MORGAN COUNTY AMBULANCE SERVICE

1000 EAST RAILROAD

FORT MORGAN, COLORADO

POLICIES, PROCEDURES AND PROTOCOLS

MANUAL

MORGAN COUNTY AMBULANCE SERVICE

1000 EAST RAILROAD

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APPENDIX FOR
POLICIES

MORGAN COUNTY AMBULANCE SERVICE

Mission Statement:

The members of Morgan County Ambulance Service are dedicated professionals who desire to provide the citizens and visitors of Morgan County the best pre-hospital care possible. Our goal as pre-hospital care providers is to do no harm and in doing so, always remembering it's what's in the best interest of our patients that's important.

Our philosophy towards patient care is one of appropriateness. We shall strive to be appropriately conservative, yet appropriately aggressive when the situation calls for it. We realize that every intervention, primarily pharmacologic and procedural, has risk for complications. Thresholds for action must correlate to the degree of acuity, taking into account the benefits to the patient verses risks of the intervention.

We pledge to be diligent in our training, always striving for optimum skills and accuracy and for making sound judgments, without jeopardizing patient outcomes.

Through teamwork and mutual respect amongst ourselves, other agencies and hospitals, we proactively look to the future of our profession, always adapting and changing, being the best that we can be.

INTRODUCTION

The contents of this manual include the Policy and Procedures set forth by the Morgan County Ambulance Service Administration. They will be inferred as written in conjunction with the Policy and Procedures of Morgan County Government as a whole.

Although certain policies are provided in this manual, those policies are provided as a guideline. It is expressly not intended that these policies shall cover all of the employment questions that may arise during the day to day operations of Morgan County Ambulance. Management expressly reserves the right to deviate from the policies set forth herein in order to best serve the citizens of Morgan County. This right must, of necessity, be reserved to the management of Morgan County Ambulance.

NOTE: Anyone knowingly and intentionally withholding information about violations of these or any other policy of MCAS will be considered to be concealing information, and will be subject to disciplinary action up to and including termination..

HIRING PROCESS

All applicants interested in obtaining a position with Morgan County Ambulance Service must submit a completed application. The application can be obtained at http://www.co.morgan.co.us/JobOpportunities.html. All applicants must meet and maintain all employment requirements. Any individuals who are already employees of Morgan County Government, unless exempt, are not eligible for ambulance service hire. Anyone who accepts a full or part time position within the Morgan County Government while on the ambulance service will forfeit their position within the ambulance service organization immediately upon your new start date. The aforementioned does not apply if you are someone who's considered an exempt employee or an elected official, seeking ambulance part time status.

Age: To be considered for hire one must be at least 20 years of age or, 18 years of age if in the cadet program for a minimum of one year, and are in good standing with the service having completed a state approved EMT course, and able to present a current state of Colorado EMT certificate.

Certification and Eligibility Requirements:

1. Current Colorado issued EMT certification and BLS
2. EMT P and EMT I must also have ACLS, and PALS.
3. Within one year of hire be able to provide documentation of completing a neonate resuscitation program course (NRP), advanced burn life support course (ABLS), and Pre hospital trauma life support (PHTLS)
4. Maintain a valid Colorado driver's license, agreeing to a biannual driving record review by the ambulance service. Reporting immediately any suspension of ones driving privileges.
5. Acceptable criminal background check

Applications will be forwarded to the Director and the hiring committee for review. A testing process will take place at the discretion of the hiring committee based on the needs of the service. If an applicant has been approved by the Director and/or hiring committee for hire, references will be checked as well as a criminal background check, driving record check and a pre-employment physical. All of which must be satisfactory prior to employment.

All applicants are subject to successfully completing the FTO program within a six-month for Part-time and three-month for Full time period of employment. Anyone who fails to meet the minimum requirements while in the FTO program could result in termination or an extension in the FTO program for remediation.

Any one who has received funds for education from Morgan County Government or organizations within the government service including the ambulance service, who fails to complete the FTO program, who drops out of or fails to complete a course for which those funds were intended, will be required to repay the funds in full within a six month period

EMPLOYEE HIRING REQUIREMENTS
Field Training Program (FTO)

PURPOSE:
To establish a two phase process that will give all new employees an opportunity to first familiarize themselves with the operational expectations of the service, followed by an evaluation program designed to assess their knowledge and capabilities in the EMS field as well as to make recommendations favoring or opposing their retainment on the service through a six month field training program (FTO).

REQUIREMENTS:
All newly hired employees who have not been with the service either as a part time employee or cadet for a minimum of one year must successfully complete both phases of the following evaluation process. This process will only commence after they have completed the orientation class and driving instruction.

Phase One- ***Third Seat***
New hired employees should ride as a "third seat" with a supervisor for their first three twelve hour shifts of employment. Each shift should be followed with a "third seat" evaluation form filled out and signed by both the supervisor and new employee. Failure to have these forms filled out, and/or unacceptable evaluation could require additional rides.

NOTE: Riding "third seat" means the new employee should occupy the front when there are no patients on board, and in the back assisting with patient care during transports. Supervisors will be providing operational information when not with a patient and patient care expectations during transport. Anytime the ambulance is enroute "routine" somewhere, an inexperienced new employee should be encouraged to gain experience driving during this period of evaluation. (Routine only)

Phase Two- ***Field Training Program***
Upon successful completion of phase 1, the newly hired employees will be assigned shifts with a FTO. Employees should be evaluated on their patient care abilities first, followed by their adaptation to the operational policies of the service.

Evaluations:

1. Employees will be required to have their preceptor fill out a patient care evaluation on them immediately following the required calls for each category listed below in order to receive credit for the call.
2. The FTO will be responsible for immediately filling out the evaluation and providing feedback. The evaluations must reflect competency in order to count towards the required number of calls for that category.
3. Employee's are required to successfully complete the required number of calls for each category or be scenario tested which showing competency before the can be discharged from the FTO program.
4. Employees will complete the FTO program by either patient care evaluations or scenario testing.
5. An extension in the FTO program of not more than three months may be granted before considerations will be made as to whether or not their services as an employee will be retained.
6. Exceptions to the amount of time spent in the FTO program, and its degree of intensity will be on a case by case base for those (1) hired with a minimum of five years experience or (2), known to the Director or Physician advisor to have the adequate skill set to forego the process..

7. Employees who aren't able to successfully complete the FTO program will be released for employment.

NOTE: **A detailed description of the field-training program can be found in the field training policy.**

JOB DESCRIPTIONS

A. EMT Basic- Follows functional job description from EMT-Basic course outline and any job descriptions set forth by the Director and Board of County Commissioner. Acts within the guidelines of 6CCR 1015-3
B. EMT Intermediate- Follows functional job description from EMT-Intermediate course outline and any job descriptions set forth by the Director and Morgan County Board of County Commissioner. Acts within the guidelines of 6 CCR 1015-3
C. EMT Paramedic - Follows functional job description from EMT-Paramedic course outline and any job descriptions set forth by the Director and Morgan County Board of County Commissioner. Acts within the guidelines of 6 CCR 1015-3
D. Operations Supervisors – Follows job descriptions for their level of certification and job description as set forth by Director and Morgan County Board of County Commissioners. Acts within the guidelines of 6 CCR 1015-3
E. Administrator/Director - Appointed by the Morgan County Board of County Commissioners
F. Agency Assist Paramedic – Follows job description

Note: See individual job descriptions for those listed above

DIRECTOR:

Follows functional job description outlined, set forth by the Board of County Commissioner. Acts within the guidelines of 6 CCR 1015-3

The Director is responsible for the daily operations of the MCAS functioning within the approved budget. The Director reports directly to the Board of County Commissioner and is the highest point in the chain of command on all phases of personnel operation with full authority to hire, dismiss, assign, and discipline employees The Director shall bear full responsibility for such decisions within the rules of the County Personnel Manuel.

REQUIRED CERTIFICATION

All levels must maintain their state certification to the level required by the State of Colorado. If a EMTs states certification expires, the EMT will be suspended until documentation is provided showing their current. Re-certification must be obtained within a two month period or the EMT may be subjected to termination. Employee's who repeatedly allow any of their certifications to expire may face termination.

The following are required certifications: (In addition to NIMS see protocol)
EMT-B – BLS, **EMT-I –** BLS, ACLS, PALS, **EMT-P** – BLS, ACLS, PALS. All ALS responders must provide proof within one year of being hired that they've certified at least once in NRP, ABLS, and PHTLS.

Note: Any mandatory training above and beyond pre-employment requirements and/or certifications may be paid for by the service. Each request will be considered separately. The service however may choose to:

1. Pay for these training courses in advance requiring re-payment if the course is not successfully completed.
2. Reimburse the employee within a thirty day period the costs of the course following evidence of course completion.

NATIONAL INCIDENT MANAGEMENT SYSTEMS
NIMS

All staff must have NIMS training, which was mandated by the Federal Government post 9-11, it states that failure to comply will result in a disqualification of the sponsoring service, group or organization from all Federal and State Grant opportunities. Therefore MCAS staff is required to have the **IS700** the **IS-100** and the **IS-200** completed within three months of hire, **no grace period** for failure to complete. Failure to complete the training will result in a suspension without pay until completed or 60 days, at which time a recommendation for termination will be made to the director.

The NIMS training is available on line and is self directed. The instructions to completing the NIMS training is as follows: To get on line go to www.training.fema.gov

1. Click on "Training and Education" (Top left)
2. Click on "On line Training"
3. Click "OK"
4. Click on "IS Training and Courses"
5. Click on (under #2) FEMA Independent Study Program course list
6. Click on "Our Courses" (to the left of the page)
7. Scroll down to the appropriate training site.
   - IS-700 National Incident Management Systems (NIMS) Introduction
   - IS-100 National Incident Command
   - IS-200 ICS Fro Single Resources and Initial Action Incidents
8. Complete the training and post test answer sheet.
9. Once you've completed the test, scroll down and submit
10. Results will be within 48 hours. Provide a copy of the completion conformation to the MCAS administration.

In addition to these the supervisors need to take the **IS-300** . Neither is on line and both are multiple days of class room training.

EDUCATION

CONTINUING MEDICAL EDUCATION

All EMT's are required to maintain their certificates. In house or local training is provided throughout the year at no cost to employees. Employees may also request to attend courses out of town. Tuition reimbursement for classes needs prior approval from the Director and will be on a case-by-case basis after 1 year of employment, unless otherwise approved. All requests must be received one month prior to the early registration deadline in order to be considered for MCAS payment of the class.

ADVANCED LEVELS OF TRAINING

Employees are encouraged and supported to receive advanced training. Individuals interested in receiving advanced training should consult with the Director for available opportunities. There are some classes that you will need the Physician Advisors approval as well.

MCAS may reimburse for any training that is successfully completed, i.e. IV training, EKG interpretation, EMT-I classes, Paramedic classes, BTLS, etc., for those EMT's who have been on the service for a minimum of one year uninterrupted by leaves of absences or disciplinary reasons and who are in good standing with MCAS. Classes must be pre-approved by the Director and possibly the Physician Advisor. Once you've completed the training, you may be obligated to repay the service via actual hours worked. Failure to repay the hours will require you to pay back any funds outstanding regardless of termination or resignation.

Items paid for may include tuition, registration, fees, books, etc.

SKILLS

Yearly skills reviews are required in order to ensure employees are proficient with equipment and the protocols.

Recruiting, Selection and Promotion

Recruiting, selection, and promotion of County employees shall be based on the candidates or employee's relative ability, knowledge, skills, and qualifications to successfully complete the requirements of a position. Department Heads and Elected Officials are responsible for applying these principles to the recruiting, selecting, and advancing of candidates and employees.

A vacancy may be filled from within a department or candidates may be limited to existing County employees. If public recruiting is used, qualified applicants may be attracted by use of private or public job recruiting services, public advertisements, posting of notices, or any other method reasonably calculated to attract qualified applicants.

Any applications shall be reviewed on the basis of the above principles. Tests, interviews, references, and other reasonable selection processes may be used to determine the most qualified

CONDUCT

All MCAS employees are subject to the conduct guidelines outlined in the county personnel policy handbook under VIII. CONDUCT AND EMPLOYEE DISCIPLINE.

In addition, members of the Morgan County Ambulance Service will be held to the highest of standards. Members of this team work in a "high profile" and respected position within the community which demands the highest level of integrity and honesty. Knowingly and or intentionally creating deception in an attempt to cover up facts will not be tolerated and will meet strict sanctions, up to and including termination.

EMS personnel encounter people who are at vulnerable times in their lives and therefore MCAS demands they be treated courteously, professionally and with the up most of respect. We must do everything in our power to protect their privacy, their dignity and their personal effects. We must also do what we can to protect their physical and emotional well being (DO NO HARM!)

Appearance and personal conduct will always be held to the highest of standards as it's a direct reflection on the entire service.

Off Duty employees of the ambulance service will be subject to the Conduct Policy if representing themselves as employee's of the service. This includes but is not limited to the wearing of ambulance uniforms or those displaying the EMS logos, or anything else that indirectly identifies you as a member of the MCAS.

Wearing full or, partial uniforms off duty or, carrying an ambulance issued portable radio should be done discreetly and is strictly prohibited in places where alcoholic beverages are sold. If you're in service or, "on call" and are in places where the public gathers and plan on responding to calls, be very discrete limiting the amount of attention drawn to you. Perception is reality and we must maintain a professional image at all times.

The use of emergency signaling equipment on privately owned vehicle will be strictly enforced per the Vehicle Operations policy (see pages 30 – 31).
NO EXCEPTIONS! A first time offense will be grounds for an immediate termination.

GIFTS AND GRATUITIES

Patients are billed for services rendered. If gifts or gratuities are offered for individual services, they should be graciously declined. If they persist, refer them to the Director and/or advise them they're welcome to make a donation to the service as a whole. Accepting individual gratuities is strictly forbidden.

GUESTS

Family, friends and significant others are welcome to visit on duty staff at each of the stations provided that all crew members are in agreement. Should the crew have to respond on a local call, "family members" are welcome to stay a short time awaiting their return. Children under the age of 14 years should not be left unattended at anytime and should stay within the crew quarters.

VISITING RULES:

Note: Cadets, and/or 3rd riders are not considered visitors but are required to depart by 8 pm unless on a call. Should this be the case, they should leave immediately after their return. 3rd riders are not permitted on Sundays.

1. No one (other than helicopter pilots awaiting the return of their crew members), will be permitted on the premises after 8 pm. This includes, off duty staff, third riders, family, friends, law enforcement (who aren't on official business) or, other visitors. Crew members violating this policy will be subject to disciplinary actions.

5. Sleeping areas – The two bedrooms at station one and the one at station two are absolutely off limits to everyone except the on duty crew member assigned to that area (no exceptions). Anyone violating this policy will be subject to disciplinary action up to termination.

6. Off duty personnel - coming from out of town who are scheduled to work the following day are an exception to all of the above (except of #5). Personnel staying overnight will be expected to cover any "all calls" this includes long distant transfers if no one else is available during this time period.

EXCEPTIONS:

Exceptions to the foregoing may be granted, on a case by case basis, by the Director.

Personnel attending trainings or other sanctioned function of the MCAS including administrative duties are exempt from the aforementioned guidelines with the exception of rule number 5.

Visited employees are responsible for all damages caused by their guests. Visited employees are also responsible for cleaning up after any guests.

NOTE: Morgan County Ambulance Service <u>will not</u> assume liability for injuries of any guest that are caused by poor judgment, horse play or things out of the control of the service.

CELLULAR PHONES

NOTE: Personal home or, cellular numbers of MCAS employee's are not to be given out unless you are absolutely positive the person making the request is a close friend or relative of the crew member. (No exceptions).

NOTE: Cellular phone use while driving an ambulance is also strictly prohibited unless; it pertains to ambulance operations and can't be avoided, this includes texting.

If you choose for the purpose of convince to use your personal cell phone for ambulance service business while on duty you may do so. However you are by no means required to do so. If you chose not to use your personal phone for ambulance service business while on duty you must notify your supervisor and the director.

CHAIN OF COMMAND

Questions, concerns or issues that relate to ambulance operations and or the safety of the crews must follow this chain of command. If the issues are unresolved, a meeting will be set up at the next higher level in the chain of command before proceeding any further. Contacting the Board of County Commissioners without following this chain of command will not be permitted and is grounds for immediate termination. If the issues or concerns are with the director, a meeting with the department of human resources within the county should be made.

Prior to taking matters up the chain of command, each of us have a personal responsibility of trying to work things out on our own, with all others involved. This should be the first step in problem resolution. If unsuccessful, follow the chain of command.

If there are problems or disputes with other agencies involved with a call for service, it should be reported in writing to the Supervisor. If the Supervisor feels it is necessary they will report it to the Director. If there are problems with equipment, ambulances, etc., report it to the Supervisor along with filling out a incident report.

Note: At no time will it be acceptable to leap frog the chain of command or to contact another departments officers/chiefs, commissioner etc. prior to contacting a supervisor or the director. This will result in disciplinary action.

Board of County Commissioners: Elected officials who oversee all departments within the county government**.** All department heads report directly to this board.

Medical Advisor: All EMT's are working under the extension of the Medical Advisor's license. The Medical Advisor has the final say as to whether or not EMT's will be allowed to work under his/her license. Anyone he/she refuses will not be permitted to work for MCAS. Protocols violated or patient care issues will be reported to the Medical Advisor.

Director: The Director is appointed by the Board of County Commissioners and is responsible for the daily operations of the ambulance service. The Director has the authority to oversee and to make decisions as needed in regards to all activities of the ambulance service including patient care issues.

Paramedic Supervisors: The Paramedic supervisors are responsible for co-coordinating all daily activities which include overseeing shift scheduling, daily duties and responsibilities of other crewmembers, coordinating any out of town transfers, reviewing reports for quality assurance, delegating duties to other crew members, acting as a liaison and ambassador of the service when in the public forum, handling any crew member disputes and/or public complaints, and issuing any disciplinary action they deem necessary as well as, overseeing the daily activity and response for service, requesting additional resources when necessary. The supervisors also have the responsibility of maintaining adequate stock of supplies and coordinating vehicle maintenance through the county shops. ALL EMT's must act within the MCAS protocols.

Shift Supervisor: In the absence of a Paramedic supervisor, the appointed shift supervisor is responsible for co-coordinating all daily activities which include overseeing shift scheduling, daily duties and responsibilities of other crewmembers, coordinating any out of town transfers, reviewing reports for quality assurance, delegating duties to other crew members, acting as a liaison and ambassador of the service when in the public forum, handling any crew member disputes and/or public complaints.

