Vista Fire Department

Standard Operating Procedures Manual

Revised June 2014
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General Operating Procedures

1.1 Standards of Conduct
All members of Vista Fire Department (VFD) or the EMT-B are expected to conduct themselves at all times in a professional, courteous, and respectful manner. Members are expected to remain objective and calm in high stress situations and use 'common sense' at all times.

Sexual Harassment is any unwanted verbal or physical advances, sexually explicit derogatory statements, or sexually discriminatory remarks made by someone in a workplace or educational setting which are offensive or objectionable to the recipient, cause the recipient discomfort or humiliation, or interfere with the recipient's job performance or educational progress. Sexual harassment is a violation of law and is intolerable in either the educational or employment setting. Sexual harassment is considered a form of misconduct and sanctions will be enforced against individuals engaging in sexual harassment and against personnel who knowingly allow such behavior to continue.

Sexual Harassment, hazing and discrimination will not be tolerated. Should a patient, member, applicant, visitor or other person believe they are being subject to such behavior they should file a formal complaint in writing with the Captain or Fire Chief. The Fire Chief and the Fire Commissioners shall review the complaint and take necessary actions to resolve the situation.

1.2 Membership and Job Description

Membership requirements are enumerated in VFD's Constitution, By-Laws and Policies.

EMT-B
The EMT-B is responsible for receiving calls from and communicating with the dispatcher using appropriate radio protocols, reading maps, operating the ambulance and all ambulance equipment. The EMT-B may delegate radio operations and determination of route to a certified driver. The EMT-B must be able to effectively communicate with others; determine the nature and extent of injury or illness through appropriate questioning and physical examination; and take vital signs. The EMT-B must be able to formulate and implement a plan of care and transport within the context of the appropriate state and regional protocols.

The EMT-B must be able to appropriately use all of the following devices: the stretcher, scoop stretcher, stair chair; spinal immobilization devices including (but not limited to) cervical collars, head immobilization devices, backboards, and the KED; limb immobilization devices including splints and traction splint; oxygen delivery devices; portable and fixed suction devices; bandaging supplies; obstetrical equipment; semi-automatic defibrillator; and respiratory equipment including the bag-valve-mask, pocket mask, oral and nasal airways. The EMT must be CPR certified.

The EMT-B must know the appropriate indications, contraindications, usage, and be able to administer oxygen and any medications approved by NY state protocols. They must also know the appropriate methods to assist patients in taking their own medications.

The EMT-B must know what situations require paramedic intervention, aeromedical evacuation, and specialty hospital transport, and the appropriate methods to summon all support services.

The EMT-B must provide for protection of the patient's property. The EMT-B must be able to: communicate with the receiving hospital, transfer the patient to the staff, and provide an oral and written report on the appropriate forms; the EMT must be able to return the ambulance to a state of readiness by appropriate cleaning and replacement of supplies.
The EMT-B shall make every effort to attend all training offered by VFD and make an effort to keep current with his or her skills and new developments in the field. The EMT-B shall recertify all appropriate certifications in a timely manner. The EMT-B must be able to contact and communicate with VFD officers regarding operational issues.

**Driver**

The VFD ambulance driver will be a currently NYS licensed driver. Complete all necessary driver training pertaining to the ambulance that is required by the VFD SOPs dated February 1992 (SOP #5). All driver training will be conducted by the Chief and all those designated by the Chief. The Driver under the direction of the EMT-B will be responsible for communicating with the dispatcher using appropriate radio protocols, reading maps, operating the ambulance and all ambulance equipment. The Driver must determine the most expeditious route to the emergency and from the scene to the appropriate medical facility. The driver must be at least 18 years of age and have a driving record acceptable to the Chief. Whenever operating the ambulance, all drivers must be in possession of their driver's license.

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 other 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 inquiries must be referred to the Fire Chief. Please remember, there are strict laws regarding confidentiality, and this is a small town. All patient information (such as PCRs) must be stored in a locked area. All patient information maintained in electronic format must comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA)**

1.4 Non-Discrimination Policy

VFD 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 of the Corps must meet the standards promulgated by the New York State Department of Health, Bureau of EMS functional job description for EMS personnel.

1.5 Training, Requirements, & 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 who ride on the ambulance maintain a variety of certifications in emergency medical care and vehicle operation, and attend training sessions to ensure competency. As required by Part 800.21(J), all members will be made aware that their personnel records must be made available to the New York State Department of Health for inspection whenever requested.

Each active member shall:

1. Be at least 16 years of age, physically capable of carrying out the duties required of him or her (see Job Description), and live or work in the Vista Fire District and adjacent communities
2. Have a physical examination as specified in the VFD Fire District's By-Laws
3. Complete and pass a CPR course. CPR must be renewed as needed.
4. Demonstrate knowledge of contents and placement of all ambulance equipment and supplies. (pass the "Rig Test")
5. If a designated driver, be at least 18 years of age, complete the Corps' driver training program and be enrolled in the License Event Notification Service.
6. If treating patients, have completed and passed a New York State Emergency Medical Technician (EMT-B) or higher-level course. EMT status must be renewed as per NYS DOH requirements. EMTs who choose to renew their certification through the CME program, VFD will maintain their records. VFD recommends attending EMT classes offered at facilities that accept NYS DOH vouchers for payment. If a member attends an EMT class in a facility that requires prepayment, VFD will compensate the member and seek reimbursement from NYS DOH.
7. Attend training sessions sponsored by the Fire Department.

VFD will encourage all members to attend any additional training offered in the area. To provide incentive for members to seek additional training, VFD will provide tuition reimbursement for courses pre-approved by the Chief. EMTs should complete a Continuing Medical Education Form (CME forms can be found on the Westchester Regional EMS Council website - www.WREMSCO.org ) for each course taken. The CME form will be kept in Corps’ member files along with a copy of member’s CPR and EMT certificates, and Driver’s License.

