

**Air Care & Mobile Care Operational Policies**

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	<u>ACMC41</u>
<b>POLICY NAME/#</b>	<u>Post-Accident/Incident Plan</u>
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>
<b>POLICY OWNER</b>	<p>_____ (Date)</p> <p>Matt Gunderman/Director</p> <p>_____ (Date)</p> <p>Dr. William Hinckley/Air Medical Director</p> <p>_____ (Date)</p> <p>Dr. Elizabeth Powell/Ground Medical Director</p>
<b>ADMINISTRATIVE APPROVAL</b>	<p>_____ (Date)</p> <p>Jennifer Jackson/VP CNO</p>
<b>ORIGINATION DATE</b>	<u>11/2005</u>
<b>LAST REVISION/ REVIEW DATE</b>	<p><b>8/2017</b></p>
	<p><b>NEXT REVIEW DATE</b></p> <p><b>8/2018</b></p>

**I. POLICY**

Associates of Air Care and Mobile Care will follow a defined process for timely and appropriate notification of individuals following identification of an actual or perceived emergency involving an Air Care or Mobile Care crew member or transport vehicle.

**II. PURPOSE**

To provide a guideline for use of the PAIP

**III. DEFINITIONS**

PAIP-Post accident/incident plan

#### IV. PROCEDURE

This plan is a formal approach to dealing with any accident or incident that may have an effect on the transport program. It is designed to be a concise, workable guide through any accident or incident involving the air or ground ambulance and personnel.

- A. This plan is a sequenced procedural guide that covers any incident or accident that may occur to an air or ground ambulance. The Post Accident/Incident Plan (PAIP) will address:
  - 1. Unscheduled Landing Protocol (Air): Any unscheduled (precautionary) landing; (e.g. mechanical deficiency, inclement weather or medical emergency).
  - 2. Missing/Overdue Transport Vehicle Protocol (Air & Mobile):
    - a) The aircraft is overdue fifteen (15) minutes after its estimated time of arrival (ETA), or has been on the ground for more than forty-five (45) minutes without an update.
    - b) An ambulance is overdue twenty (20) minutes after it's ETA, or has been on the ground/at a destination for more than forty- five (45) minutes without an update.
  - 3. Emergency Protocol (Air & Mobile): A serious emergency or accident in which the crew is in jeopardy and needs immediate help.
  - 4. Post- Accident Protocol:
    - a) Aircraft-notification that an aircraft incident or crash has occurred.
    - b) Ambulance-notification that an ambulance incident or crash has occurred.
  
- B. In the event of an air or ground ambulance incident or crash, never transmit the names of suspected injured or deceased persons over the radio.
  
- C. Only the program director or their representative of Air Care or Mobile Care Public Relations Department will release information to the media. UNDER NO CIRCUMSTANCES will any information be released to any member of the news media, Federal Aviation Administration (FAA) or any other persons unless the information is released by the above stated individuals or otherwise required by law.
  
- D. PAIP Drills
  - 1. The manager or supervisor, in collaboration with the safety committee chair (or their designee) is responsible for ensuring the PAIP plans (air and ground) are completed annually, at a minimum.

2. The PAIP drill records and follow-up recommendations are to be presented to the leadership team in a timely manner by the operations supervisor.

E. Duties & Responsibilities: The PAIP is an interdisciplinary process. The PAIP program will outline the responsibilities for both the aircraft and the ambulance personnel, to include but not limited to:

1. Aircraft: program director, medical director, clinical manager, area site manager, lead pilot, lead mechanic.
2. Ambulance: program director, medical director, clinical manager, base operations supervisor(s).

**V. RESPONSIBILITY**

**All Transport Associates**

**VI. KEY WORDS**

**None**

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS None**

	<u>ACMC01</u>
POLICY NAME/#	<u>Accident - Staff Intervention at a Public Accident</u>
POLICY TITLE	<u>Air Care and Mobile Care</u>
POLICY OWNER	 _____ (Date)  _____ (Date)  _____ (Date)  _____ (Date)
ADMINISTRATIVE APPROVAL	<u>Jennifer Jackson</u> /VP CNO (Date)
ORIGINATION DATE	<u>11/2001</u>
<b>LAST REVISION/ REVIEW DATE 12/2017</b>	<b>NEXT REVIEW DATE 12/2018</b>

**I. POLICY**

In the event that an Air Care & Mobile Care (ACMC) team comes upon a public accident with injuries at a time when there is no local EMS unit on the scene, staff will stop to assess victim condition and provide treatment using ACMC Department Policy and Procedure and The Academy of Medicine, Cincinnati Protocols and Standing Orders for Southwest Ohio.

**II. PURPOSE**

**THE PURPOSE OF THIS POLICY IS TO PROVIDE GUIDELINES FOR PERSONNEL**

**WHEN THEY ARE WITNESS TO AN ACCIDENT IN WHICH THEY ARE NOT INVOLVED. THIS POLICY ALSO ADDRESSES THE ACTIONS THAT SHOULD BE TAKEN BY PERSONNEL WITH AND WITHOUT A PATIENT ONBOARD.**

**III. DEFINITIONS**

**None**

**IV. PROCEDURE**

- A. Upon observation of a medically unassisted accident, the team will stop to assess victim's condition and contact the communication center to contact the local EMS. APMC will do so if the scene is safe and there is no perceived threat of harm to the APMC crew or vehicle. APMC Staff should take standard precautions (use of reflective vests, flares, lights, defensive vehicle positioning etc) when at the scene of any motor vehicle accident.
- B. If the Air Care & Mobile Care vehicle does not have a patient on board and the local EMS unit does not respond in adequate time to meet the accident victim's needs or cannot maintain the advanced level of care initiated, the Air Care & Mobile Care team can transport the accident victim to the nearest appropriate hospital.
- C. If the Air Care and Mobile Care vehicle does have a patient on board during these circumstances and patient condition warrants it, the paramedic can break away from the team and accompany the local EMS unit for patient transport. The APMC patient's level of care must not be downgraded.
- D. Accident victims should be assessed for injuries:
  - 1. Minor injuries: offer comfort measures.
  - 2. Major injuries: provide immediate intervention in accordance with Air Care and Mobile Care department policies or the Southwest Ohio Paramedic Protocols.
- E. Upon arrival of the local EMS unit, Air Care & Mobile Care personnel will hand off care to the appropriate medical personnel and document name and credentials on the transport record. Once report is given, Air Care & Mobile Care personnel can resume assigned duties.
- F. If the Air Care & Mobile Care vehicle has a patient on board, at least one team member must remain on board with the patient at all times.

- G. If the patient being transported by Air Care & Mobile Care is unstable, the driver should stop, inform bystanders of such, and offer to call for help while continuing on with patient transport.
- H. The communication specialist is to be contacted to update ETA as soon as possible.
- I. A written report documenting the incident must be completed on the department's transport record and n to the clinical manager who will forward a copy to the corporate director.

**V. RESPONSIBILITY**  
All Team Members

**VI. KEY WORDS**  
None

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS** None

	ACMC11	
POLICY NAME/#	Disaster Response and Assistance	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Dr. Liz Powell/Ground Medical Director (Date)	
ADMINISTRATIVE APPROVAL	_____ Jennifer Jackson /VP CNO (Date)	
ORIGINATION DATE	11/2005	
LAST REVISION/ REVIEW DATE	7/2017	NEXT REVIEW DATE
		7/2018

**I. POLICY**

The Air Care & Mobile Care (ACMC) Transport plays several roles in local and regional disasters or mass casualty events. This policy outlines those key services and when such services may be needed.

**II. PURPOSE**

To provide guidelines for the role of ACMC is a local or regional disaster response.

**III. DEFINITIONS**

None

**IV. PROCEDURE**

Response to the Disaster Site:

- A. Air Care serves as a second responder to the local public safety officers at the

- B.** scene of the request. Unless otherwise instructed, the flight team and the Air Care assets are made available to the incident command system (ICS) established on scene, provided they do not jeopardize safety or violate Air Care policies and procedures. In many cases, the focus of the response will be assisting with on-scene medical control, triage and immediate treatment. Patient transport may be a secondary priority or occur once the scene is more stable. Air Care can also be used for aerial assessment of the scene by the local ICS, shuttle additional people and/or supplies and/or provide a search platform.
- C.** Mobile Care may serve as a first responder to the University of Cincinnati campus and, as such, is initially the primary emergency medical service in a mass casualty event on the campus. Initial incident command should be established with the University of Cincinnati Police Department (CPD) and mutual aid from the Cincinnati Fire Department (CFD) should be requested immediately. The first on-scene CFD official will assume ICS and Mobile Care will follow their lead.
- D.** Mobile Care is also authorized to respond to local or regional mass casualty events at the request of the local ICS. "Freelance response" by Air Care and Mobile Care to disaster sites is prohibited, except as outlined in this policy.

#### Disaster Hospital Radio Net

- A.** The Hamilton County Disaster Council maintains a hospital disaster radio system that allows all area hospitals, several county communication centers, the American Red Cross and others to talk together during a disaster. This system has proven to be a very effective way to help distribute injured disaster victims as well as to quickly share key disaster information, such as hazardous material, number of victims, overload/at capacity hospitals, etc.
- B.** The Air Care and Mobile Care Service staff acts as the primary coordinators for the distribution of disaster or mass casualty victims with an emphasis on getting the patient to the most appropriate hospital and avoiding overload at hospital emergency departments closest to the scene. A complete review of the radio system and the role of the members of the communication center can be found in the Hamilton County, Ohio, Disaster Radio Net Operating Guide located in the communication center.

## CHEMPAK Response

- A.** The greater Cincinnati area has been selected by the federal government to receive pre-positioned medication antidote kits for use during a chemical terrorism attack. The locations of the CHEMPAKs are well secured, climate controlled and confidential. In the event of a regional attack, Mobile Care ambulances will be dispatched to one of these secret locations to pick up the CHEMPAK and to then respond to the disaster site.
  
- B.** Greater Cincinnati/Northern Kentucky International Airport (CVG) Signal 500
  - 1. In the event of an airline crash or potential airline crash (also known as a Signal 500) the Air Care helicopter(s) are immediately dispatched to CVG to assist the airport fire department with medical control, triage, treatment and transport. For an actual crash, the hospital disaster radio is also opened and manned by the Air Care and Mobile Care transport communication staff. (See the airport response policy for additional information.)

- V.** RESPONSIBILITY  
All Medical Transport Associates
  
- VI.** KEY WORDS  
None
  
- VII.** APPENDIX None
  
- VIII.** REFERENCES / CITATIONS None

	<u>ACMC30</u>
<b>POLICY NAME/#</b>	<u>Incident Report - Management of an Adverse Medical Event</u>
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>
<b>POLICY OWNER</b>	<p>_____  Matt Gunderman/Director (Date) _____</p> <p>_____  Dr. William Hinckley/Air Medical Director (Date) _____</p> <p>_____  Dr. Liz Powell Ground Medical Director (Date) _____</p>
<b>ADMINISTRATIVE APPROVAL</b>	_____ <u>Jennifer Jackson/VP CNO</u> (Date) _____
<b>ORIGINATION DATE</b>	<u>4/2003</u>
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>
	<b>NEXT REVIEW DATE</b>
	<b>7/2018</b>

**I. POLICY**

Air Care and Mobile Care strive to provide the safest patient care possible. In an effort to ensure patient safety, reporting for incidents both clinical and operationally is paramount. This will allow for proper investigation and root cause analysis. This in turn will contribute to the development of educational processes to ensure mistakes are mitigated. This policy will ensure that the proper process is conducted in the event that an adverse medical event occurs.

**II. PURPOSE**

**III. DEFINITIONS**

None

#### **IV. PROCEDURE**

- A. When a transport team member identifies an adverse medical event, the clinical director, clinical manager and the appropriate medical director will be immediately notified.
- B. An Incident Report should be completed. All reports should be complete on the UC Health intranet under MIDAS.
- C. In collaboration with the clinical director and clinical manager, the medical director will then initiate an investigation involving all the transport team members.
- D. Depending on the nature of the event, other members of University of Cincinnati Medical Center such as Risk Management/Legal Services and/or Quality Management may need to be notified so the event can be evaluated according to their policies and procedures.

#### **V. RESPONSIBILITY All Team Members**

#### **VI. KEY WORDS None**

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS Refer to UC Health Incident Report Policy**



2. Use of Seat Belts and Shoulder Harnesses
  3. Doors and Emergency Exits
  4. Survival Equipment
  5. Location and Use of the Fire Extinguishers
  6. Helipad Ground Operations
  7. Entering and Departing the Aircraft
  8. Emergency Evacuation
- D. The oral briefing is supplemented by printed passenger briefing cards for the use of each passenger. These cards contain a diagram and method of operating the emergency exits and instructions necessary for the use of emergency equipment on board the aircraft.
- E. Passengers that may accompany crew members include but are not limited to:
1. Parent or Guardian to accompany a critically ill or injured child
  2. Family member of patients transported over great distances
  3. Other medical personnel who are required to care for a patient
  4. Ride along Emergency Medicine resident (R1)
  5. Students as part of an approved program (paramedic, nursing)
  6. Public Relations personnel
  7. C-STARS personnel
  8. News media as approved by Public Relations Department
- F. Any time a passenger is taken in the patient cabin of an aircraft, a member of the Air Care transport team must accompany the passenger in the back. If patient care is given, the staff member must be a flight nurse.
- G. When the temperature is 90 degrees or above, due to high-density altitude conditions, the maximum weight of each passenger should not exceed 200 pounds. During this period, if other aviation conditions exist, (i.e. weather, aircraft weight, crew weight) then a passenger greater than 200 pounds may be considered.

**IV. RESPONSIBILITY**  
**Pilot-in-Command, All Air Medical Crew Members**

**V. KEY WORDS**  
**None**

**VI. APPENDIX** **None**

**VII. REFERENCES / CITATIONS** **None**

	<u>AC03</u>
<b>POLICY NAME/#</b>	<u>Aircraft - Additional Equipment</u>
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>
<b>POLICY OWNER</b>	_____ (Date)
	<u>Matt Gunderman/Director</u>
	_____ (Date)
	<u>Dr. William Hinckley/Air Medical Director</u>
	_____ (Date)
	<u>Bob Francis, Manager Metro Aviation</u>
	_____ (Date)
<b>ADMINISTRATIVE APPROVAL</b>	<u>Jennifer Jackson/VP CNO</u> (Date)
<b>ORIGINATION DATE</b>	<u>7/1999</u>
<b>LAST REVISION REVIEW DATE</b>	<b>8/2017</b>
<b>NEXT REVIEW DATE</b>	<b>8/2018</b>

**I. POLICY**

Any additional equipment brought on board the aircraft must be reported to the pilot in command so he/she will be informed of weight changes and ensure proper aircraft performance.

**II. DEFINITIONS**

None

**III. PROCEDURE**

- A. If an air medical team member determines additional equipment is necessary for patient care, the pilot in command will be notified of the following

**B. information prior to the flight:**

1. amount of additional weight
2. proposed placement of additional weight
3. proposed method of securing the additional weight

C. The pilot in command has final authority over all matters concerning additional weight. If the additional equipment is not suitable for flight but necessary for patient care, the medical team can coordinate, with the pilot-in-command, in prioritizing equipment to be flown or arrange for alternate transportation.

**IV. RESPONSIBILITY**

All air medical flight team members

**V. KEY WORDS**

None

**VI. APPENDIX** None

**VII. REFERENCES / CITATIONS**

None

<b>POLICY NAME/#</b>	AC01	
<b>POLICY TITLE</b>	Procedure for Preparing a Back-up Aircraft for Service	
<b>POLICY OWNER</b>	Air Care and Mobile Care	
	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
	Dr. William Hinckley/Air Medical Director	(Date)
	_____	_____
<b>ADMINISTRATIVE APPROVAL</b>	Bob Francis, Manager Metro Aviation	(Date)
	_____	_____
	Jennifer Jackson /VP CNO	(Date)
<b>ORIGINATION DATE</b>	11/2008	
<b>LAST REVISION/REVIEW DATE</b>	8/2017	<b>NEXT REVIEW DATE</b> 8/2018

**I. POLICY**

In the event that the Air Care and Mobile Care (ACMC) primary aircraft are out of service for maintenance and a back-up aircraft is used for the transport of patients and medical crew, all personnel must ensure that the back-up aircraft is prepared for normal operations.

**II. PURPOSE  
PROVIDE GUIDELINES FOR THE PROCESS TO PLACE A BACK UP AIRCRAFT  
IN SERVICE AND ASSURE PATIENT AND CREW SAFETY.**

**III. DEFINITIONS  
None**

**IV. PROCEDURE**

Completion of the below duties should be attempted before each team member's first flight in the back-up aircraft. All personnel should ensure their comfort with the back-up aircraft in a timely manner.

**A. Pilot/Mechanic**

1. Once the lead pilot or lead mechanic becomes aware that Air Care will be using a back-up aircraft at one of the bases, he will notify the pilots and mechanics, as well as the clinical manager and medical director such that appropriate notification can be given to the medical crew and communication center.
2. Pilot on duty will perform a pre-flight inspection of the aircraft before flying. If a mechanic is on-site, an initial inspection will be conducted.
3. Pilot will review all radios in the aircraft. If needed, the pilot will program radios with frequencies used in Air Care and Mobile Care daily operations. If pilot is unable to operate radios, the lead pilot must be contacted.
4. Pilot-in-command will ensure that all team members are oriented to the new radios and if required to operate radios, are able to perform required duties.
5. Pilot and/or mechanic will review and orient all team members to the stretcher/cot system.
6. At the discretion of the pilot on duty, it is strongly encouraged that the pilot takes the aircraft for a "familiarization flight" to ensure that pilot is comfort with operating the back -up aircraft. It is the responsibility of the pilot to contact the communication center and lead pilot if this is necessary.

7. If the back -up aircraft has not been licensed by the state of Ohio, the pilot will be required to fill out the “Temporary License for the State of Ohio” form located in the pilot’s office. All dates must be logged when the back-up aircraft is primary. If a crew is using an Ohio licensed aircraft, the form does not need to be filled out.

**B. Advanced Practice Nurses and Flight Nurses**

1. Nurse will review radio and stretcher operations with the pilot-on-duty.
2. Nurse will ensure that all medical equipment and supplies are secured appropriately in the aircraft.
3. If issues arise that interfere with the delivery of safe patient care, the nurse must inform the clinical manager.
4. Location of equipment and supplies must be communicated to the entire staff.
5. Proper communication must include but are not limited to e-mail, notation on the communication board and verbal communication at shift change.

**C. Flight Physician**

1. Once informed of back up aircraft, the physician will review radio and stretcher operations.
2. Physician must review location of equipment and supplies.

**V. RESPONSIBILITY**

**Pilot, Advanced Practice Nurse, Flight Nurse, Mechanic, Flight Physician**

**VI. KEY WORDS**

**None**

**VII. APPENDIX**

**None**

**VIII. REFERENCES / CITATIONS**

**None**

	AC18	
POLICY NAME/#	Aircraft - Downtime	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER		
	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
	Dr. William Hinckley/Air Medical Director	(Date)
	_____	_____
	Bob Francis, Manager Metro Aviation	(Date)
ADMINISTRATIVE APPROVAL	_____	_____
	Jennifer Jackson/VP CNO	(Date)
ORIGINATION DATE	_____	
<b>LAST</b>		
<b>REVISION/ REVIEW</b>		<b>NEXT REVIEW DATE</b>
<b>DATE 8/2017</b>		<b>8/2018</b>

**I. POLICY**

The event that the ACMC aircraft is out of service, aircraft status/availability shall be known at all times.

**II. PURPOSE**

To provide guidelines for the pilot and communication center how to communicate when an aircraft is out of service and unavailable for patient transport.

**III. DEFINITIONS**

1. Green - The aircraft and pilot are ready to respond to a request and the weather is within approved guidelines.
2. Yellow - There is a delay in response while weather conditions are

**checked or routine maintenance checks are completed. Rarely should the circumstances be surrounding a yellow status result in a delay of more than 5-10 minutes.**

3. **Red – The aircraft is out of service in excess of 60 minutes due to maintenance/other reasons.**

#### **IV. PROCEDURE**

##### Notification Process

- A. The on-duty pilot will provide a current status to the communication specialist at the beginning of each shift and as aircraft status or weather changes. If the status is yellow, the reason for the yellow status (maintenance, weather, other) and an estimate of the delay time will be given.

If the status is red, the pilot should give the reason for the red status (maintenance, weather, staffing) and, if known, an estimated time for status change.

- B. The on-duty pilot will notify the lead pilot and the Area Site Manager whenever an aircraft is grounded due to unscheduled events keeping in mind crew rest criteria.
- C. The Lead Mechanic or Area Sight Manager will notify the Program Director or their designee anytime an aircraft is grounded or returns to service due to unscheduled events.
- D. If the situation has the potential to affect staffing schedules, the Clinical Manager or their designee will be notified to coordinate appropriate staffing pattern changes.
- E. The lead pilot or on-duty pilot, in consultation with the Program Director or their designee will provide an explanation of the work being performed to the communication specialist as updates or changes warrant. They will also provide the communication specialist with notice that the aircraft is available for test flight.
- F. The communication specialist will notify the faculty physician of any unavailable aircraft and status changes.

- G. All requests for information regarding aircraft status should be directed to the communication specialist. Communication specialists will then provide the most recent information available. If additional information is needed, the communication specialist will contact the on duty pilot for an update.

**V. RESPONSIBILITY**  
**Pilot and Communications Specialists**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS**  
**None**

	<u>AC04</u>	
<b>POLICY NAME/#</b>	<u>Aircraft - Inoperative Searchlight</u>	
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>	
<b>POLICY OWNER</b>	_____	
	<u>Matt Gunderman/Director</u>	<u>(Date)</u>
	_____	
	<u>Dr. William Hinckley/Air Medical Director</u>	<u>(Date)</u>
	_____	
	<u>Bob Francis, Manager Metro Aviation</u>	<u>(Date)</u>
	_____	
<b>ADMINISTRATIVE APPROVAL</b>	<u>Jennifer Jackson/VP CNO</u>	<u>(Date)</u>
<b>ORIGINATION DATE</b>	<u>7/1999</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<u>8/2017</u>	<b>NEXT REVIEW DATE</b>
		<u>8/2018</u>

**I. POLICY**

**In order to facilitate a safe landing, the pilot-in-command will determine if a medical mission can be completed due to an inoperative searchlight.**

**II. PURPOSE**

**III. DEFINITIONS**

None

**IV. PROCEDURE**

- A.** Continued flight will be conducted in accordance with the aircraft -minimum equipment list and the helicopter vendor's operations specifications and operations manual.
- B.** The takeoff/landing site must be clearly illuminated by a lighting source that provides adequate lighting of the site and of any obstructions, which may create a potential hazard during approach, hovering, taxiing, and/or departure operations

**V. RESPONSIBILITY**  
**Pilot-in command**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**



- A. The Aviation Site Manager or their designee will ensure that daily, weekly and monthly checks are performed on storage tanks and fuel trucks at designate fuel locations.
- B. Records of the quality checks will be kept on file for 12 months in the pilots' office.
- C. The pilot-in-command will be required to obtain a fuel sample at the beginning of each shift and perform a visual inspection of the fuel.
- D. The pilot-in-command will ensure that the correct amount and fuel type is placed in the aircraft during the fueling process.
- E. All Fuel quality procedures for Air Care fueling stations will be in compliance with the air operator's Operations Manual.

**V. RESPONSIBILITY**

**Aviation Site Manager, Lead Pilot, Pilot-on-Duty**

**VI. KEY WORDS**

None

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS**

None



#### **IV. PROCEDURE**

- A. The altitude to be flown during patient transports will be determined by the pilot-in-command, consistent with safe flight operations and existing noise-abatement policies.
- B. For certain patient diagnoses, the medical team will inform the pilot about the need to observe an altitude limit. Conditions where altitude limits during transport should be considered include but are not necessarily limited to:
  - 1. Decompression sickness (dysbarism)
  - 2. Gas embolism
  - 3. Severe chronic obstructive pulmonary disease
  - 4. Persistent hypoxia despite high-flow oxygen and assisted ventilation
  - 5. Hydrocephalus with or without a VP shunt
- C. When indicated secondary to these clinical conditions, the pilot should consider flying at an altitude of 4000 feet MSL (Mean Sea Level) or less if permitted by terrain, weather, flight traffic and other aviation regulations.

#### **V. RESPONSIBILITY**

**Flight Physician, Flight Advanced Practice Nurse, Flight Nurse, Pilot**

#### **VI. KEY WORDS**

**None**

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS**

**None**

	<u>AC07</u>
POLICY NAME/#	<u>Sterile Cockpit and Cockpit Split</u>
POLICY TITLE	<u>Air Care and Mobile Care</u>
POLICY OWNER	_____ Matt Gunderman/Director (Date)  _____ Dr. William Hinckley/Air Medical Director (Date)  _____ Bob Francis, Manager Metro Aviation (Date)
ADMINISTRATIVE APPROVAL	_____ Jennifer Jackson/VP CNO (Date)
ORIGINATION DATE	<u>11/2005</u>
<b>LAST REVISION/ REVIEW DATE</b>	<b>8/2017</b>
<b>NEXT REVIEW DATE</b>	<b>8/2018</b>

- I. **POLICY**  
 To help ensure safe flight operations and enable pilot and crew to fully focus on aviation and safety, sterile cockpit procedures will be instituted and enforced. This policy does not suppress any requirements set forth by the aviation vendor/Part 135 certificate holder or the FAA.
  
- II. **DEFINITIONS**  
**Sterile Cockpit:** The automatic or ordered focus for all crew members and communications specialists of eyes up and out, ears open, and non-aviation essential communication silence. Any activity during a critical phase of flight which could distract any flight crew member from performance of his or her duties or which could interfere in any way with the proper conduct of those duties. (FAR 121.542/FAR 135.100) Activities could include: non-essential conversation and non-essential communications, texting, e-mailing, reading non-aviation essential material not related to the proper conduct of the flight, drowsiness/sleeping.
  
- Split:** A break in communication, controlled by the pilot that isolates the intercom in the patient compartment from the intercom in the pilot compartment. The pilot will not hear the medical crew on intercom and the crew will not hear the pilot on intercom.

### III. PROCEDURE

- A. A sterile cockpit will be initiated during these and all critical phases of flight:
  - 1. During pre-flight checklist
  - 2. Lifting off to cruising altitude
  - 3. From descent of the aircraft until safe landing on helipad/landing zone
  - 4. High density traffic areas
  - 5. Marginal or transitional weather
  - 6. During all aircraft emergencies
  - 7. Any time the pilot or a crew member requests a sterile cockpit
  - 8. Upon any crew member announcing an "abort"
- B. Sterile cockpit will be maintained until the aircraft is back into safe and normal flight conditions; marginal or transitional weather is safely behind aircraft and flight path, high density traffic is safely behind the aircraft and flight path, and crew agrees to end sterile cockpit.
- C. If during safe and normal flight conditions, the medical crew needs a high level of focus for performance of patient care and patient safety, they or the pilot can request that the patient compartment be "split" from the cockpit. The pilot will then split communication so the pilot is not distracted by the medical crew discussions. "Split" will not occur during the critical phases of lift-off, landing, aircraft emergencies or at request not to split. Split may occur at other critical phases, temporarily with agreement of all crew and only if the pilot and crew are confident that the split will not jeopardize safe operations of the aircraft. If "split", normal communications will be returned by the pilot upon entering any critical phase of flight as defined above or at the request of the medical crew via buzzer or the pilot.
- D. The radio control head in the patient compartment will always be set to receive aviation traffic reports from ATC with the pin switches in the on/up position and the audible volume of aviation traffic/ATC will remain at an audible level by the medical crew, even when split.

### IV. RESPONSIBILITY

All flight Crew Members

### V. KEY WORDS

None

### VI. APPENDIX None

### VII. REFERENCES / CITATIONS None

	MC01
POLICY NAME/#	Ambulance Involved In An Accident
POLICY TITLE	Air Care & Mobile Care
POLICY OWNER	
	_____ Matt Gunderman, Director (Date)
	_____ Dr. Elizabeth Powell/Ground Medical Director (Date)
ADMINISTRATIVE APPROVAL	
	_____ Jennifer Jackson /VP CNO (Date)
ORIGINATION DATE	11/2001
LAST REVISION/ REVIEW DATE	12/2017
	NEXT REVIEW DATE 12/2018

**I. POLICY**

To help assure the safety of all people involved in an accident, a systematic process outlined in the policy will be followed any time an Air Care & Mobile Care vehicle is involved in an accident.

**II. PURPOSE**

TO OUTLINE A PROCEDURE TO FOLLOW WHEN THE GROUND AMBULANCE IS INVOLVED IN AN ACCIDENT WITH DAMAGE AND/OR INJURIES.

**IV. DEFINITIONS**

#### IV. PROCEDURE

##### Transport Personnel and Communication Specialist:

- A. After the safety of all people involved in the accident is assured, the most appropriate transport team member will notify the communications center of the occurrence as well as activate the 911 system if indicated. At that time, the communication specialist will determine whether or not the Post Accident/Incident Plan (PAIP) needs to be activated (refer to the PAIP policy if activated).
- B. When an Air Care & Mobile Care vehicle is involved in an accident, the vehicle and all team members will remain at the accident scene until the police arrive, unless a patient's condition warrants otherwise.
- C. In the event a person in another vehicle is injured, a team member will remain with the patient on board (if applicable) and another team member will evaluate the injured person and render treatment.
- D. If a critically unstable patient is being transported in the ambulance and there are no other life threatening emergencies at the scene, and the vehicle is determined safe and roadworthy by all crewmembers, the team will continue to their destination after notifying the communication specialist of the location, time and details of the accident.
  - 1. Air Care & Mobile Care communication specialist will notify the appropriate police department of the circumstances of the accident and the reason why the team left the accident scene.
  - 2. The communication specialist, at the direction of the local police, will notify the driver of the vehicle involved if they need to return to the accident scene upon completion of the transport.
- E. If the Air Care & Mobile Care vehicle is not road worthy, another vehicle will be sent by the communication specialist to the accident scene or the local EMS unit will be summoned to assist with patient transport.

##### Additional Responsibilities:

###### A. Driver:

- 1. Completes the Automobile Claim Service Guide (located in the accident packet).
- 2. If the patient or a passenger riding in an Air Care & Mobile Care vehicle is injured, assures an Incident Report is completed.
- 3. Turns in the completed Accident Packet/paperwork to their supervisor as soon as possible, but no later than the end of their shift.

##### Injured UC Health Associate:

- A. Any employee injured as a result of the accident must:
  - 1. Complete an Associate Accident Report before the end of their shift and leave a copy of the report for the clinical manager.

2. Contact Employee Health for evaluation. During after-hours please contact Employee Health at 585-8000.

**B. Supervisor:**

1. In any work related incident refer to the UC Health Drug Free Workplace Policy for guidance for drug testing.
2. Reviews accident packet for completeness and makes any contacts that are indicated (i.e. Risk Management).
3. Logs the occurrence on the department accident log. Report on the incident through the department's Quality Management and Safety Program for further review.
4. The program director will report the accident to the CONCERN Network on the Air & Surface Transport Nurses Association (ASTNA) website when appropriate to do so.
5. If activated, assures the PAIP is completed and paperwork copied for review

**V. RESPONSIBILITY**  
All Mobile Care Team Members

**VI. KEY WORDS**

**VII. APPENDIX**

**VIII. REFERENCES / CITATIONS**

POLICY NAME/#	MCO2	
POLICY TITLE	Ambulance Malfunction With or Without A Patient On-Board	
POLICY OWNER	Air Care and Mobile Care	
	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
	Dr. Elizabeth Powell/Ground Medical Director	(Date)
ADMINISTRATIVE APPROVAL	_____	_____
	Jennifer Jackson/VP CNO	(Date)
ORIGINATION DATE	11/2002	
<b>LAST REVISION/ REVIEW DATE</b>	<b>12/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>12/2018</b>

**I. POLICY**

Air Care & Mobile Care maintains a regular vehicle maintenance program; however, from time to time, a mechanical failure may occur. To ensure optimal patient care and vehicle integrity, the following guidelines will be followed in the event of a vehicle breakdown.

**II. PURPOSE**

Outline the procedure to follow when the ambulance stops functioning correctly.

**III. DEFINITIONS**

None

#### **IV. PROCEDURE**

##### **A. If a transport vehicle breaks down with a patient on-board:**

1. Always assure that the vehicle is placed in as safe a location as possible, preferably off the road in a parking lot or other suitable location.
2. Telephone or radio the communication specialist for assistance.
3. The communication specialist will arrange for a backup unit and/or towing service.
4. Patient observation/assessment and treatment will continue as ordered. If patient condition requires immediate transport, the communication specialist will contact local EMS for assistance. Electrical equipment will be powered by the on-board generator if available.
5. The team will be notified by phone or radio as to the length of time involved in receiving assistance.
6. The delay is documented on the patient electronic medical record under the event log.
7. A MIDAS incident report should be filled out by the driver explaining only what is known about the vehicle break-down.

##### **B. If a transport vehicle breaks down without a patient on-board:**

1. If the malfunction is minor and does not affect the safety or function of the vehicle notify the communication specialist who will arrange for service if needed.
2. If the malfunction is major and affects the safety and function of the vehicle, it must be taken out of service and the communication specialist will be notified and will arrange for service if needed.
3. The communication specialist will note all vehicles out of service in the designated area.
4. The communication specialist will contact the base operations supervisor and/or the on call supervisor who will arrange for repair through the appropriate vendor.

#### **V. RESPONSIBILITY**

**Communication Specialist and Team Members**

#### **VI. KEY WORDS**

None

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS**

None

	<u>MC06</u>	
<b>POLICY NAME/#</b>	<u>Fire in Ambulance With &amp; Without a Patient</u>	
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>	
<b>POLICY OWNER</b>	_____	
	<u>Matt Gunderman/Director</u>	<u>(Date)</u>
	_____	
	<u>Dr. Liz Powell/Ground Medical Director</u>	<u>(Date)</u>
<b>ADMINISTRATIVE APPROVAL</b>	_____	
	<u>Jennifer Jackson/VP CNO</u>	<u>(Date)</u>
<b>ORIGINATION DATE</b>	<u>11/2001</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<u>7/2017</u>	<b>NEXT REVIEW DATE</b>
		<u>7/2018</u>

**I. POLICY**

In the event of a fire on-board delete the ambulance, it is the responsibility of the transport team to try to safely exit the ambulance and to ensure the safety of all occupants.

**II. PURPOSE**

To provide guide lines for the removal of personnel from an ambulance on fire.

**III. DEFINITIONS**

None

**IV. PROCEDURE**

- A. Assess for fire. Associate and patient safety takes precedence above preservation of property.
- B. If fire is detected:

1. Locate a safe location to stop the ambulance which is free from other hazards so that all occupants can evacuate the vehicle.
  2. If a patient is on-board, the crew shall unload the patient on the stretcher or by any other method available, to a safe area preferably in front of the ambulance – far away and bring necessary equipment to continue care for the patient.
  3. If it is possible, safe and practical in case of fire, associates should close the valve on the main oxygen tank.
  4. Assess and treat all occupants for injuries as a result of the fire.
- C. Notify communication specialist to send the appropriate emergency unit to the scene and/or notify 911 emergency personnel.
- D. If a patient is on-board, have communication specialist send the closest appropriate ambulance to complete the transport. If possible, the patient’s caregivers should proceed with the patient to provide continuity of care.
- F. The transport associates should fill out all appropriate paperwork, i.e. Incident/Occurrence Report and notify their immediate supervisor, before completion of their shift.

**V. RESPONSIBILITY**  
**All Team Members**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS**

None

	ACMC04
POLICY NAME/#	Transport of Blood and Blood Products
POLICY TITLE	Air Care and Mobile Care
POLICY OWNER	<p>_____ Matt Gunderman/Director (Date)</p> <p>_____ Dr. William Hinckley/Air Medical Director (Date)</p> <p>_____ Dr. Elizabeth Powell Ground Medical Director (Date)</p>
ADMINISTRATIVE APPROVAL	_____ <u>Jennifer Jackson</u> /VP CNO (Date)
ORIGINATION DATE	11/2001
<b>LAST REVISION/ REVIEW DATE</b> 8/2017	<b>NEXT REVIEW DATE</b> 8/2018

**I. POLICY**

Blood and blood components that have been typed and cross matched by a healthcare institution may be administered by the Air Care & Mobile Care registered nurse Enroute following The University of Cincinnati Medical Center policy for administration of blood and blood products.

**II. PURPOSE**

TO PROVIDE OPERATIONAL GUIDELINES WHEN BLOOD OR BLOOD PRODUCTS PREPARED BY ANOTHER FACILITY IS NEEDED FOR PATIENT CARE.

