

Sponsor Hospital Council of Greater Bridgeport 2026 Policy Manual



This policy manual is a “living document” developed by the Sponsor Hospital Council of Greater Bridgeport (SHCGB) in conjunction with the agencies it sponsors for medical control. This document will be formally reviewed every two years for relevance and timeliness. However, the SHCGB reserves the right to update this document at any time.

This document may not be amended, altered, or otherwise changed by any EMS agency; however, it may be reproduced and distributed to EMS agency personnel without the permission of the SHCGB.

DISCLAIMER: This policy manual is intended to be used in conjunction with individual EMS agency service policies and procedures. EMS providers are required to follow all local service policies and procedures, notwithstanding this document.

A handwritten signature in blue ink, appearing to read "D Latham".

Dr. Douglas Latham
EMS Medical Director
Bridgeport Hospital

A handwritten signature in blue ink, appearing to read "Steven Valassis".

Steven Valassis, MD, FACEP
EMS Medical Director
St. Vincent's Medical Center

A handwritten signature in blue ink, appearing to read "Leigh Goodman".

Leigh Goodman
Regional EMS Manager
Bridgeport Hospital

A handwritten signature in blue ink, appearing to read "Wesley Young".

Wesley Young
Director of EMS Operations
St. Vincent's Medical Center

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Section 1: General

Title: The Mission of SHCGB

"Incorporating the values of integrity, compassion, accountability, respect, and empathy, The Sponsor Hospital Council of Greater Bridgeport is committed to the provision of high-quality pre-hospital emergency care to the citizens and visitors of the greater Bridgeport area."

Title: General Operating Guidelines

Purpose: The purpose of this document is to guide specific Sponsor Hospital policies and procedures.

Discussion: Pre-hospital emergency medical services (EMS) aim 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 EMS care, and appropriate medical consultation, as needed. The following policies are to be used by EMS providers authorized to practice in the Sponsor Hospital Council of Greater Bridgeport (SHCGB) catchment area to ensure consistent and quality medical care and to establish standards by which pre-hospital 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 chief complaint.
- All EMS providers will adhere to the most current version of the Connecticut Statewide EMS Protocols as published on the DPH OEMS website.
- All EMS providers will adhere to SHCGB and EMS agency-specific protocols in addition to the Statewide EMS protocols.
- The EMS provider is responsible for being thoroughly familiar with all devices and therapies authorized for use in the Statewide EMS protocols and those specific to the SHCGB region.
- All treatment and diagnostic monitoring provided during transport must be continued during the transfer from the ambulance into the Emergency Department.
- Direct medical oversight (DMO) is an option anytime during the patient encounter.
- No provider shall deviate from policies or protocols without DMO.
- In the event a protocol deviation is authorized via DMO, an exception form must be completed and returned to the EMS Coordinator of the receiving hospital.
- Exception forms may be found with the EMS agency.
- Physician-obtained orders that are inappropriate or outside the scope of practice of the EMS provider must be documented, and the EMS Coordinator at the receiving facility must be notified as soon as reasonably possible.
- The paramedic has the right to refuse to implement orders or procedures that are outside of the paramedic scope of practice, outside of the current Statewide EMS protocols, and/or inappropriate for the patient's condition.

Section 2: Medical Control

Title: Sponsor Hospital Authorization of Medical Control

Purpose: This policy aims to provide a structured format for EMS providers to obtain, maintain, and renew clinical authorization to practice as EMS providers in the Sponsor Hospital of Greater Bridgeport (SHCGB) catchment area.

Scope: This policy applies to all certified and licensed EMS providers currently practicing or wishing to practice in the SHCGB catchment area.

Policy:

Initial Authorization for Paramedic Providers

- Any EMS provider interested in working in the SHCGB catchment area must align themselves with an EMS agency within the SHCGB region.
- Any EMS agency interested in hiring a licensed paramedic provider must express their interest, in writing, to each Sponsor Hospital EMS Coordinator.
- The candidate is required to submit a completed application for medical control to each Sponsor Hospital EMS Coordinator with supporting documentation, including, but not limited to, the following:
 - Proof of employment with an EMS agency sponsored by the SHCGB.
 - Current and unencumbered paramedic licensure.
 - Inactive applicants (defined as not functioning at the paramedic level with the full authorization granted by a sponsoring hospital or other credentialing agency for a period exceeding twelve months) will be required to show proof of completion of a state-approved paramedic refresher program if more than two years out of the field.
 - A letter from the primary or immediately previous sponsoring hospital verifying the applicant's status as a paramedic provider.
 - Current American Heart Association or American Red Cross BLS healthcare provider card.
 - Current American Heart Association or American Red Cross ACLS & PALS certifications.
 - Current PHTLS or ITLS certification for initial medical control applicants only.
 - This application must be submitted in its entirety before scheduling the initial medical control protocol examination.
 - New graduate paramedics must have at least three (3) live intubations before applying for medical control.
 - Candidates without at least three live intubations will be required to obtain these intubations in either of the medical control hospitals' OR.

