Boston *EMS*

Where Public Health Meets Public Safety

Policy and Procedure Manual

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A Bureau of the Boston Public Health Commission

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James Hooley, EMT-P Chief of Department	**Sophia Dyer, MD, FACEP** Medical Director

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This Manual is adopted in accordance with Chapter 147 of the Acts of 1995 of the General Court of the Commonwealth of Massachusetts (the "Enabling Act"), which established the Boston Public Health Commission and charged Boston Emergency Medical Services with the responsibility for providing emergency medical services in Boston. In addition, this Manual is adopted in accordance with Massachusetts General Law, Chapter 111c and 105 CMR 170.000 "Emergency Medical Services System". In the event that any provision, clause, sentence, paragraph, or word in this Manual is found to be invalid, such invalidity shall not affect the other provisions herein.

Boston EMS is constantly seeking ways to improve the efficiency and effectiveness of our service. Your input is welcomed and encouraged. Comments and suggestions may be sent to sopmanual@bostonems.org

Organization & Administration

Mission, Vision, and Values

MISSION
Boston EMS, the provider of emergency medical services for the City of Boston, is committed to compassionately delivering excellent pre-hospital care and protecting the safety and health of the public.

VISION
Boston EMS' vision is to expand upon our role as a critical public safety agency that delivers exceptional pre-hospital emergency medicine in an urban environment. The department will remain at the forefront of EMS advancements, driving progress in clinical care, operations, research, and training. As a leader in all-hazard emergency preparedness, we will enhance our workforce and community's ability to be resilient when confronted by man-made and natural disasters. Boston EMS will continue to be viewed as a challenging, diverse and rewarding place to work as well as a model for other EMS agencies.

VALUES

- **Patient Advocacy:** The health and well-being of the patient is always our first priority. We are professionals who treat every patient with respect and compassion.
- **Clinical Excellence:** The members of Boston EMS are highly skilled and specially trained to provide state of the art pre-hospital emergency medical services. We provide every patient with excellent clinical care.
- **Leadership & Innovation:** As a leader in the field of pre-hospital emergency medicine, we pride ourselves on innovating and leveraging the latest advances in both medicine and technology, bringing cutting edge care to the streets of Boston.
- **People:** Our people are our greatest asset. The knowledge, experience, and compassionate nature of our employees make our service exceptional. Our workforce includes skilled professionals from different backgrounds and cultures, reflecting the diversity of the communities we proudly serve.
- **Collaboration:** We strive to work effectively with our public safety and public health partners to solve problems, make decisions, and achieve common goals.
- **Pride & Unity:** We are proud of the work we do and the strength of our service. We are committed to one another and the patients we serve.
- **Preparedness:** We are a leader in the field of emergency preparedness and take an active role in planning, training, response and recovery efforts to mitigate the medical consequences of disasters. We maintain the highest level of organizational and individual preparedness.

	# Boston*EMS* ## Policy and Procedure Manual
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Boston EMS Oath

I (name) do solemnly swear;
That I will support the Constitution of the United States;
The Constitution and Laws of the Commonwealth of Massachusetts,
and of the City of Boston;

That I will bear true faith and allegiance to the same;
I will serve my patients with integrity and compassion,
and I will afford respect equally to all.
I will faithfully and impartially discharge all of the duties and responsibilities required of a City of Boston Emergency Medical Technician to the best of my abilities;

I do so affirm on this ____ day of ____ in the year ____.

Duties and Responsibilities

The following is a summary of the duties and responsibilities of some of the job descriptions within the Department. Refer to job descriptions for complete list.

EMERGENCY MEDICAL TECHNICIAN-BASIC

The Emergency Medical Technician-Basic is responsible for providing emergency treatment of ill or injured persons, and the safe and efficient transport of patients to the appropriate receiving facility. The EMT-Basic's duties and responsibilities include:

- Performs a daily routine checkout of ambulance equipment and supplies and does routine vehicle maintenance; Completes records and reports as required;
- Responds safely and promptly to all calls as directed by Dispatch Operations; Operates communications equipment in accordance with protocols and procedures. Upon arrival at the scene of an emergency, makes an immediate survey of the situation to determine the need for additional units and reports the status of the incident to Dispatch Operations;
- Directs the efforts of First Responders involved in patient care, and assumes responsibility for patient care until relieved by a ranking clinical member or the receiving facility staff;
- Renders Basic Life Support including the treatment of adult and pediatric injuries and illness; burns; environmental emergencies; cardiopulmonary disorders; abdominal pain; neurologic disorders; obstetrical and gynecological emergencies; communicable diseases; toxicological emergencies; other emergent traumatic and non-traumatic events;
- Initiates CPR to victims of cardiac arrest; requests and assists advanced life support personnel when appropriate; operates the semi-automatic defibrillator and downloads data per established protocol;
- Administers treatment for fractures of all types, and for injuries to the head, face, eyes, neck, spine, chest, abdomen, pelvis, genitalia and other injuries causing bleeding and/or shock; operates mechanical adjuncts to breathing;
- Assists patients in taking their own medications per established protocol; performs rescue tasks to access, assess, stabilize, disentangle, and remove victims of entrapment;
- Cares for emotionally disturbed, alcoholic, drug-influenced, epileptic, and agitated patients in such a manner as to ensure the safety of the patient; manages obstetrical emergencies;
- Assesses each patient, takes vital signs, and records these findings on the patient care report; operates glucometer and administers aspirin per established protocol; completes and submits a patient care report for each response unless the unit is canceled prior to arrival;
- Inspects, cleans, and washes Department vehicles and stations as required; restocks equipment and supplies so as not to fall below par level; operates Department vehicles in a safe and accepted manner;

- Attends training classes and recertification courses as required; maintains a knowledge of all rules and regulations; maintains and updates the policy manual as required;
- Maintains current certification as required per state regulations: EMT certification; Massachusetts driver's license, CPR certification.

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EMERGENCY MEDICAL TECHNICIAN-PARAMEDIC

The Emergency Medical Technician-Paramedic is responsible for providing advanced life support skills in accordance with Boston EMS/Regional clinical protocols and for performing basic life support as required. The EMT-Paramedic's duties and responsibilities include:

- Performs a daily routine check out of ambulance equipment and supplies and does routine vehicle maintenance; completes records and reports as required;
- Responds safely and promptly to 9-1-1 calls as directed by Dispatch Operations; Operates communications equipment in accordance with established procedure;
- Assumes primary responsibility for patient care at the scene of an emergency; performs basic life support procedures as required;
- Per protocol or under a physician's orders, performs advanced life support procedures including endotracheal intubation; ECG interpretation; defibrillation; synchronized cardioversion; carotid sinus massage; intravenous, intramuscular, subcutaneous, sublingual and endotracheal administration of drugs and/or fluids, chest decompression; intraosseous needle placement; and cricothyrotomy;
- Reports diagnostic information to the medical control physician; continuously monitors the patient condition on scene and en route to the receiving hospital; updates the medical control physician on any change in patient status;
- Operates Department vehicles as assigned in a safe and accepted manner; inspects, cleans, and washes Department vehicles and stations as required; restocks equipment and supplies so as not to fall below par level;
- Completes and submits a patient care report for each response unless canceled prior to arrival on scene; Submits ECG strips or downloads ECG as required;
- Maintains a thorough knowledge of all advanced life support protocols and procedures;
- Maintains a knowledge of rules and regulations; maintains and updates the policy manual as required;
- Maintains certification as required per State regulation: EMT-P certification; Massachusetts driver's license; ACLS certification; CPR certification; attends training classes and rectification courses as required.

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EMT-TELECOMMUNICATOR

The EMT-Telecommunicator, under the direction of the Dispatch Operations Supervisor, shall control and coordinate communications on designated EMS channels. In addition to responding to emergencies and providing care, the Telecommunicator's duties and responsibilities include:

- Carries out the orders of the Dispatch Operations Supervisor and the Command Staff;
- Receives, screens, and evaluates requests for service and determines the response requirements per protocol; dispatches, directs, and monitors the movement of all EMS response units; reassigns units to temporary satellite locations;
- Operates radio, telephone, and computer systems, and performs related duties as required; records and relays radio or telephone traffic according to established policy;
- Notifies public safety agencies such as Police, Fire, Marine and Air Rescue services when the response of such agencies is required; coordinates the response and radio advisories as required;
- Assigns radio channels to be used for medical direction, medical control, consultation, and notification; relays medical traffic and point of entry data as required;
- Directs ambulances, aircraft, and marine units entering the region with critical patients to proper routes, airports, docks, and hospitals;
- Notifies the Dispatch Operations Supervisor or other supervisory staff when administrative or technical problems arise;
- Develops and maintains a thorough knowledge of standard operating procedures including dispatch procedures, call-screening protocols, response areas, and city geography; works as C-MED operator as required;
- Performs related duties as required.

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LIEUTENANT

A Lieutenant may be assigned to the Field Operations, Dispatch Operations, RTQI, or other assignment as necessary. A Lieutenant is responsible for the clinical and administrative supervision of EMTs, and the administrative supervision of Paramedics in the performance of their duties. In addition to responding to emergencies and providing care, a Lieutenant's duties and responsibilities include:

- Maintains a record of all matters affecting the work shift; maintains a record of responses, vehicle change-overs, and other work activities or significant events;
- Submits a detailed written report as per established policy whenever a complaint is received concerning the performance or conduct of a Department member;
- Submits a detailed written report to the Shift Commander whenever a violation of the rules is observed; investigates complaints and/or reports of vehicle or equipment malfunctions, and takes action to return disabled response units to service;
- Submits a written report to the Shift Commander concerning recurrent false calls; chronic abuse of 9-1-1; conflict between ambulance crew members; conflict between an EMT and a member of another public safety agency, or a member of the public;
- Assumes operational responsibility at the scene of an emergency until relieved by a person of higher rank; Provides clinical supervision of EMTs; maintains a thorough knowledge of the multiple casualty incident plans;

- Reviews check-out forms, unit response summaries, motor vehicle accident reports, child abuse reports, elderly abuse reports, and other reports as required; initials each report for the completeness and accuracy; inspects ambulances and equipment for cleanliness; ensures compliance with infection control protocols;
- Reviews patient care reports for completeness and legibility as required;
- Along with the fleet mechanic and with input from the ambulance crewmakes the decision as to whether a unit should be removed from service due to mechanical problems;
- Monitors the driving ability of EMTs assigned to response units; submits a written report to the Shift Commander if negligent or reckless driving is observed and initiates corrective action;
- While assigned to Field Operations, assumes responsibility for one or more geographic divisions; responds to incidents when dispatched; remains in radio contact at all times; monitors the communications of Field units; may be reassigned to Dispatch Operations as required;
- While assigned to Dispatch Operations, directly supervises the performance of EMT-Telecommunicators in using dispatch procedures and call-screening protocols; supervises the operation of C-MED; monitors the response time, on-scene time, and in-hospital time of EMS response vehicles; staffs vacancies in Dispatch Operations Center or Field Operations by reassigning available members from the float pool or by calling overtime in compliance with established policy; updates the Shift Schedule Report and overtime list as required; acts as liaison with the Boston Police Operations Supervisors as required; may be reassigned to Field Operations as required; ensures appropriate notifications are made regarding significant events as per established procedure;
- While assigned to Training and Quality Improvement, supervises the orientation and in-service training of new employees; monitors the progress of new employees during the probationary period; submits written reports as required; assists in continuing medical education programs offered by the Department; maintains records on the certification requirements of all uniformed personnel; participates in continuous quality improvement; may be reassigned to Field Operations or Dispatch Operations as required;
- Performs related duties as required.

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TRAINING SUPERVISOR / CAPTAIN

The Training Supervisor / Captain is responsible for the supervision of EMTs, Paramedics, and Lieutenants. In addition to responding to emergencies and providing care, the Training Supervisor's duties and responsibilities include:

- Plans, develops, and implements training programs for EMS, other public safety agencies, other health care providers, and the general public;
- Prepares and conducts continuing education for EMS members;
- Conducts CPR training, CPR Instructor-Training, and CPR recertification training for Department members, other health care providers, and the general public;
- Conducts in-service training on new equipment;
- Develops, plans, and conducts Recruit training for all newly hired EMTs;

- Files the necessary forms, documentation and course material for program approval/certification with regional, state or other agencies in compliance with Massachusetts EMT-Instructor/Coordinator requirements;
- Plans and conducts Basic EMT courses as sponsored by the Department; serves as Massachusetts Instructor/Coordinator on Department sponsored EMT programs;
- Assists in planning and conducting training programs in the Department diversity recruitment program (Cadet Program);
- Serves as Field Supervisor or Dispatch Operations Supervisor as assigned. Assumes operational responsibility at the scene of an emergency until relieved by a person of higher rank; Provides clinical supervision of EMTs;
- Represents the Department at state and regional committees;
- Performs related duties as required.

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CAPTAIN / PRINCIPAL EMERGENCY MEDICAL TECHNICIAN

The Captain / Principal Emergency Medical Technician is responsible for the Supervision of EMTs, Paramedics, and Lieutenants. A Captain may be assigned to Special Operations, Dispatch Operations, Professional Standards, or another area of the Department as required. In addition to responding to emergencies and providing care, the Captain's duties and responsibilities include:

- Maintain familiarity with all EMS equipment, operate emergency vehicles and communication equipment;
- Represent the Department in meetings with members of other city agencies, the public, or regulatory agencies;
- Prepare records and reports as required. Review records and reports prepared by subordinates for completeness and accuracy;
- Respond to emergencies: serve in the Incident Command System providing supervision as assigned; provide operational supervision at multiple casualty incidents; facilitate patient care, examine, assess, and stabilize patients at emergency scenes;
- Plan, develop, and recommend policies and procedures. Interpret, apply and ensure compliance with EMS' policies and procedures;
- Assist in the development and management of systems to receive, investigate and prepare reports on complaints concerning the delivery of emergency services;
- Conduct inspections of EMS personnel, vehicles, and stations for compliance with applicable standards; conduct and investigate internal loss cases, employee conduct, worker's compensation, and related matters;
- Under direction, assists with contracts, billing, and vendor relations for assigned section or area as required.
- Performs related duties as required.

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DEPUTY SUPERINTENDENT

A Deputy Superintendent is a member of the Command Staff with authority and responsibility for management of a particular shift, special project, or one or more EMS functions or activities. In addition to responding to emergencies and providing care, a Deputy Superintendent's duties and responsibilities include:

- Implement and oversee departmental policies and procedures to enhance employee performance and insure the effective delivery of emergency medical services.
- Attend meetings with subordinate staff and others to review and discuss operational needs, managerial improvements, and enhancements to policies and procedures.
- Implement programs to document staff performance. Prepare and review records and reports of activities performed by subordinate staff; supervise and observe the work of subordinate staff to determine training needs or disciplinary action
- Conduct investigations as needed; recommend and participate in disciplinary matters as required or directed. Insure compliance with operational and/or clinical policies, procedures, and protocols;
- Prepare written materials and presentations Respond to emergency incidents to provide operational or clinical supervisor at mass casualty incidents; assume command of EMS operations and resource deployment until relieved by superior officer
- Prepare records and reports of shift or unit activities; Review records and reports prepared by subordinates for completeness and accuracy
- Represent the department before the media, civic organizations, the general public and others as directed and authorized
- Implement and oversee departmental policies and procedures to enhance employee performance and insure the effective delivery of emergency medical services
- Schedule and when necessary, change work assignments.
- May be required to be part of an on-call manager rotation and be subject to mandatory overtime. Perform other duties as required.

SUPERINTENDENT

Under the general or specific direction of the Chief or Superintendent in Chief, in addition to responding to emergencies and providing care, a Superintendent may be assigned any of the following duties and responsibilities:

- Provide direction and leadership on matters related to the management and operation of EMS. Develop, implement, and oversee departmental policies and procedures to enhance employee performance and insure the effective delivery of emergency medical services.
- Provide leadership and direction on operational needs, managerial improvements, and enhancements to policies and procedures.
- Supervise, train, and evaluate subordinate personnel. Prepare and implement programs to document staff performance. Conduct in-depth analysis of EMS

practices and procedures to assess their effectiveness and determine measures for improvements.

- Plan, develop, and conduct management training and operational training and operational training for EMS staff.
- Review and evaluate records and reports of EMS activities. Conduct investigations as needed and recommend and participate in disciplinary matters.
- Manage or oversee one or more EMS bureaus or functions. Prepare written reports and presentations for EMS and outside entities. Represent EMS at public functions and other forums.
- Insure compliance with operational and/or clinical policies, procedures and protocols. Respond to emergency incidents and fires and work in hazardous environments as required to facilitate patient care; examine, assess and stabilize patients at emergency scenes; administer treatment, prepare patients for transport, prepare documentation of care received, and transport patients.
- At emergency incidents provide operational supervision and/or command of EMS operations and resource deployment. Interact with public safety personnel at incident scenes to insure proper coordination and to enhance pre-hospital patient care.
- May be assigned to serve as a shift commander as directed; and may be required to be part of an on-call manager rotation and be subject to mandatory overtime. Perform other duties as required.

Organization and Administration

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Boston EMS is structured into a series of organizational components that represent functional groupings of employees performing similar activities. This structure provides management with a means of assigning responsibility for performance of a group of functions to a single supervisor or manager, and clarifies to whom specific employees are accountable.

The structure of the organization is management's mechanism for bringing together and coordinating resources to accomplish goals and objectives. The Chief of Department may establish any organizational units and assign functions as deemed necessary to support the effective and efficient accomplishment of the agency's goals, objectives, responsibilities, and functions. The Department will establish a table of organization, which will be periodically updated to reflect changes and will be made available to all department personnel.

SYSTEM OVERVIEW

Boston EMS is the lead agency for the provision of emergency medical services for the City of Boston. The Boston emergency medical services system is comprised of public and private organizations that provide a comprehensive delivery of pre-hospital and in-hospital emergency medical care. Boston EMS is responsible for the management of the pre-hospital component: first responders, basic life support, advanced life support, and telecommunications, including the Boston EMS Ambulance Mutual Aid (BAMA) network and the regional CMED system. Private and municipal ambulance services in the Metro Boston area provide backup support through mutual aid agreements as needed. Boston EMS and the Conference of Boston Teaching Hospitals, a consortium of local hospitals and their emergency departments, are continually evaluating and improving the delivery of emergency care especially in the area of multiple casualty preparedness.

1. ***Coordination of Scene Care*** - Working closely with other public and private agencies, EMS personnel shall direct and coordinate the provision of emergency medical care on scene and en route to a hospital.
2. ***Pre-Hospital Communications*** - Communication between units and/or with a hospital emergency department is accomplished by a multi-channel ultra-high frequency (UHF) radio coordinated by the Boston EMS Dispatch Operations Center.
3. ***Basic Life Support*** - Basic Life Support ambulances are deployed in districts throughout the city and respond to all types of medical emergencies. District ambulances are staffed by Boston EMS -certified EMTs who administer basic life support skills. EMTs are also trained in telecommunications, emergency vehicle

operation, infection control, hazardous material and mass casualty incident (MCI) management.

4. ***Advanced Life Support*** - Advanced Life Support ambulances are deployed in zones and respond primarily to emergencies considered life-threatening or urgent. Boston EMS certified Paramedics who staff the ALS units are certified to administer intravenous fluids, a wide array of pharmaceuticals; to interpret electrocardiograms and various cardiac arrhythmias, defibrillate, and perform synchronized cardioversion; to perform endotracheal intubation and cricothyrotomy; and to perform other advanced life support techniques as required.

ORGANIZATIONAL STRUCTURE

The following description is not intended to be all inclusive, but rather give an overview of the organizational structure of the Department.

CHIEF OF DEPARTMENT (C-1)
The Chief of Department serves as the head of Boston EMS. In close consultation with the Medical Director, the Chief of Department is responsible for the overall management, planning, direction and control of the Department. The Chief of Department reports to the Boston Public Health Commission Board of Directors through the Executive Director of the Public Health Commission. Within the Office of the Chief are the following areas:

- Chief of Staff
- Deputy Chief of Staff
- Peer Support Unit
- Personnel Services

MEDICAL DIRECTOR (MD-1)

The Medical Director is a physician responsible for providing clinical guidance, leadership and quality assurance for the City of Boston's three public safety departments: police, fire and EMS. The Office of the Medical Director includes:

- Associate Medical Directors
- Boston EMS Physician Fellows

The Medical Director is also responsible for providing clinical oversight to Boston EMS' Research Training Quality Improvement (RTQI) team as described under the "Professional Development and Community Initiatives" section of this document.

SUPERINTENDENT IN CHIEF (C-2)
Reporting directly to the Chief of Department, the Superintendent in Chief oversees the combined responsibilities and resources of all Boston EMS Divisions. The Superintendent in Chief assists in the formulation of Department policies and is

delegated the authority of Chief of Department in the Chief's absence. Within the Office of the Superintendent in Chief are the following areas:

- The Professional Standards Division
- Materials Management

OPERATIONS

Under the direction and oversight of a Superintendent, Operations is comprised of all field response units, including Shift Commanders, Field Supervisors, and both Basic and Advanced Life Support ambulances. Operations is also comprised of Dispatch Operations which receives, prioritizes (using established Emergency Medical Dispatch criteria), and records all incoming calls for service; dispatches emergency units in accordance with established procedures; and maintains the status of all responses. Additional areas under the direction of Operations include:

- Fleet Services
- Office of Safety

SPECIAL OPERATIONS AND EMERGENCY PREPAREDNESS

Under the direction and oversight of a Superintendent, Special Operations and Emergency Preparedness is responsible for both tactical and operational planning for major events and homeland security / preparedness issues throughout the City.

- Special Operations Division: This Division provides planning, logistics and consequence management for major events, both planned and unplanned, throughout the City including special events, VIP protection, hazardous materials and mass casualty incident support.
- Emergency Preparedness/Emergency Management Coordination

PROFESSIONAL DEVELOPMENT AND COMMUNITY INITIATIVES

Under the direction of a Superintendent, Professional Development and Community Initiatives focuses on effective recruiting, community outreach and education, ongoing training, and professional development for all employees.

- Research, Training, and Quality Improvement (RTQI): RTQI is accredited by the Massachusetts Office of Emergency Medical Services (OEMS) as a Training Institution for EMT Training at the Basic, Intermediate, and Paramedic Levels. RTQI is responsible for the following:
    - maintaining and reviewing the certification of all personnel;
    - scheduling and coordinating Continuing Education, refresher and CPR courses as required;
    - establishing and monitoring the competence of new employees through the BEMS recruit academy;
    - conducting clinical review sessions; and
    - developing public education and clinical research programs.

- Community Initiatives and Recruiting: This unit is responsible for coordinating and providing community programming designed to educate the public about important health topics. Additionally, the unit oversees the Department's recruitment efforts.

SUPPORT SERVICES

Boston EMS operations is supported by the following five Support Service units:

- Fleet Services: Fleet Services is responsible for managing all activities associated with Department vehicles including scheduling and developing specifications for replacement, distribution, maintenance, repair, and licensing.

- Materials Management: This unit manages and accounts for the supplies and equipment necessary for the ongoing needs of the department including durable and disposable equipment, uniforms and pharmaceuticals.

- Facilities Management: Facilities Management is responsible for coordinating facility maintenance repair requests and renovations for the Department's stations, administrative offices, and other facilities.

- Communications Engineering Unit (CEU): CEU is responsible for the planning, implementation, management and maintenance of critical radio systems to support Boston EMS and the Metro-Boston Central Medical Emergency Direction (CMED) radio networks.

- Management Information Systems Unit (MIS): MIS is responsible for establishing and maintaining the department information systems, technology and networks, ensuring reliability and security.

ADMINISTRATION AND FINANCE

Central to the administration and finance functions at Boston EMS is the Budget Office.

- Budget Office: The Budget Office also prepares the Department's annual budget submissions, establishes budget-related policies, manages payroll, and oversees grant administration. Additionally, the unit develops and monitors spending control plans, manages procurement, processes accounts payable and receivable, and performs associated financial analysis.

CHAIN OF COMMAND

There are two functional chains of command: operational and clinical. The operational chain of command describes the levels of responsibility and authority concerning administrative and procedural matters, e.g., the adherence to rules and regulations contained in this manual. The clinical chain of command describes the levels of

responsibility and authority according to the degree of clinical training and certification, e.g., Basic Life Support and Advanced Life Support.

Operational Chain of Command

The following are named by title and are listed according to authority and responsibility in descending order:

- Chief of Department
- Superintendent in Chief
- Superintendent
- Deputy Superintendent
- Captain
- Lieutenant
- BEMS EMT-Paramedic
- BEMS EMT
- BEMS Recruit

Clinical Chain of Command

The following are named by title and are listed according to authority and responsibility in descending order:

- Medical Director
- Associate Medical Director
- BEMS EMT-Paramedic
- BEMS EMT
- BEMS Recruit

UNITY OF COMMAND

Each member is accountable to only one supervisor at any given time. Each member shall be responsible or accountable to his regular immediate supervisor, except when working on a special assignment, incident, or temporarily assigned to another unit. In such cases, the member shall be accountable to the supervisor in charge of the assignment or incident. Similarly, each organizational component shall be under the direct command of only one supervisor as shown on the Department organizational chart. At times, a commanding officer may be required to give a lawful order to a member or component that is outside of his normal chain of command. In such cases, rank will be respected and the order shall be obeyed. Employees will be given commensurate authority to accomplish their responsibilities. Each employee will be held accountable for the use of delegated authority. Supervisory personnel are

accountable for the activities of employees under their immediate supervision and control.

COMMAND OF JOINT OPERATIONS

When two or more components within the Department are engaged in a joint operation, the person in charge shall be clearly identified to all participants at the beginning of the operation.

SUCCESSION OF COMMAND

In order to ensure continuity of command, section Commanders or managers have the authority to designate a temporary replacement for short-term absences due to vacation, training, etc. subject to approval of the Chief of Department. In the absence of the Chief, the Superintendent in Chief will act for the Chief and with his authority. The succession of Command will continue through the chain of command based on position and seniority, unless otherwise directed by competent authority. An Acting Chief is authorized to carry out all powers, authority, and duties conferred upon the Chief, except promoting or demoting a member of the Department without the authorization of the Chief or in consultation with the Executive Director of the Public Health Commission.

Standard of Care

Boston EMS must first and foremost operate as a professional medical service. As such, members providing patient care services are held accountable to a standard of care in the same manner, as are all other patient care providers.

The standard of care for Boston EMS has several components. The first component is the force of law standard. This is the standard imposed by Massachusetts General Law Chapter 111c, regulating ambulances and ambulance services and regulations hereinafter promulgated.

The next element is the standard of ethics by which an EMT or Paramedic is bound not to disclose details of patient history and/or treatment except as authorized to other professionals involved with patient care or as required by law.

The EMT and paramedic has a moral obligation to provide the best care possible to each patient he/she attends, as determined by the limits of his/her training, without regard for the patient's age, sex, religion, sexual orientation, or ability to pay.

Finally, Boston EMS has established institutional standards. These standards are described in the Statewide Treatment protocols issued by the Department of Public Health, Office of Emergency Medical Services, and by the Medical Director of Boston EMS.

Definitions

The following terms and abbreviations are commonly used in Boston EMS and in this manual:

"Acting" Position:	An employee who is filling a temporary vacancy in a promotional position until such vacancy is filled on a permanent basis;
Administration:	The management and command level of Boston EMS including administrative staff assigned to EMS Headquarters;
ALS:	Advanced Life Support: a paramedic unit or the advanced procedures and skills performed by an EMT-Paramedic
Associate Medical Director:	A physician employee of the Department who assists the Medical Director with ongoing Department training, Quality Assurance, and Research projects. May function as medical director or department liaison on special projects;
BLS:	Basic Life Support: a Basic Life Support ambulance or the procedures and skills performed by an EMT-Basic;
Bureau:	A major subdivision of Boston EMS comprised of Sections and Divisions.
Cadet or EMS Intern:	An employee in training to become eligible as a Recruit EMT;
Captain:	A ranking officer with supervisory and inspectional responsibilities as assigned; A Captain is subordinate to a Command Staff Officer and superior in rank to a Lieutenant; the "Training Supervisor" and "Principal EMT" job titles hold the rank of Captain.
Chief of Department:	Highest ranking Command Staff member charged with authority and responsibility for overseeing the day-to-day operation of the

	Department.
CMED:	Central Medical Emergency Direction; Boston EMS is the contracted provider of CMED Services for Massachusetts EMS Region IV;
CMR:	Code of Massachusetts Regulations;
COB	City of Boston
COBTH:	The Conference of Boston Teaching Hospitals; a consortium of area receiving hospitals participating in providing medical care and disaster management to the Boston area;
Command Staff:	The command level of Boston EMS with responsibility for coordinating and directing all activities of the Department;
Department:	Boston Emergency Medical Services (Boston EMS);
Deputy Superintendent	A member of the Command Staff with authority and responsibility for a particular shift, special event, or special project; superior in rank to Captain, and subordinate to Superintendent;
District:	A geographical area of the City comprised of census tracts, for the purpose of establishing ALS and BLS response and service areas;
Division:	A geographical portion of the city comprised of one or more districts (eg. Division 1, Division 2); a component of a Bureau of Boston EMS.
DPH:	The Massachusetts Department of Public Health;
Emergency Medical Technician (EMT):	A generic term describing all levels of certification as set forth in the Massachusetts General Laws, Chapter 111c and the pertinent regulations under the law;
EMT-Basic:	A Department employee who has successfully completed the Boston EMS classroom and field internship, and has become certified to perform

	Basic Life Support Skills;
EMT-Paramedic:	A Department EMT who has successfully completed the Boston EMS ALS clinical training and field internship and is certified by both State regulations and Boston EMS policies to perform Advanced Life Support skills;
EMT-Recruit:	An employee who is undergoing a didactic orientation or a field internship in order to be considered for promotion to EMT-Basic;
ETA:	Estimated Time of Arrival;
Executive Director:	The Executive Director of the Public Health Commission;
First Responder:	Public safety personnel trained in CPR and basic first aid, as set forth by 105 CMR 171.000, the Massachusetts First Responder Training Regulations;
Lieutenant :	A supervisory officer with administrative and clinical responsibility and authority over EMTs, recruits, and EMS intern, and administrative responsibility and authority over EMT-Paramedics. Lieutenants may be assigned operational supervision over Field Units and Dispatch Operations personnel. Formerly referred to as Senior EMT;
MCI:	Multiple (or Mass) Casualty Incident;
Medical Director:	The designated emergency physician with overall responsibility for clinical protocols, clinical standards and practices, clinical training, research projects, Medical Control, physician support to Boston EMS and physician overview of medical continuous quality improvement activities;
Patient Care Report (PCR):	The designated form or electronic template for documenting all aspects of patient assessment and treatment. It is completed for each ambulance response or other incident unless the unit is canceled prior to arrival. Also

	referred to as a trip sheet;
Permanent Employee:	A person employed in a civil service position: (1) following an appointment subject to serving a probationary period; (2) following a promotional appointment;
PHC:	The Boston Public Health Commission. Boston EMS is a bureau of the PHC;
Probationary Employee:	An employee who has not completed the prescribed probationary period;
Section:	A component of a Division of Boston EMS; and also a functional subdivision within the Incident Command System;
Service Zone Plan:	In accordance with MGL c 111C, a comprehensive plan that defines the local EMS resources and describes how those resources will be used and coordinated;
Shift Commander:	A Department certified EMT-Paramedic member of the Command Staff with authority and responsibility for a particular shift, division, or special project; a Shift Commander holds the rank of Deputy Superintendent;
Stations:	Designated base locations or quarters for Department personnel and equipment;
Superintendent:	A ranking Command Staff Officer superior to Deputy Superintendent, and subordinate to the Superintendent in Chief
Superintendent in Chief:	A ranking Command Staff officer with responsibility for all uniformed members of the service; superior to Superintendent, and reports directly to the Chief of Department;
Trip:	An ambulance call or run;
Two-Tiered Response:	A response requiring the dispatch of both a BLS and an ALS ambulance;
Uniformed Member:	Personnel holding the following ranks are

	considered uniformed members of the service: Chief of Department, Superintendent in Chief, Superintendent, Deputy Superintendent, Captain (Principal EMT), Captain (Training Supervisor), Lieutenant (Senior EMT), EMT-Paramedic, EMT-Basic and EMT-Recruit.
Unit:	A response vehicle; e.g., a BLS unit, or Field Supervisory unit; a specialized group such as the Bike Team Unit

Authority: EMS Agreement

The Emergency Medical Services Agreement was entered into on July 1, 1996 by and among Boston Medical Center Corporation (“the Corporation”), a charitable corporation organized under the laws of the Commonwealth of Massachusetts, the Boston Public Health Commission (“the Commission”), a public authority created pursuant to Chapter 147 of the Acts of 1995 of the General Court of the Commonwealth of Massachusetts (the “Enabling Act”), and the City of Boston (“the City”).

Whereas the Public Health Commission was established pursuant to the enabling act and is responsible, among other things, for providing or arranging for the provision of Emergency Medical Service (“EMS Services”) and other public health programs and activities; and

Whereas, pursuant to the Enabling Act, the City of Boston has entered into a certain Consolidation Agreement (“the “Consolidation Agreement”) with University Hospital, Inc. and a certain lease with the Corporation pursuant to which University and the operations of Boston City Hospital and Boston Specialty Rehabilitation Hospital are being consolidated into the Corporation; and

Whereas the Consolidation agreement provides that the City and the Commission will enter into a contract with the Corporation pursuant to which the Corporation will be the sole provider of EMS services on behalf of the City and the Commission and will use the personnel employed by the Commission in its Boston EMS unit (“Boston EMS”) to provide such EMS services.

EMS Services to be provided will include:

a) Providing emergency medical response for all geographic areas within the City of Boston, including but not limited to Massport, Metropolitan District Commission, and State and Federal Properties. Such emergency medical response coverage shall include responding to:
    a. 9-1-1 emergency calls in the City of Boston
    b. Boston Police and Fire Department stand-bys;
    c. Boston Police Bomb Squad stand-bys;
    d. Boston Police Harbor Patrol;
    e. Logan Airport Stand-bys;
    f. Decontamination of patients in hazardous materials waste situations;
    g. Presidential and heads of state stand-bys (VIP Protection details);
    h. Environmental emergencies, including but not limited to heat, cold, snow, hurricanes;
    i. Major public events including but not limited to parades, concerts, Fourth of July, First Night, Boston Marathon, Caribbean and Puerto Rican Festivals;
    j. Mass Casualty incidents

   k. U.S. Public Health Service, National Disaster Medical Systems; and
   l. Mutual aid to other cities and towns.

b) Providing emergency medical support and training for all Federal public safety agencies in the City of Boston, including but not limited to ATF, FBI, US Secret Service, DEA, INS, Department of Defense, State Department, FAA, NTSB, NHTSA, White House Medical, Federal Protective Services, Department of Interior, and US Coast Guard;
c) Pre-planning for medical emergencies in high rise buildings, in high occupancy apartments, including but not limited to Prudential Center Complex, John Hancock, and Federal Reserve Bank;
d) Providing emergency medical support and training for the Boston business community, including but not limited to hotels and convention centers;
e) Providing emergency medical support and training to MBTA, Amtrak, Conrail, MassPort Fire Department, Boston Fire Department, Boston Police Department, Suffolk County Sheriff's Department, Massachusetts Highway Department, and the Central Artery / Third Harbor Tunnel project;
f) Providing community education and public relations services, including but not limited to schools, heath fairs, senior centers, EMT and Paramedic certificate courses;
g) Providing emergency medical call answering and dispatch services for the City of Boston; and
h) Providing CMED (i.e. ambulance to hospital communications and inter-hospital communications for EMS) for the City of Boston

Advanced Life Support Affiliation Agreement

This Agreement is made and entered into on the January 01, 2005 , between the Boston Public Health Commission acting through its Emergency Medical Services bureau (the Ambulance Service) and the Boston Medical Center (the Hospital).

Preamble:

- The Ambulance Service is licensed to provide pre-hospital Advanced Life Support (ALS) emergency medical services, and its emergency medical technicians (EMTs) are certified at the appropriate ALS level of care to allow the Ambulance Service to deliver ALS at its level of licensure; and

- A key state regulatory requirement and clinical component of providing quality pre-hospital care at the ALS level is ensuring ALS personnel receive effective medical oversight services from a committed hospital with an emergency department staffed by physicians 24 hours per day, and

- The Hospital is equipped and committed to providing medical oversight services as described herein for the provision of pre-hospital ALS care by the EMTs certified to provide ALS care employed by the Ambulance Service; and

- The parties are committed to meeting the requirements of the Massachusetts Department of Public Health's (Department's) Emergency Medical Services Regulations, 105 CMR 170.300, regarding affiliation agreements between an ambulance service licensed to provide Advanced Life Support services and a hospital with an Emergency Department staffed by physicians 24 hours per day, in order to establish an effective plan for medical oversight.

THE PARTIES AGREE AS FOLLOW:

The Ambulance Service Agrees:

1. To staff its ambulances assigned to provide ALS services with EMTs fully trained, oriented and certified at the appropriate ALS level.
2. To equip all ALS ambulances with the communication, treatment, and monitoring equipment required by the Department and the Hospital in order to provide effective EMS at the level of care for which the ambulance service is licensed.
3. To provide patient care in accordance with the Statewide Treatment Protocols.
4. To participate in the quality assurance/quality improvement (QA/QI) program operated under the direction of the Affiliate Hospital Medical Director, and in accordance with requirements of this Agreement.
5. To notify the Medical Director of all certified EMTs requiring authorization to practice.

6. To notify the Medical Director of all personnel changes involving certified EMTs who will provide pre-hospital ALS.
7. To provide the Medical Director with information regarding any certified EMTs who provide ALS care against whom there has been any disciplinary action taken by the Department, and/or for whom any remediation has been ordered or indicated.
8. To ensure that its certified EMTs are providing ALS care in accordance with the Medical Director's authorization to practice.
9. To provide the Medical Director with a copy of its current dispatch protocols.
10. To provide the Medical Director with a copy of all trip records, incident reports and, upon request, any other pertinent patient care related documents and data, related to the Ambulance Service's provision of pre-hospital EMS in cases in which ALS was requested, even if not provided.
11. To ensure its certified EMTs providing ALS care participate in remediation, training and retraining, as necessary, under the oversight of the Medical Director, or his or her designee.
12. To follow Regional point-of-entry plan(s) approved by the Department and other relevant regulations, policies and administrative requirements of the Department.
13. To obtain those controlled substances indicated in the Statewide Treatment Protocols from the hospital and to adhere to the hospital's policies in regard to handling, dispensing, disposal and accounting of such substances.

The Hospital Agrees:

To provide medical control oversight to Boston Emergency Medical Services personnel.

1. To designate a medical director (Medical Director), who shall have authority over the clinical and patient care aspects of the Ambulance Service's provision of pre-hospital ALS services, including but not limited to the authorization to practice of its EMS personnel, and the denial or withdrawal of such authorization to practice.
2. To provide on-line medical direction in accordance with the Statewide Treatment Protocols 24 hours a day, seven days a week, by a hospital-based physician(s).
3. To comply with the State EMS Communication Plan regarding medical direction communications.
4. To operate, under the direction of the Medical Director, an effective quality assurance/quality improvement (QA/QI) program, in which on-line medical direction physician(s) shall participate.
5. To operate said QA/QI program in accordance with QA/QI standards and protocols.
6. To ensure that said QA/QI program shall include, but not be limited to, regular review of trip records and other data pertinent to the Ambulance Service's provision of patient care in cases in which ALS services were requested, whether ALS services were provided or not. Such review shall take place on an ongoing, regular basis through the ambulance service's Research, Training, and Quality Improvement Division.
7. In conjunction with the Boston Emergency Medical Service Research, Training, and Quality Improvement Division, operate a program for skill maintenance and

review for each of the Ambulance Service's certified EMTs providing ALS care, in accordance with standards and protocols for effective skill maintenance and review.

8. To ensure each of the Ambulance Service's certified EMTs providing ALS care have access to remediation, training and retraining, as necessary, under the oversight of the Medical Director, or his or her designee. Such access to remediation, training and retraining shall at minimum include the provision of additional clinical and/or didactic training; skill maintenance in ER, OR, ICU, or simulation laboratory setting; participation in research projects; or other means as deemed necessary and appropriate by the Medical Director.
9. To provide regular consultation opportunities between its medical and nursing staffs and the Ambulance Service's certified EMTs providing ALS care, to review and discuss various aspects concerning the performance of the Ambulance Service's delivery of ALS care, including, but not limited to, attendance at morbidity and mortality rounds and chart reviews, presentations during monthly training sessions, tabletop exercises, and ride-alongs observer programs.

Both Parties Agree:

1. To implement and maintain a program for skill maintenance and review of the Ambulance Service's certified EMTs providing ALS care, in accordance with standards and protocols for effective skill maintenance and review.
2. To implement and maintain a procedure by which a Hospital physician can maintain recorded direct verbal contact with the EMT regarding a particular patient's condition and order, when appropriate, the administration of a medication or treatment for that patient.

3. To be responsive to the other party's concerns and needs, acting in a timely manner to resolve all problems and meet reasonable needs.
4. To review this document at least annually, and make any updates necessary to ensure it is consistent with current practice.
5. To notify the Department of Public Health's Office of Emergency Medical Services in writing should any changes occur altering the specifics of the agreement.

Rules & Regulations

Annual Hair Testing Procedure

Supersedes:
Effective: 07-28-08

A. General

1. The Commission ("PHC") will provide the BPD with a list of all employees covered by the policy. The list will include the employee's name, date of birth, date of hire, employee number, social security number (for tracking purposes), and rank/title.

2. PHC and Boston EMS ("the Department") will update the list by notifying BPD promptly of the identities of any newly hired employees covered by the policy, any employees who are terminated, and any employees who have changed rank/title.

3 The Boston Police Department's Occupational Health Office ("BPD") will identify employees for testing pursuant to the BEMS Substance Abuse Testing Policy ("the policy") on a weekly basis in accordance with these procedures.

B. Employee Notification

1. On or about the fifteenth (15th) day of each calendar month, the Department will send a general notice by electronic mail or other means selected by the Department to all employees reminding them that they are obligated under the policy to submit hair specimens for drug analysis as directed during the period thirty (30) days before to thirty (30) days after their birthdays

2. On or about the last day of every calendar month, PHC will send a written notice to all employees whose birthdays fall in the month after the ensuing calendar month that reminds them of their obligations to submit a hair specimen for drug analysis pursuant to the policy. (See Form 1)

C. Scheduling of Collections

1. Each week, no later than Tuesday, the BPD will send a list to the Department that identifies the employees eligible to be tested during the following week. BPD will simultaneously inform the Department of the times and dates during the week on which specimen collection can be done.

2. Upon receiving the BPD list, the Department will take the following action:

a. Check the Telestaff schedule to determine which employees are active and scheduled to work that following week when testing is available and tentatively schedule as many employees as possible. The Department shall determine whether an employee's partner is also subject to an annual hair test under the policy and, if so, shall schedule both the employee and his/her partner to appear for specimen collection at the same time. The list of employees scheduled to appear for testing the following week will then be returned to BPD.

b. If any of the employees on the BPD list are on extended leaves of absence, the Department will send a written order to appear for specimen collection. (See Form 2A). The order shall specify the date, time, and location of the employee's specimen collection and shall be sent by certified mail to the employee's home address.

c. The Department shall inform the BPD of the employees it has tentatively scheduled for specimen collection no later than Thursday before the week in which the collection will be conducted.

3. Using the schedule provided by the Department, the BPD shall prepare a written notice to appear for specimen collection for each employee to be tested in the following week. The notice shall specify the date, shift, and location of the employee's specimen collection. The BPD shall forward the notice(s) to the Department's Professional Standards Division.

4. The Department's Professional Standards Division shall deliver the written notices to appear to the applicable Shift Commander(s). The Shift Commander or designee shall give the employee the written order to appear during the employee's work shift and make any necessary arrangements for the employee to appear for specimen collection as directed. Except in the case of an employee being notified by certified mail, no staff shall notify an employee of his/her order to appear in advance of the shift on which the employee must appear.

5. An employee shall not be relieved of duty during a shift on which he/she is scheduled to appear for specimen collection except in case of an emergency. If an employee who has been informed of his/her obligation to appear for specimen collection leaves work during his/her shift without first providing a specimen or without the express approval of the Shift Commander, the Shift Commander shall report the fact immediately to the Professional Standards Division.

6. Each week, the BPD shall provide a summary of all employees that reported for testing, and whether or not an adequate sample was collected.

7. If an employee is absent or otherwise unavailable on the day that BPD and the Department scheduled him/her to appear for specimen collection, the

Department will attempt to schedule a substitute employee, provided that the substitute is subject to testing under the policy.

D. Inadequate Specimens

1. If the BPD is unable to obtain three (3) hair specimens from an employee who appears for collection, it shall give the employee a written order from the Department advising the employee that he/she must not cut or shave any head or non-genital body hair pending further collection. See Form 3.

2. If the initial testing laboratory reports that an employee's hair specimen was inadequate for any reason, BPD and the Department will schedule another collection, provided that the time for testing the employee under the policy has not expired.

Anti-Discrimination, Harassment, and Retaliation

Supersedes: 03-12-04
Effective: 06-2008
[BPHC Policy # 103]

I. PURPOSE

The Boston Public Health Commission ("BPHC") affirms its commitment to maintain a work environment free of discrimination and harassment based on race, color, religious creed, age, national origin, disability, sex, sexual orientation, gender identity or expression, political affiliation or veteran status (in this policy, harassment based on race, color, religious creed, age, national origin, disability, sex, sexual orientation, gender identity or expression, political affiliation or veteran status is referred to as "harassment based on discrimination"). The BPHC affirms its commitment to maintain a work environment free of retaliation based on an employee having complained of or opposed discrimination or harassment based on discrimination, or based on an employee having cooperated or assisted with an investigation into discrimination or harassment based on discrimination.

II. POLICY

The BPHC expects all employees to conduct themselves in a professional manner with respect and concern for their fellow employees. Discrimination and harassment based on discrimination are unlawful and will not be tolerated. Retaliation against any employee who has complained of or opposed discrimination, harassment based on discrimination or retaliation or against any employee who has cooperated or assisted with an investigation into such conduct, is unlawful and likewise will not be tolerated.

III. PROCEDURE

A. GENERAL

1. It is BPHC's policy that all employees, clients and visitors have a right to work and be in an environment free from any type of discrimination, harassment based on discrimination or retaliation.
2. The BPHC shall post notice of the Fair Employment Law pursuant to M.G.L. c. 151B §7 at locations where it posts notices to employees of their rights under federal and state anti-discrimination laws. The BPHC is committed to adhering to applicable federal and state laws regarding discrimination, harassment based on discrimination and retaliation and will investigate and resolve any such complaints.

3. The BPHC prohibits discrimination, harassment based on discrimination and retaliation against employees, clients and visitors in any form. Such conduct will result in disciplinary action against employees up to and including termination. Clients and visitors engaging in prohibited conduct may be barred from BPHC property. Any incident may be referred for legal action or other appropriate measure to assure such activity does not recur.

B. DEFINITIONS & PROHIBITED BEHAVIOR

1. Discrimination, harassment based on discrimination and retaliation is contrary to BPHC policy and may also be against the law. The BPHC defines such conduct as follows:

a. Conduct that conditions a person's hiring, compensation, terms and conditions of employment, or access to services provided by the BPHC on that person's race, color, religious creed, age, national origin, disability, sex, sexual orientation (which shall not include a person whose sexual orientation involves minor children as a sex object), gender identity or expression, political affiliation or veteran status, unless otherwise permitted or required by applicable law;

b. Adverse employment decisions or decisions regarding access to BPHC services directed against a person in retaliation for filing a complaint of or opposing discrimination, harassment based on discrimination or retaliation, or for participating in or assisting with an investigation or proceeding related to such; or

c. Harassing conduct of any type (oral, written, graphic or physical) directed against a person: i) because of his or her race, color, religious creed, age, national origin, disability, sex, sexual orientation (which shall not include a person whose sexual orientation involves minor children as a sex object), gender identity or expression, political affiliation or veteran status OR ii) in retaliation for filing a complaint of or opposing discrimination, harassment based on discrimination or retaliation, or for participating in or assisting with an investigation or proceeding related to such AND which also unreasonably interferes with the person's work or creates a work environment that a reasonable person would find hostile, offensive, humiliating or intimidating.

2. Discrimination, harassment based on discrimination or retaliation can take many forms and deciding whether the definition is met requires looking at all of the circumstances. While it is not possible for the BPHC to list all circumstances that may constitute discrimination, harassment based on discrimination or retaliation, the following are some examples of conduct which may constitute such, depending upon the totality of the circumstances, including the severity of the conduct and its pervasiveness:

a. Directing racial or ethnic slurs at someone;

b. Telling a person they are too old to understand new technology;
c. Teasing or mocking a person because of or about that person's disability;
d. Ridiculing a person's religious beliefs;
e. Any suggestion that race, color, religious creed, age, national origin, disability, sex, sexual orientation (which shall not include a person whose sexual orientation involves minor children as a sex object), gender identity or expression, political affiliation or veteran status or any protected classification would affect one's job, promotion, performance evaluation, access to services, working conditions or housing;
f. Employment decisions (such as hiring, firing, promotion, and discipline) based on stereotypes or assumptions about the abilities, traits or performance of individuals of a certain race, color, religious creed, age, national origin, disability, sex, sexual orientation (which shall not include a person whose sexual orientation involves minor children as a sex object), gender identity or expression, political affiliation, veteran status or other protected classification;
g. Denying employment opportunities to a person because of marriage to, or association with, an individual of a particular race, color, religious creed, age, national origin, disability, sex, sexual orientation (which shall not include a person whose sexual orientation involves minor children as a sex object), gender identity or expression, political affiliation, veteran status or other protected classification;
h. Retaliation against an individual for filing a charge or opposing discrimination, harassment based on discrimination or retaliation, or for participating in or assisting with an investigation or proceeding related to such, or for associating him or herself with another who has done so by taking an adverse employment action against that individual, such as termination, discipline, negative performance evaluation, or adverse change in work assignments; or
i. Denying employment opportunities to an individual because of birthplace, ancestry, culture, or linguistic characteristics common to a specific ethnic group. A rule requiring that employees speak only English on the job may violate discrimination laws unless the requirement is necessary for conducting business. If such a rule is necessary, employees must be informed when English is required and the consequences for violating the rule.

3. The BPHC also prohibits discrimination, harassment based on discrimination or retaliation by and against a client or vistor of the BPHC. A client is anyone for whom the BPHC renders services. A visitor is anyone authorized to be on BPHC premises such as vendors, contractors and members of the public.

C. RAISING COMPLAINTS OF DISCRIMINATION, HARASSMENT BASED ON DISCRIMINATION, OR RETALIATION

1. An employee who believes he or she has been the subject of any form of discrimination, harassment based on discrimination or retaliation or has been subject to a hostile, offensive, humiliating, or intimidating work environment, is strongly encouraged to speak with her/his direct supervisor or anyone else identified in Section C(3) below.

2. All complaints of discrimination, harassment based on discrimination and retaliation will be treated with confidentiality to the extent possible consistent with the BPHC's need to investigate complaints and ensure the safety and well-being of the complainant and other employees. Complaints of discrimination, harassment based on discrimination and retaliation shall not result in reprisal or retaliation, in any form, to the informer or complainant.

3. Any complaints of discrimination, harassment based on discrimination or retaliation by an employee, supervisor, client or vistor should be presented as soon as possible. Please be advised that there are time limits for filing complaints with outside agencies (see Section C(5) below). Complaints may be submitted to the complainant's supervisor, anyone else within the chain of command of the complainant's supervisor or any one of the following individuals:

The Executive Director
1010 MassachusettsAve., 6th floor
Boston MA 02118
617-534-5264

The Director of Human Resources
1010 Massachusetts Ave., 6th floor
Boston MA 02118
617-534-5657

The Director of Labor Relations
1010 Massachusetts Ave., 6th floor
Boston MA 02118
617-534-2449

The Human Resources Administrator for Homeless Services
Long Island Campus Tobin Bldg.
PO Box, 158
Boston MA 02122
617-534-2526 ext. 313

The Chief of Emergency Medical Services
Boston EMS
785 Albany Street
Boston MA, 02118
617-343-2367

In the event that the complaint of discrimination, harassment based on discrimination or retaliation involves any one of the above listed persons, the complaint may be submitted to:

The General Counsel
1010 Massachusetts Ave., 6th floor
Boston MA 02118
617-534-4322

4. In the event of a complaint of discrimination, harassment based on discrimination or retaliation against a visitor involving a vendor or contractor, the BPHC will take action directly with the manager of the vendor or contractor in a timely fashion.

5. Any complaint of discrimination, harassment based on discrimination or retaliation may also be filed with the external agencies listed below. The use of the BPHC's complaint process does not preclude an employee from filing a complaint with these external agencies, nor does it toll the statute of limitations for filing with them. The statute of limitations for filing a complaint with the Massachusetts Commission Against Discrimination or the United States Equal Employment Opportunity Commission is 300 days from the date of the incident.

Director of Affirmative Action
City of Boston Office of Personnel Management
One City Hall Plaza
Boston, MA 02201

The Massachusetts Commission Against Discrimination ("MCAD")
One Ashburton Place
Boston MA, 02108
617-994-6000

The U.S. Equal Employment Opportunity Commission ("EEOC")
One Congress Street
Boston MA, 02114
617-565-3200

D. RESPONSIBILITY AND PROCEDURE FOR INVESTIGATION

1. Any complaint of discrimination, harassment based on discrimination or retaliation is to be taken seriously and treated with sensitivity and discretion.

2. All employees other than "Reporting Employees" (as defined in section D(3) below) who observe, become aware of or receive a complaint/report of discrimination,

harassment based on discrimination or retaliation are strongly encouraged to notify orally or submit a written report to their supervisor or any of the individuals identified in Section C(3) promptly.

3. Certain employees, referred to here as "Reporting Employees," have special reporting duties, as described in Section D(4). Reporting Employees include all employees acting in a supervisory capacity (i.e. employees with authority to direct various aspects of employment of one or more employees such as hiring, firing, discipline, attendance, scheduling, work assignments, evaluation, promotion or transfer) managers, directors and all employees to whom a complaint of discrimination, harassment or retaliation can be made pursuant to Section C(3).

4. Any Reporting Employee who personally becomes aware of or is otherwise notified of conduct which may amount to discrimination, harassment based on discrimination or retaliation shall personally make a written report describing such conduct and shall submit the report to the Director of Human Resources. Reporting Employees must report any personal awareness of possible discrimination, harassment based on discrimination or retaliation as well as any complaints/reports of such conduct received in any form and from any source, including internal complaints or reports made under this policy, union grievances and complaints filed with outside agencies. Reporting Employees shall attach to their reports any written complaints submitted by the complainant or others and shall submit their reports and attachments to the Director of Human Resources before leaving the place of employment on the day of receiving such information, or as soon as practicable, except as provided in Section D(5) below.

5. In the event that the Director of Human Resources or his/her designee is not on duty and it is after business hours, the Reporting Employee shall contact the BPHC's Manager On-Call and shall submit such report in a sealed envelope addressed to the Director of Human Resources. The Manager On-Call shall deliver the envelope to the Director of Human Resources or his/her designee by the end of the following regular business day.

6. Upon receipt of a complaint or report of discrimination, harassment based on discrimination or retaliation, the Director of Human Resources shall inform the complainant of the existence of this policy, provide a copy of the policy if needed and direct the complainant as to how to file an internal complaint.

7. The BPHC’s Director of Human Resources or his/her designee will investigate all complaints or reports of discrimination, harassment based on discrimination or retaliation in a timely and impartial manner. The investigation of any such complaints or reports shall be completed within a reasonable time frame of up to 90 days, unless there is good cause requiring additional time.

8. The General Counsel's Office shall be advised of all investigations under this policy and shall provide assistance when necessary.

9. All investigations shall be conducted in such a way as to maintain confidentiality to the extent possible consistent with the need to conduct an investigation and ensure the safety and well-being of the complainant and other employees.

10. While the extent and nature of any investigation will depend upon the circumstances of the complaint, all investigations, to the extent possible, will include the following:

a. A separate interview with the person filing the complaint;
b. A separate interview and written statement of each witness and person with knowledge relevant to the complaint;
c. A separate interview with the person alleged to have committed the discrimination, harassment based on discrimination or retaliation. The person will also be allowed to submit a written statement; and
d. A review of any material documents identified by the complainant and the person alleged to have committed the discrimination, harassment based on discrimination or retaliation.

11. All employees are responsible for cooperating with an investigation into complaints of discrimination, harassment based on discrimination or retaliation. Any employee who fails to fully cooperate or hinders the investigation may be disciplined.

12. At the conclusion of the investigation, the Director of Human Resources or his/her designee shall prepare a written report of the investigation that shall include findings of fact and an opinion as to whether there has been any violation of BPHC policy.

13. A copy of the report shall be submitted to the Executive Director and the General Counsel. The Director of Human Resources shall maintain all complaints and reports of discrimination, harassment based on discrimination or retaliation and records related to the corresponding investigations. The Director of Human Resources shall notify the appropriate program or bureau director of the results of the investigation.

E. DISCIPLINARY ACTION

If it is determined that discrimination, harassment based on discrimination or retaliation has been committed and a violation of this policy has occurred, the BPHC will take such corrective action reasonably calculated to end such conduct and protect the complainant. Such action may range from counseling to termination from employment and may include such other forms of disciplinary action as the BPHC deems appropriate under the circumstances. If it is determined that a client, visitor, vendor or contractor has violated this policy, appropriate steps will be taken to rectify or prevent the circumstances from recurring.

F. FALSE COMPLAINTS

Complainants who intentionally or knowingly file a false complaint or any other person providing false information during an investigation conducted in accordance with BPHC policy will be subject to corrective action up to and including termination of employment.

Cellular Phone and Camera Use

Supersedes:
Effective: 06-01-09

Cellular telephones, personal digital assistants (PDA), and other portable electronic devices have become commonplace tools within our society and serve as a valuable resource. However, their use must not interfere with employee safety, privacy, or patient care. To prevent distractions in the workplace and to ensure the safety and privacy of all personnel and the patients that we serve, this policy is intended to outline the acceptable use of personal electronic devices while on duty.

1. Personal cellular telephones are permitted to be carried while on duty, but should be placed on silent mode and allow voice mail to answer the call. Devices must be carried in such a way that they will not interfere with the physical requirements of the job and will not fall off or cause others to be distracted by the presence or appearance of the device.

2. Cellular phones may be used for personal purposes while on duty, except that phone use must not cause a delay in responding to an assignment or attending to a patient. Upon receipt of an assignment, department members must immediately terminate any personal cell phone calls.

3. Personnel are prohibited from using cellular telephones (voice, text messaging, or "direct connect") at any point between the dispatch of a call and the time that the assigned incident is complete, except for work-related purposes directly related to that assignment (such as calling Dispatch Operations to assist in resolving an on-scene logistical situation).

    3.1. If cellular communication is necessary for a work-related purpose while operating a department vehicle and cannot be reasonably delayed until the vehicle is parked, the passenger should handle the call. In the case of a Department member working alone and stopping the vehicle is not practical, the work-related phone call should be as brief as possible and the user should utilize a "hands-free" device if available

4. Department members are prohibited from using a cellular phone or PDA (including voice calls, text messaging, or "direct connect") for personal use when operating a department vehicle.

5. Use of a personal camera- whether cell phone camera, stand-alone camera, or cameras contained on any other such personal device (whether digital or conventional film) at any point between the dispatch of a call and the time that the assigned incident is complete is strictly prohibited.

Confidentiality of Information

Supersedes: 03-16-98
Effective: 07-11-99

1. The Enhanced 9-1-1 system gives Dispatch Operations personnel access to caller information, both listed and unlisted. This information is entrusted for use solely to assist public safety agencies with emergencies. Appropriate use and confidentiality of this information must be ensured at all times.

   1.1. All Computer Aided Dispatch printouts, Enhanced 9-1-1 Call Detail records, Department telephone lists, telephone messages, incident reports or any other documents containing confidential or personal information that are no longer needed should be torn up or shredded before disposal.

2. Personnel assigned to the Dispatch Operations Center shall not divulge the contents of any message which has been directed to an individual through the EMS Dispatch Operations Center. Should a question arise concerning the confidentiality or routing of any message, it shall be referred to the Dispatch Operations Center Supervisor.

3. It is assumed that personnel will take appropriate Body Substance Isolation precautions when responding to emergency medical incidents making the transmission of a person's confidential HIV / AIDS status over an unsecured dispatch or tactical channel unnecessary.

   3.1. If a caller divulges that a patient is known (or suspected) to be HIV+ or has AIDS, the Boston EMS Telecommunicator shall suggest the caller report that information to the emergency personnel upon their arrival.

   3.2. Boston EMS Telecommunicators shall not enter a patient's known or suspected HIV / AIDS status into the incident text when processing a call for service.

   3.3. Boston EMS Telecommunicators shall not divulge, either directly or indirectly by using "code words", a patient's known or suspected HIV / AIDS status to responding personnel.

4. Non-department personnel who have been authorized to spend time in the Dispatch Operations Center for the purpose of observation are to sign a waiver stating that they have been informed of the Department's Confidentiality policy prior to being allowed to monitor any E 9-1-1 conversations.

See related SOP "Observer Waiver Form"; Protection of Confidential Health Information

Summary of the Conflict of Interest Law for Municipal Employees

Effective: 11- 24-10

This summary of the conflict of interest law, General Laws chapter 268A, is intended to help municipal employees understand how that law applies to them. This summary is not a substitute for legal advice, nor does it mention every aspect of the law that may apply in a particular situation. Municipal employees can obtain free confidential advice about the conflict of interest law from the Commission's Legal Division at our website, phone number, and address above. Municipal counsel may also provide advice.

The conflict of interest law seeks to prevent conflicts between private interests and public duties, foster integrity in public service, and promote the public's trust and confidence in that service by placing restrictions on what municipal employees may do on the job, after hours, and after leaving public service, as described below. The sections referenced below are sections of G.L. c. 268A.

When the Commission determines that the conflict of interest law has been violated, it can impose a civil penalty of up to $10,000 ($25,000 for bribery cases) for each violation. In addition, the Commission can order the violator to repay any economic advantage he gained by the violation, and to make restitution to injured third parties. Violations of the conflict of interest law can also be prosecuted criminally.

I. Are you a municipal employee for conflict of interest law purposes?

You do not have to be a full-time, paid municipal employee to be considered a municipal employee for conflict of interest purposes. Anyone performing services for a city or town or holding a municipal position, whether paid or unpaid, including full- and part-time municipal employees, elected officials, volunteers, and consultants, is a municipal employee under the conflict of interest law. An employee of a private firm can also be a municipal employee, if the private firm has a contract with the city or town and the employee is a "key employee" under the contract, meaning the town has specifically contracted for her services. The law also covers private parties who engage in impermissible dealings with municipal employees, such as offering bribes or illegal gifts.

II. On-the-job restrictions.

(a) Bribes. Asking for and taking bribes is prohibited. (See Section 2)

A bribe is anything of value corruptly received by a municipal employee in exchange for the employee being influenced in his official actions. Giving, offering, receiving, or asking for a bribe is illegal.

Bribes are more serious than illegal gifts because they involve corrupt intent. In other words, the municipal employee intends to sell his office by agreeing to do or not do some official act, and the giver intends to influence him to do so. Bribes of any value are illegal.

(b) Gifts and gratuities. Asking for or accepting a gift because of your official position, or because of something you can do or have done in your official position, is prohibited. (See Sections 3, 23(b)(2), and 26)

Municipal employees may not accept gifts and gratuities valued at $50 or more given to influence their official actions or because of their official position. Accepting a gift intended to reward past official action or to bring about future official action is illegal, as is giving such gifts. Accepting a gift given to you because of the municipal position you hold is also illegal. Meals, entertainment event tickets, golf, gift baskets, and payment of travel expenses can all be illegal gifts if given in connection with official action or position, as can anything worth $50 or more. A number of smaller gifts together worth $50 or more may also violate these sections.

Example of violation: A town administrator accepts reduced rental payments from developers.

Example of violation: A developer offers a ski trip to a school district employee who oversees the developer's work for the school district.

Regulatory exemptions. There are situations in which a municipal employee's receipt of a gift does not present a genuine risk of a conflict of interest, and may in fact advance the public interest. The Commission has created exemptions permitting giving and receiving gifts in these situations. One commonly used exemption permits municipal employees to accept payment of travel-related expenses when doing so advances a public purpose. Another commonly used exemption permits municipal employees to accept payment of costs involved in attendance at educational and training programs. Other exemptions are listed on the Commission's website.

Example where there is no violation: A fire truck manufacturer offers to pay the travel expenses of a fire chief to a trade show where the chief can examine various kinds of fire-fighting equipment that the town may purchase. The chief fills out a disclosure form and obtains prior approval from his appointing authority.

Example where there is no violation: A town treasurer attends a two-day annual school featuring multiple substantive seminars on issues relevant to treasurers. The annual school is paid for in part by banks that do business with town treasurers. The treasurer is only required to make a disclosure if one of the sponsoring banks has official business before her in the six months before or after the annual school.

(c) Misuse of position. Using your official position to get something you are not entitled to, or to get someone else something they are not entitled to, is prohibited. Causing someone else to do these things is also prohibited. (See Sections 23(b)(2) and 26)

A municipal employee may not use her official position to get something worth $50 or more that would not be properly available to other similarly situated individuals. Similarly, a municipal employee may not use her official position to get something worth $50 or more for someone else that would not be properly available to other similarly situated individuals. Causing someone else to do these things is also prohibited.

Example of violation: A full-time town employee writes a novel on work time, using her office computer, and directing her secretary to proofread the draft.

Example of violation: A city councilor directs subordinates to drive the councilor's wife to and from the grocery store.

Example of violation: A mayor avoids a speeding ticket by asking the police officer who stops him, "Do you know who I am?" and showing his municipal I.D.

(d) Self-dealing and nepotism. Participating as a municipal employee in a matter in which you, your immediate family, your business organization, or your future employer has a financial interest is prohibited. (See Section 19)

A municipal employee may not participate in any particular matter in which he or a member of his immediate family (parents, children, siblings, spouse, and spouse's parents, children, and siblings) has a financial interest. He also may not participate in any particular matter in which a prospective employer, or a business organization of which he is a director, officer, trustee, or employee has a financial interest. Participation includes discussing as well as voting on a matter, and delegating a matter to someone else.

A financial interest may create a conflict of interest whether it is large or small, and positive or negative. In other words, it does not matter if a lot of money is involved or only a little. It also does not matter if you are putting money into your pocket or taking it out. If you, your immediate family, your business, or your employer have or has a financial interest in a matter, you may not participate. The financial interest must be direct and immediate or reasonably foreseeable to create a conflict. Financial interests which are remote, speculative or not sufficiently identifiable do not create conflicts.

Example of violation: A school committee member's wife is a teacher in the town's public schools. The school committee member votes on the budget line item for teachers' salaries.

Example of violation: A member of a town affordable housing committee is also the director of a non-profit housing development corporation. The non-profit makes an application to the committee, and the member/director participates in the discussion.

Example: A planning board member lives next door to property where a developer plans to construct a new building. Because the planning board member owns abutting property, he is presumed to have a financial interest in the matter. He cannot participate unless he provides the State Ethics Commission with an opinion from a qualified independent appraiser that the new construction will not affect his financial interest.

In many cases, where not otherwise required to participate, a municipal employee may comply with the law by simply not participating in the particular matter in which she has a financial interest. She need not give a reason for not participating.

There are several exemptions to this section of the law. An appointed municipal employee may file a written disclosure about the financial interest with his appointing authority, and seek permission to participate notwithstanding the conflict. The appointing authority may grant written permission if she determines that the financial interest in question is not so substantial that it is likely to affect the integrity of his services to the municipality. Participating without disclosing the financial interest is a violation. Elected employees cannot use the disclosure procedure because they have no appointing authority.

Example where there is no violation: An appointed member of the town zoning advisory committee, which will review and recommend changes to the town's by-laws with regard to a commercial district, is a partner at a company that owns commercial property in the district. Prior to participating in any committee discussions, the member files a disclosure with the zoning board of appeals that appointed him to his position, and that board gives him a written determination authorizing his participation, despite his company's financial interest. There is no violation.

There is also an exemption for both appointed and elected employees where the employee's task is to address a matter of general policy and the employee's financial interest is shared with a substantial portion (generally 10% or more) of the town's population, such as, for instance, a financial interest in real estate tax rates or municipal utility rates.

(e) False claims. Presenting a false claim to your employer for a payment or benefit is prohibited, and causing someone else to do so is also prohibited. (See Sections 23(b)(4) and 26)

A municipal employee may not present a false or fraudulent claim to his employer for any payment or benefit worth $50 or more, or cause another person to do so.

Example of violation: A public works director directs his secretary to fill out time sheets to show him as present at work on days when he was skiing.

(f) Appearance of conflict. Acting in a manner that would make a reasonable person think you can be improperly influenced is prohibited. (See Section 23(b)(3))

A municipal employee may not act in a manner that would cause a reasonable person to think that she would show favor toward someone or that she can be improperly influenced. Section 23(b)(3) requires a municipal employee to consider whether her relationships and affiliations could prevent her from acting fairly and objectively when she performs her duties for a city or town. If she cannot be fair and objective because of a relationship or affiliation, she should not perform her duties. However, a municipal employee, whether elected or appointed, can avoid violating this provision by making a public disclosure of the facts. An appointed employee must make the disclosure in writing to his appointing official.

Example where there is no violation: A developer who is the cousin of the chair of the conservation commission has filed an application with the commission. A reasonable person could conclude that the chair might favor her cousin. The chair files a written disclosure with her appointing authority explaining her relationship with her cousin prior to the meeting at which the application will be considered. There is no violation of Sec. 23(b)(3).

(g) Confidential information. Improperly disclosing or personally using confidential information obtained through your job is prohibited. (See Section 23(c))

Municipal employees may not improperly disclose confidential information, or make personal use of non-public information they acquired in the course of their official duties to further their personal interests.

III. After-hours restrictions.

(a) Taking a second paid job that conflicts with the duties of your municipal job is prohibited. (See Section 23(b)(1))

A municipal employee may not accept other paid employment if the responsibilities of the second job are incompatible with his or her municipal job.

Example: A police officer may not work as a paid private security guard in the town where he serves because the demands of his private employment would conflict with his duties as a police officer.

(b) Divided loyalties. Receiving pay from anyone other than the city or town to work on a matter involving the city or town is prohibited. Acting as agent or attorney for anyone other than the city or town in a matter involving the city or town is also prohibited whether or not you are paid. (See Sec. 17)

Because cities and towns are entitled to the undivided loyalty of their employees, a municipal employee may not be paid by other people and organizations in relation to a matter if the city or town has an interest in the matter. In addition, a municipal employee may not act on behalf of other people and organizations or act as an attorney for other people and organizations in which the town has an interest. Acting as agent includes contacting the municipality in person, by phone, or in writing; acting as a liaison; providing documents to the city or town; and serving as spokesman.

A municipal employee may always represent his own personal interests, even before his own municipal agency or board, on the same terms and conditions that other similarly situated members of the public would be allowed to do so. A municipal employee may also apply for building and related permits on behalf of someone else and be paid for doing so, unless he works for the permitting agency, or an agency which regulates the permitting agency.

Example of violation: A full-time health agent submits a septic system plan that she has prepared for a private client to the town's board of health.

Example of violation: A planning board member represents a private client before the board of selectmen on a request that town meeting consider rezoning the client's property.

While many municipal employees earn their livelihood in municipal jobs, some municipal employees volunteer their time to provide services to the town or receive small stipends. Others, such as a private attorney who provides legal services to a town as needed, may serve in a position in which they may have other personal or private employment during normal working hours. In recognition of the need not to unduly restrict the ability of town volunteers and part-time employees to earn a living, the law is less restrictive for "special" municipal employees than for other municipal employees.

The status of "special" municipal employee has to be assigned to a municipal position by vote of the board of selectmen, city council, or similar body. A position is eligible to be designated as "special" if it is unpaid, or if it is part-time and the employee is allowed to have another job during normal working hours, or if the employee was not paid for working more than 800 hours during the preceding 365 days. It is the position that is designated as "special" and not the person or persons holding the position. Selectmen in towns of 10,000 or fewer are automatically "special"; selectman in larger towns cannot be "specials."

If a municipal position has been designated as "special," an employee holding that position may be paid by others, act on behalf of others, and act as attorney for others with respect to matters

before municipal boards other than his own, provided that he has not officially participated in the matter, and the matter is not now, and has not within the past year been, under his official responsibility.

Example: A school committee member who has been designated as a special municipal employee appears before the board of health on behalf of a client of his private law practice, on a matter that he has not participated in or had responsibility for as a school committee member. There is no conflict. However, he may not appear before the school committee, or the school department, on behalf of a client because he has official responsibility for any matter that comes before the school committee. This is still the case even if he has recused himself from participating in the matter in his official capacity.

Example: A member who sits as an alternate on the conservation commission is a special municipal employee. Under town by-laws, he only has official responsibility for matters assigned to him. He may represent a resident who wants to file an application with the conservation commission as long as the matter is not assigned to him and he will not participate in it.

(c) Inside track. Being paid by your city or town, directly or indirectly, under some second arrangement in addition to your job is prohibited, unless an exemption applies. (See Section 20)

A municipal employee generally may not have a financial interest in a municipal contract, including a second municipal job. A municipal employee is also generally prohibited from having an indirect financial interest in a contract that the city or town has with someone else. This provision is intended to prevent municipal employees from having an "inside track" to further financial opportunities.

Example of violation: Legal counsel to the town housing authority becomes the acting executive director of the authority, and is paid in both positions.

Example of violation: A selectman buys a surplus truck from the town DPW.

Example of violation: A full-time secretary for the board of health wants to have a second paid job working part-time for the town library. She will violate Section 20 unless she can meet the requirements of an exemption.

Example of violation: A city councilor wants to work for a non-profit that receives funding under a contract with her city. Unless she can satisfy the requirements of an exemption under Section 20, she cannot take the job.

There are numerous exemptions. A municipal employee may hold multiple unpaid or elected positions. Some exemptions apply only to special municipal employees. Specific exemptions may cover serving as an unpaid volunteer in a second town position, housing-related benefits, public safety positions, certain elected positions, small towns, and other specific situations. Please call the Ethics Commission's Legal Division for advice about a specific situation.

IV. After you leave municipal employment. (See Section 18)

(a) Forever ban. After you leave your municipal job, you may never work for anyone other than the municipality on a matter that you worked on as a municipal employee.

If you participated in a matter as a municipal employee, you cannot ever be paid to work on that same matter for anyone other than the municipality, nor may you act for someone else, whether paid or not. The purpose of this restriction is to bar former employees from selling to private interests their familiarity with the facts of particular matters that are of continuing concern to their former municipal employer. The restriction does not prohibit former municipal employees from using the expertise acquired in government service in their subsequent private activities.

Example of violation: A former school department employee works for a contractor under a contract that she helped to draft and oversee for the school department.

(b) One year cooling-off period. For one year after you leave your municipal job you may not participate in any matter over which you had official responsibility during your last two years of public service.

Former municipal employees are barred for one year after they leave municipal employment from personally appearing before any agency of the municipality in connection with matters that were under their authority in their prior municipal positions during the two years before they left.

Example: An assistant town manager negotiates a three-year contract with a company. The town manager who supervised the assistant, and had official responsibility for the contract but did not participate in negotiating it, leaves her job to work for the company to which the contract was awarded. The former manager may not call or write the town in connection with the company's work on the contract for one year after leaving the town.

(c) Partners. Your partners will be subject to restrictions while you serve as a municipal employee and after your municipal service ends.

Partners of municipal employees and former municipal employees are also subject to restrictions under the conflict of interest law. If a municipal employee participated in a matter, or if he has official responsibility for a matter, then his partner may not act on behalf of anyone other than the municipality or provide services as an attorney to anyone but the city or town in relation to the matter.

Example: While serving on a city's historic district commission, an architect reviewed an application to get landmark status for a building. His partners at his architecture firm may not prepare and sign plans for the owner of the building or otherwise act on the owner's behalf in relation to the application for landmark status. In addition, because the architect has official responsibility as a commissioner for every matter that comes before the commission, his partners may not communicate with the commission or otherwise act on behalf of any client on any matter that comes before the commission during the time that the architect serves on the commission.

Example: A former town counsel joins a law firm as a partner. Because she litigated a lawsuit for the town, her new partners cannot represent any private clients in the lawsuit for one year after her job with the town ended.

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This summary is not intended to be legal advice and, because it is a summary, it does not mention every provision of the conflict law that may apply in a particular situation. Our website, http://www.mass.gov/ethics contains further information about how the law applies in many

situations. You can also contact the Commission's Legal Division via our website, by telephone, or by letter. Our contact information is at the top of this document.

Dress and Appearance

Supersedes: 04-05-89
Effective: 01-29-06

All members of Boston EMS must present a neat, clean, and professional appearance while on duty or in uniform. Employees required to wear a uniform shall do so the entire time they are at work unless specifically exempted. All attributes of departmental uniforms, including requirements, variations, and accessories are subject to final approval of the Chief of Department. The uniform must be clean, pressed, and kept in good repair. Personnel who are not required to wear a uniform shall dress in a manner that is business appropriate. Members shall not be unkempt, disheveled, or malodorous while on duty or in uniform. Hair, beards (if permitted), and mustaches must be kept neat, clean, trimmed, and well-groomed.

UNIFORMED MEMBERS

Personnel holding the following ranks are considered uniformed members of the service and shall wear a complete and proper uniform while on duty:

Chief of Department, Superintendent in Chief, Superintendent, Deputy Superintendent, Captain (Principal EMT), Captain (Training Supervisor), Lieutenant (Senior EMT), EMT-Paramedic, EMT-Basic, and EMT-Recruit.

Uniform Allotment Issued Annually

A uniform allotment shall be issued each fiscal year. Members may obtain the prevailing allotment of uniform requirements at a vendor designated by the Department and in accordance with collective bargaining agreements.

Modifications

From time to time, changes may be made in the description or specification of authorized items of uniform and equipment. When such changes occur, unless otherwise directed by the Chief of Department, existing issued items of uniform and equipment may continue to be worn or used. However, when such articles are replaced, they will be replaced with the currently approved version

Wearing the Uniform Off-Duty

The uniform shall not be worn off-duty except immediately commuting to and from work. Other than while carrying out patient care duties, it will not be worn at rallies, political meetings, demonstrations, or anywhere that would indicate departmental sanction without prior approval of the Chief of Department or the Superintendent-In-Chief.

Appearance

Hair that normally extends below the collar shall be tied up or arranged in a manner that will conform to the general shape of the head and keep hair above the collar. Hair, beards (if permitted), and mustaches must be kept neat, clean, trimmed, and well

groomed. Fingernails must be kept clean and trimmed short and smooth so as not to interfere with patient care duties.

Footwear

The proper footwear shall be either black low-cut uniform shoes, black uniform work boots, or black leather athletic style shoes that can be shined. Shoes and boots shall be cleaned, shined and scuff-free. Field personnel are strongly recommended to wear black uniform work boots. Dark brown or black socks shall be worn.

Shirts

Shirts shall be permanent press with epaulettes, badge tab and military creases as supplied. Shirts for EMTs shall be tropical beige in color. Shirts for Paramedics, Lieutenants, Captains, and above shall be white in color. Shirt tails must always be worn inside the trousers and tucked in neatly;

Members of all ranks may wear the short sleeve uniform shirt year round. Short sleeve shirts shall be worn with the top (collar) button open unless worn with a tie. A short sleeve uniform shirt shall not be worn over a long sleeve undergarment.

The long sleeve shirt may be worn from October 15th through April 30th, or whenever the temperature is forecast to drop below 65 degrees. When worn without a necktie, the long sleeve shirt will be worn with only the top button (collar) open.

Whenever a uniformed member of the service assigned to Administrative Headquarters or RTQI, a Field Supervisor, or a member of higher rank wears a long sleeve shirt, it shall be worn with a uniform tie unless worn with a turtleneck.

A plain white tee shirt shall be worn under the uniform shirt. During cold weather, a white, brown, or black turtleneck shirt may be worn under the long sleeve uniform shirt to provide an additional layer of warmth as needed. A long sleeve turtleneck shirt may not be worn under a short sleeve shirt. When worn with a turtleneck, the top (collar) button shall be opened. Personnel may opt to wear a turtleneck shirt under a department issued sweater without a uniform shirt. When worn in this manner (without a uniform shirt), the turtleneck must be the correct color related to rank (brown for an EMT, white for a Paramedic or Supervisor).

Patches/Bars/Pins

A brown and gold, “Boston Emergency Medical Services” patch with the City Seal shall be sewn midline to the outside Left sleeve 1/2" down from the shoulder seam; former “Health and Hospitals” patches are not permitted;

A red, white, and blue City of Boston patch denoting level of Department certification shall be sewn midline to the outside Right sleeve 1/2" down from the shoulder seam. Jackets for cadets, recruits, and non-clinical members of the Department shall not have a Department Certification patch;

The requirements for patches shall apply to all shirts, jackets, sweaters, coats, and jumpsuits; Lieutenants and members of higher rank shall wear a gold "EMS" pin on each collar of the shirt. The "EMS" pin shall be worn parallel to the bottom edge of the collar of the long-sleeved shirt;

EMTs and Paramedics may wear silver "EMS" pins on each collar of the shirt parallel to the bottom edge of the collar of the long-sleeved shirt;

Collar devices for the short sleeve shirt, with the top button open, shall be worn in a position perpendicular to the collar point. Long sleeve shirts (or a short sleeve shirt with a necktie) shall have the devices parallel to the neck edge of the collar;

Command Staff and Supervisory Staff shall wear gold stars or bars on both epaulettes of the uniform shirt, and on the epaulettes of the uniform coat/jacket according to designated rank:

Chief of Department	Five Stars
Superintendent in Chief	Four Stars
Superintendent	Four Stars
Deputy Superintendent	Three Stars
Captain	Two Bars
Lieutenant	One Bar

Department issued award ribbons, preceptor rockers, American Flag, union pin, or City Service pins may be worn on the uniform shirt above the right shirt pocket or on a badge holder if one is worn. (For further information on the Department's awards program and ribbons, please refer to "Commendations and Awards"). No other pins, patches, or insignias shall be worn on or with the uniform unless authorized in writing by the Chief of Department.

Badge

An official Department badge shall bear a full color, enameled City of Boston Seal in the center of the badge; the line immediately above the City Seal shall read "Boston" with a blue background; the line below the City Seal at the bottom of the badge shall read "Emergency Medical Services; The color and title of the badge indicate the rank of the member wearing the badge. EMTs and Paramedics shall wear a silver badge indicating rank. The badge for Supervisors shall be gold in color and the rank line shall read "Lieutenant", "Captain", "Deputy Superintendent", "Superintendent", Superintendent-In-Chief" or "Chief," according to the member's rank; The use of the word "Police" on any worn badge or other uniform item is forbidden;

A black elastic "mourning band" ribbon, ½" wide shall be worn on the badge, covering the seal of the City of Boston, but leaving the badge number and rank designation visible, acknowledging a death in accordance with the Department's "Death / Funeral Policy".

Uniformed members of the service shall wear the issued badge on the outermost uniform garment being worn, except when wearing a "turnout" style coat without a badge tab. In that case, a rectangular "BOSTON EMS" patch designating rank or assignment shall be worn.

Trousers

Trousers shall be straight, cuffless, 18" leg width, dark brown, and permanent press, as supplied by the Department's vendor. Trouser length should "break" over the shoelaces

when worn in the normal waist position. The Department also authorizes wool blend dress pants and BDU ("battle dress uniform") or "cargo pants".

Hats

The uniform hat shall be an 8-point hat brown in color. The visor color and the chinstrap shall be as follows:

RANK	***VISOR COLOR***	***CHIN STRAP***
EMT	Black	1/2" Black Simulated
Paramedic	Black Leather	Silver Flex Strap
Lieutenant	Black	Gold Flex Strap
Captain	Black	Gold Weave
Deputy Superintendent	Black with Gold Weave	Gold Braid
Superintendent	Black with Gold Weave	Gold Weave
Superintendent-In-Chief	Black with Gold Weave	Gold Weave
Chief	Black with Gold Weave	Gold Weave

The 8-point uniform hat shall be worn squarely on the head with the front edge horizontal. Hair must not show under the front brim. The hat should be worn as appropriate at dress functions, and may be worn at standby details and at other times while on duty;

A brown or black baseball type cap with "Boston EMS" embroidered on the front, as issued by the Department's vendor, may be worn. The cap shall be worn squarely on the head with the bottom edge horizontal. There may be no irregularities in the visor arrangement, nor additional ornamentation added;

Two optional hats may be worn during the winter months: a dark brown, trooper-type cap with Nylon/Rayon crown and acrylic ear flaps as supplied; or a black or brown woolen watch cap;

A Department approved hat device shall be worn on the front center of the 8-point hat or the trooper-type cap.

Jacket/Coat

A dark brown nylon jacket with zip-out lining, winter reefer style jacket, or Cruiser jacket as supplied may be worn during cold weather. Jackets issued as part of personal protective equipment are also permitted;

NOTE: Effective January 1, 2007 leather jackets are no longer authorized.

Sweater/Vest

An issued brown V-neck wool sweater with epaulettes patches may be worn at any time the member wishes to do so for comfort, unless directed otherwise. If the brown sweater is worn without a jacket or reefer coat, the badge shall be worn on the sweater for identification;

A brown insulated vest, as issued, may be worn during cold weather.

Raincoat/Rain Pants

A hooded raincoat and rainpants or “all weather pants”, as issued, may be worn during inclement weather, or as needed. The badge must be worn on the raincoat in the badge tabs.

Neckties and Tie Bars

Neckties shall be dark brown, with pointed bottom. A “breakaway” style tie is recommended for personnel assigned to Field duty. Neckties shall be worn in the proper, uppermost position when worn. A plain gold colored or silver colored tie bar worn at mid-pocket level may be worn to hold the necktie in place. The color of the bar shall correspond with the badge color. A gold or silver colored tie bar the City Seal is also authorized.

Belts, Buckles, and Suspenders

A black velcro belt or leather uniform belt, and a black utility belt, shall be worn as required.

Suspenders are not a mandatory uniform item. If members wish to wear suspenders with the uniform, the suspenders must be brown or white to match the uniform shirt, and may be worn only when covered by the uniform sweater or jacket when in public.

Jumpsuits may only be worn when the outside temperature is below 32 degrees Fahrenheit.

Spare Uniforms

All uniformed personnel shall keep a spare shirt, trousers, socks, and undergarments in their personal lockers or vehicle.

Service Stripes

Length of full-time, paid municipal EMS service may be visibly acknowledged by the wearing of diagonal service stripes on the left outer midline sleeve of the jacket. Each service stripe denotes five years of service. Service stripes shall be a woven gold or silver in color. The color of the stripe shall correspond with the color of the badge worn.

The “Class A” uniform shall consist of the following:

- Dark brown uniform trousers (not BDU)
- Beige long sleeve uniform shirt for EMTs
- White long sleeve uniform shirt for Paramedics, Lieutenants, and above
- Dark brown uniform tie, tie bar, and EMS Collar pins (gold or silver) commensurate with rank
- Black uniform low cut shoes
- Black socks
- Nylon jacket with liner or nylon reefer jacket.
- A brown V-Neck sweater may be worn under jacket.

The Dress Uniform shall consist of the following:

- Dark brown dress pants. EMT and Paramedics shall have a single 1” stripe down the side of the pants; Lieutenant, Captain and Deputy Superintendent shall

have two ½" stripes; while Superintendent, Superintendent in Chief, and Chief shall have a single velvet stripe;
- Beige long sleeve uniform shirt for EMTs;
- White long sleeve uniform shirt for Paramedics, Lieutenants, and above;
- Dark Brown uniform tie, tie bar, and EMS Collar pins (gold or silver) commensurate with rank;
- Black uniform low cut shoes
- Black Socks
- Uniform Hat
- Blouse Coat

Instead of wearing gold stars or bars on epaulettes of the dress uniform coat, Lieutenants and above shall have gold rank stripes around each sleeve as follows:

Lieutenant	One Gold Stripe	½" in width
Captain	Two Gold Stripes	½" in width
Deputy Superintendent	Three Gold Stripes	½" in width
Superintendent	Four Gold Stripes	½" in width
Chief	One Gold Stripe	2" in width

The rank stripes shall be 2" up from the bottom of the sleeve. There shall be a space of 5/16" between stripes.

Retired members of the service are permitted to wear the "Class A" or "Dress Uniform" to Department recognized events so long as the uniform includes a "RETIRED" rocker under the certification patch on the right shoulder.

Uniform/Equipment Items Outside the Annual Allotment

Uniformed members will be issued a helmet, body armor, raincoat, safety goggles, winter coat, safety gloves, respirator mask and filter cartridge. If any of these items becomes unusable due to normal wear and tear, the item will be replaced.

Reasonable Care of Uniform and Equipment Required.

It shall be considered neglect of duty on the part of any member to fail to secure or to take reasonable care of his/her uniform and equipment, to lose any part of his/her uniform or equipment, or to neglect to report such loss immediately to a Supervisor.

Lost or Damaged Uniform/Equipment or Badge

If any Department issued uniform/equipment item becomes damaged or destroyed in the performance of duty, the item shall be repaired or replaced by the Department;

The replacement cost for any Department issued uniform/equipment item lost, damaged, or stolen due to the member's own negligence may be deducted from the annual allotment.

Return of Uniform and Equipment

A member who separates from the Department shall return all issued items of uniforms and equipment to the Department, except that members retiring may be permitted to keep the Class A and Dress Uniform for department functions. These items shall include any issued badge, Department identification cards, keys and access passes, safety equipment, patient care equipment, and clothing;

Failure to return issued items shall be considered theft of Department property. A notice letter shall be mailed listing the missing equipment and stating the name and location of the person to whom the equipment should be returned and the date by which it should be returned. The notice letter shall also state that if the equipment is not returned by the required date, EMS will take one or more of the following steps: file a notice with the Boston Retirement Board concerning the misappropriation of public property, file a stolen property report with the Boston Police Department, and inform prospective employers of the employee's failure to return the equipment.

Specialty Units

Practical modifications may be made to the uniform policy for specialized units such as the Bike Team or Harbor Unit assignments. All such modifications shall be authorized by the Chief of Department and promulgated in the Specialized Unit's operational guideline. Modified uniforms are only permitted for personnel while working in the Specialized Unit. For example, personnel assigned to the Bike Team may only wear the authorized Bike Team uniform when assigned to a bicycle for a special event. Short-term modifications to the required uniform of the day may be made through special order issued by the Chief of Department or designee.

Members Not Required to Wear a Uniform

Short-term exceptions (less than one week) to the requirement to wear a uniform while on duty may be granted by a Division Commander or Section Director to accommodate a special circumstance. Long-term exceptions (greater than one-week) must be authorized in writing by a Superintendent. Requests to otherwise temporarily modify the uniform policy must be authorized in advance by the Superintendent in Chief or Chief of Department. Reasonable accommodation will be made for employees' religious beliefs, cultural traditions, and health care needs when they are consistent with the necessity to present a professional appearance to the public.

NON-UNIFORM OR EXEMPT EMPLOYEES

Employees, students, and observers who are not required to wear a uniform are expected to dress in a manner that is neat and clean, and which is appropriate for the work they perform. Employees are expected to dress in a professional manner. Examples of clothing which are forbidden:

- Shorts (that are not part of a dress suit)
- Tank tops or tube tops
- Hats or caps
- Tee-shirts with slogans
- Clothing that is torn, stained, or disheveled
- Beachwear (flip-flop sandals, etc.)
- Clothing with suggestive themes
- Distracting or revealing clothing
- Jeans
- Athletic / recreational clothing (sweatpants, spandex leggings, sweatshirts, jogging suits, sneakers)

Support Services / Materials and Facility Management Personnel

Personnel assigned to Fleet Services; Communication Engineering; and Materials & Facility Management play a key role in the day-to-day operation of the Department. Their duties frequently require them to operate department vehicles, interact with hospital staff, or to assist at the scene of an incident. As such, personnel assigned to these areas will wear a standardized work uniform so that their role may be easily identifiable. The uniform will consist of work pants with matching button down shirt, or coveralls. A Boston Emergency Medical Services patch will be worn on both shoulders. Relevant certification patches may be worn on the right shoulder in place of the second Boston EMS patch if approved by the area manager.

Electronic Mail

Supersedes: 06-30-97
Effective: 07-98

PURPOSE

This memorandum sets forth the policies with regard to access to, review, or disclosure of electronic mail ("e-mail" messages sent or received by Boston Public Health Commission employees with the use of the BPHC e-mail system. It also sets forth policies on the proper use of the e-mail system.

POLICY

E-mail is a corporate asset and critical component of communication. The E-mail system is provided by BPHC for employees to facilitate the performance of BPHC work. The contents are the property of the BPHC.

The BPHC monitors these systems and reserves the right to retrieve the contents when authorized by the Executive Director, Manager of Human Resources, Manager of Labor Relations, General Counsel or the Director of Security. Employees should not expect that their communications using the BPHC's e-mail are private or confidential.

PROCEDURE

ALLOWED USAGE

1. The e-mail system is provided to employees to assist them in carrying out the Commission's business. The e-mail system permits employees to communicate with each other internally and with outside individuals and entities that the BPHC, in its sole discretion, decides should be connected to the system.
2. Personal use of e-mail by employees is allowed but shall not interfere with or conflict with business use.
3. Employees should exercise good judgment regarding the reasonableness of personal use. A "junkmail" group and other ad-hoc mail groups are available for employees to exchange information or post personal notices (i.e. "for sale", "for rent", "looking to buy", etc.). Employees may sell items or post messages on junkmail or other ad-hoc mail groups as long as they do not violate the law or company policies.
4. The use of the group *ALL is limited to business purposes.
5. Use of e-mail is limited to employees and authorized vendors, temporaries, or contractors.
6. The BPHC has the capability to access, review, copy and delete any messages sent, received or stored on the e-mail system. The BPHC reserves the right to access, review, copy, or delete all such messages for legitimate business and disciplinary purposes and to disclose them to any party (inside or outside the BPHC) it deems appropriate.

7. Should employees make incidental use of the e-mail system to transmit personal messages, such messages will be treated no differently from other messages. BPHC reserves the right to access, review, copy, delete or disclose them for any purpose.
8. Use of the BPHC's communications systems to set up or conduct personal businesses or send chain letters is prohibited.
9. The Commission's confidential messages should be distributed to personnel only. Forwarding to locations outside the BPHC network is prohibited.

PASSWORDS

1. Employees and authorized users are responsible for maintaining the security of accounts and passwords.
2. Users should change their passwords and take precautions to prevent unauthorized access to their mailboxes, such as logging off when their computer is unattended.

MISUSES OF ELECTRONIC-MAIL

1. Misuses of e-mail can result in disciplinary action up to and including termination.
2. Examples of misuse include but is not limited to the following:
    - transmitting or accessing obscene, profane, erotic or offensive material over any company communications system;
    - messages, jokes, pictures or forms which violate BPHC's discrimination or harassment policy, or any other policy, or create an intimidating or hostile work environment;
    - use of the e-mail system to engage in any communications that are defamatory, obscene, offensive, harassing or disclose personal information without authorization;
    - use of copyrighted information that violates the copyright;
    - breaking into the system or unauthorized use of a password/mailbox;
    - broadcasting unsolicited personal views on social, political, religious or other non-business related matters; and,
    - solicitation to buy or sell goods or services is prohibited except through junkmail or ad-hoc mail groups.

CONFIDENTIALITY OF INFORMATION

1. Employees must exercise a greater degree of caution in transmitting confidential information on the e-mail system than they take with other means of communicating information, (e.g., written memoranda, letters or phone calls) because of the reduced effort required to redistribute such information.
2. Confidential information should never be transmitted or forwarded to outside individuals or companies not authorized to receive that information and should not even be sent or forwarded to other employees inside the BPHC who do not need to know the information in order to perform their other job duties.

3. Always use care in addressing e-mail messages to make sure that messages are not inadvertently sent to outsiders or the wrong person inside the BPHC. In particular, exercise care when using distribution lists to make sure that all addresses are appropriate recipients of the information. Lists are not always kept current and individuals using lists should take measures to ensure that the lists are current.
4. Refrain from routinely forwarding messages containing BPHC confidential information to multiple parties unless there is a clear business need to do so.

VIEWING AND PROTECTING E-MAILS

1. In order to further guard against dissemination of confidential BPHC information, employees should not access their e-mail messages for the first time in the presence of others.
2. E-mail windows should not be left open on the screen when the computer is unattended.
3. E-mail passwords (as well as other computer passwords) should be routinely changed every three to four weeks.

ATTORNEY-CLIENT PRIVILEGED COMMUNICATIONS

1. Some of the messages sent, received or stored on the BPHC e-mail system will constitute confidential, privileged communications between the BPHC and either its in-house or outside attorneys.
2. Upon receipt of a message either from or to counsel, do not forward it or its contents to others inside the BPHC without counsel's authorization.
3. Never forward such messages or their contents to any other person without authorization from the attorney who sent the e-mail.

COPYRIGHTED INFORMATION

Use of the e-mail system to copy and / or transmit any documents, software, or other information protected by the copyright laws is prohibited.

E-MAIL ETIQUETTE

Please bear in mind that your e-mail messages may be read by someone other than the addressee you send them to and may even someday have to be disclosed to outside parties or a court in connection with a litigation.

Accordingly, please take care to ensure that your messages are courteous, professional and businesslike. In general, caution should be exercised in forwarding e-mails. The original writer may not have intended the e-mail for distribution.

STORING AND DELETING E-MAIL MESSAGES

All employees shall delete in a timely manner, all personal e-mails sent or received, in order to conserve network storage space.

All e-mails regarding BPHC business are public records and shall be stored or disposed of in accordance with BPHC records policy.

BPHC Policy # 300-12; Electronic Mail; Updated July 1998

Freedom of Information Act Requests

Supersedes: 06-28-07
Effective: 07-29-09

It is the goal of Boston EMS to ensure the public prompt access to all public records within its custody. In order to ensure compliance with the requirements of M.G.L. c. 66, s. 10, the Department is promulgating the following procedure:

1. All requests to examine or obtain copies of public records made pursuant to M.G.L. c. 66, s. 10 (the Law) shall be immediately forwarded to the Professional Standards Division. Requests received by mail in headquarters shall be immediately brought to the attention of the Professional Standards Division. Should the Dispatch Operations Center receive a request for public records, that request shall be immediately faxed to the Professional Standards Division at EMS Headquarters.

2. The Commander of the Professional Standards Division (or designee) shall review the request and forward the request to the Public Health Commission legal department. Counsel for the Public Health Commission will make a determination on whether the record requested is in the public domain. PHC legal counsel shall also advise whether any of the applicable exemptions under the Law apply.

3. Simultaneous to the legal review, the Commander of the Professional Standards Division (or designee) will notify the Senior Staff of the nature of the request, and forward the request to the appropriate Boston Emergency Medical Services Division to begin the gathering and compilation of the requested records. The records will be forwarded to the Professional Standards Division pending the legal review. The appropriate Division shall provide an estimate of the scope of the search and associated cost as quickly as possible.

4. Monitoring Requests for Information: The Professional Standard Division shall maintain a log of all requests for public records. Each request shall be assigned a tracking number. The log shall contain the date received, the tracking number, name and address of the requesting party, the date the request was forwarded to counsel, the date forwarded to the responsible EMS Division, and the date of reply. A file shall also be maintained with a copy of the requesting letter, response letter, and any public records provided.

General Rules of Conduct

Supersedes: 03-28-14
Effective: 12-17-15

This section establishes the rules and regulations for the general conduct of all Department members. The purpose of this policy is to provide additional specificity to the standards of conduct embodied in the Boston EMS mission, vision, and value statements so that all members of the Department will better understand expectations pertaining to their conduct and activities while on and off duty.

The rules of conduct set forth in this policy are not intended to serve as an exhaustive treatment of requirements, limitations, or prohibitions on individual conduct and activities established by the Department. Rather, they are intended to (1) alert personnel to some of the more sensitive and often problematic matters involved in public safety personnel conduct and ethics; (2) specify, where possible, actions and inactions that are contrary to and that conflict with the duties and responsibilities of public emergency medical personnel, and (3) guide personnel in conducting themselves and their affairs in a manner that reflects standards of professionalism as required of public safety personnel. Additional guidance on matters of conduct is provided in regard to specific policies, procedures, and directives disseminated by the Boston Public Health Commission or Boston EMS.

ACCOUNTABILITY
Department members are directly accountable for their actions through the chain of command, to the Chief of Department and Medical Director.

Department members shall cooperate fully within the bounds of collective bargaining agreements in any internal administrative investigation conducted by this or other authorized agency and shall provide complete and accurate information in regard to any issue under investigation.

Department members shall be accurate, complete, and truthful in all matters.

Department members shall accept responsibility for their actions without attempting to conceal, divert, or mitigate their actions, nor shall they engage in efforts to thwart, influence, or interfere with an internal or criminal investigation.

Department members who are arrested, indicted, or summonsed to court for any criminal offense shall report this fact to a Shift Commander and Professional Standards as soon as possible.

EMTs shall file a written report with Professional Standards within five days of notice of proposed OEMS disciplinary action or final OEMS action against the EMT’s or EFR’s certification (letter of reprimand, denial, suspension, revocation or refusal to renew certification) or other OEMS response to identified deficiency (cease and desist order, letter of clinical deficiency, notice of serious deficiency, advisory letter) against the EMT or EFR.

Additionally, in accordance with 105 CMR 170.937, EMT personnel are required to file a written report with Boston EMS Professional Standards and with OEMS within five days of the following:

1. The EMT's or EFR's conviction of a misdemeanor or felony in Massachusetts or any other state, the United States, or a foreign country (including a guilty plea, nolo contendre or admission to sufficient facts), other than a minor traffic violation for which less than $1,000 was assessed. The following traffic violations are not minor and must be reported: conviction for driving under the influence, reckless driving, driving to endanger, and motor vehicle homicide;
2. Loss or suspension of the EMT's or EFR's driver's license;
3. Disciplinary action taken by another governmental licensing jurisdiction (state, United States or foreign) or the NREMT, against an EMT or other health care certification or license held by an EMT or EFR;
4. Suspension or revocation of authorization to practice by the EMT's or EFR's affiliate hospital medical director.

KNOWLEDGE OF RULES

All members are required to have a good knowledge of all applicable rules, regulations, duties, procedures, and responsibilities contained in this manual or in any authorized written directives. All members shall have a good knowledge of all duties, responsibilities, and protocols commensurate with their position and level of training.

REPORTING FOR DUTY

Employees shall report for duty at the time and place required by assignment or orders, and they shall be physically and mentally fit to perform their duties. Employees shall be properly equipped and cognizant of information required for the proper performance and assumption of their duties.

OFFICIAL WRITTEN COMMUNICATIONS

Written policies and procedures are subject to review and modification by State regulation, or administrative need. Professional Standards will be responsible for adding new and revised policies and procedures to the Department manual as these are issued. The Policy and Procedure manual will be available to all department members.

FOLLOWING ORDERS OF SUPERVISORY OFFICERS

Orders from a superior to a subordinate shall be in clear, understandable language, civil in tone, and issued pursuant to Department business. No Supervisor shall knowingly issue any order that is in violation of any law, ordinance, or department policy or procedure. Members functioning in an "Acting Capacity" shall be afforded the same respect, courtesy and obedience as members of official higher rank. All lawful orders of supervisory personnel, verbal or written, shall be followed promptly even when such orders are relayed via a Department member of equal or lesser rank as the recipient.

If a member receives an order that is in conflict with a prior order, he or she should respectfully advise the issuing supervisor of the previous order. If directed to do so, the member should follow the new order, but may pursue clarification at a later time.

AUTHORITY OF EMS COMMUNICATION CENTER

All dispatch orders transmitted by the Dispatch Operations Center to ambulance crews shall be acknowledged and executed promptly. Ambulance crews unable to respond to an incident or assignment promptly shall notify the Dispatcher.

INCIDENT REPORTS

Members who are directed to submit an Incident Report shall complete such report by the end of the work shift, or by the due date given. The Incident Report shall be written on the appropriate Departmental form or submitted electronically via the Department e-mail system and shall specifically and truthfully address the incident being reviewed or any request made by a superior officer. Only known facts and relevant observations shall be presented on Incident Reports. Failure to write an Incident Report, the submission of an incomplete report, or submission of false and/or misleading statements shall be considered grounds for discipline. The EMS Supervisor receiving the report shall ensure the report is legible and complete, sign it, and promptly route the report through the chain of Command to the appropriate area.

CURRENT ADDRESS AND TELEPHONE NUMBER

All members shall provide a current home address and telephone number to the Administrative Headquarters. Upon change of address or telephone number, notification shall be given in writing or by telephone to Professional Standards within five business days.

IDENTIFICATION AND CERTIFICATION

Members shall carry Department identification while on duty. Members whose job description requires clinical certification, CPR, or ACLS certification shall carry a current clinical certification commensurate with level of training and a current CPR and ACLS certification card as required while on duty. Members who do not possess the required certifications may be relieved of duty.

MOTOR VEHICLE OPERATOR'S LICENSE

All members shall carry and furnish upon request a current and valid motor vehicle operator's license while on duty. Additionally, a copy of a current and valid motor vehicle operator's license must be kept on file with the Office of the Superintendent in Chief.

Any member who does not possess a valid and/or current driver's license shall notify the Shift Commander immediately upon receiving knowledge that the license is expired or revoked. The member may be relieved of duty. Members shall not operate any Department motor vehicle unless duly licensed to operate such vehicle classification. Any member who knowingly operates a Department motor vehicle without a current and valid license may be relieved of duty pending an administrative hearing.

FITNESS FOR DUTY

Members are expected to keep themselves in a physical, mental, and emotional condition as required to safely, properly, and effectively perform their duties and responsibilities.

An on-duty member who is physically, mentally, or emotionally unable to perform his or her duties shall inform a Supervisor immediately. The supervisor shall inform the Shift Commander and may send the member to a medical facility for evaluation and referral. If necessary, the Department shall provide transportation to the medical facility. Any member relieved of duty for mental or physical reasons will be required to provide satisfactory documentation of fitness for duty before returning to duty. A member who is aware that another on-duty member is unfit for duty shall notify a Supervisor immediately.

DECORUM

Members shall treat coworkers, supervisory officers and subordinates with respect and dignity. A dispute between fellow workers shall be referred to the immediate Supervisor who shall attempt to settle the dispute. If the Supervisor is unable to settle the dispute, he/she shall refer the matter in writing through the chain of command. Irreconcilable differences may result in the reassignment of one or both members.

Members shall be courteous and respectful to the general public and to members of other agencies. Any dispute between a member of EMS and a member of another agency shall be referred to an immediate Supervisor as soon as possible. The Supervisor shall obtain all the relevant facts of the incident and submit a written report through the chain of command.

Department members shall treat all patients with respect, compassion and courtesy, guard against employing an overbearing attitude or language that may belittle, ridicule, or intimidate the individual, or act in a manner that unnecessarily delays the performance of their duty.

While recognizing the occasional need to demonstrate control over violent patients, department personnel shall adhere to the Department’s restraint policy and shall protect the well-being of those in their charge.

Whenever a member of the public requests the name of an EMT, the EMT shall state his name or her badge number in a courteous manner.

An EMT alleging mistreatment from a member of the public shall immediately notify the appropriate Field or Dispatch Operations Supervisor who shall conduct a preliminary investigation and send the complaint and preliminary report in writing through the chain of command. If an EMT is physically assaulted by a member of the public, an EMS Field Supervisor and the appropriate police agency shall be dispatched to the scene. Any member who files a criminal/civil complaint regarding an on duty incident shall notify his/her immediate Supervisor, who shall prepare a report describing the situation and send this report through the chain of command to Professional Standards.

USE OF ALCOHOL AND DRUGS

Department members shall not consume any intoxicating beverage while on duty or in uniform. No alcoholic beverage shall be served or consumed at an EMS satellite station or in a Boston EMS vehicle.
No member shall report to work or be on duty when alcohol, medication, or other substances have impaired his or her judgment or physical condition.

USE OF TOBACCO PRODUCTS

While on duty, department members shall not use an e-cigarette or tobacco product unless in a designated smoking area and when not conducting EMS related functions. Additionally, personnel are not permitted to use tobacco products in a Department vehicle or in an EMS facility.

ABUSE OF POSITION

Department members shall not solicit any gifts, gratuities, or other items of value in exchange for performing their duties. In addition, members may not accept unsolicited gifts, gratuities, or other items of value in the course of their employment where the value exceeds $50. If a gift, gratuity, or item is received and its value exceeds $50, that member shall promptly report in writing the circumstances of such gift to Professional Standards.

Department members shall not use their authority or position for financial gain, for obtaining or granting privileges or favors not otherwise available to them or others except as a private citizen.

Department members shall not purchase, convert to their own use, or have any claim to any found, impounded, abandoned, or recovered property.

Department members shall not solicit nor accept contributions for this agency without the express consent of the Executive Director of the Public Health Commission, or the Chief of Department.

PUBLIC STATEMENTS AND APPEARANCES

Department members shall not divulge, or willfully permit to have divulged, any information gained by reason of their position, for anything other than its official, authorized purpose.

Unless expressly authorized, Department members shall not make any statements, speeches, or appearances that could reasonably be considered to represent the views of this agency.

POLITICAL ACTIVITY

Department members shall be guided by state law regarding their participation and involvement in political activities. M.G.L. Chapter 55, the Campaign Finance Law, regulates political activity by public employees and the use of public buildings and resources in campaigns. Public employees who take part in political campaigns and the candidates and committees they support should be aware of these sections of the law.

Section 13: Public Employees.

No person employed for compensation by the Commonwealth, its cities, towns and counties, public agencies, other than an elected official, may directly or indirectly solicit or receive a contribution or anything of value for any political purpose.

A public employee may not:

- Sell tickets to a political fundraiser or otherwise solicit or collect contributions in any manner, such as by phone or mail.
- Serve as treasurer of a political committee
- Allow his name to be used in a solicitation letter or fundraising phone call
- Help identify people to be targeted for political fundraising.

A public employee may:

- Run for office (provided a committee is organized on his behalf if he plans to raise any money).
- Contribute to candidates and attend fundraisers.
- Work for campaigns and committees in a non-fundraising capacity, such as holding signs, stuffing envelopes, hosting coffees or other informational meetings, or being a member of a committee.

Section 14: Public Buildings

Soliciting or receiving campaign contributions in a public (government) building is prohibited. Examples include City or town hall, office buildings, public schools and libraries, police and fire stations and public works garages. No one (not just public employees) may:

- Sell tickets to a fundraiser or otherwise solicit or collect political contributions in a public building.
- Use a public building as the site of a fundraiser, the return address for contributions or the contact phone number for buying tickets to a fundraiser.
- Post in a public building any advertisements for a fundraiser.

USE OF PUBLIC RESOURCES

Campaign finance law prohibits the use of public resources for political campaign purposes, such as influencing the nomination or election of a candidate or the passage or defeat of a ballot question. “Public Resources” encompass just about anything that is paid for by the taxpayers, such as vehicles, office equipment and supplies, buildings, and the paid time of public employees. For example, a public employee may not, during his work day, render campaign service to a candidate or work in favor of or against a ballot question.

Where state law is silent on this issue, members shall be guided by the following examples of prohibited political activities during working hours, while in uniform, or otherwise serving as a representative of this agency:

- Placing or affixing any campaign literature on city or commission-owned property;
- Soliciting political funds from any member of this agency or another governmental agency of this jurisdiction;
- Soliciting contributions, signatures, or other forms of support for political candidates, parties, or ballot measures on Department property;
- Using official authority to interfere with any election or interfere with the political actions of other employees or the general public;

- Favoring or discriminating against any person seeking employment because of political opinions or affiliations;
- Participating in any type of political activity while in uniform unless authorized by the Chief of Department or designee.

EXPECTATIONS OF PRIVACY

Department members shall not store personal information or belongings with an expectation of personal privacy in such places as lockers, desks, departmentally owned vehicles, file cabinets, computers, or similar areas that are under the control and management of this agency. While Boston EMS recognizes the need for personnel to occasionally store personal items in such areas, Department members should be aware that these and similar places may be inspected or otherwise entered-- to meet operational needs, internal investigatory requirements, or for other reasons--at the direction of Chief of Department or designee.

DISTRICT STATIONS

Members assigned to a station in facilities provided by other City agencies, by public or private health facilities, by allied public safety agencies, or by any other agency shall follow the rules of conduct within the facilities set forth by the managing entity and Boston EMS.

The security and maintenance of the District Stations are the responsibility of the crew members on duty. No other personnel may enter or utilize these stations without proper authorization.

Members regularly assigned to a District Station may enter the Station to obtain personal and/or assigned Department equipment as needed while off-duty.

District Stations shall be kept in a clean and orderly condition as time permits.

Offensive, defamatory, derogatory, sexually explicit or sexually suggestive materials are prohibited at District Stations or any area maintained by Boston EMS.

POSSESSION OF WEAPONS

The following items shall **NOT** be carried while on duty or in uniform: Any firearm; A blackjack or similar instrument; Mace; A spring-loaded baton device; a flashlight longer than thirteen (13) inches or with a capacity to hold more than 6 “C” batteries or 5 “D” batteries; a knife with a double-edge blade or illegal length; any device which by appearance or by design may be considered as an offensive weapon.

RESTRAINTS

No device or equipment used for the restraint of a patient shall be carried on duty or in uniform unless expressly authorized in the Department’s Patient Restraint Policy.

INSPECTION AUTHORITY OF MASSACHUSETTS DPH

Inspectors from the Department of Public Health Office of Emergency Medical Services may visit and inspect at any time the following areas:

- The main ambulance garage and all other EMS garages and stations;
- Any area designated for the storage and maintenance of linen, equipment, and supplies;

- All records, including employee application forms, accident reports, trip sheets, tapes, incident reports, information relating to complaints, and documentation of current certifications.
- Any ambulance may be inspected with or without prior notice.

If an Inspector arrives without prior notice, members shall courteously request identification of the Inspector and notify the Dispatch Operations Supervisor that the ambulance is being inspected. The Communications Supervisor shall immediately notify the Shift Commander.

SPECIFICALLY FORBIDDEN ACTS

The following acts or situations are specifically forbidden and shall cause disciplinary action to be taken:

- Transmitting false or erroneous information by radio, particularly locations or status of personnel and/or units;
- Negligence in patient care as defined by protocols and/or the standard of care;
- Willful or overt neglect of duties and responsibilities;
- Theft, destruction, or neglect of city property, or negligence while operating a Department motor vehicle;
- Theft or destruction of the property of another person while on duty or in uniform or on property owned or used by the Department;
- Deliberate falsification of a patient care report (trip sheet), an Incident Report, a Motor Vehicle Accident Report, an Industrial Accident Report, a computer-input device, required certification, medical documentation supporting sick time use, or any other Department records, reports or application forms;
- Willful or overt disregard of Department rules and regulations;
- Threatening, intimidating, coercing, harassing, or fighting with another member of the Department, a first responder, a member of a private ambulance company, or a member of the public while on duty, or in uniform, or on property owned or used by the Department;
- Smoking or chewing tobacco in a Department vehicle, in a facility owned or used by the Department, while assigned to an incident, or while in the performance of duties;
- Unauthorized response to an incident and/or unauthorized movement or relocation of a response unit from an assigned location;
- Leaving an assigned duty post without first being properly relieved;
- Being employed in a second job during regular hours of employment; in any business while on sick leave, or being employed in any other business while on injured leave without notifying the Office of the Superintendent in Chief and Worker's Compensation;
- Engaging in or soliciting a strike, sabotage, a work slowdown or other illegal job action;
- Engaging in or soliciting sexual activity while on duty or in uniform or on property owned or used by the Department;
- Engaging in or soliciting sexual activity with a patient while on or off duty;
- Failure to dispatch an available appropriate ambulance to a medical emergency without delay;
- Failure to respond without delay to a call when dispatched by radio or telephone;

- Derogatory, or otherwise inappropriate verbal responses to orders or radio messages;
- Failure to honor a subpoena or summons relating to Departmental business; Absence from duty without notification to the Dispatch Operations Supervisor; if assigned to administrative or light duty, absence from duty without notification to a supervisor;
- Absence from duty without authorization; Abandonment of duty;
- Failure to supervise if so authorized or empowered

The following acts require the prior authorization of a member of the Command Staff. Committing these acts without prior authorization shall be cause for progressive discipline:

- Allowing a person to ride as an observer in an ambulance or other Department vehicle;
- Speaking to the media about matters related to the Department while on duty or in uniform;

Reference: MGL Chapter 268A:Conflict of Interest Law; MGL Chapter 55 Campaign Finance Law.

Inclement Weather / Emergency Conditions

Supersedes:
Effective: 12-16-08

Emergency conditions that arise because of inclement weather, widespread power failure, civil disorders, or other unusual circumstances may prompt the Mayor to declare an emergency. Upon a Mayoral declaration of emergency in which municipal offices are closed and non-essential employees are advised not to report for work Boston EMS may implement “Emergency Administrative Leave”. The Executive Director of the Public Health Commission or Chief of Department may also implement “Emergency Administrative Leave” for Department employees in isolated situations.

1. When emergency administrative leave due to inclement weather or other emergency is declared, emergency and essential employees are still expected to report for duty as scheduled to ensure that public safety needs or critical departmental requirements are met. For the purposes of this policy, all uniformed members of the service (EMT-Recruit, EMT-Basic, EMT-Paramedic, Lieutenant, Captain, Deputy Superintendent, Superintendent, Superintendent in Chief, and Chief), regardless of assignment, are considered “emergency and essential employees”. Similarly, personnel assigned to the Support Services Division (Communication Engineering Unit and Fleet Services Section) and Materials and Facility Management Division are considered “emergency and essential”.
2. Non-uniform personnel assigned to EMS Headquarters; Research, Training, and Quality Improvement; Public Health Preparedness; and DelValle Institute will be advised of their status prior to the emergency administrative leave declaration. Their status may change depending on the nature and duration of the emergency situation. For example, should an emergency extend past one day, an employee previously considered “non-essential” on the first day may be considered “essential” and expected to report on subsequent days due to the operating needs of the department.

   2.1. Employees that are scheduled to work and have been designated as “non-essential” may remain home, or leave work early and be placed on paid administrative leave. Employees on emergency administrative leave must remain available by telephone during work hours and may be ordered to report for duty if necessary.

   2.2. Employees who are already on approved leaves of absence, such as vacation, holiday, personal day, sick are not affected; their time off will be reported per their previously requested time off.
3. When an employee is required to report for duty, but transportation problems arise from severe conditions, Shift Commanders or area managers may excuse up to two hours of tardiness, so long as the employee had called prior to the start of their shift to report that they would be late and made reasonable efforts to report for duty. The amount of time excused will be determined by the Shift Commander or area

manager and be based on circumstances specific to each employee. Factors such as alternate forms of transportation, the distance between the residence and workplace, leaving earlier than normal to report to work, and efforts of similarly situated employees can all be taken into account. The Chief, Superintendent in Chief, Superintendent, or Director of Administration and Finance, has the authority to grant additional leave on a case-by-case basis for those unusual circumstances where an employee arrives later than two hours after the start of their regularly scheduled shift.

Infection Control

Supersedes: 09-09-10
Effective: 10-31-14

GENERAL STATEMENT

This policy sets forth infection control practices and procedures for all Department members. The purpose is to decrease the risk of contamination and infection for patients, Department members, and the general public. The Department encourages input from employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls. All unprotected exposures shall be documented and thoroughly investigated to ensure compliance with existing procedures. This policy shall be reviewed annually and updated as necessary to reflect changes in technology that eliminate or reduce exposure to bloodborne pathogens.

DEFINITIONS For the purposes of this policy and procedure, the following shall apply:

Blood means human blood, human blood components, and products made from human blood.

Bloodborne Pathogens means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV), Ebola virus disease, (EVD) and human immunodeficiency virus (HIV).

Contaminated means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

Contaminated Laundry means laundry which has been soiled with blood or other potentially infectious materials or may contain sharps.

Contaminated Sharps means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

Decontamination means the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

Designated Infection Control Officer (DICO) means the officer appointed by each ambulance service, EMS first response (EFR) service, as defined in 105 CMR 170.020, and first responder agency, as defined in 105 CMR 171.050, for the purposes of, but need not be limited to, (1) receiving notifications of exposures to infectious diseases dangerous to the public health from health care facilities and (2) notifying the indicated care provider(s) of an exposure to an infectious disease dangerous to the public health.

Engineering Controls means controls (e.g., sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered sharps injury

protections and needleless systems) that isolate or remove the bloodborne pathogens hazard from the workplace.

Exposure Incident means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

EVD means Ebola Virus Disease

HBV means hepatitis B virus.

HCV means hepatitis C virus.

HIV means human immunodeficiency virus.

Needleless systems means a device that does not use needles for:

(1) The collection of bodily fluids or withdrawal of body fluids after initial venous or arterial access is established; (2) The administration of medication or fluids; or (3) Any other procedure involving the potential for occupational exposure to bloodborne pathogens due to percutaneous injuries from contaminated sharps.

Other Potentially Infectious Materials means (1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and (3) HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

Parenteral means piercing mucous membranes or the skin barrier through such events as needle sticks, human bites, cuts, and abrasions.

Personal Protective Equipment is specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment.

Sharps are discarded medical articles that may cause puncture or cuts, including but not limited to used and discarded hypodermic needles; syringes; broken medical glassware; scalpel blades; disposable razors; venipuncture equipment.

Source Individual means any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee.

Sterilize means the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

Universal Precautions is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

Work Practice Controls means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique).

ASEPTIC PROCEDURE

Aseptic procedures shall be used to prevent cross contamination. This includes wearing appropriate protective barriers to contamination such as gloves and masks, and avoiding touching the hair, glasses, clothing or any other “unclean” surface or object immediately before or during treatment of the patient.

PRECAUTIONS

A Department member who has either been exposed to, exhibits the signs or symptoms of, or has been diagnosed with an infectious illness shall notify a Field Supervisor. Infectiousness will be determined by the BMC Department of Occupational and Environmental Medicine (OEM), Emergency Department physician, or the employee’s own health care provider. The Supervisor will notify the Shift Commander of the incident and have the Designated Infection Control Officer (DICO) notified of the exposure by email or phone. The Designated Infection Control Officer or the Occupational and Environmental Medicine will determine if it is necessary for the Department member to remain off-duty because of a potential infectious disease. Prior to returning to duty after a prolonged time away from work (> 6 months), members must check with the DICO or Medical Director to assure TB test is up to date. If not up to date, arrangements will be made to complete routine TB testing or if there is a history of + PPD, a TB screening form should be completed and returned to the DICO.