### **III. DEFINITIONS**

None

### **IV. PROCEDURE**

- A. Refer to the University of Cincinnati Medical Center Blood and Blood Products policy for administration protocols.
- B. Blood products will be checked at the patient's bedside by the referring and transport registered nurses before the transport nurse takes the blood and/or blood products for the transport.
- C. Before any blood or blood component is accepted by the Air Care & Mobile Care team, they must assure it is properly labeled. If blood is not administered immediately, it must be packaged in ice for the transport. Only blood products that can be administered during transport should be taken. No extra units should be taken from the referring facility. If available, temperature indicators should be placed on the blood for transport.
- D. Document all appropriate information for a patient receiving blood including blood type of blood product, blood type, quantity, time started and stopped, unit number(s), expiration date, whether or not a reaction occurred, number of units infused prior to arrival and amount remaining on the electronic medical record at the time of transport.
- E. Any blood accepted for use will be administered according to specific physician orders and/or The University of Cincinnati Medical Center policy for administration of blood and blood products.
- F. All blood slips will be transported with the patient and left at the receiving facility for the patient's permanent record. All documentation of blood administration must be recorded on the electronic medical record.

### **V. RESPONSIBILITY**

**Advanced Nurse Practitioner, Critical Care Transport Nurses**

### **VI. KEY WORDS**

None

### **VII. APPENDIX None**

### **VIII. REFERENCES / CITATIONS**

None

	<u>AC05</u>	
<b>POLICY NAME/#</b>	<u>Storage and Replacement of Blood/Blood Products</u>	
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>	
<b>POLICY OWNER</b>	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Bob Francis, Manager Metro Aviation (Date)	
<b>ADMINISTRATIVE APPROVAL</b>	_____ Jennifer Jackson/VP CNO (Date)	
<b>ORIGINATION DATE</b>	<u>06/1985</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>12/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>12/2018</b>

- I. **POLICY**  
 To assure that the blood that is carried on the helicopter is properly stored and monitored.
  
- II. **PURPOSE**  
 TO PROVIDE GUIDELINES IN COLLABORATION WITH THE PROCEDURES SET FORTH BY THE UNIVERSITY OF CINCINNATI BLOOD BANK FOR THE PROPER STORAGE AND MONITORING OF BLOOD PRODUCTS.
  
- III. **DEFINITIONS**  
 None

#### IV. PROCEDURE

- A. The blood products will be checked at the beginning of each shift by the on duty nurse. Documentation of expiration dates, temperature control dots within appropriate range (when applicable) will be recorded on the designated blood record.
- B. Assure that hospital approved blood coolers are available. These coolers are labeled and calibrated by The University of Cincinnati Medical Center (UCMC) Blood Bank and meet all regulatory requirements for transporting blood and blood products.
- C. The University of Cincinnati Medical Center Blood Bank will be monitoring the temperature management of the blood coolers annually and will inform the Clinical Manager if equipment needs to be replaced. All flight personnel are required to inform the Clinical Manager of damage to the cooler that could deem it inappropriate for use.
- D. Number and location of units:
  - 1. Two (2) units of O-Negative packed red blood cells and two (2) units of Fresh Frozen Plasma (FFP) will be kept in the Center for Emergency Care (CEC) blood refrigerator at all times for emergency transfusion.
  - 2. Two (2) units of O-Negative packed red blood cells and two (2) units of Liquid Plasma will be kept at Butler County Regional Airport Air Care base office refrigerator at all times for emergency transfusion.
  - 3. Two (2) units of O-Negative packed red bold cells and two (2) units of Liquid Plasma will be kept at the Mt. Orab Air Care base office refrigerator at all times for emergency transfusion.
- E. Upon notification of a patient flight, pack the cooler with ice and two units of O-Negative blood/FFP/Liquid Plasma are to be taken from the refrigerator and placed in the designated cooler. It is the responsibility of the flight nurse and flight physician to ensure that appropriate temperature of the blood is maintained throughout the duration of time the blood is not in the refrigerator. When blood is out of the blood refrigerator and stored in the blood cooler, it will be monitored at a minimum of every 4 hours to ensure appropriate temperature is maintained; every 2 hours if the ambient outside temperature is above 90 degrees F. Bags of ice will be inspected and changed as needed. Only crushed ice can be used. No cooled ice packs or melted ice allowed.

- F. For blood administration, see The University of Cincinnati Medical Center Patient Care Services Administration of Blood and Blood Products Policy.
- G. The top copy of the blood slip must remain with the patient's original chart. Remaining copies will be used for the replacement of units.
- H. Replacement of Units
  1. When blood is used, the flight nurse must write the patient's name or other identifying information on the attached blood slip and sign it. The blood slip will be sent to the UCMC Blood Bank and the blood product will be replaced by APMC Blood Bank in a timely manner. Upon return from a patient flight where blood/blood product has been taken out of the refrigerator but not used, ice is discarded and the blood returned to the refrigerator.
  2. If type-specific blood is available at a referring hospital, only bring back units that will be infused during flight. The flight nurse must document all appropriate information for a patient receiving blood including blood type, unit number(s), expiration date, number of units transfused prior to arrival and amount remaining on the electronic medical record at the time of transport.

**V. RESPONSIBILITY**  
**Advanced Practice Nurses, Flight Nurses Flight Physicians**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS** **None**

	<u>ACMC05</u>	
<b>POLICY NAME/#</b>	<u>Preparing for the Transport of the Burn Patient</u>	
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>	
<b>POLICY OWNER</b>	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Dr. Elizabeth Powell Ground Medical Director (Date)	
<b>ADMINISTRATIVE APPROVAL</b>	_____ Jennifer Jackson/VP CNO (Date)	
<b>ORIGINATION DATE</b>	<u>11/2001</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>12/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>12/2018</b>

- I. POLICY**  
 Transport of the burn patient requires precautions and preparations be performed to provide an environment which minimizes microbial contamination.
- II. PURPOSE**  
 TO PROVIDE GUIDELINES FOR THE SAFE TRANSPORT OF BURN PATIENTS.
- III. DEFINITIONS**  
 None

#### **IV. PROCEDURE**

- A. Before and after each transport of a burn patient, the Air Care & Mobile Care vehicle must be cleansed with an approved anti-microbial solution and applied according to product guidelines.
- B. All team members must uphold universal precautions. Isolation gowns are necessary when dressings are saturated or otherwise indicated. Masks are necessary only when a team member has an upper respiratory infection.
- C. Clean sheets may be placed next to the patient's body for absorbency or used if a change sheet is needed.
- D. The above procedures should be followed unless otherwise directed by the specialized burn transport team.
- E. If fluid resuscitation is needed for transport, the transport team must add additional bags of crystalloids for the transport. If this is known at the beginning of the transport than crystalloids should be taken from storeroom. If the transport team arrives at the referring facility and needs extra units to maintain fluid resuscitation, the team should collaborate with the referring facility for additional bags.

#### **V. RESPONSIBILITY All Team Members**

#### **VI. KEY WORDS None**

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS None**

	<u>AC17</u>	
<b>POLICY NAME/#</b>	<b>Notification of a Simultaneous Aircraft Response</b>	
<b>POLICY TITLE</b>	<b>Air Care and Mobile Care</b>	
<b>POLICY OWNER</b>		
	_____	_____
	<b>Matt Gunderman/Director</b>	<b>(Date)</b>
	_____	_____
	<b>Dr. William Hinckley/Air Medical Director</b>	<b>(Date)</b>
	_____	_____
	<b>Bob Francis, Manager Metro Aviation</b>	<b>(Date)</b>
<b>ADMINISTRATIVE APPROVAL</b>	_____	_____
	<b>Jennifer Jackson/VP CNO</b>	<b>(Date)</b>
<b>ORIGINATION DATE</b>	<b>11/2005</b>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>8/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>8/2018</b>

**I. POLICY**

The need for multiple aircraft to respond to one location is a frequent occurrence in the helicopter EMS environment. ACMC will respond if mitigation of risk to patient and crew can be obtained.

**II. PURPOSE**

The need for multiple aircraft to respond to one location is a frequent occurrence in the helicopter Air Ambulance environment. ACMC will respond if mitigation of risk to patient and crew can be obtained.

**III. DEFINITIONS**

None

**IV. PROCEDURE**

When dispatching an aircraft, the following guidelines are considered:

- A. The nearest aircraft will be primary for all inter-hospital and scene flights.
  - 1. Under certain circumstances, primarily being a flight with a single leg distance of greater than 50 miles, another ACMC aircraft may be responding if there is logistical support for the decision.
- B. The communication specialist will communicate with all pilots in a multi-aircraft response, to be certain they know of the other helicopter's response.
- C. The pilots are responsible for coordinating safe flight distances and coordinate landings.

**V. RESPONSIBILITY**

**Communication Specialist, Flight Team**

**VI. KEY WORDS**

None

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS**

None

	<u>ACMC12</u>	
POLICY NAME/#	<u>Dispatch Guidelines for Appropriate Team Utilization</u>	
POLICY TITLE	<u>Air Care and Mobile Care</u>	
POLICY OWNER	_____	
	<u>Matt Gunderman/Director</u>	<u>(Date)</u>
	_____	_____
	<u>Dr. William Hinckley/Air Medical Director</u>	<u>(Date)</u>
	_____	_____
	<u>Dr. Elizabeth Powell/Ground Medical Director</u>	<u>(Date)</u>
ADMINISTRATIVE APPROVAL	_____	
	<u>Jennifer Jackson/VP CNO</u>	<u>(Date)</u>
ORIGINATION DATE	<u>11/2001</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2014</b>	<b>NEXT REVIEW DATE</b>
		<b>7/2015</b>

**I. POLICY**

To assure safe and high quality patient care is being delivered by Air Care & Mobile Care, and also help assure the patient receives the most appropriate level of care and is transported by the most appropriate mode of transport, the following guidelines shall be referenced.

**II. PURPOSE**

**TO PROVIDE GUIDELINES FOR THE DISPATCHING OF THE APPROPRIATE MEDICAL TEAM TO THE PATIENT NEEDING TRANSPORT.**

**III. DEFINITIONS**

- A. Basic Life Support (BLS) - Two (2) Emergency Medical Technicians (EMT)**
- B. Advanced Life Support (ALS) - A minimum of one (1) EMT and one Paramedic (EMT-P) or two (2) EMT-P**

- C. **Critical Care ALS (CALS)-A minimum of one (1) certified critical care paramedic and one (1) ALS paramedic or (2) two certified critical care paramedic team.**
- D. **Mobile Intensive Care Unit (MICU) – A registered nurse whose training meets or exceeds the training required for paramedic; and a physician or another person designated by the medical director, who holds a valid license or certificate to practice in a health care profession.**

#### IV. PROCEDURE

- A. Basic Life Support (BLS) transports shall be defined by protocols listed in Air Care & Mobile Care Policies and may also include but are not limited to:
  - 1. Monitoring and recording pulse oximetry
  - 2. Transport of patients with saline lock and other capped venous ports
  - 3. Monitoring urinary catheters
  - 4. Transport of patients with gastric and/or enteral tubes that are capped during transport or connected to gravity drain.
  - 5. Patients with tracheostomies
  - 6. Simple and deep suctioning of the patient airway
- B. Critical Care ALS (CALS) and Advanced Life Support (ALS) transports shall be defined by the Air Care and Mobile Care Clinical Policies. Paramedics can work at a BLS level as well as protocols for Paramedics and may also include but are not limited to other medications and procedures outlined in the Air Care & Mobile Care Scope of Practice
- C. Mobile Intensive Care (MICU) transports shall be defined by protocols consistent with the Nurse Practice Act in the state of Ohio and may also include:
  - 1. Medications and procedures listed in Air Care & Mobile Care Clinical Policy Manual.
  - 2. Medically necessary transport of a patient in whom intervention beyond the practice of the EMT-A or paramedic/critical care paramedic is likely
  - 3. Individuals with complex medical and/or nursing issues which require careful and on-going assessment, planning, intervention and evaluation of care
  - 4. Examples of patients for whom Mobile ICU transport is required:
    - a) Intra-Aortic Balloon Pump
    - b) Left Ventricular Assist Device
    - c) Arterial and/or venous sheath and/or hemodynamic monitoring
    - d) Trans-venous pacing

- e) Chest tubes
- f) Intravenous continuous medications
- g) Extra-corporal membrane

D. Air Care: Same guidelines for the MICU should be reference and also the following considerations:

1. time dependence of the transfer based on patient's condition
2. if a physician is requested for patient transport.
3. transfers in which the patient may require a life sustaining procedure, during transport, that is out of the traditional scope of practice of the MICU team
4. Pericardiocentesis – Primary reason for transfer is a pericardial effusion or tamponade.
5. For scene transports, whenever possible patients will be taken to the nearest appropriate hospital (i.e. major trauma center, facility with specialized stroke care, hospital with interventional cath lab capabilities, burn center, facility with high risk OB services with level II or III NICU, etc.)

**V. RESPONSIBILITY**

**VI. KEY WORDS**  
None

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS** None

	CC05	
<b>POLICY NAME/#</b>	Dispatch- Inter-Hospital Transfers	
<b>POLICY TITLE</b>	Air Care and Mobile Care	
<b>POLICY OWNER</b>	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
<b>ADMINISTRATIVE APPROVAL</b>	_____	_____
	Jennifer Jackson/VP CNO	(Date)
<b>ORIGINATION DATE</b>	9/1999	
<b>LAST REVISION/ REVIEW DATE</b>	8/2017	<b>NEXT REVIEW DATE</b> 8/2018

**I. POLICY**

Air Care will respond to medically appropriate requests for inter-facility transport from receiving and/or transporting facility personnel.

**II. PURPOSE**

**III. DEFINITIONS**

OCC-Metro Operational Control Center

**IV. PROCEDURE**

All transport requests must go through APMC Communication Center. No request will be accepted by staff personnel at a base. If an outside agency calls the base for a transport request, they will be routed to the APMC Communication Center for assistance. Calls will be accepted from the referring/receiving physician or their designated representative.

A. Receiving the request from a facility whose ground time is greater than air time:

1. Request basic information

a) Identity of request party

- b) ask if another flight program was called Patient name and age
  - c) Patient problem
  - d) Location of patient (sending facility and unit)
  - e) Name of sending physician
  - f) Receiving facility and unit
  - g) Name of receiving physician
  - h) Call-back number
  - i) Notification of the need of a signed Physician Certification Statement
2. Emergency medicine faculty has the right to deny flight after consulting with referring facility physician.
- B. Receiving the request from referring facility/physician whose air time is greater than ground time.
- 1. In the event that the ground transport time is believed to be less than the air transport time, the communication specialist may offer Mobile ICU for transport if the patient's clinical condition falls within MICU capability.
  - 2. Helicopter transport should remain the primary option if:
    - a) An Air Care & Mobile Care ground unit is not available.
    - b) The time of the actual patient transport could affect patient outcome.
    - c) Patient's condition may require the advanced skills or equipment of the flight team.
    - d) If road conditions or traffic make transport by air more rapid or safe.
- C. Response of the helicopter – following appropriate OCC guidelines
- 1. Activate flight crew
  - 2. Relay needed information
    - a) Type of call (hospital transfer)
    - b) Location (sending facility and city)
    - c) Receiving facility (hospital and city)
    - d) Medical condition; trauma, cardiac, OB, etc.
- D. Relay information
- 1. Relay all location and directional information to the pilot (assist in determining any navigational information, if requested)
  - 2. Advise pilot of landing zone information
  - 3. Request ETE from the pilot, if unknown or uncertain
  - 4. Request faculty physician advise flight crew of patient and medical information

V. **RESPONSIBILITY**

VI. **KEY WORDS**

None

VII. **APPENDIX** None

VIII. **REFERENCES / CITATIONS** None

	CC04	
POLICY NAME/#	Communications Center - General Duties	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER	_____	
	Matt Gunderman/Director	(Date)
ADMINISTRATIVE APPROVAL	_____	
	Jennifer Jackson/VP CNO	(Date)
ORIGINATION DATE	7/1999	
LAST REVISION/ REVIEW DATE	8/2017	NEXT REVIEW DATE
		8/2018

- I. POLICY  
To ensure safe and efficient operations, written documentation will be maintained.
- II. PURPOSE
- III. DEFINITIONS  
None
- IV. PROCEDURE
  - A. Shift commencement - It is the responsibility of the communication specialist to ascertain pertinent information prior to his/her shift (i.e.: transport scheduled, transports underway, transport condition and transport teams). The communication specialist will also check the memo file for any updated information and initial it.
  - B. CAD System - The communication specialist will sign into the computer aided dispatch (CAD) system at the start of their shift. The communication specialist log will contain the following information:
    1. Weather status (established by pilot, verify through OCC)
    2. Transport associates on duty and any additional passengers
    3. Transport any potential transport inquiries

4. Vehicle maintenance downtime
  5. Other non-University aircraft activity on the helipad
- C. There will be a dedicated communicator assigned to flight following. They are responsible to track and be physically present during aircraft movements.
1. All air and ground transports (T, G/T, N/T)
  2. Refuel/maintenance activities
  3. Educational events
  4. PR and marketing events
  5. Any special events
  6. Stand-by/stand-down requests
  7. Cancelled/aborted/missed transports
  8. Down-time log
- D. Office Procedures/Responsibilities – The communication specialist will be responsible for insuring all communication center equipment is in good operating condition. If any equipment is found to be non-operational, the communication specialist will contact the supervisor on call to get direction in contacting the appropriate repair service personnel in a timely manner.
- E. Disaster Net Radio – Information relayed through the disaster net radio should be noted verbatim and relayed to the appropriate personnel verbatim. In the event that University of Cincinnati Medical Center is placed on standby for possible receipt of patients from a disaster, notify the listed personnel.
1. Air Care & Mobile Care personnel (to cover the disaster net radio).  
Only if University of Cincinnati Medical Center has not responded to the disaster net:
  2. Faculty physician (4-2636, 4-1925)
  3. Emergency Department charge nurse (4-2630 or hospital pager # 59924-1934)
  4. Hospital Centrex operators (#0)
  5. Corporate Director (260-4141 or alpha/numeric pager 366-7058)

All communication into or out of the communications center via land phone lines and air & ground radios is recorder on a digital recorder. All communications center staff shall have access to replaying these audio recordings for the purpose of customer service, concurrent review of missed information, and performance improvement.

- F. Unicom Radio – Used to communicate with pilot for discretionary communications or when the base channel is being used for medical updates.
- G. Scanner – The scanner may be used during the shift to receive periodic updates on weather and to aid the communication specialist in keeping abreast of emergency situations. The scanner can also be used to monitor flight progress (i.e.) when flying through controlled air space, monitored tower traffic for that air space. The scanner is not an approved tool for flight following but may be used as additional information for safe flight and ground operations.
- H. Base Radio – This base radio links the transport team with the communication center through the use of (2) two-way channels used for dialogue.

**V. RESPONSIBILITY**  
**Communications Specialist**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS** **None**



A. If an air or ground transport is missed (due to weather conditions or any other reason):

1. The communication specialist will complete the following:
  - a. Suggest alternative methods of transport of patient (i.e ground if appropriate)
  - b. Note the information in the computer aided dispatch (CAD) system.
  - c. Contact the two nearest Air Medical Services advising of missed flight and reason for miss.
  - d. In the event that a transport is missed, the pilot/driver will advise the communication center of weather or maintenance status and the communication center will inform the requesting agency of potential availability.

**V. RESPONSIBILITY**  
**Communication Specialist and Pilot**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX**

	CC03	
POLICY NAME/#	Communications Center - Noise Control	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER		
	_____	_____
	Matt Gunderman/Director	(Date)
ADMINISTRATIVE APPROVAL		
	_____	_____
	Jennifer Jackson/VP CNO	(Date)
ORIGINATION DATE	4/2003	
LAST REVISION/ REVIEW DATE	8/2017	NEXT REVIEW DATE
		8/2018

**I. POLICY**

Air Care and Mobile Care strive to provide the safest patient care possible. In an effort to ensure clear communication is relayed and received and the work environment is conducive to proper communication, monitoring the noise level in the communication center will be done. Non-essential activity levels in the communication centers must not interfere with safe operations.

**II. PURPOSE**

To provide guidelines to reduce noise in the communication center.

**III. DEFINITIONS**

None

**IV. PROCEDURE**

In order to ensure safe operations, efforts to limit the number of distractions in the communication center will be enforced. If, at any time, the communication specialist feels the noise level has reached a level that interferes in their job, they are to:

- A. Request to clear the area of all unnecessary associates.
- B. Lock the communication center doors to minimize traffic and help with noise control.

**V. RESPONSIBILITY**  
**Coordinators, Communication Specialists**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

	<u>AC09</u>
POLICY NAME/#	<u>Radio Communication by Flight Team with Communication</u>
POLICY TITLE	<u>Air Care and Mobile Care</u>
POLICY OWNER	<p>_____ (Date)</p> <p>Matt Gunderman/Director</p> <p>_____ (Date)</p> <p>Dr. William Hinckley/Air Medical Director</p> <p>_____ (Date)</p> <p>Bob Francis, Manager Metro Aviation</p>
ADMINISTRATIVE APPROVAL	<p>_____ (Date)</p> <p>Jennifer Jackson/VP CNO</p>
ORIGINATION DATE	<u>9/1999</u>
LAST REVISION/ REVIEW DATE	8/2017
NEXT REVIEW DATE	8/2018

- I. POLICY  
 The flight team shall establish and maintain communication with the communication center to receive and provide patient information in a timely manner.
- II. PURPOSE  
 To provide guidelines for appropriate radio communication.
- III. DEFINITIONS  
 None
- IV. PROCEDURE

- A. En-route to the referring hospital: the flight team will be given as much information as possible concerning the number, age, and clinical status of the patient(s) by the faculty physician or communication specialist. Minimum information when available, should include situation, patient weight, IV drips, and ventilator if needed. This information will primarily be given via approved communication device. Additional information or confirmation may be shared in-flight via radio.
- B. Upon arrival at a hospital: the flight team may consider calling the communication center:
  - 1. For questions or concerns and to receive the advice of the faculty physician.
  - 2. To provide patient information or special needs the flight team may have when the return flight time will be very short.
  - 3. To provide information concerning the status of the flight team and patient information when the flight distance has put helicopter radio communications out of range.
  - 4. At any time patient stabilization requires an unusual length of time.
- C. En-route to a scene: patient information may be sought from the referring agency directly. An attempt should be made to relay pertinent information to the communication center as applicable.
- D. Upon arrival at a scene: after patient assessment and stabilization is completed, in-flight to the receiving hospital, the flight team should contact the communications center or the receiving hospital directly to give a patient report.
- E. Hand-held portable radio
  - 1. MedCom telemetry frequencies
  - 2. Helicopter dispatch frequency
  - 3. Cellular phone
  - 4. Relay of information by fire or rescue personnel through their dispatch center.
  - 5. Use of land line if in a private home

**V. RESPONSIBILITY**

**Flight Nurse, Advanced Practice Nurses, Flight Physician, Pilot, Communication Specialist, Faculty Physician**

**VI. KEY WORDS**

**None**

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS**

None

	CC02	
POLICY NAME/#	Communication Center - Auto Launch (Launch and Stage) Flight Activation	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
ADMINISTRATIVE APPROVAL	_____	_____
	Jennifer Jackson/VP CNO	(Date)
ORIGINATION DATE	2/2009	
<b>LAST REVISION/ REVIEW DATE 8/2017</b>	<b>NEXT REVIEW DATE 8/2018</b>	

**I. POLICY**

Air Care and Mobile Care strive to provide the safest patient care possible. In an effort to provide safe and rapid response to a critically injured or ill patient, ACMC has established a process to “launch and stage” an aircraft.

**II. PURPOSE**

To provide guidelines for the safe operations of an aircraft that has been requested to “launch and stage”.

**III. DEFINITIONS**

None

**IV. PROCEDURE**

UCMC Air Care auto launches (launch and stage) aircraft only under the following scenarios:

- A. On all scene flights when operational condition is green and when a rapid launch would be deemed necessary and appropriate due to scene location.

- B. On cardiac transports that have a confirmed destination and accepting physician.
- C. On patient transports to University of Cincinnati Medical Center with a confirmed bed assignment and accepting physician.

Faculty is always advised of any transport and has ultimate authority to determine if patient condition warrants the need for air medical transport.

Note: There is no true auto launch (launch and stage) as every flight request must be approved by our air vendor/FAA Part 135 Certificate Holder prior to lift-off.

**V. RESPONSIBILITY**  
**Communications Specialist**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX**

**VIII. REFERENCES / CITATIONS**  
**None**

	AC08	
POLICY NAME/#	Communications Center: Flight Activated	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER		
	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
	Dr. William Hinckley/Air Medical Director	(Date)
	_____	_____
	Bob Francis, Manager Metro Aviation	(Date)
ADMINISTRATIVE APPROVAL	_____	_____
	Jennifer Jackson/VP CNO	(Date)
ORIGINATION DATE	7/1999	
<b>LAST REVISION/ REVIEW DATE</b>	<b>8/2017</b>	
	<b>NEXT REVIEW DATE</b>	<b>8/2018</b>

- I. POLICY  
 Air Care and Mobile Care strive to provide the safest patient care possible. In an effort to ensure safe operations, all flight activations will be handled in a consistent manner and all significant events will be documented.
  
- II. PURPOSE
  
- III. DEFINITIONS  
 None
  
- IV. PROCEDURE

For Inter Hospital Transports:

- A. Communication specialist will take original information and obtain medical information about the patient and determine if flight is appropriate. Supervisor or faculty physician may be contacted if assistance is needed to determine if flight is appropriate. Communication Specialist will ask if any other flight program was called for this flight.
- B. Communications specialist will contact the pilot on duty for acceptance of the flight. The pilot is not informed of the patient condition or age. If there are operational consideration (for example: weight, extra equipment etc.), the pilot will be informed after official acceptance of flight.
- C. Decision to accept flight request will be determined by the pilot-in command. Any crew-member may refuse the flight for safety reasons.
- D. According to patient information:
  - 1. The flight physician/advanced practice nurse and flight nurse will plan patient care prior to arrival at the facility.
  - 2. The flight team will ensure appropriate equipment is on board the helicopter.
- E. Communication specialist will notify the faculty physician once the aircraft has lifted.

For Scene Transports:

For scene request, communication specialist will:

- A. Take information including if any other flight program was called for this flight and contact the pilot on duty. The pilot will not be informed of the patient condition or age. If there are operational consideration (for example: weight, extra equipment etc.), the pilot will be informed after official acceptance of flight.
  - 1. If deemed safe by the pilot, the flight will be accepted.
  - 2. Notify faculty in the Emergency Department once a flight is in progress
  - 3. Give information to pilot, checking map for location and landmarks. At this time, the pilot will re-confirm destination and coordinates
  - 4. Collaborate with the pilot in checking landing coordinates.
  - 5. Advise requesting agency of ETA's (include liftoff time & flight time & landing time)
  - 6. Inform the requesting party of need for proper security at the landing site
  - 7. Keep receiving facility advised of patient ETA

8. Advise receiving facility of need for stretcher and personnel and communicate any IV medications or special equipment requirements for patient care at direction of the flight crew
9. Assist the Emergency Medicine faculty with communications with the flight team
10. Notify the clinical director and/or medical director of any flight or flight requests that are in question. For immediate assistance for determining the appropriateness of a flight, contact the faculty physician.
11. Notify the appropriate personnel of a flight activation:
  - a) Transportation, ambulance service and/or receiving hospital for unload assistance when applicable
  - b) If returning to The University Hospital & at direction of flight crew:

Emergency clerk  
 Emergency Registration  
 Emergency Social Services  
 Transfer Referral Center  
 Nursing House Supervisor at 585-9924  
 Foreign or sign language interpreter

- B. Pilot will contact Air Care base either by radio or via telephone of safe arrival.
- C. Proper radio procedures will be used during all phases of the flight.
- D. If any questions or issues arise, the faculty physician will confer with the medical director, clinical manager and /or corporate director.
- E. After the transport is completed:
  - a) Check data entry for correctness and document any exceptions in comments field
  - b) Assure that the appropriate forms are collected
  - c) Prepare any additional forms that are required by either local or state agencies

**V. RESPONSIBILITY**

**Communications Specialists, Pilot, Flight Team, Faculty Physician**

**VI. KEY WORDS**

None

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS** None

	AC13	
POLICY NAME/#	Communications: Flight Following	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/ Air Medical Director (Date)	
	_____ Bob Francis, Manager Metro Aviation (Date)	
ADMINISTRATIVE APPROVAL	_____ Jennifer Jackson /VP CNO (Date)	
ORIGINATION DATE	7/1999	
LAST REVISION/ REVIEW DATE	8/2017	NEXT REVIEW DATE
		8/2018

**I. POLICY**

To ensure the safety of others, the communication specialist must have a reasonable idea of the aircraft’s location at all times. This function becomes extremely important in the event that an aircraft encounters conditions, which preclude effective radio communications, prior to making an unscheduled landing.

**II. DEFINITIONS**

None

### III. PROCEDURE

#### Communication Specialist:

- A. In order to provide the timeliest information regarding the patient condition changes or flight progress, it is necessary that the communication specialist be present in the communications center during all aircraft movements during flight operations and maintain the ability to account for:
  1. Position of aircraft
  2. Estimated time of arrival at the requesting facility or scene
  3. Estimated time of arrival of the patient at the receiving hospital, and
  4. Personnel on board the aircraft
- B. In order to accurately monitor flight progress, the communication specialist must log all position reports as they are received. It is imperative that each position report be clear, concise and thoroughly understood.
- C. GPS satellite flight following, when available on the aircraft and in the ACMC communications center may supplant radio position reports only when the GPS path will permit predictive aircraft location based on last acquired GPS position. And GPS positions must be obtained at less than or equal to every 10 minutes. Pilots:
  - A. When GPS satellite tracking is not available in the helicopter and in the ACMC communications center, pilots will provide position reports that contain current GPS coordinates. If GPS is not available in the aircraft or if flight conditions do not permit its use a known landmark, city or town, or reference to any navigational aid as well as an estimate to the aircraft's final destination or next reporting point may be used for flight following.
  - B. Reports:
    1. Will be given by the pilot at ten (10) minute intervals during each flight.
    2. Format of reports:
      - Location of aircraft in latitude and longitude
      - Location reference any landmark; distance, bearing to or from
      - Estimated time en-route (ETE)
  - C. Upon arrival at the aircraft's destination, the pilot will:
    1. Report destination in sight
    2. Transmit to the communication center the estimated time for landing or the actual arrival time
    3. Call back via telephone if there is doubt whether the communication specialist received the arrival radio transmission.

- D. If the aircraft is operating on the fringe of effective radio communication, it is necessary that a flight team member notify the communication center by telephone as soon as possible after landing at the destination and provide the communication specialist with the time of landing and proposed departure.
- E. To ensure the aircraft is continuing on its flight and not in distress, the communication specialist must:
  - 1. Know the course of flight
  - 2. Know the flight service stations (FSS), airport traffic control stations, or hospital networks that the aircraft is flight following with along the route of flight
  - 3. If communication has not been made within fifteen (15) minutes, initiate the "Missing/Overdue Aircraft Protocol" of the Post Accident/Incident Plan (PAIP)
- F. Signal 76: To aid in maintaining the skills to locate an aircraft enroute, the signal 76 drill will be used.
  - 1. Periodically, the pilot of an aircraft on a flight will call out a signal 76.
  - 2. The pilot will note the coordinates at the time.
  - 3. The communication specialist will note where he/she thinks the aircraft is located.
  - 4. A comparison will be made upon completion of the flight.
  - 5. Any additional training will be initiated by the appropriate supervisor secondary to the results of Signal 76 drill.

IV. RESPONSIBILITY  
Pilot & Communication Specialist

V. KEY WORDS  
None

VI. APPENDIX None

VII. REFERENCES / CITATIONS None

	<b>AC12</b>	
<b>POLICY NAME/#</b>	<b>Helicopter Air Ambulance(HAA) Communication Procedure and Coordination Plan</b>	
<b>POLICY TITLE</b>	<b>Air Care and Mobile Care</b>	
<b>POLICY OWNER</b>	_____ <b>Matt Gunderman/Director</b> (Date)	
	_____ <b>Dr. William Hinckley/Air Medical Director</b> (Date)	
	_____ <b>Bob Francis, Manager Metro Aviation</b> (Date)	
<b>ADMINISTRATIVE APPROVAL</b>	_____ <b>Jennifer Jackson/VP CNO</b> (Date)	
<b>ORIGINATION DATE</b>	<b>11/2009</b>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>8/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>8/2018</b>

**I. POLICY**

To promote safety and standardized communications between air medical helicopters operating in the Greater Cincinnati geographical area.

**II. DEFINITIONS**

None

**III. PROCEDURE**

- A. All inbound HAA aircraft are requested to contact University of Cincinnati Medical Center’s (UCMC) Air Care & Mobile Care Communication Center on 462.975 PL 127.3 no later than fifteen (15) minutes prior to expected time of arrival (ETA) into the Greater Cincinnati geographical area. The Communication Specialist will provide the aircraft with known alerts including hazards, known aircraft on a helipad, etc.

- B. Metro pilots, and/or the Air Care communications specialist have the authority to refuse landing of any aircraft on the UCMC helipad. Examples of when this may occur surround issues of safe flying conditions related to weather, heliport maintenance, and multiple aircraft already on the helipad.
- C. Pilots should tune and monitor frequency 123.025 within twenty (20) nautical miles of intended landing area. Then again within five (5) nautical miles of the intending landing area the Pilots will state their intentions in the blind, and coordinate their movements with other aircraft in the area.
- D. Outbound HAA aircraft should again contact UCMC Air Care & Mobile Care's Communication Center with departure times and flight plan on frequency 462.975 PL 127.3.
- E. Pilots should give advisory call on 123.025 stating intentions and departure route.
- F. While the visiting aircraft is on the helipad, pilots are expected to stay with the aircraft. In addition, the pilot is expected to have a communication device (2-way radio, cell phone etc) with them at all times to assure communication with the Communication Center is not interrupted.
- G. In the event the HAA program is inbound to any facility other than UCMC, it will be the HAA program's responsibility to make all phone calls to set up operations for their aircraft to land (i.e. turn on helipad lights, notify security etc.) When appropriate and available the Air Care & Mobile Care communications center will assist with notification from other HAA aircraft to hospitals in the region.
- H. Any failures in communications or failure to comply with the standard operating procedures outlined within this policy, or against industry and regulatory standards, will be reported by the Program Director or their designee through the appropriate reporting forum.
- I. Air communications specialist, when receiving a flight request, will ask the referring agency if another flight program has already been contacted about this flight and has either turned the flight down or is responding as a multiple helicopter response.

**IV. RESPONSIBILITY**

**Pilot & Communication Specialist**

**V. KEY WORDS**

None

**VI. APPENDIX None**

**VII.**

**REFERENCES /  
CITATIONS**

	<u>AC11</u>
POLICY NAME/#	<u>Communication: Appropriate Radio Terminology &amp; Process</u>
POLICY TITLE	<u>Air Care and Mobile Care</u>
POLICY OWNER	<p>_____</p> <p>Matt Gunderman/Director (Date)</p> <p>_____</p> <p>Dr. William Hinckley/Air Medical Director (Date)</p> <p>_____</p> <p>Bob Francis, Manager Metro Aviation (Date)</p>
ADMINISTRATIVE APPROVAL	<p>_____</p> <p>Jennifer Jackson/VP CNO (Date)</p>
ORIGINATION DATE	<u>9/1999</u>
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>
<b>REVISION/ REVIEW DATE</b>	<b>7/2018</b>

- I. POLICY
 

All Air Care transport associates will utilize the approved terminology for effective, efficient and safe radio communications.
- II. PURPOSE
- III. DEFINITIONS
 

None
- IV. PROCEDURE
  - A. The communication center shall be referred to as Air Care Base.
  - B. The name of the unit being called should be said first (ex: if communication specialist calls Air Care I, they would say "Air Care I, Air Care base).

- C. If two units are attempting to transmit at the same time, initial contact shall be acknowledged by repeating the call sign. Acknowledge the field units message with unit call sign and time only. Unless the message has been broken during transmission, it is not necessary to repeat the message, it only wastes airtime.

NOTE: There is one exception to this procedure. If you are receiving medical or other critical information for relay, repeat all messages for clarification and accuracy.

- D. At times an operator will have emergency traffic. If so, advise the field units of it with request of standby on all other traffic.
- E. If the entire message is not transmitted clearly, reply with "say again" or "repeat all after....." and the last word you heard.
- F. Terms like "over and out" are not encouraged.
- G. Pause after keying radio to avoid "clipped" communication due to repeaters delaying voice transmissions.
- H. Only military (24 hours) time should be utilized.
- I. The base radio shall be cleared with a call letter. Keep it simple (NAM471 clear 1100) is sufficient.

