08.01.00 MISSION STATEMENT AND SCOPE OF CARE

08.01.01 There is a Mission Statement written in the present tense that describes the purpose of the service, mode(s) of transport provided and its constituents. The Mission Statement directs employees toward the Values the service was founded upon.

08.01.02 There is a written scope of care that describes the types of patients accepted. The scope of care is commensurate with the qualifications and level of initial and ongoing education required for medical personnel.

**Examples of Evidence to Meet Compliance:**
The Mission Statement describes what you do. The scope of care describes what type of service you perform, what patients you transport and what type of medical teams you provide, etc. Both are clear and concise and understood by all. The vision and mission are strategic statements developed by and unique to each organization. Values statements are separate but key underpinnings of these statements. The models of transport and constituents are not, and should not be part of these statements but, rather, should be included under a “scope of service and care” statement.

08.02.00 FINANCIAL COMMITMENT

08.02.01 There must be evidence of financial commitment to the program by the administrative structure and through financial resources that provide excellence in patient care and safety of the transport environment.

**Examples of Evidence to Meet Compliance:**
Transport vehicle is well kept – equipment and supplies are well maintained, accessible and adequate for patient population(s)/volume. Physical surroundings are well maintained. There are adequate management and staff personnel for transport volume. Education appropriate to the scope of care and to all aspects of the organization (Communications, Medical Crew, etc.) is provided.

08.02.02 Insurance – The transport service must have and maintain insurance against loss or damage of the kinds customarily insured against and in such types and amounts as are customarily carried under similar circumstances by similar businesses. The insurers must be financially sound and reputable, and they must be qualified to do business in the state(s) or country in which the transport service is located.

The types of insurance should include but are not limited to the following:

1. Auto insurance (for ground vehicles and ambulances owned by the service) – $1 million (U.S. dollars) and includes accidental death and disability
2. Medical malpractice – $1 million (U.S. dollars)
3. Worker’s Compensation – follow state or equivalent government guidelines

4. Group license insurance or accidental death and disability must be offered whether paid for by the employer or employee.

**08.03.00 MARKETING AND EDUCATION FOR THE PUBLIC**

08.03.01 The transport service will know the capabilities and resources of receiving facilities and will transport patients to appropriate facilities within the service region based on direct referral, approved EMS plan, or services available when no direction is given.

1. State license for each transport vehicle is accessible as appropriate to state or local guidelines.

2. If mutual aid relationships are developed the following apply:
   a. The service has written agreements specifying the circumstances under which mutual aid would be used.
   b. A mutual aid agreement addresses reciprocity, liability, and cost sharing/billing issues, hours of operation, phone number, and access procedure.

3. All patient care resources, including personnel and equipment, necessary to the program’s mission must be readily available in the ground transport vehicle or available for placing in the ground transport vehicle and operational prior to initiating the mission.

4. Management ensures, through policy, that all transfers of patient care occur from a lower level of care to an equal or higher level of care except for elective transfers for patient convenience or returning a patient to a referring facility/residence.

5. Whenever possible, services that respond directly to the scene will transport patients to the nearest appropriate hospital (i.e. major trauma to the nearest Level I or II trauma center, stroke patients to a hospital with specialized stroke care, acute myocardial infarction patients to a hospital with a staffed cardiac catheterization lab, major burns to a Level I or II burn center, high-risk OB patients to a hospital with OB services and a Level II or III NICU, etc.). See References for Centers for Disease Control trauma triage guidelines.

6. Accurate estimated time of arrivals (ETAs) is always provided regarding arrival of the service to the patient for emergency requests.

7. Contracts with municipalities indicate realistic response times.

8. Transport requests are accepted from authorized personnel with sensitivity to cultural differences and without discrimination due to race, creed, sex, color, age, religion, national origin, ancestry, or handicap. "Emergency calls" or those requests that involve a patient with a potentially life-threatening illness or injury who requires rapid transportation and intervention at a location within the defined service area are accepted without prescreening for the ability to pay.

9. The medical transport service should be integrated with and communicate with other public safety agencies. This may include participation in regional quality improvement reviews, regional disaster planning and mass casualty incident drills.
10. The transport service demonstrates compliance with the legal requirements and regulations of all local, state and federal agencies under whose authority it operates.

11. The transport service demonstrates environmental integration with the local community with “drive friendly” procedures.

08.04.00 ETHICAL BUSINESS PRACTICES

08.04.01 The transport service develops and demonstrates use of a written code of ethical conduct in all areas of business that demonstrate ethical practices in business, marketing and professional conduct.

1. The code of conduct guides the service when confronted with potential compliance or ethical issues.

2. The code of conduct outlines the service’s standards for ethical behavior as well as contact information and reporting protocols if a standard has been violated.

3. The code of conduct outlines ethical billing practices.

4. There is a policy that governs the taking of photos and use of photos regarding privacy implications.

5. There is a policy that addresses privacy rights in regard to photographing and using photos.

Examples of Evidence to Meet Compliance:
Policies may address such issues as proper/improper behavior toward other programs’ marketing materials, honesty in reporting data, personal cell phone use, use of social networking sites, how ethical issues are addressed, conflicts of interest, phone etiquette, acceptable and unacceptable behaviors on the worksite/on transport, acceptance of gifts from patients/vendors, etc.

08.05.00 COMPLIANCE

There is a corporate compliance officer or designated person responsible for ensuring that the service is in compliance with external laws and regulations, payer requirements, and internal policies and procedures.

08.05.01 Compliance issues may include but are not limited to and must be included in formal education for the staff:

1. Health Insurance Portability and Accountability Act (HIPAA)*

2. Federal civil statues (False Claim Act)*

3. Balanced Budget Act of 1997*

4. Office of Inspector General (OIG) Compliance Program Guidance*

5. OIG annual work plans (hospital-affiliated)*

6. Anti-kickback and Stark laws*

7. Emergency Medical Treatment and Active Labor Act (EMTALA)*
8. Red Flag Rules (Identity Theft Prevention Program) *

9. Federal sentencing guidelines

* (See References in Appendix)

08.05.02 The compliance program includes:

1. Written policies and procedures

2. Designation of a compliance officer or assignment of responsibility to a specific individual or individuals

3. Conducting effective training and education for staff that documents both initial and continuing competency

4. Developing effective lines of communication

5. Enforcing standards through published disciplinary guidelines

6. Auditing and monitoring

7. Responding to detected offenses and developing corrective action.

Examples of evidence to meet compliance:

Staff is knowledgeable about current compliance issues.

08.06.00 MANAGEMENT/POLICIES

08.06.01 There is a well-defined line of authority.

1. There is a clear reporting mechanism to upper level management. An organizational chart defines how the medical transport service fits into the governing/sponsoring institution, agency or corporation.

2. A policy should be in place that documents the employer’s disciplinary process and protects employees from capricious actions.

3. Written policies and procedures indicate what therapies can be performed without on-line medical direction.

4. The program adheres to state/provincial, national and/or local ambulance rules and regulations, including licensure requirements.

5. Management demonstrates strategic planning that aligns with the mission, values and vision of the service.


7. Managers are trained to recognize real and perceived pressures that may influence unsafe acts by staff.

8. Management sets an Emergency Response Plan that includes a PAIP and responses to unexpected occurrences involving personnel, vehicles and facilities as appropriate to the base of operations.
9. Management requires shift briefings conducted at the beginning of each shift to assure continuity between shifts.

10. Management requires a post transport debrief is conducted after each transport, as feasible.

Examples of evidence to meet compliance:
*Business plans demonstrate a needs and risk assessment when expanding the service or adding bases that includes staffing, training and management restructuring for added responsibilities.*

Examples of evidence to exceed compliance:
*Management is educated to Just Culture and applies Just Culture principles throughout the organization.*

**08.07.00 MISSION TYPES AND PROFESSIONAL LICENSURE**

**THERE WILL BE AN ADDENDUM TO THIS SECTION IN 2013 THAT WILL ORGANIZE ALONG WITH LEVELS OF CARE IN THE GENERAL SECTION**

Mission Types – Staffing should be commensurate with the mission statement and scope of care of the medical transport service. The ambulance, by virtue of medical staffing and retrofitting of medical equipment, becomes a patient care unit specific to the needs of the patient. A well-developed position description for each discipline is written.

08.07.01 Elective Transports or Convalescent Transports

1. There are patients in stable condition who may require only one medical professional of at least an EMT-B level. The medical transport service should have criteria or mechanisms to provide the appropriate care (number of medical personnel and level of care) required for patients who are requesting elective or convalescent transport.

08.07.02 Advanced Life Support – An advanced life support (ALS) mission is defined as the transport of a patient from an emergency department or critical care unit or scene who receives care commensurate with the scope of practice of an EMT-Paramedic.

1. The medical team must at a minimum consist of at least one certified EMT-Paramedic as the primary care provider.

   a. There are adequate personnel to provide full coverage with EMT-Paramedics who are primarily assigned to the medical service and are readily available within the response time determined by the service.

2. The EMT-Paramedic provider must be licensed, certified, or permitted according to the appropriate state regulations and has current relicensing, recertification, or repermitting status.

   a. The service requires pre-hire background checks and verification of employment history.

   b. A position description outlines the job qualifications and performance expectations.

3. Advanced life support missions require an additional team member, for a minimum of two medical attendants, while a patient(s) is on board, one of which may also serve as the driver. Advanced life support missions require an additional team member, one of whom may serve as a driver, for a minimum of two medical attendants while a patient(s) is on board.

   a. Personnel should be available for each transport within a response time determined by the service.
The second attendant should be at least an EMT-B level provider, EMT-I, another EMT-P or respiratory therapist.

b. Regularly scheduled personnel should be assigned to the service as his/her primary responsibility and should meet all appropriate and current state licensing, certification, or permitting requirements for respiratory therapist or EMT-B, EMT-I, EMT-Paramedic, or higher level.

