Attachment 9a-1

Solano County Health & Social Services Department

Mental Health Services
Public Health Services
Substance Abuse Services
Older & Disabled Adult Services

Eligibility Services
Employment Services
Children's Services
Administrative Services

Patrick O. Duterte, Director

EMERGENCY MEDICAL SERVICES AGENCY
275 Beck Avenue MS 5-240
Fairfield, Ca. 94533
(707) 784-8155 FAX (707) 421-6682
www.solanocounty.com

Steven P. Whiteley, MD
EMS Agency Medical Director

Ted Selby
EMS Agency Administrator

POLICY MEMORANDUM 6110

DATE: August 17, 2011

REVIEWED/APPROVED BY:

S. Whiteley MD

STEVEN P. WHITELEY, MD, EMS AGENCY MEDICAL DIRECTOR

TED SELBY, EMS AGENCY ADMINISTRATOR

SUBJECT: REQUIRED MEDICAL RECORDS FOR PATIENT CARE

AUTHORITY: CALIFORNIA CODE OF REGULATIONS, DIVISION 9, ARTICLE 6, SECTIONS 100168, 100169(e); CALIFORNIA HEALTH & SAFETY CODE, DIVISION 2.5, 1797.220

I. PATIENT CARE REPORT (PCR)

Whenever an EMS (Emergency Medical Services) team arrives on scene of an incident where a patient is identified, and contact is made, a PCR will be generated.

EMS pre-hospital care providers are required to document all of their patient care on forms that are approved in writing by the EMS Medical Director and EMS Administrator. The Patient Care Report (PCR) Form is to be completed on all calls where a patient contact occurs. Advanced Life Support (ALS) Agencies will use an electronic PCR program that is California EMS Information System (CEMSIS) complaint, capable of producing a written document; a Solano County EMS Agency approved paper PCR version may be used when appropriate. A copy of the file will be provided to the receiving facility in printed or electronic form. In the event of computer failure, the agency will use the approved Solano County paper version of the PCR and enter all information into the electronic PCR database as soon as possible. If the computer down time is expected to exceed one week, the provider agency administrative representative will notify the EMS Agency in writing of the issue and include steps being taken to restore the electronic PCR and submission of data to the EMS Agency.

All EMS personnel are required to "document provision of all patient care and treatment provided utilizing an appropriate record." This includes incidents where care is transferred to another EMS entity. Examples include but are not limited to:

A. All calls where ALS and/or BLS care is provided.

B. All (scheduled and non-scheduled) inter-facility transfers where EMS pre-hospital personnel are providing both continued assessment and treatment while a patient is being transferred between medical facilities.

C. All cases where EMS pre-hospital personnel arrived on scene and initiated a patient assessment and/or treatment.

D. All cases where the patient was found to be Dead on Arrival (DOA).

E. All cases where the patient was identified as a Do Not Resuscitate (DNR) candidate for non-resuscitation.

F. All cases where a physician assumes on-scene responsibility.

G. Scheduled round trip inter-facility transfers to a diagnostic center (e.g., Cardiac Catheter Labs, MRI Scanners, CT Scan, specialty physician offices, etc.)
[*NOTE - If EMTs are required to make assessments (monitor vital signs) and/or maintain/administer therapeutic modalities (e.g., IV medications, apply direct pressure to control bleeding, monitor ECG dysrhythmias, etc), a PCR is required for each leg of the transfer.]

III. APPROVED MEDICAL CARE FORMS

The Solano County EMS Agency recognizes the following forms as acceptable for documenting EMS medical care provided by certified pre-hospital EMS providers:

A. An approved CEMSIS-compliant Electronic PCR file.

B. The Solano County Patient Care Report Form (and attached Continuation Form).

C. Standardized Triage Tags for multi-casualty incidents; approved by the California Fire Chief's Association.

D. The Standardized non-transport first responder report form.

IV. COMPLETION OF ELECTRONIC PCR FILE OR PAPER PCR

A call is not completed and a patient is not considered transferred to a physician's care until a PCR is completed and a copy provided to a receiving facility. An EMS unit is not available for pre-scheduled transfers until all records of medical care are provided to the physician caring for the patient. In the event an EMS unit needs to be dispatched to another emergency call, the EMS team may be released from their obligation to complete required medical records at that time. The treating EMS crew must provide the treating physician a way to contact them directly before leaving the receiving facility to allow the treating physician to ask additional

questions that only the EMS crew can answer. This may be accomplished via cellular phone or via radio.

