Advisory 21-03: Updated Policies

To: All Providers

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Regional Medical Director

Date: February 24, 2021

At the February 22, 2021 meeting of the Monroe-Livingston REMAC, a number of Policies were approved after intense revision and are in effect immediately.

The “Management of Psychiatric and Violent or Potentially Violent Patients” policy is rescinded. In its place are two policies, “Care of the Mentally Ill or Emotionally Distressed Person” and “Care and Restraint of Agitated or Combative Patients”. A care bundle that accompanies each policy has been developed and serves to aid in quality improvement activities associated with the care of patients in whom these policies are applied. The MLREMS Training and Education Committee is working with other stakeholders to develop training resources relevant to these policies and those will be released as they are completed.

Also approved is the “Credentialing of Paramedic Practitioners” policy which replaces the previous policy "Credentialing of Paramedic Providers".

All updated policies are available at: https://mlrems.org/provider/policies/

All updated bundle documents are available at: https://mlrems.org/provider/performance-measures/

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CARE OF THE MENTALLY ILL OR EMOTIONALLY DISTRESSED PERSON

PURPOSE

This clinical guideline is intended to define standards and techniques that may be used for the evaluation, clinical care, and transport of patients presenting with mental health conditions.

NOTE:

- If the patient has a presenting medical or traumatic condition requiring immediate treatment, follow the appropriate protocol.
- If the patient is presenting with agitation, combativeness or is potentially violent, also refer to “Care and Restraint of Agitated and Combative Patients”

DEFINITIONS

A psychiatric patient is defined as a person encountered by EMS personnel with an actual or potential mental illness or exhibiting features of an emotionally distressed person.

Mental Illness: A disorder in which individuals experience periodic problems with feeling, thinking, behavior or judgment to such an extent that the person afflicted requires care, treatment, and rehabilitation. Mental illness may be acute, time limited, chronic, lifelong, and may occur at any time in an individual’s life.

Emotionally Distressed Person: Emotional distress is when there is a disorder or disruption to one's normal state. Emotions are influenced by a wide variety of factors including substance use, situational stress, medical conditions and mental illness. An emotionally distressed person may display irrational or bizarre behavior and/or express odd or unusual thoughts including suicidal ideation.

§9.39 Hospital: A hospital that pursuant to NYS Mental Hygiene Law (NYSMHL) Section 9.39, maintains adequate staff and facilities for the observation, examination, care, and treatment of person(s) alleged to be mentally ill.

SIGNS & SYMPTOMS OF MENTAL ILLNESS

The following are examples of signs and symptoms of behavior that may suggest mental illness. EMS practitioners should always consider other potential causes, such as underlying medical conditions, reactions to narcotics/alcohol, or temporary emotional disturbances that are situationally influenced. The EMS practitioner should evaluate the following behavior in the total context of the situation when making judgments about an individual’s mental state and need for intervention.

Mentally ill and/or emotionally distressed persons may show signs of:

- Strong and unrelenting fear of persons, places, or things. The fear of people or crowds (agoraphobia), for example may make the individual extremely reclusive, aggressive without apparent provocation, or resistant to leaving the location from which they are found.
- Demonstration of extremely inappropriate behavior(s) for a given context. For example, people who are observed yelling to themselves in a public place.
- Becoming easily frustrated in new or unforeseen circumstances and the demonstration of inappropriate or aggressive behavior(s) in dealing with the situation.

In addition, a mentally ill/emotionally distressed person may exhibit one or more of the following characteristics:

- Memory loss related to such common facts as name, home address, or phone number. Consider these also may be signs of other conditions such as brain injury, acute delirium, or dementia.
- Delusions: the belief in thoughts or ideas that are false, such as delusions of grandeur ("I am God"), paranoid delusions ("Everyone is out to get me"), or somatic delusions (the belief that one suffers from extraordinary physical maladies that are not possible).
- EMS practitioners should be alert to the fact that just because a patient appears to suffer from somatic delusions (e.g., believing their heart was stolen), does not mean that there are not serious physical symptoms worthy of assessment, such as cardiac dysrhythmia.
- Hallucinations of any of the five senses (e.g., hearing voices commanding the person to act, feeling one's skin crawl, etc.)
- Extreme fright, anxiety, or depression

THE MENTAL HYGIENE LAW

Section 9.41 of the NYSMHL allows a *law enforcement officer* to place in custody and transport to a §9.39 hospital, any person who appears to be mentally ill and is conducting him/herself in a manner which is likely to result in serious harm to him/herself or others. "Likelihood to result in serious harm" refers to:

1. Substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm; or
2. Substantial risk of physical harm to him/herself as manifested by threats of, or attempts at suicide, or serious bodily harm, or other conduct demonstrating that he/she is dangerous to him/herself.