ALS Personnel: The first ALS staff to arrive on the scene is responsible for overseeing patient care. They will perform ALS responsibilities as needed otherwise assist other personnel in providing care. They're also required to provide constructive educational feedback to others with less training and/or experience which includes all third riders who are due a clinical rotation.

BLS Personnel: Are responsible for duties assigned by ALS care givers, Supervisors and/or the Director as they pertain to patient care issues as long as it falls within their scope under the acts allowed. They will also be responsible for being familiar with all ALS equipment and supplies to lessen confusion and chaos on scenes. BLS personnel will also be responsible for providing constructive education feedback to those less trained and any third rider performing a clinical ride along.

DRESS CODE

I. **APPEARANCE**

A. Long hair (shoulder length or >) must be appropriately kept confined or put up while running calls to reduce the risk of it being grabbed. Styles and color are subject to approval by the Director.

B. Facial hair must be neat and well groomed and of natural color.

C. Earrings must be the post type. No hoops or dangling types are acceptable. No jewelry may be worn in piercing other than ears while on duty. Necklaces shall be a single chain and remain inside the shirt.

D. Personal hygiene - While "in service", you should be neat, clean and free of body odor. Strong fragrances including aftershaves and perfumes may be displeasing to others and should be avoided. Supervisors may ask for fragrances to be removed.

II. **UNIFORMS -** All uniform apparel must be neat, clean and wrinkle free.

A. Duty shirts will include a uniform type shirt which, when worn must be tucked in while on calls. A navy blue approved uniform sweater, MCAS navy blue sweat shirt and MCAS pullover for winter months can be worn. Under shirts, other than the MCAS shirts must be free from all graphics unless otherwise approved by the Director.

A. Pants should be clean, neat, and should fit well. The issued uniform pants (or others approved by the director) should be worn when on calls, standbys or other scheduled events.

D: Coats and hats displaying the approved MCAS emblem may be worn at any time. Coats or hats displaying anything other than that approved by management cannot be worn.

F. When responding to an all call off duty or as a first responder, try to wear something that identifies you as MCAS personnel. (A good idea is to leave a T-shirt or jacket in your car at all times).

B. Only (black/dark blue) closed toe shoes or boots can be worn while on duty.

UNIFORM ALLOWANCES

Full Time Staff – Upon hire, each employee will be issued the following:

3 uniform shirts
2 Pair of uniform pants
1 Office Key

Each year (January) there after the employee's will be given a $250 uniform allowance reimbursement that may be used for any of the above or, if items above aren't needed, employee's may select to purchase boots/shoes, belts, MCAS sweat shirts, hat etc, approved by the director. Employee's may carryover amounts not used up to a total of $400.00

Part Time Staff – Upon hire, each part time employee will be issued the following:

1 uniform shirt
1 Pair of uniform pants
1 Office Key

Each year (January), there after each part time employee will be allowed $75 to use for the purchase of any MCAS issued uniform apparel. Other allowances may be considered on a case by case basis for additional uniform needs. Employee's may carryover amounts not used up to a total of $200.00

NOTE: All issued items must be returned upon termination.

DISCIPLINARY ACTION POLICY

Disciplinary action may be taken against any employee who violates the rules and standards of this organization as defined in the policy and procedures manuals as well as the policy standards of Morgan County Government. The authority for initiating disciplinary action is that of the Director and the on duty supervisors appointed by the director of the ambulance service. This does not include "Acting Shift Supervisor"

MCAS will utilize, but is not limited to, a four part disciplinary notification system that may consist of a verbal warning followed by subsequent written notices dependent upon the severity of the infraction. Written notifications will require two administrative signatures, witnessing consult. Each notice will result in of one of the following actions being taken, a verbal warning, a written warning, a suspension, a dismissal, or other actions. Each warning will be accompanied by a timetable for improvement which must be satisfied within the allotted time frame. Failure to improve could result in further disciplinary actions including dismissal.

VIOLATION KEY:

The following categories may be used as identifiers for disciplinary actions and are independent as to their severity of infraction.

1. Attendance
2. Tardiness or leaving early
3. Unexcused absence from work and/or mandatory training/meetings
4. Substandard work
5. Suspected to be under the influence of drugs or alcohol while at work
6. Carelessness
7. Violation of policy, procedures and/or protocols
8. Willfully damaging equipment or materials
9. Threatening, presenting a danger or violence while at work
10. Unfit for duty
11. Insubordination
12. Violation of safety rules
13. Working on personal matters which are interfering with work duties
14. Unsatisfactory behavior towards others
15. Behavior that could reflect negatively on the service
16. Other

Employee's who receive a disciplinary notification will be given an opportunity to explain themselves and the events that surround the complaint. Employees, who rebut the actions taken, may do so in writing within 24 hours. Suspended employees will not be excused from mandatory training, certification renewal or meetings.

Violation of protocols pertaining to patient care issues will not only be subject to internal notifications and possibly disciplinary actions, but will be presented to the physician advisor. The physician advisor may choose to evoke further disciplinary actions, from remediation up to and including a suspension of one certification. Patterns in protocol violations may result in the employees' re-enrollment in the FTO program and could require additional clinical hours followed by competency exams.

QUALITY ASSURANCE

Quality assurance (QA), programs with MCAS are designed to be used as an educational tool as well as a method for tracking protocol compliance. It's also a value part of the administration for funding, ensuring adequate information is provided for billing purposes.

The QA process is a four part system of reviewing every report that's generated. QA starts with the on duty supervisors for the purpose of insuring billing information is adequately documented, and the director who will also access protocol compliance and patient treatment modalities. Other important aspects of the QA process is reviewing, en route and on scene times, transport destinations, appropriate personnel, and many others.

While it's difficult to be critiqued for the work that we do, the QA process should never be thought of a punitive (unless it's deemed necessary by protocol violation or safety issues). The QA program is designed to be an opportunity for education at all levels. The information someone puts into a trip report is what will be used in a court of law either against you, the service and/or your patient, or for you, the service and/or your patient. Therefore diligent effort must be made in making each report a clear and concise record of the events as well as treatment and the patient's response to those treatments. Valuable experience and education can be extracted from QA and thus should be looked upon as a tool of educational opportunity.

EMPLOYEE EVALUATIONS

PURPOSE:

As per MCAS policy all employees are subject to an annual evaluation process. To obtain the most effective and objective perception as to each employees participation in the missions of the MCAS, we've developed a evaluation process that identifies items which best reflects the many aspects of our job, the medical as well as the operational responsibilities of each employee. The line item approach breaks down these aspects of the positions and allows each employee to be categorically assessed, whereby making it easier to identify areas of exceptional performances as well as pinpointing areas that need improvement.

PROCCESS:

New employees (full or part time), will be evaluated at 6 months and again at one year followed by an annual evaluation. Full time employees will be evaluated every 12 months.

Evaluations will be distributed by MCAS management. Employees will be required to fill out an evaluation on themselves. Failing to complete evaluations, will result in a deduction off the employee's overall score. Scores will be averages to compute the overall score.

Evaluations will have a due date. It will be required that all evaluations be turned into the ambulance administration on or before that date. Evaluations received after the due date will not be considered and again result in a deduction for the delinquent evaluators score.

When filling out the evaluation, score each line item in a manner you feel appropriately identifies the employee's abilities to meet that objective. Score the evaluation as follows:

1. Scoring a "U" means you're unable to make an assessment due to a lack of knowledge or personal involvement and or interaction with the employee as it pertains to that line item.
2. Scoring a 1 means - you feel the employee falls below the standard
3. Scoring a 2 means - you feel the employee may meet the standard on occasion but is inconsistent with meeting the standard expectations
4. Scoring a 3 means - you feel the employee consistently meats the requirement
5. Scoring a 4 means - you feel the employee exceeds the standard
6. Scoring a 5 means - you think the employee exhibits exceptional performance with this expectation.

NOTE: If you give yourself a score of "1" or a "5", you must also provide comments to support your perception. Failing to provide comment will reflect poorly on your personal evaluation.

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EVALUATION REVIEW:

Upon completion of each evaluation, the employee will meet with the director and or supervisors to review the evaluation. The employee will have an opportunity to agree, or disagree with the results and or comments provided. This may or may not have a direct effect on the final evaluation. Evaluations will be kept on file and reviewed in arrears to assess the employees overall competencies and compliance with the MCAS mission.

Salary increases

Morgan County Ambulance is a nonprofit, self funded entity. One of the major goals of the service is to compensate employees at the highest level possible while still remaining finically viable. The amount of funds available for salary increases depends upon how well we all work together on controlling cost.
There are two types of salary increases

1. Cost of living allowance (COLA): this type of raise is a across the board raise it is usually calculated as a percent of your current rate of pay. The amount of a COLA increase is determined by the BOCC
2. Merit Pay: A total dollar amount will be allocated to the department by the BOCC for management to distribute as they see appropriate based on merit. Some factors that will be considered are work Ethic, support of MCAS mission, and attitude towards the job. The yearly evaluation with play a large part in merit increases.

Shift Coverage/Leave Policy

Purpose:

To maintain full staffing during periods of time off requests for PTO

Policy:

Accruals for PTO are as per county policy. All requests for time off will be submitted in writing and is at the discretion of administration as to whether or not the requests will be granted.

Requesting time off will be as follows:

PTO should be submitted with as much notice as possible with the appropriate Time off Request form submitted. Once the PTO has been submitted and approved by the director an initial notice will be sent to all part time employees of equivalent certification and the PTO will be placed in the shift calendar. After this initial notice you may sign up no matter how far in advance following the guidelines listed below. If the shift is not immediately covered subsequent notices will follow with available PTO. If the PTO has not been covered within 3 weeks remaining an email will then be sent to all part time and full time staff with equivalent certification. After an employee accepts a shift/day they need to contact the on duty supervisor so the supervisor is able to confirm all covered shifts/days and correctly document it into the shift calendar.

*****If the requested PTO falls on a county holiday it will be approved as long as coverage of equivalent certification can be obtained. If no coverage is available it will be the employee requesting the PTO's responsibility to cover.

*****Any other employee wishing to request PTO during another employee's granted PTO may be granted the PTO, as long as coverage of equivalent certification can be obtained after the initial request is filled, does not involve additional overtime, and is approved by the director. As long as the shifts are covered additional PTO may be permitted.

- Multiple people requesting the same shift/day off will be granted on a seniority basis. Seniority will be determined by the employee's date of hire.

*If you are requesting PTO on short notice (**less than two weeks** from shift/day) the supervisors will attempt to find coverage however, if no coverage is found it is the full time employee's responsibility to cover it, except in cases of illness, injury, or a family emergency.

Listed below is how picking up shifts works:

- Shifts can be picked up on a first come basis, with these exceptions.
  A: Part time has preference over full time, if a BLS shift BLS will have preference over ALS and vice versa.
  B: 24 hour coverage has preference over 12 hour.
  C: Regular time has preference over overtime.
- After you have accepted a shift, and you are not able to cover, you have to find coverage or cover it yourself. Of course sickness or emergencies are exceptions to this.

LEAVE OF ABSENCE:

Employees may be granted personal leave without pay for such other reasons and under such conditions and circumstances as the BOCC deem appropriate. Conditions imposed on a discretionary personal leave may include (a) continuation of health benefits at the employee's expense and (b) a limited commitment on the County's part as to restoration of employment at the expiration of the leave.

The employee will be required to exhaust all accumulated PTO, grandfathered sick leave, and other leave as a condition of receiving personal leave without pay. Except in cases of military leave and other applicable legal requirements, PTO leave accruals shall not continue during such leave. An employee may not use more than forty (40) hours of personal leave without pay during a twelve (12) month period from their anniversary date to anniversary date. In granting additional personal leave without pay, each case shall be considered individually. The employee's job performance record, employee's attendance record, and the needs of the particular department may be considered in acting on an unpaid leave application. A written request and supporting documentation may be required, at the discretion of the department head and/or Elected Official, if appropriate, and BOCC . All such leaves must be approved in writing by both the department head and/or Elected Official, if appropriate, and the BOCC before they become effective. If the employee fails to return to work on or before the date that the leave expires, or fails to provide supporting documentation or respond to additional requests for documentation supporting the need for continued leave, the employee shall be deemed to have terminated his or her employment with the County.

SEXUAL HARRASSMENT

Per Morgan County policies, at no time while engaging in work or activities associated with Morgan County Ambulance Service will any type of sexual harassment be tolerated. Any activity that may be perceived as sexual harassment will be investigated. This includes but is not limited to inappropriate physical contact between personnel, or any gestures, comments or advancement, which may be perceived as sexual harassment.

Should any member or guest of Morgan County Ambulance Service encounter a situation in which they feel uncomfortable or observe an uncomfortable situation, they should report it to the Director, on duty supervisor the director of human resources immediately. Incident reports should be filled, which details all pertinent information.

Parties found to be in violation of this policy will receive disciplinary action up to and including termination.

DRUG/ALCOHOL AND SMOKING POLICY

PURPOSE:

The ambulance service of Morgan County supports the principles of and is committed to maintaining a drug and alcohol-free work environment. Ambulance service personnel are in the public eye, in a position of trust, reliability, responsibility and are respected as role models within the community.

The non-smoking policy is designed to foster the health and safety of all employees' conducting county business. Smoking or the use of tobacco in any form is strictly prohibited in any work area of the county. Non users of tobacco shall not be subjected to the byproducts of tobacco in any form. Furthermore, employee's displaying a heavy odor of the residual smoking will be asked to change their uniform and shower if necessary.

POLICY:

In addition to the county's drug and alcohol policy which can be found in the Morgan County Personnel and Procedure Manual, the following are requirements of any person who is a member of the ambulance service and/or a visitor for the purpose of observation and/or training with the Morgan County Ambulance Service.

Note: The use of illegal drugs at anytime is strictly prohibited and will result in termination.

At no time shall a member of the ambulance service and/or visitor/student etc., be permitted on the premises and/or emergency scene while under the influence of alcohol. Nor will they be allowed to participate in any work and/or related duties affiliated with the ambulance service while under the influence of alcohol. In addition, employees must be unimpaired by prescription or over the counter medications that could impair their judgment and/or job performance. Anyone taking a prescription medication or an over the counter medication that might fall into this category must have it approved by the physician advisor prior to any engagement of work related duties. The adverse effects (whether witnessed or suspected), of alcohol or medication that cause drowsiness or impaired function must be reported immediately to the on duty supervisor or director.

The off duty consumption of alcohol is strictly prohibited while representing oneself as an MCAS employee. The consumption of any amount of alcohol 12 hours prior to responding to an emergency, scheduled shift or required training is also strictly prohibited. Anyone suspected to be in violation of this rule will be immediately suspended from duty and/or participation in training, until confirmation can be made one way or another. Refusing testing will be deemed an admission of guilt and the employee may face further disciplinary action up to termination.

Anyone (employee, visitor, student), who exhibits behavior, appearance or the odor of drug or alcohol that's consistent with its use, will be suspected to be under the influence. The observer has the responsibility and a duty to act by immediately removing that individual from service and a supervisor must be notified immediately. Student riders will have their privileges permanently revoked.

An accused employee must submit to the reasonable suspicion testing within the hour or face termination. Testing will only be performed with the employee's consent and will be administered by the Morgan County Sheriff's Department and/or one of the local Hospitals. Visitors to the service will be asked to immediately leave the premises, (but encouraged not to drive), and their privileges of involvement with the service revoked.

Anyone who tests positive to a breathalyzer or drug test will be suspended without pay and may be subject to COUNTY ACTION as stated in the counties policy manual, which could include termination.

Anyone involved in a traffic accident while under the influence or who receives a driving while under the influence summons (on or off duty) will be suspended indefinitely pending a court decision.

SMOKING

MCAS employee's will adhere to all county policies including but not limited to the smoking policy. All county buildings are smoke free buildings. This includes but is not limited to garages, storage units, vehicles, private offices, conference rooms, rest rooms, stairwells, elevators and common areas. For ambulance personnel this also includes any place an ambulance has responded too, i.e. scenes, hospital, homes, standby locations, fueling etc.

Smoking is restricted to designated areas outside county facilities. MCAS personnel may only smoke at least 15 feet of the front doors at all stations. All smoking debris including matches, cigarette butts and/or packaging must be disposed of properly. Littered butts on the grounds and/or leaving sand cans full of extinguished butts will not be permitted and could result in a complete smoking ban on the premises.

Social Media Policy

PURPOSE:

Morgan County Ambulance Service endorses the secure use of social media to enhance communication and information exchange; streamline processes; and foster productivity with its employees. This policy establishes this department's position on the use and management of social media and provides guidelines on the management, administration, and oversight. This policy is not meant to address one particular form of social media; rather social media in general terms.

II) PHILOSOPHY

Social media provides a valuable means of assisting Morgan County Ambulance Service and its personnel in meeting community education, community information, injury prevention, and other related organizational and community objectives. This policy identifies possible uses that may be evaluated and utilized as deemed necessary by administrative and supervisory personnel. This department also recognizes the role that social media tools may play in the personal lives of department personnel. The personal use of social media can have an effect on personnel in their official capacity. This policy is a means to provide guidance of a precautionary nature as well as restrictions and prohibitions on the use of social media by department personnel.

III) DEFINITIONS

1) *Blog:* A self-published diary or commentary on a particular topic that may allow visitors to post responses, reactions, or comments.
2) *Post:* Content an individual shares on a social media site or the act of publishing content on a site.

3) *Profile:* Information that a user provides about himself or herself on a social networking site.

4) *Social Media:* A category of Internet-based resources that enable the user to generate content and encourage other user participation. This includes, but is not limited to, social networking sites: Facebook, MySpace, Twitter, YouTube, Wikipedia, blogs, and other sites. (There are thousands of these types of sites and this is only a short list.)

5) *Social Networks:* Platforms where users can create profiles, share information, and socialize with others using a range of technologies.

6) *Speech:* Expression or communication of thoughts or opinions in spoken words, in writing, by expressive conduct, symbolism, photographs, videotape, or related forms of communication.
7) *Department personal:* All full time and part time employees, any volunteer staff including to but not limited to cadets

IV) POLICY

1. Strategic Policy

i. Each social media page shall include an introductory statement that clearly specifies the purpose and scope of the agency's presence on the website.

ii. Social Media page(s) should link to the department's official website.

iii. Social media page(s) shall be designed for the target audience(s) such as the community, civic leadership, employees or potential recruits.
b) Procedures

i. All department social media sites or pages shall be approved by the Director or designee and shall be administered by the departmental information services section or designee.

ii. Social media pages shall clearly indicate they are maintained by the Morgan County Ambulance Service and shall have the department logo and contact information prominently displayed.

iii. Social media content shall adhere to applicable laws, regulations, and policies, including all information technology and records management policies of the department.

iv. Social media content is subject to open public records laws.

