS Data Score at/or below the state average.

Definition:

EMS documentation of a Patient Care Report (PCR) is based on the appropriate and complete documentation of the EMS data elements as required and defined within the North Carolina College of Emergency Physician's EMS Standards. Since each EMS event and/or patient scenario is unique, only the data elements relevant to that EMS event and/or patient scenario should be completed.

The EMS Data Score is calculated on each EMS PCR as it is electronically processed into the North Carolina Office of EMS Repository Data Quality Scores are provided within the Repository. The best possible scores is a 100 and with each missing data element a point is deducted from thr data quality score.

A complete Patient Care Report (PCR) must contain the following information (as it relates to each EMS event and/or patient):

- Service delivery and crew information regarding the EMS Agency's response
- Dispatch information regarding the dispatch complaint, and EMD card number
- Patient care provided prior to EMS arrival
- Patient assessment as required by each specific complaint based protocol
- Past medical history, medications, allergies, and DNR/MOST status
- Trauma and cardiac arrest information if relevant to the EMS event or patient
- All times related to the event
- All procedures and their associated time
- All medications administered with their associated time
- Disposition and/or transport information
- Communication with medical control
- Appropriate signatures (written and/or electronic)

Purpose:

The purpose of this policy is to:

- Promote timely and complete EMS documentation.
- Promote quality documentation that can be used to evaluate and improve EMS service delivery, personnel performance, and patient care to the county's citizens.
- Promote quality documentation that will decrease EMS legal and risk management liability.
- Provide a means for continuous evaluation to assure policy compliance.

EMS Documentation and Data Quality

Procedure:

The following procedures shall be implemented to assure policy compliance:

1. All patient encounters, which result in an evaluation, must have an EMS Patient Care Report (PCR) completed and documented.

2. The EMS Patient Care Report (PCR) shall be completed as soon as possible after the time of the patient encounter.

3. Verbal patient report, paper transition of care/ written hand-off report, PCR copy, or ePCR transmission of patient care is provided to hospital personnel at time of transition of care.

4. The PCR must be electronically submitted to the Repository within 24 hours of the EMS event or patient encounter's completion. The EMS data quality feedback provided at the time of the electronic submission should be reviewed and when possible, any identified errors will be corrected within each PCR. Each PCR may be electronically resubmitted as many times as needed.

5. The North Carolina OEMS Repository uses errors and warnings as data validity checks to ensure complete and high-quality data during the collection, reporting and submission process. Errors will cause records to fail submission, while warnings will result in point deductions from the EMS Data Quality Score. In case of failed submissions, the agency must try to resolve the reason for the failure as soon as possible. The EMS Data Quality Scores for the EMS system, EMS agency and the individual EMS personnel will be reviewed regularly within the EMS System Peer Review Committee. The EMS Data Quality Scores for the EMS System, EMS Agency, and individual EMS personnel will be reviewed regularly within the EMS System Peer Review Committee.

6. Agencies that are required to submit data elements to the North Carolina Office of EMS should only use vendors that have achieved National Medical Services Information System (NEMSIS) compliance for the current version of elements. The current version of elements that OEMS accepts can be found at https://oems.nc.gov/data.

Documentation of Vital Signs

Policy:

Every patient encounter by EMS will be documented. Vital signs are a key component in the evaluation of any patient and a complete set of vital signs is to be documented for any patient who receives some assessment component.

Purpose:

To insure:

- Evaluation of every patient's volume and cardiovascular status
- Documentation of a complete set of vital signs

Procedure:

1. An **initial** complete set of vital signs includes:
    - Pulse rate
    - Systolic **AND** diastolic blood pressure
    - Respiratory rate
    - Pain / severity (when appropriate to patient complaint)
    - GCS for Injured Patients

2. When no ALS treatment is provided, palpated blood pressures are acceptable for **REPEAT** vital signs.

3. Based on patient condition and complaint, vital signs may also include:
    - Pulse Oximetry
    - Temperature
    - End Tidal CO2
    - Breath Sounds
    - Level of Response

4. If the patient refuses this evaluation, the patient's mental status and the reason for refusal of evaluation must be documented. A patient disposition form must also be completed.

