



REFERENCE

MANUAL

51

National Park Service

Emergency Medical Services

Version 1.0

Approved: __Signed: / Karen Taylor Goodrich 8/14/2006__

Associate Director, Visitor and Resource Protection

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Chapter 1

PROGRAM DIRECTION AND SCOPE

- 1.1 Introduction
 - 1.2 Overview
 - 1.3 Policy
 - 1.4 Purpose
 - 1.5 Program Funding
 - 1.5 Implementation
-

1.1 Introduction

The National Park Service (NPS) Management Policies, 2001, state that “The saving of human life will take precedence over all other management actions as the NPS strives to protect human life and provide for injury-free visits” (Section 8.2.5.1, *Visitor Safety*, page 85). The NPS ability to respond to emergency medical incidents supports that policy and is essential to the well being of all who enter NPS areas.

Because the NPS manages a wide variety of areas across the United States, with diverse physical environments and a diverse visiting public, where varying levels of Emergency Medical Services (EMS) may be required, it is necessary to provide guidance to NPS emergency medical providers for purposes of standardization of care and documentation. This document provides that guidance.

1.2 Overview

The initial response and pre-hospital care role for the NPS has grown with the increase of visitation to NPS units into a significant workload. In order to provide NPS managers with direction and guidance in establishing and managing emergency medical care programs, NPS-51, the NPS Emergency Medical Services Guideline, was released in November 1984. In October 1985, the National Association of State EMS Directors passed a resolution unanimously supporting the adoption of NPS-51 in all states and offered its assistance in its implementation. In November of the same year, the National Council of State EMS Training Coordinators unanimously supported this resolution. A second version of NPS-51 was released in January of 1991.

In 2005, the Director’s Orders 51 (DO-51) was signed and distributed to the field. In 2006, this Reference Manual 51 (RM-51) will be signed and distributed to the field. These two documents will replace the previously designated NPS Guidelines. These versions of DO-51 and RM-51 replace the previous NPS-51.

This document continues to provide a uniform approach to the policies, guidelines and procedures to be followed in order to achieve the desired Servicewide goal of providing quality patient care on a national level.

1.3 Policy

The public use of NPS areas is specifically directed by Congress, and the NPS is delegated the responsibility for the welfare of persons who use these areas.

The NPS will ensure that adequate EMS are available to visitors and employees who become ill or injured within park units. Qualified EMS in local communities may be utilized if they can provide a timely response to emergencies that occur within an NPS area. When such services are not available, the NPS will make a reasonable effort to provide a level of emergency medical service commensurate with park needs.

Each park manager will complete an EMS Needs Assessment and develop and implement a program to meet identified needs, in accordance with this Reference Manual.

The NPS will promote good neighbor relations with the state medical authorities by coordinating procedures to the benefit of both agencies.

The NPS National Medical Advisor provides national oversight and direction for the Servicewide EMS Program. The Branch Chief, Emergency Services (WASO) coordinates the Servicewide EMS Program.

1.4 Purpose

The purpose of the EMS Reference Manual is to provide the framework for an efficient program. In this Reference Manual, EMS refers to the pre-hospital care and/or transportation of the sick and injured. This broad category covers activities ranging from minor first aid to Advanced Life Support (ALS) cases in a wide variety of environmental settings. Transportation includes utilizing available resources ranging from hand-carried litters to air ambulances.

This Reference Manual will:

1. Provide program guidance
2. Define levels of care
3. Outline Needs Assessment and EMS plans
4. Establish Servicewide certification criteria
5. Establish administrative procedures
6. Establish operational procedures

1.5 Program Funding

The funding of a Park EMS Program is borne by individual park accounts and may be enhanced by donations and payment for services. Program costs may include training, supplies and equipment, vehicles, and registration fees for obtaining and maintaining EMS certifications. Section 317 of the Department of the Interior and Related Agencies Appropriations Act, 1993 (P.L. 102-381), authorizes funds that "...may (emphasis added) be used to reimburse employees for the cost of...certification fees pursuant to their employment."

1.6 Implementation

It is the responsibility of the NPS to ensure that adequate pre-hospital care is available for employees and visitors. In order to provide that service, established levels of EMS training are recommended and/or required of all employees.

Additionally, and in regard to the welfare of its EMS providers and other employees, park managers will provide for an incident debriefing (non-critique) within 36 hours following any incident involving circumstances that might have adverse emotional or psychological impacts to the EMS providers for the purpose of discussing and defusing these effects. A more formal Critical Incident Stress Debriefing session will be arranged as necessary. Any EMS member may request a Critical Incident Stress Debriefing session. Details of the Critical Incident Stress Management program may be found in RM-57 *Occupational Medical Standards and, Health and Fitness* and/or within local park policy.

Program accountability lies with the individual Park Superintendent as well as the Chief of the U.S. Park Police. Chapter 3, *Management and Supervision*, details the hierarchy of EMS medical control throughout the Service and on the park level.

Chapter 2

AUTHORITY AND JURISDICTION

- 2.1 Authority
 - 2.2 Jurisdiction
-

2.1 Authority

Traditionally, the NPS has provided visitor protection services, including varying levels of EMS. This obligation is as broad as the scope of uses within NPS areas.

The authority for providing these services began with the Organic Act of August 25, 1916 (16 USC 1-4), which states that the fundamental purpose of the NPS is "to conserve the scenery and the natural and historic objects and wildlife therein and to provide for the enjoyment of the same in such manner and by such means as will leave them unimpaired for the enjoyment of future generations."

Providing for the enjoyment of NPS-managed areas requires providing a safe environment in which visitors have access to emergency services.

The authority continues in 16 USC 12, which states that "The Secretary of the Interior is authorized to aid and assist visitors within the national parks or national monuments in emergencies...." Emergencies may include search, rescue, and medical incidents.

The authority for EMS assistance to neighboring communities and outside agencies is specifically provided for in 16 USC 1b (1), which allows the "Rendering of emergency rescue, fire fighting, and cooperative assistance to nearby law enforcement and fire prevention agencies and for related purposes outside of the National Park System."

The authority for Volunteers-In-Parks (VIP) assistance is codified in 16 USC 18 g-i.

The authority for EMS protection for NPS employees is specifically provided for through the Occupational and Safety and Health Act of 1970 (OSHA), 29 USC 651 et. seq. This states that it is "the responsibility of the head of each Federal agency to establish and maintain an effective and comprehensive occupational safety and health program ...and provide safe and healthful places and conditions of employment...."

In addition, 16 USC 13 states that "The Secretary of the Interior, in his discretion, is authorized to provide... medical attention for employees of the National Park Service located at isolated situations, including the moving of such employees to hospitals or other places where medical assistance is available...."

2.2 Jurisdiction

Although this document has been developed based upon the authorities mentioned above, it will require the close cooperation and support of the various states and local governments within which the units of the NPS are located.

The state may not impose its regulatory power upon the NPS without specific congressional consent. However, relative to EMS, park areas may adopt all or part of the policies and guidelines established by the state EMS bureau in which they are located, as long as they do not conflict with NPS Direction and Policy as provided for in DO-51 and RM-51.

Superintendents may assist other agencies with emergencies that occur outside parks, but written agreements with such agencies shall be in place in conformity with the requirements of DO-20, *Agreements*. NPS employees who are directed by their supervisors to provide emergency medical assistance to such agencies outside of their jurisdiction will be considered to be acting within the scope of employment.

Chapter 3

MANAGEMENT AND SUPERVISION

- 3.1 Introduction
 - 3.2 Overview
 - 3.3 Organizational Levels and Responsibilities
-

3.1 Introduction

The purpose of this chapter is to explain the levels of EMS oversight that have been established within the NPS. These levels, as described, provide for standardization of EMS care, documentation, and program administration within the Service.

3.2 Overview

The day-to-day management and funding of a Park EMS Program resides at the park level. It is the responsibility of each Park Superintendent to ensure that the Park EMS Program is in compliance with DO-51 and RM-51. Superintendents will appoint Park EMS Coordinators, who will work with Park EMS Medical Advisors to ensure that their programs are in compliance with Servicewide policy and regulation, as well as applicable laws. The Washington and regional offices will provide guidance and assistance to the parks.

3.3 Organizational Levels and Responsibilities

3.3.1 Branch Chief, Emergency Services

The Branch Chief, Emergency Services is located in the WASO Division of Law Enforcement and Emergency Services, and is responsible for the overall national leadership of the Servicewide EMS Program. The Branch Chief, Emergency Services will provide both short- and long-term strategic planning and programming to the NPS EMS Program.

The Branch Chief, Emergency Services represents the Visitor and Resource Protection Directorate to the NPS National EMS Medical Advisor on strategic planning, development, review and revision of national policies including protocols, Servicewide training, data collection, standards of care, and quality assurance and improvement.

The Branch Chief, Emergency Services manages the EMS testing and certification program with the National Registry of Emergency Medical

Technicians (EMTs). The Branch Chief, Emergency Services liaisons with other EMS organizations including the National Highway and Safety Transportation Administration (NHTSA), Health and Human Services, the Federal Interagency Committee on EMS, the American Red Cross, the American Heart Association, and others. The Branch Chief, Emergency Services manages issues of mutual concern with states and territories through partnerships with the National Association of State EMS Directors and the National Association of State EMS Coordinators.

The Branch Chief, Emergency Services provides, through subject matter expertise, assistance, and guidance to the regions and parks on policy and legal matters regarding EMS. The Branch Chief, Emergency Services assists regions and parks in development of contracts with hospitals and Medical Advisors. The Branch Chief, Emergency Services liaisons with the Division of Risk Management on issues of mutual interest including infectious diseases and injury prevention planning.

The Branch Chief, Emergency Services is responsible for Servicewide EMS data collection for use in identifying trends in EMS, quality improvement, and injury prevention planning. The Branch Chief, Emergency Services maintains inventories on personal resources and EMS capitalized equipment including ambulances and rescue vehicles. The Branch Chief, Emergency Services plans, develops and manages training with the WASO Training Division, the Parkmedic Training Center, and the regional offices.

3.3.2 National EMS Medical Advisor

The NPS will retain a physician(s) as the National EMS Medical Advisor to provide advice, oversight and medical direction for the Servicewide program based on sound medical practice and standards. This may include recommendations regarding quality improvement, data collection, and scope of practice, and curriculum revisions to the Parkmedic program and other medical training programs.