2. Department-Sanctioned Use

a) Department personnel representing the department via social media outlets shall do the following:
i. The use of department computers by department personnel to access social media is prohibited without authorization.

ii. Conduct themselves at all times as representatives of the department and, accordingly, shall adhere to all department standards of conduct and observe conventionally accepted protocols and proper decorum.

iii. Identify themselves as a member of the department.

iv. Not post, transmit, or otherwise disseminate confidential information, including photographs or videos, related to department training, activities, or work-related assignments without express written permission.

v. Do not conduct political activities or private business.

vi. Department personnel use of personally owned devices to manage the department's social media activities or in the course of official duties is prohibited without express written permission.

vii. Employees shall observe and abide by all copyright, trademark, and service mark restrictions in posting materials to electronic media.

3. Potential Uses

a) Social media is a valuable investigative tool when providing information about
i) Road closures,

ii) Special events,

iii) Weather emergencies, and

iv) Major ongoing events in the jurisdiction that affects the entire community.
b) Employment Opportunities - Persons seeking employment and volunteer positions use the Internet to search for opportunities.

4. Personal Use

a) Precautions and Prohibitions

Department personnel shall abide by the following when using social media.

1. Department personnel are free to express themselves as private citizens on social media sites to the degree that their speech does not impair or impede the performance of duties, impair discipline and harmony among coworkers, or negatively affect the public perception of the department.
2. Department personnel shall not disclose any information what so ever about any call for service or any patient.
3. Department personnel shall not post, transmit, or otherwise disseminate any information to which they have access as a result of their employment without written permission from the Director.

4. As public employees, department personnel are cautioned that their speech either on or off duty, and in the course of their official duties that has a nexus to the employee's professional duties and responsibilities may not necessarily be protected speech under the First Amendment.

   a. This may form the basis for discipline if deemed detrimental to the department.

   b. Department personnel should assume that their speech and related activity on social media sites will reflect upon their position within the department and of this department.

5. Department personnel are cautioned not to do the following:
   a. Display department logos, uniforms, or similar identifying items on personal social media sites without prior permission from the Director of the service.

   b. Department personnel may not divulge information gained by reason of their authority; make any statements, speeches, appearances, and endorsements; or publish materials that could reasonably be considered to represent the views or positions of this department without express authorization.

   c. Department personnel should be aware that they may be subject to civil litigation for publishing or posting false information that harms the reputation of another person, group, or organization otherwise known as defamation to include:
   publishing or posting private facts and personal information about someone, without their permission, that has not been previously revealed to the public, is not of legitimate public concern, and would be offensive to a reasonable person;

   6. Department personnel should be aware that privacy settings and social media sites are constantly in flux, and they should never assume that personal information posted on such sites is protected.

   7. Department personnel should expect that any information created, transmitted, downloaded, exchanged, or discussed in a public online forum may be accessed by the department at any time without prior notice.

V) VIOLATIONS

1) Reporting violations.
a. Any employee becoming aware of or having knowledge of a posting or of any website or webpage in violation of the provision of this policy shall notify his or her supervisor immediately for follow-up action.
2) Violation of this social media policy may result in suspension or termination.

PURCHASING

The Director is responsible for all purchasing and will authorize purchasing by others as needed. All receipts must be forward to the Director. Major purchases other than routine daily supplies must have prior approval of the Director before purchasing.

All requisitions must be signed by the Director.

INJURY ON THE JOB

Policy: Work Related Injuries or Illness

1. General:

Morgan County is committed to returning injured or ill employees to work, within safe and healthy medical practices, as soon as practical.

On the job injuries or job-related illnesses are to be reported in writing immediately, if practicable, to the employee's supervisor or to the Human Resources Department. In no event shall a report of injury be delayed beyond four (4) days. An initial report of workers' injury or illness shall be completed by the employee, or the supervisor or witness if the injured employee is unable to do so, by the end of the shift. The employee's supervisor or another County official or supervisor shall conduct an immediate inspection of the site of the injury or illness, discover the conditions and/or behaviors leading up to the injury or illness, identify any witnesses, and determine what steps or conditions would prevent a future injury or illness of a similar nature. This information is to be included on the Supervisor's Accident/Incident Report and filed within four (4) days or less under Colorado law.

If an injury or illness is determined not to be work-related, an employee may be denied workers' compensation benefits and injury leave coverage. The County reserves the right to conduct or authorize any investigations of the injury or illness or the records of the worker as deemed necessary.

Accidents involving equipment damage or personal injury, regardless of how slight, shall be promptly reported to the supervisor who shall then report to the Human Resources Department and the BOCC. The County provides Workers' Compensation Insurance in compliance with the Workers' Compensation Act of Colorado. The terms of coverage and benefits are covered by the Act, which may be amended from time to time. If personal injury occurs, the employee shall complete an "Employee's Written Notice of Injury" form and submit it to his or her supervisor within four (4) working days of the injury. The supervisor shall complete a "Supervisor's Report of Accident" and "Employer's First Report of Injury" forms and submit them along with the employee's written Notice to the Human Resources Department by noon of the next working day after receiving the Notice from the employee.

2. Medical Treatment

Except in the case of an emergency all County employees who incur a job related injury or illness which requires medical treatment are required to report to one of the County's designated medical service providers in order to be reimbursed for medical expenses.

In the case of an emergency, treatment should be sought at the nearest emergency medical facility. One of the County's designated medical service providers should be notified as soon as possible by the employee or the supervisor, if the employee is unable to do so.

3. Employee Responsibilities

The employee is required to:

Cooperate with reasonable medical treatment plans; and

Schedule and attend all follow-up medical appointments and therapy as required under the medical plan; and

Contact or visit, if possible, the supervisor promptly after each medical appointment; inform the County of his/her ability to return to work; and provide a copy of the Physician's Report, keeping the County informed of work status and conditions; and

Observe and follow all established physical and medical restrictions at all times and at all places, or return to the doctor for any necessary adjustment of those restrictions; and

Perform temporary modified duty for the County, if assigned, within medical restrictions; and
Accurately record any time charged to workers' compensation and submit time sheets as directed; and
Keep in contact as needed with Human Resources to arrange for the proper paperwork to be completed; and
Return to work as soon as possible after the medical provider has cleared the employee to go back to work; and
Provide copies of any workers' compensation checks and any other information to the Payroll Department as requested.

4. Return to Work

When the employee is medically able to return to work, a written medical release from the designated medical service provider must be submitted to the Human Resources Department. If the medical release specifies that the employee may return to work, the employee shall be returned to work immediately or as soon as practical. The medical release must be on a County approved Physician's Report form.

Morgan County reserves the right to require any treating physician to review the employee's job description, including a description of essential duties, and express an opinion whether the employee may safely perform the essential job functions, before putting the employee back to work with or without temporary modifications or more permanent accommodations.

5. Employee Compensation

An employee who has an on the job injury or job-related illness shall receive County pay for the balance of the work shift, time spent traveling to and from the designated provider's office, time spent waiting at the designated provider's office, and time in initial diagnosis and treatment. If the physician's initial report indicated the employee can return to work, then the employee is expected to work the next shift immediately following the injury. If, however, the physician's initial report indicates the employee is unable to return to regular work until a future date, the County shall pay for the balance of the day the employee was working at the time of the injury. An employee may use accrued leave for the first three (3) days absent after a work related injury, or be in a leave without pay status. Work missed as a result of a job-related illness or injury which exceeds ten (10) days shall be compensated by workers' compensation insurance as provided by law.

An employee will not receive additional payment from the County while being compensated by Workers' Compensation insurance, nor will an employee be allowed to take accrued leave for the same days they are compensated by Workers' Compensation insurance. If an employee is receiving payment from Workers' Compensation insurance and not from the County, leave accruals will not be earned.

Morgan County may require that any time off to recover from a work related injury or illness be charged against the employee's Family Medical Leave Act time to run concurrently with the time compensated by Workers' Compensation insurance.

The employee is required to follow medical instructions, including specified behaviors or conduct, whether on or off the job, to facilitate recovery and to prevent re-injury. The only exceptions made to this guideline shall be for religious beliefs of the employee.

6. Temporary Modified Duty

Morgan County is committed to returning injured employees to work, within safe and healthy medical practices, as soon as practical. If the medical release puts any limitations on the employee's physical or mental ability to fully perform the duties of the job, or limits the performance of those duties by requiring any adjustments in duties, equipment, or tasks; or any adjustments in break or work times or frequencies, then the medical release must specify in detail any physical or mental conditions which the employee still has which requires the adjustments. The medical release must also specify how long those conditions are expected or predicted to last, or how frequently they may recur. If the medical provider has any suggestions regarding possible modifications for temporary conditions to enable the employee to go on temporary modified duty, those can be included in the written medical release to return to work. Temporary modified duty for purposes of this guideline does not mean "busy work" created for the purpose of keeping the employee occupied.

The BOCC, Elected Official, or Department Head, may (but is not required to) grant an injured employee a temporary assignment while recovering from a work related injury or illness. Any such temporary assignment must be supported in detail by the written recommendation of the designated medical provider and have the approval of the Elected Official, or Department Head. Denials of temporary assignment should be based on the business necessity of the County. Such temporary assignment shall be reevaluated from physician appointment to physician appointment. This type of temporary assignment is contingent on medically appropriate work being available in the County and for which the employee is otherwise qualified under the usual minimum qualifications of the job.

If you are injured or sustain an occupational disease while at work, you may be entitled to compensation benefits as provided by law. WRITTEN NOTICE MUST BE GIVEN TO YOUR EMPLOYER WITHIN 4 WORKING DAYS OF THE ACCIDENT PURSUANT TO SECTION 8-43-102(1) AND (1.5), COLORADO REVISED STATUTES. If you fail to report your injury or occupational disease promptly, Loss of Benefit penalties may be assessed against you.

Any type of injury on the job should be reported to the Supervisor on duty or the Director or designated personnel immediately. If this is a life threatening injury or severe injury, please go directly to the nearest emergency room. All other injuries should be reported prior to seeking medical attention. The employee has the right to decide on whether immediate medical attention is necessary or if medical attention can be scheduled.

Proper paperwork must be completed on reportable workman's compensation events even if medical attention is not necessary. Paperwork includes and can be found in the folders in each station labeled Workers Compensation Forms:

1. Incident Report to be filled out by the employee
2. Employee's Written Notice of Injury to Employer
3. CTSI Supervisor's Accident/Incident Report

Body fluid exposures and needle stick injuries require an initial examination by a physician as well as three month and six month follow up appointments. The employee must then make a follow up appointment within a week with the follow up physician to obtain laboratory results, recommended treatments, counseling, and schedule follow up appointments. Recommended laboratory tests for exposures include: HIV, Hepatitis Panel, and HCV antibody tests. All exposure incidents will be recorded in the Morgan County Ambulance Service Administration Offices and followed by the manager to assure proper treatment and follow up has been provided.

CORONER

A coroner should be requested by law enforcement on a scene with an obvious death. The coroner's office requests that when airing a request for their officials to respond to the scene the following code name should be used for their department – "Mary One".

As with all patient care information, the personal information of the deceased is protected by HIPAA and the confidential policies of this department. Giving out names, causes, condition found or anything else pertaining to the death is strictly prohibited. Living in a small community can sometimes create some very uncomfortable and misfortunate situations when dealing with these types of situations. **Contacting friends or family members of the deceased from a scene is strictly prohibited and grounds for immediate termination**. It's the sole and legal responsibility of the coroners' office to make these types of announcements.

NOTE: MCAS shall respond on all unattended deaths and will cancel only if:

1. The coroner has stood you down
2. Law enforcement on scene has stood you down

Once you've arrived on scene of a DOA and after you've made ER contact for a pronouncement, the ambulance crew will not be allowed to clear the scene until:

1. The Coroner has arrived released them or,
2. Law enforcement is on scene.

Once someone has been pronounced in the field, under no circumstance should the body be moved by anyone other than the Coroner. If someone has been worked, then pronounced prior to any transport, <u>never load them into the ambulance</u>. If this happens that ambulance and crew are out of service and must stay on scene with the body still in the ambulance until the coroner arrives and removes the body. This has the potential of taking hours especially if circumstances surrounding the death are suspicious.

A. Pronouncing someone in their home, should be done prior to removing them from the house.
B. Once pronounced, do not remove the body to make family, bystanders, etc. more comfortable. Ask if they would like you to cover the body or leave them as they are and respect their wishes.
C. Working a trauma arrest is futile in nearly all circumstances. A trauma arrest should NEVER be worked if there are other patients on scene. regardless of the age of the DOA.
D. Resuscitation efforts should be withheld for any patients who are found pulseless and apnic following a blunt traumatic event or have wounds incompatible to life.
E. Confirming Asystole in three leads is the standard prior to consulting with medical control. Confirmation is not required for patients who meet the "Withholding Resuscitation Protocol", and in fact if you have no intention of working these patients, applying the monitor is highly discouraged. If, however you apply the monitor and begin resuscitation efforts including airway management, CPR, ACLS protocol and medical control, consult prior to pronouncement. Anyone found in a PEA must be afforded resuscitation efforts.

Once you've pronounced someone, your focus should turn immediately from the body to the family members and friends that may be on scene.

A. Ask if you can call anyone for them
B. Ask if you can get them anything or do anything

C. Console but DO NOT COUNCIL. Offer and then graciously move on if none is needed.

D. Asking them if they would like the body covered with a sheet or left alone instead of taking it upon yourself to simply cover up the body.

. E. Make sure you clean up the mess of resuscitation by removing ALL trash and supplies.

NEVER remove IV's, ET tubes or anything else that has been invasively performed after someone has been pronounced.

CRITICAL INCIDENT STRESS DEBRIEFING (CISM)

EMTs can request a CISD debriefing concerning any call or calls that have left them concerned or emotionally upset. These will be set up as soon as possible and should involve all parties that were on the call. Contact the crew Supervisor or if you need the services of a CISD team. The High Plains Regional CISD Team will be contacted to organize debriefing as needed.

NOTE: These meetings are highly confidential as it's encouraged to open up your emotions for the healing process to start. Any patient information discussed at a debriefing is confidential and must not be discussed outside the debriefing. Events or discussion that takes place in the debriefing must also not be discussed once you have left the debriefing.

One-on-One debriefing is available as well as professional counseling.

NUMBERS AND POINTS OF CONTACT

CIDS via the Washington / Yuma commutations center 970-848-0464

If these numbers don't prove beneficial, contact the dispatch center and ask them who's on call for CISD.

ACCIDENT ALERT STATUS

(During times of inclement weather, extreme road conditions)

Purpose:

To reduce the number of MCAS response vehicles responding to false reporting of accidents, old accidents, accidents where there are no victims, victims without complaints and / or victims who desire no medicinal assistance, during inclement weather.

Note:

When MCAS is short on resources and / or manpower due to inclement weather or local call volume, mutual aid response should be denied into mutual aid areas.

Policy:

During times of inclement weather, poor road conditions and / or poor visibility, MCAS supervisors will declare MCAS as on "Accident Alert". Notification will be made to the communication center requesting it be aired that MCAS is on "Accident Alert Status". MCAS will remain on accident alert until further notice.

Definition:

Accident Alert means only that MCAS will modify their response due to adverse weather and or poor road conditions to optimize the safety of the department, other responders and the general public.

During Accident Alert Status MCAS will respond to reports of unknown injury traffic accidents in the "non-emergent mode, informing dispatch of this upon going en route. Crews will wait to hear updated reports from first responders or, parties on scene as to the severity of the accident, MCAS will either 1- upgrade the response to "emergent", 2-continue in the "non-emergent" mode or, 3-cancel their response depending upon reports.

Upgrading Response to "Emergent":

If the initial dispatch information indicates the possibility of injuries, (or while en route additional information is reported indication the possibility of injuries other than minor injuries). MCAS will also upgrade their initial response if the dispatch information indicates mechanisms consistent with the adopted Trauma Red and Yellow protocols (unless it's reported there are only minor injuries).

Continue Non-Emergent:

Unless information indicates the need to upgrade.

Cancel Response:

MCAS will cancel their response immediately upon1- conforming reports of no injuries, 2-no accident found, 3-victims refusing EMS or, 4- victims who've left the scene.

STORMS OR INCLIMATE WEATHER

A. **Tornado WARNINGS (Safety of crewmembers is the first priority)**

1. Depending upon which district is under the warning, the on duty supervisor has primary responsibility of making sure ambulances are separated within that district, to avoid destruction of the fleet should the station be hit by the storm.
2. Moving all but one unit from the station is acceptable unless the station is thought to be in the path of a possible tornado.
3. Use any available staff to achieve this mission.
4. If possible and without putting crewmembers at risk, the units should be moved completely out of town in a direction away from the storm. Multiple units should go in multiple directions and not concentrate.
5. Placing units north and south of the railroad tracks if possible is desired for optimum coverage until the storm has past.
6 In the event of an eminent touchdown of a tornado, DO NOT attempt to “out run the tornado”. Seek cover and remain there until the danger has past.
7. If it’s been confirmed that a tornado has touched down in populated areas, make a request for an all call. All units from MCAS should respond to the area and wait instructions. (See MCI plan)
8. Winter Storms - (See Accident Alert Policy located in the Driving polices)

DRY RUN / CANCELLATION/ REFUSAL POLICY

DRY RUN

A dry run occurs anytime you're dispatched to a call (standbys excluded), and there is no patient transported, for example;

1. No patient located (i.e. drowning, left the scene, false call etc.)
2. No injuries traffic accidents
3. False calls or public assist only calls
3. Patient refusals, with base physician contact
4. Agency assists, where the patient was transported by another agency

CANCELLATION

A cancellation occurs when you are dispatched on a call and are cancelled by the following responders under these circumstances. Low speed traffic accidents, false calls, no patients found or there is no need for medical evaluation due to no complaints of injury or illness. Confirm with dispatch after being notified to cancel that there is indeed, no need for medical evaluation.

1. Law enforcement or Coroner
2. Fire department EMT
3. Another ALS agency's on scene
4. MCAS personnel on scene

If the initial call for service includes suspected injuries and/or suspicion for injuries due to a high mechanism, DO NOT stand down unless you've confirmed there's medical personnel on scene capable of making this type of determination, or unless the area has been thoroughly searched and the scene has not been located due to false reporting. Caution should be taken however when making a judgment call of whether or not to cancel when responding in bad weather or long distances. More times than not, you'll be called back to the same scene later for a simple assessment which could have been handled prior.

