



Inland Counties Emergency Medical Agency

Serving San Bernardino, Inyo, and Mono Counties

Tom Lynch, EMS Administrator

Reza Vaezazizi, MD, Medical Director

DATE: September 7, 2016

TO: EMS Providers - ALS, LALS, BLS, EMS Aircraft
Hospital CEOs, ED Directors, Nurse Managers and PLNs
EMS Training Institutions and Continuing Education Providers
Inyo, Mono and San Bernardino County EMCC Members
Medical Advisory Committee (MAC) Members
Systems Advisory Committee (SAC) Members

FROM: Tom Lynch  EMS Administrator
Reza Vaezazizi, MD  Medical Director

SUBJECT: POLICIES/PROTOCOLS FOR 15-DAY COMMENT

The following policies/protocols have been reviewed and revised by ICEMA and are now available for public comment and recommendations.

ICEMA Reference Number and Name

- 2010 - Requirements for Patient Care Records (DELETE)
- 2040 - Requirements for Patient Care Reports (NEW)
- 2050 - Requirements for Submission of EMS Data (NEW)
- 8150 - ICEMA/REMSA Ambulance Patient Offload Delay Policy (NEW)

ICEMA encourages all system participants to submit recommendations, in writing, to ICEMA during the comment period. **Written comments will be accepted until September 22, 2016, at 5:00 pm.** Comments may be sent via hardcopy, faxed to (909) 388-5850 or via e-mail to ron.holk@cao.sbcounty.gov.

TL/RV/jlm

Enclosures

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**POLICIES/PROTOCOLS CHANGES FOR 15-DAY COMMENT PERIOD
SEPTEMBER 7, 2016**

Reference #	Name	Changes
NEW		
2040	Requirements for Patient Care Reports	New ICEMA policy for the initiation, transfer, completion, review and retention of patient care reports.
2050	Requirements for Submission of EMS Data	New ICEMA policy for the submission of EMS data to the ICEMA Data System to comply with State regulations.
8150	ICEMA/REMSA Ambulance Patient Offload Delay Policy	New regional policy for the rapid transfer of patient care from EMS personnel to hospital staff.
1000 ACCREDITATION AND CERTIFICATION		
None		
2000 DATA COLLECTION		
None		
3000 EDUCATION		
None		
4000 QUALITY IMPROVEMENT		
None		
5000 MISCELLANEOUS SYSTEM POLICIES		
None		
6000 SPECIALTY PROGRAM/ PROVIDER POLICIES		
None		
7000 STANDARD DRUG & EQUIPMENT LISTS		
None		
8000 TRANSPORT/TRANSFERS AND DESTINATION POLICIES		
None		
9000 GENERAL PATIENT CARE POLICIES		
None		
10000 SKILLS		
None		
11000 ADULT EMERGENCIES		
None		
12000 END OF LIFE CARE		
None		
13000 ENVIRONMENTAL EMERGENCIES		
None		

**POLICIES/PROTOCOLS CHANGES FOR 15-DAY COMMENT PERIOD
SEPTEMBER 7, 2016**

Reference #	Name	Changes
14000 PEDIATRIC EMERGENCIES		
None		
15000 TRAUMA		
None		
DELETIONS		
2010	Requirements for Patient Care Records	Policy is outdated.
Below are some of the policies/protocols designated for review in the next few months. If there are specific policies/protocols recommended for review, please contact ICEMA.		



REQUIREMENTS FOR PATIENT CARE RECORDS

PURPOSE

To delineate requirements within the ICEMA region regarding the initiation, completion, review and retention of patient care report forms.

AUTHORITY

Title 22, California Administrative Code, Sections 1000168(6) (A-D) and 100085(6) (f).

PRINCIPLE

The patient care report form in the ICEMA region shall be comprised of a narrative patient care report form (ICEMA approved patient care report form or approved electronic Patient Care Report) and an ICEMA approved data collection device. They will be initiated each time an EMS unit is dispatched by an EMS service provider, where the outcome of the call results in patient assessment with or without service or treatment by the EMS provider.

In situations where more than one (1) patient is encountered at the scene of an incident, one (1) set of patient care record forms shall be initiated for each patient.