1.6 Uniforms & Shoes
All members responding to a call are to wear VFD issued / approved shirts, jackets, vests, jump suits or pants. Jump suits, vests and pants have been purchased and issued and should be worn by members who may be unprepared for a call. If you do not have the appropriate shirt or jacket, please don the appropriate sized jacket or vest found in the ambulance. All members will wear appropriate footwear - sandals must not be worn at any time to a call. Members may wear additional pins and insignia on the uniform as long as they are appropriate and not misleading. All uniforms should present a neat and clean appearance. **All members while on calls should display identification showing VFD affiliation.**

1.7 Blue Lights
Blue lights are utilized to alert citizens of our community that VFD members are responding to an emergency. When displaying a blue light in your car, you are a visible representative of the VFD. Accordingly, whether the light is in use or not, you should drive in a safe manner. Since many drivers are unaware of what blue 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 blue lights, nor does New York State permit vehicles displaying a blue light to violate speed limits or traffic signals.

Each operational member, after having obtained a VFD identification/blue light card issued by the Fire Chief, may affix one blue light in his vehicle. The blue 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, please follow the procedure outlined in section 3.6 for accidents involving the ambulance/rapid-response unit. You are individually liable for accidents that occur in your own vehicle.

1.8 Return of VFD Property
Any VFD property issued or entrusted to you must be returned to the Captain at the time of your
resignation, dismissal from the Department, or upon request of the Chief. Although normal wear-and-tear is expected, you are responsible for any lost or damaged items at replacement cost.

1.9 Supply & Equipment Rig Check Sheets
Members will thoroughly check the ambulances 84B1 and 84B2 and their equipment and supplies at weekly Rig Check. All patient care equipment will be maintained according to the manufacturer’s guidelines. Ambulance Check Sheets, completed as part of this process, should note that the vehicle, supplies, and equipment are in order and also note any deficiencies. The Members will sign off on the completed check sheets and turning them in to the EMS Lieutenant. Where possible, the deficiencies should be corrected immediately by the member in charge of the rig check. Those not corrected immediately should be addressed by the EMS Lieutenant as soon as possible. The completed forms are kept in the Radio Room of the Dept. Members will be assigned accountability for rig checks on a rotating basis. If you cannot fulfill the obligation on your assigned week, you must arrange to swap with another member.

1.10 Ambulance Preventive Maintenance
The ambulance is inspected weekly during rig checks as described above and outlined in the Truck Report Check Sheets. Any problems or deficiencies, contact the ambulance Foreman who will if necessary inform the District Manager.

1.11 Gifts
Because of the appearance of impropriety, individual members are not permitted to accept gifts (including, but not limited to, meals, food, or alcohol) from vendors or customers. If someone wishes to donate a gift to the Dept., the gift will be sent in care of the Fire Chief of the Department. All checks will be made out to the Vista Fire Department.

1.12 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 VFD equipment and supplies for personal use. All incidents of loss of non-disposable equipment should be reported to the Fire Chief.

1.13 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 when a member is not present. Visitors are not permitted on calls, except with the permission of the Fire Chief.

1.14 Drug & Alcohol Use
The possession of illegal drugs is forbidden on VFD property. Members are prohibited from being on VFD vehicles while under the influence of any un-prescribed mood-altering drug, including alcohol. Members engaged in operational activities who appear to be under the influence of any un-prescribed mood-altering drug, including alcohol, shall be immediately suspended. Private or organizational functions on or off premises may involve the consumption of alcohol in a lawful and sensible manner, if pre-approved by the Fire Chief.

1.15 Smoking, Food, Drink & Animals
Smoking or food and drink are not permitted in the rear of any VFD vehicle. Animals are not allowed in any part of any VFD vehicle.
1.16 Suggestions
We encourage all members to submit their suggestions to improve VFD’s operation, administration, and service. Please submit all suggestions in writing to the Fire Chief.

1.17 Records Retention
The VFD will comply with the NYS DOH Policy Statement No. 08-03 and will follow the recommended guidelines & dispose of the documents appropriately:

- Administrative documents, such as meeting minutes and financial records must be retained for 7.5 years.
- Patient Care Reports (electronic or hardcopy), must be retained for 6 years or 3 years past the patient’s eighteenth birthday, whichever is longer.
- Patient care data files containing medical treatment and/or billing information must be retained for 6 years or 3 years past the patient’s eighteenth birthday, whichever is longer.
- Summary record of all patients treated and/or transported must be retained for 3 years.
- Ambulance run chronological log must be retained for 6 years after the last entry.
- Monthly or periodic reports or listings must be retained for 3 years.
- Reports containing information on subjects (not patient specific) such as types of medical emergencies, types & amounts of supplies used, call frequency etc. must be retained for:
  - Reports containing billing information - 7 years.
  - Reports not containing billing information - 1 year
- All records pertaining to controlled substances must be retained for 5 years.
- Rescue and Disaster Response Reports and related records, covering specific incidents must be retained for 3 years.

Safety and Health Issues

2.1 General Safety Rules
VFD could list thousands of safety rules and still not cover every potential situation. All safety rules can be boiled down to "Members 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 must pay heed to the following specific rules:

1. Members shall wear long pants and appropriate shoes at all times when on an emergency call.
2. Members shall wear appropriate protective equipment when dealing with bodily fluids or other dangerous conditions such as fires, vehicle extrication, hazardous materials, etc.
3. Members shall wear reflective outerwear when working on a dark roadway.
4. No member shall enter a hazardous environment such as a building fire or a confined space without prior training, appropriate safety equipment, and sufficient support services.
5. Whenever possible, EMS providers should perform patient care skills when they are appropriately restrained in a moving vehicle or when the vehicle is stopped. While in a moving vehicle, EMS providers are strongly urged to utilize the automated vital signs monitors that are available in the ambulances to obtain blood pressure and heart rate.

2.2 Safety Training
VFD will provide all members with appropriate safety training as a part of new member orientation. Safety training will also be included in ongoing training sessions.
2.3 BBP Training
Blood borne pathogen (BBP) training, mandated by the federal government, is provided for all members as part of new member orientation and ongoing training. While VFD has a separate, comprehensive Infection Control Exposure Plan, which can be found in the office at headquarters, this section will highlight some specific policies. The member is responsible for reviewing the infection control plan in detail. The single most important infection control technique is washing your hands with hot, soapy water. All members will wash their hands whenever practical before and after patient contact. As health care workers, we are exposed to significantly more infectious illnesses than the average citizen. The best way to avoid cross-contamination of VFD members is to enforce this policy vigorously.

The patient compartment of the ambulance should be wiped down with a bleach disinfectant solution after calls, as needed, and every week at Rig Checks. Wiping down the patient compartment frequently helps limit exposure to blood and bodily fluids. If you are dealing with 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. Hand washing will be required after the removal of the gloves.