#### Message Content and Delivery:

- A. Keep messages as brief as possible, with frequent breaks to allow confirmation of receipt.
- B. Only relevant information should be transmitted over the radio and it should be done in a professional manner.
- C. Only transmit facts and do so clearly and concisely. If your message is a question, conclusion, deduction or educated guess, say so.
- D. Speak in the third person.
- E. Only proper agency names, titles and radio numbers should be used.
- F. If a location is needed in your transmission, secure it before going on the air. Be sure the location you give is as specific as possible and is one that can be understood by the receiver.

- G. Transmission of #'s should be over-exaggerated (i.e.: seven (7) as if there were two "v"s, nine (9) as "niner", forty (40) as "forty" followed by "four zero.")
- H. Do not use "thank you", "please" or similar terms.
- I. All messages should be relayed exactly as the communication specialist received it (verbatim).
- J. Transmission should not be for more than 30 seconds in length at a time. If you message goes beyond that, say, "break" and wait for a few seconds to see if there are other units needing to send a message. If you hear none, go on with your message.
- K. Flight activation: page should follow format for group page "Air Care I or II respond to Adams County Hospital for cardiac patient (repeat) NAM471, Clear 1432". No information on condition of patient is to be given on initial notification of flight.
- L. Weather check: notify pilot, per phone or radio, to perform a weather check. "Need weather check for possible flight from Adams County Hospital to University Hospital NAM471, 1336." No information on condition of patient is to be given on initial weather check.
- M. Precede medical report relay with "Air Care Base, Air Care I, and Medical Report" (not physician report as this is easily confused with position report).
- N. Department approved terminology:
  1. communication center = Air Care base
  2. want=desire
  3. get=obtain
  4. yes=affirmative
  5. no=negative
  6. can't=unable
  7. When using letters that need confirmation with a word only use words from the NATO Phonetic Alphabet

**V. RESPONSIBILITY**

**All Air Care Personnel**

**VI. KEY WORDS**

**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS** **None**

	MC05	
POLICY NAME/#	Communications: Ground Ambulance Tracking and Communications	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER	_____ Matt Gunderman/Director (Date)	
	_____ Dr. Liz Powell/Ground Medical Director (Date)	
ADMINISTRATIVE APPROVAL	_____ Jennifer Jackson/VP CNO (Date)	
ORIGINATION DATE	2/2003	
<b>LAST REVISION/ REVIEW DATE</b>	<b>8/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>8/2018</b>

**I. POLICY**

Air Care & Mobile holds safety of its personnel and customers as its number one value. A proactive safety management program is utilized to ensure that safety policies and procedures are created, implemented and followed by all Air Care & Mobile Care and contracted employees. This policy outlines how the communication between the communication center and the transport team and how teams will be tracked for safety.

**II. PURPOSE**

To provide guidelines on when and how often communications should be given to the Communication Center in regards to location of ambulances.

**III. DEFINITIONS**

None

#### IV. PROCEDURE

Timely:

- A. Transport team will call communication center with the following (at a minimum) when:
  - 1. At the beginning of shift
  - 2. enroute to referring site
  - 3. arrived at referring site
  - 4. enroute to receiving site
  - 5. arrived at receiving site
  - 6. When complete/available for service
  - 7. any delays at the bedside > 30 minutes
  - 8. any time there is a delay in the original pick up or estimated arrival time given by the communication specialist.
- B. Communication specialist will verbally acknowledge transport team member by repeating their statement, giving the current time and logging the time into the computer aided dispatch program.

Safety:

- A. Transport team and communication specialist work cooperatively to ensure the team's location is known to the communication center in the event an unforeseen situation occurs. Verbal communication will include a landmark (i.e. mile marker, exit number, major building, etc.) as outlined below:
  - 1. Normal Weather Conditions: Verbal communication with Communication Center will be made every 30 minutes while responding to referring or receiving site.
  - 2. Inclement Weather Conditions (per policy): Contact with Communication Center will be made every 15 minutes while responding to referring or receiving site.
- V. Communication specialist will verbally acknowledge transport team member by repeating their statement, giving the current time and logging the time and land mark into the computer aided dispatch program.

#### VI. RESPONSIBILITY

**All Transport Team Members, including Communication Specialist**

#### VII. KEY WORDS

None

	<u>AC35</u>	
POLICY NAME/#	<u>Flight -Referrals to/from Other Programs</u>	
POLICY TITLE	<u>Air Care and Mobile Care</u>	
POLICY OWNER	_____	
	<u>Matt Gunderman/Director</u>	<u>(Date)</u>
	_____	_____
	<u>Dr. William Hinckley/Air Medical Director</u>	<u>(Date)</u>
	_____	_____
	<u>Bob Francis, Manager Metro Aviation</u>	<u>(Date)</u>
ADMINISTRATIVE APPROVAL	_____	_____
	<u>Jennifer Jackson/VP CNO</u>	<u>(Date)</u>
ORIGINATION DATE	<u>7/1999</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>8/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>8/2018</b>

- I. POLICY  
 Flights to or from a hospital with a hospital-based (hospital owned & operated) helicopter program should be given the option to transport the patient.
- II. PURPOSE
- III. DEFINITIONS  
 ACMC-Air Care & Mobile Care
- IV. PROCEDURE

- A. Requests to transport a patient to a hospital with an existing helicopter program should be coordinated to provide the patient the highest level of medical care in transport with consideration for timeliness.
- B. As part of the initial contact, if you are considering the other flight program, advise the requester of the type of service the other program offers (RN/MD, RN/EMT-P, etc.), time delay if any and the type of aircraft. Also point ACMC service capabilities. If the requestor would prefer the other program, offer to make the arrangements.
- C. If the requester prefers to use ACMC, handle according to standard operating procedures and coordinate with the other program.

**V. RESPONSIBILITY**  
**Communication Specialists**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS**  
**None**

	<u>AC47</u>	
POLICY NAME/#	<u>Stand-By Requests</u>	
POLICY TITLE	<u>Air Care and Mobile Care</u>	
POLICY OWNER	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
	Dr. William Hinckley/Air Medical Director	(Date)
	_____	_____
	Bob Francis, Manager Metro Aviation	(Date)
ADMINISTRATIVE APPROVAL	_____	_____
	Jennifer Jackson/VP CNO	(Date)
ORIGINATION DATE	<u>9/1999</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>7/2018</b>

**I. POLICY**

Air Care shall assume a “stand-by” status when requested by an authorized referring agency.

**II. PURPOSE**

**III. DEFINITIONS**

H/H2 Physician – Physician located at the remote base

UH/R2 Physician-Physician located in the Center for Emergency Care at the University of Cincinnati Medical Center

**IV. PROCEDURE**

A. Paging “Stand-by”

1. Communications specialist, when requested by an authorized outside agency, shall page Air Care I (or II/III, per protocol) to “stand-by” stating the time, location, and nature of incident. The term “stand-by” should be restated at the end of the transmission.
2. Communication specialist shall notify the Emergency Medicine Faculty Physician of known details of the “stand-by” request.

**B. Flight Team Actions**

1. The on-duty pilot shall respond to the assigned aircraft and complete all “pre-start” checklist items. The pilot shall retain discretion to start engines, while remaining on “stand-by”, in the following instances:
  - a. To eliminate questions relating to recent maintenance,
  - b. Extended periods of inactivity for that aircraft,
  - c. During periods of cold temperatures

Once started, the aircraft should remain running until “stand-down” or “activation” orders are given.

2. Depending on who is requested for the “stand by” (Air Care 1 Air Care 2 or Air Care 3), the “UH/H/H2” flight physician shall respond immediately to assigned aircraft for lift-off.
3. The “R-2” flight physician, if determined to be “next out” shall affect appropriate disposition of his/her patients (turn over to an alternate physician, discharge, etc.) and,
  - a. If patient load in E.D. is light, immediately respond to assigned aircraft and prepare for lift-off; or
  - b. If patient load in E.D. is moderate to heavy, remain in the E.D. to assist in movement and disposition of patients until an “activation” order is given. The flight physician will then immediately respond to the assigned aircraft and prepare for liftoff.
4. The flight nurse shall immediately prepare special supplies or equipment as indicated for the nature of the incident and be prepared to immediately respond to the assigned aircraft and prepare for lift-off.

**V. RESPONSIBILITY**

**Communication Specialist, Pilot, Flight Nurse and Flight Physician**

**VI. KEY WORDS**

None

**VII. APPENDIX None**

**VIII.**

**REFERENCES /  
CITATIONS**

None

	<u>AC15</u>
POLICY NAME/#	<u>Pilot Initial and On-going Competencies/Relief Pilot Training</u>
POLICY TITLE	<u>Air Care and Mobile Care</u>
POLICY OWNER	<p>_____</p> <p>Matt Gunderman/Director (Date)</p> <p>_____</p> <p>Dr. William Hinckley/Air Medical Director (Date)</p> <p>_____</p> <p>Bob Francis, Manager Metro Aviation (Date)</p>
ADMINISTRATIVE APPROVAL	<p>_____</p> <p>Jennifer Jackson/VP CNO (Date)</p>
ORIGINATION DATE	<u>9/1999</u>
LAST REVISION/ REVIEW DATE	<p><b>12/2017</b></p>
	<p><b>NEXT REVIEW DATE</b></p> <p><b>12/2018</b></p>

**I. POLICY**

All dedicated and relief Pilots will comply with the Part 135 Certificate Holders initial and on-going competency program as well as the additional requirements as identified by Air Care & Mobile Care and the University of Cincinnati Medical Center.

**II. DEFINITIONS**

A. New or relief pilots without prior air medical experience will be assigned 25 day shifts or 20 hours of operation in the Cincinnati local area. Pilots with air medical experience will be assigned 15 days shifts or 15 hours of operation in the local Cincinnati area. In addition, relief pilots revert back to the higher minimums if they have not flown five (5) flight hours in the Cincinnati local area within the previous ninety (90) days of which

two hours must be at night as pilot in command or at the controls prior to EMS mission. New or relief pilots should only reduce weather minimums after he or she has met the 25/15 day shifts requirement, feel comfortable with the Cincinnati local area, and has approval from the aviation site manager.

### **III. PROCEDURE**

All dedicated and relief pilots will demonstrate competency upon hire and through an on-going competency program which includes but may not be limited to:

- A. Part 135 Certificate Holders initial and ongoing training policies and standard operating procedures
- B. All Air Care & Mobile Care policies and relevant educational competencies as defined by the Program Clinical Developer and/or Clinical Manager
- C. All University of Cincinnati Medical Center policies and educational competencies that apply to hired contractors
- D. Air Care & Mobile Care Safety policies and competencies including the Post Accident/Incident Plan review and drills
- E. Equipment specific to Air Care & Mobile Care and University of Cincinnati Medical Center operations
- F. 50% of initial and ongoing flight training maybe done at night.
- G. Quarterly instrument proficiency training which includes Inadvertent Instrument Meteorological Conditions procedures.
- H. Annual simulator training.

### **IV. RESPONSIBILITY**

**Part 135 Certificate Holder, Lead Pilot(s), all dedicated and relief Pilots**

### **V. KEY WORDS**

**None**

### **VI. APPENDIX**

**None**

### **VII. REFERENCES / CITATIONS**

**None**

	<u>ACMC08</u>	
<b>POLICY NAME/#</b>	<b>Driver's competency, training and operations standards</b>	
<b>POLICY TITLE</b>	<b>Air Care and Mobile Care</b>	
<b>POLICY OWNER</b>	_____ Matt Gunderman/Director (Date) _____	
	_____ Dr. William Hinckley/Air Medical Director (Date) _____	
	_____ Dr. Liz Powell/Ground Medical Director (Date) _____	
<b>ADMINISTRATIVE APPROVAL</b>	_____ Jennifer Jackson/VP CNO (Date) _____	
<b>ORIGINATION DATE</b>	<u>2/2003</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>8/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>8/2018</b>

- I. POLICY**  
 Associates operating ambulances for UC Health will be trained in the safe operations of emergency vehicles in both emergency and non-emergency situations.
- II. PURPOSE**  
 To establish standards for training of EMT's, Paramedics and other authorized personnel to operate ambulances for UC Health. This is to enhance the safety of our patients, our associates and the general public.
- III. DEFINITIONS**
  - A. Authorized Drivers**
    - 1. Ambulances: Staff operating in the function of an EMT or Paramedic

**2. Non-Patient Care Vehicle(s): All other associates B. Staff driver authorization per job classification:**

- 1. Leadership**
- 2. Flight nurse**
- 3. MICU nurse**
- 4. Communication Specialist**
- 5. RN Coordinator**

#### **IV. PROCEDURE**

##### **A. Qualifications**

1. It is the responsibility of each associate to ensure that a current copy of his or her driver's license remains on file with their supervisor.
2. All associates driving any department vehicle must meet all requirements as set forth by the company that insures the vehicles.
3. Associate operating any department vehicle must complete all required annual driving competencies.

##### **B. Training of new authorized drivers**

1. As part of the new-hire orientation process, EMT's and Paramedics (and any other associates authorized to operate ambulances for UC Health) will receive a combination of classroom, practical and observational training of a minimum of 8 hours regarding emergency vehicle operations.
2. This will include review of class room materials such as Coaching the Experienced Driver, Emergency Vehicle Driver Training, VFIS drivers training or other formalized classroom components.
3. Drivers will demonstrate proficiency (and be checked by a preceptor) in operating ambulances in non-emergency driving
4. Drivers will demonstrate proficiency (and be checked by a preceptor) in operating ambulances in emergency driving situations.
5. Drivers are responsible to understand and comply with all local, state and UC Health rules, regulations, and policies related to operating an ambulance in emergency driving situations including the use of lights & sirens

##### **C. Annual retraining of authorized drivers**

1. As part of continual annual training; EMT's, Paramedics and other authorized personnel will receive a minimum of 2-hour review training in emergency vehicle operations
2. This will include a review of class room materials and practical skills demonstration

3. Demonstrate proficiency (and be checked by a preceptor) in operating ambulances in emergency and non-emergency driving
4. Drivers are responsible to understand and comply with all local, state and UC Health rules, regulations, and policies related to operating an ambulance in emergency driving situations including the use of lights & sirens

D. Acceptance of driver's education other than provided by UC Health

1. Ideally, all associates should complete both the written and practical drivers training as provided by UC Health.
2. An associate may satisfy the training/retraining requirements with training from an outside agency if the following criteria are met:
  - a) The driver's training is a minimum of 8 hours in length.
  - b) The driver's training is VFIS, EVOC, CEVO or another nationally recognized training program. Career fire departments training may be accepted at the discretion of leadership if all other criteria are met.
  - c) The driver's training certificate must be within 6 months of the date of hire, or the annual testing/training dates, as applicable.
  - d) Written documentation is provided to UC Health APMC.
  - e) The final decision to accept or reject outside agency training is solely at the discretion of leadership.

1. While all associates must be cognizant of the safety of a vehicle, the vehicles security is the primary responsibility of the driver. Any time the vehicle is left unattended, all compartments must be secured.
2. All vehicle occupants must use the appropriate safety devices. The drivers should assure all passengers are using the appropriate safety devices.
3. It is the driver's responsibility to evaluate its road-worthiness before every mission.
4. Any person operating or assigned as the crew on a department vehicle will be responsible for its cleanliness.
5. At any time, any associate riding in a department vehicle may request that the driver of that vehicle slow down and/or use safe driving practices. The driver is expected to comply with that request.
6. When it does not interfere with the delivery of patient care, a second associate shall assist the driver in backing the vehicle. The second associate shall exit the vehicle and direct the driver from a safe position near the rear of the vehicle.

7. It is expected that all associates report to duty well rested in order to complete the requirements of their shift. If an unsafe driving practice is observed, another associate authorized to drive that vehicle shall take over the driving responsibility and a supervisor on call should be notified. All associates are expected to report any unsafe or discourteous driving practices to the appropriate supervisor in a timely manner.
8. The vehicle driver must obey all local, state and federal motor vehicle laws and regulations when driving in either emergency or non-emergency conditions.
9. Any associate using an “over-the-counter” medication or a physician prescribed drug that could cause side effects such as drowsiness or slowing down of reflexes, must advise a supervisor and be cleared to work by Employee Health before operating a vehicle.
10. All associates need to be aware that electronic monitoring of driving habits, including hard stops, speeding, rapid acceleration may be used as a re-education and re-training tool.

F. Violations:

1. The following incidents must be reported to the associates’ immediate supervisor within twenty-four (24) hours of the time of occurrence:
  - a. All moving violations either in your own vehicle or a department vehicle.
  - b. Parking tickets received in a department vehicle.
2. The operator of the vehicle assumes responsibility for timely payment of all fines resulting from traffic violations which occur in department vehicles.
3. If an associate receives a moving violation, the points as set forth by the associates state of residency will be assessed against their driving privileges in driving departmental vehicles. The associate’s supervisor may require them to complete an Emergency Vehicle Driving Course as indicated.
  - a. Accumulation of two (2) points will result in a verbal counseling excluding other circumstances as listed in this procedure.
  - b. Accumulation of four (4) points will result in a written warning excluding other circumstances as listed in this procedure.
  - c. Accumulation of six (6) points will result in the loss of the privilege to drive departmental vehicles. Appropriate corrective action will result.

4. The UC Health will check each associates driving record annually. If any unreported violations are discovered, the associate may be placed into the appropriate level of corrective action based upon the nature of the violation and/or the number of accumulated points.

G. Discipline:

1. Disciplinary action up to and including termination of employment may result for any of the following occurrences:
  - a. Any accident in a department vehicle involving serious injury or fatality determined to be the vehicle operator's fault.
  - b. Not completing the accident packet (and incident report if indicated) prior to the end of their shift when involved in accident.
  - c. Use of a department vehicle by an individual without communication specialist or management approval.
  - d. Misuse of a department vehicle.
  - e. Operating any department vehicle with a suspended or revoked driver's license will result in termination. It is the operator's responsibility to inform a supervisor of any suspension or revocation of driving privileges before operating a vehicle and within twenty-four (24) hours of suspension or notice of revocation of driving privileges.
  - f. Not properly securing a department vehicle which results in theft or damage

**V. RESPONSIBILITY**

A. Generally: All Associates

B. Training

1. New Hire Orientation Training

- a) Video/Classroom portion will be scheduled as part of the associate's initial training, early in the orientation process.
- b) Practical observation will be conducted by orientation preceptors during the associate's orientation process.
- c) Classroom: To be scheduled by the educator/administrator/manager that schedules the new associate's orientation. Practical: Associate will work with preceptors to ensure that time/forms are complete.

2. Annual Training

- a) Incorporated into the regular education cycle, with any practical evaluations being scheduled annually with safety committee members who will complete forms indicating competency.

VI. KEY WORDS

**None**

VII. APPENDIX **None**

VIII. REFERENCES / CITATIONS **None**

	<u>ACMC07</u>	
<b>POLICY NAME/#</b>	<u>Clinical Competency</u>	
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>	
<b>POLICY OWNER</b>	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Elizabeth Powell MD/Ground Medical Director (Date)	
<b>ADMINISTRATIVE APPROVAL</b>	_____ Jennifer Jackson/VP CNO (Date)	
<b>ORIGINATION DATE</b>	<u>11/2001</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>8/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>8/2018</b>

- I. POLICY**  
 Associates will be required to demonstrate core proficiency skills relevant to their job description. Assessment and validation of Clinical Competency is necessary to assure all staff are performing a level consistent with Air Care & Mobile Care (ACMC) expectations and in accordance with the Commission on Accreditation of Medical Transport systems (CAMTS) requirements.
  
- II. PURPOSE**  
 To provide guidelines and expectations of clinical competency for ACMC personnel
  
- III. DEFINITIONS**  
 None

#### IV. PROCEDURE

Competency program includes:

- A. Initial Competency: Assessed at the time of hire. Includes license/certification validation, work history, reference checks and in-person interviews by Human Resources and the hiring manager or their designee.
  
- B. Orientation: Hospital based orientation includes:
  - 1. General orientation initiated and managed by The University of Cincinnati Medical Center Staff Development.
  - 2. Department orientation initiated and managed by the transport program. An orientation document is used to measure progress of the new transport associate. The hiring manager and/or clinical program developer will monitor their progress and records are maintained in the new associate's personnel file.
  
- C. Continuing Competency: Multi-dimensional and includes:
  - 1. License/certification verification annually during performance review (at minimum)
  - 2. Specific competencies:
    - a) Core, as defined by The University of Cincinnati Medical Center in compliance with hospital regulatory entities.
    - b) Departmental, specific to job description, scope of practice and CAMTS.
    - c) Paid clinical days will be provided (to be determined by program clinical developer)
  
- D. All associates will demonstrate their proficiency in providing care. In the event an associate has not shown adequate proficiency in a required skill, individualized training will be provided. Failure to master the required skills will result in being removed from duty until deemed proficient by the appropriate supervisor.
  
- E. Associates will be held accountable for attending all pre-scheduled classes (BLS, PALS, ACLS, NRP, TNCC or their equivalent or self-scheduled classes (courses required by the department).
  - 1. If an associate must cancel attendance, 48-hour notice must be given prior to the course.
  - 2. If an associate is a "no call-no-show" the above will apply and failure to attend is considered an absence.

**V. RESPONSIBILITY**  
All Team Members

**VI. KEY WORDS**  
None

**VII. APPENDIX** None

**VIII. REFERENCES /  
CITATIONS**  
None



**None**

**IV. PROCEDURE**

- A.** When the flight nurse is in a patient care situation without a physician or is unable to reach medical control, the Air Care and Mobile Care Medical Policies may be used as a guide for practice.
  
- B.** In order to function under these protocols, the flight nurse must demonstrate competency in performing the following procedures:
  - 1.** Pericardiocentesis
  - 2.** Intraosseous needle placement
  - 3.** Needle thoracostomy
  - 4.** Tube thoracostomy
  - 5.** Finger thoracostomy
  - 6.** Needle cricothyrtotomy
  - 7.** Surgical cricothyrtotomy
  
- C.** The flight nurse will attend and successfully complete the Transport Nurse Advanced Trauma Course (TNATC) and/or an approved equivalency course.

**V. RESPONSIBILITY**

**VI. KEY WORDS**

**None**

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS**

**None**

	ACMC09
POLICY NAME/#	Use of Simulators for Clinical Education
POLICY TITLE	Air Care and Mobile Care
POLICY OWNER	_____ Matt Gunderman/Director (Date)
	_____ Dr. William Hinckley/Air Medical Director (Date)
	_____ Dr. Elizabeth Powell/Ground Medical Director (Date)
ADMINISTRATIVE APPROVAL	_____ Jennifer Jackson/VP CNO (Date)
ORIGINATION DATE	6/2002
<b>LAST REVISION/ REVIEW DATE</b>	<b>NEXT REVIEW DATE</b>
8/2017 12/2016	8/2018 12/2017

- I. POLICY  
In conjunction with clinical time in the appropriate units and didactic education, human patient stimulation will be used to train and verify clinical skills competency and critical thinking skills.
- II. PURPOSE  
To outline the skills and patient care populations that can use human patient simulation for education.
- III. DEFINITIONS  
None
- IV. PROCEDURE

A. A dynamic human patient simulator may be used for the following clinical skills:

1. Advanced Airway Management
2. Needle Decompression
3. Chest Tube Insertion
4. Needle Cricothyrtotomy
5. Surgical Cricothyrtotomy
6. Pericardiocentesis
7. Pediatric Respiratory Failure
8. Pediatric Cardiopulmonary Arrest
9. Pediatric Invasive Skills
10. Birthing skills
11. Ultrasound
12. IABP Management
13. Vent Management
14. Rapid Sequence Intubation (RSI)
15. ECMO
16. Impella

B. The pediatric simulator at Children’s Hospital, TriHealth or UCMC EM Sim Center can be used for any pediatric case scenarios that would involve a simulator. This experience can be arranged through the Emergency Medical Services for Children Education at Cincinnati Children’s Hospital Medical Center, TriHealth Center for Simulation & Education or EMS at UCMC.

C. Approved human patient simulators can be used for adult invasive skills practice.

D. Training is on an annual basis or as directed by the clinical director or their designee, medical director or the individual transport associate

E. All scenarios that are to be used as a replacement for a clinical experience for competency evaluation will be reviewed and approved by the CAMTS board.

**V. RESPONSIBILITY**

**Flight Physicians, Advanced Practice Nurse, Critical Care Transport Nurses, EMT-P and EMT**

**VI. KEY WORDS**

**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS**

**None**

	<u>ACMC06</u>	
<b>POLICY NAME/#</b>	<b>Certification and Licensure</b>	
<b>POLICY TITLE</b>	<b>Air Care and Mobile Care</b>	
<b>POLICY OWNER</b>	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Dr. Elizabeth Powell/Ground Medical Director (Date)	
<b>ADMINISTRATIVE APPROVAL</b>	_____ Jennifer Jackson/VP CNO (Date)	
<b>ORIGINATION DATE</b>	11/2001	
<b>LAST REVISION/ REVIEW DATE</b>	6/2017	<b>NEXT REVIEW DATE</b> 6/2018

**I. POLICY**

In effort to maintain minimal professional competencies, all transport associates are responsible for keeping all licenses and certifications, according to their job description, current and on file within the department.

**II. PURPOSE**

TO PROVIDE AN OUTLINE OF THE COMPETENCY REQUIRED FOR POSITIONS AT AIR CARE & MOBILE CARE (ACMC) AND HOW VERIFICATION OF CERTIFICATION AND LICENSURES WILL BE DETERMINED AND TRACKED.

**III. DEFINITIONS**

None

#### IV. PROCEDURE

- A. The associate is responsible to maintain required licenses and or certifications. The associate is responsible to maintain required valid and current licenses and/or certifications. State licensure other than primary state of employment will be reimbursed if required per job description.
- B. National certification for mobile intensive care nurses and critical care paramedics must be achieved within 2 years of employment. Flight nurses must have certification upon hire.
- C. Primary source verification will be completed by the UCMC Human Resources upon hire and again with renewal of the license/certification. Periodic review of licenses and/or certifications will be conducted by the clinical director, or designee. Associates who are found to have expired licenses and/or certifications will be removed from duty and placed on an unpaid administrative leave until such time as re-licensure and/or recertification may be validated. In accordance with the Standards of Performance and Conduct policy associates will receive corrective action up to and including termination. Deficiencies or questions about the validity of a license and/or certification will be reported to the appropriate State Agency, as required by law.
- D. The department pays the associates' hourly rate for:
  - 1. The department will assist with the continuing education requirements by providing all staff with twenty-four (24) education hours per calendar year with pay which includes work related meetings, conferences, conventions, and Hospital approved distance learning courses. Associates must obtain approval from their supervisor prior to use of these hours and must also submit proof of attendance (i.e. CEU certificate) within 14 days of attendance.
  - 2. Hospital or department mandatory education will not be counted toward the twenty-four hours per calendar year with pay.
  - 3. The department will provide staff the opportunity to attend mandatory education programs as defined by the unit specific competencies free of charge. These include but are not limited to BLS, ACLS, PALS, NRP, TNCC/TNATC or their equivalent, NAACS, MTEC. Staff will be paid their hourly rate for the time spent in class taken at UCMC. Classes that are not offered at UCMC must be preapproved by associate's supervisor.

4. Required annual competency days (clinical and safety)
5. Teaching educational classes to department staff if not being reimbursed by the class' sponsoring agency and if approved in advance by the clinical director.
6. A minimum of 16 hours of clinical rotations per year in areas approved by clinical director or their designee. If associates feel they need additional clinical time, it must be approved by the clinical director.
7. Hospital will reimburse up to \$350 the cost of one certification exam or one recertification to an active clinician regularly scheduled .5 FTE or above per year. If certification is mandatory per job description, the department will pay the full cost for successfully completing the exam to all staff. The certification must be in the clinician's current area of practice and approved by management. The associate must conduct a mutually agreed upon education presentation within 12 months following certification.

- E. The department does not reimburse for:  
Review classes, unless taken as part of associates' 24 hours referred to in section 4.a.

**V. RESPONSIBILITY**  
All Transport Team Associates

**VI. KEY WORDS**  
None

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS** None



C. In an effort to maintain adequate supply inventory, the stockroom shall be checked and restocked weekly by an assigned associate. D. Ambulance:

1. Locked cabinets/bags: seal numbers are recorded on the vehicle checklist
2. Unlocked cabinets/bags: equipment and supplies are checked for adequate amounts and good function.
3. Engine/Electronics/Fuel: Drivers will evaluate and record the items listed on the vehicle checklist to ensure safe operation.
4. Upon completion of the weekly vehicle checks, the crew will scan to acmc-equipment@UCHealth.com. If, due to a pending run, this is not practical, the form will be turned in as soon as possible.
5. Vehicle will be plugged in at the end of shift or as needed to ensure all rechargeable equipment stays fully charged. Equipment should be checked by transport team to insure that they are appropriately charging.

E. Aircraft:

1. Documentation of aircraft checks must be placed in the appropriate designated area.
2. Aircraft will be plugged in at the end of shift or as needed to ensure all rechargeable equipment stays fully charged. Equipment should be checked by transport team to insure that they are appropriately charging.

F. Equipment:

1. Rechargeable equipment will be plugged in at all times when not in use. Equipment should be checked by the transport team to insure that they are appropriately charging.
2. Any equipment that is not functioning properly will be labeled with the appropriate clinical tag with the date and nature of the problem clearly written out. This equipment will be taken to clinical engineering by the team discovering the problem and/or designated personnel. In the event that the clinical engineering department is closed, the team shall leave the equipment in the designated "broken equipment" location and inform the supervisor-on-call and communication specialist if lack of equipment will jeopardize clinically safe patient transport.
3. Damaged or lost equipment will be brought to the attention of the base supervisor and/or administrator on call immediately.
4. Equipment will be tested and maintained by clinical

engineering staff in accordance with their standard policy and procedure. Cots, stair chairs, and monitor stands will be inspected once a month by an assigned associate who has received the appropriate training.

G. Ambulances:

1. Base Operations Supervisor or their designee will post vehicle assignments based on established guidelines.
2. A thorough ambulance inventory will be completed each shift by an assigned associate.
3. Vehicle inspection and maintenance, supply and equipment records will be maintained and monitored by the base supervisor(s) or their designee.

H. Survival Kits:

1. All vehicles will carry a survival kit intended to be used in case of an emergency. The survival kits will be reviewed by staff at a minimum annually. The contents of the kits will be checked at a minimum of annually for expiration and damaged contents by Chair of the safety committees (air and ground). Expired or damaged contents will be replaced by the committee chair or their designee. If during a routine equipment and supply checks an associates discovers damaged contents, the base supervisor must be informed.

- I. Disciplinary Action -Failure to comply to department policy may result in disciplinary action.

**II. RESPONSIBILITY**

All Team Members

**III. KEY WORDS**

None

**IV. APPENDIX** None

**V. REFERENCES / CITATIONS**

None

	<u>ACMC16</u>	
<b>POLICY NAME/#</b>	<u>Equipment: Communication Equipment Failure</u>	
<b>POLICY TITLE:</b>	<u>Air Care and Mobile Care</u>	
<b>POLICY OWNER</b>	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
	Dr. William Hinckley/Air Medical Director	(Date)
<b>ADMINISTRATIVE APPROVAL</b>	_____	_____
	Jennifer Jackson/VP CNO	(Date)
	_____	_____
<b>ORIGINATION DATE</b>	<u>11/2001</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>7/2018</b>

- I. **POLICY**  
 In the event that the communication center equipment has a failure that interferes with safe operations, alternative devices will be used to ensure patient and crew safety.
- II. **PURPOSE**  
 The Air Care and Mobile Care Service associates will follow the guidelines listed below in the event of communication equipment failure.
- III. **DEFINITIONS**  
 None
- IV. **PROCEDURE**

- A. Nextel radio/cell phone outage secondary to tower outage, individual radio/cell phone failure.
  - 1. Communicate via pager, radio/cell phone, vehicle radio, or landline phone.
  
- B. Alphanumeric paging system outage secondary to tower outage, individual pager failure or computer failure:
  - 1. Communicate via Nextel, cell phone, vehicle radio or landline phone.
  
- C. The University of Cincinnati Medical Center radio system outage secondary to tower outage, individual radio failure, base station failure:
  - 1. Communicate via Nextel, pager, cell phone or landline phone.
  
- D. Any Communication Equipment Failure: The team or communication specialist will contact the supervisor on call to initiate the appropriate repair process.

**V. RESPONSIBLE**  
All Team Members

**VI. KEY WORDS**  
None

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS**  
None

	<u>ACMC17</u>
<b>POLICY NAME/#</b>	<u>Equipment: Cot and Stair Chair Safety Operation Guidelines</u>
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>
<b>POLICY OWNER</b>	<p>_____ (Date)</p> <p>Matt Gunderman/Director</p> <p>_____ (Date)</p> <p>Dr. William Hinckley/Air Medical Director</p> <p>_____ (Date)</p> <p>Dr. Liz Powell/Ground Medical Director</p>
<b>ADMINISTRATIVE APPROVAL</b>	<p>_____ (Date)</p> <p>Jennifer Jackson/VP CNO</p>
<b>ORIGINATION DATE</b>	<u>11/2001</u>
<b>LAST REVISION/ REVIEW DATE</b>	<b>NEXT REVIEW DATE</b>
<b>7/2017</b>	<b>7/2018</b>

**I. POLICY**

Cots and stair chairs are integral part of safe patient transport and operations. To ensure patient and crew safety proper training and education will be completed and authorized personnel will be required to demonstrate competency and knowledge of the device.

**II. PURPOSE**

In an effort to ensure the overall safety of the patient and the transport associates, the following guidelines shall be used when transporting a patient with a cot or stair chair.

**III. DEFINITIONS**

None

#### **IV. PROCEDURE**

Cot and Stair Chair:

Refer to the Bariatric Policy in regards to the transport of bariatric patients and the proper equipment to use.

- A. All cots and stair chairs shall have a load/capacity limit posted on them by the safety committee chairperson.
- B. No transport associate shall utilize a cot or stair chair to transport a patient that exceeds the rated limit for that device.
- C. All patients shall be secured to the device(s) with all the appropriate securing devices. Patients transported on a stretcher shall be restrained with a minimum of three cross straps and a shoulder harness restraint. Cross Straps are expected to restrain the patient at the chest, hips, and knees.
- D. Cot and stair chairs require at least two (2) transport associates for proper operations.
- E. The Power Flexx Cot, large Body Surface Board (LBS) and the Ramp System/ Lift System can be used to accommodate bariatric patients up to 1,000 lbs. or when the crew deems it necessary for the safe transport of a bariatric patient. An additional crew should be used when the Power Flexx cot is used with the LBS.
- F. The Air Care and Mobile Care Transport Service recognizes that, on rare occasions, patients who exceed the cot weight limits will require ambulance transport. In these cases, a supervisor will be notified and transportation arrangements will be made with consideration given to all available resources.
- G. All equipment on the cot (i.e. monitors, brackets, bottles, etc.) must be taken into consideration when calculating the total load limit.

#### **V. RESPONSIBILITY**

**All Mobile Care Team Members, Communication Specialists**

#### **VI. KEY WORDS**

**None**

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS**

None



#### **IV. PROCEDURE**

- A. All equipment used for patient care will be monitored and maintained according to the UC Health Policies and Procedures for Clinical Engineering.
- B. If an associate finds a piece of equipment with an expired Clinical Engineering routine maintenance tag, they are responsible for taking the equipment out of service and notify his/her supervisor who will contact Clinical Engineering.

#### **C. Initiating Repair/Replacement of Malfunctioning Equipment:**

- 1. Any equipment that is found to not be functioning properly will be labeled with the appropriate clinical tag with the date and nature of the problem clearly written out.
- 2. Damaged or lost equipment shall be brought to the attention of the management team immediately.
- 3. Equipment broken in the aircraft (i.e. headsets) shall be brought to the attention of the pilot on duty. The pilot will determine the need to call the mechanics during off hours for repair purposes.
- 4. Equipment broken on an ambulance shall be reported to the communication specialist and the base operations supervisor and/or on call supervisor.
- 5. Cots, stair chairs, and monitor stands will be inspected once a month by an assigned associate who has received the appropriate training.

#### **D. Retrieval of Equipment:**

- 1. Every effort should be made by the transport team members to assure that all equipment used during patient transport is retrieved and returned at the completion of the transport. However, if a piece of equipment is left at a referring institution or at a scene, the involved personnel should be notified and arrangements made for the return of the equipment as soon as possible.
- 2. Equipment that must be kept with the patient, but belongs to the referring facility will be cleaned and sent back as soon as possible.

#### **V. RESPONSIBILITY**

**All Transport Team Members**

#### **VI. KEY WORDS**

**None**

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS**

**None**

	<u>ACMC19</u>	
<b>POLICY NAME/#</b>	<b>Equipment - On-Board Vehicle Medical Equipment Malfunction During Patient Care</b>	
<b>POLICY TITLE</b>	<b>Air Care and Mobile Care</b>	
<b>POLICY OWNER</b>	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Dr. Liz Powell/Ground Medical Director (Date)	
<b>ADMINISTRATIVE APPROVAL</b>	_____ Jennifer Jackson/VP CNO (Date)	
<b>ORIGINATION DATE</b>	<u>11/2001</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>7/2018</b>

**I. POLICY**

In the event of on-board medical equipment malfunction, specific actions will be taken to ensure patient safety and continuity of care.