"Other conduct demonstrating that he/she is dangerous to him/herself" includes the person's refusal or inability to meet his or her essential need for food, shelter, clothing or health care, provided that such refusal or inability is likely to result in serious harm if there is not immediate hospitalization."

Pursuant to §22.09 of the NYSMHL, an individual who appears to be incapacitated by alcohol and/or substances to the degree that there is a likelihood to result in harm to the person or to others may be taken by a law enforcement officer to a treatment facility for purposes of receiving emergency services.

1. "Incapacitated" means that a person, as a result of the use of alcohol and/or substances, is unconscious or has his or her judgment otherwise so impaired that he or she is incapable of realizing and making a rational decision with respect to his or her need for treatment.

2. "Likelihood to result in harm" means a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself; or a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

A patient placed under §22.09 may be transported to any appropriate facility and does not require transport to a §9.39 facility.

VOLUNTARY AND INVOLUNTARY TRANSPORTS

- If a patient with a psychiatric condition wishes to voluntarily go to the hospital:
  - A patient may go to the hospital voluntarily and request a psychiatric evaluation. They can revoke their decision to go to the hospital at any time during the transport.
  - If the patient changes their mind and cannot be convinced to continue to the hospital, the crew is obligated to allow the patient out of the ambulance as soon as it is safe to do so. Notify law enforcement of your location so that a determination can be made as to the disposition and safety of the patient. At no time is the crew to attempt to restrain the patient who is not in law enforcement custody except in circumstances where doing so is to prevent the death or serious injury to the patient.
- In order to invoke an involuntary transport, a sworn law enforcement officer must place the patient in custody, as outlined above. Alternatively, a clinician as designated under NYSMHL §9.45 may direct law enforcement to take into custody and transport a patient to a §9.39 facility. Of note, only specific individuals designated by the Director of Community Services have been delegated authority to issue a §9.45. Emergency physicians nor EMS Medical Control have been delegated that authority. There is no middle ground: either the patient is under involuntary transport or they are not. A "voluntary" §9.41 or §9.45 is a misnomer.

- If the patient is being transported and exhibiting agitated, combative, or violent behavior, refer to “Care and Restraint of Agitated or Combative Patients” keeping in mind that EMS practitioners should use the least restrictive restraint techniques to facilitate clinical patient assessment, medically indicated treatment, and safe transport to a hospital. In all circumstances, the decision about using pharmacologic management is a health care decision that must be made by the EMS practitioner with oversight by an EMS Medical Director.
- Transport the patient to the most appropriate facility:
  - If under §22.09 the patient may be transported to any area hospital.
  - If under §9.45, the patient should be transported to the §9.39 facility listed on the form. If a facility is not specified, the patient can be transported to any §9.39 facility.
  - If under §9.41, the patient can be transported to any §9.39 facility. Absent exigent circumstances, the destination decision is ultimately determined by law enforcement but should be informed by the following considerations:
    - When possible, transport the patient to the §9.39 hospital where current psychiatric treatment is being provided.
    - If the person is not in a current treatment program (at a §9.39 facility), they should be taken to the nearest §9.39 hospital.
    - Area §9.39 Hospitals include:
      - Rochester General Hospital
      - University of Rochester Medical Center - Strong Memorial Hospital
      - Clifton Springs Hospital
      - Newark-Wayne Community Hospital
      - Olean General Hospital
      - St. Joseph’s Hospital Health Center
      - Wyoming County Community Hospital
    - Strong Memorial Hospital is the only local §9.39 facility with pediatric inpatient psychiatric beds.

Prehospital Care Bundles

The MLREMS Prehospital Care Bundles have been created to provide a simple framework to help EMS providers identify the most critical elements when caring for a patient. These bundles do not replace protocol, but are designed to assist quality assurance and performance evaluations as we work collectively to optimize the delivery of prehospital medicine. As the science and evidence changes, so will these care bundles.

