Standard Operating Guidelines

Operations

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Chapter One

Daily Operational Issues

Mecklenburg EMS Agency

SOG: 100.001.000

Standard Operating Guidelines, Operations Department, All Divisions

ISSUED: April 1, 2015 REVISED: April 1, 2015; Jan 28, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Behavioral/Conduct Expectations**

Purpose:

Operations personnel are expected to provide a high level of care and customer service. Operations Supervisors are expected to lead by example.

Clinical excellence and safe, appropriate transportation are our highest priority. No circumstance should be allowed to impede our ability to deliver excellent care to our patients. We will take the most assertive course of care to provide the maximum benefit to our patients.

Customer service is likely to benefit our patients more often than technical skills. Kindness must be shown in all situations. Actions should include the greatest possible level of courtesy and consideration for all concerned parties. Our behavior should reflect a willingness to be helpful. There are no criteria beyond a request or implied need to qualify for our service. Fulfill a request for any service within our capacity to the greatest possible degree.

Appearance can have a major impact on the public perception of our competence. A professional demeanor should be displayed at all times when interacting with the public and coworkers. Our work needs to be performed as quickly and efficiently as possible. Concern for the patient should be evident in our behavior.

Expectations of employee behavior is specifically addressed in the Employee Handbook chapter 2 item 2.1 and 2.2.

MEDIC Standards of Behavior
Developed* for *Medic Employees*, by *Medic employees

Medic Core Values

C- Compassion
CA- Customer Advocacy
F- Fairness
H- Honesty
I- Integrity
R- Responsibility
SF- Straight Forwardness

Advocacy:

- I will show care and compassion to all regardless of role, race, color, gender, sexual orientation, physical disability, origin, ancestry, religion, or socioeconomic status. **C, CA, F, I.**
- I will be committed to working with patients in finding solutions when barriers to treatment arise. **CA, R**
- I will be informed of community efforts and programs that provide additional resources and education to patients and/or the community. **CA, R**
- I will be an advocate for my patients by effectively communicating their needs to staff, family members, or community agencies/providers. I will promote their worth, champion their healthcare, and educate my patients so they can make informed decisions. **C, CA, I, R**

Appearance:

Personal:

- I will adhere to MEDIC agency, and departmental dress code policies for proper uniform/clothing, jewelry, cologne, and hygiene. **CA, R**
- I will not deface my ID badge and wear it clearly visible at all times. **R**

Facility:

- I will keep my work area and/or post clean and organized. **CA, I, R**
- I will be observant of litter, debris, and spills within the facility and handle clean up immediately. **CA, I, R**
- I will respect our allied agencies by treating their facilities with the same standards as relates to MEDIC facilities. i.e., Fire Stations, Hospitals. **CA, I, R**

Ambulance and Equipment:

- I will respect my coworkers by keeping my Ambulance and equipment clean and free of biohazards. **CA, I, R**
- I will respect all equipment, be sure it is in good working order, and use it in a proper manner. **CA, I, R**

Attitude:

- I will treat everyone in a courteous and respectful manner, as I would want to be treated; rudeness is never acceptable. **C, CA, F, I, R**
- I will help to create a culture that makes people feel appreciated, included, and valued. **C, F, I, R, SF**
- I will strive to meet the customer's need by using HEAL: **C, CA, I, R**
  - H: Hear them out
  - E: Empathize
  - A: Apologize
  - L: Leap into action to solve the problem
- I will take care of myself physically, spiritually, and mentally: recognizing if my personal life is affecting my work attitude, and seeking help as appropriate, so I can provide excellent care to mycustomers. **CA, H, I, R**
- I will remember that customers are not an interruption of my work; they are the reason I am here. **CA, F, I, R**
- I will be accountable for my actions, words, and patient care. **CA, H, I, R, SF**

Commitment to Coworkers:

- I will report to work as scheduled. I will communicate delays as appropriate. **CA, I, R**
- I will respectfully approach other healthcare professionals and refrain from discipline, or constructive criticism in public. **C, CA, F, I, R, SF**
- I will maintain a positive attitude despite any setbacks, and take responsibility for solving problems, regardless of origin. **CA, I, R, SF**
- I commit to staying on task; with any assignment I may be given. **I, R**
- I will hold my coworkers accountable (in a respectful manner) for upholding our standards of behavior, policies, and procedures. **H, I, R, SF**
- I will welcome new employees. Being supportive by offering to help and setting an example of cooperation. **C, CA, F, I, R**
- I will show respect to my first responders by listening to their report and give consideration to what may have been done prior to my arrival. **CA, F, R**

Communication:

- I will not discuss staffing, or internal issues with customers, including patients, bystanders, first responders, or allied health workers. **I, R**
- I will treat others respectfully and professionally by listening and avoiding defensiveness in oral, written, and cyber communication. **F, I, R, SF**
- I will make eye contact, smile, and greet everyone, creating a friendly environment. **C, I, R, SF**
- I will keep my radio traffic professional, without sarcasm, or innuendo. **CA, I, R**
- I will use positive body language and easy-to-understand words when communicating with patients. **CA, F, H, R, SF**
- I will always address my patients professionally: "Mr.," "Miss," or "Mrs." will be used — unless the customer invites me to use his or her first name. **C, CA, I**
- I will take the time to listen and avoid interrupting or finishing sentences for others. **F, I**

Delivery of Care:

- I will remain focused and anticipate the needs of my patients. **C, CA, R**
- I will strive to deliver prompt service, by ensuring that my unit is ready, and my out-of-chute timesare fast. **CA, I, R**
- I will provide sheets or blankets when transporting patients. **C, CA, R**
- I will seek opportunities to improve the skills needed to do my job well. **CA, I, R**
- I will demonstrate competence, and only perform tasks within the scope of my practice. **CA, I, R**
- I keep patients and families informed by using "**AIDET**" in delivering care.

  A: Acknowledge my patient and call them by name.

  I: Introduce myself and partner.

  D: Give patients an estimate of the time that will be required to deliver the care being provided.

  E: Explain procedures to patients prior to performing, and when possible, involve the patient in developing their treatment plan.

  T: Thank my patients for allowing me the opportunity to care for them. **CA, F, H, I, R**

Privacy/Confidentiality/Corporate Responsibility:

- I will follow Medic's release of information and privacy policies, reporting any breach or potential breach. **CA, H, I, R**
- I will respect patients' privacy when discussing medical matters and be mindful of my conversations in public areas. **C, CA, I, R**
- I will give patients the opportunity to decide who should be present while they are being assessed. **C, CA, F, I**
- I will ask permission prior to removing garments and ensure that my exposed patients are covered prior to being moved into a public area. **C, CA, I, R**
- I will be sensitive to the personal beliefs of others.
- I will maintain an open mind and be responsive to change with respect to new ideas, processes, and suggestions. **CA, I, R**
- I will be aware of performance expectations, and act accordingly. **H, I,**

Safety:

- I will not take unnecessary risks. **CA, I, R**
- I will protect my back when lifting, pushing, pulling, or carrying by asking for help and/or utilizing available equipment, and always using proper body mechanics. **CA, I, R**
- I will use protective clothing and equipment as required by law or policy. **CA, I, R**
- I will be aware of scene safety and potential hazards including violent persons, biological, chemical, and fire. **CA, R**

ISSUED: April 1, 2015, REVISED: May 01, 2018, Feb 2, 2022, January 01, 2024
APPROVED: May 01, 2018, BY: Operations Management Team

SUBJECT: Uniform Standard

Purpose:
The purpose of this guideline is to establish authorized uniform items, when uniforms are required, and to set standards for the correct wear of department uniforms and insignia.

Applicability:
This guideline applies to all uniformed Agency personnel.

Responsibility:
Special Operations serves as the Agency Quartermaster and must authorize all purchases by the Agency through approved vendors for Agency issued items. Uniform items, including footwear, purchased by the employee are not eligible for reimbursement.

Supervisors shall ensure that each employee under their supervision is in conformance with the standards as outlined in this guideline. Each employee is also individually responsible for conformance with these guidelines.

A supervisor may at any time require that the employee wear specific safety clothing or correct uniform items that do not meet this guideline.

Guidance:
All uniforms, T-shirts, and optional items must be clean, not faded, not wrinkled, torn or with holes.

No Agency issued clothing or accessories should be worn while off duty. Any item with the Agency logo represents you as part of the Agency. You are expected to use good judgment as to where you display any Agency logo.

If the uniform is worn it must be complete while on duty. This includes when in the office/public areas at post 100.

Unless otherwise directed, uniformed employees are permitted to wear Professional or Business Casual Attire (as outlined in Agency Policy 2.3, Dress Code) to continuing education classes.

The class A, B, or C uniform (as described below) will be worn while working Field or CMEDOperations.

The Agency issues the following uniform items from our approved vendor supply based on the employee's work assignment and the need of the Agency:

CMED Operations:

- Class A Uniform
  - Uniform Pants, Navy 4 pocket
  - Uniform Shirt, Long Sleeve, Blue (with agency/certification patches`)
  - Agency Badge, Silver
  - Tie
  - Belt
  - Footwear
- Class B Uniform
  - Uniform Pants, Navy (4 pocket or 6 pocket EMS pants)
  - Uniform Shirts, Short or Long Sleeve, Blue (with agency/certification patches)
  - Agency Badge, Silver
  - Belt
  - Footwear
  - Jacket (Water resistant shell)
  - Jacket Liner

Field Operations:

- Class A Uniform
  - Uniform Pants, Navy 4 pocket
  - Shirt, Long Sleeve, Blue (with agency/certification patches)
  - Agency Badge, Silver
  - Tie
  - Belt
  - Footwear
- Class B Uniform
  - Uniform Pants, Navy (4 pocket or 6 pocket EMS pants)
  - Performance Polo Shirt, Blue (with Agency certification printed)
  - Agency Badge, Silver
  - Belt
  - Footwear
  - Jacket (ANSI Class 2 / NFPA 1999 PPE Certified)
  - Jacket Liner
  - Pants (NFPA 1999 PPE Certified)
  - Vest (ANSI Class 2)
- Class C Uniform
  - Uniform Pants, Navy (4 pocket or 6 pocket EMS pants)
  - MEDIC T-Shirt, Navy Blue, with MEDIC in Red lettering on back(with Agency certification printed)
  - Belt
  - Footwear
  - Jacket (ANSI Class 2 / NFPA 1999 PPE Certified)
  - Jacket Liner

- Pants (NFPA 1999 PPE Certified)
- Vest (ANSI 2)

Special Operations:

- Class A Uniform
  - Uniform Pants, Navy 4 pocket
  - Shirt, Long Sleeve, Blue (with agency/certification patches)
  - Agency Badge, Silver
  - Tie
  - Belt
  - Footwear
- Class B Uniform
  - Uniform Pants, Navy (4 pocket or 6 pocket EMS pants)
  - Polo Shirt, Heather Grey (with agency logo)
  - Agency Badge, Silver
  - Belt
  - Footwear
  - Jacket (ANSI Class 2 / NFPA 1999 PPE Certified)
  - Jacket Liner
  - Pants (NFPA 1999 PPE Certified)
  - Vest (ANSI Class 2)
- Class C Uniform
  - MEDIC T-Shirt, Navy Blue, with MEDIC in red lettering on back.
  - Uniform Pants, Navy (4 pocket or 6 pocket EMS pants)
  - Belt
  - Footwear
  - Jacket (ANSI Class 2 / NFPA 1999 PPE Certified)
  - Jacket Liner
  - Pants (NFPA 1999 PPE Certified)
  - Vest (ANSI Class 2)

Operations Supervisor - Communications:

- Class A Uniform
  - Agency Badge, Gold
  - Shirt, Long Sleeve, White (with agency/certification patches)
  - Tie
  - Pants, 4 pocket
  - Belt
  - Footwear
- Class B Uniform
  - Uniform Pants, Navy, 4 pocket
  - Uniform Shirts, Short or Long Sleeve, White (with agency/certification patches)
  - Agency Badge, Gold
  - Belt
  - Footwear
  - Jacket (Water resistant shell)
  - Jacket Liner

Operations Supervisor - Field:

- Class A Uniform
  - Agency Badge, Gold
  - Shirt, Long Sleeve, White (with agency/certification patches)
  - Tie
  - Pants, 4 pocket
  - Belt
  - Footwear
- Class B Uniform
  - Uniform Pants, Navy, 4 pocket
  - Uniform Shirts, Short or Long Sleeve, White (with agency/certification patches)
  - Agency Badge, Gold
  - Belt
  - Footwear
  - Jacket (ANSI Class 2 / NFPA 1999 PPE Certified)
  - Jacket Liner
  - Pants (NFPA 1999 PPE Certified)
  - Vest (ANSI Class 2)
- Class C Uniform
  - Uniform Pants, Navy (4 pocket)
  - Performance Polo Shirt, White (with Operations printed)
  - Belt
  - Footwear
  - Jacket (ANSI Class 2 / NFPA 1999 PPE Certified)
  - Jacket Liner
  - Pants (NFPA 1999 PPE Certified)
  - Vest (ANSI Class 2)

Class A uniform items such as long sleeve button down shirts, silver badges and ties are not issued to employees until needed and authorized by Operations management.

The Agency allows employees to purchase the following optional uniform items after they have completed their probationary period:

- Sweater: “Commando Style” with V-neck collar, navy blue as supplied by the Agency approved vendor (with agency/certification patches). Authorization form must be received from the Agency Quartermaster for purchase.
- Jacket: Summit Soft Shell with hood, navy blue or black, manufactured by Condor and available from multiple vendors.
- Jacket: Phantom Soft Shell no hood, navy blue or black, manufactured by Condor and available from multiple vendors.
- Jacket: M65 Field Jacket, black, available from multiple vendors.
- Jacket: Softshell micro-fleece, black, with Agency logo, available from Agency store.
- Vest: Nylon, fleece lined, black or navy, with Agency logo, available from Agency store.
- Vest: Port Authority, Core Soft Shell Vest, black or navy, available from Agency store.

- Job Shirt: ¼ Zip Job Shirt (#72314), fire navy blue (720), with Agency patch logo on left chest, first initial and last name on right chest centered above certification level or division name (Agency specified), manufactured by 5.11, as supplied by Agency authorized vendor. **Authorization form must be received from the Agency Quartermaster for purchase.**
- Hat: Baseball style, navy blue, with Agency logo, available from Agency store.
- Hat: Knit cap, navy blue, with Agency logo, available from Agency store.
- Hat: Headband, navy blue, with Agency logo, available from Agency store.
- Hat: Baseball style, navy blue, no logo, available from multiple vendors.
- Hat: Toboggan, navy blue, no logo, available from multiple vendors.
- Hat: Headband, navy blue, no logo, available from multiple vendors.
- Hat: "Boonie" style, navy blue, no logo, available from multiple vendors.
- Pants: EMS Pants, Pocket style, manufactured by 5.11, style # 74310 or #74363, navy blue, available from multiple vendors.
- Items: Apparel from Agency store designated as "uniformed approved", as found online from My Medic website.

Employees are permitted to purchase and wear body armor as long as it meets the requirements set forth in thisSOG.

A concealable vest carrier must match the T-shirt being worn under the uniform shirt.

Tactical or other style outer vest carrier are not permitted to be worn with agency uniform unless assigned to and while functioning aspart of a Special Operations team.

NOT PERMITTED

NOT PERMITTED

Acceptable items to be displayed on the Class A or B uniform shirt:

- Identification badge (as issued by the Agency).
- Badge (Silver for non-supervisory personnel; gold for supervisor personnel)
- Name tag (optional, employee purchased) should match the badge color, will not exceed 5/8-inch height and may be displayed with attached "Serving Since XXXX" bar. The name tag will be worn centered just above the right shirt pocket.
- EMS service-related pins/bars may be worn above the right pocket or name tag. Pins/bars should not exceed the width of the pocket (three bars). Multiple pins worn should follow uniform

display standards.
- Approved pins/bars include School pin, American Flag pin or bar, Agency issued pins/bars.

Uniform shirts will be worn tucked into pants and buttoned completely, with the exception of the top button at the collar (unless worn with a tie). Hats will be worn in forward, unless the bill interferes with active PPE and patient care.

Tee shirts or turtlenecks worn under the uniform shirt and visible at the collar will be white or navy in color. No logo from an undershirt should be visible through the uniform shirt. Undergarments will not extend beyond the shirt sleeve. White turtlenecks should only be worn by supervisory staff.

Turtlenecks may be worn under the optional commando sweater without the Agency uniform shirt by CMED and Field Operations employees. All other outerwear (Job Shirt, Jackets, Etc.) require the class B or C uniform shirt to be worn at all times.

Ties are only to be worn with long sleeve uniform shirts and should not be worn with 6 pocket pants. The tie should be no longer than the middle of the belt buckle.

Uniform trousers will be properly fitted to the individual, worn waist high; length will produce a slight break at the cuff.

Belt buckle should match the color of the Agency badge unless the nylon belt is worn.
Socks, if visible should be solid colored, navy blue or black in color.

Footwear will be leather, non-permeable, black in color and must be approved by the Quartermaster.

All Operations employees must have a second uniform available when working

ISSUED: October 12, 2016 REVISED: October 12, 2016, January 01, 2024
APPROVED: October 12, 2016, BY: Operations Management Team

SUBJECT: Professional Appearance

Purpose:
To establish guidelines for the dress and grooming standards of Mecklenburg EMS Agency (Medic) employees while at work, on duty, or in uniform, to maintain the professional image of the department. Employees are expected to maintain a standard of personal appearance and grooming that creates a professional, favorable, and welcoming appearance for our patients, visitors, and the public at-large.

Applicability:
This guideline applies to all uniformed Agency personnel.

Responsibility:
Uniformed employees are responsible for ensuring they follow these guidelines. Supervisors will ensure these guidelines are followed and can, if needed, send an employee home, on personal leave, and in their personal vehicle to correct violations of this guideline. Violations will be documented utilizing progressive discipline guidance.

Guidance:
While in uniform or on duty, agency employees are always expected to maintain a professional appearance. Employees are expected to adhere to the guidelines set forth in this directive while engaging in professional department-related activities. All uniform and grooming standard guidelines must adhere to work safety standards in accordance with the Occupational Safety and Health Administration (OSHA) Respiratory Protection standard and agency respiratory protection policy.

The following policies are intended to be in effect for all agency operational employees. Their specific designations are as follows:

Operations-Field:	Uniformed and field deployed agency personnel
CMED:	Uniformed communications personnel
Dual-Role:	Administrative personnel with certifications to work in field operations.

A. **Facial Hair**

a. All operations employees assigned to CMED and Dual-Role status may grow and maintain a uniform length beard. The beard must be worn with a mustache, and the facial hair must be no longer than (0.5) inch in length at any point. The beard will be uniform in length and no portion of the beard will be longer than the rest. Beards, mustaches, and goatees must be of a naturally occurring color. They must be kept natural in shape with no patterns or designs. No braids, bows, or other accessories are allowed in facial hair.
    a. Field operations regulations may be imposed if respirator use became mandatory in CMED due to pandemic precautions.
    b. Dual-Role employees must follow all policy regulations for Operations-Field facial hair while they are functioning in uniformed field operations.

b. Operations-Field employees may have goatee style beards and mustaches. Hair growth below the bottom lip will be allowed if the facial hair can be contained within the seal pattern of their assigned agency N95 respirator, and if successful fit test can be achieved on an annual basis (OSHA). All goatees, mustaches, and hair growth must be of a uniform length, singular color, and not extend beyond ½ inch in length.
c. Mustaches are permitted; however, the mustache shall be neatly trimmed and shall not extend over the top lip.
d. In compliance with OSHA standards, operational employees who are required to properly don a respirator device (N95) as an essential function of their position will be required to achieve a proper seal during department fit testing of respirators. An annual fit test to assure proper seal is required of all operational employees regardless of facial hair status.
e. Employees shall not claim to be in a perpetual state of growth to avoid shaving on a regular basis. Facial hair must be neatly trimmed during growth stages to avoid uneven (patchy) growth patterns.
f. The wearing of facial hair shall remain at the discretion of the Deputy Director of Operations or designee.
g. Supervisors will ensure employees adhere to these standards and maintain a professional appearance. Employees who state a medical or religious condition inhibits their ability to adhere to these standards will be referred to the Human Resources department.
    a. Medical exemptions shall be reviewed on a case-by-case basis and will require a medical accommodation form to be completed by a licensed medical provider, reviewed, and approved by the Human Resources department.
    b. If the medical accommodation is approved, facial hair will be kept trimmed and neat, and will not exceed the approved restrictions detailed above.
    c. Medical accommodation will expire twelve (12) months from the date of approval. Should the employee still require a medical accommodation past twelve (12) months, the employee must reapply for an exemption.
    i. ***(#1) Current OSHA, NiOSH and CDC testing regulations do not allow for fit testing certification to be completed with facial hair covering the seal point of the mask. This is defined as the area where the N95 respirator makes a seal contact point on the face.***

B. **<u>Hair Color / Style</u>**
    a. Hair Styles
        i. All employees are required to wear their hair neatly, combed, and neatly trimmed or arranged. Hair that is unkempt is not permissible regardless of length for any employee.
        ii. Hair must of a naturally occurring color, and styles shall be in keeping with the professional image of the agency.
            1. Naturally occurring colors are black, brown, blonde, gray, and natural red
        iii. Sideburns shall not extend below the ear lobe and shall not be wider than (1) inch at the widest part of the sideburn.
            1. This standard is omitted for CMED and Dual-Role employees who elect to maintain a full beard
        iv. Alternate color highlights are permissible:
            1. These are intended to be blended and secondary to the primary color.
            2. Extreme and/or distracting hairstyles or colors will not be allowed.
                a. Color Blocking will be allowed for natural occurring hair colors only. Limited to two colors at one time (see insert)
                b. Multiple Non-Natural Colors will not be allowed (see insert)
            3. Braids may be woven or tinted with an alternate color.
            4. The wearing of alternate hair color shall remain at the discretion of the Deputy Director of Operations or designee.
            5. Supervisors will ensure employees adhere to these standards and maintain a professional appearance.
        v. Hair length and style must not interfere with the proper wear and seal of required safety equipment, to include respiratory devices, helmets, and goggles. Hair length must not obstruct vision or present a safety hazard or interfere with job performance.

vi. Hair Securing & Accessory Use
    1. All Operational Employees
        a. Long hair or braids that extend below the bottom of the collar must be pulled up off the collar while on a call for service. This can be achieved with an accessory such as a tie, clip, barrette, band, etc. (Re: ponytail, bun, etc.)
        b. This is mandated to reduce potential of injury, and to reduce hygienic concerns re: contamination with fluids or contact with patients.
        c. Hair accessories must be functional, not ornamental, and must not display items or messages that are political, divisive, or insensitive in nature.

C. **Ear Piercings**
- a. Earrings are approved for wear for all operational employees. Earrings must meet the restrictions noted below:
- b. Earrings must be of two types only:
    - i. Stud earrings with a small post.
    - ii. Small hoop earrings that stay in close circular contact with the lobe (helix style)
        1. No earrings may present below the lobe in a way that can present a safety hazard.
- c. No industrial style bars or inserts will be allowed for on-duty wear due to safety concerns.
- d. Earrings are not required to be matching sets.
- e. Multiple piercings are allowed in each ear.
    - i. Tragus piercings are allowed if they are in close contact with the ear.
- f. Gauge style earrings.
    - i. They must be flush with the flat surface of the ear.
    - ii. No colored gauges greater than 0 gauge (8mm) in diameter.
    - iii. Gauges greater than 0 gauge (8mm) in diameter must be flesh-colored or clear.
        1. Gauges larger than 0 gauge (8mm) in diameter must secured with an occlusive plug device.
    - iv. Gauges must be limited to size of 00 gauge (10mm) or smaller in diameter overall.
- g. The wearing of earrings shall remain at the discretion of the Deputy Director of Operations or designee.
- h. Supervisors will ensure employees adhere to these standards and maintain a professional appearance.

