6401	Interfacility Transfer
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 2, 2022**

PURPOSE
To serve as the utilization standard for all patient transfers between acute care facilities within Riverside County.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22. Social Security, Division 9. Prehospital Emergency Medical Services

Interfacility Transfer

Patient transfers between acute care facilities will be completed based upon the medical needs of the patient and through the cooperation of both the sending and receiving facilities in accordance with approved procedures.

- These procedures are suggested for patient transfers from sub-acute and chronic care facilities to acute care facilities.
- These procedures are not necessary for transfers to sub-acute and chronic care facilities.

Procedures

1. Application of Policy and Procedure
   This policy will be utilized for all patient transfers between acute care facilities. This procedure is not a substitute for required transfer agreements. Each facility shall have its own internal written transfer policy that clearly establishes administrative and professional responsibilities. Transfer agreements must be negotiated and signed with facilities that have specialized services not available at the transferring facility. [H&S Code 1317.3(a) and 1317.2(b)]

2. Responsibilities
   Facilities licensed to provide emergency services must fulfill their obligation under California Health and Safety Code to provide emergency treatment to all patients regardless of patient's ability to pay. Transfers made for reasons other than immediate medical necessity must be evaluated to assure that the patient can be safely transferred without hazard to the patient's health and without decreasing the patient's chance for or delaying a full recovery. In these cases, the involved physicians and facilities should generally take a conservative view, deciding in favor of patient safety. [H&S Code 1317.3(a) and 1317.2(b)]

   If a facility does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency exists and shall direct the persons seeking emergency medical care to a nearby facility which can render the needed services, and shall assist in obtaining the services, including transportation services, in every way reasonable under the circumstances. [H&S Code 1317(e)]

   Notwithstanding the fact that the receiving facility or physicians at the receiving facility have consented to the patient transfer, the transferring physician and facility have responsibility for the patient that he or she transfers until that patient arrives at the receiving facility. The transferring physician determines what professional medical assistance should be provided for the patient during the transfer (if necessary, with the consultation of the appropriate EMS Base Hospital Physician). [H&S Code 1317.2(d)]

   The transferring physician has a responsibility to candidly and completely inform the receiving physician of the patient's condition so that the receiving physician can make suitable arrangements to receive the patient. [H&S Code 1317.2(e)].
   It is the responsibility of the receiving facility, when accepting the patient, to provide personnel and equipment reasonably required in the exercise of good medical practice for the care for the transferred patient, in order to assure continuity of care. [H&S Code 1317.2a(e)]

3. Standards for Transfers
    a. Physicians considering patient transfer should exercise conservative judgment, always deciding in favor of patient safety.
    b. If the patient presents to an emergency department, the patient must be examined and evaluated to determine if the patient has an emergency medical condition or is in active labor. If an emergency exists, the emergency department must provide emergency care and emergency services when appropriate facilities and qualified personnel are available.
        i. "Emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of the physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. [H&S Code 1317.1(a)]
        Where necessary, the examination shall include consultation with specialty physicians qualified to give an opinion or to render treatment necessary to stabilize the patient. [H&S Code 1317.1(i) and 1317.2(a)]
        ii. The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
            1. Placing the patient's health in serious jeopardy.
            2. Serious impairment to bodily function, or
            3. Serious dysfunction of any bodily organ or part.
            [H&S Code 1317.1(b)]
        iii. The term "active labor" means labor at a time at which:
            1. Delivery is imminent.
            2. There is inadequate time to effect safe transfer to another hospital prior to delivery, or
            3. A transfer may pose a threat to the health and safety of the patient or the unborn child. [H&S Code 1317.1(c)]
    c. Immediate transfer of critical trauma patients – Patients who meet the REMSA trauma triage criteria as outlined in REMSA Policy, Continuation of Trauma Care, may be immediately transferred to a trauma center (Refer to REMSA Policy, EMS System Resource List, for approved trauma centers)
        1. Immediate transfer is at the discretion of the examining physician. It is recommended to select the most appropriate, expeditious transport modality available. It may be based on patient condition, availability of surgeon and operating room, but NOT financial factors.
        2. Those patients immediately transferred will be audited for both medical care and compliance with this procedure.
    d. Immediate transfer of acute STEMI patients – Patients who meet the REMSA STEMI criteria as outlined in REMSA Policy, STEMI Receiving Centers, may be immediately transferred to a STEMI Center (Refer to REMSA Policy, EMS System Resource List, for Approved STEMI Centers)
        1. Immediate transfer is at the discretion of the examining physician. It is recommended that the most appropriate and expeditious transport modality available be selected. The mode of transportation may be based on patient condition, availability of cardiologist and cardiac cath. facility, but NOT financial considerations.
        2. Those patients immediately transferred will be audited for both medical care and compliance with this procedure.
    e. The transferring physician must determine whether the patient is medically fit to transfer and, when indicated, will take steps to stabilize the patient's condition.
    f. No transfer shall be made without the consent of the receiving physician and receiving facility. The receiving facility may designate a physician who may provide consent for both the physician and the facility. It is the responsibility of the receiving physician to inform the transferring physician of the need for additional administrative consent.
    g. The patient or the patient's legal representative must be advised, if possible, of the need for the transfer. Adequate information shall be provided regarding the proposed transportation plans. This process should be documented according to State and Federal requirements. [H&S Code 1317.2(i) and 1317.3(d)]
    h. Facilities making transfers of Medi-Cal patients should refer to the California Medi-Cal Stable for Transport Guidelines, which contain the guidelines for transfer outlined by the State of California. Any inconsistent

requirements imposed by the Medi-Cal program shall preempt SB 12 with respect to Medi-Cal beneficiaries. [H&S Code 1317.7]

i. Interfacility Transports for reasons of higher level of care which are life threatening and requiring time critical intervention (non-trauma/non-STEMI), requiring ALS or CCT services, should have a reasonable response time of one (1) hour, in the absence of previously agreed upon contractual obligations. Any response times which may exceed this performance standard shall be communicated by the responding ambulance provider to the transferring facility.

