

# **STONY BROOK VOLUNTEER AMBULANCE CORPS.**



## **Standard Operating Procedures**

Effective September 2011

## **Table of contents**

| <b>Article</b> | <b>Title</b>                            |
|----------------|-----------------------------------------|
| I.             | Definitions                             |
| II.            | Definition of this Document             |
| III.           | General Policies and Regulations        |
| IV.            | Uniform and Appearance Policies         |
| V.             | Training and Qualifications             |
| VI.            | The Division of Duties                  |
| VII.           | Public Information Policies             |
| VIII.          | Interdepartmental Relations             |
| IX.            | In Quarters Shift Procedures            |
| X.             | General Procedures of Emergency Service |
| XI.            | Procedures of an Emergency Call         |
| XII.           | Company Vehicles                        |
| XIII.          | ALS Company Policies                    |
| XIV.           | Multiple Casualty Incident Procedures   |
| XV.            | Infectious Control Procedures           |
| XVI.           | Health Standards                        |

## Article I: Definitions

- i. AEMT – Advanced Emergency Medical Technician including the certifications of EMT-I, EMT-CC, and EMT-P
- ii. ALS – Advanced Life Support
- iii. BLS – Basic Life Support
- iv. BSI – Body Substance Isolation (formerly known as Personal Protective Equipment (PPE))
- v. CC – Crew Chief
- vi. Chief – Chief of Operations
- vii. Chief’s Office – Refers to the office positions of Chief of Operations, 1<sup>st</sup> Assistant Chief, and/or 2<sup>nd</sup> Assistant Chief.
- viii. CME – Continuing Medical Education
- ix. CMM – Center for Molecular Medicine
- x. CPR – Cardiopulmonary Resuscitation
- xi. DOH – Department of Health
- xii. DOT – Department of Transportation
- xiii. Drugs – Shall include all non-prescription drugs including alcohol or medications taken for recreational purposes, and all prescription medications that may cause drowsiness, inattentiveness, or any mind-altering drug or alcohol.
- xiv. EH&S – Environmental Health & Safety
- xv. EMT – Emergency Medical Technician including the certifications of EMT-B, EMT-D, EMT-I, EMT-CC, and EMT-P.
- xvi. EVO – Emergency Vehicle Operator
- xvii. FTO – Field Training Officer
- xviii. HAZMAT – Hazardous Materials
- xix. HQ – Headquarters
- xx. LISVH- Long Island States Veterans Home
- xxi. MCI – Multiple Casualty Incident
- xxii. MVA – Motor Vehicle Accident
- xxiii. NIMS – National Incident Management System
- xxiv. NYS – New York State
- xxv. OSHA – Occupational Safety and Health Administration
- xxvi. PCR – Pre-hospital Care Report
- xxvii. Police Officer – Shall include State University Police at Stony Brook, Suffolk County Police and New York State Police unless specifically stated otherwise.
- xxviii. President’s Office – Refers to the positions of President and Vice President.
- xxix. Primary Operating Territory – Stony Brook University campus, may be used interchangeably with District, and does not include any portion of SC Rte 97.
- xxx. RMA – Refusal of Medical Assistance
- xxxi. SOP – Standard Operating Procedure
- xxxii. Top Five Officers – Refers to the Officers within the Chief’s Office and the President’s Office.
- xxxiii. UPD – University Police Department

## **Article II: Definition of this Document**

### **Section 2.1: General Purpose**

The purpose of the Stony Brook Volunteer Ambulance Corps., Incorporated, henceforth known within this document as SBVAC, Standard Operating Procedures shall be to define policy and procedure, as well as to aid in the smooth functioning of SBVAC during the course of normal operations.

### **Section 2.2: With Regard to Future Administrations**

SBVAC SOPs will serve as a guide to future administrations to refer to when making policy and procedure modifications as necessary at any future date.

### **Section 2.3: With Regard to Membership**

SBVAC SOPs will serve to give the members of SBVAC a listing of policies and procedures to follow during emergency and non-emergency situations.

### **Section 2.4: Scope of this Document**

These SOPs are designed to be complete and to supplement the brevity and any ambiguities of SBVAC Bylaws. These SOPs shall cover all aspects of operation ranging from day to day of all emergency and non-emergency procedures. These SOPs should be used alongside local and state policies put out by the Suffolk County Department of Health Division of EMS and the New York State Department of Health Bureau of EMS. At no times should this document be used to overrule any policies or laws made by these institutions, but should be used to define specific company policies that would be otherwise unclear.

### **Section 2.5: Applications of this Document**

These SOPs shall be the procedures and protocols which SBVAC shall follow. All aspects of these SOPs shall apply to all members of SBVAC unless specifically stated otherwise. At no time shall these SOPs supersede any item or section stated within SBVAC Bylaws. It shall be the duties of all the designated officers of SBVAC to ensure that all members adhere to these SOPs, as well as the Bylaws of this organization.

### **Section 2.6: Amendments of this Document**

The SOPs shall be amended when seen fit by the Chief. As per the Bylaws, no ratification process is needed, although the Chief shall make every effort to give the Officers and members of SBVAC time to become familiar with the amendments. The Chief shall also attempt to make the new document readily available and to train all members on the changes, if needed.

#### **Subsection 2.6.1: Temporary Amendments of this Document**

The Chief shall make temporary changes to this document by presenting the change in the form of a Chief's Directive. A Chief's Directive may also be used to clarify a policy or Section of this document. Any statement presented to membership in the form of a Chief's Directive shall be considered an extension of this document and followed the

same way. All Directives shall be made available to all of membership by the Chief in a way seen fit by the Chief.

**Paragraph 2.6.1.1: Emergency Amendments**

There may be situations which require immediate amendments to this document. Although these SOPs define our normal policies and procedures, any Chief may verbally grant a member permission to deviate from these SOPs. All verbal amendments are temporary and only are effective for that situation.

## **Article III: General Policies and Regulations**

### **Section 3.1: Attendance**

It shall be mandatory that all active members of SBVAC be present at SBVAC HQ for all assigned weekday and weekend shifts. If a member of SBVAC cannot be present due to extenuating circumstances, said member must find a replacement with the same, or greater, medical and shift qualifications. Said member must also notify the CC of the shift that will be missed as well as the Vice President, either verbally or in writing, in a reasonable time prior to the shift. Invalid excuses or any other violation of this section is punishable by immediate suspension and subsequent dismissal.

#### **Subsection 3.1.1: Advanced Life Support Providers**

In the event that an ALS provider cannot secure coverage from another ALS provider, said member may attempt to find coverage from a BLS provider.

#### **Subsection 3.1.2: Difficulties with Shift Coverage**

In the event that a member of SBVAC is unable to find an adequate replacement, and said member has an excuse with extenuating circumstances involving situations such as medical, family, etc., said member may then contact the Vice President to arrange for coverage. Notification for coverage must be at least twenty-four (24) hours in advance. Such notice shall be delivered both verbally and in writing.

### **Section 3.2: Absences**

Any absences from shift by a member of SBVAC in which said member has found an adequate replacement as per Section 3.1 of these SOPs will be tolerated so long as such absences are not deemed excessive. Absences from shift by a member of SBVAC due to medical or personal reasons must be discussed with the Vice President and then be brought forth to the officers to determine the allowable extent of such absences. Any problems requiring extended or repeating periods of absence from shift by a member of SBVAC must be similarly addressed. Violations of this section will not be tolerated and will result in suspension and subsequent dismissal.

### **Section 3.3: Lateness**

All members of SBVAC are required to report to shift on time. No members of SBVAC should be consistently late to shift for any reason. Exceptions may be granted by the Vice President only. Repeated lateness by a member as per this section must be reported to the Vice President, both verbally and in writing, and will subject said member to disciplinary actions which may include suspension and subsequent dismissal.

### **Section 3.4: Physical and Mental Condition**

#### **Subsection 3.4.1: Definition of Ailments or Injuries**

When reporting for duty, a member of SBVAC shall be in good physical and psychological condition. There must be no ailment or injury which may prevent said

member from the performing and completion of any required duties. There must also be no ailment or injury which may pose a risk to patient or crew.

**Paragraph 3.4.1.1: Reporting of Ailment or Injury**

Any ailment or injury that may prevent said member from the performing and completion of any required duties must be immediately reported to the CC, Chief, and the Vice President. If such ailment or injury prevents said member from completing their responsibilities, said member must find a replacement as per the aforementioned guidelines.

**Subsection 3.4.2: Use of Intoxicants and Drugs**

The use of any material satisfying the definition of drugs is strictly forbidden eight (8) hours prior to shift, responding to calls, or operating or riding in any company vehicle. It is also strictly forbidden to report for shift, operate or ride in any company vehicle, or respond to calls if any substance satisfying this definition was used more than eight (8) hours prior and the effects are still seen. Any violation of this subsection shall result in the immediate suspension and subsequent dismissal of such member. No lesser actions are permissible as punishment.

**Section 3.5: Gratuities**

No member of SBVAC shall at any time accept or receive any money, gift, item, or service in return for services rendered in the capacity as a member of SBVAC. If any persons or organization would like to thank SBVAC for any services rendered, they should be directed to mail a donation to SBVAC.

**Section 3.6: Parking**

**Subsection 3.6.1: SBVAC Vehicle Parking**

The four parking spaces located directly adjacent to SBVAC HQ, reserved for SBVAC, shall be used for the vehicles belonging to SBVAC. Exceptions may be deemed valid by the Chief's Office only. Violations will result in the ticketing and/or towing of the offending vehicle at the owner's expense and the loss of all parking privileges.

**Subsection 3.6.2: Ambulance Personnel Parking**

Parking should be reserved in the parking area adjacent to SBVAC HQ. If any problems involving ticketing occur, it should be brought to the Duty Chief. This should be done promptly, both verbally and in writing. The four (4) spots located in the SBVAC apron shall be given priority to the members of the on-duty crew. If the on-duty crew does not fill up all four (4) spots, then standby crews are next in line to utilize the spots. After crews are parked and if there are spots still available, members conducting SBVAC business, training, and Officers conducting business may utilize the spots. Upon completion of shift or SBVAC business, said member must remove their vehicle immediately. All members should be understandable and reasonable during inter-shift periods, but the on-duty CC shall have overall authority over the apron spots. Should any

confusion occur, the Duty Chief or any Top Five Officer should be contacted immediately. At no time is any SBVAC member to park in the handicapped spaces, grass, or fire zones.

**Paragraph 3.6.2.1 Personnel Parking in Faculty Lot**

SBVAC personnel may park in the adjacent faculty lot for appropriate periods of duration. While parking in this area, SBVAC personnel should have a SBVAC sticker conspicuously displayed on their vehicle to prevent ticketing. Should a SBVAC member receive a ticket, they are advised to inform the Duty Chief as soon as possible. Prolonged vehicle storage in this area is prohibited. If for any reason a SBVAC member cannot remove their vehicle from this area, they must notify a Top Five Officer as soon as possible.

**Paragraph 3.6.2.2 Responding Personnel Parking**

SBVAC members responding to HQ for 2<sup>nd</sup> alarms or a Signal 3 are permitted to park in the apron. Members may double park their vehicle assuming they leave their keys in HQ and do not block in any company vehicle. Members responding for this reason may also park in the spots designated for company vehicles if there are no other parking spots in the apron, but again should leave keys in HQ. For no other reason, other than responding to 2<sup>nd</sup> alarms or a Signal 3, should members park in a company vehicle's spot, unless granted permission by a Chief. Any problems should be immediately addressed to the Duty Chief.

**Section 3.7: Presence in SBVAC Office**

No personnel other than the designated Officers of SBVAC shall be allowed to enter or remain in the Corps office without the permission and presence of an Officer. Any repeated or multiple violation of this Section shall result in immediate suspension and subsequent dismissal. No lesser actions are permissible as punishment.

**Section 3.8: Presence in SBVAC Headquarters**

SBVAC HQ shall consist of all rooms allocated to SBVAC in the Central Operations Complex adjacent to the West Campus Power Plant. All policies set forth in this Section shall be strictly adhered to. Any violations of this section may be punishable by suspension and subsequent dismissal and possible Police intervention.

**Subsection 3.8.1: Non-SBVAC Personnel**

Non-SBVAC personnel are those persons who are not members of SBVAC. Such persons shall be permitted in SBVAC HQ by accompaniment of SBVAC personnel and shall not be left alone at any time. No more than three (3) non-SBVAC personnel are permitted to accompany one (1) SBVAC member. The SBVAC member accompanying the non-SBVAC personnel shall be responsible for and held accountable for any guest(s).

**Paragraph 3.8.1.1: Exceptions**

Non-SBVAC personnel who are permitted to be left alone in SBVAC HQ shall include any Police Officer or EH&S Fire Marshal. Other exceptions may be granted by a Top Five Officer at any time.

**Subsection 3.8.2: Other Areas in the vicinity of SBVAC HQ**

All areas in the vicinity of SBVAC HQ not allocated to SBVAC should not be accessed without prior authorization of an Officer.

**Section 3.9: Messages for Members**

Personal calls and messages for members of SBVAC should be kept to a minimum, but will be tolerated as long as the frequency of such messages is not deemed excessive. Any message for a SBVAC member that is not present at quarters will be recorded on a slip of paper detailing the date, time, and name of the person taking the message, and the message itself. The slip will then be placed on the bulletin board across from office or in the appropriate Officer's mailbox. At no times are there to be any messages or personal memos to be taped or tacked up in any of the rooms without an Officer's initial.

**Section 3.10: Posting of Memoranda**

Due to the large number of members in SBVAC, it is necessary to utilize memos to communicate policy, procedure, and any other pertinent information. All such memos shall be placed upon the appropriate boards as described herein. All SBVAC members must read all posted memoranda when they report for shift, and are held accountable for any information posted if the said member has had adequate time to read such memos.

**Subsection 3.10.1: Crew Room Bulletin Boards**

There are bulletin boards located inside SBVAC crew room. Any Officer may authorize the posting of SBVAC memoranda on the bulletin boards after initialing such memoranda. At no times shall any unapproved or Non-Corps memoranda be posted in SBVAC quarters. Such memoranda will be removed and the poster subject to disciplinary action.

**Section 3.11: Securing of Equipment**

All SBVAC equipment must be kept secure to prevent loss and theft at all times. All SBVAC vehicles will be kept locked while not in use and in view by the duty crew.

**Section 3.12: Securing of Quarters**

All doors to HQ shall be locked whenever the on-duty crew leaves, regardless of purpose or any members that remain behind. SBVAC Office shall remain closed and locked at all times except when a designated Officer of SBVAC is within. Any problems securing HQ shall be brought forth to the Vice President immediately. Any problems securing HQ shall be concluded with the filing of a SBVAC Incident Report.

### **Section 3.13: Use of Personal Property**

The use of personal property of a member of SBVAC while serving on the ambulances is permitted, but not encouraged. Any member of SBVAC can carry and use personal property and items while serving on the ambulances provided such personal property and items are regularly stocked by SBVAC. Any member of SBVAC can carry and use personal property and items not regularly stocked by SBVAC while serving on the ambulances provided such personal property and items are approved by the Chief (30) and the Lieutenant (60) prior.

### **Section 3.14: Pre-hospital Care Report (PCR) Confidentiality and Filing Procedures**

The PCR is a legal medical document; strict procedures for maintaining confidentiality and storage must be followed, as described below. The Chief must approve any exceptions to these procedures. The Chief may not overrule any County, State, or Federal procedures.

1. The Agency (white) copy of the PCR must be filed in a secure location, with access limited to the Chief's Office, the Secretary, and the authorized designees.
2. The PCR or its contents are not to be discussed with any individual not authorized to have access to such information.
3. Prior to filing the PCR, the document shall be kept in a secure location access.
4. Agency copies of PCRs shall be kept on file for no less than six (6) years or three (3) years after the individual receiving medical treatment named on the PCR reaches eighteen years old, whichever period of time is longer.
5. Agency copies of PCRs generated for non-transport activity (RMAs, Standbys, etc.) must be kept on file by the agency for at least six (6) years from the date of the activity. The yellow copy is to be sent to Medical Control by the Secretary for inclusion in the NYS database by the 20<sup>th</sup> of each month. The pink copy may be destroyed.
6. When using PCRs for QA/QI or training purposes, the patient's name, address, telephone number, and the NYS certification numbers of those providing medical treatment should be blocked out. A photocopy of the document should be produced for these purposes with the original document left intact and maintained in accordance with this policy. Copies of the PCR prepared for QA/QI purposes should be destroyed when such copies are no longer needed for QA/QI purposes. Exceptions may be granted by the Chief if demographic information is essential to completing proper review of call.
7. When an agency receives a PCR (yellow) copy with a request for the completion of essential fields, it is to be kept in a secure location until reviewed and completed by the Chief, 1<sup>st</sup> Assistant Chief, or their designee. The completed PCR should be mailed back to the designated PCR collection location as soon as possible.
8. All PCRs must be completed in black ink.
9. PCRs may only be released upon the receipt of a release form signed by the patient or when subpoenaed by an attorney on behalf of a patient. Patients shall have uninhibited access to their own records, and a record of disclosure shall be kept. PCR can only be picked up in person by the patient. The patient must present with a photo I.D. prior to releasing any records. As per Section 7.4 of these SOPs, all requests for PCRs shall be forwarded to the President or Vice President and Chief of SBVAC.

**Section 3.15: Badge Numbers**

The Chief shall assign a badge number to all members who have successfully passed a CC or EVO exam. Badge numbers will be assigned from the date of the written portion of the CC or EVO exam, whichever exam is taken first. That badge number will be permanently assigned to that member, regardless of whether or not the member remains an active member.

**Section 3.16: SBVAC Member Identification Cards**

All members should be issued an I.D. card by the Chief, which should identify said member as a member of SBVAC, their rank, level of training, badge number if available, and a picture of the member. If the member is also authorized to use a green light in their personal vehicle to respond, permission will be displayed on the card. All members should carry their I.D. cards while conducting any SBVAC business, including but not limited to responding to alarms.

**Subsection 3.16.1: Surrender of I.D. Card to Office**

Any Top Five Officer may request any member to surrender I.D. card upon completion or dismissal from service. This includes members who resign their membership, probationary members asked to leave, or members dismissed by office. All members shall agree to this policy by accepting the I.D. card.

## **Article IV: Uniform and Appearance Policies**

### **Section 4.1: On-Duty Uniform**

#### **Subsection 4.1.1: Probationary Members**

All probationary members shall wear the company jumpsuit and closed toed, black shoes or boots while on shift. Clothing underneath the jumpsuit shall consist of, at minimum, shorts and a t-shirt. Underneath uniform clothing shall consist only of the following colors: white, grey, black or blue.

#### **Subsection 4.1.2: General Membership**

All members while on shift are required to wear the approved company polo shirt, EMT/BDU equivalent blue-black pants, and closed toed, black shoes or boots as approved by the Chief. The polo shall display the member's name on the upper front right side with the 'Star of Life' and the phrase 'Stony Brook Volunteer Ambulance' on the upper front left side. The rear of the polo shall consist of the 'Star of Life' in the center with the phrases of 'Stony Brook Volunteer Ambulance', 'SBVAC EMT', 'SBVAC AEMT', or 'SBVAC PARAMEDIC'. Shirts must be tucked in and of appropriate appearance. If a member's uniform is unavailable for adequate reasons, the jumpsuit may be worn as stipulated in Subsection 4.1.1 of these SOPs.

##### **Paragraph 4.1.2.1: Overnight Crews**

Overnight crews are not required to wear their company uniform while remaining in HQ on the condition that they are prepared to don an appropriate uniform prior to leaving the building for either emergency or non-emergency reasons in a timely manner.

##### **Paragraph 4.1.2.2: Supplementary Uniform**

Members may supplement the polo shirt with an approved jacket or quarter-zip by the Chief. All supplementary uniforms must display the member's name as well to be considered an on-duty uniform. The jacket shall be reflective and display the members name on the upper front right side with the 'Star of Life' and the phrase 'Stony Brook Volunteer Ambulance' on the upper front left side with the phrase 'STONY BROOK EMS' on the rear. The quarter-zip shall display the member's name on the upper front right side with the Service Patch on the left side. The member's badge number may also be placed on the right sleeve if member has been assigned a badge number.

##### **Paragraph 4.1.2.3: Exceptions to the Uniform**

The Chief may make exceptions to what can be worn as a uniform. This may be done during the winter and summer, or during any other time approved by the Chief. Temporary adjustments to the uniform policy may be made by the Chief's Office, who will inform membership of the adjustments. Adjustments may include dark

colored jeans and SBVAC approved shirts. Members may still choose to wear the standard on-duty uniform during times of exceptions if they want to.

#### **Subsection 4.1.3: Service Patch**

Each polo for the members of SBVAC shall have the patch of SBVAC sewn on the left sleeve with the top of the patch one inch below the seam of the shoulder. The Service Patch may also be used on company quarter-zips as describe in Paragraph 4.1.2.2 of these SOPs. The SBVAC patch shall not be used or displayed in any other fashion.

#### **Subsection 4.1.4: Level of Training Patch**

Each polo shirt for the members of SBVAC shall have the patch bearing the highest level of training for such member that the suit belongs to sewn on the right sleeve with the top of the patch one inch below the seam of the shoulder.

##### **Paragraph 4.1.4.1: Misrepresentation**

No member shall wear a uniform or borrow another member's uniform bearing another member's name, or a level of training patch of higher certification than his or her own. At no point shall any member respond to a call bearing the insignia or name of another agency.

#### **Subsection 4.1.5: OSHA Gear**

Pants and jackets approved by the Occupational Safety and Health Administration as resistant to blood borne pathogens (OSHA gear) shall be available in HQ at all times for use by the on duty crew or personnel responding to ambulance calls. These garments are intended to supplement, and not replace, the standard on-duty uniform as described in Subsection 4.1.1 and Subsection 4.1.2 of these SOPs. Any member of the on-duty (or responding) crew may choose to wear the OSHA gear when responding to emergency calls at his or her own discretion.

##### **Paragraph 4.1.5.1: Removal from HQ**

OSHA gear is not to be removed from HQ except for use on an emergency call, or by the duty crew if they are leaving HQ for any reason. Non-contaminated OSHA gear shall be returned to the proper location in HQ immediately upon the return of the crew to HQ. Contaminated gear is to be placed in a red bag and left in HQ. The Lieutenant shall be notified immediately of the presence of contaminated OSHA gear.

##### **Line 4.1.5.1.1: Chief's Vehicles**

The Chief and Assistant Chiefs, at the Chief's discretion, may store one set (jacket and pants) of OSHA gear in their personal vehicles for use when responding as a Chief of SBVAC to the scenes of emergency calls.

##### **Paragraph 4.1.5.2: Required Use at Roadway Scenes**

All personnel responding to any emergency call known to be situated on a roadway shall don the appropriate OSHA gear prior to responding.

#### **Line 4.1.5.2.1 ANSI Vests**

All personnel on scenes situated on or near a roadway, must don a reflective ANSI Vest prior to exiting the ambulance or responder vehicle.

#### **Paragraph 4.1.5.3: Crew Chief or Chief's Discretion**

At the scene of an emergency call, or when responding to an emergency call, the CC or any Chief may require all or some members of the crew don OSHA gear.

#### **Paragraph 4.1.5.4: Scheduled Cleaning and Decontamination**

The Lieutenant shall ensure that any OSHA gear that is not contaminated with any chemicals or bodily fluids is cleaned regularly in an interval and manner in accordance with all of the manufacturer's recommendations. Additionally, the Lieutenant shall ensure that any contaminated OSHA gear is decontaminated and cleaned as soon as possible after the incident in accordance with all of the manufacturer's recommendations.

### **Section 4.2: Officer Dress Uniform**

When deemed appropriate, the dress uniform for the designated Officers of SBVAC shall consist of a long sleeve white uniform shirt, blue-black uniform pants, matching tie, black belt, and black shoes. A SBVAC Officer pin shall be placed in the center of the tie, and pins designating the Officer's rank shall be worn on the collar. An approved name plate bearing the Officer's name and title shall be worn on the right side of the chest. An official SBVAC Officer's badge designating the Officer's rank shall be worn on the left side of the chest. The only acceptable commendation bars shall be those issued by the Chief's Office as described in Section 4.4 of these SOPs. Additional pins and bars are to be worn above the badge on a badge holder, subject to prior approval by the Chief. A short sleeve white uniform shirt may be substituted on certain occasions at the discretion of the Office. Ties shall not be worn when a short sleeve uniform shirt is used.

### **Section 4.3: Off-Duty Status**

There may be times when members shall respond to emergencies while off-duty. During an off-duty response, it is recommended but not required, that all members responding don their uniform, as per Section 4.1 of these SOPs, prior to arriving on the scene of the emergency call. If this uniform is unavailable, an approved SBVAC T-shirt or long sleeve shirt may be substituted. These shirts include the shirts that say "STONY BROOK EMS" or "STONY BROOK VOLUNTEER AMBULANCE" or "SBVAC" on the back and are dark blue. Dark jeans may also be worn. Any questions with what is considered appropriate an off-duty response uniform or uniforms responding personnel may wear, a Chief should be contacted. At no time may a member bear the insignia or name of another company or department.

### **Section 4.4: Commendation Bars**

Commendation bars shall be worn only with the Officer Dress Uniform, above the official SBVAC badge on a black badge holder. Commendation bars shall be worn respectively in the order that they appear within this section. All Commendations presented in the form of a pin

may be worn on the on-duty uniform, which includes the Meritorious Service Award, EMT Status Pin, and Years of Service Pin.

