

	State of New York Office Of Mental Health	Date Issued 5-23-12	T.L. 12-07	Page 1 of 11	Section # PC-605
	OMH Official Policy Manual	Section:			
		Patient Care			
		Directive: Emergency Medical Services			

A. Policy Statement

Each State-operated psychiatric inpatient facility is responsible for ensuring the provision of appropriate emergency medical care to patients, visitors and employees within an acceptable response time.

B. Principles

(1) Phases of Emergency Medical Services (EMS)

A complete, coordinated response to a medical emergency potentially includes three distinct phases: identification; stabilization; and transport. Although the type and level of response will vary depending on the situation, it is essential that each facility is capable of and prepared for responding to each level of care:

- (a) identifying emergency events and providing immediate basic emergency life support on site;
- (b) providing immediate medical treatment leading to stabilization; and
- (c) ensuring the transport of patients to a more acute setting if clinically indicated, while maintaining at least the level of emergency life support initiated prior to transport.

(2) Facility Plan

- (a) Each facility is responsible for developing, implementing and annually reviewing a written facility plan for the provision of EMS. This plan must include, at a minimum, the following components:
 - i. the identification of one or more appropriately trained staff members who have the authority and responsibility for implementing and coordinating the EMS system;
 - ii. the provision of 24-hour on-site coverage in each patient unit and each off-unit activity area by at least one direct care staff member who has successfully completed training in First Aid, Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) and whose current status has been appropriately reviewed and documented by the facility;

- iii. the provision of coverage during transport to off-site activities or appointments by at least one staff person who has successfully completed training in First Aid and CPR/AED, and whose current status has been appropriately reviewed and documented by the facility, who will accompany the patient during such transport;
- iv. the provision of 24-hour on-site facility coverage by at least one appropriately trained EMSS team;
- v. consistency with its Infection Control Plan;
- vi. the development, approval and periodic review of policies and procedures which, at a minimum, address the following:
 - 1. the designation of staff authorized to provide EMS;
 - 2. a process for notifying designated staff in response to a medical emergency, including contingency plans;
 - 3. a process for transferring patients to an appropriate facility;
 - 4. the availability of appropriate medications, supplies and equipment;
 - 5. the identification of the role of EMS in the facility's disaster plan;
 - 6. the documentation of all emergency medical care provided by facility staff;
 - 7. a description of the facility's level of response to any medical emergency which occurs on campus;
 - 8. the identification of required competencies of staff who are authorized to provide EMS, and a plan for meeting those competencies; and
 - 9. the identification of treatments and protocols under which staff who are authorized to provide EMS will function in the absence of patient-specific orders.
- vii. the provision of a planned, formal training program to all staff designated as providers of EMS. The program must include components which address orientation, appropriate course work consistent with approved organizations, and continuing education;
- viii. access to an ambulance service which is certified or registered by the New York State Department of Health; and
- ix. the development and implementation of mechanisms to monitor and evaluate the quality and appropriateness of emergency medical care provided.

IMPLEMENTATION STANDARDS

EMERGENCY MEDICAL SERVICES SYSTEM (PC-605)

A) Relevant Statutes and Standards

Mental Hygiene Law, §33.03, Quality of care and treatment
14 NYCRR 27.5, Medical care and treatment
9 NYCRR, Part 303, Automated External Defibrillation
TJC Accreditation Manual for Hospitals
OMH Official Policy Manual, PC-615, Referrals

B) Definitions: For purposes of these implementation standards:

- (1) **Advanced Emergency Life Support** - Includes basic emergency life support plus the use of equipment to support ventilation, the establishment of an intravenous fluid lifeline, drug administration, defibrillation, cardiac monitoring, control of arrhythmias, and post resuscitation care as appropriate.
- (2) **Automated External Defibrillator (AED)** – This is a medical device with a built-in heart rhythm analyzer. It checks the patient’s heart rhythm and detects an abnormal heart rhythm which needs defibrillation (electric shock).
- (3) **Basic Emergency Life Support (BLS)** - The provision of cardiopulmonary resuscitation and/or first aid. It also includes First Responder procedures.
- (4) **Cardiopulmonary Resuscitation (CPR)** - The combination of maintenance of an airway, artificial respiration and chest compression used in cases of cardiac arrest to maintain life until the patient recovers or additional medical treatment is available to stabilize the patient for transfer.
- (5) **Emergency Medical Services System (EMSS)** - A facility-wide, coordinated response to a serious/acute injury or sudden illness.
- (6) **EMSS Team** - A core group of appropriately trained facility-based staff designated to provide at least intermediate emergency life support on site. The EMSS team includes at least one physician and at least one nurse. The on-site physician requirement shall be automatically waived if the facility develops EMSS teams which would operate under appropriate protocols. These protocols must be approved by the Medical Staff organization and be consistent with the guidelines of the American Heart Association. **This requirement must be reflected in the facility’s policy and procedure documents.**

