**To our Members/Paid Staff Personnel:**

**We would like to welcome you to Nyack Community Ambulance Corps Inc’.**

**Enclose, you will find the documents necessary to inform you as to the Operational and Administrative policies and procedures of the corps. Please keep them in a safe place for future reference.**

**In an effort to streamline the Operations and the Administrative of the corps, these policies and procedures are the standard to which each member/paid staff personnel will be held accountable for. We anticipate your cooperation with the contents contained here and going forward. As with any other business policies, we do see changes in the future to better serve our community and ourselves.**

**Again, welcome to our organization and congratulations on taking the necessary steps to “Serving Our neighbors, Day and Night, For Health and Life”.**

**Nyack Community Ambulance Corps Inc’**

**Membership**

**HANDBOOK**

**OF**

**STANDARD OPERATING PROCEDURES**

**AND**

**REGULATIONS**

**2009**

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 **The following policies and procedures have been developed in accordance with the requirements of the State EMS Code (Part 800.21) and Article 30 of the NYS Public Health Law for Emergency Medical Services. References are made throughout this manual to specific NYSDOH Policy Statements.**

 **This manual represents the Standard Operating Procedures of the Nyack Community Ambulance Corps as of January 2009 and will be reviewed annually by the General Membership to ensure that it meets the current needs of the organization and is inclusive of any new policy statements or requirements issued by the NYSDOH.**

 **Any changes or additions to this manual will be reviewed annually with the Membership. A current copy of this manual is located on each ambulance as well as in the NCAC office and is accessible to all Members/Paid Staff Personnel at all times.**

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**NYACK COMMUNITY AMBULANCE CORPS**

**HANDBOOK OF STANDARD OPERATING PROCEDURES**

**AND REGULATIONS**

**Table of Contents**

**1. General Operating Procedures**

 1.1 Standards of Conduct

 1.2.2 Member/Paid Staff Personnel Responsibility

 1.2 Sexual Harassment

 1.2.3 Equal Treatment

 1.3 Confidential Information

 1.4 Non-Discrimination Policy

 1.5 Training, Requirements and Certifications

 1.5.1 Training Policy

 1.6 Appropriate Dress Code

 1.7 Green Lights

 1.8 Return of NCAC Property

 1.9 Drug and Alcohol Use

 1.10 Smoking, Food and Drink

 1.11 Theft and Loss

 1.12 Gifts

 1.13 NCAC Property Secureness

 1.13.1 Computers

 1.13.2 Visitors

 1.14 Ambulance and Preventive Maintenance

 1.14.1 Scheduled Maintenance of Vehicles and Equipment

 1.14.2 Cleaning and Decontamination of Ambulances and Equipment

 1.15 Supply and Equipment Inventory and Storage

 1.15.1 Personal Equipment Used in Emergency Responses

 1.15.2 Storage, Integrity, and Security of Medications and Drug Boxes

 1.15.3 Oxygen Systems and Equipment

 1.16 Members/Paid Staff Personnel hip and Job Descriptions

 1.16.1 Paid Staff Personnel

**2. Safety and Health Issues**

2.1 General Safety Rules

 2.2 Safety Training

 2.3 Exposure Control

 2.4 Decontamination

 2.5 Hazardous Materials Plan

2.5.1 Unknown Dry Substance/Suspected Anthrax Response

 2.6 Physical Exams, TB Testing, Hepatitis B

 2.7 Tuberculosis Control Plan

 2.7.1 Glossary of Terms

 2.7.2 Infection Control against BloodBurne Pathogens

 2.7.3 Cleaning, Decontamination and Disposal of Equipment

 2.7.4 Respiratory Protection Program

 2.7.5 Routine of cleaning of Rigs

 2.8 Material Safety Data Sheets

 2.9 Members/Paid Staff Personnel Injuries

 2.10 Workers’ Compensation

 2.11 CISD Referral

* 1. Unusual Occurrence Reports

2.13 Incident Reporting Requirements

**3. Emergency Medical Response and Care**

3.1 Scheduling

 3.2 Dispatch Policy

 3.3 Response to Calls

 3.3.1 Dispatching of Medics

 3.4 Mass or Multiple Casualty Incidents (MCIs)

 3.5 Radio Operations

 3.6 Driving the Ambulance

 3.6.1 Non-Emergency Driving

 3.6.2 Emergency Driving - To the Scene

 3.6.3 Emergency Driving - Transport

 3.6.4 Motor Vehicle Accidents Involving the Ambulance

 3.7 NYS/BLS Protocols

 3.8 Non-Emergency Transport

 3.9 Mutual Aid to Neighboring Towns

 3.10 Psychiatric Transports

 3.11 Paramedic (ALS) Dispatch

 3.11.1 Helicopter Transport (Stat Flight)

 3.12 Transfer of Care

 3.12.1 Transition of Care

 3.12.2 Albuterol Sulfate

 3.12.3 Aspirin

 3.12.4 Blood Glucometry

 3.13 Medical Control

 3.13.1 Quality Improvement Program

 3.14 Refusal of Medical Attention

 3.15 Unfounded Calls

 3.16 Entry into Premises

 3.17 Pronouncement

 3.18 Assessment

 3.18.1 Documentation

 3.18.2 Reporting and Removal

 3.19 Do Not Resuscitate Orders (DNRs)

 3.20 Advance Directives

 3.21 Minors

 3.21.1 Abandoned Infant

 3.22 Restraint

 3.23 Police Custody

 3.24 Crime Scenes

 3.25 Child Abuse Reporting

 3.26 Elder Abuse, Patient Abuse and other Domestic Violence Reporting

 3.27 Other Crimes

 3.28 Destination

 3.29 Restocking

 3.30 Sharps/Biohazard Disposal

 3.31 Equipment Failure and Out-of-Service Vehicle Procedure

 3.32 Diversions

 3.33 Nyack Contingency Plans

 3.34 Failure of Radio Communications

 3.35 Power Failure

 3.36 Ambulance of Service

 3.37 Inclement Weather

 3.38 MCI Plan

 3.39 Paramedics in General

 3.40 Special Operations

 3.41 PCR

 3.41.1 E-PCR

 3.41.2 Continuation Form

 3.42 Dead on Arrival Check List

 3.43 Hippa

 3.44 Administration/Operations

 Appendixes

**1. General Operating Procedures**

**1.1 Standards of Conduct**

 All Members/Paid Staff Personnel of Nyack Community Ambulance Corps (NCAC) are expected to conduct themselves at all times in a professional, courteous, and respectful manner. Members/Paid Staff Personnel are expected to remain objective and calm in high stress situations and use common sense at all times.

**1.1.2 Member/Paid Staff Personnel Responsibility**

Members respond to emergency calls to provide efficient and immediate care to the ill and injured, and to transport the patient to a medical facility. Each member

• Functions in uncommon situations

• Has a basic understanding of stress response

• Uses methods to ensure personal well-being

• Functions within scope of care as defined by state, regional, and local authorities

Each member/paid staff personnel must be able to

• Communicate effectively via radio and telephone equipment

• Lift, carry, and balance up to 125 pounds (250 pounds with assistance)

• Interpret instructions in oral, written, and diagnostic form

• Use good judgment and remain calm in high-stress situations

• Remain unaffected by loud noises and bright or flashing lights

• Function efficiently without interruption during an entire work shift

• Calculate volume and weight ratios

• Read English language, manuals and road maps

• Accurately discern street signs and addresses

• Interview patients, patient family members, and bystanders

• Document, in writing, all relevant information in prescribed format

• Converse, in English, with coworkers and hospital staff with regard to patient status

• Demonstrate good manual dexterity, with ability to perform all tasks related to patient care

• Bend, stoop, and crawl on uneven terrain

• Withstand variable environment conditions, such as extreme heat, cold, and moisture

• Work in low-light conditions and in confined spaces

• Work with other members to make appropriate care decisions

Member responds to calls when dispatched. Drivers must a general knowledge of their responding areas. NCAC provides the use of GPS and Road Maps for clarity.

Upon arrival at scene, vehicle is parked in safe location. Evaluates scene to determine scene safety, mechanism of injury or nature of illness, and number of patients. Requests additional help, as needed. Might regulate traffic, set road flares, or remove debris from roadway prior to arrival of law enforcement personnel. Uses appropriate body substance isolation precautions.

In cases of patient extrication from entrapment, the member renders all possible emergency care and protection to the entrapped patient, and assists rescue personnel in extrication. Provides simple rescue and extrication services, if not accompanied by specialized personnel.

Determines nature and extent of illness or injury and establishes care priority. Renders emergency care to adults, children and infants. Typical interventions may include, but are not limited to

• Airway management

• Artificial ventilation

• Cardiopulmonary resuscitation

• Semi-automated or fully-automated external defibrillation

• Treatment of simple and multi-system trauma, including

o Hemorrhage control

o Treatment of hypoperfusion (shock)

o Dressing wounds

o Immobilization of extremities, neck, and/or spine

• Provision of emergency medical care to

o Assist in emergency childbirth

o Manage general medical problems involving respiratory, cardiac, diabetic, anaphylactic, behavioral, poisoning, or environmental emergency

• Assisting patient with prescribed medication, including sublingual nitroglycerin, aspirin, blood glucometry and epinephrine auto-injector

• Administration of oxygen, oral glucose, activated charcoal, albuterol sulfate, and epinephrine

• Reassurance of patients and bystanders by performing tasks in a confident and efficient manner

• Avoiding mishandling and undue haste, while working expeditiously to accomplish tasks

Each member/ paid staff personnel are responsible for

• Lifting stretcher or other transport device

• Placing transport device in ambulance and ensuring that patient and device are secure

• Continuing emergency medical care while enroute to medical facility

Member uses knowledge of patient condition and information about local medical facilities to determine the ambulance destination, unless otherwise directed by medical control. Reports directly to communications center or

emergency department on nature and extent of injuries, and number being transported to each facility. Identifies assessment findings and requests any needed special services at destination.

Each Crew Member will

• Constantly reassess patient while enroute to facility

• Administer additional care as needed, or as directed by medical control

• Assist in lifting and carrying patient out of ambulance and into facility

• Report, verbally and in writing, observations and emergency medical care of the patient

After completion of transfer to receiving facility, each member will

• Restock used supplies

• Clean equipment, following appropriate disinfection procedure

• Thoroughly check all equipment and verify its readiness for instant use

• Maintain vehicle in efficient operating condition

• Ensure vehicle is clean, washed, and kept in good order

• Decontaminate vehicle, in accordance with local, state, and or federal regulation, after transporting patient with contagious infection or hazardous materials exposure

Additionally, each member

• Ensures vehicle is in proper mechanical condition, by checking and or servicing items required by procedure, and reporting when service is required

• Maintains familiarity with specialized equipment used by NCAC

• Attends continuing education and or refresher programs, as required by NCAC, medical control, or state authorities

This procedure provides general regulations for members providing medical assistance. Members are also advised to follow the appropriate BLS protocols and operating procedures as they apply to each specific call.

Members providing medical assistance will

• Survey scene and determine if additional resources and/or equipment will be needed. Notify dispatcher and specify resources and/or equipment.

• Bring to patient all equipment necessary to render appropriate care.

• Render pre-hospital care as necessary to resuscitate, stabilize, and/or transport patient.

• Treat patients, their relatives, and members of the public with respect and in a professional manner at all times. Members will

o Treat patients with dignity and not unnecessarily expose or handle them.

o Provide support and advice only to the patient’s immediate needs and make every effort to encourage and reassure patient.

• Be responsible for clothing and personal items of patient as long as patient is in care of member. Tender clothing and personal items to

 hospital staff or police officer, as appropriate. Document same on Pre-Hospital Care Report (PCR).

• Cooperate with clergy who are ministering to patient, provided patient care is not compromised.

• Accommodate reasonable requests by patient’s family member or friend who wishes to accompany patient, provided patient care is not compromised.

• Select proper patient transport device(s).

• Package patient for transport.

• Move patient to ambulance.

• Load patient into ambulance; transport patient to hospital; unload patient upon arrival.

• Transfer care to hospital staff upon arrival.

• Document all data concerning call dispatch, patient information, treatment, and transportation as completely as possible on Pre-Hospital Care Report (PCR).

It is recommended that patients presenting with the following complaints be transported to and from ambulance as indicated. Members should use best judgment when considering transport method, and account for other factors (location, etc).

• Cardiac – by stretcher or stair chair

• Chest pain – by stretcher or stair chair

• Difficulty breathing – by stretcher or stair chair

• Spine/head injury – by backboard and stretcher

• Lower extremity fracture – by stretcher

• Multi-trauma – by backboard and stretcher

• Severe abdominal pain – by stretcher or stair chair

• Back/pelvis injury – by backboard and stretcher

In other cases where patient has difficulty walking, or where member is uncertain as to patient’s condition, a stair chair or stretcher will be used to transport patient to and from the ambulance

**1.2 Sexual Harassment**

Nyack Community Ambulance Corps believes that you should be afforded the opportunity to volunteer or work in an environment free of sexual harassment. Sexual harassment is a form of misconduct that undermines the volunteer or employment relationship. No volunteers or employees, female or male, should be subjected verbally or physically to unsolicited and unwelcome sexual overtures or conduct.

Sexual harassment refers to behavior that is not welcome, that is personally offensive, and that debilitates morale and therefore, interferes with work effectiveness.

Behavior that amounts to sexual harassment may result in disciplinary action, up to and including dismissal.

**Definition**

Nyack Community Ambulance Corps has adopted, and its policy is based on, the definition of sexual harassment set forth by the Equal Employment Opportunity Commission (EEOC). The EEOC defines sexual harassment as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:

* submission to such conduct is made either explicitly or implicitly a term or condition of your volunteer status or employment
* submission to or rejection of such conduct by you is used as the basis for volunteer or employment decisions affecting you
* Such conduct has the purpose or effect of unreasonably interfering with your work performance or creating an intimidating, hostile or offensive working environment.

**Employer’s Responsibility**

Nyack Community Ambulance Corps wants you to have a work environment free of sexual harassment by management personnel, by your coworkers and by others with whom you must interact in the course of your work as a Nyack Community Ambulance Corps volunteer or employee. Sexual harassment is specifically prohibited as unlawful and as a violation of Nyack Community Ambulance Corps policy. Nyack Community Ambulance Corps is responsible for preventing sexual harassment in the workplace, for taking immediate corrective action to stop sexual harassment in the workplace and for promptly investigating any allegation of work-related sexual harassment.

**Complaint Procedure**

If you experience or witness sexual harassment in the workplace, report it immediately to the President.

You may also report harassment to any other Board Members or line officers of Nyack Community Ambulance Corps. All allegations of sexual harassment will be quickly investigated. To the extent possible, your confidentiality and that of any witnesses and the alleged harasser will be protected against any unnecessary disclosure. When the investigation is completed, you will be informed of the outcome of that investigation.

**Retaliation Prohibited**

Nyack Community Ambulance Corps will permit no volunteer or employment based retaliation against anyone who brings a complaint of sexual harassment or who speaks as a witness in the investigation of a complaint of sexual harassment.

**Written Policy**

You will receive a copy of Nyack Community Ambulance Corps sexual harassment policy when you begin volunteering or working for Nyack Community Ambulance Corps. If at any time you would like another copy of that policy, please contact the President. If Nyack Community Ambulance Corps should amend or modify its sexual harassment policy, you will receive an individual copy of the amended or modified policy.

**Penalties**

Sexual harassment will not be tolerated at Nyack Community Ambulance Corps. If an investigation of any allegation of sexual harassment shows that harassing behavior has

taken place, the harasser will be subject to disciplinary action, up to and including dismissal.

 Sexual harassment policy instituted April 2004.

 (Refer to NYSDOH Policy Statement 00-11: Sexual Harassment; Appendix 1)

* + 1. **Equal Treatment**

It is the policy of NCAC that membership/paid staff personnel be based on merit, qualifications, and competence, and that membership decisions be made without regard to any party’s race, color, age, sex, religion, national origin, citizenship, marital status, disability, veteran status, or any other basis prohibited by federal, state, or local law. This policy extends to every phase of the membership process including (but not limited to) recruiting, training, promotion, compensation, benefits, transfers, discipline, and expulsion.

**1.3 Confidential Information**

 As part of our mission, we are exposed to a great deal of confidential and private information about our patient’s lives. All call related information should only be passed on to the appropriate medical or public safety personnel who require this information in order to provide direct care to the patient or in some way lawfully discharge their duty**.** It is important to our organization’s mission that we maintain the community’s trust and that we not violate their confidences**. As a result, do not share specific details**

**about calls with others, including your families, and do not discuss this type of information where you may be overheard by others. No information should be shared with the press. All press inquires must be referred to the Captain or President.** Please reMembers/Paid Staff Personnel, there are strict laws regarding confidentiality, all **patient information (such as PCRs) must be kept confidential**. After each call, the Crew Chief will place the PCR, and any other related patient information, in the locked box located in the NCAC bay area. Only Line Officers will have access to this locked box. (Refer to NYSDOH Policy Statement 02-05: PreHospital Care Report; Appendix 2)

**1.4 Non-Discrimination Policy**

 NCAC **does not unlawfully discriminate** against any person on the basis of race, color, religion, gender, national origin, age, handicap, veteran status, or sexual orientation. Our discrimination policy notwithstanding, all riding Members/Paid Staff Personnel of the Corps

must meet the standards promulgated by the New York State Department of Health, Bureau of EMS Functional Position Description for EMS Personnel (Refer to NYSDOH Policy Statement 00-10: The Functional Position Description of an EMT-B; Appendix 3).

**1.5 Training, Requirements, and Certifications**

 **The mission of the Corps is to provide emergency medical care and transportation** **to our community**. As a result, New York State Law and Corps policy requires that Members/Paid Staff Personnel who ride on the ambulance maintain a variety of certifications in emergency medical care and vehicle operation, and attend training sessions to ensure competency.

 **Each riding Members/Paid Staff Personnel shall**:

 1. Be at least 16 years of age, physically capable of carrying out the duties

 required of him or her.

2. Complete and pass a CPR, and Defibrillation (provided by NCAC). CPR and

 Defibrillation must be renewed annually.

 3. Demonstrate knowledge of the function, use, and location of all ambulance

 equipment and supplies (covered during new-Members/Paid Staff Personnel orientation).

 4. Drivers must be at least 21 years of age, complete the Corps’ driver training

 program, and have a driving record acceptable to the Captain.

 5. If acting as a Crew Chief, must have completed and passed a NYS

 Emergency Medical Technician (EMT-B) or higher-level course. EMT status

 must be renewed as needed. NCAC participates in the NYS Pilot

 Recertification Program that allows an EMT who is in continuous practice,

 demonstrates competency and completes appropriate continuing education, to

 renew their certification without taking a certification exam. Individual

 participation is voluntary. Participants cannot allow their certification to

 expire. Expired certifications are not eligible for renewal in this program. Any

 EMT whose certification expires will need to enroll in a certified refresher

 course.

 The Program requires 72 hours of continuing education credits. NCAC drills and training provided to all Members/Paid Staff Personnel can be applied to 48 of the 72 hours. The remaining 24 core content hours must be acquired

through training provided by a New York State Certified Instructor Coordinator (CIC). NCAC will assist all participating EMTs in obtaining this core curriculum training.

 Core curriculum hours can be obtained through Rockland County Bureau of

 Emergency Services Center CIC core refresher training. Courses posted in NCAC’S Crew Room.

 The participant requirements, and all related forms for this recertification

 programs are available for all EMTs to read in the NCAC office. Further

 information is available at:www.health.state.ny.us/nysdoh/ems.com

 EMTs should complete a Continuing Education Form (CME), available in the hallway, for each course taken or call audit attended and give it to the Training Officer for filing in their personnel folders. Copies of Members/Paid Staff Personnel’s CPR and EMT cards, as well as a copy of their driver’s license, shall be filed in each Members/Paid Staff Personnel’s personnel file.

 6. All EMTs are responsible for recertification as needed. NCAC will reimburse

Members for book fees for any EMT Original or Recertification Course upon passing the NYS written Emt exam. Card must be presented to the Training Officer.

* + 1. **Training**

 Effective January 1, 2003, the Training Policy is as contained herein, as implemented and maintained by the Training Officer. This Training Policy governs all members regardless of status, excluding only those with “Active Non-Riding” status. This policy also supercedes any other Training Policy currently in place.

Youth Corps. The youth corps members, those members as defined in the by-laws as being Youth Corps, are subject to the Training Policy as indicated under this sub-section of the Training Policy. While working in conjunction with the youth corps advisor, the Training Officer will coordinate training and orientation of said members.

Youth corps members will be subject to the new member orientation session as referenced below in this policy. Youth corps members will be permitted to ride a shift in accordance with the youth corps section as explained in the Corps by-laws regarding such with any discrepancy between such policy and this subsection being presided over by the by-laws of the Nyack Community Ambulance Corps. Youth corps members will be required to possess a current CPR certification card and to attend a “New Member Awareness” seminar prior to being allowed to schedule riding time. The Training Officer will coordinate such certification and said seminar.

The performance of youth corps members will be evaluated by the crew chief with whom they ride. Members possessing youth corps status will be permitted to only ride with

those delegated as preceptors indicated by the Training Officer. While riding, youth corps members will be evaluated pursuant to our MPE (Member Performance Evaluation) process as defined below in this policy. Upon successful evaluation upon completion of the MPE process will youth corps members, then and only then; be permitted to ride with the general membership.

New Member Orientation: All new members who achieve a favorable vote at a general membership meeting of the Nyack Community Ambulance Corps are required to attend a “New Member Awareness” seminar. The Training Officer will hold this seminar, or assigned designee as indicated by the Training Officer, no more than once monthly, as indicated by new members requiring same.

This seminar will include training on the following topics; building orientation, corps orientation, ambulance orientation, equipment operation, re-stocking procedures, radio operations, uniform requirements and a questions-and-answers session. During this seminar, members will be issued a photo identification card. Members possessing new member/probationary status will only be permitted to ride after attending a “New Member Awareness” seminar and will be permitted to ride only with those delegated by the Training Officer. While riding, new/probationary members will be evaluated pursuant to our MPE (Member Performance Evaluation) process as defined below in this policy.

Upon successful completion of the MPE process, new/probationary members will be permitted to ride with the general membership. Once the MPE process has been completed, written evaluation of the new/probationary member does not continue. New/probationary members will remain on probationary status until compliance with this subsection is achieved. Then, and only then, can the probationary status be lifted after the ninety day probationary period has elapsed as specified in the By-Laws and a favorable vote is achieved when said member requests same at a general membership meeting.

Active Members: Active members, those as defined in the By-Laws as active, are subject to compliance with this subsection of the Training Policy. The Training Policy for those members with active member status is as indicated herein. Each month, as scheduled by the Training Officer, a training drill will be held. To remain active, all active members must attend half of the training sessions offered each calendar year. This number will be prorated according to when a member achieves active member status. If a member achieves active member status in June, that member will be expected to attend three of the remaining six training sessions for the year.

