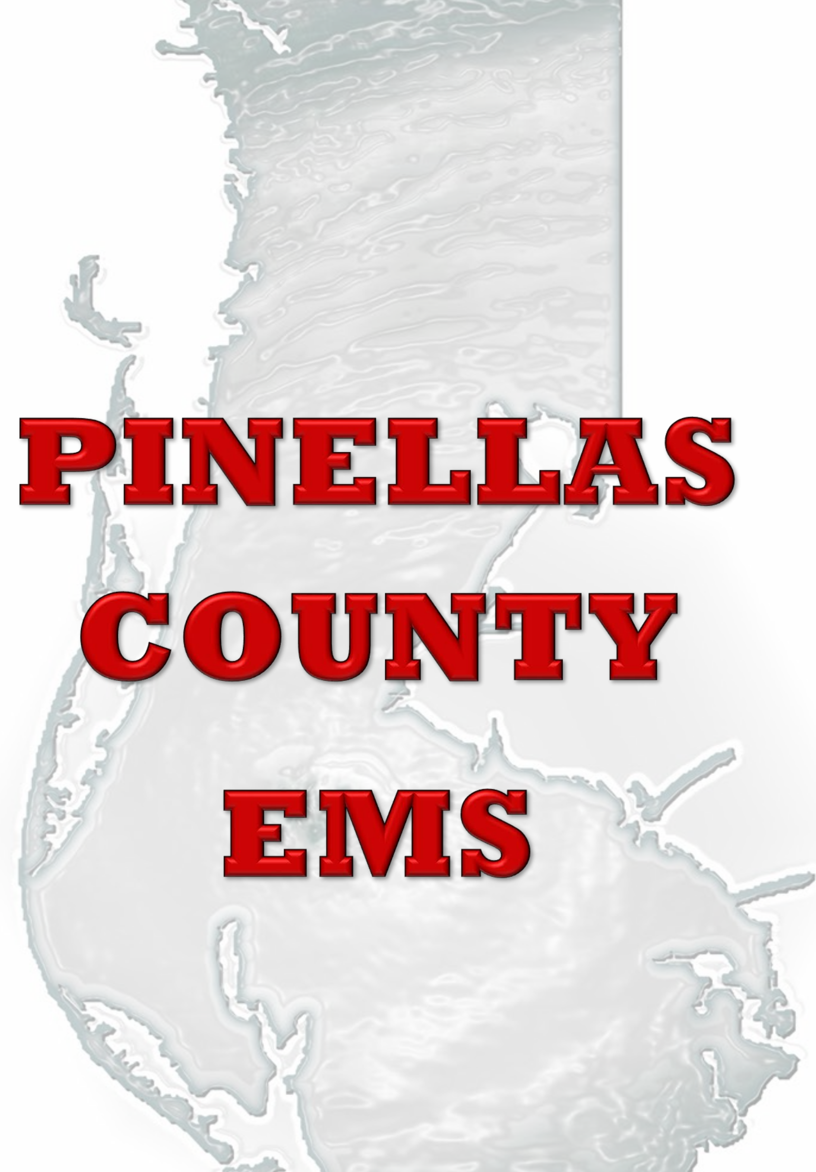
MEDICAL OPERATIONS MANUAL



PINELLAS COUNTY EMS

VOLUME 2

ADMINISTRATIVE

Issued To:

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EMS ID:

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Rev. 2024.3

CRISIS RESOURCES

988 Suicide and Crisis Lifeline - DIAL 988 or https://988lifeline.org/talk-to-someone-now/ offers free, confidential crisis counseling 24/7/365 – and you don't have to be in crisis to call or text

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Crisis Text Line also offers free 24/7 mental health support. **Text "SCRUBS" to 741741 for help**

NAMI HelpLine can be reached Monday through Friday, 10 a.m. - 10 p.m., ET.
Call 1-800-950-NAMI (6264), text "HelpLine" to 62640 or email us at helpline@nami.org

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Code Green Campaign - https://www.codegreencampaign.org/

Responder Strong - https://responderstrong.org/ We all struggle at times. If you are experiencing any crisis - work-related, substance use, depression, romantic, financial or any other - reach out by **texting "BADGE" to 741741**

American Addiction Centers or 888-300-3332: Provides first responders and their families with a toll-free, confidential phone line for immediate assistance with issues like substance abuse, stress, relationship problems, work-related concerns, and virtually anything disrupting a member's work life and overall wellness.

IAFF Recovery Center - https://www.iaffrecoverycenter.com/

Last To Ask - https://www.lasttoask.com/

Hero Helpline - DIAL 211 or https://211tampabay.org/programs/hero-helpline/

All Clear Foundation - https://allclearfoundation.org/about/

Fire Strong - https://www.firestrong.org/

REVISION HISTORY LOG

Revision Date	Section	Protocol	Revision
240110	Administrative	AD2	Revised to reflect MPDS Version 14.0 updates
		AD3	Revised to incorporate MPDS Version 14.0 updates
		AD4	Corrected Reference Protocol Numbers
240501	Administrative	AD8	▪ All Bayfront Health facility names updated to new ▪ Errata ▪ Additional of Local EMS Medical Director Trauma Alert Criteria – Active bleeding requiring a tourniquet or wound packing with continuous pressure ** to ADULT and PEDIATRIC
		AD15	Addition of information regarding: ▪ Device for Intratracheal Meconium Suctioning in Newborns ▪ Specific glucometer approved by the EMS Medical Director ▪ Removal of AMBU Blue Sensor ECG Electrodes ▪ Addition of ConMed Positrace ECG Electrodes
		AD16	▪ Philips MRx related information removed from protocol
		AD17	▪ All Zoll ePCR information removed with the move to ImageTrend ▪ Protocol re-titled Approved Abbreviations
	Administrative	AD23	Form revised and moved from AD23.4 to AD23
		AD23.1	Forms deleted due to moving to electronic applications within ImageTrend
		AD23.2	
		AD23.3	
		AD23.4	
240702	Revision History Log	N/A	2023 information removed
	Partners In Service Page		ARFF Logo updated
	Table of Contents		Title of Protocol AD11 updated
	Administrative	AD11	Updated to align with changes to FL Statute 383 that take effect July 1, 2024.

AUTHORIZATION

These protocols are granted under the authority of Chapter 401 of the Florida Statutes and 64J-1.004 of the Florida Administrative Code.

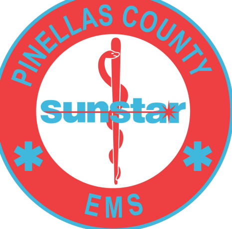
The EMS Medical Director for the following agencies under the umbrella of Pinellas County Emergency Medical Services shall be the only one authorized to make changes to these protocols.

Provider Name	License Number
City of Clearwater	ALS5204
City of Dunedin	ALS5229
City of Gulfport	ALS5207
City of Largo	ALS5210
City of Madeira Beach	ALS5212
City of Oldsmar	ALS5230
City of Pinellas Park	ALS5214
City of Safety Harbor	ALS5215
City of Seminole	ALS5228
City of South Pasadena	ALS5217
City of St. Pete Beach	ALS5218
City of St. Petersburg	ALS5219
City of Tarpon Springs	ALS5221
City of Treasure Island	ALS5222
East Lake Tarpon Special Fire Control District	ALS5205
Lealman Special Fire Control District	ALS5211
Palm Harbor Special Fire Control District	ALS5213
Pinellas County EMS DBA Sunstar	ALS5220
Pinellas Suncoast Special Fire Rescue District	ALS5208

Effective Date: January 4, 2023

Signature: Dr. Angus M. Jameson

Angus M. Jameson MD MPH FAEMS FACEP
EMS Medical Director



PARTNERS

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PINELLAS COUNTY

EMERGENCY MEDICAL SERVICES

RULES & REGULATIONS

Approved by the EMS Authority 1-28-20

Purpose

The Pinellas County EMS Rules & Regulations have been developed to facilitate on-going improvements in the quality of emergency and non-emergency prehospital and inter-facility medical care for the citizens and visitors of Pinellas County. These rules and regulations are promulgated by the Pinellas County EMS Authority in accordance with the Pinellas County Code Chapter 54 (EMS Ordinance), Chapter 401, Florida Statutes and Chapter 64-J, Florida Administrative Code with incorporation of any subsequent amendments.

Every rule, regulation or other provision herein is subject to revision when, in the judgment of the EMS Authority, it is in the best interest of the EMS System. Before such changes are implemented, the EMS Authority shall notify all affected Provider Agencies and allow them to provide input through the EMS Management Committee, a standing committee of the EMS Advisory Council. The EMS Management Committee shall periodically review these EMS Rules & Regulations.

Section 1 - Definitions

For the purpose of these rules and regulations, the following terms, phrases, words and their derivations shall have the meaning given herein. The word "shall" is always mandatory and not merely directive.

"Administrative EMT/Paramedic/RN" means a State certified EMT, Paramedic or RN employed by a Provider Agency or the EMS Authority whose regular job duties do not include staffing a BLS First Responder unit, ALS First Responder unit, or Ambulance. Such EMTs and Paramedics may include Fire Chiefs, Division Chiefs, Staff Officers, Fire Marshals, Fire Inspectors, Directors, Managers, and Program Coordinators. This administrative classification shall not apply to EMS Chiefs, EMS Coordinators, Rescue Lieutenants, EMS Staff Officers or EMS Supervisors who must maintain active certification. Such Administrative EMTs/Paramedics/RNs are not County Certified but may attend CME as a regular student to ensure they remain familiar with the training and protocols utilized by Certified Professionals.

"Administrative Directive" means an official memorandum and any support materials issued by the EMS Authority which may implement or discontinue administrative procedures as may be necessary to provide oversight and management of the EMS System.

"Administrative Proceeding" means the formal process by which a Certified Professional may be disciplined through Probation, fulfillment of a Corrective Action Plan or Revocation of Certification when, in the judgment of the EMS Medical Director, a Certified Professional has departed or failed to follow established protocols, rules regulations or standards or in any situation of misconduct.

"Advanced Life Support (ALS)" means those emergency medical services as defined by Chapter 401 of Florida Statutes.

"Advanced Practice Paramedic (APP)" means a Certified Paramedic who, through additional training and demonstration of expertise, is authorized by the EMS Medical Director to perform specific diagnostic and/or therapeutic modalities beyond the usual scope of practice of a Certified Paramedic. The APP's expanded scope of practice applies only during the operation of, and in support of, the specific Special Operations Team to which they are trained and certified.

"Ambulance" means any vehicle which is equipped to provide Basic and Advanced Life Support services, whether publicly or privately owned, which is designed, constructed, reconstructed, maintained, equipped, or operated for, and is used for or intended to be used for the transportation of Patients.

"Ambulance Contractor" means the entity selected by the EMS Authority, pursuant to the Request for Proposal process, to provide all Ambulance Services in Pinellas County, except those specifically exempted by EMS Ordinance.

"Ambulance Service" means all transports of Patients by an Ambulance in Pinellas County, Florida.

"Background Screening Affidavit" means the affidavit substantially in the form of Appendix A.

"Basic Life Support (BLS)" means those emergency medical services as defined by Chapter 401 of Florida Statutes.

"Certificate of Public Convenience and Necessity (COPCN)" means the Certificate issued by the Pinellas County Board of County Commissioners, pursuant to Chapter 401, Florida Statutes and Pinellas County Code.

"Certification" or "Certified" means the local authorization in Pinellas County of an EMT, Paramedic, RN or EMS Physician to participate in Patient care or work in the EMS System in accordance with the requirements established by the Medical Control Board, the EMS Medical Director and approved by the EMS Authority.

"Certified Professional" means an EMS Physician, Registered Nurse, Advanced Practice Paramedic, Paramedic, EMT, Wheelchair Transport/Stretcher Van Driver, or Mental Health Transport Driver who is certified by the EMS Medical Director to perform duties in the EMS System.

"Client" means any person that uses transportation such as wheelchair transport, stretcher van or mental health transport and is not classified as a Patient by the Medical Operations Manual protocols or EMS Rules & Regulations.

"Continuing Medical Education" or "CME" means the medical education training program, through distance learning or classroom-based courses, provided to meet the following purposes:

(1) core online and classroom based curriculum; (2) Advanced Cardiac Life Support (ACLS) provider, experienced provider and instructor courses; (3) Prehospital Trauma Life Support provider and instructor courses; (4) Advanced Medical Life Support (AMLS) provider and instructor courses or equivalent; (5) Emergency Pediatric Care (EPC) provider and instructor courses or equivalent; (6) specialized courses required for advanced practice Paramedics; (7) station based scenario based drills or skill labs; (8) Cardiopulmonary Resuscitation (CPR) provider and instructor courses; (9) state mandated training for re- certification; (10) additional training required by the National Registry of EMTs; and any (11) special conferences, workshops, classroom online courses or offerings identified by the Medical Director.

The CME programs shall meet the minimum requirements for EMTs and Paramedics to maintain their certification status in the Pinellas County EMS System, the State of Florida, and where applicable, the National Registry of Emergency Medical Technicians.

The CME program curriculum, except standardized courses, shall be designed and developed by the Authority's staff and approved by the Medical Director. Courses shall have clear and concise learning objectives, meet state and national EMS training standards, comply with and reinforce Medical Operations Manual protocols, and utilize adult learning principles to ensure CME Student engagement. Online courses shall incorporate audio, video, external references, references to local rules and protocols, and an assessment to ensure course completion and proficiency. Classroom based courses

shall incorporate lecture, video, hands-on skill practice, scenario-based practice and assessments that are competency based to ensure course completion and proficiency.

CME may also include specialized training for individuals or small groups to meet any remedial training requirements self-identified, identified by a Provider Agency or the Medical Director, or as a component of Quality Assurance Review or Corrective Action Plan in accordance with the Rules and Regulations.

For advanced or elective CME training, the EMS Medical Director may elect to teach classes directly or through the CME Instructors. Offerings from the advanced and elective CME program are intended to provide Certified Professionals in the System with broad opportunities for professional development.

"Concurrent Employment" means a Certified Professional that maintains employment with two Provider Agencies.

"Corrective Action Plan" means written requirements imposed by the EMS Medical Director subsequent to an Administrative Proceeding that may include, but is not limited to, Remedial Training; completion of EMS System orientation; field internship; written examination; practical skill assessment; scenario based assessment; employee assistance plan (EAP) participation or counseling; substance abuse counseling and testing. At the successful completion of a Probationary period and a Corrective Action Plan, a Respondent, without other ongoing complaints, shall be returned to active Certification by the EMS Medical Director. The EMS Medical Director shall solicit input from the Provider Agency when developing a Corrective Action Plan.

"County" means Pinellas County, Florida.

"CME Instructor" means an EMS Physician, County Certified Registered Nurse, Paramedic or EMT employed by the Authority or a Provider Agency who is approved by the Medical Director to serve as a trainer to instruct specific Course(s) on a periodic or episodic basis. CME Instructors may be utilized to teach regular CME classes, specialized Courses, EMS Academy or serve as a subject matter expert, curriculum developer or complete a specific task assignment. CME Instructors may be called upon to serve as "affiliate faculty" for the American Heart Association or National Association of EMTs programs; or to lead the EMS Academy program. New CME Instructors shall serve a provisional period as determined by the EMS Medical Director. EMTs may only teach BLS Courses as a special CME Instructor

"CME Release Form" means the authorization form that requires the release of the individual Certified Professional's continuing medical education records, individual scores and results to the Provider Agency (employer) and the EMS Medical Director.

"CME Student" means an EMT, Paramedic, or Registered Nurse who is an active volunteer with or employed by the Authority or a Provider Agency and is County Certified. A CME Student may also be an EMT or Paramedic, who is employed by an affiliated agency if approved in writing by the EMS System Director.

"Course" means any individual CME offering available online or through a sufficient number of classroom-based training classes. Regular CME Courses, online and classroom based, will typically be two (2) hours in duration.

"Critical Care Transport (CCT) Ambulance" means any ambulance which is equipped to provide advanced life support and specialty care transport services, whether publicly or privately owned, which is designed, constructed, reconstructed, maintained, equipped, or operated for, and is used for or intended to be used for land transportation of critical patients between Hospital facilities or to respond to complex 9-1-1/EMS incidents.

"Emergency Medical Technician (EMT)" means a county certified individual trained in basic life support as defined by Chapter 401 of Florida Statutes and certified by both the State of Florida and the EMS Medical Director to perform authorized procedures in the course of their duties in the EMS System.

“EMS Academy” means the EMS system orientation and field internship program for provisional EMTs, Paramedics or Registered Nurses . The program shall include two (2) weeks of classroom-based training for Paramedics and Registered Nurses and one (1) week of classroom-based training for EMTs which includes a written and practical assessment. Following the classroom-based portion of the program, all EMTs, Paramedics and Registered Nurses shall complete a field internship. Paramedics and Registered Nurses shall conclude EMS Academy with a Capstone Assessment which includes a comprehensive written examination and a scenario-based assessment. EMS Physicians may attend or instruct portions of EMS Academy as determined by the EMS Medical Director.

“EMS Advisory Council” means the Council established by the EMS Authority’s enabling legislation, Chapter 80-585, Laws of Florida, as amended, to evaluate the County's EMS System from a qualitative point of view, to include review of the operations of EMS on a county-wide basis, to recommend requirements and programs for the EMS System and monitor performance of same, to review and evaluate studies commissioned by the EMS Authority upon the EMS Authority's request, and to make such recommendations as may be necessary to the EMS Authority on needs, problems and opportunities for trauma centers, and to carry out such other duties as may be required to insure the delivery of high quality, county-wide EMS at reasonable cost.

”EMS Authority” means the Pinellas County Emergency Medical Services Authority, a special district created by Chapter 80-585, Laws of Florida, as amended; the governing body of which is the Board of County Commissioners.

“EMS Incident” means an emergency or non-emergency request processed through the Regional 9-1-1 Center that needs or is likely to need medical services.

“EMS Medical Director” means the physician who is appointed by the EMS Authority to take responsibility for clinical performance and leadership of the EMS System. The EMS Medical Director may be called upon to respond to EMS incidents, mass casualty incidents or disasters, or function in the County Emergency Operations Center when needed.

“EMS Ordinance” means Chapter 54, Article III of the EMS Ordinance, as may be amended.

“EMS Physician” means a Florida licensed physician Certified to provide Online Medical Control.

“EMS System” means the network of organizations and individuals established to provide emergency medical services and non-emergency medical services to the citizens of and visitors of Pinellas County, including, but not limited to, Emergency Medical Dispatch provided by the Regional 9-1-1 Center, all BLS and ALS First Responder services, all Ambulance Services, all Helicopter Ambulance Services, all Wheelchair Transport/Stretcher Van Services, all Hospitals, Continuing Medical Education, Online Medical Control, quality assurance and improvement, public education, and related programs and services, hereinafter referred to as the “EMS System.”

“EMS Training Group Meeting” means the meeting provided for in these rules and regulations for the EMS Authority staff and the EMS Medical Director to obtain feedback from stakeholders regarding CME requirements, all EMS related learning needs and curriculum development.

“First Responder Agency” means any public or private entity which has signed a BLS or ALS First Responder Agreement with the EMS Authority and which has been issued a Certificate of Public Convenience and Necessity.

“First Responder Agreement” means a contract which has been negotiated and entered into by the EMS Authority with First Responder Agencies.

“Fiscal Year” means the year commencing on October 1 of any given year and ending on September 30 of the immediately succeeding year.

"Helicopter Ambulance Service" means any rotary wing aircraft equipped to provide advanced life support services and medical transportation which has received a Certificate of Public Convenience and Necessity.

"Hospital" means any Hospital or Freestanding Emergency Department in Pinellas County licensed pursuant to Chapter 395, Florida Statutes.

"In Service Training" means educational materials provided to Provider Agencies by the EMS Authority or EMS Medical Director for dissemination to all Certified Professionals which may be in the form of videos, audio recording, electronic documents, or online content regarding Administrative Directives or Medical Control Directives.

"Instructor Professional Development (IPD)" means the Medical Director led or authorized training for a CME Instructor to be authorized to teach a specific CME Course. Such training shall ensure CME Instructors understand the appropriate use of all equipment and supplies; know the clinical standards and protocols; and have a regular opportunity for professional development; to ensure highly effective and engaged learning occurs in the classroom.

"Just Culture" means the framework of assuring patient safety through error prevention and process improvement; assuring and improving the quality of Patient care and Client services; supporting a professional environment and culture that encourages and supports our Certified Professionals; understands human errors occur and how accountability is assured through consoling, coaching, counseling, Remedial Training, or corrective action. Refer to Appendix B.

"Learning Management System" means the integrated Fire and EMS software system utilized by Provider Agencies for online training, classroom-based training attendance tracking, in-service education; dissemination of administrative and medical control directives, tracking receipt of protocols and directives, skill assessment and testing results. Authority's staff and Medical Director shall have administrative rights to upload and post CME curriculum, in-service training modules, administrative and medical control directives, run attendance and grade reports for all CME Students, and reports for CME Instructor activity. All Provider Agencies shall remain on a common software platform.

"Limited Practice/Communications Center Only" means a county certified EMT or Paramedic employed by the Ambulance Contractor whose job duties will not include staffing an Ambulance or providing Patient care in the field because of a medical condition, physical disability or other limited circumstance which has been approved by the EMS Medical Director. Such EMTs and Paramedics will be required to attain and maintain all initial and ongoing county certification requirements with specific exceptions authorized by the EMS Medical Director on a case by case basis (i.e. modified EMS Academy, Field Internship, or Capstone testing requirements and/or modified CME requirements) and will have corresponding specific limitations on their clinical privileges on a case by case basis (i.e. restriction to practice under a Certified Paramedic's direct supervision, limitation to BLS only, or no direct involvement in patient care). Such requests shall be provided in writing by the Ambulance Contractor with any support documentation requested by the EMS Medical Director.

"Medical Case Review" means a review conducted by the EMS Medical Director or designee, with all Certified Professionals involved with a case, to closely examine the care of a Patient using a positive and educational approach to determine where gaps in knowledge or errors occurred. Such Medical Case Reviews shall be conducted with a Just Culture framework to ensure a positive and supportive culture that encourages quality Patient care.

"Medical Control Board" means the board appointed by the EMS Authority pursuant to the EMS Ordinance to provide medical community consensus on policies and protocols of the EMS System.

“Medical Control Directive” means an official memorandum and any support materials or protocols issued by the EMS Medical Director which may institute or discontinue an emergency order; implement or discontinue protocols; alter a protocol or medication formulary; or any action as may be necessary to provide clinical oversight and management of the EMS System.

“Medical Operations Manual (MOM)” means the document which delineates the standard of Patient care and Client services for the EMS System and describes the scope of practice for Certified Professionals working in the EMS System. The MOM contains Administrative Policies, Clinical Standards, Treatment Protocols, Clinical Procedures, Medication Formularies, and Clinical Tools in an online and printed Manual.

“Medical Quality Management (MQM) Plan” or **“MQM Plan”** means the program, plan, requirements, and standards for Provider Agencies to monitor, assure, and improve the quality of patient care and services provided to Patients and Clients within the EMS System as specified by the EMS Medical Director in a document to be specifically titled the “Pinellas County EMS Medical Director Quality Assurance and Improvement Plan.”

“Observer” means a person who accompanies Certified Professionals on EMS incidents in an observation-only role to learn about the EMS System (i.e. Citizen, Elected or appointed government official, mass media representative, Hospital official, EMT or Paramedic training program faculty, or Fire/EMS explorer).

“On-Line Medical Control” means the consultation and direction given to field crews via radio or other communication links by the EMS Medical Director or an EMS Physician.

“Paramedic” means a county certified individual trained in advanced life support as defined by Chapter 401, Florida Statues and certified by both the State of Florida and by the EMS Medical Director to perform authorized procedures in the course of their duties in the EMS System.

“Patient” means an individual who is ill, sick, injured, wounded or otherwise incapacitated and is in need of or is at risk of needing medical attention or care on-scene and/or during transport to or from a healthcare facility.

“Patient Care Report User’s Manual” means the standards and guidelines established for the completion of Patient care reports as may be amended. Refer to Appendix C.

“Provisional Certification” means the initial orientation and field internship of an EMT, Paramedic or RN seeking Certification for a prescribed period of time and or until specific terms are met.

“Probation” means a set period of time and/or the Corrective Action Plan successfully completed by a Respondent subsequent to an Administrative Proceeding to maintain the individual’s status as a Certified Professional within the EMS System.

“Provider Agency” or **“Provider Agencies”** means the Ambulance Contractor; all BLS and ALS First Responder Agencies; all Helicopter Ambulance Services and all Wheelchair Transport/Stretcher Van Services which have received a Certificate of Public Convenience and Necessity.

“Quality Assurance Review” means the fact finding and administrative processes to review an EMS Incident to determine the quality of Patient care provided and compliance to protocols and clinical standards subsequent to a complaint, question, random audit, or observation. Quality Assurance Reviews are intended to be positive learning experiences based upon the framework of Just Culture.

“Registered Nurse” means a Certified individual trained and licensed as a registered nurse by the State of Florida as defined by Chapter 464, Florida Statues.

“Remedial Training” means a requirement for Certified Professional to successfully complete prescribed education or training as established by the EMS Medical Director or designee, as the result of a Quality Assurance Review or other observed need for improvement.

“Respondent” means a Certified Professional who is subject to an Administrative Proceeding.

“Restriction” means the temporary restriction of a Certified Professional's privileges for a prescribed period of time or until specified terms are met as a result of a Quality Assurance Review or incomplete CME training.

“Revocation” means an administrative action which permanently removes a Certified Professional’s Certification.

“Special Operations Teams” means teams established to respond to unique or specialized situations to include, but is not limited to, the Community Paramedic (CP) Program, the Critical Care Transport (CCT) Team, the Critical Care Paramedic (CCP) Program, the Hazardous Materials (HAZMAT) Team, Tactical EMS (TEMS) teams, and the Technical Rescue Team (TRT).

“Special Rescue Units” means BLS, partial ALS or ALS equipped Certified Personnel assigned to handle medical coverage at mass gatherings, special events or other EMS incidents utilizing non-standard response vehicles to include, but, not be limited to sport utility vehicles, non-transport all-terrain or utility vehicles, transport capable all-terrain or utility vehicles, motorcycles, bicycles, personal transporters or water rescue units.

“State” means the State of Florida.

“Student” means an EMT or Paramedic student attending an accredited EMT or Paramedic training program that has signed an agreement with the EMS Authority to participate in Patient care as part of the field internship and practical training program. Students shall function under the direct supervision of a Student Preceptor.

“Student Preceptor” means a Certified EMT or Paramedic in good standing who has been authorized by the EMS Medical Director to instruct, coach and provide field practical training to EMTs and Paramedics functioning as Students.

“Suspension” means the temporary withdrawal of a Certified Professional's privileges for a prescribed period of time; until applicable qualifications are met; during the pendency of an Administrative Proceeding; or until specified terms are met as a result of a Quality Assurance Review.

“Termination of Certification” means any Certified Professional that has ceased employment with a Provider Agency. This includes resignation, retirement, involuntary termination, or lay-off. Certification shall cease upon termination of employment.

“Training Coordinator” means the Authority’s staff member responsible for the oversight of the CME program, the development of online and classroom-based curriculum; and the evaluation, coaching and mentoring of CME Instructors. The Training Coordinator shall oversee the EMS Academy program.

“Training Plan” means the written plan of online and classroom-based courses necessary to meet CME training requirements for each Fiscal Year. Such plan shall be prepared by the Training Coordinator and discussed at an EMS Training Group Meeting by November 15th each year for the following Calendar Year. The Training Coordinator shall ensure such Training Plan meets all State, County and National Registry requirements. The Training Plan shall be finalized by the Authority through its budgetary process. The Training Plan shall remain standardized unless modified by the EMS Medical Director or EMS Authority staff.

"Training Schedule" means the Fiscal Year training calendar to ensure sufficient classes are available at each Training Site in a pattern of days, times, shifts and frequency that ensures appropriate Provider Agency availability and appropriate class sizes to not exceed thirty (30) CME Students per session and not exceed a 15:2 Student to CME Instructor ratio for regular Courses or a 6:1 ratio Student to CME Instructor ratio for specialized Courses. Such Training Schedule shall be prepared by the Training Coordinator and discussed at a EMS Training Group by November 15th each year for the following Fiscal Year. Such Training Schedule shall not exceed one hundred eighty (180) regular and make-up class sessions per Course. The Training Schedule shall remain standardized unless modified by the EMS Medical Director or the EMS Authority staff in coordination with the EMS Leadership Group (EMS-LG).

"Training Sites" means the public facilities identified for CME training as may be amended by the EMS Medical Director or EMS Authority staff. The total number of Training Sites shall not exceed twenty (20).

"Transfer of Certification" means the transfer of a Certified Professional's employment from one Provider Agency to another Provider Agency. Continuation of Certification shall be subject to the approval of the EMS Medical Director.

"Wheelchair Transport/Stretcher Van Vehicle" means any privately or publicly owned vehicle which is designed, constructed, reconstructed, maintained, equipped or operated and is used for or intended to be used for a person who is sitting in a wheelchair, reclining wheelchair or stretcher, and whose condition is such that the person does not need and is not likely to need medical attention during transport. Such vehicles may not be equipped, marked or operated as an Ambulance.

"Wheelchair Transport/Stretcher Van Service" means the transport of Clients in a Wheelchair Transport/Stretcher Van Vehicle when such persons are not in need of medical care and are not likely to need medical care during non-medical transportation.

Section 2 – System Components and Compliance Requirements

2.1 Purpose and Use. All Provider Agencies, individual Certified Professionals, Students, and Hospitals shall be in compliance with these Rules and Regulations. Non-compliance shall be subject to applicable specific provisions for due process as provided in these Rules and Regulations with consideration to the severity, potential patient impact, and any history of non-compliance.

When a representative of the EMS Authority or the EMS Medical Director is advised of a situation of potential non-compliance to these rules and regulations, the Medical Operations Manual, or is advised of any other such situation that, if true, would be evidence of a threat to public health and safety, the EMS Authority, EMS Medical Director or designee shall handle the matter consistent with these Rules and Regulations

2.2 Regional 9-1-1 Center. The Pinellas County Regional 9-1-1 Center (Public Safety Answering Point – PSAP) is staffed with trained Emergency Medical Dispatchers (EMDs) who are trained and certified by the National Academy of Emergency Dispatch. The Ambulance Contractor's communications personnel shall be Certified Paramedics or Certified EMTs who are also trained and certified as EMDs.

The Regional 9-1-1 Center answers all 9-1-1 calls and performs rapid triage of the call and simultaneously dispatches the appropriate response vehicles (BLS First Responder, ALS First Responder, and/or Ambulance) following the then current Priority Dispatch Protocols contained in the Medical Operations Manual as approved by the EMS Medical Director and the Medical Control Board. EMDs shall perform structured call-taking following the then current Medical Priority Dispatch System protocols, provide post-dispatch and pre-arrival instructions to callers, and pass along such findings and pertinent safety messages to responding Fire/EMS units.

The Pinellas County Public Safety and Intergovernmental Radio & Data Communications System shall allow the sharing of computer aided dispatch (CAD) data to responding Fire/EMS units on mobile communications terminals; allows responding Fire/EMS units to communicate via radio with each other and with the Regional 9-1-1 Center, allow on scene Fire/EMS units to communicate via radio with Online Medical Control and Hospitals; interoperable radio channels allow Fire/EMS units to communicate via radio with law enforcement agencies and other first responders at the scene of an large scale emergency; and regional and national mutual aid channels are available to support routine and disaster "mutual aid" from surrounding counties.

2.3 BLS First Responder. BLS First Response Agencies shall be under contract with the EMS Authority to participate as such in the Pinellas County EMS System. BLS First Response agencies shall be in full compliance with applicable laws, rules and regulations pertaining to the provision of non-transport BLS service in the State of Florida and Pinellas County. This compliance shall be continuous throughout the entire period of service in that capacity as a part of the Pinellas County EMS System. All BLS First Response units shall carry, at all times and at a minimum, the equipment specified on the most current pertinent inspection lists from the State and from the EMS Authority. Medical equipment and supplies not specifically authorized are prohibited. Special Rescue units are excluded from minimum equipment requirements listed above.

2.4 ALS First Responder. ALS First Responder Agencies shall be under contract with the EMS Authority to participate as such in the Pinellas County EMS System contingent upon having a current Certificate of Public Convenience and Necessity. In addition to meeting all provisions of such contracts with the EMS Authority, ALS First Responder Agencies shall be in full compliance with applicable laws, rules and regulations pertaining to the provision of non-transport ALS service in the State of Florida and Pinellas County. This compliance shall be continuous throughout the entire period of service in that capacity as a part of the Pinellas County EMS System. Special Rescue units are excluded from minimum equipment requirements listed above. ALS Engines and Rescue Units shall be staffed in accordance with the provisions of the First Responder Agreement. All ALS Engines and Rescue Units shall carry, at all times and at a minimum, the equipment specified on the most current pertinent inspection lists from the State and from the EMS Authority. Medical equipment and supplies not specifically authorized are prohibited.

2.5 - Ambulance Service. The Ambulance Contractor shall be in full compliance with all applicable laws, rules and regulations pertaining to the provision of ALS ambulance services in the State of Florida and Pinellas County. This compliance shall be continuous throughout the entire period of service in the Pinellas County EMS System. Each Ambulance shall be staffed by at minimum of one Certified Paramedic and one Certified EMT. All Ambulances shall carry, at all times and at a minimum, the equipment specified on the most current pertinent inspection lists from the State and from the EMS Authority. Medical equipment and supplies not specifically authorized are prohibited.

2.6 Wheelchair Transport/Stretcher Van (WCT) Services. Wheelchair Transport/Stretcher Van Provider Agencies may provide services contingent upon having a current Certificate of Public Convenience and Necessity (COPCN). WCT Provider Agencies shall be in full compliance with applicable laws, rules and regulations pertaining to wheelchair and stretcher van non-medical transportation in the State of Florida and Pinellas County. WCT Provider Agencies shall conform to the requirements established by the EMS Authority with regard to insurance coverage and vehicle requirements in accordance with Section 8 of the EMS Rules & Regulations or successor regulation. Each wheelchair transport unit shall be operated by at least one (1) person who is a Certified Wheelchair Transport Service driver. All wheelchair transport vehicles shall carry, at a minimum; the equipment specified on the most current pertinent inspection lists from the EMS Authority and shall be compliant with all federal, state and EMS Authority inspection requirements. WCT Provider Agencies shall be required to complete a standardized wheelchair transport report (or capture the equivalent data fields) on all cases handled by their service as specified in the Medical Operations Manual. All WCT Provider Agencies shall be required to provide periodic summary reports of Client transports to the EMS Authority as reasonably required.

2.7 Helicopter Ambulance Services. Helicopter Ambulance Services are contingent upon having a current Certificate of Public Convenience and Necessity to provide services in Pinellas County. Helicopter Ambulance Services providing scene responses in Pinellas County shall provide a monthly activity report listing all responses and transports and be actively involved in the MQM Plan. All helicopters making scene responses in Pinellas County shall have radio equipment that shall allow communications between the flight crew and the Regional 9-1-1 Center, the landing zone, and Certified Professionals on the scene.

2.8 EMS Central Supply and Equipment Standardization. All BLS and ALS First Responder Agencies and the Ambulance Service shall participate in the countywide EMS Central Supply program and comply with all inventory control procedures for requesting, tracking and restocking medications, medical equipment and medical supplies.

The intent of the EMS Central Supply program is to standardize all medical equipment, medications, and medical supplies to ensure seamless Patient care which may be rendered by multiple Certified Professionals working for different Provider Agencies.

2.9 Controlled Substances. All ALS First Responder Agencies and the Ambulance Contractor shall participate in a countywide supply, restocking, and inventory control/tracking system for controlled substances utilizing the then current electronic locking systems, standardized boxes, online accountability tracking software systems, regulations and requirements as provided by the EMS Authority and approved by the EMS Medical Director as defined in the Medical Operations Manual.

2.10 Inspections. All Provider Agencies shall participate in a countywide inspection program that has approval from the EMS Medical Director and the EMS Authority. The EMS Authority shall conduct periodic inspections of Certified Professionals, vehicles, and equipment to assure compliance with these rules and regulations. If deficiencies are found, a correction notice shall be issued by the person making the inspection. Immediate correction of a deficiency may be required by the inspector. Provider Agencies shall be notified and notice given prior to inspections to the extent possible.

2.11 Administrative Directives. The EMS Authority or designee may issue Administrative Directives as necessary to provide oversight and management of the EMS System. Such Administrative Directives shall be adhered to by Provider Agencies and Certified Personnel as any other rule, regulation or requirement. In Service Training necessary to implement Administrative Directives shall be disseminated to all Certified Professionals by Provider Agencies upon request. In Service Training shall be completed within thirty (30) calendar days unless a shorter time interval is required by the EMS Authority or designee to address an urgent situation.

2.12 Medical Records. All emergency or non-emergency EMS responses shall result in the completion of the most current version of the Pinellas County EMS Electronic Patient Care Report. Such reports shall be completed in accordance with the then current Patient Care Report User's Manual. In addition, the completion of other data entry and/or forms may be required by the State, EMS Authority, or the EMS Medical Director. Completion requirements and transfer of Patient care requirements shall be outlined in the Medical Operations Manual.

All Patient Care Reports and medical records shall be kept by the EMS Authority and shall be retained for at least the period of time specified by applicable federal and state law for records retention. First Responder Agencies and the Ambulance Contractor shall execute and maintain a Business Associate Agreement with the EMS Authority and comply with all requirements of the Health Insurance Portability and Accountability Act (HIPAA) and any related federal laws and regulations.

Section 3 – Medical Oversight and Operations

3.1 Medical Control Board. The Medical Control Board is the board appointed by the EMS Authority pursuant to the EMS Ordinance. The Medical Control Board provides medical community consensus on policies and protocols of the EMS System per their bylaws and has those duties and responsibilities as set forth in the EMS Ordinance.

3.2 EMS Medical Director. The EMS Medical Director is the physician who is responsible for the clinical performance and leadership of the Pinellas County EMS System as described in Chapter 401, Florida Statutes, Chapter 64-J, F.A.C. and the EMS Ordinance. The selection of the EMS Medical Director shall be in accordance with the EMS Ordinance. The EMS Medical Director is required by statute to perform and/or take the responsibility for the duties described for EMS Medical Directors under Chapter 64-J, Florida Administrative Code. Other responsibilities of the EMS Medical Director shall be outlined in a contractual agreement between the EMS Authority and the EMS Medical Director. The EMS Medical Director shall serve as the Medical Director for all BLS and ALS First Responder Services and the Ambulance Service.

3.3 Medical Operations Manual. The Medical Operations Manual (MOM) is a document which delineates the standard of Patient care and Client services for the EMS System and describes the scope of practice for Certified Professionals working in the EMS System. The MOM contains Administrative Policies, Clinical Standards, Treatment Protocols, Clinical Procedures, Medication Formularies, and Clinical Tools in an online and printed Manual. The MOM is subject to review and approval of the EMS Medical Director, the Medical Control Board and the EMS Authority. Any revisions or additions to the MOM are submitted by the EMS Medical Director for review and approval by the Medical Control Board. Proposed changes will be furnished to the Provider Agencies for review and comment prior to approval.

3.4 Medical Control Directive. The EMS Medical Director or designee may issue Medical Control Directives to create, alter, expand, or clarify a Medical Operations Manual policy, protocol or procedure on an as needed basis. Such Medical Control Directives shall be adhered to by Provider Agencies and Certified Personnel as any other rule, regulation or requirement. Emergency orders must be reviewed and approved by the Medical Control Board as soon as practical.

In Service Training necessary to implement Medical Control Directives shall be disseminated to all Certified Professionals by Provider Agencies upon request. In Service Training shall be completed within thirty (30) calendar days unless a shorter time interval is required by the EMS Authority or designee to address an urgent situation.

3.5 On-Line Medical Control. The EMS Medical Director, directly or through Certified EMS Physicians, shall provide 24/7 access by radio for Certified Personnel to consult with an EMS Physician in accordance with the Medical Operations Manual.

3.6 Hospital EMS Communications. Hospitals in Pinellas County who receive emergency patients must sign a Hospital EMS Communications Agreement with the EMS Authority. Hospitals are required to update the EMS Medical Director of changes in their capabilities including temporary changes due to the availability of specialty referral center resources, available beds or staffing constraints. Hospitals and Provider Agencies must comply with Medical Operations Manual Hospital Destination Policy. Hospitals must maintain State required UHF Base Stations and the EMS System Hospital Communications System as defined by the EMS Authority.

3.7 Health Information Exchange between Hospitals and EMS. A patient-physician relationship exists between patients cared for by EMS and the EMS System Medical Director. Whenever a patient is delivered by EMS to a Hospital or medical facility, a copy of the EMS medical record shall be provided to ensure continuity of care. It is therefore appropriate to require that receiving Hospitals provide the Medical Director

with access to the Hospital medical records of patients that have been in the care in the EMS System. Such information is used by the Medical Director to assess and improve the clinical performance of the EMS System. The EMS Authority and Hospitals shall develop a medical record bilateral health information exchange to provide an automated electronic means of transferring EMS medical records to Hospitals and for EMS to obtain demographic and clinical outcome information from Hospitals for Patients.

3.8 Special Events. The EMS System is often called upon to provide medical coverage of mass gatherings and other special events taking place in the community. Such events include but are not limited to sporting events (football, baseball, auto racing and boat racing), concerts, festivals and parades. When Provider Agencies provide BLS or ALS medical coverage at such events they remain under the auspices of the EMS Authority, Medical Control Board, and the EMS Medical Director. Such medical coverage shall conform to the same standards of care and other procedural requirements of the EMS System.

For large scale events, defined as coverage requiring more than two BLS or ALS units, Provider Agencies shall prepare and adhere to Fire/EMS Incident Action Plans that conform with the then current National Incident Management System (NIMS). Provider Agencies and Authority will notify each other of large-scale Special Events, which may require additional resources or adversely affect the EMS System, to ensure coordinated event coverage. The applicable First Responder Agency shall serve as the lead agency but may defer to the Ambulance Contractor on a case by case basis.

Provider Agencies may utilize Special Rescue Units to provide medical coverage at Special Events. Such units shall carry BLS and/or ALS equipment to the extent possible for the type of vehicle being utilized.

Event promoters, civic groups, or Hospitals who wish to provide medical support to special events may only provide BLS or first aid stations/tents and not interfere with the response of the EMS System to emergencies

3.9 Off-Duty Personnel. Any Certified Professional who encounters an EMS Incident while off-duty may render aid to those in need and may fully participate in Patient care in conjunction with and at the discretion and direction of the on-duty Certified Professional(s). Certified Professionals who are on-duty shall have the primary responsibility for all Patient care and incident management.

Section 4 – Certification

4.1 Purpose and Use. The EMS Medical Director authorizes individuals to participate in Patient care and Client services as a part of the Pinellas County EMS System through the issuance of County Certification. An individual may seek the status as a Certified Professional in the Pinellas County EMS System by attaining and continuously maintaining all State of Florida and Pinellas County requirements as determined by the Medical Control Board and the EMS Medical Director.

Each Certified Professional has an individual clinical relationship with the EMS Medical Director that authorizes the delegated practice of medicine. Non-compliance with any requirement may result in Restriction, Suspension or Revocation of Certification.

In the event of Termination of Employment of a Certified Professional, the Provider Agency is required to provide the EMS Medical Director written notification of such change within five (5) business days.

4.2 Administrative EMT/Paramedic/RN. Administrative EMT/Paramedic/RNs may perform CPR, hemorrhage control, basic first aid, rescue, and may utilize their skills for the public good under extraordinary circumstances in which Certified Professionals are unavailable (i.e. mass casualty incident or disaster). Administrative Paramedics and RNs must not provide ALS modalities unless it is related to a mass casualty incident or disaster. Such administrative status shall in no way restrict an Administrative EMT/Paramedic/RN from leading a Provider Agency, serving as the Incident Commander or within the Incident Command System.