**II. PURPOSE**

To provide guidelines for the alternative equipment to use in the event of a medical equipment failure with patient on board.

**III. DEFINITIONS**

None

#### **IV. PROCEDURE**

- A. In the event of on-board medical equipment malfunction, patient needs will be met by use of portable/manual equipment with constant patient observation and assessment.
  - 1. Wall Suction: use portable battery powered suction unit, or hand-held device.
  - 2. Wall Oxygen: use portable oxygen tanks.
  - 3. Cardiac Monitor: take frequent vital signs and constantly observe patient.
  - 4. Infusion Pump: use backup pump.
  - 5. Ventilator: use bag valve ventilation.
  - 6. Bariatric unit (see Bariatric patient policy) – winch failure – use manpower to push cot safely into unit. Request additional manpower to load and unload.
  - 7. Bariatric Unit (see Bariatric patient policy)- Lift failure- Use manual hydraulic pump to lower lift safely, use extra manpower to load patient safely. Request additional manpower to load and unload.
  
- B. Upon completion of patient care, the malfunction will be reported immediately to the communication specialist and the base operations supervisor and/or administrator on call who will initiate corrective repair measures. The unit will be deemed out of service until replacement equipment has been issued.
  
- C. Incident report (MIDAS) must be completed at the appropriate time and submitted to risk management.
  
- D. Handling non-functioning equipment: refer to equipment maintenance policy

#### **V. RESPONSIBILITY** All Team Members

#### **VI. KEY WORDS** None

#### **VII. APPENDIX** None

#### **VIII. REFERENCES / CITATIONS** None



#### **IV. PROCEDURE**

Air Care: Radios/department provided cell phone are to be worn and turned on at all times by transport team associates during their shift. Back-up physicians will wear pager.

Mobile Care: Portable radios/pagers/department provided cell phones will be picked up at the beginning of their shift and kept in the truck at all times.

Each transport team associate shall:

- A. Pick up radio at the beginning of their shift. (Pilot's radios are located in pilot's quarters and Mobile Care radios are kept in the garage or other designated area)
- B. Assure that the radio is on and turned to the appropriate channel if applicable.
- C. Check if the battery is functioning.
- D. Adjust volume sufficiently to hear transmissions appropriate to the environment (i.e. scenes vs. communication center).
- E. Acknowledge all transmissions (ex: "flight nurse copies", "Medic 10 copies", "MICU 3 in route").
- F. Charge radios once every twelve (12) hours or when unit indicates low battery:
  1. Place in charger at approved location
  2. Remove immediately when charge light turns green
- G. Report problems with radios to communication specialist and operations supervisor.

#### **V. RESPONSIBILITY**

#### **VI. KEY WORDS**

None

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS**

None



- A. No medical personnel shall:
  - 1. Report to work if alcohol has been consumed within 12 hours prior to being on duty.
  - 2. All hospital policies and procedures regarding drug and alcohol usage apply (refer to UC Health Drug and Alcohol Use policy.)
  - 3. Perform flight duties within 72 hours after a blood donation.
  - 4. Fly with an upper respiratory infection causing congestion of sinuses and ears that prevents the person from equalizing the pressure in their ears.
  
- B. All vendor employees shall follow the vendor's policy and procedure and the appropriate Federal Aviation Regulations on drug and alcohol usage.
  
- C. Flight Team: The height and weight limitations of Air Care flight personnel are based on aircraft performance. The Clinical Director and Metro Area Site Manager are responsible to determine the limitation and then work collaboratively with Human Resources to address.

**V. RESPONSIBILITY**

**All Transport Personnel and Communication Specialists**

**VI. KEY WORDS**

None

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS**

None

	ACMC23	
POLICY NAME/#	On Duty/Rest Times	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
	Dr. William Hinckley/Air Medical Director	(Date)
	_____	_____
	Dr. Elizabeth Powell Ground Medical Director	(Date)
ADMINISTRATIVE APPROVAL	_____	_____
	Jennifer Jackson/VP CNO	(Date)
ORIGINATION DATE	11/2001	
LAST REVISION/ REVIEW DATE	10/2017	NEXT REVIEW DATE 10/2018

**I. POLICY**

Clinical staff plays an important role in maintaining not only their own safety but also that of their colleagues, their patients and the general public. Recognizing the safety threat posed by fatigue, maximum on-duty and minimum off-duty time measures will be implemented to help ensure adequate rest.

**II. PURPOSE**

To provide guide lines for safe operations in regards to fatigue mitigation and duty time.

**III. DEFINITIONS**

**On Duty Time:** All time from when a person begins work, or is required to be in readiness to work, until the time he/she is relieved from duty and its responsibilities.

**Clinical Staff:** All associates working in a clinical position and/or driving a department vehicle. This includes transport APN's, RN's (Air & Mobile), Paramedics (Critical Care, Transport and Special Event), EMT's (Transport) and Communication Specialists (RN Coordinators, Air Care Dispatchers and Mobile Care Dispatchers).

#### **IV. PROCEDURE**

- A. **Maximum On-Duty Time:** Air Care & Mobile Care shall make every effort to assure employees do not remain on-duty past sixteen (16) hours. In cases where a patient transport or department operations will extend >16 hours the Air Care & Mobile Care On-Call Administrator will be contacted for prior approval. Other exceptions to the maximum on-duty time requirements are in the event of a disaster.
- B. **Minimum Rest Time:** All clinical and communication center associates are expected to have at least ten (10) hours of rest with no work-related interruptions prior to any scheduled shift of twelve (12) hour or prior to any on-call shifts.
  - 1. These expectations are intended to preclude back-to-back shifts with other employment or significant fatigue-causing activity prior to an on-duty shift. This minimum rest time pertains to hours off-duty from within the department as well as with other employment.
  - 2. Exceptions to the minimum rest requirements may be necessary in the event of a disaster.
  - 3. After attending an educational program or meeting or performing departmental office work, the associate must be off the clock a minimum of ten (10) hours before reporting to a clinical shift.
- C. In the event that a medical crew member or their partner determines that they or a team member is unfit for duty due to fatigue and is deemed unsafe, that associate or their team member can initiate a "time out". Once that is done, the administrator on call must be notified immediately to assess the situation and determine if the associated should be granted a reasonable rest period or released from duty. There will be no adverse personnel action or undue pressure to continue to work regardless of the shift length.
- D. Management will monitor closely the use of a time- out. Review of personnel, reason for "time out", number of transport completed by personnel and impact on transport volume will be documented.

**V. RESPONSIBILITY**  
All Clinical Staff

**VI. KEY WORDS**  
None

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS** None

	<u>ACMC43</u>	
<b>POLICY NAME/#</b>	<b>Pregnancy Policy for Air Care and Mobile Care Transport Team Members</b>	
<b>POLICY TITLE</b>	<b>Air Care and Mobile Care</b>	
<b>POLICY OWNER</b>	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Dr. Liz Powell/Ground Medical Director (Date)	
<b>ADMINISTRATIVE APPROVAL</b>	_____ Jennifer Jackson/VP CNO (Date)	
<b>ORIGINATION DATE</b>	<u>2/2003</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>7/2018</b>

**I. POLICY**

All transport team members will follow established procedures to ensure a safe transport environment for patients and associates. ACMC supports a collaborative effort to ensure the safety of all pregnant associates. Frequent assessment of job related tasks will be done with clear communication with the patient’s personal health care provider and UC Health.

**II. PURPOSE**

**III. DEFINITIONS**

None

**IV. PROCEDURE**

- A. Pregnant associates will be monitored through UC Health Employee Health Department, consistent with UC health policy and procedure and in compliance with the Family and Medical Leave Act (FMLA). The decision to discontinue or limit transport duties will be made in cooperation with the transport associate, their primary obstetrical care provider, UC Health Employee Health and departmental management.
  
- B. The transport associate has several responsibilities to ensure maternal and fetal well-being:
  - 1. To notify their manager of the pregnancy.
  - 2. To notify their primary obstetrical care provider of their transport functions to determine the safety of those functions while pregnant.
  - 3. To update regularly their primary obstetrical care provider of their ability to function in the transport environment.
  - 4. To update their manager and Employee Health, regularly, of the recommendations from their primary obstetrical care provider concerning the continuation of transport duties.
  - 5. To make sure transport vehicle seat belts fit securely. If seat belts do not fit, the associate is responsible to notify her manager.
  - 6. Proper transport attire must be maintained at all time during pregnancy. Associate must contact management if current uniforms cannot be worn as issued. If needed, alternate accommodations will be made to ensure safety of the transport associate.
  - 7. If associate cannot perform job related duties, accommodations will be made in accordance to UC Health FMLA policy and guidance of Employee Health.

**V. RESPONSIBILITY**

**All Air Care and Mobile Care Transport Team Members**

**VI. KEY WORDS**

**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS**

**None**

	AC18
POLICY NAME/#	Position of Flight Crew Members During Flight
POLICY TITLE	Air Care and Mobile Care
POLICY OWNER	<hr/> Matt Gunderman/Director (Date) _____ <hr/> Dr. William Hinckley/Air Medical Director (Date) _____ <hr/> Bob Francis, Manager Metro Aviation (Date) _____
ADMINISTRATIVE APPROVAL	<hr/> Jennifer Jackson/VP CNO (Date) _____
ORIGINATION DATE	9/1999
LAST REVISION/ REVIEW DATE	10/2017
	NEXT REVIEW DATE
	10/2018

I. POLICY

To promote safety and environmental awareness, the flight nurse will occupy the left front seat during out-bound flights. The purpose of this is to put the most experienced person in the front to assist the pilot.

II. PURPOSE

To provide guide lines on location of crew members in the helicopter. The decision of crew location is the responsibility of the pilot in command. The PIC will take into consideration aircraft performance, safety, the experience of the crew, the need to develop front seat tasks with less experienced crew and the need for night vision goggles.

### **III. DEFINITIONS**

**PIC-Pilot in Command**

### **IV. PROCEDURE**

- A. In order to facilitate the medical crew member building an extensive knowledge of the local flying area, the medical crew member will occupy the left front seat of the aircraft during out-bound flights to assist new pilots, develop less experienced crew and increase program safety.
- B. The decision related to where the flight team members may sit should be made by the pilot in command.
- C. In the event that dual controls are placed in the aircraft, pilot in command will follow the vendor's general operations manual.

### **V. RESPONSIBILITY**

**Pilot, Medical Crew Member**

### **VI. KEY WORDS**

**None**

### **VII. APPENDIX None**

### **VIII. REFERENCES / CITATIONS**

**None**

	<u>AC19</u>	
POLICY NAME/#	<u>Flight Priority</u>	
POLICY TITLE	<u>Air Care and Mobile Care</u>	
POLICY OWNER	_____	
	<u>Matt Gunderman/Director</u>	<u>(Date)</u>
	_____	
	<u>Dr. William Hinckley/Air Medical Director</u>	<u>(Date)</u>
	_____	
	<u>Bob Francis, Manager Metro Aviation</u>	<u>(Date)</u>
	_____	
ADMINISTRATIVE APPROVAL	<u>Jennifer Jackson/VP CNO</u>	<u>(Date)</u>
ORIGINATION DATE	<u>9/1999</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>	
	<b>NEXT REVIEW DATE</b>	
	<b>7/2018</b>	

**I. POLICY**

Once a flight has been initiated, only in very extreme circumstances can an aircraft be diverted to another flight request. The goal is to provide the safest and timeliest response to a critically ill or injured patient. Understanding that changing missions after activation increases a risk of error, there may be a logical need to do so.

**II. PURPOSE**

To provide guidelines when an aircraft activated for a flight request can be diverted to another flight request.

### **III. DEFINITIONS**

#### **PIC-Pilot in Command**

### **IV. PROCEDURE**

- A. Once a transport request has been accepted and flight crew activated, that flight has priority over any other flight requests unless diverted by the Emergency Medicine faculty physician, medical director or with permission of the sending physician of the original transport.
  - 1. Flight diversion should only occur for reasons of safety or clinical care needs.
- B. Typically, the priority of calls is ranked by order the call was taken.  
Additional consideration for transport priority:
  - 1. Scene
  - 2. From a non-hospital (free-standing emergency care center, etc.)
  - 3. From an emergency department
  - 4. From an in-patient facility
  - 5. Stand-by
- C. An activated flight will only be diverted if the following requirements are met:
  - 1. The second request has an equal or higher priority than the first request.
  - 2. The helicopter has not yet arrived at the location of the first request.
  - 3. The helicopter is located within a reasonable distance of the second requester's location.
  - 4. Pilot-in-command has accepted the request to divert to a different location in agreement with air vendor's operational control center.  
The Pilot-in-command is the final authority on diversion.

### **V. RESPONSIBILITY**

**Communications Specialist, Flight Nurse, Flight Physician, Flight APN, Pilot**

### **VI. KEY WORDS**

None

### **VII. APPENDIX None**

### **VIII. REFERENCES / CITATIONS**

None

	<b>AC20</b>	
<b>POLICY NAME/#</b>	<b>Flight- Transport Alternatives In The Event The Aircraft Must Use Alternate Landing Facilities Due To Deteriorating Weather/Mechanical Problems Or For Any Diverted Flight</b>	
<b>POLICY TITLE</b>	<b>Air Care and Mobile Care</b>	
<b>POLICY OWNER</b>	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Bob Francis, Manager Metro Aviation (Date)	
<b>ADMINISTRATIVE APPROVAL</b>	_____ Jennifer Jackson/VP CNO (Date)	
<b>ORIGINATION DATE</b>	4/2003	
<b>LAST REVISION/ REVIEW DATE</b>	7/2017	<b>NEXT REVIEW DATE</b> 7/2018

- I. **POLICY**  
 Alternate transport arrangements must be made whenever weather deteriorates, patient safety issue or mechanical problems require the aircraft to land at an alternate landing zone.
- II. **DEFINITIONS**  
 None
- III. **PROCEDURE**

- A. The pilot will inform the communication specialist of the need to make this precautionary landing.
- B. The communication specialist will initiate the precautionary landing procedures outlined in the Post Accident/Incident Plan-Precautionary Landing.
- C. Alternate method of transportation will be arranged by the communication specialist using the best available alternative, local squad, private contractor, or Air Care & Mobile Care (ground/air).
  - 1. The flight team will continue to provide patient care until the patient is transferred to the receiving facilities personnel.
  - 2. The flight team will communicate with the communication specialist according to the "Ground Ambulance Tracking and Communication" policy.
  - 3. If direct contact with the communication center is not available by Air Care radios, an alternate form of communication should be utilized.

**IV. RESPONSIBILITY**  
**Pilot, Communication Specialist, Flight team**

**V. KEY WORDS**  
**None**

**VI. APPENDIX** **None**

**VII. REFERENCES / CITATIONS**  
**None**

	ACMC03
POLICY NAME/#	Transport of Patient Belongings
POLICY TITLE	Air Care and Mobile Care
POLICY OWNER	<p>_____ (Date)</p> <p>Matt Gunderman/Director</p> <p>_____ (Date)</p> <p>Dr. William Hinckley/Air Medical Director</p> <p>_____ (Date)</p> <p>Dr. Elizabeth Powell/Ground Medical Director</p>
ADMINISTRATIVE APPROVAL	<p>_____ (Date)</p> <p>Jennifer Jackson/VP CNO</p>
ORIGINATION DATE	11/2001
<b>LAST REVISION/ REVIEW DATE</b> <b>8/2017</b>	<b>NEXT REVIEW DATE</b> <b>8/2018</b>

**I. POLICY**  
Patient belongings will be transported in such a manner to provide safety to all patients and transport associates and to minimize risk of exposure to infectious disease or hazardous materials.

**II. DEFINITIONS**  
None

### **III. PROCEDURE**

- A. Patient belongings may accompany a patient to their destination provided the belongings are not believed to be contaminated by infectious disease or hazardous materials. Belongings must be stowed properly (i.e. wheelchairs, walkers etc.). When appropriate, the transport associates should encourage a family member or significant other to transport patient belongings.
- B. All belongings will be searched by appropriate personnel (ACMC personnel and/or referring facility staff/security) to ensure no weapons are present. If any questionable substance, material or objects are found which brings about safety concerns, those items will be left with the patient's referring staff. If this situation arises, the staff accepting the patient at the receiving facility will be informed of the situation. These events shall be reflected in the event log of the electronic medical record.
- C. All patient belongings that accompany the patient will be documented in the valuables section of the electronic medical record.
- D. Personal patient items must be secured inside the transport vehicle or in an outside compartment.
- E. Questions about missing items should be directed to the appropriate departments (i.e. patient relations)

### **IV. RESPONSIBILITY**

#### **V. KEY WORDS**

None

#### **VI. APPENDIX None**

#### **VII. REFERENCES / CITATIONS**

None

	<u>ACMC28</u>	
<b>POLICY NAME/#</b>	<u>Department Staff Meetings</u>	
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>	
<b>POLICY OWNER</b>	_____	
	<u>Matt Gunderman/Director</u>	<u>(Date)</u>
	_____	
	<u>Dr. William Hinckley/Air Medical Director</u>	<u>(Date)</u>
	_____	
	<u>Dr. Liz Powell/Ground Medical Director</u>	<u>(Date)</u>
<b>ADMINISTRATIVE APPROVAL</b>	_____	
	<u>Jennifer Jackson/VP CNO</u>	<u>(Date)</u>
<b>ORIGINATION DATE</b>	<u>7/1999</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<u>7/2017</u>	<b>NEXT REVIEW DATE</b> <u>7/2018</u>

- I. **POLICY**  
In an effort to facilitate communication and address any patient care issues and/or hospital or department needs; all transport personnel are responsible for attending scheduled mandatory meetings.
- II. **PURPOSE**  
To provide guidelines for the expectations of participation and involvement in department- sponsored meeting.
- III. **DEFINITIONS**  
None

**IV. PROCEDURE**

- A. All meetings will be scheduled as needed and the date/time communicated in a timely manner.
- B. Attendance at the Department Staff Meeting is mandatory. If unable to attend, arrangements must be made to obtain information discussed. The Administrative Assistance will monitor attendance.
- C. Meeting agendas include but are not limited to the following topics:
  - 1. Program updates:
    - a) Program Development
    - b) Policies/Procedures/protocol updates
    - c) Supply/equipment Updates
    - d) Aviation/Ground vehicle updates
  - 2. Quality Assurance: case reviews/indicator compliance
  - 3. Discussion of any concern expressed by group/Safety Concerns/MIDAS
  - 4. In-service education session/education committee update
  - 5. Reports from department/hospital committees
- D. Failure of an associate to attend designated mandatory meetings will be noted in their annual performance appraisal.

**V. RESPONSIBILITY**

**All Transport Team Associates**

**VI. KEY WORDS**

**None**

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS**

**None**



- A. To the University of Cincinnati campus, Hoxworth Blood Center, University Hospital properties and the UC Health Business Center: All 911 transport requests shall be handled as an emergency until deemed otherwise by qualified medical personnel.
  
- B. To the community:
  - 1. Any patient with an acute injury or illness that requires immediate EMS attention should be referred to 911 for response by local EMS.
  - 2. If caller refuses 911 and prefers to wait for Air Care and Mobile Care Transport Service, the communication specialist will:
    - a. Document refusal on the dispatch record using quotations from the caller.
    - b. Provide a clear ETA of the team.
    - c. Instruct the caller to call 911 if the patient's condition worsens.
    - d. Provide the caller with the communication center direct telephone number.
    - e. Verify the correct phone number and address of the caller.
    - f. Dispatch the nearest appropriate team within 2 minutes of receiving the call.
  
  - 3. Should a BLS team be dispatched to a scene and find that the situation is outside their scope of practice, the BLS team should call 911 for assistance and/or Air Care & Mobile Care Communication Center to determine the availability of an appropriate level team.
  - 4. Mobile Care associates are reminded that safe, rapid transportation to definitive care is in many situations the most important intervention we can provide.
  
- C. All patients from first response scenes should be assessed and transported to the closest appropriate hospital unless the patient refuses transport. If the patient refuses transport, the appropriate departmental paperwork should be completed.

**V. RESPONSIBILITY**

All Communication Specialist, All Mobile Care Transport Associates

**VI. KEY WORDS**

None

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS**

None

	ACMC66	
POLICY NAME/#	Florence Freedom Dispatch Policy	
POLICY TITLE	Air Care & Mobile Care	
POLICY OWNER	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Dr. Elizabeth Powell/Ground Medical Director (Date)	
ADMINISTRATIVE APPROVAL	_____ Jennifer Jackson/VP CNO (Date)	
ORIGINATION DATE	5/1/2013	
LAST REVISION/ REVIEW DATE	7/2017	NEXT REVIEW DATE
		7/2018

**I. POLICY**

To assure safe and high quality patient care is being delivered by Air Care & Mobile Care, and also help assure the patient receives the most appropriate level of care and is transported in a timely safe manner.

**II. PURPOSE**

**III. DEFINITIONS**

None

#### **IV. PROCEDURE**

Emergency dispatch of the Air Care and Mobile Care Medical Team can be made by anyone of the following personnel:

- B.** Florence Freedom Usher
- C.** Florence Freedom Staff
- D.** Florence Police Detail Office
- E.** Air Care & Mobile Care Medical Team
- F.** Florence Freedom Team Trainer or Doctor

When a patron, staff member or player is in need of medical attention, anyone with a radio can call the Air Care & Mobile Care Medical Team for assistance. They will give the patients current location and a brief description of the medical emergency. The Medical Team will immediately go to the patient's location.

The Air Care & Mobile Care Medical Team will make the decision if the emergency can be handled at the 1st Aid Room or if the patient needs to be transported to a Hospital.

If transport is needed, the Air Care & Mobile Care Medical Team will notify the Florence Police Detail Officer and he will call the Florence Fire Department Dispatch Center. He will give a location in the Stadium and a brief medical condition of why transport is needed.

The Air Care & Mobile Care Medical Team will give a patient report to the Florence Fire Department on their arrival and assist in loading the patient for transport.

In the event that a patron, uses his cell phone to call 911 and the Boone County Dispatch center contacts the Air Care & Mobile Care crew for availability, the crew must be able to respond within 10 minutes, or advise the 911 center that they are busy with a patient and they will dispatch Florence Fire Department to assist with Mutual Aid.

#### **V. RESPONSIBILITY**

Air Care & Mobile Care

#### **VI. KEY WORDS**

None

#### **VII. APPENDIX**

None

#### **VIII. REFERENCES / CITATIONS**

None

	<u>ACMC14</u>	
<b>POLICY NAME/#</b>	<b>Emergency Medical Treatment and Active Labor Act (EMTALA) and Patient Transports</b>	
<b>POLICY TITLE</b>	<b>Air Care and Mobile Care</b>	
<b>POLICY OWNER</b>		
	_____	_____
	<b>Matt Gunderman/Director</b>	<b>(Date)</b>
	_____	_____
	<b>Dr. William Hinckley/Air Medical Director</b>	<b>(Date)</b>
	_____	_____
	<b>Dr. Elizabeth Powell/Ground Medical Director</b>	<b>(Date)</b>
<b>ADMINISTRATIVE APPROVAL</b>	_____	_____
	<b>Jennifer Jackson/VP CNO</b>	<b>(Date)</b>
<b>ORIGINATION DATE</b>	<b>11/2001</b>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>7/2018</b>

**I. POLICY**

Air Care and Mobile Care shall comply with The Emergency Medical Treatment and Active Labor Act (EMTALA) and University of Cincinnati Medical Center’s InterFacility Patient Transfer Policy. Once Air Care & Mobile Care accepts the patient transport, they become responsible to help assure the patient is transported in the most appropriate mode with the most appropriate health care provider.

**II. PURPOSE**

To provide guidelines for Air Care & Mobile Care associates to safely and effectively transfer patients between facilities and to ensure continuation of medical care in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA) regulation.

### **III. DEFINITIONS**

None

### **IV. PROCEDURE**

- A. A patient with an Emergency Medical Condition (EMC) must have a medical screening exam and be stabilized within the referring facility's capabilities. The referring facility has a duty to provide medical treatment within its scope of practice to prevent medical condition deterioration during the transfer. If the patient is unstable at the time of the transfer, the transfer may proceed at the patient's request or upon certification by the referring or receiving physician that the benefits of transfer outweigh the risks.
- B. The Air Care & Mobile Care Transport Service team will transport the patient record, including the physician's orders, and documentation of the necessity for transfer with the patient whenever possible, but will not delay transfer of a critical patient to obtain these when they can be sent via another timely means. If this occurs the transport team shall notify the communication specialist to establish and confirm delivery of the medical records
- C. The communication specialist will ensure that the receiving facility has an accepting physician and space for the patient. In addition, the Communication Specialist is also responsible for coordinating the time of pick-up at the referring facility and time of arrival at the receiving facility.
- D. Patients transported from a scene (pre-hospital missions) will be transported to the closest appropriate facility based on the Ohio State Legislation and/or the type of care they require. (For example, children under the age of fourteen (14) years of age are taken to Cincinnati Children's Hospital unless the team is directed otherwise by medical personnel at the receiving facilities' emergency department).

### **V. RESPONSIBILITY**

### **VI. KEY WORDS**

None

### **VII. APPENDIX None**

### **VIII. REFERENCES / CITATIONS**

None

	<u>ACMC21</u>	
<b>POLICY NAME/#</b>	<u>Transport State Police or Security Personnel Carrying Firearms</u>	
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>	
<b>POLICY OWNER</b>	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
	Dr. William Hinckley/Air Medical Director	(Date)
	_____	_____
	Dr. Liz Powell Ground Medical Director	(Date)
	_____	_____
<b>ADMINISTRATIVE APPROVAL</b>	<u>Jennifer Jackson/VP CNO</u>	(Date)
<b>ORIGINATION DATE</b>	<u>2/2003</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<u>7/2017</u>	<b>NEXT REVIEW DATE</b> <u>7/2018</u>

- I. POLICY**  
In the event that a law enforcement officer with a firearm is required to accompany a patient during transport, all associates will follow established procedures to ensure a safe transport environment for patients and associates.
  
- II. PURPOSE**  
To provide guide lines for the safety transport of patient and associates.
  
- III. DEFINITIONS**  
None
  
- IV. PROCEDURE**
  - A. Periodically, the Air Care and Mobile Care Medical Service is requested to transport an individual carrying a firearm.

- B. In general, firearms should not be permitted on-board the transport vehicle, however, transport associates must carefully evaluate each situation on a case-by-case basis with due consideration given to safety, health care needs of the patient, Ohio prison regulations and escape risk.
- C. Each transport associate has the right, responsibility and authority to deny the transport of any individual with a firearm.
- D. If the individual carrying the firearm is permitted to ride on-board the transport vehicle, the team should instruct the individual to keep the firearm secured at all times in or around the vehicle.
- E. The communication specialist should be notified whenever an authorized individual with a firearm is accompanying a transport.
- F. When Air Care is used to transport officers (performing searches and/or Body guard) agreement to allow the carrying of the firearm must be made by all personnel.
- G. The Air Operator policy on firearms on an aircraft must be followed.

**V. RESPONSIBILITY**  
**All Air Care & Mobile Care Associates**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS**  
**None**

	<u>ACMC24</u>
POLICY NAME/#	<u>Handling of Life Threatening Emergencies While Enroute</u>
POLICY TITLE	<u>Air Care and Mobile Care</u>
POLICY OWNER	
	_____ Matt Gunderman/Director (Date)
	_____ Dr. William Hinckley/Air Medical Director (Date)
	_____ Dr. Elizabeth Powell Ground Medical Director (Date)
ADMINISTRATIVE APPROVAL	_____ Jennifer Jackson/VP CNO (Date)
ORIGINATION DATE	<u>11/2001</u>
<b>LAST REVISION/ REVIEW DATE</b>	<b>10/2017</b>
<b>NEXT REVIEW DATE</b>	<b>10/2018</b>

**I. POLICY**

In daily operations, Air Care & Mobile Care will be faced with dealing with life threatening emergencies while in route. All trained and approved personnel are required to perform all needed interventions to ensure patient and crew safety.

**II. PURPOSE**

With the occurrence of a life-threatening emergency en-route, Air Care and Mobile Care Service associates will reference the following guidelines.

**III. DEFINITIONS**

None

#### **IV. PROCEDURE**

- A. Air Care and Mobile Care Service ground associates will adhere to the policies and protocols outlined for Air Care & Mobile Care Policies.
- B. Contact the appropriate referring and/or the receiving physician for additional orders as needed. If neither physician can be contacted or if condition is deemed time sensitive, the Mobile unit can contact the faculty physician at University of Cincinnati Medical Center (584-AMEN).
- C. The driver will be instructed by the transport associates providing patient care to either:
  - 1. Proceed as planned.
  - 2. Go to the nearest emergency department for assistance.
  - 3. Stop the vehicle and assist the team until the patient is stable.
  - 4. Proceed using lights and siren to the final destination (reference department lights and sirens policy.)
- D. The transport team will update the communication specialist on the patient's condition, who will update the receiving physician and/or facility of the patient's status. The driver, as appropriate may use the radio to update the communications center as to a change in destination and transport status (use of lights/sirens).

#### **V. RESPONSIBILITY**

**All Team Members, Communication Specialist**

#### **VI. KEY WORDS**

**None**

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS**

**None**



- A. All flight operations and vehicle driving must be done according to the rules and regulations of the State of Ohio and the Federal Aviation Administration and in accordance with the safety driving/flying policy of the hospital and/or helicopter vendor.
- B. The transport team is responsible for completing a safety “walk-around” and vehicle check, as appropriate and per policies, before each vehicle movement.
- C. As much as possible, vehicles should be operated in such a manner to reduce the impact of noise.
  - 1. Aircraft should be operated under the guidelines established under the Helicopter Association International (HAI) “Fly Neighborly” program.
  - 2. The use of sirens should be appropriate and limited to emergencies (see Lights and Sirens Policy).
  - 3. Aircraft and ambulances should not be left running for extended periods in noise sensitive areas unless weather conditions indicate.
  - 4. Flying over known noise sensitive areas should be avoided as much as safely possible (i.e. The Cincinnati Zoo, residential areas such as adjacent to area hospitals).

**V. RESPONSIBILITY**  
**All Personnel**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS**  
**None**

	<u>ACMC38</u>	
POLICY NAME/#	<u>Taking Physicians Orders</u>	
POLICY TITLE	<u>Air Care and Mobile Care</u>	
POLICY OWNER	_____	
	<u>Matt Gunderman/Director</u>	<u>(Date)</u>
	_____	_____
	<u>Dr. William Hinckley/Air Medical Director</u>	<u>(Date)</u>
	_____	_____
	<u>Dr. Elizabeth Powell Ground Medical Director</u>	<u>(Date)</u>
ADMINISTRATIVE APPROVAL	_____	
	<u>Jennifer Jackson/VP CNO</u>	<u>(Date)</u>
ORIGINATION DATE	<u>11/2001</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>7/2018</b>

**I. POLICY**

In order to assure patient safety and continuity of care, Air Care and Mobile Care associates will be directed by the physician orders in effect at the referring and receiving facilities as well as through department approved clinical policies and the facility physician in the Center for Emergency Care at University of Cincinnati Medical Center (UCMC).

**II. PURPOSE**

Guidelines to ensure patient safety when using and receiving orders by a practitioner that is not on the actual transport.

**III. DEFINITIONS**

None

#### **IV. PROCEDURE**

- A. Transport associates will continue physician orders in effect at the referring facility that is within their scope of practice. If patient care needs are outside the scope of practice for that team, the communication specialist will be notified and alternate arrangements for transport shall be made. In the event that the flight nurse is on a patient transport without the flight physician, they will use the referring or physician orders, department clinical policies or the faculty in the Center for Emergency Care at UCMC for direction.
- B. Taking verbal and/or telephone orders:
1. The RN, Paramedic, EMT and communication specialist may accept telephone/verbal orders that are within their scope of practice.
  2. If the physician order is out of the communication specialist's scope of practice, the communication specialist must conference call the appropriate transport associate.
  3. The telephone/verbal order must be read back verbatim to the physician giving the order (the associate must chart that this was done). The order must also be dated, timed and signed by the health care professional taking the order and documented that it was done.
  4. If the physician is present upon patient disposition, a signature shall be obtained for their telephone order.

#### **V. RESPONSIBILITY**

**All Team Members, Clinical Coordinator**

#### **VI. KEY WORDS**

**None**

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS**

**None**

	MC07	
POLICY NAME/#	Scope of Practice Guidelines for Critical Care and ALS Paramedic	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Dr. Elizabeth Powell/Ground Medical Director (Date)	
ADMINISTRATIVE APPROVAL	_____ Jennifer Jackson/VP CNO (Date)	
ORIGINATION DATE	11/2008	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>7/2018</b>

**I. POLICY**

Inter-facility transports of patients who require paramedic level of care en route are sometimes require medications or treatments that fall outside the Academy of Medicine of Cincinnati Paramedic Protocol for Southwest Ohio. Therefore, to ensure patient safety and in an effort to provide the most cost efficient transport, Air Care and Mobile Care has identified patient conditions and medications that paramedics who have acquired the initial training and maintained competency will be permitted to transport.

**II. PURPOSE**

THE PURPOSE OF THE POLICY IS TO DEFINE THE ROLE OF AN AIR CARE AND MOBILE CARE CERTIFIED CRITICAL CARE AND ALS PARAMEDIC IN PROVIDING SAFE TRANSPORT OF INTERFACILITY PATIENTS.

### III. DEFINITIONS

**Stable-**The status of the patient's medical condition that is not subject to change within the time ACMC personnel will provide medical care and transport. The decision of "stability" will be a joint decision between the referring physician and the transporting crew.

**Critical Care ALS (CCALS) Team-**This team consists of a Certified Critical Care Paramedic, Certified Paramedic and a Certified EMT.

### IV. PROCEDURE

#### All ACMC Transport Paramedic

Patients being transported between facilities that have any intravenous (IV) medications must be infused on an infusion pump. Fluids may be infusing through peripheral IV, accessed PICC line, accessed port-a-cath, or centrally inserted central line (placement confirmed by referring physician).

**A. IV Fluids.** The standard intravenous fluids that do not have medications added to them may be transported by all Air Care & Mobile Care paramedics include:

1. 0.9% Normal Saline
2. 0.45% Sodium Chloride
3. 5% Dextrose
4. Lactated Ringers
5. Dextrose with 0.45% Normal Saline
6. 5% Dextrose and Lactated Ringers
7. Fluids with Potassium maintenance

**B** At the discretion of the health care professional and patient's clinical condition the following infusions may be administered without an infusion device through a peripheral IV only.

1. Antibiotics that are to infuse in 30 minutes or less
2. Standard IV solutions that do not contain additional electrolytes.

**C.** Infusions less than 25 mL per hour or more than 125 mL per hour are infused via an infusion device. Standard IV solutions without medications infusing at 26ml to 124 ml/hr may infuse via gravity.

D. Medications

In patients that are noted to be stable, the following medications can be transported by qualified and trained personnel. Paramedic crews are permitted to transport one maintenance infusion and no more than two medications.

Patient > 16 years of age

1. Total Parenteral Nutrition (TPN)
2. Lidocaine drip
3. Amiodorone drip
4. Protonix drip
5. Nitroglycerin drip
6. Integralin drip
7. Heparin drip
  
8. Dopamine drip
9. Levophed Drip-In emergent situations only  
4mg in 250mL of normal saline (16 mcg/mL concentration). Start at 8 mcg/min and titrate for desired effect to a max of 12 mcg/min. Medical Control must be contacted before initiating medication. Medication must be placed on an infusion pump. IV must be flushed and patency verified.
  
10. Antibiotics:  
Patients needing antibiotic therapy may be transported by a paramedic with the following guidelines. The paramedic will:
  - a) not initiate antibiotic therapy; the antibiotic must be initiated by referring facility.
  - b) assure the antibiotic has been infusing a minimum of ten (10) minutes before the patient may leave the nursing unit.
  - c) assess the patient for:
    - i. History of allergies.
    - ii. Concurrent administration of other medications.
    - iii. maintain drip rates as established by the referring facility unless otherwise ordered by treating physician. This order must be documented and included in the patient care record. If the antibiotic is being given via infusion pump, an infusion pump will be maintained en route.
    - iv. Assess for anaphylaxis, if suspected he/she will stop the infusion and follows the department clinical policy.

11. Potassium Chloride (KCL). A maximum of 40 mEq of KCL in 1000ml of IV fluids can be transported by paramedics up to 500cc/hr through a central line. Potassium can be transported at 10mEq/hr through a peripheral line. If the patient needs a rapid fluid bolus, the IV needs to be restarted without the KCL. The patient must be transported on a cardiac monitor.
12. All trained paramedics are allowed to transport STEMI patients under APMC Code STEMI and Limited Infusion Protocol.