   Facility will refrain from activating multiple agencies for a single response. Once the decision to transfer the patient has been reached, every effort should be made to affect the transfer as rapidly and safely as possible. The transferring physician must take into account the needs of the patient during transport and the ability of the transport personnel to care for the patient. Transport personnel are not authorized to, and will not provide, services beyond their scope of practice.

   "Appendix A" details the level of service for REMSA EMT's, paramedics, CCTRN & Air CCTRN. If the patient's needs are within the scope of practice of an EMT, no interaction with the base hospital is necessary. Paramedic personnel may only deviate from existing REMSA protocols under the direction of a Base Hospital Physician. Initial contact with the transferring physician is approved and recommended in the interest of preserving the continuity of care of the patient. If the patient requires paramedic level of care, the transferring physician may potentially be contacted by the base hospital so that the patient's care can be coordinated during transport. If the patient's care needs exceed the scope of practice of the available transport personnel, the transferring physician may utilize CCT or Air transport providers. Alternatively, the transferring physician may arrange for the patient to be accompanied by appropriate facility staff, equipment or supplies necessary for patient care. In these cases, while assisting the M.D. or R.N. with patient care, ambulance personnel must function in accordance with this policy, subsections BLS, ALS, CCT & Air Transfers.

ii. Additional Requirements for Transfer for Non-Medical Reasons:
   When patients are transferred for non-medical reasons, the transferring facility must follow all of the above requirements. In particular, the transferring physician must ensure that emergency care and emergency services have been provided and shall determine the transfer would not create a medical hazard to the patient and would not decrease the patient's chances for or delay the patient's full recovery. [H&S Code 1317.2]

4. Transfer Procedures
   The following are the basic transfer procedures for all patient transfers:
   a. Transferring facility:
      i. The transferring facility will first provide all diagnostic tests, procedures, and treatment (including, if necessary, consultation) deemed appropriate by the transferring physician.
      ii. After determining the need for transfer, the transferring physician will notify the patient or his/her representative, explaining the reason for transfer. This process should be documented according to State and Federal requirements. [H&S Code 1317.3(d)]
      iii. The transferring physician will contact and consult the receiving physician. The receiving physician will be advised of all information regarding the patient's condition, test results, procedures, and current treatment. The patient may be transferred only with the approval of the receiving facility and physician. The receiving facility may designate physicians who may provide consent for both the physician and the facility. It is the responsibility of the receiving physician to inform the transferring physician of the need for additional administrative consent.

         If paramedic personnel are requested for the transfer, the transferring physician shall submit written orders designating the precise level of care deemed necessary during the transport. These orders shall be in accordance with accepted REMSA paramedic protocols and policy and within the state-recognized paramedic scope of practice. Any change in the patient's status that may require a deviation from the transferring physician's orders or jeopardize the continued safe transport of the patient to the receiving facility, necessitate contacting the transferring physician (primarily) or base station hospital (secondarily) in accordance with this policy's subsections: Advanced Life Support Transfers and paramedic transfers with patients with IV lines. The

transferring physician may then be consulted by base hospital personnel to facilitate care by transport personnel.

iv. To request a transport:
    1. Call the appropriate ambulance service directly.
    2. Identify sending and receiving facilities.
    3. Identify sending and receiving physicians.
    4. Provide patient's name, location, and condition.
    5. Detail the level of care needed (BLS, ALS, CCT, Air, or advise if an R.N. or physician will accompany the patient.

v. The transferring physician and nurse will complete documentation of the medical record. All test results, x-rays, and other patient data, including an appropriate patient transfer form will be copied and sent with the patient at the time of the transfer. If data are not available at the time of transfer, such data will be telephoned to the receiving facility and sent as soon thereafter as possible.

vi. In accordance with JCHO standards, the transferring facility shall provide any relevant patient care information to transport personnel using face-to-face communication. [Joint Commission Resources (2010). National Patient Safety Goal #2: Improving effectiveness of communication among caregivers.]

b. Receiving Facility

   The receiving facility shall instruct its personnel (including physicians, who are authorized to accept patient transfers) on the appropriate procedures for completing transfers.

5. Audit of Transfer Procedures

   All transfers using these guidelines are subject to review. Violations of transfer procedures can result from either clinical or procedural errors on the part of individual facilities and physicians, and/or other parties involved in the transfer process. Examples might include:

   - Inadequate stabilization of the patient by the sending facility.
   - Inadequately qualified transport personnel or equipment.
   - Patient subject to excessive delay in transfer.
   - Patient transferred without documentation or other records as requested by receiving facility.
   - Serious deterioration of the patient's condition en route.
   - Inappropriate or denial of transfer of patient to another facility.
   - Inappropriate utilization of facility staff to accommodate transport.