5. Document situations that preclude the evaluation of a complete set of vital signs.

6. Record the time vital signs were obtained.

7. Any abnormal vital sign should be repeated and monitored closely.

EMS Dispatch Center Time

Policy:

The EMS Dispatch Center Time will be less than 90 seconds, 90% of the time, for all events identified and classified as an emergent or hot (with lights and siren) response.

Definition:

The EMS Dispatch Center Time is defined as the time interval beginning with the time the initial 911 phone call rings at the 911 Communications Center requesting emergency medical services and ending with the dispatch time of the EMS Unit responding to the event.

Purpose:

The purpose of this policy is to:

- Provide the safest and most appropriate level of response to all EMS events within the EMS System.
- Provide a timely and reliable response for all EMS events within the EMS System.
- Provide quality EMS service and patient care to the county's citizens.
- Provide a means for continuous evaluation to assure policy compliance.

Procedure:

The following procedures shall be implemented to assure policy compliance:

1. A public calls into the 911 Communications Center requesting emergency medical assistance will never be required to speak with more than two persons before a formal EMS Unit is dispatched.

2. In EMS Dispatch Centers where Emergency Medical Dispatch (EMD) has been implemented, EMS Units will be dispatched by EMD certified personnel in accordance with the standards developed by the Medical Director and the Emergency Medical Dispatch Protocols.

3. EMS Units will be dispatched hot (with lights and sirens) or cold (no lights and sirens) by the 911 Call Center based on predetermined criteria. If First Responders are dispatched as a component of the EMS response, they should typically be dispatched hot (with lights and sirens).

4. Without question, exception, or hesitation, EMS Units will respond as dispatched (hot or cold). This includes both requests to respond on active calls and requests to "move-up" to cover areas of the System that have limited EMS resources available.

5. EMS Units may, at their discretion, request for a First Responder on Non-First Responder calls in situations where additional resources are required such as manpower, extreme response time of the EMS Unit, need for forcible entry, etc.

EMS Dispatch Center Time

6. EMS Units dispatched with a cold (no lights and sirens) response, will not upgrade to a hot (with lights and sirens) response **UNLESS**:
   - Public Safety personnel on-scene requests a hot (with lights and sirens) response.
   - Communications Center determines that the patient's condition has changed, and requests you to upgrade to a hot (with lights and sirens) response.

7. An EMS Unit may divert from a current cold (no lights and sirens) call to a higher priority hot (with lights and sirens) call **ONLY IF:**
   - The EMS Unit can get to the higher priority call before it can reach the lower priority call. Examples of High Priority Calls: Chest Pain, Respiratory Distress, CVA, etc.
   - The diverting EMS Unit must notify the EMS Dispatch Center that they are diverting to the higher priority call.
   - The diverting EMS Unit ensures that the EMS Dispatch Center dispatches an EMS Unit to their original call.
   - Once a call has been diverted, the next EMS Unit dispatched must respond to the original call. A call cannot be diverted more than one (1) time.

8. Any EMS Dispatch Center Time delays resulting in a prolonged EMS Dispatch Center Time for emergent hot (with lights and sirens) events will be documented in Patient Care Report (PCR) as an "EMS Dispatch Delay" as required and defined in the North Carolina College of Emergency Physicians (NCCEP) EMS Dataset Standards Document.

9. All EMS Dispatch Delays will be reviewed regularly within the EMS System Peer Review Committee.

Drug Assisted Airway

Policy:

Drug Assisted Intubation (DAI) requires an EMS System or Agency to follow these guidelines to ensure that this invasive procedure is performed in a safe and effective manner to benefit the citizens and guest of North Carolina.