Requirements for Administrative EMT/Paramedic/RN

a) Completed Application
b) Completed CME Release Form

c) Current State of Florida EMT Certificate, Paramedic Certificate or Registered Nurse License
d) Current CPR Card (American Heart Association Healthcare Provider or American Red Cross Professional Rescuer and must include AED training and Adult/Child/Infant CPR)
e) Completed Background Screening Affidavit
f) Approval of the EMS Medical Director

4.3 Wheelchair Transport/Stretcher Van (WCT) Driver. Wheelchair Transport (WCT) drivers seeking to obtain initial Certification shall meet the following requirements prior to participating in transportation activities:

Requirements for WCT Driver

a) Completed Application
b) Current Cardiopulmonary Resuscitation (CPR) Card (issued by the American Heart Association, American Safety & Health Institute, American Red Cross or National Safety Council and must include AED training and Adult/Child/Infant CPR)
c) Current First Aid Card (issued by the American Heart Association, American Safety & Health Institute, American Red Cross or National Safety Council)
d) Completed Orientation by Provider Agency
e) Completed Background Screening Affidavit
f) Compliance with all Protocols, Rules and Regulations of the EMS System
g) Approval of the EMS Medical Director

4.4 Mental Health Transport (MHT) Drivers. Mental Health Transport (MHT) drivers seeking to obtain initial Certification shall meet the following requirements prior to participating in transportation activities:

Requirements for MHT Driver

a) Completed Application
b) Current Cardiopulmonary Resuscitation (CPR) Card (issued by the American Heart Association, American Safety & Health Institute, American Red Cross or National Safety Council and must include AED training and Adult/Child/Infant CPR)
c) Current First Aid Card (issued by the American Heart Association, American Safety & Health Institute, American Red Cross or National Safety Council)
d) Completed 8-hour Baker Act and Verbal De-Escalation Training by Provider Agency
e) Completed Orientation by Provider Agency
f) Completed Background Screening Affidavit
g) Compliance with all Protocols, Rules and Regulations of the EMS System
h) Approval of the EMS Medical Director

4.5 Emergency Medical Technicians. Provisional Certification may be authorized at the EMT level for up to twelve (12) months. Such authorization shall be limited to clinical activities under the direct supervision of another County certified EMT or Paramedic. EMS Providers shall provide a periodic update to the EMS Medical Director on the progress of Provisional EMTs in attaining County Certification. If an individual has not met the requirements for certification by the end of the twelve-month period, Provisional Certification shall be withdrawn unless an extension of Provisional Certification is requested and approved by the EMS Medical Director at least thirty (30) days prior to the expiration. The EMS Medical Director may authorize alternative time extensions on a case by case basis.

Requirements for Provisional EMT

a) Completed Application
b) Completed CME Release Form
c) Current State of Florida EMT Certificate
d) Current CPR Card (American Heart Association Healthcare Provider or American Red Cross Professional Rescuer and must include AED training and Adult/Child/Infant CPR)
e) Completed Pinellas County EMS Academy (the classroom-based portion of the orientation program must be completed within 30 days of Provisional Certification)
f) Completed Background Screening Affidavit
g) Approval of the EMS Medical Director

Requirements for County Certified EMT

a) Completed EMS Academy
b) Compliance with all Protocols, Rules and Regulations of the EMS System
c) Compliance with all CME training requirements and any Remedial Training required
d) Approval of the EMS Medical Director

Note: Limited Practice/Communications Center Only EMTs may be authorized by the EMS Medical Director.

4.6 Paramedics. Provisional Certification may provide limited authorization for the Paramedic level for up to twelve (12) months. Such Provisional Certification shall be limited to ALS clinical interventions under the direct supervision of a County Certified Paramedic. EMS Providers shall provide a periodic update to the EMS Medical Director on the progress of Provisional Paramedics in attaining County Certification. If an individual has not met the requirements for certification by the end of the twelve-month period, such Provisional Certification shall be withdrawn at the level applied for unless an extension of Provisional Certification is requested and approved by the EMS Medical Director at least thirty (30) days prior to the expiration. The EMS Medical Director may authorize alternative time extensions on a case by case basis.

Requirements for Provisional Paramedic

a) Completed Application
b) Completed CME Release Form
c) Current State of Florida Paramedic Certificate
d) Current American Heart Association Advanced Cardiac Life Support (ACLS) Provider Card
e) Current CPR Card (American Heart Association Healthcare Provider or American Red Cross Professional Rescuer and must include AED training and Adult/Child/Infant CPR)
f) Completed Pinellas County EMS Academy (the classroom-based portion of the orientation program must be completed within 30 days of Provisional Certification)
g) Completed Background Screening Affidavit
h) Approval of the EMS Medical Director

Requirements for County Certified Paramedics

a) Completed EMS Academy
b) Current Prehospital Trauma Life Support (PHTLS) Provider Card. An International Trauma Life Support (ITLS) Provider Card may be used to meet the initial certification requirements. The Certified Professional must become certified in PHTLS when the EMS System recertifies through CME or when their ITLS Card expires whichever comes first.
c) Current Emergency Pediatric Care (EPC) Provider Card.
d) Completed EMS Academy
e) Completed Interview with EMS Medical Director or designee

f) Compliance with all Protocols, Rules and Regulations of the EMS System
g) Compliance with all CME training requirements and any Remedial Training required
h) Approval by the EMS Medical Director .

Note: Limited Practice/Communications Center Only Paramedics may be authorized by the EMS Medical Director.

4.7 Registered Nurse. Provisional Certification may provide limited authorization at the RN level for up to six (6) months. Such Provisional Certification shall be limited to the clinical activities under the direct supervision of a Certified RN. If an individual has not met the requirements for certification by the end of the six-month period, such Provisional Certification shall be withdrawn at the level applied for unless a six-month extension of Provisional Certification is requested and approved by the EMS Medical Director at least thirty (30) days prior to the expiration. The EMS Medical Director may authorize alternative time extensions on a case by case basis.

Requirements for Provisional RN

a) Completed Application
b) Completed CME Release Form
c) Minimum of three (3) years critical care experience or equivalent approved by the EMS Medical Director
d) Current State of Florida Registered Nurse License
e) Current American Heart Association Advanced Cardiac Life Support (ACLS) Provider Card
f) Current CPR Card (American Heart Association Healthcare Provider or American Red Cross Professional Rescuer and must include AED training and Adult/Child/Infant CPR)
g) Completed EMS Academy (the classroom-based portion of the program must be started within 30 days of Provisional Certification)
h) Completed Background Screening Affidavit
i) Approval of the EMS Medical Director

Requirements for County Certified RNs

a) Completed EMS System Orientation & Field Internship Program
b) Current Prehospital Trauma Life Support (PHTLS) Provider Card or American College of Surgeons Advanced Trauma Life Support (ATLS) Provider Card. An International Trauma Life Support (ITLS) Provider Card may be used to meet the initial certification requirements. The Certified Professional must become certified in PHTLS when the EMS System recertifies through CME or when their ITLS Card expires whichever comes first.
c) Completed training/education requirements required by the Commission on Accreditation of Medical Transport Services (CAMTS) within one (1) year of County Certification – Certified Transport Registered Nurse (CTRN) or Certified Flight Registered Nurse (CFRN).
d) Completed EMS Academy
e) Completed Interview with EMS Medical Director or designee
f) Compliance with all Protocols, Rules and Regulations of the EMS System
g) Compliance with all CME training requirements and any Remedial Training required
h) Approval by the EMS Medical Director

4.8 Advanced Practice Paramedics. Certified Paramedics who, through additional training and demonstration of expertise, may be authorized by the EMS Medical Director to perform specific diagnostic and/or therapeutic modalities beyond the usual scope of practice of a Pinellas County Paramedic. The APP's expanded scope of practice applies only during the operation of the specific Special Operations

Team to which they are trained and certified. A Registered Nurse or Advanced Practice Paramedic at an EMS incident involving the response of a Special Operations Team shall have clinical oversight and authority. For Critical Care Transport, the Registered Nurse shall serve as the lead clinician.

Requirements for County Certified Advanced Practice Paramedics

a) Current County Certified Paramedic in good standing
b) Submission of a request to obtain Advanced Practice Paramedic certification
c) Minimum of three (3) years Paramedic experience or equivalent approved by the EMS Medical Director
d) Completion of specific medical training for the Special Operations Team as follows:
   a. Community Paramedic – Local training curriculum or coursework
   b. Critical Care Paramedic (CCP) - Completed training/education requirements required by the Commission on Accreditation of Medical Transport Services (CAMTS) – Critical Care Paramedic -- Certified (CCP-C) or Flight Paramedic - Certified (FP-C).
   c. Hazmat – Advanced Hazardous Materials Life Support (AHLS) Provider Course or equivalent as determined by the EMS Medical Director
   d. Tactical EMS – Tactical Combat Casualty Care (TCCC) or Tactical Emergency Casualty Care (TECC) Provider Course
   e. Technical Rescue - FEMA Disaster Medical Specialist or equivalent as determined by the EMS Medical Director
e) Completion of the Special Operation Team's Orientation Program
f) Completion of all Specialized Operations Team training requirements to be an active team member
g) Completed Advanced Practice Paramedic Assessment – one day classroom-based program that includes a written comprehensive exam and a scenario-based assessment specific to the Special Operations Team certification being sought.
h) Approval by the EMS Medical Director

4.9 EMS Physicians. EMS Physicians must be a Florida licensed Physician (MD or DO), who are familiar with all Medical Operations Manual protocols, rules, regulations and have written approval of the EMS Medical Director prior to providing Online Medical Control. EMS Physicians may be called upon to act as the designee of the EMS Medical Director, respond to EMS incidents, mass casualty incidents or disasters, or function in the County Emergency Operations Center when needed.

4.10 EMT and Paramedic Students. The Pinellas County EMS System recognizes the need for EMT and Paramedic Students in accredited EMT and Paramedic training programs to participate in Patient care as part of the field internship and practical training in the field to attain State certification. For a training program to participate in Student field internships or practical training, the EMT or Paramedic training program must be accredited by the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP) and have executed an agreement with the EMS Authority for such purposes. Such training programs may include continuing education programs for U.S. military personnel provided the program has executed an agreement with the EMS Authority.

Student shall be under the direct supervision of a Student Preceptor for the level of care or procedures that the Student is providing. EMT Students may provide BLS treatment modalities. Paramedic Students may provide ALS treatment modalities.

Provider Agencies are encouraged to maintain an adequate number of Student Preceptors to meet the needs of the EMT or Paramedic training programs and Students. Provider Agencies are prohibited from entering into agreements with EMT or Paramedic training programs.

4.11 Observers. There are appropriate circumstances for persons to accompany Certified Professionals on EMS incidents for observational purposes. Observers must not directly or indirectly participate in aspect of Patient care. Observers shall complete necessary training and sign liability waivers required by the Provider Agency. The Provider Agency shall ensure patient privacy and confidentiality is maintained; blood borne pathogen and other safety training is provided; and any necessary safety equipment is provided, and safety precautions are taken. Provider Agencies are not required to allow Observers.

4.12 Termination of Certification. Termination of Certification occurs when a Certified Professional has ceased employment with a Provider Agency. Such termination of certification includes resignation, retirement, or involuntary termination. Certification shall cease upon termination of employment.

4.13 Transfer of Certification. Transfer of Certification occurs when a Certified Professional ceases employment from one Provider Agency and becomes employed by another Provider Agency. In such instances, the continuation of Certification shall be subject to the approval of the EMS Medical Director. If the EMS Medical Director does not approve of the Transfer of Certification, all initial Certification requirements must be met, and the completion of any Remedial Training required subsequent to any outstanding Quality Assurance Review(s) that occurred during employment with the prior Provider Agency must be completed. Provider Agencies shall request a "clinical status inquiry" using the form shown on Appendix C.

4.14 Concurrent Employment. Certified Professionals may be employed by more than one Provider Agency; however, each clinician has one Certification. Certified Professionals must function at the same level of Certification at all times to ensure clinicians meet the community's expectation that they will function to their level of training. Restriction, Suspension, and Corrective Action Plans apply on an EMS System-wide basis and must be adhered to by all Provider Agencies.

4.15 Voluntary Demotion. In the event that a County Certified Paramedic wishes to demote their privileges to an EMT, the Certified Paramedic must complete the EMT application, provide a State of Florida EMT certificate, and be approved by the EMS Medical Director.

4.16 Medical or Military Leave. Certified Professionals who are on extended medical leave or military duty greater than 60 days, shall be moved to an inactive status. Other circumstances, such as layoff or furlough, may be approved by the EMS Medical Director. Upon return to duty, Certified Professionals shall complete any CME training and ensure all credentials are up to date before being returned to active Certification.

4.17 Submission of Credentials. Certified Professionals must provide updated credentials, training records, and CME attendance records required to maintain continuous compliance with all Certification requirements. Such certificates or documentation must be submitted to the EMS Medical Director before the expiration date or submission deadline. Failure to submit updated credentials may result in immediate Suspension or Revocation.

4.18 Background Screening and Affidavit. Applicants seeking County Certification shall submit a signed and witnessed Background Screening Affidavit.

Section 5 – Quality Assurance

5.1 Quality Assurance Committees. The EMS Medical Director may establish standing or ad-hoc "emergency medical review committee" in accordance with Chapter 401, Florida Statutes. Such committee(s) may be assembled to review an individual EMS Incident, improve a particular facet of Patient care, or serve as a broad oversight committee.

Quality Assurance activities are confidential as provided in Chapter 401, Florida Statutes.

5.2 Provider Agency Quality Assurance Programs. Provider Agencies shall establish, maintain and actively utilize internal quality assurance and improvement programs to monitor the performance of Certified Professionals and provide coaching and training to reinforce proper Patient care techniques, and compliance with protocols at the Provider Agency level. Such programs shall include Provider Agency administrators and EMS coordinators responding to EMS Incidents to observe Patient care and field operations of Certified Professionals; reviewing electronic medical records utilizing the then current medical record auditing software provided by the EMS Authority; monitoring key performance indicators and other such activities identified in the MQM Plan. Any such program shall be based upon the tenets and framework of Just Culture.

5.3 Medical Quality Management (MQM) Plan. The EMS Medical Director shall establish, maintain and actively utilize a comprehensive Medical Quality Management (MQM)Plan to delineate all performance monitoring requirements; quality assurance and improvement activities; standards for reviewing electronic medical records utilizing the then current medical record auditing software provided by the EMS Authority; and procedural standards for Quality Assurance Reviews and Medical Case Reviews. Any such program shall be based upon the tenets and framework of Just Culture.

5.4 Quality Assurance Review - Request. A Quality Assurance Review may be requested by any person through a verbal or written complaint or question regarding the quality of Patient care or Client services provided by the EMS System. Such persons include, but are not limited to, citizens, Patients, Clients, Hospital physicians or representatives, Provider Agency representatives, and Certified Personnel). Patient complaints regarding care, treatment, or services rendered shall be reported to the EMS Medical Director in accordance with the then current MQM Plan within three (3) business days of occurrence or receipt. The EMS Medical Director shall notify affected Provider Agencies of any inquires or complaints within three (3) business days of occurrence or receipt.

5.5 Quality Assurance Review – Fact Finding and Administrative Process. A Quality Assurance Review may include access to data, medical records review, tape audits, written and verbal statements by Certified Professionals and Provider Agency representatives and attendance at interviews or meetings as may be required. Provider Agencies and Certified Professionals shall provide full cooperation in obtaining such records, verbal and written statements, and attending any interviews or meetings as may be required. Prior Quality Assurance Review records may be searched and utilized as evidence to demonstrate repeated behaviors or patterns following the Just Culture framework. All materials and records obtained shall be shared with the affected Provider Agencies and EMS Medical Director.

All Quality Assurance Review records shall be kept by the EMS Authority and shall be retained for at least the period of time specified by applicable federal and state law for records retention.

Any time a Quality Assurance Review is initiated, it shall be recorded onto a permanent record with notation of the date received, the date and notation of all information gathered, and actions taken and the date of closure. Such records shall be maintained in an active status in accordance with State records retention requirements. Such records may be accessed and referenced to observe patterns or repeated issues.

The party who requested the Quality Assurance Review shall receive written follow-up on the matter in a reasonable time frame.

All statements and records shall be submitted within fourteen (14) calendar days of request. Failure to comply with the time requirement may result in the Restriction or Suspension of the involved Certified Professional(s).

5.6 Quality Assurance Review – Case Disposition. At the conclusion of fact finding, the EMS Medical Director may determine the complaint is unfounded or unsubstantiated; the result of a protocol or policy failure; the result of an equipment failure; a situation to be referred to a Hospital or other agency that is not a Provider Agency; a substantiated complaint requiring Remedial Training; a substantiated complaint requiring a Medical Case Review; or a significant departure from expected conduct or performance which shall invoke an Administrative Proceeding.

A Just Culture framework shall be utilized to ensure a positive and supportive culture that encourages quality Patient care.

Such case disposition shall be rendered by the EMS Medical Director or designee within seven (7) calendar days after the receipt of all required case material and the conclusion of the fact-finding phase.

5.7 Remedial Training. At the conclusion of a Quality Assurance Review, the EMS Medical Director may prescribe and require Remedial Training for one or more Certified Professionals involved in the case. Such training may be referred to the Provider Agency or handled directly by the EMS Medical Director or designee.

Such training shall be completed within fourteen (14) calendar days unless excused by the Medical Director in writing prior to the expiration of such fourteen-day period.

5.8 Medical Case Review. Provider Agencies shall ensure its Certified Professionals attend Medical Case Reviews when requested. Medical Case Reviews shall include all Certified Professionals involved with the case, unless excused by the Medical Director and be conducted in a positive and educational approach to determine where gaps in knowledge or errors occurred. Such Medical Case Reviews shall be conducted with a Just Culture framework to ensure a positive and supportive culture that encourages quality Patient care. Medical Case Reviews shall be held at the EMS Center for Prehospital Medicine and include a scenario-based review and assessment of the case unless otherwise determined by the EMS Medical Director.

Such Medical Case Reviews shall be completed within fourteen (14) calendar days of request unless excused by the Medical Director in writing prior to the expiration of such fourteen-day period. Failure to complete a required Medical Case Review may result in an Administrative Proceeding.

5.9 Notification of EMS Medical Director. The EMS Medical Director shall be formally notified of complaints or other quality assurance activities that pertain to the care or service provided to Clients and Patients within three (3) business days upon discovery in accordance with the Medical Quality Management Plan. At that time EMS Medical Director shall make a determination if a Quality Assurance Review will be initiated or the situation deferred to the Provider Agency for their initial investigation and action. The Provider Agency shall update the EMS Medical Director of the outcome for a final determination if a Quality Assurance Review is warranted.

The Medical Director shall immediately be notified verbally upon discovery and subsequently formally notified within three (3) business days any time a Provider Agency, Certified Professional or the EMS Authority has a reasonable belief that the conduct or action of a Certified Professional may have violated these Rules and Regulations, or constitute one or more grounds for Restriction, Suspension or discipline by the Florida Department of Health as defined in Chapter 401, Florida Statutes.

5.10 Restriction. The EMS Medical Director or designee may restrict a Certified Professional from practicing independently and require them to work under the direct supervision of another Certified Professional at the same or higher level. Such Restriction may be invoked upon notification of a complaint or Quality Assurance Review during the fact finding, case disposition and Remedial Training phases. Such Restriction shall not extend past the closure of the Quality Assurance Review.

5.11 Suspension. The EMS Medical Director or designee may suspend a Certified Professional from the direct care of Patients or Clients in situations defined in Section 6.4 hereof. Such Suspension may be invoked upon notification of a complaint or Quality Assurance Review during the fact finding, case disposition and Remedial Training phases. Such Suspension shall not extend past the closure of the Quality Assurance Review unless the case becomes an Administrative Proceeding.

5.12 Quality Assurance Review Timeline

Component	Section	Time Limit
Verbal Notification of Serious Incidents	5.9	Immediately
Notification of Quality Assurance Review	5.4 & 5.9	Three (3) Business Days
Fact Finding and Statements Submitted	5.5	Fourteen (14) Calendar Days
Disposition by EMS Medical Director	5.6	Seven (7) Calendar Days
Remedial Training or Medical Case Review Completed	5.7 & 5.8	Fourteen (14) Calendar Days

Section 6 – Administrative Proceedings and Disciplinary Actions.

6.1 Administrative Proceeding - Purpose. Should the EMS Medical Director or designee determine, from information gathered during a Quality Assurance Review(s) or by any other means or occurrence, a Certified Professional has departed or failed to follow established protocols, rules regulations or standards or in any situation of misconduct which reasonably may have occurred, the EMS Medical Director or designee may initiate an Administrative Proceeding.

6.2 Notification of Administrative Proceeding. The Respondent and their Provider Agency shall be notified of by certified mail of an Administrative Proceeding. Such notice shall include: a detailed statement of allegations against the Respondent; a statement that the allegations, if found to be true, constitute a possible threat to the public health and safety and are cause for the EMS Medical Director to take action; a statement indicating the Respondent's Certification may be Revoked or subject to Probation and/or a Corrective Action Plan if the allegations are found to be true; a statement that the Respondent may bring any pertinent information or written statements to the Administrative Proceeding; the name of all persons to be present during the Administrative Proceeding; the date, time and location of the Administrative Proceeding; and a statement that the Respondent may request a continuance in accordance with Section 6.3 of the EMS Rules & Regulations.

6.3 Request for Continuance. A Certified Professional may request a delay or rescheduling of an Administrative Proceeding through a written "request for continuance" stating the grounds for the request. Such request must be received by the EMS Medical Director at least two (2) business days prior to the scheduled Administrative Proceeding. If both parties agree to a continuance, it must be rescheduled within thirty (30) calendar days.

6.4 Administrative Proceeding. The Administrative Proceeding shall be led by the EMS Medical Director. The EMS Medical Director's designee shall present the allegations in a sequential fashion and present any supporting documents, written statements, medical records, and incident reports to substantiate which protocols, rules, regulations, clinical or professional standards in which the Certified Professional has not complied or violated. Prior Quality Assurance Reviews may be used to show a pattern of non-compliance or recurrence.

For each allegation, the Certified Professional may offer verbal explanation of the circumstance, provide any supporting documentation or written statements.

The EMS Medical Director and the Certified Professional may enter into dialogue to clarify and seek a common understanding of the facts.

An electronic audio recording of the Administrative Proceeding shall be made, and if a written transcript of such is made, the Respondent shall be entitled to a copy without charge.

The Respondent may be accompanied by representation and/or counsel, however, such representative and/or counsel shall not directly participate or interfere with the conduct of the Administrative Proceeding.

At the conclusion of the Administrative Proceeding, the EMS Medical Director shall render a decision in writing and provide such decision to the Respondent and their Provider Agency within ten (10) calendar days. Such decision may include a conclusion that the allegation(s) are unfounded; Probation has been invoked along with a written Corrective Action Plan to be met by the Respondent; or the Respondent's Certification has been Revoked.

The following circumstances, if substantiated, may be grounds for Revocation:

1. Fraud or deceit in applying for or obtaining a Certification
2. Failure to participate in a Quality Assurance Review or Medical Case Review
3. Failure to comply with the requirements of a Corrective Action Plan
4. Repeated failure to comply with CME training requirements
5. Demonstrated inability, failure or refusal to adhere to established protocols and standards
6. Reckless behavior, repeated "at risk" behavior or repeated incidents of human error in accordance with the Just Culture framework
7. Clinical incompetence or any potential threat to public health, safety or welfare
8. Unprofessional conduct including, but not limited to, any departure from or failure to conform to the minimum prevailing standards of acceptable practice as an EMT, Paramedic, Registered Nurse or Physician
9. Performing procedures or skills for which the individual is not qualified by training and Certification or which are unauthorized
10. Violation of policies or protocols pertaining to the use, handling or storage of controlled substances
11. Violation of policies pertaining to the use of medications, medical supplies or medical equipment
12. Arrest or criminal conviction which violates Section 4.18 - Background Screening unless the individual's civil rights have been restored;
13. Substantiated patient abuse
14. Being found guilty of, or pleading nolo contendere, a crime that relates to practice as an EMT, Paramedic, Registered Nurse or Physician
15. Sexual misconduct with a Patient or Client, including inducing or attempting to induce the Patient or Client to engage, or engaging or attempting to engage a Patient or Client in sexual activity;
16. Theft or dishonesty in the performance of duty;
17. Addiction to alcohol or any controlled substance; Being under the influence of a controlled substance, illegal drug, or alcohol, at any level, while on duty;
18. Engaging in or attempting to engage in the possession (except a legitimate personal prescription from a licensed physician), sale or distribution of any controlled substance except in legitimate circumstances under the supervision of a licensed physician;
19. Practicing as a Certified Professional without reasonable skill and safety to Patients or Clients by reason of illness, drunkenness, or the use of drugs, narcotics, or chemicals or any other substance or as a result of any mental or physical condition;
20. Dishonesty, falsification or inappropriate alteration of Patient Care Reports or other documentation. or making false statements regarding a Patient or Client to the EMS Medical Director, or the Authority or their representatives;
21. Failure to report to the EMS Medical Director any person known to be in violation of these criteria.

6.5 Notification of Appeal and Evidentiary Process. Subsequent to an Administrative Proceeding and the EMS Medical Director's decision, a Respondent shall have (10) calendar days from the date of written decision to invoke an appeal in writing to the EMS Medical Director. Notice of these Appeal procedures and timeframes shall accompany or be included within the EMS Medical Director's decision. Failure to appeal within the ten (10) calendar days shall forfeit the option to appeal.

Upon receipt of an appeal, the EMS Medical Director shall, within ten (10) calendar days of such receipt, notify the State of Florida Division of Administrative Hearings (DOAH) and request a hearing officer be assigned to conduct an administrative hearing. The Medical Director shall have no input or influence over the selection of such hearing officer. The DOAH Hearing Officer shall then schedule an appeal hearing. Not later than fifteen (15) calendar days prior to the appeal hearing, the parties to the appeal and/or their legal counsels, shall provide a written pre-hearing statement to the hearing officer. Such statement shall include: a statement of the appeal, which shall be a brief, one page or less, synopsis of the Respondent's view of the significant facts and circumstances giving rise to the appeal; a list of documentary evidence which each party intends to introduce at the appeal hearing; a list of witnesses each party intends to call to testify at the hearing; and any stipulated matters upon which the parties agree relating to the hearing. The parties shall sign and be bound by their representations contained within the respective pre-hearing statements.

6.6 Appeal Hearing. The DOAH Hearing Officer/Administrative Law Judge shall utilize quasi-judicial procedures in accordance with Chapter 120, Florida Statutes and shall have the authority to issue subpoenas, administer oaths, compel the production of documents and receive evidence. The DOAH Hearing Officer shall conduct a hearing to review the testimony and documentary evidence submitted and make specific findings of fact and shall reach a conclusion as to whether the appellant committed the activities for which the disciplinary action was taken and whether the appellant's activities constituted just cause for such Probation/Corrective Action Plan or Revocation. The DOAH Hearing Officer, following the requirements of Chapter 120, Florida Statutes will issue a recommended order to both parties.

6.7 EMS Medical Director's Final Order. Subsequent to the recommended order being issued by a DOAH Hearing Officer, the EMS Medical Director, within ten (10) calendar days following receipt of the recommended order which may be adopted, modified or rejected by the EMS Medical Director, shall issue a written final order to the appellant. Such decision shall be final.

Section 7 - Continuing Medical Education (CME)

7.1 CME Program Management. The EMS Authority has the responsibility for the provision of Continuing Medical Education (CME) program in the System. The Authority shall provide, administer, and coordinate the CME Program for Registered Nurses, Paramedics, and EMTs. In administering and coordinating the CME Program, the Authority shall:

1. Provide an EMS Training Coordinator to oversee CME and EMS Academy; and
2. Prepare online and classroom-based curriculum for the review and approval of the EMS Medical Director; and
3. Ensure each Course is of high quality, consistent with EMS training standards, requires the demonstration of competency of the learning objectives; and
4. Ensure a minimum of six months of CME Course curriculum has been completed, reviewed and approved by the Medical Director at all times to ensure uninterrupted operations; and
5. Coordinate and/or lead Instructor Professional Development classes to ensure CME Instructors are prepared to teach individual Courses and held not less than thirty (30) days prior to the start of Course delivery; and
6. Coordinate EMS Academy, In Service Training, advanced practice Courses, special operation Courses and other CME Course offerings as applicable; and

7. Coordinate and/or conduct EMS related conferences, seminars, symposiums, simulation or training exercises, or disaster drills; and
8. Maintain Training Sites and Equipment with the cooperation of applicable Provider Agencies. Ensure each Training Site is equipped with instructional materials, supplies, and training equipment necessary to meet the requirements of the Course being taught; and
9. Maintain the Training Plan; and
10. Maintain the master Training Schedule to ensure uninterrupted field operations and provide active management of the Training Schedule; and
11. Review CME Student records in the Learning Management System as necessary and appropriate for the Authority, Medical Director, and Provider Agencies to verify the Courses attended, training hours completed, skills assessments, and test scores; and
12. Provide hard copy verification of completed CME training transcripts, approved by the Medical Director, to all Provider Agencies and CME Students utilizing the Learning Management System no later than thirty (30) days after each Fiscal Year.

7.2 CME Instruction. A cadre of up to sixty (60) CME Instructors system wide will be identified and certified to serve as CME Instructors to provide regular CME program training for Registered Nurses, Paramedics, and EMTs.

The EMS Medical Director may authorize special CME Instructors to assist with advanced practice Courses, special operations Courses or EMS system orientation that are not counted as part of the core CME Instructor cadre.

If the number of CME Instructors identified by Provider Agencies is insufficient, the Authority may elect to directly provide CME Instructors or have the Training Coordinator serve as a CME Instructor.

CME Instructors shall:

1. Ensure their conduct and appearance is professional and courteous at all times; and
2. Attend Instructor Professional Development classes and instructor development training; and
3. Ensure instruction is conducted in a professional manner including, but not limited to the CME Instructor being trained and prepared to conduct the class; the class being convened and released in a timely manner, and ensuring each CME Student demonstrates competency in the learning objectives or is referred for remedial training; and
4. Conduct CME classes that they are scheduled to teach or requested to teach following the Training Schedule; and
5. Notify the Authority's staff with as much advance notice as practical for any instance in which they will not be available to teach a class to ensure uninterrupted field operations and active management of the Training Schedule; and
6. Record CME Student attendance, assessments and grades at the completion of each class in the Learning Management System or provided forms to ensure records are completed in a timely and accurate manner; and
7. Complete any necessary paperwork to document reimbursable payroll expenses to meet the requirements of the CME Reimbursement Agreement between the Authority and Provider Agencies; and
8. Ensure all regular CME classes are open to all CME Students and Provider Agencies and be registered on the master Training Schedule maintained by the Authority's staff; and

9. Conduct make-up CME classes for small groups or individuals. Such make-up classes must meet all standards of a regular CME class and small group classes shall be registered on the master Training Schedule in advance. Such make-up classes are for special circumstances and not intended to replace regular CME class attendance in accordance with the Training Schedule. Individual make-up classes may be held pursuant to Section 7.5.

7.3 Medical Direction and Oversight. The EMS Medical Director has responsibility for final approval of all CME as described in Chapter 64-J, Florida Administrative Code.

The EMS Medical Director is responsible for providing clinical and editorial guidance to the Training Coordinator and the EMS Training Group Meeting in needs assessment; development of goals and objectives; curriculum development; determination of net clinical impact of training provided; To facilitate this interaction between the EMS Medical Director, the Training Coordinator and the EMS Training Group Meeting, these parties shall create a time line for development of the Training Plan and Training Schedule and for development of individual component Courses.

The Medical Control Board is responsible for advising the EMS Authority on the scope of required CME for all Certified Professionals in the System. This may be in terms of actual contact hours and/or in terms of competency based educational objectives.

7.4 EMS Training Group Meeting. A standing EMS Training Group Meeting shall be maintained to review and discuss Training Sites, the Training Schedule and the Training Plan. Such Training Plan and Training Schedule shall be prepared by the Authority's Training Coordinator and presented at the EMS Training Group Meeting prior to November 15th each year for the following Fiscal Year.

A EMS Training Group Meeting shall be held at least quarterly to review the program's effectiveness, make mid- course corrections to the Training Schedule or Training Plan, evaluate CME Student satisfaction, and serve as an offline review of CME Course curriculum. The EMS Training Group Meeting provides a means for input and feedback regarding the required (primary) and remedial CME program, the EMS Academy, and all EMS training components.

The EMS Training Group Meeting shall be hosted by the EMS Authority staff and the EMS Medical Director. The following stakeholders will be encouraged to attend:

- Pinellas County Fire Chief's Association representatives;
- EMS Coordinators from Provider Agencies and the EMS Leadership Group;
- Management representatives from the Ambulance Contractor;
- CME Instructors from Provider Agencies and the EMS Academy program;
- Pinellas County Fire Training Group (Training Chiefs).

Note: All Provider Agencies are encouraged to participate or send a representative to any meeting including Registered Nurses, Paramedics and EMTs.

7.5 CME Education Requirements. The following maximum CME hours are established by the EMS Authority. These figures may be changed by the EMS Authority with the approval of the Medical Control Board and the EMS Medical Director with input from stakeholders.

EMTs – up to 48 hours of primary CME every two years

Paramedics – up to 72 hours of primary CME every two

years

All Certified EMTs, Paramedics and RNs are expected to regularly attend and/or complete all required CME courses within 30 days of the initial offering. Certified Professionals that do not attend CME within 60 days will be placed on Restriction until the CME is completed. Repeated non-compliance to attend

and/or complete required CME in a timely manner may result in an Administrative Proceeding. Online CME courses shall be kept available and provided at no cost to Certified Professionals. The cost of classroom-based makeup classes will be at the Certified Professional's or Provider Agency's expense. The only exception to the attendance requirement is Military Duty or extended medical leave in accordance with Section 4.16 or an exception allowed by the EMS Medical Director on a case by case basis.

7.6 Training Sites, Equipment and Supplies. Authority and Provider Agencies shall identify appropriate classrooms to serve as Training Sites. Training Sites shall be located regionally throughout the County.

Training Sites shall have a designated location for storage of CME training mannequins, equipment and supplies in Authority provided cabinets. Provider Agencies that offer to provide a Training Site shall provide a liaison to coordinate classroom availability and logistics.

The Authority shall provide training simulation mannequins; instructional equipment such as a laptop computer and projector; training equipment, equipment bags, disposable medical supplies, and training supplies in sufficient numbers for each Training Site.

7.7 CME Release Form. Provider Agencies shall obtain a CME Release Form from CME Students to authorize the release to the Authority, the Medical Director, and Florida Department of Health CME Student information regarding CME Student attendance, performance, and grades.

7.8 Performance Evaluation. The Authority shall establish procedures to regularly evaluate the educational effectiveness of instruction, Courses, and programs offered with the Medical Director, Provider Agencies and CME Students to ensure the program is high performing and meeting the learning needs of CME Students and stakeholders.

The Authority shall establish, with the Medical Director, procedures to evaluate the clinical impact and effectiveness of the entire CME program as a part of its role in quality assurance and improvement for the EMS System.

The Authority, Medical Director and Provider Agencies shall cooperate and work collectively to detect and correct performance deficiencies and work together to upgrade the performance and reliability of the CME program.

Section 8 – Wheelchair Transport/Stretcher Van Standards

8.1 Dispatch Records. WCT Provider Agencies shall record all incoming telephone lines upon which requests for transport services are made and shall maintain a written or electronic dispatch record containing the following information for each call – date and time call received, Client name, pick up address, destination address, name and contact information for the person ordering transport, Audio dispatch recordings shall be kept for a minimum of six (6) months. Written or electronic dispatch records shall be kept for a minimum of three (3) years. Audio dispatch recordings and written or electronic dispatch records shall be available for inspection by the EMS Authority, the EMS Medical Director or his designee and the Medical Control Board.

8.2 Insurance Requirements. WCT Provider Agencies shall be insured or self-insured at all times and provide a certificate of insurance or evidence of self-insurance to the Authority. As a minimum WCT Provider Agencies operating wheelchair transport only must have a $100,000 bodily injury liability per person and $300,000 total bodily injured liability per accident insurance policy. As a minimum WCT Provider Agencies operating stretcher van services must have a $300,000 bodily injury liability per person and $500,000 total bodily injured liability per accident insurance policy.

8.3 Wheelchair Vehicle Requirements. WCT Provider Agencies shall only transport Clients in vehicles which have valid EMS Authority vehicle permits. Permits must be displayed on the windshield of the vehicle. Permits will be issued only to vehicles which have been inspected by the EMS Authority on an annual basis. Wheelchair Vehicles shall (a) have an inside rear-vision mirror that allows the driver to visually monitor the passenger compartment; (b) have a smooth, easily cleaned floor that can be maintained in a safe, sanitary and odor-free manner and shall extend the full length and width of the passenger compartments; (c) have a 2A:10B:C fire extinguisher or equivalent; (d) have operable interior lights; (e) be free of dents and rust that interfere with the safe operation of the vehicle;(f) have all equipment in the passenger compartment safely secured; (g) have all doors, latches, and handles in proper working order; (h) be equipped with a lift platform that is operated electronically, hydraulically, or manually with sufficient capacity to safely and smoothly lift Clients into the vehicle; (i) have, for each wheelchair or stretcher position, means of securely locking the wheelchair or stretcher to the vehicle. Locking devices shall be designed so as not to permit longitudinal or lateral movement of the wheelchair or stretcher; (j) have, for each person transported, restraining belts designed to securely confine the person to the wheelchair or stretcher; (k) vehicle interiors, stretchers, and wheelchairs shall be clean, sanitary, and in good working order.

8.4 Wheelchair and Stretcher Van Allowed Services. Transport (WCT) Providers may be used to transport Clients only. The foremost concern in all circumstances is the welfare of the Client, which is best served by the involvement of EMS and transport by Ambulance whenever the criteria of being a Patient are met.

Clients may be transported by WCT Provider Agencies under the following conditions: (a) any transport with the destination being the client's residence. The residence may be a private home, an Adult Congregate Living Facility or a Nursing Home; (b) any transport with a non-medical destination (social or recreational activities, etc.); (c) any transport with the destination being a doctor's office, a clinic, dialysis center or out-patient treatment center, provided the client does not meet any criteria that causes them to be classified as a patient; (d) any transport with the destination being a hospital unit or ward excluding the Emergency Department, Critical Care or Telemetry Units. It is presumed that the client is a patient if they are being transported to an Emergency Department or a unit that provides critical care services. However, clients may be transported to an Emergency Department for non-emergency treatment such as suture removal, urinary catheter checks, gastric tube checks, etc.; (e) any positive or colonized MRSA (Methicillin Resistant Staphylococcus Aureus) infection of the blood, urine, feces, and simple wounds. However, WCT Provider Agencies must have infection control procedures in place that meet state and federal guidelines.

8.5 Medical Oxygen use by a Client during transport. WCT Provider Agencies shall confirm, either in writing or via a recorded telephone call, that all of the following criteria are met: (a) a physician has prescribed the oxygen and has determined that the Client is able to be transported safely Wheelchair or Stretcher Van and transportation by Ambulance is unnecessary; (b) the Client is able to self-administer the oxygen and does so independently; (c) oxygen is available at the client's destination. WCT Drivers are not licensed to administer oxygen or regulate oxygen flow or dosage pursuant to Chapter 401.23 (7), F.S. and Chapter 499, F.S. Therefore, WCT Drivers are strictly prohibited from starting, stopping or adjusting the dosage or method of oxygen delivery.

8.6 Client to Patient Criteria. A Client becomes a Patient in any of the following circumstances: (a) absence or difficulty breathing; (b) absence of a pulse; (c) any alteration in the client's normal level of consciousness; (d) recent trauma (within six hours); (e) any signs of shock (pale, cool or moist skin); (f) the person needs or is likely to need medical attention during transport; (g) the Client requires continuous oxygen that is not self-administered; (h) a request made by the sending agency that additional medical support personnel attend the Client's medical needs during transport (i.e. facility nurse, respiratory tech, etc.); (i) any positive (Methicillin Resistant Staphylococcus Aureus(MRSA) infection of the respiratory

system; (j) any individual being transported for involuntary or voluntary examination or placement in accordance with the Florida Mental Health Act (Baker Act).

8.7 Medical emergencies encountered during transport. If a Client becomes a Patient during transport the WCT Driver will drive the Patient to the nearest Hospital emergency department if it is less than three miles away. If the distance is greater, the WCT Driver will summon EMS via their dispatch center or telephone. The WCT Driver will safely stop the vehicle and render first aid and/or cardiopulmonary resuscitation (CPR) while EMS is responding.

8.8 EMT or Paramedic Insignia. While operating Wheelchair Transport/Stretcher Van vehicles, individuals certified as Emergency Medical Technicians and Paramedics are not permitted to wear any insignia that identifies them as an EMT or Paramedic as they are not working for a licensed EMS provider pursuant to Section 401.27(13), Florida Statutes.

8.9 Review and Approval of EMS Medical Director. The EMS Medical Director has reviewed and approved the clinical protocol aspects of Section 8 of the EMS Rules & Regulations. For simplicity in regulating the WCT Provider Agencies all rules, regulations and clinical protocols have been formatted in one section of the EMS Rules & Regulations.

Section 9 – EMS Stakeholder Meetings

9.1 EMS Stakeholder Meetings. EMS Authority's staff and the EMS Medical Director will meet with various stakeholder groups including, but not limited to:

- EMS Coordinators (EMS Leadership Group)
- EMS Training Group Meeting
- Hospital emergency department nurse managers
- Provider Stress/wellness
- Electronic patient care reporting
- Other ad hoc meetings as needed.

Such meetings shall be held on a regular and ongoing basis to seek input from EMS System stakeholders. Such meetings shall be fact finding in nature to ensure quality improvement initiatives, training plans and other projects have stakeholder input prior to implementation.

APPENDIX A
PINELLAS COUNTY EMERGENCY MEDICAL SERVICES
RULES & REGULATIONS
BACKGROUND SCREENING AFFIDAVIT

Both the Applicant and the undersigned duly authorized representative of the Provider Agency hereby certifies and attests the information in this affidavit is true, correct and has been verified, as follows:

Applicant Full Name/Alias: ______________________________

Applicant Date of Birth: ______________________________

Provider Agency Name/ PCEMS ID: ______________________________

1. Applicant has attached a color photocopy of a Governmental Issued Photo ID, a State Photo Identification Card or Driver's License; which was verified by the Provider Agency. Applicant may redact their home address.

2. Provider Agency has conducted or attached a recent (less than forty-five day old) background check meeting the following criteria:

   - Florida Agency for Healthcare Administration (AHCA), Florida Department of Children & Families (DCF), or Florida Department of Elder Affairs (DOEA) Level 2 Background Screening Letter of Eligibility; or
   - Florida Department of Law Enforcement (FDLE) Criminal History Record Check (CHRC) Report; or
   - Provider Agency certifies the Provider Agency has run a background check to the greatest extent possible by law and to the Provider Agency's best knowledge Applicant: (1) has not been convicted of a felony, (2) has not been convicted of a misdemeanor directly related to his/her employment, or (3) has not pled nolo contendere to any charge of felony.

3. Applicant has attached their Florida Department of Health License. Provider Agency has verified the license is "CLEAR/ACTIVE" and attached a copy of the current status web inquiry. **Any discipline on file must be attached.** (www.flhealthsource.gov)

4. Provider Agency has verified the Applicant is not listed on the U.S. Department of Health & Human Services Exclusions Database for Medicare providers (exclusions.oig.hhs.gov). Attach a copy of the current status web inquiry.

5. Applicant has provided three (3) personal (non-relative) references who attest to the Applicant's moral character which have been verified by the Provider Agency.

______________________________	______________________________
APPLICANT SIGNATURE AND DATE	**PROVIDER AGENCY SIGNATURE AND DATE**
______________________________	______________________________
APPLICANT PRINTED NAME	**PROVIDER AGENCY PRINTED NAME**

APPENDIX B
PINELLAS COUNTY EMERGENCY MEDICAL SERVICES
RULES & REGULATIONS

JUST CULTURE FRAMEWORK

Duty to produce an outcome	Duty to follow established protocols & procedures	Duty to avoid causing unjustifiable risk or harm
Human Error	**At-Risk Behavior**	**Reckless Behavior**
Root cause is human error or inadvertent action-oversight, lapse or mistake.	Root cause is at-risk behavior by a clinician where the risks were unrecognized or believed to be insignificant or justified.	Root cause is a conscious disregard of substantial & unjustifiable risk by a clinician.
Improvement Efforts	**Improvement Efforts**	**Management**
Individual/Team:	**Individual/Team:**	**Individual/Team**
• Quality assurance review • Medical case review • Remedial training	• Clinical restriction (case basis) • Quality assurance review • Medical case review • Remedial training	• Clinical restriction or suspension (case basis) • Quality assurance review • Administrative proceeding • Corrective action plan • Probation • Revocation of clinical privileges
System:	**System:**	
• Continuing medical education • Protocol improvement • Situational awareness • Best practices implementation • Patient care safety systems • Process improvement • Medical equipment & supply improvements	• Supporting culture expects healthy behaviors, corrects & minimizes at-risk behavior • Continuing medical education • Situational awareness **NOTE: Repeat at-risk behavior is reckless.**	
Console	**Coach**	**Correct**

Note: Management of individual Quality Assurance Reviews or Medical Case Reviews is based upon this framework. A detailed flowchart for Just Culture implementation and decision making is contained in the EMS Medical Director's Medical Quality Management (MQM) Plan to ensure the proper application of the framework on a case by case basis.

AD23.4 CLINICAL STATUS INQUIRY

AUTHORIZATION TO RELEASE INFORMATION

REQUESTING AGENCY NAME	
AGENCY REPRESENTATIVE NAME	

I hereby authorize the release of the information below to my prospective Employer/Agency regarding my Pinellas County EMS Certification.