In the event that two (2) EMS provider agencies arrive on scene at an incident, each EMS provider having actual contact with a patient is responsible for completing a patient care report form and obtain all ICEMA required data containing an incident number and patient identification information and record those assessments, services or treatments delivered by the EMS provider completing that form. Thus, a patient receiving initial BLS level service followed by ALS treatment by another provider agency would have two (2) sets of EMS forms.

RESPONSIBILITIES FOR RECORD COMPLETION

Each set of EMS patient care record forms shall be completed as specified in the 'EMS Run Report Form Completion Instructions', which serves as an extension to this policy. Each EMS patient care provider is responsible for proper completion of patient care records. Additional responsibility for accurate and thorough completion of patient care records lies with the EMS provider agency.

EMS providers who fail to thoroughly complete patient care records according to this policy will be given an opportunity to correct errors and/or omissions, following EMS review of the form as initially submitted.

In the event that addition(s) are required to a narrative patient care record form after submission of that form to the receiving hospital, a separate, new narrative patient care record form must be completed in full with one (1) copy forwarded to the receiving hospital and one (1) copy to EMS. Correction(s) to a Scantron form are to be made on the original Data Sheet whenever possible, and corrected Data Sheets sent to EMS in batches clearly marked as "corrections".

RESPONSIBILITIES FOR RECORD RETENTION

Requirements

1. All records related to either suspected or pending litigation shall be held for an indefinite period of time.
2. The patient care records of all patients other than un-emancipated minors shall be retained by the respective agencies for a minimum of seven (7) years.
3. The records of un-emancipated minors shall be kept for at least one (1) year after such minors have reached the age of 18, but in no event less than seven (7) years following the provision of service to the minor.
4. All receiving hospital copies of the patient care record form shall accompany the patient to the receiving hospital and be retained by the receiving hospital for a minimum of one (1) year in the patient's medical record.
5. The EMS service provider agency shall be responsible for retention of the provider copy of the patient care record form.

Types of Records for Retention

1. The Base Hospital information form for each Base Hospital advanced life support radio contact.
2. Labeled tapes (not transcriptions) or other type hard copies of communications between advanced life support personnel and the Base Hospital physician and/or MICN.
3. Chronological log of each Base Hospital advanced life support radio contact.
4. Patient care records.

RESPONSIBILITIES FOR RECORD REVIEW AND EVALUATION

ICEMA may request a copy of any completed patient care record form. Responsibility for timely submission of requested forms lies with the EMS service provider agency.

Designated ICEMA staff shall be responsible for reviewing all completed patient care record forms submitted to ICEMA. Such review shall include, but not be limited to, procedures to determine the completeness of forms, methods to collect data recorded on the EMS copies of forms, and processing to produce statistical and quality assurance summary reports.

Evaluation of statistical summary reports shall be the responsibility of the ICEMA Executive Director. Evaluation of medical quality assurance summary reports shall be the responsibility of the ICEMA Medical Director. Copies of statistical summary and QA summary reports will be provided to provider agencies upon request.

DELETED



REQUIREMENTS FOR PATIENT CARE REPORTS

I. PURPOSE

To establish requirements for the initiation, transfer, completion, review and retention of patient care reports by EMS providers that is necessary to maintain medical control and continuity of patient care.

II. RESPONSIBILITIES FOR INITIATION, TRANSFER, COMPLETION AND REVIEW OF PATIENT CARE REPORTS

Initiation of Patient Care Report

- An electronic patient care report (ePCR) must be a complete and thorough representation of all patient care provided. The report shall contain all information accumulated as a result of the patient contact that is necessary to document patient assessment and care.
- The ICEMA ePCR is the only approved report for documenting patient care by EMS field personnel (AEMTs, EMTs, EMT-Ps, MICNs and RCPs) working in the ICEMA region.
 - EMS providers who elect to utilize another electronic health record (EHR) system must comply with ICEMA Reference #2050 - Requirements for Submission of EMS Data.
 - The initiation and completion of the ePCR is the responsibility of the EMS field personnel who participate in patient care.
- The ePCR must be initiated for each EMS response by:
 - All units dispatched.
 - All units canceled en route or on scene.
 - All ambulance assists.
- EMS field personnel must initiate an ePCR for all patients whenever:
 - EMS field personnel make contact with a patient.
 - The outcome of the response results in a patient assessment.
 - Medical service and/or treatment is rendered.
 - Any patient that refuses care, or is deceased on scene.
 - More than one (1) patient is encountered at the scene of an incident, an ePCR shall be initiated for each patient.
 - Two (2) or more different EMS providers arrive on scene, at least one (1) EMS field personnel for each EMS provider is responsible for completing an ePCR.

