Standard Operating Guidelines

Operations

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Chapter One

Daily Operational Issues

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Behavioral/Conduct Expectations**

Purpose:

Operations personnel are expected to provide a high level of care and customer service. Operations Supervisors are expected to lead by example.

Clinical excellence and safe, appropriate transportation are our highest priority. No circumstance should be allowed to impede our ability to deliver excellent care to our patients. We will take the most assertive course of care to provide the maximum benefit to our patients.

Customer service is likely to benefit our patients more often than technical skills. Kindness must be shown in all situations. Actions should include the greatest possible level of courtesy and consideration for all concerned parties. Our behavior should reflect a willingness to be helpful. There are no criteria beyond a request or implied need to qualify for our service. Fulfill a request for any service within our capacity to the greatest possible degree.

Appearance can have a major impact on the public perception of our competence. A professional demeanor should be displayed at all times when interacting with the public and coworkers. Our work needs to be performed as quickly and efficiently as possible. Concern for the patient should be evident in our behavior.

Expectations of employee behavior is specifically addressed in the Employee Handbook chapter 2 item 2.1 and 2.2

MEDIC Standards of Behavior
Developed* for *Medic Employees*, by *Medic employees

Medic Core Values

C- Compassion
CA- Customer Advocacy
F- Fairness
H- Honesty
I- Integrity
R- Responsibility
SF- Straight Forwardness

Advocacy:

- I will show care and compassion to all regardless of role, race, color, gender, sexual orientation, physical disability, origin, ancestry, religion, or socioeconomic status. **C, CA, F, I.**
- I will be committed to working with patients in finding solutions when barriers to treatment arise. **CA, R**
- I will be informed of community efforts and programs that provide additional resources and education to patients and/or the community. **CA, R**
- I will be an advocate for my patients by effectively communicating their needs to staff, family members, or community agencies/providers. I will promote their worth, champion their healthcare, and educate my patients so they can make informed decisions. **C, CA, I, R**

Appearance:

Personal:

- I will adhere to MEDIC agency, and departmental dress code policies for proper uniform/clothing, jewelry, cologne, and hygiene. **CA, R**
- I will not deface my ID badge and wear it clearly visible at all times. **R**

Facility:

- I will keep my work area and/or post clean and organized. **CA, I, R**
- I will be observant of litter, debris, and spills within the facility and handle clean up immediately. **CA, I, R**
- I will respect our allied agencies by treating their facilities with the same standards as relates to MEDIC facilities. i.e., Fire Stations, Hospitals. **CA, I, R**

Ambulance and Equipment:

- I will respect my coworkers by keeping my Ambulance and equipment clean and free of biohazards. **CA, I, R**
- I will respect all equipment, be sure it is in good working order, and use it in a proper manner. **CA, I, R**

Attitude:

- I will treat everyone in a courteous and respectful manner, as I would want to be treated; rudeness is never acceptable. **C, CA, F, I, R**
- I will help to create a culture that makes people feel appreciated, included, and valued. **C, F, I, R, SF**
- I will strive to meet the customer's need by using HEAL: **C, CA, I, R**
  - H: Hear them out
  - E: Empathize
  - A: Apologize
  - L: Leap into action to solve the problem
- I will take care of myself physically, spiritually, and mentally: recognizing if my personal life is affecting my work attitude, and seek help as appropriate, so I can provide excellent care to my customers. **CA, H, I, R**
- I will remember that customers are not an interruption of my work; they are the reason I am here. **CA, F, I, R**
- I will be accountable for my actions, words, and patient care. **CA, H, I, R, SF**

Commitment to Coworkers:

- I will report to work as scheduled. I will communicate delays as appropriate. **CA, I, R**
- I will respectfully approach other healthcare professionals and refrain from discipline, or constructive criticism in public. **C, CA, F, I, R, SF**
- I will maintain a positive attitude despite any setbacks, and take responsibility for solving problems, regardless of origin. **CA, I, R, SF**
- I commit to staying on task; with any assignment I may be given. **I, R**
- I will hold my coworkers accountable (in a respectful manner) for upholding our standards of behavior, policies, and procedures. **H, I, R, SF**
- I will welcome new employees. Being supportive by offering to help, and setting an example of cooperation. **C, CA, F, I, R**
- I will show respect to my first responders by listening to their report, and give consideration to what may have been done prior to my arrival. **CA, F, R**

Communication:

- I will not discuss staffing, or internal issues with customers; including patients, bystanders, first responders, or allied health workers. **I, R**
- I will treat others respectfully and professionally by listening and avoiding defensiveness in oral, written and cyber communication. **F, I, R, SF**
- I will make eye contact, smile and greet everyone creating a friendly environment. **C, I, R, SF**
- I will keep my radio traffic professional, without sarcasm, or innuendo. **CA, I, R**
- I will use positive body language and easy-to-understand words when communicating with patients. **CA, F, H, R, SF**
- I will always address my patients professionally: "Mr.," "Miss," or "Mrs." will be used — unless the customer invites me to use his or her first name. **C, CA, I**
- I will take the time to listen, and avoid interrupting or finishing sentences for others. **F, I**

Delivery of Care:

- I will remain focused and anticipate the needs of my patients. **C, CA, R**
- I will strive to deliver prompt service, by ensuring that my unit is ready and my out-of-chute times are fast. **CA, I, R**
- I will provide sheets or blankets when transporting patients. **C, CA, R**
- I will seek opportunities to improve the skills needed to do my job well. **CA, I, R**
- I will demonstrate competence, and only perform tasks within the scope of my practice. **CA, I, R**
- I keep patients, and families informed by using "**AIDET**" in delivering care.

  A: Acknowledge my patient, and call them by name.

  I: Introduce myself and partner.

  D: Give patients an estimate of the time that will be required to deliver the care being provided.

  E: Explain procedures to patients prior to performing, and when possible involve the patient in developing their treatment plan.

  T: Thank my patients for allowing me the opportunity to care for them. **CA, F, H, I, R**

Privacy/Confidentiality/Corporate Responsibility:

- I will follow Medic's release of information and privacy policies, reporting any breach or potential breach. **CA, H, I, R**
- I will respect patients' privacy when discussing medical matters, and be mindful of my conversations in public areas. **C, CA, I, R**
- I will give patients the opportunity to decide who should be present while they are being assessed. **C, CA, F, I**
- I will ask permission prior to removing garments, and ensure that my exposed patients are covered prior to being moved into a public area. **C, CA, I, R**
- I will be sensitive to the personal beliefs of others.
- I will maintain an open mind and be responsive to change with respect to new ideas, processes, and suggestions. **CA, I, R**
- I will be aware of performance expectations, and act accordingly. **H, I,**

Safety:

- I will not take unnecessary risks. **CA, I, R**
- I will protect my back when lifting, pushing, pulling, or carrying by asking for help and/or utilizing available equipment, and always using proper body mechanics. **CA, I, R**
- I will use protective clothing, and equipment as required by law or policy. **CA, I, R**
- I will be aware of scene safety and potential hazards including violent persons, biological, chemical, and fire. **CA, R**

ISSUED: April 1, 2015 REVISED: May 01, 2018
APPROVED: May 01, 2018 BY: Operations Management Team
SUBJECT: Uniform Standard

Purpose:
The purpose of this guideline is to establish authorized uniform items, when uniforms are required, and to set standards for the correct wear of department uniforms and insignia.

Applicability:
This guideline applies to all uniformed Agency personnel.

Responsibility:
Special Operations serves as the Agency Quartermaster and must authorize all purchases by the Agency through approved vendors for Agency issued items. Uniform items, including footwear, purchased by the employee are not eligible for reimbursement.

Supervisors shall ensure that each employee under their supervision is in conformance with the standards as outlined in this guideline. Each employee is also individually responsible for conformance with these guidelines.

A supervisor may at any time require that the employee wear specific safety clothing or correct uniform items that do not meet this guideline.

Guidance:
All uniforms, T-shirts, and optional items must be clean, not faded, not wrinkled, torn or with holes.

No Agency issued clothing or accessories should be worn while off duty. Any item with the Agency logo represents you as part of the Agency. You are expected to use good judgment as to where you display any Agency logo.

If the uniform is worn it must be complete. This includes transit to/from work, upon clocking in for shift, and when in the office/public areas at post 100.

Unless otherwise directed, Uniformed employees are permitted to wear Professional or Business Casual Attire (as outlined in Agency Policy 2.3, Dress Code) to continuing education classes.

The class A or B uniform (as described below) will be worn while working Field or CMED Operations.

The Agency issues the following uniform items from our approved vendor supply based on the employees work assignment:

CMED Operations:

- Class A Uniform
  - Uniform Pants, Navy 4 pocket
  - Uniform Shirt, Long Sleeve, Blue (with agency/certification patches)
  - Agency Badge, Silver
  - Tie
  - Belt
  - Footwear
- Class B Uniform
  - Uniform Pants, Navy (4 pocket or 6 pocket EMS pants)
  - Uniform Shirts, Short or Long Sleeve, Blue (with agency/certification patches)
  - Agency Badge, Silver
  - Belt
  - Footwear
  - Jacket (Water resistant shell)
  - Jacket Liner

Field Operations:

- Class A Uniform
  - Uniform Pants, Navy 4 pocket
  - Shirt, Long Sleeve, Blue (with agency/certification patches)
  - Agency Badge, Silver
  - Tie
  - Belt
  - Footwear
- Class B Uniform
  - Uniform Pants, Navy (4 pocket or 6 pocket EMS pants)
  - Uniform Shirts, Short or Long Sleeve, Blue (with agency/certification patches)
  - Agency Badge, Silver
  - Belt
  - Footwear
  - Jacket (ANSI Class 2 / NFPA 1999 PPE Certified)
  - Jacket Liner
  - Pants (NFPA 1999 PPE Certified)
  - Vest (ANSI Class 2)

Special Operations:

- Class A Uniform
  - Uniform Pants, Navy 4 pocket
  - Shirt, Long Sleeve, Blue (with agency/certification patches)
  - Agency Badge, Silver
  - Tie
  - Belt
  - Footwear
- Class B Uniform
  - Uniform Pants, Navy (4 pocket or 6 pocket EMS pants)
  - Uniform Shirts, Short or Long Sleeve, Blue (with agency/certification patches)
  - Agency Badge, Silver
  - Belt
  - Footwear
  - Jacket (ANSI Class 2 / NFPA 1999 PPE Certified)
  - Jacket Liner
  - Pants (NFPA 1999 PPE Certified)
  - Vest (ANSI Class 2)
- Class C Uniform
  - Polo Shirt, Heather Grey (with agency logo)
  - Uniform Pants, Navy (4 pocket or 6 pocket EMS pants)
  - Belt
  - Footwear
  - Jacket (ANSI Class 2 / NFPA 1999 PPE Certified)
  - Jacket Liner
  - Pants (NFPA 1999 PPE Certified)
  - Vest (ANSI Class 2)

Operations Supervisor - Communications:

- Class A Uniform
  - Dress Double Breasted Blouse Coat, rank on sleeves (with agency patches)
  - Agency Badge, Gold
  - Shirt, Long Sleeve, White (with agency/certification patches)
  - Tie
  - Pants, 4 pocket
  - Belt
  - Footwear
- Class B Uniform
  - Uniform Pants, Navy, 4 pocket
  - Uniform Shirts, Short or Long Sleeve, White (with agency/certification patches)
  - Agency Badge, Gold
  - Belt
  - Footwear
  - Jacket (Water resistant shell)
  - Jacket Liner

Operations Supervisor - Field:

- Class A Uniform
  - Dress Double Breasted Blouse Coat, rank on sleeves (with agency patches)
  - Agency Badge, Gold
  - Shirt, Long Sleeve, White (with agency/certification patches)
  - Tie
  - Pants, 4 pocket
  - Belt
  - Footwear
- Class B Uniform
  - Uniform Pants, Navy, 4 pocket
  - Uniform Shirts, Short or Long Sleeve, White (with agency/certification patches)
  - Agency Badge, Gold
  - Belt
  - Footwear
  - Jacket (ANSI Class 2 / NFPA 1999 PPE Certified)
  - Jacket Liner
  - Pants (NFPA 1999 PPE Certified)
  - Vest (ANSI Class 2)

The Agency allows employees to purchase the following optional uniform items after they have completed their probationary period:

- Sweater: "Commando Style" with V-neck collar, navy blue as supplied by the Agency approved vendor (with agency/certification patches). Authorization form must be received from the Agency Quartermaster for purchase.
- Jacket: Summit Soft Shell with hood, navy blue or black, manufactured by Condor and available from multiple vendors.
- Jacket: Phantom Soft Shell no hood, navy blue or black, manufactured by Condor and available from multiple vendors.
- Jacket: M65 Field Jacket, black, available from multiple vendors.
- Jacket: Softshell micro-fleece, black, with Agency logo, available from Agency store.
- Vest: Nylon, fleece lined, black or navy, with Agency logo, available from Agency store.
- Vest: Port Authority, Core Soft Shell Vest, black or navy, available from Agency store.
- Job Shirt: ¼ Zip Job Shirt (#72314), fire navy blue (720), with Agency patch logo on left chest, first initial and last name on right chest centered above certification level or division name (Agency specified), manufactured by 5.11, as supplied by Agency authorized vendor. **Authorization form must be received from the Agency Quartermaster for purchase.**
- Hat: Baseball style, navy blue, with Agency logo, available from Agency store.
- Hat: Knit cap, navy blue, with Agency logo, available from Agency store.
- Hat: Headband, navy blue, with Agency logo, available from Agency store.
- Hat: Baseball style, navy blue, no logo, available from multiple vendors.
- Hat: Toboggan, navy blue, no logo, available from multiple vendors.
- Hat: Headband, navy blue, no logo, available from multiple vendors.
- Hat: "Boonie" style, navy blue, no logo, available from multiple vendors.
- Pants: EMS Pants, Pocket style, manufactured by 5.11, style # 74310 or #74363, navy blue, available from multiple vendors.
- Items: Apparel from Agency store designated as "uniformed approved", as found online from My Medic website.

Employees are permitted purchase and wear body armor as long as it meets the requirements set forth in this SOG.

A concealable vest carrier must match the T-shirt being worn under the uniform shirt.

An external vest carrier must be the same style and will match the uniform shirt.

No tactical or other style outer vest carrier is permitted to be worn unless assigned to and while functioning as part of a Special Operations team.


NOT PERMITTED


NOT PERMITTED


PERMITTED


PERMITTED

Acceptable items to be displayed on the Class A or B uniform shirt:

- Identification badge (as issued by the Agency).
- Badge (Silver for non-supervisory personnel; gold for supervisor personnel)
- Name tag (optional, employee purchased) should match the badge color, will not exceed 5/8 inch height and may be displayed with attached “Serving Since XXXX” bar. The name tag will be worn centered just above the right shirt pocket.
- EMS service related pins/bars may be worn above the right pocket or name tag. Pins/bars should not exceed the width of the pocket (three bars). Multiple pins worn should follow uniform display standards.
- Approved pins/bars include School pin, American Flag pin or bar, Agency issued pins/bars.
- Colored epaulette covers will be worn by academy students.

Uniform shirts will be worn tucked into pants and buttoned completely, with the exception of the top button at the collar (unless worn with a tie).

Tee shirts or turtlenecks worn under the uniform shirt and visible at the collar will be white or navy in color. No logo from an undershirt should be visible through the uniform shirt. Undergarments will not extend beyond the shirt sleeve. White turtlenecks should only be worn by supervisory staff.

Turtlenecks may be worn under the optional commando sweater without the Agency uniform shirt by CMED and Field Operations employees. All other outerwear (Job Shirt, Jackets, Etc.) require the uniform shirt to be worn at all times.

Operations Supervisors (CMED and Field) are not permitted to wear the Job Shirt while on-duty.

Ties are only to be worn with long sleeve uniform shirts and should not be worn with 6 pocket pants. The tie should be no longer than the middle of the belt buckle.

Uniform trousers will be properly fitted to the individual, worn waist high; length will produce a slight break at the cuff.

Belt buckle should match the color of the Agency badge unless the nylon belt is worn.
Socks if visible should be solid colored, navy blue or black in color.

Footwear will be leather, non-permeable, black in color and must be approved by the Quartermaster.

All Operations employees must have a second uniform available when working.

ISSUED: October 12, 2016 REVISED: October 12, 2016
APPROVED: October 12, 2016 BY: Operations Management Team
SUBJECT: Professional Appearance

Purpose:
To ensure a professional appearance by all uniformed employees.

Applicability:
This guideline applies to all uniformed Agency personnel.

Responsibility:
Uniformed employees are responsible for ensuring they follow these guidelines. Supervisors will ensure these guidelines are followed and can, if needed, send an employee home, on personal leave, and in their personal vehicle to correct violations of this guideline. Violations will be documented utilizing the progressive discipline guidance.

Guidance:
Employees should practice good overall personal and oral hygiene to prevent offensive body odor.

Hair must be clean, neat, combed and worn in a manner that does not obscure the vision – including peripheral. Color will be conservative and of a naturally occurring color. Long hair must be worn up in such a manner as to stay close to the head and not hang down to the front of the face when bending over. Hair style should not interfere with wearing a protective helmet or the use of any safety equipment.

Makeup will be minimal and conservative.

Perfume, cologne and other fragrance toiletries are prohibited in patient care areas.

Mustaches should not extend more than ¼ inch below the upper lip and not more than ½ inch beyond the edge of the mouth. Sideburns shall be neatly trimmed and shall not extend lower than the lowest point of the ear or beyond the hair line of the temple. Except as described above, it is mandatory that uniformed Agency employees be clean-shaven (No beards or growth below the lower lip). If required to wear a respirator, no hair can be between the seal of the respirator and the face.

Fingernails should be kept clean and not worn longer than the ends of the fingers. Color will be conservative with no additional ornamentation or designs that would interfere with PPE.

Jewelry – uniformed personnel may wear only stud type earrings, with a maximum of 1 pair of matching earrings. No other facial jewelry (such as nose, eyebrow or tongue piercing wear) is permitted while in uniform. Watches are a requirement of the job. Rings such as wedding bands, engagement rings and class rings are allowed provided there are no sharp edges or points that might tear gloves or cause injury to a patient. Medical Alert bracelets are the only bracelet approved while in uniform. No necklace is permitted unless it is Medical Alert identification.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team
SUBJECT: **Weapons on Medic Units**

Refer to the Agency Employee Handbook for further details

No EMS personnel shall knowingly permit the possession or transportation of a weapon on board any Agency vehicle or on any Agency property.

Weapons meaning: firearms, ammunition and explosives clubs, (night sticks), knives (non-folding), aerosol repellant (pepper spray), electronic charge (stun gun) devices.

Acceptable items include:

Personal Flashlight – A personal flashlight may be carried – constructed of metal or composite and designed to carry no more than the equivalent of 2 D-cell batteries.

Knives – Folding with a blade not greater than 3 inches in length.

Exceptions:

1. Duly sworn Police Officers involved in the performance of duty

2. Weapons removed from patients while in transit, or on the scene when no Police Officer is available to take possession.

In the latter case, any weapon, which must be transported, should be stored in the driver's compartment. This would limit access should the patient become violent and attempt to recover the weapon.

INSURE THOROUGH DOCUMENTATION OF THE CHAIN OF CUSTODY

When feasible, Law Enforcement Officers should handle and take possession of all weapons. In cases where you must move or handle a weapon, do so in a fashion as not to damage evidence such as fingerprints. Use surgical gloves and, or lift a handgun by the rough portion of the grip.

NEVER ATTEMPT TO DISCHARGE OR UNLOAD A WEAPON.

Upon arrival at the hospital turn the weapon over to a CMPD Officer. If no officer is present, request one is sent to your location via C-MED.

***** Possession of a weapon on Agency property or inside an Agency owned vehicle may result in immediate termination.***

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Communications Devices-Electronic Equipment**

1.1 Personal Cellular Telephones or similar type devices should not be used at any time that you are operating the ambulance *(emergency or non-emergency*). They can be used for official business only while a crew is engaged in patient care. This is intended to reduce liability, increase safety, and insure that crew members focus full attention on safe navigation, response, and optimal patient care. Agency issued communications equipment i.e. portable, mobile radios are encouraged to be used during the times outlined above.

1.2 Crews are discouraged from bringing personal cellular telephones laptop computers or any personal electronic device on board the ambulance during the course of your shift. ***The Agency is in no way responsible for replacement of damaged or lost personal electronic equipment.***

1.3 Use of electronic equipment in environments other than described as above may subject employees to disciplinary action, up to and including termination.

1.4 All Medic units are equipped with a cellular telephone. The phones are for conducting official Agency business only. Reasons may include, but are not limited to:

1. Utilization during times of radio and/or paging system failures.

2. When directed to contact C-Med for the purpose of AT&T Language Line assistance.

3. Communications with CMED, supervisor, administration etc. is necessary but it is not appropriate to conduct the conversation over the radio.

4. To contact out of county hospitals

The phone numbers should not be given out unless specifically directed to do so by supervisory personnel. . Assigned personnel for a given date and time will be held accountable for unwarranted charges and subject to disciplinary action.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Unit Assignments**

Support Services assigns units for deployment.

- When applicable, highest mileage vehicles should be issued first if possible, making the best effort to do so without causing undue disruption to operations.

- Field operations crews should not ask to be changed into alternate vehicles once assignment has been made, unless there are unreported mechanical problems with the assigned vehicle.

- Controlled equipment, such as narcotics and radio should only be issued to unit Crew Chief, unless otherwise approved by the on-duty Field Operations Supervisor.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team
SUBJECT: **Citizen/3rd Party Rider Program**

Mecklenburg EMS Agency provides opportunities to provide clinical experience for a variety of different people. Each has different topics and expectations of their ride-along experience***.***

Anyone who requests to ride outside of contracted programs must send an E-Mail request to Kevin Staley that indicates the requestor's background and reason for riding on an ambulance.

The following groups participate:

- Students: persons currently enrolled and receiving clinical education for EMT-B, EMT-I or EMT-P and / or Healthcare students currently enrolled in a school whose curriculum requires an EMS clinical experience.
- Other groups determined by MEDIC Administration or designee to have a "Need to Know" in accordance with HIPAA guidelines.
- First responders, who can practice all procedures approved in their protocols.
- The general public can ride as observers with specific restrictions on their level of participation.

During the ambulance ride-along, the rider is expected to wear:

a. White or light blue shirt with a collar. Shirts may not have agency logos or patches, unless approved by Mecklenburg EMS Agency in advance.

b. Black or dark blue pants. Jeans of any color will not be allowed. Shorts are not allowed.

c. Black or dark brown shoes with non-skid soles. Shoes must be polished. Black tennis shoes are permitted. No sandals or high-heels.

d. Jackets or coats must be plain in appearance without any agency logos, agency patches, or other excessive markings.

e. Name tags / ID must be worn at all times.

f. Students are not permitted to wear any Agency uniform or anything that designates the student as an Agency employee.

g. Any required PPE's

h. All riders must have in their possession a current picture ID. Students must provide clinical / field perception guide/manual from their educational institution. An individual will not be permitted to ride without these items.

The student / observer must review Third Party Rider Guidelines and Orientation packet & sign waiver of liability.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **EPCR Tablets**

Tablet sign IN/OUT procedure

1. At the beginning of each shift a case containing one tablet (CPU), two batteries (one spare), and one power cord will be signed out to the crew chief by the OST. The case and CPU will be numbered (as the narcotics boxes are currently) and will match the unit number assigned unless a spare CPU is assigned to a unit due to repair or service. IT will be responsible for tracking spare CPUs. A sample sign out sheet is attached, and will work just like the narcotics sign out sheets that you currently use.

2. At the end of each shift the tablet and case will be signed in to Logistics. The Operations Assistant will insure that all reports are finalized and closed out on the tablet before the crew leaves for the day.

Logistics must also inspect the bag and contents for any missing items or damages from activity other than normal wear and tear:

- **Deep scratches, gouges or other damages to the screen (***The screen will, over time, begin to exhibit light scratches over the entire proximity of the screen. Any scratch that penetrates the membrane of the screen will be reported immediately to a Supervisor***)**
- **Missing, bent or cracked/broken keys on keyboard**
- **Missing or broken port doors (around perimeter of tablet)**
- **Broken screen hinge**
- **Damage to mouse pad or mouse buttons**
- **Chipped or missing enamel to tablet casing**
- **Dent's in tablet exterior**
- **Missing or damaged stylus**
- **Significant scratches or damage to tablet exterior**
- **Missing spare batteries or charger cables**
- **Damage, or significant soiling to tablet**
- **Bio-hazardous material on tablet or accessories**
- **Any other damage considered inconsistent with normal wear and tear on the device**

3. If any of the above damages or missing items is noted, they should immediately be documented and forwarded to the on-duty Operation Supervisor. The off-going crew is to prepare a Loss and Damage Form before ending their shift. The Supervisor will begin an investigation and initiate the disciplinary process. Additionally, if the tablet is to remain in service, this information is also to be recorded in the comments field of the tablet sign in/out sheet. It is the Crew Chief's responsibility to properly inspect the tablet and accessories prior to signing them out for the shift (in the same way that it is the responsibility to inspect narcotics prior to signing them out.) Damage reports must be forwarded to the Operations Manager**.**

4. Once Logistics has completed the close out and signed in the equipment, it is to be turned over for charging and storage (second set of signatures not needed for storage of equipment).

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Patient Belongings Handling-Accountability**

Agency personnel make decisions regarding the disposition of patient's personal effects/property on virtually every incident or transport they respond to. With the knowledge that a policy cannot address every contingency that may occur in our work environment, Agency personnel should follow these guidelines whenever applicable. If confronted with circumstances beyond the scope of these guidelines, the employee shall consult with their supervisor for guidance.

1. What types or amounts of personal property may Agency personnel/units agree to transport?

    - The crew chief shall exercise judgment in every circumstance with his/her primary focus being patient / crew safety and a high level of customer service. Consideration should be given to the crew's ability to safely secure the patients property while in transit. Priority should be given to items that a patient may rely on upon arrival at their destination.

2. **Safety:** Large but necessary items such as wheelchairs or walkers should be secured with seatbelts within the vehicle before transport is initiated.

3. **Security:** Property that cannot be safely transported should be secured (within the patient's residence) at the scene whenever possible. Other circumstances may require that a patient's family or allied agency personnel accept responsibility for the property while patient care and transport are carried out. Persons accepting responsibility and the property should be identified and documented in the patient care report. Patients who are conscious should identify individuals whom they wish to take charge of their property. Unidentified persons should not be allowed to take charge of personal property.

4. **Chain of Custody:** Upon Arrival at the patient's destination, all property should be turned over to facility staff and/or the patient or family members. Identification of individuals and the released property must occur and be documented in the EPCR.

5. **Thoroughness:** EMS crews should thoroughly inspect the transport vehicle for personal property before departing the patient's destination. Should items be found afterward, the crew will contact CMED for authorization to return the items to the rightful location and owner. Crews should not end a tour of duty with property remaining in their possession unless specifically authorized to do so by the on-duty Field Operations Supervisor. Should authorization be obtained, the property must be signed over to the authorizing Field Operations Supervisor, who will become responsible for the prompt return of the property. This transfer of custody must be documented as part of the patient care report.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Mutual Aid Response within Mecklenburg County**

Medic may be asked to assist another medical transportation service on occasion. Typically this is due to their patient condition worsening or mechanical problems.

The following guidelines should be used in the event of an assistance request:

- Meet the unit in a pre-designated location as determined by C-MED.
- The patient should be transferred into the Medic vehicle to insure all necessary equipment is available.
- The Medic Paramedic should assume patient care activities during the transport to the hospital.
- A patient care report should be completed as normal to include documentation of the organization that requested our response.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Mutual Aid Response outside Mecklenburg County**

There may be circumstances that will require EMS resources above and beyond those available within Mecklenburg, or any of our surrounding counties. These circumstances may occur rarely, but when they do, it is necessary for the county to obtain assistance form some outside source. No unit of government can be expected to develop and constantly maintain sufficient resources to deal with every possible situation that might arise.

The NC OEMS oversees state and regional mutual aid plans in the event that out of county response is needed on a scene in a neighboring county.

In the event Medic is activated to assist EMS outside our boundaries, keep in mind:

- Communications will be a challenge, as communications systems differ from county to county. Take direction from C-MED unless otherwise advised.
- Report to the "Staging Area" if not otherwise advised.
- Follow the Mecklenburg EMS Agency Patient Care Protocols; units operating in another county follow their home county patient care protocols.
- Any request for an out of county mutual aid assist should have notification made to the Operations Manager-Field. Deputy Director-Operations should be notified in case of the Operations Manager-Field being unavailable.

Any request for mutual aid (Medic to a neighbor) should be acted on immediately by C-MED if the system will allow starting the closest Medic unit.*

**** For complete information concerning mutual aid response, see Region F EMS Mutual Aid Response Plan***

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015

SUBJECT: **Critical Care Transport Team Assistance**

Medic may act as a backup to Critical Care Transportation Teams under certain circumstances. These transports usually occur on weekends and after normal business hours when their staffing is minimal.

During these times, the Medic crew may be dispatched "hot" to pick up staff of the Critical Care Team and may travel up to 120 miles outside Mecklenburg County to pick up a patient. The dispatch response is based on patient condition and may be time sensitive (Such as a patient being admitted directly into the Cath Lab). The transport team staff will determine if the response to the destination facility is hot or cold.

The request is intended for Medic to provide transportation only; however, this does not release the Crew Chief from the responsibility of overseeing activities in the back of the unit, or appropriate documentation of the care rendered and patient condition. ***Therefore, the Crew Chief shall always ride in the back of the unit while a patient is on board.***

Should a conflict arise between the team and Agency personnel, the Critical Care Nurse should be considered to be in charge of patient care at all times, while Medic staff is responsible for the safe operation and transport of the patient and all crew members.

- **Although Critical Care will be financial responsibility for transport, demographic and patient care information still must be obtained.**

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Incidents at or near County Line**

Call for Service at or Near Boundaries

When a call is received for an EMS/Rescue response to a location that is at, or near the county line, or if any question exists as to which county provider is responsible, the nearest Medic unit and First Responder should be dispatched. At the same time, neighboring county or jurisdiction will be informed of the situation.

1. If the incident is determined to be outside of Mecklenburg County, and there are no paramedics at the scene, response should continue to the scene.

2. Once a location has been verified, the neighboring jurisdiction should be notified. Should the incident be inside Mecklenburg County, and the neighboring responder is at the scene or closer than Medic units, they may continue with the response, or care until Medic arrives and assumes control of the incident.

3. Should either responding Agency have need of the others resources for management or transportation of patients with life threatening conditions, all efforts should be made to assure that the best decisions are made on the behalf of the patient(s).