**Subsection 4.4.1: Meritorious Service Award**

Deserving members shall be awarded a Meritorious Service Award for *intelligent and valuable* actions during an emergency call that are deemed to be “above and beyond the call of duty.” Nominations for this award shall be made in writing to the Chief’s Office.

**Subsection 4.4.2: Mark Frumkin Memorial Chief’s Award**

The Mark Frumkin Memorial Chief’s Award shall be awarded once per semester, excluding the summer and winter session, to the Crew Chief deemed to have provided the most dedicated service to SBVAC during that semester. Recipients shall be determined solely by the Chief.

**Subsection 4.4.3: Pre-hospital Save Award**

A pre-hospital save award shall be awarded for the successful resuscitation of a cardiac arrest patient. To be considered for a pre-hospital save award, the patient must have had no pulse upon arrival of the first emergency unit (including PD or EH&S), or must have had no pulse at any time while under the care of SBVAC crew. The patient must be brought into the receiving hospital with a pulse, and the patient must survive until hospital admission (transfer out of the Emergency Department to another unit of the hospital). Any crew wishing to be considered for this award must submit a written request to the Chief’s Office including the number of the PCR for the call. This award shall be given to all members of SBVAC who were participants in the eligible call.

**Subsection 4.4.4: Childbirth Award**

A childbirth award shall be awarded for the complete and successful delivery of a child by a SBVAC crew. The child must not have been born prior to the arrival of SBVAC personnel, and must have been born prior to arrival at the hospital. Cutting of the umbilical cord and/or delivery of the placenta are not necessary for a crew to be eligible for this award. Any crew wishing to be considered for this award must submit a written request to the Chief’s Office including the date and dispatch information for the call. This award shall be given to all members of SBVAC who were participants in the eligible call.

**Subsection 4.4.5: Field Training Officer Bar**

The Field Training Officer bar may only be worn by FTOs and Chiefs of SBVAC.

**Subsection 4.4.6: World Trade Center Bar**

An approved World Trade Center memorial bar may be worn by any member desiring to wear one. Only bars with the approved design may be worn.

**Subsection 4.4.7: EMT Status Pin**

Members who hold a New York State Department of Health EMT card may wear a pin designating their level of training.

**Subsection 4.4.8: Years of Service Pin**

Members will be presented pins designating years of service in yearly increments. Members may wear a pin designating years of service.

**Section 4.5: Mourning Badge Covers**

A black elastic band may be worn horizontally over the center of the badge to signify mourning when attending a funeral. A mourning band may also be worn upon notification of the line of duty death of a member of any EMS, police department, or fire department in Suffolk County, until the funeral occurs. Other uses of a mourning band must be approved by the Chief.

# **Article V: Training and Qualifications Policies**

## **Section 5.1: Minimum Progress Rate**

The Minimum Progress Rate for members of SBVAC shall be defined as those minimum requirements set forth in regards for training and advancement of all members of SBVAC as defined by the Captain (50), in consultation with the Chief, at the beginning of every semester.

### **Subsection 5.1.1: Definition of Minimum Progress Rate**

Minimum Progress will include, but may not be limited to, the completion of CPR, NIMS, HAZMAT/WMD/MCI Awareness and EMT Courses, as well as any continuing medical education and/or departmental training sessions as defined by the Captain. All members shall be enrolled in an approved EMT class by twelve months within the first day of their first probationary member class. Said member must complete that class within eighteen months of their first probationary member class. Any members wishing to seek an exception to this policy must seek approval of Office as per Section 2.1.1.2 of the SBVAC Bylaws.

## **Section 5.2: SBVAC Members**

### **Subsection 5.2.1: All Members**

All members must possess at all times a valid and current CPR certification deemed appropriate by the Captain. CFR, EMT and AEMT certifications do not imply CPR certification, and are NOT acceptable substitutes for a valid and current CPR certification under this subsection. Any member in violation of this subsection shall complete an acceptable CPR certification or refresher course within a reasonable period of time as determined by the Captain, not to exceed one semester.

### **Subsection 5.2.2: Crew Chiefs**

To hold the rank of CC in SBVAC, the member in question must successfully complete the following:

- Be currently certified as a New York State EMT or AEMT.
- Have a complete working knowledge of all SBVAC policies and procedures including but not limited to the Bylaws and SOPs of SBVAC.
- Have a working knowledge of emergency medical care and practical skills at their current level of their training.
- The member in question need not hold the position of EVO, or possess a valid New York State driver's license.
- Pass a certification examination issued by the 1<sup>st</sup> Assistant Chief (31) in consultation with the Chief (30).
- After completing the CC exam, satisfactorily run one (1) emergency call with a Charlie or greater response level in the presence of a Field Training Officer and one (1) emergency call with a Charlie or greater response level in the presence of any Chief.

- Prior to sitting for the written examination, members must complete FEMA courses ICS-100, 200, 700 and 340, as well as additional HAZMAT/WMD/MCI awareness courses deemed appropriate by the Chief's Office.

#### **Paragraph 5.2.2.1: Field Training Officers**

Field Training Officers (FTOs) shall be the only CCs who, at their own discretion, are permitted to allow EMTs or AEMTs who are not CC's to be "in charge" of any emergency call. The FTO must supervise all contact between the patient and the trainee, and must remain in the patient compartment with trainee during transport to the hospital. Additionally, the FTO may override any decision, medical or otherwise, the trainee may make, and shall be ultimately responsible for the outcome of the emergency call. This Paragraph shall be strictly enforced.

##### **Line 5.2.2.1.1: Evaluation Forms**

Upon completion of any emergency call during which an FTO permitted a non-CC EMT or AEMT to act in an "in charge" capacity, the FTO shall submit a completed evaluation form as supplied by the 1<sup>st</sup> Assistant Chief within eight (8) hours of the call and returned to the 1<sup>st</sup> Assistant Chief.

##### **Line 5.2.2.2.2: Level of Care**

A trainee under the supervision of an FTO may operate to the highest extent their level of training allows, however they may NOT operate at a higher level of care than that of the FTO. Only Suffolk County Advanced Life Support Preceptors, approved by the Chief and 1<sup>st</sup> Assistant Chief, are permitted to supervise non-CC AEMTs and AEMT students operating at the Advanced Life Support level.

##### **Line 5.2.2.2.3: Chief's Office as FTOs**

Each member of the Chief's Office shall automatically hold the status of Field Training Officer unless otherwise stated by the Chief, and at their option, act in the capacity of FTO without remaining in the patient compartment of the ambulance during transport.

#### **Subsection 5.2.3: EVOs**

To hold the rank of EVO in SBVAC, the member in question must successfully complete the following:

- Must hold a valid, non-restricted Driver's License, eyeglass restrictions notwithstanding.
- Have a complete working knowledge of all SBVAC policies and procedures including but not limited to the Bylaws and SOPs of SBVAC.
- Shall have a thorough understanding of the laws governing Emergency Vehicle Operations, campus roadways, and routes to all local hospitals.
- Complete the requirements, outlined in Paragraph 5.2.3.2 of these SOPs, prior to holding status of EVO.

- Pass a certification examination issued by the 2<sup>nd</sup> Assistant Chief (32) in consultation with the Chief (30). The examination shall consist of a written and practical evaluation driving the ambulance.
- After completing the written and practical evaluation, the member should drive two (2) satisfactory emergency calls of any lights and siren response. One (1) call must be in the presence of a senior driver trainer and one (1) in the presence of a Chief.
- Prior to sitting for the EVO exam, members must complete FEMA courses ICS-100, 200, 700 and 340, as well as additional HAZMAT/WMD/MCI awareness courses deemed appropriate by the Chief's Office.
- Any other requirements set forth by the 2<sup>nd</sup> Assistant Chief (32) in consultation with the Chief (30).

#### **Paragraph 5.2.3.1: Driver Training**

Non-EVOs may only operate a company vehicle in the presence of a Driver Trainer. Any time a non-EVO is operating a company vehicle, a Driver Trainer must be present in the front compartment and directly supervise that member, unless exempted by Subsection 10.14.3 of these SOPs.

#### **Paragraph 5.2.3.2: Driving Training Process**

Any non-EVO member who holds a valid Driver's License and does not meet any of the ineligibility components of Line 5.2.3.3.1 of these SOPs may operate a SBVAC vehicle in the presence of a Driver Trainer or Senior Driver Trainer.

##### **Line 5.2.3.2.1: In-Servicing**

For members who have never driven a SBVAC vehicle or have not driven in the past six months and do not hold the status of EVO, said member must complete an in-servicing. This in-servicing can only be completed by a Senior Driver Trainer in a vehicle pre-determined by the 2<sup>nd</sup> Assistant Chief (32). The 2<sup>nd</sup> Assistant Chief shall inform all Senior Driver Trainers which vehicle should be used as the standard vehicle for in-servicing. Member shall be in-serviced by being made familiar with the vehicle, how to operate it, and basics on driving it. Specifics of what should consist of the in-servicing should be made by the Senior Driver Trainer in consultation with the 2<sup>nd</sup> Assistant Chief.

##### **Line 5.2.3.2.2: Progression of Vehicles**

The main component of driver training shall consist of physically driver training on SBVAC vehicles. This will consist of training on one vehicle until seen proficient on handling and operating that vehicle, and then graduating onto the next vehicle. The trainee should complete training on one vehicle before moving onto another vehicle, and should complete training on a linear path. For example, a trainee should master handling one vehicle, and then move onto the next vehicle, and then the next vehicle. The 2<sup>nd</sup> Assistant Chief shall determine the order of succession. A Senior Driver Trainer shall determine when a trainee is proficient in the handling of a vehicle, and is prepared to move to the next vehicle,

in consultation with the 2<sup>nd</sup> Assistant Chief. A trainee's first session training on a vehicle after moving up should be done with a Senior Driver Trainee.

**Line 5.2.3.2.3: Lights and Siren Training**

Once a trainee has completed training on all company ambulances, and has been recommended by a Senior Driver Trainer to the 2<sup>nd</sup> Assistant Chief to begin Lights and Siren Training (L&S Training), the 2<sup>nd</sup> Assistant Chief may clear the trainee to begin L&S Training. The trainee should complete a L&S in-servicing by any Senior Driver Trainer. Following the in-servicing, the trainee may drive on any emergency call only with a Senior Driver Trainer present in the front passenger seat.

**Line 5.2.3.2.4: Completion of Driver Training**

Upon driving on a few emergency calls with a Senior Driver Trainer, and being seen as sufficient in driving emergency calls, a Senior Driver Trainer may recommend the trainee to the 2<sup>nd</sup> Assistant Chief to be evaluated for examination. At the point of recommendation, the 2<sup>nd</sup> Assistant Chief will determine the following progression of the trainee and any other requirements that should be completed. Upon completing all requirements, the trainee should be examined to receive the status of EVO.

**Line 5.2.3.2.5: Evaluation of Driver Trainee**

All Senior Driver Trainers and driver trainers must complete evaluations supplied by the 2<sup>nd</sup> Assistant Chief in a timely fashion. The evaluations should be kept by the 2<sup>nd</sup> Assistant Chief and made available to viewing by all Driver Trainers.

**Paragraph 5.2.3.3: Miscellaneous**

All drivers must submit a copy of their driver's license for verification to the company. This information will be held as confidential. All drivers shall be reevaluated annually by the 2<sup>nd</sup> Assistant Chief or Chief, as seen necessary by the Chief's Office.

**Line 5.2.3.3.1: Ineligibility**

Members may not operate a SBVAC vehicle in any capacity if they:

- Have more than nine (9) points on their license if driving more than two (2) years.
- Have more than six (6) points on their license if driving less than two (2) years.
- Have had two (2) or more chargeable accidents within the previous eighteen (18) months if driving more than two (2) years.
- Have had one (1) chargeable accident if driving less than two (2) years.
- Have a DUI or DWI conviction.
- Have a restricted license.

#### **Subsection 5.2.4: Attendants**

All members holding the rank of attendant must complete the minimum progress rate outlined in Section 5.1 of these SOPs. This may include attending company-training sessions, as well as a certain number of CC trainings and/or driver training hours. This will be determined by the Captain in consultation with the Chief's Office. All attendants must also complete an attendant check-off biannually during times determined by the Captain. The contents of the attendant check-off will be specified by the Captain, but should include material including, but not limited to, basic emergency medical services, NYS EMT-B Protocols, and a working knowledge of the SBVAC SOPs and Bylaws. Attendants should also have completed FEMA courses ICS-100, 700 and 340, as well as additional HAZMAT/WMD/MCI awareness courses deemed appropriate by the Captain, in consultation of the Chief.

#### **Subsection 5.2.5: Probationary Members**

All members selected to become a new member who falls into the category described in SBVAC Bylaws Section 2.1.2 must complete the training requirements set forth by the Captain. The Captain shall determine the specifics of training, but should include training in OSHA, CPR, NIMS/FEMA, HAZMAT/WMD/MCI awareness courses, and EMS and SBVAC operations training. Probationary members must also complete the minimum progress rate outlined in Section 5.1 of these SOPs, as well as a number of CC trainings and/or driver training hours. The requirements shall be determined by the Captain at the beginning of the semester. Any probationary member who does not meet the requirements set by the Captain will be asked to resign their status as a probationary member. Probationary members will also have to complete an attendant check-off during the beginning of their 2<sup>nd</sup> semester in SBVAC before being eligible to be sworn in.

#### **Subsection 5.2.6: Continuing Education**

The Captain shall conduct a number of company-training sessions during the semester. The Captain may have instructors and other knowledgeable people from SBVAC and other fields host these company trainings. The Captain shall announce the training dates at the first general membership meeting of each semester in order to ensure an adequate time period in which the members may free time for the allotted dates, but may update the training schedule as needed. The Captain shall also announce at this meeting the required number of company trainings each member shall be required to attend.

##### **Paragraph 5.2.6.1: Penalties**

Any active full member failing to attend the aforementioned training requirements will be subject to immediate disciplinary action. Any probationary member failing to complete the aforementioned required trainings shall also be subject to immediate disciplinary action as well, and may be subject to dismissal as per Section 2.1.2.6 of the SBVAC Bylaws.

## **Section 5.3: Quality Assurance/ Quality Improvement (QA/QI) Program**

### **Subsection 5.3.1: Definition of Quality Assurance/ Quality Improvement**

Appropriate patient care is a medical and legal necessity. NYS BLS and Suffolk County ALS protocols define such care. EMS alarms are reviewed on a routine basis. The QI approach seeks to identify the actions to determine if the organization is operating at peak efficiency, applying uniform and appropriate care and response to recognized areas of excellence, and to address deficiencies through the continuing medical educational process. At the County level, and the agency level, individual QA/QI is an on-going and important tool in ensuring standards of care are adhered to, in an effort to ensure optimal patient care consistent with established policies and protocols, reduce liability and risk to providers, agencies, the County, and all interested parties. SBVAC shall participate in QA/QI at the County level, but shall also have an internal QA/QI program in place to ensure the highest standard of care is being delivered.

### **Subsection 5.3.2: QA/QI Program in SBVAC**

The Chief of SBVAC shall be responsible for the continuing oversight of patient care of all providers within SBVAC by acting as Chair of the QA/QI Committee, or by appointing a member to serve as Chair. The Chief shall not only be involved in the activities of the Committee, but should ensure that proper trainings are provided to SBVAC as a whole to correct or improve any general areas that are seen weak by the Committee, with the 1<sup>st</sup> Assistant Chief. The Chief shall also ensure all providers within SBVAC who make any protocol violations, deviations of standard NYS and Suffolk County EMS policies, have poor patient outcome, or make any deviations from SBVAC standard operating procedures are corrected and provided with proper training to correct mistakes. The Chief may deem it appropriate to suspend a member for a serious offense, but most issues can be handled by proper review/discussion of the call and training. Although the QA/QI Committee should identify any and all violations discussed above, and should correct them via the Chief by individual and companywide trainings, the overall goal of the Committee is to improve patient care and not to place blame anywhere.

#### **Paragraph 5.3.2.1: Members of the Committee**

Committee members should consist of SBVAC members, active and inactive, and should include experienced personnel in the fields of EMS, medicine, logistics, and SBVAC. Outside persons who hold expertise in any of the fields listed above may also serve on the committee. Members should include the Chief's Office, as well as a number of additional members. The Chief shall have overall authority of the members of the Committee, but should use the resources and experience of the general membership to the fullest capabilities. This should be done by inviting medical doctors, nurses, physician assistants, paramedics, EMTs, and other highly qualified members involved in EMS, to sit on the Committee. At any time, the Chief may dismiss or invite a member to sit on the Committee.

**Paragraph 5.3.2.2: Organization of the Committee**

The Chief shall sit as Chair of the Committee, and should delegate individual responsibilities as needed. The Committee should meet physically at least monthly to review all policies and procedures being followed by the Committee, as well as to review the information obtained, but most of the communication will be done via telephone and email. The Chief is responsible for the copying, scanning, and protecting patient confidentiality of all PCRs, and distributing them to the Committee for review on a monthly basis.

**Paragraph 5.3.2.3: Goals of the Committee**

The goals of the Committee are not to punish EMTs who make protocol violations, deviations of standard NYS and Suffolk County EMS policies, have poor patient outcomes, or make any deviations from SBVAC Standard Operating Procedures, but to correct those errors by companywide trainings. The purpose of this Committee is to identify mistakes made by providers in a non-biased manor and to correct those errors. If points of weakness are discovered in patient care, those points shall be seen as general areas that need improvement by all members of the company. The Chief may also deem it necessary to individually contact a provider regarding errors discovered by the Committee regarding said provider's patient care and/or documentation. The method of evaluating shall be determined by the Chief and the Committee, but should be primarily completed by evaluating PCRs.

**Line 5.3.2.4.1: Evaluating PCRs**

All members of the Committee may participate in the collection of data and other valuable information which will be collected from all the PCRs. That collected data and information shall be discussed by the Committee at the monthly meetings, and have the statistical highlights analyzed in order to evaluate patient care. All calls ran by an AEMT at an ALS level should only be evaluated by a Committee member who is also an AEMT. All calls ran under EMT-B Protocols can be evaluated by any EMT Committee member.

## **Article VI: The Division of Duties**

All Officers of SBVAC shall have the additional following duties, and shall have the authority to appoint aides as per Section 6.3 of these SOPs.

### **Section 6.1: The Operational Board**

The Chief shall be responsible for the day-to-day operational duties of SBVAC.

#### **Subsection 6.1.1: Duties of the Chief of Operations**

Refer to Section 3.2.1 of the SBVAC Bylaws.

##### **Paragraph 6.1.1.1: Temporary Changes by the Chief**

The Chief may substitute temporary changes in operational policy and procedure when such changes are needed immediately. The Chief must notify all Operational Officers of SBVAC of changes to operational policy and procedure as soon as possible. In consultation with the President, the Chief shall convene a meeting of the Officers of SBVAC, who shall determine if such changes shall remain in effect.

##### **Paragraph 6.1.1.2: Scene of an Ambulance Call**

The Chief shall be the Officer in charge of all operations at the scene of an ambulance call involving SBVAC.

##### **Paragraph 6.1.1.3: Absence of the 1<sup>st</sup> Assistant Chief and/or 2<sup>nd</sup> Assistant Chief**

The Chief shall assume or delegate all duties and responsibilities of the absent officer or officers.

##### **Paragraph 6.1.1.4: Best Interest of the Corps**

The Chief shall at all time work in the best interest of SBVAC as determined by the Officers of SBVAC.

##### **Paragraph 6.1.1.5: In Charge of Inquiries**

The Chief shall be in charge of all inquiries of the day-to-day operations of SBVAC as well as the business of the Operational Board of SBVAC.

##### **Paragraph 6.1.1.6: Special Events CC/EVO**

The Chief, in consultation with the 1<sup>st</sup> Assistant Chief, may appoint a special event's CC. The Chief, in consultation with the 2<sup>nd</sup> Assistant Chief, may appoint a special event's EVO.

##### **Paragraph 6.1.1.7: Relations with Outside Agencies**

The Chief shall act as the liaison between SBVAC and all University and non-University agencies related to emergency operations and the like, including, but not limited to, neighboring fire or EMS departments, Police Departments, Suffolk County FRES, Suffolk County EMS, and the NYS Department of Health.

## **Subsection 6.1.2: Duties of the 1<sup>st</sup> Assistant Chief**

Refer to Section 3.2.2 of the SBVAC Bylaws.

### **Paragraph 6.1.2.1: Temporary Changes by 1<sup>st</sup> Assistant Chief**

The 1<sup>st</sup> Assistant Chief may substitute temporary changes in the operational policy and procedure when such changes are needed immediately. The 1<sup>st</sup> Assistant Chief must notify all Operational Officers of SBVAC of changes to operational policy and procedure as soon as possible. The 1<sup>st</sup> Assistant Chief shall convene a meeting of the Officers of SBVAC, who shall determine if such changes shall remain in effect.

### **Paragraph 6.1.2.2: Scene of an Ambulance Call**

At the scene of an ambulance call involving SBVAC, the 1<sup>st</sup> Assistant Chief shall, be the second in command, in charge of all operations, or in the absence of the Chief, be the first in command.

### **Paragraph 6.1.2.3: Supervision of Operations**

The 1<sup>st</sup> Assistant Chief shall supervise all of the daily ALS and communications.

#### **Line 6.1.2.3.1: Advanced Life Support**

The 1<sup>st</sup> Assistant Chief shall be responsible for all ALS equipment and training. If the 1<sup>st</sup> Assistant Chief is not a qualified ALS provider, he or she shall appoint and oversee, in consultation with the Chief, the most suitable ALS provider to act as the ALS Coordinator.

#### **Line 6.1.2.3.2: Communications Equipment**

The 1<sup>st</sup> Assistant Chief, in consultation with the Chief, shall be responsible for the inventory, maintenance, installation, and distribution of all communications assets and related accessories belonging to SBVAC. Communications assets shall include, but not be limited to pagers, portable two-way radios, mobile two-way radios, base station two-way radios and tone encoders, and cellular telephones. The 1<sup>st</sup> Assistant Chief shall keep a detailed record of each piece of equipment and the location or member to which it is assigned.

### **Paragraph 6.1.2.4: Crew Chief Training**

In consultation with the Chief, the 1<sup>st</sup> Assistant Chief shall be directly responsible for the training of CCs and potential CCs. The 1<sup>st</sup> Assistant Chief shall hold a number of CC training sessions as seen reasonable by the 1<sup>st</sup> Assistant Chief.

#### **Line 6.1.2.4.1: Crew Chief Meetings**

The 1<sup>st</sup> Assistant Chief shall hold at least one (1) CC meeting, mandatory for all CCs per semester.

**Line 6.1.2.4.2: Crew Chief Selection**

The 1<sup>st</sup> Assistant Chief shall, in consultation with the Chief, have the power to appoint qualified members of SBVAC to the rank of CC. The 1<sup>st</sup> Assistant Chief shall inform Office of any new CCs.

**Line 6.1.2.4.3: Field Training Officer Selection**

The 1<sup>st</sup> Assistant Chief shall, in consultation with the Chief, appoint highly qualified Crew Chiefs of SBVAC to the position of Field Training Officer (FTO). Members being promoted should have approximately one (1) year as an active CC in SBVAC, but the exact timeframe should be determined by the 1<sup>st</sup> Assistant Chief based on experience. The 1<sup>st</sup> Assistant Chief shall, in consultation with the Chief, also have the power to remove any member from the position of FTO. Each semester, the 1<sup>st</sup> Assistant Chief shall maintain in HQ a list of all current FTOs. In addition, before a CC can be appointed to the position of FTO, said member must complete FEMA training ICS-800 as well as any other training seen fit by the 1<sup>st</sup> Assistant Chief, in consultation with the Chief.

**Subsection 6.1.3: Duties of the 2<sup>nd</sup> Assistant Chief**

Refer to Section 3.2.3 of the SBVAC Bylaws.

**Paragraph 6.1.3.1: Drivers**

The 2<sup>nd</sup> Assistant Chief shall be responsible for the oversight and training of all EVOs and operators of any SBVAC vehicles.

**Line 6.1.3.1.1: EVO Meetings**

The 2<sup>nd</sup> Assistant Chief shall hold at least one (1) EVO meeting, mandatory for all EVOs per semester.

**Line 6.1.3.1.2: EVO Selection**

The 2<sup>nd</sup> Assistant Chief shall, in consultation with the Chief, have the power to appoint qualified members of SBVAC to the rank of EVO. The 2<sup>nd</sup> Assistant Chief shall inform Office of any new EVOs.

**Line 6.1.3.1.3: Driver Trainer Selection**

The 2<sup>nd</sup> Assistant Chief, in consultation with the Chief, shall appoint highly qualified drivers of SBVAC to the position of Driver Trainer. Members being promoted should have approximately six (6) months as an active EVO in SBVAC, but the exact timeframe should be determined by the 2<sup>nd</sup> Assistant Chief based on experience. The 2<sup>nd</sup> Assistant Chief, in consultation with the Chief, shall have the power to remove any member from the position of Driver Trainer. Each semester, the 2<sup>nd</sup> Assistant Chief shall maintain in HQ a list of all current Driver Trainers.