Patients <16 years of age

1. Total Parenteral Nutrition (TPN)
  2. Protonix drip
  3. Heparin drip
  4. Antibiotics-same guidelines as noted for the adult patient.
- E. PCA Pump-paramedics are permitted to transport patients that are required to have medications administered through a PCA pump without the assistance of the referring facility nurse. In the event that the patient is assessed to be over medicated via the PCA Pump, the paramedic will disconnect the infusion line from the patient. The paramedic will not attempt to turn off or preprogram the PCA pump. Immediate report to the receiving facility is required. If required, immediate intervention to ensure adequate airway management will be determined by the paramedic.
- F. Lab Findings:  
Paramedics are permitted to transport patients with the following abnormal lab findings:
1. Potassium 3.0-3.5 otherwise reported to be stable
  2. Sodium >120 and otherwise reported to be stable

**Critical Care Paramedics**

- A. Ventilated Patients  
The transport of ventilated patients both invasive and non-invasive can be done by a Critical Care Paramedic in a CCALS team configuration. The Critical Care Paramedic will comply with all department ventilator policies and must demonstrate competency before they can care for a patient without the supervision of a nurse. All required documentation standards for the ventilated patient must be followed by the Critical Care Paramedic. Ventilated transports done by a critical paramedic will be review in the department's Continuous Quality Assurance process.
- B. Medications-CC Paramedics are permitted to transport all medications outlined above as well as the following medications:

1. TPA
2. Levophed drip (initiation and maintenance)

- C. Blood Products-CCALS may transport patients with infusing blood product. The blood has to be running for at least 30 minutes before the patient may leave the unit. The Critical Care Paramedic will have to assess the patient for transfusion reactions. Hemolytic transfusion reactions (fever, chills, flushing, nausea, chest tightness, apprehension, joint and back pain, hypotension, dark urine, oozing from IV sites) and anaphylactic reactions (chills, vomiting, diarrhea, dyspnea, urticaria, hypotension, wheezing, angioedema) typically begin quickly, after only a small amount of blood has been transfused. Transfusion-related acute lung injury (TRALI; dyspnea, tachypnea, hypoxia, rales) can begin early or just after transfusion. In the case of any of these, stop the transfusion immediately and infuse normal saline in its place. Dopamine is indicated for hypotension or oliguria from hemolytic transfusion reaction. Treat anaphylaxis as you normally would with epinephrine, steroids, diphenhydramine, and crystalloid. For TRALI, administer supplemental oxygen and intubate if necessary. Notify the blood bank in the case of any known or suspected transfusion reaction.

Blood Product must be documented in Golden Hour according to department guidelines. All hospital required education and training will be completed by the Critical Care Paramedic.

- D. Chest Tubes-CCALS are permitted to transport patients with chest tubes.

Critical Care Paramedic and ALS Paramedic teams are permitted to transport patients to an Intensive Care Unit if the condition of the patient warrants the transport by a Paramedic level team. A patient transport is not automatically upgraded to a MICU level transport just because the patient's destination is an Intensive Care Unit.

- C. **RESPONSIBILITY**  
**Certified Critical Care Paramedics and ALS Paramedics**

- CI. **KEY WORDS**  
**None**

- CII. **APPENDIX** **None**

- CIII. **REFERENCES / CITATIONS** **None**



#### **IV. PROCEDURE**

- A. All requests for public relations visits should be received by the Program Director or their designee.
- B. A public relations visit can be made to a public service agency, hospital, freestanding healthcare center or relevant location (with prior approval) that may need patients transported for definitive care. Large public events and gatherings may also be acceptable for helicopter and ambulance visits.
- C. When a public relation event is requesting the aircraft for any public gathering, the event must be approved by the Aviation Site Manager in accordance with the air vendor's operations manual.
- D. When there are any questions about a public relations visit involving the use of a helicopter or ambulance, the agency or individual requesting the visit should be referred to the, Program Director or their designee.

#### **V. RESPONSIBILITY**

**Communication Specialists, Transport Associates**

#### **VI. KEY WORDS**

None

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS**

None

	ACMC45	
POLICY NAME/#	Minimal Requirement for Record Keeping	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
	Dr. William Hinckley/Air Medical Director	(Date)
	_____	_____
	Dr. Elizabeth Powell/Ground Medical Director	(Date)
ADMINISTRATIVE APPROVAL	_____	_____
	Jennifer Jackson/VP CNO	(Date)
ORIGINATION DATE	11/2001	
<b>LAST REVISION/ REVIEW DATE</b>	<b>8/2017</b>	<b>NEXT REVIEW DATE</b> <b>8/2018</b>

**I. POLICY**

The medical record is a written account of the patients’ care by the healthcare provider. Specific procedures will be followed in the maintenance of appropriate records.

**II. PURPOSE**

To provide guideline on the proper documentation and handling of patient health information as well as other required documents need for adequate operations.

**III. DEFINITIONS**

- EMR-Electronic Medical Record referring to the Golden Hour Clinical documentation module and the emsCharts documentation module
- PCS-Physician Certification Record
- Consent-Medicare Patient Signature Form

#### IV. PROCEDURE

- A. Preliminary Patient Care Run Reports: The patients' official medical record is an electronic document of the patients' care by the healthcare provider. Documentation aids in the diagnosis, treatment, care of the patient and communicates information among members of the interdisciplinary team.
1. A copy of the preliminary patient record will be left with the receiving facility upon disposition. If another emergent transport is pending and the preliminary patient care record could not be completed, the medical transport associate should notify the receiving healthcare provider of the situation during the patient report. All documentation will be completed before the end of the transport associate's shift and preliminary patient record forwarded to the appropriate unit at the receiving facility.
  2. All information from the preliminary form must be placed into the electronic medical record.
  3. Such records will be kept in accordance with standard hospital record keeping.
- B. Charting Requirements:
1. All patient care information i.e HPI, illness/injury, physical exam, assessments, interventions, evaluations and vital signs, treatments, medication, intake and output, patient responses, ventilator settings (if applicable) and any changes, radiographic and laboratory findings, will be recorded on the patient care record.
  2. The frequency of notations will be based on patient need and physician orders, but shall occur at least every fifteen (15) minutes.
  3. An initial and ending assessment will be recorded on all patients.
  4. Associates will complete every area where documentation is required. If a specific area is not relevant, the associate will use the "NA" abbreviation which is the only acceptable abbreviation. UC Health does not permit the use of abbreviations in the medical record. No medication abbreviations are permitted.
  5. The patient care record must reflect the indication/purpose and mode of medical transport.
  6. All preliminary patient records must be signed by the primary care givers and the discipline indicated. All electronic medical records will have electronic signatures and time stamped.
  7. Any errors on the preliminary form must be neatly lined through once and "error" recorded and initialed above the error. Liquid "white-out" or erasing entries is not acceptable.
  8. Correct notation of time is military time.

9. Completed Physician Certification Statement (PCS) must be signed by a physician or approved practitioner involved in the care of the patient and noted on the PCS form.
  10. Medicare Patient Signature Form must be completed and signed as indicated.
  11. Refer to The University of Cincinnati Medical Center "Documentation of Permanent Medical Record" policy.
- C. Schedule Retention:
1. A master copy of associate schedules will be kept in the department for reference in API Healthcare system.
  2. The supervisor(s) and/or staffing coordinator will monitor associates' schedules.
  3. All schedule changes that do not result in overtime will be made in API Healthcare.
  4. A supervisor or the staffing coordinator must approve all schedule changes that result in overtime.
- D. Vehicle Maintenance Records:
1. Ambulances:
    - a) Associates' vehicle checks will be performed and recorded daily and completed within twenty (20) minutes of the start of their shift. Completed records will be monitored for quality assurance by the designated supervisor.
    - b) Mechanic checks will be performed every 3,000 miles. All records will be retained throughout the life of the vehicle by the base operations supervisor(s) or their designee.
  2. Aircraft:
    - a) All records regarding maintenance on the aircraft(s) will be completed and monitored by the applicable air operator.
- E. Record Quality Assurance (QA):
- a) The QA committee will identify specific departmental records to be reviewed through the department's QA process.

**V. RESPONSIBILITY**  
All Team Members

**VI. KEY WORDS**  
None

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS** None



## IV. PROCEDURE

- A. The Air Care & Mobile Care associate should document with quotes from the patient regarding the reasons they are refusing transport.
- B. 911 Response Refusal for Transport
  1. Unless disregarded by police or qualified medical personnel, the Air Care & Mobile Care team shall assess each patient, unless the patient refuses such examination. An attempt should be made to obtain and document baseline vital signs, and GCS.
  2. If the patient is deemed competent, they may refuse treatment and/or transport. If the patient will not sign the "refusal of service" form, attempt to obtain a witness signature (preferably a police officer or other medical personnel at the scene) and indicate, "Patient refused to sign" on the form.
  3. Team members shall encourage the patient to call 911 if they change their mind or if symptoms worsen regarding transport.
  4. On the University of Cincinnati campus, students shall be encouraged to be seen by Student Health Services.
- C. Refusal of Inter-Facility Transport
  1. In the event a patient refuses transport, the transport team will not transport the patient. The exception is a patient who is probated.
  2. The transport team should collaborate with the referring facility staff to assure the appropriate physician is notified.
- D. Refusal of Care En-route
  1. An explanation of the importance and/or necessity of the treatment will take place.
  2. No life sustaining medications will be stopped.
  3. The patient will continue to be closely monitored.
  4. Notify the communication specialist to contact the receiving physician, who will be notified of the patient's refusal of care en-route.
- E. Refusal of Transportation En-Route
  1. Discuss with the patient concerns regarding transportation, providing support and reassurance.
  2. Inform the patient that transportation will be completed to the receiving facility; however, his/her physician will be notified immediately to discuss disposition.

3. Mobile:

If the patient exhibits violent behavior that threatens the safety of the transport team, the patient shall be released. The team shall notify both the police from the jurisdiction they are in at that time and the communication specialist. The communication specialist shall notify both referring and receiving physicians.

4. Air:

- a) If the patient exhibits violent behavior that threatens the safety of the transport team, the University of Cincinnati Medical Center Restraint Policy will be followed and the pilot immediately notified so appropriate aviation decisions can be made.
- b) The communication specialist will be notified of any change in destination and appropriate ground transportation can be arranged.

F. All transports that involve the patient refusing care and/or transport shall be reviewed in the departments Quality Management process.

**V. RESPONSIBILITY**

**VI. KEY WORDS**

None

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS None**



#### **IV. PROCEDURE**

- A. The principal investigator will be responsible for reviewing the research protocol with department administration and obtaining the necessary approval.
- B. The principal investigator will also be responsible for orientation of other key transport staff including the flight physicians, if indicated, as to the research protocol.
- C. All research protocol will be reviewed by the medical director, as well as the clinical director or their designee as appropriate.
- D. All research protocols must be approved by the Human Research Committee of The University of Cincinnati Medical Center when indicated and must obtain approval from the University of Cincinnati IRB (Internal Review Board)
- E. When transport associates participate in research protocols, they will be appropriately recognized in all publications, etc. as agreed upon when the research was initiated.
- F. Results of research protocols will be disseminated for the enhancement of patient care.

#### **V. RESPONSIBILITY**

**ACMC Associates**

#### **VI. KEY WORDS**

**None**

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS**

**None**



- D. current firefighter, EMT, paramedic, RT, RN, MD license, student of one of these, or person(s) so designated by an Air Care staff member.
- E. \*No cameras/video equipment during flight or patient transports.      \*\*Strict patient confidentiality will be mandated.
- F. Air Care observer must have pre-scheduled shift through Ride-Along Coordinator or designated flight nurse. Dates will be documented on the Ride along calendar.
- G. Advanced Practice Nurses, flight nurse or flight physician on orientation will have precedence over any additional observer (with the exception of scheduled EMS personnel).
- H. All Air Care observer personnel will be fitted for an approved helmet (and flight suit, if available) to wear during their ride-along time.
- I. The “EMS Observer Program” will be scheduled during the months of March, April, May, September, October and November (therefore avoiding the hotter summer months and colder/slower winter months). These personnel will turn in all of their completed affidavit forms and undergo an individual safety orientation prior to taking a flight.
- J. C-Star personnel will also have their shifts approved by the Ride-Along Coordinator, but will be based out of the UC Medical Center Emergency Department or ICU during their schedule flight shift. These personnel will initially undergo a group safety orientation. At the beginning of their ride-along shift, they will report to the helipad to receive a radio and review the Ride-along specifics. When not on a flight, the C Star personnel’s duty area will be in the respective ED/ICU. When a call goes out for the UCMC based aircraft, the C Star member will acknowledge their response via radio and meet the flight team on the helipad. They should only approach the helicopter when accompanied by a flight team member.
- K. Medical Student personnel will be scheduled and approved by Ride-along coordinator. These participants will be limited to medical students interested in going into the specialty of Emergency Medicine. They will go to our Butler County base and work directly with the “H” physician.

**V. RESPONSIBILITY**

**Communication Specialist, Pilot, Flight Nurse, Flight Physician**

**VI. KEY WORDS**

None

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS None**

	ACMC57
POLICY NAME/#	Sedation
POLICY TITLE	Air Care and Mobile Care
POLICY OWNER	_____ (Date) Matt Gunderman/Director
	_____ (Date) Dr. William Hinckley/Air Medical Director
	_____ (Date) Dr. Liz Powell/Ground Medical Director
ADMINISTRATIVE APPROVAL	_____ (Date) Jennifer Jackson/VP CNO
ORIGINATION DATE	12/2004
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>
<b>REVISION/ REVIEW DATE</b>	<b>7/2018</b>

**I. POLICY**  
Frequently in the transport setting, sedation and pain management will be required. To ensure the safe management of patients during the delivery of medications for sedation, throughout the medical transport, major emphasis has been placed on the clinical management to prevent airway obstruction and the need for additional airway support measures.

**II. PURPOSE**

**III. DEFINITIONS**  
None

**IV. PROCEDURE**

## Definitions:

Pharmacologically-induced sedation and analgesia occurs over a continuum, ranging from a patient who is alert to one who is comatose. States of sedation-analgesia are operationally defined below, recognizing that patients may exhibit characteristics from more than one state.

- A. Minimal Sedation (anxiolysis): A drug induces state during which patients:
  - 1. Respond normally to verbal commands
  - 2. Ventilatory and cardiovascular functions are unaffected
  - 3. Cognitive function and coordination may be impaired
  
- B. Moderate Sedation/Analgesia (“conscious sedation”): A drug induced depression of consciousness during which patients:
  - 1. Respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation
  - 2. Receive no intervention to maintain a patent airway
  - 3. Spontaneous ventilation is adequate
  - 4. Cardiovascular function is maintained
  
- C. Deep Sedation-Analgesia: A drug induced depression of consciousness during which patients:
  - 1. Cannot be easily aroused, but respond purposefully following repeated or painful stimulation
  - 2. Ability to independently maintain ventilatory function may be impaired
  - 3. May require assistance in maintaining a patent airway
  - 4. Spontaneous ventilation may be inadequate
  - 5. Cardiovascular function is usually maintained
  
- D. Anesthesia: A drug induced loss of consciousness during which patients:
  - 1. Are not arousable, even by painful stimulation
  - 2. Ability to independently maintain ventilatory function is often impaired
  - 3. Often require assistance in maintaining a patent airway May require positive pressure ventilation because of depressed spontaneous ventilation or drug induced depression of neuromuscular function
  - 4. Cardiovascular function may be impaired

## **Qualification of Air Care & Mobile Care Transport Registered Nurses and Paramedics:**

A. All medical transport associates managing a patient who has received sedation, or administers sedation while in transport, must have competency-based education. This includes:

1. Current ACLS
2. Required hospital training on Moderate Sedation. If in a test format the associate must pass the test with the predetermined score to determine competency. Transport associates must understand pharmacology of the medication, including reversal agents used in moderate sedation, dosages, expected effects, side effects and contra-indications.

### Equipment:

Patient's requiring, or expected to require, sedation during transport should be transported in an Advanced Life Support (ALS) or a Mobile Intensive Care Unit (MICU) ground ambulance with appropriate reversal agents available.

### Responsibilities:

The medical transport associate caring for the patient is responsible to assess and monitor physiological parameters and to provide resuscitation measures as needed. Physical assessment of the patient and documentation will occur every five (5) minutes during sedation and every fifteen (15) minutes post sedation, and more frequently when the patient's condition warrants.

#### A. Vital Signs

1. Pulse Oximetry: The patient's pre-procedure SaO<sub>2</sub> value should be documented. Assuming the patient's pre-sedation oxygen saturation level is greater than 90%, the oxygen saturation will be maintained above the 90% at all times.

2. The Amount of Oxygen Being Delivered to the Patient:
  - a) a minimum of two liters per minute of oxygen via nasal cannula should be administered to all patients requiring sedation, unless contraindicated. In the event the patient's saturation falls below 90%, appropriate interventions should be taken to increase the SaO<sub>2</sub> level. If all attempts fail, the patient's physician should be notified. Reversal agents should be considered.
  
3. Respiratory Rate:
  - a) In addition to assessing the respiratory rate, the primary caregiver must also assess the overall adequacy of the patient's airway and spontaneous ventilation, specifically seeking signs of airway obstruction and/or hypoventilation.
  
4. Blood Pressure:
  - a) Should be checked within two - four minutes of medication administration.
  
5. Pulse (Heart Rate):
  - a) To be continuously monitored with a heart monitor and a rhythm strip documented in the patient's chart. Any changes should be documented and appropriate interventions made.
  
6. Level of Consciousness:
  - a) Sedation and pain levels will be continuously monitored.
  
7. Sedation level to be addressed:
  - a) Agitated, anxious, restless
  - b) Calm, cooperative, oriented
  - c) Responds to verbal commands
  - d) Brisk response to light touch
  - e) Sluggish or no response to light touch
  - f) Unable to be assessed
  
8. Pain Score:
  - a) To be addressed using a 1 - 10 scale such as the Wong-Baker Pain Scale
  
- B. All fluids administered to the patient and the rates at which they were delivered should be documented.
  
- C. IV Access: a 20-gauge catheter or larger is suggested.
  - C. Any patient receiving sedation during transport may have their case reviewed by the department's internal QA process.

**V. RESPONSIBILITY**  
All Team Members

**VI. KEY WORDS**  
None

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS** None



- A. Specialty medical team members will be coordinated by the medical crew and communication specialist. (For flights the pilot has ultimate decision on whether a specialty medical team member may fly.)
- B. Documentation of all personnel on board an Air Care & Mobile Care vehicle is the responsibility of the communication center.
- C. The specialty transport personnel collaborate with the Air Care & Mobile Care teams in checking availability and functioning of specialty medical equipment and supplies prior to departure when involved in transport.
- D. All specialty team personnel will receive a safety briefing from the pilot or medical crew before departure.
- E. All special equipment must be secured by accepted methods during all legs of flight.
- F. Air Care & Mobile Care will assure that any specialty medical team member is returned to their hospital after the transport as quickly as possible.
- G. Overall transport logistics and safety are the responsibility of the primary medical crew.

**IV. RESPONSIBILITY**  
**Communication Specialist, Air Crews, Mobile Crews**

**V. KEY WORDS**  
**None**

**VI. APPENDIX** **None**

**VII. REFERENCES / CITATIONS**  
**None**

	<u>ACMC25</u>	
<b>POLICY NAME/#</b>	<u>Response to Situation Involving Hazardous Materials</u>	
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>	
<b>POLICY OWNER</b>	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Dr. Elizabeth Powell Ground Medical Director (Date)	
<b>ADMINISTRATIVE APPROVAL</b>	_____ Jennifer Jackson/VP CNO (Date)	
<b>ORIGINATION DATE</b>	<u>11/2001</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>10/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>10/2018</b>

**I. POLICY**

To establish when the transport vehicle should respond to a hazardous material scene as well as to assure the safety of all transport associates, referring and receiving personnel and the patient.

**II. PURPOSE**

**III. DEFINITIONS**

**Hazardous Materials:** Those materials which are toxic, poisonous, flammable, explosive, irritants or radioactive in nature or identified as a potential hazard by the referring agency.

**Transport Associates: Flight nurses, mobile nurses, paramedics, EMT's, pilots, flight physicians, flight Advanced Practice Nurses.**

**Transport Vehicles: Aircraft, ambulances, departmental cars**

**Material Safety Data Sheets (MSDS): Reference sheets that contain chemical safety information for use in case of an emergency.**

#### IV. PROCEDURE

##### A. Communication Center:

1. Obtain information to determine if hazardous materials may be present.
2. Attempt to determine what hazardous material is present. MSDS sheets should be used as a reference. Keep in mind; transport vehicles and associates are not equipped with special protection suites or breathing apparatus to protect them from hazardous material.
3. If the transport vehicle has not been dispatched and hazardous materials are suspected, do NOT dispatch the transport vehicle until it is confirmed that appropriate authorities have contained the scene.
4. If the transport vehicle is en-route when a hazardous material is suspected, notify the pilot or ground associates as soon as possible that hazardous materials may be present. The communication specialist should give all relevant information that is available on the conditions at the scene.
5. Contact authorities to select a landing or staging area that will avoid the possibility of contamination of the aircraft, ambulance and associates. Ask if a staging area or cold zone has been established.
  - a. Upwind from the scene or site of the accident.
  - b. If explosives, poisonous gases/vapor or chemicals with explosive potential are present, the landing/staging site should be upwind and at least one (1) mile from the site of the hazardous material and never in a low-lying area.
  - c. If radioactive material, the landing/staging site should be upwind a minimum of  $\frac{1}{4}$  to  $\frac{1}{2}$  mile from the accident unless radioactive gases are present. In these cases, move the landing/staging site at least one (1) mile upwind of the site.
6. Transport associates should determine if patient(s) has been contaminated and if proper decontamination has occurred.

B. Transport Associate in Charge:

1. Final authority regarding landing/staging area at any scene where hazardous materials may be present will be the responsibility of the pilot-in-command or the highest-ranking medical personnel in the transport vehicle.
2. Upon initial contact, ask local authorities to give their assessment of the situation. Do not assume the local authorities will know about or have a safe landing/staging area set up. If in doubt, do NOT land or enter. If hazardous materials are present, do NOT land/stage unless the area has been decontaminated or is safe. Do NOT expose the transport vehicle to radioactive hazards.
3. Always land/stage upwind at a safe distance from any scene where hazardous material may be present.
4. Do NOT load any victim or patient in the transport vehicle until they have been decontaminated.
5. Notify the receiving facility of the exposure prior to departing the scene.

C. Hazardous Materials Exposure: Cyanide

1. Cyanide Exposure Kits will be kept on all aircraft. The kit is to be utilized and administered to patients demonstrating a decreased level of consciousness and hypotension following an exposure to fire or cyanide.

D.

**V. RESPONSIBILITY**

**All Team Members, Communication Specialist, Pilots**

**VI. KEY WORDS**

**None**

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS None**

	<u>ACMC23</u>	
POLICY NAME/#	<u>Annual Health Screening</u>	
POLICY TITLE	<u>Air Care and Mobile Care</u>	
POLICY OWNER	_____	
	Matt Gunderman/Director	_____ (Date)
	_____	_____ (Date)
	Dr. William Hinckley/Air Medical Director	_____ (Date)
	_____	_____ (Date)
	Dr. Elizabeth Powell/Ground Medical Director	_____ (Date)
ADMINISTRATIVE APPROVAL	_____	
	<u>Jennifer Jackson</u> /VP CNO	_____ (Date)
ORIGINATION DATE	<u>10/2005</u>	
LAST REVISION/ REVIEW DATE	<u>10/2017</u>	NEXT REVIEW DATE
		<u>10/2018</u>

- I. POLICY  
 Air Care & Mobile Care (ACMC) works collaboratively with UC Health Employee Health & Wellness Department to provide health screenings for all associates upon hire and then on an annual basis.
- II. PURPOSE  
 Periodic health screenings help monitor and often times provide early detection of health issues. Additionally, the screenings serve as a means to mitigate risks to associate safety and well- being.
- III. DEFINITIONS  
 None
- IV. PROCEDURE

- A.** All department associates, except those exempted by vendor contracts, whether involved in direct or indirect patient care are required to complete a health screening at the time of hire as well as on an annual basis.
- B.** If an associate has a change in their medical condition (i.e. new medical diagnosis) and/or starts new medication it is the associates responsibility to report that information to UC Health's Associate Health & Wellness Department who will reevaluate their fitness for transport duty.
- C.** The APMC health screening will be conducted by UC Health Associate Health & Wellness Department and will include, at a minimum, the following:
- 1.** History of acute or chronic illness.
  - 2.** Present medications, highlighting those that may cause drowsiness, effect judgment or coordination.
  - 3.** Immunization history including tetanus, diphtheria, acellular pertussis, Hepatitis B and measles, mumps and rubella (MMR) and varicella.
  - 4.** Annual tuberculosis screenings.
  - 5.** Annual Flu Immunization
  - 6.** N95 Fit testing. Facial hair including mustaches, beards or goatees shall be neat and trimmed as to not interfere with the wearing of personal protective equipment such as N95 masks. Proper fitting and sizing of PPE devices will be determined by Associate Health & Wellness department on hire and on an annual basis (or sooner if the associate has a facial structure change). \*Any associate who is unable to pass the fit test for the 3M 1870, 1860 or TecnoL N95 mask will be determined to not be fit for duty for the APMC transport team.
- D.** The clinical director, or designee, in collaboration with Associate Health & Wellness Department, is responsible for determining the time period at which the screening will be completed each year.

- E. The Federal Aviation Association (FAA) mandates that all pilots receive annual physical exams. The physical exams will be arranged by the vendor and records of their annual physical exams will be maintained by the vendor.
  
- F. Hearing screenings for the flight team will be conducted and monitored through the Audiology Department within the Ear, Nose and Throat Clinic at The University of Cincinnati Medical Center. Refer to Air Care & Mobile Care Hearing Conservation Policy and UC Health Hearing Conservation Policy.

**V. RESPONSIBILITY**

All associates and contracted personnel who perform duties for the ACMC Transport team

**VI. KEY WORDS**

None

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS** None

	ACMC27	
POLICY NAME/#	Hearing Protection	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER	<p>_____ (Date)</p> <p>Matt Gunderman/Director</p> <p>_____ (Date)</p> <p>Dr. William Hinckley/Air Medical Director</p> <p>_____ (Date)</p> <p>Dr. Elizabeth Powell Ground Medical Director</p>	
ADMINISTRATIVE APPROVAL	_____ (Date)	_____ (Date)
ORIGINATION DATE	3/2003	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>7/2018</b>

**I. POLICY**

Air Care & Mobile Care values associate's good health and shares in the responsibility to maintain a healthy work environment. To protect associates from hearing loss due to occupational noise exposure, associates will participate in a Hearing Conservation Program. A hearing conservation program is essential to a healthy work environment and includes: a noise exposure assessment, audiometric testing, hearing protection, associate education and record keeping. Refer to The UC Health Hearing Conservation Policy.

**II. PURPOSE**

To set the expectation and guide line for hearing conservation.

### **III. DEFINITIONS**

**None**

### **IV. PROCEDURE**

- A. Approved hearing protection devices are provided to each transport team member upon hire. It is the associate's responsibility to obtain replacements from the department as needed.
- B. Helmets are required in the rotor wing setting and all associates will be issued or have access to a program provided helmet. These helmets will be inspected annually at a minimum. All maintenance of the department provided helmet will be provided by Air Care & Mobile Care. All helmet inspection information will be kept on file with the department.
- C. Associates are encouraged to use the appropriate hearing protection device:
  - a. When the siren is activated
  - b. When standing near a running generator
  - c. When near an idling engine
  - d. When near or in an aircraft with engines running
  - e. Any other situation the associate feels appropriate
- D. All patients being transported will be offered hearing protection when physical conditions warrant.
- E. Associates who believe they suffer from diminished capacity to hear will notify their supervisor and be monitored by Employee Health, in accordance with the UC Health Hearing Conservation Policy.
- F. Baseline audiograms will be performed on all Flight Nurses within six months of hire and then on an annual basis. All flight physicians will have a baseline audiogram and then recommended to have then annually.  
Refer to The UC Health Hearing Conservation Policy

### **V. RESPONSIBILITY**

**All Transport Teams**

### **VI. KEY WORDS**

**None**

### **VII. APPENDIX None**

### **VIII. REFERENCES / CITATIONS**

**None**



#### **IV. PROCEDURE**

- A. A significant exposure to a contagious or infectious disease is defined in the UC Health Blood borne Pathogens Exposure Control Plan.
- B. Following an incident that could have possibly resulted in an exposure, the transport associate will:
  - 1. notify their immediate supervisor and
  - 2. contact Employee Health (EH) via the injury line 585-8000. EH, in accordance with current CDC guidelines, will be responsible for handling occupational blood and body fluid exposures as well as exposures to infectious or contagious diseases.
  - 3. Refer to UC Health Employee Health Blood and Body Fluid Exposure Policy.
  - 4. If needed, the associate can go to the Center for Emergency Care at UCMC for assistance if situation warrants immediate medical evaluation.
- C. Those involved in exposure incidents who are not employed by UC Health should be advised to report to the Center for Emergency Care at the University of Cincinnati Medical Center for evaluation. Additional follow up will be determined by their employer/agency protocol.

#### **V. RESPONSIBILITY** **All Transport Associates**

#### **VI. KEY WORDS** **None**

#### **VII. APPENDIX** **None**

#### **VIII. REFERENCES / CITATIONS** **None**

	<u>ACMC32</u>	
<b>POLICY NAME/#</b>	<b>Latex Sensitivity in Patients &amp; Air Care &amp; Mobile Care Transport Associates</b>	
<b>POLICY TITLE</b>	<b>Air Care and Mobile Care</b>	
<b>POLICY OWNER</b>	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Dr. Elizabeth Powell/Ground Medical Director (Date)	
<b>ADMINISTRATIVE APPROVAL</b>	_____ Jennifer Jackson/VP CNO (Date)	
<b>ORIGINATION DATE</b>	<u>11/2001</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>7/2018</b>

**I. POLICY**

In some individuals, exposure to latex products causes an antigen/antibody reaction that may produce a rash; hives, itching skin, cracked skin and swelling which can lead to anaphylactic shock. The following procedure shall be used to identify associates and/or patients with a latex allergy in an effort to minimize their likelihood of exposure to latex allergens.

**II. DEFINITIONS**

None

### III. PROCEDURE

#### A. Transport associates with Known or Suspected Latex Sensitivity/Allergy:

If not life threatening, any transport associate who demonstrates signs and symptoms of latex sensitivity will be immediately referred to the UC Health Employee Health Department for evaluation. Any associate who has a positive allergy response to latex will be provided with a supply of vinyl gloves and other protective materials for their personal use, as deemed appropriate by Employee Health.

#### B. Patients with Known or Suspected Latex Sensitivity/Allergy:

Initial knowledge of any patients' environmental sensitivities should occur at the time of the report from the referring facility or home environment. The allergy should be clearly documented in the specified allergy area on the patient care records(s). Allergy information should be verified by the transport team upon patient pick-up and reported to the receiving facility upon the patient's disposition.

#### C. Transport Considerations for a Known Latex Allergy:

1. Use flat sheets to make the cot (fitted sheets contain latex.)
2. Use nylon or plastic foam pillows when possible. Rubber foam pillows must be covered with several layers of pillowcases when used.
3. Use vinyl gloves when needed in the provision of patient care.
4. Only use tubing that is latex free. Current tubing used by Air Care and Mobile Care is latex free. If an associate encounters tubing that is not latex free, rubber medication stopper and IV ports will not be used.
5. Cover IV tubing Y-injection ports with tape to prevent injection. Attach extension tubing and stopcock between needle hub and IV tubing; use stopcock to administer medication.
6. Remove latex stopper from medication vials by first using a hemostat to remove the metal collar, then withdraw the medication.
7. Patient Care:
  - a) Place monitoring devices, cords, and tubes in stockinette and secure with plastic tape.
  - b) Do not let your stethoscope tubing come in contact with the patient; cover with stockinette.
  - c) Do not use Band-Aids or adhesive tape - use 2x2 plastic tape.
  - d) Cover the arm with stockinette or patient gown prior to applying BP cuff.

8. IV Starts/Phlebotomy:
  9. Use vinyl gloves when starting an IV and/or drawing blood. Healthcare provider must not remove the gloves in direct contacts of the patient. Wash hands immediately to prevent the spread of latex particles through the air from the hands.
  10. Respiratory Care:
    - a) Cover stethoscope tubing with stockinette.
    - b) Secure mask with trach tape.
    - c) If you use a non-rebreather, remove the rubber straps and secure with trach tape.
- D. Transport Vehicles: All transport vehicles will have a latex free kit which includes:
1. One (1) box each of vinyl-based exam gloves in small, medium and large sizes.
  2. Two (2) Stockinette rolls in 4" x 36" .
  3. One (1) Latex-free tourniquet.

#### **IV. RESPONSIBILITY**



B. If tampering is suspected, the communication specialist on duty will be advised of the status of the aircraft and will be requested to notify the following authorities:

1. Police/security
2. Aviation Site Manager
3. Faculty physician
4. Medical Director
5. Clinical Director
6. Clinical Manager
7. Proper Authorities

**V. RESPONSIBILITY**

**Pilots, Mechanics, Communication Specialists, Flight Teams**

**VI. KEY WORDS**

None

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS**

None



- C. No one shall approach the aircraft until signaled by the pilot.
- D. At no time is anyone permitted near the tail of the aircraft.
- E. Always approach the aircraft from ninety (90) degrees of the pilot's door to forty-five (45) degrees of the co-pilot's door.
- F. No smoking within fifty (50) feet of the aircraft, on the helipad, or on hospital property.
- G. No running on the helipad or near the aircraft
- H. No hats or loose articles within fifty (50) feet of the aircraft
- I. No IV poles on stretchers or gurneys within fifty (50) feet of a running aircraft.
- J. Never hold IV's without-stretched arms when rotor blades are in motion.
- K. Stretchers should not have mattress pads, sheets, blankets, pans or any loose articles when brought near the aircraft to unload the patient. L. Do not throw anything from or toward the aircraft.
- M. Never approach or depart the aircraft from the uphill side when the aircraft has landed on a slope.
- N. When around the aircraft, do not lift anything higher than your head.
- O. No vehicles (i.e. ambulance or police car) are allowed to be within fifty (50) feet of the aircraft.
- P. While the aircraft is landing or taking off, artificial light must be pointed away from the aircraft (i.e. flashbulbs, flood lights).

#### Hot Loads/Offloads

#### Air Care landing at other hospitals:

- A. When unloading the aircraft at any other receiving facility other than University of Cincinnati Medical Center (UCMC), the patient will be cold unloaded. If the flight team deems it necessary to hot offload a patient at a facility other than UCMC they must ensure that the flight team can perform hot offload without the assistance of personnel from the other hospital and that the communication specialist has informed the facility of the flight teams plan.
- B. The flight team is responsible for the safety of other personnel around the helicopter and are to direct the unloading of the aircraft.

#### Aircraft other than Air Care landing at UCMC:

- A. When aircraft from other flight programs land at UCMC, the communication specialist will contact the Air Care flight team to assist with unloads.
- B. If the Air Care flight team is not available, the communication specialist will contact:

1. Mobile Care for assistance with cold offloads and escort to and from assigned destination.
2. The ED Charge Nurse to obtain trained paramedics from the ED to assist with cold offload and escort to and from assigned destination.
3. 4th year resident for assistance with cold offload and escort to and from assigned destination
4. Security for escort of cold off load to and from assigned destination.
5. Communication Specialist will instruct assistance on how to access helipad if needed and coordinate additional equipment (i.e. stretcher, oxygen).

C. All documentation of initial and recurrent offload training will be maintained by the Air Care safety officer and reviewed annually. Air Care's standard operating procedure is to never use other personnel to offload patient.

D. Flight programs that wish to offload hot will do so without assistance from personnel listed above. Air Care communication center will inform requesting flight programs of the situation and that personnel will only assist once the flight team and patient have cleared the moving rotors.

**V. RESPONSIBILITY**  
**All Personnel**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS** **None**

**All Transport Associates**

**V. KEY WORDS**  
**None**

**VI. APPENDIX** **None**

**VII. REFERENCES / CITATIONS** **None**

	<u>AC23</u>
<b>POLICY NAME/#</b>	<u>Helipad - Petroleum Liquid Waste Disposal</u>
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>
<b>POLICY OWNER</b>	<p>_____                  Matt Gunderman/Director (Date)</p> <p>_____                  Dr. William Hinckley/Air Medical Director (Date)</p> <p>_____                  Bob Francis, Manager Metro Aviation (Date)</p>
<b>ADMINISTRATIVE APPROVAL</b>	<p>_____                  Jennifer Jackson/VP CNO (Date)</p>
<b>ORIGINATION DATE</b>	<u>7/1999</u>
<b>LAST REVISION/ REVIEW DATE</b>	<b>10/2017</b>
	<b>NEXT REVIEW DATE</b>
	<b>10/2018</b>

**I. POLICY**

To ensure a safe and clean environment, all petroleum waste products from the aircraft will be disposed of properly.