Initial Authorization for EMT Level Providers

- Maintain State Certification
- AHA or American Red Cross BLS Card
- Complete a precepting process approved by the service agency and SHCGB.
- Pass the SHCGB EMT protocol exam given by the service provider with a score of at least 72%. EMS Agencies will be provided a direct link to have candidates complete the exam. This is a closed book exam. Exam must be proctored by the service. EMTs may retake the test once, after a 24-hour waiting period. Candidates may utilize 3 attempts total. Thereafter, any additional attempts will be at the discretion of the EMS service and medical control team. Services may be subject to a fee for additional testing.
- SHCGB will accept any current test taken at another sponsored service in place of completing the exam if taken within 12 months.

Paramedic Precepting Process

Note: Medical control is agency specific. A provider must submit a separate application for each service they work for. Services are highly encouraged to verify that all new clinicians are eligible for medical control prior to hiring.

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.

SHCGB has the right to refuse medical control to any applicant based on a background check, and decisions are not appealable.

- After a review and verification, the medical control process may begin.
- The candidate must complete the current region one ALS protocol exam with a 72% or higher. The test is based on the most current version of the CT Statewide Protocols, SHCGB formulary, and paramedic knowledge. SHCGB will accept any current test taken at a region one service in place of completing the exam if taken within 12 months. Failure to complete the interview process within six months of taking the exam will require a new protocol test.
- Candidates that do not successfully pass the protocol exam may retest based on the following schedule:
 - 1st Reattempt: The candidate may retest after seven calendar days.
 - 2nd Reattempt: The candidate may retest after fourteen calendar days.
 - 3rd Reattempt: 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, the medical control interview will be scheduled with both EMS coordinators and at least one EMS medical director, if available, in a timely manner.
 - 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 10 business days of completing the protocol exam.
- Candidates failing to pass the medical control interview may reinterview based on the following schedule:
 - 1st Reattempt: The candidate may reinterview after 14 calendar days.
 - 2nd Reattempt: Requires agency approval and continued sponsorship.
 - All other reattempts: Require a 90-day waiting period between interviews.

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 SHCGB policies and procedures.

- Precepting must begin within three months of successfully completing the protocol exam and interview process.
- The precepting process must be completed within six months of passing the interview process except in extreme circumstances.
- Failure to complete the process within the allotted time may result in the candidate having to begin the process over with the protocol test.
- Only field training officers (FTOs) or paramedic field instructors (PFIs) who have completed an approved two-hour training course and have been approved by medical control will be allowed to precept paramedic candidates.
- FTOs and PFIs must be in good standing with medical control and not under current action from medical control.
- Graduate paramedics requesting initial medical control must be able to run 911 calls at the sponsoring agency. An exception may be considered and granted on a case-by-case basis.
- A candidate must complete at least thirty (30) ALS calls and fifteen (15) interventions.
- Only ALS calls where a patient has been transported to a receiving facility will be counted.
 - Reciprocal medical control authorizations are considered on a case-by-case basis, depending on experience and background.
 - A minimum of three (3) ALS calls are required for candidates seeking reciprocal medical control authorization.
 - Paramedics coming from any current YNHHS or HHC medical control regions in good standing will be granted reciprocal medical control with an application and clearing ride*. Clearing rides may be waived at discretion of EMS Coordinators.
- Routine paramedic care must be performed according to the most current version of the CT Statewide protocols to constitute an ALS call.
- An intervention is defined as follows:
 - ALS medication administration, electrical therapy (cardioversion, defibrillation, TCP), or placement of an advanced airway
 - Advanced airways include supraglottic airways, endotracheal tubes, and cricothyrotomy.
 - Needle chest decompression.
 - Intraosseous (IO) / External Jugular (EJ) IV 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.
 - For example, Nitroglycerin for chest pain or CHF can be counted three times on different calls.

- Various patient encounters are required to obtain medical control, at the discretion of the EMS Coordinators.
 - Routine IV access, fluid bolus, ASA, Narcan, and Oxygen will not count as interventions.
- The paramedic candidate must schedule a review with each EMS Coordinator after 15 and 30 completed ALS calls.
 - (More often if deemed necessary).
- The paramedic candidate may not be part of a two-person crew until an EMS Coordinator has signed off on 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 non-emergency should the preceptor deem it appropriate.
 - The candidate must have a preceptor accompany them in the patient compartment on any emergent transports until they have been cleared from precepting.
- Upon completing the precepting process, the sponsoring EMS agency will request that the EMS Coordinator(s), Medical Director, or their designee, monitor the candidate during a regular road shift. The service must attest that they feel the clinician is ready for final medical control evaluation. The service may utilize their discretion and increase required calls and/or interventions if they feel it is applicable prior to scheduling their clearing ride.
- Clearing/final observations may be completed over a single shift or several shifts, depending on the call volume and performance of the candidate.
- The EMS Coordinators will complete a final review document where the candidate must receive 3's or better in all categories.
- If the candidate does not meet the aforementioned criteria, a second clearing ride will be scheduled with the other EMS Coordinator. Services are encouraged to work on any concerns raised prior to the follow-up clear ride.
- If it is the opinion of the sponsoring EMS agency and/or the EMS Coordinator(s) that the candidate has not demonstrated the 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 a successful clearing ride is completed, 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.
- During the provisional period, medical control may be withdrawn at any time. The paramedic could then be required to return to preceptor status for remediation or may be denied permanent independent medical control authorization. If no actions have been taken against the paramedic during the six (6) month provisional period, 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.

Concurrent Medical Control Precepting Processes

Paramedics doing a concurrent precepting process in another CT Medical Control region will be allowed to count up to 50% of the required calls and interventions from that process in place of SHCGB requirements.