Non-compliance with this sub-section of the Training Policy will result in a probationary status being assigned to non-compliant members. The Training Officer shall report such non-compliance to the Captain for disciplinary action in accordance with the training policy. Members obtaining probationary status as a result of non-compliance with this

Training Policy will not be permitted to ride as crew chief or driver, or enjoy benefits associated with membership, until the probationary status has been lifted and active member status has been restored. Probationary status will not be lifted until compliance is achieved.

Member Performance Evaluation (MPE): This MPE process is as defined in this subsection of the Training Policy. The MPE incorporates written evaluation and task assessment on behalf of New/Probationary members as defined herein. There are four segments of the MPE; Youth Corps, Drivers, EMT-Trainee and New/Probationary members, each defined herein.

Youth Corps: Youth Corps members are subject to the MPE-Youth Corps process to the extent specified herein. In a collaborative effort between the Training Officer and Youth Corps Advisor, youth corps members will be evaluated by select preceptors prior to said members being permitted to ride shifts with the general membership. Upon induction into the youth corps, and upon compliance with the youth corps section above, members will be permitted to ride only with those delegated as preceptors indicated by the Training Officer or Youth Corps Advisor.

The MPE-Youth Corps process is as indicated herein. The MPE-Youth Corps process will incorporate twelve (12) hours of evaluated riding time on the part of the youth corps member. This will be documented via a written form completed by the youth corps member’s preceptor. This form will evaluate the member in a wide variety of areas. The preceptor, based on his or her evaluation, has the option of giving a ‘favorable’ or ‘unfavorable’ evaluation. These written forms will be submitted by the preceptor to the Training Officer and the Youth Corps Advisor. A copy of the form will also be furnished to the member being evaluated. The preceptor will also review the evaluation with the member and will answer questions. It will be the responsibility of the youth corps member to make sure that their preceptor is aware of their need for evaluation and that they receive a copy of said evaluation at the end of their tour. Likewise, it will be the responsibility of the youth corps member to furnish a copy of all past evaluations to their preceptor for review prior to the start of their next evaluation. This will allow weak areas that were noted in prior evaluations to be focused on. Upon a member’s completion of twelve (12) hours of riding time and favorable evaluations, as indicated by the Youth Corps Advisor and/or the Training Officer review of said member’s evaluations, they will then, and only then, be permitted to schedule riding time with the general membership. Upon the conclusion of the MPE process, written evaluation does not continue. This is not to indicate that evaluation does not continue. Should a crew chief notice deficiencies in a youth corps member’s performance, such deficiencies will be reported to the Youth Corps Advisor and the Training Officer for further review.

Drivers: Active members pursuing clearance to operate any of the Corps’ vehicles must successfully complete the MPE-Driver process and be twenty-one (21) years of age or older. This process entails supervised and evaluated driver training. The MPE-Driver process is as detailed herein. All active members, once verification is made of a valid New York State License, will be permitted to pursue emergency driver education to operate the ambulances. All drivers, prior to being cleared as drivers, must successfully complete the MPE-Driver process, including favorable practical evaluations and successful completion of a New York State Certified CEVO course. The MPE-Driver evaluation entails written evaluation of practical skills demonstrated by the member being evaluated. Prior to clearance as a driver, members must demonstrate competence with all practical skills being assessed by the preceptor. A list of authorized driving instructors will be furnished by the Training Officer to those pursuing the MPE-Driver process. During the practical assessment, members will be evaluated in areas as requested by the driving instructor. All driving instructors will submit a copy of their evaluation to the Training Officer after each practical evaluation of a trainee. All trainees should request a copy of their evaluation forms. Any driver who demonstrates gross negligence, unnecessarily endangers their crew and/or other motorists, does not exercise due regard or does not operate the ambulance in a fashion consistent what that taught in CEVO or by the driving instructors can be removed from the MPE-Driver program at the discretion of the Training Officer. Once practical aptitude is demonstrated in all sections of the MPE-Driver forms by two (2) different driving instructors, the driving trainee must then be cleared by the Training Officer or Captain by means of a similar written evaluation of practical skills. Once cleared by 2 driving instructors and the Training Officer or Captain, a member will achieve “Driver” classification.

EMT-Trainee: All active members certified as NYS DOH EMT’s, prior to receiving authorization to serve as crew chief, must successfully complete the MPE-EMT process. This process is as described herein. This process entails a written practical assessment of skills demonstrated by a trainee. This evaluation occurs over 60 (Sixty) hours of evaluated riding time, with a minimum requisite number of 10 calls. The Training Officer will furnish a list of authorized EMT-Trainee preceptors to those pursuing the MPE-EMT process. The preceptor will allow the trainee to serve as crew chief under their supervision. The trainee will be expected to formulate patient care as indicated by the patient, devise a treatment plan, appropriately treat the patient, document patient care, communicate effectively with the patient and with family members and demonstrate competence in other key skill sets necessary for crew chiefs. Any trainee that demonstrates gross negligence, acts outside the scope of their practice, endangers themselves or their crew or endangers the patient must restart the MPE-EMT process regardless of riding time and evaluations accumulated to that point at the discretion of the Training Officer. The preceptor will assess practical skills and a written evaluation will be furnished to both the Training Officer and the

trainee. It will be the responsibility of the trainee to furnish all prior evaluations to their preceptor at the start of their tour. At the end of each tour, the trainee will obtain a copy of their evaluation and discuss their evaluation, including any deficiencies, with their preceptor. Upon completion of the requisite hours and demonstration of the requisite practical skills with successful evaluations on the part of the preceptor(s) and review of the evaluations by the Training Officer, the trainee will then, and only then, be permitted to ride as crew chief.

New Members: New members, being defined as those still possessing probationary status, are subject to the MPE-Probationary process. This process will continue for the duration of said member’s first twelve (12) hours of riding time. This process will entail evaluation in key areas, resulting in either satisfactory or dissatisfactory appraisals by such member’s preceptor. During a probationary member’s first twelve (12) hours, they will be permitted to ride only with those delegated as preceptors as indicated by the Training Officer. The MPE-Probationary process is a written evaluation process that evaluates the probationary member in various skill areas and also serves as an in-service orientation and instructional session for the member. During these evaluation hours, members are encouraged to ask questions and take advantage of the expertise the preceptor has to offer. Once evaluated over twelve (12) hours of riding time, the probationary member, while still possessing probationary status, will be allowed to ride with the general membership. Once new members are voted in as members of the corps and satisfactory evaluations during the MPE-Probationary process were obtained, and probationary status is lifted, they may pursue MPE-Driver or MPE-EMT as desired. This subsection does not apply to youth corps members.

**1.6 Uniforms**

 Nyack Community Ambulance Corps, Inc’s agency policy to provide uniforms for free or at minimal cost to its Members/Paid Staff Personnel. When not on duty Members/Paid Staff Personnel shall not wear NCAC attire.

**General Regulation**

• Uniforms must be clean, neat and of the appropriate size.

• All Members on a particular crew will wear matching uniforms (Special Operations)

• When responding to back-up calls, Members are encouraged to wear issued uniform clothing when possible. Picture ID cards are also provided for this purpose. In any event, civilian clothing should be neat and clean. Shorts, open footwear, sleeveless shirts, and stained, ripped, or damaged attire is prohibited.

**Uniform Clothing**

• Pants – issued to active Members at no cost. Members/Paid Staff Personnel may substitute uniform style pants in navy blue, either straight-leg or cargo style. Shorts may be used by the Bike Team.

• Boots –$125.00 reimbursement for Members every-other year from the last date of purchase. Members/Paid Staff Personnel may substitute black

 boots, steel toe or heavy shoes in a conservative style and in good condition.

• Belt – not supplied. Black leather or nylon.

• T-shirt

• Uniform shirt – see table below

 Summer Months (May 1st-September 1st) polo style button shirt or White Button down shirt

 Fall/ winter /Spring Months (L/S S/S Button down White Shirts)

 T-shirts are not an acceptable uniform by itself

∙ \*Paid Staff uniform shirt consist of Long sleeve or short sleeve White-Button down shirt all year around\*.

• Shield – issued to active Members/Paid Staff Personnel /paid staff at no cost. Worn only on designated location on a button down white shirt. The shield may

 not be worn off-duty. No other shield is permitted. (Gold Badges reserved for NCAC’S line officers only)

• Citation bars –Supplied by NCAC. Only issued as special awards

• Collar brass – Supplied by NCAC. Standard ‘EMS’ or ‘EMT’ format. Line officers may wear appropriate collar brass as determined by the Captain.

 Gold collar brass reserved for NCAC’S operational line officers only

• Turtleneck – issued to active Members/Paid Staff Personnel at no cost.

 You may substitute a regular or mock turtleneck in navy blue color with no other agency’s emblems or wording on collar. This does not substitute for a uniform shirt.

• Winter and spring jackets – issued to active Members/Paid Staff Personnel and no cost.

• Rain slicker, baseball cap, winter cap, job shirt, issued to Members/Paid Staff Personnel.

∙ Pictured ID are issued to Members/Paid Staff Personnel

1**1.7 Green Lights**

Green lights are used to alert citizens of our community that NCAC Members are responding to an emergency. **When displaying a green light in or on your car, you are a visible representative of NCAC. Accordingly, whether the light is in use or not, you should drive in a safe manner.** Since many drivers are unaware of what green lights represent, they may not yield to you. Keep this in mind. Don’t drive aggressively or in a manner which may endanger either yourself or other drivers. New York State Vehicle and Traffic Law does not require other vehicles to yield right of way to vehicles

displaying green lights, nor does New York State permit vehicles displaying a green light to violate speed limits or traffic signals.

Each riding Members, after having obtained a NCAC green light authorization by the Captain, may affix one green light on is/her vehicle per(http://www.nysgtsc.state.ny.us/emer-vt.htm). This written authorization will be issued on an annual basis and should be kept in your vehicle at all times. The green light may only be used when responding to emergency calls. Members must exercise due caution when responding to calls. **Should you become involved in a motor vehicle accident in your personal vehicle while responding to a call, you are personally liable for the accident.**

**NCAC does not authorize any Members/Paid Staff Personnel to use red lights or sirens in their personal vehicles.**

**1.8 Return of NCAC Property**

 **Any NCAC property issued or entrusted to you must immediately be returned to the Membership Committee at the time of your resignation, dismissal from the Corps, or upon request of** **the Captain**. Although normal wear-and-tear is expected, you are responsible for any lost or damaged items at replacement cost.

**1.9 Drug and Alcohol Use**

 **The possession of illegal drugs and the consumption of alcohol and/or illegal** **drugs are forbidden on NCAC property**. Members/Paid Staff Personnel are prohibited from being on NCAC property while under the influence of any mood-altering drug, including alcohol. **Members/Paid Staff Personnel engaged in operational activities who appear to be under the influence of any** **mood-altering drug, including alcohol, shall be immediately suspended**. Organizational functions (on or off premises) may involve the consumption of alcohol in a lawful and sensible manner if pre-approved by the Captain or President.

**1.10 Smoking, Food, and Drink**

 **Smoking, eating, and drinking are prohibited in work areas (including the ambulance) where there is a reasonable potential of occupational exposure**. Food and beverage may be transported, in its original container, in the front cab of the ambulance but will not be consumed anywhere inside the vehicle or NCAC’S garage. Eating and drinking are allowed in designated areas. **Smoking is prohibited inside the ambulance, within 20 feet of the ambulance, as well as within the NCAC building**. (Refer NYSDOH Policy Statement 00-07; No Smoking Policy; Appendix 4)

**1.11 Theft and Loss**

 Because of the openness of our organization and our role within the community, **theft of any type will be dealt with in the strongest means possible, including criminal** **and civil action**. Theft includes, but is not limited to, unauthorized use of NCAC equipment and supplies for personal use. All incidents of loss of non-disposable equipment should be reported to the Captain.

**1.12 Gifts**

Individual Members/Paid Staff Personnel are not permitted to accept personal gifts from vendors or patients. Any type of monetary fund/donations should be mailed to Nyack Community Ambulance Corps mailing address.

* 1. **NCAC Property Security**

All Members/Paid Staff Personnel are responsible for the security of NCAC property, i.e. Building, Vehicles Etc. When vehicles are not garaged on NCAC’S property, crews will ensure the vehicles are shut-off and locked while unattended. There are moments when it is not possible the vehicles cannot be shut off. If you are at the

mall, contact Mall Security to visualize the rig with their roof mounted cameras for additional security.

When leaving the building, ensure all windows, doors and garage doors are closed. Make sure the TV, lights, a/c, stereo is shut off. Turn the heat down to 68 degrees if applicable. Due to the sensitivity of the medications that are carried in the ambulances, DO NOT TURN THE HEAT OFF IN THE BAYS DURING THE WINTER.

* + 1. **Computers**

Using NCAC’S automation systems to access, create, view, transmit, or receive racist, sexist, threatening, or otherwise objectionable or illegal material is strictly prohibited. "Material" is defined as any visual, textual, or auditory entity. Such material violates the NCAC’S anti-harassment policies and is subject to disciplinary action (section 1.2). The organization’s electronic mail system, Internet access, and computer systems must not be used to violate the laws and regulations of the United States or any other nation or any state, city, province, or other local jurisdiction in any way. Use of company resources for illegal activity can lead to disciplinary action, up to and including dismissal and criminal prosecution. The Board of Directors will comply with requests from law enforcement and regulatory agencies for logs, diaries, archives, or files on individual Internet activities, e-mail use, and/or computer use.

It is the responsibility of the Crew Chief to ensure that all pcrs/electronic pcrs are appropriately logged and stored in the secured location.

**1.13.2 Visitors**

 While visitors are encouraged, so that the community may be made more aware of our mission, **visitors are not permitted to be in the building** **unless accompanied by** **Members/Paid Staff Personnel**. **Visitors are not permitted on calls/sleeping quarters. Only the on call crew is allowed on the property after mid-nights (12: am-7: am)**

**1.14 Ambulance and Equipment Preventive Maintenance**

Maintaining vehicles, as well as equipment, is essential to our agency’s performance. **NCAC strives to ensure that their vehicles are operating in an efficient and safe condition at all times.** The ambulances and equipment are inspected by an appointed officer weekly. A log of maintenance and repairs, as well as a weekly checklist, will be kept in the NCAC office for each vehicle and its equipment as well as logged in Red Alert. Owner’s Manuals and Operator’s guides are located in the NCAC office and equipment is maintained, calibrated and inspected according to the

manufacturer’s recommendations (Refer to NYS DOH Policy Statement 02-11: Preventive Maintenance of EMS Vehicles and Equipment; Appendix 5 A,B,C,D,E).

**1.14.1 Scheduled Maintenance of Vehicles and Equipment**

All Ambulances, First Responder Vehicles and Electric Cars shall undergo 6 month Scheduled maintenance at the discretion of Operations. All patient care equipment shall undergo 3 month scheduled maintenance at the discretion of operations. If any of the vehicles, equipment fails before the scheduled maintenance; operations shall contact the repair facility and report the failure.

**1.14.2 Cleaning and Decontamination of Ambulances and Equipment**

 **Each duty crew must keep the ambulance and its equipment in a clean and disinfected condition**. The interior of the ambulance, and equipment, shall be cleaned with the appropriate level of disinfecting cleaner after each call. On a quartly basis, the ambulances shall be decontaminated by a license company or designated by the Captain. Cleaning supplies are located on each ambulance, as well as in the NCAC garage. **Additionally, each** **ambulance will be cleaned on a monthly basis**. A cleaning

checklist must be completed and signed by the appropriate officer after each monthly cleaning.

**1.15 Supply and Equipment Inventory and Storage**

 Conducting periodic equipment and vehicle inspections helps prevent problems and equipment failures. These inspections also serve as verification that the ambulances meet the requirements listed in NYSDOH Policy Statement 98-08: EMS Vehicle Signing and Labeling, Appendix 6). **To ensure that each vehicle is operating efficiently and fully stocked, the ambulances and their equipment and supplies will be** **thoroughly checked by a designated officer each month**. **The monthly inspection will include a check and inventory of the cardiac, trauma and pediatric bags**. **As well, a check of all battery-operated equipment (including AEDs) will be performed** **weekly**. Check sheets, completed during these inspections, should note that the vehicle, supplies, and equipment are in order, free from defects, equipment properly stored and secured, and also note any deficiencies. When possible, the deficiencies will be corrected immediately. Those not corrected immediately should be addressed by the Captain as soon as possible.

**Any required repairs to AEDs will be performed by a** **technician approved by the manufacturer**. The completed forms are reviewed by the Captain and kept on file in the NCAC office. (Refer to NYSDOH Policy Statement 98-14: Ambulance Equipment Inventory; Appendix 7)

**1.15.1 Personal Equipment Used in Emergency Responses**

 **A personal first-response kit** containing items such as: penlight, shears, tape, gauze, blood pressure cuff and stethoscope etc.; may be used by individual Members/Paid Staff Personnel who are qualified (EMT) to respond to an emergency. **This equipment is to be maintained, and stored in a proper manner.** It may be stored in their personal vehicles and accompany them to an emergency call if they are responding prior to the arrival of the ambulance. The Captain reserves the right to inspect the individual’s equipment for completeness and mal-functioning equipment.

**1.15.2 Storage, Integrity, and Security of Medications and Drug Boxes**

Due to the unique nature of the PreHospital environment, **medications that are** **stored and used are subjected to extreme environmental changes**. This may have a negative impact on the stability, strength, quality and purity of these medications.

 **NCAC Senior Crew Chiefs may be issued Junior and/or Adult Epinephrine** **Injectors, aspirin and albuterol** by the NCAC Captain who maintains records of their issuance, expiration dates and inventory. **These medications are issued under the authority of NCAC’S Medical Director who provides ongoing training in regard to their usage. Only NCAC EMT-Bs, appropriately trained by the Medical Director or his/her designate, may administer any of these drugs.**

These medications are stored in an appropriate-labeled container, along with protocols and manufacturer’s directions. **These containers will be kept locked and secured at all times**. Special attention is given to the proper storage temperature ranges suggested by the manufacturers. Each time these medications are used, the Crew Chief is responsible for proper documentation on the PCR as well as notification of usage to the NCAC Captain or appropriate officer. **Used Epi-Pens should be discarded either in the sharps container issued with them or on the NCAC ambulance.**

**Each NCAC ambulance contains the same medications as discussed above. The appropriately-labeled container will be stored and secured in the “go-in bag”**. If these medications are used, the Crew Chief must notify operations for replacement of the lock and medication(s). NCAC’S ambulance garage is maintained at an even temperature year-round to assure the integrity of medications and equipment. The same policies apply in regard to usage, documentation, and inventory of medications locked on the ambulance.

 . (Refer to NYSDOH Policy Statements: 00-06, Security of Drug Boxes and Drug Paraphernalia on EMS Response Vehicles; 00-14, Storage and Integrity of Pre-Hospital Medications and Intravenous Fluids; 00-15, Storage and Safe Guarding of Medications administered by EMT-Bs, Appendix 9 A, B, C).)

**1.15.3 Oxygen Systems and Equipment**

The oxygen systems in NCAC’S ambulances are maintained in accordance with the original equipment manufacturer’s specifications and inspected periodically for leaks, cleanliness and system integrity. **These systems are checked during the monthly** **ambulance inspection**. Any defects, malfunctions or deficiencies noted by the crew should be reported immediately to the Captain or other appropriate officer.

 **All onboard and portable oxygen cylinders are inspected, tested and filled by an authorized oxygen distributor on an as-needed basis**.

 **Crew Chiefs are responsible to check onboard oxygen levels after each call and replace if the level falls below 500 psi**. **Portable oxygen cylinders will be replaced** **when the level falls below 1,000 psi**. Full and empty oxygen cylinders are located in the appropriately designated storage closets in the ambulance garage.

(Refer to NYSDOH Policy Statement 98-06; Ambulance Oxygen Systems and Equipment, Appendix 10)

 **As a safety precaution, NCAC strictly enforces its “No Smoking” policy at all times.**

**1.16 Members/Paid Staff Personnel Job Descriptions**

 Guidelines for application and Members/Paid Staff Personnel requirements are covered in the NCAC By-Laws

 **The job descriptions of adult riding Members/Paid Staff Personnel are as follows:**

 **Crew Chief:** All crew chiefs shall be NYS certified at the minimum EMT-B level. **All crew chiefs must be approved by the Captain** after recommendation from the Training Officer and may be appointed after riding as a crew chief designate (under supervision) for a minimum of 5 calls or at the designation of the Captain. The crew chief designate must assume all the responsibilities of a crew chief.

 **The crew chief is responsible for the ambulance and crew during a call if no officer is present**. The crew chief will immediately notify the Captain of any unusual circumstances or problem that arises.

 **It is the crew chief’s responsibility to determine the severity of the call and direct the crew as to the type of care and equipment to be used, and what medical facility a patient will be transported to**. The crew chief will instruct the driver as to the use of lights and sirens after assessing the patient’s condition, and will keep the driver updated as to any necessary change in the operation of the vehicle.

 **The crew chief is responsible for completing a patient care report for every call or standby**. A release form from responsibility (RMA) must be signed when a patient refuses treatment and/or transport. A run report sheet must also be filled out upon return to headquarters. A PCR must be completed when a call is cancelled if the ambulance has left headquarters. All PCRs are to be placed in the locked receptacle located in the office as soon as possible after returning to headquarters.

**The crew chief will decide who will ride in the ambulance, in addition to the patient and the crew**. The name and relationship of any additional passenger will be noted on the PCR.

 **The crew chief will be responsible for communicating with the receiving hospital, either by cell phone or radio**.

 The crew chief, upon arrival at the hospital with a patient, must advise the staff of the patient’s condition at the scene and en route. The white copy of the PCR must be signed on the back by a nurse that the patient has been received. The pink hospital copy is left with a nurse or placed in the patient’s file bin. (Refer to NYS DOH Policy Statement 02-05; Pre-Hospital Care Report; Appendix 2)

 **The crew chief is responsible for all equipment on the ambulance and must see that items are replaced and restocked**. Note on the run report sheet and on the blackboard in the garage any equipment left at a hospital, or any item that was not replaced.

 While all crew chiefs must be certified New York State EMT-Bs, many of NCAC’S drivers are also certified. Original certifications are to be produced when first

joining NCAC and whenever recertifying. A copy will be placed in each Members/Paid Staff Personnel’s file along with copies of any continuing medical education classes attended. **All personnel records are available for inspection by the DOH upon** **request**. (Refer to NYSDOH Policy Statement 00-10: The Functional Job Position EMT-B, Appendix 3)

 **Driver:** **Members/Paid Staff Personnel must be 21 years of age**, and must be off probation or at the discretion of the Captain, before beginning driver training.

 **Prospective drivers must be approved by the Captain and the Senior Driver Trainers**. They must possess a New York State driver’s license with a satisfactory license check, attended a Certified Emergency Vehicle Operations Course and a Self-Defensive Driver’s course.

