

Southern Tier Regional EMS Council  
Southern Tier Regional Emergency  
Medical Advisory Committee

# BASIC LIFE SUPPORT Policies



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## PURPOSE OF BASIC LIFE SUPPORT POLICIES

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Basic Life Support Protocols are approved by the New York State Emergency Medical Advisory Committee, and provided by the New York State Department of Health, Emergency Medical Service Program.

The Basic Life Support Policies included herein have been developed by the Southern Tier Regional Emergency Medical Advisory Committee (STREMAC) and the Basic Life Support Committee, and are both approved and promulgated by the Southern Tier Regional EMS Council and STREMS, Inc.

These policies address specific out of hospital issues and situations that are not covered in the State's BLS Protocols, and for which standardized actions are required.

Given our region's geography and telecommunication limitations, contacting medical control may not always be possible. When medical control contact is warranted but not possible, providers shall document on the patients PCR the following:

1. Time and date of Medical contact attempt(s)
2. Method of medical control contact attempt(s) - radio, cellular or land telecommunication
3. Name of Medical Control facility(s) EMS provider attempted to contact

It is the responsibility of the personnel using these BLS Policies to use their best judgment in instituting these policies while optimizing patient care. Emergency Medical Technicians are expected to function to their level of training when confronted with situations that are not addressed by the new NYS Protocols or these Policies.

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Chair, Southern Tier Regional Emergency Medical Advisory Committee  
Medical Director, Southern Tier Regional Emergency Medical Services Council

The following is the desired information in the **proper order for report**, consistent with the Southern Tier Regional EMS Council On-Line Medical Control Report form #501 10/94 (see page 27):

AMBULANCE IDENTIFICATION:

FIELD PROVIDER DATA: level of certification

AGE: approximate only, if not known

ESTIMATED TIME OF ARRIVAL:

SEX:

PERSONAL PHYSICIAN: patient's personal physician name

CHIEF COMPLAINT: chief complaint;  
significant associated symptoms or injury,  
mechanism of injury  
significant prior episodes

PHYSICAL EXAM: include positive findings and pertinent negatives  
vital signs: respiration, pulse, blood pressure  
patient's level of responsiveness as defined by AVPU  
Glasgow Coma Score  
pupils: round, regular, unequal, react to light, do not react  
to light, dilated or constricted  
skin: normal, pale, cyanotic, flushed, moist, dry, hot, cold  
CUPS status

HISTORY AND MEDICATION: Medications  
Allergies  
Past medical history

TREATMENT: example: CPR started, giving oxygen, splint, MAST suit  
on . . .

Other information as may be requested.

Patient's name is not to be given unless requested by Emergency Department personnel

**In the event of a communications failure (e.g., radio contact not possible, no telephone available), proceed with the appropriate protocol(s) up to the "Contact Medical Control" point, transport as soon as possible, and continue to attempt to contact Medical Control.**

***Do not hesitate to ask for advice from Medical Control AND contact Medical Control as soon as possible. NOTE: Telephone contact with MEDICAL CONTROL may be used if possible for reasons of patient confidentiality or radio communication difficulty.***

It is imperative that out of hospital care be delivered in an organized fashion. The Southern Tier EMS System provides for systematic physician involvement, both off-line as physician Medical Directors, as members of the Southern Tier Regional Emergency Medical Advisory Committee as well as through the provision of on-line medical control by physicians at medical control facilities. EMT and Advanced EMT out of hospital providers are often placed in a difficult situation when a physician arrives on the scene and wishes to take over Medical Control responsibility. The following guidelines have been adopted and should be followed by out of hospital personnel. The physician arriving at the scene should be informed of the following information:

As a participant in the Southern Tier Regional Emergency Medical Services System, out of hospital care providers are being supervised by a physician at a medical control hospital through direct voice contact, by the agency's physician medical director and through the STREMAC's formally written standing authorizations. Any other physician wishing to take charge of the patient at the scene of the emergency or during a transport is required to receive the approval of the on-line Medical Control physician involved in the care of the patient. If the physician at the medical control facility wishes to turn over medical responsibility to the on-scene physician, then it should further be understood that the on-scene physician must sign the provider's Prehospital Care Report form, accept responsibility for the patient's care, and accompany the patient in the ambulance to the receiving hospital.

The use of a First Response unit (either transporting or non-transporting, BLS or ALS) will maximize patient care and hopefully reduce scene time. Therefore, any EMS agency that receives a call involving any of the following conditions, and knows of a First Response agency in closer proximity, will request that unit to proceed to the scene. This utilizes the important concept of a tiered response within the EMS system.

The Southern Tier Regional Emergency Medical Advisory Committee and the Southern Tier Regional Emergency Medical Services Council has determined that in addition to implementing the tiered response within our region, the following conditions also **WARRANT** the **simultaneous** dispatching of an Advanced Life Support unit (**EMT-CC or EMT-P**).

A. Medical Conditions:

1. Cardiac/Respiratory arrest
2. Cardiac problems including chest pain of suspected cardiac origin
3. Breathing problems including shortness of breath
4. Allergic reactions
5. Diabetic problems
6. Altered Mental Status, GCS <15 and/or  
Deterioration in Mental Status if baseline GCS is <15

B. Traumatic Conditions:

1. Severe bleeding or trauma
2. Severe burns
3. Gunshot/stabbing
4. Industrial/farm machinery accident
5. Head injury
6. Serious motor vehicle/transportation incidents
7. Major Trauma as defined in NYS BLS Protocols

C. Other Conditions:

1. If requested by Basic Life Support/Intermediate Life Support unit, Fire Department or Police Agency
2. Dispatcher's discretion

*continued...*

When a Basic Life Support (BLS) service is contacted to respond to one of the preceding situations, or encounters a patient who requires ALS interface (as required by New York State BLS Protocols), they shall simultaneously request an Advanced Life Support (**EMT-CC/P**) unit to respond (if one is available). This simultaneous dispatch of ALS shall be in **ADDITION** to the dispatch of First Responder units, Basic Life Support units and/or Intermediate Life Support (ILS) units.