- Paramedics must submit completed EPCRs and daily evaluations to the EMS Coordinators for review and acceptance.

Maintaining Medical Control

All certified and licensed EMS providers must keep all required credentials current and maintain in-service records. SHCGB reserves the right to request records from an individual EMS provider or audit agency records at any time.

EMS Agencies must ensure all providers maintain the required certifications throughout their employment or volunteer time at the agency, and medical control reserves the right to audit the individual provider and agencies at any time.

Renewing Medical Control

- The medical control cycle in the SHCGB catchment area is a revolving two-year cycle that runs concurrent with the NREMT cycle.
- All paramedic providers are responsible for acquiring and submitting the required renewal application and training as outlined in Appendix C for each renewal cycle.
- EMS agencies are responsible for tracking and ensuring all EMT providers have completed the training requirements outlined in Appendix C.
- If a provider was out on injury, military deployment, or extended LOA from all sponsored services for over half of the renewal cycle, medical control may modify the CME requirements on a case-by-case basis.

Lapses in SHCGB Medical Control

- 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 renewal application is submitted, unless provider was on an approved LOA such as CT Fire Academy or approved medical LOA.
- *If renewal is not submitted within 90 days, additional requirements may be assigned at the discretion of EMS Coordinators.*
- Providers who allow a lapse in medical control for two years or less must submit a new application and submit all CME hours required for renewal to reacquire medical control.
- Providers who allow a lapse in medical control for more 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 and pass a protocol exam.

Providers who allow a lapse in medical control for two years or more must begin the precepting process as determined by medical control.

Suspension and Termination of Medical Control

Each Medical Director, in consultation with at least one EMS Coordinator, 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 then be terminated after the event review process.

Title: Medical Control Authorization for Supervisory and Chief-Level EMS Providers

Purpose: While infrequent, it is reasonable to assume executive leaders of EMS agencies will have to participate in direct patient care from time to time. The reasons for this include but are not limited to staffing shortages and unique events.

Scope: EMS providers assuming executive leadership roles within EMS agencies in the SHCGB catchment area who DO NOT hold current medical control authorization in the SHCGB region must complete the steps outlined below if they request medical control authorization:

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

- Apply for medical control with a completed application.
- Meet with the medical control council to express interest and review experience.

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

- Pass a written protocol exam
- Pass an oral medical control scenario
- Precept for a number of calls, as determined by the SHCGB.

Additionally, the candidate must provide the following documentation:

- At least two professional reference letters.
- Documentation attesting that there are no outstanding quality assurance or patient care concerns.
- Meet all other certification requirements for the region.

Title: 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 Sponsor Hospital Council of Greater Bridgeport (SHCGB), 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, SHCGB has the authority to provide medical control to EMS agencies and their providers. Therefore, the SHCGB agrees to continue to provide medical control, provided the following requirements are met.

Scope: All EMS agencies currently sponsored by SHCGB or those interested in being sponsored by SHCGB.

Policy:

- Agencies must complete an affiliation agreement with the SHCGB and renew annually.
- At the time of renewal, all sponsored services agree to comply with all SHCGB policies, protocols, and procedures as part of the MICS credentialing process.
- A full agency roster must be submitted with your annual MICS form. Services must also provide a full list of their primary EMS point of contacts to ensure accurate dissemination of information and meeting notifications.
- Beginning on 01/01/2026, services must submit their Quality Management Policy every 5 years when they submit their LEMSP.

Services will send a representative to attend quarterly medical control meetings. All sponsored agencies, including first responders, are required to attend at least two meetings per year, or they risk losing their ongoing medical control sponsorship. Each sponsored agency is responsible and accountable for maintaining the following documentation:

- Current American Heart Association (AHA) or American Red Cross (ARC) equivalent ACLS (ALS only)
- Current American Heart Association (AHA) or American Red Cross (ARC) equivalent PALS (ALS only)
- Current American Heart Association (AHA) or American Red Cross (ARC) equivalent CPR (Healthcare Provider) (All)
- CT State Paramedic License
- CT State EMR/EMT Certification

Services that fail to meet the minimum requirements will be considered ineligible for Sponsor Hospital authorization and will, under no circumstances, be allowed to function within SHCGB.

Title: Medication and Controlled Substances Policy

Purpose: Establish a standard for accountability and minimum requirements for drug inventory, documentation of usage, and replacement of controlled substances in accordance with Federal DEA rules and State of Connecticut Regulations. Only narcotics supplied by Bridgeport Hospital Pharmacy or St. Vincent's Medical Center based on current agreements may be carried on response vehicles, as authorized by the Sponsor Hospital Council of Greater Bridgeport (SHCGB).

Scope: All SHCGB Paramedics

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 immediately notify the EMS Coordinator 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 SHCGB EMS Medical Directors may be carried on ambulances. In addition, the Medical Directors and the State of Connecticut EMS Minimum Equipment List shall determine the number of drugs the EMS agency carries.
- 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 Hospital Pharmacy Department.
- Paramedics must 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.
- Any unanticipated or undesired response directly attributable to drug administration shall be reported to the receiving hospital Emergency Department physician, the EMS Coordinator, and/or EMS Medical Director(s).
- Upon entering the medical control region, all paramedics must sign the narcotic agreement detailing narcotic handling. (See Appendix D)
- All paramedics must complete a yearly narcotic signature card for signature verification.