6. Procedure for Complaint Review

   It is recommended that complaint reporting shall be performed in accordance with established internal policy & procedures. The receiving facility, and all physicians, other licensed emergency room health personnel, and certified pre-hospital emergency personnel at the receiving facility who know of apparent violations of EMTALA transfer procedures shall and the corresponding personnel at the transferring facility and the transferring facility may, report within one week of the actual or suspected violation to the State Department of Health Services on a form prescribed by the Department of Health Services. The report may be submitted by phone, fax or letter. [H&S Code 1317.4(c)]

   State Department of Health Services Licensing and Certification.

   Division Circle
   464 West 4th Street, Suite 529 5th Floor
   San Bernardino, CA 92401
   (909) 383-4777

The Department of Health Services shall promptly send a copy of the form to the facility administrator and appropriate medical staff committee of the transferring facility and the Emergency Medical Services Division, unless the Department of Health Services concludes that the complaint does not allege facts which require further investigation, or is otherwise

unmeritorious, or the Department of Health Services concludes, based upon the circumstances of the case, that its investigation of the allegations would be impeded by disclosure of the form. [H&S Code 1317.4]

When two or more persons, each otherwise mandated to report EMTALA violations, have joint knowledge of an apparent violation, a single report may be made by on behalf of the individuals if agreed to by all members. However, any individual who is otherwise required to file a report by the Health and Safety Code who disagrees with the proposed joint report has a right and duty to file a separate report. [H&S Code 1317.4(c)

BASIC LIFE SUPPORT TRANSFER

PURPOSE
Define when it is appropriate for the EMT to assist a patient with their medications and/or medical devices.

Prescribed Medical Devices

1. When requested, EMTs with appropriate training may assist patients with their own personal pre-prescribed medications and medical devices, limited to:
   a. Epi-pens and epinephrine administration devices, in cases of acute allergic reactions.
   b. Glucometers and penlets.
   c. Home nebulizers and metered dose inhalers (MDIs) of bronchodilators, in cases of bronchospasm and wheezing.
   d. Nitroglycerin tablets or metered dose spray device for patients who have been both diagnosed with heart problems or who are currently experiencing suspected cardiac related pain/discomfort.
   e. Patient-controlled analgesia administration devices.

2. Any assistance given by an EMT shall be based upon the results of a physical assessment performed on the patient as well as an evaluation of the patient's medical history. All findings and actions will be thoroughly documented.

3. EMTs are to inform patients that any treatment rendered by emergency personnel is of a temporary nature only and should be followed by/with a comprehensive medical examination by a licensed practitioner.

4. EMTs may assist patients with:
   a. Retrieval of medications from storage locations.
   b. Site preparation with alcohol or antiseptic wipes at the direction of the patient.
   c. Loading/preparation of Epi-pens, penlets, glucometer or other devices.
   d. Assisting with the placement and aiming of medication delivery systems.
   e. Application of pressure or bandage.

5. EMTs shall not draw up, measure, mix or solely administer any medications and shall not assist with the administration of medication or medical devices that are not prescribed to the patient. Any medication administered must be clearly labeled and identified as belonging to the patient.

6. In cases of assistance with nitroglycerin tablets or spray, the EMT shall monitor administration to ensure that doses are given at the prescribed times and in the prescribed amounts. If no specific directions are noted on the prescription, the EMT shall ensure that doses are given at five (5) minute intervals and that no more than a total of three (3) doses are given.
   a. Blood pressure will be taken and recorded prior to each dose.
   b. The EMT should not assist with the administration of nitroglycerin when the patient's blood pressure is < 90 mmHg systolic OR the patient has an altered level of consciousness.

PURPOSE
Define the procedure for the transfer and monitoring of patients with invasive tubes and other medical adjuncts.

EMT Medical Adjunct Monitoring

1. Nasogastric Tubes (NGTs)
   a. NGTs shall be clamped. No form of suction shall be allowed during transport.
   b. The tube shall be secured to the nose appropriately and shall also be secured to the patient's clothing to prevent accidental dislodgement or patient discomfort.
   c. Any tubing shall be clamped and no feedings shall be infused during transport to prevent the possibility of aspiration.
   d. Unless contraindicated by medical condition, any patient fed within the last two (2) hours shall be placed on the gurney in semi-fowler's position to help prevent the possibility of aspiration.

2. Abdominal Tubes - (Gastrostomy tubes, ureterostomy tubes, wound drains, etc)
   a. EMTs shall check that tubes are secured in place in an appropriate fashion, the integrity of the drainage system is intact and drainage bags are emptied prior to transfer, with the time noted. Drainage amount and characteristics shall be noted.
   b. Any tubing shall be clamped and no feedings shall be infused during transport to prevent the possibility of aspiration.
   c. Drainage bags shall be secured to the patient in an appropriate fashion to prevent dislodgement, disconnection or backflow.
   d. Any dressing drainage shall be noted and charted.
   e. Dislodged tubes shall not be reinserted. A clean, dry dressing shall be applied to the site. Time and circumstances of dislodgement shall be noted on the PCR.
   f. Unless contraindicated by medical condition, any patient fed within the last two (2) hours shall be placed on the gurney in semi-fowler's position to help prevent the possibility of aspiration.

3. Foley Catheters
   a. Catheters shall be checked prior to transfer to assure that the catheter is appropriately secured to the patient, the system is intact and the drainage bag is secured to prevent dislodgement, disconnection and backflow.
   b. Amount and characteristics of urine shall be noted.
   c. If the drainage system becomes disconnected or dislodged during transport, the EMT will clamp the foley if disconnected, but in no circumstances shall the catheter be reinserted if dislodged.

