



BRIDGEPORT HOSPITAL

EMERGENCY MEDICAL SERVICES

MILFORD MEDICAL CONTROL POLICY MANUAL 2026

DISCLAIMER

This policy manual was designed and written by Medical Control and is designed to be used in conjunction with individual service policies and procedures. EMS Providers are still required to follow all local service policies and procedures, notwithstanding this document.

BRIDGEPORT HOSPITAL MILFORD MEDICAL CONTROL POLICY

This policy manual is a "living document" developed and drafted by Bridgeport Hospital – Milford Medical Control (formerly Milford Sponsor Hospital) in conjunction with the agencies it sponsors for Medical Control. At the discretion, of medical control, the manual can be edited and updated at any time. However, the policy manual is formally reviewed, edited, and released every two years. This document may not be amended or altered; however, it may be reproduced and distributed without permission.

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GENERAL OPERATING GUIDELINES

PURPOSE: The purpose of this document is to guide specific Bridgeport Hospital – Milford Medical Control policies and procedures.

DISCUSSION: The goal of prehospital emergency medical services is to administer care to the ill and injured while safely transporting patients to appropriate definitive care. Optimal patient outcomes result from a combination of thorough patient assessment, sound prehospital emergency medical services, and appropriate medical consultation, as needed. The following policies are to be used by EMS providers authorized to practice in the Bridgeport Hospital – Milford Medical Control catchment area to ensure consistent and quality medical care and establish standards by which prehospital emergency care may be audited for quality improvement.

POLICY:

- All patients will be treated with dignity and respect.
- Anyone requesting EMS services will be offered a professional evaluation, treatment, and transportation regardless of the patient's problem or condition.
- All EMS providers will adhere to the most current version of the Connecticut Statewide EMS Protocols and treatment modalities that are Bridgeport Hospital – Milford Medical Control and EMS agency-specific.
- It is the responsibility of the EMS providers to be thoroughly familiar with all devices and therapies authorized for use in the Statewide EMS protocols and those specific to the Milford region.
- All treatment and diagnostic monitoring during transport must be continued during the transfer from the ambulance into the Emergency Department.
- Direct medical oversight is an option at any time during the patient encounter.
- No provider shall deviate from policies or protocols without direct medical oversight (DMO).
- If a protocol deviation is authorized via direct medical oversight, an exception form must be completed and returned to the receiving hospital's EMS coordinator.
- Physician-obtained orders that seem inappropriate or outside the EMS provider's scope of practice must be documented, and the EMS Coordinator at the receiving facility must be notified. The Paramedic has the right to refuse to implement orders or procedures outside of the protocol, inappropriate for the patient's condition, or outside the Paramedic's training level.

SECTION ONE: MEDICAL CONTROL

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MILFORD MEDICAL CONTROL AUTHORIZATION

PURPOSE:

- To provide a structured program for EMS providers to obtain, maintain and renew clinical authorization to practice as EMS providers in the Bridgeport Hospital Milford Medical Control Region.
- To educate candidates for authorization on MMC policies, procedures, and protocols.
- To accurately document personnel credentials.

INITIAL AUTHORIZATION FOR PARAMEDIC PROVIDERS

Any EMS agencies interested in hiring a paramedic level provider should express their interest, in writing, to the hospital EMS Coordinator before the candidate contacting the EMS Coordinator for testing.

The prospective hire is required to submit a completed application for medical control to the EMS Coordinator with supporting documentation, including but not limited to:

- Proof of employment with a designated EMS service provider sponsored by Milford Medical Control Authorized Agency.
- Current and unencumbered paramedic licensure.
- A letter from the primary or immediately previous sponsoring hospital verifying the applicant's status as a clinician at the paramedic level.
- Current American Heart Association ACLS, PALS, and BLS Healthcare Provider CPR cards.
- Current PHTLS or ITLS card.

The application must be submitted before scheduling the initial protocol test.

Providers who have been convicted of a crime or have had any action taken against them (censure, discipline, dismissal, termination, consent order, etc.) from any governmental agency, professional organization, sponsor hospital, or employer must provide a detailed account if requested.

- MMC has the right to refuse medical control to any applicant based on a background check.

After a full review and verification, the medical control process may begin.

The Medical Director may withhold authorization from a MIC-level EMS provider or service as per section 10a-179-15(b) of State Regulations.

INITIAL AUTHORIZATION FOR EMT PROVIDERS

- Maintain CT OEMS EMT Certification
- Maintain active American Heart Association (AHA) BLS Card
- Precepting policy approved by the service provider and MMC.
- Pass the MMC EMT protocol exam which may be given by authorized sponsored agencies.

PARAMEDIC PRECEPTING PROCESS

Note: Medical control is agency specific. A provider must submit a separate application for each service for which he or she works.

Providers who have been convicted of a crime or have had any legal action taken against them (censure, discipline, dismissal, termination, consent order, etc.) from any governmental agency, professional organization, sponsor hospital, or employer must provide a detailed account if requested.

Milford Medical Control has the right to refuse medical control to any applicant based on a background check. After an application review and verification, the medical control process may begin.

The candidate must complete the protocol exam with a score of 75% or higher. The protocol test is based on the most current version of the CT Statewide Protocols, MMC formulary, and basic paramedic knowledge. The precepting process must begin within three months after the completion, or a second test will be required.

Candidates failing to pass the protocol exam may retest based on the following schedule:

- 1st attempt: The candidate may retest after seven calendar days.
- 2nd attempt: The candidate may retest after fourteen calendar days.
- 3rd attempt: The candidate may re-apply for medical control authorization and retest after ninety days.
- Each additional failure will require a ninety-day waiting period for retests.

Once the candidate has completed the protocol exam, a medical control interview will be scheduled with the EMS Coordinators and/or the Medical Director.

- A National Registry oral station-type scenario and a mega code are typically offered, along with an ECG review.
- In most cases, the interview process will be held within thirty days of completing the protocol exam.
- Candidates failing to pass the medical control interview may reinterview based on the following schedule:
 - 1st attempt: The candidate may reinterview after 14 calendar days.
 - 2nd attempt: Requires agency approval and continued sponsorship.
 - All other attempts: Require a 90-day waiting period between interviews.
 - If a fourth attempt is needed, it must be after six months from the original interview date.
 - A service representative is encouraged to attend the interview process.

After successfully passing the protocol exam and medical control interview, the candidate will be granted permission to begin the precepting process according to the policies and procedures at the sponsoring EMS agency. [Candidates are responsible for understanding all MMC policies and procedures.](#)

- Precepting must begin within three months of successful completion of the protocol exam and interview process.
- The precepting process must be completed within six months of passing the interview process.
- Failure to complete the process within the allotted time may result in the candidate having to begin the process over with the protocol test.

Applicants will complete a field mentorship program based on the following criteria:

- Paramedics with any current YNHHS Medical Control- Clearance Ride only (skip steps 1-3)
- Graduate Paramedics - A minimum of thirty-Five (35) ALS patient contacts with fifteen (15) interventions.
- Paramedics with current non-YNHHS CT medical control- Five (5) ALS patient contacts, additional requirements may be required based on provider experience as determined EMS coordinator.
- Paramedics coming from Out of State-process based on experience determine by the EMS Coordinator
- Paramedics returning to clinical practice after a period greater than 12 months & not to exceed 24 months - A minimum of ten (10) ALS patient contacts and five (5) interventions; or as determined by the EMS Medical Control Officer/Coordinator.
- Paramedics returning to clinical practice after a period exceeding 24 Months - A minimum of twenty (20) ALS patient contacts with ten (10) interventions. These may be adjusted to a higher contact volume based on the time-lapse from active practice to application; or as determined by the EMS Medical Control Officer/Coordinator.
- A National Registry oral station-type scenario and a mega code are typically offered, along with an ECG review.
- The interview process will be held within thirty days of the successful completion of the protocol exam, in most cases.
- Should a candidate fail to pass the interview process, candidates may request a second interview fourteen days after the initial interview, with service approval for all future interviews.
- Should a third attempt be needed, the candidate must wait ninety days.
- If a fourth attempt is needed, it must be after six months from the original interview date.
- A service representative is encouraged to attend the interview process.

Only approved Field Training Officers or Paramedic Field Instructors who have completed an approved training course and approved by Medical Control will be allowed to train paramedics.

Field Training Officers and PFI's must be in good standing with medical control and not under current action from medical control.

- Graduate paramedics requesting initial medical control must have the ability to run 911 calls at the sponsoring agency or designated alternative agency.
- Precepting must begin within three months of the successful completion of the protocol exam and interview process. An extension may be considered and granted on a case-by-case basis.
- The precepting process must be completed within six months of passing the interview process unless the EMS Coordinator grants an extension.
- Failure to complete the process within the allotted time will result in the candidate having to begin the process over with the protocol test.
- To constitute an ALS call, routine paramedic care, as defined in the most current version of the CT Statewide protocols, must be performed. An intervention is defined as follows:
 - Any medication administration beyond BLS medications, electrical therapy (cardioversion, defibrillation, TCP), or placement of an advanced airway (including supraglottic or retroglottic airways).
 - Chest needle decompression.
 - Intraosseous (IO) placement.
 - Only two interventions of different types will be counted per call regardless of the total number of interventions performed.
 - A medication may be counted three times as an intervention for a specific complaint during the precepting process. Example: Nitroglycerin for chest pain or CHF can each be counted three times on different calls.
 - A variety of patient encounters are required to obtain medical control successfully.
- The new paramedic candidate must schedule a chart review with the EMS Coordinator at fifteen and thirty completed ALS calls to review paperwork (More often if deemed necessary).
- The paramedic candidate may not be part of a two-person crew until an EMS Coordinator has signed off the first fifteen calls.
- Following the first fifteen approved calls, the preceptor and the candidate may constitute a crew and perform paramedic level skills and interventions.
 - The candidate may be allowed to transport priority 2 level calls should the preceptor deem appropriate.
 - The candidate must have a preceptor in the patient compartment on any CMED designated priority one call until the precepting Paramedic has been cleared from precepting.
- Upon completion of the call requirements, the sponsoring EMS agency will request that the EMS Coordinator (s), Medical Director, or their designee monitor the candidate during a regular road shift.

- Clearing rides may be completed over a single shift or several shifts, depending on the candidate's call volume and performance. All clearing shifts must include at a minimum two (2) ALS calls.
- If the opinion of the sponsoring EMS agency or the EMS Coordinator(s) that the candidate has not met the minimum competency of an entry-level paramedic, the sponsoring EMS agency or EMS Coordinator may offer the candidate one additional round of precepting.
 - This may immediately follow the first precepting attempt.
 - This may also follow a retraining/remediation period at the discretion of the sponsoring EMS agency or EMS Coordinator(s).
 - The sponsoring EMS agency is under no obligation to re-precept a provider.
- Once the candidate has completed the precepting process and field clearance, the candidate will be placed on a provisional medical control status for six (6) months. The paramedic is continuously monitored for compliance with continuing education requirements, quality improvement activities, patient care guidelines, and policies and procedures.
- At any time during the provisional period, medical control can be withdrawn. The paramedic can then be requested to return to a preceptor status for remediation or be denied permanent independent medical control authorization.
- If no actions have been taken against the paramedic during the six (6) month provisional period, then permanent medical control status automatically occurs.
- Candidates completing the credentialing process with less than twelve months left in the renewal cycle will be assigned pro-rated CME requirements.

MAINTAINING MEDICAL CONTROL

All certified and licensed EMS providers are expected to keep current all required credentials and maintain in-service records. Medical Control has the right to request these records at any time for review.

- All Agency personnel must keep current all CT State OEMS required training.
- Agency personnel who maintain paramedic licensure and do not have the authorization to function at that advanced level of care must participate in an annual competency review.
- Providers who fail to meet the minimum requirements will be considered ineligible for Bridgeport Hospital MMC authorization.
- The EMS Coordinator may conduct a field evaluation of any sponsored provider at any time with prior notification to the service.

VOLUNTARY DOWNGRADE OF MEDICAL CONTROL

Active paramedics, with current Milford Medical Control, that choose to downgrade their medical control to practice at the BLS level only must provide medical control with 14 days written notice to review and approve their request. Under certain circumstances, expedited processing time will be considered by EMS Coordinator, on a case-by-case basis. Expedited processing must also be requested in writing.

RENEWING MEDICAL CONTROL

- Paramedics must renew medical control every two years by submitting a complete application and submitting all renewal CME paperwork as described on the application. (ITLS/PHTLS is not required for renewal)
- All licensed providers are responsible for acquiring and submitting the required CME hours in the appropriate categories based on current policy. (See Appendix A)
- Basic level providers are required to maintain current state certification requirements and current AHA BLS and state certification. Paramedics operating at the BLS level must follow CT OEMS EMT requirements.
- If a provider was out on injury or military deployment for greater than half of the renewal cycle, medical control could modify the requirements on a case-by-case basis.
- Paramedics failing to have all requirements, and proof thereof submitted, by the medical control deadline, will lose their ALS medical control authorization immediately.
- Providers must complete all requirements and submit supporting documentation to have their medical control reinstated. Prior to reinstatement, a complete renewal package must be submitted and approved by the EMS coordinator. Paramedics who fail to submit this for a period greater than one year, should follow the lapse/relinquish of medical control requirements.
- Certified and licensed providers failing to submit the required medical control renewal documentation by the stated deadlines will have an automatic 30-day suspension of medical control imposed from the time the late renewal application is submitted.