 **Driver training shall be instructed by one of the Corps’ appointed driver trainers**. When a Members/Paid Staff Personnel has completed driver training, he/she will be checked by a designated senior driver trainer who will verify that all testing standards have been met.

 The senior driver trainers may require a refresher training session for any driver who does not drive a minimum of one run each month**. Drivers are required to stay current with the operations of all ambulances.**

 **Driver License Monitoring**

• NCAC will monitor the driver license record of all drivers at all times, including status, violations, convictions, and accidents.

• Driver license information will be considered confidential, and will be restricted to the President and Captain. Details of driving records will not be publicized to the membership.

• NCAC may immediately suspend or revoke, as applicable, the driving privileges of any member whose license is suspended, revoked, conditional, or otherwise restricted.

• Members/Paid Staff Personnel will not be permitted to drive for NCAC when their record contains

o One or more felony convictions

o Two or more misdemeanor convictions within three years

o Five or more misdemeanor convictions at any time

o Three or more at-fault accidents within three years

o Three or more personal injury accidents within three years

o Any fatal accident at any time

• When the member’s driving record contains other convictions or accidents, the member’s petition to drive will be considered on a case-by-case basis by The President and Captain, who will make the final decision.

**Attendants:** An attendant is the third Members of the crew. The role of attendant is to assist in all aspects of the call and with patient care under the guidance of the crew chief.

**1.16.1 Paid Staff Personnel**

Paid Staff personnel are employees of Nyack Community Ambulance Corps to ensure the continuation of operations of our Charter. Employees are to arrive fifteen (15) minutes prior to the start of their shift to ensure the duty truck and the 2ndtruck is well compliant for the shift. If the Employee is late, he/she must notify the crew of their tardiness. It is the responsibility of the employee to ensure to clock in or out on their time card. Employees are to follow the uniform regulations (See 1.6) while on duty. Employees have delegated duties to be completed during the tour whether or not they are scheduled for a 12 hour tour:

1. Ensure rig check is completed
2. Proper uniforms are worn
3. The duty rig is clean interior and exterior
4. All linens are returned to the Hospital
5. Bay floors are swept
6. All equipment is clean and returned to proper

locations

1. No sleeping until all tasks for the tour is completed.

It is the responsibility of the Paid Staff Personnel to contact the scheduling coordinator at a responsible time if he/she cannot make their shift. The scheduling coordinator and Captain have the final say regarding any scheduling indifferences, i.e. overtime, deletions or add-ons.

**2. Safety and Health Issues**

**2.1 General Safety Rules**

 NCAC could list numerous safety rules and still not cover every potential situation. All safety rules can be boiled down to “**Members/Paid Staff Personnel should exercise common sense at all times and in all situations.” Once you find a**

**safety hazard, STOP**. **Don’t leave problems unattended without taking measures to warn others and/or mitigate any danger.**

In addition to exercising common sense, Members/Paid Staff Personnel must pay heed to the following specific rules:

 1. Members/Paid Staff Personnel shall wear a shirt, long pants and close-toed shoes at all times when on a call. Full turnout must be worn by all Members/Paid Staff Personnel participating in vehicle extrication or at other hazardous scenes.

 2. Members/Paid Staff Personnel shall wear appropriate protective equipment when dealing with bodily fluids or other dangerous conditions such as fires, vehicle extrication, hazardous materials, etc.

 3. Members/Paid Staff Personnel shall wear reflective clothing when working on a dark roadway.

 4. No Members/Paid Staff Personnel shall enter a hazardous environment such as a building fire or a confined space.

**2.2 Safety Training**

 **NCAC will provide all Members/Paid Staff Personnel with appropriate safety training as a part of new Members/Paid Staff Personnel orientation**. Safety training will also be included in ongoing training sessions.

2.2.1 **Driving the Emergency Vehicle**

 **Emergency Driving**

• Use emergency warning (red lights, siren) ONLY when responding to emergency call or transporting critical patients. The use of emergency warning is ONLY at the discretion of the EMT or paramedic in charge, not the driver.

• Always respond to emergency calls with emergency warning unless directed otherwise by dispatcher or units’ on-scene.

• If so advised by dispatcher or on-scene unit, discontinue emergency warning and drive to scene in routine manner.

Drive with caution and due regard to other motorists, and observe NYS Vehicle and

Traffic law as applicable to emergency response. <http://www.health.state.ny.us/nysdoh/ems/pdf/srgvat.pdf>

Sections 115-c, 139, 388, 1101, 1104, 1110, 1144

• Most patients who are transported to the hospital do NOT require emergency warning. Only use emergency warning for critical patients (e.g., multi-trauma, cardiac

arrest, etc).

• Exceed the posted speed limit only in a safe manner. Never exceed more than one-and- a-half times the posted speed limit for any reason. Never exceed the posted speed limit in inclement weather or when road conditions are poor.

• Come to a complete and full stop at all red traffic signals and stop signs. Check for pedestrians and motorists, and then cautiously continue. ‘Rolling’ stops through red traffic signals or stop signs are prohibited. The driver (and, if possible, his partner) will look both ways at each intersection. If any vehicles have not yielded or if you are not completely sure if traffic is clear, then do NOT proceed until the light has turned green or you are completely sure that there is no hazard. Make eye contact with other motorists in the intersection to ensure that they see you and that they will yield.

• Activate the siren continuously at least 100 feet before any intersection controlled by

a traffic signal or stop sign. Do NOT use short bursts (‘yelps’). Upon arrival at the intersection, change the siren sound (e.g., wail to yelp). Keep a window open at least three inches open to hear other emergency vehicles.

• Stay in the left lane until you are ready to turn left or right. Use turn signals and wait for other drivers to yield.

• Emergency warning does NOT allow you to pass school buses that have red flashing lights. Stop and wait until the lights are turned off.

• Do not force other vehicles into crossing traffic by use of the siren. If volume is heavy, motorists may not have anywhere to go. Under these circumstances, turn off your siren

(leave emergency lights on) and wait for traffic to clear normally.

**2.2.2 On-Spot Snow Chains**

• The On-Spot chains are used in ice and snow. The chains can be used at any speed between 0 MPH and 25 MPH.

• To activate the chains, keep at the vehicle slowly moving. Flip open the red switch cover and turn the toggle switch.

 To deactivate the chains, the vehicle must be moving. Turning the switch off while the vehicle is stopped, will cause damage to the vehicle

• Do not exceed 25 MPH while the chains are activated

• The air horn and the chains share certain equipment. Do not use the air horn while the chains are activate

**2.3 Exposure Control (Refer to NCAC Exposure Control Plan)**

Blood borne pathogen training, in accordance with OSHA standard 29 CFR 1910.1030, “Occupational Exposure to Blood borne Pathogens,” is provided for all Members/Paid Staff Personnel as part of new Members/Paid Staff Personnel orientation and ongoing training. NCAC has a separate, comprehensive Infection Control Plan which can be found in the NCAC office as well as on each ambulance. Each Members/Paid Staff Personnel must review the plan in detail and sign a form verifying their understanding of its contents.

 **When an exposure to Members/Paid Staff Personnel occurs, they should immediately seek medical care and report the incident to the Captain and the Infection Control Officer. The single most important infection control technique is washing your hands with** **hot, soapy water. All** **Members/Paid Staff Personnel will**

**wash their hands, whenever practical, before** **and after patient contact**. As health care providers, we are exposed to significantly more infectious illnesses than the average

citizen. The best way to avoid cross-contamination of NCAC Members/Paid Staff Personnel is to enforce this policy vigorously.

 **The** **patient compartment of the ambulance shall be cleaned, with an appropriate disinfectant solution, after calls and as needed. Monthly rig cleanings will be performed under the supervision of the appropriate officer**. A monthly rig cleaning checklist must be completed and signed after each cleaning and given to the officer for the Corps’ records. Disinfecting the patient compartment frequently helps limit exposure to blood and body fluids. (Refer to Appendix 11 A, B, C, D)

 If you are caring for a patient and wearing gloves, be aware that what you touch after patient contact can be contaminated and will need to be disinfected. Changing

gloves after patient contact, but before touching other equipment, can reduce the possibility of contamination. All necessary PPE is located on each of the ambulances and should be used according to recommendations in the NCAC ICP.

**2.4 Decontamination**

 Equipment contaminated on a call with blood or bodily fluids will be decontaminated/disposed at the receiving hospital or upon arrival back at NCAC headquarters according to the NCAC ICP. Gross decontamination of blood borne pathogens may begin at the hospital destination. (Refer to Appendix 11 A, B, C, D)

**2.5 Hazardous Materials Plan**

 **NCAC participates in the Rockland County Hazardous Materials Plan**. NCAC Members/Paid Staff Personnel are required by the federal government to be trained to the level of Hazardous Material ‘Awareness’ Level. All Members/Paid Staff Personnel will participate in ongoing training for Hazardous Material ‘Awareness.” **This section highlights some specific advice in the event of a hazardous materials incident:**

 - Call and warn the fire and police departments;

 - Stay uphill and upwind. If you can see the site, you’re too close. Don’t be

 afraid to retreat;

 - Stop the traffic and effect all necessary evacuations;

 - The DOT Hazardous Material Placard Manual and binoculars are in the driver’s

 console of each ambulance.

 - Anyone who is ‘down’ and not moving in the “hot zone” is considered dead.

 Don’t risk your life to drag out a body;

 - Tell anyone coming out of the “hot zone” to “Strip and Sit” downhill from you.

 Up to 80% of gross decontamination occurs when clothing is removed. As long

 As the contaminant is non-reactive to water, hose them off.

**2.5.1 Unknown Dry Substance/Suspected Anthrax Response**

(NYSDOH Policy Statement 01-08; Appendix 12)

When responding to a call involving a package, envelope or substance suspected of being Anthrax, there are some precautions to take:

 1. **Confirm scene safety** and type of incident. **Do not enter an affected area**

 until a competent authority has determined the scene to be safe.

2. If you arrive on the scene first, notify competent authority.

 3. If an unknown substance has been found in the air handling system, evacuate

 the premises immediately and notify the competent authority.

 4. Anthrax is not contagious. Person to person transmission has never been

 reported.

 5. **There will be little or no need for prehospital medical care**. Do not

 transport the individual to a hospital, **unless other medical conditions need**

 **to be addressed** (i.e., chest pain, severe anxiety). Patients should not be

 transported to a hospital.

 6. If patient insists on being transported to the hospital, contact medical

 control for consultation.

 7. If you transport to the hospital, **notify the receiving hospital** that you are

 bringing a patient who has been exposed to a powder/unknown substance

 and request the hospital to have staff meet you outside of the ER.

 8. **Create a list of individuals** who were in the area of exposure to be given to

 the incident commander or local police, and public health officials. All, or

 most individuals, should be released home with self-monitoring

 instructions.

 9. The need for testing of the substance will be determined by appropriate

 authorities.

 10. Lab tests take at least 24 hours to complete. There is no harm to an

 individual waiting for lab results before beginning appropriate medical

 treatment.

 11. The Center for Disease Control (CDC) has advised that no treatment is

 necessary for Anthrax in an otherwise health person exposed to an

 unknown powder/substance.

 12. If you arrive at a scene where **patients have been decontaminated**, follow the guidelines above, but assist in addressing individual concerns about

 infection and treatment.

 13. If you arrive at a scene where **patients have not been decontaminated**,

 and there is an observable substance, contact a competent authority and

 perform the following:

- If powder is on patient’s skin or clothing, ask the patient to

 remove their outer clothing. If the patient is unable to do this,

 put on PPE (gloves, mask and eye protection) and remove the patients outer or exposed clothing.

 - The patient’s clothing should be secured by the patient (if possible),

 in a clear plastic bag and left with the competent authorities on scene.

 - Contact the appropriate local agency responsible for decontamination.

 14. Members/Paid Staff Personnel are considered health care providers who the public expects will be knowledgeable about Anthrax. You may be the highest medical authority at the scene. Be prepared to work with local or state public health officials in calming public fears regarding these incidents.

**2.6 Physical Exams, TB Testing and Hepatitis B**

Members/Paid Staff Personnel health records will be maintained on all Members/Paid Staff Personnel who are active riding Members/Paid Staff Personnel of the Nyack Community Ambulance Corps. This record shall include the following, (as outlined in the NYS EMS Program Policy Statement 88-8: Guidelines For Employee (Members/Paid Staff Personnel) Health Records; Appendix 13) and will be subject to a biennial review by the NCAC Health Officer:

 - Pre-Members/Paid Staff Personnel physical examination for all Members/Paid Staff Personnel;

 - Immunization records and screening results;

 - Record of Members/Paid Staff Personnel occupational injuries or illnesses and their course; i.e.

 compensation forms filed, physician’s record, hospital record, etc;

 - NCAC incident report pertaining to Members/Paid Staff Personnel exposure to suspected hazardous

 materials, toxic products, or exposure to infectious diseases;

 - Record of annual physicals;

 - Record of physician’s approval to return to active duty after a debilitating illness

 or injury.

 Pre-Members/Paid Staff Personnel health physicals and screenings, as outlined in the NYS EMS Program Policy Statement 88-8 shall be required for all Members/Paid Staff Personnel beginning active service after April 1, 2004.

Members/Paid Staff Personnel who began active service prior to this date will be offered the opportunity to participate in any agency provided testing or inoculation program.

Routine yearly TB skin testing will be required for all Members/Paid Staff Personnel having contact with patients. For those individuals who have converted their

skin test, this SOP will be waived. Instead, an initial chest x-ray will be obtained and appropriate counseling provided regarding the need to report any signs or symptoms of TB. Further chest x-rays will only be obtained when determined necessary by our agency’s Medical Director.

Hepatitis B vaccination shall be offered to all riding Members/Paid Staff Personnel. Any Members/Paid Staff Personnel who has previously been vaccinated shall provide written documentation, and at the discretion of the health care practitioner, may be offered a titer test to determine immunity. Any Members/Paid Staff Personnel who has not been previously vaccinated, and who refuses the vaccine, shall complete a Hepatitis B Declination Form

**2.7** **TUBERCULOSIS CONTROL PLAN**

 It is the commitment of Nyack Volunteer Ambulance Corp. to comply with Federal

OSHA Employee Protection from Hazards. This program applies to all operations in our organization where one may be exposed to tuberculosis under normal conditions or during an emergency situation.

1. INTRODUCTION

The standard establishes a comprehensive program of education in order to provide necessary information to our volunteers for their protection and well-being. This program is mandatory for all volunteers who are defined as exposed or potentially exposed.

The information about this standard is provided to an exposed or potentially exposed volunteer through a variety of measures. Training and education on disease transmission, engineering controls and respiratory protection are all necessary for the transmission of information. They are all available to all personnel. All will be instructed that questions or concerns about this standard should be brought to the attention of the line officers or program director.

The Tuberculosis Control Plan describes bow the provisions of the standard will be implemented. It contains specific provisions regarding TB education, definitions, job hazard identifications, engineering controls, exposure incident, respiratory protection, PPD testing, post exposure follow-up, medical records and compliance factors to be utilized by the Members/Paid Staff Personnel .

1. PROGRAM COORDINATOR

The coordinator of the TB Control Program is the safety officer.

In cases of emergencies occurring outside normal hours, call to have the coordinator paged.

The Program Coordinator is responsible for the effective implementation of this program.

 The Coordinator will periodically review the program’s implementation, effectiveness and continuing update requirements. The Program Coordinator will establish the specifics of the TB Exposure Control Plan and coordinate the efforts and activities of all volunteers.

The principal responsibilities of the Program Coordinator are to:

1. Develop, maintain and update the TB Control Plan.
2. Administer the training and education program.
3. Maintain all documentation relating to the program.
4. Monitor compliance by personnel to this program.
5. Ensure all exposure incidents are documented, received; medical reviewed and maintain all medical documentation relating to the incident.
6. LINE OFFICERS

The responsibilities of Operations and the Training Officer are to;

 a. Assist the Program Coordinator in assuring the TB Exposure Control Plan is

 maintained.

1. Assist the Members/Paid Staff Personnel in access to all policies and procedures.
2. Assist in Members/Paid Staff Personnel training and education.
3. Advise the Program Coordinator of changes in condition, materials and work practices which would affect the TB Exposure Control Plan.
4. Assist all Members/Paid Staff Personnel who may have become exposed
5. Ensure the TB Exposure Control Plan is available for review by all Members/Paid Staff Personnel.
6. Act as a conduit of information between the Program Coordinator and all Members/Paid Staff Personnel.
7. TASKS/PROCEDURES IDENTIFICATION

FIRST RESPONDER: Evaluates potentially infectious patients. Provides treatment modalities that expose the First Responder to airborne transmission of M. Tuberculosis as a result of suctioning patients, and providing airway maneuvers.

EMERGENCY MEDICAL TECHNICIAN: Evaluates potentially infectious patients. Provides treatment modalities that expose the EMT to airborne transmission of Tuberculosis, as a result of suctioning patient and providing airway maneuvers.

EMERGENCY MEDICAL TECHNICIAN PARAMEDIC: Evaluations potentially infectious patient. In addition to the EMT duties listed above the EMT/P performs invasive treatments such as suctioning, intubations and medication administration via inhalation.

F. IMPLEMENTATION AND METHODOLOGY

All H.C.P’s will be trained and required to follow all hierarchy of control measures which include administration measures, engineering controls and respiratory protection equipment.

G. ADMINISTRATIVE CONTROLS

Upon arrival the scene of a call all H.C.P.’s will utilize a medical screening protocol for early detection of patients who may have infectious TB:

* 1. RAPID EVALUATION (using a general history)

-medically undeserved population

-homeless

-current/past prison inmate

-alcoholic

-injecting drug user

-elderly

-foreign born from an area of high TB incidence

-recent prison history

* 1. CURRENT COMPLAINTS

-persistent cough greater than 2 weeks duration

-bloody sputum

-night sweats

-unexplained weight loss

-anorexia

-fever

 THE INDEX OF SUSPICION FOR TB SHOULD BE CONSIDERED HIGH IN

 THESE TYPES OF PATIENT PRESENTATIONS:

* 1. ISOLATION

-based on a high index of suspicion all H.C.P.’s should attempt to isolate the suspected infectious person from other persons if feasible

-before continuation of a patient examination, a surgical mask should be placed on the patient, or give the patient a box of tissues and instruct patient to cover the mouth and nose if coughing, sneezing etc.

-the health care worker shall wear respiratory protection (HEPA filter)

* 1. TREATMENT

Cough inducing procedures that result in stimulation of the lower respiratory tract may increase the production of droplet nuclei being expelled in the air. Cough inducing procedures are identified as:

1. INTUBATION: High index of suspicion for infectious TB requires

 that a HEPA filter be worn before beginning this procedure, if feasible

1. SUCTIONING: High index of suspicion for infectious TB requires

that a HEPA filter be worn before beginning this procedure, if feasible

1. AIRROLIZATION OF MEDICATIONS: High index of suspicion for

: Infectious TB requires that a HEPA filter be worn before beginning this procedure

 **NOTE: Cough inducing procedure should not be performed on TB**

 **Patients, unless absolutely necessary.**

 **5.** HOSPITAL TRANSPORTS

Upon arrival at hospital for transportation of a patient from the facility all H.C.P.’s are to ensure before entering the patients room:

-the entrance to the room does not contain a warning of “RESPIRATORY ISOLATION”

-if entrance is identified as such, no H.C.P. will enter the room until a

history can be obtained from the staff of the health care facility documenting the type of respiratory isolation, status of the patient i.e. infectious, non-infectious, and any other pertinent information to the H.C.P.

-if respiratory protection is required the H.C.P.’s will utilize a HEPA filter before entering the room

-once in the room cover the patient’s mouth and nose with a surgical mask before transporting to the ambulance

6. HIGH RISK AREAS

 Upon arrival at a health care facility and the H.C.P. is directed to an area

 identified as a negative pressure room, isolation booths, or breathing

 treatment rooms identified with “respiratory protection required,” the

 H.C.P. will wear a HEPA filter before entering these areas

1. ENGINEERING CONTROLS

Whenever H.C.P.’s transport suspected infectious TB patients the patient should be wearing a surgical mask, if feasible, and H.C.P.’s will wear a HEPA filter.

Good ventilation maintains air quality by two processes: dilution of the concentration of the contaminant and supply of fresh air that is not contaminated. When a suspected infectious or known TB patient is being transported in the ambulance:

1. If feasible open all windows for air flow.
2. Ensure that all exhaust vents are in the on position.
3. Ensure that the air conditioner/heater is in a non re-circulating mode if this option is available.

Because of the inability to ensure administration and engineering controls in emergency transport situations and vehicles, all H.C.P.’s should wear HEPA filters when transporting suspected or known TB patients.

1. PERSONNEL REPIRATORY PROTECTION

Personal Respiratory Protection, including fit testing, shall be provided to H.C.P’s at no cost. This respiratory protection will consist of HEPA filter and all H.C.P.’s shall be trained to the requirements of 20 CFR 1910.134.

* + 1. Appropriate respiratory protection which can filter less than 1-5 microns shall be worn by all H.C.P.’s potentially exposed to M. Tuberculosis in conjunction with administrative and engineering controls, when presented with the following:
1. patients who have infectious TB in emergency transport vehicles
2. when patients found in health care facilities and identified as respiratory protection areas
3. any emergency call in designated TB treatment rooms or booths, or when cough inducing procedures are performed
4. when medical screening indicates a potential for infectious TB
5. whenever an H.C.P. has a high index of suspicion of TB when the following procedures are performed:

 INTUBATIONS

 SUCTIONING

 AIRROLIZATION OF MEDICATION

* + 1. Medical Condition or mask failure preventing use of the H.E.P.R.:

If due to medical conditions or mask failure, an H.C.P. is unable to wear the H.E.P.R. the following will occur:

1. EMS Calls: if patient identified as high risk potential for TB, the H.C.P. will

minimize his/her exposure to the patient by:

* 1. If basic life support call, the volunteer shall wear a surgical mask, and drive the ambulance with his/her partner in the back attending to the patient, this will help minimize the H.C.P.’s exposure to TB.

 **Note: In these cases an exposure report form and incident report needs to be**

 **filed by the H.C.P. who cannot wear the H.E.P.R., and will be followed as**

 **an exposure.**

2. If call is a hospital transport and upon arrival the patient is identified as

Active TB and the crew Members/Paid Staff Personnel cannot wear an H.E.P.R., the crew will not enter the room and dispatch will be notified of the patient condition and request a replacement crew.

1. COMPLIANCE METHODS

It is the responsibility of all personnel to ensure compliance to this TB control plan, through the use of the Hierarchy of Controls. It will be the responsibility of the program coordinator and the Line Officer staff to enforce and inspect for H.C.P. compliance to this program. It is the responsibility of all H.C.P.’s to report to your shift with your assigned respiratory protection mask. If you do not have your mask,

you must notify a line officer before beginning your shift. One will be provided to you.