**Line 6.1.3.1.4: Senior Driver Trainer Selection**

The 2<sup>nd</sup> Assistant Chief, in consultation with the Chief, shall appoint highly qualified driver trainers of SBVAC to the position of Senior Driver Trainer. Members being promoted should have approximately six (6) months as an active Driver Trainer, but the exact timeframe should be determined by the 2<sup>nd</sup> Assistant Chief based on experience. The 2<sup>nd</sup> Assistant Chief, in consultation with the Chief, shall have the power to remove any member from the position of Senior Driver Trainer. Each semester, the 2<sup>nd</sup> Assistant Chief shall maintain in HQ a list of all current Senior Driver Trainers.

**Paragraph 6.1.3.2: Vehicle and Maintenance Operations**

The 2<sup>nd</sup> Assistant Chief, in consultation with the Chief, shall have the authority to make policy and procedure with regard to SBVAC vehicle and maintenance operations.

**Line 6.1.3.2.1: Driver check**

The 2<sup>nd</sup> Assistant Chief shall ensure that a mechanical check shall be done on a regular basis ensuring the vehicle is fit for use as per NYS DOT and NYS DOH requirements, and shall complete a driver check at least once per month on each vehicle.

**2,500 mile Inspection/Maintenance:**

1. Change oil and filter.
2. Lubricate all chassis fittings, king pins, and inspect front suspension.
3. Lubricate the universal joints.
4. Check the level of the power steering, transmission, and differential fluid.
5. Check the batteries (gravity per cell) and clean connection terminals.
6. Inspect emission control system canister (for damage).
7. Check carburetor/fuel injector return line system to canister/fuel tank.
8. Check pump and belt drive.
9. Check the fuel filler cap (must be original equipment).
10. Inspect fuel lines for leaks.
11. Turn air conditioning/heating system on for 10 minutes to determine proper distribution and or heating or cooling devices.
12. Check coolant system and hoses.
13. Inspect all alarm and warning devices.
14. Check operation of wipers and blades.
15. Inspect radios and antennas.
16. Road test by 2<sup>nd</sup> Assistant Chief.
17. Set wheel lug nuts to proper torque.

**5,000 mile Inspection/Maintenance:**

1. Inspect, clean and lubricate face cam of fuel injector pump (if applicable).
2. Check engine idle speed, throttle operation and idle return spring.

3. Inspect and lubricate body mechanisms.
4. Drain water from fuel filter bowl (diesel vehicles).

10,000 mile Inspection/Maintenance:

1. Change the air cleaner, fuel filter and positive crankcase ventilation filter.
2. Change the automatic transmission fluid and filter.
3. Check the battery switch and isolator system.
4. Replace spark plugs.
5. Check distributor cap, rotor and spark plug wiring.
6. Check the operating temperatures at both the front and rear for air conditioning and heating.
7. Check the condition of the coolant fluid/gas and all parts of the air conditioning system.
8. Adjust all doors.
9. Inspect and lubricate the weather stripping, latches, door positioners, hood latch, and spare tire support system.
10. Inspect all cabinets, tighten and adjust all screws.
11. Inspect and repair upholstery.
12. Polish all paint and chrome.
13. Inspect braking system.

20,000 mile Inspection/Maintenance:

1. Replace battery cables.
2. Test battery and starter voltage draw.
3. Check radiator thermostat.
4. Check radiator cap, inspect radiator for leaks, and replace hoses as needed.
5. Check brake master cylinder fluid level.

**Line 6.1.3.2.2: Vehicle maintenance**

This operations policy addresses Section 800.21(p)(8) of the New York State EMS Code which requires that every certified ambulance service “shall have and enforce written policies concerning” preventive maintenance requirements for all authorized EMS response vehicles and patient care equipment.

**Line 6.1.3.2.3: Record of Vehicle Failures**

The 2<sup>nd</sup> Assistant Chief shall, in consultation with the Chief, maintain a record of all unexpected Ambulance and Emergency Ambulance Service Vehicle failures and corrective actions. A copy of this record shall be submitted to the NYS DOH with SBVAC’s biennial recertification application.

**Paragraph 6.1.3.3: Insurance Matters**

In consultation with the Chief, Vice President, and Treasurer, the 2<sup>nd</sup> Assistant Chief shall assist in matters pertaining to insurance.

#### **Subsection 6.1.4: Duties of the Captain**

Refer to Section 3.2.4 of the SBVAC Bylaws.

##### **Paragraph 6.1.4.1: Organization of Courses**

The Captain shall have the responsibility for the organization of all training courses offered to and required of SBVAC members.

##### **Paragraph 6.1.4.2: Training Requirement**

The Captain shall dictate the training requirements for all members of the Stony Brook Volunteer Ambulance Corps. The Captain shall forward to the Vice President a list of all members who did not complete their training requirements.

##### **Line 6.1.4.2.1: On Shift Training**

The Captain shall create a portfolio of trainings to be completed by all probationary members while on shift. These trainings shall be done under the supervision of a CC or designated aide as assigned by the Captain.

##### **Line 6.1.4.2.2: Minimum Progress Rate**

The Captain shall set the minimum progress rate of all SBVAC members at the beginning of every semester as outlined in Subsection 5.1 of these SOPs.

#### **Subsection 6.1.5: Duties of the Lieutenant**

Refer to Section 3.2.5 of the SBVAC Bylaws.

##### **Paragraph 6.1.5.1: Rig Checks**

The Lieutenant shall ensure that an ambulance equipment check is completed every shift and all necessary supplies are on the ambulance. There may be times when the Lieutenant, in consultation with the Chief, may adjust this policy, and will inform membership when doing so. The Lieutenant shall also ensure that all patient care equipment is in a clean and working order. If any discrepancies arise, the on-duty CC shall inform the Lieutenant and note such discrepancies on the rig check sheet. All completed rig check sheets are to be filed and stored for easy future reference. These records are subject to inspection by the New York State Department of Health.

##### **Line 6.1.5.1.1: Rig Checks on all Vehicles**

The Lieutenant shall ensure that rig check is completed at least once weekly on each vehicle that is considered in-service.

##### **Line 6.1.5.1.2: Record of Equipment Failures**

In the event of the discovery of any failed or defective patient care equipment that could have resulted in harm to a patient, the Lieutenant shall, in consultation with the Chief's Office, maintain a record of such failures and corrective actions taken on a NYS DOH approved form. A copy of this record shall be submitted to the New York State Department of Health with SBVAC's biennial recertification

application. If the equipment failure causes harm to a patient, the procedures described in Paragraph 11.2.7.1 of these SOPs must also be followed.

**Paragraph 6.1.5.2: Uniforms**

The Lieutenant shall ensure that uniform orders are placed in a timely fashion at the beginning of every semester, and shall be responsible for distributing them when they arrive. The Lieutenant shall ensure that all uniforms and jumpsuits that are owned by the company are washed regularly and kept in usable condition.

**Paragraph 6.1.5.3: Preventative Maintenance**

Preventive maintenance for the stretchers, stair-chairs, and scoop stretchers shall be conducted at least every six (6) months or as recommended by the manufacturer.

**Section 6.2: The Executive Board**

**Subsection 6.2.1: Duties of the President**

Refer to Section 3.1.1 of the SBVAC Bylaws.

**Paragraph 6.2.1.1: Temporary Changes by the President**

The President may substitute temporary changes in administrative policy and procedure when such changes are needed immediately. The President must notify all Officers of SBVAC of changes to administrative policy and procedure as soon as possible. The President shall convene a meeting of the Officers of SBVAC, who shall determine if such changes shall remain in effect. The President is not to institute any changes in any operational proceedings.

**Subsection 6.2.2: Duties of the Vice President**

Refer to Section 3.1.2 of the SBVAC Bylaws.

**Paragraph 6.2.2.1: Insurance Matters**

The Vice President shall, in consultation with the 2<sup>nd</sup> Assistant Chief, the Chief, and the Treasurer, shall be in charge of matters pertaining to insurance.

**Paragraph 6.2.2.2: Regular Shift Scheduling**

The Vice President shall also be responsible for the assignment of the stand-by, weekday, and weekend shifts for all members.

**Paragraph 6.2.2.3: Personnel Records**

The Vice President shall be responsible for maintaining accurate records of members, including but not limited to, membership status (active/ lifetime/ honorary/ associate/ etc.), awards, citations, disciplinary actions, etc. The Vice President shall also maintain member health records as described in Section 16.3 of these SOPs.

**Subsection 6.2.3: Duties of the Treasurer**

Refer to Section 3.1.3 of the SBVAC Bylaws.

**Subsection 6.2.4: Duties of the Secretary**

Refer to Section 3.1.4 of the SBVAC Bylaws.

**Paragraph 6.2.4.3: Quality Assurance of Patient Care Reports**

The Secretary shall examine all PCRs, in recording calls, to ensure that all data is filled in appropriately and report any shortcomings to the Chief and/or the 1<sup>st</sup> Assistant Chief.

**Section 6.3: Aides to the Officers**

Refer to Section 3.4.1 of the SBVAC Bylaws

**Subsection 6.3.1: Command Authority of Aides**

Aides shall, at the scene of an ambulance call involving SBVAC, act only in their capacity (as attendants, EVOs, etc.), and shall not exercise any special command authority.

**Section 6.4: Chain of Command at an Emergency Scene**

The Chain of Command at an emergency scene is defined as the order of authority of all those present at an emergency scene in charge of scene control.

**Subsection 6.4.1: The Chain of Command**

The Chain of Command at an emergency scene will be as follows:

1. Chief of Operations (30)
2. 1<sup>st</sup> Assistant Chief (31)
3. 2<sup>nd</sup> Assistant Chief (32)
4. Line Officer Crew Chiefs in accordance to rank
5. Field Training Officers (FTO) in order of arrival
6. On-Duty Crew Chiefs
7. Additional Crew Chiefs in order of arrival

**Paragraph 6.4.1.1: Officers on the Duty Crew**

If any Line Officer Crew Chief is a member of the primary crew that responded, such Officer is only within the Chain of Command as an “On-Duty Crew Chief” unless relieved by someone of equal standing. This Paragraph shall not apply to any Chief Officer.

**Paragraph 6.4.1.2: Incident Command System**

At any scene where the Incident Command System is invoked, the Chain of Command shall no longer apply in a linear fashion as described in this Subsection. Instead, the highest member in the Chain of Command, as described in this

Subsection, shall assume the role of, or appoint another person to the role of, the Incident Commander.

### **Section 6.5: Duties of the CCs**

The CC shall be responsible for all crew members and their actions during required shifts. The CC shall have the duty and responsibility to supervise and perform all emergency medical care during required shifts. The CC shall complete all regularly scheduled shifts and any special shift responsibilities during required shifts.

#### **Subsection 6.6.3: Emergency Response**

In consultation with the EVO, the CC shall decide upon the proper type of response needed during an ambulance call. All decisions regarding type of response shall be made in accordance with Subsections 11.1.1 and 11.3.4 of these SOPs.

### **Section 6.6: Duties of the EVOs**

EVOs shall have the responsibility of driving the ambulances to the scene of an emergency call, to the hospital, and back to base in a manner approved by the 2<sup>nd</sup> Assistant Chief. An EVO must possess a current valid driver's license. EVOs must operate the service vehicles in compliance with all applicable provisions of the Vehicle and Traffic Laws of the State of New York, and agree to periodic reviews of the NYS Department of Motor Vehicle records by an authorized officer or member of the agency. In addition, they must meet all requirements described in Subsection 5.2.3 of these SOPs.

#### **Subsection 6.6.1: Radio Transmissions**

EVOs shall be responsible for transmitting their status to the dispatcher. The status that shall be reported shall include when the unit is en route, arrived on-scene, proceeding to hospital, arrived at hospital, and ready for service/returning to HQ.

#### **Subsection 6.6.2: Status in Ambulance**

EVOs may be directed by the CC (or by any member in the Chain of Command) to remain in the ambulance at the scene of an emergency call. If this is the case, the EVO shall remain in the ambulance, in radio contact, until called by the CC to render aide, or to transport equipment between the ambulance and the scene, or otherwise directed by any member listed within the Chain of Command. Exceptions are to be made accordingly, such as in the placing of flares at the scene of a roadway accident.

### **Section 6.7: Duties of the Attendants**

Attendants shall assist the CC in rendering emergency medical care.

#### **Subsection 6.7.1: Equipment Check**

Attendants shall be responsible for checking equipment as designated by the Lieutenant and must have a thorough working knowledge of all ambulance equipment and its use.

**Section 6.8: Duties of Probationary Members**

Probationary Members shall be responsible for assisting the attendant(s) in equipment check and shall only participate in patient care at the discretion of the CC.

**Section 6.9: Emergency Medical Technicians****Subsection 6.9.1: EMT-B**

Must demonstrate competency in all NYS EMT-B skills and equipment usage, Must keep EMT-B and CPR certifications current.

**Subsection 6.9.2: AEMT-Intermediate**

Must demonstrate competency in all NYS EMT-I skills and equipment usage. Must keep EMT-I and CPR certifications current.

**Subsection 6.9.3: AEMT-Critical Care**

Must demonstrate competency in all NYS EMT-CC skills and equipment usage. Must keep EMT-CC, ACLS and CPR certifications current.

**Subsection 6.9.4: AEMT-Paramedic**

Must demonstrate competency in all NYS EMT-P skills and equipment usage. Must keep EMT-P, ACLS and CPR certifications current.

### **Section 6.10: All Positions**

All members in active duty status must be able to:

- Use appropriate body substance isolation procedures.
- Assess safety of the scene, gain access to the patient, and assess extent of injury or illness.
- Extricate patient from entrapment.
- Communicate with dispatcher requesting additional assistance or services as necessary.
- Determine nature of illness or injury.
- Visually inspect for medical identification emblems to aid in care.
- Use prescribed techniques and equipment to provide patient care.
- Provide additional emergency care following established protocols.
- Assess and monitor vital signs and general appearance of patient for change.
- Make determination regarding patient status and priority for emergency care using established criteria.
- Reassure patient, family members and bystanders.
- Assist with lifting, carrying and properly loading patient into and out of the ambulance.
- Avoids mishandling patient and undue haste.
- Determine appropriate medical facility to which patient will be transported.
- Transport patient to medical facility and providing ongoing medical care as necessary en route.
- Report nature of injury or illness to receiving facility.
- Ask for medical direction from medical control physician and carries out medical control orders as appropriate.
- Assist in moving patient from ambulance into medical facility.
- Report verbally and in writing observations of the patient's emergency and care provided to emergency department staff and assists staff as required.
- Comply with regulations in handling deceased, notifies authorities and arranges for protection of property and evidence at scene.
- Replace supplies, properly disposes of medical waste.
- Properly clean contaminated equipment according to established guidelines.
- Check all equipment for future readiness.
- Maintain ambulance in operable condition.
- Ensure cleanliness and organization of ambulance, its equipment and supplies.
- Determine vehicle readiness.
- Maintain familiarity with all specialized equipment.

## **Article VII: Public Information Policies**

### **Section 7.1: Privileged Information**

Any information contained on a call sheet shall be treated as confidential information and shall not be discussed with or disclosed to anyone except SBVAC members or observers personally involved in the call and Hospital Staff as necessary for patient care.

#### **Subsection 7.1.1: Police Officers Requesting Privileged Information**

Police Officers not present at the scene of an emergency call may NOT be given confidential information regarding any patients at said call. Any such requests shall be forwarded to the Chief immediately.

### **Section 7.2: Public Information**

Any queries that may ensue at the completion of a call must be promptly referred to the Chief or the President. The CC may disclose that there was a call, the nature of the call, and the hospital to which the patient was transported. No other information shall be disclosed.

### **Section 7.3: Media**

The President and Chief must be advised as soon as possible of any inquiries from the press. Any release of information must be deemed appropriate in accordance with Section 7.1 and Section 7.2 of these SOPs and any applicable sections of the SBVAC Bylaws.

#### **Subsection 7.3.1: Cooperation with Media**

At all times, SBVAC shall make every attempt to cooperate with the media without sacrificing patient confidentiality, unless such cooperation interferes with patient care. If the media is interfering with patient care at the scene of any emergency call, a Police Officer shall be requested to intervene.

#### **Subsection 7.3.2: Operational Inquiries**

In accordance with Paragraph 6.1.1.5 of these SOPs, the Chief shall be in charge of all inquiries of the day-to-day operations of SBVAC as well as the business of the Operational Board of SBVAC. Additionally, the Chief shall be in charge of any inquiry relating to any specific emergency call.

#### **Subsection 7.3.3: Executive Inquiries**

In accordance with Paragraph 6.2.1.4 of these SOPs, the President shall be in charge of all inquiries related to the business of the Executive Board of SBVAC.

### **Section 7.4: Release of Documents**

PCRs shall only be released to the receiving hospital. Any requests for copies or viewing of the PCR should be referred to the Chief and President or Vice President. As per Section 3.14 of these SOPs, all requests must be received in writing, and must be accompanied by permission to release the PCR executed by the patient or authorized on behalf of the patient.

## **Article VIII: Interdepartmental Relations**

### **Section 8.1: Police Officers**

The CC on-duty will handle all dealings with Police Officers at the scene of an ambulance call, including any requests for information by a Police Officer at the scene.

#### **Subsection 8.1.1: At the Scene**

Police Officers are in charge of the scene, SBVAC crews are in charge of patient care.

#### **Subsection 8.1.2: Discrepancies with Police Officers**

Any conflicts arising on the scene of an emergency call with the Police Department should not be addressed until after the patient care is rendered. Conflicts should be avoided; however, any problems shall be reported to the Chief's Office as soon as possible.

### **Section 8.2: Residence Hall Staff**

Residence Hall Staff shall consist of Resident Assistants (RAs), Residence Hall Directors (RHDs), and Quad Directors (QDs). At no time should patient care be delayed due to inappropriate requests by residential staff.

### **Section 8.3: University Health Service Administrators**

If a University Health Service Administrators requests information or has questions pertaining to the service rendered by SBVAC, they shall be referred to the Chief's Office.

### **Section 8.4: Student Health Service Center Staff**

A full report must be obtained from any Student Health Service provider passing patient care. Hospital staff should be notified origin of patient when giving hospital present via radio.

### **Section 8.5: Long Island State Veterans Home**

All calls that are received from the Veterans Home must be regarded as an emergency. Patient transport should not be delayed in order to wait for paperwork. Due to severity of LISVH emergencies, any mutual aid calls to the LISVH received from the Emergency Dispatch system, regardless of graded response, shall be upgraded to a lights and sirens response. After contact with patient, it is at the discretion of the CC to downgrade.

### **Section 8.6: Local Fire Departments**

The Stony Brook University campus is jointly protected by the Stony Brook Fire Department and the Setauket Fire Department. Either agency may be called upon for mutual aid or encountered at the scene of an incident requiring a Fire Department response. The Incident Commander or SBVAC member on scene who places highest within SBVAC Chain of Command, as per Subsection 6.4.1 of these SOPs, shall coordinate with the person in command of any Fire Department operation.

### **Subsection 8.6.1: Emergency Calls Outside SBVAC's District**

The situation may arise where a SBVAC ambulance is flagged down for or mistakenly dispatched to an incident that is outside our Primary Operating Territory as defined in Article I of these SOPs. While operating at any such incident, no additional SBVAC resources are to be requested to the scene without first requesting the resources or permission from the agency having jurisdiction over the incident.

#### **Paragraph 8.6.1.1: Flagged Down Outside SBVAC's District**

Upon being flagged down at any incident outside SBVAC's district, the crew shall immediately notify MEDCOM via radio or telephone of the exact nature, exact location, and (if known) which fire or EMS district the incident is located within. The crew shall direct MEDCOM to notify the appropriate agency, and MEDCOM shall notify SBVAC's crew via radio if the outside agency will be responding to the incident.

#### **Paragraph 8.6.1.2: Mistaken Dispatch to an Incident Outside SBVAC's District**

Immediately upon the discovery that an incident to which SBVAC has been dispatched is not entirely located within our district, the crew shall immediately notify MEDCOM via radio or telephone of the exact location of the incident, and (if known) which fire or EMS district the incident is located within. The crew shall direct MEDCOM to notify the appropriate agency, and MEDCOM shall notify SBVAC's crew via radio if the outside agency will be responding to the incident.

#### **Paragraph 8.6.1.3: Exceptions**

This Subsection shall not apply to any incident at the Long Island State Veterans Home or at University Hospital Medical Center at Stony Brook. Additionally, this Subsection shall not apply to any incident to which SBVAC is dispatched for a Signal 24 (mutual aid).

### **Section 8.7: Special Event Standbys**

The Chief may arrange for a SBVAC unit or crew to standby at a Special Event. A Special Event may include, but is not limited to a campus event expecting a large crowd, an athletic event, or covering another Fire Department's or EMS agency's district.

#### **Subsection 8.7.1: Large crowd/Athletic Event**

Any standby for an event expecting a large crowd or an athletic event shall be organized by the Chief. Based on the location and nature of the event, the Chief will design a response plan for that event, and will brief all members involved in the event on that plan. In the event where there is an alarm in district, and there is no crew available, a Chief may direct a standby crew to take the alarm and Signal 3 for a crew to standby at the original event, assuming the original standby crew was located in district.

**Paragraph 8.7.1.1: Treatment and Transportation of Patients at a Standby**

If any person at the special event requires transportation to a medical receiving facility, an attempt should be made to have the on-duty SBVAC ambulance respond to the standby if available. The on-duty crew is to stay at the standby until relieved by the standby crew.

**Line 8.7.1.1.1: Over 5,000 Attendees**

In any standby with over 5,000 attendees, a health care facility shall be established with the equipment outlined in New York State Sanitary Code Part 18.2. The health care facility must be staffed with at least one (1) CC and attendant certified as an EMT. If an ambulance is used as the health care facility, it must remain on site for the duration of the event. In addition, at least two (2) additional ambulances should be on site, if available, and must meet the minimal requirements for a full crew outlined Section 10.14 of these SOPs. At least two (2) roaming crews, each consisting of at least one (1) EMT should be on site as well. The Chief's Office may adjust these requirements if needed.

**Paragraph 8.7.1.2: Documentation at Mass Gathering Events**

At any event with over 5,000 attendees, a New York State Sanitary Code Part 18 Public Function Event Report must be completed by a Chief or the standby's incident commander, and submitted to the NYS DOH within five (5) days following the event. In addition, a New York State Sanitary Code Part 18 Public Function Medical Incident Log should be kept documenting all encounters with patients during the standby. For events with less than 5,000 attendees, a SBVAC Medical Incident Log should be kept. A PCR must be used for any patient who is transported, or any patient whom the CC believes needs to go to the hospital but refuses transport. All forms documenting the incident and patient interactions should be kept on file for seven (7) years. A PCR should also be used to document that there was a crew standing by at the large event, even if no patient contact was made.

**Subsection 8.7.2: Outside District Coverage**

A crew may be arranged to cover an outside EMS district for a set time period. The crew shall be arranged by the Chiefs, and be briefed on the district they are covering. The Chiefs will also coordinate how many crew members are needed, and if a SBVAC vehicle will be used, or if the outside agency will be providing vehicles. All members maintain their SBVAC rank while on the outside district coverage standbys, and should follow these SOPs while acting in outside districts, unless otherwise directed by the Chiefs. A PCR should be created for the standby itself, and each patient contact, with the original PCRs returned to HQ. All members must maintain a professional relationship with members of outside agencies while participating in the standby, and any issue shall be directed to a Chief immediately.

# **Article IX: In Quarters Shift Procedures**

## **Section 9.1: In House Duties**

The following duties are to be completed on every shift in the order listed below. It is also the responsibility of the crew to check the memo boards for any additional duties required or changes in procedure.

### **Subsection 9.1.1: Rig Check**

The attendants and probationary members of the shift must complete a rig check sheet as per the Lieutenant. Rig check should be performed at the beginning of all regular shifts to ensure proper equipment is stocked on the ambulance. It is the responsibility of the on-duty CC to ensure that rig check is performed. Adjustments to when rig check are performed will be made by the Chief if they are not to be performed every shift, such as during the summer and winter. Any AEMTs permitted to operate at the Advanced Life Support Level, regardless of their position on the crew, must complete an ALS Rig Check sheet provided by the 1<sup>st</sup> Assistant Chief or ALS Coordinator.

#### **Paragraph 9.1.1.1: Full Rig Check Cannot be Completed**

If the on-duty crew is unable to complete rig check for a valid reason, they must nonetheless write in the name of the crew and provide the reason they could not complete the check in the comments section of the rig check sheet.

### **Subsection 9.1.2: Vehicle Wash**

If the exterior of the on-duty vehicle is considered extensively dirty, the on-duty CC should ensure the exterior of the vehicle is washed.

### **Subsection 9.1.3: On-Shift Training**

All on-shift training, as set forth by the Captain, shall be completed before the end of the tour. It is the CC's responsibility to complete all on-shift training. In the event of ambulance calls preventing the completion of on-shift training, it shall be completed the following week.

### **Subsection 9.1.4: HQ Cleanliness**

It is the responsibility of the CC to ensure that HQ is in a clean and usable state at all times. The incoming CC does not need to accept the responsibilities of the shift until HQ is in a clean and usable state. If any problems arise, a Top Five Officer should be notified verbally and in writing. If the incoming CC accepts the responsibilities of the shift, it becomes that CC's responsibility to ensure HQ is in a clean and usable state at the completion of the tour regardless of the origin of any discrepancies.