D. **Facial / Body Piercings**
- a. Nose piercings are allowed with a stud-style insert up to 1mm.
- b. Nasal septum piercing is allowed but must not be visible on-duty. The piercing must be rounded in style and be able to be rotated up into the nares while on-duty.
- c. Eyebrow, lip, and visible transdermal piercings are not allowed.
- d. Tongue piercings are allowed but must not be visible or distracting in nature.
    - i. No surgical body modifications to the tongue are allowed (forked tongue)
- e. All body piercings that are covered by uniform must not be visible through the uniform. This includes protruding outlines of piercings that may be visible through the uniform shirt.
- f. No dermal piercings, dermal anchors, or any other dermal accessories may be visible on any employee other than as described above.
- g. The wearing of facial and body piercings shall remain at the discretion of the Deputy Director of Operations or designee
- h. Supervisors will ensure employees adhere to these standards and maintain a professional appearance.

E. **Tattoos / Scarification / Branding**
- a. All agency employees must maintain standards of appearance that project a professional image to the public. Tattoos, brands, or scarification which depict violence, are obscene in nature, contain sexually explicit language, or in any way ridicule, malign, disparage or express bias against any individual or group are not in keeping with Medic's professional image, are inappropriate for the work environment, and may

undermine public trust and confidence. All employees' tattoos, brands, or scarification are subject to the standards and review process set forth in this directive.

b. Employees are permitted to have visible tattoos, brands, or scarification provided they do not violate the following conditions:
    i. Visible tattoos, brands, or scarification to the head, face, neck, and scalp are prohibited.
    ii. Employees are allowed to have a tattoo located behind the ear or on the nape of the neck, provided it does not exceed 1 inch in length by 1 inch in width and does not violate any other section of this directive.
c. Tattoos, brands, or scarifications that depict violence, nudity, sexual acts or organs, or lewd images or content are not permitted to be visible while on duty or while on agency property regardless of duty status.
d. Tattoos, brands, or scarification that depict or refer to intolerance or discrimination against any race, color, preference, creed, religion, gender, or national origin are strictly prohibited. Tattoos, brands, or scarification that depict or refer to extremist or supremist philosophies, or any organization or group that advocates such intolerance or discrimination are strictly prohibited.
e. Tattoos, brands, or scarification that detract from the professional appearance of the employee or violates the agency Standards of Behavior are strictly prohibited.
f. Tattoos, brands, or scarification that do not meet the conditions of this directive must be covered by clothing that meets the requirements of the agency uniform policy, i.e., long sleeve uniform shirt, tattoo sleeve (navy, black, or white), or tattoo covering make-up.
g. The display of tattoos, brands, or scarification shall remain at the discretion of the Deputy Director of Operations or designee.
h. Supervisors will ensure employees adhere to these standards and maintain a professional appearance.
i. The Deputy Director of Operations or designee shall be the final authority in determining if a tattoo, brand, or scarification is considered offensive or inappropriate and deemed unfit for display in the workplace.

F. **Body Implants**
    a. No visible subdermal body implants to the face, head, neck, arms, or hands are allowed.
    b. This applies to cosmetic and decorative implants only.
    c. This directive does not apply to approved implanted medical devices.

G. **Fingernails**
    a. Must be neatly trimmed, clean, and not chipped if polished. Tips must be rounded and filed smooth.
    b. Length must be conservative and not interfere with ability to perform job function.
    c. Fingernails are not to extend (1/4) inch past the fingertip. (CDC)
    d. Nails must not have decals or imaging that are offensive or divisive in nature.
        i. Please reference Tattoo & Branding policy above for restrictions

H. **Contact Lenses**
    a. Contacts must not be distracting and be of a naturally occurring eye color.

I. **Jewelry**
    a. Earrings are permitted in within the directives as described above.
    b. Necklaces may be worn, as long as they are not exposed on the outside of the uniform.
    c. Bracelets are allowed for wear for on-duty field operations personnel with the following restrictions:
        i. Bracelets must be minimal in size and remain in close or direct contact with the wrist.
        ii. No large or loosely fitting bracelets are allowed in Field Operations due to safety concerns.
        iii. Medical alert / ID bracelets are exempt from this directive.
    d. Rings are permitted for on-duty wear.
        i. Rings must not have jagged, sharp, or protruding edges.

J. **Cosmetic Use**
    a. Makeup is allowed for all agency personnel.
    b. Makeup shall be professional and conservative in nature.
    c. Makeup must be consistent with employee skin tone.

K. **Fragrance**

a. Perfume, cologne, and other fragrance toiletries are prohibited for wear by employees in patient care areas.

i. Strong scents may be disruptive to patients or fellow employees.

ISSUED: April 1, 2015 REVISED: April 1, 2015, Feb 2. 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Weapons on Medic Units**

Refer to the Agency Employee Handbook for further details.

No EMS personnel shall knowingly permit the possession or transportation of a weapon on board any Agency vehicle or on any Agency property.

Weapons meaning firearms, ammunition and explosives clubs, (night sticks), knives (non-folding), aerosol repellant (pepper spray), electronic charge (stun gun) devices.

Acceptable items include:

Personal Flashlight – A personal flashlight may be carried – constructed of metal or composite and designed to carry no more than the equivalent of 2 D-cell batteries.

Knives – Folding with a blade not greater than 3 inches in length.

Exceptions:

1. Duly sworn Police Officers involved in the performance of duty.

2. Weapons removed from patients while in transit, or on the scene when no Police Officer is available to take possession.

In the latter case, any weapon, which must be transported, should be stored in the driver's compartment. This would limit access should the patient become violent and attempt to recover the weapon.

INSURE THOROUGH DOCUMENTATION OF THE CHAIN OF CUSTODY

When feasible, Law Enforcement Officers should handle and take possession of all weapons. In cases where you must move or handle a weapon, do so in a fashion so as not to damage evidence suchas fingerprints. Use surgical gloves and or lift a handgun by the rough portion of the grip.

NEVER ATTEMPT TO DISCHARGE OR UNLOAD A WEAPON.

Upon arrival at the hospital, turn the weapon over to a CMPD Officer. If no officer is present, requestone is sent to your location via C-MED.

***** Possession of a weapon on Agency property or inside an Agency owned vehicle may result in immediate termination.***

ISSUED: April 1, 2015 REVISED: April 1, 2015, Feb 2, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Communications Devices-Electronic Equipment**

1.1 Personal Cellular Telephones or similar type devices should not be used at any time that you are operating the ambulance *(emergency or non-emergency*). They can be used for official business only while a crew is engaged in patient care. This is intended to reduce liability, increase safety, and ensure that crew members focus full attention on safe navigation, response, and optimal patient care. Agency issued communications equipment i.e. portable, mobile radios, and mobile phones assigned to that Medic unit are encouraged to be used during the times outlined above.

1.2 If Crews choose to bring personal cellular telephones, laptop computers or any personal electronic device on board the ambulance ***the Agency is in no way responsible for the replacement of damaged or lost personal electronic equipment.***

1.3 Use of electronic equipment in environments other than described as above may subject employees to disciplinary action, up to and including termination.

1.4 All Medic units are equipped with a cellular telephone. The phones are for conducting official Agency business only. Reasons may include, but are not limited to:

1. Utilization during times of radio and/or paging system failures.
2. When directed to contact C-Med for the purpose of AT&T Language Line assistance.
3. Communication with CMED, supervisor, administration etc. is necessary but it is not appropriate to conduct the conversation over the radio.
4. To contact out of county hospitals.
5. For utilizing navigation if mobile mapping has a failure.

The phone numbers should not be given out unless specifically directed to do so by supervisory personnel.. Assigned personnel for a given date and time will be held accountable for unwarranted charges and subject to disciplinary action.

ISSUED: April 1, 2015 REVISED: April 1, 2015, Feb 2, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Unit Assignments**

Support Services assigns units for deployment.

- When applicable, highest mileage vehicles should be issued first if possible, making the best effort to do so without causing undue disruption to operations.

- Field operations crews should not ask to be changed into alternate vehicles once the assignment has been made unless there are unreported mechanical problems with the assigned vehicle.

- Controlled equipment, such as narcotics, should only be issued to unit Crew Chief, unless otherwise approved by the on-duty Field Operations Supervisor.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Jan 28, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Citizen/3rd Party Rider Program**

Mecklenburg EMS Agency provides opportunities to provide clinical experience for a variety of different people. Each has different topics and expectations of their ride-along experience***.***

Anyone who requests to ride outside of contracted programs must complete online form and process on Medic's website or email request to(Operations Manager and/or Assistant Operations Manager) that indicates the requestor's background and reason for riding on an ambulance.

The following groups participate:

- Students: persons currently enrolled and receiving clinical education for EMT-B, EMT-I or EMT-P and / or Healthcare students currently enrolled in a school whose curriculum requires EMS clinical experience.
- Other groups determined by MEDIC Administration or designee to have a "Need to Know" in accordance with HIPAA guidelines.
- First responders, who can practice all procedures approved in their protocols.
- The general public can ride as observers with specific restrictions on their level of participation.

During the ambulance ride-along, the rider is expected to wear:

a. White or light blue shirt with a collar. Shirts may not have agency logos or patches, unless approved by Mecklenburg EMS Agency in advance.

b. Black or dark blue pants. Jeans of any color will not be allowed. Shorts are not allowed.

c. Black or dark brown shoes with non-skid soles. Shoes must be polished. Black tennis shoes are permitted. No sandals or high heels.

d. Jackets or coats must be plain in appearance without any agency logos, agency patches, or other excessive markings.

e. Name tags / ID must be worn at all times.

f. Students are not permitted to wear any Agency uniform or anything that designates the student as an Agency employee.

g. Any required PPE's

h. All riders must have in their possession a current picture ID. Students must provide clinical / field perception guide/manual from their educational institution. An individual will not be permitted to ride without these items.

The student / observer must review Third Party Rider Guidelines, Orientation packet, sign waiver of liability, and any additional attestations as required by the Agency.

ISSUED: April 1, 2015 REVISED: April 1, 2015, Feb 2, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **EPCR Tablets**

Tablet sign IN/OUT procedure.

1. An EPCR tablet is each individually assigned to an ambulance and previously scanned into Operative IQ. You will find the tablet located in the front of the ambulance plugged in. An additional power cord is located in the equipment bag in the back of the ambulance that is locked. The crew chief will check out another equipment bag from the OST that includes the keys and 1 extra battery for the tablet (with additional items). IT and OA will be responsible for tracking tablets through Operative IQ
2. At the end of your shift the Operations Assistant will ensure that all reports are finalized. The crew is responsible for shutting down siren and the tablet leaving it plugged in to charge before the crew leaves for the day.

The Crew Chief must also inspect the tablet and contents in the equipment bag for any missing items or damages from activity other than normal wear and tear.

a. **Deep scratches, gouges, or other damages to the screen (***The screen will, over time, begin to exhibit light scratches over the entire proximity of the screen. Any scratch that penetrates the membrane of the screen will be reported immediately to a supervisor***)**
b. **Missing, bent or cracked/broken keys on keyboard.**
c. **Missing or broken port doors (around perimeter of tablet)**
d. **Broken screen hinge**
e. **Damage to mouse pad or mouse buttons.**
f. **Chipped or missing enamel to tablet casing**
g. **Dents in tablet exterior**
h. **Missing or damaged stylus**
i. **Significant scratches or damage to tablet exterior**
j. **Missing spare batteries or charger cables**
k. **Damage, or significant soiling to tablet.**
l. **Bio-hazardous material on tablet or accessories**
m. **Any other damage considered inconsistent with normal wear and tear on the device.**

3. If any of the above damage or missing items is noted, they should immediately be reported to the on-duty Operation Supervisor. The off-going crew is to prepare a Loss and Damage Form before ending their shift. The Supervisor will begin an investigation and initiate the disciplinary process. Additionally, if the tablet is to remain in service, this information is also to be recorded in Operative IQ by the Operations Assistant. It is the Crew Chief's responsibility to properly inspect the tablet and accessories prior to deploying on duty for the day. All lost and damaged equipment must be documented in Operations IQ so the proper department is made aware**.**

4. Once Logistics has completed the close out and signed in the equipment, they will then be responsible for charging spare batteries.

ISSUED: April 1, 2015 REVISED: April 1, 2015, Feb 2, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Patient Belongings Handling-Accountability**

Agency personnel make decisions regarding the disposition of patient's personal effects/property on virtually every incident or transport they respond to. With the knowledge that a policy cannot address every contingency that may occur in our work environment, Agency personnel should follow these guidelines whenever applicable. If confronted with circumstances beyond the scope of these guidelines, the employee shall consult with their supervisor for guidance.

1. What types or amounts of personal property may Agency personnel/units agree to transport?

    - The crew chief shall exercise judgment in every circumstance with his/her primary focus being patient / crew safety and a high level of customer service. Consideration should be given to the crew's ability to safely secure the patient's property while in transit. Priority should be given to items that a patient may rely on upon arrival at their destination.

2. **Safety:** Large but necessary items should be secured with seatbeltswithin the vehicle before transport is initiated.

3. **Security:** Property that cannot be safely transported should be secured (within the patient's residence) at the scene whenever possible. Other circumstances may require that a patient's family or allied agency personnel accept responsibility for the property while patient care and transport are carried out. Persons accepting responsibility and the property should be identified and documented in the patient care report. Patients who are conscious should identify individuals whom they wish to take charge of their property. Unidentified persons should not be allowed to take charge of personal property.

4. **Chain of Custody:** Upon Arrival at the patient's destination, all property should be turned over to facility staff and/or the patient or family members. Identification of individuals and the released property must occur and be documented in the EPCR.

5. **Thoroughness:** EMS crews should thoroughly inspect the transport vehicle for personal property before departing the patient's destination. Should items be found afterward, the crew will contact CMED for authorization to return the items to the rightful location and owner. If patient belonging/s is found at the end of shift, contact an on-duty Field Operations Supervisor for guidance. It will be the responsibility of the Crew Chief or Non-Crew Chief to return the belonging to the patient prior to clocking out for their end of shift. If the Field Operations Supervisor decides to take custody of the belonging/s, the property must be signed over to the authorizing Field Operations Supervisor, who will become responsible for the prompt return of the property. The transfer of custody must be documented as part of the patient care report.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Jan 28, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Mutual Aid Response within Mecklenburg County**

Medic may be asked to assist another medical transportation service on occasion. Typically, this is due to their patient condition worsening or mechanical problems.

The following guidelines should be used in the event of an assistance request:

a. Meet the unit in a pre-designated location as determined by C-MED.

b. The patient should be transferred into the Medic vehicle to ensure all necessary equipment is available.

c. The Medic Paramedic should assume patient care activities during the transport to the hospital.

d. A patient care report should be completed as normal to include documentation of the organization that requested our response.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Jan 28, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Mutual Aid Response outside Mecklenburg County**

There may be circumstances that will require EMS resources above and beyond those available within Mecklenburg, or any of our surrounding counties. These circumstances may occur rarely, but when they do, it is necessary for the county to obtain assistance from some outside source. No unit of government can be expected to develop and constantly maintain sufficient resources to deal with every possible situation that might arise.

The NC OEMS oversees state and regional mutual aid plans in the event that out of county response is needed on a scene in a neighboring county.

In the event Medic is activated to assist EMS outside our boundaries, keep in mind:

- Communications will be a challenge, as communications systems differ from county to county. Take direction from CMED unless otherwise advised.
- Report to the “Staging Area” if not otherwise advised.
- Follow the Mecklenburg EMS Agency Patient Care Protocols; units operating in another county follow their home county patient care protocols.
- Any request for an out of county mutual aid assist should have notification made to the Operations Manager-Field or Assistant Operations Manager on duty. Deputy Director-Operations should be notified in case of the Operations Manager-Field or designee being unavailable.

Any request for mutual aid (Medic to a neighbor) should be acted on immediately by C-MED if the system will allow starting the closest Medic unit. *

**** For complete information concerning mutual aid response, see Region F EMS Mutual Aid Response Plan***

ISSUED: April 1, 2015 REVISED: April 1, 2015, Feb 2, 2022
APPROVED: March 8, 2015

SUBJECT: Critical Care Transport Team Assistance

Medic may act as a backup to Critical Care Transportation Teams under certain circumstances. These transports usually occur on weekends and after normal business hours when their staffing is minimal.

During these times, the Medic crew may be dispatched "hot" to pick up staff of the Critical Care Team and may travel up to 120 miles outside Mecklenburg County to pick up a patient. The dispatch response is based on patient condition and may be time sensitive (Such as a patient being admitted directly into the Cath Lab). The transport team staff will determine if the response to the destination facility is hot or cold.

The request is intended for Medic to provide transportation only; however, this does not release the Crew from the responsibility of overseeing activities in the back of the unit, or appropriate documentation of the care rendered and patient condition. ***Therefore, a crew member shall always ride in the back of the unit while a patient is on board.***

Should a conflict arise between the team and Agency personnel, the Critical Care Nurse should be considered to be in charge of patient care at all times, while Medic staff is responsible for the safe operation and transport of the patient and all crew members.

- **Although Critical Care will be financial responsibility for transport, demographic and patient care information still must be obtained.**

ISSUED: April 1, 2015 REVISED: April 1, 2015; Jan 28, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Incidents at or near County Line**

Call for Service at or Near Boundaries

When a call is received for an EMS/Rescue response to a location that is at, or near the county line, or if any question exists as to which county provider is responsible, the nearest Medic unit and First Responder should be dispatched. At the same time, neighboring county or jurisdiction will be informed of the situation.

1. If the incident is determined to be outside of Mecklenburg County, and there are no paramedics at the scene, response should continue to the scene.

2. Once a location has been verified, the neighboring jurisdiction should be notified. Should the incident be inside Mecklenburg County, and the neighboring responder is at the scene or closer than Medic units, they may continue with the response, or care until Medic arrives and assumes control of the incident.

3. Should either responding Agency have need of the other resources for management or transportation of patients with life threatening conditions, all efforts should be made to assure that the best decisions are made on the behalf of the patient(s).

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 4, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Patients with Service Animals**

Patients with Service Animals

Service animals are defined as dogs that are individually trained to do work or perform tasks for people with disabilities. Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting, and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties. Service animals are working animals, not pets. The work or task a dog has been trained to provide must be directly related to the person's disability. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

If confronted with a question or situation involving the issue of transporting or securing a service animal, (such as a Seeing Eye dog), it is the policy of the Agency to do all we can to accommodate the animal. If the patient's condition is minor, the animal should be permitted to remain with its owner. In the event that the owner is in a critical condition, or the animal may pose a danger to medical personnel, or may interfere with medical care, suitable arrangements for the transportation of the animal should be made. Consider using CMPD Animal Care and Control, CMPD, the first responder, or supervisor (if available) to bring the animal to the hospital (if it can't be left safely at home).

If the animal is injured, Animal Care and Control should be called (if the patient can't direct you to another source to care for it) to transport it to proper medical attention.

The disposition of the animal should be documented with a note in the PCR or supplemental report.

- **Insure the hospital is notified that you are transporting a service animal before your arrival.**

Therapy dogs, emotional support dogs and companion dogs are not Service Animals as defined by the ADA.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 4, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Patients in Police Custody**

If a patient is in custody of law enforcement personnel and is restrained by handcuffs, **an officer must accompany the patient in the Medic unit during transport** to the emergency department (ED) or other approved destination. Having an officer follow the Medic unit in the officer's vehicle is not an acceptable alternative.

1. Having the patient handcuffed to the cot is strictly prohibited.

2. The degree of need for care should exceed considerations of the patient becoming a threat.

3. The Police Officer and the Crew Chief must agree that repositioning or removing the handcuffs is safe.

4. When repositioning handcuffs, ensure the patient still has the minimum possible ability to move and potentially cause harm.

5. The position of the handcuffs should be a mutual decision of the Police Officer and Crew Chief designed to facilitate procedures and ensure security.

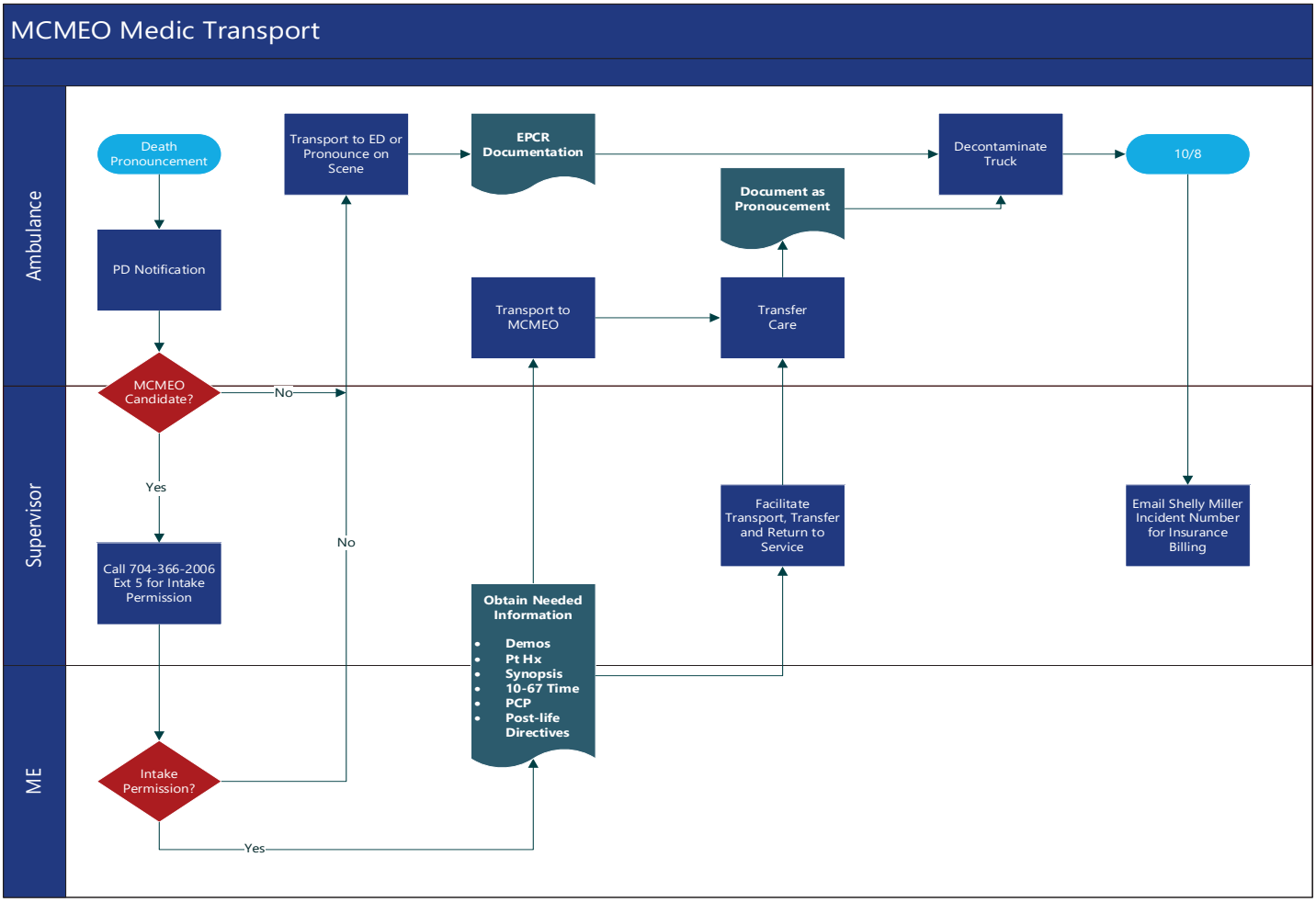
If a crew encounters any resistance from the officer on scene regarding this policy, immediate contact should be made with the on-duty Field Operations Supervisor.

ISSUED: April 1, 2015 REVISED: July 24, 2017; Feb 4, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Transports to Medical Examiner's Office**

Should a Medic unit have need to or be requested by police to transport a deceased subject – the Field Operations Supervisor should be contacted for consultation with the Medic crew before initiating the transport.

Upon determination that a need exists to conduct the transport - CMED or the Field Operations Supervisor should call the Medical Examiner's office (704-336-2006) to get approval for Medic to conduct the transport. The person authorizing transport should be documented in the ePCR as well as the CAD notes for the incident. CMED should then send the Medic crew and Field Operations Supervisor the code to the ME office facility if applicable via alpha page.
The transport should be conducted as any other transport, unit departs scene in CAD, ePCR disposition transported 911, etc. and indications for transport need documented.



ISSUED: May 2022 REVISED: Not Applicable
APPROVED: Sept 2020 BY: Operations Management Team
SUBJECT: Narcotics Care, Use, and Guidance

Purpose:
Provide guidance on the care, use and documentation of Agency issued Narcotics.