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team
SUBJECT: **Patients with Service Animals**

Patients with Service Animals

If confronted with a question or situation involving the issue of transporting or securing a service animal, (such as a Seeing Eye dog), it is the policy of the Agency to do all we can to accommodate the animal. If the patient's condition is minor, the animal should be permitted to remain with its owner. In the event that the owner is in a critical condition, or the animal may pose a danger to medical personnel, or may interfere with medical care, suitable arrangements for the transportation of the animal should be made. Consider using CMPD Animal Care and Control, CMPD, the first responder, or supervisor (if available) to bring the animal to the hospital (if it can't be left safely at home).

If the animal is injured, Animal Care and Control should be called (if the patient can't direct you to another source to care for it) to transport it to proper medical attention.

The disposition of the animal should be documented with a note in the PCR or supplemental report.

- **Insure the hospital is notified that you are transporting a service animal before your arrival.**

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Patients in Police Custody**

If a patient is in custody of law enforcement personnel and is restrained by handcuffs, **an officer must accompany the patient in the Medic unit during transport** to the emergency department (ED) or other approved destination. Having an officer follow the Medic unit in the officer's vehicle is not an acceptable alternative.

1. Having the patient handcuffed to the cot is strictly prohibited

2. The degree of need for care should exceed considerations of the patient becoming a threat.

3. The Police Officer and the Crew Chief must agree that repositioning or removing the handcuffs is safe.

4. When repositioning handcuffs, ensure the patient still has the minimum possible ability to move and potentially cause harm.

5. The position of the handcuffs should be a mutual decision of the Police Officer and Crew Chief designed to facilitate procedures and ensure security.

If a crew encounters any resistance from the officer on scene regarding this policy, immediate contact should be made with the on-duty Field Operations Supervisor.

ISSUED: April 1, 2015 REVISED: July 24, 2017
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Transports to Medical Examiner's Office**

Should a Medic unit have need to or be requested by police to transport a deceased subject – the Field Operations Supervisor should be contacted for consult with the Medic crew before initiating the transport.

Upon determination that a need exists to conduct the transport - CMED or the Field Operations Supervisor should call the Medical Examiner's office (704-336-2005) to get approval for Medic to conduct the transport. The person authorizing transport should be documented in the ePCR as well as the CAD notes for the incident. CMED should then send the Medic crew and Field Operations Supervisor the code to the ME office facility if applicable via alpha page.
The transport should be conducted as any other transport, unit departs scene in CAD, ePCR disposition transported 911, etc. and indications for transport need documented.

A notification email should be sent to S108 with incident details, reason for transport, and person authorizing transport at Medical Examiner's office.

Chapter Two

Stations / Vehicles / Equipment

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: Vehicle Operations

Mecklenburg EMS Agency is committed to the safe and appropriate transport of all employees, patients, and passengers of the Agency units. Therefore, all operators must adhere to the guidelines set forth in this departmental driving policy. Questions and additional information on this driving policy should be directed to the Field Operations Supervisor or to the Risk and Safety Specialist.

Agency vehicles are intended for use in the conduct of Agency related business or activities that promote the Agency or facilitate efficiency.

Agency Authorized Drivers - Prior to operating an Agency vehicle you must:

Complete the proper Medic required driver training program:
- Smith System
- Closed Simulated Road Course

Be properly trained and qualified on each vehicle type operated

Possess, carry, and maintain a valid North Carolina or South Carolina driver's license (state DL must be obtained within 45 days of relocating to NC or SC as stated in the State DOT Law)

Maintain an acceptable driving record as outlined in the Agency's Pre-Employment Guidelines (as published on the intranet)

Undergo an annual refresher course on defensive driving

All vehicle operators (*while running emergency traffic*) must follow the Law of Due Regard:
Sufficient notice of the ambulance's approach must be given to allow the other motorist and pedestrians to yield the right of way. Failure to give notice until a collision is inevitable, generally does not satisfy the principal of "due regard".

The Agency's independent insurance carrier reserves the right to declare an employee to be uninsurable based the employees driving/accident record. If deemed uninsurable the employee will be precluded from operating Agency vehicles. The ability to operate a vehicle is a requirement for most of the Agency's employees, specifically, but not limited to field medics and support services staff. Suspension of driving privileges may ultimately end in termination of employment with Mecklenburg EMS Agency.

Having a valid driver's license is a requirement. Anytime there is a violation, conviction, or accident (outside of Agency operation) it must be reported.

Motor Vehicle Records will be ordered and reviewed (by risk and safety), bi-annually at a minimum.

Employees shall not operate Agency vehicles while under the influence of medications and/or substances that are known to impair central nervous system functions (i.e. - Judgment, physical coordination and/or reaction time). Included in the categorization are prescribed medications that carry warnings against operating vehicles or machinery. Anytime there is a suspicion of impairment, drug use, or alcohol use a drug and/or alcohol screening will be completed.

Employees involved in vehicular collisions are subject to drug and alcohol testing as set forth in the Accident Policy.

While driving routine traffic, all agency employees will follow all North Carolina state vehicle operations laws.

Failure on the part of any Agency employee (driver, witness, passenger, etc.) to immediately report to a supervisor any vehicle collision or property damage will be subject to disciplinary action that may include termination.

Upon the occurrence of an incident the Crew Chief, Team Leader, or Agency Employee will contact CMED immediately and advise them of the unit's status, if there are any injuries, and to have Law Enforcement respond to the scene. They will then contact the on Field Operations Supervisor and alert them of the incident. Both parties will remain on scene until Law Enforcement and the on duty supervisor arrive. If vehicles involved are operable, they will be moved out of the lane of travel and into a safer area. *(Please see the Accident Policy for additional information).*
In the event of a minor collision while responding to a call that is deemed "Delta response" or when transporting a priority 1 patient; agency, driver's license, and insurance information will be exchanged rapidly with other party involved. Further paperwork will commence at a later time and unit may proceed to the patient.

Seat restraints are to be worn at all times the vehicle is in motion. Seat restraints are to be used on all persons riding in an Agency vehicle.

All pediatric patients being transported shall be properly secured. If the patient has a personal car seat then it shall be used if it can be properly secured to the cot or captain's chair. If the pt. is in full spinal protocol, then they will be secured to the cot using the four point seat belt and the hip and leg straps or secured to the bench seat using seatbelts. Children will always be properly secured and will not be placed in a parents arms while the unit is in motion.

While caring for a patient the crew member will attempt to stay restrained for as long as care will allow. It is neither possible nor practical for the care taker to remain restrained at all times. If the care taker must provide a service in which being restrained will not allow, they will carry through with the procedure and then restrain themselves using the proper safety restraints.

Prior to use of unit, all warning devices (lights and sirens) should be assessed for proper function.

Cell phone use and texting is strictly prohibited while operating an Agency owned/leased vehicle. Cell phone use of both members of the crew is strictly prohibited while the unit is being operated in an emergency mode. Company cell phone use, by the passenger, will only be allowed in the event of a failure of the dispatch system.

The mobile mapping terminal is only to be operated by the passenger in the unit while the unit is in motion. There are instances when the mobile mapping terminal will need to be used without a passenger in the cab of the unit, at this time, use of mobile mapping will be kept to a minimum while operating the ambulance.

Mobile radio use will be conducted by the passenger in the unit while the unit is in motion. If the mobile radio must be used by the driver, it will be done with extreme prejudice to the safety of the crew, passengers, and those around the unit.

Use of tobaccos products and e-cigarettes are prohibited inside any Agency owned/leased vehicles.

Agency ambulances must utilize a backer/spotter when available.

Spotter must be placed on the driver's side rear of the unit, as to ensure full vision of the spotter by the driver
The spotter must be in place prior to the unit being placed into reverse
Proper hand signals shall be used by the spotter to communicate to the driver
The unit must not exceed 1-2 mph while in reverse.

Agency vehicles are prohibited from passing a stopped school bus with its stop sign extended (this includes routine and emergency traffic modes)
The bus driver may signal the unit to proceed around the school bus while it is stopped with the sign extended. If this occurs, proceed with extreme caution around the bus.

Agency vehicles will comply with traffic signals, signs, and school crossing guard signals in school zones during school hours or when children are present.

Audible and visual warning devices must be utilized together when operating in a mobile emergency mode regardless of the time of day or traffic conditions.

Agency vehicles are prohibited from parking in fire lanes unless they are on a patient care assignment.

Employees must adhere to all safe parking principals which include:

Apply parking brake
Apply appropriate transmission (park or neutral)
Utilize wheel chocks, if applicable
Apply safe positioning of vehicle at scenes and posts as to allow easy egress
Activate high idle while on calls
Keep vehicle locked while unattended
Connect shoreline
Appropriate use of warning lights while parked, if applicable

Employees are encouraged to park in areas where backing can be avoided and egress is not compromised.

Employees will maintain a following distance of 5 seconds while in an Agency owned/leased vehicle. This distance will increase by the following for each change in driving conditions:

Rain Conditions- add one second
Snow Conditions- add two seconds
Ice Conditions- add three seconds
Use personal prudence with any non-listed situations

Emergency Traffic –
Agency vehicles shall not exceed the posted speed limited by more than ten miles per hour, with a maximum of 75 miles per hour on the interstate. When operating in school zones (during school hours) and/or in high pedestrian traffic areas, the posted speed limit must not be exceeded.

The operator will acknowledge that by use of audible and visual warning devices, they are only asking for the right of way and are not guaranteed it.

The operator will always attempt to pass stopped traffic on the left side. If this is not possible, the operator will use the lane of least resistance while using extreme prejudice for the crew's safety and the safety of those in and around the unit.

When approaching an intersection, with a yellow light, red light, stop sign, or with no traffic control devices the operator will come to a complete stop and assess all lanes of travel for oncoming or impeding traffic.

Traveling in the opposing lane of traffic should be avoided at all cost, however, when it is warranted, the operator will not exceed a speed of 15 miles per hour. The operator will utilize both sirens (if unit is equipped) and will utilize the air horn multiple times to alert oncoming traffic.
Agency policy allows a passenger to accompany a patient in the ambulance. Crews should attempt to accommodate any reasonable request to accompany a patient. A passenger should be placed in the right front seat of the ambulance and secured with a seat belt. The Crew Chief or Team Leader can allow the accompanying person to ride in the patient compartment if doing so is beneficial to patient care (parent of young child, interpreter for non-English speaking patients, etc.). The Crew Chief or Team Leader can also elect to allow more than one (1) passenger to accompany the patient if doing so will allow more expedient care and provides the appropriate support to the patient and/or family members. (THIS IS A DECISION THAT IS LEFT TO THE DESCRETION OF THE CREW CHIEF). All passengers must be secured with a seat belt. To the greatest extent possible, pediatric passengers will be placed in a car seat.
A Crew Chief or Team Leader may refuse to allow someone to accompany a patient when the requesting passenger is disruptive, intoxicated or a threat to the safety of the patient and crew. A passenger should not be allowed if they have a negative impact on treatment or transportation of a priority patient. These are the only appropriate circumstances to refuse a passenger.

The Agency reserves the right to require drivers to attend re-training anytime it is deemed necessary

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Vehicle & Fleet Maintenance**

The Fleet Supervisor and the Field Operations Supervisor must work in concert to allow for maximum efficiency in getting units into the garage for repair and P.M. while ensuring that there is adequate fleet availability to deploy units as required by the schedule.

Mechanical problems should be reported to the Field Operations Supervisor as soon as a problem is noticed.

- *To wait for a critical failure to occur before reporting a problem can be viewed as patient care negligence.*

The Field Operations Supervisor will notify the Fleet Supervisor and give specific direction to the crew. This should be done after consultation with the CMED Operations Supervisor to determine if the EMS System will allow time for the unit to be repaired. This allows the garage to make a determination if the problem is something that can be fixed on the spot or if the crew will need to switch ambulances. It is not appropriate, unless otherwise directed, for the crew to make contact with the Fleet Supervisor regarding their vehicle repairs.

Upon arriving at Post 100, the crew will fill out a vehicle maintenance repair sheet that documents in their words specific complaints, observations and circumstances with the vehicle. In some cases, a verbal report, (in addition to written), is beneficial to tracking down non-obvious problems.

- The decision to have a vehicle towed should be made by either the Field or CMED Operations Supervisor or, by the Fleet Supervisor. Regardless of who makes the decision to tow, the Fleet Supervisor or designee shall be notified immediately upon the initiation of the tow.

* See Sample Fleet Repair Form

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team
SUBJECT: **Vehicle Care/Inspections**

It is an expectation and requirement of all crew-members to insure the interior and exterior cleanliness of their assigned vehicle. Field Operations Supervisors or other administrative personnel may conduct regular inspection of ambulances, both at headquarters and at satellite stations. Careful attention should be given to the physical condition of the cab and patient compartment, cleanliness, appearance, and functionality of the equipment. Results of the inspection will be documented on a Vehicle Inspection Form and kept as a measure of the employees overall performance record.

- Vehicle exteriors should be washed daily using the vehicle washing system provided. Wheels and exterior body should be cleaned utilizing the attached brush on the appropriate, wash settings.

- Upon completion of an assigned shift, all loose and personal items should be removed from the interior of the vehicles cab. No food, drink or other items shall be left behind. Coolers and other personal items should also be immediately removed upon return to P100.

- The interior (cab, equipment, and patient care compartments) should be kept neat and inspected after each call for potentially infectious material. In the event of contamination of the cab area, any food stored in the area should be disposed of.

- All contaminated equipment should be properly cleaned or contained, identified and / or returned to Support Services for decontamination.

- In the event of transporting a patient with a known communicable disease, all exposed solid surfaces in the interior of the ambulance should be decontaminated with 10% bleach solution and paper towels or, an appropriate disinfectant wipe provided by the Agency. Any porous material such as cot straps will be bagged, tagged and returned to Operations Support for decontamination.

Particular attention should be given to proper disposal of sharps.

Vehicle Manifest is used as inspection report.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team
SUBJECT: **Vehicle Accidents Involving Agency Vehicles**

Failure to immediately report any Agency involved accident to a Field Operations Supervisor will result in disciplinary action up to and including termination.

A preventable accident is any accident where an Agency vehicle makes contact with another object/vehicle and the operator failed to do everything he/she could reasonably have done to prevent it.

When an Accident Happens

It is very important that Medic's accident procedures are followed carefully to ensure a thorough and fair investigation. A vehicle accident is defined as a collision that occurs between an Agency vehicle and another object.

1. Contact CMED, request other EMS, Police, and/or Fire if needed

2. Ensure that proper medical care is given, if needed to all involved
   Any employee injured in a workplace accident must complete the Workman's Compensation Injury Report (For further information, please see Medic's Injury Policy)

3. All Accidents will be investigated by the Risk and Safety Specialist and Field Operations Supervisor. Once the investigation is completed, it will be ruled preventable or not preventable. At that time, depending on the specifics involved such as driver's previous accidents, the Field Operations Supervisor will work with Risk and Safety to determine the next step.

4. Every accident, no matter how minor, shall be reported to the on duty Field Operations Supervisor, the Fleet Manager, and Risk and Safety Specialist.

5. The Field Operations Supervisor will respond, complete the report, complete the drug/alcohol testing, and provide further actions if needed

6. The Fleet Supervisor will get one or more repair quotes and forward a copy to the Risk and Safety Specialist

7. The Risk and Safety Specialist will investigate and report to the insurance company if necessary

8. The accident package along with statements from all occupants must be turned into the Risk and Safety Office within 24 hours of the accident. The Field Operations Supervisor who responds to the accident shall be responsible for the report, pictures, statements, and any required follow ups.
   - Relief Field Operations Supervisors that respond must contact a Field Operations Supervisor with all information obtained.
   -

9. Outside of Medic Management, Field Operations Supervisors, Risk and Safety, and Medic's insurance company, no **specific** information on accidents will be given to anyone without prior authorization. This includes other party's insurance companies and any/all media outlets including online social networks

Drug and Alcohol Testing

1. Anyone involved in an accident, regardless of severity, may be subject to a drug and alcohol test. The on duty Field Operations Supervisor and/or Risk and Safety Specialist will determine who needs to be tested.
2. Drug tests will be administered by the Occupational Health Nurse if it is during business hours, if it is outside of business hours, the Field Operations Supervisor will administer. (For more information, please see Medic's Drug and Alcohol policy)

Additional Information

After accident actions will be as follows:

1st Preventable Accident – Accident Training will occur and will be scheduled by the Risk and Safety Specialist. The training is required and will be documented and placed in the employees file. The employee's supervisor will review and determine what the next step of action will be.

Training may consist of one or more of the following: Online training; training on the operations of vehicles; a Smith System refresher; the CVOC course; monitored driving skills training.

2nd Preventable Accident – The Risk and Safety Specialist will notify the employee's supervisor who will review the information and determine what the next step of action will be.

3rd Preventable Accident – The Risk and Safety Specialist will notify the Field Operations Supervisor and Operations Manager for corrective action.

All of the above is based on a rolling 36 month period

ISSUED: April 1, 2015 REVISED: May 1, 2018
APPROVED: May 1, 2018 BY: Operations Management Team

SUBJECT: **Securing Agency Vehicles**

Current world affairs heighten our need for protective measures. Medic employees frequently inquire about what steps the department is taking to protect staff yet we repeatedly find units running and unattended in totally unnecessary situations.

The most effective way to protect medics in the field is for them to take personal responsibility for their safety.

1. Unattended EMS vehicles will be locked at all times unless the crew is working in the immediate vicinity (100 feet) of the vehicle and the vehicle is under their direct observation. (Vehicles equipped with electric door locks should be locked anytime it is unoccupied.)

2. EMS vehicles equipped with shoreline connections will be plugged into a shoreline when such lines are available at posts and personnel will confirm that shoreline and unit systems (heater/air conditioning – set at 70-75 degrees) are functioning properly. Non-functional systems or blocked access to shorelines will be immediately reported to the on-duty Field Operations Supervisor.

3. All units should be shut down upon arrival at all hospital emergency departments. Vehicles should be locked, both cab/patient compartments when the crew is away from the unit. If situations necessitate keeping the vehicle running for extended periods of time, please locate the vehicle at least 200 feet away from hospital entry doors or air handling vents.

4. All EMS personnel will assure compliance by taking action to correct non-compliant situations – to include securing other vehicles and alerting other responsible personnel to noncompliant vehicles / situations.

Any supervisor observing non-compliant vehicles and / or situations will take immediate corrective action. Supervisors will interview noncompliant personnel and if the deviation from this protocol is not clearly justified – progressive discipline guidelines will be followed. Gross disregard of safety or conduct guidelines may warrant disciplinary action beyond the next prescribed step in progressive discipline.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Fueling Agency Vehicles**

All Agency units should be fueled at headquarters fuel pumps when possible. When fueling the units, the correct mileage and correct Employee ID number should be entered into the computer prior to pumping. Failure to enter correct unit mileage information results in fuel usage tracking issues and may cause a vehicle to miss scheduled PM or other regular scheduled maintenance that is tracked by mileage.

All units will be fueled at the end of shift, prior to pulling into the wash bay. Deliberate recording of inaccurate information (such as entering incorrect employee ID number or 00000 in the place of the correct mileage) or intentional failure to adequately fuel a unit may be subject to disciplinary action.

1. The person fueling the vehicle is responsible for insuring the process is performed in a safe manner.

2. Insure the nozzle is disconnected and pump shut down before pulling away from fuel area.

3. Any fuel spilled should be covered with absorbent provided at the pump

4. Any spill requiring use of the fuel containment system (located in the cabinet beside fuel pumps), also requires notification of Fleet Manager, and other appropriate personnel.

5. If a crew has entered proper mileage but are unable to get fuel, have the crew enter the same mileage 3 times, on the 3rd time, the system override will allow fuel to be pumped. Notify Fleet Manager anytime this failsafe is used.

***In the event of an emergency, the emergency fuel shut off button is located at the pump and on the exterior wall of Post 100*.**

ISSUED: April 1, 2015 REVISED: April 1, 2015

APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Building and Grounds Service Requests/Emergencies**

It is an expectation that all Medic personnel work together to maintain the appearance, function and general sanitation of our work environments. Responsibility for repairs at satellite MEDIC stations will depend on the owner of the property. Any property damage noted should be documented and forwarded, via the Field Operations Supervisor to the Support Manager immediately via a Service Desk request.

Willful damage and destruction to Agency property will not be tolerated. This includes tampering with temperature regulation devices, locked doors, etc.

ISSUED: April 1, 2015 REVISED: April 1, 2015

APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Damage to Property**

All field personnel should immediately notify the Field Operations Supervisor if equipment has been damaged or lost. The supervisor will then make the determination if the situation requires the return of the unit to Post 100, or if it can be addressed at a later time. The involved crew should complete the "Damaged Equipment" section of the vehicle manifest as well as the "Lost & Damaged Equipment Form", with a full explanation of the issue.

- If a crew reports that equipment, either department issue or personal was stolen, Charlotte-Mecklenburg Police Department or applicable Municipal Police Department, should be notified in a timely manner, and a police report generated.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Equipment Failure**

A critical equipment failure is defined as failure of equipment to perform as it was intended during the delivery of patient care. In the event of any critical medical device failure such as cardiac monitoring equipment, the supervisor should be notified immediately by telephone or face-to-face report. The equipment should be brought to headquarters and, tagged out-of-service.

FDA regulation mandates that faulty cardiac monitoring equipment is returned for inspection in the same condition it was in when the failure occurred. **Do not remove, re-locate, or separate the batteries from the failed unit. All cables, pads and electrodes should remain intact as well. Leave the equipment in the exact condition it was in when the failure occurred.**

The crew must write a detailed description of the equipment failure and the circumstance in which it was being used, and attach the written description to the equipment when it is returned.

Contact the on-duty Field Operations Supervisor in the event of *any* equipment failure or loss to determine if you should be out of service. Failed equipment does not necessarily render a unit fully out of service. A crew may be directed to act as an “ALS First Responder”, giving care until a transport capable unit arrives at the scene.

ISSUED: April 1, 2015 REVISED: April 1, 2015

APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Unauthorized Patient Care Equipment**

Use and/or possession of unauthorized equipment, devices and/or procedures (see Agency Patient Care Protocols) by field employees are subject to disciplinary action, up to and including termination. This includes those individuals who have knowledge of such actions and fail to report appropriately.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team
SUBJECT: **Patient Movement**

Purpose

The purpose of this policy is to outline proper lifting techniques, patient handling, and patient securing. This will outline the handling in special situations: when a stretcher cannot be placed within immediate reach of the patient.

See the ergonomics policy located in the safety area of MEDIC's intranet site.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Radios on Unit**

Both crew members are issued a portable radio at the start of each shift. The second radio is provided to assure better communications when crew members are separated due to multiple patients or scene safety reasons.

Each radio is assigned a specific identifier so that CMED personnel will know which crew member they are communicating with on the scene. For example, the radio assigned to the crew chief will have the alias "Med21-P/C" (portable / crew chief) and the second will have the alias "Medic 21-P/B" (portable / basic). The radio identifier is internal and does not change how the crew should communicate with C-MED – i.e. "Medic 21 to C-MED".

When crew members need to communicate with each other while on scene, C-MED should be contacted for clearance. Permission will be granted to either go direct on the primary channel or the crew will be assigned an alternate channel. Crews should utilize the call signs portable 1 and portable 2 for these transmissions. i.e. "Medic 21 portable 1 to Medic 21 portable 2". Individual names or other identifiers should not be used.

Units must have two portable radios at the start of the shift. The Crew Chief will notify the Field Operations Supervisor if a radio is missing before deploying in the system.

The Crew Chief should assure that he/she has the appropriate radio at the start of their shift.

The Crew Chief is the primary individual responsible for all communications (this responsibility may be delegated to partner when appropriate).

The Crew Chief is responsible for assuring that radio traffic is kept to a minimum.

The unit Crew Chief is responsible for insuring that both radios are carried and monitored at all times.

ISSUED: May 1, 2018 REVISED: May 1, 2018
APPROVED: May 8, 2015 BY: Operations Management Team
SUBJECT: **Bariatric Transports**

Introduction

Transport of Bariatric Patients by Mecklenburg EMS Agency requires the use of specifically designed equipment and vehicles, capable of transporting patients whose body dimensions and/or weight are not suitable for transport on standard patient carrying equipment or vehicles.

Criteria

Bariatric in this policy refers to any person whose weight or physical dimensions exceed the capability of standard equipment in use by Mecklenburg EMS Agency.

Mapping Patient Pathway

Request for transport – ALL requests identifying bariatric patient transport will be received by MEDIC Communications (CMED). Following MPDS triaging, each case will be referred through the following pathway:

Immediate Response (Charlie/Delta/Echo Responses) – MPDS categorized urgent or time critical responses will receive an appropriate response in accordance with CMED guidelines. An ALS ambulance and the Bariatric Transport Capable Unit will be immediately dispatched to the patient. First arriving unit will assess the patient's clinical needs and confirm the transport mode using the Bariatric Assessment Tool.

Response <20 minutes (Alpha/Bravo Responses) – MPDS categorized non-urgent will receive an appropriate response in accordance with CMED guidelines. An ALS ambulance and the Bariatric Transport Capable Unit will be dispatched to the patient to assess the patient's clinical needs and confirm the transport mode using the Bariatric Assessment Tool.

Response > or <24 hours (NET Responses) – Referred to the Communications Supervisor for a review of the case. The Communications Supervisor will coordinate the appropriate staff, the bariatric vehicle response, and determine an appropriate time frame for the customer to receive service.

Note: Treatment of high priority patients should not be delayed waiting for a bariatric vehicle to arrive at the scene.

Bariatric Assessment Tool

Estimates of patients' weights are generally underestimated and should be verified by the patient, the patient's caregiver or the discharge RN requesting transport. Be aware that patients may underestimate their own weight. This tool should be used by responding field personnel or the tele-communicator to help make an informed decision as to the need for a bariatric stretcher to undertake the transport.

Use this tool to determine the patient's needs:

Does the patient weigh = or >650lb? Exceeds stretcher capability
- Yes: Must call for bariatric stretcher
- No: Proceed to next question

Does the patient's girth prohibit the seatbelts from buckling? Exceeds stretcher capability
- Yes: Must call for bariatric stretcher
- No: Proceed to next question

Is the Patient adamant about using the bariatric stretcher?
- Yes: Must call for bariatric stretcher
- No: Continue with call using MedSled and Seatbelt extenders when needed

If the answer is YES to any of these questions, a Bariatric Transport Response is necessary.

NOTE: If no bariatric stretcher is available, refer to the on-duty Field Operations Supervisor.

Execution

Once the need for the bariatric stretcher has been confirmed, each division will have its own unique and vital role in the execution of the guideline:

CMED

BLSNET 80 Series Units

1. If a BLSNET unit was dispatched initially:
    a. An ALS unit capable of transporting the bariatric stretcher will be added to the call;
        i. Either the unit closest to P100; or
        ii. The unit getting ready to check on duty (10-41)
    b. BLS unit stays on scene for patient care and lifting assistance;
    c. BAR 1 or 2 is assigned to call;
    d. ALS unit will take over patient care, document the use of the bariatric stretcher in Siren, and complete the call *(the process for airport to crew transfers will be used)*.

To document call, BAR 1 or 2 requires the following times: dispatch, scene, and available.

NET Transports

1. If the bariatric stretcher is requested, NET personnel in CMED will check/verify the weight of the patient documented on the paperwork to determine if there is a bariatric need.
2. If the request is made by the patient, and there is no documented reason, CMED will revert to the above bariatric assessment tool.
3. If the crew requests the bariatric stretcher follow steps under ALS 911 Calls below.
4. If a higher priority call is dispatched, the unit bringing the bariatric stretcher can and most likely will be diverted to that higher priority call.

To document call, BAR 1 or 2 requires the following times: dispatch, scene, and available.

ALS 911 Calls

1. Crew 1 is dispatched, identifies the need for the bariatric stretcher using the Bariatric Assessment Tool, requests bariatric stretcher.
2. Crew 1 stays with patient and treats patient while awaiting the arrival of the bariatric stretcher.
3. A second unit will be assigned to the call along with BAR 1 or 2.
4. Crew 1, if able, will continue patient care and transport. If Crew 1 is not in a vehicle that is capable of transporting the bariatric stretcher then Crew 1 will transfer care to Crew 2 using the same process used for airport to crew transfers. Crew 2 will then take over patient care and transport.
5. The non-transporting crew will help with lifting assistance before clearing.
6. Once the transporting crew has finished the call, CMED will place the unit out of service/bariatric using the appropriate out of service code.
7. **The crew will remain out of service for any calls other than DELTA or ECHO until the unit can return to Post 100 and drop off the bariatric stretcher.**

To document call, BAR 1 or 2 requires the following times: dispatch, scene, and available.

Field Personnel

ALS 911 Calls and NET Transports

1. Crew 1 arrives on scene and assesses patient using the Bariatric Assessment Tool.
2. Crew 1 determines the need for the bariatric stretcher.
3. Crew 1 notifies CMED of bariatric stretcher need and requests a Fire Department response if not already on scene.
4. Crew 1 treats the patient until the arrival of Crew 2 with the bariatric stretcher
5. Crew 1, if able, will continue patient care and transport. If Crew 1 is not in a vehicle that is capable of transporting the bariatric stretcher then Crew 1 will transfer care to Crew 2 using the same process used for airport to crew transfers. Crew 2 will then take over patient care and transport.
6. The transporting crew will document the use of the bariatric stretcher in Siren.
7. The non-transporting crew will help with lifting assistance before clearing.
8. Once the transporting crew has finished the call, they will be placed out of service (10-7) and sent to P100 to return the bariatric stretcher.
9. **The crew will remain out of service for any calls not DELTA or ECHO until the unit can return to Post 100 and drop off the bariatric stretcher**

Please Note

Transport of high priority patients should not be delayed waiting for a bariatric vehicle to arrive at the scene.

Sprinters will not transport the bariatric stretcher or patients requiring the use of the bariatric stretcher.

Document scene delay and reason for delay when appropriate

Document the reason for requesting the bariatric stretcher

Chapter Three

Evaluations / Miscellaneous Information

ISSUED: April 1, 2015 REVISED: May 1, 2018
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Media Policy**

In order to define what constitutes public information and to ensure accurate, timely and professional communication between the Agency and representatives of the media, the following guidelines will apply to release of public information and relationships with media personnel.

1. Public Information concerning incident response and patient treatment is defined as follows:

- Time of the call
- General location of the call (no specific address)
- Type of call (vehicle crash, trauma, medical)
- Number of patients
- Facility to which patient(s) were transported
- Type of transport (emergency – known internally as priority 1 or 2 or non-emergency – known internally as priority 3)
- A general statement may be made that Medic assumed responsibility for the patient who was transported by paramedics to the hospital

2. No additional information should be considered public domain unless approved by a member of the Public Relations team or a designated member of the administrative staff. Designated members include the following:

- Executive Director
- Deputy Directors

3. Communications and/or operations supervisors who have completed media training with the PRM may handle routine media inquiries (i.e. incident response, patient treatment). Supervisors may provide public information as outlined above. Please make best effort to notify a member of the PR team if this occurs.