2.4 Decontamination (routine)
Equipment contaminated on a call with blood or bodily fluids will be decontaminated at the hospital or upon arrival back VFD headquarters according to the Infection Control Exposure Plan. Gross decontamination of Blood Borne Pathogens may begin at the hospital destination.

2.5 Hazardous Materials Plan
VFD participates in the Westchester County Hazardous Materials Plan. VFD members are required by the federal government to be trained to the level of Hazardous Material 'Awareness' level. All members will receive initial training upon joining the Corps and participate in ongoing training. This section highlights some specific advice in the event of a call involving hazardous materials.

- 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 book and binoculars are in the door pouch of the front passenger seat door. Use them!
- Anybody who is 'down' and not moving in the "hot zone" is considered dead. Don't risk your life to drag out a body.
- Tell anybody 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.

2.6 Physical Exams, Tb Testing, Hepatitis and Flu Vaccine
Member health records will be maintained on all members who are active volunteer personnel with the VFD in the District Managers Office. This record shall include the following as outlined in the NYS EMS Program Policy Statement #88-8:

- Dates of physical examinations
- Immunization record & screening results for Hepatitis B vaccinations.
- Record of member occupational injuries or illnesses and their course i.e. compensation forms filed, physician's record, hospital record, etc.
• VFD incident report pertaining to member exposure to suspected hazardous materials, toxic products, or true exposures to infectious diseases.
• Record of physicals as required by the VFD By-Laws
• Record of physician's approval to return to active duty after debilitating illnesses or injuries.

Pre-membership health physicals and screening, as outlined in the NYS EMS Program Policy Statement #88-8 shall be required for all members beginning active service after June 1, 2002. As per VFD By-Laws, in order to maintain active membership, each member will be required to have a physical on an annual basis. These physicals will be administered by a Company that VFD has a contract with and will be offered several times a year either on the VFD premises or at other neighboring locations. Physicals from personal physicians will not be accepted.

Routine yearly TB skin testing will be recommended for all members 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 vaccine shall be offered to all riding members. Any member 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 member who has not been previously vaccinated and who refuses the vaccine shall complete a Hepatitis Vaccine Waiver. On an annual basis, VFD makes the flu vaccine available, free of charge, to all members.

2.7 Respirator Fitting
In addition to annual Tb testing, VFD wants to ensure that members are protected from airborne Tb droplets by providing each member with appropriate respirator masks. As a result, the Department mandates that all members be trained in the appropriate use of respirator masks and be fitted for the appropriate size.

2.8 Material Safety Data Sheets
In order to ensure a safe environment, VFD 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 VFD. This information is contained in a file consisting of a series of Material Safety Data Sheets, which is available in the Fire Chief's office. All members are encouraged to review the book to check for any new additions.

2.9 Member Injuries/Incidents
VFD wants to ensure that if a member is injured while performing Department duties, the member will receive prompt and appropriate medical care. As a result, the Department requires that members who are injured while on-duty immediately seek medical assistance or needs to report an incident, contact the Chief and the District Manager and provide VFD with written notice in an Unusual Occurrence Report (see Supplemental Information) as soon as possible. As per Title 10 New York State Codes, Rules and Regulations - Part 800.21(q), VFD is required to notify the NYS DOH by telephone within 24 hours of the event and in writing within 5 working days any time a member of the ambulance service is killed or injured to the extent that hospitalization or care by a physician is required or there is an incident involving a member responding or treating a patient while under the influence of alcohol or drugs. The Captain of VFD EMS will complete the NYS DOH Reportable Incident Form (Doh-4461) (see Supplemental Information) and submit it to the appropriate NYS Bureau of EMS Regional office.

In accordance with law, VFD maintains Workers Compensation insurance on behalf of the
membership. The NYS DOH will also be notified by telephone (212-417-4455) no later than the following business day and in writing within 5 working days any time there is an alleged incident that a member of the ambulance service has responded to an incident or treated a patient while under the influence of alcohol or non-prescribed drugs.

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 are covered by Workers' Compensation from their first day as members and coverage continues until the member resigns or is separated. Compensation forms are available in the Fire Chief's office.

2.11 Patient Injuries
VFD understands that besides the Fire Chief and EMS Captain and District Manager being notified, the NYS DOH (212-417-5960) must be notified by telephone no later than the following business day and in writing within 5 working days for every instance in which a patient is involved in any of the following occurrences:

- A patient dies, is injured or otherwise harmed due to actions of commission or omission by a member of the ambulance service.
- An EMS response vehicle operated by the service is involved in a motor vehicle crash in which a patient, member of the crew or other person is killed or injured to the extent requiring hospitalization or care by a physician.
- Patient care equipment fails while in use, causing patient harm. If a patient is injured because of equipment failure, a written record must be kept and documented what corrective action was taken.

The EMS Captain or the District Manager of VFD will complete the NYS DOH Reportable Incident Form (Doh-4461) (see Supplemental Information) and submit it to the appropriate NYS Bureau of EMS Regional office.

2.12 CISD Referral
VFD understands that this job can be very emotionally demanding and there are some events so stressful that operational members may have problems coping afterwards. In preparation for these situations, VFD has arranged for referral to a regional Critical Incident Stress Debriefing (CISD) team. CISD members are all volunteers who work in emergency services who have undergone 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.

2.13 Unusual Occurrence Reports
All members shall fill out an Unusual Occurrence Report (see Supplemental Information) 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, photocopy the document for your records, and submit to the EMS Captain.
Emergency Medical Response and Care

3.1 Scheduling
VFD maintains a Duty Shift Schedule. A minimum of a driver and EMT are required for the crew to respond. If a member is unable to respond to their assigned duty crew, it is their responsibility to find the appropriate coverage.

3.2 Dispatch Policy
- All requests for emergency medical response will be dispatched via pager system by the Westchester County-60 Control (60 Control). In the event that VFD or a member receives a request for emergency ambulance service by other means, the member will notify the dispatcher who will page out the call even if a crew is ready to respond. This ensures that the police sectors, dispatcher, and VFD members know that the ambulance is on a call. If a crew is already staffing the ambulance, once the pager goes off they may immediately signal that they are en route.