Non-facility based services may be used by the facility to provide Advanced Emergency Life Support...
- (7) **First Aid** - A supportive intervention used to stop bleeding, relieve pain, monitor vital functions and prepare the patient for more intensive treatment.
- (8) **First Responder Procedures** - A supportive intervention with associated equipment, which enable unit staff to respond to non-cardiac emergencies including choking, head/spine injury, fractures, burns, seizures, strangulation

(suicide and other), sudden illness (e.g., diabetic emergencies, shock, syncope), drug overdose and poisoning.

- (9) **Intermediate Emergency Life Support** - Includes basic emergency life support plus use of AED and airway management.
- (10) **Medical Treatment and Stabilization** - The provision of treatments which constitute at least intermediate emergency life support. Advanced emergency life support may be provided by the facility as appropriate. The specific treatments necessary are determined on an individual basis.
- (11) **National Standards/National Organizations** - A term which refers to either of the following:
 - (a) The American Heart Association; or
 - (b) The American Red Cross.

C. Implementation Process

(1) Components of Emergency Medical Services

(a) Basic Emergency Life Support

A sufficient number of direct care staff shall be designated who, upon notification of the occurrence of an emergency, are responsible for the following:

- i. identification of the medical emergency;
- ii. notification of the EMSS team, designated physician or nurse, or ambulance service;
- iii. initiation of first responder, first aid and/or CPR; and
- iv. continuation of basic emergency life support until the arrival of staff to assist with and/or initiate additional medical treatment in order to stabilize the patient for transfer.

(b) Medical Treatment and Stabilization

One or more EMSS teams shall be available on a 24-hour basis to provide medical treatment and stabilization, as well as clinical leadership in EMSS. The team, which must report to the scene of the emergency, must meet the criteria described in (B) (6) of these Implementation Standards.

(c) Equipment

At a minimum, a CPR back board, a Bag Valve Mask, a pocket mask and first aid supplies shall be available in each patient unit. A crash cart (or equivalent) capable of supporting initial treatment of emergencies, must be available to each patient floor. Each facility must have a defibrillator

distribution plan which is consistent with Part 303 of Title 9 NYCRR.

(2) Facility Plan

(a) EMSS Administration

(i) EMSS Director:

A physician shall be designated as EMSS Director with the authority and responsibility for implementing the established policies and procedures, directing the EMSS operation, and ensuring that the process for monitoring and evaluation is implemented.

(ii) EMSS Nursing Supervisor

A nurse shall be designated as EMSS Nursing Supervisor with the responsibility for supervising the emergency medical care provided by nurses, paraprofessional staff (e.g., Mental Hygiene Therapy Assistants) and other designated personnel, and for assisting the EMSS Director in the coordination of the EMSS.

(b) Policies and Procedures

EMSS policies and procedures shall be approved by the medical staff organization and facility administration, reviewed annually, and revised as necessary.

(c) Facility Training Program

(i) the orientation program for new employees who have been designated to provide emergency medical care shall include, at a minimum, a review of the facility's EMSS plan and the responsibilities related to each new staff member's level of participation in the EMSS.

(ii) the credentialing/privileging procedures must be followed according to the standards of the applicable National Organization:

- (1) First aid, provided by trainers certified by the American Heart Association or equivalent National Organization;
- (2) CPR - Basic Life Support (BLS), consistent with the standards of the American Heart Association; or
- (3) Advanced Cardiac Life Support (ACLS), a course consistent with the standards of the American Heart Association.

(iii) the continuing education program may include in service education programs, as well as continuing education programs conducted by outside sources.

(d) Staff Credentials and Training

- (i) direct care staff designated as providers of basic emergency life support must be certified in CPR and first responder procedures.
- (ii) designated nurses must be licensed to practice professional nursing in New York State, and certified in BLS.
 - (1) EMSS Team Personnel who defibrillate without the direct supervision of a physician must either be credentialed to do so or have documentation of the facility's review of their qualifications.
 - (2) nurses designated as EMS Nursing Supervisors must also have successfully completed an accredited course in ACLS that is consistent with national standards and must complete refresher courses every two years.
- (iii) designated physicians must be licensed to practice medicine in New York State, and certified in BLS.