08.07.03 Basic Life Support—A basic life support (BLS) mission is defined as the transport of a patient from an emergency department or scene who receives care commensurate with the scope of practice of an Emergency Medical Technician-B.

1. There are adequate personnel to provide full coverage with EMT-B providers who are primarily assigned to the medical transport service and are readily available within the response time determined by the service.

2. The EMT-B provider must be licensed certified or permitted according to the appropriate state regulations and have current relicensing, recertification, or repermitting status.

3. Basic life support missions require an additional EMT-B provider, for a minimum of two medical attendants, while a patient(s) is on board, one of which may also serve as the driver. Basic life support missions require an additional EMT-B provider, one of whom may serve as a driver, for a minimum of two medical attendants while a patient(s) is on board. Personnel should be available for each transport with a response time determined by the service.

   a. The additional EMT-B provider must be licensed, certified or permitted according to the current appropriate state regulations and have relicensing, recertification, or repermitting status.

      • The service requires pre-hire background checks and verification of employment history.

      • A position description outlines the job qualifications and performance expectations.

08.08.00 STAFFING
The service should have operational policies to address each area listed below.

08.08.01 Scheduling and individual work schedules demonstrate strategies to minimize duty-time fatigue, length of shift, number of shifts per week and day-to-night rotation. (See References in Appendix for circadian rhythm and other fatigue studies.)

1. On-site shifts scheduled for a period to exceed 24 hours are not acceptable. Twenty-four hour shifts are acceptable if:

   a. Medical personnel are not required to routinely perform any duties beyond those associated with the transport service.

   b. Medical personnel are provided with access to and permission for uninterrupted rest after daily medical personnel duties are met.

   c. The physical base of operations includes an appropriate place for uninterrupted rest.

   d. Medical personnel must have the right to call “time out” and be granted a reasonable rest period if the team member (or fellow team member) determines that he or she is unfit or unsafe to continue
duty, no matter what the shift length. There should be no adverse personnel action or undue pressure to continue in this circumstance.

e. Management must monitor transport volumes and personnel’s use of a “time out” policy.

2. Personnel must have at least eight \textbf{ten} hours of rest with no work-related interruptions prior to any scheduled shift of twelve hours or more. The intent is to preclude back-to-back shifts with other employment, commercial or significant fatigue-causing activity prior to a shift.

3. The number of consecutive shifts and day to night day-to-night rotation must be closely monitored by management for medical crews, communication specialists, and ground ambulance drivers.

4. Policies that address preparation for transport based on an available patient report and distance of transport to appropriately assess staffing and equipment/supplies needs.

5. Policies address crew interface so that team members are expected to stay alert on all legs of the transport, including at least one team member on empty legs, to assist the driver in staying alert.

6. Scheduling of on-call shifts must be evaluated to address fatigue in a written policy based on monitoring of duty times by managers, QM tracking and fatigue risk management.

\textbf{Examples of evidence to meet compliance:}
\texttt{Management monitors fatigue in terms of staffing patterns, patient outcomes and incidents or accidents.}

\textbf{08.09.00 PHYSICAL WELL-BEING}

08.09.01 Physical well-being is promoted through:

1. Wellness programs that promote healthy lifestyles (e.g. balanced diet, weight control, no smoking).

2. Evidence of an injury prevention program and ergonomic strategies to reduce employee injuries.

3. Protective clothing and dress code pertinent to:

   a. Mission profile such as turn-out gear available at scene for medical personnel who assist with heavy extrication

   b. Safe operations, which \textbf{may} include the following, unless specified as “required” below:

   \begin{itemize}
   \item Boots or sturdy footwear for on-scene operations \textbf{required}
   \item Wearing reflective material or striping on uniforms for night operations
   \item High-visibility reflective vests or appropriate DOT-approved clothing must be worn by ground crews according to the ANSI-SEA 107 standard or equivalent national standard. \textbf{required}
   \item Flame-retardant clothing
   \item Appropriate outerwear pertinent to survival in the environment \textbf{required}
   \end{itemize}
4. Infection control — dress codes address jewelry, hair and other personal items of medical personnel that may interfere with patient care (refer to OSHA standards).

5. Written policies addressing:
   a. Duty status during pregnancy
   c. Duty status during acute illnesses such as sinusitis or otitis
   d. Duty status while taking medications that may cause drowsiness
   e. Weight/height and/or lifting ability as specified in pre-hire requirements

   **Examples of evidence to meet compliance:**
   Personnel are observed following the program’s dress codes and are knowledgeable about policies regarding physical well-being.

**08.10.00 MEETINGS, RECORDS AND POLICIES**

08.10.01 Meetings

1. There are formal, periodic staff meetings for which minutes are kept on file. Minutes will include who attended, base identification (if multiple bases), who is presiding and discussion (versus agenda/topics only). There defined methods, such as a staff notebook or electronic mechanisms for disseminating information between meetings.
   a. Meeting minutes (Staff, Safety, QM meetings etc.) are kept on file and maintained for a minimum of three years.
   b. Minutes are dated, and personnel present (to include excused and unexcused absentees) are clearly identified by title (e.g., Director, EMT-P, EMT).

   **Examples of evidence to meet compliance:**
   Meeting minutes indicate attendance and representation by all disciplines. Action items, timelines and area of responsibility are well documented and demonstrate a flow of information that indicates tracking, trending and loop closure.

08.10.02 Records - Management ensures that patient care records, meeting minutes, policies and procedures are stored according to hospital or agency policies, and HIPAA or privacy regulations are indicative of the individual medical transport service’s sensitivity to patient confidentiality in accordance with local and national standards.

1. A record of patient care is completed, and a copy remains (electronic or other format) at the receiving facility for appropriate continuity of care.
   a. A policy outlines minimal requirements for items to be documented in the patient care records that include:
      - Purpose of the transport
      - Treatments, medications, intake and output and patient’s response to treatments and medications
• Signature of each care provider and clarity about what care was performed by each provider (administering medications and performing procedures) and indicates who actually documented patient information.

• Transport facilities (to and from) and to whom report was given to at the receiving facility

**Examples of evidence to meet compliance:**
*Patient records are signed and initialed by the crew member who performed the treatment or procedure. Records are stored in a secure area that is inaccessible to the public with accessibility limited according to applicable HIPAA guidelines.*

08.10.03 Policies – A policy manual is available and familiar to all personnel.

1. Policies are dated and signed by the appropriate manager(s).

2. Policies are reviewed on an annual basis as verified by dated manager’s signature on a cover sheet or on respective policies.

**Examples of evidence to meet compliance:**
*Policies can be broken out by department/division however there must be signatures and revision dates on each specific policy or a cover sheet that represents annual review with respective review dates and signatures.*

**08.11.00 UTILIZATION REVIEW**

08.11.01 Management ensures an appropriate utilization review process (some criteria do not apply to elective transports) through trending and tracking requests. There is evidence of feedback to the requesting agents and feedback from the patient-receiving facilities. Utilization review may be prospective, concurrent, or retrospective. Management ensures an appropriate utilization review process (does not apply to elective transports) based on:

1. Medical benefits to the patient.
   a. Timeliness of the transport as it relates to the patient's clinical status.
   b. Transport to an appropriate receiving facility:
      • Interfacility transports require physician referral/acceptance and confirmation of bed availability to ensure continuity of care and establish patient care parameters during the transport. Patient transfer protocols to comply with Federal requirements exist.
      • An appropriate receiving facility may include:
         o A hospital or facility where the patient has previously undergone specialized treatment and where the patient's previous medical records are located
         o A hospital or facility where the patient's attending physician practices to ensure continuity of care
         o A hospital or facility with a specialized level of care not available in the referring institution, referring facility
2. A structured, periodic review of transports (to determine transport appropriateness or that the mode of transport enhances medical outcome, safety or cost effectiveness cost-effectiveness over other modes of transport) performed at least semiannually and resulting in a written report (Does not apply to elective transports.)

   a. Treated at scene but not transported

   b. Transported interfacility, and the receiving facility is not a higher level of care than the referring facility.

   c. Transported from the scene of injury to any hospital that was not the closest appropriate and available trauma center (based on regional trauma plans, if present)

3. Continuity of Care – The medical service must ensure continuity of care and expeditious treatment of patients.

   a. Where appropriate, the service should promote a timely feedback to referring agency, facility or physician about patient outcome and treatment rendered before, during and after transport.

**Examples of evidence to meet compliance:**

*UR reports indicate trending and loop closure of patient outcomes. Requesting agents are contacted if there are trends that indicate over-triage or under-triage.*

*Continuous review of utilization review with applicable trending and loop closure of patient outcomes in the form of follow-up to receiving facility, documented phone calls to patient/family, etc. may provide adequate information about patient outcome. Outliers should be presented to Case Review Committee or during regularly scheduled staff meetings to discuss specifics of transport.*

**Examples of evidence to exceed compliance:**

*There is written evidence that the program routinely provides feedback and education to requesting agents regarding inappropriate requests for the transport. Program regularly meets with representatives of the EMS region and trauma center to discuss scene transports that were both undertriaged and overtriaged.*

**08.12.00 QUALITY MANAGEMENT**

08.12.01. There is an ongoing Quality Management (QM) program designed to objectively, systematically and continuously monitor, assess and improve the quality and appropriateness of patient care and safety of the transport service provided by the ground service.

08.12.02 The QM program should be integrated and include activities related to patient care (including customer satisfaction), communications, and all aspects of transport operations and equipment maintenance pertinent to the service’s mission statement.

08.12.03 The medical transport service has established patient care guidelines/standing orders that must be reviewed annually (for content accuracy) by management, QM Committee members and the medical director(s).

