

VERDE VALLEY MEDICAL CENTER
Cottonwood, Arizona 86326

EMERGENCY MEDICAL SERVICE: ORIENTATION MANUAL

The goal of this manual is to orient all Verde Valley prehospital care providers with the Emergency Medical Services System, utilizing Verde Valley Medical Center as their base station.

The information included in this manual is a combination of policies from ADHS, Regional protocols, and VVMC. To practice in the field, utilizing Medical Direction through VVMC, it is necessary to know and to follow these policies.

EMERGENCY MEDICAL SERVICES
ORIENTATION MANUAL

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DEFINITIONS Per (ADHS)**R9-25-101. Definitions (Authorized by A.R.S. §§ 36-2201, 36-2202, 36-2204, 36-2205)**

In Articles 1 through 4 and Article 5 of this Chapter, unless the context otherwise requires:

1. "Administrative medical direction" has the meaning in A.R.S. § 36-2201.
2. "Administrative medical director" means an individual qualified under R9-25-204 who provides administrative medical direction as required under R9-25-204.
3. "Advanced procedure" means an emergency medical service provided by an EMT that:
 - a. Requires skill or training beyond the basic skills or training prescribed in the Arizona EMT-B course as defined in R9-25-305; or
 - b. Is designated in A.R.S. Title 36, Chapter 21.1 or this Chapter as requiring medical direction.
4. "ALS base hospital" means the same as "advanced life support base hospital" in A.R.S. § 36-2201.
5. "Ambulance service" has the meaning in A.R.S. § 36-2201.
6. "Centralized medical direction communications center" has the meaning in A.R.S. § 36-2201.
7. "Chief administrative officer" means an individual assigned to act on behalf of an ALS base hospital or a training program certified under Article 3 of this Chapter by the body organized to govern and manage the ALS base hospital or the training program.
8. "Clinical training" means to provide an individual with experience and instruction in providing direct patient care in a health care institution.
9. "Communication protocol" means a written guideline prescribing:
 - a. How an EMT shall:
 - i. Request and receive on-line medical direction;
 - ii. Notify an on-line physician before arrival of an EMT's intent to transport a patient to a health care institution; and
 - iii. Notify a health care institution before arrival of an EMT's intent to transport a patient to the health care institution; and
 - b. What procedures and EMT shall follow in a communications equipment failure.
10. "Conspicuously post" means to make visible to patients and other individuals by displaying on an object, such as a wall or bulletin board.
11. "Course content outline" means a sequential listing of subject matter, objectives, skills, and competencies to be taught or tested.
12. "Dangerous drug" has the meaning in A.R.S. § 13-3401.
13. "Day" means a calendar day.
14. "Department" means the Arizona Department of Health Services.
15. "Drug" has the meaning in A.R.S. § 32-1901.
16. "Document" or "documentation" means signed and dated information in written, photographic, electronic, or other permanent form.
17. "Electronic signature" has the meaning in A.R.S. § 41-351.
18. "EMT" means the same as "certified emergency medical technician" in A.R.S. § 36-2201.
19. "EMT-B" means the same as "basic emergency medical technician" in A.R.S. § 36-2201.
20. "EMT-I" means the same as "intermediate emergency medical technician" in A.R.S. § 36-2201.
21. "EMT-P" means the same as "emergency paramedic" in A.R.S. § 36-2201.
22. "Emergency medical services" has the meaning in A.R.S. § 36-2201.
23. "Emergency medical services provider" has the meaning in A.R.S. § 36-2201.
24. "Field training" means to provide an individual with emergency medical services experience and training outside of a health care institution or a training program facility.
25. "General hospital" has the meaning in R9-10-201.
26. "Health care institution" has the meaning in A.R.S. § 36-401.
27. "Medical direction" means administrative medical direction or on-line medical direction.
28. "Medical record" has the meaning in A.R.S. § 36-2201.
29. "Narcotic drug" has the same meaning as "narcotic drugs" in A.R.S. § 13-3401.
30. "NREMT" means the National Registry of Emergency Medical Technicians.

DEFINITIONS Per (ADHS)con.

31. "On-line medical direction" means emergency medical services guidance or information provided to an EMT by an on-line physician through two-way voice communication.
32. "On-line physician" means an individual qualified under R9-25-205 who provides on-line medical direction as required under R9-25-205.
33. "Patient" means an individual who is sick, injured, or wounded and who requires medical monitoring, medical treatment, or transport.
34. "Person" has the meaning in A.R.S. § 1-215.
35. "Physician" has the meaning in A.R.S. § 36-2201.
36. "Prehospital incident history report" has the meaning in A.R.S. § 36-2220(E).
37. "Proficiency in advanced emergency cardiac life support" means:
 - a. Completion of 16 clock hours of organized training covering:
 - i. Electrocardiograph rhythm interpretation;
 - ii. Oral, tracheal, and nasal airway management;
 - iii. Nasotracheal intubation and surgical cricothyrotomy;
 - iv. Peripheral and central intravenous lines; and
 - v. Pharmacologic, mechanical, and electrical arrhythmia interventions; and
 - b. Every 24 months after meeting the requirement in subsection (37)(a), completion of additional training as determined by the training provider covering the subject matter listed in subsection (37)(a).
38. "Proficiency in advanced trauma life support" means:
 - a. Completion of 16 clock hours of organized training covering:
 - i. Rapid and accurate patient assessment,
 - ii. Patient resuscitation and stabilization,
 - iii. Patient transport or transfer, and
 - iv. Patient treatment and care; and
 - b. Every 48 months after meeting the requirement in subsection (38)(a), completion of additional training as determined by the training provider covering the subject matter listed in subsection (38)(a).
39. "Proficiency in cardiopulmonary resuscitation" means:
 - a. Completion of eight clock hours of organized training covering:
 - i. Adult and pediatric resuscitation,
 - ii. Rescuer scenarios and use of a bag-valve mask,
 - iii. Adult and child foreign-body airway obstruction in conscious and unconscious patients,
 - iv. Automated external defibrillation,
 - v. Special resuscitation situations, and
 - vi. Common cardiopulmonary emergencies; and
 - b. Every 24 months after meeting the requirement in subsection (39)(a), completion of additional training as determined by the training provider covering the subject matter listed in subsection (39)(a).
40. "Proficiency in pediatric emergency care" means:
 - a. Completion of 16 clock hours of organized training covering:
 - i. Pediatric rhythm interpretation;
 - ii. Oral, tracheal, and nasal airway management;
 - iii. Nasotracheal intubation and surgical cricothyrotomy;
 - iv. Peripheral and central intravenous lines;
 - v. Intraosseous infusion;
 - vi. Needle thoracostomy; and
 - vii. Pharmacologic, mechanical, and electrical arrhythmia interventions; and
 - b. Every 24 months after meeting the requirement in subsection (40)(a), completion of additional training as determined by the training provider covering the subject matter listed in subsection (40)(a).

DEFINITIONS Per (ADHS)

41. "Standing order" means a treatment protocol or triage protocol that authorizes an EMT to act without on-line medical direction.
42. "Supervise" or "supervision" means the same as "supervision" in A.R.S. § 36-401.
43. "Treatment protocol" means a written guideline that prescribes:
 - a. How an EMT shall perform a medical treatment on a patient or administer a drug to a patient; and
 - b. When on-line medical direction is required, if the protocol is not a standing order.
44. "Triage protocol" means a written guideline that prescribes:
 - a. How an EMT shall:
 - i. Assess and prioritize the medical condition of a patient,
 - ii. Select a health care institution to which a patient may be transported, and
 - iii. Transport a patient to a health care institution; and
 - b. When on-line medical direction is required, if the protocol is not a standing order.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Amended by exempt rulemaking at 7 A.A.R. 4888, effective November 1, 2001 (Supp. 01-4). Amended by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

NORTHERN ARIZONA EMERGENCY MEDICAL SERVICES COUNCIL

The purpose of this Council shall be to **serve** as the prime sponsor for the comprehensive range of emergency medical services for Apache, Coconino, Navajo and Yavapai Counties. The council shall exercise the following specific and implied for the administration of regional Emergency Medical Services coordination and planning.

- a. To act as a central agency for the exchange of information among members.
- b. To take action for mutual benefit of those agencies primarily engaged in emergency medical services in the Northern Region.
- c. To assist in planning and preparation of policies, programs and projects, including priorities.
- d. To advise in budgeting of all programs, including financial criteria, plans, conduct and administration.
- e. Members of the NAEMS Council may establish or adopt such rules for the proper operation of said Council as they deem expedient, which shall not be inconsistent with the laws of the State.

BASIC AND ALS LEGISLATION AND CERTIFICATION/RECERTIFICATION**R9-25-401. EMT General Requirements (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), and (A)(6), 36-2202(G), and 36-2204(1), (6), and (7))**

- A. An individual shall not act as an EMT-B, EMT-I, or EMT-P unless the individual has current certification or recertification from the Department.
- B. The Department shall approve or deny an application required by this Article pursuant to Article 12 of this Chapter.
- C. If the Department denies an application for certification or recertification, the applicant may request a hearing pursuant to A.R.S. Title 41, Chapter 6, Article 10.
- D. The Department shall certify or recertify an EMT for two years:
 - 1. Except as provided in R9-25-405; or
 - 2. Unless revoked by the Department pursuant to A.R.S. § 36-2211.
- E. An individual whose EMT certificate is expired shall not apply for recertification, unless the individual has been granted an extension to file an application for EMT recertification under R9-25-407.
- F. An individual whose EMT certificate is expired or denied by the Department may apply for certification pursuant to R9-25-404, or if applicable, R9-25-405.
- G. The Department shall keep confidential all criminal justice information received from the Department of Public Safety or any local, state, tribal, or federal law enforcement agency and shall not make this information available for public record review.

BASIC AND ALS LEGISLATION AND CERTIFICATION/RECERTIFICATION con.

R9-25-402. EMT Certification and Recertification Requirements (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), and (A)(6), 36-2202(G), and 36-2204(1), (6), and (7))

A. The Department shall not certify an EMT if the applicant:

1. Is currently:
 - a. Incarcerated for a criminal conviction,
 - b. On parole for a criminal conviction,
 - c. On supervised release for a criminal conviction, or
 - d. On probation for a criminal conviction;
2. Within 10 years before the date of filing an application for certification required by this Article, has been convicted of any of the following crimes, or any similarly defined crimes in this state or in any other state or jurisdiction, unless the conviction has been absolutely discharged, expunged, or vacated:
 - a. 1st or 2nd degree murder;
 - b. Attempted 1st or 2nd degree murder;
 - c. Sexual assault;
 - d. Attempted sexual assault;
 - e. Sexual abuse of a minor;
 - f. Attempted sexual abuse of a minor;
 - g. Sexual exploitation of a minor;
 - h. Attempted sexual exploitation of a minor;
 - i. Commercial sexual exploitation of a minor;
 - j. Attempted commercial sexual exploitation of a minor;
 - k. Molestation of a child;
 - l. Attempted molestation of a child; or
 - m. A dangerous crime against children as defined in A.R.S. § 13-604.01;
3. Within five years before the date of filing an application for certification required by this Article, has been convicted of a misdemeanor involving moral turpitude or a felony in this state or any other state or jurisdiction, other than a misdemeanor involving moral turpitude or a felony listed in subsection (A)(2), unless the conviction has been absolutely discharged, expunged, or vacated;
4. Within five years before the date of filing an application for certification required by this Article, has had EMT certification or recertification revoked in this state or EMT certification, recertification, or licensure revoked in any other state or jurisdiction; or
5. Knowingly provides false information in connection with an application required by this Article.

B. The Department shall not recertify an EMT, if:

1. While certified, the applicant has been convicted of a crime listed in subsection (A)(2), or any similarly defined crimes in this state or in any other state or jurisdiction, unless the conviction has been absolutely discharged, expunged, or vacated; or
2. The applicant knowingly provides false information in connection with an application required by this Article.

C. The Department shall certify or recertify an EMT who:

1. Is at least 18 years of age;
2. Is not ineligible for:
 - a. Certification pursuant to subsection (A), or
 - b. Recertification pursuant to subsection (B); and
3. Meets the applicable requirements in R9-25-404, R9-25-405, or R9-25-406.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

BASIC AND ALS LEGISLATION AND CERTIFICATION/RECERTIFICATION con.**R9-25-403. EMT Probationary Certification (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), and (A)(6), 36-2202(G), and 36-2204(1), (6), and (7))**

- A. The Department shall make probation a condition of certification under R9-25-404 or temporary certification under R9-25-405, if within two years before the date of filing an application for certification required by this Article, an applicant who is not ineligible for certification under R9-25-402 has been convicted of a misdemeanor in this state or in any other state or jurisdiction, involving:
1. Possession, use, administration, acquisition, sale, manufacture, or transportation of an intoxicating liquor, dangerous drug, or narcotic drug, unless the conviction has been absolutely discharged, expunged, or vacated; or
 2. Driving or being in physical control of a vehicle while under the influence of an intoxicating liquor, a dangerous drug, or a narcotic drug, unless the conviction has been absolutely discharged, expunged, or vacated.
- B. The Department shall fix the period and terms of probation that will:
1. Protect the public health and safety, and
 2. Remediate and educate the applicant.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

BASIC AND ALS LEGISLATION AND CERTIFICATION/RECERTIFICATION con.**R9-25-404. Application Requirements for EMT Certification (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), and (A)(4), 36-2202(G), and 36-2204(1) and (6))**

- A. An applicant for initial EMT certification shall submit to the Department an application including:
1. An application form provided by the Department containing:
 - a. The applicant's name, address, telephone number, date of birth, and social security number;
 - b. Responses to questions addressing the applicant's criminal history pursuant to R9-25-402(A) and R9-25-403(A);
 - c. Attestation that all information required as part of the application has been submitted and is true and accurate; and
 - d. The applicant's signature and date of signature;
 2. For each affirmative response to a question addressing the applicant's criminal history pursuant to R9-25-402(A) or R9-25-403(A), a detailed explanation and supporting documentation; and
 3. If applicable, a copy of EMT certification, recertification, or licensure issued to the applicant in another state or jurisdiction.
- B. In addition to the application, the following are required:
1. For EMT-B certification, both:
 - a. A certificate of course completion signed by the training program director designated for the course for either the:
 - i. Arizona EMT-B course, or
 - ii. Arizona EMT-B refresher, if the applicant has current certification, licensure, NREMT registration, or NREMT reregistration eligibility at the basic emergency medical technician level or higher level; and
 - b. Evidence of current NREMT-Basic registration;
 2. For EMT-I certification, both:
 - a. A certificate of course completion signed by the training program director designated for the course for either the:
 - i. Arizona EMT-I course, or
 - ii. Arizona ALS refresher, if the applicant has current certification, licensure, NREMT registration, or NREMT reregistration eligibility at the intermediate emergency medical technician level or higher level; and
 - b. Evidence of current NREMT-Intermediate registration; or
 3. For EMT-P certification, both:
 - a. A certificate of course completion signed by the training program director designated for the course for either the:
 - i. Arizona EMT-P course, or
 - ii. Arizona ALS refresher, if the applicant has current certification, licensure, NREMT registration, or NREMT reregistration eligibility at the paramedic emergency medical technician level; and
 - b. Evidence of current NREMT-Paramedic registration.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