In the event the EMS team responds to another emergency call without completing required medical records, the team must complete the PCR and fax as soon as possible, but in no case shall it be longer than 24 hours to submit the PCR to the appropriate medical facility. Failure to complete medical records is deemed abandonment.

V. DISTRIBUTION OF PAPER PCR FORM

A. Provider Copy (1st Layer) – This is the original record maintained by the Ambulance Service Provider. For medical/legal purposes it is considered the master medical record and all other PCR layers are copies of the master. It is the responsibility of the Provider to maintain these patient records in accordance with medical liability statues.

B. Patient Medical Record Copy (2nd Layer) – This is the copy of the PCR that is retained by the receiving facility. In most cases this will be the receiving hospital or medical facility. In special cases this layer of the medical record may be left with public safety officials or other EMS/medical care providers (e.g., coroner's office for Dead-On-Arrivals (DOAs), nursing care facilities during transfers, medical staff at diagnostic facilities such as: Cardiac Cath Lab, CT Scan, Radiography, etc.).

C. EMS Copy (3rd Layer) – This is the Local EMS Agency copy of the medical record utilized for statistical data processing. This copy is to be turned in to the Ambulance service provider's office and sent to the EMS office for processing by the 30th day of the following month.

VI. GENERAL GUIDELINES FOR MEDICAL RECORD DOCUMENTATION

Information needed to complete a PCR is dependent upon multiple sources and cannot always be precise and consistent (e.g., patient history, non-standardized clocks, multiple dispatch centers, inability to have a scribe on scene, multiple agencies responding to the scene incident, etc). PCRs are completed with EMTs making a good faith effort to appropriately and adequately complete accurate patient record keeping requirements.

If it is determined that any person alters or modifies a medical record, dispatch log, or any other EMS Quality Improvement documentation with fraudulent intent, or creates a false medical record either by including fraudulent information (e.g., vital signs reported but not taken) or omission/exclusion of essential information (e.g., missed IV or ETT attempts that are not recorded); this person is in violation of 471.5 of the California Penal Code and is subject to formal disciplinary action under 1798.200 of the California State Health & Safety Code.

If situations arise where there are multiple sources of documentation, the documentation provide by the individual(s) who actually performed the assessment, skill, treatment, etc. shall be the official legal document of record.

VIII. CONTINUATION FORM

Additional narrative information that exceeds the space provided in the paper PCR narrative section should be recorded on a Continuation Form provided by the Solano County EMS Office.

IX. ECG MONITORING STRIP

If ECG monitoring or a 12 lead EKG is a part of the patient's care and/or assessment, at a minimum one EKG strip or 12 lead EKG must be attached to the PCR either paper or electronic version of the PCR. The ECG strip or 12 lead EKG should be at least a six-second strip, with date and time noted on the strip. Multiple EKG strips or 12 lead EKGs should be sequential with the date and time noted as appropriate. Multiple EKGs or 12 lead EKGs should be attached to the PCR and submitted to the Receiving Facility and EMS Agency.

X. INSTRUCTIONS & CODE SHEET

Instructions and code sheets to complete the paper version of the Solano County PCR Form are included in Policy #6100.

XI BACK OF THE PCR (PROVIDER COPY)

A. Intubation Report and verification (complete if applicable).

B. Physician on Scene (complete if applicable):
Present the Physician with the *Solano County Note to Physician on Involvement with EMT and Paramedic* laminated card (Attachment 2) to explain the physician's options, and comply with Policy 6510, Physician on Scene.