08.12.04 The medical director(s) is responsible for ensuring timely review of patient care, utilizing the medical record and pre-established criteria.
08.12.05 There is an established Quality Management Program in place, including the medical director(s) and management, to assure the process is implemented.

1. A QM flow chart diagram is developed demonstrating organizational structure in the QM plan and linkage to the Safety and Risk Management Committees.

2. The QM program is linked with risk management so that concerns raised through the risk management program can be followed up through the continuous quality improvement program.

3. The QM program should be integrated and include activities related to patient care (including customer satisfaction), communications, and all aspects of transport operations and equipment maintenance pertinent to the service's mission statement.

08.12.06 There is a written QM plan that includes the following components:

a. Responsibility/assignment of accountability

b. Scope of care

c. Important aspects of care, including clinical outcomes

d. Operational processes, such as financial outcomes and customer needs

e. Indicators

f. Thresholds for evaluation which are appropriate to the individual service

g. Methodology – the QM process or QM tools utilized

h. Groups should be assembled to address each identified area of quality concern; these groups should include representatives of all disciplines involved, ensuring communication and problem-solving

i. The plan should emphasize the quality of services offered is considered on a continuum, with constant attention to developing new strategies for improving; maintaining the status quo or achieving arbitrary goals are not considered the end-measures.

j. Evaluation of the improvement process.

08.12.07. There will be regularly scheduled QM meetings providing a forum for all disciplines involved in the medical transport service to present their needs and areas for improvement to each other.

08.12.08. The monitoring and evaluation process has the following characteristics:

1. Driven by important aspects of care and operational practices identified by the medical transport service’s QM plan

2. Indicators and thresholds or other criteria are identified to objectively monitor the important aspects of care

3. Evidence of QM studies and evaluation in compliance with written QM plan
4. Evidence of action plans developed when problems are identified through QM and communication of these plans to the appropriate personnel

5. Evidence of reporting QM activities through established QM organizational structure

6. Evidence of ongoing re-evaluation of action plans until problem resolution occurs

7. Evidence of annual goals established prospectively for the QM program which provide direction for the work groups and which are quantitative. The emphasis must be on loop closure and resolution of problems within a finite time period.

08.12.09 Quarterly review should include (at a minimum, but may exceed) criteria based upon the important aspects of care/service. The following examples are encouraged:

1. Reason for transport

2. Mechanism of injury or illness

3. Medical interventions performed or maintained
   a. Time of intervention consistently documented
   b. Patient’s response to intervention documented
   c. Appropriateness of interventions performed or omission of needed interventions

4. Patient’s outcome (morbidity and mortality) at the time of arrival at destination
   a. Patient’s change in condition during transport

5. Timeliness of the transport/coordination of the transport form reception of request to ambulance enroute time

6. Safety practices
   a. Safety issues may be handled through the Safety Committee where a problem, incident or accident should be identified with detailed reporting and analysis of vehicular incidents and resolution of issues with findings and action plans reported back to the QM committee.
   b. There is a process to identify, document and analyze sentinel events, adverse medical events or potentially adverse events (near misses) with specific goals to improve patient safety and/or quality of patient care.
   c. QM personnel may collect data and refer to the Safety Committee for action and resolution.

7. Operational criteria to include at a minimum the following quantity indicators:
   a. Number of completed transports
   b. Number of aborted and canceled transports due to weather
c. Number of aborted and canceled transports due to maintenance

d. Number of aborted and canceled transports due to patient condition and use of alternative modes of transport

8. In addition, the communications center or organization should monitor and track (at a minimum but may exceed):
   - Request acceptance to departure times
   - All aborted and cancelled transport requests – times, reasons and disposition of patients as applicable

08.12.10 For both QM and utilization review programs, there should be evidence of actions taken in problem areas and the evaluation of the effectiveness of that action.

08.12.11 For both QM and utilization review programs, there should be evidence of reporting of results through established organizational structure to the service's sponsoring institution(s) or agency (if applicable). For both QM and utilization programs, there is direct integration of the medical transport service's activities with the sponsoring institution or agency (if applicable).

**Examples of evidence to meet compliance:**
The QM plan is current and describes the process with evidence of loop closure in subsequent reports. QM does not consist only of medical record reviews.

**Examples of important aspects of care may be:**
- Response time on emergent transports
- Controlling life-threatening dysrhythmias
- Managing cardiac chest pain
- Managing respiratory distress
- Patient and user satisfaction
- Complete and accurate documentation of care delivered
- Efficient turnaround time in referring hospitals on emergent transfers

**Other criteria may include:**
- Communications among parties involved in transfer
- Facilitating transfer of patients for referring physicians
- Appropriateness of use of transport service and absence of patient/staff injuries incurred during transfer.

**Indicators may also be in regard to:**
- Meeting response time
- Advanced procedure success rate
- Patient or employee or referring/receiving staff satisfaction
- Periodic maintenance on medical equipment, communicating vehicles in/out of service
- Appropriate mode use
Commission on Accreditation of Medical Transport Systems
8th Edition Accreditation Standards
ALS – BLS Ground

Documentation requirements, policy/procedure compliance, etc.

Thresholds are appropriate for the indicator and may be based on published standards/results, program historical results/goals and/or intuitive appropriateness, i.e. 100% is desired for correct referring location. However, 100% is not realistic success on first attempt of intubation. Examples of methodologies may be sources of data such as questionnaires, databases, medical records, administrative reports, incident reports; how numerical results are calculated, fishbone diagram, six sigma, control charts, Pareto charts, flowcharts, etc.

Examples of evidence to meet compliance:
Development of business indicators that will allow the program to improve in their processes should be developed with indicators focusing on every aspect of the program (i.e. communications, clinical, safety, etc.) A flow chart outlining the process flow when outliers and how the loop is closed to ensure that each outlier was addressed. Subsequent action to trends in activity should be noted with constant evaluate of the performance improvement process (i.e. Deming Cycle, Plan Act, Do, Check). The QM plan is current and describes the process with evidence of loop closure in subsequent reports.

Examples of evidence to meet compliance:
Outcomes from QM should drive education and training needs. Systems improvement tools are educational. The process is not punitive.

Tracking and trending response times and times on scene or at the referring/receiving hospital are evaluated in terms of benchmarks set by the program in order to evaluate the effectiveness of policies/procedures, training and/or equipment needs.

If transports are delayed – reasons for delays or referrals are tracked, as are transport requests that are conducted by an alternate means of transport (within the same program).

09.00.00 ALS-BLS GROUND PATIENT CARE

09.01.00 MEDICAL DIRECTION
Medical Director(s) – The medical director(s) of the program is a physician who is responsible for supervising and evaluating the quality of medical care provided by the medical personnel. The medical director ensures, by working with the clinical supervisor and by being familiar with the scope of practice of the transport team members and the regulations in which the transport team practices, competency and currency of all medical personnel working with the service.

09.01.01 The medical director(s) should be licensed and authorized to practice in the location in which the medical transport service is based and have educational experience in those areas of medicine that are commensurate with the mission statement of the medical transport service (i.e., adult trauma, pediatric, neonatal transport, etc.) or utilize specialty physicians as consultants when appropriate.

09.01.02 The medical director(s) should have experience in ground emergency medical services and should have education as a medical director (see Education Matrix) as appropriate to the mission statement and be familiar with the general concepts of appropriate utilization of ground transport services. In addition, the medical director should be current and demonstrate competency or provide documentation of equivalent educational experiences directed by the mission statement and scope of care. Certifications are required as pertinent to the program’s scope of care. If a physician is Board certified in an area appropriate to the mission and scope of the service, certifications #1., 2., 11., and 13. are optional.

Supporting Criteria
1. Advanced Cardiac Life Support (ACLS) according to the current standards of the American Heart Association or approved equivalent

2. Advanced Trauma Life Support (ATLS) according to the current standards of the American College of Surgeons or approved equivalent

3. Appropriate utilization of medical/ground interfacility services

4. Emergency Medical Services

5. Ground ambulance rules/regulations/driver safety course

6. Hazardous materials recognition and response


8. Infection control

9. “Just Culture” or equivalent education is strongly encouraged

10. Neonatal Resuscitation Program (NRP) according to the current standards of the American Academy of Pediatrics (AAP) and the American Heart Association (AHA)

11. Patient care capabilities and limitations (i.e., assessment and invasive procedures during transport)

12. Pediatric Advanced Life Support (PALS) according to the current standards of the American Heart Association (AHA) or Advanced Pediatric Life Support (APLS) according to the current standards of the American College of Emergency Physicians (ACEP) or national equivalent

13. Stress recognition and management

14. Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue

15. The medical director should demonstrate continuing education in transport

09.01.03 The medical director(s) is actively involved in the quality management (QM) program for the service

09.01.04 The medical director(s) is actively involved in administrative decisions affecting medical care for the service

09.01.05 The medical director sets and reviews medical guidelines (for current accepted medical practice), and medical guidelines are in a written format

09.01.06 The medical director(s) is actively involved in training and continuing education of all medical personnel for the service

09.01.07 The medical director(s) is actively involved in the care of ill and/or injured patients

09.01.08 The medical director receives Safety and Risk Management training on an annual basis (strongly encouraged) such as Threat and Error Management training or equivalent (see References)

**Examples of evidence to meet compliance:**
There is evidence of the medical director’s involvement with the program through meeting attendance records, education records, chart reviews etc.

Examples of evidence to exceed compliance:
Medical director(s) attends TEM and Just Culture training and achieves advanced transport management certifications, such as Certified Medical Transport Executive.

09.01.09 The medical director(s) ensures that ground transport is appropriate and safe for the patient’s specific disease process/needs. (For example: patients requiring use of a hyperbaric chamber are usually transported by ground, but in some geographic locations, the distance would be prohibitive for ground transport.)