NOTE: If the request to cancel comes from a private resident and is greater than15 minute drive time, you should request a call back number from dispatch. Call the caller yourself on the cell phone to assess the situation first hand. Never assume all is well, especially for these people who are a fair distant out of town. In these situations MCAS will not cancel, but should slow their response and continue all the while making every attempt to confirm first hand that the situation is indeed safe for us to cancel.

REFUSALS

A call for service does not necessarily generate "a patient". The thought that we were called, and because we've arrived, there has to be a patient is not consistent with reality. A person becomes a "patient", when they've expressed a physical complaint, been injured, or in your opinion needs medical attention and/or an evaluation by a physician. Not all contacts are considered patients and therefore do not require an evaluation and/or refusal.

Any person can refuse our treatment and physical assessment and their wishes must be respected as to not violate their civil rights. Forcing transport on someone without a hold being placed on them by a physician and/or without law enforcements involvement is strictly prohibited.

The following are exceptions to this rule:

A. Anyone meeting the following criteria may refuse treatment, assessment and transport;
    1. They must be 18 years of age or emancipated minor

2. A parent or legal guardian on scene of a minor
3. Police officer assuming liability for minor
4. Responsible party (on scene) assuming responsibility for a minor
5. No neuro deficits i.e. altered LOC
6. Not under the influence of alcohol or recreational drugs

B. All refusals require the following;

1. Complete documentation of your assessments and findings pertinent to the situation including a full set of vital signs, names, address, phone number, DOB, social security numbers and any insurance information available.
2. Patient refusing treatment or transport, or the person assuming responsibility for the patient must sign the refusal form and be instructed that they need to follow up with a physician as soon as possible.
3. Consult and approval by the base physician following a complete assessment only if you fell the patient should be treated and transported and they still refuse. Any questions or real concerns about this situation should be shared with the base physician. Keep in mind that the physician has only what you're telling them to relay on. Don't fabricate or exaggerate the facts.

C If patient is Spanish speaking only, the same applies however, use the Spanish version of the refusal form and if possible, have an interpreter go over it with you first and then the patient.

If someone is adamantly refusing, even the basics of an assessment, and they meet the refusal criteria; do not force this on them for this could be considered an assault. Make note of it and attempt to get them to sign the refusal.

All patients who are refusing treatment who have been assessed may be billed accordingly and should never be given an impression to the contrary.

COMPLAINTS

Morgan County Ambulance Service Employees are expected to represent the service as professionals when on a call, or when in the public eye wearing or displaying Morgan County Ambulance Service uniforms and/or logos. Being in the public eye also makes you an easy target for the general public to approach you with concerns or complaints. Employees of MCAS are not expected to address any such questions or concerns putting you in an uncomfortable position.

If an employee encounters a complaint from the general public, another agency or facility, the employees should avoid any type of engagement or confrontation by simply stating, they'll pass the information on to a supervisor. Any complaints or concerns from the general public and/or other agencies as it relates to a specific call should not be discussed or debated over a patient or in front of a patient's family by anyone on the service at any time. The information should be passed on to the management of MCAS for further investigation.

All complaints from the general public will be investigated openly and without assumptions. Written documentation will be ascertained from those parties involved. Any disciplinary actions will result in letters of discipline being put in the employee's file along with any rebuttal documentation from the employee.

Complaints and conflicts among co-workers are to be first addressed directly among the individuals involved. Issues that cannot be resolved needs to follow the Chain of Command. The same holds true if there are issues involving other agencies. At no time will it be acceptable to enter into a debate, discussion or argument at, or in front of, a patient and or their family members. Professionally taking someone aside to discuss the matter later is acceptable. If the issue can't be resolved, follow the appropriate steps through the chain of command.

NOTE: At no time (on or off duty), will MCAS approve of retaliation or personal threats among employee's, affiliates of other organizations or patients. **This type of behavior may result in immediate termination.**

Complaints by MCAS employee's that have to do with patient care issues concerning other facilities should not be handled one on one between MCAS personnel and personnel from other agencies or hospitals, they should instead be written in an incident report and taken to the supervisors followed by the Director.

Personnel complaints dealing with personality conflicts should be handled between the parties first, then the supervisors and lastly involving the Director if things can't be worked out.

CONFIDENTIALITY

Outside Inquiries:

ALL inquiries from outside sources (law enforcement, press, attorneys, investigators, etc.) about calls MCAS has responded to, or internal matters, must be referred to the on duty supervisors and or Director. Release of medical records can only be done with:

1. The patient (who must be 18 years of age or older) showing a picture identification, or proof of legal guardianship, parentage or power of attorney. Proper identification must be presented before reports will be released.
2. A court order signed by a judge.

All subpoenas presented by attorneys, law enforcement agencies, etc. must be given to the Director or the Privacy Officer for review before any information can be released. This policy is strict and enforced for the protection of patient information.

Any investigations requiring the EMT complete a witness statement or written report must be cleared through the Director. The Director will guide the EMT in appropriate steps needed to complete this task. Under no circumstances is a EMTs phone number or personal contact information to be given out. EMTs will not be allowed to be called at home, or approached at home, in regards to legal matters. Any situations involving an EMT beginning contacted at home or on personal time are to be reported to the Director. All matters will be addressed through the Administrative Offices. EMT's that do not follow this policy according to guidelines may be disciplined up to and including termination.

Patient information and patient care issues are confidentially demanded of all employees' of MCAS. This includes all forms of communication (i.e. oral, written, electronic, photography etc.), about any call this service responds to. Under no circumstances will patient names or other identifiers be released to anyone other than those directly involved with patient care needs or billing. Detailed information and or trip reports are not to leave the premises. At no time is an EMT allowed to look through other EMT's trip reports in an attempt to gather information about the event except for the purpose of QA. All issues relating to patient confidentiality should be directed to the on duty supervisors followed by the Director. Violation of maintaining patient confidentiality is grounds for immediate discipline up to and including termination. (*See HIPPA policies*)

MEDICAL RECORDS

Trip reports are the property of Morgan County Ambulance Service and are mandated by law as a legal medical record. All rules and regulations regarding medical records will be followed. The law prohibits anyone from using the record in which patient confidentiality can be violated. At no time are trip reports allowed to leave the building.

Copies of trip reports can be obtained from the Morgan County Administrative Offices after a medical record release form has been signed. Law enforcement agencies seeking copies of trip reports need an executed medical record release form from the patient or through a court order.

All information gathered during patient transport is to be included on the report. Any pictures taken at the scene are to be included with the report as well as monitor strips. Events taking place during the transport i.e., refusal, combative patient, delay of care, etc. should be included in the report. Other events such as medication errors or equipment failure, assaults on an EMT, verbal abuse from family, problems with other bystanders or other agencies should be addressed on a separate incident report and reported as soon as possible to the Director.

Trip reports will be completed within 12 hours following the call. Trip reports written at later dates have a great potential of inaccuracies. Addendum reports should be completed as soon as possible to reflect any changes or add information to the report. The person responsible for patient care is also responsible for writing the trip report. Only during extreme and extenuating circumstances should someone else write the report. Trip reports not completed in a timely manner will be tracked and will result in disciplinary action.

DAILY OPERATIONS
(System Status)

GENERAL DUTIES

Aside from the daily duties (see duty of the staff), it will be the staffs responsibility of maintaining system status throughout Morgan County to ensure optimum response with the supervisors being ultimately responsible for crew rotation. MCAS will be staffed with 2 full time crews 24 hours a day 7 days a week and will attempt to run with ALS if at all possible. These units will be responsible for covering the primary calls in Brush and Fort Morgan and any calls in the Wiggins district due to lack of man power. These crews will also be responsible for covering response request in the mutual aid areas when possible. Mutual Aid areas do not take precedence over our own county.

OFF DUTY PART TIME RESPONDERS NOTE:

For all calls in the Brush and Ft Morgan districts part time personnel who are in the area can respond voluntarily as a first responders, either directly to the scene or, if the call is outside the city limits, after picking up a unit. This should be done only when the primary unit's response will be delayed. Responding to traffic accidents outside the city limits in personal vehicles will not be allowed.

Once on scene it has been determined that additional crew members will be needed either to drive or for patient care, the part time crew member may accompany the primary unit to the hospital and will be compensated at their pay rate. Part time personnel may volunteer to accompany the primary crew to the hospital for patient care experience.

Responding to these calls voluntarily for experience requires notification through the dispatch center. Dispatch notification is required when responding as the primary coverage due an ALL CALL request by dispatch due a delayed response of a primary unit, or the primary units not being available. Responding as a primary responder requires you to be in constant radio contact with dispatch and other responders if you've been assigned an 800mgHxz portable radio. If you do not have an 80mgHz radio, contact dispatch by phone and remain on the line until your on scene. Failing to do so can create confusion.

When responding in a voluntarily capacity, personnel should follow dress code policy; personnel dressed inappropriately will not be allowed to assist the primary crew.

LOCATION OF CREWS:

Crews will report too their assigned station at the beginning of each shift. On coming crews will receive pass along information from off going crews, review any assignments from the on duty supervisor.

It will be the responsibility of the on duty supervisor to establish crew configuration, assign daily tasks, and assign units and any other things deemed necessary as to ambulance operations.

"Medic 700" will be the call sign used for the primary unit assigned to the Station 1 district regardless of who's staffing the unit. **Medic 720** will be the call sign used for the unit assigned to the Station 2 district irregardless of who's staffing.

SYSTEM STATUS

In order for system status to be effective, diligent efforts must be made by all employees. The goal of system status is to fill the voids left in the response areas that have been historically the busiest, ultimately reducing delays in response. The goal is also to be as efficient as possible using intra-service resources as much as possible and to avoid requests for mutual aid from other departments.

Efficiently managing this type of system requires discipline, maturity and common sense, as well as an awareness of who's available and where they're at, at all times. A mature assessment of what's truly in the best interest of the service, the community and or potential patients is of the utmost importance to maximize response while minimizing response times, for example: knowing the appropriate time to reposition the units or knowing when and when not to requests additional resources is vital.

Calls in the FM area (district 1)

District 1 calls will be the responsibility of the primary crew in FM (Medic 700) unless another crew is closer. Enroute route times should be within 1 minute during the day time hours and 3 minutes at night except for Wiggins. Wiggin's crews should be enroute within 5 minutes during the day and 7 minutes at night.

POSTING - Between the hours of 0700 and 1900

Posting to FM by the district 2 crew is mandatory and will be required if;

- The FM crew takes a LDT
- Responds greater than 10 miles from station one
- Requested by the on duty supervisor

The "posting crew" will remain in the FM district until the crew taking the LDT reports their back in district. Once the FM crew is back in there district and available to take calls the
Brush crew should return to their district as soon as possible.

Between the hours of 1900 – 0700
The district two crew will not be required to "Post" however they will be expected to be enroute to all 911 calls within 1 minute. **Falsifying times will result in disciplinary actions up to termination.**

Calls in the Brush area (district 2)

The responsibility of Medic 720 unless, other units are closer. There will be no "posting" by the FM units to cover the district 2 area. Responses to district will be done by the closets available unit.

Calls in the Wiggins District will be covered by the Wiggins part time staff with back up coming from the closets available unit. Chopper should be considered if response will be greater than 15 minutes.

ON DUTY REQUIREMNTS OF THE FULL TIME STAFF

I. Ambulances checks, which include inner and outer cabinets, jump bags and all equipment, must be checked at the beginning of each shift to ensure the adequate stock of medication and supplies, as well as to keep all equipment in good working condition. Items found to be missing must be replaced and equipment found to be damaged or not in good working condition must be taken out of service and replaced. An incident report should be done and supervisors should be notified immediately upon such discovery.

a. The beginning of each shift means 7am until completed
    i. Other daily ambulance checks include motor oil levels, windshield washer fluid levels and radiator fluid levels.
    ii. A visual inspection of all tires
    iii. An inspection of all lights and sirens to ensure proper working order.
    iv. Rotate Zoll monitor, Power cot, and AutoPulse batteries in all units at station one and two. (The first crew to take a LDT each day will be required to stop at station three and rotate batteries and perform any other task assigned to them by the supervisor. Exceptions being that the other crew is on a call or another LDT is pending.)
    v. Oxygen tank levels (house and portables)
    vi. Required paperwork

II. Each shift.

a. A shift chore list is posted at each station and should be completed by each shift. This chore list is subject to change. At the end of each shift ambulances should be clean inside and out, fueled and stocked for the oncoming crew.

III. First day of every month.

a. Check expiration dates on (this includes ambulances, jump kits, and the storage area), all medications including narcotics, defibrillation patches, NS bags and replace when expired.

b. **A bi-annual ambulance detailing and state inventory check** (April, September) will take place for every unit in the fleet. Each crew will be assigned ambulances to detail. Inventory of supplies and equipment will take place to ensure their stock and to maintain consistency throughout the counties ambulance fleet. Suction units will be tested, and replace all batteries. Flashlights, Doppler, Laryngoscope handle etc.

IV. Daily Narcotic Count

Narcotic inventory is the responsibility of all ALS personnel. A daily check of Narcotic's will be done for every unit (FM and Brush). Lock numbers must match the inventory sheet in each narcotic box. Discretion in count will be immediately reported to the Supervisors on duty and immediately passed on to the Director.

V. Restocking after calls

1. The ambulances shall be cleaned and restocked after every call. The process should start at the hospital by the crewmember that was not responsible for patient care immediately after the patient has been transferred. The medic who had patient care gives a report to ER staff, collects patient info, etc. Cleaning and restocking is the responsibility of both crew members to ensure the unit gets back into service a.s.a.p. Team work and open communication is the key to success.
2. Assisting with patient care once you have turned the patient over to the ER staff should be avoided if possible. Getting the unit ready and getting back into service is the main objective. Requests to assist with patient care by ER staff shouldn't be refused, however making sure we're available for 911 response is our main priority.

NOTE: If you are out of service secondary to the car needing a lot of cleaning or supplies, then both crewmembers will see to it that this is done immediately following the call. There is to be no delay in completing this task, no exceptions. Also consider switching to different ambulance until your unit is back in service.

MEETINGS:

There will be 2 mandatory staff meetings per year. Employees must attend both mandatory staff meetings. Timely operational memos will be distributed to all employees via email and or postings. Employees are responsible for understanding the contents.

RESPONSIBILITIES:

1. Crew members must report toothier assigned station at the beginning of their scheduled shift. The "start time" will be 0700.
2. Crew members will receive their daily assignments from the on duty supervisor at the beginning of each shift.
3. Crew members must be in their appropriate uniform at the start of each shift and will respond to calls only in the approved uniform. Back up uniforms should be available.
4. Only the approved uniforms can be worn while on duty. Off duty wearing of uniforms is prohibited.
5. Part time personnel responding to calls should be in clothing identifying them as MCAS members. The minimum clothing will include jeans, MCAS shirts/sweatshirt or jacket.
6. Uniforms must be neat, clean and free from wrinkles, stains, fading, holes or other non appeal attributes.

RESPONSIBILITIES OF THE PART TIME STAFF

The duties of the full time staff apply to all part time members while covering part or all of a full time shift. Duties of the part time staff vary slightly depending upon their role on any given day.

The part time staff is an important part of this service and will be the back bone for future growth. For coverage in Fort Morgan and Brush:

a. Work a minimum of 12 hours (average) per calendar month. Standby's are included in time earned Time volunteered doing community and PR events can count towards the minimum time required after approval by management.
b. The part time staff will be utilized for shift coverage for all sick calls, and/or vacation requests for the primary crews.
c. They will be utilized as first responders for all calls subject to an extended response time by the primary crews.
d. They will be utilized as primary responders when the system has dropped below minimal coverage.
e. They'll be used as the second crew out for LDT's when one of the primary units is already out of town on a LDT.
f. They will be utilized as the primary coverage for all standbys and special events and will have the option of either covering the event or the primary shift during the event period.

OFF DUTY RESPONSE OF PART TIME EMPLOYEE"S: (See daily operations)

GENERAL

Part time staff covering special events, standbys etc. are required to do ambulance checks <u>without exceptions</u> 30 minutes prior to the start of their shift. Failure to do so will result in disciplinary actions.

Ambulance checks are designed to ensure the adequate stock of medication and supplies are on board and to ensure equipment is in good working condition. Items found to be missing must be replaced. Equipment found to be damaged or not in good working condition must be taken out of service and replaced. An incident report should be done and the supervisor should be notified immediately upon such discovery.

Other inspections and/or duties that are required at the beginning of the shift are as follows: The beginning of each shift means 30 minutes prior to the schedule arrival time or start of the event.

a. Daily ambulance checks include motor oil levels, windshield washer fluid levels and radiator fluid levels.
g. A visual inspection of all tires
h. An inspection of all lights and siren to ensure proper working order.
i. Rotate *Zoll* monitor batteries in all units (FM and Brush)
j. Oxygen tank levels (house and portables)
k. Required paperwork

Ambulances that are used will be washed and wiped down after their use and prior to the crew member/members leaving. The cab areas wiped/dusted, the floors vacuumed or swept out.

AMBULANCE INSPECTIONS

As per the Amendments to the Rules Pertaining to Emergency Medical Services (6 CCR 1015-3), Section 12.3.3 – A, the county requires that each ambulance within the fleet is inspected annually to ensure compliance with the rules pertaining to supplies and equipment. (Morgan County Ambulance Service will however perform bi-annual checks)

MCAS supervisors will be responsible for coordinating biannual inspections (January and June), of all ambulances within the MCAS fleet. Supervisors will be held accountable for ensuring that all equipment and supplies listed on the "Minimum Equipment List", matches the inventory of each ambulance. Deficiencies will be identified and corrected immediately. Taking an ambulance out of service until it meets the requirements should be considered depending upon the critical aspect of the deficiency.

VEHICLE OPERATIONS
(See Vehicle Operations Manual)

SEAT BELTS

Seat belts are to be used in ambulances at all times by the driver and front seat passenger and should be used when possible by those providing patient care. They're to be used on all passengers in the back when feasible and when patient care is not compromised. Any patient on the cot or bench must be seat belted in place.

TAKING FAMILY MEMBERS ALONG

This is at the sole discretion of the crews. Family members of the patients are welcome to accompany the patient however, must always ride up front unless, in the judgment of the crew they would be a benefit to patient care if they road in the patient compartment. Only one family member per incident may ride along and they must be seat belted at all times no matter where their sitting.