The New York State Collaborative Protocols and the MLREMS Care Bundles are intended to improve patient care by prehospital providers. They reflect current evidence and the consensus of content matter experts. The Collaborative Protocols and the MLREMS Care Bundles are intended to provide principles and direction for the management of patients that are sufficiently flexible to accommodate the complexity of care in the prehospital environment. No Protocol or Care Bundle can be written to cover every situation that a provider may encounter, nor are they substitutes for the judgement and experience of the provider. Providers are expected to utilize their best clinical judgement to deliver care and procedures according to what is reasonable and prudent for specific situations. However, it is expected that any deviations from protocol shall be documented along with the rationale for such deviation.

NO PROTOCOL OR CARE BUNDLE IS A SUBSTITUTE FOR SOUND CLINICAL JUDGEMENT.

Care of the Mentally Ill or Emotionally Distressed Person Care Bundle

Metric	Goal
Medical Condition Assessed	Documented assessment to identify immediate life threats and medical or traumatic causes for presentation
Risk of Immediate Harm Assessed	Documented assessment of risks for immediate harm such as suicidal or homicidal ideation
De-Escalation	If used, documentation of de-escalation techniques and outcome
Type of Involuntary Transport	Should the patient be transported involuntarily, the type used by law enforcement (9.41, 9.45, or 22.09) is documented
Appropriate Destination Selection	The patient is transported to the facility most appropriate for their trauma/medical needs with the expectation that the patient is transported to a 9.39 Facility if under 9.41 or 9.45

Theory/Evidence

Medical Condition Assessed

- As there are a number of potential medical and traumatic causes for the patient's presentation, an assessment of life threats and potential causes is expected to be performed and documented. Any identified medical or traumatic conditions should result in care consistent with established Standards of Care.

Risk of Immediate Harm Assessed

- A mental health assessment should include risks for immediate harm such as suicidal or homicidal ideation.

De-escalation

- In some circumstances the patient will benefit by de-escalation techniques to include: Movement of the patient to a calmer environment such as the ambulance, limiting the number of personnel involved, speaking to the patient in a calm deliberate manor while using phrases like "slow down" in lieu of a commanding voice to "calm down", utilizing active listening, staying calm, and move slowly. EMS Providers should avoid challenging any psychotic thinking, or use an argumentative language, tone, sarcasm, or humor. Documentation should include the techniques used and their results

Type of Involuntary Transport

- If a law enforcement officer or designated clinician find the patient must be transported involuntarily, the type of transport (9.41, 9.45, or 22.09) should be documented as that information drives the selected destination

Appropriate Destination Selection

- The patient should always be transported to the facility that is most appropriate for their trauma or medical needs, particularly as it relates to specialty care (trauma, burn, stroke, STEMI, pediatrics, etc). If under a 9.41 or 9.45, the patient must be transported to a 9.39 facility that is most appropriate given their trauma or medical needs. If under a 22.09, the patient may be transported to any facility based upon their trauma or medical needs.

CARE AND RESTRAINT OF AGITATED OR COMBATIVE PATIENTS

PURPOSE

Agitated, combative, or violent behavior has varying presentations on a spectrum from agitated but cooperative to excited delirium with a dangerous inability to understand the situation or the dangers of their behavior. This guideline is intended to define standards and techniques that may be used by the EMS practitioner for the management of agitated or combative patients.

NOTE:

- If the patient is suspected to have a mental illness or appears to be emotionally distressed, also refer to "Care of the Mentally Ill or Emotionally Distressed Person"

RESPONSE GUIDELINES

The following are response guidelines to any call which may present the practitioner with an agitated, combative, or potentially violent patient:

- Based on dispatch information, a crew may always exercise the option to stage near the scene or in quarters. If the decision is made to stage, notify the respective dispatcher of your staging location.
- The general response to all staging areas is non-emergent. Response may be upgraded if you receive information that you are cleared into the scene and the reported patient's condition warrants an emergent response.
- The responding unit should consider requesting a paramedic, if not already available, to reports of extreme agitation or combativeness for consideration of advanced monitoring capabilities and, as clinically appropriate, the use of sedation per the appropriate protocol. If the patient does not need sedation and has no other indications for advanced interventions or monitoring, that patient may be released to BLS for transport, following all applicable protocols.