Purpose:

The purpose of this policy is to:

- Ensure that the procedure is performed in a safe and effective manner
- Facilitate airway management in appropriate patients

Procedure:

1. In addition to other monitoring devices, Waveform Capnography and Pulse Oximetry are required to perform Drug Assisted Airways and must be monitored throughout the procedure.

2. Two Paramedics or higher-level providers must be present and participate in the airway management of the patient during the procedure.

3. All staff must be trained and signed off by the EMS Medical Director prior to performing Drug Assisted Airways.

4. A printed copy or electronic download from the monitor defibrillator including the pulse oximetry, heart rate, heart rhythm, waveform capnography, and blood pressure must be stored with the patient care report.

5. An EMS Airway Evaluation Form must be completed on all Drug Assisted Airway Attempts.

6. The EMS Airway Evaluation Form must be reviewed and signed by the EMS Medical Director within 14 days of the Drug Assisted Airway attempts.

7. All Drug Assisted Airways must be reviewed by the EMS System or Agency and issues identified addressed through the System Peer Review Committee.

8. A copy of the EMS Airway Evaluation form for each Drug Assisted Airways must be submitted to OEMS Regional Office at the end of each month for state review.

In addition, the NC EMS Airway Evaluation Form has been revised to a one page document to improve provider compliance and promote receiving/confirming physician acceptance.

Ketamine Program Requirements

Policy:

When administered outside of the AR 3 Airway Drug Assisted Intubation Protocol, an EMS System or Agency must be approved by the State Medical Director and follow the guidelines below when administering Ketamine.

Purpose:

The purpose of this policy is to:

- Ensure that Ketamine is administered in a safe and effective manner
- Facilitate use of Ketamine in appropriate patients
- Establish a reporting mechanism for state review

Procedure:

1. The EMS system or Agency must adopt NCCEP protocols unchanged or submit equivalent protocols for review.

2. Letters of support must be obtained from all receiving hospitals where patients will be delivered after administration. These letters must be submitted to the OEMS prior to approval.

3. All personnel must be trained prior to implementation.

4. All administrations must be reviewed through the established PI/QA Medical Oversight process to include hospital outcome feedback. Concerns identified must be reviewed by the Peer Review/QA committee.

5. NCOEMS reporting:

   a. The EMS system or agency must submit to the OEMS a Ketamine Adverse Outcome Reporting Form and ePCR within 14 days for administrations that result in any of the following;
      1) Cardiac Arrest (pre-hospital or ED)
      2) Unanticipated intubation required after administration (pre-hospital or ED).

*Contact your Regional OEMS Systems Specialist for link to submit adverse outcome reports.

Craven County Standards Policy

Propofol Usage Policy

Policy:

Policy guidelines for the transport and administration of Propofol.

Purpose:

This policy is the guideline for the transport and maintenance of patients that are being transport interfaculty, that are sedated with Propofol .

Guideline:

Propofol is a medication used in the sedation of patients where the airway is supported by mechanical means. The medication is quick acting but have a number of potential dangerous side effects that the transporting paramedic must monitor to prevent a sever and/or possible death of the patient. This guideline sets out the standards for paramedics who will be transporting this drug.

I. Every paramedic will be required attend an in-service on the transport, maintenance, and increase or decrease of Propofol.

1. A yearly refresher in-service must be attended by all paramedics on the use of Propofol to discuss any changes in the transport of the drug.
2. Yearly refresher training on IV pumps must be completed by all paramedics to insure proper pump operations; this will include trouble shooting pump failures with correction action to ensure the dose of Propofol is administered as ordered by medical direction.

II. Yearly practical test will be conducted by every paramedic to show compliance with IV pump function.

1. The agency captain / paramedic supervisor / manager will ensure that all paramedics are in compliance IV pump operations
2. Any paramedic that can demonstrate IV pump operation or trouble shooting of operations a remedial course must be completed and a retest must be passed prior to being allowed to monitor or transport of Propofol.