- In a multiple casualty incident (MCI):
 - The ePCR must include all care provided to patients by the EMS field personnel that provided the care.
 - A triage tag or ribbon does not preclude any requirement for initiating an ePCR for each patient.
- EMS field personnel must obtain and document all required ICEMA data elements, including all assessments, procedures and medications administered and provided by the EMS field personnel completing the report.
- EMS field personnel shall only document procedures and treatments performed by members of their own crew.
 - EMS providers must add student and/or intern names and certification to its user list so all EMS field personnel rendering care are appropriately identified on the ePCR.
- The use of an approved paper patient care report is only permitted as a “downtime” form when the ePCR input form or hardware is not functioning at the time.
 - The approved downtime form should only be used for intermittent hardware failures.
 - All data collected on a paper patient care report must be transferred to the approved ePCR. An ePCR shall be completed after the system is restored and a scanned copy of the paper patient care report included as an attachment.
- Willful omission, misuse, tampering or falsification of documentation of patient care reports is cause for formal investigative action under the California Health and Safety Code, Section 1798.200.
- The ePCR must be signed by EMS field personnel from each EMS provider of care initiating a report.

Transfer and Distribution of Patient Care Reports

The ICEMA Data System is the preferred method of transfer of all patient care information between EMS field personnel, EMS providers, hospitals and ICEMA. This system ensures the transition of patient care by maintaining medical control, establishing specialty center inclusion criteria, directing treatment by subsequent healthcare providers and facilitating continuous quality improvement.

- EMS field personnel must complete the minimum documentation, including all assessments, medications and procedures, as described in ICEMA Reference #2030 - Minimum Documentation Requirements for Transfer of Care prior to the transfer of care.
- EMS field personnel must transfer all required information to the accepting EMS field personnel simultaneously with the verbal transfer of care by “posting” the ePCR to the ICEMA Data System or through the simultaneous transfer of data to the ICEMA Data System from the EMS provider’s data system.
 - In situations where the transfer of data is not possible due to connectivity issues, the transfer must be made at the earliest opportunity when connectivity is restored.
- All EMS field personnel, accepting the patient, must download the transfer through access to the ICEMA Data System to initiate the unified patient report process.
- EMS field personnel must provide the most current copy of the patient care report and all attachments to the base and receiving hospitals, at the time of transfer of care. This may be achieved after “posting” to the ICEMA Hospital Hub or by direct access to the EMS provider’s data system by the ICEMA Hospital Hub.
- EMS field personnel must make a copy of the patient care report available to the County Coroner if the patient is deceased and left on scene. This may be achieved by selecting the Coroner as the destination on the ePCR after posting to the ICEMA Hospital Hub or by direct access to the EMS provider’s data system by the ICEMA Hospital Hub.

Completion of Patient Care Reports

- The ePCR must be completed and locked within four (4) hours of the initiation of the ePCR.
- Changes to completed ePCRs require an addendum showing all changes to the initial ePCR. The ePCR may not be unlocked to make any changes.
- EMS providers who elect to utilize another EHR system must provide a copy of all documents generated including the transaction history or audit of all changes made to the record at the field level, including prior and current values upon request by ICEMA.

Review and Correction of Patient Care Reports

- The EMS provider is responsible to ensure that its EMS field personnel thoroughly document all ICEMA required data elements.
- EMS field personnel who fail to thoroughly complete the ePCR according to this policy will be given an opportunity to correct errors and/or omissions on the ePCR as initially submitted.

III. RESPONSIBILITIES FOR REPORT REVIEW AND EVALUATION

- ICEMA may view or request a copy of any completed ePCR for quality assurance and/or quality improvement. Responsibility for timely submission of requested information lies with the EMS provider.
- ICEMA may periodically review any completed ePCR(s) necessary for potential disciplinary review.
- The EMS provider and/or hospital must provide all documentation including recordings and/or paper patient care reports, not previously posted to the ICEMA Data System, within 24 hours of the request.
- The EMS provider is responsible for reviewing all completed ePCRs to determine accuracy, completeness and validity of data submitted.
- ICEMA may produce system-wide statistical and quality improvement summary reports based on individual or aggregate data.
- Evaluation of individual statistical or quality assurance summary reports shall be the responsibility of the EMS provider and field personnel.