4. Tracheostomy Tubes
   a. Tracheostomy tubes shall be checked to assure they are secured to the patient in an appropriate fashion.
   b. EMTs may suction at the opening only to remove secretions the patient is unable to clear. Amount and characteristic of secretions shall be noted.
   c. If the inner cannula becomes dislodged or is expelled, the EMT shall rinse it in sterile NaCl and gently reinsert it or allow the patient to reinsert it, if capable. Do not force during reinsertion.

PURPOSE

To define the procedure for transfers by EMTs with IV lines.

EMT Transport of Patients with IV Lines

1. During transfers, a certified EMT may monitor peripheral and long-term venous access lines including, but not limited to, heplocks, Broviacs, Hickmans, Port-a-Catheters and PICC lines, provided the following conditions are met:
   a. A written order signed by the transferring physician is provided to the EMTs, stating that in the opinion of the transferring physician the patient is non-critical and deemed stable for transportation by an EMT staffed ambulance. The written order must include the rate of infusion for the IV fluids and the type of solution infusing.
   b. No medications can be added to the IV fluids prior to or during transport.
   c. The following are the only IV solutions that may be monitored by the EMT during interfacility transports:
      i. D5/Water

ii. D5/0.2 NaCl
iii. D5/0.45 NaCl
iv. D5/0.9 NaCl
v. D5/Lactated Ringers
vi. 0.9 NaCl (Normal Saline)
vii. 0.45 NaCl
viii. 0.225 NaCl
ix. Ionosol-T
x. Lactated Ringers

2. Patients with vascular access lines through shunts or fistulas are not transportable by EMTs.

3. IV infusions in pediatric patients less than 8 years of age shall be administered with the use of Buretrol, dial-a-flow, mini-infuser or any other such metered infusion to safeguard against the over infusion of IV fluids.

4. IV sites shall be initially assessed and documented by the EMT. Periodic assessment for signs of infiltration or irritation shall be conducted and recorded.

5. The EMT may take no action regarding the IV infusion other than to monitor the IV flow rate and turn off the infusion if infiltration occurs.
   a. If infiltration does occur, the EMT shall document signs and symptoms, and actions taken, then notify the receiving center of such on arrival.

6. Care of lines inadvertently disconnected shall follow standard medical practice, to include site pressure and a dry sterile dressing if the cannula pulls completely out of the skin. If the IV tubing becomes disconnected, but the cannula remains in place, the disconnected tip of the line shall be cleansed with an appropriate germicide and the line reconnected at the original flow rate. Monitor IV site closely for signs of infiltration (reference #4 above). Appropriate written documentation of the incident and a verbal report on arrival will be made.

ADVANCED LIFE SUPPORT TRANSFERS

PURPOSE
To define the procedure for establishing medical control for transfers by paramedics.

1. The ALS Provider must verify with the receiving facility prior to transferring the patient that the patient transfer has been approved and that the patient is accepted for admission.

2. The paramedics shall receive patient specific transferring orders from the transferring physician prior to leaving the sending facility. These orders shall be documented in writing as directed by the transferring physician and must include a telephone number where the transferring physician can be reached during the patient transport.

3. The transferring physician, or designee, shall provide the paramedics with verbal report and written documentation regarding the care provided to the patient. This documentation shall be reviewed by the paramedic prior to the transfer.

4. The name of the receiving facility and the name of the receiving physician who has accepted the patient shall be provided in the transfer documents.

5. The paramedic shall monitor the patient during transport and shall document the ongoing assessment on the Prehospital Care Report.

6. The paramedics shall monitor the IV infusions as ordered. Refer to this policy's subsection paramedic Interfacility Transport of patient with IV lines.

7. The paramedic shall follow the directions of the transferring physician. If there are any questions or problems during transport, the paramedic should attempt to contact the transferring physician. If unable to contact the transferring physician, the paramedic may contact a Riverside County Base Hospital.

8. Paramedics may not transport patients who are being treated with procedures, medications and/or IV solutions which are outside of the paramedic scope of practice as defined by Title 22 and the Riverside County EMS Agency; nor may any such transfer orders, either written or verbal, be initiated. Excluded procedures include, but are not limited to, monitoring arterial lines and/or pulmonary artery catheters. Such transports may be done if a Registered Nurse (RN), qualified to provide such care, is available to accompany the patient who shall monitor and provide care to the patient during the transport. The RN should function pursuant to the Nurse Practice Act and the standardized procedures approved by the employing hospital.
    a. If the patient is receiving a medication which is outside the paramedic's scope of practice, but that medication is being delivered either by dermal patch, implant or patient controlled pump, the paramedic can accept the patient for transfer without the removal or discontinuance of the medication.

9. Procedures that may be performed include any of the Advanced Life Support skills as defined in the Riverside County EMS Agency Protocol, Policy, and Procedure Manual and any additional skills that the EMS Agency has approved for a provider's specialty transfer program. This includes but is not limited to: monitoring chest tubes that are connected to water sealed drainage, heplocks, and utilizing patent pre-existing vascular access devices as the transferring physician authorizes, including the administration of emergency medications through devices such as indwelling subclavian catheters (e.g., Hickman, CVP catheters). This shall be done in consultation with the transferring physician.