BASIC AND ALS LEGISLATION AND CERTIFICATION/RECERTIFICATION con.**R9-25-405. Application Requirements for Temporary Nonrenewable EMT-B or EMT-P Certification (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), and (A)(4), 36-2202(G), and 36-2204(1), (6), and (7))**

- A. An individual who holds current NREMT-Basic registration, but does not meet requirements in R9-25-404(B)(1)(a), may apply for one temporary six-month EMT-B certification.
- B. An individual who holds current NREMT-Paramedic registration, but does not meet application requirements in R9-25-404(B)(3)(a), may apply for one temporary six-month EMT-P certification.
- C. An applicant for temporary certification shall submit to the Department a copy of current NREMT registration and an application required in R9-25-404(A).
- D. The Department shall certify an applicant who meets certification requirements under this Section for six months.
- E. The Department shall automatically certify an EMT who holds a six month certificate for an additional 18 months, if the EMT:
 - 1. Continues to hold current NREMT-Basic registration or current NREMT-Paramedic registration; and
 - 2. Before the expiration of the six month certificate, meets the applicable application requirements in R9-25-404(B).
- F. The Department shall issue an EMT who complies with subsection (E) a new certificate that expires 24 months from the date the six month certificate is issued.
- G. An EMT who is not certified under subsection (E):
 - 1. Shall not act as an EMT after the expiration date of the six month certificate,
 - 2. Is not eligible to apply for another six month certificate under this Section,
 - 3. Shall not apply for recertification, and
 - 4. May apply for certification pursuant to R9-25-404.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

BASIC AND ALS LEGISLATION AND CERTIFICATION/RECERTIFICATION con.**R9-25-406. Application Requirements for EMT Recertification (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), and (A)(6), 36-2202(G), and 36-2204(1), (4), and (6))**

- A. Before the expiration of the applicant's current certificate, an applicant for EMT recertification shall submit to the Department an application including:
1. An application form provided by the Department containing:
 - a. The applicant's name, address, telephone number, date of birth, and social security number;
 - b. Responses to questions addressing the applicant's criminal history pursuant to R9-25-402(A)(3), R9-25-402(B)(1), and R9-25-411(A);
 - c. Attestation that all information required as part of the application has been submitted and is true and accurate; and
 - d. The applicant's signature and date of signature;
 2. For each affirmative response to a question addressing the applicant's criminal history pursuant to R9-25-402(A)(3), R9-25-402(B)(1), and R9-25-411(A), a detailed explanation and supporting documentation; and
 3. If applicable, a copy of each EMT certification, recertification, or licensure issued to the applicant in another state or jurisdiction that the applicant holds.
- B. In addition to the application, the following are required:
1. For EMT-B recertification, either:
 - a. A certificate of course completion signed by the training program director designated for the course showing that within two years before the expiration date of an applicant's current EMT-B certificate, the applicant completed either the:
 - i. Arizona EMT-B refresher, or
 - ii. Arizona EMT-B refresher challenge examination; or
 - b. Evidence of current NREMT-Basic registration;
 2. For EMT-I recertification, either:
 - a. Attestation that the applicant:
 - i. Has completed continuing education required under subsection (C), and
 - ii. Has and will maintain for Department review documentation verifying completion of continuing education required under subsection (C); or
 - b. Evidence of current NREMT-Intermediate registration; or
 3. For EMT-P recertification, either:
 - a. Attestation that the applicant:
 - i. Has completed continuing education required under subsection (C), and
 - ii. Has and will maintain for Department review documentation verifying completion of continuing education required under subsection (C); or
 - b. Evidence of current NREMT-Paramedic registration.
- C. An EMT-I or EMT-P required to complete continuing education requirements under subsections (B)(2)(a) or (B)(3)(a) shall complete 60 clock hours of continuing education, as follows:
1. Seven clock hours through proficiency in cardiopulmonary resuscitation and proficiency in advanced emergency cardiac life support;
 2. No more than 48 clock hours for completion of the Arizona ALS refresher;
 3. No more than 12 clock hours for passing the Arizona ALS refresher challenge examination;
 4. No more than 20 clock hours of training in a single subject covered in the Arizona EMT-I course, the Arizona EMT-P course, or the Arizona ALS refresher;
 5. No more than 20 clock hours of teaching in a single subject covered in the Arizona EMT-I course, the Arizona EMT-P course, or the Arizona ALS refresher;
 6. No more than 20 clock hours of training related to skills, procedures, or treatments authorized under Article 5 of this Chapter;
 7. No more than 20 clock hours of teaching related to skills, procedures, or treatments authorized under Article 5 of this Chapter;

BASIC AND ALS LEGISLATION AND CERTIFICATION/RECERTIFICATION con.

8. No more than 20 clock hours of training in current developments, skills, procedures, or treatments related to the practice of emergency medicine or the provision of emergency medical services;
9. No more than 20 clock hours of participation in or attendance at meetings, conferences, presentations, seminars, or lectures designed to provide understanding of current developments, skills, procedures, or treatments related to the practice of emergency medicine or the provision of emergency medical services;
10. No more than 16 clock hours of training in advanced trauma life support; and
11. No more than 16 clock hours of training in pediatric emergency care.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

BASIC AND ALS LEGISLATION AND CERTIFICATION/RECERTIFICATION con.**R9-25-407. Extension to File an Application for EMT Recertification (Authorized by A.R.S. §§ 36-2202(A)(2), (A)(3), (A)(4), and (6), 36-2202(G), and 36-2204(1), (4), (5), and (7))**

- A. Before the expiration of a current certificate, an EMT who is unable to meet the recertification requirements in R9-25-406 because of personal or family illness, military service, or authorized federal or state emergency response deployment may apply to the Department in writing for one extension of time to file for recertification.
- B. The Department may grant one extension of time to file for recertification:
 - 1. For personal or family illness, for no more than 180 days; or
 - 2. For military service or authorized federal or state emergency response deployment, for the term of service or deployment plus 180 days.
- C. An individual applying for or granted an extension of time to file for recertification remains certified pursuant to the conditions of A.R.S. § 41-1092.11.
- D. An EMT who does not meet the recertification requirements in R9-25-406 within the extension period or has the application for recertification denied by the Department:
 - 1. Is not eligible to apply for recertification; and
 - 2. May apply for certification pursuant to R9-25-404, or if applicable, R9-25-405.

Historical Note

Adopted effective October 15, 1996 (Supp. 96-4). Section repealed; new Section made by final rulemaking at 9 A.A.R. 5372, effective January 3, 2004 (Supp. 03-4).

VERDE VALLEY PROVIDER AGENCIES

<u>AGENCY</u>	<u>MAILING ADDRESS</u>
Verde Valley Ambulance Company	PO Box 1477; Cottonwood AZ 86326
Clarkdale Fire Department	PO Box 308; Clarkdale AZ 86324
Verde Valley Fire District	2700 Godard; Cottonwood AZ 86326
Cottonwood Fire Department	191 s. 6 TH St.; Cottonwood AZ 86326
Lake Montezuma/Rimrock Fire Dept	3240 Beaver Creek Rd; Rimrock AZ 86335
Sedona Fire Department	2860 S.W. Drive; Sedona AZ 86336
Jerome Fire Department	PO Box 335; Jerome 86331

PREHOSPITAL CARE/CQI COMMITTEE MEMBERS

<u>Name</u>	<u>Agency</u>
Roland Wagenbach	VVFD #31
Mike Rauton	VVFD #32
Bill Boler	SFD
Bonnie Reay	MRFD
Tim Wills	CWFD
Larry Dawson	CWFD (a)
Gail Jones	VVAC
Ron Butcher	JFD
Brenda Johnson	Clarkdale Fire
Dr. Todd Lang	VVMC EMS director
Tish Arwrin	VVMC Prehospital Manager
Madelyn McMannes	SEC
Danette Young	ED Clinical Coordinator
David Marshall	Yavapai College

PREHOSPITAL CONTINOUS QUALITY IMPROVEMENT COMMITTE

POLICY:

Prehospital continuous quality improvement will be done monthly and presented through run reviews and the prehospital committee.

PURPOSE:

To meet at least semi-annually, keep regular meeting minutes, evaluate complaints, develop continuing education courses, cooperatively work on quality management issues, and provide updates on prehospital issues which affect the base hospital or agencies with supporting service agreements with the base hospital.

MEMBERSHIP:

Prehospital Manager, SEC representative, VVMC representative, Yavapai College representative and One representative from each agency who has a supporting service agreement with the base hospital.

GOALS:

1. Establish and revise as needed the orientation plan for Emergency physicians and nurses and for EMS providers.
2. Identify continuing education needs by using CQI results, agency or individual requests skills reviews and changes/updates in ADHS rules and regulations.
3. Develop a system to review the following categories of prehospital patient encounters to assure that both prehospital and base station personnel follow established protocols and procedures.
 - a. Monthly random review of 5% of refusals to treat, to a maximum of 100/month.
 - b. All code arrests.
 - c. All do not resuscitate
 - d. Monthly review of all cardiac chest pain patients.
 - e. Additional CQI monitoring projects as needs are identified.
4. Develop a process and documentation procedure, and a corrective action plan when review of cases indicates a lapse in following protocol or procedure.
5. Use an ongoing evaluation process to identify additional roles for the committee as issues arise or needs of the EMS community change.

EMS Medical Director

Date

Prehospital Care Coordinator

Date

SUBMISSION OF RE CERTIFICATION APPLICATION

Before the expiration of the applicant's current certification, all EMTs, IEMTs, and CEPs shall submit a recertification application to Arizona Department of Health Services

PURPOSE:

To provide a written guideline to facilitate the recertification process.

PROCEDURE:

1. Six months prior to recertification date the provider may contact the prehospital manager and make an appointment for review of continuing education requirements and skills. This is an optional activity.
2. The provider should bring the following documents:
 - a. Current CPR, ACLS, and/or other certification cards.
 - b. Current ADHS certification card.
 - c. Copies of all continuing education sessions (C.E.) attended during the last recertification period.
 - d. Copies of C.E. for any skills labs attended.
 - e. Copies of any other C.E. that will meet recertification requirements.
3. The prehospital manager will help provider verify that his continuing education requirements for recertification have been met.
4. If the continuing education requirements are not met, the provider will have six months to meet the requirements before the recertification is due.
5. Please note: It is the provider's responsibility to keep accurate records of continuing education attended.

EMS Director

Date

Prehospital **Care Coordinator**

Date

IEMT and CEP RECERTIFICATION PROCESS

POLICY:

All levels of EMS based at VVMC will comply with ADHS policy for recertification and provide VVMC bases station with a current copy of his/her state certification.

PURPOSE:

To provide a written process for evaluating compliance with ADHS recertification process.

PROCEDURE:

1. The provider can choose to make an appointment with the prehospital manager to review the requirements for recertification before their current certification card expires.
2. The following categories of continuing education meet requirements for ADHS recertification:
 - a. Seven (7) clock hours through proficiency in cardiac pulmonary resuscitation and proficiency in advanced emergency cardiac life support.
 - b. No more than 48 clock hours for completion of Arizona ALS refresher.
 - c. No more than 12 clock hours for passing the Arizona ALS refresher challenge examination.
 - d. No more than 20 clock hours of training in a single subject covered in the Arizona EMT-I course, The Arizona EMT-P course, or the Arizona ALS refresher.
 - e. No more than 20 clock hours of teaching in a single subject covered in the Arizona EMT-I course, EMT-P course or ALS refresher.
 - f. No more than 20 clock hours of training related to skills, procedures, or treatments covered under the scope of practice for an Arizona EMT-I or EMT-P.
 - g. No more than 20 clock hours of teaching related to skills, procedures, or treatments covered under the scope of practice for an Arizona EMT-I or EMT-P.
 - h. No more than 20 clock hours of training I current developments, skills, procedures, or treatments related to the practice of emergency medicine or the provision of emergency medical services.
 - i. No more than 20 clock hours of participation in or attendance at meetings, conferences, presentations, seminars, or lectures designed to provide understanding of current developments, skills, procedures, or treatments related to the practice of emergency medicine or the provision of emergency medical services.
 - j. No more than 16 clock hours of training in advanced trauma life support.
 - k. No more than 16 clock hours of training in pediatric emergency care.
3. **Total continuing education credits shall equal 60 hours from the above categories OR evidence or current NREMT Intermediate or NREMT-Paramedic registration.**
4. An application form provided by ADHS shall be sent in with above educational requirements.
5. If applicable, a copy of each certification, or licensure issued to the applicant in another state shall be sent in with the application.
6. A provider who has applied for recertification shall not function as an IEMT/CEP after the expiration of the current certification until given a recertification by ADHS.

EMS director

Date

Prehospital Care Coordinator

Date

CONTINUING MEDICAL EDUCATION

1. College course (1 unit or credit = 3 hours CE). The course must have prior approval by the Department. The course must be in the health-related field. A copy of the official transcript or a grade card proving successful completion must be sent to the Department for CE credits
2. Base Station Run Reviews (1 session = 1 hour CE). Run reviews are conducted by the base hospital under the direction of the Medical Director and Coordinator for purposes of auditing and evaluating field and base hospital medical control and performances.
3. Conference / didactic / lecture session (1 hour = 1 hour CE). A presented on a subject pertaining to emergency medicine or related fields. It is suggested that out-of-state conferences be approved by the Department prior to registration.
4. Supervised clinical experience (2 hours = 1 hour CE). In-hospital clinical experience and practice with appropriate supervision and documentation by the base hospital medical director or coordinator.
5. Skills workshop (1 hour = 1 hour CE). Practice sessions relevant to EMT skills as defined by State rules and regulations or new techniques as approved by the Department.
6. Supervised audio-visual (1 hour = 1 hour CE). Audio-visual program related to emergency medicine monitored by a qualified instructor who is approved by the Department.
7. Teaching (1 hour = 1 hour CE). Conduction of a class of instruction pertaining to emergency medicine which is sponsored by an agency approved by the Department. The teaching requires research and preparation of material equal to or beyond the content of the basic EMT-level of training. A course outline must accompany the CE form.
8. ACLS (1 hour = 1 hour CE). Successful completion of an advanced cardiac life support class either approved by AHA or approved by the Department as equivalent.
9. BLS (1 hour = 1 hour CE). Successful completion of a basic life support class approved by the AHA or by the Office of EMS Training and Certification.
10. Supervised field vehicular experience (2 hours = 1 hour CE). Documented vehicular experience and practice with supervision approved by the Department (for IEMT's and Basic EMT's).
11. Medical Run Review (1 session = 1 hour CE). Run reviews are conducted by a licensed physician, registered nurse, or emergency physician's assistant for purposes of auditing and evaluating field performance.
12. Vehicular preceptorship (1 hour = 1 hour CE). Precepting of vehicular time for students enrolled in an EMT course (Basic, IEMT, IEMT-C, and Paramedic). Must be documented patient contact.