09.01.10 The medical director(s) should set a policy that insures compliance with federal EMTALA regulations. This policy should address bedside-to-bedside care for ALS Providers to prevent any diminution in level of care. The policy should also address situations where it may not be necessary to proceed from bedside to bedside with the patient. These incidents should be examined by the QM process.

09.01.11 The medical director must maintain open communications with referring and accepting physicians and be accessible for concerns expressed by referring and accepting physicians regarding controversial issues and patient management.

09.01.12. Medical Control

1. The medical director(s) is actively involved in orienting physicians providing on-line medical direction according to the policies, procedures and patient care protocols of the medical transport service.

2. Guidelines should state what parameters and disease processes need medical control input during patient transport.

3. On-line medical control physicians (who are trained and identified by the service) should have the appropriate knowledge base and experience sufficient to ensure proper medical care and medical control during transport for all patient types served by the medical transport service.

4. If the medical control physician’s experience is lacking in a clinical area, he or she should seek prompt consultation as appropriate to ensure proper medical care and medical control during transport for all patient types served by the medical transport service. This consultant should be an appropriately designated physician or the patient’s receiving attending physician.

5. Written policies and procedures indicate what therapies can be performed without on-line medical direction.

Examples of evidence to exceed compliance:
The medical director is involved in EMS on a regional and/or national basis. The medical director participates in peer-reviewed published research regarding medical transport.

09.02.00 CLINICAL CARE SUPERVISOR
Clinical Care Supervisor – Responsibility for supervision of patient care provided by the various clinical care providers (i.e., EMT-B, EMT-P, etc.) must be defined by the service. All patient care personnel must be supervised by someone knowledgeable and legally enabled to perform clinical supervision. The clinical care supervisor and medical director(s) must work collaboratively to coordinate the patient care delivery given by the various professionals and to review the overall system for delivery of patient care.

09.02.01 The clinical supervisor is actively involved in the QM/QA/PI of the program.
09.02.02 The clinical supervisor is actively involved in all administrative decisions affecting patient care.

09.02.03 The clinical care supervisor is actively involved in hiring, training and continuing education for all personnel who work for the service.

09.02.04 The clinical care supervisor must ensure adequate mechanisms for the evaluation of clinical practice of patient care providers.

09.02.05 The clinical care supervisor should demonstrate currency in the following or equivalent educational experiences as appropriate to the mission statement and scope of care. Alternatively, the clinical care supervisor must have immediate access to personnel with appropriate knowledge and experience as consultants.

1. Advanced Cardiac Life Support (ACLS) according to the current standards of the American Heart Association or equivalent

2. Auditing of Advanced Trauma Life Support (ATLS) according to the current standards of the American College of Surgeons or Transport Nurse Advanced Trauma Course (TNATC) according to the standards of the Air & Surface Transport Nurses Association or equivalent

3. Human Factors – Crew Resource Management resource management

4. “Just Culture” or equivalent education (strongly encouraged)

5. Neonatal Resuscitation Program (NRP) according to the current standards of the American Academy of Pediatrics and the American Heart Association or equivalent. According to ACOG (American College of Obstetricians and Gynecologists) Standards, NRP is a required certification if medical personnel care for high-risk OB patients.

6. Pediatric Advanced Life Support (PALS) or Advanced Pediatric Life Support (APLS) according to the current standards of the American Heart Association or equivalent

7. Patient care capabilities and limitations during transport (i.e., assessment and invasive procedures)

8. Infection control

9. Stress recognition and management

10. Appropriate utilization of medical/ground interfacility services

11. Emergency Medical Services

12. Hazardous materials recognition and response

13. Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue

14. Safety and Risk Management training on an annual basis (strongly encouraged), such as Threat and Error Management (TEM) training or equivalent

15. Knowledge of local and regional ground ambulance regulations as appropriate to scope of care
Examples of evidence to exceed compliance:
The clinical supervisor attends TEM and Just Culture training and achieves advanced certifications such as CEN, CCRN, CFRN, RNC, CTRN, and/or CMTE.

09.03.00 PROGRAM MANAGER
The program manager may have overall responsibility for a program or for a specific base with or without additional clinical responsibilities. (Follow criteria above if clinical responsibilities are part of the position description.)

09.03.01 The program manager must demonstrate currency in the following or equivalent educational experiences as appropriate to the mission statement and scope of care. Didactic education initially and on an annual basis should include but not be limited to:

1. Human Factors – Crew Resource Management. (see References)
2. “Just Culture” or equivalent education (strongly encouraged).
3. Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue
4. Stress recognition and management
5. Safety and Risk Management training on an annual basis (strongly encouraged). For example: Threat and Error Management training or equivalent
6. Quality Management QM/QA/PI of the program and its implication to best practices
7. Knowledge of local and regional ground ambulance regulations as appropriate to scope of care

Examples of evidence to exceed compliance:
The program manager attends TEM and Just Culture training and achieves advanced certifications such as Certified Medical Transport Executive (CMTE).

09.04.00 ORIENTATION, TRAINING AND CONTINUING EDUCATION PROGRAM REQUIREMENTS
A planned and structured program should be required for all regularly scheduled critical care and ALS providers. Competency and currency in these competencies must be ensured and documented through relevant continuing education programs/certification programs or their equivalent listed in this section. The orientation, training and continuing education must be directed and guided by the transport program’s scope of care and patient population, mission statement and medical direction.

09.04.01 ALS Providers

1. Initial training program requirements for all full-time and part-time ALS providers: Each ALS provider must successfully complete a comprehensive training program or show proof of recent experience/training in the categories listed below prior to assuming independent responsibility.

   a. Pre-hire qualifications should include requiring experience relevant to the program’s scope of care and patient population(s).
   
   b. Initial and ongoing training need not be absolutely equivalent depending on roles in patient care for different providers as defined by the program and/or state regulations, but both medical personnel members need to be didactically trained according to their scope of practice and medical direction.
c. **Didactic Component of Initial Education** should be specific and appropriate for the mission statement and scope of care of the medical transport service. Measurable objectives need to be developed and documented for each experience. The transport program will provide a basic outline of initial education that is not limited to, but must include:

- Advanced airway management
- Anatomy, physiology and assessment for adult, pediatric and neonatal patients
- Ambulance orientation/safety and procedures as appropriate
- Cardiac emergencies

**Compliance issues**

- Disaster and triage
- EMS radio communications
- Environmental emergencies.
- Hazardous materials recognition and response.
- High risk obstetric emergencies (bleeding, medical, trauma).
- Infection control
- “Just Culture” or equivalent education (strongly encouraged)
- Mechanical ventilation and respiratory physiology for adult and pediatric patients as appropriate to the mission statement and scope of care of the medical transport service specific to the equipment
- Metabolic/endocrine emergencies
- Multi-trauma (chest, abdomen, facial)
- Neonatal emergencies (respiratory distress, surgical, cardiac)
- Oxygen therapy in the medical transport environment: Mechanical ventilation and respiratory physiology for adult, pediatric and neonatal patients as appropriate to the mission statement and scope care of the medical transport service
- Pediatric medical emergencies
- Pediatric trauma
- Pharmacology
• Quality management: Didactic education that supports medical transport service mission statement and scope of care (for example: adult, pediatric, neonatal)

• Respiratory emergencies

• Safety and Risk Management training on an annual basis (strongly encouraged), such as Threat and Error Management training or equivalent

• Scene management/rescue/extrication

**State EMS rules and regulations regarding ground transport**

• Stress recognition and management

• Survival training

• Thermal, chemical and electrical burns

• Toxicology

d. Clinical Component – Clinical experiences should include, but not be limited to, the following experiences should be specific and appropriate for the position description, mission statement and scope of care of the medical transport service):

• Emergency care

• Prehospital care

• Invasive procedures or mannequin equivalent for practicing invasive procedures

• Obstetrics

• Tracheal intubations

2. Continuing education/staff development must be provided and documented for all fulltime and part-time ALS providers. These should be specific and appropriate for the mission statement and scope of care of the medical transport service.

a. Didactic continuing education must include:

• Emergency care courses

• Hazardous materials recognition and response

• Infection control

• State EMS rules and regulations regarding ground transport

• Stress recognition and management

• Survival training
b. Clinical and laboratory continuing education should be developed and documented on an annual basis and must include:

- Emergency/trauma care
- Invasive procedure labs
- Labor and delivery
- Prehospital experience
- Skills maintenance program documented to comply with number of skills required in a set period of time according to policy of the medical transport service (i.e., endotracheal intubations, chest tubes).

  o Since airway management is an essential lifesaving measure and endotracheal intubation is an important aspect of airway management, no less than one successful live, cadaver or mannequin intubation per quarter is required for each ALS Provider. Success rates for all live intubations are documented and monitored through the QM process with the expectation that orientation to endotracheal intubations requires no less than 5 live or cadaver intubations within the previous 24 months. This requirement may be met by documentation of 5 live or cadaver intubations previously.

  o Live, mannequin or cadaver intubation experience within the scope of practice served by the ground service: i.e., neonates less than 28 days; children age 2 to 8 years

3. Policies ensure that clinical competency is maintained by currency in the following or equivalent training as appropriate for the position description, mission statement, and scope of care of the medical transport service. Education developed by the program as an equivalent to any of the certifications below (a. through e.) must be submitted to the CAMTS Education Committee for pre-approval.

   a. Basic Life Support (BLS) – documented evidence of current BLS certification according to the American Heart Association (AHA)

   b. Advanced Cardiac Life Support (ACLS) – documented evidence of current ACLS according to the AHA

   c. BTLS or PHTLS according to the ACEP or ACS or equivalent

   d. Pediatric Advanced Life Support (PALS) or Advanced Pediatric Life Support (APLS) according to the AHA and ACEP, or equivalent education

   e. Neonatal Resuscitation Program (NRP) according to the current standards of the American Academy of Pediatrics (AAP) and the American Heart Association (AHA)