IV. RESPONSIBILITIES FOR RECORD/REPORT RETENTION

- All records pertaining to patient care must be maintained by the EMS provider, hospital, and/or ICEMA as required by State and/or federal regulation. Types of records to be retained include (but are not limited to):
 - Records related to either suspected or pending litigation
 - Electronic Patient Care Report (ePCR)
 - Electrocardiograms (EKG/ECG)
 - Capnography waveforms
 - EMS Provider refusal of care documentation
- All ePCRs created on the ICEMA Data System will be retained as required by San Bernardino County policy or State and/or federal regulation.

- EMS providers who elect to utilize another EHR system must retain a copy of the ePCR created on their system and other records as required by State and/or federal regulation.
- The EMS provider shall be responsible for retention of all copies of downtime paper patient care reports or other records as required by State and/or federal regulation.

V. PRIVACY

All EMS providers are responsible to enact policies which ensure patient privacy by restricting access and implementing electronic protections in compliance with State and federal statutes, policies, rules and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), California Civil Code, Section 56.36; Division 109; Section 130200 and California Health and Safety Code, Sections 1280.1, 1280.15 and 1280.3.

IV. REFERENCE

<u>Number</u>	<u>Name</u>
2030	Minimum Documentation Requirements for Transfer of Care
2050	Requirements for Submission of EMS Data



REQUIREMENTS FOR SUBMISSION OF EMS DATA

I. PURPOSE

To establish requirements for the collection and submission of data to the ICEMA Data System by EMS providers and dispatch centers in the ICEMA region as required by State regulations and ICEMA policy.

II. POLICY

The ICEMA Data System is the only authorized system for the collection and submission of EMS data in the ICEMA region. EMS providers using another Electronic Health Record (EHR) systems must submit data to the ICEMA Data System in real-time in order to maintain medical control and ensure the continuity of patient care within the ICEMA region.

III. RESPONSIBILITIES OF EMS PROVIDERS

- EMS providers must utilize an EHR system that:
 - Exports data in a format to the ICEMA Data System that is compliant with the current version of the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information system (NEMSIS) standards.
 - Includes all additional data elements required by ICEMA including field values and information required to identify the EMS field personnel (name, identification number, etc.).
 - Includes all attachments that documents patient care, such as ECGs, capnography waveforms and PDF copies of the electronic patient care report (ePCR).
 - Contain provisions for the electronic transfer of the patient care reports between public and private EMS providers and hospitals.

- EMS providers using its own EHR system are responsible to:
 - Setup and configure new providers and maintain a current record of all employees, stations, and vehicles on the ICEMA Data System.
 - Notify ICEMA of any system outages in excess of five (5) minutes. Notification must be made by emailing the ICEMA duty officer.

- Use an EHR system that exports data in real-time and in a format that is compliant with the current versions of the CEMSIS and NEMSIS standards.
 - EMS providers must use the same version of CEMSIS and NEMSIS as that used by ICEMA.
 - EMS providers must coordinate any updates to the current versions of CEMSIS and NEMSIS when implemented by ICEMA to coincide with the upgrade implementation date.
- Include all required ICEMA validation rules.
- Ensure that its EMS field personnel do not document procedures and/or treatments performed and documented by other EMS field personnel within its organization.
- Ensure that its EMS field personnel do not document procedures and/or treatments performed by EMS field personnel from another EMS provider.
- When requested by ICEMA, make all changes to incomplete or incorrect ePCRs within 24 hours of notification and resubmit to ICEMA.
- Use an EHR system that includes all ICEMA approved data elements and field values in collecting data.
- EMS providers using its own EHR system must submit a screen shot of all proposed input forms to ICEMA for approval at least 90 days prior to implementation. All changes to an approved input form(s) must be submitted at least 10 days prior to implementation for approval.
 - Screen shots must include all field titles and corresponding NEMSIS data element numbers/names and field values.
 - All data elements or field values with defaulted, auto-computed or auto-filled values must be described and highlighted.
- EMS providers using its own EHR system must provide ICEMA with a detailed list of all:
 - All data elements and field values currently active in the EMS Provider's Data System.
 - Documentation must show relationship between data elements and field values in the provider's system with those on the ICEMA Data System.
 - Validation rules implemented on the EMS Provider's data system.