SCENE SAFETY CONSIDERATIONS

- Often law enforcement will enter the scene first to assess the scene safety prior to the ambulance crew arriving. However, there may be situations whereby staging may not be prudent. This may include a situation where a psychiatric patient is reported to be unresponsive and to the judgment of the responding EMS practitioner based upon the circumstances at the time the risk of harm is low.
- Patient contact may be delayed if the practitioners believe the scene may be unsafe, based on either dispatch information or a scene size-up. EMS units should stage out of sight from any potentially hostile incident and notify their respective dispatch center of their staging location.

- If patient contact is delayed due to a potentially dangerous environment, it should be reported to their respective dispatch center and documented with both the reason and the time.
- If EMS practitioners are already on scene and the situation becomes hostile, the providers should exit the situation to a safe area, until law enforcement can establish a safe scene.
- Practitioners should apply the following techniques on every call to promote their safety and the safety of those around them:
    - Have two means of communication with the respective dispatch center at all times
    - Ensure that location changes are reported to the respective dispatch center
    - Be aware of an exit route from the scene
    - Have a plan for an alternate source of cover or concealment
    - Request that dogs and other potentially hostile animals be secured
    - Scan the scene for improvised weapons
    - Be alert to the body language of all persons on the scene

DE-ESCALATION

Practitioners are reminded that verbal statements made to the patient can help de-escalate the situation. The following are some standard approaches that should be used in all situations with distressed individuals:

- Use the phrase, “slow down” to encourage the individual to calm down. Using the phrase “calm down” can often have a paradoxical effect. For example, “could you please slow down a bit? I want to understand what you are saying and it’s hard to understand you when you are talking so fast.”
- Use empathy as much as possible. Empathetic statements let the patient know you understand what is upsetting them. Once a patient feels “heard”, there will be better rapport and more cooperation. To be empathetic:
    - Listen carefully to what the patient is saying
    - Pay particular attention to the emotion(s) he/she is experiencing
    - Communicate with the patient. For example: “I can understand how angry that makes you,” “That really is painful, isn’t it?” or “That’s a lot to deal with.”
    - Rather than confronting the delusions (e.g., “you can’t possibly be living without a heart”) or feeding into them (e.g.; “yes, we’ve seen other individuals who have had their heart stolen”), an empathetic approach will be much more effective. For example: "It sounds like your chest feels empty to you” and/or “that must really be scary.”

USE OF PHYSICAL RESTRAINT

EMS restraint protocols and interventions will differ from those of law enforcement. The goal of any restraint use by EMS is to prevent harm to self or others while being able to provide medical interventions and maintain the patient's dignity.

- It may be necessary for law enforcement to apply restraint techniques or devices to an individual which are not sanctioned for use by EMS practitioners. The individual being restrained may also need, or may develop a need for EMS assessment or care. In these cases, a law enforcement officer must remain immediately available while the EMS practitioner assesses and manages the patient based on established protocol and policy. At all times, the EMS practitioner must act as an advocate for the safety, medical monitoring, and clinical care of the patient.

- If a law enforcement-based restraint intervention (eg handcuffs, flex-cuffs, hobble restraint, etc) which are not sanctioned for use by EMS practitioners must be continued during patient care and transport by EMS, a law enforcement officer must accompany the patient during transport by ambulance; or the law enforcement-based restraint intervention should, when appropriate, be discontinued in favor of a sanctioned EMS-based restraint intervention. Patients who are in law enforcement custody or who are under arrest must always have a law enforcement officer present or immediately available during EMS transport.

- If the patient exhibits agitated, combative, or violent behavior, following de-escalation EMS practitioners should use the least restrictive restraint techniques to facilitate clinical patient assessment, medically indicated treatment, and safe transport to a hospital.

- In all circumstances, the decision to use pharmacologic management is a health care decision that must be made by the EMS practitioner. Refer to the Agitated Patient Protocol for patients where environmental modification and verbal de-escalation is not successful or not possible and/or the Excited Delirium Protocol for additional details about identifying and managing individuals displaying extreme behavior.