The rationale behind this criteria is that it is far better to have dispatched an ALS unit and not need it, than to discover that one is needed and not have dispatched one, causing additional time delay before Advanced Life Support can be provided to the patient. In the event that, after patient assessment, ALS is not needed, the BLS/ILS unit shall follow ALS cancellation, Policy #4.

This criteria is not intended to limit dispatchers, but to provide them with medical backing and support in the decision-making aspect of ALS dispatching.

When a BLS/ILS unit has reason to believe that a patient may need Advanced Life Support (as determined by the above list of conditions or by treatment in the NYS BLS Protocols), they are to immediately request, and meet with, an ALS unit (if an ALS unit is available) so the patient will receive the appropriate level of care.

When Simultaneous ALS dispatch has occurred or an ALS intercept has been arranged, the BLS/ILS unit is **NOT** to delay transport to wait for an ALS unit. The BLS/ILS unit shall perform to its capabilities (vital signs, patient assessment, oxygen therapy, CPR, MAST, Advanced Airway Management and IV therapy). Transportation to the hospital should begin, and the ALS unit should be met enroute; in some cases, the hospital may be the closest place where ALS is available.

When a BLS/ILS provider cares for a patient who requires an ALS interface but is refusing the ALS interface, the following statement should be used:

**“Based on your presentation, symptoms, signs, and/or physical exam, your condition warrants an Advanced Life Support interface. New York State Basic Life Support Protocols and/or Southern Tier Regional EMS Policy #3 require that I arrange an ALS Interface for you. Once ALS has evaluated you, and has determined that ALS care is warranted, you may refuse ALS care. The ALS agency will NOT bill you for their evaluation should it be determined that you do not need ALS care or if you refuse ALS care.”**

*see also Policy #6, Patient Refusing Care*

Did the patient originally, or does the patient currently, meet the criteria to require ALS dispatch as outlined in Policy #3, BLS Policies, November, 1999

9

<u>Yes</u>	<u>No</u>
9	9

Does the patient meet the criteria for treatment in any of the NYS BLS Protocols (1996) that require ALS Intercept?	<u>May cancel ALS</u>
---	-----------------------

<u>Yes</u>	<u>No</u>
9	9

<u>Refusing Transport?</u>	<u>May cancel ALS*</u>
----------------------------	------------------------

<u>Yes</u>	<u>No</u>
9	9

May cancel ALS\*  
 Follow BLS Policy #6 for Patient Refusing Treatment and/or Transport

Does the patient meet the definition of obvious death as defined by NYS:  
 ☒ Burned beyond recognition  
 ☒ Decapitation/Decomposition  
 ☒ Dependent lividity

<u>Yes</u>	9	<u>No</u>
9		9

May cancel ALS\*

Does the patient have any vital signs?  
 9

<u>Yes</u>	9	<u>No</u>
9		9

Treat under appropriate protocol

Does the patient possess a valid prehospital DNR?

=====

9

<u>Yes</u>	9	<u>No</u>
9		9

May cancel ALS\*

Begin resuscitation and treat under appropriate protocol

=====

<sup>†</sup>ALS may not be cancelled by a CFR.

\*In order to cancel ALS, the Basic EMT or EMT-I who **made** the decision to cancel ALS shall provide their level of care and NYS EMT ID number (certificate number) to the ALS unit canceled **prior to completion of the call** (document this information on the PCR).

ALS Providers are authorized to transfer care of a patient to EMT BLS providers<sup>1</sup> after ALS assessment.

ALS Assessment Complete	
9	
Does the patient meet the criteria for ALS Dispatch as outlined in <b>BLS Protocols and Policies,</b> Policy #3	
9	
9	9
Yes	No
9	9
Does patient's mechanism of injury, chief complaint, or assessment warrant ALS intervention and/or ALS transport?	ALS provider may transfer care of patient to BLS (EMT or higher NYS certified) personnel Document on BLS Agency's PCR transferring ALS provider name and EMS Number
9	9
Yes	No
9	9
ALS shall care for patient	ALS provider <b>may</b> contact Medical Control to affirm decision to transfer care of patient to BLS. Document Medical Control affirmation to transfer care of patient to BLS on PCR. ALS provider may transfer care of patient to BLS (EMT or higher NYS certified) personnel. Transfer Hospital copy of PCR to receiving institution. <sup>2</sup> <b>Document on BLS Agency's PCR transferring ALS provider name and EMS Number</b> <b>AND/OR</b> Document on ALS agency's PCR the ALS evaluation, findings, treatment and differential diagnoses. Transfer hospital copy of PCR to receiving institution <sup>2</sup>
	9
	ALS may leave scene.

<sup>1</sup>ALS may transfer patient care only to personnel certified as a Basic EMT or higher.

<sup>2</sup>BLS shall not delay transport awaiting ALS PCR.

After discussion of the need for treatment\* and/or transport with the patient and/or their family or friend(s) and the patient refuses treatment and/or transport

9

Obtain GCS

9

9

GCS = 15

Attempt/obtain vital signs and repeat GCS x3, every 5-10 minutes, document results/attempts on PCR.

9

Evaluate patient for:

- A. Attempted/threatened suicide
- B. Incompetence
- C. Communication problem
- D. Child/elder abuse
- E. Recreational drug use

9

9

A-E present or suspect presence of A-E

9

Elicit assistance from Law Enforcement agency to transport patient. Contact Medical Control.

9

GCS < 15

Elicit assistance from law enforcement agency to transport patient. Contact Medical Control.

9

No evidence of A-E present

9

Contact Medical Control; ask patient if they would like to speak with physician

9

If patient still refuses treatment and/or transport

9

- Document the absence of A-E
- Document at least 3 sets of vital signs and GCS
- Complete Release on PCR reverse
- Document names, addresses and/or affiliation of witnesses present

9

Leave scene and patient.