IMMUNIZATIONS

The Department strongly recommends that all members receive the hepatitis B vaccine and yearly tuberculosis (TB) testing. Annual PPD testing will be performed on all members who have patient contact, unless the member has a documented prior positive PPD. The PPD must be read by the DICO, Department Physician, appropriately trained Shift Commander or other health care provider that is familiar with reading TB tests. Members who are PPD+ will also have the opportunity to complete a symptom reporting review to screen for possible symptoms of re-activation. This will be reviewed by the DICO and a copy sent to OEM.

Members who have been away from work for a period that includes the date that their annual TB test would have been due will be contacted upon their return to schedule a TB test.

Members must have on file with the OEM documentation of immunity to measles, mumps, rubella, tetanus, diphtheria, and hepatitis B. Acceptable documentation shall be written records containing the appropriate vaccination dates (including month and year) or serologic test results. Members must also know whether or not they have had chickenpox (varicella) or the varicella vaccine with written documentation on record in the Department of Occupational and Environmental Medicine. Members who test positive for tuberculosis after a PPD (purified protein derivative) skin may be sent for chest x-ray if recommended by OEMS or BMC Tb clinic. If any member, particularly those with a history of positive PPD, experiences any of the following signs and

symptoms, the member must be evaluated at OEM or provide documentation of an acceptable evaluation from a personal physician: cough greater than two weeks, particularly if the cough is productive or there is hemoptysis; unintentional weight loss greater than ten (10) pounds; loss of appetite; easily fatigued without apparent reason; night sweats or fever for more than two (2) weeks.

Occupational and Environmental Medicine
Doctor's Office Building
720 Harrison Avenue, Suite 703
Boston, MA 02118
(617) 638-8400 email: occmed@bmc.org

STERILE SUPPLIES

1. All sterile supplies and sterile solutions shall be kept sealed and in a clean dry area until used. Once sterility has been compromised, supplies shall be discarded immediately and replaced.
2. All solutions and sterile supplies on the ambulance shall be checked for expiration dates and for package integrity by the assigned members during the daily equipment check. Expired or contaminated solutions or supplies shall be returned to Materials Management.

HANDWASHING REQUIRED

Handwashing is required at the start of the shift, after using toilet facilities, after each patient contact, and after vehicle or equipment cleaning or maintenance. An alcohol- based solution for hand sanitizing is available on each ambulance and shall be used after patient contact or contact with blood/body fluids when running water and soap are not available. The handwashing procedure shall be repeated with soap and running water as soon as possible.

LAUNDRY

1. Linen (sheets, towels, pillowcases and blankets) that is stored on-board vehicles for patient use shall be placed inside a clear plastic bag. Sheets, towels, or pillowcases shall be changed between each patient use. Sheets, towels, or pillowcases that have been used or soiled shall be disposed of in the appropriated laundry receptacle at the receiving emergency department.
2. Woolen blankets should not be disposed of at the receiving facility. Soiled woolen blankets should be placed inside a blue plastic soiled linen bag, and stored in the exterior compartment of the ambulance until they are exchanged or replaced at Materials Management. In the event that Materials Management is closed, and there is an excess of soiled woolen blankets stored in the exterior compartment, the excess blankets shall be deposited in the designated laundry hamper at the District Station.

PATIENTS

1. All Blood and Body Fluids shall be considered potentially infectious.

2. All members must wear gloves whenever they are involved in patient care that may expose them to blood or bodily fluids.

3. A mask, fluid shield, goggles, or a gown shall be worn as described below:

   3.1. A member treating a patient who exhibits signs and symptoms of a respiratory infection or suspected communicable disease shall apply an N-95 or other Department approved respirator. Note: a beard or mustache may diminish the effectiveness of a respirator. A surgical mask shall be placed on the patient unless it would compromise patient care..

   3.2. A gown or Tyvek suit should be worn whenever there is the potential of gross contamination from blood or bodily fluids.

   3.3. A fluid shield mask and eye protection shall be worn whenever there is the possibility of contamination of the mucous membrane of the eye, nose or mouth by means of a splash or aerosolization of bodily fluids. A fluid shield mask should be worn while inserting an airway, performing intubation, suctioning a patient, assisting in childbirth, administering fluids / medications via an Intra-osseous infusion, or whenever an exposure is likely. A fluid shield mask shall also be worn whenever cleaning equipment that is contaminated with blood or bodily fluids.

4. Fluid shield masks, masks and gowns shall be discarded as hazardous infectious waste. The CDC recommends disinfecting visibly contaminated PPE using an EPA-registered disinfectant wipe prior to taking off equipment. Additionally, CDC recommends disinfection of gloved hands using either an EPA-registered disinfectant wipe or alcohol-based hand rub between steps of taking off PPE.

5. Latex-free supplies are stocked on all ambulances.

UNPROTECTED EXPOSURE; REPORTING PROCEDURE

1. “Unprotected exposure” shall mean an exposure capable of transmitting an infectious disease dangerous to the public health and is limited to the following:

   1.1. Puncture Wounds - including punctures resulting from used needles, glass and other sharp objects contaminated with blood, or human bites.

   1.2. Blood to blood contact through open wounds which includes open cuts, sores, rashes, abrasions or conditions which interrupt skin integrity; and

   1.3. Mucous membrane contact - including such contact as would occur with mouth-to-mouth resuscitation or eye splashing with infected fluids. Such fluids would include: blood, sputum, oral and nasal secretions.” (105 CMR 172.001)

2. If an unprotected exposure occurs, the affected area should be thoroughly washed as soon as possible. The Division Supervisor and the Designated Infection Control Officer shall be notified. The following paperwork shall be completed for each unprotected exposure:

   2.1. The Boston EMS Unprotected Exposure Report completed by Supervisor.

2.2. The Massachusetts Department of Public Health Unprotected Exposure Report completed by the employee.

2.3. The Worker's Compensation Form completed by the employee.

3. The following procedures shall be in effect:

3.1. An employee who has been exposed shall contact a Supervisor.

3.2. The employee shall complete the Massachusetts Department of Public Health Unprotected Exposure Report and the Worker's Compensation Form. *The employee shall use the EMS Headquarters address as his or her home address.* The Supervisor shall complete the Boston EMS Unprotected Exposure Report. The original of the Department of Public Health Unprotected Exposure Report shall be left with the designated person at the emergency department.

3.3. The Supervisor shall fax a copy of the Department of Public Health Unprotected Exposure Report and the Worker's Compensation Form to the Department of Occupational and Environmental Medicine at 617 638-8406. The employee shall then call the OEM at 617 638-8400 as soon as possible to make a follow-up appointment if required. The follow-up appointment shall be made as a continuation of the employee's work shift, i.e., before the start or after the end of the work shift when possible. The OEM is open Monday through Friday from 07:30 to 16:00.

3.4. In the event that the employee requires immediate treatment for the exposure and the Department of OEM is closed, the employee shall be seen at the Boston Medical Center-Menino Emergency Department or the facility that accepted the patient. However, in the event of a known blood splash in the eye, the employee may be treated at the hospital to which the patient is transported for immediate evaluation, irrigation and other therapy. Blood work on the employee does not need to be done immediately and can wait until the employee can go to OEM. If any treatment or blood work results are not done at BMC or OEM it will be the responsibility of the employee to assure results and vaccines are received at OEM.

3.5. The Supervisor shall respond to the Emergency Department at which the employee is being treated and ensure that the Department of Public Health Unprotected Exposure Report and the Worker's Compensation Form have been completed, and that the Occupational and Environmental Medicine Program has been notified of the exposure by voice mail. The Supervisor shall note this on the Supervisor's Shift Summary. The Supervisor shall send a copy of the Department of Public Health Unprotected Exposure Report and the Boston EMS Unprotected Exposure Report to the Designated Infection Control Officer. The Supervisor shall also send the original Worker's Compensation Form to EMS Headquarters addressed to the "Worker's Compensation Coordinator."

3.6. If the employee does not require immediate treatment, the Supervisor shall meet with the employee as soon as possible but before the end of the work shift. The Supervisor shall confirm that the Department of Public Health Unprotected Exposure Report and the Worker' Compensation Form have been

completed and faxed to the OEM. The Supervisor shall complete the Boston EMS Unprotected Exposure Report and forward all paperwork as described in the preceding paragraph (5).

3.7. The EMS Supervisor shall complete a Boston EMS Exposure report detailing the circumstances of the exposure, whether or not appropriate precautions appear to have been taken to prevent or minimize the exposure, and recommendations for the prevention of similar occurrences in the future. The report will then be forwarded to the Designated Infection Control Officer who will review the report, ensure appropriate follow-up appointments have been made and make additional comments or recommendations as necessary. To ensure patient privacy, detailed information regarding the employee's exposure should only be given to the Medical Director and DICO.

4. Whenever a receiving hospital notifies the Designated Infection Control Officer that a patient has been diagnosed with an infectious disease, the Designated Infection Control Officer shall contact the affected members as soon as possible.

5. Whenever the Dispatch Operations Center Supervisor receives a call from a hospital that a member may have been exposed to an infectious disease, the Supervisor shall notify the Designated Infection Control Officer.

6. A member requesting information about a patient relative to an infectious disease shall notify the Designated Infection Control Officer who will contact the receiving hospital for follow up, and inform the interested member of the results of such inquiry whenever possible. Information may only be given out if an exposure occurs and by law the hospital can only release information if the DPH form has been completed and received.

7. Although not considered an exposure, if a member transports a patient with lice and/or scabies and there is significant contact (i.e. exposed skin to exposed skin contact), the member shall notify a Field Supervisor and the Designated Infection Control Officer. Members should NOT self diagnose or self treat without consultation from the Medical Director or Designated Infection Control Officer.

8. The Designated Infection Control Officer shall maintain records regarding employee exposures. The information shall be recorded and maintained in accordance with HIPAA in such manner as to protect the confidentiality of the injured employee.

SHARPS

1. Boston EMS has implemented a "needleless" system and utilizes sharps designed with built-in safety features or mechanisms that effectively reduce the risk of an exposure incident. However, EMS personnel may still encounter contaminated needles at the scene of a drug overdose, patient's home, health care facility, or other location. When disposing of a sharp, needles shall not be recapped, bent or cut. The syringe, with or without the needle covered, shall be discarded in either the needle box supplied in each ambulance or the needle box carried inside all Department- issued ALS jump bags. Replacement containers are procured from Materials Management. All syringes/needles shall be removed from the scene of an incident and discarded in these containers.

2. All ambulances- ALS and BLS- are supplied with needle boxes. The needle boxes shall be secured either by an adhesive pad or within a bracket mounted near the point of use. All units shall discard used needle boxes at a receiving facility or Materials Management whenever the box is more than half-filled but before it is completely filled.
3. If a patient is encountered who has a needle in an extremity or other body part, the needle shall be removed and discarded in the needle box.

ROUTINE CLEANING

The cleaning and disinfection of equipment and surfaces inside the ambulance is important for the health and safety of our crews and patients. When cleaning the interior of the ambulance and equipment, include any surfaces that the patient might have had contact with, or that crews may have touched with gloved hands while caring for a patient.ie switches, radio controls etc.

Department members shall wear gloves while decontaminating equipment. Fluid shield masks shall be used if splashing is anticipated. Equipment shall only be decontaminated in areas that are designated as appropriate by the facility and/or staff. After patient contact, the equipment listed below shall be cleaned of all obvious debris before being sent to Materials Management for high-level disinfection. Once grossly decontaminated, the equipment shall be placed inside a red hazardous waste plastic bag. This bag shall be stored in the outside rear compartment on the passenger side of the ambulance until exchanged or replaced.

- Suction Equipment (except suction catheters which are disposable)
- Intubation and non-disposable airway equipment
- Any other contaminated equipment (stretcher straps, oxygen bags, etc.)

If there is a suspicion of EVD or potential exposure to blood or other body fluids, a victim transport kit (VTK) should be deployed as time allows, and the walls of the ambulance draped in plastic. This, along with wearing our own PPE will afford an additional barrier to the patient's bodily substances. It will also limit contamination of surfaces inside the ambulance and equipment.

The recommendations listed should be considered in the event that we transport a patient with a concern for a communicable disease prior to returning the ambulance to service.

- Don appropriate PPE including double glove, mask and face shield or gogles, Tyvek suit or fluid impervious hospital gown. Look for signs of visible contamination. Remove all visible body fluids with towel, paper towel and make sure to clean the area fully with a disinfectant.
- Clean all medical equipment and contact surfaces that you or the patient might have contacted with an EPA approved Hospital Based disinfectant as described below
- Do not attempt to clean, rather you should dispose of any nondurable or semi durable medical equipment that has concern for contamination. Example of semi durable: BP cuff, carrying case for AED or green bag.
- Place the used cleaning materials into a red "Biohazard" medical waste container

- Doff appropriate PPE in red "Biohazard" medical waste container making sure not to touch your face or mucous membranes while taking off PPE.
- Wash your hands with soap and water.

*****If a concern exists that the vehicle is heavily contaminated in a situation with concern for EVD, the crew should consult the supervisor or shift commander. We can arrange to move the ambulance to where a contractor may clean it *

Should a member's clothing/uniform become contaminated with any patient's body fluids (e.g. blood, urine, emesis, sputum, or feces. Members should:

- Remove the contaminated clothing;
- Place the clothing in a red "Biohazard" bag or clearly labeled plastic bag;
- Clean underlying skin with soap and water (shower as needed) NO bleach on skin.
- Contact supervisor for further details regarding uniform and clothing disinfection, and reporting of possible pathogen exposure.

Selection of Disinfection & Cleaning Products:
The CDC recommends using an EPA-registered hospital disinfectant with label claims for viruses, like norovirus or influenza virus
Regardless of the product, it is ***very important*** to follow all label directions carefully, for maximum effectiveness. For example, many of the cleaning products require drying time prior to being wiped off in order to be effective.

NOTE: Bleach can burn human skin. Full-strength household bleach (sodium hypochlorite) should **never** be used on patients or personnel. Its use on durable medical equipment is not preferred.

DISPOSAL OF NON-SHARP HAZARDOUS INFECTIOUS WASTE

The term "hazardous infectious waste" (H.I.W.) means waste material with infectious characteristics causing or contributing to an increase in mortality, serious irreversible illness, or incapacitating reversible illness. It may also pose a hazard to human health or the environment when improperly treated, stored, transported, disposed of, or otherwise mismanaged. All hazardous or patient generated waste shall be disposed of at the receiving facility. Expendable non-sharp materials that have come in contact with a patient's blood or body fluid shall be sealed in two 3 mil (3/1000 inch) polyethylene bags. Each bag shall be sealed separately, and the outer bag shall be the red hazardous waste plastic precaution bag. These bags are stocked on board the ambulance. These sealed bags must be leak free from liquids and/or vapors. The sealed bag(s) shall be disposed of in a hazardous waste receptacle as soon as possible.

Related: Latex Free Kit SOP; DPH Unprotected Exposure Form; EMS Unprotected Exposure Form

105 CMR 172.000: Regulating the Reporting of Infectious Diseases Dangerous to the Public Health; Unprotected Exposure form available on-line at:

http://www.mass.gov/Eeohhs2/docs/dph/emergency_services/forms/ambulance_unprotected_exposure.pdf

Internet Use

Supersedes:
Effective: 07-98

PURPOSE

To ensure that the Internet, where available to employees of the Boston Public Health Commission, is primarily used to accomplish business related tasks.

POLICY

The Internet is to be used primarily for business purposes. Any use of the BPHC Internet, to access for personal gain or to access material which is offensive, obscene or otherwise in violation of this policy is strictly prohibited.

PROCEDURE

A. DEFINITIONS
   1. *Employees* are defined as all full-time and part-time, permanent and temporary personnel including contractors, students, consultants and vendors.
   2. *Internet access* includes viewing Web sites, sending and receiving electronic mail, transmitting or receiving files, and running Internet applications (e.g., games, catalogs) via the BPHC provided network.

B. ALLOWED USAGE GUIDELINES

   1. Internet access is provided as a tool to assist employees communicate and gather information to achieve public health objectives. It is understood that employees may spend a small portion of time on-line for personal (i.e. non-business) use, but that this should only occur during non-work hours. After business hours, employees may use BPHC provided Internet access for personal use, subject to the use guidelines noted below. The company has the right to monitor and otherwise control access to the Internet from the administrative telecommunications and computing network.
   2. Employees may not use their Internet access for any communications of a discriminatory or harassing nature or materials that are obscene or X-rated. Nor may such access be used for any purpose which is illegal or against BPHC policy or contrary to the BPHC's best interest.
   3. Solicitation of non-BPHC business or any use of the Internet for personal gain is prohibited.

C. FILE TRANSFERS

   1. To prevent computer viruses from being transmitted through the company's e-mail/Internet system, there will be no unauthorized downloading of any unauthorized software.
   2. All employees shall quarantine and scan a transferred file for viruses.

D. INTELLECTUAL PROPERTY RIGHTS

1. Employees may not disclose any confidential or proprietary BPHC information by any means, including electronic mail or otherwise over the Internet. Employees should assume all communications may be accessed by unauthorized sources.
2. Any BPHC documents transferred via the Internet must clearly indicate the BPHC as holder of the copyright. Employees must respect all copyrights of material obtained over the Internet.
3. Any issues on Intellectual Property Rights should be reviewed by the BPHC General Counsel's Office.

E. WEB SITE STANDARDS

All design and development of the BPHC Web site will be done by our Web team, headed by *(TBA),* and with the approval of senior management. Employees may only use ITG-approved software for developing Web content.

F. PERSONAL INTERNET ACCOUNTS

Employees shall not use BPC equipment to access their personal (i.e., not Commission provided) Internet account or other on-line service. Doing so raises the risks of inadvertently importing a computer virus or otherwise compromising the integrity of system security.

G. VIOLATIONS

Any violations of this policy will be subject to restriction or loss of Internet access and other corrective action up to and including termination. The BPHC also has the right to notify the appropriate authorities if it discovers evidence of any possibly illegal activities.

Reference
Boston Public Health Commission Policy and Procedure Manual #300-13

Latex Free Kit

Supersedes:
Effective: 07-18-05

Contents:

- Latex free Adult BP Cuff
- Latex Free Pediatric BP Cuff
- Latex Free Infant BPD Cuff
- Latex Free Stethescope
- Latex Free Airway Kit
- Latex Free Tourniquet Straps
- Nitrile Exam Gloves (Safeskin)
- Adult Non-rebreather mask (Hudson)
- Pediatric Non-rebreather mask (Hudson
- Nebulizer (Hudson)

OTHER FREQUENTLY USED LATEX FREE ITEMS AVAILABLE ON BOARD AMBULANCE

- BVM's, Adult & Pedi (AMBU, reusable & disposable types)
- Face Masks (LAERDAL, all sizes)
- IV Interlink Infusion Products (Baxter)**
- Endotracheal Tubes (Mallinckrodt, all sizes)
- Stylette (Mallinckrodt, adult size)
- Suction Catheters (Kendall)
- Nasopharyngeal Airways (Argyle)
- Durasensors and Oxysensors (Nellcor)
- Cardiac Electrodes (Graphic Control)
- All Dressing Supplies
- Armboards (Mark Clark)
- Salem Sumps (Argyle)
- Veni-Gard IV Dressing (Con-Med)
- Angiocaths, Insyte Autoguard (B-D, All sizes)
- 1cc/TB SYRINGE (B-D)
- EpiPen & EpiPen Jr.
- Trach Tape
- Stockinette
- Transopore Tape

**Any Baxter non-Interlink product with a port or flashball has latex. Also, IV bag ports have latex.

Related: Infection Control

Protection of Confidential Heath Information

Supersedes:
Effective: 03-05-03

PURPOSE

Each resident of the City of Boston and citizen of the Commonwealth has a fundamental right to privacy and confidentiality in his/her relationship with health care professionals and other entities that collect, use, or maintain confidential health information.

To further its mission, BPHC collects confidential health information for treatment, and use in public health surveillance, program development and evaluation, research, and for many other public health purposes. It is critical that BPHC staff and agents who carry out these core functions recognize the importance of protecting personal privacy and safeguarding the confidentiality of information obtained by BPHC to the greatest extent possible. To this end, BPHC adopts this Policy on Protection of Confidential Health Information.

This Policy is intended to ensure that BPHC staff (hereinafter includes but not limited to, employees, volunteers, contractors, agents) complies with all relevant state and federal laws and regulations concerning the protection of confidential health information. These include, but are not limited to, the Health Insurance Portability and Accountability Act (HIPAA), privacy and security regulations adopted pursuant to HIPAA, the Massachusetts Fair Information Practices Act (FIPA), and Massachusetts Executive Order #412.

POLICY PRINCIPLES

This Policy is based on the following principles:

A. **Accountability**. BPHC must be responsible for providing notice of this Policy and its requirements to its employees, volunteers, contractors, agents, and approved external researchers. Access to, use of and disclosure of confidential health information should be based on a legitimate need to know.

B. **Openness**. Individuals should be given notice about how BPHC collects, uses, maintains, and discloses confidential health information.

C. **Limiting Collection**. BPHC will collect the minimum amount of confidential health information necessary to enable BPHC to implement statutory and regulatory requirements, effectively provide health care, create public awareness of factors affecting good health, or otherwise fulfill BPHC's mission.

D. **Limiting Use**. BPHC will only use confidential health information as necessary to fulfill BPHC's mission or as authorized by the client. BPHC will also limit internal access to such information only to those staff members with a need to know.

E. **Limiting Disclosure**. BPHC may disclose confidential health information when authorized by the client as necessary to fulfill BPHC's mission provided that such disclosure is not prohibited by law. Confidential health information should not be communicated externally without the authorization of the client except: 1) in accordance with applicable research protocols established by BPHC; 2) when sharing client health

information with a direct care provider of the client; 3) for payment purposes; or 4) when otherwise permitted by law or regulations.

F. **Integrity.** BPHC shall endeavor to ensure the quality, accuracy, thoroughness, and reliability of confidential health information under its control, whether in written, electronic, or other form.

G. **Individual Access**. When BPHC collects confidential health information directly from a client, he/she shall be informed, upon request and if permitted by applicable law, of its existence, use, and disclosure and shall be given access to the information.

H. **Security**. BPHC shall establish and require from staff members a high level of physical and electronic security for client confidential health information.

SCOPE

This Policy applies to all BPHC employees, contract employees, consultants, agents, business associates, and temporary employees (including interns and volunteers). For the purposes of this Policy, all such individuals shall hereafter collectively be referred to as "BPHC staff." All BPHC staff that has access to confidential health information must adhere to this Policy. This Policy may be revised from time to time as necessary to comply with applicable state and federal law or to implement BPHC policy.

DEFINITIONS

For the purposes of this Policy, the following words and phrases shall have the following meanings:

"Access" means the provision by BPHC to an individual of an opportunity to inspect or review confidential health information about that individual held by BPHC.

"Aggregate Data" means data collected from individual-level records that have been combined for statistical or analytical purposes and that are maintained in a form that does not permit the identification of individuals.

"**Authorization**" means a written voluntary agreement by client or legal representative, consenting to the use, or disclosure of confidential health information.

"Business Associate" means a person who:

on behalf of BPHC, but other than an employee of BPHC, performs, or assists in the performance of a function or activity involving the use or disclosure of confidential health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for BPHC, other than an employee of BPHC, where the provision of the service involves the disclosure of confidential health information from BPHC, to the person or organization in the Business Associate role.

"Client" means the individual about whom the data or health information relates.

"Confidential health Information" means any individually identifiable information, including, but not limited to, medical and demographic information, that:

Reveals the identity of the client or is readily identified with the client, such as, but not limited to, name, address, telephone number, social security number, health identification number, or date of birth; or provides a reasonable basis to believe that the

information could be used, either alone or in combination with other information, to identify a client; and includes any protected health information, as defined by this Policy.

"Confidentiality" means BPHC's obligation to protect the health information with which it has been entrusted.

"Contact" means to communicate or attempt to communicate with a client or the client's parent, guardian, or health care provider by any means, including, but not limited to, in-person, telephone, facsimile, letter, or electronic mail.

"Data Linkage" means a method of assembling data contained in two or more different files or records to relate significant health and other events for the same individual, organization, community, or other unit of analysis.

"De-Identified Data" means data or information that has been subject to methods for rendering information not individually identifiable, such as removal of personal identifiers including name, address, telephone number, social security number, health identification number, or date of birth.

"Disclose" means to transfer, disseminate, release, or otherwise communicate or divulge any confidential health information to any person or entity outside BPHC.

"Health Information" means any information, whether oral or recorded in any form or medium, that: is created or received by BPHC; and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.

"Individual-Level Data" means any data or information collected and maintained concerning a specific individual.

"Individually Identifiable Health Information" means information that is a subset of health information, including demographic information collected from an individual, and:

is created or received by BPHC; and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

"Institutional Review Board" means any board, committee, or other group formally designated by an institution, and approved by the federal Health and Human Services pursuant to 45 CFR Part 46 to review, approve, and periodically evaluate research projects to protect the rights of human research subjects.

"Personal Data" means any information concerning an individual who, because of name, identifying number, mark or description can be readily associated with a particular individual, provided that such information is not contained in a public record.

"Pledge of Confidentiality" means a written statement, dated and signed by an individual who is granted access to confidential health information, that certifies the individual's agreement to abide by the confidentiality restrictions stated in the written statement.

"Privacy" means the right of an individual to control the circulation of data or information about himself or herself, freedom from unreasonable interference in an

individual's private life, and an individual's right to protection against misuse or unjustified publication of his or her personal data or information.

"Protected Health Information" means individually identifiable health information that is: 1. transmitted by electronic media; 2. maintained in any medium described in the definition of electronic media in the Privacy Regulation, or 3. is transmitted or maintained in any other form or medium. Confidential Health Information includes Protected Health Information.

"Public Health Authority" means an agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors of persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

"Public Health Purpose" means a population-based activity or individual effort primarily aimed at: the reduction of morbidity or mortality; the prevention of injury, illness, disease, disability or premature mortality; the improvement of health outcomes; or the promotion of health in the community, including assessing the health needs and status of the community through public health reporting and surveillance, developing public health policy, and responding to public health needs and emergencies.

"Research" means a systematic investigation designed primarily to develop or contribute to general knowledge, including public health, medical, social, demographic, and historical research**.**

"Security" means the manner of assessing the threats and risks posed to confidential health information data and taking the appropriate steps to protect that data against unintended or unauthorized access, use, intrusion, disclosure or such other dangers as accidental loss or destruction.

"Use" means, with respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information by BPHC.

GENERAL PRIVACY POLICY

All BPHC staff shall comply with the following policy on use and disclosure of confidential health information.

A. COMPULSORY LEGAL PROCESS

1. Except for requests by the client or the legally authorized representative of the client, any BPHC staff that receives a request for access to confidential health information in BPHC's possession or receives a subpoena, discovery request, court order or any other form of compulsory legal process to provide such confidential health information shall immediately notify the Office of the General Counsel.
2. BPHC staff shall not disclose any confidential health information unless and until authorized to do so by the Office of the General Counsel.

B. LIMITING COLLECTION OF CONFIDENTIAL HEALTH INFORMATION

1. BPHC staff shall collect no more confidential health information than is necessary for the stated purpose.
2. BPHC staff shall collect confidential health information only when such collection is:
    a. authorized by law or regulation;
    b. or when confidential health information is deemed necessary to further a public health purpose.

C. LIMITING ACCESS TO CONFIDENTIAL HEALTH INFORMATION

1. Access shall be limited to the minimum number of individuals who are reasonably necessary to conduct the public health purpose.
2. BPHC staff shall limit access to confidential health information to only those staff that have a legitimate need to access the information in order to conduct the public health purpose.

D. LIMITING USE OF CONFIDENTIAL HEALTH INFORMATION

1. BPHC staff shall limit use of confidential health information to those purposes for which the information was collected or other public health purposes permitted by law which further the mission of BPHC.
2. Whenever identifiable information is not necessary to conduct the public health purpose, the confidential health information shall be de-identified.

E. LIMITING DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

1. BPHC staff shall limit disclosure of confidential health information to only authorized persons.
2. Authorized persons include:
    a. the client;
    b. any other person authorized by the client pursuant to a written authorization;
    c. BPHC staff that need access for a public health purpose related to public health surveillance or investigation;
    d. law enforcement officers or other persons pursuant to law or court order when approved by the Office of the General Counsel; or
    e. to any other person authorized by law to receive such information when approved by the Office of the General Counsel.
3. BPHC staff shall limit disclosure of confidential Health Information to the minimum necessary amount of confidential health information that is required to accomplish the intended purpose of the use or disclosure.

F. AGREEMENT TO MAINTAIN CONFIDENTIALITY

1. All BPHC staff shall strictly maintain the confidentiality of all individually identifiable health information held by BPHC.
2. No person having access to confidential health information shall disclose, in any manner, any confidential health information except as necessary for conducting a

legitimate public health purpose, as defined in this Policy, or when authorized by law.

3. All BPHC staff will receive education and training regarding the confidentiality and security principles addressed in this Policy and the specific procedures developed and implemented pursuant to this Policy.
4. In addition, all new employees, at the time of hire, and current BPHC staff shall sign a Pledge of Confidentiality for Employees. (Form A)
5. Independent contractors, volunteers, and interns who have access to client confidential information shall enter into a written agreement agreeing to abide by this Policy.
6. BPHC staff shall agree to maintain the confidentiality of client confidential health information even after termination of employment or other contractual obligations.
7. Each supervisor shall insure that all current BPHC Staff and new employees receive a copy this Policy.
8. Copies of signed confidentiality pledges shall be maintained by the Human Resource Department for all BPHC staff.
9. Independent Consultant and Contractors of BPHC that will have access to confidential health information must sign a Business Associate Agreement. (Form B)

G. OPENNESS

1. BPHC is committed to giving individuals notice about how it collects, uses, and discloses confidential health information.
2. BPHC's Notice of Privacy Practice will be available upon request by making a written request to the Privacy Officer, Boston Public Health Commission, 1010 Massachusetts Ave., Boston, MA 02118, or visiting BPHC web site at http://www.bphc.org. This Notice of Privacy Practice is subject to change by BPHC. (Form C)

H. INDIVIDUAL ACCESS

1. When BPHC collects confidential health information directly from the client, he/she shall be informed, if permitted by applicable law, of its existence, use, and disclosure, and the client shall be given access to the information.
2. Clients may request permission to access and/or copy confidential health information about themselves in the possession of BPHC in accordance with section VII. of this Policy.
3. BPHC staff shall take reasonable measures to verify the identity of the client prior to the disclosure of the information.
4. Any confidential health information about a person other than the client shall be redacted before disclosure of confidential health information to the client.
5. A Client shall be permitted to inquire about the accuracy and completeness of confidential health information held by BPHC and to have the confidential health information amended if appropriate as set forth in section VII of this Policy.

6. BPHC may refuse to disclose information if the disclosure, as determined in writing by a licensed health care provider or the Office of the General Counsel, could reasonably be expected to:
    a. result in immediate and grave harm to the individual's safety;
    b. the information contains references to other individuals;
    c. the disclosure could reasonably be expected to harm public health or safety; or
    d. Massachusetts or federal law prevents BPHC from disclosure of the information.
7. A client shall be permitted to request in writing to receive confidential communications from BPHC if the client states that routine methods of communication would endanger the client.
8. A client shall be permitted to receive an accounting of disclosures of his/her confidential health information unless the disclosure is related to treatment, payment, health care operation or pursuant to a valid authorization.

I. SECURITY

1. BPHC staff that have access to confidential health information shall ensure that such information is maintained in a secure manner which prevents unauthorized individuals from gaining access to such information.
2. Confidential health information maintained in an electronic format shall be stored on a password-protected and secure computer system.
3. Confidential health information shall not be left in plain view or otherwise accessible on a computer screen or in a work area when the authorized user is not present.
4. Confidential health information shall not be transmitted by email.
5. All confidential health information maintained in paper format shall be stored in locked file cabinets or other appropriate storage method which prevents unauthorized access as determined and approved by the Operations Department.
6. BPHC staff shall not attempt to exceed the scope of their authorized access to client confidential health information or attempt to circumvent any BPHC systems security measures designed to prohibit unauthorized access to client confidential health information.

J. DATA INTEGRITY

1. Every effort shall be made by BPHC staff to ensure the quality, accuracy, and reliability of the data and records under its control, whether contained in written, electronic, or other format.
2. BPHC staff will only collect confidential health information that is relevant to the purposes for which it is to be used, and will use reasonable efforts to ensure that such data is accurate, complete, and timely.
3. BPHC staff must ensure that confidential health information is protected from unauthorized modification and destruction.

4. BPHC staff shall strive to maintain the accuracy of the confidential health information held, including allowing individuals to have the opportunity to review and amend their confidential health information as set forth in section VII.

K. NON-COMPLIANCE

1. All BPHC staff is required to comply with this Policy. Any BPHC staff member who fails to comply with this Policy may be denied further access to confidential health information and may be subject to disciplinary action up to and including termination of employment.
2. BPHC staff shall immediately report to his/her supervisor any violations of this Policy.
3. BPHC staff members are protected from retaliation for reporting violations of this Policy by Massachusetts law (M.G.L. c. 149, §185).
4. BPHC may audit the use and disclosure of confidential health information by BPHC staff in order to ensure compliance with this Policy.

L. CONFIDENTIALITY PROCEDURES

1. Each BPHC Department/Program shall implement the specific procedures, guidelines and utilized the forms adopted with this Policy.
2. A BPHC Department/Program may adopt additional procedures, practices or forms which specifically address the operations of the Department/Program provided that the procedures, practices, or forms are consistent with this Policy and have been approved by the Office of the General Counsel.
3. BPHC staff shall comply with all procedures and practices adopted pursuant to this Policy.

M. RESEARCH STUDIES

1. Approval of Research Project Using Confidential Health Information
    a. BPHC staff that are conducting a research project which requires access to confidential health information held by BPHC shall consult with the Director of the Research Office to ensure that appropriate research protocols are followed.
    b. BPHC staff that are conducting a research study or other public health investigation which involves contact with clients shall consult the Director of the Research Office for approval of the contact protocol (e.g., consent, authorization forms, questionnaires, interview scripts).

2. Data Linkage
    a. If confidential health information is used for data linkage, the linked data set shall be stripped of personal identifiers and all identifiers shall be destroyed unless there is a legitimate public health purpose for retaining such identifiers.
    b. BPHC staff shall conduct data linkage projects in-house whenever possible and disclose only the linked data set without personal identifiers, other than a unique identification number, unless otherwise approved in writing by the Director of the Research Office.

3. Data Destruction for Research Purposes

a. As soon as reasonably practicable, BPHC staff shall de-identify confidential health information and destroy all identifiable information used for research purposes unless there is a legitimate public health purpose for retaining such identifiable information or retention of the information is required by law.

4. Publications and Reports

a. All reports and publications based on confidential health information shall contain only aggregate data and no personally identifiable information or information which could lead to the identification of an individual.
b. A client's personal identifiable health information shall not be published or disclosed by BPHC without proper written authorization from the client which specifically grants BPHC the authority to use her/his confidential health information for such reports and publications.
c. All aggregate data presented in such reports or publications shall comply with BPHC guidelines on cell size suppression as determined by the Director of the Research Office to ensure that individuals cannot be identified based on the data presented.
d. No maps based on confidential health information may be published or disclosed with sufficient detail so as to allow for identification of individuals.

PROCEDURE, PRACTICE & GUIDELINES

A. COLLECTING AND DISCLOSING CONFIDENTIAL HEALTH INFORMATION

1. Mail

a. BPHC staff shall take reasonable measures to ensure that confidential health information being submitted to BPHC by mail or courier service is properly addressed by the sender.
b. If any Department/Program receives mail with confidential health information which was intended for a different Department/Program, a staff member must bring the mail to the appropriate Department/Program or seal it in another envelope marked "Confidential" and send it via inter-office mail to the intended recipient or appropriate program.
c. All outgoing mail containing confidential health information must have a return address (with room number, where appropriate) and shall be stamped "Confidential." All reasonable efforts shall be made to ensure that the addressee information is complete and correct.
d. All confidential health information shall be sent in a sealed envelopes which complete conceals the content of the envelope.
e. Confidential health information should be sent by registered or certified mail or other delivery service that allows for tracking delivery and receipt of documents whenever feasible.

2. E-Mail or Other Electronic Transmission

Confidential health information shall not be transmitted by e-mail. Any other electronic transmission of confidential health information shall be in accordance with BPHC policies related to the electronic transmission of information.

3. Fax
    a. BPHC staff shall make reasonable efforts to ensure that all faxes containing confidential health information are sent to secure areas.
        i. Secure areas are those areas in which only individuals that have a need to know confidential health information have access
        ii. Contact the Operations department for guidance and/or question regarding a secure location for fax machines
    b. When sending a fax containing confidential health information, BPHC staff should call the intended recipient of confidential health information to confirm the correct fax number and ensure that the intended recipient is waiting for the transmission, or that measures are in place to ensure confidentiality of the confidential health information.
    c. A cover sheet that contains a confidentiality disclaimer must accompany all faxed documents containing confidential health information. The following language must be included in all fax coversheets used to fax confidential health information.

"These transmitted documents contain confidential information and are intended solely for use by the individual named above as the recipient. If you are not the intended recipient or such recipient's employee or agent, be aware that any disclosure, copying, distribution, or use of the contents of this transmission is prohibited. If you have received this transmission in error, please notify the sender by telephone immediately so that we may arrange to retrieve this transmission at no cost to you."

4. Hand Delivery
    a. All confidential health information must be kept under protective cover, in a sealed envelope or locked briefcase, when being transported or delivered by hand.
    b. Hand delivery shall be to the intended recipient or the intended recipient's authorized agent only.
    c. Government or BPHC issued photo identification is required for all in-person releases of confidential health information unless the identity of the recipient is known.
5. Telephone
    a. Confidential health information shall not be transmitted by telephone communication unless the intended recipient is known to the caller or the intended recipient's identity can be reasonably verified.
    b. The identity and authority of unknown persons requesting confidential health information must be verified before confidential health information is released by telephone.
    c. In the case of a health care provider, verification may be made by obtaining the caller's name and phone number and returning his/her call to confirm identity before such information is released.

d. Confidential health information containing personal identifiers (e.g., names, Social Security numbers, medical record numbers, etc.) shall not be left on any voice-mail system or with a receptionist.
e. Use of a cellular phone or public telephone to communicate confidential health information should be avoided to the greatest extent possible.
f. All telephone calls in which confidential health information is discussed must be made, to the greatest extent possible, in a secure area which limits the unauthorized disclosure of client confidential health information.
g. No confidential health information shall ever be sent via a pager.
h. Confidential health information shall not be discussed in public areas, such as, but not limited to, lobbies, elevators, and cafeterias.

B. USE OF CONFIDENTIAL HEALTH INFORMATION

1. Use Within the Department/Program
   a. A Department/Program that possesses confidential health information shall use that information only for:
      i. thespecific purpose(s) for which it was collected, which includes treatment, payment,, quality assurance;
      ii. BPHC approved research as set forth in section V of this Policy,
      iii. when required by law or
      iv. as authorized by the client.
      v. access to confidential health information shall be limited to only those persons within the Department/Program that have a “need-to-know”.
2. Use Within BPHC
   a. confidential health information held by one Department/Program shall not be shared with any other Department/Program unless authorized by the Privacy Officer, required by law when approved by the Office of the General Counsel, or authorized by the client.
3. Access Rights
   a. Every BPHC staff member, including interns, volunteers and temporary employees who will be granted access to confidential health information, must sign a Pledge of Confidentiality for Employees, Contract Employees and Interns. (Form A)
   b. Independent Contractors and agents of BPHC that will have access to confidential health information must sign a Business Associate Agreement with BPHC **prior** to receiving access to confidential health information.
   c. each Department/Program shall identify in writing a list of those staff members within the Department/Program by name or job description and shall determine the level of access to confidential health information that each BPHC staff member shall have to perform his/her duties.
      i. The list must be updated as necessary to keep it current and a copy of the list shall be given to BPHC’s Privacy Officer.

ii. The list shall contain the level of access each employee has to paper files, databases, and secure areas where confidential health information is kept.

iii. A copy of this list shall be provided to the Director of Information Services and Manager of IT Users to ensure coordinate authorized access control to electronic databases.

d. Temporary employees, interns, and volunteers shall not be granted access to confidential health information, unless first authorized by the supervisor in charge of such individuals of written approval by the Department /Program Director.

C. DESIGNATED RECORD SET, STORAGE, MAINTENANCE AND DESTRUCTION OF CONFIDENTIAL HEALTH INFORMATION

1. Designated Records Set . Pursuant to this Policy, a client's right to request access, an amendment, place restriction on access and/or request copies of his/her personal health information is limited to that health information that is maintained in Designated Record Sets, as determined by each Program.

a. Evaluation of Documentation

i. Each Program/Department must evaluate client files and determine which documents contain individually identifiable confidential health information about the client. A written policy must be developed and implemented at the program level to evaluate the documentation maintained by each program to determine those groups of confidential health records that should be categorized as Designated Record Sets.

ii. The written policy should ensure that the following information is gathered about the evaluated records:

1. Documentation type (e.g., paper medical record, Sophia database)
2. Basic content (e.g., assessments, reports,, examinations)
3. Location of the documentation (e.g., School Based Health Clinic)
4. Contact person (e.g., caseworker)

b. Documentation of Designated Record Sets

i. Documentation must be maintained that supports the Programs' assessment of its records which were reviewed in making the determination of its Designated Record Sets. Documentation may be maintained electronically or on paper.

ii. Selected records which are determined to constitute the Designated Record Set shall be separate from other client information. The Designated Record Set must be kept current and available for reference should a client request access to his/her health information, including comments that identify any information included in a Designated Record Set that the client would not have a right of access, amendment, or copies.

iii. Records contained in the Designated Record Set must be maintained for a period of at least six years.

c. Inclusions Confidential health information in all types of media (e.g., paper, oral, video, electronic, film, digital) must be considered when determining what documents shall be included in the Designated Record Set. Minimally, the following categories of records should be considered Designated Record Sets:

i. Eligibility information maintained by health plans;

ii. Enrollment records maintained by health plans;

iii. Claims records submitted to or received from health plans;

iv. Remittance Advices and records of payments;

v. Client Statements related to health condition;

vi. Claims adjudication records;

vii. Case or medical management records maintained by health plans; and

viii. Other records used by BPHC to make health related decisions about individuals.

ix. Records created and/or maintained by a Business Associate for services rendered to a BPHC program must be considered when evaluating documentation for Designated Record Sets.

x. Confidential health information specifically created and/or maintained by Business Associates, when acting on behalf of a BPHC Program, is subject to the client rights provisions as set forth in section VII. to request access to or amendment of such information in accordance with the Business Associate Agreement.

d. Exclusions Confidential health information that will not be used to make decisions about treatment of a client should not be included in a Designated Record Set. Such information may be found in many types of records that include significant information not relevant to the client, as well as information about other persons.

2. Method of Storage for Paper Copies

a. All confidential health information shall be stored in locked areas that do not allow public access, including but not limited to, secured file cabinets.

b. When the Operations Department deems it feasible, a security measure including but not limited to pass code should be installed in areas where confidential health information is kept.

c. Operations shall document all security measures used by BPHC Programs/Department, their locations and who has access and/or who has authority to grant access to such secure area.

d. To protect confidential health information, BPHC staff shall not leave confidential health information on a desk or work area when he/she is away from the desk/office, unless the area is secured from unauthorized access. (e.g., locked door).

e. BPHC staff shall not take confidential health information from a assigned secured area unless it is required for a field visit, meeting, or when otherwise necessary for work r elated purposes.

3. Storage for Electronic Copies of Confidential Health Information
    a. Confidential health information stored in a computer system shall be stored in a secure manner.
    b. Access rights to stored confidential health information shall be limited to individuals who need the information to perform their job and are limited to only that information necessary to perform their job.
    c. No BPHC staff member shall share her/his passwords with anyone other than Department/Program directors, or the Director of the IT department.
    d. The IT, IS and Operations department must be immediately notified when BPHC staff are transferred, resign or are terminated. Transferees may need different access rights at their new job.
        i. Upon termination, or resignation of a BPHC staff member's employment with BPHC, all access rights shall be promptly removed, especially if they have dial-in access.
        ii. Program/Department management, Human Resources, Operations and IT Services staff shall coordinate the date and time of the termination of the staff member's employment so that computer network access and other access to confidential health information are terminated in a timely manner.
    e. To prevent BPHC staff from inadvertently displaying confidential health information when away from their workstation, computers providing access to confidential health information shall have screen saver or a desktop log-off that is automatically activated.
    f. If confidential health information is on a stand-alone computer and not on the network, then the stand-alone computer must be in a secured area and the confidential health information must be password protected.
4. <u>Maintenance</u>
    a. Policies and procedures adopted in this Policy and program policies created in accordance with this Policy to protect Confidential health information which is collected, used, and stored by the program shall be enforced within each Program/Department by a data custodian appointed by the Department/Program Director and approved by the Privacy Officer.
    b. Such data custodian shall implement this Policy and other reasonable measures which are in accordance with this Policy to protect the integrity of the information.
5. <u>Destruction</u>
    a. Confidential health information that is no longer needed should be destroyed whenever possible, or archived, consistent with BPHC's record retention policies whichever is later. The Director of Operations shall provide each Department/Program Director with a copy of BPHC's record retention policy.

b. Upon written approval by Operations and the Privacy Officer, each program should have access to a shredder to use for disposal of all records with personal identifiers.
c. Any materials containing confidential health information that is not required to be retained (See BPHC Retention Policy) must be shredded as soon as they are no longer needed.
d. Confidential health information stored on electronic media (e.g., disk, CD, etc.) shall be completely erased or destroyed before disposal of the electronic media.

D. PROCEDURES FOR RELEASE/DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION

1. When Confidential Health Information May Be Disclosed
    a. Confidential health information may not be disclosed to non-staff members, agents or business associates of BPHC without the written authorization of the client, except for the following purposes:
        i. The disclosure is authorized by law or regulation and the Office of the General Counsel has approved such disclosure.
        ii. The disclosure is required by judicial order or other legal process, and the disclosure is approved by the Office of the General Counsel. A subpoena does not mean automatic release of confidential health information. When BPHC staff person receives a subpoena potentially related to the release of confidential health information, he or she must immediately notify his/her supervisor and the Office of the General Counsel.
        iii. The disclosure is authorized by BPHC for research which has been approved in writing by the Director of the Research Office /or a member of the Executive Administration department. A Pledge of Confidentiality must be signed and returned to BPHC by all researchers who will have access to the data before confidential health information is disclosed.
        iv. The disclosure is required for coordination of benefits or for treatment, payment or health care operations consistent with the requirements of HIPAA.
2. To Whom Confidential Health Information May Be Disclosed
    a. Confidential health information may be disclosed under the circumstances listed above to the appropriate individual authorized to receive the information for the specified purpose.
    b. Each Department/Program must develop and maintain a list which specifies to whom it releases confidential health information on a routine basis and a specific contact person to whom information is disseminated. The list should be updated as necessary and a copy of this list shall be given to BPHC's Privacy Officer.
3. Accounting of Disclosures

a. Each Department/Program must maintain a log of disclosures of confidential health information with relevant information including, at a minimum:
    i. the date of the disclosure;
    ii. to whom, by whom, and the information provided;
    iii. A brief description of the information disclose; and
    iv. Purpose or basis for disclosure.
b. These logs must be maintained in a secure manner and retained for a period no less than six years or in accordance with BPHC retention policy whichever is later.

4. Disclosure Procedures
    a. Requests for disclosure of confidential health information should be in writing unless necessary for the urgent care of an individual which makes a written request unfeasible.
    b. Each Department/Program should utilize the authorization form issued pursuant to this Policy (Form I) to document all requests for disclosure of confidential health information.
    c. Disclosure of confidential health information should be by mail or in-person delivery, whenever feasible. Disclosure shall not be made by telephone unless necessary for the urgent care of an individual.
5. Verification of Authorized. Recipient Reasonable measures must be taken to verify the identity of the client or the individual authorized by the client to receive confidential health information.
    a. When the request is made by a client, the client must present government issued photo identification before disclosing confidential health information.
    b. When the request for disclosure is made by a representative/agent of the client, no disclosure shall be made without a written authorization which specifies to whom the confidential information can be disclosed and what information shall be disclosed along with government issued photo identification.

CLIENT RIGHTS AND THE COMPLAINT PROCESS

A. CLIENT RIGHTS

1. This Policy, in accordance with the HIPAA Privacy Rule, requires that BPHC staff providing direct and indirect health care shall provide the client, upon first contact, with a copy of BPHC's Notice of Privacy, (Form C) and/or inform the Client where the Notice of Privacy is located in the facility
    a. After providing the client with a copy of BPHC's Notice of Privacy, BPHC staff shall obtain the client's written acknowledgement of receipt or opportunity to receive BPHC's Notice of Privacy Practice using the coversheet of Form D of this Policy.
    b. The executed Notice of Privacy Practices Acknowledgment Form shall be placed in the client's designated health records for a period of no less than

six years or in accordance with BPHC's retention policy, whichever is later.

2. BPHC staff shall provide clients upon written request, reasonable access to designated records sets containing confidential health information about the client, to request an amendment to the designated record set and an accounting of the disclosure or his/her confidential health information not related to treatment, payment, health operations, or pursuant to a client's authorization.
3. BPHC staff shall provide a client, upon request, the proper Form as set forth in Section IX of this policy, to request access, to request an amendment, to request a limitation to the disclosure or an accounting of disclosure of disclosure of his/her confidential health information.
4. All privacy request for access, request to amend, request to restrict disclosure and/or request for an accounting of disclosures must be documented and given the staff member's immediate supervisor.
5. BPHC shall not amend, at a client's request, any information in a record that the Program/Department knows to be true and accurate.
6. The supervisor shall forward the client's request(s) for amending, placing restrictions and an accounting of disclosure of their confidential health information to the Privacy Officer and/or his/her designee(s) within the Department.
7. The Privacy Officer shall ensure that all client requests related to this Policy are recorded accurately, and are retained for a period of at least six years from either the date of creation or the date when it was last in effect, whichever is later.
8. The Privacy Officer shall consult with a license health care provider and/or the Office of the General Counsel when necessary to determine whether to grant or deny the client's rights as set forth in Article VII, Section A2 of this Policy.

B. COMPLAINT PROCEDURE

1. When a BPHC staff member receives a complaint from a client and/ or wishes to file a complaint regarding a violation of this Policy, the staff member shall report the complaint immediately to his/her supervisor who shall report the alleged violation to the Privacy Officer or his/her designee within the Department.
2. The Privacy Officer and/or his/her designees shall respond immediately to privacy complaints that are general in nature and do not require additional research or privacy expertise.
3. The Privacy Officer shall document all the facts provided by an individual and the resolution, if any, in their information referral system.
4. The Privacy Officer shall forward all privacy complaints that require additional research to the Office of the General Counsel for resolution.
5. The documentation of all privacy complaints and the resolutions of such complaint shall be maintained by the Privacy Officer for a period of at least six years from either the date of creation or the date when it was last in effect,

whichever is later, and shall contain no individually identifiable health information other than that provided by the individual.

6. The Privacy Officer shall provide reports about privacy complaints to the Director of Administration each quarter and as requested by the Director of Administration.
7. Such report information will be used for evaluation and process and/or procedure enhancement, as appropriate.

C. IMPLEMENTATION

The Privacy Officer shall use designated a staff member within each Department that create, use or disclose protected health information to document the receipt and disposition of all written request for access, amendments to his/her designated record set and complaints alleging a violation of this Policy

CONTACT INFORMATION

Any questions concerning this Policy and/or Procedures should be directed to the Office of the General Counsel, in writing at:

Boston Public Health Commission
Office of the General Counsel
1010 Massachusetts Ave., 6th Fl.
Boston, MA 02118

Sexual Harassment

Supersedes: 07-98
Effective: 06-2008

I. PURPOSE

The Boston Public Health Commission ("BPHC") affirms its commitment to maintain an environment free of sexual harassment and free of retaliation based on an employee, client or visitor having complained of or opposed sexual harassment, or cooperated or assisted with an investigation into sexual harassment allegations. In order to achieve this goal, any form of sexual harassment, including the conduct that is described in this policy, will not be tolerated and procedures are provided according to which inappropriate conduct will be addressed.

II. POLICY

BPHC expects all employees to conduct themselves in a professional manner with respect and concern for their fellow employees as well as BPHC clients and visitors. Sexual harassment is unlawful and will not be tolerated. Retaliation against anyone who has complained of or opposed sexual harassment at BPHC or who has cooperated or assisted with an investigation into such, is unlawful and likewise will not be tolerated.

III. PROCEDURE

A. GENERAL

1. It is BPHC's policy that all employees, clients and visitors have a right to work or be in an environment free from any type of discrimination, including freedom from sexual harassment regardless of sexual orientation, gender or gender identity or expression.

2. The BPHC shall post notice of the Fair Employment Law pursuant to M.G.L. c.151B §7. The BPHC is committed to adhering to applicable federal and state laws regarding sexual harassment. The BPHC will investigate and resolve complaints arising out of activity or behavior considered to be sexual harassment.

3. The BPHC prohibits sexual harassment of employees, clients and visitors in any form. Such conduct may result in disciplinary action against employees up to and including termination. Clients and visitors engaging in prohibited conduct may be barred from BPHC property. Any incident may be referred for legal action or any other appropriate measure to assure such activity does not recur.

B. DEFINITIONS

1. Sexual harassment: sexual advances, requests for sexual favors, and verbal or physical conduct of a sexual nature when:

a. submission to or rejection of such advances, requests or conduct is made either explicitly or implicitly a term or condition of employment or as a basis for employment decisions, or term or condition for receiving BPHC services; or

b. such advances, requests or conduct are unwelcome and create an intimidating, hostile, humiliating or sexually offensive work or clinical environment.

2. Workplace: Any place that a BPHC on-duty employee may be found.

3. Client: Anyone for whom the BPHC renders services. This includes, but is not limited to, anyone requesting or receiving emergency medical services, tenants of BPHC owned/operated property and homeless shelter residents.

4. Visitor: Any non-employee authorized to be on BPHC premises. This includes, but is not limited to, vendors, contractors and members of the public attending meetings.

C. PROHIBITED BEHAVIOR

1. No supervisor or employee shall threaten or insinuate, either explicitly or implicitly, that an employee, client or visitor's refusal to submit to sexual advances will adversely affect the employee, client or visitor's employment, performance reviews, advancement, assigned duties, shifts, or any other condition of employment, career development, program participation or service of delivery.

2. No supervisor, employee, client or visitor shall engage in any conduct of a sexual nature, whether intended or not, that is unwelcome and has the effect of creating a workplace environment that is hostile, offensive, intimidating or humiliating to male or female workers since such conduct may also constitute sexual harassment. While it is not possible for the BPHC to list all circumstances that may constitute sexual harassment, the following are some examples of conduct, which if unwelcome, may constitute sexual harassment depending upon the totality of the circumstances including the severity of the conduct and its pervasiveness:

a. Sexual assault and coerced sexual acts;

b. Unwelcome sexual advances, whether they involve physical touching or not;
c. Unwelcome leering, whistling, brushing against the body, sexual gestures, suggestive or insulting comments, sexual flirtations or propositions;
d. Written or oral references to sexual conduct or gossip regarding one's sex life;
e. Sexual slurs, sexual epithets, or sexually degrading descriptions;
f. Unwelcome graphic comments about an individual's body or overly personal conversations of a sexual nature;
g. Unwelcome sexual jokes, stories, drawings, pictures, videos, video games, e-mails or gestures;
h. Spreading of sexual rumors;
i. Unwelcome touching of an individual's body, clothing or objects in a sexual way;
j. Discussion of an individuals (including one's own) sexual activities and/or interests;
k. Inquiries into an employees sexual experiences or preferences;
l. Cornering, blocking normal movements in a sexual manner, and/or
m. Displaying sexually suggestive objects in the workplace.

3. No employee shall make any sexual advances or accept any sexual advances from a client or a client's family. No employee shall threaten either implicitly or explicitly that a client's refusal, client's family member's refusal or a visitor's refusal to submit to sexual advances will adversely affect the client's status or eligibility for programs or service provided by BPHC.

4. Retaliation against an individual who has complained about sexual harassment and retaliation or against individuals for cooperating with an investigation of a sexual harassment complaint is unlawful and will not be tolerated.

D. RAISING COMPLAINTS OF SEXUAL HARASSMENT OR RETALIATION

1. An employee, client or visitor who believes he or she has been the subject of any form of sexual harassment or retaliation is strongly encouraged to speak with the individuals identified in Section D(3) below.

2. All complaints of sexual harassment and retaliation will be treated with confidentiality to the extent possible consistent with the BPHC's need to investigate complaints and ensure the safety and well-being of the complainant and other employees. Complaints of sexual harassment and retaliation shall not result in reprisal or retaliation in any form to the complaining party or to the reporting party.

3. Any complaint by a person subject to sexual harassment or retaliation should be presented as soon as possible. Please be advised that there are time limits for filing

complaints with outside agencies (see Section D(5) below). Complaints may be submitted to the complainant's supervisor, anyone else within the chain of command of the complainant's supervisor or any one of the following individuals:

The Executive Director
1010 Massachusetts Ave., 6th floor
Boston MA 02118
617-534-5264

The Director of Human Resources
1010 Massachusetts Ave., 6th floor
Boston MA 02118
617-534-5657

The Director of Labor Relations
1010 Massachusetts Ave., 6th floor
Boston MA 02118
617-534-2449

The Human Resources Administrator for Homeless Services
Long Island Campus, Tobin Bldg.
PO Box 158
Boston MA 02122
617-534-2526

Chief of Emergency Medical Services
Boston EMS
785 Albany Street
Boston MA, 02118
617-343-2367

In the event that the complaint of sexual harassment or retaliation involves any one of the above listed persons, the complaint may be submitted to:

The General Counsel
1010 Massachusetts Ave., 6th floor
Boston MA 02118
617-534-4322

In the event that the persons listed above are not on duty, the complainant may contact the BPHC's Manager On-Call, who is on duty nights and weekends, at pager number (781) 669-5672.

4. In the event of a complaint of sexual harassment or retaliation against a visitor involving a vendor or contractor, the BPHC will take action directly with the manager of the vendor or contractor in a timely fashion.

5. Any complaint of sexual harassment or retaliation may also be filed with the external agencies listed below. The use of the BPHC's complaint process does not preclude an employee from filing a complaint with these external agencies, nor does it toll the statute of limitations for filing with them. The statute of limitations for filing a complaint with the Massachusetts Commission Against Discrimination or the United States Equal Employment Opportunity Commission is 300 days from the date of the incident.

Director of Affirmative Action
City of Boston Office of Personnel Management
Boston City Hall
One City Hall Plaza
Boston, MA 02201
(617) 635-2788

The Massachusetts Commission Against Discrimination ("MCAD")
One Ashburton Place
Boston MA, 02108
617-994-6000

The U.S. Equal Employment Opportunity Commission ("EEOC")
One Congress Street
Boston MA, 02114
617-565-3200

E. RESPONSIBILITY AND PROCEDURE FOR INVESTIGATION

1. Any complaint of sexual harassment or retaliation is to be taken seriously and treated with sensitivity and discretion.

2. All employees other than "Reporting Employees" (as defined in section E(3) below) who observe, become aware of or receive a complaint or report of sexual harassment or retaliation are strongly encouraged to notify orally or submit a written report to their supervisor or any of the individuals identified in Section D(3) above promptly.

3. Certain employees, referred to here as "Reporting Employees," have special reporting duties, as described in Section E(4) below. Reporting Employees include all employees acting in a supervisory capacity (i.e. employees with authority to direct various aspects of employment of one or more employees such as hiring, firing, discipline, attendance, scheduling, work assignments, evaluation, promotion or transfer) and all managers, directors and all employees to whom a complaint of sexual harassment or retaliation can be made pursuant to Section C(3) above.

4. Any Reporting Employee who personally becomes aware of or is otherwise notified of conduct which may amount to sexual harassment or retaliation shall personally make a written report describing such conduct and shall submit the report to the Director of

Human Resources. Reporting Employees must report any personal awareness of possible sexual harassment or retaliation as well as any complaints or reports of the same they receive in any form and from any source, including internal complaints or reports made under this Policy, union grievances, and complaints filed with outside agencies. Reporting Employees shall attach to their reports any written complaints submitted by the complaintant or others and shall submit their reports and attachments to the Director of Human Resources before leaving the place of employment on the day of receiving such information, or as soon as practicable, except as provided in Section E(5) below.

5. In the event that the Director of Human Resources is not on duty and it is after business hours, the Reporting Employee shall contact the BPHC's Manager On-Call and shall submit such report in a sealed envelope addressed to the Director of Human Resources. The Manager On-Call shall deliver the envelope to the Director of Human Resources or his/her designee by the end of the following regular business day.

6. Upon receipt of a complaint or report of sexual harassment or retaliation, the Director of Human Resources shall inform the complainant of the existence of this policy, provide a copy of the policy if needed and direct the complainant as to how to file an internal complaint.

7. The BPHC's Director of Human Resources or his/her designee will investigate all complaints of sexual harassment or retaliation in a timely and impartial manner. Investigation into any such complaints or reports shall be completed within a reasonable time frame of up to 90 days, unless there is good cause requiring additional time.

8. The General Counsel's Office shall be advised of all investigations under this policy and shall provide assistance when necessary.

9. All investigations shall be conducted in such a way as to maintain confidentiality to the extent possible consistent with the need to conduct an investigation and ensure the safety and well-being of the complainant and other employees.

10. While the extent and nature of any investigation will depend upon the circumstances of the complaint, all investigations, to the extent possible, will include the following:

a. A separate interview with the person filing the complaint;
b. A separate interview and written statement of each witness and person with knowledge relevant to the complaint;
c. A separate interview with the person alleged to have committed the sexual harassment or retaliation. The person will also be allowed to submit a written statement; and

d. A review of any material documents identified by the complainant and the person alleged to have committed the sexual harassment or retaliation.

11. All employees are responsible for cooperating with an investigation into complaints of sexual harassment or retaliation. Any employee who fails to fully cooperate or hinders the investigation may be disciplined.

12. At the conclusion of the investigation, the Director of Human Resources or his/her designee shall prepare a written report of the investigation that shall include findings of fact and an opinion as to whether there has been any violation of BPHC policy. A copy of the complaint, along with all written statements of any witnesses and the person alleged to have committed the sexual harassment or retaliation shall be attached to the report.

13. A copy of the report shall be submitted to the Executive Director and the General Counsel. The Director of Human Resources shall maintain all complaints and reports of sexual harassment or retaliation. The Director of Human Resources shall notify the appropriate program or bureau director of the results of the investigation.

F. DISCIPLINARY ACTION

If it is determined that sexual harassment or retaliation has occurred and a violation of this policy has occurred, the BPHC will take such corrective action reasonably calculated to end such conduct and protect the complainant. Such action may range from counseling to termination from employment and may include such other forms of disciplinary action as the BPHC deems appropriate under the circumstances. If it is determined that a client, visitor, vendor, or contractor has violated this policy, appropriate steps will be taken to rectify or prevent the circumstances from recurring.

G. FALSE COMPLAINTS

Complainants who intentionally or knowingly file a false complaint or any other person providing false information during an investigation conducted in accordance with BPHC policy will be subject to corrective action up to and including termination of employment.

Ref: BPHC Policy #104

Substance Abuse Policy

Supersedes: 03-24-08
Effective: 06-16-08

I. INTRODUCTION

Boston Emergency Medical Services ("the Department") is a public health and public safety service that provides and manages the pre-hospital care system for the City of Boston. As part of their regular duties, Emergency Medical Technicians ("EMTs") at Boston EMS receive, process, and respond to calls for emergency medical care, operate departmental ambulances and other departmental vehicles, and provide emergency medical care to patients, including life-saving treatment when necessary. Illegal drug use and abuse of alcohol by employees pose a threat to patients, Boston EMS employees, and the general public. This policy is intended to detect and prevent any illegal drug use and abuse of alcohol by EMTs at Boston EMS and to assist in the rehabilitation of employees when possible. Treatment and discipline are both important aspects of this policy. The following policy and procedures provide the Department with reasonable measures to ensure that illegal drug use and abuse of alcohol do not jeopardize the public and Boston EMS employees or interfere with the delivery of emergency medical services.

It is the general intent of the policy to create a humanitarian program which includes the following principles:

1) emphasis on treatment and counseling rather than just discipline in many cases;

2) use of drug and alcohol testing procedures in great part to overcome the user's denial that a problem exists, to protect the public, and to provide help and treatment as appropriate; and

3) require all uniform personnel to attend comprehensive awareness and training programs.

The testing components of the program will not be instituted until this policy has been in effect for 90 days. Prior to the implementation of this policy, all employees will receive up to three hours educational training in the effect of drugs and alcohol in general as well as in the workplace. The training shall also include a review of this policy. All such training will occur on Department time.

The Commission reserves the right to modify, amend, rescind, and replace this policy and the procedures set forth herein, provided that the Commission will give the Union notice and an opportunity to bargain about such changes.

II. DEFINITIONS

A) Controlled Substances – any drug included in Schedules I through V, as defined by Section 802(6) of Title 21 of the United States Code (21 USC 802(6)), the possession of which is unlawful under Chapter 13 of that title, or any drug included within the definition of "Controlled substance" in Chapter 94C of the Massachusetts General Laws (for example, but not limited to: cocaine, marijuana, valium, morphine, anabolic steroids). The term does not include the use of prescribed drugs which have been legally obtained and are being used for the purpose for which they were prescribed.

B) Illegally-Used Drug – any prescribed drug which is legally obtainable but has not been legally obtained or is not being used for prescribed purposes, all designer drugs not listed in the Controlled Substances Act (for example, but not limited to: MDA, fentanyl), and any other over-the-counter or non-drug substances (for example, but not limited to: airplane glue) being used for other than their intended purpose.

C) Alcohol – colorless, volatile and flammable liquid that is the intoxicating agent in fermented and distilled liquors. It includes, but is not limited to, beer, wine and liquor. It does not include alcohol used in chemical processing, cleaning or testing.

D) Department Property – includes buildings, offices, facilities, equipment, vehicles, land, and parking lots owned, loaned, utilized or leased by the Department. It also includes any other site at which business of the Department is transacted whether on or away from Department owned, loaned, or leased property.

E) Accident – an unplanned, unexpected and unintended event, including but not limited to a motor vehicle accident involving a departmental vehicle or ambulance, which a) occurs on Department property, on Department business, or during working hours, and b) initially appears to have been caused wholly or partially by an EMT, and c) results in either i) a fatality; ii. bodily injury requiring medical treatment away from the scene of the event, or iii) damage to property in excess of $2,500.

F) Drug Paraphernalia - any item which is clearly intended for use for the administering, transferring, manufacturing, testing or storing of a controlled substance.

G) Reasonable Suspicion of Drug and/or Alcohol Use - the reasonable suspicion standard for drug testing of uniformed personnel is based upon a specific

objective fact(s) and reasonable inferences drawn from that fact(s) in light of experience that the individual may be involved in the use of any illegally-used drug, controlled substance, or alcohol. Examples would include one or more of the following:

1. Observable phenomena, such as direct observation of on-duty alcohol use or possession and/or direct observation of on-duty or off-duty use or possession of illicit drugs, and/or the on-duty display of behaviors which appear to be indicative of the use of any illegally-used drug, controlled substance, or alcohol and are not attributable to other factors;

2. a pattern of abnormal conduct, erratic behavior or deteriorating work performance, including but not limited to, frequent absenteeism, excessive tardiness, or frequent accidents, not attributable to other factors and which appears to be related to drug and/or alcohol abuse;

3. arrest, indictment, or conviction for a drug-related offense;

4. newly discovered evidence that the EMT has tampered with a prior drug/alcohol test;

5. repeated or flagrant violations of the Department's rules and procedures which are determined by a supervisor to pose a substantial risk of injury or property damage and which are not attributable to other factors and appear to be related to drug and/or alcohol abuse;

The above examples are not all inclusive, but are intended to be illustrative. The symptoms of being affected by a drug or by alcohol are not confined to those consistent with misbehavior or to obvious impairment of physical or mental ability, such as slurred speech or difficulty in maintaining balance. Although reasonable suspicion does not require certainty, mere “hunches” are not sufficient to meet this standard. Any member ordered to undergo reasonable suspicion drug and alcohol testing under this policy may request to consult with a union representative before submitting to the test, but the inability to secure a union representative shall not delay the collection of specimens from the employee or administration of the tests.

H) Under the Influence of an Unauthorized Controlled Substance. Illegally-used Drug and/or Alcohol - The presence of a .04 alcohol content in the blood, or a verified positive drug test, at levels specified by the National Institute of Drug Abuse (NIDA), for an unauthorized controlled substance or an illegally-used drug.

I) Medical Review Officer (MRO) – A licensed physician responsible for receiving laboratory drug testing results who has knowledge of substance abuse disorders and has appropriate medical training to interpret and evaluate a positive test relative to the employees medical history and other relevant biomedical information.

J. Emergency Medical Technicians or "EMT" - For the purposes of this policy shall mean all Emergency Medical Technicians at the Department, including but not limited to employees in the titles of Emergency Medical Technician, Emergency Medical Technician Intermediate, Emergency Medical Technician Recruit, Emergency Medical Technician Paramedic, Senior Emergency Medical Technician, Principal Emergency Medical Technician, Emergency Medical Technician Training Supervisor, and any other uniformed personnel covered by this policy.

K) Supervisor – A uniformed member of the Department ranked at any operational level above the entry level position of emergency medical technician, except that employees in the title of Emergency Medical Technician-Paramedic shall not be considered supervisors for the purposes of this policy.

III. AUTHORIZED USE OF PRESCRIPTION MEDICINE; EXPOSURE TO ILLEGAL DRUGS

EMTs undergoing prescribed medical treatment with any drug that may affect their ability to perform their duties as an EMT must report the drug used to the licensed physician designated by the Department. EMTs exposed to illegal drugs during their work shall report and disclose their exposure to a licensed physician designated by the Department so that a determination can be made as to the EMT's ability to perform his/her duties.

IV. PROHIBITED CONDUCT

The following conduct by uniformed personnel is prohibited:

A) Unauthorized use, possession, manufacture, distribution, dispensation or sale of a controlled substance, illegally-used drug, drug paraphernalia, or alcohol on Department property, on Department business, in Department supplied vehicles, in vehicles being used for Department purposes, or during work hours;

B) Unauthorized storage in a desk, locker, automobile or other repository on Department property of any illegally-used drug, controlled substances, drug paraphernalia, or alcohol;

C) Being under the influence of an unauthorized controlled substance, illegally-used drug or alcohol on Department property, on Department business, in Department supplied vehicles or vehicles being used for Department business or during working hours;

D) Possession, use, manufacture, distribution, dispensation or sale of illegally-used drug or controlled substances while off duty;

E) Switching or adulterating any sample for testing;

F) Refusing consent to testing or refusing to submit a breath, urine, hair, or blood sample for testing (except as regards “Condition of Promotion” testing);

G) Failing to adhere to the terms of any Rehabilitation Agreement (sample attached) which the EMT has signed;

H) Conviction under any drug or alcohol statute;

I) Failure to immediately notify the Department of any arrest or conviction under the drug or alcohol statute;

J) Failure to notify the licensed physician designated by the Department of the use of a prescription drug that affects the EMT’s ability to perform his/her duties as an EMT;

K) Refusing to sign a) a receipt for the Department’s Substance Abuse Policy, b) the Consent and Release Form, c) the Chain of Custody Form, or d) a Rehabilitation Agreement.

V. TESTING

Uniformed personnel of the Department will be tested for drugs and/or alcohol under the following circumstances:

A) Reasonable Suspicion of Drug and/or Alcohol Use: Uniformed personnel will be tested for drugs and/or alcohol when a supervisor who has been trained in making determinations of reasonable suspicion has made such a determination. Referrals for reasonable suspicion testing will be made using the procedure set forth in Appendix A of these procedures. Where reasonable suspicion exists to test for alcohol, the EMT shall be given the option of submitting to either a breath screen test or a blood alcohol test. All breath screen tests shall be administered by a certified collection site facility utilizing DOT approved equipment and DOT procedures. All blood alcohol tests shall be administered by a certified collection site facility following procedures with reasonable identification and chain-of-custody safeguards.

B) Follow-up Testing – EMTs referred by the Department to treatment will be subject to unannounced testing for a period of five (5) years following a return to full duties.

C) Pre-Employment Testing – All applicants for the position of EMT will be required to submit to a drug test. All applicants for the position of EMT will be advised in

connection with their application for employment that, prior to being offered a position, they will be required to submit to a drug screen. Failure to consent to such a test, or a verified positive result, will disqualify the applicant for employment as an EMT.

D) Probation Period Testing – All probationary personnel are subject to drug testing during their post-hire probation period without prior warning and at random intervals.

E) Condition of Promotion/Rating/Appointment Testing – EMTs who are offered a promotion/appointment to the positions of Senior EMT, Principal EMT, Paramedic, or EMT Training Supervisor will be required to submit to a drug test, provided the employee did not receive his/her annual drug test as required by subsection F within sixty (60) days prior to the offer. A negative test result shall be a condition of such promotion/appointment. Such EMTs may refuse to submit to such a drug test without penalty or risk of disciplinary procedures, however such refusal shall be considered a declination of the offer of promotion/appointment.

F) Annual Drug Testing (Hair) - In a joint desire to achieve and maintain a work force that is 100% drug free, the parties agree that all EMTs shall be subject to an annual drug test to be conducted through a hair analysis testing system in accordance with this policy. Each EMT shall submit to an annual test on or within thirty (30) calendar days of each EMTs birthday as directed by the Department. The Department will send employees written notice within thirty (30) days of the start of their annual testing period under this paragraph to remind them of the provisions of this paragraph. A general notice to all employees shall be sufficient. Failure to provide the written notice described in this paragraph shall not excuse an employee from submitting to the annual drug test as directed or prevent the Department from enforcing the provisions of this policy in the event of a positive test result.

G) Post-Accident. The operator of a departmental vehicle/ambulance involved in an accident as defined in Section II(E) of this policy will be subject to drug and alcohol testing. The collection of specimens for testing shall occur as soon as possible following the accident and before the employee is relieved of duty, except that necessary medical treatment shall not be delayed in order to collect the specimen.

H) Procedures for Drug Testing. The Commission will adhere to written specimen collection and testing guidelines established or approved by the laboratory that will perform the drug test to ensure the accuracy and integrity of the test and process. The Commission will give the Union notice and an opportunity to bargain about such guidelines, except that the parties agree that the Boston Police Department specimen collection and testing guidelines, as set forth in Appendix C and Appendix D of the Boston Police Department Rule 111, shall

apply if the Boston Police Department administers specimen collection and testing under this policy. Copies of the specimen collection and testing guidelines shall be given to the Union, and the Union shall be notified promptly in writing of any new or amended procedures that occur after this policy takes effect. The procedures for testing on hair shall include the following:

1. Three hair samples will be collected at the time of testing. Two samples will be sent under applicable chain of custody standards to the testing lab. The third sample will be maintained under secure storage conditions by the Department.

2. To be identified as positive, the initial test must have:

Minimum of 5ng/10mg of cocaine; and
Contain nor cocaine (1ng); or
Contain Benzyleconine at a ratio of 5% or greater.

3. If the initial test is positive, the lab will perform a second test on the second hair sample. If the result of that test is within 30% of the result of the first test, the result of the first test will be deemed confirmed, provided that the result meets the minimum standard set forth in Section 2. Otherwise, the test will be deemed negative.

4. A bargaining unit member whose two test results are positive may, at the EMT's expense, have the third hair sample tested at Quest Laboratories at the laboratory's limit of detection for the substance(s) in question (50 ng/mg for all drugs except marijuana which is 0.05 ng/mg). The employee must request the third hair sample be tested within seventy (72) hours of being notified of the positive test. If the test result does not meet that laboratory's limit of detection for the substance(s) in question, the test shall be deemed negative.

Drug tests will consist of determinations of the presence of these five drugs, classes of drugs, or their metabolites: marijuana metabolites, cocaine metabolites, opiate metabolites, phencyclidine (PCP), and amphetamines. In the course of testing for Reasonable Suspicion of Drug and/or Alcohol Use or post-accident testing, other drugs or their metabolites may be tested for if their particular use is suspected. Such other drugs may include, but need not be limited to: lysergic acid diethylamide (LSD), methaqualone, barbiturates, and benzodiazepines. Drug tests shall consist of an initial screening such as immunoassay and, if the initial screening is positive at the cut offs used by the laboratory performing the test, shall be confirmed using "GC/MS" (gas chromotagraphy/mass spectrometry) or some equally reliable methodology at the cut off levels used by the laboratory performing the test. In a GC/MS test, the specimen is heated and the vapors are passed through a column of absorbent material, where traces of the drugs separate into colored bands (gas chromatography). A mass spectrometer then analyzes the precise chemical composition of each band. GC/MS is generally considered to be the most conclusive method of confirming the presence of a drug in urine. *GC/MS* results are accepted as evidence in criminal cases. Positive

GC/MS results are first communicated to a Medical Review Officer (MRO) who investigates the possibility of a legitimate explanation of the test result.

VI. CONSEQUENCES OF A POSITIVE TEST

ILLEGAL DRUGS

EMTs who receive a verified positive test result for illegal drugs will be subject to termination. However, where the EMT's only violation is a positive test for illegal drug use and it is the EMT's first offense, the Department shall offer voluntary submission to the following alternative program:

- up to a 45 day suspension without pay.
- Execution of a Rehabilitation Agreement and submission to treatment/rehabilitation.
- Temporary reassignment by the Department.
- Submission to follow-up testing as described in section V(B) above.

Note that failure to comply with the terms of the Rehabilitation Agreement either during or after the suspension period would constitute a separate violation of this policy and shall result in termination.

ALCOHOL OR ILLEGALLY-USED DRUGS

EMTs who test positive for alcohol or illegally-used drugs shall be subject to disciplinary procedures up to and including termination. However, the first time, an EMT tests positive for alcohol or illegally used drugs, the EMT shall be offered and the EMT shall sign a Rehabilitation Agreement and the EMT shall receive up to a 5 day suspension. Note that refusing to sign the Rehabilitation Agreement under these circumstances constitutes a separate violation of this policy. EMTs who sign the Rehabilitation Agreement and undergo treatment may be assigned administrative duties until such time as they are certified, by the treatment provider, to be recovering and able to safely perform their duties. They will also be subject to follow-up drug testing as described in Section V(B) above.

REHABILITATION

1. Leave of Absence. An employee who is on an approved leave of absence for the purpose of receiving substance abuse treatment must use accrued paid leave in accordance with Department policy and may also use compensatory time or holiday time. If the employee has exhausted all such paid leave, he/she may apply for additional paid leave from the Catastrophic Illness Leave Bank (CILB) in accordance with the CILB policy. In the event the

employee receives no compensation and is receiving substance abuse treatment the employee's health insurance coverage shall remain in place during his/her leave of absences and the employee will be responsible for his/her share of the health insurance premium. If the employee fails to pay his/her share of the health insurance premium, the Commission may recoup any payments made on the employee's behalf by payroll deduction from any monies owed to the employee.

2. Treatment Expenses For Employees Who Test Positive. If an employee who tested positive for drugs is required to receive substance abuse counseling or treatment pursuant to a Rehabilitation Agreement and the cost of such treatment exceeds the coverage of any health insurance or disability coverage available to the employee, the Department will contribute an amount not to exceed five thousand dollars ($5000.00) towards the cost of the employee's required treatment, except that the Department's total annual contribution to employees under this paragraph shall not exceed fifty thousand dollars ($50,000.00) in any fiscal year.

VIII. CONSEQUENCES OF VIOLATION OF THE POLICY

Any violation of the Substance Abuse Policy shall lead to disciplinary action up to and including termination. The severity of the action chosen will depend on the circumstances of each case. The Chief of the Department may at his discretion, suspend any disciplinary action while an EMT is undergoing substance abuse treatment subject to a Rehabilitation Agreement (see: Consequences of a Positive Test: above). Refusing to sign a Rehabilitation Agreement shall result in termination.

Refusing to submit to a drug or alcohol test (except as regards Condition of Promotion testing), or switching or adulterating any blood or urine sample, shall result in termination.

Failure to adhere to the terms of the rehabilitation agreement shall result in disciplinary action up to and including termination.

APPENDIX A

REFERRAL PROCEDURES FOR SUPERVISORS

The Department's supervisors are responsible for being alert to declining job performance, erratic behavior or other symptoms of possible substance abuse. Whenever a supervisor who has been trained in the making of determinations of reasonable suspicion of drug and/or alcohol use (as defined in Section II of these procedures) makes such a determination the following steps will be taken:

A) The supervisor will document in writing all circumstances, information and facts leading to and supporting his/her suspicion. At a minimum, the report will include appropriate dates and times of suspect behavior, reliable/reliable sources of information, rationale leading to referral for testing and the actions(s) taken.

B) Prior to referring an EMT for testing, the supervisor will discuss the problem with the EMT in a private location with one witness, preferably another supervisor present. Caution will be taken not to accuse the EMT of substance abuse, but the EMT will be presented with instances of questionable behavior. If the EMT does not have an acceptable explanation for his questioned behavior, the supervisor will continue with the procedures set forth in this section. Nothing in this procedure is intended to prevent the EMT from invoking any Weingarten rights the EMT may have.

C) The supervisor shall consult with a second supervisor of a higher rank and they shall jointly decide whether to refer an EMT for testing. If, after consultation, there is a decision to test, both supervisors shall file a joint report as set forth in paragraph A. All persons involved in the decision-making process will have received training in the identification of actions, appearance, and conduct which are indicative of the use of alcohol and/or drugs.

D) In those cases where the supervisor determines that the person's behavior causes a potential threat of harm to himself or others, the EMT will be immediately removed from the work site and where there is no other misconduct resulting in suspension the EMT shall be placed on administrative leave and shall be subject to customary restrictions of such leave.

E) Once a determination has been made to refer an EMT for testing, it will be the responsibility of the supervisor to advise the EMT of such decision and to escort the EMT to a collection facility. The supervisor should remain with the EMT at the collection site facility until testing is concluded. In the event that leaving the scene and/or remaining with the EMT is not feasible, the supervisor will 1) arrange transportation to the collection facility (the EMT will be instructed not to drive a vehicle), 2) notify the collection facility that the EMT is being sent for testing, 3) request that the collection facility notify the supervisor when collection procedures are completed, 4) arrange transportation for the EMT following the collection process, and 5) notify the EMT that he or she is not to return to work pending receipt of the test result by the Department.

F) Upon conclusion of the examination the supervisor will ensure that the EMT is escorted to his destination. The supervisor will direct the EMT not to drive himself/herself to his destination. The EMT will be relieved from duty pending receipt by the Department of the test results and the EMT will be notified of this change in status.

G) In those cases where a supervisor discovers an EMT who possesses what appears to be a controlled substance, illegally-used drug or alcohol, he or she will proceed as described above for instances where reasonable suspicion exists, and, if the substance in question appears to be a controlled substance or illegally-used drug, will in addition perform the following steps:

1) Immediately confiscate the substance and all equipment or paraphernalia directly employed with the substance. Wrap them in any available clean material (e.g. paper towel, copier paper, handkerchief). The supervisor will keep the package on his or her person or where he or she can be absolutely sure it cannot be tampered with and shall strive to process the materials as soon as possible.

2) As soon as the supervisor can, he or she will put the wrapped materials, still in the wrapping, into a large envelope and seal the envelope completely. The supervisor's initials will be written over the seam of the envelope in several places.

3) The supervisor will write the EMT's name, his or her own name, and the date at the top of the envelope, will promptly notify his or her commanding officer, and will turn the envelope over as soon as possible to the Professional Standards Office. The supervisor will witness the signing and dating of the envelope by the person to whom he or she turns it over.

4) All employees who subsequently and for whatever reason have possession of the envelope will sign and date it in the presence of the previous supervisor.

APPENDIX B

REHABILITATION AGREEMENT

Name:_____ Date:_____

Department: Boston EMS

Dear _____:

On _____, the Department agreed to your request to seek counseling and referral to a rehabilitation program for alcohol and/or drug abuse. The following conditions apply to your rehabilitation program.

1. You must authorize your treatment provider to provide proof to the Office of Professional Standards of enrollment in a rehabilitation program and proof of attendance at all required sessions on a monthly basis. Your attendance will be monitored closely.

2. You must adhere to all of the requirements of the drug or alcohol treatments or counseling program in which you are enrolled.

3. If you are absent from work during the rehabilitation period without prior authorization, you must promptly submit a written doctor's certificate explaining the reason for such absence. The Department will take disciplinary action if you are absent as a result of alcohol or drug use.

4. You will pay for all costs of rehabilitation which are not covered under your health plan or assumed by the Department pursuant to Section IV (B) (2) of the Substance Abuse Policy.

5. During the five (5) years following the completion of your rehabilitation program, the Department will test you for alcohol and/or drug use on a random basis. The Department will take prompt disciplinary action if you refuse to submit to testing or if you test positive during this period.

6. You must submit a fitness for duty certificate signed by a licensed physician confirming that you are fit to perform the duties of an EMT as a condition of returning to work**.**

7. Failure to comply with all of the above conditions will result in termination. Furthermore, rehabilitation personnel will notify the Department in writing or appear for testimony at administrative, civil service and superior court hearings in the event you have not complied with the designated rehabilitation program.

I hereby voluntarily agree to all of the above conditions and authorize my treatment provider to provide the Office of Professional Standards with proof of my enrollment and attendance at the recommended rehabilitation program. I sign this rehabilitation agreement of my own free will, and without duress.

_____	_____
EMT's Name	Department Representative's Name
_____	_____
EMT's Signature	Department Representative's Signature

_____
Union Representative's Name

_____
Union Representative's Signature

_____ _____
Date Date

Substance Abuse Policy: Designated Physician

Supersedes: 7-11-16
Effective: 3-19-19

Department members undergoing prescribed medical treatment with any drug that may affect their ability to perform their duties as an EMT must report this information to the licensed physician designated by the Department.

Attention: Medical Director of Working Well Clinic at BMC
Department of Occupational & Environmental Medicine
Doctor's Office Building
720 Harrison Avenue, Suite 703
Boston, MA 02118-2393
Phone: 617-638-8400 (Mon-Friday 07:30-16:00)
Email: Workingwellclinic@bmc.org

Information may be sent in one of two ways: it can be delivered personally, or by electronic mail with a scanned copy of the prescription or photo attachment. Be sure to include your contact information, job title (EMT, LT, Captain, etc.), and assignment (Dispatch Operations, Unit, etc.) in the notification. The use of a fax is not an acceptable means of disclosure. Disclosure must be made to the Medical Director of the BMC Working Well Clinic (or his/her designee) . There is no obligation on your part to share your confidential medical information with your Supervisor, Shift Commander, or Professional Standards.

At our request, the Department of Occupational & Environmental Medicine has identified the following categories of prescription drugs that may affect a staff member's ability to perform their duties. If you have been prescribed any of the categories of drugs listed below, you must report that fact to the physician designated by the Department immediately when prescribed. The list below is meant to be illustrative and is not an exhaustive list of prescription drugs that may affect performance of duties or that are subject to the reporting requirements.

- Opioid based pain medication (examples include oxycodone, morphine, and methadone)
- Potentially sedating pain medications, including opioid based medications mixed with acetaminophen and tramadol.
- Sedative medications (examples include lorazepam, alprazolam, diazepam).
- Antipsychotic medications (examples include haldoperidol and risperidone)
- Muscle relaxants (example includes flexeril)

Failure to report use of prescription drugs as required can place the Department, its staff, and our patients at risk and it is specifically listed as prohibited conduct in the Boston EMS Substance Abuse policy. If you have any questions about Department

policy or your reporting obligations, please contact the Professional Standards Division (617-343-1144). If you are unsure of whether a prescription drug you are using may affect your ability to perform your duties as an EMT, please contact the Working Well Clinic Medical Director at 617-638-8400 (Monday-Friday 07:30-16:00).

Requesting Blood Products

Supersedes:
Effective: 03-01-00

In rare instances, prolonged extrication or multiple casualty events necessitate the need for O negative blood to be delivered to the scene. Blood may be obtained from the Boston Medical Center, Harrison Avenue Pavilion Blood Bank through the BMC-Menino Emergency Department Charge Nurse. All blood products that leave the hospital must be accompanied by a physician to the scene. The physician will be responsible for administering the blood products.

1. The first arriving BEMS paramedic or EMT, or the BEMS Incident Commander will make the determination that blood products may be required at the scene.
2. The EMT/ EMT-P/ IC will contact the Boston Medical Center-Menino Pavilion Emergency department either through CMED radio or via Dispatch Operations ringdown. The Emergency Department will be informed of the event parameters, the need for blood products, and the incident number will be provided to the ED Charge nurse.
3. Dispatch Operations will arrange for pickup and transport of an Emergency Department MD and the blood products to the scene (see section 3 above).
4. The ED Charge Nurse will be responsible for filling out a RED blood request form with the words “EMS INCIDENT” followed by the Incident number in the patient identification area in the upper right hand corner. This will be sent to the blood bank via runner. The blood bank will release two units of O Negative blood.
5. An Emergency Department Physician will accompany the blood products to the scene via EMS or Boston Police transport. The ED MD will be responsible for administration of all blood products. Blood tubing and a cooler are provided in the “To Go” box.
6. The form entitled “Transfusion Report Blood Bank” will be returned to the blood bank after the patient has arrived at the hospital. This form will include the EMS incident number, the patient’s name and birth date if known, the receiving hospital name, and the receiving hospital patient record number. This information is vital for the blood bank. The BEMS Shift Commander or BEMS Incident Commander will be responsible for guaranteeing this form is returned completed to the blood bank.

Vaccine Storage and Handling

Supersedes: 03-22-10
Effective: 11-12-14

The purpose of this procedure is to ensure the safe storage and handling of vaccines in order to maintain optimum potency. Failure to adhere to recommended specifications for storage and handling can reduce vaccine potency, resulting in inadequate immune responses in the recipients and inadequate protection against disease.

The Department's Designated Infection Control Officer (DICO) serves as the Vaccine Manager and is responsible for the oversight of all vaccine storage and handling.

Vaccine Receipt

1. Upon arrival at Boston EMS, vaccines will immediately be counted and compared with the packing list and original order form making sure the order and delivery is correct, with all expiration dates and lot numbers matching.
2. The recipient will check the cold chain monitors to make sure the temperature stayed within appropriate range during transport.
3. If there are any concerns or inaccuracies with the vaccine order or cold chain monitors, the Vaccine Manager or designee will contact the MDPH Vaccine Management Unit at (617) 983-6828 for guidance. McKesson Specialty Customer Care at (877)-822-7746 can be contacted for cold chain monitor concerns.
4. Once an inventory is completed, the vaccine shall be immediately placed the refrigerator/freezer designated for vaccine storage only.

Vaccine Storage

1. All refrigerated vaccines must be stored within the temperature range of 2° C to 8° C, or 35° F to 46° F, in the refrigerator designated for vaccine storage only.
2. All refrigerators designated for vaccine storage will be set to maintain the proper temperature using a calibrated product temperature thermometer. The thermometer should be placed in a central area of the refrigerator unit adjacent to the vaccine.
3. The Vaccine Manager or designee will rotate stock ensuring that short-dated vaccine is used first. Ensure that private purchased vaccines can be differentiated from state-supplied vaccines.
4. Vaccines should be stored centrally in the refrigerator, not on the door, in bins or on the bottom of the storage unit, and sufficiently away from walls to allow for proper air circulation.
5. Bottles of water should be placed in the refrigerator, if space allows, in order to maintain the internal temperatures of the storage unit.

Temperature Monitoring

1. Refrigerator temperatures will be monitored and recorded at least twice daily on temperature logs attached to each unit, one time at the start of the workday and

one time at the end of the workday. Temperature logs must be maintained for at least 3 years.
2. The Vaccine Manager must review temperature logs at least once a week for completeness and any deviations from recommended temperature ranges.

Temperature Out of Range Alarm

1. The refrigerator designated for storing vaccine is equipped with a temperature alarm that is remotely monitored by ADT Security. The alarm will be activated if there is a power failure and/or the temperature in the refrigerator stays at 31° F or below or 50° F or above for 25 minutes.
2. During normal business hours (Monday-Friday from 08:00-16:00), ADT will first contact RTQI to notify that an alarm has activated. If there is no answer, or during non-business hours, ADT will contact Dispatch Operations. Upon notification that the vaccine refrigerator alarm has been activated, the Dispatch Operations Supervisor should notify the on-duty Shift Commander who will coordinate a response to check on the alarm activation.

Power Failure/Refrigerator Failure

1. A "Do Not Unplug" sign is posted next to the refrigerator power outlet. In the event of an extended building power failure or refrigerator failure, vaccines will be packed in insulated containers with cool packs and transported to Materials Management or another available refrigerator.
2. In the event the vaccines need to be removed, there is a cooler with cold packs stocked inside the Vaccine Manager's office. All vaccines should be removed, including the inside portable thermometer (not probe) and placed together inside the cooler.
3. When a problem is discovered, the exposed vaccine must be maintained at proper temperature and marked "Do Not Use". Vaccine Management Unit staff will determine if the vaccine is still viable for use.
4. All out of range temperatures require immediate reporting to the MDPH Vaccine Management Unit with actions and results of these actions documented on the temperature logs.

Transporting Vaccine

1. If vaccine transportation to another site is required, it is critical that the cold chain be maintained throughout the process to ensure the viability of the vaccine.
    a. Place ice packs on bottom of Styrofoam container.
    b. Place bubble wrap or foam wrap on top of ice packs (vaccine should NOT come in direct contact with ice packs.)
    c. Place vaccine in container on top of the bubble/foam wrap.
    d. Insert temperature monitors near the center of the vaccine.
    e. Place more bubble wrap or foam wrap on top of vaccine.
    f. Place more ice packs on top of bubble wrap.
    g. Ensure vaccine is secure in the container and close and seal the lid.

h. Clearly label the container “Vaccine- Refrigerate Immediately” and deliver vaccine to destination without delay.

Vaccine Returns

1. All vaccines that cannot be used due to expiration or exposure to unsafe temperatures must be reported to the Vaccine Management Unit and appropriately coded on a *Vaccine Return Form*. Opened multi-dose vials are the exception. Please dispose of those doses in your biohazard trash.
2. The Vaccine Manager will fax completed*Vaccine Return Request Form* to MDPH Vaccine Management Unit (617) 983-6924 for review. Once reviewed, the Vaccine Management Unit will fax back the approved form for shipping. A shipping label will be mailed within a week of approval.
3. Pack Vaccine in a McKesson shipping box, with the return form and return shipping label provided and the Vaccine Management Unit will arrange to have the non-viable vaccine picked up.

HR / Injury / LOA

Exit Interview Process

Supersedes:
Effective: 08-23-11

Background
Boston EMS is committed to recruiting, developing and retaining quality employees. To support this commitment, the Department's Professional Standards Division will conduct an exit interview with every employee leaving the organization. The exit interview will consist of a list of questions designed to elicit information about the employee's experience at Boston EMS, and will provide important background as to why the employee has chosen to leave the organization. Exit interviews will offer invaluable insight that will help Boston EMS to identify areas in the work environment that could be improved upon. The policy described below outlines the steps involved with conducting the exit interview.

General Process

1. Once an employee provides notice that he/she is leaving the organization, the immediate supervisor should contact Professional Standards to initiate the exit interview process. The supervisor should provide the employee's name, contact information and last date of employment.

2. A member of Professional Standards will contact the employee to schedule a time to meet and collect all Department issued equipment, complete any outstanding paperwork, and review benefits. The employee will also be encouraged to participate in an exit interview.

3. Depending on how much notice the employee has provided prior to separation from service, the exit interview can be conducted either (1) face-to-face (2) online via Survey Monkey or (3) via a paper form. Those who agree to a face-to-face interview will also be asked to complete an electronic survey for data analysis purposes.

4. In order to create an environment where the employee can provide direct and honest feedback, Professional Standards, as opposed to the employee's supervisor, will conduct face-to-face interviews. If an employee is uncomfortable providing feedback in-person, he/she will have the option to complete a survey as described above.

5. Employees will be notified that all responses will be kept as confidential as possible. However, in the event that an allegation of discrimination or misconduct is raised, Professional Standards will conduct an investigation as appropriate. Boston EMS will not tolerate retaliation against anyone making a complaint of workplace wrongdoing or for participating in an investigation.

Face-to-face Interviews

1. If the employee agrees to a face-to-face interview, Professional Standards will aim to schedule the interview on the employee's last day of employment, schedule allowing.

2. Professional Standards will stress that the meeting is voluntary and confidential.

3. The interview will be held in a private conference room to create an atmosphere of comfort.

4. Professional Standards will ask a series of questions about the employee's work experience and will allow him/her to express their thoughts and feelings without interruption. They will take notes on the employee's responses and remain objective throughout the interview.
5. Upon completion of the face-to-face interview, Professional Standards will ask the employee to complete an electronic survey for data analysis purposes.

Electronic and Paper Surveys

1. If Professional Standards is unable to complete the interview process before the employee's last day, a member of the Division will email the employee a link to the electronic version of the survey or mail a paper version along with a postage paid return envelope to the employee's home address within 30 days. Upon receiving the completed paper survey, Professional Standards will input the data into Survey Monkey.

Certificate of Appreciation

1. Professional Standards will notify the Office of the Chief when an individual decides to leave the organization. All non-probationary members of the Department who leave in good standing will receive a certificate of appreciation to be prepared by the Office of the Chief. Whenever possible, a member of the Senior Command staff will present the departing employee with the certificate.

Follow-up

1. Professional Standards will prepare a document summarizing the employee's responses to questions asked during the face-to-face interview. If any employee reports discrimination or misconduct, Professional Standards will fully document the allegations and follow established reporting procedures. Professional Standards will summarize the findings of face-to-face interviews on a quarterly basis to preserve anonymity. The report will be submitted to the Chief and Superintendent-in-Chief for review.

2. On a quarterly basis, Professional Standards will download the information captured in Survey Monkey to conduct analysis. Subsequently, Professional Standards will prepare a written report for senior leadership outlining the survey findings.

Family and Medical Leave Act (FMLA)

Supersedes: June 2008
Effective: July 2009

I. PURPOSE

This policy explains rights and responsibilities in regards to obtaining leave under the Family and Medical Leave Act (FMLA) and establishes procedures for receiving and responding to requests for leave that qualifies as FMLA leave.

II. POLICY

It is the Commission's policy to comply with the FMLA and to grant FMLA leave to eligible employees who are entitled to such leave. The FMLA entitles eligible employees to up to a total of 12 workweeks of unpaid leave during any 12-month period for one or more qualifying reasons and up to a total of 26 workweeks of unpaid leave during a "single 12-month period" needed to care for a spouse, son, daughter, parent, or next of kin who is a covered service member and has a serious injury or illness incurred in the line of duty on active duty. Employees are eligible for FMLA if they have worked for the Boston Public Health Commission for a total of 12 months and have worked 1,250 hours over the previous 12 months. It is the Commission's policy to use forms based on the prototypes promulgated by the United States Department of Labor to notify employees of their eligibility for FMLA leave when required, to designate leave as FMLA, and to obtain healthcare provider and other certifications and documentation that employees must submit to obtain FMLA leave.

III. PROCEDURE

A. QUALIFYING REASONS FOR FMLA LEAVE

1. The birth and care of a newborn child of the employee;

2. The placement of a child with the employee for adoption or foster care;

3. The employee has a serious health condition that makes him/her unable to perform the functions of his/her job.

4. The employee is needed to care for a spouse, child, or parent with a serious health condition;

5. The employee needs leave for a qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member who is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation as a member of a reserve

component of the Regular Armed Forces or as a retired member of the Regular Armed Forces or Reserve (hereinafter "Qualifying Exigency Leave"); and

6. The employee is needed to care for a spouse, son, daughter, parent, or next of kin who is a covered service member and has a serious injury or illness incurred in the line of duty on active duty (hereinafter "Military Caregiver Leave").

B. EMPLOYEE NOTICE AND RESPONSIBILITIES

1. Employees must provide the Commission with enough information about the reasons that they are requesting or taking leave to enable the Commission to determine whether the leave qualifies as FMLA leave. Absent unusual circumstances, employees who need FMLA leave must notify the Benefits Administrator in the Human Resources Office and complete a Request for FMLA Leave Form identifying the reason(s) for the leave. Requests for FMLA leave should not be directed to supervisors.

2. Employees seeking to use FMLA leave based on the expected birth or placement of a child or for planned medical treatment for themselves, qualifying family members, or a covered service member must provide the Commission with thirty (30) days advance notice of the need for such leave if the need is foreseeable and such notice is practicable. In all other cases, leave must be requested as soon as practicable under the facts and circumstances of the particular case – generally, either the same or next business day after which the employee becomes aware of the need for leave. Unless excused by the Commission, employees must comply with the Commission's usual and customary notice and procedural requirements for requesting leave.

3. The employee must provide the Commission with a complete and sufficient certification when a certification is required under this Policy and must clarify the certification as necessary. Certifications will be required as a condition of certain qualifying leaves as follows:

    a. Employees who need leave due to their own serious health condition must submit a completed *Certification of Health Care Provider for Employee's Serious Health Condition* within the time period established by the Commission, which shall not be less than fifteen (15) calendar days.

    b. Employees who need leave to care for a spouse, child, or parent with a serious health condition must submit a completed *Certification of Health Care Provider for Family Member's Serious Health Condition* form within the time period established

by the Commission, which shall not be less than fifteen (15) calendar days.

c. Employees who need Qualifying Exigency Leave must submit a completed *Certification of Qualifying Exigency for Military Leave* form within the time period established by the Commission, which shall not be less than fifteen (15) calendar days, and such certification shall include available written documentation that supports the need for the leave.

d. Employees who need Military Caregiver Leave must submit a completed *Certification for Serious Injury or Illness of Covered Servicemember for Military Family Leave* within the time established by the Commission, which shall not be less than fifteen (15) calendar days.

Certification forms are available in the Human Resources Office and on the Commission's Intranet.

4. The Commission may require an employee who needs leave due to his/her own serious health condition to obtain a second, and in some cases third, opinion at the Commission's expense. It may also contact the employee's healthcare provider for the sole purposes of authenticating or clarifying a medical certification of a serious health condition that was provided by the healthcare provider, except that only a health care provider, a human resource professional, leave administrator, or authorized management official may contact the employee's healthcare provider for these purposes. The employee's direct supervisor shall not contact the employee's healthcare provider under any circumstances.

5. The Commission may require an employee who needs leave due to his/her own serious health condition to submit periodic recertification of his/her serious health condition.

C. EMPLOYER NOTICE AND RESPONSIBLITY

1. A copy of this policy and a general notice concerning employees' rights under the FMLA will be posted on the Commission Intranet, placed in the Commission Employee Handbook, and distributed to new hires.

2. When a Program Director or Department Manager acquires knowledge that an employee needs or is taking leave that may qualify as FMLA leave, he/she must notify the Human Resources Office on the same business day they acquire such knowledge.

3. The Director of Human Resources Office or his/her designee will determine whether an employee is eligible for FMLA leave. Absent extenuating circumstances, the Director of Human Resources/designee shall send the employee an Eligibility Notice within five (5) business days of the request/stated need that notifies the employee whether he/she is eligible to obtain FMLA leave. If an employee is eligible to obtain FMLA leave, the Eligibility Notice will identify any certification, documentation, or other information that the employee must submit to obtain FMLA leave and advise the employee of his/her general responsibilities while on leave.

4. The Director of Human Resources/designee will notify the employee that his/her leave has been designated as FMLA leave when such leave has been approved. He/she shall send the employee such designation within five (5) business days of receiving a completed certification and/or the necessary information to make such designation. If an employee submits a certification that is incomplete or insufficient, the Director of Human Resources/designee will notify the employee, advise the employee what additional information is required, and give the employee at least seven (7) calendar days to complete the certification or provide the necessary information.

D. CALCULATION OF LEAVE

1. Each absence from work by an eligible employee for an FMLA-qualifying reason will be considered as FMLA leave and will count toward fulfillment of the 12 weeks (or 26 weeks in the case of Military Caregiver Leave) within the 12-month period, except that the Commission shall not be required to designate leave as FMLA retroactively if the employee failed to give timely notice of the need for leave and/or otherwise failed to satisfy the conditions precedent to obtaining FMLA leave. The 12-month period is a “rolling” period measured backward from the date of any FMLA usage. The “single twelve month period” for purposes of Military Caregiver Leave will be calculated in accordance with the FMLA regulations.

2. If an employee and his/her spouse are both employed by the Commission, then they may be limited to a combined total of twelve (12) weeks of leave if the leave is taken for the birth of the employee’s child, to care for the child after birth, for placement of a child for adoption or foster care, to care for the child after placement, or to care for a parent who has a serious health condition. The employees may be further be limited to a combined total of twenty six (26) weeks of Military Caregiver Leave.

3. Any worker’s compensation/industrial accident leave that qualifies as FMLA leave will be counted against the employee’s FMLA entitlement.

E. CONDITIONS OF LEAVE

1. While on FMLA leave, an employee must use all accrued sick, personal, vacation and compensatory time, except that employees may request to reserve up to two (2) weeks of accrued vacation leave for when they return from FMLA. The request to reserve two (2) weeks of vacation time must be made in writing to the Director of Human Resources at the beginning of the FMLA leave. Any leave taken after exhausting accrued paid leave will be unpaid. Employees on unpaid leaves of absence, including unpaid FMLA leave, do not accrue seniority, vacation, and sick leave during such periods of unpaid leave except as otherwise provided by a collective bargaining agreement.

2. An employee on FMLA may continue coverage under their health insurance. The employee is responsible for her/his share of premium payments during the leave and s/he must mail the monthly premium before the first of every month to:

   Boston Public Health Commission
   Human Resources
   1010 Mass. Ave., 6th Floor
   Boston, MA 02118
   Attn: Benefits Administrator

3. Weekly time sheets must reflect that an employee is on FMLA leave. If an employee is using paid leave as required by this policy, then the time sheets must reflect the applicable code (e.g. FMLA-Sick in the event that an employee is using sick leave).

4. Under some circumstances, employees may take FMLA intermittently (taking the leave in separate blocks of time for a single qualifying reason) or on a reduced leave schedule (reducing the employee's usual weekly or daily work schedule). When leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer's operation. If FMLA leave is for birth and care, or placement for adoption or foster care, use of intermittent leave is subject to the employer's approval.

5. Employees must report on their status and intent to return to work periodically as directed by the Commission.

F. RETURNING FROM LEAVE

1. Following a FMLA protected leave, an employee will return to the same or similar job and rate of pay as held before going out on leave or an equivalent position with equivalent benefits, pay and other terms and conditions of employment. An employee whose position is eliminated while on FMLA is entitled to the same rights and benefits as other employees whose positions are eliminated. However, s/he will have no greater rights to reinstatement or

other benefits and conditions of employment than if s/he had continued to work.

2. Employees returning from leave for their own serious health condition must submit a fitness for duty certification from their healthcare provider indicating that they are medically able to perform their jobs as a condition precedent to returning to work. If reasonable safety concerns or concerns of an employee's ability to perform the essential functions of their job exist, the Commission may, under certain circumstances, require such a certification for employees returning from intermittent FMLA leave.

3. Employees must return to work with or without accommodations at the end of their authorized leaves unless they obtain authorization for additional leave in accordance with Commission policy or their collective bargaining agreement. Employees who fail to return to work at the end of their leaves without authorization may be subject to discipline up to and including discharge for unauthorized absence.

G. LEAVE AFTER FMLA LEAVE IS EXHAUSTED

1. Additional medical leave beyond an employee's entitlement under the FMLA is at the discretion of the Commission and subject to operating needs, and the employee must abide by any terms and conditions set by the Commission or applicable collective bargaining agreement for such additional leave. If an employee needs leave due to their own serious health condition beyond the 12 weeks provided by the FMLA, he/she must request additional leave from the Human Resources Office in writing. The Director of Human Resources/designee may require the employee to submit medical documentation to support the request for additional leave.

2. The Commission will not grant additional medical leave to employees who have been on a leave of absence for twelve (12) months, except that the Director of Human Resources may, subject to operating needs, grant an employee up to an additional three (3) months of leave as an accommodation if the employee provides evidence acceptable to the Commission indicating that he/she intends to return to work and will be capable of performing the essential functions of his/her job with or without accommodations within that three (3) month period.

(BPHC Policy 145)

Workplace Injury Documentation

Supersedes:
Effective: 12-05-05

As part of a risk management and injury prevention program, the Department documents all work-related accidents and injuries, whether they result in time lost from work or not.

NOTIFICATION

1. Whenever an employee sustains a work-related injury, the Dispatch Operations Supervisor should be notified of the incident as soon as possible and will make appropriate notifications depending on the nature and severity of the injury. The Shift Commander will be notified of the incident, and the appropriate Division Supervisor will respond to assist the employee with necessary paperwork and documentation.
2. In the case of an emergency, Department members should seek emergency care (via ambulance if necessary) at the closest appropriate emergency care facility. If follow-up care is required after emergency treatment OR if the injury does not require emergent evaluation or treatment, the employee's first scheduled appointment must be with one of the City's "Preferred Provider Arrangement" (PPA) medical vendors.

DOCUMENTATION

It is important that all work-related injuries be fully documented, regardless of whether the employee required medical treatment or lost time from work. A detailed report will assist with assessing the claim and in identifying injury trends that can lead to changes in policy, procedure, equipment, or training to reduce the likelihood of similar incidents in the future.

1. Whenever an employee suffers a work-related accident or injury, a City of Boston "Report of Occupational Injury or Accident" form shall be completed. If the injury is due to an **unprotected exposure**, the employee should also refer to the documentation requirements in the "Infection Control" SOP.
2. Whenever an employee suffers a work-related injury, any other Department members who witnessed the circumstances that led up to an injury shall use a standard incident report form to complete a witness statement.
3. All reports should fully describe the circumstances that led up to the accident and the extent of any injury. For example, rather than writing "back injury," the report should be specific: "While carrying the top of the stair chair down a flight of stairs,

the patient suddenly reached out causing the weight to shift resulting in right lower back pain to employee."

4. The Supervisor taking the report(s) shall ensure that they are legible and as detailed as possible. The supervisor will then complete Part II of the Workers' Compensation form, listing actions taken, contributing factors, and any recommendations to prevent a similar accident from happening in the future.
5. The Supervisor handling the reports will then notify the Boston EMS Workers' Compensation liaison (Ms. Nancy Laughter) of the incident via telephone (617 343-1159) during normal business hours, or by Department email. The completed reports and any medical paperwork will then be promptly forwarded to the Workers' Compensation liaison at EMS headquarters.
6. Failure to promptly complete the necessary paperwork and forward it to the EMS Headquarters may result in the employee being charged for service not compliant with the Preferred Provider Arrangement.

Administration & Finance

Compassionate Billing Procedure

Supersedes: 09-16-16
Effective: 01-23-19

Boston EMS provides emergency medical services to patients regardless of their ability to pay. The Department is sensitive to those who face financial hardship and understands that a patient's illness or injury can create large medical bills which may impact the ability to pay. Two federal laws, the Civil Monetary Penalties Law and the Anti-Kickback Statute, prohibit providers from waiving or reducing patients' cost sharing amount (which includes co-pays and deductibles). The only exemptions are related to financial hardship and uninsured patients. Through the Department's compassionate billing policy, patients who can demonstrate financial hardship will have the fee waived and those without insurance will be afforded discount options.

POLICY

Boston EMS, through its ambulance billing provider, accepts all major credit cards and will work with the responsible party to establish a payment plan whenever possible. Patients (or their representative) who claim financial hardship will be asked to complete the "Boston EMS Financial Hardship Application" as well as submit the required supporting documentation. Boston EMS will utilize the current poverty income guidelines established by the US Department of Health and Human Services (HHS) as a means of guiding whether an individual qualifies for fees to be waived. The threshold for granting a fee waiver will be 400% of the poverty guideline for the lower 48 states and the District of Columbia.

While Boston EMS will utilize the HHS Poverty Guidelines as the primary means of determining eligibility, additional circumstances may be considered such as catastrophic financial hardship due to extended illness or injury, loss of all income, or incapacitating injury or illness. Patients must provide appropriate documentation to support such circumstances. Upon application review, the patient will be contacted to finalize determination of application approval and the appropriate level of adjustment.

PATIENT CONTACT

In an effort to determine payer status, the billing company may send Requests for Information (RFI), invoices and additionally mailings to ensure the correct insurance information is collected and patients are aware of the portion of the bill they are responsible for. In addition to mail, the billing company may contact the patient by phone. All communication must be in alignment with the language and intent of this policy. The billing company shall work collaboratively with those able to pay and guide those experiencing financial hardship through the process of verifying their status.

FINANCIAL HARDSHIP PROCEDURE

1. Before any bill is considered for reduction, Boston EMS's billing vendor will ensure that all insurance benefits have been maximized.

2. If the patient is unable to pay the full bill, but does not meet the threshold for financial hardship, the vendor will arrange for the patient to make monthly interest-free payments (typically over a 6-month period) in a dollar amount that is financially affordable to the patient.

3. If a patient claims financial hardship, Boston EMS's billing vendor will offer the "Boston EMS Financial Hardship Application".

4. The patient or representative shall complete and submit the "Boston EMS Financial Hardship Application" along with proof of income and/or additional supporting documentation to the billing vendor, as outlined in the application.

   4.1. Acceptable forms of proof of income include (a) a current IRS W-2 form; (b) most recent income tax return; (c) copies of two (2) current pay stubs from the head of household; (d) an unemployment check stub; (e) a notarized statement of unemployment; or (f) other documentation supporting the level of income or financial hardship claim.

5. Patients shall be informed that during the application review process, they will continue to receive invoices from Boston EMS's billing vendor.

6. A representative at the billing vendor will review the application and supporting documentation. If the patient is able to show proof they qualify for financial hardship, the billing vendor is authorized to waive the fee. If the patient does not meet the federal poverty level threshold of 400%, and the billing company is uncertain they meet the qualification for extenuating circumstances associated with financial hardship, the billing company shall contact Boston EMS for guidance (patients should not be referred to Boston EMS).

7. If the billing company is able to verify financial hardship without contacting the patient, such as for patients who are eligible for Health Safety Net (HSN) offered by MassHealth, or those who have qualified for financial hardship previously in the same year, the account may be written off as Charity Care prior to billing the patient.

8. The billing company shall provide Boston EMS a monthly spreadsheet outlining all hardship requests and resolutions for review.

UNINSURED PATIENTS

For patients who do not qualify for charity care or financial assistance as defined above, Boston EMS requires the vendor to promptly bill patients for services provided using Boston EMS billed charges less the Standard Uninsured Discount: 40% reduction of billed charges. Uninsured patients will also be offered a 10% prompt payment discount if payment is made within 30 days.

UNPAID INVOICES

The Boston EMS billing company may not refer patient accounts to a collections agency. Upon exhausting all efforts to successfully bill a patient's insurance, the billing vendor will send the patient up to four invoices at thirty (30) day intervals. If there is no activity on the account within sixty (60) days after the final invoice is sent, the account is eligible to be written off as bad debt.

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http://aspe.hhs.gov/poverty/index.cfm

Attendance & Schedule

Catastrophic Illness Leave Bank

Supersedes:
Effective: 07-01-04

I. PURPOSE

The purpose of this policy is to provide additional paid leave to eligible uniformed employees of Boston EMS, a bureau of the Public Health Commission, for recovery from or treatment for a catastrophic illness. Uniformed employees of Boston EMS include EMS Division BPPA members and uniformed command staff not represented by the EMS Division BPPA.

II. POLICY

Subject to the provisions of this policy, recipients may receive a maximum of 120 days of additional paid leave every two (2) calendar years, provided that whenever a recipient has used 100 days of paid leave from the CILB, the matter will be referred to the CILB Committee for consideration of additional leave beyond 120 days. All benefit-eligible, full-time uniformed employees of Boston EMS may participate in the CILB.

III. ELIGIBILITY

The recipient eligibility requirements are as follows:

- Applicant must be full-time employee and uniformed members of Boston EMS who are eligible to earn, and have exhausted his/her entire balances of accrued paid leave, including sick, personal, holiday compensatory and vacation time.
- Applicant must not be entitled to receive Worker's Compensation.
- All publicly funded disability benefits for the catastrophic illness and any compensation provided by or through the Commission shall reduce payments under this policy on a dollar for dollar basis.
- The Boston EMS CILB Committee must approve applicant by a majority vote of all committee members.
- Effective July 1, 2004, to be eligible to receive benefits from the CILB the applicant must have contributed a minimum of eight (8) hours of sick, personal, or vacation time pursuant to the procedures described below in Section IV. (Provided that this requirement shall not limit the ability to implement this policy on a case-by-case basis prior to July 1, 2004).
- Applicant must not have received 120 days paid leave or more from the CILB within the previous two (2) calendar years, except as provided in Section II above.
- Applicant must provide any medical documentation required by this policy and any other medical documentation requested by the EMS CILB Committee.

IV. CONTRIBUTION CRITERIA

In order to participate as a recipient in the CILB uniformed employees of Boston EMS must have a minimum of one (1) year service as a uniformed employee of Boston EMS and must contribute a minimum of eight (8) hours of accrued sick, personal, or vacation time annually to the CILB during the CILB contribution period. The CILB contribution period shall be in January each year and uniformed employees may contribute earned sick, personal or vacation time to the CILB. A maximum of eighty (80) hours of earned time may be contributed annually, provided that the Boston EMS CILB Committee may authorize additional contributions in order to maintain a sufficient balance in the CILB. Contributions shall be made using the CILB Contribution Form, which shall be available from the EMS Bureau of Professional Standards. At the end of each year unused hours that have been contributed shall remain in the CILB for the future use.

V. RECIPIENT CRITERIA

All applicants to the CILB, or those applying in the applicant's behalf (e.g., family member, coworker), must submit a written request to the Bureau of Professional Standards in order to be considered by the CILB Committee for participation.

The EMS Bureau of Professional Standards must obtain, either through a request by the applicant or by solicitation, valid documentation from the applicant's health care provider attesting to the illness. Applicants must sign any releases required under the Health Insurance Portability Accountability Act ("HIPAA") to enable the CILB Committee to receive and review medical documentation necessary to respond to the application.

The Bureau of Professional Standards will notify the CILB Committee of each request and furnish all documentation necessary for the Committee to make an informed decision.

VI. CATASTROPHIC ILLNESS LEAVE BANK COMMITTEE

The Boston EMS CILB Committee shall be comprised of the following persons or his/her designee: the Medical Director of the Boston Public Health Commission; the Boston Public Health Commission Director of Human Resources, the Superintendent in Chief of Boston EMS; and the president of the EMS Division/BPPA union local. The committee shall have the following duties:

- Maintaining oversight of the CILB and policy.
- Reviewing and making a timely decision on all applications to the CILB.
- Determining the appropriate amount of paid leave to be allocated to each recipient based upon the number of available days in the CILB.
- Determine the frequency of employee contributions to the CILB.
- Notify all eligible employees of the CILB annually.
- Reserve the right to cancel benefits, or deem ineligible any applicant or participant.

VII. CATASTROPHIC ILLNESS DETERMINATIONS

In compliance with FMLA the employee must provide medical documentation from a licensed health care provider. Such documentation shall state that either the employee has been diagnosed with a serious illness or injury. A serious illness or injury is one that necessitates life-saving or life-sustaining treatment and prolonged incapacity or rehabilitation.

Detail Overtime

Supersedes:
Effective: 06-11-12

A paid detail is a non-City or non-Commission sponsored event where a medical service is performed by a full-time member of the Department during off-duty time, which is paid for by the person or persons making the request for such services (including training), and the Department knows, in advance, that it will be paid or reimbursed for the assignment of personnel, and which is related in any way to the performance of medical services.

CODE OF CONDUCT

A department member that accepts a paid detail as defined in the collective bargaining agreement:

1. Shall report to the detail on time and will notify Dispatch Operations if there is a delay.
2. Shall report in uniform and with equipment appropriate for the assignment.
3. Shall act in a professional manner.
4. Shall not bring guests on a detail.
5. If assigned a specific location at the detail site, the member shall remain at that specific site when not responding to an emergency.
6. A Department member working a detail must remain at the detail location until relieved by the vendor's representatives, a Boston EMS Supervisor, oncoming relief, or the detail has ended. If the hours of the detail are extended, this must be reported to Dispatch Operations.

FAILURE TO REPORT FOR A DETAIL

1. If a Department member accepts a detail and cannot keep the commitment, Dispatch Operations shall be notified immediately, and the reason for cancelling must be reported.
2. Details must be cancelled at least twenty four (24) hours in advance. The only reason for cancellation with less than 24 hours' notice should be an emergency. For the purposes of this SOP, "emergency" is defined as a serious, unexpected situation that requires immediate attention.
3. "No Call/No Show" for a detail will result in an automatic 90 day removal from all detail lists (bike, boat, CPR, events, or any other detail list not mentioned).
4. Cancelling a detail without reason, less than 24 hours prior to the scheduled start of a detail, or in order to be eligible for overtime, shall result in a written notice for the first offense.
   - 4.1. A second offense will result in a seven (7) day removal from any and all detail lists.
   - 4.2. A third offense will result in a forty-five (45) removal from any and all detail lists.

ELIGIBILITY
Eligible Department member wishing to be added to a detail list shall contact the Special Events scheduling coordinator in writing.

Mandatory Overtime

Supersedes: 09-13-13
Effective: 01-06-19

1. Mandatory overtime will be implemented when the Department is unable to reach the level of scheduled staffing for the oncoming shift. An example of scheduled staffing could be:

Days and Evenings	Nights
21 BLS Units	12 BLS
5 ALS	3 ALS
2 Field Supervisors	2 Field Supervisors
6 Telecommunicators	5 Telecommunicators
1 Dispatch Ops Supervisor	1 Dispatch Ops Supervisor

2. Before any employee can be ordered to work mandatory overtime, all current regular methods of attempting to fill the vacant slot(s) on a volunteer basis shall be exhausted.
3. All employees who have been mandated to stay on overtime shall be afforded the ability to have eight consecutive hours off duty before being required to return to duty.
4. When necessary, mandatory overtime shall be assigned to the most junior eligible person, who shall be sent to the vacant slot where the overtime exists. That person may be released from their current assignment in such a fashion as to permit a timely shift change at the station where the overtime exists, as approved by the on-duty shift commander.
5. When oncoming units reach the level of staffing scheduled for that shift, then members on mandatory OT shall be released at the member's option.
6. If agreeable to the shift commander and the employee who is working mandatory overtime, the employee may have their next scheduled shift off as compensatory time and receive four (4) hours of additional compensation time to be utilized at a later time.