Medical direction involves giving approval and accepting responsibility for the care provided by EMS personnel, and includes participation in the management of the program to ensure compliance with contemporary standards of medical protocol. Quality medical direction is an essential component in providing quality care for patients, and in the development of a proactive public safety prevention program.

The National EMS Medical Advisor will help develop and recommend Servicewide medical protocols covering nationally recognized procedures for established levels of care. Additionally, the National EMS Medical Advisor will collaborate with the Park EMS Medical Advisors to ensure compliance with

national standards. Parks with Level IV-VI programs and Automated External Defibrillator (AED) programs that are unable to obtain a Park EMS Medical Advisor through contractual agreement must obtain oversight and approval of protocols by the National EMS Medical Advisor.

3.3.3 Regional EMS Coordinator

Each region will assign a person to assist the National EMS Program Manager with EMS issues affecting parks in their region, the coordination and collection of EMS data, regional training, and coordination of recommendations made for revisions to national EMS policy. The Regional EMS Coordinator will maintain a resource list of EMS providers and EMS equipment available within the region.

3.3.4 Park EMS Coordinator

The day-to-day management of EMS Programs in the individual units of the NPS resides at the park level, and it is the responsibility of Park Superintendents to ensure that their programs are in compliance with the DO-51 and RM-51. Park Superintendents will appoint an EMS Coordinator to fulfill these obligations.

Duties of the Park EMS Coordinator include the following:

- Liaison with the Park EMS Medical Advisor
- Evaluate the welfare and effectiveness of the EMS Program and apprise park management and the Park EMS Medical Advisor
- Ensure that the area EMS plans are consistent and in compliance with DO-51 and RM-51
- Coordinate park EMS training and serve as EMS training officer
- Coordinate the purchase of controlled substances, EMS supplies and equipment
- Maintain necessary records such as personnel resources, and supply and equipment inventories
- Issue White Cards (EMS provider authorizations) and ensure that appropriate credentials are maintained
- Prepare and submit a summary of park EMS activities and the number of Level III, IV, V and VI EMS providers to the National EMS Program Manager and Regional EMS Coordinator at the end of each calendar year
- Provide for as necessary, Critical Incident Stress Management follow-up for all employees and supervisors who may be involved in emergency response and/or support; the specific details regarding Critical Incident Stress Management are to be published in RM-57 *Occupational Medical Standards and Health and Fitness Guidelines*
- Conduct EMS Needs Assessment for the park every 3 years

3.3.5 Park EMS Medical Advisor

Park EMS Medical Advisors are licensed doctors, preferably hospital-based emergency medicine physicians, and are approved by the Park Superintendent.

Park areas that provide Level IV-VI EMS Programs and all parks with AED programs must have a Park EMS Medical Advisor. The relationship will be formalized through a General Agreement or other appropriate Instrument of Agreement (see Chapter 17, *Instruments of Agreement*, and NPS DO-20 and RM-20).

Park EMS Medical Advisors will provide advice and oversight to individual park programs, including online medical control, quality improvement, data collection, continuing education, protocol implementation and development of local protocols when national protocols are not available, treatment authorizations, endorsement of qualified applicants for National Registry of EMTs certification at Levels IV-VI, and assist Park EMS Coordinators with the administration of examinations.

3.3.6 National EMS Advisory Group

The Branch Chief, Emergency Services may convene the National EMS Advisory Group to advise and work on issues important to the Servicewide EMS Program. This advisory group will represent a cross-section of the Servicewide EMS Program enlisted from EMS Program managers, advisors and technical experts.

The group size will be limited to nine. (See Chapter 8, *Medical Oversight*, section 3.8, for further details.)

The main focus of this group is to review and recommend changes to the DO and RM for EMS.

Chapter 4

NEEDS ASSESSMENT

- 4.1 Introduction
 - 4.2 Overview
 - 4.3 Guidelines
-

4.1 Introduction

This chapter provides guidelines to aid in the organization of a Needs Assessment.

The EMS Needs Assessment is the process used to assist managers in the development and ongoing evaluation of the Park EMS Program. The need for an EMS Program will be based on an evaluation of many attributes to determine if, and at what level, an EMS Program is appropriate. Per DO-51, an EMS Needs Assessment will be completed at least once every 3 years.

4.2 Overview

The objectives of the Needs Assessment are to identify current and projected needs, rather than to justify current operating conditions. The Needs Assessment process is a tool to be used to assess the current condition of EMS within a park and then to determine if those services being provided are consistent with contemporary standards. Continued improvements in emergency medical care are a major reason why the NPS reevaluates its EMS Program regularly on a park-by-park basis with attention to technological advances and current research.

A Needs Assessment identifies and evaluates (1) available internal and external resources, (2) the park's EMS workload, (3) requirements for training and certification, (4) transport capabilities and response times, (5) location and capability of the local area's medical facilities, (5) fiscal resources, (6) EMS communications, and (7) special considerations (e.g., mutual aid, out-of-park response, geographic location).

4.3 Guidelines

This section provides a suggested outline for completion of a Needs Assessment. Consider using the park's EMS data from no less than the previous 3 years to obtain an accurate representation of the Park EMS Program.

4.3.1 Park Information

- Visitation (total and by season if appropriate)
- EMS staffing levels (by season if appropriate)
- Hours of operation

4.3.2 Incident Information (incidents occurring within the park only)

- Total number of patients by type: medical (cardiac, seizure, stroke, diabetic, etc.) and trauma (fractures, soft tissue, etc.)
- Number of patients that received ALS; also valuable to identify cases where ALS was not available but would have been appropriate
- Number of patients that received Basic Life Support (BLS)
- Number of patients treated and released at the scene due to the minor nature of their injury/illness
- Total number of extended care patients (more than 1 hour with the patient)
- Fatalities by type
- Total number of patients transported
- Method of transport
- Average time to patient contact by a basic EMS provider
- Average time from BLS provider to ALS provider
- Average time from patient contact to arrival at hospital; may be helpful to separate remote evacuations from roadside in order to gain a meaningful average time frame of time spent with the patient in each setting
- Patient category (NPS employees, concession employees, visitors)

4.3.3 EMS Resources

An inventory of park and local community EMS resources can be compiled using the following:

- Locations, numbers, certification levels, and availability of EMS providers (NPS and non-NPS)
- Average response times to NPS EMS incidents by EMS providers from inside and/or outside the park
- Period of time that resources need to be available for response (hours and days of operation)
- Inventory and location of supplies and equipment

4.3.4 Transportation Services (air, ground and water)

- Total number patients transported by the NPS

- Total number of patients transported by non-NPS
- NPS patient transport unit types (air/ground/vessel), numbers, and availability
- Non-NPS patient transport unit types (air/ground/vessel), numbers, and availability
- Average time it takes transport unit to arrive on-scene from time notified
- Average time from scene to hospital or rendezvous with other EMS transport

4.3.5 Mutual Aid

- Total number of out-of-park patients treated by NPS EMS providers and the average response time to the patient
- Total number of in-park patients treated by outside agencies and their average response time to the patient
- Identify existing agreements (if any) and what they require

4.3.6 Area Medical Facilities

- Identify the local and regional medical facilities, distance from the park, their capabilities, and the number of patients that each receives from the park

4.3.7 Training Program

- Identify the current EMS training program and the availability of internal and external training available to park EMS personnel

4.3.8 Medical Advisor and Base Hospital

- For parks operating at Level IV or above (or if considering operating at this level) is there an EMS Medical Advisor available; is there an agreement in place with a local EMS Medical Advisor and Base Hospital
- Assess for appropriateness (EMS credentials, clinical capabilities, online communications, etc.)

4.3.9 Communications

- Determine how the EMS system is activated by both the public and employees and assess for appropriateness
- Factors that may exist that cause response times to be adversely affected
- Communications system available in-park or through external resource
- Nearest available 24/7 communications center
- Determine if 911 coverage exists

- Determine if employees responsible for EMS have on-scene communications (hand-held radios, etc.)
- Identify “dead spots” in the radio system
- Availability of online communications with a hospital (medical control)
- EMS providers trained and familiar with communication procedures
- Identify if the park’s communication center personnel (dispatchers) utilize Emergency Medical Dispatch and if they have been trained and certified in Emergency Medical Dispatch.

4.3.10 Fiscal Considerations

- Current EMS Program costs (training, supplies and equipment, and operations to the park)
- Non-programmed costs over \$500 billed to the National Search and Rescue (SAR) account
- Park’s annual EMS funding level

4.3.11 Other Considerations

- Status of the park’s current EMS plan and its relationship with other park plans such as Safety Plan, Exposure Control Plan, Aviation Plan, Emergency Response Plan, Critical Incident Stress Management Plan, Mass Casualty Incident Plan, etc.
- Each park area has its own unique set of circumstances to consider when completing a Needs Assessment; attributes such as hazardous materials storages, a highway passing through the unit, aircraft landing zone locations, remote locations such as mountainous regions, large expanses of water, etc., and how they may affect each component of the EMS system should be considered

4.3.12 Conclusion

The collection and analysis of the EMS data will allow park management (EMS Coordinator, Chief Ranger, and Superintendent) to assess the strengths and weaknesses of each component of their EMS Program, and enable them to make informed decisions as to where improvement is needed and what level of EMS may be most appropriate for them to provide at their park. Once a level has been selected, a plan for implementation (EMS plan) may be developed either within an existing plan (such as the park’s Emergency Operations Plan) or as an independent document.

Chapter 5

EMERGENCY MEDICAL SERVICES PLAN

- 5.1 Introduction
 - 5.2 Overview
 - 5.3 Guidelines
-

5.1 Introduction

Every park unit with an EMS Program will have an EMS plan approved by the Park Superintendent. For parks that provide EMS at Level IV and above, the plan should be reviewed and recommended by the Park EMS Medical Advisor. It is intended to be the guiding document for the park's specific EMS Program. This document needs to be written after a Needs Assessment has been completed. Per DO-51, the Park EMS plan will be reviewed at least once every 3 years in conjunction with the needs assessment and revised as necessary.

5.2 Overview

The EMS plan is an administrative document, and is intended to address the functions of the day-to-day operations of the Park EMS Program. Parks that rely on a non-NPS EMS provider may have a very brief plan, while others that provide a complex NPS EMS Program may have an extensive plan.

5.3 Guidelines

The EMS plan is a comprehensive document that provides the reader with information about the program and how it is to be implemented. It is intended to reflect local park policies and procedures consistent with DO-51 and RM-51.