1. Obey all traffic laws
2. Use appropriate signals and lighting when merging into traffic, turning corners or driving at dusk or later.
3. Anticipate stopping. Ambulances are heavy and will take much longer to get stopped.
4. Keep radio volumes turned down enough that they aren't a distraction, NEVER use head phones.
5. Maintain clear fields of vision by keeping windows and windshield clean at all times.
6. Never use a cell phone for personal use while driving.
7. Always wear a seat belt while in the front and whenever possible while in the patient compartment.

ACCIDENTS

(Involving responding units)

An accident is any event in which a Morgan County Ambulance vehicle or any MCAS member's personal vehicle, when responding to a call for medical assistance (emergent or non-emergent), is damaged or causes damage and/or bodily injury by striking an animate or inanimate object or person, or is damaged by leaving the roadway. Any EMT involved in any motor vehicle accident while on duty or responding to a call shall report it immediately to the proper law enforcement authority, as necessary, and immediately to the on duty supervisor who will notify the Director. If the accident occurs while driving, and there are injuries the EMT will be taken out of service and be required to submit to a drug and alcohol screening as per county policy. If an EMT is involved in an accident in their personal vehicle while responding to a call, the ambulance service is not responsible for property damage only for bodily injury. Workman's compensation does not cover felony charges and therefore may not support the EMT in the event of an accident that occurs while responding to a call in a personal vehicle if the EMT has broke any traffic laws. If an EMT is injured in the accident, they should seek appropriate medical attention as needed and advise the on duty supervisor as soon as possible afterwards. All accidents shall be documented as to the events within 48 hours of the incident.

The following are guidelines in the event of an accident involving a MCAS vehicle while responding to a call in a MCAS vehicle:

1. Notify dispatch to respond law enforcement to investigate the accident and dispatch another ambulance to the initial call and to your location if necessary.
2. Leave vehicle in crash position if possible
3. Check for injuries, treat and transport if necessary.
4. Call for additional resources as needed, fire, ambulance, etc.
5. Notify the on duty supervisor or, director or, designee immediately
6. Obtain names of witnesses, if any.

NOTE: If injury or fatality occurs to any MCAS employee, patient, pedestrian, or occupant of any vehicle involved in an accident with MCAS vehicle, no equipment or material should be moved prior to arrival of or, approval of Director unless law enforcement deems it necessary to prevent additional hazards or to facilitate removal of victim(s).

The same guidelines above apply in the event of an accident while responding to a call in a personal vehicle, as well as the following:

1. Request another EMT to respond to the original call.
2. Stay on the scene for law enforcement to arrive.
3. The EMT involved in the accident will not be allowed to proceed with the original call.
4. Document the events on an incident report within 48 hours.

For accidents that are witnessed while your Enroute to a call for service should be reported to the dispatch center. Only stop momentarily to assess the seriousness of the situation. Call for additional units and inform those on scene that help is on its way. DO NOT delay your response to the original call for any length of time other then to give a quick visual assessment of the situation.

If the accident is behind you, or you have already passed, DO NOT turn around and return. Continue to the call you were originally dispatched too calling for additional units for the accident you had passed.

Any event which causes an ambulance or its equipment to strike or be struck by any other objects, no matter how insignificant or severe the damage appears to be, report the damage immediately to an on duty supervisor, and fill out an incident report. Failing to do so may result in disciplinary actions up to and including termination.

The Director will review all accidents and the individuals involved may be placed on a driving suspension, disciplined as necessary terminated.

An incident report must be filled out immediately following an event or accident. Listing names of those present, time, situation and events that led up to the accident, as well as any activity surrounding the event. List all damage caused.

PATIENT CARE REPORTS

Trip reports are medical records that need to be completed as accurately as possible, using the Image Trend software which should include a narrative. Repots are required to be on the Image Trend server on later than 12 hours after the call. All reports and paperwork must be submitted at the end of each shift, if it is necessary to stay over to complete the employ must get permission from the supervisor and log the time on their time card. A trip report must be filled out for every call the service responds to whether a patient transport is generated or not. Reports must be signed by the author, and should be reviewed and signed by the author's partner upon completion.

Multiple reports using the same call for service number will be necessary for multiple patient scenes. Multiple ambulances responding to the same scene will require a call for service for each additional responding ambulance. A triage report needs to be a separate part of the original report or, accompany the initial call for service report logged as an addendum.

All reports need to provide complete information concerning the call, including patient demographics information, to include social security numbers, name, address, date of birth, phone numbers, and any medical insurance policy information you can gather. The report also needs to show two (2) complete set of vitals signs (including times), a narrative that includes a complete patient assessment, objective findings, an assessment for the patients condition, treatment and response as well as dispatch call for service information .

Traffic accident reports should include a description of vehicle damage and mechanism. Any patient having be put on the heart monitor should include a copy of the rhythm strip ran in the field.

COMMUNICATING WITH DISPATCH

Following are general guidelines followed by Morgan County Communications Center in dispatching an ambulance: (for additional information see Incident Command Protocol)

EMERGENCIES

1. The following calls are considered to be emergencies unless stated otherwise;
   a. Any call for medical assistance from any location other than a hospital. This includes calls from a doctor's office requesting a patient be "transferred" to the hospital unless it is a previously scheduled transfer.
   b. Any call for assistance from a physician's office.
   c. Any call for assistance from a nursing home unless it is a scheduled transfer.
   d. All traffic accidents unless otherwise stated.
3. If a non-emergent response is requested by police, RP, or other officials, the request should be honored whenever possible however, it will be the crews discretion whether or not to respond emergent or not. Crews should shut down when possible and as far from the scene as they possibly can.
4. ***MCAS personnel should use discretion in using emergency response for calls that appears to be minor in nature based on dispatch information, especially where response times will be relatively short (1-2 minutes), and when traffic wont be an issue (late night early mornings).***

DESTINATION POLICY
MEDICAL AND TRAUMA PATIENT TRANSPORT

NOTE: Any time a call for service is handled by only **BLS responders** and the patient is in serious or critical condition, it should be considered a load and go situation. Transports should not be delayed waiting for ALS to arrive unless a helicopter has be called and their ETA is less than that of a rapid transport to the nearest appropriate facility and or designated LZ. Rendezvous with ALS in appropriate as long as it will not delay transport.

I. Medical Patients

Medical patients cared for by Morgan County Ambulance will be transported to either Colorado Plains Medical Center or East Morgan County Hospital except in the following situations:

- Unstable medical patients shall be transported to the closest appropriate facility, no exceptions.
- Stable patients may request the facility of their choice which includes NCMC if transported from the Wiggins area and or western/northwestern Morgan county or eastern Weld county, and SRMC if transported from the New Raymer area. Crews may however insist on transporting to the closest Morgan County facility depending upon system status and or the time it could take to get an ambulance back in service**.** Road and weather conditions should also be taken into considered for transports beyond a closer facility.
- Notification to the receiving facility should be done as soon as possible.

II. Trauma Patients

Trauma patients being transported by MCAS, who meet the Limited or Full Trauma criteria, should be transported to Colorado Plains Medical Center except in the following situations:

- A stable patient who meets the "trauma yellow criteria", who is relatively unremarkable, has minor trauma, stable vital signs and no loss of consciousness, may be transported to facilities other than CPMC but only, after the base physician has been contacted and has given his/her approval to divert.
- When Colorado Plains Medical Center is on Trauma Divert Status, the next closest trauma facility should be utilized (EMCH, NCMC, SRMC).
- Patients whose airway cannot be managed should be transported to the closest ER in time not distance.
- During an MCI, absolute destinations aren't practical and medics have to use sound judgment in selecting the appropriate facility. If you have destination questions, contact the base physician.
- Air medical transport has been arranged and is less 15 minutes from scene.
    - Each situation is different and common sense has to be used, for example; services unavailable at the local level (i.e. neuro patients), MCI, may warrant air medical transport. When in doubt, contact base physician.
    - Trauma patients who will benefit from a level I or level II trauma center and who have their airways protected, IV's established and manageable vital signs should be considered a candidate for air medical transport if ground transport exceeds 20 minutes to the local trauma center.
    - Air medical activation and their ETA play an important role in whether or not you fly the patient.

NOTE: Base contact is not necessary when transporting a critical patient by air when ground transportation is greater than 20 minutes to CPMC and the arrival of the helicopter is within those 20 minutes. This includes extrication time, or a multiple patient scenes with multiple serious injuries.

PATIENT REPORTS TO RECEIVING HOSPITALS:

1. All patient transports from a scene should include a brief patient report to the receiving hospital as time permits without jeopardizing patient care. Reports should be given as early as possible thus allowing the receiving facility time to prepare for the patients arrival. Patient reports should be done by the attending medic however if applicable a non attending member of the ambulance service may provide the report.

   a. Reports should be brief and to the point only providing a brief history of events that surround today's event and the patient's chief complaint
   b. Reports should include a full set of vital signs
   c. Reports should include a report on treatments including medications and any invasive procedures as well as the patient's response.
   d. Reports should include an ETA and any special instructions (ie. lift assist)
   e. Reports should always be professional without the use of slang, profanity, sarcasm or horse play.

2. If both members are busy with a critical patient, ask whoever is driving to request dispatch contact the ER with your ETA and type of patient (ie. cardiac arrest in 3 minutes).

3. Full Trauma Team activation should be done as early as possible. If time permits without (jeopardizing patient care), this may be done from the scene as an F.Y.I. to allow the ER staff more time. Reports should be as brief as possible (ie. unresponsive GSW to the abdomen, hypotensive and intubated)

4. Using a cell phone for a patient report is prohibited unless this is your only means of communication. Calling in via cell phone for refusals and field pronouncements is the exception.

5. **DO NOT call the base physician with a request to deviate from protocol** unless it's to report a stable, minor injury patient that otherwise meets Limited Trauma criteria who you would like to transport to EMCH, due to poor weather, low system status, patient request, or mechanical failure. Calling to request a deviation puts the base physician in a bad predicament since they haven't been able to make an assessment on their own. Protocols are in place for a reason and should be followed with few exceptions.

III. Patient Transfer Request:

Patient transports that are requested from the field to medical facilities other than CPMC, EMCH or NCMC from the Wiggins area are prohibited unless the travel time is less than or equal transporting to local facilities or approval is granted by medical control. This includes, but is not limited to, requests from private residences, Doctor's offices, nursing homes, correctional facilities, health care facilities, etc. If such a request is made, gather all pertinent patient information, inform them that transfers that bypass our base facility (CPMC), are only allowed by MCAS after being approved by medical control prior to transport.

If a request to transport a patient from a scene (i.e. Dr's office), to a facility outside the district has been made and is approved by the base physician, based solely on the information provided over the phone, the attending medic may elect to turn down the transfer request until a more thorough evaluation has been performed by an ER physician.

SETTING UP TRANSFERS

All local and long distance transfers should be responded too in a non-emergent manner. Response times to the receiving facility should be 20 minutes or less (unless the sending facility does not have the patient ready to go) so not to delay transports.

Helicopter transfers from the Station one LZ:

1. The EMT basic with assist with the transport leaving the ALS crew member free to respond to 911 calls.
2. The EMT basic transferring the flight crew must stay with them until the patient has been returned to the aircraft.
3. Never approach the helicopter until summoned by the crew and always approach the aircraft from the front.
4. Never drive an ambulance under the main rotors or near the tail of the aircraft.
5. Always assist the flight crew with their equipment and patient loading, following their instructions.
6. Once the patient is loaded into the aircraft, move the unit a safe distance away from the aircraft remaining in full view of the pilot and out of the departure path. Remain here until the aircraft has departed.

ALL Interfaculty transfer requests must come through the communication center. A trip number must be generated and a report filled out regardless of whether we took it or not. Reasons for declining should coincide with policy and must also be recorded in the Image Trend report. All transports must be confirmed by the ALS crew member taking the transfer and with the transferring facility staff to ensure patient care needs can be met during transport depending upon crew configuration. Special requests by the transferring facility for ALS responders vs. BLS responders may be made and should be honored whenever possible without jeopardizing local coverage and/or system status. The supervisors will make the ultimate decision on crew configuration. If a request for a transfer is made and the on duty supervisor isn't available due to call volume or being out of town on a previous transfer:

1. It becomes the responsibility of the most experienced MCAS crew member.
2. If their on a local call and no one else is available to set up the transfer, the transfer will have to wait until someone is available.
3. Crew members will be allowed to refuse a transport depending upon their comfort as it relates to patient care needs, and of course CCR 1015-3. Should these issues arise, the on duty Supervisor should be contacted and advised prior to refusing the transfer.
4. Supervisors will use judgment for declining transports due to staffing and or weather concerns. During "Accident Alert", transfers should be declined. (see Accident Alert)

Note: Although it's the discretion of the crew whether or not they are comfortable taking a transfers based on patient care needs, other solutions should be sought out before totally turning the transfer down, i.e. seek out another medic comfortable doing the transport; suggest a critical care team transport. Transfers that are denied or turned down by a MCAS supervisors, need to Documented in the Image trend report.

LONG DISTANT TRANSFERS (LDT'S)

All hospital long distant transfer requests must filter through the 911 center. As with a 911 call, the paged out information needs to be acknowledged by on duty staff followed by a call to the requesting facility to gather transfer information. Clear communication with the requesting facility as to whether or not we can or cannot take the transfer must be conveyed along with and ETA. Transfers must follow rule 6 CCR 1015-3 and or MCAS protocol.

If it's imperative for a supervisor to remain local, it will be the supervisor discretion as to who will be assigned to take requested LDTs. Part time and off duty personnel should be used for all secondary LDTs if one of the primary units is already out of town. Having both primary units on LDT's at the same time will not be permitted unless off duty personnel are in service and at Station One. If a 2nd LDT is requested the information should be gathered by the most experienced on duty person. Ask dispatch to page an all call for the appropriate personnel to, 1: take the transfer or 2: cover calls as primary.

In order to ensure the system runs smoothly and efficiently crews must be en route to LDT within twenty minutes of it being paged. The exception to this would be the sending faculty is not ready in which case this should be documented.

If a LDT is pending with the first crew out on a 911 or LDT as soon as the first crew clears the 2nd crew should already be at or near(within ten minutes) the sending hospital to expedite the LDT.

After the patient is delivered to the receiving hospital and the crew has replaced linen it is essential that you return to service as soon as possible. A brief stop is permitted for food or bathroom break, providing it takes 10 minutes or less and is on the route back. Failure to comply with this will result in discipline and possibly dismissal.

INTRA –FACILTY TRANSPORTS

(Hospital to Hospital)

****Critical Patients as defined below**

PURPOSE:

To ensure safe and effective transports of patients from local facilities to facilities better suited for managing specific patient conditions. The following formulary follows the guidelines set for the by the Board of Medical Examiners for the State of Colorado and outlined in 6 CCR 1015-3 as they pertain to hospital transports.

Medications (see "Maintenance of IV Infusion Protocol"), and procedures (refer to the act allowed) that are approved for inter-facility transports under 6 CCR 1015-3 and local physician advisor, will require that they be initiated by the transferring facility prior to transport. EMS continuation and maintenance of those agents are allowed however titration must first be approved by physician.

Transport requests that make crew members uncomfortable enough to question their abilities or abilities to adequately manage the transferring patient's condition; will be at the crew's discretion whether or not the transfer will be accepted without a CTN, regardless of protocol, 6 CCR 1015-3 or, any other policies of Morgan County Ambulance.

PROCEDURE:

Medication infusions are allowed, and are not to be administered without an infusion pump. Refer to specific protocols for information on the specific medications and administration and or physician transfer orders.

Note: The hemodynamically unstable patient, as well as the critical patient that requires vasopressors, ionotropes, or other vasoactive medications, or continuous anti-convulsant or sedative infusion represent an unstable or critical patient and should be **transported by preferably a specially trained critical care team** or, may be accompanied by an physician/RN from the transferring facility who is familiar with the patients needs.

Note: Depending upon the patient's condition, "Out of Hospital Times" must be considered in the best interest of the patients.

Patients that **will not be transported (out of the county), by MCAS without a critical care provider or at least an RN** familiar with the patient care needs from the transferring facility will be as follows:

1. Patients less than 30 days old
2. High risk OB patients
    A. Transports of patient's dilated > 6cm should be delayed until delivery has taken place.
3. Patients needing respiratory assistance (bagging, intubation)
4. Patients from an ICU who are on more than 2 approved medicated drips
5. Unstable spinal fractures
6. Pediatric patients with altered mental status or, who are in respiratory distress Ie. RR > 40/min, retractions, SaO2 <93%, stridor, on continuous nebulized Treatments or who have been in distress for an extended period of time.
7. 2nd or 3rd degree burns > 10% TBS, suspected airway burns or burns to the hands, face or genitals (ABLS recommendations)
8. Post cath lab patients that require transport for interventions needing to be performed as soon as possible.
1. Epidural bleeds or IC bleeds with altered LOC, seizures and the presents of a midline shift.

Patients that **<u>will not be transported</u>** by MCAS personnel will be as follows:

1. Patients who are under arrest without law enforcement accompany
2. Patient's being transported to detox centers
3. Bariatric patients (> 600 lbs)– A geriatric unit form Denver or Ft. Collins should be called.
4. Patient's being transported to physic care facilities that do not have a medical reason for needing ambulance transportation.
5. Patients whom the transferring facility cannot provide crew members with written verification of the accepting physician's name.
8. Multiple patients who are not from the same family.
9 Transport requested as "only needing a ride" unless pre-payment arrangements have been made.
10. Bad Weather:
    During severe weather and or roads conditions that make travel unsafe.

Patient transports that will be delayed or denied if the facility is unwilling or unable to delay their transports are:

A. A full time MCAS unit is already out of town on a transfer and there are no other staff members available to take the additional transfer/transfers
B. MCAS has no additional staff available to cover ALL CALL's during periods of time where pre-scheduled standbys or events require our attendance.

CREW CONFIGURATION:

#1: The transport team for all critical patients as describe above will consist of at least an RN from the transferring facility as well as one ALS provider who will assist with patient care needs during the transport and at a minimum one basic provider as a driver. A Respiratory therapist may accompany non-critical patients being transported on a ventilator in addition to the basic crew configuration.

#2: In extenuating circumstances (and only if approved by the transferring physician), an EMT Basic may assist with patient care needs as long as the RN and EMT are comfortable with this configuration. This however should only be as a last resort.