PROCEDURE FOR DETERMINING MEMBER TO BE MANDATED

1. Three lists will be created according to rank: EMT, Paramedic, and Lieutenant. Members will appear on the appropriate list in inverse seniority with a designation indicating whether they are eligible to be mandated in Dispatch Operations or a Field assignment. By having a single list according to rank, this will eliminate confusion caused when a member changes assignments and moves from one shift to another.
2. On January 1 of each year, the lists will reset and members will be shown as having a "zero" balance of working mandatory overtime.

3. After having followed established procedures for filling vacancies and determining a member must be mandated, the Dispatch Operations Lieutenant will refer to the appropriate list based where the vacancy exists.
4. Starting at the top of the list (most junior person in grade), the Lieutenant will begin to move down the list looking for the most junior available person. If a person is not on duty, they are bypassed with no notation necessary. Similarly, if the spot is for the Field and the junior person is only eligible to be mandated in Dispatch Operations (or vice versa), the person is bypassed with no notation necessary.
5. If a person is on duty, but does not qualify because they are on a swap [called in advance & on the schedule], overtime, or it would result in working three consecutive shifts, that should be noted and the person then bypassed.
6. After determining the junior eligible person in grade, the Lieutenant will then check to see if the person has already been mandated. No person shall be held for a second mandatory overtime shift unless the other eligible persons on duty at that grade on that shift have been held once on mandatory overtime. No person will be ordered to work more than two shifts of mandatory overtime in any calendar month. A notation indicating the date of the mandatory overtime shift or reason for bypass should be entered onto the list.
7. Any mandatory overtime three (3) hours or over where another employee works the remainder of the shift shall constitute on mandatory overtime shift. Late trips and late relief shall not constitute mandatory overtime unless an employee works three (3) hours or more, which shall constitute one mandatory overtime shift. No person shall be required to work beyond sixteen hours from the beginning of the first of the two shifts.

Overtime Distribution

Supersedes: 01-01-13
Effective: 11-13-14

Overtime opportunities created by an absence for which there is proper advance notice shall be distributed among eligible members as equitably as possible. At all times, employees are expected to be physically and mentally fit to perform their assigned duties. When vacancies still exist, the process of calling overtime for the upcoming shift will be as follows:

1. Any member available and interested in working the upcoming shift shall notify the Dispatch Operations Supervisor (or designee) and request their name be placed on a list.

    1.1 Personnel interested in working overtime on an upcoming shift must notify the Dispatch Operations Center between the following times:

        23:30 – 05:00 to work the upcoming Day Shift
        07:30 – 12:00 to work the upcoming Evening Shift
        15:30 – 18:00 to work the upcoming Night Shift

2. The Dispatch Operations Supervisor (or designee) will note the location of “the box” and begin to call back personnel who have expressed a willingness to work in the order in which they appear on the overtime list.

    2.1 The awarding of overtime shall be with respect to both schedule conflict and rank/grade. If awarding overtime to an individual would result in a schedule conflict, that individual shall be bypassed. Similarly, overtime shall not be awarded to an individual of a higher rank/grade than is required at this point. For example: a Paramedic should not be offered a BLS overtime assignment, nor should a Captain be offered a Lieutenant overtime assignment. For the purposes of this policy, a 10-hour shift followed by an 8-hour shift (or vice versa) is permissible.

    2.2 Personnel who decline a particular assignment when called back will not be penalized and should be asked if they are willing to work either the first or last half of the shift. Overtime shifts may be “split” if there are no other members on the list available to work the entire shift AND there is someone available to work both the first and last half of the shift.

3. If a vacancy remains after calling back the list of eligible personnel, individuals interested in working overtime but initially bypassed because of a schedule conflict (section 2.1) may be offered the overtime opportunity.

4. If a vacancy still remains, a Group Page of the rank/grade (or specialty in the case of an EMT-T) of the vacancy should be transmitted along with an announcement on TAC-1 that overtime opportunities exist.

   4.1 If more than one individual calls to accept the overtime, it shall be awarded on a “first come / first served” basis with respect to schedule conflict. Generally, there will be a 10-minute time limit from the time the announcement is made until it is awarded.

5. If a vacancy still remains, individuals initially bypassed because they were of a higher rank/grade than required (section 2.1) may be offered the overtime opportunity. Overtime should be offered to the individual closest in rank/grade to the actual opening. For example, a LT would be offered an EMT vacancy before a Captain or Paramedic.

   5.1 When overtime is awarded to an eligible member off a back-up list, the “box” will be adjusted accordingly on the back-up list, but does not move on the person’s primary list.

6. If a vacancy still exists after allowing for schedule conflicts or hiring individuals of a higher rank/grade than required, a group page of all eligible ranks will be transmitted (for example: paging EMT, LT, Captain and Paramedic for a BLS opening) along with an announcement on TAC-1 that an overtime opportunity exists and mandatory overtime may be invoked.

   6.1 Overtime shall be awarded on a “first come / first served” basis with respect to shift conflict and rank/grade. For example, if the first person to call for an available BLS slot is a Paramedic, the overtime will not be awarded to the Paramedic unless no other EMT calls to request the shift. Similarly, if the first EMT who calls to accept the overtime has a schedule conflict, the overtime will not be awarded unless no other EMT without a schedule conflict calls to accept. Generally, there will be a 10 minute time limit from the time the announcement is made until it is awarded. Because this is considered emergency overtime, “the box” does not move.

7. If, after having made a radio announcement and group page(s), a vacancy still exists, the Dispatch Operations Center Supervisor (or designee) shall begin to call the overtime list. Beginning at “the box”, the supervisor should attempt to contact as many qualified members as possible. The vacancy should be considered “emergency overtime” and there is no minimum amount of time the supervisor must wait for a reply to a page or answering machine message. The overtime should be awarded without regard to shift conflict or rank/grade.

8. If a vacancy still remains, an employee who has reported himself or herself sick from his or her assigned shift and would otherwise be ineligible to work voluntary

overtime for the two shifts immediately following the shift for which the employee reported himself or herself absent, may be awarded the overtime to prevent another Department employee being mandated to work.

Shift Swaps / Tardiness

Supersedes: 06-03-11 (reissued)
Effective: 12-05-11

POLICY

A shift swap is permissible when two members voluntarily substitute work tours with each other by their mutual agreement and with the Department's prior approval. Employees who desire to swap tours must request approval in accordance with the procedures set forth below, and employees may not swap tours without prior approval by the Department. All swaps must be approved in advance by the Department and recorded on the schedule.

Shift swaps shall be on a time-for-time basis only. Employees may only swap shifts with another employee of equal rank and qualifications. Employees may not work a swap during any period in which they have been suspended without pay or are otherwise not available for regular duty. A swap must be an equal exchange of an entire shift; in no case shall a portion of a shift be allowed. Swaps involving any shift conflict because of overlapping start/end times are not permitted. Boston EMS may regulate and suspend swap privileges for any member as deemed necessary.

SHIFT SWAP REQUESTS

1. Both members requesting a swap must submit their request electronically (email) or in written form to the Shift Captain or Shift Commander at least sixteen (16) hours prior to the start of the scheduled shift. In an emergency, the Shift Commander may give verbal permission for a shift swap. Where verbal permission for an emergency swap is given, a written request shall be completed and filed as soon as possible.
2. Once approved, the swap shall be entered into Telestaff noting which member is "SN" (Swap Not Working) and "SW" (Swap Working). The ID number of the supervisor approving the swap must also be entered.
3. The member who agrees to work another's shift ("SW") is responsible for working the shift. Failure to meet the swap obligation will result in the person who was originally scheduled to work forfeiting pay for the shift.
4. Once a swap is approved, the tour of duty becomes the SW's scheduled work shift and subject to all Department attendance rules and policies. A member who agrees to work another member's shift but becomes sick or injured and cannot report for duty may cancel the swap. The person who was originally scheduled to work will then be responsible for reporting for duty or may find another person to work the swap provided that the swap can be arranged in accordance with Department procedure.

REPORTING FOR DUTY / TARDINESS

Department members must report to work punctually and be ready and able to work at the start of their scheduled shift. As soon as a Department member realizes they will be late to work, they must notify Dispatch Operations and state their estimated time of arrival.

1.1. Employees may not arrange for coverage of any absence due to tardiness or other reason without contacting Dispatch Operations. Prior approval of the supervisor must be obtained and recorded on the schedule. Any violation may result in discipline.

1.2. An employee who fails to call-in to the designated person within thirty (30) minutes after the start of his/her scheduled shift shall be considered absent without leave (AWOL) and may not be permitted to work that day. If the employee is not permitted to work that day, he/she will not be paid and his/her absence shall count as a suspension day for the purposes of this paragraph. Discipline for AWOL shall be imposed progressively in accordance with the collective bargaining agreement.

2. An employee may relieve a member of the off-going shift early as a matter of courtesy, provided that such early relief occurs no more than thirty (30) minutes prior to the scheduled start of the employee's shift. Any arrangements made among members which results in a person being relieved more than thirty (30) minutes before the end of their scheduled tour of duty must be approved in advance by a supervisor and noted on the schedule via the "notes" function.

3. For accountability and safety purposes, if one member of the off-going shift has been relieved when the unit is assigned to a response, the dispatcher shall be advised that the crew is "half and half" and the Department ID numbers of the crew responding to the incident shall be noted in the CAD Incident History. Once both members of an off-going crew have been relieved, the oncoming crew shall log onto the CAD system with their roster information and correct shift designator (D/E/N).

Sick Leave Policy (BPPA-EMS Members)

Supersedes: 01-01-08
Effective: 11-13-14

I. PURPOSE

It is the Commission's and the Boston Emergency Medical Services division's mandate to ensure the efficient and economical delivery of emergency medical services. Sick leave abuse, excessive absenteeism, and unauthorized absence undermine this mandate, disrupt operations and services, and create unwarranted costs. Sick leave is a benefit only to be used in accordance with the provisions of a governing collective bargaining agreement and Commission policy for absence caused by the employee's personal illness or injury or the serious illness of a member of the employee's immediate family.

II. POLICY

This policy sets guidelines for the proper use of sick leave benefits and consequences of sick leave abuse, excessive absenteeism, and unauthorized absence. These guidelines are not intended to proscribe an employee's legitimate use of sick leave benefits, but rather to define certain standards of behavior in an attempt to improve overall attendance, verify proper use of sick leave, and eliminate abuse. Nothing in this policy shall limit or prevent the Commission from enforcing time and attendance requirements that are not specifically referenced in this policy, including but not limited to tardiness and failing to call in absent in a timely manner.

III. PROCEDURE

A. DEFINITIONS

The definitions herein apply for the exclusive purposes of this policy.

1. **Sick Time** – Any hours of absence from work after an employee either calls-in absent or leaves work during the course of a shift for any of the following reasons: (1) the employee's own illness, injury, or exposure to contagious disease; (2) the illness or death of a member of the employee's immediate family; (3) an illness or disability arising out of or caused by pregnancy or childbirth.

2. **Medical Letter** - A medical letter is a letter from a licensed healthcare provider as defined below, who is not an employee or a member of the employee's family, which states that an employee's absence was caused by the employee's personal illness or injury or the serious illness of a member of the employee's immediate family and meets all of the following criteria. The letter must be an original letter on the health care provider official stationery that clearly specifies each of the date(s) the employee was required to be absent and bears the original signature of

the health care provider. The letter must be submitted to the Professional Standards Office or designee within seven (7) calendar days after the employee first returns to work following the absence, and any letter submitted after that time is untimely and shall not excuse the absence. Notwithstanding anything in this paragraph, the Chief of the Department/designee shall have discretion to authorize an employee to submit a medical letter at reasonable intervals to excuse absences due to serious chronic illness, provided that the Chief/designee's discretion shall not be subject to the grievance and arbitration procedures of any collective bargaining agreement. A licensed health care provider is defined as including any doctor of medicine or osteopathy, physician's assistants, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, nurse practitioners, nurse midwives and clinical social workers who are authorized to practice under state law and who are performing within the scope of their practice under state law.

3. **Undocumented Sick Time** – Sick time hours are considered undocumented if an employee fails to submit a timely medical letter to excuse them. Notwithstanding any provision of this paragraph or policy, sick time hours shall be considered undocumented regardless of whether the employee submits a timely medical letter if and to the extent that the employee has no accrued paid sick leave. Absences that the Commission has excused as family, medical, or other approved leave shall not be considered undocumented sick time.

B. CORRECTIVE ACTION

1. The Commission shall monitor sick leave use on a quarterly basis except that discipline may be imposed during the quarter if an employee's undocumented sick leave is excessive. Employees who are regularly scheduled to work eight (8) hour shifts shall be deemed in violation of this policy and subject to corrective action in accordance with paragraph B (2) of this section if they use twenty five (25) or more hours of undocumented sick time in a quarter. Employees who are regularly scheduled to work ten (10) hour shifts shall be deemed in violation of this policy and subject to corrective action in accordance with paragraph B (2) of this section if they use thirty one (31) or more hours of undocumented sick time in a quarter.

2. Employees shall receive an oral warning the first time they violate this policy. Employees who have received oral warnings shall be subject to discipline in accordance with the following progression for each subsequent violation of this policy:

Written Warning
One (1) Day Suspension
Five (5) Day Suspension
Ten (10) Day Suspension
Discharge

3. A GOOD quarter is a quarter in which an employee has actually worked without violating this policy. An employee who has

received corrective action for violating this policy shall regress one level of discipline in the progression if he/she completes four (4) consecutive good quarters before violating the policy again.

C. ABSENCE WITHOUT LEAVE (AWOL)

1. An employee who fails to call-in to the designated person within thirty (30) minutes after the start of his/her scheduled shift shall be considered absent without leave (AWOL) and may not be permitted to work that day. If the employee is not permitted to work that day, he/she will not be paid and his/her absence shall count as a suspension day for the purposes of this paragraph. Discipline for AWOL shall be imposed progressively in accordance with the following progression:

One (1) Day Suspension
Three (3) Day Suspension
Five (5) Day Suspension
Ten (10) Day Suspension
Discharge

If an employee is AWOL on consecutive days, he/she shall receive one additional level of discipline in the progression set forth in paragraph C (1) for each day that he/she is AWOL upon his/her return to work and, if he/she is AWOL five (5) consecutive days, shall be discharged.

2. Notwithstanding anything in paragraph C(1) to the contrary, an employee who is AWOL for a scheduled voluntary overtime shift shall not be subject to discipline under paragraph C(1). An employee who is AWOL for a scheduled voluntary overtime shift shall receive written notice of their offense, which shall not constitute discipline, and a copy of the notice shall be sent to a representative of the Union. An employee who is AWOL for a scheduled overtime shift after having previously received a written notice pursuant to the preceding sentence shall be disqualified from all voluntary overtime opportunities for a period of time determined by the Department, not to exceed one (1) month. An employee who is AWOL for a scheduled overtime shift after having been previously disqualified from voluntary overtime opportunities pursuant to the preceding sentence shall be disqualified from all voluntary overtime opportunities for a period of time determined by the Department, not to exceed six (6) months. Nothing in this paragraph shall limit or otherwise affect an employee's obligations to perform mandatory overtime.

3. The Chief of Department/designee shall have discretion to excuse an employee from discipline under this section for being AWOL,

provided that his/her discretion shall not be subject to the grievance and arbitration procedures of any collective bargaining agreement.

D. WORK ELIGIBILITY

Any employee who has reported himself or herself absent from his or her assigned shift pursuant to Article 22 (Sick Leave) of the parties' collective bargaining agreement ("CBA") shall be ineligible to work any voluntary overtime and details (but not including swaps previously approved by the Department) for the two shifts immediately following the shift for which the employee reported himself or herself absent pursuant to Article 22 of the CBA, except in the following situations:

1. Where the employee has been subpoenaed or summoned to appear in court or at a deposition as part of his/her official duties;
2. Where the restriction on the employee from working voluntary overtime will result in another Department employee being mandated to work overtime pursuant to CBA, Article 11, Section 5(a);
3. Where an employee attends a Department-run training required to maintain his/her certification and there are no other opportunities to attend the training in the re-certification period;
4. Where an employee works a "Special Event" shift , where a "Special Event" shift is limited to an overtime shift associated with New Year's Eve, New Year's Day, the Boston Marathon, and the Fourth of July;
5. Where the Chief or his Designee has specifically authorized the employee to work notwithstanding his/her ineligibility.

Supervisory / Professional Standards

Awards and Honors

Boston EMS & Boston EMS Relief Association honors are divided into 2 categories: those awarded for valor and those awarded for merit. Honors also differ in the manner in which they are awarded: at an honors ceremony or immediately upon satisfaction of the criteria. For purposes of this document, descriptions will include the following notations:

V–Valor
M–Merit
C–Ceremony
I–Immediately

MEDAL OF HONOR [V, C]
Awarded to any member of the Service who distinguishes himself or herself conspicuously by gallantry and intrepidity at the risk of his or her life above and beyond the call of duty. The deed performed must have been one of personal bravery or self-sacrifice so conspicuous as to clearly distinguish the individual above his or her comrades and must have involved risk of life. Incontestable proof of the performance of the service will be exacted and each recommendation for the award of this decoration will be considered on the standard of extraordinary merit.

MEDAL OF VALOR [V, C]
Awarded to any member of the Service who distinguishes himself or herself by extraordinary heroism not justifying the award of a Medal of Honor. The act or acts of heroism must have been so notable and involved risk of life so extraordinary as to set the individual apart from his or her comrades.

LIFESAVING MEDAL [V, C]
Awarded to members of the Service who are directly responsible for saving a human life through the professional application of life support in an unusual situation and under extreme or adverse conditions.

LEGION OF MERIT [M, C]
Awarded to any member of the Service who has distinguished himself or herself by exceptionally meritorious conduct in the performance of outstanding services and achievements. The performance must have been such as to merit recognition for service rendered in a clearly exceptional manner; service in the nature of a special requirement; or of an extremely difficult duty performed in an unprecedented and clearly exceptional manner. Performance of duties normal to the grade, branch, specialty or assignment and experience of an individual is not an adequate basis for this award.

MERITORIOUS SERVICE MEDAL [M, C]
Awarded to any member of the Service for repeated acts of intelligent and valuable service; demonstration of unusual faithfulness and/or perseverance in patient care or performance of duties; or acts which demonstrate highly credible integrity and loyalty to the Service.

MERITORIOUS ACHIEVEMENT MEDAL [M, C]
Awarded to any member of the Service for an act of intelligent and valuable service; demonstration of unusual faithfulness and/or perseverance in patient care or performance of duties; or an act that demonstrates highly credible integrity and loyalty to the Service.
DR. MICHAEL POZEN EMT/PARAMEDIC OF THE YEAR AWARD [M, C]
Awarded to one Department EMT and Paramedic who distinguish themselves through the exemplary practice of emergency care, contributions to the advancement of EMS, and demonstrations of commitment. Such attributes are felt to carry the legacy of Dr. Michael Pozen, and his surviving family sponsors the awards named for him.
DAVID WILLIAM LASHMAN HUMANITARIAN AWARD [M, C]
Awarded to one Department EMT or Paramedic who best exemplifies the warm, humanitarian, and compassionate manner that David Lashman provided to each and every patient, every day. The Lashman family, in memory of David, sponsors this award.
CHIEF OF DEPARTMENT'S AWARD [M, C]
Awarded at the discretion of the EMS Chief to any Department member who shows outstanding dedication, or who distinguishes him or herself through outstanding actions or services.
EDWARD J. PIKE COMMUNITY SERVICE AWARD [M, C]
Awarded to any Department member who has demonstrated a commitment to community service. This award specifically is intended for a Department member who, through his or her own initiative, enhances the image of Boston Emergency Medical Services in the community.
UNIT CITATION [M, C]
Awarded to any group of Department members, who, *while working as a unit*, distinguish themselves through intelligent, extraordinary action in the line of duty.
DEPARTMENT CITATION [M, C]
Awarded to any Department member who distinguishes him or herself through intelligent, extraordinary action, either on or off duty.
SPECIAL CITATION [M, C]
Awarded to any person, including civilian or member of another Department or service, who distinguishes him or herself through intelligent, extraordinary actions that result in improving Emergency Medical Services, either during a specific incident, or through continuous contribution.
LT GEORGE CARTER MEMORIAL LEADERSHIP AWARD [M, C]
The Lieutenant George Carter Memorial Award for Leadership is awarded to a member of the Boston EMS Relief Association, who, through the years, consistently demonstrates good judgment and supervisory skill, displays compassion to patients, co-workers and others, and understands what needs to be done and does it, often with a sense of humor. The recipient has the courage of his or her convictions and serves as a mentor to anyone who seeks one. His or her advice and counsel is sought out by other members of the Department and is freely given, without thought of recompense. The recipient, in general, best exemplifies the character and quality of Lieutenant George Carter.
BOSTON EMS PRIDE AND PROFESSIONALISM AWARD {M, C}
(Committee)
Awarded to any member who promotes the Department beyond their shift, through dedication of volunteering at union and department sponsored events, acting as a patient care advocate and as a peer who has shown the true compassion of a Boston

EMS member. This is sponsored by the East Coast Training Academy, owner by James Scopa and Edmund Burke.

PRE-HOSPITAL SAVE MEDAL [M, I]
Awarded to uniformed members of the Service who have successfully resuscitated a patient found to be clinically dead prior to delivering the patient to Emergency Department staff.
CERTIFICATE OF COMMENDATION [M, I]
Awarded to any member of the Service whose performance of duty is noteworthy, but not to the degree that warrants recognition in the form of an EMS medal or award.
DEFINITIONS
gallantry n 1: the qualities of a hero or heroine; exceptional or heroic courage when facing danger (especially in battle); "he showed great heroism in battle"; "he received a medal for valor" [syn: heroism, valor, valour, valorousness, valourousness, valiance, valiancy] 2: courtesy towards women [syn: chivalry, politesse] 3: polite attentiveness to women
intrepidity n: The quality or state of being intrepid; fearless bravery; courage; resoluteness; valor; "Sir Roger had acquitted himself of two or three sentences with a look of much business and great intrepidity. —Addison." [Syn: Courage; heroism; bravery; fortitude; gallantry; valor].

Complaint Handling and Disciplinary Procedures

Supersedes: 11-21-05
Effective: 08-14-06

In an effort to improve the delivery of patient care and identify potential opportunities for system improvement, Boston EMS has promulgated the following policy and procedure. It is the goal of this Department to provide the highest standard of patient care and to treat all patients, their family members, and the public with dignity, compassion, and respect. Accordingly, any complaint concerning the quality of care, the way in which an individual was treated by a member of the Department, or system issues will be investigated thoroughly, objectively, and efficiently.

Whenever a person indicates a desire to file a complaint, the Department member so advised will encourage the complainant to speak to a supervisor and shall facilitate the referral in any way possible. Personnel will not dissuade a member of the public from filing a complaint or, if so authorized to receive a complaint, shall not refuse to do so.

DUTY TO COOPERATE

All employees of Boston EMS, regardless of rank, have a duty to cooperate during any Commission or departmental investigation. Cooperation includes being truthful and complete in the answers or statements provided. In order to preserve the confidentiality and integrity of a Professional Standards investigation, employees may sometimes be ordered by the investigator to not discuss the nature of the investigation, or the details of their interview, or in some cases even the fact that there is an investigation in progress.

DOCUMENTATION

Boston EMS utilizes an administrative incident management software tool as the primary means to record complaints against the department or any of its personnel, whether from citizens, outside agencies, hospitals or members of the Department. The initial documentation shall contain a detailed description of the nature of the complaint, including date; time and place; names or descriptions of Department employees involved in the incident; the names and addresses of witnesses, if known; and any other relevant information. Should the computerized data collection tool be unavailable, or the individual processing the complaint is not trained in its use, a complaint control form shall be used to record receipt of the complaint.

MANNER OF RECORDING COMPLAINTS

All complaints shall be received and recorded courteously. No person shall be denied an opportunity to register a complaint. When the information received from the complainant includes the complainant’s name and address, the supervisor taking the complaint shall inform the complainant that he or she will be contacted by a member of the Department assigned to investigate the complaint. The complainant shall be advised to telephone Boston Emergency Medical Services’ Professional Standards

Division at the EMS Administrative Headquarters if not contacted by a member of the Department within seventy-two hours of making the complaint.

1. Walk in Complaints: Whenever a person indicates a desire to make a complaint, that person shall be directed to a member of the Professional Standards Division or the nearest available supervisor or manager. If necessary, the complainant shall be assisted in making contact with a supervisor.
2. Telephone Complaints: Complainants contacting Dispatch Operations by telephone shall be referred to the Dispatch Operations Supervisor. If the supervisor is unavailable, the EMT Telecommunicator taking the call shall request the caller's name and call-back number. If the caller prefers to remain anonymous, the telecommunicator should encourage the caller to call back later when the supervisor is available or contact the Professional Standards Division at Boston EMS Headquarters during business hours. Complainants contacting any other areas of the Department by telephone shall be transferred to the Professional Standards Division or, if not available, to a supervisor who will obtain as much information as possible from the complainant and document receipt of the complaint. In no case shall a telephone complaint be refused because a supervisor is unavailable or because the complainant is not identified.
3. Written Complaints: Complaints received via letters, email, or other written form shall be immediately forwarded to the Professional Standards Division. A supervisor assigned to the Professional Standards Division will document receipt of the complaint and attach the written document (letter, email, fax, etc).
4. Complaints by a Department member alleging conduct that violates rights protected by law specifically of a sexual, racial, gender, sexual orientation, religious, national origin or age nature shall be recorded and processed in accordance with the Boston Public Health Commission's Anti-discrimination, harassment, and Retaliation policy.

IMMEDIATE RESOLUTION OF COMPLAINTS

All complaints, including those involving lost or missing property, resolved at the time of the initial complaint to the complainant's satisfaction shall be documented with a notation of the resolution and forwarded to Professional Standards Division.

NOTIFICATION OF PROFESSIONAL STANDARDS DIVISION

In addition to Professional Standards, the Chief of Department, Superintendent in Chief, and Superintendents (C1-5 in the paging system) and the Medical Director shall be notified immediately (24 hours/day, 7 days/week) upon receipt of a complaint of a major case alleging:

1. Physical abuse, death or serious injury resulting from the action or inaction of a Department employee;
2. The commission of a felony by a Department employee;
3. Major motor vehicle crash of a department vehicle resulting in any death or serious injury;

This immediate notification will be in addition to and separate from notifications that may be required in other procedures. If there is no response to the initial page, subsequent pages or alternate means of notification (cellular phone, etc.) shall be attempted.

MONITORING OF COMPLAINTS

Each complaint shall be assigned a unique identifying number so that the processing of complaints can be monitored.

The Professional Standards Division shall maintain a log of all complaints. The log shall record the complaint control number, the date the complaint was received, the name and rank of the supervisor who recorded the complaint, the name of the investigating department member, the date closed, and final disposition.

The Professional Standards Division will maintain a file of all cases investigated, including but not limited to any Complaint Control Form, tape cassettes, patient care reports, incident reports, investigatory reports, and response letter.

CONFIDENTIALITY OF INVESTIGATORY PROCESS

Records of the Professional Standards Division are considered confidential, and will be maintained in a secure manner. Prior to the completion of the investigation of a complaint, information concerning such an investigation shall not be released unless authorized by the Chief of Department or PHC General Counsel. The fact that a complaint was received and a departmental investigation is under way may be disclosed unless the Professional Standards Division determines that for security reasons or to protect the integrity of the investigation, that too should remain confidential.

INITIATING AN INVESTIGATION

Upon receipt or notification of a complaint concerning an employee on his or her shift or division, the Shift Commander or area manager will determine whether the matter can be appropriately dealt with at the shift level. Generally, types of complaints handled at the shift level involve relatively minor infractions such as tardiness, improper uniform, or other minor procedural errors. In such cases, the Shift Commander or area manager will document receipt of the complaint, and initiate an investigation or appoint an investigating officer. The Professional Standards Division will be notified of the complaint as soon as possible and may intervene at any time to assume control of the investigation. The Professional Standards Division will be kept informed about the status of all investigations in a timely manner.

If the Shift Commander or commanding officer determines that the complaint is not appropriate for investigation at the shift level, it shall be referred to the Professional Standards Division for investigation. In such cases, the Commander of the Professional Standards Division shall appoint an investigating officer, or may return the complaint to the commanding officer of the person that is the subject of the complaint for investigation at the shift level.

Upon receipt or notification of a complaint, the Commander of Professional Standards will make a determination whether the matter can be appropriately dealt with at the shift level. In such cases, the matter will then be referred to the appropriate Shift

Commander or commanding officer of the employee involved. If the complaint investigation will be conducted by the Professional Standards Division, the Shift Commander or manager of the person that is the subject of the complaint will be advised of the general nature of the complaint unless such notification might compromise the integrity of the investigation. The complainant, if known, will be sent a letter by Professional Standards within 72 hours of making a complaint indicating a contact person, telephone number, and the complaint control number.

A member of the Department who is identified as the subject of an investigation will be formally notified of the investigation as soon as possible so long as such notification would not jeopardize or compromise the investigation. An employee against whom a complaint has been made or any coworker shall not attempt, directly or indirectly, by threat, appeal, persuasion or the payment or promise of money or other things of value, to secure the withdrawal or abandonment of the complaint, or in any way penalize the complainant. Such actions will be dealt with very strictly by the Department.

In an effort to continually improve the quality of patient care rendered and as part of the overall investigation, the Medical Director or designee will review matters under investigation that involve a potential patient care issue. RTQI will assist in the determination as to whether the patient care was appropriate and in accordance with Department treatment protocols and standards. The results of these reviews shall be included in the quarterly reports compiled by the Professional Standards Division and provided to the Chief of Department and Medical Director.

All investigations will be conducted professionally and with prudence. At no time shall an investigator engage in any technique which violates civil or criminal law, Department policy or procedure, or the appropriate collective bargaining agreement in effect at the time of the investigation.

FACT-FINDING INTERVIEWS OF MEMBERS OF THE DEPARTMENT

The following provisions shall apply whenever, as part of an investigation of alleged violation of Department Policies and Procedures, a member of the department is ordered to submit to a fact-finding interview:

1. A fact-finding interview of a member of the department shall be at a reasonable hour, preferably when the member of the department is on duty, unless the urgency of the investigation dictate otherwise. No member shall suffer loss of pay for the time spent while being interviewed.
2. The fact-finding interview shall take place at a location designated by the investigating officer. If a member of the department is directed to leave his/her post and report for an interview, the commanding officer or shift commander shall be promptly notified of the member’s whereabouts.
3. Whenever possible, interviews conducted as part of a Professional Standards investigation should be audio recorded or recorded by a stenographer.
4. The subject of the fact-finding interview may be entitled to have representation present during the interview. The representative(s) may not be another employee who is identified as being involved in the same allegation or incident. The

representative may participate to the extent permissible by law, but may not answer questions for the employee or unduly interfere with the interview.

5. If the interview becomes extended in duration, reasonable periodic breaks will occur.
6. The subject of the interview will be treated with courtesy and respect during the interview. There will be no offensive language, coercive behavior, threats of punitive action, or promises of reward. Employees must truthfully answer questions regarding matters pertaining to the scope of their employment and their fitness for duty posed by an investigator in an administrative investigation.
7. Prior to the administrative interview, the employee will be advised in writing (or orally, if the interview is being conducted by telephone and the conversation is recorded) of the following:

> Your failure to provide the information requested, including any evasiveness, false statements, or failure to comply with any of the instructions given to you in connection with this investigation, may lead us to consider allegations against you as unchallenged or unrefuted. In addition, your failure to cooperate may lead to disciplinary action against you, including dismissal.

SEARCHES

Desks, lockers, storage space, rooms, offices, equipment, information systems, work areas, and vehicles that are the property of the Department are subject to inspection. They may also be searched to retrieve Boston EMS, Boston Public Health Commission, or City of Boston property, or to discover evidence of work related misconduct, if there is reason to suspect such evidence is there. Private property can be stored in areas mentioned above; however, employees should not expect privacy in those areas. Only those employees who are acting in their official capacity may be authorized by the Chief of Department, Superintendent-in-Chief, or Superintendent to search or inspect areas assigned to other employees.

INVESTIGATIVE REPORT

Complaint investigations should be completed and a summary report prepared within 30 days of the initiation of an investigation, though not at the expense of a thorough, objective investigation. If an investigation requires additional time to complete, the Superintendent of Field Support may authorize an extension of seven (7) days, however a status report must be submitted documenting the justification for the extension. There is no limit on the number of extensions that may be granted, providing there is adequate justification.

The investigator's report will summarize all evidence gathered during the investigation and will make a recommendation that the complaint be found:

1. Exonerated: The investigation showed that while the actions did occur, either the named employee was not involved, or the employee acted properly and reasonably; or
2. Unfounded: The investigation revealed the alleged conduct did not occur; or
3. Not Sustained: The investigation failed to prove or disprove the allegations. This definition also includes incomplete investigations. An incomplete investigation is an

investigation that cannot be thoroughly or properly completed due to lack of cooperation by the complainant or witness(es) and / or physical evidence is not available.

4. Sustained: The investigation disclosed sufficient evidence to support allegations in the complaint; or
5. Misconduct Not Based on Complaint: There is substantiated evidence of employee misconduct that was not identified in the original complaint, but which was disclosed as a result of the investigation.
6. Policy/Procedure: The allegation is true, and although the action of the agency or individual is not inconsistent with existing agency policy or procedure, the complainant suffered harm.

Once submitted, the Commander of Professional Standards will review the investigatory report to ensure the investigation was adequate and the summary report is complete before forwarding up the chain of command for further review and disposition.

CORRECTIVE ACTION GUIDELINES FOR SUSTAINED ALLEGATIONS

A number of factors will be taken into consideration when deciding the appropriate disposition of an internal investigation that results in a “sustained” finding. While these decisions will be as inclusive and collaborative as possible, often times involving the Commander of Professional Standards; Shift Commander; Superintendents; PHC Labor Relations and Human Resources Department; and the EMS Medical Director, the ultimate authority for the adjudication of culpability and disposition of sustained complaints rests within EMS with the EMS Chief and within the Commission with the Executive Director.

SPECTRUM OF DISCIPLINE

Some collective bargaining agreements stipulate the terms under which disciplinary action may be taken, and how such action is recorded. All disciplinary matters shall be handled in accordance with applicable collective bargaining agreements and civil service law. In general, the spectrum of discipline is as follows:

Oral Counseling: An oral counseling is generally given for minor violations or multiple minor violations of the rules and regulations. A Supervisor issues this counseling formally and makes it clear to the involved member that while the counseling itself is not considered discipline, further violations will result in progressively stricter disciplinary action. The issuing supervisor will complete a written record of the oral counseling session, and a forward a copy to the employee’s Shift Commander or Manager, and the Professional Standards Division.

Written Warning. Written warnings are issued or approved by a member of the Command Staff for minor offenses committed by employees for whom an oral counseling has proven ineffective, or for more serious offenses in which an oral counseling would be inappropriate. A copy of the written warning and all of the particulars relating to the offense will be sent to Professional Standards who in turn will forward a copy to PHC Office of Labor Relations and Human Resources.

Suspensions. Suspensions are periods of time during which an employee is relieved of duty and for which the employee is usually not paid. Whenever the Department is contemplating imposing a suspension of several days without pay, the employee may be entitled to a hearing in accordance with applicable collective bargaining agreements or civil service law.

Immediate Relief of Duty: Upon determination by a supervisor that an employee is in severe violation of the rules of conduct or other Department rule or regulation or is otherwise unfit for duty, he / she shall immediately temporarily relieve such person from duty and notify the Shift Commander or other member of the Command Staff. In circumstances making such action advisable or necessary, a member of the Command Staff may relieve a member from duty for the remainder of the shift pending further disciplinary action. A detailed written report of such action will immediately be forwarded to Professional Standards. Additional notifications of appropriate supervisors and Command Staff shall be performed as required. Whenever an employee is relieved of duty, emergency suspension from duty is not in and of itself a disciplinary measure. An employee may be required to report to work as directed (to the EMS Headquarters for example) or contact the Department for instructions on scheduled work days. All pay and benefits shall continue uninterrupted during any emergency or administrative suspension from duty.

Discharge or Reduction in Rank. An employee may be discharged or reduced in rank only after a formal department hearing or waiver of such hearing by the employee.

NOTIFICATIONS

If the investigation was inaugurated by a complaint from outside the department, upon completion of the investigation the Commander of the Professional Standards Division or designee will send a letter to the complainant informing him or her that the matter was investigated is now closed.

The accused employee will also be notified in writing of the final disposition of each allegation. This notification will occur as soon as practical after the disposition is made.

OVERSIGHT OF THE INVESTIGATORY PROCESS

The Superintendent of Field Support shall review all cases in an effort to identify trends, which represent opportunities for improvement in the Department’s policies and procedures. The Professional Standards Division will provide a quarterly report concerning the status of investigations to the Superintendents, Superintendent in Chief, Medical Director, and Chief of Department.

Department Cameras

Supersedes: 03-05-04
Effective: 06-01-09

The department issued cameras and associated equipment are intended to aid Supervisory personnel in the collection and documentation of pertinent physical conditions at the scene of an incident. The priority use should be to document the presence or absence of dynamic or perishable conditions during the course of an investigation or other Department related matter.

1. The daily vehicle inventory or “check-out” should include ensuring that any Department issued camera and related equipment is present and appears to be in good condition. Missing and/or damaged equipment should be reported to the Shift Commander.
2. The loaning of the camera, memory card medium, or other accessories to non-Department or non-Supervisory personnel without the express permission of a member of the BEMS Command Staff is prohibited as is the use of the camera or any of its related equipment for non-Department related matters.
3. As part of a thorough investigation, in addition to collecting applicable incident reports and / or witness statements, Supervisors are encouraged to photograph the following types of situations:
   - 3.1. Property damage allegedly caused by a department vehicle or member (see #4)
   - 3.2. Preservation of physical evidence involving an alleged infraction of Department Rules and Rules and Regulations, or Standard Operating Procedure
   - 3.3. Potential health or safety concern, or failure of a critical piece of equipment.
   - 3.4. Documentation of a patient’s environment where the mechanism of injury appears inconsistent with the patient’s physical presentation. For example, assisting emergency department personnel by documenting severe vehicle damage in the case of a patient presenting with relatively minor injuries.
   - 3.5. Any other situation in which the Supervisor feels photographs would be useful in the investigation or documentation of an incident.
4. The Boston Police Department’s Identification Unit is the primary unit responsible for photographic documentation of major or personal injury crashes involving City or Department vehicles, and can be called for twenty-four (24) hours a day through Dispatch Operations. Collecting photographic evidence at the scene of an incident involving personal injury will be considered secondary to ensuring adequate patient care is being provided and coordinating the EMS response to the incident. Once these primary duties and responsibilities have been met, Supervisors may document photographic evidence at a crash scene in conjunction with the BPD ID unit, or while awaiting their arrival.

5. At the end of each photographic session, the memory card should be removed from the camera and placed in a plastic protector case. The memory card should then be delivered to EMS Headquarters either in person or via inter-department mail along with the MVC paperwork, and other incident reports as required. Please note which vehicle the memory card(s) came from so that the Profession Standards Division can keep a ready stock of cards available in each vehicle.
6. Photographs will be downloaded and labeled by Professional Standards, and the memory cards will then be returned to the appropriate vehicle. At least three memory cards will be issued with each camera, thus ensuring an adequate supply.

7. Any photographs containing individually identifiable information are covered by the HIPAA Privacy rule and must be protected in the same manner as patient care reports and other such documentation.

8. Any on-scene images and any other images taken by an employee in the course and scope of their employment are solely the property of Boston EMS and not the property of the individual department member. This includes any image inadvertently taken with a department member's personally owned cell phone camera or other digital imaging device.

9. Except for the provisions noted in section 5 and 6 of this policy, no images taken by an employee in the course and scope of their employment may be used, printed, copied, scanned, emailed, posted, shared or distributed in any other manner without prior approval by a member of the Boston EMS Command Staff. This prohibition includes posting photos or videos on personal websites such as FaceBook or MySpace, or on websites such as YouTube, or emailing images to friends or colleagues.

Boston EMS Public Information Plan

Supersedes: Media Relations 02-19-98 & Media Inquiries 03-16-98
Effective 12-20-17

I. INTRODUCTION

Boston EMS, the City's municipal 9-1-1 emergency medical services provider and a bureau of the Boston Public Health Commission (BPHC), responds to over 122,000 clinical incidents per year, with as many as 400 or more incidents in a day. Requests for information from local media outlets is commonplace and may vary from a single inquiry verifying transport from an incident location to more complex requests for information.

Boston EMS department members may not represent the department, with the media or in any other public forum, outside of their normal duties, without explicit authorization, as set forth in this document.

II. PURPOSE

The Boston EMS Public Information Plan serves as a communication guide for the department. This plan is inclusive of all forms of public communication, including television, print, digital and radio media inquiries, social media, press releases, speaking engagements, public recognitions, interviews, and requests for information/data. It will also serve as a guide for the role of public information officer, within the construct of the Incident Command System (ICS).

This plan will assist Boston EMS in meeting its operational mission as well as public information obligations. Effective and accurate communication can help ensure credibility, strengthen public trust and promote lifesaving measures.

The Public Information Plan will describe how Boston EMS will respond to varying requests for public information and the flow of communication following the initial request. Furthermore, this plan defines the activities that should take place depending on the level of the incident and at different stages of the emergency response, including notification to the BPHC Communications Office, as well as Boston EMS's participation at a joint information center (JIC).

This plan outlines key assumptions for the response to public information requests, refers to relevant legal authorities and defines the roles and responsibilities for managing public information requests. It is designed to work in-concert with BPHC, city, state and federal plans. It addresses the evolving spectrum of activities related to communications during incident management response and recovery actions.

III. ORGANIZATION & AUTHORITY

Within Boston EMS, the Chief of Department serves as the spokesperson and lead authority for public information decisions and requests. As a bureau of the BPHC, Boston EMS is supported by the BPHC Communications Office. When authorization from the BPHC Executive Director and/or the Mayor's Press Office, is required, this is coordinated by the Office of the Chief, through the BPHC Communications Office.

IV. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Boston EMS patient records are considered Protected Health Information (PHI), any disclosure of information pertaining to one or more incidents, must comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Protected individually identifiable health information is information that relates to:

- the individual's past, present or future physical or mental health or condition,

- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual,
- and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual (including name, gender, address and birthdate).

This information can only be shared if a HIPAA release form is signed by the patient or the patient's guardian.

V. INCIDENT COMMAND SYSTEM AND THE PUBLIC INFORMATION OFFICER ROLE

As a first response service, Boston EMS organizes much of its day-to-day functions in a manner consistent with the Incident Command System (ICS). ICS is designed to be flexible, with the ability to expand, as appropriate, given the scale, complexity and duration of an incident. Responsibility and authority begins with the Incident Commander (IC), who is typically the senior ranking person on scene. Within the ICS structure, the Public Information Officer (PIO) functions and responsibilities fall under the prevue of the IC, assuming he or she is a Supervisor or member of Command Staff, until a PIO is designated.

The PIO may gather, verify, coordinate and disseminate accurate, accessible, and timely information, in accordance with the guidance set forth below.

VI. INCIDENT-SPECIFIC MEDIA REQUESTS

Requests for public information, associated with recent or active incidents, are generally categorized into (A) day-to-day small-scale routine incidents of media interest, with requests to verify transport of patient(s) and receiving hospital(s) or (B) larger scale / high profile events, which may last multiple hours or days.

Unless authorized by the Chief of Department, Boston EMS personnel may not make an unsolicited notification to the media regarding an incident.

A. Routine Incident Requests

Local media outlets routinely submit requests for information pertaining to active or recent incidents, usually occurring in a public location, where they seek to augment their story with confirmation of EMS transport.

1. Communication Protocol

Because such incidents have a relatively short on-scene time and requests for information may occur after Boston EMS has left the scene, it is unlikely that a PIO will be designated. For this reason, anyone in the following rank, role or office may respond to such inquiries:

- On-duty Field Supervisor or Captain (if he or she responded to the incident)
- Dispatch Operations Supervisor or Deputy Superintendent
- On-duty Shift Commander
- Superintendent of Operations
- Superintendent in Chief
- Office of the Chief
- Medical Director
- BPHC Communications Office

Those authorized to speak about such incidents may provide the following information, if approached by the media:

- Verify whether we responded to the location,
- Note the number of patients and how many were transported
- Provide the disposition (numbers evaluated, treated, transported, and/or referred to the medical examiner) and receiving hospital breakdown
- Their name and rank/title, to serve as the source of the information (if desired)

Under the following circumstances, Boston EMS personnel should limit information to ONLY verifying a response:

- Incidents involving other public safety personnel, whether they are a patient or directly connected to the incident.
- Any incidents that involve a police investigation, such as a shooting, stabbing or domestic violence. In such scenarios, publicly disclosing disposition(s) or receiving hospital(s) may place patient safety at risk.

As with all requests for information, the person communicating the information will use discretion when disclosing incident-specific information. Personnel shall not provide names of department members or unit designations that responded to an incident, without approval.

AS SOON AS POSSIBLE after communicating information to the media, the Office of the Chief (including the Chief of Department, Chief of Staff and Deputy Chief of Staff) and BPHC Communications office must be notified, either via an email to media@bostonems.orgor a phone call to any one representative within either office, who will then notify others. The notice should include the name of the media outlet the information was provided to and a brief summary of what was communicated.

B. Large Scale / High Profile Incidents/Events

Large scale responses, such as mass casualty incidents, disasters and special events may lead to an increase in requests for information from local and national media outlets. These requests can range from questions about response activities (i.e. resources involved) to the number of patients encountered and/or transported. The IC shall notify the Chief of Department as soon as possible, if he is not already aware of the incident. As a default, the PIO role will follow ICS protocol, with the Boston EMS IC taking on that function, unless someone else is designated. The Chief of Department may opt to serve as the spokesperson for the incident, even if he is not the IC, and/or may designate a PIO. Alternatively, it may be determined that all communication is routed through a Joint Information Center (JIC), the BPHC Communications office or the Mayor's Press Office.

1. Communication Protocol

Although the PIO is bound by the same constraints regarding what can and cannot be communicated to the media (as set forth in the previous section), a more protracted incident may allow for additional detail pertaining to response and recovery operations, as well as safety.

If there is an opportunity for further communication, the PIO may also consider:

- Promoting the hard work of department members, the difficult conditions and physical demands they face, as well as their dedication to serving others.
- Explaining the measures Boston EMS takes to prepare for responding to such incidents, including training, exercises, drills, interagency coordination, planning, and equipment investments.
- Providing guidance on safety and injury prevention efforts the public can take to avoid or prepare themselves for such events.

In the case of multi-patient incidents, the PIO may make the determination to provide additional incident information regarding age group (such as 'adults' or 'minors') or injury status (i.e. 'non-life threatening') to avoid confusion and/or incorrect assumptions.

Boston EMS personnel are advised against representing the work of our public safety partners. The focus of any communication to the media should be on our work, the incident at hand, and what we know; assumptions, opinions, generalities, information on trends and off-topic inquiries should be avoided.

AS SOON AS POSSIBLE after communicating information to the media, the Office of the Chief and BPHC Communications office must be notified, either via an email to media@bostonems.orgor a phone call to any one representative within either office, who will then notify others. The notice should include the name of the media outlet the information was provided to and a brief summary of what was provided.

The Boston EMS Office of the Chief, upon notification to the BPHC Communications office, and in coordination with the PIO, may convey incident summary information (e.g. patient counts, disposition and hospital distribution) via social media, to mitigate continued demand for updates during an active incident.

2. Joint Information Center

Significant incidents may require a press conference and/or establishment of a joint information center. Decisions about who to represent the department will be made by the Chief of Department.

Depending on the severity of an incident/emergency a Joint Information Center (JIC) may assume the primary responsibility for all public information efforts and media relations activities. In the event that a JIC is to be established and Boston EMS personnel are requested at the JIC, the Chief or his designee will assign a PIO to the JIC, in coordination with the BPHC Communications Director. The PIO(s) staffing the JIC will attend media briefings and be responsible for bi-directional communication, feeding information in and ensuring relevant information is communicated back out to appropriate parties within Boston EMS.

VII. REQUESTS FOR INFORMATION/DATA

In addition to incident-specific media requests, Boston EMS receives a substantial number of inquiries pertaining to other aspects of department operations, which typically come in the form of interview and/or data requests. Examples of topics include the impact of extreme weather (i.e. heat, cold, storms), marathon bombing lessons learned, special event/disaster preparedness efforts, trends associated with specific incident types (such as Narcotic Related Illness), ambulance response times, and call volume statistics.

In all such instances, prior approval is necessary before speaking to the media or communicating the information to any external party, principally to ensure the department provides a vetted and uniform message. Although recipients of media requests are often determined to be best suited to represent the department, the Chief may opt to respond himself or select another person. In anticipation of media requests, such as in advance of a storm or special event, the Chief of Department may communicate with Command Staff to provide messaging language and pre-authorization to individuals who may be approached by the media.

In the case of data requests, any communication of department data, whether to the media or any third party, that has not already been made public by Boston EMS, must be approved by the Chief of Department. Because a department member has access to data is not an inherent authorization to share that data with others. It is imperative that any data communicated outside of the department has been vetted and is consistent with other instances of sharing similar data. Additionally, Boston EMS is responsible for ensuring the department's data is not misrepresented by others. For this reason, restrictions are often placed on recipients to ensure they adequately site Boston EMS as the source and accurately represent the information.

For all other requests, the requester should be referred to the media@bostonems.orgemail (which includes representatives from both the Office of the Chief and Communications Office). If an immediate response is required, the person receiving the request should provide the BPHC Communications Office phone number, which serves as the public line for all media requests. For urgent requests, the department member receiving the inquiry may also notify a representative from the Office of the Chief by phone (the Chief of Department's phone number should never be provided to the media). The Boston EMS Office of the Chief and BPHC Communications Office will work collaboratively to address the request. If BPHC Executive Director or Mayor's Office approval is necessary, the BPHC Communications Office will coordinate such authorizations.

Inquiries may also come in the form of a public information request, which would require a formal response from the Boston Public Health Commission General Counsel's office. The General Counsel's Office will work in coordination with the Office of the Chief, Professional Standards, and/or BPHC Communications Office to respond to the request.

VIII. PRESS RELEASES/PROMOTING A GOOD STORY

Boston EMS department members save lives on a daily basis; it is not uncommon for both internal personnel and members of the public to brush off the heroism associated with these "routine" accomplishments. That said, certain situations do cause individuals within the department to take pause and determine that praise, beyond an internal commendation, is warranted. Such opportunities serve to highlight the great work of individuals, while also shedding light on the tremendous dedication, skill and accomplishments of all department members.

For these instances, as well as other occasions, such as graduations and awards banquets, where the opportunity arises for Boston EMS to be the subject of a positive story, efforts can be made to entice the media. The most common method of engagement is via Twitter, although formal press releases may also be drafted. These efforts are managed through the Office of the Chief, in coordination with the BPHC Communications Office.

IX. REQUESTS FOR AN EMS REPRESENTATIVE

Boston EMS is nationally recognized as a leader in EMS and personnel are often called upon to speak on the department's behalf. Requests come in various forms and frequently through informal channels. When a department member is asked to speak or participate in a public forum or on a committee, by virtue of their role and/or work at Boston EMS, they are inherently serving as a representative of the department. All such requests should be sent to the Office of the Chief, to ensure they are vetted and approved by the Chief of Department (as well as any other necessary parties). This is inclusive, but not limited to, the following scenarios:

- Requests to present or serve on a panel at conferences, educational forums, public events, etc.
- Press conferences, whether speaking or standing on stage
- Requests to represent Boston EMS on a committee
- Requests to be honored or spotlighted, or select another department member to be recognized
- Any other situation where the individual is identified as a representative of Boston EMS, including, but not limited to, in-person or television appearances, as well as radio, print, or online journals/blogs

It is not uncommon for multiple individuals within the department to be contacted for such requests, leading to confusion and duplication of efforts. And, even small-scale events, can have influential attendees, where it is essential the Chief is aware of and has authorized the person to represent the department.

Ultimately, the Chief is accountable to the department as a whole, as well as his superiors, including the Executive Director and Mayor. It is imperative he is not only aware of, but has provided authorization for, all public references to Boston EMS and its membership.

SOCIAL MEDIA

Social media is an important tool in promoting the department and disseminating timely information. Boston EMS manages both a Facebook (www.facebook.com/officialbostonems) and Twitter account (@Boston_EMS). Both accounts are managed by the Boston EMS Office of the Chief. All members of the department are encouraged to provide feedback and suggest stories to promote on social media.

For personal social media accounts, Boston EMS personnel must comply with any current and future guidelines set forth by the department, Boston Public Health Commission and City of Boston. Boston EMS does not have an official policy regarding personal social media accounts,

although current policy, prohibiting disclosure of patient protected health information and taking unauthorized pictures of patients/incidents, would extend to social media.

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http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/index.html

Releasing Tapes to Media

Supersedes:
Effective: 06-30-97

1. The ability of EMT-Telecommunicators to quickly calm down a caller and provide pre-arrival instructions is often instrumental in saving a patient's life. Requests from the media for copies of these tapes shall be referred to the on-duty Shift Commander or Commander of Dispatch Operations.
2. A determination will be made as to whether the request will be honored at which time the established procedure for obtaining a copy of the Master logging tape shall be followed.
3. A member of the Command Staff shall listen to the tape to ensure its appropriateness for release.
4. The caller who made the 9-1-1 call shall be contacted and allowed to hear a copy of the tape.
5. A waiver will be signed by the caller (or guardian in the case of a minor) prior to making the tape available for duplication by the media.

See related SOP: "Master Logging Tape: Duplication" & "Tape Release To Media Form"

Video Monitoring System (LiveWave)

Supersedes:
Effective: 04-14-08

Boston EMS has been granted limited use of the Boston Police Department's LiveWave closed circuit video system (CCTV) for the purposes of improving the delivery of services and enhancing the safety of the public and responders within the City of Boston. Authorized BEMS users will operate the system in accordance with established BEMS and BPD Policy and Procedures related to the equipment.

1. Authorized BEMS Personnel shall use the LiveWave system in accordance with policies and procedures established for its use. The system should not be used when there is a reasonable expectation of privacy by citizens.

2. During any joint agency event, BEMS should contact the BPD LiveWave representative or the UCC LiveWave operator before taking camera control (see FirstView Training and User Manual), and camera view shall always be returned to the original selection.

3. The BPD is responsible for maintaining video data. All data, except evidentiary recordings, but including routine recordings, activity logs, and procedures regarding the CCTV system shall be considered public information unless otherwise classified under MGL Ch 4 Sec. 7 Clause 26th (f).

4. The Commander of the Dispatch Operations Division shall submit a list of BEMS personnel to the BPD Chief, Bureau of Field Services (and/or designee) for approval and authorization to operate the LiveWave system.

5. BEMS Personnel authorized to operate the CCTV system shall be familiar with and shall abide by the policies and procedures regarding its use contained in the BPD CCTV Policy.

6. The BPD superior officer in charge of compliance shall periodically monitor operation of the CCTV system to ensure that operators are complying with all policies and procedures.

Guidelines for Appearing as a Witness in Legal Proceedings

Supersedes:
Effective: 11-15-05

I. Introduction

Boston EMS personnel testify at trials, depositions, and other legal proceedings several hundred times each year. Sometimes they testify as witnesses in civil lawsuits as employees of the Boston Public Health Commission when the Commission is sued as a result of either a motor vehicle crash involving EMS personnel or care and treatment rendered by EMS personnel in emergency situations. In these cases, the Boston Public Health Commission's General Counsel's Office is defending lawsuits that directly relate to EMS employees alleged involvement as drivers of EMS vehicles or as caregivers in emergency situations.

In addition to the Boston Public Health Commission litigation cases in which EMS personnel are directly involved, EMS personnel may testify in civil lawsuits involving personal injury or other civil matters that do not involve the Commission.

More frequently, EMS personnel appear on behalf of the state government in criminal prosecutions. Because EMTs and paramedics respond to crime scenes regularly, and because they arrive almost immediately after the crime has occurred, they often possess information not available from any other source. As a result, the testimony of EMS personnel may play a crucial role in the outcome of a criminal trial.

EMTs and paramedics who understand the workings of the legal system make better witnesses. The purpose of these guidelines, therefore, is to prepare Boston EMS personnel for appearances at trials and other legal proceedings.

II. Overview of the Criminal Trial Process

The Massachusetts criminal court system consists of one Superior Court and several district courts in each county. Superior Courts have jurisdiction over felonies—crimes that carry a sentence of at least two and a half years in state prison. Lesser crimes, known as misdemeanors, are tried in the district courts. Many of Boston's neighborhoods have their own district courts, including South Boston, Dorchester, and Roxbury. The district court for downtown Boston is called Boston Municipal Court (BMC).

The Suffolk County District Attorney's Office or the Massachusetts Attorney General's Offices are responsible for prosecuting state crimes committed in Boston. For this reason, the district attorney's office and its personnel are known collectively as "the

prosecution." At least one assistant district attorney (ADA) or assistant attorney general represents the prosecution at each criminal trial. The person accused of the crime is called the defendant. A defendant may be represented by a privately-hired attorney, or, if indigent, by an attorney appointed and paid for by the state.

Criminal proceedings in the district courts begin with the filing of a written complaint by a crime victim, a police officer, or by the district attorney's office. The complaint identifies the defendant and the crime with which he is charged. In Superior Court, the process is somewhat more complex. There, an ADA presents evidence to a 23-member grand jury in a closed proceeding. If, after viewing the ADA's presentation, at least 12 of the 23 grand jurors agree that the defendant probably committed a crime, then the court issues a document known as an indictment, and the case proceeds to trial. Otherwise, the charges are dismissed.

Criminal jury trials, federal and state, consist of the following events:

• *Jury selection*. The prosecution and defense must agree on six jurors for district court trials, and 12 jurors for Superior Court trials. In addition, the judge usually requires the selection of one or more alternates, to serve in the event that a regular juror becomes unavailable or incapacitated. This process may take as little as one hour, or, in particularly complex or high-profile cases, as long as several weeks.

• *Opening statements*. Each side describes the merits of its case to the jury, and outlines the evidence it intends to present. The prosecution goes first; the defense makes its statement afterward.

• *Presentation of evidence*. The prosecution shows charts, photographs, weapons, articles of clothing, and other items to the jury in an effort to prove beyond a reasonable doubt that the defendant committed the crime with which he has been charged. The most persuasive evidence may be the testimony of witnesses who have personal knowledge of the events surrounding the crime. Boston EMS personnel generally testify during this point in the trial. After the prosecution has completed its presentation, the defense presents its own evidence.

• *Closing arguments*. Each side summarizes the evidence. The defense urges the jury to find the defendant not guilty; the prosecution urges the jury to convict.

• *Jury Instructions*. The judge instructs the jury regarding the law.

• *Jury deliberation*. The jury retires to decide in private whether the prosecution has proven, beyond a reasonable doubt, that the defendant committed the crime as charged. The verdict—guilty or not guilty—must be unanimous among all jurors. If the members cannot agree, the judge may declare a mistrial, and another trial may be held, from the beginning.

• *Announcement of verdict*. One member of the jury, designated by the judge as foreman, announces the vote of the jury.

Criminal trials usually include the following participants:

• *Judge*. The judge acts as a referee, making decisions about what type of evidence the jury may hear, resolving disputes between the prosecution and defense, and overseeing the trial in general. The judge sits at the head of the courtroom, in an elevated chair known as a “bench.”

• *Prosecutor*. The goal of the prosecutor is to convince the jury to find the defendant guilty. Generally, the prosecutor sits at a desk facing the judge, to the judge’s left. In a state court, the prosecutor is an Assistant District Attorney or an Assistant Attorney General. In federal court, the prosecutor is an Assistant United States Attorney.

• *Defense attorney*. The defense attorney represents the defendant. Usually the defense attorney sits at a desk facing the judge, to the judge’s right.

• *Defendant*. The person accused of committing a crime.

• *Witnesses*. These individuals provide information, called testimony, that helps to determine whether the defendant is guilty or innocent.

• *Jury*. The members of the jury observe the presentations of the prosecution and defense and listen to the testimony of the witnesses. At the end of the trial, they decide whether the defendant is guilty or not guilty. The defendant has a right to waive a trial by jury, and have the judge rule on his guilt instead.

• *Clerk*. This individual assists the judge by keeping track of paperwork, scheduling hearings, and performing other administrative tasks. The clerk issues the summons the compels each witness to appear in court.

• *Court officers*. Also known as “bailiffs,” they maintain order in the courtroom under directions from the judge. In Massachusetts courts, they carry handcuffs, but are not armed.

• *Stenographer*. This individual keeps a written record of everything said during the trial. Sometimes the stenographer types the transcript; other times it is dictated for later transcription.

III. Notice to Appear

Under Massachusetts law, each witness must receive written notice of the time and place at which to appear. In the past, notice given to the defendant was called a “summons,” while notice given to a witness was called a “subpoena.” Today, every notice to appear at a criminal trial is referred to as a summons. A witness may be called

into court by the prosecution or by the defense. In either event, the request is presented to the clerk of the court, who issues the written summons. The summons must be hand-delivered to the witness, or, when the witness cannot be located, it may be left at the last known place of residence. A special agreement between Boston EMS and the Suffolk County District Attorney's Office makes it possible for a witness summons to be delivered to Boston EMS headquarters and forwarded to the witness during regular work hours.

Trials sometimes last several weeks, and ADAs understand that coming to the courthouse on every day of the trial may pose a hardship for Boston EMS personnel. To resolve this problem, ADAs generally are willing to work out an arrangement that will allow the EMT or paramedic to come to court only when that individual's testimony actually will begin. Such arrangements may involve notification by pager or telephone. Because ADAs make these arrangements out of courtesy, it is essential that the EMT or paramedic appear as promised.

IV. Failure to Appear

A witness who fails to appear after being properly notified may be arrested and brought before the court. While this does not happen often, the judge may find the witness in contempt of court, and may impose a fine or even a jail sentence. The Boston EMS Professional Standards Division works closely with the Suffolk County District Attorney's Office (SCDA) and has established a system whereby the SCDA will endeavor to give BEMS at least three days notice of court cases whenever possible. Boston EMS has also instituted a procedure to expedite the notification and delivery of court requests to our members as quickly as possible. When a subpoena arrives, Professional Standards identifies the primary EMT of record. That EMT is notified by e-mail that a subpoena has been issued and the date, place, and time that the case is scheduled for. The subpoena is then photocopied, attached to a "sign-for" return-receipt envelope, and forwarded to the appropriate Shift Commander's mailbox for distribution to the department member. The Shift Commander is responsible for ensuring that this time sensitive mail is delivered, and that the return-receipts are forwarded back to Headquarters. However, based on court system volume, secret grand juries, or other sealed indictments, etc, we sometimes receive these requests with relatively little notice. The "three days notice" is a privilege, not a requirement.

Frequently, there are instructions in the subpoena for calling the Assistant District Attorney (ADA) to verify that you have useful testimony. If you are excused from testimony after such a telephone conference, you must notify Professional Standards of that fact. Conversely, if you are required to be present in court for more than the days listed on the subpoena, you must notify the Professional Standards Division of that fact as well. It is important for members to know that there is no right, or privilege, to ignore affidavits, interrogatories, or a court or deposition appointment.

Once you have been notified by the Department to attend a legal proceeding, your attendance is mandatory. A failure to appear as ordered frequently extends court

proceedings, tarnishes the reputation of Boston EMS, and may be cause for discipline. Depending on the circumstances, failure to appear could even result in civil or criminal actions being brought against individual EMTs. If you are unable to report to court or a deposition as scheduled, because of a *very* emergent and extenuating circumstance, you must immediately notify the Assistant District Attorney assigned to the case (or the clerk of the court in the jurisdiction you are due to testify in), or the private attorney's office responsible for a deposition, *and* the Professional Standards Division. Department members who are notified directly that they either are no longer required to attend OR are notified that they need to attend a court proceeding on additional days, need to notify both Dispatch Operations and Professional Standards so the schedule can be updated. Department members who fail to show up for any such appointments, without notice, may be subject to discipline. Department members assigned to attend a legal proceeding will complete a Boston EMS Witness Appearance Form and forward the completed form to the Professional Standards Division. An employee shall only be paid for those appearances that are authorized by, and scheduled through the Professional Standards Division. Any subpoena fee received by an employee in connection with an appearance involving Department business shall be forwarded to Professional Standards by the employee.

Lastly, if you are contacted at your private residence or at your station, relative to any legal proceeding, please notify Professional Standards, as soon as possible.

Boston EMS personnel are recognized as valuable witnesses in a variety of legal situations. Members of the legal system realize that Department EMTs and Paramedics are frequently among the first to arrive on scene and have first-hand knowledge about the circumstances at accident scenes, crimes, and civil liability incidents. Responding to depositions, affidavits, interrogatories, and/or presenting testimony in court on department related matters are an essential obligation of Department EMTs. The Department expects that EMTs will honor orders to appear, will dress appropriately and present a professional appearance, complete and return interrogatories, arrive at their appointments on time, and present truthful testimony without prejudice.

V. Giving Testimony In Criminal Matters

In virtually all criminal cases, the judge orders witnesses "sequestered," or kept separate from other witnesses as they testify. In effect, this means that witnesses are allowed in the courtroom only when they are actually testifying. Boston EMS personnel should presume this to be true, unless they are expressly told otherwise by the ADA prosecuting the case.

A court officer will announce the name of the witness when it is time to testify. Once inside the courtroom, the witness must promise to tell "the truth, the whole truth, and nothing but the truth, so help me God." A witness who objects to this statement on religious grounds may, upon request to the judge, make an alternative promise called an "affirmation" that eliminates the reference to God.

The court officer will instruct the witness to sit in a chair immediately to the judge's side. Often the judge will instruct the witness to speak into a microphone, which amplifies the testimony for the benefit of the judge and the jury. When the witness appears at the request of the prosecution, the prosecution asks the first round of questions. This questioning is called "direct examination." Since Boston EMS personnel almost always appear as witnesses for the prosecution, the ADA generally will pose the first round of questions to the EMT or paramedic. Once the ADA has completed his questioning, the defense attorney has the option of asking additional questions. This round of questioning is known as "cross-examination." In general, cross-examination is not as extensive as direct examination, when it occurs at all.

The judge dismisses the witness once the testimony is complete. At this time, the witness must leave the courtroom.

When testifying, it is important to observe the following principles:

• Listen carefully to the question. If you do not understand the question, ask for it to be repeated.

• Answer the question precisely as it is posed. Do not provide additional information that goes beyond the scope of the question. If the prosecutor asks, "Do you recall responding to a call on Blue Hill Avenue?" the proper response is simply, "Yes." Do not say, "Yes, we responded to a stabbing call there."

• Think carefully before answering. Make sure your answers are correct, and remember the answers you have given. Your credibility may be destroyed if you answer a question one way, and then answer the same question differently later on.

• If you do not recall the answer to a particular question, say so. If you can answer a question only with an estimate, make this clear.

• Answering questions under cross-examination can be a stressful experience. When confronted with a hostile line of questioning, remain calm, show no anger, and continue to answer truthfully. Be aware that the attorney may attempt to trip you up by paraphrasing your previous statements incorrectly. Do not be afraid to point out these inconsistencies. If the attorney asks, "So, are you saying that your patient was not hurt?" you may respond by saying, "No, I didn't say that. I said that we found no obvious injuries when we first examined him."

• The testimony of EMS personnel is unusual in that it combines "eyewitness testimony" with "expert testimony." At times you will be asked to explain technical terms and medical procedures. Be prepared to describe your training and experience, and to describe in detail the responsibilities of an EMT or paramedic.

• Sometimes an attorney will rise and announce, "Objection!" while you are testifying. Do not let this bother you. Attorneys must adhere to complex rules of trial procedure

when questioning witnesses, and most objections are technical in nature. The fact that an attorney raises an objection does not necessarily reflect poorly on the answer you have given.

VI. Standard Questions and Answers

Certain questions will be asked of virtually all EMTs and paramedics who testify in a criminal trial. Below are some questions that EMS personnel are likely to be asked. The accompanying answers may prove useful in responding.

QUESTION: Who are you employed by?
ANSWER: The Boston Public Health Commission, Emergency Medical Services Division.

QUESTION: What kind of training did you have, to become an EMT?
ANSWER: EMT training is similar in length to a 6-credit college course. We learn to perform CPR, administer oxygen, control bleeding, splint fractures, immobilize patients with spinal injuries, use a defibrillator to start hearts that have stopped beating, administer certain medications, and operate emergency vehicles quickly and safely. (A paramedic would describe the didactic and clinical components of a paramedic curriculum, and would go on to describe endotracheal intubation, intravenous infusion, medication administration, and cardiac monitoring and pacing.) All Boston EMS personnel receive some level of training in hazardous materials, and mass casualty incidents.

QUESTION: What kind of continuing education courses are you required to take?
ANSWER: Every two years, EMTs must take 24 hours of continuing education courses on various topics. (Forty-eight hours for paramedics.) EMTs and paramedics also must attend a month-long “refresher course” every two years. EMTs must maintain certification in CPR. Paramedics also must maintain certification in Advanced Cardiac Life Support.

QUESTION: What’s the difference between an EMT and a paramedic?
ANSWER: The job descriptions are very similar, but paramedics have more training and can perform certain procedures that EMTs are not trained to perform.

QUESTION: How many calls does Boston EMS respond to in a year?
ANSWER: About 100,000.

VII. Testifying Before a Grand Jury

Occasionally, EMS personnel must testify before a grand jury. Unlike a trial, a grand jury investigation is a closed proceeding. Only the ADA, the grand jurors, and witnesses called by the ADA may be present. A judge does not oversee the proceedings, and the defendant has no opportunity to respond to the ADA’s allegations. In fact, the defendant and the defense attorney are not even allowed to be present.

Overall, testifying before a grand jury is quite similar to testifying in court. The ADA asks the same kinds of questions, and the same principles apply when answering. Grand jury testimony differs from trial testimony in two important respects, however. Since no defense attorney is present, the witness does not have to contend with objections. There is no cross-examination, obviously.

The other main difference is that the members of the grand jury get to question the witness directly at the conclusion of the ADA's questioning. Often, the grand jury members will ask only one or two questions about a matter that has confused them. At times, though, they will ask questions about material the ADA did not cover.

VIII. Decorum

Courtrooms have a code of etiquette that is strictly enforced. Everyone in the courtroom must stand up when the judge enters. Address the judge as "your honor." Reading is strictly prohibited, except when referring to a document while testifying. Since physical appearance affects credibility in the eyes of the jury, EMS personnel should always come to court wearing a clean, long-sleeved uniform with a tie.

IX. Civil Actions

A civil action—also known as a lawsuit—is a legal proceeding held for the purpose of resolving a dispute or enforcing a private right. This type of action may arise, for example, when one motorist sues another over injuries suffered in a collision. The person who initiates the civil action is known as the plaintiff. The person being sued is the defendant. Together, the plaintiff and defendant are known as the "parties" to the suit.

As EMS personnel, you may be directly involved in legal proceedings where the Boston Public Health Commission is the defendant in a lawsuit. You may be directly involved simply because you were the operator of a motor vehicle involved in a collision and the other operator has sued the Commission for personal injuries. Or, your involvement may directly relate to care and treatment you are alleged to have rendered in an emergency situation. In those cases where the Boston Public Health Commission has been named as a party, your participation in these legal matters will be directed by the General Counsel's Office of the Boston Public Health Commission. You must participate in these legal proceedings by answering written questions and appearing as witnesses at depositions and trials.

Boston EMS personnel are required to appear as witnesses in civil actions that do not involve the Boston Public Health Commission. The notification procedure for civil actions and criminal actions is identical, except that the written notice—known as a "subpoena"—is issued by the attorney for one of the parties and approved by the clerk of the court before delivery to the witness. Do not ignore a subpoena. Like a witness

who fails to appear at a criminal trial, a witness who does not show up to testify in a civil trial may be held in contempt by the judge, fined, and even jailed.

To reduce the length of a civil action, the parties often agree to question some or all of the witnesses outside the courtroom, before the trial begins. These proceedings, known as depositions, are conducted with all the formality of a trial, except that they do not occur in the presence of a judge. Witnesses receive subpoenas just as they do before a civil trial, and the penalty for failing to appear at a deposition can be the same as the penalty for failing to appear in court.

BOSTON EMS COURTHOUSE DIRECTORY

Federal Court

Federal District Court for the District of Massachusetts
Northern Avenue at Fort Point Channel, South Boston
(617) 748-9152
Parking available on street, or may be available in adjacent lot; inquire of U.S. Marshal on site.

Suffolk County District Attorney

Suffolk County District Attorney's Office
1 Bulfinch Place, Boston (adjacent to BPD Area A-1)
(617) 619-4000
Parking may be available at BPD Area A-1; inquire by telephone in advance.

Suffolk County Superior Courts

Suffolk County Superior Court (Criminal Division)
1 Post Office Square
(617) 788-8160
Parking available in Post Office Square underground parking lot (for fee).

Suffolk County Superior Court (Civil Division)
1 Post Office Square
(617) 788-8175
Parking available in Post Office Square underground parking lot (for fee).

Suffolk County District Courts

Boston Municipal Court
Pemberton Square, Boston (on hill adjacent to Ashburton Street)
(617) 788-8793
Parking may be available at BPD Area A-1; inquire by telephone in advance.

Brighton District Court
52 Academy Hill Road, Brighton
(617)782-6521
Parking available on street, and sometimes in lot behind courthouse (with permission of court officers).

Charlestown District Court
City Square, Charlestown (on north side of City Square Common)
(617)242-5400
Limited parking available on street.

Dorchester District Court
510 Washington Street, Dorchester
(617)288-9500
Parking available on street.

East Boston District Court
Paris Street, East Boston (adjacent to BPD Area A-7)
(617)569-7550
Parking available on street.

Roxbury District Court
Dudley Square, Roxbury (adjacent to BPD Area B-2)
(617)427-7000
Parking may be available at BPD Area B-2; inquire by telephone in advance. Parking also may be available in lot behind courthouse and police station (with permission of court officers).

South Boston District Court
535 East Broadway, South Boston
(617)268-9292
Parking available on street.

West Roxbury District Court
445 Arborway, Jamaica Plain (adjacent to Forest Fills overpass)
(617)971-1200
Parking available on street. Parking also may be available in lot behind courthouse (with permission of court officers).

Dispatch OPS Rules

General Work Rules

Supersedes: 06-01-09
Effective: 03-01-12

1. No cursing, loud talking, yelling, loud laughing or physical horseplay is permitted in the Dispatch Operations Center.
2. The Dispatch and call receiving areas shall be kept neat and orderly at all times. The temporary posting of messages or memos shall be done on bulletin boards only. Postings should not be affixed directly to the painted wall surfaces with tape or thumbtacks.
3. Telecommunicators shall remain awake and alert while on duty.

   3.1. Telecommunicators who wish to sleep either before or after their shift or during their break shall do so outside of the dispatch / calltaking area.
4. Telecommunicators will log on to the workstation(s) at each position as appropriate for that position. This includes CAD terminals, CMED/PENTA consoles, and VESTA workstations. Issued credentials / IDs / Passwords specific to the user shall be used and not generic credentials, unless the telcommunicator is otherwise unable to log on. Supervisors will be notified in the event that credentials do not function. In that case, an incident report noting the operator, terminal, time, and problem should be submitted to the Commander of Dispatch Operations for resolution.
5. Smoking is prohibited throughout the building.
6. Limited non-work related activities will be permitted at dispatch or calltaking positions with Supervisor approval. These activities must not conflict with work responsibilities or be distracting or disruptive to the orderly operation of the Dispatch Operations center. Such permission is to be considered a privilege and abuse will be dealt with on an individual basis.
7. Never attempt to repair any equipment in the Dispatch Operations Center unless you are qualified and authorized to perform the repair.

   7.1. All equipment must be disconnected from its power source before dismantling for inspection or maintenance.

   7.2. Report any mechanical defects in chair or console immediately to the Dispatch Operations Center supervisor.

   7.3. Supervisors shall evaluate any reported mechanical defect and, using their best judgment, determine whether the equipment is safe for continued use. A notation shall be made on the Dispatch Center Supervisor Summary documenting the defect and its cause, if known.

8. Eating is not permitted within the Dispatch Operations area. All drinks must be in "spill-resistant" containers.

9. Personal Electronic Devices (including, but not limited to: cellular phones, "Blackberry" type devices, laptop computers, MP3 type players, CD players, and similar devices) have the potential to distract members from their duties and may cause electronic interference with radio and telephone communications systems components in Dispatch Operations.

   9.1. Personal cellular telephones are permitted to be carried while on duty in Dispatch Operations, but should be placed on silent mode and allow voice mail to answer the call. Except in the case of a telephone system failure, Department members are prohibited from making or receiving a voice call on a personal cellular device in Dispatch Operations. Personnel may step out of the Operations Center to retrieve messages while on an authorized break.

   9.2. The use of personal cellular telephones (voice, text messaging, "direct connect"), blackberry type devices, personal computers, or other personal electronic devices is prohibited while at any Dispatch (EDT01, 02, 03, 04) position.

   9.3. Personnel assigned to non dispatch positions (Call taking, CMED, clerk, supervisor) are permitted to utilize a cellular phone or blackberry-type device for text messaging so long as it does not conflict with work responsibilities. Personnel are not permitted to use earphones to monitor a personal radio, television, compact disc, or MP3 type player. The volume on any external speaker must be kept low enough so that at no time can the audio from a personal listening device be heard in the background over the radio network or telephone. The use of any personal listening device must not disturb or otherwise distract other personnel and is at the discretion of the supervisor.

Minimum Staffing Levels- Dispatch OPS

Supersedes: 07-11-99
Effective: 01-06-02

1. Between the hours of 07:30 and 23:30, the minimum staffing level of the Dispatch Operations Center shall be six (6) EMT- Telecommunicators and one (1) Supervisor.

   1.1. Of these six (6) EMT- Telecommunicators, at least three (3) shall be “full operators” and no more than one (1) of the six shall be a “CMED only” limited operator.

   1.2. A “full operator” is defined as a telecommunicator who has successfully completed training in all three Dispatch Operations positions: Calltaking, CMED and Citywide dispatch.

   1.3. A “limited operator” is defined as a telecommunicator who has successfully completed training in Calltaking and / or CMED, but has not yet been cleared at Citywide dispatch.

2. Between the hours of 23:30 and 07:30, the minimum staffing level of the Dispatch Operations Center shall be five (5) EMT- Telecommunicators and one (1) Supervisor.

   2.1. Of these five (5) EMT-Telecommunicators, at least three (3) shall be “full operators” and no more than one (1) of the 5 shall be a “CMED only” limited operator.

3. The on-duty Shift Commander, or in his / her absence, the on-call Manager, and the Commander of Dispatch Operations shall be notified whenever staffing levels fall below these minimum levels.

Personal Phone Calls

Supersedes: 06-30-97
Effective: 07-19-98

Outlines policies and procedures for Telecommunicators receiving and making personal phone calls.

1. Personal phone calls must not interfere with, delay, or take priority over the telecommunicator's job responsibilities in any manner.
2. Personal phone calls shall be limited to ten (10) minutes or less in length.
3. The frequency of personal phone calls is to be kept to a minimum. When in question, the supervisor's judgment as to what constitutes an acceptable minimum will prevail.
4. All personal phone calls are to be made over administrative lines. Personal calls are not to be made or accepted via a VESTA Workstation.
5. Personal toll calls are not permitted except in emergency situations with prior approval of the supervisor.
6. Use of the phone system for personal gain, such as its use by telecommunicators to conduct "part time" business is strictly prohibited.

Releasing Personal Phone Numbers

Supersedes: 01-13-97
Effective: 06-30-97

1. Home phone numbers or personal pager numbers of Boston EMS department employees shall only be given out to Department employees.
2. Under no circumstance will a phone number marked “private”, “do not give out” or any similar notation be released without the prior approval of a supervisor.
3. Persons requesting personal phone numbers who are not Boston EMS department members will not be given this information. The calling party’s name and number will be taken by the Telecommunicator who will, if the work load permits, attempt to contact the employee and give him/her the information to call the party back. If the employee cannot be contacted in a reasonable length of time, the party will be called back and so advised.
4. The same policy (#2) shall be followed when non-department members call requesting the work schedule, district, shift or current location of a department member.
5. If the calling party insists it is an emergency, the caller shall be referred to the Dispatch Operations Center supervisor for resolution.

Tours and Visitors

Supersedes:
Effective: 01-13-97

Uncontrolled visits to the Dispatch Operations Center can be disruptive to its operation.

1. All tours or visits of the Dispatch Operations Center shall be pre-arranged with either the Commander of Dispatch Operations, Shift Commander or on-duty Dispatch Operations Center supervisor.
2. Off duty personnel normally assigned to Dispatch Operations shall be allowed to visit the Dispatch Operations Center without prior permission.
3. On-duty field personnel (non-supervisory) are required to have prior permission from the Dispatch Operations Center supervisor before visiting Dispatch Operations.
4. Visits by field personnel are often disruptive to dispatch operations and should be limited to special circumstances only.
5. Before being allowed entry into the Dispatch Operations Center, all visitors will check in with the supervisor to be sure the visit or tour can be accommodated operationally at that time.
   5.1. The supervisor will insure that the Dispatch Operations Center is presentable before allowing visitors or tours to enter the room.
   5.2. Telecommunicators are to handle themselves professionally at all times.
6. It is strictly prohibited for a telecommunicator to have an individual visit the Dispatch Operations Center so as to conduct business, such as from a Telecommunicator's part time job.
7. All tours or requests may be limited or suspended at the discretion of the supervisor.

Uniform Policy: Dispatch OPS

Supersedes:
Effective: 01-13-97

This policy establishes the dress code standards for Dispatch Operations Center personnel.

1. All Dispatch Operations personnel shall wear the prescribed uniform as provided by the Department.
2. Telecommunicators who choose to remain in the dispatch operations area while on break are subject to this policy.
3. Supervisors shall have the right to refuse entry to any scheduled observer, student or recruit who is deemed to be inappropriately dressed for the professional work environment we strive to maintain.

Work Breaks

Supersedes: 09-22-97
Effective: 03-16-98

1. Telecommunicators (except those that have been properly relieved) are required to get permission from the supervisor prior to leaving any dispatch or calltaking console.
2. Personnel on duty for an eight or ten hour shift are entitled to a one-hour break during the shift.
   2.1. The Department shall use the “first in/first choice” method for choosing dispatch time and break time. In this case, “first in” shall be considered the first person on-duty in the Dispatch Operations Center.
   2.2. All requests to “swap” break time or “give” break time to another telecommunicator must be approved by the on-duty Dispatch Operations Center supervisor.
3. Breaks are subject to the operating needs of the department. Every effort shall be made to grant each telecommunicator an uninterrupted break. However, call volume or staffing needs may necessitate the shortening or cancellation of break periods.
   3.1. All breaks shall be canceled whenever operating below “minimum staffing” levels.
   3.2. The on-duty Dispatch Operations Center supervisor shall cancel all breaks whenever an incident requires an additional dispatcher dedicated to a tactical channel.
   3.3. The on-duty Dispatch Operations Center supervisor or any member of the Command Staff has the authority to shorten or cancel all breaks whenever the call volume or workload necessitates the additional personnel.
4. Personnel on break must remain available for recall. Telecommunicators leaving the immediate area shall take a department pager or department radio.
   4.1. If there is no department pager or radio available, telecommunicators leaving the area must be available by personal pager or phone.
5. Members notified to return from break must do so as soon as reasonably possible.
6. Personnel returning late from a break will be considered “tardy” and may, at the supervisor’s discretion, have the time deducted from their day’s pay.
7. The supervisor retains the right to assign all console or break times regardless of the order in which telecommunicators arrived for duty.

Call Receipt & Processing

ANI / ALI Verification

Supersedes: 12-05-11
Effective: 06-17-14

1. Upon receiving a call via the E 9-1-1 system, telecommunicators shall verify the caller's incident location, including section of the City, and callback number. The incident location and call back number shall be verified by repeating back the address and call back number given by the caller (ECHO) so the caller hears it and ensures you received it correctly. It should never be assumed that the ANI / ALI screen is correct or the actual location of the reported incident.
2. In the event information cannot be verified with the ANI / ALI information provided, the call shall be entered into the CAD based on the ALI data provided. (Examples: caller does not know location, unable to speak or there is a language problem)
3. If the ANI / ALI information is correct and verified as the incident location, < F11> shall be used to transfer the data to the incident location portion of the CAD incident mask.
4. If the ANI / ALI information is correct, but the reported emergency is at a different location, the incident location information shall be manually entered.
5. Calltakers shall not give the information provided by the ANI / ALI screen to the caller.
6. Once E 9-1-1 data is transferred to the CAD or entered manually, the telecommunicator must validate the address, including section of the City, in the CAD Geofile. If the address does not validate (i.e. no match) the call taker shall select from the "pick list" the correct file match or correct the data and re-validate.
7. An E 9-1-1 ALI Discrepancy Form shall be completed when a discrepancy appears on the ALI screen. Reportable discrepancies include incorrect address displayed, "no record found" message displayed, street misspellings which cause the address not to verify when transferred into CAD or misrouted calls. A Geofile Correction Request form shall be completed whenever a properly spelled address provided by the Verizon Database does not validate in CAD or the cross streets listed are known or suspected to be incorrect.

   7.1. Completed Forms shall be forwarded to the on-duty Dispatch Operations Center Supervisor who will ensure they are filled out completely and legibly.

   7.2. Completed E 9-1-1 Discrepancy Forms shall then be forwarded by the Supervisor to the Boston Police Operations Supervisor for processing with the PSAP coordinator. Completed Geofile Correction Request forms shall be faxed to the number listed on the form.

7.3. A copy of all completed ALI Discrepancy and Geofile Correction Request Forms shall be forwarded to the Commander of Dispatch Operations.

[See Related: “ALI Discrepancy Form” and “Geofile Correction Request Form”]

Duplicate Calls

Supersedes: 11-16-07
Effective: 06-17-14

The Dispatch Operations Center may receive multiple calls reporting the same incident. It is important to process each of these calls for several reasons:

- To determine whether there are two separate incidents in the same area, or whether the location and / or access information needs to be updated;
- To determine if the patient status has changed since the original call entry necessitating a change in the level of EMS or ancillary agency response;
- To determine if the latest caller is willing / able to accept pre-arrival instructions.

1. All requests for emergency medical services received by the Boston EMS Dispatch Operations Center shall be entered into the CAD system.
2. When prompted by the CAD System that an incident is a possible duplicate, the EMS Telecommunicator should review the original incident in an attempt to determine whether the call being processed is a separate (new) or duplicate incident.
   2.1. The calltaker shall confirm (repeat back) the location of the incident, including any special access information to confirm whether the incident is a new incident or duplicate.
   2.2. If the EMS Telecommunicator is unable to quickly determine whether the call being processed is a separate (new) incident or duplicate, it shall be entered into the CAD system as a new incident.
3. If the call being processed is found to be a duplicate of an existing incident, the EMS Telecommunicator shall ensure that the correct incident location and EMS TYPE Code have been assigned to the existing (original) incident.
   3.1. If the information in the original incident is accurate, remarks should be added to the existing incident.
   3.2. If the incident location or EMS TYPE Code assigned to the existing incident is no longer accurate, the original call shall be updated and combined with the appropriate ancillary agencies based on the latest information available.
   3.3. Whenever an incident location, access, scene safety, or TYPE Code information is modified prior to the arrival of the EMS unit, this information shall be broadcast via voice radio to the responding crew(s).

3.4. When a caller with the patient calls back to report that “no one has arrived” (but a unit is shown on scene in CAD) and the location has detailed access instructions (for example, large complexes such as shopping malls, convention center, outdoor park, etc.) confirm the access information. When necessary, keep the caller on the line until the location / access information is clarified or the unit arrives with the patient.

4. Every effort shall be made to provide appropriate prearrival instructions to all non-medically trained callers reporting a medical emergency.

Use of EMD Guidecards / Promising Service

Supersedes: 03-16-98
Effective: 07-11-99

1. Telecommunicators shall adhere to Department approved Emergency Medical Dispatch guidecards when processing all calls for emergency medical assistance.
2. Having followed the Department approved guidecards and reaching a TYPE code, the reason for any downgrading of predetermined priority for that TYPE code should be documented in the text.
3. Having followed the Department approved guidecards and reaching a TYPE code, the reason for deleting an ancillary agency from a recommended combined response should be documented in the text.

   3.1. Deleting an ancillary agency from a combined response does not have to be documented if the reason is covered by another policy in this manual (for example, deleting the Boston Fire Department from a response at Logan International Airport).
4. Every effort shall be made to provide appropriate prearrival instructions to all non-medically trained callers reporting a medical emergency.
5. Unless it is scripted in the EMD pre-arrival instructions, telecommunicators should not inform a caller that “help is on the way” unless an EMS or first responder unit has been dispatched to the location. Callers can be informed “I’ve sent the call to the dispatcher” (if the call has been entered into the CAD System) or “we’ll be there as soon as possible” which will reassure the caller without creating an unrealistic expectation or special duty.

EMS Incidents with Medical Personnel On Scene

Supersedes: 04-16-04
Effective: 02-23-15

1. NOTIFICATION OF FIRST RESPONDERS In that many health centers, physician's offices, clinics, and long term care facilities in the City of Boston have personnel on site that are capable of providing patient care that meets or exceeds first-responder protocols, patient outcome would not be improved by using EMS first responders to such locations. Therefore, after having followed established EMD Guidecard criteria and arriving at a TYPE Code that would normally generate a combined response, first responders may be deleted during call entry under the following circumstances:

   1.1. When a caller states the incident is at a location with personnel trained to provide patient care and the TYPE code is normally combined with first responders, quickly determine the following: are medical personnel with immediate access to oxygen and a defibrillator currently treating the patient? If the answer is NO, combine the incident. If medically trained staff and appropriate equipment are available, a first responder response is not necessary, with the following exceptions:

   1.2. First responders should <u>not</u> be deleted during call entry from a CARST.

2. PRIMARY AMBULANCE RESPONSE: HEALTH CLINICS AND HOSPITALS

   2.1. Boston EMS is the primary EMS response agency to any hazardous material incident, building fire, incendiary device standby, trauma or any other incident involving a potential for building evacuation or multiple casualties.

   2.2. Boston EMS is the primary EMS response agency to a medical emergency at a Health Clinic, Hospital, or physician's office where the patient is NOT located in a patient care area (such as a parking garage or administrative office building).

   2.3. Upon receipt of a reported Priority 1P Incident (CARST, CHOKE, EXHEM1), or OBGYN1, SHOT, STAB, or STROKE, the Dispatcher should dispatch the appropriate BEMS units, utilizing back-up services as needed per standard operating procedure.

   2.4. With the exception of the Incident TYPEs listed above, upon receipt of a reported Priority 1-3 incident in a staffed treatment area of a Licensed Health Clinic (designated with the prefix "HC" in CAD), Hospital (designated with the prefix "HOSP" in CAD), or physician's office, the dispatcher should <u>first</u> poll the availability of private EMS providers.

      2.4.1. If an appropriate level (based on the TYPE code) private EMS unit is available to respond, and their response time is not significantly longer than it would take a

Boston EMS unit to respond, the incident shall be referred to the private ambulance for service.

2.4.2. Boston EMS will respond to a licensed health clinic, hospital, nursing home, or physician's office when back-up services are not immediately available, thereby striving to maintain Boston EMS unit availability for simultaneous occurring emergencies at other locations throughout the City.

Headset Use & Storage

Supersedes: 07-11-99
Effective: 01-14-02

Headset use is considered the standard in the telecommunication industry.

1. Telecommunicators shall wear department issued headsets while staffing any VESTA calltaking or primary dispatch position (EDT01, EDT02, or EDT03). Personnel operating at a dispatch position equipped with a “gooseneck” style microphone or department issued handset are not required to wear a headset.
2. When not in use, department issued headsets, like all department property, should be securely stored to prevent loss, damage or theft. Headsets should be taken home or secured in a locker when not in use. Storing a headset in a “mail slot” of the intra-department mailbox does not constitute secure storage.
3. Personnel may give their headset to the Dispatch Operations Supervisor for short-term safekeeping when leaving the area to go on break or to use the facilities.

See related SOP “Headset: Repair / Replacement

Hangup / Abandoned 9-1-1 Calls

Supersedes: 06-30-97
Effective: 05-07-07

1. If a transfer is being made from the Primary PSAP to Boston EMS and the caller hangs up or is otherwise disconnected prior to being connected to a Boston EMS Telecommunicator, clarify with the initial calltaker who will enter the call into the CAD system. It is essential that the call be entered into the system and there should be no misunderstanding about which agency is going to handle the call entry.

   1.1. In the case of a wireless transfer where either ANI information was not presented, or it was presented but attempts to reach the caller are unsuccessful (busy, no answer, etc), the Massachusetts State Police should be contacted to determine if an incident address or any other pertinent information was provided prior to the call transfer to BEMS.

2. After receiving a transfer and the caller either hangs up or it otherwise disconnected, use the ANI / ALI information to attempt a callback.

   2.1. If the callback is successful and the caller indicates there is NO emergency, enter the call as an ADVISED incident and close the call.

   2.2. If the callback is successful and the caller does have an emergency, process the call as a normal 9-1-1 call.

   2.3. If the callback is successful and the caller is vague about whether or not there is an emergency, enter the call into the CAD and dispatch appropriate resources to investigate the situation.

   2.4. If the callback is unsuccessful, the call shall be entered into the CAD system based on the ALI information provided.

3. If no ANI / ALI information was initially displayed, the Telecommunicator should attempt to “re-bid” for ANI/ALI information. The telecommunicator should also review any available IRR (instant recall recorder) information, or seek the supervisor’s assistance to review “MagIC” call detail record information.

Related topic: Wireless Call Trace Procedure

Out of Jurisdiction Emergency Calls

Supersedes: 12-18-96
Effective: 07-19-98

Occasionally, Boston EMS Telecommunicators receive requests for emergency assistance to locations outside of the City. This can happen in a variety of ways: a person in Boston may have called 9-1-1 requesting an ambulance for a relative in a neighboring city or town or Brookline's PSAP is busy and we receive a call acting as their backup.

1. Process the call as you would any other emergency call.
2. Based on the premise that the 9-1-1 system should be totally transparent to the citizens using it, there is no need to inform the caller that they have reached the wrong PSAP for their town.
3. Enter the call into the CAD with the appropriate TYPE Code and create an ADVISED incident.
4. Using the PSAP directory in VESTA or the Massachusetts PSAP directory, contact the designated PSAP for the city or town in which the reported emergency exists. Private ambulances who are contracted to provide EMS in neighboring cities and towns should not be contacted directly by Boston EMS in these situations.

   4.1. This procedure only applies to emergency situations outside of the City. Private ambulance services may still be contacted directly by Boston EMS when we are seeking their mutual aid to emergency or routine transfers within the City.
5. Document in the CAD text which agency was notified of the emergency and close the incident.
6. Telecommunicators receiving an emergency call in which the caller dialed 9-1-1 from another jurisdiction [misrouted 9-1-1 call or overflow from the Brookline PSAP] shall complete an ALI Discrepancy Form.

See related SOP: "ANI / ALI Verification"

Silent Calls

Supersedes: 06-30-97
Effective: 07-19-98

1. If, upon receipt of a call via the E 9-1-1 system, the caller does not respond verbally, the telecommunicator will then begin to process the call as a silent call.

   1.1. Enable TTY by clicking on the TTY Icon. The first TTY greeting message will be sent, “9-1-1 nd polce fire amblance q ga”.

   1.2. If there is no response, the telecommunicator shall send the message a second time by “double clicking” on the pre-programmed greeting.

2. Having determined that the call can not be processed as a TTY call, click the TTY disable button to come out of the TTY mode and reestablish voice path.

3. The Telecommunicator will continue to process the call for those individuals who may have called 9-1-1 with the ability to hear but without the ability to speak.

4. Verbally advise the caller: “if you need the Police, Press “1” on the touchtone pad; Fire, Press “2”; and ambulance, Press “3”. Monitor the ALI screen for digits to appear on the display.

   4.1. If no response, repeat the request once more. If there is still no response, process the call as UNKEMS.

   4.2. If you receive a response to this request, confirm the indicated response by having the caller enter the response again via the keypad.

5. Upon confirmation of assistance needed at the location, the telecommunicator may ask additional questions in a “yes” or “no” format by utilizing a “4” for yes and a “5” for no.

1= Police, 2= Fire, 3=EMS, 4=Yes, 5=No

Telephone Answering Procedure

Supersedes: 07-11-99
Effective: 12-22-00

The purpose of this policy is to standardize the way Boston EMS Telecommunicators answer incoming administrative and emergency calls. The general call handling techniques taught in the forty (40) hour Association of Public Safety Communication Officials (APCO) Basic Telecommunicator course are the methods approved by the Department.

1. All Boston EMS Administrative telephone lines are to be answered "Boston EMS" followed by the telecommunicator's department ID (badge number) or last name.

    1.1. Administrative lines include all 7 digit emergency and non-emergency numbers as well as all direct "ringdowns" to hospitals, EMS Stations, and other public safety agencies.

2. Boston EMS 9-1-1 transfer lines are to be answered with "Ambulance, (department ID is optional) what is the address of your emergency?" Immediately after this initial greeting, the EMS Calltaker should say "go ahead" which will serve as an acknowledgement to the BPD Calltaker that the call has been received. The BPD Calltaker should then release the line to allow ANI/ALI information to be presented.

3. PSAP Telecommunicators need not identify themselves when answering 9-1-1 calls. If a citizen requests the PSAP Telecommunicator to identify themself, he/she will give their Department ID (badge number) and agency affiliation (Boston EMS).Telecommunicators are not required to provide their name to callers.

4. Should the E 9-1-1 system go into Bypass Mode, all E 9-1-1 calls should be answered "9-1-1, this line is being recorded, what is your emergency?"

Unattended VESTA Positions

Supersedes:
Effective: 02-01-00

1. The Boston EMS VESTA workstations have been configured to allow for “forced” or “automatic” call delivery of emergency calls. Through this process, 7-digit emergency calls or 9-1-1 calls transferred from the Boston Police calltakers are immediately presented to an available Answering Position Unit and answered automatically, virtually eliminating any transfer delay.
2. To prevent the inadvertent delivery of an emergency call to an unattended VESTA position, EMS Telecommunicators should “LOG OFF” VESTA and remove the headset from the jack whenever leaving a workstation unattended.

Wireless Call Trace Procedure

Supersedes:
Effective: 05-07-07

PURPOSE OF DOCUMENT
The following document establishes a procedure for obtaining tower or subscriber information for wireless 9-1-1 calls. This procedure may be used in the event the caller has been disconnected and is believed to be in an emergency situation where the billing information (often the home address) may provide the location of the caller. For example, a call is received where a person is screaming hysterically and then is suddenly disconnected. If the dispatcher is unable to reach the caller by using the call back number they may choose to use this procedure. Following this procedure, a dispatcher can use the callback number provided on the ALI screen to obtain the home address of the person who owns that phone in hopes of obtaining further information on where the caller may be located.

DEFINITIONS
This policy applies only to wireless 9-1-1 calls and not wireline 9-1-1 calls. For the purposes of this document, the terms below are defined as follows;

Subscriber Information Number: This number will provide you with subscriber name, billing address, home number, and other identifying information. In the event the Subscriber Information Number listed in this policy is not correct, contact the NOC to obtain a contact number for subscriber information.

NOC Number: This number will provide you with tower location information. The Network Operation Center (NOC) **CANNOT** provide subscriber information. The NOC generally provides cell tower information only. The NOC should be able to provide a contact for subscriber information should these numbers change. The NOC number is also provided on the ALI screen.

PROCEDURE
The procedure for obtaining tower or subscriber information differs for each wireless carrier. Each wireless carrier does require that a written request be faxed to them after first calling with a verbal request. The SETB and State Police, with the cooperation of all wireless carriers in Massachusetts, have created a universal form (attached) to use when requesting tower and subscriber information from all wireless carriers named “Wireless Subscriber Information Request Form”. You should complete and forward this form to the appropriate wireless carrier when requesting tower/subscriber information. The phone number displayed on the Automatic Location Identification (ALI) screen is the carrier’s Network Operations Center (NOC) contact number. The NOC cannot provide subscriber information. If for some reason you cannot reach the appropriate person at the Subscriber Information Number listed below, the NOC should provide you with a contact number that you can call for subscriber information. In a case

where the ALI screen does not provide cell location/face information, you should contact the NOC number for assistance.
In some instances you may get ALI information for a wireless carrier that is not the subscriber's carrier. The FCC requires carriers to accept calls from any other carrier's subscriber base during a 9-1-1 call. Due to this 9-1-1 feature, the SETB recommends you first call the Customer Care Center (CCC) (800) 391-1435 with the callback number to verify the carrier information. The CCC has live access to a mobile telephone database and can lookup most callback numbers. If the lookup is successful, the CCC will provide the appropriate subscriber information number for that carrier. Once the carrier has been verified by the CCC, you may proceed with the call trace procedure.

*Please note that the carriers are not obligated to provide subscriber information within a specified time period and therefore do not guarantee a timely response. Escalation Contacts are provided below for the purpose of reporting problems with obtaining Call Trace information.

The following are technical issues that may cause problems with obtaining call trace Information:
(1) FCC regulations require all wireless carriers to complete 9-1-1 calls even if the call is originating from different wireless carriers phone. Therefore it is possible to have a Verizon customer reach the call center via a Cingular tower. The ALI screen would display Cingular as the carrier even though it's a Verizon customer.
(2) Inactive phones cannot be traced. Inactive phones are ones that do not have normal calling capabilities, but due to FCC regulations, wireless carriers must complete the call. Due to the inactive nature of these phones, however, it is impossible for a wireless carrier to provide subscriber information. Inactive phones will typically be sent with an area code of (911) followed by a random 7 digit code (xxx-yyyy).
(3) "Throw Away" or disposable phones, and some pre-paid account phones cannot be called back or traced because there isn't any subscriber information associated with the phone.

If faced with one of these situations, follow one of the following procedures:

Phase I or Phase II– ALI screen displays the carrier name without cell site data (a.k.a. Carrier Shell Record).
Call the NOC number listed on the ALI screen to obtain Phase I data and to determine the reason for/report Phase I ALI failure.

Phase 0 – Phone number only is displayed or Phase 1 – ALI screen displays "No Record Found", "No ALI Received Yet".
Call the CCC (800) 391-1435 for assistance in determining which carrier the number belongs to. Once you have the wireless carrier name, call either the subscriber information number or the NOC number depending on the type of information needed.

Shell Record Example

WPH1 14:53 07/01
COID=
VERIZON WRLS 1-800-242-7622
LOC INFO & CALLBK NOT AVAILABLE
ESN=604 MTN:
LAT: LON:
ELV:+0000 COF: COP:
REGION 4 POLICE
REGION 4 FIRE
REGION 4 EMS

NOTE:
Refer to Reference Section in rear of EMD Guidecard rack for Wireless Carrier contact information.

Source:
Wireless Call Trace Procedure
Commonwealth of Massachusetts SETB
Version 1.6- 3/7/06

Verizon Telephone Security

Supersedes: 09-22-97
Effective: 01-14-02

Verizon Telephone Security is a valuable resource to the telecommunicator trying to verify an incident location.

1. Verizon Telephone Security may be contacted at 1-800-772-4275 whenever a telecommunicator is attempting to verify an incident location based on a given phone number.
2. Verizon Telephone Security personnel may request documentation of your request. If this is the case, a "Verizon Telephone Security Information Request Form" shall be completed and faxed to the number listed on the form.

   2.1. Once completed and faxed, all forms shall be forwarded to the Commander of Dispatch Operations.

See Related SOP: Verizon Telephone Security Information Request"

Special Call Entry Situations

Construction Site / Confined Space Incidents

Supersedes: 95-008
Effective: 06-30-97

1. Regardless of the EMS TYPE Code, the Boston Fire Department shall be notified of all confined space or tunnel accident incidents within their jurisdiction.

   1.1. For the purposes of this policy, a confined space incident is considered any incident in a space having limited means of access and egress which is subject to accumulation of toxic or flammable contaminants or has an oxygen deficient atmosphere. Examples include manholes, tunnels, boilers, storage tanks or the hull of a ship.

2. The EMT-Telecommunicator entering the call shall create a combined CAD Incident response using REQF with remarks when using an EMS TYPE code that does not automatically create a combined response.

3. The Dispatcher, or his / her designee, shall create a combined CAD Incident response using REQF with remarks when receiving such an incident from a civilian calltaker or police dispatcher that has not been combined with the Boston Fire Department.

4. Regardless of the EMS TYPE Code, the Boston Fire Department shall be notified of all EMS incidents occurring within their jurisdiction at a construction site in which the victim is located anywhere other than ground level (such as in a basement, scaffolding or on an upper floor of a building under construction).

EMS Incidents at Logan International Airport

Supersedes: 06-13-94
Effective: 06-30-97

The MassPort Fire Rescue provides first responder services for Boston EMS incidents at MassPort property and facilities located at Logan International Airport.

1. Upon notification of a medical emergency occurring on MassPort -Logan International Airport property, the EMT Telecommunicator shall modify the combined incident mask to delete the Boston Fire Department and Boston Police from any combined incident prior to CAD entry.

   1.1. Calls received directly from MassPort Fire Alarm or Massachusetts State Police assigned to Logan International Airport shall be assumed to be on MassPort property unless otherwise noted by the caller.

   1.2. Any call received via the E 9-1-1 system in which the ALI monitor shows the Emergency Service Zone to be MassPort Fire Rescue and Massachusetts State Police (ESN 479) shall be modified to delete the Boston Fire Department and Boston Police Department from the combined incident prior to CAD entry.

2. The MassPort Fire Alarm shall be notified of all medical emergencies occurring on MassPort-Logan International Airport property reported to Boston EMS by any person or agency other than the MassPort Fire Alarm or Massachusetts State Police.

   2.1. The EMT Telecommunicator entering the call is responsible for notifying the MassPort Fire Alarm of the nature and location of the emergency.

3. It shall be the responsibility of MassPort Fire Alarm personnel to notify other MassPort units and airport agencies (MassPort Fire Rescue, State Police, US Customs, Airline Security, etc.) of the incident.

4. MassPort Fire Alarm is responsible for notifying the Boston Fire Department of any mutual aid requests.

Caller Requests Limited Response

Supersedes:
Effective: 06-30-97

EMT Telecommunicators may sometimes be asked by callers to limit or otherwise alter a predetermined response level to a reported medical emergency. Callers may request that the Fire Department not be sent or that responding units do not use emergency lights or siren.

1. Unless superseded by another policy in this manual, requests to limit or otherwise alter a predetermined response level to a reported medical emergency shall not be honored. Callers requesting a limited response shall politely be informed that, based on the nature of the emergency, a predetermined response level will be initiated.
2. Requests for a “silent response” should be entered into the CAD text if call volume allows. This information should be relayed to the responding units who will make the determination, based upon traffic and the nature of the emergency (e.g. jumper, hostage), whether it can be honored on their final approach to the scene without delaying their response.

Calls from United States Coast Guard

Supersedes:
Effective: 05-10-06

Upon request, the Dispatch Operations Division, in conjunction with Metro-Boston C-MED, provides logistical support for incidents occurring and / or terminating in the Metro-Boston C-MED jurisdiction. The Dispatch Operations Supervisor, or designee, shall be notified of any calls from the Department of Homeland Security United States Coast Guard (USCG) requesting assistance. The Dispatch Operations Supervisor shall coordinate communication and deployment of support resources, relaying all necessary information to the appropriate USCG units, ground units and receiving facilities as appropriate.

1. Active Emergencies: Upon receipt of a request for emergency services, the Dispatch Operations Telecommuncicator shall enter the call into the Computer Aided Dispatch system using established EMD criteria and other relevant standard operating procedures. The Telecommunicator should also attempt to ascertain any special conditions, such as docks, ramps or obstacles to transfer, and/or landing zone area. In conjunction with the Dispatch Operations Supervisor, the appropriate resource(s) shall be notified to respond to a designated rendezvous point for transfer of patient care and/or transport. Additional inter-agency resources activated could include, but not be limited to, the Boston Police Harbor Patrol or other vessels for water incidents, EMS/private ambulance services, or other ancillary agencies.
2. Inter-Facility Transfers: Upon receipt of a request from the USCG for assistance with an inter-facility transfer, the Dispatch Operations Telecommunicator shall attempt to ascertain the originating facility and contact information, the destination facility and contact information, the type of patient / specialty care needs, and whether the USCG mission transport was initiated by Boston MedFlight or another commercial aero medical service.
   2.1. If the patient's condition warrants emergency intervention, Boston EMS or the appropriate pre-hospital provider shall respond to provide patient care and transport.
   2.2. If the patient is considered stable, and Boston MedFlight initiated the response, the Dispatch Operations Supervisor, or designee, shall contact Boston MedFlight (800-233-8998) to ascertain whether arrangements were already made for ground transfer and transport. In most cases, Boston MedFlight has already done this, and they will assist in providing ground transport and/or other ground logistical support.
   2.3. If the patient is stable, and the response was initiated by the receiving facility, the Dispatch Operations Supervisor or designee shall contact the destination facility to determine the preferred EMS/private ambulance service provider and coordinate the response, transfer and transport with that provider. If the preferred provider is unable, BEMS DOD shall coordinate response of a back-up provider in accordance with normal procedures.
3. All USCG calls for assistance shall be documented in the CAD IH and on the Supervisor's Shift Summary report noting the caller (Name, Rank), the unit, the callback number, the location or Active Incident Area (AIA) when applicable, and whether it is an active emergency incident or an inter-facility transfer. If/when a rendezvous point is established, document that and the ETA as well.

Medical or Bio-Hazardous Waste

Supersedes: 03-16-98
Effective: 07-24-13

RED-BAG BIO-HAZARD AND SHARPS CONTAINER WASTE

Red hazardous waste containers ("sharps containers") must be properly sealed in order for the disposal process to work safely. Once reaching capacity, sharps containers may be brought directly to Materials Management for disposal. Alternately, sharps containers may be left, properly sealed, at the satellite stations near the D Tank rack where Materials Management staff will remove them during their nightly rounds. Red bio-hazard bags are also removed by Materials Management staff during their Evening shift rounds. A contracted vendor removes red bag and sharps containers weekly from Materials Management. Only hazardous waste from Boston EMS should be left at Material Management; the Boston Police and Fire Departments have separate contracts in place and are responsible for the disposal of their red hazardous waste containers.

REQUEST FOR NEEDLE RETRIEVAL / BIOW

1. Boston EMS occasionally receives requests to retrieve hypodermic needles or other medical or bio-hazardous waste improperly disposed of in the public domain. These requests typically come via the Mayor's 24-Hour constituent hotline, but may also be received via the 9-1-1 system or other City agencies.

   1.1. Boston EMS will intercede when the medical or bio-hazardous waste is related to an EMS incident (e.g. bloody gloves or bandages).

   1.2. Boston EMS will intercede if the medical or bio-hazardous waste is not related to an EMS incident, but the amount of material is relatively limited and can be quickly retrieved. Incidents involving medical or bio-hazardous waste that exceeds the capacity of a one-gallon red hazardous waste container shall be referred to the Boston Fire Department for mitigation.

2. Between the hours of 07:30-17:00 on weekdays, the Project Manager of the BPHC "AHOPE" (Addicts Health Opportunity Prevention Education) program may be contacted to check on the availability of the needle exchange van to retrieve the discarded waste. Contact Sarah Mackin at **617 534-3967** or smackin@bphc.org.

   2.1. If the needle exchange van is not available to retrieve the item(s), a Tango unit or Division Supervisor should be dispatched.

   2.2. At the discretion of the Dispatch Operations Supervisor, an ambulance may be sent to handle the disposal of the waste, especially in instances involving a small

amount of waste (such as one or two syringes) or when the Division Supervisor may be delayed.

Unit Deployment

East Boston EMS Coverage

Supersedes: 01-26-97
Effective: 04-12-04

The fact that the neighborhood of East Boston is physically separated from Boston proper poses some unique challenges to Boston EMS in our effort to provide the highest level of prehospital care for all residents and visitors of our city.

1. Keeping in mind the relative limited accessibility of East Boston, the Dispatch Operations Supervisor (or above) may authorize Ambulance 7, the primary BLS unit normally assigned to East Boston, to be reposted to the "Boston Side" to enhance system wide coverage. Given the ongoing construction and associated traffic pattern reconfigurations associated with the Central Artery and Tunnel ("Big Dig") project, developing a standard set of conditions to guide this decision is impractical. Like all other unit deployment decisions, factors such as call volume, unit availability, and access / egress options should be taken into account.

   1.1. After clearing a response or other assignment on the "Boston side", Ambulance 7 may be used for a response on the Boston side without prior supervisor approval if their response time to the scene would be less than another BLS unit.

2. Whenever Ambulance 7 is unavailable for a response, another BLS unit should be reposted for East Boston coverage whenever possible.

   2.1. Ambulance 8, the designated zone impact unit for Haymarket Square / East Boston, should normally repost to the East Boston side of the Callahan Tunnel unless they are unavailable or otherwise re-posted (e.g.: Charlestown 23:00---01:45).

   2.2. When both A7 and A8 are unavailable, an available "extra" BLS unit (A-30, A-31 if in service) should be reposted to the East Boston side of the Callahan tunnel for East Boston coverage.

   2.3. When Ambulance 7 and Ambulance 8 are unavailable and there is no "extra" BLS unit available to repost (or their ETA is extended), Ambulance 1 or Ambulance 6 should be reposted to a location near the entrance to a harbor tunnel, which will afford them relatively quick access to East Boston.

   2.4. When other downtown units are unavailable, Ambulance 15 (Ambulance 8 during the hours of 23:00-01:45) or another available unit should be reposted to the downtown area to provide coverage.

   2.5. If there are no Boston EMS units available for Haymarket/East Boston/Charlestown coverage, private ambulance services should be contacted to check their availability to provide back- up service.

A7 → A8 Eastie → (A30 Eastie) → A1 / A6 Tunnel Access → A15 Haymarket Sq → Poll Privates

West Zone EMS Coverage

Supersedes: 07-11-99
Effective: 10-31-14

The neighborhoods of West Roxbury, Hyde Park, Readville and Roslindale ("West Zone") pose unique challenges to Boston EMS in our effort to provide the highest level of prehospital care for all residents and visitors to our city. The large geographical area results in longer travel time to both the scene of the emergency and to the receiving hospital which, in turn, leads to longer "cycle time" and decreases unit availability to respond to other incidents.

1. When clear and available, Ambulance Five will be posted at Holy Name Circle (the intersection of Centre Street and West Roxbury Parkway).
   1.1. Ambulance Five may return to the Faulkner Hospital for shift change fifteen minutes before the end of each shift.
   1.2. On-coming crews should repost to Holy Name Circle as expeditiously as possible.

Dispatch & Radio Procedures

Announcing Dispatch Information on TAC-1

Supersedes: 06-30-97
Effective: 01-01-13

1. Whenever an EMS unit is dispatched to an incident via telephone, ringdown or MDT, the dispatcher shall announce the response on TAC-1.

   1.1. When dispatching a Boston EMS unit, the unit's call sign, location of the incident and the EMS TYPE code shall be announced.

   1.2. When dispatching a private EMS unit, the name of the service, the location of the incident, the EMS TYPE code and their ETA, if known, shall be announced on TAC-1.

2. When EMS units are dispatched to provide an EMS Standby with the Boston Police Entry team or other situations where it may not be appropriate to announce the exact address of the incident, the call sign of the units dispatched and EMS TYPE code only shall be announced.

3. Dispatch Operations shall announce the name of the service, the location of the incident and the EMS TYPE code whenever notified that a Private Ambulance service is in response to an incident or has an "on-site" in the City of Boston.

General Dispatch Procedures

Supersedes: 02-01-00
Effective: 09-29-08

1. The oncoming crew is solely responsible for notifying Dispatch Operations that a shift change has occurred. The only crews that need to "log off" are those that have no incoming relief such as 16 hour or detail units.

   1.1. When a crew logs on, they shall be advised of the current diversion status of hospitals within the BEMS point of entry plan and the three digit Julian date.

   1.2. The new Julian date shall also be announced during the 00:00 station ID broadcast.

2. To standardize the use of alert tones, the following guidelines should be used:

   2.1. Steady Alert: This alert tone shall be used prior to transmitting routine or administrative messages. Examples in which this alert tone shall be used include the station ID or prior to a special announcement such as a road closing or hospital diversion. This tone shall also be used when attempting to contact a unit that has failed to answer their radio.

   2.2. Warble Alert: This alert tone shall precede the dispatch of two or more units to the same incident. Multiple units are not to be called individually prior to dispatch. Examples in which this alert tone shall be used include ALS / BLS and BLS / Supervisor response.

   2.3. Hi-Low Alert: This alert tone is reserved for use only with high priority messages such as announcing an EMS OT or when advising on-scene units to evacuate a hazardous location or situation.

3. In an effort to standardize the radio traffic throughout the department, the following terms shall be used by both field and Dispatch Operations personnel to reflect various status changes:

Cancel; Dispatch; En Route; On scene; Transporting; Transport Complete; Clear

4. Any BLS unit that transports to a hospital and does not request an L-20 will be asked their status by the dispatcher after 20 minutes. Any ALS unit that transports to a hospital (with an ALS case) and does not request an L-20 shall have their status verified by the dispatcher after 30 minutes.

5. Units shall state their ETA when volunteering for a response that another unit is already assigned. For example, rather than "Boston, A-4; I'm not sure where A-9 is coming from but we can do that call" simply state "Boston, A-4; we have a 3 minute ETA to 123 Main Street". The original unit assigned the response will then be asked if they have a shorter ETA. This will minimize radio traffic and ensure that the unit with the shortest ETA will be sent to the call.

6. The safety and well being of department members is paramount to EMS operations. Whenever an off duty member notifies Dispatch Operations that they have stopped at an incident to assist or render care, that member shall be logged onto CAD with their ID (EMT###). An incident shall be generated (if not already entered) and that member assigned to the incident. The dispatcher shall obtain as much information as possible and enter that information into the incident. Appropriate additional resources should be added as requested by the member on scene. When the incident is secured, the appropriate disposition code shall be entered into CAD and the department member logged off.

General Radio Procedures

Supersedes:
Effective: 02-01-00

1. **F.C.C. Rules:** The applicable rules and regulations of the Federal Communications Commission shall govern the general operation of the EMS radio channels.
2. **Monitor Frequency**: All persons operating EMS radios must monitor the frequency on which they desire to operate, prior to transmitting.
3. **Transmitting Names:** All communications shall be kept impersonal. When names are transmitted, the full name or last name with title only shall be used. Names may also be substituted for call signs. In order to maintain patient privacy rights, patient names shall not be transmitted except in cases of extreme emergency, and only when the conduct of the medical care to be provided requires specific patient identification.
4. **Identify Every Transmission:** Unit identifiers are to be said in every transmission.
5. **Intonation and Voice level**: Word or voice inflections that reflect irritation, disgust or sarcasm must not be used. Relations with other users shall remain cordial at all times. Do not yell under any circumstances.
6. **Message Brevity:** All messages shall be kept brief and to the point.
7. **Answering Radio Calls**: All radio calls must be answered. When busy with patient care activities or traffic on another channel, the phrase “STAND-BY” shall be used to indicate receipt of call and intent to answer when available.
8. **Prowords and Phrases**: Experience has proven that some words when spoken over a two-way radio can be easily confused with other words and result in disastrous miscommunication. The words and phrases in this list are ideal for avoiding this type of problem and all radio users should become comfortable with their use.

Word or Phrase	Definition (for radio use)
ACKNOWLEDGED	I have received your message and will act upon it.
ACUTE	Condition of rapid onset.
AFFIRMATIVE	Yes. (Spoken over a radio, “yes” is easily confused).
ARRIVAL	Unit has arrived at its intended location
ASSIGNMENT	Assignment to an incident or radio channel.
BREAK	To interrupt in an emergency, or to separate

	parts of a group of messages.
CALIBRATION	A telemetry signal that when transmitted produces a 1mv output at the EKG display. (Similar to ”standardizing” an EKG strip)
CHANNEL (e.g. MED 1)	The radio frequency or pair of frequencies used in a radio system.
CONTACT	Establish communications.
CLEAR	Available; I am terminating this communication (or incident).
DISREGARD	Do not take action on last transmission.
ENGAGED/DISENGAGED	Radio patch connected/disconnected.
ENROUTE	Traveling to a specified destination.
FREQUENCY	The technical expression of an electronic signal expressed in cycles-per-second (cps), or hertz (Hz), or megahertz (MHz) of a base-line signal. In general use frequency refers to the signal used in a radio system. (E.g., 155.340 MHz, or tone code 7A~192.8 cps).
HOLD	Remain at present location or specified position.
INCIDENT	An emergency at which EMS is required.
INCORRECT	Wrong.
LANDLINE	Order to make call by phone or refers to telephone company supplied circuits that connect a radio system.
MONITOR	Listen to all traffic on a radio channel.
NEGATIVE	No.
OBTAIN	Get.
OUT	I have finished all messages, do not expect a replay and the channel is open to others.
OVER	I have finished my message and expect a reply from you.
QUIET RESPONSE	Without use of siren.
RELAY	Pass the traffic on to another person or station (repeat message verbatim).
ROGER	As in acknowledge, I have received your

	message and will act on it.
REPEAT	Administer the indicated therapy an additional time. (See SAY AGAIN).
SAY AGAIN	Repeat the last message transmitted. (Not to be confused with REPEAT).
SHIFT	Change channel as ordered.
SHIFT AND ACKNOWLEDGE	Change channel as instructed and say on the new channel your ID and acknowledge the shift.
SHIFT AND CONTACT	Change channel as instructed and call the desired station.
SHIFT AND STANDBY	Change channel as instructed and listen for further traffic.
STAND-BY	Answer to request is not immediately available, or user is busy with competing traffic. The order stand-by implies that a unit should stay on channel until called upon; order should not be acknowledged.
STATUS	A unit's present activity.
TRAFFIC	Messages transmitted by radio between units and/or stations.
TRANSPORT	Commence transportation of a patient by ambulance.

9. **Transmitting Directions**: When transmitting directions by radio, providers should use proper names and avoid using slang or abbreviations, particularly when describing locations. Use specific instructions, said in phrases, such as "PROCEED TO", "TURN", "HOLD", "MONITOR", "ADMINISTER", etc.

See Related SOP: Metro Boston EMS Communication Network

Reference: This document is based in part on the "Massachusetts Emergency Medical Services Systems Communications Plan" which was adopted by the Department of Public Health's Emergency Medical Care Advisory Board in June, 1984.