Some elements to consider when drafting a Park EMS plan include the following:

- Introduction
 1. Describe the park unit
 - a. size and characteristics
 - b. visitation levels
 - c. general overview of EMS
- Summary of NPS authority and policy
- Purpose and goals of EMS Program

- Program management roles
 1. Park Superintendent
 2. Chief/District Ranger
 3. Park EMS Coordinator
 4. EMS Providers
 5. Park Medical Advisor
 6. Online Medical Control

- Level of care provided at the park
 1. Definitions
 2. Who is authorized to do ALS
 3. Who is accountable for medications
 4. Where are the medications maintained
 5. Who obtains the drugs
 6. What kind of system is in place to assure narcotics are current, secure, inventoried and exchanged
 7. Who inspects drug kits
 8. How often
 9. Who needs to be present
 10. Is there a checklist of supplies

- Overview of Needs Assessment
 1. What was determine by the Needs Assessment
 2. What is the workload
 3. Special concerns (i.e., remote wilderness settings)

- Training and Continuing Education
 1. Based on the level of care being provided address the training and continuing
 2. Education requirements (include the who, when, where, and how as appropriate for the park)

- Continuous Quality Improvement
 1. Describe the review process for the EMS incidents in terms of who conducts the sessions, how often, and who is required to attend (feedback to providers)
 2. Describe the review and approval process for the patient care records (PCRs)
 3. Describe procedures for addressing substandard performance
 4. Documentation
 - a. Describe process for routing, reviewing, approving PCRs
 - b. Address Freedom of Information Act and patient confidentiality issues

- Communications
Describe how the park's dispatch system is designed to work for EMS incidents including the role and responsibility for each link in the system
- Critical Incident Stress Management
Describe the park's mechanism for providing assistance to employees involved in critical incidents
 1. Multi-Casualty Incidents (MCI)
 2. State that the NPS utilizes the Incident Command System for MCIs and how the process is to be implemented
 3. If specific MCI scenarios are likely (hazardous materials storage facilities present, busy highways, etc.), provide a pre-plan including maps, potential hazards, staging and triage areas, etc.
 4. Provide a list of resources, both internal and external
- Patient Transport
 1. Describe the process of providing for ambulance transport (internal or external); if the ambulance is NPS operated, describe the operation in terms ambulance location(s), and responsibilities for maintenance, inventory, driver qualifications, fee schedules, billing procedures, patient transfers, and other components of the park's program
 2. Describe policies and procedures for air ambulance transports including pre-designated landing zones, altitude considerations, wilderness issues, etc.
- AED Program
Include AED policy and procedures
- Supplies and Equipment
 1. Responsible person(s) for purchasing and maintaining
 2. Procedures for replacing supplies when patient care is transferred
 3. Supply inventory list(s) for EMS kits
 4. EMS equipment and kit locations
 5. Procedures for cleaning reusable supplies and equipment
- General Agreements
Describe or include the General Agreements that are in place for the park relative to EMS
- Infectious Diseases policies and procedures for:
 1. Hepatitis B and other vaccination requirements for EMS providers
 2. Personal protective equipment
 3. Bloodborne pathogens. OSHA developed a compliance standard to protect employees who may be occupationally exposed to human blood or

other potentially infectious materials. Parks are required to comply with the OSHA Occupational Exposure to Bloodborne Pathogens Standard found in Title 29, Code of Federal Regulations, Part 1910.1030. The Exposure Control Plan (ECP) is for park employees who may have an occupational exposure to human blood, blood products, and other potentially infectious materials. (29 CFR 1910.1030 is available at www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051)

- Standing Orders and Treatment Protocols
Include a reference to NPS National Standard Protocols as appropriate and attach; protocols that are approved locally by the Park EMS Medical Advisor should also be included in this section
- Appendices
Include samples of all forms or other documents utilized in the Park EMS Program

Chapter 6

CERTIFYING ORGANIZATIONS, TRAINING, AND LEVELS OF CARE

- 6.1 Introduction
 - 6.2 Certifying Organizations
 - 6.3 Training and Levels of Care
-

6.1. Introduction

The NPS will provide employees the opportunity to obtain the level of EMS training required of them to perform their duties. To help ensure a comprehensive approach in providing patient care, Cardio Pulmonary Resuscitation (CPR) and First Aid are recommended for all NPS employees. Some parks, depending on their level of public contact and public safety responsibilities, may need to provide additional EMS training to some employees. In rural and wilderness areas, or where the existence of local EMS is limited or delayed, advanced levels of emergency care may be necessary in order to ensure that the transportation and care of patients is contemporary with today's standards.

Section 317 of the Department of the Interior and Related Agencies Appropriations Act, 1993 (P.L. 102-381) authorizes funds that "...may (emphasis added) be used to reimburse employees for the cost of...certification fees pursuant to their employment."

The NPS recognizes that it is appropriate for parks to provide different levels of EMS care. The appropriate level of care, determined by careful analysis of a park's individual Needs Assessment, is dependent upon many factors as described in Chapter 4, *Needs Assessment*.

The NPS recognizes six levels of care ranging from CPR (recommended for all park employees) to Paramedic. These levels correspond to national standards of certification that have been established by the American Red Cross, American Safety Health Institute, National Safety Council, American Heart Association, U.S. Department of Transportation and the NPS. NPS recognition of training and certification has been standardized within each level.

It is beyond the scope of this program to establish licensing requirements for medical professionals such as physicians and registered nurses. Their participation in the NPS EMS Program will be based upon licensing requirements in their respective states, and authorization by the Park EMS Medical Advisor. Chapter 7, *Certification and Authorization*, provides information in greater detail, regarding guidelines for registered nurses.

This chapter outlines the specific course of training and certifying organizations that the NPS has approved for each level of care.

6.2 Certifying Organizations

The following are the NPS recognized training and/or certifying organizations for courses in first aid and EMS. For current, detailed information on the courses listed below. Additionally, see each organization's website.

6.2.1 American Heart Association

The American Heart Association is a national voluntary health agency whose mission is to reduce disability and death from cardiovascular diseases and stroke. www.americanheart.org

6.2.2 American Red Cross

The American Red Cross is a humanitarian organization led by volunteers, guided by its Congressional Charter and the Fundamental Principles of the International Red Cross Movement, and provides relief to victims of disasters and helps people prevent, prepare for, and respond to emergencies. www.redcross.org

6.2.3 American Safety and Health Institute

The American Safety and Health Institute is an association dedicated to designing and delivering instructional programs. Reaching worldwide, these programs foster a learning process that advances the well-being of organizations and individuals. www.ashinstitute.com

6.2.4 National Safety Council

The National Safety Council's mission is to educate and influence society to adopt safety, health and environmental policies, practices and procedures that prevent and mitigate human suffering and economic losses arising from preventable causes. www.nsc.org

6.2.5 National Registry of Emergency Medical Technicians

The National Registry of EMTs is the NPS approved certifying (not licensing) organization for Level III (First Responder) through Level VI (Paramedic). EMS providers may be state certified as well, but not in lieu of the National Registry of EMTs certification.

The purpose of the National Registry of EMTs is to certify and register EMS professionals throughout their careers by a valid and uniform process that assesses the knowledge and skills for competent practice. However, the National Registry

of EMTs is not a licensing agency and cannot authorize medical personnel to perform EMS in any jurisdiction.

The National Registry establishes and implements uniform requirements for First Responders and Emergency Medical Technicians, their training, examination, and continuing education.

The National Registry of EMTs examinations for First Responder and EMT-Basic may be given and proctored by the Park EMS Coordinator in the park. An NPS application form letter is to be completed and submitted by the Park EMS Coordinator and sent to the Branch Chief, Emergency Services for approval (see Exhibits 1 and 2). Examinations will be conducted in accordance with National Registry of EMTs requirements, including proctoring of the exam, storage and treatment of examination materials, and mailing and verification procedures.
www.nremt.org

Applications to administer NREMT EMT-Intermediate exams will be approved by the Branch Chief, Emergency Services for special circumstances only. The NREMT paramedic exam will not be administered by the NPS.

6.2.6 Wilderness Medical Institute
www.nols.edu/wmi

6.2.7 Wilderness Medical Associates
www.wildmed.com

6.2.8 SOLO Wilderness Medicine
www.soloschools.com

6.2.9 National Ski Patrol
www.nsp.org

6.3 Training and Levels of Care

6.3.1 Level I: CPR/AED Provider

Description

Level I courses teach employees how to recognize and treat life-threatening emergencies, including cardiac arrest and foreign-body airway obstruction for adult, child, and infant victims. Employees learn the proper application and use of an AED. Employees also learn to use infectious disease barrier devices in CPR.

Target Audience

All NPS employees

Approved Courses

A certificate of completion from any nationally recognized training agency or organization is acceptable. The CPR and AED components must be completed. Professional level CPR/AED may be substituted for the basic CPR/AED class. Examples of acceptable courses are as follows:

- American Heart Association or equivalent
- American Red Cross or equivalent

Refresher Process

A CPR/AED refresher is required every 2 years from a nationally recognized organization. There must be a hands-on practical element to the recertification course. There are many refresher courses available in the web. Employees may participate in refresher course work so long as the hands-on practical elements are completed with a certified CPR instructor from a national recognized training agency or organization.

6.3.2 Level II: Basic First Aid Provider

Description

Basic First Aid courses teach employees to respond to injuries and sudden illness in a systematic approach combining life-saving techniques with traditional first aid information and skills. These courses train employees to cope with life-threatening emergencies, as well as less-serious incidents, by teaching them how to use the EMS system in their parks and communities and what to do until more advanced help arrives.

First aid training is primarily received through the American Red Cross, the National Safety Council, and private institutions. The American Red Cross offers standard and advanced first aid courses via their local chapters. After completing the course and successfully passing the written and practical tests, trainees receive two certificates (adult CPR and first aid). An emphasis on quick response to first aid situations is incorporated throughout the program. Other program elements include: basic first aid intervention, basic adult CPR, and universal precautions for self-protection. Specific program elements include training specific to the type of injury: shock, bleeding, poisoning, burns, temperature extremes, muscular-skeletal injuries, bites and stings, medical emergencies, and confined spaces. Instruction in the principles and first aid intervention of injuries will cover the following sites: head and neck, eye, nose, mouth and teeth, chest,

abdomen, and hand, finger, and foot injuries. Employers are responsible for the type, amount, and maintenance of first aid supplies needed for their particular program. The training program should be periodically reviewed with current first aid techniques and knowledge. Basic adult CPR retesting should occur every year and first aid skills and knowledge should be reviewed every 3 years. The references below provide further fundamentals to help develop and maintain first aid program and skills.