- If you are unsure of any response, exercise caution and refer media member(s) to the PRM or a Director.

4. All media requests, aside from on-site incident responses outlined above, should be directed to the PRM or designated administrative staff.

5. Any employee, except for those outlined above, who is contacted by a media representative must contact their supervisor and the PRM before discussing any issue, incident, patient information, or Agency affairs. Employees can be held liable for divulging non-public information or misstatements of fact concerning the Agency.

- Most members of the media are aware of the “Media Protocol Policy”. This is also found on our Medic911.com website.

- At no time should an employee speculate on causation, prognosis or other patient care issues not specifically defined as public information.

6. Non- Medic employees are not allowed to use video or still cameras or audio recorders on ambulances in accordance with NC General Statute. Medic employees using such equipment must have advanced approval from the PRM.

7. 911 call recordings will no longer be released to the media in accordance with NC General Statute 143-518, unless approved by the PRM or Director and with full redaction.

ISSUED: April 1, 2015 REVISED: May 1, 2018
APPROVED: March 8, 2015 BY: Operations Management Team
SUBJECT: **Outside Request for Information**

MEDIA PROTOCOL

In an effort to broaden the availability of information pertaining to stories involving Medic or Medic personnel, the following protocol has been initiated by Medic's Public Relations Department. Your cooperation in following this protocol is very much appreciated, and should lead to a greater availability of useful information in a shorter period of time.

Between the hours of 6:00 am and 9:00 pm, all MEDIC related inquiries must be made directly through:

Lester Oliva
Community Engagement Coordinator
704.516.0650
lestero@medic911.com

OR

Tiffany Archibald
Internal Communications Specialist
tiffanya@medic911.com

@**Medic911Press** Twitter
**Members of the press are encouraged to use Medic's private Twitter feed, @Medic911Press. Upon requesting to join, news media will have access to current, late-breaking information on a regular and continuous basis.

After Hours

Between the hours of 9:00 pm and 6:00 am, an incident related inquiry may be made into Medic's CMED call center at 704.943.6238, under the following guidelines:

- No media calls will be taken until 15 minutes after an emergency call is dispatched. Please respect this request and hold your team accountable for it.
- CMED Supervisors are likely to be coordinating the emergency response to a serious incident. The patients and the Medic crews in the field are their first responsibility. If the CMED Supervisor fails to pick up the Media hotline, please be patient and try back again in 5 minutes.
- The exception to this contact protocol would be if a major, mass casualty incident occurs in Mecklenburg County such as a plane crash, bus crash, large scale multi-vehicle accident, natural disaster, act of terrorism, etc. During such an event, Medic's PR Department will absolutely be in the field and available directly to the media by CELL PHONE regardless of the time of day.

Additional Points

- Whenever possible Medic's PR Department will proactively respond to incidents in the field that are known to be of higher level interest to the media. When photos are released from the Medic PR team via email or @Medic911Press, this information can be used by your team and hopefully this quick response strategy will help you with breaking news type stories. All we ask in return is for Medic to be specifically recognized by name in any story you run where we are involved.

- Due to strict HIPAA regulations and personal privacy laws, Medic will not provide any information that could identify a patient*. The information we will provide will be general in nature, limited to the number of people involved, the emergency response assets on scene, the patient's condition enroute to the hospital, and what facility any patients are being taken to.

  *This also means that Medic cannot respond to incident requests with specific addresses. To ensure timely responses, please inquire with a street name, block number & street, or intersection location.

- Any stories that your organization is working on where a Medic comment is warranted must be authorized by Medic's Public Information Officer (PIO). On scene interviews should be limited to a member of Medic's PR Department, or to a ranking member of Medic's Operation Team, identifiable by their white shirts and gold badges.

ISSUED: April 1, 2015 REVISED: April 1, 2015

APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Service Inquiries/Complaints/Commendations**

A Service Inquiry Form will be completed whenever there is contact with anyone who has a commendation or complaint about our service. All incidents will be processed in the same way to provide consistency, to assure that the review and follow-up are handled promptly and to assure that a case is closed in a timely manner. Realizing there may be circumstances that force delay in investigation, it is requested that all inquiries must be reviewed and follow-up initiated and or completed within 14 days of assignment.

When a Service Inquiry (commendation or complaint) is received, open the Service Inquiry Database and enter the information. This database is located in the "Shared" drive, then in the "Admin" folder, then inside the "Service Inquiry" folder. (Shared/Admin/ServiceInquiry/serviceinquiry.mdb)

The Medical Director will be advised of major clinical incidents as soon as possible, as described in Patient Care Protocols, Medical Incident Review Process. The Deputy Director-Operations should be notified of all Presumptive Category One or Two clinical incidents.

Service Inquiry Process:

1. When a call or letter comes in, the person receiving the call or letter should initiate a new Service Inquiry record by first opening the Service Inquiry data base and then click on the Add New Record button on the right side of the form. Complete as many fields on the form as possible. Refer to the document: *Service Inquiry Data Entry Form Comments* for tips on the data entry screen.

2. After entering information on the data entry form, notify the appropriate supervisor of the inquiry.

3. After investigation, follow-up and closing the inquiry in the database this information is included on monthly reports to Mecklenburg County.

4. After closure, the report should be printed, attaching any additional paperwork and forwarded to the Operations Manager for review if necessary.

5. The completed report should then be sent to the Deputy Director-Operations for review if necessary.

ISSUED: April 1, 2015 REVISED: April 1, 2015

APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Scene Evaluations**

Field Operations Supervisors are routinely dispatched to major incidents. The supervisors are also expected to monitor the quality of care that crews provide on general medical calls as well. When the opportunity presents itself, the Field Operations Supervisor should monitor the entire scene activity (to include interaction with allied agency personnel) and document their performance. This should be reviewed with the crew and appropriate feedback provided.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Supervisor Shift Change**

It is customary for the on-coming Field Operations Supervisor to arrive at work prepared to respond to a call, approximately 10 minutes prior to the beginning of the shift. This should allow time for the off-going Field Operations Supervisor to provide the on-coming Field Operations Supervisor with the most pertinent information that will be needed to begin the shift.

The off-going Field Operations Supervisor is expected to fully complete the Off-Going Supervisor Report before the end of their shift. This contains essential information that may be referred to by the on-coming supervisor during the course of their shift. This information is used by the Deputy Director and Operations Managers to monitor important issues and events that have been handled in the Supervisor's office during the course of a shift.

- All narcotics and controlled substances should be properly accounted for and face –to –face sign off should be completed. If there is a discrepancy, indicate on control log and write correct count. Place initial by correction.
- All medications should be monitored through periodic audits.
- All appropriate radio equipment, pagers, keys camera, etc. should be exchanged
- The on-coming Field Operations Supervisor should fully review the day's shift schedule, maintenance log and crew/vehicle assignment with the Operations Assistant to assure clear understanding of priorities...
- Field Operations Supervisors should meet face to face with Communications Operations Supervisors daily to assure clear communication of shift priorities.

ISSUED: April 1, 2015 REVISED: April 1, 2015

APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Benefit Leave for Field Operations Supervisors**

All scheduled leave requests should be submitted the Operations Manager-Field for approval prior to the Scheduling Department. The Operations Manager-Field will evaluate impact on deployment plan and notify the scheduling coordinator who will document the decline or approval. Any deviations from scheduled duty should be reported to the Operations Manager-Field.

Chapter Four

Scheduled / Non-Emergency Transport

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Scheduled/Non-Emergency Transport**

As mandated by the Mecklenburg Board of County Commissions, Mecklenburg EMS Agency is the designated medical transportation service provider for Mecklenburg County. It is our charge to provide safe, consistent, and courteous medical transportation services giving the same attention to detail to emergency requests as well as non-emergency.

The Agency may utilize crews specifically designated to handle prescheduled transports, however, any unit may be assigned to handle the non-emergency call.

Overview:

The ALS NET program is designed to offset the daily peak non-emergency call volume while continuing to provide maximum customer service and patient care. This program requires great emphasis on customer service, as the program is highly visible to its customers and the public. It will require constant evaluation and fine-tuning in order to keep it running optimally. The personnel involved in this program must desire to provide customer service and patient care in the highest manner possible.

ALS NET Shifts:

The ALS NET units work shifts are based on peak times of need. The hours may be adjusted as deemed appropriate to maximize the effectiveness of this unit. The program is monitored to assure that fairness is provided to all parties involved. When not being utilized for pre-scheduled and non-emergency transports, these units will be added to the 911 posting plan.

Performance Expectations:

Any obstacle to delivery of service should be immediately reported to the Non-emergency Transport (NET) telecommunicator in CMED or NET Operations Supervisor for guidance on how to resolve issues that prevent optimal performance. An operations supervisor will investigate reports of poor customer service habits through the usual method.

Emergency vs. Non-emergency Assignments:

The ALS NET Units are not designated as “non-emergency” units. While the majority of calls assigned may be scheduled, system needs will drive their call assignment. ALS NET Units can reasonably expect to respond to a mix of both scheduled and 911 calls. The ALS NET Unit is predominantly used to handle non-emergency calls; however, if there are no pending scheduled calls, the ALS NET Unit should be placed at the highest priority post location.

The BLS NET Units are specifically intended to handle the scheduled discharge of patients from hospital facilities. They can also be utilized to handle the Omega transport only 911 calls. It is possible that BLS NET units will be closest to a “Delta – Life-threatening” emergency and may be dispatched as a first responder, in addition to an ALS Paramedic Unit. In these instances, BLS crews are to provide patient care at their scope of practice until the arrival of the paramedic unit. Only the arrival of the ALS Paramedic unit can stop the response time clock.

The EMD may use a “double post assignment,” or “equal-alternate post assignment” for the ALS NET unit if they have knowledge of pending calls, or demands that will be placed on the system. **The EMD will not hold a call for the ALS NET Unit past the scheduled pickup time.** If the ALS NET Unit cannot pick up the call on time, it may be handled by another truck in the system.

Scheduling and Incentive Pay:

Crews are scheduled for duty in a manner to reduce load on overall system demand. Frequent review of system demand by the Scheduling Supervisor will determine scheduled shift start/stop times. Your assigned shift may be periodically adjusted in order most effectively meet call demand.

NET division crews will participate in a separate holiday leave bid process for the following holidays: Thanksgiving Day, Christmas Eve, and Christmas Day. The NET team follows current system wide holiday bid policy for all operations employees. Available time off will be based on a review of system demand.

Time off will be considered by position (crew chief, non-crew chief, team leader, non-team leader) and will be awarded by random drawing and Seniority (same formula as Field but separate process and separate decision process on number of NET team members that may be permitted to have the holiday off). After completion of the bid process, any available remaining time off will be awarded on a first come-first served basis.

There is no incentive pay associated with this program. The program is set up mainly to allow the units to work during the peak hours. Overtime begins after all scheduled hours of work have been completed for the pay week.

Continuing Education:

Members of the NET division both ALS and BLS Team are expected to meet all continuing education requirements as well as all other required field employee prerequisites (i.e. driver license, NCOEMS certification, employee safety/TB/fit testing, etc…).

BLS Utilization in an Emergency Incident

In the event that the BLS NET Unit is either confronted with or dispatched to an emergency incident, the duties of the BLS crew shall be as follows:

1. Provide ancillary emergency medical services as a BLS first responder/transport unit. Such services shall be provided under the direction and supervision of Agency Operations. The emergency medical readiness of the BLS Unit, medical competence of assigned crews, maintenance and use of appropriate emergency equipment and all treatment protocols are subject to review and approval by the Agency Executive Director, Deputy Directors, and Medical Director.

2. Provide emergency medical services at the scene of an accident or other emergency crisis situation whenever requested by CMED. The BLS Crew shall also provide emergency medical services in conjunction with other responsible operations and, if such services are not provided pursuant to a CMED dispatch, the BLS Crew shall immediately notify CMED of the situation.
3. Provide initial emergency medical assistance as may be necessary to stabilize the patient pending arrival of the responding paramedic unit. The ALS paramedic unit, upon arrival at the scene, shall assume responsibility over all matters relating to such medical emergency. The BLS Unit shall provide whatever continued assistance may be requested by the ALS Paramedic Unit to cope with the problems presented by such emergency medical situation.

4. If the BLS Unit arrives upon a crime scene prior to appropriate law enforcement agencies, the BLS Unit shall preserve the crime scene to the extent possible, without sacrificing the priority on providing

emergency medical treatment within the BLS crew's scope of practice. When law enforcement arrives, the BLS Crew shall cooperate with their efforts without unreasonably compromising the quality of emergency medical services provided.

5. When circumstances at the scene are such that the BLS Crew reasonably concludes, on the basis of established written medical protocols, that immediate transportation of the patient(s) is required to prevent loss of life or serious aggravation of the patient's condition, the BLS Crew may transport the patient upon notifying CMED and the Field Operations supervisor. If medical protocol dictates, CMED may arrange for enroute transfer of patients between the BLS Crew and an ALS Paramedic Unit. Patients shall be transported only to a full-service hospital emergency department under these circumstances, unless otherwise authorized by an on-line medical control physician via CMED.

6. Maintain ALS equipment on board the BLS Unit in the event that additional ALS units are needed and a certified paramedic is placed aboard the BLS Unit. The ALS equipment must remain sealed and locked. BLS crews may not use equipment that is beyond their approved scope of practice under any circumstances.

7. Cooperate in developing standards, protocols and procedures to improve the quality and responsiveness of the BLS transportation service.

8. With the Omega program, some calls may be given back to MEDIC for transport only. These patients have been evaluated by the Omega nurse and only require transport to the hospital. After on scene patient evaluation, BLS units may transport patients that were dispatched as "Omega-transport only".

Documentation of Care

1. It is imperative and mandatory that Patient Care Reports be completed on all patients encountered regardless of clinical care provided. An encounter is defined as making contact with a patient and initiating a conversation regarding their health (refer to 2.1 DEFINITIONS protocol).
2. Under normal circumstances when system resources are not in critical demand, completed Patient Care Reports will ALWAYS be left with the attending paramedic.

BLS Fleet

There will be maintained on staff of small group of individuals that will be identified as relief BLS Team Leaders. Throughout the system there are also relief Team Leaders, these individuals will be of the EMT-Basic certification and will serve in the NCC status on a day to day basis; however these individuals will have extra training and will be able to serve in the 'Team Leader' when needed. Examples of such situations are: special events stand-bys, emergency staffing situations etc. These team leaders will be utilized only as situations arise.
Team leaders are expected to maintain all credentials as other personnel of equal certification, as well as extra initial training prior to being identified as a team leader.

BLS Emergency Bag / Emergency Equipment

In addition to all routinely stocked equipment, the BLS team leaders will have available a BLS Bag. This bag will contain specialized equipment to be utilized in the event the crew encounters an emergency. This bag will contain an AED and any other necessary equipment for emergency response.

Medical Guidelines for BLS NET Unit Transportation from a Scene

These guidelines are intended to aid the BLS NET Unit to more fully understand their roles and responsibilities in providing care and possible transportation of emergency medical patients.

Mecklenburg County's Emergency Medical Services System has been designed such that primary objectives to be fulfilled by BLS Units are as follows:

1. Provide the fastest possible medical assistance to life-threatening medical emergency incidents

2. Assure ALS Paramedic Unit is dispatched to the scene

3. Medically evaluate and stabilize patients for ALS Paramedic Unit transportation to full-service emergency facilities when required

4. If necessary, provide emergency transportation to an en route ALS Paramedic Unit, or full service medical facilities when medical and logistic conditions so dictate

5. With the Omega program, calls may be given back to MEDIC for transport only. These patients have been evaluated by the Omega nurse and only require transport to the hospital. After on scene patient evaluation, BLS units may transport patients that were dispatched as "Omega-transport only"

6. When an ALS unit on the scene has multiple patients requesting transport and have thoroughly evaluated all patients to deem that BLS unit would be appropriate to assist with transports. This also must be approved by an Operations supervisor, Operations manager or Deputy Director.

BLS Crews are authorized to transport, when and only when the following medical situations are encountered and, upon notifying the on duty Field Operations Supervisor:

1. When a serious life-threatening situation is encountered and the BLS Crew concludes that waiting for an ALS Paramedic Unit to transport would seriously aggravate the patient's condition

2. When there is not an ALS Paramedic Unit available for transportation

3. When the estimated time of arrival of the ALS Paramedic Unit is deemed excessive relative to the need for delivery to a full service emergency facility and advanced life support personnel and equipment is not required

4. When patient condition is such that transportation to an enroute transfer point to an ALS Paramedic Unit's greater medical capabilities and equipment is deemed in the best interests of the patient (i.e. when critical time could be saved in transport from outlying areas by meeting a higher level care paramedic unit enroute to a full service medical facility)

5. When dispatched on Omega transport only and have evaluated the patient thoroughly to confirm that the patient does not require an ALS unit.

Proper interpretation and implementation of the above guidelines are subject to the Agency's Medical Audit and Review process, as conflicting purposes can result from improper consideration of one or more of the above parameters.

Chapter Five

Rescue / Emergency Management / Special Operations

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: First Responder Services

The Agency contracts with multiple fire and rescue departments to provide First Responder service as part of the EMS System for Mecklenburg County. These contracted providers provide first aid and rescue services in their individual response areas and in mutual aid responses at the EMT level. The only exception is The Mint Hill Volunteer Fire Department and Ambulance Service, who operate at the Paramedic level.

When interacting with First Responders while representing Medic:

- Be receptive to their report.
- Give consideration to what they have already done for the patient.
- Communicate your expectations / provide direction.

* See First Responders Contract for additional information

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015

SUBJECT: **Crime Scenes**

By the nature of our work, crewmembers may frequently find themselves involved in crime scene situations. The following guidelines should be followed in such situations:

Ensure that the scene is safe to enter and that the police department is responding. If officers are not present upon your arrival it is acceptable to stage away from the scene until it is declared safe by the police department.

- Use caution when entering the environment, not touching any surroundings unless absolutely necessary to avoid contamination of the crime scene. Do not leave any personal items (gum wrappers, medical supplies/packaging, etc.) at the scene. If anything is moved, such as furniture and including a deceased victim, inform the police investigator at the scene.

- Limit access to essential personnel only. Entry and exit routes should remain the same.

- Report suspicious bystanders or activity to the police.

- Physical contact with any suspected suicide case that will not result in treatment and transport should be extremely limited. If a viable patient is encountered, proceed with appropriate medical/trauma protocol.

Exceptional situations:

Hangings- Leave all knots intact, including the knot that the victim may have been suspended from. The rope should be cut in an area halfway between the noose and the suspension point.

Weapons – Should only be moved if they are interfering with patient care, and should only be handled by police officers if possible. Keep bystanders and other responders away from the weapon until the police have secured it. Under no circumstance should a Medic employee tamper with, open or attempt to unload a firearm.

When treating patients that have sustained penetrating wounds, clothing should be cut in a fashion that will preserve any evidence, such as entry points of projectiles and blades. *Do not cut through holes made by penetrating objects.*

Sexual Assaults – victims of sexual assault should be moved quickly to a safe environment. Psychological support and understanding are essential in these delicate situations. It is vital the patient preserve evidence. They should be discouraged from showering or washing any part of their body. Nor should they change clothing or use the bathroom if possible.

If the Medic employee is directly involved as a victim, the operations supervisor should be notified immediately and a police report generated.

* See Crime Scenes specifically addressed in the Agency Patient Care & EMD Protocols.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team
SUBJECT: **Forced Entry**

1. Be certain that a forced entry is necessary.

    - Check to see if you can see someone down inside the house.

    - Check to see if the call taker lost contact with the patient while talking on the telephone.

    - Consider contacting neighbors who may have information in regard to patient health history; neighbors may have a key.

2. Ensure the police department is enroute, preferably at the scene before entry is made.

    - The fire department should make the forced entry under direction of the police department.

    - Medic personnel should not make a forced entry without the police and fire department at the scene unless a critical need is obvious, such as a visible person down, appearing unconscious, or with strong evidence of a life safety hazard. (Smoke/ fire visible, possible person(s) trapped inside)

3. Ensure there will be someone available to secure the residence after entry has been made.

4. Document thoroughly why the forced entry was justified.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Aircraft Emergency ALERT II**

"ALERT II" is a broad-spectrum term used for an aircraft experiencing trouble / problems, not a crash. When responding to an "ALERT II" keep the following in mind:

The typical dispatch address is **4801 Express Drive.**

The typical dispatch configuration includes:

- 1 MCI Unit (1 ALS unit if MCI unit unavailable)
- 1 Operations Supervisor (closest)

Response to an ALERT II will be non-emergency, unless specific information dictates otherwise.

The supervisor may upgrade to a higher response as needed, based on information being received.

When dispatched, you will be assigned an operations channel and given specific information regarding incident if available such as:

- Size and type of aircraft
- Number of passengers (referred to as "Souls on Board")
- Specific problem the aircraft has encountered
- Amount of fuel on board

It is recommended the responding units monitor CFD working channel on one of the portable radios (Normally CFD-OPS-1J). Responding units should stage on Express Drive and await further instruction.

Under no circumstances should a Medic unit go onto runways, taxiways or tarmac unless instructed to by the Incident Commander (IC).

YOU MUST HAVE AN ESCORT ON ALL RAMPS, RUNWAYS, TAXIWAYS AND TARMAC AT ALL TIMES.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team
SUBJECT: **Aircraft Emergency ALERT III**

The term "ALERT III" indicates that there is an aircraft down and has crashed, or that a crash is imminent. Rarely do these incidents occur on airport property. Response level will depend on size of the aircraft and the number of souls on board and location of the downed aircraft. This scenario should be treated as a multiple casualty incident, rescue/entrapment, as well as a hazardous materials incident until otherwise indicated; keeping in mind that personal and personnel safety should be a primary concern.

Keep in mind the following as well:

- Access in and out of the scene should be established early. Keep roads open for responding personnel and ambulance exit.
- Try to determine if additional resources will be needed and report findings to the operations supervisor as soon as possible.
- Establish a unified command with partner agencies (Airport, Fire and Police) as soon as possible to coordinate the response of resources.

**For further detail, see MCI Plan*.

Mecklenburg EMS Agency SOG: 500.020.000

Standard Operating Guidelines, Operations Department, All Divisions

ISSUED: April 1, 2015 REVISED: April 1st, 2015; June 8th, 2021
APPROVED: March 8, 2015
SUBJECT: **Response to Airport Terminal**

Purpose:
To provide guidance for all incoming crews to the airport for patient care/transport.

Applicability:
All MEDIC employees that respond to the airport.

Guidance:
Mecklenburg EMS Agency is contracted with the Charlotte Douglas International Airport to provide EMS personnel for response to incidents inside the terminal and ramp level.

When requested to the airport, crews must follow instructions provided by CMED and airport EMS units. Consider the following:

- Pay close attention to the radio channeled assigned upon dispatch.
- Airport EMS will communicate how the patient will be transferred to the incoming crew, and communicate any potential riders or other special considerations.
- When airport EMS staff is not available, follow instructions provided by CMED.
- Unless told otherwise, bring in the stretcher and all equipment needed as outlined in the "Mecklenburg EMS Agency Patient Care Protocols" and "Initial Approach to Scene."

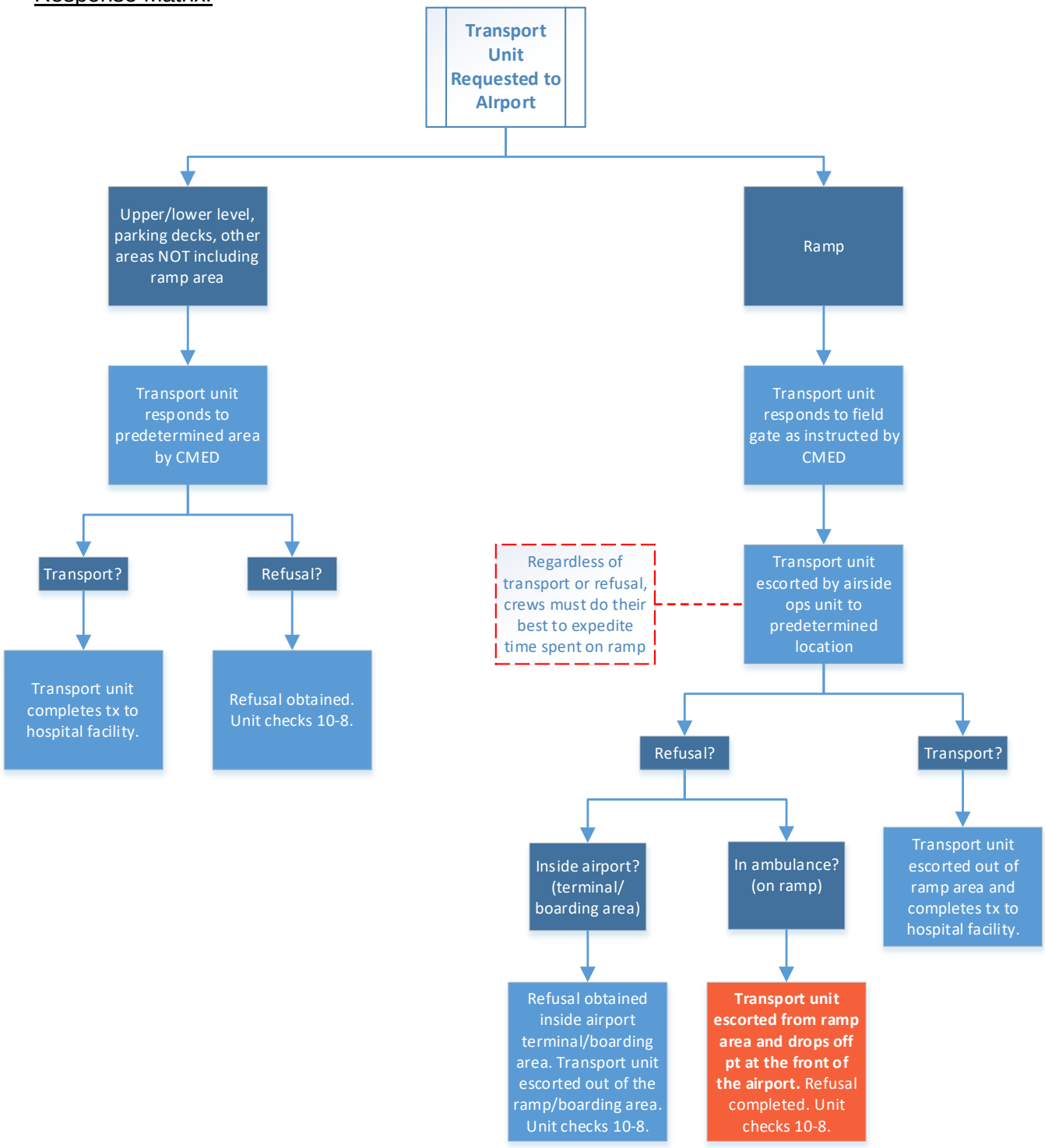
Crews may be requested to report to alternative gates to access the airport ramp. When using alternative access locations, keep in mind the following:

- Crews must respond to where directed by CMED, and follow recommended routing guidelines.
- Access inside the perimeter fence (ramp area) **always requires an escort** by an authorized airport airside unit.
- Always stay **directly behind** the escort vehicle.
- Always assure all emergency lights are on while driving on the ramp; headlights should be on low beam.
- Park where indicated/escorted by airport airside unit.
- Once a patient has entered the back of the ambulance, **expedite** the time spent on the ramp (time spent on ramp area should be < 10 minutes).
- If special circumstances arise that delay time spent on the ramp, CMED and Airport Ops must be informed.

Additional Information:

- MEDIC personnel who do not have a SIDA badge must be escorted inside the airport's secured area by authorized airport personnel. At no point should any crew separate from their assigned escort.
- When a patient is egressed from the boarding area to the ramp, the patient exits an area defined by the airport as "sterile" and enters a "non-sterile" area. This means that any patient loaded into an ambulance on the ramp area CANNOT reenter the airport through the pathway they exited from. For a patient to reenter the airport, they must enter through the front of the airport to be rescreened through a TSA security checkpoint.

Response Matrix:



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APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Response to Bomb Incidents**

Medic will be charged with providing standby coverage for both bomb threats and emergency response to actual bombings.

- ***If you arrive at the scene of a bomb threat before the CMPD bomb team, staging should be a minimum of 500 feet from the threat location.***

- ***Once the bomb unit is at the scene, follow the direction of the incident commander. You may be asked to move to an alternate location.***

- ***If you are responding to an actual explosion, stage a minimum of 500 feet from explosion site, and follow Agency MCI Response Plan.***

There are several key things to remember when responding to a bombing or bomb threat.

The outside of a building is the most common place for a bomb to be placed.

If you are directed to enter inside the "Hot Zone" (Within 200 feet of the threat location), you may need to leave 800 MHz radios and your cell phones in your unit. Check with bomb unit personnel for specific instructions.

Mecklenburg EMS personnel that have trained with the CMPD Bomb team will assist once on scene and will provide appropriate instructions.

<u>If you are responding to an actual explosion, it is common for secondary devices to be set specifically targeting emergency responders.</u>

- ***Park vehicles away from structures***

- ***Do not touch anything except the patient***

- ***Listen to the directions of the bomb personnel at the scene.***

- ***Outerwear & helmet is required for entering a structure that may have suffered damage from a blast.***

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SUBJECT: **Hazardous Materials Incidents (HAZMAT)**

When responding to potential hazardous materials incidents, safety of emergency responders is a primary concern. Should you happen to be the first on scene responder at a potential hazardous materials incident do the following:

- Call for assistance from the fire department; try to give as much information as possible regarding the suspected product.
- Utilize the Emergency Response Guide (ERG) located in the MCI clipboard to help with identification.
- Approach the scene from upwind and uphill of the incident site when practical.
- Limit access to the area; no one (including you) should enter the hazard area until the product is identified and appropriate protective measures have been taken.
- Anyone inside the area should be evacuated; do not become a victim yourself in efforts to assist. *It may be necessary to use your vehicle public address system to direct bystanders / ambulatory victims to safe areas.*

When performing stand by duties at hazardous materials incidents your primary duties are:

- Giving care to potentially exposed patients.
- Medical monitoring of the HAZMAT Technicians working at the scene. *See Mecklenburg EMS Agency Patient Care Protocols, Medical Monitoring for further information.
- Standing by in case injuries occur during the operation.

The Incident Commander should be able to inform you of the staging area for your unit. Park upwind from the incident, insuring your position does not interfere with other agencies that may need to access the scene. If possible, locate the ambulance close to the HAZMAT truck. Load necessary equipment onto the cot and contact the Incident Commander on the radio to confirm your assignment.

Attempt to ascertain the type of hazardous product from the HAZMAT Team. Obtain copy of MSDS (Material Safety Data Sheet) from HAZMAT Team to take to the hospital. The MSDS may be faxed directly to the hospital if the sheet is not readily available at the time of transport. If all you can get is the product(s) name, make sure you have the correct spelling for hospital staff.