### **Subsection 9.1.5: Miscellaneous Responsibilities**

Office may request tasks of the crew before the conclusion of the tour. The on-duty crew must do their best to complete said tasks.

## **Section 9.2: Food in Company Vehicles**

Absolutely no eating or drinking will be tolerated in any company vehicle at any time. Exception shall only be made for the purpose of providing rehabilitation at an incident. Food and beverages may be transported in an ambulance provided that at no time shall there be any food or beverage in the patient compartment. Alcoholic beverages may not be present in any company vehicle at any time, without exception.

### **Subsection 9.2.1: Plastic containers**

As per NYS Part 800 requirements, any volume of liquid in excess of 249 milliliters must be in a plastic container to be transported on the ambulance.

## **Section 9.3: Non-Corps. Work**

Any work not related to SBVAC may only be done when all Corps work has been completed.

## **Section 9.4: State of Readiness**

The on-duty crew of SBVAC will always be in a state of readiness for the emergency and non-emergency operations outlined in these SOPs. Any on-duty crew must always maintain the ability to respond to an emergency without unreasonable delay. If a delay is encountered, said crew must contact the Duty Chief as soon as possible and communicate the reason.

## **Section 9.5: Change of Tours**

### **Subsection 9.5.1: General Information**

All members of SBVAC should arrive promptly to each shift so as to assure a smooth transition of personnel at the change of tours. If any members are late, those from the preceding tour must remain until adequate coverage is maintained. No member may leave until dismissed by the on-duty CC within reasonable limits.

#### **Paragraph 9.5.1.1: Procedure for Missing Personnel**

If any SBVAC personnel fail to arrive at the appointed time for their assigned shifts, the CC should attempt to contact them by telephone and notify the Vice President. In the event that the CC and/or EVO that is replacing the previous crew is missing or late, and every attempt has been made by the CC and EVO to contact their relief, the Duty Chief should be contacted ASAP. If the CC and EVO on shift are not relieved at the end of their assigned tour, they are not permitted to leave HQ and must remain on shift to ensure district coverage. Other CCs and EVOs may be contacted to provide coverage, but the Duty Chief should be informed immediately.

# **Article X: General Procedures of Emergency Service**

## **Section 10.1: Pagers**

Active CCs and EVOs are to be given pagers by the 1<sup>st</sup> Assistant Chief to respond to calls. Each pager is the responsibility of the member to whom it is assigned. At no time shall a member give a pager to any other member without the direct approval of the Chief's Office. If a member shall be unavailable for an extended period, the pager must be returned to the Chief's Office.

### **Subsection 10.1.1: Use of Pagers**

Pagers shall be utilized whenever SBVAC is providing on-duty service to its district or if the on-duty crew is not in headquarters. If there is no scheduled on-duty crew, members may respond to the ambulance or first responder vehicle in an "off-duty" capacity as necessary. Members will also be notified of 2<sup>nd</sup> or 3<sup>rd</sup> alarms and Signal 3 via activation of their pager. Members should keep their pagers on when not in HQ and not on-duty but available, to ensure sufficient manpower can be organized if a Signal 3 is requested.

## **Section 10.2: Additional Personnel to Scene**

A SBVAC Chief or the on-duty CC may request additional personnel to respond to scene by requesting MEDCOM activate SBVAC for a Signal 3. All members responding to scene for any reason approved in Article X of these SOPs should inform MEDCOM and provide their badge number and rank. Only CCs and EVOs will be expected to respond to scenes for a Signal 3 to scene if requested. If a Signal 3 is requested by MEDCOM for a full crew, members must respond to HQ to bring an additional ambulance to scene in a manner outlined in Subsection 10.10.1 of these SOPs. CCs and EVOs may respond automatically without a Signal 3 to scene with an ambulance if the nature of the alarm falls under the categories described in Subsection 10.12.1 of these SOPs. Only under extreme circumstances will non-CCs and non-EVOs be approved. Any non-approved member responding to scene will face disciplinary action at the discretion of the Chief's Office.

### **Subsection 10.2.1: Officers**

Chief Officers may respond to the scene of any emergency call to oversee the functioning of the crew and ensure their safety. Other Operational Line Officers may not respond to the scene of any emergency call unless granted specific prior permission by the Chief's Office.

### **Subsection 10.2.2: AEMTs**

Any AEMT credentialed to provide Advanced Life Support by SBVAC, as per Subsection 13.1.3 of these SOPs, may respond to the scene of any emergency call they reasonably believe may require ALS interventions. AEMTs responding should inform MEDCOM of their en route and on scene statuses, and should attempt to contact the Duty Chief.

### **Subsection 10.2.3: Other Personnel**

Off-duty personnel may not respond to any scene unless granted prior approval from the Chief's Office or as outlined in Section 10.2 of these SOPs. Additional personnel responding to the scene shall assist the duty crew and shall serve at the expense of the on-duty CC. At anytime, the responding off-duty member may be informed by the on-duty CC that their help is not needed. That member shall comply with the on-duty CC's request under all circumstances. This does not apply to AEMTs who believe that the patient requires care that can only be provided under protocols they are allowed to perform by Suffolk County ALS Protocols. All parties shall keep patient care as their first priority and any disagreements shall be presented to a Chief.

#### **Paragraph 10.2.3.1: At Scene Prior to Crew**

If any off duty personnel are at the scene prior to the on-duty crew's arrival, they will give a report of any information they have obtained and relinquish aid to the CC unless otherwise instructed.

#### **Paragraph 10.2.3.2: Emergency Calls at a Roadway**

It is suggested that all personnel responding for a Signal 3 to the scene take an ambulance if a full crew is available, especially when responding to a roadway scene. Some circumstances may contradict responding to HQ to use an ambulance, for example passing the scene to respond to HQ. Once MEDCOM has been informed that said member is responding, said member may contact the Duty Chief for advice as to whether or not to respond directly to the roadway scene or respond to HQ first.

## **Section 10.3: Use of Personal Property**

Responding personnel as per Section 3.13 of these SOPs may use personal property.

### **Subsection 10.3.1: Personal Vehicles**

Personal vehicles are not to be used to respond to calls unless given approval by the Chiefs of SBVAC. At no times shall a member drive in any area designated as "inner quad" or "academic mall" unless otherwise directed by a Chief.

#### **Paragraph 10.3.1.1: Green Light**

It is advised, but not required, that personnel who regularly respond with their personal vehicles purchase a green light for their vehicle as outlined by the NYS DOT. In addition, said member must contact the Chief to receive a "green light card" to authorize the use of such lights. Only active CCs and EVOs may request permission to receive authorization to use a green light on their SBVAC I.D. card according to Section 3.16 of these SOPs, assuming they meet other NYS Department of Motor Vehicle's requirements. The 2<sup>nd</sup> Assistant Chief shall also give the CC and EVO a brief description of how to respond using a green light prior to authorization.

**Paragraph 10.3.1.2: Blue lights**

The use of blue lights is prohibited when responding as a member of SBVAC, unless prior consent is granted by the Chief's Office.

**Paragraph 10.3.1.3: Red Lights (Emergency Ambulance Service Vehicles)**

The use of red lights in a personal vehicle is strictly regulated by NYS law. The use of red lights may be granted solely at the discretion of the Chief and is strictly prohibited otherwise. Authorizing a personal vehicle to display red lights requires that the vehicle be classified as an Emergency Ambulance Service Vehicle (EASV) and that the appropriate paperwork is filed with the NYS DOH. The procedure for NYS DOH authorization of an EASV is found in NYS EMS Policy Statement 01-01. It is strongly recommended that a copy of the policy statement and these SOPs be carried in the vehicle for reference purposes.

**Line 10.3.1.3.1: Training Requirements**

The owner of a personally owned vehicle classified as an EASV must hold a minimum NYS certification of EMT. In addition, SBVAC shall require that the member using their personal vehicle as an EASV be a CC and an EVO with the company.

**Line 10.3.1.3.2: Equipment Requirements**

The EASV must be stocked to meet the requirements of Part 800.26 at all times. All equipment shall be the responsibility of the member. The equipment must be checked and inventoried at least biweekly using a NYS DOH Inspection Worksheet for EASVs. This form may be found in the NYS EMS Agency Operational Resource Guide. Completed forms must be given to the Lieutenant who will file them accordingly.

**Line 10.3.1.3.3: Maintenance**

The member shall be responsible for maintaining the EASV and equipment in accordance with all manufacturers' recommendations.

**Line 10.3.1.3.4: ALS Equipment**

As per Suffolk County protocols, ALS equipment, such as sharps, and medications, is not to be carried in a personally owned EASV except as stated in Subsection 13.2.7 of these SOPs.

**Line 10.3.1.3.5: Insurance Coverage**

The EASV must be insured by the owner of the vehicle; however any accident that occurs while responding to a call shall be covered by SBVAC's insurance policy.

**Line 10.3.1.3.6: Vehicle Response Policy**

The EASV is to respond using the policies specified in Subsection 11.1.1 of these SOPs and may respond to HQ or the scene of any call, unless otherwise specified by the Chief.

**Line 10.3.1.3.7: SBVAC Records**

SBVAC shall keep on file copies of the following for any vehicle certified as an EASV: EMT certification, Driver's License, Vehicle Registration, Proof of Insurance, DMV Safety/Emissions inspection verification, a copy of the NYS DOH issued Emergency Vehicle Authorization Card, and Equipment Checklists.

**Line 10.3.1.3.8: Expiration of Authorization**

The expiration date of the EASV authorization shall be determined by the Chief, but must not exceed the expiration of the member's EMT certification. The authorization shall be automatically considered invalid if the individual is no longer an active member of SBVAC or if the individual is not a currently certified EMT or AEMT.

**Line 10.3.1.3.9: Inspection by SBVAC**

Any EASVs authorized by SBVAC are subject to state inspection, and SBVAC will be held accountable by the NYS DOH for any violations. Therefore, any vehicle authorized by SBVAC as an EASV may be inspected by any member of the Chief's Office at any time for the purpose of ensuring compliance with Part 800 and correcting any potential violations. It is recommended that such an inspection be conducted at least twice per year.

**Line 10.3.1.3.10: Revocation of Authorization**

The Chief may revoke an EASV authorization for any reason at any time with or without explanation. When an authorization is revoked or expired, the Chief shall mail a written notice to the NYS DOH.

**Section 10.4: Non-Corps. Personnel in Company Vehicles**

No Non-Corps personnel shall ride in any vehicle owned by SBVAC at any time with the following exemptions:

**Subsection 10.4.1: Patients and Acquaintances**

Non-SBVAC personnel permitted in the ambulances shall include the patient and no more than one of the patient's acquaintances. The patient's acquaintance must ride in the front passenger seat and remain buckled for the duration of the trip. Exceptions may be granted at the discretion of the CC (i.e. transporting a minor).

**Subsection 10.4.2: Medical Staff**

Non-SBVAC personnel permitted in the ambulances shall include any nurses, Physicians, or EMS personnel of higher medical ability, or as deemed appropriate by the CC.

### **Subsection 10.4.3: Police and Fire Marshals**

Any Police Officer or Fire Marshal may be permitted to ride in any company vehicle as deemed appropriate by the CC.

### **Subsection 10.4.4: Observers**

Non-SBVAC personnel permitted in any company vehicle shall include observers having obtained prior written approval from the Chief, and agree to and sign a confidentiality agreement. Observers may include, but are not limited to, any EMT/AEMT student, the press, and any other layperson who wishes to observe on ambulance calls. Observers shall not have the rights of a member, and may be dismissed at any point at the discretion of any Top Five Officer or on-duty CC. Observers may not be in charge of patient care; however, they may assist at the discretion of the preceptor/CC. They are never to perform any procedures above the level of their training or that of the preceptor/CC they are observing under. All Observers must sign a waiver of responsibility in order to participate in this program, and must be dressed appropriately; a conservative color (black, white, grey or dark blue) polo shirt and BDUs or pants.

## **Section 10.5: Crew Responsibilities**

### **Subsection 10.5.1: CC Responsibilities**

The CC on duty will be responsible for the administration of all patient care while on shift and the safety of the crew.

#### **Paragraph 10.5.1.1: Ambulance**

The CC on duty will be responsible for the ambulance and its equipment while on shift.

#### **Paragraph 10.5.1.2: Problems on Shift**

The CC on duty will be responsible for the notification to the Duty Chief of any problems or difficulties that occurred while on shift.

#### **Paragraph 10.5.1.3: Communications**

The CC will be responsible for communicating with hospital staff concerning any patients being transported to the hospital, as well as all communication with Medical Control. The CC shall assist the EVO in communicating with the dispatcher, as well as any other personnel required to be contacted during the course of the alarm.

#### **Paragraph 10.5.1.4: Incidents Requiring Immediate Notification**

The CC will be responsible for the immediate notification to the Chief's Office by telephone or email for every instance in which the crew encounters a situation outside of normal operating procedures. The CC will also be responsible for filling out an approved SBVAC Incident Report no later than twenty-four (24) hours if the crew encounters a situation outside of normal operating procedures. Any Chief may request the CC to fill out an Incident Report, even if not required by these SOPs.

### **Subsection 10.5.2: EVO Responsibilities**

The EVO will be responsible for the driving operations of the emergency vehicle at all times, its contents and overall crew safety in consultation with the CC.

#### **Paragraph 10.5.2.1: Communications**

The EVO shall be responsible for all radio communications with the assistance of the CC to MEDCOM. MEDCOM must be kept advised of the vehicle's status at all times during a call situation, including, but not limited to when the unit is en route, arrived on-scene, proceeding to hospital, arrived at hospital, and ready for service/returning to HQ.

#### **Paragraph 10.5.2.2: On Scene Vehicle Procedures**

All SBVAC vehicles shall be positioned in a manner to facilitate crew accessibility to the scene and the equipment on the ambulance.

##### **Line 10.5.2.2.1: Ambulance Unsupervised**

As appropriate, the engine shall be left running in high idle, any needed warning lights left on, the parking brake engaged, the ignition override engaged and the keys removed. The driver shall also ensure that all doors are locked before leaving the vehicle unattended. Although environmental and public health should be considered when leaving an engine running, it is appropriate, and legal under NYS DOT laws, to leave an engine running during the course of an emergency call to keep the patient compartment warm or cool, depending on the external environment conditions.

#### **Paragraph 10.5.2.3: Incidents Requiring Immediate Notification**

The CC may request the EVO fill out an approved SBVAC Incident Report no later than twenty-four (24) hours after an incident. This should be done in every instance in which the crew encounters a situation outside of normal operating procedures. The EVO should comply with the CC's request to fill out an Incident Report. Any Chief may request the EVO to fill out an Incident Report as well, even if not required by these SOPs. In addition, the EVO may fill out an Incident Report even if the CC does not believe one is needed.

#### **Paragraph 10.5.2.3: Collision with Ambulance**

If involved in a collision, the crew shall:

1. Protect the scene with warning lights or flares. If the vehicles are in a hazardous location and they are drivable, they may be moved to the side.
2. Notify MEDCOM, preferably by telephone, that the unit was involved in a collision, and:
  - a. Request a SBVAC Chief and Police to respond to scene as well as any other necessary fire/rescue apparatus.

- b. If the ambulance was en route to the scene of a call, instruct MEDCOM to dispatch another ambulance to that assignment.
  - c. If the ambulance is transporting a patient and has been rendered inoperable, instruct MEDCOM to send an additional ambulance to transport the patient.
  - d. If the ambulance has not been rendered inoperable, inform MEDCOM that an additional ambulance for the current patient is not necessary.
3. Ascertain if there are any injuries to any SBVAC personnel or others.
4. If the ambulance is transporting a patient who is critical/ unstable, the ambulance is not rendered inoperable, and there are no other critical/ unstable patients at the scene, instruct the other vehicle operator to remain on the scene and await the return of the ambulance. Give the involved party the company name, vehicle identifier, the EVO's name; record their name, vehicle type, make, and license number before leaving the scene. If the crew has a dispensable member, have them remain on scene to begin paperwork.
5. Care for any injured persons and request additional ambulance(s) as necessary.
6. Do not make any statements to other drivers concerning the collision, and speak only with police and patients until a Chief arrives on scene. Exchange necessary information with others involved. Record the Police Officer's name, shield number, any tickets issued, and draw a rough sketch of the accident scene.
7. Obtain name, address, telephone number, and brief statement from any witnesses.
8. Ensure that even the minor injuries are well documented and receive appropriate emergency department follow-up as needed.
9. Complete a SBVAC Incident Report within twenty-four (24) hours of any collision.
10. Report incident to the New York State Bureau of EMS in writing.
11. Any driver involved in an accident will be immediately suspended from driving any SBVAC vehicle for at least one (1) week, pending a safety hearing and review of driving skills by the Chief's Office.

#### **Paragraph 10.5.2.4: Vehicle Breakdown**

In the event that a SBVAC vehicle breaks down either during the course of an emergency call or under normal operating procedures, the EVO will advise MEDCOM and request a Chief of SBVAC to respond to the scene. If the vehicle failure occurs during normal operations, an Incident Report is not required, but may be requested at the discretion of the Chief's Office.

##### **Line 10.5.2.4.1: Emergency Call**

If the vehicle breaks down during the course of an emergency call, MEDCOM shall be instructed to tone out for another SBVAC ambulance, if available, or

request mutual aid from another agency to respond to the appropriate location. A SBVAC Incident Report must be completed, and the New York State Bureau of EMS informed in writing as well.

#### **Subsection 10.5.3: Attendant Responsibilities**

The Attendant will be responsible for assisting with patient care as directed by the CC.

#### **Subsection 10.5.4: Probationary Members' Responsibilities**

The probationary member is responsible for carrying out actions as deemed appropriate within their level of training as instructed by the CC.

### **Section 10.6: Change of Tours**

It is the responsibility of the previous crew to exchange any information or knowledge necessary to the functioning of the following crew. No crew member may leave before their appropriate replacement arrives for shift, unless a reasonable amount of time has passed, or dismissed by the on-duty CC.

### **Section 10.7: Refueling of Vehicles**

It is the responsibility of all crews to refuel the on-duty vehicle when the fuel level drops to three-quarters fuel tank capacity or below.

#### **Subsection 10.7.1: Primary Refueling at Setauket Fire Department Fuel Station**

All vehicles shall be refueled at the Setauket Fire Department Fuel Station. Both diesel and gasoline pumps are located there, so all company vehicles can be refueled there. The engine should be off during any time the vehicles are being refueled. Any problems with the fuel station, the EVO should attempt to contact the Setauket FD Dispatcher and inform them that they are from SBVAC, your unit number, and the problem. Judgments as to how long to wait to refuel should be made with the CC. The Duty Chief should be contacted for any prolonged wait, or in any unusual event.

### **Section 10.8: Additional Assistance**

#### **Subsection 10.8.1: Additional Personnel**

In the event that additional personnel or ambulances are needed at a scene, MEDCOM must be contacted by the CC with the appropriate request. If the circumstances permit, the CC must also notify the Duty Chief of the request to facilitate the response.

#### **Subsection 10.8.2: Mutual Aid**

In the event that mutual aid is necessary, the CC will contact MEDCOM with the appropriate signal and state what is required at the scene of the emergency call. If the circumstances permit, the CC must also notify the Duty Chief of the request to facilitate the inter-agency response.

### **Subsection 10.8.3: Advanced Life Support**

In the event that the CC determines, either before arrival at scene or upon arrival at scene, that Advanced Life Support interventions may be necessary, a Signal 3 for ALS to respond to scene may be transmitted through MEDCOM. The CC must initiate and continue any BLS care and preparations for transport, including transfer to the ambulance, as if no ALS assistance was available. Even if ALS personnel are known to be en route, transport is not to be delayed at any time to wait for an ALS response. If the circumstances permit, the CC must also notify the Duty Chief of the request to facilitate the ALS provider's response.

## **Section 10.9: Crew Confirmation and ALS Graded Response**

SBVAC shall participate in Suffolk County Fire Rescue and Emergency Services (FRES) mutual aid plan, and authorizes MEDCOM to request mutual aid responses on our behalf as necessary. MEDCOM shall request mutual aid in accordance with their own protocols, taking into account the incident location, location of the mutual aid agency, primary service territory, authorized level of service, staff, and apparatus availability, as well as any other pertinent information when requesting mutual aid on behalf of SBVAC.

### **Subsection 10.9.1: For all Alpha, Bravo and Charlie calls**

1. Any crews shall notify MEDCOM that they are in or en route to HQ within two (2) minutes.
2. If a complete crew cannot be identified within two (2) minutes from initial dispatch, a call for additional personnel (Signal 3) shall be initiated.
3. If a complete crew cannot be identified at four (4) minutes from time of initial MEDCOM, a request for mutual aid (Signal 24) shall be initiated. The Duty Chief shall continue to attempt to muster a crew until MEDCOM notifies SBVAC that the ambulance has arrived on scene.

### **Subsection 10.9.2: For all Delta and Echo calls**

1. Any crews shall notify MEDCOM that they are in or en route to HQ within two (2) minutes.
2. If a complete crew cannot be identified at two (2) minutes, a request for mutual aid (Signal 24) shall be initiated. The Duty Chief shall continue to attempt to muster a crew until MEDCOM notifies SBVAC that the ambulance has arrived on scene.

#### **Paragraph 10.9.2.1: Extending time to request Mutual Aid**

The first arriving Emergency Medical Technician on scene may extend or shorten the time to request mutual aid as medically appropriate or as scene conditions dictate.

### **Subsection 10.9.3: ALS Graded Response**

For reasons outlined in Paragraph 11.1.1.2 of these SOPs, any available ALS personnel are to contact the Duty Chief during any Charlie, Delta, or Echo alarms. If an ALS provider is unable to make contact with the Duty Chief, they may proceed to scene after

contacting MEDCOM and identifying themselves, their badge number, and their level of training, and their en route and on scene status.

## **Section 10.10: Simultaneous Alarms or No Response Activation**

### **Subsection 10.10.1: 2<sup>nd</sup> and 3<sup>rd</sup> Alarm Activation**

In the event that SBVAC is dispatched to a 2<sup>nd</sup> or 3<sup>rd</sup> alarm, all available members are to contact MEDCOM and identify themselves by providing their SBVAC badge number and rank. After informing MEDCOM of their status, responding member shall respond to HQ and wait in the next due ambulance. Member shall advise MEDCOM the ambulance is on a Signal 9 and request any call ins over the radio, and await further instructions by MEDCOM. MEDCOM may request member to respond to scene alone if he or she is an EVO and a CC will respond to scene. At no times shall any member respond directly to scene unless specifically requested by MEDCOM or a Chief. Once a full crew, defined by Section 10.14 of these SOPs, has arrived and is in the ambulance, the crew may proceed to alarm. Once a full crew is ready, there should be no delay to wait for other responding members, even if they are known to be en route to HQ. Attendants and probationary members may join the full crew of a 2<sup>nd</sup> or 3<sup>rd</sup> alarm if they are already at HQ at the time of activation. No attendant or probationary member may respond to HQ for any additional alarm unless specifically requested by the Chiefs. Responding members may call HQ prior to responding to HQ or calling MEDCOM in order to inquire about a possible second crew already at HQ. Once an attempt has been made to contact HQ and if no second crew has been identified, available members must contact MEDCOM and respond immediately.

### **Subsection 10.10.2: SBVAC No Response Activation**

In the event that no member responds to an initial activation, MEDCOM shall reactivate for a full crew needed. All available members are to contact MEDCOM and identify themselves by providing their SBVAC badge number and rank, and follow the similar procedures outlined in Subsection 10.10.1 of these SOPs.

#### **Paragraph 10.10.2.1: Standby (Signal 9) Use**

MEDCOM will automatically place the additional crew on a Signal 9 once a CC and EVO have called in and have been identified. No member should request a Signal 9 while calling in since MEDCOM will automatically do it once a full crew has been identified and is responding to HQ.

#### **Paragraph 10.10.2.2: MCI and Disaster Operations**

During an MCI or Disaster situation, as determined by Suffolk County FRES, the maximum call receipt interval shall not be in effect.

## **Section 10.11: Automatic Fire Alarm**

SBVAC may get activated to standby for an automatic fire alarm in district. In the event that SBVAC is activated to standby for an automatic alarm, the EVO shall immediately notify

MEDCOM via landline or radio that a full crew is in quarters and is standing by (Signal 9). The EVO shall then contact UPD Dispatch, if the alarm is on campus, and inquire about the nature of the alarm. If the report is an automatic alarm, the crew may choose to continue standing by at HQ and continuously check in with UPD Dispatch. If there are any reports of smoke or fire, or the nature is unclear, the crew must notify MEDCOM of the status and proceed to scene.

#### **Subsection 10.11.1: Disposition**

If the crew remains on a standby for the duration of the alarm at the direction of UPD or MEDCOM, and is cleared from the automatic alarm without ever proceeding to scene, the crew may return to service and complete a standby PCR and document the events. If the crew is directed to scene for any reason, the crew must proceed in the ways outlined in Article XI of these SOPs. If any prolonged time spent on scene of an automatic alarm, the Duty Chief shall be notified.

#### **Subsection 10.11.2: Outside District Fire Standby**

SBVAC may be activated for an outside district fire standby on a mutual aid. The EVO shall inquire via MEDCOM if the crew is to respond directly to scene of the fire, or to stand by at a pre-determined location in that fire district, such as a fire department station. The crew shall proceed in the normal manner outlined in Article XI of these SOPs, based on the dispatch information (i.e.: the priority).