Building Fire (STB) Response

Supersedes: 07-03-07
Effective: 06-17-14

BACKGROUND

In March of 2007, the Boston Fire Department modified their criteria for declaring a suspected building fire or “Struck Box” incident. By adopting a more conservative approach to what constitutes a “Struck Box” incident, there has been a significant increase in the number of requests for an EMS standby at suspected fire related incidents. Fortunately, a relatively small percentage of STB incidents result in a need for EMS services. However, the routine dispatch of both BLS and Supervisory resources to unconfirmed incidents often results in units being committed for an extended period of time. Because of the relatively large number of available resources, the Boston Fire Department can typically arrive at an incident quickly and confirm whether or not there is a fire and / or smoke condition which would warrant an EMS response and standby.

PROCEDURE

1. Upon receipt of a STB (Building Fire- Struck Box) incident, the EMS Dispatcher will quickly note the location of reported incident, and review any supplemental text.
2. EMS units should be dispatched as quickly as possible to any STB incident meeting any of the following criteria:
   - 2.1. STB incident between the hours of 23:00 and 07:00
   - 2.2. STB incident in which there are reported injuries or question of entrapment.
   - 2.3. STB incident at an Elderly Housing (EH), Hotel (HOTEL), Nursing Home (NH), Hospital (HOSP), MBTA Station (MBTA), or School (SCH).
   - 2.4. STB incident in which multiple calls are received (indicated by DUP incidents)
   - 2.5. Whenever a Police unit, private ambulance, or other agency official has on-sited a confirmed building fire.
3. Absent any of the above noted criteria, the EMS dispatcher may place the STB incident on HOLD pending an update from the first arriving Fire Company. Upon arrival, the first arriving company will provide an update to Boston Fire Alarm. Fire Alarm will add remarks noting a “CONFIRMED FIRE” whenever the fire companies on scene confirm a smoke or fire condition, at which time an EMS response will then be initiated.

Clearing Codes & Hospital Abbreviations for MDW Use

Supersedes: 07-11-10
Effective: 09-01-14

1. Unless cancelled by Dispatch Operations prior to arrival, it is the responsibility of the responding unit to clear an incident with the most appropriate DISPOsition code. Keep in mind that a DISPO code is simply a CAD command to clear a unit- it does not replace a well documented PCR clearly describing the observations and actions of the on scene EMS crew.

2. Disposition and clearing codes authorized for use by field units are:

C	Clear (Service Assignment or other EMS Unit to give final DISPO
CFD	Cancelled by the Boston Fire Department
COA	Cancelled by Other Agency (specify in comments)
CPD	Cancelled by the Boston Police Department
NON	EMS Standby / Non-Transport
PDN	Party Denies Need for EMS
RALS	Referred to ALS (Boston EMS)
RBLS	Referred to BLS (Boston EMS)
REF	Patient Refusing Treatment and/or Transport
RME	Referred to Medical Examiner
ROA	Referred to Other Agency (specify in comments)
TRN	Transported to a Hospital
UTL	Unable to Locate incident or patient

3. The following abbreviations shall be used in the MDW when transporting a patient to a hospital. Requests to transport a patient to a facility not included on this list shall be made through Dispatch Operations.

BID	Beth Israel Deaconess	**FLK**	Faulkner
BMCM	BMC-Menino	**MEEI**	Mass. Eye & Ear
BMCP	BMC-Pediatrics	**MGH**	Mass. General
BWH	Brigham & Women's	**MILT**	Milton Hospital
CHMC	Children's Hospital	**TMC**	New England Medical
CRN	Carney Hospital	**STE**	St. Elizabeth's
EBHC	East Boston Health Center	**WRVA**	West Roxbury Veteran's

Dispatch Format

Supersedes: 11-16-07
Effective: 06-16-08

1. All requests for emergency medical services shall be dispatched as expeditiously as possible based upon available resources, call priority and call volume.

   1.1. An exception is an incident in which the patient is not scheduled to arrive for some time, such as in the case of an inbound aircraft or boat.

   1.2. Any factors impeding the ability of the dispatcher to dispatch an appropriate EMS unit to the scene of a reported emergency shall be documented in the call incident text (e.g. polling privates, closer unit will be clearing a hospital shortly, etc).

2. Units responding to an incident in which there is known or suspected violence (e.g. weapons, violent patient or bystander) shall be advised of all pertinent information including the status of the police and directed to use caution when approaching the scene.

   2.1. If the scene is not secure on arrival of the EMS units, the location of the staging area should be documented in the incident text.

   2.2. In the case of an EDP in which the patient reportedly has no medical complaints or injury, but is known or suspected to have weapons or be violent, responding EMS units should stage a safe distance from the scene (approximately 1-2 blocks away).

   2.3. Boston EMS units shall be directed not to enter the scene until it has been secured by the police.

3. In order to provide a standardized dispatch format and ensure accurate receipt of the information by response units, the following format shall be used.

   Unit ID (s), “respond to a(n)”...
   TYPE Code “at”
   Location [Street address, Section of the City], *repeat* *
   Common place name if any
   Remarks pertaining to crew safety
   “Time Out (at)” [Radio Console time]

* Note: Addresses should be given out using two methods: using thousands, hundreds or tens, followed by the street name; then, the numbers should be given out individually. When an address has only one or two numbers preceding the street name, it is helpful to use the word “number” prior to saying the actual number.
For example:

20 Main Street would be given out as “Number Twenty Main Street, that’s two-zero Main Street”, followed by the city section.

“934 Commonwealth Avenue” would be broadcast as: “Nine Hundred, Thirty-Four Commonwealth Avenue (pause), that’s NINE, THREE, FOUR COMMONWEALTH AVENUE.” (city section)

4. Whenever an incident location, access, scene safety, or TYPE code information is modified prior to the arrival of the EMS unit, this information shall be broadcast via voice radio to the responding crew (s)

[See Related SOP “Mobile Data Workstations”; "General Dispatch Procedures"]

Documenting Cancellation Requests

Supersedes: 06-01-98
Effective: 07-11-99

The source of all cancellation requests should be documented in the call history.

1. Dispatchers receiving a cancellation request from the Police or Fire Department in the form of a terminal to terminal CAD message should append the message into the call history to document the source of the EMS cancellation.
2. Dispatchers receiving a cancellation request in person from a Police Dispatcher who has entered the EMS Dispatch area or over the telephone should enter that fact into the call history to document the source of the EMS cancellation.
3. Unless otherwise noted in the text, a CAD supplement entered by Boston Fire Alarm that the “ALL OUT” has been transmitted may be treated as a cancellation request for EMS.

Language Line

Supersedes: 02-01-00
Effective: 10-31-14

Dispatch Operations has access to an interpreter service through Qwest Communications. This service is a valuable resource to Telecommunicators attempting to process requests for service from callers who do not speak English. Interpreting in over 150 languages, Qwest Communications will allow 9-1-1 call takers to conference in an interpreter when they receive an emergency call from a caller who does not speak English.

1. Upon receipt of an emergency call from a non-English speaking caller, the Telecommunicator shall attempt to determine the language the caller speaks.
2. If there is no one immediately available to act as translator and the nature of the emergency can not be quickly determined, the call shall be entered into the CAD system with the TYPE Code “UNKEMS”.
3. Qwest can be contacted by utilizing the VESTA Auto-Dial feature (“Special Services-Interpreter Service”) or by calling 1-877-790-3111. When the operator answers, the Telecommunicator should tell the operator which language the caller speaks.
4. Once on the line, the translator shall be used to determine the nature of the emergency and provide prearrival instructions when indicated.
5. Given the multi-cultural population that we serve, Boston EMS personnel will frequently encounter patients who are unable to communicate in English. In cases where a Field unit has access to a telephone; is able to determine the patient’s language; and has a patient stable enough to delay transport and use translator services, the Dispatch Operations Center may be contacted to establish a conference call with the interpreter service.

Missing Person Announcements

Supersedes:
Effective: 08-01-08

Boston EMS is occasionally asked to assist other departments in locating missing persons. These requests are typically related to an AMBER Alert, missing Alzheimer or otherwise mentally challenged adult, or a missing child.

1. Requests for announcements regarding a missing person in the Boston area shall be referred to the Dispatch Operations Supervisor who will gather the pertinent information and, in conjunction with the on-duty Shift Commander, determine the appropriate means of disseminating the information. In addition to radio announcements, a department email and / or alphanumeric page notifications may be made.
2. When a radio announcement is made, the information should be entered and tracked in the CAD System using the TYPE code BOLO (Be On the Look Out). The CAD Text should include as much detail as is known at the time, such as the missing person's name, age, description, clothing and (in the case of an AMBER Alert) any suspect or vehicle information.

    2.1. Radio announcements should be relatively brief, giving a description of the individual, last known location and direction of travel. The announcement should include the CAD Incident number where members can look up more detailed information.

    2.2. After making the radio announcement, the dispatcher will log on the "BOLO" unit, and assign the incident to the BOLO unit. Doing so will remove the incident from the dispatcher's pending incident list. A notation should be made in the incident history (miscellaneous comment or supplement) when the radio announcement is broadcast.

    2.3. The frequency of the announcement will be determined by the Supervisor and will depend on the situation. Generally, the announcement will be made every other hour for a period of 16 hours. If the BOLO remains active at that time, the information will be sent to Department members via email and the incident will be closed in the CAD System. If the BOLO is cancelled prior to that time, an announcement should be made when the alert is cancelled, at which time the BOLO incident can be closed.

Reference Information:

AMBER ALERT (America's Missing: Broadcast Emergency Response) notifications are coordinate through the Massachusetts State Police (see also Massachusetts AMBER Alert Plan). All information shall be verified for accuracy with the Boston Police Department, or if necessary the Massachusetts State Police Communications Section.

http://www.masschiefs.org/documents/AMBER%20ALERT%20PLAN%20INFO%20AND%20OUTLINE.pdf

SAFE RETURN is a program organized for patient with dementia by the Alzheimer's Association in conjunction with Medic Alert. If a caller notes that the missing person is part of the SAFE RETURN program or a confused person is found wearing a Medic Alert bracelet, contact 800-667-2565 for additional information and resources.

Non-Response Procedure

Supersedes: 01-14-02
Effective: 01-01-13

1. While on duty, all personnel issued a department radio shall closely monitor radio traffic and quickly acknowledge when called by the dispatcher.
   1.1. If a response unit is available and fails to respond to the dispatcher after having been called two (2) consecutive times a brief alert tone shall be transmitted and the unit called a third time. If there is still no response from the unit, they shall be given a “non-response”.
   1.2. If the unit was being called to dispatch them to a reported emergency, the response shall be given to another unit.
2. The Dispatch Operations Center Supervisor and the appropriate Division Supervisor shall be notified of the unit’s last known location and status as well as the unit’s current location according to the AVL system (if so equipped). Attempts to reach the unit shall be made via pager, "all out" broadcasts, satellite ringdown or at the unit’s last known location.
   2.1. When located, the unit’s portable or vehicle radio shall be tested and arrangements made for any repair or replacement if necessary.
3. Dispatchers are responsible for ensuring that response units properly acknowledge each response.
   3.1. The dispatcher shall direct any response unit failing to properly acknowledge a response to do so in the proper format (unit ID, full street address or common place name and direction if on MBTA or limited access roadway).
   3.2. A unit’s continued failure to acknowledge a response in the proper format shall be considered a “non-response”.
4. The Division Supervisor shall collect an incident report filed by the crew for all “non-responses” regardless of whether the unit was being called for a routine message or priority response. A copy of all “non-response” incident reports shall be forwarded to the on-duty Shift Commander and the Commander of Dispatch Operations.

See Related SOP: “Response Acknowledgement Format”

Military Time

Supersedes: 07-19-98
Effective: 07-11-99

1. Twenty-four hundred hour (“military time”) shall be used when transmitting and recording the movement of all EMS units.
2. The time shall be transmitted when acknowledging all unit status changes, change in hospital diversion status, station ID broadcast or special announcements.
3. Twenty-four hundred hour (“military time”) shall be used when completing all department reports or other official records.
4. Netclock® shall be used as the system standard for coordinating all time displays.
5. Any discrepancy between the time-synchronized systems (CAD, E 9-1-1, CMED or wall mounted clocks) should be referred to the Dispatch Operations Center supervisor.

   5.1. Supervisors shall document time display discrepancies on the Dispatch Operations Center Supervisor shift summary report.

   5.2. Supervisors shall notify Communication Engineering Unit of all time display discrepancies.

Mobile Data Workstations / Status Changes

Supersedes: 09-29-08
Effective: 06-17-14

1. Safety: The use of a Mobile Data Workstation (herein after referred to as MDW) by the operator of a department vehicle in motion is secondary to the safe operation of the vehicle and crew safety.
2. Confidentiality: The Enhanced 9-1-1 system gives personnel access to caller information, both listed and unlisted. This information is entrusted for use solely to assist public safety agencies with emergencies. Appropriate use and confidentiality of this information must be ensured at all times. The MDW screen should be cleared prior to leaving the vehicle unattended or turned in such a way so as to prevent civilians riding in the vehicle from viewing confidential information.
3. Equipment Inspection: Personnel reporting for duty shall inspect the MDW for signs of damage and ensure it is functioning properly as part of the daily vehicle inspection. Damaged, missing or improperly functioning equipment shall be immediately reported to the Dispatch Operations Supervisor.
4. Log ON / Log OFF

   Log ON: The primary operator (driver) of a vehicle equipped with a functioning MDW is responsible for logging the unit on the MDW as soon after the shift change is complete as possible. The LOG ON “mask” shall be filled in completely and include the Unit ID, vehicle identification (license plate), crew members, and portable radio numbers. The names of any non-department members assigned to the unit (e.g. observers) shall be included in the “comments” portion of the LOG ON mask.

   RELOG: Personnel shall update information if there is a change in crew members, vehicle, or portable radio numbers during the shift. Having up to date information available to Dispatch Operations personnel enhances crew safety in the event of a trouble alarm or similar situation.

   Log OFF: Personnel shall not LOG OFF the MDW unless they have no relief; doing so causes the unit to be removed from the dispatcher’s screen. Requests to LOG OFF a unit, either for the purposes of a RELOG or when the unit is going out of service for the upcoming shift, shall be made through the dispatcher.
5. Message Content: Like other Department electronic medium (i.e. computer network), all messages sent via the Computer Aided Dispatch system (including MDW) are documented and may be reviewed for appropriateness. Messages sent via CAD / MDW shall be in compliance with all Boston Public Health Commission and BEMS policies as they relate to electronic mail.

6. Dispatch Format: In order to provide a standardized dispatch format and ensure accurate receipt of the information by response units, the following format shall be used:

Unit ID(s), "respond to a(n)"…

TYPE CODE "at"
Location [Street address, Section of the City], repeat
Common place name if any
Remarks pertaining to crew safety

"Time Out (at)" [Radio console time]

Example: Ambulance 2, Paramedic 2 respond to an UNCONSCIOUS at 1700 Washington Street / South End, 1-7-0-0 Washington Street / South End at 13:34.

Ambulance 11, respond to an MVA at Columbia Road and Geneva Ave / Dorchester; Columbia Road and Geneva Ave / Dorchester -be advised possible fight in progress; time out 19:27.

7. Dispatch Acknowledgment: To ensure that the dispatch information has been received correctly, response units must acknowledge each response in the following format:

   Unit ID; Full street address (number and name of the street) or Common Place location; Direction if on MBTA or limited access roadway (e.g. Storrow Drive or Massachusetts Turnpike)

8. Self Initiated Assignments: Non-supervisory units shall not assign themselves to an incident or service assignment (LUNCH, HQTRS, VMAINT, etc.) via the MDW. All such requests shall be routed through Dispatch Operations for authorization.

9. Premise History: When an incident occurs at an address in which Premise Information is available, the LOI (Location of Interest) button will be illuminated. . Responding units should review the premise history, if available, for an incident location by clicking on the LOI button, or scrolling further down in the incident record..

10. Incident History: Incidents are frequently updated (TYPE Code or Incident location changed) or remarks added as more information becomes available. The dispatcher shall notify responding units by radio whenever an incident TYPE Code or incident location has been updated. Assigned units will receive a message on their workstation indicating "updates available".

11. Callbacks / Cancellations Requests: Field personnel must not assume there is no further information available for their incident simply because no callback number is listed in the assigned incident history. It is possible that a duplicate call has been received for the incident, which does contain a callback number or further information. A unit responding to an incident shall not, under any circumstances, make a callback in an effort to speak to the patient or determine the need for

EMS. These types of conversations need to be made from Dispatch Operations so they may be recorded for documentation purposes. Similarly, EMS units should not send CAD messages to other agencies (either their dispatcher or individual unit) requesting they initiate or cancel a response. All such requests shall be made through EMS Dispatch Operations.

12. Status Changes. All status changes (on scene, transporting, at hospital, clear, etc.) shall be promptly reported to the dispatcher as they occur.

    Dispatched: The "D" command should be used after dispatching units to an incident and receiving an acknowledgment from the unit(s).

    En Route: Once in the vehicle and physically responding to the incident, the assigned crew shall immediately update their status by pressing the "ENROUTE" button on the mobile data workstation, or by notifying the dispatcher via voice radio.

    Dispatch/Enroute ("DE") If the crew is already in the ambulance at the time of their dispatch and begins their response immediately, they may notify the dispatcher by acknowledging the incident location in the standard format and then stating "en route", at which time the dispatcher will use the "DE" (dispatch / enroute) command, as opposed to "D" (dispatch).

    On Scene: Upon arrival at the given incident location, responding units shall press the "ARRIVE" button. Units who arrive at a given incident location and are then directed to another location (by someone other than the dispatcher) shall notify the dispatcher via radio of the updated location.

    Enroute Hospital: When transporting a patient to a hospital, the operator shall press the "TRANSPORT" button and a "pick list" of area hospitals will then be displayed. The operator shall select the appropriate hospital abbreviation, note the mileage if necessary, and then submit the form. Transport to hospitals not included on the list requires prior approval by Dispatch Operations.

    Transport Complete: Upon arrival at the receiving facility, the operator shall press the "Transport Arrive" button.. Note: When two units are involved in the transport of a single patient (e.g. BLS *and* ALS unit transporting a single patient), the operator of both vehicles should transmit the transport/transport arrive commands for their individual unit.

    Clear: When clearing an incident, units shall press the "CLEAR" button and a list of authorized DISPO codes will be displayed; enter the appropriate code, enter comments as necessary, and submit the form.

Relevant comments may be appended to incident history by selecting the "add comments" button. It is important to note that all comments appended to the incident history become a permanent part of the call history. These can not be deleted and are easily viewed by anyone with access to CAD. The comments also do not eliminate the need to properly document relevant information on the incident PCR.

See Related Dispatch Operations Standard Operating Procedures:

“Dispatch Format”; “Response Acknowledgement”; “Clearing Codes & Hospital Abbreviations for MDW Use”; “Electronic Mail”

Response Acknowledgment Format

Supersedes: 09-29-08
Effective: 12-05-11

1. To ensure that the dispatch information has been received correctly, response units must acknowledge each response in the following format:

   1.1. Unit ID, full street address (number and name of the street) or Common Place name, and direction if on MBTA or limited access roadway (such as Storrow Drive or the Massachusetts Turnpike).

2. Dispatchers are responsible to ensure that response units properly acknowledge each response.

   2.1. The dispatcher shall direct a response unit failing to properly acknowledge a response to do so in the proper format.

   2.2. A unit's continued failure to acknowledge a response in the proper format shall be considered a "non-response".

3. In addition to acknowledging the incident location, responding crews are also responsible for notifying the dispatcher whenever they estimate their time of arrival at the scene of a reported medical emergency to be eight (8) minutes or more.

   3.1. Responding crews shall use the pro-word "**extended**" to advise the dispatcher that their ETA is eight (8) minutes or more.

4. Once in the vehicle and physically responding to the incident, the assigned crew shall immediately update their status by pressing the "EN ROUTE" soft key on the mobile data workstation, or by notifying the dispatcher via voice radio.

   4.1. If the crew is already in the vehicle at the time of their dispatch and begins their response immediately, they may notify the dispatcher by acknowledging the incident location in the standard format and then stating "en route", at which time the dispatcher will use the "DE" (dispatch / enroute) command, as opposed to "D" (dispatch).

   4.2. If a unit is "Dispatched" but does not place themselves "En Route" within two minutes, their status automatically turns to reverse-video in the CAD System as a prompt to the dispatcher. Unless the unit has already advised the dispatcher that they would be delayed going en route (which is then supplemented into the incident), the dispatcher should check the status of the unit to ensure they are enroute to the assignment.

Example of a unit already in the ambulance at time of dispatch acknowledging a response: "Boston, A-20 has 123 Main Street in Charlestown- en route"

See related SOP “Non-Response Procedure, “Extended EMS Response”, General Dispatch Procedures, Mobile Data Workstation / Status Changes

Service Codes

Supersedes:
Effective: 07-01-09

EMS SERVICE CODES

VEHICLE	
EMS Vehicle Crash	EMSMVA
Scheduled Vehicle Swap	VSWAP
Vehicle Breakdown	BRKDN
Vehicle Maintenance / Repair	VMAINT
Vehicle Checkout	CHKOUT
Refueling Vehicle	FUEL
PERSONNEL	
Injured / ill Member	INJMEM
Personal Emergency (non illness)	PEREMR
Special Assignment	ASGNMT
Annual Drug Testing	ADTEST
EQUIPMENT / SUPPLIES	
Mobile / Portable Radio Maintenance	RMAINT
Mobile Workstation Maintenance	MMAINT
SafetyPad Maintenance	SMAINT
Supply / Pharmacy	SUPPLY
ADMINISTRATIVE	
Shift Change	GOIN
EMS HQ Assignment	HQTRS
Meal Break	LUNCH
Training Assignment: Out of Service	OUTTRN
Writing Reports	REPORT

Special Broadcast Requests

Supersedes: 06-30-97
Effective: 01-01-13

1. Requests for special broadcast of messages must be made in writing and approved by a member of the Command Staff prior to broadcast. Broadcasts of road closings, hospital diversion or other routine broadcasts are not intended to be subject to this policy.
2. Every effort shall be made to honor special broadcast requests involving important union matters, funeral arrangements of public safety officers, upcoming training opportunities or other matters that may affect a large number of Boston EMS personnel.
3. Unless otherwise requested, these announcements shall be broadcast on TAC-1 at 10:00, 18:00 and 02:00 for a maximum of 3 (three) days. A brief alert tone shall precede the reading of any special announcement.

   3.1. At the Dispatch Operations Center Supervisor's discretion, a special broadcast message may be postponed if, because of high call volume, it may interfere with dispatch operations.

   3.2. Special broadcast messages forced to be postponed shall be made as soon as radio traffic permits.

See related SOP: "Special Broadcast Request Form"

Unit Status at Shift Change

Supersedes: 01-14-02
Effective: 08-10-09

1. Field units shall be considered in service and available for response during shift change. Reasonable efforts should be made to allow personnel the opportunity to return to satellite and be relieved as close to the scheduled shift change time as possible.
2. Ten (10) minutes prior to the scheduled completion of their shift, units may request to be put on a "**GO IN**". Like other service assignments (e.g. LUNCH, FUEL), CAD will still recommend the unit for responses, but the dispatcher will have a visual reminder that the unit is nearing the completion of their regularly scheduled tour of duty.
   2.1. Units scheduled for shift change and assigned to a "GO IN" may be dispatched to a PRIORITY 1 or PRIORITY 2 incident only if there is no other unit of the same level (i.e. ALS, BLS) available with a similar ETA.
   2.2. Units scheduled for shift change and assigned to a "GO IN" should not be dispatched to a PRIORITY 3 incident unless authorized by a Supervisor.
   2.3. Units working past their scheduled time of shift may be dispatched to a PRIORITY 1 incident only if there is no other unit of the same level (i.e. ALS, BLS) available with a similar ETA.
   2.4. Units working past their scheduled time of shift should not be dispatched to a PRIORITY 2 or PRIORITY 3 incident unless authorized by a Supervisor.
3. At the beginning of each shift, or as soon as practicable thereafter, the primary operator of the vehicle for the oncoming shift shall perform a thorough checkout of the mechanical condition of the vehicle. This should include at a minimum a check of fluid levels or evidence of leaks, fan belt check, tire condition, lights and siren, and evidence of any damage to the vehicle. The vehicle operator is also responsible for ensuring the presence and good condition of equipment in all exterior cabinets. The "attendant" (or primary operator in the case of single person units) is responsible for checking out all of the equipment and supplies inside the vehicle, including the AED/Monitor/Defibrillator, jump kit/first aid bag(s), oxygen and associated delivery devices, and ensuring that the medication inventory is completed and properly documented.
   3.1. Whenever a unit receives a response and is unable to immediately respond (performing narcotic count, vehicle checkout, etc.), they shall acknowledge the response, the reason for their delay, and the estimated time until they will be able to respond.

4. Upon arrival at satellite, field units without an oncoming relief (16 hour or detail units for example) should be allowed to go “out of service” 10 minutes prior to the completion of their shift to restock, complete paperwork, and prepare the vehicle for the next shift. Personnel shall be available by radio until the completion of their shift.

5. Crews reporting for duty to units that were not in service the previous shift should be allotted time to check the equipment prior to their first response.

   5.1. ALS units, if possible, shall be given 15 minutes to perform drug inventory, vehicle and equipment checkout. BLS units, if possible, shall be given 10 minutes to perform vehicle and equipment checkout.

   5.2. Personnel shall be available by radio from the start of their shift.

Utilization of Tactical Channels

Supersedes: 01-01-13
Effective: 03-01-16

1. The repeater on Boston EMS TAC Channels controlled by Dispatch Operations should normally be enabled to allow unit-to-unit communication or when a unit is providing an update to Dispatch Operations about an incident. By enabling the repeater, Field Units, Supervisors and Command Staff will be able to monitor these updates.

   1.1. A TAC Channel repeater may be disabled upon request from a field unit when the information being transmitted is of a sensitive nature (such as telephone numbers or incidents involving department members).

2. The Operations dispatcher functions as the Net Control station in the BEMS Communications System. All requests to use a Tactical Channel must be routed through the dispatcher. Field users should not request a specific channel, instead the request should be made for a “Tac Channel”, and the dispatcher will direct the user(s) to an available channel.

3. Whenever an incident involves multiple EMS resources (ALERT 2, PHASE 1, etc) or is expected to involve extended operations (such as a multiple alarm fire or building evacuation), every effort should be made to move the operations to a TAC Channel as soon as possible so as not to interfere with Citywide dispatch.

   3.1. Moving an incident to a TAC Channel should be coordinated with the incident commander, and consideration must be given to the Citywide call volume and the number of Dispatch Operations personnel available at the time. Units assigned to an incident shall not switch to a TAC Channel until directed to do so by Dispatch Operations personnel.

4. Whenever a TAC Channel is committed to an incident, it is no longer available for other traffic. For prolonged incidents, the Operations Dispatcher shall announce this fact on TAC-1 every 30-minutes for the duration of the restriction.

   “All units be advised TAC Channel “x” is restricted for <incident location>”

5. The Incident Command System shall be utilized at any incident of enough size or scope to warrant a dedicated TAC Channel. In accordance with the Department’s Mass Casualty Incident Plan, the first arriving unit at an incident shall assume (or be prompted by the dispatcher to assume) the “Incident Command” call sign until relieved by the first arriving Supervisor.

See Related: MassDOT Interoperability

Vehicle Operation & Response

Administrative Vehicle Use

Supersedes: 11-23-08
Effective: 01-13-12

Administrative Vehicles

For the purposes of this policy, all unmarked Boston EMS vehicles available for use by administrative personnel are referred to as ‘Administrative Vehicles’.

Requirements for Use

Non-uniform staff must provide a copy of their valid driver’s license to the Professional Standards Division and sign an “Administrative Vehicle Use Agreement” prior to operating any department vehicle. Each employee authorized to drive an Administrative Vehicle will be approved for specific vehicles, depending on work area and type of vehicle required.
All department employees are required to operate vehicles in a safe and lawful manner in accordance with Massachusetts or other applicable traffic laws. Employees are required to carry a current and valid Massachusetts motor vehicle operator’s license whenever operating a department vehicle. An employee whose job duties require a valid driver’s license shall notify Professional Standards whenever the employee’s license is expired, suspended, or revoked. Only full time employees of Boston EMS are permitted to operate Department vehicles (interns, consultants, temporary employees may not operate a department vehicle). The use of tobacco products or transport of alcohol in a department vehicle is prohibited.

Purpose of Use

Boston EMS vehicles are to be driven for the purpose of department business only. Personal use of vehicles is strictly prohibited. Further, the use of department vehicles for personal gain, such as delivering goods or services, is also prohibited. Employees shall not drive any Administrative Vehicle to their place of residence to be parked overnight unless he/she receives approval from the Chief of Department or designee.

Vehicle Operation

Administrative Vehicles are not considered emergency response units; all drivers and passengers shall adhere to posted traffic regulations, restrictions, proper road etiquette and seat belt laws. Department members not in compliance will be subject to all fines and penalties associated with any infractions of the vehicle and traffic laws. No more than the legal maximum capacity of passengers shall be transported at any one time in any vehicle

Massachusetts law prohibits unnecessary idling of vehicles for more than 5 minutes (MGL CH. 90 Sect 16A). In addition to causing pollutants to enter the atmosphere, prolonged vehicle idling wastes fuel and causes increased wear on the engine. Department vehicles should not idle unnecessarily.

Seat and Shoulder Belts

All department members, passengers, and observers riding in a vehicle shall wear fastened seat and shoulder belts while the vehicle is in motion. It shall be the responsibility of the vehicle operator to ensure that all passengers are properly secured prior to moving the vehicle. Children under the age of twelve (12) should not be transported in the front seat of an administrative vehicle equipped with a passenger side airbag. Children under the age of twelve should be properly secured in the rear seats of vehicles. When appropriate, children should be transported in a child safety seat.

Use of Electronic Devices While Driving

Cellular telephones, personal digital assistants (PDA), and other portable electronic devices have become commonplace tools within our society and serve as a valuable resource. However, their use must not interfere with employee safety. In accordance with the Massachusetts Safe Driving Law, vehicle operators cannot use any mobile telephone or handheld device capable of accessing the Internet to write, send, or read an electronic message including text messages, emails, and instant messages or to access the Internet while operating a vehicle. The law applies even if the vehicle is stopped in traffic. If cellular phone communication is necessary for a work-related purpose while operating a department vehicle and cannot be reasonably delayed until the vehicle is parked, the passenger should handle the call. In the case of a department member working alone and stopping the vehicle is not practical, the work-related phone call should be as brief as possible and the user should utilize a “hands-free” device if available. Department members are prohibited from using a cellular phone for personal use when operating a department vehicle.

Parking

Vehicles should be parked, when not in use, in their designated parking areas. Whenever possible, vehicles stored at EMS Headquarters will be parked in the lowest level of the parking garage, closest to the building entrance.

Within the City of Boston, drivers of department vehicles are not required to deposit a fee in a parking meter. Operators may park department vehicles in spaces that are posted “Commercial Loading Zones” or spaces posted as “Reserved for City Vehicles Only”. Commercial parking is available in various locations throughout the City. Parking “Reserved for City Vehicles Only” is located on portions of several streets in downtown Boston including: Court, Devonshire, Water, Hawley, and Kilby Street. Drivers are prohibited from parking a department vehicle in a manner that may cause a “Public Safety Violation” unless on scene at a designated medical or other similar emergency.
Drivers are prohibited from:

- Double parking
- Parking in No Stopping/No Standing zones
- Parking within twenty feet of an intersection
- Parking in a bus stop
- Parking within a pedestrian crosswalk
- Parking less than ten feet from a fire lane
- Parking on a sidewalk
- Parking in a handicap zone or blocking a handicap ramp
- Parking next to a fire hydrant
- Parking in a space designated on for HP/V Plate Parking

Drivers must comply with the parking regulations of any municipality in which they drive. Any driver who receives a parking ticket or causes a department vehicle to be towed because he/she has caused a “Public Safety Violation” will be responsible for all payments related to the infraction. The Professional Standards Division should be notified immediately after a department vehicle has been ticketed or towed.

Fuel

It is the responsibility of the driver to ensure there is sufficient fuel each time the vehicle is operated, with more than one-half of a tank of fuel remaining for the next user.
City of Boston fuel sites should be used whenever possible. Public self-service dispensers may be used when the City sites are not available. The most cost-effective vendor should be used. Pay out of pocket, keep a copy of the receipt and submit it to the Budget Director for reimbursement.

The closest fuel site to Boston EMS Headquarters is located at the DPW Central Maintenance facility at 400 Frontage Road. Take Albany Street north toward the I-90 connector, go under the freeway staying in the right-most lane, proceeding directly across the street into the drive way. Ensure you have pulled up next to the appropriate fuel type. Before turning off the vehicle, capture the current odometer reading. Go to the center console between the pumps and gently touch the FOB to the reader and then enter the odometer

reading (mileage) as prompted, next select the appropriate pump number and press enter. At this point you may turn the handle on the pump and begin fueling the vehicle.

Vehicle Collision

A “collision” occurs when any part of a department vehicle comes in contact with another vehicle, pedestrian, animal, or property resulting in property damage and / or injury. Incidental “bumper to bumper” contact while parallel parking is not considered a “collision” unless it results in property damage or injury.

Whenever a department vehicle is involved in a collision, the operator should bring the vehicle to a stop and position it in the safest possible place near the point of contact. Department members should assess any hazards created by the collision and create and maintain a safety zone to protect personnel and property from further injury or damage by activating hazard and/or warning lights as appropriate.

If the vehicles are in a hazardous location or blocking traffic, it may be appropriate to move to the side of the road or a side street for safety. Department members should then assess for the presence of any injuries. **Whenever a department vehicle is involved in a collision Boston EMS Dispatch Operations (617-343-1400) must be notified immediately. If the accident is significant, there is an injury or injuries and/or a traffic hazard exists, call 9-1-1.** The initial report should include the location and brief description of the incident, extent of any injuries, and what other resources are needed. Lastly, if all other needs are being met, department members should identify potential witnesses and preserve evidence at the collision site. The Dispatch Operations Center will make additional notifications as required by other policies and procedures, including requesting the Boston Police Identification / Photography Unit and / or Accident Investigation Unit for collisions involving personal injury.

Exchanging Operator / Contact Information

Department operators should cooperate fully with all involved parties and exchange any required information, including all motor vehicle operator’s license information and department vehicle registration information. Department members should not engage or question others as to the validity of their operator’s license, motor vehicle registration, or the legal operation of their motor vehicle. Any suspected discrepancies in these areas should be brought to the attention of the first arriving police officer. A copy of all required forms should be in the glove compartment of each vehicle and may also be obtained from a Field Supervisor by contacting Dispatch Operations (617-343-1400).

Documentation

Whenever a department member has a motor vehicle collision involving a department vehicle, the operator must complete a Commonwealth of Massachusetts Operator's Report of Motor Vehicle Accident Form and a Boston EMS Vehicle Collision Report. Additionally, any department member that witnessed the incident must fill out or co-sign a Boston EMS Vehicle Collision Report.

Reporters will be given reasonable time to complete required documentation. All documentation must be completed and hand delivered to a Field Supervisor immediately following the collision or to Professional Standards by the following

business day. Hand-written documents must be legible, all fields completed (using the abbreviation “n/a”, for any information Not Available or Not Applicable at the time the report is completed), and must be signed and correctly dated.

Incident Review / Driving Restriction

The department recognizes that being involved in a motor vehicle collision, no matter how minor, can be a stressful event. Whenever an operator of a department motor vehicle is involved in a collision, they are to refrain from driving a department vehicle for the remainder of that day, whenever possible.
Whenever a department motor vehicle is involved in a collision serious enough that it results in a personal injury or inoperability of either vehicle requiring a tow from the scene, the operator of the department vehicle will have their driving privileges restricted to the extent possible until the incident can be reviewed by Professional Standards.

Vehicle Maintenance

All department vehicles, unless approved by the Fleet Services Division, are serviced and repaired at the Fleet Maintenance Division’s maintenance facility on Shirley Street. In the case of an emergency or vehicle breakdown beyond the City limits, Fleet Maintenance may authorize other options. Drivers are responsible for the appearance, interior and exterior cleanliness, and general condition of the vehicle.

Alterations or Modifications

Employees shall not alter, add or remove equipment from any Boston EMS vehicle or affix any signs or political stickers without written permission from the Chief of Department or designee.

Travel Outside of Massachusetts

Except under unusual circumstances, department vehicles may not be driven outside of the Commonwealth of Massachusetts without prior approval from the Chief of Department or Superintendent-in-Chief, who will then seek approval from the BPHC Legal Counsel’s Office and notify appropriate programs/personnel.

Employee Agreement

This document is a compilation of multiple department policies. It is the responsibility of each department member to be familiar with and abide by all department policies that

pertain to them; any change in relevant department policies shall supersede any language within this document.
By signing this agreement, the employee attests that he/she understands and meets all requirements for Administrative Vehicle use and will abide by all rules set forth.

_____
Employee Name

_____
Employee Signature

_____
Program/Division

_____
Date

_____
Supervisor Signature

_____
Date

_____
Chief of Department (or SIC) Signature

_____
Date

Department Motor Vehicle Collisions

Supersedes:
Effective: 11-21-05

PURPOSE

The purpose of this policy is to provide direction regarding the proper action to be taken in the event of a collision involving a Department vehicle. For the purposes of this policy, a “collision” is when any part of a department vehicle comes in contact with another vehicle, pedestrian, animal, or property and results in property damage and / or injury. Incidental “bumper to bumper” contact while parallel parking is not considered a “collision” unless it results in property damage or injury.

VEHICLE COLLISIONS IN GENERAL

Whenever a Department vehicle is involved in a collision, the operator should bring the vehicle to a stop and position the vehicle in the safest possible place near the point of contact. Department members should assess any hazards created by the collision and create and maintain a safety zone to protect personnel and property from further injury or damage by activating warning lights or road flares as appropriate.

If the vehicles are in a hazardous location or blocking traffic, it may be appropriate to move to the side of the road or a side street for safety. Department members will then assess for the presence of any injuries and treat to the extent possible. At the same time, Dispatch Operations will be notified of the situation. The initial report should include the location and brief description of the incident, extent of any injuries, and what other resources are needed. Lastly, if all other needs are being met, department members should identify potential witnesses and preserve evidence at the collision site. Based on this report, Dispatch Operations will notify the appropriate ancillary agencies, dispatch a Field Supervisor to the scene, and notify the Shift Commander of the incident. The Dispatch Operations Center will make additional notifications as required by other policies and procedures, including requesting the Boston Police Identification / Photography Unit and / or Accident Investigation Unit for collisions involving personal injury.

COLLISION WHILE ON AN EMERGENCY RESPONSE

EMS Vehicle Inoperable

If the EMS vehicle was enroute to the scene of an emergency and has been rendered inoperable, another available ambulance will be sent to the original incident. Similarly, if a patient was being transported and the ambulance has been rendered inoperable, another available ambulance will be sent to the incident location to assume and / or assist in patient care and complete the transport.

EMS Vehicle Operable

If the ambulance is transporting an unstable patient when involved in a collision but the ambulance is not rendered inoperable, Dispatch Operations shall be immediately notified of the incident. If the vehicle is in a hazardous location and cannot be moved, there are unstable patients on scene, or staying on scene to await the arrival of another EMS unit is unlikely to compromise the original patient's condition, the EMS unit should remain on scene. If, however, the vehicle and its occupants are not in a hazardous location, there are no other unstable patients on scene, and waiting for another EMS unit to arrive and assume patient care will likely be harmful to the unstable patient already in the ambulance, the operator of the EMS vehicle should note the registration number of the other vehicle involved, give the other operator a department contact form and advise him/her to remain on scene until the arrival of the police and an EMS Supervisor. If the collision involved an unoccupied vehicle, the contact form will be affixed to the vehicle's windshield. The EMS personnel may then continue to the hospital or ALS intercept point while updating Dispatch Operations.

If the ambulance is transporting a stable patient at the time of the collision, assure that care is being provided to the original patient while administering patient care to any other injured persons and awaiting additional resources.

If the ambulance was enroute to a high priority incident when involved in a collision, but the ambulance is not rendered inoperable, and there are no patients on the scene, Dispatch Operations shall be notified of the situation. If there are no other EMS units available to respond to the high priority incident in a timely manner, the Dispatch Operations Supervisor may authorize the EMS unit to continue on its original response. In that case, the operator of the EMS vehicle should note the registration number of the other vehicle involved, give the operator a department contact form and advise him/her to remain on scene until the arrival of the police and an EMS Supervisor. If the collision involved an unoccupied vehicle, the contact form will be affixed to the vehicle's windshield. If the EMS unit is cancelled or cleared from the response in a timely fashion, they must return to the scene and meet the Field Supervisor or the Boston Police unless directed to do otherwise.

EXCHANGING OPERATOR / CONTACT INFORMATION

Department operators should cooperate fully with all involved parties and exchange any required information, including all motor vehicle operator's license information and department vehicle registration information. Department members should not engage or question civilians as to the validity of their operator's license, motor vehicle registration, or the legal operation of their motor vehicle. Any suspected discrepancies in these areas should be brought to the attention of the first arriving police officer.

PRELIMINARY INVESTIGATION

Field Supervisors shall manage the collision scene ensuring that department protocols are being followed, assist in the caring of any injured Department members or civilians, and preserve and photograph pertinent evidence.

The Field Supervisor shall attempt to obtain statements and contact information (name, address, phone number) from all known witnesses the incident. The statement shall describe in as much detail as possible the recollections of the witnesses as to direction

of travel, estimated speed, use or warning lights and/or siren, and other observations about the vehicles either before or after the incident.

Supervisors should record the weather and road conditions on scene, position of the vehicles, and any other physical evidence including signs of transfer evidence such as paint chips, tire marks, or debris patterns. Supervisor should assist in the testing and/or inspection of department vehicles, safely and to the best of their ability, whenever defective equipment is alleged or suspected.

DOCUMENTATION

Whenever a Department member has a motor vehicle collision involving a Department vehicle, the operator must complete a Commonwealth of Massachusetts Operator's Report of Motor Vehicle Accident Form and a Boston EMS Vehicle Collision Report. Additionally, any Department member that witnessed the incident must fill out or co-sign a Boston EMS Vehicle Collision Report.

Reporters will be given reasonable time to complete required documentation. All documentation must be completed and hand delivered to a Field Supervisor prior to the conclusion of the shift in which the incident occurred. Hand-written documents must be legible, all fields completed (using the abbreviation “n/a”, for any information Not Available or Applicable at the time the report is completed), and must be signed and correctly dated.

The investigating Supervisor shall review all produced documentation for accuracy, insuring that all reports provided by Department operators are complete. The Supervisor will then attach photographs (or flash card) of the accident scene, copies of the Police report, if available, and submit the package to Professional Standards. If the accident occurs at or near the end of the work shift, the Field Supervisor shall not be considered relieved of duty until all required reports have been completed, unless authorized by the Shift Commander.

INCIDENT REVIEW / DRIVING RESTRICTION

The Department recognizes that being involved in a motor vehicle collision, no matter how minor, can be a stressful event. Whenever an operator of a Department motor vehicle is involved in a collision, they are to refrain from driving a Department vehicle for the remainder of that shift whenever possible. This will not be possible in the case of a supervisor, or other single-person unit, or when a BLS crew must split up to drive an ALS unit to a hospital. In that case, the operator who had been involved in a collision earlier in the shift should drive the “empty” unit when possible.

Whenever a Department motor vehicle is involved in a collision serious enough that it results in a personal injury or either vehicle is inoperable and requires a tow from the scene, the operator of the Department vehicle will have their driving privileges restricted to the extent possible until the incident can be reviewed by Professional Standards.

Extended EMS Response

Supersedes: 03-03-05
Effective: 01-11-11

1. Unless there are medical personnel already on scene treating the patient (such as at a health center), the Boston Fire Department shall be notified and requested to respond to incidents within their jurisdiction having the TYPE Code: **ILL1, OBGYN1, INHEM1, SHOT, STAB, INJ2, RESP2, or EMSINV** whenever one of the following situations exists:

   1.1. If, after polling unit availability or preempting units from lower priority assignments, the dispatcher has no unit available and has reason to believe no unit will become available within five (5) minutes of call entry.

   1.2. Whenever a unit will become available shortly (within five minutes of call entry) but because of their location or traffic conditions the dispatcher has reason to believe that their ETA will be eight (8) minutes or greater.

   1.3. Whenever a unit (or all units in the case of a multi-unit response) is dispatched to an incident and advises the dispatcher they will have an "**extended**" ETA in reaching the incident location.

   1.4. Whenever the dispatcher feels it may be beneficial for the patient to receive a first responder assignment regardless of the TYPE Code or unit availability (e.g. when a patient suffers a minor foot injury but is outside during a snowstorm).

See related SOP: "Response Acknowledgment Format"

Fleet Status

Supersedes: 05-05-04
Effective: 08-10-09

PURPOSE

The purpose of this procedure is to provide better tracking of the status and location of units requiring maintenance during the course of the day. This procedure is also intended to ensure more efficient scheduling of non-critical requests for vehicle service from in-service units.

PROCEDURE

VEHICLE CHECKOUT

1 At the beginning of each shift, or as soon as practicable thereafter, the primary operator of the vehicle shall perform a thorough checkout of the mechanical condition of the vehicle. This should include at a minimum a check of fluid levels or evidence of leaks, fan belt check, tire condition, lights and siren, and evidence of any damage to the vehicle. The vehicle operator is also responsible for ensuring the presence and good condition of equipment in all exterior cabinets. The "attendant" (or primary operator in the case of single person units) is responsible for checking out all of the equipment and supplies inside the vehicle, including the AED/Monitor/Defibrillator, jump kit/first aid bag(s), oxygen and associated delivery devices, and ensuring that the medication inventory is completed and properly documented.

REQUESTING FLEET SERVICES

2 In-Service: All requests from an in-service unit seeking permission to go to Fleet Services for minor maintenance shall be referred to the Dispatch Operations Supervisor. The Dispatch Operations Supervisor will evaluate unit availability, call-load, and the number of units already at Fleet Services prior to granting permission and will advise the On-Duty Shift Commander of the service assignment. In-service units are not to report to Fleet Service without having first obtained permission from Dispatch Operations. Once approved, the dispatcher will place the unit on a "**VMAINT**" assignment in the CAD system with a brief notation in the comments indicating the type of problem (e.g.: "getting washer fluid", "getting air in a tire").

3 Out of Service: Whenever a vehicle develops a mechanical problem that requires it to be taken out of service, the dispatcher should place the unit on a "**BRKDN**" assignment in the CAD system with a brief notation in the comments section indicating the type of problem (e.g.: "won't start", "flat tire", etc.). The Shift Commander and appropriate Division Supervisor shall be notified whenever a vehicle is out of service for any reason. The Division Supervisor shall be responsible for investigating the circumstances of the vehicle being out of service, and ensure steps are taken to get the unit back in service as expeditiously as possible.

4 Vehicle Swap: The Service Code “**VSWAP**” shall be used whenever a unit is sent to Fleet Services for a scheduled / routine vehicle swap.

Global Positioning System (GPS) Units

Supersedes:
Effective: 05-07-07

Boston EMS units are frequently called upon to provide emergency medical services outside of the City, or to provide medical monitoring or other operational and logistical support to neighboring agencies. A number of BEMS units will be equipped with global positioning system (GPS) navigation devices. These units may be useful when responding outside of our normal coverage area, to assist responding personnel who may be unfamiliar with the most direct route to an emergency scene within the City, or to assist routing to an unfamiliar hospital or staging area.

1. Security. Portable GPS units are cited by police agencies as among the most commonly stolen type of device from a vehicle. Department members are reminded to properly secure the vehicle whenever it is left unattended. To the extent possible, the unit should not be left in plain view when the vehicle is left unattended. As is the case with all department property, any loss or damage to the GPS unit should be immediately reported to a supervisor. The unit is placed in such as way so as not to obstruct the driver's view of the road or interfere with vehicle operating controls, such as the steering wheel, or gear shift selector. The unit should not be placed in the path of any installed airbag.

2. Operation. The GPS navigators feature a simple touchscreen interface, with automatic route calculation to any destination and turn-by-turn voice-prompted directions along the way. Selecting a destination is straightforward and requires only a limited amount of input from the user. The unit allows the user to choose between a three-dimensional navigation view or the more traditional "bird's eye" overhead view.

    2.1. When navigating, carefully compare information displayed on the unit to your existing district familiarity and all available navigation sources, including information from street signs, your visual observations, and maps or street guides. The unit is intended to provide route suggestions. It is not designed to replace the need for driver attentiveness regarding road closures or road conditions, traffic congestion, weather conditions, or other factors that may affect safety while driving.

    2.2. Always operate the vehicle in a safe manner. Do not become distracted by the GPS unit while driving, and always be fully aware of all driving conditions. Minimize the amount of time spent viewing the unit's screen while driving and use the voice prompts whenever possible. Do not input destinations, change settings, or access any of the functions requiring prolonged use of the unit's controls while driving. If the operator's partner is not available to input information, the operator should pull over in a safe manner before attempting such operations.

3. Maintenance. Clean the screen with water, isopropyl alcohol, or eyeglass cleaner; do not use cleaners containing ammonia, which can harm the coating on the screen. To the extent possible, do not leave the unit exposed to a heat source or in a high temperature location, such as in the sun in an unattended vehicle on a hot day.

Off Duty Department Vehicle Use

Supersedes: 08-14-06
Effective: 02-23-11

POLICY
Boston EMS personnel may be authorized to use a Department vehicle while off-duty for the purposes of commuting to and from work, attending official functions (award ceremonies, funerals, court appearances, training classes, etc.), or as part of on-call responsibilities where a timely response to an incident is required. Department vehicles shall be protected against loss or damage. The employee shall accept full responsibility for fines incurred as a result of any driving, parking, or traffic violation. "Low profile" Department vehicles shall be marked with "Boston EMS" on the front fenders and have blue municipal license plates.

PERSONNEL AUTHORIZED FOR OFF-DUTY DEPARTMENT VEHICLE USE:
1. Chief of Department
2. Medical Director
3. Superintendent in Chief
4. Superintendent
5. Communications System Engineer
6. On-Call Field Shift Commander

TEMPORARY USE AUTHORIZATION
Personnel other than those listed above may receive temporary authorization to use a Department vehicle while off duty for the purposes of attending official functions (award ceremonies, funerals, court appearances, training classes), as part of on-call responsibly, or for other specifically identified need. Such temporary authorization must be approved in advance by the Chief of Department or Superintendent in Chief, and written notification will be made to Professional Standards indicating the person authorized to use a Department vehicle, vehicle number, and duration of the authorized period.

REQUIRED EQUIPMENT FOR OFF DUTY OPERATION
When operating a department vehicle while off-duty, members must be appropriately attired and possess necessary identification and equipment commensurate with their training and certification. Department vehicles shall be equipped, at a minimum, with an oxygen resuscitator, AED or monitor / defibrillator, and a first aid kit / jump kit whenever operated by a Department EMT, Paramedic, or Physician.

OFF-DUTY ACTIVITIES
When using a Department vehicle during off duty hours within radio range, the member shall at all times monitor the appropriate BEMS dispatch channel. The member shall

notify Dispatch Operations when responding to a medical emergency or stopping to assist at the scene of an incident.

Personnel are encouraged to stop at any incident which requires immediate attention such as vehicle crashes, stalled vehicles in a potentially dangerous location, or when being flagged down by citizens. Personnel should remember that public perception of Boston EMS employees is important and influenced by how and where the public sees Department vehicles being used. Department vehicles are not meant to replace personal vehicles, and drivers should not make incidental stops at locations the public would perceive as inappropriate.

During periods of off-duty operation of a Department vehicle, personnel shall wear conservative clothing, in good condition, suitable for members representing the Department. If not in uniform, personnel shall have in their possession an approved uniform jacket. The jacket should be worn for identification purposes whenever a member in civilian attire stops to perform EMS related activities while operating a Department vehicle.

VEHICLE RESPONSIBILITY / LOSS OF PRIVILEGES

Take home vehicle privileges may be terminated by the Chief of Department or designee upon violation of any of the provisions of this policy, the general department vehicle operation policy, or for any other reason as may be determined. Willful negligence on the part of the member in the care or operation of an assigned vehicle or failure to follow these policies will cause the vehicle to be taken away and take-home privileges suspended or permanently revoked. Appropriate disciplinary action for a policy violation may be taken in addition to the loss of the privilege of a take-home vehicle.

Members on disciplinary suspension for any reason shall automatically lose their take-home vehicle privileges during the period of the suspension. Department members out injured or on modified duty may have their take home privileges temporarily suspended.

All Department employees are required to operate vehicles in a safe and lawful manner in accordance with Massachusetts, or other applicable traffic laws. A valid Massachusetts Driver’s license is required for anyone operating a Department vehicle. Occupants of Department vehicles shall wear seat and shoulder belts in accordance with the manufacturer’s recommendations.

The use of tobacco products or transport of alcohol in a Department vehicle is prohibited. Use of Department vehicles for personal gain, such as delivering goods or services, is prohibited.

VEHICLE MAINTENANCE

All Department vehicles, unless approved by the Fleet Services Division, are serviced and repaired at the Fleet Maintenance Division’s maintenance facility on Shirley Street. In the case of an emergency of vehicle breakdown beyond the City limits Fleet

Maintenance may authorize other options. Drivers are responsible for the appearance, interior and exterior cleanliness, and general condition of the vehicle.

City of Boston fuel sites should be used whenever possible. Public self-service dispensers may be used when the City sites are not available. The most cost-effective vendor should be used.

ALTERATIONS OR MODIFICATIONS
Employees shall not alter, add or remove equipment in or out of any Boston EMS vehicle or affix any signs or political stickers without written permission from the Chief of Department or designee.

TRAVEL OUTSIDE OF MASSACHUSETTS
Except under unusual circumstances, Department vehicles may not be driven outside of the Commonwealth of Massachusetts without prior approval from the Chief of Department, Superintendent-in-Chief, or a Superintendent. Once authorized, the Commander of Support Services, Commander of Professional Standards, and the PHC Legal Counsel's office should be notified of the vehicle identification, destination, operator(s) and anticipated departure / return dates.

FRINGE BENEFIT
Internal Revenue Service (IRS) rules provide that in certain circumstances, the personal use of a take home vehicle includes commuting to and from work. Personal use is considered a fringe benefit by the IRS and must be included in the employee's wages and may be subject to income taxes. Employees should consult a tax specialist regarding the potential tax implications of a take home vehicle.

See Related SOP: Vehicle Operation

Special Responses, Routing and Contra-Flow

Supersedes: 09-29-08
Effective: 12-05-11

When an incident occurs on a limited access roadway such as the Massachusetts Turnpike, Storrow Drive, or I-93, traffic can quickly become backed-up making access via normal means difficult. Sometimes, the most efficient means to access the scene is by going against the normal flow of traffic ("contra-flow"), either by driving up an exit ramp, or accessing via the normal means but then backing down the roadway to the incident. Contra-Flow response requires coordination between Boston EMS and the law enforcement agency responsible for controlling traffic at the scene to ensure the safety of all involved. In the case of an incident on I-93 or I-90, the Massachusetts Department of Transportation (MassDOT) Highway Operations Control Center may also be involved as they can often monitor the incident via a series of cameras and are in direct communication with Massachusetts State Police.

PROCEDURE

1. If an incident on a limited access roadway cannot be accessed via normal means (due to traffic or routing issues), responding personnel should notify the dispatcher of the issues involved so that alternate routing can be determined.
2. The Dispatch OPS Supervisor or designee shall contact the law enforcement agency with jurisdiction for the roadway (or, in the case of an I-93 or I-90 response, the responding crew can coordinate directly with the Massachusetts Highway Operations Control Center) to advise them of the response issue(s) and request alternate routing information.

    2.1. Contra-Flow staging and routing information shall be voice broadcast to the field unit. The unit shall advise when on scene at the designated Contra-Flow staging location and not proceed until directed.

    2.2. Should an escort not be available, the Dispatch Operations duty supervisor or designee shall have the unit stand by the Contra-Flow staging until the on scene traffic control unit advises traffic has been stopped and it is safe to proceed. The dispatch supervisor/designee shall verbally reconfirm it is safe to proceed, relay to the dispatcher to have the unit "proceed using extreme caution" and units should proceed carefully.

See Related: MassDOT Interoperable Communications

Vehicle Operation

Supersedes: 11-21-05
Effective: 11-23-08

1. Department members operating a BEMS owned vehicle while not in emergency response shall obey all posted traffic regulations and restrictions, as specified in Massachusetts General Law, including among other things compliance with traffic signals, posted speed limits, and stop signs. Department members not in compliance will be subject to all fines and penalties associated with any infractions of the vehicle and traffic laws. The following provisions of Chapters 89 of the Massachusetts General Laws apply to the operation of ambulances and other emergency vehicles during responses. All members should be familiar with the following laws.

   1.1. *Chapter 89, Section 7*. The members and apparatus of a fire department while going to a fire or responding to an alarm, police patrol vehicles and ambulances, and ambulances on a call for the purpose of hospitalizing a sick or injured person shall have the right of way through any street, way, lane or alley. Whoever willfully obstructs or retards the passage of any of the foregoing in the exercise of such right shall be punished by a fine of fifty dollars or by imprisonment for not more than three months for the first offense and by a fine of not more than five hundred dollars or by imprisonment for up to one year for a second and subsequent offenses; provided, however, that for a third or subsequent offense the court or the registry of motor vehicles, in addition to any such fine or imprisonment, may suspend the license of the person so convicted and may order mandatory classroom retraining in motor vehicle and traffic laws;

   1.2. *Chapter 89, Section 7A*. Upon the approach of any fire apparatus, police vehicle, ambulance or disaster vehicle which is going to a fire or responding to call, alarm or emergency situation, every person driving a vehicle on a way shall immediately drive said vehicle as far as possible toward the right-hand curb or side of said way and shall keep the same at a standstill until such fire apparatus, police vehicle, ambulance or disaster vehicle has passed. No person shall drive a vehicle over a hose of a fire department without the consent of a member of such department. No person shall drive a vehicle within three hundred feet of any fire apparatus going to a fire or responding to an alarm, nor drive said vehicle, or park or leave the same unattended, within eight hundred feet of a fire or within the fire lanes established by the fire department, or upon or beside any traveled way, whether public or private, leading to the scene of a fire, in such a manner as to obstruct the approach to the fire of any fire apparatus or any ambulance, safety or police vehicle, or of any vehicle bearing an official fire or police department designation. Authorized police or fire department personnel may tow a vehicle found to be in violation of the provisions of this section or which is illegally parked or standing in a fire lane as established by the fire

department, whether or not a fire is in progress, and such personnel shall not be subject to the provisions of section one hundred and twenty D of chapter two hundred and sixty-six. No person shall operate a motor vehicle behind any such fire apparatus, ambulance, safety or police vehicle, or any vehicle bearing an official fire or police department designation which is operating with emergency systems on, for a distance of three hundred feet. Violation of any provision of this section shall be punished by a fine of not more than one hundred dollars.

1.3. *Chapter 89, Section 7B*. The driver of a vehicle of a fire, police or recognized protective department and the driver of an ambulance shall be subject to the provisions of any statute, rule, regulation, ordinance or by-law relating to the operation or parking of vehicles, except that a driver of fire apparatus while going to a fire or responding to an alarm, or the driver of a vehicle of a police or recognized protective department or the driver of an ambulance, in an emergency and while in performance of a public duty or while transporting a sick or injured person to a hospital or other destination where professional medical services are available, may drive such vehicle at a speed in excess of the applicable speed limit if he exercises caution and due regard under the circumstances for the safety of persons and property, and may drive such vehicle through an intersection of ways contrary to any traffic signs or signals regulating traffic at such intersection if he first brings such vehicle to a full stop and then proceeds with caution and due regard for the safety of persons and property, unless otherwise directed by a police officer regulating traffic at such intersection. The driver of any such approaching emergency vehicle shall comply with the provisions of section fourteen of chapter ninety when approaching a school bus which has stopped to allow passengers to alight or board from the same, and whose red lamps are flashing;

2. Vehicle Parking and Idling

2.1. Massachusetts law prohibits unnecessary idling of vehicles for more than 5 minutes (MGL CH. 90 Sect 16A). In addition to causing pollutants to enter the atmosphere, prolonged vehicle idling wastes fuel and causes increased wear on the engine. Unless engaged in an operation for which engine power is necessary for an associated power need other than movement, such as to maintain climate control or electrical power, Department vehicles should not idle unnecessarily. This is especially true when vehicles are parked near a hospital emergency room or ambulance satellite station where fumes may be drawn into the building.

2.2. Within the City of Boston, department vehicles may park on the street in spaces that are posted “Commercial Loading Zones” or spaces posted as “Reserved for City Vehicles Only”. Commercial parking is in various locations and parking for City vehicles only is located on portions of several streets in downtown: Court, Devonshire, Water, Hawley, and Kilby Streets. Drivers are prohibited from parking a department vehicle in a manner that may cause a “Public Safety Violation” unless on scene at a designated medical or other similar emergency. Drivers are prohibited from:

- Double parking
- Parking in No Stopping/No Standing zones
- Parking within twenty feet of an intersection
- Parking in a Bus Stop
- Parking within a pedestrian crosswalk
- Parking less than ten feet from a fire lane
- Parking on a sidewalk
- Parking in a handicap zone or blocking a handicap ramp
- Parking next to a fire hydrant
- Parking in a space designated on for HP/V Plate Parking

Drivers must comply with the parking regulations of any municipality in which they drive. Any driver who receives a parking ticket or causes a department vehicle to be towed because he/she has caused a "Public Safety Violation" will be responsible for all payments related to the infraction. If the ticket was issued in error, the employee should contact the Office of the General Counsel.

3. Seat and Shoulder Belts

3.1. All Department members, passengers, and observers riding in the cabs of ambulances, supervisory vehicles, or special service units, shall wear fastened seat and shoulder belts while the vehicle is in motion.

3.2. Seatbelts shall be worn by all occupants in the patient care compartment unless impractical to provide patient care. Patients or family members who are transported on the jump seat/bench seat in a sitting position must be belted in with the seat belt.

3.3. Patients transported by stretcher must have at least three strap type restraining devices (chest, hip, and knee) to prevent longitudinal or transverse dislodgment of the patient during transit. Additionally, the head of the cot shall be furnished with upper torso (over shoulder) restraints that mitigate forward motion of the patient during severe braking or in a frontal impact crash. If use of the shoulder harness is precluded due to patient care needs (CPR, Defibrillation, shoulder/clavicle injury), this must be noted on the patient care report. When appropriate, children should be transported in a child safety seat.

3.4. It shall be the responsibility of the vehicle operator to ensure that all passengers and patients are properly secured prior to moving the vehicle. If a family member or friend who wishes to accompany the patient refuses to wear a seat belt, the operator shall inform the person that Department policy prohibits people from riding in an ambulance without a seat belt. If the person continues to refuse, the operator shall not transport such person;

3.5. Children under the age of twelve (12) should not be transported in the cab of a vehicle equipped with a passenger side airbag except in extreme circumstances. Children under the age of twelve should be properly secured in the rear seats of vehicles.

4. Backing and Negotiating Tight Spaces.

4.1. Whenever a Department ambulance not carrying a patient is backing up or negotiating a tight space, the passenger shall assist the vehicle operator in maneuvering the vehicle so as to avoid collision. The passenger will get out of the vehicle, station himself or herself at the rear of the vehicle in the view of the rear view mirror, direct the vehicle operator, and the guide oncoming traffic, as needed.

4.2. Whenever a Department ambulance is backing up or negotiating a tight space while carrying a patient, the EMT-Attendant should assist the operator to the extent possible without leaving the patient. When no one is available to act as a guide, the driver must back using extreme caution and activate the vehicle back-up alarm if so equipped.

5. Use of Warning Lights and Siren

5.1. Responding. Emergency warning lights and siren shall be used while on an emergency response. While enroute to an emergency, the vehicle's headlights and all emergency lights shall be illuminated. The siren should normally be continuously activated while enroute to an emergency, but this may not always be practical. For example, when operating on a limited access roadway with no other traffic in sight, or when operating on a single lane road or tunnel, the continuous use of the siren may not be necessary. Department members should exercise good judgment in the use of the siren, taking into account whether other EMS personnel are already on scene, distance from the location, traffic congestion, road conditions, and time of day. If the siren is being used intermittently, it must be in operation continuously when approaching and passing through an intersection with a red light or stop sign. One-way, no turn, and other regulations may be disregarded during emergency operation only when necessary. When disregarded, driving shall be done at a slow rate of speed, with all warning devices engaged. Vehicle operators may proceed, after coming to a complete stop, though red lights, stop signs, and other traffic control devices.

5.2. Slow/Continue. When a responding unit is directed to "slow but continue" by an on scene unit, the vehicle operator shall continue operating in the emergency mode, but reduce the speed of the vehicle accordingly and comply with all traffic regulations (e.g. one way and other traffic control devices). Vehicle operators may proceed, after coming to a complete stop, though red lights, stop signs, and other traffic control devices. If the siren is being used intermittently, it must be in operation continuously when approaching and passing through an intersection with a red light or stop sign.

5.3. Transport. The use of the siren and rapid transportation of a patient is rarely indicated. While warning lights should be activated during transport, Department members should exercise good judgment and discretion in the use of the siren while transporting a patient to a hospital, taking into account the patient's condition, distance to the hospital, traffic congestion, road conditions, and time of day. If the siren is being used intermittently, it must be in operation

continuously when approaching and passing through an intersection with a red light or stop sign.

6. Duty of Driver When Following Other Emergency Vehicles.

6.1. The driver of any Department vehicle shall not race or pass other responding emergency vehicles unless signaled to do so by the operator of the other vehicle(s).

6.2. A minimum distance between responding units shall be maintained. The second unit shall not pass any point on the roadway sooner than two seconds after the leading response unit has passed the same point on the roadway. Reference points shall be the rear bumper of the lead vehicle, and the front bumper of the second vehicle.

7. Securing Vehicle and Equipment.

7.1. To the extent possible, all loose equipment should be secured whenever a vehicle is in motion.

7.2. Department vehicles are to be locked whenever left unattended. If so equipped, anti-theft devices shall be engaged whenever a vehicle must be left running while unattended. The ignition key shall be removed whenever engaging an anti-theft device that allows the engine to continue running when the ignition is turned to the “off” position.

7.3. The parking brake shall be set whenever a Department vehicle is parked on an incline, or whenever a vehicle without a transmission interlock system is left unattended. (With a transmission interlock system, the gear selector cannot be moved out of Park unless the brake pedal is applied.)

8. Improper / Unauthorized Vehicle Use

8.1. A Department vehicle should not be used to chase, obstruct another motor vehicle, and/or confront its occupants. If an ambulance crew witnesses a person fleeing or driving from the scene of a crime, the appropriate police agency shall be notified via Dispatch Operations, and the relevant information given to that police agency.

8.2. The driver should use care at all times when operating a department vehicle and should not drive the vehicle over high curbing, onto sidewalks, or over the median strips of roadways, except in extreme situations. When such actions must be taken, the driver should do so slowly so as to keep the vehicle under constant control and minimize potential damage. Any known or suspected vehicle damage should be reported to a supervisor at the conclusion of the call.

8.3. Personnel should not permit an ambulance to be moved by anyone other than a Department member. However, in extreme circumstances, a Boston Police Officer or a Boston Firefighter may be authorized to reposition the vehicle, or assist by driving an ambulance not carrying a patient to a hospital.

(11-23-08 Section regarding vehicle positioning removed and put in “Vehicle Positioning / High Visibility Apparel” SOP)

Vehicle Positioning and High Visibility Apparel

Supersedes:
Effective: 11-23-08

Each year, more than 100 workers are killed and over 20,000 are injured after being struck while operating at roadway incidents. Department members should understand and appreciate the high risk that responding personnel are exposed to when operating in or near moving vehicle traffic, and always consider moving vehicles a threat to your safety.

1. Parking and Stationing At An Incident

1.1. Upon arrival at the scene of an emergency, the operator shall position and park the vehicle in a safe place, out of the way of other emergency vehicles, local traffic, and other on-scene activities, if possible. The operator should consider the following variables when parking the vehicle: access to the incident; ability to leave the scene; other responding emergency vehicles; (at a fire scene, always anticipate the possibility of being blocked in by subsequently arriving emergency apparatus); traffic and weather conditions;

1.2. Always look before stepping out of vehicle, or into any traffic areas. When walking around the ambulance parked adjacent to moving traffic, keep an eye on traffic and walk as close to ambulance as possible. Avoid turning your back on approaching traffic to the extent possible.

1.3. Upon arrival at a roadway incident where other emergency vehicles are already on scene, the ambulance operator should position the vehicle beyond the accident scene, if possible, preferably along the shoulder of the road. The EMS vehicle should be positioned as close as possible to the incident, taking care to avoid any fuel spills or other scene hazards.

1.4. At a highway or other high speed roadway incident where an EMS vehicle is the first emergency vehicle on scene:

- Advise the dispatcher of the need for additional resources to assist with traffic control.
- Position the EMS vehicle, with the appropriate warning lights on, in such a manner as to protect the working environment and warn approaching motorists of the hazard. Close as many lanes of traffic as necessary to ensure a safe working environment. Personnel should use extreme caution while working under these conditions.
- Field Supervisors should be cognizant of incidents on the highway or other high speed roadways in which the EMS vehicle is the only emergency vehicle on scene and make every effort to respond and ensure that EMS personnel are operating in a safe environment.

- If conditions at the scene make a previously safe positioning of the ambulance unsafe, the vehicle should be moved to a safe, unimpeded location with the above factors still in mind.

2. High Visibility Safety Apparel. Department personnel are required to wear department issued or approved high visibility safety apparel whenever operating at the scene of a motor vehicle collision or other roadway incident in which personnel will be exposed to vehicular traffic. If not already being worn, the high visibility jacket or vest is to be immediately available in the cab of the vehicle, and donned upon exiting the vehicle at the scene of a roadway incident.

   2.1. "High visibility safety apparel" means personal protective safety clothing that is intended to provide conspicuity during both daytime and nighttime usage, and meets the performance Class 2 or 3 requirements of ANSI / ISEA 107-2004.

   2.2. Department issued "florescent" rain jackets (Blauer 2695-1) are considered ANSI 107-2004 Class 2 compliant. Vests meeting the "Public Safety Vest" standard (ANSI 207-2006) have been deemed to meet the requirements of 23 CFR 634 and may be used in lieu of Class 2 garments.

Reference: Federal Highway Administration; 23 CFR Part 634: "Worker Visibility"

Vehicle Shoreline Connections

Supersedes:
Effective: 10-31-14

PURPOSE

Department vehicles are equipped with a shoreline vehicle connection in order to charge the vehicles batteries as well as run or charge other electrical systems or equipment. No other method of charging batteries is as effective as utilizing shoreline connections.

POLICY

All vehicles, where so equipped, are to be plugged into a shoreline connection whenever parked at a department station. Vehicles will avail themselves of the *opportunity* to connect to shorelines whenever possible.

SCOPE

Applies to *all* department vehicles equipped with a shoreline connection

PROCEDURE

1. Personnel are to plug the vehicle into a yellow shoreline connection, noting the correct function of the socket and also noticing the position of the polarity and grounding prongs. (Recall that some supervisor and specialty vehicles have other colored receptacles for special duties).

2. If the cord is reel mounted, personnel should manually unplug and slowly retract the plug and cord carefully, even though some vehicles have an auto-eject function. This prevents the plug from striking objects or people, protects the reel somewhat, and insures the plug has fully retracted and is not hung up on some part of the vehicle.

3. Some facilities may have a direct charge outlet on an exterior wall. These outlets may be used during clement weather conditions. The charging cord should be removed from the wall socket first and gathered up and secured in an outside vehicle compartment between assignments.

4. When the shorelines are unplugged from the vehicle, regardless of wall or ceiling mounted, they should be placed in a way that will not cause them damage, such as leaving plugs on the floor where they could be run over.

5. Shorelines should not be used as “rope” or for any other unintended purpose.

6. When charging the batteries personnel will note the condition of the batteries, either by the bar graph, or a digital read-out gauge on the side of the vehicle.

TROUBLESHOOTING

1. If no display is showing on the bar graphs or the digital display after plugging the vehicle in, plug in some other three pronged electrical appliance to see there is power to the plug. If not, report the incident to Facilities.

2. If the plug has power, report the incident to Fleet.

3. Vehicles that display a low reading, either by bar graph or digital display should be reported to Fleet, noting which bar graph or display (Left, Right or Single) are reporting below normal.

On-Scene Operations

Accessing Patient or Call Location

Supersedes: 07-01-05
Effective: 03-01-16

1. While enroute to an incident location, responding crews should monitor the radio and mobile workstation for updated location or access information. Upon arrival on scene, personnel should proceed directly to the location as provided by the dispatcher with appropriate equipment, based upon the nature of the reported emergency and location of the patient.
2. If the incident and/or patient cannot be located, personnel should notify the dispatcher to request verification of the address/location to ensure the unit has responded to the correct location. When appropriate, EMS personnel should initiate dialogue with bystanders to determine if they can provide any further information or assistance.
   2.1. If the incident was reported to be at an indoor location and there is no response to attempts to enter the location, personnel should check to make sure the door is locked and that there is not an alternate means into the location. Attempts should be made to contact individuals who are authorized to gain access such as neighbors, building manager, security guard, or Housing authority police, etc.
   2.2. When appropriate, responding crews should initiate a search of the immediate area. The scope of the search will often depend on the nature of the incident. For example, when investigating a reported motor vehicle collision it may involve investigating several cross streets. While investigating a reported person down, it may involve looking in adjacent doorways or alley.
3. Having been notified that there is no visible incident and/or patient, or that a crew is unable to gain access to the location, the dispatcher shall review the incident history to verify incident information, and ensure the unit has the most up to date location and access information.
4. At the same time, the dispatcher (or designee) should attempt a callback to obtain further information about the location of the incident and/or patient or to request access for the crew.
   4.1. If the callback goes to an answering machine or voice mail, a message should be left advising the caller to contact 9-1-1 to provide further information.
   4.2. Cross-referenced incidents, or incidents already closed as “duplicate” should be reviewed in case they contain different callback information. A notation shall be made in the CAD text indicating the results of any attempted callback (no answer, voice mail, etc.)

4.3. In situations where the reporting party cannot be contacted on callback, the BEMS calltaker or supervisor should review the 9-1-1 recording to confirm the entered location information is correct. If another agency entered the incident, that agency's dispatch supervisor should be contacted to review the call recording.

5. If access to the location / patient still cannot be achieved, a determination should be made as to the need for further resources to force entry. This determination should be made based on a variety of factors, including type of reported emergency, history of the premises or patient, number of witnesses in the area, etc. Field and/or Dispatch Supervisors should assist with the decision to force entry.

5.1. When the nature of the call or information in the call entry text presents a reasonable suspicion that the patient may be unable to assist members in gaining access and forced entry is warranted, the Boston Fire Department should be requested to assist.

5.2. The Boston Police Department, or police agency in whose jurisdiction the premises are located will be responsible for securing the premises after a forced entry.

5.3. In some circumstances, it may be appropriate for EMS personnel to force entry prior to the arrival of ancillary agencies (for example: when the patient is in plain view on the floor and appears to be seriously ill or injured). In such cases, members should try to use the least intrusive method to gain access.

6. Personnel shall document all significant findings on the PCR (or CAD incident text in the case of the Dispatcher).

Cancellation of Ancillary Agencies

Supersedes: 05-01-10
Effective: 06-17-14

Depending on the nature and location of a reported emergency, other public safety agencies may initiate a response along with Boston EMS to the same incident. Whenever it is determined that the services of another responding agency are not required, every effort should be made to contact that agency so that they may cancel their response. Not only does this reduce the number of unnecessary emergency responses throughout the City, it increases the number of public safety resources available to respond to other emergencies occurring simultaneously.

1. Unless already notified, Boston EMS personnel shall request (and not cancel) the appropriate Fire Department respond to any incident in which a hazardous condition exists and take appropriate scene safety precautions until their arrival. For the purposes of this SOP, "hazardous condition" shall include, but is not limited to: confined space or tunnel accident incidents, reported FIRE or HAZMAT incidents, as well as incidents occurring at a construction site in which the victim is located anywhere other than ground level (such as in a basement, scaffolding or on an upper floor of a building under construction).
2. Telecommunicator: Dispatch Operations personnel may send a cancellation request to another agency when updated information reveals the incident no longer meets the criteria for their response. [For example: A caller requests an ambulance and hangs up before any further information can be ascertained. After entering the call as UNKEMS, the Telecommunicator uses the ANI to call back the home and speaks to the patient. The TYPE Code is updated to ILL3 (a TYPE Code which does not normally receive a BPD or BFD response) and a cancellation request may then be sent to the other agencies.]
3. Field Units: Boston EMS Field Units may request other agencies cancel their response under the following circumstances.
   3.1. **No Incident Found**: A Boston EMS unit is on scene at the given incident location and EMS personnel have determined that there is No Incident and / or Patient. [For example: Unit arrives on scene and bystanders state patient was already transported by private vehicle].
   3.2. **Active Incident**: A Boston EMS unit is on scene at the given incident location and EMS personnel are physically with the patient(s). The crew has determined there is no need for a first responder or ancillary agency response. In the case of cardiac arrest, research has shown that rescuer fatigue may lead to inadequate compression rates or depth, even after just one minute of compressions. Unless other trained rescuers are on scene to assist (such as at

a medical facility), first responders should not be cancelled until the arrival of a second EMS unit to assist with the resuscitation.

4. All requests from an on-scene Field Unit to cancel another responding agency shall include the reason for the request (e.g. “EMS with Patient”, “Patient Gone on Arrival”, “No Visible Incident”).
5. When requesting the Boston Police or Fire Department cancel from a combined incident, the request shall include a comment in the dialog box noting the reason for the cancellation request.
6. When canceling any other agency, such as the Massachusetts State Police or a Private ambulance service, the agency shall be contacted directly and a notation entered into the incident text documenting the cancellation request.

Consent & Refusal of Medical Care

Supersedes: 09-13-13
Effective: 03-01-16

A competent adult or competent emancipated minor has the right to determine the course of his/her own medical care and shall be allowed to make decisions affecting his/her own medical care. With the exception of minors not requiring parental consent, a patient less than eighteen (18) years old may not refuse evaluation, treatment, or transport for an emergency condition unless a parent or legal guardian concurs with such refusal.

1. Competence: In order to be considered competent, a patient must possess both legal capacity and functional capacity.

   Legal Capacity. A patient is presumed to have the legal capacity to consent when he or she is over the age of eighteen, or has been emancipated. An individual is considered emancipated when he or she is:

   - Married, widowed, or divorced;
   - the parent of a child;
   - a member of the armed forces;
   - pregnant or believes herself to be pregnant; or
   - living separate and apart from a parent or legal guardian and is managing his or her own financial affairs.

   A patient does not have legal capacity, however, when he or she has a court-appointed guardian. A guardian is a court-appointed person entrusted with the legal power to manage the affairs of another person because the person under guardianship lacks the ability to understand the nature and significance of those affairs.

   Decisional or Functional Capacity. The second element required for valid consent to medical treatment or transport is decisional capacity. A patient has decisional capacity if he/she can understand the nature and consequences of authorizing treatment or transport. Language barriers can complicate this assessment. Conditions such as head injury, hypoxia, hypoglycemia, psychiatric illness, and intoxication by drugs or alcohol can affect a person's ability to reason and should be taken into account when evaluating decisional capacity. Specifically, the patient must be capable of understanding:

   - The nature and extent of his or her illness or injury;
   - The nature of the proposed treatment;
   - The potential risks and benefits of accepting such treatment; and
   - The potential risks of refusing such treatment.

2. Means of Consent. Consent is either express or implied.

   2.1. Express consent exists when the patient gives verbal permission to receive treatment.

   2.2. Implied consent results from the circumstances of the particular incident. If the patient is silent and capable of objecting verbally when treatment is initiated, consent is implied. Consent is also implied if the patient exhibits any actions that indicate a willingness to be treated. The most common example of implied consent is in the emergency situation. An unconscious patient, or a patient with altered mental status, is presumed to give implied consent.

3. Competent Patient Refusing Treatment and/or Transport: Patient Refusals must be initiated solely by the patient and shall not be suggested or prompted by the EMS personnel. Except in the case where a valid “section 12” order exists (refer to section 5 of this procedure), when a patient with both legal and decisional capacity is refusing treatment and/or transport, Boston EMS personnel shall:

   3.1. Ask the patient (or in the case of a minor, the patient’s guardian) directly which hospital they would like to be transported to. Do not suggest or prompt a refusal of care. Only the patient may initiate such a refusal. Ensure the patient is answering questions appropriately.

   3.2. Ensure the patient’s ability to reason does not appear to be affected by illness, injury, drugs, or alcohol. Inform the patient of the need to receive treatment and potential consequences of not receiving treatment and/or going to a hospital. Advise the patient to call 9-1-1 back or seek emergency care if they change their mind or their condition changes.

   3.3. Some patient complaints represent potentially higher risk for the patient such as chest pain, shortness of breath, syncope, new onset of severe headache or seizure, TIA/Stroke symptoms, pregnancy complaints, or injury/illness involving elderly or pediatric patients. Supervisor and/or Medical Control advice should be sought as needed to convince high risk patients to be transported.

   3.4. A patient refusal shall be thoroughly documented whenever a competent patient refuses to be treated and/or transported to the hospital. The patient, parent, or legal guardian should sign the designated refusal section located in the “Outcomes” portion of the SafetyPad software. If the patient or legal guardian refuses to sign the form, the EMT shall write “Refused To Sign Form” in place of the patient signature.

   3.5. In cases where the SafetyPad device is not readily available, the patient refusal may be documented on a Department approved paper Boston EMS Patient Refusal form which shall then be submitted along with other paperwork at the end of the shift. The form will be scanned and attached to the associated electronic PCR.

4. Patient Not Competent to Refuse: In cases where the patient lacks legal or decisional capacity to refuse treatment and transport, every effort shall be made to convince the patient to be transported voluntarily. If the patient cannot be convinced to be transported voluntarily, personnel shall:

4.1. Request the assistance of the Field Supervisor and when necessary, the appropriate police agency.

4.2. When time permits, notify Medical Control by radio on a C-MED channel, describe the situation, and seek advice.

4.3. EMTs may restrain a patient who presents an immediate or serious threat of bodily harm to himself or others. Any such restraint shall be in accordance with the department's restraint policy and documented in the patient care report.

4.4. In situations where a patient is thought to be a threat to themselves and has left the scene but is still in the immediate area, attempts will be made to maintain visual contact with the individual from a safe distance so a description and direction of flight can be relayed to law enforcement.

5. MGL Chapter 123, Section 12 (a) or "Pink Paper" Situations. By law, certain individuals in the Commonwealth of Massachusetts (physician, qualified psychiatric nurse mental health clinical specialist, psychologist, licensed independent clinical social worker, police officer) who, after examining a person (or based on the facts and circumstances when an examination is not possible), has reason to believe that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness may restrain or authorize the restraint of such person for the purpose of transportation to a hospital for evaluation.

5.1. Boston EMS may be notified and presented with a "pink paper" in one of two ways: the document may be faxed to the Dispatch Operations Center by the caller requesting that a patient be transported, or the responding ambulance crew may be presented with the document upon arrival at the scene. In either event, the initial patient assessment and treatment is no different than any other emergency response. A patient that consents to treatment and transport, is lacking legal and/or decisional capacity to refuse, or one that the EMTs deem to be an immediate or serious threat to themselves or others shall be treated and transported in accordance with Department policy, Statewide Treatment protocols, and point of entry plan regardless of the "pink paper".

5.2. In situations where Boston EMS is presented with a "pink paper" but the patient named on the order appears competent in the relatively brief assessment by EMS personnel, does not appear to be an immediate threat to themself, and does not agree to be transported voluntarily, the appropriate police agency, if not already on scene, and Division Supervisor shall be notified and requested to respond.

5.2.1. Enforcement of the "pink paper" should then be referred to the appropriate police agency. If a person is restrained by police pursuant to a Section 12 or is under arrest and requires transport by ambulance, a police officer should accompany the patient inside the ambulance when practical to provide protection to the patient and EMTs, as well as to alter the restraints as necessary for medical treatment. If riding in the ambulance is not practical, the police officer will escort the ambulance to the hospital.

5.3. Whenever a person with a “pink paper” is transported by ambulance to the hospital- either because they are a danger to themselves, voluntarily, or when the order is enforced by a police officer, the patient should be transported in accordance with established point of entry plans, which may result in the patient being transported to a facility other than the one noted on the “pink paper”. If that is the case, the originator of the pink paper will be notified of the change in destination whenever possible either by the ambulance crew on scene, or through Dispatch Operations. Upon arrival at the hospital, the staff at the receiving facility shall be notified of the existence of the pink paper and provided with a copy (either hand delivered, or faxed by Dispatch Operations). The existence of a “pink paper” shall also be noted in the patient care report.

OEMS A/R 5-610 http://www.mass.gov/eohhs/docs/dph/emergency-services/ar/5-610.pdf

Chapter 54 of the Acts of 2000, section 18. http://www.malegislature.gov/Laws/SessionLaws/Acts/2000/Chapter54/Print

http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter123/Section12

OEMS A/R “Requirement for EMT Use of Patient Restraints” See part II.B.b.iii http://www.mass.gov/eohhs/docs/dph/emergency-services/ar/5-500.pdf

Crime Scene Operations

Supersedes:
Effective: 05-07-07

1. The primary responsibility of EMS members at the scene of a crime is to provide emergency medical care to persons who may require such care. However, members should be aware of the responsibilities of other agencies, which may be operating at the crime scene. The actions and observations of Department members at crime scenes are frequently an important part of court testimony, thereby requiring accurate documentation.

   1.1. For the purposes of this policy, a crime scene is defined as any location at which evidence of a crime or suspected crime is found. This includes, but is not limited to: homicide, suicide, rape, motor vehicle-pedestrian crashes, motor vehicle crashes involving serious injury or death, aircraft crash incidents, fires of a suspicious origin, assaults, or discovery of drug manufacture or paraphernalia. Any location in which a deceased person is found is to be considered a crime scene until otherwise designated by law enforcement.

2. All members are expected to utilize good judgment in the recognition of, and subsequent operation at known or suspected crime scenes. Personnel shall refrain from smoking, eating, or drinking at a crime scene. Personnel should also refrain from using the sink, toilet, telephones, or any other conveniences at the crime scene.

3. After evaluating the scene for personal hazards, the rendering of immediate patient care and transportation is the primary responsibility of EMS personnel. Patient care should not be compromised in order to protect a crime scene or evidence. However, patient care shall be rendered with as little disruption to potential evidence as possible. Cutting directly through bullet holes or knife marks, etc., should be avoided wherever possible.

4. All members operating at a potential crime scene should consider the entire location (apartment, park, etc) as being involved in the crime scene. Upon entering or leaving the scene, use a single path of travel, if possible, and have all members entering and leaving the scene utilize the same path. Department members should be particularly aware of issues of “transfer”, where their footprints, fingerprints, or medical waste left behind might complicate investigations and at no time should EMS personnel unnecessarily examine or move crash debris, shell casings, suicide notes, or any other physical evidence.

5. In the absence of a law enforcement agency, BEMS personnel should attempt to limit the number of personnel entering the scene to those necessary to treating and/or removing the patient(s). All non-essential members or first responders are to remain outside the crime scene area until their assistance is required. Responding agencies should consider designating one member to represent each agency to

enter the crime scene, and only as required. The EMS representative should be noted on the PCR.

6. In the absence of law enforcement personnel at the scene, attempt to limit the access of bystanders, family members and witnesses. Department members may not restrain, eject, or otherwise physically restrict the movements of anyone at the scene, but should be aware that allowing unnecessary persons into the scene may impede the investigation of the crime.
7. After establishing a presumptive diagnosis of death, personnel should refrain from otherwise moving or disturbing the body. In addition, no obviously dead victim of a hanging should be cut down, nor any bound body be untied, following the determination of death. Refrain from covering a dead body at a potential crime scene, except in cases of public view.
8. Boston EMS personnel shall restrict comments and/or opinions to known facts when communicating with other authorities. No statements or information regarding a crime scene investigation shall be disseminated to the media, civilians, or other agencies without authorization from the law enforcement agency in charge.

Determination of Death in the Prehospital Setting

Supersedes: 02-03-09
Effective: 12-01-16

PURPOSE

The purpose of this procedure is to establish guidelines for the withholding or termination of resuscitation efforts by Boston EMS personnel in the setting of Prehospital cardiopulmonary arrest.

DEFINITIONS

EMS First Responder: For the purposes of this policy refers to a person who has, at a minimum, successfully completed a course in emergency medical care approved by OEMS pursuant to MGL Chapter 111 § 201 and 105 CMR 170.000, and who provides first responder service in association with Boston EMS.

EMS Personnel: For the purposes of this policy refers collectively to Emergency Medical Technicians and EMS first responders.

Lividity: redness caused by blood pooling in the dependent parts of the body that is generally seen fifteen to thirty minutes after death. When the body is appropriately examined, there is a clear demarcation of pooled blood within the body.

Putrefaction: Decomposition or decay of tissue. The skin surface (not only in isolated areas) is bloated or ruptured, with sloughing of soft tissue and the odor of decaying flesh.

Rigor Mortis: muscular rigidity following death which affects all muscles at the same time, but which is generally first detectable in the short muscles. Determination of rigor mortis should include immobility of major joints (e.g. jaw, shoulders, elbows, hips, or knees).

POLICY

CPR shall be initiated whenever the patient is found to be unresponsive, apneic, and pulseless unless there is a contraindication as described in this policy and procedure. If any doubt exists as to the existence of vital signs or any of the conditions described herein, EMS personnel should begin resuscitation efforts.

PROCEDURE

1. Emergency Medical Dispatch. EMT-Telecommunicators shall make every effort to provide appropriate pre-arrival instructions to all non-medically trained callers reporting a medical emergency. In the case of suspected cardiac arrest, the EMT-Telecommunicators should not ask the caller if they wish to perform CPR, but shall offer instructions until the caller refuses to perform CPR.
2. Exceptions to Initiation of Resuscitation

EMS personnel should declare an apparent death and withhold resuscitation efforts when the patient is found to be in cardiac arrest (pulseless & apneic) and one of the following conditions exists:

2.1. Current, valid DNR verified per the Comfort Care Protocol.

2.2. Trauma incompatible with survival such as cardiac arrest documented at first EMS evaluation when such condition is the result of significant blunt or penetrating trauma and the arrest is obviously due to such trauma, EXCEPT in the specific case of arrest due to penetrating chest trauma and short transport time to definitive care (interval from estimated time of injury to arrival at hospital would be 15 minutes or less).

2.3. Body condition clearly indicating biological death such as decomposition of body tissue and/or putrefaction.

2.4. Post mortem dependent lividity and / or rigor. Assessment and documentation also includes:

- Respirations are absent for at least 30 seconds and;
- Carotid pulse is absent for at least 30 seconds and;
- Lung sounds auscultated by stethoscope bilaterally are absent for at least 30 seconds and;
- Both pupils, if assessable, are non-reactive to light.

2.5. Declared mass-casualty incident where triage principles or limited resources preclude the initiation of CPR.

2.6. Resuscitation efforts could reasonably pose a danger to the health and/or safety of the rescuers.

3. Termination of Resuscitation

3.1. EMS personnel arriving at the scene of a cardiac arrest in which resuscitative efforts have been initiated should cease resuscitative efforts at any time when an “Exception to Initiation of Resuscitation” as identified in Section 2 above is determined to be present.

3.2. Advanced Life Support (EMT-P) personnel should make a determination of death and terminate resuscitation efforts in a pulseless and apneic adult patient meeting the following criteria:

- There is no evidence or suspicion of hypothermia; the patient is not visibly pregnant; there is no reversible cause of the arrest evident; and
- Indicated standard ACLS measures have been successfully undertaken (including for example effective airway support, intravenous/intraosseous access, medications, transcutaneous pacing, and rhythm monitoring) and the patient is in asystole or pulseless electrical activity (PEA), and remains so persistently, unresponsive to resuscitative efforts, for at least twenty (20) minutes while resuscitative efforts continue; and
- An on-line medical control physician has given an order to terminate resuscitative efforts.

4. Special Considerations

4.1. Prior to deciding whether to withhold resuscitation efforts, or to discontinue such efforts, logistical factors should also be considered, such as collapse in a public place, family wishes, and the safety of the crew and public.

4.2. Consideration must be given to initiate and/or continue resuscitation efforts in the case of short transport time; pediatric patients; victim of hypothermia, overdose, lightning strike; or organ donor who otherwise may meet the criteria for declaration.

4.3. Cardiopulmonary arrest patients who have sustained trauma, but the mechanism of injury does not correlate with the clinical condition, thus suggesting either a case of commotio-cortis (blunt, non-penetrating chest impact that causes arrhythmia) or an underlying primary medical arrest followed by a traumatic incident should have standard (medical) resuscitation efforts initiated.

4.4. Determination of non-viablity is especially challenging in the pediatric population. It can be difficult to determine pulselessness in a poorly perfusing or hypothermic child, especially in children under 5 years of age. A critically ill child may have marked peripheral cyanosis and cold extremities. Mottling, for example, can be confused for dependent lividity in the young child.

In very young children (age 5 years old or less), resuscitation should be initiated unless the child has absent vital signs and injuries clearly incompatible with life (decapitation, transection, 100% BSA incineration or decomposition), or has a valid DNR/MOLST. In children not meeting these criteria, it is more appropriate to initiate resuscitation and obtain further physiological data, such as cardiac and EtCO2 monitoring.

If an ALS assessment yields asystole on the monitor in the presence of other indicators of non-viability such as dependent lividity and/or rigor mortis of the extremities, withholding resuscitation may be authorized by ALS after consultation with an on-line medical control physician. Should an operational decision be made to transport a non-viable child, ALS will accompany the patient and make appropriate pre-arrival notifications regarding the circumstances to the receiving facility.

5. Documentation

5.1. If not already on scene, a police unit shall be requested to the scene. EMS Personnel should make every reasonable effort to secure the scene of a sudden death until the arrival of the appropriate police agency.

5.2. It is the responsibility of Boston EMS to document all reported cases of sudden death reported through the City of Boston Operations Center. Documentation shall include a complete Patient Care Report (PCR) including all pertinent times, incident number, and the time of declaration noted. Documentation shall clearly include criteria for withholding or terminating resuscitation efforts. Whenever possible, the PCR shall include readily available information about the deceased including past medical history and medications. Under no circumstances shall members search through clothing or property of the victim in an effort to obtain

this information. The PCR shall document the position of the body in relation to its environment, clothing and the condition of clothing, and any visible jewelry or personal effects. The PCR shall also document the source of information regarding the deceased and pertinent observations of the Boston EMS personnel on scene.

5.3. Supplemental reports shall also be completed (Exposure Report, Suspected Child Abuse/Neglect Form- 51-A, etc.) as indicated.

5.4. Whenever resuscitation efforts are discontinued in the field, all intravenous catheter(s), endotracheal tube, and electrodes shall be left in place unless removal is authorized by the Medical Examiner. An ECG strip confirming either asystole or pulseless electrical activity in two leads shall be attached to the patient care report.

5.5. The Boston EMS member responsible for completing the PCR shall notify the Office of the Chief Medical Examiner (617- 267-6767) of the death whenever possible. If a telephone is not readily available, the police officer shall be responsible for making said notification. A copy of the Patient Care Report shall be made available electronically to the police..

5.6. When the death has occurred at a licensed health care facility such as nursing home, chronic care facility, or tertiary hospital and the patient has been under a physician's care, a police response is generally not necessary so long as the medical staff is willing to accept responsibility for the patient. However, if there is any evidence to suggest foul play, unusual circumstance, or there is no medical staff on scene willing to accept responsibility for the patient, the case should be treated as any other out of hospital declaration and the police department and Office of the Chief Medical Examiner notified.

5.7. To the extent possible, the on-scene providers and family of the victim should have access to resources such as clergy, crisis workers, and social workers.

6. Public View / Fire Scenes / Transportation

6.1. A body found in public view shall be covered with a yellow disposable blanket or clean sheet with minimum disruption to the scene or body.

6.2. In the case of a fatality at a fire scene, the body should remain in the fire building unless it interferes with firefighting operations. At the discretion of the Fire Incident Commander, Boston EMS personnel may enter the fire building once it is declared safe to do so to confirm the patient meets the criteria for non-resuscitation.

6.3. Should the body need to be removed from the fire building, it should be removed from the building in a body bag. If the body is removed from the scene and placed in public view, it should be covered with a yellow disposable blanket or clean sheet with minimum disruption to the scene or body.

6.4. Under the direction and request of the Police Department Incident Commander (or Fire Incident Commander in the case of a fire-related fatality) and in conjunction with a BEMS Supervisor, the body may be moved out of public view

to either a police prisoner transport wagon, Fire Investigation Unit vehicle, or as a last resort, to a Boston EMS unit and held until transportation to the morgue can be arranged.

6.5. In special circumstances, a non-viable patient may be transported by ambulance when it is in the interest of public health and / or safety to do so (105 CMR 170.365), or when a delay on scene may reasonably pose a danger to the EMS crew or be socially unacceptable. This may occur after a patient has been placed in the rear of an ambulance and it is determined that the patient is non-viable and resuscitation efforts are withheld, or in cases where ongoing resuscitation efforts are terminated in accordance with section 3 and 4 above. In such cases, resuscitative efforts may be withheld while the victim is transported to the closest appropriate emergency room to be pronounced. The body should be covered with a sheet and transported in as discrete and dignified a manner as possible, and the receiving hospital notified in advance.

Field Amputations

Supersedes:
Effective: 07-11-99

On rare occasions, patients with partially amputated limbs may require field amputation. This almost always occurs when an entrapped limb prevents extrication.

1. On scene field personnel should notify Dispatch Operations that a surgeon is needed at the scene.
2. The BMC-Menino Attending Physician shall be notified via the CMED radio of the situation and advised that a surgical proceed-out team has been requested. The proceed-out team and equipment will be assembled and await pickup at the ambulance entrance to the BMC-Menino.
   2.1. If available, a Field Supervisor should be dispatched to the BMC-Menino Emergency Department where the team will be picked up and transported to the scene.
   2.2. If a Field Supervisor is unavailable or otherwise delayed, the Boston Police Department shall be notified and requested to respond to the BMC-Menino to provide this service.
3. Attempts to extricate the victim shall continue while awaiting the arrival of the surgeon.
4. The final decision to perform the amputation at the scene is left to the responding physician.

First Responder Determination of Death

Supersedes:
Effective: 05-01-05

PURPOSE

The purpose of this procedure is to establish guidelines for the withholding or termination of resuscitation efforts by Boston EMS first responder agencies (Boston Fire Department, MassPort Fire Rescue) in the setting of Prehospital cardiopulmonary arrest.

POLICY

CPR shall be initiated whenever the patient is found to be unresponsive, apneic, and pulseless unless there is a contraindication as described in this policy and procedure. If any doubt exists as to the existence of vital signs or any of the conditions described herein, first responder personnel should begin resuscitation efforts.

PROCEDURE

1. Exceptions to Initiation of Resuscitation. First Responder personnel may withhold resuscitation efforts when the patient is found to be in cardiac arrest (pulseless & apneic) and one of the following conditions exists:

   1.1. Current, valid “Do Not Resuscitate” Order verified per the Comfort Care Protocol.

   1.2. Trauma incompatible with survival such as:

   - Cardiac Arrest documented at first evaluation when such condition is the result of significant blunt or penetrating trauma and the arrest is obviously due to such trauma, EXCEPT in the specific case of arrest due to penetrating chest trauma and short transport time to definitive care.
   - Decapitation: severing of the vital structures of the head from the remainder of the patient’s body
   - Transection of the torso: body is completely cut across below the shoulders and above the hips
   - Incineration of the body
   - Evident complete destruction of brain or heart

   1.3. Body condition clearly indicating biological death such as decomposition of body tissue and/or putrefaction. Putrefaction is caused by decomposition or decay of tissue. The skin surface (not only in isolated areas) is bloated or ruptured, with sloughing of soft tissue and the odor of decaying flesh.

   1.4. Post mortem dependent lividity and / or rigor. Lividity is redness caused by blood pooling in the dependent parts of the body that is generally seen fifteen to

thirty minutes after death. When the body is appropriately examined, there is a clear demarcation of pooled blood within the body. Rigor mortis is muscular rigidity following death which affects all muscles at the same time, but which is generally first detectable in the short muscles. Determination of rigor mortis should include immobility of major joints (e.g. jaw, shoulders, elbows, hips, or knees)**.** Assessment also includes:

- Respirations are absent for at least 30 seconds and;
- Carotid pulse is absent for at least 30 seconds and;
- Both pupils, if assessable, are non-reactive to light.
- Lung sounds auscultated by stethoscope (if available) bilaterally are absent for at least 30 seconds

1.5. Declared mass-casualty incident where triage principles or limited resources preclude the initiation of CPR

1.6. Resuscitation efforts could reasonably pose a danger to the health and/or safety of the rescuers.

2. TERMINATION OF RESUSCITATION

First responder personnel arriving at the scene of a cardiac arrest in which resuscitative efforts have been initiated may cease resuscitative efforts at any time when an “Exception to Initiation of Resuscitation” as identified in Section 1 above is determined to be present.

3. SPECIAL CONSIDERATIONS

3.1. Prior to deciding whether to withhold resuscitation efforts, or to discontinue such efforts, logistical factors should also be considered, such as collapse in a public place, family wishes, and the safety of the crew and public.

3.2. Consideration must be given to initiate and/or continue resuscitation efforts in the case of short transport time; pediatric patients; victim of hypothermia, overdose, lightning strike; or organ donor who otherwise may meet the criteria for declaration.

3.3. Cardiopulmonary arrest patients who have sustained trauma, but the mechanism of injury does not correlate with the clinical condition, thus suggesting either a case of commotio-cortis (blunt, non-penetrating chest impact that causes arrhythmia) or an underlying primary medical arrest followed by a traumatic incident should have standard (medical) resuscitation efforts initiated.

4. PUBLIC VIEW / FIRE SCENES / TRANSPORTATION

4.1. A body found in public view shall be covered with a yellow disposable blanket or clean white burn sheet with minimum disruption to the scene or body.

4.2. In the case of a fatality at a fire scene, the body should remain in the fire building unless it interferes with firefighting operations. At the discretion of the Fire Incident Commander, Boston EMS personnel may enter the fire building

once it is declared safe to do so to confirm the patient meets the criteria for non-resuscitation.

4.3. Should the body need to be removed from the fire building, it should be removed from the building in a body bag. If the body is removed from the scene and placed in public view, it should be covered with a yellow disposable blanket or clean white burn sheet with minimum disruption to the scene or body.

4.4. Under the direction and request of the Police Department Incident Commander (or Fire Incident Commander in the case of a fire-related fatality) and in conjunction with a BEMS Supervisor, the body may be moved out of public view to either a police prisoner transport wagon, Fire Investigation Unit vehicle, or as a last resort, to a Boston EMS unit and held until transportation to the morgue can be arranged.

Minor Patients Refusing Treatment or Transport

Supersedes:
Effective: 01-18-05

BACKGROUND

Under 105 CMR 170.355, ambulance services and their agents, including EMTs, have a duty, in the case of an emergency, to dispatch, assess and treat patients in accordance with the Statewide Treatment Protocols, and to transport patients to appropriate health care facilities in their operating area. No regulation, administrative requirement, protocol or policy permits ambulance services or their EMTs to discharge any emergency patient from their care absent a documented patient refusal.

In responding to a scene, an ambulance service and its EMTs may encounter minors refusing treatment and/or transport who have an emergency condition or the potential for one based on clinical assessment and mechanism of injury. This administrative requirement clarifies ambulance services' and EMTs' duties and responsibilities with regard to such minors. It is based on M.G.L. c. 112, §12 F, the Massachusetts law that identifies those minors who have legal standing to consent to medical care and treatment.

Definitions: A "minor" and "emancipated minor" are defined as follows:

A. Minor: A person under the age of 18, who is not an emancipated minor (see below).
B. Emancipated Minor: For the purposes of making decisions regarding medical care and treatment, an emancipated minor is a person under the age of 18 who is
    a. Married, widowed or divorced;
    b. The parent of a child;
    c. A member of the armed forces;
    d. Pregnant or believes herself to be pregnant; or
    e. Living separate and apart from a parent/legal guardian and is managing his or her own financial affairs.

REQUIREMENTS

Although a minor cannot legally consent to medical treatment, consent is legally implied in an emergency. In assessing whether there is an emergency, particularly with regard to motor vehicle crashes, EMTs must include the mechanism of injury in their analysis

A. A minor who is not emancipated cannot legally refuse medical care and / or transportation or legally sign a patient refusal. When an ambulance service and its EMTs are dealing with a minor, only a refusal of treatment and / or transportation made by a parent or legal guardian can be honored by an EMT.
B. An emancipated minor does have the right to refuse medical care and / or transportation and to sign a patient refusal.

C. EMTs must use reasonable care and judgment in ascertaining the age of the patient and determining if a minor is emancipated or not.
D. OEMS will consider ambulance services and their EMTs to be in compliance with 105 CMR 170.355 when they treat / transport a minor who is refusing treatment / transportation and for whom a refusal by a parent or legal guardian cannot be reasonably obtained when, based on clinical assessment and mechanism of injury, that minor has an emergency medical condition or the potential for an emergency medical condition.
E. OEMS will consider ambulance services and their EMTs to be in compliance with 105 CMR 170.355 when they treat / transport a minor claiming to be emancipated who is refusing treatment / transportation and whose emancipation status cannot be reasonably determined when, based on clinical assessment and mechanism of injury, that minor has an emergency medical condition or the potential for an emergency medical condition.
F. As in all cases, the need for EMTs to document in detail their findings, actions and reasons for those actions cannot be overstated. This is even more imperative when dealing with minors and emancipated minors who express a desire to refuse EMS treatment and / or ambulance transport.

OEMS A/R 5-610 01-18-05
Related SOP: Consent and Refusal of Medical Care

Medical Orders for Life Sustaining Treatment (MOLST) and Comfort Care / Do Not Resuscitate (DNR) Order Verification

Supersedes: 01-22-07
Effective: 10-20-15 (OEMS Statewide Treatment Protocol 2015.1)

INTRODUCTION

EMS personnel at all levels are required to provide emergency care and transport patients to appropriate health care facilities. EMS personnel are further required to provide treatment to the fullest extent possible, subject to their level of certification and the level of licensure of the ambulance service for which they are working. However, more and more patients, where it is medically appropriate, are opting for limitations on life-sustaining treatments, such as cardiopulmonary resuscitation (CPR), in the event of cardiac arrest. Thus, EMS personnel may encounter a patient who has chosen such options and has either a Massachusetts Medical Orders for Life Sustaining Treatments (MOLST) or the Comfort Care/DNR Order Verification Form or bracelet (CC/DNR). These documents provide for a statewide, standardized form, approved by the Massachusetts Department of Public Health (DPH), Office of Emergency Medical Services (OEMS), that EMS personnel can instantly recognize as an actionable order (MOLST) or verification of such an order (CC/DNR) regarding the use of life sustaining treatments. This protocol governs EMS personnel response to a patient with a MOLST or CC/DNR form.

IMPLEMENTATION PROCEDURES

1. Confirm the identity of the individual with the MOLST or CC/DNR Order Verification Form or bracelet;
2. Check validity:

   a. CC/DNR: To assure that a DNR order is recognized in any out-of-hospital setting, an attending physician, nurse practitioner, or authorized physician assistant, who is licensed in Massachusetts, must provide a patient who has a current DNR order, with a fully executed CC/DNR Order Verification form to verify the existence of a DNR order. To be valid, the CC/DNR Order Verification Form shall contain:

   i. the patient’s name, and all other patient identifiers requested on the form;
   ii. date of issuance;
   iii. the signature and telephone number of an attending physician, nurse practitioner, or authorized physician assistant;
   iv. the signature and printed name of the patient, guardian or health care agent signing the form, and:

v. a date of expiration, **if any,** of the underlying DNR order. If there is a date of expiration, and that date has passed, the CC/DNR is not valid.

b. MOLST: Alternatively, to assure a patient with a desire to document decisions regarding DNR and/or other life-sustaining treatments (LST, which includes CPR, intubation with ventilation, and non-invasive ventilation, such as continuous positive airway pressure, or CPAP) has those preferences honored, a Massachusetts-licensed attending physician, nurse practitioner or authorized physician assistant can provide a patient with a MOLST form. The MOLST form represents actual medical orders to EMS personnel related to a patient's preferences for resuscitation, ventilation and hospitalization. To be valid, the MOLST form must contain:

i. patient name and appropriate identifiers as requested on the form,

ii. box D and E of the MOLST form must be fully completed for page 1 to be considered valid – which is all that is relevant for EMS personnel. A MOLST order that has an expiration date or revocation date that is in the past is not valid.

c. Revocation: A MOLST order for DNR or CC/DNR form may state it has been revoked. If that is the case, the order or form is not valid.

3. Action of EMS if no valid CC/DNR or no valid MOLST that includes a DNR order: In accordance with standard EMS Statewide Treatment Protocols, EMS personnel will resuscitate patients without a valid CC/DNR Order Verification Form or without a MOLST that has documented a DNR order, as well as a patient who has a MOLST form indicating a preference FOR resuscitation. Remember, if there is any doubt about the current validity of a MOLST or CC/DNR Order Verification form, EMS personnel are to resuscitate and provide care in accordance with the Statewide Treatment Protocols.

4. Patient Care for confirmed valid CC/DNR or MOLST with orders for DNR:

a. If the patient is **in full respiratory or cardiac arrest**, the EMS personnel shall not resuscitate, which means:

i. do not initiate CPR,

ii. do not insert an oropharyngeal airway (OPA),

iii. do not provide ventilatory assistance,

iv. do not artificially ventilate the patient (e.g. mouth-to-mouth, bag valve mask)

v. do not administer chest compressions,

vi. do not initiate advanced airway measures

vii. do not administer cardiac resuscitation drugs, and

viii. do not defibrillate.

b. If the patient is **not in full respiratory or cardiac arrest**, but the patient's heartbeat or breathing is inadequate, EMS personnel shall not resuscitate but shall

provide, within the scope of their training and level of certification, full palliative care and transport, as appropriate, including:

i. additional interventions a patient has indicated be given on the MOLST form, including intubation with ventilation or non-invasive ventilation such as CPAP.

ii. emotional support;

iii. suction airway;

iv. administer oxygen;

v. application of cardiac monitor;

vi. control bleeding;

vii. splint;

viii. position for comfort;

ix. initiate IV line; and,

x. contact Medical Control, if appropriate for further orders, including necessary medications.

c. If the patient is not in respiratory or cardiac arrest, and the patient's heart beat and breathing are adequate, but **there is some other emergency illness or injury**, the EMS personnel shall provide full treatment and transport, as appropriate, within the scope of their training and level of certification.

5. Questions about the MOLST or CC/DNR: If EMS personnel have any questions regarding the applicability of the MOLST or CC/DNR form with regard to any specific individual, or a good-faith basis to doubt the continued validity of the MOLST or CC/DNR form, EMS personnel shall verify with the patient if the patient is able to respond. If the patient cannot respond, EMS personnel shall provide full treatment and transport, or contact Medical Control for further orders. In all cases, EMS personnel shall document the circumstances on the trip record.

6. Previously-initiated CPR: In the event of respiratory or cardiac arrest and resuscitative efforts are initiated prior to EMS confirmation of the valid DNR order on the MOLST form or a valid CC/DNR Order Verification form, EMS shall discontinue the following measures: a) CPR; b) cardiac medications, and c) advanced airway measures.

7. Documentation: EMS personnel must document the existence and validity of the MOLST order or CC/DNR form on their trip record. For a MOLST form, EMS personnel must specifically document on the trip record all clinical information on the MOLST form regarding the patient's preferences for care. For both MOLST and CC/DNR Order Verification Form, EMS personnel must also document on the trip record all care they provided to the patient, including palliative measures.

8. Revocation on scene: The MOLST order with DNR or CC/DNR may be revoked by the patient at any time, regardless of mental or physical condition, by the destruction

or affirmative revocation of the MOLST or CC/DNR Order Verification, or by the patient’s direction that the MOLST or CC/DNR Order Verification not be followed by EMS personnel or be destroyed. EMS personnel, upon witnessing or verifying a revocation, shall communicate that revocation in writing to the hospital to ensure its inclusion in the patient's medical record. EMS personnel shall also document the revocation on their trip record.

Patient Assessment and Transport

Supersedes: 07-01-11
Effective: 09-13-13

MINIMUM EQUIPMENT TO BE CARRIED UPON APPROACH TO THE PATIENT
The minimum equipment to be carried upon initial approach to a patient will often depend on a variety of factors, including the location of the patient (on the street, in a home, at a construction site), the number of EMS personnel arriving (single Supervisor vs. two person BLS or ALS crew), level of certification of the EMS personnel involved (e.g.: Basic Life Support vs. Advanced Life Support), the number of patients (single patient vs. multiple casualty incident), the age of the patient, and the reported nature of the emergency (medical call vs. trauma).

In general, the minimum equipment to be carried by BLS personnel upon the initial approach to a patient will be a jump kit/first aid kit, “green bag” (with oxygen and BVM), and semi-automatic defibrillator. A stair-chair, wheel-cot, or other appropriate means of transporting the patient to the ambulance shall also be brought to the patient’s side upon initial approach. Minimum equipment to be carried by ALS personnel upon the initial approach to a patient will be a jump kit, “green bag” (with oxygen and BVM), monitor / defibrillator, and medication box. When the ALS crew is sent “solo” or there will be a significant delay until the arrival of the BLS crew, the ALS crew should also bring a transport device upon initial patient approach.

SHARED RESPONSIBILITY FOR PATIENT CARE
When EMS was in its infancy, the “ambulance driver” and “attendant” had very defined roles. Because the “ambulance driver” had no medical training, all patient care activities were the responsibility of the “attendant”. Nowadays, both crewmembers are highly trained medical professionals and essentially act as team at the scene of an emergency. As such, all members on scene have a duty to ensure that the patient is receiving adequate and appropriate treatment. Disagreement over the scope of patient care shall be settled with a conservative approach. For example, if there is a question as to whether a splint should be applied or not, the splint shall be applied; if there is any question as to whether oxygen should be administered, or a long backboard should be applied, the more aggressive course of treatment shall be pursued.

Patients to be Carried to THE Ambulance

Personnel are reminded not to allow patients with certain medical or trauma conditions to walk, or otherwise exert themselves. A patient with any of the following conditions should be carried by the appropriate means (stair chair, wheeled-cot, orthopedic stretcher, etc.) to the ambulance:

- Abdominal Pain

- Altered Mental Status / Unconscious
- Cardiac Related Chest Pain
- CVA (Stroke)
- Pregnancy: Active Labor
- Pregnancy: Vaginal Bleeding
- Respiratory Distress
- Seizure Disorder
- Significant Head Injury or other trauma
- Syncope; Orthostatic or Hypotensive Patient
- Suspected Lower Extremity Fracture or Sprain
- Suspected Pelvic Fracture
- Restrained patients
- Any elderly, physically challenged, intoxicated, or other patient with difficulty ambulating
- Patients who specifically ask to be carried, or otherwise demonstrate their expectation to be carried (e.g.: “It hurts too much to walk” or “I would have driven myself but I couldn’t get down the stairs”, etc.)

Patients shall be appropriately covered to keep them warm and dry, and to maintain their privacy to the extent possible. Whenever a patient refuses to be carried and instead insists on ambulating against medical advice, the patient shall be assisted to the extent possible and closely monitored to prevent further injury. This refusal to be carried shall be documented on the patient care report.

SAFETY TIPS

- Prior to moving a patient, personnel should assess the scene for hazards that may inhibit moving the patient safely (plush carpet; soft ground; inclined surfaces; narrow hallways etc.)
- Select and utilize the proper lifting device
- Know your physical abilities and limitations and also those of your partner
- Use proper lifting techniques and keep the weight you’re lifting close to your body
- Communicate clearly and frequently with your partner(s). Verbalize all commands
- Don’t hesitate to request assistance with the lift or movement of the patient
- Once on a wheeled-cot, a patient should <u>never</u> be left unattended. Whenever moving a raised stretcher, especially on an incline or uneven surface, use a minimum of two operators to manipulate the cot. When the stretcher is stationary on a flat surface, such as at a hospital triage area, at least one member shall remain with the patient to control the stretcher and prevent it from moving or tipping over. In such cases, whenever possible, the stretcher should be buttressed against a wall for additional support.

PATIENTS TO BE TRANSPORTED ON WHEELCOT

<u>Securing Patient</u>: Prior to beginning transport, the patient shall be properly secured to the ambulance cot, using all of the required straps. Buckle the 5-point restraint straps across the patient’s chest/shoulders, waist, and legs to minimize horizontal, latitudinal

and rotational movement. If patient care requires that a strap be removed, the strap must be re-secured as soon as practical". Patients who are ambulatory may be assisted to a wheelchair upon arrival at the hospital for transport into the emergency room.

In the event a patient adamantly refuses to be transported by stretcher, a field supervisor may be requested to respond to witness the refusal. However, transportation should not be unduly delayed, especially if it may adversely affect the patient's condition. In any case, the patient's refusal to be transported on the stretcher must be fully documented on the patient care report. All PCRs in which a patient was noted to be transported on bench seat will be reviewed by the appropriate Shift Commander.

Patients that are a potential management issue and/or flight risk for whatever reason, but do not require restraint may be secured using a "BuckleGarde" or similar type device. BuckleGarde is a security cover that surrounds the release mechanism of the seatbelt, deterring the patient from actuating the push button and releasing the buckle. If the patient attempts to release the safety buckle, the device is intended to introduce enough of a delay for other interventions to be taken. Personnel must have immediate access to a pair of scissors, key, or other device to remove the BuckleGarde should the patient seize or need to be repositioned.

Multiple Patients: In cases where more than one patient is being transported simultaneously in the same ambulance, additional patients must be transported in a position appropriate to the chief complaint and/or nature of the illness or injury and properly secured to the squad bench.

Children: Children should ideally be transported in a size-appropriate car seat that is properly secured to the ambulance cot. If this is not practical or achievable, a child whose condition does not require continuous and/or intensive medical monitoring may be transported in the integrated Guardian Safety seat. If this is not available, or the child requires continuous and/or intensive medical monitoring or interventions, the child should be secured to the cot head first with horizontal and vertical (shoulder) restraints. A child whose condition requires spinal immobilization and/or lying flat should be secured to a size-appropriate spine board and secure the spineboard to the cot, head first, with a tether at the foot (if possible) to prevent forward movement. A child should never be transported while unrestrained or held in an adult's lap or arms.

RELATIVE OR FRIEND ACCOMPANYING PATIENT

At the discretion of the crew, a reasonable effort shall be made to accommodate transport of an accompanying family member or friend of the patient. All passengers shall have a seat belt engaged. A minor child should not accompany a patient to the hospital unless there is no appropriate adult supervision on scene.

An injured or sick child who is to be transported to a hospital or other medical facility by an ambulance or other emergency vehicle shall be accompanied by a parent upon such parent's request, unless the emergency medical technician or other person in charge determines that the medical situation is life threatening or that the presence of a parent

would create a potential risk to such child. Such determination shall be noted in the written report of said emergency medical technician and a copy of such report shall be sent to such parent within thirty days of such determination. (MGL Chapter 111C, section 17);

At the discretion of the crew, the parent or guardian of a pediatric patient may accompany the patient in the rear compartment of the ambulance.

NHTSA Working Group Best-Practice Recommendations for the Safe Transportation of Children in Emergency Ground Ambulances, September 2012. http://www.ems.gov/BestPracticeRecomendations.htm

Patient Property

Supersedes:
Effective: 1-16-06

1. Members shall not inspect a wallet, handbag, back-pack, luggage, or other personal property unless there is a medical necessity, such as when searching for a MedicAlert card, or when attempting to determine if any “ICE” (In Case of Emergency) contact information is stored in a cellular telephone. If any personal item is removed from the patient or given to the police, it shall be documented on the PCR.

2. An EMS crew on scene in a home or business establishment shall not inspect the premises unless there is a direct bearing on patient care, e.g., to gain access or egress. Bureaus, cabinets, drawers or other furniture shall not be inspected unless the patient, a family member, a Field Supervisor, or a member of the Boston Police Department is present and is fully aware of the search.

3. If there is a clinical need to remove a ring, watch, necklace, or other jewelry from the patient, the EMT removing the item shall be responsible for taking custody of the jewelry. A notation shall be made on the PCR indicating that the jewelry was removed, and to whom it was transferred to at the receiving hospital.

4. If there is a clinical need to remove dentures, eyeglasses, or other prosthetics, the EMT removing the item shall be responsible for taking custody of these items. A notation shall be made on the PCR indicating that the item was removed, and to whom it was transferred to at the receiving facility.

5. If the patient is conscious and competent, and a family member, friend, or co-worker is present, the patient may elect to transfer his personal effects (wallet, handbag, etc.) to such person.

6. If the patient is not responsive (or is conscious but not competent), except for a spouse, parent of a minor child, or police officer, no other person should be given the personal effects of the patient while the patient is under the care of EMS personnel. Personal property shall be put in a plastic “patient belongings” bag and transferred to the responsible staff person at the receiving facility. The name or title of the staff person should be noted on the Patient Care Report;

7. If there is a clinical need to remove the patient's clothing, an effort shall be made to remove the clothing without cutting. If the nature and severity of the injuries warrants cutting clothing items, they should be cut off as discreetly as possible while avoiding cutting through potential physical evidence such as bullet holes and knife marks, etc;

8. Items of personal property (wallet, cellular phone, handbag, jewelry, identification cards, etc.) found in the ambulance after the patient has been transported shall be returned to the patient as soon as possible. If the owner of the property is unknown or can not be located, the property shall be turned in to a Field Supervisor as soon as possible along with an incident report indicating where, when, and by whom the property was discovered. Found property and associated reports will then be turned in to the Professional Standards Division at the EMS Administrative Headquarters.

Patient Restraint

Supersedes: 12-14-15
Effective: 6-10-18

1. INTRODUCTION

1.1. Patients have the right to refuse treatment and/or transport if they are of legal age and are competent. Competence is defined as the capacity or ability to understand the nature and effects of one's acts or decisions. A patient under the age of 18 should be transported unless a competent parent or guardian refuses treatment for the patient. A person is considered to be competent until proven otherwise. There are situations, however, in which the interests of the general public outweigh an individual's right to liberty.

1.2. Certain medical, traumatic, and psychological conditions can cause incompetence and behavior that interferes with the ability of EMS personnel to care for the patient, or that threatens the physical well-being and safety of the patient or others. These conditions include, but are not limited to: drugs, metabolic disturbances, central nervous system injury or insult, infections, hypo/hypertension, hypo/hyperthermia, hypoxia, psychological disorders, poisons and toxins.