If physical restraint is required to protect the patient and/or practitioners from injury, the following represents the approach and techniques sanctioned for use by EMS practitioners:

- If safe and feasible, the EMS practitioner should explain to the patient and as appropriate bystanders such as family, the reasons for restraint use.
- ***Maintain constant, direct supervision of the restrained patient at all times.***
- Patients should be restrained on a backboard or gurney in a supine position. ***The patient may never be restrained in a prone (face-down) position.***

- When placing a patient into restraints:
  1. The patient's limbs should be restrained preferably using a commercial soft restraint, however in its absence a cravat or spiral gauze may be used.
  2. Place a webbed belt or strap around the patients' lower thighs, just above the knee; and upper chest, immediately underneath the armpits. Both belts should be secured tightly but the chest belt must not restrict chest expansion. Any additional belts may be used to secure the patient provided they do not restrict chest expansion.
  3. One hand is to be secured to the backboard slot above the patient's head or the head of gurney.
  4. The other hand is to be secured to the backboard slot or gurney rail at the patient's side (on the same side as the limb being restrained).

- When transitioning a handcuffed patient to a backboard:
  1. Move the patient to a backboard or gurney.
  2. Apply thigh strap above the knees.
  3. Apply soft restraints to both wrists.
  4. Remove one hand from handcuffs.
  5. Ideally, secure the right arm to the backboard/gurney above the patient's head, then secure the left arm to the backboard/gurney.
  6. Apply chest strap as high up on the chest as possible.
  7. Re-tighten all straps, check all limb restraints.
  8. Assure breathing is not compromised with strap placement.

- If necessary, the patient's ankles can be secured with commercial soft restraints, cravats, or gauze to the lower slots of the backboard or gurney frame.

MONITORING THE PATIENT DURING RESTRAINT USE

Once restraints are applied, the EMS Practitioner must:

- Regularly reassess vital signs, to include respiratory rate and quality.
- Assess restrained extremities for circulatory, motor, and sensory status distal to the restraint.
- Monitor restrained extremities for constriction, ischemia, or other signs of injury.
- Continually monitor the patient's overall medical status.
- If sedation has been used, when safe and feasible, the paramedic is expected to continuously monitor capnography and oxygen saturation at a minimum.
- **The patient may never be left alone.**

USE OF HANDCUFFS

- Neither handcuffs, flex-cuffs, nor hobble restraints are sanctioned restraint devices for EMS practitioners.
- Handcuffs or flexi-cuffs should be replaced with commercial soft restraints, gauze, or cravats if feasible.
- Handcuffing to a backboard is favored over handcuffing to a gurney to allow for patient movement should their condition deteriorate.
- If handcuffs are requested by law enforcement, a means for removal must be readily available at all times to allow rapid access to the patient for medical management.

LAW ENFORCEMENT ACCOMPANYING EMS

- If the patient is restrained using the accepted restraint guideline (above) and the EMS practitioner feels comfortable with transporting the patient, the responsible law enforcement officer may follow the ambulance to the hospital.
- If the EMS practitioner is not comfortable transporting the patient alone, the responsible law enforcement officer should be requested to ride along in the patient compartment.
- The responsible law enforcement officer may at their discretion decide to ride in the ambulance even if the EMS provider does not request it.
- If there is disagreement between the EMS practitioner and responsible law enforcement officer with regard to the proper method of safe transport in the ambulance, or the request of the officer to ride along, the EMS practitioner should contact their supervisor, as well as the appropriate law enforcement supervisor.

USE OF SPIT CONTROL DEVICES

- If the patient is spitting, it is appropriate to apply either: a nonrebreather mask with oxygen flowing if oxygen administration is necessary, a surgical mask, or a “Spit Sock” to reduce the practitioners’ biohazard exposure risk.
- The EMS practitioner must constantly monitor the patient’s airway, respiratory status, and level of consciousness while the spit control device is in place.
- The use of a spit control device should be discontinued as soon as practical.

QUALITY IMPROVEMENT

- Agencies are expected to have in place a program that allows for reviewing all uses of restraint for consistency with this guideline and best practice.
- Agencies must review all uses of sedation when given for agitation or excited delirium.
- Best practices for documentation include:
  - Steps taken to control patient prior to use of physical restraints, including the reasons restraints were needed and why less restrictive measures were unable to be utilized.
  - Baseline skin color and integrity prior to application of restraints.
  - The time restraints were applied.
  - Pertinent observations, including vital signs, and any changes in behavior.
  - Name of law enforcement agency, and if possible, name of law enforcement officer if the individual is being transported involuntarily.
  - A patient evaluation should be documented at least every 5 minutes for restrained patients.

Prehospital Care Bundles

The MLREMS Prehospital Care Bundles have been created to provide a simple framework to help EMS providers identify the most critical elements when caring for a patient. These bundles do not replace protocol, but are designed to assist quality assurance and performance evaluations as we work collectively to optimize the delivery of prehospital medicine. As the science and evidence changes, so will these care bundles.