LAPSES AND/OR RELINQUISHMENT OF MEDICAL CONTROL; REINSTATEMENT REQUIREMENTS

Certified and licensed providers failing to submit the required credentials by stated deadlines will not be authorized to practice in the MMC region.

Certified and licensed providers failing to submit the required medical control renewal documentation by the stated deadlines will have an automatic 30-day suspension of medical control imposed from the time the late renewal application is submitted.

Any providers who allow a lapse in or relinquish medical control must submit proof of current required certifications with their application.

ALL providers who allow a lapse in or relinquish medical control that continues through the next renewal cycle, must complete, and submit proof of all previous cycle renewal requirements. Exceptions will be considered on a case-by-case basis by EMS coordinator.

Providers who allow a lapse in or relinquish medical control for one year or less only must submit a new application for review to reacquire medical control, along with completing any medical control required training prior to application submission.

Providers who allow a lapse in or relinquish medical control for greater than one year but less than two years and are not actively working as a paramedic in another region will be required to complete a new application, pass a protocol exam, and complete any medical control required training prior to application submission.

Providers who allow a lapse in or relinquish medical control for greater than one year but less than two years and are actively working as a paramedic in another region will be required to complete a new application; additional requirements may be required if deemed appropriate based on a case by review, at discretion of MMC.

Providers who allow a lapse in or relinquish medical control for two years or more will be required to begin the precepting process as determined by medical control.

Inactive applicants (defined as not functioning at the paramedic level with the full authorization granted by a sponsor hospital or other credentialing agency for a period exceeding 24 months) will be required to show proof of completion of a state-approved paramedic refresher program or continuing medical education credits equivalent to those required for Milford Medical Control renewal.

All reinstatement requests must be confirmed by the EMS Coordinator in writing. Requests will be processed and may take up to 14 days to review and complete.

SUSPENSION & TERMINATION OF MEDICAL CONTROL

The Medical Director, in consultation with the EMS Coordinator, or his/her designee is authorized to impose temporary suspensions or other temporary discipline upon EMS or Mobile Intensive Care (MIC) providers who are subject to medical control until the Medical Control Council can meet, which should be as soon as possible. Medical control may be terminated after the event review process.

MEDICAL CONTROL AUTHORIZATION FOR SUPERVISORY AND CHIEF-LEVEL EMS PROVIDERS

PURPOSE: While infrequent, it is reasonable to assume executive leaders of EMS agencies, from time to time, will have to participate in direct patient care. Reasons for this are many and include but are not limited to staffing shortages and unique events. As such, MMC expects that executive leaders obtain medical control authorization*** and maintain such authorization as current for the duration of their leadership tenure. ****Any service that does not require executive leaders to provide patient care at the paramedic level are exempt from this requirement. Exempt leaders, without current Milford Medical Control, responding to calls on duty, or if responding to a scene in a command role, may only provide care within the BLS clinical scope of practice.*

SCOPE: EMS providers assuming executive leadership roles with EMS agencies within the Milford Medical Control catchment area who DO NOT hold current medical control authorization in the MMC region must complete the steps outlined below:

Executive leaders with current/ active medical control in another region within CT or YNHH medical control catchment area and have not had a lapse of work greater than six months at the time of their appointment will be required to pass:

- A written protocol exam
- An oral medical control scenario
- Two ALS calls with either EMS coordinator

Executive leaders with current medical control in another region or medical control catchment area but have had a lapse in work six months or greater will be required to pass:

A written protocol exam

- An oral medical control scenario
- Precept for a specified number of calls determined by the MMC.

Additionally, the candidate must provide the following documentation:

- At least two professional references
- A selection of patient care reports for review by the EMS coordinator
- Documentation attesting that there are no outstanding quality assurance or patient care concerns.

MEDICAL CONTROL OVERSIGHT--MICS

PURPOSE: For all service providers to comply with all conditions set forth by this Sponsor Hospital for Mobile Intensive Care (MICS) and/or BLS skill authorization, including, but not limited to, initial provider training and ongoing maintenance of competency, on behalf of the Bridgeport Hospital Milford Medical Control, we agree to continue to provide medical control in accordance with Section 19a-179-12 of the Regulations of Connecticut.

Discussion: Under Section 19a-179-12 of the Regulations of Connecticut State Agencies that govern the delivery of pre-hospital emergency medical services, Bridgeport Hospital MMC has the authority to provide medical control to EMS agencies and their providers. Therefore, the Bridgeport Hospital MMC agrees to continue to provide medical control, provided the following requirements are met.

SCOPE: All EMS agencies currently sponsored by Milford Medical Control or those interested in being sponsored by MMC.

POLICY:

- Agencies must complete an affiliation agreement with the MMC and renew annually.
- At the time of renewal, all sponsored services agree to comply with all MMC policies, protocols, and procedures as part of the MICS credentialing process.
- Connecticut MICS forms and the completed state-required informational packet must be submitted to both hospital EMS Coordinators for signatures every year. The packet will also include the service's Quality Assurance policy approved by MMC.
- Services agree to attend quarterly medical control meetings.
- Each sponsored agency is responsible and accountable for maintaining the following documentation:
 - Paramedics maintain, at a minimum, American Heart Association (AHA) ACLS, PALS, BLS, and State Licensure.
 - Verification that new EMT providers hold a current CT OEMS EMT certificate, AHA BLS card and have demonstrated competency in the following skills:
 - Epinephrine auto-injector administration
 - Intranasal naloxone administration
 - Automated external defibrillator
 - Assistance with nitroglycerin administration
 - Assistance with beta-agonist inhaler administration
 - Suctioning of inserted airway
 - Tracheostomy Care
 - Airway management including BVM with PEEP
 - CPAP if an EMS agency utilizes that procedure.
 - Pelvic Fracture Stabilization

Services that fail to meet the minimum requirements will be considered ineligible for Milford Medical Control authorization and, under no circumstances, be allowed to function within the MMC region.

FIELD MENTORING PROGRAM

PURPOSE: Bridgeport Hospital Medical Control recognizes that direct observation of field performance provides the most reliable and accurate method of orienting and evaluating paramedic clinical practice. The process provides immediate critique and maximum educational impact while preserving patient safety.

POLICY:

Preceptors are required to complete a Daily Field Internship Form reviewed at the end of every shift, regardless of call volume. Upon completion of requirements, all precepting forms and a letter from the primary mentor identifying successful completion of the service's orientation will be forwarded to the EMS Coordinator.

MENTOR RESPONSIBILITIES

- Train the candidate on all state and local regulations and protocols: service procedures, and equipment, including the hospital Pyxis system.
- Review with the candidate the knowledge, skills, and personal behaviors/attitudes required of an entry-level practitioner in our system.
- Provide the candidate with feedback and evaluation regarding his/her clinical performance related to an entry-level practitioner's objectives.
- Provide objective written and oral evaluations to the service and the EMS Coordinator, documenting the student's progress toward mastery of the Field Mentoring objectives and attaining entry-level competency.
- Maintain full authority and responsibility for the patient and crew. It is the mentor's responsibility to ensure quality and appropriate patient care and documentation.
- Advise the designated service representative and the EMS Coordinator immediately of any significant problems with candidate knowledge, skills, or personal behaviors/attitudes that require immediate intervention.

AUTHORIZED MENTOR QUALIFICATIONS

The Milford Medical Control Program understands that the key to a successful precepting process is selecting quality mentors and FTOs.

- Only Medical Control-approved mentors may precept candidates.
- PFI/FTO privileges may be withheld while conducting a clinical investigation at the discretion of EMS Coordinator.

The following qualifications have been set forth for approved mentors:

- The service provider must recommend the applicant for Authorized mentor status.
- Complete an approved training course.
- A minimum of two years paramedic authorization in good standing with local medical control.
- Good standing with all other sponsor hospital programs in which ALS authorization is maintained. Written documentation will be provided on request.

MEDICATION AND CONTROLLED SUBSTANCE POLICY

PURPOSE: Establish a standard for accountability and minimum requirements for drug inventory, documentation of usage, and replacement of controlled substances per Federal DEA rules and State of Connecticut Regulations. Only narcotics supplied by Bridgeport Hospital Milford Campus pharmacy may be carried on any response vehicle.

POLICY:

- All personnel authorized to administer drugs and all duly appointed supervisory staff responsible for inventory will always abide by this policy.
- The sponsored agency will notify the EMS coordinator immediately when a paramedic is no longer affiliated with their agency.
- An authorized EMS provider shall not administer or assist with administering a drug without the verbal or written order of an authorized Emergency Department physician or as directed by written protocol.
- Only drugs approved by the EMS Medical Directors may be carried on emergency vehicles. In addition, the Medical Directors and the State of Connecticut EMS Minimum Equipment List shall determine the number of drugs carried by the EMS agency.
- Drugs may not be administered after their expiration date. All multi-drug kits will be labeled with the earliest expiration date of any product contained within, and that date shall be recorded during routine inspections. Expiration date labeling shall be the responsibility of the Bridgeport Hospital Milford Campus pharmacy department.
- Paramedics are required to record all drugs administered with documentation of dosage, route, time, waste, and authorization on the ambulance run report. The Paramedic will complete the run report and leave the hospital copy with the person assuming patient care.
- All required paperwork must be completed when removing a kit out of the Pyxis machine.
- Any unanticipated or undesired response directly attributable to administering a drug shall be reported to the receiving hospital Emergency Department physician and the EMS Coordinator.
- All paramedics must sign the narcotic agreement detailing narcotic handling upon entering the medical control region. (See Appendix B)
- All paramedics must complete a yearly narcotic signature card for signature verification.

CONTROLLED SUBSTANCES

PATIENT CARE RESPONSIBILITY AND PROCEDURE

Every time a controlled substance kit is inspected or used, or direct responsibility for the kit changes hands, audit documentation must be generated and maintained.

After administration, the Paramedic must record the medication, dosage, time, route, and Sponsor Hospital authorization on the narcotic administration paperwork.

STORAGE AND SECURITY OF CONTROLLED SUBSTANCE KITS

- Under no circumstances will controlled substances issued by any other facility other than Bridgeport Hospital Milford Campus be carried and stored in any vehicle.
- All sponsored agencies and providers must provide adequate controls and procedures to guard against theft and diversion of controlled substances.
- Controlled substance kits will be stored in a securely locked, substantially constructed vault, with at least two locks. The locks may be keyed or a combination but must be independent of the vehicle locks. Electronic locks shall be capable of manual override when power to the vault is compromised. The on-duty shift commander shall maintain override access.
- At no time will EMS agencies or providers store controlled medications outside of the vehicle's locked vault when not involved in delivering patient care.
- The sealed controlled medication kit may be removed from the vault and carried on the Paramedic's person when there is a potential to administer the medications at a location removed from immediate access to the paramedic vehicle.
- The vehicle must always be locked when unattended if available on the vehicle.
- The sealed controlled medication kit may be transferred between vehicles of the same service approved at the paramedic level. The Paramedic assigned to the vehicle maintains the responsibility for the kit.
- When a paramedic vehicle is taken out of service for no more than twenty-four hours, the controlled medication kit will remain secured in the vault. The vehicle will remain locked and placed under the direct control of the on-duty shift commander. The Paramedic will inspect the controlled kit before going off-duty.
- When a paramedic vehicle is placed back in service, the oncoming Paramedic inspects the controlled kit.
- If a unit is removed from service for a period greater than twenty-four hours. In that case, the service should follow their current narcotic agreement with medical control.

PARAMEDIC ACCOUNTABILITY

- The on-duty Paramedic assigned to the vehicle is responsible for the controlled medication kit at all times. If the controlled substance kit is secured in an electronic vault with keypad access, the Paramedic must commit to memory his/her unique access codes. If the vault is key-controlled, the Paramedic must always carry the keys on his/her person. Access to codes and/or keys that allow entry to the controlled substance vault shall be limited to the Paramedic directly assigned to and responsible for the controlled substances. Keys shall only be passed from the off-going Paramedic to the oncoming Paramedic after the kit is inspected.
- Paramedics will visually inspect controlled substances every time responsibility for the kit changes hands (i.e., the beginning and end of every shift). Both the oncoming and an off-going paramedic will evaluate the kit for seal damage, alterations in medication color and clarity, expired medications, and volume discrepancies. Inspections must be verifiable by audit documentation.
- Any discrepancies in the controlled medication inventory will be documented in writing and reported immediately to the EMS Coordinator and the Bridgeport Pharmacy Department.
- Every time a controlled substance kit is inspected, used, or direct responsibility for the kit changes hands, complete audit documentation in the form of a signature log or other electronically generated documentation must be maintained.