**When a BLS/ILS provider cares for a patient who requires an ALS interface but is refusing the ALS interface, the following statement should be used:** “Based on your presentation, symptoms, signs, and/or physical exam, your condition warrants an Advanced Life Support interface. New York State Basic Life Support Protocols and/or Southern Tier Regional EMS Policy #3 require that I arrange an ALS Interface for you. Once ALS has evaluated you, and has determined that ALS care is warranted, you may refuse ALS care. The ALS agency will NOT bill you for their evaluation should it be determined that you do not need ALS care or if you refuse ALS care.”

\*

Leaving the Scene in a Multiple Patient Scenario

Determine the number of patients and CUPS status of each patient

9

Does the number of patients and/or the patients' status exceed the responding agency's capabilities:

9

9

YES

9

Call for assistance and/or consider declaration of an MCI according to BLS Policy #8

9

Contact Medical Control, as soon as possible and prior to leaving the scene, relate patient numbers and patient status

9

9

9

9

NO

9

Proceed with patient assessment and treatment as per protocol

=====

If more than one patient with status of C or U is present, remain on the scene until a provider with equal or higher NYS certification arrives, unless authorized<sup>1</sup> to do otherwise by Medical Control.

9

Transport the most critical patient first and efficiently utilize resources as they become available.

If only one C or U patient is present and other P or S patients are present:

9

**Contact Medical Control**, request authorization<sup>1</sup> to leave P or S patient(s) with lower NYS Certified personnel.

9

On the PCR of the patient left, document Medical control authorization to leave.  
On the PCR of the patient transported, document reasons why and Medical Control authorization to leave other patient.

<sup>1</sup> *Authorization to leave a patient with a lower NYS Certified provider must be obtained from Medical Control.*

Definition: a Mass Casualty Incident is an occurrence when the destructive effects of nature and/or manmade forces overwhelm the ability of an EMS agency [and/or the utilization of its Mutual Aid Agreements] to meet the demand for Emergency Medical Services.

Does the number of patients and/or patients' statuses overwhelm the responding agencies' capabilities and/or the resources readily available with its Mutual Aid Agreements?<sup>1</sup>

9	
9	9
Yes	No
9	9

Declare a Mass Casualty Incident. Providers shall follow the NYS DOH EMS Field Manual for MCI Management*	Refer to BLS Policy #7 “Leaving the Scene in a Multiple Patient Scenario”
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\*Note: this Manual is to be found in the NYS DOH MCI Response kit (see NYS DOH Policy 98-18 “Management Kits for MCI Field Response,” Appendix p. 28).

**All EMS agencies shall have at least one MCI Response kit as defined by NYS DOH EMS Program.**

<sup>1</sup>Each agency needs to continuously define their service's capabilities to determine when a given situation may exceed their agency's capabilities.

- A. Assess the situation
  1. Evidence of immediate danger:
    - a. Protect yourself and others
    - b. Summon law enforcement officers, if indicated by patient's behavior and if necessary to render care.
    - c. When the danger is removed:
      - initiate assessment per protocol
      - treat according to appropriate protocol
      - consider ALS interface for sedation of the combative/dangerous patient
  2. No evidence of immediate danger:
    - a. One EMS person should be responsible for assessment, treatment and communication, if possible (more than one contact person will tend to confuse the issue).
    - b. Initial assessment per protocol.
    - c. Treat according to appropriate protocol.
- B. Obtain complete patient history, including details of what led to the present situation.
- C. Always be calm, reassuring, honest, and confident when dealing with the emotionally disturbed patient. Move slowly and be direct. Do not be judgmental.
- D. Transportation
  1. With patient consent:
    - a. Maintain continuity of contact with one EMT
    - b. Transport as a non-emergency unless illness/injuries dictate otherwise.
  2. If patient refuses:
    - a. Follow "Patient Refusing Treatment and/or Transport" Protocol
    - b. If condition indicates, request assistance from law enforcement officer, to restrain patient for transport.

**NOTE:** Transport the patient handcuffed only if the law enforcement officer accompanies patient. At the discretion of the EMS provider, law enforcement may be asked to accompany the patient either in the ambulance or in a following vehicle.

- . Interfacility transfers shall occur in compliance with all State and Federal regulation. EMS providers may transport patients with the following equipment and/or medication:

**Provider****Level of  
Certification****Equipment/Medication**

Basic EMT	Saline/Heparin Lock Stable patient with no anticipation of further interventions en route
AEMT-I	Peripheral IV lines of d5W or NS Stable, non-intubated patients with no anticipation of further interventions en route.
AEMT-CC	Peripheral IV lines Cardiac monitor/defibrillator Intubated Adult Patients Protocol drugs in form listed in protocol Capped central lines
AEMT-P	Cardiac monitor/defibrillator Intubated patients any age Central venous lines Hickman catheters Subclavian IV Internal jugular IV Capped central lines Arterial lines IV drips Protocol drugs in form given in protocol

- Interfacility transfers shall occur consistent with applicable state and federal laws, rules and regulations.
- Composition of the transfer crew may be verified with the transferring physician by the EMS providers.

When EMS Providers participate in an interfacility transfer and facility staff accompany the patient in the ambulance, all personnel shall conduct themselves in a cooperative manner to optimize patient care. Any supplies used for the transfer are to be supplied by either the sending or receiving institution either prior to or at the conclusion of the interfacility transfer.

A valid prehospital order not to resuscitate (DNR) presented to the EMS provider either on NYS DOH Form #3474 (2/92) or by bracelet indicates that the patient has made an informed decision that they do not wish cardiopulmonary resuscitation be performed if needed.

This does **not** mean that all prehospital care should be withheld.

**Any and all BLS and ALS treatments  
indicated and required by the patient's presentation  
must be offered and instituted  
unless specifically refused by the patient.**

All treatments should occur per protocol  
except for the institution of  
cardiopulmonary resuscitation  
(assisted ventilation and/or chest compressions)

Bring DNR order (NYS DOH Form #3474 (2/92) [*see Appendix page 26*])  
or DNR Bracelet with patient to hospital

***IF THE NEED IS NOT CLEAR, contact Medical Control as soon as possible to aid in determining the need for helicopter utilization.***

## HELICOPTER TRANSPORT OF A PATIENT IS INDICATED WHEN:

The transport of the patient(s) by helicopter will improve their arrival time at the appropriate facility when compared to patient's ground arrival time at the appropriate facility.

