



## EMS POLICIES AND PROCEDURES

POLICY #: 28  
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SUBJECT: **PARAMEDIC INTERFACILITY TRANSFER (CCT-P) PROGRAM STANDARDS**

APPROVED BY:

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### I. PURPOSE

The CCT-P Program has been developed to provide an alternative means of transferring stable patients who require, or who may require, care within the CCT-Paramedic Scope of Practice during transfer. CCT-P units may be used to transfer patients from acute care facilities, or other medical facilities approved by the EMS Medical Director, to other acute care facilities.

Contra Costa EMS authorizes and contracts with interested ambulance companies that meet the training, staffing, equipment and oversight requirements for providing this level of service and that agree to comply with program standards. Program authorization may be denied or withdrawn for failure to comply with program standards or failure to submit required fees.

### II. STAFFING

A CCT-P unit is a fully equipped advanced life support ambulance, staffed with a minimum of two (2) qualified staff that includes at least one (1) paramedic.

A. Paramedic Personnel: Paramedics assigned to CCT-P units shall meet the following minimum qualifications:

1. Current and valid California Paramedic License,
2. Current accreditation in Contra Costa County,
3. At least two (2) years full-time field experience as a paramedic in an ALS system,
4. Current and continuously renewed provider status in BCLS, ACLS, PALS, PEPP, and PHTLS or BTLS,
5. Successful completion of EMS Agency approved provider training and orientation programs specific to skills used on interfacility transfers.

B. EMT-1 Personnel

EMT's assigned to CCT-P units shall meet the following minimum qualifications:

1. Current and valid EMT-I certification in California,
2. Current provider status in BCLS,
3. Successful completion of EMS Agency approved training program specific to skills used to assist paramedics with patient care during ALS interfacility transfers, and,

C. Employer shall provide the EMS Agency with a list of all staff working on a CCT-P unit and shall see that this list is updated whenever there is a change in personnel.

D. Employer shall retain on file, at all times, copies of current and valid credentials for all personnel performing services under this program.

### III. MEDICAL DIRECTION

Personnel assigned to a CCT-P unit work under the existing medical control system and follow Contra Costa County EMS policies and procedures, as approved by the EMS Medical Director.

**A. CCT- Paramedic Scope of Practice**

The County CCT-P Scope of Practice includes the County Basic and Optional Scopes of Practice for paramedics listed in the Contra Costa Prehospital Care Manual. In addition, CCT-P's have an expanded scope that includes the administration of intravenous (IV) nitroglycerin (NTG), potassium chloride (KCl) and heparin by IV pump.

**B. Transferring Physician Orders**

The transferring physician specifies standing orders for a patient based on skills and medications included in the County CCT-P scope of practice using a County-approved form.

**C. Patient Care Outside of the Paramedic Scope of Practice**

1. When a patient's treatment/care is beyond the CCT-P paramedic scope of practice, that patient may be transported by a CCT-P unit only when:
  - a. A licensed medical professional (e.g. RN, Nurse Practitioner, Nurse-midwife, PA or MD) is in attendance and assumes control and responsibility for providing patient care outside the Paramedic Scope of Practice; AND,
  - b. Medication or equipment needed by the patient that is not stocked on the ambulance unit are provided by the sending facility.
2. Accompanying licensed medical personnel providing care function under their own written standing orders and document any care provided.

**D. Exceptional Situations**

1. Critical patients and "on views". If the CCT-P unit either responds to a private request for a transport and finds a patient that requires immediate ALS care, or "on-views" an emergency scene, the CCT personnel shall:
  - a. Activate the 9-1-1 system.
  - b. Provide appropriate patient care, which may include any indicated ALS interventions following Contra Costa County field treatment guidelines.
  - c. Initiate transport if emergency transport unit is not on-scene and ETA to closest appropriate receiving facility is shorter than ETA of the emergency transport unit.
2. Patient deterioration during transport. If the CCT-P unit responds to a private request for transport and the patient begins to deteriorate after transport has begun, personnel shall:
  - a. Provide appropriate patient care that may include any indicated ALS interventions following Contra Costa County EMS Field Treatment Guidelines.
  - b. Make base hospital contact if required by EMS protocol.
  - c. Divert to a closer facility if necessary and appropriate, based on patient condition and base hospital direction.

CCT-P personnel shall submit a written report fully explaining the circumstances of any exceptional situations including those described above together with a copy of the patient care report and related dispatch records to the EMS Agency within 24 hours of the incident.

**IV. DOCUMENTATION****A. Patient Care Report**

A written patient care report (PCR), format of which has been approved by the EMS Agency, shall be accurately completed on each patient.

1. The PCR shall contain available information regarding call demographics, patient assessment, care rendered, and patient response to care.

2. A copy of the PCR shall be given to the receiving facility prior to the transfer unit departing the facility.
3. If the patient is turned over to an emergency transport unit, a copy of the PCR shall be sent with the patient if time permits. If the PCR cannot be completed prior to patient transport, the CCT-P paramedic shall complete the PCR and fax it to the Emergency Department of the receiving facility as soon as possible.
4. A copy of each PCR shall be sent by the first business day following the transfer to:
  - a. The EMS Agency.
  - b. The base hospital if involved in transfer.