Controlled Substances

Patient Care Responsibility and Procedure

- Audit documentation must be generated and maintained every time a controlled substance kit is inspected or used or if direct responsibility for the kit changes hands.
- 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 facility other than Bridgeport Hospital or St. Vincent's Medical Center be carried and stored in any vehicle.
- No changes to a service's approved narcotics policy may be made without pharmacy and Drug Control's approval.
- 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 the delivery of patient care. (See service agreements)
- The sealed controlled medication kit may be removed from the vault and carried on the paramedic's person when there is a potential need to administer the medications at a location removed from immediate access to the paramedic vehicle.
- The vehicle must always be locked when unattended.
- 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 responsibility for the kit.
- The controlled medication kit will remain in the vault when a paramedic's vehicle is taken out of service for no more than twenty-four hours. 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 back in service, the oncoming paramedic inspects the controlled kit.
- If a unit is permanently removed from service for a period greater than twenty-four hours, the controlled medication kit assigned to that vehicle will be immediately turned into the Bridgeport Hospital pharmacy or the hospital's Pyxis machine for proper disposition.

Paramedic Accountability

- The on-duty paramedic assigned to the vehicle is always responsible for the controlled medication kit. The paramedic must remember their unique access code if the controlled substance kit is secured in an electronic vault with keypad access. If the vault is key-controlled, the paramedic must always carry the keys on their 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. After the kit is inspected, keys shall only be passed from the off-going paramedic to the oncoming paramedic.
- Paramedics will visually inspect controlled substances every time responsibility for the kit changes hands (i.e., at the beginning and end of every shift). The oncoming and off-going paramedic will evaluate the kit for seal damage, medication color, clarity alterations, 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 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.
- Any time 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 following documentation:
 - Time of administration
 - Patient Name (Last name, First name)
 - Patient Home Address
 - Date of administration
 - Dosage and route of administration
 - Name and signature of authorizing Sponsor Hospital physician
 - Name of receiving facility
 - Name and signature of the paramedic who administered the medication.

- Any unused amount of the opened medication must be wasted in the presence of an Emergency Department registered nurse or physician, and 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.

Section 3: Clinical Care

Title: Clinical Authority on 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 on the most appropriate care for the patient(s).

Scope: All EMS agencies authorized as such operating within the SHCGB catchment area.

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.

Pursuant to the following documents:

- Public Act No. 15-223
- 2012 Sponsor Hospital Council of Greater Bridgeport (SHCGB) Medical Control Agreement with each agency.

It is the position of the SHCGB 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.

Further, the SHCGB recognizes the following:

- *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 SHCGB catchment area shall be responsible for making decisions regarding patient care on the scene of an emergency.
 - During Requests for Service requiring a multi-agency 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 SHCGB-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 receive care from appropriate, acceptable practitioners. Only paramedics with current Sponsor Hospital 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 Section 20-206ll or 20-206mm provisions.
- **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 Section 20-206ll or 20-206mm provisions.
- **Firefighter:** A uniformed paid municipal, state, or volunteer fire department member.
- **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 for-profit or nonprofit, whose primary purpose is to deliver medical care or services, including such medical-related care services as ambulance transportation.

Title: Patient Care Documentation Policy

Purpose: This policy is intended to outline the minimum required elements for patient care documentation for EMS agencies sponsored by the Sponsor Hospital Council of Greater Bridgeport (SHCGB). This policy applies to all levels of providers, including those credentialed to provide specialty care transport.

Discussion: The primary purpose of the EMS chart review is to ensure patient care adheres to treatment protocols outlined in the current version of the Connecticut EMS Statewide Protocols. Chart review is used to identify quality improvement initiatives via data collection and analysis. As such, patient care reports must contain a minimum set of elements to ensure proper patient care and continuity of care. Further, opportunities for improvement may be identified before any harm comes to a patient or provider.

Policy:

- An ePCR is mandatory for any activation, or “call to service,” that is requested, regardless of incident disposition. If there are multiple patients, an ePCR must be completed for each patient.
- Documentation of assessments and patient care shall be done on all patients evaluated including, but not limited to: emergency calls, transfers, patient refusals, downgrades, and stand-by circumstances. A “patient” is classified as any person that had or has a medical complaint at the time of 911 activation. If canceled enroute or on scene where there was no “patient” identified, the EMS provider should follow their agencies policies. (MVC, man down, etc.)
- The EMS Patient Care Report (PCR) is a medical record and the primary source of information for continuous quality improvement review. Prehospital care personnel shall be responsible for providing clear, concise, complete, and accurate documentation. The use of AI is discouraged and, if used, clinicians must review for accuracy. Clinicians will be accountable for the information documented.
- Documentation of patient care shall be done as soon as possible following completion of patient care and/or transfer of care at the receiving hospital. Vital information should also be immediately communicated to the Emergency Department staff for efficient and safe transfer of care.
- In the event the crew is called out of the hospital to respond to an emergency call, the run form must be completed as soon as possible. All PCRs must be completed before end of shift preferably and/or within eight hours (8) of arrival at the hospital.
- All 12-Lead EKGs shall be left at the receiving Emergency Department with the patient’s name and DOB written on the top of the strip. If unable to print, the agency must have the ability to submit electronically or retrieve upon medical control request. Every effort shall be made to be certain that the nurse and/or physician responsible for care receives the strip.
- Units that do not accompany the patient to the hospital, but provide initial assessment and/or care, must complete an ePCR as soon as possible and always before the end of the shift, and select the hospital that the patient was transported to in the destination field of the ePCR.
- Paramedics who downgrade to BLS must document their assessment and findings for every ALS to BLS downgrade, per the SHCGB downgrade policy. If the paramedic is one of the

crew members on the responding ambulance and deems the present patient can be downgraded to the basic level, that paramedic is to add an ALS assessment to the PCR prior to completion.