USE AND DISPOSAL

- The administration of controlled substances will be uniformly documented to reflect usage and waste accurately.
- Opened kits will be returned to the Pyxis machine for exchange immediately after the call on which the drug(s) was used, or, if that is not possible, within that working shift.
- Whenever a controlled medication kit's seal is broken, the kit must be returned for proper exchange regardless of medication usage.
- When exchanging kits, the completed Record of Use for Controlled Substances on Paramedic Vehicles form must be included with the required documentation:
- Any unused amount of the opened medication must be wasted at the receiving facility with a registered nurse or physician's direct presence. Its disposal is documented on the Record of Use for Controlled Substances on Paramedic Vehicles form. Signatures of the Paramedic and appropriate witnesses are required. Waste must be done at the hospital to which the patient was transported. No medication in opened vials may be carried in a narcotic kit.
- Accidental wastage, if not witnessed, must be thoroughly documented, and explained by the Paramedic on the Record of Use for Controlled Substances on Paramedic Vehicles form. The authorizing physician must sign the record of wastage form.

See Addendum E *** MMC Controlled Substance Kit Procedures

SECTION TWO: CLINICAL CARE

SECTION TWO: CLINICAL CARE

CLINICAL AUTHORITY AT SCENE

PURPOSE: This policy aims to delineate EMS provider authority and outline a process in the event of provider or inter-agency conflict regarding patient care.

DISCUSSION: A hierarchy of clinical responsibility must be established to maintain orderly scene management and allow for the rapid resolution of interprofessional conflicts.

In the event of disagreements regarding patient care, the focus must remain on what is in the patient's best interest. It is the responsibility of the on-scene credentialed providers to reach a consensus as to the most appropriate care for the patient(s).

SCOPE: All EMS agencies and providers sponsored as such in the Milford Medical Control (MMC) Region.

POLICY:

Nothing in this statement shall be construed to limit the authority of the fire officer in charge under section 7-313e of the Connecticut General Statutes to control and direct activities at the scene of an emergency. The Fire Department within the municipality maintains responsibility for the management of the scene and the safety of all providers.

It is the position of Bridgeport Hospital MMC that all EMS, fire, and police personnel at the scene of an emergency work **collaboratively** to ensure the safe, orderly, and timely transfer of patient care and forward movement of patients. **This document is a best practice guideline. No document can be drafted that covers every variation of an emergency response.**

A provider, as defined in Section 19a-175 of the Connecticut General Statutes (CGS), holding the highest classification of licensure or certification from the Department of Public Health under chapters 368d and 384d of the CGS and is authorized to practice at the said level within the Bridgeport Hospital MMC catchment area shall be responsible for making decisions regarding patient care on the scene of an emergency.

- Requests for Service requiring a multiagency response (i.e., EMS, fire, and/or police), the EMS organization providing transport shall assume responsibility for making patient care decisions once they arrive on scene AND after establishing communication, ideally face to face, with the provider/fire officer in charge.
- The provider/fire officer in charge of “boots on the ground” situational awareness may allocate resources as necessary in the interest of patient care while awaiting the arrival of EMS personnel.
- Under routine circumstances, resources allocated to an emergency scene should not be canceled by a transporting EMS agency while en route to a scene.
 - A transporting EMS agency may cancel allocated resources with direct situational awareness regarding EMS system status after establishing direct radio communication with the provider/fire officer in charge on the scene as written in the municipality’s standard operating guidelines.
 - Any requests for mutual aid resources should be coordinated as written in the municipality’s standard operating guidelines.

A provider assuming decision-making responsibility for patient care shall transfer care to a provider with a higher classification of licensure or certification upon arrival of such person on the scene of an emergency. For this statement, the order of licensure or certification from highest to lowest is:

- Paramedic
- Emergency Medical Technician
- Emergency Medical Responder

The Milford Medical Control credentialed paramedic on-scene has ultimate responsibility for patient care unless the care of that patient is transferred to another appropriately certified or licensed provider in accordance with Public Act No. 15-223

In the event of unresolved conflict, the senior credentialed transport provider has final authority and responsibility for decisions regarding patient care.

If there is a conflict involving a supervised provider (i.e., graduate paramedic or student), the assigned Field Training Officer has the authority and should be consulted.

All significant or unresolved conflicts are to be reported to the respective agencies involved via their chain of command, and their agency policies and procedures are to be consulted. Any such events will be reviewed in accordance with each agency's event review process.

All providers are encouraged to report any on-scene conflicts if they feel patient care was adversely affected. The provider should reach out to the EMS Coordinator of the receiving hospital as soon as possible.

Our collective desire is to work collaboratively with appropriately identified healthcare professionals on the scene of a medical emergency to enhance patient care. Our collective responsibility is to ensure that our patients only receive care from appropriate, acceptable practitioners. Only paramedics with current MMC authorization will wear clothing and other markers identifying themselves as paramedics to avoid on-scene confusion.

For this document, the following definitions are used:

- **Emergency Medical Responder:** An individual certified to practice as an EMR under the provisions of Section 20-206ll or 20-206mm.
- **Emergency Medical Services Organization:** A public, private, or voluntary organization that offers transportation or treatment services to patients primarily under emergency conditions.
- **Emergency Medical Technician:** An individual certified to practice as an EMT under the provisions of Section 20-206ll or 20-206mm.
- **Firefighter:** A uniformed member of a paid municipal, state, or volunteer fire department.
- **Paramedic:** A person licensed to practice as a paramedic under the provisions of Section 20-206ll.
- **Patient:** An ill, injured, or physically disabled person requiring assistance and transportation.
- **Provider:** Any person, corporation, or organization, whether profit or nonprofit, whose primary purpose is to deliver medical care or services, including such medical-related care services as ambulance transportation.

PARAMEDIC DOWNGRADE OF CARE TO A BASIC LEVEL PROVIDER

PURPOSE: To outline the criteria necessary for a paramedic level provider's transfer of patient care to a basic level provider.

SCOPE: All EMS agencies are authorized per Bridgeport Hospital Milford Medical Control policy operating within the Milford Medical Control Region.

DISCUSSION: Basic level providers have access to more knowledge and technology than ever before. As such, patients traditionally transported by paramedic level providers may no longer require this level of care. It has been proven that basic level providers can provide the necessary level of care for specific patient types, ensuring the patient is receiving the right level of care at the right time. However, a process and criteria for safely transferring care from a paramedic level provider to a basic level provider are not without risks. Therefore, clear criteria and a transparent process are necessary to reduce the likelihood of adverse events. Basic level providers have the right to decline the transition of patient care.

POLICY: A paramedic may transfer care to an EMT level provider or crew for further care and transport only if all the following criteria have been met:

- The Paramedic has performed a complete and thorough documented patient assessment.
- The Paramedic has a high degree of confidence that the patient would not benefit from advanced life support measures such as continuous hemodynamic monitoring, cardiac monitoring, IV placement, or medication administration.
- The paramedic and basic level provider(s) agree on a plan of care.
- The EMT level provider(s) agree to accept responsibility for subsequent patient care.
- It is the medical control position that the EMT level provider may attend to the patient and document the relevant patient management and the rationale for the triage to BLS. It is unnecessary to generate two separate run forms where an EMT and Paramedic are staffing the ambulance.

A paramedic may not transfer care to an EMT level provider/crew if any of the following exist:

- The advanced level and EMT level providers cannot agree on a subsequent BLS plan of care.
- Interventions that have been implemented that are outside the basic level scope of practice.
 - 4 or 12 Lead ECG monitoring and/ or Waveform capnography
- ALS interventions/procedures were initiated, including but not limited to vascular access and /or any medication administration, except those authorized under the basic level provider scope of practice or authorized for use in the MMC catchment area.
- An EMT level provider or crew is unwilling or expresses any concern with taking responsibility for patient care.
- The advanced level and EMT level providers cannot agree on a subsequent BLS plan of care.
- The Paramedic must thoroughly document all cases in which patients are released to the care of BLS personnel.
- Individual EMS agencies are responsible for ensuring all transfer of care events from ALS to BLS are documented per agency policies and procedures.

FIELD COMMUNICATIONS / DIRECT MEDICAL OVERSIGHT

PURPOSE: Timely and appropriate communications can allow EMS personnel to obtain direct medical oversight. They can allow the receiving facility to plan for appropriate resources, activate clinical response protocols, and improve overall hospital patient flow management.

POLICY:

Priority one and two patients or multiple patients, require an early notification via CMEDSWRCC.

CMED SWRCC will be notified of all patient transports to notify the hospitals when a patch notification is not required.

Field to hospital communications should take place before leaving the scene if possible.

All Milford Medical Control - sponsored response vehicles shall have two-way voice communication equipment to directly contact hospital emergency departments throughout the response and patient contact.

Phone notification to any hospital must go through CMED SWRCC to ensure the call is on a recorded line.

PROCEDURE

To establish contact with Bridgeport Hospital-Milford Campus:

- Contact CMED SWRCC by radio or phone and request a patch to Milford Campus
- Identify whether you wish to give a standard report or consult with medical direction.
- Identify any special circumstance qualifiers (i.e., STEMI Alert, Stroke Alert, Infectious Disease etc.)

When consulting DMO, verify that a physician is on the line and obtain identification when possible.

For the high-acuity patient, the report should include the following:

- Age and gender
- Nature of illness or mechanism of injury
- Chief complaint and history of the present event
- Vital signs and pertinent positive and negative assessment findings
- Treatment initiated and patient response
- Estimated time of arrival and specific needs (i.e., security, lift assistance, etc.)

For the non-emergent patient, the report can be shortened and only the following provided:

- Age and gender
- Baseline Vital Signs
- Chief complaint with a summary of event, illness, and vital signs, and estimated time of arrival and specific needs (i.e., security, lift assistance, etc.)
- Trauma notifications need to relay detailed and accurate information on all inclusionary and exclusionary findings related to the Connecticut State Trauma Regulations Field Triage Protocol.

DIRECT MEDICAL OVERSIGHT (DMO)

- It is often necessary to contact a physician for assistance with patient care/transport decisions or approve specific clinical treatment.
- If contact with DMO is required, it should be requested from the expected receiving facility. If the patient is requesting a facility that conflicts with protocol, Milford Campus DMO will be contacted. Unless DMO approves an alternate facility, the patient should be transported to the contacted facility.
- To ensure continuity of care, once DMO has been established, the Paramedic will follow the physician's medical orders within the protocols' scope.
- Orders from DMO must be conveyed via a CMED SWRCC -recorded med channel or over a recorded phone line and fully documented on the run report.
- When DMO gives an order, repeat the order to verify its accuracy.
- Verify receipt of information and wait for DMO to verify the conclusion of communications.
- DMO signature must be obtained for any orders outside of Connecticut State Protocols.

PATIENT DESTINATION DETERMINATION

PURPOSE: Patients shall be transported to a licensed acute care hospital equipped, staffed, and prepared to receive emergency cases and administer emergency medical care appropriate to the patient's needs. (Note: this does not preclude the transport of a patient to other facilities during non-emergency inter-facility transfers or scheduled non-emergency transports at the request or direction of the patient's private physician.)

Appropriate receiving hospitals are defined as hospitals with no restrictions on receiving patients and are located within our sponsored services' operational boundaries.

DESTINATION DETERMINATION

Patients shall be transported to the hospital of their preference **unless** clinical condition or required resources necessitate transport to the closest appropriate receiving facility.

During periods of high system demand (e.g., elevated 911 call volume) or adverse weather conditions, all patients will be transported to the closest appropriate hospital based on patient condition and receiving facility capabilities.

If no hospital preference is expressed, the patient will be transported to the closest appropriate facility.

Milford Campus does **not** provide inpatient obstetrical services. The following patients shall **not** be transported to Milford Campus:

- Active labor
- Abdominal pain in the second or third trimester
- Vaginal bleeding in the second or third trimester

If a patient meeting the above criteria requests Milford Campus:

- Advise transport to the facility affiliated with their obstetric provider
- If no established obstetric care exists, transport to the closest appropriate facility
- If the patient continues to request Milford Campus, contact Medical Control (DMO) from the scene for destination determination

Trauma patients shall be transported in accordance with the Milford Medical Control Trauma Alert Policy and Connecticut State Trauma Regulations.

If a trauma patient requests Milford Campus, contact Medical Control (DMO) from the scene for destination determination.

STEMI patients shall be transported to the closest PCI-capable center in accordance with the Milford Medical Control STEMI Alert Policy.

Surge and High-Volume Operations

During periods of system surge, high call volume, limited unit availability, or other operational constraints impacting response capability, the agency may temporarily limit non-essential transports outside of its primary service area to preserve local emergency response coverage.

These limitations shall **not** apply when:

- The patient's clinical condition requires transport to the closest appropriate receiving facility
- The receiving facility possesses specialized capabilities not available within the primary service area
- Transport is required under applicable state regulations or by Medical Control direction

Clinical need and patient safety shall take precedence over all operational considerations.