09.04.02 BLS Providers

1. Initial Training Program – Each BLS provider must successfully complete a comprehensive training program or show proof of recent experience/training in the categories listed below prior to assuming independent
responsibility. The appropriate training and continuing education program will be guided by the service’s mission statement, scope of care, and medical direction.

a. Didactic Component – Should be specific and appropriate for the mission statement and scope of care of the medical transport service

- Basic Trauma Life Support (BTLS) or equivalent education
- Care of cardiac, medical, trauma, pediatric, neonatal and obstetric emergencies
- EMS radio communications
- Hazardous materials recognition and response
  - Human Factors – Crew Resource Management
- Infection control
- “Just Culture” or equivalent education (strongly encouraged)
- Quality management
- Safety and Risk Management training on an annual basis (strongly encouraged), such as Threat and Error Management training or equivalent
- Scene management/rescue/extrication
  - Sleep Deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue
- Stress recognition and management
- Survival training

b. Clinical Component – Clinical experiences should include, but not be limited to, the following (experiences should be specific and appropriate for the position description, mission statement and scope of care of the medical transport service):

- Emergency care
- Prehospital care

2. Continuing education/staff development—Continuing education must be provided and documented for all full-time and part-time BLS providers. These should be specific and appropriate to the mission statement and scope of care of the medical transport service:

a. Didactic continuing education must include:

- BTLS or equivalent education to address the initial care of a trauma patient
- Emergency care courses-basic level
• Hazardous materials recognition and response

• **Human Factors – Crew Resource Management**

• Infection control

• **Just Culture or equivalent education is strongly encouraged.**

• Safety and Risk Management training on an annual basis (strongly encouraged), such as Threat and Error Management training or equivalent

• Scene management/rescue/extrication

• **Sleep Deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue**

• Stress recognition and management

• Survival training

b. Clinical continuing education should be developed and documented on an annual basis. Measurable objectives need to be developed and documented for each experience and must include:

• Emergency/trauma care

• Prehospital experience

c. Clinical competency must be maintained by currency in the following or equivalent training as appropriate for the position description, mission statement and scope of care.

   Education developed by the program as an equivalent to any of the certifications below (a. through e.) must be submitted to the CAMTS Education Committee for pre-approval.

   • Basic Life Support (BLS)-documented evidence of current BLS certification according to the AHA

   • BTLS or equivalent education to address the initial care of trauma victims

09.04.03 Education Specific to the ground transport environment

1. Completion of all the following educational components should be documented for each of the ALS and BLS ground transport personnel. These components should be included in initial education as well as reviewed on an annual basis with all regularly scheduled, part-time or temporarily scheduled personnel or specialty care providers as appropriate for the mission statement and scope of care of the ground service.

   a. EMS communications (radios) and familiarization with EMS system

   b. Extrication devices and rescue operations

   c. General safety to be included on an annual basis. (It is strongly recommended to have the ambulance physically present when providing this training.)

   • Ambulance evacuation procedures (exits and emergency release mechanisms)
• Fire suppression procedures (location and use of fire extinguishers)
• Patient loading and unloading procedures
• Refueling procedure with patient(s) on board
• Use of road hazard equipment
• Specific capabilities, limitations and safety measures for each ambulance used which includes specific training for backup or occasionally-used ambulances
d. Hazardous materials recognition and response
e. Survival training/techniques/equipment-pertinent to the environment/geographic coverage area of the medical transport service.

09.05.00 MEDICAL CONFIGURATION OF THE AMBULANCE
Any in-service ambulance should be configured in such a way that the medical transport personnel can provide patient care consistent with the mission statement and scope of care of the medical transport service. Patient care issues are considered when choosing ground vehicle.

09.05.01 Configuration of the ambulance interior should not compromise the ability to provide appropriate care or prevent providers from performing emergency procedures if necessary.

09.05.02 Medical transport personnel have access to the patient in order to begin and maintain basic and advanced life support treatment.

09.05.03 The ambulance configuration allows for stabilizing and childbirth procedures if that is part of the service's mission.

09.05.04 The service's mission and ability to transport two or more patients should not compromise the airway or stabilization or the ability to perform emergency procedures on any on-board patient.

09.05.05 The ambulance should have access for simultaneous airway management if there is a two-patient configuration.

09.05.06 For all transports, there are written guidelines describing types of patients that can be transported in a two-patient litter configuration if the ambulance configuration does not allow for full access to the second patient.

09.05.07 For all transports, strict policies will address: weight limitations, patient condition based on anticipated needs, and patient position in the ambulance. Policies will be written and adhered to for one or more patient transports if the interior configuration of the ambulance does not allow for uninhibited access to one or more patients while in enroute. Policies will address under what circumstances two critical patients may or may not be transported, including staffing and equipment.

09.05.08 Maintaining airway

1. There should be access and necessary space to ensure any on-board patient's airway is maintained and to provide adequate ventilatory support from the secured, seat-belted position of medical transport personnel.
02.05.05. Airway and alternate airways - There should be access and necessary space to ensure any on-board patient's airway is maintained and to provide adequate ventilatory support from the secured, seat-belted position of medical transport personnel.

1. It is strongly encouraged that seating be designed in the ground ambulance so that patient care can be rendered from a seat-belted position. Shoulder harnesses on side facing bench seats should not be used. (See References)

09.05.09 Delivering oxygen

1. Oxygen is installed according to state and federal regulations (and international guidelines as appropriate) for ambulances. Medical transport personnel can determine if oxygen is on by pressure gauges mounted in the patient care area.

   a. Oxygen flow can be stopped at or near the oxygen source from inside the ambulance.

2. The following indicators are accessible to medical transport personnel while enroute:

   a. Quantity of oxygen remaining

   b. Measurement of liter flow

3. A variety of oxygen delivery devices consistent with the service's scope of care must be available.

4. Adequate amounts (for anticipated liter flow and length of transport with an emergency reserve) of oxygen must be available for every mission.

5. An appropriately secured portable oxygen tank with a delivery device must be carried on the ambulance so that oxygen delivery is not disrupted when transferring the patient from a scene or hospital to and from the ambulance. A portable oxygen tank is never to be secured between patient’s legs or immediately adjacent to the patient while the ambulance is in motion.

6. There must be a backup source of oxygen (of sufficient quantity to get safely to a facility for replacements) in the event the main system fails.

7. There is appropriate storage of oxygen in the facility according to OSHA standards.

8. Oxygen flow meters and outlets must be padded, flush mounted, or so located to prevent injury to medical transport personnel.

09.05.10 Maintaining IV fluids (for ALS Providers)

1. IV supplies and fluids are readily available.

2. Hangers/hooks are available that secure IV solutions in place or a mechanism to provide high flow fluids if needed

3. All IV hooks are padded, flush mounted, or so located to prevent head trauma to the medical transport personnel in the event of an emergency with the ambulance.
09.05.11 Medications consistent with the service’s scope of care are accessible.

1. Medications are easily accessible. Controlled substances are in a locked system or kept in a manner consistent with state law.

2. Controlled substances are in a locked system and kept in a manner consistent with local and national regulations.

   a. For services that transport medications between bases, a policy exists that assures safe and secure transport of medications between bases that is consistent with state and/or national laws. In the U.S., there is a DEA license required for each base that stores and dispenses narcotics. A hospital pharmacy that stocks controlled substances for various locations needs a terminal distribution license, for example.

3. Storage of medications allows for protection from extreme temperature changes if environment deems it necessary.

   a. If there is a refrigerator on the vehicle for medications, a temperature monitoring and tracking policy is required and the refrigerator is labeled “for med use only”.

4. There is a method to check expiration dates of medications on a regular basis.

09.05.12 Medical supplies and equipment must be consistent with the service’s mission statement and scope of care. Additionally, the following equipment must be on the ambulance or immediately available for all ALS Providers and as relevant to BLS Providers.

09.05.13 Cardiac monitoring capabilities

1. Cardiac monitor, defibrillator and external pacemaker are secured and positioned so that displays are visible.

2. Extra batteries or power source are available for cardiac monitor/defibrillator or external pacemaker.

3. Ambulance is configured for effective CPR. There is a policy for providing CPR specific to each vehicle’s configuration.

09.05.14 Defibrillator

1. Defibrillator is secured and positioned for easy access.

2. Semiautomatic or automatic external defibrillator may be required for some BLS Providers (where permitted as scope of care for EMT-B).

3. Pediatric paddles available if applicable to the scope of care of the medical transport service.

09.05.15 Advanced airway and ventilatory support equipment

1. Laryngoscope and tracheal intubation supplies, including laryngoscope blades, bag-valve mask and oxygen supplies, including PEEP valves appropriate for ages and potential needs of patients transported
2. Two suction units, one of which is mechanical and both of which must be required to deliver adequate suction

3. Pulse oximetry on-board or immediately available

4. End-tidal CO2 monitoring capabilities available

09.05.16 Automatic blood pressure device or sphygmomanometer

09.05.17 Devices for decompressing a pneumothorax and performing an emergency cricothyroidotomy available if applicable to scope of care of the medical transport service

09.05.18 The ambulance design and configuration must not compromise patient stability in either loading, unloading or enroute operations.

1. The ambulance must have an entry that allows loading and unloading without excessive maneuvering (no more than 45 degrees about the lateral axis and 30 degrees about the longitudinal axis) of the patient, and does not compromise functioning of monitoring systems, intravenous lines, and manual or mechanical ventilation.