Paramedic Transport of Patients with IV Lines

1. During transfers, an accredited paramedic may monitor peripheral and long-term venous access lines including, but not limited to, heplocks, Broviacs, Hickmans, Port-a-Catheters and PICC lines, provided the following conditions are met:
    a. A written order by the transferring physician is provided to the paramedics, stating that, in the opinion of the transferring physician, the patient is non-critical and deemed stable for transportation by a paramedic staffed ambulance. The written order must include the rate of infusion for the IV fluids and the type of solution infusing.
    b. The following are the only IV solutions that may be monitored by the paramedic during interfacility transports:
        i. D5/Water
        ii. D5/0.2 NaCl
        iii. D5/0.45 NaCl
        iv. D5/0.9NaCl
        v. D5/Lactated Ringers
        vi. 0.9% NaCl (Normal Saline)
        vii. 0.45 NaCl
        viii. 0.225 NaCl
        ix. Ionosol-T
        x. Lactated Ringers
    c. The following medicated IV infusions are the only ones that may be monitored by the paramedic during interfacility transports:
        i. Intropin (Dopamine)
        ii. Isoproterenol (Isuprel)
        iii. KCl of ≤ 40mEq/1000cc
        iv. Morphine Sulfate
        v. Xylocaine HCL (Lidocaine)

2. IV sites shall be initially assessed and documented by the paramedic. Periodic assessment for signs of infiltration or irritation shall be conducted and recorded.

3. Paramedic interventions will be performed under the medical direction of the transferring physician or Base Hospital physician, either directly or through pre-signed "Standing Orders". Refer to this policy's subsection Advanced Life Support Transfers.

CRITICAL CARE TRANSFER

PURPOSE
To state the requirements for Critical Care Transport (CCT) units meeting all local, county, Riverside County Emergency Medical Services Agency (REMSA) and state requirements.

1. Request for program approval must be made in writing ninety (90) days prior to the anticipated starting date of service to the REMSA Administrator and include:
   a. Proposed identification and location of the CCT unit
   b. All procedures and protocols
   c. Documentation of qualifications for the Physician Advisor
   d. Documentation of qualifications for the Clinical Coordinator
   e. Quality Assurance plan
   f. Agreement to comply with all REMSA policies and procedures

2. Within twelve (12) working days of receiving the applicant's request for approval, REMSA will notify the applicant of any further documentation requirements.

3. The applicant shall be notified in writing within thirty (30) days of receipt of complete package of the approval or denial of program.

4. Definition: A CCT unit shall be defined as minimally meeting Riverside County Ambulance Ordinance 756 CCT Transport unit staffing requirements and may include staffing such as physicians, mid-level providers (Registered Nurse Practitioner or Physician Assistant) in-lieu or in adjunct to Registered Nurse. Critical Care Transport Paramedic may be an adjunct team member.

5. Minimum requirements for Registered Nurse personnel:
   a. RN with current unrestricted licensed to practice in the State of California.
   b. At the CCT provider's option, an RN may be employed by the CCT ambulance provider or be a contract employee
   c. Current American Heart Association BLS, ACLS and PALS or PEPP certification. One of the following courses will be required within 6 months of hire: Trauma Nurse Core Curriculum (TNCC), Advanced Trauma Care for Nurses (ATCN) or Prehospital Trauma Life Support (PHTLS).
   d. A minimum of two (2) years full time experience as RN AND either two (2) years of full time ICU/ED experience OR two (2) years of full-time experience as a CCTRN with a CCT provider in the previous three (3) years prior to employment with the CCT ambulance provider.
   e. Successful completion of an in-house orientation program related to REMSA protocol and procedures and as approved by REMSA, additional training, continuing education, tailored to the CCT-RN specific job description and scope including but not limited to basic and advanced airway management commensurate with Advanced Life Support (ALS) level of care.
   f. Needle Cricothyrotomy will remain an option for each agency.
   g. Certification in any of the following is desirable but not required: Certified Emergency Nurse (CEN); Certified Critical Care Registered Nurse (CCRN); Certified Transport Registered Nurse (CTRN); Mobile Intensive Care Nurse (MICN); Neonatal Resuscitation Provider (NRP).
   h. Continuing education requirement documentation:
      i. Maintain current California State RN license, BLS, ACLS and PALS or PEPP certification.

ii. On-going training and competencies for low frequency and high-risk skills will be based on the individual provider's CCT scope of practice and standardized procedures. However, REMSA reserves the right to review.

6. Equipment
   a. In addition to the items required by California Administrative Code, Title 13, the ambulance provider shall provide, at a minimum, the following equipment:
      i. BLS equipment and supplies per REMSA Policy for Drug and Equipment List.
      ii. Cardiac monitor with external pacemaker/defibrillator, 12 lead, SPO2, and capnography capabilities.
      iii. Infusion pump(s).
      iv. Portable ventilator.
      v. Back-up power source (Inverter).
      vi. Each CCT unit shall have equipment and supplies commensurate with the scope of practice for the medical personnel. This requirement may be fulfilled through the utilization of appropriate kits (pack/cases), which must be removed if the vehicle is being utilized for BLS transport purposes.
      vii. CCT providers shall ensure that transport personnel are thoroughly trained in the safe operation of all patient care equipment utilized on board the CCT unit.
      viii. Nothing in this policy is intended to limit a CCT provider agency from utilizing or maintaining additional equipment or medications on board the CCT unit, as long as patient care personnel are fully trained on the safe and effective use of that equipment or medication.