AND

A patient's outcome could be improved by an earlier arrival time at the appropriate facility.

OR

The extrication time and the institution of ALS is expected to be longer than the helicopter's response time to the scene.

OR

Special circumstances exist such as:

- a. MCI
- b. Facilitation of rescue, search and/or extrication

OR

The patient meets the definition of Major Trauma

- @ A helicopter service should be alerted to "stand-by" status as soon as a potential need is identified.
- @ Requests from the scene for helicopter **transport** should be made by the highest trained EMS provider, and simultaneously with a request for ground ALS intervention/**intercept**.
- **PATIENT TRANSPORT SHOULD NOT BE DELAYED AWAITING A HELICOPTER OR GROUND ALS UNLESS INSTRUCTED TO DO SO BY MEDICAL CONTROL.**

**WHEN IN DOUBT, CONTACT MEDICAL CONTROL**

The purpose of this policy is to provide authorization, **as required by New York State BLS Protocols**, for the use of PASG/MAST (Pneumatic Anti-Shock Garment / Medical Anti-Shock Trousers) in the Southern Tier Regional Emergency Medical Services System. EMS providers may utilize the PASG/MAST in the following situations:

- I. The patient meets the criteria for treatment under the New York State BLS Protocol, Shock, (cf NYS DOH BLS Protocol, **Rev. 8/97**, page 58, IV).

**OR**

- II. The patient meets the criteria for treatment under the New York State BLS Protocol, Adult Major Trauma, (cf NYS DOH BLS Protocol, **Rev. 8/97**, page 45, III, A, 5

**OR**

NYS DOH BLS Protocol, **Rev. 8/97**, Page 45, III, B, 4 ).

**OR**

- III. The patient meets the criteria for treatment under the New York State BLS Protocol, Fracture/Dislocation, (cf NYS DOH BLS Protocol, **Rev. 8/97**, page 42, VI, E).

**Note:**

**PASG/MAST should not be used on the pediatric patient age 8 years old or younger**

**When in doubt, contact Medical Control  
for authorization to utilize PASG/MAST.**

*This procedure is based on New York State Law, Article 17-A (see Appendix, page 24).*

I. At the Scene

A. If you are called to a scene where there is OBVIOUS DEATH,<sup>1</sup> including suspected sudden infant death syndrome (SIDS), **do not move the body or alter the scene in any way.**

1. Preserve all scene evidence and contact Law Enforcement.
2. If Law Enforcement is present at the scene, allow Law Enforcement the responsibility to contact the Medical Examiner or Coroner<sup>2</sup>

OR

notify the Medical Examiner or Coroner by phone or radio and give available information.

II. Crossing County Lines

A. In cases of obvious death, all rules outlined above apply.

B. Possible life: transport doing CPR to *NEAREST HOSPITAL* regardless of county lines.

III. Declaration of death: Once a physician has declared death, the transportation of the body is the responsibility of the medical examiner or coroner, not that of ambulance personnel. The ambulance may be requested to transport the body by the medical examiner or coroner.

Whenever doubt exists: It should be pointed out that because situations involving death differ in each case, there can be no strict set of rules governing the procedures to be taken in any given case. Common sense should prevail, and the decision whether to transport the patient to the hospital will have to be left up to the discretion of those first on the scene. **IF DOUBT EXISTS** regarding whether a patient is "obviously dead" or not, begin CPR and transport to the nearest hospital. *GIVE THE PATIENT THE BENEFIT OF THE DOUBT, while preserving all possible evidence.*

<sup>1</sup>Definitions

- Obviously dead:
  1. Dependent lividity and/or rigor mortis
  2. Severe traumatic injury (decapitation, brain avulsion, burned beyond recognition)
  3. Decomposition
- Possible life - any case when obvious death does not exist.
- Medical Examiner's or Coroner's case - defined in section 673 of Article 17-A of the New York State Law (see Appendix, page 24).

<sup>2</sup>By New York State law, a coroner or medical examiner has jurisdiction and authority to investigate any death which is or appears to be:

- A violent death, whether by criminal violence, suicide, or accident
- A death caused by criminal neglect or an unlawful act
- A death occurring in a suspicious, unusual or unexplained manner
- A death while unattended by a physician (i.e., the patient has not previously been ill or has a valid prehospital DNR)
- A death of a person confined in a public institution other than a hospital, infirmary or nursing home.

- I. Title: Emergency Medical Dispatch and Public Safety Agencies Receiving Direct Dialed Calls From the Public Requesting Emergency Medical Service assistance.
- II. Purpose: To provide a standardized approach for public safety agencies (fire, police, ambulance) who receive direct dialed calls from the public for EMS assistance.
- III. Perceived Problem: In the region's counties where a 911 dispatch center exists, the public has, on occasion, inadvertently directly dialed a public safety agency and requested Emergency Medical Service assistance. The resultant dispatch of EMS and provision of prearrival instructions may either be inconsistent with existing EMD protocols and/or be delayed while that public safety agency attempts to fulfill the 911 center's function.
- IV. Policy: If a public safety agency receives a call from the public requesting Emergency Medical Service Assistance, the agency shall:
- A. Collect appropriate dispatch information:
    - 1. Name and Location of both caller and/or patient(s)
    - 2. Reason for call (complaint, problem)
    - 3. Phone number calling from
    - 4. Instruct caller to redial 911
  - B. Relay appropriate dispatch information to the 911 Dispatch Center
  - C. Insure that subsequent actions by the public safety agency do not delay the 911 Dispatch Center's notification

## I. Title: New Treatment/Procedure/Equipment Policy

II. Purpose: To establish a guideline for an EMS agency that is desirous of initiating a new treatment, procedure(s), implementing the use of new equipment or allowing a provider to perform a skill not currently authorized by that provider level scope of practice. This will insure the new treatment, procedure(s), equipment or skill is used within the regionally approved scope of practice of the agency's providers and consistent with the Southern Tier Regional EMS prehospital protocols.