**II. PURPOSE**

To provide guidelines for the disposal of petroleum liquid waste from UCMC helipad and off site hangars.

**III. DEFINITIONS**

UCMC-University of Cincinnati Medical Center

**IV. PROCEDURE**

- A. No fuels or other fluids (oil, cleaning solvents, etc.) are to be deliberately poured into the helipad or hospital drainage or waste system.
- B. If a spill of petroleum liquid waste should occur, block off the area and contact the appropriate maintenance department at each facility immediately for further actions.
- C. At the University of Cincinnati Medical Center (UCMC) base, if a disposal is identified, the associate shall contact the Environmental Services Department to request a container. After the container is delivered to the hangar and it is utilized by the appropriate associate, the container should be left in the hangar and the associate shall notify Environmental Services Department when the container is ready for pick-up.
- D. For flight operations at hangar locations, disposal of petroleum products must be in compliant to air vendor, airport and EPA guidelines.

**V. RESPONSIBILITY**

All Personnel

**VI. KEY WORDS**

None

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS**

None



- A. The West helipad is primarily for the use of the UCMC assigned aircraft.
- B. The East helipad is intended for on and off load of patients and crewmembers. Aircraft using the East pad will on or off load their patient/crew and then vacate the pad. If the aircraft needs to be shut down for on/off load the Pilot in Command (PIC) is requested to taxi as far to the North and East as safely possible to maximize the approach corridor for aircraft landing or departing from the West helipad.

**Third Helicopter:**

By exception, a third helicopter may land on the UCMC helipad if the two preceding aircraft are parked on the helipad perimeter and, in the opinion of the PIC, a safe approach can be made without over-flying parked aircraft.

**PROCEDURE:**

- A. The communication specialist will notify the UCMC's Air Operator on-duty pilot that a third aircraft has asked for permission to use the UCMC helipad.
- B. Unless the on-duty pilot decides that it is unsafe to land an additional aircraft, the third aircraft is allowed to land solely at the PIC's discretion.
- C. If determined that a third aircraft cannot land safely, the communication specialist will coordinate with the on-duty pilot to potentially move one of the aircraft currently on the helipad or coordinate with the landing pilot (s) and alternate facilities to identify an alternate landing site for the incoming aircraft.
- D. If the incoming aircraft lands at an alternate facility the communication specialist will assist in arranging ground transport of the incoming patient to UCMC.

\*No policy that addresses a situation such as this can cover every possible contingency. In order to meet the demands of patient transport and safety of all involved, other solutions may be explored to meet extreme circumstances. In every event, all efforts will be made by everyone involved to accommodate all helicopters in the safest manner possible.

**V. RESPONSIBILITY**  
**Pilots, Communication Specialists**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS**  
**None**

	AC25																
POLICY NAME/#	<u>Helipad - Weight Limitations</u>																
POLICY TITLE	<u>Air Care and Mobile Care</u>																
POLICY OWNER	<table border="0"> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>Matt Gunderman/Director</td> <td>(Date)</td> </tr> <tr> <td colspan="2"> </td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>Dr. William Hinckley/Air Medical Director</td> <td>(Date)</td> </tr> <tr> <td colspan="2"> </td> </tr> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>Bob Francis, Manager Metro Aviation</td> <td>(Date)</td> </tr> </table>	_____	_____	Matt Gunderman/Director	(Date)			_____	_____	Dr. William Hinckley/Air Medical Director	(Date)			_____	_____	Bob Francis, Manager Metro Aviation	(Date)
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ADMINISTRATIVE APPROVAL	<table border="0"> <tr> <td>_____</td> <td>_____</td> </tr> <tr> <td>Jennifer Jackson/VP CNO</td> <td>(Date)</td> </tr> </table>	_____	_____	Jennifer Jackson/VP CNO	(Date)												
_____	_____																
Jennifer Jackson/VP CNO	(Date)																
ORIGINATION DATE	<u>7/1999</u>																
<b>LAST REVISION/ REVIEW DATE</b>	<b>10/2017</b>																
	<b>NEXT REVIEW DATE</b>																
	<b>10/2018</b>																

- I. POLICY  
No aircraft that exceeds the helipad’s weight limits will be permitted to land on University of Cincinnati Medical Center helipad (UCMC).
  
- II. PURPOSE
  
- III. DEFINITIONS  
UCMC-University of Cincinnati Medical Center
  
- IV. PROCEDURE

The following weight restrictions apply to UCMC helipad. This information is for the record and should be addressed in the event another helicopter requests to land UCMC helipad.

Maximum landing weight for aircraft landing on UCMC helipad is as follows: A.  
West pad 10,000 lbs.  
B. East pad 12,000 lbs.

**V. RESPONSIBILITY**  
All Personnel

**VI. KEY WORDS**  
None

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS** None

	AC26	
POLICY NAME/#	Helipad: Other Facility Helipad Review/Pre-determine landing zones	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER	<p>_____ Matt Gunderman/Director (Date)</p> <p>_____ Dr. William Hinckley/Air Medical Director (Date)</p> <p>_____ Bob Francis, Manager Metro Aviation (Date)</p>	
ADMINISTRATIVE APPROVAL	<p>_____ Jennifer Jackson/VP CNO (Date)</p>	
ORIGINATION DATE	10/1999	
<b>LAST REVISION/ REVIEW DATE</b>	<b>10/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>10/2018</b>

- I. POLICY  
All routine and pre-determined hospital helipad and landing zones should be inspected to insure viability for safe usage by Air Care.
- II. PURPOSE
- III. DEFINITIONS  
None

#### **IV. PROCEDURE**

- A. During normal flight operations to other helipads, the line pilots should perform a visual inspection of the helipad. If issues arise, the pilot will submit a Concern Form so it can be addressed. If significant changes occurred, the Landing Zone File should be updated.
- B. An annual review should be made of the files to identify any landing zones that have not been inspected during the normal flight operations.
- C. Annually the database for helipads and pre-determine landings zones should be reviewed so an organized effort can be made to visually inspect the locations. Inspection can be complete by pilot-on duty, safety pilot or their designee. Documentation of review of helipad/landing zones must be updated after each inspection.

#### **V. RESPONSIBILITY** **Pilots, Safety Committee**

#### **VI. KEY WORDS** **None**

#### **VII. APPENDIX** **None**

#### **VIII. REFERENCES / CITATIONS** **None**

	<u>AC27</u>
POLICY NAME/#	<u>Distractions During Aircraft Maintenance</u>
POLICY TITLE	<u>Air Care and Mobile Care</u>
POLICY OWNER	<p>_____ Matt Gunderman/Director (Date) _____</p> <p>_____ Dr. William Hinckley/Air Medical Director (Date) _____</p> <p>_____ Bob Francis, Manager Metro Aviation (Date) _____</p>
ADMINISTRATIVE APPROVAL	_____ Jennifer Jackson/VP CNO (Date) _____
ORIGINATION DATE	<u>7/1999</u>
<b>LAST REVISION/ REVIEW DATE</b>	<b>8/2017</b>
	<b>NEXT REVIEW DATE</b>
	<b>8/2018</b>

**I. POLICY**

To foster an environment of safety, every attempt will be made to reduce the likelihood of interruptions and distractions to mechanics engaged in aircraft maintenance or inspection.

**II. PURPOSE**

To outline the responsibilities of the mechanics and pilots in regards to reducing the likelihood of interruptions and distractions to the mechanic while performing maintenance.

**III. DEFINITIONS**

None

**IV. PROCEDURE**

- A. In order to minimize distractions when the mechanics are performing maintenance, all communication will be through the pilots on duty as to the status of the aircraft. All calls and inquiries regarding the aircraft status will be screened by the pilot.
- B. While maintenance is in progress, mechanics will not be informed of pending flights.
- C. No tours in the maintenance area will be conducted during periods of major maintenance tasks.
- D. The helipad's traffic flow should be kept at a minimum especially when the mechanic(s) are performing aircraft maintenance.
- E. The mechanic has the right and responsibility to clear all non-essential personnel from the area while maintenance is being performed.

**V. RESPONSIBILITY**  
**All Air Care Personnel**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS**  
**None**

	<u>AC53</u>	
POLICY NAME/#	<u>Air Care &amp; Mobile Care Tool Control Policy</u>	
POLICY TITLE	<u>Air Care and Mobile Care</u>	
POLICY OWNER	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Bob Francis, Manager Metro Aviation (Date)	
ADMINISTRATIVE APPROVAL	_____ Jennifer Jackson/VP CNO (Date)	
ORIGINATION DATE	<u>2/2013</u>	
LAST REVISION/ REVIEW DATE	<u>8/2017</u>	NEXT REVIEW DATE <u>8/2018</u>

**I. POLICY**

Air Care & Mobile holds safety of its personnel and customers as its number one value. A proactive safety management program is utilized to ensure that safety policies and procedures are created, implemented and followed by all Air Care & Mobile Care and contracted employees. This policy will foster a systematic approach to tool control and the course for accountability for all personnel responsible for any maintenance on owned or leased vehicles. The failure to comply with this policy will result in corrective action as outlined by the health systems or contracted entities policy.

**II. PURPOSE**

The purpose of this Policy is to increase Operations and Maintenance awareness of Tool Control and prevent any Foreign Object Damage.

**III. DEFINITIONS**

FOD-Foreign Object Damage (Debris)

#### **IV. PROCEDURE**

Mechanics will do the following:

- A. Always secure and account for tools.
- B. Tools inventories will be conducted at the beginning and completion of each maintenance activity.
- C. Keep a current inventory of all tools by drawer or container. Any travel cases must also be inventoried. Toolboxes should contain shadowed tool positions; if toolboxes/bags cannot be shadowed, then an alternate, adequate, and practical means of tool accountability will be used, e.g., photos of individual drawers, labels on wrench racks, or tools stored in specific cases.
- D. If a tool required calibration, the tool must be tagged with documentation of last calibration and the next due date.
- E. Do not temporarily place tools on an aircraft surfaces.
- F. Use only the tools required to complete a specific task.
- G. After completion of work on the aircraft, and before returning it to service, a pilot and/or mechanic will check the aircraft for FOD and tools.
- H. If aviation vendor allows personal tools to be used, there is a process to ensure personal tools are currently calibrated.

The post-maintenance check shall consist of a face-to-face briefing with the person conducting the post maintenance inspection of the work area. The briefing will include the maintenance task that was performed, any cowlings/panels that were opened/removed, any components/lines that were repositioned or removed in order to facilitate maintenance, and an inventory of the mechanics tools. The Post Maintenance Check must be performed before the aircraft is returned to service.

The Post Maintenance Check should include, at a minimum, a thorough pre-flight/visual check for:

- A. General condition and security of all components.
- B. Loose, missing, or extra hardware in the area of maintenance.
- C. Obvious defects in the area of maintenance.
- D. Tools, loose hardware, rags, or foreign objects left on the aircraft.
- E. Proper safeties and cotter pins in the area of maintenance.

#### **V. RESPONSIBILITY**

**Mechanics, Pilots**

#### **VI. KEY WORDS**

**None**

#### **VII. APPENDIX** **None**

#### **VIII. REFERENCES / CITATIONS** **None**

	<u>AC28</u>
POLICY NAME/#	<u>Procedures for Mechanics Not Trained for Task Required</u>
POLICY TITLE	<u>Air Care and Mobile Care</u>
POLICY OWNER	<div style="margin-bottom: 10px;"><u>        </u> <span style="float: right;"><u>        </u></span></div> <div style="margin-bottom: 10px;">Matt Gunderman/Director <span style="float: right;">(Date)</span></div> <div style="margin-bottom: 10px;"><u>        </u> <span style="float: right;"><u>        </u></span></div> <div style="margin-bottom: 10px;">Dr. William Hinckley/Air Medical Director <span style="float: right;">(Date)</span></div> <div style="margin-bottom: 10px;"><u>        </u> <span style="float: right;"><u>        </u></span></div> <div style="margin-bottom: 10px;">Bob Francis, Manager Metro Aviation <span style="float: right;">(Date)</span></div>
ADMINISTRATIVE APPROVAL	<u>Jennifer Jackson /VP CNO</u> <span style="float: right;"><u>        </u></span> <span style="float: right;">(Date)</span>
ORIGINATION DATE	<u>7/1999</u>
<span style="color: red;">LAST REVISION/ REVIEW DATE</span> <b>8/2017</b>	<span style="color: red;">NEXT REVIEW DATE</span> <b>8/2018</b>

**I. POLICY**

Air Care & Mobile holds safety of its personnel and customers as its number one value. A proactive safety management program is utilized to ensure that safety policies and procedures are created, implemented and followed by all Air Care & Mobile Care and contracted employees. This policy grants a mechanic the permission without fear of reprisal to decline a maintenance assignment in a task where appropriate training has not been given until an appropriately trained mechanic is available to directly supervise or assist.

**II. PURPOSE**

This policy provides the guidelines for the mechanic permission to decline performing maintenance critical to flight that he/she has not been trained to perform. This will ensure that that an appropriately trained mechanic is available for direct supervision or assistance.

**III. DEFINITIONS**

None

**IV. PROCEDURE**

- A. If a mechanic should refuse to perform any maintenance that they feel they are not trained for, he/she will notify the lead mechanic and the lead pilot.
- B. The mechanics will follow the procedures according to contracted air operator.
- C. The Maintenance Supervisor or Director of Maintenance will be notified and appropriate steps will be taken to solve the problem.

**V. RESPONSIBILITY**

Mechanic, Pilot

**VI. KEY WORDS**

None

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS**

None



**III. DEFINITIONS**

**CCHMC-Cincinnati Children's Hospital Medical Center**

**IV. PROCEDURE**

Neonate: Infant up to a month (28 days) old who has never been discharged from the hospital.

- A. The Air Care & Mobile Care medical team will assist in the resuscitation of the neonate at the referring institution.
- B. If needed a call could be placed to the Neonatal Faculty at University of Cincinnati Medical Center for consultation.
- C. Cincinnati Children's Hospital Medical Center Transport Team should be called to respond to the referring institution for continued care and transport of the neonate.
- D. The Air Care & Mobile Care medical team will stay with the infant at the referring institution until the arrival of the CCHMC Transport Team.

**V. RESPONSIBILITY**

**All Personnel**

**VI. KEY WORDS**

**None**

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS**

**None**



#### **IV. PROCEDURE**

- A. To provide appropriate medical personnel, transfer of a neonate is defined as an infant up to a month old (28 days) who needs radiant warmer for thermoregulation and/or without hospital discharge since birth. If the ACMC Communication Center receives a request of this nature, these transports should be referred to Cincinnati Children's Hospital Medical Center (CCHMC) Transport Team.
- B. If the patient's condition warrants, the CCHMC Transport Team can be flown by Air Care to the requesting facility.
- C. Upon the request, the communication specialist will complete the following:
  - 1. Notify the flight team of a potential flight alert for the CCHMC Transport Team. Give the destination and estimated time of arrival of the team.
  - 2. Notify the faculty physician of the request.
  - 3. The pilot will determine, based on aircraft performance, weights and fuel load, the total weight acceptable for the CCHMC Transport Team.
  - 4. In cases where a patient is to be transported, and an independent CCHMC team is not available, a ACMC flight personnel must be present as the role of safety officer.
  - 5. While waiting for the CCHMC Transport Team, the flight team will prepare the aircraft.
  - 6. The CCHMC Transport Team will obtain and maintain all needed education as a flight crew member from the aviation vendor. All documentation will be kept by the air vendor.
  - 7. Flight following, notifications and all other procedures will remain the same as for any other flight. The aircraft, flight nurse and pilot will stay with the non-independent CCHMC Transport Team until released by them or upon return of the team to the Air Care helipad. In the event that the aircraft needs to depart due to weather before the CCHMC team is ready, every effort will be made to provide another aircraft or ground assistance with the CCHMC ground transport team.
  - 8. See the "Safety Officer" policy for expectations and role of the ACMC safety officer.

#### **V. RESPONSIBILITY**

**Communication Specialists, Pilots, Flight Nurses, APN, Physician, Faculty Physicians**

#### **VI. KEY WORDS**

None

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS None**

	ACMC39	
POLICY NAME/#	Oxygen Supply and Storage	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Dr. Elizabeth Powell Ground Medical Director (Date)	
ADMINISTRATIVE APPROVAL	_____ Jennifer Jackson/VP CNO (Date)	
ORIGINATION DATE	11/2001	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>7/2018</b>

- I. POLICY  
 Air Care and Mobile Care uses medical grade oxygen cylinders of various sizes. Transport associates shall assure that safety considerations are maintained and that ample oxygen is available on transports.
  
- II. PURPOSE  
 TO PROVIDE GUIDELINES ON WHEN TO EXCHANGE OXYGEN TANKS TO ASSURE PATIENT SAFETY.
  
- III. DEFINITIONS  
 None

#### **IV. PROCEDURE**

- A. Air Care and Mobile Care shall be responsible for temporary storage and transportation of oxygen cylinders to and from storage areas, transport vehicles, airway packs, cots, etc.
  - 1. All oxygen cylinders must be secured with the approved securing device.
  - 2. Protective caps should be kept on cylinders while not in use. D type cylinders are the exception.
  - 3. The cylinder valve should not be opened unless the cylinder is secured appropriately.
  - 4. The number of oxygen cylinders that are kept available cannot exceed the number of appropriate securing devices.
  - 5. In the event of a fire or motor vehicle accident involving the ambulance, consider shutting off all oxygen sources if the safety of all occupants is not compromised in doing so.
- B. Air Care and Mobile Care shall provide an adequate supply of oxygen for each transport.
  - 1. All main oxygen tanks on the ambulances will be exchanged for a full bottle at 500psi minimum.
  - 2. All portable oxygen tanks shall be replaced at 500 lbs.
- C. Oxygen cylinder lifts
  - 1. Yellow oxygen cylinder lifts should be utilized whenever possible for main H & M tanks.
  - 2. Yellow oxygen cylinder lifts with battery chargers are located at Webster garage, West Chester Medical Center & Drake
  - 3. TWO associates are required to move and/or lift "H" sized main oxygen tank, in the event the O2 cylinder lift is not available.
- D. "H" sized tanks will only be installed in ambulances that have been properly prepared for the larger tanks. All other ambulances will still be supplied with an "M" sized tank.
- E. Ambulances supplied with horizontal main oxygen tanks require two associates for replacing bottles.

#### **V. RESPONSIBILITY**

All Team Members

#### **VI. KEY WORDS**

None

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS**

None

	<u>AC31</u>
POLICY NAME/#	<u>Oxygen Systems-Maintenance of On-Board Oxygen (Air Care)</u>
POLICY TITLE	<u>Air Care and Mobile Care</u>
POLICY OWNER	_____
	<u>Matt Gunderman/Director</u> (Date)
	_____
	<u>Dr. William Hinckley/Air Medical Director</u> (Date)
	_____
	<u>Bob Francis, Manager Metro Aviation</u> (Date)
ADMINISTRATIVE APPROVAL	_____
	<u>Jennifer Jackson/VP CNO</u> (Date)
ORIGINATION DATE	<u>9/1999</u>
<b>LAST REVISION/ REVIEW DATE 8/2017</b>	<b>NEXT REVIEW DATE 8/2018</b>

**I. POLICY**

Only personnel with an FAA Airframe and Power (A&P) Plant license and personnel trained by FAA A & P mechanics are authorized to change, refill or service fixed oxygen tanks in the aircraft.

**II. DEFINITIONS**

None

**III. PROCEDURE**

A. Duties and responsibilities – appropriately trained personnel with an FAA Airframe and Power Plant license or their designee are the only individuals authorized by federal regulations and the helicopter vendor to install, service, or remove medical oxygen tanks.

- B. The medical crew member is responsible for notifying the pilot or aircraft mechanic on duty of low levels of oxygen in the aircraft. The oxygen will also be checked as follows:
  - 1. 4.0 – mechanic will check aircraft daily and make sure liquid oxygen (LOX) is at a minimum of 4.0 liters before leaving for the day.
  - 2. 3.0 –the nurse will inform the pilot/mechanic of the oxygen level so LOX can be changed the following shift.
  
- C. Records for Tank or Bottle Services – all bottle installations, services or removal will be changed in accordance with the helicopter vendors and federal regulations.
  
- D. Training:
  - 1. Aviation personnel must receive training by the hospital in oxygen use.
  - 2. The flight nurse must have received training in clinical and physical use of oxygen prior to flying.
  - 3. Personnel will receive an annual review regarding emergency oxygen shut- down procedures.
  
- E. Inspection – the portable tanks which are located on the helicopter will be checked following each flight and at the beginning of each shift by the flight nurse. The flight nurse will be briefed by the mechanic on the aircraft oxygen amounts during shift briefing.
  - 1. Visual checks of connectors, lines and brackets should be done daily. All deficiencies should be noted and corrected.
  - 2. Post flight – oxygen should be turned off at the completion of the transport.
  
- F. Storing – all tanks must be securely inserted in the holders located in the equipment room or, when carried on the helicopter, must be properly fastened in their holders. Air Care will have no more than 12 cylinders of O<sub>2</sub> at any aircraft location at one time.
  
- G. Oxygen will be ordered through the administrative assistant by the appropriate personnel assigned to do so and documented as required.

**IV. RESPONSIBILITY**

**Mechanic, Pilot, Flight RN**

**V. KEY WORDS**

**None**

**VI. APPENDIX** **None**

**VII. REFERENCES / CITATIONS** **None**

	<u>AC33</u>												
<b>POLICY NAME/#</b>	<u>Pilot as Final Authority</u>												
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>												
<b>POLICY OWNER</b>	<table border="0" style="width: 100%;"> <tr> <td style="border-bottom: 1px solid black; width: 60%;"></td> <td style="border-bottom: 1px solid black; width: 40%;"></td> </tr> <tr> <td>Matt Gunderman/Director</td> <td>(Date)</td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td>Dr. William Hinckley/Air Medical Director</td> <td>(Date)</td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td>Bob Francis, Manager Metro Aviation</td> <td>(Date)</td> </tr> </table>			Matt Gunderman/Director	(Date)			Dr. William Hinckley/Air Medical Director	(Date)			Bob Francis, Manager Metro Aviation	(Date)
Matt Gunderman/Director	(Date)												
Dr. William Hinckley/Air Medical Director	(Date)												
Bob Francis, Manager Metro Aviation	(Date)												
<b>ADMINISTRATIVE APPROVAL</b>	<u>Jennifer Jackson/VP CNO</u> (Date)												
<b>ORIGINATION DATE</b>	<u>11/2008</u>												
<b>LAST REVISION/ REVIEW DATE</b>	<b>6/2017</b>												
	<b>NEXT REVIEW DATE</b>												
	<b>6/2018</b>												

**I. POLICY**

To ensure that proper operational control and safety of all crew members is maintained at all times, the pilot-in-command has the final authority on all go/no-go decisions of the aircraft.

**II. PURPOSE**

To identify the Pilot-In-Command as the final authority in air operations.

**III. DEFINITIONS**

None

**IV. PROCEDURE**

- A. In compliance with FAR 91.3 the pilot-in-command is the final authority for all operations of the aircraft.

- B. All medical crew have the right to refuse to launch or request the pilot to return to safer conditions.

**V. RESPONSIBILITY**

**Pilot**

**VI. KEY WORDS**

**None**

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS None**



WCH DRAKE


AMBULATORY/UCPC

MEDICATION MGMT  
POLICY OTHER

<b>POLICY #</b>	AC55		
<b>POLICY NAME</b>	Preflight Actions		
<b>ORIGINATION DATE</b>	10/10/2017		
<b>SPONSORED BY</b>	Air Care & Mobile Care	<b>DATE</b>	10/10/2017
<b>ADMINISTRATIVE APPROVAL</b>	_____	<b>DATE</b>	_____
<b>LAST REVIEW / REVISION DATE</b>	10/2017	<b>NEXT REVIEW DATE</b>	10/2018

Administrative  
  Interdepartmental  
  Departmental  
  Unit Specific

**I. POLICY**  
To Standardize preflight operations at each base to the start of pilot shift change

**II. PURPOSE**  
Preflight activities are vital to mitigate risk and maintain operational readiness

**III. DEFINITIONS**  
None

**IV. PROCEDURE**

A. Upon arrival to the base, the pilot will call the communication center and initiate their preflight duties with the hand held radio in their possession. The communication center will note they are on a delay for preflight. Pilots are not to be disturbed during the 20-minute window from the communication center or

medical crew unless pilot initiates discussion pertaining to the work shift. As a general rule, preflight will typically be completed within 20-minutes, however more time may be needed if they find a problem during preflight.

- B. If a request for service originates during the 20-minute delay, the communication center may activate another base with a quicker response.
- D. If prior to the 20 minutes for preflighting the pilot hears the communication center assigning a different aircraft for a flight and determines his team would have a quicker response to the patient, then the pilot can and should contact communication center and state they are finishing their preflight and will be ready to accept that flight.
- C. After 20 minutes, the Communication Center may call the pilot with a pending request to determine if more time is necessary to complete preflight activities. This will allow for a safe and thorough preflight while still allowing the Communication Center the ability to assign a call to the base when there are no other, more timely, Air Care options available. If more preflight time is required, the pilot will inform the communication Center and no additional flight information will be given to the pilot.
- E. If additional time is required, the Communication Center will add that time to the standard lift time and advise the requesting agency of the anticipated ETE.
- F. Once all preflight duties are complete, the pilot will call and advise the Communication Center they are ready for the shift. The Communication Center will then annotate the aircraft is ready for flights and process all requests normally.

**V. RESPONSIBILITY**

Pilots, Flight Nurses, APNs, Physicians and Communication Specialists

**VI. KEY WORDS**

None

**VII. APPENDIX**

None

**VIII. RELATED FORMS**

None

**IX. REFERENCES / CITATIONS**

None

	AC34						
POLICY NAME/#	Quality Management and Improvement Program-Pilots						
POLICY TITLE	Air Care and Mobile Care						
POLICY OWNER							
	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; border-top: 1px solid black;">Matt Gunderman/Director</td> <td style="width: 50%; border-top: 1px solid black;">(Date)</td> </tr> <tr> <td style="border-top: 1px solid black;">Dr. William Hinckley/Air Medical Director</td> <td style="border-top: 1px solid black;">(Date)</td> </tr> <tr> <td style="border-top: 1px solid black;">Bob Francis, Manager Metro Aviation</td> <td style="border-top: 1px solid black;">(Date)</td> </tr> </table>	Matt Gunderman/Director	(Date)	Dr. William Hinckley/Air Medical Director	(Date)	Bob Francis, Manager Metro Aviation	(Date)
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ADMINISTRATIVE APPROVAL	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%; border-top: 1px solid black;">Jennifer Jackson/VP CNO</td> <td style="width: 50%; border-top: 1px solid black;">(Date)</td> </tr> </table>	Jennifer Jackson/VP CNO	(Date)				
Jennifer Jackson/VP CNO	(Date)						
ORIGINATION DATE	9/1999						
LAST REVISION/ REVIEW DATE	8/2017						
	NEXT REVIEW DATE 8/2018						

- I. POLICY  
All ACMC program operations and contracted personnel operations are subject to a documented and pre-planned quality management process and improvement program to ensure high quality, safe operations and patient care.
  
- II. PURPOSE  
Aviation personnel are required to provide evidence of the outline indicators to demonstrate continued competence and performance improvement.
  
- III. DEFINITIONS  
None
  
- IV. PROCEDURE

The Area Site Manager (AMS) or his representative will be responsible for assuring pilot's knowledge of aviation subjects and AMS responsibilities. The contract vendor's check airmen are the principal trainers and evaluators. Pilots are subject to inspection at any time by the FAA.

- A. Initial, transition and recurrent training will be conducted in accordance with FAA and air operator's operations manual.
- B. New and relief pilots will comply with vendor's operations manual prior to operating in the Cincinnati geographical and service areas. Proper briefings are detailed concerning flight safety for the type of operations and area.
- C. Line checks will be conducted in accordance to FAR 135.299 and the air operator's operations manual.
- D. Random manifests checks will be conducted to ensure compliance with weight and balance limitations, rules, regulations and guidelines.
- E. Annual review of frequently used helipads and pre-determined landing zones.
- F. Daily inspections of base helipad and facilities.
- G. Random written testing of aviation subjects for pilots.
- H. Flight simulation training as outlined by the aviation vendor
- I. Daily briefings with each crew to facilitate discussion of aviation matters.
- J. Verification of QA fuel quality compliance at refueling locations.

**V. RESPONSIBILITY**  
**Area Site Manager, Lead Pilot, Pilot**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS**  
**None**

	<u>ACMC44</u>
<b>POLICY NAME/#</b>	<u>Quality Management</u>
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>
<b>POLICY OWNER</b>	<p>_____ Matt Gunderman/Director (Date)</p> <p>_____ Dr. William Hinckley/Air Medical Director (Date)</p> <p>_____ Dr. Elizabeth Powell/Ground Medical Director (Date)</p>
<b>ADMINISTRATIVE APPROVAL</b>	_____ Jennifer Jackson/VP CNO (Date)
<b>ORIGINATION DATE</b>	<u>9/1999</u>
<b>LAST REVISION/ REVIEW DATE</b>	<b>8/2017</b>
	<b>NEXT REVIEW DATE</b>
	<b>8/2018</b>

**I. POLICY**

The mission of the Air Care & Mobile Care Quality Management (QM) program supports and reflects the department’s mission. The QM mission is to promote excellence and seek process improvement measures which promote high quality and safe patient care for all customers by bringing the world class care of University of Cincinnati Medical Center to the patient through advance transport medicine.

**II. PURPOSE**

Outline the QM efforts of ACMC and areas that are reviewed on either a weekly, monthly, or annual basis and result in performance improvement initiatives if needed

**III. DEFINITIONS**

None

#### **IV. PROCEDURE**

- A. A wide range of factors influence the delivery of quality care; therefore, a wide range of quality indicators are identified within the structure of the QM program as indicated. QM indicators should include, but not limited to:
1. Direct patient care
  2. Safety
  3. Efficiency and productivity
  4. Environment of care
  5. Competencies
  6. Associate health and well being
  7. Reimbursement/Business Ethics
  8. Customer satisfaction
  9. Daily operations
  10. Utilization Review
- B. QM initiatives, data, report and meeting minutes are considered confidential and are subject to protection from disclosure by state law.
- C. The effectiveness of the QM program and its initiatives will be re-evaluated at a minimum of annually.

#### **V. RESPONSIBILITY All Team Members**

#### **VI. KEY WORDS None**

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS None**



- C. The communication specialist will note gallons received on the flight request in computer aided dispatch system.
- D. Aircrafts will be considered “ready for transports” with no less than one hundred (100) gallons of fuel

**V. RESPONSIBILITY**  
**Pilot**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS**  
**None**



#### **IV. PROCEDURE**

- A. An employee, staff member or public service agency individual should be encouraged to contact Air Care & Mobile Care communication specialist when he/she is going to be on hospital property and available for a refuel flight. The information the communication specialist should obtain from the rider includes: name, phone/pager number, hours available (tell rider if a flight becomes available and time permits, the communication specialist will make one (1) attempt to contact the rider.)
- B. Air Care will NOT maintain a list to call personnel for an indefinite amount of time.
- C. The employee or staff member must be available upon a moment's notice and must have secured supervisory permission where necessary.
- D. The rider shall be escorted up to the helipad to assure there is no loitering on the helipad while waiting for a ride.
- E. Riders must ride in the front seat unless accompanied in the back by one of the Air Care Flight Team Members.
- F. Typically, due to the high volume of requests, each person requesting to fly along will only be able to do so one (1) time, unless the ride-along program coordinator or clinical manager approves otherwise.
- G. All potential riders must go through a safety briefing by the pilot-on-duty before the flight.
- H. Final approval for accepting riders will remain with the pilot-in-command.

#### **V. RESPONSIBILITY**

**Communication Specialist, Pilot, Flight Nurse**

#### **VI. KEY WORDS**

**None**

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS**

**None**



- B. If refueling is required during a transport, one team member will be responsible for fueling while the other maintains patient care.
- C. At the end of each shift, the fuel should be at least  $\frac{3}{4}$  full. Under unusual circumstances, it may not be possible to refuel. In those instances, notify the communication specialist.

**V. RESPONSIBILITY**  
**All Transport Team Members**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**



- safety. The clinical director, all clinical managers/supervisors, Aviation Site Manager, lead pilot(s), and lead mechanic are to assist the program director in all aspects of the SMS.
- B. There will be an advisory council for each segment of the program, i.e. air and ground. All disciplines will be represented on the councils by at least 2 associates: physicians, advanced practice nurses, critical care nurses, paramedic/EMT's, communications specialists, pilots, and mechanics.
  - C. Each safety advisory council will have a chairperson designated by the program director. Each chair-person will be responsible for the functioning of their respective council by conducting meetings, broadcasting electronic meetings by means of email, documenting minutes, and organizing formal safety exercises and safety education classes for associates.
  - D. Each safety advisory council has the responsibility of conducting a formal incident/accident investigation and analysis for the disposition of "safety concerns" submitted by associates.
  - E. The safety advisory councils will report their "actions/recommendations" for each concern that is submitted, to the management staff.
  - F. This program will maintain a Just Culture in which reporting of all safety hazards to management will not initiate disciplinary action against any personnel who, in good faith, discloses a hazard or safety occurrence.
  - G. The chairperson of each safety advisory council will organize and conduct quarterly safety meetings, as well as record minutes for such meetings.
  - H. All program members must attend a minimum of 75% of quarterly safety meetings. Only valid excuses will be accepted and must be reported to the appropriate manager previous to the date of the scheduled meeting.
  - I. On-going safety education for flight physicians will be accomplished by quarterly education sessions conducted at the regularly scheduled Grand Rounds.
  - J. The management staff, together with the chairs of the safety advisory councils, are also charged with keeping informed with current changes/recommendations and practices put forth by professional/national organizations cogent to the medical transport community.
  - K. Safety Training for program associates will be accomplished by means of: quarterly safety meetings, safety presentations at state of the department

meetings, annual AMRM classes, annual skills days, field exercises such as survival training/missing aircraft/ambulance training, attending national or regional conferences, special training classes deemed immediately necessary by the management staff/safety councils.

**Risk Management**

- A. It will be the posture of Air Care & Mobile Care personnel to be proactive in the risk management process.
- B. Being a proactive program will require the following:
  - 1. Seek to identify potential hazards through the analysis of everyday activities
  - 2. Utilize the program’s safety reporting systems
  - 3. Creating a data base of “concerns” submitted, for the purpose of monitoring and analyzing trends
  - 4. Tracking of hazard controls for the effectiveness of corrective action
- C. Pilots will conduct a risk assessment at the beginning of their shift as per the FAA guidelines for HEMS. Ground personnel will conduct a risk assessment via department process.
- D. Each safety concern will be quantified for risk according to the following risk assessment matrix:

		PROBABILITY				
		Frequent	Probable	Occasional	Remote	Improbable
SEVERITY	Catastrophic	1	2	4	8	12
	Critical	3	5	6	10	15
	Marginal	7	9	11	14	17
	Negligible	13	16	18	19	20

- E. Definition of terms used in the risk matrix:
  - 1. Negligible-no system disruption
  - 2. Marginal-aircraft damage or minor injury or loss of critical aircraft system
  - 3. Critical-Serious personal injury, substantial aircraft damage

4. Catastrophic-loss of life, loss of aircraft
5. Improbable-not likely to ever occur
6. Remote-likely to occur once every 20 years
7. Occasional-likely to occur once a year
8. Probable-likely to occur twice a month
9. Frequent-likely to occur once a week

F. A safety concern rated from 1-5 requires a face-to-face meeting of the respective safety council within 48 hours.

G. Depending on industry resources, Air Care & Mobile Care will under-go external safety audit every 4 years. Hospital and vendor mandated audits will be done on a periodic basis.

H. Each respective advisory council is responsible for monitoring the disposition of a safety concern. On-going monitoring will be documented as “reviewed” at least every 6 months and evidence of a corrective path should be demonstrated.

**V. RESPONSIBILITY**  
**All Associates**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS** **None**



### III. PROCEDURE

- A. Safety concern form can be accessed on [www.aircareandmobilecare.com](http://www.aircareandmobilecare.com).
- B. When an associate identifies a safety concern, they should access the website, click on the "staff "only" section. Complete the form and submit.
- C. The form will then be forwarded to the leadership team, the administrative assistant and the safety officers for air and ground. Upon receiving the concern form, the administrative assistant will record the concern on the appropriate safety log, with the date received.
- D. The program director and chairperson of the safety committee will address any concerns that require immediate action.
- E. The respective safety committee chairperson will contact the associate who submitted the concern and inform them of receipt of the concern and how the process will go forward. The chairperson will then inform members of the safety committee of the concern and recruit 1 or 2 members to conduct the analysis of the concern. The analysis and recommendations for the concern will be discussed/finalized at the next meeting of the safety committee. The chairperson will then inform the associate who submitted the concern of the final action.
- F. The final resolution of the concern shall be given to the administrative assistant for entry on the safety log.
- G. The concern and its resolution should be communicated to all associates for educational purposes.
- H. In the event that the associate is unable to access the ACMC web site, a paper Form of the Concern process is available.