7. Physician Advisor
   a. Physician Advisor: A full or part-time physician licensed in the State of California and qualified by training and experience with recent, within the last five (5) years, practice in emergency or acute critical care medicine. The REMSA Medical Director must approve the candidate for physician advisor. The duties of the physician advisor shall include but not be limited to:
      i. Sign and approve, in advance, all medical protocols to be followed by the CCT personnel.
      ii. The CCT provider agency physician advisor shall ensure that all nursing/medical staff on a CCT collectively possesses the skills and knowledge to provide a level of care commensurate with the specific and anticipated needs of the patient. The CCT provider agency physician advisor shall be accountable for all medical procedures performed by provider agency staff.
      iii. Ensure the quality of patient transfers being conducted by the provider agency, including familiarity with COBRA (Consolidated Omnibus Budget Reconciliation Act) and EMTALA (Emergency Medical Treatment & Active Labor Act).
      iv. The CCT provider agency physician advisor shall ensure that a comprehensive, written quality assurance (QA) and quality improvement (QI) program or Performance Improvement Program (PIP) is in place to evaluate the medical/nursing care provided to all patients. This QA/QI or PIP program shall integrate with the countywide prehospital QA/QI or PIP program. Any incidents that result in a negative patient outcome shall be reported to the REMSA Medical Director according to the timeline defined in REMSA policy for the CQI System.
   b. Clinical Coordinator: A provider shall have a Clinical Coordinator who minimally meets the requirements of Section 5 and has a minimum of one (1) year full time experience in ambulance transports.
      i. The Clinical Coordinator may function as the Respiratory Care Practitioner (RCP) Coordinator in conjunction with the Transport Physician Advisor.
      ii. Duties of the CCT Clinical Coordinator include:
         1. Sign and approve, in advance, all nursing procedures to be followed by the RN.
         2. Oversee ongoing training for all medical personnel involved.
         3. Ensure quality of patient transfers being conducted by the provider by conducting patient care audits.

8. Procedure/Protocols
   a. Each company providing Critical Care Transport units shall develop and maintain procedures for the hiring and training of personnel and vehicle staffing
   b. Each provider must develop a manual to include the following:
      i. Malpractice insurance coverage.

ii. Identity and accessibility of the Physician Director and Clinical Coordinator.
iii. Vehicle inventory lists.
iv. Copies of all related inter-facility transfer paperwork.
v. The identity of the Transport Physician Advisor, the CCT Clinical Coordinator, and RCP Coordinator (if applicable). The EMS Agency shall be notified in writing of any changes of these key personnel.
vi. A description of the procedure for contacting the Transport Physician Advisor, CCT Clinical Coordinator and RCP Coordinator if needed during a patient transport.
vii. Statement of Responsibility of the sending physician for the patient during transfer in accordance with COBRA and EMTALA laws.
viii. Narcotics:
    1. Physician Order Form for Narcotics (DEA 222)
    2. Waste procedure
    3. Turnover procedure
    4. Storage of Narcotics
    5. Usage documentation
    6. Discrepancy procedure
    7. Copy of the Physician Advisor's DEA License.

9. Quality Assurance
   a. Submit to REMSA a quality improvement plan.
   b. All CCT providers shall conform to REMSA policy, the CQI System.
   c. Periodic staff conference on audits of Patient Care Reports and outcomes are required in order to improve or revise protocols.
   d. Records of all these activities shall be kept by the provider and be made available for inspection and audit by REMSA.
   e. REMSA shall perform periodic on-site audits of records to ensure compliance with this policy.

AIR MEDICAL TRANSFER

PURPOSE

To state the requirements for air (rotor wing) medical staffed units meeting all local, county, Riverside County Emergency Medical Services Agency (REMSA) and state requirements.

1. Request for program approval must be made in writing ninety (90) days prior to the anticipated starting date of service to the REMSA Administrator and include:
   a. Proposed identification and location of the air medical staffed unit
   b. All procedures and protocols
   c. Documentation of qualifications for the Physician Advisor
   d. Documentation of qualifications for the Clinical Coordinator
   e. Quality Assurance plan
   f. Agreement to comply with all REMSA policies and procedures
   g. Provide and maintain proof of full accreditation by the Commission on Accreditation of Medical Transport Services (CAMTS) Certification

2. REMSA will notify the applicant in writing within twelve (12) working days following receipt of request for approval if any further documentation is needed.

3. The applicant shall be notified in writing within thirty (30) days of receipt of complete package of the approval or denial of program.

4. Minimum requirements for air medical personnel:
   a. RN currently unrestricted licensed to practice in the State of California.

b. At the air medical provider’s option, an RN may be employed by the air medical provider or be a contract employee.
c. Current American Heart Association BLS, ACLS, NRP and PALS /PEPP certification. One of the following courses will be required within 6 months of hire: Trauma Nurse Core Curriculum (TNCC), Advanced Trauma Care for Nurses (ATCN) or Prehospital Trauma Life Support (PHTLS).
d. A minimum of four (4) years of experience in emergency department or critical care unit in the past five (5) years before working as a flight nurse in Riverside.
e. Successful completion of an in-house orientation program related to REMSA protocol and procedures and as approved by REMSA, additional training, continuing education, tailored to the flight nurse specific job description and scope including but not limited to basic and advanced airway management commensurate with Advanced Life Support (ALS) level of care.
f. Needle Cricothyrotomy will remain an option for each agency.
g. Certification in any of the following is desirable but not required: Certified Emergency Nurse (CEN); Certified Critical Care Registered Nurse (CCRN); Certified Transport Registered Nurse (CTRN); Mobile Intensive Care Nurse (MICN); Certified Flight Registered Nurse (CFRN).
h. Continuing education requirement documentation:
    i. Maintain current California State RN license, BLS, ACLS, NRP and PALS or PEPP certification.
    ii. On-going training and competencies for low frequency and high-risk skills will be based on the individual provider’s air transport scope of practice and standardized procedures. However, REMSA reserves the right to review.