CLINICIAN NAME	
CLINICIAN SIGNATURE	
DATE	
PREVIOUS OR CURRENT PINELLAS COUNTY EMS ID NUMBER(S)	

DO NOT WRITE BELOW – EMS & FIRE ADMINISTRATION USE ONLY

Clinical Status (current or most recent)

Certified		Provisional		Restricted	
Suspended		Revoked		Inactive	

Any open/outstanding quality assurance reviews (QARs)	YES		NO	
Continuing medical education/training	Current		Not Current	

The quality assurance (QA)/service record has been reviewed and the transfer of certification is anticipated to be:	Approved		Not Approved	

EMS MEDICAL DIRECTOR SIGNATURE OR DESIGNEE		DATE	

NOTE: This informational status review does not grant clinical privileges nor guarantee that clinical privileges will be granted after review of the full application packet.

AD23.4 CLINICAL STATUS INQUIRY

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AD2 911 CALL PROCESSING AND RESPONSE ASSIGNMENT

Purpose:

To establish a procedure to ensure that the appropriate response resources are dispatched in the appropriate response modes to 911 requests for assistance received by the Pinellas County EMS System.

Description:

The Pinellas County EMS System responds to a large number of requests for emergency and non-emergency medical assistance every day. To ensure that all requests receive a consistent determination of appropriate response assignment, gathering of information to relay to responders, and pre-arrival medical instructions, a comprehensive and pre-determined system of call classification and triage is necessary.

Definitions:

- "Response Mode" means either an "Emergency Response" (lights and sirens) or a "Downgraded Emergency" response (no lights and sirens).
- "Emergency Response" may be called "HOT" or "Upgraded" and indicates use of lights and sirens.
- "Downgraded Emergency" may be called "COLD" or "Downgraded" and indicates that no lights or sirens are being used.
- "Response Configuration" means First Responder, Ambulance, or both sent to a call for assistance.
- "EMD" means an Emergency Medical Dispatcher certified by the International Academies of Emergency Medical Dispatch.
- "911 Center" means the Pinellas County Regional 911 Center
- "Sunstar Communications" means the Sunstar staff located in the 911 center who perform call taking, dispatching, and System Status Management.
- "911 Dispatcher" means a 911 Center staff member who is performing EMD or radio channel operator function.
- "Medical Priority Dispatch System" or "MPDS" means the International Academies of Emergency Medical Dispatch System that is currently approved for use by Pinellas County EMS.
- "EMD Determinant" means the code assigned to each type of 911 call processed using the MPDS.
- "Unfounded Incident" means an incident that is unable to be located or has no patient able to be found when responders arrive.
- "At Patient" means that a responder has arrived at the patient's side such that patient assessment and care can be initiated.
- "On Scene" means that a responder has arrived at the address or physical location of the incident. In general, this is the time at which the response vehicle is parked.

Definitions (cont.):

- "Medical Professional in attendance" means a licensed health care worker that is with the patient and will remain with the patient until arrival of EMS. This *classification* includes LPN, RN, ARNP, PA-C, and medical physician.
- "Skilled Nursing Facility" means a licensed residential care facility able to be verified as the source of the 911 call by the call taker.

Policy

911 Call Handling

The Pinellas County EMS System shall employ the International Academies of Emergency Dispatch's Medical Priority Dispatch System (MPDS), Version 14.0. From time to time, it may become necessary for the system to amend or modify call handling procedures, interrogation questions, pre-arrival medical instructions, and response configurations because of medical research, local needs, and the evolution of the MPDS via protocol or medical control directive (Ref. AD3 MPDS Local Options).

Unit Assignment

Upon receipt of a 9-1-1/EMS call, Pinellas County Emergency Communications (9-1-1) will process the call and dispatch the appropriate unit(s) by closest available unit regardless of jurisdiction. The Sunstar Communications Center will dispatch the closest available and most appropriate ambulance(s).

911 Call Response Modes

All Pinellas County EMS ALS First Responders and Ambulances will respond to 911 calls for assistance in the following response modes:

MPDS Call Determinant Level	ALS First Responder	ALS Ambulance
Echo	Emergency	Emergency
Delta	Emergency	Emergency
Charlie	Emergency	Emergency
Bravo	Emergency	Emergency
Alpha	Downgraded Emergency	Downgraded Emergency
Omega	Downgraded Emergency	Downgraded Emergency

911 Call Response Configurations

In general, Pinellas County EMS shall assign both an ALS First Responder and an ALS Ambulance to respond to all 911 calls for assistance. The following MPDS Determinants will have a reduced response configuration:

AD2 911 CALL PROCESSING AND RESPONSE ASSIGNMENT

First Responder Only Determinants

Card #	Category	Determinants
2	Allergies (reactions)/Envenomation (stings, bites)	02A01, 02A02
3	Animal Bites/Attacks	03A01, 03A02, 03A03
4	Assault/Sexual Assault/Stun Gun	04A01, 04A02, 04B00, 04B01, 04B02, 04B03
7	Burns (scalds)/Explosion (blast)	07A01, 07A02, 07A03
8	Carbon Monoxide/Inhalation/Hazmat/CBRN	08O01, 08B00, 08B01
9	Cardiac or Respiratory Arrest/Death	09O01, 09B00, 09B01 (a-g, x, y)
16	Eye Problems/Injuries	16A01, 16A02, 16A03
20	Health/Cold Exposure	20A01, 20B00, 20B01, 20B02
22	Inaccessible incident/Other entrapments	22A01
29	Traffic/Transportation incidents	29O01, 29A01
32	Unknown Problem (man down)	32B01, 32B02, 32B03, 32B04

Response Configuration Exceptions

1. 23 Ω may be processed with Poison Information Center consultation prior to dispatching response units (Ref. AD5 Poison Information Center Consultation).

2. Calls received on the 911 line for a patient with a medical professional in attendance, when that patient is located in a facility licensed under Florida Statute 395 or located in a verified Skilled Nursing Facility unit, may have initial dispatch deferred while being processed via MPDS and shipped to Sunstar Communications for an ambulance only response if an alpha level determinant is received. 911 call takers must ensure standard dispatch is initiated immediately upon identifying any priority symptoms.

3. When the response configuration is determined to be a single resource type (e.g., Ambulance only) the following exceptions shall apply:

   a. If the single resource type is predicted to have a likely response time of greater than 20 minutes, the call shall immediately have an additional resource type (e.g., First Responder) assigned.
   b. If during patient assessment or transport, the patient is determined to be Category RED, the treating Paramedic shall use best judgement as to if the best course of action is to initiate/continue transport to the nearest appropriate ED (Ref CS4) or request the assignment of additional ALS resources.

4. From time to time, it may become necessary for the system to amend or modify response configurations due to local needs and circumstances via medical control directive.

AD2 911 CALL PROCESSING AND RESPONSE ASSIGNMENT

Initial Dispatch and Response Mode Determination

All EMS Units will initially respond EMERGENCY to an incident until an EMD Determinant is reached unless noted in exceptions above. The 9-1-1 Dispatcher and the Sunstar SSC will advise responding units of any scene safety information, the primary complaint (chest pain, falls, etc.) and response mode (emergency vs. downgraded emergency). Patient's age, sex, conscious and breathing status may also be relayed as time permits and when appropriate.

The EMD will document additional information obtained during the caller interrogation (medical, scene safety, infection control precautions) in the call notes and will update the response configuration and response mode when the EMD Determinant has been established.

The 911 Dispatcher and Sunstar Communications will advise the responding units of the response determinant over the assigned radio tactical channels or via Mobile Communications Terminal (MCT). Units will alter their response upon receipt of the determinant via radio or MCT message.

Response Mode Coordination

Upon receipt of the response information, First Responder and Ambulance units will monitor and utilize the working Fire Tactical Channel as assigned during response and on-scene operations and will promptly acknowledge upgrades, downgrades, cancellations and requests for locations or estimated time of arrival (ETA). The first arriving ALS (First Responder or Ambulance) unit will advise "On-Scene" and "At Patient" on the working Fire Tactical Channel. BLS Units will advise "On-Scene" and "At-Patient" when they arrive before any ALS unit.

The first arriving ALS or BLS unit shall assess the condition of the patient(s) and scene and rapidly advise other responding units to upgrade or downgrade and request any additional resources needed. The first ALS Unit may cancel other responding units as appropriate after patient assessment. A BLS unit or a law enforcement officer on scene may downgrade but cannot cancel the nearest ALS Unit. At least one licensed/permitted ALS Unit (or BLS Unit with a County Certified paramedic) must arrive to evaluate all patients.

If the Ambulance is the first ALS unit to reach the scene of a motor vehicle crash with all patients refusing EMS evaluation and transport, the Ambulance will downgrade the incoming First Responders and complete the refusal documentation. The Ambulance will not cancel the First Responders. First Responders will continue in non-emergency, await law enforcement, and perform hazard assessment and abatement as necessary. The Ambulance will go available when refusals are completed, and scene is turned over to First Responders. If multiple First Responder units are enroute to the scene, First Responders will use their discretion to cancel other incoming First Response units as appropriate, as long as one First Responder unit continues to the scene.

AD2 911 CALL PROCESSING AND RESPONSE ASSIGNMENT

Sunstar Communications staff shall advise ambulance units when they are being assigned as a closer unit at the time of dispatch. When an ambulance is advised that they are being dispatched as a "Closer Unit," they will immediately come up on the Fire Tactical Channel using their portable radio and advise the First Responder unit that they are responding as a closer unit, their response mode, and location/ETA.

When responding with the First Responder to a fire incident, Ambulances are to respond non-emergency unless requested emergency by the incident commander or pre-arrival information indicates possible or known patients at the scene. Ambulances will not prompt Command for an assignment or staging location.

Staging

When responding to volatile, violent, or unsecured incidents requiring staging, First Responder or Ambulance units will respond emergency to the staging location unless their ETA to the staging location is less than five minutes; or another ALS unit has arrived at the staging location; or the call has been downgraded by EMD. If the scene is cleared by law enforcement while enroute non-emergency, the unit may then upgrade if necessary. (Ref AD5 Staging)

Units Self-Altering Response Mode

First Responders, Ambulances, and other Pinellas County EMS System personnel responding to requests for assistance may deviate (upgrade or downgrade) from the response determinant at their discretion as conditions dictate (e.g., staging, scene hazards, weather, heavy traffic, or additional patient information). All response mode deviations will be relayed to the appropriate 9-1-1 working tactical dispatcher and documented in the "notes" of the call. This is a mandatory reporting requirement. First Responder and Ambulance Units may not order the upgrade or downgrade of any other responding units until they are physically with the patient and completed a primary patient assessment.

Cancellation Enroute

A Pinellas County EMS unit must continue to the scene of every 911 request for service and determine the need for EMS firsthand. An EMS response shall not be cancelled by the general public or law enforcement.

"Unfounded" Incidents

"Unfounded" Incidents shall be investigated with the highest degree of diligence (e.g., thorough search of the reported incident location and perimeter, forced entry consideration, call back attempts to the location by either the Sunstar Communications Center or 9-1-1, confirmation of CAD information, etc.). The first arriving EMS unit at the dispatched scene location will advise 9-1-1 or the Sunstar Communications Center of all efforts made to locate the patient and reason for cancellation of EMS units as applicable.

AD2 911 CALL PROCESSING AND RESPONSE ASSIGNMENT

Calls to 911 Requesting Services Other Than an Emergency Medical System Response

1. "Request for Information" (medical related)
   The EMD will process the incident with the MPDS. If the caller refuses EMS response, the EMD may advise the caller of other options (e.g., ER, immediate care clinic, call their physician, etc.). EMD will document all information in CAD. EMD's may not give patient care instructions outside of the MPDS protocols, or above a BLS level of care (e.g., stingray treatment with hot water, bleeding control, etc. are acceptable, but medication administration is not.)

2. Request for Poison Information - Reference Protocol AD5.

3. Request for Directions
   If a caller is requesting directions to a care facility, the EMD will provide the caller with the option of an EMS response to their vehicle if they will stop. If the caller refuses to stop, EMD may give the requested information to the caller. EMD will document all information in CAD.

AD3 MEDICAL PRIORITY DISPATCH (MPDS) LOCAL OPTIONS

Purpose:

To define the local options authorized for use with Version 14.0 of the Medical Priority Dispatch System (MPDS)

Description:

The Pinellas County EMS System processes calls for service using the MPDS System. Certain protocols within the system allow for the local EMS Medical Director to specify options. Additionally, the local EMS Medical Director may alter specific parts of the system as deemed necessary. This directive applies only to call processing/dispatching and not to the care provided at the side of a patient.

Policy:

Protocol 1: Abdominal Pain/Problems

- When a call-taker codes a call with the determinate 1-A-2 Non-traumatic testicle or groin pain (male) they are to upgrade the call to a 1-C-O for emergency response.

Protocol 2: Allergies (Reactions) Envenomation (Stings, Bites)

- Panel 7 (P7) Expired Injector Kit:
  - **DO NOT** read the following instructions:

    "It is common to have an expired kit, which may be discolored or have particles in it. Out-of-date injectors can still contain significant amounts of adrenaline (epinephrine) that can help her/him.
  - **DO NOT** read the following instructions:

    "They just might not be as strong."
  - **DO NOT** read the following instructions:

    "Unless you have another one immediately handy, we advise you to use this one now."

Protocol 9: Cardiac or Respiratory Arrest/Death

- The following criteria **ARE AUTHORIZED** to be defined as "Obvious Death":

A - Cold and stiff in a warm environment	D - Incineration
B - Decapitation	E - Non-recent death (6 hours or more)
C - Decomposition	F - Severe injuries obviously incompatible with life

AD3 MEDICAL PRIORITY DISPATCH (MPDS) LOCAL OPTIONS

Protocol 9: Cardiac or Respiratory Arrest/Death (cont.)

- The following criteria **ARE AUTHORIZED** to be defined as "Expected Death":

  Note: Pinellas County EMS responds on all Expected Death calls (Ref. AD1)

X - Terminal Illness	Y - Do Not Resuscitate Order (DNR)

- The "C Only – Continuous compressions until responder arrival" as the "Cardiac Arrest Pathway" **IS AUTHORIZED**.
- The ventilations pathway **IS AUTHORIZED** for use on patients less than eight years old
- The Call-Taker is not to abort the Pre-Arrival instructions in the event an expected death situation is discovered. The call taker is to remain in the pre-arrival instruction panel until EMS arrives on scene. If the caller refuses to perform CPR, do not attempt to force him/her to do it. Proceed to the unstable patient panel and remain on the line with the caller.

Protocol 24 Pregnancy/Childbirth/Miscarriage

- The "OMEGA Referral" for "Waters Broken" is **NOT AUTHORIZED**.
  - Pinellas County EMS responds on all Pregnancy/Childbirth/Miscarriage calls.
- On Panel F-23 Breech delivery: The call-taker will add the words "or pull" and read line 1 of the panel as follows:
  - "*Do not touch or pull the baby. The mother should be able to deliver this way.*"
- In the case of a *Still Birth (non-viable baby born)* as defined by the EMD protocol, the instruction found in G-2-Wrap Fetus (and afterbirth):
  - "*I'm very sorry. There's **nothing** we can do for the baby*" is **NOT AUTHORIZED** to be read to the caller.
- The ***HIGH-RISK*** Complications List found in the Additional Information (AI) section under Protocol 24 **IS AUTHORIZED** in its entirety with the following addition "A physician has told you that you are ***HIGH-RISK***".

Protocol 28 Stroke (CVA)

- Twenty-four (24) hours **IS AUTHORIZED** as the amount of time for the "stroke treatment window"

AD3 MEDICAL PRIORITY DISPATCH (MPDS) LOCAL OPTIONS

Stroke Diagnostic Tool

- The Stroke Diagnostic Tool is to be used only after the SEND point has been reached and sent, by ProQA or only after an EMD determinant has been reached and sent via use of the card set (post-dispatch)

Aspirin Diagnostic & Instruction Tool

- Aspirin administration **IS AUTHORIZED** in patients presenting to EMS with chest pain or heart attack symptoms per MPDS criteria.
- Aspirin (ASA) is the only approved medication for the EMD to advise to administer.
  - The other medications listed on the "Aspirin-Containing Medication" list found in the "Additional Information (AI)" section of the "Aspirin Diagnostics and Instructions" are **NOT AUTHORIZED** for use.
  - The Call-Taker will omit the words "or medication containing aspirin" and read "Does anyone there have any aspirin available?"
- Rule 8: "Use of the Aspirin Diagnostic & Instruction Tool may be considered when a patient reported to be not alert is known to be awake, talking, and responding. Sips of water should only be provided upon patient request." is **NOT AUTHORIZED** for use. Aspirin should only be administered to a patient who is alert.

Protocol 45 Specialized Unscheduled Up-Care Transport

- Determinant 45-C-13 is **NOT AUTHORIZED** for use.

Case Exit

- The new CEI (Critical EMD Information) is not to be followed on the Universal Instructions section on Protocol X, "Sips of water may be permitted for alert patients who request it when climate and/or prolonged response times are an issue."

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AD4 NON-EMERGENCY LINE CALL PROCESSING AND AMBULANCE RESPONSE ASSIGNMENT

Purpose

To establish a procedure to ensure that the appropriate response configuration and resources are dispatched in the appropriate response modes to requests for assistance received by the Pinellas County EMS System on the 7-digit non-emergency line.

Description

The Pinellas County EMS System responds to a large number of requests for emergency and non-emergency medical assistance every day. To ensure that all requests receive a consistent determination of appropriate response assignment, gathering of information to relay to responders, and pre-arrival medical instructions, a comprehensive and pre-determined system of call classification and triage is necessary.

Definitions

- “Medical Professional in attendance” means a licensed health care worker who is with the patient and will remain with the patient until arrival of EMS. This classification includes: LPN, RN, ARNP, PA-C, and Medical Physician.

- “Acute Care Facility” means a hospital, hospital ER, Freestanding ER, or PCSO Jail Medical Facility/Ward.
  - Note: The PCSO intake area (aka “Sallyport”), Psychiatric Crisis Stabilization Units, and Inpatient Psychiatric Hospital wards are not considered “Acute Care Facilities” for the purposes of this protocol.

- “Non-Emergency Line” means the telephone number other than 911 used to access the Sunstar Communications Center for the purposes of making a request for service.

Policy

General Guidance

Sunstar Communications Staff who answer calls on the non-emergency line will upgrade to a normal 911-system response and ship the call to the 911 Dispatcher anytime there is uncertainty regarding the appropriate response and when there is an identified patient who does not fall into one of the categories on the next page.

AD4 NON-EMERGENCY LINE CALL PROCESSING AND AMBULANCE RESPONSE ASSIGNMENT

Establishing Ambulance Response Priority Codes

Sunstar Communications Staff will code requests for service using the following Response Priority Codes:

Ambulance Response Priority Codes	
Priority 1	Emergency Request
Priority 2	Downgraded Emergency Request
Priority 3	Non-Emergency Request Scheduled
Priority 4	Non-Emergency Request Pre-Scheduled
Priority 5	Omega/Hold Call
Priority 6	Long Distance Transfer Scheduled
Priority 8	Long Distance Transfer – Pre-scheduled
Priority 7	Critical Care Transport
Priority 10	Mental Health Transport

Establishing Acuity Levels for Interfacility Ambulance Transfers

Interfacility Ambulance Transfer Acuity Levels (Ref. AD6 and CT27 for criteria)	
Acuity Level I	CCT / CCP Ambulance (Ref. CCT MOM AP1, CT2)
Acuity Level II	ALS Ambulance
Acuity Level III	BLS Ambulance

General Public Calling Party and Patient with a Chief Complaint

All calls received on the non-emergency line from the general public in which a chief complaint or priority symptom is identified will be processed as if they were received on the 911 line and assigned as Priority 1 or Priority 2. (Ref. AD2)

Interfacility Transfers – Acute Care Facility to Acute Care Facility

Calls received on the non-emergency line from medical professionals who are in attendance with the patient at an acute care facility and are requesting an interfacility transfer to another acute care hospital, will initially be processed using MPDS Protocol Card 45. Sunstar Communication Center Staff will refer to Protocol AD7 and CT24 and assign the appropriate acuity level/transport unit type based upon needed scope of care.

Note that calls from an acute care hospital on the 911 line will still generate a full system response.

AD4 NON-EMERGENCY LINE CALL PROCESSING AND AMBULANCE RESPONSE ASSIGNMENT

Interfacility Transfers to a Higher Level of Care (*excluding acute care to acute care*)

Calls received on the non-emergency line from medical professionals who are in attendance with the patient at a residential or non-acute care facility and requesting an interfacility transfer to a higher level of care may be processed using MPDS Protocol Card 45 if no chief complaint is stated. If a chief complaint is stated, calls will be processed using standard MPDS protocols. If MPDS call processing yields a determinant other than 45 ***OR*** higher priority than Alpha on 1 – 32 Protocols, the call will be shipped to the 911 Dispatcher for full system response (Priority 1) (Ref. AD2)

Once EMD has been completed and the EMD determinant level is an Alpha level response or 45 determinant, the incident should be coded as a Priority 2 response, with only an ambulance being assigned to the incident. (Acuity Level II)

Interfacility Transfers to a Lower Level of Care, Discharges, and Other Routine Patient Transfers

Calls from staff at a medical facility for transfer to a lower level of care (hospital discharge to a nursing facility, dialysis appointment, wound care treatment, doctor's appointment etc.) may be processed using MPDS. Calls may be assigned an acuity level (I, II, or III) based upon needed resources (Ref AD7 and CT24). If all criteria in AD6 are met, a Mental Health Transport Unit may be dispatched in place of an ambulance.

Law Enforcement Requests for Non-Emergency Response

All calls received on the non-emergency line from law enforcement in which a chief complaint or priority symptom is identified will be processed as if they were received on a 911 line and assigned as Priority 1 or Priority 2. (Reference AD4)

Requests from Law Enforcement Agencies for non-emergency transport (e.g., Baker Act, sick person, "routine transport") with Law Enforcement on scene may be coded as Priority 2 and not shipped to 911 Dispatchers. Sunstar Communications Staff (must be EMD) will employ the MPDS to assign an appropriate determinant to the incident. The EMD may use discretion to upgrade call to Priority 1 or Priority 2 and ship to 9-1-1 due to Priority symptoms, lack of patient information and/or no confirmation that Law Enforcement will remain with the patient until the arrival of EMS.

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AD5 RESPONDER SAFETY AND STAGING

Purpose:

The purpose of this policy is to authorize appropriate response alterations when responding to potentially unsafe incidents, thereby ensuring the safety of responding personnel

Description:

Pinellas County EMS responders are often dispatched to violent, potentially violent, volatile, or otherwise unsafe situations. Although responders have a duty to act, this duty does not supersede the need for responder safety

Definitions:

- **High Risk Scene –** Any situation suspected of posing an elevated risk of the threat of violence to responders
- **Staging** – The deliberate slowing of response to allow law enforcement to enter and secure a high-risk scene prior to the arrival of EMS personnel at patient
- **Retreat** – The withdraw from an unanticipated High-Risk Scene, with or without extricating the patient, due to a perceived elevated risk of violence or harm to EMS personnel
- **Patient Abandonment** – The premature or inappropriate cessation of patient care

Policy:

- Staging
  - Decision to Stage
    - Dispatch Initiated
      - The 911 Center and Sunstar Communications personnel will relay scene safety concerns based upon caller information or law enforcement reports to responding units and may advise to consider staging
    - Responder Initiated
      - Responders are authorized to make the decision to delay patient contact for staging based upon dispatch information, law enforcement reports, or encountered conditions
  - Staging Actions
    - Upon making the decision to stage, responding units will immediately notify dispatch of:
      - The decision to stage
      - Staging location
      - Recommended safe access route for additional units
      - The need for law enforcement if not already responding

- Upon notification of a staging situation, all units shall take the following actions:
  - Downgrade to non-emergency response and turn off lights and sirens unless responding from a distance or notified differently
  - If responding from a distance, units shall downgrade while still enough distance from the scene/staging location to maintain safety
  - Park out of sight of the scene location or safely outside the Danger Zone (an area of about 120 degrees in front of the scene that is normally partially exposed)
  - Monitor for situation updates from dispatch and law enforcement and consider donning appropriate PPE (ballistic vest and helmet)
  - Once law enforcement has stabilized the area, emergency units may enter the scene with caution.

- Retreat:
  - Responders are authorized to make the decision to retreat when encountering an unanticipated violent situation or otherwise high-risk scene to ensure safety.
  - Responders are not obligated to extract the patient during a retreat.
  - Neither the decision to retreat nor the inability to extract the patient constitute patient abandonment.

AD6 POISON INFORMATION CENTER CONSULTATION

Purpose

To establish the procedure for Emergency Medical Dispatchers to handle consultations and transfers between the Pinellas County EMS System and the Florida Poison Information Center - Tampa (Poison Center)

Description

The Pinellas County EMS System and the Florida Poison Information Center – Tampa are obligated to work cooperatively to minimize the impact of poisonings and overdoses on our community. This policy describes the ways in which the Pinellas County EMS System will access the Poison Center's resources.

Policy

Emergency Medical Dispatchers

Emergency Medical Dispatchers (EMDs) will process all calls to 911 and the seven-digit non-emergency number for a patient experiencing an overdose and poisoning utilizing the Medical Priority Dispatch System (MPDS) and other established protocols (Ref. AD2, AD3, AD4). After completing call classification, dispatching, and giving appropriate Post-Dispatch Instructions, an EMD may elect to contact Poison Center to obtain further information regarding the case for relay to responding units.

An EMD may conference a caller with the Poison Center to assist in determining the need for an EMS response only if the patient is ***asymptomatic, the exposure was unintentional, and the 23-Ω-1*** determinant is reached. The EMD must remain on the line to initiate an EMS response as recommended by the Poison Center.

An EMD may transfer a call to the Poison Center without initiating an EMS response only if the caller is seeking information about a medication or poisoning and there has been ***no ingestion***. An EMD will verify the address, transfer the call to Poison Control and may disconnect the line.

Pinellas County Certified Professionals

Pinellas County Certified Clinicians may consult the Poison Center to obtain information regarding a case ***only after consultation with the OLMC Physician***. Every effort should be made to conference the Clinician, the OLMC Physician, and the Poison Center on a single line to ensure common understanding of a situation and continuity of care.

AD6 POISON INFORMATION CENTER CONSULTATION

Medical Direction Standing Orders for Consultation

From time to time, the Pinellas County EMS Medical Director may initiate automatic or standing consultation to the Poison Center to assist in the management and investigation of cases deemed associated with a threat to public health, large-scale gathering, mass casualty incident, or other significant events. Such consultations may be initiated using an automated system.

AD7 INTERFACILITY TRANSPORT SPECIALTY UNIT UTILIZATION

Purpose:

To enable the safe and appropriate use of Specialty Transport Units including Critical Care Ambulances, Bariatric Ambulances, Basic Life Support (BLS) Ambulances, and Mental Health Transport (MHT) Units when assigning response resources to calls for assistance received on the non-emergency line.

Description:

This policy establishes criteria for the safe and appropriate utilization of specialty transport resources.

Definitions:

- **"Critical Care Team Ambulance"** is an ambulance with specialized supplies and equipment staffed with a minimum of one Certified Registered Nurse, one Certified Critical Care Paramedic, and one Certified Emergency Medical Technician.
- **"Critical Care Paramedic Ambulance"** is an ambulance with specialized supplies and equipment staffed with a minimum of one Certified Critical Care Paramedic and one Certified Emergency Medical Technician.
- **"Bariatric ALS Ambulance"** is an ambulance equipped with specialized patient movement equipment and staffed with a minimum of one Certified Paramedic and one Certified Emergency Medical Technician.
- **"ALS Ambulance"** is an ambulance staffed with a minimum of one Certified Paramedic and one Certified Emergency Medical Technician
- **"Basic Life Support ambulance"** is an ambulance staffed with a minimum of two Certified Emergency Medical Technicians.
- **"Mental Health Client"** means an individual who is voluntarily or involuntarily protected in accordance with the Florida Mental Health Law (Baker Act), Chapter 394, Florida Statutes, and requires transportation to or from a Health Care Facility.
- **"Mental Health Transport Driver"** or **"MHT Driver"** means any person who is specially trained and certified for Mental Health transport, and who is County Certified to perform such services.
- **"Acuity Level I Patient"** is a patient requiring emergency or non-emergency transport to another health-care facility, discharge, or other routine transport that requires monitoring or treatment management at the Critical Care Paramedic Ambulance or Critical Care Team Ambulance level.
- **"Acuity Level II Patient"** is a patient requiring emergency or non-emergency transport to another health-care facility, discharge, or other routine transport that requires monitoring or treatment management at the ALS Ambulance level.

Definitions (cont.):

- **"Acuity Level III patient"** is a patient requiring non-emergency transport to another healthcare facility, discharge, or other routine transport that can be safely managed by a BLS ambulance.

Policy

Sunstar Communications Center Staff shall assign an ALS ambulance to all requests for service. A specialty transport unit may be substituted as authorized below and in accordance with CT24 – Interfacility Transport Levels of Care

Critical Care Team Ambulance, Critical Care Paramedic Ambulance, and ALS Ambulance Utilization

Sunstar communications staff shall reference CT24 – Interfacility Transport Levels of Care to determine a patient's required level of monitoring/scope of care and appropriateness to determine the appropriate transport unit type (Acuity I and II)

Bariatric ALS Ambulance Utilization

Sunstar Communications staff may substitute a Bariatric ALS Ambulance response for an ALS Ambulance response to perform an interfacility transfer when any of the following criteria are met:

1. Patient weight exceeds 700 pounds
2. Patient weight and/or size is anticipated to interfere with the provision of safe care and transport using standard ALS Ambulance equipment and personnel

Bariatric ALS Ambulance Safety Precautions and Special Circumstances

The safety of both the patient and EMS personnel are the highest priority. The following precautions are to always be observed when performing a bariatric transport:

1. Additional personnel shall be assigned to ensure adequate resources are present for the safe movement of a patient.
2. A Sunstar Field Supervisor or other personnel specifically trained to manage the safety of bariatric patient movements shall be assigned whenever possible.

AD7 INTERFACILITY TRANSPORT SPECIALTY UNIT UTILIZATION

BLS Ambulance Utilization

An interfacility transfer patient may be considered “Acuity Level III” and transported by Basic Life Support (BLS) ambulance if the patient condition falls within the BLS criteria in CT24 – Interfacility Transport Levels of Care, so long as NONE of the following additional exclusion criteria are met:

Category	BLS Exclusions
A - Airway	Patient requires airway management beyond simple suctioning Patient requires airway monitoring due to recent compromise or any potential for impending compromise
B - Breathing	Patient requires respiratory/ventilation assistance beyond supplemental oxyegn that is not being titrated Patient requires respiratory monitoring (e.g., SpO2, EtCO2, etc.) due to recent compromise and/or potential for impending respiratory failure or requirement for assistance
C - Cardiac	Patient requires continuous cardiac monitoring or is being transferred to a monitored bed Patient has recently experienced an arrhythmia, ACS, or other significant cardiac event
D - Disability and Drugs	Patient may require pain medication during transport Patient requires seizure precautions or has had recent seizure activity (less than 24 hrs.) Patient is combative and requires/may require chemical sedation Patient has any fluids or medications running (*Note that BLS may transport peripheral and central IV catheters so long as no fluids or medications are infusing or will need to be infused during transport*)
E - Exam	The sending facility and/or EMD determined that the patient requires ALS or CCT transport due to any other reasons The EMT has conducted an initial assessment and determined that the patient is not a candidate for BLS transport due to current or potential complications during transport that will require ALS intervention. The EMT shall notify the communications center in this instance

AD7 INTERFACILITY TRANSPORT SPECIALTY UNIT UTILIZATION

BLS Ambulance Special Circumstances

BLS Ambulances may be utilized to respond to and transport other types of patients during a disaster, EMS Emergency, or other special circumstances as approved by the EMS Medical Director.

Should the patient deteriorate to the point of requiring ALS intervention, the EMT shall use best judgement as to if the best course of action is to divert to the nearest ED or wait for ALS assistance to arrive.

In the case of an emergency (e.g., combative patient, etc.), press the emergency button on the portable or on-board radio and advise nature of the emergency.

BLS units may not cancel an EMS Response. Responding units may elect to upgrade or downgrade according to pre-arrival information given.

Should a BLS unit witness or come across an emergency scene (e.g., MVC or other emergency) they will notify Sunstar Communications Center and render BLS care if appropriate. At no time is a patient to be alone in the patient compartment.

Mental Health Transport Unit Utilization

A person requiring interfacility transfer may be considered a client rather than a patient and eligible for transport by Mental Health Transport (MHT) Unit (Priority 10) if the individual's condition falls within the MHT criteria in CT24—Interfacility Transport Levels of Care, so long as ***ALL*** the following inclusion criteria are met:

1. Transport is from a hospital to Mental Health Receiving Facility or between two Mental Health Receiving facilities within Pinellas or adjoining counties
2. Individual has been medically cleared by a physician to be transported as a mental health client rather than as a patient and there is no expected requirement for oxygen, restraints, or other medical care during transport, and the physician (or RN authorized by the physician) has signed the required EMS Transfer Form
3. Client is ambulatory without restriction (able to walk to and from transport unit without assistance)
4. Client has not exhibited current or recent violent behavior and is not high risk for Elopement

AD7 INTERFACILITY TRANSPORT SPECIALTY UNIT UTILIZATION

Mental Health Transport Unit Safety Precautions and Special Circumstances

The safety of both the client and the MHT Driver is the highest priority. The following precautions will be observed at all time when dispatching and performing a Mental Health Transport:

1. The EMD and the MHT Driver will independently verify that the client meets criteria reflected on Page 4 Mental Health Unit Utilization section
2. If the MHT Driver, during the process of assessing or transferring the client, deems the transfer by MHT would be unsafe, they may stop the transport and require the client be transported by ambulance. The MHT Driver will notify dispatch and their supervisor
3. Only one client may be inside a MHT unit at a time
4. The client must have been determined to not be in possession of any weapons and all the client's belongings must be transported in a separate compartment of the MHT Unit
5. The MHT Driver will obtain the assistance of staff from the sending and receiving facilities during transfer between vehicle and facility to ensure the safety of both the client and the MHT Driver
6. If at any time the client requires medical assistance, makes any type of threat, becomes violent, attempts to harm themselves, or attempts to escape, the MHT Driver will immediately call for assistance on the appropriate radio channel or depress their emergency ("Code H") radio button.
   - If a client becomes violent, the MHT Driver will remain in the cab of the vehicle and utilize verbal de-escalation techniques, unless the MHT driver determines that physical restraint is warranted and is safe to be performed by one person (e.g., pediatric patients and/or the frail elderly)
   - If a client escapes, the MHT Driver will follow the Client at a safe distance and not attempt physical confrontation without assistance, unless the MHT driver determines that physical restraint is warranted and is safe to be performed by one person
   - If a client requires medical assistance, the MHT Driver will render first aid and/or cardiopulmonary resuscitation (CPR) until EMS arrives on scene, if the MHT Driver determines that it is safe to do so.

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Pinellas County EMS

TRAUMA TRANSPORT PROTOCOL

2024-2027

AD8 TRAUMA TRANSPORT PROTOCOL

Dispatch Procedures

Requirements for Soliciting Information:

1. *The TTPs shall include a description of the system that allows the public and other agencies to notify the provider that emergency medical services are needed. The agency responsible for operating the system shall be identified. A description of the information to be solicited from the individual requesting emergency medical assistance in order to determine the number of patients, location of the incident, and extent and severity of reported injuries shall be included.*

   A. The Pinellas County 9-1-1 Regional Communications Center operates as the single primary public safety answering point (PSAP) for all 9-1-1 calls originating in Pinellas County – the center answers over 900,000 emergency calls per year. Calls for law enforcement assistance are transferred to the appropriate agency. If a fire department or ambulance response is needed, 9-1-1 telecommunicators will dispatch units and support their activities during the emergency.

   B. The Communications Center is a necessary link between the person with the problem and the personnel who can help resolve it most effectively. It is the primary goal of the Communications Center to obtain and transfer necessary information in a timely and efficient manner. Accomplishing this goal ensures the effective and timely management of both Fire/EMS apparatus and law enforcement units in their response to the public's need.

   C. The 9-1-1 Telecommunicator ascertains the following information when an individual requests emergency medical services and will conduct caller interrogation in accordance with the current Pinellas County version of the Medical Priority Dispatch System (MPDS) protocols:

      - nature of the emergency
      - address of the emergency
      - call back number
      - difficult access
      - specific routing
      - extent and severity of the emergency
      - number of victims

Requirements for Dispatching Emergency Vehicles:

1. *A description must be included describing the methods used to ensure that the appropriately staffed and equipped EMS vehicle most readily available is identified and dispatched to the location of the incident.*

A. The closest response unit is determined by the 9-1-1 Center's Computer Aided Dispatch (CAD) system. The CAD system immediately assigns the appropriately staffed and equipped emergency service provider that is closest to the call location regardless of jurisdiction, following the automatic aid/closest unit response policy. In the event the closest unit is unavailable, the CAD system will assign the next closest unit.

a. Initial dispatch information includes:

- location of the call
- units being dispatched
- nature of the call
- assigned radio tac channel
- response priority

Requirements for Emergency Agency Assistance:

1. *A description of the criteria and process used to request additional EMS air or ground vehicles and/or other emergency response agencies shall be included.*

A. The process used to request assistance for specialized resources or additional assistance is as follows:

a. Requests for additional or specialized resources (e.g., Fire apparatus, ambulances, law enforcement, HazMat Team, Marine Patrol, etc.) is made by on-scene personnel through the 9-1-1 Center. The 9-1-1 Center will then coordinate the requested action via telephone, State Warning Point line, and/or radio, as applicable. The 9-1-1 Center, if required, will call for mutual aid.

B. The procedures used by the 9-1-1 Center to request a helicopter to the scene of a "Trauma Alert" patient for transport to a trauma center are as follows:

a. On-scene personnel will request an "Air Transport" through the 9-1-1 Center.
b. The 9-1-1 Center will contact the designated helicopter dispatch center and request their response.
c. The 9-1-1 Center will advise the helicopter dispatcher of the scene location, any available patient information, working radio channel, and the radio designation of the on-scene Incident Commander.
d. The 9-1-1 Center will request the estimated time of arrival (ETA) of the helicopter.
e. The 9-1-1 Center will notify the on-scene Incident Commander of the ETA and radio designation of the responding helicopter service.

C. An "**air transport upgrade"** will be called for all emergencies requiring a helicopter.

AD8 TRAUMA TRANSPORT PROTOCOL

Requirements for Transport Assistance:

1. *The TTPs must identify the criteria used to include and differentiate between ground and air ambulance services when transport assistance is requested. The TTPs must identify from what agencies assistance can be requested and the process used for obtaining assistance. In the event that air transport is not available within the service area of the provider, the TTPs should state that air ambulance service is not available.*

   A. All patients in the Pinellas County EMS System shall be transported by a Sunstar BLS or ALS ambulance or a local first responder transport capable unit.
   B. As stipulated in these protocols, an ALS helicopter shall be utilized for the transportation of a trauma patient that meets the Trauma Scorecard Methodology standards as stipulated in Chapters 64J-2.004 and 64J-2.005, F.A.C., and as follows:

      a. When LOCAL CONDITIONS (heavy traffic/gridlock, multi-victim/mass casualty incident, remote or barrier island) exist and in the judgment of the attending EMT, Paramedic, or Incident Commander would make transport by Helicopter Ambulance faster than transport by Ground Ambulance.
      b. When SCENE CONDITIONS (extended extrication, heavy machinery extrication, technical rescue, remote location) exist and in the judgment of the attending EMT, Paramedic, or Incident Commander would make transport by Helicopter Ambulance air faster than transport by Ground Ambulance.
      c. When PATIENT CONDITIONS (requirement for Burn Center, Re- implantation Surgery or Hyperbaric Chamber) exist that in the judgment of the attending EMT, Paramedic, or Incident Commander would make transport by Helicopter Ambulance faster than transport by Ground Ambulance.

   C. ALS helicopter services, each have a Certificate of Public Convenience and Necessity from the Pinellas County Board of County Commissioners as an ALS provider in this County.

TRAUMA PATIENT ASSESSMENT FOR ADULT AND PEDIATRIC

Requirements for Adult Assessment:

1. *The adult trauma scorecard assessment shall be documented in accordance with the requirements of section 64J-2.004, F.A.C.*

   A. Patients will be evaluated according to the severity of injury and anatomy and mechanism of injury as follows:
      a. Each EMS provider shall ensure that upon arrival at the location of an incident, an EMT or paramedic shall:

i. Assess the condition of each adult trauma patient using the Adult Trauma Scorecard Methodology, as provided in this section, to whether the patient should be a “Trauma Alert” per Chapter 64J- 2.004, F.A.C.

ii. In assessing the condition of each adult trauma patient, the EMT or paramedic shall evaluate the patient's status for each of the following components: airway, circulation, best motor response (a component of the Glasgow Coma Scale, which is defined and incorporated by reference in subsection 64J-2.001(5), F.A.C., cutaneous, long-bone fracture, patient's age, and mechanism of injury. The patient's age and mechanism of injury shall only be assessment factors when used in conjunction with assessment criteria included in Subsection C (f and g) of this section.

B. The EMT or paramedic shall assess all adult trauma patients using the following criteria in the order presented and, if any **ONE** of the following conditions is identified, the patient shall be considered a “Trauma Alert” patient:

a. Airway: The patient receives active airway assistance beyond the administration of oxygen.

b. Circulation: The patient lacks a radial pulse with a sustained heart rate greater than 120 beats per minute or has a blood pressure less than 90 mmHg.

c. Best Motor Response (BMR): The patient exhibits a score of four or less on the motor assessment component of the Glasgow Coma Scale, or exhibits the presence of paralysis, or there is the suspicion of a spinal cord injury or the loss of sensation.

d. Cutaneous: The patient has 2nd or 3rd degree burns to 15 percent or more of the total body surface area, or amputation proximal to the wrist or ankle, or any penetrating injury to the head, neck, or torso (excluding superficial wounds where the depth of the wound can be determined).

e. Long-Bone Fracture: The patient reveals signs or symptoms of two or more long-bone fracture sites (humerus [radius, ulna] or femur [tibia, fibula]).

C. Should the patient not be identified as a “Trauma Alert” using the criteria in Subsection B above, the trauma patient shall be further assessed using the following criteria and shall be considered a “Trauma Alert” patient when a condition is identified from any **TWO** of the following seven components:

a. Airway: The patient has a respiratory rate of 30 or greater.

b. Circulation: The patient has a sustained heart rate of 120 beats per minute or greater.

c. BMR: The patient has a BMR of five on the motor component of the Glasgow Coma Scale.

d. Cutaneous: The patient has a soft tissue loss from either a major degloving injury, or a major flap avulsion greater than five inches, or has sustained a gunshot wound to the extremities of the body.

e. Long-Bone Fracture: The patient reveals signs or symptoms of a single long- bone fracture resulting from a motor vehicle collision or a fall from an elevation of ten feet or greater.
f. Age: The patient is 55 years of age or greater.
g. Mechanism of Injury: The patient has been ejected from a motor vehicle (excluding any motorcycle, moped, all- terrain vehicle, bicycle, or the open body of a pickup truck), or the driver of the motor vehicle has impacted with the steering wheel causing steering wheel deformity.

D. If the patient is not identified as a “Trauma Alert” patient after evaluating the patient using the criteria in Subsections B and C of this section, the trauma patient will be evaluated using all the elements of the Glasgow Coma Scale. If the patient's score is 12 or less, the patient shall be considered a “Trauma Alert” patient (excluding patients whose normal Glasgow Coma Scale score is 12 or less, as established by the patient's medical history or preexisting medical condition when known).

E. Where additional local “Trauma Alert” criteria has been approved by the Medical Director of the EMS service and presented as part of the State Trauma Transport Protocols' approval process, the use of local “Trauma Alert” criteria as the basis for calling a “Trauma Alert” shall be documented as required in Chapter 64J-1.014, F.A.C. Local trauma assessment criteria can only be applied after the patient has been assessed as provided in Subsections B, C, and D of this section.

a. The EMT or paramedic shall assess all adult trauma patients using the following criteria in the order presented and, if any **ONE** of the following conditions is identified, the patient shall be considered a “Trauma Alert” patient per Pinellas County Local Criteria:

- Signs and symptoms/suspicion of a skull fracture, flail chest and/or pelvic fracture
- Death of another passenger from trauma
- Any ejection (complete or partial) from a motor vehicle
- Major blunt trauma to the head, neck, trunk, or pelvis
- Active bleeding requiring a tourniquet or wound packing with continuous pressure

F. In the event that none of the conditions are identified using the criteria in Subsections B, C, D, or E of this section in the assessment of the adult trauma patient, the EMT or paramedic can call a “Trauma Alert” if, in his or her judgment, the patient's condition warrants such action. Where the EMT's or paramedic's judgment is used as the basis for calling a “Trauma Alert,” it shall be documented as required in Chapter 64J-1.014, F.A.C.

G. The results of the patient assessment shall be recorded and reported in accordance with the requirements of Chapter 64J-2.002(5), F.A.C. through the completion of a Pinellas County Emergency Medical Services (PCEMS) Patient Care Report.