2. There is a written policy on conducting CPR during transport.

3. A minimum of one stretcher should be provided that can be carried to the patient.

   a. Ambulance stretchers must comply with state and federal laws.

   b. The stretcher should be large enough to carry the 95th percentile adult American patient, full length in the supine position. (The 95th percentile adult American male is 6 ft. and 232 lbs.) The type and model of stretcher indicates the maximum gross weight allowed (inclusive of patient and equipment) as labeled on the stretcher.

   c. The stretcher should be sturdy and rigid enough that it can support cardiopulmonary resuscitation. If a back-board or equivalent device is required to achieve this, such device will be readily available.

   d. If the ambulance stretcher is floor supported by its own wheels, there is a mechanism to secure it in position under all conditions. These restraints permit quick attachment and detachment for patient transfer.

   e. The head of the stretcher is capable of being elevated at least 30 degrees for patient care and comfort.

3. Ambulance patients are securely restrained in accordance with state and federal law.

   a. Patients less than 40 pounds (18 kg.) should be provided with an appropriately sized restraining device (for patient’s height and weight) which is further secured by a locking device.

   b. There must be some type of restraining device within the isolette to protect the infant in the event of poor road conditions.

   c. All patients from 10 to 40 pounds (4.5 – 18 kg) less than 40 pounds must be secured in a five-point safety strap device that allows good access to the patient from all sides and permits the patient’s head to be raised at least 30 degrees. Velcro straps are not encouraged for use on pediatric devices.
4. Ambulance equipment and supplies must be secured according to state or federal laws at all times while the ambulance is in motion.

09.06.00 OPERATIONAL ISSUES - AMBULANCE

09.06.01 There should be specific policies and procedures regarding ambulance operations and evidence of training in the following areas:

1. Medical transport personnel must ensure that all medical equipment is in working order and all equipment/supplies are validated through documented checklists for both the primary and backup ambulance.
   a. Equipment must be periodically tested and inspected by a certified clinical engineer.
   b. Equipment inspections will be recorded according to the program's guidelines.
   c. For long distance transports, adequate back-up battery supply must be available to ensure all medical equipment remains functional during transport.

2. Refueling policies for normal and emergency situations: For ambulance, refueling with the engine running, and/or passengers on-board is not recommended. However, emergency situations of this type can arise. Specific and rigid procedures should be developed by the operator to handle these occurrences. Such "rapid refueling" procedures will be covered by the operator's training program. Refueling policies should address:
   a. Refueling with engine(s) running or shut down
   b. Refueling with medical transport personnel or patient(s) on board that includes a requirement that at least one medical transport person should remain with the patient at all times during refueling or stopover

3. Specific policy to address the combative patient
   a. Additional physical and/or chemical restraints should be available and used for combative patients who potentially endanger themselves, the personnel or the ambulance.
   b. A policy should address refusal to transport patients, family members or others who may be considered a threat to the safety of the transport and/or medical transport personnel.

4. Policy to address response to hazardous materials requests or unanticipated contact with hazardous materials.
   a. There is an outlined plan of action according to pre-established policies with appropriate training of the medical transport team.
   b. A plan for patient decontamination procedures prior to transport, including removal of patient clothing and other decontamination procedures for saturation of gasoline or other hazardous chemicals.
   c. The medical transport team must be fully informed about the nature of the hazardous materials.
   d. A list of contaminated materials, which could pose a threat to the medical transport team or render transport inappropriate, must be readily available.
e. A policy addressing carry-on baggage of patient or passengers, which must be checked for hazardous materials before loading on the transport ambulance.

f. A policy addresses the presence of firearms on the transport vehicle.

09.06.02 The floor, sides and ceiling in the patient cabin of the ambulance must be a surface capable of being cleaned and disinfected in accordance with OSHA regulations with the appropriate disinfectant.

**09.07.00 AMBULANCE EQUIPMENT**

09.07.01 A fire extinguisher must be accessible to medical transport personnel and/or driver while in motion.

09.07.02 "No smoking" signs are prominently displayed inside the ambulance.

09.07.03 Rescue equipment is on the ambulance according to state requirements.

09.07.04 Interior of the ambulance must be climate controlled. The cabin temperature should be maintained between 68 degrees F and 78 degrees F (see KKK reference)

1. Cabin temperatures must be measured and documented every 15 minutes during a patient transport until temperatures are maintained within the range of 68 – 78 degrees F (-12 - +4 degrees C). Thermometer is to be mounted inside the cabin.

2. The program has written policies that address measures to be taken to avoid adverse effects of temperature extremes on patients and personnel on board.

3. In the event cabin temperatures are less than 68 degrees F or greater than 78 degrees F, the program will require documentation be red flagged for the QM process to evaluate what measures were taken to mitigate adverse effects on the patient and crew and what outcomes resulted.

**09.08.00 INFECTION CONTROL**

Policies and procedures addressing patient transport issues involving communicable diseases, infectious processes and health precautions for emergency personnel as well as for patients must be current with the local standard of practice or national standards (or in the U.S. – OSHA) and as published by the Center for Disease Control (CDC).

09.08.01 Policies and procedures must be written and readily available to all personnel of the medical transport service.

09.08.02. There is an Exposure Control Plan consistent with national (in the U.S. - OSHA guidelines).

09.08.03 Additional medical and agency resources pertinent to infection control must be identified and made available in the policy manual to all medical transport personnel. For example, isolation precautions for specific diseases/conditions.

09.08.04 Education programs will include the institution's/service's infection control resources, programs, policies and CDC recommendations. Policies and procedures will be reviewed on an annual basis.

09.08.05 Education programs and policies regarding latex allergies may include:

1. Patients and employees at risk for latex sensitivities and symptoms manifested by an allergic reaction

2. Maintaining a latex-safe environment
3. Methods to minimize latex exposure to lessen risks of allergic reactions in medical personnel

09.08.06 Preventive measures. Medical transport teams transporting patients must practice preventive measures lessening the likelihood of transmission of pathogens. Policies and procedures address:

1. Personnel health concerns and records of:

   a. Pre-employment and annual physical exams or medical screening to include:

      • History of acute or chronic illnesses

      • Illnesses requiring use of medications that may cause drowsiness, affect judgment or coordination

      • Immunization history – transport team members are encouraged to have tetanus and hepatitis B immunization. Measles, mumps, and rubella (MMR) immunizations are encouraged for those born after 1957.

      • Weight and lifting/strength/agility testing as appropriate to policies of the service

      • Determination of whether individual is fit for duty

   b. Provide annual tuberculosis testing (purified protein derivative) and other testings, screenings and vaccinations as consistent with current national (CDC in the U.S.) guidelines. This includes medical personnel, drivers and mechanics.

   c. International immunization history of the transport team is documented if appropriate to the scope of care

2. Management of communicable diseases and infection control in the transport environment is outlined in policies.

   a. Use of gloves, eye and mouth protection. Personal protective equipment is readily accessible in the ambulance or issued to the medical transport team.

   b. Use of safety needles and blunt or other type system to lessen the risk of needlesticks to those who come in contact

   c. Sharps disposal container for contaminated needles and collection container for soiled disposable items on the ambulance. Policy will promote proper disposal of sharps as well as tracking and investigation of sharps that are not properly disposed.

   d. Cleaning and disinfecting with appropriate disinfectant of the patient cabin/compartment area, equipment, and personnel's soiled uniforms

   e. Mechanism for identifying those at risk for exposure to an infectious disease

   f. A plan for communication between the medical transport service personnel, EMS providers, and hospital when exposure is suspected/confirmed to include what follow-up is necessary
Written notification should go out in an expedient manner

Follow-up is documented

g. A policy for special precautions when transporting patients with known infectious diseases

- There is also a method to verify patient’s immunization history for international transport.
- Blood specimens or other potentially infectious materials should be placed in a leak-proof, sealed container during transport.
- Disposal of contaminated materials from the ambulance meets federal OSHA guidelines.

h. Proper cleaning or sterilization of all appropriate instruments or equipment

i. Hand washing before and after each invasive patient intervention and after removing gloves

- When hand washing facilities are not available, antiseptic hand cleaners or towelettes should be used.
- If antiseptic hand cleaners or towelettes are used, hands should be washed as soon as feasible with soap and running water.

j. Management maintains documentation related to blood borne and airborne pathogens including confidential records of exposure incidents and post-exposure follow-up, hepatitis B vaccination status and initial and on-going training for all employees.

k. A policy addresses access to post exposure prophylaxis (PEP) medications for HIV, meningococcal infections, etc. The PEP medications should be available in a timely manner for all team members.

l. Where there is likelihood of occupational exposure, the following are prohibited: eating, drinking, applying cosmetics or handling contact lenses.

m. Food and drink will not be stored where blood or other potentially infectious materials are present. If the service performs transports with long in-flight times, there should be a policy to address the nutritional needs of patients and personnel.

10.00.00 - ALS-BLS GROUND COMMUNICATIONS

10.01.00 COMMUNICATIONS EQUIPMENT ON THE AMBULANCE

All ambulance communications equipment must be capable of transmitting and receiving clear and understandable voice communications to and from the base station at a reasonable distance. All communications equipment must be maintained in full operating condition and in good repair. Radios on ambulances (as range permits) should be capable of transmitting and receiving the following:

10.01.01 Medical direction

10.01.02 Communications center
10.01.03 EMS and law enforcement agencies

10.01.04 Radio frequencies are consistent with the state EMS radio communications plan

10.01.05 Intercommunications between the driver and patient care compartment are possible, and there is a talk/listen switch accessible to the driver

10.01.06 There is a public address amplifier with two exterior mounted speakers

1. There is a power output of at least 45 watts

2. The amplifier is independent of the mobile radio unit

10.01.07 There is a policy that addresses if cellular phones are part of the on-board communications equipment, they are to be used in accordance with FCC regulations and are not to be used while the ambulance is in motion. Texting is prohibited while driving by written policy.

1. Ground providers whose medical director(s) has established the requirement for transmission of biomedical telemetry may utilize the cellular telephone system for such communications. Other communications equipment such as cellular phones are in addition to and not in place of the radio equipment and should not be used in the presence of pacemakers or other equipment sensitive to interference.