5. Equipment
    a. In addition to the items required by California Administrative Code, Title 13, the ambulance provider shall provide, at a minimum, the following equipment:
        i. BLS equipment and supplies per REMSA Policy for the Drug & Equipment List. (This may have to be revised – Air exemption)
        ii. Cardiac monitor with external pacemaker/defibrillator, 12 lead, SpO_2, and capnography capabilities.
        iii. Infusion pump(s).
        iv. Portable ventilator.
        v. Back-up power source (Inverter).
        vi. Each air transport unit shall have equipment and supplies commensurate with the scope of practice for the medical personnel. This requirement may be fulfilled through the utilization of appropriate kits (pack/cases).
        vii. Air transport providers shall ensure that transport personnel are thoroughly trained in the safe operation of all patient care equipment utilized on board the air transport unit.
        viii. Nothing in this policy is intended to limit a air transport provider agency from utilizing or maintaining additional equipment or medications on board the air transport unit, as long as patient care personnel are fully trained on the safe and effective use of that equipment or medication.
        ix. Air provider’s list.

6. Physician Advisor
    a. Physician Advisor: A full or part-time physician licensed in the state of California and qualified by training and experience with recent, within the last five (5) years, practice in emergency or acute critical care medicine. The REMSA Medical Director must approve the candidate for physician advisor. The duties of the physician advisor shall include but not be limited to:
        i. Sign and approve, in advance, all medical protocols to be followed by the RN.
        ii. The air transport provider agency physician advisor shall ensure that all nursing/medical staff on an air transport unit collectively possess the skills and knowledge to provide a level of care commensurate with the specific and anticipated needs of the patient. The air transport provider agency physician advisor shall be accountable for all medical procedures performed by provider agency staff.
        iii. The air transport provider agency physician advisor shall ensure that a comprehensive, written quality assurance (QA) and quality improvement (QI) program or Performance Improvement Program (PIP) is in place to evaluate the medical/nursing care provided to all patients. This QA/QI or PIP program shall integrate with the countywide prehospital QA/QI or PIP program. Any incidents that result in a negative patient outcome

shall be reported to the REMSA Medical Director according to the timeline defined in REMSA policy, the CQI System.

b. Clinical Coordinator: A provider shall have a Clinical Coordinator who meets the requirements of Section 4 and has a minimum of one (1) year full time experience in air medical transports.
    i. Duties of the air transport Clinical Coordinator include:
        1. Sign and approve, in advance, all nursing procedures to be followed by the RN.
        2. Oversee ongoing training for all air medical personnel involved.
        3. Ensure quality of patient transfers being conducted by the provider by conducting patient care audits.

7. Procedure/Protocols
    a. Each company providing air medical staffed Critical Care units shall develop and maintain procedures for the hiring and training of nursing personnel and helicopter staffing.
    b. Each provider must develop a manual to include the following:
        i. Malpractice insurance coverage.
        ii. Identity and accessibility of the Physician Director and Clinical Coordinator.
        iii. Helicopter inventory lists.
        iv. Copies of all related inter-facility transfer paperwork.
        v. The identity of the air transport Physician Advisor and the air transport Clinical Coordinator. The EMS Agency shall be notified in writing of any changes in these key personnel.
        vi. A description of the procedure for contacting the air transport Physician Advisor or air transport Clinical Coordinator if needed during a patient transport.
        vii. Statement of Responsibility of the sending physician for the patient during transfer in accordance with COBRA and EMTALA laws.
        viii. Narcotics:
            1. Physician Order Form for Narcotics (DEA 222)
            2. Waste procedure
            3. Turnover procedure
            4. Storage of Narcotics
            5. Usage documentation
            6. Discrepancy procedure
            7. Copy of the Physician Advisor’s DEA License.

8. Quality Assurance
    a. Submit to REMSA a quality improvement plan.
    b. All air medical providers shall conform to REMSA policy for the CQI System.
    c. Periodic staff conference on audits of Patient Care Reports and outcomes are required in order to improve or revise protocols.
    d. Records of all these activities shall be kept by the provider and be made available for inspection and audit by REMSA.
    e. REMSA shall perform periodic on-site audits of records to ensure compliance with this policy.

APPENDIX A

This appendix is provided to give facilities a general guideline of the provider's capabilities.