Assure the Field Operations Supervisor is aware of the incident and request additional resources as needed.

Decontamination procedures should be performed under the direction of the Hazardous Materials Team and Incident Commander.

Remain at the scene until you are cleared to leave the by the Incident Commander.

Hot Zone: Area where release of product is occurring or has occurred; should only be entered by the HAZMAT team wearing appropriate PPE.

Warm Zone: Area of contamination control. As appropriate PPE is required in the warm zone EMS personnel generally will not enter.

Cold Zone: Non-contaminated area. No risk of secondary contamination should exist. This area is where the command post, treatment, and staging are located. PPE protection from the HAZMAT product should not be required.

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SUBJECT: **Water Rescue Incidents**

Lakes, creeks, or areas that have experienced flooding may be difficult to navigate. With safety being the key issue, keep the following information in mind.

- Personnel must wear a Personal Flotation Device (PFD) when operating within five (5) feet of water at an incident where a water rescue is in progress (swift water or by watercraft).
- Maintain as close communication as possible with the first responders, as they will have more intimate knowledge of the area of response.
- Try to pre-determine a suitable takeout point for your patient, and stage a unit at that area.
- ***Medic personnel should always notify the Field Operations Supervisor before boarding any watercraft.***
- Medic may be requested to stand by for divers or rescue personnel during a search.

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SUBJECT: **Missing Person Incidents**

If Medic becomes involved with a search for a missing person, we are there to offer medical support for police, first responders and rescue personnel. It would be rare that Medic personnel become active in searching for a missing person. The following guidelines apply to the missing person incident:

- Make contact with the Incident Commander. The typical assignment and purpose will be setting up rehabilitation facility for rescuers and/or medical monitoring.
- If it appears you will be on scene for extended amounts of time, contact C-MED for possible rotation period between other Medic units.
- Insure the Field Operations Supervisor is aware of the incident.
- Stand by as needed until cleared by the Incident Commander.

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SUBJECT: **Rescue Incidents**

At a rescue assignment it is the paramedic's responsibility to concentrate on overall scene safety and patient care. Coordinate all members of the team to work together for the common good of the patient. The first thing to be established is that there is a need for rescue. Rescue response is indicated under the following circumstances:

- Patient entrapped or pinned in machinery, vehicle, or by some type of object.
- The patient is above or below grade and cannot be removed without assistance.
- The patient is in water and cannot be removed without assistance.
- Confined space situation (culvert, elevator shaft, etc.)

Scene safety is a primary concern. Other information such as estimated number of patients and their severity of injuries will be needed to adequately determine the need for additional resources.

- Insure all personnel are wearing appropriate protective equipment for the evolution being performed.
- Assure the patient is properly protected from weather, debris and further injury during the operation.

Mecklenburg EMS Personnel are responsible for all patient care activities.

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SUBJECT: **Industrial Accidents**

Industrial Accidents

Industrial accidents are typically classified as accidents that involved a patient being injured or trapped by some type of heavy machinery. Each situation may vary and depends on the type of machine involved. Some factors to keep in mind when responding to this response:

- Determine if the scene is safe.
- Determine if the patient is trapped. Request additional resources if needed.
- Determine if a shop mechanic is available at the site. This may be your best resource in the event the machine must be disassembled, or to give advice on how the machine may react if certain parts are moved.
- Assure all personnel at the scene have appropriate protective gear for the situation.
- Insure the power supply is disconnected and the machine is locked and tagged out.
- Assure the Field Operations Supervisor is aware of the situation.
- Assure the patient is properly protected from weather, debris and further injury during the operation.

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SUBJECT: **SWAT Incidents**

Mecklenburg EMS Agency employs a specialty team of Tactical Paramedics that train with Local, State, and Federal Law Enforcement Agencies, to respond to high-risk situations such as hostage events. However there may be occasions when the regular field unit is deployed to a situation before the Tactical Team.

1. On arrival, locate the command post, and insure the Incident Commander is aware of your presence at the scene.
    - Inform the Incident Commander that you are not a Tactical Team member.
    - Insure that C-MED is aware a tactical Medic is needed, and have them advise you of the ETA.

2. **AT NO TIME IS ANY NON-TACTICAL MEDICAL PERSONNEL TO ENTER THE "HOT ZONE" OF A SITUATION THAT IS NOT COMPLETELY UNDER CONTROL.** Medic personnel may enter the scene only after Law Enforcement has declared the scene safe or secure.

3. Remain at the scene until relieved by the Tactical Team or until cleared by the Incident Commander. The first in unit may be requested to stand-by in support of the Tactical Paramedics.

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SUBJECT: **Fire Department Support**

Medic provides mutual aid service to Charlotte Fire Department and County Fire Departments by responding to all working fires or hazardous incidents when requested. The primary role of the stand by unit is to be ready to receive any patients that may have resulted from the initial fire, be available to assist in the event of firefighter(s) becoming ill or injured while fighting the fire and setting up a rehabilitation area.

1. Park in an area upwind from the incident and out of the way of fire apparatus and other responders. Insure your exit is not blocked by additional responding apparatus / vehicles. ***DO NOT DRIVE OVER A CHARGED FIRE HOSE*** *OR HOSELINE BEING LAID BETWEEN FIRE HYDRANT AND APPARATUS.*

2. Assure all EMS personnel are wearing adequate protective equipment.

3. Load necessary equipment onto cot and proceed to the command post, unless otherwise instructed.

4. Advise the Incident Commander of your presence and request assignment. Go to the fire frequency to monitor. Advise C-MED that you will be on the fire channel. Monitor MEDIC channel with secondary radio if possible.

5. Request additional resources as needed. Once committed to a patient that appears to be in need of transport, request another unit for stand-by.

6. Units may be pulled from fire support calls to respond to nearby, higher priority incidents. C-MED may elect to hold units in a 10-8 status at fire scenes if EMS system status warrants.

    - *If pulled from a standby, advise the Incident Commander that you are leaving and have C-MED advise "Alarm"(Charlotte Fire Department Dispatch) if required.*

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SUBJECT: **Radiological Incidents**

Due to the potential danger, the complicated technical nature, and the unique characteristics of radioactive material, it is imperative that the Incident Commander follows a course of specific action. As a Paramedic responding to the scene, your role in an incident involving radioactive material will be limited to treating injured patients and preventing further contamination. The following are guidelines for proper response to known radiological incidents:

- A Field Operations Supervisor must be notified of any Radiological Incident.
- Lifesaving functions take priority over radiation exposure. Victims should be removed to a safe environment as soon as possible.
- Exposure time in the “hot zone” should be kept to an absolute minimum. The number of workers in the zone should be kept to a minimum.
- All emergency response personnel shall keep a record of exposure.
- As with any hazardous material response, approach upwind. If a radiation hazard is suspected, personnel, vehicles and command post should be staged at least 1000 feet from the incident. Distances may change when personnel arrive on the scene with instrumentation and advise command of the situation.
- Always advise hospitals in advance and as soon as practical that you could be transporting contaminated person(s).
- Isolate, tag, and secure all equipment, trash, and other items inside the “Hot Zone”. Proper decontamination or disposal will be completed after transport.
- All eating, drinking and smoking should be prohibited in the area.
- Medic personnel will remain unavailable for additional duties until decontamination has been completed and they are clear to return to regular duties.

See preparation and dress down procedure for radiological incidents.

PROTECTIVE CLOTHING
DRESSING SEQUENCE
(Suggested Checklist)

1. Use the restroom
2. Attach TLD to clothing
3. Tyvek pants, shirt, or body suit
4. Booties – secure with masking tape, over pants, leave pull-tab for dress down)
5. Head cover / hood
6. First gloves (taped to outside of sleeve of protective garment – leave tab for dress down)
7. Second gloves – do not tape- change as needed
8. Face shield
9. Attach dosimeter at neck level ("zero" and report reading every 15-30 minutes to RSO / Recorder)

UNDRESSING SEQUENCE / EXIT PROCEDURES
(Suggested Checklist)

1. RRT member goes to the "control line" and removes protective clothing (place in plastic container).
    a. Remove dosimeter and place in plastic bag held by controller
    b. Unzip protective garment
    c. Remove tape on inner gloves and booties
    d. Remove outer gloves
    e. Tilt head forward and remove face shield
    f. Tilt head back and remove face shield
    g. Remove protective garment – inside out, DO NOT SHAKE
    h. Remove booties and step on step-off pad
    i. Remove inner gloves
2. Complete body frisk – final monitoring
3. Remove TLD, give it to RSO
4. Take a shower

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SUBJECT: **McGuire Nuclear Power Station Incidents**

McGuire Nuclear Power Station is located on Hwy 73 in northern Mecklenburg County on Lake Norman and is owned by Duke Energy. This facility houses 2 nuclear reactors that produce electricity for the region.

McGuire has a Medical Emergency Response Team that is deployed to all medical emergencies and accidents at the facility. All members of the team have first aid training. The facility also has a Radiological Protection Team that are trained to perform monitoring for radiological contamination.

This is a security sensitive area. When responding to this facility you will be met at the gate by a security team, who will lead you to the appropriate area to find your patient.

- The Medic unit must stop at the gate and be prepared to present their photo ID. Personnel without a photo ID, such as a ride along, may be directed to wait outside the facility gate until the unit is ready for departure.
- The ambulance is subject to search.
- A security officer may accompany the crew on board the ambulance while on facility grounds

The McGuire Nuclear Power Station staff fully appreciates our need to quickly reach patients in life threatening situations and will take measures to facilitate our passage as rapidly as possible. Please have your ID properly displayed and give their officers your full cooperation as is typical of Medic's highly regarded staff.

You will be notified ahead of time in the event you will be transporting a contaminated patient, in order to prepare yourself and your vehicle. Keep in mind if you will be transporting a contaminated patient, you may not be admitted into certain areas of the facility. The MERT crew will decontaminate the patient as much as possible, and bring the patient to the waiting ambulance.

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SUBJECT: **Dedicated Medical and High School Football Coverage**

Dedicated Medical and High School Football Coverage

Medic provides dedicated EMS unit coverage at various events throughout Mecklenburg County for a user fee. Information and rates are available at https://www.medic911.com/event-coverage/dedicated-coverage.

A Dedicated Medical Standby (85D) provides for a unit on the scene of an event such as a 5K, college football game, boxing, etc. where the event promoter pays the Agency for the service. Units on the scene of these events will generally not transport unless a priority 1 patient should be encountered. In cases where immediate transport is required, another unit should be sent to provide coverage until the original unit can return.

A School Football Standby (85F) is a public or private middle or high school game coverage where the school has contracted with Medic to provide an ambulance to standby during their home football game at a per game rate. Units on the scene of these events will generally not transport unless a priority 1 patient should be encountered. In cases where an immediate transport is required, another unit should be sent to provide coverage until the original unit can return.

On occasion Medic provides coverage at mass gatherings where the size of the event could have a significant impact on EMS system operation. These coverages are coordinated in advance with partner agencies to ensure adequate EMS system delivery. Coverage may include the use of an ambulance or other specialized asset.

Any difficulties should be reported immediately through the normal chain of communication and thoroughly documented.

Chapter Six

Communications Guidelines

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team
SUBJECT: **Call Processing**

Line Answer Priority:

911 lines are the **first** priority. IF a 911 line rings, personal phone calls will be placed on hold and the 911 line answered. EMS Dispatch, Ops-3 positions and primary Fire Dispatch (when a working fire is in progress) should answer 911 only as a last resort (with the answering order being Fire Dispatch/Ops-4, then Ops-3 and EMS Dispatch Controller as very last resort).

Answering Phone Lines:

All lines, except 911, should be answered with, "MEDIC and County Fire _____" and your name, first or last.
911 lines should be answered, "MEDIC and County Fire, What is the address of your emergency?"

Placing a caller on hold:

When it is necessary to place a caller on hold, it is the responsibility fo the call taker to ensure the call is attended to in a timely manner. This applies to ALL lines, NET (6190, 6191), 911 trunk lines, ring down lines, and administrative phone lines. If the call is for another Telecommunicator, the call taker should receive and acknowledgment from the correct Telecommunicator when they are informed a call is on hold for them. It is also acceptable to send a message with the line number via the phone messaging system.

CAD Failure:

In the event of a total CAD failure, CMED personnel will initiate the manual back up procedure. This will consist of using call entry sheets kept at each console.

All times should be documented and should be formatted as hours:minutes:seconds.

When a 911 call is received, once the case entry information is obtained, the sheet will be passed to the Controller for Dispatch. The call will continue to be processed with MPDS/FPDS card sets kept at each console. The Controller/Ops-3/Primary Fire Dispatcher/Ops-4 Radio Operator should be kept up to date with patient/incident information as it becomes available. The call entry sheet shall be updated as needed with pertinent information.

Recorded times can be provided to the units, however an incident number may not exist. Those requesting incident numbers should be directed to call back at a later time. The incident number will be assigned when the call is entered into CAD.

IF staffing permits, the calls should be entered into CAD when CAD is back online, using “Offline Entry Editor”. All call entry sheets should be collected and forwarded to the Operations Manager – Communications upon completion.

Processing All Requests:

Communications will process ALL calls for service using Medical Priority Dispatch (MPDS) or Fire Priority Dispatch (EFD) systems and initial a response to ALL requests for service.

911 transfers from a PSAP are considered a request for service. Asking if a response is needed is prohibited (i.e., “Do you/they need an ambulance?” “Do you/they need the fire department?” A call should be entered for the incident type identified without questions.

MEDIC personnel will never refuse treatment or transport nor suggest alternative transportation or follow-up options to any patient at any time. Presumptive diagnoses or other expressed medical opinions that might suggest a minor clinical condition and/or influence a patient from not being transported by EMS is strictly forbidden.

9-1-1 Hang Up/Disconnect – Call Back Procedure

The EMD/EFD is required to redial the number provided by the caller or displayed on PSAP screen. Multiple attempts should be made immediately after the hang up, if connected to voice mail, a message should be left. Messages should read similar to:

> 9-1-1 Call without a Location:
> “This is Mecklenburg EMS Agency/Mecklenburg County Fire. We received a 911 call from this number and were disconnected. Please call us back at 911. We will attempt to obtain an address for this number and respond with Police, Fire and MEDIC.”
>
> 9-1-1 Call with a Reported Location:
> “This is Mecklenburg EMS Agency/Mecklenburg County Fire. We received a 911 call from this number and were disconnected. Currently, we have Police, Fire and MEDIC responding to (read the address we are responding to). Please call 911 so that we can obtain additional information.”

The EMD should also recontact the Police (if not still on the line) to attempt to obtain additional information regarding the incident.

MEDIC, First Responders and County Fire will be dispatched immediately for incidents in the County (where a need for EMS or Fire cannot be verified). The responding units will be advised of the 911 hang up/disconnect and that attempts to recontact the caller are being made. The results of attempts will also be provided to all responding personnel/agencies. Police response verification should follow the Fire/MEDIC dispatch. For County Fire responses, a radio-equipped officer responding in a POV may serve as apparatus for response time purposes.

Contacting the Patient for 3rd Party Calls and Medical Alarm Company Requests for Service:

Requests should be processed through Pro QA. The Emergency Dispatcher (ED) shall obtain the patients name and phone number information for all third party/alarm company calls. After obtaining the information and processing the call through ProQA, the ED will make an attempt to contact the patient or someone with the patient. Once contacted, the address should be verified along with processing the incident through ProQA a second time.

The Police Department for the area of the response should be notified to respond for any possible forced entry event.

Police AED Dispatch Guideline:

Pineville PD, Huntersville PD, Cornelius PD, Matthews PD, Davidson PD and Mint Hill PD all have officers on duty that carry AED's in their patrol cars. Their respective Communications Centers are to be contacted as per the following policy: It is CMED's responsibility to notify the appropriate Communication Centers. Incidents that may start out with a chief complain other than Cardiac Arrest and during interrogation change into a Cardiac Arrest will also require notification. All **confirmed** Signal 31 incidents should include a request for officer carrying AED to the appropriate Communications Center.

It is the responsibility of the call taker to alert someone to make the call to police if they are not able to complete this task themselves. These are the type of incidents where early defibrillation can make a difference. These notifications need to be made and be made in a timely fashion. Failure to do so is the equivalent of "failure to send" a medical First Responder on an EMS Incident.

Information Relay Responsibility:

It is the responsibility of the Call Taker to ensure that all pertinent information regarding a call is forwarded to EMS Dispatch, Ops-3 or Fire Dispatch/Ops-4 to ensure relay to the appropriate crews. "Notify Comments" should be utilized to ensure that immediate scene safety information is relayed within CMED and then to First Responders/County Fire Personnel.

Scene safety information should be placed in the LOCATION NAME field in CAD to ensure prompt receipt by CFD when an incident is within city limits of Charlotte. **A phone call via ring down should also be placed to CFD Alarm for any SCENE SAFETY information that needs to be relayed to ensure receipt of that information in their Center. It is also acceptable to relay scene safety information via the Emergency Bridge Channel (radio terminal).** A "CFD Updated" entry should be marked in CAD when CFD is updated of additional patient information/response mode change. This is not necessary for information updated in CAD's location name field as it is automatically received by CFD.

Call takers should ensure they receive a verbal acknowledgment from the appropriate radio operator indicating s/he received the information and will relay said information. When a request is made to forward information to a unit, the information shall be forwarded. **Information received should be relayed to the unit(s) or requested recipient regardless of the Telecommunicator's opinion of relevance.**

Language Line:

If Language Line services are required, transfer the caller by using the appropriate steps for the Intrado Phone System. This can be done to assist with 911 call or to assist a unit on scene who calls in on a 7-digit line.
Once connected, you will be asked for Client ID, Organization name and Personal Code (employee ID) prior to an interpreter coming on the line.

Medical Calls for Assistance (Lifting or No Injury):

The EMD will process the call in MPDS on Card 17. If an answer to a key question is obvious or has already been provided, the question does not need to be asked. If the complainant did not fall, then there is no need to ask "What caused the fall?" The intent of using Card 17 is to verify that the complainant is completely awake, breathing normally and not injured.

Within the City of Charlotte:

If the response determinant indicates an "Alpha" or "Bravo Cold" response at the end of questioning, then the EMD may transfer the call to the Charlotte Fire Department. The MEDIC unit will then be cancelled for the incident and Charlotte Fire notified of the cancellation. If the response determinant indicates "Charlie", "Delta", or "Echo" response then that level of dispatch should occur and MEDIC should continue to respond.

Outside the City of Charlotte:

If the response determinant indicates an "Alpha" or "Bravo Cold" response at the end of questioning, then the MEDIC unit will continue to the incident with the appropriate First Responder. The MEDIC unit can be cancelled by the First Responder only after contact with the person requiring assistance.

First Responder Notification to a Skilled Nursing Facility (SNF) or an Approved Medical Facility (AMF):

Upon receiving a 911 Call from a SNF or AMF, the EMD will process the call as appropriate per EMD protocol. If the situation is prioritized by protocol to be an Alpha, Bravo or Charlie response, the EMD will ask if either a physician or registered nurse (RN) is with the patient or has been evaluated by the physician or RN. If yes, the EMD will advised dispatch that First Responders are not required if the situation has been classified as a Charlie Response. Alarm should automatically disregard assigning a response for SNF and AMF locations and County First Responders do not need to be alerted for Charlie responses within their jurisdiction.

The appropriate First Responder may also be continued for Charlie, Bravo or Alpha responses at the discretion of the EMD processing the call. If the response is in Charlotte Fire's jurisdiction, the EMD (or team member designated by the EMD responsible for the call) should contact Alarm and advise them that a response is necessary. For any County First Responder response, the EMD will advise the Controller that County First Responders are required and the Controller should dispatch the appropriate First Responder. The Controller shall advise the responding crew that no first responder is enroute due to medical personnel being in attendance with the patient.

If at any point the patient's condition deteriorates to a Delta or Echo level, the EMD (or designated team member) shall immediately notify Alarm and request their response or the Controller shall be notified and the appropriate County First Responder Dispatched to respond. The call taker will ensure that CFD has been notified by marking CFD NOTIFIED in the call taking screen and by contacting CFD Alarm via Ring Down.

Use of First Responders (City or County) for Alpha or Bravo responses is not prohibited. An example of circumstances that may warrant dispatch of First Responders to Alpha or Bravo incidents might be a call for a minor trauma where the system is at low status levels and the closes MEDIC unit has and ETA of greater than 15 minutes. In this case, the EMD may elect to dispatch First Responders (non-emergency) to the scene to further evaluate, treat and possibly cancel the MEDIC response.

CMED should expect to receive requests from the MEDIC crews for manpower assistance from First Responders. MEDIC units should request their assistance once the non-emergency scene has been evaluated and need is determined. The MEDIC unit should specify the response level (Hot or Cold) when requesting assistance.

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SUBJECT: **EMS Dispatch/County Fire Radio Guidelines**

Radio Etiquette

All units must be acknowledged with the unit number, i.e. “M5 on scene”, “Cornelius Engine 4 on scene”. Acknowledgement of just “10-4” is **not** acceptable and an acknowledgment of “Cornelius” is **not** acceptable.

EMS Dispatch/Radio Guidelines

Once a call is received in queue for dispatch, the telecommunicator shall determine the most appropriate unit based on unit location or utilizing the Deployment Monitor as needed. Unit location is determined by the Global Positioning Satellite System (GPS). The CAD’s map display shall be utilized for determining the unit with best access to the call.

The telecommunicator should consider factors such as traffic flow patterns, freeway access, physical barriers, etc. when selecting the unit for the incident. The closest unit to the incident (straight line distance) may not have the fastest access to the scene.

Dispatch information will be provided to the responders by both the voice paging system and the alpha numeric paging system. The Agency’s goal for queue to alert is ***30 seconds***.

The format for all EMS/County Fire dispatches is as follows:

Activate radio alert/pager encoder by depressing "page send" button. Always activate pager tones of all responding departments before making any broadcasts so that all personnel will hear the entire broadcast.

Broadcast the nature and location of the call in the following format:

- Units / Department(s)
- Response level
- Type of incident (plain text, one time)
- Street address (twice) 4525 Statesville Rd would be dispatched “Forty Five Twenty Five Statesville Road, Four Five Two Five Statesville Rd”
- Name of business or institution (if applicable)
- Cross streets (county) / general location/direction to head (city)
- Ops channel assignment

All dispatch information will be GIVEN IN CLEAR TEXT FORMAT. AVOID USING ANY "10" CODES DURING DISPATCH PHASE.

MEC-OPS-3 Secondary to Dispatch in City of Charlotte

All non-multiple unit incidents inside the Charlotte City limits will be assigned to MEC-OPS-3.

MEC- OPS-4 (Secondary to County Fire and EMS Dispatch in Mecklenburg County

All necessary information (verbal directions/additional patient information) will be transmitted using Simulcast (MEC-DISP, MEC-OPS-4, FIRE-VHF) or by Simulcast (MEC-DISP, MEC-OPS-XX, FIRE-VHF) for incidents within the County (outside city of Charlotte).

Alert of County First Responders/County Fire Incidents

First responders within Mecklenburg County shall be alerted via the voice minitor paging system at the same time that the EMS unit is alerted/dispatched.

Dispatch of MEDIC and County First Responders together

When dispatching a call involving MEDIC and County Responders, please use MSel-2, to include EMS-DISP, MEC-DISP, and FIRE-VHF.

Dispatch of Mecklenburg County Fire Departments (fire call only)

Simulcast on MEC-DISP and FIRE-VHF.

MEC-CONF

MEC-CONF is available for use as a conference channel for County VFD and County First Responder agencies.

Scene Safety Information

Any information regarding scene safety shall be immediately relayed to responding EMS unit(s) as well as all other responding allied agencies (Simulcast on all channels related to the incident).

Responders should be advised to stage on signal 4, 25, 27, 47 and 32 unknown situations.
Units shall be staged for any incident that presents the possibility of danger to field personnel. The appropriate police department must indicate that “scene is secure” for entry. “Officer is on scene” is not acceptable for scene secure.

If the first responder advises the scene is “secure” without police stating same, the information received shall be relayed to the Medic unit. Additional information relayed at this time should include the channel and Responder unit number of the unit on scene. The judgment call to enter scene based on the report they get from the first responder is the responsibility of the Crew Chief on the unit.

Information Relay Responsibilities of SSC and Radio Operators

All information pertaining to a call: i.e. location, scene safety, patient information that is provided to the Medic unit **must** be relayed to first responders.

CFD: Information may be updated via CAD to CAD in the Location field of the call or by ring down to Alarm. It is also acceptable to relay this information via our Bridge 4 channel.

A "CFD UPDATED" entry should be made in the CAD when CFD is updated of additional patient information/response mode change. This is not necessary if the information is updated in CAD's location name field as CFD automatically receives it.

If information is SCENE SAFETY related, it should also be relayed VERBALLY by the call taker to Alarm via ring down line or Bridge 4 channel.

CMPD or other Police Departments: Information may be relayed via their respective Communications Centers via ring down or by phone (Admin Lines).

County Responders (EMS and County Fire): It is imperative that response information, particularly scene safely, incident location and cancellation updates be broadcast (simulcast) on the associated dispatch (EMS/Fire) channel as well as the operations channel for both County Fire and County EMS incidents. Responders with only monitor pagers are not able to switch to the operations channel and will not hear the appropriate information that is broadcast only on the operations channel. **Not ensuring this information is broadcast on BOTH channels risks responders and public safely.**

Information Relay Responsibilities of Call Takers processing Call for Service

It is the responsibility of the call taker to ensure that all pertinent information regarding a call is forwarded to EMS Dispatch, 1, Ops-3 or Fire Dispatch, Ops-4 to ensure relay to the appropriate crews.

Notify Comments should be utilized to assure that immediate scene safety information is relayed within CMED.

When a call taker relays information verbally to a radio operator (i.e. Dispatch 1, Ops-3, Fire Dispatch), the call taker must receive a verbal acknowledgement from the radio operator that indicates s/he received the information. A verbal room announcement does not satisfy this rule, an acknowledgment is required.

A "CFD UPDATED" entry should be made in the CAD when CFD is updated of additional patient information/response mode change. This is not necessary if the information is updated in CAD's location name field as CFD automatically receives it.

If information is SCENE SAFETY related, it should also be relayed VERBALLY by the call taker to Alarm via ring down line or Bridge 4 channel.

When a request is made to forward information to a unit, the information shall be forwarded. ***Information received should be relayed to the unit(s) or requested recipient regardless to the dispatcher's opinion of relevance.***

Relay examples

Telecommunicator (regardless of position) receives a cancellation by the caller. Call taker shall notify the appropriate radio operator (MEC-OPS-3, MEC-OPS-4 or SSC) and CFD as needed, marking "CFD cancelled" in the appropriate box of the call taking screen.

County First Responder calls should be cancelled by having the Controller or Ops Operator simulcast on the Operations channel assigned and on the Main Dispatch (EMS or County Fire) Channel to relay appropriate information.

Call takers are responsible for notification of any upgrade/downgrade information to the appropriate radio operator for the incident (CFD or County Incidents).

Caller advises "entrapment" on a call already dispatched, call taker is responsible for notifying the SSC, CFD as needed and ensure VFD is dispatched as appropriate.

CFD requests a MEDIC unit to contact their Fire unit on CFD's channel. This request shall be fulfilled. MEDIC on scene does NOT negate this rule; the request should still be relayed regardless as to the telecommunicator's opinion of relevance to the situation.

A firefighter/first responder calls CMED/Central and requests information be relayed on the air. This request shall be fulfilled, regardless as to the telecommunicator's opinion of relevance to the situation.

Tracking of Responding Units

It is the responsibility of Communications personnel to continuously track all responding units via the GPS system and to provide all available information regarding the most efficient response routes in order to facilitate their safe response to the scene. Routing information should be provided if requested unless radio traffic or excessive workload does not allow its transmission or if the unit's destination is a common destination: SNF, doctor's offices, etc.

Delayed Available Status

If a crew contacts CMED to advise of a delay at hospital, comments should be added to the call to include the reason and unit status should be changed to "delayed available". Delayed available should only be utilized after contact with the crew has been made. A unit's status should be changed to "delayed available" at the time that the unit says they are delayed.

Hospital to hospital transport requests

Hospital to hospital calls for immediate dispatch should be dispatched with a Bravo response determinant. **Further Clarification:** Hospital to Hospital calls that do not require immediate dispatch may be scheduled, i.e. a direct admit may be scheduled if acceptable to the discharging facility. If the transfer is such that the patient needs to receive a higher level of care, Bravo is appropriate. Emergency transfers may necessitate a Charlie response; if in doubt, ask the discharging facility if Medic needs to respond emergency or refer to CMED Operations Supervisor to make the decision.

Contract Response Time Requirement Note

Units are at scene when they arrive at dispatched location.
"In the area, looking" or "In the complex, looking" is not considered as on scene.
Do not cancel and reenter calls.
Units that are accidentally cleared should be placed "Out of Service" marked cleared in error ("OOS-cleared in error"). Additional times for status changes should be noted, then the call edited by the Supervisor after the unit clears the incident (hh:mm:ss).

Deployed Hours/Unit 10-42

A unit's 10-42 is the end time of their "deployed hours". Units should arrive post 100 at or prior to their 10-42 time unless system status levels prevent their deployment to post 100.
If a unit is delayed, the Controller should relay this information to the CMED Operations Supervisor as soon as it is possible.
The Controller is primarily responsible for, and must aggressively monitor 10-42 times in an effort to ensure units arrive post 100 at or before their deployed hours expire.
Units are to remain in CAD until their 10-42 times.
No unit will be taken off duty in CAD while enroute to post 100.

Network Clock Time

The verbalizing of time during a broadcast where required must be CAD/Net clock time.

Posting Units at Post 100/Headquarters

Available units should be posted at 100 for 10-41, 10-42 only. Post 100 is not acceptable for post 53 unless an Operations Supervisor or other Administration requests to meet with a unit. These events should be rare in occurrence.

Incident Reassignment (between MEDIC units)

When reassigning a call to a unit with better access, wait until the 2nd unit dispatched checks enroute to the incident before canceling the original unit. EMS Dispatch will make the appropriate reassignment changes in CAD or will coordinate who makes the changes. Be aware that multiple positions making unit changes simultaneously may result in CAD problems with the unit.

Activation of Emergency Button on Radio

CMED will immediately notify police, first responders and dispatch a Field Operations Supervisor and an additional Medic unit (will respond "hot" to the scene, where they will stage as needed).

When a crew's emergency button is activated, the code word "e-status" will be sent to the unit on the alpha pager.

CMED will not contact the unit by radio unless the unit calls CMED first.

If the unit activated their emergency button: page the crew via alpha pager (using E-Status Portable # or Mobile).

Downgraded Calls

Calls may be downgraded in CAD and to the Medic unit when advised to downgrade by a contracted First Responder on scene.