10.01.08 A Communication Specialist must be assigned to receive and coordinate all requests for the medical transport service.

1. Initial training of the designated person should be commensurate with the scope of responsibility of the Communications Center personnel and include:

   a. Assistance with the hazardous materials response and recognition procedure using appropriate reference materials

   b. Crew Resource Management (CRM) pertinent to communications

   c. Computer literacy and software training

   d. Customer service/public relations/phone etiquette

   e. EMT certification, or the equivalent in knowledge or experience, which minimally includes:

      • Medical terminology

      • Knowledge of EMS-roles and responsibilities of the various levels of training – BLS/ALS, EMT/ EMT-Paramedic

      • State and local regulations regarding EMS

      • Familiarization with equipment used in the field setting

   f. Knowledge of Federal Communications Commission regulations pertinent to medical transport service.
g. Post Accident/Incident Plan (PAIP)

h. Quality management

i. Types of radio frequency bands used by ground EMS

j. Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue

k. Stress recognition and management to include resources for Critical Incident Stress Debriefing or other type of post critical incident counseling

2. There is evidence of recurrent training and of training as policies and equipment changes occur and also includes:

   a. Crew Resource Management (CRM) pertinent to communications

   b. Post Accident/Incident Plan (PAIP)

   c. Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue

   d. Stress recognition and management to include resources for Critical Incident Stress Debriefing or other type of post critical incident counseling

3. Staffing

   a. Scheduling and individual work schedules demonstrate strategies to minimize duty-time, fatigue, length of shift, number of shifts per week and day-to-night rotation.

   b. Call volume and other required duties are considerations in the number of communication specialists on duty at any one time. (Programs should be able to demonstrate how they assign staffing levels, for example, number of Communication Specialists on duty per shift relevant to the number of vehicles and teams in service.)

   c. There are relief personnel with the appropriate training available for periodic breaks.

   d. Personnel must have at least eight hours of rest with no work-related interruptions prior to any scheduled shift of twelve hours or more. The intent is to preclude back-to-back shifts with other employment, commercial or military flying, or significant fatigue-causing activity prior to a shift.

   e. On-site shifts are routinely scheduled for a period not to exceed 18 hours. Twenty-four hour shifts are not acceptable. In addition:
   
   - Personnel must have the right to call “time out” and be granted a reasonable rest period if a team member determines that he or she is unfit or unsafe to continue duty, no matter what the shift length. There should be no adverse personnel action or undue pressure to continue in this circumstance.
Management must monitor transport volumes and personnel’s use of the “time out” policy to ensure that medical personnel utilize the right to call “time-out” appropriately.

10.01.09 Communications policies must be in writing and include the following:

1. There should be a written plan to initiate assistance in the event the ambulance is disabled.

   a. Written post incident/accident plans are easily identified, readily available, and understood by all program personnel and minimally include:

      • List of personnel (with current phone numbers) to notify in order of priority (for communication specialist to activate) in the event of a program incident/accident

      • Consecutive guidelines to follow in attempts to:

          o Communicate with the ambulance

          o Initiate search and rescue or ground support

          o Have a backup plan for transporting the ground ambulance patient in the event that the ambulance is inoperable

      • Preplanned time frame to activate the post incident/accident for overdue ambulance

      • A method to insure accurate information dissemination

      • Procedure to secure all documents and tape recordings related to the particular incident/accident

      • Procedure to deal with releasing information to the press

   b. An annual drill is conducted to exercise the post incident/accident plan. This drill should include medical team, communications personnel, mechanics and administrative personnel. Written debriefing and critique of PIAP drills should be shared with all staff members. An actual incident may be used as appropriate if documented and documentation includes loop closure.

   c. A general test of all emergency procedures to include fire drill, intruder on premises, catastrophic failure of the communications center, helipad mishaps, forces of nature etc. should also be conducted on an annual basis.

   d. A disaster preparedness drill should be part of the general test of all emergency procedures or conducted separately as an annual drill.

Examples of evidence to meet compliance:

The PIAP plan and drills to test the plan include all modes of transport performed by the program. Results of the drill are disseminated to the entire staff. A drill to test other emergency procedures as they apply to the facility is planned and documented.
2. Formal periodic meetings (separately held or part of the program’s staff meetings) are strongly encouraged for which minutes are kept on file. Minutes will include who is presiding, discussion and who was present. There are defined methods, such as a communications book or electronic mechanisms for disseminating minutes and information between meetings.

3. Communications is part of the program’s QM program and communications personnel participate in staff, safety and QM meetings.

10.01.10 Initial coordination must be documented and continuous following must be monitored and documented and should consist of the following: (Although it may not be possible to maintain radio contact throughout a ground transport, the criteria below designated as “G, also” should be documented for ground interfacility transports).

1. Initial coordination to include communication and documentation of:
   a. Time call received
   b. Name and phone number of requesting agency
   c. Time ambulance departed
   d. Number and names of persons on board
   e. Estimated time of arrival (ETA)
   f. Age, diagnosis or mechanism of injury
   g. Referring and receiving physician and facilities (for interfacility transports) as per policy of the medical service
   h. Verification of acceptance of patient and verification of bed availability by referring physician and facility (interfacility transports)
   i. Actual time of arrival

10.01.11 The Communications Center must contain the following:

1. At least one dedicated phone line for the medical transport service

2. A system for recording all incoming and outgoing telephone and radio transmissions with time recording and playback capabilities. Recordings to be kept for 30 days

3. Capability to immediately notify the medical team and on-line medical direction (through radio, pager, telephone, etc)

4. Backup emergency power source for communications equipment, or a policy delineating methods for maintaining communications during power outages and in disaster situations

5. Communications policy and procedures manual

6. Seating and workstations that are ergonomically appropriate for each communications specialist on duty
11.00.00 – ALS-BLS GROUND SAFETY AND ENVIRONMENT

11.01.00 GENERAL SECTION

11.01.01 There is evidence that safety issues are addressed that are specific to the operational environment (i.e. weather and road conditions).

11.01.02 The physical base or of operations demonstrates an appropriate and safe work environment for all personnel with adequate lighting, ventilation, and equipment storage for patient care and care of the transport ambulance.

1. Oxygen storage should be 10 feet from any open flame and 20 feet from combustibles in a well ventilated area with “No Smoking” signs posted or in accordance with national regulations. (See FDA Section 211.42 guidelines in references.)

2. Hangar or building facility under authority of the program complies with OSHA (see specifics to be added to the site surveyor checklist).

11.01.03 Ambulance and personnel security

1. A policy addresses the security of the ambulance and physical environment.
   a. Security of the ambulance if left unattended on a hospital ramp or unsecured parking lot
   b. Training for drivers and medical personnel to recognize signs of ambulance tampering
   c. Plan to address ambulance tampering

Examples of evidence to meet compliance:
*Drivers and medical personnel are able to identify signs of ambulance tampering as outlined in an education program.*

2. Personnel security – Medical team is required to carry photo IDs (driver’s license is acceptable) with first and last name while on duty.

Examples of evidence to meet compliance:
*Policy requires wearing or carrying ID’s while on duty*

3. Patient security – Family members or other passengers who accompany patients must be properly identified and listed by name (in compliance with HIPAA regulations) in the communications center by the transport coordinator.

11.02.00 SAFETY EDUCATION

11.02.01 Education Specific to the Ground Transport Environment

1. Completion of all the following educational components should be documented for each of the medical personnel. These components should be included in initial education as well as reviewed on an annual basis with all regularly scheduled, part-time or temporarily scheduled medical personnel and specialty care providers as appropriate for the mission statement and scope of care of the medical service.
a. Medical patient transport considerations (assessment/treatment/preparation handling/equipment)

b. EMS communications (radios) and familiarization with EMS system

c. Extrication devices and rescue operations if part of the program scope of service

d. General safety. (It is strongly recommended to have the ambulance physically present when providing this training.) This training addresses:
   - Ambulance evacuation procedures (exits and emergency release mechanisms)
   - Fire suppression procedures (location and use of fire extinguishers)
   - Patient loading and unloading procedures
   - Refueling procedure with patient(s) on board
   - Use of road hazard equipment
   - Specific capabilities, limitations and safety measures for each ambulance used, which includes specific training for backup or occasionally used ambulances

e. Hazardous materials recognition and response

f. Highway scene safety management (see references)

g. Survival training/techniques/equipment that is pertinent to the environment/geographic coverage area of the medical transport service but must include at a minimum:
   - Safety and survival equipment requirements
   - Smoke in the cabin, firefighting in the cabin
   - Emergency evacuation of crew(s) and patient(s).

h. Vehicle conspicuity (reflectivity/chevrons, etc.)

11.02.02 Community Outreach Safety Program

1. The medical service should facilitate integration of all emergency services and transport modalities by supporting joint continuing education programs and operational procedures to include but not be limited to:


   b. Disaster response/triage.

      • The medical transport service should be integrated with and communicate with other public safety agencies, including other ground emergency service providers. This may include participation in regional quality improvement reviews, regional disaster planning and mass casualty incident drills that include an integrated response to terrorist events.
• There is a response plan to all types of disaster, including weapons of mass destruction, terrorist events and natural disasters.

• All personnel are familiar with the plan to respond to disasters.

• FEMA or other Emergency Management classes for scene and disaster response.

2. Interface of the medical team with other regional resources.
   a. For services that respond to incident scenes and support disaster response, staff has completed the Federal Emergency Management Agency Independent Study Courses on Incident Command (see References).
   
   b. For services that are involved in national disaster response, management staff should also have completed IS-800b. – National Response Framework, An Introduction.

3. Records are kept of initial and recurrent safety training of prehospital, referring and receiving ground support personnel.

11.03.00 EQUIPMENT AND OPERATIONS AROUND THE AMBULANCE
(For medical configuration, see Section 09.05.00)

11.03.01 Vehicles Section—Vehicles must meet KKK 1822A standards or state licensure requirements in place at the time the vehicle was built.