3.3 Due to critical importance to pre-arrival instruction and resource prioritization associated with emergency medical calls, the Westchester REMSCO urges all dispatch centers to institute the use of Priority Emergency Medical Dispatch (EMD) with a quality improvement procedure. EMS agencies authorized by the REMAC to provide ALS services will be required to be dispatched by EMD Centers effective January 1, 2013. Every EMS dispatch center operating within Westchester County shall be responsible to dispatch an ambulance to every call for emergency medical assistance unless it is determined by EMD protocol that ambulance response is unnecessary. Simultaneous dispatch of ALS services, when appropriate, is required and the use of rapid first responders is strongly recommended. Dispatch Centers should utilize the Westchester Regional Advanced Life Support Utilization Criteria when developing simultaneous dispatching policies and/or algorithms.

3.4 Response to Calls

In accordance with Section 3005-A, Article 30 of the Public Health Law, the minimum staffing for a VFD ambulance on an emergency call is one EMT and one driver. An EMT must attend the patient at all times. At no time shall a VFD ambulance respond to an emergency call when the driver is not assured of having an EMT on the scene upon his arrival. Absent unusual circumstances, no more than four members should respond in the ambulance or to the scene for an emergency call.

A crew member should respond to the scene only if:
- The member is an EMT equipped with (at least) barrier protection devices.
- The member is not needed to drive the ambulance.

At no time should members respond directly to the scene at sensitive locations designated as by the PD/FD or an unstable event such as a violent police scene.

The regional dispatch to response time interval goal (time the agency is dispatched to time the EMS unit is "en-route to scene") for all ambulance and advanced life support for response (ALSFR) services is less than 3 minutes. In the event of insufficient responding VFD EMT-B staff after an initial dispatch, the police will dispatch the call up to one more time. Upon the second page for assistance, any available and appropriate member should respond even during periods of assigned night crew coverage. If after two pages there is still insufficient staff, 60 Control will dispatch the
nearest available mutual aid service.

60 Control will dispatch ALS (paramedics) to all calls, which meet dual dispatch response criteria. In the event that paramedics are not on-scene but required VFD members shall request dispatch through 60-Control.

Our goal is to have the ambulance reach the patient within six minutes of the initial dispatch time. In the event of any delays exceeding 6 minutes from dispatch to arriving at the patient's side, the crew chief is to notify the Captain after the call.

In the event that there is another call and all Corps ambulances are on an assignment, 60 Control will follow the established Mutual Aid policy and contact another ambulance service provider. This will allow us to meet the response time standard for our community.

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

Every member who responds to a call should be listed on the driver's report. The PCR shall list all those (up to four members) who had direct patient contact and is to be filled out by the crew chief and turned in at the VFD building 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 exceed the resources currently available. In practice, when ours is the first and only ambulance to respond to an event in which there are more than two patients, that event qualifies as an MCI. (In certain cases, the severity of the injuries may necessitate a second ambulance when there are only two patients.)

In such an event, the MCI plan should be activated. Each member 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. The driver is responsible for staying with the ambulance 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 60 Control to request that Pound Ridge, or LVAC respond.

The Captain, or any officer acting on behalf of the Captain, should be notified of the MCI. You may request that 60 Control page VFD members 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 60-Control by means of the fire radio in the ambulance.
3.5 Radio Operations
All members shall keep all radio transmissions clear, concise, and professional. Standard radio communications from the ambulance to the 60 Control are:

1. En-route
2. Arrival at scene
3. Departure from scene, noting destination
4. Arrival at hospital
5. Back in service

3.6 Driving the Ambulance
Only driver certified members may drive the ambulance. All drivers shall carry their driver's licenses on their person at all times. All drivers, passengers and members shall wear seat belts at all times. Children shall be restrained in an appropriate child safety seat secured to the Captain's chair facing toward the rear.

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. Please take time to extend every courtesy to other drivers. Please re-fuel the vehicle when the tank is below ¾. Refuel the vehicle with diesel/gas at the Getty gas station. Please do not set the emergency brake when the vehicle is parked garage. When leaving the ambulance at the garage please plug in the battery conditioner. Do not forget to unplug the cord before starting up the vehicle.

Never retract the snow chains while the vehicle is in a stopped position! Do not idle the vehicle inside the garage with the garage bay doors in the closed position. If this is done dangerous carbon monoxide levels may build up and cause death or injury.

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 any accident. You may be personally liable for an accident. Your negligence could cause injury to yourself, your colleagues, your patient, and bystanders. If an ambulance is knocked out of service due to an accident, our ability to respond is reduced. Please drive cautiously. 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 situation demands it, and then use due caution.
• Please 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 along the side of 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; it is qualified and cannot be taken forcefully.
• 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 a member 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!**

• When the emergency scene is a home or building, park safely, 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; 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 or triangles if necessary. These warning devices should be placed a significant distance in advance of the accident in order to achieve optimal warning value.
• No member should be operating on the scene of an emergency on a roadway without a reflective vest or a turnout coat with reflective piping, 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 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, remember to park uphill and upwind. In a hostile situation maintain safe distance and consult police for specific instructions.
• When at the scene of an MCI, remember 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.

**Emergency Driving - Transport**

**Transport to the hospital rarely involves use of either lights or sirens.** The highest certified individual on board 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.

**Motor Vehicle Accidents Involving the Ambulance**

*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.

1. Notify dispatch immediately to request the following:
   • An officer of VFD or the Fire Chief (you should make this notification yourself)
   • The appropriate police agency
   • Any other necessary service such as Fire Department or towing service, etc.

2. If the EMS vehicle was en-route 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 5) and proceed to the call. Advise the police of this action.

3. 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.

4. 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:
   - Service name;
   - Vehicle identifier; and
   - The ambulance operator's name
   - Record the name, vehicle type, make, and license number of the other vehicle before leaving the scene with your patient.
   - If the crew has an extra person, leave him/her at the scene to begin the paperwork.

5. 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.

6. Administer patient care to any injured persons.

7. If there is no patient exchange necessary, obtain information with the 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 appropriate 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 that 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.