LOSS OF CERTIFICATION/UNPROFESSIONAL CONDUCT

- A. Under ARS 36-2211, unprofessional conduct is an act or omission made by an EMT that is contrary to the recognized standards or ethics of the EMT profession or that may constitute a danger to the health, welfare, or safety of a patient or the public, including but not limited to:
1. Impersonation of an EMT of a higher level of certification or impersonation of a health professional as defined in A.R.S. 32-3201.
 2. Permitting or allowing another individual to use the EMT certification for any purpose.
 3. Aiding or abetting an individual who is not certified as an EMT, who is acting as an EMT or in representing that the individual is certified as an EMT;
 4. Engaging in or soliciting sexual relationships, whether consensual or nonconsensual with a patient while acting as an EMT;
 5. Physically or verbally harassing, abusing, threatening, or intimidating a patient or another individual while acting as an EMT;
 6. Making false or materially incorrect entries in a medical record or willful destruction of a medical record;
 7. Failing or refusing to maintain adequate records on a patient;
 8. Soliciting or obtaining monies or goods from a patient by fraud, deceit, or misrepresentation;
 9. Aiding or abetting an individual in fraud, deceit, or misrepresentation in meeting or attempting to meet the application requirements for EMT certification or EMT recertification in the State of Arizona, including the requirements established for:
 - a. Completing and passing a course provided by a training program; and
 - b. The NREMT examination process and NREMT registration process;
 10. Providing false information or making fraudulent or untrue statements to the Arizona Department of Health Services (ADHS) or about the ADHS during an investigation conducted by the ADHS.
 11. Being incarcerated or being placed on parole, supervised release, or probation for any criminal conviction;
 12. Being convicted of a misdemeanor identified in R9-25-403A, which has not been absolutely discharged, expunged, or vacated.
 13. Having NREMT registration revoked or suspended by NREMT for material non-compliance with NREMT rules or standards; and
 14. Having EMT certification, recertification, or licensure revoked or suspended in another state or jurisdiction.
- B. Under ARS 36-2211 physical or mental incompetence of an EMT is the EMT's lack of physical or mental ability to provide emergency medical services as required by EMT scope of practice.
- C. Under ARS 36-2211, gross incompetence or gross negligence is an EMT's willful act or willful omission of a act that is made in disregard of an individual's life, health, or safety and that may cause death or injury.
- D. If, in the opinion of the EMS director, there is sufficient information indicating the EMT-B, EMT-I, or EMT-P has engaged in the activities listed above, the director may request an informal interview with the involved party(ies). If the EMT-B, EMT-I, or EMT-P accepts the same and if the results of such an interview indicate suspension or revocation of certification might be in order, then a complaint may be issued to the ADHS from the base station requesting formal investigation.

EMS Director

Date

Prehospital Care Coordinator

Date

APPLICATION FOR LETTER OF RECOMMENDATION FOR ALS/BLS PROVIDERS

PURPOSE:

To establish a procedure to be used when a letter of recommendation is needed from the base station to apply for admission to a training program or other education programs.

POLICY:

Anyone who is requesting a letter of recommendation must follow the step in this policy. Verbal requests for a recommendation without an interview will not be honored.

PROCEDURE:

1. Contact prehospital manager at (928)639-6178 and request an appointment for the purpose of obtaining a letter of recommendation from the base station.
2. Assemble and bring to the appointment the following items: current certification card, a brief self evaluation of your strengths and weaknesses relating to EMS issues, samples of documentation on recent EMS calls.
3. Be prepared for an informal interview with the prehospital manager and/or EMS director.
4. Bring the name and address of the person the letter should be directed to.
5. At the completion of the interview the applicant will be given a letter of recommendation or be given suggestions for ways to improve their basic skills before reapplying at a future time.

EMS Director

Date

Prehospital Care Coordinator

Date

APPLICATION FOR MEDICAL DIRECTION

POLICY:

Each newly certified or newly hired ALS provider will apply to the base station and will be approved by the EMS director and prehospital manager before he/she may function in the field.

PURPOSE:

To provide a consistent way of evaluating and orienting each new ALS provider to the policies and expectations of the base station.

PROCEDURE:

1. Make an appointment with the prehospital manager, phone number 639-6178.
2. Provide the prehospital manager with the following:
 - a. Copies of current CPR, ACLS, and ADHS certification cards.
 - b. Summary of previous experience, education, and employers.
 - c. Summary of previous base station affiliations.
 - d. List of references upon request.
3. Read and sign verification of understanding of the VVMC EMS orientation manual (III-IA).
4. Complete the orientation checklist and summary of experience during the appointment with the prehospital manager (III-2) & (III-4).
5. Complete up to eight (8) hours of clinical time at VVMC/SEC ED's.
6. Read and sign ALS Performance Contract utilizing VVMC as base station (III-3).
7. ALS providers not meeting all criteria will not be assigned to VVMC base station and may not function in the field as an ALS provider using VVMC as their base station.

EMS Director

Date

Prehospital Care Coordinator

Date

VERIFICATION OF REVIEW AND UNDERSTANDING OF ORIENTATION MANUAL

I have read and reviewed the policies and procedures in the EMS orientation manual. I agree to perform my duties in compliance with the policies and procedures in this manual.

Name

Date

Verde Valley Medical Center ALS Orientation Checklist

Date: _____

1. Summary of EMS experience completed.
2. Copy of current CPR/ACLS card.
3. Copy of current ADHS certification card.
4. Read following polices in EMS orientation manual.
 - a. medical direction
 - b. documentation guidelines
 - c. radio/telephone patch guidelines
 - d. recertification procedure/CE requirements
 - e. field treatment protocols
 - f. re-supply/drug box procedures
 - g. conflict resolution
 - h. refusal/nontransported patients
 - i. ALS interfacility transports
5. Meet base hospital medical director
6. Meet prehospital care coordinator
7. ____ hours emergency department clinical time al VVMC or Sedona Emergicenter.

Medical Director

Date

Prehospital Care Coordinator

Date

ALS PERFORMANCE CONTRACT UTILIZING VERDE VALLEY MEDICAL CENTER AS BASE STATION

I, _____, agree to perform my IEMT/CEP duties at the Standard of Care required by my base station (Verde Valley Medical Center). I will adhere to polices and procedures set forth by my base station and by Arizona state certification requirements.

I will maintain my patient care skills by adequate ride time, supplemental clinical time, attending at least 8 tape and chart reviews in a two year recertification period, attending an Airway skills workshop in each recertification period, and attending additional continuing education opportunities required by Arizona Department of Health Services to meet recertification requirements. I will keep my BCLS and ACLS certifications current. I will keep my ADHS certification current. I understand that quarterly attendance at tape an chart is necessary to continue utilizing VVMC as my base station.

I will complete my patient care encounter form quickly and accurately, and place with patient's chart in the emergency department. I will place a copy in the designated file for CQI review. I will restock only those supplies used in the care of the patient, and will provide the pharmacy with a copy of the patient care form when medications have been used.

I will maintain confidentiality on all patient encounters in the field and in the Emergency Department. Patient information reviewed in monthly tape and chart sessions also will be handled with the strictest confidence.

I understand that when I am providing patient care, I am working under the physician's license at my base station. I will provide care utilizing regional protocols and I will contact my base station for orders as quickly as possible. I understand that without the approval of my base station EMS director agreeing to supply medical direction, I cannot provide patient care.

I agree to perform as stated above. I have read and understand all the information in the EMS orientation manual.

EMS Provider
Agency_____

Date

EMS Director

Date

Prehospital Care Coordinator

Date

SUMMARY OF EMS EXPERIENCE

Name: _____ Date: _____

Certification level and number: _____

Certification date (first): _____ **Expiration date:** _____

Training program(s), date(s) and instructor(s): _____

Identify previous field experiences: _____

Previous base station affiliation: _____

Teaching experience, ACLS, PHTLS, CPR, etc. _____

Any other comments: _____

Verde Valley employer: _____

Signature

Date

SUSPENSION/WITHDRAWAL OF MEDICAL CONTROL

POLICY:

Problems which may result in suspension or withdrawal of medical control will be addressed by the personnel involved, base station EMS director, and prehospital manager

PURPOSE:

To provide a means of identifying, investigating, and resolving issues which could result in suspension or withdrawal of medical control.

PROCEDURE:

1. Any violation of state certification requirements, base station policies and procedures or confidentiality guidelines will be brought to the attention of the EMS director and prehospital manager.
2. All pertinent information will be gathered and verified. These may include prehospital records, medication records, ESCOMM/patch phone tapes, and written statements from involved personnel. Verbal accounts will not be accepted.
3. A meeting will be scheduled with the involved personnel; the person's employing agency representative (optional), the EMS director, and the prehospital manager. All facts will be reviewed. If a violation has occurred the EMS director will make a decision to suspend or withdraw medical control if needed.
4. A suspension will include a time frame, a corrective action plan, and a date for reevaluation for possible reinstatement of medical control. This will be put in writing and placed in the person's base station file. A copy will be given to the person involved and the employing agency.
5. A withdrawal of medical control will be put in writing and put in the person's base station file. The person and the employing agency will be given a copy of the withdrawal; this will be delivered by certified mail.
6. In the event of withdrawal of medical control a letter will be sent to ADHS noting that the person is no longer eligible for medical control from the base station at Verde Valley Medical Center.
7. It will be the policy of the EMS Director to avoid punitive measures in favor of remedial and educational interventions if at all possible

EMS Director

Date

Prehospital Care Coordinator

Date

BASE STATION POLICY ON CONTINUING EDUCATION

POLICY:

Verde Valley Medical Center will offer supervised clinical time to ALS personnel who desire additional clinical time or for those who require it for skills proficiency. In addition VVMC base station will provide a minimum of two (2) hours of formal prehospital education a month in the form of run reviews and lecture. This education will follow ADHS requirements as described in R-9-23-206(I)(2). VVMC will provide training for any new ADHS approved treatment, protocol, skill or drug within 90 days of receiving notification from ADHS that the new item has been adopted in rule. VVMC will provide a minimum of one airway skills lab per year that meets the requirement for ALS recertification.

PURPOSE:

To provide a policy to ensure opportunities for continuing education. These opportunities will meet requirements for ADHS recertification.

PROCEDURE:

1. VVMC will provide the facilities, equipment, and audio-visual aids for the continuing education offered.
2. Prehospital case reviews will be included in the 24 clock hours of continuing education per year. These may be incorporated into didactic or clinical skills.
3. VVMC will require these cases to be prepared under the direction of the EMS director or prehospital manager.
4. Base station run reviews will be held on a scheduled and posted basis. Changes from this schedule will be announced in advance.
5. All providers who are based at VVMC are welcome to attend all VVMC run reviews. Twelve of these sessions are needed in a two year period to recertify.
6. Medics who are not based at VVMC may attend on a space available basis.
7. Clinical time is arranged through the prehospital manager and needs to be set up in advance.
8. Clinical time needs to be documented and submitted to the prehospital manager to receive CE's.
9. CE's for run reviews will be handed out after the session or mailed to the provider's agency. It is the provider's responsibility to keep track of their own paperwork.

EMS director

Date

Prehospital Care Coordinator

Date

CONFIDENTIALITY

POLICY:

Information EMS personnel receive during patient treatment, tape and chart review, clinical time, class time, EMS calls, and in the Emergency Department is privileged information. This information is never to be discussed with anyone not involved in the patient's care. Particular care needs to be used to not talk about a patient or a situation within hearing of others in a public place, (cafeteria etc.).

A person who questions you regarding a patient's condition, treatment, or outcome should be referred to the nurse taking care of the patient. The patient has the option to discuss their care/condition with anyone they choose.

EMS personnel who are contacted by lawyers, newspapers, insurance companies, or law enforcement officers should not release information without letting their employer and the prehospital manager know that they have been approached for information. The employer/prehospital manager will make arrangements to provide information, if possible, in a way that does not compromise confidentiality.

EMS director

Date

Prehospital Care Coordinator

Date

CLINICAL TIME FOR EMS PROVIDERS

GUIDELINES:

Certified EMT's, IEMT's, and CEP's may do clinical time at Verde Valley Medical Center or Sedona Emergency Center. Medics must work for an agency and have professional liability coverage through their agency.

Clinical time may be done in the Emergency Department, Critical Care Unit, Obstetrics and Same Day Surgery with prior scheduling and approval.

EMT's, IEMT's and CEP's may practice skills which they are certified to do with the approval and supervision of an RN and/or physician. A preceptor will be assigned to the person for the clinical period.

Clinical time should be documented on the proper form and submitted to the prehospital manager to be credited for CE. The person should also keep a copy for his/her records.

EMS director

Date

Prehospital Care Coordinator

Date

CLINICAL TIME DOCUMENTATION

Name: _____

Date: _____ Hours: _____

Registered Nurse: _____

Physician: _____

PATIENT CARE AND PROCEDURES

*Key: S=Successful U=Unsuccessful

DIAGNOSIS	AGE	ASSESSMENT	PROCEDURE(S)	S / U

Medic Comments: _____

Signature: _____ Date: _____

RN / Physician Comments: _____

Signature: _____ Date: _____

PATIENT OUTCOME INFORMATION

POLICY:

Prehospital providers may request follow-up and outcome data on patients they have provided care to.

PURPOSE:

To allow providers access to outcome data to give continuity of care and insight into disease process and follow-up treatments.

PROCEDURE:

1. Provider will fill out a follow-up form and submit it to the prehospital manager. (See attached example).
2. Prehospital manager will complete the follow-up form and contact the provider.
3. All information about patient will be considered confidential and will not be discussed with others. HIPAA guidelines will be followed when patient follow-up is given.
4. Any cases that will be used for education/training purposes will also remain confidential. Names, addresses, and any other identifying features will be removed before being used as case studies.

EMS Director

Date

Prehospital Care Coordinator

Date

REQUEST FOR DATA OUTCOME

Patient Name: _____

Date seen: _____

Transporting Agency: _____

Receiving facility: _____

Initial chief complaint/s: _____

Provider requesting data outcome: _____ (Name)

Data outcome results: _____

ALS DRUG BOX MAINTENANCE AND CONTROL**PURPOSE:**

To establish procedures for the provision and control of the ALS drug boxes as required by the Arizona Department of Health Services and the Arizona State Board of Pharmacy.

POLICY:

The pharmacy department of Verde Valley Medical Center shall supply the contents of drug boxes to the ALS agencies based out of Verde Valley Medical Center. All drug boxes will be standardized and will contain medications and supplies as outlined in the ADHS drug box regulations. Each ALS vehicle may be issued a drug box. Each EMS provider agency will acquire sufficient containers to serve as the drug boxes to meet peak demands in its service area.