IV FLUID & MEDICATION ADMINISTRATION AND MONITORING	BLS	ALS	CCT	Air
Infusion Pump	No	No	Yes	Yes
Titration of IV Infusion to effect	No	No	Yes	Yes
ACLS Medications	No	Yes	Yes	Yes
Any Medications	No	No	Yes	Yes
Blood/Blood Products	No	No	Yes	Yes
Chemotherapeutic Agents	**No**	**No**	**No**	**No**
D5/0.2% NS IV (no meds)	Yes	Yes	Yes	Yes
D5/0.45% NS IV (no meds)	Yes	Yes	Yes	Yes
D5/0.9% NS IV (no meds)	Yes	Yes	Yes	Yes
D5W/IV (no meds)	Yes	Yes	Yes	Yes
Intropin (Dopamine)	No	Yes	Yes	Yes
Ionosol T	Yes	Yes	Yes	Yes
Isoproterenol (Isuprel)	No	Yes	Yes	Yes
KCl of > 40 mEq/1000 cc	No	Yes	Yes	Yes
Lactated Ringers	Yes	Yes	Yes	Yes
Morphine Sulfate	No	Yes	Yes	Yes
NaCl 0.225%	Yes	Yes	Yes	Yes
NaCl 0.45%	Yes	Yes	Yes	Yes
NaCl 0.9%	Yes	Yes	Yes	Yes
Narcotic Analgesic (PCA pump)	Yes	Yes	Yes	Yes
Nutritional IV	No	No	Yes	Yes
Xylocaine HCL (Lidocaine)	No	Yes	Yes	Yes
AIRWAY MONITORING AND PROCEDURES	**BLS**	**ALS**	**CCT**	**Air**
Bi-PAP (Bi Level) Ventilation*	No	No	Yes	Yes
Capnography (Continuous CO2 monitoring)	No	Yes	Yes	Yes
Combitube (insertion)	No	No	Yes	Yes
Combitube (monitoring)	No	No	Yes	Yes
C-PAP (Continuous)	No	Yes	Yes	Yes
Cricothyrotomy (Surgical / Needle) (initiate)	No	No	Yes	Yes
Endotracheal Tube (initiate)	No	Yes	Yes	Yes
King Airway (initiate)	No	No	Yes	Yes
Nasotracheal Intubation*	No	No	Yes	Yes
Pulse Oximetry	Yes	Yes	Yes	Yes
Rapid Sequence Intubation (RSI)*	No	No	No	Yes
Tracheostomy	Yes	Yes	Yes	Yes
Tracheostomy (Deep Suctioning)	No	Yes	Yes	Yes
Tracheostomy (Stoma Suctioning)	Yes	Yes	Yes	Yes
Ventilator	No	No	Yes	Yes
ARTERIAL & VENOUS ACCESS AND MONITORING	**BLS**	**ALS**	**CCT**	**Air**
Arterial Lines to keep intact	No	No	Yes	Yes
Arterial Venous Sheaths	No	No	Yes	Yes
Broviac/Hickman Catheters	Yes	Yes	Yes	Yes

Central Line (monitoring)	No	Yes	Yes	Yes
Central Line placement (Femoral)	No	No	No	Yes
Central Line placement (Subclavian)	No	No	No	Yes
Central Venous Access (Long Term)	Yes	Yes	Yes	Yes
CVP or Central Venous Pressure Lines	No	No	Yes	Yes
Dialysis shunts (access)	No	No	Yes	Yes
Dialysis shunts with complications (monitor)	No	No	Yes	Yes
Heplock (monitor)	Yes	Yes	Yes	Yes
Intraosseous (initiate)	No	Yes	Yes	Yes
Intraosseous (monitor)	Yes	Yes	Yes	Yes
Peripheral IV (insertion)	No	Yes	Yes	Yes
Peripheral IV (monitoring)	Yes	Yes	Yes	Yes
PICC Lines (access)	No	Yes	Yes	Yes
PICC Lines (monitor)	Yes	Yes	Yes	Yes
Porta-Caths (access)	No	Yes	Yes	Yes
Porta-Caths (monitor)	Yes	Yes	Yes	Yes
Pulmonary Artery Lines (Swan Ganz Cath.) (monitoring)	No	No	Yes	Yes
Pulmonary Artery Lines to keep intact	No	No	Yes	Yes
Saline lock (initiate)	No	Yes	Yes	Yes
Saline lock (monitor)	Yes	Yes	Yes	Yes
CARDIAC MONITORING AND PROCEDURES	**BLS**	**ALS**	**CCT**	**Air**
Automatic External Defibrillation*	Yes	Yes	Yes	Yes
Cardioversion	No	Yes	Yes	Yes
ECG (monitoring)	No	Yes	Yes	Yes
ECG (12-lead) (initiate and interpret)	No	Yes	Yes	Yes
Hemodynamic Monitoring	No	No	Yes	Yes
IABP or Intra-Aortic Balloon Pump	No	No	Yes	Yes
Manual Defibrillation	No	Yes	Yes	Yes
CARDIOTHORACIC MONITORING AND PROCEDURES	**BLS**	**ALS**	**CCT**	**Air**
Chest Tube Insertion*	No	No	No	Yes
Chest Tube to Suction	No	No	Yes	Yes
Chest Tube to Water Seal	No	Yes	Yes	Yes
Needle Thoracostomy (initiate)	No	Yes	Yes	Yes
Pericardiocentesis*	No	No	No	Yes
CATHETER / TUBE ACCESS AND MONITORING	**BLS**	**ALS**	**CCT**	**Air**
Abdominal Tube (G-tube, J-tube, Peg, JP, etc.)	Yes	Yes	Yes	Yes
Foley Catheters	Yes	Yes	Yes	Yes
Nasogastric Tube (Clamped)	Yes	Yes	Yes	Yes
Nasogastric Tube (Suction Required)	No	Yes	Yes	Yes
Orogastric Tube (Clamped)	No	Yes	Yes	Yes
Orogastric Tube (Suction Required)	No	Yes	Yes	Yes
NEURO / CRANIAL MONITORING	**BLS**	**ALS**	**CCT**	**Air**
ICP or Intracanial Pressure Lines	No	No	Yes	Yes
Ventriculostomy	No	No	Yes	Yes

OTHER PROCEDURES AND MONITORING	BLS	ALS	CCT	Air
Blood Glucose Monitoring (Capillary)	Yes	Yes	Yes	Yes
Escharotomy* (monitoring)	No	No	No	Yes
Fetal Monitoring (External)	No	No	No	Yes
Wound Vac	Yes	Yes	Yes	Yes