The only exception is that units will continue to run HOT on confirmed "10-67" calls by first responders or CMPD.

Emergency Bridge

The Emergency Bridge Radio Channel shall be monitored at all times. This will serve the primary means of contact between the communication centers in the event of a failure or major system problem.

This channel may also be used to relay information between centers when time sensitive information is being relayed (emergency traffic, scene safety information, etc.). Discretion should be used on information relayed on this channel with decisions for using it based on need for a "quicker relay" than the phone/ring down line would allow.

CAD to CAD

The System Status Controller is responsible for ensuring that incidents within Charlotte City Fire jurisdiction go to (sent and acknowledged) CFD via CAD to CAD. If the information is not showing as sent to CFD Alarm or acknowledged by CFD Alarm, the Controller is responsible for ensuring that CFD receives the information verbally via ring down line or Emergency Bridge and that the CMED Operations Supervisor is made aware of possible CAD to CAD failure.

CFD or County First Responder response needed for SNF

If CFD is needed to continue responding to a nursing home, "CFD NOTIFIED" will be marked on the call taking screen by the individual making notification to CFD.

It is the call takers responsibility to ensure CFD is sent to these call, though it is acceptable to ask another team member to make this call.

It is the call taker's responsibility to ensure the SSC is made aware of a need for a First Responder on calls to a skilled facility in the county.

CFD requested as First Responder in County

If CFD is requested to respond to a county call the Telecommunicator will click the SEND TO CFD button in the call taking screen and will ensure that the CAD to CAD notification is made in the comments field in the call.

A follow up phone call should also be made whenever a request is made for CFD to respond into the County. The telecommunicator making the notification will also mark CFD NOTIFIED in the call taking screen.

Cancellation of First Responder Responses

If a cancellation for CFD is appropriate, the "CFD CANCELLED" tab will be marked in the call taking screen and notification made by phone to ensure receipt and acknowledgment of information.

If County First Responder cancellation is appropriate, the SSC shall simulcast the cancellation on the Main Dispatch (EMS or County Fire) channel and the assigned Operations Channel.

Welfare Checks

Welfare checks where there is no immediate indication of an emergency should ordinarily be dispatched as an **Alpha** response. A Charlie response should be assigned if circumstances indicate the likelihood of a medical emergency. CMPD and first responders should be notified and advised of Medic's response mode.

Time Stamps in CAD Call Taking Incident Screen

Time stamp when the crew advises "ROSC", Patient Contact, Unit Staged, DOA, CPR, Baby Delivered, Control Time, hospital diversion, paged 2nd time, patient not ready, police requested, and others as requested (by field responders) in the appropriate field in the Call Taking Incident screen.

Airport Alerts:

"ALERT II" is a broad-spectrum term used for an aircraft experiencing trouble / problems, not a crash.
The typical dispatch address to be utilized is 4800 Express Drive.
The typical dispatch configuration for an Alert II includes:

- MCI Unit (1 ALS unit if MCI unit unavailable)
- 1 Special Operations Supervisor
- 1 Field Operations Supervisor (for notification)

MEDIC Responses to airport codes will be non-emergency (Bravo Response), unless specific information dictates otherwise.
Any Operations Supervisor may upgrade to a higher response as needed, **based on information being received**. *This typically is based upon the reported severity of the aircraft problem and the number of souls on board.*
When dispatched, CMED will assign an operations channel and will relay specific information regarding incident if available such as:

- Size and type of aircraft
- Number of passengers (referred to as "Souls on Board")
- Specific problem the aircraft has encountered
- Amount of fuel on board
- CFD working channel (if applicable – typically CFD-OPS-1J) as responding units should plan to monitor via one of the portable radios.

Responding units should stage on Express Drive and await further instruction.

Airport Alert Definitions

Standard Definitions Used by Airport/CFD Personnel:
Alert 1 – Indicates an aircraft approaching the airport is experiencing minor difficulties. **Medic will not be required to respond to Alert 1's unless specifically requested by CFD.**

Alert 2 – Indicates an aircraft approaching the airport is experiencing major difficulties. Medic will respond Bravo (non-emergency) to the designated staging area.

Alert 3 – Indicates an aircraft has been involved in an accident on or near the airport and emergency equipment should proceed immediately to the scene (staging area). Medic crews will respond in an emergency mode to Alert 3.

Airport Medical Incidents and MEDIC Coverage

Mecklenburg EMS Agency is contracted with the Charlotte Douglas International Airport to provide EMS personnel for response to incidents inside the terminal and ramp level. Staffing currently occurs between 06:00 – 23:00.

CLT EMS Call Processing Guidelines

Call is received via one button transfer to CMED from CLT Control Room. Caller is connected with EMD within CMED. MPDS is followed according to Communications Guidelines.
If call is received via 911 from cell phone caller, Control Room should be contacted by phone with information regarding patient's location / Chief Complaint regardless of whether or not Airport LEO is responding or whether or not MEDIC is immediately dispatching a transport unit per Response Guidelines below.
EMD continues to obtain call information, handling as per MPDS Guidelines, offering instructions as appropriate or until MEDIC team arrival with patient.
Do NOT delay giving PAI's to caller however in order to obtain specific location information from a caller with a Delta/Echo patient, another (CMED) team member can call Control Room to inquire as to this information if necessary.

CLT EMS Dispatch Guidelines

When MEDIC team arrives with patient, responding crew should advise CMED of "patient contact" time on MEC-OPS-13 (*no MDT*). CLT EMS team should be acknowledged and time marked within CAD (by MEC-OPS-3 operator).
MEDIC team assesses patient.
Transport decision is reached; MEDIC team advises CMED of decision:

- If yes, CLT EMS team may determine if transport is appropriate.
- If no, CLT EMS team obtains refusal.

Once refusal is obtained or patient care is transferred to responding unit, MEDIC team will check available on MEC-OPS-13 (*no MDT, crew is not able to do this function on their own*).
Responses will be simulcast on EMS-DISP **and** MEC-OPS-13, per response guidelines.
If Echo is initial determinant, CMED call taker should inquire from Control Room as to best location for Transport unit arrival in order to potentially transfer patient care from MEDIC team to transport crew. DO NOT delay giving PAI's to caller in order to obtain this information, another (CMED) team member can call Control Room to inquire as to this information if necessary.

Operations Channel Assignments for CLT EMS Responses

MEDIC Team, CFD, and responding transport crews are assigned to MEC-OPS-13 on initial dispatch. It is the responsibility of the Telecommunicator working MEC-OPS-3 position to monitor / acknowledge units on MEC-OPS-13.

Other potential CLT EMS Response Scenarios:

If two crews are available and a **second call for service** is received, same format as above for the 2nd MEDIC team responding.
If both MEDIC teams are enroute to or already with patients and a **third call for service** is received; OR, **if second call is received with only one MEDIC team available** (06:00 – 11:00 or 18:00 – 23:00):

- CLT EMS team member(s) may respond **if** team member(s) can break free and respond knowing that Airport LEO and CFD will soon be with MEDIC team.
- If this occurs, please ensure that additional resources are dispatched as appropriate per Response Guidelines.

If MEDIC team NOT available, Response Guidelines will be followed as listed above.

Transport requested/necessary for CLT EMS Response

The MEDIC team should advise CMED on MEC-OPS-13 that transport is necessary. MEDIC team should also advise if transport is ALS or BLS appropriate (after patient assessment).
CMED should add appropriate ALS / BLS transport unit to the incident within CAD. When the MEDIC team advises reference transport, the team should also designate a location to transfer patient care for the incoming MEDIC transport crew.
Responding transport unit will be assigned to and move radio traffic to MEC-OPS-13. The responding transport unit should remain on MEC-OPS-13 until they are departing CLT property at which time radio traffic should be switched back to MEC-OPS-3 for duration of the incident (excluding encode).
On occasion crews may be requested to report to alternative gates to access airport property, such as GATE 81.

BLS Transport Guidelines

MEDIC team may request BLS transport (if ALS not available at time of determinant) and only after EMT-P assessment (if transport is appropriate).

Omega Referrals at CLT

Once appropriate Omega determinant is reached, Omega referral may be utilized as per current CMED Guidelines.

EMS Dispatch/Transport Guidelines for Stand-By Events

Dedicated Medical and High School Football Coverage

Medic provides dedicated EMS unit coverage at various events throughout Mecklenburg County for a user fee. Information and rates are available at www.medic911.com.

A Dedicated Medical Standby (85D) provides for a unit on the scene of an event such as a 5K, college football game, boxing, etc. where the event promoter pays the Agency for the service. Units on the scene of these events will generally not transport unless a priority 1 patient should be encountered. In cases where immediate transport is required, another unit should be sent to provide coverage until the original unit can return.

A School Football Standby (85F) is a public or private middle or high school game coverage where the school has contracted with Medic to provide an ambulance to standby during their home football game at a per game rate. Units on the scene of these events will generally not transport unless a priority 1 patient should be encountered. In cases where an immediate transport is required, another unit should be sent to provide coverage until the original unit can return.

On occasion Medic provides coverage at mass gatherings where the size of the event could have a significant impact on EMS system operation. These coverages are coordinated in advance with partner agencies to ensure adequate EMS system delivery. Coverage may include the use of an ambulance or other specialized asset.

Any difficulties should be reported immediately through the normal chain of communication and thoroughly documented.

Operations Channel Utilization for incidents in City limits of Charlotte

MEC-OPS-3 for routine calls
MEC-OPS-13 for CLT (airport calls)
ODD OPS Channel assignments for other incidents as needed: MEC-OPS-5, -7, -9 (MEC-OPS-11 and 13 are reserved channels and should not be utilized)
MEC-OPS-3 operator is responsible for monitoring these channels for any and all traffic unless channel is assigned to an incident and handed off to other available Telecommunicators
** If more than (4) OPS channels are needed for City of Charlotte incidents, use EVEN channels, working backward from MEC-OPS-12. These incidents should be monitored from a position other than County Dispatch/MEC-OPS-3 (assigned to other available Telecommunicators).

Operations Channel Utilization for EMS or fire incidents in county:

MEC-OPS-4 for routine EMS calls (no change)
EVEN OPS channels for other incidents as needed: MEC-OPS-6, 8, 10, 12
MEC-OPS-12 should be the last OPS channel assigned
MEC-CONF is now available for use as a conference channel for VFD & 1st responder agencies
MEC-DISP/MEC-OPS-4 position is responsible for monitoring these channels for any and all traffic unless channel is assigned to an incident and handed off to another T/C.
** If more than (4) OPS channels are needed for county calls, use ODD channels, working backward from MEC-OPS-11. These incidents should be monitored from a position other than MEC-DISP/MEC OPS-4 (assigned to other available Telecommunicators).

Mutual Aid Requests from Mecklenburg County

For any department who requests a mutual aid response: If the requestor specifies a department but does not specify EMS or FIRE mutual aid ask the requestor if they need EMS, FIRE or both. (Exception North Meck)
CMED/Central will immediately follow through with any mutual aid request.
CAD response plans are set up to reflect pre-determined mutual aid responses for certain areas/departments correctly, however, the SSC must still be able to utilize CAD maps and determine appropriate dispatch of First Responders, Primary and Secondary Fire Departments.

Mutual Aid Response from Agencies outside Mecklenburg County
Applies to responders from Cabarrus, Union, York and Iredell counties with 800 MHz radios and access to the Charlotte/Mecklenburg radio system.

If responding agency does not have access to the assigned MEC-OPS channel they can be assigned to a Regional Operations Channel (REG-OPS), EVT8-VFD, or EVT3-EMS and patched to the assigned MEC-OPS channel.

Any major events (i.e. Speed Street/Panthers/etc.) should be handled on an events Channel. Channel will be assigned prior to event by CMED Operations Supervisor or Special Operations Supervisor according to policy to avoid multiple agencies using the same channel.

Operations Channel Assignment Record

An operation channel assignment shall be noted in the Primary Tac field. The channel should be selected in drop down box of CAD located in the Additional Information tab.

Response Cancellation Protocol

Responding EMS units may be canceled in the following circumstances:

- Response address is verified to be fraudulent.
- On-scene public safety unit (police, fire, EMS) advises either no patients at scene or incident does not require medical care
- Cancellation due to the availability of a closer unit
- The original requesting party or patient re-contacts CMED and cancels the EMS request
- Poison control recommendation with confirmation by caller
- The call is accepted by an OMEGA Nurse (after an appropriate OMEGA determinant

Fire / Rescue Response Plan Changes

Changes relative to response plans will occur by contacting the CMED Lead Supervisor or Operations Manager-Communications. This includes extended temporary changes.

EXAMPLE: Matthews's ladder is out of service for a few weeks and they have requested a Mint Hill ladder be added to their response on all calls.

EXAMPLE: An officer can make short-term changes to CMED Operations Supervisor; i.e. Pineville is having a Christmas party and requests Carolina respond on all calls for the evening. This shall be noted in the dispatcher notes and a message sent via the phone system to all workstations.

Alerting of EMS Units

The following guidelines shall be strictly followed for the alerting of Medic units.

Medic Crews shall be alerted again after 90 seconds if they do not acknowledge the initial call notification. If no response within 30 seconds of the second alert, the next closest available unit shall be dispatched and the Field Operations Supervisor notified.

Communications personnel will not discuss pager problems and/or debate the number of times that the unit was alerted. Crews should be directed to contact CMED Operations Supervisor via telephone at the completion of the assignment.

Crews should not be alerted again if they acknowledge the call on the air. However, the unit will not be placed responding by any Telecommunicator until such time that the crew advises CMED that they are enroute via the mobile radio.

If the time exceeds 60 seconds from the crew's acknowledgement of the call without the unit being enroute or moving per GPS, the on-duty Field Operations Supervisor shall be notified of the delay.

Alerting a second unit will be the discretion of the Controller. If the unit marks responding via mobile mapping and is not moving within 60 seconds, the unit should be contacted to verify their enroute status.

Retoning of County First Responders

The following guidelines shall be strictly followed for the retoning of County First Responders.

County volunteer first responders will be allowed three (3) minutes to acknowledge and check enroute to the incident prior to reactivation of their tones.

A member enroute POV should be considered as a departmental response.

If after the second pager activation, 60 seconds pass without acknowledgement, then the **next closest** first responder, city or county, should be dispatched.

Dispatching Additional Transport Units to an Incident

When a request is made by a unit on scene for additional units to be sent for transportation, CMED personnel should determine from the crew on scene if the response is emergency or non-emergency.

Upon the request for a second unit, an Operations channel should be assigned and on dispatch the second unit should also be advised of the proper MEC-OPS channel.

When a Medic unit is utilized for an incident near the end of their shift and a second unit is being sent strictly for transport purposes, the second unit shall respond non-emergency. (If a unit is requested emergency by the crew on scene due to patient condition, the unit on scene should complete the transport).

If the initial crew requests the second unit to respond emergency, then the initial crew should be directed to handle the call and conduct the transport.

Delta and Echo final determinant calls will be assigned to the unit with best access prior to their 10-42 times with no transport truck.

If there are any questions regarding the dispatch of an additional unit for transport, the Controller should discuss with CMED Operations Supervisor who will make the final decision.

Units at 100 are considered available for emergency calls until their 10-42.

The 10-42 times of Demo / Public Relations or a Dedicated Standby unit is at the completion of their event, not arrival at 100.

EMS Exception Coding by Supervisor

Exception definition: Incidents where the response time exceeds the Agency's response time standard.

The supervisor or assistant should be notified as needed for proper real time management coding.

It is the responsibility of the CMED Operations Supervisor or Assistant Communications Operations Supervisor to code each exception.

The Field Operations Supervisor should be notified with the response number and incident details for exceptions that apply to field units.

Proper documentation shall occur in the CAD's User Data section, and elsewhere as dictated by Communications Manager.

All exceptions shall be coded with a valid reason at the completion of each shift.

Unit Deployment Guidelines

The information provided below is to assist the System Status Controller in developing a plan for positioning ALS resources. The System Status Controller should not review each item listed before assigning a post, but should generally apply these guidelines as required. It is understood that during low system status levels many of these guidelines will not be applicable. As the System Status Controller becomes more experienced, these practices should become second nature.

- The System Status Controller (SSC) should continuously be thinking of a plan of action.
- The SSC should determine what changes if any are necessary within 60 seconds (not greater than) of a change in system status levels.
- Consider alternatives before making a move. Is there a unit coming on duty that could cover an area as soon as or prior to another unit being in place? Is there a unit at the hospital that can become available? Check with the unit(s) for an ETA to clear reference system coverage. Is there a unit currently enroute to a lower priority post that is in good position to be diverted?
- It is acceptable to leave a low priority post uncovered as long as the higher priority posts are covered.
- In order to cover a larger area on a temporary basis, consideration should be given to posting a unit in between two uncovered posts.
- Is there a unit on the scene of a call that you suspect will be a non-transport in the uncovered area? Check to see if they will be transporting.
- Are there units covering posts surrounding the uncovered post that could reach into the area if needed?
- When dropping to low status levels, units on non-dedicated standby's and available NET units should be considered covering the area of their location.
- When posting in the area of an outlying hospital, i.e. CMC-Pineville, Presbyterian Matthews and CMC-University, consider units transporting to these facilities for future coverage of those posts. Example: a truck is at post 73 and another truck is transporting to Presbyterian Matthews. Consider leaving post 19 open to accommodate one of the units when the transporting unit clears the hospital.
- Consider moving 2 units to cover post locations that would otherwise take greater than 20 minutes to cover if only one unit was utilized. However, avoid the domino effect of moving multiple units to cover areas of shorter travel time. Unit travel distances are generally reduced during rush hour periods and extended during late night hours.
- Do not have a unit getting off duty to be the sole unit covering post 53, unless the system is at low status levels. Have a different unit cover post 53 to prevent the off going unit from receiving an assignment.
- Monitor unit destination lines on the CAD map, are there units crossing paths? If so, is it relevant and beneficial (to patient care) to swap units enroute to incidents?
- Monitor unit locations in relation to the deployed 10-42 time. Your plan should accommodate units nearing 10-42 without creating system wide moves or seriously jeopardizing coverage to an area.
- Special Unit Requests: Crews are not allowed to request special assignments due to personal needs or because of a desired area of the county to cover. The only exception to this policy would be when an individual/crew has received pre-authorization for a special assignment from Agency Administration. Any such requests by a field unit should be directed to the on-duty Field or CMED Operations Supervisor.
- Equitable Distribution of Workload: It is understood that the workload distribution will vary from unit to unit on a daily basis. However, over the course of several weeks, the workload should develop into a more equitable distribution. No unit should routinely receive outlying posts, nor should a unit routinely be assigned in high demand areas. EMD's that demonstrate tendencies of favoritism towards particular crews will be subject to disciplinary action.
- Extended Duty Hour Trucks: an attempt may be made to post units that have been on duty for greater than 14 hours to outlying posts, provided the post is in the system status plan. Coverage to high priority posts should not be compromised.

- Utilize the Demand Monitor to determine if adequate coverage exists before making a post move.

System Status Plan

Crew assignment to a post is to be based on the following criteria:

- Demand as reflected on the Demand Monitor
- Crew access/routing to a post
- Consideration of the crews' end of shift time
- Selection of a specific crew in order to prevent multiple post moves
- An "in between" post in order to meet demand as specified on the Demand Monitor

The Agency will not tolerate any form of favoritism when making a post assignment. Crews are not allowed to request special assignments due to personal needs or because of a desired area of the county to cover.

CMED Operations Supervisors are instructed to monitor this activity closely and field personnel are asked to forward any situations that appear to be inappropriate for the Agency to investigate. Anyone found to be showing favoritism to specific individuals/crews will have these actions addressed through the disciplinary process (Conduct issue).

The only exception to this policy would be when an individual/crew has received a **pre-authorization** for a special assignment from Agency Administration.

ALS First Responder Involving Mint Hill

When Medic or Mint Hill is not on stand-by in the others area but are indicated to be the closest unit to an emergency response in the others area, the Controller should use judgment in assigning a unit. Particularly in critical Delta/Echo incidents, a closer Mint Hill unit should be considered and possibly dispatched in conjunction with the nearest Medic unit.

The purpose being that Mint Hill could act as a Paramedic (ALS) first responder with the Medic unit arriving to assume control and conduct transport.

The same example could apply in reverse with a closer Medic unit responding into Mint Hill as a Paramedic first responder.

The purpose is to deliver the most appropriate and most timely level of care in Delta/Echo level incidents. Neither service would be prohibited from transporting prior to the others arrival should patient condition warrant immediate transport.

Matthews Paging Protocol

Matthews VFD should be alerted and assigned to ANY Traffic Accidents within Matthew's EMS district.

Matthews Engine 2, Engine 121, Brush 126, Squad 129, Ladder 124, Rescue 128, Engine 221, and Engine 222 will be tracked in CAD.

Matthews apparatus times should be tracked with the CAD icons listed above **AND** the generic MATF icon. The generic MATF icon should be assigned to ALL fire incidents as **this is the only resource that has Matthews Alpha pagers attached to it.**

Idlewild Paging Protocol

Idlewild Engine 91, Engine 92, Engine 93, Brush 96, and Squad 99 will be tracked in CAD.

Idlewild apparatus times should be tracked with the CAD icons listed above **AND** the generic IDL-F icon. The generic IDLF icon should be attached to ALL fire incidents as **this is the only resource that has Idlewild Alpha pagers attached to it.**

Mint Hill Ambulance Paging Protocol

Mint Hill Ambulance has paid personnel to answer the first call within their response area twenty-four hours a day. Often times there are several 1st calls throughout the night only needing the response of the on-duty crew to handle. To assist Mint Hill in identifying *volunteer personnel* to respond to second calls in their area particularly at night, as well as facilitating additional personnel resources when needed, follow this procedure:

Activate the paging resource icon "**Mint Hill AMB**" for all initial Mint Hill responses.
Activate the "Mint Hill AMB and Mint Hill 2ND **" tone on the following:

- All 2nd or additional ambulance calls in Mint Hill EMS Response Area
- Any time as requested by Mint Hill EMS personnel
- Any time as deemed necessary by CMED SSC or Operations Supervisor-Communications (i.e. multi casualty incidents, rescue incidents and incidents where additional personnel may be needed)

Anytime the "**Mint Hill 2ND****" tone is activated the "**Mint Hill AMB**" tone should also be activated. This will ensure all Mint Hill personnel are aware of multiple responses and the department can coordinate and respond accordingly.

The "Mint Hill 2ND"** paging resource icon has a dark blue border to differentiate it from the other icons on the CRT (computerized radio terminal).

Davidson Dispatch Protocol

Davidson Engine 1 is equipped with mobile mapping. Because of this, Davidson Engine 1 (DavE1) will now need to be assigned to **ALL** EMS and Fire incidents. Davidson will then determine which apparatus will respond and CMED will be responsible for unit tracking of times for the unit that checks enroute. (However, if BOTH assigned units check enroute, the radio operator is responsible for tracking BOTH apparatus' times.)

If a second incident occurs, a generic Davidson unit will be assigned. Once Davidson determines which unit will respond to the second call, remove the responding unit from the first incident and add it to the second.

CAD will recommend both units (DavE1 and another Dav resource) with initial assignment. However, if initial assignment is not used, BOTH should be added to ALL fire AND EMS calls.

Mutual Aid Interstate Responses

I-485 Responses:

Calls on I-485 (either direction) between I-85 and Steele Creek Rd are to be dual dispatch of West Meck Fire and Rescue and Steele Creek Fire and Rescue.
Calls on I-485 (either direction) between I-85 and Moores Chapel Rd are to be dual dispatch of West Meck Fire and Rescue and Charlotte Fire Department (send via CAD to CAD with follow up phone call to Alarm).
Calls on I-485 Outer Loop between Providence Rd and John St are to be dual dispatch of Matthews Fire & Rescue and Charlotte Fire Station 9 (send via CAD to CAD with follow up phone call to Alarm).

I-85 Responses:

Calls on I-85 (either direction) from Billy Graham Py to Sam Wilson Rd are to be dual dispatch of West Meck Fire and Rescue and Charlotte Fire Department (again via CAD to CAD with follow up phone call to Alarm).
Calls on I-85 (either direction) from Sam Wilson Rd to the river are to be dual dispatch of West Meck Fire and Rescue and Belmont (phone call to Gaston Co Communications).

CAD response plans are set up to reflect the above mutual aid responses correctly, however, the SSC must still be able to utilize CAD maps and determine/ensure appropriate dispatch of First Responders, Primary and Secondary Fire Departments.

SWAT Guidelines and SWAT Team Member Cell Phone Numbers:

All SWAT calls will be assigned to MEC-OPS-23.

Once a SWAT call is initiated, CMED will assign a standby MEDIC Unit to a location designated by SWAT member assigned to the incident.

The location of the SWAT call should NEVER be broadcast on any channel except for MEC-OPS-23. Once the scene has been deemed secure, the SWAT units will contact CMED and Control will issue and all clear page.

SWAT Team Members and Cell Phone Numbers are located in CAD and updated as necessary.

Bomb/CEU Team Members and Cell Phone Numbers are located in CAD and updated as necessary.

Back Up Radio Usage (Contingency for CRT Failure)

The back-up radios are located in the LAN room and are mounted in a rack.

The primary function of the back-up radios is to provide an expeditious way to resume communications when normal radio console operations are interrupted. With this goal in mind, seven of the nine back-up radios are dedicated to specific talk groups and should not be changed.

In the event of a confirmed console failure, Radio positions should change to the Ops BackUp tab and select their primary talk group. Keep in mind MEDIC radio paging will **not** go out over the back-up radios.

Note If the consoles fail, everything will fail at first. Within approximately 10-20 seconds, the "red-X" will disappear from the back-up resources on the back-up page. If the consoles are still down, the "red-X" will remain on the normal talk groups. When the consoles re-establish connection with the server, the back-up radios will again fail for a few seconds and the system will return to normal.

Radio01 Medic thru Radio04 Medic are dedicated to primary CLT/MEC talk groups (EMS-DISP, MEC-DISP, MEC-OPS-3, and EMS-NET-1).

Radio05 Medic is dedicated to AIRPORT-1, as the signal from this repeater located on airport property does not work well from a portable in CMED.

Radio06 Medic and Radio07 Medic are dedicated to State VIPER channels V-SW-CALL and V-RoamEMS2 respectively.

These dedicated talk groups are indicated on the console resource for reference.

Radio08 Medic and Radio09 Medic can be used to monitor or communicate on any talk group. These two radios can facilitate communications on additional MEC-OPS channels, EMS-CONF, EMS-ADMIN, etc. during a console failure. They can also be used to monitor channels not available on our consoles, such as York County talk groups or other VIPER channels.

The default volumes for these resources is "zero", except for AIRPORT-1 (set for 2) and V-SW-CALL and V-RoamEMS2 (set for 5 and 6 respectively). Monitoring AIRPORT-1 is optional, but ensure volumes for V-SW-CALL and V-RoamEMS2 are maintained so calls to CMED are heard.

Unlike normal console resources, the back-up radios function much like a portable radio. When you press the transmit button on a back-up radio resource you will hear a talk-permit tone. Wait for the tone and then speak.
For convenience, V-RoamEMS2 is also located on the City Ops tab under RESCUE 280. REG-CALL and V-SW-CALL are also now located under the Msel/patch panel on the City Ops tab.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015

SUBJECT: **Scheduled Calls**

Entering Scheduled Call Information

Obtain essential information from the caller according to the scheduled call taking form. Information must be written on hard copy by the requesting facility (must be legible with the appropriate signature lines complete) and then entered into CAD. The hard copy of the completed request should then be placed in the file under the date of transport.

Pick-Up information required

Caller name, pick up location (be as specific as possible, including room/bed number and time of pick up).

If caller is requesting pick up from a Skilled Nursing Facility, ask if the patient (resident) is in a Medicare "part A" bed.

Destination information required

Is the call for a Doctor's Appointment? Is the transport an out of county transport?

Medic does not normally provide wait assistance with patient to a doctor's appointment. If the patient needs to be monitored by a nurse, family member, or staff member from a nursing facility, the family or staff should ensure that those arrangements are made prior to transport.

A completed Medical Necessity form is REQUIRED for all transports that did not initiate from a 911 call.

- The forms should be completed in full and faxed for all patients in and outside of Mecklenburg County.
- The form must be signed by an RN or attending physician if leaving the hospital and must have all applicable conditions initialed or marked on the form.
- The form must be faxed by to Communications prior to scheduling the call.

Medical Necessity forms are also required for all transports from a residence or facility to a doctor's appointment and these must be signed by the physician the patient is seeing (RN or Physician's Assistant are NOT acceptable) these must also be completed prior to scheduling.

If no fax machine is available from pick up location (typically scheduled call originating at a residence at request of home health or hospice) then the Telecommunicator may enter the information into hard copy (and CAD) and must then place their initials and timestamp the request at the bottom to indicate that the information was entered by the Telecommunicator. If home health or hospice is calling and they indicate they will fax the request later, please also indicate this on the form so that when it arrives, the original request can be attached to the faxed request.

Billing Information required

- Patient name, age, sex, date of birth, social security number
- Medicare/Medicaid number or private insurance information
- If the patient is being discharged from a hospital, the medical record number is needed
- If the patient is being discharged from a Skilled Nursing Facility, you must ask " is the trip related to the Plan of Care?" Does the patient have any special needs? (IV, O2, Medications, Cardiac Monitor, Bariatric Cot)

Entering Requested Pick Up, Promised Pick Up and Appointment Times

When entering a scheduled call, please accurately enter the requestor's first choice in "requested pick up time" field. If the caller requests transportation at a time that is busy, offer an alternative time slot. If the call can only be scheduled at the requested time, such as patient appointment, we will make every effort to complete the call at the requested time. Any discharges from the ED should be scheduled with a goal pick up time of 45 minutes to 1 hour from the time the request is made and the form is completed.

ED Discharge

Generally calls coming out of the ED, dismissing from a specialty area of hospital (NON-inpatient), a return from an MD office and hospice patients going from residence to hospice care should be scheduled 1 hour from the time the completed paperwork is faxed to CMED (unless a specific later time is requested by facility/caller).

Requirements for Transport Request entry in CAD

Prior to entering calls in the computer, ensure that the form is filled out correctly and completely. The form must have a signature and the name legible **before** it is to be entered.
All lines should have an entry to ensure ease for others to find any information that they may need.

Other Guidelines regarding Scheduled or Hospital to Hospital Transports

Ensure source of call (facility making request, i.e. Novant Presbyterian Medical Center or Hospice), a specific contact person and their phone number are received and entered.

All scheduled calls should be entered as scheduled task until transport has been verified and confirmed for pick up (Do not assume any needs based on what the requester puts on the paperwork, i.e monitor, IV O2 etc). After transport is confirmed, change the priority to either scheduled BLS or ALS based on information given.

If the pickup location is a residence, only an ALS unit can transport.