PROCEDURE:

1. Use of the contents of the drug box is prohibited without medical direction from the base station physician.
2. The drug list may be periodically modified to include new drugs and delete existing drugs as needed with changes in ADHS rules. Additional training will be provided as needed when new drugs are added.
3. A drug may be given by EMS providers only by order of the base station physician, by indirect communication through a nurse intermediary, as directed in VVMC off-line protocols, or by following Northern Arizona EMS protocols.
4. When ordering a controlled substance the physician must sign the telemetry form to verify this order. A copy of this signed telemetry form MUST accompany the first care form in order to restock the medication from the Omnicell.
5. The drug box and contents can only be used by currently certified ALS personnel.
6. Drug box contents are part of VVMC pharmacy's inventory and records of accountability.
7. On duty ALS personnel are responsible for the drug box and contents at their agency and are accountable to the pharmacy for its contents.
8. Each EMS provider agency is responsible for checking their drug boxes for expiration dates, drug damage and deterioration, package damage, illegible labels, and for replacing outdates and damaged items as needed through the Omnicell.
9. Drug boxes must be stored in vehicles with a secured compartment. Each EMS provider is responsible for security and environmental control of the drug boxes while on duty.
10. When changing shifts EMS personnel are responsible for assignment of the drug box to the oncoming shift. A record of drug box inspection shall be made prior to an individual assuming accountability for the drug box.
11. When a discrepancy is found, (broken container, missing drugs etc.), an immediate report must be made to the duty supervisor and the VVMC pharmacy. An incident report shall be filed with the pharmacy. If the incident involves a Class II controlled substance it will also be reported to the State Board of Pharmacy, DPS narcotics division, DEA and local authorities.
12. All drugs administered will be recorded on the patient's first care form. The original will go with the patient's medical record and a copy will be placed in the Omnicell when restocking the drug box.
13. All drug boxes will be standardized; the same contents will be used by all agencies having supporting service agreements with Verde Valley Medical Center.
14. Each drug box will be supplied with all drugs authorized in the ADHS drug lists. Administration of drugs shall be limited to those designated for the appropriate skill level of the care provider.
15. Drug boxes shall be restocked "drug for drug" using the Omnicell in both the Cottonwood and Sedona emergency departments.
16. When narcotics are titrated and the entire dose is not used, the remaining medication will be wasted upon arrival to the Emergency Department. Wasting of medication will be witnessed by a second licensed individual and will be documented on the first care form. The waste will also be documented in the Omnicell system.

ALS DRUG BOX MAINTENANCE AND CONTROL con.

17. If an entire new drug box is needed, an exchange can be done by taking the old box to the pharmacy. If an exchange is needed after the pharmacy is closed, an ED nurse will make the exchange.
18. If a drug box is used on transport of a patient to a facility without the capability to restock a drug, the drug may be replaced from the Omnicell at either ED's upon return from the transport.
19. All drug boxes will be standardized to Plano model 7Y7 M, unless special arrangement has been made with VVMC pharmacy.
20. Each drug box will contain a standard amount of each drug. This amount complies with the amount recommended in the ADHS drug list.
21. An EMS provider shall be allowed to carry additional quantities of a drug to satisfy the specific needs of a local service area. A written request and ADHS approval is needed to carry supplies in excess of the standard amounts.
22. Controlled substances shall not be subject to supply flexibility.

EMS director

Date

Prehospital Care Coordinator

Date

INTEGRITY AND SECURITY OF DRUG BOXES IN THE FIELD

POLICY:

The integrity and security of the drug box is the responsibility of the VVMC pharmacy and the agency personnel to which it is assigned.

PURPOSE:

To provide a procedure for maintaining the integrity of the drug box and its contents.

PROCEDURE:

1. Drug boxes are initially obtained through the VVMC pharmacy department.
2. When exchanging/obtaining a new drug box the receiving medic should inspect the box to assure that all contents are intact per ADHS regulations. The drug box should be locked at all times unless in use or during inspection times.
3. Required needles, syringes, alcohol and betadine preps are kept in the Omnicell in the ED and should be restocked as needed. (See restocking procedure III-27).It is the responsibility of the provider to maintain the box itself (repairs, cleanliness). If a box needs to be replaced pharmacy should be notified at the time of the damage.
4. Each agency will have a system for assuring that the contents are intact and secure at change of each shift. Numbered locks along with a documentation sheet are recommended.
5. Each agency will have a system for checking for outdated medicines. Outdated medications may be replaced through the Omnicell stock.
6. If, at any time, narcotics are missing from the drug box, it should be reported at the time of discovery to the pharmacy. An incident form must be filled out for the pharmacy and a copy will go to the prehospital manager. Reporting procedures are listed in ALS Drug Box Maintenance and Control (III-9).
7. All drugs used from the drug box shall be recorded on the first care form. Medical direction for the orders to give medications should be noted on the telemetry form (in the ED), signed by the physician on duty, and a copy attached to the first care form and sent back to the pharmacy via the Omnicell.

EMS director

Date

Prehospital Care Coordinator

Date

EMT-P AND EMT-Q DRUG LIST

AGENT	MINIMUM SUPPLY
ADENOSINE	30 mg
ALBUTEROL SULFATE * (sulfite free)	10 mg
AMIODARONE (optional)	300 mg
ASPIRIN	324 mg
ATROPINE SULFATE	4 prefilled syringes, total of 4 mg 8 mg multidose vial (1)
CALCIUM CHLORIDE	1g
CHARCOAL, ACTIVATED (without sorbitol)	50 g
DEXAMETHASONE (optional)	8mg
DEXTROSE	50 g
DIAZEPAM	20 mg
DIAZEPAM RECTAL DELIVERY GEL (optional)	20 mg
DIPHENHYDRAMINE HC1	50 mg
DILTIAZEM (optional)	25 mg
DOPAMINE HC1	400 mg
EPINEPHRINE HCl, 1:1,000 Solution	2 mg, 30 mg multidose vial (1)
EPINEPHRINE HCl, 1:10,000 Solution	6 mg
ETOMIDATE (optional)	80 mg
FUROSEMIDE or BUMETANIDE	100 mg 4 mg
GLUCAGON	2 mg
IPRATROPIUM BROMIDE * 0.02%	5 ml
LIDOCANE HCl IV	3 prefilled syringes, total of 300 mg 1 g vial or premixed infusion, total of 2 g
MAGNESIUM SULFATE	5 g

EMT-P AND EMT-Q DRUG LIST con.

AGENT	MINIMUM SUPPLY
METHYLPREDNISOLONE SODIUM SUCCINATE	250mg
MIDAZLAM (versed) (optional)	10 mg
MORPHINE SULFATE	20 mg
NALOXONE HCl (optional)	10 mg
NITROGLYCERIN TABLETS	1 bottle
OXYTOCIN (optional)	10 units
PHENYLEPHRINE NASAL SPRAY 0.5%	1 bottle
SODIUM BICARBONATE 8.4%	100 mEq
SUCCINYLCHOLINE (optional)	400 mg
THIAMINE HCl	100 mg
VASOPRESSIN (optional)	40 units
VERAPAMIL HCl	10 mg
NITROUS OXIDE (optional)	Nitrous oxide 50% / Oxygen 50% fixed ratio setup with O ₂ fail-safe device and self-administration mask, 1 setup
FILTER NEEDLES	5 micron (3)
NON-FILTER NEEDLES	assorted sizes
INTRAVENOUS SOLUTIONS:	
DEXTROSE, 5% in water	250 ml bag (1)
LACTATED RINGER'S	1 l bag (4)
NORMAL SALINE	1 l bag (4) 250 ml bag (3) 50 ml bag (2)

EMT-I DRUG LIST

AGENT	MINIMUM SUPPLY
ALBUTEROL SULFATE *(sulfite free)	10 mg
ASPIRIN	324 mg
ATROPINE SULFATE	8 mg multidose vial (1)
ACTIVATED CHARCOAL (without sorbitol)	50 g
DEXTROSE	50 g
DIAZEPAM	20 mg
DIAZEPAM RECTAL DELIVERY GEL (optional)	20 mg
DIPHENHYDRAMINE HCl	50 mg
EPINEPHRINE HCl, 1:1,000 Solution	2 mg
EPINEPHRINE HCl, 1:10,000 Solution	6 mg
FUROSEMIDE or BUMETANIDE	100 mg 4 mg
GLUCAGON	2 mg
IPRATROPIUM BROMIDE * 0.02%	5 ml
METHYLPREDNISOLONE SODIUM SUCCINATE	250 mg
MIDZOLAM (versed) (optional)	10 mg
MORPHINE SULFATE	20 mg
NALMEFENE HCl (optional)	4 mg
NALOXONE HCl	10 mg
NITROGLYCERIN TABLETS	1 bottle
OXYTOCIN (optional)	10 units
PHENYLEPHRINE NASAL SPRAY 0.5%	1 bottle
SODIUM BICARBONATE 8.4%	100 mEq
THIAMINE HCl	100 mg
NITROUS OXIDE (optional)	Nitrous oxide 50% / Oxygen 50% fixed ratio setup with O ₂ fail-safe device and self-administration mask, 1 setup

EMT-I DRUG LIST con.

AGENT	MINIMUM SUPPLY
SYRINGES	1 ml tuberculin (2) 3 ml (4) 10-12 ml (4) 20 ml (2) 50-60 ml (2)
FILTER NEEDLES	5 micro (3)
NON-FILTER NEEDLES	assorted sizes
INTRAVENOUS SOLUTIONS:	
DEXTROSE, 5% in water	250 ml bag (1)
LACTATED RINGER'S	1 l bag (4)
NORMAL SALINE	1 l bag (4) 250 ml bag (3) 50 ml bag (2)

EMT-B DRUG LIST

AGENT	MINIMUM SUPPLY
ASPIRIN	324 mg
EPINEPHRINE AUTO-INJECTOR	2 adult auto-injectors 2 pediatric auto-injectors

EMERGENCY MEDICAL SERVICES: ORIENTATION MANUAL

III-16

IV INFUSION TO BE MONITORED

IV INFUSION	EMT-B	EMT-I	QUALIFIED EMT-I AND EMT-P	INFUSION PUMP
AMIODARONE			X	X
ANTIBIOTICS		X	X	
PROCAINAMIDE HCl			X	X
BRETYLIUM TOSYLATE			X	X
BLOOD			X	
CALCIUM CHLORIDE			X	X
COLLOIDS DEXTRAN HETASTARCH SERUM ALBUMIN MANNITOL PLASMANATE		X X X	X X X	X X X
CORTICOSTEROIDS		X	X	X
DILTIAZEM			X	X
DIURETICS			X	X
DOPAMINE HCl			X	X
EPINEPHRINE HCl			X	X
FOSPHENYTOIN NA OR PHENYTOIN NA			X	X
GLYCOPROTEIN IIb/IIa INHIBITORS ABCIXMAB (Reopro) EPTIFIBATIDE (Integrelin) TIROFIBAN (Aggrastat)			X X X	X X X
HEPARIN NA			X	X
LIDOCAINE HCl			X	X
MAGNESIUM SULFATE			X	X
MIDAZOLAM (VERSED)			X	X
MORPHINE SULFATE		X	X	X
NITROGLYCERIN			X	X
OXYTOCIN			X	X
PHENOBARBITAL NA			X	X

IV INFUSION TO BE MONITORED con>

IV INFUSION	EMT-B	EMT-I	QUALIFIED EMT-I AND EMT-P	INFUSION PUMP
POTASSIUM SALTS			X	X
SODIUM BICARBONATE		X	X	
THEOPHYLLINE			X	X
TOTAL PARENTERAL NUTRITION			X	X
VITAMINS		X	X	
WATER / ELECTROLYTIES / CRYSTALLOIDS (Commercial Preparations)	X	X	X	

SMALL VOLUME NEBULIZER MEDICATIONS TO BE MONITORED

SVN MEDICATION	EMT-B	EMT-I	QUALIFIED EMT-I AND EMT-P
VAPONEFRIN			X

Field Blood Draw Guidelines

Guideline: Blood can be drawn in the field for use in the VVMC/SEC labs by CEP's and IEMT's who have been trained in the correct procedures. Equipment needed to draw and collect the blood will be provided by VVMC/SEC labs or ED. Blood will be drawn from an IV site from the IV angiocatheter. Blood will be drawn for medical purposes only. Legal blood draws requested by law enforcement are not covered under these guidelines.

Equipment:

- 1. BD brand vacutainer tubes, 1 each red, blue, green, purple.
- 2. Vacutainer jacket
- 3. Red patient ID wrist band
- 4. Numbered patient labels, ident-a blood brand

PROCEDURE:

- 1. Perform successful IV start using angiocatheter and aseptic technique.
- 2. Before attaching IV tubing and releasing tourniquet, insert vacutainer jacket into hub of angiocath and collect blood into vacutainer tubes.
 - a. Tubes to be drawn in the following order: RED, BLUE, GREEN, PURPLE, BLUE, GREEN, PURPLE tubes require mixing by inverting them *gently 5-10 times*.
- 3. Release tourniquet and attach IV tubing. Administer fluid as directed.
- 4. Fill out and label patient ID wristband and blood tubes. Labels and blood tubes need two (2) unique identifiers to be accepted by the VVMC/SEC labs for processing. Refer to attached examples of labels and ID band for correct labeling information.

****Tubes should be labeled with date/time, drawer's initials, and small numbered label. ****

NEVER LEAVE THE PATIENT'S SIDE WITHOUT AT LEAST TWO (2) UNIQUE IDENTIFIERS ON EVERY SPECIMEN AND AN ID BAND ON THE PATIENT. Failure to do so will result in an unacceptable specimen.

- 5. Give labels and all four tubes to ED staff person who is accepting care of patient.
- 6. Restock by getting fresh lab draw packet from the ED staff.

EMS Director

Date

Prehospital Care Coordinator

Date

Field Blood Draw Labeling Examples

DO NOT remove from label card

DATE NAME Compatible with Donor No. _____	T1215	1st Unit-BLOOD	LOCATION	SPECIMEN TUBE Patient, Name DATE / TIME Drawer's INITIALS IDENT-A* BLOOD SYSTEM T1215 Recipient Blood-Tab* Labels Hollister Incorporated Libertyville, IL 60048 Dist. in Canada by Hollister Limited Aurora, Ontario L4G 1G3 FORM 6309	TECH.	RACK LABEL
DATE NAME Compatible with Donor No. _____	T1215	2nd Unit-BLOOD	LOCATION		T1215	
DATE NAME Compatible with Donor No. _____	T1215	3rd Unit-BLOOD	LOCATION		PATIENT	
DATE NAME Compatible with Donor No. _____	T1215	4th Unit-BLOOD	LOCATION			

FOR EASY REMOVAL OF LABELS, BEND SHEET VERTICALLY AT LABEL ENDS

T1215 LOG BOOK	4th Unit T1215 CHART <i>RED</i>	3rd Unit T1215 CHART <i>BLUE</i>	2nd Unit T1215 CHART <i>GREEN</i>	1st Unit T1215 CHART <i>PURPLE</i>
----------------	---------------------------------	----------------------------------	-----------------------------------	------------------------------------

FOR EASY REMOVAL OF LABELS, BEND SHEET VERTICALLY AT LABEL ENDS

T1215	4th Unit T1215 BLOOD BANK <i>First care form</i>	3rd Unit T1215 BLOOD BANK	2nd Unit T1215 BLOOD BANK	1st Unit T1215 BLOOD BANK
-------	--	---------------------------	---------------------------	---------------------------

FOR EASY REMOVAL OF LABELS, BEND SHEET VERTICALLY AT LABEL ENDS

T1215	4th Unit T1215 IDENTIFICATION	3rd Unit T1215 IDENTIFICATION	2nd Unit T1215 IDENTIFICATION	1st Unit T1215 IDENTIFICATION
-------	-------------------------------	-------------------------------	-------------------------------	-------------------------------

FOR EASY REMOVAL OF LABELS, BEND SHEET VERTICALLY AT LABEL ENDS

T1215	4th Unit T1215 CHARGE	3rd Unit T1215 CHARGE	2nd Unit T1215 CHARGE	1st Unit T1215 CHARGE
-------	-----------------------	-----------------------	-----------------------	-----------------------

CHART RECORD

MADE IN U.S.A. PRINTED IN U.S.A. *Trademarks of Hollister Incorporated

T1215	4th Unit T1215	3rd Unit T1215	2nd Unit T1215	1st Unit T1215
-------	----------------	----------------	----------------	----------------

T1215 PT NAME DATE/TIME INITIALS

1. Fill out card. Do not remove backing. 2. Push it deeply into Ident-A*Blood Recipient Band. 3. Snap off stub at dotted line.