Responsibility:
It is the assigned Crew Chief's responsibility to obtain all check out equipment at the beginning of their shift for their assigned unit. The storage of narcotics should be done within the provided locked box present in every unit. Unsecured narcotics that are not being utilized are a direct violation of this policy.

All narcotics used require appropriate documentation of their use, this includes correct dosages, routes, and signatures.

Guidance:

If a "Zero Waste" scenario occurs:

Navigate to the "Zero Narcotic Waste" signature field.
Select the administered medication(s) – you can select more than one.
Type the name of the provider who administered the medication.
Administering provider signs the "Zero Narcotic Waste" in the signature field.
No Further Signature are required or allowed.

If a "Waste" scenario occurs:

Administering provider will need to navigate to 2 separate fields – "Narcotic Waste" and "Witness Narcotic Waste."
"Narcotic Waste Field"
Waste is prepopulated.
Enter the administered medication and the **administered amount.**
Administering provider signs in the signature field
"Witness – Narcotic Waste"
Enter the administered medication and the **amount being wasted.**
Name of the person witnessing the waste
Witness signs in the signature field.

For both scenarios, the provider will make all attempts to retain the vial and both plastic locks from the narcotics box. Those items will be placed into the empty plastic bag provided inside the narcotics box. The lock inside the box will be secured to the outside of the box and the key secured the Crew Chief keychain with the box returned to the lock box in the unit.

Chapter Two

Stations / Vehicles / Equipment

ISSUED: April 1, 2015 REVISED: January 2024
APPROVED: March 8, 2015, BY: Operations Management Team
SUBJECT: **Vehicle Operations**

Purpose

Mecklenburg EMS Agency is committed to the safe transport of employees, patients, and other occupants of Agency vehicles. Therefore, all operators must adhere to the guidelines set forth in this driving policy. Questions and additional information regarding vehicle operations should be directed to the Operations Supervisor or to the Risk and Safety Office.

Agency vehicles are intended for use in the conduct of Agency related business or activities that promote the Agency or facilitate efficiency.

Vehicle Operator Requirements

In addition to the requirements set forth in Attachment A, MEDIC Motor Vehicle Record Guidelines, employees expected to operate an agency-owned vehicle for any reason must first successfully complete the approved agency driving courses with an authorized trainer or safety instructor. For non-field position specific driver's training requirements refer to Attachment B, Training Requirements for Vehicle Operations (Non-Field).

All vehicle operators (while running emergency traffic) must follow the Law of Due Regard.

- Law of Due Regard: Sufficient notice of the ambulance's approach must be given to allow the other motorist and pedestrians to yield the right of way. Failure to give notice until a collision is inevitable generally does not satisfy the principle of "due regard".

The Agency's independent insurance carrier reserves the right to declare an employee to be uninsurable based on the employee's driving/accident record. If deemed uninsurable, the employee will be unable to operate Agency vehicles.

Employees shall not operate Agency vehicles while under the influence of medications and/or substances that are known to impair central nervous system functions (i.e., judgment, physical coordination and/or reaction time). Included in the categorization are prescribed medications that carry warnings against operating vehicles or machinery. Anytime there is a suspicion of impairment, drug use, or alcohol use a drug and/or alcohol screening will be completed per the guidelines set forth in the Employee Handbook, 2.11 Drug and Alcohol Testing.

While driving routine traffic, agency employees will follow North Carolina state (in-state) vehicle operations laws.

Agency vehicles are prohibited from passing a stopped school bus with its stop sign extended (this includes routine and emergency traffic modes).

The bus driver may signal the unit to proceed around the school bus while it is stopped with the sign extended. If this occurs, proceed with extreme caution around the bus.

Agency vehicles will comply with traffic signals, signs, and school crossing guard signals in school zones during school hours and anytime children are present.

Audible and visual warning devices must be utilized together when operating in emergency mode regardless of the time of day or traffic conditions.

Agency vehicles are prohibited from parking in fire lanes unless they are on a patient care assignment.

Every vehicle occupant must remain seated and restrained any time the vehicle is in motion. For Agency employees this means wearing a seatbelt or seat restraint. Patients are to be properly secured to the stretcher using all seat belts.

While caring for a patient, the crew members will attempt to stay restrained for as long as care will allow. It is neither possible nor practical for the caretaker to always remain restrained. If the caretaker must provide a service in which being restrained will not allow, they will carry through with the procedure and then restrain themselves using the proper safety restraints.

Pediatric patients can be transported via the Ferno Pedi-Mate properly secured to the stretcher, Ferno Pedi-Pal properly anchored to the bulkhead bench seat or, or patient provided car seat properly secured to the stretcher or bulkhead bench seat.

Emergency Traffic

- Agency vehicles shall not exceed the posted speed limit by more than ten miles per hour, with a maximum of 75 miles per hour on the interstate. When operating in school zones (during school hours) and/or in high pedestrian traffic areas, the posted speed limit must not be exceeded.
- The operator will acknowledge that by use of audible and visual warning devices, they are only asking for the right of way and are not granted it.
- The operator will always attempt to pass stopped traffic on the left side. If this is not possible, the operator will use the lane of least resistance while using extreme prejudice for the crew's safety and the safety of those in and around the unit.
- When approaching an intersection with a yellow light, red light, stop sign or with no traffic control devices, the operator will come to a complete stop and assess all lanes of travel at 5 mph one at a time for oncoming or impeding traffic. The operator will not exceed a speed of 15 miles per hour when clearing the entire intersection.
- Traveling in the opposing lane of traffic should be avoided at all costs, however, when it is warranted, the operator will not exceed a speed of 15 miles per hour. The operator will utilize both sirens (if the unit is equipped) and will utilize the air horn multiple times to alert oncoming traffic.

Prior to use of the vehicle, all warning devices (lights and sirens) shall be assessed for proper function. This will be performed at time of deployment from P100 outside of the bay.

Cell phone use, including blue tooth or other hands-free devices, and texting is strictly prohibited while

operating an Agency owned/leased vehicle. Cell phone use of both members of the crew is strictly prohibited while the unit is being operated in an emergency mode. Company cell phone use, by the passenger, will only be allowed in the event of a failure of the dispatch system or failure of the mobile mapping system and used for routing. Cell phone use by supervisors, managers and directors should be kept to a minimum and only used when necessary.

The mobile mapping terminal should only be operated by the passenger in the unit while the unit is in motion. There are instances when the mobile mapping terminal will need to be used without a passenger in the cab of the unit. At this time, use of mobile mapping will be kept to a minimum while operating the ambulance.

Mobile radio use will be conducted by the passenger in the unit while the unit is in motion. If the mobile radio must be used by the driver, it will be done with extreme prejudice to the safety of the crew, passengers, and those around the unit.

Use of tobaccos products and e-cigarettes are prohibited inside any Agency owned/leased vehicle.

Vehicle Accidents

Failure on the part of any agency employee (driver, witness, passenger, etc.) to immediately report to a supervisor and CMED any vehicle collision or property damage will be subject to disciplinary action that may include termination.

- Upon the occurrence of an incident, the Crew Chief, or Agency employee will contact CMED immediately and advise them of the unit's status. If there are any injuries, have law enforcement respond to the scene. The agency vehicle will remain on scene until law enforcement and the on-duty supervisor arrive, unless advised otherwise. If vehicles involved are operable, they will be moved out of the lane of travel and into a safer area. Refer to RS-002-1 Vehicle Accident Policy for additional information.

Agency ambulances must utilize a backer/spotter when available.

- Backing accidents that are deemed preventable may result in both employees receiving corrective action following the PIPD process. Refer to RS-002-1 Vehicle Accident Policy for additional information.
- Spotters must be placed on the driver's side rear of the unit. This will ensure full vision of the spotter by the driver.
    - The spotter must be in place prior to the unit being placed into reverse.
    - Universal hand signals shall be used by the spotter to communicate with the driver. Refer to Appendix A, Proper Backing Hand Signals, of this document.
    - The unit must not exceed 1-2 mph while in reverse.
    - Use a backing spotter every time and everywhere you back with the following exception:
        - If you need to back on a busy highway or Interstate, use your lights and sirens and back with due regard. Do not get out of the ambulance in traffic to push the spotter button.

At no time during a response or during routine operations will it be permissible to cross a median with an agency vehicle. This is due to the unknown and non-standard heights of concrete medians in Mecklenburg County. It is also not permissible to cross grass or other style medians due to the unknown composition and the chance of getting an agency vehicle stuck.

• If an agency vehicle becomes stuck on or in a median, this will be considered a preventable accident and will be subject to disciplinary action.

Employees must adhere to all safe parking principals which include:

- Apply parking brake.
- Apply appropriate transmission (park or neutral).
- Apply safe positioning of vehicle at scenes and posts to allow easy egress.
- Activate high idle while on calls.
- Keep vehicle locked while unattended.
- Connect shoreline when appropriate.
- Use appropriate warning lights while parked, if applicable

Employees are encouraged to park in areas where backing can be avoided, and egress is not compromised.

Employees will maintain a following distance of 6 seconds while in an Agency owned/leased vehicle. This distance will increase by the following for each change in driving conditions:

- Rain conditions - add one second.
- Snow conditions - add two seconds.
- Ice conditions - add three seconds.
- Use personal prudence with any non-listed situations.

The Agency reserves the right to require drivers to attend re-training anytime it is deemed necessary.

Agency policy allows a passenger to accompany a patient in the ambulance. Crews should attempt to accommodate any reasonable request to accompany a patient. A passenger should be placed in the front-right seat of the ambulance and secured with a seat belt. The Crew Chief can allow the accompanying person to ride in the patient compartment if doing so is beneficial to patient care (parent of young child, interpreter for non-English speaking patients, etc.).

The Crew Chief can also elect to allow more than one (1) passenger to accompany the patient if doing so will allow more expedient care and provides the appropriate support to the patient and/or family members. (THIS IS A DECISION THAT IS LEFT TO THE DESCRETION OF THE CREW CHIEF). All passengers must be secured with a seat belt. To the greatest extent possible, pediatric passengers will be placed in a car seat.

A Crew Chief may refuse to allow someone to accompany a patient when the requesting passenger is disruptive, intoxicated or a threat to the safety of the patient and crew. A passenger should not beallowed if they have a negative impact on treatment or transportation of a priority patient. These are the only appropriate circumstances to refuse a passenger.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 9, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Vehicle & Fleet Maintenance**

The Fleet Manager and the Field Operations Supervisor must work in concert to allow for maximum efficiency in getting units into the garage for repair and P.M. while ensuring that there is adequate fleet availability to deploy units as required by the schedule.

Mechanical problems should be reported to CMED so the unit can be taken out of service and put in contact with the Field Operations Supervisor as soon as a problem is noticed.

- *To wait for a critical failure to occur before reporting a problem can be viewed as patient care negligence.*

The Field Operations Supervisor will give specific directions to the crew. The Operations Supervisor will decide if the crew can remain on the truck until the end of shift and then report the issue to the OA, drive directly to Fleet and see if the problem can be solved quickly, or if the crew needs to swap out ambulances completely. Once this is determined the supervisor will notify the CMED Operations Supervisor immediately after speaking with Crew. Once the crew arrives to Fleet, the crew will make contact with Fleet personnel and Fleet will make a determination if the problem is something that can be fixed on the spot or if the crew will need to switch ambulances. Crew must remain with their truck in the Fleet area.

Upon arriving at Post 100, the crew will fill out a vehicle maintenance repair sheet that documents in their word's specific complaints, observations and circumstances with the vehicle. In some cases, a verbal report, (inaddition to written), is beneficial to tracking down non-obvious problems. This report will then be handed to the OA to be entered into Operative IQ.

- The decision to have a vehicle towed should be made by either the Field or CMED Operations Supervisor or by the Fleet Supervisor. Regardless of who makes the decision to tow, the Fleet Manager or designee shall be notified immediately upon the initiation of the tow.

* See Sample Fleet Repair Form

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 7, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Vehicle Care/Inspections**

It is an expectation and requirement of all crewmembers to insure the interior and exterior cleanliness of their assigned vehicle. Field Operations Supervisors or other administrative personnel may conduct regular inspection of ambulances, both at headquarters and at satellite stations. Careful attention should be given to the physical condition of the cab and patient compartment, cleanliness, appearance, and functionality of the equipment. Results of the inspection will be documented on a Vehicle Inspection Form and kept as a measure of the employee's overall performance record.

- Vehicle exteriors should be washed daily using the automatic vehicle washing bay. If the automatic washing bay is 10-7 crews must use the manual side to wash their vehicle for the day.

- Upon completion of an assigned shift, all loose and personal items should be removed from the interior of the vehicles cab. No food, drink or other items shall be left behind. Coolers and other personal items should also be immediately removed upon return to P100.

- The interior (cab, equipment, and patient care compartments) should be kept neat and inspected after each call for potentially infectious material. In the event of contamination of the cab area, any food stored in the area should be disposed of.

- All contaminated equipment should be properly cleaned or contained, identified and / or returned to Support Services for decontamination.

- In the event of transporting a patient with a known communicable disease, all exposed solid surfaces in the interior of the ambulance should be decontaminated with *cleaning products proved by logistics* or, *Victory Sprayer* found in the infectious disease compartment. Any porous material such as cot straps will be bagged, tagged, and returned to Operations Support for decontamination.

Particular attention should be given to proper disposal of sharps.

ISSUED: April 1, 2015 REVISED: January 2024
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: Vehicle Accidents Involving Agency Vehicles

Purpose

The purpose of this policy is to outline proper procedure following an accident involving an Agency vehicle.

Definitions

Vehicle Accident - A collision that occurs between an Agency vehicle and another object or vehicle.

Preventable Accident - Any accident where an Agency vehicle makes contact with another object/vehicle and the operator failed to do everything he/she could reasonably have done to prevent it.

When an Accident Happens

It is important to follow all agency procedures to ensure a fair and thorough investigation. Following an accident, no matter how minor, the crew will:

1. Contact CMED, request other EMS, Police and/or Fire if needed.
2. Contact an on-duty supervisor.
3. Ensure that proper medical care is given, if needed
    - Any employee injured in a workplace vehicle accident must complete an OJI report via WebApps or complete the OJI paperwork, available via the OA or on duty supervisor.

Once an accident is reported, the on-duty supervisor will:

1. Respond to the accident scene, gather all information needed to investigate, and complete the drug/alcohol testing as outlined in Agency drug/alcohol testing policies.
2. Complete the accident report within 24hrs via Webpps. Include pictures, crew supplementals, police report numbers, and all other relevant information. The Operations Supervisor who responds to the accident shall be responsible for the report, drug testing, and any required follow-up.

All accidents will be investigated on scene by the responding supervisor. Once the supervisor submits the accident report and supporting information, the Risk and Safety Office will continue the investigation and deem the accident preventable or not preventable.

Depending on the severity and fault of the accident, employees involved may be asked to give a recorded statement to Medic's insurance company. If this occurs, the Risk and Safety Office will notify the employee and provide the contact information. The employee is then required to contact the insurance company as soon as possible.

Outside of Medic Management, Operations Supervisors, Safety, and Medic's insurance company, no information on accidents will be given to anyone without prior authorization. This includes other party's insurance companies and any/all media outlets including online social networks.

Additional Information

Post-Accident Training - Corrective Action

1st Preventable Accident –The Risk and Safety Office will notify the employee and the employee's

direct supervisor referencing post-accident one-on-one training. The employee involved in the preventable accident is required to respond to the email with a date and time that they will attend one of the available training dates. The employee has 30 days from the date of the email sent by Risk and Safety to complete one-on-one training. Failure to do so will result in the employee entering the PIPD process.

Any additional preventable accident within a 36-month period, the Risk and Safety Office will notify the employee and the employee's direct supervisor who will review the information and issue appropriate level PIO/PIPD.

Any preventable accident that is a result of a direct policy violation will result in the employee entering the PIPD process. If the accident is the 1st preventable accident for that employee in the 36-month time frame, the employee will also receive one-on-one drivers training.

Accidents that involve backing, that are deemed preventable may result in both employees receiving one-on-one training and both entering the PIPD process.

Note: All accidents, regardless of severity, must be reported immediately. Failure to do so will result in disciplinary action up to and including termination.

ISSUED: April 1, 2015 REVISED: May 1, 2018; Feb 4, 2022

APPROVED: May 1, 2018, BY: Operations Management Team

SUBJECT: **Securing Agency Vehicles**

Current world affairs heighten our need for protective measures. Medic employees frequently inquire about what steps the department is taking to protect staff, yet we repeatedly find units running and unattended in totally unnecessary situations.

The most effective way to protect medics in the field is for them to take personal responsibility for their safety.

1. Unattended EMS vehicles will be locked at all times unless the crew is working in the immediate vicinity (100 feet) of the vehicle and the vehicle is under their direct observation. (Vehicles equipped with electric door locks should be locked anytime it is unoccupied.)

2. EMS vehicles equipped with shoreline connections will be plugged into a shoreline when such lines are available at posts and personnel will confirm that shoreline and unit systems (heater/air conditioning – set at 70-75 degrees) are functioning properly. Non-functional systems or blocked access to shorelines will be immediately reported to the on-duty Field Operations Supervisor.

3. All units should be shut down upon arrival at all hospital emergency departments. Vehicles should be locked, both cab/patient compartments when the crew is away from the unit. If situations necessitate keeping the vehicle running for extended periods of time, please locate the vehicle at least 200 feet away from hospital entry doors or air handling vents.

4. All EMS personnel will ensure compliance by taking action to correct non-compliant situations – to include securing other vehicles and alerting other responsible personnel to noncompliant vehicles / situations.

Any supervisor observing non-compliant vehicles and / or situations will take immediate corrective action. Supervisors will interview noncompliant personnel and if the deviation from this protocol is not clearly justified – progressive discipline guidelines will be followed. Gross disregard of safety or conduct guidelines may warrant disciplinary action beyond the next prescribed step in progressive discipline.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Jan 28, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Fueling Agency Vehicles**

All Agency units should be fueled at headquarters fuel pumps when possible. When fueling the units, the correct mileage and correct Employee ID number should be entered into the computer prior to pumping. Failure to enter correct unit mileage information results in fuel usage tracking issues and may cause a vehicle to miss scheduled PM or other regular scheduled maintenance that is tracked by mileage.

All units will be fueled at the end of shift, prior to pulling into the wash bay. Deliberate recording of inaccurate information (such as entering incorrect employee ID number or 00000 in the place of the correct mileage) or intentional failure to adequately fuel a unit may be subject to disciplinary action.

1. The person fueling the vehicle is responsible for ensuring the process is performed in a safe manner.

2. Ensure the nozzle is disconnected and pump shuts down before pulling away from fuel area.

3. Any fuel spilled should be covered with absorbent provided at the pump.

4. Any spill requiring use of the fuel containment system (located in the cabinet beside fuel pumps), also requires notification of Fleet Manager, and other appropriate personnel.

5. If a crew has entered proper mileage but is unable to get fuel, have the crew enter the same mileage 3 times, on the 3rd time, the system override will allow fuel to be pumped. Notify Fleet Manager anytime this failsafe is used.

In the event of an emergency, the emergency fuel shut off button is located on the Island near the parking lot by the fuel pumps. Located on a pole with a sign stating EMERGENCY SHUT OFF VALVE.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Jan 28, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Building and Grounds Service Requests/Emergencies**

It is an expectation that all Medic personnel work together to maintain the appearance, function, and generalsanitation of our work environments. Responsibility for repairs at satellite MEDIC stations will depend on theowner of the property. Any property damage noted should be documented and forwarded, via the Field Operations Supervisor to the Support Manager immediately via a Service Desk request.

Willful damage and destruction to Agency property will not be tolerated. This includes tampering with temperature regulation devices, locked doors, etc.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 20,2022

APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Damage to Property**

All field personnel should immediately notify the Field Operations Supervisor if equipment has been damaged or lost. The supervisor will then make the determination if the situation requires the return of the unit to Post 100, or if it can be addressed at a later time. The involved crew should complete the “Lost & Damaged Equipment Form”, with a full explanation of theissue.

- If a crew reports that equipment, either department issue or personal was stolen, Charlotte-Mecklenburg Police Department or applicable Municipal Police Department, should be notified in a timely manner, and a police report generated.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 4, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Equipment Failure**

A critical equipment failure is defined as failure of equipment to perform as it was intended during the delivery of patient care. In the event of any critical medical device failure such as cardiac monitoring equipment, the supervisor should be notified immediately by telephone or face-to-face report. **Attempt proper, approved cleaning/trouble shooting techniques.** The equipment should be brought to headquarters and tagged out-of-service.

FDA regulation mandates that faulty cardiac monitoring equipment is returned for inspection in the same condition it was in when the failure occurred. **Do not remove, re-locate, or separate the batteries from the failed unit. All cables, pads and electrodes should remain intact as well. Leave the equipment in the exact condition it was in when the failure occurred.**

The crew must write a detailed description of the equipment failure and the circumstance in which it was being used and attach the written description to the equipment when it is returned.

Contact the on-duty Field Operations Supervisor in the event of *any* equipment failure or loss to determine if you should be out of service. Failed equipment does not necessarily render a unit fully out of service. A crew may be directed to act as an “ALS First Responder”, giving care until a transport capable unit arrives at the scene.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 4, 2022

APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Unauthorized Patient Care Equipment**

Use and/or possession of unauthorized equipment, devices and/or procedures (see Agency Patient Care Protocols) by field employees are subject to disciplinary action, up to and including termination. This includes those individuals who have knowledge of such actions and fail to report appropriately.

ISSUED: April 1, 2015 REVISED: January 2024
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Patient Lifting and Moving**

Purpose

The purpose of this policy is to outline proper lifting techniques, safe movement of patients, and best practices related to the use of the PMD or patient moving devices.

Definitions

Stretcher or Cot – A wheeled apparatus used for moving patients up to 700lbs, preferably on stable, even ground. Requires a minimum of two providers, one at the head and the other at the foot.

Bariatric Stretcher or Cot – A wheeled apparatus used for moving patients up to 850lbs, preferably on stable, even ground. Requires a minimum of two providers, one at the head and the other at the foot.

Stair Chair - A chair designed to allow for safe movement of patients up and down stairs. Requires a minimum of two providers, one at the head and the other at the foot.

Bariatric Tarp or Mega Mover - A portable patient transport device used for transporting patients from areas that are inaccessible to the stretcher, to assist with bariatric transports, and for bed to stretcher transfers. Requires a minimum of two providers, one on each side.

MEDSLED - A sturdy plastic carrying device that can be easily moved across most terrains. Its primary use is for moving patients out of small spaces. It can also be used to assist with bariatric transport.

Scoop Stretcher - A device used specifically for moving injured patients from the ground or flat surface to the stretcher. The device has two parts that connect and eliminate the need to log-roll the patient. Requires a minimum of two providers, one at the head and the other at the foot.

Back Board/PEDS Spinal Board - A device that provides rigid support while moving patients with suspected spinal or limb injuries to the stretcher. Requires a minimum of two providers, one at the head and the other at the foot.

Pedi Mate - A device designed to secure pediatric patients weighing 10-40lbs to the stretcher for transport.

Pedi Pal - A device designed to secure pediatric patients up to 40lbs in an upright position.

Planning Your Move

Communicate clearly and frequently with your partner and any others assisting with patient movement. Decide which PMD is best to move your patient from the scene to the stretcher, what verbal commands will be used, and what your exit route will be. Call for help when you need it.

Moving Patients

Continue to communicate during your lifting and moving. Keep both of your hands on the PMD during the movement and while stationary. A minimum of two providers are needed with each move. At least one will be a Medic field provider who will lead and communicate the lifts and movements.

Proper Lifting Technique

Using proper lifting techniques can help prevent injury. No matter which patient moving device you choose, you want to keep the weight as close to your body as possible, keep your feet flat on the ground using a strong, stable stance and while maintaining a firm hold on the device you are using.

Squat down, bending through your hips and knees, you can also take a staggered stance, with one foot half kneeling in front. Keep your back straight and shoulders back. Lift the weight by straightening your hips and knees,

rather than pulling up through your back.

As lifting takes place, keep your shoulders level and facing in the same direction as your hips. Turn by moving your feet, do not twist or rotate your torso.

Hand Placement – When lifting, both of your hands should be palms up.