1.3. MGL Chapter 54 of the Acts of 2000 states that "subject to regulations and guidelines promulgated by the department, an emergency medical technician may restrain a patient who presents an immediate or serious threat of bodily harm to himself or others. Any such restraint shall be noted in the written report of said emergency medical technician." If an EMS provider feels uncomfortable with any patient, even when they have not been actively combative, the provider has the right to provide the patient and others with the security of patient restraint. Verbal threats are a legitimate reason for restraint. The following is a guideline for the use of restraints in the prehospital care setting. It is not intended to dictate police action that may be necessary to subdue someone.

2. GENERAL GUIDELINES

2.1. The safety of EMS personnel is the paramount factor during prehospital patient restraint, followed by the importance of protecting patients from injuring themselves or others.

2.2. Law enforcement officers should be involved in all cases when a patient poses a threat to EMS personnel or others. If law enforcement is not immediately available, EMS personnel should retreat to a safe place and await the arrival of law enforcement. If there is no option for retreat, EMS personnel may use reasonable force to defend themselves against an attack.

2.3. All personnel must recognize that there is no duty to act when faced with violent behavior, whether that behavior is being directed at a caregiver, a patient or their family, or another member of the community at large.

2.4. Law Enforcement personnel have statutory authority and training to deal with violent persons and should be part of any prepared incident management plan.

2.5. Patient dignity should be maintained during restraint, and the method of restraint should be individualized to use the least restrictive method of restraint that protects the patient and EMS personnel from harm.

2.6. The goal of managing a patient exhibiting violent behavior is to prevent further harm to the patient and others by exercising only that force which is necessary to neutralize the aberrant behavior, without causing harm to the patient, EMS personnel, or bystanders.

2.7. EMS personnel should anticipate the potential for exposure to blood and body fluids. Based on the situation, appropriate barrier protection should be worn during patient restraint activities.

2.8. Any restraint used should allow for rapid removal if the patient vomits or develops respiratory distress. Whenever a restraint is utilized, a key (in the case of handcuffs) or scissors must be immediately available should the restraint need to be removed.

3. USE OF CONTROL CONTINUUM. The methods of restraint include verbal de-escalation and increasing levels of physical restraint. The chosen method of restraint should be the least restrictive method that assures the safety of the patient and EMS personnel. These methods of restraint may be used in a sequential fashion in many cases, but in extremely violent individuals, immediate physical restraint may be indicated to assure the safety of the patient and personnel. The patient's presentation or actions dictate what level of control is exercised. EMS personnel must document what actions on the part of the patient forced the care-provider to choose or escalate to each progressive intervention level.

3.1. Command Presence – Often times, a professional and competent presentation will be enough to defuse a situation. Personnel should identify themselves and Department affiliation and desire to render assistance (e.g. "I'm an EMT from Boston EMS and we were called here to see how we could help you"). Providers should try to avoid encroachment upon the patient's personal space, as this may provoke stress and anxiety. A show of force may initially be sufficient to gain cooperation of the patient.

3.2. Verbal Commands – The application of verbal techniques to calm the patient is the next method that EMS personnel should employ. This method is safest because it does not require any physical contact with the patient. Verbal intervention sometimes diffuses the situation, and can prevent further escalation, and may avoid the need for further restraint tactics. Request that the patient follow commands relative to treatment and transportation.

3.3. Focused Direction - Using hand signals, body position, or natural barriers to channel a patient toward the transport device.

3.4. Physical Restraint - Application of Department approved restraints using least invasive applications necessary. When physically restraining a patient, EMS personnel should make every effort to avoid injuring the patient.

4. APPROVED RESTRAINT DEVICES. The department approves the use of the following restraint devices.

   4.1. Soft roller bandage or “Kling”

   4.2. Webbed straps to augment limb restraint devices and to stabilize patients on backboards, wheeled cots, stair-chairs, and scoop stretchers.

   4.3. Hard restraints, such as handcuffs or “flex-cuffs”. These devices may be used for initial restraint when other approved devices are not practical or readily available. If carried, handcuffs must be kept in a covered case.

5. RESTRAINT PROCEDURE

   5.1. Dispatch Operations should be notified immediately that a potential prehospital patient restraint situation exists. Following the notification to Dispatch Operations, a supervisor along with other appropriate resources should be dispatched to the incident. If available, a supervisor should be present during the restraint process. If a supervisor is unable to respond to the incident, a supervisor should meet up with the crew as soon as practical to check on the crew, the patient and review the response.

   5.2. Ensure sufficient personnel are present to control the patient. As resources allow, four (4) to five (5) public safety personnel will develop and implement an action plan to temporarily immobilize each of the patient’s limbs as required.

   5.3. A wheeled cot, backboard, or stairchair should be brought to the patient’s side or to a staging area in the immediate active incident area. When the situation allows, an explanation of the restraint process will be made to the patient and bystanders and the patient will be given a last opportunity to choose transportation without restraint providing that that mode of transportation does not compromise the safety of the EMS personnel, bystanders, or patient.

   5.4. Personnel will restrain patients using the least amount of force necessary to meet the patient’s resistance. The least number of points of control will be used to meet the objective of effectively controlling the patient.

   5.5. Restrained patients shall be placed in a supine position, a lateral recumbent position, or semi-fowler’s position. Restrained patients shall not be transported in a prone or “hog tied” position, nor shall they be “sandwiched” between backboards or scoop stretcher. No restraint should be applied over the patient’s face, or so tightly across the chest that it interferes with respirations.

   5.6. A continuing dialog will be maintained with the patient and bystanders to communicate that everything possible is being done to ensure the patient’s safety.

   5.7. The patient will be closely monitored for signs of potentially negative affects of restraint, including respiratory compromise or circulatory impairment. The patient’s restraints will be checked for such compromises at a minimum of five (5) minute intervals.

5.8. Patients that are actively seizing should not be restrained. An active incident area will be cleared and the patient will be supported and padding placed around the patient to minimize potential for injury until the tonic-clonic activity subsides or the patient receives medical intervention.

5.9. Changing the type of restraint from a hard-mechanical restraint to a softer form of restraint is recommended whenever possible. It may also be appropriate to reduce the number of restraint points if a patient's condition improves due to medical intervention.

5.10. If a person is restrained by police pursuant to a Section 12 or is under arrest and requires transport by ambulance, a police officer should accompany the patient inside the ambulance when practical to provide protection to the patient and EMTs, as well as to alter the restraints as necessary for medical treatment. If riding in the ambulance is not practical, the police officer will escort the ambulance to the hospital.

5.11. A patient in restraint must never be left unattended. Personnel must have immediate access to a pair of scissors or, when handcuffs have been applied, a key to be able to remove the restraint should the patient seize or need to be repositioned.

6. SPITTING PATIENT

6.1. Consider placing a non-rebreather mask (use only 15 lpm) or a face mask (NOT N95/P100) on the spitting patient's face. If either of these options are not feasible given patient agitation and provider safety, consider utilizing a Department approved "spit sock" device.

6.2. The spit sock is a lightweight, see through protective mesh material. It is designed to allow the patient to breathe without obstruction but does not allow saliva to be projected to the outside. The "spit sock" is a single patient use disposable piece of equipment.

6.3. The "spit sock" is not appropriate if a patient requires oxygen. Patients with a spit sock applied shall be frequently evaluated for change in mental status or cyanosis. If any signs of medical distress are observed, the spit sock should be removed to initiate appropriate medical care. Consider monitoring oxygen saturation whenever practical.

7. TRANSPORT ISSUES

7.1. The decision to restrain a patient should usually be made prior to transport.

7.2. If an unrestrained patient becomes assaultive during transport, the vehicle operator will bring the vehicle to a safe stop and assist his/her partner in the patient care compartment. The standard "ambulance in trouble" response will be initiated as necessary.

7.3. If the crew believes their personal safety is at risk, they should not inhibit a patient's ability to leave the ambulance. Every effort should be made to release the patient into a safe environment.

7.4. Restrained patients must be carried on a wheeled cot, backboard, scoop stretcher, or stair-chair.

8. CHEMICAL RESTRAINTS: In circumstances when a violent patient is unable to be restrained by physical means and the safety of the patient or EMTs is compromised, chemical restraint should be considered. The statewide treatment protocols allow for specific medications to be used for acute behavioral emergencies, ALS providers should keep up to date on the current medications, dosage and precautions.

9. PEDIATRIC CONSIDERATIONS

Always attempt to involve parents when restraining children.

10. PREGNANCY CONSIDERATIONS

Pregnant women requiring restraint should be transported in a semi-reclining or left lateral recumbent position.

11. DOCUMENTATION REQUIREMENTS

All uses of restraints and spit sock must be documented thoroughly on the patient care report, and at a minimum must include:

a. reason for restraint use:
b. time of application:
c. types of restraints used in addition to cot straps;
d. patient position;
e. neurovascular evaluation of extremities;
f. issues encountered during transport;
g. other treatment rendered;
h. police and/or other agency assistance; and
i. whether any injuries occurred during the restraint procedure.

All responses involving the application of restraints will be reviewed as part of the continuous quality improvement (CQI) process to ensure conformity with department policy.

MGL Chapter 54, section 18: https://malegislature.gov/Laws/SessionLaws/Acts/2000/Chapter54

OEMS A/R "Requirement for EMT Use of Patient Restraints" See part II.B.b.iii http://www.mass.gov/eohhs/docs/dph/emergency-services/ar/5-500.pdf

Power-Pro Stretcher

Supersedes: 03-01-16
Effective: 06-15-16

Boston EMS has transitioned to the Stryker **Power-PRO™** wheeled stretcher, which has a battery-powered hydraulic lift system intended to help reduce the effort required by the operator to raise and lower the cot. The stretcher is rated to a maximum capacity of 700 lb. (sum of the patient, mattress, and any accessory weight).

Safety Precautions and Restraint Straps
Once on a wheeled-cot, a patient should never be left unattended. The patient shall be properly secured, using all required straps. Buckle the restraint straps across the patient's chest/shoulders, waist, and legs to minimize horizontal, latitudinal, and rotational movement.

Only restraint straps approved for use with the Power-Pro Stretcher shall be used, and they must be attached to the stretcher in accordance with the manufacturer's recommendations. Boston EMS utilizes X-Restraints which are compliant with SAE J3027 (Ambulance Litter Integrity, Retention, and Patient Restraint) requirements. The proper attachment locations are marked on the stretcher, and each set of straps has an illustration on the tag showing whether they are leg, thigh, or waist straps.

The mattress on the stretcher comes in two pieces to accommodate the shoulder straps. While this may make it slightly more inconvenient to put a sheet on the entire mattress, the design and location of the shoulder straps affords the maximum crash safety for the patient. A sheet can be placed on the main part of the mattress, and a towel can go on the head-rest / pillow portion.

Patients that are a potential management issue and/or flight risk for whatever reason, but do not require restraint may be secured using a “BuckleGarde” or similar type device. BuckleGarde is a security cover that surrounds the release mechanism of the seatbelt, deterring the patient from actuating the push button and releasing the buckle. If the patient attempts to release the safety buckle, the device is intended to introduce enough of a delay for other interventions to be taken. Personnel must have immediate access to a pair of scissors, key, or other device to remove the BuckleGarde should the patient seize or need to be repositioned.

Whenever moving a loaded stretcher, especially on an incline or uneven surface, use a minimum of two operators to manipulate the cot. Position an operator at the foot end and one at the head end of the cot at all times when rolling the cot with a patient on it. Approach door sills and/or other low obstacles squarely and lift each set of wheels over the obstacle separately. Transporting the cot sideways can cause the cot to tip. Transporting the cot in a lowered position, head or foot end first, minimizes the potential of a cot tip.

When the stretcher is stationary on a flat surface, such as at a hospital triage area, at least one member shall remain with the patient to control the stretcher and prevent it

from moving or tipping over. In such cases, whenever possible, the stretcher should be buttressed against a wall for additional support.

Do not apply the optional wheel locks while a patient is on the cot. Wheel locks are only intended to help prevent the cot from rolling while unattended and to aid in patient transfer.

Battery Charger

When the SMRT Pak is fully charged and ready for use, the charger indicator LED turns to solid green. For extended storage, the SMRT Pak should remain on the SMRT Charger to trickle charge and ensure that the SMRT Pak remains fully charged.

SMRT Charger Indicator LED	Status
GREEN (flashing)	SMRT Charger is charging the SMRT Pak. The optimum charge time is two hours.
GREEN (solid)	SMRT Pak is fully charged an ready for use.
AMBER (flashing)	SMRT Pak temperature delay. The SMRT Charger is waiting for the SMRT Pak to reach an allowable temperature range of 43°F to 88°F.
AMBER (solid)	SMRT Pak error

Ambulances equipped with a Power-LOAD mounting system automatically charge the SMRT Pak battery when the cot is locked into Power-LOAD in the transport position. The cot battery LED indicator will momentarily flash green to signify that it is charging.

Changing Battery at the Start of Each Shift
Each stretcher is issued with two fully charged batteries and an AC Charger for the satellite station. Like all batteries, they begin to lose their charge when removed from the charger for an extended period. Because of this, it is not recommended that the spare battery be carried in the ambulance. Instead, the spare battery should remain in the charger when not in use.

At the beginning of each shift, a fully charged battery (indicated by solid green LED light on the charger) should be inserted into the cot, and the alternate battery then placed in the charger. After any battery change, and periodically throughout the shift, members can push the small power button located above the +/- buttons to check the battery power. If the battery pack indicator level is GREEN, the battery does not need to be changed. A SMRT Pak that is in good working condition and is fully charged provides up to 15-20 “calls” with a 250 pound patient.

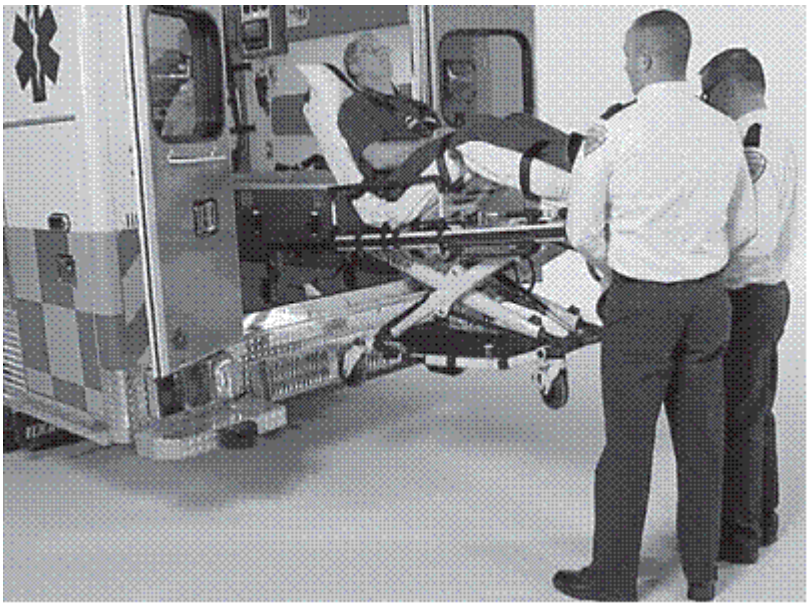
If the indicator begins to flash AMBER, the battery should be changed as soon as possible. A flashing AMBER light means there are approximately 15 up/down movements remaining. Depending on unit location and status, crews will be directed to their station or Materials Management to retrieve a fully charged battery, or will be met

by a Field Supervisor or Tango Unit that carry spare batteries in their vehicle. Even if the battery were to completely run out of power, the stretcher can still be operated in the manual mode.

Unloading the Stretcher

Unloading an occupied cot from a vehicle requires a minimum of two (2) trained operators. One or two operators can lift from the foot end of the cot. Stryker recommends that both operators are at the foot end to reduce the load on each operator.

To avoid injury, verify that the safety bar has engaged the safety hook before removing the cot completely from the patient compartment. Do not press the extend (+) button until the safety bar has engaged the safety hook.



Manual Override

In the event of loss of electrical function, the cot is equipped with a manual override to allow manual operation of the product until electrical functionality is restored. You can use the red manual back-up release handle to raise or lower the cot. The red manual back-up release handle is located along the patient left side of the lower lift bar at the foot end of the cot.

Stretcher Loading

Loading an occupied cot into a vehicle requires a minimum of two (2) trained operators. One or two operators can lift from the foot end of the cot. Stryker recommends that both operators are at the foot end to reduce the load on each operator.

The stretcher is equipped with a STEER-LOCK System that locks the head-end caster into a straight position preventing cot drift when putting the stretcher into the

ambulance. This can be especially useful if the ambulance is parked on an uneven surface.

The head section telescopes from a first position suitable for loading the cot into the ambulance to a second position retracted within the litter frame. When retracted, the cot can roll in any direction on the caster wheels even in the lowest position, allowing for improved mobility and maneuverability.

Do not attempt to load the cot into the patient compartment with the head section retracted. Loading the cot with the head section retracted may cause the stretcher to tip or not engage properly in the cot fastener.

Requesting Blood Products

Supersedes:
Effective: 03-01-00

In rare instances, prolonged extrication or multiple casualty events necessitate the need for O negative blood to be delivered to the scene. Blood may be obtained from the Boston Medical Center, Harrison Avenue Pavilion Blood Bank through the BMC-Menino Emergency Department Charge Nurse. All blood products that leave the hospital must be accompanied by a physician to the scene. The physician will be responsible for administering the blood products.

1. The first arriving BEMS paramedic or EMT, or the BEMS Incident Commander will make the determination that blood products may be required at the scene.
2. The EMT/ EMT-P/ IC will contact the Boston Medical Center-Menino Pavilion Emergency department either through CMED radio or via Dispatch Operations ringdown. The Emergency Department will be informed of the event parameters, the need for blood products, and the incident number will be provided to the ED Charge nurse.
3. Dispatch Operations will arrange for pickup and transport of an Emergency Department MD and the blood products to the scene (see section 3 above).
4. The ED Charge Nurse will be responsible for filling out a RED blood request form with the words “EMS INCIDENT” followed by the Incident number in the patient identification area in the upper right hand corner. This will be sent to the blood bank via runner. The blood bank will release two units of O Negative blood.
5. An Emergency Department Physician will accompany the blood products to the scene via EMS or Boston Police transport. The ED MD will be responsible for administration of all blood products. Blood tubing and a cooler are provided in the “To Go” box.
6. The form entitled “Transfusion Report Blood Bank” will be returned to the blood bank after the patient has arrived at the hospital. This form will include the EMS incident number, the patient’s name and birth date if known, the receiving hospital name, and the receiving hospital patient record number. This information is vital for the blood bank. The BEMS Shift Commander or BEMS Incident Commander will be responsible for guaranteeing this form is returned completed to the blood bank.

Requesting Police / Trouble Alarms

Supersedes: 07-23-07
Effective: 06-17-14

1. Requesting Police Assistance: When requesting a Police response, EMS units should include the priority of the request ("OT", "Police Assistance", or "Routine") as well as a brief description of the situation for inclusion in the CAD text if possible.

   1.1. **OT**: "OT" is used for situations in which the scene is unsafe and an immediate multiple police unit response is requested (TYPE Code: OT). Declaring an "OT" will also generate a response from an EMS Field Supervisor and an additional ambulance. [e.g. "Boston, A-4- Requesting the police for an OT at our location; man with a knife"].

   1.2. **Police Assistance**: Requesting "Police Assistance" will result in a Priority 1 CAD notification to the Boston Police (TYPE Code: ASTEMS). Requesting "Police Assistance" should be used for situations in which the scene is still under control but could potentially become violent or there is some other reason for a rapid police response. [e.g. "Boston, A-4- requesting Police Assistance at our location for an agitated EDP"]

   1.3. **ROUTINE**: Requesting the police for a "Routine" response will result in a Priority 3 CAD notification to the Boston Police (TYPE Code: REQP). As the pro-word implies, this type of request is used in situations where there is no threat present and a routine police response would be appropriate. [e.g. "Boston, A-4- requesting the police ROUTINE at our location for an assault report"]

2. Voiced OT Call: Upon receipt of a voiced "OT" or "HELP" call, the dispatcher shall immediately transmit a brief **high-low alert tone** indicating high priority radio traffic to follow.

   2.1. The Dispatcher will then announce "All units stand by- <Unit ID> has an OT at <Incident Location> --All units Stand by". The closest available ambulance and Division Supervisor will then be dispatched to the incident. Only units that have been assigned to the incident should respond to maintain unit accountability and to ensure police have access to the scene.

   2.2. The dispatcher will create an "OT" incident in the CAD System, or, in the case of an incident in another jurisdiction such as Logan Airport or on the Expressway, contact the appropriate law enforcement agency. [Note: if the Primary law enforcement agency will be delayed, the Boston Police will be requested to respond]. The Dispatch Operations Supervisor will liaison with the Police Supervisor to ensure a timely police response.

   2.3. The incident will deescalate when an on scene unit broadcasts information indicating the situation is under control. The Dispatcher will again transmit a brief **high-low alert tone** indicating high priority radio traffic to follow, and announce: "All units, be advised the < Incident Address > situation is now under

control- repeat, < Incident Address > situation is now under control. All units resume normal." The dispatcher will then update the CAD incident text as necessary.

3. Portable / Vehicular Trouble Alarm Activation: Upon receipt of a portable or vehicle "trouble alarm", the dispatcher shall transmit a brief **high-low alert** tone indicating high priority radio traffic to follow and advise "All Units Stand by". Using the "RADIO" command in the CAD system, the Dispatcher will attempt to identify the person or vehicle assigned the radio that has been activated.

   3.1. When contacting the unit, they should not be asked "Are you in trouble?" It should be assumed the crew has activated their trouble alarm because they are not in a position to speak freely until proven otherwise. The crew should be asked "What is your **Activation Status**?" Using the phrase "Activation Status" will let the crew know their alarm had been activated without raising the suspicions of other individuals in the immediate area. If the crew does not clearly indicate the alarm was an accidental activation and they are in no danger, the situation should be treated as an OT (above).

   3.2. If there is no response after calling the unit, the unit's last known location (or current location if equipped with AVL) should be broadcast and appropriate resources dispatched. The dispatcher shall continue to attempt to determine the status of the unit that has activated their alarm to ensure their safety while police and EMS units investigate.

   3.3. If the unit assigned the portable or vehicle is not known, the dispatcher will announce the portable or vehicle ID number and request they identify themselves to confirm their status. If it can not be determined which unit has activated their trouble alarm, a roll call of all units should be taken. Units currently assigned to incidents and still on scene shall be called first as they have the highest likelihood to be experiencing a dangerous situation. Having ascertained the safety of all units on scene of an incident, other units will then be contacted.

4. Any vehicle or portable radio that is found to frequently transmit "accidental" trouble alarms should be turned in for evaluation.

Safe Haven Act MGL CH 119

Supersedes:
Effective: 10-29-04

The “Safe Haven Act of Massachusetts”, allows a parent or guardian to legally abandon newborn infants 7 days old or younger at a hospital, police station, or manned fire station. The law became effective on October 29, 2004. The Safe Haven Act is an amendment to Chapter 119 of the General Laws, section 39.5

The statute allows the parent(s) of a newborn to be brought to a Police or Fire Station or a hospital and left in the custody a Police Officer, Firefighter or hospital staff ***without question***. The City of Boston in complying with this new statute has crafted an MOU that spells out how the City’s public safety agencies will respond in the event of such an occurrence. The City has recognized that EMS has a major role in an incident such as this and believes that the statute should be amended to allow an infant to also be dropped at an EMS facility. However, at this time, as written EMS facilities are not mentioned as a potential drop off location. That said, it is quite likely that a member of the public would believe it safe to abandon an infant at an EMS facility without question.

If a parent decides to take advantage of this new law, several steps will occur. A BPD or BFD uniformed member would take custody of the infant. They in turn will notify EMS and we will dispatch to the disclosed location. The Officer or Firefighter will be required to tryto collect information as outlined in the law using a form that will be supplied by DSS and he/she will notify DSS by calling the DSS Area Office or, after 5:00pm, on weekends, and holidays, the Child at Risk Hotline (800-792-5200). They must follow up in writing by filing a ***51A form marked “Safe Havens” with DSS as is required***.

Boston EMS will respond to a Police or Fire station where an infant is left under the Safe Havens Law, evaluate, provide any necessary medical intervention and shall transport the infant to an appropriate hospital emergency room per protocol and point of entry. EMS Personnel will notify the receiving facility through C-MED of their impending arrival and nature of the incident. Information obtained by BPD or BFD personnel with respect to the infant’s history should be gathered when possible and shall be kept in strictest confidence and given only to appropriate ER staff and DSS staff.

If there is suspected abuse or neglect, personnel will file a 51A report as mandated with DSS. An abandoned infant with no suspicion of neglect or abuse shall not warrant a 51A report, as this new law allows this exception. As stated above there will be a separate 51A form marked “Safe Havens” that must be filed at this time by BPD or BFD.

Sharing of information among the 3 agencies with respect to an abandoned infant should occur to facilitate the best possible care and outcome for the infant. If relatives or others inquire with any department about custody of a newborn left under the Safe Havens Law or any other child they should be referred to the DSS Area Office.

No personnel involved in a given incident will engage in any inquiry/conversation with members of the media. Additional information and directives will follow as they become available.

Please keep in mind that the catalyst for this new law is to help prohibit a newborn from being left abandoned in an area/place where he/she may succumb to the elements and lack of medical attention. If you are confronted with an occurrence of this nature do not pressure the parent(s) to the point of them leaving and taking the infant, only to be abandoned elsewhere. If the parents co-operate garner as much information as possible. The law allows the parent(s) to do this and personal bias/beliefs must not intercede.

Service Animals

Supersedes: 11-23-08
Effective: 09-13-13

1. Beginning on March 15, 2011, only dogs are recognized as service animals under titles II and III of the ADA. Provisions have also been made for miniature horses.
2. Service animals shall be permitted to accompany a patient or guardian of a minor patient in the ambulance unless the presence of the service animal will disrupt patient care, or there is some basis for the crew members to believe that the safety of the crew, the patient or others would be compromised by the presence of the service animal in the ambulance.
   2.1. Growling may be considered threatening behavior in which case the service animal may be transported by other means. Barking may also be considered threatening, however, specific service animals are required to bark to get their owners attention.
3. When it is not obvious what service an animal provides, only limited inquiries are allowed. Staff may ask two questions: (1) is the dog a service animal required because of a disability, and (2) what work or task has the dog been trained to perform. Staff cannot ask about the person's disability, require medical documentation, require a special identification card or training documentation for the dog, or ask that the dog demonstrate its ability to perform the work or task.
4. When practical, Boston EMS personnel should allow the patient to address the service animal with any commands that may be needed while being examined, treated, or transferred.
5. When transporting a patient with a service animal, every effort should be made to do so in a safe manner for the patient, the animal and the crew members. If possible, the animal should be secured in some manner in order to prevent injury to either the animal or the crew during transport. The patient should be loaded into the vehicle first, and then the service animal. Whenever possible, the receiving hospital should be notified that you are enroute with a service animal.
6. When the presence of a service animal in the ambulance might interfere with patient care, jeopardize the safety of the crew, the patient or others, personnel should make other arrangements for simultaneous transport of the service animal to the receiving facility.
   6.1. Acceptable alternative methods of transporting a service animal to the receiving facility include, but are not necessarily limited to, family members, friends or neighbors of the patient, animal control, an EMS Supervisor, or a law enforcement official.
7. Personnel should document on the Patient Care Report (PCR) instances where the patient or guardian accompanying a minor patient utilizes a service animal and note

whether or not the service animal was transport with the patient. If the animal was not transported in the ambulance with the patient, the PCR should contain the reason(s) and the means by which the animal was transported.

OVERVIEW OF UPDATED ADA REQUIREMENTS

The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) for title II (State and local government services) and title III (public accommodations and commercial facilities) on September 15, 2010, in the Federal Register. These requirements, or rules, clarify and refine issues that have arisen over the past 20 years and contain new, and updated, requirements, including the 2010 Standards for Accessible Design (2010 Standards).

OVERVIEW:

- Beginning on March 15, 2011, only dogs are recognized as service animals under titles II and III of the ADA.
- A service animal is a dog that is individually trained to do work or perform tasks for a person with a disability.
- Generally, title II and title III entities must permit service animals to accompany people with disabilities in all areas where members of the public are allowed to go.

DEFINITION

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

WHERE SERVICE ANIMALS ARE ALLOWED

Under the ADA, State and local governments, businesses, and nonprofit organizations that serve the public generally must allow service animals to accompany people with disabilities in all areas of the facility where the public is normally allowed to go. For example, in a hospital it would be inappropriate to exclude a service animal from areas such as patient rooms, clinics, cafeterias, or examination rooms. However, it may be appropriate to exclude a service animal from operating rooms or burn units where the animal's presence may compromise a sterile environment.

CONTROL

Under the ADA, service animals must be harnessed, leashed, or tethered, unless these devices interfere with the service animal's work or the individual's disability prevents

using these devices. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls.

PERMISSIBLE INQUIRIES

- When it is not obvious what service an animal provides, only limited inquiries are allowed. Staff may ask two questions: (1) is the dog a service animal required because of a disability, and (2) what work or task has the dog been trained to perform. Staff cannot ask about the person's disability, require medical documentation, require a special identification card or training documentation for the dog, or ask that the dog demonstrate its ability to perform the work or task.
- Allergies and fear of dogs are not valid reasons for denying access or refusing service to people using service animals. When a person who is allergic to dog dander and a person who uses a service animal must spend time in the same room or facility, for example, in a school classroom or at a homeless shelter, they both should be accommodated by assigning them, if possible, to different locations within the room or different rooms in the facility.
- A person with a disability cannot be asked to remove his service animal from the premises unless: (1) the dog is out of control and the handler does not take effective action to control it or (2) the dog is not housebroken. When there is a legitimate reason to ask that a service animal be removed, staff must offer the person with the disability the opportunity to obtain goods or services without the animal's presence.
- Staff are not required to provide care or food for a service animal.

MINIATURE HORSES

In addition to the provisions about service dogs, the Department of Justice's revised ADA regulations have a new, separate provision about miniature horses that have been individually trained to do work or perform tasks for people with disabilities. (Miniature horses generally range in height from 24 inches to 34 inches measured to the shoulders and generally weigh between 70 and 100 pounds.) Entities covered by the ADA must modify their policies to permit miniature horses where reasonable. The regulations set out four assessment factors to assist entities in determining whether miniature horses can be accommodated in their facility. The assessment factors are (1) whether the miniature horse is housebroken; (2) whether the miniature horse is under the owner's control; (3) whether the facility can accommodate the miniature horse's type, size, and weight; and (4) whether the miniature horse's presence will not compromise legitimate safety requirements necessary for safe operation of the facility.

References:
http://www.mass.gov/ago/consumer-resources/your-rights/civil-rights/disability-rights/information-about-service-animals.html

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http://www.ada.gov/service_animals_2010.htm

Warm Zone Operations at Tactical Incidents

Supersedes: 10-31-14
Effective: 07-18-16

While this policy and procedure refers primarily to active shooter incidents, the same concepts apply to other situations involving multiple severely injured patients at unsecured scenes.

DEFINITIONS

Active Shooter: An active shooter is an individual actively engaged in killing or attempting to kill people in a confined and populated area; in most cases, active shooters use firearm(s) and there is no pattern or method to their selection of victims.

Casualty Collection Point: A facility or location in the warm or cold zone where victims may be extracted to for initial evaluation and treatment.

Contact Team: The swift and immediate deployment of law enforcement (LE) personnel and resources to an ongoing, life-threatening situation where delayed deployment of personnel could otherwise result in death or great bodily injury to innocent persons. Contact Team tactics are not a substitute for conventional response tactics to a barricaded gunman.

EMS Extraction Officer: The individual responsible for coordinating the removal of patients from the active incident area to the Casualty Collection Point or Treatment Area.

Extraction Team: Group equipped to enter an active incident area and remove victims with appropriate stabilization, to a casualty collection point or treatment area. Depending on the situation, the extraction team may consist of a LE Rescue Team, a joint LE/EMS Rescue Task Force, or EMS personnel assisted by certified first responder trained personnel from the police and/or fire Department.

Hartford Consensus: Consensus document which includes the actions contained in the mnemonic "THREAT"

- **T** - Threat suppression
- **H** - Hemorrhage control
- **RE** - Rapid Extrication to safety
- **A** - Assessment by medical providers
- **T** - Transport to definitive care

Rescue Task Force (RTF): A Rescue Task Force is a team jointly consisting of law enforcement and EMS personnel deployed to provide point of wound care to victims where there is an on-going ballistic or explosive threat. These teams treat, stabilize, and remove the injured in a rapid manner, while wearing ballistic protective equipment and under the protection of a law enforcement. When possible, a RTF team should include at least one ALS provider.

Rescue Team: The deployment of law enforcement personnel tasked to respond to known locations of injured victims for the purposed of immediate first aid and rapid extraction to a more secure location. Since most traditional rescue teams are comprised solely of law enforcement personnel, it can transition into a contact team if a threat or active shooter is encountered. Rescue teams are typically deployed after a contact team has neutralized the immediate threat.

Hot Zone: The geographic area, consisting of the immediate incident location, where there is a known or suspected hazard with direct and immediate threat to personal safety or health. Rescue Task Forces will not be deployed into a Hot Zone.

Warm Zone: This zone is an area of indirect threat that has been swept by Law Enforcement and cleared of any immediate threats. The Rescue Task Force may deploy in this area, under force protection, to treat victims.

Cold Zone: The cold zone is where responding personnel can operate with minimal threat to personal safety or health. This area is a distance from the active incident, or an area that has been cleared *and* secured by law enforcement.

POLICY

Boston EMS personnel will not knowingly be deployed into a “hot zone”/ direct-threat area. Based on the circumstances and in consultation with EMS and Law Enforcement Incident Commanders, Boston EMS personnel may be escorted under force protection as part of a Rescue Task Force into areas of mitigated risk (“warm zone”) which have been cleared by Law Enforcement to execute triage, medical stabilization at the point of wounding, and provide for evacuation or sheltering in place.

PROCEDURE

EMS personnel should recognize that LE will initially be fully engaged with the primary mission of neutralizing the threat(s). There will be rapid deployment of LE officers in the form of contact teams into the impacted area to directly engage the threat, secure the perimeter to ensure the perpetrator(s) does not evade/escape, and to minimize access to the area. Current law enforcement policy is to bypass any wounded / dead until their primary objective / mission is complete.

As areas are cleared and resources permit, LE operations may initially include deployment of Rescue Teams that focus on extraction of wounded victims to a designated casualty collection point (CCP) for EMS personnel to render initial aid. Boston EMS personnel may be requested to join a law enforcement Rescue Team(s), thereby forming a Rescue Task Force for operation in the warm zone to provide medical operations including triage, primary point of wounding treatment (hemorrhage control and airway), and assist with extraction of victims based on available resources and capabilities.

Unified Command (U/C) should establish an accountability process for all incident responders using a check in / check out procedure. Under no circumstances should EMS personnel enter an area that has not been cleared without LE consent and protective escort. Personnel operating at an incident should consider secondary devices

or other threats. Should threats be identified, it would necessitate upgrading the area to one of direct threat ("hot zone") requiring rapid evacuation of all EMS personnel and surviving patients.

Anticipate a protracted event. Research and history have indicated that the active risk at most incidents is over before first responders arrive on scene, or shortly thereafter, but they may also require extended operations. Depending on the size of a building or active incident area, number of victims and/or reported shooters, it could take several hours to fully clear a scene and declare it completely safe. The EMS response should include sufficient resources when available for victim management and law enforcement, EMS, and other on scene public safety personnel support for the duration of the event.

EMS RESPONSE

When responding to a reported active shooter or similar incident, consider turning off emergency lights and warning devices when on approach to the area. Dispatch Operations should attempt to determine the most appropriate routing, access, and staging areas for responding EMS personnel. Remember that frightened citizens fleeing the event may act in an unsafe manner.

If assigned staging is designated via Dispatch Operations, immediately assess upon arrival for safe zone adequacy. First arriving unit(s) should position themselves in a safe area that does not block key access / egress for additional responders if possible. If EMS staging is designated by the on scene unit(s), ensure all additional response personnel have the exact location and safest means of access. When establishing a staging area, consider the possibility of improvised explosive device (IED) or other secondary threats.

Establish Unified Command. Advise law enforcement of available EMS resources and staging location. Personnel should place all anticipated necessary medical equipment on the wheel cot. Depending on the situation and distance from incident, consider leaving the stretcher in the ambulance until requested for victim removal. To the extent possible, all units should be positioned to allow rapid egress from the scene should transport or relocation to an alternate staging area becomes necessary.

Supervisor, Command, Paramedic, and Special Operations units are equipped with "multi-patient hemorrhage control" kits. Whenever possible, these kits should be made available to EMS personnel that will be operating in the warm zone. These kits contain:

Qty	Item		Qty	Item
6	C-A-T Tourniquets		4	HyFinn Vent Chest Seal
2	ARS Needles; 10g 3.25" (ALS)		10	4 x 4 Gauze
4	Hemostatic Gauze Dressings		2	6" Elastic roll bandages
2	4" Israeli Bandage		2	6" Israeli Bandage
1	Roll of tape		4	Pair of Gloves (Large)

10	MCI Tags		5	MCI Tags (dead)
1	Trauma Shears		6	Nasal Airways / Surgilube

Appropriate personal protective equipment (PPE) shall be donned at the direction of the EMS Incident Commander. Department issued body armor, respiratory protection, and helmet should be immediately available and donned as directed. Additional or higher-level PPE may be used when available.

In certain cases, it may be appropriate to limit initial warm zone operations to sweep triage. Ambulatory victims should be directed by the team to self-evacuate, if safe to do so. Communication back to EMS IC and LE IC advising of incoming victims should be confirmed as soon as possible.

Non-viable victim(s) should be clearly marked to allow for easy identification and to avoid repeated evaluations by additional rescue / extraction teams. Secondary triage should occur as victims are brought to the designated CCA.

Rescue Task Force teams can be deployed for victim treatment, victim extraction from warm to cold zone, movement of supplies from cold to warm zone, and any other duties deemed necessary to accomplish the overall mission. Team(s) should work within LE security at all times.

As the incident evolves, law enforcement may begin to designate areas as cleared *and* secured. EMS may begin to operate in previously designated warm zones without the requirement of immediate force protection from LE. The EMS I/C will coordinate with the LE I/C to determine if it is necessary to continue rescue operations under law enforcement force protection.

U.S. Department of Homeland Security "Active Shooter Response" booklet http://www.dhs.gov/xlibrary/assets/active_shooter_booklet.pdf

http://www.naemt.org/Libraries/Trauma%20Resources/Hartford%20Consensus%20Document%20Final%204-8-13.sflb and http://bulletin.facs.org/2013/09/hartford-consensus-ii/

NIMS definition of "Task Force" is any combination of single resources, but typically two to five, assembled to meet a specific tactical need.

Accessing Patient or Call Location

Supersedes: 07-01-05
Effective: 03-01-16

1. While enroute to an incident location, responding crews should monitor the radio and mobile workstation for updated location or access information. Upon arrival on scene, personnel should proceed directly to the location as provided by the dispatcher with appropriate equipment, based upon the nature of the reported emergency and location of the patient.
2. If the incident and/or patient cannot be located, personnel should notify the dispatcher to request verification of the address/location to ensure the unit has responded to the correct location. When appropriate, EMS personnel should initiate dialogue with bystanders to determine if they can provide any further information or assistance.
   2.1. If the incident was reported to be at an indoor location and there is no response to attempts to enter the location, personnel should check to make sure the door is locked and that there is not an alternate means into the location. Attempts should be made to contact individuals who are authorized to gain access such as neighbors, building manager, security guard, or Housing authority police, etc.
   2.2. When appropriate, responding crews should initiate a search of the immediate area. The scope of the search will often depend on the nature of the incident. For example, when investigating a reported motor vehicle collision it may involve investigating several cross streets. While investigating a reported person down, it may involve looking in adjacent doorways or alley.
3. Having been notified that there is no visible incident and/or patient, or that a crew is unable to gain access to the location, the dispatcher shall review the incident history to verify incident information, and ensure the unit has the most up to date location and access information.
4. At the same time, the dispatcher (or designee) should attempt a callback to obtain further information about the location of the incident and/or patient or to request access for the crew.
   4.1. If the callback goes to an answering machine or voice mail, a message should be left advising the caller to contact 9-1-1 to provide further information.
   4.2. Cross-referenced incidents, or incidents already closed as “duplicate” should be reviewed in case they contain different callback information. A notation shall be made in the CAD text indicating the results of any attempted callback (no answer, voice mail, etc.)
   4.3. In situations where the reporting party cannot be contacted on callback, the BEMS calltaker or supervisor should review the 9-1-1 recording to confirm the entered location information is correct. If another agency entered the incident,

that agency's dispatch supervisor should be contacted to review the call recording.

5. If access to the location / patient still cannot be achieved, a determination should be made as to the need for further resources to force entry. This determination should be made based on a variety of factors, including type of reported emergency, history of the premises or patient, number of witnesses in the area, etc. Field and/or Dispatch Supervisors should assist with the decision to force entry.

   5.1. When the nature of the call or information in the call entry text presents a reasonable suspicion that the patient may be unable to assist members in gaining access and forced entry is warranted, the Boston Fire Department should be requested to assist.

   5.2. The Boston Police Department, or police agency in whose jurisdiction the premises are located will be responsible for securing the premises after a forced entry.

   5.3. In some circumstances, it may be appropriate for EMS personnel to force entry prior to the arrival of ancillary agencies (for example: when the patient is in plain view on the floor and appears to be seriously ill or injured). In such cases, members should try to use the least intrusive method to gain access.

6. Personnel shall document all significant findings on the PCR (or CAD incident text in the case of the Dispatcher).

Treatment Protocols / Special Project Waivers

Advanced Airway Monitoring for ALS Patient

Supersedes:
Effective: 07-23-07

PURPOSE

1. To introduce guidelines to standardize continuous capnometry /capnography and oxygen saturation measurement in addition to vital sign monitoring.
2. Provide initial and ongoing confirmation of proper endotracheal tube placement in the intubated patient, and continuous assessment of oxygenation and ventilatory support in the perfusing patient throughout the course of treatment and transport to the receiving hospital.
3. To further assess the continuous ventilatory support provided to patients receiving MAI, CPAP or bag valve mask ventilation.
4. Assess effectiveness of resuscitation efforts in cardiac arrest patients. Studies have shown that that a PCO2 value < 10 at 20 min into the resuscitation indicate non-viability. Additionally, a sudden rise in PCO2 can indicate a return of spontaneous circulation (ROSC), often before a pulse or blood pressure can be obtained.
5. Assess the ventilatory status of the patient with bronchospasic disease (asthma, COPD), where ETCO2 waveform may be helpful in determining therapy plans.

HISTORY
Endotracheal intubation (ETI), though an indispensable skill in the hands of a well trained ALS clinician, requires constant monitoring to insure proper tube position and ventilatory technique. Once ETI is established, constant SPO2/ ETCO2monitoring is now obtainable through the use of the Physio-Control LP-15 whenever these monitoring devices are applied to the perfusing patient. SPO2 / ETCO2 monitoring provides a quantitative measurement of the event and is recorded along with heart and respiratory rate by the code summary / trending analysis feature of the LP-15 monitor.

RATIONALE
Boston EMS paramedics have received extensive training in advanced airway techniques, and in a large urban EMS system like Boston, are provided with opportunities to maintain these skills on a regular basis. BEMS paramedics have an extremely high ETI success rate in the adult and pediatric patient. However, many EMS systems need to improve their quality assurance efforts to address critical training and performance issues related to endotracheal intubation. Oxygen desaturation during attempts to intubate as well as over-aggressive manual ventilation inducing hypocapnea (contributing to cerebral hypo perfusion in patients with head injuries), can contribute to poor patient outcome.

Proper endotracheal tube placement is only one aspect of the procedure that needs confirmation, equally important is ensuring the tube is not displaced and monitoring the quality of ventilatory support given following the procedure. In order to provide continuous

measurement of SPO2 and ETCO2 values in perfusing patients intubated by Boston EMS paramedics, Microstream® ETCO2 monitoring provided by the Physio-Control LP-15 will replace the Easy-Cap® capnometry device in all but those clinically or logistically justified cases. The Microstream® ETC02 device fits the BVM mask as well as the endotracheal tube and should provide the clinician with a good assessment of a patient's spontaneous respiratory or assisted ventilatory status.

PROCEDURE

1. In addition to clinical assessment, vital sign monitoring, and confirmation of proper tube placement, ALS personnel caring for an intubated patient with a perfusing rhythm shall carefully monitor the effectiveness of ventilations by continuously monitoring the presence of an ETC02 value, and maintaining an SPO2 value. Unless justifiable, clinical judgment or logistics dictate otherwise, all patients with a perfusing rhythm requiring endotrachael intubation shall have their ETCO2 / SPO2 measurements continuously monitored immediately prior and during any endotracheal intubation attempt, and continuously monitored after successful intubation until patient care is transferred to another provider.

2. Documentation of Medication Assisted Intubations (MAI) must include all dosing and Controlled Medication information (CSR# , wasted amount). Similar to EKG data, the Safety Pad data cable will interface with the LP-15 and will merge transmit all event trending data (ETC02, SP02, HR, and RR) with the PCR prior to transmission to the Safety Pad server.

CLINICAL BENCHMARKS FOR ETI ASSESSMENT

- ETCO2 value > 8mmhg required to capture respiratory rate trending.
- Guidelines suggest maintaining SpO2 levels > 95% in pre-oxygenated patients. ETCO2 levels desired CO2 in head trauma: 35-40mmhg; for head trauma with signs of herniation desired levels are 25-30mmhg.
- AHA guidelines suggest ventilation of the apneic patient at 10-12 per minute in adult, 12-20 in pediatric cases

Cancellation of ALS By On-Scene BLS; Guidelines for ALS Transport

Supersedes: 05-01-10
Effective: 10-31-14

PURPOSE
To clarify for Department EMTs, in the context of their duties under 105 CMR 170.355, the procedures when on-scene Basic Life Support personnel may cancel Advanced Life Support (ALS) that has been dispatched, but has not yet established direct patient contact; and to provide guidelines for initiation of advanced life support by ALS personnel that have arrived at an incident and established direct patient contact.

CLINICAL CRITERIA
The Massachusetts Office of Emergency Medical Services requires that each ambulance service develop written guidelines (A/R 5-615) for use by BLS in determining when it is appropriate to cancel ALS. These same guidelines should be used by ALS personnel who have established direct patient contact when determining whether ALS intervention is appropriate. The term guideline implies a direction for care, but it is not an absolute. Guidelines are not meant to override justifiable, good clinical judgment. Two examples: an 80 year old suffering chest pain that is clearly from Herpes Zoster does not need ALS transport just because he/she is 80 with chest pain; conversely a 26 year old with suggestive chest pain and a family history of coronary artery disease may benefit from ALS despite the fact that he/she is only 26.

Boston EMS recognizes that there is no way to list every possible situation where ALS should transport, and strives to provide the best possible training and experience to its members to assist with these important decisions. Some situations are obvious: status epilepticus or cardiac arrest, for example. Many situations are not as clear cut, and require objective history taking, an appropriate exam, and low index of suspicion to always do what is best for the patient.

Boston EMS has established the following written guidelines for four high volume/high risk areas. In each of these areas there is variability in practice within BEMS and among all providers. The goal of these guidelines is to narrow that variability and provide the best care we can.

CHEST PAIN (Atraumatic): Absent recent history suggestive of non-cardiac etiology (rib fracture, dx of pneumonia, etc.), or clinical judgment or logistics that dictate otherwise, ALS should transport the following chest pain patients:
History (language barrier should lower threshold for ALS transport of chest pain patient):

Age 40 or older, especially with suggestive past medical history: coronary artery disease, diabetes, hypertension, hyperlipidemia, or family history of coronary artery disease. Pain suggestive of acute coronary syndrome: pressure, squeezing, heaviness, tightness, radiation to left upper extremity or jaw and/or associated signs and symptoms such as diaphoresis, nausea, dyspnea, syncope, or near syncope.

ASTHMA / BRONCHOSPASM:
Based on NIH guidelines and in consultation with BMC Pediatric Emergency Physicians, the Boston EMS physician group has the following expectations regarding when BLS can cancel ALS (assuming that it is not a situation when transport would be quicker than ALS contact) or when ALS can refer a patient to BLS. Unless justifiable, clinical judgment or logistics dictate otherwise, ALS should transport the following asthma / bronchospasm patients:

For Children 6 months to 2 years
- Oxygen Saturation < 95% (decreased saturation is often an indicator of severe obstruction in children)
- RR > 60
- respiratory distress (severe retractions, biphasic wheezing, use of accessory muscles, cyanosis)
- history of intubation or PICU admission
- hospital visit (including ED or admission) within past month

BLS prehospital Albuterol program is not open to children less than 6 months old.

For children 2 years - 15 years
- Oxygen Saturation < 95%
- RR > 40
- Presence of respiratory distress (severe retractions, biphasic wheezing, use of accessory muscles, cyanosis)
- prior history of intubation
- recent hospital visit (including ED, admission or PICU) within past month

Adults > 15 years
- Oxygen Saturation < 92%
- RR > 24
- prior history of intubation or MICU stay for asthma
- history of repeat ED visits for asthma within the last month
- Inability to speak in full sentences
- Patient states that symptoms are not improving with current treatment provided by EMS

SYNCOPE: Unless justifiable, clinical judgment or logistics dictate otherwise, ALS should transport the following types of patients following a syncopal episode(s):
<u>History</u>:

Age 50 or older; past medical history of Coronary Artery Disease or Congestive Heart Failure; History of present illness or exam suggests acute coronary syndrome or congestive heart failure; or Syncope occurred while supine or seated..

Physical Exam

- Heart rate <50 or >110 (adults)
- Systolic Blood Pressure <90
- Rales on chest exam
- If available, EKG shows brady or tachyarrythmia; long Q-T syndrome; or ST-T wave changes

SEIZURE: Unless justifiable, clinical judgment or logistics dictate otherwise, ALS should transport the following types of patients following a seizure:

History: Except in the case of a patient between the ages of 6 months and 5 years who is status post a single suspected febrile seizure, any patient with a known or suspected first time seizure should be transported by ALS. A patient of any age with continuous seizure of five minutes or more, or who has two or more discrete seizures within 30 minutes of each other should also be treated / transported by ALS.

TRANSPORT

Boston EMS utilizes a two-tier (BLS / ALS) response configuration to incidents likely to require Advanced Life Support intervention. Studies comparing various system configurations found that cities that deploy fewer paramedics in a two-tier response configuration tend to have better patient outcomes. Sending both a BLS and ALS unit to critical incidents allows the prehospital team to quickly assess, treat, and stabilize the patient prior to transport. In an effort to make the most efficient use of available resources, the BLS unit should be cleared whenever an ALS unit is transporting a patient unless both units are necessary for logistical or patient care purposes.

CANCELLATION OF ALS BY BLS: PROCEDURE

1. BLS Personnel must:
   1.1. Complete an appropriate patient assessment and provide treatment in accordance with the Statewide treatment protocols;
   1.2. Having determined there is no foreseeable need for ALS based on the written guidelines (above), or determining that the patient can be transported to an appropriate health care facility in less time than it would take ALS to arrive on scene, or intercept BLS during transport, the on scene BLS unit may cancel a responding ALS unit.
   1.3. Document their assessment and treatment of the patient on their patient care report (PCR); and
   1.4. Document the cancellation and reason(s) for cancellation on the patient care report.

Reference: OEMS A/R 5-615 "Cancellation of ALS", 07-11-05

Related: ALS Referral to BLS

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http://www.usatoday.com/news/health/2006-05-21-paramedics_x.htm

ALS Referral to BLS for Transport

Supersedes:
Effective: 10-20-05

PURPOSE
The purpose of this SOP is to emphasize that the basic duties of all EMTs, pursuant to 105 CMR 170.355, are to assess and treat patients in accordance with the Statewide Treatment protocols, to transport patients to appropriate health care facilities, and to document the assessment and care they provided.

REQUIREMENTS
Advanced Life Support (ALS) personnel who have established direct patient contact must complete an appropriate assessment in accordance with the standards of their certification and training. Based on the findings of that assessment, ALS personnel then have a duty to provide appropriate treatment in accordance with Boston EMS and Statewide Treatment Protocols. If an ALS intervention is initiated, or could be anticipated, for the patient, ALS personnel are required to attend the patient throughout the transport, under 105 CMR 170.305 (E)(2).

If ALS personnel determine that an ALS intervention is not needed or anticipated, and Basic Life Support (BLS) personnel are in accord with transfer of the patient to their care for transport, the patient may be transferred to BLS for transport to an appropriate health care facility. Boston EMS provides policy guidance and instruction for performing appropriate patient assessments and for documenting the results of such assessments for all patients.

Reference: OEMS A/R 5-620 “ALS Transfer of Calls to BLS”, 07-11-05

See Related: ALS Cancellation by BLS / Guidelines for ALS Transport

Drug Security Policy

Supersedes: 07-18-16
Effective: 04-12-18

OVERVIEW

This policy establishes Boston Emergency Medical Services' procedures for the administration, documentation, storage and inventory levels of Schedule II, Schedule III, Schedule IV, and Schedule VI drugs, and for the control of keys required for the security of these drugs. Boston EMS personnel are authorized to administer approved medications, or assist in the administration of medications in accordance with standing orders as listed in the Commonwealth of Massachusetts Statewide Treatment protocols, and / or under the direction of a Boston Medical Center (BMC) Emergency Department medical control physician as part of an affiliate hospital agreement. Except for medications prescribed to a department member or patient, no other drugs or pharmaceutical equipment or supplies are permitted in an ALS ambulance or at a district station. A list of all approved medications is included in the appendix of this policy.

DRUG BOX KEYS

1. Each ALS unit is issued two sets of drug keys. Drug keys are keyed to each drug box, are not interchangeable, and cannot be duplicated without authorization. These keys shall remain in the custody and control of the on-duty paramedic until passed on to the paramedic of the oncoming shift, or properly secured at the end of shift. Each set will include a key for the designated storage compartment for the drug box, and the locked compartment located within the drug box itself.

MEDICATION STORAGE / EXPIRATION

1. All drug boxes containing controlled substances will be stored inside a locked compartment of the EMS Unit. ALS level drugs will be carried in a Department-issued drug box inside of which shall be an additional locked compartment for succinylcholine and Schedule II, Schedule III, & Schedule IV medications. A separate Department issued drug box will be designated for nerve agent response; these boxes contain diazepam as well as pralidoxime and atropine, and are accessed by a key lock as well as the removal of a pharmacy tag.
2. Stock levels of Schedule VI drugs shall be stored inside a compartment of the ALS unit. Stock supplies of Schedule II, III, and IV drugs shall be stored at the Boston Medical Center Emergency Department and accessed via the Pyxis System terminal. Succinylcholine and Etomidate are stored in the secure ALS equipment room at Materials Management, with Succinylcholine restocked from the refrigerator.
3. Additional authorized Schedule VI drugs shall be stored in the designated locked area at each ALS Station. Only personnel authorized by Boston EMS to administer controlled substances shall have unsupervised access to these locked areas. The quantities of Schedule VI drugs shall be within the parameters outlined for each ALS Station (see appendix) and within the parameters outlined for the drug box and for the ambulance.

4. BLS units shall store albuterol unit doses and the EpiPen Auto Injector inside the metal BLS medication box within their portable oxygen bag. BLS units will also be issued a pelican case with DuoDote autoinjectors (see next section).

5. All controlled medications shall have a specific expiration date (MM/DD/YY) noted on the Controlled Substance Record accompanying the plastic kit containing the medications. The expiration date will be determined by the pharmacy prior to distribution. When removing Succinylcholine from the refrigerator at Materials Management, a notation "Out of Fridge" and the date shall be clearly marked on the vial. Once procured from Materials Management, Succinylcholine shall be stored in the ALS drug box and will be considered expired 60 days after removal from refrigeration.

6. For the purpose of inventory control of other medications, intravenous fluids, or supplies that do not list a specific expiration date, these items shall be considered as expired on the last day of the month immediately preceding the expiration date written on the package. For example, a medication or intravenous bag with an expiration date of 04/18 shall be considered expired on 03/31/18.

DuoDOTE™ AUTO-INJECTOR ("BLACK BOX")

Each BLS and Supervisory response unit shall carry a locked black Pelican case containing thirty (30) DuoDOTE auto injectors. The box will be stored in the dedicated, front wall interior cabinet of the Ford ambulances and under the bench seat in the rear compartment of non-Ford ambulances. Two keys will be provided for each District truck so that both crewmembers will have a key to maintain security of the black pelican case. At the beginning of each shift, the oncoming crew shall be responsible for inspecting the box and confirming that the padlock is secure, and the inventory control tag is intact. The inventory control tag number shall be recorded in the daily special equipment log, accompanied by the signatures of both crewmembers. If the inventory control tag is missing or broken, the Shift Commander shall be immediately notified. The Shift Commander or designee will then conduct an inventory of the box and reseal the case with a new inventory control tag.

DRUG INVENTORY DOCUMENTATION

1. The controlled medication inventory for Schedule II, Schedule III, Schedule IV drugs, and succinylcholine shall be performed at the beginning and the end of each shift with two paramedics present simultaneously; one from the shift that is ending and one from the shift that is beginning when possible. Recognizing that personnel sometimes alternate between vehicle operation and primary patient care duties throughout the course of a shift, the paramedic acting as the primary "attendant" at the beginning of the shift is responsible for checking out all of the equipment and supplies inside the vehicle, including the AED/Monitor/Defibrillator, jump kit / first aid bag(s), oxygen and associated delivery devices at the beginning of each shift, or as soon as practicable thereafter, and ensuring that the medication inventory is completed and properly documented.

2. Paramedics performing the inventory shall ensure that the plastic kit seal is intact, the seal number matches the CSR number, the kit is not damaged, the contents of the kit appear undamaged, and that there is no liquid in the kit. They shall also verify the presence of one

yellow auxiliary seal for the plastic controlled substance box. These findings shall be documented on the DCSAL by circling the 'Y' or 'N' in the appropriate place.

3. Whenever a unit is dispatched but unable to immediately respond (performing narcotic inventory, changing on-board oxygen tank, etc.), the crew should acknowledge the response, state the reason for their delay, and give the estimated time until they will be able to respond. The dispatcher shall supplement this into the CAD incident history, and poll other units to determine if there is another appropriate resource with a shorter ETA.

4. The inventory check and the time (military time) will be documented in the appropriate space on the DCSAL along with the corresponding CSR number. Simply writing "no change" is not acceptable. Both paramedics will attest to the accuracy of the inventory check with their signatures and medic ID numbers. All documentation shall be in black or blue ink. The serial numbers from the inventory control tags on the "black box" and the "grey box" shall be noted in the appropriate spot on the DCSAL. When not in use, the drug logbook shall be kept in the vehicle.

5. Schedule VI drugs are stocked inside locked cabinets at the ALS Stations. Paramedics removing drugs from or adding drugs to the cabinets shall record the amount taken or added, indicate the remaining balance, and write their name and ID number on the inventory form.

6. On a daily basis, a Shift Commander shall inspect the drug box inventory control tag of each ALS drug box containing controlled substances stored at the Theodore Glynn Way station, and a random sample of in-service units to ensure it matches the number noted in the associated DCSAL form. These inspections shall be reported to Professional Standards and the Shift Commander group on a daily basis. Each ALS unit will have an inventory of the drug box, the ambulance, and the ALS station performed at least monthly by a Shift Commander. A copy of the ALS Drug Inventory form shall be kept on file by Professional Standards for at least three years.

INITIAL ACCESS / SECURING CONTROLLED SUBSTANCE KIT (BLUE SEAL)

1. In accordance with Statewide Treatment Protocol and/or on-line medical control order, Department paramedics needing to access a controlled substance will remove the plastic medication kit from the secured drug box, and break off the RED security plastic seal to access the medications. The red seal will then be placed inside the box.

2. Vials that are labeled as single-dose or single-use should be used for a single patient and single case/procedure. Even if a single-dose or single-use vial appears to contain multiple doses or contains more medication than is needed for a single patient, that vial should not be used for more than one patient. Once a single-use vial has been opened or accessed, subsequent doses for the same patient should be drawn from that vial until the contents are exhausted before accessing another vial for the purposes of minimizing waste.

3. Once on arrival at the hospital (or sooner, if access to controlled medications is no longer anticipated), the plastic case with its remaining medications (and the RED security seal) will be closed and sealed with the corresponding BLUE security seal. The resealing of the kit shall be documented by both paramedics in the "Kit Resealed" section of the CSR.

MULTI-CASUALTY INCIDENT/ALS ADMINISTRATION EXCEPTION

Rare situations, such as multi-casualty incidents, may require ALS providers to administer Schedule II, III or IV medications to patients out of direct line of sight of a fellow department ALS provider. In such cases, during demobilization of patient care, ALS providers shall do the following: 1) witness the waste of any medications still in syringes, 2) seal remaining unopened vials per protocol, 3) update the shift commander of the situation, 4) complete all necessary documentation, including an Unusual Occurrence Form, 5) notify the department Medical Director or designee.

DOCUMENTATION OF CONTROLLED MEDICATIONS ADMINISTERED OR WASTED

1. After administration of a Schedule II, III or IV drug, the paramedic shall document usage of the drug on the CSR and the DCSAL. The documentation shall include the date, the time, the patient's name, ALS unit, the drug, the dose, the waste, the Medical Control Physician's call sign (if applicable), the paramedic's signatures and medic numbers, and the balance remaining in the ALS unit. The Patient Care Report shall include the name of the drug, the CSR number, the dose, waste of open or remaining drugs, route and the time of each dose administered, and the effect of the drug.
2. Whenever there is a Schedule II, III or IV drug open or remaining after the physician's orders have been carried out, all unused drugs shall be immediately discarded upon arrival at the receiving facility before exiting the ambulance. Unused medications shall be discharged from the syringe by one Department paramedic with a second Department paramedic physically present with direct visualization of the process as a witness. "Wasted" drugs shall be documented on the CSR under "medication administration" in the "waste" column and on the DCSAL. Both paramedics shall sign the CSR, DCSAL, and the PCR.
3. Sharps/controlled substance waste, in the red receptacle, shall be discarded prior to exceeding ¾ full.

DOCUMENTATION REVIEW

1. The designated Boston EMS pharmacy liaison will regularly retrieve completed original CSRs from the BMC pharmacy.
2. The Boston EMS designated pharmacy liaison will review the CSR and supporting documents (PCR, Daily Inventory forms) to ensure the controlled medications are properly and completely documented. The CSR is then forwarded to the Medical Director's office for clinical review.
3. The Medical Director (or designee) will review the controlled medication administration for clinical appropriateness and sign the CSR when appropriate.
4. If inappropriate documentation is discovered (with the CSR or DCSAL) or a clinical issue identified, a copy of the relevant document(s) will be forwarded to the Professional Standards Division for prompt review. The Professional Standards Division and /or the Medical Director will determine the necessary corrective actions to ensure a timely resolution. The Professional Standards Division will notify the BMC pharmacy of any inappropriate or incorrect documentation or accounting of controlled medications. Any corrected document(s) will be returned to the BEMS designated pharmacy liaison who will add them to the record.

5. The documents supporting the correct administration and discard of controlled medication will be saved in pdf. These will include the PCRs, a scanned image of the CSR and the DCSAL) and stored in an electronic file that is routinely backed up.
6. The original signed CSRs will be returned to the BMC pharmacy along with all supporting documentation. All paperwork shall be reconciled and returned to BMC pharmacy within 14 business days.
7. During weekly meetings, the Boston EMS designated pharmacy liaison and BMC pharmacy will review kit expirations. BMC pharmacy shall validate receipt of expired kits and the completeness of documentation to ensure all CSKs are accounted for.
8. The controlled substance log, maintained by the Boston EMS designated pharmacy liaison, will be reviewed in coordination with Professional Standards and the Medical Director. Any discrepancies, including accuracy and timeliness for completing necessary review steps, will be assessed and a corrective action plan established.

RETURNING CONTROLLED SUBSTANCES

1. All controlled medications need to be returned to the BMC Pharmacy as soon as possible after the CSK has been accessed. If the pharmacist on duty is not available, or refuses to accept returned medications, paramedics should keep the medications and the corresponding CSR and notify the on-duty shift commander. Under no circumstances should controlled medications be returned to the Pyxis machine.
2. When returning medications, the paramedics will fill in the appropriate parts of the CSR and both paramedics will sign the CSR. The paramedics should have the pharmacist on duty sign the white CSR acknowledging receipt of the returned medications. After the pharmacist has signed the "Kit Received by" section, separate the pages of the CSR, keeping the pink page as your receipt, and leaving the white original with the pharmacist.
3. When logistics make it necessary, paramedics may return a used kit, with the blue or yellow security seal, to the on-duty Shift Commander in exchange for a new kit (the new kit will be sealed with a RED security seal which was applied by the pharmacist who prepared the kit). This exchange should be documented on the DCSAL in the appropriate spaces. The Shift Commander will then be responsible for returning the used kit to the BMC Pharmacy.

SECONDARY ACCESS / SECURING CONTROLLED SUBSTANCE KIT (YELLOW SEAL)

The Shift Commander should be notified whenever an ALS unit with a previously used medication kit is dispatched to another response. If possible, the Shift Commander should respond and exchange the medication kits prior to use. While the plastic controlled substance kit is primarily intended to be a single-use kit that is returned to the BMC Pharmacy or exchanged with a Shift Commander after initial use, it may become necessary for Paramedics to break off the BLUE security seal to access controlled medications in order to treat a second patient whose clinical presentation necessitates the administration of a controlled substance.

1. In accordance with Statewide Treatment Protocol and/or on-line medical control order, Department paramedics needing to access a controlled substance will remove the plastic medication kit from the secured drug box, and break off the previously applied BLUE

security plastic seal to access the medications. The BLUE seal will then be placed inside the box along with the corresponding RED seal which should already be in the kit.

2. Once on arrival at the hospital (or sooner, if the access to controlled medications is no longer anticipated), the plastic case with its remaining medications will be closed and sealed with the unit's YELLOW security seal.
3. In addition to the standard documentation, the ALS Crew will document on an "Unusual Occurrence Form" the reason for entry into the resealed, previously used, controlled substance kit.
4. After returning a medication kit with a YELLOW security seal, the crew will receive a replacement YELLOW seal from the Shift Commander and store it in the metal medication box mounted in the drug box.

UNUSUAL OCCURRENCE / DISCREPANCIES

1. Whenever a controlled key, inventory control tag of a grey or black pelican case, or security envelope is noted to be damaged, missing, lost or stolen, the ALS crew shall immediately notify the Shift Commander, and incident reports, documenting the circumstances, shall be completed by personnel involved.
2. Whenever a controlled medication kit is found to be damaged, the kit seal is damaged or missing, the kit seal number does not match the CSR number, any of the contents of a kit appear damaged, or there appears to be liquid in the kit, the paramedics making the discovery shall immediately notify the on-duty Shift Commander. The paramedic(s) shall complete a Controlled Medication Unusual Occurrence Form, and the entire kit, including any damaged vials, syringes, carpuject, and associated packaging shall be returned to the BMC pharmacy. The on-duty Shift Commander taking the report shall notify Professional Standards of the incident, and promptly forward all associated documentation (incident report(s), controlled medication unusual occurrence form, etc.) to Professional Standards for review.
3. Unusual occurrences will be reviewed on a weekly basis during the designated Boston EMS pharmacy liaison's regularly scheduled meeting with the BMC pharmacy.

RESTOCKING

1. Schedule II, III and IV drugs shall be procured from the Pyxis machine located in the Boston Medical Center Emergency Department. Two department certified paramedics must be present simultaneously to remove medications from the Pyxis. Whenever possible, both paramedics should be from the same unit, but it is acceptable for the second / witness member to be a Shift Commander or paramedic from another unit, if necessary.
2. Controlled Medications are dispensed in sealed clear plastic kits. The kits will be accompanied by a numbered CSR consisting of a white original page and attached pink carbon copy listing the controlled medications in the kit. The kits are sealed with a numbered RED plastic security seal. The number on the red security seal should match the number of the accompanying CSR. The kits will contain a numbered BLUE security seal to secure the kit after controlled medications have been initially accessed for patient administration. The number on the blue seal should be the same as the number on the red seal and on the CSR.

The kit will also contain all of the controlled medications to be stocked in BEMS ALS units, with the exception of Ketamine, which will be stored in its own sealed clear plastic kit. When restocking controlled medications, both paramedics shall complete the "Kit Removed By" section of the CSR (including signature, badge number, and printed name of both members, ALS unit, and date removed) as well as documenting the issuance of a new kit on the "Inventory Change Record" portion of the DCSAL form.

3. Succinylcholine is restocked from the refrigerator in the ALS equipment room at Materials Management.

GRAY NERVE AGENT BOX ("GRAY BOX")

1. Each ALS unit shall store a gray pelican case containing drugs necessary to treat a patient exposed to organophosphate based nerve agents. Each box will contain the following:

    - 30 Duodotes
    - 30 auto injector diazepam 10 mg
    - 18 pralidoxime chloride (Protopam) (2-Pam) 1 gm/vial
    - 25 atropine 1mg/ml vials
    - 50 syringes, 3 ml with needle
    - 2 patient belonging bags for splitting contents of box during an MCI
    - Instructions on dosing for atropine, pralidoxime chloride and diazepam for nerve agent poisoning
    - Instructions on dilution of pralidoxime
    - Isopropyl alcohol prep pads

2. There are two (2) keys for the lock on each gray box so each paramedic can secure the box. The box shall be kept in a locked interior compartment of the ALS ambulance. An inventory control tag with an imprinted number will be affixed to the outside of the gray box. If the seal is missing or broken, the crew shall immediately notify the Shift Commander and a full inventory of the box shall take place.

3. On the outside of each box there is a sticker indicating the expiration date of the item with the earliest expiration date. One (1) month before the indicated expiration date the crew shall do an inventory of the box and exchange soon to expire items at Materials Management. A new inventory control tag and a new expiration sticker shall then be secured.

ALS UNIT OUT OF SERVICE

1. When an ALS unit goes out of service (O.O.S), the two paramedics on duty shall conduct the end of shift controlled substance inventory. They shall complete the 'If OOS at end of shift" portion of the DSCAL indicating the CSR#___, the Seal Tag # ____ they are securing the box with, and the Time OOS:___. Both Medics shall sign the OOS portion of the DSCAL. (For example, if P-40 days goes in for shift change at 15:00 and there is no evening shift, they would complete the OOS at end of shift section of the DCSAL under Day Shift. When P3 goes OOS at 22:30, they would complete the OOS at end of shift section under the evening shift.)

2. The drug keys shall be placed in a controlled envelope and sealed. The paramedic placing the keys in the envelope shall sign on the line "Sealed By", and include date and time. The

other paramedic shall sign on the line "Witnessed By". The keys shall be placed inside the drug box, and a uniquely numbered inventory control tag shall then be affixed to the drug box, preventing it from being opened. The serial number of the inventory control tag shall also be recorded on the DSCAL sheet in the OOS at end of shift section at the bottom of the DCSAL.

3. If the ALS unit is anticipated to be out of service for a single shift (e.g. P3, P16), the gray nerve agent drug box and orange medication box (containing sealed key envelope), and DCSAL will be secured inside the ALS closet in the station if so equipped. When the unit will be out of service for longer than one shift (e.g. P40, P41), or if there is a problem with the stations secure drug closet, the gray nerve agent drug box and orange medication box (containing sealed key envelope), and DCSAL will be stored in the ALS equipment storage closet at Theodore Glynn Way.
4. All user access transactions for the ALS closets will be reviewed by Professional Standards monthly.

RESTRICTED ACCESS

1. Only personnel authorized by Boston EMS to administer Schedule II, Schedule III or Schedule IV drugs may be allowed unaccompanied in the patient compartment of any unit when these drugs are accessible. Personnel not authorized by Boston EMS to administer these drugs must be accompanied by authorized personnel when Schedule II, Schedule III or Schedule IV drugs are accessible.
2. All ALS drugs, equipment and supplies shall be removed from an ambulance prior to being sent to a vendor for repair or other service. Fleet Services shall notify the Shift Commander so that Materials Management Personnel may facilitate the removal of drugs, equipment and supplies.

PYXIS MACHINE: REGISTRATION PROCESS

Requests to establish, suspend, or terminate access to the Pyxis dispensing unit, including any password changes, shall be made in writing to the Professional Standards Division, who in turn will coordinate all changes in access with BMC Pharmacy personnel. The list of active users within Pyxis will be reviewed monthly by the Boston EMS Pharmacy Liaison, with any inappropriate access immediately reported to Professional Standards for review.

PYXIS: NARCOTIC REMOVAL PROCEDURE

1. First paramedic logs in to Pyxis using their name and fingerprint and selects "ALL AVAILABLE Patients" icon at the bottom left of the screen.
2. On the next screen, select the "Add Temporary Patient" icon on the bottom right.
3. On the next screen, enter the information as follows:
   3.1. The last name field will always be "Boston EMS"
   3.2. The first name field will always be the Paramedic Unit designation (i.e. 3P55)
   3.3. Select "EMS" from the drop-down box in the Unit field. Everything else, including the "patient ID" field should remain blank, and click the Accept icon.
4. On the next screen, select "EMS Go To Kit", select "1"and OK. "EMS Go To Kit" will move to the right side of the screen. Click on "Remove Med" at the bottom right.

5. PYXIS will now advise that a witness is required for the transaction and will prompt the witness (second Paramedic) to enter their username and BIO-ID
6. PYXIS drawer and pocket will now open and the screen will ask for a count. After confirming that there is one kit, enter "`1" and click "accept". Remove kit and click "accept" again.
7. The next screen will prompt you for the LOT Number. Enter the CSR number that appears on the kit you just removed, and click "accept".
8. Close the lid of the pocket, and then close the drawer, and sign out.
9. The Paramedics should then inspect the Kit ensuring that the Kit is intact, the red kit seal is intact, the contents of the kit appear undamaged, there is a blue replacement seal in the kit, and that the CSR number matches both the red and blue security seal numbers.
10. If there is anything wrong with the kit, its contents, the CSR, or any error messages or unusual behavior of the PYXIS machine immediately notify the on-duty Shift Commander, return the kit and CSR to the BMC Pharmacy on the 5th floor of the BMC-Menino, and complete an unusual occurrence form.

EMPLOYEE RESPONSIBILITY TO REPORT DRUG DIVERSION

Reports of drug diversion by fellow employees is not only a necessary part of an overall employee security program but also serves the public interest at large. It is, therefore, the position of DEA that an employee who has knowledge of drug diversion from his employer by a fellow employee has an obligation to report such information to a responsible security official of the employer (which, in the case of Boston EMS shall be Professional Standards and the Medical Director). The employer shall treat such information as confidential and shall take all reasonable steps to protect the confidentiality of the information and the identity of the employee furnishing the information. A failure to report information of drug diversion will be considered in determining the feasibility of continuing to allow an employee to work in a drug security area. The employer shall inform all employees concerning this policy. (see: 21CFR1301.91)

EZ Intra-Osseous Infusion Device

Supersedes: 11-22-11
Effective: 11-01-16

INDICATIONS
Boston EMS Advanced EMTs or Paramedics may initiate an EZ intra-osseous infusion for any patient who is in need of volume replacement or medication administration due to a life threatening condition and where standard attempts at IV cannulation have failed or when IV access appears to be difficult or unlikely.

CONTRAINDICATIONS:
- Patient has evidence of current pelvic injury, bony or vascular injury to the thigh precluding tibial IO placement (may use humeral head if not contraindicated), or
- Patient has evidence of previous or current injury, or prior surgery to the knee or shoulder on that extremity (may use the other side if not contraindicated), or
- Evidence of infection at the insertion site, or
- Excessive tissue at insertion site / inability to identify landmarks

RELATIVE CONTRAINDICATIONS:
- Burns at the insertion site, except when no reasonable alternative is available
- Known severe osteoporosis

MEDICATIONS APPROVED FOR INFUSION:
All intravenous medications currently used in Boston EMS ALS ambulances are approved for infusion via intra-osseous route with one exception: HYPERTONIC SALINE may not be infused through an intra-osseous route.

EQUIPMENT:
- EZ-IO™ Driver and Needle Set
- Chlorascrub Swabs
- EZ-Connect™
- 10 ml Syringe
- 2% Lidocaine HCL
- Normal Saline (or suitable sterile fluid)
- Tape or gauze
- Pressure bag

PROCEDURE:
1. Determine EZ-IO™ Indications.
2. Rule out contraindications.
3. If the patient is conscious, advise them of the EMERGENT NEED for this procedure.
4. Wear approved Body Substance Isolation Equipment.

5. Locate insertion site. The primary EZ-IO™ needle introduction site is the proximal tibia. The humeral head can be used as an *alternative* needle introduction site if there are any contraindications to placement or inability to gain access in the proximal tibia. In pediatric patients 39kg or less, the distal femur insertion site may be used.
6. If the humeral head is used as the needle insertion site, be sure that the upper extremity is appropriately stabilized.
7. Cleanse insertion site using aseptic technique.
8. Select the appropriate needle size for the patient (See appendix below for manufacture's recommended needle size guide).
9. Prepare the EZ-IO™ driver and needle set.
10. Stabilize the target extremity and insert EZ-IO™ needle set. *Gently* power or press needle set until needle set tip touches bone. Ensure at least 5 mm of the catheter is visible.
11. Penetrate bone cortex until a sudden "give" is felt and the desired insertion depth is achieved.
12. Remove the driver from the needle set while stabilizing catheter hub.
13. Remove stylet from needle set, place stylet in sharps container.
14. Confirm placement by aspiration of bone marrow.
15. Connect primed EZ-Connect™ – extension set.
16. Flush or rapidly bolus the EZ-IO™ catheter with 10 ml of normal saline using a 10 ml syringe. Alternatively, administer 20 mg of lidocaine 2% (0.5 mg/kg IO bolus up to 20 mg for pediatric patients) via the EZ-IO™ catheter followed by 10 ml NS flush for local anesthesia if the patient reports pain at the insertion site. Any additional doses of lidocaine for local IO anesthesia require consultation with medical control.
17. Place a pressure bag on solution being infused where applicable. For medications utilizing an IV infusion pump, the medication should be infused directly via the IO catheter.
18. Begin infusion.
19. For medications utilizing IV infusion pump 'piggy back' medication on pressure bag infusion line when appropriate.
20. Dress site, secure tubing and apply wristband.
21. Frequently monitor IO catheter site and patient condition.
22. If placement is unsuccessful on the first attempt, the other leg (or humeral head) may be used to attempt IO placement if there are no contraindications. No more than one attempt may be made for each extremity.

REMOVAL OF IO CATHETER

Once inserted, the IO catheter should remain in place until removed by hospital staff at the receiving facility. In very rare cases (intractable severe pain, uncontrolled bleeding at insertion site, etc.), the IO catheter may be removed by pre-hospital personnel. Personnel should utilize the following procedure for IO removal:

1. Attach a sterile 10 ml syringe to the catheter hub.
2. Support the patient's extremity and rotate the catheter in a clockwise direction (the same direction used to attach the syringe) while gently withdrawing the catheter.
3. Always maintain 90 degree angle to the skin over the insertion site while removing catheter to minimize complications.
4. Never rock the catheter back and forth while removing. This may cause separation of the catheter from the hub.

5. If the catheter and hub do separate, use a hemostat and remove catheter in same manner as suggested above (grasp, rotate, and gently pull).
6. If the broken catheter set is not accessible, notify emergency department staff at the receiving facility. They should contact the emergency number on the yellow wrist band for further removal instructions.

PAR LEVELS:
Three EZ-IO™ needle sets, three wristbands and three EZ-Connect™ IV tubing sets are included in each case with the driver. Restocking for each item should occur when the par level falls below two. Restocking should be done at Materials Management Division (Supply).

DOCUMENTATION OF IO NEEDLE INSERTION:
Use the Safety Pad™ to document intra-osseous needle placement in adults. EZ-IO™ needle cannula size is 15 gauge.

APPENDICES:
• Needle Sizing
15 mm needle (pink hub): patient weighs 3 – 39 kg
25 mm needle (blue hub): patient weighs 40 kg or more
45 mm needle (yellow hub): patient weighs 40 kg or more with excessive tissue over the targeted insertion site

• Manufacturer's insertion instructions can be accessed at
http://www.vidacare.com/admin/files/VIDO5-8016-REVH_02-26_HIRES.pdf

Prehospital Medication Assisted Intubation

Supersedes: 09-11-06
Effective: 01-29-10

This document includes the protocol for prehospital medication assisted intubation (MAI). Also included are clinical algorithms, educational recommendations and guidelines for quality assurance.

The efficacy of sedatives and neuromuscular blocking medications has been demonstrated for prehospital as well as hospital use to facilitate intubation. The success of a prehospital medication assisted intubation program depends on several factors.

- First, there needs to be a comprehensive initial educational program that includes operating room observation time. The initial education is supplemented with monthly case review and semi annual skills review.

- The quality assurance program requires commitment by the service medical director and paramedic manager. An interdisciplinary committee should review MAI cases on a regular basis. The case review is so important for the successful use of the protocol that meeting attendance is mandatory. The service medical director and paramedic manager should participate in all the meetings of the interdisciplinary committee. In their absence they should send a designee who would be able to report information back to their service. More than one unexcused absence threatens the quality performance of the service. Thus, a service should be suspended from using the protocol until they can comply with regular attendance and participation in the quality review process.

- A standard database should be used so that intubation data can be merged from multiple services.

- Individual paramedic should have performed 20 intubations per year to use the protocol as a standing order. The paramedic service should have performed over 100 intubations per year.

- Two-paramedic crews may use the protocol as a standing order.

EDUCATION

The initial educational program consists of didactic lectures, skills labs and observation time in the Operating Room. The initial program takes approximately 20-24 hours to complete. The continuing education program includes monthly case reviews and semi-annual skills review.

I. The classroom time will be approximately 8 hours and should include the following:

a. Anatomy and physiology - including systems for grading the airway.

b. Pharmacology - focusing on contraindications, indications, mechanism of action, onset, duration of action, dosing, special considerations for pediatric patients and drug interactions.

c. Advanced airway management - includes review of the algorithm and case scenarios with attention to the complicated airway section of the algorithm. The use of the LMA, transtracheal jet insufflation, needle and surgical cricothyrotomy should be covered in detail. End tidal $C0_2$ monitoring should be reviewed.

II. The labs will need approximately 8 hours and should include the following:

a. Review techniques for needle and surgical cricothyrotomies and LMA. Procedures can be performed on mannequins and animal necks. Use some case scenarios to incorporate the use of the procedures as rescue airways as part of the algorithm

III. Operating Room Observation

a. Observe the use of neuromuscular blocking agents by anesthesia. Knowledge objectives should include contraindications, dosing, drug onset and duration, estimation of pediatric weight, airway equipment sizes and lip line estimates, Each paramedic needs to have done 20 intubations (field or O.R.) per year prior to using the protocol

IV. Completion of written and practical exam given by the Medical Director.

QUALITY ASSURANCE

Quality assurance will be performed by each service. The Service Medical Director and Advanced Life Support (ALS) Manager will review each MAI case individually and keep a written record of their review. Sample forms are included.

The paramedics will enter the appropriate information from MAI case into the standardized database. The service MAI data may be merged with data from other services upon the request of OEMS.

At least bimonthly, MAI cases should be reviewed by an interdisciplinary committee. The committee should include, but not be limited to, paramedics, emergency physicians, pediatric emergency physicians, and anesthesiologists.

The interdisciplinary committee should review cases and make recommendations for continuing education of the paramedics. Also the committee should review service data regarding utilization, etc., on an annual basis.

(Greater than 30 kg/66 lbs.)

GENERAL INDICATIONS

Any patient who has the need for definitive airway control and/or prolonged ventilatory assistance in whom such control has not been established by more conventional means.

CONTRAINDICATIONS

- Inability to ventilate patient with Bag-Valve Mask
- Upper airway obstruction
- Tracheal obstruction (i.e., foreign body, tumor)
- Suspected pharyngeal infection (i.e., epiglottitis, peritonsillar or retro-pharyngeal abscess)
- Patients at high risk for hyperkalemia
- Neuro-muscular disorders (i.e., multiple sclerosis, muscular dystrophy, ALS etc.)

PROCEDURE

Assemble equipment:

- Intubation set (including all blades and Magill forceps)
- Endotracheal tubes (two of each size)
- Malleable stylet (pediatric and adult)
- Pulse oximeter (capable of constant reading)
- Cardiac monitor
- Bag-Valve-Mask with oxygen
- Suction with Yankaur tip
- End tidal CO_2 detector
- NASO gastric tube (to be placed following intubation if time allows)
- Melker Cricothyrotomy Kit
- Adjunctive airway system (BVM, OPA, NPA, LMA)

MEDICATION ASSISTED INTUBATION

PATIENT PREPARATION

1. Intubate patient by conventional methods unless the patient's clinical condition (i.e., agitation, combativeness or increased muscle tone) requires sedating/paralytic agents and that a first attempt by conventional methods would delay obtaining a definitive airway.

2. Grade the airway. Consider the contraindications to using medications, including succinylcholine.

   2.1. Contraindications for Succinylcholine
   - Patients at high risk for hyperkalemia
   - Neuromuscular disorders (e.g., multiple sclerosis, muscular dystrophy, "ALS" Lou Gehrig's Disease, Guillian-Barre, severe muscular atrophy diseases)
   - Burns over 48% BSA
   - Patient of familial history malignant hyperthermia
   - While not a contraindication, caution should be used in patients suspected of organophosphate / nerve agent exposure as it may potentiate effect and cause prolonged paralysis

3. Patient should have all applicable monitoring devices attached and working.

4. IV should be established with a large bore catheter and secured appropriately.

5. Pre-oxygenate with 100% oxygen prior to administration of medications.

6. Medications should be prepared during high flow O_2 period.

MEDICATION ADMINISTRATION

1. Fentanyl and/or midazolam or etomidate may be used for sedation. Fentanyl alone and/or etomidate is preferable for hemodynamically compromised trauma or medical patients. Remember when using Etomidate for a patient age 10 or older in shock, the dose is reduced from 0.3 mg/kg to 0.2 mg/kg with maximum dosing of 20 mg. The dose of fentanyl 1-2 mcg/kg I.V.

2. Midazolam (2.0-2.5 mg I.V.) or Etomidate 0.3 mg/kg may be used alone, if there is a contraindication to using fentanyl. Also midazolam or etomidate may be used in addition to fentanyl, if sedation with fentanyl is inadequate or to relieve muscular rigidity caused by higher doses of fentanyl. Remember the increased potential for lowering blood pressure when using two medications together. For patients who are already heavily sedated with narcotics or sedatives, etomidate, midazolam and fentanyl may not be necessary prior to neuromuscular blockade.

3. Rate the difficulty of intubation before neuromuscular blockade (i.e., short neck syndrome, very anterior airway position, micrognathia, etc.). If the patient's airway would be too difficult to intubate with the use of paralytic medications, then ventilate patient by mask and transport to the hospital.

4. Administer succinylcholine 1.5 mg per kilogram IV push. Dosing is based on patient's lean body mass. Maximum dose of succinylcholine should not exceed 120 mg.

5. Apply cricoid pressure until intubation completed. C-collar may need to be removed to maintain cricoid pressure and to maintain in line stabilization.

6. Pass endotracheal tube, if patient's sedation is adequate at this time..

7. Upon evidence of paralysis (apnea, jaw relaxed and decreased resistance to bag-mask ventilation) proceed with intubation. Maintain C-spine immobilization when indicated. If patient is not intubated within twenty (20) seconds, stop and re-ventilate patient for thirty (30) seconds to one (1) minute before attempting to intubate patient again. Continuously monitor heart rate and pulse oximeter. If patient is unable to be intubated, then ventilate patient by bag-valve-mask until muscular paralysis abates. If bag-valve-mask ventilation is ineffective, go to the "Rescue Airway Algorithm" and contact Medical Control.

8. After passing the endotracheal tube, placement should be confirmed by auscultation of breath sounds bilaterally, the absence of abdominal sounds and using the end tidal CO_2 detector. Continuous monitoring of heart rate and pulse is imperative.

9. Document lip line. Contact Medical Control. Fentanyl and/or midazolam may be used for post sedation. The doses and hemodynamic concerns are the same as noted above for pre-intubation sedation.

10. Post intubation some patient's may become severely agitated despite sedatives. If the patient's agitation threatens the loss of the ET tube contact medical control for an order for Vecuronium 0.1 mg/kg. Vecuronium is only for patient's age 16 or older and maximum dose is 10 mg IV/IO. Vecuronium is a standing order in the therapeutic hypothermia protocol only.

11. Placing an oral gastric tube while en route to the receiving facility is optimal, but should not detract from other more important patient care duties.

12. Complete written documentation including airway assessment and degree of difficulty to be included in patient's hospital record.

MONITORING / DOCUMENTATION

Documentation for all medically assisted intubations should include blood pressure, heart rate, respiratory rate, oxygen saturation, and end tidal C02. If there are any situations where this cannot be caputred by your monitoring system(s), please document that in the ePCR.

PEDIATRIC

(less than 30 kg/66 lbs.)

GENERAL INDICATIONS

The indications for prehospital endotracheal intubation of the pediatric patient are unchanged whether or not paralytic medications are available. Within the population of children for whom intubation is indicated, the prehospital use of paralytic agents as an adjunct to endotracheal intubation should be restricted to those children whose trachea cannot be intubated after administration of the sedative induction agents prescribed in this protocol.

CONTRAINDICATIONS

- Inability to ventilate patient with Bag-Vale Mask
- Upper airway obstruction
- Tracheal obstruction (i.e., foreign body, tumor)
- Suspected pharyngeal infection (i.e., epiglottitis, peritonsillar or retro-pharyngeal abscess)
- Patients at high risk for hyperkalemia
- Neuro-muscular disorders (i.e. muscular dystrophy, multiple sclerosis, etc.)

PROCEDURE

Assemble equipment:

- Intubation set (including all blades and Magill forceps)
- Endotracheal tubes (two of each size)
- Malleable stylet (pediatric and adult)
- Pulse oximeter (capable of constant reading)
- Cardiac monitor
- Bag-Valve-Mask with oxygen
- Suction with Yankaur tip
- End tidal CO_2 detector
- NASO gastric tube (to be placed following intubation if time allows)
- Melker Cricothyrotomy Kit
- Adjunctive airway system (BVM, OPA, NPA, LMA)

MEDICATION ASSISTED INTUBATION

PATIENT PREPARATION

1. Intubate patient by conventional methods unless the patient's clinical condition (i.e., agitation, combativeness or increased muscle tone) requires sedating/ paralytic agents and that a first attempt by conventional methods would delay obtaining a definitive airway.

2. Grade the airway. Consider the contraindications to using medications, including succinylcholine.

3. Patient should have all applicable monitoring devices attached and working.

4. IV should be established with a large-bore catheter and secured appropriately.

5. Pre-Oxygenate with 100% oxygen prior to administration of medications.

6. Medications should be prepared during high flow O_2 period.

MEDICATION ADMINISTRATION

1. Fentanyl and/or midazolam may be used for sedation. Fentanyl alone is preferable for hemodynamically compromised trauma or medical patients. Administer fentanyl 1-2 mcg/kg I.V. Midazolam may be used alone, if there is a contraindication to using fentanyl. Also midazolam may be used in addition to fentanyl, if sedation with fentanyl is inadequate or to relieve muscular rigidity caused by higher doses of fentanyl. Midazolam dose is 0.05-0.1 mg/kg IV push (up to 2.5 mg total per dose). Remember the increased potential for lowering blood pressure when using both medications together. For patients who are already heavily sedated with narcotics or sedatives, midazolam and fentanyl should not be necessary prior to neuromuscular blockade. Etomidate can be used for children over 10 years of age, dosing is 0.2 mg/kg in shock and 0.3 mg/kg in patients not in shock. Maximum dosing is 20 mg IV/IO. Etomidate is not appropriate for post intubation sedation. Etomidate can be use with either midazolam or fentanyl, but typically will not need to be combined with other medications for sedation.

2. If clinical condition still warrants the use of paralytics rate the difficulty of intubation before neuromuscular blockade (i.e., short neck syndrome, very anterior airway position, micrognathia, etc.). If the patient's airway would be too difficult to intubate with the use of paralytic medications, then ventilate patient by mask and transport to the hospital.

3. Premedicate with Atropine 0.01 mg/kg to prevent bradycardia. Minimum dose of Atropine is 0.1 mg to prevent paradoxical bradycardia. Maximum dose of Atropine is 0.5 mg. Administer succinylcholine 1.5-2.0 mg per kilogram IV push. Dosing of succinylcholine is based on patient's lean body mass.

4. Apply cricoid pressure until intubation completed. C-collar may need to be removed to maintain cricoid pressure and to maintain in line stabilization.

5. Upon evidence of paralysis (apnea, jaw relaxed and decreased resistance to bag-mask ventilation) proceed with intubation. Maintain C-spine immobilization when indicated. If patient is not intubated within twenty (20) seconds, stop and re-ventilate patient for thirty (30) seconds to one (1) minute before attempting to intubate patient again. Continuously monitor heart rate and pulse oximeter. If patient is unable to be intubated, then ventilate patient by bag-valve-mask until muscular paralysis abates. If bag-valve-mask ventilation is ineffective, go to the "Rescue Airway Algorithm" and contact Medical Control.

6. After passing the endotracheal tube, placement should be confirmed by auscultation of breath sounds bilaterally, the absence of abdominal sounds and using the end tidal CO_2 detector. ETCO2 caps vary in their accuracy depending on humidification. Continuous monitoring of heart rate and pulse is imperative.

7. Document lip line. Lip line should be about 12 plus ½ age for a child greater than 5 kg and 10 plus the age for a child less than 5 kg. Contact Medical Control. Fentanyl and/or midazolam may be used for post sedation. The doses and hemodynamic concerns are the same as noted above for pre-intubation sedation.

8. Placing an oral gastric tube while en route to the receiving facility is optimal, but should not detract from other more important patient care duties.

9. Complete written documentation including airway assessment and degree of difficulty to be included in the patient care report. Documentation should also include blood pressure, heart rate, respiratory rate, oxygen saturation and end-tidal CO2 levels. If there are any situations where this cannot be captured by moniotiring system, please document that in ePCR.

RESCUE AIRWAY PROTOCOL

I. Attempt basic airway maneuvers prior to advanced procedures:

A. Head tilt/chin lift or jaw thrust

B. BVM with OPA/NPA

C. Endotracheal intubation

D. LMA

II. In the event of unsuccessful intubation, following the administration of a neuromuscular blockade, continue to ventilate with BVM until the blockade has abated.

III. If spontaneous respiration does not occur and bag-mask ventilation is impossible or inadequate, administer Naloxone intravenously and insert LMA. If unable to use LMA, perform surgical circothyrotomy for adult or needle cricothrotomy for childless than 30 kg or 9 years old.

A. LMA

B. Needle Cricothyrotomy (see Cricothyrotomy Protocol)

C. Surgical Cricothyrotomy (see Cricothyrotomy Protocol)

CRICOTHYROTOMY

Cricothyrotomy is an invasive procedure performed only when a patient is in imminent danger of death due to airway compromise which cannot be alleviated by other means.

Needle Cricothyrotomy is the preferred procedure in children under the age of 8 years old. It may also be performed in adults prior to the surgical method or as a means of allowing air into the airway until a more suitable airway can be obtained.

CONTRAINDICATIONS

No absolute contraindication relative to the given situation.

EQUIPMENT

Melker Emergency Cricothyrotomy Catheter Set *or Quick Trach kit*

Contained in the kit: #14 gauge needle, scalpel, introducer, dilator, guide wire, 6mm endo-tube.

This device may be use for both Needle and Surgical procedures.

PROCEDURE

Hyperextend the neck if there is no evidence of trauma. Identify landmarks and prep the neck. Palpate the thyroid and cricoid cartilage, then palpate the cricoid membrane. Identify this membrane by placing the left index finger on the membrane while stabilizing the trachea with the thumb and middle finger of the left hand. Prep area with right hand while you maintain the landmark with the left hand.

1. Clean area in the usual fashion.

2. Insert the #14G needle in to the crico-membrane; aspirate air. You can attempt ventilation at this time by using the 21/15mm adapter from a #3.0mm endotracheal tube. There will not be chest rise with ventilation just breath sound auscultated over lung fields.

3. To continue with a surgical cricothyrotomy insert the soft end of the guide wire through the catheter.

4. Once in place remove the catheter and thread the Introducer/dilator/tube down the wire so it is touching the throat.

5. Using the scalpel, make a small vertical incision through the skin.

6. Insert the introducer, then the tube. Remove the introducer and guide wire.

7. Ventilate and auscultate breath sounds bilaterally.

8. Secure the tube.

REFERENCES

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Selective Spine Assessment & Spinal Motion Restriction

Supersedes: 02-09-15
Effective: 10-20-15

Spinal cord injury may be the result of direct blunt and/or penetrating trauma, compression forces (axial loading), abnormal motion (hyper-flexion, hyperextension, hyper-rotation, lateral bending and distraction (i.e., hanging). Most spinal injuries result from motor vehicle crashes, falls, firearms, and recreational activities.

Spinal injuries may be classified into sprains, strains, fractures, dislocations and/or actual cord injuries. Spinal cord injuries are classified as complete or incomplete and may be the result of pressure, contusion, or laceration of the cord.

Individuals should be assessed and treated for possible spinal injury, and immobilized if necessary, if they have sustained an injury with a concerning mechanism, and either have symptoms of injury and/or have a reason not to adequately perceive or to be able to communicate the symptoms of such injury.

Long backboards are NOT considered standard of care in most cases of potential spinal injury. Instead, use spinal motion restriction (SMR) with a cervical collar and cot in most cases. Note that there are exceptions, such as a patient with a potential spinal injury who cannot be logrolled while being transported and may be at risk of a compromised airway, an unstable trauma patient requiring rapid transport to the nearest trauma center, suspected injuries that require other interventions or minimizing excess movement (e.g. patient requiring a traction splint), or in cases where removal of longboard is not practical (obese patient, inadequate space to perform removal, etc.). In these cases, it may be more appropriate to initiate transport while leaving the patient on a long spine board or scoop.

Concerning mechanisms that may result in spinal column injury:

- Fall from over 3 feet, including adult fall from standing, or 5+ stair steps
- MVC at 30+ mph, or rollover or ejection
- Motorcycle, bicycle, other mobile conveyance, or pedestrian-vehicle accident
- Diving or axial load
- Electric shock

Symptoms of spinal column injury may include:

- Posterior neck or back pain or tenderness;

- Paresthesias or loss of sensation in extremities;
- Weakness or paralysis of extremities;

Conditions placing individuals at risk to not perceive or complain of the symptoms of spinal column injuries:

- Altered mental status due to disease, injury, intoxication, or other causes;
- Inability to adequately communicate;
- History of cervical spine injury or abnormality, or conditions causing fragile bones;
- Distracting injury (such as long-bone fracture);
- Age extremes (including >65 years of age);

Individuals sustaining lesser injuries, patients who do not have symptoms of spinal column injury and do not experience a condition that would impair the patient's ability to perceive or communicate symptoms of spinal column injuries do not require spinal immobilization

Penetrating injuries to the neck generally do not require spinal immobilization.

ASSESSMENT / TREATMENT PRIORITIES

1. Ensure scene safety, appropriate universal precautions, request additional EMS resources (BLS or ALS) as necessary, perform thorough primary survey, treat any life threatening injuries immediately, appropriate oxygen and IV therapy
2. If patient is assessed as stable and there is a suspicion of possible c-spine injury begin assessment and history to determine if the patient needs to be placed in a collar and undergo spinal motion restriction. Mechanism of Injury should be used as a historical component of the assessment and lead to further spine assessment (i.e. Axial loading (diving), blunt trauma, motor vehicle crash (MVC)*****, fall >3ft, adult fall from standing height.

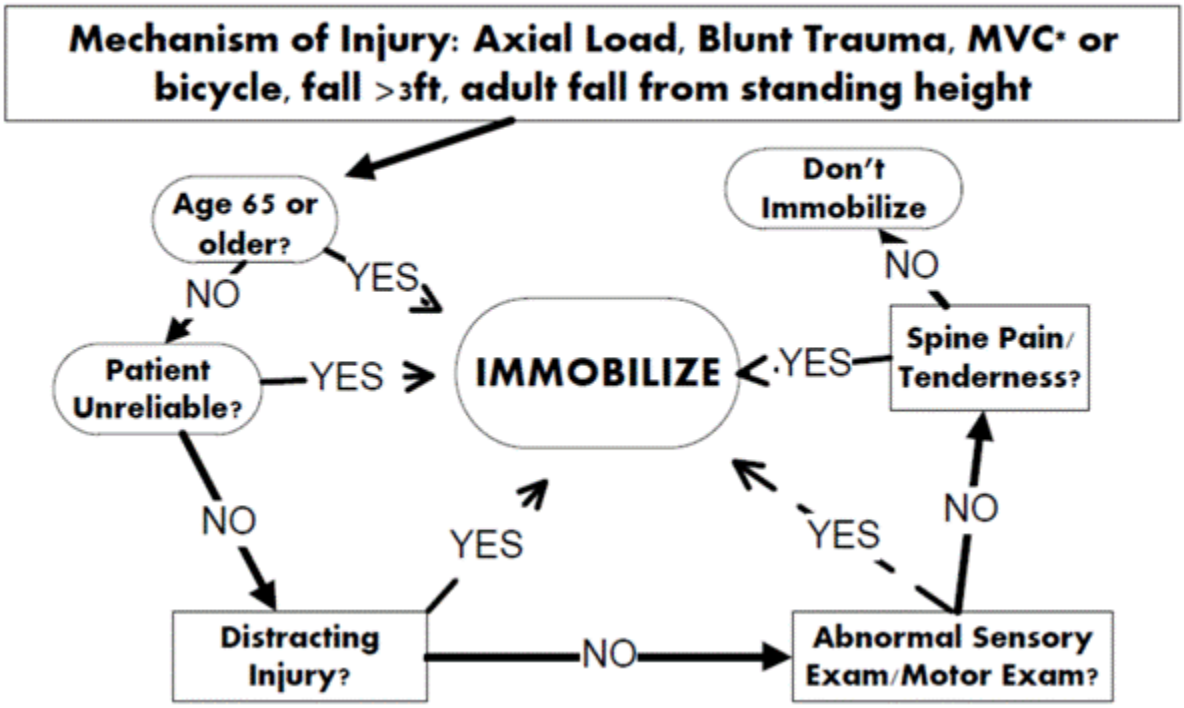
   *MVC applies to crashes of all motorized vehicles: e.g. automobile, motorcycle, snowmobile, etc.)
3. If a concerning mechanism exists, the provider should go to the Selective Spine Assessment Protocol (SSAP) to determine if any of the inclusion criteria exist for spinal immobilization.
4. Spinal precautions should be maintained until all components of SSAP have been completed. For patients who have *isolated* thoracic or lumbar/sacral spine pain/tenderness, cervical collar placement is not necessary unless the patient has another criteria for cervical spine immobilization (age > 65, unreliable patient,

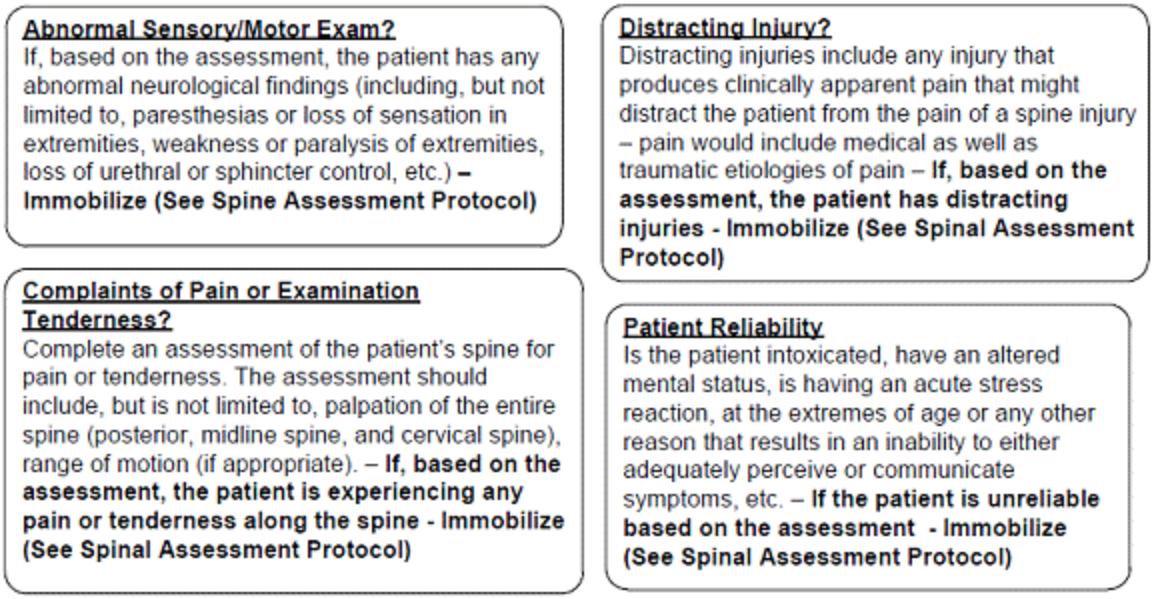
distracting injury or abnormal sensory/motor deficits). If there is any doubt on cervical spine involvement, cervical collar use is appropriate.

5. Attempting to force an uncooperative patient into spinal immobilization may be counter-productive. Contact on-line medical control for any question about indications for spinal immobilization.

NOTE: If patient is < 65 years old and it is determined through a complete assessment that the patient is 1) Reliable (including ability to communicate adequately) 2) Has no distracting injuries 3) Has no abnormal sensory/motor deficits 4) Has no spine pain/tenderness – DO NOT IMMOBILIZE.

Spine Assessment Protocol





CAUTION: This protocol **cannot** be used to rule out need for immobilization in any patient age 65 or older.

SPINAL MOTION RESTRICTION (SMR) PROCESS

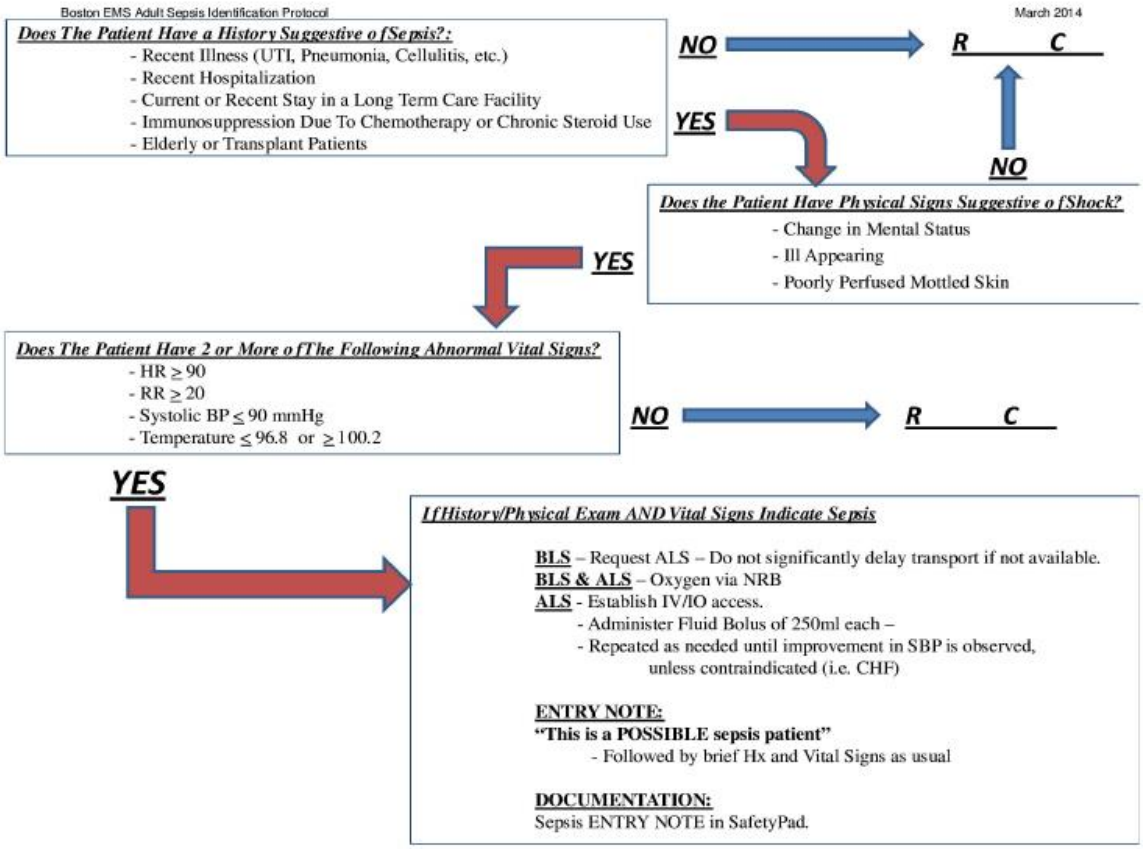
1. Establish manual c-spine stabilization in the position that the patient is found.
2. Assess for correct size and properly apply a cervical collar.
3. Move patient from the position found to the location of the ambulance stretcher utilizing a device such as a scoop stretcher, long spine board, or if necessary, by having the patient stand and pivot to the stretcher.

   DO NOT permit the patient to struggle to their feet from a supine position.
4. Position patient on the ambulance stretcher.
5. Remove scoop or logroll patient off long spine board or other device (if such device was utilized).
6. A blanket roll or blocks and tape attached to the stretcher may be used to minimize lateral movement of head during transport.
7. Once on the ambulance stretcher, instruct patient to lie still.
8. The head of the stretcher may be elevated 20-30 degrees in a position of comfort.
9. Secure cross stretcher straps and over-the-shoulder belts firmly.
10. Utilize a SLIDE BOARD at the destination to move the patient smoothly to the hospital stretcher.
11. Ensure appropriate documentation of procedure in patient care report.

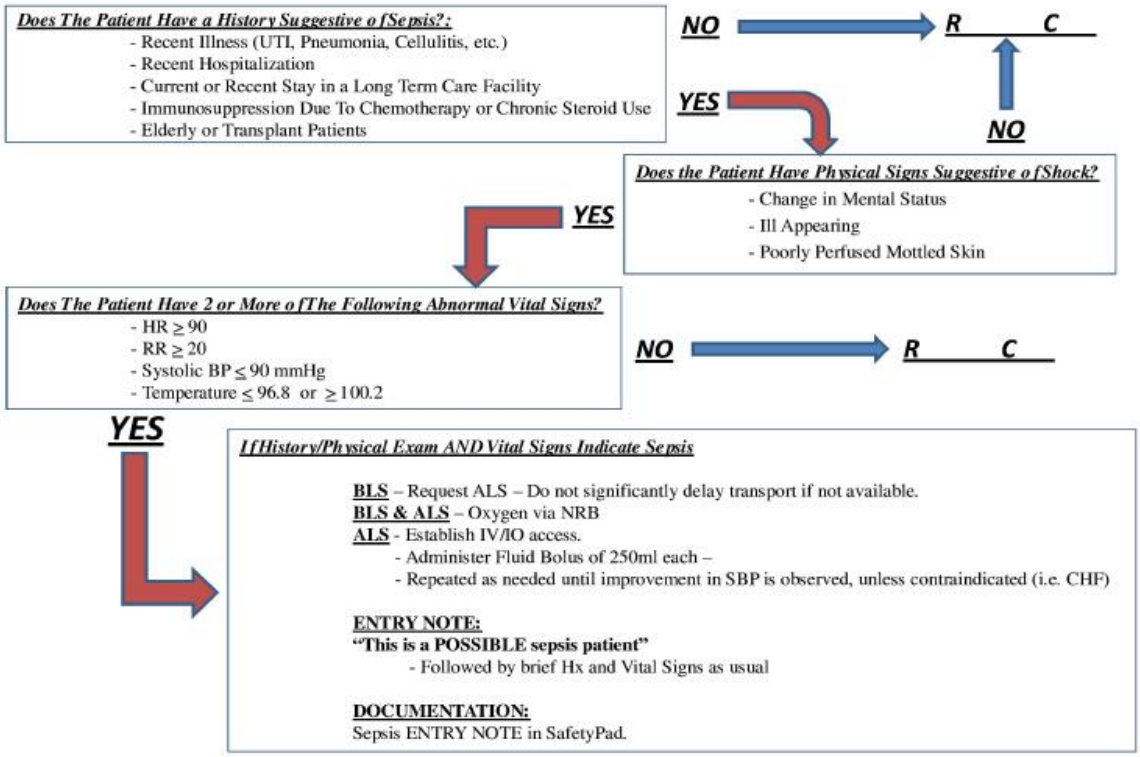
APPLICATION OF SELECTIVE SPINE ASSESSMENT AFTER FIRST RESPONDER IMMOBILIZATION

In some cases, a patient may be in the process of being immobilized or has already undergone complete spinal immobilization performed by first responders prior to EMT or Paramedic selective spinal assessment protocol. The selective spinal assessment protocol allows the EMT or paramedic to appropriately assess the need for spinal immobilization and does not apply to certified first response services. Spinal immobilization is considered a medical intervention and should not be continued if not medically indicated based on the selective spinal assessment protocol.

1. If the patient has been completely immobilized to a long backboard or scoop stretcher, place the patient on the ambulance cot and into the ambulance when practical for SSAP assessment. Explain to the patient and first responders on scene the plan to perform selective spinal assessment.
2. If the patient has not yet been fully strapped to the long backboard on-scene, SSAP assessment can be performed to determine if immobilization should be continued. DO NOT lift, carry or transfer an unstrapped or unsecured patient to the ambulance. If it is not possible to perform on-scene SSAP (i.e. active highway or roadway), secure the patient to the long backboard and move the patient into the ambulance for SSAP assessment.
3. Perform the SSAP to determine if there are any criteria for spinal immobilization present [Age ≥ 65, Unreliable, Distracting injury present, Abnormal sensory/motor exam, Spine pain or tenderness]. This includes log rolling the patient with cervical spine precautions to assess the midline spine and removal of the long backboard. Assessment for midline cervical spine pain/tenderness can be performed with the collar open.
4. If it is determined through assessment that the patient is reliable, has no distracting injuries, has no abnormal sensory/motor findings, and has no spine pain / tenderness, the patient does not need spinal motion restriction / immobilization. The patient can be transported in a position appropriate for their chief complaint.
5. If there are any criteria for spinal immobilization or concerns over spinal injury, then SMR should be performed.
6. In the case of multiple patients requiring spinal immobilization, a longboard, scoop stretcher, or other appropriate patient carrying device can be used over the crew bench seats for spinal motion restriction during transport.


Boston EMS Adult Sepsis Identification Protocol
March 2014
Does The Patient Have a History Suggestive of Sepsis?:
- Recent Illness (UTI, Pneumonia, Cellulitis, etc.)
- Recent Hospitalization
- Current or Recent Stay in a Long Term Care Facility
- Immunosuppression Due To Chemotherapy or Chronic Steroid Use
- Elderly or Transplant Patients
NO
R C
YES
NO
Does the Patient Have Physical Signs Suggestive of Shock?
- Change in Mental Status
- Ill Appearing
- Poorly Perfused Mottled Skin
YES
Does The Patient Have 2 or More of The Following Abnormal Vital Signs?
- HR ≥ 90
- RR ≥ 20
- Systolic BP ≤ 90 mmHg
- Temperature ≤ 96.8 or ≥ 100.2
NO
R C
YES
If History/Physical Exam AND Vital Signs Indicate Sepsis
BLS – Request ALS – Do not significantly delay transport if not available.
BLS & ALS – Oxygen via NRB
ALS - Establish IV/IO access.
- Administer Fluid Bolus of 250ml each –
- Repeated as needed until improvement in SBP is observed, unless contraindicated (i.e. CHF)
ENTRY NOTE:
"This is a POSSIBLE sepsis patient"
- Followed by brief Hx and Vital Signs as usual
DOCUMENTATION:
Sepsis ENTRY NOTE in SafetyPad.

Boston EMS Adult Sepsis Identification Protocol March 2014



Severe Hemorrhage Control: HemCon ChitoGauze / Tourniquet

Supersedes: 12-13-10
Effective: 10-28-13

PURPOSE
Hemorrhage remains a leading cause of death in civilian trauma. Recent advancements on the battlefield have lead to both a better understanding of tourniquet use as well as new hemostatic control agents which have been deployed into civilian EMS agencies. **HemCon® ChitoGauze** is a *prescription* hemostatic dressing for the external, temporary control of severely bleeding wounds. HemCon® has been shown to be an effective tool in controlling severe hemorrhage when standard methods (direct pressure, pressure bandage, elevation, etc) are not effective. This protocol also incorporates the SOP for the proper use of tourniquets.

Boston EMS has recognized the importance of tourniquets in the pre-hospital setting for over a decade. Recent events, including the marathon bombings and other active shooter events continue to demonstrate the importance of early control of exsanguinating hemorrhage. Additionally, these events have highlighted the importance of having appropriate equipment available immediately for application. As a result, the Department will issue one Combat Application Tourniquet (CAT) to each department member to be kept on their person. This will ensure that in the event of another mass casualty incident (MCI) with potential threat to self and other responders, every department member will have on hand a tourniquet ready for use.

A few key points on the issuance of the CAT:

- The purpose of the individual issued CAT is primarily for self-aid or buddy-aid of another department member or emergency responder.
- The current BEMS Hemorrhage Control Kits utilizing rubber tubing/hemostat should be the primary kit used for severe hemorrhage control, when available.
- Alternatively, the CAT can be used if a rubber tubing/hemostat tourniquet is not immediately available, or is ineffective in stopping hemorrhage.
- Providers should consider the preferred use of a rubber tubing/hemostat tourniquet for upper thigh/high groin hemorrhage where CAT placement may not be as effective.
- The supplies of CAT are limited. As such, individual issue CATs will be replaced after a documented use or contamination when possible.

INDICATIONS:

Tourniquet

- Placed for traumatic injury when required to prevent death due to life-threatening hemorrhage in wounds amenable to treatment with a tourniquet (e.g. extremity trauma, amputation)
- Life-threatening venous or arterial hemorrhage which is uncontrolled by standard treatment

HemCon ChitoGauze

- Severe venous or arterial hemorrhage which is uncontrolled by standard treatment

- Life-threatening bleeding not amenable to tourniquet use (e.g. head, neck, torso injury)
- In conjunction with tourniquet use

CONTRAINDICATIONS:

- Bleeding controlled by standard treatment
- HemCon ChitoGauze should NOT be applied over eyes.
- Seafood allergy is NOT a contraindication for using HemCon ChitoGauze

PROCEDURE:

Tourniquet

- Place the tourniquet as distal as possible on the limb, but 2-3 inches above the wound. Do not apply directly over a joint.
- Place tourniquet directly on skin whenever possible to avoid slippage
- Place tubing over top of the injured limb, pull tubing outward prior to folding under the limb. Cross the tubing over itself.
- Pull tubing outward again and then cross tubing on top of the injured limb crossing tubing over itself again
- Secure the tubing with hemostats to avoid tubing from releasing
- Document use and time of placement in SafetyPad
- Notify and advise receiving hospital staff of use and area of placement of tourniquet
- Tourniquets placed in the field should not be removed unless advised to do so with medical direction

HemCon ChitoGauze

- Identify source of bleeding.
- Open foil pouch and remove ChitoGauze, unfold bandage.
- Pack ChitoGauze into wound using enough ChitoGauze to fill wound. Ensure that the surface of the ChitoGauze is in contact with the bleeding surfaces of the wound.
- In the case of bleeding dialysis fistula/graft, place HemCon directly over maximal site of bleeding.
- Apply standard 4x4 gauze over ChitoGauze to apply pressure to wound for at least 3 minutes, and if possible secure with Kerlex or similar bandage.
- HemCon ChitoGauze is a *prescription* item, it will be deployed to each ambulance and Supervisor vehicle- not to the individual. Like all other medications, it should be accounted for at the beginning of each shift. It will be distributed as part of a severe hemorrhage kit, including a HemCon ChitoGauze, tourniquet, hemostats, and standard gauze. Par level of 2 per vehicle.
- Document use in SafetyPad.
- Notify and advise receiving hospital staff that HemCon ChitoGauze use has been administered. In order for hospital staff to remove HemCon ChitoGauze, advise them to use saline irrigation for removal.

Targeted Temperature Management after Cardiac Arrest

Supersedes: 04-06-09
Effective: 11-24-15

BACKGROUND
Mild induced hypothermia has been a component of comprehensive cardiac care for victims of out of hospital cardiac arrest. A complex cascade of physiological changes occurs in the post arrest patient. Some of these changes, specifically hyperthermia, have known detrimental impact on neurological recovery. The most recent evolution of mild induced hypothermia, after several studies looking at outcomes in cardiac arrest victims, is now Targeted Temperature Management [TTM] between 32-36 degrees C. In the prehospital setting, components of TTM are important for continued neurological recovery. However, the routine prehospital cooling of patients with rapid infusion of large volume cold IV fluids after ROSC is not recommended and not a prehospital component of TTM.

INDICATIONS FOR TTM
- Age 16 or older, and
- ROSC – patient demonstrates no purposeful movement to sternal rub or response to commands 5 minutes into ROSC, and
- Palpable Carotid pulse with a stable cardiac rhythm, and
- Patient temperature was checked by esophageal probe and is 36 degree C or greater and
- Pt is intubated

CONTRAINDICATIONS FOR TTM
- Age < 16, or
- Traumatic arrest, or
- Hypothermia exists (< 36° C) by esophageal temp prior to onset of treatment, or
- Identified Pregnancy, or
- Major Surgery within the past 2 weeks, or
- Known bleeding disorder, i.e. idiopathic thrombocytopenic purpura, thrombotic thrombocytopenic purpura, hemophilia etc.

Note: STEMI is NOT a contraindication for TTM.

METHOD
- Maintain supportive care. Do not delay transport to initiate cooling. TTM should be initiated in the ambulance. If patient becomes unstable, focus on the ongoing resuscitation issues, cooling can be reassessed when patient is stable.
- Place esophageal thermometer probe to establish patient's baseline body temperature
- If patient's esophageal probe temperature is between 32 degrees and 36 degrees C, continue active monitoring of temperature. Keep patient's temperature in this range by maintaining temperature in the ambulance compartment.