H. The paramedic or EMT will use the phrase "Trauma Alert" when notifying the 9-1-1 Center and receiving facility.

Requirements for Pediatric Assessment:

1. *The pediatric trauma scorecard assessment shall be documented in accordance with the requirements of section 64J-2.005, F.A.C.*

A. Each EMS provider shall ensure that upon arrival at the location of an incident, the EMT or paramedic shall assess the pediatric trauma patient by evaluating the patient's status for each of the following components: Airway, Consciousness, Circulation, Fracture, Cutaneous, and the pediatric patient's size when used in conjunction with the other components in Subsection C of this section. The assessment of the pediatric patient using the weight and length parameter and the other components of this section shall be referred to as the Pediatric Trauma Scorecard Methodology. In assessing the pediatric patient, the criteria for each of the components in Subsections B and C of this section shall be used to determine the transport destination for pediatric trauma patients.

B. The EMT or paramedic shall assess all pediatric trauma patients using the following criteria, and if any of the following conditions are identified, the patient shall be considered a pediatric “Trauma Alert” patient:

a. Airway: In order to maintain optimal ventilation, the patient is intubated, or the patient's breathing is maintained through such measures as manual jaw thrust, continuous suctioning, or through the use of other adjuncts to assist ventilatory efforts.
b. Consciousness: The patient exhibits an altered mental status that includes drowsiness, lethargy, the inability to follow commands, unresponsiveness to voice, totally unresponsive, is in a coma, there is the presence of paralysis, the suspicion of a spinal cord injury, or loss of sensation.
c. Circulation: The patient has a faint or non-palpable carotid, femoral pulse, or the patient has a systolic blood pressure of less than 50 mmHg.
d. Fracture: There is evidence of an open, long-bone (humerus, (radius, ulna), femur (tibia, or fibula)) fracture, or there are multiple fracture sites or multiple dislocations (except for isolated wrist or ankle fractures or dislocations).
e. Cutaneous: The patient has a major soft tissue disruption, including major degloving injury; major flap avulsions; 2nd or 3rd degree bums to ten percent or more of the total body surface area; amputation at or above the wrist or ankle; or any penetrating injury to the head, neck, or torso (excluding superficial wounds where the depth of the wound can be determined).

C. In addition to the criteria listed in Subsection B of this section, a “Trauma Alert” shall be called when a condition is identified from any two of the components listed below:

a. Consciousness: The patient exhibits symptoms of amnesia or there is loss of consciousness.
b. Circulation: The carotid or femoral pulse is palpable, but the radial or pedal pulses are not palpable, or the systolic blood pressure is less than 90 mmHg.
c. Fracture: The patient reveals signs or symptoms of a single closed, long-bone fracture. Long-bone fractures do not include isolated wrist or ankle fractures.
d. Size: Pediatric trauma patients weighing 11 kilograms or less, or the body length is equivalent to this weight on a pediatric length and weight emergency tape (the equivalent of 33 inches in measurement or less).

D. Where additional local “Trauma Alert” criteria has been approved by the Medical Director of the EMS service and presented as part of the State Trauma Transport Protocols' approval process, the use of local “Trauma Alert” criteria as the basis for calling a “Trauma Alert” shall be documented as required in Chapter 64J-1.014, F.A.C. Local trauma assessment criteria can only be applied after the patient has been assessed as provided in Subsections B and C of this section.

a. The EMT or paramedic shall assess all pediatric trauma patients using the following criteria in the order presented and, if any **ONE** of the following conditions is identified, the patient shall be considered a “Trauma Alert” patient per Pinellas County Local Criteria:

- Signs and symptoms/suspicion of a skull fracture, flail chest and/or pelvic fracture
- Death of another passenger from trauma
- Any ejection (complete or partial) from a motor vehicle
- Major blunt trauma to the head, neck, trunk, or pelvis
- Active bleeding requiring a tourniquet or wound packing with continuous pressure

E. In the event that none of the conditions are identified using the criteria in Subsections B, C, or D of this section in the assessment of the pediatric trauma patient, the EMT or paramedic can call a “Trauma Alert” if, in his or her judgment, the patient's condition warrants such action. Where the EMT's or paramedic's judgment is used as the basis for calling a “Trauma Alert,” it shall be documented as required in Chapter 64J-1.014, F.A.C.

Trauma Destination Requirements:

1. *All trauma alert patients must be transported to a Trauma Center or Pediatric Trauma Center nearest the location of the incident if the incident is within 30 minutes by ground or air transport or within 50 miles by air transport. The medical director shall identify any exceptions to this standard in the EMS provider’s or trauma agency’s TTPs with explanation and justification. All patients meeting Trauma Alert Criteria shall be transported to the nearest Trauma Center or Pediatric Trauma Center.*

AD8 TRAUMA TRANSPORT PROTOCOL

A. All adult patients meeting the Trauma Alert Criteria as specified above shall be transported to the nearest Trauma Center.

B. All pediatric patients meeting the Trauma Alert Criteria as specified above shall be transported to the nearest State Approved Pediatric Trauma Center.

2. *All hospitals to which trauma patients are routinely transported must meet state and federal emergency access to care laws and be capable of delivering care commensurate with the patient's medical needs.*

A. All hospitals to which all trauma patients are routinely transported meet state and federal emergency access to care laws and are capable of delivering care commensurate with the patient's medical needs.

B. Please reference the Hospital attestation letters included.

3. *If there are situations where the EMS provider's medical director has determined it would be in the best medical interest of the trauma alert patient to be transported to a hospital other than those specified in paragraph (1) above, a list of such situations must be identified in the TTPs.*

A. In cases where local conditions (weather, traffic, special event, disaster etc.) exist that would make transport to the nearest Trauma Center take longer than transport to another Trauma Center, the patient shall be transported to the Trauma Center able to be reached in the shortest amount of time.

B. In cases where the nearest Trauma Center has suffered a degradation of capability to provide standard trauma care (internal or external disaster, lack of hospital staffing/resources/equipment, etc.) the EMS Medical Director will direct a trauma alert patient to the most appropriate facility based upon current conditions.

C. In cases where patient factors (traumatic cardiac arrest, inability to secure the airway, inability to obtain intravenous/intraosseous access, etc.) exist that in the judgment of the attending EMT, Paramedic, or Incident Commander would make transport to the closest initial receiving facility or another Trauma Center in the patient's best interest, the patient shall be transported to the most appropriate facility.

D. A burn patient shall be transported to a Burn Center. If the patient is suffering from multi-system trauma and transport to the Burn Center would take significantly longer than transport to the nearest trauma center, the patient shall be transported to the nearest Trauma Center.

4. *The EMS provider must submit documentation to the department that all hospitals, trauma centers to which the EMS provider routinely transports have been provided a copy of the TTPs which the EMS provider will follow to determine trauma transport destinations submitted upon initial licensure and after revisions of the TTPs.*

   A. Reference included documentation.

5. *A list of trauma centers and hospitals to which the EMS provider routinely transports adult and pediatric trauma alert patients must be identified in the TTPs.*

2024 – 2027 TRAUMA CENTERS

Hospital Name	Address	Phone Number
Level 1 Pediatric/Adult Trauma Center		
Tampa General Hospital[1]	One Tampa General Circle, Tampa, FL 33606	(813) 251-7000
Level 2 Pediatric Trauma Center		
All Children's Hospital	501 – 6 Avenue South, St. Petersburg, FL 33701	(727) 898-7451
Level 2 Pediatric/Adult Trauma Center		
St. Joseph's Hospital	3001 W. Dr. Martin Luther King Jr. Boulevard, Tampa, FL 33607	(813) 870-4000
Level 2 Adult Trauma Center		
Orlando Health Bayfront Hospital	701 Sixth Street South, St. Petersburg, FL 33701	(727) 823-1234
HCA Florida Blake Hospital[1]	2020 – 59 Street West, Bradenton, FL 34209	(941) 792-6611
HCA Florida Bayonet Point Hospital	14000 Fivay Road, Hudson, FL 34667	(727) 819-2929
Sarasota Memorial Hospital	1700 South Tamiami Trail, Sarasota, FL 34239	(941) 917-9000

[1] Tampa General Hospital and Blake Medical Center are Burn Centers

AD8 TRAUMA TRANSPORT PROTOCOL

2024 - 2027 INITIAL RECEIVING FACILITIES

Hospital Name	Address	Phone Number
Initial Receiving Facilities		
Orlando Health Emergency Room – Pinellas Park	3070 Grand Avenue, Pinellas Park, FL 33782	(727) 893-6195
Orlando Health Emergency Room - Crossroads	1800 – 66 St. N. St. Petersburg, FL 33710	(727) 893-6325
Bay Pines Veterans Administration Hospital	10000 Bay Pines Boulevard, St. Petersburg, FL 33744	(727) 398-6661
Advent Health North Pinellas	1395 South Pinellas Avenue, Tarpon Springs, FL 34689	(844) 876-0241
Advent Health Palm Harbor ER	34106 US19 North, Palm Harbor, FL 34684	(844) 876-0241
HCA Florida Largo Hospital	201 – 14 Street, Largo, FL 33770	(727) 588-5200
ER at HCA Florida Largo West Hospital	2025 Indian Rocks Road, Largo, FL 33774	(727) 586-7120
HCA Florida Clearwater Emergency	2339 Gulf to Bay Boulevard, Clearwater, FL 33765	(727) 588-5200
HCA Florida Northside Hospital	6000 – 49 Street North, St. Petersburg, FL 33709	(727) 521-4411
HCA Florida Pasadena Hospital	1501 Pasadena Avenue S. St. Petersburg, FL 33707	(727) 381-1000
HCA Florida St. Petersburg Hospital	6500 – 38 Avenue North, St. Petersburg, FL 33710	(727) 384-1414
HCA Florida Lake Tarpon Emergency	35750 US19 North, Palm Harbor, FL 34684	(727) 789-8420
Morton Plant Hospital	300 Pinellas Street, Clearwater, FL 33756	(727) 462-7000
Bardmoor Emergency Center	8839 Bryan Dairy Road, Largo, FL 33777	(727) 395-2600
Mease Countryside Hospital	3231 McMullen Booth Road, Safety Harbor, FL 34695	(727) 725-6111
Mease Dunedin Hospital	601 Main Street, Dunedin, FL 34698	(727) 733-1111
St. Anthony's Hospital	1200 – Seventh Avenue North, St. Petersburg, FL 33705	(727) 825-1100

2024 – 2027 OUT-OF-COUNTY HOSPITALS

Hospital Name	Address	Phone Number
Out-Of-County Initial Receiving Facility		
HCA Florida Trinity Hospital	9330 State Road 54, Trinity, FL 34655	(727) 834-4000

AD8 TRAUMA TRANSPORT PROTOCOL

TRANSFER OF PATIENT CARE INFORMATION

1. *The EMS transporting provider must include in the TTPs, requirements and procedures to be followed by EMTs and paramedics for completion of the patient care record as defined under section 64J-2.001(9), F.A.C., and required under section 64J-2.004, F.A.C., and the trauma information as required under section 64J-2.002(5), F.A.C., and the delivery of such information in writing with the trauma patient to a trauma center, or hospital at the time the patient is presented for care.*

   A. The EMS provider responsible for the patient shall ensure that a prehospital trauma alert is issued upon determining that a trauma patient meets the requirements of Rules 64J-2.004 and 64J-2.005, F.A.C.

   B. The words “trauma alert” shall be used when notifying the trauma center, or hospital that EMS is enroute with a trauma alert patient.

   C. The medical director of the EMS provider issuing the trauma alert, or physician at the receiving trauma center, or hospital, are the only people authorized to change the trauma alert status.

   D. The EMS provider issuing the trauma alert shall also provide the trauma center or hospital with information required under subsection 64J-1.1014(5), F.A.C. and the information listed below at the time the patient is transferred to the personnel of the receiving trauma center or hospital:

      a. Time of injury if different from the time of the call
      b. Date of injury if different from day of call
      c. County of injury
      d. County of residence of patient
      e. Cause of injury
      f. Injury Site/type
      g. Trauma alert criteria if met as defined in Rule 64J-2.004 or 64J- 2.005, F.A.C. and
      h. Protective devices if motor vehicle crash, bicycle, or marine crash

   E. The information listed above shall be documented on the Pinellas County Emergency Medical Services (PCEMS) Patient Care Report of the transporting unit that delivered the patient in accordance with the requirements of Rule 64J-1.014, F.A.C.

AD8 TRAUMA TRANSPORT PROTOCOL

EMERGENCY INTER-FACILITY TRANSFER PROCEDURES

1. *The EMS provider must have in place, as part of its TTPs, procedures for the rapid emergency inter-facility transfer of a trauma alert patient. The provider must be available within 30 minutes of receiving a call from the requesting hospital to provide inter-facility emergency medical service transfer of a trauma alert patient. The medical director shall identify any exceptions to this standard in the EMS provider's TTPs with explanation and justification. If an EMS provider does not provide inter-facility transfer services that shall be documented in the TTPs.* *(Reference next 2 pages)*

AD8 TRAUMA TRANSPORT PROTOCOL

ATTESTATION OF MEDICAL DIRECTOR'S PARTICIPATION, REVIEW AND APPROVAL OF TTP'S

Pinellas County Emergency Medical
Services System
12490 Ulmerton Road
Suite #134
Largo, FL 33774
Telephone (727) 582-5750

As the EMS Medical Director of Pinellas County Emergency Medical Services System (comprised of 19 individually licensed providers), I have developed and/or directed the development of the trauma transport protocols presented in this document.

________________________________ ________________________________
Signature – EMS Medical Director Approval Date

Pinellas County EMS Licensed ALS Providers

Provider Name	License Number
City of Clearwater	ALS5204
City of Dunedin	ALS5229
East Lake Tarpon Special Fire Control District	ALS5205
City of Gulfport	ALS5207
City of Largo	ALS5210
Lealman Special Fire Control District	ALS5211
City of Madeira Beach	ALS5212
City of Oldsmar	ALS5230
Palm Harbor Special Fire Control District	ALS5213
Pinellas County EMS DBA Sunstar	ALS5220
City of Pinellas Park	ALS5214
Pinellas Suncoast Special Fire Rescue District	ALS5208
City of Safety Harbor	ALS5215
City of Seminole	ALS5228
City of South Pasadena	ALS5217
City of St. Pete Beach	ALS5218
City of St. Petersburg	ALS5219
City of Tarpon Springs	ALS5221
City of Treasure Island	ALS5222

AD9 MUTUAL AID MEDICAL CARE

Purpose:

The purpose of this protocol is to define the roles and responsibilities of Pinellas County Certified EMTs and Paramedics when responding to a routine mutual aid request and when deploying to a disaster outside of Pinellas County

Description:

The Pinellas County EMS System may be called to provide services outside of Pinellas County. This includes routine mutual aid responses to neighboring EMS Systems and deployment of system resources to events when requested by local, state, or federal partners. Clinical standing and responsibilities may vary depending on the nature and location of the mutual aid response.

Policy:

Providing Care Outside Pinellas County

1. Routine Mutual Aid Requests to Neighboring EMS Systems

When responding to Mutual Aid requests from neighboring EMS systems where no other EMS personnel are in attendance with a patient, all standard system equipment, procedures, and clinical protocols including specialty teams (e.g., Critical Care, Hazmat, Tech Rescue, Tactical) are to be followed. Essentially the care provided should be identical to what would occur if the call were located within Pinellas County. If unable to contact OLMC via radio, clinicians should initiate contact via cell phone as needed.

If neighboring EMS System personnel are also on scene and wish to assume or retain care of a patient, Pinellas County personnel will ensure that an appropriate level of care (ALS may not transfer to BLS) is available prior to turning over patient care responsibility. If there is concern regarding appropriate level of care, treatment, or disposition, OLMC consultation shall be initiated.

2. Deployments Within the State of Florida

When responding to deployments within the state of Florida, Pinellas County EMS certified clinicians may assume their normal clinical standing.

Care provided should be in accordance with Pinellas County EMS protocols and standards of care including specialty teams (e.g., Critical Care, Hazmat, Tech Rescue, Tactical) whenever possible. When operating in austere environments (e.g., MCI, disaster, etc.) the standard of care may need to be altered based upon available resources. Clinicians should use their best judgment in providing the highest standard

of care possible with available resources. In the event online medical control is not available, clinicians are authorized to provide OLMC options under standing orders.

In certain exceptional circumstances, the State of Florida EMS Medical Director may choose to implement the Florida Statewide Disaster Medical Protocols. If this occurs, Pinellas County EMS clinicians are authorized to follow the statewide protocols.

3. Deployments Outside of the State of Florida

When responding to deployments outside the state of Florida, Pinellas County EMS Certified clinicians will have clinical standing based upon Interstate or Federal Disaster Mutual Aid Agreements. This clinical standing should be defined prior to deployment. The Pinellas County EMS standard of care and scope of practice including specialty teams (e.g., Critical Care, Hazmat, Tech Rescue, Tactical) should be followed whenever possible but it is recognized that the standard of care maybe altered due to operations in the austere environments. In this case, clinicians should use their best judgment in providing the highest standard of care possible with available resources. In the event online medical control is not available, clinicians are authorized to provide OLMC options under standing orders.

Documentation

When responding to routine local mutual aid requests standard patient care report requirements apply as per CS7-Patient Care Report and Transfer of Care. Standard requirements also apply when responding to deployments beyond routine local mutual aid with the exception that if a paper PCR was utilized due to computer failure or lack of availability, a subsequent web-based ePCR is not required.

Supplies and Equipment

1. Par Levels:

When responding to deployments beyond routine local mutual aid, it may be necessary to alter the standard inventory of supplies, equipment, and medications. In general, standard inventories will be supplemented to provide for prolonged operations but specific inventory changes will be determined based upon the parameters of the individual deployment.

2. Controlled Substances:

When responding to deployments beyond routine local mutual aid with controlled substances, standard electronic key/lockbox functions, storage, and handling procedures may need to be altered. Such alterations must be approved by the EMS Medical Director or designee prior to deployment. During deployment, clinicians shall ensure that at a minimum, Core Principles 2 and 3 as defined in Protocol AD13 Controlled Substance Management are always followed.

AD10 OCCUPATIONAL EXPOSURE

Purpose:

To provide guidance to field clinicians regarding actions to be taken following an occupational exposure

Background:

The provision of emergency medical care is known to have associated hazards to providers including occupational exposures. Although Pinellas County EMS has committed to taking all reasonable steps to minimize the risk of such exposure from time to time they may still occur.

Definitions:

Occupational Exposure: Contact with a potentially harmful physical, chemical, or biological agent as a result of one's work.

Designated Officer: The individual identified by each agency who serves as that agency point of contact for employees, healthcare providers, healthcare facilities, and public health officials when a possible occupational exposure has occurred to an emergency response employee as defined and required by Part G of the Ryan White Act 2009.

Policy:

1. Pinellas County EMS Clinicians should always take appropriate precautions to minimize the risk of occupational exposure.
2. Pinellas County EMS Clinicians should follow their individual agency procedures in contacting their supervisor and/or Designated Officer for immediate referral to occupational health and coordination of obtaining source patient information and ensuring testing of source patient blood when indicated.
3. If at any time a Pinellas County EMS Clinician has questions related to a potential or actual exposure, difficulty obtaining source patient information or blood testing, or difficulty in obtaining appropriate post-exposure evaluation and care contact the Medical Director or Associate Medical Director for assistance.

References:

- https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030
- https://www.cdc.gov/niosh/topics/ryanwhite/default.html
- https://www.cdc.gov/niosh/docs/2020-119/default.html

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AD11 INFANT SURRENDERED TO FIRE/EMS

Treatment of a Surrendered Infant

Florida Statutes Chapter 383 allows for the following:

- Authorizes a parent to surrender an infant (30 days old or younger) at a Fire or EMS Station

- Authorizes a parent to surrender an infant by calling 911 to request that an emergency medical services provider meet the surrendering parent at a specific location
    - Requiring the surrendering parent to stay with the infant until the emergency medical services provider arrives to take custody of the infant

- Except when there is actual or suspected child abuse or neglect, any parent who leaves an infant at a Fire/EMS Station has the absolute right to remain anonymous and to leave at any time and may not be pursued or followed unless the parent seeks to reclaim the newborn infant

There is a presumption that the parent who leaves the infant in accordance with the noted statute intended to leave the newborn infant and consented to termination of parental rights

Requirements

Each emergency medical services station or fire station staffed with full-time firefighters, emergency medical technicians, or paramedics shall accept any infant left with a firefighter, emergency medical technician, or paramedic. The firefighter, emergency medical technician, or paramedic shall consider these actions as implied consent to and shall:

1. Provide emergency medical services to the infant to the extent he or she is trained to provide those services
2. Document all information on a Patient Care Report & Transfer of Care (Ref. CS7)
3. Arrange for the immediate transportation of the infant to the nearest hospital having emergency services following all standard protocols
4. Refer to PCEMS MOM Volume 1 Protocol P5 Neonatal Resuscitation (Ref. P5)

If an infant is placed in the physical custody of an employee or agent of a licensee or fire department, such placement shall be considered implied consent for treatment and transport

A licensee, a fire department, or an employee or agent of a licensee or fire department is immune from criminal or civil liability for acting in good faith pursuant to this section

Reference

- Section 383.50 Florida Statutes (2024) http://www.leg.state.fl.us/Statutes/index.cfm?Mode=View%20Statutes&Submenu=1&Tab=statutes
- FL CS/HB 775: Surrendered Infants

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AD12 BLOOD PRESSURE SCREENING

Paramedics and EMTs are occasionally requested to provide non-emergency health promotion and screening activities, such as blood pressure assessment. Electrocardiograms (ECGs) and blood sugar assessment are never to be utilized as a component of health promotion and screening activities.

Any significantly abnormal values or symptoms discovered shall result in the individual becoming a patient.

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AD13 CONTROLLED SUBSTANCE MANAGEMENT PLAN - ADMINISTRATIVE

Core Principles:

- Promote patient safety
- Establish controls related to ordering, receiving, dispensing, administering, and documenting CSs
- Define monitoring processes that provide early detection of medication control irregularities
- Follow federal and state-CS laws and regulations, in addition to any Pinellas County Emergency Medical Services and local agency policies and procedures

Background:

The EMS Medical Director, as a Registrant of the Drug Enforcement Administration and according to Federal Regulations:

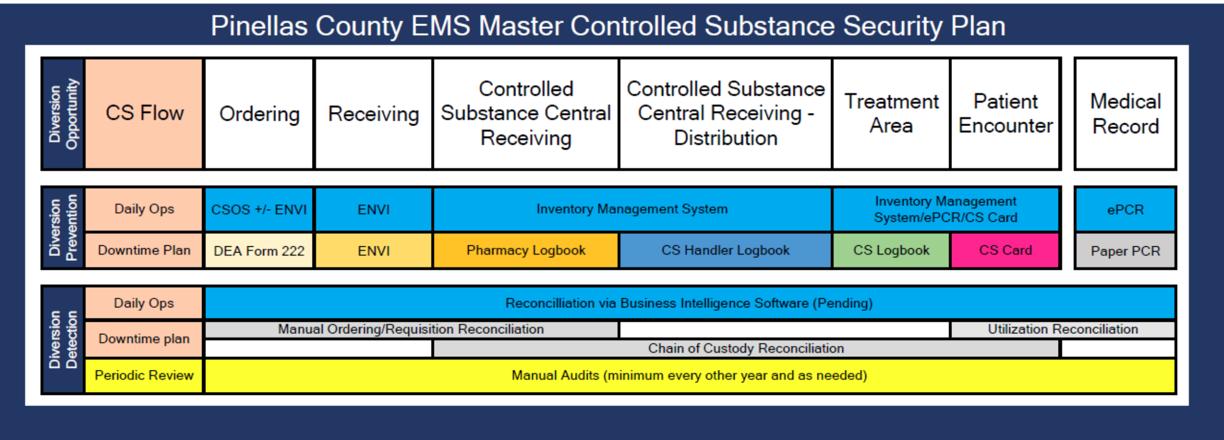
- May, at any time, perform an audit/inspection, take possession of, or cause to be forensically tested:
  - any container of CS
  - a CS box(es)
  - an electronic key
- Must have documentation reflecting the flow of CSs into and out of the EMS System - including any time a CS is:

	PSTrax	ENVI	Incident Report	DEA222	DEA41	DEA106	Reverse 222	DEA Authorized Vendor	ePCR	Authorized Vendor - Destruction Confirmation	CS Card	Law Enforcement
Acquired	X	X		X								
Dispensed	X	X										
Administered	X								X		X	
Distributed	X											
Stolen	X		X			X						X
Lost	X		X		X							X
Destruction	X						X	X		X		
Inventoried	X											

- Must report thefts or significant losses within one business day to the DEA and local law enforcement. The occurrence must be recorded on DEA Form 106 (hardcopy or online). https://apps2.deadiversion.usdoj.gov/TLR/login.xhtml;jsessionid=obnnNMbGNQ1TxNrdahd65r4dKUkOsTZlYEhf94qV.web1

  - Failure to report theft or loss of CSs may result in penalties under Section 402 and 403 of the Controlled Substance Act.
- Must record all CS destruction/spills on DEA Form 41 and keep the form on file ensuring it is readily retrievable. https://www.deadiversion.usdoj.gov/21cfr_reports/surrend/41_form.pdf
- Must affect an inventory of all controlled substances biennially on May 1st or two (2) years from the day of the last inventory

It is recognized that specific emphasis on security is warranted given current trends in opioid abuse. The following Master Controlled Substance Security Plan is adopted to ensure appropriate prevention and detection of controlled substance theft and/or diversion.



SAFETY ALERT

ANY/ALL Deviations from this protocol must be immediately reported to the EMS Medical Director or Designee via cell phone/text regardless of the agency controlled substance coordinator being notified

Any possession, access, or use of PCEMS Controlled Substances except in accordance with this protocol (all sections) may be reported to law enforcement and may constitute grounds for revocation of certification

Definitions:

Accountability in the Workplace: the responsibility of an employee to complete their assigned tasks, to perform the duties required by their job, and to be present for their proper shifts in order to fulfill or further the goals of the organization.

Administer: the direct application of a controlled substance to the body of a patient by an individual practitioner (or, in his presence, by his authorized agent), whether such application be by injection, ingestion, or any other means.

Administration: the obtaining and giving of a single dose of medicinal drugs by a legally authorized person to a patient for her or his consumption.

Ambulance Controlled Substance Technician (ACST): A Vehicle Supply Technician of the current ambulance contractor, identified by the ambulance CS-C and authorized by the EMS Medical Director or designee to engage in the transfer of custody of CSs.

Ambulance Controlled Substance Handler (ACS-H): an individual, as designated by the Chief Operating Officer or designee of the ambulance contractor, who possesses written authorization from the EMS Medical Director or designee to possess and transport CSs in the Pinellas County EMS System for the sole purpose of replacing expired or damaged medications and resupply of used medications.

Approve – to give formal or official sanction.

Assumption of Custody: A process in which the EMS Medical Director or designee, CS-C, or CSH takes custody of a controlled substance and/or associated components, controlled substance box and/or controlled substance key without a standard transfer of control.

Audit Trail: A record showing who has accessed an information technology application and what operations the user performed during a given period.

Authorize: to endorse, empower, justify, or permit by or as if by some recognized or proper authority (such as custom, evidence, personal right, or regulating power); to invest especially with legal authority.

Blind Count: A physical inventory taken by personnel who perform a hands-on count of inventory without access to the quantities currently shown on electronic or other inventory systems. Blind counts are used to assess the integrity of automated inventory systems

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AD13 CONTROLLED SUBSTANCE MANAGEMENT PLAN - ADMINISTRATIVE

Definitions (cont.):

Broken Chain of Custody: any period, regardless of duration, when one or more CS(s) or CS box containing one or more CS(s), or its assigned key, is not under direct custody of the individual who is documented to have custody at that time. Broken Chain of Custody

- includes but is not limited to:
  - leaving a CS box behind on the scene of an incident
  - loss or misplacement of an electronic key
  - loss or misplacement of a compartment key (if a part of security CS13.1)
- but does not include:
  - reasonable accommodation for operational specific activities while remaining in compliance with CS13.1 such as
    - shopping
    - physicals
    - CME attendance
    - Accompanying a patient to the hospital via ambulance

Certified Professional: means the one (1) individual, as defined in the then current PCEMS Rules and Regulations, excluding Wheelchair Transport Driver and Mental Health Transport Driver

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Chain of Custody: the sequential documentation or trail that accounts for the sequence of custody, transfer, and disposition of CS(s) and associated components (i.e., CS box, CS key, lanyard, etc.).

Container: A container for pharmaceutical use is an article which holds or is intended to contain and protect a drug and is or may be in direct contact with it. The closure is a part of the container. The container and its closure must not interact physically or chemically with the substance within in any way that would alter its quality.

Control Number: any distinctive symbols, such as a distinctive combination of letters and numbers approved for assignment by the EMS Medical Director or designee to each individual CS pharmaceutical container.

Controlled Substance (CS): any substance, listed in:

- The United States Controlled Substance Act (CSA), current version ***or***
- Title 21 United States Code part 1300-end ***or***
- Chapter 499 and Chapter 893, Florida Statutes ***or***
- Identified by the EMS Medical Director to have characteristics that make it a potential risk to public safety, abuse, dependence or diversion

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Controlled Substance Act (CSA): Establishes a unified legal framework to regulate certain drugs that are deemed to pose a risk of abuse and dependence.

Definitions (cont.):

Controlled Substance (CS) Box: a specific transportable brand and style (i.e., watertight, color, size) authorized by the EMS Medical Director or designee and provided by PCEMS. The box incorporates specific anti-diversion design features as well as custom labeling and an integrated electronic lock for the containment and transport of CSs.

NOTE: The transportable lock boxes are not considered secure by themselves.

Controlled Substance (CS) Repository: a specific fixed, semi-permanent mounted, brand and style strong cabinet authorized by the EMS Medical Director or designee and provided by PCEMS. The repository incorporates specific anti-diversion design features as well as custom labeling and an integrated electronic lock for the expressed purpose of secure containment of CSs.

Controlled Substance (CS) Card – A fillable card containing a control number, approved by the EMS Medical Director or designee for issuance to each individual pharmaceutical container. The card provides space for documenting specific mandated data elements.

Controlled Substance Central Receiving (CS-CR) - Location determined, authorized, and established by the Pinellas County EMS System Director and EMS Medical Director

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Controlled Substance Central Receiving Coordinator (CS-CRC): Primary individual, as designated by the Chief Operating Officer of the ambulance contractor or designee, who possesses written authorization from the EMS Medical Director, to handle procurement, distribution, scheduling destruction of and records management/retention of CSs at CS-CR.

Controlled Substance Central Receiving Handler (CS-CRH): Secondary individual(s), as designated by the Chief Operating Officer of the ambulance contractor or designee, who possesses written authorization from the EMS Medical Director, to handle procurement, distribution, scheduling destruction of and records management/retention of CSs at CS-CR.

Controlled Substance Compliance Coordinator (CS-CC): An employee of Pinellas County EMS Administration, assigned by the Director of Pinellas County EMS Administration and authorized by the EMS Medical Director or designee, as a liaison between the EMS Medical Director and all first responder agencies and the ambulance contractor.

AD13 CONTROLLED SUBSTANCE MANAGEMENT PLAN - ADMINISTRATIVE

Definitions (cont.):

Controlled Substance Coordinator (CS-C): the EMS Coordinator, as designated by each individual first responder agency Fire Chief or the Chief Operating Officer of the ambulance contractor, who is a certified professional and possesses written authorization from the EMS Medical Director or designee to possess and transport CSs in the Pinellas County EMS System for the purpose of replacing expired or damaged medications, resupply of used medications and other related duties as described within this protocol.

Controlled Substance Handler (CS-H): an individual, who is a certified professional, identified by the agency CS-C who possesses written authorization from the EMS Medical Director or designee to possess and transport CSs in the Pinellas County EMS System for the purpose of replacing expired or damaged medications, resupply of used medications and other related duties as described within this protocol.

Controlled Substance Incident Report (CS-IR): a written or electronic document used to communicate information to other people and to document unusual or significant occurrences. It is extremely important for the content of the CS-IR ***to reflect clear, detailed information in a factual, unbiased manner to avoid passing along opinions and judgements.***

Controlled Substance (CS) Logbook: A written document authorized by the EMS Medical Director or designee and provided by PCEMS to record the chain of custody of CSs. Utilized during periods of downtime of the established electronic inventory management system, out of county disaster deployments, etc.

Controlled Substance (CS) Schedules: Drugs and other substances that are considered CSs under the Controlled Substances Act (CSA) are divided into five schedules.

- An updated and complete list of the schedules is published annually in **Title 21 Code of Federal Regulations (C.F.R.) §§ 1308.11 through 1308.15**.
- Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused.

Controlled Substance (CS) Waste: Waste may include products expiring, products prepared for administration, but not administered to the patient (e.g., when no longer indicated, physician discontinues or a patient refuses administration), and drug product remaining after a partial dose is removed from its packaged container. Waste may also include overfill in vials.

Definitions (cont.):

Custody: The care, possession, and control of an item. The retention, inspection, guarding, maintenance, or security of an item within the immediate care and control of the person to whom it is committed.

DEA: U.S. Drug Enforcement Agency – Primarily responsible for enforcing the CSA's registration provisions and works with the Criminal Division of the Department of Justice to enforce the Act's trafficking provisions.

DEA Controlled Substance Ordering System (CSOS): Program that allows for secure electronic CS orders without the supporting paper DEA Form 222.

DEA Form 41: Registrant Record of Controlled Substances Destroyed – Form mandated by the DEA to record the destruction of CSs that remain in the closed system of distribution (not applicable for destruction when CSs are handled by a reverse distributor). A CS dispensed for immediate administration pursuant to an order for medication in an institutional setting remains under the custody and control of that registered institution even if the substance is not fully exhausted (e.g., some of the substance remains in a vial, tube, or syringe after administration but cannot or may not be further utilized, commonly referred to as ''drug wastage'' and ''pharmaceutical wastage''). Such remaining substance must be properly recorded, stored, and destroyed in accordance with DEA regulations (e.g., § 1304.22(c)), and all applicable Federal, State, tribal, and local laws and regulations, although the destruction need not be recorded on a DEA Form 41.

DEA Form 82: Notice of Inspection of Controlled Premises – Form utilized when the DEA appears to perform an unannounced administrative inspection.

DEA Form 106: Form mandated by the DEA to be completed upon discovery, of any thefts or significant losses of CSs and submitted to the FDA for such theft or loss

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DEA Form 222: A single page serialized form, ordered by an authorized registrant from the DEA, that is required to order any Schedule II CS.

Deliver: the term refers to the actual, constructive, or attempted transfer of a CS or a listed chemical, whether there exists an agency relationship or not

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Distribute: the term means to deliver (other than by administering or dispensing) a CS or a listed chemical.

AD13 CONTROLLED SUBSTANCE MANAGEMENT PLAN - ADMINISTRATIVE

Definitions (cont.):

Drug Diversion: The term includes any unaccountable loss, theft, use for unintended purposes, or tampering of a drug. For purposes of these guidelines, drug diversion is a medical and legal concept involving the transfer of any legally prescribed drug from the individual for whom it was prescribed to another person for any illicit use, including any deviation that removes a prescription drug from its intended path from the manufacturer to the intended patient

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Electronic Key: A type of key designed to provide a time-stamped access record every time it meets an electronic lock resulting in full visibility of all access attempts, whether successful or not. The brand and type are authorized by the EMS Medical Director and provided by PCEMS.

Electronic Lock: A type of lock designed to provide a time-stamped access record every time it meets an electronic key resulting in full visibility of all access attempts, whether successful or not. The brand and type are authorized by the EMS Medical Director and provided by PCEMS.

Employee of a Registrant: subject to direct oversight by the registrant; required, as a condition of employment, to follow the registrant's procedures and guidelines pertaining to the handling of CSs and required to render services at the registrant's registered location.

FDA: U.S. Food and Drug Administration; Responsible for enforcing the FD & C Act.

Federal Food, Drug and Cosmetic Act (FD&C Act): All pharmaceutical drugs are subject to the FD&C Act. Amongst other things, prohibits the "introduction or delivery for introduction into interstate commerce of any drug that is adulterated or misbranded. The FD&C Act provides that a drug is deemed to be adulterated if, among other things, it "consists in whole or in part of any filthy, putrid, or decomposed substance," "it has been prepared, packed, or held under insanitary conditions," its container is made of "any poisonous or deleterious substance," or its strength, quality, or purity is not as represented

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Immediately – At once; instantly; without any intervening time or space

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Inventory – Stocks in finished form of a CS manufactured or otherwise acquired by a registrant, whether in bulk, commercial containers, or contained in pharmaceutical preparations in the possession of the registrant

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Definitions (cont.):

Inventory Management System: The process by which CSs are tracked throughout the entire supply chain, from purchasing to handling to end disposition. This process is documented using an electronic web-based system or written logbook authorized by the EMS Medical Director and provided by PCEMS.

Locked Vehicle Compartment: a locked, permanently, and substantially constructed compartment or area of a vehicle, that has been designated as the secure storage area for the CS lock box. Even though the Federal regulations do not specifically define construction, the intent of the law is that CSs must be adequately safeguarded. The general security requirements set forth in the Code of Federal Regulations (CFR) require all registrants (e.g., EMS Medical Director) to provide effective physical security controls and operating procedures to guard against theft and diversion of CSs.

Non-retrievable: for the purpose of destruction, the condition or state to which a CS must be rendered following a process that permanently alters that CSs physical or chemical condition or state through irreversible means and thereby renders the CS unavailable and unusable for all practical purposes. The process to achieve a non-retrievable condition or state may be unique to a substance's chemical or physical properties. A CS is considered ''non-retrievable'' when it cannot be transformed to a physical or chemical condition or state as a CS or CS analogue. The purpose of destruction is to render the CS(s) to a non-retrievable state and thus prevent diversion of any such substance to illicit purposes.

On-Site: means located on or at the physical premises of the registrant's registered location.

PCEMS: means Pinellas County EMS and Fire Administration

PCEMS Identification Number: a unique number issued by PCEMS to each Certified Professional that serves as identification for the individual upon entry into the system

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Pharmaceutical Disposal System – Liquid: A system that makes liquid pharmaceutical products non-retrievable.

Physical Inspection: the process of handling and visually examining something with the naked eye.

PSTrax: The current electronic inventory management system.

Definitions (cont.):

Readily Retrievable: Certain records are kept by automatic data processing systems or other electronic or mechanized record keeping systems in such a manner that they can be separated out from all other records in a reasonable time and/or records are kept on which certain items are asterisked, redlined, or in some other manner visually identifiable apart from other items appearing on the records.

Registrant: means any person who is registered pursuant to either section 303 or section 1008 of the Act (21 U.S.C. 823 or 958).

Reverse Distribute: means to acquire CSs from another registrant for the purpose of:

- Return to the registered manufacturer or another registrant authorized by the manufacturer to accept returns on the manufacturer's behalf; or
- Destruction

Reverse Distributor: a person registered with the DEA as a reverse distributor.

Significant Loss: the standard of theft has not been met, but it is clear that a CS cannot be accounted for, even after reasonable efforts have been taken to find it, and that loss is "Significant." For purposes of this policy, "Significant" means that either (a) the quantity lost is greater than one Purchased Unit or (b) there is a pattern of losses associated with a particular employee(s).

Specialty Unit: Specialty unit(s) identified by an agency which may be activated or upgraded to ALS status, including issuance of CSs, authorized by the EMS Medical Director or designee. Examples include special event units and medical tents.

Stryker Cactus PharmaLock: The current liquid pharmaceutical disposal system.

Tamper Evident Bag/Container: A tamper-evident package, according to the regulations of the Food and Drug Administration "is one having one or more indicators or barriers to entry which, if breached or missing, can reasonably be expected to provide visible evidence to consumers that tampering has occurred." In addition, the indicator or barrier must be "distinctive by design," which means the tamper-evident feature is designed from material not readily available to the public. Therefore, it can't be easily duplicated.

Theft: generic term for all crimes in which a person intentionally takes personal property of another without permission or consent and with the intent to convert it to the taker's use (including potential sale).

Definitions (cont.):

Transfer of Custody: a real-time, face-to-face transaction whereby the off-going certified professional, ACST or a CS-C/CS-H relinquishes custody of each individual CS container, the CS box, CS electronic key and vehicle compartment key (if applicable) to the on-coming certified professional, ACST or a CS-C/CS-H and that individual accepts custody of each individual CS container, the CS box, electronic key and vehicle compartment key (if applicable). This transaction must not be precalculated or pre-signed and must include a physical inspection by both individuals. Once the physical inspection is complete then appropriate documentation (inventory management system or logbook) must take place.

AD13 CONTROLLED SUBSTANCE MANAGEMENT PLAN - ADMINISTRATIVE

AD13.1 CS CENTRAL RECEIVING (CS-CR)

1. Authorizations:
   - Authorization is granted by the EMS Medical Director for procurement of, receiving into inventory, distribution, and facilitation of the destruction of CSs in accordance with all applicable federal and state laws and regulations related to CSs, in addition to any Pinellas County Emergency Medical Services and/or local agency policies and procedures.
   - The following personnel are authorized to be in the CS Central Receiving (CS-CR) physical space while conducting official tasks:
     - EMS Medical Director or designee
     - CS Receiving Coordinator/Handler
     - Agency CS Coordinator/Handler
     - Pinellas County EMS Administrative Staff

   NOTE: No other access to this location is permitted without prior approval of the EMS Medical Director or designee.

2. Security:
   - In accordance with Federal and State Controlled Substance Laws:
     - Unless a blind count, audit or other activity warranting immediate access to CSs is being performed, all doors (building, safes, cabinets, refrigerators, etc.) are to remain closed and secured with all applicable installed locks engaged preventing access.
     - No more than fifty (50) containers of CSs must be out visible at any given time except as authorized
     - In the event packaging, documentation for destruction, etc. is occurring and a request is made from an agency coordinator or handler to access CS-CR, all inventory out will be secured prior to providing access to the CS-CR physical space.
     - Electronic locks providing security and tracking of CSs must not be accessed unless as a component of defined daily operations
     - An assigned electronic key must not be utilized by anyone other than the individual the key is assigned
     - Passwords, pins, usernames, etc. must not be shared
     - Physical structural doors must remain closed and secured with all applicable installed locks while any type of CS transaction(s) is occurring in the CS-CR

3. Inventory
   - In accordance with Federal and State Controlled Substance Laws, the following items are to remain segregated under individual security:
     - Schedule II CSs
     - Schedule III-V CSs
     - CSs, CS Boxes, CS Electronic Keys under review/investigation
     - CS that are damaged or have expired

   - The above items must not be co-mingled without formal written pre-approval from the EMS Medical Director or designee. The formal request must include the following when submitted:
     - Specific request (e.g., CS Box under investigation stored with in date Schedule V CSs).
     - Specific details surrounding the request (e.g. broken lock on a safe, overstock, etc.)
     - Defined start and stop date and time
     - Immediate options that exist to prevent the co-mingling from having to be done (e.g., clear pending CS boxes being held for review/investigation)

   - Master system CS inventory par levels:
     - Determined through ongoing evaluation of historical data, in addition to other factors, including national shortages, storms (e.g. hurricanes), etc. to establish high, low and safety stock levels.
     - Established levels are reviewed and authorized by the EMS Medical Director (Registrant)
     - Any changes to the master system CS inventory par levels requires the submission of a formal written request from the CS-CRC to the EMS Medical Director or designee for review.
     - The EMS Medical Director or designee will review and evaluate all requests to increase or decrease inventory par levels and provide direction in writing
     - To ensure the highest level of security, these par levels are not published

   - Distribution
     - Each individual CS container must be distributed in a PCEMS issued tamper evident bag and/or container as authorized by the EMS Medical Director or designee.
     - A clear CS container secondary containment device is to be utilized when directed by the EMS Medical Director or designee

4. Procurement:
   - Must be coordinated with the EMS Medical Director or designee.
     - **Schedule II CS - Procurement**
       1. A fully executed DEA Form 222 is required.
          - Possession of "Extra" (signed or unsigned) DEA Form 222s is prohibited.
       2. The CS-CR Coordinator or Handler will request a signed DEA Form 222 from the EMS Medical Director through the PCEMS CS-CC a minimum of two weeks prior to the planned procurement submission
       3. A DEA Form 222 must be hand delivered from the EMS Medical Director or designee to the authorized CSCR Coordinator or Handler
       4. Upon receipt of the DEA Form 222, the CSCR Coordinator or Handler must immediately complete, per the form instructions, or secure the document with the Schedule II CSs if time does not permit proper completion and submission.
       5. The DEA 222 Form number must be documented:
          - on the accompanying Purchase Order (PO) prior to submission and approval of the Purchase Order
          - on all forms associated with the specific DEA 222 Form (i.e., invoices, records of destruction, incident reports, packing slips, etc.)
       6. A CS Cover Sheet must be initiated for each procurement transaction.