Target Audience

The target audience is employees who would rarely provide emergency medical care, are not involved in routine visitor contact work, but may on occasion be confronted with having to provide initial BLS or first aid, and/or assist other trained EMS personnel.

Approved Courses

In addition to the following requirements, all requirements of Level I will be fulfilled. Any of the following courses may be used for Level II.

- American Red Cross
 - Basic First Aid
 - Community First Aid and Safety
- American Safety and Health Institute
 - Basic First Aid and CPR
- National Safety Council
 - The Standard First Aid, CPR and AED
- American Heart Association
 - Basic First Aid and CPR
- National Ski Patrol
 - Outdoor First Care

Recertification Process

The NPS has adopted the recommendations of each approved certifying organization listed above regarding re-certification and refresher training. Contact the specific agency for current details.

6.3.3 Level III: First Responder (Emergency Medical Responder)

Description

Level III, First Responder, is designed for persons who may be first on the scene of an emergency medical incident.

Scene assessment and security, and initial patient management are emphasized. First Responders normally are not involved with the transport of patients, long-term patient care, or the use of sophisticated medical equipment.

Certification at the First Responder level and above requires the successful completion of a Professional or Healthcare CPR/AED class (see Level I).

Based on recommendation of the Park EMS Medical Advisor, the expanded scope of practice that includes the use of epinephrine for acute allergic reactions and the use of oxygen delivery equipment may be adopted to meet a specific park's needs. Persons authorized to perform these procedures must have received documented training per the NPS National Standard Protocols and be authorized by the Park EMS Coordinator through the White Card process.

Target Audience

This level is appropriate for employees routinely involved with the public and whose primary duties are fire suppression, SAR, law enforcement and backcountry operations. Depending on availability of EMS providers, extent of visitor contact, and other factors such as isolation, it also may be appropriate for interpretive personnel, environmental educators, campground personnel, field researchers and field personnel on road, trail, and youth crews. This is the recommended minimum level for emergency service personnel.

Approved Courses

There are a number of agencies and companies that offer First Responder and Wilderness First Responder courses that comply with the NHTSA course curriculum. Any of these courses are acceptable so long as they comply with the NHTSA First Responder course curriculum.

Re-certification Process

In order to recertify, the National Registry of EMTs requires that a current professional level CPR course and a First Responder refresher course utilizing the NHTSA be successfully completed prior to the certification expiration date. The refresher class is a 12-hour (minimum) course designed to review the course curriculum. The National Registry of EMTs requires re-registration every 2 years.

6.3.4 Level IV: EMT Basic

Description

The EMT-Basic is recognized as the first component of the EMS system that involves specialized skills and equipment, and methods of patient transport. It is

comprised of classroom instruction, emergency room clinical time, and a field internship with an ambulance service.

The participant receives instruction in role and responsibilities, patient assessment, triage, anatomy and physiology, medical and traumatic emergencies involving the major body systems, childbirth, pediatric emergencies, and crisis intervention. Specialized skill training includes the use of instruments for recording vital signs, adjuncts for administering oxygen therapy, suction equipment, splints (including cervical, traction, and full body), and patient transport equipment.

Based on the recommendation of the Park EMS Medical Advisor, the expanded scope of practice that includes the use of epinephrine for acute allergic reactions may be adopted to meet a specific park's needs. Persons authorized to perform that procedure must have received documented training per the NPS National Standard Protocols and be authorized by the Park EMS Coordinator through the White Card process.

In order to maintain the integrity of the NPS EMS standards, parks that have recognized the need for expanded scopes of practice such as intravenous therapy, advanced airway techniques, and pharmacology, may accomplish those needs by upgrading their programs to Level V and will provide their EMS personnel with the opportunity to acquire Parkmedic training.

Target Audience

This course is appropriate for park personnel responsible for providing emergency medical care in an NPS area that has identified a need for NPS-provided EMT-Basic care. It is the minimum level of training required for EMS personnel in parks that provide an ambulance transport service.

Approved Courses

The approved Level IV curriculum for EMT-Basic is the NHTSA EMT Basic curriculum. Once a course based on this curriculum has been successfully completed, an National Registry of EMTs certification will be required within 1 year in order for the EMT-Basic to be authorized to perform in the NPS at this level. (See Chapter 7, *Certification and Authorization*.)

Recertification Process

The National Registry of EMTs requires recertification every 2 years. An National Registry of EMTs 24-hour refresher class is required in addition to 48 hours of continuing education per 2-year cycle. A valid professional-level CPR certification is also required.

6.3.5 Level V: Parkmedic and Parkmedic-Cardiac

Description

This level is designed to provide the EMS provider with an in-depth knowledge of anatomy, physiology, patho-physiology and clinical symptoms as they pertain to pre-hospital emergency care of pediatric and adult patients. Emphasis is placed on ALS in the medical, trauma, and cardiac settings. Parkmedics spend extensive time in the clinical and internship components of this course in order to develop the important skills necessary to perform at this level.

- Parkmedic – The Parkmedic certification course, designed specifically for the NPS, incorporates the EMT-Intermediate National Standard Curriculum (1985) with additional training in pharmacology and wilderness/environmental medicine.
- Parkmedic-Cardiac – Requires completion of the 1999 EMT-Intermediate National Standard Curriculum or an NPS approved “bridge course” that bridges requirements for Parkmedic certification to the requirements in the 1999 EMT-Intermediate National Standard Curriculum.

Target Audience

This level is for the employee who may be required to provide EMS in a park that has determined a need for an ALS program.

Approved Courses

The Parkmedic course is comprised of the NPS curriculum for Level V. This course is offered through the NPS at University Medical Center, Fresno, CA. Certification at this level requires successful completion of the course and passing the Parkmedic and National Registry of EMTs - Intermediate (1985) exams.

The Level V curriculum for Parkmedic-Cardiac is the Department of Transportation 1999 National Standard Curriculum for Intermediate EMT. Certification at this level requires successful completion of the course and passing the Parkmedic and the National Registry of EMTs - Intermediate (1999) exam.

A Level V bridge course may be developed to allow an EMS provider to “bridge” from Parkmedic to Parkmedic-Cardiac. Approval of the curriculum for this course will be made by the Branch Chief, Emergency Services and the National EMS Medical Advisor. Once the course has been approved and the candidates successfully complete the course, they may apply for the National Registry of EMTs - Intermediate (1999) exam and certification. The park may then authorize those EMS providers to perform at the Parkmedic-Cardiac level.

Recertification Process

The National Registry of EMTs requires recertification every 2 years. A 36-hour refresher class per the National Standard Curriculum for EMT-Intermediate (1985 for Parkmedic or 1999 for Parkmedic-Cardiac) inclusive of the Parkmedic refresher training components, and a valid professional rescuer CPR certification are required.

6.3.6 Level VI: Paramedic

Description

This course is designed to provide the student with in-depth knowledge of anatomy, physiology, pathophysiology and clinical symptoms as they pertain to pre-hospital emergency care. Emphasis is placed on ALS in the cardiac and trauma settings. Extensive time is spent in the clinical and internship components of this course in order to allow the student full opportunity to develop important skills necessary to perform at this level.

Target Audience

This program is designed for the employee who may be required to provide EMS in a park that has determined a need for a fully comprehensive ALS program.

Approved Courses

The Level VI training course for EMT-Paramedic is the Emergency Medical Technician-Paramedic: National Standard Curriculum. At present, this comprehensive course is taught only at the state level in colleges, medical universities, and some hospitals with paramedic instructor-staffs.

Park areas that have determined a need for this level of care traditionally have relied on the recruitment of paramedics for targeted positions.

Successful completion of a paramedic course based on the National Standard Curriculum and certification by the National Registry of EMTs is required to become authorized as an NPS EMT-P.

Recertification Process

The National Registry of EMTs requires recertification every 2 years. A 48-hour refresher class is required in addition to 24 hours of continuing education unit hours. Valid professional rescuer CPR and Advanced Cardiac Life Support certification are also required.

Exhibit 1



Date

National Registry of Emergency Medical Technicians
P.O. Box 29233
Columbus, OH 43229

To: National Registry of EMTs Exam Coordinator

I would like to schedule a First Responder examination. All candidates meet the registration entry requirements set forth by the National Registry of EMTs. Please ship **XX** First Responder written examinations and applications to me at the address listed below.

Name EMS Coordinator/Park Area
Park Name
Physical Address (No P.O. Boxes)

Test Date: **00/00/00**
Test Location: **Park Location**
Site Code: National Park Service
Test Coordinator: **Name and Phone Number**
Test Proctor: **Name, EMS Coordinator**
Medical Director: **Name and Phone Number**

I accept full responsibility for the examination materials which will be maintained in total security and returned promptly at the completion of the examination.

Thank you for your assistance.

Name Date
Park EMS Coordinator

Approved By:

NPS Chief, Emergency Services Date

Exhibit 2



Date

National Registry of Emergency Medical Technicians
P.O. Box 29233
Columbus, OH 43229

To: National Registry of EMTs Exam Coordinator

I would like to schedule an EMT-Basic examination. All candidates meet the registration entry requirements set forth by the National Registry of EMTs. Please ship **XX** EMT-Basic written examinations and applications to me at the address listed below.

Name, EMS Coordinator
Park Name
Physical Address (No P.O. Boxes)

Test Date: **00/00/00**
Test Location: **Park Location**
Site Code: National Park Service
Test Coordinator: **Name and Phone Number**
Test Proctor: **Name and Phone Number**
Medical Director: **Name and Phone number.**

I accept full responsibility for the examination materials that will be maintained in total security and returned promptly at the completion of the examination.

Thank you for your assistance.

Name
Park EMS Coordinator

Date

Approved By:

NPS Chief, Emergency Services

Date

Chapter 7

CERTIFICATION AND AUTHORIZATION

- 7.1 Introduction
 - 7.2 Overview
 - 7.3 Guidelines
-

7.1 Normal

A large percentage of NPS EMS providers are trained by or transfer from agencies outside the Service. In addition, there is a high degree of mobility within the NPS that results in EMS providers regularly transferring between parks. The purpose of this chapter is to provide policy and guidelines for certification and authorization procedures within the NPS.

