Virginia Beach Department of Emergency Medical Services

Field Operations

Procedures and Performance Expectations

PURPOSE: This document provides a standard set of procedures and performance expectations for members operating in the field as a patient care provider or supervisor.

APPLICABILITY: This policy applies to all Department of EMS career employees and all volunteers working solely under Department of EMS affiliation while engaged in field operations under the oversight of the Command Duty Officer.

General Performance Expectations

Members will comply with all City and Department Policies.

Members will provide patient care within the protocols and regulations outlined by the Department, the Tidewater EMS Council and Virginia Department of Health Office of EMS.

Members will provide the highest standards of customer service and patient care. Quality service expectations are outlined in Addendum A of this document.

Members will treat everyone including fellow medics, patients, other providers, and bystanders with courtesy and respect.

Members will operate with safety as a priority. Personal protective equipment safety expectations are defined in this document.

Members are mentors and trainers.

There is no differentiation between career and volunteer members in terms of performance standards, certifications, and input to the organization.

Operational Oversight

The Command Duty Officer (call-sign ECH10) is responsible and accountable for apparatus and employees during the active operational period. A minimum of two Shift Captains will be assigned (call-signs EMS1 and EMS2) during operational period. The Shift Captains are responsible for personnel involved in the provision of emergency care and as such serve as the medical officers for the operational period. The Command Duty Officer's staff may include additional field supervisors who will support service delivery. Unless otherwise specified in this policy, Shift Captains refer to EMS1 or EMS2. All supervisors communicate with each other while on duty.

Operational Supervisory Response Zones

ECH10 has City-Wide jurisdictional coverage and is responsible for the entire geographic boundaries of the City of Virginia Beach and all EMS operations therein. The Command Duty Officer has authority to approve all EMS mutual aid requests. EMS1 and EMS2 have response zones that are qualified by boundary primarily and then secondarily, encompassing the entire geographic boundaries of the City of Virginia Beach. These zones are referenced in the response area map; however, the response areas primarily are:

EMS1 has a primary response zone from the west side of the Lynnhaven inlet in the north, west of Rosemont Road central and west of Elbow Road and the Chesapeake line in the south progressing west to the border of the City of Chesapeake and the City of Norfolk respectively.

EMS2 has a primary response zone from the east side of the Lynnhaven inlet in the north, east of Rosemont Road central and east of Elbow Road and the Chesapeake line in the south progressing east to the Atlantic Ocean.

EMS3 is a volunteer Field Supervisor with responsibility for city wide response coverage in support of the volunteer workforce on all incidents and is subordinate to the Command Duty Officer for specialized areas such as special events, drills, standby's etc. During extenuating circumstances a primary response zone may be assigned at the discretion of the Command Duty Officer.

Scheduling

All Members

Shift Captains may assign or reassign members to any apparatus as needed to compensate for absences, illness, service demand etc.

If the assigned apparatus is unavailable for any reason, the member should contact their Shift Captain for direction.

EMS Department Career Medics

EMS career medics will be assigned to specific shift schedules. The Command Duty Officer, Shift Captain or the Departmental Scheduling Officer will make specific vehicle assignments to best provide coverage for the City.

EMS Department Volunteers

Volunteer providers will be assigned to an ambulance, zone car, specialty apparatus or supervisor vehicle by the scheduling officer in accordance with the EMS Duty policy. Shift assignments will be made based on availabilities processed thru the centralized scheduling system.

Shift Periods

Members are primarily assigned to 12-hour shifts, which are: 0600-1800, 0900-2100, 1800-0600, or any variation thereof. Members are expected to report duty at least fifteen (15) minutes prior to their assigned shift start time.

Members are expected to be immediately available to respond to calls any time during their shift. Assigned apparatus shall be placed on duty as early as possible by MDT log on—promptly at the start of the shift. The supervising Shift Captain must be notified if a medic identifies a reason for a delay of more than 10 minutes. Members are expected to report to work rested and ready to perform all assigned tasks for the entire length of their shift.

Off-going shift members must be awake and prepared to start turnover on the apparatus floor no later than thirty minutes prior to the scheduled end of the shift. A member assigned to a 24 hr shift from night into day at the same station may contact the Shift Captain for that area to request permission for an alternative “on the floor” time. Any off going member who feels they cannot safely travel home without taking a nap first shall notify the Shift Captain for that station’s area at the conclusion of the medic’s shift.

Once a career medic has been relieved, he/she is to remain at the station until the end of their assigned shift. This period of time is a good opportunity for a member to finish any chores or paperwork that couldn’t be addressed earlier in the shift. The Shift Captain may also direct the member to staff an additional apparatus or respond to emergent calls up until the designated time when the shift ends. If a member has a personal need to request to leave early, his/her supervisor will consider that on a case-by-case basis.