Mutual Aid and Contingency Transport Planning

To ensure continuity of care during surge conditions, the agency shall maintain a formal surge and contingency transport plan, including:

- Pre-established mutual aid and/or transport agreements with neighboring EMS agencies or transport providers
- Clearly defined activation criteria for out-of-area transport assistance during surge events
- Coordination procedures through dispatch and Medical Control
- Documentation requirements for all mutual aid utilization

These measures are intended to maintain patient access to appropriate care while preserving operational readiness within the agency's primary service area.

PURPOSE: To identify patients with active ST-segment elevation MI as early as possible and to allow pre-hospital activation of the cardiac catheterization lab. This protocol is being enacted 24 hours a day, 7 days a week.

CRITERIA

To qualify for EMS STEMI Alert, the patient must meet ALL of the following criteria:

- Active chest pain and/or dyspnea at the time of EMS primary assessment OR exhibit signs and symptoms suggestive of cardiac ischemia (nausea/vomiting, diaphoresis, dizziness, near syncope, pain suggestive of cardiac ischemia).
- Age of 35 or greater.
- 12 lead ECG demonstrating ST segment elevations of at least 1mm in 2 or more contiguous limb leads or 2mm in 2 or more contiguous precordial leads (V1-V6).
- Monitor quality (i.e., 3 or 4 lead ECGs) exhibiting ST elevations are unreliable and must not be considered diagnostic.
- NO EVIDENCE of paced rhythm or Left Bundle Branch Block (QRS duration of more than 3 small blocks or 120ms).

Supporting Criteria:

- Reciprocal changes, defined as ST segment depression in opposing leads.
- Machine diagnosis of “ACUTE MI SUSPECTED”.

ECG machine diagnosis of “Acute MI” may be considered as supportive of STEMI. However, a computer interpretation of “Acute MI” is NOT required to declare a STEMI alert. Furthermore, even with a computer interpretation of “Acute MI”, the above criteria must be met.

ACTION:

For patients meeting the above criteria, the paramedic will advise SWRCC or local dispatch they have a “STEMI Alert”. The paramedic will request an “early” STEMI alert notification from the bedside as soon as possible. Those utilizing TIGERCONNECT may use TIGERCONNECT at bedside to activate their early STEMI Alert, including a photo of the ECG, and then update further details enroute. Once transporting, the paramedic may either patch into the receiving facility via radio or the Twiage application. EMS crews should treat the patient based on existing CT OEMS protocols and be ready to present the diagnostic 12 lead ECG to RN or MD immediately on arrival.

SUGGESTIONS:

- Patients exhibiting ST segment elevations in the inferior leads should have a right sided V4R performed to determine any right ventricular involvement prior to administration of nitroglycerin.
- Patients exhibiting isolated ST depression in leads V1-V4 should have posterior leads V7 - V9 completed for any posterior wall involvement.
- Patients exhibiting isolated ST elevations in lead V6 should have posterior leads V7 - V9 completed to identify any posterior wall involvement.

If unsure if the criteria have been met contact Medical Control for Guidance.

TIGERCONNECT NOTIFICATION:

- Agencies with TigerConnect capabilities must attach and transmit a clear photograph of the DIAGNOSTIC ECG via the TigerConnect application along with the STEMI alert notification.
- Early Notification is essential to timely cardiac care. **Bedside activation is preferred.**
- Only ECGs meeting STEMI alert criteria should be transmitted with alert activation. If unsure if the criteria have been met contact Medical Control for Guidance.

Receiving hospitals will make every effort to give a room assignment at the time of patch. The receiving facility will activate its STEMI team in accordance with its own internal policies.

Every attempt should be made to complete your run form before departing the receiving facility. If this is not possible, the run form must be completed as soon as possible per the Medical Control documentation policy.

Purpose: To rapidly and reliably identify patients suffering from a cerebrovascular accident, ensure the appropriate resources are available when the patient arrives at the receiving facility, and facilitate rapid transfer to endovascular therapy capable facilities when appropriate.

Scope: All emergency medical services agencies sponsored in Bridgeport Hospital Milford Medical Control

Policy:

- Conduct a patient assessment and treat the patient per Protocol 2.25 Stroke-Adult and Pediatric.
- Obtain a blood glucose reading. If below 60 mg/dL, treat per protocol 2.12A-Hypoglycemia.
- Clearly identify the last time the patient was known well.
 - Defined as the last time the patient was observed to be at their baseline.
- Perform a BE-FAST Stroke Scale.

BE-FAST Stroke Scale	
Balance: Perform bilateral index finger-to-nose test and bilateral heel-to-shin test	
Does the patient have sudden loss of balance or coordination, trouble walking or dizziness?	
Eyes: Assess 4 quadrants of visual field by having patient locate your index finger.	
Does the patient have acute trouble seeing out of one or both eyes, visual field loss or double vision?	
Facial Droop: Have the patient smile and show teeth.	
Does the patient's face look uneven, have acute drooping or numbness on one side?	
Arm Drift: Have patient close their eyes, raise and extend both arms with palms up for 10 seconds.	
Does one arm pronate (rotate inward), drift downward, or is there acute weakness of one arm?	
Speech: Ask the patient to repeat a phrase such as, "You can't teach an old dog new tricks".	
Does the patient have slurred speech, trouble speaking, understanding or seem confused?	
Time: What time was the patient last known well (last appear normal)?	____:____
What time did the symptoms start ?	____:____
If 1 or more of the above signs are abnormal, then your patient may be experiencing a stroke and, if <24 hours since patient was last known well, transport emergently and activate a stroke alert.	

- If, after performing the stroke scale, the patient has **ANY** positive findings **AND** the last known well is **24 hours or less** place the receiving facility on a **STROKE ALERT** as soon as possible, preferably from the patient's bed side.
- Package the patient, elevating the head of the bed 30 degrees.
- Keep on scene times as short as possible, preferably less than 15 minutes
- Obtain a 12-lead EKG if possible.
- If available, transport a reliable witness with the patient to verify the onset of the symptoms. **At minimum, obtain phone number for reliable witness to pass on to receiving team.**
- Reassess the patient frequently for resolution or worsening of symptoms.

BRIDGEPORT HOSPITAL MILFORD MEDICAL CONTROL TRAUMA ALERT POLICY

PURPOSE: This policy is intended to outline the process for activating a prehospital trauma alert when a patient meets the criteria listed below.

POLICY:

Prehospital providers will place the intended receiving facility on a trauma alert when a patient(s) meets one or more of the following criteria. Please note: There are no "levels" for trauma alerts for prehospital providers. It is either a trauma alert, or it is not.

Once alerted, the receiving facility will determine the patient's appropriate alert level based on the receiving facility's pre-established guidelines. Hospital-specific terminology should not be used to describe EMS trauma alert activations.

****PLEASE PLACE THE TRAUMA ALERT AS SOON AS POSSIBLE, IDEALLY WHILE STILL ON SCENE. ****

PHYSIOLOGIC CRITERIA

- SBP less than 90 mmHg in an adult or SBP less than $(70+2 \times \text{age in years})$ in a child.
- GCS of 13 or less or a deviation from the patient's baseline resulting from a traumatic mechanism.
- Respiratory distress or airway compromise.

ANATOMIC CRITERIA

- Penetrating injuries to the head, neck, torso, abdomen, pelvis, or extremities excluding the hands or feet.
- Chest wall instability, including flail chest.
- Evidence of spinal cord injury with motor deficits (i.e., paralysis, paraplegia, quadriplegia, lateralizing signs) or sensory deficits (i.e., paresthesia or sensory changes).
- 2d or 3d-degree burns with greater than 5% TBSA or ANY burns involving the airway.
- Traumatic limb amputation excluding digits.
- Multiple or open long bone fractures.
- Injuries to one or more organ systems.
- Crushed, de-gloved, pulseless, or mangled extremity.
- Open or depressed skull fracture.
- Pelvic fracture as evidenced by visible deformity or pelvic instability.

MECHANISM CRITERIA

- Significant vehicle deformity with at least 12 inches of intrusion into the passenger compartment, steering wheel deformity, dash deformity, or at least 18 inches of intrusion to any part of the vehicle.
- Partial or complete ejection from a vehicle.
- Unrestrained occupant in a rollover.
- Prolonged extrication (greater than 20 minutes).
- Death of same-vehicle occupant.
- Pedestrian or bicyclist struck, run over, or thrown by an automobile traveling greater than 20mph.
- Hanging or drowning event.
- Fall from a height greater than 20 feet for an adult or greater than 10 feet for a child.

FALLS ON ANTICOAGULANT CRITERIA

Anticoagulation medications*** including, but not limited to, Coumadin (Warfarin), Pradaxa (Dabigatran), Eliquis (Apixaban), Xarelto (Rivaroxaban), Lovenox (Enoxaparin) or Savaysa (Edoxaban).

***Excludes anti-platelet drugs like aspirin, Plavix, and Brilinta

Falls on Anticoagulation with evidence of head injury are appropriate for MC ER if there are none of the following:

- Height higher than standing (Ladder, stairs...)
- AMS from baseline.
- Vital signs that meet Physiologic Criteria and would normally trigger a trauma alert.
- Signs of intracranial injury such as abnormal pupils, signs of major trauma to the head or localizing signs.
- Other distracting injuries and/or other trauma that may benefit from a trauma center.

If one (1) of the above criteria is met, initiate transport to an appropriate trauma center.

**Provider discretion should always play a role as not all scenarios are straightforward or predictable.*

OTHER CONSIDERATIONS

- Extremes of age: Less than five or greater than 55 years old.
- 20 weeks gestation or more.
- Provider discretion when a high index of suspicion warrants trauma alert activation.
- Whenever possible, keep family members together.
- Bridgeport Hospital is the preferred destination for critically ill/ injured children or adult and pediatric burn victims unless the patient is in cardiac arrest or has an unstable airway.

Upon arrival at ED:

- Only those EMS providers directly involved in patient care should be in the trauma room.
- Exceptions include the need for additional manpower to assist with lifting and moving a patient.
- After observing the "EMS Time-Out," the EMS provider should give a full verbal report to the ED physician or trauma surgeon.
- The provider should remain available to answer questions from the ED physician or trauma surgeon.
- EMS crew members needed for another emergency response will be relieved immediately upon notification of the ED physician or trauma surgeon.

Every attempt should be made to complete your run form before departing the receiving facility. If this is not possible, the run form must be completed as soon as possible per the Medical Control documentation policy.

ADULT SEPSIS/SEPTIC SHOCK ALERT

PURPOSE: The purpose of this policy is to outline criteria to rapidly identify patients that are at higher risk of being septic.

DISCUSSION: Sepsis is defined as a systemic inflammatory response of the body in response to infection. The infecting pathogen triggers an overwhelming immune response causing widespread inflammation, microvascular blood clots, and fluid shifts impairing blood flow and oxygenation to critical organs such as the brain, lungs, kidneys, or liver. When sepsis is not suspected or treated promptly, hypotension, organ damage, or MODS may result.

POLICY:

The provider will place the receiving facility on a SEPSIS alert when a patient exhibits at least two Systemic Inflammatory Response criteria (SIRS) criteria with a suspected or confirmed infection. It is expected that all potential sepsis patients have a temperature taken by EMS as part of the standard assessment.

- Must be over 17 years old.
- SIRS Criteria
 - Temperature less than 96.8 degrees (F), greater than 100.4 degrees (F), or feels clinically febrile.
 - Heart rate higher than 90 beats per minute.
 - Respirations higher than 20 breaths per minute OR the patient is mechanically ventilated.
 - New onset altered mental status or a change in mental status from the patient's baseline.
 - Hypoperfusion is evidenced by SBP less than 90 mmHg or MAP less than 65 mmHg.
 - EtCO₂ is less than or equal to 25 cmH₂O.
- Confirmed infection or history highly suggestive of infection including but not limited to:
 - Recent antibiotic therapy.
 - Recent medical/surgical infection or recent hospitalization.
 - Indwelling Foley catheter.
 - Tubes into body cavities (PICC, central lines, PEG tubes, etc.).
 - Immuno-compromised patients (AIDS, cancer, etc.).
 - Chemotherapy within the last six weeks.
 - A resident of a skilled nursing or rehabilitation facility.
 - Evidence of cellulitis, dysuria, cough with or without sputum production, bedsores or other non-healing wounds, diarrhea, or abdominal pain.

Prehospital management of the septic shock patient will follow Connecticut EMS Statewide protocol 2.22.A.

INTERFACILITY AMBULANCE TRANSFER GUIDELINES

PURPOSE: To provide appropriate care for patients during interfacility transports in accordance with federal and state regulations and Bridgeport Hospital MMC guidelines.

DEFINITION: An interfacility ambulance transfer is defined as any EMS ambulance transport from one healthcare facility to another. Examples include hospital-to-hospital, hospital-to-rehabilitation, and hospital-to-long term care. (Guide for Interfacility Patient Transfer, NHTSA, April 2006.)