7.2 Overview

The NPS hires a substantial number of seasonal and permanent employees that regularly travel and transfer between parks. The NPS must have a structured system in place to evaluate and authorize employees to perform emergency care on park lands. The NPS may defray all costs associated with required EMS training and certification, pursuant to authority contained in 5 USC 4109.

7.3 Guidelines

7.3.1 Certification

It is important that EMS providers understand the distinction between *certification* and *authorization*. Possession of an EMS certification is not an authorization or license to perform EMS in a National Park.

It is the policy of the NPS that all providers at Levels III-VI will be *certified* by the National Registry of EMTs. A Park EMS Coordinator may *authorize* a person who possesses a state certification to be an EMS provider when it is based on the National Standard Curriculum and that person meets the requirements for National Registry of EMTs testing. The EMS provider must then become National Registry of EMTs certified within one year of entry into the NPS EMS system or the authorization will be suspended.

7.3.2 Authorization (Licensure)

Licensure is the approval by park management for certified EMS providers to perform EMS within a designated scope of practice. Under a defined scope, only those who are licensed may perform those tasks.

The first step in authorizing or licensing personnel to provide EMS in the park begins with the Park EMS Coordinator evaluating and verifying the prospective provider's certifications. Once certifications are verified, the EMS Coordinator may issue a White Card for specific levels of care based on the needs of the park program, the position description of the provider, and when appropriate, the recommendation of the Park EMS Medical Advisor. The White Card is covered in further detail later in this chapter.

7.3.3 Criteria

The following are certification/authorization criteria for Levels III-VI and Registered Nurses:

- First Responder First Responder

An EMS provider with a current First Responder certification obtained through a training course based on the NHTSA Standards and has passed a National Registry of EMTs exam, qualifies for authorization, and issuance of an NPS White Card.

- EMT-Basic

An EMS provider with a current EMT-Basic certification obtained through an EMS agency in which the course was based on the NHTSA standards and has passed the National Registry of EMTs examination qualifies for authorization and issuance of an NPS White Card.

- Parkmedic and Parkmedic-Cardiac

An EMS provider certified as a Parkmedic after completion of the NPS approved Parkmedic Course qualifies for authorization. A Park EMS Medical Advisor may recommend that qualifying candidates receive additional training, clinical hours, or testing as necessary.

EMS providers trained through other programs, such as a state EMT-Intermediate course may qualify for certification and authorization as a Parkmedic. In these cases, the EMS provider must have completed a course that meets or exceeds the Parkmedic curriculum and successfully completes the Parkmedic written and practical exam. The Park EMS Medical Advisor may

recommend that the EMS provider fulfill didactic, clinical or internship requirements prior to providing ALS care, in order to ensure that his/her knowledge and skills are consistent with the NPS national training standards for Parkmedic.

An EMS provider who has completed a state approved EMT-I (1999 NHTSA - I-99) course or, as a Parkmedic, has completed an approved Parkmedic bridge course to meet the requirements of the EMT-I (I-99), and qualifies for National Registry of EMTs I-99 testing, may be certified and authorized as a Parkmedic-Cardiac.

- EMT-Paramedic EMT-Paramedic

An EMS provider with a current EMT-Paramedic certification obtained through an EMS agency of any state qualifies for authorization as an NPS EMT Paramedic if the certification course was based on the NHSTA standards and the provider meets the requirements for National Registry of EMTs testing.

- Registered Nurses

Pre-hospital nursing is recognized as a special area of practice within emergency nursing by the Emergency Nurses Association. Professional registered nurses are obligated to acquire whatever knowledge and skills are required beyond their basic education to render safe and efficient care according to those standards. The association has taken the position that no certification beyond professional licensure should be mandated for nursing practice in the pre-hospital setting. Nurses in this area of practice are held accountable to professional nursing standards and not to standards for other health care providers. It is incumbent upon professional nurses to recognize deficiencies in their education and to obtain the necessary knowledge and skills required for nursing practice in the pre-hospital setting or to refrain from such practice.

It is recognized that the regulation of pre-hospital nursing practice should be a collaborative effort between the State Board of Nursing through the State Nurse Practice Act and the state EMS agency through pre-hospital legislation/regulations. The Emergency Nurses Association recognizes the State Boards of Nursing as the regulatory agency for the profession of nursing. Pre-hospital nursing is identified as a special area of practice within emergency nursing, thus, the association recommends that the State Board of Nursing be the regulatory agency and definitive authority in pre-hospital nursing. However, some states have enacted legislation that invests all authority for the regulation of EMS activities, including pre-hospital nursing, with the State EMS agency. As pre-hospital nursing is specifically practiced in the pre-

hospital environment, regulation of practice is state specific versus one Federal guideline.

Pre-hospital nurses working in the parks must be aware of the position of the State Board of Nursing within the state where they are working and must be licensed to practice in that state. The Medical Advisor in each park must be in agreement with these recommendations and be willing to provide medical direction to registered nurses who have the appropriate additional education to function in this role.

The EMS Coordinator may authorize registered nurses to perform pre-hospital care as NPS EMS providers, based on the recommendation of the Medical Advisor.

7.3.4 Details to Other Parks

Occasionally, park EMS providers are assigned temporarily to other parks. During emergencies, when training and protocol consistency cannot be evaluated, park EMS providers must possess a White Card and can only perform up to a BLS level of care.

During extended details with advance notice, ALS providers can be authorized by the receiving Park EMS Coordinator (with the recommendation of the Park EMS Medical Advisor) to perform ALS procedures up to their level of training and utilizing the NPS National Standard Protocols. This process will require the coordination between Park EMS Medical Advisors and EMS Coordinators. The ALS provider should receive adequate orientation and be equipped to access the receiving park's online medical control. The agreed upon scope of practice for the provider should be documented in writing with copies to the Park EMS Medical Advisor, the EMS Coordinator, and the EMS provider. The ability for NPS EMS providers to move from park to park and provide a specific level of care is anticipated to become more seamless as the Service begins to implement the NPS National Standard Protocols.

7.3.5 Out-of-Park Details

Periodically, NPS providers respond to areas outside their jurisdiction. In these circumstances, EMS providers may function only up to a BLS level unless operating within the scope of an agreement with the agency of jurisdiction.

7.3.6 Incident Management

All EMS incidents will be managed under the Incident Command System without regard to complexity or size. A single EMS provider on scene is the Incident

Commander until other EMS providers arrive on scene and a mutual agreement as to a delegation of incident management tasks is established.

7.3.7 White Card

The White Card is the EMS provider's evidence of NPS authorization to perform EMS at a specified level of care based on a certification, and while acting within their scope employment. White cards are issued for certification Levels III and above.

The White Card is issued at the park level once the Park EMS Coordinator has verified the applicant's qualifications and suitability as an EMS provider and the park's need for that provider in its EMS system. The White Card is returned to the Park EMS Coordinator when the employee is no longer employed at that park or for other reasons listed below.

Park, regional and national EMS Coordinators are the only persons authorized to issue the White Card and only after careful review of the provider's application packet. It is important that the EMS Coordinator verifies for each applicant the following:


- The applicant possesses valid certifications for all levels of care that will appear on the White Card.
- The applicant is in a position description that allows them to perform EMS duties.
- The applicant has provided documentation of required immunizations.
- For Level V and VI providers, the Park EMS Coordinators will consult with the Park EMS Medical Advisor as part of the application review to ensure didactic, clinical, and testing requirements are met.

Instructions for Completing the White Card

The designee is authorized to provide emergency medical care for the National Park Service at the levels listed as prescribed by the DO-51, RM-51 and other applicable laws and policies.		
_____ Signature of EMS Provider		
_____ Signature of Park EMS Coordinator		
_____ Issue Date	_____ Expiration Date	_____ National Registry Number

(Back side of the White Card)

(Front side of White Card)

United States Department of the Interior National Park Service Emergency Medical Services	
Name	
National Park Unit	
Certification (s)	

- Type all entries. Attach photo to the right portion of the front side of the card. Laminate after completion.
- Blocks for name, signature, park unit, and issue date are self-explanatory.
- Certification(s): All Certifications listed on the White Card should correspond to those in Chapter 6, *Certifying Organizations, Training, and Levels of Care*. Only those levels of care that an EMS provider is being authorized to perform should be listed (e.g., a Parkmedic-Cardiac who will not be authorized to perform ACLS should not have ACLS listed on the White Card).
- Expiration Date: The expiration date on the White Card should correspond to the expiration date of the employee's EMS certification card. For example, an employee with an EMT-B certification would have their National Registry of EMTs certification expiration date as the expiration date of the White Card. Once the EMT renews their EMT certification, the White Card would be re-issued with a new expiration date. Seasonal employees should be issued White Cards with an expiration date that corresponds with the end of their season or their EMS certification expiration date, whichever comes first.

Suspension or Revocation

The Park Superintendent will suspend the EMS provider's White Card based on the recommendation of the Park EMS Coordinator and the Park EMS Medical Advisor. Suspensions are administrative provisions for failure to comply with the certification/re-certification criteria of this document or deviations in standards of care that may be harmful to the patient.

The Park Superintendent will revoke the provider's White Card based on the recommendation of a Board of Review (Chapter 20, *National Park Service Field*

Manual). Revocation will result from negligence, misconduct, incompetence, and other non-administrative failures of compliance with this reference manual.

The Park EMS Coordinator will notify the NPS National EMS Office (Branch Chief, Emergency Services), with a copy to the Regional EMS Coordinator, of all revocations and any suspensions of greater than 60 days. The Branch Chief, Emergency Services will notify the National Registry of EMTs of the EMS provider's status. The status of the provider's National Registry of EMTs certification will then be determined by that organization.

The Chief Ranger or Park EMS Coordinator can obtain White Cards from the Branch Chief, Emergency Services.

Chapter 8

MEDICAL OVERSIGHT

- 8.1 Introduction
 - 8.2 Overview
 - 8.3 Guidelines
-

8.1. Introduction

The purpose of this chapter is to establish guidelines for medical oversight of EMS Programs operating at Levels IV-VI.

8.2 Overview

NPS areas that provide patient care at Levels IV-VI are required to have an EMS Medical Advisor for their EMS Program, and areas with Level III programs are encouraged to do the same. All NPS areas that provide AED services are required to have a Medical Advisor to provide oversight for that specific program.