Unless directed otherwise by a Shift Captain due to call demand, a member may sign their apparatus off duty on the hour (0600, 1800, or 2100hrs). The remaining 15 minutes of career medic shift time can be utilized for finishing paperwork, assisting oncoming crews, removing PPE/personal gear, chores, etc.

Apparatus assignments are highly variable, so career medics may not always have a relief assigned. However, if a career medic recognizes that their scheduled relief has not reported for duty, he/she should notify the supervising Shift Captain prior to signing off on the hour.

On Duty Practices

Routine Activities

While on duty, all members will be under control of ECH10, EMS1, EMS2, EMS3 or another designated supervisor for operational direction. This direction could include, but is not limited to, responding to calls, posting, shifting zones, training, standbys, and maintenance.

The member will check off the equipment on his/her response vehicle and ensure it is appropriately maintained. The daily shift check off shall be documented on an appropriate check off form in the medic's apparatus log.

The zone car medic will assist with the check off ALS equipment on the duty ambulance at their station early in the shift.

EMS Medics will ensure that the 2nd run ambulance at their station is ready for response to calls. If their zone covers more than one ambulance location, efforts should be made to verify the readiness of ambulances at those locations as well. Spare zone cars are also to be checked. Priority order for completing check offs should be: assigned apparatus, 2nd run ambulance and other spare apparatus (unstaffed zone cars, additional ambulances, etc).

All members are encouraged to participate in training or conduct drills with ambulance and fire crews.

All members are responsible for the general cleaning and upkeep of EMS spaces and equipment/vehicles in their assigned station. This includes, but is not limited to, vacuuming floors, washing dishes, cleaning bathrooms, emptying trashcans, test operating equipment and washing all zone cars.

Special duties may be assigned to any member as required including AED inspections, drug/IV box, equipment testing, data entry, etc.

When not on calls or otherwise completing required tasks, the member may travel or post anywhere within their first due area as defined by the numerical designator of the zone car or ambulance. Out-of-service compensated breaks are not included in the shift schedule. However, members are free to take reasonable break periods between their required work duties. No apparatus will be taken out of service for breaks unless directed by a supervisor.

Due to the highly variable nature of call demands, compensated meal breaks are not formally scheduled in during a shift. However, there is typically time between

calls for service when members can obtain a meal. Medics are expected to manage their time and activities independently so they have at least one 30 minute period for a meal sometime during course of their shift. Apparatus will not be taken out of service for meals. If a member finds themselves in a situation where they were unable to have 30 minutes of down time to eat during their entire shift, he/she should consult with their supervising Shift Captain.

Basing

Should a need arise to leave a first due area between calls, the member must obtain approval from the Shift Captain supervising that area. Once the move is cleared, the dispatcher should be advised when the member departs their first due area and when they return.

Bunk space is provided at each rescue station housing a zone car. At stations without dedicated zone car bunkrooms, members should coordinate directly with the host ambulance crew to determine sleeping arrangements. Most stations require that the member provide their own bedding.

Posting at a private residence is not authorized.

Equipment

Medical Supplies

If items are missing from their assigned apparatus, the member should work with station to stock missing items. If the necessary supplies are unavailable at the station, the member will contact EMS1, EMS2 or EMS3 for assistance.

Communications Equipment

All assigned communications equipment shall be inventoried and accounted for at the start of every shift. Members shall keep a portable radio with them at all times when on duty; the portable radio should be turned on and monitored during the hours of 0600-2200 If a communications equipment is missing the member should contact EMS1, EMS2 or EMS3 immediately.

Each zone car and ambulance is equipped with a mobile data terminal (MDT). These devices perform a variety of functions including dispatcher communication, in-vehicle mapping and vehicle location. Members are not permitted to modify the MDT settings or hardware. Of note, disabling an automated vehicle locator (AVL) system is equivalent to severing all communications with the dispatcher while on duty. Such an act will be considered a breach of the member's Duty to Act and will be met with significant corrective action.

Injuries/Accidents

A member who becomes injured or involved in an accident shall notify EMS1, 2 or 3 at the time of the event. An EMS supervisor will respond and complete the appropriate paperwork.

Identification

A “P” designator will be attached to the unit number of all ALS apparatus except zone cars.

A Department of EMS ID card will be worn at all times when on duty. Students will also be required to wear an ID card with the picture facing outward.

Passport icons will be color-coded to match certifications. Icons shall be affixed to the vehicle passport when on duty.