## **V. CCT-P STAFF PREPARATION AND COURSE APPROVAL PROCESS**

- A. Submit a Paramedic Interfacility Transfer Program Application, completed checklist, and supporting documentation to the EMS Agency for approval at least 2 weeks prior to the course start date.
- B. Paramedic interfacility didactic and clinical training requirements
  1. Education - didactic
    - a. Minimum number of hours for course = 80 didactic hours
    - b. Describe the method of assessing successful course achievement/evaluation
    - c. Principle instructor of paramedic training must be a registered nurse or physician knowledgeable in the subject matter. Principle instructor of EMT-I training may be a paramedic, registered nurse or physician.
    - d. Provide course content and objectives
    - e. Course content to include:
      - 1) EMTALA
      - 2) Review of County paramedic and expanded paramedic scopes of practice
      - 3) Recognition of patients who require a higher level of care
      - 4) What to do if the patient deteriorates:
        - a) Diversion
        - b) Implement Contra Costa County Policies
        - c) Base contact is not required unless the patient deteriorates and requires care not covered by the transferring physician orders, or unless specifically mandated by EMS treatment protocol.
      - 5) Obtaining and receiving reports from sending / receiving facilities
      - 6) Notification to receiving hospital while enroute (cell phone)
        - a) Patient status and ETA
      - 7) Breathing and Airway Management
        - a. Anatomy, physiology, pathophysiology, signs and symptoms, assessment
        - b. Tracheostomies
        - c. Endotracheal intubation and Needle Cricothyrotomy (review of procedure)
        - d. Pharmacologic agents
        - e. Chest tubes (operation, troubleshooting, assessment)
        - f. Pleural Decompression (review of procedure)
        - g. Portable ventilators
      - 8) Laboratory Values
        - a. Review of common blood analyses including arterial blood gas, urinalysis
          - Normal/abnormal findings and implications

- Practical application of values to patient presentations
- 9) Pharmacology:
    - a. Review of common medications, including sedatives, analgesics, paralytics, antihypertensives, vasopressors, volume expanders, bronchodilators, antiarrhythmics, antianginals, thrombolytics, anticoagulants.
    - b. Drug calculations (bolus and infusions, by volume and rate)
    - c. Detailed instruction (drug actions, indications, dosages, calculation, adverse reactions, contraindications and precautions) on the following:
      - Intravenous NTG
      - Intravenous heparin
      - KCl infusion
      - Lidocaine
      - Dopamine.
    - d. Review of other agents not in CCT-P scope (magnesium sulfate, mannitol, oxytocin, procainamide, use of blood products--including transfusion reaction recognition and management.)
  - 10) Infusion pumps
    - a. Operation and troubleshooting
    - b. Review of variety of available equipment
    - c. Practical application (setting drip rates, troubleshooting)
  - 11) Hemodynamic monitoring
    - a. Non-Invasive monitoring
      - NIBP, pulse oximetry, capnography, auscultation
    - b. Invasive monitoring (review only, not in scope of CCT-P)
      - Arterial lines, Swan-Ganz
    - c. Existing vascular access devices (e.g., Hickman, Broviak, Porta-Cath, PIC and others)
      - Evaluation, troubleshooting, potential complications
    - d. Wound care at site of devices
  - 12) ECG Interpretation
    - a. Arrhythmia, coronary ischemia
  - 13) Implanted defibrillators
    - a. Mechanism, complications and patient management
  - 14) Cardiac Pacemakers
    - a. Implanted devices, transvenous (not in CCT-P scope), transcutaneous
  - 15) Indwelling Tubes:
    - a. Urinary: Foley and suprapubic catheters
    - b. Nasogastric, PEG, Dobhoff tubes
  - 16) Shock and multi-organ failure
  - 17) Special populations
    - a. Including renal and peritoneal dialysis patients, pediatric, obstetric, neurologic, and trauma patients
  - 18) Isolation issues
    - a) VRE, MRSA
    - b) Procedures
  - 19) Documentation

2. Education – clinical – 40 hours (total)
  - a. Minimum number of hours with Respiratory Therapist = 4 hours
  - b. Minimum observational time spent on IFT ride-along = 8 hours (must include *at least 2* separate transports)

C. EMT-I interfacility didactic and clinical training requirements

Minimum four (4) hours didactic and clinical instruction specific to the skills needed to assist a single paramedic in-patient care delivery during CCT-P calls. Completion of the Contra Costa “Partners” course meets this requirement.

**VI. CONTINUOUS QUALITY IMPROVEMENT (CQI) PLAN**

- A. A CCT-P program shall have a written CQI plan approved by the EMS Agency.
- B. A Registered Nurse or physician shall have clinical oversight of the CCT-P CQI plan.
- C. Provider’s CQI staff shall evaluate all CCT-P transfers for medical appropriateness.
  1. Specific review for use of intravenous NTG, heparin and KCl will include:
    - a. Review of transferring physician’s orders and evidence of compliance with orders.
    - b. Documentation of vital signs, including frequency.
    - c. Documentation of any side effects/complications including hypotension, bradycardia, increasing chest pain, arrhythmia, altered mental status, and interventions with these events.
    - d. Documentation of any unanticipated discontinuation or rate adjustments of infusions along with rationale and outcome.
    - e. Review of any base contact or contact or transferring physician for orders during transport.
  2. Significant complications shall be communicated to the EMS agency by the next business day.
- D. EMS Agency will receive quarterly reports summarizing CQI activity, identified trends, and resolutions.