It is Servicewide policy that the NPS National Standard Protocols known as the NPS Field Manual will be implemented for Levels IV, V and VI Park EMS levels of care. This will ensure consistency throughout the Service and reduce liability concerns for local Park EMS Medical Advisors since protocol approval has shifted to the national level. All local protocols for Levels IV-VI will be reviewed by the National EMS Medical Advisors for quality assurance. At a minimum, the NPS National EMS Medical Advisor and the Branch Chief, Emergency Services will review the NPS EMS Field Manual annually and revise them as necessary. Recommendations from the field will be solicited and considered during this process. The U.S Park Police Aviation Section will establish a separate set of medical protocols at the Paramedic level.

8.3 Guidelines

8.3.1 Selection of a Park EMS Medical Advisor

As established by this policy, the Park EMS Medical Advisor is responsible for advising the Park EMS Coordinator and park EMS providers regarding all aspects of patient care including protocols, standing orders, online medical direction, and quality assurance and improvement.

To assure that treatment in an EMS Program is based on sound medical concepts, there must be strong medical oversight. The key to medical oversight is the Park EMS Medical Advisor, who has the responsibility for developing the medical

guidelines of the local program. When selecting a Medical Advisor, the American College of Emergency Physicians recommends the following criteria:

- Experience in pre-hospital and emergency department care of the acutely ill or injured patient
- Routine participation in base station radio direction of EMS providers
- Routine active participation in emergency department management of the acutely ill or injured patient
- Active involvement in the training of emergency care personnel
- Active involvement in the medical audit, review and critique of emergency medical care provided by EMS personnel
- Familiarity with the legislative processes affecting the pre-hospital EMS system

8.3.2 Components of Medical Oversight

- EMS Medical Advisor

As described in Chapter 3, *Management and Supervision*, the Medical Advisor is a physician that provides program oversight and is preferably a member of a hospital emergency department staff. He/she is responsible for recommending and reviewing policies, national protocol implementation, the development of local protocols as necessary, providing for and organizing continuing education, endorsing candidates for national certification, conducting incident reviews, and arranging for online medical control.

Pre-hospital care provided by NPS EMS personnel is considered to be an extension of the hospital-based physician. Therefore, the Park EMS Medical Advisor must have a high degree of confidence in the competency of the EMS providers. He/she must approve EMS providers to administer ALS procedures under their license and be supportive of the national training standards, scope of practice, NPS National Standard Protocols, and quality improvement for the Servicewide EMS Program.

The Park EMS Medical Advisor must work closely with the Park EMS Coordinator to ensure park EMS providers adhere to appropriate standards of care.

- Resident Liaison Physician

In some programs the Park EMS Medical Advisor has designated a resident physician at the base hospital to act as liaison with the park area. However, ultimate responsibility for medical oversight of the Park EMS Program remains with the Park EMS Medical Advisor.

- Base Station Physicians

Base Station Physicians are resident or staff physicians at the base hospital who provide immediate online control to EMS providers and may assist the Park EMS Medical Advisor in his/her duties. Mobile Intensive Care Nurses may also function as online medical control if appropriately trained, supervised, and approved by the Park EMS Medical Advisor.

8.3.3 Responsibilities

Medical control of an EMS Program requires appropriate physician involvement in all levels of EMS planning, administration and evaluation. Additionally, ALS programs require some skills that are practiced only through orders from a physician or previously approved standing orders. Multiple participants are involved in medical oversight both on and offline. Online medical control involves direct communication between a physician and EMS provider during an incident. Offline medical control involves planning and development and quality improvement.

8.3.4 Policies and Procedures

Nearly all policies pertinent to the EMS Program have some medical content; therefore the Medical Advisor should be directly involved in policy development. The Park Superintendent has the authority to approve all EMS policies and procedures at the park level.

8.3.5 Certification/Recertification Endorsement

In accordance with this document, the National Registry of EMTs, and local program direction, the Park EMS Coordinator, with the concurrence of the Park EMS Medical Advisor, will ensure that Park EMS providers meet all requirements prior to endorsement for National Registry of EMTs certification.

8.3.6 Protocols

Protocols provide a standard approach to commonly encountered medical emergencies. Protocols should be reviewed periodically, and at a minimum of once per year, to ensure that they are contemporary with today's emergency medical standards.

The NPS will implement the Servicewide NPS EMS Field Manual for EMS Levels IV-VI. Deviations from the Field Manual protocols, procedures and drugs need to be submitted to the Branch Chief, Emergency Services, who will consult with the National EMS Medical Advisors. This team will be known as the NPS

EMS Field Manual Review Board. If the deviation is approved by the Review Board, the new protocols, procedures, or drugs will be added to the NPS EMS Field Manual or approved for use at the local level.

If a deviation is not approved by the Branch Chief, Emergency Services and National EMS Medical Advisors, an appeal can be made to a special NPS EMS Field Manual Appeals Committee made up of two Park Medical Advisors, two Park EMS Coordinators and the Branch Chief, Emergency Services. No member of the appeals committee may be from the appealing park.

The U.S. Park Police Aviation unit will create and maintain separate Paramedic Protocols.

8.3.7 Standing Orders

The approved use of medications and advanced life-saving emergency medical procedures that EMS personnel may provide without direct communication with a physician, are known as standing orders. They authorize treatment before radio contact is made with online direction, usually when delay in patient care would be harmful or when online direction is unnecessary.

They also provide authorization for treatment when direct contact with online medical control is not possible (i.e., inoperative radio). Standing orders are established to provide clear instructions for patient care. In addition, standing orders:

- provide a written outline of systematic patient assessment and management in the field, and
- coordinate and standardize pre-hospital care for the program.

Standing orders may be established by the Park EMS Medical Advisor to permit the EMS provider to initiate treatment based on independent judgment. They will be based on the NPS EMS Field Manual, provider's level of training, and identified patient need. Standing orders based on protocols will be approved per guidelines established in section 3.6 of this chapter.

Standing orders provide legal authority to carry out procedures on behalf of the physician who signed them. When standing orders are used, there must be a review in a timely manner as to the actions taken by the EMS provider. Without this review, medical control would not exist and the provider becomes an independent practitioner. Standing orders are not transferable to other park EMS programs.

Without approved standing orders or online medical control, the Level IV-VI

EMT is authorized only to perform those skills within the parameters of the basic EMT, regardless of his/her training, experience, or certification.

The U.S. Park Police Aviation unit will create and maintain separate Paramedic Standing Orders.

8.3.8 National EMS - Advisory Group

The Branch Chief, Emergency Services will convene the National EMS Advisory Group to advise and work on issues important to the Servicewide EMS Program. The purpose of the committee will be solely to exchange views, information, or advice relating to the management or implementation of the NPS EMS Program and make recommendations to change or review policies set forth in the DO-51 and RM-51.

Membership will come from the Park EMS Coordinators, advisors and program managers. The group will consist of two Park Medical Advisors, two NPS EMT Basics, a Parkmedic, a paramedic, the Branch Chief, Emergency Services, Park Chief Ranger and a Regional Chief Ranger or Regional EMS Coordinator for a total of nine persons. One of the nine members must come from the Alaska Region.

The National EMS Advisory Group members will be appointed by the Branch Chief, Emergency Services for the initial appointments. Thereafter, appointments will be made by the National EMS Advisory Group through majority vote. A chairman and a secretary will be appointed by the group, neither of which can be held by Branch Chief, Emergency Services. Appointments will consist of a 2-year commitment.

The National EMS Advisory Group will meet annually or in conjunction with the NPS EMS Conference or as often as needed to resolve the issues at hand. The National EMS Advisory Group will be administered in a manner that does not entail chartering under the Federal Advisory Committee Act.

8.3.9 Continuing Education

As part of continuing quality improvement, ongoing continuing education programs should include individual and group feedback, as well as information and data obtained from PCRs and other sources.

Through coordination with the Park EMS Coordinator, the Park EMS Medical Advisor is encouraged to provide continuing education sessions that are focused on topics driven by Continuing Quality Improvement data.

Credit for continuing education courses for Levels IV-VI is subject to review by the Park EMS Medical Advisor.

8.3.10 Advanced Life Support Program Approval

Approval to implement an ALS program is the responsibility of the Park Superintendent and the Park EMS Medical Advisor. (See Chapter 4, *Needs Assessment*, for guidance on assessing EMS needs in the parks, and Chapter 6, *Certifying Organizations, Training, and Levels of Care*, for the components required in an ALS program.)

8.3.11 Physician On-Scene

On the scene of an emergency medical incident, EMS personnel may not provide ALS under the direction of a physician on the scene unless that physician has had the authority for control of that scene transferred to him by the base hospital physician. In most cases, if any ALS orders are carried out upon the order of the physician on the scene, that physician will be required to accompany the patient to the hospital and sign the PCR as having authorized the treatment provided. If the physician on the scene prefers to help, but not be primarily in charge, his/her assistance may be utilized through medical control.

There are rare situations where medical control cannot be established (radio out, isolation, etc.) and the assistance of a qualified physician has been offered. Assistance can be accepted, but the NPS provider will have to take measures to authenticate that the person on scene is in fact a physician. A state medical license number or other information regarding a medical practice or hospital affiliation should be obtained prior to accepting medical services. If ALS services are performed under that person's direction, the same procedures will apply as described above in paragraph one.

8.3.12 Quality Assurance/Continuing Quality Improvement

It is of utmost importance to provide quality assurance and quality improvement (QA/QI) in both the training and provider aspects of an EMS Program.

The EMS provider's ability to render appropriate emergency pre-hospital care at the ALS level is a direct reflection on the NPS, the Park EMS Medical Advisor and his/her staff. Ongoing quality improvement can be maintained in several ways:

- All PCRs will be reviewed by the EMS provider's supervisor, EMS Coordinator, and as appropriate, the Park EMS Medical Advisor.
- Regular review will help generate an increased awareness of the EMS provider's responsibilities, while potentially decreasing Service liability during medical responses.