AUTHORITY:

- COBRA regulations require all medical facilities and physicians who participate in Medicare to have a transfer organized through qualified personnel and transport equipment for each patient who must be transferred. This is the responsibility of the referring hospital.
- Personnel should be trained to deal with the patient's current medical condition and any reasonably foreseeable complications that could occur during transport.
- Sponsored EMS agencies are responsible for notifying the EMS Coordinator of the types of transfers being requested to facilitate personnel assessment and training by the sponsoring hospital.
- Patient care responsibility during transfer lies with the referring institution until the patient is received at another facility. Overlapping responsibilities with the EMS provider's Sponsor Hospital may occur if the patient deteriorates enroute and unforeseen treatment is required.

PROCEDURE:

AUTHORIZED BY LEVEL OF PROVIDER

Emergency Medical Technician

- Must be a stable patient with no risk for deterioration.
- Permitted non-contact therapies and devices, which must not be manipulated by EMS personnel.
- Saline lock (No IV infusions).
- Previously inserted Foley catheter, suprapubic tube, established feeding tube (NG, PEG, J-tube not connected to infusion or suction).
- Patient-managed medication pumps (Route of administration must be through a venous catheter).

Paramedic

- Transcutaneous pacing
- Advanced airway management
- CPAP
- Medical monitoring devices, procedures, and medication monitoring and administration consistent with the current formulary and scope of practice. Monitoring of heparin and nitroglycerin infusions permitted.
- Monitor central venous catheters (e.g., CVP line without active monitoring; triple lumen catheter; subclavian, internal jugular, or femoral line - but NOT including Swan Ganz catheters), or Implantable Central Venous Catheters (e.g., Hickman or Broviac Catheter).

When the level of care required exceeds EMS personnel's training and/or capabilities, an ***SCT-endorsed paramedic*** shall be sent, or hospital staff shall accompany the patient. Examples of conditions which may require accompaniment by hospital-provided personnel (MD, RN, and RT) include:

- Medications administered are beyond the scope of paramedic/SCT training.
- Equipment/devices in use are beyond the scope of paramedic/SCT training.
- When the attending physician directs that other staff are needed.

EMS personnel will not transfer patients receiving treatments or utilizing equipment for which they have not received documented training and MMC endorsement without being accompanied by personnel appropriately credentialed in such treatments/devices.

TRANSFER ORDERS

- EMS personnel will receive a patient history and a patient status report from the hospital physician, sending the patient and access all pertinent medical information.
- Written orders for care during transfer will be obtained by the paramedic from the referring hospital staff.
- In the event of a change in patient condition during a non-physician accompanied transport, standing orders appropriate to the patient condition will be implemented, and DMO will be contacted from the referring facility for implementation of options per Sponsor Hospital guidelines.
- If the patient is not stabilized following these interventions, and DMO is not available for consultation, the patient will be transported to the nearest appropriate facility for stabilization.

COMMUNICATION

- EMS providers must follow their sponsoring hospital guidelines regarding the notification of DMO before the transport of patients and radio reports to receiving facilities.
- Any unanticipated deterioration of the patient enroute should be communicated to the receiving facility or the sending facility, depending on location and radio reception availability.

DOCUMENTATION

- All patient transfers will have a thorough run report completed. All assessment, care, and interventions must be documented in keeping with current standards.
- The name(s) of any hospital staff accompanying the patient should be documented on the EMS report.
- A copy of the completed chart or timely access to a printout of the electronic ambulance record must be provided to the receiving facility at the time of the transfer.
- A copy of the chart shall be submitted to the EMS Coordinator on request for performance review.

SPECIALTY CARE TRANSPORTS

PURPOSE: To provide appropriate care levels for patients during interfacility transports following COBRA & EMTLA regulations and responsible Sponsor Hospital guidelines.

POLICY: Specific guidelines will be provided to paramedics who provide interfacility transports and wish to receive additional training to allow them to transfer patients with medications and equipment beyond those contained in this document. Only those paramedics trained and authorized by MMC and their service may utilize these advanced guidelines.

RESPONSIBILITY:

- The referring facility and physician's responsibility is to ensure any interfacility transport complies with all applicable COBRA regulations and is affected through qualified medical personnel using equipment appropriate for the patient encounter.
- Interfacility personnel should be trained to manage the patient's current medical condition and any reasonably foreseeable complications that could occur during transport. If any personnel are not trained, authorized, and/or comfortable with the patient's complexity, medications, medical devices, and/or equipment, they must advise the sending facility personnel and request an appropriate staff member accompany the crew for transport.
- During the transfer, patient care responsibility lies with the referring institution until the patient is received at the destination facility. Overlapping responsibilities with the EMS provider's sponsoring hospital may occur if the patient deteriorates enroute.
- Sponsored EMS providers are responsible for retrospectively notifying their Medical Director of the types of transfers being requested to facilitate assessment and training of personnel by the sponsoring hospital.

OVERSIGHT:

Milford Medical Control will maintain oversight of all interfacility transfers under these guidelines and will review all transports with the transporting agency's quality assurance department. The transporting agency will forward all SCT level EHRs to the EMS Coordinators for review monthly.

- All SCT level paramedics will be required to attend a refresher/recertification course on a bi-annual basis sponsored by their EMS agency. The EMS Coordinators will attend these courses.

PROCEDURE

- Specific guidelines will be provided to paramedics who provide interfacility transports and wish to receive additional training to allow them to transfer patients with medications and equipment beyond those contained in this document. Only those paramedics trained and authorized by MMC and their service may utilize these advanced guidelines.
- Paramedics must attend an MMC approved SCT/CCT course, consisting of no less than forty hours of advanced patient care curriculum.
- **Emergency medical personnel wishing to gain credentials at the specialty care transport-level must have a minimum of six (6) month's experience to attend a course, and one (1) years' experience before practicing as an SCT Medic.**
- Interfacility transport personnel will not transfer patients receiving treatments or utilizing equipment outside the scope of practice for the level of training. This may require that hospital personnel are present in the patient compartment during transport. In cases with polypharmacy and/or sophisticated equipment, either the provider or the sending facility may elect to send or request trained staff to accompany EMS.

TRANSFER ORDERS

- During the transfer on a non-physician accompanied transport, written orders for ALS care will be obtained \ from the referring hospital staff by the paramedic.
- EMS personnel will receive patient history and a patient status report from the sending facility staff and access pertinent medical information. This will include consultation with respiratory for all patients needing airway support.
- If a change in patient condition during a non-physician accompanied transport, standing orders appropriate to the patient's condition will be implemented, and medical direction will be contacted to implement medical direction options per Bridgeport Hospital MMC guidelines.
- If the patient is not stabilized following these interventions, and medical direction is not available for consultation, the patient will be transported to the nearest appropriate facility for stabilization.

COMMUNICATION

- EMS providers must follow their sponsoring hospital guidelines regarding medical direction notification before transporting patients and radio reports to receiving facilities.
- Any unanticipated deterioration of the patient enroute should be communicated to the receiving facility or the sending facility, depending on location and radio reception availability.

DOCUMENTATION

All interfacility transfers will have an Emergency Medical Service run form or electronic Patient Care Report (ePCR) or authorized equivalent completed. All assessments, patient care, and interventions must be documented in keeping with current standards.

- The SCT transport form is required to be completed and submitted with the EHR when completed. The form should be attached to the run form where possible. The form must be clear and easy to read regardless of how attached.
- The name(s) and appropriate credentials of any hospital staff accompanying the patient should be documented on the run form.
- At a minimum, the narrative should contain a history of the present illness, including the circumstances leading to the transfer's initial admission and reason.
- All medications or other equipment settings must be documented on the EHR.
- A copy of the completed run form and the transfer orders should be left at the transfer time at the receiving facility.
- The service should retain a copy of the completed run form.
- A copy of both forms should be submitted to the provider's sponsoring hospital per their documentation guidelines.
- The ventilator setting must be documented on the ePCR at the beginning and end of the transfer.

SCOPE OF PRACTICE

- The Specialty Care Transport Program includes state and sponsoring hospital-specific protocols as approved by the EMS Medical Director.
- All providers are required to follow the current formulary listed in the policy manual.

Blood Transfusion Policy Overview

The Bridgeport Hospital Blood Transfusion Program is a collaborative initiative between the Bridgeport Hospital Department of EMS, Bridgeport Hospital Trauma Center, and the Bridgeport Hospital Blood Bank to ensure timely, safe, and effective prehospital administration of whole blood from the point of injury through arrival at definitive care. The program is supported by the SHCGB and MMC, helping enhance regional emergency response capabilities by enabling specially trained paramedics to deliver life-saving transfusions in the field.

Program Purpose & Structure

The program establishes a regional performance improvement system to support prehospital blood administration under standardized clinical guidelines. Participation requires agency sponsorship, approved training, strict competency maintenance, and adherence to SHCGB and Connecticut OEMS protocols.

Training & Credentialing

- **Initial Training:** Paramedics must complete an approved Initial Blood Transfusion Training Program, including hands-on skills demonstration, storage procedures, and simulation-based resuscitation scenarios.
- **Annual Recertification:** Authorized providers must complete yearly competency checks and training. Rosters of authorized transfusion paramedics are maintained jointly by EMS agencies and MMC Medical Control.

Clinical Protocols

- Prehospital whole blood administration must follow CT OEMS Protocol 4.3 and current BH MMC/SHCGB Prehospital Transfusion Guidelines.
- Paramedics are permitted to waive DMO requirements for specific indications (5, 6, 7 in CT OEMS 4.3) when physiological criteria are met.
- Use of Low-Titer Type O Whole Blood (LTOWB) is authorized; transfusion in women of childbearing potential requires extreme caution.

Contraindications

Transfusion is prohibited in cases of:

- Known transfusion reactions
- Patient refusal or guardian refusal
- Patients <5 years old
- Non-survivable traumatic injury
- Conflicting medical control orders
- Patients meeting CT resuscitation termination guidelines

Blood Allocation, Storage & Transport

The BH Blood Bank supplies EMS units with O-positive LTOWB or RBC units, which must be stored in temperature-controlled, monitored coolers designed for safe blood handling. Unused blood is rotated back into hospital inventory to support a zero-waste strategy. Cloud-based alerts and strict return timelines minimize spoilage and maintain product integrity.

Transfusion Procedure & Documentation

Paramedics must follow all approved transfusion procedures and documentation requirements. If blood is administered:

- EMS must notify the Blood Bank
- Emergency Release forms and transfusions records must be submitted
- Storage and handling logs must be maintained daily

Quality Management

MMC EMS leadership conducts 100% review of all prehospital blood utilization events, assessing:

- Appropriateness of use
- Patient response and outcomes
- Temperature control
- Lab Values (H&H)
- Compliance with policy and protocols

Both EMS and Blood Bank provide continuous quality assessment, supporting data-driven performance improvement.

Questions regarding this program may be submitted to:

Leigh.Goodman@bpthosp.org or Ryan.Nuzzo@bpthosp.org

SECTION THREE: QUALITY ASSURANCE & IMPROVEMENT

SECTION THREE: QUALITY ASSURANCE & IMPROVEMENT

QUALITY ASSURANCE AND IMPROVEMENT

PURPOSE: Bridgeport Hospital Milford Campus is committed to providing quality prehospital care and has agreed to assume the responsibilities outlined in the Regulations Governing the Delivery of Emergency Medical Services June 1988, section 19a-179-12, items (6) and (7). Bridgeport Hospital Milford Medical Control has enacted this policy to monitor and maintain the quality of prehospital care delivered. The EMS Coordinators and Medical Director may withhold authorization from a MIC-level EMS provider or service as per state regulation section 10a-179-15(b) of State Regulations.

POLICY:

- Each sponsored agency will foster an environment that encourages reporting of clinical concerns and errors, including self-reporting.
- When clinical concerns are identified, a systematic evaluation of the actions and/or omissions associated with the specific event or situation will be performed to identify improvement opportunities. A clinical event review does not require actual harm or a negative patient outcome to have occurred.
- For this process to be most effective, it must be fair, objective, and patient-centered. It must emphasize the importance of identifying the fundamental cause of errors. Seeking to identify blame and the personal fault will not be the focus.

ROLES & RESPONSIBILITIES

SPONSORED AGENCIES

- Foster an environment that encourages reporting of clinical concerns and potential errors.
- Ensure all personnel are provided with the skills, knowledge, and training required to perform all aspects of clinical practice.
- Establish an Event Reporting process for the agency.
- Provide data or access to data required for ongoing PI Reviews and initiatives.

MILFORD MEDICAL CONTROL

- Promote the reporting of clinical events.
- Perform event reviews as needed.
- Receive and analyze the ongoing PI review and PI initiative data.
- Update and maintain the event review process.

Bridgeport Hospital Department of EMS has a MMC quality assurance and risk management plan intended to meet the following objectives:

- Assure high quality out-of-hospital care to all patients transported to, evaluated, and treated in the Emergency Department.
- Comply with The Joint Commission and Connecticut Department of Health Office of Emergency Medical Services standards and regulations.
- Identification of trends and early recognition of areas of concern and the prevention of adverse events reaching the patient.
- Provide a mechanism for evaluating and improving an individual practitioner's knowledge and skill base.

As part of the Emergency Department's Quality Assurance Program, the quality of out of hospital care provided by EMS personnel are continuously monitored and evaluated.