The New York State Collaborative Protocols and the MLREMS Care Bundles are intended to improve patient care by prehospital providers. They reflect current evidence and the consensus of content matter experts. The Collaborative Protocols and the MLREMS Care Bundles are intended to provide principles and direction for the management of patients that are sufficiently flexible to accommodate the complexity of care in the prehospital environment. No Protocol or Care Bundle can be written to cover every situation that a provider may encounter, nor are they substitutes for the judgement and experience of the provider. Providers are expected to utilize their best clinical judgement to deliver care and procedures according to what is reasonable and prudent for specific situations. However, it is expected that any deviations from protocol shall be documented along with the rationale for such deviation.

NO PROTOCOL OR CARE BUNDLE IS A SUBSTITUTE FOR SOUND CLINICAL JUDGEMENT.

Care of the Agitated or Combative Person

Care Bundle

Metric	Goal
Medical Condition Assessed	Documented assessment to identify immediate life threats and medical or traumatic causes for presentation
De-Escalation	Documented assessment of risks for immediate harm such as suicidal or homicidal ideation
Patient Positioning	Use and documentation of the safest means of restraint to facilitate a safe transport
Patient Monitoring	The patients' clinical presentation and vital signs were monitored throughout EMS contact and where safe and feasible cardiac monitoring and waveform capnography was applied if sedation was used.
Type of Involuntary Transport	Should the patient be transported involuntarily, the type used by law enforcement (9.41, 9.45, or 22.09) is documented
Appropriate Destination Selection	The patient is transported to the facility most appropriate for their trauma/medical needs with the expectation that the patient is transported to a 9.39 Facility if under 9.41 or 9.45

Theory/Evidence

Medical Condition Assessed

- As there are a number of potential medical and traumatic causes for the patient's presentation, an assessment of life threats and potential causes is expected to be performed and documented. Any identified medical or traumatic conditions should result in care consistent with established Standards of Care.

De-escalation

- In some circumstances the patient will benefit by de-escalation techniques to include: Movement of the patient to a calmer environment such as the ambulance, limiting the number of personnel involved, speaking to the patient in a calm deliberate manor while using phrases like "slow down" in lieu of a commanding voice to "calm down", utilizing active listening, staying calm, and move slowly. EMS Providers should avoid challenging any psychotic thinking, or use an argumentative language, tone, sarcasm, or humor. Documentation should include the techniques used and their results

Patient Positioning

- Documentation of the patient's transport is in accordance with the Care and Restraint of the Agitated or Combative Patient Policy unless otherwise documented the reasons why (eg not safe or feasible given the circumstances).
    - The patient was not transported prone.
    - The patient was retrained using the least restrictive measures necessary.
    - If the patient is restrained with a law enforcement-based restraint intervention (eg handcuffs, flex-cuffs, hobble restraint, etc) which are not sanctioned for use by EMS practitioners, a law enforcement officer was present.

Patient Monitoring

- The patient was continuously monitored throughout contact and such monitoring was documented, to include respiratory rate and effort and vital signs. If any sedation was used, application of a cardiac monitor, pulse oximetry, and waveform capnography was used throughout if their application was safe and feasible.
- Any restrained limb must have a documented exam to include an assessment of distal circulation.

Type of Involuntary Transport

- If a law enforcement officer or designated clinician find the patient must be transported involuntarily, the type of transport (9.41, 9.45, or 22.09) should be documented as that information drives the selected destination

Appropriate Destination Selection

- The patient should always be transported to the facility that is most appropriate for their trauma or medical needs, particularly as it relates to specialty care (trauma, burn, stroke, STEMI, pediatrics, etc). If under a 9.41 or 9.45, the patient must be transported to a 9.39 facility that is most appropriate given their trauma or medical needs. If under a 22.09, the patient may be transported to any facility based upon their trauma or medical needs.

CREDENTIALING OF PARAMEDIC PRACTITIONERS

PURPOSE

To outline the procedure by which Paramedic practitioners are credentialed to practice in the Monroe-Livingston Emergency Medical Services (EMS) System.

POLICY

Paramedics wishing to practice in the Monroe-Livingston Region shall be credentialed according to the following policy established by the Monroe-Livingston Regional Emergency Medical Advisory Committee (REMAC). It is the responsibility of the Regional Medical Director to enforce this policy. Any appeal of this policy will be heard by the REMAC.