Patient Extrication

Patients may be found in a vast array of different places and positions with many of these being more difficult to move the patient than others. For these situations, Medic will provide the appropriate equipment and extra manpower if need be. **Safety should always be the primary focus**.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Jan 28, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Radios on Unit**

Both crew members are issued a portable radio at the start of each shift. The second radio is provided to assure better communications when crew members are separated due to multiple patients or scene safety reasons.

Each radio is assigned a specific identifier so that CMED personnel will know which crew member they are communicating with on the scene. For example, the radio assigned to the crew chief will have the alias “Med21-P1” (Portable one) and the second will have the alias “Medic 21-P2” (Portable 2). The radio identifier is internal and does not change how the crew should communicate with C-MED – i.e. “Medic 21to C-MED”.

When crew members need to communicate with each other while on scene, C-MED should be contacted for clearance. Permission will be granted to either go direct on the primary channel or the crew will be assigned an alternate channel. Crews should utilize the call signs portable 1 and portable 2 for these transmissions. i.e. “Medic 21 portable 1 to Medic 21 portable 2”. Individual names or other identifiers should not be used.

Units must have two portable radios at the start of the shift. The Crew Chief will notify the Field Operations Supervisor if a radio is missing before deploying in the system and write up the missing equipment on a lost and damage form.

The Crew Chief should ensure that he/she has the appropriate radio at the start of their shift.

The Crew Chief is the primary individual responsible for all communications (this responsibility may be delegated to a partner when appropriate).

The Crew Chief is responsible for ensuring that radio traffic is kept to a minimum.

The unit Crew Chief is responsible for insuring that both radios are carried and monitored at all times.

Mecklenburg EMS Agency

SOG: 200.061.000

Standard Operating Guidelines, Operations Department, All Uniformed Employees

ISSUED: May 1, 2022, REVISED: Not Applicable
APPROVED: Nov 2021 BY: Operations Management Team
SUBJECT: Emergency Button Activation

Purpose:
The purpose of this guideline is to establish a standard progression of actions in the event of an emergency button activation (EA=Emergency Activation) on Mecklenburg EMS Agency assigned radios.

Applicability:
This guidance applies to all Communications Personnel as well as Field Operations Personnel.

Guidance:

Communications:

- Activation of Emergency Button on portable or mobile radio occurs.
- The CMED dispatcher responsible for the talk-group the unit is currently assigned will immediately ACKNOWLEDGE (NOT KNOCK DOWN) the Emergency Activation then attempt to raise the unit. Any other dispatchers at radio positions will only silence the activation at their console.
    - This should be done by simulcasting on the Emergency Channel and the appropriate operations channel for that unit.
- Two attempts shall be made to contact a unit once an EA has occurred:
    - "CMED to M16, do you have emergency traffic?"
    - Count 4 seconds.
    - "CMED to M16, do you have emergency traffic?"
- If the unit reports an emergency, "10-18" is stated, or there is no response from the unit after two attempts, it shall be considered a true emergency.
- Resetting of the emergency button without verbal confirmation from the crew should remain a true emergency until verbal confirmation is obtained.
- In the event of a true emergency CMED will immediately notify police, first responders and dispatch the closest Operations Supervisor – Field and an additional closest Medic unit (all will respond emergency traffic to the scene, where they will stage if needed).
- All responding MEDIC units will be assigned to the CNTY-EMG3 channel:
    a. MEDIC Field Ops Portable Template: Zone 3 position 16 (Last position on the radio
    b. Admin/Special Ops Portable Template: Zone 1 position 16 (Last position on the radio) or Zone 3 position 16 (Last position on the radio)
- Only after the unit advises there is no emergency, should the emergency channel be cleared. CMED/Central should never clear an emergency activation until it is confirmed the activation was accidental OR after the emergency is considered under control.

Field Operations:

- By the nature of our work, crew members may find themselves in an unsafe situation where they feel that their wellbeing is threatened. In the event that this occurs an "Emergency Button" activation (EA) is appropriate.
- Once an emergency button has been pressed on the radios no additional communication is required. CMED will attempt to make radio contact with the crew twice before declaring a true emergency, as outlined above.

- If a true emergency is declared, the closest Operations Supervisor - Field will be dispatched along with Law Enforcement, Fire Services and an additional closest Medic Unit.
    - Please keep your responding radio traffic to an absolute minimum. This will allow CMED to continue to reach out to the crew and obtain and relay information to all parties. Responding units should not need to communicate any status changes during an emergency activation event.
- If possible, during the event causing the activation, attempt to provide any information possible to CMED, which will be shared among responding personnel, along with the original call information.
    - The METHANE pneumonic can be utilized during the event as a prescribed method of communication. However, in the event the activating crew is unable to provide additional information no additional radio traffic is still appropriate.
        - Major Incident Declare
        - Exact Location
        - Type of Incident
        - Hazards present or suspected.
        - Access – routes safe to use.
        - Number, type, severity of casualties.
        - Emergency services required (PD, Fire, Hazmat, etc.)
- In the event of a false activation, notify CMED as soon as possible to avoid dispatching the additional resources.
- If the EA is accidental, the unit will advise CMED of the following:

  “M16 to CMED, **negative** EA” or “M16 to CMED, **negative** Emergency Activation”
- An inadvertent Emergency Button activation should be cleared on the mobile/portable radio by holding the Emergency Button down for 3-5 seconds, you will hear an audible tone indicating that the activation is cleared. Do NOT clear the emergency without answering/advising CMED/Central of accidental activation first.

ISSUED: May 1, 2018 REVISED: January 2024
APPROVED: May 8, 2015, BY: Operations Management Team
SUBJECT: **Bariatric Transports**

Introduction

Transport of Bariatric Patients by Mecklenburg EMS Agency requires the use of specifically designed equipment and vehicles, capable of transporting patients whose body dimensions and/or weight are not suitable for transport on standard patient carrying equipment or vehicles.

Criteria

Bariatric in this policy refers to any person whose weight or physical dimensions exceed the capability of standard equipment in use by Mecklenburg EMS Agency.

Mapping Patient Pathway

Request for transport – ALL requests identifying bariatric patient transport will be received by MEDIC Communications (CMED). Following MPDS triaging, each case will be referred through the following pathway:

Immediate Response (Charlie/Delta/Echo Responses) – MPDS categorized urgent, or time critical responses will receive an appropriate response in accordance with CMED guidelines. Response configuration and availability of units will indicate ALS or BLS ambulance response and the Bariatric Transport Capable Unit will be immediately dispatched to the patient. The first arriving unit will assess the patient's clinical needs and confirm the transport mode using the Bariatric Assessment Tool.

Response <20 minutes (Alpha/Bravo Responses) – MPDS categorized non-urgent will receive an appropriate response in accordance with CMED guidelines. An ambulance and the Bariatric Transport Capable Unit will be dispatched to the patient to assess the patient's clinical needs and confirm the transport mode using the Bariatric Assessment Tool.

Response > or <24 hours (NET Responses) – Referred to the Communications Supervisor for a review of the case. The Communications Supervisor will coordinate the appropriate staff, the bariatric vehicle response, and determine an appropriate time frame for the customer to receive service.

Note: Treatment of high priority patients should not be delayed waiting for a bariatric vehicle to arrive at the scene.

Bariatric Assessment Tool

Estimates of patients' weights are generally underestimated and should be verified by the patient, the patient's caregiver or the discharge RN requesting transport. Be aware that patients may underestimate their own weight. This tool should be used by responding field personnel or the tele-communicator to help make an informed decision as to the need for a bariatric stretcher to undertake the transport.

Use this tool to determine the patient's needs:

Does the patient weigh >700lb? Exceeds stretcher capability.

Yes: Must call for bariatric stretcher
No: Proceed to next question

Does the patient's girth prohibit the seatbelts from buckling?

Yes: Continue with call using MedSled and Seatbelt extenders when needed
No: Proceed to next question

Is the Patient adamant about using the bariatric stretcher?

Yes: Consult with on duty supervisor before requesting bariatric stretcher
No: Continue with call using MedSled and Seatbelt extenders when needed

The bariatric stretcher should be reserved for patients over 700lb capability of the power stretchers.

NOTE: If no bariatric stretcher is available, refer to the on-duty Field Operations Supervisor.

Execution

Once the need for the bariatric stretcher has been confirmed, each division will have its own unique and vital role in the execution of the guideline:

CMED

1. If a non-bariatric capable unit was dispatched initially:
    a. A unit capable of transporting the bariatric stretcher will be added to the call.
        i. Either the unit closest to P100; or
        ii. The unit getting ready to check on duty (10-41)
    b. Initial unit stays on scene for patient care and lifting assistance.
    c. BAR 1 or 2 is assigned to call.
    d. The bariatric capable unit will take over patient care, document the use of the bariatric stretcher in Siren, and complete the call *(the process for airport to crew transfers will be used)*.

To document call, BAR 1 or 2 requires the following times: dispatch, scene, and available.

NET Transports

1. If the bariatric stretcher is requested, NET personnel in CMED will check/verify the weight of the patient documented on the paperwork to determine if there is a bariatric need.
2. If the request is made by the patient, and there is no documented reason, CMED will revert to the above bariatric assessment tool.
3. If the crew requests the bariatric stretcher, follow steps under 911 Calls below.
4. If a higher priority call is dispatched, the unit bringing the bariatric stretcher can and most likely will be diverted to that higher priority call.

To document call, BAR 1 or 2 requires the following times: dispatch, scene, and available.

911 Calls

1. Crew 1 is dispatched, identifies the need for the bariatric stretcher using the Bariatric Assessment Tool, requests bariatric stretcher.
2. Crew 1 stays with patient and treats patient while awaiting the arrival of the bariatric stretcher.
3. A second unit will be assigned to the call along with BAR 1 or 2.
4. Crew 1, if able, will continue patient care and transport. If Crew 1 is not in a vehicle that is capable of transporting the bariatric stretcher, then Crew 1 will transfer care to Crew 2 using the same process used for airport to crew transfers. Crew 2 will then take over patient care and transport.
5. The non-transporting crew will help with lifting assistance before clearing.
6. Once the transporting crew has finished the call, CMED will place the unit out of service/bariatric using the appropriate out of service code.
7. **The crew will remain out of service for any calls other than DELTA or ECHO until the unit can return to Post 100 and drop off the bariatric stretcher.**

To document call, BAR 1 or 2 requires the following times: dispatch, scene, and available.

Field Personnel

911 Calls and NET Transports

1. Crew 1 arrives on scene and assesses patient using the Bariatric Assessment Tool.
2. Crew 1 determines the need for the bariatric stretcher.
3. Crew 1 notifies CMED of bariatric stretcher need and requests additional lifting assistance ifnot already on scene.
4. Crew 1 treats the patient until the arrival of Crew 2 with the bariatric stretcher.
5. Crew 1, if able, will continue patient care and transport. If Crew 1 is not in a vehicle that is capable of transporting the bariatric stretcher, then Crew 1 will transfer care to Crew 2 using thesame process used for airport to crew transfers. Crew 2 will then take over patient care and transport.
6. The transporting crew will document the use of the bariatric stretcher in Siren.
7. The non-transporting crew will help with lifting assistance before clearing.
8. Once the transporting crew has finished the call, they will be placed out of service (10-7) and sentto P100 to return the bariatric stretcher.
9. **The crew will remain out of service for any calls not DELTA or ECHO until the unit can returnto Post 100 and drop off the bariatric stretcher.**

Please Note

Transport of high priority patients should not be delayed waiting for a bariatric vehicle to arrive at the scene.

Document scene delay and reason for delay when appropriate.

Document the reason for requesting the bariatric stretcher.

Chapter Three

Evaluations / Miscellaneous Information

ISSUED: April 1, 2015 REVISED: May 1, 2018; Feb 8, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Media Policy**

In order to define what constitutes public information and to ensure accurate, timely and professional communication between the Agency and representatives of the media, the following guidelines will apply to release of public information and relationships with media personnel.

1. Public Information concerning incident response and patient treatment is defined as follows:

- Time of the call
- General location of the call (no specific address)
- Type of call (vehicle crash, trauma, medical)
- Number of patients
- Facility to which patient(s) were transported.
- Type of transport (emergency – known internally as priority 1 or 2 or non-emergency – known internally as priority 3)
- A general statement may be made that Medic assumed responsibility for the patient who was transported by paramedics to the hospital.

2. No additional information should be considered public domain unless approved by a member of the Public Relations team or a designated member of the administrative staff. Designated members include the following:

- Executive Director or Deputy Directors

3. Communications and/or operations supervisors who have completed media training with the PR manager mayhandle routine media inquiries (i.e. incident response, patient treatment). Supervisors may provide publicinformation as outlined above. Please make best effort to notify a member of the PR team if this occurs.

- If you are unsure of any response, exercise caution and refer media member(s) to the PR manager or a Deputy Director.

4. All media requests, aside from on-site incident responses outlined above, should be directed to the PR manager, ordesignated administrative staff.

5. Any employee, except for those outlined above, who is contacted by a media representative must contact their supervisor and the PR manager before discussing any issue, incident, patient information, or Agency affairs. Employees can be held liable for divulging non-public information or misstatements of facts concerning the Agency.

- Most members of the media are aware of the “Media Protocol Policy”. This is also found on our Medic911.com website.

- At no time should an employee speculate on causation, prognosis or other patient care issues not specifically defined as public information.

6. Non- Medic employees are not allowed to use video or still cameras or audio recorders on ambulances in accordance with NC General Statute. Medic employees using such equipment must have advanced approval from the PR Manager.

7. 911 call recordings will no longer be released to the media in accordance with NC General Statute 143-518, unless approved by the PR Manager or Director and with full redaction.

ISSUED: April 1, 2015 REVISED: January 2024
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Outside Request for Information**

MEDIA PROTOCOL

In an effort to broaden the availability of information pertaining to stories involving Medic or Medic personnel, the following protocol has been initiated by Medic's Public Relations Department. Your cooperation in following this protocol is very much appreciated and should lead to a greater availability of useful information in a shorter period of time.

Between the hours of 6:00 am and 9:00 pm, all MEDIC related inquiries must be made directly through:

Lester Oliva
Public Information Specialist
704.448.7088
lestero@medic911.com

OR

Grace Nelson

Public Relations Manager

GraceN@medic911.com

@Medic911Press Twitter
**Members of the press are encouraged to use Medic's private Twitter feed, @Medic911Press. Upon requesting to join, news media will have access to current, late-breaking information on a regular and continuous basis.

After Hours

Between the hours of 9:00 pm and 6:00 am, an incident related inquiry may be made into Medic's CMED call center at 704.943.6238, under the following guidelines:

- No media calls will be taken until 15 minutes after an emergency call is dispatched. Please respect this request and hold your team accountable for it.

- CMED Supervisors are likely to be coordinating the emergency response to a serious incident. The patients and the Medic crews in the field are their first responsibility. If the CMED Supervisor fails to pick up the Media hotline, please be patient and try back again in 5 minutes.

- The exception to this contact protocol would be if a major, mass casualty incident occurs in Mecklenburg County such as a plane crash, bus crash, large scale multi-vehicle accident, natural disaster, act of terrorism, etc. During such an event, Medic's PR Department will absolutely be in the field and available directly to the media by CELL PHONE regardless of the time of day.

Additional Points

- Whenever possible Medic's PR Department will proactively respond to incidents in the field that are known to be of higher-level interest to the media. When photos are released from the Medic PR team via email or @Medic911Press, this information can be used by your team and hopefully this quick response strategy will help you with breaking news type stories. All we ask in return is for Medic to be specifically recognized by name in any story you run where we are involved.

- Due to strict HIPAA regulations and personal privacy laws, Medic will not provide any information that could identify a patient*. The information we will provide will be general in nature, limited to the number of people involved, the emergency response assets on scene, the patient's condition enroute to the hospital, and what facility any patients are being taken to.

  *This also means that Medic cannot respond to incident requests with specific addresses. To ensure timely responses, please inquire with a street name, block number & street, or intersection location.

- Any stories that your organization is working on where a Medic comment is warranted must be authorized by Medic's Public Information Officer (PIO). On scene interviews should be limited to a member of Medic's PR Department, or to a ranking member of Medic's Operation Team, identifiable by their white shirts and gold badges.

ISSUED: April 1, 2015 REVISED: April 1, 2015 / January 27, 2022

APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Service Inquiries/Complaints/Commendations**

A Service Inquiry Form will be completed whenever there is contact with anyone who has a commendation or complaint about our service. All incidents will be processed in the same way to provide consistency, to assure that the review and follow-up are handled promptly and to assure that a case is closed in a timely manner. Realizing there may be circumstances that force delay in investigation, it is requested that all inquiries must be reviewed, and follow-up initiated and or completed within 14 days of assignment.

When a Service Inquiry (commendation or complaint) is received, open the Service Inquiry Database, and enter the information. This database is accessed via the Medic WebApps, using the following address: http://webapps.medic911.com/Medic-WebApp.

The Medical Director will be advised of major clinical incidents as soon as possible, as described in Patient Care Protocols, Medical Incident Review Process. The Deputy Director-Operations should be notified of all Presumptive Category One or Two clinical incidents.

Service Inquiry Process:

1. When a call or letter comes in, the person receiving the call or letter should initiate a new Service Inquiry record by first opening the Service Inquiry data base and then click on the Inquiry button in the middle of the page, then select New Inquiry to open the form. At the top of the form, you will need to select which form to complete (Commendation or Complaint), then enter as much information as is available. Once finished, clicking the 'Save' button at the bottom of the form creates the Service Inquiry Number and saves the form to the database.
2. After entering information on the data entry form, notify the appropriate supervisor of the inquiry.
3. After investigation, follow-up and closing the inquiry in the database this information is included on monthly reports to Mecklenburg County.
4. After closure, the report should be printed, attaching any additional paperwork, and forwarded to theOperations Manager for review if necessary.
5. The completed report should then be sent to the Deputy Director-Operations for review if necessary.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Jan 28, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Scene Evaluations**

Field Operations Supervisors are routinely dispatched to major incidents. The supervisors are also expected to monitor the quality of care that crews provide on general medical calls as well. When the opportunity presents itself, the Field Operations Supervisor should monitor the entire scene activity (to include interaction with allied agency personnel) and document their performance. This should be reviewed with the crew and appropriate feedback provided.

ISSUED: April 1, 2015 REVISED: January 2024
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Supervisor Shift Change – FGS Hand-off**

Each shift will operate with a designated Field Group Supervisor (FGS). The shift FGS is responsible for completing an ICS 214 Activity Log, containing pertinent operations information for their shift, as well as any predetermined response information as identified by the Operations Management Team.

The off-going FGS will attach the shift 214 and any additional documentation to an email sent to the Operations Management Team, Deputy Director – Operations, and the on-coming FGS for the next shift. A direct phone call is strongly encouraged between the FGSs to facilitate any information requiring immediate or continued engagement by the on-coming FGS.

Examples of pertinent information to include in hand-off:

- Staffing report (Field / OA / OSF-AOSF)
    - OJIs (complete/pending)
- System performance (SSL / UHU / Additional Deployment concerns)
- Pertinent facility information (HTAT concerns / Diversion status / Planned or Completed LTC Site Visits)
- Any facility issues at Medic stations or posts
- Active major incidents

It is customary for the on-coming Field Operations Supervisor to arrive at work prepared to respond to a call, approximately 10 minutes prior to the beginning of the shift. This should allow time for the off-going Field Operations Supervisor to provide the on-coming Field Operations Supervisor with the most pertinent information that will be needed to begin the shift.
The off-going Field Operations Supervisor is expected to fully complete the Off-Going Supervisor Report before the end of their shift. This contains essential information that may be referred to by the on-coming supervisor during the course of their shift. This information is used by the Deputy Director and Operations Managers to monitor important issues and events that have been handled in the Supervisor's office during the course of a shift.

- All medications should be monitored through periodic audits.
- All appropriate radio equipment, pagers, keys camera, etc. should be exchanged.
- The on-coming Field Operations Supervisor should fully review the day's shift schedule, maintenance log and crew/vehicle assignment with the Operations Assistant to assure clear understanding of priorities...
- Field Group Supervisor should meet face to face with Communications Operations Supervisors daily to assure clear communication of shift priorities.

ISSUED: April 1, 2015 REVISED: January 2024
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Benefit Leave for Field Operations Supervisors**

All scheduled leave requests should be submitted the Assistant Operations Manager for approval prior to the Scheduling Department. The Assistant Operations Manager will evaluate the impact on deployment plan and notifythe scheduling coordinator who will document the decline or approval. Any deviations from scheduled duty should be reported to the Assistant Operations Manager.

Once approved, changes should be reflected in Epro as soon as that period's schedule is released. This should be completed by the AOM or OM approving time off

Chapter Four

Scheduled / Non-Emergency Transport

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 19, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Scheduled/Non-Emergency Transport**

As mandated by the Mecklenburg Board of County Commissions, Mecklenburg EMS Agency is the designated medical transportation service provider for Mecklenburg County. It is our charge to provide safe, consistent, and courteous medical transportation services giving the same attention to detail to emergency requests as well as non-emergency.

The Agency may utilize crews specifically designated to handle prescheduled transports; however, any unit may be assigned to handle the non-emergency call.

Overview:

The NET program is designed to offset the daily peak non-emergency call volume while continuing to provide maximum customer service and patient care. This program requires great emphasis on customer service, as the program is highly visible to its customers and the public. It will require constant evaluation andfine-tuning in order to keep it running optimally. The personnel involved in this program must desire to providecustomer service and patient care in the highest manner possible.

ALS NET Shifts:

The ALS NET units work shifts are based on peak times of need. The hours may be adjusted as deemed appropriate to maximize the effectiveness of this unit. The program is monitored to assure that fairness is provided to all parties involved. When not being utilized for pre-scheduled and non-emergency transport, these units will be added to the 911 posting plan.

Performance Expectations:

Any obstacle to delivery of service should be immediately reported to the Non-emergency Transport (NET) tele communicator in CMED or Operations Supervisor for guidance on how to resolve issues that prevent optimal performance. An operations supervisor will investigate reports of poor customer service habits throughthe usual method.

Emergency vs. Non-emergency Assignments:

The ALS NET Units are not designated as “non-emergency” units. While the majority of calls assigned may be scheduled, system needs will drive their call assignment. ALS NET Units can reasonably expect to respond to a mix of both scheduled and 911 calls. The ALS NET Unit is predominantly used to handle non-emergency calls; however, if there are no pending scheduled calls, the ALS NET Unit should be placed at the highest priority post location.

The BLS NET Units are specifically intended to handle the scheduled discharge of patients from hospital facilities. They can also be utilized to handle the BLS appropriate 911 responses. It is possible that BLS NET units will be closest to a “Delta – Life-threatening” emergency and may be dispatched as a first responder, in addition to an ALS Paramedic Unit. In these instances, BLS crews are to provide patient care at their scope of practice until the arrival of the paramedic unit or if closer to hospital, transports to the closest hospital.

The EMD may use a “double post assignment,” or “equal-alternate post assignment” for the ALS NET unit if they have knowledge of pending calls or demands that will be placed on the system. **The EMD will not hold a call for the NET Unit past the scheduled pickup time, unless SSL indicates.**

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Continuing Education:

Members of the NET team both ALS and BLS are expected to meet all continuing education requirements as well as all other required field employee prerequisites (i.e. driver license, NCOEMS certification, employee safety/TB/fit testing, etc.…).

Chapter Five

Rescue / Emergency Management / Special Operations

ISSUED: April 1, 2015 REVISED: April 1, 2015; Jan 28, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: First Responder Services

The Agency contracts with multiple fire and rescue departments to provide First Responder service as part of the EMS System for Mecklenburg County. These contracted providers provide first aid and rescue services in their individual response areas and in mutual aid responses at the EMT level.

When interacting with First Responders while representing Medic:

- Be receptive to their report.
- Give consideration to what they have already done for the patient.
- Communicate your expectations / provide direction.

* See First Responders Contract for additional information.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 2, 2022
APPROVED: March 8, 2015

SUBJECT: **Crime Scenes**

By the nature of our work, crewmembers may frequently find themselves involved in crime scene situations. The following guidelines should be followed in such situations:

Ensure that the scene is safe to enter and that the police department is responding. If officers are not present upon your arrival it is acceptable to stage away from the scene until it is declared safe by the police department.