     - **Schedule II CS – Receipt of Delivery**
       1. Upon delivery of Schedule II CSs to the EMS Central Supply Warehouse:
       2. The shipment from the distributor/manufacturer must be delivered immediately to an authorized CS-CR Coordinator or Handler including the original packing slip and any other associated paperwork (electronic or hardcopy).
       3. The sealed package must be opened immediately upon receipt and a physical inspection must be conducted.
       4. Once a physical inspection is complete, the results of the inspection are to be documented on the CS Cover Sheet.
       5. The received inventory, regardless of condition received, will be secured in the designated Schedule II safe
       6. All accompanying paperwork (regardless of perceived importance) must be:
       7. Signed (including date and time received) by the CSCR Coordinator or Handler completing the physical inspection.
       8. Associated DEA 222 Form Number must be documented on all paperwork received.
       9. The CS Cover Sheet is to be finalized

AD13 CONTROLLED SUBSTANCE MANAGEMENT PLAN - ADMINISTRATIVE

10. The completed CS Cover Sheet, DEA 222 Form, Approved Purchase Order, packing slip and ALL other accompanying paperwork (electronic or hardcopy) must be scanned and uploaded to the primary inventory management system for Pinellas County EMS as one scanned file.
    - Once all paperwork is uploaded, the upload is to be reviewed to ensure 100% beyond a reasonable doubt it is legible.
    - In the event there is a question of legibility related to the upload, ***ALL*** paperwork is to be re-scanned and uploaded
    - This process is to continue until such a time that the scanned package of paperwork is legible beyond a reasonable doubt.
11. All scanned paperwork must be assembled with the applicable CS Cover Sheet as the first page and delivered to the EMS Medical Director or designee.
12. A CS Card request is to be completed and e-mailed to the Pinellas County EMS CS-CC.
13. The quantity of CS Cards requested is to equal the exact quantity of controlled substance containers received in the delivery. A "Spare or Reserve" quantity of cards is not to be retained in the CS-CR.
14. Any discrepancies noted in paperwork, external packaging, initial physical inspection, physical inspection of the internal contents or quantity received must be immediately reported to the EMS Medical Director via phone (office, cell, or text) with a follow-up e-mail.
    - Discrepancies must also be documented on the CS Cover Sheet
15. Upon receipt of the CS Cards, each individual CS container must be packaged in an individual tamper evident bag with an individual CS Card.

- **Schedule III-V CS Procurement and Receipt of Delivery**
  1. A DEA Form 222 is ***NOT*** required.
  2. Follow all other procedures as noted for the Procurement of Schedule II CSs

5. Destruction:
   - In accordance with Federal and State Controlled Substance Laws:
     - CSs being sent for destruction are to be quarantined from all other inventory
     - Must be handled by a DEA authorized reverse distributor
       - prior authorization must be obtained from the EMS Medical Director of the reverse distributor selected to handle destruction
       - A written plan describing the destruction process will be submitted to the EMS Medical Director prior to commencing any destruction activity
       - A change in reverse distributors requires prior authorization from the EMS Medical Director
       - The reverse distributor must employ software that:

- Complies with all applicable Federal and State Controlled Substance laws for chain of custody, destruction and records management
- Provides Pinellas County EMS Administration Personnel and the EMS Medical Director or Designee full access to all CS destruction information related to Pinellas County Emergency Medical Services
- Provides the ability to download all CS destruction information related to Pinellas County Emergency Medical Services

- A scheduled destruction event must occur at least once every 90 days.
- The EMS Medical Director or designee and the EMS Controlled Substance Compliance Coordinator must be notified prior to scheduling destruction.
- One week prior to the scheduled destruction event, the EMS Controlled Substance Compliance Coordinator and the CSCR Controlled Substance Coordinator will schedule time to:
  - Count and document all inventory scheduled for destruction
  - Inventory counted must be secured in a system serialized tamper evident bag with the serialized number documented.
  - The bags are to be quarantined from patient inventory and secured in accordance with all applicable federal and state CS laws and regulations, in addition to any Pinellas County Emergency Medical Services and local agency policies and procedures.
  - Written notification (electronic) to the EMS Medical Director must be provided documenting the following from each container of CS:
    - Drug name (generic)
    - National Drug Code (NDC)
    - Expiration Date
    - Drug concentration
    - Drug volume
    - Serial number of tamper evident bag utilized
- Upon completion of the onsite destruction event:
  - All applicable paperwork from the event must be scanned and uploaded to the primary inventory management system for Pinellas County EMS as one scanned file.
  - Once all paperwork is uploaded, the upload is to be reviewed to ensure 100% beyond a reasonable doubt it is legible.
  - In the event there is a question of legibility related to the upload, ***ALL*** paperwork is to be re-scanned and uploaded
  - This process is to continue until such a time that the scanned package of paperwork is legible beyond a reasonable doubt.
  - All scanned paperwork must then be delivered to the EMS Medical Director or designee.

6. Cactus – The Cactus Cartridge upon max capacity or 90 days from first used is to be sealed per manufacturers instructions and destroyed in accordance with Federal, State and Local pharmaceutical waste laws and regulations.

AD13 CONTROLLED SUBSTANCE MANAGEMENT PLAN - ADMINISTRATIVE

AD13.2 CS COORDINATOR SPECIFIC RESPONSIBILITIES

1. No later than January 15th of each year and upon any changes ensure that the following are submitted to the EMS Medical Director or designee for approval:
   a. Agency specific written operating procedures for CS procurement, storage, handling, dispensing, and disposal as required by Florida 64J-1.021 and in compliance with this policy.
   b. A completed agency authorized CS-C, CS-H, ACS-T and ACS-H Request form.
   c. A completed agency authorized CS Lock Box assignment request form.
   d. A summary of internal audit/inspection activities occurring during the previous calendar year.
2. Ensure adequate employee screening per PCEMS Rules and Regulations.
3. Ensure restock of soon to expire, used, and damaged medications.
   a. The CS-C may utilize a CS-H to assist in this function.
   b. Expiring dosing units:
      - Must be removed as per AD14.
      - Must be sealed intact in a Sunstar Medication Bag to ensure segregation from active stock and prevent the possibility of an accidental administration. The bag shall have the word "**EXPIRED**" prominently written on the outside.
      - Must be returned to CS Central Supply upon removal and must not be stored.
4. Conduct and document the following CS Audit/Inspections:
   a. Irregularly timed, quarterly, and unannounced Audit/Inspection of at least 25% of the CSs assigned to the agency.
   b. Audit/Inspection documentation shall include the following minimum information:
      - Date and time of the audit, list of CS(s) examined with Control Numbers and volume, verification that status in Inventory Management System and any irregularities found.
5. Make immediate notification, upon discovery, to the Medical Director or designee of the following:
   a. Any discrepancies or possible diversion related activities found during audit or routine activities.
   b. Any personnel arrests or criminal charges related to CSs or illicit drugs.
   c. Any personnel substance abuse or dependence issues.
   d. Any allegations made regarding irregularities in CS handling or administration.

AD13.3 CS SUBSTANCE HANDLER RESPONSIBILITIES

1. Maintain a PCEMS electronic lock box AND master electronic lock box key
2. Connect, charge, and sync electronic key with current PCEMS lock/key database
3. Maintain a PCEMS approved Handler CS Logbook for Legacy hard copy tracking in the event the electronic inventory management system is unavailable for any reason.
4. Conduct quarterly audits of individual CS Inventory Management System, Legacy hard copy tracking logbook, and individual lockbox inventory
5. Ensure CS cards are properly and completely documented
6. Transport expired/damaged CSs to EMS Central Supply for exchange and restock
7. Transport CSs from EMS Central Supply to individual units/lock boxes
8. Resupply/exchange/restock any CSs within the same shift they were obtained for any reason
9. Ensure Protocol compliance for all clinicians responsible for controlled substance lockbox/lock key
10. Make proper notifications for suspected/known diversions
    a. Follow Assumption of Control procedures when a CS Lock Box/Key is in a loss of control situation

AD13.4 FIELD OPERATIONS

1. Authorization –
   - Each FIRST RESPONDER agency is authorized (subject to review and approval of the EMS Medical Director):
     - One (1) PCEMS issued operational controlled substance box with accompanying electronic key per EMS Authority authorized ALS Unit
     - One (1) PCEMS issued operational controlled substance box with accompanying electronic key per EMS Authority authorized supervisory vehicle (e.g. Lieutenant Rescue or District Chief).
     - One (1) or more unscheduled spare PCEMS Controlled Substance Boxes and/or electronic keys for emergent scheduling and deployment
     - One (1) or more PCEMS Administrative CS boxes for the explicit purpose of replacing expired or damaged medications and resupply of used medications
   - The AMBULANCE agency is authorized (subject to review and approval of the EMS Medical Director):
     - A quantity of controlled substance boxes and accompanying electronic keys to meet daily operational needs. This quantity is less than 1 per unit by design.
     - One (1) PCEMS issued operational controlled substance box with accompanying electronic key per EMS Authority authorized supervisory vehicle (e.g. Field Supervisor).
   - Each First Responder agency and Ambulance agency is authorized (subject to review and approval of the EMS Medical Director):
     - One (1) issued electronic key per individually named Controlled Substance Coordinator and Controlled Substance Handler with defined programming to complete Coordinator/Handler authorized actions
2. Administrative Security -
   - Administrative Controlled Substance Box:
     - Use is restricted to an authorized PCEMS Controlled Substance Coordinator or Handler
     - Must always be in the direct custody of an authorized PCEMS Controlled Substance Coordinator or Handler *when in use*
     - Must always remain locked except:
       - During transfer of custody
       - When expired, damaged or recalled containers are being replaced
       - At the time re-supply is received

CS13.5 ALS Specialty Units

1. In the event a Specialty Unit is activated to ALS status or placed in service, the Specialty Unit will acquire controlled substances in the following manner:
   a. The Unit will have their controlled substances issued to them by the CS Coordinator or Handler.
   b. The CS Coordinator or Handler will designate a reserve CS Lock Box with the inventory of controlled substances, CS Key, and CS Logbook to the Specialty Unit's Certified Professional using the transfer of control procedures.
   c. When the ALS Unit status is decommissioned, the CS handler or coordinator will retrieve the controlled substances using the transfer of control procedures.
   d. When applicable, the controlled substances must be returned to county central supply according to the specified agreement.
   e. In the event that a CS coordinator or Handler is not immediately available, the controlled substances may be placed on an available in-service unit until the earliest possible retrieval
2. A CS box may be moved from an in-service unit to a specialty unit for short duration events if county agreements are being followed.

CS13.6 Assumption of Custody

- A CS Coordinator or Handler may assume control of a CS container, CS box, CS repository or electronic key without following the standard chain of custody transfer/accountability procedures in the following circumstances:
  1. In the case of emergency leave in which the certified professional with custody/accountability becomes incapacitated
  2. A loss of custody event
  3. In the event there is no on-coming certified professional available
  4. When tampering, diversion or loss of control is suspected to have occurred
- In the event a CSH or CSC assumes control of a CS container, controlled substance box, controlled substance repository or electronic key, the following must occur:
  1. The EMS Medical Director of designee must be immediately notified.
  2. The CSC must be notified in the case CSH has assumed control.
  3. The controlled substance box/repository must be accessed using the CSC or CSH's key (not the box, ACST or CSH assigned key) and an inventory/inspection must be conducted.
  4. The assumption of custody must be documented in the PCEMS Controlled Substance Inventory Management System
- If the CSC or CSH has assumed custody due to suspected tampering or diversion, law enforcement must be notified and the procedures in Section CS13.5 must be followed.

CS13.7 DEA Inspection Preparedness

The U.S. Department of Justice Drug Enforcement Agency (DEA) makes periodic unannounced inspections to audit registered controlled substance storage locations. In a typical audit, DEA Diversion Investigators ensure that the controlled substance licensee/registrant is compliant with the Controlled Substance Act or, if applicable, bring them back into compliance.

- Areas/Procedures Likely to be Inspected:
  - Security practices: authorized personnel, controlled substance storage
  - Record keeping practices: DEA Form 222 (if applicable), invoices, complete and accurate inventories, use, and waste logs. Particular attention will be paid to documented discrepancies.

Do's & Don'ts During the Inspection:

- Be sure to have an action plan to immediately retrieve records during a DEA inspection.
- Answer the DEA investigator's questions as truthfully and as concisely as possible.
- If you do not know the answer to a question, ***DO NOT*** speculate on the answer.
- Do not argue or debate with the DEA investigator.
- Take notes of all recommendations and observations made by the DEA Investigators.
- Ask any questions you might have regarding the DEA findings so corrective actions can be implemented.
- Copy any records required by the DEA and obtain a receipt (DEA Form 12) for any original records and/or controlled substances taken off-site.

If approached by a representative for the DEA for Inspection:

1. Immediately contact the EMS Medical Director or designee
2. Review the DEA investigators' credentials, photo identification, and their contact information (business card)
3. Reserve a conference room for the investigators to use.
4. Be prepared to provide all relevant records
5. Answer the DEA investigator's questions as concisely as possible. Always be truthful; don't speculate. If you don't know the answer to a question, be thoughtful and helpful in your answer, explaining, "I don't have the answer offhand, but I know where to find it".
6. Be polite and cordial. Do not argue or debate the DEA investigator.

AD13 CONTROLLED SUBSTANCE MANAGEMENT PLAN - ADMINISTRATIVE

CS13.8 Records Retention

- Every inventory and other records required must be kept by the registrant and be available, for at least 2 years from the date of such inventory or records, for inspection and copying
- Financial and shipping records (such as invoices and packing slips but not executed order forms subject to CFR1305.17 and 1305.27) must be kept at the registered location
- The registrant agrees to allow authorized employees of the Administration to inspect such records at the central location upon request by such employees without a warrant of any kind.
- Inventories and records of controlled substances listed in Schedules I and II must be maintained separately from all the records of the registrant
- Inventories and records of controlled substances listed in Schedules III, IV, and V must be maintained either separately from all other records of the registrant or in such form that the information required is readily retrievable from the ordinary business records of the registrant.

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AD14 EMS SUPPLY HANDLING

Purpose

To describe the proper inventory, accounting, disposal, and record keeping for *ALL* non-controlled pharmaceuticals (including intravenous fluids) and single use disposable medical supplies purchased by Pinellas County EMS and then requisitioned and distributed through the Pinellas County EMS Central Supply Warehouse.

This is applicable to all disciplines under the auspices of Pinellas County EMS (e.g., Hazmat, Tech Rescue, Lifeguards, Tactical, etc.)

- Inventory shall be managed and controlled through the current computerized inventory control system
- All inventory will be physically examined monthly for damage, soiled, dirty, partially used, expiration and discoloration.
- Inventory shall be rotated on a first expire (or oldest), first out (FEFO) method moving the oldest dated product closest to the end user
- Removal of expired items:
  - Single Use Medical Supplies:

    - Supplies with an expiration date expressed as month and year (e.g., 02/19) shall be removed and replaced during the listed expiration month (e.g., an item that expires 02/19 would be removed and replaced during the month of February 2019)
    - Supplies with an expiration date expressed as month, day and year (e.g., 02/01/19) shall be removed and replaced during the month prior to expiration (e.g., an item that expires 02/01/19 would be removed and replaced during the month of January 2019)
    - Items ***are NOT*** to be removed earlier to ensure we are maximizing the use
  - Pharmaceuticals:
    - Pharmaceuticals with an expiration date expressed as month and year (e.g., 02/19) shall be removed and replaced during the last week of the listed month (e.g., an item that expires 02/19 would be removed and replaced during the last week of February 2019).

AD14 EMS SUPPLY HANDLING

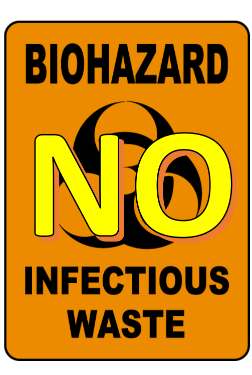
- Pharmaceuticals with an expiration date expressed as month, day and year (e.g., 02/01/19) shall be removed and replaced during the last week of the prior month (e.g., an item that expires 02/01/19 would be removed and replaced during the last week of January 2019).
- Items ***are NOT*** to be removed earlier to ensure we are maximizing the use

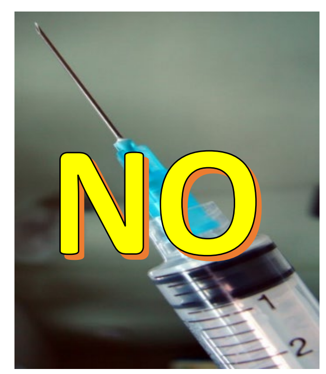
- All items deemed “recalled, expired, or unusable” shall be:
  - Kept in the original packaging, whenever possible
  - Placed in the Pinellas County EMS “Expired” container (blue in color)

- The “Expired” container (blue in color) shall be:
  - Stored in a separate location from in-date active inventory
  - Returned to Pinellas County EMS Central Supply on the first of each month if the container has any items for return (regardless how full the container is at the time of return)

- ***EXPOSED NEEDLES, BROKEN GLASS, LEAKING CONTAINERS, BIOHAZARD WASTE and/or REGULAR TRASH SHALL NEVER BE PLACED IN THE EXPIRED BIN!!***

- ***EXPIRED MEDICATIONS ARE NOT TO BE DISPOSED OF IN THE REGULAR TRASH OR BIOHAZARD WASTE CONTAINER***





- Any damaged items that contain “sharps” shall be placed in a sharp’s safety container for proper disposal

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AD15 BLS/ALS PHARMACEUTICAL & MEDICAL SUPPLY AUTHORIZATIONS & SUBSTITUTIONS

The following BLS/ALS Pharmaceutical & Medical Supply Authorizations and Substitutions are granted under the authority of Chapter 401 of the Florida Statutes and 64J of the Florida Administrative Code.

- ***Short Spine Board and Two Straps or Equivalent***
  - Chapter 64J-1.002, Table 1, #11 Ground Vehicle BLS Equipment and Supplies, Florida Administrative Code requires a Short Spine Board and Two Straps or Equivalent. As EMS Medical Director, I authorize the substitution of the half size vacuum mattress, based on current medical research, in lieu of a Short Spine Board and Two Straps in Pinellas County EMS

- ***Cervical Immobilization Devices***
  - Chapter 64J-1.002, Table 1, #12, Florida Administrative Code requires the EMS Medical Director to approve the Adult and Pediatric Cervical Immobilization Devices (CID) used in the EMS System. As EMS Medical Director, I authorize the iTec Multi-Grip Head Immobilizer and the MDI Pediatric Vacuum Mattress in Pinellas County EMS

- ***Burn Sheets***
  - Chapter 64J-1.002, Table 1, #22, Florida Administrative Code requires Burn Sheets. As EMS Medical Director, I authorize substitution of disposable sheets/blankets and/or cotton sheets/blankets in lieu of Burn Sheets for ALS permitted vehicles in Pinellas County EMS

- ***Rigid Cervical Collars***
  - Chapter 64J-1.002, Table 1, #29, Florida Administrative Code requires the EMS Medical Director to approve in writing the Rigid Cervical Collars used in the EMS System. As EMS Medical Director, I authorize the AMBU “Perfit” adjustable style Rigid Cervical Collar and the AMBU Perfit “Mini-Ace” adjustable style Rigid Cervical Collar in Pinellas County EMS

- ***Thermal Absorbent Reflective Blanket***
  - Chapter 64J-1.002, Table 1, #34, Florida Administrative Code requires a Thermal Absorbent Reflective Blanket. As EMS Medical Director, I authorize substitution of regular cotton or wool blankets and cotton baby receiving blankets in lieu of Thermal Absorbent Reflective Blankets in Pinellas County EMS

- ***Disposable Endotracheal Tubes – Uncuffed Below Size 5.5***
  - Chapter 64J-1.003, Table 2, EQUIPMENT (d), Florida Administrative Code requires all endotracheal tubes below size 5.5, be uncuffed. As EMS Medical Director, I authorize substitution of cuffed endotracheal tubes size 3.0 – size 5.0 in lieu of uncuffed endotracheal tubes size 3.0 – size 5.0 in Pinellas County EMS

AD15 BLS/ALS PHARMACEUTICAL & MEDICAL SUPPLY AUTHORIZATIONS & SUBSTITUTIONS

- ***Monitoring Electrodes for Adult and Pediatrics***
  - Chapter 64J-1.003, Table 2, EQUIPMENT (q), Florida Administrative Code requires monitoring electrodes for adults and pediatrics. As EMS Medical Director, I authorize the use of ConMed Positrace or Nissha Vermed brands of electrodes for adults and pediatrics in Pinellas County EMS

- ***Dextrose, 50 Percent***
  - Chapter 64J-1.003, Table 2, GROUND VEHICLE ALS EQUIPMENT AND MEDICATIONS #2, Florida Administrative Code requires Dextrose, 50 Percent. As EMS Medical Director, I authorize the substitution of Dextrose 10 Percent, 250 mL IV Fluid and/or Oral Glucose Gel 15g in lieu of Dextrose 50 Percent in Pinellas County EMS

- ***Device For Intratracheal Meconium Suctioning In Newborns***
  - Chapter 64J-1.003, Table 2, GROUND VEHICLE ALS EQUIPMENT AND MEDICATIONS, EQUIPMENT (g), Florida Administrative Code requires a device for intratracheal meconium suctioning in newborns. As EMS Medical Director, I authorize the removal of this device based on current literature regarding the delivery of a newborn with Meconium-Stained Amniotic Fluid as follows:

    - https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/03/delivery-of-a-newborn-with-meconium-stained-amniotic-fluid#:~:text=The%20Committee%20on%20Obstetric%20Practice,longer%20routinely%20receive%20intrapartum%20suctioning
    - https://downloads.aap.org/DOICH/NRP%20Instructor%20Update%20Spring_Summer%202019.pdf
    - https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9027554/
    - https://www.ucsfbenioffchildrens.org/-/media/project/ucsf/ucsf-bch/pdf/manuals/5_meconiumaf.pdf

- ***Glucometer Approved by the EMS Medical Director***
  - State of Florida Department of Health – Emergency Medical Services Advanced Life Support Vehicle Inspection Report (Section 401.31, F.S.) requires a glucometer approved by the EMS Medical Director. As EMS Medical Director I authorize the use of the Bayer Contour Glucometer in Pinellas County EMS.

Signature: ____

Angus M. Jameson MD MPH FAEMS FACEP
EMS Medical Director

AD16 CARDIAC MONITOR/DEFIBRILLATOR - AED CLINICAL CONFIGURATION

AD16.1 Stryker Lifepak 15

The Stryker LP15 Clinical Configuration is the clinical standard for patient care in Pinellas County EMS. It reflects a standard configuration for **ALL** Stryker LP15 devices utilized as a component of patient care under the auspices of Pinellas County EMS. This configuration is not to be altered without prior approval of the EMS Medical Director.

Options					
SpO2	NIBP	EtCO2	12-Lead	12-Lead Tx	Pacing

Setting	Value
Setup/General	
Code Summary	Long
Trend Summary	Off
Auto Log	On
Line Filter	60Hz
Timeout Speed	30 seconds
Setup/Manual Mode	
Sync After Shock	On
Pads Default	Energy Protocol
Internal Default	10
Voice Prompts	On
Shock Tone	On
Manual Access	Manual / Direct
Passcode	0000
Setup/Manual Mode/Energy Protocol	
Energy 1	200
Energy 2	300
Energy 3	360
Setup/AED Mode	
Auto Analyze	Off
Motion Detection	On
Pulse Check	Never
Setup/AED Mode/Energy Protocol	
Energy 1	200
Energy 2	300
Energy 3	360
Stacked Shocks	Off
Setup/AED Mode/CPR	
CPR Time 1	120 seconds
CPR Time 2	120 seconds
Initial CPR	Off
Initial CPR Time	120 seconds
PreShock CPR	Off
Setup/CPR Metronome	
Metronome	On
Adult - No Airway	30:2
Adult - Airway	10:1
Youth - No Airway	15:2
Youth - Airway	10:1
Setup/Pacing	
Rate	60 PPM
Current	60 mA
Mode	Demand
Internal Pacer	Detection On
Setup/Monitoring	
Continuous Data	ECG Channel 1
SpO2 Tone	Off
Trends	On
Setup/Monitoring/Channels	
Default Set	Set 1
Setup/Monitoring/Channels/Set 1	
Channel 1	ECG Lead II
Channel 2	ECG Lead III
Channel 3	SpO2
Setup/Monitoring/Channels/Set 2	
Channel 1	ECG Lead II
Channel 2	SpO2
Channel 3	CO2
Setup/Monitoring/Channels/Set 3	
Channel 1	ECG Lead II
Channel 2	ECG Lead III
Channel 3	ECG Lead aVF
Setup/Monitoring/Channels/Set 4	
Channel 1	ECG Lead II
Channel 2	None
Channel 3	None
Setup/Monitoring/Channels/Set 5	
Channel 1	Paddles
Channel 2	SpO2
Channel 3	CO2
Setup/Monitoring/CO2	
Units	mmHg
BTPS	On
Setup/Monitoring/Temperature	
Units	°C
Setup/Monitoring/NIBP	
Initial Pressure	160 mmHg
Interval	5 min
Setup/12-Lead	
Auto Transmit	Off
Auto Print	On
Print Speed	25mm/sec
Interpretation	On
Format	3-Channel Standard

Device Model: LIFEPAK 15
Device Software Version: LIFEPAK 15 - 3313494-017

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AD16 CARDIAC MONITOR/DEFIBRILLATOR - AED CLINICAL CONFIGURATION

Setup/Events	
Event 2	None
Event 3	None
Event 4	None
Event 5	None
Event 6	None
Event 7	None
Event 8	None
Event 9	None
Event 10	None
Event 11	None
Event 12	None
Event 13	None
Event 14	None
Event 15	None
Event 16	None
Event 17	None
Event 18	None
Event 19	None
Event 20	None
Event 21	None
Event 22	None
Setup/Alarms	
Volume	5
Alarms	On
VF/VT Alarm	On
Setup/Printer	
ECG Mode	Diagnostic
Monitor Mode	1-30Hz
Diagnostic Mode	.05-40Hz
Alarm Waveforms	On
Event Waveforms	On
Vitals Waveforms	On
Setup/Printer/Auto Print	
Defibrillation	On
Pacing	Off
Check Patient	Off
SAS	Off
Patient Alarms	Off
Events	Off
Initial Rhythm	Off

Setup/Transmission	
Default Site	IMAGETREND
Default Report	All
Wireless	On
Search Filter	Off
Streaming	Enable
Setup/Transmission/Sites/Site 1	
Name	IMAGETREND (linked)
Output Port	Direct Connect
Setup/Transmission/Sites/Site 2	
Name	BFH (linked)
Output Port	Direct Connect
Setup/Transmission/Sites/Site 3	
Name	SAH (linked)
Output Port	Direct Connect
Setup/Transmission/Sites/Site 4	
Name	MPH (linked)
Output Port	Direct Connect
Setup/Transmission/Sites/Site 5	
Name	MCS (linked)
Output Port	Direct Connect
Setup/Transmission/Sites/Site 6	
Name	SJH (linked)
Output Port	Direct Connect
Setup/Transmission/Sites/Site 7	
Name	TEST (linked)
Output Port	Direct Connect
Setup/Clock	
Synchronize with the LIFENET System	Yes
Clock Mode	Elapsed Time
DST	On
Time Zone	(UTC-05:00) Eastern Time (US & Canada)
Setup/Self Test	
Transmit Results	On
Setup/Passcodes	
Setup Mode	■
Archives Access	No Passcode
Archives Mode	0000
Delete Records	■
Service Mode	■

Device Model: LIFEPAK 15
Device Software Version: LIFEPAK 15 - 3313494-017

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AD16 CARDIAC MONITOR/DEFIBRILLATOR – AED CLINICAL CONFIGURATION

AD16.2 Philips FR3 AED

DEVICE	
Volume	Loud
ECG Display	On
Record Audio	Off
Carry Case Auto-On	Off
Wireless Pin	2490
DEFIBRILLATION	
Shock Series	1
Shock Series Interval	N/A
Advanced Mode Use	Off
Advanced Use Prompt Repeat Rate	N/A
SELF TEST	
Test for Pads	On
Test for Data Card	Off
GENERAL CPR	
Metronome	Off
CPR While Armed	Off
CPR First	Off
No Shock Advised (NSA) Action	NSA CPR
NSA CPR Coaching	Always
NSA Monitor Prompt Repeat Rate	N/A
CPR Option Button	Off
Analyze Option Button	Off
PROTOCOL - SPECIFIC CPR	
Adult CPR First Duration	N/A
Adult Basic CPR Duration	2.0
Adult NSA CPR Duration	2.0
Infant/Child CPR Fist Duration	N/A
Infant/Child Basic CPR Duration	2.0
Infant/Child NSA CPR Duration	2.0

AD17 APPROVED ABBREVIATIONS

A			
AAA	Abdominal Aortic Aneurysm	ALTE	Apparent Life-Threatening Event
ABC	Airway, Breathing and Circulation	AMI	Acute Myocardial Infarction
ABD	Abdomen	ARDS	Acute Respiratory Distress Syndrome
ACLS	Advanced Cardiac Life Support	ARNP	Advanced Registered Nurse Practitioner
ACS	Acute Coronary Syndrome	ASA	Aspirin
ADR	Adverse Drug Report	AV	Atrioventricular
AED	Automatic External Defibrillator	AVB	Atrioventricular Block
AICD	Automatic Implantable Cardioverter/Defibrillator	AVPU	Awake/Verbal/Pain/ Unresponsiveness
AEIOU TIPPS	Alcohol/Endocrine - Electrolytes - Encephalopathy/Insulin/Opiates/Uremia/ Trauma - Head Injury - Shock/Intracranial - Infection/Poisoning - Psychiatric/Seizures - Syncope	APGAR	Appearance/Pulse Rate/Grimace/Activity/Respiratory Effort

B			
BBB	Bundle Branch Block	BSA	Body Surface Area
BiPAP	Bi-level Positive Airway Pressure	BUN	Blood Urea Nitrogen
BP	Blood Pressure	BURP	Backward, Upward, Rightward Pressure
BPM	Beats Per Minute	BVM	Bag-Valve-Mask

C			
CA	Cancer	CNS	Central Nervous System
CAB	Compression, Airway and Breathing	CO	Carbon Monoxide
CABG	Coronary Artery Bypass Graft	CO_2	Carbon Dioxide
CAD	Coronary Artery Disease	COPD	Chronic Obstructive Pulmonary Disease
CNA	Certified Nursing Assistant	CP	Chest Pain
CAT	Combat Application Tourniquet	CPAP	Continuous Positive Airway Pressure
CC	Chief Complaint	CPR	Cardiopulmonary Resuscitation
cmH_2O	Centimeters of water	CSF	Cerebrospinal Fluid
CCU	Cardiac Care Unit	CT Scan	Computerized Axial Tomography Scan
CF	Cystic Fibrosis	CVA	Cerebrovascular Accident
CHF	Congestive Heart Failure	CXR	Chest X-ray
cm	centimeter		

AD17 APPROVED ABBREVIATIONS

D			
D & C	Dilation and Curettage	DCF	Department of Children and Families
DC	Discontinue	dL	deciliter
DIC	Disseminated Intravascular Coagulopathy	DNRO	Do Not Resuscitate Order
DKA	Diabetic Ketoacidosis	DOT	Department of Transportation
D.O.	Doctor of Osteopathy	d/t	Due To
D50	Dextrose 50%	DVT	Deep Vein Thrombosis
D5W	Dextrose 5% in Water	DX	Diagnosis
DOPE	Displacement/Obstruction/Pneumothorax /Equipment	DUMBELLS	Diarrhea/Urination/Miosis/ Bradycardia/Emesis/Lacrimation/ Lethargy/Salivation

E			
e.g.,	for example,	ERG	Emergency Response Guidebook
ECG	Electrocardiogram	ESF8	Emergency Support Function - 8
ED	Emergency Department	ET	Endotracheal
EMD	Emergency Medical Dispatcher	ETA	Estimated Time of Arrival
EMS	Emergency Medical Service	$ETCO_2$	End-Tidal Carbon Dioxide
EMT	Emergency Medical Technician	ETOH	Ethanol
ENT	Ears, Nose and Throat	ETT	Endotracheal Tube
EOC	Emergency Operations Center	ePCR	Electronic Patient Care Record

F			
FAST	Face, Arms, Speech, Time	FiO2	Fraction of Inspired Oxygen
FDA	Food and Drug Administration	Fr	french
FEV	Forced Expiratory Volume	FRC	Functional Reserve Capacity
FFP	Fresh Frozen Plasma	FTT	Failure To Thrive
FHP	Florida Highway Patrol	FVC	Forced Vital Capacity

G			
g	gram	GPA (GPAb)	Gravida Para Abortions
G Tube	Gastrostomy Tube	GSW	Gun Shot Wound
GCS	Glasgow Coma Scale	gtt	Drops
GI	Gastrointestinal		

AD17 APPROVED ABBREVIATIONS

H			
H_2O	Water	Hgb	Hemoglobin
HA	Headache	HIV	Human immunodeficiency virus
HBP	High Blood Pressure	HME	Heat Moisture Exchanger
HCT	Hematocrit	HPI	History of Present Illness
HDL	High Density Lipoprotein	HR	Heart Rate
HEENT	Head, Eyes, Ears, Nose, Throat	H	hour
HEMS	Helicopter Emergency Medical Service	HTN	Hypertension

I			
I&D	Incision and Drainage	ID	Identification
I:E	Inspiratory to Expiratory Ratio	IM	Intramuscular
I&O	Input and Output	INF	Intravenous Flush
IABP	Intra-aortic Balloon Pump	IO	Intraosseous
ICH	Intracranial Hemorrhage	IOP	Intraosseous Push
ICP	Intracranial pressure	IV	Intravenous
ICS	Incident Command Structure	IVP	Intravenous Push
ICU	Intensive Care Unit		

J			
J	Joules	JVD	Jugular Venous Distention
J Tube	Jejunostomy Tube		

K			
kg	Kilogram	KVO	Keep Vein Open
KUB	Kidneys, Ureters, Bladder		

L			
L	Liter	LPN	Licensed Practical Nurse
LAD	Left Anterior Descending	LR	Lactated Ringers
LBBB	Left Bundle Branch Block	LUQ	Left Upper Quadrant
LLQ	Left Lower Quadrant	LVAD	Left Ventricular Assist Device
LMP	Last Menstrual Period	LVH	Left Ventricular Hypertrophy
lpm	Liters per minute		

AD17 APPROVED ABBREVIATIONS

M			
M.D.	Medical Doctor	min.	Minute
mA	milliamp	mL	milliliter
MAP	Mean Arterial Pressure	mM	millimeter
mcg	Microgram	mM ID	millimeter Inner Diameter
MCI	Mass Casualty Incident	mM OD	millimeter Outer Diameter
MDI	Metered Dose Inhaler	mM Hg	millimeter of Mercury
MEND	Miami Emergency Neurologic Deficit	MOI	Mechanism of Injury
mEq	milliequivalent	mph	miles per hour
mg	Milligram	MRI	Magnetic Resonance Imaging
MI	Myocardial Infarction		

N			
NC	Nasal Cannula	NPO	Nothing by mouth
NG	Nasogastric	NRB	Non-rebreather mask
NGT	Nasogastric Tube	NS	Normal Saline
NIDDM	Non-insulin Dependent Diabetes Mellitus	NSAID	Non-Steroidal Anti-Inflammatory Drug
NKDA	No Known Drug Allergies	NSR	Normal Sinus Rhythm
NOS	Not otherwise specified	NSTEMI	Non- ST Segment Elevation Myocardial Infarction
NPA	Nasopharyngeal Airway	NPO	Nothing by mouth

O			
O_2	Oxygen	OGT	Orogastric Tube
OB	Obstetrics	OLMC	Online Medical Control
ODT	Oral Disintegrating Tablet	OPA	Oropharyngeal Airway
OPQRST	Onset of Event/Provocation/ Quality/Radiation/Severity/Time (history)		

P			
PO	By Mouth	PMS	Pulse, Motor, Sensation
PA	Physician's Assistant	POLST	Physician Orders for Life Sustaining Treatment
PAC	Premature Atrial Contraction	PPE	Personal Protective Equipment
paO_2	Partial pressure of oxygen in arterial blood	PPV	Positive Pressure Ventilation
PAT	Paroxysmal Atrial Tachycardia	PRBC	Packed Red Blood Cells
PCR	Patient Care Record	PRN	As needed
PCSO	Pinellas County Sheriff's Office	PSI	Pounds per square inch
PD	Police Department	PSVT	Paroxysmal Supraventricular Tachycardia
PE	Pulmonary Embolus	Pt	Patient
PEA	Pulseless Electrical Activity	PT	Prothrombin Time
PEEP	Positive End-Expiratory Pressure	PTCA	Percutaneous Transluminal Coronary Angioplasty

AD17 APPROVED ABBREVIATIONS

P			
PEG Tube	Percutaneous Endoscopic Gastrostomy Tube	PTT	Partial Thromboplastin Time
PEP	Post Exposure Prophylaxis	PVC	Premature ventricular contraction
PFT	Pulmonary Function Test	PVD	Peripheral Vascular Disease
PICC	Peripherally inserted central catheter	PHAILS	Pesticides/Heavy Metals/Acids - Alkalis - Alcohols/Iron/Lithium/Solvents

Q	

R			
RBBB	Right Bundle Branch Block	ROSC	Return of Spontaneous Circulation
RBC	Red Blood Cell	RR	Respiratory Rate
RCA	Right Coronary Artery	RT	Respiratory Therapy
RLQ	Right Lower Quadrant	R/T	Related To
RN	Registered Nurse	RUQ	Right Upper Quadrant
ROM	Range of Motion	RVH	Right Ventricular Hypertrophy

S			
SA	Sinoatrial	SMR	Spinal Motion Restriction
SAH	Subarachnoid Hemorrhage	SOAP	Subjective, Objective, Assessment, Plan
SDH	Subdural Hematoma	SpCO	Carboxyhemoglobin
s/s	Signs and symptoms	SpO_2	Arterial Oxygen Level determined by pulse ox
SBP	Systolic Blood Pressure	STEMI	ST Segment Elevation Myocardial Infarction
SL	Sublingual	SAMPLE	Symptoms/Allergies/Medications/ Past History/Last Oral Intake/Event Leading Up To The Injury or Illness
SLUDGEM	Salivation/Lacrimation/Urination/ Defecation/GI Upset/Emesis/Miosis		

T			
TB	Tuberculosis	TKO	To keep open
TBSA	Total body surface area	TPN	Total Parenteral Nutrition
TCA	Tricyclic Antidepressants	TSH	Thyroid Simulating Hormone
TCP	Transcutaneous Pacing	V_t	Tidal Volume
TIA	Transient Ischemic Attack	TVP	Transvenous Pacemaker
TICLS	Tone/Interactiveness/Consolability/ Look or Gaze/Speech or Cry		

AD17 APPROVED ABBREVIATIONS

U			
UA	Urinalysis	U.S.	United States
URI	Upper Respiratory Infection	UTI	Urinary Tract Infection

V			
VAD	Ventricular assist device	V/Q	Ventilation-Perfusion
VCV	Volume Controlled Ventilation	VRE	Vancomycin-resistant enterococcus
VS	Vital signs	VT	Ventricular Tachycardia

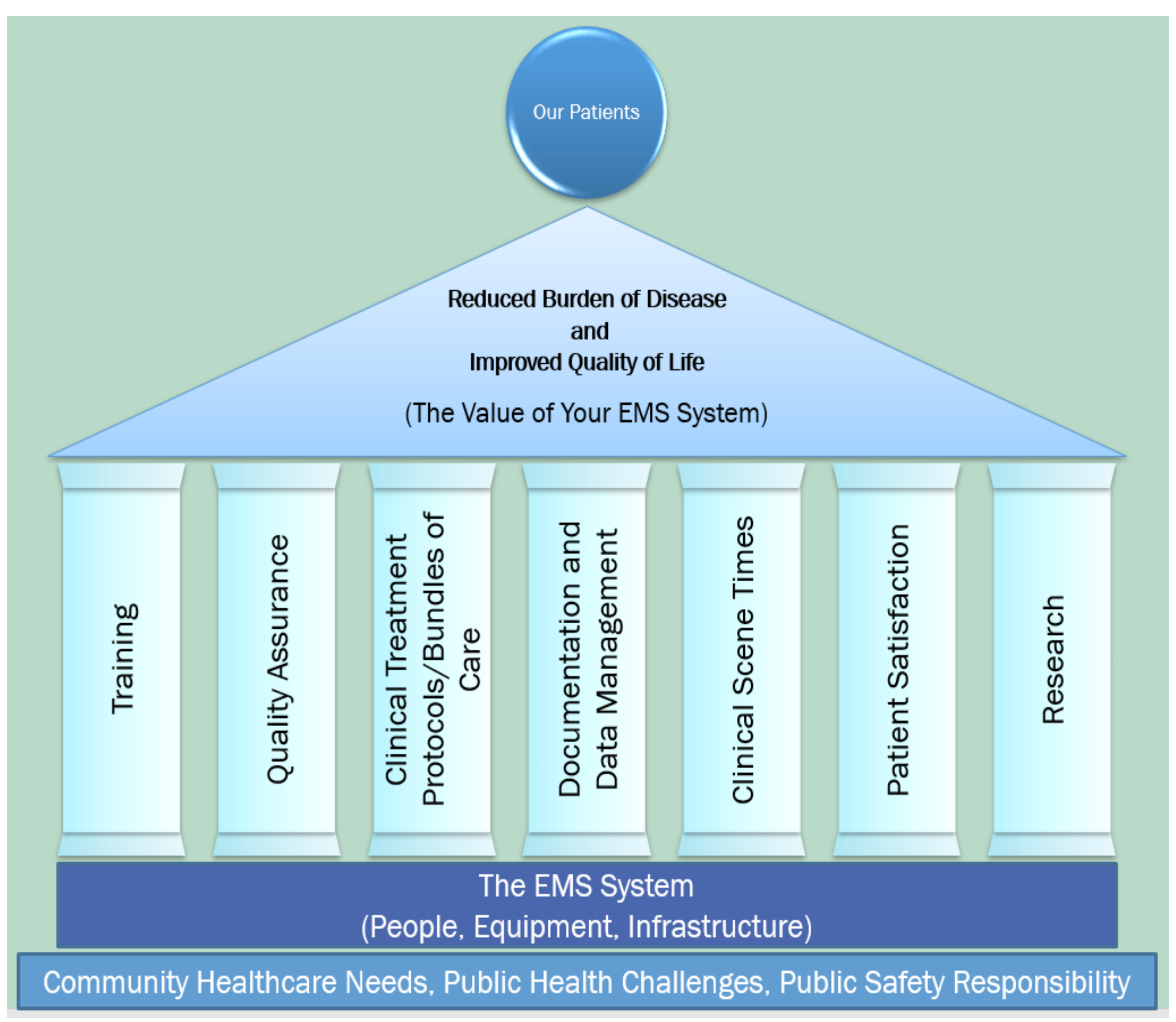
W			
WBC	White Blood Cell	WPM	Wolff-Parkinson-White

X	

Y	

Z	

AD18 Pinellas County Emergency Medical Services System Medical Quality Management Plan



AD18 Pinellas County Emergency Medical Services System Medical Quality Management Plan

AD18 - MEDICAL QUALITY MANAGEMENT PLAN

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AD18 Pinellas County Emergency Medical Services System Medical Quality Management Plan

1. Introduction

This document defines the Medical Quality Management plan for Pinellas County EMS. This plan is propagated to fulfill our collective and individual responsibility to ensure the highest quality of care to the citizens of and visitors to Pinellas County. All activities undertaken and documentation produced as part of the medical quality improvement activities outlined in this plan are protected as provided in Florida Statute.

The Pinellas County EMS Medical Quality Management plan will always adhere to the principles of and be driven by the “Just Culture Framework” and in accordance with the Pinellas County EMS Rules and Regulations as delineated on the next page:

Duty to produce an outcome	Duty to follow established protocols & procedures	Duty to avoid causing unjustifiable risk or harm
Human Error	**At-Risk Behavior**	**Reckless Behavior**
Root cause is human error or inadvertent action- oversight, lapse, or mistake.	Root cause is at-risk behavior by a clinician where the risks were unrecognized or believed to be insignificant or justified.	Root cause is a conscious disregard of substantial & unjustifiable risk by a clinician.
Improvement Efforts	**Improvement Efforts**	**Management**
Individual/Team:	**Individual/Team:**	**Individual/Team**
• Quality assurance review • Medical case review • Remedial training	• Clinical restriction (case basis) • Quality assurance review • Medical case review • Remedial training	• Clinical restriction or suspension (case basis) • Quality assurance review • Administrative proceeding • Corrective action plan • Probation • Revocation of clinical privileges
System:	**System:**	
• Continuing medical education • Protocol improvement • Situational awareness • Best practices implementation • Patient care safety systems • Process improvement • Medical equipment & supply improvements	• Supporting culture expects healthy behaviors, corrects & minimizes at-risk behavior • Continuing medical education • Situational awareness **NOTE: Repeat at-risk behavior is reckless.**	
Console	**Coach**	**Correct**

2. Attainment and Maintenance of Certification

In addition to statutory and rule obligation, the EMS Medical Director has a professional and ethical obligation to ensure the competency of each clinician in the system. This obligation is carried out through the establishment of criteria for initial and continuing system certification as well as through the adequate and effective supervision of medical practice within the system. Minimum criteria for achieving system certification at each level are delineated in the Rules and Regulations of the Pinellas County EMS System. The specifics of the current EMS Academy Program may be found in AD20. The specific procedures and requirements for achieving and maintaining Advanced Practice/Specialty Certification may be found in AD21. All certification application and change forms may be found in AD23.