Secure and confidential files are maintained on all out of hospital care providers who are authorized to function within the MMC region. These records include but are not limited to medical control remediation or discipline, commendations, CME attendance, and call reviews.

The EMS Coordinators are responsible for the Quality Assurance and Improvement process as it relates to out-of-hospital personnel. Any Emergency Department or other staff member with concerns about the EMS system or an individual EMS provider's actions or patient care may escalate their concern(s) directly to the EMS Coordinators or through their management to the EMS Coordinator.

The Milford Medical Control Program maintains planned and systematic quality management processes through the following means:

- Ambulance Call Report Review

The EMS Coordinator reviews EMS call reports generated for all patient contacts and responses. Reports are screened for completeness, response and on-scene times, appropriateness and accuracy of assessment, and treatment adherence to all operating policies and protocols. EMS providers receive timely feedback on patients via the ESO follow-up program. All patients should have hospital ID bands scanned into the ESO system if the hospital has the capabilities.

- Incident-Based Report of Care Above or Below the Expected Standard

The EMS Coordinator maintains Incident Reporting Forms for documenting allegations of substandard care or commendations for care above the expected standard. The EMS Coordinator follows up these reports immediately, and the results of the investigation are forwarded directly to the Medical Director as needed.

- Field Observation

The EMS Coordinator reserves the right to conduct field observations and accompany any Bridgeport Hospital -credentialed provider on calls to monitor the provider or service's proficiency in rendering quality patient care.

The EMS Coordinator works closely with the EMS Medical Director and is responsible for monitoring the quality of care provided by prehospital personnel.

The Emergency Department is continually staffed with dedicated emergency physicians responsible for providing direct medical oversight to EMS personnel. The Southwest Regional Communications Center (CMED SWRCC) links the Emergency Department physicians to EMS personnel.

The Milford Medical Control Program actively participates in quality improvement by providing scheduled didactic and skill-based training sessions to prehospital personnel.

Secure and confidential files are maintained on all advanced-level prehospital care providers with authorization to function within the Milford Medical Control CQA/CQI system. Records are kept regarding medical control remediation or discipline, commendations, and call audits. Incident-based report of care below the expected standard.

EMS Coordinators will have access to all EMS services Electronic Health Records (EHR) systems for QA activities.

A complaint or concern brought to the attention of the EMS Coordinators will initiate an investigation.

EMS Coordinators will review a percentage of monthly records generated for all transports. The selection of EHRs is focused on high acuity patient encounters, such as cardiac arrest, trauma, STEMI, stroke, etc. Reports are screened for completeness, times, and protocol adherence, along with local operating policies and procedures.

Additionally, each EMS Coordinator may review all EMS charts, including IFTs, SCTs, and refusals, monthly.

During the advanced provider's medical control authorization renewal process, proficiency is assessed by both the number and success rate of advanced interventions (e.g., intubations, IV's, etc.), an ALS skill station review, and potential written protocol exam. A review of CME hours is also conducted to ensure that providers meet MMC standards.

Each EMS Service receiving sponsorship from MMC must submit a written QA program for their service identifying the Quality Assurance Officer and a brief description of their internal QA process. The process must include a proactive review of agreed-upon quality metrics and must have the ability to locate review criteria. Furthermore, the EMS service must report to MMC any identified QA concerns, which are suspected to involve clinical care that does not meet the standard of care, including but not limited to deviations from existing protocols and policies.

CLINICAL EVENT REVIEW PROCESS

For any issues that are identified, regardless of how the issues are determined (i.e., whether found reactively or proactively), the clinical event review process is as follows:

- EMS Coordinator initiates an investigation and determines if there is reasonable cause to proceed.
- EMS Coordinator may consult with one or both EMS Medical Director(s) if needed/desired.
- EMS Coordinator will advise the other EMS Coordinator of the concern that was identified.
- If the concern is of considerable significance, one Medical Director, in consult with at least one EMS Coordinator, is authorized to impose temporary suspensions or other temporary action upon any EMS services or EMS providers who are subject to medical control until the Medical Control Council can meet, which should be as soon as possible.
- EMS Coordinator will forward concerns identified to the EMS quality assurance officer or designee and ask for a service review of the concern before medical action unless deemed critical intervention is needed.
- The EMS Coordinator will review the service's findings and recommendations in consultation with the EMS Medical Director's may accept or modify the service's proposed remediation activities (e.g., education/consultation with a provider).
- If determined to be necessary, the EMS Coordinators will conduct an additional call review with the EMS providers involved, along with the service representative(s) and at least one EMS Medical Director.

CLINICAL PERFORMANCE REVIEW

- The EMS Coordinator will convene a Clinical Performance Review when sufficient information exists to warrant a more thorough and complete investigation before making decisions regarding a provider's credentialing privileges. All Clinical Performance Reviews are peer-protected and will be conducted fairly, objectively, respectfully, and patient-focused manner.
- The EMS Medical Director may manage conflicts of interest to ensure a fair and objective review.
- All review aspects, including the proceedings' notes and documents, are considered confidential. No recordings will be allowed unless authorized explicitly by the Medical Control Council.
- All persons involved in the review follow all requirements for confidentiality, as described in the Clinical Performance Review Process document.
- Each organization and individual provider will fully participate in the Clinical Performance Review, as requested by the EMS Coordinator. Failure to do so may result in the suspension or permanent revocation of a provider's credentials by the Medical Control Council.

- The Clinical Performance Review will be conducted in an expedient manner without compromising the focus on performance improvement and thorough review. The EMS Coordinator will designate a meeting time and date, and the provider and service representative are expected to arrive on time to the designated location. The service Chief is responsible for ensuring both the provider and service representative will be present on that date unless a conflict is discussed with the EMS Coordinators before the meeting date.
- The EMS Coordinators will maintain the original Clinical Performance Review records.
- The final disposition of the investigation and recommendations for action(s) at or above the level of suspension shall require the agreement of both EMS Medical Directors in consultation with both EMS Coordinators.

COURSES OF ACTION

No Action Taken / Matter Resolved - A documented review of a case determined not to have negatively impacted patient care or outcome. The EMS provider's actions were appropriate based on the results of the investigation.

Remediation - The review must involve a deficiency in performance and knowledge base and/or critical thinking ability. Medical Control reserves the right to return the provider to probationary status and require clinical competency evaluations to be performed before returning to good standing status. The duration of the remediation program will be determined based on the findings relevant to the case.

To ensure improvements are made, the EMS Coordinator may draft a plan outlining the recommendations for improvements. The plan should include the specific objective, the specific actions to be implemented, and the person(s) responsible for ensuring the recommended improvements. Most importantly, each improvement should be tied to a finding of causation identified in this process's previous phase.

Suspension - Temporary removal of Milford Medical Control authorization based upon a clinical incident or pattern of incidents deemed significant enough by the Medical Director or designee not to allow the provider to practice until proof of remediation and clinical competency has been determined. The EMS provider will be given a list of objectives that he/she must meet to regain Milford Medical Control authorization. Upon reinstatement of Milford Medical Control authorization, the provider will be placed on probationary status for a minimum period of one year.

Revocation - Permanent removal of Milford Medical Control authorization based on a clinical incident or pattern of incidents deemed significant enough by the Medical Control group not to allow the provider to practice within the auspices of Bridgeport Medical Control regions.

PROVIDER ACTIONS

- The provider may appeal any decision by notifying the EMS Coordinator in writing within ten days of notification to the provider. The appeal letter must include new or alternative evidence not presented in the initial review process. Failure to disclose new evidence will result in an immediate appeal denial.
- In the case of suspension, providers may accept and complete the actions. Upon doing so, they may request a review before the completion of the intended suspension time to appeal for earlier reinstatement.

DOCUMENTATION AND CONFIDENTIALITY

- The EMS Coordinator will maintain the official event review records provided to the Medical Director as required in this process's Documentation section. All records will be maintained as required in the Confidentiality section.
- Each organization shall limit discussions related to clinical performance concerns/complaints, clinical event reviews, and the outcomes of clinical event reviews to those directly involved in the review process or the agency's Quality Committee. The Agency Executive staff may also need to be aware of limited details involving significant adverse events under review.

QUALITY ASSURANCE DATA REPORTING

SCOPE: All agencies with current MICS sponsorship

PURPOSE: Milford Medical Control recognizes that a comprehensive Quality Assurance/ Quality Improvement program begins with accurate data collection of EMS activities.

EMS Quality Metric Report

EMS agencies are required to submit a detailed report based on the current metrics to the EMS Coordinators. This report will be due by the second week of each quarter. These metrics are reviewed periodically, at least every two years, when this policy manual is reviewed. Metrics will be removed, added, or updated as needed.

CONTINUING MEDICAL EDUCATION

CME ETIQUETTE

- Providers are to arrive on time so that the presenter may start the CME session according to schedule. Cell phones and pagers must be turned off during the CME session unless on-duty.
- Providers should demonstrate respect for the instructor and fellow participants by refraining from distracting behavior such as disruptive eating and holding side conversations throughout the session.
- Providers are expected to help maintain the appearance of the classroom.

RECORD OF ATTENDANCE

- Attendance will be taken at each session. You MUST sign the attendance sheet to gain proper credit and are required to obtain the CME certificate after each course.
- Providers are required to maintain their certifications and documentation needed for renewal.
- Medical Control and instructors do not keep copies of CME certificates.

CONTINUING EDUCATION ETHICAL STANDARDS

Falsification of continuing medical education documentation or attendance sign-in sheets will result in the permanent removal of medical authorization. Failure to maintain required CME hours and provide documentation of current licensing and certification will result in progressive discipline and the withdrawal of ALS authorization by the Milford Medical Control Program Medical Director.

SECTION FOUR: MANDATORY REPORTING

SECTION FOUR: MANDATORY REPORTING

MANDATORY REPORTING FOR EMS PROVIDERS

PURPOSE: To outline the circumstances when and the process for EMS providers to report instances of suspected abuse of special populations and opioid overdoses.

POLICY:

Licensed health care providers have legislatively mandated reporters of suspected abuse, neglect, or exploitation of particular groups of people. Legislation in June Special Session Public Act 15-5, Section 480 includes new requirements regarding mandatory reporting of impairment for certain health professionals effective October 1, 2015.

Children

Pursuant to Section 17a-101 of the Connecticut General Statutes, certain health professionals regulated by the Department of Public Health are mandated to report suspected child abuse or neglect to the Department of Children and Families (DCF), Child Abuse and Neglect Careline (1-800-842-2288), or a law enforcement agency.

Reports must be made within twelve hours when the practitioner suspects the abuse/neglect has occurred. Suspected child maltreatment of any kind, regardless of the alleged perpetrator's identity, must be reported. The Careline can answer questions regarding these laws.

Persons with Disabilities

Pursuant to Section 46a-11b of the Connecticut General Statutes, a health care provider who has reasonable cause to suspect or believe that any person with intellectual disability has been abused or neglected shall, within five calendar days, report such information or cause a report to be made in any reasonable manner to the Director of the Office of Protection and Advocacy for Persons with Disabilities or to persons the Director designates to receive such reports. Such a report shall be followed up by a written report within five additional calendar days.

Residents of Long-Term Care Facilities

Pursuant to Sec. 17b-407 of the Connecticut General Statutes, a health care provider who has reasonable cause to suspect or believe that a resident in a long-term care facility has been abused, neglected, exploited or abandoned, or is in a condition that is the result of such abuse, neglect, exploitation or abandonment, shall within five calendar days report such information or cause a report to be made in any reasonable manner to the Commissioner of Social Services pursuant to chapter 319dd.

The Elderly

Pursuant to Section 17b-451 of the Connecticut General Statutes, a health care provider who has reasonable cause to suspect or believe that an elderly patient has been abused, neglected, exploited or abandoned, or is in a condition which is the result of such abuse, neglect, exploitation or abandonment, or who needs protective services, shall within five calendar days report such information or cause a report to be made in any reasonable manner to the Commissioner of Social Services or to the person or persons designated by the commissioner to receive such reports.

Impaired Practitioners

Effective October 1, 2015, any health care professional or hospital shall file a petition if that hospital or health care professional has any information that demonstrates that another health care professional is (or is suspected to be) unable to practice his or her profession with reasonable skill or safety.

DCF MANDATORY REPORTING LINK

<https://portal.ct.gov/DCF/1-DCF/Reporting-Child-Abuse-and-Neglect>

SOCIAL SERVICES REFERRAL PROGRAM

PURPOSE: Define the indications and process for EMS providers to identify patients who may benefit from assistance provided by the hospital's Social Services Department.

POLICY:

- Emergency medical technicians and paramedics often provide emergency health care services in the homes of their patients.
- EMS providers are in the position to assess their patients' living environment and those patients' ability to provide for their care and comfort and the safety of those patients' surroundings.
- In cooperation with a multidisciplinary program through the Emergency Department, the Milford Medical Control Programs, and the Department of Social Services, prehospital personnel is encouraged to identify persons who may benefit from intervention through this process.
- Persons identified as having a risk of insufficient care and/or comfort at home will be contacted by local Social Services for follow up.
- As required by state law and statewide protocols, mandatory reporting to appropriate agencies must be completed immediately after transfer of care by all EMS providers.