### **Section 10.12: Second Ambulance to Scene**

The nature of some alarms may require the assistance of a second ambulance to scene. This may be because the nature requires additional manpower, or the high likelihood of additional patients. The on-duty crew shall respond normally to scene of any of the alarms outlined in Subsection 10.12.1 of these SOPs. If a second crew is in quarters, or if off-duty members respond to HQ, a second ambulance may respond to scene as well. A Signal 3 will not be toned out unless the on-duty CC requests one through MEDCOM, so it is up to the additional available off-duty members to respond to HQ and bring a second ambulance to scene if the on-duty CC does not specifically request it. The on-duty CC shall be in command of the scene, and may cancel the additional ambulance by transmitting a request for the responding unit to take a Signal 5 and 25. The on-duty CC may request the additional crew to return to HQ at anytime, even if they are already on scene. The procedures outlined in Subsection 10.2.3 of these SOPs shall be followed for all the additional personnel on scene.

#### **Subsection 10.12.1: Alarms Requiring Assistance of a Second Crew**

The following alarms may require the assistance of a second crew, and members may respond in a manner described in the above paragraphs and these SOPs:

- Cardiac Arrests
- Any Echo priority alarm
- Motor Vehicle Accidents
- HAZMAT Incidents
- Working Structure, Vehicle, or Brush Fires

**Section 10.13: Inter-facility Transports**

SBVAC does not routinely provide inter-facility transport services; however the need to perform an inter-facility transport may arise. An inter-facility transport may be authorized at the discretion of a Chief, provided there is a second crew available to cover any emergency calls during the time of the transport and authorization is obtained from Suffolk County EMS.

**Section 10.14: Minimum Staffing**

The ambulance must be staffed by an EVO and a CC at all times, with the following exceptions. Any ambulance with a CC and EVO shall be considered a full crew.

**Subsection 10.14.1: Driver Training**

The minimum staffing requirement for a vehicle that is driver training is waived; however there must be at least one (1) EMT on an ambulance at all times.

**Subsection 10.14.2: Personnel On-Scene**

An EVO may drive the ambulance to the scene of a call with the expectation of meeting a CC who is already on-scene. A CC/EVO may also drive the ambulance to the scene of a call with the expectation of meeting an EVO who is already on scene.

**Subsection 10.14.3: Non-Corps Drivers On-Scene**

At the Chief's discretion, certain Non-Corps members such as Police Officers or Fire Marshals may be permitted to drive a company vehicle. At the beginning of each semester the Chief shall determine who, if anyone, these people are. Therefore, a CC/EVO may drive the ambulance to the scene of a call if they are able to verify, through MEDCOM or other means, that an approved Non-Corps driver is already on-scene and is willing to drive the ambulance from scene.

**Subsection 10.14.3: Chief's Discretion**

Exceptions to the minimum staffing requirement may be granted by any Chief, provided that there is at least one (1) EMT on any in-service ambulance at all times.

# **Article XI: Procedures of an Emergency Call**

The following is a general guideline to follow during the course of an emergency call. All knowledge obtained through EMT class, CC training, EVO training, and any other applicable training as well as regulations by the Chief's Office should be incorporated into the rational decisions made throughout the course of the emergency call.

## **Section 11.1: En route to the Scene**

When responding to an emergency, the EVO shall respond in a reasonable and prudent manner with due regard.

### **Subsection 11.1.1: Lights and Sirens**

The use of Emergency Warning Devices should follow the rule of "all or none". The decision on whether or not such Emergency Warning Devices shall be used will be based on the graded response information given by the dispatcher.

#### **Paragraph 11.1.1.1: Types of Response**

A cold response is a response in which no Emergency Warning Devices are used. A hot response is a response in which all Emergency Warning Devices are utilized.

#### **Paragraph 11.1.1.2: Graded Response**

During an Alpha response, all responding units shall respond cold. During a Bravo or Charlie response, the first responding unit shall respond hot and all additional units shall respond cold. During a Delta or Echo response, all responding units shall respond hot. Alpha and Bravo calls are associated with BLS care. Charlie and Delta calls are associated with ALS care. Echo calls are associated with an immediate life threat, and are also ALS emergencies. For the purposes of this paragraph, the "first responding unit" shall be defined as the ambulance, first-responder vehicle, or personally owned EASV (as described and authorized under Paragraph 10.3.1.3 of these SOPs) that first proceeds en route to the emergency call.

##### **Line 11.1.1.2.1: Additional Time Needed for an Alpha Call**

When an Alpha call is dispatched, responding personnel do not have increased time to contact MEDCOM. In the event the responding crew is en route to the hospital or at the hospital with a prior patient, the crew must contact MEDCOM, and if able to respond within ten (10) minutes may request MEDCOM to put them on a standby with an approximate time until available. If the crew will not be able to respond within ten (10) minutes, the crew shall request an additional unit to respond to the scene of the Alpha call.

##### **Line 11.1.1.2.2: Prioritizing Responses**

If the responding crew, while en route to a call, receives a dispatch for a second call, they may NOT divert the response based on dispatch priority. In extreme situations, the CC or any Chief may divert the response of the ambulance to a

second call deemed to be severely life threatening in nature, provided the ambulance is not within sight or sound range of the original call. The CC must first attempt to seek authorization from the Duty Chief, if the CC cannot make contact, they may divert at his or her discretion. When diverting, the responding crew must inform MEDCOM of the change in response and request another ambulance to be dispatched for the original call. The Chief shall be notified immediately upon completion of the call and the CC or the Chief who ordered the ambulance to divert shall complete a SBVAC Incident Report within twenty-four (24) hours.

**Line 11.1.1.2.3: Incident Under Control**

If, at any time, a responding crew is informed that a Signal 4 (Incident under control) has been declared by MEDCOM, a Chief or by a Police Officer, the crew shall immediately downgrade their response to cold.

**Subsection 11.1.2: Radio Transmissions**

Radio transmissions should be kept short, concise, and appropriate as per Suffolk County Fire, Rescue and Emergency Services (FRES) protocols.

**Paragraph 11.1.2.1: Large Scale Incident Management**

In the event of a MCI or regional incident, the applicable EMS Commander may issue an authorization for use of simple language as defined through the National Incident Management System (NIMS).

**Subsection 11.1.3: Approach to a Motor Vehicle Accident**

The ambulance should be placed at the scene of an MVA in a manner as to minimize the exposure of the crew to oncoming traffic. If flares have not been set up prior to the ambulance's arrival, the EVO shall position flares as necessary to direct traffic away from the MVA and the crews on the roadway.

**Section 11.2: On-Scene Procedures**

**Subsection 11.2.1: Refusal of Medical Assistance**

A patient's refusal of medical assistance (RMA) may be obtained only in accordance with the following protocols:

**Paragraph 11.2.1.1: High Risk Criteria**

An RMA should not be considered without contacting Medical Control if any of the following conditions exist:

1. The patient has received medication, either by administration or self-assistance of an EMS provider;
2. The patient has an altered mental status or a suspected head injury;
3. The patient is less than eighteen (18), including situations where the legal

- guardian is on scene;
4. The patient is older than seventy (70) years of age for any condition;
  5. The patient has neurological, cardiac, or respiratory symptoms;
  6. The patient's Glasgow Coma Score is less than 15;
  7. The patient's vital signs are outside of normal limits;
  8. There is known or suspected alcohol or drug use involved;
  9. There is a carbon monoxide exposure;
  10. The patient attempted suicide.

**Paragraph 11.2.1.2: No Injuries or Illness**

In the event that SBVAC responds to a reported medical emergency where both the individuals at the scene and the CC believe that no injuries or illness exist and that there are no individuals requiring or requesting EMS assistance:

1. A PCR shall be completed using the following disposition codes, 008 "Gone on arrival" or 009 "Unfounded"
2. A physical assessment may be necessary to make the determination that there are no patients on the scene.
3. Consider the criteria specified in Paragraph 11.2.1.1 of these SOPs before determining that there are no patients at the scene.
4. An RMA signature is not required but is suggested for purposes of documentation.

**Paragraph 11.2.1.3: Refusal of Treatment and/or Transport**

If in the judgment of the CC there is a patient at the scene who requires treatment or ambulance transport and refuses treatment and or transport:

1. If the CC believes that ambulance transport is indicated, Medical Control must be contacted.
2. If the patient continues to refuse either treatment or transport after Medical Control is contacted, the refusal must be documented thoroughly on the PCR, signed by the patient, and witnessed by a Police Officer, preferably.
3. In the event that a patient receives BLS treatment but refuses transportation by ambulance, and the CC agrees that the ambulance transportation is not warranted and no high-risk illness or injury exists as specified in Paragraph 11.2.1.1 of these SOPs, Medical Control need not be contacted. This decision, and any recommended follow-up by the patient, should be noted on the PCR and the RMA signed by the patient, indicating he/she has refused transportation.
4. In situations with multiple patients where only some are transported, such as MVAs, an RMA must be obtained from every patient that is not transported.
5. In all cases where there is no transport to a hospital, the Secretary must send the yellow copy of the PCR to the PCR collection site at Medical Control at University Hospital.

**Paragraph 11.2.1.4: Refusal of Medical Aid by Minors**

Any minor, under the age of eighteen (18), with or without direct supervision of a parent or guardian, shall be allowed to refuse medical aid only after Medical Control has been contacted and the patient has spoken to a Medical Control Physician. If the Medical Control Physician allows the patient to RMA then the crew shall have the patient sign the back of the PCR and follow the aforementioned guidelines. The PCR should be documented to reflect the situation and the Medical Control Physician's I.D. number documented as well.

**Paragraph 11.2.1.5: Refusal of Medical Aid by the Elderly**

Any person over the age of seventy (70) may not be permitted to RMA without contacting Medical Control and receiving authorization to do so.

**Subsection 11.2.2: Lack of Cooperation**

If the CC deems necessary, regardless of reason, a Police Officer may be requested to accompany the patient in the patient compartment.

**Paragraph 11.2.2.1: Uncooperative Patient / Suspected Psychiatric Patient**

If a patient is being uncooperative or if a life threatening condition exists, any patient may be placed under protective custody by a Police Officer. If the patient is experience a possible psychiatric emergency and may pose a danger to themselves, the crew, or other people, it is strongly recommended that a Police Officer accompany the patient in the ambulance during transport.

**Line 11.2.2.1.1: Restraints**

Medical Control may be contacted in cases where questions about necessity of restrain or care arise. Patients do have right to refuse treatment and/or transport if they are of legal age and are capable of making an informed decision, but there are situations where the interests of the general public outweigh an individual's right to liberty, which include; the individual is threatening self harm or suicide; and/or the individual presents a threat to third parties, including medical care-givers. The purpose of this SOP is to provide guidelines on the use of humane medical restraint in out-of hospital situations for patients who are violent, potentially violent, or who may harm themselves or others, regardless of the underlying cause, when restraint is necessary to limit mobility or temporarily immobilize such patients. The crew shall use the minimum and least restrictive amount of humane restraint necessary to safely accomplish patient care and transportation with regard to both patient and provider safety. The CC shall be able to document a reasonable belief that the patient would be a threat to self or others. In any circumstance which would require or potentially require the use of restraints, PD should be notified immediately. PD should comply with the crew's request to restrain the patient if indicated medically. The crew may be able to restrain the patient without PD assistance and by following Suffolk County policies, but should be avoided when possible. Ideally, the patient should be restrained in four

(4) points, one (1) restraint applied to each limb, and done by four (4) people, assuming the CC has decided to restrain the patient without PD. The CC shall further ensure that the patient's position does not compromise the patient's respiratory or circulatory systems, or does not preclude any necessary medical intervention to protect the patient's airway should vomiting occur. In addition, the patient should be transported in the supine or left lateral recumbent position. The patient should never be placed in the prone position. Furthermore, it is prohibited to strain a patient's hand and feet behind the patient, as well as "sandwich" a patient between backboards or scoop-stretchers. In addition, the CC must notify the receiving hospital of the restraints applied and reasons, as well as document it on the PCR. Vehicle mileage should be documented on the PCR and with MEDCOM.

**Paragraph 11.2.2.2: Uncooperative Bystander**

If a bystander is being uncooperative or is hampering patient care, the Police should be contacted for assistance.

**Paragraph 11.2.2.3: Prisoner Patient Procedure**

If transport of a prisoner/patient is required, a Police Officer must ride with the crew in the patient compartment. Vehicle mileage should be documented on the PCR and with MEDCOM.

**Line 11.2.2.3.1: Hospital Notification**

If the ambulance is transporting a prisoner/patient, the CC must advise the hospital that the ambulance has a Police Officer on board for a patient in custody.

**Subsection 11.2.3: Cardiac Arrest / Unattended Death**

**Paragraph 11.2.3.1: Police Department Presence**

If the Police Department is not present at the scene of a cardiac arrest upon the arrival of the first arriving EMS unit, a sector car response must be requested before the EMS unit transports the patient or leaves the scene following the determination that pre-hospital care and transport are not required. Do not delay transport if the Police Department is not on the scene.

**Paragraph 11.2.3.2: Obligation to Perform CPR**

In cardiac arrest situations, certified EMS providers are obligated to perform CPR or other prescribed resuscitative measures, unless a valid New York State "Do Not Resuscitate" (DNR) form or bracelet, or a valid New York State MOLST form is presented, or there are signs of obvious death present.

**Line 11.2.3.2.1: Bystander CPR**

In instances where bystander CPR is initiated prior to the arrival of the EMS unit and it is determined by the arriving EMS personnel that there are signs of obvious

death present, the EMS personnel may elect to refrain from continuing resuscitative measures.

**Paragraph 11.2.3.3: Crime Scene Operations**

Any location at which a cardiac arrest or an unattended death found, and where there are no family members or witnesses present, it is to be considered a crime scene until otherwise designated by proper authority. Refer to Subsection 11.2.11 of these SOPs for Crime Scene operating procedures.

**Paragraph 11.2.3.4: Obvious Death**

CPR must be provided to all patients unless a valid NYS DNR form or MOLST form indicating DNR is presented, or there are signs of obvious death, such as decapitation or similarly mortal injuries, rigor mortis, tissue decomposition or extreme dependent lividity. If CPR has been initiated by an untrained bystander in the presence of signs of obvious death, the CC may elect to discontinue CPR. AEDs and cardiac monitors are not to be used in this decision. Transportation shall not occur to any patient who falls within this paragraph, although a person with a valid DNR or MOLST form indicating DNR who expires in a public location or in the ambulance after transportation has already begun, may be transported to the hospital without resuscitative measures. If a patient falls into this Paragraph, the CC must notify the Police and no transport shall be attempted. The appropriate paperwork shall be filed.

**Line 11.2.3.4.1: Do Not Resuscitate (DNR) Orders/Advanced Directives:**

A DNR order is an order not to perform ventilations, compressions, defibrillation, intubation, or medication administration in the event of a cardiac or respiratory arrest, including mechanical ventilations after removal of a foreign body airway obstruction if ventilations are not spontaneously restored. A MOLST Form is an advanced directive where a patient or the surrogate decision maker has communicated end-of-life wishes extending beyond the DNR, with implications for the EMS provider regarding limited medical interventions, pain management, fluid resuscitation and transportation to the hospital. All DNR orders and MOLST Forms are considered valid as long as they have been signed and there is no indication the order has been modified. CPR must be initiated in the absence of a DNR order or MOLST Form, but may be stopped once the DNR or MOLST Form is produced.

**Line 11.2.3.4.2: Discontinuation of Field Resuscitation**

Only for adult patients, at the discretion of the Medical Control Physician, and with the consent of the family present, it is appropriate for full ALS resuscitation attempts that do not result in the return of spontaneous circulation, to be terminated, the patient pronounced dead, and not transported to the hospital. If the family requests resuscitation efforts be continued, the patient is to be transported to the hospital and the family's request honored.

**Paragraph 11.2.3.5: Medical Control Contact**

Suffolk County protocol requires that Medical Control be contacted at 631-444-3600 for a post-call Signal 34 following any cardiac arrest, whether or not an AED was applied when resuscitation has been attempted. The CC is responsible for placing this call. Refer to Section 11.5 of these SOPs for the proper procedure to follow.

**Subsection 11.2.4: Bystander Assistance**

The CC may utilize any bystander assistance. This includes the Police, Environmental Health and Safety (EH&S), and any other persons encountered at the scene of a call. Appropriate documentation must be completed.

**Subsection 11.2.5: Unable to Locate Patient**

If the crew arrives at the reported scene of a medical emergency and is unable to locate the patient, they shall take the following actions:

1. Confirm, through the dispatcher, that they have the correct address.
2. Confirm, through the dispatcher, that a telephone call back was made to verify the alarm location.
3. Sound the siren/horn for fifteen (15) second intervals for no less than one (1) minute.
4. Confirm, or if necessary, request Police Department response to the scene.
5. Confirm with Police and/or Environmental Health & Safety (EH&S) on-scene the location of the alarm.
6. If, after an adequate search effort, the call is determined to be unfounded, a PCR must be completed with all actions taken at the scene documented and all times noted. In addition, MEDCOM must be notified.

**Subsection 11.2.6: Unable to gain entry**

If patient access cannot be accomplished through normal procedures, the Police should be called to gain entry to buildings. If Heavy Rescue, HAZMAT or any other resources are required, MEDCOM shall be contacted for assistance. The crew should not place themselves in danger to gain access to a patient. If forcible entry is necessary, the following guidelines must be adhered:

1. The crew must confirm that the patient is in a secured building/area or in a locked or inaccessible private residence before forcible entry is attempted by the crew.
2. If the crew is unable to confirm that the patient is present in a secured, locked or inaccessible location, the Police Department is to assume responsibility for a forcible entry decision.
3. In the event of a fire or suspected fire at the location in question, the Fire Department shall assume the forcible entry responsibilities.
4. Fire Department assistance in forcible entry may be requested if SBVAC crew and the Police are not equipped to provide forcible entry.

### **Subsection 11.2.7: Unusual Incidents**

Any incidents outside the norm occurring at the scene of a call, whether involving patient, crew, or other, shall be fully documented on a SBVAC Incident Report, in addition to an immediate notification made to the Duty Chief. Any incident involving the patient that is outside the norm should be documented on the PCR as well.

#### **Paragraph 11.2.7.1: Reportable Incidents to the NYS Bureau of EMS**

Section 800.219(q) of Part 800 of the New York State EMS Code requires that every certified ambulance service must, upon discovery or report to the governing authority of the ambulance service, inform the New York State EMS area office by telephone (212) 268-6632 no later than the next business day, and in writing within five (5) business days of any incident in which:

1. A patient dies, is injured, or harmed due to the actions of a member of the ambulance service.
2. An EMS response vehicle/ambulance is involved in a motor vehicle crash in which a patient, member of the crew, or other person is killed or injured to the extent of requiring hospitalization or the care of a physician.
3. Any member of the ambulance service is killed or injured in the line of duty to the extent of requiring hospitalization or the care of a physician.
4. Patient care equipment fails or is misused causing harm to a patient.
5. It is alleged that any member of the ambulance service has responded to a call or has treated a patient while under the influence of alcohol or drugs. This includes prescription drugs that may impair the thought process or mechanical/physical abilities of the patient care providers.

#### **Line 11.2.7.1.1: Incident Report:**

A SBVAC Incident Report shall be completed for agency records when any incident specified in Paragraph 11.2.7.1 of these SOPs is reported to the New York State Bureau of EMS.

#### **Paragraph 11.2.7.2: Animal Bites**

Suffolk County law requires that the ambulance responding to an incident that involves an animal bite file a report with the Suffolk County Police Department, the Suffolk County Department of Health Services- Division of Public Health, and the animal control shelter. The CC on the call of this incident shall be responsible for complying with the law. The following procedures must be followed:

1. The ANIMAL BITE REGISTRY form must be completed and mailed to the authorized agencies within twenty-four (24) hours of the incident.
2. A copy of the form shall be kept with SBVAC's copy of the PCR (white copy).
3. A copy of the form shall be mailed to the Suffolk County Police Department – Police Headquarters, 30 Yaphank Ave, Yaphank, NY 11980.
4. A copy of the form shall be mailed to the Suffolk County Department of Health

Service's Division of Public Health – 225 Rabro Drive, Hauppauge, NY 11788.

5. A copy of the form shall be mailed to the Animal Control Shelter in the township in which the bite incident occurred.
6. Complete a SBVAC Incident Report.

#### **Subsection 11.2.8: Hospital Disposition**

All patients should be transported to the closest appropriate hospital Emergency Department. If the patient requires an advanced level of care or has a condition considered life threatening, the patient should be transported to the nearest hospital, unless the patient requires another facility described in state or regional protocols, or directed by a Medical Control Physician. Some patients may require specialized care at one of these facilities, such as a Trauma Center, Stroke Center, Burn Center, STEMI Center, a SANE Center, etc, and may require transport to that specialized center. Any patient who falls into the criteria requiring one of these types of centers should be transported there, with consultation with Medical Control, and according to NYS Protocols. Patients who are considered in stable condition may be transported to the non-closest emergency department, as long as the difference does not exceed ten (10) additional minutes of transport time. The Duty Chief should be notified for any unusual transport.

##### **Paragraph 11.2.8.1: Patient Request to an Out of Area Hospital**

If a patient requests an out of area hospital, the crew shall inform the patient of our response policy. If the patient still requests a hospital out of the response area, Medical Control should be contacted for advice in addition to the Duty Chief if available, to obtain a possible solution to the situation. The on-duty crew shall not transport a patient to a hospital when such transport will put them out of service for an extended period of time, unless an appropriate backup is available, or if the patient requires transport to a specialized or specific Emergency Department as outlined in Subsection 11.2.8 of these SOPs.

##### **Paragraph 11.2.8.2: Inter-Facility Transports**

This policy does not apply to inter-facility transports which are ordered by a physician, and which may or may not require that a physician accompany the patient. Transport shall be made to the hospital requested by the physician ordering the transport. If at any time the patient's condition becomes unstable, the CC shall divert the ambulance to the closest hospital at that time.

##### **Paragraph 11.2.8.3: Multiple Casualty Incidents**

This policy does not apply to mass casualty incidents, where triage functions may dictate transportation of patients to other than the nearest medical facility. When transporting from the scene of an MCI, transport will be to the hospital specified by the Transportation Officer, Incident Commander, or other authorized individual.

**Paragraph 11.2.8.4: Mutual Aid and Calls Outside SBVAC's District**

Crews shall become familiar with hospitals in neighboring districts, or in districts for which they are providing coverage. Patients shall still be transported to the nearest Emergency Department unless contradicted by BLS/ALS Protocol, where the patient should be transported to a hospital with a specialized center, outlined in Subsection 11.2.8 of these SOPs and in the NYS and Suffolk County protocols. If a patient requests to be transported to a hospital considered out of area hospital, refer to Paragraph 11.2.8.1 of these SOPs.

**Subsection 11.2.9: Hospital Diversion:**

Section 405.19 (e) (4) of the NYS Hospital Code authorizes hospitals to request diversion of ambulances to other facilities when the acceptance of another critical patient might endanger the life of that or another patient. A request for diversion does not require that the ambulance divert from that facility. EMS personnel are not obligated to honor such a request if they believe that a critically ill or injured patient's condition warrants transport to the nearest hospital. If it is determined that the patient is stable, the diversion request may be honored. Contact Medical Control to assist in the transport decision. Complete documentation on the PCR should fully describe the reason(s) for the EMS provider's (non) diversion decision.

**Subsection 11.2.10: HAZMAT Situations**

SBVAC shall participate in Suffolk County's HAZMAT response plan and shall operate under Suffolk County's Guidelines for Response to HAZMAT Incidents with Contaminated or Potentially Contaminated Patients. A copy of this document may be obtained from any Chief.

**Paragraph 11.2.10.1: HAZMAT Standbys**

In the event of a HAZMAT emergency on campus, EH&S will require an ambulance to standby. MEDCOM should notify the crew if EMS is cleared to respond to scene, and any other instructions that are pertinent. SBVAC will situate as instructed by MEDCOM or EH&S if on campus, and the on-duty CC must notify the Duty Chief as soon as possible. A second ambulance may respond to scene if staffing is sufficient. Members may respond to HQ in a fashion similar to the procedures outlined in Section 10.2 and Subsection 10.10.1 of these SOPs.

**Line 11.2.10.1.1: Center for Molecular Medicine BSL3 Response**

The crew must first confirm through UPD or the Fire Marshals that the dispatch to CMM is HAZMAT or general aided case (non-HAZMAT injury). For any confirmed HAZMAT to the Biosafety Level 3 (BSL3) Laboratories response at the CMM, the on-duty crew must situate the ambulance by the rear of the building by the CMM loading docks. The crew must not enter the building or any restricted area without first confirming with the EH&S officials (Fire Marshals) on scene. UPD can be contacted for further instructions if on-scene communication has not been established. The position of the ambulance should not interfere with fire or

police operations, but should be in a close proximity to the staging area. Depending on the incident, (if an Incident Command has been established by EH&S) the ambulance may be requested to position in a staging area away from the loading dock. UPD and EH&S should be contacted for consultation during any HAZMAT incident if a SBVAC Chief is not on scene. The CID Incident Response Plan For Selective Agent BSL3 Laboratories, published by EH&S, should be used as the incident plan for any HAZMAT situation involving the CMM. The SBVAC member on scene who ranks in the highest position according to the Chain of Command shall act as the EMS Incident Commander, and should join the Unified Command with fire, police, and other officials from other departments. The EVO should ensure that the MEDCOM frequency is constantly being monitored to ensure directions transmitted by MEDCOM are received by the crew. If the crew confirms HAZMAT nature for any location outside of the BSL3-negative pressure zone, the crew must situate as instructed by a Chief, the EH&S officials (Fire Marshals), or UPD. CCs should always err on the side of caution. If a Fire Marshal or Police Officer recommends standing-by in a zone that the CC or EVO deems unsafe, they should not do so and call the Duty Chief as soon as possible for clarification.