III. Policy: Any EMS agency that wishes to utilize a new:

1. medical treatment
2. procedure
3. piece of equipment
4. skill not currently authorized by a provider's scope of practice which has previously not been used by that agency or provider level within the Southern Tier Region, shall obtain from the Southern Tier Regional Emergency Medical Advisory Committee, authorization to do so before its use is initiated.

To obtain authorization for use of the new treatment, procedure, skill or equipment from the Southern Tier Regional Emergency Medical Advisory Committee, the agency's Service Medical Director must present the case to the STREMAC.

**I. Title: Coordination of EMS Resources****II. Impacted Personnel:**

- A. All Emergency Medical Service Providers certified by the State of New York, responding as part of an EMS Agency's Response System within the SouthernTier Regional Emergency Medical Services System in the counties of Chemung, Schuyler, and Steuben are effected by this policy.
- B. Agencies authorized as EMS Providers are those agencies who are dispatched and respond to Emergency Medical Service calls within Chemung, Schuyler or Steuben counties.

**III. Policy:**

- A. Consistent with state and county policy, the National Interagency Incident Management System (NIIMS) is established as the standard for Incident Command and the local public safety official in charge of the overall scene command is recognized as the Incident Commander and is in charge and is responsible for the safety of all personnel involved.
- B. Prehospital care personnel responding with authority are those New York State certified prehospital care providers who respond as part of an agency's response system, duly dispatched and asked to respond to an emergency medical service call.
- C. Patient care responsibilities are the responsibility of the New York State certified prehospital care personnel responding with authority.
- D. The individual provider having the highest level of regional credentialing, responding with authority, will have the authority to direct patient care.
- E. When two or more EMS providers with the same level of certification respond from more than one agency, operating at the same scene, the EMS provider of the transporting agency will have the authority to direct patient care.
- F. When two or more EMS providers with the same level of certification respond from more than one agency, operating at the same scene neither of whom will transport the patient, the EMS provider with the most seniority, as evidenced by the date first credentialed in the STREMS system will have authority to direct patient care.
- G. When two or more EMS providers with the same level of certification respond from the same agency, operating at the same scene, the EMS provider with the most seniority as evidenced by the date first credentialed in the STREMS system will have authority to direct patient care.
- H. EMS providers with the authority to direct patient care may provide that care or delegate another New York State certified provider to provide care.
- I. Transfer of care between two certified providers shall occur consistent with regional protocols, and on the authority of the provider authorized to direct patient care and/or by on-line medical control authorization.
- J. All EMS providers will provide care consistent with NYS Statewide and regional protocols and policies.

- K. The authority to direct patient care includes the authority to request specialized medically related EMS resources such as HAZMAT intervention or ALS Interface as well as transport mode (including aeromedical evacuation) and destination, consistent with regional protocols. The Incident Commander shall be informed of any request(s) for specialized EMS resources.
- L. All EMS providers must wear regionally approved and issued picture identification that delineates date first credentialed, date credentialed, level of certification and status.
- M. All EMS providers will document care on the New York State PCR
- N. All EMS providers will document problems encountered with this policy and its implementation on the PCR's comment section.
- O. If a situation arises where the resolution of a conflict as a result of this protocol does not readily occur, on-line medical control will be contacted to resolve such a conflict.
  - 1. Conflict resolution, medical control contact and the involved EMS providers' identifications will be documented on the PCR.
- P. All PCRs with documentation of coordination of EMS resources problem will be reviewed by the region's appropriate QI Coordinator and, if appropriate, referred to the area or Regional QI Committee and/or the STREMAC for further action.
- Q. Physicians who become involved at an EMS scene shall be dealt with according to the STREMS BLS Policy #2, Physician on the Scene.

Title: Emergency Department Diversion Protocol and Policy

Policy

- I. A hospital is considered to be on diversion status when the hospital determines that its Emergency Department is operating at capacity AND that the acceptance of an additional patient may endanger the life of that patient or the patient(s) already present in the Emergency Department.
- II. Each hospital shall:
  - A. Establish internal criteria for deciding that a Diversion Status must be invoked.
  - B. Promptly inform the appropriate dispatch center of the decision to implement or change Diversion Status utilizing STREMS Form 499- Hospital Diversion Status Report.
  - C. Promptly inform the ALS Service(s) that routinely transport patients to the hospital of the decision to implement or change Diversion Status utilizing STREMS Form 499- Hospital Diversion Status Report.
  - D. Promptly transmit via fax or mail a copy of each STREMS Form 499 to the STREMS Office.
- III. Each 911 EMD Center shall:
  - A. Make record of a Hospital decision to implement or change Diversion status.
  - B. Record shall be documented on STREMS EMD Diversion Form Log 401 and include date, time, diversion status and name of person making the diversion status. (If STREMS Form 499 is received, attach each to Form 401)
  - C. A hospital's Diversion Status will be communicated to all transporting agencies dispatched that will likely transport a patient to a hospital on diversion status.
  - D. Submit a copy of each STREMS Form 401 used to the STREMS Regional Medical Director on a monthly basis.
- IV. Each Transporting Agency shall insure that EMS Providers:
  - A. Inform a patient of a hospital's diversion status if that patient falls into the class of patients being diverted by that hospital on diversion status
  - B. Inform the patient of the hospital diversion status using the Prehospital Patients' Diversion Status Statement.
  - C. Transport the patient according to protocol, REGARDLESS of hospital diversion status, if **any** of the following conditions are met:
    1. Patient insists on going to a hospital on diversion despite being read STREMS Prehospital Patients' Diversion Status Statement.
    2. The patient has an unmanageable airway or is being given CPR
    3. An Online Medical Control Physician at the hospital on diversion status directs that the patient be transported to his/her hospital.