### 3.7 Driving the Paramedic Fly Car
In order to minimize the time that the paramedic is out of service, a member of the Corps, if available, may drive the paramedic's fly car, at the paramedic's request, to the hospital to meet the ambulance. The crew member must be a New York State license driver to drive the fly car. Since our role is to transport the vehicle to the hospital, **it must be driven without lights or siren and in compliance with all traffic laws.**

### 3.8 NYS/BLS Protocols
All emergency medical care provided by VFD shall conform to Westchester Regional EMS and New York State Protocols. Access to any protocol can be obtained on-line at [www.health.state.ny.us](http://www.health.state.ny.us) and [www.wremsco.org](http://www.wremsco.org).
1. **NYS BLS Protocol Updates - 2013**

The New York State Emergency Medical Services Council adopted the National Educational Standards to be used in NYS. All CFRs and EMTs will be tested on the new Educational Standards beginning with the December 20, 2012 exam.

All EMTs who submit for recertification on or after December 20, 2012 must provide proof to VFD that they have completed all newly developed objectives either through agency based training or training through a BEMS Course Sponsor. For the EMTs who are participating in the CME Program, NYS will supply a document for each level that will contain objectives to be covered in each course. This document will be signed by the update course's CIC and will be kept on file in the VFD's personnel files.

3.9 **Non-Emergency Transfers**

All arrangements for all transfers or transports must be made in advance through the Captain. The crew will consist of a minimum of an EMT and a driver.

3.10 **Mutual Aid to Neighboring Towns**

Because demand for emergency medical services is unpredictable and demand may occasionally outstrip resources, VFD has entered into Mutual Aid agreements with Westchester County and all neighboring ambulance service providers and neighboring police departments. These agreements require that when neighboring ambulance service providers are faced with more demand for emergency medical resources than they can provide VFD will provide a fully staffed ambulance to respond to emergencies in the neighboring area. *All EMS Mutual Aid plans originating in the Westchester Region must be developed in conjunction with the Westchester County EMS Coordinator and approved by the Westchester REMSCO.* Copies of the Westchester County EMS Mutual Aid Plan Agreement are on file in the appropriate offices. *Agencies should report all incidents of excessive Mutual Aid requests to the Westchester Regional EMS Office for review and assistance.*

Should the 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 our dispatcher, Westchester County Communications (60 Control) or the mutual aid district has ordered a paramedic response with VFD on the Mutual Aid response. If the crew is not familiar with the neighboring area, the crew may contact our dispatcher to request a police escort from the neighboring police department.

Should the Mutual Aid request be for assistance at a Multiple Casualty Incident, after informing 60 Control that we are responding, all communications should then go through 60 Control. 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 60 Control for frequency instructions.

All VFD 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.

3.11 **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. A police officer must accompany unstable or potentially unstable patients in the ambulance.

3.12 **Paramedic (ALS) Dispatch**

ALS should be dispatched simultaneously with VFD by 60 Control according to the pre-established
protocol based on call-type. A copy of this protocol is posted at headquarters. When the paramedic arrives on the scene, a crew member should guide him to the patient and give an initial report. Keep in mind that once the paramedic arrives, he becomes the highest medical authority on scene. EMTs should continue to perform BLS skills, including preparation for transport, and assist the paramedic as requested.

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 60 Control. For a major trauma patient who is not in cardiac arrest and who has a manageable airway, begin transport to the closest Trauma Center (Westchester Medical Center) 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 30 minutes of the accident. Because of our proximity to a Level One Trauma Center and availability of paramedics, aeromedical evacuation (Air Methods) should only be considered in circumstances when (a) there is no paramedic available and/or (b) transport would be faster by use of this scarce resource.

3.13 Transfer of Care

When transferring care to Emergency Department staff, it is VFD 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 (EMT-P, RN, NP, PA or MD). All the patient's belongings must be transferred.

3.14 Medical Control

VFD 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. Medical Control can be divided into Westchester Region on-line (spoken) Medical Control, and Westchester Region's and New York State's off-line (written)

- Westchester 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. Please document physician contact and hospital/physician name on the PCR.
- VFD Medical Director approves medical protocols and ensures appropriate retrospective call review. Quality assurance call review 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.
- Off-line Medical Control consists of policies/protocols disseminated by the NYS DOH BEMS SEMAC and Westchester Regional EMS Council/Regional Medical Advisory Committee.

3.15 Physician at Scene

VFD appreciates the relationship between a private practitioner of medicine and his patient. Westchester Regional EMS Protocol allows physicians on the scene to assert medical direction under certain circumstances. VFD should contact medical control and advise them that the physician at the scene has requested control. The physician must then take personal accountability for the patient and accompany the patient to the Emergency Room. Physicians must still act within the standard of care. Generally speaking, only a NYS Licensed Physician with some background in emergency medicine should be allowed to attend the patient. Podiatrists, registered nurses, psychologists, and other health care providers may assist in care
but may not assert medical direction. In the event that an on-scene physician directs the EMT to act within the scope of their duties and in accord with protocol, the EMT may comply. In the event that the on-scene physician directs care outside of the EMT's training and protocol, the physician must implement the order, utilize his own drugs and equipment, and physically accompany the patient in the ambulance to the hospital. In either situation, the physician must complete and sign a Physician Release Form (see Supplemental Information) which is kept in the PCR box on the ambulance. The completed form should be attached to the PCR.

It is left to the EMT's discretion to request that the physician produce photo identification which clearly identifies him as a currently licensed physician in the State of New York. If the EMT believes that the physician is acting in a manner contrary to the patient's best interest, the EMT should contact Medical Control and request advice.

3.16 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:

a. Attempt to gain understanding of rationale for refusal, include family whenever possible. Investigate alternatives that would be acceptable to patient. Provide all appropriate care that patient permits.

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

c. Explain reasonably anticipated consequences and potential risks of refusing care.

d. Communicate with medical control if ALS is indicated or 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.

e. Involve the appropriate police agency. The police officer should witness the patient's signature on the PCR.

f. Document the following items on the PCR:
   i. Findings (e.g. history, vital signs, physical exam, mental status, behavior);
   ii. Recommendation for follow up;
   iii. Signature of patient or guardian/proxy on PCR. If patient or guardian/proxy refuses to sign, document refusal;
   iv. Signature of independent witness not from EMS agency.

g. Ensure patient reads RMA or read RMA to patient. If the patient only speaks a language other than English, have competent bilingual third party read RMA to patient in the patient's language and document the interpreter's name. Have patient verbally confirm that he understands what the RMA says and agrees to it in the presence of the witness before signing RMA. Inform the patient about alternatives to care and inform patient that he/she can call 911 again without penalty.