- If the patient's esophageal probe temperature is **36 degrees C or greater**, proceed to the following maneuvers:
  - Remove additional clothing from patient

- If feasible, control environmental temperature in ambulance compartment
- Ice packs to axilla, groin and neck area

Warmed Intravenous Fluids

Supersedes:
Effective: 04-06-09

PURPOSE

The purpose of this procedure is to ensure the proper rotation and use of warmed intravenous fluids in the treatment of hypothermic patients. Manufacturer recommendations dictate that intravenous fluids stay in an IV Fluid warmer for no more that two weeks to prevent chemical leaching into the solution.

PROCEDURE

1. Intravenous fluids shall remain stored in their original protective packaging until use.
2. When an intravenous fluid is placed in a Department issued warmer, the “IN” date and projected “OUT” date (14 days after the fluid is first entered into the warmer) shall be noted in a conspicuous location on the bag. This may be accomplished with tape or by affixing a drug label available at Materials and Facility Management.
3. Intravenous fluids may remain in a warmer for a maximum of **14 days**. If the warmed fluid has not been used within that time, it shall be removed from the warmer and returned to the shelf stock, so long as it is not otherwise expired.

   3.1. If an intravenous bag is found to be in a warmer without an “IN/OUT” notation on the bag, it should be assumed that it has been in the warmer for 14 days. It should be removed from the warmer, a label affixed noting that it has already been warmed, and may be returned to the stock shelf so long as it is not otherwise expired.

Specialized Medical Devices & Equipment

Unique Cardiac Defibrillators

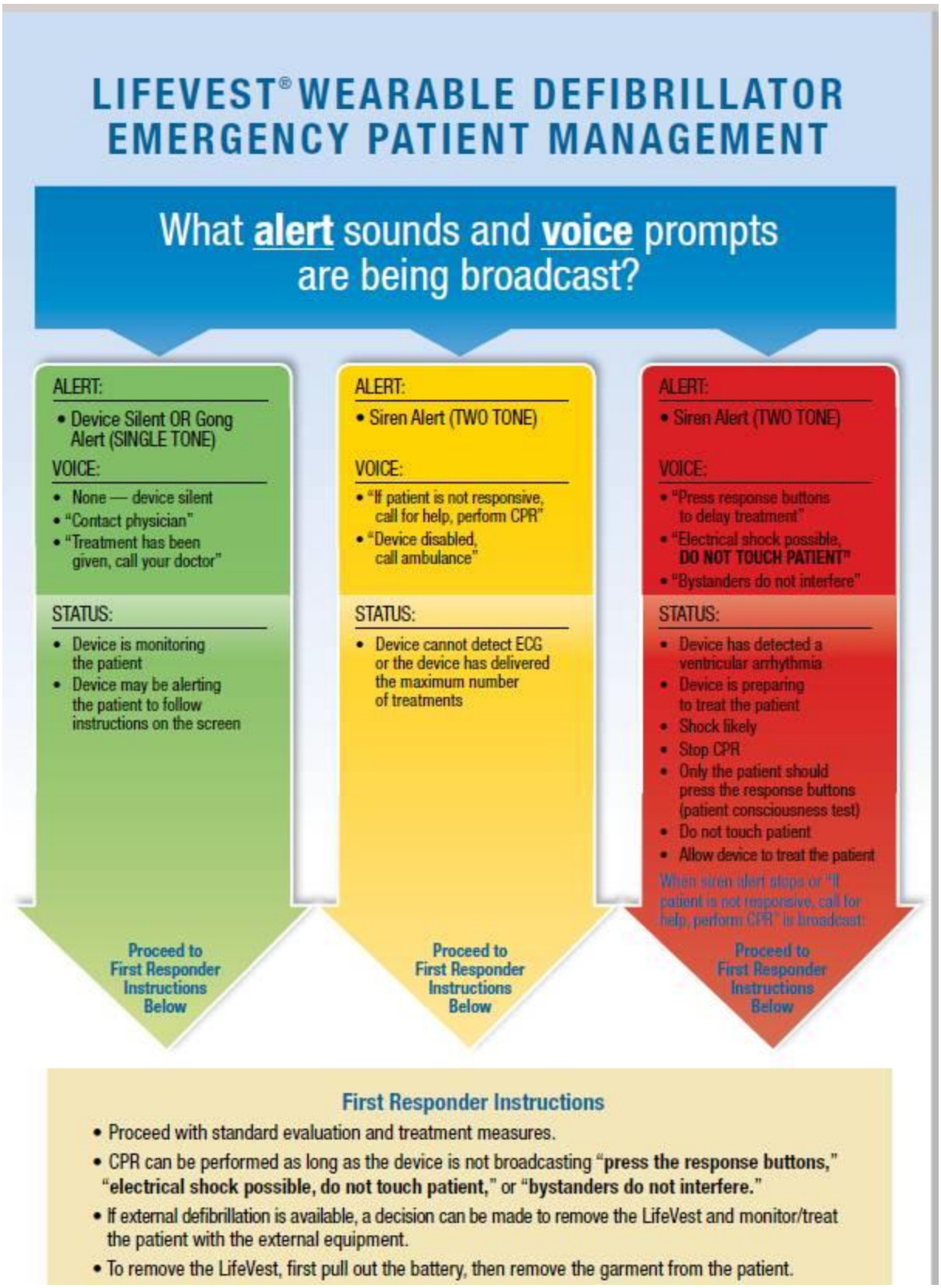
Supersedes:
Effective: 06-01-16

With advances in medical technology, we are expecting to interact with unique cardiac defibrillators. Two recent examples are the Boston Scientific Subcutaneous Implantable Defibrillator and the Zoll LifeVest.

Subcutaneous Implantable Defibrillator
A new device and technique of subcutaneous implantable defibrillator (S-ICD) has been developed: EMBLEM-S-ICD by Boston Scientific. For more information: http://www.bostonscientific.com/en-US/products/defibrillators/emblem-s-icd-system/device-overview/implant-procedure.html

The new S-ICD are unlike a standard implantable pacer-defibrillator. The standard implantable pacer-defib is implanted in the left upper chest, similar to a standard pacemaker. In these new S-ICD, the battery/monitor is larger and implanted under the left lateral breast tissue. **If you encounter a patient in cardiac arrest, the manufacturer's recommendation is to place the lateral defibrillation pad in the posterior position. Avoid placing the pad directly over the battery pack.**

Zoll LifeVest
The LIfeVest ™ is an alternative to a standard implantable defibrillator. The device is worn externally, with skin contact. The device has several warming levels about impending defibrillation for the patient to respond to prior to delivery of a shock.


LIFEVEST® WEARABLE DEFIBRILLATOR
EMERGENCY PATIENT MANAGEMENT
What alert sounds and voice prompts are being broadcast?
ALERT:
• Device Silent OR Gong Alert (SINGLE TONE)
VOICE:
• None — device silent
• "Contact physician"
• "Treatment has been given, call your doctor"
STATUS:
• Device is monitoring the patient
• Device may be alerting the patient to follow instructions on the screen
Proceed to First Responder Instructions Below
ALERT:
• Siren Alert (TWO TONE)
VOICE:
• "If patient is not responsive, call for help, perform CPR"
• "Device disabled, call ambulance"
STATUS:
• Device cannot detect ECG or the device has delivered the maximum number of treatments
Proceed to First Responder Instructions Below
ALERT:
• Siren Alert (TWO TONE)
VOICE:
• "Press response buttons to delay treatment"
• "Electrical shock possible, DO NOT TOUCH PATIENT"
• "Bystanders do not interfere"
STATUS:
• Device has detected a ventricular arrhythmia
• Device is preparing to treat the patient
• Shock likely
• Stop CPR
• Only the patient should press the response buttons (patient consciousness test)
• Do not touch patient
• Allow device to treat the patient
When siren alert stops or "If patient is not responsive, call for help, perform CPR" is broadcast:
Proceed to First Responder Instructions Below
First Responder Instructions
• Proceed with standard evaluation and treatment measures.
• CPR can be performed as long as the device is not broadcasting "press the response buttons," "electrical shock possible, do not touch patient," or "bystanders do not interfere."
• If external defibrillation is available, a decision can be made to remove the LifeVest and monitor/treat the patient with the external equipment.
• To remove the LifeVest, first pull out the battery, then remove the garment from the patient.

Transport / Point of Entry / CMED

Code Black Checklist

Supersedes:
Effective: 01-06-15

Dispatch Operations Supervisor should honor all requests for Code Black status on receipt from hospital staff.

Ask for further information

1. What is the nature of the problem?
2. How long is this expected to last?
3. Who is the designated contact person in the hospital for information about the event?
4. Remind caller it is their (the hospital) responsibility to call DPH Emergency Preparedness (on call #617 339-8351) and DPH Health Care Quality (1-800-462-5540).

Follow up actions

1. Place hospital on Code Black in CMED Diversion Website
2. Announcement on TAC-1 and BAMA
3. Page Notification to C1-5, On-Duty Shift Commander, MD-1 [or designee]
4. Notify Boston Med-Flight (1-800-233-8998)
5. Notify Region IV Director, Mr. Derrick Congdon [cell (781) 454-7369]
6. Notify Public Health Preparedness via email to MIC@bphc.org

Condition Specific Point-of-Entry: Cardiac, OB, Sexual Assault

Supersedes: 06-17-15
Effective: 03-24-16

This policy is being issued to define the point-of- entry for the cardiac and OB patient. It does not change or modify the existing point-of-entry plan for the Trauma or Stroke patient.

All patients should be transported to the closest appropriate hospital. Sometimes, a patient's medical condition makes it more appropriate to take the patient to a hospital that is not the closest geographically. When determining which hospital is the closest appropriate facility, consideration should be given to condition-specific point of entry plans and special project waivers.

CARDIAC

1. A patient identified as having a Definite or Possible STEMI should be transported to one of the following hospitals capable of providing PTCA (percutaneous transluminal coronary angioplasty):
    - Beth Israel-Deaconess
    - Boston Medical Center
    - Brigham and Women's
    - Massachusetts General
    - Tufts Medical Center
    - Saint Elizabeth's

2. When transporting a patient suspected of having a Definite or Possible STEMI, the receiving hospital shall be notified via CMED radio as soon as possible to expedite door to balloon time.

Definitions

Definite STEMI: ≥ 2mm ST elevation in 2 contiguous precordial leads or ≥1mm in limb leads in 2 contiguous leads, without presence of ST elevation mimics

Possible STEMI: ST elevations present but **not** in contiguous leads, **not** ≥2mm ST elevation in precordial leads or ≥1mm in limb leads, or presence of ST elevation mimics such as pericarditis, LBBB, suspected hyperkalemia, early repolarization

In general, **ST depressions** do not indicate a STEMI (except in the case of a posterior wall MI in which there are ST depressions in leads V1 and V2), because by definition there are no ST segment elevations. Therefore, patients with only ST segment depressions should not be called in to the receiving hospital as a STEMI or possible STEMI. Instead if appropriate, the call should be for a patient with ischemic chest pain with a description of the EKG.

OBSTETRIC

Obstetric patients should typically be transported to the receiving facility's Emergency Department. Hospital personnel will be responsible for monitoring the patient and making arrangements, when appropriate, to transfer the patient to the Labor and Delivery unit. In cases involving time-sensitive or potentially critical OB patients, Boston EMS personnel will institute an "OB ALERT" and provide as much notice to the receiving facility as possible via CMED radio (preferably), or ring-down. Examples of critical conditions warranting an "OB ALERT" include:

- Footling breech
- Impending or out of hospital delivery
- Suspected placenta previa or abruption
- Maternal illness such as eclampsia or pre-eclampsia
- Cord prolapse

For cases involving OB ALERTS, upon arrival at the Emergency Department the hospital medical staff (which may include labor and delivery clinicians) will determine if the patient will be:

- Treated in the Emergency Department
- Transferred to a hospital stretcher for transport by hospital staff to Labor and Delivery, or
- Remain on the BEMS stretcher for transport by EMS personnel along with appropriate clinical staff and equipment to Labor and Delivery.

NOTE: An exception to this concept involves OB patients transported to the **Beth Israel-Deaconess Medical Center** where the Labor and Delivery unit is located in a separate campus and not accessible from the Emergency Department. In both routine and OB ALERT cases being transported to the Beth Israel-Deaconess Medical Center, efforts will be made to provide timely notification to the receiving facility, but the patient will be transported directly to the Labor and Delivery (East Campus) unless directed to the Emergency Department (West Campus) by hospital personnel.

SEXUAL ASSAULT

The Massachusetts Sexual Assault Nurse Examiner (SANE) Program currently provides 24/7 emergency response for sexual assault patients across the Commonwealth. SANEs are trained and certified by DPH to provide specialized, forensic care for sexual assault patients, and to provide court testimony if a case moves forward to prosecution.

Patient Eligibility

- Age 12 years and older
- Assault occurred within a 120 hour/5 day period.

SANE Sites: Boston Region

- Beth Israel Deaconess Hospital
- Boston Medical Center
- Brigham and Women's Hospital
- *Cambridge Hospital**
- Children's Hospital-Boston
- Massachusetts General Hospital

- *Newton-Wellesley Hospital**

**not typically in the Boston EMS point of entry*

Metropolitan Boston Emergency Medical Services Council Inc.
Reference Guide For EMS Field Providers
Emergency Hospital Entry Plan

	CONTACT INFORMATION		CAPABILITIES											
HOSPITAL	ADDRESS	ER PHONE	ATC	PTC	BURN	OB LOCATION	PEDI	PEDI PSYCH	STEMI	DIAL	DECON	DECON LOCATION	
Beth Israel-Deaconess - West Campus	1 Deaconess Road , Boston	(6 7) 754-2400	Y		14		Y	EAST CAMPUS (c4)			Y	Y	Y	WEST CAMPUS	
Beth Israel Deaconess - Needham	148 Chestnut Street, Needham	(781) 453-3400									Y				
Boston Medical Center-Newton Pavilion	88 East Newton Street, Boston	(6 7) 638-6240										Y			
Boston Medical Center-Menino Pavilion	One Boston Medical Center Place, Boston	(6 7) 414-4075	Y	Y	0		Y	Menino 3W	Y	Y	Y		Y	Menino ED	Y
Brigham and Womens	75 Francis Street, Boston	(6 7) 732-5636	Y		14	Y	Y	CWN Building			Y	Y	Y	Shattuck St. ED	Y
Cambridge Hospital	1493 Cambridge Street, Cambridge	(6 7) 665-1430					Y	5th Floor			Y				
Caritas Norwood Hospital	800 Washington Street, Norwood	(781) 769-2950					Y	Draper Building 2nd floor			Y	Y	Y	ED entrance	Y
Carney Hospital	2100 Dorchester Avenue, Dorchester	(6 7) 296-4000							Y	Y	Y		Y	Ambulance Bay	
Childrens Hospital Boston	300 Longwood Avenue, Boston	(6 7) 355-6601		Y	0	Y			Y	Y			Y	Binney St ED entrance	Y
Emerson Hospital	133 Old Road to Nine Acre Corner, Concord	(978) 369-1400					Y	3rd Floor			Y		Y	ED entrance	Y
Faulkner Hospital	1153 Centre Street, Jamaica Plain	(6 7) 533-3800, ext. 7700							Y	Y	Y		Y	ED entrance	Y
Lahey Clinic	41 Mall Road, Burlington	(781) 744-5100	Y								Y	Y	Y	ED entrance	Y
Massachusetts General Hospital	55 Fruit Street, Boston	(6 7) 724-4100	Y	Y	0	Y	Y	Main Entrance	Y	Y	Y	Y	Y	Fruit St ED entrance	Y
Milton Hospital	92 Highland Street, Milton	(6 7) 696-8389									Y		Y	ED entrance	Y
Mt. Auburn Hospital	330 Mount Auburn Street,Cambridge	(6 7) 499-5025					Y	South 5			Y	Y	Y	ED entrance	Y
MWMC Framingham Campus	115 Lincoln Street, Framingham	(508) 383-1000					Y	3rd Floor			Y	Y	Y	ED entrance	Y
MWMC Leonard Morse Campus	67 Union Street, Natick	(508) 650-7000									Y		Y	ED entrance	Y
Tufts Medical Center	750 Washington Street, Boston	(6 7) 636-5566	Y	Y	0		Y	Prager 2	Y	Y	Y	Y	Y	TMC ED	Y
Newton Wellesley Hospital	2014 Washington Street, Newton	(6 7) 243-6000					Y	6th Floor	Y		Y		Y	ED Parking Lot	Y
Quincy Medical Center	114 Whitwell Street, Quincy	(6 7) 773-6100									Y		Y	ED entrance	Y
Somerville Hospital	230 Highland Ave., Somerville	(6 7) 591-4700									Y				
South Shore Hospital	55 Fogg Rd., Weymouth	(781) 340 - 8321	Y				Y	Emilson Bldg	Y	Y	Y	Y	Y	Ambulance Bay	Y
St. Elizabeth's Medical Center	736 Cambridge Street, Brighton	(6 7) 789-2666			15		Y	Women's Health	Y	Y	Y	Y	Y	ED Parking Lot	
Marlborough Hospital	157 Union Street, Marlborough	(508) 481-5000									Y		Y	ED entrance	Y
West Roxbury VA Hospital	1400 VFW Parkway, West Roxbury	(6 7) 323-7700, ext. 5425													
Winchester Hospital	41 Highland Avenue, Winchester	(781) 729-9000					Y	2nd floor			Y		Y	ED entrance	Y

KEY
ATC=Adult Trauma Center — PTC=Pediatric Trauma Center — STEMI=ST-Segment Elevation Myocardial Infarction — DIAL=Dialysis — Y=Yes
BURN=Burn Capabilities — OB/Location= Obstetrics and Location at facility — PEDI PSYC= Pediatric Psychiatric — STROKE=Stroke Center
DECON= Decontamination Capabilities

Metro Boston EMS Communication Network

Supersedes:
Effective: 02-01-00

The statewide EMS radio network is comprised of discrete regional radio systems. Each system has the following components: a CMED center, associated ambulance services, hospitals, rescue squads and municipal agencies. The system is designed to meet local needs but adhere to a common design strategy that will afford compatibility across regional boundaries and the interconnection of systems into the statewide network. Operational and medical communications are primarily accomplished via two-way land mobile radio, which usually operates on two bands: very high frequency (VHF) and ultra high frequency (UHF). Utilization shall be as follows:

155.280 MHz	Point-to-Point coordinating frequency and mass casualty channel.
155.340 MHz	Ambulance-to-Hospital channel
462.950/467.950 MHz	"TAC-9", Intrasystem coordinating and on-scene working/triage channel
463.000/468.000 MHz 463.025/468.025 MHz 463.050.468.050 MHz	("MED-1") Ambulance-to-Hospital channels ("MED-2") ("MED-3")
463.075/468.075 MHz	("MED-4") Common calling and coordination channel
463.100/468.100 MHz 463.125/468.125 MHz 463.150/468.150 MHz 463.175/468.175 MHz	("MED-5") Ambulance-to-Hospital channels ("MED-6") ("MED-7") ("MED-8")

BIOMEDICAL CHANNEL UTILIZATION AND ALLOCATION PLAN
Massachusetts uses a planned utilization of the medical channels, which includes a "common calling" channel (MED-4), a "critical" channel that is not duplicated with adjacent systems, "secondary" channels that are shared and "overflow" channels. Assignments for the channels are made by the Department of Public Health for each system prospectively with the shared channels to be used according to the principles of real-time sharing.
The utilization plan is intended to:

- Make maximum use of all channels in a spectrum-efficient manner;
- Ensure that at least one channel per system is substantially free of co-channel interference from neighboring systems and thus can be relied on for communications of the most critical nature. Systems must endeavor to fully utilize their critical channels, for only the top priority uses resulting in low loading levels are contrary to the concept of critical channel utilization.

Channel utilization is defined below:

Common Calling Channel (MED-4; all systems)

UHF-equipped EMS units shall obtain channel coordination from Boston CMED by first calling on MED-4, advising Boston CMED of the unit's location and needs and following the instructions of CMED.

Critical Channel

Critical channel use will follow specific system policies and CMED operator discretion. In general, the system's more important communications should take place on this channel. Loading of the channel should be as full as practical. CMED operators should attempt to shift concurrent traffic taking place on a shared channel to the critical channel as it becomes available.

Shared Channel

These channels may be utilized by adjacent systems. Monitoring of the channel to determine its availability shall always precede assignment of a channel by CMED. Short notifications by basic EMS units may be assigned a shared channel directly, even when the critical channel is free, provided that the system's overall utilization of the critical channel remains high. CMED to CMED coordination of shared channels on a real-time basis through the use of 155.280 MHz is encouraged.

Overflow Channels

One system's overflow channels will be the adjacent systems' critical channels. Utilization of an overflow channel shall be only when absolutely necessary and the communication can not be delayed. Use of an overflow channel must be ended no later than 60 seconds following the availability of a critical or shared channel within the system. The field unit shall be instructed to shift channels at the first opportunity.

For purposes of discussion, Boston CMED's channel utilization plan is as follows:

Description	Med Channel
Common Calling	4
Critical	3
Shared	6, 8, 5
Overflow	7, 1, 2

Utilization of shared channels should be according to the listed order. The first channel should be used most heavily of the shared group, the last used the least.

METRO-BOSTON CMED
Boston CMED provides for the coordination of EMS telecommunications in the region. The center is staffed 24 hours a day with specifically trained EMT-Telecommunicators. Boston CMED is responsible for coordinating communications for 62 cities and towns (Region IV). Listed below are a few of the functions of Boston CMED:

- Manage EMS channel usage within the region.

- Coordinate channel management with neighboring CMEDs as a part of the statewide network.
- Serve as a clearinghouse for EMS resource status information (e.g., emergency room diversions, loading, bed status, specialty care facilities, ambulances, etc.).
- Monitor the radio traffic to determine the quantity and quality of transmissions and to detect and resolve outages.
- Provide Command/Control/Communications/Intelligence (C^3I) functions during mass casualty or disaster responses in cooperation with authorized scene commanders and medical control physicians.
- Coordinate EMS with other public safety agencies through the use of radio channel patch capabilities.
- Provide general assistance as requested by any EMS agency in accordance with system procedures.
- Aid out-of-region ("foreign") ambulances and other EMS units entering or passing through the region.

System Elements

EMS Provider agencies in the Metropolitan Boston region utilize both UHF and VHF band radios to coordinate field operations and medical direction. The communications system that employs these radios also includes special telephone and microwave links for interconnection of certain fixed points. Basic components of a communications system generally include (1) portable and mobile transceivers; (2) base stations; and (3) central and remote control consoles.

Special Features

Operationally, this design provides total control of base stations and mobile relays so that interference and extraneous signals are minimized. More importantly, this centralization allows functions such as radio-telephone crosspatching, UHF/VHF crossbanding and dynamic channel assignments to be performed.

This EMS communications system is designed for maximum technical efficiency and channel utilization. However, the system's efficiency is primarily a function of how the user verbally communicates his information. With this in mind, this protocol for communications has been written to assist the Basic EMT, Advanced EMT, emergency department nurse and medical control physician in operating an EMS radio.

Dedicated Network

CMED Responsibility

Radio communications which concern any of the Metro Boston network hospitals should be coordinated by the designated network control station ("Boston CMED"). CMED is responsible for continually monitoring and expediting radio traffic to keep the network operating efficiently. All UHF communications between field units and hospitals, and those VHF communications to and from hospitals that do not possess VHF equipment,

shall be directed to CMED for the particular frequency being used, or agency being called upon. VHF communications concerning basic life support activities between field units and hospitals equipped with VHF radios shall be direct and on 155.340 MHz.

Radio Frequencies

Tone Squelch Assignments for UHF Radio Equipment

Metro Boston: 151.4 Hz
Statewide: 192.8 Hz

Digital Dial and Touch-Tone ™ Squelch for VHF Radio Equipment

Boston CMED: 3100

Point-to-Point Communications

- Point-to-Point communications for coordination of critical transfers, mutual assistance and mass casualty incident management will normally be conducted on VHF radio frequency 155.280 MHz.
- Coordination of Intersystem MED-channel assignments shall be conducted on MED-channel FOUR by monitoring the co-user base station transmit frequency (463.075 MHz). While communications between CMED centers is normally restricted to the VHF frequency 155.280MHz, certain emergencies will permit the use of MED-4 for coordination purposes.
- Where capabilities exist, point-to-point communications may be conducted on remote radio control lines or microwave audio sub-carrier channels.
- Where VHF radio frequency 155.280 MHz is not available at certain resource coordination centers, frequency 155.340 MHz may be used for intersystem coordination.

GENERAL PROCEDURES

F.C.C Rules

The applicable rules and regulations of the Federal Communications Commission shall govern the general operation of the EMS radio channels.

Monitor Frequency

All persons operating EMS radios must monitor the frequency on which they desire to operate, prior to transmitting.

Transmitting Names

All communications shall be kept impersonal. When names are transmitted, the full name or last name with title only shall be used. Names may also be substituted for call signs.

In order to maintain patient privacy rights, patient names shall not be transmitted except in cases of extreme emergency, and only when the conduct of the medical care to be

provided requires specific patient identification. Only medical personnel at a hospital may determine that a patient's name needs to be transmitted.

Identify Every Transmission

Unit identifiers are to be said in every transmission.

Intonation and Voice Level

Word or voice inflections that reflect irritation, disgust or sarcasm must not be used. Relations with other users shall remain cordial at all times. Do not yell under any circumstances.

Message Brevity

All messages shall be kept brief and to the point.

Answering Radio Calls

All radio calls must be answered. When busy with patient care activities or traffic on another channel, the phrase "STAND-BY" shall be used to indicate receipt of call and intent to answer when available.

Radio unit Identifiers

Every user should utilize an ID consistent with these procedures. Each ID shall have a short and long form. The long form of an ID shall be used when initially establishing contact with another unit. The short form may be used to enable brevity through the balance of a message. When in doubt, use the long form ID

Composition

Radio unit identifiers shall be issued by the Commanding Officer of the Boston EMS Dispatch Operations Division, or his designee. Identifiers shall be alphanumeric characters or proper names of persons, hospitals or geographic locations. Examples:

Long Form	**Short Form**
North Shore CMED Center	North Shore
Worcester CMED Center	Worcester
Massachusetts General Hospital	MGH
Boston Medical Center-Harrison	BMCH

Mobile Units

A mobile (or portable) unit may be an ambulance, a paramedic squad or an EMS supervisor. Mobiles and their corresponding portables shall incorporate a number in their ID; the short form ID being the number alone. The first digit of the number will correspond to the unit's region; the succeeding digits will be assigned according to a regional plan that meets local needs.

Personnel Identifiers

All medical control communications will identify EMS personnel by an assigned ID in addition to the use of unit ID's. BLS units requesting consultation (advice) shall also use personnel ID's. After initial contact has been made by using the long form unit ID, communicating personnel shall use their personnel ID instead of the short form unit ID.

Examples:

EMT Jones	For a Basic EMT
Intermediate Jones	For an EMT-I
Paramedic Jones	For an EMT-P
RN Jones	For a nurse
Dr Jones	For a physician

Regions and/or locales may opt for assigning numbers in place of surnames. The level of certification should still precede such a number for the complete (long form) identifier; e.g. "Paramedic 123".

Purpose of Call Signs

According to F.C.C. rules, call signs are to be used as identification. In addition, unit identifiers will be used at the beginning of a transmission to prompt the voice-actuation circuits in a "patch" condition. Any unit (i.e., two-way radio) must be authorized for use by an F.C.C. license. Mobile and portable units are typically authorized under a base station or system license. In such instances, the unit identifier may be used alone. Base stations located at hospitals (VHF) or stations operated in a system with a C-MED Center (VHF and UHF) shall normally say the call sign at the close of a series of transmissions.

Example:

"4-2-2-2, Metro Boston C-MED. Roger your arrival at MGH. This is KIR-735, Boston CMED, out."

Language Format

These procedures endorse the principal that Plain English, coupled with accepted medical terminology, is the surest way to accomplish effective communications, either via radio, telephone or in person. This document lists preferred terms or phrases that have been shown to be particularly effective. EMS personnel are encouraged to routinely use these terms. Except for Priority Codes, radio codes are discouraged as a rule. Should local needs dictate the use of codes they should be minimized. In such areas, EMS personnel should be capable of switching to a code-free message when operations demand communications with non-local hospitals, ambulances or CMEDs.

CALLING PROCEDURE

Procedure When Requesting Channel Assignment and/or Radio Patch

Field providers hailing CMED on MED channel 4 should always note their proper Unit ID and physical location. For example "Metro-Boston CMED, this is Framingham Paramedic 1 on Rte 9 in

Framingham calling". The CMED operator will answer the unit on the correct base station and clearly state "Framingham P-1, this is Metro-Boston CMED, go ahead". Once acknowledged by the CMED operator, the field unit will then proceed with their request: "Metro-Boston CMED, this if Framingham Paramedic 1 requesting a Priority 2 entry note to Metro-West Framingham". The CMED Operator will then acknowledge the request and direct the unit to a specific medical channel. "Framingham P1 from Metro-Boston CMED: please shift to MED 7 for your entry note to Metro-West Framingham."
Using the above procedure will help prevent confusion when multiple units simultaneously call CMED. This specific information is essential for each call, as it allows the CMED operator to quickly and easily: 1) know which unit to answer, 2) which base station to use (for best coverage), and 3) how to prioritize radio traffic when handling multiple, simultaneous requests.

Initial Contact With a Hospital

When calling a station, say the name of the station or unit you are calling, followed by the words, "This is" and then your call sign, ending with the proword "OVER."

"Carney Hospital, this is Medic One Ten, over."

Answering Procedure

To answer a call, use the same procedure as described above.

Message Precedence

In order to distinguish between routine message and those which require immediate action, the following prowords shall be used (as necessary) to identify the priority of the radio traffic which is to be transmitted.

PROWORD	MEANING
"Priority One"	Communications concerning a life-threatening condition, requiring an immediate patch to a hospital.
"Priority Two"	Communications concerning a potentially life-threatening condition, requiring a patch as soon as possible.
"Priority Three"	Communications concerning conditions which are not life-threatening, requiring a patch as soon as possible.
"Priority Four"	Communications which are administrative or informational only.

Whenever possible, Priority Four traffic should be relayed through a local dispatcher and then by telephone so as to avoid unnecessary congestion of the system.

Note: Most Boston hospitals do not require Priority Three notifications. Conference of Boston Teaching Hospitals (COBTH) policy states that no Boston hospital shall require Priority Four notifications.

Acknowledging Messages

Messages should be acknowledged by saying the unit identifier, the proword “ROGER” and repeating the essential parts of the text of the message back. If there is a question as to whether or not the received message is correct, the proword “CONFIRMED” shall be said at the end of the message when repeated.

Prowords and Phrases

Experience has proven that some words when spoken over a two-way radio can be easily confused with other words and result in disastrous miscommunication. The words and phrases in this list are ideal for avoiding this type of problem and all radio users should become comfortable with their use.

Word or Phrase	Definition (for radio use)
ACKNOWLEDGED	I have received your message and will act upon it.
ACUTE	Condition of rapid onset.
AFFIRMATIVE	Yes. (Spoken over a radio, “yes” is easily confused).
ARRIVAL	Unit has arrived at its intended destination.
ASSIGNMENT	Assignment to an incident or radio channel.
BREAK	To interrupt in an emergency, or to separate parts of a group of messages.
CALIBRATION	A telemetry signal that when transmitted produces a 1mv output at the EKG display. (Similar to “standardizing” an EKG strip)
CHANNEL (e.g. MED 1)	The radio frequency or pair of frequencies used in a radio system.
CONTACT	Establish communications.
CLEAR	Available; I am terminating this communication (or incident).
DISREGARD	Do not take action on last transmission.
ENGAGED/DISENGAGED	Radio patch connected/disconnected.
ENROUTE	Traveling to a specified destination.
FREQUENCY	The technical expression of an electronic signal expressed in cycles-per-second (cps), or hertz (Hz), or megahertz (MHz) of a base-line signal. In general use frequency refers to the signal used in a radio system. (E.g., 155.340 MHz, or tone code 7A~192.8 cps).
HOLD	Remain at present location or specified position.
INCIDENT	An emergency at which EMS is required.

INCORRECT	Wrong.
LANDLINE	Order to make call by phone or refers to telephone company supplied circuits that connect a radio system.
MONITOR	Listen to all traffic on a radio channel.
NEGATIVE	No.
OBTAIN	Get.
OUT	I have finished all messages, do not expect a replay and the channel is open to others.
OVER	I have finished my message and expect a reply from you.
QUIET RESPONSE	Without use of siren.
RELAY	Pass the traffic on to another person or station (repeat message verbatim).
ROGER	As in acknowledge, I have received your message and will act on it.
REPEAT	Administer the indicated therapy an additional time. (See SAY AGAIN).
SAY AGAIN	Repeat the last message transmitted. (Not to be confused with REPEAT).
SHIFT	Change channel as ordered.
SHIFT AND ACKNOWLEDGE	Change channel as instructed and say on the new channel your ID and acknowledge the shift.
SHIFT AND CONTACT	Change channel as instructed and call the desired station.
SHIFT AND STANDBY	Change channel as instructed and listen for further traffic.
STAND-BY	Answer to request is not immediately available, or user is busy with competing traffic. The order stand-by implies that a unit should stay on channel until called upon; order should not be acknowledged.
STATUS	A unit’s present activity.
TRAFFIC	Messages transmitted by radio between units and/or stations.
TRANSPORT	Commence transportation of a patient by ambulance.

Transmitting Numbers

In order to avoid errors when measurements of medications are ordered, or addresses are transmitted, numbers should be transmitted DIGIT-BY-DIGIT and pronounced as described below:

1	"WUN"	Strong W and N
2	"TOO"	Strong and long OO
3	"THA-REE"	Strong TH and R
4	"FOWER"	Strong O, Strong W and Final R
5	"FIE-YIV"	Strong I changing to Strong Y and V
6	"SIKS"	Strong S and KS
7	"SEV-VEN"	Strong S and V
8	"ATE"	Strong A and long T
9	"NINER"	Strong NI and sounded ER
0	"ZEE-RO"	Strong Z and Short RO

Transmitting Directions

When transmitting directions by radio, providers should use proper names and avoid using slang or abbreviations, particularly when describing locations. Use specific instructions, said in phrases, such as "PROCEED TO", "TURN", "HOLD", "MONITOR", "ADMINISTER", etc.

MEDICAL COMMUNICATIONS

Medical communications, and medical consultation refer to communications which take place between the field and hospital, or the field, specialty center and hospital. Whether the communications are to direct ALS treatment, support the Basic Life Support effort, or exchange critical patient care data, the communications must be accurate if they are to be effective.

In the following paragraphs are guidelines that essentially create the structure for reporting and exchanging patient data and clinical information. These guidelines have been written with consideration that medical communications are lengthy in duration and are often much more detailed than dispatch or operational traffic. Throughout this chapter, special phrases and radio prowords are used to facilitate brevity; however, the main concern is that the communicating parties clearly understand each other.

The primary goal in communicating clinical information by radio is to assist the nurse and/or physician decision-maker. In order to provide this assistance, the EMT, Advanced EMT and EMS Supervisor must communicate his information clearly, directly, and in an objective manner to create an accurate mental picture for the nurse or physician.

Secondarily, structured medical communications supports the transition between first responder, EMT, Advanced EMT, nurse and physician provider. In a sense, the guidelines that follow create a context for the entire system to communicate the patient's condition to the next level of care.

Coordination and Monitoring of Medical Traffic

All advanced life support communications concerning patient care, ambulance transportation to the hospital, point-of-entry and hospital-to-hospital traffic shall be coordinated by the communications coordinating center, “CMED.”

The CMED Operator shall assign channels, activate hospital remote control stations, alert medical control physicians and continually monitor the voice and telemetry signals to ensure reliability of the communications in progress. In addition, he will collect and maintain status data on hospital resources, supervise point-of-entry plans and, in general, be responsible for establishing the communications required between the field and the hospitals.

MEDICAL CONTROL

Receiving Hospital Conference

Ambulances transporting patients under medical control shall notify the receiving hospital as soon as is practical during transport. As necessary, or as directed by Medical Control, the hospital receiving the patient may confer with the Medical Control Physician.

EKG Telemetry

The use of EKG telemetry will be in conformance with the Statewide “Advanced Life Support Pre-Hospital Clinical Protocols.”

Individual transmissions of EKG telemetry signals shall not last longer than 30 seconds. Medical Control will request repeat transmissions as often as is felt to be appropriate.

General Overview of Patient Report

Radio medical reports will always be concise and as brief as possible. They do not replace nor are they the same as a complete run report that is transferred in writing and/or orally after arrival at a hospital. Patient Care Reports include much information that, while important, should not be communicated by radio. Any prolonged communication must contain periodic breaks in the transmission so that other users who have a need to communicate can be detected.

PATIENT NAMES

In order to respect patient confidentiality, patient names must not be routinely transmitted over the air. In rare instances, and only as a last resort, a patient’s name may be transmitted if there is a medical reason that will directly effect patient care on arrival of that patient at the hospital. Only medical personnel at a hospital are appropriate to determine if there is a justifiable reason to request a name.

In general, ALS cases and Priority Ones and Twos will provide complete medical reports. Priority Three cases should normally limit the report to Age, Sex, and Chief Complaint followed by the ETA.

The presentation of a patient by radio or telephone requires that particular attention be paid to certain discrete areas. These are:

- Identification of the patient in terms of age, sex and a reference to the degree of distress.
- The chief complaint in a word or phrase.
- Present status in more specific terms; what body systems are affected or stressful.
- Pertinent negatives which are diagnostic.
- Past medical history.
- Medications.
- Physical findings to include vital signs.
- Treatment rendered thus far, to include transportation.

Reference Assessment Procedures

The presentation of a patient report by radio or telephone is a function of the initial assessment. An incomplete assessment leads to an incomplete communication, which in turn, leads to incomplete patient care. On the other hand, lengthy, rambling, unstructured presentations are a waste of time and often are as detrimental to the patient as a fragmented report.

To reinforce the structure and completeness of the patient report, a thorough assessment is necessary.

Become thoroughly familiar with these assessment procedures so that only pertinent data is communicated in your patient report.

General Voice Procedures

Avoid abbreviations that are not commonly used. Instead, use commonly accepted descriptive clinical terms.

Identify each transmission using identifiers, especially when acknowledging orders.

Acknowledge treatment orders by repeating them back exactly as you have received them.

Follow the order of the reporting format when transmitting a patient report

Disaster Procedures

Definitive disaster procedures are the responsibility of regional and local agencies. EMS users are expected to be thoroughly familiar with local procedures. These procedures include basic principles that should be common statewide.

Most “disasters” are mass casualty incidents (MCI) and as such only local units should be involved per local plans. True disasters may utilize foreign units but such units shall only participate when requested by the EMS agency in primary command. Local units by definition, have compatible communications, foreign units may not.

Ambulance response and scene command shall be conducted on a separate frequency from the one used for medical communications, if possible. Medical communications should be coordinated by a C-MED center or other party according to plan. Ambulances evacuating patients to hospitals shall be assigned by C-MED or scene commander and will not radio a full medical report.

Users of VHF channel 155.340 should respect that the channel will be in use in nearby areas for routine operations. MCI operations may not ”take over” 155.340, thus interfering with communications in areas unaffected by the incident.

Hospital resources or other special needs not available regionally will be requested via an adjacent region’s C-MED. In most cases a local C-MED will be asked by an EMS commander to secure specified resources, such as burn beds. That local C-MED will contact an appropriate distant C-MED which will in turn poll for resources within its jurisdiction.

Prompt and repeated updates of an incident shall be communicated to all hospitals with a potential to receive patients and to nearby hospitals which may be indirectly impacted by an MCI. The hospital will use such information and determine if its institutional disaster plan should be executed. All information should be qualified according to the degree of information needed to be transmitted.

Local ambulances with emergencies unconnected with an MCI in progress shall follow local procedure for such circumstance. Foreign units unknowingly encountering an area with a MCI shall be asked by the C-MED or hospital: ”We have an MCI in progress, what is your priority?” If the Priority is Three or Four, the ambulance should be told to defer to another facility and/or discontinue further use of the communications channel(s). If the Priority is One or Two, the ambulance should be interrogated further to determine what is best for the patient considering the circumstances of the MCI. Critical patients should not be arbitrarily deferred.

Reference: This document is based on the “Massachusetts Emergency Medical Services Systems Communication Plan” which was adopted by the Department of Public Health’s Emergency Medical Care Advisory Board in June, 1984

Point of Entry Plan; Closest Appropriate Hospital

Supersedes: 08-07-08
Effective: 03-24-16

Boston EMS and other providers operating within the service zone pursuant to a provider contract or agreement to provide back up services shall transport patients to an appropriate health care facility in accordance with 105 CMR 170.000: Emergency Medical Services System regulations and an OEMS approved point of entry plan.

1. All patients should be transported to the closest appropriate hospital. Sometimes, a patient's medical condition makes it more appropriate to take the patient to a hospital that is not the closest geographically. When determining which hospital is the closest appropriate facility, consideration should be given to condition-specific point of entry plans such as those for trauma or stroke, and special project waivers.

2. Unstable patient should be transported to the closest emergency department, or as required under a condition specific point of entry plan. For the purposes of this policy, OEMS defines an unstable patient as "one whose vital signs have significantly changed (either upwards or downwards) from normal ranges, in the absence of interventions. If there is any question about the stability of the patient, transport to the closest hospital.

3. Stable Patients: Considerations: Based on an appropriate assessment of the patient, including obtaining the patient's medical history, EMTs may consider transporting a patient to a hospital other than the closest, if the more distant hospital is more appropriate to the patient's specific medical condition and needs, based on the following factors:

    3.1. The more distant hospital better meets the medical needs of the patient because:

        a. The patient's current physician and medical records are there; the patient has recently been discharged from that hospital; the patient has had previous hospitalizations there; the patient's complex medical history is followed at that hospital; or

        b. The patient's specific medical condition needs one of the following specialty services for which the hospital is licensed: Burn Unit, Obstetrics, STEMI (percutaneous coronary intervention capability), or pediatrics; or

        c. The patient's specific medical condition would be most appropriately addressed at a hospital designated by the Department of Public Health as a Massachusetts Sexual Assault Nurse Examiner (SANE) site.

3.2. The additional time required to transport the patient to the more distant hospital does not exceed 20 minutes. Multiple hospitals for which estimated transport time from the patient is less than 10 minutes are considered to be of equal transport distance.

3.3. The care capabilities of the EMTs are appropriate to the patient's needs during transport.

3.4. The available EMS resources in the system at the time of the call would be capable of handling the additional transport time for this unit

4. Medical Control Input:

4.1. If there is any question about whether, based on the above considerations, the patient should be transported to the more distant hospital, contact medical control.

4.2. If the additional transport time to the more distant hospital, compared to the closest hospital, is less than 20 minutes, EMTs may transport the patient to the more distant hospital under this point of entry plan.

4.3. If the additional transport time to the more distant hospital may be more than 20 minutes, contact medical control.

5. Documentation and Quality Assurance

5.1. When transporting to a hospital more than 10 minutes further than the closest hospital, EMTs must document on their trip record the clinically based reason for deviating from transport to the closest hospital emergency department. EMTs must also document on the trip record the name of the authorizing physician if medical control was contacted.

5.2. The Department will maintain a system for reviewing instances in which patients are transported to a hospital more distant than the closest hospital emergency department.

6. Boston EMS units may transport a patient to one of the following hospitals located outside of City limits if the transport time is not significantly longer than it would be to an appropriate medical facility within the City.

Milton Hospital; Mt. Auburn Hospital; Whidden Memorial Hospital

7. The Shift Commander shall be notified for all other "out of City" transport requests. If the Shift Commander is not immediately available, the Dispatch Operations Center Supervisor may authorize the request. The decision should be based on a variety of factors including the stability of the patient, ETA to the out of City hospital, system call volume, and the availability and ETA of a private ambulance to perform the transport.

VHF Disaster Test

Supersedes: 06-30-97
Effective: 07-11-99

1. The on-duty Dispatch Operations Center Supervisor shall ensure that a VHF Disaster Network test is performed each shift.
2. The EMT-Telecommunicator performing the test shall fill out a “VHF Disaster Test” report form documenting the results of the test.

Records & Reports

Child Abuse and Neglect

Supersedes: 12-05-05
Effective: 05-15-09

DEFINITIONS OF CHILD ABUSE AND NEGLECT

The following definitions may be found under the Department of Children and Families Regulations (110 CMR, section 2.00):

Abuse: the non-accidental commission of any act by a caretaker upon a child under age 18 which causes, or creates a substantial risk of, physical or emotional injury; or constitutes a sexual offense under the laws of the Commonwealth; or any sexual contact between a caretaker and a child under the care of that individual. This definition is not dependent upon location (i.e., abuse can occur while the child is in an out-of-home or in-home setting.

Shaken Baby Syndrome: infants, babies or small children who suffer injuries or death from severe shaking, jerking, pushing or puling may have been victims of Shaken Baby Syndrome. The act of shaking a baby is considered physical abuse, as spinal, head and neck injuries often result from violently shaking young children.

Neglect: Failure by a caretaker, either deliberately or through negligence or inability to take those actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth, or other essential care; provided, however, that such inability is not due solely to inadequate economic resources or solely to the existence of a handicapping condition. This definition is not dependent upon location (i.e., neglect can occur while the child is in an out-of-home setting).

Emotional Injury: an impairment to or disorder of the intellectual or psychological capacity of a child as evidenced by observable and substantial reduction in the child's ability to function within a normal range of performance and behavior.

Physical Injury: Death; or fracture of a bone, subdural hematoma, burns, impairment of any organ, and any other such nontrivial injury; or soft tissue swelling or skin bruising, depending upon such factors as the child's age, circumstances under which the injury occurred and the number and location of bruises; or addiction to a drug or drugs at birth; or failure to thrive.

Institutional Abuse or Neglect: Abuse or neglect which occurs in any facility for children, including, but not limited to, group homes, residential or public or private

schools, hospitals, detention and treatment facilities, family foster care homes, group day care centers and family day care homes.

REPORT CHILD ABUSE

To report possible child abuse or neglect in Massachusetts, you must first file an oral report by calling the Child-at-Risk Hotline at 1-800-792-5200 to notify the appropriate area office of the Department of Children and Families (DCF). Even if you complete the 51A Report Form, you must also first phone DCF directly or the Child-at-Risk Hotline. DCF relies on reports from professionals and other concerned individuals to learn about children who may need protection. DCF receives reports on more than 100,000 children each year. Certain professionals are mandated to report child abuse and neglect (listed below); however, anyone can report child abuse and neglect. If you learn that a child has been abused or neglected, or if you are concerned that a child may be in danger of abuse and neglect, please first call DCF and file an oral report immediately - before you mail or fax the 51A Report Form. Qualified professionals are available 24 hours a day to take reports and address your concerns.

When you call DCF to report child abuse and neglect, please do your best to provide the following information:

- The name, address, sex, date of birth or approximate age, present whereabouts of the reported child or children, and any other children in the household;
- The names, addresses and telephone numbers of the child's parents or other persons responsible for the child's care;
- The primary language spoken by the child and the child's caretaker.
- If you are a mandated reporter: your name, address, telephone number, profession and relationship to the child; if you are a non-mandated reporter: your name, address, telephone number, profession and relationship to the child; or you may remain anonymous;
- The nature and extent of the abuse or neglect;
- Any evidence or knowledge of prior injury, abuse, maltreatment or neglect;
- Your opinion of current risk to the reported child and to any other child in the home or substitute care setting;
- If the above information was given to you by a third party, the identity of that person, unless the third party has requested anonymity;
- The circumstances under which you first became aware of the child's alleged injuries, abuse or neglect;
- Any action taken to treat, shelter or assist the child;
- Any additional information you believe may be helpful in establishing the cause of the child's injury or the person responsible.

MANDATED REPORTERS:

Massachusetts law requires many professionals who work with children to notify DCF if they suspect that any child has been, or is at risk of being, abused or neglected. Massachusetts law defines the following professionals as mandated reporters:

- Physicians, medical interns, hospital personnel engaged in the examination, care or treatment of persons, medical examiners;

- Psychologists, **emergency medical technicians**, dentists, nurses, chiropractors, podiatrists, optometrists, osteopaths;
- Public or private schoolteachers, educational administrators, guidance or family counselors;
- Office of Child Care Services licensors;
- Day care and child care workers, including any person paid to care for, or work with, a child in any public or private facility, or home or program funded or licensed by the Commonwealth, which provides day care or residential services. This includes child care resource and referral agencies, as well as voucher management agencies, family day care and child care food programs;
- Social workers, foster parents, probation officers, clerks magistrate of the district courts, and parole officers;
- Firefighters or police officers;
- School attendance officers, allied mental health and licensed human services professionals;
- Psychiatrists, and clinical social workers, drug and alcoholism counselors; and
- Priests, rabbis, clergy members, ordained or licensed ministers, leaders of any church or religious body, accredited Christian Science practitioners, or a person employed by a church or religious body to supervise, educate, teach, train or counsel a child on a regular basis.

Mandated reporters who are staff members of medical or other public or private institutions, schools or facilities, must either notify the Department directly or notify the person in charge of the institution, school or facility, or his/her designee, who then becomes responsible for filing the report. Should the designee/person in charge advise against filing, the staff member retains the right to contact DCF directly.

Massachusetts law requires mandated reporters to immediately make an oral report to the Department of Children and Families (DCF) when, in their professional capacity, they have reasonable cause to believe that a child under the age of 18 years is suffering from abuse or neglect. You should report any physical or emotional injury resulting from abuse, including sexual abuse; or any indication of neglect, including malnutrition; or any instance in which a child is determined to be physically dependent upon an addictive drug at birth.

After you file an oral report with DCF, a written report must be submitted to DCF within 48 hours after the oral report has been filed. [Boston EMS Personnel should note on the PCR that a 51-A has been filed, and submit the written report to EMS Headquarters where it will then be forwarded to DCF]. Please note that any mandated reporter who fails to file required oral and written reports can be punished by a fine of up to $1,000.00.
During the screening and investigation of a 51A Report, any mandated reporter who has information that she believes might aid the Department in determining whether a child has been abused or neglected shall, upon request by DCF, disclose the relevant information to the Department. Under the law, mandated reporters are protected from

liability in any civil or criminal action, and from any discriminatory or retaliatory actions by an employer.

References to Massachusetts Law are citations from Chapter 119, sections 51A-E.
Source: Department of Social Services website 11/05

Reference material:
http://www.mass.gov/eohhs/consumer/basic-needs/report-child-abuse.html

Mandated Reporter Form (51-A):
http://www.mass.gov/eohhs/docs/dcf/can-reporting-form.pdf

Elder Abuse Reporting

Supersedes:
Effective: 12-05-05

A. Introduction

The Massachusetts Legislature passed the Elder Abuse Reporting Law on December 31, 1982 as the Acts of 1982, ch. 604. Emergency provisions were passed to allow for statewide implementation of the program on July 1, 1983. The bill assigned the responsibilities of the Elder Protective Services Program to the Executive Office of Elder Affairs. Specifically, the Department was charged with the responsibility of: (a) establishing a mechanism to receive reports on a twenty-four hour basis; (b) designating local agencies within each geographic service area to receive reports, conduct investigations, utilize existing services to establish protective services; and (c) monitoring the assessments, evaluations, and provision of protective services by the designees.

Like other forms of abuse, elder abuse is complex and often includes multiple forms of abuse in a single case. In general, the term elder abuse encompasses abuse (including physical, sexual, and emotional), neglect, and financial exploitation. On July 1, 2004 the Massachusetts legislature added self-neglect as a reportable condition of elder abuse. Key terms regarding elder abuse under M.G.L. Chapter 19A, § 14:

1. Massachusetts law defines **ELDER ABUSE** as occurring when "an individual who is sixty years of age or over" has been subject to one or more of the following conditions:
    1.1. **Abuse**: an act or omission that results in serious physical or emotional injury to an elder or financial exploitation. The act or omission may include one or more of the following:
        1.1.1. **Physical Abuse**: the non-accidental infliction of serious physical injury to an elder or the threat of serious physical injury. Serious physical injury is to be determined by the elder's physical condition, type of physical injuries, circumstances of the injury and the potential for injury or the escalation of the abuse, and the emotional impact on the elder.
        1.1.2. **Sexual Abuse**: Sexual assault, rape, sexual misuse or exploitation of an elder, as well as threats of sexual abuse where the perpetrator has the intent and the capacity to carry out the threatened abuse.
        1.1.3. **Emotional Abuse**: the non-accidental infliction of serious emotional injury to an elder. There must be an established relationship between the abusive actions or behaviors and the resulting effect upon the elder's emotional health or functioning.
    1.2. **Neglect**: The failure or refusal by a caretaker to provide one or more necessities essential for physical well-being, which may include food, clothing,

shelter, personal care and medical care, and which has resulted in, or where there is a substantial belief that the failure to provide such necessities will immediately result in, serious physical harm to an elder.

1.3. **Self-Neglect**: The failure or refusal of an elderly person to provide for one or more of the necessities essential for his or her own physical and emotional well-being where there is reason to believe that there is the immediate risk of serious harm to the elder, and which prevents the elder from remaining safely in the community. This may include one or more of the necessities of living such as food, clothing, shelter, personal care and medical care.

1.4. **Financial Exploitation**: A non-accidental act or omission by another, without the elder's consent, that causes substantial monetary or property loss to the elder, or a gain that should have benefited the elder.

B. Key Features of the Massachusetts Law

1. **Mandated Reporting**: Requires reporting by specific professional or licensed groups, such as emergency medical technicians, physicians, dentists, nurses, police, or social workers. Failure to report can result in a fine of up to $1,000. Any other person who makes a report is neither civilly nor criminally liable so long as the report was made in "good faith" and the reporter is not the perpetrator of the abuse.

   1.1. **Reasonable Cause Standard**: The standard for reporting is based on specific facts that were either directly observed or obtained from reliable sources that support a belief that the event took place or the conditions still exist.

   1.2. **Mandated Reporting Process**: A verbal report must be made through the statewide Elder Abuse Hotline at **1-800-922-2275** or to Ethos at **617-522-6700** (Monday-Friday, 09:00-17:00), the local protective services agency that covers the city of Boston. A written report must follow within 48 hours of the oral report to the department's designee. Boston EMS personnel filing a 19A report should note this on the patient care report. The written report should be sent to the EMS Headquarters where it will then be forwarded to the appropriate protective services agency.

2. **Self-Determination**: The concept of self-determination is a governing force of the elder protective services system in Massachusetts. Under this view, elders retain the same rights of decision-making they acquired entering adulthood. This includes the right to: (a) decide where and how to live; (b) choose whether to accept community or social services assistance; and (c) make choices that others might consider to be detrimental, unless they hurt others. Elders are considered to have the capacity to consent when they are able to "... understand and appreciate the nature and consequences of decisions about Protective Services, including the benefits and risks of and alternatives to any proposed services, and to reach an informed decision."

C. Reporting Protections under the Massachusetts Elder Abuse Law, M.G.L. c. 19A, § 15

1. No person required to make a report pursuant to the statute can be held civilly or criminally liable, unless they perpetrated the abuse, neglect, or exploitation.

2. No reporter may be discharged, demoted, transferred, suffer reduced pay or benefits as a result of filing a report of elder abuse.

3. Privileges related to confidential communications between a patient and therapist or client and social worker will not interfere with the professional's responsibility to report suspected cases of elder abuse under the state elder abuse statute.

D. Links to laws and regulations

M.G. L. c.19A regarding Elders Residing in a Community Setting: (**http://www.mass.gov/legis/laws/mgl/gl-19a-toc.htm**):

651 CMR 5.00 Elder Abuse Reporting and Protective Services Regulations: (**http://www.mass.gov/Eelders/docs/reg_651cmr005.doc**)

Source: Office of Attorney General Website: http://www.ago.state.ma.us/sp.cfm?pageid=1784

MATRIS Data Dictionary

Supersedes:
Effective: 09-24-10

Data Element	Definition
Unit Information	
Incident Number	The unique 9 digit incident number assigned to the incident by the computer aided dispatch system
EMS Unit (Vehicle) Response Number	Unit ID
Type of Response Delay	The response delays, if any, of the unit associated with the patient encounter
Type of Scene Delay	The scene delays, if any, of the unit associated with the patient encounter
Type of Transport Delay	The transport delays, if any, of the unit associated with the patient encounter
Vehicle Dispatch Location	The location of the unit at time of dispatch
Odometer Reading of Responding Vehicle	The mileage (odometer reading) of the vehicle when it arrives at the patient's destination
Ending Odometer Reading of Responding Vehicle	The ending mileage (odometer reading) of the vehicle (at time back in service)
Complaint Reported by Dispatch	The TYPE Code reported to the responding unit.
Crew Member ID	The State Certification/Licensure ID number assigned to the crew member
Times	
Unit Notified by Dispatch Date/Time	The date the responding unit was notified by dispatch
Unit En Route Date/Time	The date/time the unit responded; that is, the time the vehicle started moving
Unit Arrived on Scene Date/Time	The date/time the responding unit arrived on the scene; that is, the time the vehicle stopped moving
Arrived at Patient Date/Time	The date/time the responding unit arrived at the patient's side
Unit Left Scene Date/Time	The date/time the responding unit left the scene (started moving)
Patient Arrived at Destination Date/Time	The date/time the responding unit arrived with the patient at the destination
Unit Back in Service Date/Time	The date/time the unit back in service and available for response .
Patient / Billing	
Last Name	The patient's last (family) name
First Name	The patient's first (given) name

Middle Initial/Name	The patient's middle name, if any
Patient's Home Address	The patient's home mailing or street address
Patient's Home City	The patient's home city or township or residence
Patient's Home State	The patient's home state, territory, or province, or District of Columbia, where the patient resides
Patient's Home Zip Code	The patient's home ZIP code of residence
Social Security Number	The patient's social security number
Gender	The patient's gender
Age	The patient's age (either calculated from date of birth or best approximation)
Age Units	The units which the age is documented in (Hours, Days, Months, Years)
Date of Birth	The patient's date of birth
Primary or Home Telephone Number	The patient's home or primary telephone number
Primary Method of Payment	The primary method of payment or type of insurance associated with this EMS encounter
Insurance Company ID/Name	The ID number of the patient's insurance company
Insurance Policy ID Number	The ID number of the patient's insurance policy
Work-Related	Indication of whether or not the injury is work related.
Closest Relative/Guardian Last Name	The last (family) name of the patient's closest relative or guardian
First Name of the Closest Relative/ Guardian	The first (given) name of the patient's closest relative or guardian
Closest Relative/ Guardian Street Address	The home street address of the patient's closest relative or guardian
Closest Relative/ Guardian City	The home city of the patient's closest relative or guardian
Closest Relative/ Guardian State	The home state of the patient's closest relative or guardian
Closest Relative/ Guardian Zip Code	The home Zip Code of the patient's closest relative or guardian
Closest Relative/ Guardian Phone Number	The home or other phone number of the patient's closest relative or guardian
Closest Relative/ Guardian Relationship	The relationship of the patient's closest relative or guardian
Scene	
Other EMS Agencies at Scene	Other EMS agencies that were at the scene, if any
Other Services at Scene	Other services that were at the scene, if any
Number of Patients at Scene	Indicator of how many total patients were at the scene
Incident Location Type	The kind of location where the incident happened
Incident Address	The street address, including city section to which the unit responded.
Incident ZIP Code	The ZIP code of the incident location
Situation	

Prior Aid	Any care which was provided to the patient prior to the arrival of this unit.
Prior Aid Performed by	The type of individual who performed the care prior to the arrival of this unit.
Outcome of the Prior Aid	outcome or result of the care performed prior to the arrival of the unit?
Possible Injury	This data element provides documentation to classify the EMS Reason for Encounter as either injury or non-injury related.
Chief Complaint	The statement of the problem by the patient or the history provider in one or two words
Duration of Chief Complaint	The time duration of the chief complaint
Time Units of Duration of Chief Complaint	The time units of the duration of the patient's chief complaint
Chief Complaint Anatomic Location	The primary anatomic location of the chief complaint as identified by EMS personnel
Primary Symptom	The primary sign and symptom present in the patient or observed by EMS personnel
Other Associated Symptoms	Other symptoms identified by the patient or observed by EMS personnel
Providers Primary Impression	The EMS personnel’s impression of the patient’s primary problem or most significant condition which led to the management given to the patient (treatments, medications, or procedures).
Provider’s Secondary Impression	The EMS personnel’s impression of the patient’s secondary problem or which led to the management given to the patient (treatments, medications, or procedures).
Trauma	
Cause of Injury	The category of the reported/suspected external cause of the injury
Mechanism of Injury	The mechanism of the event which caused the injury.
Vehicular Injury Indicators	The kind of risk factor predictors associated with the vehicle involved in the incident
Area of the Vehicle impacted by the collision	The area or location of impact on the vehicle
Seat Row Location of Patient in Vehicle	The seat row location of the patient in vehicle at the time of the crash with the front seat numbered as 1.
Position of Patient in the Seat of the Vehicle	The position of the patient in seat of the vehicle at the time of the crash
Use of Occupant Safety Equipment	Safety equipment in use by the patient at the time of the injury
Airbag Deployment	Indication of Airbag deployment during the motor vehicle crash.

Height of Fall	The distance in feet the patient fell, measured from the lowest point of the patient to the ground.
CPR	
Cardiac Arrest	Indication of the presence of a cardiac arrest at any time associated with the EMS evert.
Cardiac Arrest Etiology	Indication of the etiology or cause of the cardiac arrest (classified as cardiac, non-cardiac, etc.)
Resuscitation Attempted	Indication of an attempt to resuscitate the patient who is in cardiac arrest (attempted, not attempted due to DNR, etc.)
Arrest Witnessed by	Indication of who the cardiac arrest was witnessed by
First Monitored Rhythm of the Patient	Documentation of what the first monitored rhythm which was noted
Any Return of Spontaneous Circulation	Indication whether or not there was any return of spontaneous circulation at any time during the EMS evert.
Estimated Time of Arrest Prior to EMS Arrival	The length of time the patient was down (estimated) before the responding unit arrived at the patient
Date/Time Resuscitation Discontinued	The date/time the CPR was discontinued (or could be time of death)
Reason CPR Discontinued	The reason that CPR or the resuscitation efforts were discontinued.
Cardiac Rhythm on Arrival at Destination	The patient's cardiac rhythm upon delivery or transfer to the destination
Medical History	
Barriers to Patient Care	Indication of whether or not there were any patient specific barriers to serving the patient at the scene
Medication Allergies	The patient’s medication allergies
Medical/Surgical History	The patient’s pre-existing medical and surgery history of the patient
Current Medications	The medications the patient currently takes
Current Medication Dose	The numeric dose or amount of the patient’s current medication
Current Medication Dosage Unit	The dosage unit of the patient’s current medication
Current Medication Administration Route	The administration route (po, SQ, etc.) of the patients current medication
Alcohol/Drug Use Indicators	Indicators for the potential use of Alcohol or Drugs by the patient.
Run Report Narrative	The narrative of the run report
Assessment	
Date/Time Vital Signs Taken	Date/Time Vital Signs Taken
Cardiac Rhythm	The initial cardiac rhythm of the patient as interpreted by EMS personnel
SBP (Systolic Blood Pressure)	The patient's systolic blood pressure
DBP (Diastolic Blood Pressure)	The patient's diastolic blood pressure

Pulse Rate	The patient's pulse rate, palpated or auscultated, expressed as a number per minute
Pulse Oximetry	The patient's oxygen saturation
Respiratory Rate	The patient's respiratory rate expressed as a number per minute
Carbon Dioxide	The patient's end-tidal or other CO2 level.
Blood Glucose Level	The patient's blood glucose level
Glasgow Coma Score-Eye	The patient's Glasgow Coma Score Eye opening
Glasgow Coma Score-Verbal	The patient's Glasgow Coma Score Verbal
Glasgow Coma Score-Motor	The patient's Glasgow Coma Score Motor
Glasgow Coma Score-Qualifier	Documentation of factors which make the GCS score more meaningful.
Total Glasgow Coma Score	The patient's total Glasgow Coma Score
Temperature	The patient's body temperature in degrees celsius/centigrade.
Level of Responsiveness	The patients level of responsiveness
Pain Scale	The patient's indication of pain from a scale of 0 / 10.
Stroke Scale	The patient's Los Angeles or Cincinnati Stroke Scale Results
APGAR	The patient's total APGAR score (0-10). Recommended to be taken at 1 and 5 minutes after the infants birth
Revised Trauma Score	The patient's Revised Trauma Score
Medication	
Date/Time Medication Administered	The date/time medication administered to the patient
Medication Administered Prior to this Units EMS Care	Indicates that the medication administration which is documented was administered prior to this EMS unit's care.
Medication Given	The medication given to the patient
Medication Administered Route	The route that the medication was administered to the patient.
Medication Dosage	The dose or amount of medication given to the patient
Medication Dosage Units	The units of medication dosage given to patient
Response to Medication	The patient's response to the medication.
Medication Complication	Any complication (abnormal effect on the patient) associated with the administration of the medication to the patient by EMS
Medication Crew Member ID	The ID number of the EMS crew member giving the treatment to the patient
Procedure	
Procedure	The procedure performed on the patient.
Size of Procedure Equipment	The size of equipment used in the procedure on the patient
Number of Procedure Attempts	The number of attempts taken to complete a procedure or intervention regardless of success

Procedure Successful	Indication of whether or not the procedure performed on the patient was successful
Procedure Complication	Any complication associated with the performance of the procedure on the patient
Response to Procedure	The patient's response to the procedure
Procedure Crew Members ID	The ID number of the EMS crew member performing the procedure on the patient
Procedure Authorization	The type of procedure authorization obtained
Procedure Authorizing Physician	The last name of the authorizing physician ordering the procedure, if the order was provided by any manner other than protocol (standing order)
Successful IV Site	The location of the IV site (if applicable) on the patient
Tube Confirmation	Endotracheal Tube placement verification at the time the airway procedure was done
Destination Confirmation of Tube Placement	Endotracheal Tube location verification on the arrival at the Destination (if applicable)
Disposition	
Destination/Transferred To, Name	The destination the patient was delivered or transferred to
Incident/Patient Disposition	Type of disposition treatment and/or transport of the patient.
How Patient Was Moved to Ambulance	The method the patient was moved to the ambulance from the scene
Position of Patient During Transport	The position of the patient during transport from the scene
How Patient Was Transported From Ambulance	The method the patient was moved from the ambulance to the destination
Reason for Choosing Destination	The reason the unit chose to deliver or transfer the patient to the destination
Medical Device	
AED, Pacing, or CO2 Mode	The mode of operation the device is operating in during the defibrillation, pacing, or rhythm analysis by the device (if appropriate for the event)
ECG Lead	The lead or source which the medical device used to obtain the rhythm (if appropriate for the event)
ECG Interpretation	The interpretation of the rhythm by the device (if appropriate for the event)
Shock or Pacing Energy	The energy used for the shock or pacing event (if appropriate for the event)
Total Number of Shocks Delivered	The number of times the patient was defibrillated, if the patient was defibrillated during the patient encounter.
Pacing Rate	The rate the device was calibrated to pace during the event, if appropriate.

Massachusetts Ambulance Trip Information Sytem
http://www.mass.gov/Eeohhs2/docs/dph/emergency_services/ar/5_403.pdf

Boston EMS - MDU Notification Form

ACTIVATE CAD INCIDENT #:_____ Poll Number: _____

Date: _____ Time: _____ Agency: _____ Name: _____

Hospital	SURVEY I. NOTIFICATION (Time)	SURVEY II. Can ACTIVATE (Time or NEG)	ACTION III. HOSPITAL(s) to Activate (Time)	ACTION IV. ACKNOWLEDGED (Time)	ACTION V. DEACTIVATE (Time)
BID					
BMCM					
BWH					
CRN					
FLK					
MGH					
NEMC					
STE					
CAMB					
SMRV					
WHID					

DEACTIVATE

Date: _____ Time: _____ Agency: _____ Name: _____

Procedure

- Select 155.280 Base and transmit to the COBTH Disaster Net Group:

"Attention Boston Hospitals, this is a Metro-Boston C-MED MDU Notification., A potential hazardous materials Incident has occurred at (location). Please stand by for roll-call, acknowledging with "Roger MDU". In 15 minutes, C-MED will poll for the time each hospital can deploy and ACTIVATE."

- Roll-call the hospitals. **Column I:** Note time they acknowledge. Complete roll-call. Individually encode any hospital that did not answer; note their response. If still no response, ring down hospital ED *when possible*.
- Wait 15 minutes. Roll-call the hospitals. **Column II:** Note the Time they will be able to deploy and ACTIVATE. If a hospital reports they are unable to activate, note "NEG".

Transmit, ***"Please stand by. C-MED will advise the selected hospitals when to ACTIVATE MDU."***

  - Notify IC/BFA (of the time each hospital can ACTIVATE). **Notified: _____(TIME)**
  - Coordinate with IC/BFA which hospital(s) to ACTIVATE. **Column III:** Note the time next to any hospital activated. Note the time of any subsequent activation next to the hospital(s) activated.
  - BFA will confirm BFD response to support hospital(s) MDUs.

Transmit alert tone. ***"The following hospitals will ACTIVATE MDU. Please acknowledge when called."***

- Advise selected hospital(s) to ACTIVATE. **Column IV:** Note the time they acknowledge.
- When directed by IC/BFA to Deactivate, C-MED will call the COBTH Disaster Net Group, direct hospitals to deactivate. **Column VI:** Note the time they acknowledge deactivation.

1. *Note:* ***Replace MDU Notification with Emergency MDU Activation*** *if patient number(s) and/or absence of RAM Decon warrant. ALL hospitals will instead Deploy and Activate. To coordinate BFD response, C-MED will still note & communicate to IC/BFA the time hospital(s) they can Deploy & Activate their MDU (Column II).*

Notify the duty supervisor immediately of any problems. Please document any issues with MDU deployment on the back of this form, noting the time and briefly describing the issue/resolution.

PRESS HARD WHEN WRITING

EMERGENCY MEDICAL SERVICES - AMBULANCE

CITY OF BOSTON EMERGENCY MEDICAL SERVICES (DISPATCH OPERATIONS 617-343-1400)

OFFICE/BILLING

MR# 2501 (Rev. 10/01)

INCIDENT NO.: 0 ____ 0 ____ | DATE: / / | DAY | NATURE

AMBULANCE DISPATCHED TO: | STREET AND NUMBER | SECTION/ZIP

DSP TIME	SCENE ARRIVAL
PT CONTACT TIME	SCENE DEPARTURE
HOSP ARRIVAL	BACK IN SERVICE

TOTAL TRANSPORT MILEAGE ____

LOCATION AT DISPATCH / SPECIAL LOCATION

SOCIAL SECURITY NUMBER | D.O.B. | SEX

PATIENT NAME | PHONE

INSURANCE ____

NUMBERS: ____

COMMENTS-PATIENT'S CHIEF COMPLAINT-HISTORY-CHANGE IN PATIENT STATUS

ADDRESS | STREET & NO. | CITY

NEXT OF KIN | NAME | RELATIONSHIP | PHONE

ADDRESS | STREET & NO. | CITY

NO PATIENT TRANSPORTED - REASON

CANCELLED BY: ☐ OPERATIONS ☐ POLICE ☐ FIRE

PATIENT TRANSPORTED BY: ☐ POLICE ☐ OTHER AMB ☐ FIRE ☐ ALS

REFERRED TO: ☐ POLICE ☐ MED. EXAMINER ☐ PRIV. AMB ☐ ALS

MISCELLANEOUS: ☐ PATIENT LEFT SCENE ☐ PATIENT REFUSAL

☐ INCORRECT ADDRESS ☐ NO VISIBLE INCIDENT ☐ MVA/FIRE - NO INJURIES

ALSO RESPONDING: ☐ POLICE ☐ FIRE ☐ SUPV ☐ ALS

☐ OTHER ____

PHYSICAL EXAM

NEURO STATUS			SKIN CONDITION
EYE OPENING:	☐ SPONTANEOUS ☐ TO VOICE	☐ TO PAIN ☐ NONE	☐ NORMAL ☐ COOL ☐ HOT ☐ PALE ☐ FLUSHED ☐ CYANOTIC ☐ DIAPHORETIC
VERBAL RESPONSE:	☐ ORIENTED ☐ CONFUSED ☐ INAPPROPRIATE	☐ INCOMPREHENSIBLE ☐ NONE	
MOTOR RESPONSE:	☐ OBEDIENCE ☐ PURPOSEFUL ☐ WITHDRAWAL	☐ FLEXION ☐ EXTENSION ☐ NONE	

VITAL SIGNS:

TIME	BP	PULSE	CAPIL RETURN	RESPIRATIONS RATE/EFFORT	O_2 SAT

EMERGENCY CARE: BLOOD GLUCOSE: mg/dl

BLS SKILLS	✓	EMT #	ALS SKILLS	✓	EMT #
CPR			INTRAVENOUS		
SAED			INTUBATION		
BACK / NECK IMMOB.			COUNTER SHOCK		
EXTRICATION RAPID			PACING		
SPLINT			CHEST / DECOMP		
MAST DEVICE			CRICO		
EPIPEN			I / O		
MEDICAL ASSIST	✓	EMT #	12 LEAD ECG		
ALBUTEROL					
NITRO					
NEBULIZER					
OTHER					

TIME:

OXYGEN | DEVICE / RATE | ETT NTT OPA NPA (CIRCLE ONE) | SIZE

POST INTUBATION ___ BILATERAL BS ___ $ETCO_2$ ___ CORDS VISUALIZED

TRANSPORTED TO: ____ BY UNIT: ____

☐ PER SOP ☐ PATIENT REQUEST ☐ STAIR CHAIR ☐ WHEELCOT

AT RISK POPULATION:

☐ DOMESTIC VIOLENCE ☐ ELDERS ☐ SUBSTANCE ABUSE

☐ PEDIATRIC ☐ MATERNITY/PRENATAL ☐ OTHER ____

UNIT: | NAMES OF EMTS: NAME / EMT # | NAME / EMT # | NAME / EMT #

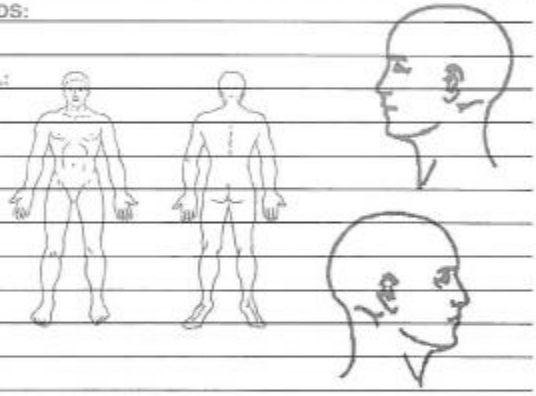
HPI:

PMH:

MEDS:

ALL:

PE:



TX:

MEDICAL CONSULT:

____ MD/RN ____ HOSPITAL

MEDICATIONS

TIME	FLUID/DRUG	RATE/DOSE/LOT	ROUTE (SPECIFY IV SITE)

TOTAL VOLUME FLUIDS INFUSED: MLS

Patient Care Report Documentation

Supersedes: 06-01-16
Effective: 05-07-18

Overview
The Patient Care Report (PCR) is the fundamental tool for documenting the care and services we provide to our patients. The PCR is an important medical record that must document available information regarding the incident, patient assessment, and care provided to the patient in a clear, concise, accurate, and complete manner.

The PCR also forms the basis for determining the amount that each patient is to be billed. Therefore, the PCR must accurately provide a picture of the response, assessment and treatment provided to each patient so that billing personnel may accurately determine the level of service that is to be billed along with an accurate summation of that service on the billing claim form. It is essential that Boston EMS maintain a strict quality assurance procedure to ensure that the accuracy and clarity of our patient care documentation is at the highest possible level at all times.

Boston EMS uses an electronic patient care reporting and information management system. The system allows users to collect and document call and patient information on mobile Android tablet throughout the course of the EMS call. PCRs are prepared contemporaneously with, or as soon as practicable, after each response, and are then available for review by the hospital staff immediately after upload to the server in accordance with 105 CMR 170.345 (B). The system is HIPAA compliant and allows hospital personnel to review reports on patients transported only to their facility, while providing EMS managers and physicians with valuable QA, statistical, billing, and demographic information.

Minimum Documentation Requirements
Unless cancelled prior to arrival on scene, responding ambulance crews are required to complete a Patient Care Report (PCR) for each response. The PCR should include all applicable information about the EMS response it documents. In cases where there are multiple patients involved in the same incident, a PCR must be completed for each patient.

The Commonwealth of Massachusetts, Office of Emergency Medical Services has established the Massachusetts Ambulance Trip Information System (MATRIS), a minimum EMS data set based on the National EMS Information System Dataset (NEMSIS), as set out in the 2006 National Highway Traffic Safety Administration Uniform Prehospital Dataset Document.[1] .

Patient Assessment and Treatment Information
The PCR should document the history of the patient's present illness or injury and the present condition of the patient. Include all associated symptoms that the patient is experiencing and other pertinent medical information that is obtained during the patient assessment. Pertinent negatives should be documented on all assessment questions asked. The completed PCR should include a description of all procedures, interventions, or medications provided as well as the time they were performed, by whom, and any resulting changes in the patient's status.

ALS Assessment / Refer to BLS
Advanced Life Support (ALS) personnel who have established direct patient contact must complete an appropriate assessment in accordance with the standards of their certification and training. If ALS personnel determine that an ALS intervention is not needed or anticipated, the patient may be referred to BLS for transport to an appropriate health care facility. Paramedics should note the assessment in SafetyPAD by selecting "ALS Assessment" from the treatment dropdown list, and clear the incident with the RBLS (Refer to BLS) disposition. The Department is entitled to submit for reimbursement of this assessment, so it is important that it be properly documented for medical, legal, and financial purposes.

ALS Schedule II, III, IV, and VI Drug Documentation
Department Paramedics who treat a patient with a Schedule II, III, IV, and VI drug must document both the amount of drug given and the amount of the drug wasted in the ePCR and complete the signature Form (controlled Substance, Waste).

Financial Responsibility and Assignment of Benefits
Personnel shall attempt to obtain the signature of the responsible party for all patient transports. Signatures of responsibility and authority to release medical records may be obtained from an adult family member present at the time of transport (identify their relationship to the patient). When a patient is unable to sign, a reasonable explanation must be provided stating why the patient's signature was unobtainable and the attending EMT/Paramedic must sign in the space provided. Acceptable reasons for not obtaining a signature are: patient is unresponsive, combative, refuses, or is contaminated and a family member is not present to sign.

Patient Refusal
A patient refusal shall be thoroughly documented whenever a competent patient refuses to be treated and transported to the hospital. The patient, parent, or legal guardian should sign the designated refusal section located in the "Outcomes" portion of the SafetyPAD software. In cases where the SafetyPAD device is not readily available, the patient refusal may be documented on an approved (paper) Boston EMS Patient Refusal form.

Submission of the Patient Care Report
After the Patient Care Report is complete, use the CLOSE and SEND Icon to submit the report. Once successfully submitted, a copy will be automatically faxed to the receiving hospital and an electronic version will be available to authorized personnel via Webviewer. If the network connection is down, ePCRs can still be completed on the handheld device and closed and queued to be uploaded to the server once cellular connectivity is reestablished uploaded to the server at a later time.

Handwritten / Paper Documentation
In the event a handheld device is not available, all required information shall be documented on a standard Boston EMS paper PCR and (if applicable) Patient Refusal form (available from Field Supervisors and/or Material Management). A copy of the paper PCR report shall be left at the receiving facility. Any paper generated 51-A reports, patient refusals, PCRs, or other patient care related documentation should be sealed in an envelope. Arrangements should be made for a

Supervisor to collect the paperwork and deliver it to the EMS Administrative Headquarters where it will be scanned and attached to the accompanying PCR record as soon as possible.

Amendment of Patient Care Reports
PCRs create a legal record of an ambulance call. It is the responsibility of all personnel to ensure that their PCRs accurately reflect patient information, care given and the medical condition of the patient. To that end, Supervisory personnel or management of Boston EMS may request that staff members modify, amend or fully complete PCRs for a given call when PCR reviews suggest that the information documented may be incorrect or incomplete. Information for each patient call must be complete, accurate, honest and wholly based on the patient's condition. It is legally permissible for staff members to amend PCRs for reasons of completeness, correction, and clarity, and in compliance with the procedures outlined below. Boston EMS does not endorse nor will it tolerate any staff member who embellishes or falsifies medical necessity, mileage, services rendered, supplies used or any other information for the purpose of obtaining or enhancing reimbursement.

Proper reasons for modifying a patient care report may include correcting erroneous information, such as the patient's name, address, insurance numbers, incident number, dispatched information or patient care-related information. Medical information on PCRs should only be modified by the original author. When an amendment of medical information is required, arrangements shall be made for the original author to come to the EMS Administrative Headquarters where the ePCR will be “reopened” by a system administrator, and any necessary modifications or additions may be made. Any modification will automatically be time stamped by the computer system to clearly show the amendment and when the changes were made. Other personnel (billing, QA, etc.) may amend patient demographic information (name, address, insurance numbers, mileage, etc.), correct spelling errors and make other changes not related to patient care documentation. In all cases, any change to a previously submitted PCR (either electronic or hand written) shall include the name of the person making the change, as well and the date and time the change was made.

Mileage Reporting
Mileage reporting has been automated and is auto populated by the system

Abbreviations / Standard Terminology
To help reduce the numbers of errors related to incorrect use of terminology, only standardized, commonly accepted abbreviations should be used. One of the major causes of medication errors is the use of potentially dangerous abbreviations and dose expressions. Underlying factors contributing too many of these errors are illegible or confusing handwriting by clinicians and the failure of health care providers to communicate clearly with one another.

Examples of especially problematic abbreviations include the use of trailing zeros (e.g., 2.0 vs. 2) or use of a leading decimal point without a leading zero (e.g. .2 instead of 0.2). The decimal point is sometimes not seen when dosages are handwritten using trailing zeros or no leading zeros. To help reduce the numbers of medical errors related to incorrect use of terminology, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) issued a list of abbreviations, acronyms, and symbols that should no longer be used [2]. While the initiative was

intended for in-hospital use, the same safety concepts are applicable to the prehospital setting as well because patient medication information and field treatment notes are often initially written down on index cards and can be misinterpreted when passed among prehospital providers.

Abbreviation	***Potential Problem***	***Preferred Term***
U (for unit)	Mistaken as zero, four or cc.	Write "unit"
IU (for international unit)	Mistaken as IV (intravenous) or 10 (ten)	Write "international unit"
Q.D., Q.O.D. (Latin abbreviation for once daily and every other day)	Mistaken for each other. The period after the Q can be mistaken for an "I" and the "O" can be mistaken for "I"	Write "daily" and "every other day"
Trailing zero (X.0 mg), Lack of leading zero (.X mg)	Decimal point is missed	Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)
MS MSO_4 $MgSO_4$	Confused for one another Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" or "magnesium sulfate"
>(greater than) <(less than)	Misinterpreted as the number “7” or the letter “L”	Write “greater than” or “less than”
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write full drug name
@	Mistaken for the number “2”	Write “at”
Cc	Mistaken for U (units) when poorly written	Write “ml” or “milliliters”
µg	Mistaken for mg (milligrams) resulting in one thousand-fold overdose	Write “mcg” or “microgram”

[1] OEMS Administrative Requirement, A/R 5-403 http://www.mass.gov/eohhs/docs/dph/emergency-services/ar/5-403.pdf

[2] http://www.jointcommission.org/patientsafety/donotuselist/ In addition, the Institute for Safe Medication Practices (ISMP) has published a list of dangerous abbreviations relating to medication use that it recommends should not be used. The list is available on the ISMP Website at: http://www.ismp.org/Tools/errorproneabbreviations.pdf

Patient Signature Requirement

Supersedes:
Effective: 05-01-10

PURPOSE

The purpose of this policy is to ensure compliance with the CY 2009 Medicare Physician Fee Schedule Final Rule, which requires ambulance service providers to obtain patient signatures as a condition for Medicare reimbursement. The patient signature also (1) authorizes the release of information to ambulance services and Medicare/insurance companies; (2) acknowledges the patient's financial responsibility for the ambulance transport; (3) provides a mechanism to appeal a claim that has been denied; (4) verifies that the ambulance services were actually provided as claimed; and (5) authorizes payment to the ambulance service provider.

Obtaining patient signatures at the time of transport will help Boston EMS ensure its revenue stream and will also help to alleviate patient stress. When signatures are obtained upfront, the patient will not have to revisit the trauma or medical event that precipitated the ambulance transport and his/her ambulance claim can be paid in a timely manner thereby eliminating unnecessary billing inquiries.

PROCEDURE

1. Whenever possible, Boston EMS personnel should make reasonable efforts to obtain an electronic patient signature in SafetyPAD from every mentally and physically capable patient (age 18 or older) at the time of transport. If the patient is a minor, the patient's parent or legal guardian should sign on behalf of the patient. *See Screens #1 and #3 below.*

   1.1 SafetyPAD contains an electronic "Patient/Guardian Signature Form" which explains to the patient that he/she is financially responsible for the services provided by Boston EMS, regardless of insurance coverage. The form also explains that the patient assigns all rights of benefits to Boston EMS for compensation of the services provided. *See Screen #2 below*.

   1.2 The patient should not be asked to sign if he/she is mentally or physically incapable of signing his/her name. Examples of this include: a patient who is mentally incapacitated, a patient under the influence of drugs or alcohol, a patient who is restrained and unable to sign, a patient in great pain, or crticially ill or injured patient. If a patient signature is obtained, the crew need not obtain any other signatures.

2. If a patient is physically and mentally capable of signing at the time of transport, but refuses to sign the "Patient/Guardian Signature Form", the ambulance crew should document the patient's refusal to sign. *See Screen #1. The crew need not obtain any other signatures and should not sign on the patient's behalf. Boston EMS is permitted to bill the patient directly if he/she refuses to sign the form.*

3. If the patient is physically or mentally incapable of signing at the time of service, the ambulance crew must properly document the patient's incapacity as shown in the drop down of *Screen #4* as well as in the narrative. The crew then must make reasonable efforts at the time of service to obtain a signature from an authorized signer on the patient's behalf. Authorized signers include:

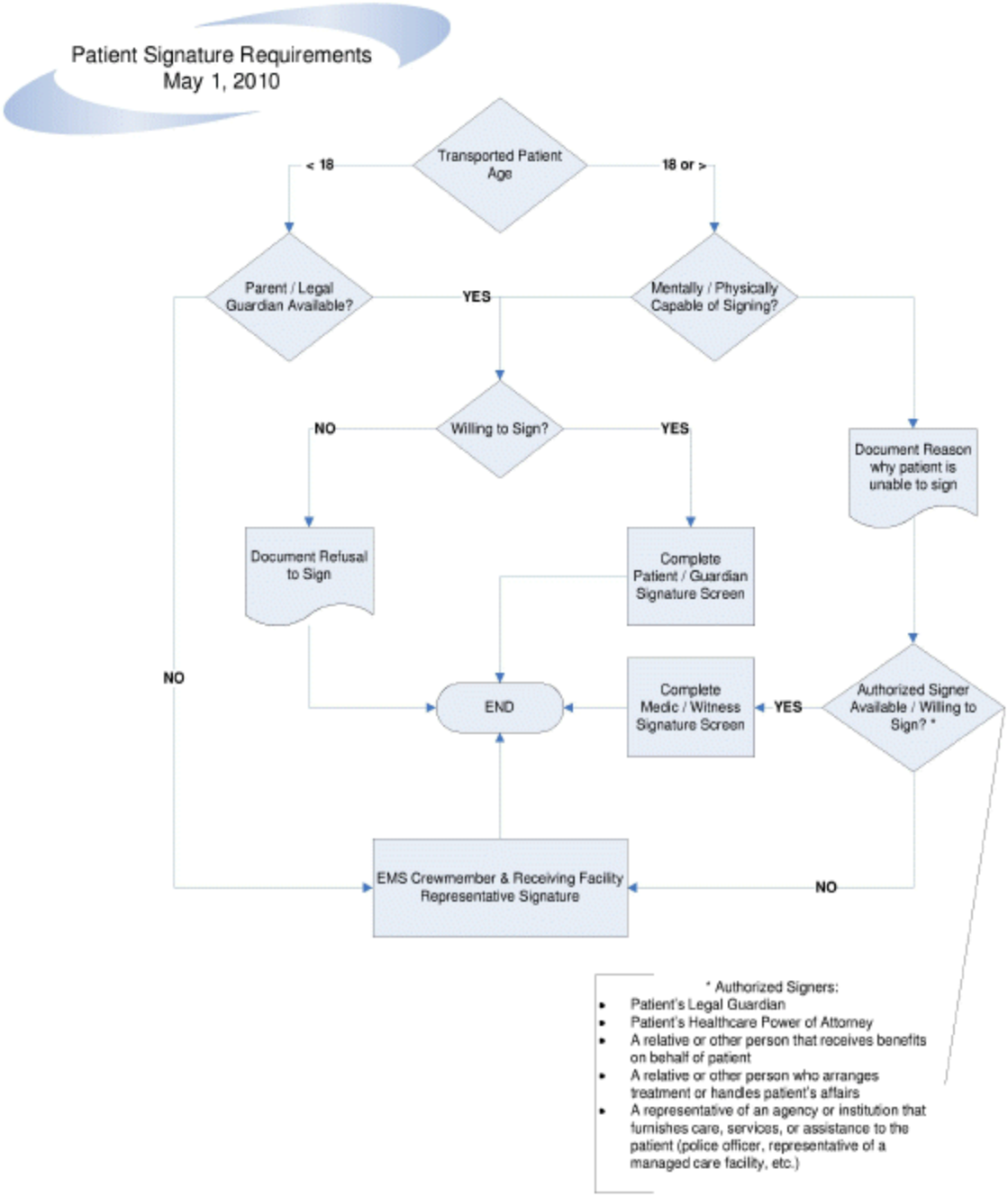
   - The patient's legal guardian, if the patient is NOT a minor;
   - The patient's Healthcare Power of Attorney (Healthcare POA);
   - A relative or other person who receives government benefits on behalf of the patient;
   - A relative or other person who arranges treatment or handles the patient's affairs; or
   - A representative of an agency or institution that furnished care, services, or assistance to the patient (i.e. a police officer, a representative of a managed care facility, etc.)

   The crew must document the authorized signer's type (i.e. Healthcare POA, wife, husband, police officer, etc.) as shown in*Screen #5* and then capture his/her signature as shown in Screen *#6.* Once the signature of an authorized signer is obtained, the crew need not capture any other signatures

4. If the crew cannot obtain the signature of the patient because the patient is physically or mentally incapable of signing AND the crew cannot obtain the signature of an authorized signer at the time of service, a member of the transporting crew along with a representative of the receiving facility may sign contemporaneously on the patient's behalf.

   4.1 The crew member will select his/her name and rank from the dropdown as shown in *Screen #7*. The "EMS Crew Signature" notice will appear prompting the crew member to sign and to obtain the signature of a representative from the receiving facility. *See Screen #8.* As shown in *Screen #9*, the crew member will be prompted to sign.

   4.2 The crew must also obtain the signature of a representative of the receiving facility. The representative may be a clerk or other administrative personnel, a nurse, a doctor, etc. The crew member must select the type of representative as shown in *Screen #10*. SafetyPAD contains an electronic "Receiving Facility Representative" notice *(See Screen #11)* which explains to the signing representative of the receiving facility that his/her signature does not obligate any responsibility for payment either personally or to the hospital, but is merely a confirmation of transport which will allow Boston EMS to submit for reimbursement. The representative of the receiving facility will be prompted to sign as shown in *Screen #12*.


Patient Signature Requirements
May 1, 2010
Transported Patient Age
< 18
18 or >
Parent / Legal Guardian Available?
YES
Mentally / Physically Capable of Signing?
NO
Willing to Sign?
YES
Document Reason why patient is unable to sign
Document Refusal to Sign
Complete Patient / Guardian Signature Screen
NO
END
Complete Medic / Witness Signature Screen
YES
Authorized Signer Available / Willing to Sign? *
EMS Crewmember & Receiving Facility Representative Signature
NO
* Authorized Signers:
Patient's Legal Guardian
Patient's Healthcare Power of Attorney
A relative or other person that receives benefits on behalf of patient
A relative or other person who arranges treatment or handles patient's affairs
A representative of an agency or institution that furnishes care, services, or assistance to the patient (police officer, representative of a managed care facility, etc.)

SafetyPAD ePCR Instructions

Supersedes:
Effective: 09-24-10

CREW SETUP

NOTE: ePCR devices should be power cycled at the beginning of each shift to refresh the crew set-up and install any new software updates.

- UNIT -Select the correct unit designator as identified within CAD.
- SHIFT -Select the correct shift.
- SKILL -Select the appropriate unit skill level. ALS for all ALS units, BLS for BLS units.

CALL

DISPATCH

- DISPATCH -The time the unit was dispatched to the incident.
- ENROUTE - The time your unit departed its location and was en route to the scene of the incident.
- INCIDENT TYPE -Select the incident type.
- DATE DISPATCHED -Enter the date.
- INCIDENT # -Enter the nine digit incident (#ED) number.
- STREET -Enter the dispatched street address.
- AT SCENE -Enter the time your unit arrived at the scene.

  Note: Many of the fields will be automatically populated via a CAD "push". If the information is missing, it must be entered manually

PATIENT

IDENTIFY

- LAST NAME -Enter the patient's last name. If unknown, use the *"Unknown*?" button.
- FIRST NAME -Enter the patient's first name. If unknown, write unknown.
- SSN -Enter the patient's social security number on all patients transported by your unit.
- AT PATIENT -Enter the time first contact is made with patient.
- DOB -Enter the patient's date-of-birth. If DOB is unknown, approximate in the Age field.
- AGE -Enter the patient's age only if DOB is unknown, approximate if necessary or select the age in months/weeks/day's/hours -as appropriate, if less than 1 yr.
- SEX -Select the appropriate response.
- *ADDRESS*
  - STREET -Enter the patient's home mailing address.
  - CITY -Enter the patient's home mailing city.
  - STATE -Enter the patient's home mailing State.
  - POSTCODE -Enter the patient's home mailing zip-code.

FINDINGS

This section shall indicate the findings of the patient exam which will be supported by documentation in the narrative area of the report. Entries in these fields shall reflect the relevant clinical findings, or lack of findings, for the proper assessment and treatment of the patient.

VITALS

Record the time. Pulse - Only palpable pulses will be recorded, (no electronic readings will be placed in the pulse section). Respiration -Document the respiratory rate. Blood Pressure - Document systolic and diastolic. If palpated, select "Palp". Select the position the patient was in when the blood pressure and pulse were taken. Sp02%, select if the Sp02% was obtained at room air or with oxygen being delivered.

INITIAL

NOTE: The primary assessment will be documented in this section.

- PT FOUND -Select the appropriate response.
- LOC -Select the appropriate response to both questions.
- AIRWAY -Select the appropriate response.
- BREATHING -Select the appropriate response.
- CIRCUL -Select the appropriate response to each question.
- GCS -Select Adult or Pedi and answer appropriately.
- SKIN -Select the appropriate response.
- EYES -Select the appropriate response question.
- NEURO -Select the appropriate response to each question when a stroke assessment is completed.
- BLOOD SUGAR -Document the blood sugar, select High or Low if indicated on the Glucometer. Repeat Blood sugar documentation is required for a treat and release of a person treated for a hypoglycemic event.
- ECG -Select the appropriate response to each question as applicable. If an ECG is conducted, whenever possible a merge and attach with the LifePak and the ePCR must be completed.
- EtC02 -Required on all intubated patients.
- SCORES / PAIN -Required for any patient that complains of pain.
- SCORES / APGAR –if applicable**.**

PHYSICAL

This section is used to document those findings that are observed. You are required to document the areas which are positive for findings and those which are suspected due to the patent's complaint. This area is where pertinent negatives of a physical assessment would be recorded. Many physical findings have additional details that are required to fully document the assessment and shall be completed where appropriate.

IMPRESSION
This section is used to document your impression of the present illness or complaint. Many of the impressions have additional details that are required to fully document your findings.

HX PRESENT
COMPLAINT
This section is used to document what the patient tells you, or why others, such as family or a bystander, called. This is where the patient's “chief complaint" will be documented. Many of the complaints have additional details that are required to fully document the patient's history of present illness.

SYMPTOM
This section is used to document the symptoms that the patient and/or bystanders use to describe the associations with the chief complaint and secondary symptoms. Many of the symptoms have additional details that are required to fully document the patient's history of present illness. This area is where pertinent negatives of the present complaint will be recorded.

CAUSE
The cause is what you suspect is the origin of the present illness. Many of the causes have additional details that are required to fully document the patient's history of present illness.

HXPAST
ALLERGIES
Document the patient's allergies as appropriate.

MEDS
Document the patient's medications.

PREEXIST
Document the patient's preexisting medical conditions. Pertinent negatives of preexisting medical conditions may also be documented here.

TREAT
PROCEDURE
Document all treatments given to the patient in the order in which they were given as well as changes in the patient's condition that are observed following treatment. Many of the treatments require additional details. Below are some common procedures with mandatory documentation details.

OUTCOME
RESULT
- DEPARTED -Enter the time your unit left the scene.

- AT DESTINATION -Enter the time your unit arrived at the hospital.
- DISPOSITION -Check the factors that apply.
- CURRENT DISPOSITION -Select AFTER choosing all factors that apply to disposition.
- MEDICAL CONSULTANT -Select the appropriate response when applicable.

TRANSPORT

- DESTINATION -Choose the hospital the patient was transported to.
- REASON FOR TRANSPORT -Select the reason for transport.
- REASON FOR DESTINATION -Select the reason for destination
- HOSPITAL PT# -Record the patient's hospital number if available.

SIGNATURE

Capture the signature of crewmembers, patient, patient representative, or facility representative in accordance with the "Patient Signature Requirement" SOP as applicable.

NARRATIVE

TEXT

After reviewing the report, the NARRATIVE TEXT of the ePCR should be completed as the sequence of events took place, from arrival until the patient's transfer of care. All treatment initiated by BLS and ALS units on each patient will be documented on each report. When entering text in this section, choose the appropriate category from the drop-down.

Unusual Occurrence Reporting

Supersedes: 09-24-10
Effective: 06-29-18

PURPOSE

Boston EMS recognizes that competent and caring professionals will occasionally make mistakes, and the intent is to create a "just culture" atmosphere where an employee can openly discuss errors of commission or omission, process improvements, and / or systems improvements without fear of reprisal. A just culture does not mean personnel will not be held accountable for their actions. When sub-standard performance is revealed after careful collection of facts, and/or there is reckless or willful violation of policies or negligent behavior, corrective or disciplinary action may be appropriate. Errors and accidents should be tracked in an attempt to establish trends and patterns to learn from them and prevent reoccurrence, thus improving patient safety and the delivery of care. Error and "near miss" reporting are critical components of any patient safety and risk management program. The purpose of this procedure is to set forth guidelines for the immediate identification, reporting, and documentation of an unusual occurrence in order to ensure timely notification and appropriate response to the situation.

DEFINITION

For the purposes of this procedure, an "unusual occurrence" is defined as any situation involving Boston EMS personnel, property, or equipment which is not consistent with routine operations or routine care of a particular patient, or any incident which results in an injury or is reasonably likely to result in a complaint or negative public attention. Such occurrences include, but are not limited to, the following examples:

1. An incident that results in exacerbation, complication, or other deterioration of a patient's condition not ordinarily expected as a result of the patient's condition.

    1.1. Medication Errors and omissions, such as inappropriate drug choice, dosage, or route.
    1.2. Treatment errors: failure to properly assess, initiate or administer care in accordance with established treatment protocols, resulting in serious injury;
    1.3. Equipment failure or user error which delays or otherwise interferes with patient care;

2. Violence toward EMS providers that results in injury or delays the provider from providing appropriate care;

3. An injury occurring to a patient or bystander after Boston EMS personnel have arrived on scene;

4. Any verbal and/or physical altercation between an EMS provider, patient and/or bystander. Including those that may occur in defense of one's self or another. Similarly, any department member who witnesses such interaction has an obligation to report the unusual occurrence.

5. An incident involving a patient transfer (ambulance stretcher, stair chair, backboard, etc.) that results in a mechanical failure of equipment and / or the patient being dropped, regardless of whether or not the patient sustained an injury.

6. Damage to personal property by a member of Boston EMS, except for intentional damage as part of patient assessment or care (e.g. cutting clothes, etc.)

7. Theft of any EMS property or equipment; fire affecting an EMS vehicle or property

8. Any call entry, dispatch, or response error which significantly delays the arrival of appropriate resources to the scene of an emergency (e.g.: call entry with wrong section of the City; canceling an incident as a "duplicate" when in fact it was a separate incident; failure to enter an incident into the CAD system, responding to the wrong location, etc.).

NOTIFICATION

1. When an unusual occurrence is noted, the Department member shall complete the assignment without delay and without compromising patient care.

2. A department member with direct knowledge of an unusual occurrence shall notify a Supervisor as soon as possible. A department member who hears another unit reporting a vehicle fire via the radio, for example, does not have direct knowledge of the incident and is therefore not required to notify a supervisor. However, the crew of the vehicle involved does have direct knowledge and is required to notify a supervisor. Similarly, a unit sent to an address in one section of the City but then cancelled because the incident is actually in another section of the City is not required to report the incident. However, the dispatcher who did a call back and discovered a potential call entry error would be required to notify the supervisor if it resulted in a delayed EMS response.

3. When directed by a supervisor, each member involved shall complete an incident report noting relevant information concerning the incident. The Supervisor shall then forward all reports to Professional Standards for review.

Read more about Just Culture and Sentinel Event reporting at the Joint Commission website: http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_43.htm

HAZMAT / PPE

Biohazard Detection System

Supersedes:
Effective: 05-20-04

The Biohazard Detection System (BDS) is an environmental detection device designed to detect anthrax in certain postal facilities using an automated air sampling and internal testing system. This system is now operational at the South Boston Postal Annex. The Postal Annex is the largest mail processing facility in New England and consists of two large buildings that have separate HVAC systems. The BDS operates in only one of these buildings (commonly referred to as "the new building").

Sampling and Testing: BDS continuously collects air samples in the area of pre-identified aerosol-generating machines. Every 30 minutes a sample is analyzed by an automated polymerase chain reaction (PCR) test. A positive PCR test results in a "positive BDS signal" which triggers the system to sound an alarm. These systems are specifically designed to detect *B. anthracis* (anthrax). Sensitivity and specificity of these tests are high, but a false positive is expected to occur about once a year. Any environmental specimen positive by BDS testing will automatically have subsequent confirmatory testing done at the Massachusetts State Laboratory Institute. Confirmatory testing consists of PCR and culture. PCR test results at SLI are expected to be available within 8-12 hours of the BDS alarm.

PROCEDURE

1. Initial Notification

    1.1. In the event of a Biohazard Detection System (BDS) alarm at the South Boston Postal Annex, a unit supervisor from the United States Postal Service (USPS) will call 9-1-1 and request to be transferred to EMS. Simultaneously, the BDS machine will send an automatic notification to 19 other agencies, including the FBI and Department of Homeland Security.

    1.2. The Boston EMS calltaker will enter the call using the TYPE Code "**BIOC**" with comments indicating an activation of the BDS Alarm system, whether there were any reported injuries, and other pertinent information.

2. Building Evacuation

    2.1. In the event of a BDS alert, any potentially aerosol-generating equipment will be shut down to minimize the extent of contamination. HVAC units serving the production/processing area will be shut down, and all elevators in the old and new buildings will be shut down.

2.2. All employees and persons at the South Boston Postal Annex will be evacuated according to pre-determined risk groups to a designated area to minimize cross-contamination.

3. EMS Response and Notifications

3.1. Upon receipt of a BDS Alarm activation with evacuation, Boston EMS will dispatch the following units, when available: 1 ALS, 2 BLS, Division Supervisor, Shift Commander

3.2. The Boston EMS Supervisor will transmit the "**BIOC"** and "**PHC"** Group pages with pertinent information.

3.3. The CMED Operator will notify the Conference of Boston Teaching Hospitals (COBTH) via the disaster radio that there has been a BDS Alarm at the South Postal Annex, and that further information will be forthcoming when available.

4. On-Scene Decontamination

4.1. A decontamination shower will be done at the facility for those at highest risk of exposure (those who were in the immediate area of a high pressure generating postal processing machine). As part of an interim plan, persons at moderate risk (those on the production floor, but not in close proximity to high pressure generating postal processing machines) will also be offered a decontamination shower on site.

4.2. Decontamination is not being recommended for persons who were in not in the "new building" around the time of the BDS alert.

5. Post-Exposure Prophylaxis (PEP):

5.1. Post-exposure antibiotics and vaccine are used for the prevention of inhalational anthrax.

5.2. Post-exposure prophylaxis (PEP) will be initiated only after PCR testing at the SLI confirms anthrax.

5.3. If antimicrobial prophylaxis is necessary, a post event prophylaxis (PEP) clinic will take place the following morning for all appropriate South Boston Postal Annex employees. Individuals will be given a five-day supply of antibiotics while awaiting culture results from the SLI.

5.4. If the culture results from the SLI are positive, a 60-day course of antibiotics and a 3-dose regimen of anthrax vaccine (using IND protocols) will be initiated.

5.5. South Postal Annex employees who present for post exposure prophylaxis following a BDS alert can be referred to the PEP clinic. In addition, symptomatic employees should be evaluated for potential anthrax.

5.6. Additional information on treatment and PEP clinics will be provided to health care providers should a BDS alert be confirmed.

Body Armor

Supersedes: 09-20-01
Effective: 10-31-14

The Department issued body armor provides significant protection against fired projectile penetration and many other forms of blunt trauma. The armor, while not certified to resist direct stabbing objects, can provide additional protection against slashing.

Many armor wearers have reported surviving falls and reducing the effects of blunt trauma forces, such as those incurred in MVCs, as a direct result of wearing their body armor. The Department strongly encourages each member to wear their body armor to afford themselves such protection.

For the purposes of this Standard Operating Procedure, "body armor" shall include the ballistic panels, undergarment carrier and the brown nylon external- wear utility vest.

1. Department members will maintain their issued body armor in good, clean condition, while keeping in mind that wet or humid conditions potentially degrades the efficiency of the system. Any damage to the body armor must be reported to the Materials Management manager immediately.

2. A lost or stolen vest represents a significant risk to other public safety agencies and a monetary loss to the department. Department members will secure their equipment in a safe place and exercise due diligence in maintaining control over the equipment at all times.

3. If body armor is lost or stolen, Department members must immediately file a police report in the municipality where the incident occurred. Copies of said police reports, and a Department incident report, must be filed immediately with the Bureau of Professional Standards and the Materials Management Manager.

4. Department members are required to secure their body armor in their assigned vehicle while on duty and to maintain it in a condition of operational readiness.

Carbon Monoxide Exposure: Dräger PAC 3500 & RAD-57

Supersedes: 10-23-06
Effective: 12-02-13

PURPOSE
Carbon monoxide poisoning is one of the single most common poisoning exposure in the United States. Carbon monoxide, or CO, is an odorless, colorless gas that can cause sudden illness and death. Carbon monoxide is found in combustion fumes, such as those produced by cars and trucks, gasoline engines, camp stoves, lanterns, burning charcoal and wood, gas ranges, heating systems, generators and poorly vented chimneys. Structural fires are another common source of CO exposure for both victims and fire fighters. Carbon monoxide from these sources can build up in enclosed or semi-enclosed spaces. Breathing it can poison people and animals in these spaces. All people and animals are at risk for carbon monoxide poisoning Certain groups including pregnant women/fetuses, infants, and people with chronic heart disease, anemia, or respiratory problems are more susceptible to its effects.

CO toxicity causes impaired oxygen delivery and utilization at the cellular level. CO affects several different sites within the body but has its most profound impact on the organs with the highest oxygen requirement (e.g., brain, heart). Misdiagnosis commonly occurs because of the vagueness and broad spectrum of complaints. Symptoms often are attributed to a viral illness, frequently “the flu” in winter months. It is important to remember that symptoms may not correlate well with measured HbCO levels.

The following list includes commonly recognized symptoms associated with carbon monoxide poisoning. Any of the following should alert suspicion if related to a potential source of CO and when more than one patient in a group or household presents with similar complaints at the same time:

Malaise, flu-like symptoms	Dyspnea on exertion	Coma
Chest pain, palpitations	Lethargy	Headache, drowsiness
Confusion, fatigue	Depression	Syncope; seizure
Impulsiveness	Distractibility	Dizziness; weakness
Hallucinations	Agitation	Memory / gait disturbance
Nausea, Vomiting, Diarrhea	Visual Disturbance	Abdominal Pain, Incontinence

Carbon monoxide should be a diagnosis of exclusion, within the scope of pre-hospital practice. Common, identifiable causes of the above symptoms should be entertained. For example, hypoglycemia or drug overdose.
Not just a winter phenomenon, carbon monoxide poisoning has been seen in other climates and seasons after natural disasters, when residents use generators or pumps

which are not properly ventilated. Any process which burns fuel [gasoline, diesel, kerosene, propane, natural gas, charcoal, wood etc.] in an engine, heater or construction equipment can emit CO
Additional information that is helpful in assessing carbon monoxide exposure includes presence of detectors as well as environmental readings on the environment available from BFD, Inspectional Services or utilities such as Keyspan or National Grid.

DRÄGER PAC® 3500

The Drager Pac 3500 single gas monitor is designed for industrial personal monitoring applications, and can quickly detect carbon monoxide in the range of 0-500 parts per million (ppm). The device has two alarm settings: Alarm 1: ≥ 35 ppm, and Alarm 2: ≥ 50 ppm. In addition to a vibrating alarm, the Drager Pac 3500 emits an audible, multi-tone signal and a clear, 360 degree visual alarm via bright flashing LEDs at the top and base of the instrument.
When Alarm 1 (≥ 35 ppm) has been activated, the user can hit the "OK" button to silence the audible alarm, but it will continue to vibrate as long as it detects CO of 35 ppm or greater. When Alarm 2 (≥ 50ppm) has been activated, the audible alarm can not be silenced until CO levels are below 50 ppm.
When operating in area scene where elevated levels of carbon monoxide are suspected, personnel should direct all those potentially exposed to a ventilated area as quickly as possible, and notify the appropriate ancillary agencies.
The Drager Pac 3500 CO Detector is to be attached to the green oxygen bag so one is present on every response. Whenever the device is noted to be missing, damaged, or has an error/service message (a black "X" on the display), notify a supervisor.

RAD-57 OPERATION

The Rad-57 Handheld Pulse CO-Oximeter with Masimo Rainbow® SET® Technology is a noninvasive, arterial oxygen saturation and pulse rate monitor. The Rad-57 features a multicolored LED display that continuously displays numeric values for SpO2, Perfusion Index (PI) and pulse rate (PR), a Low Signal IQ Indicator (Low SIQ) indicator, alarm status, alarm silence and battery life.

SpO2 General Description

Pulse oximetry is a continuous and non-invasive method of measuring the level of arterial oxygen saturation in blood. The measurement is taken by placing a sensor on a patient's fingertip; avoid using small finger or thumb as it relies on signals bounced off the bone: (thumb is too dense and small finger not dense enough). The sensor connects to the pulse oximetry instrument with a patient cable. The sensor collects signal data from the patient and sends it to the instrument. The instrument displays the calculated data in two ways: as a percent value for arterial oxygen saturation (SpO2), and as a pulse rate (PR)

SpCO General Description

Pulse CO-Oximetry is a continuous and non-invasive method of measuring the levels of carbon monoxide concentration (SpCO) in arterial blood. It relies on the same basic principles of pulse oximetry (spectrophotometry) to make its SpCO measurement. The measurement is obtained by placing a sensor on a patient. The sensor collects signal data from the patient and sends it to the instrument. The Rad-57 displays the calculated data as percentage value for the SpCO, which reflect blood levels of carbon monoxide bound to hemoglobin.

- As with all biological sensors, dropping the device might lead to damage. The finger probe is not compatible with other devices. The finger probe should be kept with the device at all times. The device should also not be submerged or be exposed to very wet conditions.
- Do not use the Rad-57 or sensor during defibrillation.
- The Rad-57 will display a standard O2 saturation (SpO2) and perfusion index.
- Make sure the probe is seated on the finger, with light sensors going thru the nailbed
- The sensing light for the Rad-57 is sensitive to certain waves of light, shielding probe under clothing, blanket or with your hand may be helpful if you are not getting a reading with the Rad-57.
- To change to the carboxyhemoglobin display, press the button labeled 'SpCO'. The carboxyhemoglobin will be displayed as a number on the upper readout as '%SpCO'. The Rad-57 can be used to spot check patients, as trending is not necessary in most situations.
- All elevated readings above 12% should be reconfirmed on another digit

The SpCO reading is to be use as a screening measure. Definitive carboxyhemoglobin determinations should be performed via blood draw. The level in combination with signs and symptoms will assist the physician in making determinations about treatment options. In the prehospital setting any patient with suspected carbon monoxide poisoning should receive oxygen by a non-rebreather mask, unless otherwise contraindicated.

TREATMENT

Rad-57 readings should not be the sole determining factor in treating carbon monoxide exposure. Like any biological monitor, data should be considered in combination with history of exposure (chronic vs. acute) with attention to signs, symptoms and any special considerations. Treat all possibly exposed patients with high concentration oxygen if there is any doubt.

0-5%	Considered normal in non-smokers. When >3% with symptoms, consider high flow oxygen and evaluate environment for CO sources. Consider measuring others in the same room/office/vehicle as patient
5-10%	Considered normal in smokers, abnormal in non-smokers. If symptoms are present, consider high flow oxygen and inquire if others are ill.
10-15%	Abnormal in any patient. Assess for symptoms, provide high-flow oxygen.
>15%	Significantly abnormal in any patient. Administer high-flow oxygen, assess for symptoms.
>25%	Consider transport to hyperbaric facility.

SPECIAL CONSIDERATIONS

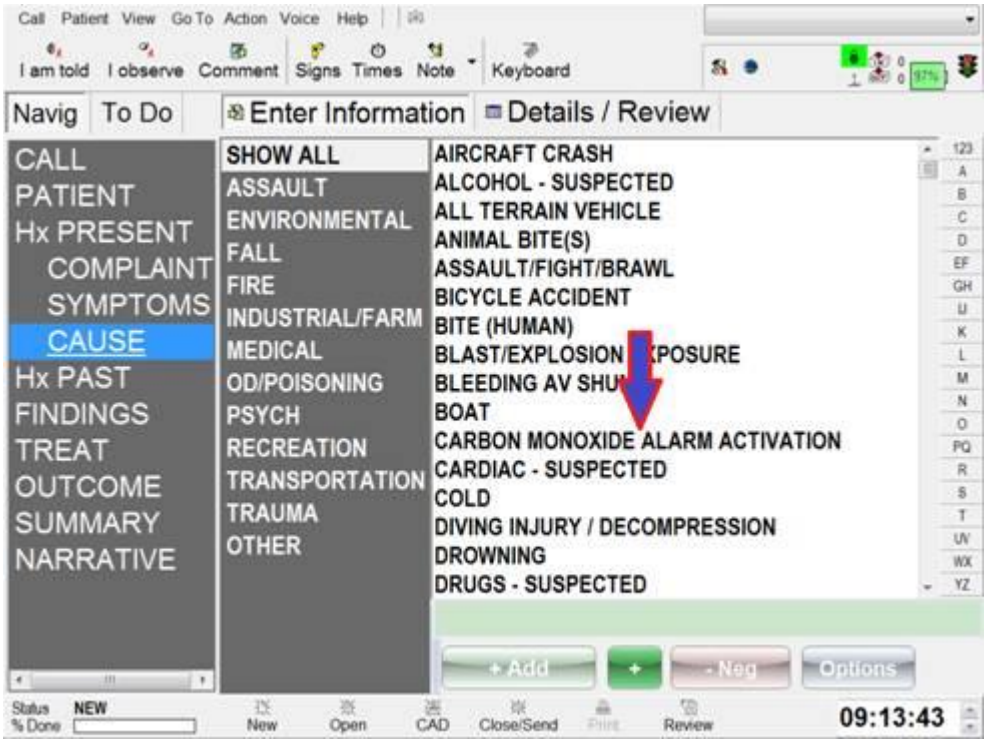
Pregnant Women

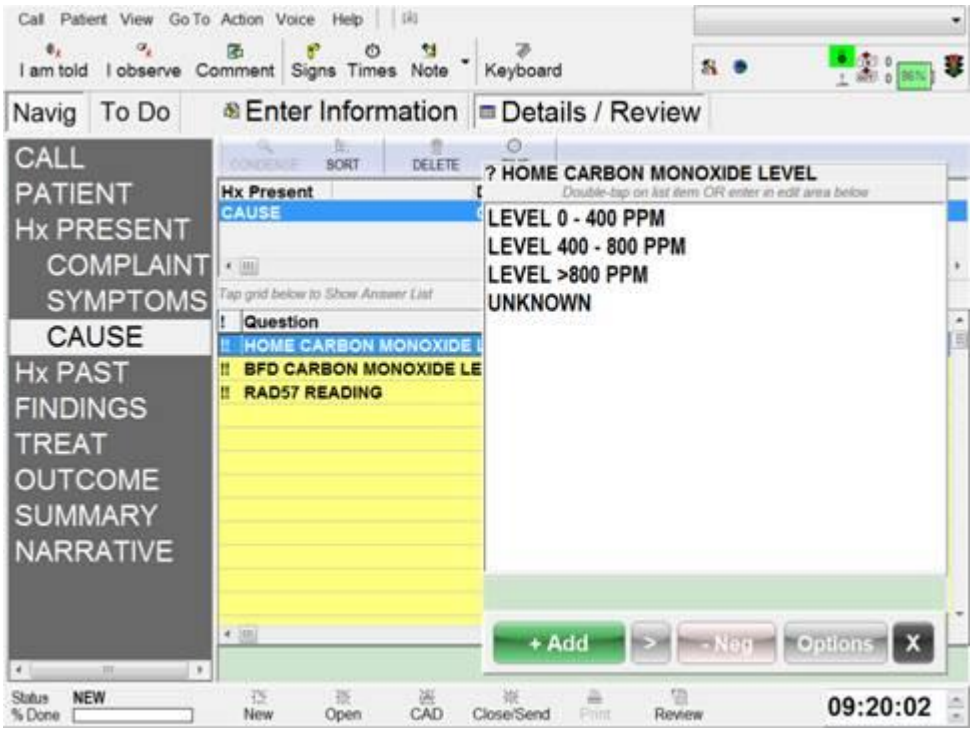
Pregnant women maybe at higher risk in carbon monoxide situations. This is because of the increased susceptibility of the fetus to the effects of carbon monoxide. The fetal SpCO% maybe 10-15% higher than the maternal readings. All pregnant women with possible CO exposure should be encouraged to have definitive COHb blood levels and physician evaluation.

Multiple Patient Events
The Rad-57 could be most useful as an early screening tool. It may prove to be helpful in decisions to prioritize patients for transportation and in selecting hospital destinations for a multiple casualty incident.

The Rad-57 does not have to be turned off between multiple patient use. However, if you remove the sensor from one patient, be sure to completely close the sensor clip for a minimum of five seconds before reapplying to a new patient. Closing the sensor clip for at least five seconds signals to the device that the probe is off and the RAD-57 will stop all monitoring activity before beginning a new measurement.

DOCUMENTATION
Patient's SpCO% reading must be documented as part of the Patient Care Report. In the case of a multiple patients, the SpCO% should also be documented on triage tag. SafetyPAD has been customized to allow for documentation of findings in suspected carbon monoxide exposure cases.