- EMS providers using its own EHR system must submit an ePCR paper output form (printed document) for the transfer of patient care to ICEMA for approval at least 90 days prior to implementation that includes:
 - All elements shown on the current ICEMA ePCR output form.
 - Highlight all fields on EMS provider's printed form that are equal to those on the ICEMA form.
 - All supplementary documentation and field assessment detail, such as capnography waveforms and ECGs.
- EMS providers using its own EHR system and its vendor(s) must guarantee that all ICEMA approved data elements and field values are included in the datasets submitted to the ICEMA Data System and:
 - Ensure that data element numbers match those in the ICEMA Data System.
 - Provide a detailed report from the EMS Provider's data system for all data elements and values showing element descriptions/IDs, and provide a detailed document demonstrating the process used to verify values with those in the ICEMA Data System.
 - Guarantee the accuracy and validity of all submitted data and guarantee real-time integration with the ICEMA Data System.
 - Include any changes in the ICEMA required data values in its datasets within 24 hours of notification.
 - Maintain ability to integrate real-time data with the ICEMA Data System within 24 hours of a change in ICEMA required data elements and/or field values. (All non-emergency changes will be made between Monday and Wednesday.)
 - Guarantee that any changes in the ICEMA required data elements are implemented in the EMS provider's input/output forms within 24 hours of notification.
 - Ensure that all ICEMA required data elements and field values are included in the EMS provider's input/output form.
- EMS providers using its own EHR system and its vendors must maintain a system that:
 - Ensures all data is submitted to the ICEMA Data System automatically and simultaneously with transfer of patient care to a subsequent EMS provider and hospital.
 - Ensures all data is submitted to the ICEMA Data System at the conclusion of each call.
 - Resubmits all records, if opened and changed for any reason, at the time of the next scheduled submission of data.

- EMS providers using its own EHR system and its vendor(s) must demonstrate, test, and ensure that its data system is compatible with the ICEMA Data System and:
 - Develop and implement processes to demonstrate, test, and ensure that any changes in its datasets are compatible with the ICEMA Data System.
 - Is responsible for all associated costs to demonstrate, test, and or validate the integration of data with the ICEMA Data System.
 - Must submit a document that includes mapping of all EMS provider's data elements and ICEMA data elements to ICEMA for approval at least 90 days prior to implementation of the EMS provider's data system.
 - Mapping that is equal between systems must be noted.
- EMS providers using its own EHR system and its vendor(s) are responsible for ensuring that all data submitted to the state or national data repositories, via the ICEMA Data System, meet minimum validation rules for inclusion.
 - EMS providers whose data is not accepted by the state or national data repositories will be excluded from further data submissions until the EMS provider can demonstrate that they are compliant with CEMISIS and/or NEMISIS standards or as required by state and/or federal regulations.
- Data submitted by EMS providers who are using its own EHR system will not be used or included:
 - In ICEMA system and EMS provider reports.
 - In ICEMA EMS Health Information Exchange or other projects designed to facilitate the exchange of health information.
 - In Unified Care Reports with EMS providers on the ICEMA Data System.
 - On the ICEMA hospital dashboard unless provisions are made for direct access to the EMS provider's data system.
 - On the ICEMA Coroner dashboard unless provisions are made for direct access to the provider's data system.
- EMS providers shall reimburse ICEMA or other associated San Bernardino County departments for:
 - All costs associated with the integration of the EMS provider's data and/or review of its mapping schemas necessary for integration with the ICEMA Data System.

- All costs necessary to monitor or verify the demonstration, testing, and/or validation of the integration of data elements and field values into the ICEMA Data System.
- All costs for processes necessary to ensure continuity of patient care, including but not limited to:
 - Transfer of care between EMS providers and hospitals in real time.
 - Integration of documents related to the inclusion criteria for STEMI, Stroke, and/or Trauma patients.
 - Integration of patient care information in the ICEMA specialty care registries.
- All costs necessary for the processing of data or the submission of data required for state or federal data reporting.