#### **Line 11.2.10.1.2: Relief of Crews**

In the event that this standby goes beyond normal crew times and/or crewmembers need to be dismissed, additional crew can be requested to scene. This should be done only in coordination with the Duty Chief. The on-coming crew shall take the secondary ambulance to the scene; relieve the on-scene crew, which shall then take the secondary ambulance back to HQ. This procedure shall also apply to fire standbys.

#### **Paragraph 11.2.10.2: Chemical Protective Clothing**

Multiple sets of chemical protective clothing, including full face air purifying respirators, shall be located in HQ. Each CC shall be trained in the donning and use of these items. The chemical protective clothing affords the user Level C protection, and is to be used in “warm to cold” zones exclusively. The chemical protective clothing is to be used in any situation where the CC or any Chief suspects that the crew may come into contact with equipment or patients not be completely decontaminated of any known or suspected hazardous materials. AT NO TIME SHALL ANY MEMBER ENTER INTO ANY AREA DESIGNATED AS OR SUSPECTED TO BE A “HOT ZONE”, EVEN WHILE WEARING THE CHEMICAL PROTECTIVE CLOTHING.

#### **Line 11.2.10.2.1: Notification Procedure**

Immediately following any call at which the Chemical Protective Clothing is used, the crew must notify the Chief and a SBVAC Incident Report filed within twenty-four (24) hours.

### **Subsection 11.2.11: Operating at a Crime Scene or Suspected Crime Scene**

The primary responsibility of EMS personnel operating at a crime scene or suspected crime scene is to render proper emergency medical care to those persons in need of such care. Patient care shall not be compromised in order to protect the crime scene or evidence. However, every attempt should be made not to disturb any physical evidence at the scene if possible. EMS providers should be aware of the responsibilities of other agencies operating at crime scenes. The actions and observations of EMS providers at crime scenes are frequently an important part of court testimony, requiring accurate documentation at the time of the incident.

#### **Paragraph 11.2.11.1: Definition of Crime Scene**

A crime scene shall be defined as any location at which evidence of a crime or suspected crime is found, including, but not limited to: homicide, suicide, sexual assault, chemical, biological, nuclear, or explosive weapon release, vehicle pedestrian accidents, or other MVAs involving serious injury or death. Any location at which a deceased is found is to be considered a crime scene until otherwise designated by the proper authority.

#### **Paragraph 11.2.11.2: Crime Scene Operations**

After evaluating the scene for potential hazards, the following steps should be taken:

1. Consider the entire location as being involved in the crime scene.
2. Upon entering or leaving the scene, use a single path of travel if possible and have all personnel entering or leaving the scene use the same path.
3. Limit the number of EMS providers entering the scene to only those necessary to evaluate, treat and/or remove patients. All non-essential EMS providers are to remain outside the crime scene.
4. If a presumptive diagnosis of obvious death is made, refrain from otherwise moving or disturbing the victim's remains.
5. Refrain from using sinks, toilets, or telephones within the immediate area.
6. Remove nothing from the scene and restrict the handling of any objects found.
7. Offer information on observations pertinent to the incident to the proper authority. Do not offer information or observations to those who do not have a legal need for such information or observations.
8. Restrict comments and opinions to known facts when speaking to other authorities. Inter-department communications regarding the incident shall be directed to the proper authority at the scene. Do not offer information to unauthorized parties such as the media, civilians, or other agencies as this may impede the investigation.
9. Complete all PCR's and related records pertaining to the incident accurately, using specific language to indicate the position in which the patient was found, the presence of visible wounds and other pertinent data including the clinical information that led to the decision to withhold resuscitative measures. PCR's are legal documents subject to subpoena and must be complete, legible, and accurate.

### **Subsection 11.2.12: Suspected Abuse, Maltreatment, or Assault**

After evaluating the scene for potential hazards, the following steps should be taken:

1. Avoid unnecessary disturbance of the patient or physical evidence. Limit physical patient contact to the treatment of injuries only. Do not cleanse or cover wounds unless necessary. Discourage the patient from rinsing, showering, combing hair, changing clothes, or brushing teeth.
2. Notify the Police Department immediately upon determination that a crime has occurred. The patient's permission is NOT needed to make such notification.
3. Limit the patient interview to pre-hospital medical care questioning pertinent to visible injuries or those claimed by the patient. Reenactment of the assault/incident may not be conducive to a good patient care outcome.
4. If the patient must be transported prior to the arrival of the Police Department, advise the patient not to wash or discard clothing worn during the incident. If possible and where appropriate, transport the patient with a female technician or be sure to report and record beginning and ending mileage to MEDCOM.
5. The patient is not only a victim of physical trauma, but also a victim of emotional/psychological trauma. Treat the patient accordingly.
6. All ambulances shall transport the patient to the hospital designated by the Suffolk County transport protocol and these SOPs. If a request is made to deviate from protocol (i.e., to a SANE Center), contact Medical Control at 631-689-1430. Where possible, try to honor the patient's request concerning the destination hospital.
7. Prepare a PCR. Keep accurate records of the times, any findings and observations, and treatments rendered.
8. Avoid discussing the patient or the incident within hearing range of the patient or the patient's family.

#### **Paragraph 11.2.12.1: Reporting of Suspected Child Abuse or Maltreatment**

New York State Social Services Law requires Emergency Medical Technicians to report suspected child abuse or maltreatment they come across while performing their duties. Members who are not EMTs are not mandated reporters under the law; however, they are encouraged to discuss with their CC any suspicions of child abuse they come across while responding as a member of SBVAC. Members are asked to use their "best judgment" when considering whether or not a case constitutes abuse.

##### **Line 11.2.12.1.1: Definition of Child Abuse**

An "abused child" is a child less than eighteen (18) years of age whose parent or other person legally responsible for his/her care:

1. Inflicts or allows to be inflicted upon the child's serious physical injury; or
2. Creates or allows to be created a substantial risk of physical injury; or
3. Commits or allows to be committed against the child a sexual offense as defined in the penal law.

**Line 11.2.12.1.2: Definition of Child Maltreatment**

A “maltreated child” is a child under eighteen (18) years of age who has had serious physical injury inflicted upon him/her by other than accidental means.

A "maltreated child" is also a child under eighteen (18) years of age whose physical, mental or emotional condition has been impaired, or is in danger of becoming impaired as a result of the failure of his/her parent(s), or other person legally responsible for his/her care to exercise a minimum degree of care:

1. In supplying the child with adequate food, clothing, shelter, education, medical or surgical care, though financially able to do so, or offered financial or other reasonable means to do so; or
2. In providing the child with proper supervision or guardianship; or
3. By unreasonably inflicting, or allowing to be inflicted, harm or substantial risk thereof, including the infliction of excessive corporal punishment; or
4. By using a drug or drugs; or
5. By using alcoholic beverages to the extent that he/she loses self-control of his/her actions; or
6. By any acts of a similarly serious nature requiring the aid of Family Court.

**Line 11.2.12.1.3: Reporting Procedure**

In the event that any EMT who is a member of SBVAC suspects that a child is being abused or maltreated while on duty the following steps must be performed:

1. If the EMT is not the CC on the call, he/she must inform the CC of his/her suspicions.
2. The CC shall notify the Emergency Department staff of their suspicions and findings upon arrival at the hospital.
3. The CC must document on the PCR all relevant patient assessment findings, observations, times, and treatment provided. Be as objective as possible in documenting the reasons for suspecting abuse.
4. If every EMT on the crew does not support the suspicion of child abuse or maltreatment, indicate on the PCR which EMTs are suspecting of abuse and which EMTs are not. The CC must document the suspected abuse by another EMT even if they are not suspecting themselves.
5. Immediately upon the crew returning to headquarters, a Chief Officer is to be notified who will be responsible for ensuring that this procedure is followed according to applicable protocol and law.
6. The CC shall telephone the NYS Child Abuse and Maltreatment Register at 1-800-635-1522 as soon as possible after the call. If the CC is not suspecting of child abuse, any EMT on the crew who is suspecting of abuse must call. Only one telephone call needs to be placed per incident regardless of the number of EMTs on the crew who suspect abuse. The person calling shall inform the

operator if they are making a report for multiple EMTs. Oral reporting by telephone is required by law to be made immediately following the incident.

7. Form DSS-2221-A, Report of Suspected Child Abuse or Maltreatment, shall be filled out as soon after the incident as possible by the CC or EMT on the crew who is suspecting of child abuse. Only one form shall be filed per incident regardless of the number of EMTs on the crew; however the names of all EMTs suspecting of abuse should be indicated on the form. This form may be found in the NYS EMS Agency Operational Resource Guide, or on the internet. This written report must be mailed or faxed to the local Child Protective Services office within forty-eight (48) hours of reporting the incident.
8. A SBVAC Incident Report shall be completed by every member of the crew and kept on file.

**Line 11.2.12.1.4: Immunity from Liability**

Immunity from liability for reporting is provided to those individuals required to report such cases under **S 419** for the Social Services Law so long as the individual was acting in “good faith”.

**Line 11.2.12.1.5: Failure to Report**

**S 420** of the Social Services Law states:

1. Any person, official or institution required by this title to report a case of suspected child abuse or maltreatment who willfully fails to do so shall be guilty of a class A misdemeanor.
2. Any person, official or institution required by this title to report a case of suspected child abuse or maltreatment who knowingly and willfully fails to do so shall be civilly liable for the damages proximately caused by such failure.

**Subsection 11.2.13: Treatment of Minors**

A minor, in New York State, is described as a person under the age of eighteen (18) years of age. It is further described by General Obligations Law **S 1-202**, Domestic Relations Law **S 2**, and Public Health Law **S 2504**.

**Paragraph 11.2.13.1: Consent for Medical Treatment**

The following is excerpted from Public Health Law **S 2504**:

1. Any person who is eighteen (18) years of age or older, or is the parent of a child or has married, may give effective consent for medical, dental, health and hospital services for him/herself, and the consent of no other person shall be necessary.
2. Any person who has been married or who has borne a child may give consent for medical, dental, health and hospital services for his/her child.
3. Any person who is pregnant may give effective consent for medical, dental, health and hospital services relating to prenatal care.

4. Medical, dental, health and hospital services may be rendered to persons of any age without the consent of a parent or legal guardian when, in a physician's judgment, an emergency exists and the person is in immediate need of medical attention and an attempt to secure consent would result in delay of treatment, which would increase the risk to the person's life or health.
5. Anyone who acts in good faith based on the representation by a person that he is eligible to consent pursuant to the terms aforementioned shall be deemed to have received effective consent.

**Paragraph 11.2.13.2: Treatment of Minors if Consent cannot be Obtained**

Complete an assessment of the patient. Fully document all circumstances including subjective and objective findings. Attempt to contact parents or responsible parties, note any objections or refusals by the patient and all other pertinent situational facts. Include witness statements. Act in the best interest of the patient. There may be instances in which a minor appears mature enough to make an independent judgment; however, legally the minor is unable to make a decision. Common sense, prior agreements, sufficient documentation, and acting in the best interest of the patient must prevail. Contact Medical Control for assistance if necessary. Refer to Paragraph 11.2.1.4 of these SOPs regarding Refusal of Medical Assistance by a minor.

**Subsection 11.2.14: Role of On-Scene Health Care Professionals**

On occasion, a physician or other medical professional may be present at the scene of an out-of-hospital emergency.

**Paragraph 11.2.14.1: Designated EMS Physicians**

The EMS Medical Director, a Medical Control Physician, or a Designated EMS Field Physician may provide on-scene medical control in accordance with Suffolk County protocols. These physicians may accompany the patient to the hospital, but are NOT obligated to do so.

**Paragraph 11.2.14.2: Other Physicians**

In the event that a non-designated physician is at the scene and wishes to assume responsibility for the care of a patient, the physician must be properly identified. Acceptable forms of identification include, but are not limited to, a medical society card, professional organization membership card, or vehicle registration. Until proper identification has been established, the CC shall render care to the patient in the usual manner.

**Line 11.2.14.2.1: Procedure for Other Physicians to Assume Responsibility**

To assume responsibility for the care of a patient, an on-scene physician must agree to assume all responsibility for the patient, document the assumption of responsibility on the PCR, and agree to accompany the patient to the hospital in the ambulance. If the on-scene physician agrees to these terms, the physician's

orders may be carried out. However, such orders must conform to the level of training of the EMT or AEMT on scene and to New York State and Suffolk County BLS and ALS protocols. Any out-of-protocol procedures initiated by a non-designated physician will remain the responsibility of that physician at the scene and during transport. Medical Control need not be contacted until the post-event telephone report, unless the EMT or AEMT is uncomfortable with the non-designated physician's actions.

If the on-scene physician is reluctant to agree to these terms, or orders an out-of-protocol procedure, the EMT or AEMT must contact Medical Control. The Medical Control Physician will make a judgment concerning the on-scene physician's participation and responsibility. Communication between the two physicians is encouraged. If the on-scene physician refuses to communicate with the Medical Control Physician, the EMT or AEMT must inform the on-scene physician that they may only accept the orders of the Medical Control Physician.

**Line 11.2.14.2.2: Physician at the Site of a Disaster**

Once a scene has been declared a disaster by a county official, the orders of any properly identified on-scene physician may be followed and documented on the PCR or triage tag.

**Paragraph 11.2.14.3: Role of Physician Extenders at the Scene**

If a "Physician Extender" (Physician Assistant or Nurse Practitioner) is present at an emergency in their usual employment setting, and requests to assume responsibility for the care of the patient, under the license of their absentee supervising physician, the "physician extender" may do so, provided that the individual has been properly identified. Acceptable forms of identification include, but are not limited to, a state registration certificate or professional society card. Until proper identification has been established the EMT or AEMT shall render care to the patient in the usual manner. The "physician extender" must abide by the terms and conditions defined for "other physicians" as stated in Paragraph 11.2.14.2 of these SOPs. A "physician extender" outside the normal setting of his/her usual place of employment may not provide on-scene medical direction.

**Paragraph 11.2.14.4: Other Health Care Professionals at the Scene**

In any event where a health care professional other than a physician or physician extender, as specified above, is at the scene, the EMT or AEMT is to maintain responsibility for patient care.

**Subsection 11.2.15: MEDEVAC Service**

To determine if the use of the MEDEVAC service is appropriate, the following should be considered; patient's condition, distance from a designated specialty hospital, physical findings, mechanism of injury, contraindications for MEDEVAC service, and logistics of removing a patient unique to the given situation.

**Paragraph 11.2.15.1: Contraindications for MEDEVAC Service**

If the patient fits the exclusion criteria, the patient should be transported to the nearest hospital by ground ambulance.

**Line 11.2.15.1.1: Exclusion Criteria**

- In cardiac arrest
- Has an unmanageable airway

**Paragraph 11.2.15.2: Indications for MEDEVAC Service**

If the patient fits into the inclusion criteria, the MEDEVAC service should be requested to scene. In cases of trauma patients, MEDEVAC services should not be requested unless it will save ten (10) minutes or more than transportation by ground patients OR warranted by multiple critical patients. MEDEVAC services may be used to distribute patients to more distant trauma centers in cases where there are more than two (2) patients perceived to require operative interventions. MEDEVAC services may also be requested for medical patients because of situations that limit ground access or in cases where ground transport to a designated specialty care hospital is prolonged.

**Line 11.2.15.2.1: Inclusion Criteria**

- Requires expeditious transport to a hospital providing specialized care, such as a Trauma Center, Stroke Center, Burn Center, STEMI Center, etc.
- Requires specialized services offered by the air medical crew not offered by the ground crew.
- Has a “life or limb” threatening situation demanding intensive multi-disciplinary treatment and care.
- Has signs/symptoms/physical findings suggestive of an unstable trauma patient.
- Includes critical burn patients as defined by the burn protocol
- Has signs/symptoms/physical findings suggestive of an unstable medical patient.

**Paragraph 11.2.15.3: Requesting and/or Canceling MEDEVAC Services**

The first CC on-scene is responsible for making the determination that MEDEVAC service is appropriate. To avoid confusion, the same CC making the request for MEDEVAC service should be the CC to cancel the request, if needed. FRES may automatically put a helicopter on standby, based on dispatch information, pending confirmation of need, or cancellation by the first CC on-scene.

**Line 11.2.15.3.1: Contacting the MEDEVAC Service**

The primary method of requesting the MEDEVAC service is through the Suffolk County Police Officer (SCPD) on scene. If there is no SCPD on-scene, the MEDEVAC service should be requested through MEDCOM.

#### **Line 11.2.15.3.2: Landing Zone Selection**

The landing zone should be chosen and set up by SCPD, but in the presence of no SCPD, the CC and EVO should be familiar with how to.

- The landing zone should be a minimum of 100 sq. ft. in the daytime, and 150 sq. ft. in the nighttime, or during windy condition.
- The landing zone should not contain snow, ice, sand, dirt, or loose debris. If so, report any condition to the on-scene SCPD officer, or through MEDCOM. Any obstacles, such as overhead wires, light poles or trees should be reported in the same way.
- Avoid placing traffic cones or any other objects that could be blown away. Lights should never be pointed directly at the aircraft.
- Pedestrian or vehicle traffic should be kept at least 200 ft. away from the landing zone.
- Ensure all ground equipment is secured, including all patient care devices.
- Never approach the aircraft until advised to do so by the flight crew.
- Only approach and depart from the front of the aircraft. NEVER from the rear.

#### **Subsection 11.2.16: Response to School Incidents and School Bus Accidents**

The New York State Education Law §912 places legal guardianship of all the children involved on the school board/school district, including the health and welfare of all the children during the administration of emergency medical evaluation and care for all ill or injured children while in their charge. During the transportation phase (i.e.: on the school bus), the transportation company acts as an agent of the school district and the bus driver is able to make legal decisions for the children until the school board/district/bus company representatives arrive. There is no NYS or Suffolk County EMS policy that states all the children must be taken to the hospital if an ambulance is on-scene. Each child should fit into one of the following dispositions:

- Transportation to the hospital
- RMA, as per Suffolk County RMA policy and Paragraph 11.2.1.4 of these SOPs
- No Patient Found designation

A complete PCR and RMA Checklist are required in cases where a child is a patient and is transported, or where an RMA is executed. It may also be appropriate to document all of the children's names and dates of birth to confirm EMS did evaluate all potential patients.

#### **Subsection 11.2.17: Emergency Incident Rehabilitation (Rehab)**

SBVAC may be activated to standby on-scene of a working fire. Standing by for a working fire is designed to provide evaluation to on-scene emergency personnel, such as firefighters and other emergency personnel working in hazardous situations, as well as provide treatment of any acute illness or injuries of on-scene personnel. While a SBVAC unit is working as a Rehab sector on scene, they are to provide routine medical monitoring and evaluation of the emergency personnel. The crew shall be evaluating the emergency personnel by taking their vitals frequently, rehydrating them, and allowing for appropriate periods of rest.

**Paragraph 11.2.17.1: Setting up a Rehab Sector**

Any time a SBVAC unit is activated to a working fire, the Duty Chief shall be contacted and requested to assist the on-duty crew. After arriving on-scene, the following steps shall occur:

1. Attempt to contact the Incident Commander of the fire scene and ask where the SBVAC unit should stage. The EVO shall position the vehicle in a way as not to impede in the operations of the fire ground, but in a manner that is accessible to the crew and is able to be driven away easily. The EVO shall ensure the vehicle is in a position where it will not be blocked in by firefighting equipment. The ambulance should not be positioned near, or in front of the burning or hazardous structure, or near any water hydrants.
2. The CC may choose to bring equipment off the ambulance and closer to the scene in order to set up a Rehab sector close to the fire ground operations. Safety should be the number one concern of the crew, and the CC shall attempt to consult with the Incident Commander or Fire Chief as to where they should set up the sector.
3. Once the CC has determined the location of the Rehab sector, the CC should contact the Duty Chief and inform the Chief of their location and status.

**Paragraph 11.2.17.2: Medical Evaluation of Emergency Personnel**

Emergency personnel working in hazardous conditions should be monitored for every forty- five (45) minutes of work by getting their vital signs checked out and then resting for at least ten (10) minutes. When performing Rehab as part of routine medical monitoring, a PCR is not necessary. During the resting phase of an emergency personnel's time on scene, they should be rehydrated with at least 12 oz. of water or sports drink. An Emergency Incident Rehab Log Sheet should be used to record all activity in the Rehab sector and retained with the standby PCR.

**Line 11.2.17.2.1: Emergency Personnel as Patients**

Anytime an emergency personnel presents with a chief complaint, signs/symptoms, and/or abnormal vital signs, the responder becomes a patient, a PCR is required, and all applicable NYS and Suffolk County policies and protocols must be followed. Another ambulance shall be requested to take over as Rehab sector. Patient care and transport shall not be delayed to wait for a second crew to respond. It may be necessary to split up the crew, leaving an attendant certified as an EMT to remain on-scene and continue evaluation until relieved by a second crew. The Duty Chief shall be contacted and consulted in this situation, if not already on scene.

**Line 11.2.17.2.2: Additional Resources**

Based on the size of the scene and the amount of emergency workers, the highest ranking member of SBVAC in the Chain of Command on-scene, as per Subsection 6.4.1 of these SOPs, may request additional units to respond to scene to assist in the Rehab Sector. It may be necessary to request assistance from

outside agencies. In this case, all additional resources should be requested to MEDCOM.

### **Section 11.3: Response to Hospital Procedures**

#### **Subsection 11.3.1: Hospital Notification**

The receiving hospital shall be contacted via the radio, either on the Hospital North or Hospital South talk group, of the status of any and all incoming patients as soon as appropriate patient care and assessment has been completed.

##### **Paragraph 11.3.1.1: Unable to Contact Receiving Hospital**

In the event that the receiving hospital does not respond to the crew's attempt to report the patient's status, MEDCOM and/or Medical Control can contact the receiving hospital on the crew's behalf. This should only be done in extreme situations where it is extremely important to prepare the receiving hospital for their patient's arrival.

#### **Subsection 11.3.2: Hospital Quiet Zone**

The area immediately surrounding University Hospital is considered a "Quiet Zone" and the use of audible warning devices should be limited to absolute necessity only.

#### **Subsection 11.3.3: Multiple Transports**

Any SBVAC ambulance may transport more than one patient at a time according to the following guidelines. At no time should any patient be permitted to sit in the front cab unless under extreme circumstances. All patients must remain in the patient care compartment of the vehicle accompanied and under the direct supervision of at least one (1) EMT.

##### **Paragraph 11.3.3.1: Transporting Critical or Unstable Patients**

It is strongly recommended that only one (1) Critical or Unstable patient be transported at any given time. If under special circumstances two (2) Critical or Unstable patients may be transferred at one time. There must be at minimum one (1) EMT in the patient compartment attending to each patient with no more than five (5) total passengers in the patient compartment including both crew and patients.

##### **Paragraph 11.3.3.2: Transporting Potentially Unstable or Stable Patients**

Up to four (4) patients may be transported at one time in the patient care compartment of the vehicle. Three (3) patients may be situated on the bench while one (1) patient is situated on the stretcher. All patients shall be properly seat belted during transport. There must be a minimum of one (1) EMT in the patient compartment at all times to attend to the patients, though it is recommended that there be at least one (1) EMT per patient if possible. There shall be no more than five (5) passengers in the patient care compartment including both crew and patients at any time. It is at the discretion of

the EMT in the patient care compartment as to how many patients may be transported at once.

#### **Subsection 11.3.4: Lights and Sirens Usage**

The CC shall determine the need for emergency warning devices while transporting the patient to the hospital.

### **Section 11.4: At Hospital Procedures**

#### **Subsection 11.4.1: Arrival at Hospital**

All patients shall be escorted into the hospital either on a stretcher or in a wheelchair depending on their condition.

#### **Subsection 11.4.2: Equipment at Hospital**

All equipment used during the course of a call shall be restocked at the discretion of the EMS office. If certain pertinent supplies cannot be restocked immediately, the Lieutenant shall be contacted immediately to determine how to appropriately restock the ambulance.

#### **Subsection 11.4.3: Cleaning/Decontamination and Restocking of Vehicles/Equipment**

At the conclusion of every call, the following procedures must be carried out prior to calling the unit back in service or responding to any other calls. If it is necessary to return to headquarters prior to completing restocking/cleaning, a "Signal 5, negative 28" may be given. The vehicle is not to be called "back in service" if it is not decontaminated and restocked in compliance with NYS DOH Part 800 requirements for minimum equipment.