1. EXPOSURE NOTIFICATION

Upon an H.C.P. notification of an exposure incident, The Health Care Facility will be contacted to determine the TB status of the patient. If active TB is present, the H.C.P. will receive an initial PPD Test. If the initial test is negative, a second PPD will be administered after twelve weeks.

Upon notification that an H.C.P. was exposed to infectious TB, a review of that H.C.P.’s medical file will be conducted and that H.C.P. will be referred for PPD testing (as above).

1. ANNUAL PPD TESTING

All volunteers/paid staff personnel will be at least annually tested for exposure to TB. This PPD testing will be at no cost to the volunteer/paid staff personnel. All new volunteers paid staff personnel will also receive PPD testing.

PPD testing will be conducted at least annually. As a result of the Risk Assessment Evaluation, testing can or will occur more frequently. H.C.P. confidentiality will be maintained and test results will be place in the volunteers Confidential Medical File.

Medical Director will conduct PPD and Risk Assessment.

1. PPD POSITIVE RESPONSE

Upon review of an H.C.P. PPD Test, it is found that the H.C.P.’s test indicates a positive reaction>5mm in duration. That employee will be referred to: Nyack Hospital for further evaluation which includes chest x-rays to determine if that person has converted and receive AFB Sputum Smears if indicated. The H.C.P. will be counseled on all aspects of potential TB and subsequent follow-up measures and preventive therapy.

1. SYMPTOMATIC PRESENTATION:

If an H.C.P. begins to notice symptoms such as persistent cough, night sweats, unexplained weight loss, anorexia, and bloody sputum, that employee should immediately contact the OSHA designed officer or Line Officer and that H.C.P. will be immediately referred to: Nyack Hospital for screening, counseling and preventive treatment as deemed necessary. The H.C.P. will remain off duty until TB is excluded or the H.C.P. is on therapy and documented to be not infectious.

1. ALL H.C.P.’S WILL RECEIVE EDUCATION AND TRAINING ABOUT TB

THAT IS APPROPRIATE TO THEIR TASKS.

 The following elements are included in this education:

1. Concepts of TB
	1. Transmission
	2. Pathogen
	3. Diagnosis
	4. Latent TB
	5. Active TB
2. Signs and symptoms of TB
3. Occupational exposure
4. Hierarchy of TB infection control
5. Written Policy and Procedure
6. PPD Testing
7. Medical evaluation
8. Drug Therapy for active TB
9. Notification of Health Department
10. Confidentiality
11. High risk patients for TB
12. Policy on volunteer assignments
13. RECORD KEEPING

All records required by this standard will be maintained by the Line Officers. All H.C.P.’s have right of access to their medical evaluation and record keeping as defined by OSHA Standard 1910.20.

1. ANNUAL TRAINING

All volunteers will receive annual updates and PPD Testing.

1. All provisions required by this Standard will be implemented by:

Date of Standard 10/8/93

Respiratory Protection 1/8/94

* + 1. **Glossary of Terms**

**Acid-Fast Bacilli** – Bacteria that retain certain dyes even when washed with acid solution. Most acid – fast organisms are mycobacterium. When seen on a stained smear of sputum or other clinical specimen, a diagnosis of TB should be considered. However, the diagnosis is not confirmed until a culture is grown and identified as M. tuberculosis.

**Bactericidal** – Capable of killing bacteria. Isoniazid and Rifampin are the two most potent bactericidal antituberculosis drugs (see Bacteriostatic).

**BCG (Bacillus of Calmetta and Guerin)** – A TB vaccine widely used in some parts of the world.

**Booster Phenomenon** – Seen when an individual with infection does not react to tuberculin because his/her body’s cell responses to tuberculin have gradually waned over the years. An initial tuberculin test may stimulate (boost) the immune system so that the next test will be positive. This phenomenon is important in infection control in order to distinguish between recent converters and people who have been infected for a long time and determine if in fact transmission is taking place. Although the booster phenomenon may occur at any age, it is most frequent among persons over 55.

**Droplet Nuclei** – Microscopic particles (1 to 5 microns in diameter) produced when a persons coughs, sneezes, shouts or sings. The droplets can carry tubercle bacilli and remain in the air currents in the room.

**Exposure** – The condition of being subjected to something, such as infectious agents, which may have a harmful effect. A person exposed to TB does not necessarily become infected. (see Transmission)

**H.C.P**.: Health Care Professional

**HEPA (High – Efficiency Particulate Air) Filter** – Specialized filter that is capable of removing 99.9% of particles 0.3 microns in diameter. It may be of assistance in control of TB transmission. Requires expertise in installation and maintenance.

**Human Immunodeficiency Virus or HIV Infection** – Infection with the virus that causes acquired immunodeficiency syndrome (AIDS). It is the most potent risk factor for progression from TB infection to active TB.

**Immunosuppressed** – Persons with severe cellular immunosuppressant (e.g. HIV infected or organ transplant patients on immunosuppressive therapy). These patients are at a greater increased risk for developing TB once infected. There are no data available on whether they are also at risk of becoming infected with M. tuberculosis if exposed.

**Infectious** – Capable of causing infection. In TB, a person is infectious only if he/she has clinically active TB. TB patients whose sputum is AFB smear positive are often infectious.

**Mantoux Test** – A tuberculin test given by injecting a measured amount of liquid tuberculin into the dermis (second layer of the skin) with a needle and syringe. It is the most reliable and best standardized technique for tuberculin testing (see Tuberculin Skin Test and Purified Protein Derivative Test).

**Mycobacterium Tuberculosis Complex** – The complex of mycobacterium species that causes TB: it includes M. tuberculosis, M. bovis and M. africanum.

**Pathogenesis** – The natural development of a disease in the body without intervention (i.e. without treatment)

**Positive PPD Reaction** – A reaction to the purified protein derivative (PPD) test that suggests the individual tested is infected with tubercle bacilli. Determination of the reaction is largely dependent on interpretation by the person evaluating the test given the patients or Haw’s medical history and risk factors.

**Purified Protein Derivative (PPD)** – A type of purified tuberculin preparation derived from old tuberculin (OT) and developed in the 1930’s. The standard Mantoux test uses 5 TU (tuberculin units) of PPD.

**Purified Protein Derivative (PPD) Test** – A method to determine whether a person is infected with Mycobacterium tuberculosis. A small dose of the antigen from M. tuberculosis is injected just beneath the surface of the skin and the area is examined 48 – 72 hours after the injection. A positive reaction is measured according to the size of the indurations. The classifications for positive reaction depend on the patient’s medical history and various risk factors (see Mantoux Test).

**Purified Protein Derivative (PPD) Test Conversion** – Growth in duration within a two – year period after an initial negative reaction with a difference of 10 or more millimeters or indurations. Such “conversion” may represent new infection which is associated with a high risk of developing disease, or may occur as a result of the Booster Phenomenon.

**Resistance** – The ability of some strains of bacteria (including M. tuberculosis) to grow and multiply even in the presence of certain drugs which normally kill them. (Such strains are referred to as “drug resistant strains.”)

**Smear (AFB Smear)** – A laboratory technique for visualizing mycobacteria. The specimen is smeared onto a slide, stain and then placed under the microscope for examination. Smear results should be available within 24 hours. Large amount mycobacteria usually indicate infectiousness; however, a “positive” result is not definitive for TB.

**Source Case** – An infectious individual who has transmitted tubercle bacilli to another person or persons.

**Source Control** – Control of a contaminant at the source of generation rather than permitting it to enter the general work space.

**Sputum** – Material coughed up from deep within the lungs. If a patient has a pulmonary infection, an examination of the sputum by a smear and culture can indicate what organism is responsible for the infection. It should not be confused with saliva or with nasal secretions.

**Sputum Smear Positive** – AFB are visible after staining when viewed under a microscope. Individuals with sputum smear positive for AFB are considered more infectious than those with smear – negative sputum.

**Tubercle Bacilli** – The term often used to refer to the organism Mycobacterium tuberculosis.

**Tuberculin Skin Test** – A method to determine whether a person is infected with Mycobacterium tuberculosis. A small dose of the antigen from M. tuberculosis. A small dose of the antigen from M. tuberculosis is injected just beneath the surface of the skin and the area is examined 48 – 72 hours after injection. A positive reaction is measured according to the size of the swelling. The classifications for positive reactions depend on the patient’s medical history and various risk factors (see Mantoux Test, PPD Test).

**Tuberculosis (TB)** – A clinically apparent active disease process caused by Mycobacterium tuberculosis complex (usually M. tuberculosis or, rarely, M. bovis or M. africanum).

**Tuberculosis Infection** – A condition in which living tubercle bacilli are present in the body, without producing clinically active disease. Although the infected

Individual has a positive tuberculin reaction; he or she has no symptoms related to the infection and is not infectious. However, the infected individual remains at lifelong risk of developing disease unless preventive therapy is given.

**Tuberculosis (TB) Isolation Precautions** – Infection control procedures that should be applied when persons with known or suspected infectious TB are hospitalized or residing in other inpatient facilities. These precautions include the use of a private room with negative pressure in relation to surrounding air and removal of air from the room directly to the outside. Not the same as “respiratory isolation” which calls for a private room but does not require negative pressure and exhaust of room air to the outside.

**Two-Step Testing** – A procedure used among people who receive tuberculin skin test periodically (such as health care workers) to reduce the likelihood of mistaking a boosted reaction for a recent infection. If the initial tuberculin test is classified as negative, a second test is repeated one week later. If the reaction to the second test in positive, it probably represents a boosted reaction. If the second test result remains negative, the person is classified as being uninfected.

**Ultraviolet Germicidal Irradiation (UVGI)** – A form of radiation intermediate between visible light and X-rays. UVGI is effective in killing many bacteria, including tubercle bacilli.

**Virulence** – Refers to the ability of a microorganism, such as M. tuberculosis, to produce serious disease. M. tuberculosis is a virulent organism. Some non-tuberculosis mycobacterium are virulent (e.g., M. kansasii), while others (e.g. M. gordonae) are not. (Pathogenicity is a related, though not identical, concept.)

***2.7.2***

***INFECTION CONTROL AGAINST BLOODBORNE PATHOGENS***

A. PURPOSE:

By virtue of the employment mandate of Nyack Community Ambulance Corps, to wit: the interaction with the sick and/or injured for their benefit of the greater society in an uncontrolled and sometimes adversarial (hostile) environment, it is recognized that there is a significant risk for occupational Blood Borne Pathogen exposure to our Members/Paid Staff Personnel. Furthermore, it is recognized that this exposure creates a risk of our Members/Paid Staff Personnel contracting certain diseases to include, but not limited, to AIDS (HIV) and Hepatitis B (HBV) viruses.

It is the purpose of this plan to eliminate when and where possible exposure to Blood Borne Pathogens. In those instances where elimination of exposure is not possible

practical, it is the intent of this plan to minimize the exposure to said Pathogens. In addition, the following procedures will be instituted, adhered to and enforced.

B. EXPOSURE DETERMINATION

1. All NCAC Members/Paid Staff Personnel who have direct contact with the living, dying or dead; that individual’s person, bodily fluid or parts are at risk of occupational exposure. The NCAC Members/Paid Staff Personnel included in this plan are as follows:

a. Emergency Medical Technicians

b. Drivers

c. Trainees/Observers

d. Youth Corp. Members/Paid Staff Personnel

e. Paid Staff Administration

This plan will apply to all current and future Members/Paid Staff Personnel of Nyack Community Ambulance Corps.

1. Members/Paid Staff Personnel who, as part of their personal lives, engage in activity considered to be “High Risk Behavior” are always at a risk of exposure to Blood Borne Pathogens and such exposure will not be considered occupational and is not covered by this policy.
2. Any tasks involving the exposure of NCAC Members/Paid Staff Personnel

or potentially infected persons living, dying or dead; contaminated bodily fluid or parts; contaminated equipment, transportation devices, vehicles or any other material place our

Members/Paid Staff Personnel at risk of occupational exposure. These tasks may include, but are not limited to, the following:

a. Airway, breathing and circulation control include rescue breathing, assisting with intubations, cleaning and bandaging wounds, assisting with the establishment of intravenous therapy, etc.

b. Assisting with the drawing of bloods

c. Assisting with the parenteral, sublingual, and endotracheal administration of medications.

d. Infant delivery in childbirth

e. Care of open fractures

f. Collection of emesis

g. Collection, examination, packaging, destruction of contaminated materials

h. Cleaning of contaminated equipment, transportation devices, vehicles etc.

The above exposure determinations are made without regard to the use of personal protective equipment.

C. METHODS OF COMPLIANCE

1. Universal Precautions will be observed to prevent contact with bodily fluids or other potentially infectious materials. All bodily fluids will be considered suspect. These precautions will include, but not necessarily be limited to, the following:

a. Wearing of appropriate protective gear to include, but not necessarily be limited to, gloves; masks (with or without face shields) that cover the nose and mouth; goggles or other eye protection; and gowns. The amount and type of protection needed will be determined by the Members/Paid Staff Personnel, based on the analysis of the instant situation, but will always include the potential for splashing, splattering, spraying or droplet generation of, ( potentially ), infected body fluids.

b. It is recognized that there may be a rare instance when the wearing of protective equipment would have prevented or delayed beyond a reasonable time

the delivery of emergency medical cares and/or endangered the Members/Paid Staff Personnel or a co-worker. Any instance of this nature will be immediately brought to the attention of a supervisor who will investigate the situation and determine if this type of situation can be prevented in the future.

1. All Members/Paid Staff Personnel must wash their hands with soap and water using recognized scrubbing and proper hand drying procedures, as soon as possible after exposure whether or not protective gear was worn. Facilities will be made available in work areas for this purpose. In the field,
2. Members/Paid Staff Personnel must find wash facilities as soon as practical following exposure.

If wash facilities are not available immediately or within a reasonable period, antiseptic towels or hand cleaner will be provided and should be used. Members/Paid Staff Personnel must then wash their hands with soap and water, in the prescribed manner at the earliest practical time.

d. Other body surfaces shall be washed with soap and water and/or flushed immediately (or as soon as practical) following exposure to potentially infected bodily fluids or other materials. Any body area where the use of soap is inappropriate will be flushed with water.

e. Members/Paid Staff Personnel shall not eat, drink, smoke, apply cosmetics or lip balm if they have been exposed to contaminated bodily fluids or other material until they are out of the effected environment and have been appropriately decontaminated, especially as it pertains to washing of hands and/or other exposed skin surfaces. There will be NO eating or drinking in work areas designated as being potentially infected by Blood Borne Pathogens.

f. Sharps shall not be bent, sheared or broken. RECAPPING IS PROHIBITED, unless it is the only feasible alternative and MUST be accomplished using a mechanical device or one – hand technique. All sharps shall be placed in sharps containers located on the ambulance, Paramedic’s boxes or receiving facility.

g. All procedures specifically referred to or implied by the nature and intent of this policy in B above will be accomplished while wearing the appropriate protective equipment and in such a manner as to minimize splashing, splattering, spraying, or generation of bodily fluids.

h. Specimens of blood or other bodily fluids shall be placed in a container which prevents leakage from collection through delivery to the appropriate facility for processing or disposal.

2. Personal Protective Equipment:

a. Appropriate personal protective equipment shall be provided at no cost to the Members/Paid Staff Personnel.

b. This equipment shall include, but is not limited to; gloves, gowns, face shields or masks, eye protection, pocket masks or other ventilation devices.

c. Appropriate personal protective equipment gear in appropriate sizes will not only be, in some instances, issued but will be available to the employee in the workplace. Provisions will be made for Members/Paid Staff Personnel allergic or sensitive to particular products. In those cases, hypoallergenic materials will be substituted for standard issue.

d. Contaminated personal protective gear will be cleaned, laundered, or disposed of as necessary and appropriate at no cost to the employee. Items that need to be repaired or replaced will be done at the expense of NCAC.

e. Garments worn that are penetrated by (potentially) infectious body fluids will be removed as soon as possible.

f. Personal protective gear, when removed, shall be placed in appropriate designated areas located at each station for cleaning, decontamination or disposal.

g. Contaminated work and environmental surfaces, transportation devices, vehicles, clothing, personal protective equipment, etc. shall be cleaned and decontaminated immediately or as soon as is feasible, following exposure to potentially infectious bodily fluids or other materials. Cleaning shall be accomplished with an appropriate disinfectant.

D. VACCINATION PROCEDURE

1. Hepatitis B vaccine is available to all Members/Paid Staff Personnel of NCAC, (paid/volunteer), at

no charge. This includes the initial vaccination series and any booster doses.

2. The vaccination process together with all necessary medical evaluations is coordinated by the safety officer.

3. Members/Paid Staff Personnel who decline to accept the Hepatitis B vaccination must sign a statement indicating their refusal. Members/Paid Staff Personnel who initially decline may at a later date accept the vaccination and NCAC will make the vaccination available at that time.

E. METHOD FOR EVALUATION OF EXPOSURE INCIDENTS

Any Members/Paid Staff Personnel of Nyack Community Ambulance Corps involved in an exposure incident will take the following action IMMEDIATELY:

 Notify the D.O. of the incident, action taken, medical attention required and extent of possible exposure.

2. The D.O. will ensure that the Members/Paid Staff Personnel is sent to an appropriate medical facility for post-exposure evaluation and treatment, *if so required.*

3. As soon as possible, complete a *LINE OF DUTY INJURY PACKAGE.* The completed package is to be sealed in the envelope provided and sent to the Designated Officer.

4. The D.O. will complete the Designated Officer’s Investigation Report of the exposure incident. The D.O. will investigate and review the incident that has occurred, all actions taken and any reporting or follow-up still required to be completed.

5. The D.O. will ensure that the incident is properly reported, and all required

 documentation and follow-up is completed and remains part of the employee’s

 medical record.

F. REVIEW OF THE EXPOSURE CONTROL PLAN

This plan will be reviewed on a minimum of a yearly basis, or more frequently, based upon changes in OSHA standards or recommendations from the Centers for Disease Control. All changes or updates of the Exposure Control Plan will be in writing and will be distributed to all affected Members/Paid Staff Personnel, along with additional training.

G. POST EXPOSURE EVALUATION AND FOLLOW-UP

Following any exposure incident (a specific eye, mouth, mucous membrane, non-intact skin or parenteral contact with blood or other potentially infectious material), the affected Members/Paid Staff Personnel will immediately obtain a confidential medical evaluation and follow-up. Nyack Community Ambulance Corps will:

1. Document the route of exposure, and the circumstances surrounding the event.
2. Identify the source individual, if possible, unless proof exists that to do so is either not feasible or prevented by law.
3. Complete an Exposure Evaluation Form and send it to the D.O. of the receiving facility as per the provisions of the Ryan White Act.
4. PPD (Mantoux) testing will be conducted for the Members/Paid Staff Personnel who is exposed to TB patients for whom adequate infection control measure were not taken.

H. INFORMATION PROVIDED TO HEALTHCARE PROFESSIONALS

Nyack Community Ambulance Corps will make available to a healthcare professional overseeing our Exposure Control Program the following:

1. A description of the Members/Paid Staff Personnel’s duties related to particular exposure incidents.
2. Documentation of the route of exposure and the circumstances surrounding particular exposure incidents.
3. Results of the source individual’s blood testing, if available, where there has been an exposure incident.
4. All relevant medical records of exposed Members/Paid Staff Personnel, including vaccination status.

I. HEALTHCARE PROFESSIONAL’S WRITTEN OPINION

NCAC’S D.O. will obtain a copy of the written opinion of the healthcare professional within 15 days of the completed evaluation, and provide it to the exposed employee.

The healthcare professional’s written opinion will be limited to the following areas:

1. That the Members/Paid Staff Personnel has been informed of the results of the evaluation.
2. That the Members/Paid Staff Personnel has been told about any medical condition that may result

from the exposure to, or other potentially infectious material that may

require other medical evaluation or treatment.

1. All other findings of diagnoses will remain confidential and will not be

included in the written report.

J. MEDICAL RECORD KEEPING

All medical records required in Standard 1910.1030 will be kept in accordance with the provisions of the Standard as identified later in this document. OSHA forms 101 and 200 will be used in this record keeping.

K. COMMUNICATION OF HAZARDS TO MEMBERS/PAID STAFF PERSONNEL AND PAID STAFF

1. Members/Paid Staff Personnel Training

All Members/Paid Staff Personnel and paid staff will be required to attend training programs held at the stations they are assigned to. Nyack Community Ambulance Corps will provide instructors knowledgeable in the subject matter to be presented, and will use the appropriate content, language, and vocabulary suitable to the literacy and educational background of the Members/Paid Staff Personnel.

1. Training Content
	1. Each Members/Paid Staff Personnel will be issued his or her own copy of the Exposure Control Plan. The instructors will explain the epidemiology and symptoms of blood borne and airborne diseases and the modes of transmission. The instructors will explain the Exposure Control Plan, and review the processes likely to involve exposure to blood borne and airborne pathogens. The instructors will review and demonstrate procedures, techniques and equipment used to limit Members/Paid Staff Personnel exposure.

b. This will include appropriate engineering controls, work practices and

 the types/proper use of personal protective equipment. This will also

 cover a selection of personal protective equipment, proper use,

 location, removal, handling, decontamination and appropriate disposal

c. During this session the Members/Paid Staff Personnel will also receive information

concerning the PPD (Mantoux), testing. It will also cover efficacy, safety and method of administration and the benefits of testing. All Members/Paid Staff Personnel /paid staff will be reminded that testing is free of charge to them and even if they have previously declined it, at any time they decide that they wish to be tested they will receive at no charge.

d. If an exposure incident has occurred, the employee/Members/Paid Staff Personnel will be

required to report it immediately, to the Designated Officer, for evaluation and follow-up care. They will be reminded that all medical evaluation and follow-up will be done free of charge, confidential and testing will be done with permission only. A review of the previously specified policies for reporting and follow-up medical evaluations will be done at this time.

1. Members/Paid Staff Personnel / will be encouraged to ask questions throughout

the program and a question period will follow the session.

3. Documentation of Training

The Designated Officer will keep all training records pursuant to OSHA

Regulations for a period of three (3) years. Each record will list the training date, subject, synopsis of content, names/titles of all staff attending and the name and credentials of the instructors.

L. MEDICAL RECORDKEEPING

 Nyack Community Ambulance Corps will maintain medical records on all Members/Paid Staff Personnel

 These records will be kept secure and locked in the office of the Designated

 Officer. Members/Paid Staff Personnel have the right to review their medical records by arranging for a

 mutually convenient time for the D.O. In most cases this may be immediately, but

 in no case will it be more than (5) working days from the receipt of the request. If

 the Members/Paid Staff Personnel /paid staff wishes for someone else to review their records, even in his/

 her presence, this request must be made in writing.