If the scheduled transport is from or to a residence, please make sure you have a phone number for the resident. If you are picking up from a location, we will need a phone number to call and confirm the patient will be ready. If the destination is a residence, we will need a contact phone number in case the patient cannot get into the residence and someone will need to receive the patient.

When entering calls for new patients, enter all available demographic information.
Ensure that if you cannot honor the requested time for pick up that you write the promised time on the paperwork as well as enter this time in the computer.

All calls received should be stamped with date and time stamp (received). Please add your initials on the data sheet after you have entered the request for service.
Note any special needs for the patient should be marked in the comments section.

Out of town transports should have responsible party signatures, addresses for the destinations, etc.
Call the RN station 1 hour prior to dispatch to verify patient is still scheduled.

Dispatching Scheduled Calls

All attempts should be made to ensure the crews have advance warning of a pending scheduled call. It is optimal that the crew is on scene at least 10 minutes before promised pick up time.

Arrivals later than the agreed upon pick up time

It is the responsibility of the Communications NET Coordinator (or a designated CMED team member assigned as NET Coordinator for the shift or the CMED Assistant Operations Supervisor) to ensure that the customer receives a courtesy call when a unit is going to be late for a scheduled call.

Responding crew should receive the following information upon initial dispatch

- Patient location (be as specific as possible)
- Promised /Requested pick up time
- Appointment time
- Destination information
- Return trip information if possible

If patient has any special needs or requirements, such as respiratory isolation, communicable diseases, precautions, etc. This information should be placed in the comments section for the crews to receive upon dispatch.

NET Call Assignments

The closest appropriate unit should be sent to scheduled calls.

The schedule should be checked daily to ensure that units are strategically place throughout the county as to ensure that the units will be on time for the transports.

If all the NET units are being utilized, the appropriate 911 unit will be assigned to the call schedule permitting.

Please be considerate of the start and end shift times of the crews assigned for local and out of town transports.

Prescheduled Out of County Transports

The Agency will provide prescheduled out of county transportation as requested. The following are the general guidelines for providing this service to our community.

If the patient is being transferred from one hospital to another, acceptance at the receiving facility must be verified before Medic departure. The person receiving the request for transport should ask requestor for a contact person and telephone number at the destination facility to confirm acceptance. Also, attempt to get the name of the receiving physician if a hospital is our destination.

Patient must meet medical necessity in order for Medicare or other insurance to pay. The Federal guidelines are as follows:

- Emergent situation (accident, injury, acute illness)
- Patient is in need of restraints
- Unconscious or in shock
- Requires oxygen or other emergent treatment on the way to their destination
- Must remain immobile because of an unstable fracture or possibility of a fracture
- Has sustained an acute stroke or heart attack
- Experiencing severe hemorrhage
- Confined to bed before and after the ambulance trip

Transport out of Mecklenburg County > 1 hour:

Any out of town transport greater than 1 county away in distance from Mecklenburg County will require 24 hour notice. The call taker receiving the information will inform the requestor that Medic requires guarantee of payment prior to scheduling the transport and guaranteeing a crew for transport. The requestor will also be made aware of the cost of the transfer at that time. The fees are located in the card file in the cad listed under the nursing homes tab under NET transport fees. They can also be located on the in the front of the daily file. After guarantee of payment is made, NET Operations Supervisor will be made aware of the request for an out of town transport and that guarantee of payment has been met. The NET Operations Supervisor (or CMED Operations Supervisor if NET Operations Supervisor is not available will determine if an off duty crew will be needed to handle the transport or if the system can handle with the OOC NET unit. Any special needs will be noted and the facilities first choice of transport time and date will be noted and met if possible.

Pick up Outside of Mecklenburg County

There are only two incidents where MEDIC would be authorized to pick up a patient outside of Mecklenburg County:

- If the EMS Service in the residing county declines to pick up the patient, CMED may contact the EMS service direct for verification. Once confirmed, Medic can handle the transport if system status permits and if the transport is to Mecklenburg County. CMED Operations Supervisor should notify the Field Operations Supervisor.
- If a neighboring county requests mutual aid and MEDIC is utilized by that county for transport. The initial request for mutual aid should be cleared by both Field and CMED Operations Supervisors.

NET Fees

The fees are located in the card file in the cad listed under the nursing homes tab under NET transport fees.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team
SUBJECT: **Scheduling**

Mandatory Staffing Guidelines

Purpose: On occasion it is difficult to adequately staff Communications. The number of employees assisting with coverage is typically limited. This alternative eliminates the need for Communications employees to be on-call during their days off.

To prevent the need for on-call personnel, this policy has been developed. The policy below will require assistance from every employee, and at times be inconvenient. Those employees who volunteer on occasion to assist with staffing needs will typically not be directed to work unscheduled duty hours.

Guideline Components, Voluntary Mandatory List: To equally distribute the workload and to encourage volunteer participation, many parts of the plan will involve an employee list. The *Voluntary Mandatory* list will rank employees each time they volunteer or are mandated to work. This list will be maintained and updated continuously by the supervisors. Employees will be ranked based upon their participation in assisting Communications during a staffing need. Those closest to the top of the list will be vulnerable for receiving a directive to assist with staffing. Thus, an employee who volunteers is less likely of receiving a directive or receiving a shift reassignment.

Each time an employee meets the following criteria; their name will go to the bottom of the voluntary mandatory list:

- Each time an employee assists with a staffing need on the floor in CMED of 4 hours or greater.
- Each time an employee assists by adjusting their regularly scheduled hours by 4 hours or greater. Example: an employee scheduled to work 14:30-02:30 adjusts to work 18:30-0630.
- Responding to CMED after a page from the supervisor for immediate assistance needed. This may include but not limited to severe weather events, an employee on duty that needs to leave as a result of a family emergency or illness. The 4 hour or greater requirement does not apply to this type of an event.
- Peak Hour shift adjustments that accumulate 4 hours. i.e., 08:30-20:30. 12:30-00:30. Example: 12:30-00:30 shift adjusts or stays over for 2 hours twice.

Coverage Guidelines:

Steps To Obtain **Immediate Coverage:**

- Check “Shift Pick up” tab in ePro to see if anyone has signed up to be available for the shift needing coverage. If no one has signed up to be available, typically the employee nearest the top of the *Voluntary Mandatory* list should be contacted first.

- Check to see if those working are interested in staying over or can assist in another way.

- Send a CMED all call page for the hours needed.

- Call employees from the *Voluntary Mandatory* list. Direct the first person contacted. Instruct the employee to report at a specified time.

- Repeated attempts should be made to get an off duty employee for coverage.

- If no one is available, employees on duty will be utilized. The supervisor will use the *Voluntary Mandatory* list to direct on duty employees for coverage. The first employee to be directed will stay over from their current shift. If another employee is needed and instructed to leave and return, they will not be assessed benefit time for lost hours, but may be required to return for a 16 hour shift.

  Examples may include but not limited to the following:

  - An employee staying over for preferably a maximum of 16 consecutive hours. Example: an employee working 06:30-18:30 may be directed to stay until 22:30. An employee working 18:30-06:30 may be directed to stay until 10:30.

  - An employee may be directed to leave and return at a specified time. There should preferably an 8 hour gap from the time the employee leaves and returns for work. Example: an employee working 06:30-18:30 may be directed to leave at 14:30 and return at 22:30. An employee working 18:30-06:30 may be directed to leave at 02:30 and return at 10:30.

Steps To Obtain Advanced Coverage:

- Check “Shift Pick up” tab in ePro to see if anyone has signed up to be available for the shift needing coverage.
- Typically the employee nearest the top of the *Voluntary Mandatory* list will be contacted first.
- Check to see if those working are interested in assisting.
- Send a CMED all call page for the hours needed.
- Repeated attempts should be made to obtain a volunteer. If no one is available, employees on duty will be utilized or those scheduled to work prior to the day in need. The supervisor will use the *Voluntary Mandatory* list to mandate employees for coverage. Example: coverage is needed for Saturday 06:30-18:30, an employee working Wednesday 06:30-18:30 will likely be told they have been assigned to work 06:30-18:30 on Saturday. This **may include** but not limited to the following:
    - An employee working their scheduled day off as overtime.
    - An employee given a scheduled workday off in place of working the mandated day, no overtime.

**Typically, shifts with the same hours will be responsible for assisting the other shift. For example, A shift nights will primarily be responsible for assisting B shift nights and vice versa. A shift days will primarily be responsible for assisting B shift days. Switching day shift employees to night shift and vice versa will be done so as a last resort.

Voluntary Sign up (Wanting to work)

Employees may voluntarily sign up one month in advance by signing their name in the schedule book. This will be a non-committal sign up. Should multiple people sign up, it will be the supervisor’s discretion as to who to call. Typically the employee nearest to the top of the *Voluntary Mandatory* list will be contacted first. Employees who routinely sign up, but are unable to work when contacted may lose this privilege.

Directing an Employee to Work

As a last resort, the supervisor will issue a directive to an employee. This will be done so from the *Voluntary Mandatory* list. The employee nearest the top of the list will be contacted or receive a shift reassignment as the need dictates.

- Employees who are given a shift reassignment should receive a 48 hour notice in **most** circumstances; however, a 48 hour notice will not always be possible.

Refusing a Directive

Refusing a directive is considered insubordination and will be referred to the CMED Lead Supervisor and/or Operations Manager-Communication for action up to and including termination.

Process for Requesting the use of Accrued Vacation/Holiday Leave:

***Due to operational needs each department may differ with vacation approvals. All employees must consult with their department supervisor, manager or director for specific departmental policy prior to making plans for time off*.

All requests for vacation or holiday leave are to be submitted in ePro software. Vacation and holiday leave benefits may be requested up to 180 days (**for Communications) in advance from the date the request in being made. Benefit requests made prior to the 180 days in advance will be DENIED.

Benefit requests received within 2(two) hours of the employee's scheduled start of work time WILL be denied. Any exception to 2 (two) hour minimum notice must be due to extraordinary circumstances and will be reviewed by Lead Supervisor/Operations Manager –Communications on a case-by-case basis.

Maximum Number of Consecutive Hours Worked:

The maximum number of hours that can be worked consecutively is 16. However, this may be extended at the Lead Supervisor and/or Operations Manager - Communications discretion.

Maximum Number of 12-Hour Shifts Worked:

The maximum number of **12-hour shifts** that can be worked consecutively is 4 (12 on, 12 hours off between shifts). However, a 5th day may be approved at the Lead Supervisor and/or Operations Manager - Communications discretion.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Continuing Education**

Purpose: To provide clarification to Agency Policy as it applies to Communications with regard to Continuing Education.

Employees must meet the training requirements set by the Agency. (It is required the Communications personnel receive twenty-four (24) hours of training per calendar year. This requirement meets North Carolina's minimum standards for EMD and EFD certifications.

A schedule listing of all educational programs will be made in advance of the event.

- A tentative schedule for In-Service will be emailed to all employees and posted well in advance of the specified In-Service dates.
- Employees are required to attend the In-Service scheduled on their regularly scheduled day off unless otherwise approved in advance by the Communications Manager or Communications Lead Supervisor.
- Any change to the In-Service schedule will be made at least two (2) weeks in advance when able to do so. Communications Personnel will be notified of the change via email at least two (2) week prior to the new In-Service date whenever possible.

In-Service is considered "scheduled work" for the purpose of attendance. Agency Attendance Policy applies and attendance occurrence point(s) will be assessed.

The Agency will make available all continuing education necessary to maintain certifications required for employment. However, the responsibility to attend Continuing Education is the employee's. In the event that an employee misses scheduled continuing education, it is their responsibility to make up the continuing education hours. Make up classes and topics will be made available at the discretion of the Communications QI/Training Supervisor.

Communications employees are required to wear designated uniforms as determined by current uniform policy for all In-Service/Continuing Education classes.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team
SUBJECT: **Electronic Devices**

Personal Electronic Devices

Cell phones must be kept on silent or vibrate in the Communications Center. Answering or returning calls on a cell phone **must** be done so outside of the Communications Center. This policy applies to on and off duty personnel.

Employees may lose their use of personal electronic device (inclusive of phones, laptops or any other electronic device) privilege should the item interfere with job performance. This may be enforced at the discretion of the CMED Operations Supervisor, CMED Assistant Operations Supervisor on duty, CMED Lead Supervisor or Operations Manager-Communications and may be enforced at the individual, team or Center levels at any time deemed necessary.

TV Channel restrictions

Authorized channels include any 24-hour news channels and the weather channel during regular business hours. Regular business hours are considered as Monday – Friday, 0800-1700. The Supervisor may override any restrictions at any time dependent upon material in violation of Agency Standards of Behavior. Employees should be mindful of both TV volume and conversation volume within the room due to the sensitivity of mic's on headsets as they may possibly pick up a large amount of background noise.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team
SUBJECT: **Visitors**

Any visitor in CMED must be pre-approved by the CMED Lead Supervisor, Operations Manager-Communications or any Deputy Director. In addition, it is strictly prohibited for an individual, not employed by the Agency, to answer telephone lines (911 OR 7-digit/ring down), transmit on the radio system, enter data in CAD or perform any other Communications activity. Authorized visitors are to function in an observation only role. Former employees (in good standing with no prior history of conduct issues) who wish to visit may do so at approval of CMED Lead Supervisor or Operations Manager-Communications but should only do so between the hours of 0800-1700 Monday thru Friday. Any observer should also be pre-approved and scheduled in advance, though some exceptions may occur. Examples of those who may observe are CHS Residents, CFD/CMPD Telecommunicators, County First Responders, etc. The same restrictions apply as above in regards to answering telephone lines, transmitting on the radio system, entering CAD data or performing any other Communications activity. Authorized observers are to function in an observation only role.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team
SUBJECT: **Cleaning Duties**

Kitchen Area

- Dishes, glasses, cups, etc. should not be left in the sink. They should be either washed and put away or placed in the dishwasher when finished.

- The countertops should be wiped down, especially around the coffee maker area, periodically during the shift.

- The microwave should be cleaned after each use.

- The Sunday night team will be responsible for a detailed cleaning of the microwave. The refrigerator will also be cleaned out every Sunday night. All employees should remove their personal food items at the end of their two day or weekend rotation. Items such as liquid coffee creamer, salad dressings, etc. that the employee wishes to save longer than this period of time, should clearly be marked with their name and have a visible expiration date.

Main Communications Area

- Each workstation shall be cleaned at the end of each shift.

- All newspapers, books, personal items, etc. shall be stored either in a drawer at your workstation or in a locker. The surface of each workstation should remain as clear and clean as possible. Also, cleaning supplies should be stored out of sight.

- CMED personnel will be responsible for vacuuming the Communications area. This will be the responsibility of the night shift and should be done daily.

- The Sunday night team should also be responsible for cleaning monitor screens and keyboards as well as areas around and under the monitors, telephone equipment, etc.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: Hospital Diversion/Redistribution

Any phone calls or faxes regarding diversion or redistribution at a local hospital facility should be referred to the CMED Operations Supervisor ASAP.
Upon being notified by a facility that the facility is diverting patients, CMED Operations Supervisor shall obtain the following information (same information should be on any fax received from a facility reference diversion/redistribution):

- Name, title and call back number of the individual making the notification.
- Type of diversion and any specifics, i.e. 'facility at capacity and only accepting CPR in progress/airway compromise, Code STEMI, Code COOL".
- Estimated duration (if available).

Following this notification, the Supervisor shall page all on duty units (to include Mint Hill) using the command line "PAC" function and advise of any specifics from the facility.

MEDIC and Mint Hill crews shall be notified again via alpha paging once the Diversion/Redistribution is lifted.

ISSUED: April 1, 2015 REVISED: April 1, 2015
APPROVED: March 8, 2015 BY: Operations Management Team
SUBJECT: **Non-hospital staff requests for response to Mecklenburg County Hospitals**

The following Guidelines are for processing 9-1-1 requests for service by individuals (visitor, patient, non-hospital staff) requesting response **inside** any Mecklenburg County Hospital**.

This guideline **excludes requests for services outside of the hospital, i.e. in parking lots and decks, physician offices separate from hospital facilities, etc.

Procedure:

- Call Taker should enter the request for service into CAD and initiate an **ALPHA (non-emergency) response** and should utilize MPDS as appropriate. The call taker should inquire of the caller if hospital assistance has been initiated (contact made with closest nurses' station, reception desk or any other hospital employee).

- Controller should assign and dispatch the non-emergency response as appropriate (no First Responder).

- **Response level should remain Alpha (non–emergency).** Controller should also complete radio notification of on duty **Field Operations Supervisor** regarding the incident simultaneous with unit assignment.

The CMED team member working MEC-OPS-3 should initiate a radio transmission with the hospital Emergency Department. CMED should advise the ED of the following:

- Advise the ED that MEDIC has been requested, via 91-1, to respond within the healthcare facility and that MEDIC is responding NON-EMERGENCY.

- Advise ED of the location of the incident (as specific as possible)

- Advise ED of the Chief Complaint for the incident (Chest pain, Cardiac arrest, etc.).

- Request that the ED notify their "House Supervisor" of the 9-1-1 request within their facility and of Medic's non-emergency response.

- Inquire as to whether or not MEDIC should cancel their response.

If MEDIC does cancel their response to the facility, please ensure the call taker advises the caller that the facility will have someone responding to assist with their emergency and advise the caller MEDIC is cancelling their response. As long as call volume dictates, the call taker should remain on the phone with the caller until someone from the facility is **with** the patient.

If the hospital ED is contacted and the ED advises CMED that they **do NOT** have anyone available to respond internally to the incident, the following should take place:

- MEDIC should continue to respond non-emergency.
- Attempts should be made to locate the department, floor nurses' station or reception desk closest to the patient, based on the information obtained from the caller.
- Once we are able to speak to someone near the patient, confirm that they (hospital) are aware of our non-emergency response to the facility and confirm they are requesting MEDIC to continue responding.
- Obtain the name of the individual you are speaking with and their title with the hospital facility.

CMED Operations Supervisor (or designee) should also email Deputy Director–Operations and CMED Lead Supervisor with the incident number, any response specifics and outcome.

ISSUED: April 1, 2015 REVISED: November 21, 2017
APPROVED: March 8, 2015

SUBJECT: **Air Medical Transport Dispatch**

Air Medical Transport may be dispatched at the request of CMED or any of the following:

- Any first responder physically present on the scene of the incident.
- A member of the responding EMS crew enroute or on the scene.
- The Medical Director, on-duty Operations Supervisor, or Administrative staff personnel.

The following information will be provided to MedCenter Air (MCA) at the time of the request:

- Incident Location (street/intersection location) and latitude/longitude coordinates.
- Nature of the incident.
- Radio identifier of the fire unit to contact for Landing Zone (LZ) information.

CMED personnel shall accept and relay requests for dispatch only. In situations where units request "availability" of or request the helicopter be placed on "stand-by", CMED should consider these as an actual **dispatch of flight service**.

The LZ Incident Officer on the scene has sole authority for communicating with and directing the landing zone for the helicopter.

All radio traffic for flight service operations will be on "CMC-LZ-1", "CMC-LZ-2", or "V-LZ-WEST".

Once the request for Air Medical Transport has been made it can only be cancelled by the following:

- EMS Unit Crew Chief after patient evaluation.
- The Medical Director, on-duty Operations Supervisor, or Administrative staff personnel.

An on duty Field Operations Supervisor shall be notified for **ALL** helicopter requests. This includes notification of requests when MCA is not available or is unable to respond (i.e. weather).

Chapter Seven

Response Configuration / Notifications

ISSUED: May 1, 2015 REVISED: May 1, 2015
APPROVED: April 21, 2015 BY: Operations Management Team
SUBJECT: **Active Violence Incident Response**

Purpose: To establish Initial Assignment for response to an Active Violence Incident (AVI) as defined in the Joint Agency Active Violence Incident Plan.

Active Violence Incident (AVI) – Incidents where any armed person has used or is using deadly physical force on other persons in public and continues to do so while having unrestricted access to additional victims. Active shooter and active assailant incidents are examples of an active violence incident.

Dispatch Configuration:

- 1 Ambulance Strike Team (AST)
  - 1 Field Operations Supervisor
  - 5 ALS Ambulances
- 1 MCI unit (M701)
- 1 Ambulance Bus (M702 or M703)
- 1 Additional Field Operations Supervisor
- 1 Supervisor Special Operations (S108)

Notification (if not already assigned to incident)

Deputy Directors Group

Operations Managers Group

Field Operations Supervisor Group

Special Operations Group

SWAT Group

Public Information Officer

ISSUED: May 1, 2015 REVISED: May 1, 2015
APPROVED: April 21, 2015 BY: Operations Management Team
SUBJECT: **Aircraft Emergency ALERT II**

Purpose: To establish Initial Assignment for response to an ALERT II – Aircraft Incident.

Dispatch Configuration:

- 1 MCI Unit (1 ALS unit if MCI unit unavailable)
- 1 Operations Supervisor (closest)

Optional:

- 1 Ambulance Bus (Staffing dependant)

Appendix A

Miscellaneous Forms

Vehicle Maintenance Notification

Place in 'Forms' Section

Purpose: To improve the reliability and comfort of the vehicles you operate every day through improved reporting to Fleet Maintenance.

Directions: Please complete this form at the end of your shift and deliver to the OA who will assure that Fleet Maintenance is notified.

How did your vehicle perform today?

_____ ***Normal and without any noted mechanical problems or issues***

_____ ***Unit has mechanical issues or needs as identified below (Describe)***

Unit #_____ CC: _____ / NCC_____ Date/Time_____

List a phone number and best time to call you if fleet has questions: _____

Category	Good	Problem	Define Problem or Symptoms
Engine			
Transmission			
Suspension (ride) *(Circle One)* Front or Rear?			
Steering			
Brakes			
Tires			
Electrical			
A/C or **Heaters** *(Circle One)* **Front** or **Rear**?			
Lights			
Equipment			

Vehicle Accident Report

March 2011

VEHICLE ACCIDENT REPORT FORM

Date/Time of Accident: _____ Location: _____

Driver: _____ Date of Hire Title: _____

Driver's License #: _____ State Issued: _____ Phone: _____

Unit #: _____ Year/Make: _____ Part/s Damaged: _____

Driver's Previous Preventable Accidents/Dates _

Driver's Description of Accident: _____

Were emergency lights and/or sirens in use? Weather/Road Condition:

INJURY INFORMATION

Any Injuries: If Yes, Patient / Passenger/Self Taken To: _____

Injured Name: _____ Nature of Injury: _____

Injured Name: _____ Nature of Injury: _____

Injured Name: _____ Nature of Injury: _____

ADDITIONAL PASSENGER INFORMATION

(Agency Vehicle)

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Estimate Received - Total Estimate: _____

Additional Information

_____

_____

_____

_____

PREVENTION

Driver Retraining - Coaching - Other Corrective Measures : _____

Type of Retraining to Take Place and When:

_____

_____

Was This Accident Preventable :

Why: _

_____

_____

WITNESS INFORMATION

Witness Name:_____

Witness Name: _____ Phone #: _____

Witness Name: _____ Phone #: _____

USE THE AREA BELOW TO DRAW A DIAGRAM OF ACCIDENT SCENE

Police Report ____ _____ Officer Name: _____

** Attach all information prior to forwarding this report (photos, supplemental information etc.) to the Risk and Safety Office **

Reporting ____ ___ _____ **Date:** _____
Print

Reporting Supervisor _____ **Phone:** _____
Signature

Lost and Damage Report

Date: _____ Incident Date: _____

CC / TL _____ NCC _____

Vehicle # _____ Report # _____

Call # _____ Police Report (if applicable) _____

Critical Equipment Failure? Y □ N□ Transport Delayed? Y□ N□

Estimated Time Delay _____ During Response? Y□ N□ Transport? Y□ N□

Item (Lost) or (Damaged) _____

Explanation:_____

_____

_____

_____

Crew Name _____ Signature _____ Date _____

Crew Name _____ Signature _____ Date _____

OST Name _____ Signature _____ Date _____

Supervisor Notified (Name) _____ at (time) _____

Person notifying Supervisor _____

Notified by: Phone □ *-or-* In person □ Followed up via email? Y□ N□

Item: Recovered □ *-or-* Replaced □ **Issue Closed Y□ N□**

Investigating Supervisor_____ Date _____

When any equipment is reported lost or damages, the reporting person must make direct contact with an Operations Supervisor. This supervisor becomes responsible for this Lost and Damaged report and the report will be directed to this supervisor. The responsible supervisor

may refer this Lost and Damaged report to another supervisor. The initial supervisor must make proper notification to the supervisor to whom the report is referred. The responsible supervisor will complete the Lost and Damaged report and include what actions were taken to replace or recover items as well as their opinion of fault. The form will be routed to;

- **IT for computer equipment**

Whom Notified _____ Time Notified _____

Date Notified _____ Method Notified _____

- **Support Services for any ambulance equipment**

Whom Notified _____ Time Notified _____

Date Notified _____ Method Notified _____

- **CMED for radio equipment.**

Whom Notified _____ Time Notified _____

Date Notified _____ Method Notified _____

- **SOTS for uniform equipment**

Whom Notified _____ Time Notified _____

Date Notified _____ Method Notified _____

- **Fleet for anything related to posts.**

Whom Notified _____ Time Notified _____

Date Notified _____ Method Notified _____

MEDIC
Mecklenburg EMS Agency

PHILIPS MRx Monitor

Philips Cardiac Monitor Lost and Damage Report

Date:_____ **Employee Name: _____**

Incident Number: _____ **Monitor Number: _____**

Battery Numbers: _____

Explanation of failure or problem:

_____

_____

_____

_____

Was monitor attached to patient: (Yes) or (No)

Was patient care affected by failure: (Yes) or (No) If Yes briefly explain how:

_____

_____

_____

Supervisor Notified: _____ **Monitor turned in to: Supervisor, OA or Logistics**

Receiving Signature: _____ **Crew Chief Signature: _____**

Support Services Only **Critical Failure (Yes) or (No)**

Issue Type

__ BA __ COM __ HRD__ CPR __ DEF __ EKG

__ EM __ ET __ LL __ MEM __ PCA __ POU

__ POW __ PR __ SP __ THC __ TRC __ VL

Service Desk # _____ **Monitor Serial #: _____**

Philips Case #: _____

MEDIC Field Operations Supervisor Shift Report

Date : **Shift Time:**
Reporting Field Operations Supervisor:

Problems related to **Medic Stations**
Information related to **Service inquiries**
Demo / Dedicated Medical Stand-by information
Vehicle Accidents - reports and notifications
OJI and Exposure-reports and notifications
Critical Unit and Equipment Failures

Positions to be filled:

See Schedule

Other Issues and information for the on-coming Field Operations Supervisor:

Comments

* *

Crew members/CMED made aware of changes in Assignment for Shifts?
_____

Relief Field Operations Supervisor Keys turned over? _____

Were Supervisor **Narcotics**, **Camera** and **Pager** Turned Over?
_____

Off-Going Field Operations Supervisor: _____ Date: _____ Time: _____

On-Coming Field Operations Supervisor: _____Date: _____ Time: _____

Write any additional comments on back of form

This page intentionally left blank.

Appendix B

Additional Policy Reference

Additional Policies located on intranet (My Medic)

Agency Accident Policy

Agency Handbook

Agency PPE Policy

Ergonomics

Respiratory program

Vehicle Operations Policy

Appendix M

MCI Plan

MASS CASUALTY INCIDENT MANAGEMENT PLAN

CHARLOTTE-MECKLENBURG COUNTY, NORTH CAROLINA

09102008.2mwsF

PREFACE

This manual is published by Mecklenburg EMS Agency and is intended as the primary reference and standard operating guideline for response, training, and guidance of emergency medical, fire, and rescue personnel in the management of mass casualty incidents.

This plan is purposely structured to work in concert with the Charlotte-Mecklenburg All Hazard Plan, the North Carolina Office of EMS, Region F Disaster Plan, and the Emergency Department Disaster Plans for the Carolina's Medical Center (Charlotte region's Level I Trauma Center) and Presbyterian Hospital.

All Agency employees that will be involved in the management of an incident must complete the following FEMA online coursework:

IS-100 (ICS 100) Introduction to the Incident Command System, I-100
IS-200 (ICS-200) ICS for Single Resources and Initial Action Incidents
IS-700 National Incident Management System (NIMS), an Introduction

Agency senior staff and supervisors that will be involved in the management of an incident must complete the following additional FEMA coursework:

IS-300 (ICS-300) Intermediate Incident Command System
IS-400 (ICS-400) Advanced Incident Command System
IS-800.B The National Response Framework, An Introduction

INCIDENT COMMAND SYSTEM

The command function must be clearly established from the beginning of incident operations. The agency with primary jurisdictional authority over the incident designates the individual at the scene responsible for establishing command. When command is transferred, the process must include a briefing that captures all essential information for continuing safe and effective operations.

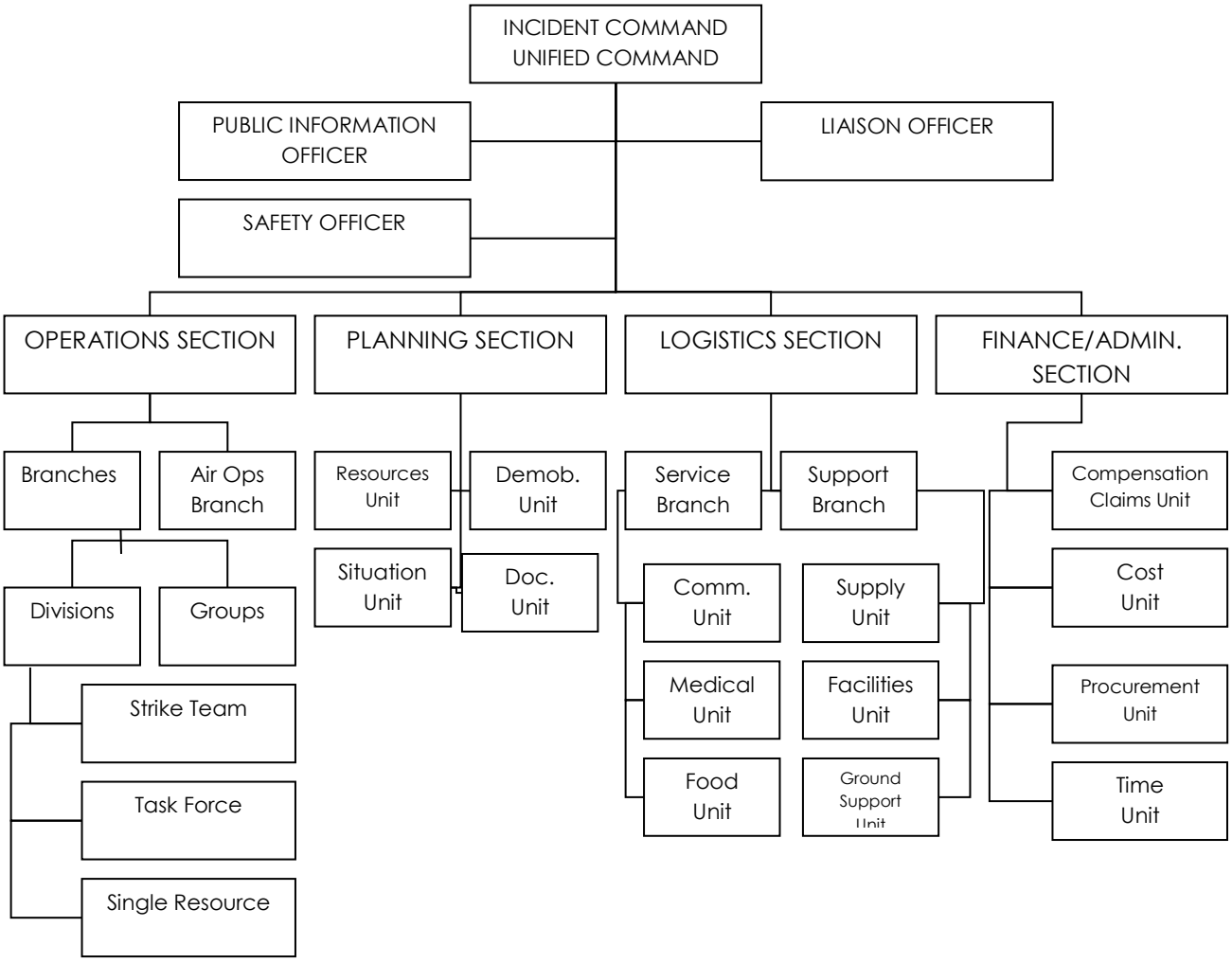
In incidents involving multiple jurisdictions, a single jurisdiction with multiagency involvement, or multiple jurisdictions with multiagency involvement, unified command allows agencies with different legal, geographic, and functional authorities and responsibilities to work together effectively without affecting individual agency authority, responsibility, or accountability.