Physicians designated as EMSS Directors must also be board eligible or certified in an approved American Medical Association specialty, must have successfully completed an accredited course in ACLS that is consistent with national standards and must complete ACLS refresher courses every two years.

- (iv) at facilities that **NEVER** respond at a level higher than Intermediate Emergency Life Support as defined in these Implementation Standards, it is recommended, but not required, that the EMS Nursing Supervisor and EMS Medical Director complete an accredited course in ACLS with refresher courses every two years.

(e) Drills

Regularly scheduled drills must be conducted and documented to assess staff readiness and response to notification of medical emergency. Drills may be conducted by assessing staff knowledge of the facility's EMSS plan, including accessibility and status of equipment, during rounds by the EMSS Nursing Supervisor. Drills must be conducted on at least a quarterly basis.

(f) Quality Assurance Activities

Monitoring of medical emergencies shall address, at a minimum:

- (i) the timeliness of staff response and arrival of equipment;
- (ii) the actions taken and the outcome;
- (iii) any problems encountered;
- (iv) the development of corrective action plans in response to problems encountered;

- (v) the effectiveness of corrective action plans; and
- (vi) compliance with the facility's EMSS policies and procedures.

(g) Standards for Responding to On-Grounds Medical Emergencies.

The following standards shall apply in responding to medical emergencies which occur on the grounds of the psychiatric center, but outside the main patient buildings. These may be in OMH operated facilities or within tenant organizations, and include, but are not limited to, emergencies that occur in non-patient buildings (such as Administration or power plant); non-inpatient residential facilities (such as State Operated Community Residences, or crisis units); inpatient non-residential space (such as a rehab center, sheltered workshop, or outpatient service site); and campus grounds.

- (i) the minimum level of response, for on-grounds medical emergencies, is Basic Emergency Life Support plus Automated Electronic Defibrillation (AED) plus basic airway management as taught in the BLS training program.
- (ii) for a given location on campus, the level of response must be the same regardless of the whether the person experiencing the medical emergency is a patient, staff member or visitor.
- (iii) the response team can be different depending on the location on campus, (e.g., a facility may utilize appropriately trained staff from the specific site/building for its response team), but the response must be consistent with the facility's EMSS policy.

(h) Standards for Responding to Medical Emergencies that Occur in Tenant Organizations.

Tenant Organizations include, but are not limited to: Addiction Treatment Centers or any other non-OMH service (e.g., tenant) that is located on a facility's campus. Facilities which have tenant organizations must develop a local agreement with each tenant organization. That agreement must describe:

- (i) the level of emergency medical service coverage at the tenant location;
- (ii) the specific roles (if any) and responsibilities (if any) for both the OMH facility and the tenant in providing that coverage; and
- (iii) the mechanism for contacting the ambulance services in response to medical emergencies.

(i) Standards for Off-Grounds Medical Emergencies:

In cases where facilities are asked to respond to community requests for medical emergencies which occur off the grounds but in the general proximity

of the psychiatric center, the following standards shall apply:

- (i) the person receiving the request for assistance will initiate the facility's EMSS response. The response must include a call to 911 for an ambulance.
- (ii) if the location is within a reasonable distance from the psychiatric center, (e.g., within a distance that would likely enable the response team to be on the scene prior to the ambulance), the response team shall go to the scene and determine if there is a life threatening situation.
- (iii) if a life threatening situation exists, the response team shall take appropriate action to stabilize the patient and avoid further serious imminent injury or death while waiting for the ambulance.
- (iv) if the situation is not life threatening, the response team shall provide reassurance to the patient and/or family that the ambulance is on the way.

The team should avoid initiating any unnecessary treatment while waiting for the ambulance to arrive.

(j) Standards for Off-Grounds OMH Operated Outpatient Sites:

OMH has executed an agreement with the New York State Department of Health that allows for the use of AEDs (by staff other than physicians or nurses) at OMH operated community based sites. The choice of whether to provide EMSS program at an off-grounds OMH outpatient site is a facility decision. If the facility decides to have a program involving the use of AEDs, then the facility must complete at least the following:

- (i) the facility Emergency Medical Services Committee must evaluate the clinical needs of the outpatient sites and recommend the appropriate response level. The recommendations shall be documented within their committee minutes and forwarded to the facility Medical Staff Organization for review and approval.
- (ii) the facility Medical Staff Organization must approve the Emergency Medical Services Committee recommendations and shall document that approval in their minutes.