 Medical records for all Members/Paid Staff Personnel are reviewed annually by the D.O. A Biennial

 Medical Evaluation Form is completed by each Members/Paid Staff Personnel, reviewed and kept in the

 Members/Paid Staff Personnel’s medical record.

* 1. CONTENT OF MEDICAL RECORDS

All medical records will contain information about an occupational exposure or injury and specifically the following information:

* 1. Members/Paid Staff Personnel name and social security number.
	2. Indications for Hepatitis B vaccination and date of vaccination if received.
	3. Signed Hepatitis B vaccination declination statement.
	4. Documentation of the routes and circumstances of all exposure incidents.
	5. Results of source individual’s blood testing if available.
	6. Documentation that the employee was informed of the evaluation of the post-exposure medical evaluation and the need for any follow-up.
	7. A copy of the OSHA 101 form completed for each occupational exposure incident.
1. CONFIDENTIAL MEDICAL RECORDS – EXPOSURE INCIDENTS

Nyack Community Ambulance Corps will not have access to the confidential

medical records of the Members/Paid Staff Personnel after they have received a post exposure evaluation and follow-up. (Nyack Community Ambulance Corps will provide the Members/Paid Staff Personnel and the licensed healthcare professional conducting the evaluation.) The following list of items that should be included in the post exposure evaluation:

A medical evaluation of the exposure incident:

1. The counseling information provided;
2. The post exposure prophylactics provided;
3. The evaluation of any reported illness related to the exposure incident;
4. The contract physician or physician group will retain this information in the physician’s permanent medical records.
5. TRANSFER OF RECORDS

Nyack Community Ambulance Corps agree to transfer all medical records to a successor should we cease to do business. If there is no successor, NCAC will notify the affected Members/Paid Staff Personnel at least (3) months prior to the cessation of operation of their rights of access to the records and will notify the Director of the National Institute for Occupational Safety and Health (NIOSH) of the cessation of operation and the transfer of Members/Paid Staff Personnel records to the Director’s office. The Director will also be notified at least three (3) months in advance of the cessation of business and records that are scheduled for disposal (after thirty years).

**SECTION XXII-MANDATED REPORTING TO DEPARTMENT OF HEALTH**

 Upon the discovery by or report to the management of Nyack Community

 Ambulance Corps, we shall report to the Department’s Area Office by

 telephone no later than the following business day and in writing within

 5 days every instance in which:

 A. A patient dies, is injured or otherwise harmed due to the actions of

 B. An NCAC vehicle being operated by a Members/Paid Staff Personnel of the Service is

 involved in a motor vehicle crash in which a patient, Members/Paid Staff Personnel of

 the crew or other person is killed or injured to the extent

 requiring hospitalization or care by physician.

 C. Any Members/Paid Staff Personnel of the Service is killed or injured to the extent

D. Patient care equipment fails while in use, causing patient harm.

 E. It is alleged that any Members/Paid Staff Personnel of the Service has responded to an

 incident or treated a patient while under the influence of alcohol or

 Drugs.

 F. Patient abuse by a Members/Paid Staff Personnel of the Service or other EMS provider.

**APPENDIX A**

**2.7.3** Cleaning, Decontamination, Disposal of Equipment

1. All equipment contaminated with blood or other potentially infectious materials must

 be either cleaned and decontaminated, or disposed of properly prior to replacement

 should the vehicle be exposed to infectious material. The vehicle will be taken out of

 service and decontaminated, according to OSHA guidelines. The following chart

 provides guidelines for determining what should be done with specific equipment

 items

2. When handling and/or cleaning any contaminated equipment, personal protective

 equipment ***MUST*** be worn and extreme care ***MUST*** be used.

3. When cleaning/disinfecting any equipment, use a 1:10 solution of bleach and water or

 an approved disposable disinfectant wipe (i.e. SANI-CLOTH).

4. Any items that are to be disposed of, must be placed in a red bag and disposed of at

 the receiving hospital.

EQUIPMENT DECONTAMINATION PROCEDURE

Airway Bag Clean/disinfect by wiping. Bag for

 Decontamination through H.Q.

Airways:

 Nasopharyngeal Dispose

 Oropharyngeal Dispose

Backboards Clean/disinfect by wiping

KEDS Clean/disinfect by wiping

BP Cuffs Bag for decontamination at H.Q.

Bag Valve Masks (BVM)

 Bag, valve, and mask Dispose

Bulb Syringe (aspirator) Dispose

Cervical Collars Dispose

Cold Packs Dispose

Dressings, if package is open or wet Dispose

Hot Packs Dispose

MAST Bag for Decontamination at H.Q.

Other electronic equipment Clean/disinfect by wiping

Oxygen Delivery Equipment

 Extension tubing Dispose

 Face Mask Dispose

 Nasal Cannula Dispose

 Oxygen Nebulizers Dispose

 Oxygen Regulators Clean/disinfect by wiping

Penlights Clean/disinfect by wiping or Dispose

Personal equipment (shoes, belts, holsters

flashlights, etc.) Clean/disinfect by wiping

Personal Protective Equipment

 Gloves Dispose

 Face shields and masks Dispose

 Aprons and shoe covers Dispose

Pocket Masks Dispose

Safety Pins Dispose

Scissors Clean/disinfect by wiping

Splints Clean/disinfect by wiping or dispose

Stethoscope Clean/disinfect by wiping

Straps Dispose

Suction Units (exterior) Clean/disinfect by wiping

 Collection Bottle Dispose

 Catheters Dispose

 Suction tubing Dispose

Trauma Bag Clean/disinfect by wiping or bag for

 Decontamination at H.Q.

Crew Chiefs shall notify Operations if any non disposable items were disposed of.

**2.7.4 RESPIRATORY PROTECTION PROGRAM**

**CFR 1910.134**

A. GENERAL COMPANY POLICY

In the control of occupational diseases caused by breathing air contaminated with potentially infectious TB, it is the commitment of Nyack Volunteer Corp. to comply with Federal OSHA Occupational Protection Plan 1910.134 Respiratory Protection.

B. OTHER CORPORATE POLICIES AND PROCEDURES

It is the intention of the company to incorporate and utilize all previously existing safety and health policies, procedures and rules within this program. Unless specifically conflicting with the intent and procedures involved herein, all such policies, procedures and rules remain in full force and effect.

C. INTRODUCTION

The standard establishes a comprehensive program of education and information to our Members/Paid Staff Personnel for their election and use of respiratory protection. This program is mandatory for all Members/Paid Staff Personnel who are defined as potentially exposed to TB.

The information and education is provided to all who are potentially exposed through a variety of measures. All employees are trained in the TB exposure plan. The Respiratory Protection Program addresses the use and selection of respiratory protection. Written operating procedures governing the selection and use of respirators, proper use of respirators and their limitations, hazard recognition, inspection of respirators, cleaning and disinfection of respirators, fit testing and checking and compliance methods for adherence to this program. Members/Paid Staff Personnel will be instructed that questions or concerns about this standard be brought to the attention of their immediate supervisor or program director.

D. PROGRAM COORDINATOR

The Program coordinator of the Respiratory Protection Program is the Safety Officer.

The Program Coordinator is responsible for the effective implementation of this program.

The Coordinator will periodically report on the programs implementation, effectiveness and continuing update requirements. The Program Coordinator will establish the specifics of the Respiratory Protection Program, and coordinate the efforts and activities of volunteers and line officers.

The principal responsibilities of the Program Coordinator are to:

a. Develop, maintain and update the Respiratory Protection Program.

b. Administer the training and education program.

c. Maintain all documentation relating to the program.

d. Monitor compliance by Members/Paid Staff Personnel to the program.

e. Ensure all fit testing is documented and Members/Paid Staff Personnel receive medical review and maintain all medical documentation relating to this program.

E. DEPARTMENT SUPERVISORS

The responsibilities of the Line Officers are to:

a. Assist the Program Coordinator in assuring the Respiratory Protection Program is maintained.

b. Assist in Members/Paid Staff Personnel access to all department policies and procedures.

c. Assist in Members/Paid Staff Personnel training and education.

d. Advise the Program Coordinator of changes in conditions, materials and work practices which would affect the Respiratory Protection Program.

e. Assist all Members/Paid Staff Personnel who may have become exposed.

f. Ensure the Respiratory Protection Program is available for review by all Members/Paid Staff Personnel in the following work areas: Supply, Dispatch, All EMS Stations, and Supervisors vehicles.

g. Act as a conduit of information between the Program Coordinator and Members/Paid Staff Personnel.

F. TASKS/PROCEDURES IDENTIFICATION

The following task procedures identify those Members/Paid Staff Personnel that require respiratory protection:

FIRST RESPONDERS: Evaluates potentially infectious patients. Provide

treatment modalities that expose the First Responder to airborne transmission of M. Tuberculosis, as a result of suctioning patients and providing airway maneuvers.

EMERGENCY MEDICAL TECHNICIAN: Evaluates potentially infectious patients. Provides treatment modalities that expose the EMT to airborne transmission of M. Tuberculosis, as a result of suctioning patients, and providing airway maneuvers.

EMERGENCY MEDICAL TECHNICIAN/PARAMEDIC: Evaluates potentially infectious patients. In addition to the EMT duties listed above the EMT/P performs invasive treatments such as suctioning, intubation, and medication administration via inhalation.

SUPERVISORY PERSONNEL: In addition to the duties listed above, the supervisory personnel are responsible to assist all Members/Paid Staff Personnel whenever needed, evaluate on scene performance and compliance to these policies and procedure.

SUPPLY PERSONNEL: No direct exposure.

G. IMPLEMENTATION/METHODOLOGY

Volunteer respiratory protection is provided at no cost to the Members/Paid Staff Personnel. All Members/Paid Staff Personnel /Paid Staff will be trained in the proper selection and use of NIOSH Approved High Efficiency Particulate Respirator. A HEPR mask can filter .03 microns. The HEPR mask is utilized for patients who have potentially infectious TB. The MTB droplet ranges in the 1-5 micron size. The HEPR mask provides protection under this standard to filter this micron droplet.

H. HAZARD

All Members/Paid Staff Personnel as required by the TB Exposure Control Plan will utilize an initial rapid evaluation of the patient to determine the potential for infectious

TB. Upon identification of potential infectious TB patient the Members/Paid Staff Personnel will follow all administrative and emergency controls as defined in the TB

Exposure Plan. The Members/Paid Staff Personnel will immediately wear their HEPR mask, or as soon as feasible.

I. HOSPITAL TRANSPORT

As defined in the TB Exposure Control Plan all Members/Paid Staff Personnel upon entering any TB treatment rooms, booths, or entering a patient room that warns of required respiratory isolation, that Members/Paid Staff Personnel shall not enter until he/she has utilized proper respiratory protection by the HEPR Mask. J. High Efficiency Particulate Respirator.

The HEPR is used for protection against infectious TB presentations. All volunteers will be trained in and fit tested for use and limitations of NIOSH High Efficiency Particulate Respirator. All Members/Paid Staff Personnel shall be provided with a proper fitted checked respirator at no cost to that Members/Paid Staff Personnel.

K. TRAINING

The HEPR is identified by the color purple (Magenta) which protects against the following contaminants: Radio-nucleous materials – dust, process mineral, arsenic and other substances. All Members/Paid Staff Personnel shall be trained in the proper application of a HEPR mask as described by the manufactures of the respirator. The volunteer will perform properly:

1. Threading the top and bottom straps through the buckle.
2. Placing the bottom straps just below the ears and the top strap resting above the ears at the top back of the head.
3. Adjusting the strap tension by pulling the straps.
4. Decreasing strap tension by pushing out on the back of the buckle.
5. Placing fingers from both hands at the top of the metal nose piece and molding the nose area to the shape of your nose.
6. Training the Members/Paid Staff Personnel in covering the front of the respirator with hands, inhaling sharply and identifying negative pressure in the mask.
7. The Members/Paid Staff Personnel will be trained to readjust the position of the respirator and/or tension of the straps according to the manufacturer’s steps until a negative pressure is identified.
8. The Members/Paid Staff Personnel will be instructed that a proper fit cannot be obtained, that volunteer is not to enter a contaminated area.
9. That Members/Paid Staff Personnel also will be trained if he/she cannot obtain a proper fit and will have to immediately notify a supervisor.
10. The Members/Paid Staff Personnel will be trained to assure the proper protection from hazard and the face piece will be checked for fit by the wearer each time he/she puts on the respirator.
11. The Members/Paid Staff Personnel will be trained if dizziness or difficulty in breathing occurs or the respirator becomes damaged he/she will leave the area immediately and a supervisor must be notified immediately.

L. FIT TESTING

Once the Members/Paid Staff Personnel has been trained in the proper application of the HEPR Mask that Members/Paid Staff Personnel will then be fit tested utilizing a Saccharin Qualitative Fit Test. The Members/Paid Staff Personnel will be required to normally breath, deep breath, turning head side to side, nodding head up and down, talking and the Members/Paid Staff Personnel shall read aloud and slowly the “Rainbow passage.” The test is terminated any time the sweet taste of the aerosol is detected because this indicates an inadequate fit. The Members/Paid Staff Personnel shall be retested after fifteen minutes. If the entire test is completed without tasting the aerosol, the test is successful and the respirator fit is deemed adequate.

M. LIMITATIONS

1. The Members/Paid Staff Personnel shall not use for protection against gases, vapors or asbestos, or in sandblasting, or paint spray operations, or in atmospheres containing less than 19.5% oxygen.

2. Will not use when concentrators of contaminants are immediately dangerous to life and to health, are unknown or when concentrations exceeds applicable OSHA standards or ten times the permissible exposure limit, whichever is lower.

3. The Members/Paid Staff Personnel will not abuse or misuse this respirator.

4. Respirators shall not be worn when conditions will not permit a good face seal. Such conditions can be beards or facial hair that prevents direct contact between the face and the edge of the respirator; therefore it is policy that all Members/Paid Staff Personnel must be clean shaven when reporting for shift. To assure proper protection, the Members/Paid Staff Personnel each time he/she uses the HEPR he/she shall check the mask for creation of negative pressure before entering any area with the mask on.

5. The Members/Paid Staff Personnel will not use if, he/she cannot create a negative pressure after proper application of the HEPR mask.

6. If the volunteer cannot wear an H.E.P.R. due to a medical condition, the Members/Paid Staff Personnel must minimize his/her direct exposure to the patient. At a minimum the Members/Paid Staff Personnel must wear a surgical mask and notify a supervisor to respond to the scene while maintaining hierarchy of controls as designed in the TB exposure control plan.

N. INSPECTION

At the beginning of the shift, and after each use, the Members/Paid Staff Personnel shall inspect the HEPR mask for the following:

 - The straps are not worn, frayed or broken.

 - The buckles are intact and securely attached to the mast.

 - The nosepiece is intact, not broken or unduly out of shape.

 - The rubber seal area of the mask is no torn, cracked or out of shape and

 - The HEPR is not moist.

 - The HEPR is not dirty.

 - The one way valve is seated properly, not torn, missing or broken

 - The HEPR is not damaged in any way.

Upon inspection, if the mask is found to meet one of the above criteria that Members/Paid Staff Personnel shall immediately notify a line officer for a replacement. No Members/Paid Staff Personnel shall repair any parts of the HEPR mask itself. The respirator must be replaced.

Once inspection is completed, the Members/Paid Staff Personnel should store his/her HEPR mask so the face piece and exhalation valve will rest in a normal position so function will not be impaired.

O. CLEANING/DISINFECTION

When the Members/Paid Staff Personnel uses the HEPR mask, that employee shall clean the face seal area with soap and water before storing the HEPR.

P. COMPLIANCE

It is the responsibility of all Members/Paid Staff Personnel to ensure that they have their HEPR mask with them when reporting for duty. If the Members/Paid Staff Personnel

does not have his/her respirator with them, that Members/Paid Staff Personnel shall be given a new respirator from supply before beginning his/her shift.

All supervisory staff will periodically inspect Members/Paid Staff Personnel for adherence to this standard, as well as review the training requirements on proper application of techniques for respiratory protection.

All Members/Paid Staff Personnel are to report immediately any noncompliance to their immediate line officer. An administrative review of this program shall occur to evaluate any changes in training or education or that may be required for the employee.

All records required by this standard shall be maintained by the Program Coordinator.

Q. Dates

 All requirements of this standard shall be completed by January 20, 1994

2.7 **ROUTINE CLEANING OF VEHICLES**

Periodic routine cleaning of the vehicles is required. During the vehicle check out at the start of each shift, the vehicle shall be inspected inside and out for cleanliness. The exterior of the truck shall be cleaned with a standard detergent and water as needed. The interior of the vehicle, including cabinetry, shall be vacuumed and cleaned with either a household detergent and water or a disinfectant cleaning solution as deemed appropriate

**2.8 Material Safety Data Sheets**

 In order to ensure a safe environment, NCAC is required by the federal government to provide information outlining the risks and safe use of a variety of potentially harmful substances used by the Corps. **This information is contained in a file consisting of a series of Material Safety Data Sheets located in the NCAC** **office**. All Members/Paid Staff Personnel are encouraged to review the book to check for any new additions.

**2.9 Members/Paid Staff Personnel Injuries**

 NCAC wants to ensure that if a Members/Paid Staff Personnel is injured while performing Corps duties, the Members/Paid Staff Personnel will receive prompt and appropriate medical care. **As a result, the Corps requires that Members/Paid Staff Personnel who are injured immediately seek medical assistance, contact the Captain, and provide NCAC with written notice in an Unusual Occurrence Report**

(Refer to Appendix 14) as soon as possible. All medical bills, phone calls must be submitted to NCAC for completion. In accordance with law, NCAC maintains Workers’ Compensation.

**2.10 Workers’ Compensation**

Workers’ Compensation is a state-mandated insurance plan which provides for medical expenses, rehabilitation services and payment for lost wages in the event of an on-the-job injury. **All Members/Paid Staff Personnel are covered by Workers’ Compensation from their first day as Members/Paid Staff Personnel and coverage continues until the Members/Paid Staff Personnel resigns or is separated**. Notice regarding benefits and availability of Workers’ Compensation shall be posted in the NCAC Building. In the event Members/Paid Staff Personnel are injured while on a job, an Incident Report must be written, notification to Operations, and more importantly, you must seek medical treatment. All bills must be forwarded to Nyack Community Ambulance Corps for proper filing.

**2.11 CISD Referral**

NCAC understands that the tasks performed by its Members/Paid Staff Personnel can be very emotionally demanding and there are some events so stressful that Members/Paid Staff Personnel may have problems coping afterwards. In preparation for these situations, NCAC has arranged for referral to a regional Critical Incident Stress Debriefing (CISD) Team. CISD Personnel are all volunteers who work in emergency services, have been exposed to similar overwhelming experiences, and who have had special training in teaching coping techniques.

 **In the event of a particularly stressful call, please call the Captain immediately and he/she will arrange for a CISD within 24 hours. Information regarding CISD intervention is posted in the NCAC office**.

**2.12 Unusual Occurrence Reports**

All Members/Paid Staff Personnel shall fill out an Unusual Occurrence Report (Refer to Appendix 14) whenever an event occurs that must be reported to the officers or Board either by specific policy or required by the “dictates of common sense.” Please fill out the form, located in the NCAC office, photocopy the document for your records, and submit the original to the Captain.

**2.13 Incident Reporting Requirements**

 **The purpose of this policy is to clarify the requirements of Section 21.q of Part 800 which specifies incident Reporting responsibilities and requirements for EMS services**. Reports must be made for incidents in which a patient under the charge and care of the service was injured or harmed by actions or omissions of a service employee as well as for on duty death or injury of a service Members/Paid Staff Personnel.

The Captain or President is required to notify the DOH Area Office of the occurrence of any incident or circumstances in which a patient, or Members/Paid Staff Personnel is harmed, injured, or killed in any of the circumstances listed below. Questionable situations should be referred to the area office for resolution.

 Notification must be made to the DOH office by telephone by the close of business the day following the incident and in writing within five days.

 The following **types of situations** must be reported to the DOH:

 1. A patient dies, is injured, killed or otherwise harmed due to actions of

commission or omission by a Members/Paid Staff Personnel of the ambulance service;

 2. An EMS response vehicle operated by the service is involved in a motor

 vehicle crash in which a patient, Members/Paid Staff Personnel of the crew or other person is killed

 or injured to the extent requiring hospitalization or care by a physician;

 3. Any Members/Paid Staff Personnel of the ambulance service, while on duty, is killed or injured

 to the extent requiring hospitalization or care by a physician;

 4. Patient care equipment fails while in use, causing patient harm;

 5. It is alleged that any Members/Paid Staff Personnel of the ambulance service has responded to an

 incident or treated a patient while under the influence of alcohol or drugs.

 **The DOH’s interest is in those events in which a patient, under the charge and care of the service, is injured or harmed by acts of commission or omission by a service Members/Paid Staff Personnel**. Examples might include failure to maintain an airway, failure to resuscitate, not honoring a properly executed DNR order, dropping a patient, etc. **The situations described here are not to be considered an all inclusive list.**

 The DOH also requires the reporting of any line of duty death or serious injury of a Members/Paid Staff Personnel. If a Members/Paid Staff Personnel is killed or seriously

injured in a sudden or unexpected circumstance (not a chronic situation) a report to the Area Office must be made.

 The written report to the Area Office should describe the circumstances, outcomes and injuries or deaths of all involved. A copy of any motor vehicle accident report should be included.

 **Services are to notify the Bureau of EMS in writing, of all unexpected authorized EMS response vehicle and/or patient care equipment failure that could have resulted in harm to a patient**. One example is a defibrillator failing to discharge. Any corrective actions taken by the service should be included. The intent of this section is to track trends in vehicle or equipment failures so that reports may be made to manufacturers and other appropriate agencies.

In addition, the US Food and Drug Administration (FDA) require mandatory medical device reporting (Refer to NYSDOH Policy Statement 98-11; Incident Reporting Requirements, Appendix 15).

**3. Emergency Medical Response and Care**

**3.1 Scheduling**

 **In an effort to provide emergency service to the community, NCAC maintains a 24-hour** **roster**. All riding Members are required to serve 24 hours per month on duty. At no time can more than 4 Members be on a crew (crew chief, driver, and 2 attendants) a copy of the current duty roster is posted in the NCAC’S building at all times. All new Members/Paid Staff Personnel must contact the scheduling coordinator to be placed on whentowork.com roster.

**3.2 Dispatch Policy**

All requests for emergency medical response will be dispatched via pager system, by the Clarkstown Police Dept (201 or dispatch). In the event that NCAC or a Members/Paid Staff Personnel receives a request for emergency ambulance service by other means (walk-in at headquarters), the Members/Paid Staff Personnel will notify the dispatcher who will page out the call. This ensures that the police and fire sectors, ALS, and NCAC Members/Paid Staff Personnel know that there is an emergency call.