The Charlotte-Mecklenburg All Hazard Plan requires the use of a Unified Command for incident management.

Unified Command (UC) is an important element in multiagency domestic incident management. It provides guidelines to enable agencies with different legal, geographic, and functional responsibilities to coordinate, plan, and interact effectively. As a team effort, UC overcomes much of the inefficiency and duplication of effort that can occur when agencies from different functional or levels of government, operate without a common system or organizational framework. All agencies with functional responsibility for any or all aspects of an incident and those able to provide specific resource support participate in the UC structure and contribute to the process of determining overall incident strategies; selecting objectives; ensuring that joint planning for tactical activities is accomplished in accordance with approved incident objectives; ensuring the integration of tactical operations; and approving, committing, and making optimum use of all assigned resources. The exact composition of the UC structure will depend on the location(s) of the incident (i.e., which geographical administrative jurisdictions are involved). In the case of some multijurisdictional or multi-agency incidents, the designation of a single Incident Commander (IC) may be considered to promote greater unity of effort and efficiency. The additional agency representatives shall be designated as Deputy Incident Commanders and be fully capable to assume the Incident Commander role upon a change in the incident.

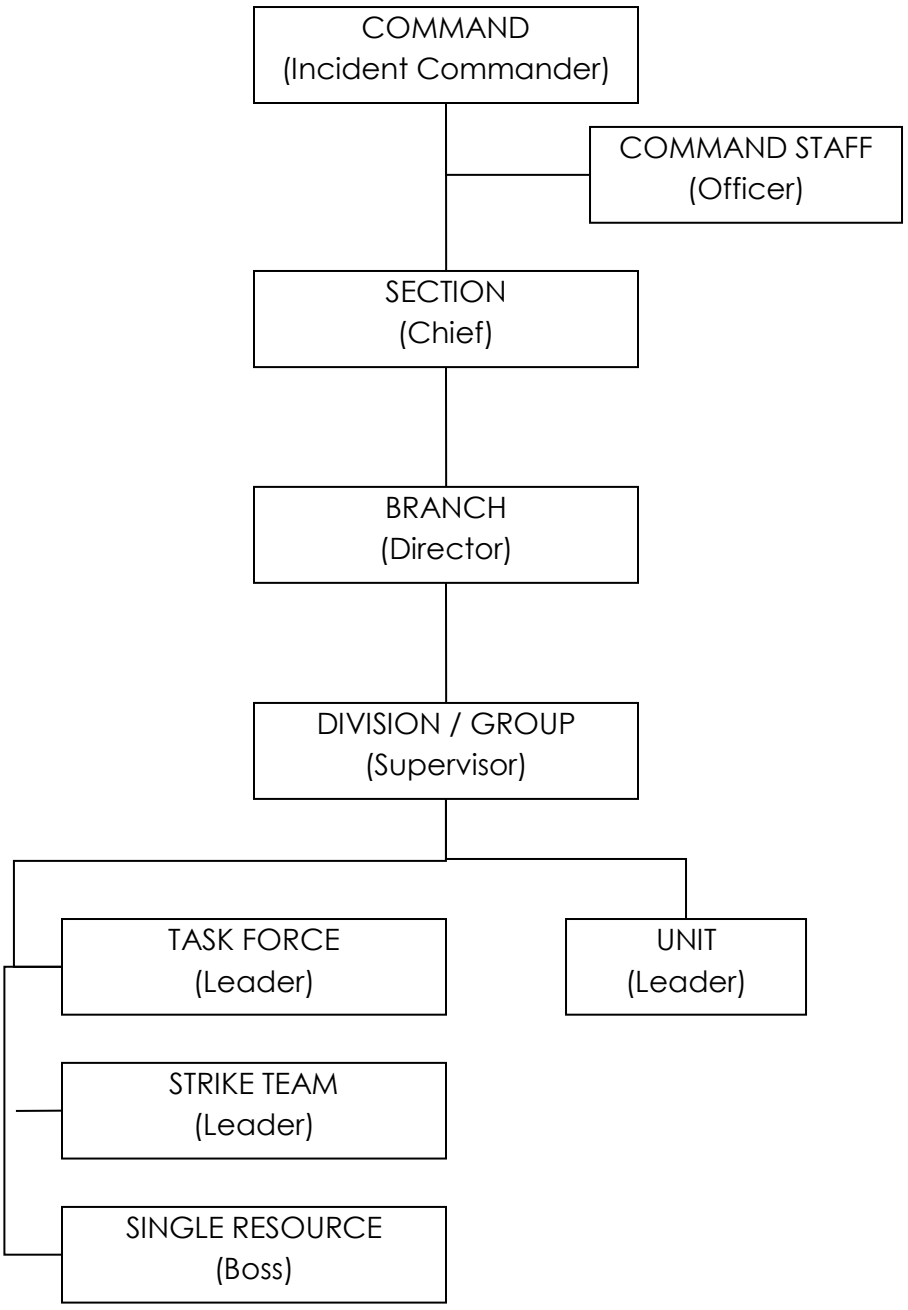
Advantages of Using Unified Command

- A single set of objectives is developed for the entire incident
- A collective approach is used to develop strategies to achieve incident objectives
- Information flow and coordination is improved between all agencies involved in the incident
- All agencies with responsibility for the incident have an understanding of joint priorities and restrictions
- No agency's legal authorities will be compromised or neglected
- The combined efforts of all agencies are optimized as they perform their respective assignments under a single Incident Action Plan (IAP)



ICS Organizational Components

POSITION and (Title) ICS structure under NIMS



SCOPE AND PURPOSE

This Mass Casualty Incident (MCI) Management Plan is intended to address techniques in field operations that must be employed when the number of patients exceeds immediately available resources. In addition, it serves as the basis for routine operations. The key elements for successfully managing any incident are command, control, and coordination.

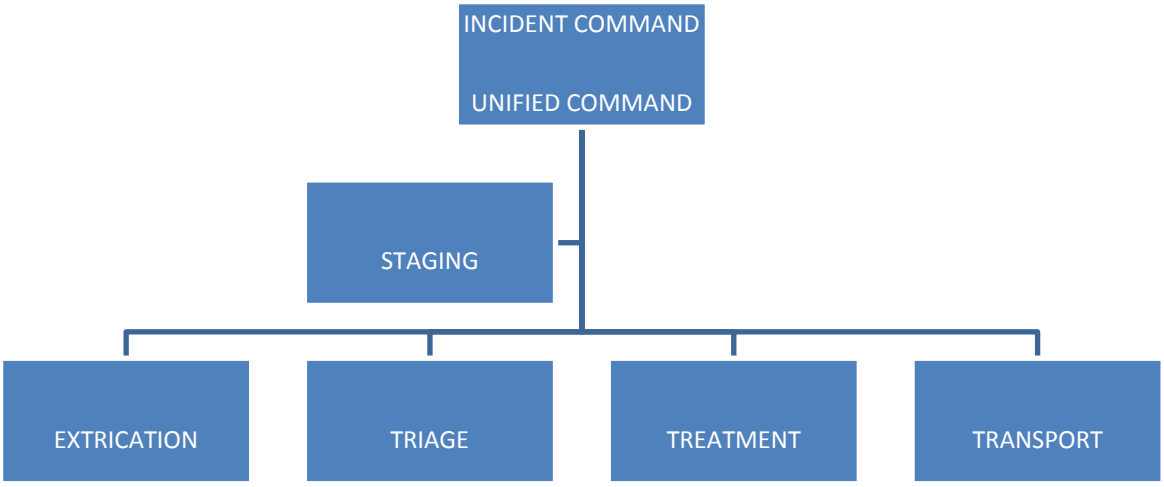
This plan standardizes operations during mass casualty incidents. It is intended to be an "all hazards" plan to meet the needs of any MCI regardless of the incident's cause. If necessary, these procedures can be modified based on the number of patients, the cause or severity of injuries, and for special circumstances involved in the incident.

Mass Casualty Incidents response will initially be determined by the number of patients. The first arriving unit (fire, rescue, or EMS) will, as part of the initial size up, estimate what EMS resources will be needed based on the categories below.

- **MCI Level 4** (3-10 Priority 1 [red]/Priority 2 [yellow] victims)
  - 5 Ambulances
  - 12 First Responder personnel (3 CFD companies)
  - 1 EMS Supervisor
- **MCI Level 3** (11-20 [regardless of priority] victims)
  - 10 Ambulances
  - 20 First Responder personnel (5 CFD companies)
  - 2 EMS Supervisors
  - 1 MCI unit (Medic 701)
  - 1 MCET Bus (Medic 702 **or** 703)
- **MCI Level 2** (21-100 [regardless of priority] victims)
  - 15 Ambulances
  - 36 First Responder personnel (9 CFD companies)
  - 3 EMS Supervisors
  - 1 MCI Unit (Medic 701)
  - 2 MCET Buses (Medic 702 and 703)
- **MCI Level 1** (101-1000+ [regardless of priority] victims)
  - 20 Ambulances
  - 52 First Responder personnel (13 CFD companies)
  - 5 EMS Supervisors
  - 1 MCI Unit (Medic 701)
  - 2 MCET Buses (Medic 702 and 703)

MCI Level 4 (3-10 Priority 1 [red]/Priority 2 [yellow] victims)

At a small incident involving just a few patients, COMMAND may also assume the MEDICAL and the STAGING functions.

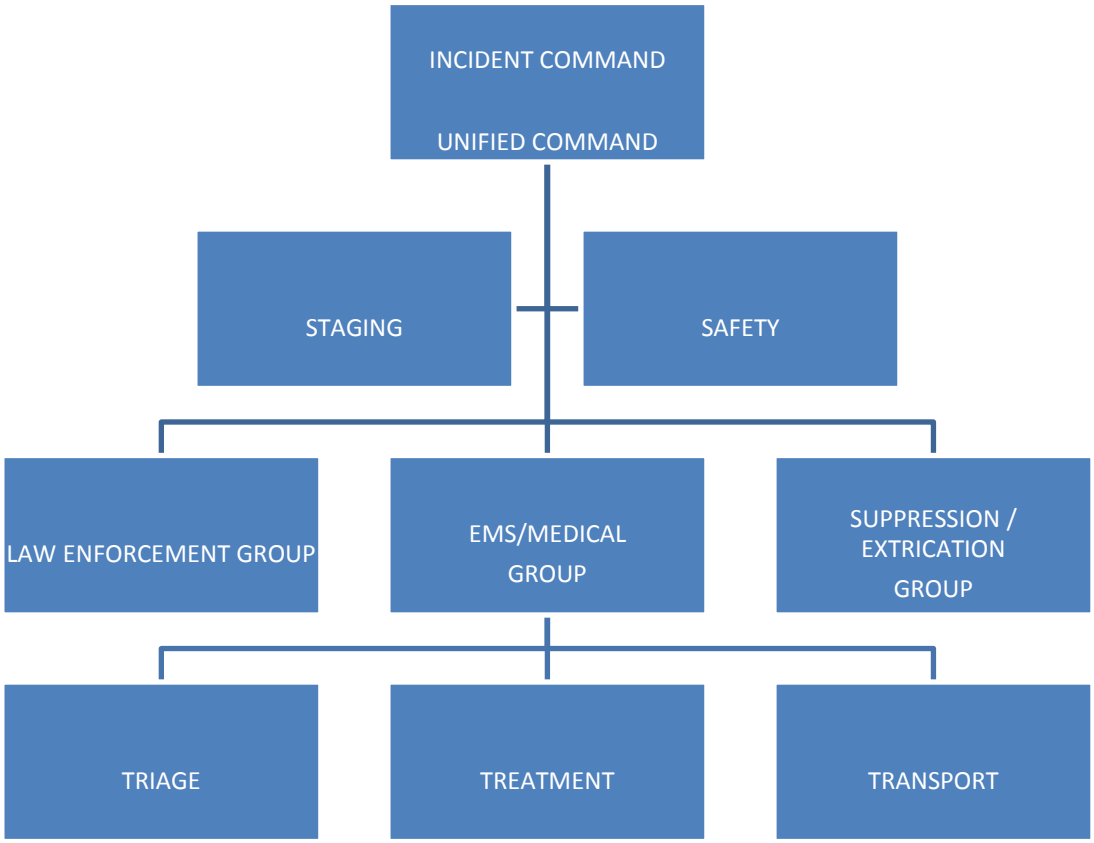


This depicts a typical response to a small incident.

This scale of incident can be managed by an incident commander and the designated functions of STAGING, EXTRICATION, TRIAGE, TREATMENT, and TRANSPORTATION. In a small incident, one person may assume more than one function, i.e. TRIAGE and TREATMENT may be done by the same person or TRANSPORTATION and STAGING can be handled by the same person. As trained MCI management personnel become available, these positions should be filled. As the incident unfolds, the command structure must expand.

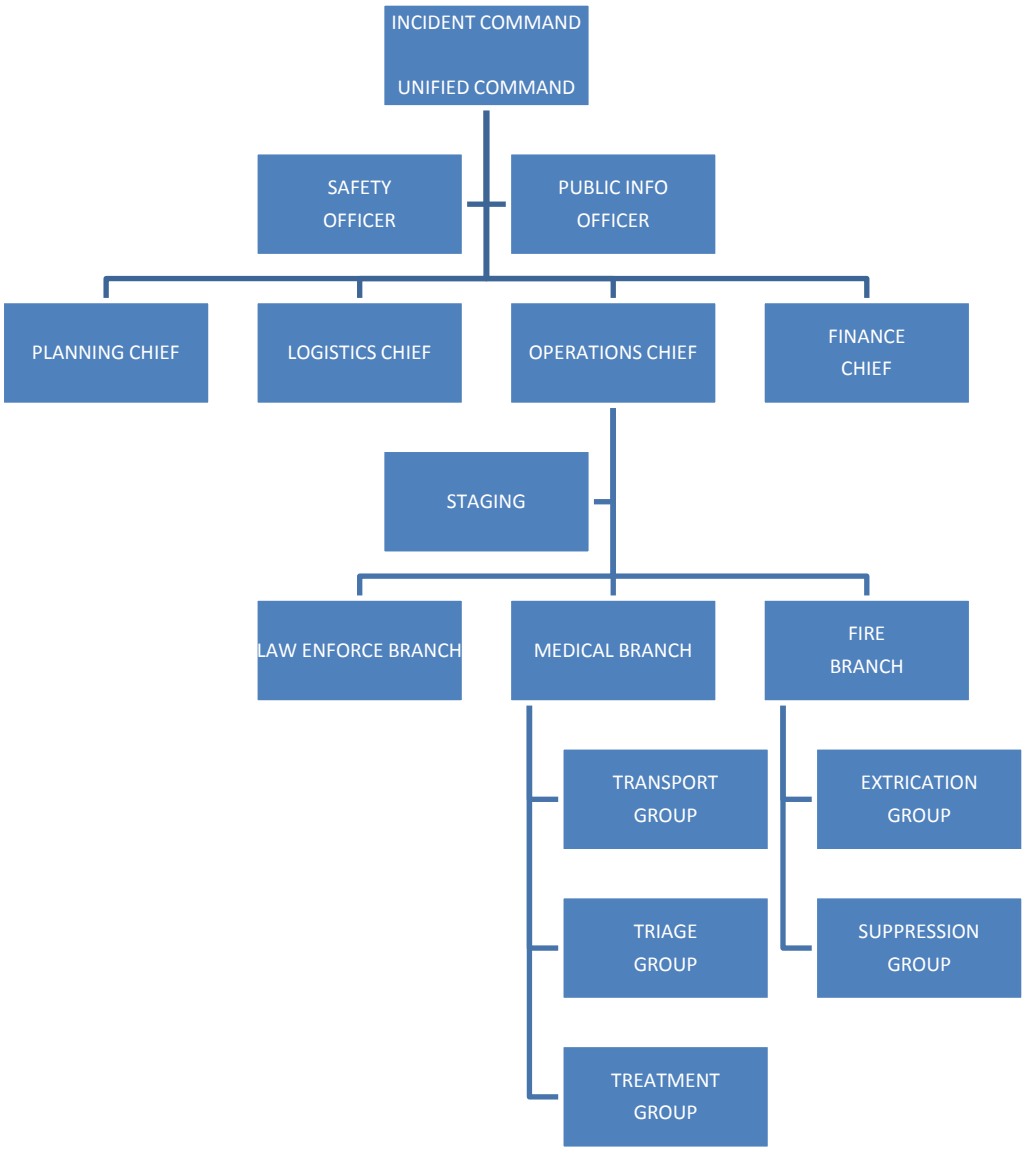
MCI Level 3 (11-20 [regardless of priority] victims)

At expanded/extended medical incidents, the INCIDENT COMMANDER or OPERATIONS SECTION CHIEF would appoint someone to manage the “MEDICAL” function.
This chart depicts a larger or expanded medical incident with a fully deployed medical group.



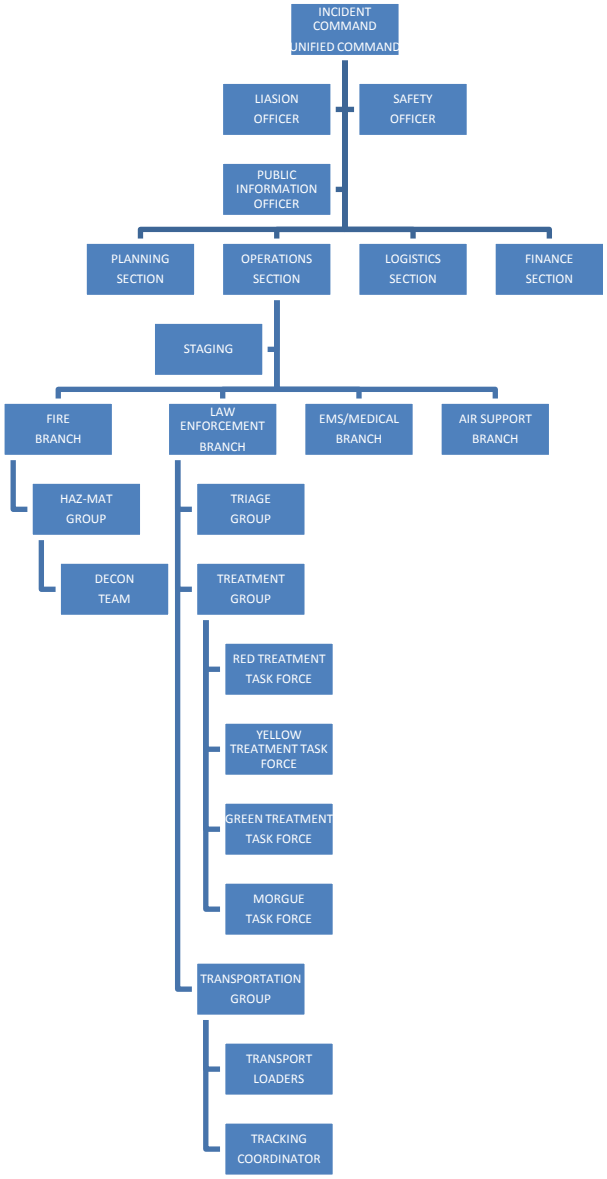
MCI Level 2 (21-100 [regardless of priority] victims)

An even larger or major medical incident may require the addition of functions such as PLANNING, LOGISTICS, and FINANCE. This may be dictated by incidents covering large areas or of extended duration. This chart depicts a major medical incident.



MCI Level 1 (100-1000+ [regardless of priority] victims)

In the event of a medical disaster involving greater than one hundred patients, the command structure would expand to look like the chart below. This allows for components from outside Mecklenburg County to fill standardized functions. This also allows for proper management of the incident.



Concept of MCI Levels

In an effort to make this document compliant with the National Incident Management System (NIMS), MCI Levels have been integrated to allow for scalability. Depending upon time of day and day of the week, Mecklenburg EMS Agency (MEDIC) may be capable of managing larger numbers of patients without mutual aid from outside EMS Agencies.

Single resources will be requested from dispatch (CMED) and told to report to staging, where they may be assembled into larger resources.

This leaves the Incident Commander or the Operations Chief to manage the number of Ambulances assembled. As patients are transported, units should be directed by the Transport Group on whether they should clear the hospital then return to staging or clear and return to the system. The capacity to assemble Strike Teams will be limited by available resources and by the time needed to deploy them. The Incident Commander must practice scarce resource management. State and Federal resources should be requested as soon as their need is identified.

EMS efforts in a mass casualty incident will begin small and expand to meet the needs of the incident. The first arriving unit (fire, rescue, or EMS) should establish Incident Command. That unit should assess scene **Safety**, conduct a scene **Size-up** and **Send** that information to communications over the radio, then begin to **Set up** (triage and treatment areas), and **START** Triage. This will ensure that Staging, Triage, Treatment, and Transportation functions are implemented as needed. In a larger incident, Incident Command may establish a Medical Group or Medical Branch to oversee some or all of the above functions.

Some incidents may be so large, or the sense of danger so pervasive (such as a terrorist incident), that victims may not wish to remain on the scene and will self-refer to known medical facilities. During such incidents, EMS triage and treatment resources may have to be co-located at hospitals, assembled at multiple points, and/or situated remotely out of harm's way.

Communications (CMED) Responsibilities

Once the first arriving unit (Fire, EMS, or Rescue) establishes command and declares an MCI, CMED will dispatch the appropriate resources for the level of MCI declared based on the response matrix guide (see attachment to this plan).

CMED will also multi-select all the Mecklenburg County hospital talkgroups and establish communications with each hospital. Upon verification that all hospitals are monitoring, CMED will announce that an MCI has been declared, giving the MCI level and size up information from the first arriving unit. CMED will then advise all hospitals to be prepared to advise the approximate number of patients by priority that their facility can handle when they are recalled. Here is an example of the hospital notification:

"CMED to all Mecklenburg County hospitals, this is a level 3 MCI notification, I repeat a level 3 MCI notification. Units are currently on the scene of a traffic accident involving 14 vehicles; no further information is available at this time. Units on scene have declared a level 3 MCI. In approximately five minutes, be prepared to advise the number of patients by priority that your facility can handle. CMED will contact you on the radio to obtain this information shortly. No further information is available at this time, CMED clear".

CMED should then contact each hospital individually on their talkgroup to obtain their information. This should be recorded on the hospital tally sheet (attachment to this plan). Once all hospitals have reported their information, CMED should notify the EMS GROUP / BRANCH (if none then COMMAND) that hospital information is available. Someone will then be assigned to collect the information from CMED.

For hospitals that are not operating on a radio talkgroup (currently Gaston Memorial, CMC-Union, Lake Norman Regional, Piedmont Medical, and CMC-Northeast) CMED should notify them via telephone of the incident and request they contact CMED with the information needed as soon as possible.
By having communications announce and collect this important information, it allows the resources on the scene to focus on proper management of the MCI.

As an incident grows in size, CMED should be prepared to utilize additional operations channels for specific functions. There may be a need for a command channel, a triage and treatment channel, as well as a transport channel. Each incident will dictate the need for additional talkgroups.

Hospital Responsibilities

When notified of an MCI, hospital personnel should refer to this guidebook as a source for information on the number of potential victims. Hospitals should follow their disaster plans based on the information provided.

Communications (CMED) will contact each hospital; they will not be able to provide *detailed information*. They will only be able to provide a brief incident description. Hospital personnel must follow the instructions provided by CMED and should take no longer than five minutes to gather the information that is requested. Someone should remain at the radio or phone in case further information is provided or needed to assist with the proper response to the incident in progress.

Each hospital will be contacted when a unit departs the scene with a patient enroute to their location. This contact will not be made by the unit transporting (unless specific medical orders are required). You will get a brief report of the patient's primary complaint and priority by the Tracking Coordinator position (TRACKING) who is located at the incident scene.

Hospitals must ensure a quick transfer of the patient from the ambulance to the hospital so that the unit can return to service as quickly as possible.

BASIC PRINCIPALS

Mass Casualty Incident Management Goals

1. **Do the greatest good for the greatest number.**
2. **Make the best use of personnel, equipment, and facility resources.**
3. **Do not relocate the disaster.**

Standard Triage Methods

The method of initial field triage to be utilized is the **START** (Simple Triage and Rapid Treatment) method for adult patients. Pediatric patients, ages 8 and under, will be better served by using **JumpSTART**.

Ambulatory patients are initially directed to a designated treatment area where they will be assessed and secondary triage performed as personnel become available. For all remaining patients, triage personnel quickly move from patient to patient, using **START** to apply color-coded triage tags.

Triage Categories

PRIORITY 3 Green Triage Tag Color

- Victim with relatively minor injuries
- Status unlikely to deteriorate over days
- May be able to assist in own care: "Walking Wounded"

PRIORITY 2 Yellow Triage Tag Color

- Victim's transport can be delayed
- Includes serious and potentially life-threatening injuries, but status not expected to deteriorate significantly over several hours

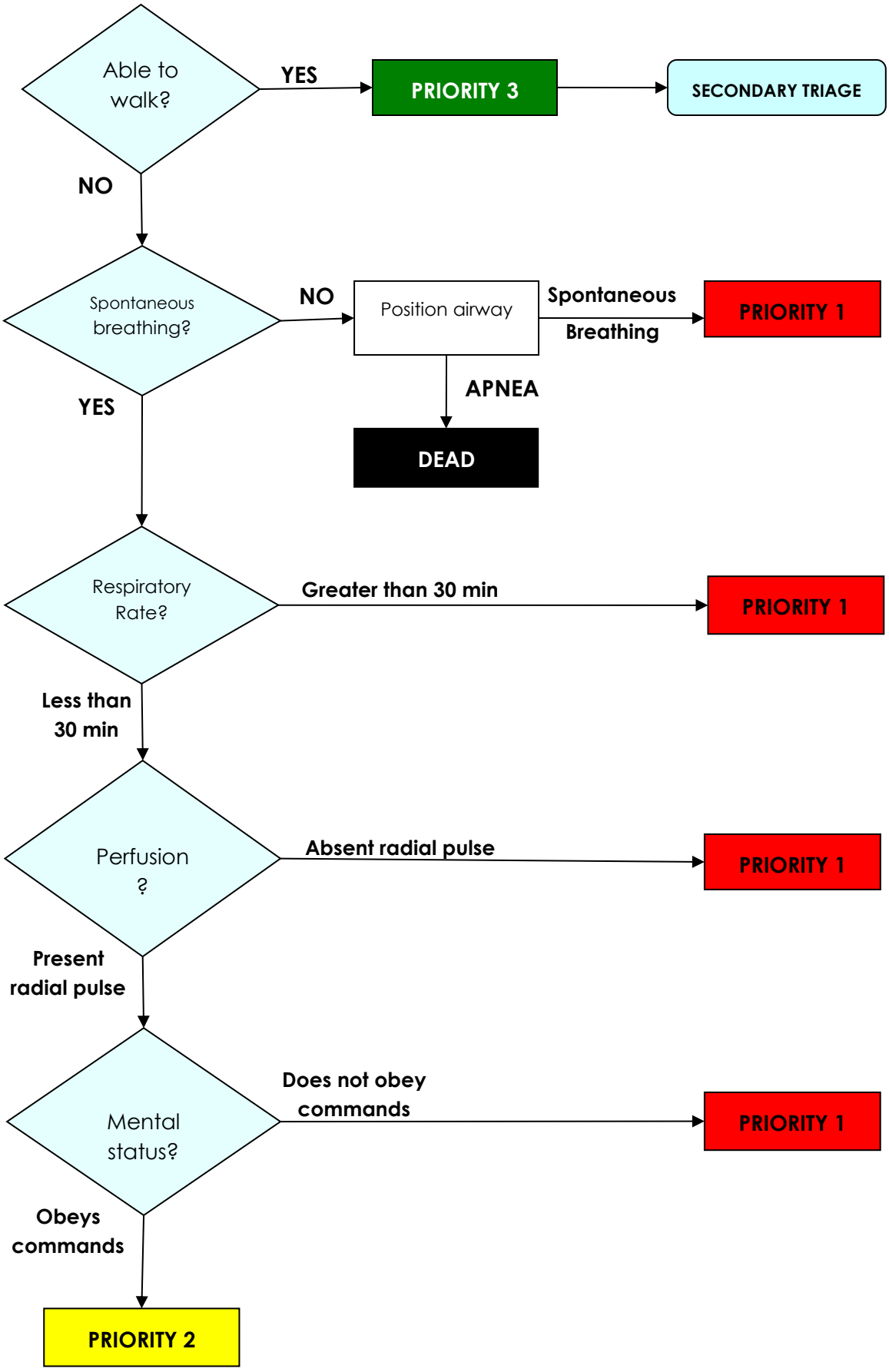
PRIORITY 1 Red Triage Tag Color

- Victim can be helped by immediate intervention and transport
- Requires medical attention within minutes for survival (up to 60)
- Includes compromises to patient's Airway, Breathing, Circulation

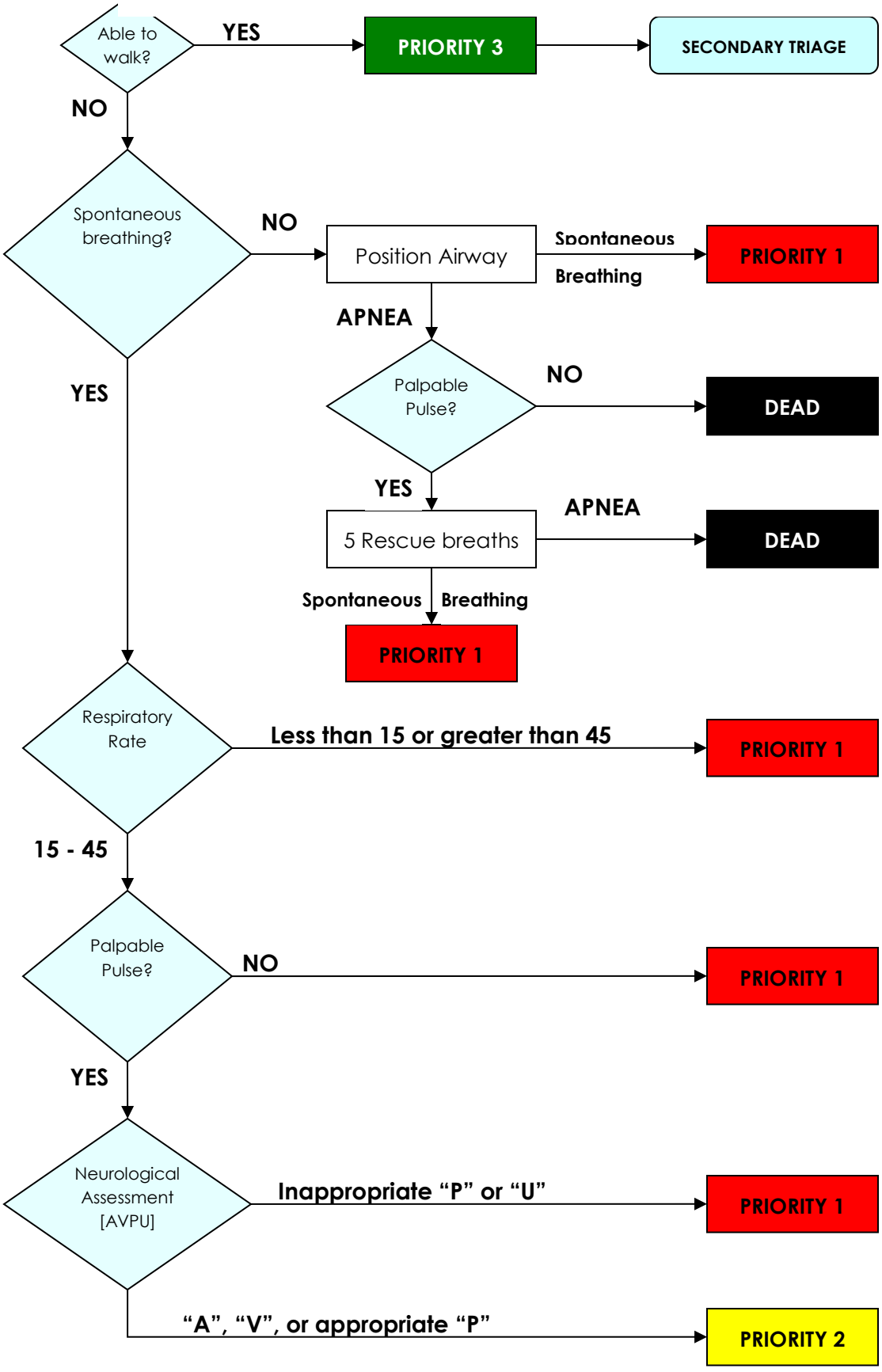
DEAD Black Triage Tag Color

- Victim unlikely to survive given severity of injuries, level of available care, or both
- Palliative care and pain relief should be provided

START Multiple Casualty Triage



JumpSTART Multiple Casualty Triage



Mass Casualty Patient Flow

The Incident Scene

Ambulatory patients are directed to a safe place as soon as one is identified.
(Green Treatment Area)

- Those who are able should be asked to assist with others.
- Self treatment supplies should be distributed.