1. Licensure – The ambulance will be licensed in accordance with the applicable state laws.

2. The ambulance must have adequate interior lighting equipment to ensure complete observation of the patient and monitoring equipment used on the patient.

3. The ambulance configuration and patient placement allows for safe medical personnel egress.
   a. Doors must be fully operable from the interior

4. Ambulance operational controls and communications equipment are physically protected from any intended or accidental interference by the patient, medical transport personnel, or equipment and supplies.

5. Lighting, electric power sources and communications equipment
   a. In an ambulance, the interior lighting includes an overhead or dome light that is configured so as not to cause reflection and impair the driver’s vision while driving.
   
   b. Electric power outlet and/or invertors required for specialized medical equipment should not compromise the operation of any electrical ambulance equipment.

5. Medical or communications equipment will be functional on the ambulance without interfering with the mechanical components of the ambulance or vice-versa.

6. The head-strike envelope in the ambulance should be clear of hard objects that could cause injury in the event
of poor road conditions or sudden stops.

7. **Securing equipment and supplies** – Ambulance equipment must be secured by an appropriate clamp, strap, or other mechanism to the vehicle or stretcher/isolette to prevent movement during a crash or abrupt stop.
   
   a. If an engineered mount is provided for specific equipment, that equipment must be secured in the mount at all times during the transport.
   
   b. Softpacs and equipment bags are not to be stored with belts that loop through the handles (as these handles can easily tear and dislodge)

8. For long distance transports, there are diversion and contingency plans that address if patient’s condition deteriorates and for mechanical issues

9. Ambulance equipment

   a. The ambulance must have a fuel capacity to provide no less than a 175-mile range

   b. The ambulance should also be equipped with survival gear in remote coverage areas
      
      • Survival gear will be maintained appropriately per written policy and should be available to personnel on board.
      
      • A written policy must be in place regarding checking survival kit contents and expiration dates on timed supplies.

   c. A fire extinguisher must be accessible to medical transport personnel and driver while in motion.

   d. "No smoking" signs are prominently displayed inside the ambulance.

   e. The ambulance must have ground clearance of at least 6 inches at gross vehicle weight.

   f. The ambulance must be able to fully perform at ambient temperatures minus 30 degrees to 122 degrees F.

   g. The ambulance must be marked clearly to show the name of the service in letters not less than 3 inches high, and to allow identification of the service from the sides and rear of the vehicle.

   h. Lights and sirens
      
      • The ambulance must be equipped with a siren capable of emitting sound that is audible under normal conditions from a distance of not less than 500 feet.
      
      • The ambulance must have at least one light capable of displaying red light (with a 360 degree capacity) or strobe lights that are visible under normal atmospheric conditions from a distance of 500 feet from the front of the ambulance.

10. Use of occupant restraint devices – personnel must be seat belted when the ambulance is in motion unless emergent patient condition precludes it.

   a. Front seat occupants must always be belted
b. Overhead grab rails must be present in the patient care area

c. It is strongly encouraged to have forward and aft-facing individual seats. Side-facing bench seats not recommended. If the ambulance has side-facing bench seats, seat belt mountings must be situated at the pelvic level in order to restrain personnel/passengers. Shoulder harnesses should not be used on side-facing bench seats (see references).

11. The ambulance is equipped with road hazard equipment to be used in the event of a breakdown to minimally include:

   a. Flashlight
   
   b. Road marking device – cones, flares or triangles, for example
   
   c. Tools: wrench, screwdriver, hammer
   
   d. Leather heavy-duty gloves
   
   e. Reflective vests
   
   f. Hatchet or band saw (in case of a fallen tree)
   
   g. Equipment for dealing with snow as appropriate to the environment

12. It is strongly encouraged that ambulances be equipped with safety technology such as real-time feedback mechanisms, event-recording cameras, speed governors and/or weather alert systems.

11.04.00 QUALIFICATION OF DRIVERS

11.04.01 All persons who drive the ambulance should be at a minimum certified as an Emergency Medical Technician Basic (EMT-B) or have equivalent training.

11.04.02 Drivers must have a minimum of two years experience as a licensed driver or operator.

11.04.03 Drivers are required to complete defensive driving training program that is developed by the provider or outside agency. The training must include an Emergency Vehicle Operations Course (EVOC) or equivalent, which consists of at least four hours of reviewed ambulance driving under emergency conditions.

11.04.04 This training program should be repeated for each driver at least every four years.

11.05.00 AMBULANCE MAINTENANCE

11.05.01 Each ambulance must be maintained in full operating condition and in good repair, and documentation of maintenance must be kept on file. In addition, there should be a regular documented preventive maintenance program in accordance with the requirements of the manufacturer and other regulatory agencies.

   1. There are documented daily checks of the vehicle for damages and equipment failure.
11.05.02 There should be no evidence of damage penetrating the body of the ambulance or holes that may allow exhaust gases to enter the patient compartment.

11.05.03 The interior of the ambulance, including all storage areas, must be kept clean in compliance with OSHA (or equivalent) standards, that is free of dirt, grease and other bio hazardous or noxious matter.

11.05.04 The ambulance must be cleaned after each patient transport as appropriate. All interior surfaces in the ambulance and medical equipment surfaces that came in contact with the patient must be immediately cleaned and disinfected or disposed of in a secure biohazard container.

**11.06.00 MECHANIC**

The mechanic should have experience as a certified mechanic in a shop environment, or the maintenance should be done at a certified shop specific for the make and model of the chassis.

**11.07.00 POLICIES**

11.07.01 There is a written policy that addresses speed limitations and all aspects of traffic law compliance that pertain to ambulance operations.

11.07.02 There is a written policy that describes the appropriate use of lights and sirens. Red lights and sirens should be used only when time is critical to the patient’s outcome. When responding with lights and sirens, the ambulance should come to a complete stop at intersections as appropriate.

11.07.03 There is a written policy that addresses a procedure to follow when the ground ambulance comes upon an accident scene. Policy must be consistent with state regulations.

11.07.04 There is a written policy that outlines a procedure to follow when the ground ambulance is involved in an accident with damage and/or injuries.

11.07.05 There is a written policy outlining the procedure for a mandatory drug test of the driver after any accident.

11.07.06 There is a written policy outlining the procedure to follow when the ambulance breaks down.

11.07.07 There is a written policy dealing with safety aspects of driving:

1. Driver duty and rest time

2. Inclement weather and responsibility for aborting the transport if there is a safety concern

3. Driving records (speeding and other traffic violations) are reviewed by management minimally on an annual basis

11.07.08 There are weather conditions that prohibit transport such as zero/zero visibility and highway patrol road closures.

11.07.09 Policy that addresses DNR orders

11.07.10 Policy that addresses transfer and security of patient’s personal property
11.07.11 Policy that addresses use of an unusual occurrence form

11.08.00 SAFETY MANAGEMENT SYSTEM
Management is responsible for a Safety Management System (See References in Appendix) but management and staff is responsible for making operations safer.

11.08.01 The Safety Management System is proactive in identifying risks and eliminating injuries to personnel and patients and damage to equipment.

11.08.02 A Safety Management System includes:

1. A statement of policy commitment from the accountable executive
2. A non-punitive system for employees to report hazards and safety concerns
3. A system to track, trend and mitigate errors or hazards
4. A system to track and document incident root cause analysis
5. A safety manual
6. A system to audit and review organizational policy and procedures, ongoing safety training for all personnel (including managers), a system of pro-active and reactive procedures to insure compliance, etc.

11.08.03 There is evidence of management’s decisive response to non-compliance in adverse safety or risk situations.

1. Senior management should establish a process to identify risk escalation to ensure that safety and risk issues are addressed by the appropriate level of management up to and including the senior level.

2. Operational Risk Assessment tools should include but not be limited to issues such as transport acceptance (which includes tools for assessing driver and crew alertness and fatigue), public relations events, training, maintenance and re-positioning trips.

11.08.04 The program has a process to measure their safety culture by addressing:

1. Accountability – employees are held accountable for their actions.
2. Authority – those who are responsible have the authority to assess and make changes and adjustments as necessary.
   a. Standards, policies and administrative control are evident.
   b. Written procedures are clear and followed by all.
   c. Training is organized, thorough and consistent according to written guidelines.
   d. Managers represent a positive role model promoting an atmosphere of trust and respect.
3. Professionalism – as evidenced by personal pride and contributions to the program’s positive safety culture.
4. Organizational Dynamics
   
a. Teamwork is evident between management and staff and among the different disciplines regardless of employer status as evidenced by open bi-directional and inter-disciplinary communications that are not representative of a “silo” mentality.

b. Organization represents a practice of encouraging criticism and safety observations, and there is evidence of acting upon identified issues in a positive way.

c. Organization values are clear to all employees and embedded in everyday practice.

5. A Safety Management System includes all disciplines and processes of the organization. A Safety Committee is organized to solicit input from each discipline and should meet at least quarterly with written reports sent to management and kept on file as dictated by policy.

   a. Written variances relating to safety issues will be addressed in Safety Committee meetings.

   b. The committee will promote interaction between medical transport personnel, communications personnel and drivers addressing safety practice, concerns, issues and questions.

   c. There is evidence of action plans, evaluation and loop closure.

6. There should be a designated safety person for the ground transport service.

7. The Safety Committee is linked to CQI and risk management.

8. Aviation- and ambulance-related events are identified and tracked to minimize risks. (See Glossary in Appendix for definition of event.)

   a. Medical transport services are required to report ambulance accidents to CAMTS and strongly encouraged to report incidents to the CONCERN network and must report to the appropriate government agencies. There is a written policy that addresses reporting incidents or accidents and assigns certain individual(s) with the responsibility to report.