- Team members will work under the protocols that have been established by the physician advisor affiliated with their employer and will not be permitted to deviate from these protocols for any reason.
- Should a question or concern as it pertains to patient care arise while intransient, base physician contact or contact with the physician who ordered the transfer should be made by the RN for further orders.
- En route, the team will consist of two qualified team members accompanying the patient at all times A Morgan County Ambulance crewmember will always be driving.
- Should there be a need for an advance airway or ACLS en route. The most experienced person dealing with this crisis should take the lead in this situation for the team.
- Patient care will be the responsibility of the RN following transfer orders however, MCAS personnel will be required to document the transports as they would with a normal call for service including all required documentation, ABN's if applicable, physician certs etc. A copy of the RN patient care report must accompany MCAS documentation.

"LOCAL" TRANSFERS WITH A RETURN TRIP:

For patients who are being transported from one local facility to another for diagnostic procedures who will require a return trip;

1. The crew will stay at the facility with the patient until the procedure is complete if the estimated wait time will not exceed thirty minutes
2. There are other units available to take 911 calls.

Note: Patients SHOULD NOT be left on ambulance cots until procedures can be performed. Returning to service a.s.a.p. is a priority.

3. If the anticipated wait will be longer than 30 minutes or, there isn't another crew available for calls, the crew is to go back into service immediately upon arrival at the receiving facility.
4. Each trip will require a new call for service number and a separate trip report.
5. Billing responsibility will be that of the requesting facility and should be noted.

Non- Critical Patients

Patients who do not meet the unstable or critical criteria who need transported to facilities outside our local area will be transported by MCAS personnel as long as the attending EMT/Paramedic is comfortable with the transport and patient care treatment modalities are within 6 CCR 1015-3. The transports will be classified as ALS or BLS transfers with the appropriate personnel attending to patient care needs.

Note: Only one full time ALS ambulance will be out of the local area at a time doing inter-facility transports. If another request comes in for an additional transport, part time staff may be utilized for the transfer. If

however there's no other crews available, the transfer will either have to hold or be schedule through another agency.
Making the arrangement for such a transport is not the responsibility of MCAS however our assistance may be well appreciated.

UNSCHEDULED NON- EMERGENT TRANSFER POLICY

(Required Documentation)

Definition:
Any patient, who is a permanent or temporary resident of an assisted living facility under direct or indirect physician care, and who is being transported from a treatment facility back to his/her place of resident.

Transport Policy:
Attendants involved in the transportation of the above-mentioned patients from any facility, i.e. hospitals, clinics diagnostic centers, etc., Must, without exception, ensure that the required documentation PCS accompanies the patient, and that it is appropriately filled out and signed by an appropriate caregiver prior to leaving the said facility. The required signature must come from the attending physician or discharge planner who is employed by the facility where the patient was treated, with knowledge of the patient's condition at the time the transferred was ordered. If the attending physician is unavailable to sign, one of the following discharge planners is acceptable:

1. Physicians Assistant (PA)
2. Certified Nurse Specialist (CNS)
3. Nurse Practitioner (NP)
4. Registered Nurse (RN)

Attendants who leave the transferring facility without the afore-mentioned documentation will be subject to disciplinary actions. This document does not apply to patients who are being transported back to their homes, or homes that are not considered assisted living facilities.
Advanced Beneficiary Notice (ABN) must be signed by the patient or a patient's family member or guardian prior to transport when it's thought that the transport may not be covered by insurance including Medicare/Medicaid due to medical necessity not being met. The responding EMT must explain to the patient or patient's family members that the insurance may deny payment of this bill in which case the patient will be responsible. This explanation must also be written on the ABN as well as an estimate for the cost of transport prior to the patient or patients' family signature. Failing to do this automatically excludes MCAS from being able to bill the patient for services rendered.

Required Trip Report Documentation:

The documentation and the information needed should be consistent with all other documentation forms pertaining to patients care needs and findings. The exception to this is that the *diagnosis* used for the return trip. This should be consistent with the diagnosis used for the patients admitting diagnosis (i.e. rule out respiratory arrest or rule sepsis etc.).

HELICOPTER GUIDELINES

Helicopters are a unique tool that should be used to expedite a patient's transport from scenes and/or facility to other facilities who are better equipped to treat a patient's acute crisis. Their crews are specially trained and considered a critical care mode of transportation. They provide not only a stable platform for patient stability but an expedient mode of transportation unimpeded by traffic or road conditions. The Key to effective use of helicopters depends solely on early activation.

Because many emergency situations occur in rural locations, the role of the EMT becomes even more important. The primary purpose of an efficient EMS system should be to first recognize the magnitude of the illness, provide initial stabilization with emphasis on the ABC's, and to facilitate expeditious transport to the "most appropriate facility". This role can be enhanced through recognition skills of a critical or life threatening situation and requesting that a helicopter be dispatched without hesitation.

Helicopter Requests and Communications:

All helicopter requests made by MCAS and other first responders within Morgan County will be made through Morgan County Communications (MCC). The MCC should then contact the Med Evac dispatch center via telephone, requesting a Med Evac helicopter. Should a Med Evac helicopter not be readily available, it's the responsibility of the Med Evac dispatch center to summons another service.

All helicopter communications will be done on the 800mgHz channel STAC (found in zone 4, position 6).

Helicopter "STAND BY" vs. "GO"

There are two types of "Stand By's" that can be requested and or a "GO".

1. "Stand By" – means the helicopter does not lift off until requested on a GO. This should be used for all calls outside the fly boundaries that meet the trauma criteria, MI's, CVA, SOB or other requests that sound as though they could be serious.

Note: For the first 5- 8 minutes the activities of the flight crews for a "Stand By" and a "Go" are pretty much synonymous. By placing a helicopter on "Stand By", you buy your self time to figure out if they'll indeed be of benefit.

2. "Airborne Stand By" – means the aircraft lifts off (usually within 5 - 8 minutes) and is enroute to the "area". This should be used on all calls outside Morgan County and calls outside the fly zone that are serious in nature. This type of "Stand By is basically the same as a "GO" request. The only difference is the ship will not come all the way in unless instructed to do so.

3. "Helicopter GO" – means the helicopter lifts off (usually within 5 -8 minutes) and comes directly to the scene unless stood down.

If the information given by dispatch sounds serious and it's within the fly boundaries, the MCAS crews should request either a "Stand By" or "Air Bourne Stand By" immediately upon copying the call. If you've requested a "Stand By", gather as much information as possible while enroute to the call to determine the need for a helicopter.

Note: If responding to a residence, call dispatch on the cell phone and ask for a phone patch. The phone patch will enable you to do a phone assessment of the patient's condition assisting you in identifying the seriousness of the call.

If a helicopter is anticipated, it is imperative the helicopter be dispatched early in order to be effective. Helicopter's can be stood down at any time if it's later determined helicopter transport will not be beneficial.

Try to avoid however, standing them down if they're ETA is within 2-3 minutes unless you're absolutely positive they'll be of no benefit. Dispatching a helicopter back to the scene once you've stood them down, only delays patient care and could affect the overall patient outcome.

I. Helicopter Boundary Considerations for critically ill or injured patients

- Consider dispatching a helicopter when ground transport time is greater than 20 minutes to local facility and flight time is less than 20 minutes
- The boundaries to be used as guidelines for flying critical patients or multiple patient scenes are: *(refer to the no fly zone map)*
- The "No Fly Zone" is a recommendation only and should be referred to when considering whether or not to utilize a helicopter.

NOTE: If a helicopter isn't dispatched early, it creates a delay that often times makes ground transport more appropriate. If a delay has been created, DO NOT sit on scene and wait for the helicopter. Consider using a designated rendezvous site or transport to a local facility.

- The NO FLY boundaries are roughly a 15 mile radius from CPMC
  i. North of MCR EE
  ii. South of MCR F
  iii. East of MCR 31
  iv. West of MCR 6
- Within the NO FLY boundaries there are some grey areas that could be very difficult to access by ground depended upon road conditions, and limited directional access, thus extending patient transport times. Therefore these areas should be considered "possible fly zones".
- The term "NO FLY ZONE" <u>should not</u> be thought of as an absolute rather a "highly discourage" area to bring in helicopters. Because there are many situations that could delay patient contact or patient transport, the NO FLY ZONE boundaries <u>can not</u> be thought of as an absolute. Medics need to use sound judgment and common sense when making these difficult decisions.
- As long as the patients' airway has been managed and the patients' vital signs can be or, are stabilized, rendezvous or helicopter transports from the scene can be considered outside the no fly zone without base contact (ALS only).
- Scene flights within the no fly zone should have base contact unless access to the patient will be delayed by ground or unless responding to a mass casualty incident.

Note: Transporting a patient past <u>any ER</u>, regardless of trauma criteria whose airway can not be managed is strictly prohibited.

II. MEDICAL CONSIDERATIONS FOR AIR TRANSPORT:

- Chest pain in patient 40 years or older:
  Previous cardiac history or associated symptoms
  High index of suspicion of cardiac related problems
- Unresponsive to verbal or painful stimuli
- Overdose with medications
- Status seizures or more than two seizures in 30 minutes
- Return of Spontaneous Pulses after cardiac arrest when ground transport is greater than 15 minutes and a helicopter is enroute.

III TRAUMA CONSIDERATIONS FOR AIR TRANSPORT:

- Any serious traumatic injury meeting the above mentioned medical consideration (exception blunt force trauma arrest patients should not be flown)
- Penetrating trauma to abdomen, head, chest, pelvis, or artery
- Any accident with fatality of other victim involved
- Drowning or near drowning
- Suspected spinal cord injuries as manifested by neurological complaint or deficit
- Total or partial amputation of extremities excluding thumb, great toe that appear salvageable
- Crush injuries to head, chest, or abdomen
- Major burns, including electrical or chemical, 10% of total body surface, or more, or burns involving face, hands, feet, perineum, or suspected respiratory involvement
- Mass Causality irregardless of patient conditions
- Serious traumatic injuries involving children under the age of 18

IV. MECHANISM

- Vehicle striking a pedestrian greater than 20 MPH
- Falls greater than 20 feet
- Ejection from vehicle with positive loss of consciousness
- Multiple victims that over whelm responders irregardless of injuries
- Death of another occupant in the same vehicle
- Prolonged extrication which is greater than 20 minutes
- Difficult access such as wilderness or impeded access
- Mass Casualty irregardless of patient condition

V LANDING ZONE REQUIREMENTS (LZ)

The primary landing zone for interfaculty transports out of CPMC will be at the CPMC rooftop LZ. The secondary site will be the approximate 40 x 40 dirt pad just east of station 1 in the area designated . A third site will be the Beaver street site just to the south of the Fort Morgan police department, in the street at the dead end. (This LZ requires FMPD securing the LZ)

NOTE: Even though our dispatch center does not do flight tracking, it's always a good idea to notify dispatch that center "the helicopter has landed" or "has taken off.

Primary Site – Morgan County Ambulance personnel will have no responsibilities and/or duties for patient transport from this site. If at the ER (and in an emergency or extreme situation), you're asked to assist with patient transport to the roof, you may "assist" only. Never assume patient care and never accompany the patient to the roof without the flight crew and/or ER staff. You are still in service and must be able to respond immediately.

Secondary LZ site- (no need for law enforcement or fire at this site)

The responding crew will be responsible for providing landing zone information to the incoming pilot but only if prompted to do so. All communication should be done on the 800mgHz STAC channel. Required information should include an estimate of the wind description and direction. (mild, moderate, strong, steady, gusting out of the north east) It should also include information about potential obstacles, i.e. power lines marked with orange line balls running east and west on the north side off the street that boards the LZ to the north.

Alternate LZ site- Located at Beaver Street (in the street at the dead end), in front of the police department.

Law enforcement must be notified prior to arrival of the in bound helicopter so that the street can be closed down.

Same as above

Scene location- (requires LZ command, usually fire)

LZ command will usually be the responsibility of the responding fire departments. If however they are unavailable at the time, MCAS crew members must establish an LZ. During the day light hours, the helicopter pilot may choose to land prior to an LZ being established. For all designated LZ, no LZ command is needed however encouraged. LZ command should communicate on the 800mgHz STAC channel. and are responsible for the following:

- Provide pilots with a landing zone area that is 100 yards by 100 yards and free of obstacles
  - Obstacles can be identified by the LZ commander holding his/her arm out in front of them at a 45 degree angle. Anything visible above your hand should be considered an obstacle. Animals running loose in a field are considered obstacles.
- **Communicating obstacles and wind direction is crucial.** Wires are invisible from the air and need to be pointed out along with there direction of traveling.
- Rotor wash can be powerful and therefore an LZ that has a lot of debris should be avoided.
- NO ONE should be inside the LZ during the final approach and/or landing. It's not necessary to "bring the helicopter in". This only creates unnecessary risk and will be strictly enforced as it presents a real danger to anyone within the LZ.
- Night landings will not take place without establishment of LZ command

IV Helicopter Crew Transports to and from CPMC

When the primary LZ is out of service, MCAS crews will be responsible for transporting crews to and from the LZ to CPMC

- Once you've been notified of an inbound helicopter, immediately go to the STAC channel to make contact with the flight crew.
- Respond to Station 1 and pull the ambulance out and to the north or south of the building.
  - Face the unit to the West for best visibility and turn on the emergency lights
- The EMT crew member should be assigned to the helicopter transport and will remain with the crew at all times.
- The ALS crew member will remain in service

V HELICOPTER SAFETY

During an emergency situation involving the transfer of a patient into a running helicopter, things can easily become chaotic. The dynamics of the scene as well as the noise of the helicopter created by the jet engines and the rotor wash can cause some disorientation and anxiety. Only those experienced in loading and off loading patients under these extreme conditions should participate.

In all other situations it's of the up most importance that everyone involved in loading and/or unloading a patient into the helicopters moves slowly and methodically, following the instructions and guidance of the flight crew to ensure everyone's safety.

- NEVER, NEVER, EVER RUN when approaching a running helicopter!
- Always remain calm and keep a cool head.
- Never carrying anything above your head i.e. IV poles, when the rotors are turning.
- Never approach the helicopter by ground or with an ambulance until summoned by the flight crew or pilot.

- Never drive the unit under the rotor blades.
- Never approach the aircraft from the rear, always approach from the front of the helicopter, in view of the pilot and only after you've gotten an O.K. signal.
- Never walk under the tail boom or near the rear of the aircraft.
- Hats should not be worn when walking under the turning rotor blades. If however this should happen and someone's hat blows off, DO NOT chase after it.
- Sheets should be secured under straps, should they be sucked upward, DO NOT grab for them or chase them should they blow off.
- Don't chase paper work or anything else blown away.
- Once the patient has been placed on the loading tray, exit to the front of the aircraft (unless asked by a crew member to stay and assist). Hanging out to help without be asked too make you a real hindrance.
- Do not operate doors or equipment on the aircraft.
- During take offs and landings, it's not necessary to have someone in the LZ "bring the ship in". Clear the area and avoid standing out in the open. The safest place is behind something BIG! The most dangerous time period is during take offs and landings.
- In the event of a hard landing, DO NOT approach the helicopter until everything has stopped turning. Turn off the fuel switch if possible (Always the big RED switch in the cock pit (found on the control panel). Attempt to free the crew by what ever means possible irregardless of damaging the aircraft.

NOTE: As the aircraft is making its final approach, or is taking off from the scene, there should be absolutely no radio communication, unless you've spotted imminent danger. In which case alert the pilot by calling out pull up, pull up or abort, abort!

V. DESIGNATED RENDEZVOUS SITES

The following rendezvous sites have been approved by the land owners and/or organizations for helicopter rendezvous. Each site has been carefully selected to provide optimum safety and is recognized by GPS co-ordnance.

Note: All designated LZ's have been assigned names. <u>Only the names</u> of the LZ sites are to be used for scheduling a rendezvous.

The helicopter programs in Denver, Greeley and Scottsbluff Nebraska have all been provided with this information.

Ambulance Station #1 –
Located in Ft. Morgan at station #1.
GPS N40°14.834
W103°47.120

Fort Morgan Airport - GPS N40°19.682
W103°48.196

Brush Airport - GPS N40°15.778
W103°35.015

Wiggins Fire Department – GPS N40°14.021
W104°04.820

Wiggins Hill –

Located approximately 8 miles west of Wiggins on I76 and approximately ¼ of a mile back to the east at mile marker 57. Take the exit and proceed on the north frontage road back to the east to WCR 91. LZ is on the east side of WCR 91 approximately 50 yards north of the frontage road intersection.

GPS N40°13.196
W104°12.384

The Blue Tops –

This LZ is located on Hwy 34 at mile marker 137 (east of Deerfield). LZ is north of the Hwy approximately 100 yards on the west side of the driveway.