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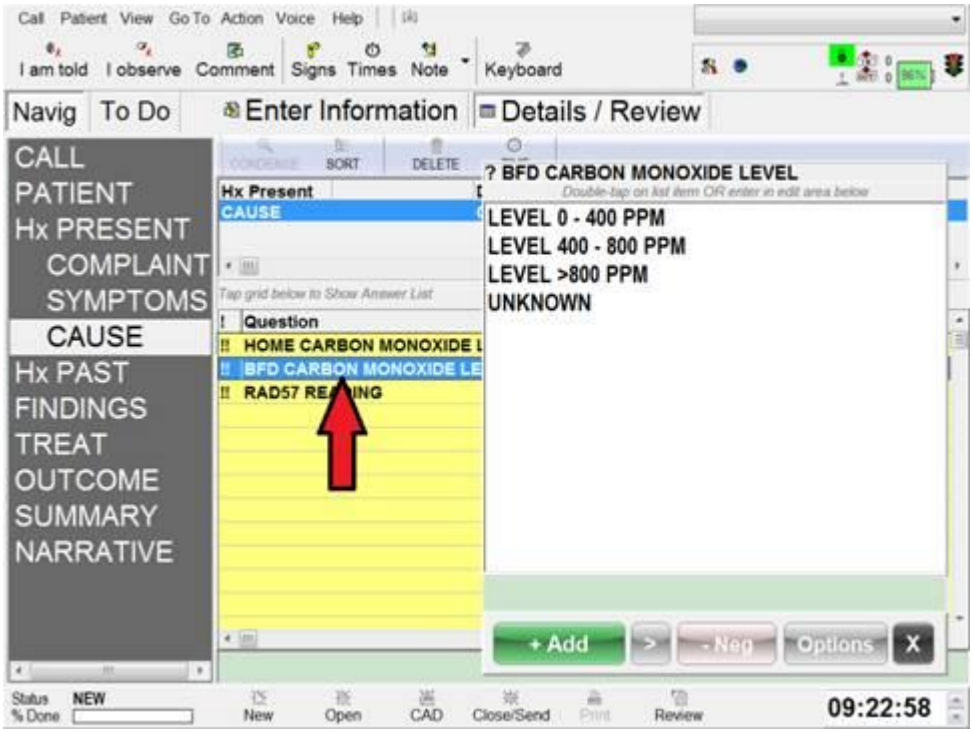
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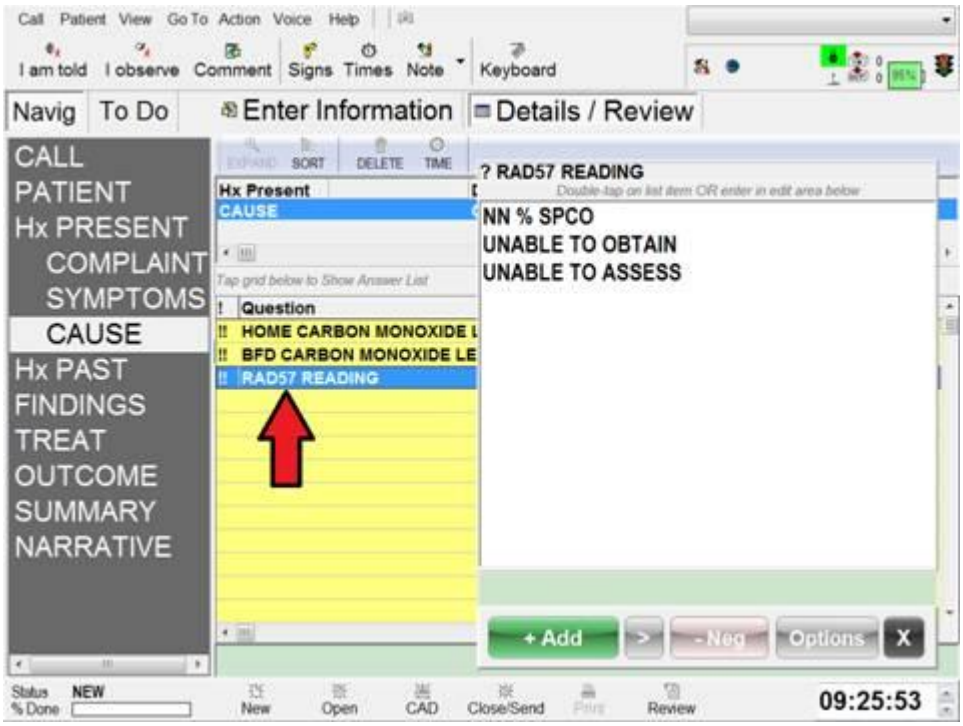
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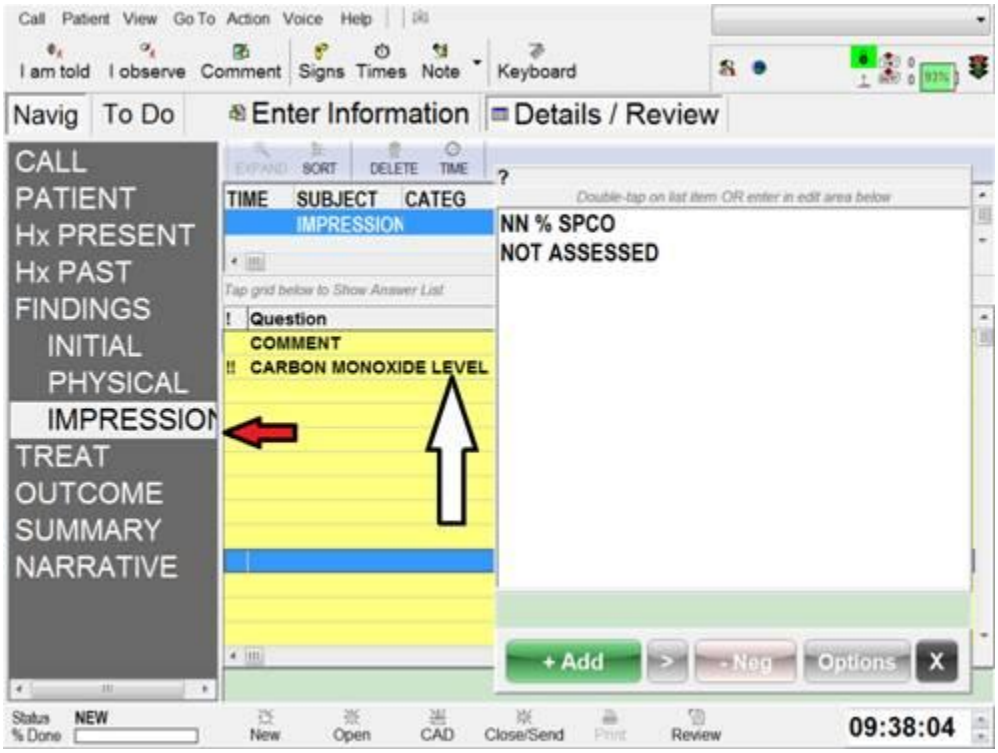
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Cyanide Antidote Kits

Supersedes:
Effective: 11-24-03

As a result of funding from The U.S. Department Homeland Defense, BEMS is increasing its level of supplies, antidotes and antibiotics to respond to a variety of CBRNE threats. One goal was to increase our supply of cyanide antidote kits. Effective immediately two kits will be issued to every ALS unit. In addition two kits will be issued to the Shift Commander. A much larger cache of antidote will be staged and available for rapid deployment. The use of these kits is a medical control option. Please take the time to review this document and inspect the antidote kits in your ambulances.

Cyanide is available in several forms. It can exist as a salt, such as sodium or potassium cyanide. Or as a liquid that can form a gas, as is found with cyanogens chloride, which can have an irritating, pungent odor and is also less volatile. Hydrogen cyanide can also exist as a liquid, but is easy to volatilize and poses a significant inhalation risk. It can be a hazard for many routes of entry: dermal, ingestion and most importantly inhalation route of exposure. Many people cannot smell the characteristics “bitter almond” odor of hydrogen cyanide, so this should not be used as an absolute criteria for considering cyanide exposure. Most cyanide forms cause rapid symptoms, effects of the poisoning can be seen within several minutes of exposure.

The various forms of cyanide are used for industrial purposed: electroplating, photo processing, metal recovery and fumigation. Cyanides can also be found in laboratories. Protective equipment should be donned whenever approaching a patient that could be contaminated with one of the cyanide forms. Personnel approaching a suspected or confirmed cyanide incident should not enter the warm or hot zone.

Scott AV 2000 and MPC plus canister will provide approximately 30 minutes of protection under escape and evasion/relocation circumstances. Scott air-pack (supplied air respirator) will provide more protection. Open spaces will decrease the risk and level of potential exposure to a cyanide contamination.

Patients with liquid, solid (sodium or potassium cyanide) or gas exposure should be decontaminated prior to contact with BEMS personnel. Patients that have been determined to be **fully decontaminated** can be approached using department issued protective turn out gear and are safe to receive medical attention without respiratory protection. If there is any doubt as to a patient’s decontamination status the crew should immediately don their Scott AV 2000 with MPC plus canister while relocating to a safe area, uphill and upwind.

Treatment of the patient with known or suspected dermal contamination should only be undertaken by personnel who have been trained to the 40-hour hazardous materials response level. Personnel will don respiratory and dermal protection (level b chemical protective suit) to respond to direct patient care issues, this will be undertaken when issued and authorized by the incident commander.

SIGNS AND SYMPTOMS OF CYANIDE EXPOSURE

Cyanogen Chloride: Be aware that initial and low dose exposure might be those of irritation after exposure to cyanogens chloride, similar to other irritant gasses such as pepper spray. However, typical irritant gasses will not be associated with more serious symptoms of seizures, respiratory or cardiovascular collapse.

- In low doses
  - Bronchorrhea
  - Lacrimation
  - Rhinorrhea
- In moderate doses
  - Transient hyperpnea
  - Feelings of anxiety or apprehension
  - Vertigo
  - Nausea and/or vomiting
  - Prolonged prodrome prior to loss of consciousness
  - Seizures
  - Bradypnea followed by apnea
  - Cardiac arrest
- In high doses
  - Transient hyperpnea
  - Seizures 15-30 seconds later
  - Apnea 2-3 minutes later
  - Cardiac arrest 6-8 minutes post exposure
  - Onset possibly takes several minutes, except for immediate irritant effects

Hydrogen Cyanide:

- Symptoms after exposure to lower vapor concentrations or after ingestion and/or liquid exposure
  - May be several minutes before onset
  - Transient hyperpnea
  - Feelings of apprehension or anxiety
  - Vertigo
  - Feeling of weakness
  - Nausea with or without vomiting
  - Muscular trembling
  - Progression of symptoms to unconsciousness
  - Bradypnea followed by apnea
  - Convulsions
  - Cardiac dysrhythmias followed by cardiac arrest
- Symptoms after high vapor exposure
  - Transient hyperpnea and hypertension 15 seconds after inhalation
  - Convulsions 15-30 seconds later
  - Respiratory arrest 2-3 minutes later
  - Bradycardia, hypotension, and cardiac arrest within 6-8 minutes of exposure

Antidote/Treatment of Patients suffering from cyanide poisoning

- Pre-oxygenation using BVM or Non-rebreather facemask, patients with low dose exposures might only require oxygen therapy, antidotal therapy best saved for those with moderated to severe exposure
- Amyl nitrite ampoule are to be used if intravenous access is not yet available
- Cyanide antidote kit is a medical control option

Part I of Cyanide Antidote Kit

Amyl nitrite (Isoamyl Nitrate) -- Ampoules can be crushed into gauze and inhaled or broken into an Ambu bag and ventilated into the patient; only a temporary measure until IV access is obtained.	
Adult Dose	1 amp (0.2 mL) for 30-60 sec along with 100% oxygen until IV access is obtained
Pediatric Dose	Not Established
Contraindications	Documented hypersensitivity; severe anemia; closed-angle glaucoma; head trauma; postural hypertension and hypotension; cerebral hemorrhage
Interactions	Co-administration with alcohol may cause severe hypotension and cardiovascular collapse; with calcium channel blockers, may produce symptomatic orthostatic hypotension; aspirin may increase nitrate serum concentrations
Pregnancy	C- Safety for use during pregnancy has not been established
Precautions	Can cause severe methemoglobinemia in overdose or in those with G-6-PD deficiency; in rare instances has caused hemolytic anemia

Part II of Cyanide Antidote Kit

Sodium nitrite -- DOC if IV access is available. Creates methemoglobinemia more effectively than amyl nitrite. This dose assumes hemoglobin level of 12 mg/dL; dosage adjustment necessary in patients with anemia. Half original dose may be repeated in 1 h if patient continues to exhibit signs of cyanide toxicity.	

Adult Dose	300 mg (10 mL 3% sol) IV over 5-20 min; slow infusion if patient develops hypotension
Pediatric Dose	0.33 mL/kg of 10% solution IV over 5-20 min, not to exceed 300 mg
Contraindications	Documented hypersensitivity; severe carbon monoxide poisoning
Interactions	May potentiate hypotensive effects of other medications
Pregnancy	C - Safety for use during pregnancy has not been established
Precautions	Can cause severe methemoglobinemia in overdose or in those with G-6-PD deficiency; in rare instances has caused hemolytic anemia

Part III of Cyanide Antidote Kit

Sodium thiosulfate (Tinver) -- Acts as donor of sulfane sulfur, which is used as a substrate by rhodanese and other sulfurtransferases for conversion of cyanide to thiocyanate. DOC for treating cyanide toxicity with concomitant carbon monoxide poisoning.	
Adult Dose	12.5 g (50 mL) IV delivered over 10 min; repeat at half initial dose in 1 h if symptoms persist
Pediatric Dose	1.65 mL/kg of 25% solution over 10 min, not to exceed 12.5 g; repeat in 1 h at half initial dose if symptoms persist
Contraindications	Documented hypersensitivity
Interactions	None reported
Pregnancy	C - Safety for use during pregnancy has not been established.
Precautions	Rapid IV infusion may cause transient hypotension and ECG changes

Source: emedicine

Helmet Use

Supersedes:
Effective 9-20-01

The Department issued helmet provides significant protection to the head and portions of the face, with the face shield deployed, against falling objects or other objects in motion. Additionally, the helmet serves as a personnel location marker and identifies Department affiliation and rank.

For the purposes of this Standard Operating Procedure, the term "helmet" shall include the protective outer shell, fire retardant liner/neck protector, internal suspension and sizing system, and an attached faceshield and/or accompanying Department issued goggle set.

1. Department members will maintain their issued helmet in good, clean condition. Any damage to any part of the helmet must be reported to the Support Services Manager.

2. A lost or stolen helmet represents a significant lack of protection to the employee and a monetary loss to the Department. If a helmet is lost or stolen, the Department member must immediately file a police report in the municipality where the incident occurred. Copies of said police reports, and a Department Incident Report, must be filed immediately with the Bureau of Professional Standards and the Support Services Manager.

3. Department members are required to secure their helmets in their assigned vehicle while on duty and to maintain it in a condition of operational readiness.

4. Under the following circumstances, wearing the Department issued helmet is **mandatory:**

   4.1. Any fire operations stand-by;
   4.2. Any police tactical operations stand-by;
   4.3. Airport phase incidents;
   4.4. Construction sites or other posted "hard hat required" areas, and within 50 feet of the site;
   4.5. Any extrication involving heavy rescue tools;
   4.6. Any incident where there is a potential of falling debris;
   4.7. Below grade operations such as tunnels, construction, transit system pits, manholes, or similar conditions;
   4.8. Incidents of civil unrest or other public disturbance;
   4.9. Incidents where cable/wire are under tension;
   4.10. At the discretion of a supervisor where the safety, location, identity of Department personnel would be enhanced.

Isolation and Quarantine

Supersedes:
Effective: 11-05-2003

Boston Public Health Commission Regulation for the Isolation and Quarantine of Individuals with Infectious Disease Dangerous to the Public Health

WHEREAS, the recent epidemic of SARS (Severe Acute Respiratory Syndrome) necessitated large scale quarantines in Asia and Canada;

WHEREAS, additional new infectious diseases are expected to arise and require public health containment measures, and;

WHEREAS, the continued threat of bioterrorism, presents public health issues, unprecedented in modern times, that may require the isolation or quarantine of individuals; and,

WHEREAS, the laws of the Commonwealth of Massachusetts requires that a board of health investigate diseases dangerous to the public health and take such measures as may be necessary to prevent the spread of such disease, including the use of isolation and quarantine.

NOW THEREFORE the Boston Public Health Commission enacts the following regulation, to be adopted for the express purpose of protecting the public health from Infectious Disease Dangerous to the Public Health.

I. Definitions

Health Care Provider. Any doctor of medicine, osteopathy, or dental science, or a registered nurse, social worker, doctor of chiropractic, or psychologist licensed under the provisions of chapter one hundred and twelve, or an intern, or a resident, fellow, or medical officer licensed under section nine of said chapter one hundred and twelve, or a hospital, clinic or nursing home licensed under the provisions of chapter one hundred and eleven and its agents and employees, or a public hospital and its agents and employees or any Emergency Medical Technician as define in M.G.L. c. 111 section 1.

Infectious Disease Dangerous to the Public Health. For the purpose of these protocols shall mean all diseases reportable to a local board of health pursuant to 105 CMR 300.100, any uncommon, unusual or rare diseases reportable pursuant to 105 CMR 300.133 or any illness believed to be part of an outbreak or cluster reportable pursuant to 105 CMR 300.134.

Isolation. Separation, for the period of communicability, of infected persons from others in such places and under such conditions as will prevent the direct or indirect transmission of an infectious agent to susceptible people or to those who may spread the agent to others. This applies also to animals.

Quarantine. Restricting the freedom of movement of well persons who have been exposed to a communicable disease for a period of time relating to the usual incubation period of the disease, in order to prevent effective contact with those not so exposed.

II. Guidelines

The Executive Director of the Boston Public Health Commission may issue guidelines for the implementation of this regulation, including but not limited to definitions of terms as used in these regulations and in the guidelines. In the event of a conflict between these regulations and the guidelines, as either may be amended, the regulation shall control.

III. Duty to Report

1. Cases or suspected cases of any infectious disease dangerous to the public health, shall be reported by household members, physicians and all other health care providers in the City of Boston, by telephone, in writing, facsimile or other electronic means, as approved by the Executive Director, immediately but in no case more then 24 hours after diagnosis or identification. When available, name, date of birth, age, sex, address, place of employment, school and disease must be included for each report.

2. Failure to report, report in a timely manner or provide adequate information regarding any infectious disease dangerous to the public health may result in the assessment of a fine pursuant to Section X of this regulation.

IV. Investigation

A. Threat assessment

1. Upon notification that a infectious disease dangerous to the public health, including those diseases listed in 105 CMR 172.001, may exist in the City of Boston, the Director of the Communicable Disease Control for the Boston Public Health Commission (hereinafter “Director”) shall authorize the investigation into the existence, source, spread and effect of such disease.

2. The Director shall notify the Executive Director of the Boston Public Health Commission (hereinafter “Executive Director”) and appoint such Officers as are necessary to complete the investigation in a timely manner.

3. The investigation shall have priority access to resources of the Boston Public Health Commission and shall conduct such interviews, tests, collection of samples and any other procedures as necessary.

4. All subjects of the investigation, including healthcare providers, shall cooperate to the fullest extent with all requests of the investigating officers. Failure to provide necessary information or otherwise cooperate shall be considered a violation of this regulation and may be the subject of a fine, isolation or quarantine.

B. Notification

1. During the investigation, the Director shall notify the Executive Director of the results of the investigation and provide a list of individuals who have been confirmed to be infected with the disease, persons exhibiting symptoms of the disease and persons who may have been significantly exposed to the disease.

2. If an infectious disease listed in 105 CMR 172.001 has been identified, the Executive Director or designee, shall notify the Massachusetts Department of Public Health pursuant to 105 CMR 300.110.

3. In addition, the Executive Director or designee shall notify each member of the Board of the Boston Public Health Commission.

V. Plan of Action

A. General Response

1. Based upon the findings of the investigation, the Director shall advise the Executive Director on a plan of action which shall include:
   a. Treatment protocols;
   b. Public Education strategies;
   c. Containment strategy; and,
   d. Risk assessment.

2. The Director shall issue written treatment guidelines and information sheets to healthcare providers, universities or other educational institutions and correctional facilities in the City of Boston, as appropriate.
   a. Such treatment guidelines shall be in accordance with good clinical practice, to the extent possible, with any treatment guidelines issued by the Center for Disease Control and Prevention and the Massachusetts Department of Public Health.
   b. Failure of any healthcare provider, university or other educational institution or correctional facility to provide treatment in accordance with said guidelines shall be a violation of this regulation and subject to a fine.

3. The Director shall update the plan of action on a regular basis as necessary.

B. Individual Response

1. All individuals who have been confirmed to be infected with the disease, exhibit symptoms of the disease or may have been significantly exposed to the disease shall be examined and be provided with the appropriate treatment protocols.

2. With the approval of the Director, an individual may obtain treatment from a private healthcare provider in accordance with

the prescribed treatment protocols and voluntarily comply with any isolation or quarantine provisions in the treatment protocols.

3. In an effort to ensure voluntary compliance the Director shall provide the individual with suitable material regarding the effects of the disease, guidelines for isolation or quarantine and follow up visits by Commission staff, as deemed necessary.

VI. Isolation

A. Determination of Need for Involuntary Isolation

1. If, in the opinion of the Director and the Medical Director of the Boston Public Health Commission (hereinafter "Medical Director") the course of treatment prescribed in the treatment protocols and voluntary isolation, is not sufficient to contain the spread of the disease the Director shall recommend that the Executive Director issue an order of isolation.

2. The Executive Director upon determining the individual or individuals in question are a significant threat to the public health may issue an order of isolation.

B. Order of Isolation

1. An order of isolation shall provide that the individual and all other individuals residing on the premises shall be under the jurisdiction of the Boston Public Health Commission and that violation of such order shall subject the offender to fines and/or arrest.

2. In addition the order shall contain the following:
   a. Name and identifying information of the individual(s) subject to the order;
   b. Brief statement of the facts warranting the isolation;
   c. Conditions for termination of the order;
   d. Duration of isolation period;
   e. The place of isolation;
   f. Required treatment protocols;
   g. Guidelines for visitation if allowed;
   h. Instructions on the disinfecting or disposal of any personal property of the individual;

i. Precautions to prevent the spread of the subject disease; and,
j. Individuals right to an independent medical exam and appeal procedures.

3. Upon determination of the Director that the individual is no longer a significant threat to the public health or upon the expiration of such time designated by the Order of Isolation, the individual shall be released from isolation, unless a further Order of Isolation is issued.

4. No Order of Isolation shall exceed fourteen (14) days in duration. If at the conclusion of the fourteen (14) day period the Director determines that the individual is still a significant threat to the public health, he/she shall so advise the Executive Director, who after reviewing the recommendations of the Director and any other relevant information may issue a further Order of Isolation.

5. Upon release from isolation, the individual shall still be under the jurisdiction of the Board until such time as the Director shall issue a Certificate of Health, certifying that the individual has completed the terms of the Order of Isolation and successfully completed the prescribed course of treatment.

C. Enforcement of Order of Isolation

1. Upon issuance of an order of isolation, the Director shall designate a facility in which the individual shall be confined. Such facility shall provide for, no contact with the public, suitable living space and any other amenity specified by the Director.

2. Isolation, whenever possible, shall be provided for in the residence of the individual if the residence provides a suitable area of isolation. At the request of the individual, the Director may approve an alternative place for isolation.

3. All places of isolation shall provide for minimum contact with the public.

4. The Emergency Medical Service Division of the Boston Public Health Commission shall be responsible for the transportation of an individual, if necessary, to the facility designated by the Director.

5. Security Officers of the Boston Public Health Commission or Boston Police Officers may assist in the transportation of the individual at the request of Boston EMS.

6. If the Director determines that there is a possibility that individual or individuals under an order of isolation may violate the conditions of the order, the individual shall be monitored by an agent of the Boston Public Health Commission. The agent may take such measures as are reasonably necessary to ensure that the individual does not violate the terms of the isolation.

VII. Quarantine

A. Determination of Need for Quarantine

1. If any individual, group of individuals or neighborhood, has been exposed to a communicable disease and in the opinion of the Director, pose a significant threat to the public health than the Director may seek an Order of Quarantine.

2. The Executive Director, upon the determination that the individual, group of individuals or a neighborhood exposed to or thought to have been exposed to the subject disease are a significant threat to the public health, and having further determined that there is no other reasonable means to prevent effective contact with those not so exposed, shall issue an order of quarantine.

B. Order of Quarantine

1. An order of quarantine shall provide that the individual, group of individuals or neighborhood shall be under the jurisdiction of the Boston Public Health Commission and that violation of such order shall subject the offender(s) to fines.

2. An order of quarantine shall contain the following:
   a. Name, identifying information or other description of the individual, group of individuals or geographic location subject to the order;
   b. Brief statement of the facts warranting the quarantine;

c. Conditions for termination of the order;
d. Specified duration of quarantine, not to exceed fourteen (14) days;
e. The place or area of quarantine;
f. No contact except as approved by the Director or designee;
g. Symptoms of the subject disease and a course of treatment;
h. Instructions on the disinfecting or disposal of any personal property;
i. Precautions to prevent the spread of the subject disease; and,
j. An individual's right to an independent medical exam and appeal procedures.

3. Upon determination of the Director that the individual, group of individuals or a neighborhood is no longer a significant threat to the public health or upon the expiration of such time designated by the Order of Quarantine, the individual, group of individuals or neighborhood shall be released from quarantine, unless a further Order of Quarantine is issued.

4. No Order of Quarantine shall exceed fourteen (14) days in duration. If at the conclusion of the fourteen (14) day period the Director determines that the individual, group of individuals or neighborhood, is still a significant threat to the public health, he/she shall so advise the Executive Director, who after reviewing the recommendations of the Director and any other relevant information may issue a further order of quarantine or isolation.

5. Upon release from quarantine, the individual, group of individuals or neighborhood, shall still be under the jurisdiction of the Board until such time as the Director shall issue a Certificate of Health, certifying that the individual, group of individuals or neighborhood, has completed the terms of the Order of Quarantine.

C. Enforcement of Order of Quarantine

1. The Director shall prescribe such steps as are necessary to ensure compliance with the order of quarantine, including periodic or continuous surveillance of the place or area of quarantine by an Agent of the Boston Public Health Commission.

2. All individuals who become infected with the subject disease shall be subject to an order of isolation.

D. Emergency Order of Quarantine

1. If an individual or group of individuals who, have been confirmed to be infected with, exhibit symptoms of or may have been significantly exposed to a contagious disease, arrive in the City of Boston by airplane, train, bus, ship or other form of transportation, the EMT, Paramedic or other Staff of the Commission responding to such notification, shall immediately advise the Director or designee by telephone.

2. Upon determination that the subject or subjects are confirmed to be infected with, exhibit symptoms of or have been significantly exposed to a contagious disease, the Director shall issue an emergency order of quarantine or isolation for the subject or subjects.

3. The subjects of such order shall be, at the discretion of the Director, transferred to the Boston Medical Center or such other suitable facility or detained at the place of disembarkation until such time as the Director may physically exam the subject or subjects.

4. Upon examination of the subjects, the Director shall notify the Executive Director with the appropriate plan of action.

VIII. Appeal Process

A. Examination by an independent physician

1. Each individual under an order of isolation or quarantine may request an examination by his/her treating physician or an independent physician.

2. All medical examinations shall be conducted in accordance with the specifications of the Director. No examinations may be conducted if in the opinion of the Director, such examination constitutes a threat to the public health.

3. Any examination by an independent physician shall not delay or otherwise impede the imposition of an order of isolation or quarantine.

B. Appeal to the Executive Director

1. Any individual subjected to an order of isolation or an order of quarantine or any authorized representative of such individual, including a treating physician, may appeal the order of isolation or quarantine to the Executive Director.

2. Any appeal contesting an order shall be in writing to the Executive Director, received by the Executive Director within forty-eight hours of the order or examination by a physician pursuant to Section VII A of this regulation, setting forth the reasons for the appeal.

3. The Executive Director may conduct a hearing with regards to the appeal. Any request for a hearing shall not be unreasonably denied. The Executive Director may appoint a hearing officer to conduct any hearing and find facts with regards to the order of isolation or quarantine. The Executive Director shall then make a written recommendation to the Chairperson of the Commission Board. The full record shall be made available to the Chairperson if so requested. The Chairperson shall accept, reject or amend the recommendation. The Chairperson's decision shall be the final decision of the Boston Public Health Commission.

4. Any appeal shall not delay or otherwise impede the imposition of an order of isolation or quarantine.

C. Review of an Order

1. Upon the expiration of an order, if the Director does not issue a certificate of Health, the Executive Director shall review the Order of Isolation or Order of Quarantine.

2. If it is the determination of the Director that the individual is a significant threat to the public health, the Executive Director shall determine the least intrusive methods of protecting the public health and issue the appropriate order in accordance with the protocols and procedures set forth above.

IX. Enforcement

1. Authority to enforce this regulation shall be held by the Boston Public Health Commission, its subsidiary programs or designees and the City of Boston Police Department.

2. Any violation of this regulation may be enforced in the manner provided in M.G.L. c.111 §187, by the Boston Public Health Commission, its subsidiary programs or designees.

X. Violation

1. Any person or healthcare provider who violates any provision of this regulation may be subject to a fine, not to exceed $1000.00 per violation.

2. Each violation of this regulation shall be deemed a separate offense.

XI. Severability

If any provision, clause, sentence, paragraph or word of this regulation or the application thereof to any person, entity or circumstances shall be held invalid, such invalidity shall not affect the other provisions of this article which can be given effect without the invalid provisions or application and to this end the provisions of this regulation are declared severable.

XII. Effective Date

This regulation shall take effect immediately upon acceptance by the Board of the Boston Public Health Commission.

Personal Dosimeters

Supersedes:
Effective: 01-19-05

Boston EMS ALS and BLS response units are each equipped with 2 (two) MGP DMC 2000s personal Dosimeters. Supervisory and Command units will be equipped with a single monitoring device. Specialty units (X-Ray units, Squad, etc) will be issued one dosimeter at the start of their shift, which will then be returned to a Supervisor at the conclusion of their tour of duty.

These Dosimeters are designed to measure gamma radiation and will serve to warn personnel if they are in proximity to a potentially dangerous gamma radiation source. The devices should be worn on the person of the staff member on duty during their shift, and may be worn under a sweater / jacket, or carried in a pocket. A belt clip and nylon carrying pouch will also be supplied. The device is also designed to record any exposure.

TRANSFER

The MGP 2000 devices must be transferred between the staff members during change of shift. Any staff member who does not receive a personnel dosimeter at the start of their shift shall notify their supervisor immediately. Units that do not have an oncoming relief will secure the dosimeters at their satellite station in the same location as vehicle keys.

OPERATION

While the MGP DMC 2000S is in the "*Pause Mode*" the LCD screen will display the unit ID assignment ie "EA01-A". In this setting the device will record exposure but it will not display dose, rate or alarm. Therefore the MGP DMC 2000S should always be turned on in the "*Measurement Mode*". In this mode, the device measures and records both **dose rate** and accumulated **dose**. While in the "*Measurement Mode*" the screen will display the letter "d" for dose and if you depress the button once the display will toggle to "r" for rate.

To change the device from the "*Pause Mode*" pause to the "*Measurement Mode"*, depress and release the button once. The screen will display "CHANGE" then "ENTER". While ENTER is displayed depress the button once more. The word "IN" should display. Quickly press the button once more. The dosimeter should then activate and will display "d" for dose.

To switch the device into the "*Pause Mode*" you must depress and hold the button down for several seconds. The screen should read "change", continue to hold the button down, it will read "OUT". At that point quickly release then depress the button one more time. The display should change to the unit ID.

ALARMS

The DMC 2000 has four alarms settings. There are two alarm levels for both dose rate and for dose, which will sound and alert the wearer when a predetermined threshold is met.

The alarm level settings are recommended by the National Council on Radiation Protection and Measurements and by the National Institute of Standards and Technology. These alarm points were chosen to afford *protection* for first responders.

Lower level alarms will afford *detection* but are not optimal for first responders. BEMS members routinely encounter patients who may have therapeutic radiological sources in their bodies. In addition BEMS members are frequently inside hospitals or clinic areas where legitimate sources of radiation are present. Such low level and transient sources of radiation are harmless but can trigger nuisance alarms on detectors with lower settings.

Regardless of the alarm setting, the dosimeter will record *any* exposure for personal protection and documentation.

If you get an alarm and cannot identify a legitimate reason for it, then you should consider the item to be a potential hazard. EXAMPLE; At a MVC a truck triggers an alarm, you should separate the driver/victims from the truck to determine which is the source. If an object or area is suspicious, isolate it and notify police and fire.

Dose Rate Alarm Settings

The initial “pre-alarm” or warning setting for the dose rate is 10mR/hr. This rate is low enough to offer protection to members to continue emergency medical care. Once this threshold is reached the DMC2000S will sound a series of three short beeps, a red LED will flash while the display will read “Dose” and display a warning sign. This will continue until acknowledged by pressing the button and holding it down for three seconds. Once silenced, the device will still continue to record the dose rate.

The second dose rate alarm setting is 75 R/hr. {75,000 mRhr.}. A series of three long beeps will constantly sound. The red LED will flash and the display will read “RATE ALARM” and the value be displayed. This alarm cannot be silenced. The wearer should immediately assist others in leaving the immediate area and notify Dispatch Operations.

DOSE ALARM SETTINGS

The initial dose alarm {warning} setting is 2.5 Rem or [2,500 millirem]. The detector will sound a succession of three short beeps, the red LED will flash and the screen will display “DOSE” with a warning symbol. The alarm can be silenced/acknowledged by depressing the button three seconds. The dosimeter will continue to measure dose.

This dose level {2,500 millirem or 2.5 REM} represents one half of the annual allowed dose level for workers in the nuclear industry. The member should now pay attention to any increase in dose. While this dose is within levels determined to be safe and allowable, consideration should be given to leaving the area or rotating other members into the area to complete patient care.

The secondary dose alarm is set for 10Rem {10,000 millirem}. This alarm will sound a succession of three long beeps, the red LED will flash and the display will read DOSE

and the value. This alarm cannot be silenced and is considered a “turnaround and leave dose”.

SAIC-PD3SI PERSONAL ELECTRONIC DOSIMETER

Boston EMS owns 6 of these older style units and may deploy them on an as needed basis. These units are different from the MGP2000s in that they have a single alarm setting for dose rate and one alarm setting for dose. It measures gamma radiation in mR [millirem], and R [Rems] units. The dose rate alarm will sound (beep) when threshold of 10 mR/hr is detected. This is a safe level and the alarm will prompt the wearer to be aware, to investigate further, to notify police and fire and to relocate if possible. The dose alarm setting is 2.5 REM dose. Total accumulated dose is recorded as well on this unit.

Pharmaceutical Deployment Protocol

Supersedes:
Effective: 03-25-13

INTRODUCTION

The Boston Emergency Medical Services (EMS) Pharmaceutical Stockpile provides rapidly-deployable emergency prophylaxis for first responders. "First responders" refers primarily to Boston Emergency Medical Services field personnel, and will also cover a percentage of the Boston Fire Department and Boston Police Department as appropriate. The intent of the pharmaceutical cache is to prophylax first responders during suspected chemical, biological and radiological incidents.

All pharmaceuticals are securely stored at Boston EMS Materials Management under the direction of the Director of Materials Management. This facility provides security, emergency back-up power and climate controls. The pharmaceuticals are stored in two separate locations at EMS Materials Management. Boston EMS Materials Management is staffed 24 hours daily.

AUTHORIZATION

The Chief of Boston EMS, the Medical Director of Boston Public Safety Departments, the Director of Infectious Disease at the Boston Public Health Commission, or an appointed designee shall authorize distribution of the Boston EMS pharmaceutical stockpile.

The authority to order or designate the order for the release and distribution of the Boston EMS stockpile from the Boston EMS Materials Management Facility has been granted to the following individuals.

Chief, Boston EMS:

James Hooley

Office: 617-343-1101

Cell: 617-438-0604

Medical Director, Boston EMS/Boston Police/Boston Fire:

Sophia Dyer, M.D.

Office: 617-343-1359

Cell: 617-719-8316

Director, Infectious Disease, Boston Public Health Commission

Anita Barry, M.D.

Office: 617-534-5611

Cell: 617-733-5874

INDIVIDUALS WHO MAY GAIN ACCESS TO THE DEPLOYABLE PHARMACEUTICAL CACHE:

1. Dr. Sophia Dyer and/or designee
2. Special Operations personnel
3. Shift Commanders
4. Senior Program Manager, Office of Public Health Preparedness

COMMUNICATION/NOTIFICATION

Whenever an incident may potentially require deployment of the pharmaceutical stockpile, the authorizing party will notify the Director of Materials Management or designee that the stockpile should be prepared for distribution.

STORAGE

The lockbox securing the keys to access the pharmaceuticals are located outside the office of the Director of Materials Management, room B105. Located inside the lockbox are three labeled keys. The key labeled B100D, opens a closet (room B100D), located next to room B105. Inside room B100D, on the right will be two storage cabinets.

The remaining pharmaceutical cache is located in the EMS Materials Storage room in 2 black storage cabinets. The two black cabinets are labeled **"MMRS/UASI PHARMS."** The keys to access the 2 cabinets are also labeled and secured in the lockbox outside room B105 labeled "MMRS".

TRANSFER OF PHARMACEUTICALS

In the instance the pharmaceuticals are distributed or released from EMS Materials Management, a Boston EMS Pharmaceutical Transfer Form must be completed.

INCIDENT SPECIFIC DISTRIBUTION

The Medical Director or his/her designee will facilitate the pharmaceutical distribution process. An EMS Shift Commander or designee will be tasked with transferring the pharmaceuticals from EMS Materials Management to the identified site location for distribution to EMS personnel.

CONTACTS

Office of Public Health Preparedness

Erin Curran, Senior Program Manager

(O) 617-343-6953

(C) 617-413-0549

Stacey Kokaram, Associate Director

(O) 617-343-1165

(C) 617-438-7684

Boston EMS Materials Management

Jean Yawkey Place

780 (Rear) Albany Street

Boston, MA 02118

Materials Management: (617) 343-1174

Primary Contact at Boston EMS Materials Management:

Walter Michalik

Director of Materials Management

Office: Room B105

(O): (617) 343-1187

(C): (857) 998-8054

Page: (617) 927-0700

Email: Michalik@bostonems.org

Secondary Contact at Boston EMS Materials Management:

Boston EMS Facilities Contact:

John Cushing

(O) 617-343-1315

(C) 617-821-1315

Email: cushing@bostonems.org

PHARMACEUTICAL	DOSAGE	UNIT	# of Units	Quantity
Atropine	1 mg/ml	25/pk	18	450
Cyano Kits	1 IV set	1	26	26
Cyano Kits	1 IV set	1	34	34
Ciprofloxacin (Tablet)	500 mg	500/Btl	20	10,000
Ciprofloxacin (Tablet)	500 mg	100/Btl	10	1000
Ciprofloxacin (Tablet)	500 mg	100/Btl	10	1000
Ciprofloxacin (Tablet)	500 mg	100/Btl	5	500
Ciprofloxacin (Oral)	Susp 5% 250MG/5ML	Btl	28	28
Ciprofloxacin (Oral)	Susp 5% 250MG/5ML	Btl	2	2
Doxycycline (Tablet)	100 mg	500/BTL	30	15000
Doxycycline (Tablet)	100 mg	100/Btl	6	600
Doxycycline (Tablet)	100 mg	100/Btl	17	1700
Doxycycline (Tablet)	100 mg	100/Btl	1	100

Doxycycline (Tablet)	100 mg	100/Btl	1	100
Doxycycline (Tablet)	100 mg	100/Btl	12	1200
Doxycycline (Tablet)	100mg	100/BTl	2	200
Duodote Auto	7 ML	30/Bx	30	900
Tamiflu	75 mg	10/pk	57	571
Tamiflu	75 mg	10/pk	13	130
Tamiflu	75 mg	10/pk	300	3000
Potassium Iodide	130 mg	14 Dose Strips	1560	21,840
Potassium Iodide	130 mg	14 Dose Strips	86	1,204

TRANSFER OF CUSTODY FORM

BEMS Materials Management Point of Contact :

Name: _____ Rank & ID #/Title: _____

(Print)

Signature: _____

Transfer authorized by:_____ Date/Time: _____

Inventory transferred:

Pharmaceutical Name	Lot #	Quantity	Notes
1.			
2.			
3.			

Number of kits transferred:_____

Inventory transferred by:

Agency:_____

Name:_____ Rank & ID #/Title:_____

(Print)

Signature:_____ Date/Time:_____

Inventory transported to the following location:

Receiving agency: _____

Received by:_____ Rank & ID #/Title:_____

(Print Name)

Signature: _____ Date/Time: _____

Protective Outerwear

Supersedes:
Effective: 9-20-01

The Department has issued protective outerwear, consisting of a jacket and pant combination garment, and boots. This outerwear can provide additional protection against abrasions, cuts, and blood-borne pathogens; however, all precautions possible should be taken for protection against exposure to liquid-borne pathogens.

The garment is not for use in any structural firefighting. It may afford protection against some chemical exposures, such as riot control agents. See manufacturers *User Information Guide* for further.

1. Department members will maintain their issued protective outerwear in good, clean condition. The garment should be visually inspected before and after each use for tears, holes, or cuts in the fabric. Any significant damage to the garment must be reported to the Support Services Manager immediately.

2. Lost or stolen protective outerwear may present a significant risk to other public safety agencies, and a monetary loss to the department. Department members will secure their equipment in a safe place and exercise due diligence in maintaining control over the equipment at all times.

3. If protective outerwear is lost or stolen, Department members must immediately file a police report in the municipality where the incident occurred, and notify the appropriate supervisor. Copies of said police reports and a Department incident report must be filed immediately with the Bureau of Professional Standards and the Support Services Manager.

4. Department members are required to secure their protective outerwear in their assigned vehicle, or work area, while on duty and to maintain it in a condition of operational readiness.

5. Under the following circumstances, wearing the Department issued protective jacket, at a minimum, is **mandatory:**

   5.1. Any extrication involving heavy rescue tools.

   5.2. Any Explosive Ordnance Device stand-by.

   5.3. Fire Stand-bys.

   5.4. At the discretion of the Superintendent-in-Chief or designee.

Respiratory Protection

Supersedes:
Effective: 9-20-01

1. Introduction

   1.1. In our continuing effort to enhance the safety of Boston Emergency Medical Services (BEMS) personnel, the Scott AV-2000 full facepiece with Scott 642-MPC-P100 cartridges have been issued.

   1.2. The intent is to allow BEMS personnel to escape from environments contaminated with harmful or toxic materials.

   1.3. The Scott AV-2000 full facepiece with appropriate canister(s) may be worn to manage patients under certain conditions (example: outdoor activity with adequate ventilation and product such as riot control agent).

2. Responsibilities

   2.1. The Scott full facepiece and canisters must be kept with you, in your assigned unit, whenever you are working.

   2.2. While stored, canisters must be kept in sealed containers.

   2.3. Immediately notify your supervisor if either your mask or canisters are damaged.

3. Use of Respirators

   3.1. The Scott AV-2000 full facepiece and canister ensemble will be donned when directed by a supervisor or command personnel.

   3.2. If supervisory or command personnel are not on scene, the facepiece and canister ensemble may be donned to escape or protect you from known or suspected hazardous environments. (For example: ill/injured patient presenting contaminated with some product, or someone inadequately decontaminated presenting to you)

   3.3. Do not knowingly enter a contaminated atmosphere.

4. Respirator Limitations

   4.1. These respirators should generally be worn only to escape from an environment contaminated with harmful or toxic materials. They are not for use in an atmosphere immediately dangerous to life or health (IDLH).

   4.2. All oxygen-deficient atmospheres shall be considered IDLH.

   4.3. The respirator is not for use in an oxygen-deficient atmosphere (an atmosphere containing less than 19.5 % oxygen). The canister or cartridge does not supply the respirator user with breathing air from a source independent of the ambient

atmosphere (a supplied air respirator (SAR) or self-contained breathing apparatus (SCBA) must be used in an oxygen deficient atmosphere.)

4.4. The 642-MPC-P100 cartridge – (P-100 particulate filter), combination filter cartridge, is approved for escape from an atmosphere contaminated with an identified product that falls into one of the categories below:

- OV- Organic Vapor
- AN- Ammonia
- MA- Methylamine Chlorine
- HC- Hydrogen Chloride
- SD- Sulfur Dioxide
- CD Chloride Dioxide
- HF- Hydrogen Fluoride
- FM- Formaldehyde
- HS- Hydrogen Sulfide

4.5. The P-100 cartridge is a HEPA filter, and as such will protect against the inhalation of biological hazards.

4.6. Facepiece seals and valves are important in tight-fitting respirators.

4.6.1. Tight-fitting respirators must have a complete seal to the face.

4.6.2. If there is a leak in the seal of a tight-fitting respirator or valve, then the respirator cannot reduce the wearer's exposure to respiratory hazards.

4.6.3. Nothing should interfere with the seal of the respirator to the user's face or with the valves.

4.6.4. Facial hair, jewelry, corrective glasses or goggles, helmets and other personal protective equipment must not interfere with the sealing surface of the tight-fitting facepiece and the face.

5. Cleaning, Disinfecting and Maintenance

5.1. The AV-2000 is normally cleaned and inspected after each use.

5.1.1. Refer to SCOTT *Cleaning and Maintenance Instructions for AV-2000 Full Facepiece*

5.1.2. Normal cleaning

5.1.3. Removal, maintenance, and replacement of nosecup assembly

5.1.4. Removal and replacement of voicemitter and voicemitter ducts

5.1.5. Removal, maintenance and reinstallation of head harness assembly

5.1.6. Removal and replacement of lens, seal and frame

5.1.7. Replacement parts

6. Storage

6.1. You must store your respirator and equipment in a manner that:

6.1.1. Allows accessibility at all times

6.1.2. Protects from contamination, dust, sunlight, extreme temperatures, excessive moisture, damaging chemicals, or other destructive conditions.

6.1.3. Prevents the facepiece or valves from becoming deformed

6.1.4. Follows all storage precautions issued by the respirator manufacturer

7. Inspection

7.1. Emergency use respirators must be inspected before and after each use, at least monthly, and during cleaning and disinfection, checking for proper function.

7.2. All respirator inspections must include:

7.2.1. A check of respirator function, i.e., visual inspection to identify any parts that may be missing, distorted, blocked, loose, deteriorated, or otherwise interfere with proper performance.

7.2.2. A check of rubber parts for pliability and deterioration.

8. Repairs

8.1. If your respirator does not pass inspection, you must immediately report it to your supervisor, or shift commander

8.2. Examples of when a respirator should be removed from service:

8.2.1. A cartridge has become saturated or a contaminant has broken through the cartridge and must be replaced.

8.2.2. A respirator strap, valve, or connection damaged or missing

8.2.3. The mask portion of a respirator is misshapen or degraded and can no longer form a good seal around the user's face.

8.3. Repairs may be performed only by an appropriately trained person, who must use NIOSH-approved parts designed for that particular respirator.

9. Definitions

9.1. Canister or cartridge means a container with a filter, sorbent, or catalyst, or combination of these items, which removes specific contaminates from the air passed through the container.

9.2. <u>High efficiency particulate air (HEPA) filter</u> means a filter that is at least 99.97% efficient in removing monodisperse particles of 0.3 micrometers in diameter. The equivalent NIOSH 42 CFR 84 particulate filters are the N100, R100, and P100 filters.

9.3. <u>Immediately dangerous to life or health (IDLH)</u> means an atmosphere that poses an immediate threat to life, would cause irreversible adverse health effects, or would impair an individual's ability to escape from a dangerous atmosphere.

9.4. Tight-fitting facepiece means a respiratory inlet covering that forms a complete seal with the face.

9.5. Oxygen-deficient atmosphere means an atmosphere with an oxygen content below 19.5% by volume.

Radiation Detection and Metering

Supersedes:
Effective: 11-6-02

1.0 Background

In conjunction with the Boston M.M.R.S, BEMS shall maintain and operate radiological detectors and metering devices. The purpose for this S.O.P. is to ensure safety and health of all patients and department members operating at a suspected radiological incident. BEMS monitoring equipment will be used to: Warn members as they enter a radiation field, assist in defining borders of the control area, survey patients for contamination; survey patients to monitor the adequacy of decontamination prior to loading and transport; survey BEMS personnel, vehicles and equipment after scene operations; and assist in with survey of patients or staff at a hospital or any scene where the Boston M.M.R.S. has been activated.

2.0 Authority

2.1 Only members trained in the operation of department owned detectors and meters will be allowed to operate the same.

2.2 Field Supervisors, Shift Commanders and Special Operations Division members will be responsible for storage and use of the radiations monitoring equipment.

2.3 Field Supervisors and Shift Commanders shall have a sound working knowledge of BEMS policies and procedures regarding MCI's, Hazmat incidents, and response actions at radiation incidents and the Incident Command System.

3.0 Equipment

3.1 Dosimeters: a battery operated "pager style" electronic dosimeter will be worn by the Division Supervisor and Shift Commander when on duty. The current model is the "SAIC PD-31-S"; this model measures gamma radiation and is programmed to alarm at preset levels. This device is always "on" and will serve to warn the member as he or she approaches a gamma radiation source. This device is sensitive and will respond to gamma radiation from a safe distance. It measures in uR [microrem], mR [millirem], and R [Rems].

3.2 Initial alarm will sound (beep) when threshold of 10 mR/hr is detected. This is a safe level and the alarm will prompt the wearer to be aware, to investigate further, to notify police and fire and to relocate if possible. The second alarm setting will be at 2.5 REM dose. This is

known as the “turn around and leave” level for first responders. Total accumulated dose is recorded as well on this unit.

3.3 T.L.D. Thermo Luminescent Dosimeter, when operating in an area of in creased radiation, the supervisor will issue aTLD to each member in the controlled area. The serial # of the TLD and the name of the employee must be recorded. The TLD is not to be exchanged or transferred between department members. Once issued it is designated for exclusive use by that member. After the incident is secured, the TLD is collected and sent for reading at a laboratory. This becomes the legal record of an employee’s exposure.

3.4 Self reading pocket dosimeters (pencil type) capable of reading 0-20 Rem, will be carried by the on duty Division Supervisor and issued to members operating at a radiological event. Prior to issue, these devices must be “charged” and the indicator set to zero. These devices are worn outside of clothing. They are read optically at intervals beginning fifteen minutes after entry to a controlled area.

3.5 Readings: If any dosimeter, electronic or self-reading dosimeter should begin to show an increase of measured radiation, closer monitoring of the device will be required. As levels rise consider rotating teams of members to complete tasks. Exposure of radiation to the whole body should always be minimized.

Once a 5 Rem dose is accumulated, BEMS members should be removed from and replaced in the control area. If while conducting EMS Operations at a radiation incident a dosimeter should alarm at 2.5 R dose or a self-reading pocket dosimeter read 2.5 R dose, all members should leave the area immediately.

While 2.5 R dose is considered a “turn around level”, this may also be a decision point for an I.C. Members may be allowed to work briefly at an exposure rate of 5 R dose if it is deemed necessary to finish a task or get out of a zone. A one-time total body exposure to 25 Rem may be authorized by the IC or safety officer if necessary to save a life. A member receiving a whole body exposure to 25Rem shall not be allowed to return to duty at a radiation incident.

3.6 Records – All names, times and subsequent reading of dosimeters assigned to personnel shall be recorded by a supervisor serving as the safety officer.

4.0 Survey Meters

Ludlum model 2241 meter has a digital readout which records with automatic ranging in uR, mR and R per hour. It is also equipped with a scaler. It comes with a handheld Gieger-Muller pancake probe that is used to survey surfaces such as equipment, clothing and skin for alpha, beta and or gamma radiation. The Ludlum survey meter is carried in the Division Supervisor, Shift Commander and Special Operations vehicles.

Units equipped with a pancake probe are to be used to survey for surface contamination. These units will read out in counts per minute.

4.1 The meter shall be stored in the protective case. The batteries and meter should be stored together, with the batteries remaining uninstalled until the unit is ready to use. The instruction manual must remain with the unit.

4.2 To use the meter, remove it from the case. To install the required two "D" cell batteries, loosen the thumbscrew on the face of the meter and insert the batteries. Ensure proper polarity, as indicated on the inside of the battery compartment cover. After properly inserting the batteries, close the compartment and retighten the thumbscrew. Remove the red plastic protective cover from the pancake probe. Assemble the meter by attaching the handheld probe to the cable, and the cable to the meter. Switch the selector switch to "rate meter." Flip the "F / S" switch to the "F" position. Flip the "AUD" switch (audio control) to the on position. Verify meter operation by placing the probe over the "check source" (the yellow plastic square located on the left side of the meter). Operation is verified if the meter readout displays digits and the audio output chirps at a high frequency.

5.0 Patient Survey Procedure

5.1 With PPE donned, approach patient with handheld pancake probe. Maintaining an arms-length distance from the patient, reach towards the patient with handheld pancake probe. Ensure the screen side of the probe is facing the patient. In order to detect some alpha and beta radiation you must get the probe close but not in contact with the subject of the survey. *If a contaminated source comes into direct contact with the pancake probe, the meter could become contaminated – rendering it inoperable.*

5.2 Beginning survey at the head and moving progressively toward the feet, sweep the pancake probe *slowly and methodically* over the subject at a distance of no more than one inch away from the surface and at a rate of 1-2 inches per second. An increase in the chirping and/or an increase in the numbers on digital readout are indicative of contamination. Note any and all sources of contamination. Pay particular attention to nose, eyes, ears, mouth, and any areas where contamination could be shielded from detection (i.e. armpits, groin, buttocks, back of knees, folds of skin, etc.). If patient condition allows, decontamination should be completed prior to treatment or transport. Lifesaving treatment should not be withheld.

5.3 After decontamination, if patient condition allows, re-survey the patient as explained above in 5.2. If contamination remains, the area of contamination should be noted and the meter reading recorded. To minimize the spread of contamination, cover the contaminated area utilizing, dressings and/or blankets. Notify the receiving facility of the contamination status.

5.4 Department members operating in radiation controlled areas should be surveyed prior to departure from the controlled area. Also, department members who transport a contaminated patient should be surveyed prior to returning in service. Pay particular attention to the soles of shoes, hands and arms, radio equipment and any other area that may have been contaminated.

5.5 Any area, surface, or piece of equipment in the ambulance that is suspected of having become contaminated should be surveyed prior to returning in service.

Suspected Biological Agent

Supersedes:
Effective: 10-12-01

In collaboration with Boston Public Health Commission, the BPD and BFD, Boston EMS has developed the following response guidelines to a suspected biological agent in a parcel or letter.

1. Call Taking: 9-1-1 callers will be triaged and given pre-arrival instructions by BEMS call takers. In accordance with EMD guidelines. The call will be entered in the CAD system as a BIOT or BIOC.
2. Dispatch: Unless the patient has some current medical complaint, BEMS will dispatch a single person unit, i.e. supervisors, squad or tango unit. If not available, an ambulance should be dispatched. Boston Police and BFD will also respond.
3. On scene Operations: BPD will secure the scene, BFD will be responsible to enter any building and isolate any possible biological substance. The BFD may test the substance, however a sample will be secured and delivered to State Laboratory in Jamaica Plain for definite testing by the BPD.
4. Patient Care and Decontamination: Any victim that handled the parcel that has a suspected biological agent on it should be instructed to wash their hands with soap and water. It is only necessary to remove clothing if the substance was spread on it. In any case it is advisable for the victim to wash their clothes as soon as possible. . After washing hands and removing any exposed clothing, it is safe to evaluate and treat any patient.

   4.1. If a patient reports symptoms immediately after exposure, it is most likely not a biological incident your are dealing with. You should consider a chemical agent. A patient who develops symptoms sometime after a known exposure may be infected.

   4.2. Documentation/Patient Contact Form: Unless a victim is currently complaining of any medical symptoms, there is no indication for transport to a medical facility for any victim who has handled a suspected biological agent, or was in close proximity. (within 3 feet of package when it was opened is considered close proximity). However, if anyone wishes transport we shall transport. BEMS personnel will fill out a BPHC contact information sheet for any victim that was in close proximity. The BPHC contact information form has instructions for the patient, and contact number at Public Health. In addition, the patient's personal information is collected on a portion of this form. BEMS will retain the patient information and forward it to Public Health. Any patient evaluation or care should be documented on a BEMS PCR.

Wallet Card Dosimeter

Supersedes:
Effective: 03-08-05

Effective immediately, all Boston EMS members will be issued a T.L.D. [thermoluminescent dosimeter] wallet card. This device augments personal protective equipment in that it will record exposure with gamma radiation to the wearer. This exposure is measured and recorded by an independent lab, which will provide documentation for the employee.

A T.L.D personal dosimeter card is a *passive* radiation monitor. It does not alarm or alert the wearer to radiation exposure. It does record cumulative exposure to whole body radiation. A T.L.D. is basically similar to the film badge type of dosimeter that radiation technicians wear at work. It will measure and record chronic low level as well as brief high-energy exposures. The department issued MGP2000 personal electronic dosimeter is an *active* monitor that alerts the employee at pre-set levels. It is recommended that both devices be utilized.

OPERATION

Each member will be issued a personalized laminated T.L.D. “wallet” card. The T.L.D. card will have your name and a barcode printed on it. The card also has an issue date from the factory. The card is good for one year. All that is required to record any work related radiation exposure is to keep it on your person while at work. A pocket or wallet are suggested sites to carry it. It is recommended that you always have it on your person in work. If you wish you may carry it all of the time. In that case it will measure any off duty radiation as well.

As the anniversary date approaches, BEMS will issue a new T.L.D. card and the old card will be collected for processing. Alternatively, if there is a suspected exposure or release in the work place, we can collect the cards immediately for an expedited reading. This will determine if an employee was exposed and a permanent record will exist. That exposure record will become part of your confidential health record and be available to you.

SPECIAL CONSIDERATIONS

- Please confine the use of this card to the assigned individual.
- It is recommended that you do not take this card with you during medical procedures involving the use of ionizing radiation.
- If it is lost notify your supervisor.

Special OPS / Major Incidents

Bicycle Team

Supersedes: 05-01-05
Effective: 05-01-06

FUNCTION

The primary functions of the team are rapid response, patient assessment and primary intervention, and development of an incident action and evacuation plan for specific responses during restricted access special operations. The option to provide those same services in congested, traffic-intensive areas of the city is being evaluated. Additionally, the team provides close contact between Boston *EMS* and the general public, public relations support to department events and fosters a general improvement in physical fitness for employees assigned to the unit and those training for the selection process.

UNIT ACTIVATION

Event requests will be evaluated by the Special Operations Division Supervisor for possible deployment of the Bicycle Team and then approved by the Superintendent-In-Chief or his designee. The unit should be considered for deployment at the following types of events:

- Large scale special events;
- Crowd-intensive operations;
- Foot, road or bicycle races;
- Events conducted on rural, uneven or inaccessible terrain;
- Special Operations assignments;
- Public relations and education programs;
- Assignments authorized by the Superintendent-in-Chief.

SUPERVISION AND CHAIN OF COMMAND

The Special Operations Supervisor or designee will coordinate the administrative, maintenance and quality assurance responsibilities of the unit. The Special Operations Supervisor or designee will provide tactical supervision at large-scale events or when multiple members of the team are deployed. The Special Operations Supervisor or designee may assign a team leader for smaller events. The team leader will report to the Incident Commander, Shift Commander or Division Field Supervisor, whichever is applicable, for deployment and other tactical instructions.

DEPLOYMENT

Bike team members will report to the team storage facility, and meet a Division or Bike Team Supervisor for access if necessary. Members will prepare, clean, and check out

bikes. Members will sign out equipment as needed. Whenever possible, a fully stocked vehicle will be signed out for transport of personnel and bikes as space allows. If approved by the Bike Team or Dispatch Operations Supervisor, members of the team may choose to ride directly to the event location, if it is timely.

The vehicle will be placed at the scene to serve as an aid station *(if appropriate)*, respite area for bike team members, and equipment cache. If a designated bike team member will not be in visual proximity to the unit at all times to make contact with potential patients who may report to it than the vehicle should be secured out-of-sight.

At the conclusion of the event, all bikes and bike equipment will be wiped down and secured. Any repairs needed should be noted on a form provided by the Bike Team Supervisor and a copy forwarded to the Special Operations Division.

COMMUNICATIONS

Bicycle units will use the call-sign prefix ***"X-Ray"*** and then their unit number depending on the total number of units fielded. The X-Ray Team Leader will call the Dispatch Operations Center prior to an event and request a log-on for the X-Ray Team units being fielded for the event including the names of EMT'S, call-signs, radio ID numbers and their SAED capability.

X-Ray Team members will use the same tactical channel designated for the event as other response units. The bicycle-capable supervisor or team leader assigned to an event will always assume the callsign "X-Ray One".

DOCUMENTATION

Each set of panniers will have a complete supply of paperwork and a clipboard to assist in maintaining all department patient documentation standards. The Bike Team Supervisor or team leader will collect all PCRs, patient refusal forms, patient contact logs and other documentation and transfer it to a Division Supervisor at the end of the tour of duty.

BICYCLE EQUIPMENT

Department owned bikes will be secured at the Bragdon Street Facility and their maintenance will be monitored by the Special Operations Division. These bikes will be used whenever possible as the primary response units. The Department will supply a Department bicycle (as available), stocked panniers, helmets, oxygen / resuscitation equipment and an SAED unit. Employees are responsible for providing all required personal equipment including:

- Whistle
- Sunglasses
- Riding gloves
- Tie-backs
- Water bottle*(s)*

Pedals of department bikes may be modified to clip or clipless pedals, but must be returned to standard pedal configuration at the end of the tour of duty.

UNIFORM

- HELMET: Department issued white Bell Maxus or Triumph bicycle helmets with Department approved logos, *(No additional adornment of any kind is permitted).*
- JACKET: Nylon recruit jacket with Orange/Reflectorized side facing out, *(weather permitting)*. A Department issued Bike Team jacket and pants will be signed out when available and returned at the end of the shift.
- SHIRT: A Polo shirt with embroidered Boston *EMS* logo over the front, left side and color to be consistent with rank, or standard issue short or long sleeve uniform shirt.
- PANTS: Brown uniform shorts either dress or cargo style or brown uniform pants with tiebacks applied.
- SOCKS: White, brown or black socks when worn with shorts and brown or black only when worn with long pants.
- FOOTWEAR: Black uniform or "coach" style sneakers, or black BX shoes.
- PERSONAL DUTY EQUIPMENT: Standard utility belt with extra keeper straps if needed. All department rules and regulations apply pertaining to the carry and storage of additional personal equipment.
- INCLEMENT WEATHER UNIFORM: Department issued orange raincoat and black or brown rain resistant pants

ALS EQUIPMENT

Whenever a BEMS paramedic is deployed as an ALS bicycle response unit, the following list of medical supplies shall be considered as standard equipment and must be carried. The Medical Director, his or her designee or the Shift Commander must approve any additions, deletions or substitutions.

Oxygen with 1 adult and 1 pedi non-rebreather and 1 adult and 1 pedi nasal canula
1 nebulizer acorn; combivent and albuterol
Intubation roll with Magill forceps, BVM, colorometric end title CO2
2 baby ASA
1 canister of nitrospray (.4 mg /spray)
2 2mg 1 cc vials of Ativan
1 Accucheck
2 2mg prefilled syringes of Narcan
2 50 cc prefilled syringes of D50
1 1mg glucagon
1 24 gm oral insta-glucose paste
1 epinephrine 1:1000 10 cc prefilled syringe (1 mg)
3 epinephrine 1:10,000 10 cc prefilled syringe (1 mg)
2 100mg 10 cc prefilled syringes of lidocaine
2 150mg bristojet amiodarone
2 1 mg 10 cc prefilled syringes of atropine
2 50 mg vials of benadryl
2 500cc NS plus IV catheters and tubing
2 tourniquets and Kelly clamp
1 OB Kit

1 roll of Kling
1 box of 4x4's
1 occlusive dressing
1 BP cuff and 1 stethoscope
AED

Additional equipment may be evaluated by the Department from time to time, and added to the equipment list.

MASS CASUALTY INCIDENT RESPONSE PLAN

METRO-BOSTON
Urban Area Security Initiative

JANUARY 2011

MCI Response Plan
Supersedes: 11-01-06
Effective: 01-2011

Metro-Boston Urban Area Security Initiative (UASI) Mass Casualty Incident Response Plan

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NIMS STATEMENT

In March 2004, the Secretary of Homeland Security, at the request of the President, released the National Incident Management System (NIMS). The NIMS is a comprehensive system to improve response operations, using the Incident Command System (ICS) and other standard procedures and preparedness measures. It will also promote development of cross-jurisdictional, statewide, and interstate regional mechanisms for coordinating incident management and obtaining assistance during large-scale or complex incidents.

The NIMS Integration Center (NIC) recognizes that the overwhelming majority of emergency incidents are handled on a daily basis by a single jurisdiction at the local level. However, it is critically important that all jurisdictions comply with the NIMS because the nation may face challenges far greater than the capabilities of any one jurisdiction. However, these challenges are not greater than the combined efforts of all. Homeland Security Presidential Directive 5 (HSPD- 5), Management of Domestic Incidents, requires all federal departments and agencies to adopt and implement the NIMS, and requires states, territories, tribes, and local governments to implement the NIMS to receive federal preparedness funding.

When NIMS is fully implemented, states and local jurisdictions will be able to:

- Ensure common and proven incident management doctrine, practices and principles are used to plan for, protect against, respond to and recover from emergency incidents and preplanned events;
- Maintain a response operation capable of expanding to meet an escalating situation and the ability to integrate resources and equipment from intrastate and interstate mutual aid agreements, state-provided assistance and federal government response;
- Order and track response assets using common resource typing and definitions, and draw on mutual aid agreements for additional assistance;
- Establish staging and allocation plans for the re-distribution of equipment, supplies and aid coming into the area from other localities, states or the federal government through mutual aid agreements;

U.A.S.I. MCI Response Plan

• Conduct situational assessments and establish the appropriate ICS organizational structure to effectively manage the incident; and

• Establish communication processes, procedures and protocols that will ensure effective interoperable communications among emergency responders, 9-1-1 centers, and multi-agency coordination systems such as Emergency Operations Centers (EOC).

GENERAL OVERVIEW

The Metro-Boston Homeland Security region includes the City of Boston and eight of the surrounding cities and towns including Brookline, Cambridge, Chelsea, Everett, Quincy, Revere, Somerville, and Winthrop. The Emergency Medical Service (EMS) provider(s) in each jurisdiction assist in pre-hospital medical emergencies that may overwhelm any of the regional Urban Area Security Initiative (U.A.S.I.) partners. The regional partners are committed to a system of ongoing and open communications, planning, and prevention strategy development. The U.A.S.I. EMS partners are especially committed to the coordination of assets for the consistent training of all members in the regional EMS community. This process will ensure confidence, proficiency, and safety for the jurisdictional EMS providers.

The Metro-Boston U.A.S.I. Region is densely populated and steeped in history and culture, making it a target rich environment for acts of terrorism. The region is also vulnerable to natural disasters such as winter storms, summer heat waves, hurricanes, and flooding. Hazardous land, air, and sea cargo shipments regularly pass through the region. Hundreds of bio level one, two, and three research labs currently operate in the region, and plans exist for a bio level four research facility in the near future. The region is less than fifty miles from two large, commercial nuclear power plants as well as smaller reactors at local universities.

The Metro-Boston U.A.S.I. EMS providers are committed to a mutual aid system of providing response to any member community that requests EMS assistance.

U.A.S.I. MCI Response Plan

MASS CASUALTY INCIDENT

Any incident, whether intentional or accidental, which could potentially generate a number of victims that requires resources beyond those normally available from local, regional or statewide sources. In any incident with more than five victims at a scene, the first arriving crew should begin using MCI protocols.

PHASED INCIDENTS

A "Phased Incident Response" is a system of responding resources to an incident based on the number of potential victims that could be generated from that incident. The phases indicate the number of potential causalities at a declared mass casualty incident (MCI) should any of the regional EMS providers ask for a mutual aid response.

PHASE DESIGNATIONS

Phase 1	1 to 10 potential victims
Phase 2	11 to 30 potential victims
Phase 3	31 to 50 potential victims
Phase 4	51 to 200 potential victims
Phase 5	Greater than 200 potential victims
Phase 6	Incident or Event Requiring Sustained EMS Operations (longer than twenty-four hours)

MUTUAL AID STATEMENT

A Metro-Boston U.A.S.I. city or town requesting mutual aid will advise the Metro-Boston regional C-MED center located at Boston EMS Dispatch Operations, of the nature, location and

declared phase of an incident. Metro-Boston C-MED will call member agencies and determine available resources and an estimated time for a potential response. Metro-Boston C-MED will ascertain the number of response units, support personnel or specialty equipment requested to respond, and the established staging location. The nearest adjoining member agency will provide the initial mutual aid response if resources are available. Response will default to the next neighboring system until the needs are met.

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The primary affected jurisdiction shall establish incident command, and all mutual aid response will report to that command. If requested, responding mutual aid partners may undertake positions in the established ICS structure. When feasible, U.A.S.I. partners will assign supervisory staff to respond with any resources dispatched to an incident.

If the affected jurisdiction establishes a Unified Command Center (UCC), the affected jurisdiction's principal EMS provider shall provide EMS representation in the UCC. The UCC may be at a predetermined location in the jurisdiction, or it may be at an ad hoc location near the MCI site. The UCC should include at least one representative from each discipline involved in the MCI response.

SECTION 1: PHASE DESIGNATIONS

PHASE ONE

In any MCI, the first arriving crew is responsible for performing triage and a situation size-up. Any incident where the potential for up to ten patients exists may be designated a phase one incident and trigger the institution of the ICS System. The transport unit commitment will be based on specific need and may include U.A.S.I. member agency units. Special units may also be called on an individual basis, as required.

The following actions are suggested for a phase one response, depending on the primary jurisdiction's capabilities. A phase one incident should be a mandated response for a Supervisor

/ Command level officer. Declared phase incidents should be announced on all Dispatch and Tactical channels to alert field units to expedite patient transfers at hospitals and to exercise radio traffic brevity. A Tactical frequency with a dedicated Telecommunicator should be established for incident coordination. An internal Command level notification to the primary jurisdiction's command staff should be instituted for any declared phase incident. The Incident Commander may notify C-MED of a phase one incident if he or she expects the situation to escalate. Consider mutual aid and other outside requests early in the incident.

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PHASE TWO

An incident where the potential for eleven to thirty patients exists will be designated a phase two incident and cause the institution of the ICS System. The following actions are suggested for a phase two response, depending on the primary jurisdiction's capabilities. A Supervisor / Command level officer from the affected jurisdiction should respond, if available. Any Special / MCI support assets should be automatically notified, readied and available to respond. An internal Command level notification should be instituted for any updated information on the phase incident. Metro-Boston C-MED should be notified of any incident above phase one and updated as escalation occurs, whether mutual aid is required or not. Consider mutual aid and other outside requests early in the incident.

Due to patient number, difficulty in extraction, or hazards present, such incidents may require that distinct Incident Operations, Patient Triage & Treatment, Patient Transportation, and Resource Staging Areas be established and staffed.

PHASE THREE

An incident where the potential for thirty-one to fifty patients exists shall be designated a phase three incident. Command level officers shall report to their respective areas of responsibility to

manage operations. Any Special / MCI assets including Equipment Trailers, Technical Support Unit(s), a Mobile Command Unit (if available), Regional EMS representative (if applicable), and MMRS Coordinator shall be notified. Additional Support personnel may be activated at the discretion of the Incident Commander. An internal Command level notification shall be instituted for any updated information on the phase incident. Metro-Boston C-MED shall be notified of any declared phase incident, and updated as escalation occurs, whether mutual aid is required or not. Consider mutual aid and other outside requests early in the incident. The Incident Commander may determine that a selective or general recall of off-duty personnel is warranted within his or her agency.

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PHASE FOUR

An incident where the potential for fifty-one to two hundred patients exists shall be designated a phase four incident. All provisions for lower phases apply. The primary jurisdiction's EMS provider should notify mutual aid partners who will immediately dispatch at least one transport asset and one supervisor to a designated staging area. A phase four incident may require redistribution of patients to hospitals beyond initial receiving or out of the area facilities, necessitating State EMS Ambulance Task Force assets, aero-medical operations, and/or other EMS resources. All efforts will be made to distribute patients among nearby receiving facilities to avoid overwhelming any one facility.

PHASE FIVE

An incident where the potential for greater than two hundred patients exists shall be designated a phase five incident. Such an incident may exceed the ability of the city, town or regional mutual-aid resources to manage and may result in a local / state declaration of a disaster

area. Regional disasters such as earthquakes, tornadoes, conflagrations, or major terrorist attacks, which may require state assistance, fall into this category. The primary jurisdiction should establish an Emergency Operations Center (EOC). The jurisdictional Incident Command System (ICS) will shift to accommodate this operation. The primary jurisdiction's EOC shall notify the Massachusetts Emergency Management Agency (MEMA) of the situation. NIMS format operations shall be instituted and a general recall of all public safety personnel should be considered. Special work assignments and shifts could be necessitated. Provisions for food and shelter for off-shift personnel should be considered early in the response. The agencies involved should arrange for specifically designated Critical Incident Stress Management (CISM), Pastoral Services, and Employee Family Support if their personnel might need these services. Federal agencies such as the Department of Homeland Security *(DHS)*, Federal Emergency Management Agency *(FEMA)*, National Disaster Medical System *(NDMS)*, etc. may be requested to respond and assist if the incident overwhelms local, regional, and state capabilities.

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PHASE SIX

Any incident that will require continual EMS response for an extended period shall be designated a phase six incident, regardless of the number of casualties expected. A pandemic flu outbreak or a biological terror attack would be an example of a phase six incident. Affected jurisdictions may need to change shift schedules to respond to higher demand. The Incident Commander should establish the planning and administration sections of the MCI Organization Chart (Appendix A) if these sections are not yet established. The public may make large donations during a phase six incident, and the materials management and fiscal affairs sections should handle these donations.

EMS providers may need to provide food and shelter for their personnel during a phase six incident. Providers should work to develop agreements with other organizations or businesses

that could supply food, fuel, or lodging during a prolonged incident. Providers may need to apply contingency plans for alternative forms of transportation for lower priority cases. Non-uniformed personnel may need to be recalled. EMS providers should develop plans for treating their own personnel who may become sick or injured during a phase six incident.

SECTION 2: INCIDENT NOTIFICATION / ACTIVATION

DISPATCH CENTER / FIRE ALARM

The Dispatch Center / Fire Alarm (for municipalities without a separate EMS dispatch center), under the initial direction of the onsite supervisor, and later, the command level staff, is responsible for the notification, activation, and initial assignment of response personnel and equipment to a potential Multiple Casualty Incident.

See Appendix E.1, Dispatch Center / Fire Alarm Checklist

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SECTION 3: UNITS ASSIGNED TO THE INCIDENT OPERATIONS AREA

The area affected by and directly adjacent to the incident, including the building involved, area of debris, total area containing patients down, as well as any area where potential hazards exist, shall be known as the Incident Operations Area**.** This area is under the direction of one of the first arriving EMTs who will assume the designation of Incident Commander.

Any EMS personnel working in the incident operations area while hazards are present will don personal protective equipment (PPE) prior to entry into the incident operations area or will be excluded until the area is deemed safe.

The objective of the first arriving EMS unit, regardless of clinical level or rank, will be to perform a situation size-up, organize operations, and begin triage. One EMT assumes the size-up and ICS organizational responsibilities as the Incident Commander while another assumes the Triage Officer role. Some limitation of duties will occur when the first arriving unit is a Supervisor or Commander who is alone.

Upon arrival of the first supervisory personnel, who will assume Incident Command, the most previous EMS personnel acting as I/C will transition to the “EXTRACTION OFFICER” position to ensure rapid clearing of the affected victims from the Incident Operations Area to the Treatment Area in a quick and efficient manner.

In order that incident operations are quickly organized, the first unit on scene will have the authority to activate the system and escalate as high as a phase two incident without the authorization of the responding Supervisor, Commander, or other command level staff.

INCIDENT SIZE-UP METHOD FOR FIRST RESPONDING UNIT:

When first arriving at the scene of a potential MCI, certain steps are necessary to evaluate the situation. Be aware of everything around you: the bystanders on the scene, the objects or people that caused the injury, the injured parties, the mechanisms of the injury, any hostile parties involved and their location, weapons, hazardous materials, etc. Remember, "everyone sees, but few observe." A proven method of incident observation is listed here for your use.

U.A.S.I. MCI Response Plan

M E T H A N E *(acronym adopted from the London Ambulance Service)*

M = major incident declared
E = exact location
T = type of incident
H = hazards present
A = access
N = number of causalities & severity
E = emergency services required

INCIDENT SIZE: Estimate by the use of geographic boundaries, building size, number of affected locations, and approximate number of patients.

HAZARDS: Visible hazards such as fire/smoke/plume, partially collapsed structures or unstable working surfaces should be noted. Invisible hazards such as known or suspected toxic fumes or liquids, suspected structural damage, suspected secondary devices, or other hazards should also be considered and noted in the report.

EMS NEEDS: An assessment of the expected resources needed. The declaration of the appropriate Phase level is based on the number of **potential** patients expected for the duration of the immediate incident. Additional resources including special equipment needed above the phase level should be noted as soon as possible.

See Appendix E.2, Operations Area Checklists

SECTION 4: TREATMENT AREA

The Treatment Area is under the direction of the second arriving unit, one member who shall assume the designation of "Treatment Officer" until relieved by the first arriving Paramedic. When available, a Department Physician may respond to the incident and assume this role. All personnel, including physicians, nurses and other health professionals working in this area will be under the operational control of the Treatment Officer. This does not include the direction of specific medical care for patients by a physician on scene. Such decisions will be the responsibility of the treating physician.

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The Treatment Area shall be established in a safe location adjacent to the Incident Operations Area. All patients removed from the Incident Operations Area will be taken to the Treatment Area for triage conformation; tagging and medical care with the exception of "walking wounded" that may be assembled in another controlled area. All contaminated personnel, patients, and equipment must be decontaminated before entering the treatment area.

Within the Treatment Area, teams may be established to treat patients based on their priority classification or grouping, [i.e. RED (Immediate), YELLOW (Delayed), GREEN (Minor)]. A team leader will be assigned by the Treatment Officer and answer to the call sign "Red Team", "Yellow Team", etc. Personnel assigned as team leaders will monitor the condition of patients and supervise the treatment based on the level established by the Treatment Officer.

Each agency should use its Basic Life Support *(BLS)* Protocols as the standard of care to achieve a patent airway, control hemorrhage, and relieve or prevent shock. The jurisdiction Incident Commander or designee shall set all other levels or extent of care. Any patients without spontaneous respirations or pulse that are classified BLACK *(Expectant),* will only be removed to the designated morgue site at the direction of the jurisdiction Incident Commander. Exceptions to the non-resuscitation rule can be made at the discretion of the Treatment Officer in smaller incidents where sufficient resources are available.

Precautionary spinal immobilization and fracture splinting will be a low priority and may be delayed until the patient is in the transport mode. Advanced Life Support *(ALS)* measures shall be avoided and such treatment will be conducted only when resources permit and at the discretion of the jurisdiction Incident Commander.

STAFF: EMT FROM THE SECOND ARRIVING VEHICLE

See Appendix E.3, Treatment Area Checklists

U.A.S.I. MCI Response Plan

SECTION 5: TRANSPORTATION AREA

The patient Transportation Area will be located adjacent to the patient Treatment Area so that patients can be quickly moved into position for loading into vehicles and matched for transport. Patients shall be grouped, wherever possible, so those patients with compatible needs for care are loaded together. For example, one would avoid loading two patients with airway compromise into the same ambulance.

The second arriving Supervisor shall assume the designation of "Transportation Officer". An EMT from an additional arriving vehicle may assume the designation of "Loading Officer". If the Treatment Officer or Triage Officer is overburdened, an EMT from an additional arriving vehicle may assist with treatment or triage and wait for additional personnel to arrive before designating a Loading Officer. The Transportation Officer and Loading Officer will both staff the Transportation Area. It shall be the duty of the Loading Officer to monitor his/her radio on the event tactical radio channel, assign transport priority, and determine the compatibility of care for patients to be loaded into vehicles and to serve as the recorder of patients being transported. The Transportation Officer shall have the duty to change his/her radio to an assigned Metro Boston C-MED radio channel, designate prioritized patients to ambulances and assigning hospital destination through consultation with C-MED. Hospital destination shall be determined when the Transportation Officer notifies C-MED that a number of prioritized patients are ready for transport via radio. C-MED will then assign a hospital destination. The Transportation Officer will advise the transporting unit of their destination and mark the destination on the transportation log or board. The Transportation Officer will then enter the patient into the patient tracking system, (if applicable).

The Transportation Officer, upon receiving a hospital destination from Metro Boston C-MED, will transmit the ambulance identification *(number, and organization)*, the number and color priority of patients on board, and the name of the receiving hospital.

Backboards or other devices from equipment trailers may convey patients directly to the ambulances and directly from the ambulances to a hospital stretcher.

U.A.S.I. MCI Response Plan

Ambulances transporting patients should not transmit voice messages by radio of their "en-route" or "arriving at hospital" status, nor will they make hospital notifications. Upon clearing a hospital, the ambulance should again return to the Staging Area without voice radio

transmission, unless otherwise directed by the Dispatch Center / Fire Alarm. If available, CAD unit updates will be used to monitor vehicle status.

STAFF: Assigned as applicable.

See Appendix E.4, Transportation Area Checklists

SECTION 6: STAGING AREA

In order to maintain control of EMS resources, vehicles and equipment will be pooled in a location approximately 1-2 minutes driving time from the Transportation Area. The Staging Area shall be established by a Supervisor or designated Department member who shall assume the designation of "Staging Officer".

All ambulances and other equipment not immediately needed at the incident site shall report to the Staging Area, check in with the Staging Officer, and stand by until directed elsewhere. Ambulances that clear a hospital transport will return to the Staging Area and will report directly to the Staging Officer unless directed otherwise by the Dispatch Center / Fire Alarm.

STAFF: Designated EMT or Supervisor.

See Appendix E.5, Staging Officer Checklist

SECTION 7: INCIDENT COMMAND SYSTEM

An EMT from the first arriving vehicle will assume EMS command of an incident by using the "Incident Command" call sign. "I/C" shall be prefaced with the location of the incident (i.e., "Logan I/C" for an incident at Logan Airport). The first Supervisor assumes command upon his/her arrival and assumes the "IC" call sign. The first arriving Command level officer will relieve the Supervisor. The Supervisor will then assume the duties of another ICS staff position at the discretion of the Incident Commander.

Upon the arrival of a Senior Command Staff officer, the Commander may pass off Incident Command. The Senior Command Staff officer may defer Incident Command to a member of the Command Staff of lower rank at his/her discretion.

MAJOR EMERGENCY OPERATIONS AND THE INCIDENT COMMAND SYSTEM

For any incident at or above a Phase Three, or whenever a Command level officer directs, an expanded NIMS format Incident Command System will be activated to manage additional responsibilities. Designated or Supervisory level staff will respond and assume command of the Administration Section, Planning Section, Logistics Section, Operations Section and Incident Commander's Staff (Safety, Liaison, Public Information and Intelligence) as needed.

See Appendix A, MCI Organizational Chart.

OPERATIONS SECTION

The Operations Section is responsible for directing and coordinating all of the tactical operations involved in the consequence management of an event. The Operations Section is broken down into three functional branches. These branches are Dispatch Center / Fire Alarm Operations, Field Operations and Special Operations.

Dispatch Center / Fire Alarm Operations Branch, under the direction of the Incident Commander or designee, shall establish and maintain systems needed to enable clear communications and control. They shall provide frequency designation, coordination and establish information links with Metro-Boston C-MED and other public safety or support agencies for the timely exchange of information and resources relative to the incident.

Field Operations Branch, under the direction of the Incident Commander or designee, shall establish and maintain systems including actual emergency triage, extraction, treatment, and transportation of patients from the MCI and progress reporting to the jurisdictional I/C. The on scene MCI management plan is subdivided into four functional areas, which are manned by personnel from this division. These areas are the Incident Operations Area, the Treatment Area, the Transportation Area, and the Staging Area.

U.A.S.I. MCI Response Plan

Special Operations Branch, under the direction of the Incident Commander or designee, shall establish and maintain systems in support of the consequence management effort. Personnel from this division may respond with specialty vehicles and equipment, provide and maintain portable radios, batteries, lighting, shelter, and auxiliary power, as required. Personnel from this division may also be assigned, as needed, to coordinate EMS perimeter and operating area safety and security. Technical specialists such as toxicologists, mass care and shelter personnel, CISM, etc., may be assigned under this section. Such personnel are intended to provide information and technical assistance allowing the primary jurisdiction to adapt to meet special needs. All other sections work to provide support to the Operations Section.

INCIDENT COMMANDER'S STAFF

Dependent on incident scope, the Incident Commander may establish the positions of *Safety Officer*, *Liaison Officer*, *Public Information Officer*, and *Intelligence Officer*. A Safety Officer's primary responsibility is to monitor and oversee the safety of the incident operations, with the authority to immediately suspend unsafe procedures. The Safety Officer should be the first appointed member of the Incident Commander's staff. The Liaison Officer coordinates with other public and private agencies that may respond to the incident. A Public Information Officer can assist the Incident Commander in dealing with media relations. An Intelligence Officer's primary responsibility is to monitor and interpret information on special circumstances and hazards present on scene and patient information from hospitals post arrival of victims.

See Appendix E.7, Incident Commander Checklist

LOGISTICS SECTION

The Incident Commander may designate a Logistics Officer to oversee all logistics functions. This section will be divided into functional branches from within different EMS Bureaus.

Communications Engineering Branch, under the direction of the Incident Commander or Logistics Officer (if one is designated), shall establish and maintain systems, that may necessitate the establishment of a Mobile Communications Unit, establishing a remote repeater

system, supporting telephone communication capability, and maintaining the technical integrity of the overall communications system.

U.A.S.I. MCI Response Plan

Materials Management / Support Services Branch, under the direction of the Incident Commander or Logistics Officer (if designated), shall establish and maintain systems, for the assembly of reserve ambulances, equipment and supplies that will be readied for deployment to an incident under the control of the Staging Area Officer. Demobilization will also occur through this section. In conjunction with the Incident Commander, a process for the release or relief of units will be determined. The demobilization function will also necessitate the restocking and cleaning of units in preparation to return to normal service. The Support Services Branch may also be responsible for the acquisition and preparation of satellite treatment areas, morgues, etc.

Fleet Services Branch, under the direction of the Incident Commander or Logistics Officer (if designated), shall establish and maintain systems, for the operational readiness, maintenance, fueling and repair of vehicles and equipment involved in the incident.

Management Information Systems Branch, under the direction of the Incident Commander or Logistics Officer (if designated), shall establish and maintain systems, for the operational readiness, maintenance, modification and functionality of the management information system and equipment.

PLANNING SECTION

Personnel from this Section shall work as the Resource Officer and staff, who will maintain a running record of resources and the incident situation status to enable planning for the continuation of the operation. Documentation of all aspects of the incident beyond the transport of patients is assigned under this Section. Personnel to staff the Jurisdiction EOC, once activated, will report under this Section.

See Appendix E.6, Resource Officer Checklist

ADMINISTRATION SECTION

The Administration Section, under the direction of appropriate personnel, will be activated for large scale or long-term operations.

The Fiscal Branch, under the direction of appropriate personnel, will be responsible for time keeping and payroll for long-term operations. It is also responsible for the purchase, rental, or loan of supplies, equipment, or services, as they may be needed. This section will work to control and record all expenditures outside of normal EMS costs. This section will work in close physical proximity to and in cooperation with, the Planning and Logistics Sections.

The Human Resource Branch, under the direction of a designee, will be responsible for all personnel and workers' compensation / injury issues.

The Legal Affairs Branch, under the direction of a designee, will address post incident issues that will include determining what costs can be recovered for the operation under existing state and federal laws or regulations. Claims by civilians, personnel, or services will also be directed to the Legal Affairs Office.

SECTION 8: EMS PERSONNEL RECALL

Whenever possible, off-duty personnel will be recalled to duty in a prescribed manner. If an MCI occurs close to a shift change, the IC will consider holding off-going members as part of a recall. All off-duty personnel will report to a designated muster location*(s).* Personnel will be directed to staff stocked spare ambulances, special equipment, or serve in other functions at the incident.

SECTION 9: MUTUAL AID POLICY

Metro-Boston U.A.S.I. member agencies will maintain a current back-up agreement with each other and shall be called to provide additional MCI support capability or to provide jurisdictional coverage. Requests will be made on a location-dependent basis just as in routine operations.

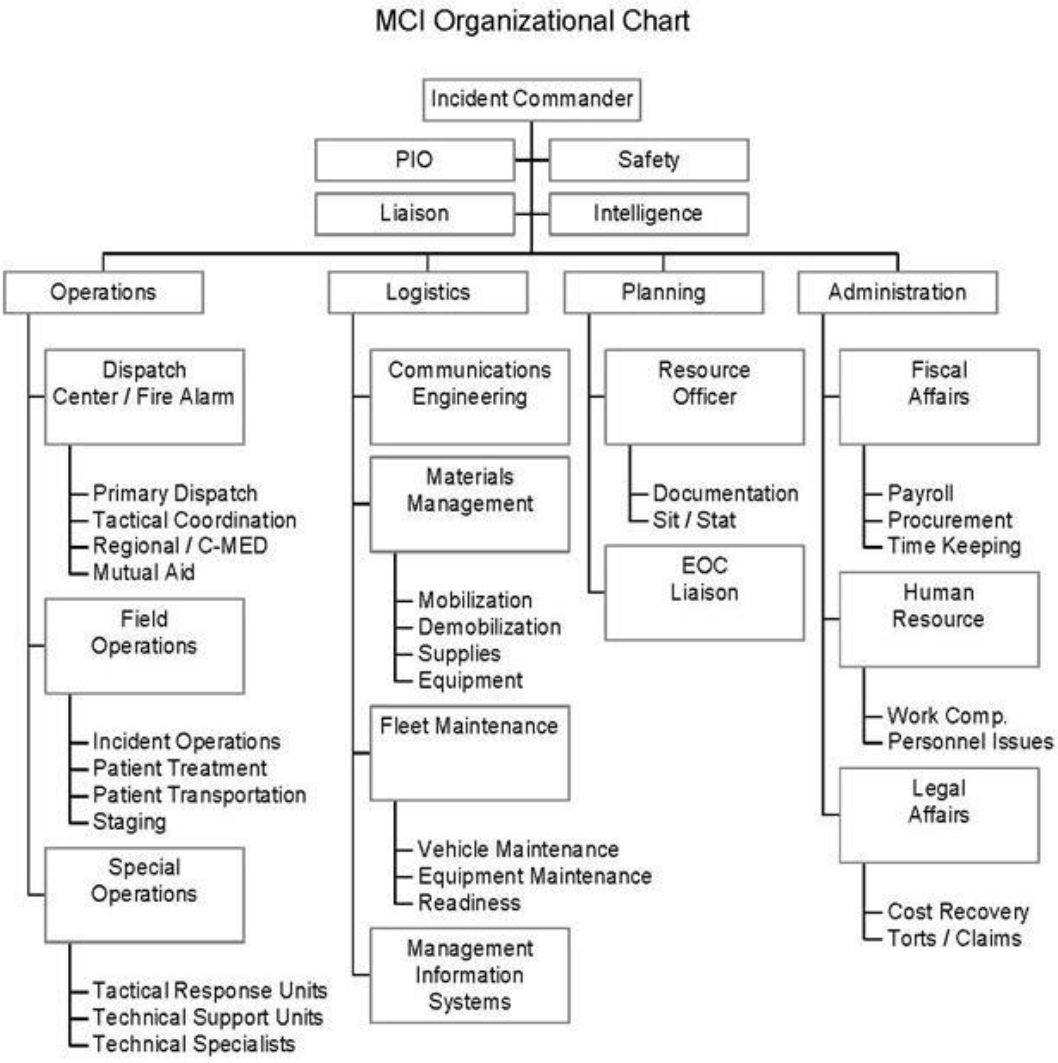
Any outside EMS agency units responding to a declared Multiple Casualty Incident will be directed to the Staging Area for briefing and deployment, if needed. The Dispatch Center / Fire Alarm Operations Branch will announce the location of the EMS Staging Area to state and local

police who will be instructed to direct any independent units found arriving on scene to report to the established Staging Area.

It is the U.A.S.I. member agency's responsibility to make effective use of all available resources by including them in a coordinated effort. This will insure absolute personnel accountability, quality patient care, and proper documentation of designated hospital destinations.

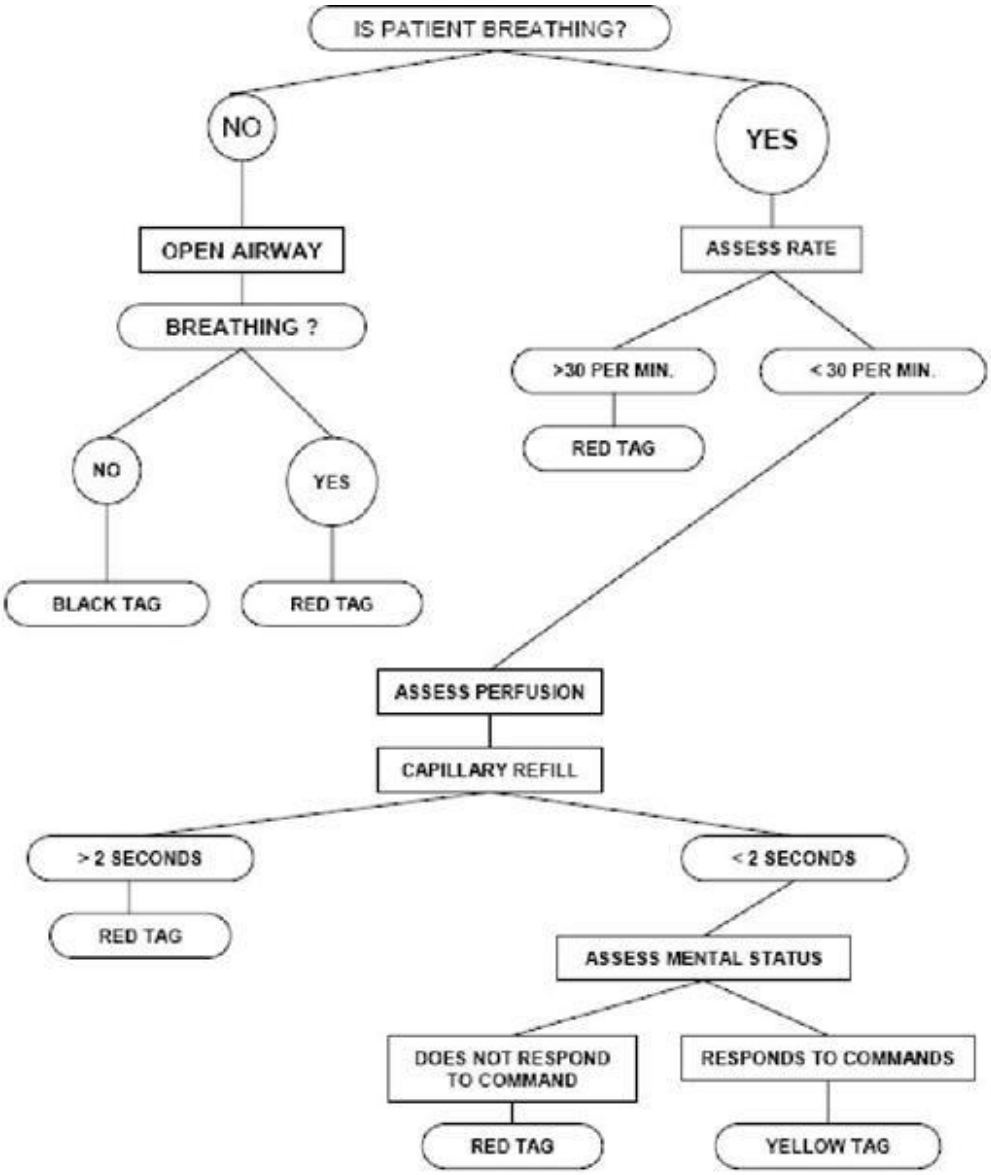
U.A.S.I. MCI Response Plan

Appendix A



Appendix B

START Triage Protocol


IS PATIENT BREATHING?
NO
YES
OPEN AIRWAY
ASSESS RATE
BREATHING ?
>30 PER MIN.
< 30 PER MIN.
RED TAG
NO
YES
BLACK TAG
RED TAG
ASSESS PERFUSION
CAPILLARY REFILL
> 2 SECONDS
< 2 SECONDS
RED TAG
ASSESS MENTAL STATUS
DOES NOT RESPOND TO COMMAND
RESPONDS TO COMMANDS
RED TAG
YELLOW TAG

Appendix C

MCI SWEEP TRIAGE & TAG INSTRUCTIONS

- Triage patient using **S.T.A.R.T.** protocol and affix appropriate tape or tag to extremity.
- Remove patient to treatment area and re-assess condition, as required.
- Adjust tag to appropriate color classification.
- Mark the anatomical chart to identify injury sites.

  L = *laceration*
  B = *burn*
  F = *fracture*
- Acquire patient information as conditions permit and document on tag.
- Affix the tag around patient's extremity.
- Tear off the patient information / transport tab *(with transport marking)* at the loading area, and give it to the Transportation Officer.

MCI TAG INJURY / SEVERITY CLASSIFICATION

MCI TAGS shall be used whenever up to Ten *(10)* or more patients are expected.

RED: IMMEDIATE - Patients that you think will only survive for about one hour until they reach a definitive care facility, patients in an uncontrollable emotional state, or a co-worker regardless of severity.

YELLOW: DELAYED - Patients that you think could survive for up to two hours until they reach a definitive care facility. Some of these patients may need surgery. However, they do not appear to have any "life- threatening" injuries.

GREEN: MINOR - Injuries or conditions which, even if untreated for an extensive period, will not likely lead to shock, respiratory compromise or altered mental status. This category includes all "walking wounded".

BLACK: NON-TRANSPORT - Deceased

	Patients	Field Supervisor	Command Staff Response	Special Units	Notification
Phase 1	1-10	1	Shift Commander	TRU on request	Agency Head, Agency Medical Director
Phase 2	11-30	2	On-duty Command Staff	Special OPS; TRU	Command Staff
Phase 3	31-50	Recall	On-Call Command Staff	TRU, TSU, MCU, Communication Support	Command Staff
Phase 4	51-200	Recall	Recall	Mutual Aid, State Ambulance Task Force	Command Staff
Phase 5	>200	Recall	Recall	State and Federal Assistance	Command Staff
Phase 6	Long Term OPS	As Needed	As Needed	As Needed	Command Staff, update regularly

Definitions: TRU= Tactical Response Unit
TSU= Tactical Support Unit
MCU= Mass Casualty Unit

Appendix E.1

DISPATCH CENTER / FIRE ALARM CHECKLIST

PHASE ONE INCIDENT - TEN or LESS PATIENTS EXPECTED

- Bring initial minimum dispatch package to three ambulances, (2 BLS & 1 ALS), to reflect minimum staffing needs to manage ICS positions.
- Respond Field Supervisor.
- Respond on-duty Commander.
- Announce Phase One Incident in progress on dispatch and TAC channels.
- Dedicate and staff a TACTICAL channel.
- Initiate PHASE alert to METRO-BOSTON C-MED.
- Transmit the appropriate system notifications.
- If phased incident declaration is expected, announce, “MCI Protocols are in effect for this response.”

PHASE TWO INCIDENT – ELEVEN TO THIRTY PATIENTS EXPECTED

- Bring minimum dispatch package to total of six *(6)* ambulances, *(4 BLS & 2 ALS)*.
- Confirm appropriate Phase One actions are completed.
- Announce Phase Two Incident in progress on dispatch and TAC channels.
- Respond On-Call Commander to the scene.
- Respond second Field Supervisor.
- Respond additional Special / Mutual Aid Units as needed.
- Identify/Announce ICS positions and their transitions.
- Announce the location of the Incident Operations Area

  _____
- Announce the location of the Treatment Area

  _____
- Announce the location of the Transportation Area

  _____
- Announce the location of the Staging Area

  _____

- Declare location of Staging Area to police departments.

Appendix E.1

- Transmit the appropriate paging system incident updates.
- Recall off-duty commanders to fill the Incident Command System as needed or requested by the Incident Commander.
- Recall any off-site Dispatch Center / Fire Alarm personnel, if necessary.
- Notify the mayor's office of the primary jurisdiction.
- Poll mutual aid providers for resource availability.
- Consider contacting the MBTA for additional transportation capabilities, if needed.
- Access mapping or GIS resources of affected area.
- If a television is available, turn on a local news channel to see any media coverage of the event.

PHASE THREE INCIDENT – THIRTY-ONE TO FIFTY PATIENTS EXPECTED

- Bring minimum dispatch package to eight (8) ambulances, (5 BLS & 3 ALS).
- Confirm appropriate actions from lower Phases are completed.
- Transmit the appropriate paging system incident updates.
- Prepare to make selective or general recall of personnel.

PHASE FOUR INCIDENT – FIFTY-ONE TO TWO HUNDRED PATIENTS EXPECTED

- Confirm actions from lower phases are completed.
- Notify all mutual aid partners of a phase four incident, and direct them to dispatch one transport asset and one supervisor to the designated staging area.

- Confirm that the Incident Commander has notified C-MED of a phase four incident.

Appendix E.1

PHASE FIVE INCIDENT – MORE THAN TWO HUNDRED PATIENTS EXPECTED

- Confirm all actions from lower phases are completed.
- Ensure all additional requests or notifications go through the Incident Commander.

PHASE SIX INCIDENT – SUSTAINED OPERATIONS

- No additional checklist items.

Appendix E.2

INCIDENT OPERATIONS AREA CHECKLISTS

INCIDENT COMMANDER (FROM FIRST ARRIVING EMS CREW):

- Assume call sign "_____ I/C" until the first supervisor arrives, then assume call sign "_____ EXTRACTION".
- Don appropriate PPE and identification vest.
- Conduct initial situation size-up, *"M-E-T-H-A-N-E".*
- Assign a Phase level.
- Direct in-coming units.
- Designate operational areas.
  - Incident Operations Area _____
  - Treatment Area _____
  - Transportation Area _____
  - Staging Area _____

- Direct the removal of patients by other public safety / rescue personnel in order of triage priority.
- Advise I/C of additional resource needs if any.
- After incident, complete after action report and submit to the incident commander.

TRANSITION: FROM INITIAL INCIDENT I/C, TO INCIDENT OPERATIONS AREA - EXTRACTION OFFICER. MAY BE RELIEVED ONCE INCIDENT OPERATIONS AREA IS CLEARED OF AFFECTED VICTIMS OR AT THE DIRECTION OF THE I/C.

Appendix E.2

TRIAGE OFFICER (SECOND MEMBER OF FIRST ARRIVING EMS CREW)

- Assume call sign "_____TRIAGE".
- Don appropriate PPE and identification vest.
- Assess potential hazards and safety of operations. If another agency is in control of the area (i.e. the Police or Fire Department), wait for an assurance of safety by the agency in control.
- If hazards prevent triage within the Incident Operations Area, patients will be extricated to a triage point in a safe location adjacent to the Treatment Areas. Affected personnel, patients, and equipment must be decontaminated before they are allowed to transfer to the treatment areas.
- Begin triage process using the START Protocol and SWEEP TRIAGE method (See Appendices B and C).

- Direct supplemental EMS personnel in triage of patients.

Initial interventions instituted for patients within the following limitations:

- Airway controls by use of oral / nasal airway or head positioning.
- Control of severe bleeding by use of standard measures.
- Treatment of shock by Trendelenburg *(or similar)* positioning.
- Prolonged or in-depth treatment shall be limited to entrapped patients. Such medical care will start only after triage is complete or if there is sufficient staff on hand to ensure that triage will be completed immediately.
- Whenever possible, "walking wounded" or bystanders can be used to assist in patient interventions.

TRANSITION: WHEN TRIAGE IS COMPLETE, TRANSITION TO OPS STAFF.

Appendix E.2

OTHER UNIFORMED PERSONNEL WORKING IN THE INCIDENT OPERATIONS AREA

- Don appropriate PPE.
- Complete triage and taping/tagging of all patients.
- Assist in the removal of patients with other public safety/rescue personnel in order of triage priority.

Treat patients within the following limitations:

- Airway controls by use of oral airway or head position.
- Control of severe bleeding by use of standard measures.
- Treatment of shock by Trendelenburg (or similar) position.

Prolonged or in-depth treatment shall be limited to patients entrapped. Such medical care will start only after triage is complete or there is sufficient staff on hand to ensure that triage will be complete immediately. Whenever possible, "walking wounded" or bystanders can be used to care for patients.

Appendix E.2

FIRST ARRIVING SUPERVISOR:

- Assume "_____IC" call sign.
- Don appropriate PPE and identification vest.
- Obtain situation report from previous I/C.
- Provide radio updates every 10 minutes, and escalate Phase level as necessary.
- Replenish Triage Officer's supply of MCI equipment, if necessary.

- Ensure victim extraction operations are moving efficiently.
- Request additional resources from Dispatch Center / Fire Alarm as necessary.
- Distribute ICS position identification vests.
- Designate location of Command Post.
- Establish Unified Command with other Public Safety Agencies.
- After incident, complete after action report and submit to the incident commander.

TRANSITION: RELIEVED BY COMMANDER, TRANSITION TO INCIDENT OPERATIONS OFFICER.

Appendix E.3

TREATMENT AREA CHECKLISTS

TREATMENT OFFICER

- Assume "_____ TREATMENT" call sign.
- Don appropriate PPE and identification vest.

- Establish treatment area in safe and accessible location adjacent to the incident operations area.
- Identify and delineate area with tape, cones, signage, or other resources.
- Screen patients for proper decontamination.
- Re-triage incoming patients or delegate task.
- Assign treatment teams and leaders if necessary.
- Supervise patient care.
- Coordinate with the Transportation Officer to maximize transport resources.
- Update I/C at regular intervals.
- After incident, complete after action report and submit to the incident commander.

TRANSITION: *RELIEVED BY FIRST ARRIVING PARAMEDIC, TRANSITION TO TREATMENT AREA STAFF.*

Appendix E.3

OTHER TREATMENT STAFF:

- Don appropriate PPE.

- Direct / divide patients into treatment groups.
- All contaminated personnel, patients, and equipment must be decontaminated before entering the treatment area.
- Treat patients to level established by TREATMENT OFFICER and EMS Treatment Protocols.
- Prepare patients for transport.

TRANSITION: *NO TRANSITION EXPECTED.*

Appendix E.4

TRANSPORTATION AREA CHECKLISTS

TRANSPORATION OFFICER

- Assume "_____ TRANSPORTATION" call sign.
- Don identification vest.
- Identify a resource officer as soon as possible to assist in documenting patients or communicating over the radio.
- Establish Transportation Area next to Treatment Area with good access and egress. Coordinate with the Police Department when possible.
- Announce location of Transportation Area on event tactical channel.
- Secure assignment of a coordination radio channel from C-MED.

- Identify priority patients for transport from Treatment Area.
- Relay patient information to C-MED as patients are loaded.
- Secure hospital designations from C-MED & direct ambulances to designated hospitals.
- Transmit patient information for receiving hospitals to monitor.
- Maintain proper documentation of patients transported on MCI Tag Transportation Tab.
- Scan barcode into Patient Tracking System, *(if applicable).*
- Request additional resources through IC as needed.
- After incident, complete after action report and submit to incident commander

TRANSITION: RELIEVED BY SECOND ARRIVING SUPERVISOR, TRANSITION TO "LOADING OFFICER".

Appendix E.4

LOADING OFFICER

- Assume "_____LOADING" call sign.
- Don identification vest.
- Monitor event tactical radio channel for operational updates & report to TRANSPORTATION OFFICER.
- Assign transport priorities for vehicle loading.
- Group patients for transport compatibility.
- Maintain records of patients transported.
- Request additional resources through TRANSPORTATION OFFICER as needed.
- After incident, complete after action report and submit to the incident commander.

TRANSITION: RELIEVED BY ADDITIONAL ARRIVING SUPERVISOR (if applicable), TRANSITION TO"TRANSPORTATION AREA STAFF".

Appendix E.5

STAGING OFFICER

- Assume "_____STAGING" call sign.
- Don identification vest.
- Coordinate with police for traffic control of area.
- Establish Staging Area.
- Announce staging area location to IC and C-MED.
- Monitor frequency and dispatch resources as needed.
- Assemble resources in orderly fashion.
- Ensure that vehicles conserve electric power and fuel.
- Instruct drivers to stay with their vehicles.
- Advise IC when special units arrive.
- Segregate resources as required (BLS; ALS; SPECIALITY; etc.).
- After incident, complete after action report and submit to the incident commander.

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Appendix F

RESOURCE OFFICER CHECKLIST

- Assume "_____Resource" call sign.
- Don identification vest.
- Develop a brief description of the incident.
- Develop a map of the affected area.
- Assess and record current resources deployed.
- Record level of activity of other Public Safety Agencies.
- Make recommendations to IC and Planning/Logistics Section of additional resources needed or changes needed in location of operational areas, etc.
- Record and maintain status reports of the activity in the four main operational areas to include:

  Number of patients remaining.

  Number of personnel engaged.

  Progress of operations.

  Supply status.

  Remaining uncommitted resources
- Make progress reports to EMS Incident Commander at established intervals. Remain near EOC except while gathering information from other areas.

- Interface with Elected Officials and State and Federal Agency Representatives as needed.

Appendix F

INCIDENT COMMANDER CHECKLIST

STAFF: HIGHEST-RANKING COMMAND STAFF MEMBER

- Report to command post.
- Receive briefing from preceding EMS IC.
- Assume IC call sign.
- Don identification vest.
- Meet with IC support staff to assess situation.
- Develop plan to re-deploy resources if needed.
- Interface with ICs from other public safety agencies.
- Prepare to assign an On-Scene Incident Commander and move to EOC if necessary.
- Interface with elected officials and state and federal agency representatives as needed.
- Determine appropriate time to de-escalate.
- Re-align staffs to fortify post incident recovery assignments.
- Oversee final report of EMS operation.
- Request additional assets as needed.
- Consider palliative care if overwhelming number of expectant patients are possible.

- Collect after action reports, write Incident Commander after action report, and give to the Superintendent of Communications & Professional Standards.

Appendix F

AFTER ACTION REPORT	
Name	**ICS Position**
Time of Incident	**Location of Incident**
Type of Incident	

Chronological Summary of Events

Appendix F

Interacting Systems, Agencies, and Programs: Include mutual aid systems (law enforcement, fire/rescue, medical, etc.); cooperating entities (utilities, American Red Cross, university departments, etc.); telecommunications and media interactions.

Improvements, Conclusions, Recommendations: As applicable, include a description of actions taken, assignments, associated costs or budget, timetable for completion or correction, and follow-up responsibility.
Training Needs
Recovery Activities
References: Maps, charts, training materials, etc.

Satellite Telephone Equipment

Supersedes:
Effective: 5-14-2007

Section 1.0 Introduction

(a) Metro-Boston Homeland Security Region (MBHSR) public safety agencies recognize the need for reliable backup communications capabilities to support interoperable communications across disciplines and jurisdictions. To address this need, portable satellite phones have been purchased for key leaders across the MBHSR to ensure backup communications capabilities for public safety agencies and first responders in the event of a loss of primary and/or secondary communications means.

(b) The purpose of this SOP is to establish the authority, procedures and guidelines for operating and maintaining the portable satellite phones within the MBHSR and is applicable to the nine MBHSR jurisdictions receiving said equipment. These nine jurisdictions include: Boston, Brookline, Cambridge, Chelsea, Everett, Quincy, Revere, Somerville, and Winthrop.

Section 2.0 Purpose

(a) The principal objective of the regional satellite phone effort is to provide key leaders from various MBHSR agencies a backup means of communications. Not only can this equipment serve as a backup communications capability for use at each agency's discretion in day-to-day operations, but it will additionally provide an interoperable communications resource in the event all other forms of communication fail.

(b) The satellite phones are assigned to the agency heads of MBHSR police departments, fire departments, public health, emergency management, jurisdiction executives, and other key leaders. These personnel and their assigned satellite phone are provided in Appendix A.

Section 3.0 Authority

(a) The U.S. Department of Homeland Security designated Boston a high-threat urban area in July 2003 as part of the Office for Domestic Preparedness' (ODP) Urban Area Security Initiative (UASI) grant program. As the core city, Boston oversaw the delineation of the region, and created the Boston Mayor's Office of Homeland Security (MOHS) to integrate and manage all homeland security activities. The UASI region was subsequently named the Metro Boston Homeland Security Region (MBHSR) and consists of nine jurisdictions: Boston, Brookline, Cambridge, Chelsea, Everett, Quincy, Revere, Somerville, and Winthrop. The MOHS was subsequently renamed as the Mayor's Office of Emergency Preparedness (MOEP).

(b) In partnership with the region's Communications Interoperability Subcommittee (CIS), MOEP led an effort to develop a Communications Interoperability 5-year

Strategic Plan that addresses and prioritizes how the MBHSR can enhance interoperable communications capabilities during response to emergency incidents.

(c) As part of the implementation of the MBSHR Communications Interoperability 5-year Strategic Plan, the region has purchased Iridium 9505A portable satellite phones for key public safety leaders across the region.

Section 4.0 Overview of the Equipment

(a) The satellite equipment included in this effort is comprised of Iridium 9505A portable phones in ruggedized cases that are supported by the Iridium Satellite system. Each jurisdiction has agreed to pay for the monthly operating costs of the phones and is therefore responsible for its monthly bill from SatCom Direct, the current provider of Iridium satellite phone equipment and service. Monthly reoccurring costs include, but are not limited to, the monthly base rate for activation as well as the per minute fee for phone usage.

(b) An overview of the key functions of the satellite phone and guidelines for operation are provided in Appendix B.

Section 5.0 Operating Procedures

(a) The Iridium 9505A satellite phone provides a backup means of communications when used **outdoors** and is not capable of providing service within buildings. To operate the 9505A, the user must be within a clear line-of-site of the sky in all directions. This is to ensure connection with the Iridium satellites. In the Boston area, at any given time one to three satellites are within view.

(b) Daily use of the portable satellite phones is at the discretion of the public safety agency and user who accept responsible for the costs incurred. The following procedures are intended to establish common guidelines for use in the event of a regional emergency as well as procedures for regular use in testing and planned events to ensure equipment familiarity.

(c) In the event of a regional emergency, all portable satellite phones should be powered on to support regional communications. The following are examples of the types of incidents or regional activities which shall cause users to power on their portable 9505A satellite phones:

i) **The region wide failure of both the Public Switched Telephone Network (PSTN) and the cellular telephone network.** This failure could be the result of major infrastructure damage sustained during a hurricane, earthquake, or other natural event; the result of an extended region wide power failure; the result of technical problems within telephone switching systems; or the result of sabotage or a major terrorist attack.

ii) **The region wide opening of MBHSR Emergency Operations Centers (EOC):** If a jurisdiction currently has dispatch center notification policies in place, the powering on of portable satellite phones should be included in said notification scheme.

(d) The following are examples of the types of incidents or regional activities which may cause users to power on their portable 9505A satellite phones; a decision which is at the discretion of each jurisdiction:

i) **The failure of either or both the Public Switched Telephone Network (PSTN) and the cellular telephone network within a city or major part of a city.** Failure in this context may also mean that the networks are technically operational but congested to the point of being inaccessible.

ii) **The opening of a MBHSR Emergency Operations Center (EOC):** If a jurisdiction currently has dispatch center notification policies in place, the powering on of portable satellite phones should be included in said notification scheme, particularly when communications problems are apparent during EOC activation.

iii) Any other event in which one or more users determine that satellite phone communications are useful to support public safety communications needs.

Section 6.0 Testing and Usage

(a) The testing and usage outlined in this SOP is intended to ensure that the user is familiar with the basic operation of the satellite equipment and that the equipment is functional. Testing is a key aspect of any regional satellite phone as outlined in the federal report "Independent Panel Reviewing the Impact of Hurricane Katrina on communications Networks: Report and Recommendations to the FCC",

"There were functionality issues with satellite communications – largely due to lack of user training and equipment preparation… Users who had not been trained or used a satellite phone… reported frustration and difficulty in rapid and effective use of these devices."

Based on these lessons learned and best practices throughout the country, the MBHSR has developed a regional testing and usage procedure as outlined below.

(b) Regular, monthly testing will be conducted on all portable satellite phones for the first year of activation to ensure a user is familiar with the procedures for placing and receiving a call. After a year, the frequency of testing will be reviewed by the CIS and new guidelines will be reissued at that time. It is the responsibility of each jurisdiction to ensure compliance with the following testing procedures:

i) Testing will be conducted monthly for the first year of activation and managed by each jurisdiction/agency's dispatch center or designee. The dispatch center or designee will track and initiate calls to all portable satellite phones in the jurisdiction.

ii) Monthly at a set, scheduled time, the responsible dispatch center or designee will place a call to each portable satellite phone within their jurisdiction/agency.

iii) The user will successfully answer the call, conduct a voice quality check and end the call.

iv) The user will then place a call back to the dispatch center or designee using the portable satellite phone, conduct a voice quality check, and end the call.

v) Each jurisdiction must submit a report to MOEP at the end of every testing period reporting completion of these testing procedures. MOEP will track compliance, contact any jurisdictions that are failing to regularly conduct testing and periodically notify the CIS of the status of regional compliance.

(c) The MBHSR region should utilize the portable satellite phones, as appropriate, in planned events to ensure regular usage of the equipment. The portable satellite phones may be utilized to support communications between key MBHSR leaders for the purposes of command and control functions, emergency response coordination, or other public safety communications deemed necessary.

Section 7.0 Maintenance Procedures

(a) The following guidelines outline regular maintenance intended to ensure that the equipment is fully operational.

(b) In order to properly maintain the satellite equipment each agency must ensure that the following steps are taken regularly:

i) Each jurisdiction must ensure that both lithium ion batteries provided with the portable satellite phones are fully charged. The battery level should be checked during the testing period outlined above. The charge for both batteries will need to be verified by placing the battery within a portable satellite phone and visually checking the battery status bars on the front menu screen. Depending on the method of charging (AC or DC power source), the time required to fully charge the battery can range anywhere from four to six hours.

ii) Rotate and extend the antenna to ensure functionality.

Equipment & Facilities

Boston EMS Headquarters Access

Supersedes: 09-19-01
Effective: 12-05-11

Background
Boston EMS is committed to ensuring a safe and secure working environment. In early 2011, the Department consolidated its headquarters to a single building located in the larger Northampton Square Complex. The complex houses the South End Fitness Center, a parking garage and BPHC housing and allows access to Boston Medical Center. The shared use of the complex coupled with multiple entrances presents challenges specific to controlling access to EMS Headquarters. As such, the Department developed the "Boston EMS Headquarters Access Policy" to establish a series of procedures aimed at improving building security and enhancing employee safety. Every Boston EMS employee is responsible for playing a role in ensuring that the Department's headquarters is safe and secure.

Headquarters Hours of Operation
Boston EMS' official business hours are 8AM – 5PM, Monday through Friday, except holidays. The reception desk on the 4th floor is staffed accordingly. However, because Boston EMS is a 24/7 operation, department employees and visitors are often in the building outside of official business hours.

Building Entrances
Boston EMS Headquarters can be entered in four different ways:

- Via the 785 Albany Street door ***(main entrance for visitors)***
- Via the elevators from the Northampton Square Parking Garage (1st, 2nd and 3rd floors)
- Via the 4th floor from 35 Northampton Street ***(wheelchair accessible entrance)***
- Via the unmarked door on the Massachusetts Avenue side of the building (***employee only***)

Individuals without card key access attempting to enter headquarters through 785 Albany Street must be buzzed into the building. Visitors seeking access for non-Boston EMS purposes (i.e. seeking access to the South End Fitness Center, BMC, etc.) should be directed to enter the complex via the 35 Northampton Street entrance. Only individuals with business at Boston EMS Headquarters will be allowed to enter through 785 Albany Street.

Upon admittance to headquarters, all visitors are required to check-in at the 4th floor reception desk regardless of their entry route.

Only employees shall have the ability to enter headquarters via the unmarked door on the Massachusetts Avenue side of the building.
Employees shall not prop open exterior doors or admit unauthorized persons into the building at any time.

BPHC Security
BPHC Security provides 24/7 security services for the entire Northampton Square Complex including Boston EMS Headquarters. Two security officers are stationed in the Northampton Square Parking Garage in an office located directly to the right of the garage entrance. **BPHC Security can be reached immediately by phone at 617-534-5847.** If BPHC Security is unavailable, employees should dial 9-1-1.

BPHC Security routinely conducts security checks on all floors of headquarters 7 days a week at various times, both during and outside official business hours. If BPHC Security notices suspicious behavior they will alert a member of the Office of the Chief or Professional Standards as soon as possible. If unavailable, they can also alert Boston EMS Dispatch Operations. If an officer notices any maintenance related issues, he/she will contact the Boston EMS Director of Facilities.

Employee Identification Cards
When in the building, department members not in uniform should wear a valid identification card (ID) issued by Boston EMS or BPHC AT ALL TIMES. The ID must be visible on the employee's person.

Employees must report lost or stolen ID cards to Professional Standards (617-343-1144) immediately so card access can be deactivated. Further, employees reporting a lost or stolen ID card will follow the steps outlined in the department's "Care and Use of Department Equipment" policy.

Outside Visitors
Outside visitors regularly frequent headquarters during and outside official business hours. It is therefore imperative that all employees follow the guidelines issued below to ensure safety and security.

Visitor Information

1. Employees expecting a visitor should direct him/her to enter through one of three visitor access points: 785 Albany Street, the Northampton Square Parking Garage or 35 Northampton Street.

2. Upon entry to Boston EMS Headquarters, all visitors should proceed to the 4th floor reception area. Employees should instruct visitors to arrive 5-10 minutes early to ensure ample time for the registration and ID issuance process.

3. Employees may direct first time visitors to the department website for headquarters access instructions found at http://www.cityofboston.gov/ems/contact.asp.

Reception Desk Notification

1. Whenever possible, employees shall notify the reception desk at least 24 hours in advance of a visitor's arrival, providing the information outlined below:
   - Visitor's name
   - Visitor's title and organization
   - Date and time of visit
   - Nature of visit
   - Contact information of the person to alert upon visitor's arrival

   Notification shall be sent via email to receptiondesk@bostonems.org.

2. If an employee is hosting a large group (10+ people) during official business hours, he/she will make every effort to provide attendance information as far in advance as possible (no less than 24 hours) as a courtesy to reception desk personnel. Whenever possible, employees will also attempt to collect RSVPs to help ensure a more definitive list of attendees.

3. If an employee regularly hosts an event with a large group (10+ people), either during or outside of official business hours, he/she will provide the reception desk with details including the meeting name, Boston EMS contact, and meeting frequency. He/she will also provide meeting date, time, location and attendee information if available.

Visitor Registration, ID Issuance and Exit

1. **All visitors are required to register at the reception desk on the 4th floor.**

2. Upon registration, visitors will be issued a temporary sticker ID with photo which must be worn in a visible location on their person at all times while on Boston EMS premises. Any employee hosting a visitor is responsible for ensuring the person is wearing the issued sticker ID.

3. Once a visitor arrives and is issued a visitor ID, the reception desk will notify the visitor's host via phone or email. If the host is available, he/she can greet the visitor on the 4th floor or the reception desk will direct the visitor to the meeting location. If the host is unavailable, the visitor will be required to wait on the 4th floor until he/she receives further direction.

4. The host is responsible for ensuring the visitor remains attended for the length of the visit. Further the host will ensure the visitor does not have access to unauthorized portions of the building. At the end of the visit, the host will direct the visitor to exit headquarters.

5. If an employee is expecting a visitor outside of official business hours, he/she will be responsible for directing the visitor to the 35 Northampton Street entrance or arranging for an alternate entrance. Visitors arriving outside of official business hours will not be issued visitor IDs. Therefore, it is even more imperative that the host account for visitor whereabouts and ensure proper exit of the building upon the meeting's conclusion.

Note: Uniformed visitors from other city public safety agencies as well as city employees wearing valid employee ID cards do not need to be issued a temporary sticker ID.

Noncompliance

1. Visitors who do not follow the guidelines outlined above may be asked to leave the building and may be placed on the "deny entry" list (see below).

Packages

Upon delivery, reception desk personnel will alert recipients by phone or page that a package has arrived. The recipient, if available, will arrange for someone to come to 4th floor reception to meet and sign for his/her package. If unavailable, reception desk personnel will store the package in a secure location on the 4th floor.

Suspicious Behavior

Employees shall immediately report suspicious persons or behavior to BPHC Security (617-534-5847) or the Boston Police (9-1-1). Reported persons/behaviors should also be brought to the attention of the Office of Safety (617-343-1166).
If an employee feels uncomfortable exiting the building or walking to his/her car alone, the department recommends the use of the buddy system. Alternatively, the employee

can contact Professional Standards (617-343-1144) or BPHC Security (617-534-5847) to arrange an escort.

Reception Desk Panic Button
The 4th reception desk is equipped with a panic button to be used only in the event of an emergency. Reception desk staff can find an orange panic button under the reception desk to the right of the computer screen. If the button is pressed, an alert will sound in BPHC Security and an officer will immediately be dispatched to 4th floor reception. Any time the button is pressed, even in error, an officer is required to respond.
Once the issue is resolved, reception desk staff must reset the panic button using the white horseshoe shaped key located in the top drawer of the reception desk. Note, BPHC Security also has a copy of the reset key.

In the event of immediate danger reception desk staff should dial 9-1-1 and press the panic button.