III. **The use of Propofol is restricted to IV infusion only (No SubQ or IM or Bolus IV)**

1. The Propofol will not be given in the bolus form of administration.

2. Propofol will not be stored in any means on any unit. The hospital requesting transport will supply the medication as a drip. This drug will already being administered by an infusion.

Propofol Usage Policy

IV. Requirements at Transferring Hospital.

1. The paramedic will confirm ETT tube placement before movement of the patient to the stretcher, once the patient has been moved the paramedic will again confirm ETT tube placement.
2. End tidal CO2 with waveform will be attached and captured prior to leaving the ordering hospital.
3. The paramedic will ensure he or she fully understands the operation and trouble shooting of the IV pump if they are using the ordering hospital pump prior to leaving the bedside of the hospital.
4. A full report will be received on the trends of the patient since the start of administration of Propofol at the ordering hospital.

V. The paramedic will document in PCR Propofol;

1. Amount of propofol on hand.
2. Amount of propofol administered prior to arrival of the paramedic.
3. Dose of propofol.
4. Any increase or decrease of the propofol being administered during transport.
5. The amount of propofol turned over to the receiving hospital.
6. RN, MD/DO, PA signature on the form transferring and receiving hospital.
7. Transporting paramedic signature.

VI. Requirements during transport

1. The patient will be placed on the cardiac monitor
2. Vital signs will be obtained every 15 minutes with a cardiac strip & IV Pump Rate
3. End tidal CO2 with wave form will be obtained with cardiac strips. End tidal CO2 must be used throughout the transport.
4. Second caregiver will be present with the paramedic to assist as directed by the transporting paramedic

VII. Requirements at Receiving Hospital

1. Prior to moving the patient ETT tube placement will be confirmed with End tidal CO2 with waveform.
2. The paramedic will document on the transport sheet amount of propofol infused, amount of propofol left on hand, and the present dose of propofol the patient is receiving.
3. The paramedic will have the receiving RN, MD/DO, or PA will sign receipt of the medication on the transfer form.
4. The paramedic will sign confirming the turnover of the medication to the receiving hospital.
5. The paramedic will supply a copy of all trends in vitals, cardiac strips and wave forms to the receiving hospital.
6. The originals of the trends of vitals, cardiac strip with wave forms will be forwarded with the patient care report.

Propofol Usage Policy

Titration of Propofol during Transport

If the transporting paramedic determine that the patient needs to have the dose of Propofol increased the following steps must be taken;

1. The following is the dose range for increasing of the infused Propofol: Propofol increase is **20mcg/kg/min with a 5 minute** wait between dose increases, the **Max dose of Propofol is 200mcg/kg/min.**
2. Prior to increasing the dose vitals must be obtained.
3. The dose must be in small steps with a wait of 5 minutes between each increase.
4. Blood pressures will be obtained at a rate of every 5 minutes for the first 10 minutes with a cardiac strip and wave form for each set of vitals.
5. The transporting paramedic will document the reason he or she felt the need for increase of propofol was needed.
6. If the patient become Hypotensive during the transport the Propofol rate will be decrease at the rate of 20mcg/kg/min
7. The transporting paramedic will treat the hypotension will be treated per protocol for hypotension.
8. Additional agents may utilized to control pain and assist in ventilator compliance.

The paramedic will notify receiving hospital of any patient reactions to the propofol infusion.

All transports involving Propofol will be forwarded to the Medical Director.

All charts will go thru the peer review process.

Child with Special Health Care Needs (NC Kidbase)

Policy:

Medical technology, changes in the healthcare industry, and increased home health capabilities have created a special population of patients that interface with the EMS system. It is important for EMS to understand and provide quality care to children with special health care needs.

Purpose:

The purpose of this policy is to:

- Provide quality patient care and EMS services to children with special health care needs.
- Understand the need to communicate with the parents and caregivers regarding healthcare needs and devices that EMS may not have experience with.
- Promote, request, and use the "Kidbase" form, which catalogs the health care problems, needs, and issues of each child with a special healthcare need.