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

3.17 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 for whom they were originally called. The location of the call should be reconfirmed by requesting that the police department call back the person who originally placed the 911 call to verify the location. Any bystanders should be questioned to see if they have any knowledge of the whereabouts of the patient. The requesting police department should assist with the search and if after a reasonable search, no patient is located, the ambulance crew and paramedic shall declare the patient unfounded and advise the requesting police department of same and that they are
back in service. All these measures will be documented on the PCR - including date, time dispatched, arrived and back in service, location of the call and the fact that no patient was found.

3.18 Entry into Premise
Unless there is an obvious and compelling reason, VFD EMTs will not break into premises without police or fire department assistance. If forced entry is necessary, all incidents will be turned over to the police department on the scene. All this will be documented on the patient's PCR.

3.19 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.

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 in more than one ECG lead.
- Any significant medical history or traumatic event
- Time lapse since patient was last seen alive

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.

Documentation
As per NYS DOH policy, a PCR for the call must be generated. 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 events
- Existing physical conditions which precluded performance of resuscitation efforts
- Any EMS contact with Medical Control
  - In whose custody the body was left, if a police officer, the PCR should document the Officer's name and badge number and which police department.

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

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 or not. If the Medical Examiner's Office does not authorize the removal, they will assume control 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.

3.20 DNR Orders/MOLST
VFD members shall observe and comply with all valid nonhospital DNR (Do Not Resuscitate) orders issued on the standard Department of Health Non-hospital DNR and Medical Orders for Life-Sustaining Treatment (MOLST) forms. (see Supplemental Information) 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 presented with the MOLST form, the EMT will review the form for any advanced directives for life-sustaining treatments. 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.

3.21 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 pre-hospital setting. Therefore, the crew should provide care, transport the patient to the hospital, and allow the hospital personnel to make decisions regarding advance directives.

3.22 Minors
Minors are defined as persons under the age of 18 years. Minors who have a psychological, medical or surgical emergency do 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. Efforts should be made 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 America; requesting treatment for drug abuse or sexually transmitted disease; living alone and self sustaining and otherwise ruled emancipated by a competent authority.

3.23 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. Remember 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 there be at least three crew members present. If the crew is in danger, the appropriate thing to do is retreat! Patients should be transported with a crew member of the same gender, if possible. Patients not in police custody should not be handcuffed. Patients should never be transported face down or with their respiratory capacity restricted in any way. All restrained patients must be continually monitored.
3.24 Police Custody
All patients in police custody shall be handcuffed by the police. No patient shall be transported face down. 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. Victims of significant violent crime should be accompanied by a police officer. The officer should maintain the chain of custody for all evidence. VFD members shall make due effort not to interfere with or contaminate any potential evidence.

3.25 Crime Scenes
If called to a potential crime scene and 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 and call the police. When called to a crime scene that is safe, the first priority is to provide emergency medical care and transportation. The second priority is to protect the crime scene. This means minimizing the number of crew on the scene, touching only what is necessary, wearing gloves, and alerting police to any physical evidence. Please keep both goals in mind, but remember their priority.

3.26 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:

- Document the injuries and the statements of the suspected abusers on the PCR.
- Give an oral report to the ER and the appropriate authorities describing the suspected abuse.
- As soon as the call is over, provide an oral report to the NYS Child Abuse Maltreatment. Register at: 800-635-1522.
- Notify the Captain of the suspected abuse as soon as the call is over.
- Within 48 hours of oral report, complete a written report on Form DSS-2221-A Report of Suspected Child Abuse or Maltreatment (see Supplemental Information) as instructed on the form.
- Attach a copy of the completed form DSS-221-A to the agency (yellow) 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.

3.27 Elder Abuse and other Domestic Violence Report
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 to giving an oral report to the ER 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 other tenets of confidentiality still apply.

3.28 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.
3.29 Destination
Crews should use their best judgment in selecting the appropriate hospital. When a paramedic is on the call, he or she will make the destination decision. Unstable or potentially unstable patients without paramedics onboard should be transported to the closest ER or psychiatric center. Under normal circumstances the only transportation destinations for our agency are: Norwalk Hospital and Northern Westchester Medical Center.
Trauma patients who fit the New York State Adult Major Trauma protocol should be transported to the closest Trauma Center (Norwalk Hospital) with paramedic intercept requested.

As per New York protocol, stroke patients who show no signs of trauma, should be transported to the closest Stroke Center (attached is the list of the stroke centers located in Westchester Region). Paramedic support will be requested.

3.30 Re-stocking
In accordance with the Federal Anti-Kickback Statue "Safe Harbor", the Emergency Ambulance Restocking Policy, VFD will adhere to the policy that is in effect within the Westchester EMS Region. This program pertains to all New York State certified emergency ambulances and the approved 911 receiving hospitals operating in the Westchester Region / County (see attached Appendix). It does not apply to intra-facility or contracted non-emergency ambulance transports. The Anti-kickback Statute makes it a criminal offense to knowingly and willingly offer to pay, solicit or receive any remuneration to induce referrals of items or services reimbursable by the Federal Health Care Program. The purpose of this Restocking policy is to provide a means of maintaining essential emergency medical supplies on emergency ambulances through a one-for-one exchange system with area hospital emergency departments and hospital pharmacies. Hospitals will exchange, on a one-for-one basis, certain supplies and pharmaceuticals used by participating EMS agencies on patients transported to the hospital (see attached Appendix).
Therefore, upon completion of a call the crew chief is responsible for seeing that the vehicle is returned to a state of operational readiness including re-stocking of all used supplies. The crew shall restock linens and disposable equipment at the receiving hospital or at headquarters. Crew members should also check for VFD equipment left behind at the hospital on previous calls. VFD, will restock all expired Epi pens and Albuterol at their facility.