IV. RESPONSIBILITIES OF COMPUTER AIDED DISPATCH (CAD) CENTERS

- All dispatch centers (or its contractors) shall submit computer aided dispatch data to ICEMA in an electronic format that is acceptable to ICEMA which shall:
 - Be submitted in real-time or within five (5) minutes of the initiation of the call.
 - Include records for all emergency and non-emergency ambulance or medical aid requests.
 - Be submitted in a format that is compatible with the ICEMA Data System.
- Each computer dispatch record submitted to ICEMA shall contain the data elements as described in the current NEMSIS CAD Data Standard (currently NEMSIS v 3.4.0)



ICEMA/REMSA AMBULANCE PATIENT OFFLOAD DELAY POLICY

I. PURPOSE

To establish policy for the safe and rapid transfer of patient care responsibilities between Emergency Medical Services (EMS) personnel and emergency department (ED) medical personnel.

II. CONSIDERATIONS

Delays in the transfer of patient care and offloading of patients delivered to designated receiving hospitals by EMS ambulance adversely affects patient care, safety and the availability of ambulances for emergency responses throughout Riverside and San Bernardino counties. It is incumbent upon receiving hospitals and ambulance providers to minimize the time required to transfer patient care and return ambulances to service to ensure optimal patient care, safety and EMS system integrity.

III. DEFINITIONS

Ambulance Arrival at ED - The time the ambulance stops (actual wheel stop) at the location outside the hospital ED where the patient is unloaded from the ambulance.

Ambulance Patient Offload Time (APOT) - The interval between the arrival of an ambulance patient at an ED and the time that the patient is transferred to an ED gurney, bed, chair or other acceptable location and the ED assumes responsibility for care of the patient.ⁱ

Ambulance Patient Offload Time (APOT-1) Standard - Ambulance patient offload time (APOT-1) of 25 minutes or less in San Bernardino County or 30 minutes or less in Riverside County (25/30).

Ambulance Patient Offload Delay (APOD) - Any delay in ambulance patient offload time (APOT) that exceeds the local ambulance patient offload time standard of 25/30 minutes. This shall also be synonymous with “non-standard patient offload time” as referenced in the Health and Safety Code.ⁱⁱ

Designated Receiving Hospital - A hospital that has been designated by the EMS Agency to receive EMS patients transported by ambulance.

Emergency Department (ED) Medical Personnel - An ED physician, mid-level practitioner (e.g., Physician Assistant, Nurse Practitioner) or Registered Nurse (RN).

EMS Personnel - EMTs, AEMTs, EMT-II and/or EMT-Ps responsible for out of hospital patient care and transport consistent with the scope of practice as authorized by their level of credentialing.

Medical Triage - Medical sorting and prioritization of a patient by ED medical personnel. Medical triage includes acceptance of a verbal patient report from EMS personnel.

Transfer of Patient Care - The orderly transition of patient care duties from EMS personnel to receiving hospital ED medical personnel.

Unusual Event - An incident that significantly impacts or threatens public health, environmental health or emergency medical services.ⁱⁱⁱ

Verbal Patient Report - The face-to-face or two-way radio verbal exchange of key patient information between EMS personnel and ED medical personnel.

Written EMS Report - The written report supplied to ED medical personnel (either through the electronic patient care record (ePCR), or actual written report (if ePCR is not available) that details patient assessment and care that was provided by EMS personnel.

IV. DIRECTION OF EMS PERSONNEL

EMS personnel have a responsibility to continue to provide and document patient care including advanced life support (ALS) by paramedics (EMT-Ps) prior to the transfer of patient care to the designated receiving hospital ED medical personnel. Medical control and management of the EMS system, including EMS personnel, remain the responsibility of the EMS agency medical director and all care provided to the patient must be pursuant to the respective Riverside EMS Agency (REMSA) and the Inland Counties Emergency Medical Agency (ICEMA) treatment protocols and policies.^{iv}

V. PATIENT CARE RESPONSIBILITY

The responsibility for patient care belongs to the designated receiving hospital once the patient arrives on hospital grounds.^v Designated receiving hospitals should implement processes for ED medical personnel to immediately triage and provide the appropriate emergency medical care for ill or injured patients upon arrival at the ED by ambulance.