- Use caution when entering the environment, not touching any surroundings unless absolutely necessary to avoid contamination of the crime scene. Do not leave any personal items (gum wrappers,medical supplies/packaging, etc.) at the scene. If anything is moved, such as furniture and including a deceased victim, inform the police investigator at the scene.

- Limit access to essential personnel only. Entry and exit routes should remain the same.

- Report suspicious bystanders or activity to the police.

- Physical contact with any suspected suicide case that will not result in treatment and transport should be extremely limited. If a viable patient is encountered, proceed with appropriate medical/trauma protocol.

Exceptional situations:

Hangings- Leave all knots intact, including the knot that the victim may have been suspended from. The rope should be cut in an area halfway between the noose and the suspension point.

Weapons – Should only be moved if they are interfering with patient care and should only be handled by police officers if possible. Keep bystanders and other responders away from the weapon until the police have secured it. Under no circumstance should a Medic employee tamper with, open or attempt to unload a firearm.

When treating patients that have sustained penetrating wounds, clothing should be cut in a fashion that will preserve any evidence, such as entry points of projectiles and blades. *Do not cut through holes made by penetrating objects.*

Sexual Assaults – victims of sexual assault should be moved quickly to a safe environment. Psychological support and understanding are essential in these delicate situations. It is vital the patient preserves evidence. They should be discouraged from showering or washing any part of their body. Nor should they change clothing or use the bathroom if possible.

If the Medic employee is directly involved as a victim, the operations supervisor should be notified immediately, and a police report generated.

* See Crime Scenes specifically addressed in the Agency Patient Care & EMD Protocols (Section 1, page 62).

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 4, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Forced Entry**

1. Be certain that a forced entry is necessary.

    - Check to see if you can see someone down inside the house.
    - Check to see if the call taker lost contact with the patient while talking on the telephone.
    - Consider contacting neighbors who may have information in regard to patient health history; neighbors may have a key.

2. Ensure the police department is enroute, preferably at the scene before entry is made.

    - The fire department should make the forced entry under direction of the police department.
    - Medic personnel should not make a forced entry without the police and fire department at the scene unless a critical need is obvious, such as a visible person down, appearing unconscious, or with strong evidence of a life safety hazard. (Smoke/ fire visible, possible person(s) trapped inside)

3. Ensure there will be someone available to secure the residence after entry has been made.

4. Document thoroughly why the forced entry was justified.

ISSUED: April 1, 2015 REVISED: April 1, 2015, February 5, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Aircraft Emergency ALERT II**

"ALERT II" is a broad-spectrum term used for an aircraft experiencing trouble / problems, not a crash. When responding to an "ALERT II" keep the following in mind:

The typical dispatch address is **4801 Express Drive.**

The typical dispatch configuration includes:

- 1 MCI Unit (1 ALS unit if MCI unit unavailable)
- 1 Operations Supervisor (closest)

Response to an ALERT II will be non-emergency unless specific information dictates otherwise.

The supervisor may upgrade to a higher response as needed, based on information being received.

When dispatched, you will be assigned an operations channel and given specific information regarding incident if available such as:

- Size and type of aircraft
- Number of passengers (referred to as "Souls on Board")
- Specific problem the aircraft has encountered.
- Amount of fuel on board

It is recommended the responding units monitor CFD working channel on one of the portable radios (Normally CFD-OPS-1J). Responding units should stage on Express Drive and await further instruction.

Under no circumstances should a Medic unit go onto runways, taxiways or tarmac unless instructed to by the Incident Commander (IC).

YOU MUST HAVE AN ESCORT ON ALL RAMPS, RUNWAYS, TAXIWAYS AND TARMAC AT ALL TIMES.

ISSUED: April 1, 2015 REVISED: April 1, 2015, February 5, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Aircraft Emergency ALERT III**

The term "ALERT III" indicates that there is an aircraft down and has crashed, or that a crash is imminent. Rarely do these incidents occur on airport property. Response level will depend on size of the aircraft and the number of souls on board and location of the downed aircraft. This scenario should be treated as a multiple casualty incident, rescue/entrapment, as well as a hazardous materials incident until otherwise indicated; keeping in mind that personal and personnel safety should be a primary concern.

Keep in mind the following as well:

- Access in and out of the scene should be established early. Keep roads open for responding personnel and ambulance exit.
- Try to determine if additional resources will be needed and report the findings to the operations supervisoras soon as possible.
- Establish a unified command with partner agencies (Airport, Fire and Police) as soon as possible to coordinate the response of resources.

**For further details, see MCI Plan*.

Mecklenburg EMS Agency SOG: 500.020.000

Standard Operating Guidelines, Operations Department, All Divisions

ISSUED: April 1, 2015, REVISED: April 1st, 2015; June 8th, 2021
APPROVED: March 8, 2015
SUBJECT: **Response to Airport Terminal**

Purpose:
To provide guidance for all incoming crews to the airport for patient care/transport.

Applicability:
All MEDIC employees that respond to the airport.

Guidance:
Mecklenburg EMS Agency is contracted with the Charlotte Douglas International Airport to provide EMS personnel for response to incidents inside the terminal and ramp level.

When requested to the airport, crews must follow instructions provided by CMED and airport EMS units. Consider the following:

- Pay close attention to the radio channel assigned upon dispatch.
- Airport EMS will communicate how the patient will be transferred to the incoming crew and communicate any potential riders or other special considerations.
- When airport EMS staff is not available, follow instructions provided by CMED.
- Unless told otherwise, bring in the stretcher and all equipment needed as outlined in the "Mecklenburg EMS Agency Patient Care Protocols" and "Initial Approach to Scene."

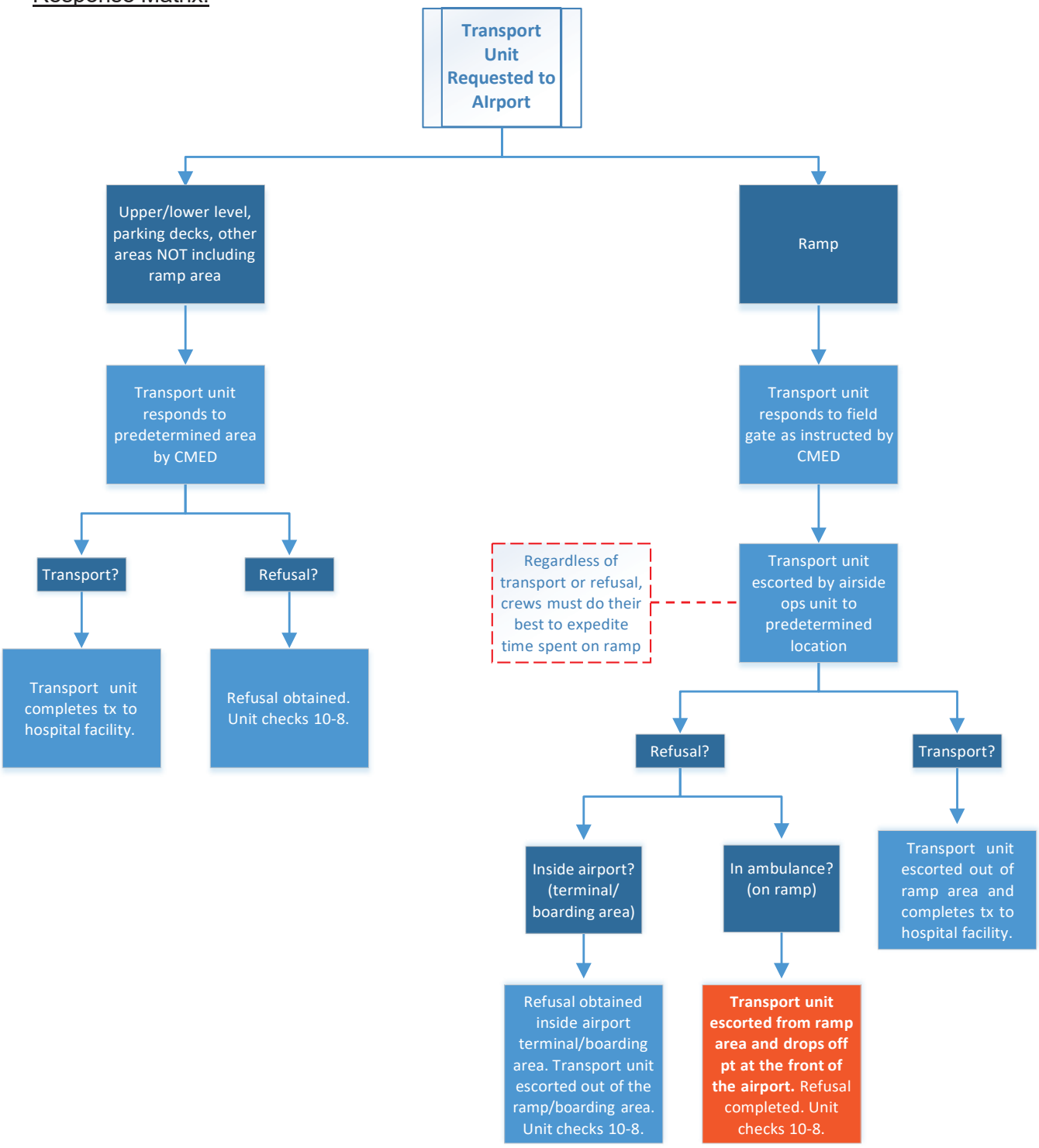
Crews may be requested to report to alternative gates to access the airport ramp. When using alternative access locations, keep in mind the following:

- Crews must respond to where directed by CMED, and follow recommended routing guidelines.
- Access inside the perimeter fence (ramp area) **always requires an escort** by an authorized airport airside unit.
- Always stay **directly behind** the escort vehicle.
- Always be sure all emergency lights are on while driving on the ramp; headlights shouldbe on low beam.
- Park where indicated/escorted by airport airside unit.
- Once a patient has entered the back of the ambulance, **expedite** the time spent on the ramp (time spent on ramp area should be < 10 minutes).
- If special circumstances arise that delay time spent on the ramp, CMED and Airport Ops must be informed.

Additional Information:

- MEDIC personnel who do not have a SIDA badge must be escorted inside the airport's secured area by authorized airport personnel. At no point should any crew separate from their assigned escort.
- When a patient is egressed from the boarding area to the ramp, the patient exits an area defined by the airport as "sterile" and enters a "non-sterile" area. This means that any patient loaded into an ambulance on the ramp area CANNOT reenter the airport through the pathway they exited from. For a patient to reenter the airport, they must enter through the front of the airport to be rescreened through a TSA security checkpoint.

Response Matrix:



ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 2, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Response to Bomb Incidents**

Medic will be charged with providing standby coverage for both bomb threats and emergency response to actual bombings.

- ***If you arrive at the scene of a bomb threat before the CMPD bomb team, staging should be a minimum of 500 feet from the threat location.***

- ***Once the bomb unit is at the scene, follow the direction of the incident commander. You may be asked to move to an alternate location.***

- ***If you are responding to an actual explosion, stage a minimum of 500 feet from the explosion site,and follow Agency MCI Response Plan.***

There are several key things to remember when responding to a bombing or bomb threat.

The outside of a building is the most common place for a bomb to be placed.

If you are directed to enter inside the "Hot Zone" (Within 200 feet of the threat location), you may need to leave 800 MHz radios and your cell phones in your unit. Check with bomb unit personnel for specific instructions.

Special Operations Medics attached to CMPD Hazardous Device Technicians (HDT) will assist once on scene and provide further instruction.

<u>If you are responding to an actual explosion, it is common for secondary devices to be set specifically targeting emergency responders.</u>

- ***Park vehicles away from structures***

- ***Do not touch anything except the patient.***

- ***Listen to the directions of the Special Operations Medic/CMPD HDT personnel at the scene.***

- ***Outerwear & helmet is required for entering a structure that may have suffered damage from a blast.***

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 2, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Hazardous Materials Incidents (HAZMAT)**

When responding to potential hazardous materials incidents, safety of emergency responders is a primary concern. Should you happen to be the first on scene responder at a potential hazardous materials incident do the following:

- Call for assistance from the fire department; try to give as much information as possible regarding the suspected product.
- Utilize the Emergency Response Guide (ERG) located in the MCI clipboard to help with identification.
- Approach the scene from upwind and uphill of the incident site when practical.
- Limit access to the area; no one (including you) should enter the hazard area until the product is identified and appropriate protective measures have been taken.
- Anyone inside the area should be evacuated; do not become a victim yourself in efforts to assist. *It may be necessary to use your vehicle public address system to direct bystanders / ambulatory victims to safe areas.*

When performing stand by duties at hazardous materials incidents your primary duties are:

- Giving care to potentially exposed patients.
- Medical monitoring of the HAZMAT Technicians working at the scene. *See Mecklenburg EMS Agency Patient Care Protocols, Medical Monitoring for further information.
- Standing by in case injuries occur during the operation.

The Incident Commander should be able to inform you of the staging area for your unit. Park upwind from the incident, ensuring your position does not interfere with other agencies that may need to access the scene. If possible, locate the ambulance close to the HAZMAT truck. Load necessary equipment onto the cot and contact the Incident Commander on the radio to confirm your assignment.

Attempt to ascertain the type of hazardous product from the HAZMAT Team. Obtain copy of MSDS (Material Safety Data Sheet) from HAZMAT Team to take to the hospital. The MSDS may be faxed directly to the hospital if the sheet is not readily available at the time of transport. If all you can get is the product(s) name, make sure you have the correct spelling for hospital staff.

Assure the Field Operations Supervisor is aware of the incident and request additional resources as needed.

Decontamination procedures should be performed under the direction of the Hazardous Materials Team and Incident Commander.

Remain at the scene until you are cleared to leave the by the Incident Commander.

Hot Zone: Area where release of product is occurring or has occurred; should only be entered by the HAZMAT team wearing appropriate PPE.

Warm Zone: Area of contamination control. As appropriate PPE is required in the warm zone EMS personnel generally will not enter.

Cold Zone: Non-contaminated area. No risk of secondary contamination should exist. This area is where the command post, treatment, and staging are located. PPE protection from the HAZMAT product should not be required.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 2, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Water Rescue Incidents**

Lakes, creeks, or areas that have experienced flooding may be difficult to navigate. With safety being the key issue, keep the following information in mind.

- Personnel must wear a Personal Flotation Device (PFD) when operating within five (5) feet of water at an incident where a water rescue is in progress (swift water or by watercraft).
- Maintain as close communication as possible with the first responders, as they will have more intimate knowledge of the area of response.
- Try to pre-determine a suitable takeout point for your patient, and stage a unit at that area.
- ***Medic personnel should always notify the Field Operations Supervisor before boarding any watercraft.***
- Medic may be requested to stand by for divers or rescue personnel during a search.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 2, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Missing Person Incidents**

If Medic becomes involved with a search for a missing person, we are there to offer medical support for police, first responders and rescue personnel. It would be rare that Medic personnel become active in searching for a missing person. The following guidelines apply to the missing person incident:

- Make contact with the Incident Commander. The typical assignment and purpose will be setting up rehabilitation facility for rescuers and/or medical monitoring. If no assignment given report to command post for further direction.

- If it appears you will be on scene for extended amounts of time, contact C-MED for possible rotation period between other Medic units.

- Ensure the Field Operations Supervisor is aware of the incident.

- Stand by as needed until cleared by the Incident Commander.

ISSUED: April 1, 2015 REVISED: January 2024
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Rescue Incidents**

At a rescue assignment it is the Crew Chief's responsibility to concentrate on overall scene safety and patient care. Coordinate all members of the team to work together for the common good of the patient. The first thing to be established is that there is a need for rescue. Rescue response is indicated under the following circumstances:

- Patient entrapped or pinned in machinery, vehicle, or by some type of object.
- The patient is above or below grade and cannot be removed without assistance.
- The patient is in water and cannot be removed without assistance.
- Confined space situation (culvert, elevator shaft, etc.)

Scene safety is a primary concern. Other information such as estimated number of patients and their severity of injuries will be needed to adequately determine the need for additional resources.

- Ensure all personnel are wearing appropriate protective equipment for the evolution beingperformed.
- Assure the patient is properly protected from weather, debris, and further injury during theoperation.
- An on-duty Medic Supervisor should be made aware of any extended rescue situations.

Mecklenburg EMS Personnel are responsible for all patient care activities.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 2, 2022
APPROVED: March 8, 2015 BY: Operations Management Team

SUBJECT: **Industrial Accidents**

Industrial Accidents

Industrial accidents are typically classified as accidents that involve a patient being injured or trapped by some type of heavy machinery. Each situation may vary and depends on the type of machine involved. Some factors to keep in mind when responding to this response:

- Determine if the scene is safe.
- Determine if the patient is trapped. Request additional resources if needed.
- Determine if a shop mechanic is available at the site. This may be your best resource in the event the machine must be disassembled, or to give advice on how the machine may react if certain parts are moved.
- Assure all personnel at the scene have appropriate protective gear for the situation.
- Ensure the power supply is disconnected and the machine is locked and tagged out.
- Assure the Field Operations Supervisor is aware of the situation.
- Assure the patient is properly protected from weather, debris, and further injury during theoperation.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 2, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **SWAT Incidents**

Mecklenburg EMS Agency employs a specialty team of Special Operations Medics that train with Local, State, and Federal Law Enforcement Agencies, to respond to high-risk situations such as hostage events. However there may be occasions when a regular field unit is deployed to a situation before the Special Operations Medic arrives. .

1. On arrival, locate the command post, and ensure the Incident Commander is aware of your presence at the scene.
    - Inform the Incident Commander that you are not a Special Operations Medic member.
    - Ensure that C-MED is aware a tactical Medic is needed and have them advise you of the ETA.
2. **AT NO TIME IS ANY NON-SPECIAL OPERATIONS MEDIC TO ENTER THE "HOT ZONE" OF A SITUATION THAT IS NOT COMPLETELY UNDER CONTROL.** Medic personnel may enter the scene only after Law Enforcement has declared the scene safe or secure.
3. Remain at the scene until relieved by the Special Operations Medic or until cleared by the Incident Commander. The first in unit may be requested to stand-by in support of the Special Operations Medic.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Oct 10, 2021
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Fire Department Support**

Medic provides mutual aid service to Charlotte Fire Department and County Fire Departments by responding to all working fires or hazardous incidents when requested. The primary role of the standby unit is to be ready to receive any patients that may have resulted from the initial fire, be available to assist in the event of firefighter(s) becoming ill or injured while fighting the fire and setting up a rehabilitation area.

1. Park in an area upwind from the incident and out of the way of fire apparatus and other responders. Ensure your exit is not blocked by additional responding apparatus / vehicles. ***DO NOT DRIVE OVER A CHARGED FIRE HOSE*** *OR HOSELINE BEING LAID BETWEEN FIRE HYDRANT AND APPARATUS.*

2. Assure all EMS personnel are wearing adequate protective equipment.

3. Load necessary equipment onto the cot, report to the Incident Commander, and locate a suitable area for rehabilitation of the firefighters. Go to the fire department's operating channel to monitor with one radio and monitor the MEDIC channel with the second radio.

4. Request additional resources as needed. Once committed to a patient that appears to be in need of transport, request another unit for stand-by and for separate run numbers for that patient.

5. When rehabilitation activities are started, the on-scene EMS unit will coordinate with the Safety Officer or Incident Command to ensure all fire personnel are rotated through rehabilitation.

6. Follow **Medical Monitoring** protocol for rehabilitation operations with fire department members.

7. The crew must notify CMED when they become committed to an active rehab operation.

8. If crews are **not** currently committed to an active rehab operation, the unit could be pulled from fire support calls to respond to nearby, higher priority incidents. C-MED may elect to hold units in available status at fire scenes if EMS system status warrants.

- *If pulled from standby, advise the Incident Commander that you are leaving for a higher priority call and have C-MED advise "Alarm"(Charlotte Fire Department Dispatch) if required.*

Response levels will be as follows:

- Working Fire:
  - 1 ALS ambulance or MCI bus Bravo response for standby.
- Haz-Mat Response:
  - 1 ALS Ambulance or MCI bus Bravo for standby.
- Working Fire with reported victim/s or confirmed "MAYDAY" by the Fire Department: Same as above plus:
  - 1 Ops Supervisor Charlie Response.
  - 1 ALS ambulance, per reported victim or unaccounted for firefighter, Emergent Response. (Limit 3 emergent units on initial dispatch. Additional resources as requested by command).

    - If on-duty, 1 MCI Bus Bravo response.
    - Consider separate Medic operations channel.
- 2nd Alarm fire incident and higher (In addition to initial standby response):
    - If on-duty, 1 MCI Bus Bravo response.
    - 1 additional ambulance, per alarm level, Bravo Response. (Limit 3 total standby units)
    - 1 Ops Supervisor Bravo response.
    - Consider separate Medic operations channel.
- Working fire with ambient outdoor temperature of 90 degrees F or higher:
    - Add 1 MCI bus, Bravo response, to standard standby dispatch.
- In low system status situations, the on-duty CMED and Field Supervisors should consult each other and use discretion when assigning additional resources.

Medical Group Supervisor/Command on the scene may request additional resources, or cancel responding resources as they see

ISSUED: April 1, 2015 REVISED: April 1, 2015, February 5, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Radiological Incidents**

Due to the potential danger, the complicated technical nature, and the unique characteristics of radioactive material, it is imperative that the Incident Commander follows a course of specific action. As the medical provider responding to the scene, your role in an incident involving radioactive material will be limited to treating injuredpatients and preventing further contamination. The following are guidelines for proper response to known radiological incidents:

- A Field Operations Supervisor must be notified of any Radiological Incident.
- Lifesaving functions take priority over radiation exposure. Victims should be removed to a safe environment as soon as possible.
- Exposure time in the “hot zone” should be kept to an absolute minimum. The number of workers in the zone should be kept to a minimum.
- All emergency response personnel shall keep a record of exposure.
- As with any hazardous material response, approach upwind. If a radiation hazard is suspected, personnel, vehicles and command post should be staged at least 1000 feet from the incident. Distances may change when personnel arrive on the scene with instrumentation and advise command of the situation.
- Always advise hospitals in advance and as soon as practical that you could be transporting contaminated person(s).
- Isolate, tag, and secure all equipment, trash, and other items inside the “Hot Zone”. Proper decontamination or disposal will be completed after transport.
- All eating, drinking and smoking should be prohibited in the area.
- Medic personnel will remain unavailable for additional duties until decontamination has been completed and they are clear to return to regular duties.

See preparation and dress down procedure for radiological incidents.

PROTECTIVE CLOTHING
DRESSING SEQUENCE
(Suggested Checklist)

1. Use the restroom.
2. Attach TLD to clothing.
3. Tyvek pants, shirt, or body suit
4. Booties – secure with masking tape, over pants, leave pull-tab for dress down)
5. Head cover / hood.
6. First gloves (taped to outside of sleeve of protective garment – leave tab for dress down)
7. Second gloves – do not tape- change as needed.
8. Face shield
9. Attach dosimeter at neck level ("zero" and report reading every 15-30 minutes to RSO / Recorder)

UNDRESSING SEQUENCE / EXIT PROCEDURES
(Suggested Checklist)

1. RRT member goes to the "control line" and removes protective clothing (place in plastic container).
    a. Remove dosimeter and place in plastic bag held by controller.
    b. Unzip protective garment.
    c. Remove tape on inner gloves and booties.
    d. Remove outer gloves.
    e. Tilt head forward and remove face shield.
    f. Tilt head back and remove face shield.
    g. Remove protective garment – inside out, DO NOT SHAKE
    h. Remove booties and step on step-off pad.
    i. Remove inner gloves.
2. Complete body frisk – final monitoring
3. Remove TLD, give it to RSO.
4. Take a shower

ISSUED: April 1, 2015 REVISED: April 1, 2015, February 5, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **McGuire Nuclear Power Station Incidents**

McGuire Nuclear Power Station is located on Hwy 73 in northern Mecklenburg County on Lake Norman and is owned by Duke Energy. This facility houses 2 nuclear reactors that produce electricity for the region.

McGuire has a Medical Emergency Response Team that is deployed to all medical emergencies and accidents at the facility. All members of the team have first aid training. The facility also has a Radiological Protection Team that are trained to perform monitoring for radiological contamination.

This is a security sensitive area. When responding to this facility you will be met at the gate by a security team, who will lead you to the appropriate area to find your patient.