Response and Activity

Response - No ERS Units on Scene

Until personnel arrive on scene and assess the situation, only the on-duty EMS supervisor may downgrade or cancel a responding unit during actual response.

Individual responding AICs may request the additional response of the closest engine due to time/distance considerations. Responding AICs are not authorized to special call a fire apparatus outside its first due area.

If a responding ALS member feels additional ALS support may be needed, he/she should contact an on-duty EMS supervisor. It is generally not appropriate to select a specific unit, simply request another ALS provider. EMS1, 2 or 3 in conjunction with the dispatcher will identify the best resource to respond.

To provide the most effective management of the City’s emergency response system resources, recommendations for special calls for any apparatus to an emergency medical incident should be made directly to EMS1, EMS2 or EMS3. Supervisors will monitor overall call demands and may request the response of an ALS fire apparatus outside their first due area to provide a more timely response than the closest responding zone car or ALS ambulance.

No member will divert themselves from one incident to another without permission from the appropriate EMS supervisor. If the member feels such a switch is optimal for the response, he/she may make that recommendation to EMS1, EMS2 or EMS3. However, final approval rests with the supervisor.

Response – ERS Units are on Scene

Upon arrival and assessment, any unit on scene may alter response to the appropriate level.

Once incident command is established on the EMS Command Channel, the incident commander will coordinate any resource requests from the scene.

On Scene Care

Members are expected to function within the scope of their training and certification under the Virginia Beach medical control system.

Members are expected to provide the highest standard of care possible for their patients until the patient is turned over to a crew with the appropriate level of training (ALS or BLS).

Members are expected to perform all aspects of patient care, scene leadership, documentation, etc. required for the incident.

ALS providers will utilize all personnel and equipment available to provide the most appropriate ALS interventions in a timely fashion.

ALS providers are expected to work together in meeting the patient's needs as well as ensure a smooth turnover between first response, transporting medics and emergency department staff.

BLS crews should be involved in care as much as possible. Mentoring and field training are essential to build a strong BLS team.

First response ALS providers will assist with transport as the primary or assist ALS provider when needed.

Even though another ALS provider may still be responding, patient care should not be delayed solely to wait for a relief. If the patient is ready for transport, transport should be initiated and the responding ALS provider cancelled.

Patient Transport & Destinations

ALS providers functioning solely on fire apparatus may be required to ride to the hospital on an ambulance when their ALS services are needed to meet continuum of care standards. When operational needs or response times dictate, EMS1, EMS2 or EMS3 may request the Fire Medic provide patient care through the transport phase and cancel a responding ALS resource.

When all hospitals are open, the transporting medic determines the hospital destination appropriate for his/her patient. Medical control and EMS1, EMS2 or

EMS3 have the right to divert the ambulance during normal operations on a case-by-case basis.

When hospital overload conditions exist, EMS1, EMS2 or EMS3 may direct specific transport destinations.

Stable patients who do not need a specialty care facility will be transported to the hospital of their choice as often as feasible within operational demands. Appropriate routine destinations are: Virginia Beach General, Independence, Leigh Memorial and Princess Anne.

With approval from EMS1, EMS2 or EMS3 on a case-by-case basis, patients in the southwest portion of the city may be transported to Chesapeake General.

Low acuity patients will not be transported to Norfolk General, Children's Hospital, DePaul or Portsmouth Naval Medical Center as a matter of routine. If a patient, family member or clinician insists on transport to one of these facilities, the member must contact EMS1, 2 or 3 for guidance.

It is acceptable to transport to Norfolk General or Children's Hospital if the transporting member feels specialty care is needed or if diverted by medical control. EMS1, EMS2 or EMS3 should be notified any time this occurs so other resources can be adjusted while the ambulance is out of the city.

Returning to Service

Members are encouraged to return to service after a call as soon as possible. If a prolonged turnaround is expected, the member should advise EMS1, EMS2 or EMS3.

In general, members should not keep an ambulance out of service solely to return an ALS provider to their zone car. If the ambulance is sent to a call before getting back to their car, the ALS provider will accompany the ambulance as a paramedic unit. In the event it is a BLS call, the medic should contact EMS1, EMS2 or EMS3 to see if alternate transportation can be arranged. Should an ALS provider feel that operationally it would be better to keep the ambulance out of service until retrieving the zone car, he/she should make a recommendation to EMS1, EMS2 or EMS3.

Driver-only ambulances augmented by a firefighter will remain out of service until the firefighter is returned. Members on these trucks should keep EMS1, 2 or 3 advised of their status. Emergent calls along the return route of the ambulance may be answered with direction from EMS1, 2 or 3.