- Incident reviews should be conducted on a regularly scheduled basis in order to have any value to the improvement of the system. The PCR is the primary document to be used for case reviews.
- Any member of the EMS Program may initiate reports indicating a need to review any component of the EMS Program for improvement. Concerns may also arise from outside the NPS. The Park EMS Coordinator and Park EMS Medical Advisor will review those issues and provide recommendations to the Superintendent.
- Continuing education must be provided for and completed by EMS providers within a specified timeframe in order to maintain current certifications.
- The administration of National Registry of EMTs examinations is performed by the Park EMS Coordinator with endorsement of the Park EMS Medical Advisor and approval from the Branch Chief, Emergency Services.
- Periodic inspection and maintenance of all EMS equipment is to be performed as necessary to ensure proper function. Regular inventories of all emergency medical supplies, including medications, are necessary to ensure that they are current and in adequate supply.
- Scheduled radio communication checks should be performed where applicable to ensure contact with medical control.
- The Park EMS Medical Advisor is responsible for reviewing any cases in which disciplinary action is being considered (Chapter 7, *Certification and Authorization*). When necessary, an EMS provider's White Card may be suspended or revoked.
- All EMS providers must maintain the knowledge and skill proficiency required for their level of certification. This is accomplished by providing patient care in either the field or hospital setting and obtaining ongoing continuing education. Level V and VI EMS providers must maintain ALS skill proficiency as required by the Park EMS Medical Advisors. It is the responsibility of the EMS provider to ensure documentation of their EMS experience and education.

8.3.13 Statistical Review

A file of all PCRs (NPS Form 10-342) will be maintained by the Park EMS Coordinator containing, at a minimum, the nature of the complaint, persons involved, treatment rendered, and disposition of each incident. In keeping with the Privacy Act, non-patient specific EMS data will be provided in the form of an annual report for use by park management, as well as to the regional and national office for statistical purposes (Chapter 9, *Documentation*).

8.3.14 Deficient Performance

Refer to Chapter 18, *Performance and Conduct Issues*

8.3.15 Emergency Medical Communications

All parks providing Level IV-VI EMS Programs will establish a communication link with their Park EMS Medical Advisor or a designated emergency physician and/or hospital emergency department.

Online medical direction allows EMS providers to communicate directly (by telephone or radio) with a physician or Mobile Intensive Care Nurse who assumes responsibility and gives direction for patient management. This allows for retrospective review for both continuing education and continuing quality improvement. Once contact has been made, the pre-hospital provider becomes the agent of the online physician regardless of any other employee-employer relationship. The Park EMS Medical Advisor should approve all base stations established for online medical control.

ALS may be administered only while in voice contact with a base station physician unless the Park EMS Medical Advisor has included standing orders within the program protocols. For parks providing care at Levels IV-VI, it is essential that EMS providers have access to direct 24-hour-a-day communications with a medical facility and/or physician to help ensure that adequate patient care is being delivered.

Parks should evaluate their technical capability to effectively communicate with their Park EMS Medical Advisor. Regulations may allow a park's frequency to be placed in the base hospital radio. Phone patch technology has been successfully utilized for voice and biotelemetry (for ECG transmission) applications in some parks. Parks are encouraged to explore opportunities to enter into agreements with local EMS organizations to utilize existing EMS frequencies.

Areas that have a Level V (Parkmedic-Cardiac) and Level VI (Paramedic) programs should have biotelemetry capability in order to transmit ECG information directly to the base hospital. This is normally accomplished through one of 10 specifically designated EMS frequencies reserved by the FCC for that purpose.

Communications for the online medical direction should be located, where possible, in an emergency department and be staffed 24 hours by physicians experienced in emergency medicine. The online physician should be familiar with the EMS provider's training and capabilities, and have access to the program's emergency medical protocols. This will minimize the chance of deviation from established guidelines, as well as reduce expectations for the EMS

provider to perform procedures that he/she is not capable or authorized to perform.

In some NPS areas, more than one base station may be necessary due to considerations such as a park's geography. The Park EMS Medical Advisor should also review those incidents for continuing quality assurance.

Chapter 9

DOCUMENTATION

- 9.1 Introduction
 - 9.2 Guidelines
-

9.1 Introduction

An important component of an EMS Program is a well-maintained system of complete and accurate medical records. It is the practice of the NPS to maintain written records in the form of a PCR (Exhibit 3) whenever an on-duty employee treats or evaluates a patient. The PCR contains information that the physician will use in evaluating and treating the patient. A Servicewide PCR (Form 10-342) is available for this purpose. It has been developed to document BLS and ALS incidents. In addition to being the Bureau's official record of medical care provided, it is used in case reviews as a component of the quality improvement and assurance aspect of the EMS Program. The non-Privacy Act information is also used for regional and national data collection, in conformance with the Department of Transportation's *EMS Data Points and their Definitions*. This document contains 80 EMS data points and their definitions as agreed upon by at the August 1993 Uniform Pre-Hospital EMS Data Conference sponsored by the National Traffic Safety Administration. It is available at www.nhtsa.dot.gov/people/injury/ems/products.htm

9.2 Guidelines

9.2.1 Patient Care Record

Field-level reports have been the basis for legal action alleging negligence due to the omission or poor documentation of patient information.

Quality assurance provided by reviewing supervisors or EMS Coordinators is essential in reducing the potential for litigation as well as ensuring professional EMS in the field.

The PCR and its contents should be treated with patient confidentiality in mind. Information made available under the Freedom of Information Act should contain only a summary of the type of EMS incident. Further information regarding patient confidentiality is presented in Chapter 16, *Legal Aspects of Emergency Medical Services*.

Considerations for completing the PCR:

- The primary purpose of the report is to obtain and document a pertinent past and current patient history, physical exam, and to record the treatment provided.
- If a procedure is not written down, it will be perceived as not having been performed.
- Use only simple medical abbreviations that are easy to understand.
- If an item on the PCR is not applicable, write N/A or draw a line through the box.
- One PCR will be completed per patient. If extra narrative space is needed, use the supplementary patient care report.

Considerations for supervisors and EMS Coordinators who review the PCR:

- All blanks filled in
- Narratives initialed
- Errors: draw a single line through an error; date and initial.
- Correct spelling and terminology
- Times recorded accurately
- Documentation is performed chronologically
- Mechanism and time of injury/chief complaint stated
- Primary survey performed and recorded
- Medical signs and symptoms derived from secondary survey recorded
- Vital signs taken on all patients and repeated when appropriate
- Assessment appropriate to method of injury and/or chief complaint
- All treatment recorded, including change in patient status and response resulting from the treatment
- Use supplemental reports if information needs to be added or changed
- Appropriate care given with respect to the assessment
- Appropriate protocols utilized

9.2.2 Patient Refusal

There are times when a patient will refuse treatment and/or transportation. To refuse treatment and/or transportation the patient must meet the following conditions:

- Adult (18 years old or greater, or emancipated minor)
- Mentally Competent
- Alert and oriented

- Is not impaired due to alcohol or drugs
- Has no obvious medical or traumatic condition that would impair the patient's ability to make an informed decision
- Informed of physical condition and presumptive condition requiring transport.
- Informed of risk of not going to the hospital or medical facility

When a patient meets the above criteria, and the EMS provider and/or online medical control recommends that they be evaluated by a physician, complete the Patient Refusal Form found on the backside of the NPS PCR. The patient should read the refusal form statement. Explain the statement to them, and make sure that they understand it by answering in the affirmative. Ask them to sign the release form. Ask an impartial witness sign if possible (i.e., a non-government employee).

Complete the PCR and document how the patient met the refusal criteria. Document what information and/or instructions were relayed to the patient regarding their condition and the need for transportation and treatment.

Online medical control may be able to convince the patient to be treated and/or transported. The EMS provider should attempt to contact medical control before releasing the patient.

When a patient is not an adult, the patient's parent or legal guardian will make the decision to refuse treatment and transportation. The parent/guardian needs to read, state that he understands, and then sign the form. If a parent/guardian is not available, contact medical control for orders, guidance, and assistance.

When there is a language barrier making it difficult for the patient to make an informed decision to refuse care, contact medical control for orders, guidance, and assistance. Attempt to locate and utilize a translator that can assist you.

When a patient refuses EMS, to the best of your ability, document the patient's physical condition by observation. When a patient refuses to sign the Refusal Form, document that the patient refuses to sign and obtain witness signatures.

When the crew believes that the patient is not mentally competent to refuse care, contact medical control for guidance. If medical control orders the transportation of the patient, request Protection Rangers to assist with the transportation of the patient. Protection Rangers may place the patient into protective custody and transport them to the hospital. Refer also to Chapter 16, *Legal Aspects of Emergency Medical Services*.

If the patient refuses a specific treatment, document refusal and continue with other treatments as appropriate.

9.2.3 Training and Re-certification

Either through the EMS Coordinator or other designated means, the park is responsible for ensuring that EMS training provided by the park is documented for quality assurance. Those documents are the administrative record for EMS provider re-certification, program audits, statistical information, and other related purposes.

9.2.4 Annual Reports

At the end of each calendar year, the parks are responsible for reporting annual data to the regional offices. The data in those reports will be compiled and forwarded to the Branch Chief, Emergency Services by February 1 of the following year.

9.2.5 Records Retention

Managers are required by policy to maintain records in all cases where emergency care is provided by EMS personnel. This information may serve to protect the rights of the patient as well as the rights of the EMS provider if any legal questions arise. The Park will maintain a file of all EMS cases, and compile an annual statistical report (Exhibit 4). PCRs should remain on file as follows:

- Major visitor accidents resulting in death or tort claim *Permanent
- Minor visitor accidents *2 years
- Accidents resulting in government property damage *6 years after case is closed
- Employee accidents (file alphabetically by name) *6 years after case is closed

* NPS Records Disposition Schedule, approved 1986.

The written record provides information to the physician and others about what has occurred and the patient status while under the care of the NPS EMS provider. This information may serve to protect the rights of all parties involved, if any legal questions arise.

Exhibit 3

Prehospital Care Record
NPS Form-10-342
Instructions

- **Case Number (C.I #) :** _____

Enter Park case incident number and four letter code

- **Date**

Enter incident date that EMS was notified- MM/DD/YY.

- **Location**

Enter incident location based upon common names. Include incident site coordinates in either Lat/Long or UTM

- **Medical or Trauma**

Incident Type- mark Medical or Trauma based upon complaint and mechanism of injury

- **FA/BLS/ALS/ACLS**

Indicate if First Responder, BLS, ALS or Advanced Cardiac Life Support care is initiated.

- **Patient's Age**

Enter patient's age in years or months.

- **DOB**

DOB- Date of Birth: MM/DD/YY.

- **Sex**

Check box to indicate patient's sex M (male) or F (female)

- **Weight**

Enter patient's weight in pounds.

- **SSN**

Enter Social Security Number of patient if U.S. Resident. SSN is required for EMS transport billing.

- **Patient Name, Address and Phone Number**

Enter identifier information for patient including legal name and current mailing address.

- **Chief Problems/Complaints**

Use patients own words in direct "quotes" to record what they describe as the main problem(s). When the patient is unable to provide the information, describe what the EMS provider observes. Include time of onset for injury or illness.