### IV. RESPONSIBILITY

All Transport Associates

### V. KEY WORDS

None

### VI. APPENDIX None

### VII. REFERENCES / CITATIONS

None

	ACMC51
POLICY NAME/#	Safety - General
POLICY TITLE	Air Care and Mobile Care
POLICY OWNER	
	_____ Matt Gunderman/Director (Date)
	_____ Dr. William Hinckley/Air Medical Director (Date)
	_____ Dr. Elizabeth Powell/Ground Medical Director (Date)
ADMINISTRATIVE APPROVAL	_____ Jennifer Jackson/VP CNO (Date)
ORIGINATION DATE	7/1999
<b>LAST REVISION/ REVIEW DATE</b>	<b>6/2017</b>
	<b>NEXT REVIEW DATE</b>
	<b>6/2018</b>

- I. **POLICY**  
 Air Care and Mobile Care strive to provide the safest patient care possible. In an effort to ensure patient safety, general safety concepts will be followed. This policy provides a wide over-view of general safety concepts that all team members must abide.
  
- II. **DEFINITIONS**  
 None
  
- III. **PROCEDURE**
  - A. The pilot-in-command/ambulance driver holds the final authority for flight/ground transport safety, selection of landing areas/parking areas, loading and equipment storage issues, and all operations procedures.

- B. All transport associates have the responsibility and authority to cancel or discontinue a transport due to conditions perceived to be unsafe (i.e. weather, LZ conditions, and patient uncooperativeness).
- C. All equipment will be secured with the restraint devices provided by the aircraft/ambulance manufacturers before each vehicle movement.
- D. The transport team will wear seat belts, shoulder harnesses, and approved department uniforms (refer to department Uniform Policy), whenever in a moving vehicle (air or ground.) When indicated for patient care, the transport team may release the harness and belt but only after notifying the pilot/driver.
- E. The transport team will assist the pilot/driver in: watching for other air/ground traffic; clearing the tail of the aircraft; and clearing the main rotor blades/backing the ambulance; in general, watching for any hazard that should be brought to the pilot's/driver's attention.
- F. The flight/ground team will never disembark the aircraft/ambulance without the pilot's/driver's permission.
- G. All flight/ground team members are expected to stay alert on all legs of a transport, including at least one team member on empty legs, to assist the pilot/driver in staying alert.
- H. No patient should be placed in reversed position on the cot for transport.
- I. Pilot in command will conduct a shift brief at the beginning of each shift. Twice a day, a program-wide shift briefing will be conducted which includes on duty crews, mechanic on duty, communication specialist on duty, any specialty team members and management when available will be done. Pre-determined topics will be discussed. Ground personnel will conduct a shift briefing with their immediate crews and contact the communication specialist with any questions or concerns.
- J. Post transport debriefings will be conducted after each transport as response readiness permits.

**IV. RESPONSIBILITY**

All Associates

**V. KEY WORDS**

None

**VI. APPENDIX None**

**VII. REFERENCES / CITATIONS**

None



#### **IV. PROCEDURE**

##### **A. Patient Disposition at the Receiving Facility:**

1. Report is given to the receiving caregiver. The receiving caregiver shall sign the Preliminary Transport Form.
2. A copy of the preliminary form with left at the receiving facility for continuity of care.
3. The patient's bed is placed in the lowest position with side rails raised according to The University of Cincinnati Medical Center policy (refer to Restraint and/or Seclusion: Non-Violent/Non-Self Destructive Behavior and Violent/Self Destructive Behavior Policy.) to prevent patient from "fall out of the bed".
4. A call light will be made available to the patient and instructions will be given on its use. If the patient is unable to use the call light, other means for summoning available assistance will be initiated.
5. Patients who had medical safety devices in place at the referring facility will have them continued en-route and secured at the receiving facility.
6. Equipment change over (cardiac monitor, oxygen, infusion pumps, etc.) will be completed by the transport associates in collaboration with the receiving staff.

#### **V. RESPONSIBILITY** **All Team Members**

#### **VI. KEY WORDS** **None**

#### **VII. APPENDIX** None

#### **VIII. REFERENCES / CITATIONS** None

	ACMC53	
POLICY NAME/#	Vehicle Occupants Safety Guidelines/Safety Restraints	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER		
	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
	Dr. William Hinckley/Air Medical Director	(Date)
	_____	_____
	Dr. Elizabeth Powell/Ground Medical Director	(Date)
ADMINISTRATIVE APPROVAL	_____	_____
	Jennifer Jackson /VP CNO	(Date)
ORIGINATION DATE	10/2004	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>	
	<b>NEXT REVIEW DATE</b>	
	<b>7/2018</b>	

**I. POLICY**

Air Care and Mobile Care strive to provide the safest patient care possible. In an effort to ensure patient and associate safety, all occupants in an Air Care or Mobile Care vehicles are safely secured with appropriate safety restraints.

**II. PURPOSE**

The purpose of this policy is to define the use of restraints in the transport environment. The use of manufacturer installed and age specific manufacturer approved restraints have to be used for securing patients per Ohio state laws and FAA regulations. Additionally, other restraint devices (soft or leather restraints) may have to be used after alternative strategies have been exhausted to ensure the immediate physical safety of patients, staff and others. Uncooperative and combative patients in the transport setting increase the risk of harm to staff and other occupants of the vehicle and others sharing roadways.

### III. DEFINITIONS

None

### IV. PROCEDURE

#### A. Passengers/Patients:

1. Standard seatbelts and age appropriate restraining devices supplied in the ambulance by the manufacturer(s) should be worn at all times by all vehicle occupants. The number of passengers will not exceed the number of available seatbelts in the ambulance.
2. Three (3) cot straps and the shoulder harness should be worn at all times by any patient weighing forty (40) pounds or more.
3. Seatbelts and harnesses may be removed during transport as dictated by patient care. After patient care has been rendered, seat belts and harnesses must be refastened. However, the driver must be notified whenever any passenger is out of their safety restraints.
4. No patients will be placed in a backward position on a cot.

#### B. Pediatric Patients:

1. Due to limitations of safety restraints, patients weighing less than ten (10) pounds should be referred to an appropriate transport service.
2. Pediatric patients weighing ten (10) to forty (40) pounds should be restrained with age appropriate restraining devices for transport.

#### C. Combative Patients:

In the rare occasion during transport where patient behavior is deemed to be such that patient and staff safety is in jeopardy and/or property damage may occur, the medical team should follow the "Restraint and/or Seclusion: Non-Violent/Non Self Destructive Behavior and Violent/Self Destructive Behavior" policy.

1. The restraints are to be used during transport only and removed from the patient upon arrival to the receiving unit. Clear communication of events surrounding the need for restraints must be done so the receiving unit can determine the continued need for restraints.
2. Documentation of behavior and need for restraints must be placed in the event log of the electronic medical record.

- D. For the safety of the crew and patients, instances where patients cannot be appropriately restrained, in the opinion of the transport team, will not be transported.

- E. Patients who are restrained and managed will be assessed based on the “Restraint and/or Seclusion: Non-Violent/Non-Self Destructive and Violent/Self Destructive Behavior” policy.

**V. RESPONSIBILITY**  
**All Team Members**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS** **None**

	ACMC65	
POLICY NAME/#	Transport Team Members serving in the role of a Safety Officer	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Dr. Elizabeth Powell/Ground Medical Director (Date)	
ADMINISTRATIVE APPROVAL	_____ Jennifer Jackson/VP CNO (Date)	
ORIGINATION DATE	11/2012	
<b>LAST REVISION/ REVIEW DATE</b>	<b>6/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>6/2018</b>

- I. **POLICY**  
 When transporting Specialty Care personnel on any air or ground mission, Air Care & Mobile Care (ACMC) will provide at least one regularly scheduled medical personnel from the transport team (Registered Nurse, Physician, Paramedic, EMT or Mid- Level Provider) to serve as a Safety Officer.
  
- II. **PURPOSE**  
 To provide a trained ACMC crew member to support safe and efficient operations when specialty care personnel are involved with an air or ground transport mission.
  
- III. **DEFINITIONS**  
 Specialty Care personnel: healthcare providers with specialized training and education (such as neonatal, pediatric, perinatal, respiratory, or cardiac medical teams) who are not regularly scheduled medical personnel with ACMC's transport team.

**Regularly scheduled medical personnel: Any RN, Physician, Mid- Level Provider, Paramedic or EMT from the ACMC department within University of Cincinnati Medical Center Patient Care Services who has the appropriate licensure/certification and training as defined by current:**

- A.
- B. Air Care & Mobile Care policy and procedures
- C. Commission on Accreditation of Medical Transport Systems Accreditation Standards
- D. Air Operator's Medical Attendant Training (If applicable)

**Safety Officer: regularly scheduled medical personnel from the ACMC transport team (RN, Physician, Paramedic, EMT or Mid -Level Provider) who accompanies Specialty Care personnel on an air or ground mission (patient or non-patient flight).**

#### **IV. PROCEDURE**

- A. The Safety Officer(s) role is to, in collaboration with the Pilot-In-Command (PIC) or EMT/Paramedic ambulance driver, help assure safe, cohesive and efficient operations in and around the aircraft/ambulance by enforcing ACMC and the air operators' procedures and policies within their scope of training.
- B. The PIC or EMT/Paramedic ambulance driver holds the final authority for safety, selection of landing areas/parking areas, loading and equipment storage issues, seating assignments and all operational procedures (such as extra equipment or personnel based on weights and balances and aircraft performance).
- C. The primary role of the Safety Officer is not to be a provider of patient care; patient care is the responsibility of the Specialty Care personnel who is functioning under their own medical direction. However, if the Safety Officer is requested by any Specialty Care personnel to assist in patient care, if deemed their assistance does not impede the safety of the mission and is in the best interest of the patient, the Safety Officer may do so as long as they are practicing within their own scope of practice.
- D. When the ACMC Transport Team is responsible for providing patient care during a patient transport but elects to bring along a Specialty Care Provider (such as a Respiratory Therapist or Perfusionist, etc.), the regularly scheduled ACMC Transport personnel will also serve in the role of a Safety Officer.

- E. All associates involved in a transport mission (RN, Physician, Mid -Level Provider, Paramedic, EMT, PIC, Safety Officer, Specialty Care personnel, Communications Specialist, Mechanic etc.) have the responsibility and authority to cancel or discontinue a transport due to conditions perceived to be unsafe (i.e. weather, LZ conditions, worthiness of the aircraft/ambulance and patient or aircraft/ambulance limitations).

**V. RESPONSIBILITY**  
**All team members from ACMC**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**IX. REFERENCES / CITATIONS** **None**



- A. The lead pilot has the overall responsibility for the FOD prevention program. The lead pilot will insure that an aggressive and continuing program is in effect. He/she will brief all personnel on the program to insure they understand their responsibilities.
- B. The aviation site manager will continuously monitor the program and insure all newly assigned personnel are briefed.
- C. It is the responsibility of all pilots, mechanics and medical team associates to:
  - 1. Perform visual checks around aircraft for possible FOD items. As part of the FOD prevention program, on-duty personnel will perform daily facilities inspections to identify problem areas and take necessary actions.
  - 2. Insure all internal cargo is properly stored.
  - 3. During off-site operations, scenes and at other hospitals, be alert for loose equipment and debris.
  - 4. To assure cockpits are kept free of loose objects.
- D. Pilots and mechanics check detailed inspection of all area on aircraft and remove all objects that could cause FOD.
- E. At the finish of maintenance work, the mechanics will:
  - 1. Account for all tools.
  - 2. Place covers or caps over items susceptible to FOD.

**V. RESPONSIBILITY**  
**All flight crew members**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS**  
**None**



### III. PROCEDURE

- A. The use of lights and sirens is reserved for emergency situations and 911 calls only. An emergency is defined as a situation in which the patient's condition is such that the time En-route may be a critical factor that may negatively impact patient outcome.
- B. En-route to the receiving facility, the decision to use lights and sirens must be agreed upon by all team members.
- C. In the event the patient's condition warrants lights and sirens, laws established by the Ohio Revised Code will be strictly followed in Ohio or the applicable state.
- D. Documentation of the need for lights and sirens will be reflected in the patient's electronic medical record (EMR) in the event log and the appropriate field in the EMR will be completed so reports can be generated and all transports reviewed in the department QA process.
- E. For associate hearing protection, all vehicle windows should be closed when sirens are in use.
- F. When lights and sirens are in use, all posted speed limits will be strictly observed.
- G. When lights and sirens are in use, the ambulance must come to a complete stop at all traffic control devices, intersections or other locations with a high risk of cross traffic impact.
- H. Anyone following the patient in a separate vehicle must be advised, prior to transport, NOT to attempt to follow the ambulance closely if it is operating in emergency mode.
- I. If being followed closely through intersections or congested traffic and the safety of the patient, crew and other motorist has been determined, the safest course of action is to stop operating the ambulance in emergency mode and continue on with the normal flow of traffic.

**IV. RESPONSIBILITY**  
**All Team Members Including Communication Specialist**

**V. KEY WORDS**  
**None**

**VI. APPENDIX** **None**

**VII. REFERENCES / CITATIONS**  
**None**

	<u>AC39</u>	
<b>POLICY NAME/#</b>	<b>Safety: Educational Flights/Safety Presentations</b>	
<b>POLICY TITLE</b>	<b>Air Care and Mobile Care</b>	
<b>POLICY OWNER</b>		
	_____	_____
	<b>Matt Gunderman/Director</b>	<b>(Date)</b>
	_____	_____
	<b>Dr. William Hinckley/Air Medical Director</b>	<b>(Date)</b>
	_____	_____
	<b>Bob Francis, Manager Metro Aviation</b>	<b>(Date)</b>
<b>ADMINISTRATIVE APPROVAL</b>		
	_____	_____
	<b>Jennifer Jackson /VP CNO</b>	<b>(Date)</b>
<b>ORIGINATION DATE</b>	<b>7/1999</b>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>6/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>6/2018</b>

**I. POLICY**

Air Care and Mobile Care strive to provide the safest patient care possible. In an effort to ensure patient safety and the safety of ACMC crews during scene operations, the presentation of safety material and landing zones preparation is a safety committee initiative.

**II. PURPOSE**

To outline the process of scheduling landing zone/educational classes for community services.

**III. DEFINITIONS**

None

#### **IV. PROCEDURE**

1. The Community Outreach coordinator or their designee will:
  - a. Schedule all requests for educational flights or safety trainings. The designated person in collaboration with the county liaison will monitor their assigned EMS agencies to encourage periodical safety training and make recommendations as needed.
  - b. Gather the needed information to schedule the educational flight or safety training. When there is concern about whether a particular event should be scheduled, the coordinator will contact the appropriate supervisor before scheduling the event.
  - c. Ask if the requesting agency has a copy of the relevant training or education materials. If they do not, the information will be provided by the flight nurse giving the presentation
2. The scheduler will try not to schedule requests during shift change or other educational obligations of the flight crew. All attempts will be made to accommodate the requests as the schedules and flights allow.
3. After a date, time location and type of presentation have been agreed upon; a flight request with relevant information will be entered into the Community Outreach calendar.
4. The communication specialist on duty the day of the training will enter the flight into the computer aided dispatch system.
5. Record of completed safety training flights will be maintained on a database and Community Outreach calendar.

#### **V. RESPONSIBILITY**

All Personnel

#### **VI. KEY WORDS**

#### **VII. APPENDIX**

POLICY NAME/#	MC14	
POLICY TITLE	Ambulance Security	
POLICY OWNER	Air Care and Mobile Care	
	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
	Dr. Liz Powell/Ground Medical Director	(Date)
ADMINISTRATIVE APPROVAL	_____	_____
	Jennifer Jackson/VP CNO	(Date)
ORIGINATION DATE	11/2005	
<b>LAST REVISION/ REVIEW DATE</b>	<b>8/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>8/2018</b>

**I. POLICY**

Ambulances must have engines off and all doors locked when not being driven or monitored by crew who is in-sight of the ambulance.

**II. PURPOSE**

Maintain the security of the ambulance and its equipment along with providing for safety of the public by discouraging the theft of the ambulance, equipment or medications.

**III. DEFINITIONS**

None

#### **IV. PROCEDURE**

- A. The transport team is responsible for inspecting the ambulance for any signs of tampering or damage before the vehicle is moved. If tampering is suspected, the crew is to contact the communication center, administrator on call and appropriate authorities. Once all required reports have been completed, leadership will contact Risk Management as needed.
- B. Any time that an ambulance is left unattended, it will be secure.
- C. A vehicle will be considered secured when it is parked in a safe location, engine is off and the cab, patient compartment and equipment compartments have been locked.
- D. Ambulances may not be kept running while unattended. Requests for exceptions to this rule must be approved on a case-by-case basis by department management.
- E. Upon parking the ambulance in the garage at the end of the shift, the keys will be left in the ambulance. If the vehicle is left outside, the keys will be secured in the key box.

#### **V. RESPONSIBILITY**

**All Mobile Care Transport Crew Members and Communications Specialists**

#### **VI. KEY WORDS**

**None**

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS**

**None**



regulations. Additionally, restraints may have to be used after alternative strategies have been exhausted to ensure the immediate physical safety of patients, staff and others.

### III. DEFINITIONS

None

### IV. PROCEDURE

- A. All patients will be secured to an appropriate cot or age appropriate transport device.
- B. All patients will be secured with the approved cot straps (three sets of straps and shoulder harness).
- C. No patient will be loaded and/or restrained backwards on a cot. This includes obstetric patients.

In the rare occasion during transport where patient behavior is deemed to be such that patient and staff safety is in jeopardy and/or property damage may occur, the medical team should follow the “Restraint and/or Seclusion: Non-Violent/Non Self Destructive Behavior and Violent/Self Destructive Behavior” policy.

- A. The restraints are to be used during transport only and removed from the patient upon arrival to the receiving unit. Clear communication of events surrounding the need for restraints must be done so the receiving unit can determine the continued need for restraints.
- B. Documentation of behavior and need for restraints must be placed in the event log [or comments section](#) of the electronic medical record.
- D. For the safety of the crew and patients, instances where patients cannot be appropriately restrained, in the opinion of the transport team, will not be transported.
- E. Patients who are restrained and managed will be assessed based on the “Restraint and/or Seclusion: Non-Violent/Non-Self Destructive and Violent/Self Destructive Behavior” policy. and/or Southwest Ohio Paramedic EMS Protocols as applicable.

### V. RESPONSIBILITY

All Transport Team Associates

### VI. KEY WORDS

None

### VII. APPENDIX None

### VIII. REFERENCES / CITATIONS

None



- A. The aircraft will be assigned the following call signs and be primarily based as follows:
  - 1. EC-145-N145UC will be Air Care I.
  - 2. EC-145-N145WC will be Air Care II.
  - 3. BK117B2-N317UH will be Air Care III.
  - 4. BK117B2-N945ME will be the space aircraft.
- 5. One aircraft will be based 24 hours a day at UCMC helipad. One aircraft will be based 24 hours a day at the Butler County Regional Airport. One aircraft will be based 24 hours a day at Mt. Orab, OH in Brown County.
- 6. When an aircraft is down for maintenance, the relief aircraft will assume the name of the aircraft it is backing up (Air Care I, II or III).
- B. Flight Activation
  - 1. The designation of primary aircraft will be determined on a daily basis due to aviation/maintenance considerations.
  - 2. All radio traffic should include the aircraft number (ex: Air Care I...base).
- C. Stand-By Situations
  - 1. In the event of two stand-by requests received at the same time, both on duty flight teams will follow the stand-by process.
  - 2. If a second stand-by request comes in while the first aircraft is out, the remaining aircraft will follow the stand-by policy until activated, stood down, or otherwise directed by the communication center.
- D. Refueling
  - 1. Both aircraft will routinely refuel at a location with a contractual agreement.
- E. Unloading of Multiple Aircraft upon return to UCMC
  - 1. An aircraft will not be unloaded until the pilot gives the command.
  - 2. It is up to the discretion of the flight team and/or faculty physician to determine if there will be a hot unload of any UCMC aircraft based on policy.
  - 3. Both aircraft can unload hot at UCMC helipad. The entire crew must be in agreement to unload hot.

**V. RESPONSIBILITY**  
**All Air Care Personnel**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES**  
**/ CITATIONS**



#### IV. PROCEDURE

- A. All transport requests must go through ACMC Communication Center. No request will be accepted by staff personnel at a base. If an outside agency calls the base for a transport request, they will be routed to the ACMC Communication Center for assistance. Scene requests will be accepted from recognized law enforcement agencies: police and/or fire departments, ambulance companies, County 911 dispatch centers or other authorized agencies. If requests are received from the general public, local public safety officials will be notified and the aircraft will be placed on “stand-by.”
  
- B. Receiving the Call
  - 1. Basic Information to be requested:
    - a. Identification and location of caller
    - b. Agency represented
    - c. Call-back number
    - d. Scene Location (address, cross street)
    - e. Type of call (traffic accident, fire, etc.)
    - f. Number of victims- child or adult
    - g. Approximate weight of patient
    - h. Radio frequency they can be contacted on
    - i. Command unit on scene
  - 2. Inform pilot-in-command and flight team of the Air Care helicopter with the closest nautical miles to the scene of the flight request
  - 3. Request weather check from the pilot-in-command.
  - 4. Locate scene location/ position on map
  - 5. Inquire if another service has been called to the scene.
  
- C. Activating the Helicopter
  - 1. Once the pilot has accepted the flight, activate the flight team immediately
  - 2. Relay the following information to the Flight Team via approved device:
    - a. Type of call
    - b. Location
    - c. Number of victims
    - d. Reporting agency
    - e. Time

- D. Obtain Additional Information
1. Major streets, highway, intersections
  2. Landmarks (large buildings, towers, lakes, rivers, railroad tracks, etc.)
  3. Map coordinates
  4. Heading and distances from present position to scene / destination
  5. Operational Control Center Flight Number
- E. Relay Information
1. Relay all location and directional information to the pilot (assist in determining any navigational information) if requested.
  2. Advise the pilot of ground contact, on scene commander, frequency, etc.
  3. Request ETA
  4. Notify the University of Cincinnati Medical Center Medical Control MD of the flight and give general information.
- F. Utilizing Call-Back Number
1. Advise requesting party of ETA
  2. Request update of any conditions at the scene.
  3. If there is a possibility of loss of radio communications with the aircraft, request constant landline contact with the requesting party.
- G. In the event of any unanticipated delay to a scene request from the ETA given such as a delay due to a potential aircraft maintenance issue the following process shall occur. (Once activated if there is a delay in Air Care's response due to unanticipated weather, refer to Weather turndown algorithm):
1. If Air Care's second aircraft is available and is the next closest aircraft to the scene, activate the second aircraft to respond to the scene. Then update the referring agency with an ETA.
  2. If Air Care's second aircraft is not available or not the next closest aircraft to the scene, immediately contact the next closest flight program to the scene request. Once that program is activated call the referring agency with an updated ETA for the backup flight program who will be responding to the scene.
  3. Mark the original Air Care transport request to be reviewed through the Quality Assurance Program.

- H. Departing the Scene
1. Monitor and acknowledge all information given by the pilot and / or flight crew. Medical information should be taken by faculty physician or his / her designee.
  2. Notify designated receiving hospital Emergency Department giving ETA and any known updates on patient condition.
  3. Confirm landing site and designated receiving hospital and coordinate any necessary resources i.e public safety to assist the flight Team.
  4. In the event of no direct radio contact with the helicopter, request all information be relayed through radio facilities of the reporting party.

All persons involved in the patient flight (i.e. requesting facility, accepting facility, flight team, another flight program etc...) will be kept aware of any and all updated information including accurate ETA's and it should be done so in a timely manner.

**V. RESPONSIBILITY**  
**Communication Specialist, Pilot, Flight Physician, Flight Nurse**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS** **None**

	<u>AC42</u>	
POLICY NAME/#	Scene Response - Landing Minimums	
POLICY TITLE	Air Care and Mobile Care	
POLICY OWNER	_____ Matt Gunderman/Director (Date)	
	_____ Dr. William Hinckley/Air Medical Director (Date)	
	_____ Bob Francis, Manager Metro Aviation (Date)	
ADMINISTRATIVE APPROVAL	_____ Jennifer Jackson/VP CNO (Date)	
ORIGINATION DATE	9/1999	
<b>LAST REVISION/ REVIEW DATE</b>	<b>6/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>6/2018</b>

**I. POLICY**

All scenes should meet the minimum standards before the pilot lands.

**II. PURPOSE**

**III. DEFINITIONS**

None

**IV. PROCEDURE**

- A. Appropriate high and low reconnaissance will be conducted prior to landing, to assure the pilot has had an opportunity to see obstacles.

- B. Night operations will be conducted in accordance with the contract vendor operations manual. The landing site must be clearly illuminated by a lighting source that will provide adequate lighting of the site and of obstructions that may create a potential hazard during approach, hovering, taxiing and departure operations. Also, night operations must be conducted under Night Vision Goggles (See NVG Policy).
  
- C. Communication with ground units should be established prior to landing. If communication cannot be established even through attempts from UCMC communication center to requesting dispatch center, the landing must be made to an area obviously away from equipment or people whose welfare could be affected by the helicopter.
  
- D. Required touchdown landing area should be a clear area measuring 100'x100' with a slope no more than five (5) degrees.

**V. RESPONSIBILITY**  
**Pilot, Flight Crew**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS**  
**None**

	<u>AC43</u>	
<b>POLICY NAME/#</b>	<u>Scene Response-Two or More Aircraft</u>	
<b>POLICY TITLE</b>	<u>Air Care and Mobile Care</u>	
<b>POLICY OWNER</b>		
	<u>Matt Gunderman/Director</u>	<u>(Date)</u>
	<u>Dr. William Hinckley/Air Medical Director</u>	<u>(Date)</u>
	<u>Bob Francis, Manager Metro Aviation</u>	<u>(Date)</u>
<b>ADMINISTRATIVE APPROVAL</b>	<u>Jennifer Jackson/VP CNO</u>	<u>(Date)</u>
<b>ORIGINATION DATE</b>	<u>9/1999</u>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>6/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>6/2018</b>

**I. POLICY**

On occasion, Air Care will be called to scene where multiple aircraft are needed to transport patients. Safety is of the utmost importance when dealing with a multiple aircraft scene.

**II. PURPOSE**

To establish procedures for two or more helicopters responding to a scene requested by EMS, police or public safety agencies.

**III. DEFINITIONS**

Referring EMS Agency: EMS provider, public safety personnel, police

#### IV. PROCEDURE

- A. Primary and secondary aircraft response to the scene with the same landing zone.
  - 1. Once a request for two or more aircraft have been received from a referring EMS agency, with approval of pilot-in-command for each aircraft, the communication specialist will activate all flight teams to respond to the scene.
  - 2. The communication specialist will notify the Emergency Medicine faculty that two or more aircraft have been requested at a scene.
  - 3. The first on scene aircrafts crew will do the following after arrival at the scene where the same landing zone is to be used for additional aircraft:
    - a. The pilot will determine if it is safe for each additional aircraft to land, maneuver and depart from the area if needed.
    - b. The pilot will relay all information of hazards, obstacles and conditions of the landing zone to the pilot of each additional aircraft by the appropriate communication radio frequency/
    - c. The medical team will evaluate the patient care requirements to determine if the additional helicopters and their medical teams should continue to land at the scene.
- B. Primary and secondary aircraft response to the scene with different landing zones.
  - 1. Each pilot should coordinate arrivals and aerial reconnaissance to ensure safety of their aircraft.
  - 2. Arrivals and departures should be staggered.
  - 3. Radio communications must be maintained between both aircraft at all times through air to air communication frequency 123.025, or Air Care primary radio frequency.

**In all cases, the pilot-in-command of the aircraft is the final approving authority for all aircraft operations.**

**V. RESPONSIBILITY**

**Communication Specialist, Pilot, Flight Physician, Advance Practice Nurse, Flight Nurse**

**VI. KEY WORDS**

**None**

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS**

**None**



Open positions on the master schedule will be filled using all the following criteria:

- A. Department seniority
- B. Performance evaluations
- C. Corrective actions within the last twelve (12) months
- D. Attendance
- E. Availability and contributions to the department.
- F. Any scheduling requirements with another employer will be reviewed so back-to-back shifts are avoided. (Refer to the department's On Duty/Rest Time Policy.)

**V. RESPONSIBILITY**  
**All Union Free Department Associates**

**VI. KEY WORDS**  
**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS**  
**None**



#### **IV. PROCEDURE**

- A. An agreement and clear understanding between those involved in trading scheduled time must be established.
- B. Trading will be done only within the appropriate category (ex: RN for RN, EMTP for EMT-P or basic EMT for basic EMT) unless approved by a supervisor.
- C. When an agreement and clear understanding has been reached and approved by the supervisor, the appropriate changes will be made in API Healthcare and if needed to the communication center via the supervisor or their designee.
- D. All scheduled hours are the responsibility of the individual to whom they were assigned. Failure to meet their responsibility will lead to corrective counseling.
- E. No associate can engage in a trade that will result in overtime for themselves or a co-worker. All trades that will result in overtime must be approved by their immediate supervisor.
- F. Trades that result in coverage of half a shift and not the entire scheduled shift will not be permitted unless approved by a supervisor. If multiple associates want to work together to cover an entire shift, the trade may be approved by their supervisor.

#### **V. RESPONSIBILITY All Team Members**

#### **VI. KEY WORDS None**

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS None**

POLICY NAME/#	ACMC56	
POLICY TITLE	Scheduling Requirements	
POLICY OWNER	Air Care and Mobile Care	
	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
	Dr. William Hinckley/Air Medical Director	(Date)
	_____	_____
	Dr. Elizabeth Powell/Ground Medical Director	(Date)
ADMINISTRATIVE APPROVAL	_____	_____
	Jennifer Jackson/VP CNO	(Date)
ORIGINATION DATE	11/2001	
<b>LAST REVISION/ REVIEW DATE</b>	<b>6/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>6/2018</b>

**I. POLICY**  
Scheduling Requirements

**II. PURPOSE**  
To set guidelines for associate scheduling to ensure that operational needs of Air Care & Mobile Care are met.

**III. DEFINITIONS**  
PTO-Paid Time Off  
Seniority-Based on UC Health hire date.

#### **IV. PROCEDURE**

ACMC operates under a rotating master schedule that is reviewed and awarded to the associate upon hire. All schedules will be published in API Healthcare two weeks before the start of the six-week schedule. The master schedule is the associates permanent schedule and can only be altered with approval from their immediate supervisor. Other deviations from the master may occur on holiday weeks, PTO requests or agreed upon trades.

Weekends:

A. The department's managerial staff defines what days and hours constitute a weekend shift. Weekend requirements will be based on departmental needs.

1. Weekends are defined as:

- a) Saturday and Sunday day shifts (any shift starting between 5:00a.m. and 5:00 p.m.)
- b) Friday and Saturday night shifts (any shift starting between 6:00 p.m. and Midnight.)

2. An associate who calls off for a weekend shift may be rescheduled to another weekend shift based on the needs of the department. For ONA staff it will be in accordance to the union contract. Holidays:

A. To ensure adequate staffing is met on holidays associates may be scheduled to work a shift they are not typically scheduled to work (days/nights). Holidays are scheduled according to the holiday selection process.

B. Night shift holidays will be scheduled in accordance to the UC Health policy. For associates working the night shift, holiday shifts begin at 6 p.m. on the evening prior to the holiday.

C. Air Care holiday requirements will abide by current contract language.

D. Mobile Care Holidays requirements will be divided into winter and summer holidays. The staffing requirements for holidays will be reviewed at the beginning of each year and the number of trucks needed will be communicated to staff. Mobile Care staff will have a pre-determined time to submit holiday availability before February 15<sup>th</sup> each year with a finalized holiday assignment by March 15<sup>th</sup>. After the holiday availability process is concluded, any staff member who has not submitted availability will be assigned to a holiday determined by department needs. The following holidays that will be observed with alteration of scheduled trucks will be:

1. Memorial Day
2. July 4<sup>th</sup>
3. Labor Day
4. Thanksgiving
5. Christmas
6. New Year's Day

Martin Luther King Day will not result in an adjustment of the number of scheduled trucks. Staff scheduled for that holiday will be determined by the associates master rotating schedule.

- D. Requests for PTO for other important days of the year (Easter, Halloween, the day after Thanksgiving, Christmas Eve and New Year's Eve) must be submitted in the Bulk Vacation Process. If PTO has not been approved in that process, PTO or requesting to switch off that day will be granted only if staffing on those days meets the department needs.
- E. An associate who calls off or is absent for a holiday shift may be scheduled to work an additional holiday shift at the discretion of the clinical manager or their designee to meet departmental needs. Please refer to the Time & Attendance Policy as it relates to unscheduled call-offs for assigned shifts, especially around the holidays and previously denied PTO requests.)
- F. After holiday shifts have been assigned, if an employee no longer wishes to work their holiday, they will be responsible for finding coverage for their shift, and will be reassigned to a different holiday at the discretion of the Clinical Manager or their designee.

PTO (Vacation):

- A. All PTO requests must be submitted in writing via email to the appropriate department scheduling email address.
1. Mobile Care: [ACMC-MC-Schedule@UCHealth.com](mailto:ACMC-MC-Schedule@UCHealth.com)
  2. Air Care: [ACMC-AC-Schedule@UCHealth.com](mailto:ACMC-AC-Schedule@UCHealth.com)
  3. Communication Center: [ACMC-Comm-Schedule@UCHealth.com](mailto:ACMC-Comm-Schedule@UCHealth.com)

- B. Vacation requests for the period of April 1 through October 1 request can be submitted starting Jan 1 and are due no later than 11:59pm on February 15th of the current calendar year. Vacation requests for the period of October 2 through March 31 requests can be submitted starting July 1 and are due no later than 11:59pm on August 15th of the current calendar year. Submissions received within the given time frame will be awarded based on UC Health seniority. Any requests received after the time frame will be awarded on a first come, first serve basis and dependent upon availability and department needs. All other requests submitted after the predetermined dates will be approved at the discretion of the Clinical Manager or their designee.
- C. Vacation requests will be limited to no more than four weeks per year. Any additional weeks will be reviewed by the clinical manager and approved or denied on a case by case basis. Vacations will be approved for no more than two consecutive weeks at a time based on UC Health seniority.
- D. Associate requests for paid time off in the days/weeks before or after UC Health designated holidays will be reviewed by the clinical manager and approved or denied based on department operational needs and in accordance with this policy. Typically, no more than 1.0 FTE per week will be scheduled off at one time. Any variance from this standard is up to the discretion of the Clinical Manager or their designee. The manager approving PTO will also assess greater than 1.0 FTE off on a case-by-case situation and overall impact to operations.
- E. PTO will not be approved for a request submitted for a week in the currently published schedule. The associate must find their own coverage. Once the schedule has been published, all PTO requests will be at the discretion of the associate's immediate supervisor. All finalized schedules will be published in API two weeks prior to the schedule start date.
- H. PTO request for union staff will be in accordance to the union contract or any agreed upon Air Care Staffing Guidelines.

PRN Positions:

- A. PRN associates are required to work one shift every pay period or as otherwise indicated by department supervisors. Availability must be given for both day and night shifts.
- B. Any confirmed shifts scheduled for PRN employees become their responsibility. If an associate is unable to work their scheduled shift, they will be required to find coverage from another employee (not resulting in overtime) or through a trade.

- C. PRN associates must give availability to work one summer and one winter holiday. The scheduling of a PRN associate on a holiday will be at the discretion of the Clinical Manager or their designee.
- D. An associate who has dedicated FTE's in another UC Health facility must have the flexibility to work the required shift for Air Care & Mobile Care without accrual of overtime.

Trades:

- A. An agreement and clear understanding between those involved in trading scheduled time must be established and communicated in writing to the appropriate scheduling email address, including both parties involved in the trade.
- B. Trading will be done only within the appropriate category (ex: RN for RN, EMTP for EMT-P or basic EMT for basic EMT) unless approved by a Clinical Manager or their designee.
- C. When an agreement and clear understanding has been reached and approved by the Clinical Manager or their designee, the appropriate changes will be made in API Healthcare and the daily Manpower.
- D. All scheduled hours are the responsibility of the individual to whom they were assigned. Failure to meet their responsibility will lead to corrective counseling.
- E. No associate can engage in a trade that will result in overtime for themselves or a co-worker. Any proposed trades that will result in overtime must be approved by their immediate supervisor.
- F. All trades must abide by Department Rest Duty policies and cannot negatively impact department operations (i.e. interfering with On Call shifts, decreasing operation hours of trucks in service, etc.)  
Trades that result in coverage of half a shift and not the entire scheduled shift will not be permitted unless approved by a supervisor. If multiple associates want to work together to cover an entire shift, the trade may be approved by their supervisor.