Zone Car Operations

Routine Incidents

ALS providers assigned to a zone car can expect to provide services over wide areas as operational call demands dictate. If they are closer to an incident than another zone car, they should advise EMS1, EMS2 or EMS3 so reassignment can be considered.

Some responses may include the co-response of an ambulance staffed solely by a driver. The ALS provider assigned to a zone car or a provider assigned to a fire apparatus will act as the attendant (or driver) for the ambulance if needed for patient transport to the hospital at the direction of EMS1, EMS2 or EMS3.

Some responses may include the co-response of an ALS ambulance. Unless the ALS ambulance or an ALS first responder unit is closer by time and distance, then the zone car will respond in order to provide care until relieved by the ambulance ALS provider.

EMS1, EMS2 and EMS3 will monitor unit utilization and adjust as needed. Only a supervisor is empowered to cancel a responding zone car and direct the fire engine medic to act for the transport.

When not on a call, ALS providers assigned to a zone car are expected to maintain situational awareness of citywide call demands. During peak demand periods, ALS providers assigned to a zone car should report to the closest station in order to staff an ambulance driver-only if needed. EMS1, EMS2 or EMS3 should be notified by the zone medic when he/she is in position to change apparatus.

Response to Special Operations Incidents

Members may be directed to respond onboard or co-respond with specialty units if needed (i.e. MCI2). This may require the medic to place the zone car out of service.

EMS1, 2 or 3 will work with the Incident Commander to best utilize the medic at the incident or may request that they be returned to service for other calls.

Safety Practices

Members will carry department-issued traffic safety vests and any issued PPE onboard their assigned apparatus while on duty.

On all accidents or incidents on or in the vicinity of public roadways, traffic safety vests will be worn. Members are encouraged to don the vests prior to responding.

On all accidents with entrapments, members with department-issued extrication PPE will don their turnout gear upon arrival at the scene. The only exception will be when the member has been directed to a specific patient/location away from the action area prior to arrival.

Members will not enter into hazardous environments without proper PPE.

ORDERED:

1/31/2018

EMS Chief **Date**

Originated: 01/20/2015 Revised/Reviewed:01/31/2018

ADDENDUM A: Quality Expectations

VIRGINIA BEACH EMS
OPERATIONS DIVISION
QUALITY SERVICE EXPECTATIONS

Quality Expectation #1: Our providers are well trained.

How achieved?

- ALS providers are trained in ACLS, PALS, RSI, ITLS and specialized rescue techniques as required by the OMD.
- An aggressive in-service training program is provided.
- Lessons learned from the field are included in all courses.
- We participate in on-duty drills with fellow responders.

How measured?

- Providers complete at least 48 hours of training annually
- Input on training plans solicited annually from outside stakeholders (TEMS, EPT, Medical Advisory Board, members)
- Critical topics are offered at a variety of times for member convenience
- A near miss reporting system will provide indicators for additional training needs
- Repetitive mistakes will be monitored and corrective training action provided

Quality Expectation #2: Our providers are well equipped.

How achieved?

- Our vehicles exceed Virginia Department of Health equipment standards.
- We check our equipment daily at the beginning of the work shift.
- The latest technology is utilized.
- Comprehensive safety equipment and protective clothing is provided and utilized.
- A department equipment committee meets on a regular basis.

How measured?

- Bi-annual Department of Health vehicle inspections
- Annual Department of EMS vehicle inspections
- Annual review of capabilities by Operations Division with recommendations to the Chief and OMD
- Incident after-action reports should include references to the need for additional equipment and PPE
- Routine checks by field supervisors

Quality Expectation #3: Our providers work as part of a team.

How achieved?

- Career and volunteer personnel are integrated in training and operations.
- Our ERS partners are integrated into training and operations to the greatest extent possible.
- All members--career, volunteer and ERS--work to jointly plan initiatives and quality oversight.
- We provide positive reinforcement and mentoring to junior technicians whenever possible.
- We participate fully in the paramilitary structure of the ERS organization and recognize the associated ranks/positions of all members.
- We participate fully in the Incident Management System.

How measured?

- Routine meetings between officers from all stakeholder groups
- Direct observation of incident scenes by supervisors
- Annual internal member surveys
- Evaluate the time it takes for students to be released
- Compliance with NIMS/ICS training requirements

Quality Expectation #4: We treat everyone with dignity and respect.

How achieved?

- We follow good interpersonal practices including introducing ourselves on arrival, being polite and maintaining a professional demeanor.
- We explain procedures to our patients.
- We maintain a dialogue with friends and family members whenever possible.
- We consider the needs of everyone at the scene including responders and bystanders.

How measured?