VI. TRANSFER OF PATIENT CARE

Patients Under Care of EMS Personnel

Upon arrival of a patient at the hospital by ambulance the ED medical personnel should make every attempt to medically triage the patient and offload the patient to a hospital bed or other suitable sitting or reclining device at the earliest possible time not to exceed 25/30 minutes. During triage by ED medical personnel, EMS personnel will

provide a verbal patient report containing any pertinent information necessary for the ongoing care of the patient. Transfer of patient care is completed once the ED medical staff has completed medical triage of the patient. If the transfer of care and patient offloading from the ambulance gurney exceeds the 25/30 minute standard, it will be documented and tracked as APOD.

The transporting EMS personnel are not responsible to continue monitoring the patient or provide care within the hospital setting after transfer of patient care to ED medical personnel has occurred.^{vi}

EMS personnel are responsible for immediately returning to response ready status once patient care has been transferred to ED medical personnel and the patient has been offloaded from the ambulance gurney.

VII. APOD MITIGATION PROCEDURES

Designated receiving hospitals have a responsibility to ensure policies and processes are in place that facilitates the rapid and appropriate transfer of patient care from EMS personnel to the ED medical personnel within 25/30 minutes of arrival at the ED. ED medical personnel should consider the following to prevent APOD:

- Immediately acknowledge the arrival of each patient transported by EMS;
- Accept a verbal patient report from EMS personnel. This may be accomplished by face-to-face or by two way radio communication; and
- Triage patients transported by ambulance within 25/30 minutes of arrival in the ED; and
- Transfer patient to the hospital gurney, bed, chair, wheelchair or waiting room as appropriate for patient condition within 25/30 minutes of arrival at the hospital ED.

If APOD does occur, the hospital should make every attempt to:

- Provide a safe area in the ED within direct sight of ED medical personnel where the ambulance crew can temporarily wait while the hospital's patient remains on the ambulance gurney.
- Inform the attending paramedic or EMT of the anticipated time for the offload of the patient.
- Provide information to the supervisor of the EMS personnel regarding the steps that are being taken by the hospital to resolve APOD.

Hospitals will provide details to REMSA, ICEMA and EMS providers of the following related to APOD mitigation and communication:

- Processes for the immediate notification of the following hospital staff through their internal escalation process of the occurrence of APOD:
 - ED/Attending Physician
 - ED Nurse Manager/Director or Designee (i.e., Charge Nurse)
 - House Supervisor
 - Administrator on call
- Processes to alert the following affected partners via ReddiNet when a condition exists that effects the timely offload of ambulance patients:
 - Local receiving hospitals/base hospitals
 - Fire department and ambulance dispatch centers
- Processes for ED medical personnel to immediately respond to and provide care for the patient if the attending EMS personnel alert the ED medical personnel of a decline in the condition of a patient being temporarily held on the ambulance gurney.

EMS personnel are directed to do the following to prevent APOD:

- Provide the receiving hospital ED with the earliest possible notification via two-way radio that a patient is being transported to their facility.
- Utilizing the appropriate safety precautions, walk-in ambulatory patients or use a wheelchair rather than an ambulance gurney if appropriate for the patient's condition.
- Provide a verbal patient report to the ED medical personnel within 25/30 minutes of arrival to the ED.
- Contact the EMS supervisor for direction if the ED medical personnel do not offload the patient within the 25/30 minute local ambulance patient offload time standard.
- Complete the respective ICEMA/REMSA required authorized patient care documentation.
- Work cooperatively with the receiving hospital staff to transition patient care within the timeframes established in this policy.

VIII. CONTENT AND FORMATTING OF THE VERBAL PATIENT REPORT

The verbal patient report may be provided by face-to-face or two-way radio communication utilizing the SBAR format. The verbal patient report will include the following elements:

Situation

- Patient age, sex, weight
- Patient condition (mild, moderate or severe)
- Patient chief complaint

Background

- Mechanism of injury or history of present illness
- Assessment findings
 - Responsiveness/Glasgow Coma Scale (GCS)
 - Airway
 - Breathing
 - Circulation
 - Disability
- Vital Signs
- Past medical history, medications and allergies

Assessment

- Primary impression

Recommendations

- Treatment/interventions provided
- Patient response to treatment/interventions
- Request for orders (If it is a medical direction call)

IX. CLINICAL PRACTICES FOR EMS PERSONNEL TO REDUCE APOD

The EMS personnel shall utilize sound clinical judgment and follow the appropriate ICEMA/REMSA policies and treatment protocols including:

- Initiate care as clinically indicated with the appropriate basic life support (BLS) and advanced life support (ALS) interventions.
- Initiate vascular access only as clinically indicated. IV therapy should only be initiated pursuant to ICEMA/REMSA treatment protocols for patients that require the following:
 - a. Administration of IV medication(s), or
 - b. Administration of IV fluid bolus or fluid resuscitation.