1. Prepare vehicle for cleaning/decontamination:
  - a. Always wear utility gloves throughout clean-up procedure.
  - b. Remove used or soiled linen and place in a designated bag for laundering.
  - c. Discard any soiled dressings, bloody materials, and other contaminated non-sharps in a red bag and leave at the Hospital.
  - d. Place reusable equipment that needs reprocessing in a plastic bag (any color other than red).
  - e. Check the vehicle for any needles or other sharps which may have been left and carefully dispose in a sharps container.
2. Check for areas soiled with blood or other visible body substances and remove.
  - a. Remove moist blood and other body substances with disposable toweling and discard in a red bag.
  - b. Spray cleaner on affected area and remove any remaining blood or body substances. Dispose of towels in a red bag.
  - c. Spray disinfectant on affected area, wipe over the surface, and allow to air dry. Dispose of towels in a red bag.
3. Spray cleaner on remaining surfaces with which the patient had contact as well as surfaces which were used in the course of providing pre-hospital care. Wipe the surface with toweling and allow to air dry.

4. Restock any disposable supplies used at the hospital and ensure that all essential equipment is present as required by NYS DOH Part 800. This includes, but is not limited to, at least one (1) KED and at least one (1) backboard.

## **Section 11.5: Post-Call Procedures**

### **Subsection 11.5.1: Automated External Defibrillator Reporting**

For medical-legal, quality improvement and system wide data analysis purposes, all events where the AED is used must be reported to the EMS system. An AED event must be reported in the prescribed manner by the technician of record whenever an AED is used, regardless of whether or not the device delivers a shock. This includes cases where care is transferred to an ALS provider. The following steps outline the reporting procedure:

1. Medical Control must be contacted via telephone at 631-444-3600, as soon as possible after the call, to register demographic information. The CC is responsible for making this telephone call.
2. If the Zoll Monitor/Defibrillator was used as an AED, the CC must print the event summary within 90 minutes of the call to prevent this data from being automatically erased. The printout is obtained by pressing 'Summary,' followed by 'Print Chart' and 'Print All'.
3. The CC is responsible for contacting any Chief after the call. The Chief will then ensure that the protocols specified in this subsection have been properly carried out and will arrange for all necessary materials to be mailed to Suffolk County EMS.
4. The hard copy of the event log (or micro-cassette tape), ECG summary **and** a copy of the PCR are to be forwarded to the EMS Division at the below address within twenty-four (24) hours of the call.

Suffolk County EMS  
P.O. Box 6100  
Hauppauge, N.Y. 11788-0099  
Att: AED Coordinator

### **Subsection 11.5.2: Post-Call Medical Control Contact**

After any ALS call, or any BLS call during which a medication (such as albuterol or epinephrine) is administered, Medical Control must be contacted at 631-444-3600 for a Post-Call Signal 34. Medical Control must also be contacted following any cardiac arrest, whether or not the AED was applied. Post-Call contact must also be made after any call during which Medical Control was contacted unless it is specifically stated that a Post-Call 34 is not required.

## **Article XII: Company Vehicles**

The following procedures shall outline all policies regarding SBVAC vehicles not made clear in the rest of these SOPs. The 2<sup>nd</sup> Assistant Chief, in consultation with the Chief, shall be responsible for all the maintenance, training, and other uses regarding company vehicles.

### **Section 12.1: Operating a SBVAC Vehicle**

Only those meeting the requirements outlined in Subsection 5.2.3 of these SOPs, or training as per Paragraph 5.2.3.1 of these SOPs, may operate a SBVAC vehicle. All vehicles shall be driven in both emergency and non-emergency situations in a manner approved by the 2<sup>nd</sup> Assistant Chief and these SOPs.

#### **Subsection 12.1.1: SBVAC Ambulances**

As stated above, approved members may operate and drive any SBVAC ambulance in accordance to policies of the State, County, and the Chief's Office. The minimum staffing requirements outlined in Section 10.14 of these SOPs must be followed for all ambulances, without exception. Furthermore, Non-Corps drivers may operate a SBVAC ambulance only in accordance with Subsection 10.14.3 of these SOPs. SBVAC ambulances should only be operated while on-shift, or for training purposes approved by the Chief's Office. All other uses of SBVAC ambulances which fall outside of the category outlined in this Subsection must be approved by a Chief.

#### **Subsection 12.1.2: SBVAC Responder Vehicles**

Only those holding the rank of CC and EVO, and with permission of the Chief's Office, may operate a responder vehicle. Exceptions to this rule may apply if approved by the Chief. In addition, at no times should a responder vehicle be staffed by anything less than an EMT. The Lieutenant shall be responsible for the maintenance and equipping of all responder vehicles.

##### **Paragraph 12.1.2.1: Appropriate Uses of Responder Vehicles**

All SBVAC responder vehicles may be used for completing company business approved by the Chief's Office. Furthermore, responder vehicles may be used as a BLS first responder, ALS first responder, command post during MCIs, or as a Chief's vehicle. All members seeking permission to use SBVAC responder vehicles for any SBVAC business must seek prior approval of any Chief.

##### **Paragraph 12.1.2.2: Vehicle Log of Responder**

All company responder vehicles shall have their odometer readings logged during their weekly rig checks.

#### **Subsection 12.1.3: Non-Emergency Use**

It may be appropriate to use company vehicles in a non-emergency capacity. Only approved members, who meet the requirements outlined in Subsection 5.2.3 of these SOPs or are training as per Paragraph 5.2.3.1 of these SOPs, may drive a company

vehicle in a non-emergency capacity. The minimum staffing requirement in Section 10.14 of these SOPs must be followed at all times, with no exceptions. Appropriate reasons to use company vehicles in a non-emergency capacity include the duty crew utilizing the duty ambulance while on shift and driver training as per Paragraph 5.2.3.2 of these SOPs. All members must seek permission from a Chief to use a company vehicle in a non-emergency capacity not described in this Subsection.

## **Section 12.2: Equipment on SBVAC Vehicles**

The Lieutenant, in consultation with the Chief, shall decide the appropriate level of equipment essential to carry on SBVAC vehicles, including the ambulances and responders. For ambulances, the Lieutenant shall ensure that the levels of equipment meet the minimal levels outlined in New York Public Health Law Code Part 800.24. For all responder vehicles, the equipment shall meet minimal levels outlined in New York Public Health Law Code Part 800.26. The Lieutenant, in consultation with the Chief, may decide to require more equipment to be stored on the vehicles than required by the State.

### **Subsection 12.2.1: ALS Equipment**

All SBVAC Vehicles designated to be ALS by the Chief's Office must meet the minimal equipment requirements designated by Suffolk County. The 1<sup>st</sup> Assistant Chief and/or ALS Coordinator may decide to amend the ALS equipment as long as the County requirements are met. The 1<sup>st</sup> Assistant Chief and/or ALS Coordinator are responsible for the equipment, as well as the maintenance of that equipment. The policies outlined in Subsection 13.1.2 of these SOPs regarding ALS Equipment should be considered an extension of this Subsection as well.

### **Subsection 12.2.2: Maintenance and Storage of Equipment**

The Lieutenant shall be responsible for the maintenance and storage of all SBVAC equipment, both those that are stored on and off the vehicles. The Lieutenant shall ensure there is proper available restocked equipment to replace used or missing equipment on SBVAC vehicles.

#### **Paragraph 12.2.2.1: Rig Check**

The Lieutenant shall create and maintain rig check sheets and make them available to crews. The equipment outlined on the rig check sheets shall be considered the equipment approved and required on SBVAC vehicles.

##### **Line 12.2.2.1.2: Completing Rig Check for Ambulance**

The Lieutenant, in consultation with the Chief, shall determine how frequently completing rig check is appropriate. Normally, rig check should be completed and documented on rig check sheets at the beginning of each shift by the attendants and probationary members as per Subsection 9.1.1 of these SOPs. The Lieutenant, in consultation with the Chief, may adjust this policy, and will inform membership when doing so. Once the appropriate rig check sheet is completed, it should be placed into the Lieutenants mailbox. The sheet is not considered

complete until all the equipment on the sheet is accounted for in their proper places. Any missing equipment should be restocked immediately, and if the equipment is not available, the Lieutenant or Duty Chief shall be notified immediately. If rig check cannot be completed, refer to Line 9.1.1.1 of these SOPs. For replacing equipment after a call, refer to Subsections 11.4.2 and 11.4.3 of these SOPs.

**Line 12.2.2.1.3: Completing Rig Check for Responder Vehicle**

Rig Checks should be completed on responder vehicles weekly by the Lieutenant. The Lieutenant, in consultation with the Chief, may chose to complete responder rig checks more frequently. Any equipment used during a call from a responder must be replaced immediately. If equipment cannot be restocked properly, the Lieutenant or Duty Chief should be contacted.

**Paragraph 12.2.2.2: Storage of Equipment**

The Lieutenant shall ensure there is sufficient equipment available in HQ to replace missing equipment on the ambulances, as well as ensure SBVAC is properly equipped and able to replace equipment used on calls or that have expired in a timely fashion. It is the responsibility of the Lieutenant to ensure there is sufficient supply of equipment located in HQ. The Lieutenant shall ensure commonly used equipment is accessible by crews to replace frequently, and that the bulk of equipment is secured. Any problems with restocking, the Lieutenant or Duty Chief shall be contacted.

**Subsection 12.2.3: Medications Stored in Vehicles**

This policy shall cover all medications approved for BLS administration, including albuterol for inhalation, Epinephrine auto-injectors, oral glucose, and aspirin. In addition, all medications approved for BLS administration must be secured in a pouch. All ALS medications shall be regulated under Subsection 12.2.1 and Subsection 13.1.2 of these SOPs.

**Paragraph 12.2.3.1: Quantity in Vehicles**

The Lieutenant, in consultation with the Chief, shall determine the appropriate quantity of each medication to be carried in the ambulances.

**Line 3.15.1.1.1: Epinephrine Auto-Injectors**

As per SBVAC's agreement with Suffolk County, at least three adult and three pediatric, and at most six (6) adult and six (6) pediatric Epinephrine auto-injectors must be carried in each ambulance.

**Subsection 12.2.4: Access Cards**

The Chief shall ensure each vehicle is properly equipped to gain immediate access to all buildings and structures located in on campus, as seen appropriate by the Chief. This

includes, but is not limited to all building access cards, parking garage access cards, and elevator keys.

**Paragraph 12.2.4.1: All Building Access Cards**

Each company vehicle shall have a proximity key card programmed to grant access to the exterior doors of all buildings on the Stony Brook University campus. The cards will be secured in the PCR clipboard, located in each vehicle. These cards are individually assigned to each vehicle and are not interchangeable between vehicles. Each crew shall verify the presence of this card at the beginning of every shift as part of their required rig check, and shall notify the Chief immediately if it is absent. These key cards are not to be removed from their assigned location in the company vehicle for ANY reason other than gaining entry to the scene of an emergency call. If a key card is removed for this purpose, it shall be returned to its proper location within the vehicle IMMEDIATELY upon the return of the crew to the ambulance or responder vehicle. Any violation of this Paragraph shall be grounds for immediate suspension. Subsequent termination from SBVAC may be considered at the discretion of the Chief's Office.

**Paragraph 12.2.4.2: Parking Garage Access Cards**

Each company vehicle shall have a proximity key card programmed to grant access to all the parking garage structures on the Stony Brook University campus. These cards are individually assigned to each vehicle and are not interchangeable between vehicles. Each crew shall verify the presence of this card at the beginning of every shift as part of their required rig check, and shall notify the Chief immediately if it is absent. These key cards are not to be removed from their assigned location in the company vehicle for ANY reason other than gaining entry to the scene of an emergency call. If a key card is removed for this purpose, it shall be returned to its proper location within the vehicle IMMEDIATELY upon the return of the crew to the ambulance or responder vehicle. Any violation of this Paragraph shall be grounds for immediate suspension. Subsequent termination from SBVAC may be considered at the discretion of the Chief's Office.

**Paragraph 12.2.4.3: Elevator Keys**

Each company vehicle should have a key secured within the vehicle that should gain access to the majority of elevators on the Stony Brook University campus. Each crew shall verify the presence of the key at the beginning of every shift as part of their required rig check, and shall notify the Chief immediately if it is absent. Like the access cards in the previous two paragraphs, the key should only be used to gain or assist entry to a scene of an emergency call. The key must be returned to the proper location within the vehicle IMMEDIATELY upon the crew to the ambulance or responder vehicle. Any violation of this Paragraph shall be grounds for immediate suspension. Subsequent termination from SBVAC may be considered at the discretion of the Chief's Office.

**Line 12.2.4.3.1: Out of Service Vehicles**

If a vehicle is temporarily placed out-of-service for repair or any other reason, and will be accessed by Non-Corps personnel, the Chiefs shall remove all access cards and elevator keys from the vehicle and place it in HQ for safe keeping. The access cards and elevator keys shall be returned to the vehicle immediately upon its return to in-service status.

**Section 12.4: Vehicle Maintenance**

The 2<sup>nd</sup> Assistant Chief is responsible for the maintenance of all company vehicles as per Paragraph 6.1.3.2 of these SOPs.

**Subsection 12.4.1: Vehicle Out of Service**

The 2<sup>nd</sup> Assistant Chief, in consultation with the Chief, is responsible for determining the need to take a company vehicle out of service. This may be due to the vehicle failing to meet NYS DOT and/or NYS DOH requirements, needing maintenance, or any other reason the 2<sup>nd</sup> Assistant Chief sees fit. Upon determining that a vehicle is to be placed out of service, the 2<sup>nd</sup> Assistant Chief shall inform membership, as well as properly mark the vehicle as being out of service. In addition, certain pieces of equipment are to be removed from the vehicle that is out of service, such as ALS equipment, the Zoll, and any other equipment determined by the Chief. No member shall drive or operate a SBVAC vehicle determined to be out of service without expressed permission from a Chief.

## **Article XIII: ALS Company Policies**

These procedures shall be for company policy only and shall not supersede any State or local policies and procedures on the administration of Advanced Life Support.

### **Section 13.1: ALS Coordinator**

The 1<sup>st</sup> Assistant Chief shall be in charge of all ALS activities, providers, procedures, equipment, and training. If the 1<sup>st</sup> Assistant Chief is not a qualified ALS provider, an ALS provider shall be appointed ALS Coordinator, in consultation with the Chief, as per Line 6.1.2.3.1 of the SOPs.

#### **Subsection 13.1.1: Responsibilities of ALS Coordinator**

The ALS Coordinator shall directly oversee all matters regarding ALS, including, but not limited to:

- Equipment and Supply
- Training and Clearing ALS Providers
- Overseeing ALS Providers

#### **Subsection 13.1.2: Equipment and Supply**

The ALS Coordinator shall be responsible for maintaining all equipment considered essential for providing Advanced Life Support. The ALS Coordinator shall maintain equipment checks in the form of a written log, as well as keep an inventory of all equipment and ensure proper equipment is available. Any problems with ALS equipment shall be directed to the 1<sup>st</sup> Assistant Chief and/or ALS Coordinator.

##### **Paragraph 13.1.2.1: Glucometers**

This maintenance includes, but is not limited to, calibration and control testing in accordance with manufacturer specifications. These checks shall be performed whenever a new batch of reagent strips is utilized.

##### **Paragraph 13.1.2.2: Cardiac Monitor**

The ALS Coordinator shall be responsible, along with the Lieutenant, for all maintenance, and all other issues regarding the cardiac monitor.

##### **Paragraph 13.1.2.3: Sharps**

No person is permitted to remove, restock, practice with, or otherwise handle any sharps if that person is not a credentialed Advanced Life Support provider with SBVAC as per Paragraph 13.1.3.1 of these SOPs. This includes students in EMT-CC courses and AEMTs who are not cleared for ALS.

##### **Paragraph 13.1.2.4: Restocking of Sharps**

The Chiefs and the Lieutenant may handle sharps if they are not credentialed ALS providers for the purposes of restocking only.

**Paragraph 13.1.2.5: Disposal of Used Sharps**

Any person who discovers used sharps that have not been properly disposed of may place them in a sharps container as per Section 15.3 of these SOPs.

**Paragraph 13.1.2.6: AEMT Students**

AEMT students may handle and practice with sharps only while under the direct supervision of a Suffolk County ALS Preceptor who is also a credentialed ALS provider for SBVAC.

**Subsection 13.1.3: Training and Clearing ALS Providers**

The ALS Coordinator shall be responsible for the training and clearing of ALS Providers in SBVAC.

**Paragraph 13.1.3.1: ALS Credentialed Providers**

Members holding the certification of AEMT may participate at the ALS care level provided they have gained clearance through Suffolk County and the Chief's Office. Clearance shall be at the discretion of the Chief's Office and may be conditional upon written, practical, and/or verbal testing in addition to patient call review.

**Paragraph 13.1.3.2: Credentialed AEMTs**

In order to become a credentialed AEMT to operate at the ALS level within SBVAC the following guidelines must be realized. All decisions on whether an individual may operate at the ALS level reside with the Chief and 1<sup>st</sup> Assistant Chief. The Chief and 1<sup>st</sup> Assistant Chief may override any stipulated guidelines. The following guidelines are based under the assumption that said individual has already gained clearance to operate in Suffolk County according to local protocol.

- Complete at least five (5) ALS calls with an approved Suffolk County preceptor. Inter-facility transports shall not be considered an acceptable ALS call.
- Obtain a written statement by a Suffolk County preceptor with whom the majority of the ALS calls were performed, stating the preceptor's professional opinion on the preparedness for said individual to operate in a solo environment. If the preceptor possesses valid reasons for no longer holding Suffolk County preceptor status and shows adequate experience in the field of EMS, the Suffolk County preceptor status requirement may be waived at the discretion of the Chief or 1<sup>st</sup> Assistant Chief.

**Line 13.1.3.2.1: Credentialing the Chief or 1<sup>st</sup> Assistant Chief**

In the event that the AEMT desiring to be credentialed as an ALS provider within SBVAC is the Chief, the 1<sup>st</sup> Assistant Chief and the 2<sup>nd</sup> Assistant Chief shall be solely responsible for all decisions in accordance with the guidelines stated above. In the event that the AEMT desiring to be credentialed as an ALS provider within SBVAC is the 1<sup>st</sup> Assistant Chief, the Chief and the 2<sup>nd</sup> Assistant Chief shall be solely responsible for all decisions in accordance with the guidelines stated above.

**Paragraph 13.1.3.2: Suffolk County ALS Preceptor Status**

Suffolk County ALS Preceptors shall be the only providers permitted to observe non-credentialed AEMT's and AEMT students performing advanced skills on emergency calls or in controlled practice environments. AEMT students shall only be allowed to practice advanced skills while actively enrolled in a current EMT-CC or EMT-P class within Suffolk County.

**Line 13.1.3.2.1: Approved Preceptors**

Preceptors must have written approval from the Chief and 1<sup>st</sup> Assistant Chief in order to act in the capacity of a preceptor within the company.

**Line 13.1.3.2.2: Nomination of New Preceptors**

The Chief, in conjunction with the 1<sup>st</sup> Assistant Chief, may choose to nominate to Suffolk EMS any credentialed ALS provider for appointment as a Suffolk County ALS Preceptor. SBVAC shall only nominate ALS providers known to meet the requirements imposed upon potential preceptors by Suffolk County EMS, including, but not limited to:

- The potential preceptor must have provided active ALS service within Suffolk County for a period of at least one (1) year.
- The potential preceptor must have provided advanced care to at least twelve (12) patients within the one-year period preceding nomination.
- The potential preceptor must be free of any major incidents on record with Suffolk EMS and/or Medical Control within the one-year period preceding nomination.
- The potential preceptor must have taken Suffolk County EMS's Advanced Airway and Preceptor Class.

**Subsection 13.1.4: Overseeing ALS Providers**

The ALS Coordinator shall oversee and review all SBVAC's ALS calls. If the ALS Coordinator is not the 1<sup>st</sup> Assistant Chief or any other Chief, the ALS Coordinator must review ALS calls with the 1<sup>st</sup> Assistant Chief. The ALS Coordinator shall also be a member of the QA/QI Committee, and review all the ALS calls in a manner described outlined in Section 5.3 of these SOPs. The ALS Coordinator, with consultation of the 1<sup>st</sup> Assistant Chief and Chief may revoke anyone's SBVAC ALS privileges at any time.

**Section 13.2: Company Protocols**

The following company protocols shall apply to all AEMTs credentialed by SBVAC to operate at the ALS level.

**Subsection 13.2.1: Blood Glucose Determination**

Blood Glucose Determination will be performed adhering to the guidelines set forth by Suffolk County ALS protocols or as directed by an authorized Medical Control Physician. Use of the glucometer should follow the set procedures as dictated to the operator's manual.

### **Subsection 13.2.2: Endotracheal Intubation**

Prevention of unrecognized esophageal intubation is of paramount importance and is a medical and legal necessity. Therefore the use of waveform capnography, an ET tube verification device (such as a Tube-Check bulb), AND immobilization of the head are required on ALL endotracheal intubations performed in Suffolk County.

### **Subsection 13.2.3: Contact with Medical Control**

Although “O2/IV/Monitor” is the standard of care for EMT-CCs and EMT-Ps and does not require routine on-line contact with Medical Control, such on-line contact **is still required** whenever a patient fits a protocol, exhibits abnormal vital signs or EKG, presents with a cardiac, respiratory or neurological chief complaint, or in any other situation where the AEMT determines that physician consultation is in order. In any situation, on-line contact with Medical Control is required by Suffolk County Protocol within twenty (20) minutes of initial patient contact, unless the patient fits into a no contact protocol.

#### **Paragraph 13.2.3.1: Post-Call Signal 34**

Medical Control must be contacted at the completion of any call during which any ALS intervention or diagnostic procedure was performed.

#### **Paragraph 13.2.3.2: Catastrophic Communications Failure**

In the event of Catastrophic Communications Failure, as defined by Suffolk County protocols, on-line contact with Medical Control is no longer necessary. Standing Orders as well as Medical Control Options which the AEMT reasonably believes will benefit the patient may be carried out. All interventions must be documented appropriately on the PCR. Only Suffolk County EMS may declare a state of Catastrophic Communications Failure, and MEDCOM will notify SBVAC in the event one is declared.

### **Subsection 13.2.4: Patient Transfer Protocol**

A New York State certified EMS provider with a higher level of certification may transfer responsibility for the ongoing care of a patient to a provider with a lesser New York State certification if the following conditions are met:

1. The provider with the higher level of certification must have assessed the patient and made an affirmative decision to transfer care of the patient to a provider with a lesser certification.
2. The provider with the higher level of certification must have made the determination that the patient will not require any care or skills which would be possessed by the provider with the higher level of certification and not possessed by the provider with the lesser level of certification.
3. The provider with the lesser level of certification must agree to assume responsibility for patient care. If the provider with the lesser level of certification refuses to accept

that responsibility, the provider with the higher level of certification must continue to care for the patient until the transfer to the hospital is complete.

4. If either provider who is a party to the transfer has any questions concerning the appropriateness of the transfer they must contact Medical Control for a physician consultation.
5. The patient transfer must be documented on the PCR.

#### **Subsection 13.2.5: Securing of ALS Equipment, Medications and Sharps in Vehicles**

All ALS supplies, with the exception of medications approved for use by EMT-B's, are to be secured in a locked cabinet on the vehicle at all times when they are not in use.

##### **Paragraph 13.2.7.1: Exceptions**

The Lieutenant and the 1<sup>st</sup> Assistant Chief/ ALS Coordinator may, at their discretion, decide to stock certain ALS supplies outside of the locked cabinets, so long as these supplies do not contain sharps or medications. Examples may include, but are not limited to, intravenous fluids, administration sets and endotracheal tubes.

##### **Paragraph 13.2.7.2: ALS Keys**

Keys/codes to the locked ALS cabinets on the vehicles shall only be given to and carried by credentialed AEMTs, as per Paragraph 13.1.3.2 of these SOPs, and the Chiefs.

#### **Subsection 13.2.6: Securing of ALS Equipment, Medications and Sharps**

All ALS supplies that are stored in headquarters shall be secured in the ALS supply closet. Only credentialed AEMTs, as per Paragraph 13.1.3.2 of these SOPs, and the Chiefs have access to this area and are permitted to handle ALS medications and sharps.

#### **Subsection 13.2.7: ALS Equipment in Personal Vehicles**

As per Suffolk County protocol, except as provided for in the next paragraph, ALS personnel are NOT authorized to carry any item that requires a physician's prescription in their private vehicle. Such items include, but are not limited to, needles, syringes, medications, and defibrillators.

The only circumstance under which such equipment may be legitimately carried in a private vehicle is when the vehicle operator is serving in the capacity of an "ALS first-responder" for SBVAC. The ALS equipment may be carried ONLY with the prior knowledge and approval of the Chief's Office. All such ALS equipment must be able to be used under protocols applicable to the AEMT's level of certification, and MUST include, but is not limited to, IV administration supplies and fluids, monitor/defibrillator, endotracheal intubation equipment, telemetry equipment, and communications equipment. The AEMT operating the vehicle shall be responsible for all equipment and medications, and must ensure that they are operational and non-expired.

## **Article XIV: Multiple Casualty Incident Procedures**

The policies and plans outlined in this Article shall take effect while any SBVAC unit is operating in a situation determined to be a multiple casualty incident (MCI). The first arriving CC may be the first medically trained responder on scene of the potential MCI, and will need to declare such an event. The procedures followed during the course of an MCI shall follow all applicable New York and Suffolk County protocols for operating during an MCI. SBVAC shall participate in Suffolk County's Multiple Casualty Incident and Disaster Plan, and shall operate under Suffolk County's Disaster and MCI Management procedures. This article shall specify and outline SBVAC procedures SBVAC members should follow while on the scene of an MCI.