↑
Tear off & insert into Band.
Place on patient's Wrist
↓



Use small numbered labels on Blood tubes.
Use one small label in lower left hand corner of first care form.

PREHOSPITAL CONFLICT RESOLUTION-ADMINISTRATIVE

POLICY:

Problems which may arise concerning administrative relationships of field personnel and the ED staff, physicians, EMS director, prehospital manager, or other hospital staff will be addressed by all personnel involved and if needed, by the prehospital manager and the EMS director.

PURPOSE:

To provide a means of identifying and resolving conflict issues within the prehospital team. To provide a means to arbitrate issues which cannot be resolved on an individual basis.

PROCEDURE:

1. Attempt to solve the problem on a one to one basis, if resolved this policy need not be followed further.
2. If a private resolution is not reached, the personnel involved may contact their agency representative and present the conflict and all pertinent facts. All information should be submitted in writing to the prehospital manager and EMS medical director. The agency representatives have the option to ask for the Prehospital Committee to be involved in the resolution process.
3. Any personnel dissatisfied with the actions taken may submit a written request for further investigation and action to the EMS director. He will then determine if additional facts or investigations are needed. After all facts are considered the EMS director will act as mediator for all parties and will issue a written recommendation. This recommendation will be considered final.
4. The EMS director or prehospital manager will, if circumstances are appropriate, offer facilitation and mediation for individuals involved in a conflict who request assistance in reaching a resolution without involving the agency representative.

EMS Director

Date

Prehospital Care Coordinator

Date

PREHOSPITAL CONFLICT RESOLUTION-MEDICAL

POLICY:

Conflicts which involve medical competence or clinical performance by medics assigned to the VVMC base hospital for medical direction will be addressed by the EMS director.

PURPOSE:

To provide a means of identifying and resolving conflict issues which involve clinical performance and/or medical competence.

PROCEDURE:

1. If a conflict arises concerning a clinical problem it will be brought to the attention not the prehospital manager and EMS director in writing; along with a copy of the EMS records.
2. All pertinent facts will be collected.
3. The EMS director and/or the prehospital manager and all involved personnel will first meet and discuss all areas of concern if needed. The involved personnel may bring an agency representative if they wish. The involved personnel will be counseled on corrective actions written and/or verbal. A counseling documentation form will be initiated, (see attached example).
4. When the corrective actions are completed the personnel will be re-evaluated. Additional corrective action would be given at this time if necessary. If all requirements have been met a copy of the corrective action will be placed in the person's file. The incident would be considered closed at this time.
5. If all corrective actions have not been adequate it is at the discretion of the EMS director to assign additional requirements or to withdraw medical control.
6. The involved personnel may ask for review of the above actions by the Prehospital committee if it is felt that they are inappropriate or unjustified. Withdrawal of medical control would remain in effect pending review by the prehospital committee.
7. It is recognized that some actions are so unacceptable that all or part of this policy may be bypassed and medical control withdraw immediately. In this case the person and their employing agency would be notified both verbally and by certified mail.
8. It is desirable to avoid punitive measures in favor of remedial and educational interventions.

EMS Director

Date

Prehospital Care Coordinator

Date

COUNSELLING DOCUMENTATION

Medic: _____

Agency: _____

Date: _____

Situation Summary: _____

Medical Director/Prehospital Manager Comments: _____

Provider Comments: _____

Corrective Action Needs: _____

Follow-up Plan: _____

Medical Director

Date

Prehospital Manager

Date

Medic

Date

INFECTION CONTROL AND DISPOSAL OF WASTES

POLICY:

Universal precautions are to be used in the prehospital setting on every patient encounter. Contaminated wastes will be disposed of using the hospital policy for biohazard wastes. The environment of care manual will be used as a reference for questions on individual cases and questions. See attached pages III-17A and III-17B for additional details.

Any needlestick or mucous membrane exposure to body fluid shall be reported and the involved personnel evaluated per individual agency guidelines for on-the-job injuries.

EMS Director

Date

Prehospital Care Coordinator

Date

UNIVERSAL PRECAUTIONS**Information from *The Federal Register*, Vol. 56, No. 235:
Rules and Regulations, 12/6/91.**

"Universal Precautions" is an approach to infection control. According to the concept of universal precautions, all human blood and certain human body fluids are treated as if known to be infectious for human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other blood-borne pathogens. The other body fluids included in this definition are semen, vaginal secretions, cerebrospinal fluids, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva, any body fluid visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.

Universal precautions shall be observed to prevent an exposure incident with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials. An exposure incident means an eye, mouth or other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials. Parenteral contact means piercing mucous membranes or the skin barrier through such events as needle sticks, human bites, cuts and abrasions.

Precautions to be taken are:

1. Contaminated sharps shall be discarded immediately or as soon as feasible in containers that are:
(a) closable; (b) puncture resistant; and (c) leakproof.
2. Recapping of contaminated sharps shall only be done if appropriate containers are not immediately accessible. Recapping should be done utilizing one-handed technique or by mechanical device (ie, On-Gard, Hemostats).
3. Gloves shall be worn while treating patients with blood or body fluids exposed.
4. Gloves shall be worn while starting IVs.
5. Hands shall be washed with soap and water after treating patient or removal of gloves. When running water is not available, antiseptic hand cleanser in conjunction with clean cloth/paper towels may be used until soap-and-water wash is available; wash hands at first possible opportunity.
6. All equipment and working surfaces shall be cleaned and decontaminated if contacted with blood or other potentially infectious materials.
7. Contaminated laundry shall be handled as little as possible with a minimum of agitation. Laundry shall be placed in hamper in hospital. Protective gloves should be worn when handling contaminated laundry.
8. Protective eye wear should be worn in situations where splattering of secretions is likely to occur (such as trauma cases or intubations).

CONTAMINATED WASTES

BIO-HAZARDOUS MEDICAL WASTE IS REDBAG WASTE. Such waste should include only those materials which are capable of producing an infectious disease during handling and disposal. The waste is considered infectious only if it contains pathogens of sufficient virulence and quantity so that exposure to the waste by a susceptible human host could result in an infectious disease. Normal indigenous microorganisms associated with the body found in feces, urine, sweat, tears and vomitus are not considered to be highly infectious unless they contain visible blood, and thus do not pose a threat during the usual handling of waste designated for disposal.

Sources: All patient care areas, Surgery, Emergency Room, Pathology, Laboratory.

1. Regulated Medical Waste

- a.) Liquid or semi-liquid blood or body fluids; contaminated items that would release blood or body fluids in a liquid or semi-liquid state if compressed; items caked with dried blood or body fluids that are capable of releasing these materials during handling.
- b.) Contaminated sharps; and pathological and microbiology laboratory wastes containing blood or body fluids.
- c.) Cultures and stocks of infectious agents from medical laboratories.
- d.) Biological waste and discarded materials contaminated with blood, excretion, exudates or secretions from patients who are isolated to protect others from highly communicable diseases.

2. Discarded Medical Equipment:

- a.) Discarded medical equipment and parts which have been in contact with known infectious agents.

Co-mingling of waste stream:

Ordinary waste shall not be co-mingled with medical waste. Ordinary waste when co-mingled with medical waste becomes medical waste.

WHEN IN DOUBT: CALL THE SAFETY OFFICER DEFINITIONS:

"Infectious agent" means a type of microorganism, bacteria, mold, parasite or virus which normally causes, or significantly contributes to the cause of, increased morbidity or mortality of human beings.

ALS RECERTIFICATION POLICY

POLICY:

All ALS personnel who use Verde Valley Medical Center as a base station will use this policy as a guideline to organize their recertification process.

PURPOSE:

To standardize the recertification process.

PROCEDURE:

1. All ALS personnel are responsible for current knowledge of C.E. requirements **for** recertification. See II-2A and II-2B for detailed information.
2. ALS personnel based at VVMC shall attend at least 4 run reviews at VVMC per year, (1 per quarter). C.E. requirements for Arizona recertification may be met by attending other ADHS approved educational activities.
3. ALS personnel are to maintain an ongoing, current file of all C.E. hours completed.
4. Six months prior to his/her recertification date each ALS person may make an appointment with the prehospital manager. All CE's received to date will be reviewed and additional needs identified.
5. Not less than 60 days prior to the certification expiration date, each ALS provider may submit all CE records and ADHS recertification paperwork to the prehospital manager for final review.
6. The prehospital manager can verify that the required CE has been met. It is the responsibility of the provider to submit necessary forms for recertification to ADHS.
7. ALS providers must submit the following documents to ADHS with their recertification application.
 - a. Copy of ACLS card (CEP).
 - b. Copy of BCLS card (CEP and IEMT).
 - c. Recertification form.
 - d. Physical verification form..,
8. CE's accumulated after submission of application can be applied to the hours to **be** tabulated for the next recertification period.
9. A copy of the new certification shall be sent to the prehospital manager when it is received by the ALS provider

EMS Director

Date

Prehospital Care Coordinator

Date

RESTOCKING OF SUPPLIES

POLICY:

Prehospital care providers working under an agreement with Verde Valley Medical Center as their base station can exchange and restock supplies and medications at Verde Valley Medical Center. The charge medic of the crew will be responsible for accurate restocking through the Omnicell system.

PURPOSE:

To give a guideline for restocking and exchanging supplies/medications used during an EMS call and for accurate accounting of supplies/medications removed from the EMS Omnicell.

PROCEDURE:

1. Supplies/medications to be restocked are to be taken from the EMS Omnicell. Only supplies used for a patient are to be restocked.
2. If "extras" are needed they need to be taken from the Omnicell but checked out to the restocking agency, i.e.: VVFD, not to a patient name.
3. IV solutions are also on the Omnicell and are restocked the same way as supplies.
4. Medications are kept in the Omnicell by the EMS report room; the only exceptions are valium and morphine that are in the ED nursing department Omnicell.
5. A copy of the EMS report needs to accompany any drug restocks. A physician **must sign** the telemetry sheet for any patient who is given medications in the field.
6. Any problems with passwords or operation of the Omnicell can be addressed to a pharmacy tech or to the prehospital manager.
8. Outdated medications may be exchanged through the Omnicell system. The outdated drugs should be locked in the cabinet below the sink in the EMS room. The key to the lockbox can be accessed in the Omnicell

EMS Director

Date

Prehospital Care Coordinator

Date

PREHOSPITAL MAINTENANCE OF SKILLS

POLICY:

Verde Valley Medical Center as base station will provide opportunities for ALS providers to maintain their skills through clinical time, workshops, run reviews, and individual update programs as needed.

PURPOSE:

To provide a guideline for educational opportunities and skill maintenance for ALS providers based at Verde Valley Medical Center.

PROCEDURE:

1. Each agency is responsible for keeping a record of their ALS employees' skills.
2. If the prehospital manager, through direct observation or chart audits determines a need for additional skills practice he/she will contact the provider and will schedule time for practice, clinical time, and/or review.
3. A preceptor will be assigned to the ALS provider in each clinical area.
4. The ALS provider will complete a clinical time documentation form for each clinical experience (III-A).
5. Run review/lecture will be provided monthly. This form of continuing education will meet the requirements for ADHS recertification.
6. Airway skills labs will be provided once a year to meet requirements for ADHS recertification.
7. ALS providers are welcome to enroll in education provided by WMC education department, (ACLS, PALS, EKG classes etc.).
8. ALS providers are encouraged to schedule clinical time at any time they feel the need to refresh their skills.
9. Clinical time can be scheduled through the prehospital manager

EMS Director

Date

Prehospital Care Coordinator

Date

ER CLINICAL TIME LOG

Name: _____

Date: _____

Hours: _____ to _____

Skills

Observed

Preformed

<u>Skills</u>	<u>Observed</u>	<u>Preformed</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Preceptor Comments: _____

Preceptor Signature: _____

EMS STANDING ORDERS POLICY

- Standing orders are designed for use in critical situations when care must be initiated immediately, prior to communication with the base station or when communication is not possible due to technical problems.
- Verde Valley Medical Center shall utilize NAEMS regional protocols as standing orders when a situation warrants treatment prior to contact with the base station.
- All providers are to be familiar with the NAEMS protocols before they are scheduled for duty.
- Medical control at VVMC shall be notified when EMS elects to dispatch helicopter transport of a patient. Cases will be reviewed and evaluated for medical necessity

EMS Director

Date

Prehospital Care Coordinator

Date

EMS FIELD TREATMENT/TRIAGE POLICY**FIELD TRIAGE GUIDELINES**

Due to the rural and isolated nature of much of this region, coupled with the long distances between communities, the emergency patient is usually taken to the nearest emergency receiving facility.

Exceptions may occur when:

1. A rational and oriented patient specifically requests transport to another facility, and the EMS personnel deem it feasible to do so. This requires a verbal order.
2. The nature of the patient's illness or injury requires services not available at the nearest facility. The decision to bypass the nearest facility should be substantiated during direct communication with the responsible medical control physician at the base hospital.
3. Multiple victims have been identified by prehospital personnel and possible overloading of the nearest hospital's resources may prompt directing transport of a victim(s) directly to another facility.

Ordinarily, priority will be given to the most critical patient(s). However, when the number of patients exceeds the EMS resources immediately available, then priority must be given to more salvageable patients. Under these circumstances, patients who are apparently non-salvageable, e.g., trauma codes and massive head injuries, may be relegated to a low priority.

TRIAGE PRIORITIES**Highest Priority (to be transported first and treated immediately)^**

- Airway and breathing difficulties
- Cardiac arrest (non-traumatic; resuscitated in the field)
- Uncontrolled or suspected severe bleeding
- Severe head injury or unconsciousness
- Severe medical problems (heat stroke, hypothermia, etc.)
- Open or crushed chest and/or abdominal wound
- Severe shock
- Spinal cord injury

Second Priority (transportation and treatment may be deferred)

- Burns
- Major fractures (multiple)
- Back injuries with or without spinal cord
- Damage Moderate bleeding (< 2 pts.)

Third Priority (to be transported or treated last)

- Fractures or minor injuries.
- Obviously mortal wounds where death appears reasonably certain

lowest Priority

- Obvious death; dead on arrival (DOA)
- Cardiac arrest without restoration of pulse in the field

VEHICULAR EXPERIENCE FOR PHYSICIANS AND NURSES

POLICY:

All medical control authorities and nurse intermediaries will complete 24 clock hours of vehicular experience, (ambulance ride time), during the first year of employment. Twelve of these hours shall be completed in the first 3 months of employment. In subsequent years attendance at run reviews, teaching in the prehospital setting, or participation in prehospital administrative activities may be substituted for vehicular time.

PURPOSE:

To assure that all base station ED physicians and nurse intermediaries have the opportunity to become more familiar with prehospital care. To acquaint new personnel with the local field capabilities, including procedures, personnel, and equipment.