Procedure:

1. Caregivers who call 911 to report an emergency involving a child with special health care needs may report that the emergency involves a "Kidbase child" (if they are familiar with the NC Kidbase program) or may state that the situation involves a special needs child.

2. Responding EMS personnel should ask the caregiver of a special needs child for a copy of the "Kidbase Form", which is the North Carolina terminology for the Emergency Information Form (EIF).

3. EMS personnel may choose to contact the child's primary care physician for assistance with specific conditions or devices or for advice regarding appropriate treatment and/or transport of the child in the specific situation.

4. Transportation of the child, if necessary, will be made to the hospital appropriate for the specific condition of the child. In some cases this may involve bypassing the closest facility for a more distant yet more medically appropriate destination.

Infant Abandonment

Policy:

Article 5A, “Safe Surrender of Infants”, of the North Carolina General Statute provides a mechanism for unwanted infants to be taken under temporary custody by a law enforcement officer, social services worker, healthcare provider, or EMS personnel if an infant is presented by the parent and are no more than 30 days old. Emergency Medical Services will accept and protect infants who are presented to EMS in this manner, until custody of the child can be released to the Department of Social Services. The provisions of this Article apply exclusively to safely surrendered infants as defined in G.S. 7B-101(19a).

A first responder, including a law enforcement officer, a **certified emergency medical services worker**, or a firefighter shall, without a court order, take into temporary custody an infant reasonably believed to be not more than 30 days of age that is voluntarily delivered to the individual by the infant's parent who does not express an intent to return for the infant.

“An individual who takes an infant into temporary custody under this subsection shall perform any act necessary to protect the physical health and well-being of the infant and shall immediately notify the department of social services. Any individual who takes an infant into temporary custody under this subsection may inquire as to the parents' identities and as to any relevant medical history, but the parent is not required to provide this information.”

Purpose:

To provide:

- Protection to infants that are placed into the custody of EMS under this law
- Protection to EMS systems and personnel when confronted with this issue

Procedure:

1. Initiate the Pediatric Assessment Procedure.
2. Initiate Newly Born Protocol as appropriate.
3. Initiate other treatment as appropriate and transport to medical facility as per local protocol.
4. Keep infant warm.
5. Call local Department of Social Services or the county equivalent as soon as infant is stabilized.
6. Document protocols, procedures, and agency notifications in the PCR.

EMS Back in Service Time

Policy:

All EMS Units transporting a patient to a medical facility shall transfer the care of the patient and complete all required operational tasks to be back in service for the next potential EMS event within 30 minutes of arrival to the medical facility, 90% of the time.

Definition:

The EMS Back in Service Time is defined as the time interval beginning with the time the transporting EMS Unit arrives at the medical facility destination and ending with the time the EMS Unit checks back in service and available for the next EMS event.

Purpose:

The purpose of this policy is to:

- Assure that the care of each EMS patient transported to a medical facility is transferred to the medical facility staff in a timely manner.
- Assure that the EMS unit is cleaned, disinfected, restocked, and available for the next EMS event in a timely manner.
- Assure that an interim or complete EMS patient care report (PCR) is completed and left with the receiving medical facility documenting, at a minimum, the evaluation and care provided by EMS for that patient (It is acceptable to leave the PreMIS Preliminary Report or equivalent if the final PCR cannot be completed before leaving the facility).
- Provide quality EMS service and patient care to the county's citizens.
- Provide a means for continuous evaluation to assure policy compliance.

Procedure:

The following procedures shall be implemented to assure policy compliance:

1. The EMS Unit's priority upon arrival at the medical facility will be to transfer the care of the patient to medical facility staff as soon as possible.

2. EMS personnel will provide a verbal patient report on to the receiving medical facility staff.

3. EMS personnel will provide an interim (PreMIS Preliminary Report or equivalent) or final Patient Care Report (PCR) to the receiving medical facility staff, prior to leaving the facility, that documents at a minimum the patient's evaluation and care provided by EMS prior to arrival at the medical facility. A complete PCR should be completed as soon as possible but should not cause a delay in the EMS Back in Service Time.