C. Solano County SIDS Report (Complete if applicable and fax to Solano County Coroner).

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Steven P. Whiteley, MD
EMS Agency Medical Director

Ted Selby
EMS Agency Administrator

POLICY MEMORANDUM 6170

DATE: August 31, 2011

REVIEWED/APPROVED BY:

STEVE WHITELEY, MD, EMS AGENCY MEDICAL DIRECTOR

TED SELBY, EMS AGENCY AMINISTRATOR

SUBJECT: INFECTION CONTROL/COMMUNICABLE DISEASE

AUTHORITY: CALIFORNIA HEALTY & SAFETY CODE, SECTIONS 1797.188 & 1797.189; RYAN WHITE COMPREHENSIVE AIDS RESOURCES EMERGENCY CARE ACT (PUBLIC LAW 101-3810), Chapter 1.155 (commencing with Section 199-65) to Part 1 of the Health & Safety Code.

PURPOSE/POLICY:
Preventing exposure to Infectious Disease, preventing the spread of Infectious Disease and reporting an exposure to Infectious Disease is EVERY EMS Worker's responsibility. This Policy deals with five (5) components:

I. Universal Precautions
II. Equipment Sanitation
III. Exposure Reporting
IV. Medical Facility Reporting Obligations
V. Prevention

DEFINITION:
Exposure is defined as contact with blood or body fluids to:
I. Non-intact skin or mucus membranes; and/or
II. Accidental puncture/cut of skin or mucus membranes; and/or
III. Full facial contact to an aerosolized moistened particulate matter (mist, cough).

I. UNIVERSAL PRECAUTIONS

The Centers for Disease Control and Prevention (CDC) recommends universal precautions emphasizing that **all patient contacts should be assumed to be infectious for blood borne and/or body fluid pathogens; and may be infectious with aerosolized pathogens.**

Universal Precautions **shall** include:

A. Appropriate latex gloves (put on prior to patient contact) for touching blood and body fluids, changed after each contact.

B. Appropriate masks, protective eye wear, gowns, or aprons should be worn during procedures that could generate splashes of body fluid.

C. Hand washing with soap and water and/or disinfectant solution immediately after contact with blood or body fluid, and after removing gloves.

D. Extra precautions to be used to prevent injuries generated by "sharps." Proper disposal of used needles without recapping them in a puncture resistant container is mandated, as well as appropriate bio-hazard disposal.

E. Pocket masks or other appropriate ventilation devices as indicated.

F. EMS personnel who have open sores or dermatitis should refrain from direct patient contact and sanitation of potentially infected equipment until the condition is resolved.

II. EQUIPMENT SANITATION

The sanitation of EMS equipment is a vital link in preventing the spread of any infectious disease. Proper disposal of all non-reusable equipment shall follow Manufacturer Guidelines.

A. **Laryngoscope blades, McGill Forceps, and Endotracheal Tube Stylets** shall **ALL** be cleaned with soap and water and then disinfected with the high level disinfectant chemical sterilant, Glutaraldehyde, as recommended by APIC (Association for Practitioners in Infection Control) guidelines for Infection Control Practice, **OR** solution/mechanism approved by the County Health Officer.

B. **General clean-up** of the Ambulance compartment shall follow both CDC guidelines and Cal OSHA Standards.

III. EXPOSURE REPORTING

Section 1797.188 of the Health and Safety Code requires hospitals to notify the County Health Officer when EMS personnel have been exposed to an infectious disease. The Ryan White Act requires medical facilities to notify the designated officer when emergency response employees are exposed to specified infectious diseases during the transport of a patient to the hospital.

The law further states that it is the responsibility of EMS personnel to provide information to the receiving hospital when they perceive that a significant exposure has occurred, (e.g., oral contact to blood or body fluids, including but not limited to mouth-to-mouth resuscitation; blood splash in the face; or accidental needle stick.)

A. Transported Cases

All EMS Personnel, including Police and Fire Department Personnel, should report any significant exposure to the hospital where the patient was transported. Reporting forms are available in all of the Hospital Emergency Departments (see attachment A). The form should be turned into the Base Hospital Liaison Nurse, Charge/Lead Nurse, or the Infectious Disease Nurse and/or designee at the receiving hospital. The exposed individual shall keep a copy of the exposure report for their record. Significant exposures to positive infectious disease sources will be followed-up on by each hospital and reported to the "designated officer" of the agency involved. Individual calls from emergency response personnel will not be answered.