**3.3 Response to Calls**

 **In accordance with Section 3005-A, Article 30 of the Public Health Law, the minimum staffing for a NCAC ambulance on an emergency call is one EMT and one driver.** **An EMT must attend the patient at all times**. **At no time shall an NCAC ambulance respond to an emergency call when the driver is not assured of having an EMT on the scene upon his arrival** (Refer to NYSDOH Policy Statement 01-4: EMT

Staffing for Volunteer Ambulance Services; Appendix 17).

 When an emergency call is received over the pager system, the Members/Paid Staff Personnel on duty (the Crew) shall respond via radio to dispatch, identifying themselves with their radio call number and role on the crew, and inform the dispatcher whether they are responding to the ambulance or to the scene. When the Crew Chief has acklodged the call, the proper acklodgment is, “Nyack (Portable number) has received the call 201”.

 In the event that there is insufficient staff, the dispatcher will dispatch the call up to two more times. Upon the second page for assistance, any available and appropriate Members/Paid Staff Personnel should respond. **If, after three pages, there is still**

**insufficient staff, the dispatcher will dispatch the nearest available mutual aid service**.

Clarkstown Police will dispatch ALS (paramedics) to all calls simultaneously with NCAC according to a pre-established protocol and contract. **In the event that paramedics are not on-scene but the call meets ALS Criteria, NCAC’S Crew Chief shall request dispatch for ALS through dispatch.**

 **NCAC’S goal is to have the ambulance reach the patient within 10 minutes of call receipt.** In the event of any delays from dispatch to arriving at the patient’s side, the Crew Chief is to notify the Captain after the call. Should a crew Members/Paid Staff Personnel face a delay in responding to an emergency call, the Members/Paid Staff Personnel shall immediately contact the Crew Chief and advised of the delay. If appropriate, the Crew Chief shall contact the dispatcher and advise of the delay and request another page out for additional crew response.

 If both ambulances are engaged in patient transport, and unavailable to respond to another emergency call, the dispatcher will dispatch the nearest available mutual aid service meeting necessary location, level of service and availability requirements.

 At minimum, the crew shall bring the appropriate jump kit, the oxygen bag, and prepare to bring the appropriate means of patient transport (carrying device) into each call. Other equipment such as the AED, immobilization devices, suction, etc. shall
be carried to the patient as needed.

 “Every on-duty Members/Paid Staff Personnel who responds to a call should be listed on the PCR. The PCR is to be filled out by the Crew Chief and placed in the locked PCR container located in the NCAC office immediately following the call”.

**3.4 Mass or Multiple Casualty Incidents (MCIs)**

A mass or multiple casualty incident (MCI) is defined as one in which the number of potential patients exceeds the resources currently available. **In practice, when ours are the first and second ambulances to respond to an event in which there are more than four patients, the event qualifies as an MCI.**  (In certain cases, the severity of the injuries may necessitate a third ambulance when there are only three patients).

 In such an event, the MCI plan should be activated. Each Members/Paid Staff Personnel of the crew has specific responsibilities under this plan. **The Crew Chief is responsible for conducting a rapid scene size-up and determining what resources are required**. Any EMTs on the crew should begin rapid triage. DO NOT BEGIN TREATING PATIENTS. Drivers are responsible for staying with the ambulances and coordinating communications.

 As with all procedures in this manual, use common sense and good judgment in determining the amount and type of additional resources you will require. **Small-scale MCIs may only require one additional ambulance. In this case, you should ask dispatch to request mutual aid response.**

**For large-scale MCIs, follow the procedures contained in the MCI command kit**. The Captain, or any officer acting on behalf of the Captain, should be notified of the MCI. You may request that dispatch page NCAC Members/Paid Staff Personnel to respond to headquarters for a controlled response with additional supplies. The response

of resources from other communities for a large-scale MCI should be coordinated through dispatch by EMS radio in the ambulance (Refer to Appendix 16, A, B, C)

**3.5 Radio Operations**

All Members/Paid Staff Personnel shall keep all radio transmissions clear, concise, and professional. Standard radio communications from the ambulance (24B1, B2 or B3) to dispatch are:

 1. Enroute;

 2. Arrival at scene;

 3. Departure from scene, noting destination; ALS OR BLS

 4. Arrival at hospital;

 5. Back in Service

**3.6 Driving the Ambulance**

 **Only driver-certified NCAC Members/Paid Staff Personnel may drive the ambulance**. All drivers shall carry their driver’s license on their person at all times. Drivers, passengers and Members/Paid Staff Personnel shall wear seat belts at all times. Children shall be restrained in an appropriate child safety seat.

**3.6.1 Non-Emergency Driving**

 **When operating the ambulance in non-emergency mode, all drivers must observe** **all applicable traffic laws**. Headlights must be on at all times, but other lights and sirens should not be used. Keep in mind that the ambulance is a highly visible public vehicle. Take time to extend every courtesy to other drivers. Fuel the vehicle when the tank is below ½ with diesel. When leaving the ambulance at the garage, plug in the battery conditioner. Do not forget to unplug the cord before starting up the vehicle. Never shut off the battery switch (located at the bottom left side of the driver seat) while the vehicle is turned on! Never retract the snow chains while the vehicle is in a stopped position! **Do not idle any vehicle inside the garage. Dangerous carbon monoxide levels may build up and cause death or injury**. The duty crew may use their assigned vehicle for meals and short personal errands. All trips of this nature should be restricted to local areas and should not be outside of Nyack Community Ambulance Corps’s territory.

Vehicles should not be used between 2400-0500 except for call response.

No matter what the situation, unless the crew has previously notified both line officer and the dispatcher, the crew and vehicle will remain available for emergency response at all times.

All Ambulances are on a rotating schedule. Use of the duty vehicle for response is mandatory, unless special circumstance demands otherwise. Notify a line officer if another vehicle must be used. Generate an Incident Report and tender to Captain. Crews shall not cruise in ambulances, unnecessarily.

**3.6.2 Emergency Driving – To the Scene**

 **When responding to emergency calls, use extreme caution**. Although ambulances may violate some traffic laws for due cause, **drivers are responsible for safe operation of the vehicle at all times and assume responsibility in the event of an** **accident.** **You may be personally liable for any accident**. Your negligence could cause

injury to yourself, your colleagues, your patient, and bystanders. **Please drive cautiously and keep the following points in mind**:

 - Use all lights for maximum visibility. Use the siren when necessary.

 - Before entering an intersection, reduce speed to be able to stop. Come to a complete stop if you have a red signal or stop sign, then proceed if it is safe to

 do so.

 - Exceed the speed limit only if the situation demands it, and then use due

 caution.

 - Remember that the ambulance is a big, top-heavy truck. It takes a long time to

 stop and it may tip over if you take a turn too fast or if you are broad-sided at

 even moderate speeds. Tight turns may cause you to strike objects alongside the

 ambulance.

 - Consider weather, road conditions, light, and roadway layout (blind corners,

 limited visibility turns, wet leaves on road, black ice) when determining safe

 speed.

 - Consider other characteristics of our operating area: children, animals, etc.

 - Do not overtake other vehicles without providing them with an opportunity to

 safely pull over. The ambulance does not have absolute right of way.

 - Do not cross railroad tracks that have visible warning indicators engaged

 unless directed by an on-scene official. If the signal is broken and crossing is

 vital, have Members/Paid Staff Personnel of the crew exit the vehicle and direct the crossing.

 - Do not overtake a school bus that has flashing red lights engaged.

 - Do not use the public address system or siren unnecessarily. Communicate

 appropriately with other drivers.

 - In snowy weather, engage the tire chains. To do this, flip the toggle switch

 located on the front console, while cruising (not depressing the gas or brake)

 at approximately ten (10) miles per hour. To disengage, just reverse the

 procedure (again, while cruising). **Do not disengage the chains when the**

 **ambulance is stopped!**

 **- 24 B1 has 4wheel drive. To engage, the vehicle must be complety stopped and the gear shift in park. Shift Vehicle gear into neutral and follow the diagram on the shift knob to the desired driving condition. Do not use 4x4 on ICE.**

When the emergency scene is a home or building, park safely and put on the parking brake, leaving the scene lights and the headlights on. Position the vehicle so that patients will be exposed to the elements for as little time as possible. **DO NOT leave the back doors of the ambulance open for any longer than necessary as it allows carbon**

**monoxide to build up in the patient compartment, promotes theft, and alters temperature**.

 When arriving at the scene of an emergency on the street, park the vehicle so that the crew and patient are safe from oncoming cars, and put on the emergency brake. On scene, consider reducing the number of emergency lights engaged to reduce rubbernecking and the ‘moth effect’. Consider turning off headlights if they will blind oncoming drivers. **Place road flares if necessary (or triangles) if hazards exist.** These warning devices should be placed a significant distance in advance of the accident in order to achieve optimal warning value. **No Members/Paid Staff Personnel should be operating on the scene of an emergency on a roadway without reflective clothing, especially at night**.

 When on the scene of a fire, do not block the hydrant or the front of the building. At any fire, MCI, or unusual response situation, establish a command post in a position where you can maintain egress, keep the driver with the vehicle, have the crew remove the stretcher, backboard, head blocks, collars, technician’s bag, and oxygen and stay by the ambulance ready to respond. Have the Crew Chief report to the ranking fire or police officer for instructions. **When on the scene of a hazardous materials event,**

**Members/Paid Staff Personnel must park up hill and upwind.** **In a hostile situation maintain safe distance and consult police for specific instructions.**

 **When at the scene of an MCI, Members/Paid Staff Personnel that if you are first on the scene, your first responsibility is to call for additional resources, establish a command post, then begin triage and treat patients. Transport is the responsibility of secondary units**.

**3.6.3. Emergency Driving – Transport**

 Transport to the hospital rarely involves use of either lights or sirens. Patients who are either C or U on the CUPS scale should be transported rapidly with lights and sirens (when necessary) **unless they are suffering from myocardial infarction without signs of shock, hypothermia, or eclampsia – these patients should be transported with the least amount of disturbance possible.** Patients who are either P or S on the CUPS scale should be transported **without lights or sirens, obeying all traffic laws.** The Crew Chief is responsible for patient care, and shall make all decisions with regard to response, treatment and transportation/destination. If emergency mode is chosen for transport, follow the driving guidelines outlined in the Emergency Driving section.

(Refer to NYSDOH Policy Statements 00-13: Operation of EMS Vehicles; and 89-04: Standard Operating Procedures to Follow in Respect to Backing and Parking the Ambulance, Appendix 19, A and B).

**3.6.4. Motor Vehicle Accidents Involving the Ambulance or Rapid Response Car**

1. **Stop and protect the scene with warning lights and/or flares**. If the vehicles

 are in a hazardous location or blocking traffic, they may be moved to the

 side of the street.

 2. **Notify dispatch immediately to request the following**:

 a. The appropriate policy agency.

 b. Any other necessary services such as Fire Department or towing

 service, etc.

 c. If the EMS vehicle was enroute to the scene of a call notify the

 dispatcher to immediately dispatch another EMS unit to that

 assignment. If the accident is ‘minor’ and there are no injuries,

 exchange vital information (noted below under item 3) and proceed

 to the call. Advise the police of this action.

d. If a patient was being transported in the ambulance and the ambulance

 has been rendered inoperable, have the dispatcher send an ambulance

 to transport the patient. If an ambulance, or the First Response Vehicle is taken out of service as the result of an accident or mechanical failure, notify dispatch immediately, place an “Out of Service” vehicle sticker on the vehicle (Refer to section 3.32).

 3. If the **patient being transported is** **unstable** and the ambulance is not rendered inoperable, and there are **no other unstable patients** on the scene, then instruct the other vehicle operator to remain at the scene until police arrive and provide them with:

 a. Service name;

 b. Vehicle identifier; and

 c. The ambulance operator’s name.

 d. Record the name, vehicle type, make, and license number of the other

 vehicle before leaving the scene with your patient.

 e. If the crew has an extra person, leave him/her at the scene to begin the

 paperwork.

 4. If a **stable patient** is being transported assure that care is being provided to the

 patient by an EMT while awaiting the arrival of the police, if waiting will not

 cause excessive delay. While waiting for police to arrive exchange information then continue transport to the original destination upon arrival of

 the police. Return to the scene after delivering the patient to their destination.

 5. **Administer** patient care to any injured persons.

 6. **Notify** an officer of the Corps (you should make this notification yourself).

 7. If there is no patient exchange necessary, **obtain** **information from other**

 **involved person** (license, registration and insurance card). Record the police

 officer’s name, shield number, department, if any tickets are issued and make

 a rough sketch of the pertinent aspects of the scene.

 8. **Obtain** **name, address, telephone number and a brief statement from any**

 **witness.**

 9. Make sure even the minor injuries are well-documented and receive appro-

 priate emergency department follow-up as needed.

 10. Per 10 NYCRR Part 800.21, our Captain will report to the Department of

 Health EMS Bureau Representative for our region, within 24 hours, any

 Accident involving personal injury and/or any accident results in an

 Ambulance being placed out of service.

 11. New York State Vehicle and Traffic Law also requires the owner of any

 vehicle involved in an accident resulting in any personal injury, death and/or

 damage exceeding $1,000 (to any one vehicle) to file a report with the

 Department of Motor Vehicles within 10 days. The required MV-104

 form may be obtained at any police station or DMV office (Refer to NYSDOH Policy Statement 01-07: Guidelines to Follow in Case of an EMS

 Vehicle collision; Appendix 20).

**3.7 NYS/BLS Protocols**

 **All emergency medical care provided by NCAC shall conform to Hudson Valley Regional EMS and New York State Protocols**. Copies of these protocols are in the NCAC office. **Each EMT may access this copy at NCAC headquarters or on-line at** [**www.health.state.ny.us**](http://www.health.state.ny.us) **and** [**www.remsco.org**](http://www.wremsco.org)**.**

**3.8 Non-Emergency Transports**

 **A non-emergency transport request must be approved by the Captain**. Transports are secondary to emergency calls. A second crew and secondary ambulance must be used on a transport call. No transport is to leave headquarters until the emergency ambulance is back in territory and available. If a transport is delayed in leaving, the hospital or person requesting transport should be notified.

**3.9 Mutual Aid to Neighboring Towns**

Because demand for emergency medical services is unpredictable and demand may occasionally outstrip resources, **NCAC has entered into Mutual Aid agreements within Rockland County and neighboring ambulance service providers**. NCAC will provide a fully staffed ambulance to respond to emergencies in the neighboring area.

 Should a crew be paged to a Mutual Aid ambulance call, they should respond as usual. If the dispatch type falls within the previously established paramedic criteria, ensure that dispatch has ordered a paramedic response with NCAC on the Mutual Aid response (Refer to Appendix 18). If the crew if not familiar with the neighboring area,

Should the Mutual Aid request be for assistance at an MCI, all communications should go through dispatch. Request the staging location and report to the Staging Officer upon arrival. A UHF portable radio is located on the ambulance for short-range use during an MCI. Consult dispatch for frequency instructions.

**All NCAC policies remain in effect during a Mutual Aid response** unless otherwise noted in the Mutual Aid contract. All Mutual Aid calls should be marked “Mutual Aid” or “MA” in the dispatch information section of the PCR (Refer to NYSDOH Policy Statement 95-04: EMS Mutual Aid, Appendix 21).t Effective January 1, 2003, the Training Policy is as contained herein, as implemented and maintained by the Training Officer. This Training Policy governs all members regardless of status, excluding only those with “Active Non-Riding” status. This policy also supercedes any other Training Policy currently in place.

**3.10 Psychiatric Transports**

Patients with psychiatric emergencies will be transported to the closest 911 receiving hospital with psychiatric care. In cases where a psychiatric patient has a medical emergency, the destination decision will follow regular protocol. **These patients** **could potentially have violent tendencies. To insure the safety of the crew and the**

**patient, it may be necessary for a police officer to accompany unstable or potentially dangerous patients in the ambulance**

**3.11 Paramedic (ALS) Dispatch**

 **ALS is dispatched simultaneously with NCAC by dispatch according to the pre-established protocol**.

 When the paramedic arrives on the scene, a crew Members/Paid Staff Personnel should guide him/her to the patient and give an initial report. Keep in mind that once the paramedic arrives, he/she becomes the highest medical authority on scene. EMTs should continue to perform BLS skills, including preparation for transport, and assist the paramedic as requested. The paramedic is another Members/Paid Staff Personnel of the EMS team who is there to help you and the patient.

 In the event that a patient requires paramedic care but one was not initially dispatched, the ambulance crew is to initiate care and request paramedic intercept from dispatch. For a major trauma patient who is not in cardiac arrest and who has a manageable airway begin transport to the closest Trauma Center (Nyack Hospital, Westchester Medical Center Good Samaritan Hospital) and arrange for paramedic intercept en route. For major trauma patients in cardiac arrest or with an unmanageable airway, begin transport to the closest hospital and arrange for paramedic intercept en route. **The standard for major trauma scene time is ten minutes. The goal is to have the patient at the trauma center within 60 minutes of the accident.**

Cancellation of a paramedic response must be requested through dispatch. **The Crew Chief must identify him/herself as an EMT with Nyack Ambulance when requesting cancellation of a paramedic response** (Refer to Appendix 18).

**3.11.1 Helicopter Transport (Stat Flight)**

 **Aeromedical transport should be considered in situations wherein the transport of critically ill/injured patient(s) to an appropriate medical facility will be faster by helicopter than by ground ambulance, if time is determined to be a factor in patient care**.

 Police, Fire or NCAC will evaluate the situation/condition and, if necessary, place a helicopter on standby via dispatch.

 **A helicopter can be requested to respond to the scene when**:

 - ALS personnel request a helicopter;

 - BLS personnel request a helicopter when ALS is delayed or unavailable;

 - In the absence of an EMS agency, any emergency agency can request a

 helicopter.

 **If it is later determined by the highest qualified EMS personnel (EMT-B, EMT-I, EMT-CC, EMT-P) on the scene that a helicopter is not needed, it must be cancelled as soon as possible**.

 **Transport of a patient by helicopter should be considered under the following conditions**:

 - Ground transportation to the appropriate critical care facility will exceed

 30 minutes;

 - The helicopter can be airborne and transport to the designated hospital

 quicker than an ambulance can transport the patient(s) to the nearest

 appropriate hospital;

 - Ground transportation is compromised;

 - A proper helicopter-landing site is available;

 - A Multiple Casualty Incident (MCI) threatens to overload local capabilities;

 - Difficult access situations (e.g., wilderness rescue, EMS access or egress is

 impeded at the scene, traffic, or other situations cleared by the helicopter

 team);

 - Helicopter should not be called for patients that are in cardiac arrest (except

 for hypothermic patients).

 - Transport of trauma patients by helicopter falls under the helicopter trauma

 transport protocol.

 dispatch should be notified if more than one patient requires air transport. If

available, one medivac helicopter will be dispatched per critical patient requiring air

transport.

**3.12 Transfer of Care**

 When transferring care to Emergency Department staff, it is NCAC’S policy that **care may only be transferred to a licensed or certified clinical care provider**. Report must be both verbal and written on a PCR, which must be signed by the licensed or certified clinical care provider (RN, NP, PA or MD)... All the patient’s belongings must be transferred.

**3.12.1 Transition of Care**

With the passage of Chapter 552 of the Laws of 1998 (Public Access Defibrillation) and more recently, Chapter 578 of the Laws of 1999 (Epinephrine Auto-Injector), EMS providers may encounter situations where a patient has been defibrillated or administered epinephrine prior to EMS arrival. It is important that there be smooth and orderly “transition of care” between civilians and EMS providers as well as between EMS providers of different levels. This includes the transfer of information and continuation of appropriate care (Refer to NYSDOH Policy Statement 00-03: Transition of Care; Appendix 22).

 **Public Access Defibrillation**: When arriving at a call where a patient is being treated by a “first responder” with an AED, **you should immediately confirm the patient’s** **status (responsive, unresponsive, apneic, pulseless, etc.), and determine if a “shock” is indicated**. **The “first responder’s” AED should remain on the patient**

**until a** **full cycle of the AED has been completed**. The AED and/or pads are usually changed when the patient is ready for transport or upon treatment by an ALS provider.

 **For patients where “no shock” is indicated**, you should continue CPR (verify that CPR is being performed correctly) and prepare for immediate transport.

 **For patients where “shock” is indicated**, you should administer a complete set of 3 “shocks” and prepare for immediate transport.

 The Crew Chief should attempt to gather the following information:

 1. How long the patient has been down;

 2. When was CPR initiated;

 3. When was the patient first “shocked”;

 4. How many “shocks” the patient has received; and
 5. Any pertinent patient history that is available.

 **Epinephrine Auto-Injector for Anaphylactic Reactions with Respiratory Distress or Shock:** When arriving on the scene of a patient experiencing an anaphylactic reaction, if the patient is being treated by a “first responder” who has administered epinephrine by an auto-injector, you should immediately confirm the patient’s status. Pay close attention to the patient’s airway, respiratory distress and any signs or symptoms

of hypoperfusion. Treat the patient appropriately, request ALS and prepare for immediate transport.

 The Crew Chief should attempt to gather the following information:

 1. Determine the substance the patient was exposed to;

 2. How long ago the exposure occurred;

 3. The initial symptoms the patient reported;

 4. The time and dosage of the epinephrine administered;

 5. The name of the individual who administered it; and

 6. The patient’s response to the treatment.

 **Medical Control must be contacted prior to administering a second epinephrine injection** (Refer to NYSDOH Policy Statement 00-03: Transition of Care; Appendix 22).

**3.12.2**

**Albuterol Sulfate**

NCAC MEMBERS/PAID STAFF who wish to administer albuterol sulfate (commonly known as “Albuterol”) must be certified at the EMT-B level or above. They must attend a Corps training class on the subject. They must receive approval from the Training Officer.

In addition to following state and local protocols, when members encounter patients who are between one and sixty-five years of age, and when these patients are experiencing an exacerbation of their previously diagnosed asthma, these members will

• Assess the patient’s airway.

• Administer high-concentration oxygen with a suitable oxygen mask.

• Request advanced life support (ALS) unit from dispatcher. **Do not delay transport to await ALS assistance!**

• Monitor respiration closely. **If patient exhibits signs of imminent respiratory failure or arrest, immediately begin treatment as defined in New York State BLS protocols for adult or pediatric respiratory arrest!**

• Encourage the patient to avoid physical activity.

• Place the patient on the stretcher in the Fowler’s or semi-Fowler’s position.

• Assess the following before administration of first nebulized treatment:

o Vital signs

o Patient’s ability speak in complete sentences

o Accessory muscle usage

o Wheezing

o Assessment of difficulty in breathing (i.e., peak flow meter or Borg scale)

• Begin transport. **For patients with a history of angina, myocardial infarction, arrhythmia, or congestive heart failure, contact Medical Control before proceeding with the next step.**

• Administer albuterol sulfate, 2.5mg/3cc normal saline, with 6-10 liters per minute of oxygen, via nebulizer. **Do not delay transport to complete administration.**

• Repeat treatment once, after ten minutes, should symptoms persist (totaling 2 doses).