ELIGIBILITY

Paramedics are expected to maintain the following to practice as a Paramedic in the Monroe-Livingston Region:

- Be certified by the New York State Department of Health Bureau of EMS at the Paramedic level.
- Maintain any certifications as required by the New York State Department of Health Bureau of EMS.
- Maintain affiliation with an ALS service in the Monroe-Livingston Region.

Paramedics are expected to maintain active practice at the level of a Paramedic while practicing in the Monroe-Livingston Region. Active practice is ideally a minimum of thirty primary patient contacts per rolling 12-month period as documented by being the primary care practitioner on a patient care record. Alternatively, a simulation program may be used in lieu of up to fifty percent of the expected primary patient contacts per rolling 12-month period. Compliance with this expectation is at the affiliated agency(ies) discretion. The agency should maintain a policy or written expectations outlining any performance and/or competency expectations of Paramedic skill performance while practicing at the agency.

CREDENTIALING PROCEDURE

The ALS agency with which the Paramedic desires to practice at the Paramedic level shall, upon onboarding:

- Verify all required certifications.
- Verify familiarity with the NYS Collaborative EMS Protocols.

The ALS agency must then verify the Paramedic's competency for independent practice through a clearing process:

- The clearing process must be documented and the expectations for clearance available to the Paramedic.
- The clearing process should be competency-based, and will vary in duration based on the practitioner's previous experience (e.g. newly certified Paramedic versus a seasoned Paramedic).
- The clearing process must use at least two different MLREMS credentialed preceptors to evaluate the Paramedics' ability to meet independent practice expectations.
- A "workup" used to evaluate the Paramedic's performance is defined as patient care that involves ALS skills such as medication administration, diagnostic data acquisition and interpretation (e.g. 12-lead EKG, $EtCO_2$,), or procedure (e.g. cardioversion/defibrillation, CPAP, intubation, intravenous access).
- In addition to verifying the Paramedic's clinical competency, the agency is expected to provide an orientation to include, but not be limited to, a review of agency-specific tasks, BLS and ALS equipment, vehicle operation, quality improvement, and controlled substance policies.
- The agency is expected to obtain and document its Medical Director's approval of the Paramedic's independent practice at the completion of the clearing process.

The Paramedic must meet any additional requirements established by the agency for continued practice as a Paramedic at that agency.

EXPECTED NOTIFICATIONS

Within five business days, an agency official or officer is expected to notify the MLREMS Program Agency via email (mlrems@mlrems.org) of:

- A Paramedic that is newly credentialed for independent practice at the agency.
- A Paramedic that has been removed from independent practice at the agency.

SUSPENSION AND REINSTATEMENT

Suspension of Privileges

- The responsible official or officer of an agency shall notify within five business days the REMAC Patient Safety Committee of any patient care issues leading to removal of the practitioner from practice at that agency. The Regional Medical Director, Chair of the Regional Patient Safety Committee and the Regional Patient Safety Coordinator will work with the agency Medical Director to determine the appropriate course of action.
- Any practitioner who has their certification revoked or suspended by the State of New York (NYCRR Title 10 Part 800.16) must notify their agency Medical Director and the agency retains the responsibility to notify the MLREMS Program Agency.

- The Regional Medical Director, in conjunction with agency Medical Director, shall have the ability to suspend a credentialed practitioner's ability to provide any level care due to any patient care concerns, or failure to meet the requirements as outlined in this document. The responsible agency official/officer and agency Medical Director shall be notified of such a decision within twenty four hours. Any suspension shall automatically be forwarded to the REMAC Patient Safety Committee.
- In the event that the Regional Medical Director or the Regional Patient Safety Committee are notified of a patient care concern independently, they will notify the Agency Medical Director per the Regional Patient Safety Policy and Procedure.

Reinstatement of Privileges

In order to have their privileges reinstated, the Paramedic must:

- Provide the agency and MLREMS with documentation indicating the resolution of their certification being revoked or suspended by the State of New York (if applicable), and
- Have satisfactorily completed any performance improvement plans required by the agency and/or the REMAC and its Patient Safety Committee.
- Complete a competency-based re-credentialing process consistent with the above section "Credentialing Procedure" which will vary in duration and focus based on the practitioner's reasons for leave.