B. Non-Transported Cases

Exposure cases involving a non-transported victim (Coroner's case, Against Medical Advice [AMA], etc., must be reported on an Exposure Form [Attachment A]). Follow-up will occur through the Solano County Public Health Communicable Disease Program coordinating Infectious Disease reporting for Solano County. Forms should be mailed or faxed to:

Solano County Public Health Communicable Disease Program
355 Tuolumne Street
Vallejo, CA 94590
FAX NUMBER: 707-553-5649.

A telephone report should be made in addition by calling 707-553-5555, Monday through Friday, during normal business hours.

C. Out-of-County Transfers

Out-of- County transfers where an exposure has occurred shall be reported on an exposure form to the patient's final destination hospital.

In all cases, the responsibility for reporting Infectious Disease exposures belongs to the exposed EMS worker. This report must be made to both the hospital and employer.

IV. MEDICAL FACILITY REPORTING OBLIGATIONS

A. **Facility-Initiated Reports to Designated Officer**. If a patient is determined to have an **airborne infectious disease**, the facility must report this to the designated officer of the emergency response employees who transported the patient to the facility.

1. The only currently disease specified airborne in this category is **infectious pulmonary tuberculosis**. Persons undergoing tuberculosis drug therapy, and skin test converters who are not infectious, should not be reported.
2. The facility must notify only the designated officer of the emergency response employees who transported the victim, not those who may have also treated the victim prior to transport. Any emergency response employee who attended, treated, assisted, or transported a patient may request a determination as to whether there was an exposure to an infectious disease (Refer to Section B).
3. This notification must be made as soon as it is practicable, but not later than 48 hours after determination is made.
   a. The facility must inform the designated officer of the name of the infectious disease involved (infectious pulmonary tuberculosis), and the date on which the patient was transported by emergency response employees to the facility. No other information, including the name of the patient, should be released.
   b. If the required notification to the designated officer is made by mail, the facility must inform the (by telephone or in person) that the notification has been sent; the designated officer must, within 10 days, inform the facility whether the notification was received.
4. If a patient dies at or before reaching the hospital, the medical facility ascertaining the cause of death (if not the hospital) must make the required notification.

B. Facility Response to designated office inquiries. If any emergency response employee believes he or she may have been exposed to an infectious disease from a patient transported to a medical facility, the emergency response employees may request his or her employer to review the circumstances surrounding the potential exposure.

1. Infectious diseases addressed in policy are:

   a. Airborne Diseases <u>which include, but are not limited to:</u>
      - Infectious Pulmonary Tuberculosis

   b. Other Infectious Diseases <u>which include, but are not limited to:</u>
      - Hepatitis B
      - HIV infection (including AIDS)
      - Diphtheria (Corynebacterium diphtheriae)
      - Meningococcal Disease (Neisseria Meningitides)
      - Plague (Yersinia Pestis)
      - Hemorrhagic fevers (Lassa, Marburg, Ebola, Crimean-Congo, and other viruses yet to be identified)
      - Rabies

2. If the designated officer determines that the emergency response employees may have been exposed to one or more of these infectious diseases, the designated officer must submit a request for response to the facility to which the patient was transported. This request must be in writing, contain a statement of the facts surrounding the circumstances of the potential exposure, and be signed by the designated officer.

3. The facility must evaluate the facts submitted by the designated officer and determine if the emergency response employee was exposed to an infectious disease listed above based on the medical information possessed by the facility regarding the patient.

4. If the facility determines that an emergency response employee was exposed to an infectious disease listed above, the facility must notify the designated officer in writing as soon as is practicable, but no later than 48 hours after receiving the request.

   a. The facility must inform the designated officer of the name of the infectious disease involved and the date on which the patient was transported by emergency response employees to the facility. No other information, including the name of the patient, should be released.

   b. If the required notification to the designated officer is made by mail, the facility must inform the designated officer (by telephone or in person) that the notification has been sent; the designated officer must, within 10 days, inform the facility whether the notification was received.