- The transporting crew must include the name of the first responder service and any relevant information received when they took over care of the patient on their ePCR. Transporting crews (including paramedic intercept units) shall select the hospital that the patient was transported to in the destination field of the ePCR.
- EMS Crews will follow all CT OEMS documentation guidance and regulations.
- All patients receiving a weight-based medication should have a weight documented.
- All advanced airway attempts must be documented.

ALERTS

- Time of prehospital alert notification must be documented on all patients meeting alert criteria. If patient meets alert criteria and no alert notification is made, the reason for this must be documented.

See Addendum G for documentation pearls.

Title: 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 authorized as such operating within the SHCGB catchment area.

Discussion: Basic-level providers have access to more knowledge and technology than ever before. 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 receives the right level of care at the right time. However, the process and criteria for safely transferring care from a paramedic-level provider to a basic-level provider is not without risks. Therefore, clear criteria 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 thoroughly 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 position of the SHCGB 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 not necessary 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:

- Interventions have been implemented outside the basic level scope of practice.
 - 4 or 12-Lead ECG monitoring
 - Waveform capnography
 - ALS interventions/procedures 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 SHCGB catchment area.
- An EMT-level provider or crew is unwilling or expresses any concern about taking responsibility for patient care.
- The advanced level and EMT level providers cannot agree on a subsequent BLS plan of care.

- All cases in which patients are released to the care of BLS personnel must be thoroughly documented by the paramedic.
- Individual EMS agencies are responsible for ensuring all transfer of care events from ALS to BLS are documented in accordance with agency policies and procedures.

Title: Paramedic Downgrade of Care to a Basic Level Provider Cont.

- In most cases, the need for ALS should be determined in the first few minutes of patient contact, or if patient acuity changes during assessment.
- Patients who are deemed to be critical or high acuity shall be transported with minimal or no delay (when possible).
- Paramedic level of care shall be considered for the following conditions (but not limited to):
 - Altered Mental Status.
 - Any undiagnosed abdominal pain that presents with a pulsatile mass or distention. (Upper abdominal pain that radiates to the back or shoulder in a patient over 30 requires a 12 lead EKG.)
 - Any symptomatic Allergic or Anaphylactic reaction where Epinephrine was used PTA or otherwise.
 - Burns of partial thickness or higher or burns that cover 20% body mass.
 - Any symptomatic difficulty breathing patient.
 - Any Chest Pain patient who c/o pain radiation, SOB, and/or dizziness.
 - Dizziness of an unknown etiology that presents with headache and HTN.
 - Extreme environmental emergencies.
 - Hypoglycemia that presents with AMS.
 - Overdoses where Narcan has been pushed.
 - Poisoning.
 - Seizures, even if they happened PTA.
 - Sepsis or shock of any kind.
 - Stroke/CVA.
 - Syncope of an unknown etiology.
 - Trauma with a high M.O.I or multisystem trauma.
 - Provider clinical judgement.

Title: STEMI Alert (STEMI ONLY, Do not use CARDIAC ALERT)

Purpose: To identify patients with active ST-segment elevation MI (STEMI) as early as possible and to allow pre-hospital activation of the cardiac catheterization lab. Prehospital cath lab activation requires the term STEMI ALERT. The term cardiac alert MUST NOT be used.

Scope: All EMS agencies authorized as such operating within the SHCGB catchment area.

Discussion: "Time is muscle." It has been proven that reducing the time from the onset of STEMI to reperfusion improves outcomes in these patient types.

Criteria: To qualify for EMS STEMI Alert, the patient must have a 12-Lead ECG meeting the standards below & in most cases exhibit signs and symptoms suggestive of acute coronary syndrome:

- Generally, 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.
- Patients exhibiting isolated ST depression in leads V1-V4 should have posterior leads V8- V9 completed for any posterior wall involvement.
- **Initial 12-Lead must be done within 8 mins of patient contact for patients exhibiting s/s of ACS.**
- **Prehospital STEMI Alert activation must be made within 2 mins of ECG recognition.**
- **NO EVIDENCE** of paced rhythm or Left Bundle Branch Block; Sgarbossa's criteria is not used in the region.

Supporting Criteria (not required):

- 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 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.

Twiage 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.
- If it is unclear if the alert criteria is met or if there is a questionable EKG, contact Medical Control for Guidance.

Actions:

For patients meeting the above criteria, advise SWRCC (CMED) or do a TigerConnect alert that they have a “STEMI Alert” within 2 minutes of confirming STEMI. The paramedic will request an “early STEMI alert notification” from the bedside as soon as possible.