3.31 Sharps/Red Bag
All sharps including IV catheters and vacutainers shall be disposed of in appropriate sharps containers. All items significantly contaminated with blood or other potentially infectious material should be disposed of in a red biohazard bag. The red bag should be disposed of at the hospital. All other items can be placed in the regular garbage either at the hospital or headquarters. Use common sense. (see Infection Control Plan)

3.32 Equipment Failure
Should equipment be found to be missing or non-operational during routine rig check, the crew shall immediately contact the Captain. Should State 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.
3.33 Diversions

Diversions status is a courtesy requested by a hospital in unusual circumstances. In this event the hospital will notify Westchester County 60-Control and Lewisboro PD 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 without paramedics must go to the closest hospital. For non-stable patients receiving paramedic intervention, defer to the paramedic's judgment in destination. Please 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 Westchester County 60-Control for instructions regarding destination so that adjacent hospitals are not overwhelmed.

3.34 Cardiac Protocol Updates

The 2010 American Heart Association (AHA) Guidelines for Basic Life Support (BLS) were approved by the State Emergency Medical Services Council (SEMSCO) in November of 2011 and the BLS Protocols have been updated to reflect these changes. As per this directive from the NYS Bureau of Emergency Medical Services (BEMS), VFD members training on the new guidelines will be completed by June 1, 2012. Members will be trained to "press hard, press fast and have full chest recoil and minimize interruptions of chest compressions". Compressions to ventilation ratio is 30 to 2 for one person CPR for adult, child and infant, for two person CPR the ratio is 30 to 2 for Adult and 15 to 2 for child and infant.

The Automated External Defibrillators (AEDs) that VFD have in service all have been replaced or re-programmed to meet the new standards recommended by the 2005 AHA Guidelines. The VFD AEDs are capable of treating all age groups. As per the new BLS Cardiac Arrest Protocol, "a maximum of three (3) defibrillations may be delivered at the scene prior to initiating transport". Transportation of patients will not be delayed to perform additional defibrillations. If transport is not available or is delayed, the treatment and defibrillation of the patient will continue as per the 2010 Guidelines. As per the guidelines, after the first defibrillation, CPR will begin immediately for 5 cycles (approximately 2 minutes), without checking for a pulse, before the next rhythm check and/or defibrillation.

The updated AHA Guidelines recommends that pre-hospital providers should administer aspirin to those patients who may be suffering from an acute coronary syndrome. These recommendations were added to the NYS BLS protocols (M-5) for EMT-Bs to administer aspirin to patients who are classified as "cardiac related" patients. Under the guidance of our Medical Director, Dr. Jill Waldman, VFD EMTs will be updated in this protocol by June 1, 2012 by a certified state instructor. VFD EMT-Bs will complete a written and practical exam demonstrating their understanding of the material in the aspirin protocol update. Training will be completed before the aspirin is placed in the VFD ambulances. VFD members who are currently in a NYS EMT class, will obtain this training through the class.

VFD will stock non-coated low dose aspirin (i.e. baby aspirin), supplied in 81 mg tablets. The aspirin will be stored according to the NYS Policy Statement 00-15: Storage and safe guarding of medications administered by EMT-Bs, with any other BLS administered medications and secured to the extent that a patient or child cannot gain access to it to prevent accidental or intentional overdose. The aspirin will be for patient use only. During the rig check, the EMTs will check the aspirin for inventory control and expiration dates and will notify the District Manager if the aspirin needs to be replaced or if aspirin appears to be missing.

As per the NYS protocol, before administering the aspirin to the patient, who is complaining of chest pains, the EMT-B will complete the initial assessment, obtain a set of vital signs and verify that the patient is not allergic to aspirin. The EMT-B will explain to the patient the need for the medication
and obtain patient consent. The EMT-B will ensure that the medication is not expired and will administer the correct dosage to the patient. The EMT-B will verify that the patient was able to chew and ingest the medication. The EMT-B will re-assess patient for any changes and assures that there are no immediate adverse reactions.

VFD will maintain the documentation of their compliance with the update including the attendance records, copies of all education materials, copies of all written evaluation materials and tools and documentation of any remediation. These records will be kept at the Agency so that they may be available for inspection by the NYS DOH.

The complete 2010 AHA Guidelines and the aspirin BLS protocol are available both on the NYS DOH BEMS website www.health.state.ny.us/nysdoh/ems/protocolsnew.htm and the Westchester Regional EMS website www.wremsco.org.

3.35 Suspected Spinal Injury Protocol Update
State of New York Department of Health updated the New York State Basic Life Support Protocols for EMTs and A-EMTs. These protocols were developed by SEMAC and approved by the State EMS Council and cannot be implemented until all VFD EMTs have completed the training. All VFD EMTs will be updated on the Suspected Spinal Injury protocol no later than December 31, 2008 by a Certified Instructor Coordinator (CIC) or a CLI. In the event a CIC or a CLI are unavailable, the appropriate training officer will conduct the training with the approval of our Medical Director, Dr. Waldman.

3.36 Stroke Protocol
State of New York Department of Health's suspected Stroke Protocol states that all appropriate stroke patients will be transported to a State designated stroke center. A list of appropriate stroke centers located in Westchester County is attached to the VFD SOPs. The appropriate stroke patient will be diverted only if the patient can arrive at the stroke center within two (20 hours of the onset of stroke symptoms. The VFD EMT will notify the stroke center as soon as possible that a stroke patient is being transported to their facility.

All VFD EMS personnel will be trained by a Certified Instructor Coordinator (CIC) or a Certified Lab Instructor (CLI) in recognizing the signs and symptoms of a patient experiencing a stroke. In the event a CIC or a CLI are unavailable, the appropriate training officer will conduct the training with the approval of our Medical Director, Dr. Waldman. This training will include other causes of altered mental status and how to administer the Cincinnati Pre-Hospital Stroke Scale and the care for a stroke patient. The patient will be transported to the closest hospital even if it not a designated stroke center if the patient is in cardiac arrest, has an unmanageable airway, another medical condition(s) that warrant(s) transport to the closest hospital or the signs and symptoms first began to when the patient is expected to arrive at the Stroke Center is greater than two (2) hours.

Quality Improvement (QI) Plan

4.1 Organization of the Committee
The QI Committee will work collaboratively with neighboring Agencies and a coordinating or acting hospital.

4.2 Agency QI Officers
Will be an active member for at least three (3) years of service. They will have experience in EMS education & training & be certified at least as an EMT.
4.3 Educational Opportunities
Educational and training opportunities will be offered through WREMS in the form of Call Audits and Video Conferences. In house training will also be offered.

4.4 Membership
The EMS QI Committee at WREMS will consist of one (1) member from each of the participating Agencies plus two (2) nonparticipating members plus a Medical Control Physician and with Phelps as the coordinating Agency.