### **Section 14.1: Definition of a Multiple Casualty Incident**

If an MCI has not been declared prior to the arrival of the first arriving SBVAC unit, it is the responsibility of the highest ranking member of SBVAC, as per Subsection 6.4.1 of these SOPs, to declare an MCI. An MCI should be declared for an incident requiring the resources that cannot be supplied by SBVAC as a department or our immediate neighboring departments.

#### **Subsection 14.1.1: Size of Multiple Casualty Incidents**

The size and severity of the MCI will help determine a proper estimate for the number and type of resources required. By completing a proper scene-size up, and estimating the number of resources that are needed, the highest ranking member of SBVAC, as per Subsection 6.4.1 of these SOPs, can determine the size. Some incidents may be small enough to only require a few departments' assistance, while other incidents may require the County, State, and Federal Government to supply assistance and manpower.

##### **Paragraph 14.1.1.2: Small-Scaled MCIs**

An MCI may be declared for an incident that may not require County and State resources. These types of incidents are known as small-scale MCIs, and may only require a few of the neighboring departments to assist in the triage, treatment, and transport of patients.

##### **Paragraph 14.1.1.3: Large-Scaled MCIs**

An MCI may be declared for large incidents requiring the assistance of many neighboring departments from across the County. An incident of that nature may require the assistance of County Coordinators to help coordinate all the various departments. Some incidents may even require assistance from the State and Federal Government if the number of resources needed outnumber the resources available by the County.

### **Section 14.2: Declaring an Multiple Casualty Incident**

As stated above, if an MCI has not been declared prior to the arrival of the first arriving SBVAC unit, it is the responsibility of the highest ranking member of SBVAC, as per Subsection 6.4.1 of these SOPs, to declare an MCI.

**Subsection 14.2.1: Completing a Scene-Size Up**

Prior to determining that an incident is indeed an MCI, a proper scene-size up must occur. This is to estimate the number of patients, the nature of the incident, and the number of resources required to properly handle the incident. The scene-size up should occur prior to any declaration of an MCI, and should be completed immediately upon arriving on scene.

**Subsection 14.2.2: Informing Proper Authorities**

Once completing a scene-size up, MEDCOM should be notified immediately of the incident over the radio. The highest ranking member of SBVAC, as per Subsection 6.4.1 of these SOPs, on scene is responsible for doing this. In addition to requesting and informing MEDCOM of the resources that are needed, a SBVAC Chief should be requested to scene via MEDCOM.

**Paragraph 14.2.2.1: Requesting Resources**

The SBVAC member making the request should inform MEDCOM of the following:

1. The nature of the incident
2. The expected/estimated number of patients
3. The number of ambulances that are needed to the scene
4. Any special equipment or personnel that are required (i.e.: HAZMAT, heavy rescue, fire, etc.)
5. County EMS Supervisors and County Deputy Fire Coordinators if needed

MEDCOM should also be informed where the command post will be situated, as well as where all additional ambulances and resources should stage.

**Paragraph 14.2.2.2: Contacting Medical Control**

Medical Control should be contacted during any MCI to inform them of the nature, expected number of patients, and an estimated account on the severity of the patients. Medical Control can help coordinate the mobilization of medical resources to the field, as well as help inform and determine where to transport patients. Medical Control should be requested to inform Stony Brook University Medical Center and other local hospitals of the incident, and to expect a large influx of patients.

**Section 14.3: Setting up Command**

The highest ranking member of SBVAC, as per Subsection 6.4.1 of these SOPs, initially on scene is responsible for assuming the authority, or assigning someone else, as EMS Incident Commander (IC). The Incident Commander should use the first SBVAC vehicle on scene as the command post, and position it in an overlooking position which will ensure the IC is in view of the scene. This position should also allow for safe and adequate command and control of the incident. The IC should be sure to integrate the command post with a Unified Command with other responding departments. The command post should include the commanders from other departments handling the various aspects of the MCI, such as PD,

Fire, HAZMAT, etc. The IC is responsible for the communication with the County and other resources, as well for the establishment and development of the branches of the Incident Command System (ICS).

### **Subsection 14.3.1: Triage**

The first branch set up by the Incident Commander should be Triage. The IC should appoint a qualified EMT to be the Triage Officer and oversee all aspects involving the triage of patients, and continuously report back to the IC.

#### **Paragraph 14.3.1.1: Triaging Patients**

All medical personnel on scene without a position assigned to them by the Incident Commander should assume a position in the triage branch in the initial moments of the incident. Using the triage tags located on all of the SBVAC vehicles, all patients should be triaged as efficiently and effectively by the standards outlined in the START Triage method. All of the patients should be triaged, and tagged, and NOT treated until all the patients have been triaged. The triage branch, and ultimately the Triage Officer, is responsible for the following:

1. Coordinate patient removal from danger with rescue/extrication personnel
2. Provide Command with updates
3. Identify/correct life-threats without slowing triage
4. Assess, categorize, tag
5. Continuously re-triage

#### **Line 14.3.1.1.1: Completion of Triaging**

Once all the patients have been triaged, the Incident Commander may reassign those assigned to the branch section to report to another branch. Some EMTs will remain in the triage branch, under the Triage Officer, to begin the process of re-triaging patients.

### **Subsection 14.3.2: Staging**

The second branch set up by the Incident Commander should be Staging Branch. The IC should appoint a qualified member to be the Staging Officer and oversee all aspects involving the staging of vehicles and equipment, and continuously report back to the IC.

#### **Paragraph 14.3.2.1: Staging Vehicles, Equipment, and Resources**

The Staging Officer is responsible for identifying a safe location for vehicle staging, assuring access route, orderly parking and traffic flow, categorize resources and capabilities, assign units as requested, and inform Command of status. Upon the arrival of any ambulance to the incident, the Staging Officer should coordinate the removal of most of the excess equipment off the ambulance to be placed in a centralized equipment area. This is to ensure available medical equipment in the event all ambulances are transporting, as well as to provide the treatment branch adequate equipment. The Staging Officer is responsible for the coordination of all the

equipment from the staging area to the scene, as well as coordinating manpower to assist the various branches on scene at the request of the IC.

### **Subsection 14.3.3: Treatment**

The next branch set up should be the treatment branch. The IC should appoint a qualified EMT to be the Treatment Officer and oversee all aspects involving the treatment of patients on scene.

#### **Paragraph 14.3.3.1: Treatment of Patients**

EMTs should be assigned to the treatment branch and report directly to the Treatment Officer. Patients should be treated in the order of immediate (red), delayed (yellow), and hold (green). Once patients are stabilized in the location they are found, the members of the treatment branch should relocate patients to a centralized treatment area for continued treatment and observation. The treatment branch should also categorize and arrange medical equipment transferred from the staging area to the scene.

##### **Line 14.3.3.1.1: Designated Treatment Area**

The Treatment Officer is responsible for setting up and maintaining a treatment area, where all patients should be relocated to allow for easy access, continuing treatment, and observation. The treatment area should be a clearly visible area which is easily accessible by the transporting units. The treatment area should contain EMTs assigned to that area, as well as a stockpile of equipment.

##### **Line 14.3.3.1.2: Maintaining Equipment**

The Treatment Officer is responsible for maintaining an area designated for the drop off of all excess medical equipment from the ambulances. All the ambulances participating in the incident should remove non-essential equipment and place it in a centralized equipment area maintained by the treatment branch. This area should be clearly marked, and should be easily accessible by those treating patients on scene as well as in the treatment area outlined in Line 14.3.3.1.1 of these SOPs.

##### **Line 14.3.3.1.3: Advanced Life Support at MCIs**

Providing care to the level of the advanced life support level may not be efficient and effective in all incidents considered an MCI. Some large-scaled incidents with many critical patients may require ALS treatment, and benefit from it. ALS should only be provided if adequate providers and equipment are available on scene. The decision to treat at the ALS level should be made by the Treatment Officer, with advice from the IC and Medical Control.

##### **Line 14.3.3.1.4: Morgue Unit**

Depending on the size of the incident, the IC may decide to set up a unit designated for handling all the deceased patients. This unit should be coordinated

with Medical Control, and the Suffolk County Medical Examiner's Office should be requested to assist through the police on scene.

#### **Subsection 14.3.4: Transport**

The transport branch should be set up next, and the IC should appoint a qualified EMT to be the Transport Officer. The Transport Officer should work with the Staging and Treatment Officers to coordinate the ultimate goal of evacuating all patients from the scene to a hospital. Depending on the number of available ambulances, patients should be transported in order of most critical to least critical. It may be necessary for the Transport Officer to work with the IC and Medical Control to determine where each patient is being transported based on their condition. Once the treatment branch reports a patient's condition, it is the responsibility of the Transport Officer to ensure the patient is transported to the appropriate facility. Less critical patients may be transported to further hospitals to ensure closer hospitals are not overwhelmed with the influx of patients.

##### **Paragraph 14.3.4.1: MEDEVAC Patients**

It may be appropriate to MEDEVAC patients during an MCI to spread out critical patients, or patients requiring specialized care. The guidelines in Paragraph 11.2.15.2 of these SOPs, as well the advice and direction given by Medical Control should be considered when deciding if to use the MEDEVAC services. Coordinating the MEDEVAC service during an MCI can be done by Medical Control if the decision is made by the Transport Officer.

##### **Paragraph 14.3.4.2: Using Medical Control**

Medical Control should be contacted as early as possible to assist in the decision of where to transport patients based on their condition and the available resources at each hospital. Patients requiring specialized care may not be advised to be transported to a certain hospital if that hospital's resources are overwhelmed. Medical Control can also assist in the decision making of when to use the MEDEVAC service.

##### **Paragraph 14.3.4.3: Rapid Intervention Team**

If the incident is considered a large-scaled MCI, the IC may decide to assign the transport branch a rapid intervention team. This team would be made up of a crew and an ambulance dedicated to treating injured rescuers working on the incident. Depending on the size of the incident, it may be appropriate to require more than one rapid intervention team.

##### **Line 14.3.4.3.1: Rehab for Incident**

The IC may decide to set up a Rehab unit under the coordination of the Transport Officer. The guidelines stated in Subsection 11.2.17 of these SOPs should be considered when setting up any Rehab unit during an MCI.

#### **Subsection 14.3.5: Demobilization**

Once all patients have been evacuated from the scene, and no responders require medical attention, efforts shift from triage, treatment, and transporting to demobilization. The Incident Commander should notify MEDCOM and Medical Control all patients have been evacuated, and demobilization efforts have begun. If a morgue unit was created, the deceased patients should be removed as per the policies of the Suffolk County Medical Examiner's Office, who should be on scene, or requested if not. The cleanup of equipment and the return of all units and personnel to normal operations should begin under the coordination of the Incident Commander. It may be necessary to request the Critical Incident Stress Management (CISM) team to respond to scene and assist in the demobilization process.

### **Section 14.4: Unified Command and the Incident Command System in SBVAC**

The policies outlined in this article are to outline the procedures SBVAC personnel should follow while operating on the scene of an MCI. SBVAC's role in an MCI is to provide EMS Command and EMS support to the operation. SBVAC should be one of the many departments working on the MCI. We should be part of the larger unified command, which will be made up of Police, Fire, EMS, and other departments handling the specialized services required to operate on the scene of an MCI.

#### **Subsection 14.4.1: Transition of Authority**

The command structure may not take the linear format outlined in the Chain of Command of Subsection 6.4.1 of these SOPs, but rather another type of format. The Incident Commander may transfer the authority as IC to another member of SBVAC at anytime, as long as all the information is passed on. Furthermore, the various members assigned "officer" titles in the incident command system may transfer the authority of their branch to other members as well. The highest ranking member of SBVAC, as per Subsection 6.4.1 of these SOPs, should ensure this SOP is followed, but does not necessarily need to be the Incident Commander.

#### **Subsection 14.4.2: The Incident Command System in SBVAC**

The policies and procedures outlined in this article are meant as a guideline to follow during an MCI. Each incident is different, and may require a different approach, but the procedures outlined in this article can be used generically to organize and arrange an incident command system. Depending on the size of the incident, the on-scene procedures may be more or less specific than this article. Furthermore, the policies outlined in the rest of these SOPs should still be followed when applicable and possible.

## **Article XV: Infection Control Procedures**

Infection Control Procedures shall be consistent with current guidelines for emergency workers as most recently published by the Centers for Disease Control (CDC) and Occupational Safety and Health Administration (OSHA).

### **Section 15.1: OSHA Bloodborne Pathogen Regulations**

As per OSHA Bloodborne Pathogens Regulations (29 CFR 1910.1030), all members must wear protective equipment.

#### **Subsection 15.1.1: Body Substance Isolation**

BSI protection should be selected with careful considerations for each specific situation, and the overall risk associated with the task. Factors to consider during evaluation include type of body fluid and volume of blood or body fluid.

#### **Subsection 15.1.2: Training**

All active members must attend one (1) OSHA Bloodborne Pathogen training session annually. The training session will be organized by the Captain (50), and be part of the minimum progress rate of all active members according to Subsection 5.1.1 of these SOPs. The Captain shall report any member who has not completed an annual OSHA Bloodborne Pathogen training session to the Chief's Office. Said members are subject to immediate suspension until proper training has been documented.

### **Section 15.2: Universal Precautions/Body Substance Isolations**

It is prudent to employ practices to protect against exposure to potentially infectious material when having contact with all patients since many persons who are infected with blood borne pathogens are not always diagnosed or identifiable.

#### **Subsection 15.2.1: Definitions**

##### **Paragraph 15.2.1.1: Body fluids**

Body fluids are defined as blood, sputum, saliva, semen, vaginal secretions, wound draining, amniotic fluids, breast milk, tears, urine, and feces.

##### **Paragraph 15.2.1.2: Exposure**

Exposure is defined as the actual direct contact to the above secretions. Potential exposure is defined as to the potential for an exposure to occur. Clinical judgment enters into all decisions.

#### **Subsection 15.2.2: Responsibility**

All members are responsible for complying with these policies.

### **Subsection 15.2.3: Procedures**

1. Protective attire is to be used to prevent accidental exposure to blood and other fluids.
  - a. Gloves must be worn when touching mucous membranes or non-intact skin of all patients and changed between all patient contacts.
  - b. Gloves must be worn when having contact with blood or body fluids and when handling items containing or contaminated with blood or body fluids.
  - c. Gloves must be worn for venipuncture and other vascular access procedures.
  - d. If a glove is torn or a needle stick or other injury occurs which will decrease the ability to function as a barrier during an invasive procedure, the glove must be changed as promptly as safety permits, and the needle or instrument removed from the sterile field.
  - e. If splashing of blood or other body fluids is likely to occur, and eye, nose or mouth contamination can be reasonably anticipated, protective eye coverings must be worn, in addition to a mask, gloves, and a gown or other protective clothing.
2. All procedures involving blood or other potentially infectious body fluids shall be performed in such a manner as to minimize splashing, spraying and generation of droplets.
3. Gloves, surgical masks, and protective eyewear must be worn for all invasive procedures. Invasive procedures include all procedures that commonly result in generation of droplets, splashing of blood or body fluids, or generation of bone chips. Gowns or aprons made of materials that provide an effective barrier must be worn during invasive procedures.
  - a. An invasive procedure is defined as surgical entry into tissues, cavities, or organs. Repair of traumatic injuries:
    - i. The manipulation, cutting or removal of any oral or perioral tissues during which bleeding or potential for bleeding exists.
    - ii. A vaginal or caesarian delivery or other obstetric procedures during which bleeding may occur.
  - b. Gloves, gowns, and face shields must be worn when handling the placenta or newborn infant until blood and amniotic fluids have been removed from the infant's skin. Gloves should be worn during post-delivery care of the umbilical cord.
4. Hands and any other skin must be washed thoroughly and immediately with soap/water or waterless soap, or flush mucous membranes if accidentally contaminated with blood or body fluids. Hands must be washed immediately or as soon as possible after the removal of gloves and/or other personal protective equipment.

5. All BSI shall be removed prior to leaving the work area. It must be placed in the appropriate designated area or disposal receptacle.
6. Contaminated sharp items (needles, and other sharp instruments) should be considered as potentially infectious and be handled with extraordinary care to prevent accidental injuries.
7. Disposable syringes and needles and other sharp items should be placed into puncture resistant containers. To prevent needle stick injuries, needles should not be recapped, purposefully bent, broken, clipped, or otherwise manipulated by hand.
8. Resuscitation bags or mouthpieces are to be used in place of mouth-to-mouth resuscitation and must be readily available where they are likely to be needed.
9. Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in the work areas where there is a likelihood of occupational exposure.
10. Food and drink shall not be kept on shelves, in cabinets, or on counters where blood or potentially infectious material is present.
11. If a percutaneous (e.g. needle stick, bites, lacerations, etc.) ocular, mucous membrane, or open skin lesion exposure to blood or body fluids occurs, immediate evaluation for necessary management is required. This includes the filing of an Incident Report.
12. When caring for and/or performing a procedure on an uncooperative/combatative patient, caution should be taken to prevent exposure to blood or body fluids. Assistance should be utilized in these situations.
13. All equipment and environmental and working surfaces shall be cleaned and decontaminated after contact with blood or other potentially infectious material.
14. Hospital shall be notified of the need for isolation prior to bringing patient into the hospital.

### **Section 15.3: Disposal of Needles and Syringes (Sharps)**

All needles and syringes should be disposed of immediately to prevent accidental injury.

#### **Subsection 15.3.1: Procedures**

1. Personnel should exercise meticulous care when handling syringes and needles contaminated with blood. Accidental needle sticks should be avoided. If an accident occurs, it should be reported to the 2<sup>nd</sup> Assistant Chief and an Incident Report filed. Follow up will be done by the company or personal physician.
2. Disposable needles and syringes are used and never reused.
3. Used needles should not be purposely bent, because an accidental needle puncture may occur. They should be immediately discarded in the impervious puncture resistant container located in each ambulance. These containers shall be puncture resistant, leak proof on the sides and bottom, and have a biohazard label.

4. Filled puncture proof containers should have the top locked on the opening. The containers should be dropped off at the hospital when full. The Lieutenant and 1<sup>st</sup> Assistant Chief and/or ALS Coordinator should arrange this.

#### **Section 15.4: Care of Equipment Used in Isolation**

All equipment touched by the patient and personnel providing care for the isolation patient must be cleaned, disinfected, and sterilized before being used on another patient.

##### **Subsection 15.4.1: Procedure**

All equipment removed from the ambulance must be bagged and arranged for drop-off at hospital. Consult the Lieutenant or 2<sup>nd</sup> Assistant Chief for details.

#### **Section 15.5: Blood Spill Policy**

Cleaning of all spills consisting of blood or body fluids must be done in such a manner as to avoid contamination of other surfaces.

##### **Subsection 15.5.1: Procedures**

1. Spills of blood or body fluids are to be covered with chlorinated encapsulating powder as soon as it is noticed.
2. The person cleaning the spill will wear gloves and a mask with face shield.
3. After the congealed product of the spill has been removed and placed in a red plastic bag for disposal as regulated medical waste, the area is to be decontaminated using an approved disinfectant that is tuberculocidal when used at recommended dilutions.
4. The mop head is to be changed and red bagged for transport to a storeroom for laundering.
5. The mopping bucket and mop handle is to be decontaminated immediately following use.
6. Reusable latex gloves are to be decontaminated prior to removal, and hands are to be washed immediately following removal.

#### **Section 15.6: HIV Positive Health Care Workers**

In accordance with principles and recommendations by the New York State Department of Health, January 1991 Policy statement, SBVAC has adopted the following guidelines:

1. HIV infected health professionals may continue all professional practices for which they are qualified with strict adherence to infection control practices.
2. Limiting practice of HIV infected Health Care professionals is not necessary unless:
  - a. There is clear evidence that the worker poses a significant risk of transmitting infection through the inability to meet basic infection control standards.
  - b. They are functionally unable to care for patients based on the individual's ability to perform up to generally accepted standards and practices expected of all health care personnel.

3. Decisions about the work responsibilities of HIV infected health care workers with functional impairment or lack of infection control competence will be made on a case-by-case basis involving the worker's personal physician.
4. Education of personnel regarding the following principles will be performed:
  - a. Health care workers are encouraged to learn their HIV status to protect and improve their own health.
  - b. HIV infected individuals are encouraged to seek periodic evaluation for functional limitations that could significantly compromise quality of care.
  - c. HIV infected health care workers are encouraged to inform SBVAC when there is a significant risk of compromised patient care.
5. SBVAC is not required by New York State Law to disclose information to patients about HIV infection in personnel.
6. In the event a situation warrants disclosure, a worker's written consent to release information must be obtained. The disclosure to the patient will not identify the infected worker. The NYS DOH will be informed if disclosure of information is to be done, and provide technical assistance.

#### **Section 15.7: Periodic Cleaning of Rescue Vehicles**

The interior and exterior of the ambulances shall be cleaned periodically according to the following guidelines:

1. On a weekly basis, the floors, walls, interior and exterior cabinets and drawers, benches, and other surfaces will be cleaned thoroughly.
2. The vehicle shall be cleaned using the same cleaning agent as used between responses and after transports.
3. A cleaning supply kit containing household utility gloves, plastic spray bottle with cleaning agent, plastic spray bottle with disinfecting solution or a bottle with concentrated household bleach to be diluted with water (1:100), disposable towels, plastic bags (red bags and household plastic bags) and a carrying device for the cleaning supplies, shall be kept in a central location. The Lieutenant will be responsible for maintaining these supplies.
4. Carpeting and permeable seat covers are not permitted in the patient compartment of ambulances due to the difficulties encountered in keeping them clean and sanitary.
5. A designated disinfecting area shall be assigned for all medical equipment cleaning and disinfecting. Dirty or contaminated emergency medical equipment shall not be cleaned or disinfected in any hygiene areas around HQ.
6. Appropriate protective infection control garments and equipment, such as fluid resistant clothing, splash-resistant eyewear, and medical gloves, shall be used whenever there is a potential for exposure to body fluids or potentially infectious material during cleaning and disinfecting.
7. All disinfectants shall be registered and approved for use by the U.S. Environmental Protection Agency and shall be registered as tuberculocidal.
8. Dirty or contaminated run-off from emergency medical equipment and cleaning and disinfecting solutions shall be disposed of into a sanitary sewer system.

9. Metal, electronic equipment, and emergency medical equipment shall be cleaned and disinfected according to the manufacturers' instructions.
10. Reusable emergency medical equipment that comes in contact with blood or other bodily fluids shall require cleaning and high level disinfecting as per manufacturer.
11. Environmental surfaces shall be cleaned and disinfected as per manufacturers.

## **Article XVI: Health Standards**

### **Section 16.1: Yearly physical**

All members are required to have a yearly physical to ensure that they are in a fit state to work on an ambulance. The physical will in no way serve to prevent any person from membership, but rather to help identify level of activity that can be safe for the member.

### **Section 16.2: Ill or Injured Member**

If any member of SBVAC becomes injured due to events outside of SBVAC, they shall be put on a medical leave of absence until a physician deems them fit for active service.

### **Section 16.3: Member Health Records**

Member health records will be maintained on all members who are active personnel with SBVAC. This record shall include the following as outlined in the NYS EMS Program Policy Statement Number 88-8:

1. Pre-employment physical examination;
2. Immunization record and screening results;
3. Record of member occupational injuries or illnesses and their course, i.e.: compensation forms filed, Physician's record, hospital record, etc.;
4. SBVAC Incident Reports pertaining to member exposure to suspected hazardous materials, toxic products, or true exposures to infectious diseases;
5. Record of annual physicals;
6. Record of Physician's approval to return to active duty after debilitating illnesses or injuries.

#### **Subsection 16.3.1: Pre-employment Physicals**

Pre-employment health physicals and screening, as outlined in the NYS EMS Program Policy Statement Number 88-8, shall be required for all members beginning service after September 1, 2002. Members who began active service prior to this date will be offered the opportunity to participate in any agency provided testing or inoculation program.

#### **Subsection 16.3.2: Tuberculosis Testing**

Routine yearly tuberculosis (TB) testing will be required for all members having contact with patients. For those who have converted their skin test, this SOP will be waived. Instead, an initial chest x-ray will be obtained and appropriate counseling provided regarding the need to report any signs or symptoms of TB. Further chest x-rays will only be obtained when determined necessary by SBVAC's Medical Director.

#### **Subsection 16.3.3: Storage and Access to Member Health Records**

Members' health records shall be stored in a secured location separate from the personnel files. Members' health records shall be considered extremely confidential. As such, access to members' health records shall be restricted to the Vice President and the Chief's

Office. These files are to be accessed only as necessary strictly to update the information contained within, or for reference in the event of an emergency.

#### **Section 16.4: Hepatitis B Vaccination**

SBVAC shall offer Hepatitis B vaccinations to all new members at no charge. Any member who chooses not to receive this vaccination must either provide proof of immunity to Hepatitis B or sign a vaccine declination form. This form shall be kept with the member's health record.

#### **Section 16.5: Required Fit Testing**

All members shall be fit tested annually for N95 respirators (HEPA masks) and full-face air purifying respirators (gas masks). Fit testing shall be conducted more frequently for members suspected to have changed mask sizes due to the gain or loss of weight or other factors.

##### **Subsection 16.5.1: Facial Hair**

Members shall not be permitted to have facial hair that interferes with the proper fit and seal of an N95 or full-face respirator.