PROCEDURE:

- Timely evaluation and treatment must not be delayed or withheld.
- Information relevant to completing a Social Service Referral Form must be obtained during the standard patient assessment and treatment process with information obtained from the patient, family members, and bystanders.
- At no time will a sponsored EMS provider perform an inspection of the house and surroundings outside of the assessment performed within the standards set forth by the National EMS Standards and the Connecticut Statewide Protocols.
- Upon conclusion of patient care contact, the EMS provider may complete a Social Service Notification Form documenting the suspicions for potential intervention.
- This form will be placed in a sealed envelope and marked "Social Services," then passed on to the On Duty Charge Nurse
- Patient confidentiality must always be respected and maintained.

CT STATEWIDE OPIOID REPORTING DIRECTIVE (SWORD)

The Connecticut Department of Public Health Office of Emergency Medical Services (OEMS), in collaboration with the Connecticut Poison Control Center (CPCC) at UCONN Health, and pursuant to Public Act No. 18-166, Sec. 5 have enacted a real time reporting mechanism for Opioid Overdoses in the State through Emergency Medical Services called the CT EMS Statewide Opioid Reporting Directive (SWORD). All CT certified and licensed EMS organizations and providers are now reporting to the CPCC after any call where the patient is suspected of opioid use causing decreased responsiveness, respiratory depression, or death, whether or not naloxone was administered.

<https://portal.ct.gov/DPH/Emergency-Medical-Services/EMS/OEMS---SWORD>

APPENDIX A

MMC FORMULARY CY2026

DRUGS REQUIRED FOR ALL ALS UNITS:

Adenosine	Ipratropium Bromide
Albuterol	Lidocaine
Acetaminophen (Oral)	Lorazepam- (Only if Versed out of stock)
Amiodarone	Magnesium Sulfate
ASA	Methylprednisolone
Atropine	Metoclopramide
Calcium Chloride	Metoprolol
Dextrose (Oral & IV)	Midazolam
Diltiazem	Naloxone
Benadryl	Nitroglycerin SL
Epinephrine (1-1 & 1-10)	Norepinephrine
Sodium Bicarbonate	Ondansetron
Fentanyl	IV Acetaminophen or Ketorolac
Glucagon	Rocuronium- RSI Services only
Ibuprofen PO	Etomidate- RSI Services only
Ketamine for RSI Induction	Phenylephrine- RSI Services only
Droperidol or Haldol for Sedation	

DRUGS AND SKILLS OPTIONAL FOR SERVICES

Lidocaine for Cardiac Bolus and infusion	King-LTD Airway-Optional
Pepcid	LMA/ I-Gels
Decadron	Alcaine
Nitroglycerin IV/ Tridil for PE	Racemic Epinephrine
Rapid Sequence Intubation	Bioshield for OC Decontamination
DuoDotes Kit	Procainamide
Whole blood once supply stabilizes – requires additional training.	Xopenex
Droperidol for Nausea/Vomiting	Succinylcholine
IM Epinephrine for Asthma (EMT)	Buprenorphine
IM Naloxone by EMR	Junctional Tourniquet
Tranexemic Acid TXA	OG Tubes RSI – Services
Calcium Gluconate	Hydroxocobalmin/Cynokit
Compazine	Cefazolin
Epinephrine for Asthma IM (EMT)	Dexamethasone
Lactated Ringers	Ketamine for Pain Management
Pediatric CPAP	Nitroglycerin IV
	Junctional Tourniquets

MEDICATIONS AND SKILLS NOT CURRENTLY SPONSORING

Hydrocortisone	Hydromorphone
Surgical Cricothyrotomy-Bougie Assisted	Compazine
Zyprexa	Pediatric RSI Protocol
Vecuronium	Phenylephrine (for Non-RSI services)
Ketamine for Excited Delirium	Glucagon increase to 5mg IV for CCB & BB Calcium
Gluconate	Ketamine for Pain Management
Diazepam	Lorazepam
Rocuronium	

APPENDIX B

IFT FORMULARY CY2026

Medication/Device	Standard Paramedic	SCT Paramedic	Hospital Staff Required
Analgesics			
Demerol (Meperidine)	X		
Dilaudid (Hydromorphone)	X		
Fentanyl	X		
Ketamine	X		
Ketorolac (Toradol)	X		
Morphine	X		
Nalbuphine HCl		X	
Nitrous Oxide		X	
IV Tylenol	X		
Antianginals			
Nitrates (All)	X		
Ranolazine (Ranexa)		X	
Antiarrhythmics			
Calcium Channel Blockers Infusions (ALL)	X		
Beta Blockers Infusions (ALL)	X		
Adenosine	X		
Amiodarone	X		
Amrinone		X	
Atropine	X		
Digoxin		X	
Esmolol (Brevibloc)		X	
Ilbutilide		X	
Isuprel		X	
Lidocaine	X		
Magnesium Sulfate	X		
Procainamide	X		
Propranolol		X	
Verapamil		X	
Antibiotics			
All	X		

Anticoagulants - TITRATE WITH MD ORDERS ONLY			
Ticagrelor (Brilinta)		X	
Clopidogrel (Plavix)		X	
Ticlopidone (Ticlid)		X	
Dabigatran (Pradaxa)		X	
Abciximab (ReoPro)		X	
Eptifibatide (Integrilin)		X	
Tirofiban (Aggrastat)		X	
Prasugrel (Effient)		X	
Arixtra		X	
Fragmin (Dalteparin)		X	
Heparin	X		
Lovenox (Enoxaparin)	X		
Anticonvulsants			
Diazepam (Valium)	X		
Dilantin (Phenytoin)		X	
Tegretol (Carbamazepine)		X	
Lorazepam (Ativan)	X		
Keppra (Levetiracetam)		X	
Valproic Acid (Depakote)		X	
Midazolam (Versed)	X		
Antidotals			
Flumazenil		X	
Naloxone (Narcan)	X		
Antiemetic's			
Ondansetron (Zofran)	X		
Phenergan (Promethazine)	X		
Reglan (Metoclopramide)	X		
Antihypertensives- TITRATE WITH MD ORDERS ONLY			
Beta Blockers (All)		X	
Calcium Channel Blockers (All)		X	
ACE Inhibitors (All)		X	
Clonidine		X	
Sodium Nitroprusside		X	
Hydralazine		X	
OB Medications			
Magnesium Sulfate	X		
Methergine		X	
Oxytocin (Pitocin)		X	
Terbutaline		X	

Bronchodilators			
Albuterol	X		
Aminophylline		X	
Epinephrine	X		
Ipratropium	X		
Levalbuterol (Xopenex)	X		
Terbutaline	X		
Diuretics			
Bumetanide (Bumex)	X		
Furosemide (Lasix)	X		
Mannitol		X	
Electrolytes			
Calcium chloride	X		
Magnesium sulfate	X		
Sodium Bicarbonate	X		
Potassium chloride	X		
Endocrines			
Glucagon	X		
Insulin		X	RN Needed to Titrate < 16 y/o
Octreotide (Sandostatin)		X	
Pitocin (Oxytocin)	X		
Vasopressin	X		
Neuromuscular Blocking Agents, Paralytics			
Pancuronium		X	
Rocuronium	X		
Succinylcholine	X		
Tarcrium		X	
Vecuronium	X		
Nimbex (Cisatracurium)		X	
Parenteral Nutrition			
Multivitamins		X	
Partial Parenteral Nutrition (PPN)		X	
Total Parenteral Nutrition (TPN)		X	
Thiamine	X		
Phosphodiesterase 3 Inhibitors			
Amrinone		X	
Cilostazol (Pletal)		X	
Milrinone		X	
Enoximone		X	

Sedative Hypnotics			
Etomidate	X		
Haloperidol (Haldol)	X		
Ketamine	X		
Lorazepam (Ativan)	X		
Midazolam (Versed)	X		
Propofol		X	
Dexmedetomidine		X	
Precedex		X	
Diazepam	X		
Steroids			
Depo-Medrol		X	
Dexamethasone	X		
Hydrocortisone		X	
Methylprednisolone	X		
Prednisolone	X		
Thrombolytics- Infusion Only			
Alteplase		X	
Retaplast		X	
Tenecteplase (TNK)		X	
t-PA		X	
Vasopressors			
Amrinone		X	
Dobutamine		X	
Dopamine		X	
Epinephrine		X	
Isoproterenol		X	
Milrinone		X	
Norepinephrine (Levophed)		X	
Phenylephrine		X	
Pitressin		X	

Volume Expanders			
Albumin		X	
Dextran		X	
Kcentra		X	
Platelets		X	
Factor VIII		X	
Intralipid	X	X	
Hetastarch		X	
Crystalloids (All)	X		
Fresh Frozen Plasma	X		
Packed Cells	X		
TXA	X		
Whole Blood	X		
Other			
Antihistamines (All)	X		
H2 Blockers	X		
Mannitol		X	RN Needed to Titrate
Nesiritide		X	
Protonix		X	

Skills/Devices			
Cpap	X		If Not on Ventilator
BiPap		X	
Chest Tubes (2) on suction		X	RN Needed - Med Control Call
Single Chest Tube Sealed or on suction		X	
Ventilator		X	Mode Dependent or RT Needed
Tracheostomy	X	X	SCT if under 24 hours old
PICC	X		
Triple Lumen/Central Line Monitor Only – NO MEDS	X		No medication being admin, Lines must be capped
Triple Lumen/Central Line Monitor Only - MEDS			Medication being admin, you can monitor and protect lines only
PortaCath	X		
Atrial/venous sheaths		X	
Continuous Urinary Catheter irrigation	X		
Epidural Catheter (must be capped)		X	
*** Skills/Devices Requiring Hospital Staff to Accompany Crew ***			
Balloon Pumps			X
ECMO			X
Impella			X
Chemotherapy Agents			X
New Epidural Infusion unless PCA			X
Swan Ganz			X
Transvenous Pacer			X
Invasive Monitoring			X
ICP Monitoring			X
*** 3% NaCL Infusion ***			X
Arterial Lines			Conditional Hospital Staff Requirements

EMT Transport			
IV Med lock, (Clamped, no medications running)		EMT Transport	
Porta Cath (Nothing Running)		EMT Transport	
PICC (Nothing Running)		EMT Transport	
Tracheostomy (No Ventilator Assist) (Pt able to self-manage and >48 hours of placement)		EMT Transport	
Naloxone (Narcan)	Given/No Infusion	EMT Transport	
Locked PCA Pumps >24 hours		EMT Transport	

APPENDIX C

MMC RSI POLICY

The RSI procedure is OPTIONAL for the EMS agencies within the Milford Medical Control region.

Those services electing to continue using RSI, the following requirements must be followed:

EMS Agencies who add the RSI protocol, must notify MMC in writing of their intent to do so. Those who already participate only need to notify MMC of any changes.

EMS agencies utilizing RSI are mandated to hold, at a minimum, at least one airway management lecture based and one airway management practical based CME annually. (Can combine the practical with the lecture)

Paramedics who work at an RSI service must attend an annual advanced airway lecture and practical skills simulation. CME must be a MMC approved program.

Services who opt to use RSI must follow the MMC approved medication formulary (page 55) when performing the procedure.

APPENDIX D

MMC CONTROLLED SUBSTANCE LOU

This document outlines the policies and procedures you agree to follow for compliance with Bridgeport Hospital and State of CT controlled substance policies. Failure to comply with all provisions can lead to the withdrawal of controlled substance privileges.

1. Security and Storage

- a. Controlled substance kits will only be carried in vehicles that are authorized to carry the same. These vehicles are listed explicitly by the number filed with the State of CT.
- b. Controlled substance kits will be kept in a double-locked safe except when used or when anticipated to be in use. You may carry controlled substance kits on your person if:
 - i. You are doing a kit exchange.
 - ii. You are on a call where you might reasonably expect to need the controlled substances, and distance from the vehicle might adversely impact patient care.
- c. The vehicle doors do not constitute a second lock in the double lock requirement.
- d. Vehicles that have controlled substance kits onboard will be locked at all times when unattended. This includes hospital bays, service garages, and all other locations.
- e. The keys to the onboard safe will be in possession of the paramedic who has always signed for them.

2. Kit Exchange

- a. Controlled substance waste must be done and witnessed before returning a kit to the Pyxis system. Kit exchange can only be done at Bridgeport Hospital Milford Campus.
- b. Controlled substances dispensed under STANDING ORDERS may have the words PER PROTOCOL written into the MD/CRNA signature spot by the paramedic, and an MD/CRNA signature may be omitted. Controlled substances dispensed with on-line medical direction, whether on standing orders or not, require an MD/CRNA signature in that spot.
- c. If there is waste, it must be signed for by the MD or CRNA, or by an RN or PA at the receiving hospital.
- d. Deposit waste in specially marked bins in the ER if the ER is so equipped.
- e. If controlled substances are drawn up but not used due to change in the patient's condition, both the amount that was drawn up and the remainder should be counted into waste and so documented.
- f. The kit should be resealed with the remaining seal before placing the kit in the return bin.
- g. Each paramedic's signature form, who may administer controlled substances, will be kept on file at the pharmacy. This signature form must be renewed yearly. An exchange will be denied if the paramedic requesting the exchange does not have a valid signature form on file.