- Once transportation commences, the paramedic may patch into the receiving facility via radio or the TigerConnect application.
- Receiving hospitals will make every effort to give a room assignment at the time of patch. The receiving facility will activate its STEMI team following its internal policies.
- EMS crews should treat the patient based on existing protocols and be ready to present the diagnostic 12-Lead ECG to the RN or MD immediately upon arrival.

This protocol is enacted 24 hours a day. 7 days a week.

Suggestions:

- Patients exhibiting ST segment elevations in the inferior leads should have a right-sided V4R performed to determine any right ventricular involvement before administration of nitroglycerin.

Title: Stroke Alert

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 EMS agencies authorized as such operating within the SHCGB catchment area.

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 2.12 A: 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.	

- 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 a phone number for a reliable witness to pass on to the receiving team.**
- Reassess the patient frequently for resolution or worsening of symptoms.

Revised: 09/18, 11/25

Title: Adult Sepsis/Septic Shock Alert

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

Scope: All EMS agencies authorized as such operating within the SHCGB catchment area.

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 (SIRS) criteria with a suspected or confirmed infection. All potential sepsis patients are expected to 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 (F), greater than 100.4 (F), or feels clinically febrile.
 - Heart rate greater than 90 beats per minute.
 - Respirations greater 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 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.

Pre-hospital management of the septic shock patient will follow Connecticut EMS Statewide Protocol 2.22 A.

Title: Trauma Alert

Purpose: This policy is intended to outline the process for activating a pre-hospital trauma alert when a patient meets the criteria listed below.

Scope: All EMS agencies authorized as such operating within the SHCGB catchment area.

Policy: Pre-hospital 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 pre-hospital providers. It is either a trauma alert or it is not. Once alerted, the receiving facility will determine the appropriate alert level for the patient 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).
 - 2nd or 3rd 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 rollover.
 - Prolonged extrication (greater than 20 minutes).

- Death of same-vehicle occupant.
- A pedestrian or bicyclist struck, ran over, or thrown by an automobile traveling greater than 20mph.
- Hanging or drowning event.
- Fall from a height greater than 10 feet for all ages.
- Falls with evidence of/or history of a head injury/strike while on anticoagulation 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.
- **Other Considerations**
 - Extremes of age: Less than 5 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 designated 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 lift and move 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 ED physician or trauma surgeon questions.
- EMS crew members needed for another emergency response will be relieved immediately upon notification by the ED physician or trauma surgeon.
- Every attempt should be made to complete your ePCR before departing the receiving facility. If this is not possible, the ePCR must be completed as soon as possible per the SHCGB documentation policy.

Title: Patient Destination Determination

Purpose: This policy provides guidance for transporting EMS agencies when determining the appropriate destination for patients who cannot identify a preferred facility or do not have a preference.

Scope: All EMS agencies authorized to operate within the SHCGB catchment area.

Discussion: Any patient requesting emergency medical services who consents to transport shall be transported to a licensed acute care hospital as defined by one that is 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 interfacility transfers or scheduled non-emergency transports at the request or direction of the patient's private physician.)

Policy: A patient should be transported to their facility of choice unless one of the following circumstances exist:

- The patient does not state a preference. The patient should be transported to the closest appropriate facility within the region based on agency operating guidance approved by SHCGB.
- Every effort should be made to transport critically ill or injured patients to the appropriate closest facility, regardless of the patient's preference for the management of any life threats.
- Bridgeport Hospital and St. Vincent's Medical Center are considered equivalent with regard to capabilities. Except for diversion, transporting patients to either facility will be considered acceptable.
- Trauma patient destination shall be determined following the State of Connecticut Trauma Regulations.
- All current EMTLA laws should be followed.
- Bridgeport Hospital is the designated destination for critically ill/injured children and/or adult and pediatric burn victims. Patients meeting these criteria may be transported to St. Vincent's Medical Center if the patient does not have a secure airway or is otherwise too unstable to be transported to Bridgeport Hospital.

Title: Field Communications / Direct Medical Oversight (DMO)

Purpose: This policy is intended to guide all levels of field providers regarding radio transmissions and requests for DMO.

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

Policy:

- All SHCGB-sponsored response vehicles shall have two-way voice communication equipment to provide direct contact with hospital Emergency Departments based on current state requirements.
- Any incident involving three or more patients should be considered for the implementation of an Incident Command System (ICS). Communication with the hospital(s) should be centralized through the transportation group.
- Field-to-hospital communications should take place before leaving the scene.
- In complex cases involving high acuity or multiple patients, an early notification with limited but accurate information is more important than a detailed report made just before arriving at the hospital.

Procedure:

- To establish contact with the hospitals, contact CMED by radio or phone and request a patch from the receiving hospital. All phone calls should be via CMED only and not directly calling the ED to ensure a recorded line unless an agency uses Twiage, then communication should be used in that platform. At no time should a patch or medical direction call be made directly to the receiving hospital without using one of the methods listed.
- Identify whether you wish to give a standard report or consult with medical direction.
- Identify any unique circumstantial qualifiers (i.e., STEMI Alert, Stroke Alert, HazMat).
- 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:
 - Unit ID and level of provider
 - Age and gender
 - Chief complaint
 - History of the present illness
 - Findings of the physical exam
 - Mental status
 - Vital signs
 - Treatments/Interventions
 - Response to treatments/interventions
 - Questions
 - ETA

Direct Medical Oversight (DMO)