3. Areas of Special Emphasis

There are several areas of local interest related to quality improvement initiatives that have been identified for action. These are:

- Cardiac Arrest
- Clinical Time Measures
- Controlled Substance Management
- Stroke Triage
- STEMI
- Preventable Infant Death

The specific areas for improvement as well as the initial planned actions are delineated in the table reflected on the next page. It is recognized that these priorities, measures, and strategies may evolve.

Focus Area	Goals	Actions
Cardiac Arrest	CPR Fraction 90%+	1. Implement CPR Report Cards providing feedback to field clinicians on each arrest 2. Obtain outcome data on all cardiac arrest patients 3. Continue reporting outcomes according to standard definitions
Clinical Time Measures	Stemi/Stroke/Trauma Alert Scene Time Goals: Mean < 10 min. 90th Percentile < 15 min.	1. Monitor and report performance 2. Review outliers with scene time > 20 min. 3. Address gaps with education
Controlled Substance Management	Enhance usability and security of control systems	1. Implement electronic tracking system 2. Develop more robust utilization review systems
STEMI	Improve Sensitivity and Specificity of STEMI triage	1. Measure accuracy of triage 2. Refine triage criteria 3. Provide ongoing education in ECG interpretation
Stroke	Improve Sensitivity and Specificity of Stroke Triage	1. Measure accuracy of triage 2. Develop refined triage criteria with consideration of LVO 3. Provide ongoing education on Stroke Triage
Preventable Infant Deaths	Reduce the incidence of preventable infant deaths in Pinellas County	1. Partner with JWB 2. Provide ongoing education to field clinicians 3. Provide information dissemination and education to families on scene
Opioid Use Disorder	Reduce the incidence of preventable deaths in Pinellas County	1. COSSAP 2. Leave Behind Narcan 3. Provide agency education to field clinicians

4. Sentinel Event Monitoring

Certain clinical events deserve real time monitoring and evaluation. The EMS Medical Director, Pinellas County EMS Administration, and individual agency clinical supervisors should receive notification of these events for immediate or urgent review. The following clinical events are designated as Sentinel Events and are included in the real time notification system:

- Cricothyroidotomy
- Tourniquet Use
- Hemostatic Dressing Use
- Needle Thoracostomy
- Failed Airway
- Overdoses and Public Health Emergencies
- Large incidents (3+, 10+)

5. Active Chart Review

Any medical quality plan must include chart review. The Pinellas County EMS System generates between 800 and 1200 electronic Patient Care Reports (ePCRs) each day. This level of activity clearly precludes a 100% chart review. In order to ensure that an appropriate subset of these ePCRs is reviewed, Pinellas County EMS has implemented the FirstPass system. This system checks each record to evaluate if defined core quality measures have been documented. If a chart does not record the appropriate quality measures, the case must be evaluated by a reviewer. The intent of the system is to focus available human reviewer time on those cases most likely to benefit from a clinical review.

5.1 FirstPass User Guide

The FirstPass User Guide may be found in AD19. The components of each protocol are listed in the "Quality Measures" Section near the bottom of each applicable clinical protocol or procedure. Detailed descriptions of the rationale, components, and standards for each protocol may be found in the FirstPass User Guide (Ref. AD19).

5.2 Clinician Responsibilities

1. Ensure all appropriate care is implemented to your level of certification. Producing a complete and accurate medical record is part of patient care.
2. Document all interventions including those performed by another agency and those performed prior to your arrival.
3. Use the drop-down list to assign the clinician (EMT or Medic) who performed each intervention or assessment even if they are from another agency.
4. Inclusion of vital signs obtained by other clinicians caring for the patient is acceptable (e.g., first responders may use the initial vital signs obtained by a Sunstar crew as their second set and the Sunstar crew should note the initial vital signs obtained by first responders) if they match and include the name of the clinician who obtained them.
5. It is encouraged to work together to provide complete and appropriate patient care including documentation, but each agency is required to have a complete ePCR that meets all FirstPass standards.

5.3 Agency Responsibilities

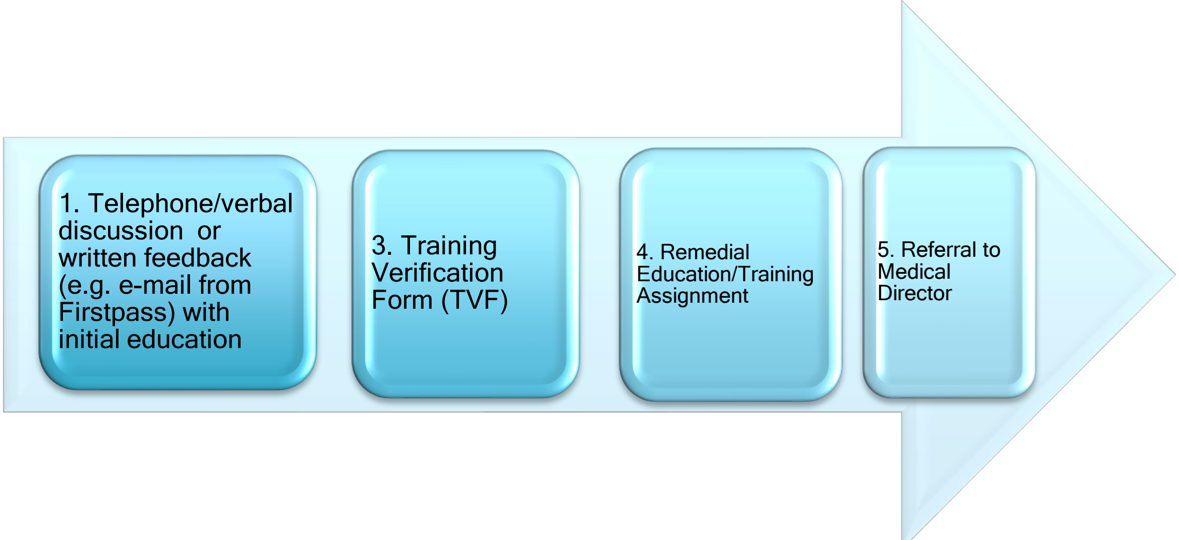
Individual agencies are responsible to process all calls that are identified by the FirstPass system as not meeting criteria. To ensure useful feedback to clinicians, this processing should be done as soon after the call as possible and no later than 14 days after call occurrence. This time frame does not apply to protocols that are under development or reflected in the "test que"

5.3.1 Reviewer Expectations

Reviewers must be paramedics at a minimum. An EMS Coordinator, preceptor, and/or field trainer is the preferred reviewer to maintain appropriate clinical judgment in the review process. The agency EMS Coordinator shall monitor the activity level of the reviewer(s) within their agency on a periodic basis using the FirstPass reports system to ensure an appropriate level of critical review is occurring and to ensure appropriate calls are being referred to the agency EMS Coordinator and the Pinellas County EMS QA Coordinator/EMS Medical Director.

5.3.2 Providing Feedback to Clinicians

When reviewing calls using the FirstPass system, every effort should be made to focus on root cause analysis and education of the field clinician(s). The principles of Just Culture apply to this activity. An escalating response to failure to meet the standards is *suggested* including:



All such activities must be documented in the FirstPass system to demonstrate closure of the feedback loop with the field clinician.

5.3.3 Referring calls to the Medical Director

Agency personnel <u>may</u> forward any case identified during FirstPass system call processing to the EMS Medical Director for review or to ask a question when unsure how to handle the case. This is done by changing the status of the call to "Medical Director Review" and **WILL NOT AUTOMATICALLY** generate a "QAR".

NOTE: Forwarding a call to the PCEMS Quality Assurance Coordinator or EMS Medical Director within the FirstPass system does not meet the requirements for immediate or routine notification as described in section 6.2 below

5.3.4 Referring calls to the System QA Process

Agency personnel must forward cases identified during FirstPass system call processing to the Pinellas County EMS QA Coordinator if any of the following are present:

- Protocol violation or significant departure from the standard of care
- Medication error or other patient safety concerns
- Criteria met for immediate or routine notification of the EMS Medical Director
- Field clinician refuses to participate in the call review/educational process or is repeatedly unwilling/unable to meet the standards.

This is done by changing the status of the call to "County QA Review" and **MAY** generate a "QAR" for further review according to the Just Culture Framework.

NOTE: Forwarding a call to the PCEMS Quality Assurance Coordinator or EMS Medical Director within the FirstPass system does not meet the requirements for immediate or routine notification as described in section 6.2 below

5.4 ePCR Corrections and Addenda

Corrections and addenda to ePCRs are unable to be completed in FirstPass and will still require use of the ePCR workflow to ensure proper capturing and display of change tracking.

6. Quality Assurance Process

6.1 Roles and Responsibilities

6.1.1 System Responsibilities

The Pinellas County EMS System is comprised of nearly 2000 highly skilled professionals including Emergency Medical Dispatchers, Emergency Medical Technicians, Paramedics, Nurses, Physicians, and Administrators. Each member of the system is accountable not only to individually meet the professional standards of the system but to ensure that others – and therefore the system as a whole – maintain those same standards. This is the defining characteristic of a profession.

6.1.2 Clinician Responsibilities

All Pinellas County EMS System Clinicians have an obligation to work to continually improve the quality of care provided to our patients. To accomplish this, all Certified Professionals must adhere to the reporting requirements outlined below. Failure to abide by these requirements or failure to participate in Medical Quality Management activities may be grounds for Administrative Proceeding for Revocation of Certification as per PCEMS Rules and Regulations 6.4.2 and 6.4.3.

6.1.3 Supervisor Responsibilities

All Pinellas County EMS System Provider Agency EMS Coordinators and other supervisors have an obligation to establish, maintain, and actively utilize internal quality assurance programs and to participate in the system-wide Medical Quality Management Plan as per PCEMS Rules and Regulations Section 5.2. Supervisors who are also Certified Professionals are subject to clinician responsibilities as above.

6.2 Reporting Requirements

6.2.1 System Reporting Requirements

1. Certain events require notification of the EMS Medical Director or designee over and above consultation with an OLMC Physician.
2. Notification may be immediate or routine depending on the event type.
3. The EMS Medical Director or designee may be contacted at any time via the Sunstar Communications Supervisor (727-582-2003).
4. All system personnel (EMD, EMT, Paramedic, Nurse, OLMC Physician, Supervisor, and Administrator) are required to ensure appropriate immediate and/or routine notifications are made. Failure to do so may result in Administrative Proceeding.

6.2.2 Immediate Reporting Requirements (Ref MOM Vol.1 CT28)

The Medical Director must be contacted immediately by telephone in the following circumstances:

1. Any circumstance that in the judgment of the Certified Professional requires immediate notification of the Medical Director
2. Known or suspected esophageal intubation and/or failure to employ continuous $EtCO_2$ waveform capnography on an advanced airway

3. Known or suspected medication error or other patient harm resulting from therapeutic misadventure
4. Known or suspected patient harm resulting from failure to adhere to established protocols and standards (6.4.5) or reckless behavior
5. Known or suspected clinical incompetence or any potential threat to public health, safety, or welfare (6.4.7) including but not limited to
6. Performance of unauthorized procedures or skills (6.4.9)
7. Known or suspected patient abuse (6.4.13) or sexual misconduct with a patient (6.4.15)
8. Being under the influence of a controlled substance, illegal drug, or alcohol, at any level, while on duty (6.4.17)
9. Arrest or criminal conviction which violates PCEMS Rules and Regulations Section 4.18 (6.4.12)
10. Known or suspected violation of policies or protocols pertaining to the use, handling, or storage of controlled substances (6.4.10) or controlled substance Tampering or Diversion (6.4.18) (AD19)

Note that OLMC Consult does not satisfy this requirement

6.2.3 Routine Reporting Requirements

The following events listed below require notification of the Medical Director or Designee within 3 business days of occurrence or discovery:

1. Any case which the Certified Professional or agency supervisor feels would be beneficial to review
2. Equipment failure(s)
3. Protocol failure(s)
4. Complaint(s) from healthcare provider
5. Substantiated, serious, or serial citizen complaint(s)
6. Any violation of Pinellas County EMS Rules and Regulations section 6.4, not listed above or previously reported.

Note that OLMC Consult does not satisfy this requirement

6.2.4 Reporting Requirements Summary Table

Immediate Reporting Requirements
Any circumstances that in the judgement of the Certified Professional requires immediate notification of the Medical Director
Known or suspected Esophageal Intubation and/or failure to employ continuous EtCO2 waveform capnography on an advanced airway (CP1, CP5)
Known or suspected medication error or other patient harm resulting from therapeutic misadventure (CS3, CS15)
Known or suspected patient harm resulting from failure to adhere to established protocols and standards (6.4 #5 or reckless behavior)
Known or suspected clinical incompetence or any potential threat to public health, safety, or welfare (6.4 #7) including but not limited to:
Performance of unauthorized procedures or skills (6.4 #9)
Known or suspected patient abuse (6.4 #13) or sexual misconduct with a patient (6.4 #15)
Being under the influence of a controlled substance, illegal drug, or alcohol, at any level, while on duty (6.4 #17)
Arrest or conviction which violates PCEMS Rules & Regulations Section 4.18 (6.4 #12)
Known or suspected violation of policies or protocols pertaining to the use, handling, or storage of controlled substances (6.4 #10) or controlled substance tampering or diversion (6.4 #18) (AD13)

Routine Reporting Requirements (3 business days)
Any case which the Certified Professional or agency supervisor feels would be beneficial to review
Equipment failures
Protocol failures
Complaints from healthcare providers
Substantiated, serious, or serial citizen complaints
Any violation of Pinellas County Rules & Regulations Section 6.4 not listed above or previously reported

Note: Immediate Reporting Requirements (ALL Certified Clinicians) - Requires verbal discussion with MD1 who may be accessed 24 hrs. a day via Sunstar Communications Supervisor.
OLMC CONTACT DOES NOT SATISFY THIS CRITERIA!

6.3 Other Sources of Requests for Quality Reviews

Quality assurance reviews may be initiated by the Office of the Medical Director in response to concerns brought by patients, patient's families, other healthcare providers, and Pinellas County EMS and Fire Administration.

6.4 Agency Internal QA Activity Quarterly reporting

It is recognized that the individual agencies that comprise the Pinellas County EMS System perform a significant amount of independent and internal Medical Quality Management activity. In order to capture and document this activity, promote sharing of ideas among system agencies, and facilitate system wide benefit through incorporation of these activities in training plan development, a summary report of activities and distribution of subject matter shall be provided quarterly to the Pinellas County EMS Quality Assurance Coordinator.

6.5 Restriction/Suspension of Clinical Privileges

From time to time, it may be necessary to restrict or suspend the clinical privileges of an EMT or Paramedic. This action may be taken by the EMS Medical Director or designee in accordance with Sections 5.10 and 5.11 of the Pinellas County EMS Rules and Regulations. Agency supervisors will be notified verbally and in writing.

6.6 Processing (see County Rules and Regs)

It is the goal of the Medical Quality Management Plan to ensure as rapid an investigation and disposition as possible of all Quality Assurance Reviews. Specific time intervals are delineated in Pinellas County Rules and Regulations Section 5.12.

6.7 Clinician Input in Case Review

The ePCR serves as a clinician's primary documentation of any patient care encounter. Electronic monitoring data, CAD data, audio recordings, and other relevant materials may also be included in the case review. Clinicians may also be requested to complete statements including Post Incident Evaluation forms or Incident Reports to expound upon the details of an event. Statements in this form also serve to allow the involved clinician to share their assessment of potential root causes and potential areas for system improvement

6.8 Peer Review

From time to time the EMS Medical Director may seek the input of a Clinician Peer Review Process by way of convening a Pinellas Quality Staff Advisory Council. This committee shall serve as both a "Quality Assurance Committee" as defined in FL Statute 401.265, and an "Emergency Medical Review Committee" as defined in FL Statute 401.425 and its activities are protected as provided in statute.

6.9 Disposition

As authorized in Section 5.6 of the Pinellas County EMS Rules and Regulations, at the conclusion of fact finding, the EMS Medical Director or designee will review the case and determine a disposition. The EMS Medical Director or designee may require the completion of a Training Verification Form **(See Appendix 2)** or convene a Medical Case Review **(See Appendix 1).**

7. Administrative Processes

All certified professionals are entitled to due process and will be afforded all considerations as delineated in Section 6 of the Pinellas County EMS Rules and Regulations.

Appendix 1: Medical Case Review Template

Pinellas County EMS Medical Quality Management ***Confidential and Protected***

QA File Number: 16-xxx **Date:** 1/2/2016

Investigator: Angus Jameson MD MPH
Medical Director

Personnel Involved: Paramedic John Doe (FD) #111111
EMT Jane Doe (FD) #222222
Paramedic Jane Doe (SS) #xxxxxx
EMT Jane Doe (SS) #111111
Chief John Doe (FD) [observing]
Supervisor Jane Doe (SS) [observing]

Assignment Information:
Date: 1/1/2016
FD Incident #: 123456
Sunstar Run #: 123456
Call Type: Cardiac Arrest (Delta)
Unit: E100, T200, SS123

Issues:
1. Concern

Findings / Continuing Medical Education:
1. Finding
2. Discussion

Recommendations:
1. TVF on Protocol A1
2. Closure for all participants

Submitted By: ______________________________ **Date:** 1/1/2016
Angus M. Jameson MD MPH

Appendix 2: Training Verification Form

Pinellas County EMS Medical Quality Management ***Confidential and Protected***

☐ Agency Prescribed Training ☐ Medical Director Prescribed Training

Pinellas County QA File #: _______________ Agency QA File #: _________________
Date of Training Completion: _____________ Name of Trainer: __________________

Assignment Information:

Incident Date: _______________ Call Type: ______________________
FD Incident #: ________________ Sunstar Run #: _________________

Personnel:

Clinician 1: ____
Clinician 2: ____
Clinician 3: ____
Clinician 4: ____
Name PCEMS ID#

Training Topics and Description of Activity:

1. ____
2. ____
3. ____
4. ____

Clinician's Signature ________________________________ Date _________
Clinician's Signature ________________________________ Date _________
Clinician's Signature ________________________________ Date _________
Clinician's Signature ________________________________ Date _________

Training Officer Signature ____________________________ Date _________
Medical Director's Office _____________________________ Date _________
(Approved By)

AD19 FIRST PASS USER GUIDE

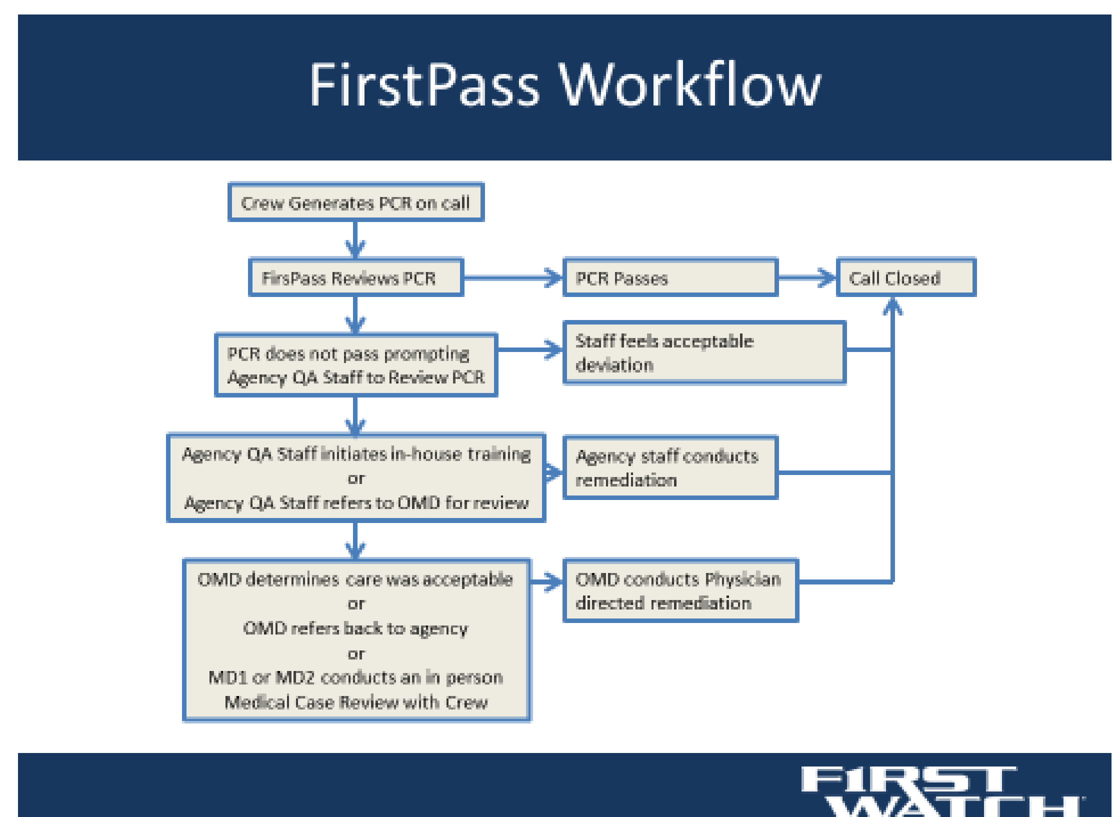
Introduction

Any medical quality plan must include chart review. The Pinellas County EMS System generates between 800 and 1200 electronic Patient Care Reports (ePCRs) each day. This volume of activity precludes a 100% chart review. Pinellas County EMS implemented the FirstPass system in order to ensure that an appropriate subset of these ePCRs is reviewed. The system reviews each record to evaluate if defined core quality measures have been documented. If a chart does not record the appropriate quality measures, the case must be evaluated by a human reviewer. The intent of the system is to focus available human reviewer time on those cases most likely to benefit from a clinical review.

Implementation

The specific implementation of FirstPass will vary by agency staffing and size (e.g., presence of dedicated trainers, clinical reviewers, or supervisors). Regardless of the resources, the minimum required standard is that **all agency calls appearing in the "Clinical Review" status are reviewed within 14 days of the date of the call to ensure prompt and actionable feedback to clinicians.**

Workflow



Tests and Criteria

Universal

Criteria:

1. Two complete sets of vital signs at least 5 minutes apart
2. SpO2 measured and if less than 94% was O2 administered
3. Chief Complaint documented
4. Medical history, medications, and allergies of the patient documented

Specifics:

1. Two complete sets of vital signs at least 5 minutes apart?

   This is a requirement in all cases in which patient contact occurs. Vital signs must be at least five (5) minutes apart and include at a minimum the systolic blood pressure, heart rate, respiratory rate, pain scale and GCS to count as a complete set.

2. SpO2 measured and if less than 94%, was O2 administered?

   Although SpO2 is not a required part of the vital signs it is encouraged on all patients. If SpO2 is obtained and is less than 94%, supplemental Oxygen should be administered.

3. Chief Complaint documented?

   A chief complaint must be documented. If there is none, then document as such.

4. Medical history, medications, and allergies of the patient documented?

   The medical history, current medications, and allergies must be documented. If "none" or "unknown" then document as such as this is important to the continuity of patient care.

AD19 FIRST PASS USER GUIDE

Major Trauma

Criteria:

1. Scene time less than or equal to ten (10) minutes (Sunstar)/At Patient to Trauma Alert time less than or equal to five (5) minutes (FD)
2. Oxygen delivered
3. IV access established
4. Trauma Alert declared, if indicated
5. Spinal precautions performed (Track/Trend)

Specifics:

1. Scene time less than or equal to ten (10) minutes (Sunstar)/At Patient to Trauma Alert time less than or equal to five (5) minutes (FD):

   Definitive care of the trauma patient occurs at a trauma center and minimizing time to definitive care has been shown to improve outcomes. Scene time is measured from transport unit on scene to enroute to hospital. Additionally, early recognition and maintaining a high index of suspicion is critical to the effective care of trauma patients. First Responders should declare a trauma alert early and often.

2. Oxygen delivered:

   Supplemental oxygen should be administered to trauma patients to support tissue perfusion. This is particularly critical in head injury patients where a single prehospital SpO2 less than 90% results in doubling of mortality.

3. IV access established:

   IV access should be established in all trauma patients due to the high likelihood of requiring fluid resuscitation, airway management, and pain control.

4. Trauma Alert declared, if indicated:

   This means exactly what it implies; was a trauma alert declared? The FirstPass “Major Trauma” protocol is applied to a patient who is likely to meet Trauma Alert criteria. Human review ensures that a FirstPass record will be passed if the patient truly did not meet criteria.

Major Trauma (cont.)

Specifics (cont.):

5. Spinal precautions performed (Track/Trend):

   This is a track/trend metric only and is an important piece of data as we evolve our approach to and use of spinal motion restriction interventions.

AD19 FIRST PASS USER GUIDE

Acute Coronary Syndrome/Chest Pain

Criteria:
1. 12 Lead ECG performed
2. Aspirin administered or allergic
3. Nitroglycerin administered or allergic or BP less than 90
4. Final pain score less than initial pain score
5. 12 Lead ECG transmitted, if STEMI Alert declared
6. 12 Lead performed within five (5) minutes of at patient (Tracking only)

Specifics:

1. 12 Lead ECG acquired?

   The acquisition of a 12 lead ECG must be documented as an intervention in the ePCR. If the 12 lead ECG was performed prior to arrival (e.g., in the case of a doctor's office) then it needs to be documented as "PTA". If the 12 lead ECG was obtained by another PCEMS clinician, their name must be selected from the dropdown.

2. Aspirin administered or allergic?

   This means that the patient received aspirin. If the patient self-administered aspirin, at a dispatcher instruction, or was administered by another PCEMS clinician it must be documented to prevent double administration. Note that if an aspirin allergy is documented, the requirement is eliminated.

3. Was nitroglycerin administered or allergic or BP less than 90?

   Nitroglycerin should be administered to a patient with suspected ACS who is not allergic and has an adequate blood pressure. If nitroglycerin is withheld for another reason (e.g., erectile dysfunction drug, etc.) it must be documented.

4. Final pain score less than initial pain score?

   This criterion evaluates our overall success in managing ischemia through vasodilation using nitroglycerin and when necessary, opiates. The criteria compares the initial pain score and the final pain scores as documented in the vital signs.

Acute Coronary Syndrome/Chest Pain (cont.)

Specifics (cont.):

5. 12-Lead ECG Transmitted, if STEMI Alert declared

   This test is run to ensure that if a STEMI was declared, a 12 lead ECG was transmitted. This information should be documented using the interventions tab.

6. 12-lead performed within 5 minutes of patient contact (TRACK/TREND ONLY)

"Refusal"

Criteria:
1. Were two complete sets of vital signs obtained at least 5 minutes apart?
2. Final GCS equals 15?
3. Was a Chief Complaint documented?
4. Was the medical history, medications, and allergies of the patient documented?
5. Witness signature obtained
6. Narrative greater than 300 characters
7. Free text "Decisional Capacity" present

Specifics:

1. Were two completed sets of vital signs obtained at least 5 minutes apart?

   This is the same criteria as the universal protocol.

2. Final GCS equals 15?

   Accepting a refusal from a patient with a GCS less than 15 is an unusual event and worth reviewing. There should be clear documentation as to why this was appropriate.

3. Was a Chief Complaint documented?

   This is the same criteria as in the universal protocol.

4. Was the medical history, medications, and allergies of the patient documented?

   This is the same criteria as in the universal protocol.

5. Witness signature obtained?

   At least one witness signature must be captured for every refusal accepted.

"Refusal" (cont.)

Specifics (cont.):

6. Narrative greater than 300 characters?

   The narrative documentation is often longer on a refusal than any other type of call and it would be an unusual event to be able to adequately describe the circumstances of a refusal in less than 300 characters.

7. Free text "Decisional Capacity" present?

   This test searches for the words "Decisional Capacity" in the narrative. Protocol CS12 states that *"Documentation for a patient refusing part or all of the evaluation, treatment, and transport, must include at a minimum: the criteria used to establish decisional capacity; the benefits of allowing care, the risks of refusing the proposed care including severe complications or death, and the alternatives explained to the patient."*

"Airway Management"

Criteria:
1. Ventilation assistance provided
2. Single airway type used
3. Confirmation of placement with EtCO2
4. Airway re-confirmed
5. Multiple EtCO2 values

Specifics:

1. Ventilation assistance provided:

   MOM Protocol CP1 states *"All patients requiring ventilatory assistance will be managed with a bag-valve-mask (BVM) and airway adjunct (OPA/NPA) until choice of advanced airway device is made and preparations for placement are completed."* The Quick-Log button labeled "BVM" should be used to document this.

2. Single airway type used:

   MOM Protocol CP1 states *"If Step #2 or #3 is unsuccessful, the alternate may be attempted."* In such situations it is important to review the event to ensure we are not seeing a pattern of equipment or protocol failures.

3. Confirmation of placement with EtCO2

   This means an initial EtCO2 value was captured, as required (Ref. MOM Protocol CP1).

4. Airway re-confirmed:

   This means exactly what it implies; that the advanced airway device used was re-checked at least once during the call. The Quick-Log button "Re-Confirm Airway" should be used for this. It is strongly recommended that an advanced airway device be reconfirmed multiple times during a call and at least at every patient movement event.

"Airway Management" (cont.)

Specifics (cont.):

5. Multiple EtCO2 values:

   Protocol CP5:
   - Continuous waveform capnography use is ***mandatory*** in:
     - Advanced airway placement (endotracheal tube or King airway)
       - Continuous waveform capnography is the only acceptable method of confirmation for endotracheal tube placement

   EtCO2 values may be recorded in the vital signs or by using the Quick-Log button "Capnography".

AD19 FIRST PASS USER GUIDE

"Cardiac Arrest"

Criteria:

1. Patient transported to hospital (Track/Trend)
2. EtCO2 monitored
3. Extraglottic airway used
4. Compressions initiated within 1 minute
5. OLMC contact performed if patient not transported
6. EtCO2 less than 35 if not transported

Specifics:

1. Patient transported to hospital (Track/Trend):

   This is only a tracking and trending parameter to provide statistics on the number of patients in cardiac arrest transported to a hospital versus pronouncement on scene. There is no "correct" outcome and this parameter alone will not cause a chart to be reviewed.

2. EtCO2 monitored:

   A patient in cardiac arrest should have continuous monitoring of EtCO2 to guide treatment and evaluate the effectiveness of resuscitative efforts. The EtCO2 values may be recorded in the vital signs or by using the Quick-Log button "Capnography".

3. Extraglottic airway used:

   Per MOM Protocol CP1 *"Patients in cardiac arrest…will have the King Airway device employed primarily."* If a patient in cardiac arrest is intubated the chart will be reviewed to ensure this was an appropriate protocol deviation.

4. Compressions initiated within 1 minute:

   Rapid initiation of high-quality chest compressions is the single biggest contributing factor to cardiac arrest survival. The initiation time of chest compressions should be documented using the "1st Compression" Quick-Log button.

"Cardiac Arrest" (cont.)

Specifics (cont.):

5. OLMC contact made if patient not transported:

   MOM Protocols CS15 and C5 require OLMC contact prior to cessation of efforts. The Quick-Log button labeled "OLMC Contact" should be used to document this.

AD19 FIRST PASS USER GUIDE

"Sepsis"

Criteria:

1. Capillary blood glucose measured
2. IV access established and fluid administered
3. At least 1000 mL of fluid administered if "Time with patient" greater than or equal to 20 minutes
4. Norepinephrine administered if no response to fluid (e.g. SBP remains less than 90) and "Time with patient" greater than or equal to 25 minutes
5. *Sepsis Alert* declared
6. Final SBP greater than or equal to 90 (Track/Trend only)

   Note: "Time with patient" = "At Patient" to "At Destination"

Specifics:

1. Capillary blood glucose measured:

   A patient in sepsis may be suffering from hypoglycemia and other metabolic derangements due to the physiologic stress of fighting the infection. It is also important to rule out hyperglycemia (with associated dehydration and altered mental status) or hypoglycemia (with sympathetic response – tachycardia, diaphoresis, and altered mental status) which both may mimic sepsis in their clinical presentation.

2. IV access established and fluid administered

   Protocol "M9 Suspected Sepsis" calls for an initial bolus 1000 mL 0.9% sodium chloride to be administered to an adult patient with suspected sepsis. There is broad agreement in the literature that early and aggressive resuscitation of a septic patient improves survival. This rationale also applies to Criteria #3.

3. At least 1000 mL of fluid administered if "Time with patient" greater than or equal to 20 minutes

4. Norepinephrine administered if no response to fluid (e.g. SBP remains less than 90) and "Time with patient" greater than or equal to 25 minutes

   Protocol "M9 Suspected Sepsis" calls for vasopressor support if SBP remains less than 90 mmHg after initial bolus.

"Sepsis" (cont.)

Specifics (cont.):

5. Sepsis Alert declared

   This test looks to see if the sepsis alert criteria in Protocol M9 were present, and if so, was a Sepsis Alert declared.

6. Final SBP greater than or equal to 90 (Track/Trend only):

"Congestive Heart Failure"

Criteria:

1. Bilateral lung sounds documented at least twice (minimum five (5) minutes apart)
2. EtCO2 monitored
3. Respiratory rate improved (if initial less than eight (8), was final greater than fourteen (14) or if initial greater than 35 was final decreased).
4. SpO2 improved (if initial less than 94% was final greater than 94%)?
5. BP improved (if initial SBP greater than 140 was final less than 140)?
6. Nitroglycerin administered or documented contraindications (erectile dysfunction medications or SBP less than 90)
7. CPAP not applied if contraindicated (SBP less than 90 mmHg or GCS less than 14 prior to application)
8. Both nitroglycerine and albuterol not administered to same patient
9. If nitroglycerine administered, was first dose less than 5 min after at patient (Tracking only)

Specifics:

1. Bilateral lung sounds documented at least twice (minimum five (5) minutes apart)?

   The goal is to ensure that we are assessing lung sounds at least twice during the care of a patient. The first assessment establishes the cause of the respiratory distress. The second assessment assesses the effect of treatment(s). Lung sounds must be documented in at least one field on both the right and left to count and there must be two sets at least five (5) minutes apart.

2. EtCO2 monitored

   Any patient who is in respiratory distress should have continuous monitoring of EtCO2 to guide treatment and evaluate the effectiveness of treatment. The EtCO2 values may be recorded in the vital signs or by using the Quick-Log button "Capnography".

3. Respiratory rate improved (if initial less than eight (8), was final greater than fourteen (14) or if initial greater than 35, was final decreased.

   This test assesses our overall success in managing respiratory distress patients. It is important to evaluate not only individual interventions, but the effectiveness of the treatment protocol.

"Congestive Heart Failure" (cont.)

Specifics (cont.):

4. SpO2 improved (if initial less than 94% was final greater than 94%)

   This test assesses our overall success in managing a hypoxic patient. It is important to evaluate not only individual interventions, but the effectiveness of the treatment protocol.

5. BP improved (if initial SBP greater than 140 was final less than 140)

   This test assesses our overall success in managing the hemodynamic status of CHF patients. It is important to evaluate not only individual interventions, but the effectiveness of the treatment protocol.

6. Nitroglycerin administered or documented contraindications (erectile dysfunction medications or SBP less than 90)

   MOM Protocol "C7 Congestive Heart Failure/Pulmonary Edema" calls for aggressive treatment with nitroglycerine for hypertensive patients in CHF/Pulmonary Edema. This test ensures that nitroglycerine was administered unless contraindicated by hypotension, recent erectile dysfunction medication, or allergy.

7. CPAP not applied if contraindicated (SBP less than 90 mmHg or GCS less than 14 prior to application)

   This test looks to ensure that CPAP was not applied if it was contraindicated by hypotension or altered mental status as per Protocol CP6 Continuous Positive Airway Pressure (CPAP).

8. Both nitroglycerine and albuterol not administered to same patient.

   This test is attempting to evaluate if clinicians are combining potentially counterproductive treatments or are changing course from one treatment protocol to another during patient care. It is understood that it may be reasonable to switch as the call unfolds and more information (e.g. history, exam, and diagnostics such as EtCO2 waveform, BP, etc.) becomes available and reviewers should assess the appropriateness of the initial and subsequent protocol choice in determining if treatment met standards.

"Congestive Heart Failure" (cont.)

Specifics (cont.):

9. If nitroglycerine administered was first dose < 5 min after at patient (Tracking only)

   This test was added by FirstPass reviewers during the beta-testing due to concern for prolonged time to complete initial assessment and implement treatment

AD19 FIRST PASS USER GUIDE

"Asthma/COPD"

Criteria:

1. Bilateral lung sounds documented at least twice (min 5 minutes apart)
2. EtCO2 monitored
3. Respiratory rate improved (if initial less than eight (8) was final greater than 14 or if initial greater than 35 was final decreased)
4. SpO2 improved (if initial less than 94 was final greater than 94%)
5. Methylprednisolone sodium succinate administered
6. CPAP not applied if contraindicated (SBP less than 90 or GCS less than 14 prior to application)
7. Both nitroglycerin and albuterol not administered to same patient
8. Epinephrine not administered if age greater than 35 (tracking only)

Specifics:

1. Bilateral lung sounds documented at least twice (min 5 minutes apart)

   The goal of this test is to ensure that we are assessing lung sounds at least twice during care. The first set helps establish the cause of the respiratory distress and the second helps assess the effect of our treatment. Lung sounds must be documented in at least one field on both the right and left to count and there must be two sets at least five (5) minutes apart.

2. EtCO2 monitored

   Any patient who is in respiratory distress should have continuous monitoring of EtCO2 to guide treatment and evaluate the effectiveness of treatment. The EtCO2 values may be recorded in the vital signs or by using the Quick-Log button "Capnography".

3. Respiratory rate improved (if initial less than eight (8) was final greater than 14 or if initial greater than 35 was final decreased)

   This test assesses our overall success in managing respiratory distress patients. It is important to evaluate not only the interventions on an individual case, but the effectiveness of the treatment protocol.

"Asthma/COPD" (cont.)

Specifics (cont.):

4. SpO2 improved (if initial less than 94 was final greater than 94%)

   This test assesses our overall success in managing hypoxic patients. It is important to evaluate not only the interventions on an individual case, but the effectiveness of the treatment protocol.

5. Methylprednisolone sodium succinate administered

   Both asthma and COPD have an inflammatory component and require steroids in addition to bronchodilators.

6. CPAP not applied if contraindicated (SBP less than 90 or GCS less than 14 prior to application)

   This test looks to ensure that CPAP was not applied if it was contraindicated by hypotension or altered mental status as per Protocol CP6 Continuous Positive Airway Pressure (CPAP).

7. Both nitroglycerin and albuterol not administered to same patient

   This test is attempting to evaluate if clinicians are combining potentially counterproductive treatments or are changing course from one treatment protocol to another during patient care. It is understood that it may be reasonable to switch as the call unfolds and more information (e.g. history, exam, and diagnostics such as EtCO2 waveform, BP, etc.) becomes available and reviewers should assess the appropriateness of the initial and subsequent protocol choice in determining if treatment met standards.

8. Epinephrine administered if age greater than 35 (tracking only)

   While epinephrine is appropriate in younger patients with severe asthma/bronchospasm, it is less appropriate in older patients with COPD and likely cardiac comorbidities. This test is allowing the FirstPass reviewers the opportunity to review the utilization of epinephrine in patients >35 years of age.

AD19 FIRST PASS USER GUIDE

"Controlled Substance Utilization"

Criteria:

1. Complete set of vital signs no less than five (5) minutes before and one (1) to five (5) minutes after the administration of a controlled substance
2. EtCO2 documented with each administration
3. Waste documented if name of administering clinician matches crew on ePCR
4. Benzodiazepines and opiates not combined
5. Pediatric administration
6. Single fentanyl dose does not exceed max or OLMC contact initiated
7. Total fentanyl dose does not exceed max or OLMC contact initiated
8. Midazolam dose does not exceed max or OLMC contact initiated

Specifics:

1. Complete set of vital signs no less than five (5) minutes before and one (1) to five (5) minutes after the administration of a controlled substance?

   Any patient receiving sedative medications should have vital signs and pain scores documented before and after administration for safety.

2. EtCO2 documented with each administration?

   EtCO2 will help assess the safety of initial and subsequent doses of sedative medications.

3. Waste documented if name of administering clinician matches crew on ePCR?

   This test calculates the total dose of controlled substance administered and if there should have been any left to waste. The waste intervention/signature is only required on the ePCR of the clinician who had custody of the drug.

4. Benzodiazepines and opiates not combined

   Benzodiazepines should not be combined due to safety concerns except in cases of facilitated intubation or post-intubation/post cardiac arrest sedation

"Controlled Substance Utilization" (cont.)

Specifics (cont.):

5. Pediatric administration?

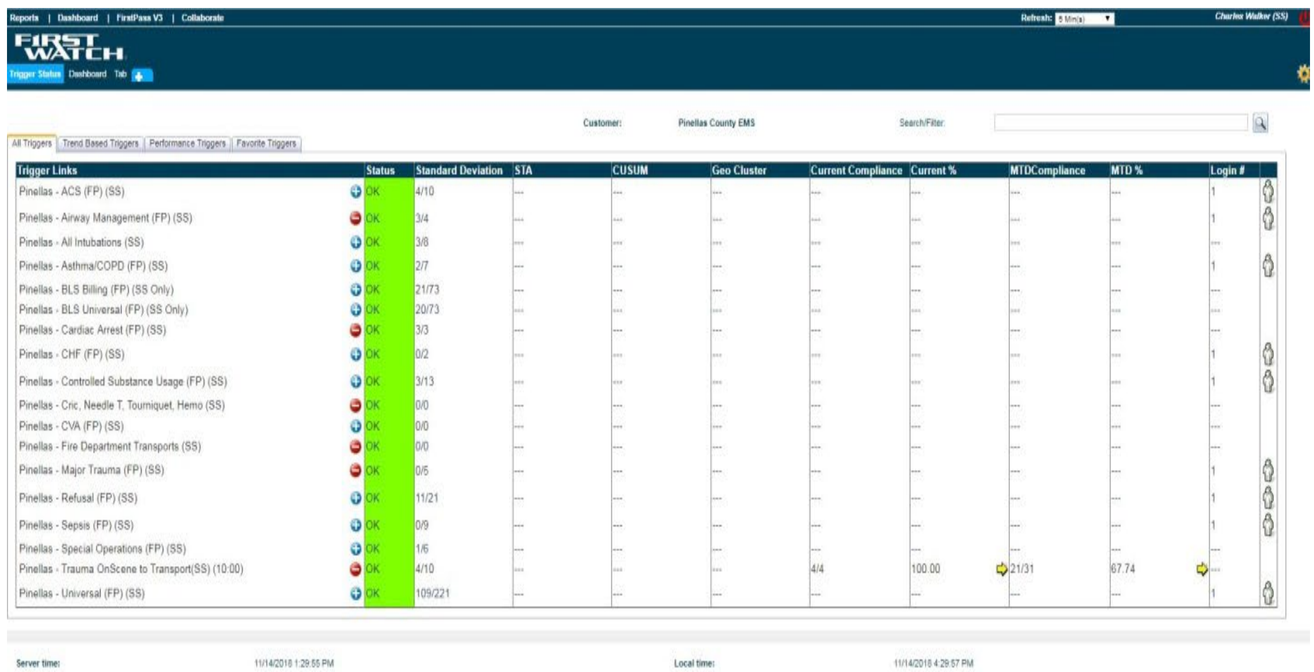
   Controlled substances are rarely given to pediatric patients. Any pediatric administration will flag for automatic review.

6. (also #7 & #8) Dose Checking:

   These tests evaluate to ensure that doses do not exceed maximums without OLMC consultation. These tests do not apply to pediatric/weight-based dosing since all pediatric calls are automatically reviewed.