- D. Insure that EMS providers document on the a patient's PCR the following:
  - 1. Time Prehospital Patients' Diversion Status Statement is read to patient
  - 2. Results of Diversion Statement:
    - a. Patient diverted from Hospital ABC to Hospital XYZ
    - b. Patient insisted on transport to Hospital ABC
  - 3. Patient transported to hospital ABC because of:
    - a. Unstable Airway
    - b. CPR being performed
    - c. On Line Medical Control Physician (name) instructed provider to do so.
  
- E. Insure that a copy of the PCR of each patient transported according to this protocol is forwarded to the service's Medical Director and the regional Medical Director within 5 business days of transport.
  
- V. Each EMS Provider completing a PCR on a Patient Cared for under this Protocol shall:
  - A. Inform a patient of a hospital's diversion status if that patient falls into the class of patients being diverted by that hospital on diversion status.
  - B. Inform the patient of the hospital diversion status using the Prehospital Patients' Diversion Status Statement.
  - C. Transport the patient according to protocol, REGARDLESS of hospital diversion status, if any of the following conditions are met:
    - 1. Patient insists on going to a hospital on diversion despite being read STREMS Prehospital Patients' Diversion Status Statement.
    - 2. The patient has an unmanageable airway or is being given CPR
    - 3. An Online Medical Control Physician at the hospital on diversion status directs that the patient be transported to the hospital on diversion status.
  - D. Document on the a patient's PCR the following:
    - 1. Time Prehospital Patients' Diversion Status Statement read to patient
    - 2. Results of Diversion Statement:
      - a. Patient diverted from Hospital ABC to Hospital XYZ
      - b. Patient insisted on transport to Hospital ABC
    - 3. Patient transported to hospital ABC because of:
      - a. Unstable Airway
      - b. CPR being performed
      - c. On Line Medical Control Physician (name) instructed provider to do so.

## **STREMS Region**

# **Prehospital Patients' Diversion Status Statement**

The following statement should be read to all patients, patient's caregivers and/or child's guardian when the patient requests transport to a hospital on diversion status for that patient.

It shall be communicated in such a way to encourage transport to a hospital not on diversion status.

You have requested to be transported to hospital ABC. At this time, that hospital is on diversion status and has requested that patients **with your condition not** be transported to that facility. The hospital at this time is experiencing a situation limiting its ability to care for you. Hospital ABC may not be able to care for you and your presence may threaten your life and the lives of patients already in the Emergency Department.

We are recommending that at this time we transport you to XYZ hospital where, **at this time**, they will be more adequately able to care for you.

If you insist we take you to ABC hospital, we will do so. Please understand that by going to ABC hospital, you may experience delays, and you may not be evaluated or treated as promptly as you might be at another hospital. This may cause your condition or those of patients already at the hospital to worsen.

**Purpose:**

To delineate the use of the Emergency Medical Dispatch Number and the Emergency Medical Dispatch Code in the Regional Emergency Medical Service System. The EMD Number and Code, documented on the PCR, will now allow quality improvement activities to occur from the moment the public contacts the EMS system.

**Affected Personnel:**

All Emergency Medical Dispatchers utilizing STREMS Approved EMD Protocols  
*and*  
All New York State Certified EMS Personnel dispatched by a Emergency Medical Dispatch center in the STREMS region, completing a Patient Care Report form

**Policy:**

1. The Emergency Medical Dispatch Number is defined as the unique number, generated by the dispatching center, that identifies the patient or patient care situation necessitating the dispatch of Emergency Medical Personnel.
2. The Emergency Medical Dispatch Code is defined as the unique code, taken from the Emergency Medical Dispatch protocols, that identifies the patient type and type of response dispatched by the dispatching center.
3. All Emergency Medical Dispatchers, utilizing STREMS EMD Protocols shall provide, in a timely manner, to either the dispatched agency or the dispatched EMS provider, the Emergency Medical Dispatch Number and the Emergency Medical Dispatch Code.
4. All EMS providers, dispatched by a EMD center of the STREMS Region, completing a PCR, shall clearly document the Emergency Medical Dispatch Number on the PCR in the area of the PCR to the **right** of the title, Prehospital Care Report, above the agency code and vehicle ID boxes. (See attached PCR sample).
5. All EMS providers, dispatched by a EMD center of the STREMS Region, completing a PCR, shall clearly document the Emergency Medical Dispatch Code on the PCR in the area of the PCR to the **left** of the title, Prehospital Care Report, above the run no. box. (See attached PCR sample).

NEW YORK STATE COUNTY LAW  
ARTICLE 17-A

§673. **Deaths concerning which a coroner, coroner and coroner's physician or medical examiner has jurisdiction to investigate.**

1. A coroner or medical examiner has jurisdiction and authority to investigate the death of every person dying within his county, or whose body is found within the county, which is or appears to be:
  - (a) A violent death, whether by criminal violence, suicide or casualty;
  - (b) A death caused by unlawful act or criminal neglect;
  - (c) A death occurring in a suspicious, unusual or unexplained manner;
  - (d) A death caused by suspected criminal abortion;
  - (e) A death while unattended by a physician, so far as can be discovered, or where no physician able to certify the cause of death as provided in the public health law and in form as prescribed by the commissioner of health can be found;
  - (f) A death of a person confined in a public institution other than a hospital, infirmary or nursing home.
2. When a coroner is not a physician duly licensed to practice medicine in this state, the jurisdiction and authority specified in this section must be exercised jointly by the coroner and coroner's physician.

§674. **Manner of investigation.**

1. When a coroner or medical examiner is informed of the occurrence of a death within his jurisdiction as defined in section six hundred seventy-three, he shall go at once to the place where the body is and take charge of it. If the coroner is not a physician duly licensed to practice medicine in this state, he shall at once notify and designate a coroner's physician to act with him. If no coroner's physician is available, he shall employ and designate a physician qualified to make postmortem examinations and dissections and to testify thereon, and the physician so employed shall be deemed a coroner's physician for the purpose of the investigation, and any statute referring to a coroner's physician shall be applicable to him so far as concerns that investigation. Such coroner's physician so notified or employed, and designated, shall also go to the place where the body is, and the coroner and such coroner's physician shall jointly take charge of the body. Notwithstanding any general, special or local law, the coroner, or coroner and coroner's physician, or the medical examiner, shall have authority to the extent required for the investigation to remove and transport the body upon taking charge of it.