PROCEDURE:

1. Time will be scheduled through the prehospital manager.
2. Physicians and nurses will report for duty wearing business casual attire and name badge. Lab coat and scrubs are also appropriate.
3. Time is primarily observation time but personnel may assist with patient care as desired within the limits of the individual's job description.
4. Ride time will be scheduled with Verde Valley Ambulance, Verde Valley Fire District or Sedona Fire District.
5. Upon completion of ride time a "prehospital vehicular experience" form (III-25) is to be filled out and put in the base station CE book.
6. These hours will count towards total yearly CE

EMS Director

Date

Prehospital Care Coordinator

Date

PREHOSPITAL VEHICULAR EXPERIENCE

Name / Title: _____

Date: _____ Time(s): _____ Total Time: _____

Agency: _____ Medic Signature: _____

Briefly Describe Call(s): _____

Describe Skills Observed and By Whom: _____

Describe Problems. If Ant, You Encountered: _____

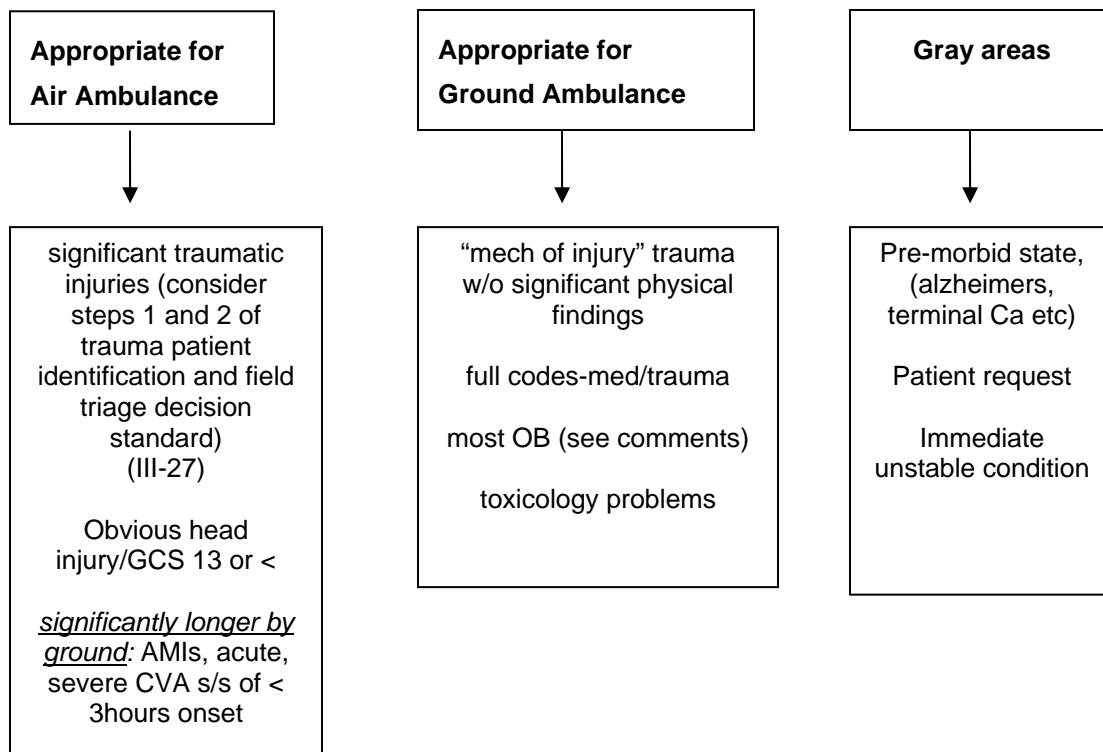
Describe Education Needs. If Any, You Observed: _____

General Comments Regarding Experience: _____

GROUND VS. AIR TRANSPORT GUIDELINES

Goals:

- Care will be fast and definitive
- Maximize cost effective use of EMS resources
- Correct identification of initial chief complaint



Comments:

Emergent need for C-section should use fastest/closest options for transport and care.
 Preterm labor alone should use ground transport to VVAC/FMC (closest/fastest).

Appropriate ground vs air decisions are at the discretion of the medics at the scene in collaboration with base station medical control.

VVEMS TRAUMA PATIENT IDENTIFICATION & FIELD TRIAGE DECISION TREE

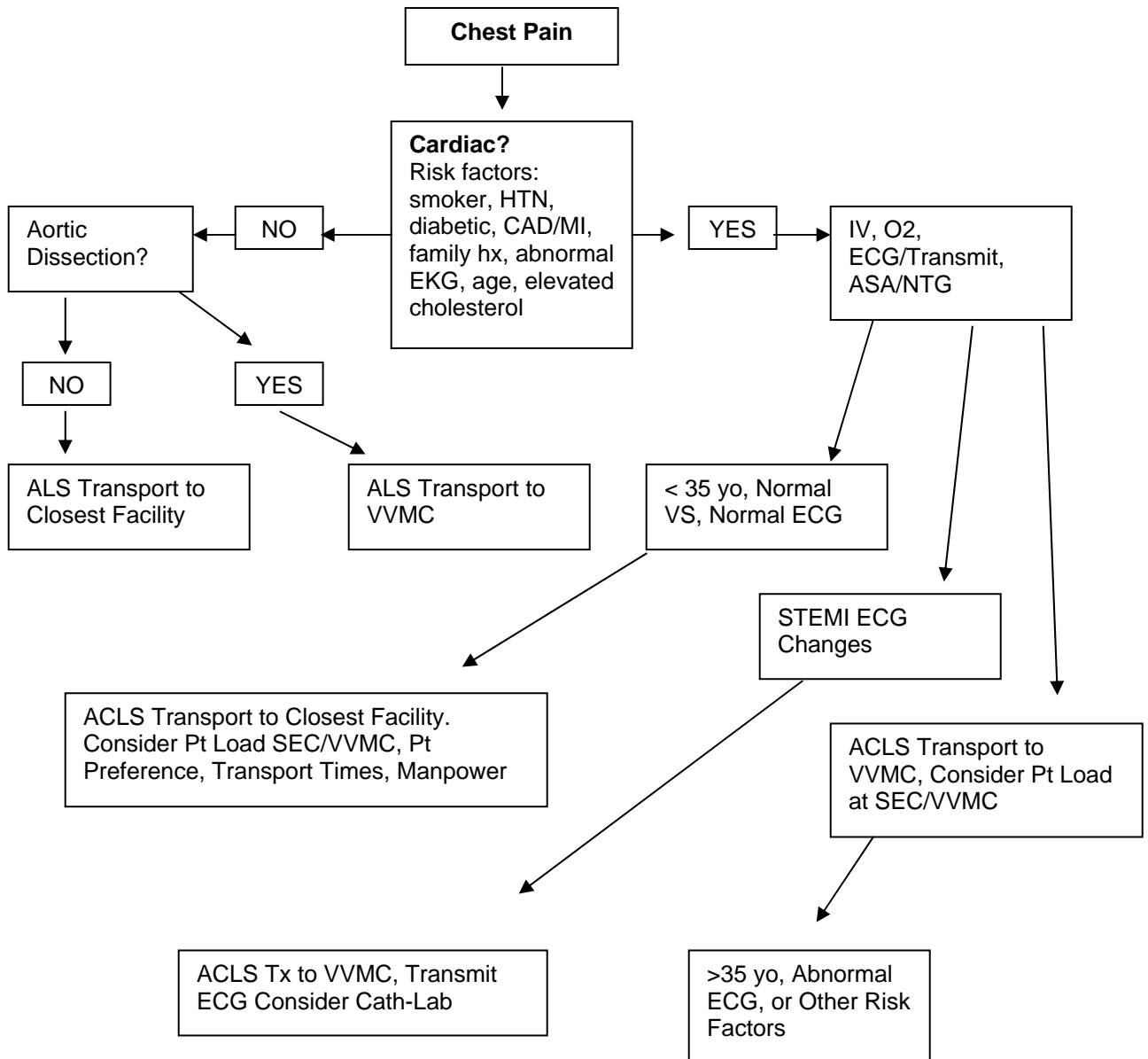
	Measure vital signs and level of consciousness	
<u>Step One</u>	Glasgow Coma Scale<14 or Systolic blood pressure<90 or Respiratory rate<10 or >29 Revised Trauma Score (see Table 2)<11	
	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Take to trauma center; alert trauma team. Steps 1 and 2 triage attempts identify the most seriously injured patients in the field. In a trauma system, these patients would preferentially be transported to the highest level of care within the system	Assess anatomy of injury
<u>Step Two</u>	<ul style="list-style-type: none"> * All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee * Flail chest * Combination trauma with burns * Two or more proximal long-bone fractures * Pelvic fractures * Open and depressed skull fracture * Paralysis * Amputation proximal to wrist and ankle * Major burns (see Chapter 14: Guidelines for the Operation of Burn Units) 	
	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Take to trauma center; alert trauma team Steps 1 and 2 triage attempts identify the most seriously injured patients in the field. In a trauma system, these patients would preferentially be transported to the highest level of care within the system	Evaluate for evidence of mechanism of injury and high-energy impact
<u>Step Three</u>	<ul style="list-style-type: none"> * Ejection from automobile * Extrication time >20 minutes * Rollover * High-speed auto crash 	
	<ul style="list-style-type: none"> * Falls >20 feet for adult patient >14 yrs of age * Falls 2x the height of the pediatric patient <=14 yrs of age * Death in same passenger compartment Initial speed >40 mph Major auto deformity > 20 inches Intrusion into passenger compartment > 12 inches 	
	Auto-pedestrian/auto-bicycle injury with significant (>5 mph) impact Pedestrian thrown or run over Motorcycle crash >20 mph or with separation of rider from bike	
	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<u>Step Four</u>	Contact medical direction and consider transport to a trauma center Consider trauma team alert	
	<ul style="list-style-type: none"> * Age <5 or >55 * Cardiac disease, respiratory disease * Insulin-dependent diabetes, cirrhosis, or morbid obesity * Pregnancy * Immunosuppressed patients * Patients with bleeding disorder or patient on anticoagulants 	
	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Contact medical direction and consider transport to trauma center Consider trauma team alert	Reevaluate with medical direction

Immediate unstable patients should be taken to closest facility for immediate care.
Adopted from the Arizona Trauma Patient Identification & Field Triage Decision Standard. Major trauma patients should be taken to the highest level Trauma Center within a 30-minute transport time

CARDIAC TRANSPORT GUIDELINES
August 30, 2005

Goals:

- Care will be fast and definitive
- Communication will be timely and accurate
- Use of SEC to maximize good patient care and minimize re-transport.
- Correct identification of cardiac versus non-cardiac chest pain while in the field.



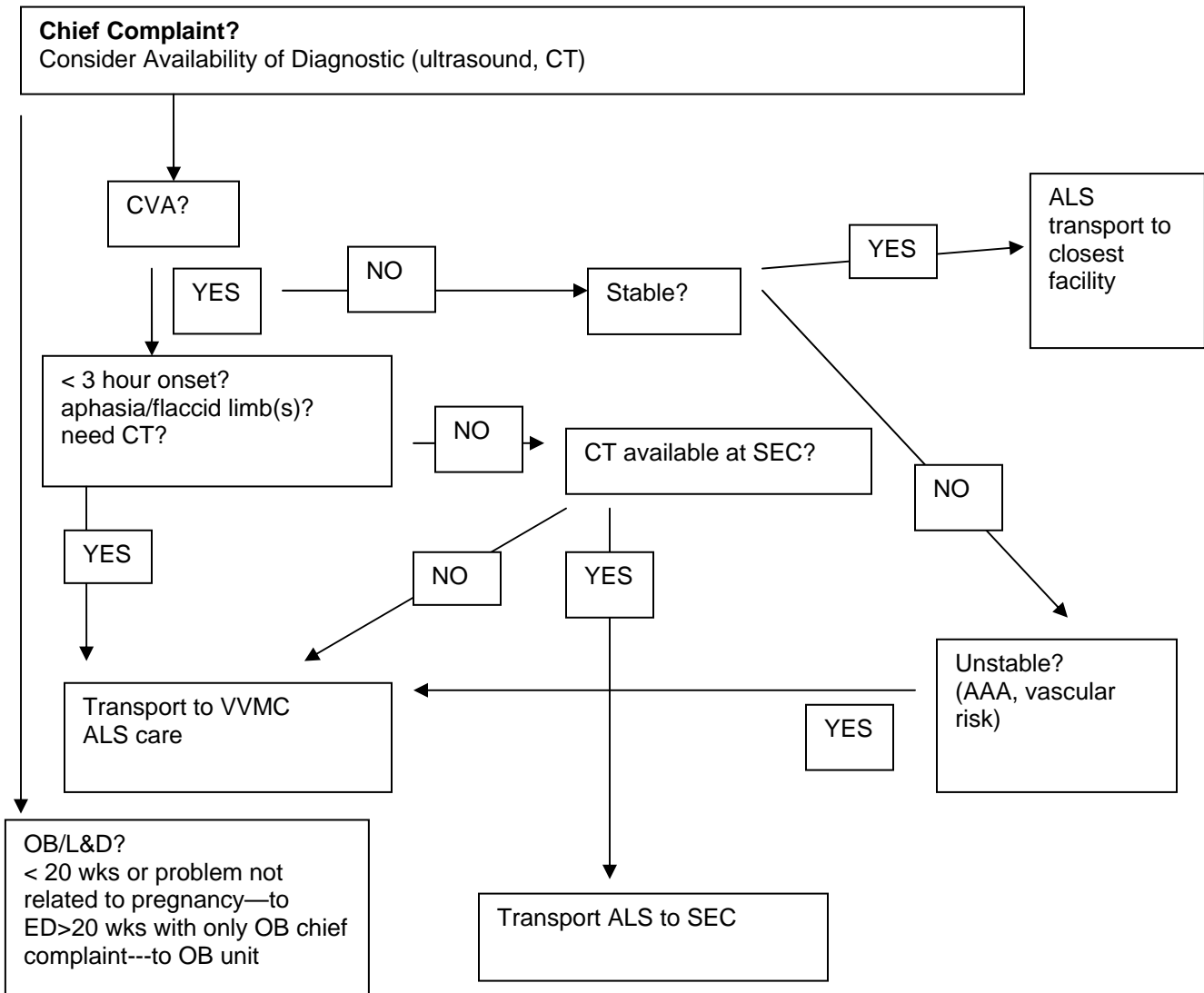
Generally cardiac patients from Jerome, Cottonwood, Comville, Camp Verde, Sedona, **VOC**, and Montezuma/Rimrock should be transported by ground. Variants include traffic holdups, manpower issues, and backwoods/rescue scenes.

Air Ambulance Use: When transport by ground is considerably longer and the patient is unstable.
Appropriate ground vs air and VVMC vs SEC decisions are at the discretion of medics at the scene in collaboration with base station medical control

MEDICAL TRANSPORT GUIDELINES
August 30, 2005

Goals:

- Care will be fast and definitive
- Maximize cost effective use of EMS resources
- Correct identification of chief complaint
- Use of SEC/VVMC to maximize good patient care and minimize re-transport.



COMMENTS:

Generally medical patients from Jerome, Cottonwood, Cornville, Camp Verde, Sedona, VOC, and Montezuma/Rimrock should be transported by ground. Variants include traffic holdups, manpower issues, and backwoods/rescue scenes.

Air Ambulance Use: The decision to fly a patient should be discussed with the base station physician. Conditions include considerably longer ground transport times and a patients who are unstable and seem to have a time sensitive condition.