On-Call:

- A. All mobile transport staff will be required to fulfill on call shifts. The on-call (OC) process will be based on the discretion of the associate's direct supervisors and is based on department needs.

Call-Off Process:

- A. Air Care: Employee will contact Clinical Manager who will make appropriate notifications.

Mobile Care and Communication Center: Employee will contact Communication Center who will who will complete a "Call Off "Form and place in the designated area. The Department administrative assistant will retrieve the "Call Off "forms and file appropriately. The "Call Off "Form should include the following information: Employee name, date, scheduled shift, any applicable information provided by the associate. If appropriate, the communication center associate will notify the OC Call person to cover the shift.

Schedule Changes:

- A. Any other schedule change requests will be limited, and taken into consideration while keeping the department's optimal operational needs in mind.

**II. RESPONSIBILITY**

All associates of Air Care & Mobile Care

**III. KEY WORDS**

None

**IV. APPENDIX**

**V. REFERENCES / CITATIONS**

**UCH-HR-EMPLOYEE RELATIONS-009-05 Time and Attendance**

**UCH-HR-Benefits-005-05 Paid Time Off (PTO)**

**UCH-HR-Compensation-001-02**



- B. There are times when an aircraft will not be operational because of weather, maintenance or other reasons. The pilot is expected to remain with the aircraft. The following circumstances might allow the pilot to be released from duty but the Program Director and Area Site Manager must be in agreement and aircraft asset is deemed to be in a secure location.
1. If weather forecasts indicate weather minimums will remain below the air operator's acceptable guidelines for the balance of the pilot's scheduled shift.
- OR
2. If maintenance will prohibit the aircraft from flying during the balance of the pilot's shift,
- AND
3. Pilot's and/or mechanic agree the pilot should notify the communication specialist of the situation.
- I. The communication specialist will notify the program director and area site manager of the unavailability of the aircraft.
  - J. If the clinical director and area site manager agree that the pilot can be released early, the pilot will be notified.
  - K. The Area Site Manager may assign another task instead of releasing the pilot.
  - L. On the rare occasion the flight physician is released from duty, the department's Business Manager must be notified for documentation of paid flight physician hours. The standard procedure for the flight physician is for them to report to The University of Cincinnati Medical Center for the remainder of their shift to assist in air transports by ground or staff the UCMC aircraft if the other aircraft is down for maintenance.
  - M. The Nurse Manager or designee will discuss with the flight nurses other scheduling options and/or tasks to be completed before release. Flight nurse may be needed to assist as the primary or secondary transport nurse on critical care ground units. Flight nurses will have a familiarization shift on the Mobile Intensive Care Unit during their initial orientation. If more time is needed, it is the responsibility of the flight nurse to info the clinical manager or program educator. Determination of Low Census or Down staffing of ONA nurse will be in compliance with current ONA contract.
  - N. The Nurse Manager or designee will notify the Air Care Medical Director for approval of release of on-duty flight physician
  - O. Shut down of the program may only be done with the approval of the Program Director.

**IV. RESPONSIBILITY**

**Communication Specialist, Pilot, Flight Nurse, Flight Physician and Faculty**

**V. KEY WORDS**

**None**

**VI. APPENDIX None**

**VII. REFERENCES / CITATIONS**



### III. DEFINITIONS

None

### IV. PROCEDURE

- A. Rarely, Air Care will be requested to transport two patients simultaneously. To ensure the safe transport of these patients and the safety of the crew, the following consideration must be discussed.
1. Pilot confirms appropriate weight and balance of aircraft.
  2. Both patients must be assessed and acuity determined. If the decision is made to transport both patients, the patient with the more critical condition must be placed on the most accessible litter.
  3. Aircraft is stocked with the appropriate medical equipment, supplies and medications to provide optimal patient care.
  4. If patient destinations are different, the delay to the receiving destination for one patient must be considered. For example, if an adult and pediatric are being transported, will adverse effects result from the delay to the receiving facility? Also, when off-loading patient 1 who will be providing care for patient 2. If optimal patient care cannot be continuously provided, two patients cannot be transported.
- B. A patient receiving Cardio-Pulmonary resuscitation (CPR) at a referring facility will not be transported. The transport team will remain at the referring facility during CPR and provide transport only if the patient's condition stabilizes and the benefits of being transported outweigh the risks of staying at the referring facility.
- C. Patients in active labor, where birth is imminent as determined by the referring physician, should refer to Air Care and Mobile Care Transfer of a High Risk Obstetrical Patient Policy. If birth is determined to not be imminent and patient is transported, the patient is not to be placed in reverse position on the stretcher.
- D. If a patient is suspected of being exposed to a hazardous material that could potentially contaminate the transport team, the transport will not occur until decontamination is completed. (Refer to the Hazardous Material Policy).
- E. Any patient whose behavior is combative and patient de-escalation techniques are not effective and/or chemical or physical restraints are not appropriate after patient assessment, patient will not be transported. Ground transportation should be arranged via the Air Care & Mobile Care Communication Center.
- F. Any patient whose weight exceeds the predetermined weight limit set forth by the pilot in command will not be transported. Ground transportation should be arranged via the Air Care & Mobile Care Communication Center.

- G. If any of the above situations occur, the administrator on call should be notified immediately.

**V. RESPONSIBILITY**

**All Air Care Transport Associates and Communications Specialists**

**VI. KEY WORDS**

**None**

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS None**



#### **IV. PROCEDURE**

- A. The ground transport vehicle will only transport one patient at a time unless there is a situation of mass injury or casualty. If two patients are to be transported, both cannot be critical. The final determination will be made by the transport nurse for MICU units or paramedic on ALS units.
- B. A patient receiving Cardio-Pulmonary resuscitation (CPR) at a referring facility will not be transported. The transport team will remain at the referring facility during CPR and provide transport only if the patient's condition stabilizes and the benefits of being transported outweigh the risks of staying at the referring facility.
- C. Patients in active labor, where birth is imminent as determined by the referring physician, should refer to Air Care and Mobile Care Transfer of a High Risk Obstetrical Patient Policy.
- D. If a patient is suspected of being exposed to a hazardous material that could potentially contaminate the transport team, the transport will not occur until decontamination is completed. (Refer to the Hazardous Material Policy).
- E. Any patient whose behavior is combative and patient de-escalation techniques are not effective and/or chemical or physical restraints are not appropriate after patient assessment, patient will not be transported at that time. Measures should be taken in collaboration with the referring facility and/or security to address the issue and prepare the patient for transport.

If any of the above situations occur, the administrator on call should be notified immediately.

#### **V. RESPONSIBILITY**

**All Mobile Care Transport Associates and Communications Specialists**

#### **VI. KEY WORDS**

None

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS**

None



#### **IV. PROCEDURE**

- A. When transport of two patients is considered desirable in the judgment of the medical crew, the pilot-in-command shall have the final decision regarding reconfiguration of the aircraft and transport of two patients based on aviation and safety considerations.
- B. All ACMC aircraft can be reconfigured for two patient transports with the use of the appropriate restraining devices.
- C. The medical crew should weigh several factors when considering a dual patient transport, including:
  - 1. Time required to re-configure and load the aircraft
  - 2. Care needs of the patients to be transported while the flight nurse is occupied by the re-configuration
  - 3. Care needs of the patients during loading and flight given the limited crew resources and compromised patient access
  - 4. Care capabilities of EMS providers at the scene, distance to the nearest hospital and the care capabilities of the nearest hospital when encountering a scene with multiple victims
  - 5. Care capabilities of the referring center, distance to the nearest appropriate receiving center and the availability of alternative transport resources and time required to mobilize these resources when performing an inter-hospital transport
  - 6. Can potentially life- saving measures be provided for either patient while in transport? (childbirth, CPR, etc.)
  - 7. Can routine patient care be provided to both patients simultaneous during transport? (cardiac monitoring, airway management, IV access, etc.)
  - 8. Can the aircraft/ vehicle be safely configured to handle both patients with all medical supplies and equipment secured during transport?
  - 9. Is the aircraft/ vehicle still within acceptable weight limits and weight and balance perimeters?
  - 10. Are all team members comfortable with the two patient transport?
- D. When two patients are to be transported, the receiving center should be notified of the fact as soon as possible to allow preparation for receipt of multiple patients.

#### **V. RESPONSIBILITY**

**Pilot, Flight Physician, Advance Practice Nurse, Flight Nurse**

#### **VI. KEY WORDS**

None

#### **VII. APPENDIX None**

#### **VIII. REFERENCES / CITATIONS**

None



- A. Any Air Care & Mobile Care personnel may request that a transport is aborted or delayed if they believe the mission will jeopardize safety.
- B. The associate will notify the pilot (Air) or the driver (Mobile) of their request to return to base or to land as soon as possible. For Air, the pilot will make the decision on where to land.
- C. The associate will explain the reason that they are uncomfortable.
- D. The associate will notify the communication center of the abort. The communication specialist will follow mission aborted/cancelled process.
- E. Once returned to base, the associate initiating the abort should contact their supervisor and explain the reason and, if known, a recommendation for action.
- F. Any aborted flight should be referred to the appropriate safety committee for review.

**NOTE:** It is both the right and responsibility of Air Care and Mobile Care Transport Service associate to identify unsafe and potentially unsafe activities and to communicate them to appropriate personnel.

**VI. RESPONSIBILITY**  
**All Transport Associates**

**VII. KEY WORDS**  
**None**

**VIII. APPENDIX** **None**

**IX. REFERENCES / CITATIONS**  
**None**

	<u>ACMC60</u>	
<b>POLICY NAME/#</b>	<b>Travel and Mileage Reimbursement</b>	
<b>POLICY TITLE</b>	<b>Air Care and Mobile Care</b>	
<b>POLICY OWNER</b>	_____ <b>Matt Gunderman/Director</b> (Date)	
	_____ <b>Dr. William Hinckley/Air Medical Director</b> (Date)	
	_____ <b>Dr. Elizabeth Powell/Ground Medical Director</b> (Date)	
<b>ADMINISTRATIVE APPROVAL</b>	_____ <b>Jennifer Jackson/VP CNO</b> (Date)	
<b>ORIGINATION DATE</b>	<b>1/2006</b>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>7/2018</b>

**I. POLICY**

Air Care & Mobile Care will have staff you will be eligible for mileage reimbursement under predetermined criteria. This policy will create guidelines for Air Care & Mobile Care associates who are requesting reimbursement for approved expenditures related to:

- A. Community outreach programs and supplies
- B. Travel and/or mileage reimbursement

**II. PURPOSE**

The following policy outlines the process for obtaining approval for community outreach program reimbursement as well as any approved travel and/or mileage reimbursement.

**III. DEFINITIONS**

None

**IV. PROCEDURE**

**A. Travel/Mileage Reimbursement**

1. Approval Procedures: Once the travel/mileage reimbursement is approved, associates can be reimbursed for their travel and/or mileage. Mileage will be reimbursed at the current IRS mileage rate for miles accrued in personal vehicles. The following steps shall apply:
  - a. All forms and original receipts must be given to the business manager within 5 business days of completing the travel.
  - b. Any submissions not meeting this deadline may not be reimbursed.
  - c. The business manager will complete all required financial reimbursement expense vouchers and submit to the appropriate financial department as required per policy.
  - d. Reimbursements will be included in associate's paycheck per UC Health policy.
2. Mileage reimbursement for travel to satellite bases other than The University of Cincinnati Medical Center (UCMC) will be in accordance with the agreement between UCMC and the Ohio Nurses Association article 28, section 9. Submission of mileage will be on a monthly basis.
  - a. All requests must be submitted by the end of the business day on the fifth (5th) of the month for the prior month.
  - b. Any submission that does not meet these deadlines will not be reimbursed.
  - c. Requests must be e-mailed, etc. to the business manager with the actual dates and satellite base worked identified.
  - d. Reimbursements will be included in associate's paycheck per UC Health policy.
  - e. Submission for reimbursement will be the responsibility of the associate.
  - f. Each associate will have designated mileage agreed upon by the associate and the business manager. This will be used to determine the miles traveled in excess of the normal miles the associate would travel to The University Hospital.
  - g. The business manager will complete all required financial reimbursement expense vouchers and submit to the appropriate financial department as required by policy.

**V. RESPONSIBILITY**

All Associates

**VI. KEY WORDS**

None

**VII. APPENDIX**

None

**VIII. REFERENCES / CITATIONS**

None



A. For patients for whom a DNR Comfort Care protocol is activated, you:

1. Will:
  - Suction the airway
  - Administer oxygen
  - Position for comfort
  - Splint or immobilize
  - Control bleeding
  - Provide pain medication
  - Provide emotional support
  - Contact other appropriate health care providers such as hospital, home health, attending physician/CNP/CNS/PA if needed
  
2. Will Not:
  - Administer chest compressions
  - Insert artificial airway
  - Administer resuscitative drugs
  - Defibrillate or cardiovert
  - Provide respiratory assistance (other than that listed above)
  - Initiate resuscitative IV
  - Initiate cardiac monitoring

#### IV. PROCEDURE

A. A DNR Comfort Care or DNR Comfort Care-Arrest Patient status is recognized and can be confirmed by ONE of the following ways:

1. DNR Comfort Care card or form completed for the patient.
2. A completed State of Ohio living will (declaration) form that states that the patient does not want CPR (in the case of a patient who has been determined by two doctors to be in a terminal or permanently unconscious state).
3. A DNR Comfort Care necklace or bracelet bearing the DNR Comfort Care official Logo.
4. A DNR order signed by the patient's physician or, when authorized section 2133.211 of the Ohio Revised Code, a certified nurse practitioner (CNP), clinical nurse specialist (CNS), or physician assistant (PA). This order can be a printed copy from the hospital's electronic medical record.
5. A verbal DNR order is issued by the patient's attending physician, CNP, CNS, PA.

- B. A completed State of Ohio living will (declaration) form that states that the patient does not want CPR (in the case of a patient who has been determined by two doctors to be in a terminal or permanently unconscious state).
- C. As part of the information process for all inter-facility transports, the communication specialist will attempt to inquire of the patient's DNR status and request that a copy of the order be placed with the transfer paperwork.
  
- D. Upon arrival to the referring facility, and the DNR status has become known, the transport team will confirm there is a copy of the DNR order in the patient's chart. Verification of identity is not required for patients or residents of health care facilities when a DNR order is present on the person's chart.
  
- E. On occasion, the transport team might encounter a reported DNR status with no DNR forms easily accessible at time of transport and patient has no clinical indications that arrest or the need to enact the DNR protocol will occur. To prevent transport delays, the transport team may transport the patient without a copy of the DNR status.
  
- F. The transport team will assure a copy of the DNR order stays with the patient and a second copy is attached to the transport record.
  
- G. The medical team will confer with the facility and /or the family regarding the disposition of the patient should death occur prior to completion of the transport. Any conflicts or questions should be resolved through contacting Air Care & Mobile Care (ACMC) Management for guidance. If needed ACMC may contact UC Health Risk Management.
  
- H. If a death occurs during transport:
  - 1. The medical team will comply with the guidelines outlined in the DNR order.
  - 2. Hospice patients should be transported to the predetermined receiving facility.
  - 3. The medical team should have the communication specialist inform the receiving facility that death has occurred.
  
- I. In the case of long distance transports outside of our normal operating area:
  - 1. The patient will be taken to the closest appropriate facility preferable within the same county that the patient expired to be pronounced.

2. If medical team is unable to locate an emergency room, they should contact the local law enforcement or local coroner for assistance of notifying the appropriate authorities for their jurisdiction to pronounce the patient and determine disposition of the deceased.

J. On occasion, the ground division of Air Care & Mobile Care will be requested to transport a DNR-Comfort Care patient from a health care facility to a patient's home for the sole intent for end of life to occur at home. The transport crew, communication center and hospice nurse and /or social work will work collaboratively to provide all needed resource so this can occur. APMC management may be requested for review of patient home for safety purposes.

**V. DOCUMENTATION**

A. Transport crews will document DNR status and any relevant information in the electronic medical record.

B. Copy of the DNR status will be scanned into the electronic transport record.

**VI. QUALITY MANAGEMENT**

A. All Charts may be reviewed by the Medical Director as part of the Quality Improvement Process.

**VII. RESPONSIBILITY**

**All Team Members, Communications Specialist**

**VIII. KEY WORDS**

None

**IX. APPENDIX None**

**X. REFERENCES / CITATIONS**

**Ohio Administrative Code (OAC) 3701-62**

<https://www.odh.ohio.gov/rules/final/3701-60-69/f3701-62.aspx>



- A. All patients requiring support of an IABP shall be transported by Air Care or the Mobile Intensive Care Unit. Additional personnel may be added as indicated and as safety restraints permit and weight and balance permit.
- B. Additional considerations:
  - 1. The IABP will be secured in the transport vehicle with the appropriate securing device(s). Any IABP that cannot be secured with the approved securing device(s) will not be transported.
  - 2. The communication specialist should coordinate with the receiving facility additional personnel to assist with off-loading the patient from the transport vehicle as available

**V. RESPONSIBILITY**

**All Communication Specialist, All Transport Associates**

**VI. KEY WORDS**

**None**

**VII. APPENDIX** **None**

**VIII. REFERENCES / CITATIONS**

**None**

POLICY NAME/#	MC13	
POLICY TITLE	Transport to Patient Residence	
POLICY OWNER	Air Care and Mobile Care	
	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
	Dr. Elizabeth Powell Ground Medical Director	(Date)
ADMINISTRATIVE APPROVAL	_____	_____
	Jennifer Jackson/VP CNO	(Date)
ORIGINATION DATE	2/2001	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>7/2018</b>

**I. POLICY**

On occasion, Air Care & Mobile Care ground units might be requested to take a patient back to their residence. It is under strict and pre-determined situations that this will be allowed. Due to the possibility of unforeseen risk, ACMC will limit when and where a transport request of this nature will be completed.

**II. PURPOSE**

To assure the safety of patients and team members, the following procedures will be followed when transporting to a patient residence.

**III. DEFINITIONS**

None

**IV. PROCEDURE**

- A. As a general rule, the communication specialist should try to schedule residential transports during daylight conditions (dawn to dusk.) The following conditions MUST be communicated to the requesting agency/ personnel:
  - 2. The residence steps need to be free from debris/environmental hazards.
  - 3. the area is well lit
  - 4. all team members and communication specialists should feel comfortable with the patient's and team member's safety during the transport
  - 5. If additional manpower is needed to ensure the safety of the patient and crew, the team should contact Air Care and Mobile Care Communications Center to dispatch additional manpower.
  
- B. If the transport cannot be completed by the Air Care or Mobile Care team under these conditions, the transport should be held until the conditions can be met. If necessary, another ambulance service can be arranged to complete the transport. If this occurs, the referring facility social worker and/or RN will be notified that another transport service will be providing transport. Reason(s) for cancellation of transport will be noted in the-Golden Hour system.
  
- C. When the ambulance is left unattended, the transport team will lock all doors.
  
- D. Electronic Medical Record will be completed and signature of responsible person receiving the patient at the time of the transport is needed but not required.

**V. RESPONSIBILITY**

**All Mobile Care Team Members and Communications Specialists**

**VI. KEY WORDS**

None

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS**

None



#### IV. PROCEDURE

- A. The benefit of managing the patient's airway prior to loading should be weighed against the time-cost of doing so.
- B. The benefit of securing one Intravenous line before loading should be weighed against the time cost of doing so. In most cases, a second IV should be obtained in-transport pending patient condition.
- C. When appropriate, a nasogastric tube should be inserted and gastric contents removed from patient who are at risk for aspiration. Some examples include:
  - 1. Multiple trauma patients
  - 2. Unconscious patients from any cause
  - 3. Intoxicated or sedated patients
  - 4. Patients with a recent history of nausea and/or vomiting
  - 5. Patients with recent food intake
- D. The use of restraints should be considered for the following patients: see The University of Cincinnati medical Center's "Restraint and /or Seclusion: non-violent/non Self Destructive Behavior and Violent/Self Destructive Behavior Policy."
- E. Upon arrival at a scene or referring agency the crew will:
  - 1. Leave the ship with the appropriate equipment
  - 2. Assure that no one approaches the ship while it is running
  - 3. At a scene, notify the pilot as soon as possible about the weight of the patient
  - 4. At a hospital, the crew may choose to leave the aircraft while it is running or after it has been shut down
  - 5. Ear protection should be worn by the flight crew at times while the aircraft is running

F. Prior to departure from a referring facility, the following precautions are necessary:

1. The flight crew will direct the loading of the patient and the equipment
2. The aircraft doors will be closed by the flight crew
3. Instruct all ground personnel to leave the area of aircraft departure
4. All ground personnel should shield their eyes as dirt or foreign objects may be thrown.

**V. RESPONSIBILITY**

All crew members

**VI. KEY WORDS**

None

**VII. APPENDIX** None

**VIII. REFERENCES / CITATIONS**

None



- B. Non local, Non Mountainous 1000' ceiling and 3 miles visibility
  
- C. Mountainous Areas  
1500' ceiling and 5 miles visibility for all pilots

### **Night Hours**

- A. Local (30-mile radius from 8OH9, Butler County Airport, Mt. Orab) 1000' ceiling and 3 miles visibility-with or without Night Vision Systems (NVIS)
  
- B. Non-Local 1000' ceiling and 3 miles visibility-with NVIS or TAWS  
1000' ceiling and 5 miles visibility-without NVIS or HTAWS
  
- C. Mountainous Areas, Non-Local Flying Area  
1000' ceiling and 5 miles visibility for all pilots with NVIS or HTAWS  
  
1500' ceiling and 5 miles visibility for all pilots without NVIS or HTAWS

**New pilots and relief pilots refer to air vendor general operations manual for VFR weather minimums.**

**Flight operations will be conducted under Visible Meteorological Conditions (VMC). Air Care has the capability to operate under IFR in accordance with air vendors Instrument Flight Rules (IFR) procedures.**

- A. During the hours of daylight, the pilot must have a visible horizon and surface reference. During the hours of darkness, the pilot will have visible horizon and surface light reference. NOTE: If the pilot-in-command determines the ceiling or visibility is not at or above weather minimums, he or she will abort the flight.
  
- B. Medical reason or patient condition must not be factored into weather decisions.
  
- C. Mountainous areas are depicted in Figure 5-6-3 of the Airman's Information Manual.

D. New or relief pilots without prior air medical experience will be assigned 25 day shifts or 20 hours of operation in the Cincinnati local area. Pilots with air medical experience will be assigned 15 days shifts or 15 hours of operation in the local Cincinnati area. In addition, relief pilots revert back to the higher minimums if they have not flown five (5) flight hours in the Cincinnati local area within the previous ninety (90) days of which two hours must be at night as pilot in command or at the controls prior to EMS mission. New or relief pilots should only reduce weather minimums after he or she has met the 25/15 day shift requirement, feel comfortable with the Cincinnati local area, and has approval from the aviation site manager.

E. For all weather minimums reference the air vendor's general operations manual.

**V. RESPONSIBILITY**

**Pilot**

**VI. KEY WORDS**

**None**

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS None**

POLICY NAME/#	MC12	
POLICY TITLE	Hazardous Weather	
POLICY OWNER	Air Care and Mobile Care	
	_____	_____
	Matt Gunderman/Director	(Date)
	_____	_____
	Dr. Elizabeth Powell Ground Medical Director	(Date)
ADMINISTRATIVE APPROVAL	_____	_____
	Jennifer Jackson/VP CNO	(Date)
ORIGINATION DATE	11/2001	
<b>LAST REVISION/ REVIEW DATE</b>	<b>7/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>7/2018</b>

- I. POLICY  
 The following guidelines shall be referenced when hazardous weather conditions exist to assure the safest possible transfer for the patient and transport associates.
  
- II. DEFINITIONS  
 None
  
- III. PROCEDURE

- A. Weather conditions will be monitored using a variety of resources, including but not limited to:
1. Direct visualization (including referring facility)
  2. Weather radio in communications center
  3. Weather radar
  4. Internet weather sites
  5. Artemis Traffic System
  6. Local television stations weather reporting
- B. The decision to complete a patient transport will be based on the following criteria:
1. Weather conditions at the point of origin, destination and along the intended route of travel (consider alternate routes)
  2. Patient acuity
  3. Patient needs at referring facility
  4. Risk Assessment Score and risk mitigation factors
- C. In times of questionable weather, the communication specialist will consult with the transport team and the referring facility to help determine if the transport can be accomplished safely. If any member of the transport team feels conditions are unsafe, the transport will be placed on hold until the conditions improve. If the patient transport can be placed on hold until weather permits a safer transfer, this option should be discussed with appropriate personnel involved in providing the patient care.
- D. Weather encompasses many conditions and it is impossible to plan for all scenarios. Following are guidelines when hazards exist in transit:
1. Snow and / or Ice: During periods of heavy snow and/or ice, decreased visibility is likely. All aspects of communications will be used including contacting security at the point of destination to help determine safety of the transport. The decision to transport is made in collaboration with all team members: however, any associate can cancel a transport if they feel their safety is compromised. If conditions deteriorate En-route such that continuing may jeopardize the health and safety of the patient and transport team members, the transport team should abort and go to a safe location. If stopped on the side of the road, four-way warning and emergency beacons should be activated to provide ample warning. The communication specialist will be immediately notified who will in turn contact the referring and/or receiving facility.

2. Rain and/or Flooding: Contact the Communications Center to inform them that the transport may be delayed until severe weather passes. When decreased visibility exists, the driver shall pull the transport vehicle to the far right shoulder of the roadway and remain idling with four-way emergency flashes and emergency beacons activated to provide ample warning to other motorists. The communication specialist will be immediately notified and will contract the referring and/or receiving facility with an update on their ETA.

3. High Water: The driver shall not enter a flooded road with has become obscured and where the lane markers, if provided, are no longer visible. The driver shall not enter running water if the depth cannot be easily determined.

4. Tornado Watch/Warning: A tornado watch indicates weather conditions are favorable for the production of a tornado. - Air Care/Mobile Care - will evaluate the urgency of the transport using the above criteria. A tornado warning indicates a tornado has been spotted. Transport teams will avoid the area within the warning. Contact the Communications Center to inform them that the transport may be delayed until severe weather passes. If the warning occurs during transport, team members will identify an alternate route or attempt to find appropriate cover.

5. Strong or Gusting Winds: High velocity winds affect high profile vehicles differently, and have the potential to create hazardous operation of the vehicle. If winds are encountered that are strong enough to impede control of the vehicle, the driver shall pull to the far right shoulder of the roadway and remain idling with four-way emergency flashers and emergency beacons activated to provide ample warning to other motorists. The communication specialist will be immediately notified who will in turn contact the referring and/or receiving facility and be given an updated ETA.

**IV. RESPONSIBILITY**

**All Mobile Care Team Members and Communication Specialist**

**V. KEY WORDS**

**None**

**VI. APPENDIX None**

**VII. REFERENCES / CITATIONS None**



#### IV. PROCEDURE

- A. The **maximum** ambient air temperature limitations for aircraft operations are as follows:
  - 1. BK117: ISA +35 degrees C, Max. +50 degrees C (122 degrees F)
  - 2. EC 145: ISA +35 degrees C, Max. +50 degrees C (122 degrees F)
- B. The **minimum** ambient air temperature limitation for aircraft operations are as follows:
  - 1. BK 117: -35 degrees C (-32 degrees F)
  - 2. EC 145: -30 degrees C (-22 degrees F)
- C. During the shift briefings, the flight team shall discuss any potential weather extremes.
- D. No flights will be conducted at temperatures below -30 degrees F.
- E. All Air Care & Mobile Care aircraft will be placed in the hangar when the outside temperature is below 25 degrees F or below 32 degrees F and visible moisture.
- F. The aircraft will not depart for temporary staging locations unless the weather will be flyable for greater than 4 hours.
- G. Wind chills and heat index factors must be considered. All flight team members should take the necessary precautions. Dress appropriately for cold weather, minimize exposed flesh. Bring extra blankets on-board the aircraft. During hot weather periods, bring additional fluids for consumption.
- H. In all cases, the primary concern shall be the survival of the aircraft occupants should there be a need for an unscheduled landing.
- I. When the temperature is expected to remain above or below acceptable maximums and minimums for an extended period of time, the crews may be released from duty, with the approval of the lead pilot and clinical manager.

#### V. RESPONSIBILITY

ALL FLIGHT TEAM MEMBERS SHOULD DRESS APPROPRIATELY FOR THE WEATHER AND EXPECT TO BE OUTSIDE THE AIRCRAFT AND OTHER HEATED/COOLED AREAS FOR EXTENDED PERIODS OF TIME.

#### VI. KEY WORDS

#### VII. APPENDIX

#### VIII. REFERENCES / CITATIONS

	<u>AC50</u>	
<b>POLICY NAME/#</b>	<b>Weight Limit for Helicopter Patients</b>	
<b>POLICY TITLE</b>	<b>Air Care and Mobile Care</b>	
<b>POLICY OWNER</b>	<p>_____ (Date)</p> <p><b>Matt Gunderman/Director</b></p> <p>_____ (Date)</p> <p><b>Dr. William Hinckley/Air Medical Director</b></p> <p>_____ (Date)</p> <p><b>Bob Francis, Manager Metro Aviation</b></p>	
<b>ADMINISTRATIVE APPROVAL</b>	<p>_____ (Date)</p> <p><b>Jennifer Jackson/VP CNO</b></p>	
<b>ORIGINATION DATE</b>	<b>10/1999</b>	
<b>LAST REVISION/ REVIEW DATE</b>	<b>6/2017</b>	<b>NEXT REVIEW DATE</b>
		<b>6/2018</b>

- I. **POLICY**  
The transport team shall determine whether patients weighing more than 250 pounds can be safely transported.
- II. **PURPOSE**
- III. **DEFINITIONS**  
None
- IV. **PROCEDURE**

- A. While obtaining medical report on the patient, the crew will obtain the weight of the patient requested for transport.
- B. If the patient weighs in excess of 250 pounds (113 kg), the medical crew will determine the appropriateness for air medical transport by evaluating patient condition, patient size, and crew weights and aircraft performance.
- C. If a patient weighing in excess of 300 pounds is accepted for flight, communication specialist will advise the referring and/or receiving facility of the need for lifting assistance.
- D. When responding to a scene, the medical crew must assess the patient's suitability for flight. If the patient's weight appears to exceed stretcher weight capability, the ground EMS service should be informed that they would need to make alternative arrangements for ground transportation. If this occurs, the medical crew will accompany the patient in the ambulance to assure continuity of care.
- E. Weight restrictions may change based on the type of stretcher that is used for patient transport. Weight limits should be posted on all stretchers.

**V. RESPONSIBILITY**

**VI. KEY WORDS**

None

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS**

None



### **III. PROCEDURE**

- A. The pilot-in-command will determine the maximum allowable gross weight for hover in ground effect and hover out of ground effect performance. These values will vary with pressure altitude and outside temperature. Generally, as density altitude\* increase, available payload decrease.
- B. Prior to flight, the communications specialist or a medical team member should notify the pilot-in-command of the patient and/or passenger weights.
- C. The pilot-in-command will compute weight and balance for the aircraft and corroborate that no limitations have been exceeded.
- D. If the pilot-in-command determines that the allowable weight has been exceeded, weight must be off-loaded. Options for reducing weight are as follows:
  - 1. Fuel may be burned off, if there is sufficient time available.
  - 2. Ride along personnel may be asked to stay behind.
  - 3. Unnecessary equipment may be removed.
  - 4. Flight physician/ APN or flight nurse may be left behind.

### **IV. RESPONSIBILITY**

#### **V. KEY WORDS**

None

#### **VI. APPENDIX None**

#### **VII. REFERENCES / CITATIONS**

None



Obesity - The CDC defines a body mass index greater than 30 as obese

Morbid Obesity - body mass index (BMI) greater than 40

Body Mass Index (BMI) -  $\text{Weight in pounds} \times 703 / \text{height in inches squared}$

Bariatric stretcher - Any mobile care stretcher/cot rated to carry a patient equal to or greater than 650 lbs in the up position and is wide enough or has the capability of width extensions to provide a stable platform for the patient.

Bariatric ambulance - Any mobile care ambulance that has a loading assist device that decreases the lifting required by the medical crew. This can be a ramp and winch or a lift system.

Patients with a weight greater than 300 lbs, regardless of their BMI, will fall into this policy.

Patients whose size, shape, width, or tissue viability, could cause additional risk to the patient or crew, may be cared for under this policy at the discretion of the communications center or clinical crew.

#### **IV. PROCEDURE**

The Air Care & Mobile Care Communications Center will attempt to obtain the weight of all patients being transported by Air Care & Mobile Care or any other service in which Air Care & Mobile Care is an interacting agency. This weight will be given to the medical crew with the patient report or as soon as the information is available.

- A.** It is understood that sometimes it is impossible to obtain an accurate weight on patients. This is primarily with ground 911 or Air Care scene responses. It is also further understood that the weight relayed to the communications center may be an estimate and the actual weight could be higher or lower.
- B.** For all patients who have a reported weight equal to or greater than 300 lbs (135kg), ACMC Communications Center will attempt to gain additional patient information.
  1. Patient's width (not waist size/circumference) at the widest part of their body, typically the waist or shoulders.
  2. Patient's height. (May be an estimate by referring facility.)
  3. Level of mobility.
  4. Any current areas of skin or other tissue breakdown.
  5. Any special needs related to patient's size such as positioning, splinting, and securing of lines & tubes.
  6. Environmental concerns such as number of steps at referring and receiving destination.

- C. For all inter-facility transfers of patients equal to or greater than 300 lbs, the ACMC Communications Center will arrange lifting assistance at the sending and receiving facility, or have communication with the transport crew that additional lifting assistance is not needed. This is at the crew's discretion.
  - 1. Lifting assistance can be additional ACMC crew members, staff at either facility, or other resources.
  - 2. Lifting assistance does not need to be on the ambulance of a transport. Different people can assist on each end of the transport.
  - 3. The medical crew can request additional assistance to ride in the ambulance during the transfer if patient condition requires.
- D. ACMC Communications Center will give an accurate ETA to the referring facility taking into consideration the need to:
  - 1. Arrange additional lifting assistance.
  - 2. Provide time for the crew to obtain the appropriate bariatric equipment that may be housed at another base.
  - 3. Consultation with crew may be required prior to giving an ETA to the referring facility.
- E. If the medical crew arrives at a referring facility and assesses their patient to need additional lifting or other assistance or a bariatric cot or ambulance, regardless of the patient's weight, the crew should call the communications center.
  - 1. If only lifting assistance is needed, soliciting help from personnel at the facility should occur first as this will speed the transport along.
  - 2. If lifting assistance is not readily available or a different stretcher or truck is needed, the communications center will make notifications of the delay.
- F. Medical crews should never place a patient on a cot in which the total weight of the patient and medical equipment (heart monitor, ventilator, etc) exceeds the maximum capacity of that cot.
  - 1. Medical crews can carry this equipment or request a cot with a higher weight capacity.
- G. For the patient's safety and associate safety – the use of lift assist devices, slide boards, multiple people is strongly recommended.
  - 1. ACMC crew may only use lift assist device they have been trained to use and proven competence. In general, hospital personnel should use the equipment with ACMC assistance.
  - 2. ACMC crew should use the ambulance lift equipment when it is available and there is a risk of lifting related injury to the crew or patient.
- H. If the transport request is for Air Care and the patient weighs 250 lbs (113 kg) or more, the communications specialist should consult with the pilot as soon as possible.

1. Current Air Care stretchers are rated at either 400 lbs or 650 lbs depending on the stretcher.
  2. Often the width of the patient is as much a factor as weight for Air Care. It may be required to obtain patients width and height.
  3. Although they do often help, the pilots should not be considered as lifting assistance for Air Care.
- I. It's important that ACMC associates operate in a manor to preserve the dignity of bariatric patients. Clear communications; explaining the different procedures that will occur, and reminding the patient that the differences in procedures is for their safety are all excellent measures to reduce the anxiety and embarrassment that bariatric patients can feel at times of transfer. ACMC associates should be very sensitive to the patient's needs and consider where/how they are conversing about the safest manor to move the patient.

**V. RESPONSIBILITY**

**A. Air Care & Mobile Care Communications Center, communications specialists and nurses.**

**B. Air Care & Mobile Care medical crews and pilots.**

**VI. KEY WORDS**

None

**VII. APPENDIX None**

**VIII. REFERENCES / CITATIONS**

A. Thomas, Shirley (RN) & Lee-Fong, Mary(RN-C) (2010) "Maintaining dignity of patients with morbid obesity in hospital setting" Bariatric Times 8(4):20-25