All victims are accounted for; trapped victims are rescued or extricated.

- Patients are accounted for and quickly triaged (**START**).
- Triage tags are applied.

Non-ambulatory patients are removed from the scene to the Treatment Area by triage personnel after triage has been completed.

Patients are decontaminated (as needed) prior to leaving the incident scene, prior to arrival in the Treatment Area.

Deceased victims are left as they are unless they must be moved to access live patients.

The Treatment Area

Patients are continuously reevaluated (re-triaged) using the secondary triage method.

Patients arriving from the incident scene are prioritized for treatment using the SMARTTAG© **secondary triage** method and the triage tag is updated if needed.

Patients are placed in the Treatment Area and emergency medical care is provided on the basis of the triage priority.

- Separate areas may be created in the Treatment Area for PRIORITY 1 (RED), PRIORITY 2 (YELLOW), and PRIORITY 3 (GREEN) patients.
- A separate isolated area (Temporary Morgue) is created for victims who die in the Treatment Area. This area should not be visible and must not be located near the PRIORITY 3 treatment area.

Personnel, equipment, and medical care resources are allocated to patients based on triage priority.

The Transportation Area

Emergency Departments are contacted (early in the incident by communications) to obtain information to assist with the most appropriate patient distribution to medical facilities.

Transportation resources are assigned based on triage priority.

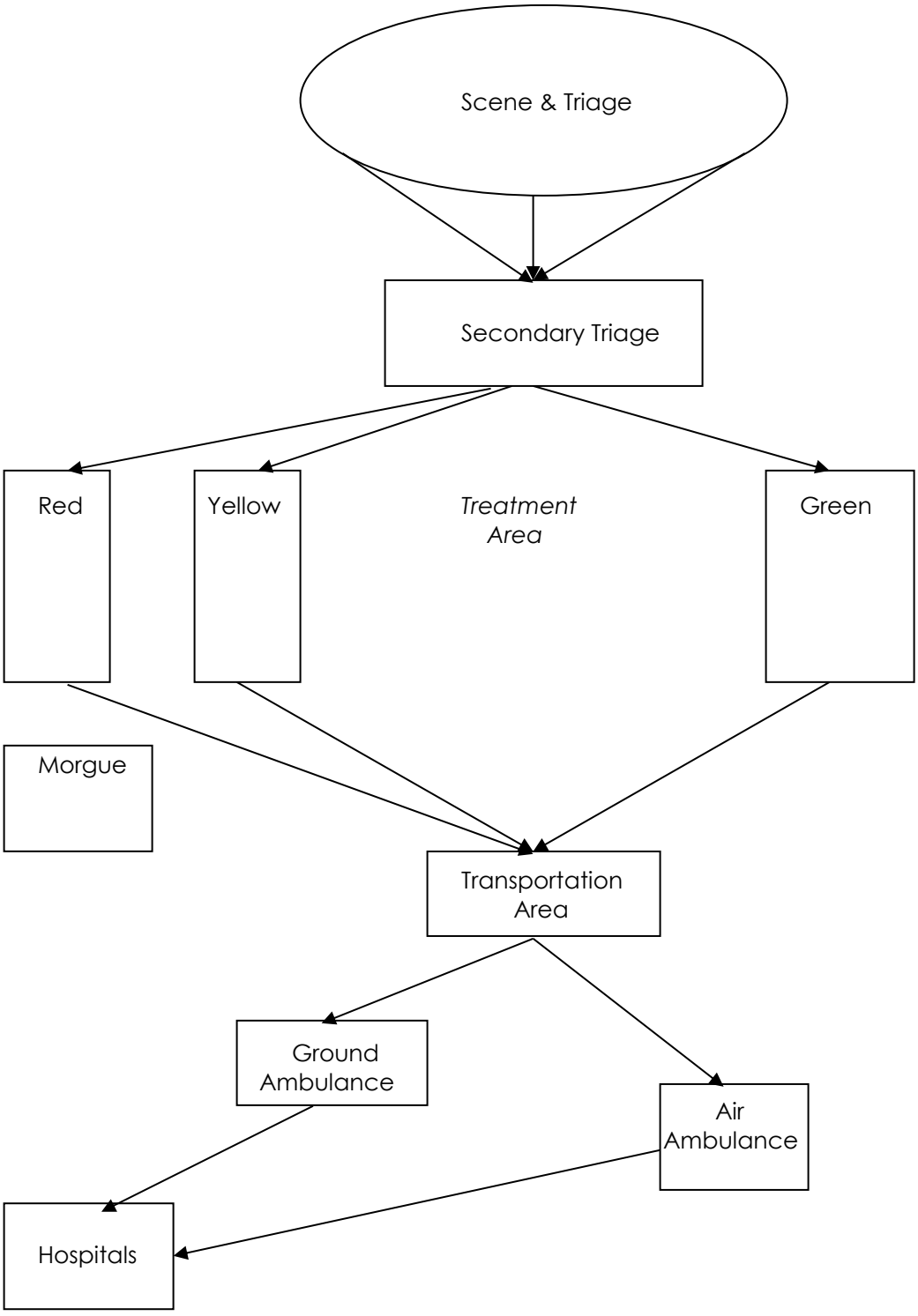
Patients are moved to the Transportation Area to the appropriate vehicle by Transport Loaders.

The Tracking Coordinator is established to provide patient priority, type, and estimated time of arrival to destination hospitals. Units transporting patients from the incident **will not** give patient reports to their destination facility.

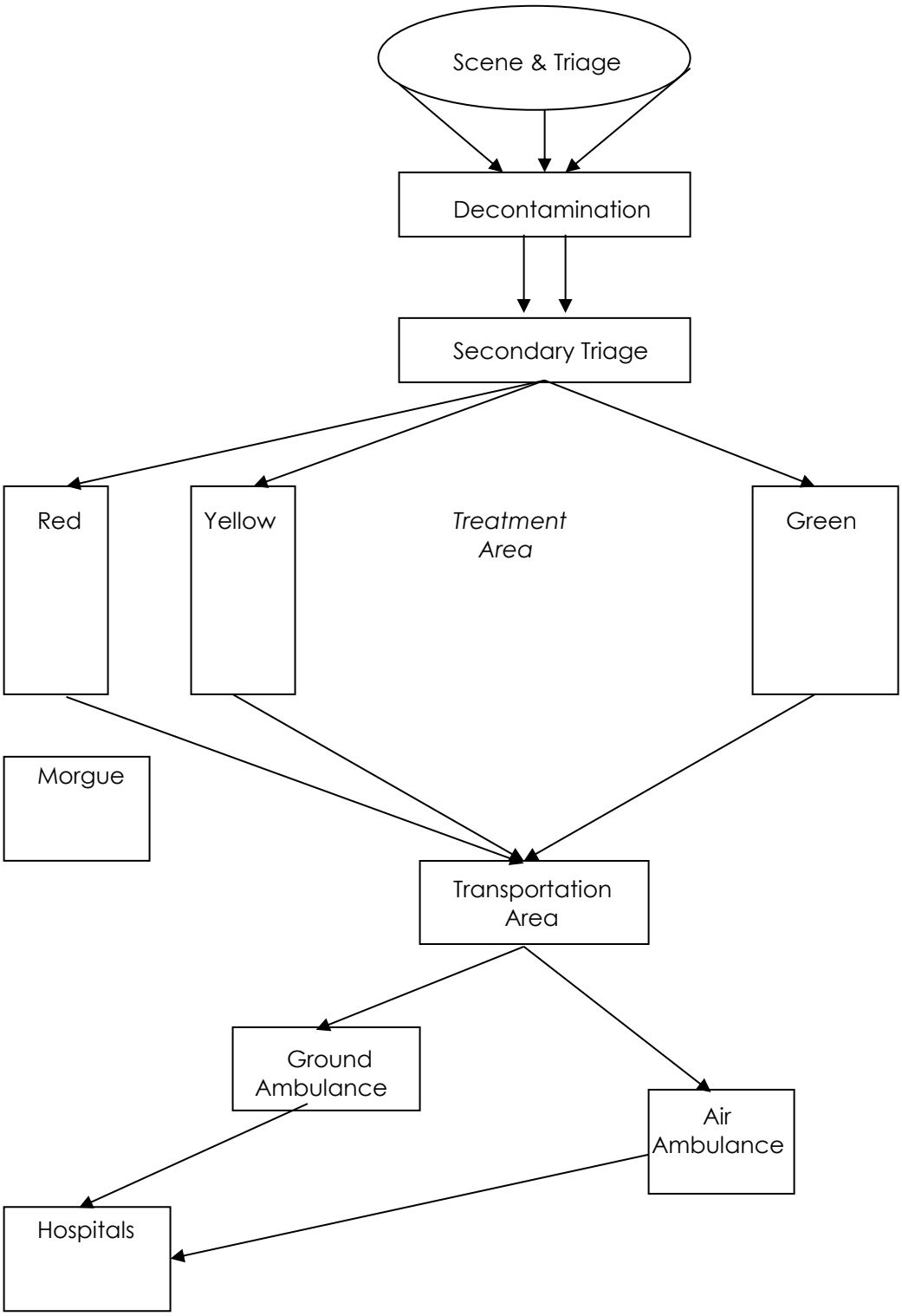
Patients are transported to the most appropriate medical facility by the most appropriate means available. Emergency medical care is continued enroute to the hospital.

All patient movements are documented. A patient care report must be started for each patient that is transported. The identification number from the SMARTTAG© triage tag should be entered in the appropriate location on the patient care report. Demographics and patient care documentation can be entered at a later time provided they are documented on the SMARTTAG© triage tag.

Patient Flow Diagram



Contaminated Patient Flow Diagram



FIRST AGENCY ON SCENE
(FIRE, RESCUE, OR EMS)

First Agency on scene should switch from the role of care giver and provide incident management. They then give a visual size-up, assume and announce command, and confirm the incident location, then the 5 S's:
[Once command has been established, all additional resources must get their assignment from the INCIDENT COMMANDER]

SAFETY assessment: Assess the scene observing for:

- Electrical hazards.
- Flammable liquids.
- Hazardous Materials.
- Weapons of Mass Destruction (CBRNE)
- Other life threatening situations.
- Be aware of the potential for secondary explosive devices.

SIZE UP the scene: How big and how bad is it? Survey incident scene for:

- Type and/or cause of incident.
- Approximate number of patients.
- Severity level of injuries (either Major or Minor).
- Area involved, including problems with scene access.

SEND information:

- Contact dispatch with your size-up information.
- Request additional resources.

SETUP the scene for management of the casualties:

- Establish staging area.
- Identify access and egress routes.
- Identify adequate work areas for Triage, Treatment, and Transportation.

START (**S**imple **T**riage **A**nd **R**apid **T**reatment) and **JumpSTART** (for pediatric patients).

- Begin where you are.
- Ask anyone who can walk to move to a designated area.
- Use triage tags to mark patient priority.
- Move quickly from patient to patient.
- Maintain patient count by triage color.
- Provide minimal treatment.
- Keep moving!

Remember…. Establish COMMAND, **S**AFETY, **S**URVEY, **S**END, **S**ET-UP, AND **START/JumpSTART**
Command should be transferred upon the arrival of a more qualified person. This can be done via radio or by a face to face meeting.

Key Terms and Definitions

Advanced Life Support (ALS): When referring to an ambulance from outside Mecklenburg County, operating at the EMT-Intermediate level and above. Mecklenburg County ambulances would be EMT-Paramedic level.

Ambulance: A vehicle capable of transporting patients from the scene. It could be BLS or ALS depending upon staff supplied.

Assessment: The evaluation and interpretation of measurements and other information to provide a basis for decision-making.

Assignments: Tasks given to resources to perform within a given operational period that are based on operational objectives defined in the IAP.

Assistant: Title for subordinates of principal Command Staff positions. The title indicates a level of technical capability, qualifications, and responsibility subordinate to the primary positions. Assistants may also be assigned unit leaders.

Available Resources: Resources assigned to an incident, checked in, and available for a mission assignment, normally located in a Staging Area.

Basic Life Support (BLS): When referring to an ambulance, EMT-Basic level only.

Branch: The organizational level having functional or geographical responsibility for major aspects of incident operations. A branch is organizationally situated between the section and the division or group in the Operations Section, and between the section and units in the Logistics Section. Branches are identified by the use of Roman numerals or by functional area (Medical Branch, Fire Branch, Law Enforcement Branch).

Chain of Command: A series of command, control, executive, or management positions in hierarchical order of authority.

Check-In: The process through which resources first report to an incident. Check-in locations include the incident command post, Resources Unit, incident base, camps, staging areas, or directly on the site.

Chief: The ICS title for individuals responsible for management of functional sections: Operations, Planning, Logistics, Finance/Administration, and Intelligence (if established as a separate section).

Command: The act of directing, ordering, or controlling by virtue of explicit statutory, regulatory, or delegated authority.

Command Staff: In an incident management organization, the Command Staff consists of the Incident Command and the special staff positions of Public Information Officer, Safety Officer, Liaison Officer, and other positions as required, who report directly to the Incident Commander. They may have and assistant or assistants, as needed.

Demobilization Unit Leader: This ICS position reports to the Planning Section Chief and oversees demobilization of non-essential resources once released by the Operations Section Chief back to the staging area.

Deputy: A fully qualified individual who, in absence of a superior, can be delegated the authority to manage a functional operation or perform a specific task. In some cases, a deputy can act as relief for a superior and, therefore, must be fully qualified in the position. Deputies can be assigned to the Incident Commander, General Staff, and Branch Directors.

Division: The partition of an incident into geographical areas of operation. Divisions are established when the number of resources exceeds the manageable span of control of the Operations Chief. A division is located within the ICS organization between the branch and resources in the Operations Section.

Engine Company: A Fire apparatus consisting of firefighters one of which is assumed to be qualified as a company level officer. In an MCI event the Engine Company can expect to be used both as manpower and to perform patient care to their level of training. There should be an expectation that they will be broken up into Individual Resources at the discretion of Command.

Function: Function refers to the five major activities in ICS: Command, Operations, Planning, Logistics, and Finance/Administration. The term function is also used when describing the activity involved, e.g., the planning function. A sixth function, Intelligence, may be established, if required, to meet incident management needs.

General Staff: A group of incident management personnel organized according to function and reporting to the Incident Commander. The General Staff normally consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief, Finance/Administration Section Chief, and Intelligence Section Chief.

Group: Established to divide the incident management structure into functional areas of operation. Groups are composed of resources assembled to perform a special function not necessarily within a single geographic division. Groups, when activated, are located between branches and resources in the Operations Section.

Hazard: Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome.

Incident: An occurrence or event, natural or human-caused, that requires an emergency response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, wildland and urban fires, floods, hazardous material spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response.

Incident Action Plan: An oral or written plan containing general objectives reflecting the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods.

Incident Command Post (ICP): The field location at which the primary tactical-level, on-scene incident command functions are performed. The ICP may be collocated with the incident base or other incident facilities and is normally identified by a green rotating or flashing light.

Incident Command System (ICS): A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

Incident Commander (IC): The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site.

Initial Action: The actions taken by those responders first to arrive at an incident site.

Initial Response: Resources initially committed to an incident.

JumpSTART Triage: A system that allows field care personnel to triage pediatric patients aged 1-8 years into one of four categories:
Priority 1 (RED), Priority 2 (YELLOW), Priority 3 (GREEN), Dead (BLACK)

Ladder Company: For the purposes of this document, see Engine Company.

Liaison Officer: A member of the Command Staff responsible for coordinating with representatives from cooperating and assisting agencies.

Logistics Section: The section responsible for providing facilities, services, and material support for the incident.

Multi-Casualty Incident: An incident in which the combination of numbers of injured victims and type of injuries go beyond the capability of an entity's normal first response.

Operational Period: The time scheduled for executing a given set of operation actions, as specified in the Incident Action Plan (IAP). Operational periods can be of various lengths, although usually not over 24 hours.

Operations Section: The section responsible for all tactical incident operations. In ICS, it normally includes subordinate branches, divisions, and/or groups.

Personnel Accountability: The ability to account for the location and welfare of incident personnel. It is accomplished when supervisors ensure that ICS principles and processes are functional and that personnel are working within established incident management guidelines.

Planning Section: Responsible for the collection, evaluation, and dissemination of operational information related to the incident, and for the preparation and documentation of the IAP. This section also maintains information on the current and forecasted situation and on the status of resources assigned to the incident.

Public Information Officer: A member of the Command Staff responsible for interfacing with the public and media or with other agencies with incident-related information requirements.

Rescue Company: For the purposes of this document, see Engine Company. Sometimes referred to as a Squad.

Resources: Personnel and major items of equipment, supplies, and facilities available or potentially available for assignment to incident operations and for which status is maintained. Resources are described by kind and type and may be used in operational support or supervisory capacities at and incident.

Resource Unit Leader: This ICS position works for the Planning Section Chief and tracks all resources on the scene. When additional resources are ordered, the Incident Commander shall notify the Planning Section Chief who will advise the Resource Unit Leader so tracking of these resources can be established once they arrive on scene.

Safety Officer: A member of the Command Staff responsible for monitoring and assessing safety hazards or unsafe situations and for developing measures for ensuring personnel safety.

Secondary Triage: The patients GCS score, Respiratory rate, and Systolic Blood Pressure as outlined on the SMART tag. The total of the scores places the patient into triage categories.

Section: The organizational level having responsibility for a major functional area of incident management, e.g., Operations, Planning, Logistics, Finance/Administration, and Intelligence (if established). The section is organizationally situated between the branch and the Incident Command.

Situation Unit Leader: This ICS position reports to the Planning Section Chief and is responsible for the collection of information to provide the Incident Commander with the most up to the minute situational awareness.

SMART Tag: Triage tag system adopted for statewide use by the North Carolina Office of Emergency Medical Services. Utilizing START and JumpSTART methods of initial patient triage as well as a secondary triage system.

Span of Control: The number of individuals a supervisor is responsible for, usually expressed as a ration of supervisors to individuals. (Under NIMS, an appropriate span of control is between 1:3 and 1:7).

Staging Area: Location established where resources can be placed while awaiting a tactical assignment. The Operations Section manages Staging Areas.

START Triage: acronym for Simple Triage And Rapid Treatment. This is the initial triage system that has been adopted for use by Mecklenburg EMS Agency that allows field care personnel to triage patients greater than 8 years of age into one of four categories:
Priority 1 (RED), Priority 2 (YELLOW), Priority 3 (GREEN), Dead (BLACK)

Strike Team: A set number of resources of the same kind and type that have an established minimum number of personnel lead by a single leader. Strike Teams should be designated by their function. (Extrication Strike Team)

Task Force: Any combination of resources assembled to support a specific mission or operational need. All resource elements within a Task Force must have common communications and a single leader. Task Forces should be designated by their function. (Treatment Task Force)

Unified Command (UC): An application of ICS used when there is more than one agency with incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the UC, often the senior person from agencies and/or disciplines participating in the UC, to establish a common set of objectives and strategies and a single IAP. There is one Incident Commander designated from the discipline with the highest current priority, the remaining representatives will assume the role of Deputy Incident Commanders and be fully capable to assume the Incident Commander role when the situation changes in scope or needs.

Unit: The organizational element having functional responsibility for a specific incident planning, logistics, or finance/administration activity.

Unity of Command: The concept by which each person within an organization reports to one and only one designated person. The purpose of unity of command is to ensure unity of effort under one responsible commander for every objective.

Weapons of Mass Destruction: A weapon which can kill large numbers of humans and/or cause great damage to man-made structures, natural structures, or the biosphere in general. The term covers several weapons types, including Chemical, Biological, Radiological, Nuclear, and Explosive. (CBRNE)

POSITION: **MEDICAL or EMS**

LEVEL (TACTICAL CALLSIGN):

BRANCH DIRECTOR	**(MEDICAL BRANCH) (EMS BRANCH)**
GROUP SUPERVISOR	**(MEDICAL GROUP) (EMS GROUP)**

PERSONNEL ASSIGNED: EMS Supervisor (preferred), Paramedic, EMT, Firefighter

FUNCTION: Establish supervision and direct the activities within a medical group or branch at a multi-casualty incident (MCI)

REPORTS TO: OPERATIONS
(*if none then*)
COMMAND

SUPERVISES: TRIAGE, TREATMENT, TRANSPORT

DUTIES:

- Don Position Vest
- Read this duty checklist
- Assess and report situation
- Order needed resources through OPERATIONS
- Monitor Operations/Command Channel
- Establish Medical Communications on Secondary Channel if needed
- Assume roles until assigned
  - TRIAGE
  - TREATMENT
  - TRANSPORT
- Collect all records from incident and forward to designated Mecklenburg EMS Agency staff

POSITION: **TRIAGE**

LEVEL (TACTICAL CALLSIGN):

TEAM	**(TRIAGE)**
GROUP SUPERVISOR	**(TRIAGE GROUP)**

PERSONNEL ASSIGNED: EMS Supervisor, Paramedic (preferred), EMT, Firefighter

FUNCTION: Coordinate Evaluation, Triaging, and Movement of patients from the incident scene to the treatment area.

REPORTS TO: MEDICAL or EMS
(if none then)
OPERATIONS
(if none then)
COMMAND

SUPERVISES: TRIAGE

DUTIES:

- Don Position Vest
- Read this duty checklist
- Assess and report situation
- Establish Triage Area
- Establish teams to triage, package, and move patients to the treatment area.
- Keep chain of command informed regarding number and extent of injured.
- Collect all records from incident and forward to designated Mecklenburg EMS Agency staff

POSITION: TREATMENT

LEVEL (TACTICAL CALLSIGN):

TEAM	**(TREATMENT)**
GROUP SUPERVISOR	**(TREATMENT GROUP)**

PERSONNEL ASSIGNED: EMS Supervisor (preferred), Paramedic, EMT, Firefighter

FUNCTION: Coordinate treatment of triaged patients in the treatment area.

REPORTS TO: MEDICAL or EMS
(if none then)
OPERATIONS
(if none then)
COMMAND

SUPERVISES: TREATMENT

DUTIES:

- Don Position Vest
- Read this duty checklist
- Assess and report situation
- Request needed resources and supplies
- Establish treatment teams
  - RED (Priority 1)
  - YELLOW (Priority 2)
  - GREEN (Priority 3)
- Keep chain of command informed as to the number of patients in treatment
- Collect all records from incident and forward to designated Mecklenburg EMS Agency staff

POSITION: **TRANSPORT**

LEVEL (TACTICAL CALLSIGN):

TEAM	**(TRANSPORT)**
GROUP SUPERVISOR	**(TRANSPORT GROUP)**

PERSONNEL ASSIGNED: EMS Supervisor (preferred), Paramedic, EMT, Firefighter

FUNCTION: Coordinates loading and disposition of **all patients** from the scene

REPORTS TO: MEDICAL or EMS
(if none then)
OPERATIONS
(if none then)
COMMAND

SUPERVISES: Transport Loaders, Tracking Coordinator, and all Units being used for transport

DUTIES:

- Don Position Vest
- Read this duty checklist
- Assess and report situation
- Establish patient loading area
- Advise chain of command on best access for transport units
- Obtain hospital availability from communications (C-MED)
- Assign Transport recorder if needed
- Assign MEDCOM position if needed
- Assign unit to transport destination and maintain transportation log
- Request patients from TREATMENT
- Request additional transport equipment from chain of command
- Advise chain of command and all hospitals when all patients have been transported
- Collect all records from incident and forward to designated Mecklenburg EMS Agency staff

POSITION: TRACKING COORDINATOR

LEVEL
(TACTICAL CALLSIGN): **RESOURCE** **(TRACKING)**

PERSONNEL ASSIGNED: EMS Supervisor, Paramedic, EMT (preferred),Firefighter

FUNCTION: Handles all scene to hospital radio traffic for Transportation Group, handles all radio traffic between Transport resources and Transport Group

REPORTS TO: TRANSPORT

SUPERVISES: none

DUTIES:

- Don Position Vest
- Read this duty checklist
- Monitor Medical operations channel
- Contact hospitals as each transport unit departs informing them of the unit number, type and number of patients, and estimated time of arrival to their facility
- Coordinate transport unit movement from Staging to Transport pick up location
- Collect all records from incident and forward to designated Mecklenburg EMS Agency staff

POSITION: TRANSPORT LOADERS

LEVEL
(TACTICAL CALLSIGN): **TEAM** **(LOADTEAM-#)**

PERSONNEL ASSIGNED: EMT or Firefighter (preferred)

FUNCTION: Safe movement of patients from Treatment area to Transport loading area

REPORTS TO: TRANSPORT

SUPERVISES: none

DUTIES:

- Read this duty checklist
- Monitor MEDICAL operations channel
- Report to treatment area designated by TRANSPORT and collect a patient
- Safely transport patient to transport loading area
- Ensure patient is delivered to correct unit for transportation to hospital
- Return for further assignment by TRANSPORT

POSITION: STAGING MANAGER

LEVEL
(TACTICAL CALLSIGN): **AREA MANAGER** **(STAGING)**

PERSONNEL ASSIGNED: EMT or Firefighter (preferred)

FUNCTION: Manage Staging Area

REPORTS TO: OPERATIONS
(if none then)
COMMAND

SUPERVISES: Resources in Staging Area

DUTIES:

- Read this duty checklist
- Monitor MEDICAL operations channel
- Manage resources until requested
- Maintain accurate list of resources based on type (ALS, BLS)
- Maintain a log of all resources in & out of staging
- Advise crews to off-load equipment when applicable
- Ensure keys are with any vehicles that are left unattended in Staging Area
- Collect all records from incident and forward to designated Mecklenburg EMS Agency staff

POSITION: HELICOPTER COORDINATOR

TACTICAL CALLSIGN: LZ COORDINATOR

PERSONNEL ASSIGNED: EMT (preferred) or Firefighter

FUNCTION: Manage patient loading / destination for all patients transported by Helicopter from the LZ

REPORTS TO: OPERATIONS
(if none then)
COMMAND

SUPERVISES: Medical Helicopters at LZ

DUTIES:

- Read this duty checklist
- Monitor MEDICAL operations channel
- Manage resources until requested
- Maintain accurate list of resources at LZ
- Ensure patients are loaded on appropriate Helicopter
- Ensure Helicopter crew is aware of patient destination assigned
- Collect all records from incident and forward to designated Mecklenburg EMS Agency staff

Appendix Z

Guideline Updates

April 1, 2015

SOG Document created and approved by OMT

December 1, 2016

Uniform Standard	100.010.004

February 1, 2017

Final, Final, Draft published on shared drive for OMT and OSG review.

November 21, 2017

Air Medical Transport Dispatch	600.055.001

May 1, 2018

Uniform Standard	100.010.005
Bariatric Transports	200.065.000
Securing Agency Vehicles	200.025.001

July 1, 2018

Call Processing	600.001.001

Medical Calls for Assistance (Lifting or No Injury) corrected to continue MEDIC unit outside city limits of Charlotte.

Removed North Meck Rescue paging.