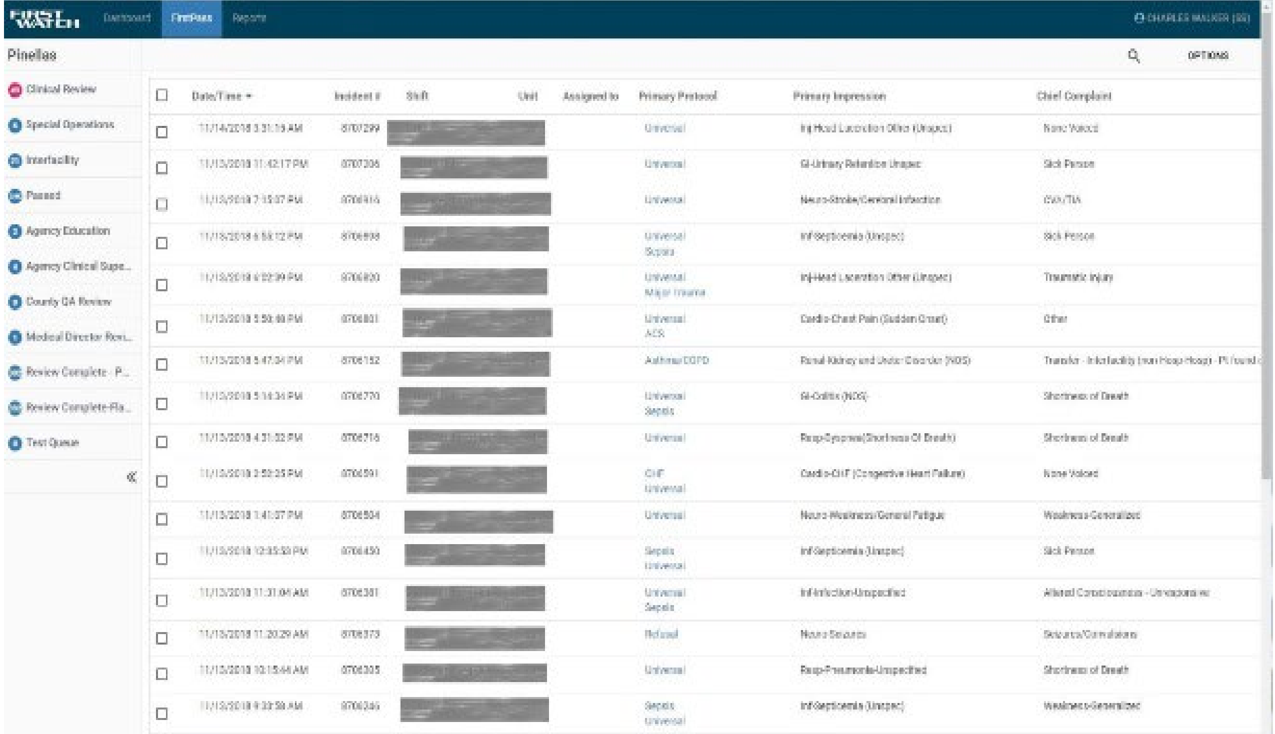
AD19 FIRST PASS USER GUIDE

Login Screen



First Pass opens with a screen which summerizes the test triggers which correspond to each First Pass protocol test. The Actual call listing is accessed by clicking on the FirstPass V3 button found in the overhead . This brings up the actual call list:

Review Screen



AD19 FIRST PASS USER GUIDE

On the left side of the screen are the call buckets. Each Department's list will be slightly different however the common buckets to be familiar with are:

Status Bucket Bar (Left Side of Screen):

Clinical Review – This is the bucket calls are deposited in that are flagged for review. Calls are in chonological order and are displayed showing the Date/Time, incident number, unit number, who the call is assigned to, the primary protocol or test affected, the primary impression that was charted in the EPCR, the chief complaint that was noted in the EPCR, the destination the patient was transported to, the resolution of the fall, the address, the employee who submitted the call, the First Pass owner/reviewer and the agency involved.

Passed – This bucket contains calls that were examined by the program and found to have no flags.

Agency Education – This bucket can by used by each agency to park calls for further review and/or education.

Agency Clinical Supervior – This bucket is used by a reviewer to send a call to be reviewed by the agencies EMS director.

County QA Review – This bucket is used to refer calls for county review that were not previously identified or reported during normal QA activities but are discovered during chart review. Agency personnel must forward cases identified during FirstPass system call processing to the System QA Coordinator if any of the following are present:

- Protocol violation or significant departure from the standard of care
- Medication error or other patient safety concern
- Criteria for immediate or routine notification of the Medical Director are met
- Field clinician refuses to participate in the call review/educational process or is repeatedly unwilling/unable to meet the standards.

Medical Director Review – This bucket is used to forward calls directly to the medical director

Review Complete - Passed – This is where calls are parked when this disposition is used after reviewing a call

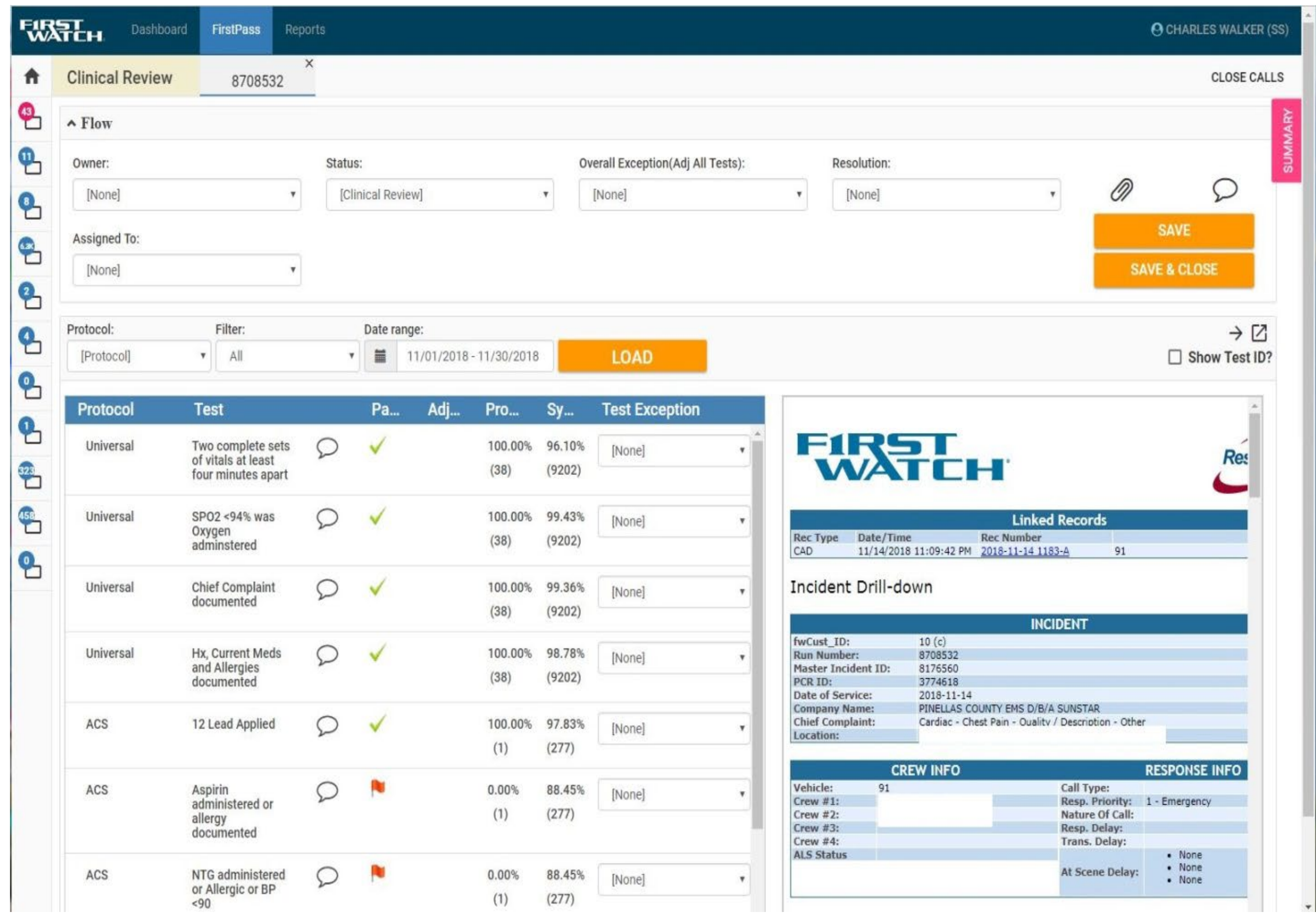
Review Complete – Flagged - This is where calls are parked when this disposition is used after reviewing a call

Test Queue – This bucket is used to evaluated new protocol tests prior to implimentation

AD19 FIRST PASS USER GUIDE

Calls are displayed by date which is customizable with the options tab at the upper right of the screen. The options tab also allows for calls to be displayed by protocol, owner or agency and individual calls can be searched for using the search icon located next to the options button.

Once a call is clicked on, it brings up the call grading view:



The grading page is split into three sections:

1. Top section:
    - sets the owner, status, overall exception, resolution, and a field for assigning the call to another reviewer
    - has buttons for saving and saving and closing the call, a comment bubble, and an attachment icon.
    - the summary tab at the far upper right has specific crew and call information taken from the ePCR

2. Left hand section (located under the blue heading):
    - is the test review area
    - contains the actual protocol test

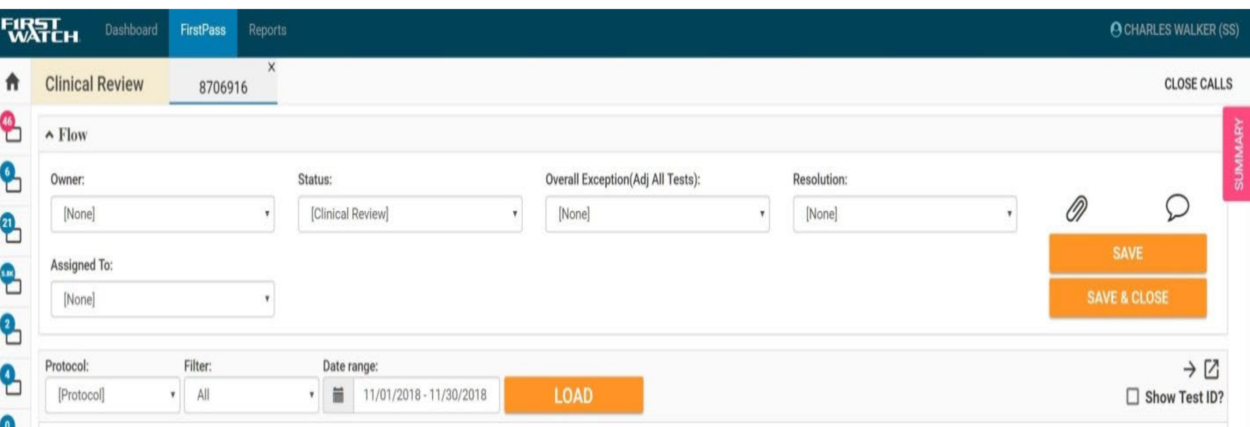
- the upper headings describe:
  - *Protocol* – specific protocol the test is referencing
  - *Test* – actual test in question
  - *Comment Bubble* – icon that opens a note field
  - *Pass/Flagged* –
    - = test passed
    - = flagged for review
  - *Adjusted Pass/Flagged* – A heading that populates after review with a check or flag, dependent on outcome.
  - *Provider %* - A heading that shows the number of calls of this type that the submitting clinician has run during the selected time frame – in parenthesis - and their test compliance.
  - *System %* - Shows the number of calls of this type that have been run by the system during this time frame and the overall system compliance.
  - *Test Exception* – A list of modifiers used to justify passing a call that was originally flagged.

3. Right hand section (located under the blue First Watch heading):
   - called the drill down
   - formatted copy of the submitted ePCR

In reviewing calls, it is important that all call reviewers have a shared understanding of the definitions and use of each of the user selected options. The table below describes the fields and how they are to be employed:

Owner – the initial reviewer of the call should assign themselves as the “owner” of the call and remains the “owner” throughout the review process. The “owner” may assign the call for further review and/or follow-up by “assigning” the call or changing the “status” as below.
Person Assigned To – A call may be assigned to another reviewer/officer/coordinator who is responsible for review and/or follow-up who then completes the review and reports the completion back to the owner.
Status – This determines which cue or “bucket” the call will appear in (e.g clinical review, agency clinical supervisor, review complete—passed). Users may change a status to ship a call to another user or agency, recommend a call for higher level review, or to move the call to its final disposition. Agency Clinical Supervisor and Agency Education are available for internal use by provider agencies and may be employed to match organization structure.

Review Complete – Passed (Found under status) – This is a disposition that will close a call and should be used when clinical care and documentation were appropriate. If this status is chosen, the call will show up in the Adjusted Pass Rate on reports. **When Review Complete Passed is employed an "exception reason" must be chosen.**
Review Complete – Flagged (Found under status) -- This is a disposition that will close a call and should be used when care or documentation did not meet clinical standards or was inappropriate. **If this status is used, a "resolution" must be chosen.**
Resolution – This is a list of practices or activities that will be carried out for calls that do not meet standards and/or serve to close the loop on addressing any clinical concerns. If a call status is changed to "Review Complete – Passed," the resolution "No additional action needed" will most often apply. For all other cases, a reviewer may choose to utilize the resolution they deem appropriate.
Overall Exception – A rarely used outcome that when applied will automatically pass every flagged test in a call. Should be used only for events such as mass casualty incidents where the normal clinical standard does not apply.



Resolutions:

Agency training – Specific feedback provided in the form of verbal or written communication addressing any clinical or documentation deficiency.
IR – A request for the crew to generate an incident report for further information or follow-up.
MCR – A Medical Case Review with a Medical Director.
No additional action needed – For review complete passed calls
TVF – A call that generates specific training that is documented with a Training Verification Form.

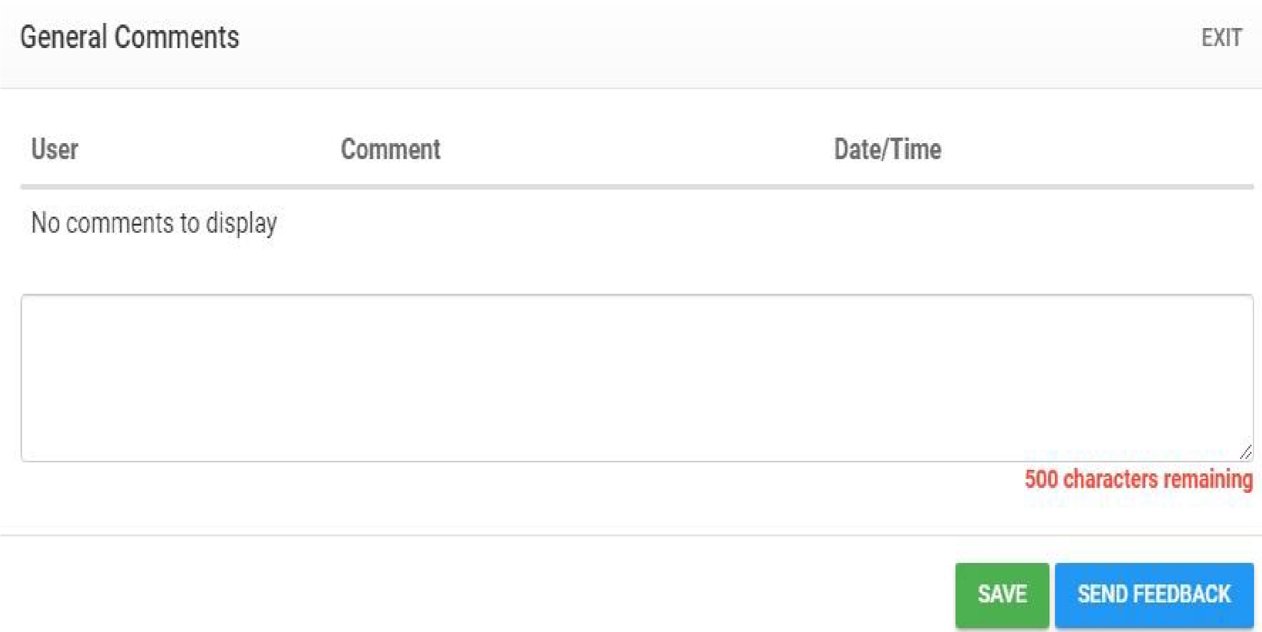
Protocol	Test	Pass...	Adj. ...	Prov...	Syst...	Test Exception
Universal	Two complete sets of vitals at least four minutes apart	✓		97.73% (44)	95.98% (8599)	[None]
Universal	SPO2 <94% was Oxygen adminstered	🚩		97.73% (44)	99.45% (8599)	[None]
Universal	Chief Complaint documented	✓		100.00% (44)	99.34% (8599)	[None]
Universal	Hx, Current Meds and Allergies documented	✓		100.00% (44)	98.78% (8599)	[None]

When a specific protocol test is reviewed and passed, an exception reason must document the rationale for passing the test.

Test Exceptions:

Equipment Failure - Applied when a specific equipment failure prevents protocol compliance.
Interventions Appropriate for Patient - Covers situations that may have tripped a First Pass flag but that still met protocol standards for patient care.
MCI/Disaster - First Pass compliance may be suspended by OMD during such events.
Other (Explained in Comments) - Applied when any other acceptable factor modifies adherence to protocol.
Outlier (Explained in Comments) - Applied when a circumstance or occurrence that is outside of the norm modifies protocol adherence.
Patient Allergy/Refusal - Applied when a documented patient allergy prevents the administration of a specific therapy.
Patient condition precluded compliance - Applied when a patient condition or action prevents compliance with a therapy or standard.
Patient unresponsive to appropriate treatment - Cases where the therapy administered met all protocol standards however the desired outcome was not achieved.
Pediatric Patient - Applied when a pediatric patient's size, weight or age prevents the application of a therapy or standard.
Specific Medical Control Order - Applied when an OLMC consult results in a documented order that is outside a protocol or test parameter.

Comment Bubble -This is used to record any descriptions and details in connection with tests that are passed from a flagged state. The Comment bubble in the upper right corner opens the dialogue below:



First Pass has the option to provide direct feedback to an individual or crew using a direct email link and form. This provides the incident number, date and time of the call as well as the reviewer's comments.

When the general comments button is accessed in the upper right part of the review page, it reveals the Send Feedback button. This opens an email template. It is important for the individual agencies to update the county's employee email database. The TO button opens a searchable employee list to populate the heading.

This direct feedback serves as ongoing documentation education as well as closing the loop for flagged reports.

Feedback to Crew EXIT

* TO

From reviewer:

Charles Walker (SS)

Incident #:

8704906

Response Date:

11/12/2018 9:50:46 AM

* Subject:

200 characters remaining

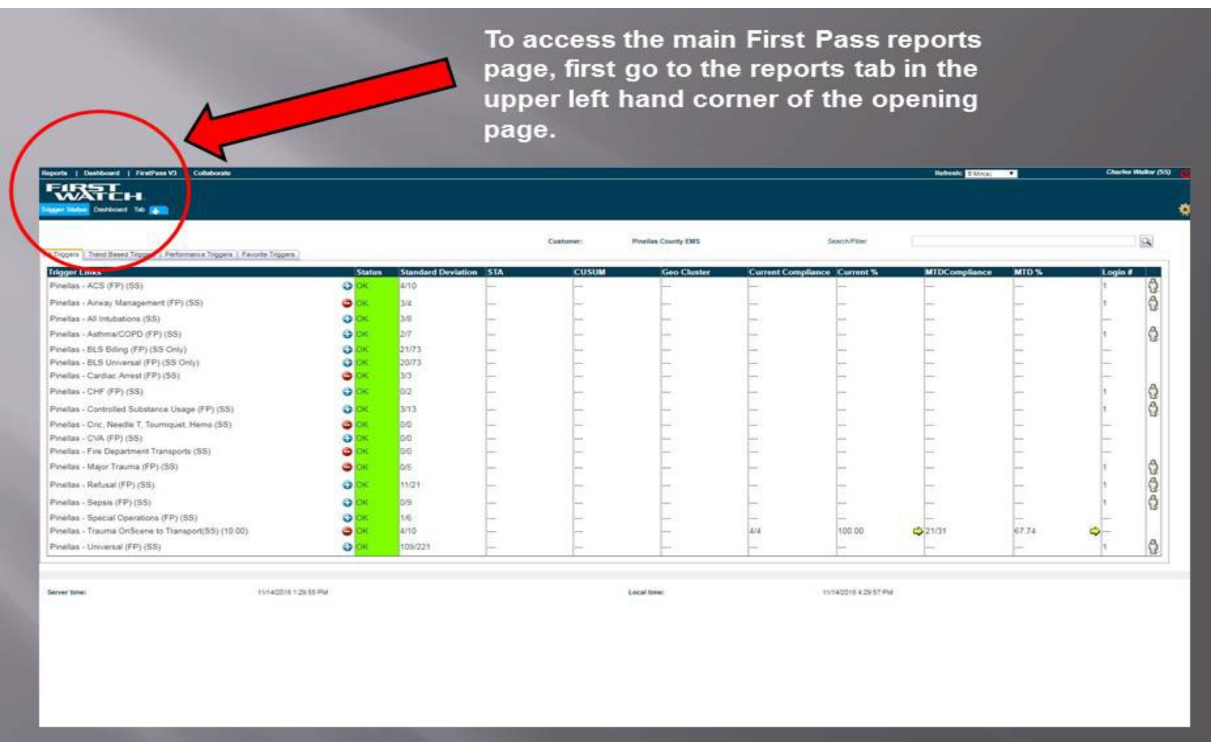
* Reviewer Comment:

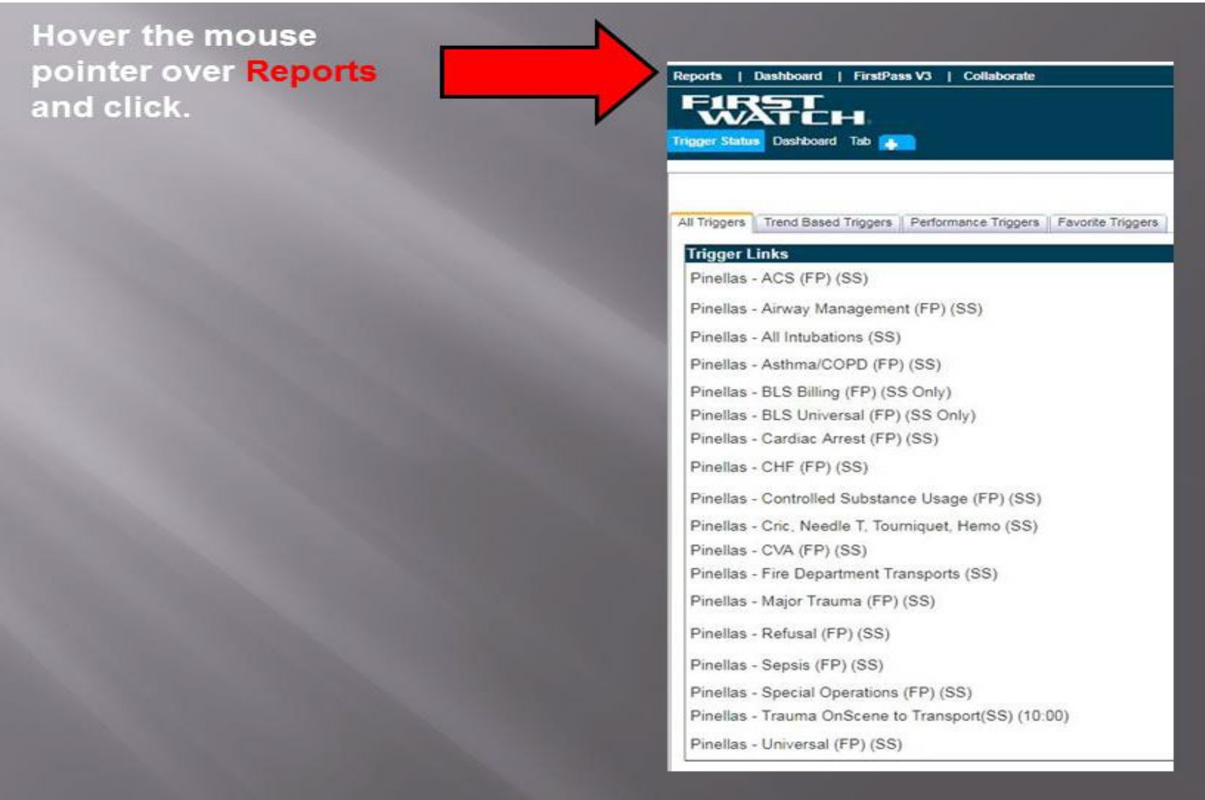
500 characters remaining

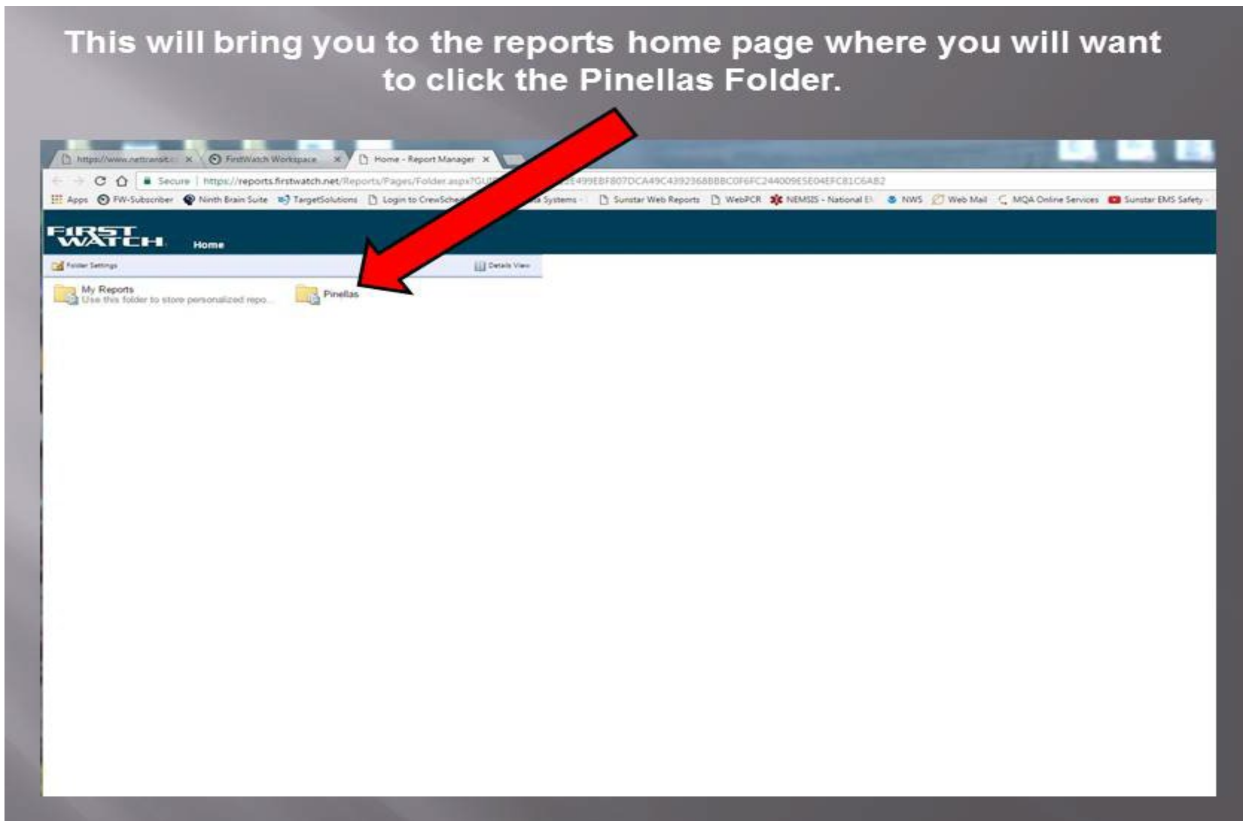
SEND

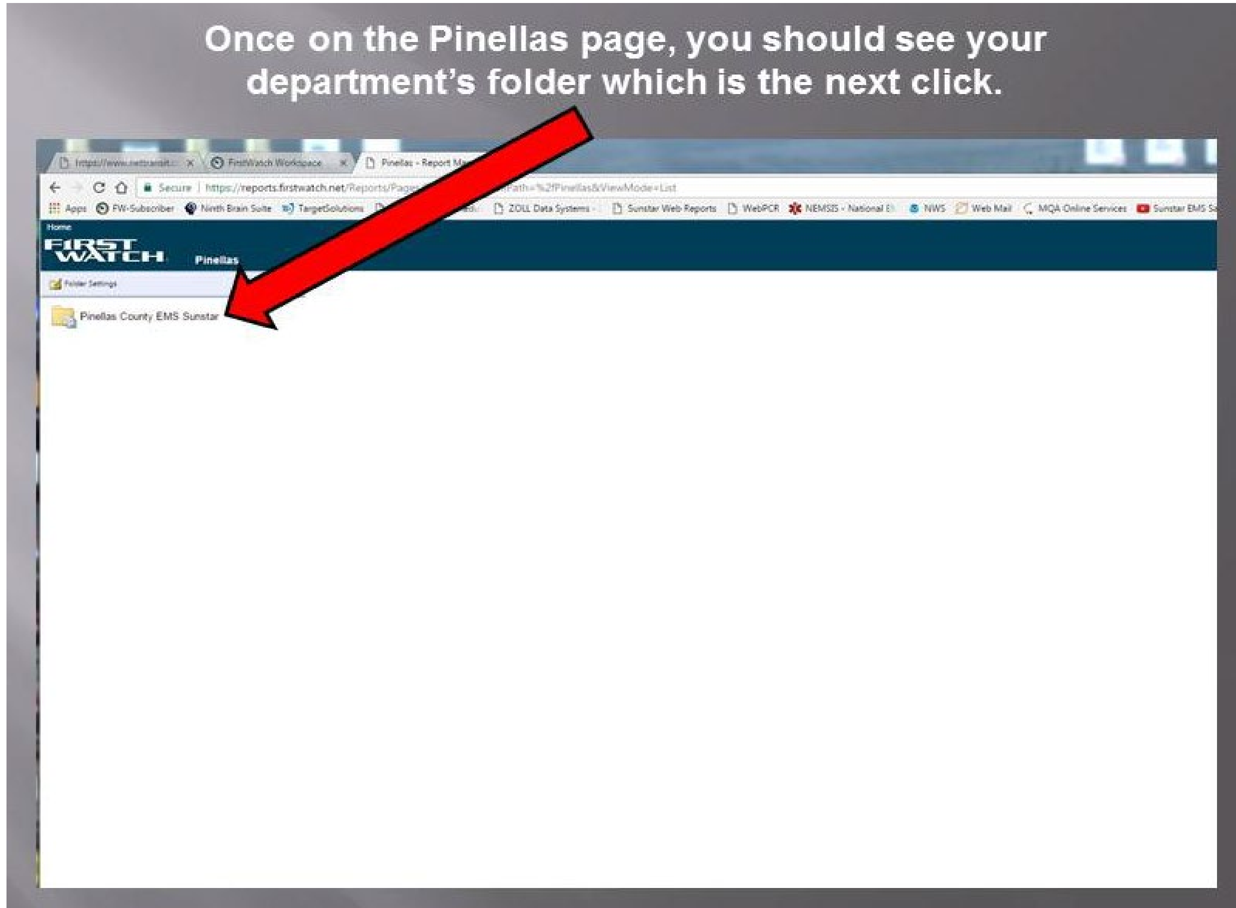
AD19 FIRST PASS USER GUIDE

First Pass can also generate several different reports that can be used to evaluation individual and agency performance, identify trends in compliance and spotlight areas for training. These reports can be accessed from the initial First Pass log in page and from inside V3 itself.






This will bring you to the reports home page where you will want to click the Pinellas Folder.
Home
My Reports
Pinellas


Once on the Pinellas page, you should see your department's folder which is the next click.
Pinellas
Pinellas County EMS Sunstar

You are now on the primary report page for your department. The three reports you will probably reference most often are the **Provider Protocol Compliance** , **System Protocol Compliance** and **Test Compliance by Protocol.**

Home › Pinellas › FirstPass

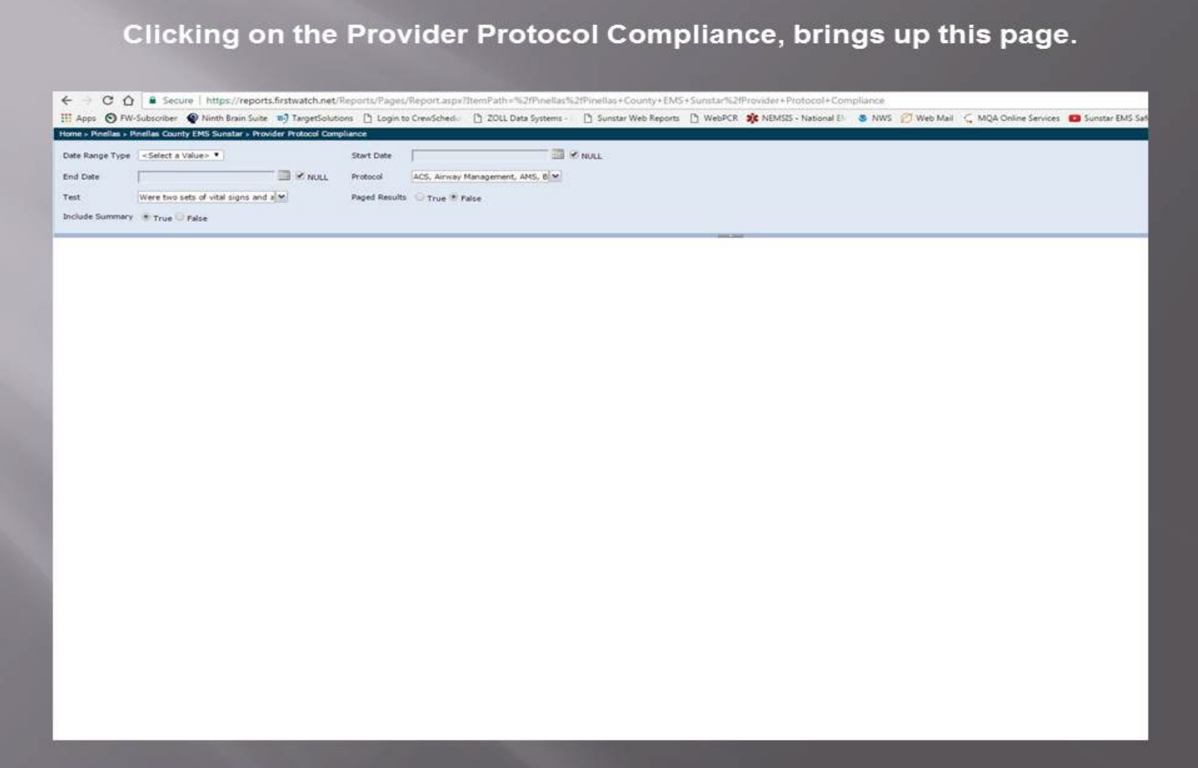
Home | My Subscriptions | Help

FIRST WATCH Pinellas County EMS Sunstar

Folder Settings

Details View

1 - Call Review Status Report
2 - Protocol Compliance Dashboard
3 - Protocol Summary Report
4 - Protocol Compliance Graph
5 - Provider Protocol Compliance
6 - Summary of Tests by Protocol
7 - System Protocol Compliance
8 - Test Compliance by Protocol
9 - Top Crew Protocol Not Completed
Unassigned 14d Call Review Status



This report contains each individual employee that has synced a report on the EPCR, along with their compliance, reported in percentages, with each test that First Pass now runs.

It also shows how they compare to the overall scores of your department and is very useful for identifying trends as well as providing both positive and corrective feedback.

And there are several options for downloading and saving the data.

- In the header are different options for presenting the data. The Date range type gives you several canned options for the time frame of the report such as: previous day or previous week. Or, if you uncheck the two boxes that say null, you can specify any date range that you wish.
- The Protocol drop down button lists each protocol that First Pass reviews and allows you to run a comprehensive report on all, or to choose any individual protocol, or any combination.
- The Test button is an individual listing of the tests run under each Protocol, so that you may run a report based of them all, or choose a specific test to focus on.
- The Paged results button gives you control on how the information is presented. False and the results are displayed in one continuous presentation. True and the results are separated by provider on each page.
- Finally, the Include Summary gives you the option of viewing a list of all the providers compliance with all the protocols in the report.

AD19 FIRST PASS USER GUIDE

The System Protocol Compliance begins with a page that has the similar date options as the Provider Report. When it opens, The data is presented in a paged fashion with a header like below.

Another helpful button to be familiar with is save and download, which is in the same place for all reports. It allows you to save your report with several different options.

Home > Pinellas > Pinellas County EMS Sunstar > System Protocol C

Start Date NULL | Date NULL
Date Range Type Previous Month | Results True False
Protocol ACS, Airway Management, AMS, B | Were two sets of vital signs and a

1 of 9 Find | Next

Pinellas County EMERGENCY MEDICAL SERVICES

Pinellas System Protocol Compliance

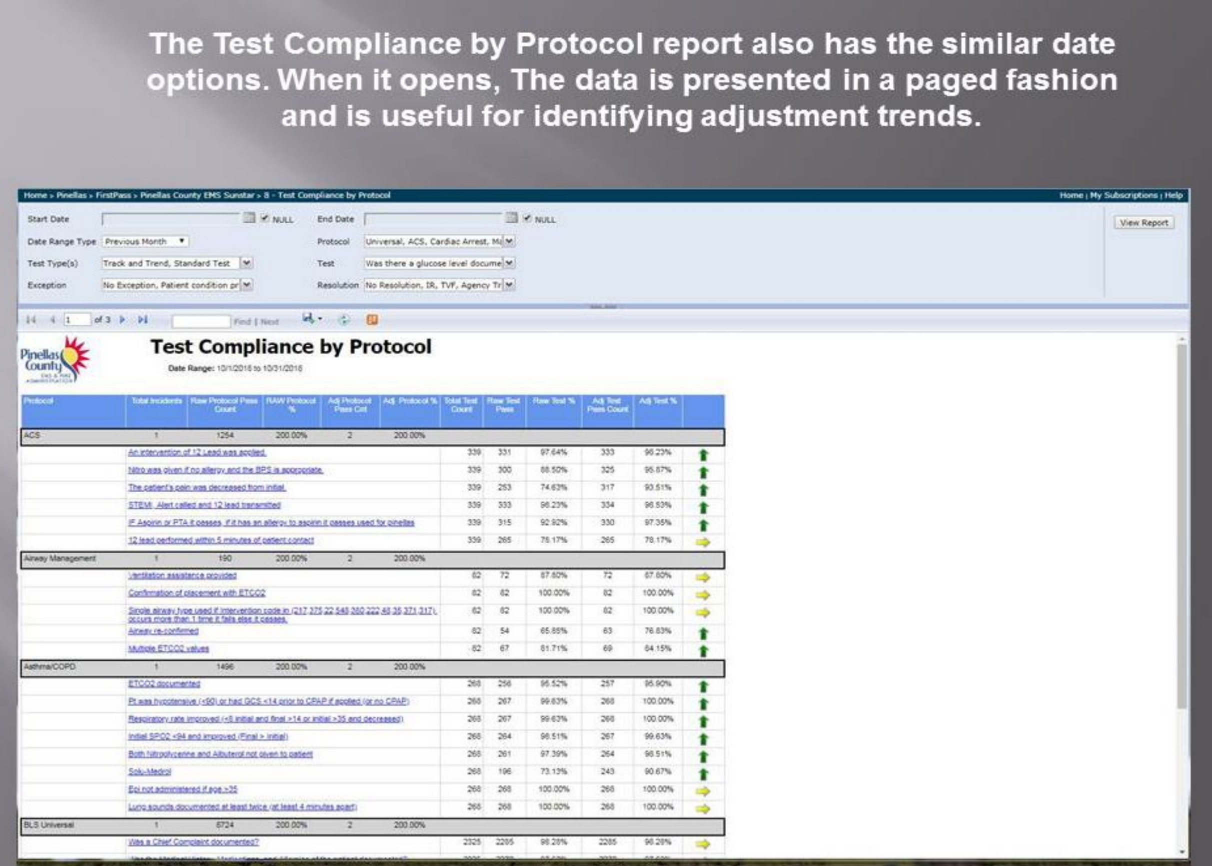
Agency: PINELLAS COUNTY EMS D/B/A SUNSTAR

Criteria:

Date Range: 1/1/2017 to 1/31/2017

Protocol(s): All

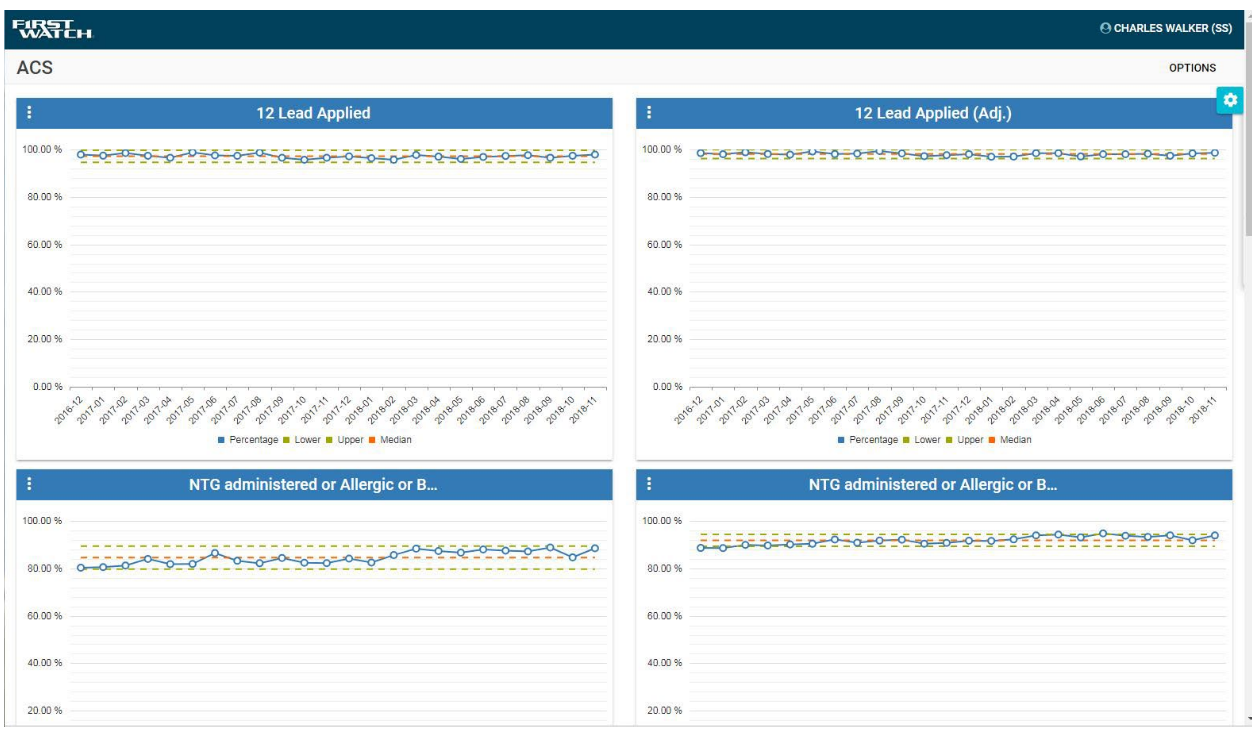
Test(s): All

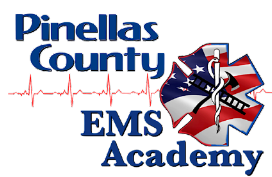


Another very useful report can be found when you click the Dashboard tab from inside the V3 test article. This opens a view of each protocol test in a graph format that displays both the raw and adjusted protocol compliance over time.

Each protocol can be expanded to display how each individual test can be customized for time by the small gear icon in the upper right-hand corner.

This information can be utilized to spot trending and identify training needs as well as quality checking review status and adjusted pass rates.


FIRST WATCH
CHARLES WALKER (SS)
ACS
OPTIONS
12 Lead Applied
12 Lead Applied (Adj.)
NTG administered or Allergic or B...
NTG administered or Allergic or B...
Percentage
Lower
Upper
Median



AD20 EMS ACADEMY

Dear Candidate,

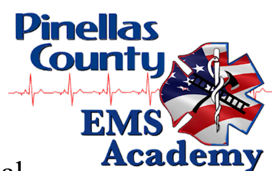
Welcome to Pinellas County EMS! On behalf of our EMS Medical Director, Dr. Angus Jameson, M.D., we are excited and proud you have chosen to join nearly 2,000 EMTs and paramedics in service of the residents and visitors of Pinellas County. Pinellas County EMS is a fast-growing, innovative, and dynamic EMS system. Running nearly 225,000 EMS calls per year, Pinellas County EMS is also one of the busiest EMS systems in the nation, and you will be working alongside some of the most dedicated and passionate EMS clinicians in the world.

Your Pinellas County EMS journey will begin with "EMS Academy," our foundational learning pathway to certification with our EMS Medical Director. EMS Academy is designed to introduce you to Pinellas County EMS. The system's unique history and structure provide basic and advanced learning for all clinicians centered around Dr. Jameson's patient care philosophies. EMTs and paramedics will complete the first five days of EMS Academy together, focusing on EMS care basics. Paramedics will continue in EMS Academy for five additional days to receive advanced instruction on Pinellas County EMS protocols and procedures. After each of the five days, clinicians will complete both written and practical examinations and skills evaluations prior to entering their field internship. After EMS Academy, EMTs and paramedics will begin their field internship, EMTs for a minimum of ten shifts, and paramedics for a minimum of fifteen. During your field internship, you will respond to emergency calls with your crew and be evaluated on a myriad of competencies and clinical abilities.