4. The EMS Unit will be cleaned, disinfected, and restocked (if necessary) during the EMS Back in Service Time interval.

5. Any EMS Back in Service Time delay resulting in a prolonged EMS Back in Service Time will be documented in Patient Care Report (PCR) as an "EMS Turn-Around Delay" as required and defined in the North Carolina College of Emergency Physicians (NCCEP) EMS Dataset Standards Document.

6. All EMS Turn-Around Delays will be reviewed regularly within the EMS System Peer Review Committee.

EMS Wheels Rolling (Turn-Out) Time

Policy:

The EMS Wheels Rolling (Turn-out) Time will be less than 90 seconds, 90% of the time, for all events identified and classified as an emergent or hot (with lights and siren) response.

Definition:

The EMS Wheels Rolling (Turn-out) Time is defined as the time interval beginning with the time the EMS Dispatch Center notifies an EMS Unit to respond to a specific EMS event and ending with the time the EMS Unit is moving en route to the scene of the event.

Purpose:

The purpose of this policy is to:

- Provide a timely and reliable response for all EMS events within the EMS System.
- Provide quality EMS service and patient care to the county's citizens.
- Provide a means for continuous evaluation to assure policy compliance.

Procedure:

The following procedures shall be implemented to assure policy compliance:

1. In EMS Dispatch Centers where Emergency Medical Dispatch (EMD) has been implemented, EMS Units will be dispatched by EMD certified personnel in accordance with the standards developed by the Medical Director and the Emergency Medical Dispatch Protocols.
2. The EMS Unit Wheels Rolling (Turn-out) time will be less than 90 seconds from time of dispatch, 90% of the time. If a unit fails to check en route within 2:59 (mm:ss), the next available EMS unit will be dispatched.
3. Without question, exception, or hesitation, EMS Units will respond as dispatched (hot or cold). This includes both requests to respond on active calls and requests to "move-up" to cover areas of the System that have limited EMS resources available.
4. An EMS Unit may divert from a current cold (no lights and sirens) call to a higher priority hot (with lights and sirens) call **ONLY IF:**
   - The EMS Unit can get to the higher priority call before it can reach the lower priority call. Examples of High Priority Calls: Chest Pain, Respiratory Distress, CVA, etc.
   - The diverting EMS Unit must notify the EMS Dispatch Center that they are diverting to the higher priority call.
   - The diverting EMS Unit ensures that the EMS Dispatch Center dispatches an EMS Unit to their original call.
   - Once a call has been diverted, the next EMS Unit dispatched must respond to the original call. A call cannot be diverted more than one (1) time.
5. Any EMS Wheels Rolling (Turn-out) Time delay resulting in a prolonged EMS Response Time for emergent hot (with lights and sirens) events will be documented in Patient Care Report (PCR) as an "EMS Response Delay" as required and defined in the North Carolina College of Emergency Physicians (NCCEP) EMS Dataset Standards Document.
6. All EMS Response Delays will be reviewed regularly within the EMS System Peer Review Committee.

State Poison Center

Policy:

The state poison center should be utilized by the 911 centers and the responding EMS services to obtain assistance with the prehospital triage and treatment of patients who have a potential or actual poisoning.

Purpose:

The purpose of this policy is to:

- Improve the care of patients with poisonings, envenomations, and environmental/biochemical terrorism exposures in the prehospital setting.
- Provide for the most timely and appropriate level of care to the patient, including the decision to transport or treat on the scene.
- Integrate the State Poison Center into the prehospital response for hazardous materials and biochemical terrorism responses

Procedure:

1. The 911 call center will identify and if EMD capable, complete key questions for the Overdose/ Poisoning, Animal Bites/Attacks, or Carbon Monoxide/Inhalation/HazMat emergency medical dispatch complaints and dispatch the appropriate EMS services and/or directly contact the State Poison Center for consultation.
2. If no immediate life threat or need for transport is identified, EMS personnel may conference the patient/caller with the Poison Center Specialist at the **State Poison Center at 800-222-1222**. If possible, dispatch personnel should remain on the line during conference evaluation.
3. The Poison Center Specialist at the State Poison Center will evaluate the exposure and make recommendations regarding the need for on-site treatment and/or hospital transport in a timely manner. If dispatch personnel are not on-line, the Specialist will recontact the 911 center and communicate these recommendations.
4. If the patient is determined to need EMS transport, the poison center Specialist will contact the receiving hospital and provide information regarding the poisoning, including treatment recommendations. EMS may contact medical control for further instructions or to discuss transport options.
5. If the patient is determined not to require EMS transport, personnel will give the phone number of the patient/caller to the Poison Center Specialist. The Specialist will initiate a minimum of one follow-up call to the patient/caller to determine the status of patient.
6. Minimal information that should be obtained from the patient for the state poison center includes:
   - Name and age of patient
   - Time of exposure
   - Signs and symptoms
   - Substance(s) involved
   - Any treatment given
7. Minimal information which should be provided to the state poison center for mass poisonings, including biochemical terrorism and HazMat, includes:
   - Substance(s) involved
   - Signs and symptoms
   - Time of exposure
   - Any treatment given

Air Transport

Policy:

Air transport should be utilized whenever patient care can be improved by decreasing transport time or by giving advanced care not available from ground EMS services, but available from air medical transport services (i.e. blood).

Purpose:

The purpose of this policy is to:

- Improve patient care in the prehospital setting.
- Allow for expedient transport in serious, mass casualty settings.
- Provide life-saving treatment such as blood transfusion.
- Provide more timely access to interventional care in acute Stroke and ST-elevation myocardial infarction (STEMI) patients

Procedure:

Patient transportation via ground ambulance will not be delayed to wait for helicopter transportation. If the patient is packaged and ready for transport and the helicopter is not on the ground, or within a reasonable distance, the transportation will be initiated by ground ambulance.

Air transport should be considered if any of the following criteria apply**:**

- High priority patient with > 20 minute transport time
- Entrapped patients with > 10 minute estimated extrication time
- Multiple casualty incident with red/yellow tag patients
- Multi-trauma or medical patient requiring life-saving treatment not available in prehospital environment (i.e., blood transfusion, invasive procedure, operative intervention)
- Time dependent medical conditions such as acute ST-elevation myocardial infarctions (STEMI) or acute Stroke that could benefit from the resources at a specialty center as per the EMS System's Stroke and STEMI Plans.

If a potential need for air transport is anticipated, but not yet confirmed, an air medical transport service can be placed on standby.

If the scene conditions or patient situation improves after activation of the air medical transport service and air transport is determined not to be necessary, paramedic or administrative personnel may cancel the request for air transport.

Minimal Information which should be provided to the air medical transport service include:

- Number of patients
- Age of patients
- Sex of patients
- Mechanism of injury or complaint (MVC, fall, etc)

Safe Transport of Pediatric Patients

Policy:

Without special considerations children are at risk of injury when transported by EMS. EMS must provide appropriate stabilization and protection to pediatric patients during EMS transport.

Purpose:

To provide:

- Provide a safe method of transporting pediatric patients within an ambulance.
- Protect the EMS system and personnel from potential harm and liability associated with the transportation of pediatric patients.

Procedure:

1. Drive cautiously at safe speeds observing traffic laws.
2. Tightly secure all monitoring devices and other equipment.
3. Insure that all pediatric patient less than 40 lbs are restrained with an approved child restraint device secured appropriately to the stretcher or captains chair.
3. Insure that all EMS personnel use the available restraint systems during the transport.
4. Transport adults and children who are not patients, properly restrained, in an alternate passenger vehicle, whenever possible.
5. Do not allow parents, caregivers, or other passengers to be unrestrained during transport.
6. NEVER attempt to hold or allow the parents or caregivers to hold the patient during transport.