- Achieve at least a 90% score on related questions from patient surveys
- Monitor for trends linking negative (and positive) surveys to particular medics
- Receive customer complaints from <1% of all calls
- Direct observation by supervisors

Quality Expectation #5: We follow protocols.

How achieved?

- Protocol refresher topics are included in our training program.
- Protocols are integrated into in-service programs.
- Protocol manuals are issued to each medic and are available on each ambulance.
- We are encouraged to contact supervisors or medical control whenever protocol or procedure questions arise during an emergency medical incident.

How measured?

- Monthly review of various case types identified by the CQI Coordinator with a satisfactory score on 100% of cases
- Automatic review of calls with high acuity, low frequency skills (i.e. chest decompression)
- Annual survey of area hospital medical directors
- Annual review of in-service curriculum by Chiefs of Training and Operations
- Direct observation by supervisors

Quality Expectation #6: We are technically proficient.

How achieved?

- We remain clam and in control even in the worst situations.
- We will regularly practice our skills both in the field and in the classroom.
- We complete proficiency check-offs on seldom-used techniques.

How measured?

- All advanced life support providers will ride to the hospital as AIC 4-6 at least times monthly
- 100% of providers pass annual proficiency checks
- Specific error rates will be monitored with a performance goal assigned (i.e. fewer then 1 medication error per 1,000 patient encounters)
- Direct observation by superiors

Quality Expectation #7: We completely document all care provided.

How achieved?

- We submit a complete PPCR for each patient encounter.
- Documentation training is mandatory for all new and returning members.
- Incomplete reports are returned to the provider.
- Patterns of inadequate documentation are used as a trigger to implement additional training.

How measured?

- Reports will be review at random and graded. 90% scores should be achieved
- Volume of returned reports will be monitored
- Quality documentation will be a factor in all case reviews

Quality Expectation #8: We consistently set high standards.

How achieved?

- A list of best practices is promulgated by the department (i.e. blood pressure checked after each medication administration).
- Best practices are included in all basic and continuing education programs.
- Leadership sets the example for our students and fellow responders to follow.

How measured?

- Include practice compliance in PPCR and case reviews
- A functional after action and near miss reporting system is actively used
- Direct observation by superiors

Quality Expectation #9: We have the confidence of the community.

How achieved?

- We consistently provide quality service.
- We maintain a professional image in both appearance and actions.
- We interact with the community on a regular basis.
- We participate in community education programs such as CPR and injury prevention on a regular basis.

How measured?

- Greater than 90% results on patient surveys
- Greater than 90% results on citizen surveys
- Annual survey of hospital partners and other stakeholders
- Volume of contacts with citizen groups/civic organizations
- Supervisors monitor crew and vehicle appearance

Quality Expectation #10: We are part of a larger service delivery system that includes City of Virginia Beach resources and the health care community at large.

How achieved?

- We engage other departments in delivering and improving service delivery.
- We represent the City.
- We are good stewards of public resources.
- We never forget that taxpayers and donors fund our efforts.
- We don't validate patient complaints about negative experiences with hospitals, doctor's officers or other providers.

How measured?

- Regular meetings with ERS partner departments
- Greater than 90% results on citizen surveys
- Demonstration of stewardship in Annual Report
- Dialogue with Management Services

BEST PRACTICES

- Conduct a turnover with first responders
- Introduce yourself to the patient
- Explain procedures to the patient
- Explain situation to family/bystanders as appropriate
- Allow family members to participate in patient care when appropriate
- Explain assessments and care to junior providers as feasible
- Utilize all personnel on the scene effectively (i.e. have the EMT-E start the IV)
- Remain calm and in control
- Document initial vital signs taken by first responders
- Take vitals every 15 minutes for routine patients and every 5 minutes for critical patients
- Take vitals after every medication administration
- Assess and document breath sounds and pulse ox after every breathing treatment
- Use secondary confirmation of ET tube placement
- Secure ET tubes with commercial device and full spinal immobilization
- Verify ET tube position after every patient movement
- Complete the "5 rights" for every medication administration
- When a qualified member is present, have them verify all medication dosages
- Ensure the appropriate equipment and personnel required to perform a technical skill are in place prior to performing that skill
- Review the call with the transport crew prior to leaving the hospital (when not required to clear for another call)
- Say goodbye to your patient after turning them over to the hospital staff
- Maintain patient confidentiality
- Always use appropriate PPE and ensure you crew does the same
- Vehicles are cleaned inside and out each shift
- Position vehicle with provider and patient safety in mind
- Always operate the vehicle in a safe, courteous manner
- Maintain a professional demeanor and be careful not to engage in unacceptable conversations in the public or hospital rescue rooms