• Re-assess the patient after each treatment and prior to transfer of care.

• Document all pertinent findings on Pre-Hospital Care Report (PCR). Include number of doses, and effect of medication.

• Complete any administration log as required by the Training Officer.

**3.12.3 Aspirin**

**1.** Assures that the patient’s airway is open and that breathing and circulation are adequate.

**2.** Administer high concentration oxygen.

3. Place the patient in a position of comfort, while assuring the patient and loosening tight or restrictive clothing.

4. Transport, keeping the patient warm

5. Ongoing assessment, obtain and record the patient’s vital signs, repeat enroute as often as the situation indicates

6. If the patient has not taken aspirin and has no history of aspirin allergy and no evidence of recent gastrointestinal bleeding, administer nonenteric chewable aspirin (160 to 325 mg).

7. **If the chest pain is present and if the patient possesses nitro prescribed by his/her physician and has a systolic blood pressure of 120 mh or greater,** the EMT-B may assist the patient in self-administration of the patient’s prescribed sublingual nitro as indicated on the medicine container.

**3.12.4 Blood Glucometry**

1. Indications
	1. Suspected diabetic emergencies.
	2. Any coma of unknown etiology.
	3. Status epilepticus of uncertain etiology.
	4. Syncope, stroke, or seizures with focal deficit.
	5. Altered mental status.
2. Therapeutic Effects
	1. Gives estimate blood glucose level.
3. Contraindications
	1. None
4. Adverse Effects
	1. None
5. Equipment
	1. Lancet, lancing device (optional).
	2. Gloves and face protection, as necessary.
	3. Antiseptic solution. (Note: alcohol may reduce the accuracy of the glucose

test strip, be sure to let it dry before lancing finger).

* 1. Band-Aid.
	2. Glucose test strip for glucose determination of capillary or venous blood.
	3. Cotton balls.
1. Procedure
	1. Put on gloves and use face protection, as necessary.
	2. Assemble all necessary supplies and equipment.
	3. Select a suitable site (generally the dependent side of the second or third

digit of either hand).

* 1. Prepare the site. Cleanse the site thoroughly with antiseptic solution.

Wipe the site with a dry cotton ball.

* 1. Use your thumb proximal to the puncture site to function as a mild

tourniquet and to stabilize the skin over the puncture site.

* 1. Gently puncture the site with the lancet.
	2. Dispose of the lancet in a provided “puncture resistant” biohazard

container.

* 1. “Milk” the finger by applying gentle pressure to the site, then let go,

allowing blood to fill finger, then squeeze again.

* 1. Turn the finger over and allow the accumulated drop of blood to drip

freely onto the strip. Do not “wipe” the blood off of the finger with the

strip.

* 1. Follow manufacturer’s directions on reading the glucose test strip.
	2. Cleanse the site again with antiseptic solution. Apply a dry, sterile

dressing (band aid is fine).

1. Special Information
	1. If the patient is very dehydrated or has poor circulation to extremities, then the results may be inaccurate.

All pertinent information (times, levels) must be documented on the PCR.

**3.13 Medical Control**

 **NCAC operates under the medical license of our Medical Director**. The Medical Director is responsible for ensuring quality within our organization, and may establish medical standards for our agency. The Medical Director shall be a physician, approved by the Board of Directors, and trained as a medical doctor or doctor of osteopathic medicine and licensed in the State of New York. The Medical Director shall have particular knowledge of current EMS practices, and he/she, or his/her delegate, is responsible for all NCAC training and continuing education.

 Medical Control can be divided into Hudson Valley Region on-line (spoken) Medical Control, and Hudson Valley’s Region and New York State’s off-line (written) Medical Control (Refer to NYSDOH Policy Statements 03-07: Providing Medical Direction; and, 95-01: Providing Medical Control, Appendix 23 A and B).

 - Hudson Valley’s Region on-line Medical Control consists of Medical Control

 provided by hospital-based physicians in accordance with State and

 Regional protocol. **You may contact any destination hospital at any time**

 **for physician advice.** Contact may be by telephone or via the HEAR radio.

 Document physician contact and hospital/physician name on the PCR.

- NCAC’S Medical Director approves medical protocols and conducts appropriate

 retrospective call reviews. Quality insurance call reviews will include review of

 all defibrillation events, all medication administration, all assistance with

 medication, all cardiac arrests, unusual calls and at least 10% of randomly

 selected calls.

NCAC participates in the Quality Improvement Program with Rockland County Emergency Medical Council, with several other local agencies

 - Off-line Medical Control consists of policies/protocols promulgated by the

 NYS DOH BEMS SEMAC and Hudson Valley’s Regional EMS Council/

 Regional Medical Advisory Committee.

**3.13.1 Quality Improvement Program**

 **In accordance with Article 30, Section 3006, of the NYSDOH Bureau of Emergency Medical Services EMS Service Operational Resource Guide**,NCAC participates in the Rockland County’s Emergency Medical Council Quality Improvement Program. Meetings. The purpose of this Program is to monitor and evaluate the quality and appropriateness of the medical care provided by NCAC, and the other participating agencies and to pursue opportunities to improve patient care and to resolve identified problems. All agency Members/Paid Staff Personnel who participate in this Program and attend meetings will sign a Confidentiality Agreement.

This Program includes a Committee of at least five Members/Paid Staff Personnel, at least three of whom do not participate in the provision of care by the services. At least one Members/Paid Staff Personnel is a physician, and the others are nurses, EMTs or AEMTs, or other appropriately qualified allied health personnel.

 The Committee will review care rendered to patients by the participating agencies and notify the governing body of significant deficiencies and recommend policy and procedure changes as necessary. The Committee will periodically review the credentials and performance of all persons providing emergency medical care on behalf of the agencies. As well, the Committee will review information concerning compliance with standard of care procedures and protocols, grievances filed by patients or their families, and the occurrence of any incidents injurious or potentially injurious to patients and will participate in system-wide evaluation. Data collected by the Committee will be presented to the Regional Medical Advisory Committee. Any records, including PCR data, which identifies names of individuals, will be kept confidential. The Committee’s responsibilities and objectives are clearly outlined in Article 30, Section 3006 of the

NYSDOH EMS Service Operational Resource Guide (Appendix 24).

**3.14 Refusal of Medical Attention**

 **Patients have the right to accept or refuse treatment**; that right may be infringed upon only if the patient or responsible guardian/proxy doesn’t have the capacity to make the decision to accept or refuse the service.

 **When a patient or guardian/proxy refuses treatment or transport all of the following will be documented:**

 1. Attempt to gain an understanding of the rationale for refusal, include family

 whenever possible. Document if the patient was or was not the person requesting EMS. Investigate acceptable alternatives with the patient.

 Provide all appropriate care that the patient permits.

 2. Evaluate mental status and capacity for decision-making in this specific

 situation. Include any findings as they pertain to the absence or presence

 of intoxicants.

 3. Explain reasonably anticipated consequences and potential risks of

 refusing care more than once. Include a family Members/Paid Staff Personnel or bystander

 to ask the patient to agree and document their names.

 4. Communicate with medical control if the crew feels that

 refusing care would be seriously detrimental to the patient’s best interest **or**

 if the patient’s refusal would reasonably lead to a threat to public safety.

5. Involve the appropriate police agency. The police officer should witness the

 patient’s signature on the PCR. Document officer’s shield number.

 6. Also include the following:

 a. Findings (e.g. chief complaint, past medical history and history of present illness (including any acute psychiatric illness), 2 sets of vital signs, general appearance, physical exam or patient’s refusal to permit a physical exam, mental status and behavior);

 b. Recommendation for follow-up;

 c. Signature of patient or guardian/proxy on PCR. If patient or

 guardian/proxy refuses to sign, document refusal;

 d. If police officer is not on scene, print name, title or relationship and signature of independent witness not from EMS agency.

 7. Ensure patient reads RMA or read RMA to patient. If the patient only speaks a

 language other than English, try to have a competent bilingual third party read the RMA to the patient in the patient’s language and document the interpreter’s name. Have the patient verbally confirm that he understands what the RMA says and agrees to it in the presence of the witness before signing the RMA. Inform the patient about alternatives to care and inform the patient that he/she can call 911 again without penalty if they change their mind or their

 condition worsens.

8. Try to ensure that the patient is left with another competent person.

**3.15 Unfounded Calls**

When arriving on the scene and no patient can be found, the ambulance crew shall

use common sense measures to locate the patient, question bystanders and conduct a reasonable search for the patient. If no patient is found, the crew shall request that the dispatch Dispatcher telephone the “call back” number to speak to the original caller in order to better determine the location of the patient. All measures taken to locate the patient should be documented on the PCR.

**3.16 Entry Into Premises**

 **NCAC will not break into premises without police or fire department assistance**. Police shall be requested to any scene where the crew cannot gain access to the premises. Should the police determine that the call is unfounded without gaining entry to the premises, document the officer’s name and shield number on the PCR.

**3.17 Pronouncement**

 Pronouncement of Death is the process of recognition and documentation of the physical signs of death. It is the basis of the decision not to engage in resuscitation efforts.

 Certification of Death is the legal documentation required at the end of a life. A concise and complete statement of the terminal event and its causes, it is witnessed by the signature of a physician as per NYS Public Health Law.

**3.18 Assessment**

 **Patients may be pronounced dead and unable to be resuscitated when pre-hospital providers have found, in addition to apnea and pulselessness that one or more of the following conditions exist:**

 - Tissue decomposition;

 - Rigor mortis;

 - Extreme dependent lividity;

 - Obvious mortal injury (decapitation, exsanguinations, etc.)

 - A valid Do Not Resuscitate (DNR) order.

 **In addition to these conditions, pre-hospital providers should also attempt to determine:**

 - Confirmation with an AED that “No Shock Advised” or presence of

 asystole;

 - Any significant medical history or traumatic event;

 - Time lapse since patient was last seen alive;

 - Assess surroundings and consider possible crime scene. If so, the crew shall

 leave the scene, and contact police if not already on scene. Crime Scene

 procedures, as explained in Section 3.25, shall be followed.

 **As with any patient, EMS can contact Medical Control for consultation if there are questions regarding the patient’s presentation and the decision not to attempt resuscitation.**

**3.18.1 Documentation**

As per NYSDOH policy, a PCR must be generated for each call. **The disposition** **code 010 (Other)** **should be used with the description “obvious death” entered in the** **disposition box**. A PCR for a pre-hospital pronouncement of death should include:

 - A description of the body’s physical location and presentation;

- Any significant medical history or traumatic event;
 - Existing physical conditions which precluded performance of

 resuscitation efforts;

 - Any EMS contact with Medical Control;

 - In whose custody the body was left.

 **Since the body will not be transported to the hospital, a copy of the PCR may be left with the law enforcement or medical examiner representative on scene as part of the official record**.

**3.18.2 Reporting and Removal**

As per the “Guide to Reporting Deaths to the Medical Examiner,” all unlawful, violent, unattended, sudden or suspicious deaths, either known or suspected, must be immediately reported to the ME’s office. If a death appears to meet these criteria, EMS

should contact local police, if not already on scene, and take care not to move the body or disturb the area unnecessarily. The police will notify the ME’s office and preserve any evidence.

 For all other deaths, the Medical Examiner still must be notified. The deceased’s attending physician will be contacted by police or the Medical Examiner’s Office regarding the completion of the Death Certificate. Based on all the information provided,

the Medical Examiner’s Office will decide to authorize removal of the body from the police.

 It is possible that, in some special situations, the police may order EMS to transport a body to the closest hospital if, in their judgment, expedient removal of the corpse is necessary.

**3.19 DNR Orders**

 **NCAC Members/Paid Staff Personnel shall observe and comply with all valid Nonhospital DNR (Do Not Resuscitate) orders issued on the standard DOH Nonhospital DNR form** (Refer to NYSDOH Policy Statement 99-10: Frequently Asked Questions Regarding DNRs, Appendix 26 A and B). **If a patient wears a DOH standard DNR bracelet, the EMT** **should assume that a DNR order is in place**. Just because the patient has a DNR form doesn’t mean that you should discontinue all care. If transporting the patient, the form and/or bracelet should be taken to the hospital with the patient. If CPR has been initiated prior to the form being presented, it may be discontinued upon presentation of the standard form without contacting Medical Control. **For unusual situations or questions**, **contact Medical Control**.

**3.20 Advance Directives**

At the current time, although New York State does permit Health Care Proxies and Living Wills, the State Department of Health has issued a policy stating that they are **not valid in the prehospital setting**. Therefore, the crew should provide care, transport the patient to the hospital, and allow the hospital personnel to make decisions regarding advance directives.

**3.21 Minors**

 **Minors are defined as persons under the age of 18 years**. **Minors who have a psychological, medical or surgical emergency to not have the ability to refuse medical** **care**. As a result, in the absence of a parent or guardian, emergency care and transport is provided for minors under the doctrine of implied consent. The crew should make every effort to contact a parent or guardian.

 **There are three exceptions to this rule**: minors who are married can refuse treatment for themselves or their children; female minors with children can refuse for themselves or their children; and, finally, minors who have been legally emancipated can refuse for themselves or their children. An emancipated minor is one who is: enlisted in the armed forces of the United States of American; requesting treatment for drug abuse or sexually transmitted disease; living alone and self sustaining and otherwise ruled emancipated by a competent authority. **If treatment and/or transport is refused by the patient, an RMA must be appropriately completed, signed, and witnessed as explained in Section 3.16** (Refer to NYSDOH Policy Statement 99-09: Patient Care and Consent for Minors; Appendix 27).

**3.21.1 Abandoned Infant**

(NYSDOH Policy Statement 01-05: Abandoned Infant Protection Act, Appendix 28)

 **Under the Abandoned Infant Protection Act, Chapter 156 of the Laws of 2000**; a parent, guardian, or other legally responsible person, may leave their infant (who must be 5 days old or less) at a safe place. The law requires that an adult must intend that the child be safe from physical injury, cared for in an appropriate manner, with an appropriate person, in a suitable location and promptly notify an appropriate person of the child’s location. People leaving an infant in compliance with this law are not required to provide their names. County district attorneys have individually defined what constitutes a safe place within their county. Some suggested safe places include hospitals, police stations and fire stations.

 **Individuals who give up their infants do not automatically surrender their parental rights and may later seek to reclaim the child**. It is important to note that this legislation does not amend provisions of the Social Services law which make

abandonment of an infant reportable to the NYS Central Register for Child Abuse and Maltreatment.

 **In the event a parent or legal guardian chooses to relinquish care of their newborn infant to an emergency medical service agency; the following guidelines should be considered**:

 1. Parents are not required to provide their names to the safe location or staff.

 In a non-judgmental manner, EMS staff may ask the presenting adult if there

 Is any medical information that is important to know regarding the infant.

 2. EMS services and systems may want to contact their County Office of the

 District Attorney to determine what, if any locations, have been identified as

 “safe places” by the District Attorney.

 3. Infants received by an EMS service agency should be transported to the

 nearest hospital for medical assessment and care. The agency should not

 be expected to interact with local child protection service agencies unless

 directed to do so.

 5. If a parent seeks follow-up information about the child they relinquished

 to the care of the EMS service agency, a referral should be made to the hospital

 where the infant was transported or the local office of social services.

**3.22 Restraint**

When necessary for the patient and/or crew’s safety, in addition to the straps on the stretcher a patient may be restrained using the least amount of force and restraint necessary. **Members/Paid Staff Personnel that the most effective restraint device is a calm, firm, professional demeanor.** The first step is to request the police to place the patient in temporary police custody. In the absence of the police, the EMT should attempt to gain permission from the patient’s parent (if a minor) or guardian, or contact

medical direction for advice. In the event that neither the police nor a parent or guardian (for a minor) is present, the EMT may restrain the patient if it is safe (for both the crew and patient) and you determine that the patient may be a danger to himself or others. It is preferred that at least three crew Members/Paid Staff Personnel are present. **If the crew is in danger, the appropriate thing to do is retreat!**

 Patients should be transported with a crew Members/Paid Staff Personnel of the same gender, if possible. **Any patient who is handcuffed shall be considered in police custody**. **Patients should never be transported face down or with their respiratory capacity restricted in any way**. All restrained patients must be continually monitored.

**3.23 Police Custody**

 **All patients in police custody shall be handcuffed by the police**. **No patient shall be transported face down or with their respiratory capacity restricted in any way**. Patients in police custody shall be accompanied by a police officer at all times. It is strongly preferred that **all police officers carrying handguns sit in the Captain’s**

**chair**. A victim of a significant violent crime should be accompanied by a police officer. The officer should maintain the chain of custody for all evidence. **NCAC Members/Paid Staff Personnel should make an effort not to interfere with or contaminate any potential evidence**.

**3.24 Crime Scenes**

 **If called to a potential crime scene where there is any danger, do not enter until the** **scene has been secured by the police**. If the police are not present and the crew finds itself in danger, leave the scene and call the police. When called to a crime scene that is safe and already secured by the police, **the first priority is to provide** **emergency medical care and transportation to the patient**. **The second priority is to** **protect the integrity of the crime scene**. This means minimizing the number of crew Members/Paid Staff Personnel on the scene, touching only what is necessary, wearing gloves, and alerting police to any physical evidence. **Keep both goals in mind, but Members/Paid Staff Personnel their priority**.

**3.25 Child Abuse Reporting**

Under an amendment to the New York State Department of Health Social Services Law, effective February 1, 2002, **an EMT who comes across suspected child abuse while performing his or her duties must report the case as follows:** (Refer to NYSDOH Policy Statement 02-01: Requirement to Report Instances of Suspected Child Abuse or Maltreatment; Appendix 29 A & B).

 1. Document the injuries and the statements of the suspected abusers on the PCR.

 2. Give an oral report to the ER describing the suspected abuse.

 3. As soon as possible, provide an oral report to the NYS Child Abuse Maltreat-

 ment Register at: 1-800-635-1522.

 4. Notify the Captain of the suspected abuse as soon as the call is over.

 5. Within 48 hours of the oral report, the Crew Chief must complete a written

 report on Form LDSS-2221-A; Report of Suspected Child Abuse or

 Maltreatment (Refer to Appendix 29 B), and attach a copy of the form to the

 agency copy of the PCR.

**Under this amendment to the law, willful failure of an EMT to properly report a** **case of suspected child abuse is a Class A Misdemeanor**. It is important to Members/Paid Staff Personnel that although the parent may be the abuser, the needs of the injured child should come first. This may mean having the possible abusive parent accompany the child in order to make the child more comfortable, or separating the parent from the child. **Don’t confront the abuser**. **Use common sense**. **All confidentiality policies still apply.**

 NY Social Services Law, Section 419 States: “Any person (mandated by law or not), official or institution participating in good faith in the making of a report, taking

photographs, placing a child in protective custody or providing a service pursuant to the duties of the child protective service according to the law has immunity from any liability, civil or criminal, that might otherwise result for such actions. For the purpose of any proceeding, civil or criminal, the good faith of persons, officials or institutions required to report cases of child abuse or maltreatment is presumed as long as they were acting in the discharge of their duties and within the scope of their employment. This protection does not apply to acts of willful misconduct or gross negligence.”

**3.26 Elder Abuse, Patient Abuse and other Domestic Violence Reporting**

In the event that the crew suspects abuse, neglect or maltreatment, the crew shall document the injuries and/or injury patterns (and any relevant statements) on the PCR. In addition, an oral report will be given to the ER staff and the police. The crew should report the incident to the Captain following the call. **Don’t confront the possible abuser. Use common sense. All confidentiality policies still apply.**

**3.27 Other Crimes**

When an ambulance crew reasonably believes that a crime has been committed, **request that the police respond** and report suspicions to the police officer. Report the incident to the Captain following the call.

**3.28 Destination**

NCAC’S goal is to transport in the safest and most efficient manner in order to ensure availability of ambulance service for the community. Crews should use their best judgment in selecting the appropriate hospital. **Unstable or potentially unstable patients should be transported to the closest receiving** **hospital ER or psychiatric**

**center**. **Trauma patients who fit the New York State Adult** **Major Trauma or Pediatric Major Trauma protocols should be transported to the closest** **Trauma**

**Center (with paramedic intercept requested)**, unless the patient is in **cardiac arrest** or has an **unstable airway** in which case **transport to the nearest hospital**.

 Environmental factors and road conditions should be considered when selecting a destination. Under normal circumstances the only transportation destinations for our agency are: **Nyack Hospital, Good Samaritan Hospital, Westchester Medical Center and Phelps Memorial Hospital**. As a matter of policy, we do not transport patients to doctor’s offices or other such facilities.

**3.29 Restocking**

 **Upon completion of a call, the Crew Chief is responsible for seeing that the ambulance is returned to a state of operational readiness, including restocking of all used** **supplies**. The crew shall restock linens and disposable equipment at the receiving hospital or at headquarters. Crew Members/Paid Staff Personnel should also check for

NCAC equipment left behind at the hospital on previous calls. Extra linens, equipment, and supplies are located in the medical closet. **If the crew is unable to restock any necessary items, contact the Captain or appropriate officer for assistance. Any NCAC equipment left at the hospital should be noted on the garage blackboard as well as the run report.**

**3.30 Sharps/Biohazard Disposal**

All sharps, including IV catheters, shall be disposed of in an appropriate sharps container. These containers are located on each ambulance. When full, sharps containers shall be appropriately sealed and disposed of in the hospital emergency department. **Use common sense. NCAC discourages any Members/Paid Staff Personnel from handling any sharps and suggests that only the attending paramedic do so.**

 **All items contaminated with blood or other potentially infectious material should be disposed of in a red biohazard bag**. Whenever possible, the red bag should be disposed of in the appropriate Biohazard receptacle located in the emergency department at the hospital. Otherwise, the red bags should be disposed of in the Biohazard receptacle located and in the NCAC garage. The NCAC receptacle will be disinfected regularly and its contents transported to the emergency department at the hospital for disposal.

**3.31 Equipment Failure and Out-of-Service Vehicle Procedure**

 **Should equipment be found to be missing or non-operational** during routine rig checks, the crew shall immediately contact the Captain. Should mandated equipment necessary for the current patient’s care or transport be found to be missing or non-

operational during a call, the crew shall provide all possible care and request a mutual aid ambulance for transport. Should the equipment not be necessary for the current patient’s

care or transport, complete the call and inform the Captain immediately following the call.

 **When an ambulance is removed from service**, **whether for vehicle maintenance reasons or lack of patient care equipment, and it is believed that this** **removal will be temporary, the following procedure is to be used:**

 1. **Place a state** **“Out of Service” sticker** on the outside of the windshield, over

 the State Certification sticker.

 2. **Notify dispatch, and the NCAC Captain**, that the vehicle is out of service.

 **When an ambulance that has been temporarily removed from service is returned to service the Captain, or appropriate officer, will perform the following**:

 1. **Assure that the vehicle is in compliance with Part 800** of the codes of

 the New York State Department of Health.