GPS N40°17.517
W104°16.149

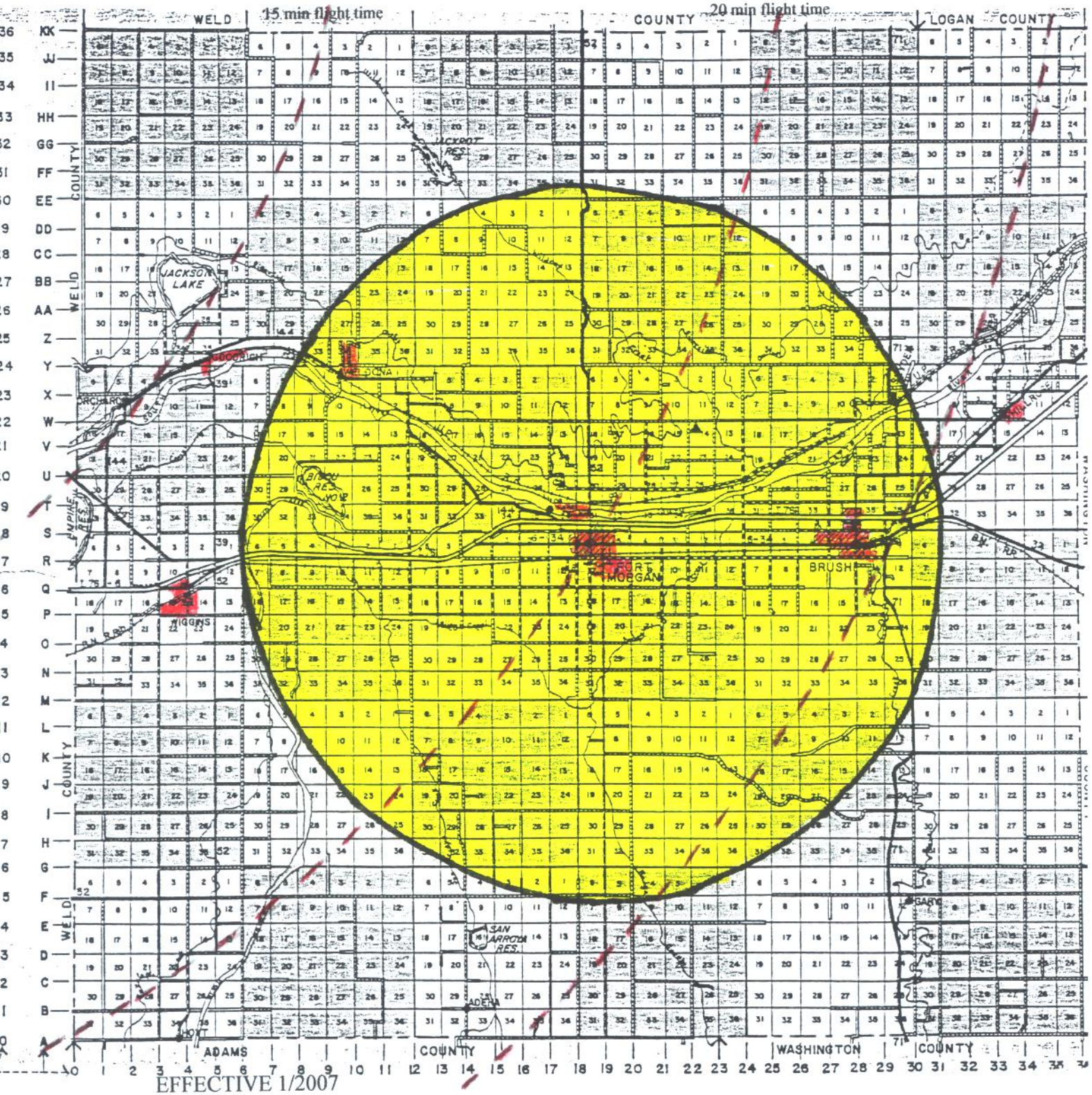
Orchard Lodge –

This LZ is located in Orchard on the north side of MCR X between Grand Ave and Washington Ave.

GPS N 40°.20.17
W104°16.637

Morgan County Ambulance Service
Helicopter NO FLY ZONE Map

YELLOW = The No Fly Zone is approximately 15 minutes by ground to CPMC. The recommended no fly zone, should not be thought of as an absolute as there are many variances the have to be factored in when considering helicopter utilization (see helicopter utilization protocol.



EFFECTIVE 1/2007

Helicopter Rendezvous Protocol

As part of our mission statement, "doing what's in the best interest of our patients without jeopardizing patient outcomes", is what this protocol emphasis. First responders, EMT's and Paramedic's play an important role in delivering emergency services to the people of Morgan County and neighboring mutual aid counties.

Because many emergency situations take place in rural locations, the role of the pre-hospital responders becomes even more important. The primary focus of the EMS system is to first anticipate then, recognize the magnitude of the illness or injury, provide initial stabilization, with an emphasis on the ABC's, and to facilitate an expeditions transport to the "most appropriate facility". In order for this process to be efficient, pre-hospital responders must be trained to anticipate (based on dispatch or pre-arrival information), and recognize critical or life threatening situations. They must be given the authority to make requests for helicopter transports early, integrating ground and air services to optimize patient outcomes.

The following are guidelines that emphasize how important a medic's ability to recognize early on, potential life threats. Patients that will benefit from the utilization of these valuable recourses, which expedite transport to higher level of care facility is very important in patient outcomes.

DEFINITION:

When the decision has been made on scene that a patient's condition warrant's transportation to a level I or level II trauma center *(see no fly zone policy)*, a request for a helicopter should be made as soon as possible (preferably shortly after you've received your initial page out). Provided helicopter ETA's are within an acceptable time period and waiting won't put the patient at risk, transportation to a local hospital should be diverted in order to expedite the patients arrival to a level I or level II trauma center. This may be done by standing orders for ALS responders only, as long as the patient's airway has been managed and vital signs can been stabilized. For patients whose life threatening needs can't be met, transportation to the local trauma center should be immediate *(exception airway compromise, see trauma destination protocol)*. Base contact should be made as soon as possible for any questions about patients with these concerns or indecisiveness about waiting or rendezvousing with a helicopter vs. transporting to CPMC.

PURPOSE:

Provide direction for responding crews to assist with the destination decisions for a critical patient as well as establish guidelines for responding crews to use as a tool when making sound judgments in the best interest of our patients. These guidelines will ultimately help improve patient outcomes when diverting their transport to a level I or level II trauma center.

Delaying transport while waiting on a helicopter can be difficult to understand, especially to those untrained and or, who may not understand the term "appropriate facility". Emergency rooms and hospital capabilities can differ greatly in the services they provide. It's important to know what services are offered and what the capabilities of the receiving hospital are. In many of these cases, time is of the essence, and patient outcomes can be greatly affected, hence the term "The Golden Hour".

Scene delays should not exceed 20 minutes waiting on air transportation if ground transport to CPMC can be safely achieved within 15 minutes. An alternative to waiting idol at the scene is to rendezvous. Rendezvous can decrease responder's anxiety as well as cut down on valuable minutes a patient spends outside the appropriate hospital. Planning ahead is essential as is knowing which direction your patient needs to go and where the aircraft is coming from. Equally important is picking a rendezvous site and thus timing your arrival to that of the helicopters.

For safety concerns, rendezvousing at one of the designated LZ's (especially an airport), is strongly encouraged if time permits based on the ETA of an inbound helicopter, as apposed to sitting idol on scene for an extended period of time. If the decision to fly has changes based on the patient's condition notify the hospital you'll be diverting to the hospital. Consider continuation of the helicopters directly to the hospital.

Note: Airway and intravenous access must be secured or, patients should be transported to local facilities without delay. Patients who are hemodynamically unstable and not responding to fluids and/or who present with uncontrollable hemorrhaging should be transported to CPMC without delay.

See the “Helicopter Guidelines Protocol” for additional utilization criteria of medical patients and for the listing and location of all the designated sites.

MASS CASUALTY INCIDENT PLAN

The majority of Emergency Medical incidents involving between one and five victims are normally handled by initial responding units with subsequent requests for additional assistance depending upon the number of victims involved and the severity of their injuries.

Large multi-casualty incidents will quickly overwhelm the initial responding crews and local hospitals. For this reason, it's important to have a common plan that allows other agencies as well as mutual aid responders from other regions to function in an organized manner.

Morgan County Ambulance has therefore adopted as its MCI plan, the Northeast Colorado All Hazards region Mass Casualty Plan, developed and adopted as the standard by the physician's advisor board to the NCRETAC.

This plan has specific roles and responsibility for a medical branch of a unified incident command. MCAS personnel will only assume incident command (IC) if they are the first to arrive on a scene. This role will be immediately turned over to fire personnel upon their arrival. MCAS will branch off into a unified command with the most qualified personnel on scene assuming the role of Medical Command. MCAS personnel Medical Command will be identified by wearing a blue vest.

There are four branches of Medical Incident Command. Operations, Planning, Logistics and Financial. (see section 11, page 5 of 36 in the MCI NCAHR Plan)

There are two primary branches of this command that will be utilized in the field when delaying with an MCI. Operations and Logistics.

Operations – this where the scene management will be handled. Triaging and transporting
Logistics- this branch that will handle the organization and response of other mutual aid agencies responding.

Both branches will of course have branches of there own depending upon the magnitude of the situation at hand. (refer to the plan section 11)

To simplify decision making on how big an incident is, and what it should be categorized the following categories have been developed and should be adhered to.

MCI CATEGORIES

MCI O – MINI MCI (2-5 patients with at least 1 critical)
MCI I - Expanded Medical Emergency (6-15 patients)
MCI II -Major Medical Emergency (16-50 patients)
MCI III - Medical Disaster (more than 50 patients)

TRANSPORT STRATEGIES

1-2 critical patients = Split the first arriving crew and call for (one additional units)
3-5 critical patients= first unit in, last out (2 – 4 additional units)
> 5 critical patients = Maximum EMS response establishing Medical Command

FIRST AMBULANCE TO ARRIVE

The first unit to arrive will take charge of and coordinate patient care activities. All additional responding units will coordinate their efforts as directed.

Responsibilities of the first crew in, is as follows;

1. Announce the category of the event "MINI MCI" over the radio
2. Report to or establish IC command
3. Most qualified EMT immediately attends to the most serious patient

4. EMT “B” should perform triage (scene survey, mechanism, number of patients, severity of injuries) then reports back to a Paramedic
5. Triage and tag every single patients involved
6. Request additional recourses through IC command
7. Rapidly package all patients and assemble them in central collection locations.
8. Most qualified EMT attended to critical patients

TRIAGING ***(****see triage protocol)*

ACTIVATION OF TRAUMA TEAMS

The best rule of thumb is that over triaging costs money while under triaging costs lives. It is therefore better to over triage when activating a trauma team when you’re just not sure which direction to go.

Full Trauma patient criteria are based primarily on vital signs while Limited Trauma activation is more in line with mechanisms. MCAS will utilize the trauma activation criteria recognized across the front range *(see Triage Criteria Protocol below),* and should alert the receiving facility as soon as possible as to the likely hood of them receiving trauma patients. The initial report can be something as simple as, “we’ll be enroute with two trauma reds within the next 10 minutes”. This should be followed by a more descriptive report once enroute and able to do so, without jeopardizing patient care.

NOTE: Communication is the key to success in MCI situations. There must be an Incident Commander (usually fire) and a separate Medical Commander; all decisions must go through them.

Patients must be staged in collection areas that are divided and separated by color coding.

Additional responding units should stage a fare distant from the scene so as no to clog things up. Patients are moved from the collection areas to a transport area as other units arrive. This should be organized by a transport officer.

Refer to the NCAHR Mass Causality Plan for an in depth review. In order to be efficient in management of an MCI, this plan must be reviewed and practiced well in advance of an actual event.

TRIAGING PROTOCOL

The purpose of triaging is to enable responders to be able to focus their efforts of sorting patients during an otherwise very chaotic and confusing situation. Triage personnel must identify and separate patients rapidly, according to the severity of their injuries. Making sure all patients are triaged without providing treatment is a difficult task. In order for optimum patient care however, it's imperative that triage officers remain steadfast in the objective in order to achieve this goal.

EN ROUTE

While you're responding to the scene of an incident, you should be preparing yourself mentally for what you may find. Perhaps you've been to the same location. Where will help come from? How long will it take them to arrive? Anticipating the worst is the best policy. In outlying areas, strongly consider responding a second ambulance routine unless reliable information indicates there's no need.

Always consider calling for helicopters, especially if critical or serious injuries are suspected. Helicopter request should be done as soon as possible. Waiting until you've arrived on scene, wastes valuable time.

NOTE: A good rule of thumb for initial requests for additional ambulances should be 1 ambulance for every 3 patients for an MCI I (5-16 patients). This request could change depending upon severity of injuries (injured vs. walking wounded).

UPON ARRIVAL

You must make an initial report upon arriving on scene. This report is the most important message because it sets the emotional stage for everything that follows. If your panicked, all others responding will respond in a panic mode. If you're précis, clear, calm and speak without shouting, others will then have a clear mental picture of the task at hand. Key points that must be given are:

Location of the incident?
Type of incident?
Any hazards?
Approximate number of victims?
Type of assistance required?

MCAS personnel will use the S.T.A.R.T. and Jump S.T.A.R.T triage method for any scene that has 3 or more patients. All patients must be tagged whether transported or not with the upper corner of the triage tag included in the patient report.

See AMBULANCE TRIAGE MANUAL for additional information as this plan is considered policy.

MUTUAL AID

Purpose:

To provide mutual aid to other pre-hospital agencies, in areas outside Morgan County when requested, and when Morgan County Ambulance service is available to do so depending upon manpower and unit availability. Morgan County Ambulance Service will not leave Morgan County completely uncovered to respond for a mutual aid request. It will be the dispatch centers responsibility to advise the requesting agency of this denial, and a helicopter should be dispatched if applicable.

Helicopters should be considered for all mutual aid requests.

Mutual Aid Boundaries:

Weld County-	Hwy 34 and mm134.5
	Hwy 14 and WCR 81 (to the west)
	mm 216 or Logan County line (to the east)
	I-76 and mm 57
	Hwy 52 and Hwy 14 (to north)
	WCR 81 (to west)
Logan County-	I-76 and mm 104
	Hwy 14 and County line
Washington County-	Hwy 34 and mm185 (“midway”)
	Hwy 71 and mm 156
	Hwy 6 and mm 383.5

The above locations are only guidelines. If requested to respond further in to a mutual aid area, Morgan County Ambulance will do so on a case by case basis, without jeopardizing Morgan County coverage. Again, consider dispatching a helicopter.

Unaffiliated responders:

An unaffiliated responder is considered to be someone who is rendering care prior to the arrival of a Morgan County Ambulance Service employee, who is not a member of Morgan County Ambulance (i.e. Physician, Nurse, EMT at any level, firemen, law enforcement, bystander, etc.). Anyone rendering care that is, or claims to be a trained medical person, should turn care over to Morgan County personnel immediately upon arrival. If they refuse and are persistent in there efforts, ask them if they would like to accompany the patient to the emergency room. If they continue to hinder your efforts putting the patient at risk, have law enforcement remove them from the scene.

Morgan County protocols should be followed at all times, if there is a discrepancy between the Morgan County medic on scene, and the unaffiliated responder, If the unaffiliated person is a physician, explain to them that our protocols must be followed. If they wise to withhold care or substitute care outside the scope of our protocols, remind them that they must accompany the patient in the ambulance to the ER.

Note: At no time will an unaffiliated responder be allowed to initiate care after the arrival of the ambulance, regardless of the responder’s level of training. Independent use of ambulance equipment or medications by an unaffiliated responder is strictly prohibited.

EMS Agencies:

When responding to provide mutual aid for, or receiving mutual aid from an outside agency, or when rendezvousing with an outside agency and/or helicopter service, the following applies:

Upon being dispatched – All crews responding on mutual aid requests Will immediately ask for the requesting medical crews ETA before going enroute. If their ETA is shorter to or equal to ours, stand down, DO NOT respond unless, Dispatch can confirm a possible MCI. If their ETA is greater than ours, respond as normal. A BLS response must wait on scene for their mutual aid ALS crews to arrive unless you've made radio contact with them and they give you permission to transport prior to their arrival.

Accepting care - Obtain a history from the medic's on scene simultaneously with a primary survey. History should include the event, findings, treatment provided and any changes. Once enroute, do a completed and secondary survey and treat per protocol. You can not accept care from someone with a higher level of certification.

Surrendering care to an ambulance crew- Opposite of "Accepting care"

Surrendering care to flight crew- Same as above, however, allow the flight crew to asses the patient before moving toward the helicopter. Once the patient is in the helicopter it's impossible to assess them. Assist in carrying the patient to the helicopter following the flight crews instruction.

TRAFFIC ACCIDENTS WHILE TRANSPORTING PATIENTS

STOPPING FOR ACCIDENTS

If while responding to a call or transporting a patient o the hospital, you witness or come upon a traffic accident or someone in need of assistance, the following applies:

1. **While transporting a patient emergent** - report accident and location immediately to dispatch without stopping.
2. **While transporting a patient non-emergent** - stop and report accident and location immediately to dispatch. Driver will check for injuries, provide care as needed and attendant will stay with patient on ambulance. Continue transport as soon as possible.
3. **When responding emergent to a scene** - report accident and location immediately to dispatch without stopping.
4. **When responding non-emergent to a scene** - stop and report accident to dispatch, check for and treat injuries, transport as necessary and have dispatch respond another ambulance to the original non-emergent call. If accident is non-injury, remain on scene until law enforcement arrives, give them any statements they require, and continue with original call.
5. **If involved in an accident** – stop immediately, report accident and location, advise dispatch of injuries to anyone Involved, and have dispatch respond another ambulance to the original call and one to your accident if necessary. Leave ambulance in position of impact, if possible, for the police investigation. If you have a patient on board, request another ambulance.

6 The Director should be contacted immediately for any accidents involving the ambulance or crew. Notify dispatch to contact Director.

RADIOS

Radios are to be used for ambulance business only for going in and out of service, and to communicate with your partner and the dispatch center while responding to or while on a call. Traffic not pertaining to a call, special event, unit status, or ambulance business is strictly prohibited. Unnecessary use of county issued radios will result in disciplinary actions and possibly immediate termination.

RADIO UTILIZATION POLICY:

All users of the Morgan County Ambulance portable and mobile radios are reminded that use of these radios is restricted to public safety and ambulance related business only. Transmissions on the 800mgHz system can be heard state-wide and beyond. FCC regulations apply to all radio transmissions on these systems. Transmissions must be done in a professional manner at all times. Profanity, perceived chit chat, and non-ambulance business transmissions are strictly prohibited and could result in disciplinary actions and/or termination.

DAILY OPERATIONS:

The radio templates have been customized for Morgan County Ambulance and have been programmed to simplify navigating from channel to channel. The primary channels have been set so that without looking at the display screen, one should be able to navigate by simply turning the dial. The primary EMS channel (1MC EMS DIP) is located with the dials turned all the way to the left. This includes the "Zone" select switch, as well as the channel select/channel dial. The operations channel is one click to the right, with the primary channel that will be used for *mutual aid responders within Morgan County*, (Morgan MAC or the mutual aid channel) channel found by clicking the dial all the way to the right or channel 16 on zone. All other channels for coordinating talk groups for mutual aid responders outside the county will be assigned by the dispatch centers.

The three most frequently used hospitals by Morgan County Ambulance can be found in two locations in the following order (CPMC, EMCH, and NCMC).

1. In Zone 1 (A), they can be found in order, by clicking the channel select to the right two clicks, or channel 3, three clicks channel 4 and so on.
2. Zone Two (or displayed as "B" on the zone switch), has been set up for nothing but hospital channels, they're in the same order as above plus 12 other hospital we frequent.

PRIMARY CHANNELS: Found in Zone One

1. The Morgan County Ambulance Service's main channel (home channel) will be 1MC EMS DSP (zone 1 Morgan County Emergency Medical Service Dispatch). All calls for service will be done on this channel and communications between dispatch, ambulance personnel and any other EMS related traffic will be initiated on this channel.
2. Morgan County Ambulance Service personnel can move unit to unit traffic for daily operations to the 1MC EMS OPS (operations channel). This request should be done with the least amount of radio traffic as possible and should be done as follows. Example: "701, 702 on ops". ("On OPS" will signify… move traffic to the ops channel). If 702 heard the traffic he should respond with "702 copy"… at which time they move to the ops channel and await 701's transmission. If 702 did not respond to the initial request, 701 could try again once within the next few minutes but should not continue.
    a. The OPS channel can be used for everyday ambulance operations information only.
    b. All traffic should be kept to a minimum.