Deny Entry
Visitors who are unauthorized to be in Boston EMS Headquarters can be classified as "deny entry" in the Boston EMS visitor ID system. If such an individual arrives at the 4th floor reception desk and attempts to obtain a visitor ID, reception desk staff will receive a "deny entry" notification. Further, the system will automatically send an email alert to denyentry@bostonems.org which is distributed to Pro Standards, BPHC Security, the Office of Safety, Command Staff, Captains, the Director of Administration and Finance and the Director of Facilities. Reception desk staff should immediately contact BPHC Security (617-534-5847) for assistance if needed.
If an employee feels an individual is a threat to security and should be denied future entry, he/she should contact Pro Standards (617-343-1144) who will work with reception desk staff to classify the individual as "deny entry" in the visitor ID system. Pro Standards will further alert BPHC Security (617-534-5847).

General Safety Guidelines
All employees must play a part in ensuring department safety and should follow the guidelines below:

- Do not admit unauthorized persons into the building.
- Report suspicious persons or behavior to BPHC Security (617-534-5847) or the Boston Police (9-1-1). Please also alert the Office of Safety (617-343-1166).
- Do not prop open exterior doors at any time.
- Direct all visitors to report to the 4th floor reception area for registration and ID issuance.
- When in the building, non-uniform staff must wear a valid identification badge (ID) issued by Boston EMS AT ALL TIMES.
- Report a lost or stolen ID card to Professional Standards (617-343-1144) immediately so card access can be deactivated.
- Use the buddy system whenever possible when walking through the parking garage or at night when exiting the building.
- Secure department vehicles when not in use.
- To the extent possible, park department vehicles on the lowest level of the parking garage closest to the headquarters entrance.

Computer Aided Dispatch System Failure

Supersedes: 01-01-13
Effective: 06-17-14

1. If advance notice is given that the Computer Aided Dispatch (CAD) System will be inaccessible/inoperable ("down"), the dispatcher shall print a copy of all active incidents. If no notice is given prior to the system becoming unusable, the dispatcher shall attempt to retrieve as much information as possible from the monitor.

   1.1. The TAC-1 Dispatcher will transmit an alert tone on all BEMS channels and broadcast a message advising field units that the CAD system is "down".

   1.2. The Dispatch Operations Supervisor will notify Technical Services and the Commander of Dispatch Operations via the EMS paging system whenever the CAD System is out of service.

2. Telecommunicators shall use the same callhandling procedures, regardless of the status of the CAD system. Relevant information for each request for service or initiated activity (e.g. onsites) that would normally be recorded via the CAD system will be recorded on "Green Cards" (EMS Form AM 5201) or whatever form is developed in the future for this purpose.

   2.1. Relevant information includes: date and time of request; location of incident reported; call-back number to reporting party; name and address of complainant (if possible); type of incident reported; identification of unit(s) assigned; ancillary agencies notified; time of each status changes (dispatch, on scene, en route hospital, at hospital, return to service); and the disposition or status of reported incident.

   2.2. For calls requiring a Boston Police response, a separate card will be created and forwarded to the appropriate police dispatcher. For calls requiring a Boston Fire Department, MassPort Fire, Massachusetts State Police or other ancillary agency response, the Telecommunicator handling the call entry shall be responsible for notifying the appropriate agency by landline.

   2.3. The Dispatch Operations Supervisor shall designate one member to act as "runner" to facilitate the delivery of "green cards" from EMS calltakers to EMS and BPD Dispatchers.

3. Once the CAD system has been restored, the dispatcher shall confirm that the equipment is operating properly and log on, assume control of the appropriate dispatch group(s) and reconfigure the monitor as necessary. Incidents that began before CAD went down and are still active can be updated using the normal CAD commands.

4. All “green cards” shall then be forwarded to the Dispatch Operations Supervisor for further processing. The Dispatch Operations Supervisor, or his/her designee, shall enter incidents that began and were completed while CAD was down and for incidents that began before CAD went down and were completed while CAD was down.

Care and Use of Department Property and Equipment

Supersedes:
Effective: 11-21-05

POLICY

All employees having or using any equipment or property belonging to Boston EMS shall be responsible for the proper care and handling of that equipment or property. Department equipment shall not be used for other than assigned purposes without prior permission from the Chief of Department or designee. Equipment or property which is lost, wasted, or damaged through negligence, carelessness, or improper use may be charged against the employee responsible. Depending on the circumstances, the employee may be disciplined and / or required to replace the item or pay a portion of the replacement cost as determined by the Department.

REPORTING DAMAGED, DESTROYED, LOST, OR STOLEN EQUIPMENT

In the event of damage or loss to Department property or equipment, the person responsible shall immediately report the damage or loss to their supervisor, who in turn, will investigate the situation. A thorough incident report shall be completed when reporting needed repairs for all types of equipment, including building repairs. When requesting replacement of issued equipment, for any reason, Department personnel shall give a detailed account of how the equipment was damaged, destroyed, lost, or stolen.

A police report shall be filed in the appropriate jurisdiction whenever a piece of Department equipment is alleged to have been stolen. A police report shall also be filed whenever a sensitive piece of Department equipment has been lost. For the purposes of this policy, a sensitive piece of equipment means any item that can be used to transmit on a Boston EMS radio frequency, impersonate a member of the Department, or allow access to an EMS facility. Loss of items such as a badge; portable radio; uniform shirt or jacket; personal protective equipment such as respirator, helmet, or bullet-resistant vest; laptop computer; or Department ID card shall be reported to the police in addition to Boston EMS.

The report(s) shall then be forwarded to Professional Standards, and a copy sent to the area responsible for issuing the piece of equipment or property. Equipment that is damaged or malfunctioning shall be turned in before new equipment is issued. Reissue of essential equipment shall be accomplished through the responsible Unit (e.g., Communications Engineering, Fleet Services, Materials/Facility Management, etc.) as soon as possible.

SAFEGUARDING EQUIPMENT

The Department has provided replacement equipment for items that have been damaged, destroyed, or stolen in the performance of duty. Department personnel may be disciplined and/or liable for reimbursement costs for any items damaged, destroyed,

lost, or stolen during the employee’s shift if proper care was not taken to safeguard the property.

Evacuation of Primary PSAP

Supersedes: 10-31-14
Effective: 04-09-18

Alternate PSAP / Backup Center

Boston Fire Alarm, located at 59 the Fenway, serves as the Back Up Center for the City of Boston. Five additional Next Gen 9-1-1 call taking positions are located in the main operations area at Fire Alarm and are continuously logged-on and available to receive any alternate routed 9-1-1 calls. A back-up operating center is housed in the basement area of Fire Alarm for receiving 9-1-1 calls and dispatching EMS and Police units should an evacuation of the Primary PSAP become necessary. The backup center is equipped as follows:

Ten (10) Telephone Positions:

- Five (5) 9-1-1 Police Answering Positions
- One (1) Police Duty Supervisor Position
- One (1) Police Clerk Position
- One (1) EMS Supervisor Position
- Two (2) EMS Answering Positions

Eight (8) Dispatch Positions:

- Six (6) Police Dispatching Positions
- Two (2) EMS Dispatching Positions

The decision to order an evacuation of the Primary PSAP and begin operating from the back-up Center shall be a decision based upon multiple factors and must include coordination by Boston Police, Boston EMS and Boston Fire Department personnel. Even under the best of circumstances, the ability to receive and process requests for emergency service from the back-up Center will be limited because of the reduced number of calltaking positions, dispatch capability and support services. It is conceivable that under certain types of equipment failures, the back-up center could be activated on a partial basis. For example, telephone answering could be completed at the back-up center while Citywide Dispatch, CMED and BAPERN operations continued at the primary PSAP. Prior to ordering any evacuation, caution should be exercised assuring there are no other reasonable alternatives.

Unless there appears to be a clear and present danger to Dispatch Operations personnel, the evacuation order for the Primary PSAP shall include consultation with the following Command Staff and Technical personnel: Superintendent in Chief; Superintendent of Field Services; Superintendent of Field Support, and the Commander of Dispatch Operations.

As soon as it appears an evacuation may become necessary, the **GDIT Help Desk (1-855-626-4911** and Boston Fire Alarm should be notified of the situation and requested to begin preparing for possible activation of the back-up center.

- At least one dispatch qualified EMS Telecommunicator shall be sent to Fire Alarm with a portable radio to prepare to take over dispatch functions. This Telecommunicator does not necessarily have to be sent from Dispatch Operations and may come from a field unit or the administrative office if available.

- Upon arrival at Fire Alarm, the EMS Telecommunicator will be given access to a supervisor CAD workstation (if functioning) on the main floor of Fire Alarm. [CAD terminal **FDS03** has been designated for this purpose]. The Telecommunicator shall monitor the EMS incidents and prepare to take control of the EMS CAD group should an evacuation of the Primary PSAP become necessary.
- BFD***:*** The senior operator or his/her designee shall open up the back-up Center and ensure that all Computer Aided Dispatch (CAD) computers are powered up and functional. Fire Alarm personnel should not log onto Next Gen 9-1-1 units in the back-up center at this time as this may cause alternate routed calls to be delivered to the back-up center, rather than the main operations area upstairs.

Non-Emergent Evacuation

In situations where an evacuation is necessary, but there is no immediate threat to the life-safety of personnel, the following steps should be taken prior to, or in conjunction with, the routine evacuation of the Dispatch Center:

- Fire Alarm should be notified of the decision to evacuate and to prepare to handle alternate or re-routed 9-1-1 calls.
- Arrangements should be made to transport personnel to Fire Alarm via BPD and /or EMS units.
- Supervisors should ensure that all CAD and Next Gen 9-1-1 Terminals are "LOGGED OFF" prior to evacuation. Personnel should take their headsets with them to Fire Alarm.
- EMS: Communications Engineering will be called to "call forward" the EMS Dispatch Operations administrative numbers to Fire Alarm. Calls will be directed to ring at the EMS Supervisor position in the backup Center.
- An announcement shall be made via TAC-1, BAMA, and MED-4 advising units that CMED capabilities will be limited. The CMED operator shall select the COBTH group and announce "Attention all hospitals, be advised that Metro-Boston CMED is unable to coordinate patch requests at this time. Hospitals are directed to monitor their radios for incoming radio traffic until further notice. " The following Patch groups will then be established:

BASE	CHANNEL	HOSPITALS
2 W. ROXBURY	8	BWH, FLK
3 BOSTON	5	BID, BMCM# 1, BMCP, TMC
5 QUINCY	7.2	CRN, BID-MILT
6 CHELSEA	5.2	CHA-CAMB, MGH, SMRV
7 FOXBORO	4.2	BIDN, NORW
8 NATICK	1N	MWF, MWN
9 BURLINGTON	2.2	LAHY, WNCH
10 NEWTON	1.2	MNTA, NWH, STE
12 SCITUATE	7N	QMC, SSH
13 LITTLETON	8.2	EMER

- Once patch groups have been established, announce "The COBTH Disaster Network has been activated. Hospitals are now configured into their preset patches. Station KIR735, Metro Boston CMED, (operator ID), (time)"
- MassPort Fire Rescue and the Massachusetts State Police should be advised that 10 digit emergency numbers will be temporarily out of service. Requests for EMS or BPD response should be forwarded through Boston Fire Alarm Emergency 2-way number (617 536-1500).
- The "Evacuation 1 Schroeder" group page shall be transmitted with a notation that the back-up center at 59 The Fenway is being activated.
- The supervisor shall take a portable radio and, if available, a cellular phone. These items shall remain with the supervisor and taken to the back-up site.

Emergency Evacuation

If the cause of the evacuation is due to a catastrophic event or other hazardous condition making the Dispatch Center uninhabitable, the BPD and EMS Supervisors will advise their personnel to immediately evacuate the building.

- Should the Supervisor be injured or otherwise unable to fulfill these duties, the most senior Telecommunicator shall be in charge until relieved by a person of higher rank or a more senior Department member.
- Personnel shall be advised to meet in the designated meeting area (the corner of Tremont St. and Prentiss St. The Supervisor shall direct personnel to an alternate meeting site if it is determined that the designated meeting site cannot be utilized.
- EMS Personnel should assist in the evacuation of any injured employees or wheelchair bound personnel. Using the Evacuation chairs one on the BPD side and two on the EMS side near CNED and the AED (See "Fire at Dispatch Operations Center").
- Evacuated personnel should assemble at the meeting location for roll call. In the event any personnel are missing and cannot be accounted for, the supervisor shall immediately notify the incident commander of the person's last known location or assignment.
- Once the emergency evacuation is complete, any outstanding agency specific tasks outlined in Section 4 ("Non-Emergent Evacuation") should be completed as soon as possible.

Transition to Back-Up Center Operations

Call Routing:

- If the police Call takers remained logged-on / ready during the evacuation, 9-1-1 calls will be presented to their terminal. If the call is not answered within approximately 55 seconds, the call will then be sent to a standby Next Gen 9-1-1 terminal at Fire Alarm through alternate routing.
- If the police Calltakers remained logged on / not ready during the evacuation, the Miran Card system will determine Calltakers are logged on but none are available. Callers will receive a recorded message to stay on the line and the call will be placed in queue.
- If a 9-1-1 call is placed and there are NO police Calltakers logged on to the system, the call will be sent to Call Takers at Framingham State 9-1-1, until someone logs on to Next Gen 9-1-1at Fire Alarm.

- Upon notification that an evacuation of the Primary PSAP is underway, all available personnel at Fire Alarm should be prepared to staff the alternate PSAP positions. BFD Personnel should be prepared to receive alternate routed emergency calls over these lines.

Call Handling Procedures

- At a minimum, the following information should be elicited from every caller: Location of the reported emergency; call back number; Type of problem or description of incident.
- The information shall be used to generate a CAD incident using the same TYPE Code system used during normal operations (specifically, BFD Calltakers should use REQP when entering a request for police services or REQE when requesting EMS). In the event the CAD system is not functioning, calls shall be recorded legibly on cards with one card made out for each agency that will be responding.
- Because of the limited number of calltaking positions, call-handling procedures may have to be modified in order to ensure calls are processed in an efficient and orderly manner. Providing complete pre-arrival instructions or responding to lower priority calls may be temporarily suspended. This decision will be made by the supervisory staff on scene at the time and will take into account the number of personnel available to answer calls and call volume.

Dispatching

- It is imperative that a dispatch qualified Telecommunicator arrive at Fire Alarm as soon as possible to assume Citywide dispatch of EMS units. Initially, dispatching may be done by portable radio from the main operations area of Fire Alarm. Depending on the status of the radio equipment at Schroeder Plaza, there may be limited "portable to portable" coverage in some areas of the City, but "portable to vehicle" coverage should be acceptable.
- In the unlikely event that a complete evacuation of the Primary is PSAP is necessary before an EMS Telecommunicator has arrived at Fire Alarm, the Dispatch Operations Supervisor or designee shall contact Boston Fire Alarm (343-2880) by cellular telephone and remain in voice contact while enroute to the backup center. Fire Alarm personnel shall notify the EMS personnel of any EMS related incidents they have received and an EMS unit will be dispatched by EMS Dispatch Operations personnel while enroute to the back-up center.
- Upon arrival at the backup center, all pending EMS calls should be reviewed and appropriate EMS TYPE Codes assigned using the APCO EMD Guidelines. A roll call of EMS units should be performed to update their status and normal dispatch operations will commence.
- As more EMS Telecommunicators arrive, the EMS Supervisor shall assign them to assist the dispatcher as needed, function as Calltakers, monitor MED-4, or move downstairs to begin operating from the back-up Center.
- The telecommunicator assigned to CMED should direct units with Priority 2 or Priority 3 traffic to seek an alternate means of hospital notification (contacting the hospital via cellular phone or going through their own dispatch center). Units with Priority 1 traffic for a hospital with an existing patch (see section 4) should be directed to the appropriate MED channel with instructions to hail the hospital directly. If an existing patch is not available and the unit having Priority 1 traffic has no other means of notification, the CMED operator may provide a brief notification to the hospital via telephone or the VHF disaster radio.

Back-Up Center Activation

- Once a sufficient number of personnel have arrived and radio transmitters and digital logging recorders have been activated by BPD and EMS technical services personnel, Calltakers should begin logging on to the calltaking equipment in the back-up center. These calls can then be transferred, as appropriate to EMS or BFD calltaker positions for call entry.

Restoration of Operations

When a determination is made by Technical and Command staff personnel that operations at the Primary PSAP can be restored, the transition from the back-up Center to the Primary PSAP will be closely coordinated between all agencies involved.

Equipment Checkout

Supersedes:
Effective: 06-30-97

1. The on-duty Dispatch Operations Center Supervisor or his / her designee is responsible for inspecting the emergency medical equipment stored at the Dispatch Operations Center in accordance with current Department policy.
2. The SAED log book shall be completed per Department policy.
3. A notation shall be made on the supervisor summary documenting the time the equipment was checked.

Fire at Dispatch Operations Center

Supersedes: 02-01-00
Effective: 10-31-14

Dispatch Operations personnel shall use the "R-A-C-E" plan to respond to fire or smoke conditions occurring at the Dispatch Operations Center.

RESCUE:

- Rescue / Remove people from immediate fire scene.

ALERT:

- Notify co-workers and Supervisor about location of fire or smoke.
- Notify the Boston Fire Department.
  - Fire Alarm "pull stations" are located in the following areas of the 4th floor:
  - Adjacent to "Strategic Planning" on 4-South
  - Left hand side as you exit bridge into 4-South
  - Left hand side as you enter bridge towards 4-South
  - Adjacent to exit doors on either side of 4-North Elevator area
  - Right side of hallway leading to Dispatch Operations Center
  - Right side, just inside secure area of Dispatch Operations opposite mailboxes
  - On wall between secure door to BFS and training Room
  - On wall just outside double doors near CMED
- Send an REQF via CAD to the Fire Department regarding size, location of incident.
- Dispatch appropriate EMS resources based on incident

CONFINE:

- Close all doors to area

EXTINGUISH:

- The Dispatch Operations Center is equipped with heat and smoke detectors and an automatic sprinkler system
- Fire Department Standpipes are located in stairwell outside CMED, adjacent to the 4-North Elevator, outside the Police Commissioner's Suite and in the 4-South Stairwell.

EVACUATE:

- The decision to evacuate the facility shall be a decision based upon multiple factors and shall include coordination by all supervisory personnel on site. Prior to ordering an evacuation, caution should be exercised assuring that evacuation is the only alternative.
  - Fire exit next to CMED leads out to Ruggles Street Side of the building.

    - Fire exits on either side of 4-North Elevator lead down to the North lobby
    - Fire exit at 4-South end of the building leads out near parking lot.
- The supervisor shall ensure that all wheelchair bound or injured personnel are assisted down the stairs by on scene EMS or BPD personnel.
- All evacuated EMS personnel shall assemble at the ventilation stacks in the rear of the building near the Southwest Corridor park for roll call per the BPD evacuation plan.

[See Related SOP: Evacuation of Primary PSAP]

Glucometer Use

Supersedes: 10-31-14
Effective: 10-06-16

PURPOSE

Point of care glucose testing holds many advantages for the evaluation and differential diagnosis of the patient presenting with an acute change in mental status. The use of capillary blood testing can aid in confirmation of a diagnosis of hypoglycemia for both the BLS and ALS provider. Recognizing that portable glucose testing might not be as accurate as testing performed using hospital laboratory equipment, the goal of this SOP is to assure the best degree of accuracy given the current available technology.

STORAGE

Glucometers will be maintained on every Boston EMS ambulance. Solutions for testing the glucometer include both high and low reading solutions and will be supplied by Boston EMS Materials Management Division. These solutions will be stored either in a heated compartment of the ambulance or in the ambulance satellite. The glucometer strips and high/low solutions will be marked with the day, month, and year opened, and replaced every 90 days. Solutions that are found at either extremes of temperature prior to the change out date will be discarded by the crew and replaced prior to the scheduled change date.

TESTING / QUALITY ASSURANCE OF GLUCOMETER

The glucometer must be checked on a daily basis using control solution to confirm that the monitor and test strips are working properly. Control results must be within the "expected results" printed on the test strip instruction sheet included with the test strip packaging. Ensure the lot number printed on the instruction sheet matches the lot number printed on the test strip foil packet.

Depending on the type of unit (ALS vs. BLS), the results of the daily high/low test will be recorded on either the BLS Special Equipment Log or the ALS daily Controlled Substance Activity Log. These documents will be turned in on a monthly basis to RTQI. The Medical Director or designee will be responsible for overseeing the high/low data collected on these documents.

If the crew finds that while testing either of the control solutions is out of the determined range, the solution(s) will be replaced and the device retested. If on replacement of solutions a discrepancy still exists, the glucometer itself will be replaced.

Whenever there is a change of test strips, the appropriate procedures should be followed according to the manufacturer’s guidelines.

Whenever the Glucometer is used for testing patients' blood sugar, it shall be used in accordance with the Department's Infection Control Policy utilizing appropriate blood barrier protection and an appropriate safety lancet device. It is important to remember that whenever using the Glucometer for blood sugar analysis or control testing, the device should be placed horizontally, preferably on a table or similar resting platform to ensure that accurate results are obtained.

Headsets: Repair and Replacement

Supersedes: 07-11-99
Effective: 10-10-04

1. Telecommunicators suspecting a problem with their Department issued headsets should turn the headset in to the on-duty Dispatch Operations Center Supervisor.
   1.1. Headsets shall be turned in with headband and storage bag.
   1.2. Mouth and earpieces shall be removed and kept for use with a spare headset to be issued by the Dispatch Operations Center Supervisor.
   1.3. An incident report noting the day and time of the problem, the calltaker or dispatch positions where the problem occurred and a full description of the problem experienced shall be completed and submitted to the Dispatch Operations Center Supervisor.
   1.4. The Dispatch Operations Center Supervisor shall sign the report. If the headset appears damaged, attempt to ascertain how this damage occurred and document this on the incident report as well.
   1.5. The Dispatch Operations Center Supervisor shall then arrange to have the headset to the Commanding Officer of Dispatch Operations.
2. Issuance of a spare headset shall be documented on the Dispatch Operations Center Supervisor Summary report.
   2.1. Time of issuance, who it was issued to and time it was returned should be documented.
   2.2. Spare headsets shall be secured in the Dispatch Operations Center Supervisor's desk and inventoried during each shift.
   2.3. Missing headsets shall be documented on the Dispatch Operations Center Supervisor Summary report.

See Related SOP: "Headset Use"

Monitor / Defibrillator Inspection

Supersedes:
Effective: 05-07-12

The Physio-Control LIFEPAK monitor / defibrillator is to inspected and tested at the start of each shift in accordance with following manufacturer's recommendations. The inspection / documentation should be noted on the daily controlled substance administration log (DCSAL), and a supervisor notified of any problems necessitating replacement of equipment or supplies.

Inspect physical conditions for:
- Foreign Substances
- Damage or Cracks

Inspect Batteries for:
- Broken, loose, or worn battery pins
- Damaged or leaking battery

Inspect ECG Cable for
- Cracking, damage, broken or bent parts or pins

Check ECG and therapy electrodes for
- Expiration date
- Sufficient spare electrodes

Power On the Machine:
- Press green ON button.
- Momentary illumination of self-test messages and LED
- Look for "LOW BATTERY" or "REPLACE BATTERY" message
- Look for "SERVICE INDICATED" message

Test the Therapy Cable
- Examine cable for cracking, damage, broken or bent parts or pins
- Connect therapy cable to defibrillator and the Test Load
- Select 200 joules, and press CHARGE
- Press the SHOCK button to deliver charge into test loader.
- Confirm ENERGY DELIVERED message appears.
- Remove the Test Load from cable

Perform USER Test
- Press the options button.
- Using the selector knob, highlight and select USER TEST
- USER TEST will take approximately 30 seconds

- Confirm test results printed

Supplies:

- Adequate paper supply
- Pulse Oximetry (adult and pedi)
- End tidal CO2 (adult, pedi, and ETT)
- SafetyPad merge and attach cable
- Spare battery

Oxygen Tank Regulator Safety

Supersedes:
Effective: 05-07-06

Background

The FDA has received several reports in which regulators used with oxygen cylinders have burned or exploded, in some cases injuring personnel. Some of the incidents occurred during emergency medical use or during routine equipment checks. FDA and NIOSH believe that improper use of gaskets/washers in these regulators was a major factor in both the ignition and severity of the fires, although there are likely other contributing factors.

Two types of washers, referred to as CGA 870 seals, are commonly used to create the seal at the cylinder valve / regulator interface: The type required by many regulator manufacturers is a metal-bound elastomeric **sealing washer** that is designed for multiple use applications. The other common type, often supplied free-of-charge with refilled oxygen cylinders, is a plastic (usually Nylon ®) **crush gasket** suitable for single use applications.

The nylon crush gaskets require higher torque than the elastomeric sealing washers in order to seal the cylinder valve / regulator interface, and if they are used again, they require more torque with each successive use. The cylinder valve / regulator connection is designed to be hand-tightened. If the crush gaskets are re-used, the need for increased torque may require using a wrench or other hand tool, which can deform the crush gasket and damage the cylinder valve and regulator. This can result in leakage of oxygen past the cylinder valve seat and across the nylon crush gasket. According to a forensic analysis supported by FDA and NIOSH, "flow friction" caused by this leakage of compressed oxygen across the surface of the crush gasket may produce enough thermal energy to spontaneously ignite the nylon gasket material.

Recommendations

Plastic crush gaskets should never be reused, as they may require additional torque to obtain the necessary seal with each subsequent use. This can deform the gasket, increasing the likelihood that oxygen will leak around the seal and ignite.

The following general safety precautions should also be taken to avoid explosions, tank ruptures and fires from oxygen regulators.

- Always "crack" cylinder valves (open the valve just enough to allow gas to escape for a very short time) before attaching regulators in order to expel foreign matter from the outlet port of the valve.

- Always follow the regulator manufacturer's instructions for attaching the regulator to an oxygen cylinder.
- Always use the sealing gasket specified by the regulator manufacturer.
- Always inspect the regulator and CGA 870 seal before attaching it to the valve to insure that the regulator and seal are in good condition and the regulator is equipped with only one integral metal and rubber seal that is in good condition. Avoid plastic seals.
- Tighten the T-handle firmly by hand, but do not use wrenches or other hand tools that may over-torque the handle.
- Open the post valve slowly, while maintaining a grip on the valve wrench so that it can be closed quickly if gas escapes at the juncture of the regulator and valve.

Figure 1 : Examples of crush gaskets available for CGA 870 type medical post valves

.**Figure 2: Examples of some sealing washers available for CGA 870 Style medical post valves.**

Personal Issue Radios and Pagers

Supersedes: 08-25-99
Effective: 02-14-01

The following policy and standard operating procedures shall apply to all personnel issued personal operational equipment. Personal operational equipment may include, but not be limited to portable radios, batteries, pagers or wireless phones.

BEMS owns and maintains property to properly carry out business as an EMS provider. The careful handling, maintenance and storage of this property will not only reduce the Department's replacement costs but also ensures that sufficient modern equipment will be available for use by members.

It is the policy of BEMS that each employee will be responsible for the department-owned property that he/she is issued, uses or comes in contact with. Damaged or lost property may subject the responsible employee to reimbursement charges or appropriate disciplinary action.

Operational equipment issued to employees of BEMS shall remain the property of BEMS. All employees shall maintain Department property assigned to them in good working condition.

ON DUTY USE

1. All BEMS personnel issued a Department portable radio shall have that radio with them when they report for duty. When on duty, all BEMS personnel shall carry Department owned radios in issued carrying case/holster.
2. Personal issue radios include 2 batteries. It is the employee's responsibility to have a spare charged battery available for use while on duty.
3. All BEMS personnel issued a Department pager shall have that pager with them when they report for duty. The pager shall not be set to "no alert" while on duty.

OFF DUTY USE

1. It shall be the employee's responsibility to safely and securely store any issued operational equipment including radio, batteries, charger, and holster while off duty.
2. While off duty it is the employee's responsibility to properly charge the batteries.
3. It is encouraged although not required for employees to carry Department issued pagers while off duty. These pagers may be used for personal, business and while off duty, the employee may set the "no alert" option on the pager.
4. Personnel are not required to carry personal issued Department radios while off duty.
5. While off duty, personnel may use the radio to monitor radio traffic.

6. While off duty, personnel may use the radio to transmit in limited circumstances.

   6.1. Off duty personnel may transmit for assistance if they identify a life safety situation. (For example, if you on site a pedestrian struck.)

   6.2. Whenever possible, less urgent incidents (stalled vehicles, malfunctioning traffic lights, etc.) should be reported by other means to the appropriate agencies.

   6.3. Department administrative business (calling out sick, tardy, etc.) shall not be transmitted by a member.

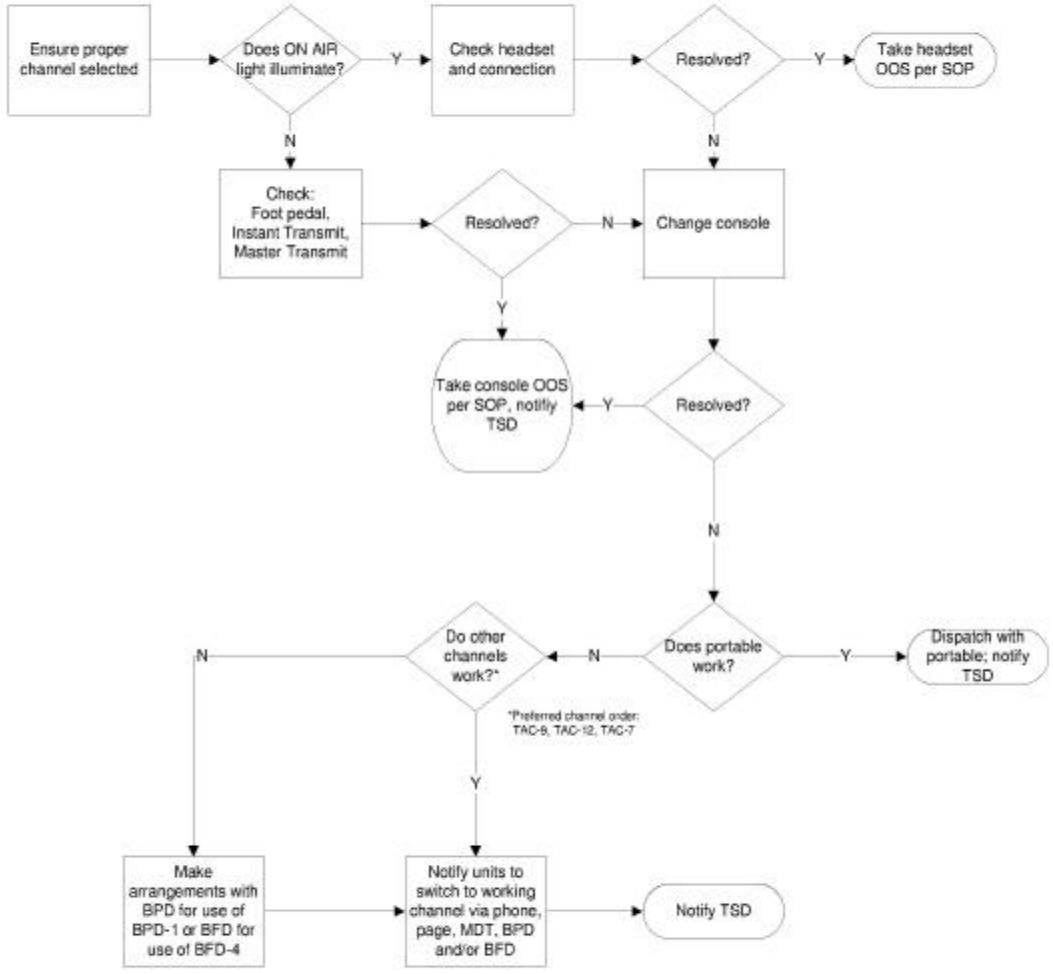
   6.4. Administrative messages may be transmitted if approved by the Supervisor of Dispatch Operations. For example, while off duty and monitoring the radio, the Supervisor may direct the dispatcher to call you by your individual call sign. In a recall situation, a group broadcast to off duty members may direct you to reply.

GENERAL

1. The attached lapel speaker/microphone shall not be removed.
2. Personnel experiencing a problem with their radio, pager, or other issued equipment shall notify their supervisor so arrangements for repair or replacement may be made.
3. It is your responsibility to notify Dispatch Operations whenever your radio is changed. The roster will be updated to reflect the change.
4. Personnel shall not mark, alter, or deface any Department property. Modifications (including removal of lapel speaker/microphone), repairs or reprogramming of radios, pagers, cellular telephones, or other equipment without the approval of T.S.B. is prohibited.
5. Personnel shall immediately report to their supervisor, on designated forms, any loss or damage to department property assigned to them, including radio, batteries, charger or holster. Failure to file a timely report shall result in discipline.
6. Any member, on or off duty, found to use a radio maliciously to jam, obstruct, or harass any member or legitimate radio traffic will be subject to discipline.
7. Subject to the operating needs of the department, any member may be directed to return all radio equipment to BEMS.
8. Any member, who will have prolonged absence from duty including, but not limited to any LOA or injury, will return the radio, charger, batteries, and case to the Department when directed.
9. All employees are required to surrender all department property upon separation from service.

Radio Failure

(BEMS OPS/Tactical Channels)



Reporting Technical Problems

Supersedes: 07-11-99
Effective: 01-01-05

1. Dispatch Operations Center personnel suspecting a technical problem with any equipment shall notify the on-duty Dispatch Operations Center Supervisor.
2. The on-duty Dispatch Operations Center Supervisor shall evaluate the situation and determine whether it is an **urgent** or **non-urgent** issue.
3. The Communication Engineering Unit shall be notified of all urgent technical problems by transmitting the “CEU” group call in the alphamate.
4. The Communication Engineering Unit should be notified of all non-urgent technical problems by sending an e-mail message to the CEU group via the department computer network.

   4.1. If the computer network is not available, the Supervisor reporting the problem should call 343-1140 and leave a voice mail message.

5. All notifications should include the following:
   - Note the equipment (type and location), who was using it and what they were doing when the problem occurred.
   - Provide as much detail as necessary to accurately convey the problem experienced.
   - Note when the problem occurred, if it is still occurring, and any actions taken thus far.
   - Note whom to contact and at what phone number.

Satellite Telephone Equipment

Supersedes:
Effective: 5-14-2007

Section 1.0 Introduction

(a) Metro-Boston Homeland Security Region (MBHSR) public safety agencies recognize the need for reliable backup communications capabilities to support interoperable communications across disciplines and jurisdictions. To address this need, portable satellite phones have been purchased for key leaders across the MBHSR to ensure backup communications capabilities for public safety agencies and first responders in the event of a loss of primary and/or secondary communications means.

(b) The purpose of this SOP is to establish the authority, procedures and guidelines for operating and maintaining the portable satellite phones within the MBHSR and is applicable to the nine MBHSR jurisdictions receiving said equipment. These nine jurisdictions include: Boston, Brookline, Cambridge, Chelsea, Everett, Quincy, Revere, Somerville, and Winthrop.

Section 2.0 Purpose

(a) The principal objective of the regional satellite phone effort is to provide key leaders from various MBHSR agencies a backup means of communications. Not only can this equipment serve as a backup communications capability for use at each agency's discretion in day-to-day operations, but it will additionally provide an interoperable communications resource in the event all other forms of communication fail.

(b) The satellite phones are assigned to the agency heads of MBHSR police departments, fire departments, public health, emergency management, jurisdiction executives, and other key leaders. These personnel and their assigned satellite phone are provided in Appendix A.

Section 3.0 Authority

(a) The U.S. Department of Homeland Security designated Boston a high-threat urban area in July 2003 as part of the Office for Domestic Preparedness' (ODP) Urban Area Security Initiative (UASI) grant program. As the core city, Boston oversaw the delineation of the region, and created the Boston Mayor's Office of Homeland Security (MOHS) to integrate and manage all homeland security activities. The UASI region was subsequently named the Metro Boston Homeland Security Region (MBHSR) and consists of nine jurisdictions: Boston, Brookline, Cambridge, Chelsea, Everett, Quincy, Revere, Somerville, and Winthrop. The MOHS was subsequently renamed as the Mayor's Office of Emergency Preparedness (MOEP).

(b) In partnership with the region's Communications Interoperability Subcommittee (CIS), MOEP led an effort to develop a Communications Interoperability 5-year Strategic Plan that addresses and prioritizes how the MBHSR can enhance

interoperable communications capabilities during response to emergency incidents.

(c) As part of the implementation of the MBSHR Communications Interoperability 5-year Strategic Plan, the region has purchased Iridium 9505A portable satellite phones for key public safety leaders across the region.

Section 4.0 Overview of the Equipment

(a) The satellite equipment included in this effort is comprised of Iridium 9505A portable phones in ruggedized cases that are supported by the Iridium Satellite system. Each jurisdiction has agreed to pay for the monthly operating costs of the phones and is therefore responsible for its monthly bill from SatCom Direct, the current provider of Iridium satellite phone equipment and service. Monthly reoccurring costs include, but are not limited to, the monthly base rate for activation as well as the per minute fee for phone usage.

(b) An overview of the key functions of the satellite phone and guidelines for operation are provided in Appendix B.

Section 5.0 Operating Procedures

(a) The Iridium 9505A satellite phone provides a backup means of communications when used **outdoors** and is not capable of providing service within buildings. To operate the 9505A, the user must be within a clear line-of-site of the sky in all directions. This is to ensure connection with the Iridium satellites. In the Boston area, at any given time one to three satellites are within view.

(b) Daily use of the portable satellite phones is at the discretion of the public safety agency and user who accept responsible for the costs incurred. The following procedures are intended to establish common guidelines for use in the event of a regional emergency as well as procedures for regular use in testing and planned events to ensure equipment familiarity.

(c) In the event of a regional emergency, all portable satellite phones should be powered on to support regional communications. The following are examples of the types of incidents or regional activities which shall cause users to power on their portable 9505A satellite phones:

i) **The region wide failure of both the Public Switched Telephone Network (PSTN) and the cellular telephone network.** This failure could be the result of major infrastructure damage sustained during a hurricane, earthquake, or other natural event; the result of an extended region wide power failure; the result of technical problems within telephone switching systems; or the result of sabotage or a major terrorist attack.

ii) **The region wide opening of MBHSR Emergency Operations Centers (EOC):** If a jurisdiction currently has dispatch center notification policies in place, the powering on of portable satellite phones should be included in said notification scheme.

(d) The following are examples of the types of incidents or regional activities which may cause users to power on their portable 9505A satellite phones; a decision which is at the discretion of each jurisdiction:

i) **The failure of either or both the Public Switched Telephone Network (PSTN) and the cellular telephone network within a city or major part of a city.** Failure in this context may also mean that the networks are technically operational but congested to the point of being inaccessible.

ii) **The opening of a MBHSR Emergency Operations Center (EOC):** If a jurisdiction currently has dispatch center notification policies in place, the powering on of portable satellite phones should be included in said notification scheme, particularly when communications problems are apparent during EOC activation.

iii) Any other event in which one or more users determine that satellite phone communications are useful to support public safety communications needs.

Section 6.0 Testing and Usage

(a) The testing and usage outlined in this SOP is intended to ensure that the user is familiar with the basic operation of the satellite equipment and that the equipment is functional. Testing is a key aspect of any regional satellite phone as outlined in the federal report "Independent Panel Reviewing the Impact of Hurricane Katrina on communications Networks: Report and Recommendations to the FCC",

"There were functionality issues with satellite communications – largely due to lack of user training and equipment preparation… Users who had not been trained or used a satellite phone… reported frustration and difficulty in rapid and effective use of these devices."

Based on these lessons learned and best practices throughout the country, the MBHSR has developed a regional testing and usage procedure as outlined below.

(b) Regular, monthly testing will be conducted on all portable satellite phones for the first year of activation to ensure a user is familiar with the procedures for placing and receiving a call. After a year, the frequency of testing will be reviewed by the CIS and new guidelines will be reissued at that time. It is the responsibility of each jurisdiction to ensure compliance with the following testing procedures:

i) Testing will be conducted monthly for the first year of activation and managed by each jurisdiction/agency's dispatch center or designee. The dispatch center or designee will track and initiate calls to all portable satellite phones in the jurisdiction.

ii) Monthly at a set, scheduled time, the responsible dispatch center or designee will place a call to each portable satellite phone within their jurisdiction/agency.

iii) The user will successfully answer the call, conduct a voice quality check and end the call.

iv) The user will then place a call back to the dispatch center or designee using the portable satellite phone, conduct a voice quality check, and end the call.

v) Each jurisdiction must submit a report to MOEP at the end of every testing period reporting completion of these testing procedures. MOEP will track compliance, contact any jurisdictions that are failing to regularly conduct testing and periodically notify the CIS of the status of regional compliance.

(c) The MBHSR region should utilize the portable satellite phones, as appropriate, in planned events to ensure regular usage of the equipment. The portable satellite phones may be utilized to support communications between key MBHSR leaders for the purposes of command and control functions, emergency response coordination, or other public safety communications deemed necessary.

Section 7.0 Maintenance Procedures

(a) The following guidelines outline regular maintenance intended to ensure that the equipment is fully operational.

(b) In order to properly maintain the satellite equipment each agency must ensure that the following steps are taken regularly:

i) Each jurisdiction must ensure that both lithium ion batteries provided with the portable satellite phones are fully charged. The battery level should be checked during the testing period outlined above. The charge for both batteries will need to be verified by placing the battery within a portable satellite phone and visually checking the battery status bars on the front menu screen. Depending on the method of charging (AC or DC power source), the time required to fully charge the battery can range anywhere from four to six hours.

ii) Rotate and extend the antenna to ensure functionality.

Interagency Coordination

Interagency Cooperation

Supersedes:
Effective: 01-16-06

1. First Responders

   1.1. Designated First Responders such as the Boston Fire Department or the Boston Police Department shall be requested by the Dispatch Operation as stated in the dispatch protocols.

   1.2. When a Boston EMS unit arrives at a scene at which First Responders are present, the assumption of medical responsibility by EMS personnel shall occur as soon as possible. The transition shall be smooth and orderly and any pertinent information, if available, shall be obtained.

   1.3. The Boston EMS crew shall be responsible for releasing First Responders from the scene as soon as there is no further need for assistance.

2. Conflict Between Agencies

   Any dispute between EMS personnel and members of other public agencies concerning patient care, scene management, or general conduct shall be referred to the Field Supervisor immediately. The Field Supervisor shall obtain the relevant facts from the involved personnel of both agencies, attempt to resolve the dispute, and submit a written report to the Shift Commander before the end of the work shift.

3. Request For Additional EMS Assistance

   A BLS unit on scene shall request the dispatch of an ALS unit whenever warranted by the status of the patient, (e.g., altered mental status, respiratory distress, hypotension, etc.) and the ETA of the ALS unit is shorter than the time it would take for the BLS unit to transport the patient to the nearest appropriate receiving facility;

   An ALS unit on scene should request the dispatch of a BLS unit whenever a patient is deemed not to be in need of advanced life support, and the ETA of the BLS unit is shorter than the time it would take for the ALS unit to transport the patient to the nearest appropriate receiving facility;

4. An EMS unit shall notify Dispatch Operations if one of the following situations exists and the Shift Commander and appropriate Division Supervisor shall then be notified. This list is not meant to be all inclusive, but rather is a general guideline for incidents warranting supervisory notification.

   4.1. a conflict with a member of the public or another public agency;

   4.2. a homicide, suicide, hostage situation, or other suspicious or unusual incident;

   4.3. a question of child abuse or elderly abuse;

4.4. a disagreement over patient care or transportation;

4.5. the threat of harm to an EMT on scene; a violent patient or patient requiring restraint

4.6. an incident requiring a prolonged time on scene (e.g., entrapment, fire, awaiting a police escort, etc.)

4.7. a question of an explosive or other incendiary device.

4.8. Department vehicle crash, equipment failure, or theft of department equipment

4.9. Any other significant or high profile incident where a Supervisor and/or Command Staff response may be warranted.

Boston Area Ambulance Mutual Aid (BAMA) Network

Supersedes:
Effective: 03-15-09

The Boston Ambulance Mutual Aid (BAMA) Network is engineered to provide voice communications between Boston Emergency Medical Services (BEMS) and its mutual aid EMS providers. The BAMA network may be used to request mutual aid assistance and coordinate the response of additional medical resources. Operational and tactical communications are primarily accomplished via two-way land mobile radio, which operate on the ultra high frequency (UHF) band.

Phase I will initiate transmission of road closures, hazards, and hospital diversions and other special announcements pertinent to EMS providers. Phase II implementation will add dispatch center to dispatch center communications via the BAMA network.

Future phases will add mobile/field unit communication to BAMA control ("Boston") and eventually, direct communications between mobile units, portable units, and dispatch centers via the controlled network.

"BOSTON"- NETWORK CONTROL
"Boston" is the BAMA Network Control and responsible for coordinating interoperable EMS communications among participating agencies within the Metropolitan Boston Homeland Security Region (MBHSR). The Center is staffed 24 hours a day with specifically trained EMT-Telecommunicators. "Boston" oversees UASI EMS traffic, resource coordination, incident management, mitigation and recovery, complimenting the EMS Region IV role and responsibility of Metro-Boston CMED in coordinating medical communication and patient deployment to area hospitals. Listed below are a few of the functions of "Boston":

- Coordinate and manage BAMA channel usage within the region, assisting interoperable EMS communication with other public safety agencies and resources.
- Support coordinated deployment of EMS resources.
- Serve as a clearinghouse for EMS operational and logistical resource requests (non CMED) for agencies participating on the BAMA network.
- Monitor the radio traffic to determine the quantity and quality of transmissions; detect and resolve communications resource issues and outages.
- Provide general assistance as requested by any agency in accordance with system procedures.

CHANNEL PLAN
The Metro-Boston Homeland Security Region (MBHSR) uses a Tactical Interoperable Communication Plan (TICP) to coordinate shared channels used according to the principles of real-time sharing. Unlike BAPERN or Metro-Fire, the BAMA network is

currently designed for mobile and “in street” portable coverage within the City of Boston on a single frequency.

RULES OF USE

“Boston” Responsibility: Radio communications which concern any of the BAMA network transmissions should be coordinated by the designated network control station, and “Boston” will receive and process all requests for Medical Group radio communications support from any of the participating MBHSR EMS agencies. Any authorized MBHSR Incident Command or designee shall contact “Boston” and detail the communication need; “Boston” will attempt to provide the most appropriate resource based on the type of incident, extent of involvement and projected operation period, location and coverage area, units/resources involved, and current channel availability. Boston will also provide day-to-day “cross talk” ability for provider-to-provider interoperable communication; see also TICP Talk path process flow analysis.

All UHF communications between field units and bases shall be directed to “Boston” for the particular coordination, and/or agency being called upon. *O*pen cross-talk between providers is permitted except when a significant incident, requiring multiple providers, occurs. “Boston” will then become the control point and all BAMA radio traffic will be directed through “Boston”. “Boston” is responsible for continually monitoring and expediting radio traffic to keep the network operating efficiently – transmissions should be as complete and brief as necessary. “Boston” will regularly test BAMA to ensure network reliability and radio consolette operation. Preservation of incident communications shall be prioritized over individual use; any user issue identified by “Boston” shall be immediately addressed by the responsible agency.

STANDARD OPERATING PROCEDURES

BAMA is designed for dispatch and deployment of EMS resources within MBHSR, as well as EMS incident interoperable communication including operations, logistics, and recovery purposes. **BAMA *does not* supplant the role and responsibility of Metro-Boston CMED to coordinate EMS resources for EMS Region IV, communicate with the Loading/Transportation officer and direct patient hospital deployment during an MCI, or support other regional EMS and Hospital functions.**

DISPATCH

Boston EMS: Under the State Office of Emergency Medical Services (OEMS) approved Service Zone Plan, Boston EMS is charged with provision of EMS for the City of Boston. Memorandums of Understanding (MOU) are in place with back-up EMS providers and Boston will use BAMA to poll participating back-up providers for unit availability and dispatch purposes.

“Boston” will call the provider by landline (phase II), based on area they typically cover in the city, to request a back-up response and determine unit availability (BLS or ALS); information transmitted will include the address, the type, and priority of incident. The back-up provider shall advise their unit availability, including call sign and Estimated Time of Arrival (ETA), or “Not Available”. If not available, “Boston” will continue to poll

providers based on their area of coverage looking for the closest, most appropriate unit type. When the back-up provider assigns a unit to the incident, the dispatch center will notify “Boston” via BAMA to advise that the unit is enroute with the unit number and nature of the call.

Example:
“Boston, this is Armstrong calling on BAMA.”

“Armstrong, this is Boston answering on BAMA.”

“Boston, Armstrong ambulance 21 is responding to 40 Wallingford Rd. in Brighton for the Illness 2, that’s Armstrong ambulance 21 to four - zero Wallingford Rd. Brighton, ETA 3 minutes.

“Armstrong, Boston, roger, Armstrong 21 responding to 40 Wallingford Rd, Brighton, ETA 3.”

or

“Boston” will confirm unit dispatch, and the back-up provider dispatcher will contact Boston via BAMA if they experience any response delay, when their unit arrives on scene, and when enroute hospital noting their destination or, in the case of a non-transport incident, the reason for clearing (no visible incident, patient refusal, etc).. Should a closer unit become available, “Boston” may reconfirm the ETA of the back-up provider to ensure the closest, most appropriate unit is sent. Requests for response support (location, directions, etc.) or additional information may eventually be transmitted on BAMA; currently, Boston EMS directs those requests be made via telephone to the Dispatch Operations Division @ 617-343-1400.

OTHER PROVIDERS
Other providers may request assistance from Boston EMS by telephoning the EMS Emergency Administrative Number, 617-343-4510. Boston EMS call-takers will process the request and enter the information into the CAD (Computer Aided Dispatch) system. In an emergency, when the safety of EMS providers or the public may be at risk, BAMA can be used to expedite a call for assistance. “Boston” allows other providers “open cross talk” between dispatch centers to call each other directly, requesting a back up response; providers should follow the radio procedures and examples as outline above.

SPECIAL INCIDENTS- PLANNED / UNPLANNED MCI
Participating agencies may use BAMA Dispatch when additional response units are required. Providers may contact adjacent providers directly to request assistance. Should the projected number of patients warrants a regional response, providers shall then contact “Boston”, noting the address of the incident, projected number of patients needing treatment or possible transport and types of resources required, staging location for units and contact (e.g. STAGING Officer), and any HAZARDS or special response instructions. “Boston” will poll MBHSR providers to determine unit availability by type (BLS, ALS, Chair Car, Bus, etc.) and inform the

requesting agency of the unit(s) responding and ETA (when possible). NOTE: Metro-Boston CMED provides Medical communication including, but not limited to, hospital ED Care Capability and direction of patient deployment to hospital.

TRAINING AND TESTING

BAMA Members, in conjunction with the MBHSR Training Subcommittee, will establish training materials and course curriculum for providers to use with their personnel. “Boston”, or designee, will conduct regular (daily or eventually shift-by-shift) testing of BAMA, using a roll call procedure, to ensure network reliability and operation of discrete radio equipment. “Boston” will monitor BAMA use and work with providers to ensure any user issue that is identified can be immediately addressed by the responsible agency. Boston EMS will work with other providers to establish test schedules to ensure that personnel on all shifts understand use of the equipment and proper procedures for BAMA. (See also BAMA Test Form.)

Boston Health Center and Hospital Radio Network

Supersedes: 11-01-06
Effective: 10-31-14

BOSTON HEALTH CENTER & HOSPITAL RADIO NETWORK
Boston Metropolitan Medical Response System (MMRS), in conjunction with the City of Boston, established the Boston Health Center & Hospital Radio Network to afford command center communications between the Boston Public Health Commission, affiliated health centers, hospitals, and the Boston Emergency Medical Services (BEMS). Utilizing the City of Boston 800 Mega Hertz (MHz) network (trunking and conventional), it is designed for coverage within the City of Boston. The network may be used to ensure day-to-day communication in the event of a local or network telephone outage, provide command and control communication during emergency events, or request assistance and coordinate the response of additional medical resources.

"BOSTON"- NETWORK CONTROL
"Boston" – Network Control provides for the coordination of communications over the Boston Health Center & Hospital Radio Network. The center is staffed 24 hours a day with specifically trained Boston EMS EMT-Telecommunicators. Listed below are a few of the functions of "Boston":

- Coordinate Talk Group/Channel management with users and network resources.
- Monitor, as possible, radio traffic to determine the quantity and quality of transmissions, as well as conduct regular testing of the network, to detect and resolve outages.
- Provide general assistance as requested by any agency in accordance with system procedures.
- Provide Command/Control/Communications/Intelligence (C^3I) functions during mass casualty or disaster responses in cooperation with authorized incident commanders.
- Serve as a regional clearinghouse for medical resource requests.

TALK GROUP CHANNEL PLAN
Four dedicated Talk Groups, hereafter referred to as "Channels", have been allocated for the Boston Health Center & Hospital Radio Network, along with channel use of other Boston "channels" in Zone A; Zone B contains public safety channels for emergency use – health centers and hospitals are not expected to use any of these "channels". (See Zone/Channel matrix attached.) Additionally, a non-dedicated TALKAROUND, or "direct", channel for non-network portable to portable transmission has been included in the event of a problem with the 800 MHz network. The following dedicated channels/names shall be used according to the principles of real-time sharing, make maximum use of the channels in a efficient manner, and ensure that the

channels can be relied on for communications needs of the most critical nature. (See Zone/Channel matrix attached.)

EMS 1: Monitored at BEMS Dispatch Operations Division, used to contact “Boston” (network control).

HEALTH CTR: The **primary** channel radio users should monitor at all times, as notifications of incidents and/or information will be broadcast here. This also serves as the “common calling” channel: if one health center would like to communicate with another, they should call each other here, and then shift their conversation over to the adjacent Hospital 3 channel; lengthy, detailed, or time consuming communication should not occur on HEALTH CTR channel. Regular testing of the network will performed on this channel as well.

HOSPITAL 3: Assigned Inter-Health Center communication, it also serves as a back-up for Hospital Command (Hospital 1) and Logistics (Hospital 2) communication. Used for day-to-day, routine communication, users will shift to this channel after hailing each other on the primary channel; again, channel coordination will be conducted on the primary channel, HEALTH CTR.

HOSPITAL 2: Assigned Inter-Hospital Logistic communication, it also serves as back-up for Hospital Command (Hospital 1) and Inter-Health Center (Hospital 3). Used to coordinate Logistic communication, users will shift to this channel after being hailed on the primary channel; again, channel coordination will be conducted on the primary channel, HEALTH CTR.

HOSPITAL 1: Assigned Inter-Hospital Command communication, it also serves as back-up for Hospital Logistics (Hospital 2) and Inter-Health Center (Hospital 3). Used to coordinate command and control communication, users will shift to this channel after being hailed on the primary channel; again, channel coordination will be conducted on the primary channel, HEALTH CTR.

TALKAROUND: Assigned for portable to portable communications, the transmissions do not go through the network and therefore have a very limited range. The channel is shared by all City users and all transmissions may be monitored.

CITY EVENT: Assigned for City special event coordination, health centers and hospitals would not normally monitor this channel unless specifically directed to do so.

CITY EMERG: Assigned to all radios in the system, this channel may be used to contact the Municipal Police Department in the event of an emergency (and may be monitored by Boston EMS Dispatch Operations).

Zone B contains public safety channels for emergency use – health centers and hospitals are not expected to use any of the channels.

RULES OF USE

"Boston" Responsibility

Radio communications which concern any of the Boston Health Center & Hospital Radio Network transmissions should be coordinated by the designated network control station, and "Boston" will receive and process all requests for group radio communications and/or support from any of the MBHSR agencies in the event of an emergency or large scale incident. Day-to-day use of the Boston Health Center & Hospital Radio Network is provided through the use of a common calling channel (HEALTH CTR) where different facilities can contact each other and shift to an appropriately designated channel for detailed communication.

During an emergency, communications between facilities shall be directed to "Boston" for coordination, unless open cross-talk has been authorized. "Boston" is responsible for monitoring and expediting radio traffic as possible to keep the network operating efficiently – transmissions should be as complete and brief as necessary. User issues identified by "Boston" shall be immediately addressed by the responsible facility; preservation of incident communications shall be prioritized over individual use.

GENERAL PROCEDURES

FCC Rules

The applicable rules and regulations of the Federal Communications Commission shall govern the general operation of the radio channels.

Monitor Frequency

All persons operating radios must monitor the frequency on which they desire to operate, prior to transmitting.

Alert Tones

Various alert tones shall be transmitted as necessary.

Transmitting Names

All communications shall be kept impersonal. When names are transmitted, the full name or last name with title only shall be used. Names may also be substituted for call signs.

In order to maintain patient privacy rights (HIPAA), patient names shall not be transmitted except in cases of extreme emergency.

Identify Every Transmission

Unit identifiers (health center ID name) are to be said in every transmission.

Push To Talk (PTT) ID

A radio ID is sent each time the transmit button is engaged. Radios may/may not make sound an audible tone when transmitting ID, so remember that anything you say during

ID transmission will not be received. Always pause when transmitting to ensure your voice audio is sent and received.

Roll Call
Command and coordination of incidents is a must. Roll calls may be used when shifting resources from one channel to another to ensure compliance, or to confirm receipt of critical information such as security or safety updates. When called, users shall respond and work with network control to ensure radio operation and personnel safety.

Intonation and Voice Level
Word or voice inflections that reflect irritation, disgust or sarcasm must not be used. Relations with other users shall remain cordial at all times. Do not yell under any circumstances.

Message Brevity
All messages shall be kept brief and to the point.

Answering Radio Calls
All radio calls must be answered. When busy with patient care activities or traffic on another channel, the phrase “STAND-BY” shall be used to indicate receipt of call and intent to answer when available.

Radio unit Identifiers
Every user should utilize an ID consistent with these procedures. Each ID shall have a short and long form. The long form of an ID shall be used when initially establishing contact with another unit. The short form may be used to enable brevity through the balance of a message. When in doubt, use the long form ID

Composition
Radio unit identifiers shall be issued by the Commanding Officer of the Boston EMS Dispatch Operations Division, or his designee. Identifiers shall be alphanumeric characters or proper names of persons, roles or facilities (see attached ID list).

Examples:

Long Form	Short Form
“Boston Control” (BEMS Dispatcher)	“Boston”
“Boston Medical Center”	“BMC”
“Boston Public Health Commission”	“BPHC”
“Bowdoin Street Health Center”	“Bowdoin HC” or “Bowdoin”

Personnel Identifiers
All communications will identify personnel by an assigned ID in addition to the use of facility name. After initial contact has been made by using the unit ID, communicating personnel shall use their Facility Name and Personnel ID instead of the short form unit ID.

Personnel, primarily Field, assuming NIMS/ICS roles and responsibilities shall assume the appropriate IDs for those roles. For example, the Incident Commander would assume the location name of the incident, followed by IC, or "Tobin Bridge IC". For singular MCIs, roles such as Area Command, Staging, Treatment, Triage or Loading, to name a few, may be transmitted without the incident location/name designation.

Examples:

"John Jones" (administrative or staff personnel)
"EMT Jones" (for an EMT-Basic)
"Intermediate Jones" (for an EMT-I)
"Paramedic Jones" (for an EMT-P)
"RN Jones" (for a nurse)
"Dr. Jones" (for a physician)

Purpose of Call Signs
According to F.C.C. rules, call signs are to be used as identification. In addition, identifiers will be used at the beginning of a transmission (to prompt the voice-actuation circuits if in a "patch" condition). Any unit (i.e., two-way radio) must be authorized for use by an F.C.C. license. Mobile and portable units are typically authorized under a base station or system license. In such instances, the identifier may be used alone.

Example:
"*Boston, this is BPHC*, over."
"*BPHC*, (this is) *Boston.*"
"*Boston, BPHC* requesting to talk with *Martha Elliot* about their staffing issue."
"*BPHC*, *Boston*, roger your request to cross talk with *Martha Elliot.* Shift and standby HOSPITAL 2."
"*Martha Elliot, Boston* calling."
"Boston, this is *Martha Elliot*."
"*Martha Elliot, Boston,* shift and standby HOSPITAL 2 to cross-talk with *BPHC."*

Language Format
These procedures endorse the principle that Plain English (coupled with accepted medical terminology if necessary) is the surest way to accomplish effective communications, either via radio, telephone or in person. This document lists preferred terms or phrases that have been shown to be particularly effective. To minimize confusion, health center personnel are encouraged to routinely use these terms. Local radio "codes" should not be used.

CALLING PROCEDURE

Initial Contact
Before speaking, always listen to the channel to ensure it is clear to use – avoid transmitting over ongoing communication.

When calling a station, say the name of the station or unit you are calling, followed by the words, “This is” and then your call sign, ending with the proword “OVER.”

“Boston, this is BPHC, over.”

Answering Procedure
To answer a call, use the same procedure as described above.

Acknowledging Messages
Messages should be acknowledged by saying the unit identifier, the proword “ROGER” and repeating the essential parts of the text of the message back. If there is a question as to whether or not the received message is correct, the proword “CONFIRMED” shall be said at the end of the message when repeated.

PROWORDS AND PHRASES
Experience has proven that some words when spoken over a two-way radio can be easily confused with other words and result in disastrous miscommunication. The words and phrases in this list are ideal for avoiding this type of problem and all radio users should become comfortable with their use.

Word or Phrase	**Definition (for radio use)**
ACKNOWLEDGED	I have received your message and will act upon it.
ACUTE	Condition of rapid onset.
AFFIRMATIVE	Yes. (Spoken over a radio, “yes” is easily confused).
ARRIVAL	Unit has arrived at its intended destination.
ASSIGNMENT	Assignment to an incident or radio channel.
BREAK	To interrupt in an emergency, or to separate parts of a group of messages.
CHANNEL (*e.g.* Hospital 1)	The Talk Group used in the Boston Health Center & Hospital Radio Network.
CONTACT	Establish communications.
CLEAR	Available; I am terminating this communication (or incident).
DISREGARD	Do not take action on last transmission.
ENGAGED/DISENGAGED	Radio patch connected/disconnected.
ENROUTE	Traveling to a specified destination.
HOLD	Remain at present location or specified position.
INCORRECT	Wrong.
LANDLINE	Order to make call by telephone.

MONITOR	Listen to all traffic on a radio channel.
NEGATIVE	No.
OBTAIN	Get.
OUT	I have finished all messages; do not expect a replay and the channel is open to others.
OVER	I have finished my message and expect a reply from you.
RELAY	Pass the traffic on to another person or station (repeat message verbatim).
ROGER	As in acknowledge, I have received your message and will act on it.
REPEAT	Administer the indicated therapy an additional time. (See SAY AGAIN).
SAY AGAIN	Repeat the last message transmitted. (Not to be confused with REPEAT).
SHIFT	Change channel as ordered.
SHIFT AND ACKNOWLEDGE	Change channel as instructed and say on the new channel your ID and acknowledge the shift.
SHIFT AND CONTACT	Change channel as instructed and call the desired station.
SHIFT AND STANDBY	Change channel as instructed and listen for further traffic.
STAND-BY	Answer to request is not immediately available, or user is busy with competing traffic. The order stand-by implies that a unit should stay on channel until called upon; order should not be acknowledged.
STATUS	A unit's present activity.
TRAFFIC	Messages transmitted by radio between units and/or stations.

Transmitting Numbers

In order to avoid errors when measurements of medications are ordered, or addresses are transmitted, numbers should be transmitted DIGIT-BY-DIGIT and pronounced as described below:

1	"WUN"	Strong W and N
2	"TOO"	Strong and long OO
3	"THA-REE"	Strong TH and R
4	"FOWER"	Strong O, Strong W and Final R
5	"FIE-YIV"	Strong I changing to Strong Y and V
6	"SIKS"	Strong S and KS
7	"SEV-VEN"	Strong S and V
8	"ATE"	Strong A and long T

9	“NINER”	Strong NI and sounded ER
0	“ZEE-RO”	Strong Z and Short RO

Transmitting Letters

The Phonetic Alphabet is used to spell out letters in place of just saying the letter itself. By using a word for each letter there is less chance that the person listening will confuse letters. For instance, some letters that can easily be confused are "D" and "B". Using the phonetic alphabet, "**D**elta" and "**B**ravo" can be easily distinguished. The phonetic alphabet is used primarily used in two-way radio communications. The effects of noise, weak signals, distorted audio, and radio operator accent are reduced through use of the phonetic alphabet.

A Alpha (AL fah)	J Juliet (JEW lee ETT)	R Romeo (ROW me oh)
B Bravo (BRAH VOH)	K Kilo (KEY loh)	S Sierra (see AIR rah)
C Charlie (CHAR lee)	L Lima (LEE mah)	T Tango (TANG go)
D Delta (DELL tah)	M Mike (MIKE)	U Uniform (YOU nee form)
E Echo (ECK oh)	N November (no VEM ber)	V Victor (VIK tah)
F Foxtrot (FOKS trot)	O Oscar (OSS cah)	W Whiskey (WISS key)
G Golf (GOLF)	P Papa (pah PAH)	Y Yankee (YANG key)
H Hotel (hoh TELL)	Q Quebec (keh BECK)	Z Zulu (ZOO loo)
I India (IN dee ah)		

Transmitting Directions

When transmitting directions by radio, providers should use proper names and avoid using slang or abbreviations, particularly when describing locations. Use specific instructions, said in phrases, such as “PROCEED TO”, “TURN”, “HOLD”, “MONITOR”, “REQUEST”, “VERIFY”, “PROVIDE”, “ADMINISTER”, etc.

Reference Assessment Procedures

Communication on the Boston Health Center & Hospital Radio Network is in “clear” (non-encrypted) mode and may be monitored. *Communication should never include patient identifiers that could associate a patient to other historical or medical record information.*

Reports should be as complete and brief as possible; lengthy, rambling, unstructured reports are a waste of time and often as unclear as a fragmented report.

General Voice Procedures

Avoid abbreviations that are not commonly used. Instead, use commonly accepted and understood terms, including when identifying incident and/or event locations – do not use local language or descriptions that are not be commonly understood.

Identify each transmission using identifiers, especially when acknowledging orders.

Acknowledge orders by repeating them back exactly as you have received them.

Disaster /Significant Event Procedures

Definitive disaster procedures are the responsibility of regional and local agencies and individual facilities in conjunction with MMRS, BPHC and other City organizations. Users are expected to be thoroughly familiar with local procedures, the basic principles of the incident command system and those outlined in your own emergency plans (COOP and Pandemic Flu, Anthrax, Mass Dispensing, etc.). The Health Center and Hospital Radio Network is designed to support communication during emergency situations, both local and large scale, or when simultaneous communication with all health centers and hospitals improves the information relay or the coordination of joint decision making. While the channel plan has been designed flexible enough to meet the changing needs of an event, the following channel assignments have been designated to provide structure for the use of designated channels.

Command and control shall be conducted on HOSPITAL 1, while any Logistics traffic shall be on HOSPITAL 2, with health center cross talk communicated on HOSPITAL 3. (Again, cross-talk between Community Health Centers can be coordinated initially on HEALTH CTR, and if prolonged discussion is needed, both parties may shift to Hospital 3. Listen briefly before transmitting to ensure your transmission does not interfere with communication already on that channel.) Some examples of different types of communication, and the channels they might use, are explained below.

Public Health Commission Emergency: Command and control communication may be conducted on HOSPITAL 1 to discuss the Community Health Center role and responsibility in during an emergency. HOSPITAL 1 could also be used to give senior administrative staff ongoing situational updates and to be aware of shifts in the status of the health centers. A health center needing to close, due to a facility failure or resources being exhausted, would have significant impacts on the rest of the health network and would be another issue communicated on HOSPITAL 1.

Protracted MCI: In the event of a Mass Casualty Incident, patients may self present at community health centers, overwhelming on site resources and requiring support by BPHC and EMS personnel. A community health center may request an immediate BEMS response to the site, and also to advise BPHC and BEMS command of its status. Issues related to site access, security and transportation may be conducted on the command and control channel: HOSPITAL 1, while immediate, individual requests for personnel, supplies or other support communication may be conducted on the Logistics channel: HOSPITAL 2.

Mass Exposures and Prophylaxis: In the event of a major exposure (e.g. Anthrax), medication will be deployed to pre-determined dispensing sites. BPHC will communicate information to the public about site locations via the media and also through Health Centers, which might be communicated on the Command Channel: HOSPITAL 1. Review of Community Health Center operations, including impacts to internal staff and efforts to mitigate staff shortages, might be another example of Command, or Hospital 1 channel traffic. BPHC could also request the availability and

redeployment of personnel, both clinical and support staff, to support dispensing sites, which might be communicated on the Logistic Channel: HOSPITAL 2.

In a Pandemic, patients presenting with flu like symptoms may be better directed to a Mass Care Shelter or Health Center. Here again, BPHC/MMRS might communicate information to the public about site locations via the media and also through Health Centers, which might be communicated on the Command Channel: HOSPITAL 1. Coordinated review of health center activity, including patient volume and type, or neighborhood health issues might also be communicated on HOSPITAL 1. Health Centers needing to refer patients into facilities for more definitive or extended care might coordinate the logistics of point of entry via HOSPITAL 2.

When the Boston Health Center & Hospital Radio Network is utilized during an emergency, prompt and repeated updates regarding the incident shall be communicated to and provided by “Boston” (or designated coordinator). Requests for assistance will be directed to the designated coordinator on a logistic channel. Hospitals that may receive patients, or nearby hospitals which may be indirectly impacted by an MCI, shall receive communication updates via normal procedure; a hospital might also use such information and determine if its institutional disaster plan should be executed. All information should be qualified according to the degree of information needed to be transmitted.

Boston INTEROP Channel

Supersedes:
Effective: 11-29-04

Introduction
The primary Public Safety agencies within the City of Boston recognize the need for interagency communication, interoperability, and cooperation. Boston Police, Fire, and Emergency Medical Services (EMS) have well-established interoperability capability and mutual aid agreements in place. While these plans and agreements extend beyond jurisdictions, they often tend to remain intra-discipline. In other words, police have established a network to talk with other police agencies, fire with their fire counterparts, and EMS with other EMS agencies. The events of September 11, 2001 have highlighted the need for agencies to work together to establish communication interoperability and mutual aid plans not only across traditional jurisdictional boundaries, but across disciplines as well.

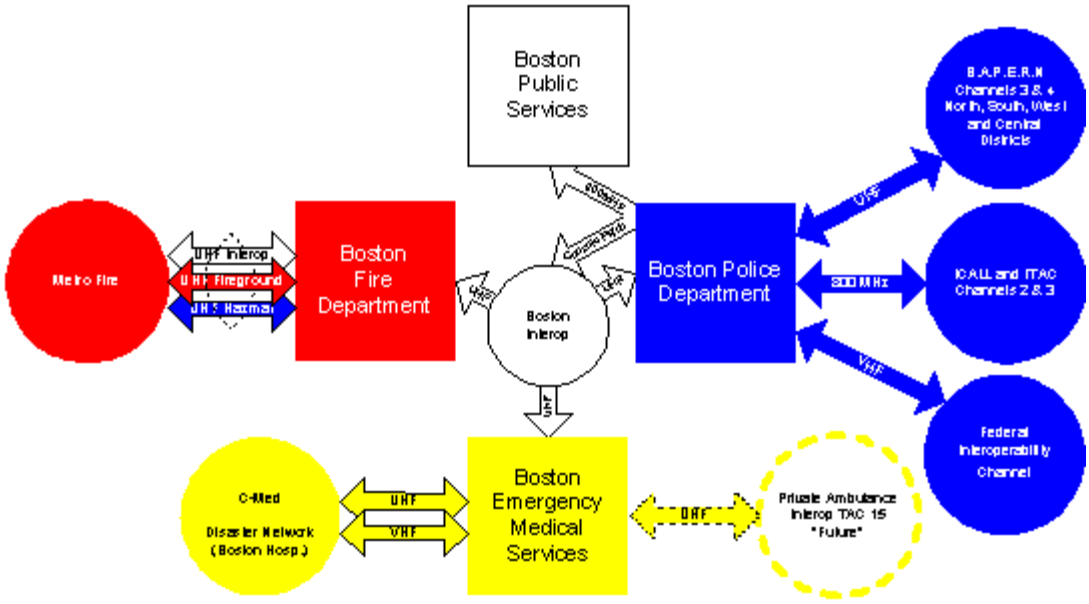
In order to address this concern, the City of Boston's Public Safety agencies, (Boston Police, Boston Fire, and Boston Emergency Medical Service), as well as the City's Public Service agencies (Mayor's Office, Boston Emergency Management Agency (BEMA), City Hall) have worked cooperatively to develop a solution called the Boston Interoperability Initiative (BOSTON INTEROP). The BOSTON INTEROP establishes dedicated radio channels with procedures, which will be accessible on communication equipment used by key Public Service officials, Public Safety officials and Public/Private Service executives deemed necessary by the Incident Commander.

Purpose
The principle objective of BOSTON INTEROP is to provide key decision makers from various agencies a real-time means of direct voice communication. Not only will this enhance the efficiency of a multi-agency response, it will save lives by quickly disseminating critical information to participating first responder agencies at the scene of a significant incident anywhere in the City.
The purpose of this SOP is to delineate the authority, roles, and procedures for the City agency supervisory personnel to use the BOSTON INTEROP channel. These personnel are outlined in Figure 1. This SOP also recognizes a number of interoperable communications alternatives to BOSTON INTEROP which allow the City of Boston's Public Safety and Public Service personnel to communicate during critical incidents.
Scope
The scope of this SOP includes the City of Boston's Public Safety agencies, including Boston Police, Boston Fire, and Boston Emergency Medical Services as well as the City's Public Service agencies including the Mayor's Office, BEMA, and City Hall. These agencies have worked cooperatively to develop the BOSTON INTEROP channel and standard operating procedures, which will be used at the agency command level during critical incidents or at the discretion of the Mayor. In the future, other agencies may

enter into a Memorandum of Understanding (MOU) with the City of Boston for the use of BOSTON INTEROP and will agree to operate according to the procedures outlined in this document.

Communications Structure
Figure 1
This structure demonstrates the various levels of command within each agency and the reporting relationship of all Boston personnel issued radios with the capability to access BOSTON INTEROP. It is expected that the most frequent use of BOSTON INTEROP will be by the lowest level of personnel on this diagram. There is a complete list of personnel with INTEROP capabilities listed in Appendix 1.
The horizontal arrows represent bi-directional, cross-jurisdictional communications.
*B*oston_INTEROP_Figure_1

Figure 2
The structure below shows the current communication capabilities between Boston Public Services, the Boston Police Department, Boston Emergency Medical Services, and the Boston Fire Department.



<u>Channel Patching and Monitoring</u>

Patching of INTEROP
The BOSTON INTEROP channel consists of a dedicated UHF radio channel patched to an 800 MHz INTEROP talk group. This patched network permits users operating on either frequency band to communicate directly with other BOSTON INTEROP users. This continuous patch alleviates the need to set up a patch during an actual incident. Should the UHF/800 patch need to be separated, Boston INTEROP would still serve as a valuable interoperability resource. While UHF users would lose the ability to

communicate directly with users on the 800 frequency, users may still be able to communicate with other users operating within their own frequency.

BOSTON INTEROP Channel Monitoring

The BOSTON INTEROP channel will be monitored by all agencies' dispatch/radio communication centers. Once BOSTON INTEROP is activated, all dispatch/radio communications centers shall be required to monitor the BOSTON INTEROP channel on a priority basis until the channel use is discontinued.

Activation, Transfer, and Discontinuation

Rules of Use

Plain Language

Plain language is to be used when communicating on BOSTON INTEROP. When necessary, the phonetic alphabet may be used to communicate over BOSTON INTEROP. See Appendix 2 for an example of the military phonetic alphabet.

Incident Command System

Each agency will use the Incident Command System (ICS) as an operational guide at incidents where the BOSTON INTEROP channel is activated.

Emergency Information Transmission

Once BOSTON INTEROP is activated, information that poses an imminent danger condition should be communicated between dispatch/radio communications centers (i.e. Boston Police Dispatch Center, Fire Alarm and/or Boston EMS). The receiving dispatch/radio communications center is required to acknowledge receipt of the emergency information. Additionally, each agency is responsible for disseminating this information to its respective personnel.

In the case of an imminent danger condition where BOSTON INTEROP is not activated, agencies operating at the scene shall be notified of the situation as quickly as possible. Some options for this notification are the use of the computer aided dispatch (CAD) center, telephone, or ring down.

Operation Procedure and Guidelines for Limited and Full Activation

Limited Activation

Limited activation is appropriate when an incident can be resolved by the resources of the Public Safety or Public Service agencies. During these incidents, Public Safety or Public Service agencies can use BOSTON INTEROP.

Full Activation

Full activation is appropriate when an incident requires the activation of the Boston Emergency Operations Center (BEOC) as ordered by the Mayor and/or Emergency Management Director. During a large-scale incident, operational transmission procedures will be on the BOSTON INTEROP channel until the BEOC is fully staffed.

Agency heads will be able to speak to each other for acquisition of resources. Once the BEOC is fully staffed, the Operations Officer at the BEOC will be the primary source for acquisition of resources. At this point, the BOSTON INTEROP Channel's function will shift to unified command, incident mitigation and personnel safety.

Radio Channel Activation Authority

Use of the BOSTON INTEROP channel may be requested whenever an agency's Incident Commander (highest-ranking officer of the controlling agency) determines the need to communicate directly with other agency representatives with access to the BOSTON INTEROP channel. Each agency has the right to use BOSTON INTEROP as it suits that agency's needs for public safety and availability of necessary resources. It is important to note that the use of BOSTON INTEROP is not intended to replace the establishment of an on-scene unified command post among responding agencies. BOSTON INTEROP is intended to facilitate communication until a command post can be established, or to speak to an agency representative not yet on scene.

Establishing and Transferring Lead Dispatch Radio Command Control

The Incident Commander (IC), identifying the need for interoperability communication, will contact their respective dispatch/radio communication center (i.e. Mayor's Office, Boston Police Dispatch Center, Fire Alarm and/or Boston EMS) and identify the agencies requested to switch their radio to BOSTON INTEROP. The dispatch/radio communication center of the agency that initiates use of the BOSTON INTEROP channel has the responsibility to notify all other required agencies by radio or telephone in accordance with the procedures outlined in this SOP. The dispatch/radio communications center of the agency activating the interoperability channel will become the lead dispatch/radio communications center.

The designation of the lead dispatch/radio communications center may be changed as required or requested by the lead agency.

If the Incident Commander is transferred, the new Incident Commander shall notify their respective dispatch/radio communications center by radio or telephone that s/he is the new Incident Commander for his/her agency. This dispatch/radio communication center will then become the lead dispatch/radio communication center of BOSTON INTEROP.

Please refer to Appendix 3 for dispatch/radio communications center contact information.

Notification Process for Establishing Command Control

Each agency participating in BOSTON INTEROP will follow its own internal notification procedures for establishing command and control. The Mayor, Police Commissioner, Fire Commissioner, EMS Chief, and BEMA Director or their designees are authorized to activate BOSTON INTEROP.

Discontinuation of the INTEROP Channel

At such a time that communication on the BOSTON INTEROP channel is no longer required, the Incident Commander of the lead agency will notify their respective

dispatch/radio communications center to discontinue active use of the BOSTON INTEROP radio channel and normal monitoring will resume. The lead dispatch/radio communication center will notify all participating dispatch/radio communications centers that BOSTON INTEROP is no longer in use.

Separation of the INTEROP Channel Due to Interference

In the event that there is intentional or unintentional interference with the BOSTON INTEROP frequency, the dispatch/radio communications center and/or Incident Commander (IC) should notify the Boston Police Department Dispatch Center Duty Supervisor by telephone. The Police Duty Supervisor will notify the Director of Communications to take down the patch; however, the responsibility of ensuring the patch is terminated belongs to the police Duty Supervisor. When the patch between the UHF and 800 MHz trunked systems is separated, the radios may still work within their own frequency.

Communication Alternatives

Several alternatives have been identified to ensure interoperable communications remains available among all agencies if BOSTON INTEROP is inoperable. These alternatives may be used instead of or in addition to BOSTON INTEROP.

- Telephone Conference Bridges

Telephone Conference bridges permit direct communication among a number of users, assuming they have access to telephone service. See Appendix 4 for instructions to set up the conference bridge.

- Cellular / Push to Talk Commercial Wireless Technology

Currently, most City agencies use cellular/push to talk commercial wireless communication technology. In the event that the BOSTON INTEROP Channel is malfunctioning, this technology may be used to disseminate critical information to department heads and/or designees.

- Computerized Emergency Notification System

The computerized emergency notification system shall be programmed to contact specific individuals and agencies, depending on the nature of the incident. This includes appropriate media outlets, which could be used to inform the general public of situation updates, specific instructions, and/or emergency locations if warranted.

- Internet/E-mail

Another lesson learned from September 11, 2001 was the power of the Internet and email. While conventional communication outlets (i.e. wireless phones and land lines) were either damaged or overwhelmed, the Internet was up and provided an invaluable service to concerned members of the general public. The Web EOC® can be used as a means to pass information to various agencies that are participating in the event.

- Satellite Phones

Satellite phones have been assigned to the agency heads of BPD, BFD, BEMS, BEMA, and the Mayor's Office for intercommunications in the event that conventional phone lines become impaired. A cache of satellite phones will be stored at the BEOC and assigned for use by the BEMA Director and/or Operations Officer. The satellite phone numbers for agency heads are listed in Appendix 5.

- Cache of 800 MHz Portable Radios

Three caches of 800 MHz portable radios (18 total) are available through BEMA. These radios are able to provide a communication system on a local, regional and statewide level in accordance with existing mutual aid, MOU's, resource sharing agreements and requests from other first responder agencies. Because these radios work only on ITAC channels, their activation must be coordinated with the Massachusetts State Police or the Massachusetts Emergency Management Agency, prior to use.

- Mobile Capabilities with Conventional Channels (Future Capability)

Several Command Posts and Communication Support vehicles are available through the various public safety agencies. These resources can be deployed to provide: a cache of spare UHF radio equipment, spare batteries, provide network video downlink capability, cross band patching, or base station repeaters to help support an extended operation, or replace a damaged fixed repeater site.

- Dispatch/Radio Communications Center to Dispatch/Radio Communications Center Messaging

Boston Police, Fire and EMS share a common computer aided dispatch (CAD) system capable of providing text messaging between users.

- Runner System

In the unlikely event that BOSTON INTEROP and redundant back-up systems are all unavailable, the BPD will arrange for a "runner system" in which designated personnel respond to the residence of Department heads and other key agency representatives to make notifications and provide transportation as necessary.

Training Requirements

Personnel Training Requirements

Participating agencies will be responsible for ensuring that their personnel are familiar with this SOP and are properly trained in accordance with the guiding principles in Appendix 6.

Testing Requirements

Radio Testing: During standardized testing, the testing agency will communicate with participating Public Safety and Public Service agencies on the BOSTON INTEROP channel. There will be two different phases of radio testing:

- Communications Center Testing

This weekly test of the BOSTON INTEROP Channel (Wednesdays at 1:00pm) will be done between the Public Safety and Public Service Dispatch/Radio Communication

Centers (BPD, EMS, FIRE, BEMA and MUNI PD for City Hall). The agency radio technician shall monitor the UHF and 800 MHz trunked systems during testing.

- Operational Testing

Each agency will decide when testing should take place. All agency heads or designated representatives with radios pre-set with the BOSTON INTEROP channel will participate in this testing. During this test, the technical support will be checking the accuracy and performance of various sites.

Responsibility

Responsibility for SOP Compliance
It shall be the agency heads' responsibility to ensure that these standard operating procedures are followed when necessary.

It shall be the responsibility of all communication personnel to be familiar with and comply with this SOP.

Appendix 1
Personnel with BOSTON INTEROP Capabilities:
Boston Police Department

Title
Commissioner
B.F.S. Bureau Chief
O.P.C., Chief Hearings Officer
B.F.S., Night Command
B.P. Dev., Bureau Chief
B.I.S. Bureau Chief.
O.P.C., DNC Planning Group
B.A.T. Bureau Chief
B.I.I., Bureau Chief
B.F.S. Asst. Bureau Chief
O.P.C., Labor Relations Officer
B.I.I., Asst. Bureau Chief
B.F.S., Night Command
B.I.S., Invest. Support Div
B.F.S., Special Operations Div
B.A.T., Operations Division
O.P.C., Chief of Staff
B.P. Dev., Assistant Chief
B.I.S., Homicide Unit
B.I.S., Major Cases Division
B.I.S., Family Justice Division

O.P.C., Media Relations
Mayor's Office
B.A.T., Assistant Chief
B.F.S., Detail Assignment Unit
B.F.S., Staff Inspections
B.F.S., Area A-1
B.F.S., Area B-2
B.F.S., Area B-3
B.F.S., Area D-4
B.F.S., Area E-5
B.F.S., Area C-6
B.F.S., Area A-7
B.F.S., Area C-11
B.F.S., Area E-13
B.F.S., Area D-14
B.F.S., Area E-18
B.F.S., Operations Division
B.P. Dev., Training & Education
B.F.S., Special Operations
B.I.S., Forensic Technology
B.A.T., C.A.T. Details
B.A.T., Hackney Carriage Unit
B.F.S. Court Unit
B.S.O. MOP
B.S.O. Y.V.S.F.
B.S.O. Bomb Squad
B.S.O. Harbor
B.S.O. Mounted
B.P.D. Professional Development
Mayor’s Driver
Drug Control Division

Date of Last Revision_____
Name and Title_____

Personnel with BOSTON INTEROP Capabilities:
Boston Fire Department

Title/Rank
Commissioner
Chief of Field Operations
Chief of Support Operations
Personnel Division
Emergency Management Div/BEMA

Training Division
Information Technology Division
Fire Prevention Division
Fire Alarm Division
Special Operations Command
Emergency Management Div/BEMA
Division 1
Division 2
District 1
District 3
District 4
District 5
District 6
District 7
District 8
District 9
District 10
District 11
District 12
Safety Chief
Mobile Command Post
Marine Unit 1
Marine Unit 2

Date of Last Revision_____
Name and Title_____

Personnel with BOSTON INTEROP Capabilities:
Boston Emergency Medical Services

RANK/TITLE
Chief of Boston EMS
Medical Director
Superintendent-In-Chief
Superintendents
Deputy Superintendents
Captains
Communication System Engineer
Communication Specialist-II

Date of Last Revision_____
Name and Title_____

Personnel with BOSTON INTEROP Capabilities:

City of Boston

Title/Rank
Mayor
24 Hour Service
Chief Operating Officer
Deputy Chief Operating Officer
Chief Financial Operator
Chief of Health & Human Resources
Chief of Staff
Deputy Chief of Staff
Chief of Policy & Planning
Chief of Basic Services
Director of Operations
Animal Control
Director, Mayor's Office of Homeland Security
Deputy Director, Mayor's Office of Homeland Security
City Auditor
City Treasurer
Municipal Police
Municipal Police Dispatch
Commissioner – Transportation
Deputy Commissioner - Eng & Ops
Operations Director
Supervisor, Traffic Enforcement
Enforcement
Towing
Commissioner - Public Works
Superintendent – Highways
Assistant Superintendent- Highways
Superintendent - Street Lighting
Director Central Fleet Maintenance
Sanitary Division
Radio Shop Central Fleet Maintenance
Commissioner -Parks & Recreation
Director - Park Maintenance
General Superintendent
Administration
Chief Ranger
Commissioner - Inspectional Services
ISD Senior Manager
Commissioner - Elderly Commission
Deputy Commissioner - Planning
Deputy Commissioner - Transportation

Senior Shuttle - Fleet Service Director
Superintendent - School Department
Emergency Operations Leader
Director of Engineering - EDIC
Chief Information Officer - Mgmt Info
Director of Technology
Telecommunications Manager
Public Safety Director
Special Events
Superintendent - Suffolk H.O.C.
Deputy Chief - Boston Housing Police

Date of Last Revision_____
Name and Title_____

Appendix 2
The Military Phonetic Alphabet

The phonetic alphabet may be used to communicate over BOSTON INTEROP only when necessary. Plain language should be used whenever possible.

The phonetic alphabet system, provided below, is a recommendation for those agencies lacking an operational alphabet system.

Alpha	**B**ravo	**C**harlie	**D**elta
Echo	**F**oxtrot	**G**olf	**H**otel
India	**J**uliet	**K**ilo	**L**ima
Mike	**N**ovember	**O**scar	**P**apa
Quebec	**R**omeo	**S**ierra	**T**ango
Uniform	**V**ictor	**W**hiskey	**X**-ray
Yankee	**Z**ulu		

Appendix 3
Communications Centers Contact Information

Discipline	Communication Center/POC	Phone Number
Boston EMS	Dispatch operation supervisor (24 hour number)	617-343-1400
Boston Fire	Fire alarm operations/Officer in Charge	617-343-2880
Boston Police	Boston Police Dispatch center/Duty Supervisor	617-343-5449 617-343-4680 (supervisor's clerk)
BEMA	Fire alarm operations	617-343-2880
City agencies	Mayor's 24 hour hotline	617-635-4500

Date of Last Revision_____
Name and Title_____

Appendix 4
City of Boston Telephone Conference Bridge

To use the City of Boston telephone conference bridge each participant will need the conference dial-in phone number and the pass code.

Dial-in Number: 1-866-441-2942
Passcode: 6354783

Participant Directions:

1) Participant: Please dial 1-866-441-2942
2) When answered, you will be prompted to dial the passcode, 6354783, followed by a #.
3) Wait and listen. Do not dial or press anything.
4) Hear a message announcing that you are in a "Quick Start Conference" and that you will be put into conference, please stand by.
5) You will now hear the other participants and may announce your name.

Appendix 5
City of Boston Satellite Phone Numbers

Satellite Tel #	Agency/Department

881631446470	**Mayor's Office**
881631446469	**BPD**
881631446468	**BFD**
881631446467	**EMS**
881631446466	**BEMA**

Irridium Motorola Satellite Phone User Guide

Please Read Before Use. The Iridium Satellite equipment and service is an invaluable tool. It does not function like a cellular phone, however it will operate well when used as directed.

To achieve the greatest success with your new Iridium phone:

1. Always use the phone outside with clear line of sight of the sky. Move away from buildings, tall structures and trees. The rule of thumb is "if you are in an area where you can fly a kite, the phone will usually work very well"
2. Check to make sure that the rotating antenna is fully "seated" into the phone. It should fit tightly and rotate with a slight resistance. Prior to making your call, snap the antenna into the upright position.
3. Extend the antenna to its full length – pointing at the sky.
4. Turn the phone on by pushing the button on the lower left. The phone will display several screens and startup information. YOU CAN IGNORE THE MESSAGE "Insert cassette".
5. To be sure the phone is properly connected to the satellite network your phone should indicate that it has "REGISTERED". Once connected to the network the display will show signal strength in the upper left hand corner using small bars.
6. Once you have at least 1 bar signal strength begin dialing – please note that you must always dial the international prefix of 00 before placing any calls, whether local or international.

   Example:

   00 + country code + area code + phone number
7. After you've dialed your number push the send button like any mobile phone. Antenna MUST still be pointed towards sky, even while talking.
8. Unlike a normal mobile phone you will hear a series of beeps while the satellite network connects the call. The beeps will be followed by the normal ringing tone indicating your call is being connected. You should now be successfully talking to your intended party.
9. For questions or briefing on the Iridium Satellite service and equipment please contact us at 1-888-WORLDCELL or 1-301-960-0078

POWERING UP THE PHONE

The antenna MUST have a clear view of the sky in order to operate. The antenna may dislodge during shipping. Please check or press the release button at the top of the phone and remove the antenna. Reinsert it in the down position by holding the release button until it locks into place.

• Following powering, screen will display "REGISTERING"

• When you see 'REGISTERED" and the signal strength indicator (green light top of the phone) or the home signal on the phone screen.

• If you see "ROTATE ANTENNA" or "ORIENT ANTENNA" extend the antenna upward

and make sure you have a clear view of the Sky.
• If you see “CALL FAILED”, “SYSTEM BUSY”, “RESTRICTED AREA” or “WEAK SIGNAL” this means the phone is unable to access the network. Try again in a few minutes. This means a satellite may not be available to take you into the system at that time. The phone will continue trying to connect until a new satellite moves into range.

OUTGOING CALLS
Rotate antenna upward and extend it fully. The antenna MUST have a clear view of the sky in order to operate.

- All calls must be dialed in the international format. Begin call by pressing and holding down **0+** key until **“+”** symbol appears on phone display, or by using the international access code of **00**
- Enter the country code
- Enter the city/area code (excluding the 0 if applicable)
- Enter the telephone number and press **OK**.
- Phone beeps while connecting your call. **DO NOT HANG UP.** Phone will begin ringing tone as soon as it connects.

Example: Calling a North American number from any country:
+ 1 212 555-1234 **or** 00 1 212 555-1234 **OK**
Example: Satellite to Satellite calling, from any country:
+ 8816 314-12345 **or** 00 8816-314-12345 **OK**

HOW TO REACH YOU
People trying to reach you from your office in the U.S. or Canada **MUST** dial **011-8816** followed by your Iridium eight-digit phone number. If calling you from other countries and want to reach you they **MUST** dial **00-8816** followed by your Iridium eight-digit phone number.

Appendix 6
Training Guiding Principles

At a minimum each agency will give its own overview of the following:

- How the radio is set up
- How to select the right channel
- Proper terminology and Radio Etiquette
  - Agencies using BOSTON INTEROP must use plain English
  - Agencies using BOSTON INTEROP will use agency affiliation and title (Fire Incident Commander, EMS Staging Officer, etc) in lieu of established agency call signs
- Who to notify in their agency if they have a radio problem

Proper terminology and Radio Etiquette Examples/Reference Guide

1. Contact is established before a message is given.

Contact is initiated by holding the microphone 3 inches from the mouth, keying the radio, waiting 1-2 seconds before speaking. The initiating party identifies his/her agency affiliation and title in addition to those of the person being called.

Example:

"Fire District 5 to Public Works Highway Superintendent, have 3 front-end loaders report to Tremont and Stuart for removal of debris."

2. The basic content of messages requiring an action is repeated back to the originator.

   Example:

   "Public Works Highway Superintendent to fire District 5, sending 3 front-end loaders to Tremont and Stuart for removal of debris."

3. If the person being called responds with "Who is calling the Public Works Highway Superintendent?" he/she did not understand who was calling him/her. The initiating party would then repeat his/her agency affiliation and title in addition to those of the person being called to establish contact.

   Example:

   "Fire District 5 to Public Works Highway Superintendent"

Ring Down is defined as a hotline that applies to Boston city agencies.

MassDOT Interoperable Communications on Limited Access Roadways (I-90 / I-93 including their tunnels)

Supersedes: 01-19-12
Effective: 01-01-13

Boston EMS responds to incidents on limited access roadways under the control of Massachusetts Department of Transportation (MassDOT). These roadways include I-93 (north and south from the Somerville line to the Milton line), and I-90 (Massachusetts Turnpike eastbound and westbound from the Newton line to the Revere line). The multiple ramps on and off of these roadways have the potential to delay an EMS response. The MassDOT Highway Operations Center (HOC) has multiple cameras and is able to visualize most portions of these roadways 24 hours a day. When aware of an incident, the HOCis able to provide timely information to responding BEMS units via TAC-3.

PROCEDURE:

1. The MassDOT Highway Operations Center will use the call sign “HIGHWAY OPERATIONS” when operating on interagency radio channels.
2. The MassDOT Highway Operations Center will monitor Boston EMS radio channel TAC-3 whenever notified that BEMS units are responding to an incident involving MassDOT roadways or tunnels.
3. Once dispatched to an incident on one of these roadways, Boston EMS Dispatch Operations should advise responding unit(s) to switch one radio (portable or mobile) to TAC-3 unless the channel is already in use.
4. The responding BEMS unit should notify Highway Operations on TAC-3 that they are responding in order to confirm the incident location and obtain information relative to the best access route to the incident.
   4.1. If multiple Boston EMS units are responding to an incident (ALS/BLS, BLS/Supervisor, etc) and one unit is already receiving updates from MassDOT Highway Operations, the other responding unit(s) may simply monitor the traffic.
5. Boston EMS Dispatch Operations should restrict further use of TAC-3 until the incident is secure. TAC-5 or TAC-7 are available for citywide tactical use.
6. Boston EMS Dispatch Operations will use the call sign “BOSTON EMS DISPATCH” when contacting Highway Operations by radio.

Example:

Highway Operations, Boston Ambulance 6 calling

Highway Operations is answering Boston Ambulance 6

Highway Operations, Boston Ambulance 6 responding Northbound I-93 at exit 26 for an MVA with Injuries

Boston Ambulance 6, Highway Operations Received, we have two State Police cruisers on scene confirming injuries. They are in the far left hand lane

Highway Operations from Boston Ambulance 6- we have that, our ETA is 3 minutes

See Related: Special Responses, Routing and Contra-Flow

MassPort Fire-Rescue Radio Channels

Supersedes: 01-19-12
Effective: 10-31-14

In an effort to improve interagency communication and coordination during a combined incident at Logan International Airport (Logan) or other location at which MassPort Fire-Rescue (MFR) is operating, MFR frequencies have been programmed in the 800 megahertz radio at Dispatch Operations and several BEMS Command, Supervisory and Special Operations vehicles. Additionally, MFR has patched their "Fire Ground" talk group to a radio frequency available in Boston EMS mobile and portable UHF radios.

1. 800 MHz Radios

1.1. The MassPort Fire-Rescue talk-groups are identified as follows:

Talk Group
MPA Fireground
MPA Emergency 1
MPA Emergency 3

1.2. "MPA Fire Ground" will be the selected talk group for the radio at Dispatch Operations unless directed to another talk-group by MassPort Fire-Rescue personnel.

1.3. The radios in the mobile units are configured to enable the user to "scan" the various talk groups. When responding to an incident at Logan, BEMS units so equipped should select and monitor "Fire Ground" unless directed to another talk-group by MassPort Fire-Rescue personnel.

2. UHF Radios

2.1. The BFD / MFR interoperability channel is programmed in two zones of Boston EMS mobile and portable radios

- The channel is located in the BEMS zone with the channel name MASSPORT (position 16).
- The Channel is also located in the INTEROPERABILITY Zone (IOP) with the channel name MASSPORT (position 5).

3. Channel Use and Callsigns

3.1. Most interagency interagency communications will likely be handled by the Dispatch Operations Center (callsign "Boston EMS Dispatch") and the MassPort Fire-Rescue Dispatcher (callsign "MassPort Fire Alarm"). However, there may be situations in which a responding BEMS unit wishes to speak with "MassPort Fire Alarm" directly to obtain further information regarding access instructions or patient care update.

For these purposes, Boston EMS personnel should assume a callsign designating the type of unit when operating on the Massport Fire-Rescue talk group (800 mHz radio) or interoperability channel. For example, the Shift Commander would utilize “Boston EMS Command”, a Supervisor would utilize “Boston EMS Supervisor”, and an ambulance crew would utilize their unit ID such as “Boston EMS A-7”.

All requests for a Boston EMS unit to speak directly with an on scene MassPort Fire-Rescue Unit shall be coordinated through MassPort Fire Alarm.

Examples:

(*Massport Fire Rescue* Initiated)

Boston EMS dispatch from MassPort Fire Alarm

MassPort Fire Alarm- Boston EMS Dispatch Answering

Boston EMS Dispatch from Massport Fire Alarm- the ALERT2 has been secured with no injuries, you can cancel your responding units.

MassPort Fire Alarm- Boston EMS Dispatch has that: we will cancel our units.

(Boston EMS A7 Initiated)

MassPort Fire Alarm- Boston EMS A7 calling

Boston EMS A7- MassPort Fire Alarm Answering

MassPort Fire Alarm, Boston EMS A7- we are on scene at Terminal B, upper level Gate 4 but cannot find your unit. Can you have them meet us or give us a better location?.

Boston EMS A7 from MassPort Fire Alarm- stay at your current location and we’ll send a Trooper to meet you. Or “Boston EMS A7 from MassPort Fire Alarm, cross talk directly with Terminal E command.”

MBHSR Public Safety Communications Interoperability

Supersedes:
Effective: 05-10-06

PURPOSE
Background: In the aftermath of September 11, 2001, the United States Department of Homeland Security (DHS) initiated the Urban Area Security Initiative (UASI) to address national security issues on a regional basis. UASI identified communications interoperability, the ability of public safety agencies to talk across disciplines and jurisdictions, as a priority for the nation.

The purpose of the Metro-Boston Homeland Security Region (MBHSR) Public Safety Communications Interoperability project is to ensure that MBHSR first responders have the ability to share data and communicate at optimal efficiency, in real time, across jurisdictions and disciplines. Increased communications interoperability enables more effective emergency response during day-to-day operations and large-scale events. The mission of the MBHSR communications interoperability project is to improve regional communications interoperability among first responder agencies and improve the efficiency and effectiveness of the region's overall response capabilities.

Towards that end, the participating agencies have created a Standard Regional Channel Plan for Communications Interoperability that will allow for other regional agencies to transmit and receive on their licensed frequencies. This plan (as modified and agreed to) with associated radio frequencies is to be installed on all portable, mobile and dispatch center radios as appropriate for the purpose of regional communications interoperability. This document allows for that use and defines the frequencies and policy for use.

AUTHORITY
The U.S. Department of Homeland Security designated Boston a *high-threat* urban area in July 2003 as part of the Office for Domestic Preparedness' (ODP) Urban Area Security Initiative (UASI) grant program. As the core city, Boston oversaw the delineation of the region, and created the Boston Mayor's Office of Homeland Security (MOHS) to integrate and manage all homeland security activities. The UASI region was subsequently named the Metro Boston Homeland Security Region and consists of nine jurisdictions: Boston, Brookline, Cambridge, Chelsea, Everett, Quincy, Revere, Somerville, and Winthrop.

The MOHS led an effort to develop a Strategic Plan for Communications Interoperability that addresses and prioritizes how the MBHSR can enhance interoperable communications capabilities during response to emergency incidents. The development of standard regional channel plans was identified as Initiative 1B in the MBHSR Communications Interoperability 5-year Strategic Plan.

PRINCIPLES
The Participating agencies will abide by the following principles:
1. That all parties will install or program the entire MBHSR Standard Regional Channel Plan as provided in the MBHSR Standard Code Plug, without changes, on all public safety radios

controlled by them that possess the capability to support it and utilize the channel nomenclature.

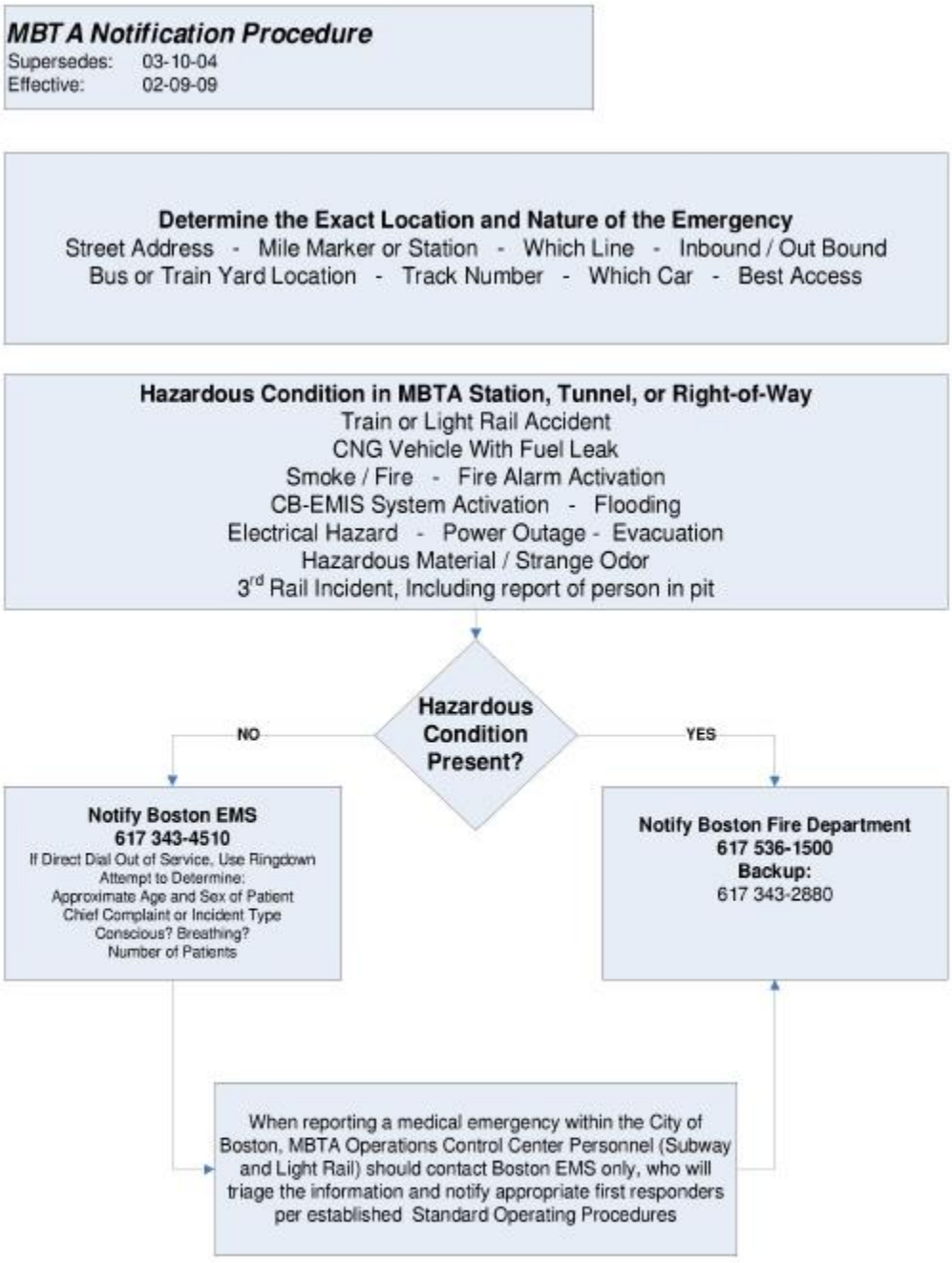
2. That all participating agencies authorize the emergency use of their licensed frequencies by other MBHSR agencies (parties) as outlined in the MBHSR Standard Regional Channel Plan and according to the Interim Guidelines and any future Standard Operating Procedures promulgated and agreed to by participating agencies.
3. That all participating agencies will utilize their block of assigned radio IDs as put forth by the MBHSR-CIS in consecutive order when possible.
4. That all participating agencies will ensure training on and adherence to the Interim Guidelines and any future Standard Operating Procedures promulgated and agreed to by participating agencies and that they will impose appropriate corrective action on personnel found to be in violation.
5. That all participating agencies will implement radio communications procedures for Communications Interoperability Channels consistent with the National Incident Management System (NIMS) and Incident Command System (ICS), to ensure that effective communications processes and systems exist to support a complete spectrum of incident management activities, to include, but not limited to, the following excerpts from the NIMS Incident Management Communications requirements to:
   5.1. Individual Jurisdictions: They will be required to comply with national interoperable communications standards, once such standards are developed. Standards appropriate for NIMS
   users will be designated by the NIMS Integration Center (NIC) in partnership with recognized standards development organizations (SDOs).
   5.2. Incident Communications: Incident communications will follow the standards called for under the ICS. The Incident Commander (IC) manages communications at an incident, using a common communications plan and an incident-based communications center established solely for use by the command, tactical, and support resources assigned to the incident. All entities involved in managing the incident will utilize common terminology, prescribed by the NIMS, for communications.
6. That all participating agencies will ensure that communications operators at dispatch centers monitor appropriate interoperability calling channels. (e.g. BAPERN 3, Metro Red, UCALL)
7. That all participating agencies will ensure that interoperability-calling channels are monitored at the Incident Command Post on major incidents requiring significant aid from agencies beyond routine local interoperability. (e.g. BAPERN 3, Metro Red, UCALL)

INTERIM GUIDELINES FOR USE OF MBHSR CHANNEL PLAN

1. Users are only permitted to transmit on channels they have been assigned to by a control point or in the case of no control point, their Incident Commander.
2. All transmission within the standard regional channel plan other than the user's home frequency must use a call sign including city, agency, and user assigned ID.
3. All transmissions on frequencies not controlled by the user's agency must follow the policies and procedures set forth by the channel's control point.
4. Control points may authorize other agencies and their personnel to transmit on their frequencies.
5. Incident Commanders must seek approval from the channel's control point to transmit or allow others to transmit for the purpose of interoperability.
6. Use of any of these frequencies must adhere to the principles of the National Incident Management System and the Incident Command System.

[Source: Based on MBHSR Public Safety Communications Interoperability Memorandum of Understanding]

NIMS Compliance Document, Chapter 5 “Communications and Information Management” (http://www.fema.gov/txt/nims/nims_doc3-5.txt)


MBTA Notification Procedure
Supersedes: 03-10-04
Effective: 02-09-09
Determine the Exact Location and Nature of the Emergency
Street Address - Mile Marker or Station - Which Line - Inbound / Out Bound
Bus or Train Yard Location - Track Number - Which Car - Best Access
Hazardous Condition in MBTA Station, Tunnel, or Right-of-Way
Train or Light Rail Accident
CNG Vehicle With Fuel Leak
Smoke / Fire - Fire Alarm Activation
CB-EMIS System Activation - Flooding
Electrical Hazard - Power Outage - Evacuation
Hazardous Material / Strange Odor
3rd Rail Incident, Including report of person in pit
Hazardous Condition Present?
NO
YES
Notify Boston EMS
617 343-4510
If Direct Dial Out of Service, Use Ringdown
Attempt to Determine:
Approximate Age and Sex of Patient
Chief Complaint or Incident Type
Conscious? Breathing?
Number of Patients
Notify Boston Fire Department
617 536-1500
Backup:
617 343-2880
When reporting a medical emergency within the City of Boston, MBTA Operations Control Center Personnel (Subway and Light Rail) should contact Boston EMS only, who will triage the information and notify appropriate first responders per established Standard Operating Procedures

MBTA Tunnel Communications

Supersedes: 06-17-14
Effective: 03-01-16

INTRODUCTION

The Massachusetts Bay Transportation Authority (MBTA) has upgraded its radio communication system to provide enhanced radio communications within the MBTA's tunnels for Boston Emergency Medical Services, the Boston Fire and Police Departments, MetroFire (Regional Fire Network that supports 35 fire departments), BAPERN (Boston Area Police Emergency Radio Network that supports over 100 police departments), the Cambridge Fire and Police Departments, the Somerville Fire and Police Departments, the Massachusetts State Police, and the MBTA Transit Police Department.

PROCEDURE

1. Boston EMS personnel operating at the scene of an incident in an underground MBTA station or subway tunnel needing to communicate with the Boston EMS Dispatcher should first attempt to contact the BEMS dispatcher via the assigned operating BEMS frequency (e.g. TAC-1, TAC-5, etc.)

2. If unable to contact the EMS dispatcher via a BEMS channel, one member should switch to Boston Fire Department channel 4. This channel is located in **BEMS** zone with the channel name **BOSTON 4**. Therefore, when properly selected, the display will read: **BEMS BFD 4**

   2.1. EMS users should contact the Boston Fire Alarm Dispatcher using the format: "Fire Alarm, Boston EMS <Unit> Calling on Channel 4.

   2.2. Emergency Requests: Once acknowledged by Boston Fire Alarm, an EMS unit with an emergency request will state their Unit ID, Location, and Nature of the Emergency. The Fire Alarm Dispatcher will act upon the request (emergency request for the police, for example) and then quickly notify the EMS Dispatcher of the situation.

   2.3. Non-Emergency Requests: Once acknowledged by Boston Fire Alarm, an EMS unit with a non-emergency request will state their Unit ID, Location, and Request the EMS Dispatcher.

   2.4. Unless the EMS Dispatcher is monitoring BFD Channel 4 and immediately responds, the Fire Alarm Operator will update the EMS Incident indicating that the Unit is requesting the EMS Dispatcher on Channel 4. If the EMS Dispatcher does not come up on BFD Channel 4 after the CAD message has been entered, the Fire Alarm Dispatcher shall notify the EMS Dispatcher via ringdown.

   Example: Emergency
   EMS Unit: "Fire Alarm, Boston EMS A-1 Calling on Channel 4"
   Fire Alarm: "Fire Alarm Answering Boston EMS Ambulance 1"

Unit: "Fire Alarm- Boston EMS Ambulance 1 at Park Street MBTA requesting Police Assistance for a Violent Patient"
Fire Alarm: "Fire Alarm to Boston EMS Ambulance 1- we'll send the Police to Park Street for a violent patient"

In this case, the Fire Alarm operator should notify the MBTA Police and simultaneously update the CAD incident text.

Example: Non-Emergency
EMS Unit: "Fire Alarm, Boston EMS Ambulance 1 Calling on Channel 4"
Fire Alarm: "Fire Alarm Answering Boston EMS Ambulance 1"
EMS Unit: "Fire Alarm Boston EMS Ambulance 1 at Park Street MBTA requesting the EMS Dispatcher"

The fire alarm dispatcher will then update the Park Street incident indicating the Unit is requesting the EMS dispatcher. The EMS Dispatcher will then come up on BFD Channel 4

EMS Dispatcher: "Ambulance 1, this is Boston"
EMS Unit: "Boston, Ambulance 1—you can cancel the Paramedics to this location. Have the MBTA Police continue for an assault report"
EMS Dispatcher: "Ambulance 1, Boston- roger, cancel the paramedics and continue the MBTA police routine for a report."

If BFD Channel 4 is not available, a secondary interoperability channel is MBTA Transit Police Channel 1

1. This channel is located in POL zone with the channel name MBTA PD1. Therefore, when properly selected, the display will read: **POL MBTA PD1**
   1.1. EMS users shall contact the MBTA Transit Police Dispatcher: "Transit Police, Boston EMS <Unit> Calling on Channel 1.
   1.2. Once acknowledged by MBTA Transit Police Dispatcher, the EMS unit will state their Unit ID, Location, and message. The MBTA Transit Police Dispatcher will act upon the request (emergency request for the police, for example) and then notify the EMS Dispatcher of the situation.

Mutual Aid Requests

Supersedes: 07-01-11
Effective: 01-01-13

INTRODUCTION
Boston EMS recognizes that on occasion, circumstances may develop that severely limits available public safety resources in Boston or neighboring communities. Under these circumstances, Boston EMS may be asked to provide mutual aid assistance to another agency, or may request assistance from other agencies. Mutual Aid refers to the organized, coordinated, and cooperative response of emergency medical services personnel and equipment to a request for assistance in an emergency when local resources have been expended. The response is predicated upon agreements among participating agencies or jurisdictions

EXISTING AGREEMENTS
The Metro-Boston Homeland Security Region (MBHSR) includes the City of Boston and the surrounding cities and towns of Brookline, Cambridge, Chelsea, Everett, Quincy, Revere, Somerville, and Winthrop. The primary EMS providers in each of these jurisdictions (Boston EMS, Fallon, Cataldo, and Professional) are committed to a system of ongoing and open communications, planning, and prevention strategy development. The MBHSR EMS providers are also committed to a mutual aid system of providing response to any member community that requests EMS assistance, as evidenced by the standardized regional MCI Response plan.

Boston EMS has also entered into agreements with the primary EMS providers of other contiguous communities not within the federally designated MBHSR area (such as Dedham, Newton and Milton), and several private ambulance services normally operating in and around the City of Boston EMS Service Zone. These agreements are in accordance with 105 CMR 170.385(A)(3)(a) and (b) to provide, through mutual cooperation, a pre-determined plan by which each might render aid to the other in case of an emergency which demands emergency ambulance services to a degree beyond the existing capability of the requesting party. (A complete list of agencies with which Boston EMS maintains Back-up / Service Zone agreements is maintained in the Boston EMS Service Zone Plan.)

COMMUNICATIONS
The Boston EMS Ambulance mutual aid (BAMA) channel is engineered to afford inter-dispatch center communication between Boston Emergency Medical Services and its backup providers. A UHF multi-site conventional network operating narrow band with analog and encrypted digital communication, it is currently comprised of one UHF radio channel designed for portable in-street coverage within the City of Boston. The BAMA network will be used to request mutual aid assistance and coordinate the response of additional medical resources. Pending future funding, coverage will be extended to the

other eight cities and towns within the Metro-Boston Homeland Security Region (MBHSR). The expanded system would adhere to a design strategy that will afford compatibility across other boundaries and future interoperability with State and Federal systems.

REQUESTING MUTUAL AID: BLS

1. Private ambulance services with a valid mutual aid agreement in place may be requested to respond to a pending incident whenever an appropriate BEMS unit is unavailable, or in the case of an incident in which the patient is requesting transport for a non-emergency situation (clinic appointment or direct admission), or transportation to a hospital other than the closest appropriate facility.
2. When a private ambulance is contacted and has a BLS ambulance available, an ETA for their response should be obtained and supplemented into the CAD incident text. The dispatcher will announce on TAC-1 the name of the ambulance service, the incident address, and TYPE Code of the incident. The unit will be logged on in CAD and all status changes (dispatch, on scene, en route hospital, etc) shall be noted.

REQUESTING MUTUAL AID: ALS

1. Massachusetts OEMS regulations (105 CMR 170.305) require that an ambulance transporting a patient at the Paramedic level of ALS be staffed with a minimum of two EMTs, both of whom are certified as the EMT-Paramedic level unless certain requirements are met. The medical director of Boston EMS has determined that two paramedics are required to provide appropriate assessment and treatment of patients requiring prehospital advanced life support, therefore Boston EMS calls determined to require an ALS response will only be referred to private ambulance services with valid mutual aid agreements meeting the dual paramedic staffing configuration.
2. Private ALS (dual paramedic) response should be initiated when a Boston EMS Paramedic unit is not available, and:
   - report of a cardiac arrest (CARST) or entrapped patient (TRAUMA), or
   - upon request for ALS from an on scene Boston EMS unit, or
   - ALS TYPE Code incident at a health center or clinic where the patient is already being treated by medical personnel, or
   - at the discretion of a supervisor or command staff member.
3. When a private ambulance service having a valid mutual aid agreement is contacted and has an ALS unit with dual paramedic staffing configuration available, an ETA for their response should be obtained and supplemented into the CAD incident text. The dispatcher will announce on TAC-1 the name of the ambulance service, the incident address, and TYPE Code of the incident. The unit will be logged on in CAD and all status changes (dispatch, on scene, en route hospital, etc) shall be noted.
4. Patient Transport:

If the responding private ALS unit is a non-transporting unit, the patient will be transported in the Boston EMS ambulance driven by Boston EMS personnel.

If the responding private ALS unit is a patient transport vehicle, the patient will be transported in the private ambulance whenever possible.

BEMS REQUESTED OUTSIDE OF CITY

1. The Dispatch Operations Supervisor shall be immediately notified whenever Boston EMS is contacted by another agency requesting a mutual aid response outside of the City of Boston. The Supervisor shall quickly review the request and make a determination as to the location, nature of the incident (ALS vs. BLS), BEMS system call load, and availability of appropriate Boston EMS units.

   1.1. If an appropriate BEMS unit is not available to respond, the agency requesting back-up shall be so advised.

   1.2. If appropriate BEMS resources are available, the Dispatch Operations Supervisor may authorize the initial dispatch of a BEMS ALS and / or a BLS unit to a community within the Metro-Boston Urban Security Region (Brookline, Cambridge, Chelsea, Everett, Quincy, Revere, Somerville, or Winthrop), or to the neighboring towns of Dedham, Milton or Newton.

   1.3. If available, a BEMS Field Supervisor should also respond whenever a BEMS unit is dispatched out of the City pursuant to a mutual aid request.

2. The Shift Commander shall be promptly notified of all requests for mutual aid outside of the City. A notification shall also be made via the Department's paging system to the <C1-C5> group page.

3. A Shift Commander (or above) must authorize the initial dispatch of any BEMS resources to a non-contiguous / non- MBHSR community, or the dispatch of any BEMS resources (including personnel, vehicles, Special Operations assets, or other specialized equipment) in addition to those previously authorized in section 1.2.

4. BEMS Personnel operating in another community as part of a mutual aid request shall follow all applicable treatment protocols and procedures. All patient care activities shall be documented appropriately, and arrangements will be made to deliver a copy of the PCR to facilities not equipped to accept BEMS electronic patient care reports.

United States Coast Guard

Supersedes:
Effective: 02-01-00

During the past several years, the facilities of the 1st District of the United States Coast Guard have upgraded their communications capabilities to include the insertion of the VHF frequency 155.280 MHz into the radios of most of their fleet of rescue boats, cutters and aircraft. With this frequency, the USCG is better able to handle medical emergencies that occur at sea by allowing them to contact area hospitals through Boston CMED.

During a natural or man-made disaster, Boston CMED may well be the only link between civilian rescuers and USCG units involved in disaster management. The USCG Air Station at Otis Air Force Base in Falmouth is now in the process of upgrading their airborne radio equipment to allow them to contact Boston CMED for ALS medical direction on the UHF frequencies. This will be accomplished by the use of low-power portable radios connected to external antennae on the aircraft.

1. Through an agreement between the USCG and the New England Medical Service Council, all CMEDs should be capable of assisting the Coast Guard during offshore search and rescue (SAR) missions. Boston CMED operators should be ready to give advice as to what types of medical facilities are best suited to certain types of injuries, but the final decision as to the immediate course of treatment and ultimate destination of the patient should be made by the physician on duty at the medical control facility nearest the Coast Guard unit.
2. Boston CMED operators should be aware of possible aircraft landing sites in the area, and be ready to alert local EMS agencies and/or fire departments to provide fire/crash/rescue support and ground transportation when needed.
3. When Boston CMED is contacted by a USCG unit, the radio traffic should be handled in a manner similar to that of other field providers.
4. A list of USCG facilities and telephone numbers will be maintained at both the Dispatch Operations Supervisor area and CMED consoles for reference as the need arises.

Rescue Coordination Center (RCC) Boston, MA	617-223-3644
Headquarters – Group Boston, MA	617-223-6978
Station Gloucester	978-283-0704
Station Newburyport	978-465-0731
Station Point Allerton (Hull)	781-925-0165

Station Scituate	781-545-3800
Headquarters – Group Woods Hole, MA	508-548-5151
Station Brant Point (Nantucket)	508-228-0388
Station Cape Cod Canal (Sandwich)	508-888-0335
Station Chatham	508-945-0164
Station Menemsha (Martha’s Vineyard)	508-645-2611
Station Provincetown	508-487-0070
Station Block Island, RI	401-466-2411
Station Castle Hill (Newport, RI)	401-846-3675
Station Point Judith (Narragansett, RI)	401-783-3021
Headquarters – Air Station Cape Cod	508-968-5360

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