3. Controlled Substance Receipt and Exchange

- a. By your required daily signature on the controlled substances log maintained by your service, you affirm visual inspection and acceptance of a controlled substances kit with intact seals and valid drug expiration dates. Any deviation from this must be noted on the log, and the kit exchanged out with the pharmacy at once. Service supervisors will contact the EMS Coordinator to report the deviation.
- b. In the event of damage to a kit or damage to seals while the kit is in your possession, contact service supervision to arrange for documentation of the same and replacement of the kit. Leave all contents of the kit as is, do not attempt to clean or repack it. Pictures should be taken of the damaged kit ASAP.
- c. All damaged kits or missing items must be returned to the pharmacy, not Pyxis.
- d. If the Controlled Drug Accountability record cannot be found, notify your supervisor, who will notify the EMS Coordinator who will call the pharmacy. The sheet will be reprinted.
- e. Only one kit may be kept in a vehicle. In the event a supervisor is doing an emergency resupply, more than one kit may be on that vehicle only for the duration of that resupply.
- f. Failure to correctly complete all required paperwork and waste before the kit being returned to the Pyxis system will result in the following:
 - 1. First offense results in a warning placed in the file.
 - 2. The second offense results in a suspension of Pyxis privileges and all kits must be returned to the pharmacy for two months.
 - 3. Third offense results in permanent removal from the Pyxis system for narcotic exchanges.
- g. Any kit turned in without properly completed paperwork will require to the paramedic to return to the pharmacy to correct within 24 hours of notification or potentially lose the ability to handle narcotics in the future.

4. Use of Controlled Substances

- a. Drug administration will encompass best practices, including verification of drug, indication, and expiration. Whenever possible, a third party will visually confirm that the drug selected is the drug desired and the same document in the call report. Many bottles look similar, and cap colors can change based on supply.
- b. Patient age, sex, and weight (estimated in kg) will be documented in all call reports.
- c. Drug concentrations can vary depending on supply. Care must be taken in drawing up the intended dose.
- d. Deviations, errors, or adverse reactions to medication will be reported to the appropriate parties without delay.
- e. Dosages will follow the MHSHP protocol exactly. For exceptional circumstances, on-line medical direction will be used for deviation from protocol and the same documented.

I acknowledge I understand and agree to follow the policies outlined above and have received a copy of this document by my signature.

Print Name:

_____.Services_____

Signed:_____ Date_____

APPENDIX E

MMC CONTROLLED SUBSTANCE KIT PROCEDURES

Paramedics log on to the pyxis using their username and fingerprint. The initial setup will require the paramedic's fingerprint to be scanned three times. A fingerprint must be taken to complete the initial activation.

Usernames will be issued by the pharmacy. They usually try to follow the format below but can vary if the name is already in use.

Username: First Five of the Last Name, First Initial

EXAMPLE:

Name: Leigh Goodman

Username: GOODML

The pharmacy will issue the best match if your last name has less than five letters.

Temporary Password: 87654321 or as assigned.

The password will be changed on the first login.

Paramedics must be sure to remain active in the system. This requires the user to log on at least once every three months. You do not need to exchange a kit to do this. You can type your username in, scan your fingerprint, and then hit cancel/log out.

MMC-issued narcotics must be exchanged using the Milford Campus Pyxis. In the event you are exchanging narcotics after transporting your patient to an alternate destination facility, such as but not limited to Bridgeport Hospital, SVMC, YNH-YSC, or YNH-SRC, you must still return the used kit via the Milford Campus Pyxis. **While your waste should be witnessed by staff at the destination facility associated with the call, you must then seal the kit and return the kit to the Milford Pyxis.**

WASTE PROCEDURES

If there is waste, it must be signed for by the MD or CRNA or by an RN or PA at the receiving destination hospital.

If controlled substances are drawn up but not used due to a change in the patient's condition, the amount drawn up and the remainder should be counted into waste and documented.

Waste is signed for using the Controlled Drug Accountability Record, which must be filled out each time you use controlled substances.

You must document the amount wasted and the reason. Waste reasons are broken down into the following three categories:

E

B

C

EXCESS

BROKEN

CONTAMINATED

Milford Campus Bridgeport Hospital
PARMEDIC KIT 01
Controlled Substance Accountability
Record

0001

REFILLED BY: authorizedemployee@ymhb.org

DISPENSED TO	Leigh Goodman, Paramedic
DATE	5/8/2023
ISSUED BY	

Sample Documentation

Patient's Full Name	Name of Medication	Dose	Waste/Returned	Waste Reason	MD/CRNA Signature
Jane Doe	Fentanyl	100 mcg	150 mcg	E B C	Per Protocol**
	Signature Returned To	Date & Time Wasted		Signature Witness Waste	
	N/A	05/08/23 10AM		MilfordNurseRN	

Patient's Full Name	Name of Medication	Dose	Waste/Returned	Waste Reason	MD/CRNA Signature
Jane Doe	Versed	10 mg	NONE	E B C	Per Protocol**
	Signature Returned To	Date & Time Wasted		Signature Witness Waste	
	N/A	05/08/23 10AM		MilfordNurseRN	

****This signature is ONLY required if controlled substances were used secondary to direct medical oversight**

Deposit waste in controlled substance waste bins in the ER.

NO OPEN VIALS of medications should be returned with the controlled substance kit to the Pyxis.

No SHARPS should be returned with the controlled substance kit to the Pyxis.

The kit should be resealed with the remaining seal before placing the kit in the return bin. Both forms must be filled out with provider information, medication amounts used, wasted, and patient demographics.

RETURN PROCEDURES

Ask Emergency Department ED Nurse to witness the return and removal transaction. RN will not witness the removal of the kit unless they have visually witnessed the return.

Confirm that the kit has been resealed with the remaining seal before placing the kit in the return bin. Ensure both controlled substance forms have been filled out with provider information, medication amounts used, wasted, and patient demographics.

- 1 Ask Emergency Department ED Nurse to witness the return and removal transaction. RN will only witness the removal of the kit if they have visually witnessed the return.
- 2 EMS Personnel will log into the assigned PYXIS using their Username and BioID.
- 3 The pyxis will then ask you to SELECT TASK TO START
EMS should select **ALL AVAILABLE PATIENTS** from the taskbar at the bottom of the screen.
- 4 SELECT **EMS PATIENT** and then SELECT **RETURN** from the bottom task bar.
- 5 Choose any **PARAMEDIC KIT** and then select **RETURN** and accept.
- 6 Please place the sealed kit with the printed receipt and both sheets of completed paperwork into the external return bin to the left of the PYXIS machine and make sure the kit falls securely into the lockbox.

REMOVAL PROCEDURES

- 1 From the main menu, select **ALL AVAILABLE PATIENTS**.
Choose **EMS Patient** associated with your Service; for example, Milford FD will select "Milford EMS Patient".
- 2 Select **OVERRIDE** and select **Paramedic Ambulance Kit**.
- 3 Enter the quantity "**1**" and select **REMOVE MED**.
An alert will pop up requesting RN Verification. Click **ACCEPT** to continue.
- 4 Follow prompts, if asked, for which truck/unit number you are replacing the kit to and select from the drop-down options. Select **Accept Response**.
- 5 The assigned drawer will open, and you will be asked to confirm the beginning count. **Remove the assigned kit and close drawer**.
- 6 The kit will include a **delivery signature sheet outside the kit, which must be completed legibly upon receipt**, and have the date, service, & assigned unit/truck #. This must be kept with the kit & returned when exchanging the kit.

- **I need help remembering my user ID or password. What should I do?**
 - Go and see the pharmacy team.
- **The last time I was active in the Pyxis was three months ago. What should I do?**
 - Go and see the pharmacy team.
- **I misplaced one of the forms that I needed to complete during the call. What should I do?**
 - Proceed to the pharmacy and request a reprint of the paperwork. Email your service supervisor and the EMS Coordinator as soon as possible. The pharmacy can be visited 24 hours a day.
- **I had an issue when drawing up narcotics. What should I do?**
 - Email your service supervisor and the EMS Coordinator as soon as possible and describe the issue.
- **I noticed a discrepancy in my narcotic paperwork. What should I do?**
 - Email your service supervisor and the EMS Coordinator as soon as possible to report the issue.

[illegible][illegible]

APPENDIX F
MMC MEDICAL CONTROL APPLICATION

Email the EMS team for application packet.

APPENDIX G

MMC CONTACT INFORMATION

NAME	Ryan Nuzzo, NRP
ROLE	MMC EMS Coordinator
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NAME	Leigh Goodman, NRP
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NAME	Richard Greiner, MD
ROLE	MMC Medical Director
EMAIL	Richard.Greiner@bpthosp.org

APPENDIX H

HELPFUL RESOURCE LINKS

CT OEMS PROTOCOLS

<https://portal.ct.gov/DPH/Emergency-Medical-Services/EMS/Statewide-EMS-Protocols>

CT OEMS HOME PAGE

<https://portal.ct.gov/DPH/Emergency-Medical-Services/EMS/Office-of-Emergency-Medical-Services-Homepage>

CTEMS ADVISORY BOARD (CEMSAB)

<https://portal.ct.gov/DPH/Emergency-Medical-Services/CEMSAB/Boards-and-Commissions>

CT EMS PROVIDER HEALTH & WELLNESS RESOURCES

<https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/ems/pdf/Health-and-Wellness/Resiliency-Resource-Listing---Updated-June-2022.pdf>

<https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/ems/pdf/Health-and-Wellness/State-of-Connecticut-EMS-Resource-Manual---Updated-62222.pdf>

CT STATEWIDE OPIOID REPORTING DIRECTIVE (SWORD)

<https://portal.ct.gov/DPH/Emergency-Medical-Services/EMS/OEMS---SWORD>

DCF MANDATORY REPORTING

<https://portal.ct.gov/DCF/1-DCF/Reporting-Child-Abuse-and-Neglect>

HUMAN ANTI-TRAFFICKING RESPONSE TEAM (HART) IN CONNECTICUT

<https://portal.ct.gov/DCF/HART/Home>

CT EMS FOR CHILDREN

<https://emscimprovement.center/state-organizations/ct/>

APPENDIX I

2026-2028 POLICY MANUAL ACKNOWLEDGEMENT FORM

The Milford Medical Control 2026-2028 Policy will be live beginning February 1st, 2026. Should the policy be updated, Milford Medical Control will send out a revision summary for review. All providers MUST sign this policy acknowledgement form, or an approved electronic service specific copy.

PROVIDER ATTESTATION

I acknowledge that I have received, reviewed & understood the policies and guidelines within the document provided by Bridgeport Hospital, Milford Medical Control (MMC). I understand that it is my responsibility to comply with the policies and procedures included in the document.

Provider Printed Name	
Provider Title/Level of care	
Provider Signature	
Date Signed	

Witnessed by:

Supervisor Printed Name	
Supervisor Title/Level of care	
Supervisor Signature	
Date	

Should you have questions or concerns regarding the policy, please email your Milford EMS Coordinator.

APPENDIX J

MILFORD MEDICAL CONTROL POLICY MANUAL REVISION SUMMARY CY2026

This document contains some, but not all, of the 2026 policy revisions. Most changes were minor grammatical changes, language corrections such as MMC replacing MSHP etc. Significant changes have been summarized below for your review.

PAGE	TOPIC	REVISION SUMMARY
11	PROVIDERS WHO DO NOT SUBMIT RENEWAL ON TIME, GET AUTOMATIC 30-DAY SUSPENSION OF MEDICAL CONTROL IMPOSED FROM THE TIME THE LATE RENEWAL APPLICATION IS SUBMITTED	New
13	MEDICAL CONTROL AUTHORIZATION FOR SUPERVISORY AND CHIEF-LEVEL EMS PROVIDERS	New
15	AUTHORIZED MENTOR QUALIFICATIONS	Added "PFI in good standing"
16	CONTROLLED SUBSTANCES	Updated to include user guide
27	MMC STEMI ALERT	Reflects most current version
29	MMC STROKE ALERT	Reflects most current version
30	MMC TRAUMA ALERT	Reflects most current version
33	MMC SEPSIS ALERT	Update age and temperature
56	MMC FORMULARY 2026 UPDATE	Spreadsheet shows changes
58	IFT FORMULARY 2026 UPDATE	
63	MMC RSI POLICY	Reflects most current version
67	MMC CONTROLLED SUBSTANCE KIT PROCEDURES	New
73	MMC CONTACT INFORMATION	New
74	HELPFUL RESOURCE LINKS	New

Date Revised	01/30/2026
Revisions Respectfully Submitted by	Ryan Nuzzo, EMS Coordinator
On behalf of	Bridgeport Hospital Emergency Medical Services-Milford Medical Control