Note: While on the OPS channel, you run the risk of missing a call for service if your radio is not in the scan YES mode.

c. General information and/or personal discussions will not be tolerated on this channel.

3. Hospital Channels – There are five primary hospital channels that have been programmed into the radios in two different zones for our convenience. The five primary channels in order as they appear in the radios are CPMC, EMCH, NCMC, MCR, PVH. In zone one (our primary zone), they are channels 3-7. They can also be found in zone two, the hospital channel zone.
4. Mutual Aid Channels – Local – Regional – State

There are 6 mutual aid channels in the primary zone used to communicate with other agency responders at the local, regional and state level. They're listed as MAC ___ NE (Mutual Aid Channels for North Eastern Colorado). The primary out of district MAC channels are MAC 5, 6, 7, and 8.

a. There is a State (ST), mutual aid channel listed as MAC 21 ST that will be used only in a state wide response.
b. Our local MAC channel is displayed as Morgan MAC. This channel will be utilized as the Morgan County responders' "GO TO" channel. For all calls that require multiple disciplinaries respond, dispatch will ask everyone responding to move their channel to the "GO TO" channel. Unless busy, this will be the primary "GO TO" Channel. If this channel is busy, dispatch will assign one of the TAC channels as the "GO TO" channel.

Note: While on a Mutual Aid channel, you run the risk of missing a call for service especially if your radio is not in the scan on mode.

5. Tactical Channels – These channels (TAC 1, 2), will be used as on scene for tactical channels for on scene command and communication (if the Morgan Mac channel is busy), and will also be assigned by the dispatch center.
6. Fire Dispatch – MC FIRE DSP channel is also found in our zone one. This channel is for fire and dispatch communications only. The channel will be used for primary call for service as well as communications between the fire departments and dispatch.

EMERGENCY ACTIVATION ALARM POLICY

800mgHz

PURPOSE:

To ensure proper use of the emergency activation alarm system that is programmed into all 800mgHz portable radios. Provide information about the activation of this system and what it represents. Procedures to follow should a false activation occur.

EMERGENCY ACTIVATION FEATURE:

The 800mgHz portable radios are factory designed with an emergency activation button (also referred to as a "panic button"), as a safety feature for responders. The button is an orange push button located just right and in front of the antenna and should only be used in an extreme emergency situation.

ACTIVATION:

To activate the emergency or panic button, push down on it briefly. This is not a silent alarm, the portable radio will emit a beep which simultaneously will set off alarms <u>on every dispatch console throughout the state</u> that are simultaneously programmed with the same channel selected on the portable radio at the time of activation.

I.e. you're on channel MAC 8 when your panic button is pushed. All dispatch center consoles programmed with MAC 8 (every console has all MAC's) throughout the state will be alerted that you have an emergency.

All radios distributed will be matched to the user by the serial number of the radio. The assigned user must maintain an accurate and up to date contact number (as well as an emergency contact number), located not only with Morgan County Ambulance Service, but the dispatch center as well. When the radios are keyed or, the panic button has been activated the serial number is displayed on the dispatchers consol for immediate identification.

In the event of an emergency, the radio that has been activated will emit an emergency signal. This signal will continue to emit an emergency signal until the radio has been manually re-set. The portable radio's have to be re-set before any dispatcher's console (throughout the state), can be re-set. These alarms will sound approximately every 15 seconds until the portable has been manually reset. Therefore in the event that the radio can't be re-set, the radio will be deactivated by the state through the local dispatch centers request.

INDICATIONS FOR ACTIVATION OF THE EMERGENCY BUTTON:

The emergency activation system on the portable radios is indicated for any life threatening emergency situation which cannot otherwise be broadcast over the radios due to equipment malfunction, inability to access and transmit, situations where attempting to broadcast could further endanger oneself, or previous emergency transmission attempts have failed.

ACCIDENTAL ACTIVATION:

An incident report must be filed with MCAS within 24 hours of an accidental activation.

To prevent accidental activation,

1. Familiarize yourself with the equipment and the location of all buttons
2. Store the radio out of the reach of children
3. Turn the radio off if it's not being monitored
4. Familiarize others including family members with the importance of this safety feature and the seriousness of its activation.
5. Do not self test the activation button

In the event your radios emergency signal has been activated accidentally;

1. Contact dispatch <u>immediately</u> with an all clear via radio or telephone
2. Re-set the emergency transmit button immediately by pushing the panic button (orange button) in and holding it for 10 seconds, or by turning the radio off for 5 seconds.
3. Contact dispatch to confirm that the re-set has been confirmed.

Dispatch will attempt to contact you first via radio to assess your emergency needs. The on duty supervisors will also be notified. If however you are not on duty or have not been assigned to a call, it may be difficult if not impossible to locate you. After all efforts to contact you have been exhausted, a request will be made to the state to deactivate your radio. Once your radio has been deactivated, it will have to be re-programmed to re-active. Any costs involved with reprogramming, will be absorbed by the user of the radio.

All false activation of this emergency safety device will be taken seriously and could result in disciplinary action including termination.

SPECIAL EVENTS STANDBY

I. General Information

- Special events are considered to be any event that the ambulance service has been requested to standby at, where large groups of people gather i.e. football games, festivals etc.
- All requests for standby must be approved in advance by ambulance administration.
- Part time staff will have the option, when signing up for a special event to #1, cover the event or #2, cover the primary shift requiring the full time staff to cover the event.
- While at the event, crew members are required to have their equipment ready to respond, which means:
  - Loading the cot with a back board and supplies for spinal immobilization, O2, jump kit, monitor, suction. This gear should be securely strapped to the cot and must be established immediately upon arrival at the stand by.
  - In bad weather the gear should remain in the unit. On nicer days, have the gear and cot out ready to go.
- Crews that are working a standby are still available for service, and will be required to respond on 911 calls for service as a last resort. Standbys DO NOT take precedent over any 911 call for service.
- Ambulances should always be parked to ensure quick departure if applicable.

III. Staff Scheduled to Cover Standbys

a. All standby events will be posted in advance (permitting notification) with part time personnel having priority of signing up.
b. The Supervisors will be responsible for checking the standby schedule and for ensuring coverage. Full time crews will cover standbys as the last resort leaving for 911 calls and returning immediately after the call.
c. The EMT's covering the stand bys are expected to be on time and in uniform. If you cannot fulfill the requirement of the standby, it is your responsibility to find a replacement.
d. For varsity football games, standby crews must be in place at least 30 minutes prior to kick off and must remain until the majority of people have exited the venue.
e. Crews must remain with or in close proximity to the equipment for the duration of the standby. Cots will be set up immediately upon arrival at the standbys with the jump kit, monitor, spinal immobilization, O2 strapped to the cots and ready to go.
f. All trip sheets and standby documentation must be completed immediately following the standby.
g. Restocking and washing the units must be done immediately following the stand by.

IV. Documentation

- Anyone contacted at the event who presents with a complaint of injury or illness must have a report filled out on them.
- Minor Patients (under 18 years of age) will require a parent or guardian signature on the refusal/release form before they can be released for any complaint that warrants in the opinion of the medical crew a physician evaluation. If un-accompanied, they must be transported without exception.
- All standbys require a CR number and a brief documentation describing the events and if there were or weren't any contacts.

V. Treatment and Transport Guidelines

- Crews that are working an event are assigned to the event and should not transport unless, the event is nearing its end, there are multiple patients, or a patient's condition warrants rapid transport. In this situation, the responding crew would assume standby duties until the original crew could return.
- In the event patient transports are imminent, request an additional unit (non –emergent if possible). Patient care should be transferred to the responding unit if applicable, unless the event crew has already loaded the patient and is ready for transport.
- The following patients DO NOT require ALS or Base Physician contact
    - Superficial abrasions, lacerations, without neurovascular compromise
    - Minor orthopedic injuries with minimal discomfort and/or swelling which doesn't display any neurovascular abnormalities
    - Patients who have a team or events physician in attendance.
        - In this situation follow the physicians lead, document the events, the physicians name and relationship to the event/patient
        - Injuries sustained during an event should only require MCAS evaluations and treatment once sequestered by coaches, trainers or physicians on scene.
        - Once called and assuming full patient responsibility, follow protocol. If a physician is in attendance and taken patient responsibility, follow their direction but stay within 6 CCR 1015-3.
    - First or second degree burns to less than 5% body surface area, without inhalation injury, burns to the hands, face or genitalia.
    - Blisters
    - Ear aches, mild head aches
    - Rash without shortness of breath, dizziness or tightness in throat
    - Eye irritation or foreign body sensation
    - Sunburn

VI. **Fire/Hazmat Standbys**

In the event of being paged to a fire and or Hazmat standby the ETMB will respond while the ALS crew member remains available for 911 calls. Respond non-emergent for any fire and/or Hazmat event unless dispatched 911 because of possible injuries. Crews should report to the incident commander and stage in the suggested area. Crews will confirm with IC prior to arrival where they need to stage ensuring the staging area is free from any immediate danger. If there are any doubts, stage further back until you can confirm it's safe.

Ambulance personnel are not to get involved with decontamination of patients and **no one who hasn't been decontaminated is allowed to enter the ambulance**. Contaminated units will be taken immediately out of service until they can be full decontaminated (no exceptions)

All patients are to be brought to the crews a safe distant away from any hazmat or fire scene.

Evaluations of firefighters and others for the purpose of simple rehab will include vital signs and O2 if applicable. In this situation they will not be considered patients however, on your report, list everyone treated for rehab documenting name, distress level and response to treatment.

If however they have a complaint that requires treatment or care over and above simple rehab, they now become patients. Protocols must be followed including treatment modalities, reporting and documentation, which include refusals. Make sure they or their supervisors understand that their respective departments will be billed under their workers compensation so that all required documentation can be filled out appropriately.

NOTE: Any crew member who feels their in eminent danger may request to pull back. These wishes will be respected by all MCAS crew members without hesitation.

THIRD RIDER REQUIREMENTS

Third riding, other than that of a newly hired employ with Morgan County Ambulance, in any capacity is a privilege not a right. Third riding privileges may be revoked at any time for undermining the policies and procedure guidelines of Morgan County Ambulance, or for any violation of contractual agreements between MCAS and the students sponsoring facility, and/or any unprofessional misconduct.

MCAS will have third riders in the following circumstances:

1. New employees making the third rides as per their FTO program.
2. EMT students doing third rides for clinical experience.
3. Members of the MCAS Cadet Program
4. Guest of an on duty crew member

Students

Clinical third rides will be allowed under contractual agreements and must adhere to all policies as they pertain. The purpose will be to assist students with patient assessment and care. All students will be respected as such as should be allowed to participate in all aspects of patient care as long as patient isn't jeopardized.

Students will **NOT** be allowed to drive under any situations, nor will they be allowed to operate any equipment or perform patient procedures without direct supervision. Students will NEVER be assigned nor should they assume total patient care and/or triage. Radio communication is prohibited except for the purposes of patient reports to the hospital under direct supervisor.

General Public

Participants may include anyone from the general public over 16 years of age, family members of staff, firemen, EMT's from other agencies or any other person interested in learning or gaining experience from riding on the ambulance. Riders in this capacity are observer only.
Rides may be scheduled between the hours of 8am and 8pm.

NOTE: General public riders are limited to two-12 hour shifts per week, no more than four per month with a maximum of six per year.

A "Ride Along" application must be completed and approved by the supervisor or director before any rides will be permitted. An application can be obtained from the ambulance administrative office in Ft. Morgan.

Riders do so at their own risk and are not covered under the MCAS liability policy. Each rider must sign a waiver prior to riding or have one on file. In case of an injury to a ride along participant, an incident report will be completed and the supervisor will be notified immediately. Morgan County Ambulance Service is not responsible for injuries sustained by the rider.

The rider's are only allowed (except family members), to ride with the Fort Morgan crews and must remain with them at all times. Delay in responding to a call while waiting for a 3rd rider is prohibited.

All Third Riders must have either been trained on Protected Health Information (PHI) and provide documentation to support this, or be trained prior to riding with MCAS. This can be accomplished by watching the HIPAA video. At the completion of the training, riders must sign the appropriate PHI education form and adhere to the rules of MCAS as they pertain to patient's information.

PARAMEDIC
AGENCY ASSIST PROTOCOL

PURPOSE:

To establish guidelines for the assistance of Paramedics who respond with local fire departments, simultaneously with the ambulance service, but who are not affiliated with Morgan County Ambulance Service, who choose to function as a Paramedic, performing invasive procedures under the advisory of the Morgan County Ambulance Physician Advisor when responding to medical or trauma calls.

GUIDELINES:

Anyone choosing to function as an Agency Assist Paramedic, must first meet with and be approved by the ambulance service physician advisor. Once approved by the physician advisor, the candidate must follow the protocols of the ambulance service as they pertain to conduct and patient care as well as the following modifications:

1. Be familiar with the Morgan County Ambulance Service Protocols or agency protocols which are concordant with Morgan County Ambulance Service Protocols and function under the guidelines set forth by them.
2. Provide documentation to the ambulance service (including a completed trip sheet, patient refusal forms and monitor strips when used) within (24) hours for every call responded to when patient care has been established. The Morgan County Ambulance Service trip sheet is the preferred form for documentation, although other forms may be used when approved by the physician advisor.
3. Provide a copy of the trip report to the physician advisor within 48 hours of the call.
4. Provide feedback relevant to the performance improvement program in a timely manner when requested by the ambulance service director or physician advisors.
5. Provide the MCAS and the physician advisor with an annual list of their continuing education activities each December. Provide documentation to support a minimum of (6) successful endotracheal intubations and (12) successful intravenous access performed within the past year.
6. Provide copies of current certifications and notify the service and the physician advisor immediately of any lapse in certification or any disciplinary actions taken against you as a result of your employment with other agencies.
7. Maintain a current Colorado State approved Paramedic certification as well as Basic Life Support (BLS). For Paramedic's or EMT I they must also maintain Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS) certifications.
8. Demonstrate competencies on an annual basis of the following:
    a. Cardiac monitor used by the service to include tracings, pacing, adult and pediatric defibrillation (paddles and hands free), AED and battery function.
    b. Basic EKG interpretation exam
    c. 50 question protocol exam on medications carried by the service
    d. Doppler functions
    e. Use of medical radio equipment

PROCEDURES:

When responding on calls as an Agency Assist Paramedic the participant will be expected to perform triage as indicated as well as full patient assessments as necessary immediately upon arrival and prior to any invasive interventions. Once the ambulance service has arrived on scene, patient care becomes the responsibility of the responding MCAS personnel, unless the attendants are of a lesser certification. The Agency Assist Paramedic will immediately give a brief report to include the patient's chief complaint, findings and any treatments performed), followed by a handoff of patient care to the responding MCAS personnel.

If invasive procedures are performed by an Agency Assist Paramedic as well as any off duty MCAS personnel who may be on scene with fire or other agencies, the person performing the procedure must accompany the patient to the hospital for continuity of care. Documentation should include procedures performed by Agency Assist personnel.

Medications that can be administered in the field following medical control consult by the Agency Assisting Paramedic's must conform to 6 CCR 1015-3 and will include only the following:

1. Oxygen
2. Normal Saline
3. Glucose
4. D50
5. Narcan
6. First line ACLS medications
7. Nebulized Proventil

Morgan County Ambulance Service will not provide any drugs or IV Supplies for Agency Assisting Paramedic's.

Narcotics will not be available for Agency Assisting Paramedics.

EMT BASIC
AGENCY ASSIST PROTOCOL

PURPOSE:

To establish guidelines for the assistance of EMT Basic's who respond with local fire departments, simultaneously with the ambulance service, but who are not affiliated with Morgan County Ambulance Service, who choose to function as a EMT Basic , performing invasive procedures under the advisory of the Morgan County Ambulance Physician Advisor when responding to medical or trauma calls.

GUIDELINES:

Anyone choosing to function as an Agency Assist EMT Basic, must first meet with and be approved by the ambulance service physician advisor. Once approved by the physician advisor, the candidate must follow the protocols of the ambulance service as they pertain to conduct and patient care as well as the following modifications:

9. Be familiar with the Morgan County Ambulance Service Protocols or agency protocols which are concordant with Morgan County Ambulance Service Protocols and function under the guidelines set forth by them.
10. Provide documentation to the ambulance service (including a completed trip sheet, patient refusal forms and monitor strips when used) within (24) hours for every call responded to when patient care has been established. The Morgan County Ambulance Service trip sheet is the preferred form for documentation, although other forms may be used when approved by the physician advisor.
11. Provide a copy of the trip report to the physician advisor within 48 hours of the call.
12. Provide feed back relevant to the performance improvement program in a timely manner when requested by the ambulance service director or physician advisor.
13. Provide the MCAS and the physician advisor with an annual list of their continuing education activities each December. Provide documentation to support a minimum of (12) successful intravenous access performed within the past year.
14. Provide copies of current certifications and notify the service and the Ambulance Director and physician advisor immediately of any lapse in certification or any disciplinary actions taken against you as a result of your employment with other agencies.
15. Maintain a current Colorado State approved EMT certification as well as Basic Life Support (BLS).
16. Demonstrate competencies on an annual basis of the following:
    a. AED and battery function.
    b. 50 question protocol exam
    c. Use of medical radio equipment

PROCEDURES:

When responding on calls as an Agency Assist EMT the participant will be expected to perform triage as indicated as well as full patient assessments as necessary immediately upon arrival and prior to any invasive interventions. Once the ambulance service has arrived on scene, patient care becomes the responsibility of the responding MCAS personnel, unless the attendants are of a lesser certification. The Agency Assist EMT Basic will immediately give a brief report to include the patient's chief complaint, findings and any treatments performed), followed by a handoff of patient care to the responding MCAS personnel.

If procedures are performed by an Agency Assist Paramedic or EMT, documentation should include procedures performed by Agency Assist personnel.

Medications that can be administered in the field following medical control consult by the Agency Assisting Paramedic's or EMT's must conform to 6 CCR 1015-3 and will include only the following:

8. Oxygen
9. Normal Saline
10. Glucose
11. Aspirin
12. Nebulized Proventil

Morgan County Ambulance Service will not provide any drugs or IV Supplies for Agency Assisting EMT Basics.