*...continued*

2. The coroner, or the coroner and coroner's physician, or the medical examiner, shall fully investigate the essential facts concerning the death, taking the names and addresses of as many witnesses thereto as it may be practicable to obtain, and before leaving the premises shall reduce all such facts to writing. He or they shall take possession of any portable object which, in his or their opinion, may be useful in establishing the cause of means of death.
3. (a) In the course of the investigation, the coroner or coroner and coroner's physician, or the medical examiner, shall make or cause to be made such examinations, including an autopsy, as in his or their opinion are necessary to establish the cause of death, or to determine the means or manner of death, or to discover facts, the ascertainment of which is requested in writing by a district attorney, or a sheriff, or the chief of a police department of a city or county, or the superintendent of state police, or the commissioner of correction; provided, that if the coroner is not a physician duly licensed to practice medicine in this state, the determination whether an autopsy or any subsequent examination or analysis of tissue or organs is necessary shall be made by the coroner's physician, and any such autopsy, examination or analysis shall be made by him or at his direction, and provided further that, if so provided by local law of the county, written concurrence of the district attorney or the county health officer or the sheriff, or written concurrence of all or any of them, as the local law shall specify, shall be required for any determination by a coroner's physician under this subdivision whether acting as such physician or as deputy coroner pursuant to subdivision four-b of section four hundred of this chapter, or for any determination by the medical examiner, than an autopsy or any subsequent examination or analysis of tissue or organs is necessary. The authority to make any examination as provided in this section includes authority to remove, retain and transport or send, for the purpose of the examination, any tissue or organs and any portable object.

(b) The coroner or coroner and coroner's physician, or the medical examiner, also shall make or cause to be made, quantitative tests for alcohol on the body of every operator of a motor vehicle or a pedestrian eighteen years of age or older who was involved in and died as a result of a motor vehicle accident; provided, however, such tests shall not be made pursuant to the provisions of this paragraph if such coroner, coroner's physician or medical examiner has actual knowledge that the decedent is of a religious faith which is opposed to such test on religious or moral grounds. Such results shall be used only for the purpose of compiling statistical data and shall not be admitted into evidence or otherwise disclosed in any legal action or other proceeding.
4. A coroner, coroner's physician or medical examiner shall have power to subpoena and examine witnesses under oath in the same manner as a magistrate in holding a court of special sessions.

State of New York  
Department of Health

Nonhospital Order Not to Resuscitate  
(DNR Order)

Person's Name \_\_\_\_\_

Date of Birth \_\_\_ / \_\_\_ / \_\_\_

Do not resuscitate the person named above.

Physician's Signature \_\_\_\_\_

Print Name \_\_\_\_\_

License Number \_\_\_\_\_

Date \_\_\_ / \_\_\_ / \_\_\_

It is the responsibility of the physician to determine, at least every 90 days, whether this order continued to be appropriate, and to indicate this by a note in the person's medical chart. The issuance of a new form is **NOT** required, and under the law this order should be considered valid unless it is known that it has been revoked. This order remains valid and must be followed, even if it has not been reviewed within the 90 day period.

DOH-3474 (2/92)

**Southern Tier Regional EMS Council**  
 Serving Chemung, Schuylar and Steuben Counties  
**ON-LINE MEDICAL CONTROL REPORT**



Patient Name \_\_\_\_\_

Patient Address \_\_\_\_\_

Medical Record # \_\_\_\_\_

PCR #

Date \_\_\_\_\_

Time \_\_\_\_\_

ETA \_\_\_\_\_

**Ambulance Service:**

\_\_\_\_\_

Car # \_\_\_\_\_

**Field Provider Data:**

Level of Care: " CFR " EMT-D

" EMT-I " AEMT-CC

" AEMT-P " \_\_\_\_\_

Provider ID # \_\_\_\_\_

**Patient Informaiton**

Age \_\_\_\_\_

Sex " M " F

Medical Control M.D.:

Report Received By:

PMD:

Chief Complaint:

Associated Symptoms:

Mechanism of Injury/Illness:

**PHYSICAL EXAM:**

Time	Resp	Pulse	BP	LOC	GCS	Pupils	Skin	CUPS	Comments
				" " " "					
				A V P U					
				" " " "					
				A V P U					
				" " " "					
				A V P U					
				" " " "					
				A V P U					

**HISTORY:**

Medications: \_\_\_\_\_

\_\_\_\_\_

Allergies:

" NKA

Past Medical History

" DM " COPD " CA

" Hypertension " Heart Disease " Asthma

" MI " CVA " Seizures

" Other:

**TREATMENT:**

IV #1 \_\_\_\_\_ IV #2 \_\_\_\_\_ O2 LPM \_\_\_\_\_ Immobilization " Yes " No

Rate \_\_\_\_\_ Rate \_\_\_\_\_ " 100% Mask

Size \_\_\_\_\_ Size \_\_\_\_\_ " Nasal Cannula

ga \_\_\_\_\_ ga \_\_\_\_\_ " ETT # \_\_\_\_\_

Site \_\_\_\_\_ Site \_\_\_\_\_ Prehospital DNR " Yes " No

Time	Treatment	Response

" Telemetry Strip Attached on Reverse



New York State  
Department of Health

**Emergency Medical Services Program**

**OPERATIONAL  
UPDATE**

Supersedes/Updates: 87-41 Reissued

No. 98-18

Date 12/30/98

Re: MANAGEMENT KITS  
FOR MCI FIELD  
RESPONSE

Page 1 of 4



# NYS-EMS

**MULTIPLE CASUALTY INCIDENT**

## **M.C.I. RESPONSE KIT**

**IMPORTANT IMPORTANT IMPORTANT**

- **Do not respond to the incident, unless directed to.**
- **Be sure to load all disaster supplies to take to the site.**
- **Open this kit, review the field manual and your local response plan for specific responsibilities.**
- **Contact EMS COMMAND by radio prior to arriving on site for assignment.**

**DRIVER ALWAYS STAY WITH  
THE AMBULANCE.  
DO NOT LEAVE IT UNATTENDED.**

**NEW YORK STATE DEPARTMENT OF HEALTH  
EMERGENCY MEDICAL SERVICES PROGRAM**

\* New York State Emergency Medical Services has supplied Mass Casualty Incident (MCI) response kits to all ambulance agencies, many EMS first response units, course sponsors and county EMS program offices. These kits are designed for one time use at any real incident and it is suggested that use of the kit be so restricted. The field kit should be stored in your emergency response vehicle in a location that keeps it from being damaged, yet is accessible. \* Distributed in 1987

Several EMS vendors supply the kits, their components and other items related to MCI management.