 2. **Remove the “Out of Service” sticker** from the vehicle windshield.

 3. **Notify dispatch** that the vehicle is back in service.

 **When an ambulance is permanently removed from service the Captain or appropriate officer will perform the following**:

 1. Notify in writing, on official letterhead, the appropriate State EMS Repre-

 sentative of the following vehicle information:

 - Make

 - Year

 - Vehicle/Radio ID

 - License Plate Number

 2. Remove ALL New York State EMS logos from the sides and rear of the

 vehicle.

 3. Remove the Department of Health Certificate of Inspection sticker from

 the windshield.

 The same procedure applies to the First Response Vehicle. “Out of Service” stickers are located with the vehicle registration on each vehicle (Refer to NYSDOH Policy Statement 89-14: Out of Service Vehicles, Appendix 31).

 Contingency plans to address communications and other equipment failures are in Appendix 30.

**3.32 Diversions**

Diversion status is a courtesy requested by a hospital in unusual circumstances. In this event the hospital will notify dispatch of the status. If an area hospital goes on

diversion, the ambulance crew should make an effort to redirect stable patients to another hospital within 15 minutes’ travel time. **Non-stable medical patients** (C, U, P patients), **without a paramedic, must go to the closest hospital. Non-stable patients receiving paramedic intervention may be diverted to another location if approved by the paramedic**. Keep in mind that **diversion is only a request, and that no hospital can refuse to accept a patient requesting emergency care**.

 In the unlikely event of a hospital closure due to an emergency, contact dispatch for instructions regarding destination so that adjacent hospitals are not overwhelmed.

**3.33**

**NYACK COMMUNITY AMBULANCE CORPS**

**Contingency Plan**

**Failure of Pager System**

There are two measures in place to check on the functionality of the NCAC pager

system:

1. Dispatch will do a 7am/7pm to ensure that NCAC is in service for the tour.

 2. Dispatch will immediately notify the NCAC Captain if they

 detect any problem with our pager or communication system or no crew’s acklodgement

 **In the event of pager failure or malfunction**, a NCAC officer should report the problem to dispatch as soon as possible. If a malfunction is detected by dispatch, they will notify the NCAC Captain, or next available line officer, as soon as possible.

 **In the event of pager failure, the following procedure will be followed**:

 1. The NCAC Captain, or next available line officer, will be notified

 as soon as possible. In turn, this officer will report the problem to

 dispatch.

 2. If necessary, the officer will contact the authorized transmitter repair

 company and request immediate service response.

 3. dispatch will be requested to contact the highest-ranking available

 officer by telephone, at home or headquarters, as to call type and

 location.

1. The officer will then contact the on-duty Crew Chief and Driver by phone to notify them of the type and location of the call. This procedure will continue until repairs are completed and a successful pager test is performed by the officer.

**3.35 Failure of Radio Communications**

Should radio communications **fail with dispatch**, we may use a telephone or ambulance cell phone to contact dispatch. We may also try to use alternate fire frequencies on the ambulance.

Should radio communications **fail with the receiving hospital**, we may use a cell phone (personal or on ambulance) to directly contact medical control or the receiving hospital. **Numbers for dispatch and all receiving hospitals are located in each ambulance near the rear radio controls and in the PCR boxes**.

**3.35.1 Power Failure at Headquarters**

In the event of a power failure, garage doors can be manually raised after pulling down on the white rope/chains which disconnects the latch connecting the linkage to the door.

**3.36 Ambulance Out of Service**

In the event either of our ambulances is out of service (**for any reason**), the Captain, or other officer, shall be promptly notified by a crew Members/Paid Staff Personnel. Dispatch shall be promptly notified by the Captain, or other officer. **An “Out-Of-Service” Sticker will immediately be placed on the vehicle.**

**3.37 Inclement Weather Plan**

In the event of inclement weather that threatens public safety or integrity of infra-

structure, the Captain, or other officer, shall coordinate planning with the duty crew (or additional crew if necessary). Such weather conditions may include: Heavy rain or flooding, ice, snow, high heat, high winds, etc. Examples of anticipated actions may include standby at headquarters or other location, and use of alternate vehicles (town truck) for access through high water or snow.

**3.38 MCI Plan**

 **In the event that NCAC is called upon to respond to a large-scale MCI outside of** **our jurisdiction, Members/Paid Staff Personnel shall assemble at our headquarters** and the Captain, or other officer, will determine which Members/Paid

Staff Personnel shall respond on the call, how calls within our jurisdiction will be handled, and what equipment/apparatus to assign. **Small scale MCIs outside of our jurisdiction will usually require a response from the duty crew and ambulance to the scene.**

* 1. **Paramedics**

Rockland Paramedics Services provides Advanced Life Support Services to the responding area of NCAC. Though the Paramedic(s) have the higher medical authority while attending to patient care, the NCAC Crew Chief shall remain in

charge of the crew, the ambulance and any disastrous/ mci event until a NCAC’S Line Officer(s) has taken the authority. At the descreption of the Crew Chief, a NCAC member may drive the Paramedic Vehicle to the hospital or to its designation.

After each call, it is the responsibility of the Paramedic to clean their paraphernalia after each patient care.

**3.40 The SPECIAL OPS TEAM**

Bike Team/Gem Cars has been assembled to provide BLS (basic life support) in areas where gaining access to patients with conventional vehicles would be difficult or impossible. The SPECIAL OPS TEAM is designed for implementation during parades, street fairs, walk-a-thons, festivals, fireworks displays, and other special events where restricted access and large crowds may occur.

During operations, personnel will interact on an intimate level with the public for extended periods of time. Personnel are expected to maintain a professional and polite demeanor at all times.

**Personnel Requirements**

NCAC Members who become members of the Special OPS TEAM will

• Be Crew Chief EMT’s off probation, and be off membership probation.

• Be in good physical condition, and be willing to submit to physical examination if requested by the Captain.

• Be approved by the Captain.

• Complete in-service, detailing operating procedures of the Team.

**Team Deployment**

• Ambulances will be staffed first. The SPECIAL OPS TEAM holds a secondary priority.

• If foul weather develops, personnel will be reassigned to ambulances.

• Assignment and deployment of the SPECIAL OPS TEAM will be directed by the officer in charge at the event location.

• The bicycles may not be operated unless the operator is properly assigned to do so as part of a scheduled patrol.

•

**Maintenance**

• The EMS Bicycle/Gem Cars are to be repaired by a technician of certification. It is a complicated device that requires special tools for the majority of maintenance and repair. Some basic adjustments and emergency repairs can be performed in the field. However, personnel are stringently prohibited from adding, removing, or otherwise altering any part of the Bicycle/Gem Cars unless dire emergency requires it.

• Equipment will be checked prior to the start of any patrol tour. This will

 include medical supplies as well as mechanical operability.

• Abuse or neglect of the bicycles/Gem Cars will result in disciplinary action.

• Personnel will not operate a Bicycle/Gem Cars that is malfunctioning, exhibits a safety defect, or requires repair to prevent further damage.

• During daylight hours, the battery pack and light should be removed from the Bicycle prevent theft of these items.

• If the Bicycle is to be laid on the ground, it must be placed on the side that does not anchor the drive chain. This prevents damage to

 the derailleur.

 Please remove the key and shut off the battery switch when the Gem car is not in use.

• While on patrol, personnel are responsible for routine and emergency maintenance such as flat tire repair, minor brake adjustment, lubrication of gears, and general cleaning.

Should a more difficult problem arise, personnel will notify the officer in charge and stop riding/driving immediately.

**Uniform**

Members will be issued shorts and/or pants, reflective Bicycle/Gem Cars uniform shirt, helmet, gloves, and eye protection. Members will be required to supply black sneakers or Bicycle/Gem Cars shoes. Issued uniform equipment remains the property of NCAC at all times and must be surrendered upon demand.

**Operations**

Upon assignment to a tour of duty, personnel will

• Select a properly sized bicycle.

• Adjust seat and check Bicycle/Gem Cars for mechanical defect.

• Check all equipment and medical supplies.

• Complete necessary paperwork prior to start of tour.

• Wear properly sized helmet at all times.

• Operate the Bicycle/Gem Cars in a safe manner, with due regard for vehicles and pedestrians.

• Report to officer in charge upon arrival. Become familiar with operational area, access routes, and schedule. Follow event plan regarding communications and other parameters.

Personnel are responsible for first aid at the scene only. Should transport to a hospital be required, personnel will request a transport vehicle. Personnel will report to arriving units and transfer care, and then restock Bicycle/Gem Cars from transport unit.

Personnel will clear crossing traffic as necessary by sounding an audible device or politely asking to clear the path of travel.

Equipment will be secured at all times, and never out of sight of the operator.

**Communication and Documentation**

SPECIAL OPS TEAM personnel will follow standard procedure for operations at events, including communication and documentation. The bicycles may be identified as “Bike 1”, “Bike 2”, and GEM CARS “3” or “4”.

Each member will complete a check sheet for their Bicycle/Gem Cars prior to start

of tour.

A Pre-Hospital Care Report (PCR) must be completed for each patient encountered. The Vehicle ID number is the radio identifier (e.g., “Bike 1”). In the event a patient is removed to a hospital by a transporting vehicle, enter Disposition Code 004, “Treated by this unit and transported by another unit”.

When the gem cars are returned back to the property of NCAC, personnel must turn the batteries off/plug the vehicles back into electricity and cover. All equipment must remain in the locked trunk.

**3.41 PCR**

Complete a Pre-Hospital Care Report (PCR) for every patient and every call. This will include cancelled calls, standby calls, refusal of medical aid/transportation (RMA/RMT), etc. A PCR is not completed when the vehicle is used for administrative purposes, such as driver training or vehicle maintenance.

A separate PCR is completed for each patient. When mother and newborn infant are transported together, or when baby is delivered enroute, separate PCRs are completed for mother and each infant.

A separate PCR is completed for each transport. Should the patient be transported to another facility, a second PCR must be completed for the second trip.

When more than one NCAC vehicle(s) responds, each crew should complete a separate PCR. Each PCR should reflect only the actions taken by that particular crew. Similarly, when units from other agencies respond to the same call (e.g. advanced life support from Rockland Paramedic Services) the PCR should only reflect the actions of the NCAC crew.

Should the patient be treated by one NCAC crew, but transported by another vehicle or agency, the PCR should be completed as usual. The PCR should note that care was transferred to the other vehicle or agency. The Disposition Code 004, “Treated by this unit and transported by another”, should be used.

**5 Call Times**

Military time is used for all time entries on the Pre-Hospital Care Report (PCR). Military time is easily calculated by adding twelve hours to any time

after noon and before midnight.

 12:00 PM (noon) 1200

 3:00 PM 1500

 12:00 AM (midnight) 2400

 12:05 AM 0005

**Features of the PCR**

Some areas of the PCR are shaded gray. The areas contain information that should be communicated to the hospital when giving a report on the patient. Other features include

• Non-Hospital Disposition Codes – are used when the patient is not transported to a hospital (RMA/RMT, unfounded, etc).

• Hospital Receiving Agent – this area must be signed by the hospital staff during transfer of patient care. When used, open the form so that the signature is on the white copy only.

• Refusal of Treatment/Transportation Release – this section provides

 an area for the patient to sign when treatment and/or transportation is refused. When used, open the form so that the signature is on the white copy only. Circle “treatment” and/or “transport to a hospital”. If necessary, write in the specific treatment declined. Have the patient and witness sign on the line provided.

• Rule of Nines – Refer to the chart to assess burn severity.

•Agency Name: Nyack Community Ambulance Corps

∙-Date-ex: 02-09-2009

-Run Number-Obtained from computer after call is logged

-Agency Code-04317

-Vehicle Number-The Ambulance that is being used for the tour

-Dispatch Information-Information obtained from Dispatch

-Call Location-Where the crew is being dispatched to

-First Name-Patient Name. If you cannot obtain a name, use “unknown”. Do not use “John Doe or Jane Doe”

-Last Name-Same as above

Street Address-Where the patient lives

-City-Same as above

-State-Same as above

-Age-Patient’s actual age

-Date of Birth-Patient’s Birthday

-Male or Female-Patient’s sex

-Social Security Number-Patient’s SS# number. If unable to obtain, use “000-00-0000”

-Physician-Patient’s Doctor

-Care in Progress on Arrival-Who was rendering care to the patient upon your arrival.

-Mechanism of Injury-How was the patient injured

-Extrication required-Yes or No

-Seatbelt used-Yes or No…Reported by….

-Chief Complaint-In the patients own words, his/her problem. If unable to obtain a c/c, document none stated.

-Subjective Assessment-What you observed

-Presenting Problem-Circle the correct problem

-Past Medical History-Medications, and past History

-Vital Signs- Times, Respiratory (Rate, Regular, Shallow, Labored), Pulse Rate, Circle regular or irregular. If irregular, count for a full minute, B/P, Level of Conscious (circle the appropriate patient’s status) Gloss Coma Scale (Determines patient alertness, motor skills and verbal), Pupils (Circle the appropriate response with a pen light), Skin (circle the appropriate response regarding the patient’s skin condition), Status (Critical, Unstable, potential stable and stable) circle the appropriate patient’s status.

-Objective Physical Assessment- Continuation from the subjective and what treatment you provided to the patient.

-Comments-Continuation from the above.

-Treatment Given-Circle all that applies to the medical treatment that patient receives from the Emt Crew Chief.

-Disposition-Where the patient was taken or if there was a rma, cancellation, unfounded etc. Find the correct code on the back of the pcr.

-In Charge-The Arthur of the PCR

-Driver-Who ever drove the ambulance

-Attendants-Paramedics(if the call was ALS), Trainees, and/or Youth Corps

* + 1. **E-Pcr Under Construction**
		2. **Continuation Forms**

All EMTS must use continuation forms when it becomes necessary to finish authoring the PCR. The continuation pcr must have the original PCR NUMBER, Vitals Signs, medications, times, treatment given and all attendants of the crew. The nurse or Doctor must also sign the continuation form.

**3.42 Doa Check List**

Rockland County’s Medical Examiner has given Emergency Medical Technicians the authority to pronounce a patient dead. NCAC’S Crew Chief must complete a “Dead on Arrival” check list if the crew is the first on the scene of a pronouncement in the County of Rockland. The checklist must be written completely and collaborate with your PCR. If the Crew Chief does not feel comfortable pronouncing, let the Paramedics pronounce. A copy of the pcr and the check list must be left with the Police Officer. The Crew cannot leave a deceased body unless there is Law Enforcement on the scene.

**3.43 Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  PLEASE REVIEW IT CAREFULLY.**

Nyack Community Ambulance Corps, Inc. ("Nyack Ambulance") is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI.  Nyack Ambulance is also required to abide by the terms of the version of this Notice currently in effect.

*Uses and Disclosures of PHI:* Nyack Ambulance may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission.  Examples of our use of your PHI:

For treatment.  This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as doctors and nurses who give orders to allow us to provide treatment to you.  We may give your PHI to other health care providers involved in your treatment, and may transfer your PHI via radio or telephone to the hospital or dispatch center.

For payment.  This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies, making medical necessity determinations and collecting outstanding accounts.

For health care operations.  This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions.

Reminders for Scheduled Transports and Information on Other Services*.* We may also contact you to provide you with a reminder of any scheduled appointments for non-emergency ambulance and medical transportation, or to provide information about other services we render.

*Use and Disclosure of PHI Without Your Authorization.*  Nyack Ambulance is permitted to use PHI *without* your written authorization, or opportunity to object, in certain situations, and unless prohibited by a more stringent state law, including:

* For the treatment, payment or health care operations activities of another health care provider who treats you;
* For health care and legal compliance activities;
* To a family Members/Paid Staff Personnel, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection, and in certain other circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interests;
* To a public health authority in certain situations as required by law (such as to report abuse, neglect or domestic violence;
* For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
* For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
* For law enforcement activities in limited situations, such as when responding to a warrant;
* For military, national defense and security and other special government functions;
* To avert a serious threat to the health and safety of a person or the public at large;
* For workers' compensation purposes, and in compliance with workers' compensation laws;
* To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
* If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
* For research projects, but this will be subject to strict oversight and approvals;
* We may also use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Any other use or disclosure of PHI, other than those listed above will only be made with your written authorization.  You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.

*Patient Rights:*  As a patient, you have a number of rights with respect to your PHI, including:

*The right to access, copy or inspect your PHI*.  This means you may inspect and copy most of the medical information about you that we maintain.  We will normally provide you with access to this information within 30 days of your request.  We may also charge you a reasonable fee for you to copy any medical information that you have the right to access.  In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials.  We have available forms to request

access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights.  You also have the right to receive confidential communications of your PHI.  If you wish to inspect and copy your medical information, you should contact our privacy officer.

*The right to amend your PHI*.  You have the right to ask us to amend written medical information that we may have about you.  We will generally amend your information within 60 days of your request and will notify you when we have amended the information.  We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct.  If you wish to request that we amend the medical information that we have about you, you should contact our privacy officer.

*The right to request an accounting*.  You may request an accounting from us of certain disclosures of your medical information that we have made in the six years prior to the date of your request.  We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, like our billing company or a medical facility from/to which we have transported you.  We are also not required to give you an accounting of our uses of protected health information for which you have already given us written authorization.  If you wish to request an accounting, contact our privacy officer.

*The right to request that we restrict the uses and disclosures of your PHI*. You have the right to request that we restrict how we use and disclose your medical information that we have about you.  Nyack Ambulance is not required to agree to any restrictions you request, but any restrictions agreed to by Nyack Ambulance in writing are binding on Nyack Ambulance.

*Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request.* If we maintain a web site, we will prominently post a copy of this Notice on our web site.  If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

*Revisions to the Notice:*   Nyack Ambulance reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain.  Any material changes to the Notice will be promptly posted in our facilities and posted to our web site, if we maintain one.  You can get a copy of the latest version of this Notice by contacting our privacy officer.

*Your Legal Rights and Complaints:* You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government.

Should you have any questions, comments or complaints you may direct all inquiries to our privacy officer.

*Privacy Officer Contact Information:*

Nyack Community Ambulance Corps

Willie White, Privacy Officer

PO Box 213

Nyack, NY 10960

845-358-2424

*Effective Date of the Notice*: April 14, 2003

Nyack Community Ambulance Corps

Administrative Personnel

President/ Safety Officer/ Paid Staff -William McDowell

V-President/Scheduling- Tracy Johnson

Secretary- Jeremy Griffel

Treasure-Cathy Radziemski

Board Members at Large-Mike Baer and Susan Hellauer

Training Officer-Willie R.J.White

Operations Personnel:

Captain-Paul Morer

1st Lt. Ivan Guerra

2nd Lt. Jeremy Griffel

**NCAC STANDARD OPERATING PROCEDURES**

**APPENDIXES**

 1.1 **Sexual Harassment**: NYSDOH Policy Statement 00-11

 1.2. **Pre Hospital Care Report**: NYSDOH Policy Statement 02-05

 3. **The Functional Position Description of EMT-B**: NYSDOH

 Policy Statement 00-10

 4. **No Smoking Policy**: NYSDOH Policy Statement 00-07

5. **Preventive Maintenance of EMS Vehicles and Equipment**:

 NYSDOH 02-11; **NCAC Maintenance Procedures**; **AED Maintenance**;

 **Cot and Stair Chair Maintenance**; **Maintenance Checklist**.

 6. **EMS Vehicle Signing and Labeling**: NYSDOH Policy Statement

98-08

 7. **Ambulance Equipment Inventory**: NYSDOH Policy Statement

 98-14

 8. **Personal Equipment on Ambulance Vehicles**: NYSDOH Policy

 Statement 98-03

 9. **Security of Drug Boxes and Drug Paraphernalia on EMS Response**

 **Vehicles**: NYSDOH Policy Statement 00-06; **Storage and Integrity**

 **of Pre-Hospital Medications and Intravenous Fluids**: NYSDOH

 Policy Statement 00-14; **Storage and Safe Guarding of Medications**

 **Administered by EMT-Bs**: NYSDOH Policy Statement 00-15

 10. **Ambulance Oxygen Systems and Equipment**: NYSDOH Policy

 Statement 98-06

 11. **Recommendations for Decontamination and Cleanup of Rescue**

 **Vehicles; NCAC Monthly Rig Cleaning Checklist**

12. **Unknown Dry Substance/Suspected Anthrax Response**: NYSDOH

Policy Statement 01-08

 13. **Guidelines For Employee (Members/Paid Staff Personnel) Health Records**: NYSDOH Policy

 Statement 88-8

 14. **Unusual Occurrence Report**

 15. **Incident Reporting Requirements**: NYSDOH Policy Statement 98-11

 16. **EMS Use of the Incident Command System**: NYSDOH Policy Statement 1-02; **Incident Command Structure**; **S.T.A.R.T. System**

 17. **EMT Staffing For Volunteer Ambulance Services**: NYSDOH Policy

 Statement 01-04

 18. **ALS Call Criteria**

19. **The Operation of Emergency Medical Services Vehicles**: NYSDOH Policy Statement 00-13; **Sample Standard Operating Procedures to**

**Follow** **in Respect to Backing and Parking the Ambulance**: NYSDOH Policy Statement 89-04

**APPENDIXES**

(continued)

 20. **Guidelines to Follow in Case of an EMS Vehicle Collision**: NYSDOH

 Policy Statement 01-07

 21. **EMS Mutual Aid**: NYSDOH Policy Statement 95-04

22. **Transition of Care**: NYSDOH Policy Statement 00-03

 23. **Providing Medical Direction**: NYSDOH Policy Statement 03-07;

 **Providing Medical Control**: NYSDOH Policy Statement 95-01

 24. **Quality Improvement Program**: Article 30, Section 3006 of NYSDOH

 EMS service Operational Resource Guide

 25. **Physician Release Form**

26. **Frequently Asked Questions About DNRs**: NYSDOH Policy

 Statement 99-10; **NYSDOH Nonhospital Order Not to Resuscitate**

 27. **Patient Care and Consent for Minors**: NYSDOH Policy Statement

 99-09

 28. **Abandoned Infant Protection Act**: NYSDOH Policy Statement

 01-05

 29. **Requirements to Report Instances of Suspected Child Abuse or**

 **Maltreatment** : NYSDOH Policy Statement 02-01; **Form LDSS-**

 **2221-A, Report of Suspected Child Abuse or Maltreatment**

30. **NCAC Contingency Plan**

 31. **Out of Service Vehicles**: NYSDOH Policy Statement 89-14

 32. **Basic Life Support Protocols:** [**www.remsco.org**](http://www.remsco.org)

 **33.** [**www.health.state.ny.us**](http://www.health.state.ny.us)

**Nyack Community Ambulance Corps Inc’**

**251 North Midland Ave**

**Nyack, NY 10960**

**845-358-4824**

All Nyack Community Ambulance Corps Inc’ Membership and Paid Staff are required to sign that they have received and read these Standard Operating Procedure Manual and agree to accept the verbiage.