Transport

Policy:

All individuals served by the EMS system will be evaluated, treated, and furnished transportation (if indicated) in the most timely and appropriate manner for each individual situation.

Purpose:

To provide:

- Rapid emergency EMS transport when needed.
- Appropriate medical stabilization and treatment at the scene when necessary
- Protection of patients, EMS personnel, and citizens from undue risk when possible.

Procedure:

1. All trauma patients with significant mechanism or history for multiple system trauma will be transported as soon as possible. The scene time should be 10 minutes or less.

2. All acute Stroke and acute ST-Elevation Myocardial Infarction patients will be transported as soon as possible. The scene time should be 10 minutes or less for acute Stroke patients and 15 minutes or less (with 12 Lead ECG) for STEMI patients

2. Other Medical patients will be transported in the most efficient manner possible considering the medical condition. Advanced life support therapy should be provided at the scene if it would positively impact patient care. Justification for scene times greater than 20 minutes should be documented.

3. No patients will be transported in initial response non-transport vehicles.

4. In unusual circumstances, transport in other vehicles may be appropriate when directed by EMS administration.

Weapons and Explosive Devices

Policy:

Pursuant to 10A NCAC 13P .0216; Weapons, whether lethal, less lethal or non-lethal, and explosives (concealed or visible) shall not be worn or carried aboard an ambulance or EMS non-transporting vehicle within the State of North Carolina when the vehicle is operating in any patient treatment or transport capacity or is available for such function.

Weapons authorized for use by *EMS personnel attached to a law enforcement tactical team in accordance with the weapons policy as set forth in Rule .0201* of this Section may be secured in a locked, dedicated compartment or gun safe mounted within the ambulance or non-transporting vehicle for use when dispatched in support of the law enforcement tactical team, but are not to be worn or carried open or concealed by any EMS personnel in the performance of normal EMS duties under any circumstances. Rule .0201 requires every EMS System to have "a weapons plan for any weapon as set forth in Rule 10A NCAC 13P .0216 of this Section;" This NCCEP policy does not supersede local EMS system policy.

Purpose:

To ensure the safety of EMS personnel, patients, and the public at large.

Definitions:

Conducted electrical weapons and chemical irritants such as mace, pepper (oleoresin capsicum) spray, and tear gas shall be considered weapons for the purpose of this Rule.

- Weapon is defined as any device with a tube, including mechanical attachments, from which a projectile is delivered by force of an explosive and may be lethal or less lethal including conducted electrical device. Weapons may be either concealed or visible
- Chemicals considered weapons:
  Mace or Pepper spray (OC - oleoresin capsicum, CS – orthochlorbenzalmalonitrile
  CN – alphachloroacetaphenone)
- Projectile is typically represented by bullets, shells, or slugs and may be metallic are non-metallic in composition

Procedure:

- During scene size-up and during your secondary patient assessment all patients should be screened for weapons or explosive devices, preferably before entering an ambulance.
- Screen all patients regardless if they have been screened by Law Enforcement.
- Individuals riding in the ambulance (friends, family) should be asked about concealed weapons.
- In the event a weapon or explosive device is found in an ambulance during transportation, the weapon or explosive device will be safely secured or turned over to Law Enforcement.
- Ask all patients, including family/friends, transported if they have a concealed weapon.
  - "Do you have any firearms or weapons on your person"
- Likely scenarios EMS may encounter with individual found carrying a weapon:
  - Individual has capacity, or does not have capacity, but is cooperative
  - **Individual does not have capacity and is not cooperative:**
    - In this situation EMS personnel should retreat immediately to safety and notify Law Enforcement to secure the scene
- It is recommended that EMS systems have a lock-box of sufficient size to accommodate a typical hand-gun on each EMS vehicle or available to EMS crews to safely and securely stow and transport a weapon.
- This Rule shall not apply to duly appointed law enforcement officers.