5. If the facility determines that an emergency response employee was not exposed to a listed infectious disease, the facility must notify the designated officer in writing as soon as practicable, but not later than 48 hours after receiving the request.
6. If a facility finds that the facts are insufficient to determine whether the emergency response employee was exposed to a listed infectious disease, the facility must notify the designated officer in writing of the insufficiency of the facts as soon as practicable, but not later than 48 hours after receiving the request.
   a. If the designated officer requests, the County Health Officer may evaluate the request and the response, and make an independent determination and response to the designated officer.
   b. If the County Health Officer believes the facts provided to the facility were sufficient or the County Health Officer obtains additional and sufficient facts, the County Health Officer will submit the request to the facility. The facility must then provide the designated officer the appropriate response.
7. If a facility determines that it possesses no information on whether the patient had an infectious disease listed above, the facility must notify the designated officer in writing of the insufficiency of the medical information as soon as is practicable, but no later than 48 hours after receiving the request. However, if the facility later determines that the patient had a listed infectious disease, the facility must notify the designated officer (See Section C below for specific requirements).
8. If a patient dies at or before reaching the hospital, and the hospital receives a request for response under the Act, the hospital must provide a copy of the request to the facility ascertaining the cause of death, if there is a different facility involved. That medical facility then has the responsibility of making the required determination and appropriate response.

C. Limitations on Facility Duties

The Ryan White Comprehensive Aids Resources Emergency Care Act specifically limits the responsibilities of the facility as follows:

1. The duties of facilities under the Ryan White Comprehensive Aids Resources Emergency Care Act terminate at the end of the period during which the facility provides medical care to the victim for conditions arising from the emergency, or at the end of the 60-day period beginning on the date the victim is transported by emergency response employees to the facility, *whichever period is shorter* – except that the facility's duties will continue if a request is received within 30 days of the date of the applicable period.

EXAMPLES:

Example 1: If a victim is transported to a medical facility and released after two days, the facility must respond to a request if it is received within 30 days of the date the victim was discharged from the facility.

Example 2: If the victim remains in the facility for more than 60 days, the facility must respond to a request if it is received within 30 days of the expiration of the 60-day period (this turns out to be 90 days from the date of the alleged exposure, which would be the maximum period of time that the facility would have notification obligations for that exposure).

2. The Ryan White Comprehensive Aids Resources Emergency Care Act does not authorize or require a facility to test any patient for any infectious disease. As a result, facilities and practitioners must follow existing consent requirements, including the requirements for informed and written consent for HIV tests. In this regard, testing may fall under Federal and State regulations, State - 8 CA CCR § 5193(f)(3), Federal - 29 C.F.R. §1910.1030(f)(3), requiring employers to test a source individual's blood for HIV and Hepatitis B following any occupational exposure - but only after consent is obtained from the source individual. Under some circumstances, if the source patient or the authorized legal representative of the source patient refuses to an HIV test after a documented effort has been made to obtain consent, then any available blood or patient sample of the source patient may be tested. A new sample may not be obtained. The source patient or authorized legal representative of the source patient shall be informed that an available blood sample or other tissue or material will be tested despite his or her refusal, and that the exposed individual shall be informed of the HIV test results. If a source patient is incapacitated and therefore is unable to provide informed consent and has no legal representative, then HIV testing on the source patient or available blood or tissue of the source patient shall not be permitted. (Refer to Chapter 1.155 commencing with Section 199.65 of Part 1 of Division 1 of the Health and Safety Code.)

3. The Ryan White Comprehensive Aids Resources Emergency Care Act also does not authorize or require any facility, designated officer, or emergency response employee to disclose identifying information with respect to a patient or an emergency response employee.

4. The Ryan White Comprehensive Aids Resources Emergency Care Act does not authorize any emergency response employee to fail to respond to, or deny services to, any victim of an emergency.

V. COMMUNICABLE DISEASE EXPOSURE PREVENTION

A. All Solano County EMS Service Providers shall develop an Infection Control Plan consistent with Cal OSHA (Occupational Safety and Health Act including Aerosol Transmissible Disease (ATD) Standard) and CDC requirements; to be approved by the EMS Agency.

B. Quality Assurance mechanisms for compliance addressing all five components of this EMS Policy shall be included as part of the Infection Control Plan.

C. Infection Control Plans shall include an immunization program, at no cost to the employee, of MMR (Measles, Mumps & Rubella), HBV (Hepatitis B), annual tuberculosis PPD (Purified Protein Derivative), and/or any other immunizations specified by the County Health Officer.

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