Appropriate ground vs. air and VVMC vs. SEC decisions are at the discretion of the medics at the scene in collaboration with base station medical control

ESOPHAGEAL TRACHEAL DOUBLE LUMEN AIRWAY DEVICE (COMBITUBE) USE BY BLS PERSONNEL

POLICY:

VVEMS Medical Direction supports the use of the Esophageal Tracheal Double Lumen Airway Device (ETDLAD) as a optional rescue airway device by properly trained BLS providers in recognition of its potentially lifesaving results and ease of successful use.

PURPOSE:

This airway adjunct is to be used by BLS providers only after attempts to ventilate with a BVM is unsuccessful and/or inadequate; and when no ALS providers are available for advanced airway management.

PROCEDURE:

1. Initial and ongoing training shall be performed at the agency level.
2. Records on training shall be maintained at the agency level.
3. BLS providers will complete a training session on ETDLAD's at the agency level.
4. Agency level training will be provided by an ALS trained provider.
5. Initial training will use GD-081-PHS-EMS from ADHS as a basis for the training curriculum.
6. Initial training shall include no less than 5 successful manikin airway placements.
7. Ongoing training shall be quarterly manikin practice of no less than 3 successful manikins airway placements.
8. All training, initial and ongoing shall be documented with a minimum of date, location, number of successful placements and signature of trainee and trainer.

EMS Director

Date

Prehospital Care Coordinator

Date

**ESOPHAGEAL TRACHEAL DOUBLE LUMEN AIRWAY DEVICE (COMBITUBE) USE BY BLS PERSONNEL
con.****INTRODUCTION**

The esophageal tracheal double lumen airway device (ETDLAD) is designed for use in emergency situations, can be inserted blindly, and can be used to ventilate a patient whether inserted into the esophagus or the trachea.

The Arizona Department of Health Services (ADHS) views the ETDLAD as a useful tool for prehospital airway management and has added use of an ETDLAD to the EMT-B scope of practice as an optional skill acquired through prescribed training. This document provides information about the ETDLAD design and function and ADHS's recommendations for EMT-B use of an ETDLAD in the prehospital EMS environment. ADHS intends for this document to be a guideline for the prescribed training under A.A.C. R9-25-511(C).

ETDLAD DESIGN AND FUNCTION

The ETDLAD is a device that combines an esophageal obturator lumen (longer tube) with a tracheal lumen (shorter tube) and features a large esophageal balloon approximately at midpoint and a smaller distal cuff at the distal end of the device (each with a connecting tube for inflation). The esophageal obturator lumen is blocked at the distal end and has perforations at the pharyngeal level. The tracheal lumen is open at both ends. When inflated, the oropharyngeal balloon seals the mouth and nose, and the distal cuff seals either the esophagus or trachea (depending on ETDLAD placement). When the ETDLAD is placed in the esophagus, ventilation is accomplished through the esophageal obturator lumen when air blown in escapes the esophageal lumen through the perforations, enters the pharynx, is blocked by the oropharyngeal balloon and distal cuff, and is thus forced into the trachea. When the ETDLAD is placed in the trachea, ventilation is accomplished through the tracheal lumen by blowing air directly into the trachea.

RECOMMENDATIONS FOR EMT-B USE OF AN ETDLAD**Indications:**

Cardiac arrest or apnea

Contraindications:

Intact gag reflex
Height less than 4 feet
Known esophageal pathology
Recent ingestion of a caustic substance
Central airway obstruction

**ESOPHAGEAL TRACHEAL DOUBLE LUMEN AIRWAY DEVICE (COMBITUBE) USE BY BLS PERSONNEL
con.****Advantages:**

- Non invasive
- Helpful under difficult circumstances of space and light
- Blind insertion possible
- Simultaneous fixation after inflation of oropharyngeal balloon
- Effective in tracheal or esophageal position
- Minimized risk of aspiration
- No need for electrical power supply

Potential Complications:

- Increased incidence of sore throat, dysphagia, and upper airway hematoma (compared to endotracheal intubation and laryngeal mask airway)
- Esophageal rupture (rare)
- Barotrauma possible

Available Sizes:

- Small ETDLAD (37 F) recommended for use with patients 4 - 5.5 feet tall
- Large ETDLAD (41 F) recommended for use with patients 5 feet tall and taller

Insertion Procedure:

1. Select appropriate size ETDLAD based on patient height.
2. Test the oropharyngeal balloon and distal cuff by attaching the appropriate syringe to the connecting tube for each and:
 - a. If using the smaller ETDLAD, inflating 85 cc of air into the oropharyngeal balloon and 12 cc of air into the distal cuff;
 - b. If using the larger ETDLAD, inflating 100 cc of air into the oropharyngeal balloon and 15 cc of air into the distal cuff; and
 - c. Ensuring that the oropharyngeal balloon and distal cuff remain inflated.
3. Deflate the oropharyngeal balloon and distal cuff.
4. Lubricate the ETDLAD with water-soluble gel.
5. Hold the distal end of the ETDLAD bent for a few seconds to alleviate insertion by curving the ETDLAD.
6. Insert the ETDLAD (distal end first) gently in a curved downward motion by grasping the back of the tongue and jaw between thumb and forefinger and lifting the jaw, inserting until the printed ringmarks are positioned between the teeth or alveolar ridges. **DO NOT USE FORCE.**
7. Do one of the following:
 - a. If no resistance is encountered, go to step #8; or
 - b. If resistance is encountered, stop insertion, remove the ETDLAD, and do one of the following:
 - i. If this is the first attempt to insert the ETDLAD, go back to step #5 to attempt another insertion; or
 - ii. If this is the second attempt to insert the ETDLAD, maintain the patient's airway and ventilate using basic airway techniques; do NOT proceed to step #8.
8. Once the ETDLAD is inserted:
 - a. Use the larger syringe to inflate the oropharyngeal balloon with:
 - i. If using the smaller ETDLAD, 85 cc of air; or
 - ii. If using the larger ETDLAD, 100 cc of air;

ESOPHAGEAL TRACHEAL DOUBLE LUMEN AIRWAY DEVICE (COMBITUBE) USE BY BLS PERSONNEL
con.

- b. Confirm that the oropharyngeal balloon remains inflated and observe the placement of the oropharyngeal balloon (should be in the posterior pharynx behind the hard palate);
 - c. Use the smaller syringe to inflate the distal cuff with:
 - i. If using the smaller ETDLAD, 5-12 cc of air; or
 - ii. If using the larger ETDLAD, 5-15 cc of air; and
 - d. Confirm that the oropharyngeal balloon remains inflated.
9. Attach the ventilation bag to the esophageal obturator lumen (the longer tube marked #1) and begin ventilations.
10. Listen for breath sounds in the lungs and gurgling sounds in the epigastrium and do one of the following:
 - a. If there are breath sounds in the lungs, continue to ventilate through the esophageal obturator lumen and go to step #12;
 - b. If there are no breath sounds in the lungs, and there are gurgling sounds in the epigastrium, move the ventilation bag to the tracheal lumen (the shorter tube marked #2) and begin ventilations; and
 - c. If there are no breath sounds in the lungs and no gurgling sounds in the epigastrium, deflate the oropharyngeal balloon with the larger syringe, deflate the distal cuff with the smaller syringe, and:
 - i. If this is the first time adjusting the ETDLAD, pull the ETDLAD out 2-3 cm, and go to step #8; or
 - ii. If this is the second time adjusting the ETDLAD, remove the ETDLAD, ventilate using basic airway techniques, and do not go to step #11.
11. Listen for breath sounds in the lungs and do one of the following:
 - a. If there are breath sounds in the lungs, continue to ventilate through the tracheal lumen and go to step #12; and
 - b. If there are no breath sounds in the lungs, deflate the oropharyngeal balloon with the larger syringe, deflate the distal cuff with the smaller syringe, remove the ETDLAD, and ventilate using basic airway techniques.
12. Continue patient ventilation and verify proper delivery of ventilations at least every 5 minutes by:
 - a. Listening for breath sounds on both sides of the chest,
 - b. Using a CO₂ detector and pulse oximeter and recording readings as part of patient vitals, and
 - c. Verifying chest rise with each ventilation.
13. Continually reassess patient for spontaneous respirations and pulse and remove the ETDLAD if:
 - a. The patient develops a gag reflex,
 - b. The patient becomes conscious, or
 - c. Ventilation is inadequate due to ETDLAD placement (then ventilate using basic airway techniques).

RAPID SEQUENCE INTUBATION (RSI) USE BY EMT-P'S

VVEMS medical direction supports the use of RSI as an optional advanced airway management skill by properly trained EMT-Ps in recognition of it's potentially lifesaving results.

Purpose:

This airway management skill will be used in situations where placement of a prehospital endotracheal tube using RSI is indicated by patient conditions *and* where there is clear benefit of performing RSI in the prehospital environment.

Procedure:

1. EMT-P will work full-time for an agency that supports the optional RSI program.
2. EMT-P will complete the VVMC RSI training program before beginning to perform RSI in the field.
3. EMT-P will perform RSI using the Arizona Department of Health Services Recommendations for RSI in the field (ADHS, 2005).
4. EMT-P will complete a minimum of 12 patient or mannequin intubations/year to continue to be included in the RSI program.
5. EMT-P will complete an annual RSI refresher course.
6. EMT-P will participate in mandatory immediate self assessment and ongoing departmental CQI on all RSI in the field cases.
7. If requested, EMT-P will participate in review of cases through the Prehospital Peer Review Committee.

EMS Director

Date

Prehospital Care Coordinator

Date

EMT-D QUALITY ASSURANCE AND PERFORMANCE REVIEW

Purpose:

To provide guidelines related to the performance and documentation of techniques of EMT, IEMT, and CEP personnel who operate under the EMT-D program.

Policy:

The EMT/IEMT/CEP shall:

1. Have a current certification as a EMT, IEMT, or CEP.
2. Be employed by an EMS agency that has AED equipment.
3. Have current certification of training and proficiency in the use of automatic/semi-automatic defibrillation equipment.
4. Use only AED/semiautomatic defibrillator models that they have been trained to use.
5. Ensure proper documentation of each patient encounter where the AED/semiautomatic defibrillator was used.
6. Attend a bi-annual review of training on AED equipment usage. This requirement can be met by attending training at an agency level.
7. Perform monthly practice and review at the agency level.
8. The provider will submit tape and first care form to prehospital office within 24 hours of the defibrillation event.
- 9 Review of each AED patient encounter and tape, f available, will be done by the prehospital manager.

Medical Director

Date

Prehospital Care Coordinator

Date

EMT-D Continuing Education and Biannual Review

Purpose:

To provide guidelines related to annual review of EMT-D knowledge and skills.

Policy:

A review of the protocols and procedures of automatic/semi-automatic defibrillation will be provided for all certified personnel who are employed by an agency using AED/SAED equipment. This review will be conducted bi-annually to ensure competency in identifying and treating patients requiring AED/SAED use.

The review may be conducted by the prehospital manager, medical director, program director, or approved instructor. Agencies with AED/SAED equipment may conduct the review sessions.

The review will be performed with the AED/SAED equipment that is used by the providers. EMS providers employed by departments using more than one type of AED/SAED equipment must train all types they may use during patient care.

Procedure:

1. Review of basic life support principles.
2. Review assessment of cardiac patient.
3. Review instructions for attachment of AED/SAED to patient.
4. Review principles of defibrillation.
5. Review troubleshooting actions in event of AED/SAED failure to operate.
6. Review medical control requirements.
7. Review AED/SAED defibrillation protocols.
8. Review device maintenance.
9. Review of documentation-written and verbal.
10. Practical demonstration of correct AED/SAED use by provider.

Medical Director

Date

Prehospital Care Coordinator

Date

Emergency Medical Services: Orientation Manual

IV-3

EMT-D Contra-Indications

Purpose:

Guidelines for assessing possible contraindications for automatic/semiautomatic defibrillator use in the field.

Contraindications to AED/SAED Use Are:

- 1.Children under eight (8) years of age.
2. Patients weighing less than fifty-five (55) pounds.
3. Victims of trauma or massive blood loss.
- 4.Victims of hypothermia (severe).
5. Victims of drowning, until out of water and dry.
- 6.Patients not in full cardiac arrest.
7. Patients in a moving vehicle.

EMS Director

Date

Prehospital Care Coordinator

Date

EMT-D Cardiac Arrest Algorithm

EMT-D Withdrawal of Medical Control

Purpose:

Provide procedure for withdrawal of EMT-D medical control.

Policy:

An EMS provider based at VVMC who is not following base hospital policies and procedures for AED/SAED or is not functioning at the required standard of care for AED/SAED operation, will have medical control for the AED program withdrawn.

Additional training and education will be offered to the individual and medical control can be re-instated after successful evaluation of the completed education.

Non punitive methods will be preferred and remediation attempted.

Medical Director

Date

Prehospital Care Coordinator

Date

EMT-D LEARNING AND PERFORMANCE CONTRACT

I _____, agree to perform my EMT-D duties at the standard of care required by my Base Station, Verde Valley Medical Center. I will adhere to policies and procedures set forth by the Base Hospital.

I agree to maintain my future readiness to respond competently as an EMT-D by:

1. Reviewing my syllabus, standing orders, and procedures monthly.
2. Completing a "check" of a simulated EMT-D call utilizing the simulator and skills station checklist monthly. I will file my practice checklists, completed by my partner, for Base Hospital review at the agency.
3. Attending debriefings, reviews, and continuing education as scheduled.
4. Maintaining current BCLS and EMT certification.

I agree to document my EMT-D responses in the following manner:

1. Verbalize responder names, patient indications, patient conditions, patient assessment, therapies, and responses to therapies throughout every EMT-D call.
2. Establish Base Hospital contact as soon as possible during the call without obstructing life-saving care.
3. Complete an approved First Care form, including narrative documentation.
4. Obtain a "hard copy" printout of the EMT-D care rendered for the Base Hospital. Place with a copy of the First Care form on the desk of Sheri Earls.
5. Submit the tape and hard copy of the call to the Base Hospital immediately following each EMT-D call. Do not rewind tape.
6. Call the Base Hospital Coordinator or designate and discuss the call as soon as appropriate after each EMT-D call.

I have the following expectations from my EMT-D medical control authorities:

Provider

Agency

Date

Prehospital Care Coordinator

Date

COMMUNICATION BETWEEN VVMC AND PROVIDERS

POLICY:

All EMS providers will notify VVMC base station of all ALS patient contacts, transports and refusals. Prehospital providers must notify the receiving facility prior to arriving at the ED. A courtesy notification will be given to the receiving facility when the transport meets "off-line" criteria.

PURPOSE:

Provide a guideline for requesting and receiving medical direction. Ensure that the receiving facility has advance notice of patient arrival.

PROCEDURE:

1. Radio or recorded telephone communication with VVMC ED will be established on all ALS patients who are given care, including refusals of care.
2. Refer in the orientation manual to the policies on "Communication (V-4) and Criteria for Base Hospital Contact (V-5)" for specifics as to which patient contacts need to be patched on.
3. If the provider is unable to contact the base hospital by phone or by radio, follow NAEMS protocols and transport as quickly as possible. Notify the prehospital manager of the incident.
4. Prehospital communication should be organized and limited to pertinent information. Use the field use sheet to help organize your assessment. (See attached sample V-3).
5. Information on the patch should give a clear picture of what the patient's condition is in the field so that appropriate medical direction and hospital preparation can take place.
6. If transporting a patient to a hospital other than your base station, state this at the beginning of your patch.
7. Confirm with your base station who will contact the receiving facility about this patient. If using EMSCOM radio you may request a dual patch with the receiving facility.