- Any request for medical control orders from DMO must be relayed via a CMED or Twiagerecorded MED channel or over a recorded phone line.
- When a provider wishes to consult with a DMO for patient care/transport decisions or approval of a specific clinical treatment, direct radio communication should be established between the field provider and the physician at the intended receiving facility.
- The provider *must* request "direct medical oversight" when requesting a patch.
- Once the DMO has been established, the paramedic will follow the physician's medical orders within the current CT Statewide EMS Protocols scope to ensure continuity of care.
- The patient care report must document orders relayed via DMO, including physician names.
- When DMO gives an order, the provider will repeat it to verify its accuracy.
- If the DMO requests an intervention outside the scope of practice for the given provider, the provider will advise the DMO. ***Under no circumstances should a provider perform an intervention outside his/her scope of practice.***
- Verify receipt of information and wait for DMO to verify the conclusion of communications.
- In the event DMO at the requested facility is not available, clinicians may reach out to the alternate facility for DMO consultation. Please notify EMS Coordinator via email if initial DMO request was delayed or not available.
- If online medical direction is unavailable, providers should follow protocols and document unsuccessful attempts to contact medical control.

Title: Interfacility Ambulance Transfer Guidelines

Purpose: To provide appropriate care for patients during interfacility transports in accordance with federal and state regulations and Sponsor Hospital 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 current medical condition of the patient and any reasonably foreseeable complication that could occur during transport.
- Sponsored EMS agencies are responsible for notifying the EMS Coordinator of the types of transfers being requested to facilitate the assessment and training of personnel 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 must not be manipulated by EMS personnel.
- Saline lock (No IV infusions).
- Previously inserted foley catheter, suprapubic tube, an 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 are 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 the training and/or capabilities of EMS personnel, an SCT-endorsed paramedic shall be sent, or hospital staff shall accompany the patient. Examples of conditions that may require accompaniment by hospital-provided personnel (MD, RN, 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 SHCGB 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 will have access to all pertinent medical information.
- The paramedic will obtain written orders for care from the referring hospital staff during transfer.
- In the event of a change in patient condition during a non-physician accompanied transport, standing orders appropriate to the patient's 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 unavailable for consultation, the patient will be transported to the nearest appropriate facility for stabilization.

Communication

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

Documentation

- All patient transfers will have a thorough run report completed. All assessments, care, and interventions must be documented per 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 chart copy shall be submitted to the SHCGB EMS Coordinator on request for performance review.

Title: Specialty Care Transports

Purpose: To provide appropriate levels of care for patients during interfacility transports in accordance with 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 SHCGB and their service may utilize these advanced guidelines.

****See Appendix B**

Section 4: Quality Assurance/Improvement

Title: Quality Assurance and Improvement

Purpose: To outline the SHCGB Quality Assurance and Quality Improvement Program.

Scope: All EMS agencies authorized as such in the Sponsor Hospital Council of Greater Bridgeport (SHCGB) catchment area.

Policy:

The Sponsor Hospital Council of Greater Bridgeport (SHCGB) is committed to the provision of quality out-of-hospital emergency care as outlined in the Regulations Governing the Delivery of Emergency Medical Services June 1988, Section 19a-179-12, items (6) and (7). As the sponsor to several approved Mobile Intensive Care Services within our community, SHCGB has agreed to assume the responsibilities outlined in Connecticut General Statutes and Regulations governing the delivery of Emergency Medical Services.

Both St. Vincent's Medical Center and Bridgeport Hospital appoint EMS Medical Directors, EMS Coordinators, and Emergency Department Administrators to serve on SHCGB. The EMS Coordinators work closely with the EMS Medical Directors and are responsible for monitoring the quality of care provided by pre-hospital personnel. St. Vincent's Medical Center and Bridgeport Hospital are staffed twenty-four hours a day with dedicated emergency physicians responsible for providing online medical direction to pre-hospital personnel. The Southwest Regional Communications Center and the TigerConnect application link Emergency Department physicians to out-of-hospital personnel via radio, recorded phone lines, and mobile phone application.

SHCGB Program's Quality Assurance Function:

Bridgeport Hospital and St. Vincent's Medical Center's Department of Emergency Medicine have a 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.
- Identify trends and early recognition of areas of concern and prevent adverse events from 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 is continuously monitored and evaluated.

Secure and confidential files are maintained by all out-of-hospital care providers who are authorized to function within the SHCGB. 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.

SHCGB, through its EMS Medical Directors, may withhold authorization from a MIC-level EMS provider or service as per state regulations.

The SHCGB maintains a planned and systematic quality management process through the following means:

- The incident-based report of care is below the expected standard.
- EMS Coordinators will have access to all EMS services ePCR systems for QA activities.
- An investigation is initiated when a complaint or concern is brought to the attention of one or both of the EMS Coordinators.
- The EMS Coordinators will review a percentage of monthly EMS ePCRs generated for all transports. The selection of ePCRs is focused on high-acuity patient encounters, such as cardiac arrest, trauma, STEMI, and stroke. Reports are screened for completeness and adherence to current Statewide EMS protocols and local operating policies and procedures.
- All sponsored agencies agree to grant access to all EPCRs requested by SHCGB coordinators for medical service calls, including interfacility transports, specialty care transports, canceled calls, and patient refusals. During the paramedic providers' medical control renewal process, proficiency is assessed by both the number and success rate of advanced interventions (e.g., intubations, IVs, etc.), an ALS skill station review, and a potential written protocol exam. A review of CME hours is also conducted to ensure that providers meet SHCGB standards.
- Medical Control reserves the right to conduct field observations and accompany any SHCGB provider on calls to monitor the provider or service's proficiency in rendering quality patient care. Results are forwarded directly to the MIC Medical Directors.
- Each SHCGB-sponsored agency must submit, on a 5-year basis, 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 process for proactive review of agreed-upon quality metrics and must have the ability to generate reports for the criteria. Furthermore, the EMS service must report to SHCGB any suspected QA concerns that involve clinical 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:

- The 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.
- The 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 consultation 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 at the earliest possible date.
- The 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 control action unless deemed critical intervention is needed. (See Appendix G)
- The EMS Coordinator will review the service's findings and recommendations in consultation with the EMS Medical Director's and 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.
- 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 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 case review determined that the incident did not negatively impact the patient or patient outcome. The EMS provider's actions were appropriate based on the results of the investigation.

Remediation - A case review has identified a deficiency in performance, knowledge base, and/or critical thinking ability. The Medical Director reserves the right to return the provider to probationary status and requires clinical competency evaluations to be performed before returning to good standing. The duration of the remediation program will be determined based on the relevant findings of the case. Any assigned continuing medical education courses will be no less than two hours in length per course and must be approved by the EMS Coordinators prior to completion.

Suspension – A significant clinical incident or pattern of incidents that warrants the EMS Medical Director or designee to temporarily suspend an EMS provider's authorization to practice as an EMS provider. The EMS provider will be given a list of objectives that he/she must meet to regain Sponsor Hospital authorization. Upon reinstatement of Sponsor Hospital authorization, the provider will be placed on probationary status for a minimum period of one year.

Revocation - A significant clinical incident or pattern of incidents that warrants the EMS Medical Director or designee to permanently remove Sponsor Hospital authorization. Cases where authorization has been revoked may be, at the discretion of the EMS Coordinators and EMS Medical Directors, referred to the Office of Emergency Medical Services for further review and investigation.

Provider Actions

- The provider may appeal any decision by notifying SHCGB 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.
- The provider may request that the full Council hear the appeal (i.e., to include the two hospital administrative representatives). Post-appeal decisions shall require the agreement of both EMS Medical Directors in consultation with the other Council members.
- In the case of suspension, providers may accept and complete the actions. Upon doing so, they may request a review prior to the completion of the intended suspension time to appeal for earlier reinstatement.

Title: Quality Assurance Data Reporting

Scope: All EMT & Paramedic agencies with current MICS sponsorship

Purpose: The Sponsor Hospital Council of Greater Bridgeport (SHCGB) recognizes that a comprehensive Quality Assurance/Quality Improvement program begins with accurate data collection of EMS activities.

EMS Quality Metric Report

All EMS agencies are required to submit a detailed report to the EMS Coordinators based on the current metrics. This report will be due by the first week of each quarter but no later than the SHCGB quarterly meeting. 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.

****See Appendix E for current Quality Metrics**

Section 5: Mandatory Reporting

Title: Mandatory Reporting for EMS Providers

Scope: All EMS agencies authorized as such to operate within the Sponsor Hospital Council of Greater Bridgeport (SHCGB) catchment area.

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

Policy:

Licensed healthcare providers are 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 of the moment 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 any elderly person 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 is in need of 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 hospital or health care professional shall file a petition if that hospital or health care professional has any information demonstrating that another health care professional is (or is suspected to be) unable to practice his or her profession with reasonable skill or safety.

Section 6: Summary of Revised Changes

- General formatting and grammar updates throughout document
- BLS EMT protocol exam requirements and process updates including closed book online exam.
- Medical Control Interview date will be offered to candidates within 10 business days of interview eligibility.
- MC Renewal requirements updated, and cycle dates changed
- SHCGB meeting minimum attendance requirements.
- SHCGB MICS process changes including rosters and QA plan submissions
- Direct Medical Control contact policy updated
- SHCGB position on AI generated EPCRs
- STEMI alert updates, alert guidance.
- Stroke Alert updated.
- Pediatric Rapid Sequence Intubation (RSI) is now authorized for current RSI services for patients 8 years old or above.
- Social Services referral removed
- RSI policy updates
- IFT/SCT policy updated
- KPI requirements added and updated for all transporting services
- Two new mandatory medications have been added for Advanced Life Support (ALS) services: TXA and Ancef
- Several new medications and skills in the 2025 protocols will not be supported in the region due to costs, limited potential utilization, or required training, including:
 - IN Glucagon,
 - Dual sequential defibrillation,
 - IM Epinephrine for asthma by EMTs,
 - EMT SGA use

Section 7: Appendices

Appendix A: SHCGB Approved Medication & Skill Formulary

Appendix B: SHCGB Approved SCT Medication & Skill Formulary

Appendix C: SHCGB Medical Control Renewal Requirements

Appendix D: SHCGB Narcotic Letter of Understanding

Appendix E: SHCGB CQA/CQI KPI Quarterly Reporting

Appendix F: SHCGB Application for Medical Control Authorization

Appendix G: SHCGB QA Review Form

Appendix H: SHCGB Documentation Guidance

Appendix I: SHCGB RSI Policy

Appendix J: SHCGB Whole Blood Policy