4.5 Rules and Regulations
The QI Committee will follow those pertinent Regulations as outlined in Article 30 and Article 30a of the New York State Public Health Law. Confidentiality will be maintained pursuant to Section 3004A of Article 30. All members or their designates must attend four (4) out of the six (6) scheduled meetings. PCR's selected for review will be pulled from the beginning of the period in question in order of date as outlined in the WREMAC policy guide.

4.6 The Process
Results from QI studies will be used as follows:
- Individuals who show deficiencies in the study area will be remediated either by retraining or counseling followed by a probation period.
- General deficiencies will be corrected by mandatory training sessions either in house or through Phelps Memorial Hospital Center.
- Deficiencies found to be institutional will be corrected in counsel with Phelps Memorial Hospital Center or other appropriate Agencies.

4.7 Mandatory Regional MAC Requirements
The Westchester Regional Emergency Medical Advisory Committee (WREMAC) QI Committee will annually select topics for mandatory review by all QI Committees from the following list of events:
1. ALS Criteria Trauma Calls
2. ALS Unavailable when indicated
3. Cardiac or Respiratory Arrest/Obvious Death
4. Helicopter Request Calls
5. Hospital Diversions
6. Medical Control Order Requests
7. Patients Initially Treated by a Public Access Defibrillation (PAD) Organization
8. Pediatric Call (age < 15 years)
9. Rapid Sequence Intubations
10. Refusal of Care
11. Unconscious Patients
12. Unusual Occurrences
13. Local or Regional Focused Study

4.8 QI Reporting
The QI Committee will conduct retrospective reviews on a regular basis of all mandatory events outlined by the WREMAC, studies selected by the collaborative QQI Committee and by the Vista Volunteer Fire Department Ambulance Corps Officers.

WREMAC forms will be used when appropriate and similar forms will be developed as needed for local studies.
Results of QI studies will be reported to the Agency's membership at monthly meetings and in the form of an annual report to the Officers outlining reviews and results for the past year and for future studies. Written summaries will be sent to the WREMAC office biannually.

4.9 Parameters for QI

The QI Committee will review the following criteria on a regular basis:

- Time interval from the time of call for help is placed to the time of dispatch of emergency services.
- Time of response to the scene.
- Time patient contact is initiated.
- Effectiveness of patient assessment and accuracy of presumptive field diagnosis.
- Appropriateness and effectiveness of pre-hospital medical care.
- Compliance with existing triage, treatment and transport protocols.
- Appropriateness of scene time.
- Appropriateness of patient transport procedure and destination.
- Continuity of pre-hospital to hospital care (e.g. communication, transfer of care, etc.).
- Accuracy, legibility and completeness of PCR and all related documentation.
- Internal and external customer feedback.
- Efficacy of care.

Review Procedures will include:

- Retrospective review of PCRs and complaints
- Concurrent or real time review which could include field observations or on line medical control.
- Prospective review measuring future events against predetermined parameters.
Vista Fire Department

Contingency Plan

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1. Failure of pager system
2. Failure of radio communications
3. With 60 Control
4. With Hospitals
5. Failure of overhead garage doors
6. Ambulance out of service
7. Inclement Weather Plan

Failure of Pager System
In the event of pager failure:
1. The Fire Chiefs will be contacted. Available mechanisms to contact officers include: home & office telephone, cell phone, and home visit.
2. The Chief’s Office will contact the authorized pager repair company and request immediate response.

If the pager system is inoperable, the VFD operating officer in charge shall contact all duty personnel (and additional personnel for redundancy) and shall determine how these crew members may be contacted to respond to a call. The Officer shall inform 60 Control who the Crew Chief is, and how the crew chief may be contacted. The Crew Chief shall be designated as the person to receive the initial call for ambulance service, and the Crew Chief shall then inform the other crew members using a telephone tree. Or a standby in quarters for the designated crew will be requested by the Ambulance Captain or Fire Chief.

Failure of Radio Communications
With 60 Control
Should radio communications fail with 60 Control, we may endeavor to utilize the ambulance cell or alternate fire radio frequencies. We may contact alternate dispatch centers, such as State Police or neighboring towns.

With Hospitals
Should radio communications fail with the hospital, we may endeavor to utilize a cell phone to directly contact medical control or the receiving hospital.

Failure of Overhead Garage Doors
Should the overhead garage doors fail to operate electronically, crew members may manually open the doors using the pull chain located on the side of both of the doors. This mechanism may also be used to close the doors. The Senior Operating Officer shall be notified by the crew, and arrangements made by the Officer to have the door fixed promptly. A conspicuous note shall be left for other volunteers, so that the condition of the doors is clearly communicated.

Ambulance Out of Service
In the event one of our ambulances is out of service (for any reason), the Captain or the Officer in Charge and the Fire Chief shall be promptly notified by the crew member discovering the outage. The Fire Chief and 60 Control shall be promptly notified by the Captain or the Officer in Charge, and arrangements made for mutual aid coverage through our neighboring services. An "out of service" sign will be displayed on the dashboard of the ambulance in question.

Inclement Weather Plan
In the event of inclement weather that threatens public safety or integrity of infrastructure, the Fire Chief shall coordinate incident planning with local authorities such as 60 Control, LBPD. Such weather
conditions may include: drought, heavy rain or flood, ice, snow, high heat, etc. Examples of anticipated actions may include standby at headquarters or another centralized location, and use of alternate vehicles (ie. industrial Town truck) for access through high water or snow.

**MCI Plan**
In the event that VFD is called upon to respond to a large-scale MCI outside of our jurisdiction, members shall assemble at our building and the senior officer shall determine which members shall respond on the call, how calls within our jurisdiction will be handled, and what equipment / apparatus to assign.

Small scale MCIs outside our jurisdiction will usually require a response from the duty crew and ambulance to the scene. Once again, all members should meet at the headquarters building prior to a response outside our community.

For MCIs within our jurisdiction, the first arriving crew shall establish incident command and assess / request additional resources. Subsequent responders may respond to the scene directly, though arrangements should be coordinated by field personnel to acquire any supplies from headquarters that may be needed at the scene.

**Building Equipment Cache**
- Spare Portable Oxygen Bottles
- Spare large oxygen bottles
- Backboards