- In the judgement of the attending paramedic the patient's condition could worsen and either (a) or (b) noted above may become necessary prior to arrival at the receiving hospital ED.
- Discontinue ECG monitoring before removing the patient from the ambulance if there are no clinical indications for cardiac monitoring.

X. APOD UNUSUAL EVENTS

The proliferation of APOD that leads to the lack of sufficient ambulances to respond to emergencies are considered APOD Unusual Events. These events threaten public health and safety by preventing EMS response to emergency medical incidents. To mitigate the effects of these APOD Unusual Events the following are hereby established:

- Criteria for an APOD Unusual Event:
 - APOD exceeding 25/30 minutes is occurring, and;
 - The ambulance provider identifies and documents low EMS system ambulance availability due to APOD

APOD Unusual Event Procedures

- EMS personnel are authorized to inform ED medical personnel that they are transitioning patient care and immediately offloading a patient on APOD to a hospital bed or other suitable hospital sitting or reclining device as appropriate for patient condition provided the patient meets the following criteria:
 - Stable vital signs
 - Alert and oriented
 - No ALS interventions in place
 - Is not on a Welfare and Institutions Code (WIC) 5150 hold
- EMS personnel shall make every attempt to notify ED medical personnel that they must immediately return to service.
- EMS personnel may use the written EMS report for transfer of care if ED medical personnel are unavailable to take a verbal report and then post ePCR to hospital dashboard.
- In the event of a major emergency that requires immediate availability of ambulances, the Riverside or San Bernardino County Medical Health Operational Area Coordinator may give direction to EMS personnel to

immediately transfer patient care to ED medical personnel and return to service to support the EMS system resource needs.

ⁱ California Health and Safety Code, Division 2.5, Chapter 3, Section 1797.120(b)

ⁱⁱ California Health and Safety Code, Division 2.5, Chapter 4, Section 1797.225(c)(1)

ⁱⁱⁱ California Public Health and Medical Emergency Operations Manual, 2011

^{iv} California Health and Safety Code, Division 2.5, Chapter 5, 1798.0 - 1798.6

^v Emergency Medical Treatment and Active Labor Act (EMTALA), 42 US Code of Federal Regulations

^{vi} California Code of Regulations, Title 22, Chapter 4, 100146

ATTACHMENT A

HOSPITAL BEST PRACTICES FOR AVOIDING APOD

Hospitals should consider implementing policies to reduce patient offload times. The following strategies have been shown to reduce APOD and should be considered: ^{vi}

- ED Intake strategies
 - Bedside registration
 - Orders from triage
 - Direct to bed policies
 - Mid-level provider or physician at triage
 - Greeter/patient liaison
- ED throughput strategies
 - Effective ordering of lab and imaging
 - Innovating staffing utilization
 - Code alert for ED overcrowding
- ED output strategies
 - Accelerated inpatient intake practices
 - Discharge accelerator
 - Use of Clinical Decision Unit (CDU)
 - Discharge instructions upon arrival
- Hospital Inpatient bed availability strategies
 - Standardized discharge process
 - Rapid Admission Unit (RAU)
 - Bed turnover process
 - Universal telemetry
 - Standardized ICU step down bed management

Other strategies to reduce APOD:

- Bedside registration or assigning a bed prior to arrival of patient.
- Streamlining the triage process.
- Bed assignment on patient arrival.

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- Zero allowance for APOD time by EMS agency and hospital.
 - Once a bed for an admitted patient is identified, floor/unit has thirty (30) minutes to retrieve patient, if not, department head is called.
 - Standardize discharge program including earlier patient rounds and discharge.
 - Consider holding areas for patients and those who are awaiting tests or delayed procedures.
 - Assign patient to specific hospital medical staff prior to placement in a bed may create patient ownership.
 - Redesign hospital documentation to improve ease of entry and flow. Facilitate bedside lab tests (blood, urine).

^{vi} Toolkit to Reduce Ambulance Patient Offload Delays in the Emergency Department, CHA, Aug 2014