- The Medic unit must stop at the gate and be prepared to present their photo ID. Personnel without a photo ID, such as a ride along, may be directed to wait outside the facility gate until the unit is ready for departure.
- The ambulance is subject to search.
- A security officer may accompany the crew on board the ambulance while on facility grounds.

The McGuire Nuclear Power Station staff fully appreciate our need to quickly reach patients in life threatening situations and will take measures to facilitate our passage as rapidly as possible. Please have your ID properly displayed and give their officers your full cooperation as is typical of Medic's highly regarded staff.

You will be notified ahead of time in the event you will be transporting a contaminated patient, in order to prepare yourself and your vehicle. Keep in mind if you will be transporting a contaminated patient, you may not be admitted into certain areas of the facility. The MERT crew will decontaminate the patient as much as possible and bring the patient to the waiting ambulance.

ISSUED: April 1, 2015 REVISED: April 1, 2015; Feb 4, 2022
APPROVED: March 8, 2015, BY: Operations Management Team

SUBJECT: **Dedicated Medical and High School Football Coverage**

Dedicated Medical and High School Football Coverage

Medic provides dedicated EMS unit coverage at various events throughout Mecklenburg County for a user fee. Information and rates are available at https://www.medic911.com/event-coverage/dedicated-coverage.

A Dedicated Medical Standby (85D) provides for a unit on the scene of an event such as a 5K, college football game, boxing, etc. where the event promoter pays the Agency for the service. Units on the scene of these events will generally not transport unless a priority 1 patient should be encountered. In cases where immediate transport is required, another unit should be sent to provide coverage until the original unit can return.

A School Football Standby (85F) is a public or private middle or high school game coverage where the school has contracted with Medic to provide an ambulance to standby during their home football game at a per game rate. Units on the scene of these events will generally not transport unless a priority 1 patient should be encountered. In cases where an immediate transport is required, another unit should be sent to provide coverage until the original unit can return.

On occasion Medic provides coverage at mass gatherings where the size of the event could have a significant impact on EMS system operation. These coverages are coordinated in advance with partner agencies to ensure adequate EMS system delivery. Coverage may include the use of an ambulance or other specialized asset.

Any difficulties should be reported immediately through the normal chain of communication and thoroughly documented.

Chapter Seven

Response Configuration / Notifications

ISSUED: May 1, 2015 REVISED: May 1, 2015; Feb 7, 2022
APPROVED: April 21, 2015, BY: Operations Management Team

SUBJECT: **Active Violence Incident Response**

Purpose: To establish Initial Assignment for response to an Active Violence Incident (AVI) as defined in the Joint Agency Active Violence Incident Plan.

Active Violence Incident (AVI) – Incidents where any armed person has used or is using deadly physical force on other persons in public and continues to do so while having unrestricted access to additional victims. Active shooter and active assailant incidents are examples of an active violence incident.

Dispatch Configuration:

- 1 Ambulance Strike Team (AST)
  - 1 Field Operations Supervisor
  - 5 ALS Ambulances
- 1 MCI unit (M701)
- 1 Ambulance Bus (M702 or M703)
- 1 Additional Field Operations Supervisor
- 1 Special Operations Vehicle (M704)

Notification (if not already assigned to incident)

Deputy Directors Group

Operations Managers Group

Field Operations Supervisor Group

Special Operations Group

SWAT Group

Public Information Officer

Appendix A

Miscellaneous Forms

Vehicle Maintenance Notification

Place in 'Forms' Section

Purpose: To improve the reliability and comfort of the vehicles you operate every day through improved reporting to Fleet Maintenance.

Directions: Please complete this form at the end of your shift and deliver to the OA who will assure that Fleet Maintenance is notified.

How did your vehicle perform today?

_____ ***Normal and without any noted mechanical problems or issues***

_____ ***Unit has mechanical issues or needs as identified below (Describe)***

Unit #_____CC:_____/ NCC_____Date/Time_____

List a phone number and best time to call you if fleet has questions: _____

Category	Good	Problem	Define Problem or Symptoms
Engine			
Transmission			
Suspension (ride) *(Circle One)* Front or Rear?			
Steering			
Brakes			
Tires			
Electrical			
A/C or **Heaters** *(Circle One)* **Front** or **Rear**?			
Lights			
Equipment			

MEDIC
Mecklenburg EMS Agency

Lost and Damaged Report

Date: _____ Incident Date: _____
CC/TL _____ NCC _____
Vehicle # _____ Report # _____
Call # _____ Police Report (if applicable) _____
Critical Equipment Failure? Y__ N__ Transport Delayed? Y__ N__
Asset Number: _____ Input into IQ? _____
Mask kit # _____
Supervisor notified: _____
Follow-up by: _____
Explanation:

_____
_____
_____
_____
_____
_____
_____

_____

Crew Name: _____ Signature: _____ Date: _____
Crew Name: _____ Signature: _____ Date: _____
OST Name: _____ Signature: _____ Date: _____

Supervisor Notified _____ at time _____

MEDIC
Mecklenburg EMS Agency

Monitor Complaint Form

Date: _____ **Vehicle #** ____ Monitor # _____ **Run #**_____

Crew Chief _____ **Contact # / Email** _____

Supervisor Notified? Y___ N___ **Supervisor Name**: _____

Item Lost/Damaged _____

Failure Complaint _____

Explanation _____

_____

_____

_____

Failure / Lost or Damaged (Circle items)

- 4 Lead / 12 Lead
- Trunk Cable
- BP Cuff
- Adult SpO2
- Pediatric SpO2
- Printer
- QCPR Puck
- Therapy Cable for Pads
- Charging Cable
- Charging / Battery
    1. Battery A # _____
    2. Battery B # _____
- ETCO2
- Case
- Screen
- EOS Unable to Transmit
- Mounting Bracket

(Steps taken to troubleshoot failure)

_____

_____

_____

_____

_____

_____

Support Services Only

Serial # _____

Case # _____

To help resolve issues please email any photos and/or detailed explanation of failure to: DustyE@medic911.com and CharlesG@medic911.com

A-7

Support services Only

Repair Technician _____
Resolution: Confirmed Complaint _____
Unable to Duplicate _____
Date _____

Notes:

MEDIC Field Operations Supervisor Shift Report

- **Each shift will have an assigned Field Group Supervisor (FGS). The FGS is responsible for coordinating pre-determined aspects of the shift to support even workload amongst their peers and documenting pertinent shift operations items on the daily ICS 214 Activity Log. At the end of the FGS's shift, the 214 and any associated documentation will be emailed to the Operations Management Team and Deputy Director of Operations (and any additional as required by OMT).**

ACTIVITY LOG (ICS 214)

1. Incident Name:	2. Operational Period: Date From: Time From:	Date To: Time To:
3. Name:	4. ICS Position:	5. Home Agency (and Unit):

6. Resources Assigned:

Name	ICS Position	Home Agency (and Unit)

7. Activity Log:

Date/Time	Notable Activities

8. Prepared by: Name: _____ Position/Title: _____ Signature: _____

ICS 214, Page 1 of _____ Date/Time: _____

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Appendix B

Additional Policy Reference

Additional Policies located on intranet (My Medic)

Agency Handbook

Risk and Safety

Personal Protective

Equipment

Respiratory

Protection

On the Job Injuries

Exposure Control Plan

Hazard Communications

Appendix M

MCI Plan

MASS CASUALTY INCIDENT MANAGEMENT PLAN

CHARLOTTE-MECKLENBURG COUNTY, NORTH CAROLINA

09102008.2mwsF

PREFACE

This manual is published by Mecklenburg EMS Agency and is intended as the primary reference and standard operating guideline for response, training, and guidance of emergency medical, fire, and rescue personnel in the management of mass casualty incidents.

This plan is purposely structured to work in concert with the Charlotte-Mecklenburg All Hazard Plan, the North Carolina Office of EMS, Region F Disaster Plan, and the Emergency Department Disaster Plans for the Carolina's Medical Center (Charlotte region's Level I Trauma Center) and Presbyterian Hospital.

All Agency employees that will be involved in the management of an incident must complete the following FEMA online coursework:

IS-100 (ICS 100) Introduction to the Incident Command System, I-100
IS-200 (ICS-200) ICS for Single Resources and Initial Action Incidents
IS-700 National Incident Management System (NIMS), an Introduction

Agency senior staff and supervisors that will be involved in the management of an incident must complete the following additional FEMA coursework:

IS-300 (ICS-300) Intermediate Incident Command System
IS-400 (ICS-400) Advanced Incident Command System
IS-800.B The National Response Framework, An Introduction

INCIDENT COMMAND SYSTEM

The command function must be clearly established from the beginning of incident operations. The agency with primary jurisdictional authority over the incident designates the individual at the scene responsible for establishing command. When command is transferred, the process must include a briefing that captures all essential information for continuing safe and effective operations.

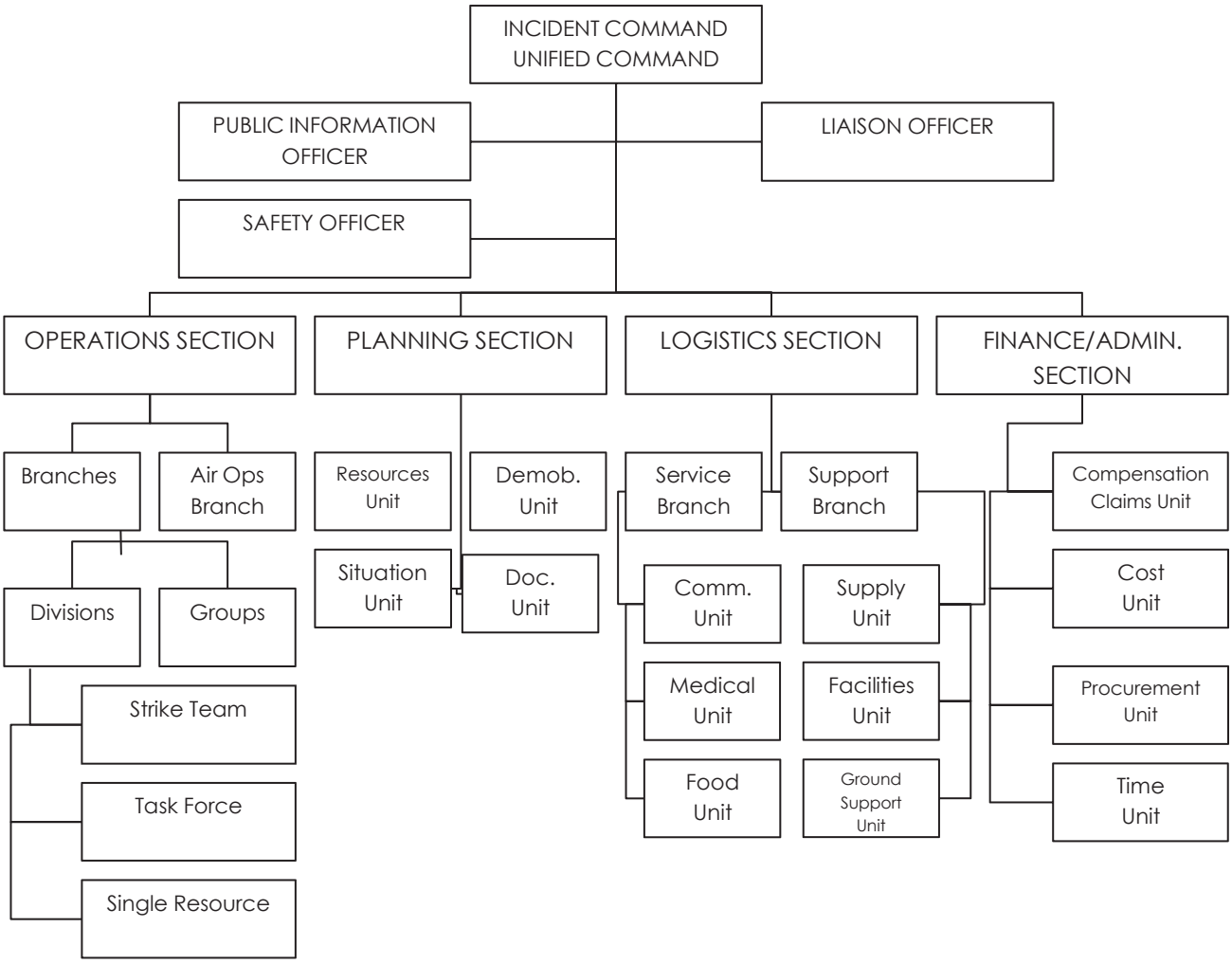
In incidents involving multiple jurisdictions, a single jurisdiction with multiagency involvement, or multiple jurisdictions with multiagency involvement, unified command allows agencies with different legal, geographic, and functional authorities and responsibilities to work together effectively without affecting individual agency authority, responsibility, or accountability.

The Charlotte-Mecklenburg All Hazard Plan requires the use of a Unified Command for incident management.

Unified Command (UC) is an important element in multiagency domestic incident management. It provides guidelines to enable agencies with different legal, geographic, and functional responsibilities to coordinate, plan, and interact effectively. As a team effort, UC overcomes much of the inefficiency and duplication of effort that can occur when agencies from different functional or levels of government operate without a common system or organizational framework. All agencies with functional responsibility for any or all aspects of an incident and those able to provide specific resource support participate in the UC structure and contribute to the process of determining overall incident strategies; selecting objectives; ensuring that joint planning for tactical activities is accomplished in accordance with approved incident objectives; ensuring the integration of tactical operations; and approving, committing, and making optimum use of all assigned resources. The exact composition of the UC structure will depend on the location(s) of the incident (i.e., which geographical administrative jurisdictions are involved). In the case of some multijurisdictional or multi-agency incidents, the designation of a single Incident Commander (IC) may be considered to promote greater unity of effort and efficiency. The additional agency representatives shall be designated as Deputy Incident Commanders and be fully capable to assume the Incident Commander role upon a change in the incident.

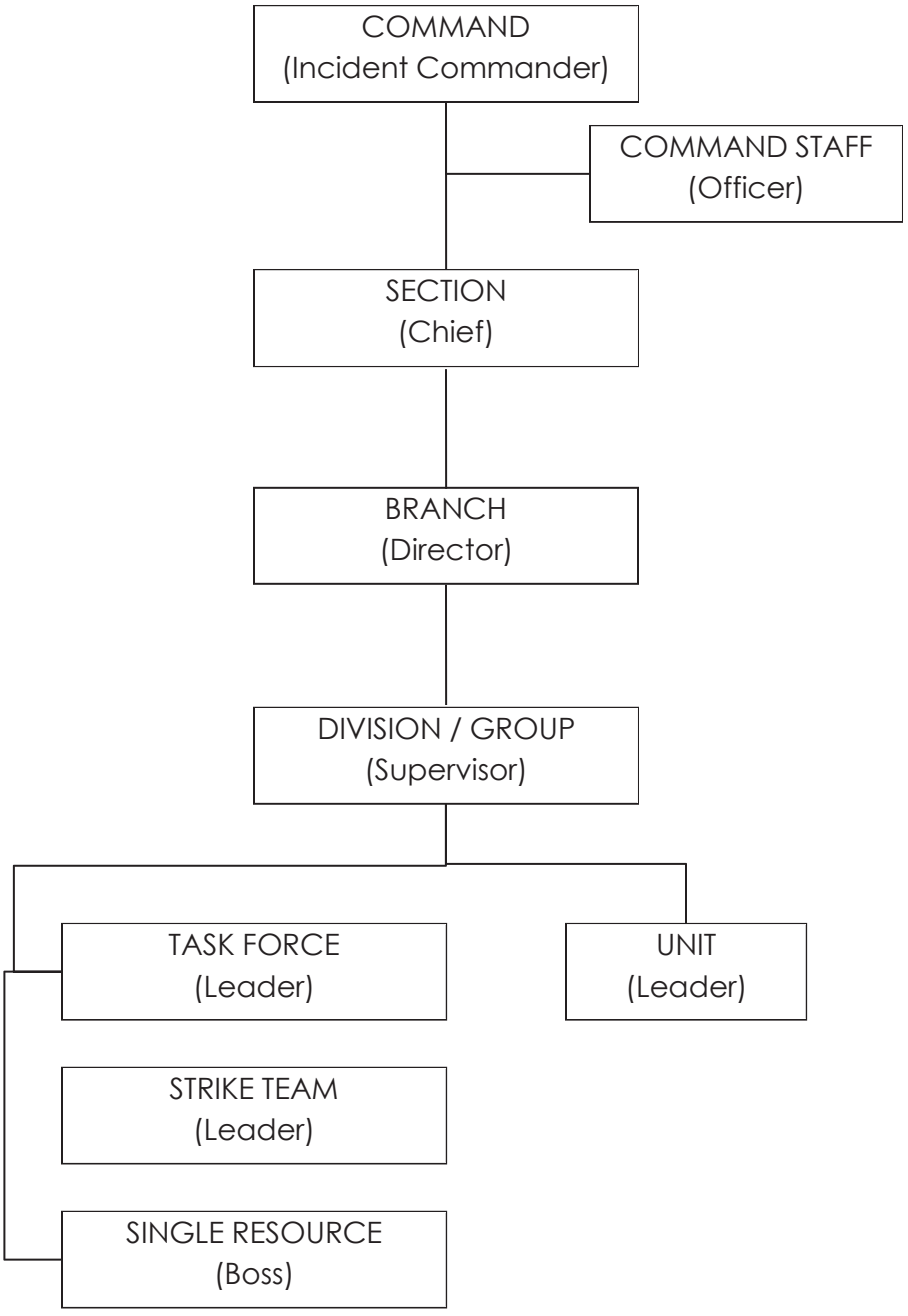
Advantages of Using Unified Command

- A single set of objectives is developed for the entire incident.
- A collective approach is used to develop strategies to achieve incident objectives.
- Information flow and coordination is improved between all agencies involved in the incident.
- All agencies with responsibility for the incident have an understanding of joint priorities and restrictions.
- No agency's legal authorities will be compromised or neglected.
- The combined efforts of all agencies are optimized as they perform their respective assignments under a single Incident Action Plan (IAP)



ICS Organizational Components

POSITION and (Title) ICS structure under NIMS



SCOPE AND PURPOSE

This Mass Casualty Incident (MCI) Management Plan is intended to address techniques in field operations that must be employed when the number of patients exceeds immediately available resources. In addition, it serves as the basis for routine operations. The key elements for successfully managing any incident are command, control, and coordination.

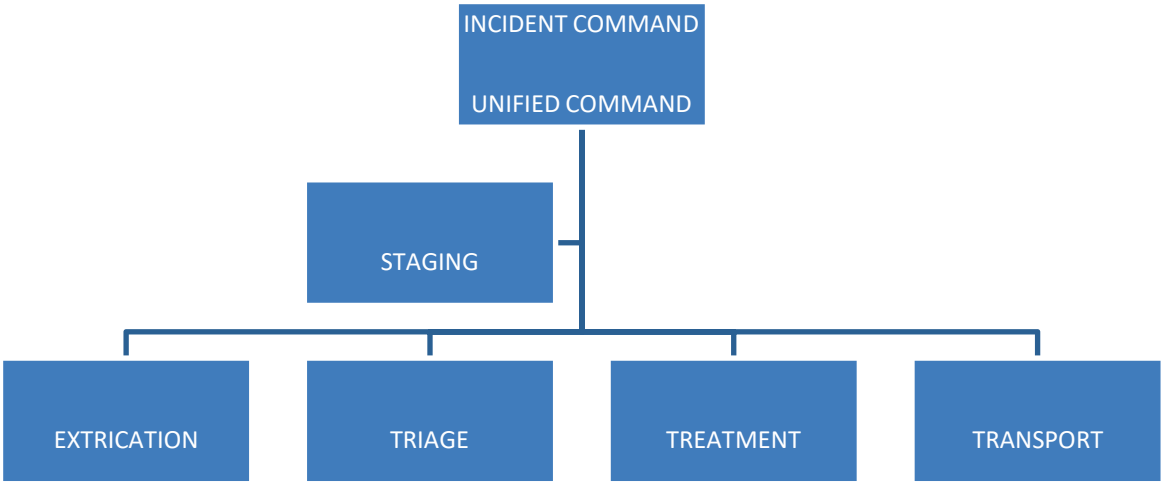
This plan standardizes operations during mass casualty incidents. It is intended to be an "all hazards" plan to meet the needs of any MCI regardless of the incident's cause. If necessary, these procedures can be modified based on the number of patients, the cause or severity of injuries, and for special circumstances involved in the incident.

Mass Casualty Incidents response will initially be determined by the number of patients. The first arriving unit (fire, rescue, or EMS) will, as part of the initial size up, estimate what EMS resources will be needed based on the categories below.

- **MCI Level 4** (3-10 Priority 1 [red]/Priority 2 [yellow] victims)
  - 5 Ambulances
  - 12 First Responder personnel (3 CFD companies)
  - 1 EMS Supervisor
- **MCI Level 3** (11-20 [regardless of priority] victims)
  - 10 Ambulances
  - 20 First Responder personnel (5 CFD companies)
  - 2 EMS Supervisors
  - 1 MCI unit (Medic 701)
  - 1 MCET Bus (Medic 702 **or** 703)
- **MCI Level 2** (21-100 [regardless of priority] victims)
  - 15 Ambulances
  - 36 First Responder personnel (9 CFD companies)
  - 3 EMS Supervisors
  - 1 MCI Unit (Medic 701)
  - 2 MCET Buses (Medic 702 and 703)
- **MCI Level 1** (101-1000+ [regardless of priority] victims)
  - 20 Ambulances
  - 52 First Responder personnel (13 CFD companies)
  - 5 EMS Supervisors
  - 1 MCI Unit (Medic 701)
  - 2 MCET Buses (Medic 702 and 703)

MCI Level 4 (3-10 Priority 1 [red]/Priority 2 [yellow] victims)

At a small incident involving just a few patients, COMMAND may also assume the MEDICAL and the STAGING functions.

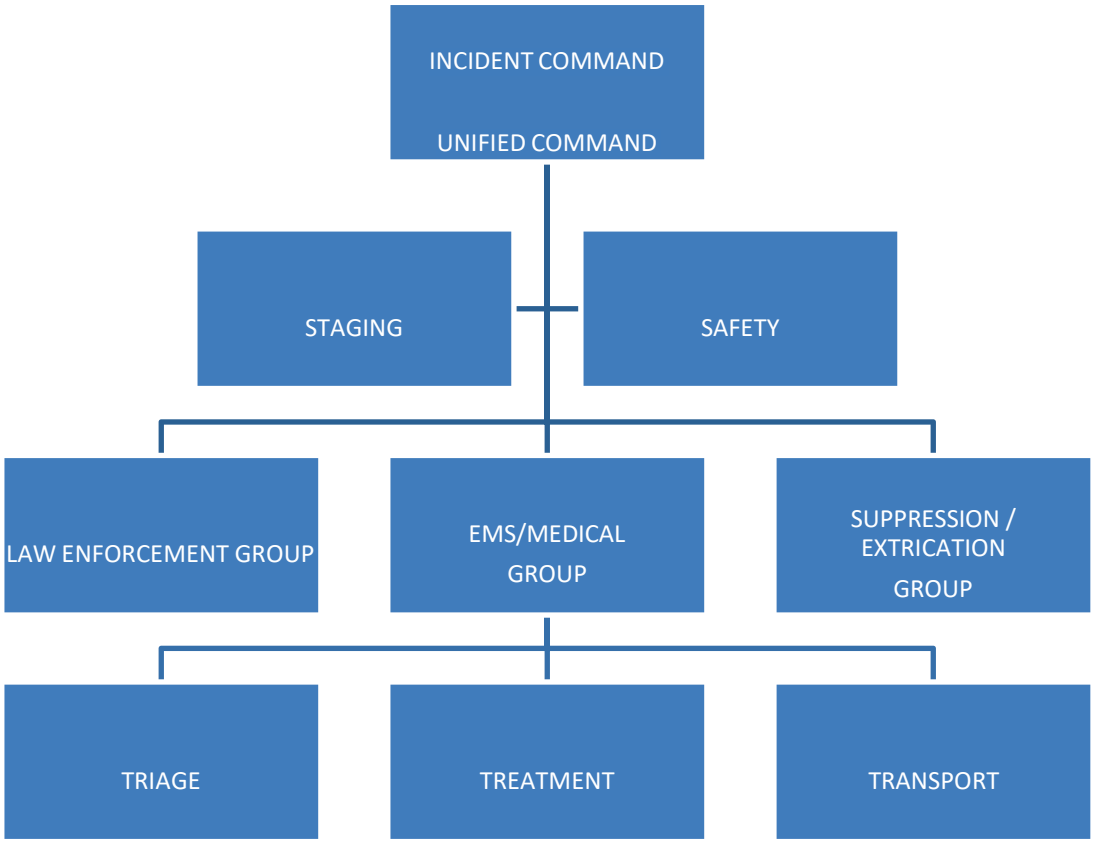


This depicts a typical response to a small incident.