Some kits that were previously distributed by EMS agencies may have components which are compatible with the new standard contained in the new NYS kits, which uses the Incident Command System as its base. Old kits should be replaced and used for training (with inappropriate components discarded).

## **The NYS-EMS MCI Field Management Kit contains the following items:**

- Field Manuals
- Command Officer Identification Vests
- Command Post & Area I.D. Signs
- Plastic Ribbon for Triage & Area Marking
- Armbands for ancillary personnel
- Pencils (#2) & grease pencil

There are other items that may be useful resources for your agency's response plan. You need to consider the following:

### **Equipment and Supplies**

#### **1. Equipment**

All equipment must be boldly marked identifying the agency of ownership.

All cots/stretchers should be boldly marked to identify the agency and specific vehicle assigned to.

#### **2. Agency Disaster Supplies:**

Additional medical patient handling and administrative supplies need to be stored and made available. Typically these supplies include:

- 10 - 6' x 16" wooden spineboards
- Bandages, dressings
- Splints
- Oxygen & resuscitation equipment
- Pencils, clipboards & felt tips or indelible markers
- Flashlights & lanterns
- Blankets
- Ground cover/tarps (conveniently colored red/yellow/green)
- Tape
- ALS equipment
- Plastic ziploc bags
- Masking or duct tape
- Pylons
- Stapler
- Morgue bag
- Boundary marking tape
- Rope or perimeter

#### **3. Replenishment of Supplies:**

- At scene
- After incident
- Special supplies (ALS)

Although the kit provided is intended for one time use, the intentional use of individual components in training can enhance MCI preparation and education. Using Triage tags on specific days, patient types or multiple accident patients will familiarize ambulance personnel and hospitals with them. Staging, patient prioritizing and patient handling are good drills for the education of all agency members. Management and incident command concepts should be applied at many incidents and events occurring almost daily.



# New York State Department of Health Bureau of Emergency Medical Services MCI Drills & Exercises

Simulated exercises are held to test the components of the MCI Model independently and the local MCI Plan in its entirety. These exercises are the learning experiences that train emergency personnel in the community. Drills should be conducted with this purpose in mind and planned to achieve the maximum possible learning for all participants.

## Considerations in Planning Drills:

- 1) **Purpose of Drill** — Predefine the purposes the drill is to accomplish. Is it to test patient transportation, vehicle staging, triage, communications, medical treatment, command functions, the hospital **ED** or the system, etc.? Keep your goals practical and within the capability and experience of all participants.
- 2) **Pre-announced or unannounced ("Surprise") drills** — For most purposes, pre-announced drills function better than unannounced ones. You can plan for personnel shortages and other problems that frequently occur in training. Any "Surprise" drill must be preceded by many announced component drills so all participants are totally familiar with the entire model and plan. Everyone involved must also be familiar with all administrative aspects before beginning with patient care problems.
- 3) **Victims** — After deciding on the purpose and scope of the drill, determine the scenario, the type and number of injuries, and select groups from which to recruit possible victims. Experiences have been good with boy/girl scouts, nursing schools, senior citizen groups, EMT candidates, ambulance squad members and junior corps and school groups including teachers. However, remember the victims need to match the situation.
- 4) **Timing** — Weekday, week night, weekend. What do the participating operations need to test or try. What groups have not had the experience of participation and what groups are available.
- 5) **Moulage** — It is effective only if field medical treatment is part of the scenario. If the exercise is transport only, communications, hospital flow, etc., and no patient care is included, moulage is not necessary. Use tags with injuries, vital signs and priority predetermined. If you use moulage, consider setting up a tracking system by numerically or alphabetically identifying each victim so a later critique can be provided to evaluate planned vs. recognized injuries, treatment, patient flow, times, etc.
- 6) **Scenario** — A realistic story and detailed script needs to be prepared to adequately run the exercise. A time line should also be developed as a guideline for later evaluation. Do not become trapped by the usual bus or airplane accident, look at your community or other events for examples. Amusement rides, grandstands, buildings, trains, mass sickness, gas leaks, smoke conditions are all examples.
- 7) **Staging** — For drills to be effective, realistic response times need to be provided. Estimate real response times (including crew response) and plan each unit's entry accordingly. In this manner, full crews can be in station or at a nearby staging area and dispatched accordingly. Similar dispatch timing procedures can be used from a simulated site for hospital drills where only a traffic or patient flow needs to be evaluated.
- 8) **Emergency operating conditions (lights and sirens)** — is **never** justifiable in a drill situation. Speed does not contribute to a drill's effectiveness. The confusion to the public and risk to all participants is unwarranted. Safety must be first and foremost always.
- 9) **Evaluation** - Recruit qualified observers to evaluate the exercise. Provide them with goals, objectives, injury set-up, time lines and evaluation forms. Attempt **not** to use local agency officers, crew chiefs, etc. Those persons who would normally be available and expected to be at a real exercise should participate in the EMS leadership roles. Provide evaluation checklists for each drill to identify the items being tested.

**Issued by:** John J. Clair, *Senior EMS Representative*

**Authorized by:** Michael Gilbertson, *Director, Emergency Medical Services Development Program*

**Distribution:** Regional EMS Councils; Regional EMS Programs; Course Sponsors; Ambulance Services; First Responder Agencies; Disaster Coordinators; County EMS Coordinators; Hospital Emergency Department Directors.