Medical Director

Date

Prehospital Care Coordinator

Date

EMS POLICY ON COMMUNICATION PROTOCOLS

Policy:

Verde Valley Medical Center will adopt the communications guidelines from the NAEMS protocols.

Purpose:

To provide a guideline for concise and clear communication of information to and from the prehospital setting.

Procedure:

1. Contact with the base station should be completed as quickly as possible. It is desirable to patch initially from the scene instead of waiting until en route to the ED to patch.
2. Telephone is the preferred route for most patches.
3. EMSCOMM radio is also available for patches in areas where telephone is not practical or available.
4. Use the field use sheet to give report, be prepared to give information in an organized and timely manner.
5. Do not lengthen radio transmissions with extensive history of non-pertinent information.
6. A repatch is needed in any situation which involves a change in patient condition or if updates are requested by medical control.
7. When using off-line protocols, a courtesy patch is needed to alert the ED of incoming patients. This should be done before going en route to the hospital when possible.

Medical Director

Date

Prehospital Care Coordinator

Date

COMMUNICATIONS

Radio or telephone contact with the base hospital is necessary on all calls. Regardless of the level of provider on scene, with critical patients, radio or telephone communication should be made after the initial succinct primary survey and after emergency standing orders are carried out.

Basic Radio Procedures

All communications must include the following information:

- | | |
|--|-------------------------------------|
| 1. Emscom vehicle ID | 5. Chief complaint(s) |
| 2. Personnel ID | 6. History and objective finding(s) |
| 3. Status of call (emergency/nonemergency traffic) | 7. Treatment |
| 4. Number of patients | 8. ETA |

Communications Guidelines

1. Allow for a 2-second delay after depressing transmit key before talking. This allows electronics to fully engage.
2. Stop frequently and release transmit key to insure that the base hospital has received your transmissions.
3. Ask for base hospital physician to come on line for any ALS calls regarding patients you think might be unstable, or any time the scope or complexity of information requires direct contact with the physician.
4. Present information so listener gets an overview early (e.g., "... a 68-year old male, auto accident victim in acute respiratory distress...."). Report findings in same order you evaluate a patient, i.e., primary assessment, vital signs and secondary assessment.
5. You need not list all relatively minor findings that do not affect immediate patient care decisions.
6. Communicate with courtesy, brevity and clarity.
7. Remember: Many people are listening to your radio communication, so avoid use of patient names and unprofessional comments.
8. Follow Arizona Department of Public Safety (ADPS) EMSCOM operations manual.
9. Patches on BLS patients should consume a minimum amount of time and only the most pertinent information.

Ten-Minute Rule

The Ten Minute Rule simply states that when communication with the base hospital is not possible from the critical patient's side, the field providers should have the patient in the ambulance within ten minutes so hospital contact may be made. Since assessment and treatment of ABCs in most cases can be accomplished within ten minutes, running back and forth from patient to ambulance in order to communicate is an unacceptable alternative. There are exceptions to the 10-Minute Rule, such as when extrication problems exist.

Communications Systems Failures

If unable to contact the base station via hospital radio or dedicated telephone lines, contact should be made with your alternate base station. Follow standing orders and complete a communications incident form for the base station nurse coordinator upon completion of patient care. Any situation where procedures are performed, which by these protocols require a verbal order, and such verbal order is not obtained because of failure to establish radio contact, will be reviewed individually as to their appropriateness. You must be sure clear-cut indications for procedures exist. Remember: Failure to contact the base hospital-for any reason-results in an automatic audit.

Base hospitals shall develop plans for medical control in the event of local equipment failure. Such plans should include contingencies for radio failure, power outages, structural failures, etc.

CRITERIA FOR BASE HOSPITAL CONTACT

ALS providers shall contact the base hospital for medical direction in the following circumstances and under all circumstances where ALS protocols need to be instituted:

1. Medical Cases

- | | |
|---|---|
| <ul style="list-style-type: none"> a. Chest pain b. Shortness of breath c. Hematemesis, melena or hematochezia d. Loss of consciousness (syncope, seizures) e. Possible drug overdose or ingestion of poisonous substances | <ul style="list-style-type: none"> f. Recent change in mental status g. More than one acutely-ill person h. Painful, cold, pulseless extremity i. Acute abdominal pain with abnormal vital signs j. Terminal malignancy in distress. |
|---|---|

2. Trauma Cases

- a. Motorcycle, auto versus pedestrian, or auto versus bicycle accidents.
- b. Suspected fractures of femur, pelvis, spine or skull.
- c. Extremity wounds with distal neurological and/or vascular compromise.
- d. Head injuries with history of loss of consciousness or presently-impaired mental status.
- e. Penetrating wounds of head, neck, chest, abdomen or thigh.
- f. Blunt trauma to abdomen or precordium.
- g. Facial, neck, electrical or extensive burns (+20 percent),
- h. Significant acute external blood loss.
- i. Water accidents and near drownings
- j. Extrication problems
- k. Multiple casualties

3. Obstetrical / Gynecological Cases

- a. Vaginal hemorrhage
- b. Abortion
- c. Childbirth
- d. Ectopic pregnancy

4. Psychiatric Cases

- a. Suicide (attempts or verbalization)
- b. Hallucinations with behavioral problem
- c. Violent or dangerous patients (result of mental disorders)

5. General Cases

- a. Signs of shock:
 - 1. Hypotension (systolic blood pressure of 90 or less in adult)
 - 2. Altered mental status
 - 3. Weak, thready peripheral pulses
 - 4. Cold, clammy extremities
- b. To confirm asystole in suspected DOA.
- c. Any patient who, in the opinion of ALS personnel, would benefit from base hospital consultation.
- d. Any patients with identified medical emergencies who refuse treatment or transportation to a hospital.
- e. Abnormal body temperatures.
- f. Where there is a physician on the scene who wishes to take control of patient care.

ALS responders may patch in any questionable situation:

- 1. Any uncomfortable condition:
 - a. environmental hazard.
 - b. security problems
- 2. When disagreements arise between responding EMS providers or with law enforcement.

BACK-UP MEDICAL CONTROL WITH FLAGSTAFF MEDICAL CENTER**Policy**

Flagstaff Medical Center (FMC) will provide on-line medical control to any ALS unit assigned to Verde Valley Medical Center (VVMC) who is unable to contact VVMC for emergency on-line medical control due to a communication failure.

Purpose

To assure continuous on-line medical supervision to ALS field personnel in the event of a communication failure of any kind between VVMC and an assigned ALS unit. Communication failure shall include not only power failure, but also the ALS units inability to contact VVMC by telephone, cellular phone, or EMSCOM for any reason.

Procedure for Notification by VVMC

1. In case of power failure at VVMC or the failure of the repeaters serving VVMC, the Emergency Department clinical coordinator or designee will notify FMC's Emergency Department that they will need to assume on-line medical supervision and the estimated time this will be in effect. This information will then be provided to the EMSCOM dispatcher by the clinical coordinator/designee and EMSCOM will notify each provider agency at that time.
2. When the power failure situation is over, the Emergency Department clinical coordinator will notify FMC that VVMC will resume on-line medical control.
3. FMC's Emergency Department will immediately communicate all pertinent patient information to the on duty physician/nurse intermediary at the receiving facility.
4. FMC's prehospital coordinator will forward copies of the telemetry forms from the VVMC based units to the prehospital coordinator at VVMC.

Procedure for Notification by ALS Units

1. A VVMC based ALS unit who needs on-line medical direction and who has unsuccessfully attempted twice to contact VVMC by either/or cell phone, telephone or EMSCOM may contact FMC's Emergency Department for medical direction.
2. The ALS unit will identify themselves, state their inability to contact VVMC and request medical direction from FMC.
3. The ALS unit may choose EMSCOM (C-1190), phone line or cell phone to initiate communication with FMC.
4. A report will be filed with the prehospital coordinator with in 72 hours each time the alternate base station is used for medical control. The report needs to include a copy of the patient first care form and the nature of the communication failure.

Resumption of Medical Direction by VVMC

The cause of the communication failure will be corrected by the VVMC or by the provider agency as soon as possible. As soon as the communications failure has been resolved, the Emergency Department clinical coordinator will notify FMC ED and the EMSCOM dispatcher. EMSCOM will notify each provider agency to resume medical direction with VVMC.

Medical Director

Date

Prehospital Care Coordinator

Date

BACK-UP COMMUNICATION PLAN

The Emergency Department automatically is on an emergency power system in case of power outage. The emergency system comes within on ten (10) seconds after the power goes out.

If the EMSCOM unit fails, Verde Valley Medical Center (VVMC) Emergency department can be contacted on dedicated line **928-634-2052**.

Back-up base station for VVMC is Flagstaff Medical Center (FMC). If a provider agency is unable to initiate communication with VVMC for on-line medical control they should contact FMC on dedicated line **928-779-1851, or EMSCOM Coconino 1190**.

Medical Director

Date

Prehospital Care Coordinator

Date

NURSE INTERMEDIARY’S RESPONSIBILITY IN PROVIDING MEDICAL DIRECTION

Policy

A nurse intermediary is a ED registered nurse who has completed the prehospital orientation and twenty four hours of ambulance ride-along time. All radio/telephone patches with VVMC base station will be taped.

Purpose

To provide a guideline for the nurse intermediary to assist with on-line and off-line medical direction under the supervision of the base station medical director. EMS providers should identify the patch as courtesy/advisory or as a request for medical control.

Procedure

1. The nurse intermediary who answers the radio/telephone on an ALS call will ask the ED physician to come to the radio/phone. If the physician can not immediately come to the radio/phone, the nurse intermediary will relay the information to him/her. If orders are needed the nurse intermediary will relay those orders to the ALS providers.
2. When relaying verbal medical direction to providers in the field, the nurse intermediary shall identify themselves and the ED physician by name and title.
3. The nurse intermediary will complete the telemetry form. This will include patient complaint and condition, vital signs, ETA to ED, any medical direction requested and given, and name of the provider who initiated the patch.
4. Communication will be recorded, all information/medical direction will be done in a timely and professional manner.
5. When a patient is transported to another facility, the nurse intermediary will relay all available information to the physician or nurse at the receiving facility. For example, a patch comes to VVMC and patient is directed to Sedona Emergicenter.

Medical Director

Date

Prehospital Care Coordinator

Date

EMERGENCY PHYSICIAN'S RESPONSIBILITY IN PROVIDING MEDICAL DIRECTION

Policy

The physician on duty in the Emergency Department shall be responsible for providing on-line and off-line medical direction for EMS providers based at Verde Valley Medical Center (VVMC). Radio/telephone communications will be recorded.

Purpose

To provide a guideline for the Emergency Department physician when giving medical direction.

Procedure

1. The emergency physician on duty shall respond to all ALS radio/telephone patches unless engaged in rendering care to another emergency department patient or engaged in another ALS radio/telephone communication. »
2. If above circumstances apply, the physician will have a ED nurse intermediary respond and relay verbal medical direction to the field unit.
3. The emergency physician on duty shall be accountable and responsible for the on-line medical direction given to the ALS field units.
4. Communications will be recorded, all information/medical direction shall be done in a timely and professional manner.
5. The emergency physician on duty shall be responsible for completing the telemetry form, including signature, on all ALS communication/medical direction. PLEASE NOTE: A PHYSICIAN SIGNATURE IS REQUIRED FOR ANY MEDICATIONS ORDERED AND GIVEN IN THE FIELD.
6. When a patient is transported to another facility, the emergency physician will relay al available information to the physician or nurse at the receiving facility. A nurse intermediary may do this under the emergency physician's direction

Medical Director

Date

Prehospital Care Coordinator

Date

ED TELEMETRY PATCH RECORD

DESCRIPTION OF RADIO, TELEPHONE, AND RECORDING EQUIPMENT

The radio is a General Electric Model # RCI4SH, (serial number- 96-03-004-REV-J) with Omnicom TCC-14 talking clock calendar and Omnicom commercial tape recorder model #VLR-1CT. It is voice activated and is utilized for recording incoming radio transmissions and recording communications coming in through the dedicated phone line.

This is located in the middle work station of the Emergency Department adjacent to the ED physician work area.

This unit performs the following functions:

1. Alerts staff to incoming radio/telephone calls.
2. Provides alternate channel selection
3. Records both radio and telephone communication on standard magnetic tapes.

The radio ID is: Yavapai-1100

The dedicated telephone line number is: 928-634-2052

Medical Director

Date

Prehospital Care Coordinator

Date

PREHOSPITAL DOCUMENTATION POLICY

Policy

All providers will fill out an EMS incident report on each patient they assess and treat.

Purpose

To ensure consistent and timely completion of information on each prehospital encounter. To serve as a guideline of needs to be assessed on at each patient encounter.

Procedure

1. An EMS incident report will be completed on each patient who is treated whether they are transported or not.
2. The provider will use the incident report form of the agency he/she is working for that day. The report form will be filled out at the time of service and given to the ED nurse who is assuming care of the patient.
3. A primary and secondary survey will be performed upon arrival of the provider, including chief complaint, mechanism of injury, past history, pertinent physical findings, response to any treatments or medications, and documentation of any procedure done in the field.
4. Document any patches to the base station and any orders received.
5. Document time of arrival on the scene and time of leaving the scene.
6. Document patient condition upon arrival at the ED and any changes that occurred enroute.
7. Document who assumed patient care on arrival to the ED and what time patient care was turned over.
8. When the incident report form is complete sign it legibly, including your certification level.
9. Paperwork flow: Original goes to the hospital medical record, one copy goes to the prehospital manager, use the files in EMS drawer in ED, one copy goes to agency records.

Medical Director

Date

Prehospital Care Coordinator

Date

CONTINUOUS QUALITY IMPROVEMENT ACTION PLAN

POLICY:

To monitor prehospital care services in the Verde Valley Medical Center base station area. A corrective action plan will be used when review of cases indicates a lapse in following protocol and/or procedure. It will be the policy of the EMS director to avoid punitive measures in favor of remedial and educational interventions if at all possible.

PURPOSE:

To develop a consistent way of identifying real or potential problems. To give feedback to the prehospital providers on the quality of care, and to initiate corrective action when needed.

PROCEDURE:

1. Monthly chart review will be done in compliance with ADHS rules.
2. When a problem is identified it will be evaluated in the Prehospital CQI committee. The committee will look at what opportunities exist to make changes and improvements. The evaluation may include looking at trends in patient care that relate to specific providers, agencies, skills and/or patient complaints.
3. When the evaluation is complete, a corrective action plan will be implemented. The plan will specify what the identified problem is, who/what is expected to change, who is responsible for implementing the corrective action plan, and a time frame for the expected change to occur.
4. When the plan has been implemented a follow up will be done to assess the effectiveness of the changes, and to determine if additional problem solving is needed.
5. Results of the corrective action process will be reported in the Prehospital CQI committee meeting and noted in the minutes.
6. The conflict resolution policy will be used to address CQI issues with individuals.
7. Monthly review of field lab draws, all full codes, all do not resuscitate cases, and other identified cases will be conducted to identify potential problems areas.

Medical Director

Date

Prehospital Care Coordinator

Date