Your EMS Academy instructors are part of the Pinellas County EMS Continuing Medical Education (CME) instructor group. The EMS Academy Instructors have experience levels that span the last twenty years working in Pinellas County, among nearly every agency. They are committed to ensuring EMS Academy is an enjoyable, educational, and successful experience for you and every candidate. Just as your instructors are committed to your success, they expect your commitment to being successful.

Professionalism is of the highest priority in Pinellas County EMS. Not only do you represent yourself and the system as a clinician, but you are also an extension of Dr. Jameson and your agency. Please ensure your attire is business casual, at a minimum. Department uniforms with a minimum of long pants and a button-up shirt are preferred. EMS Academy will start promptly at **08:00** every morning; please arrive on time, just as you would for a regularly scheduled shift. We understand life happens; however, if you will be late to class please follow your agencies standard operating procedure. A list of expectations and a map of the EMS Academy classroom are included for your convenience.

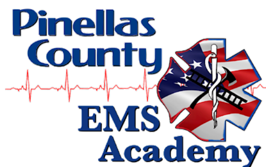
We are glad to have you as part of the Pinellas County EMS family and wish you a long, safe, and prosperous career. Should you have any questions about EMS Academy



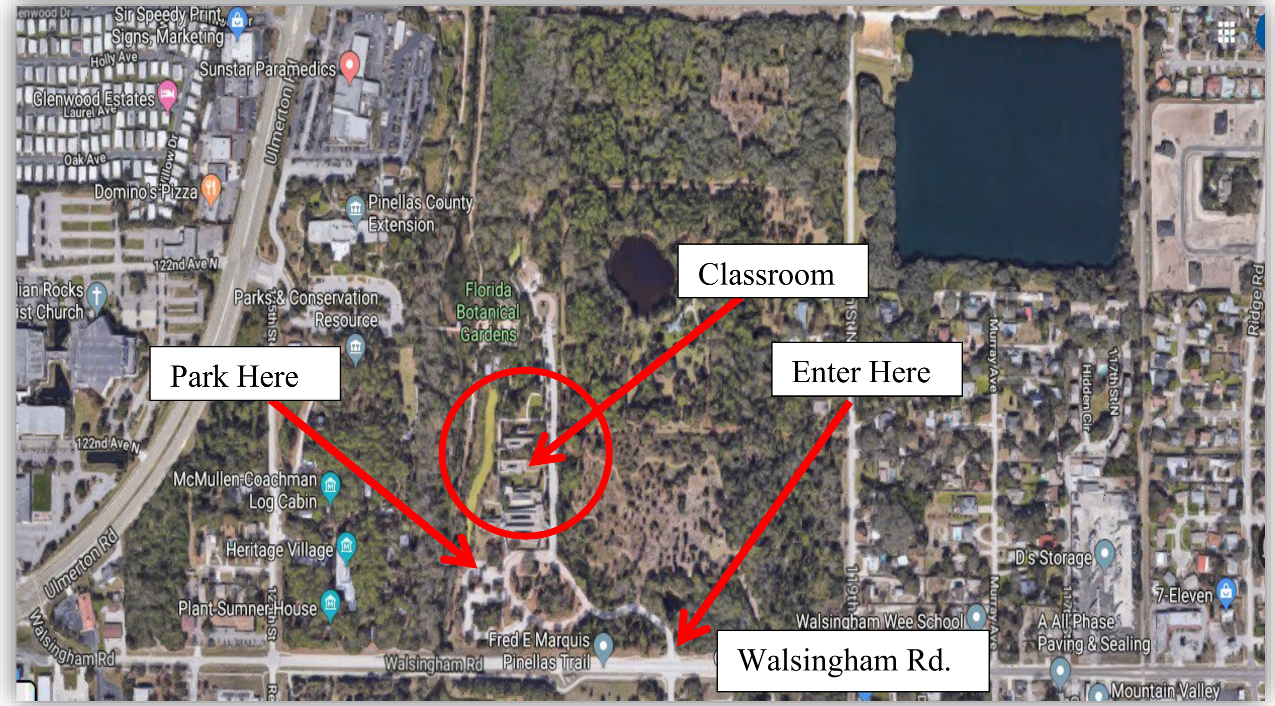
or other elements of your training and certification process with the EMS Medical Director, please do not hesitate to ask an instructor or supervisor.

Welcome to the family!

AD20 EMS ACADEMY

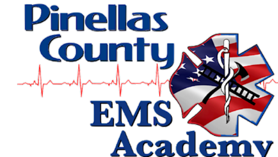


EMS Academy is located in the Pinellas County EMS Center for Prehospital Medicine (CPM) at 12211 Walsingham Road, Largo, FL 33774. CPM shares a campus with the Florida Botanical Gardens and Heritage Village. Parking for EMS Academy is on the south side of the campus, near the auditorium. Please do not park



on the east side of the campus.

COMPLEX ENTRANCE



AD20 EMS ACADEMY

No parking

Auditorium

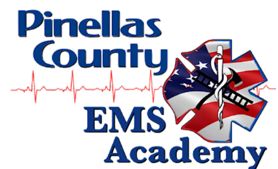
Enter Here

Park Here

Google

Fred E Marquis

AD20 EMS ACADEMY



Today you are an Emergency Medical Services Professional!

"Excellence is not a skill; it is an attitude!"
-Ralph Marston

EXPECTATIONS

There are only two expectations:

- Excellence is required for the successful completion of EMS Academy.
- There are **NO** exceptions to the first expectation.

STANDARDS OF CONDUCT

General rules of decorum are in place

- Be polite.
- Respect your instructors and your colleagues.
- Leave the class better than you found it.
    - Clean up after yourself, wipe your table and chairs down, & push chairs in at the end of the day.
- You are further responsible for compliance with the policies of your agency.

Cell phones

- Please silence your phone when you enter the classroom.
- Do not answer calls/texts in the classroom; excuse yourself from the room.

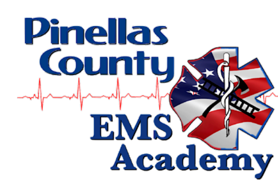
Breaks

- Breaks will be provided approximately every hour.
- Lunch is generally taken from 12:00 – 13:00.
- A cafeteria is located on the 2nd floor of the Pinellas County EMS & Fire Administration building.
- An instructor must be present for you to stay in the classroom during lunch.
- Please return from lunch/breaks at the designated time.

DRESS CODE

- Adherence to your agency's uniform policy and dress code
- Required throughout your orientation experience.
- If you have not been issued uniforms, please dress in appropriate business casual attire. Close-toe shoes are STRONGLY encouraged.
- Please minimize the use of colognes, perfumes, lotions, etc.

AD20 EMS ACADEMY



CLASSROOM

- Pinellas County owns the classroom, and we are guests in the room.
- It is not uncommon for "special guests" to make appearances.
- The public visits the Botanical Gardens and will be present throughout the day.
- The classroom is often quite cold; a jacket or sweater is recommended.
- The classroom does not have the best acoustics; please minimize noises that may distract your colleagues.
- There is no microwave or refrigeration available for students at CPM, so plan your lunch breaks accordingly.
- Restrooms are located at the east end of the classroom building.

PARTICIPATION

- This is your orientation to the Pinellas County EMS system, and you are expected to participate as a team member in the system.
- PLEASE ask questions and be involved in the class.
- There are no wrong answers or stupid questions; they are both learning opportunities!

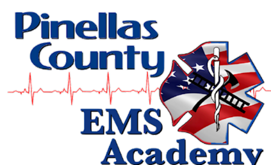
EVALUATIONS

- Evaluations are mandatory.
- Please complete your evaluations at the end of each day.
- Sign your EMS Academy workbook to confirm you have completed the daily survey.
    - Please be critical, student input continues to shape the orientation process, and your voice matters.
    - If any element of orientation requires immediate attention, please notify your instructor immediately.
    - CPM tends to have poor cellular service. Pinellas County has a free *"Guest"* Wifi.

ADDITIONAL INFORMATION

- For many of you, this is the first step in what is hopefully a long career in Pinellas County. Have fun and learn as much as you can

AD20 EMS ACADEMY



EMS Academy & Field Internship
Program Guide

Introduction and Intent

Welcome to Pinellas County Emergency Medical Services. This document describes the process for new EMTs and paramedics to achieve certification as clinical professionals within the Pinellas County EMS System.

There are two levels of EMS certifications in Pinellas County (EMT & paramedic) and three different candidates recognized in the EMS Academy. Candidates have three different pathways in which to complete their respective certifications. There are four steps each candidate must complete to obtain a certification in PCEMS.

Candidate Definitions

- **New Paramedic Candidate** – New paramedic seeking initial certification.
- **Transition Paramedic Candidate** – New paramedic seeking certification and has completed week one of the EMS Academy within the last 18 months as an EMT.
- **EMT Candidate** – New EMT seeking initial certification.

Steps to Obtain Certification

STEP 1 – Application Process

Completed by your agency prior to EMS Academy.

STEP 2 – EMS Academy

Successfully complete EMS Academy. Step 2 is required of all Certified Professionals except for Wheelchair Van Drivers, Mental Health Transport Drivers, and EMS Physicians. During Step 2, new paramedic candidates will attend all ten days of EMS Academy, transition paramedic candidates will attend five days of the EMS Academy (week 2), and EMT candidates will attend five days of the EMS Academy (week 1).

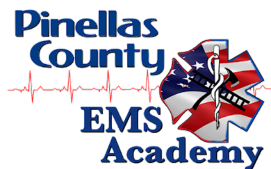
For information regarding Remediation & Failure procedures, see under the "EMS Academy and Field Internship Program" section, subsection "Program Description."

STEP 3 – Field Internship

Successfully complete the Field Internship Program with the candidate's agency. During Step 3, new paramedics and transition paramedic candidates will complete a minimum of 15 shifts in the field with a county-certified paramedic.

EMT candidates will complete a minimum of 10 shifts in the field with a county-certified clinician. After new EMT candidates successfully complete Step 3, the candidate will be credentialed as a Certified Professional with the accompanying rights and responsibilities for providing patient care in the Pinellas County EMS System.

AD20 EMS ACADEMY



STEP 4 – Capstone *(Paramedics ONLY)*

The final step in the process for paramedic candidates is capstone testing. The testing process is a

culmination of everything a candidate has learned during the EMS Academy and Field Internship. Capstone testing for a new paramedic or a transition paramedic candidate consists of a written exam and practical scenarios. All exam questions are derived from the current edition of the Pinellas County Medical Operations Manual (MOM), Volume 1, as well as any Medical Control Directives that were released after the current version of the MOM. After successfully completing the capstone test, a new paramedic or transition paramedic candidate will be credentialed as a Certified Professional with the accompanying rights and responsibilities for providing patient care in the Pinellas County EMS System.

Any candidate who does not successfully complete the certification process after remediation and/or represents a situation not defined herein shall be handled on a case-by-case basis with the Pinellas County EMS Medical Director.

Pathway to Paramedic Certification					
Step 1	Step 2	Step 3	Step 4		
Submission of **Application** for Provisional Certification *(requires affiliation with system agency)*	Successful Completion of EMS Academy **10 days**	**Field Internship** Phase 1 – 5 shifts Phase 2 – 5 shifts Phase 3 – 5 shifts **Minimum of 15 shifts**	**Capstone Process** Capstone Written Exam Capstone Practical Scenario	→	Issued County Paramedic Certification

Pathway to Transition Paramedic Certification					
Step 1	Step 2	Step 3	Step 4		
Submission of **Application** for Provisional Certification *(requires affiliation with system agency)*	Successful Completion of EMS Academy Week 2 **5 days**	**Field Internship** Phase 1 – 5 shifts Phase 2 – 5 shifts Phase 3 – 5 shifts **Minimum of 15 shifts**	**Capstone Process** Capstone Written Exam Capstone Practical Scenario	→	Issued County Paramedic Certification

Pathway to EMT Certification				
Step 1	Step 2	Step 3		
Submission of **Application** for Provisional Certification *(requires affiliation with system agency)*	Successful Completion of EMS Academy Week 1 **5 days**	**Field Internship** Skills Checkoffs **Minimum of 10 shifts**	→	Issued County EMT Certification

AD20 EMS ACADEMY

Pathway to Field Internship

EMS Academy

Written Exam
Did you pass with an 80% or >?

&

Practical Skills Competencies Testing
Were you successful in all stations?
**If 3 or more steps missed = remediate and retake entire skill (passed if successful after remediation)*
***If 2 or less steps missed = remediate and retake missed steps (passed if successful after remediation)*
****If no steps missed = SUCCESSFUL*

Written Exam → Failed → Remediate → **Retake Written Exam** *(Version 2)* → Passed / Failed

Passed Both → **Scenario Testing**
Week One (BLS) = 1 Adult & 1 Pedi Trauma Scenario
Week Two (ALS) = 1 Adult & 1 Pedi Medical Scenario
How many did you pass?

- Passed Both → CONGRATULATIONS!
- Passed 1 & Failed 1 → Remediate → Retake Practical → Passed → CONGRATULATIONS! / Failed
- Failed Both

Practical Skills Competencies Testing → Failed

Candidates who are unsuccessful after standard remediation will receive a written **"Remediation Recommendation Plan"** from the EMS Medical Director on a case by case basis

Remedial Training Plan as approved by the EMS Medical Director may include one or more of the following:

- Ride time for up to "X" shifts
- No ride time until classroom remedial training occurs at the agency
- Repeat selected days of EMS Academy to meet training deficits (non-punitive)
- Training verification by the agency's EMS Coordinator or designee
- Return to repeat scenario-based testing or repeat written examination

CONGRATULATIONS!
You are moving on to Field Internship

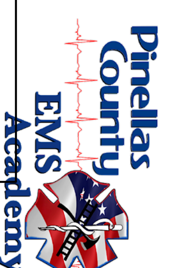
Candidates who are unsuccessful after standard remediation will receive a written **"Remediation Recommendation Plan"** from the EMS Medical Director on a case by case basis

Remedial Training Plan as approved by the EMS Medical Director may include one or more of the following:

- Ride time for up to "X" shifts
- No ride time until classroom remedial training occurs at the agency
- Repeat selected days of EMS Academy to meet training deficits (non-punitive)
- Training verification by the agency's EMS Coordinator or designee
- Return to repeat scenario-based testing or repeat written examination

Repeated unsuccessful attempts at testing after remediation may result in refusal of issuance

AD20 EMS ACADEMY



EMS Academy
Remediation Recommendation Plan

Candidate Name: ______________________ Date: ______________

EMS ID #: ______________

JUSTIFICATION FOR REMEDIATION RECOMMENDATION

REMEDIATION RECOMMENDATION

Candidates shall work on the deficiencies noted below prior to attending the next EMS Academy.

PT. ASSESSMENT AND ORGANIZATION	CLINICAL PROCEDURES	PROTOCOL
☐ Systematic Approach	☐ Airway Management	☐ Medical Operations Manual
☐ General Impression	☐ Basic Airway	☐ Clinical Standards
☐ Recognition of Life Threats	☐ King Airway Intubation	☐ Universal Approach to Patient Care
☐ Primary Assessment (XABCDE)	☐ Endotracheal Intubation	☐ Airway
☐ Secondary Assessment	☐ Surgical/Needle Cricothyrotomy	☐ Cardiac
☐ Vital Signs	☐ ECG and Electrotherapy	☐ Medical
☐ History (SAMPLER/OPQRST)	☐ Rhythm Recognition	☐ Trauma
☐ Physical Exam	☐ Defibrillation	☐ Pediatric
☐ Additional Items:	☐ Synchronized Cardioversion/Pacing	☐ Pharmacology & Dosages
☐ Crew Resource Management	☐ Pediatric Care	Specific Medication *(specified below)*:
☐ Taking Lead & Delegation	☐ Handtevy Medication & Equipment Guidebook Familiarization	
☐ I-MACC	☐ Trauma Care	
☐ Appropriate Treatment Plan	☐ Tourniquet/Wound Packing	
☐ Other *(details listed below)*:	☐ Needle Thoracostomy/Hyfin Seal	☐ Other *(details listed below)*:
	☐ Other *(details listed below)*:	

☐ Behavior Remediation *(specified below)*:

Additional remediation requirements prior to attending the next EMS Academy:

EMS Academy
Remediation Recommendation Plan

I, ______________________, confirm that I have read and understand the EMS Academy Remediation Recommendation Plan. I will work to improve the aforementioned deficiencies as specified by the Pinellas County Medical Director's Office with my agency prior to attending the next available EMS Academy. I understand I will not be allowed to continue on to the Field Internship Program until I successfully complete EMS Academy.

______________________ ______________
Candidate Signature Date

I have reviewed the EMS Academy Remediation Recommendation Plan with the candidate.

______________________ ______________
EMS Academy Facilitator Signature & EMS ID # Date

Pursuant to the Rules and Regulations of the Pinellas County Emergency Medical Services System, the candidate is required to work on correcting the deficiencies listed in the Remediation Recommendation Plan prior to attending the next available EMS Academy. The candidate shall not continue on to the clinical Field Internship Program until successful completion of EMS Academy.

______________________ ______________
Candidate's EMS Coordinator Signature Date

OFFICIAL USE ONLY

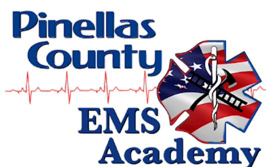
1st Written Exam Attempt Score	2nd Written Exam Attempt Score	Adult Practical Scenario (Pass/Fail):	Pediatric Practical Scenario (Pass/Fail):	☐ Candidates Agency Notified

I confirm that I have read, understand and agreed with the Remediation Recommendation Plan set forth by the EMS Academy Facilitator.

______________________ ______________
Pinellas County EMS Academy Coordinator Date

______________________ ______________
Pinellas County Medical Director Date

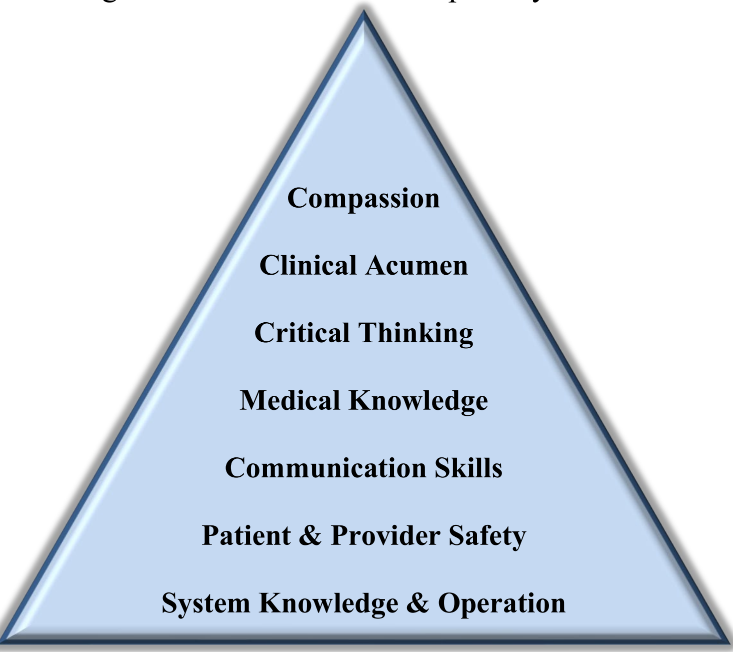
AD20 EMS ACADEMY



Pinellas County EMS Clinical Competencies

Overview

To excel at the complex and challenging work of providing excellent medical care in the uncontrolled pre-hospital environment, Pinellas County EMS clinicians will be required to have expertise in each of the following seven Core Clinical Competency Areas:



To assist in designing a qualification program and defining for providers those areas they will be responsible for, each of these areas has been further defined and broken down into its components.

Core Competency Definitions

System Knowledge & Operations – The ability to understand how Pinellas County EMS System functions on a day-to-day basis and the ability to operate as a clinician as it relates to the Medical Operations Manual(s).

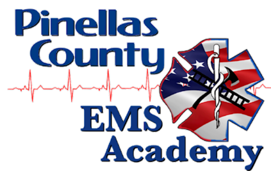
Patient and Provider Safety – The ability to provide a safe working environment for your fellow patient care providers and ensure that movement and transportation of a patient are done with the highest level of safety is provided.

Effective Communications – The ability to communicate with a patient, family members, EMS, law enforcement, skilled nursing facilities, and receiving healthcare facility members ensures that all pertinent information is obtained to provide the best possible outcome for the patient.

Medical Knowledge – The ability to assess a patient, obtain pertinent medical and social history, develop a differential diagnosis and treat using therapeutic skills at the highest level.

Independent and Critical Thinking – The ability to process the information gathered during assessment and history gathering, provide the most effective care for a patient, and transport a patient to the most appropriate facility.

AD20 EMS ACADEMY



Clinical Acumen – The ability to assess the scene and a patient, obtain pertinent medical and social history, and perform skills at the highest level.

Compassion – The ability to provide a comforting, caring, and empathic experience for a patient.

EMS Academy and Field Internship Program

Individuals seeking a Pinellas County Certification must initially obtain a Provisional Certification *(Step 1)* and then successfully complete the EMS Academy and Field Internship Program as required for their level of certification.

Provisional Certification

The requirements for obtaining Provisional Certification are described in the Pinellas County EMS Rules and Regulations Section 4.2 through 4.8. Your agency handles the application process.

Program Description

The following requirements and procedures are established to facilitate a uniform and consistent program across the entire Pinellas County EMS System.

Registration

Registration is handled by your agency at least 14-days prior to the start of EMS Academy.

Attendance

Attendance at all course components is mandatory and missed time must be made up prior to completing the program.

Remediation

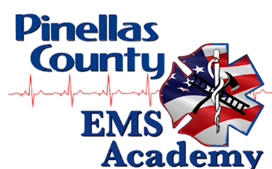
Candidates may attempt any written, online, practical, or other examinations or evaluations required during EMS Academy and Field Internship Program (i.e., prior to Capstone) up to 2 times.

If there is a failure in any portion of written, practical skills, or scenario testing, your agency will be notified prior to retesting the same day. A remedial plan will be discussed with your agency and the EMS Medical Director prior to retesting the same day.

Failure

When candidates are unsuccessful after standard remediation, they will receive a written Remediation Recommendation Plan from the EMS Medical Director on a case-by-case basis. The Remedial Training Plan as approved by the EMS Medical Director, may include one or more of the following:

- Ride time for up to “X” shifts *(number of shifts will be determined by the EMS Medical Director)*
- No ride time until classroom remedial training occurs at the agency
- Repeat selected days of EMS Academy to meet training deficits (non-punitive)



- Training verification by the agency's EMS Coordinator or designee
- Return to repeat scenario-based testing or repeat written examination

Repeated unsuccessful attempts at testing after remediation may result in refusal of issuance by the EMS Medical Director.

Special certifications (i.e., American Heart Association's BLS, ACLS, or National Association of Emergency Medical Technicians AMLS, PHTLS, or EPC) will follow their respective founding bodies testing procedures.

Program Components & Expected Timelines

New Paramedic Candidates

EMS Academy and Field Internship Program for a new paramedic candidate is comprised of five components. These components entail face-to-face training, online self-study, and supervised field experience. Each component must be completed in order and in its entirety.

COMPONENT 1 – EMS Academy is broken up into two weeks.

- Week 1 concentrates on system overview/history, stress first aid, basic medical knowledge, and refinement of basic clinical skills.
- Week 2 concentrates on advanced medical knowledge, ALS care of a patient, PCEMS Medical Operations Manual Protocols, and refinement of advanced clinical skills.

COMPONENT 2 – Field Internship is broken up into three phases. Each phase has a unique focus to allow for a candidate's medical knowledge and clinical decision-making to be evaluated while functioning in the field as a provisional paramedic.

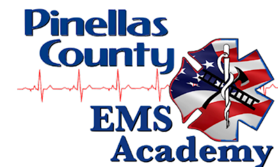
- Phase 1 (5 shifts) – Focuses on universal approach to patient care, basic medical knowledge & BLS care.
- Phase 2 (5 shifts) – Focuses on advanced medical knowledge, advanced clinical skills & ALS care.
- Phase 3 (5 shifts) – Focuses on putting everything together, including patient/family interaction, clinical decision making & scene management.

There is no set time frame to complete the three phases; however, it should take an anticipated 45 days to complete the required 15 shifts.

COMPONENT 3 – Online self-study & required certification can be completed any time during Field Internship. The content includes additional medical training that will enhance the candidate's overall knowledge base. New paramedic candidates are required to have a current American Heart Association Advanced Cardiac Life Support (ACLS) certification, National Association of Emergency Medical Technician Prehospital Trauma Life Support (PHTLS) certification, and Emergency Pediatric Care (EPC) certification. If the candidate holds a certification that expires prior to the next county cycle, the candidate must complete the certification prior to attending capstone testing.

COMPONENT 4 – Capstone Testing – The EMS Academy and Field Internship program culminates in a capstone testing process consisting of written and practical evaluations.

AD20 EMS ACADEMY



New Paramedic Candidates Expected Timeline				
EMS Academy at CPM		**Field Internship**	**Online Self-Study & Required Certs.**	**Capstone**[1]
Week 1 **Day 1 - 5**	**Week 2** **Day 8 - 12**	**Day** **13 - 53 or 55**[2]	**Complete Between Day** **13 - 67**	**Calendar Day 68**
		Phase 1, 2 & 3	**Required as needed**	
Focus System Overview/History Stress First Aid, Basic Medical Knowledge & BLS Clinical Skills	**Focus** Advanced Medical Knowledge, ALS Care, MOM Protocols & Advanced Clinical Skills	**Focus** Phase 1 – Universal Approach to Patient Care, Basic Medical Knowledge & BLS Care Phase 2 – Advanced Medical Knowledge, Advanced Clinical Skills & ALS Care Phase 3 – Patient/Family Interaction, Clinical Decision Making & Scene Management	ACLS Refresher[3] PHTLS Hybrid[4] EPC Hybrid[5]	Written Testing Practical Testing

Notes:

- This schedule indicates the quickest path **(68 days)**[1] to completing the program for paramedic candidates and eligible for Capstone Testing.
- Field Internship includes Phase 1, 2 & 3. Skills checkoffs must be signed off by Agency EMS Coordinator, County CME Instructor, or a Pinellas County Certified Paramedic in good standing.

[1]Capstone testing is offered a minimum of once per month.

[2]Field Internship completion date will be a minimum of (53) days for the Clearwater/Dunedin FD schedule or a minimum of (55) days for the Typical 24/48 schedule.

[3]If the candidate's AHA ACLS certification has an expiration date after the next PCEMS ACLS certification class, a refresher class will be required before Capstone testing.

[4]If the candidate does not currently have a PHTLS/ITLS certification with an expiration date after the next PCEMS trauma certification class, a Hybrid class will be required before Capstone testing.

[5]If the candidate does not currently have an EPC certification with an expiration date after the next PCEMS pediatric certification class, a Hybrid class will be required before Capstone testing.

Transition Paramedic Candidates

EMS Academy and Field Internship Program for a transition paramedic candidate is comprised of five components. These components entail face-to-face training, online self-study, and supervised field experience. Each component must be completed in order and in its entirety.

COMPONENT 1 – EMS Academy is broken up into two weeks.

- Week 1 *previously completed EMS Academy as an EMT within the last 18 months*
- Week 2 concentrates on advanced medical knowledge, ALS care of a patient, PCEMS Medical Operations Manual Protocols, and refinement of advanced clinical skills.

COMPONENT 2 – Field Internship is broken up into three phases. Each phase has a unique focus to allow for the candidate's medical knowledge and clinical decision-making to be evaluated while functioning in the field as a provisional paramedic.

- Phase 1 (5 shifts) – Focuses on universal approach to patient care, basic medical knowledge & BLS care.
- Phase 2 (5 shifts) – Focuses on advanced medical knowledge, advanced clinical skills & ALS care.
- Phase 3 (5 shifts) – Focuses on putting everything together, including patient/family interaction, clinical decision making & scene management.

There is no set time frame to complete the three phases; however, it should take an anticipated 45 days to complete the required 15 shifts.

COMPONENT 3 – Online self-study & required certification can be completed any time during Field Internship. The content includes additional medical training that will enhance the candidate's overall knowledge base. New paramedic candidates are required to have a current American Heart Association Advanced Cardiac Life Support (ACLS) certification, National

Association of Emergency Medical Technician Prehospital Trauma Life Support (PHTLS) certification, and Emergency Pediatric Care (EPC) certification. If the candidate holds a certification that expires prior to the next county cycle, the candidate must complete the certification prior to attending capstone testing.

COMPONENT 4 – Capstone Testing – The EMS Academy and Field Internship program culminates in a capstone testing process consisting of both written and practical evaluations.

Transition Paramedic Candidates
Expected Timeline

EMS Academy at CPM		Field Internship	Online Self-Study & Required Certs.	Capstone[1]
Previously completed within the last 18 months	Week 2 Day 1 - 5	Day 6 - 46 or 48[2]	Complete Between Day 6 - 60	Day 61
		Phase 1, 2 & 3	Required as needed	
Focus System Overview/History, Stress First Aid, Basic Medical Knowledge & BLS Clinical Skills	**Focus** Advanced Medical Knowledge, ALS Care, MOM Protocols & Advanced Clinical Skills	**Focus** Phase 1 – Universal Approach to Patient Care, Basic Medical Knowledge & BLS Care Phase 2 – Advanced Medical Knowledge, Advanced Clinical Skills & ALS Care Phase 3 – Patient/Family Interaction, Clinical Decision Making & Scene Management	ACLS Refresher[3] PHTLS Hybrid[4] EPC Hybrid[5]	Written Testing Practical Testing

Notes:

- This schedule indicates the quickest path **(61 days)**[1] to completing the program for transition paramedic candidates and eligible for Capstone Testing.
- EMS Academy – Week 1 previously completed as an EMT Candidate
- Field Internship includes Phase 1, 2 & 3. Skills checkoffs must be signed off by Agency EMS Coordinator, County CME Instructor, or a Pinellas County Certified Paramedic in good standing.

[1]Capstone testing is offered a minimum of once per month.

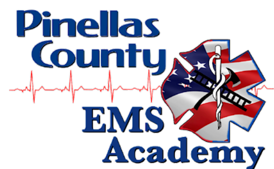
[2]Field Internship completion date will be a minimum of (53) days for the Clearwater/Dunedin FD schedule or a minimum of (55) days for the Typical 24/48 schedule.

[3]If the candidate's AHA ACLS certification has an expiration date after the next PCEMS ACLS certification class, a refresher class will be required before Capstone testing.

[4]If the candidate does not currently have a PHTLS/ITLS certification with an expiration date after the next PCEMS trauma certification class, a Hybrid class will be required before Capstone testing.

[5]If the candidate does not currently have an EPC certification with an expiration date after the next PCEMS pediatric certification class, a Hybrid class will be required before Capstone testing.

AD20 EMS ACADEMY



New EMT Candidates

EMS Academy and Field Internship Program for a new EMT candidate is comprised of two components. These components entail face-to-face training and supervised field experience. Each component must be completed in order and in its entirety.

COMPONENT 1 – EMS Academy for a new EMT candidate is one week.

- Week 1 concentrates on the system overview/history, stress first aid, basic medical knowledge, and refinement of basic clinical skills.

COMPONENT 2 – Field Internship Program is an integrative period focused on applying skills learned during the EMS Academy, which includes patient/family interaction, crew resource management, and basic hands-on skills while functioning in the field as a provisional EMT. There is no set time frame to complete the third step; however, it should take an anticipated ten shifts to complete the required hands-on skills check-offs.

New EMT Candidates Expected Timeline	
EMS Academy at CPM	**Field Internship**
Week 1 **Day 1 - 5**	**Day** **6 - 34 or 40[1]** Skills Checkoffs
Focus System Overview/History, Stress First Aid, Basic Medical Knowledge & BLS Clinical Skills	**Focus** Patient/Family Interaction, Crew Resource Management, Applying Skills Learned During the EMS Academy & Skills Check-off Completion
Notes: • This schedule indicates the quickest path **(34 to 40 days)[1]** to completing the program for EMT candidates. • Field Internship includes skills check-offs that must be signed off by Agency EMS Coordinator, County CME Instructor, or a Pinellas County Certified EMT or Paramedic in good standing. [1]It will take a minimum of (34) days to complete the Field Internship using the Typical 24/48 FD schedule & a minimum of (40) days to complete the process using the Clearwater/Dunedin FD schedules.	

Additional Information

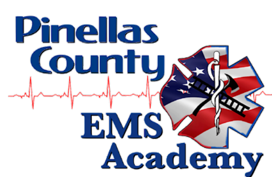
Passing Score for Written Examinations

The minimum passing score on all PCEMS written examinations is 80%. Special certifications (i.e., American Heart Association's BLS, ACLS, or National Association of Emergency Medical Technicians' AMLS, PHTLS, or EPC) will follow their respective founding bodies testing procedures.

Academic Honesty Policy

Academic dishonesty, including but not limited to falsification, deception, misrepresentation, cheating, copying, or unauthorized sharing of evaluation materials or answers, shall be considered a violation of Section 6.4.1 of the Pinellas County EMS Rules and Regulations and as such, may be grounds for administrative proceeding and/or refusal or revocation of certification.

AD20 EMS ACADEMY



EMS Academy Schedule

**Subject to Change*

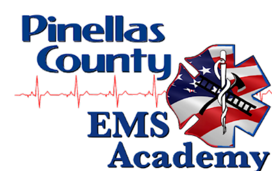
Objectives for each lecture are located in the EMS Academy Orientation Textbook at the beginning of each PowerPoint. Skills competencies located in the MOM & EMS Academy & Field Internship workbook.

Week 1 – BLS

- Concentration
    - Basic Medical Knowledge
    - BLS Skills Competencies
    - Standardize Equipment Overview
    - Universal Approach to Patient Care
    - Application of BLS Care During Scenarios

General Outline

- System Overview/History
- Introduction to the Medical Director
- Medical Operations Overview (Vol. 1 & 2)
- Universal Approach to Patient Care
- EMS Academy & Field Internship Program Overview and Workbook
- Standardized Equipment Overview & Familiarization
- Systematic Approach to Patient Care
- Scene Safety
- Crew Resource Management
- Intervention – Medication Administration Cross Check
- PIT Crew
- Management of a Trauma Patient
- Diabetic Emergencies
- Stroke Management
- Hemorrhage Control
- Cardiac Monitor Familiarization (Ops. Check, Lead Placement, CPR Feedback Device, Transmission of a 12-Lead)
- Pediatric Assessment & Protocol Review
- Handtevy™ System Overview & Equipment Overview
- Stress First Aid & Mental Health
- Documentation
- Controlled Substance Management (C.S. Box, CyberKey, Controlled Substance Waste Procedures)
- Assisting with Vascular Access
- Practical BLS Scenario Practice
- Skills Competencies Checkoffs
    - CPR (Adult, Child, & Infant)
    - BVM Ventilation & Airway Adjunct (Adult & Pediatric)
    - CPAP
    - Nebulizer Inhalation Therapy w/ CPAP & Intubation
    - Hemorrhage Control (Wound Packing, QuickClot® Combat Gauze, ETD, Combat Application Tourniquet [CAT], Hyfin® Vent Compact Chest Seal
- Final Testing



    - Written Exam
    - Skills Competencies
    - Final BLS Practical Scenarios (Adult & Pediatric)

Week 2 – ALS

- Concentration
  - Advanced Medical Knowledge
  - ALS Care
  - MOM Protocol
  - Advanced Clinical Skills

General Outline

- Respiratory
- Cardiac
- Advanced Trauma & Case Studies
- OB GYN & Neonatal Care
- Pharmacology
- Sepsis (Adult & Pediatric)
- Abdominal Disorders
- Stress First Aid
- Practical BLS Scenario Practice
- Skills Competencies Checkoffs
  - Orogastric Tube Insertion
  - King Airway
  - Endotracheal Intubation (Adult & Pediatric)
  - Medication Facilitated Intubation
  - IO Access
  - Needle Thoracostomy
  - Surgical Cricothyrotomy
  - Defibrillation
  - Transcutaneous Pacing
  - Synchronized Cardioversion
  - Needle Cricothyrotomy
- Final Testing
  - Written Exam
  - Skills Competencies
  - Final ALS Practical Scenarios (Adult & Pediatric)

AD22 CONTINUING MEDICAL EDUCATION (CME) STUDENT/INSTRUCTOR GUIDELINES

This has been developed as a resource for the Pinellas County Continuing Medical Education (CME) program. It explains the various operational aspects for its instructors and students.

Introduction

All CME Instructors will have access to the EMS Training Coordinator, the EMS Medical Director and specific certification course faculty and staff (e.g., AHA, NAEMT) for information regarding policy and procedures either in person, by phone, or by email.

Each course shall follow the current Medical Operations Manual Protocols or standardized course requirements and guidelines set forth in the most current editions of course textbooks and instructor manuals and be approved by the EMS Medical Director. The most current editions of the certification agency course materials must serve as the primary instructional resource during the course.

Professional Conduct

As a Pinellas County Certified Clinician all instructors and students are required to conduct themselves in a professional manner. Inappropriate behavior will be reported to the appropriate agency, EMS Coordinator or Supervisor.

CME Training Site Coordinator

A CME Training site is a pre-designated location that has been approved by EMS and Fire Administration to operate as a self-sufficient training location.

- Supervise the operation of their CME Training Site
- Coordinate the calendar for the availability/booking of the Training Site on behalf of the host agency with the EMS Coordinator.
- Ensure asset management and control for all training equipment, mannequins, computers, projectors, and supplies.
- Sign necessary hand receipts for the County's inventory management.
- Maintain or cause to be maintained all training equipment, mannequins, computers, projectors, and supplies. Maintenance updates to be coordinated by the EMS Training Coordinator.
- Inventory and replenish through a supply ordering procedure, any medical supplies needed. This may be delegated to the instructors, but each site coordinator must ensure the Training Site is kept stocked and in working order.
- Comply with inventory inspections annually or as needed.
- Ensure the security of the training equipment and supplies located at each Training Site.

- Report any discrepancies to the County EMS Training Coordinator immediately.

CME Instructors

CME instructors are responsible for the following:

- Ensure proper use of training equipment and report any damaged or missing equipment
- Complete the data entry and/or transmit student rosters by the close of business (or completion of the class) that day and ensure that rosters are legible
- Ensure that all courses are taught in accordance to standards, including Instructor to student ratio
- Report all student issues to the EMS Training Coordinator
- Follow the dress code
    - Instructors may wear their departmental uniform, departmental uniform with County CME Instructor shirt or business casual with County CME Instructor shirt

Exam Security Guidelines

The current written tests and skills tests are the only tests used to determine successful course completion. New testing materials, from the appropriate certification agency, will be implemented whenever necessary to prevent possible compromise of the examination contents.

Instructors shall take precautions to ensure the integrity of final examinations by a certification agency. For these examinations to be valid instruments of measurement, students must not have access to them outside of the classroom environment. Every Instructor, regardless of leading or assisting a class, is always responsible to maintain examination security.

Instructors shall:

- Not give tests as pre-course material to be studied; use the appropriate pre-test
- Not leave tests lying around
- Hard copies of examinations will be stored in the Cyberlock exam box provided at each Training Site or other approved locked location.
- Ensure the most current version of the test is used
- Ensure each student returns his or her test and answer sheet
- Count the tests before and after administering to your students

- Examinations should be duplicated only in the number needed for testing and need to be numbered before being distributed in class. Immediately notify the EMS Training Coordinator of any duplication of testing materials.
- Instructors will check out each numbered hard copy and will check them back in after testing.
- Verify that all tests and answer sheets have been returned.
- Secure copies of any examinations which are no longer to be used in class and notify EMS Training Coordinator.
- Not use or distribute any examination in any way other than for its intended purpose.
- Report any discrepancies regarding exam security to the EMS Training Coordinator immediately.
- Any Instructor found in violation of the exam security guidelines is subject to an Administrative Proceeding following the EMS Rules & Regulations.

Performance Evaluation

The following procedures will be implemented by all Instructors and the EMS Training Coordinator:

- All courses will be conducted according to published standards, such as but not limited to class length, student-to-instructor ratio, student-to equipment ratio, classroom characteristics, audio- visual materials, etc., by the respective certification agency. When one of these variables exceeds the limits as defined by the certification agency, the PCEMS CME Program policy is to adjust one or more of the other variables to account for this (for instance, if there are additional students and the instructor number cannot be increased, the course length must be increased). In these instances, instructors will confirm with the Training Site Coordinator the acceptable accommodations to be made for students.
- Course evaluations will be made available to every student at the end of every class Instructors are not to have students complete the evaluations prior to the end of the class.
- The EMS Training Coordinator, or designee, will review all student evaluations and results of follow-up calls, and after review, will make them available to the instructor.

Student Requirements and Classroom Decorum

Students and Instructors are responsible for the following:

- Arrive at classroom-based training on time and ready to learn.
- Students arriving 15 minutes or more after the scheduled start time will be required to reschedule and attend another class.

AD22 CONTINUING MEDICAL EDUCATION (CME) STUDENT/INSTRUCTOR GUIDELINES

- Classes and courses are designed to last the scheduled time and students are expected to remain for the duration. The scheduled class duration shall be adhered to unless all learning objectives have been met in a shorter period. Classes should rarely run over the allotted time and students shall only be held over if necessary.
- On duty units will be made available for response or move-up assignments if a Condition 3 or greater is declared by Central Dispatch. Cancelled classes will be rescheduled or completed after field operations return to Condition 1 or 2. Off duty classes may continue.
- Be clean, neat, and dressed in a Provider Agency approved uniform or business casual attire.
- Ensure that training is conducted in a positive, engaging, neutral, and professional manner.
- Ensure students actively participate and maintain a professional learning environment.
- Refrain from excessive use of electronic devices during training. Electronic device usage is not allowed during testing.
- Follow all rules at the Training Site including, but not limited to parking and smoking/tobacco use.
- Ensure a high level of professionalism in the interaction between instructors, students, and the public.
- Ensure personal biases are kept outside of the training environment.
- Problems and disagreements must be addressed out of earshot of other students and reported to the EMS Training Coordinator if not resolved.
- Telephone and email communication are held to the same standard as face-to-face and written communication.
- Participate in all lectures, hands-on skill instruction, skill evaluations and complete all necessary evaluation forms, rosters, tests, quizzes or evaluation instruments.
- Demonstrate competency and proficiency for any skills being tested as outlined in the course requirements and ensure a passing score for all written and practical evaluations.
    - Students that are unable to successfully complete any aspect of a course will be subject to a remedial training plan in coordination with their EMS Provider Agency and the EMS Medical Director.
- All students must have the current appropriate course textbook for their individual use before, during, and after the course.
- Each student must have the appropriate textbook with them when required; have completed any required pre- work; and a valid certification card (e.g., ACLS, PHTLS, etc.) for any renewal courses

Maintenance and Cleaning of Training Equipment

All equipment used to train students must be in good working condition and decontaminated appropriately after each use. To ensure the proper working condition of teaching equipment, the following procedures will be implemented as follows:

1. Instructors will check and clean, if necessary, all equipment prior to the start of class to ensure all equipment is working order and is clean and ready for training.
2. If equipment needs maintenance, the instructor will notify the Training Site Coordinator or the EMS Training Coordinator.
3. During class, precautions must be taken to prevent the transmission of pathogens and diseases. Each time a different participant uses the manikin in a class, the use of individual protective equipment shall be utilized.
4. Between participants or after the instructor demonstrates a procedure such as clearing an obstruction from the airway, the manikin face and the inside of the mouth should be wiped vigorously.
5. All parts in contact with the student's exhalations should be replaced and/or decontaminated between each student use.
6. For equipment that is stored at the Training Sites, Instructors are responsible to clean up the classroom and place equipment back on to the equipment carts in the proper place.
7. Site Coordinators will periodically check equipment to ensure that all equipment and parts are present and functional.
8. For Gaumard specific mannequins and trainers:
    - The simulator should be cleaned with a cloth dampened with diluted liquid dish washing soap.
    - If medical adhesives remain on the skin, clean with alcohol wipes. Lacquer thinner works best for removing adhesives
    - ***DO NOT*** use GooGone® or similar products, as the citric acid in the formula will cause pitting of the various materials comprising your simulator.
    - Remove all traces of any lubricant. ***DO NOT*** clean with harsh abrasives. ***DO NOT*** use povidone iodine on the simulator.
    - The simulator is "splash-proof" but not waterproof. Do not submerge or allow water to enter the interior of the simulator.
9. Ensure sanitary practices for the manikins and equipment that are used in the class. Wear protective gloves and eyewear when decontaminating equipment.
10. Return manikins and equipment to their respective cases and store in the CME Training Site cart or storage room.

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AD23 CLINICAL STATUS INQUIRY

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of the information below to my prospective Employer/Agency regarding my Pinellas County EMS Certification.

CLINICIAN NAME	
CLINICIAN SIGNATURE	
DATE	
PREVIOUS OR CURRENT PINELLAS COUNTY EMS ID NUMBER(S)	

REQUESTING AGENCY NAME	
AGENCY REPRESENTATIVE NAME	