This scale of incident can be managed by an incident commander and the designated functions of STAGING, EXTRICATION, TRIAGE, TREATMENT, and TRANSPORTATION. In a small incident, one person may assume more than one function, i.e. TRIAGE and TREATMENT may be done by the same person or TRANSPORTATION and STAGING can be handled by the same person. As trained MCI management personnel become available, these positions should be filled. As the incident unfolds, the command structure must expand.

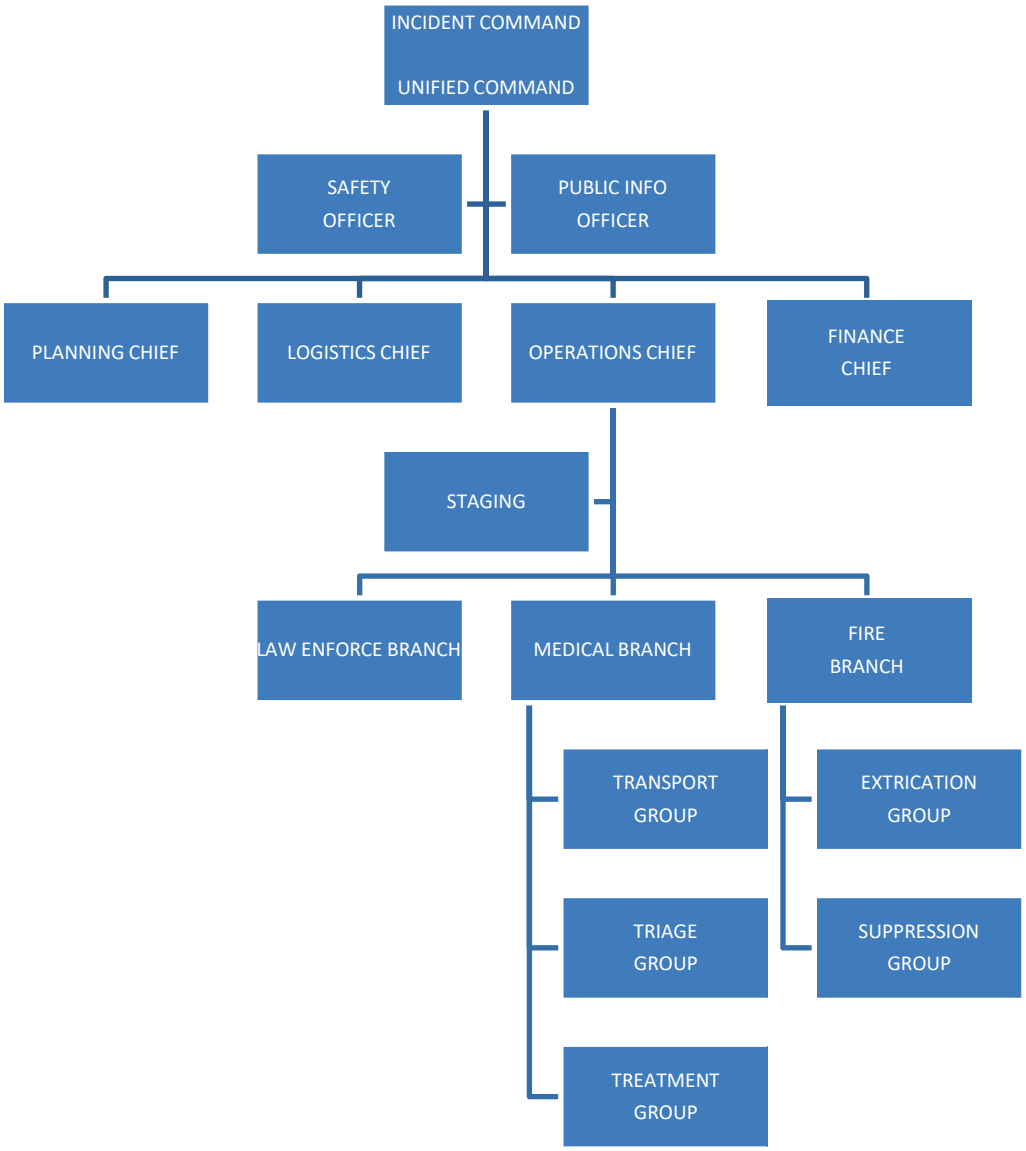
MCI Level 3 (11-20 [regardless of priority] victims)

At expanded/extended medical incidents, the INCIDENT COMMANDER or OPERATIONS SECTION CHIEF would appoint someone to manage the “MEDICAL” function.
This chart depicts a larger or expanded medical incident with a fully deployed medical group.



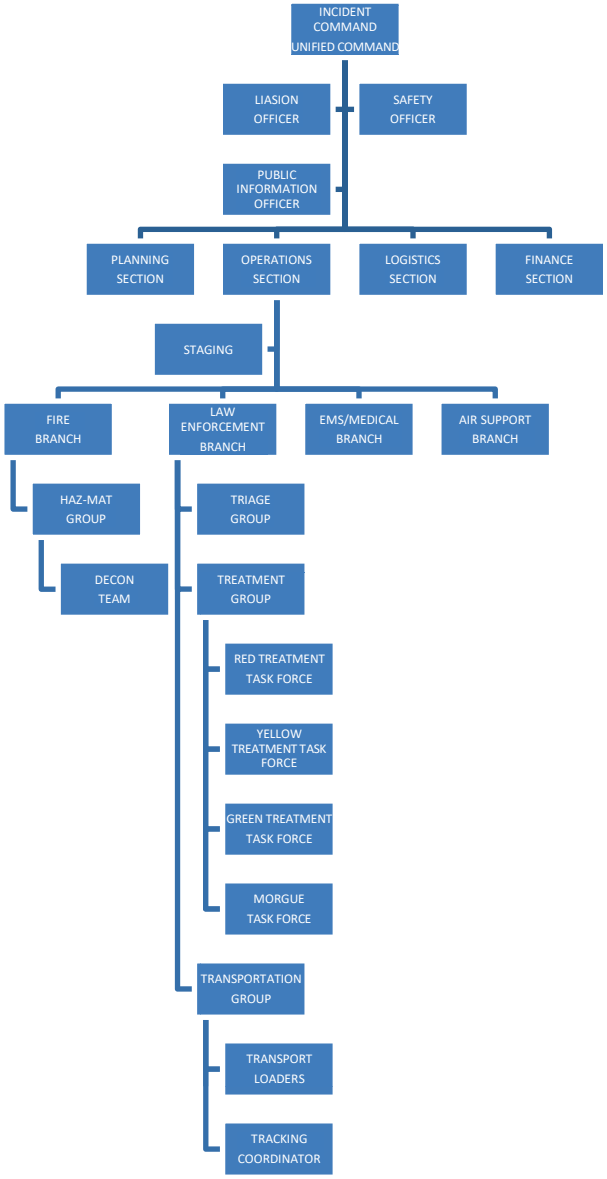
MCI Level 2 (21-100 [regardless of priority] victims)

An even larger or major medical incident may require the addition of functions such as PLANNING, LOGISTICS, and FINANCE. This may be dictated by incidents covering large areas or of extended duration. This chart depicts a major medical incident.



MCI Level 1 (100-1000+ [regardless of priority] victims)

In the event of a medical disaster involving greater than one hundred patients, the command structure would expand to look like the chart below. This allows for components from outside Mecklenburg County to fill standardized functions. This also allows for proper management of the incident.



Concept of MCI Levels

In an effort to make this document compliant with the National Incident Management System (NIMS), MCI Levels have been integrated to allow for scalability. Depending upon time of day and day of the week, Mecklenburg EMS Agency (MEDIC) may be capable of managing larger numbers of patients without mutual aid from outside EMS Agencies.

Single resources will be requested from dispatch (CMED) and told to report to staging, where they may be assembled into larger resources.

This leaves the Incident Commander or the Operations Chief to manage the number of Ambulances assembled. As patients are transported, units should be directed by the Transport Group on whether they should clear the hospital then return to staging or clear and return to the system. The capacity to assemble Strike Teams will be limited by available resources and by the time needed to deploy them. The Incident Commander must practice scarce resource management. State and Federal resources should be requested as soon as their need is identified.

EMS efforts in a mass casualty incident will begin small and expand to meet the needs of the incident. The first arriving unit (fire, rescue, or EMS) should establish Incident Command. That unit should assess scene **Safety**, conduct a scene **Size-up** and **Send** that information to communications over the radio, then begin to **Set up** (triage and treatment areas), and **START** Triage. This will ensure that Staging, Triage, Treatment, and Transportation functions are implemented as needed. In a larger incident, Incident Command may establish a Medical Group or Medical Branch to oversee some or all of the above functions.

Some incidents may be so large, or the sense of danger so pervasive (such as a terrorist incident), that victims may not wish to remain on the scene and will self-refer to known medical facilities. During such incidents, EMS triage and treatment resources may have to be co-located at hospitals, assembled at multiple points, and/or situated remotely out of harm's way.

Communications (CMED) Responsibilities

Once the first arriving unit (Fire, EMS, or Rescue) establishes command and declares an MCI, CMED will dispatch the appropriate resources for the level of MCI declared based on the response matrix guide (see attachment to this plan).

CMED will also multi-select all the Mecklenburg County hospital talkgroups and establish communications with each hospital. Upon verification that all hospitals are monitoring, CMED will announce that an MCI has been declared, giving the MCI level and size up information from the first arriving unit. CMED will then advise all hospitals to be prepared to advise the approximate number of patients by priority that their facility can handle when they are recalled. Here is an example of the hospital notification:

"CMED to all Mecklenburg County hospitals, this is a level 3 MCI notification, I repeat a level 3 MCI notification. Units are currently on the scene of a traffic accident involving 14 vehicles; no further information is available at this time. Units on scene have declared a level 3 MCI. In approximately five minutes, be prepared to advise the number of patients by priority that your facility can handle. CMED will contact you on the radio to obtain this information shortly. No further information is available at this time, CMED clear".

CMED should then contact each hospital individually on their talkgroup to obtain their information. This should be recorded on the hospital tally sheet (attachment to this plan). Once all hospitals have reported their information, CMED should notify the EMS GROUP / BRANCH (if none then COMMAND) that hospital information is available. Someone will then be assigned to collect the information from CMED.

For hospitals that are not operating on a radio talkgroup (currently Gaston Memorial, CMC-Union, Lake Norman Regional, Piedmont Medical, and CMC-Northeast) CMED should notify them via telephone of the incident and request they contact CMED with the information needed as soon as possible.
By having communications announce and collect this important information, it allows the resources on the scene to focus on proper management of the MCI.

As an incident grows in size, CMED should be prepared to utilize additional operations channels for specific functions. There may be a need for a command channel, a triage and treatment channel, as well as a transport channel. Each incident will dictate the need for additional talkgroups.

Hospital Responsibilities

When notified of an MCI, hospital personnel should refer to this guidebook as a source for information on the number of potential victims. Hospitals should follow their disaster plans based on the information provided.

Communications (CMED) will contact each hospital; they will not be able to provide *detailed information*. They will only be able to provide a brief incident description. Hospital personnel must follow the instructions provided by CMED and should take no longer than five minutes to gather the information that is requested. Someone should remain at the radio or phone in case further information is provided or needed to assist with the proper response to the incident in progress.

Each hospital will be contacted when a unit departs the scene with a patient enroute to their location. This contact will not be made by the unit transporting (unless specific medical orders are required). You will get a brief report of the patient's primary complaint and priority by the Tracking Coordinator position (TRACKING) who is located at the incident scene.

Hospitals must ensure a quick transfer of the patient from the ambulance to the hospital so that the unit can return to service as quickly as possible.

BASIC PRINCIPALS

Mass Casualty Incident Management Goals

1. **Do the greatest good for the greatest number.**
2. **Make the best use of personnel, equipment, and facility resources.**
3. **Do not relocate the disaster.**

Standard Triage Methods

The method of initial field triage to be utilized is the **START** (Simple Triage and Rapid Treatment) method for adult patients. Pediatric patients, ages 8 and under, will be better served by using **JumpSTART**.

Ambulatory patients are initially directed to a designated treatment area where they will be assessed, and secondary triage performed as personnel become available. For all remaining patients, triage personnel quickly move from patient to patient, using **START** to apply color-coded triage tags.

Triage Categories

PRIORITY 3 Green Triage Tag Color

- Victim with relatively minor injuries
- Status unlikely to deteriorate over days.
- May be able to assist in own care: "Walking Wounded."

PRIORITY 2 Yellow Triage Tag Color

- Victim's transport can be delayed.
- Includes serious and potentially life-threatening injuries, but status not expected to deteriorate significantly over several hours.

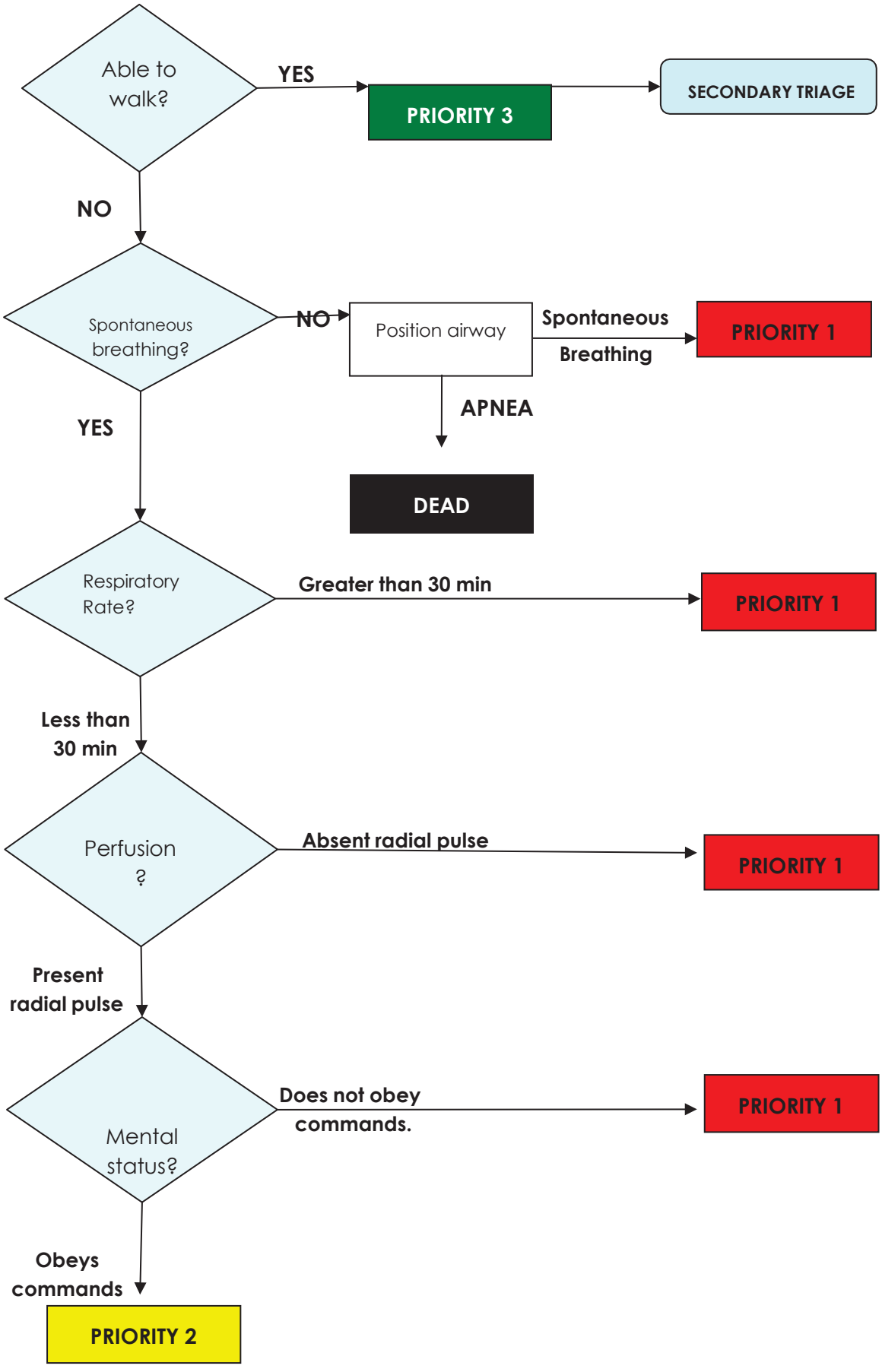
PRIORITY 1 Red Triage Tag Color

- Victim can be helped by immediate intervention and transport.
- Requires medical attention within minutes for survival (up to 60)
- Includes compromises to patient's Airway, Breathing, Circulation

DEAD Black Triage Tag Color

- Victim unlikely to survive given severity of injuries, level of available care, or both.
- Palliative care and pain relief should be provided.

START Multiple Casualty Triage



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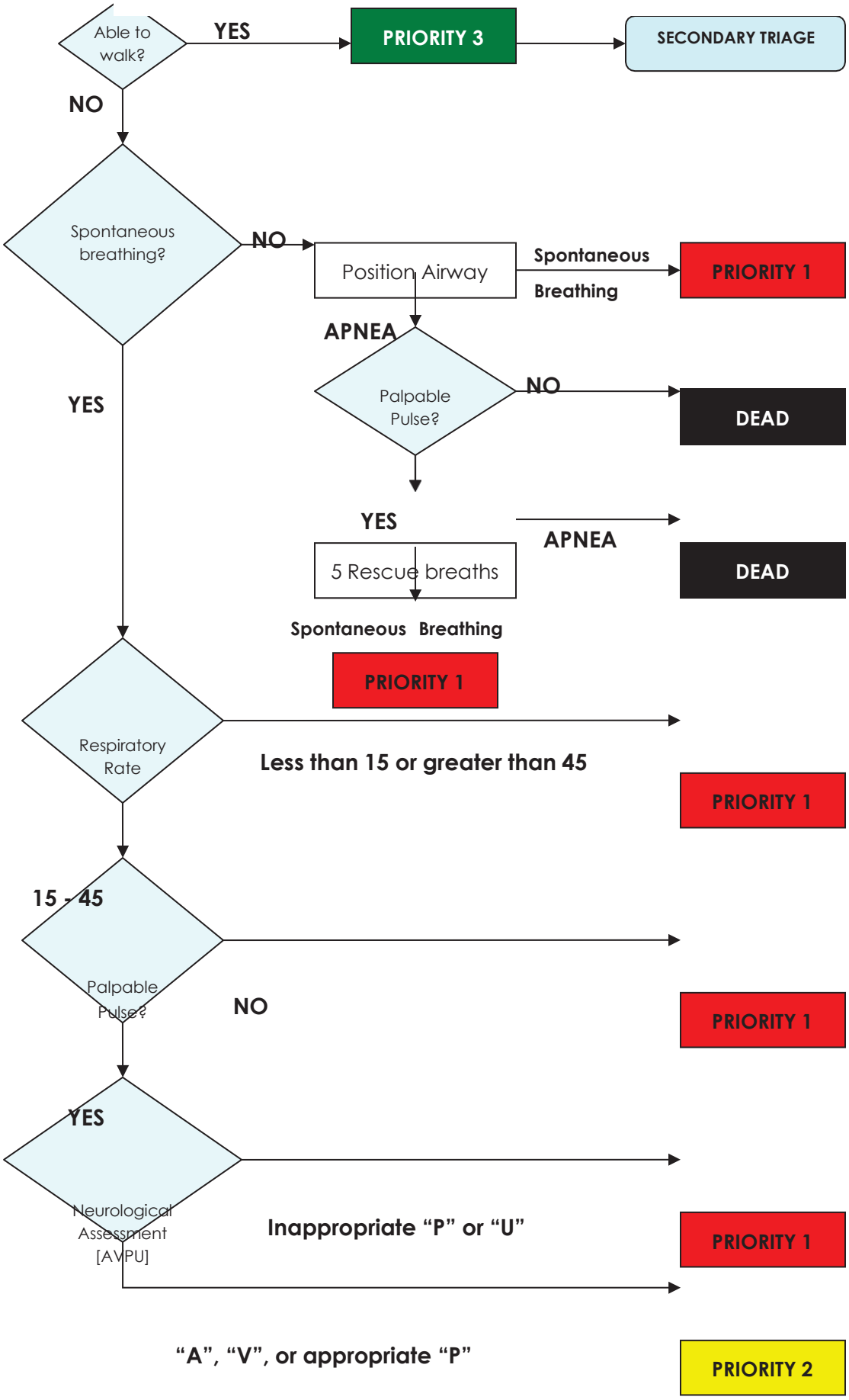
JumpSTART Multiple Casualty Triage



Mass Casualty Patient Flow

The Incident Scene

Ambulatory patients are directed to a safe place as soon as one is identified.
(Green Treatment Area)

- Those who are able should be asked to assist with others.
- Self-treatment supplies should be distributed.

All victims are accounted for; trapped victims are rescued or extricated.

- Patients are accounted for and quickly triaged (**START**).
- Triage tags are applied.

Non-ambulatory patients are removed from the scene to the Treatment Area by triage personnel after triage has been completed.

Patients are decontaminated (as needed) prior to leaving the incident scene, prior to arrival in the Treatment Area.

Deceased victims are left as they are unless they must be moved to access live patients.

The Treatment Area

Patients are continuously reevaluated (re-triaged) using the secondary triage method.

Patients arriving from the incident scene are prioritized for treatment using the SMARTTAG© **secondary triage** method and the triage tag is updated if needed.

Patients are placed in the Treatment Area and emergency medical care is provided on the basis of triage priority.

- Separate areas may be created in the Treatment Area for PRIORITY 1 (RED), PRIORITY 2 (YELLOW), and PRIORITY 3 (GREEN) patients.
- A separate isolated area (Temporary Morgue) is created for victims who die in the Treatment Area. This area should not be visible and must not be located near the PRIORITY 3 treatment area.

Personnel, equipment, and medical care resources are allocated to patients based on triage priority.

The Transportation Area

Emergency Departments are contacted (early in the incident by communications) to obtain information to assist with the most appropriate patient distribution to medical facilities.

Transportation resources are assigned based on triage priority.

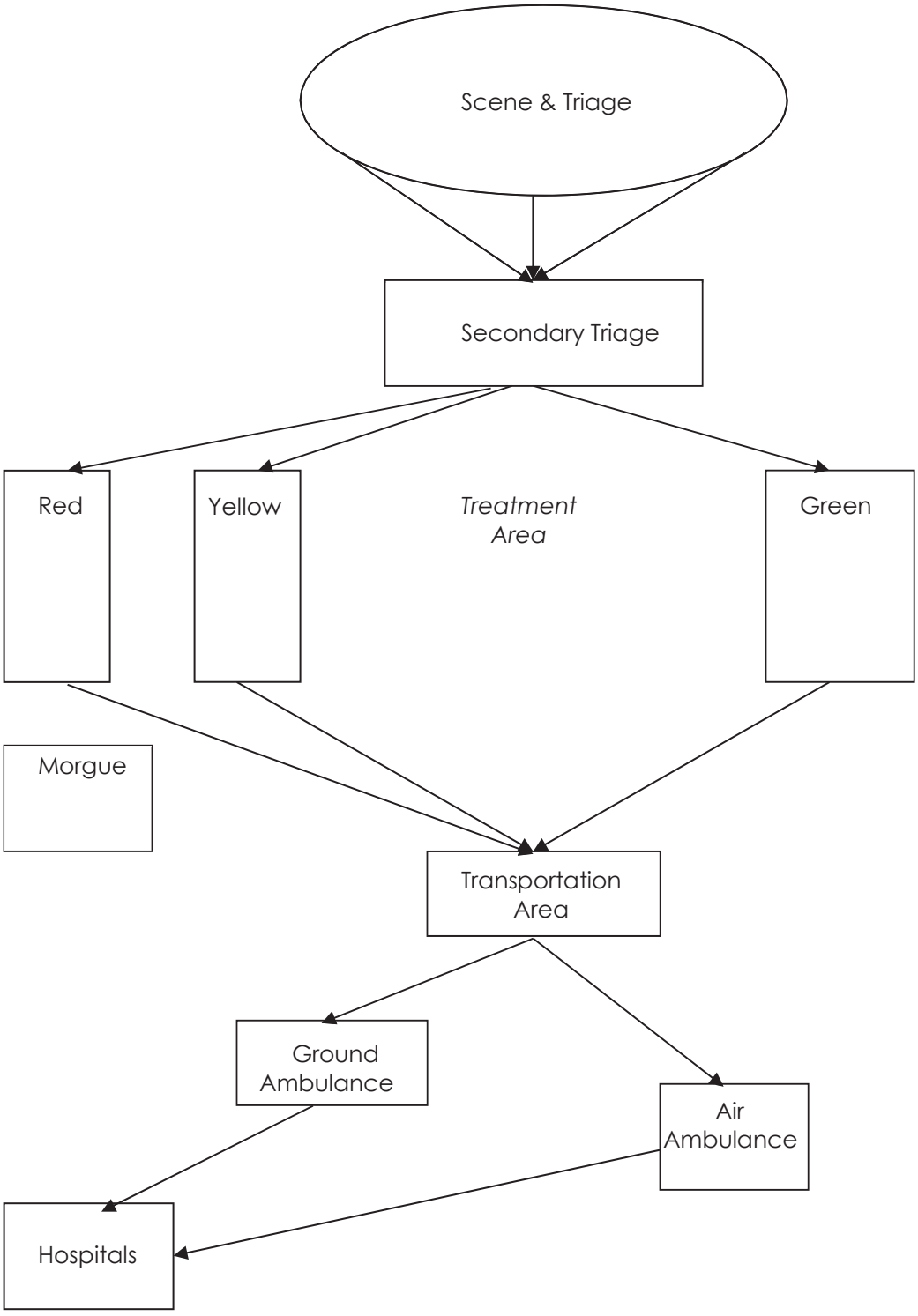
Patients are moved to the Transportation Area to the appropriate vehicle by Transport Loaders.

The Tracking Coordinator is established to provide patient priority, type, and estimated time of arrival to destination hospitals. Units transporting patients from the incident **will not** give patient reports to their destination facility.

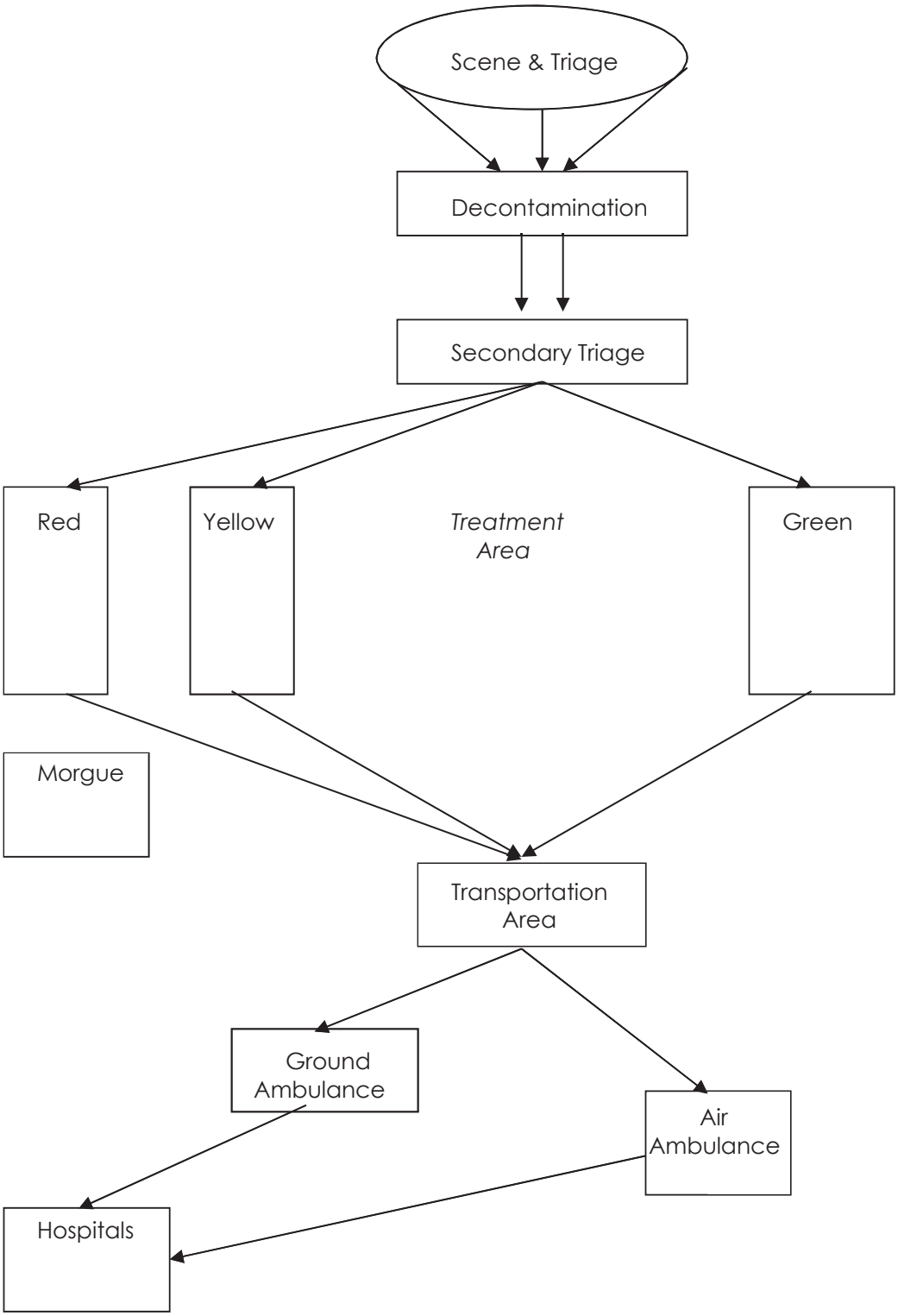
Patients are transported to the most appropriate medical facility by the most appropriate means available. Emergency medical care is continued enroute to the hospital.

All patient movements are documented. A patient care report must be started for each patient that is transported. The identification number from the SMARTTAG© triage tag should be entered in the appropriate location on the patient care report. Demographics and patient care documentation can be entered at a later time provided they are documented on the SMARTTAG© triage tag.

Patient Flow Diagram



Contaminated Patient Flow Diagram



FIRST AGENCY ON SCENE
(FIRE, RESCUE, OR EMS)

First Agency on scene should switch from the role of care giver and provide incident management. They then give a visual size-up, assume and announce command, and confirm the incident location, then the 5 S's:
[Once command has been established, all additional resources must get their assignment from the INCIDENT COMMANDER]

SAFETY assessment: Assess the scene observing for:

- Electrical hazards.
- Flammable liquids.
- Hazardous Materials.
- Weapons of Mass Destruction (CBRNE)
- Other life-threatening situations.
- Be aware of the potential for secondary explosive devices.

SIZE UP the scene: How big and how bad is it? Survey incident scene for:

- Type and/or cause of incident.
- Approximate number of patients.
- Severity level of injuries (either Major or Minor).
- Area involved, including problems with scene access.

SEND information:

- Contact dispatch with your size-up information.
- Request additional resources.

SETUP the scene for management of the casualties:

- Establish staging area.
- Identify access and egress routes.
- Identify adequate work areas for Triage, Treatment, and Transportation.

START (**S**imple **T**riage **And R**apid **T**reatment) and **JumpSTART** (for pediatric patients).

- Begin where you are.
- Ask anyone who can walk to move to a designated area.
- Use triage tags to mark patient priority.
- Move quickly from patient to patient.
- Maintain patient count by triage color.
- Provide minimal treatment.
- Keep moving!

Remember…. Establish COMMAND, **S**AFETY, **S**URVEY, **S**END, **S**ET-UP, AND **START**/**JumpSTART**
Command should be transferred upon the arrival of a more qualified person. This can be done via radio or by a face-to-face meeting.

Key Terms and Definitions

Advanced Life Support (ALS): When referring to an ambulance from outside Mecklenburg County, operating at the EMT-Intermediate level and above. Mecklenburg County ambulances would be EMT-Paramedic level.

Ambulance: A vehicle capable of transporting patients from the scene. It could be BLS or ALS depending upon the staff supplied.

Assessment: The evaluation and interpretation of measurements and other information to provide a basis for decision-making.

Assignments: Tasks given to resources to perform within a given operational period that are based on operational objectives defined in the IAP.

Assistant: Title for subordinates of principal Command Staff positions. The title indicates a level of technical capability, qualifications, and responsibility subordinate to the primary positions. Assistants may also be assigned unit leaders.

Available Resources: Resources assigned to an incident, checked in, and available for a mission assignment, normally located in a Staging Area.

Basic Life Support (BLS): When referring to an ambulance, EMT-Basic level only.

Branch: The organizational level having functional or geographical responsibility for major aspects of incident operations. A branch is organizationally situated between the section and the division or group in the Operations Section, and between the section and units in the Logistics Section. Branches are identified by the use of Roman numerals or by functional area (Medical Branch, Fire Branch, Law Enforcement Branch).

Chain of Command: A series of command, control, executive, or management positions in hierarchical order of authority.

Check-In: The process through which resources first report to an incident. Check-in locations include the incident command post, Resources Unit, incident base, camps, staging areas, or directly on the site.

Chief: The ICS title for individuals responsible for management of functional sections: Operations, Planning, Logistics, Finance/Administration, and Intelligence (if established as a separate section).

Command: The act of directing, ordering, or controlling by virtue of explicit statutory, regulatory, or delegated authority.

Command Staff: In an incident management organization, the Command Staff consists of the Incident Command and the special staff positions of Public Information Officer, Safety Officer, Liaison Officer, and other positions as required, who report directly to the Incident Commander. They may have an assistant or assistants, as needed.

Demobilization Unit Leader: This ICS position reports to the Planning Section Chief and oversees demobilization of non-essential resources once released by the Operations Section Chief back to the staging area.

Deputy: A fully qualified individual who, in the absence of a superior, can be delegated the authority to manage afunctional operation or perform a specific task. In some cases, a deputy can act as relief for a superior and, therefore, must be fully qualified in the position. Deputies can be assigned to the Incident Commander, General Staff, and Branch Directors.

Division: The partition of an incident into geographical areas of operation. Divisions are established when the number of resources exceeds the manageable span of control of the Operations Chief. A division is located within the ICS organization between the branch and resources in the Operations Section.

Engine Company: A Fire apparatus consisting of firefighters, one of which is assumed to be qualified as a company level officer. In an MCI event the Engine Company can expect to be used both as manpower and to perform patient care to their level of training. There should be an expectation that they will be broken up into Individual Resources at the discretion of Command.

Function: Function refers to the five major activities in ICS: Command, Operations, Planning, Logistics, and Finance/Administration. The term function is also used when describing the activity involved, e.g., the planning function. A sixth function, Intelligence, may be established, if required, to meet incident management needs.

General Staff: A group of incident management personnel organized according to function and reporting to the Incident Commander. The General Staff normally consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief, Finance/Administration Section Chief, and Intelligence Section Chief.

Group: Established to divide the incident management structure into functional areas of operation. Groups are composed of resources assembled to perform a special function not necessarily within a single geographic division. Groups, when activated, are located between branches and resources in the Operations Section.

Hazard: Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome.

Incident: An occurrence or event, natural or human-caused, that requires an emergency response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, wildland and urban fires, floods, hazardous material spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response.

Incident Action Plan: An oral or written plan containing general objective reflecting the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide directions and important information for management of the incident during one or more operational periods.

Incident Command Post (ICP): The field location at which the primary tactical-level, on-scene incident command functions are performed. The ICP may be collocated with the incident base or other incident facilities and is normally identified by a green rotating or flashing light.

Incident Command System (ICS): A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

Incident Commander (IC): The individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site.

Initial Action: The actions taken by those responders first to arrive at an incident site.

Initial Response: Resources initially committed to an incident.

JumpSTART Triage: A system that allows field care personnel to triage pediatric patients aged 1-8 years into one of four categories:
Priority 1 (RED), Priority 2 (YELLOW), Priority 3 (GREEN), Dead (BLACK)

Ladder Company: For the purposes of this document, see Engine Company.

Liaison Officer: A member of the Command Staff responsible for coordinating with representatives from cooperating and assisting agencies.

Logistics Section: The section responsible for providing facilities, services, and material support for the incident.

Multi-Casualty Incident: An incident in which the combination of numbers of injured victims and type of injuries go beyond the capability of an entity's normal first response.

Operational Period: The time scheduled for executing a given set of operation actions, as specified in the Incident Action Plan (IAP). Operational periods can be of various lengths, although usually not over 24 hours.

Operations Section: The section responsible for all tactical incident operations. In ICS, it normally includes subordinate branches, divisions, and/or groups.

Personnel Accountability: The ability to account for the location and welfare of incident personnel. It is accomplished when supervisors ensure that ICS principles and processes are functional and that personnel are working within established incident management guidelines.

Planning Section: Responsible for the collection, evaluation, and dissemination of operational information related to the incident, and for the preparation and documentation of the IAP. This section also maintains information on the current and forecasted situation and on the status of resources assigned to the incident.

Public Information Officer: A member of the Command Staff responsible for interfacing with the public and media or with other agencies with incident-related information requirements.

Rescue Company: For the purposes of this document, see Engine Company. Sometimes referred to as a Squad.

Resources: Personnel and major items of equipment, supplies, and facilities available or potentially available for assignment to incident operations and for which status is maintained. Resources are described by kind and type and may be used in operational support or supervisory capacities at and incident.

Resource Unit Leader: This ICS position works for the Planning Section Chief and tracks all resources on the scene. When additional resources are ordered, the Incident Commander shall notify the Planning Section Chief who will advise the Resource Unit Leader so tracking of these resources can be established once they arrive on scene.

Safety Officer: A member of the Command Staff responsible for monitoring and assessing safety hazards or unsafe situations and for developing measures for ensuring personnel safety.

Secondary Triage: The patients GCS score, Respiratory rate, and Systolic Blood Pressure as outlined on the SMART tag. The total of the scores places the patient into triage categories.

Section: The organizational level having responsibility for a major functional area of incident management, e.g., Operations, Planning, Logistics, Finance/Administration, and Intelligence (if established). The section is organizationally situated between the branch and the Incident Command.

Situation Unit Leader: This ICS position reports to the Planning Section Chief and is responsible for the collection of information to provide the Incident Commander with the most up to the minute situational awareness.

SMART Tag: Triage tag system adopted for statewide use by the North Carolina Office of Emergency Medical Services. Utilizing START and JumpSTART methods of initial patient triage as well as a secondary triage system.

Span of Control: The number of individuals a supervisor is responsible for, usually expressed as a ration of supervisors to individuals. (Under NIMS, an appropriate span of control is between 1:3 and 1:7).

Staging Area: Location established where resources can be placed while awaiting a tactical assignment. The Operations Section manages Staging Areas.

START Triage: acronym for Simple Triage And Rapid Treatment. This is the initial triage system that has been adopted for use by Mecklenburg EMS Agency that allows field care personnel to triage patients greater than 8 years of age into one of four categories:
Priority 1 (RED), Priority 2 (YELLOW), Priority 3 (GREEN), Dead (BLACK)

Strike Team: A set number of resources of the same kind and type that have an established minimum number of personnel lead by a single leader. Strike Teams should be designated by their function. (Extrication Strike Team)

Task Force: Any combination of resources assembled to support a specific mission or operational need. All resource elements within a Task Force must have common communications and a single leader. Task Forces should be designated by their function. (Treatment Task Force)

Unified Command (UC): An application of ICS used when there is more than one agency with incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the UC, often the senior person from agencies and/or disciplines participating in the UC, to establish a common set of objectives and strategies and a single IAP. There is one Incident Commander designated from the discipline with the highest current priority, the remaining representatives will assume the role of Deputy Incident Commanders and be fully capable to assume the Incident Commander role when the situation changes in scope or needs.

Unit: The organizational element having functional responsibility for a specific incident planning, logistics, or finance/administration activity.

Unity of Command: The concept by which each person within an organization reports to one and only one designated person. The purpose of unity of command is to ensure unity of effort under one responsible commander for every objective.

Weapons of Mass Destruction: A weapon which can kill large numbers of humans and/or cause great damage to man-made structures, natural structures, or the biosphere in general. The term covers several weapon types, including Chemical, Biological, Radiological, Nuclear, and Explosive. (CBRNE)

POSITION: **MEDICAL or EMS**

LEVEL (TACTICAL CALLSIGN):

BRANCH DIRECTOR	**(MEDICAL BRANCH) (EMS BRANCH)**
GROUP SUPERVISOR	**(MEDICAL GROUP) (EMS GROUP)**

PERSONNEL ASSIGNED: EMS Supervisor (preferred), Paramedic, EMT, Firefighter

FUNCTION: Establish supervision and direct the activities within a medical group or branch at a multi-casualty incident (MCI)

REPORTS TO: OPERATIONS
(*if none then*)
COMMAND

SUPERVISES: TRIAGE, TREATMENT, TRANSPORT

DUTIES:

- Don Position Vest
- Read this duty checklist.
- Assess and report situation.
- Order needed resources through OPERATIONS.
- Monitor Operations/Command Channel
- Establish Medical Communications on Secondary Channel if needed.
- Assume roles until assigned.
    - TRIAGE
    - TREATMENT
    - TRANSPORT
- Collect all records from incident and forward to designated Mecklenburg EMS Agency staff.

POSITION: **TRIAGE**

LEVEL
(TACTICAL CALLSIGN):

TEAM	**(TRIAGE)**
GROUP SUPERVISOR	**(TRIAGE GROUP)**

PERSONNEL ASSIGNED: EMS Supervisor, Paramedic (preferred), EMT, Firefighter

FUNCTION: Coordinate Evaluation, Triaging, and Movement of patients from the incident scene to the treatment area.

REPORTS TO: MEDICAL or EMS
(if none then)
OPERATIONS
(if none then)
COMMAND

SUPERVISES: TRIAGE

DUTIES:

- Don Position Vest
- Read this duty checklist.
- Assess and report situation.
- Establish Triage Area
- Establish teams to triage, package, and move patients to the treatment area.
- Keep chain of command informed regarding number and extent of injured.
- Collect all records from incident and forward to designated Mecklenburg EMS Agency staff.

POSITION: TREATMENT

LEVEL
(TACTICAL CALLSIGN):

TEAM	**(TREATMENT)**
GROUP SUPERVISOR	**(TREATMENT GROUP)**

PERSONNEL ASSIGNED: EMS Supervisor (preferred), Paramedic, EMT, Firefighter

FUNCTION: Coordinate treatment of triaged patients in the treatment area.

REPORTS TO: MEDICAL or EMS
(if none then)
OPERATIONS
(if none then)
COMMAND

SUPERVISES: TREATMENT

DUTIES:

- Don Position Vest
- Read this duty checklist.
- Assess and report situation.
- Request needed resources and supplies.
- Establish treatment teams.
  - RED (Priority 1)
  - YELLOW (Priority 2)
  - GREEN (Priority 3)
- Keep chain of command informed as to the number of patients in treatment.
- Collect all records from incident and forward to designated Mecklenburg EMS Agency staff.

POSITION: **TRANSPORT**

LEVEL
(TACTICAL CALLSIGN):

TEAM	**(TRANSPORT)**
GROUP SUPERVISOR	**(TRANSPORT GROUP)**

PERSONNEL ASSIGNED: EMS Supervisor (preferred), Paramedic, EMT, Firefighter

FUNCTION: Coordinates loading and disposition of **all patients** from the scene

REPORTS TO: MEDICAL or EMS
(if none then)
OPERATIONS
(if none then)
COMMAND

SUPERVISES: Transport Loaders, Tracking Coordinator, and all Units being used for transport

DUTIES:

- Don Position Vest
- Read this duty checklist.
- Assess and report situation.
- Establish patient loading area.
- Advise chain of command on best access for transport units
- Obtain hospital availability from communications (C-MED)
- Assign Transport recorder if needed.
- Assign MEDCOM position if needed.
- Assign unit to transport destination and maintain transportation log.
- Request patients from TREATMENT.
- Request additional transport equipment from chain of command.
- Advise chain of command and all hospitals when all patients have been transported.
- Collect all records from incident and forward to designated Mecklenburg EMS Agency staff.

POSITION: TRACKING COORDINATOR

LEVEL
(TACTICAL CALLSIGN): **RESOURCE** **(TRACKING)**

PERSONNEL ASSIGNED: EMS Supervisor, Paramedic, EMT (preferred), Firefighter.

FUNCTION: Handles all scene to hospital radio traffic for Transportation Group, handles all radio traffic between Transport resources and Transport Group

REPORTS TO: TRANSPORT

SUPERVISES: none

DUTIES:

- Don Position Vest
- Read this duty checklist.
- Monitor Medical operations channel.
- Contact hospitals as each transport unit departs informing them of the unit number, type and number of patients, and estimated time of arrival to their facility.
- Coordinate transport unit movement from Staging to Transport pick up location.
- Collect all records from incident and forward to designated Mecklenburg EMS Agency staff.

POSITION: TRANSPORT LOADERS

LEVEL
(TACTICAL CALLSIGN): **TEAM** **(LOADTEAM-#)**

PERSONNEL ASSIGNED: EMT or Firefighter (preferred)

FUNCTION: Safe movement of patients from Treatment area to Transport loading area

REPORTS TO: TRANSPORT

SUPERVISES: none

DUTIES:

- Read this duty checklist.
- Monitor MEDICAL operations channel.
- Report to treatment area designated by TRANSPORT and collect a patient.
- Safely transport patient to transport loading area.
- Ensure patient is delivered to correct unit for transportation to hospital.
- Return for further assignment by TRANSPORT.

POSITION: STAGING MANAGER

LEVEL
(TACTICAL CALLSIGN): **AREA MANAGER** **(STAGING)**

PERSONNEL ASSIGNED: EMT or Firefighter (preferred)

FUNCTION: Manage Staging Area

REPORTS TO: OPERATIONS
(if none then)
COMMAND

SUPERVISES: Resources in Staging Area

DUTIES:

- Read this duty checklist.
- Monitor MEDICAL operations channel.
- Manage resources until requested.
- Maintain accurate list of resources based on type (ALS, BLS)
- Maintain a log of all resources in & out of staging.
- Advise crews to off-load equipment when applicable.
- Ensure keys are with any vehicles that are left unattended in Staging Area
- Collect all records from incident and forward to designated Mecklenburg EMS Agency staff.

POSITION: HELICOPTER COORDINATOR

TACTICAL CALLSIGN: LZ COORDINATOR

PERSONNEL ASSIGNED: EMT (preferred) or Firefighter

FUNCTION: Manage patient loading / destination for all patients transported by Helicopter from the LZ

REPORTS TO: OPERATIONS
(if none then)
COMMAND

SUPERVISES: Medical Helicopters at LZ

DUTIES:

- Read this duty checklist.
- Monitor MEDICAL operations channel.
- Manage resources until requested.
- Maintain accurate list of resources at LZ.
- Ensure patients are loaded on appropriate Helicopter.
- Ensure Helicopter crew is aware of patient destination assigned.
- Collect all records from incident and forward to designated Mecklenburg EMS Agency staff.

Appendix Z

Guideline Updates

April 1, 2015

SOG Document created and approved by OMT

December 1, 2016

Uniform Standard	100.010.004

February 1, 2017

Final, Final, Draft published on shared drive for OMT and OSG review.

November 21, 2017

Air Medical Transport Dispatch	600.055.001

May 1, 2018

Uniform Standard	100.010.005
Bariatric Transports	200.065.000
Securing Agency Vehicles	200.025.001

July 1, 2018

Call Processing	600.001.001

Medical Calls for Assistance (Lifting or No Injury) corrected to continue MEDIC unit outside city limits of Charlotte.

Removed North Meck Rescue paging.

February 20, 2022

Full review and update of SOG document by SOG work team.

January 2024

Final review of 2022 updates and merger of Risk and Safety updates