- **Mechanism of Injury/History of Present Illness**

Cause of the injury/illness if known.

- **Allergies**

Record patient allergies to medications or other substances

- **Medications**

Record all medications (prescribed or otherwise) that the patient has taken or is prescribed to take. Include time(s) last taken and dosage.

- **Pertinent Medical History**

Record any significant past medical history (e.g., ailment involving heart, lungs, kidneys, diabetes, etc.)

- **Last Meal/Drink/Urination/Menstruation**

Note intake of food, water and outputs of urine or vaginal bleeding

- **Events of Incident/Prior Care/Anticipated Problems**

Document situation and any major medical care, patient movement or medications taken prior to arrival of EMS.

- **Narrative**

Provide a detailed and articulate description of what the patient and witnesses tell you, assessment made and care provided. Accepted formats for charting a detailed narrative include SSOAP (Scene, Subjective, Objective, Assessment and Plan). Be sure to record the time and description of all treatments applied to the patient and their responses to the therapy if not documented elsewhere on this record. This includes all medication administrations, reduction maneuvers, etc. Record scene description as appropriate. Check the box if narrative is continued on the reverse side.

- **Treatment/Response**

- **Time**

Indicate time of measurement.

- **Position**

Note position of patient (supine, sitting, standing). Stick figures may be easily used to indicate patient position.

- **Pulse**

Record the rate per minute and whether it is regular or irregular.

- **Blood Pressure**

Record the patients blood pressure as systolic over diastolic when auscultated, or systolic over P when palpated.

- **Resp**

Record how many times the patient breathes per minute.

- **Lung Sounds**

Record sounds from left and right lungs (bilaterally)

- **Temp**

Patient's core temperature. Designate Fahrenheit or Celsius, and method used to record (oral, rectal, axillary).

- **Skin**

Record patient's skin color, temperature and moisture.

- **SP₀₂**

Record oxygen saturation percentage if a pulse oximeter is used.

- **Glucose**

Record blood glucose reading from a glucometer.

- **EKG/Defib**

Document patient's EKG rhythm (NSR- normal sinus rhythm), AED shocks and defibrillation.

- **GCS**

Record Glasgow Coma Scale score

- **Time/Drug/Dose/Route/Treatments**

Record interventions such as drugs administered, including the route it was delivered (e.g., IV, ETT, SQ, etc) and dosage. Document all other treatments and responses such as spinal immobilization, splinting, CPR, , etc.

- **Airway Procedures**

Check appropriate box for the type of airway used. Record how many liters per minute of oxygen was administered and check the appropriate box for the type of device used to deliver oxygen.

- **IV Therapy**

Check appropriate box for the type of IV solution used; LR (Lactated Ringer's), NS (Normal Saline) or Saline Lock. Record the gauge of the IV needle. Record the location of the IV. Record the flow rate of the IV - to keep open (TKO), ml/min, etc. Record the time when the IV was initiated. Record the volume of fluid administered to the patient while under control of the EMS provider that initiated the therapy. Record the number of unsuccessful attempts performed to establish the IV. Note the name of the provider that established or attempted the IV.

- **Provider Name**

Complete name of the primary care provider.

- **Time of Onset:**

Time provider received the call

- **Initial Call- Time Received**

Time of the initial report to dispatch

- **First Unit- Time Arrive On Scene**

Time of arrival of the first unit (care provider) on the scene.

- **Ambulance/Transport- Time Arrived On Scene**

Time of arrival for responding ambulance, helicopter or vessel.

- **Ambulance/Transport- Time Depart Scene**

Time of departure for responding ambulance, helicopter or vessel.

- **Ambulance/Transport- Time Arrived Destination**

Time of arrival at destination. This may include a landing zone or rendezvous point with another transporting ambulance.

- **SAR Number**

SAR incident number (if applicable)

- **Base Hospital Contact**

Check the appropriate box whether contact was made with the base hospital.

- **Time of Contact**

Time communication was established with base hospital.

- **Hospital Name**

Name of base hospital

- **Contact Name**

List persons contacted (MD or RN).

- **NPS Mileage Transported**

Mileage that patient was transported by NPS ambulance. Record distance from the location of the ambulance at time of call to the point of patient transfer.

- **Level/Certification:**

Circle the appropriate care provider level for the primary EMS provider administering care to the patient named on this document; First Responder, EMT, EMT-Intermediate, EMT- Paramedic or Registered Nurse. Include certification number for care provider issued by state agency or National Registry of EMTs

- **Additional Team/Certification**

Name(s) and certification level(s) of other EMS providers

- **Mutual Aid Response**

Check box for yes or no

- **Service or Agency**

Name of Mutual Aid response agency or service.

- **Time Called**

Time Mutual Aid unit was call to response

- **Time Arrived**

Time Mutual Aid unit arrived on scene

- **Glasgow Coma (GCS)**

- **Verbal and Motor Response, Eye Opening**

Circle appropriate number and total of all three categories into Initial GCS

- **Loss of Consciousness**

Did the patient lose consciousness - Yes or No

- **Duration**

Length of time patient was unconscious

- **Initial GCS**

The first GCS that was taken

- **Time**

Time the first GCS was taken

- **Physical Exam**

- **General Appearance**

Record how the patient presents (well or appears ill, comfortable or in pain). For any aspect of the physical exam, if there are no unusual findings, check the box marked “WNL” (within normal limits).

- **Head/Face**

Palpate the head and face. Include ears, eyes, nose, jaw, teeth and tongue in exam. Record trauma, pain, tenderness and deformities. Include all unusual observations such as cerebrospinal fluid, blood in the hair, wounds, airway obstructions, breath odor, etc. Pupils PERRL (pupils equal, round and reactive to light).

- **Neck**

Palpate neck. Record pain, tenderness or deformities. Record unusual observations such as tracheal deviation, stoma, etc. Look for a medical alert tag. Full ROM (range of motion). JVD (jugular venous distention)

- **Chest/Back**

Palpate, observe and auscultate the chest. Record trauma, pain, tenderness and deformities. Observe for unusual signs such as unilateral chest movement, subcutaneous air, “floating” sections of the chest wall, diminished, gurgling, wheezing or other abnormal lung sounds. Breath sounds are normally recorded from auscultation (stethoscope) but may be audible without it. Record unusual breathing sounds such as stridor, crackles, wheezing, etc. Report if one or both sides are diminished or absent. If breath sounds are clear and equal bilaterally, record as normal or WNL. Sub Q (subcutaneous) air.

- **Abdomen**

Palpate and observe the abdomen and record trauma, pain, tenderness and deformities. Record findings if the abdomen is tender, rigid or distended and/or observations such as a colostomy bag, guarding, etc.

- **Pelvis**

Observe and palpate. Record trauma, tenderness, or deformities. Record findings such as genital bleeding, priapism, etc.

- **Extremities**

Palpate and observe arms, hands, legs and feet. Record trauma, pain, tenderness and/or deformities. Record findings such as crepitus presence/absence/quality of distal pulses, inward or outward rotation of legs and arms, capillary refill, medical alert tag, etc. Determine status of motor sensory functions. Record all abnormalities. Full ROM- Full Range of motion. *CSM* (circulation, sensation and motor movement) *Intact X4* refers to all four extremities. Intact pre- and post-splinting refers to a check of CSM prior to the application of a splint and following splint being applied.

- **Method of Transport**

If patient was transported to a medical facility indicate by what means. If method of transport is not listed, indicate under other category. AMA indicates “against medical advice.” Include ID number for ambulance or aeromedical helicopter receiving patient.

- **Disposition**

Record the hospital or ambulance name to which the patient was transferred. Time that the transfer took place. Signature of person to whom patient care was transferred. If signature is unreadable, it is advisable to print the individual’s name next to the signature. Signature of primary NPS EMS provider.

Reverse Side of Form

- **Continuation and Narrative**

Additional space to continue narrative from front page.

- **Signature of Provider**

Signature of primary EMS provider.

- **Waiver of Treatment**

To be used if the patient refuses medical treatment and/or transportation to a hospital after being advised by the EMS provider and/or medical control that their condition may result in serious injury, illness or death. Before the patient/guardian signs the statement, explain the potential consequences to the patient if they do not see a doctor. Print the patient’s name or guardians (for a minor) signature. If guardian, identify relationship to patient. Witness signature (preferably an impartial, non-government employee).

- **NPS Ambulance Transport Billing**

Completed when NPS unit bills patient for medical transport costs. Signature of patient is required to acknowledge they understand there is a cost associated with this emergency transport. Their signature also authorizes the release of their medical record information (individually identifiable health information) as identified by HIPAA (Health Insurance Portability and Accountability Act of 1996). Where NPS units are involved in ambulance transport

billing and exchange individually identifiable health information with covered entities the following security provisions apply;

- **Administrative Safeguards** - policies and procedures designed to clearly show how the entity will comply with the act
 - Covered entities (entities that must comply with HIPAA requirements) must adopt a written set of privacy procedures and designate a privacy officer to be responsible for developing and implementing all required policies and procedures.
 - The policies and procedures must reference management oversight and organizational buy-in to compliance with the documented security controls.
 - Procedures should clearly identify employees or classes of employees who will have access to protected health information (PHI). Access to PHI in all forms must be restricted to only those employees who have a need for it to complete their job function.
 - The procedures must address access authorization, establishment, modification, and termination.
 - Entities must show that an appropriate ongoing training program regarding the handling PHI is provided to employees performing health plan administrative functions.
 - Covered entities that out-source some of their business processes to a third party must ensure that their vendors also have a framework in place to comply with HIPAA requirements. Companies typically gain this assurance through clauses in the contracts stating that the vendor will meet the same data protection requirements that apply to the covered entity. Care must be taken to determine if the vendor further out-sources any data handling functions to other vendors and monitor whether appropriate contracts and controls are in place.
 - A contingency plan should be in place for responding to emergencies. Covered entities are responsible for backing up their data and having disaster recovery procedures in place. The plan should document data priority and failure analysis, testing activities, and change control procedures.
 - Internal audits play a key role in HIPAA compliance by reviewing operations with the goal of identifying potential security violations. Policies and procedures should specifically document the scope, frequency, and procedures of audits. Audits should be both routine and event-based.

- Procedures should document instructions for addressing and responding to security breaches that are identified either during the audit or the normal course of operations.
- **Physical Safeguards** - controlling physical access to protect against inappropriate access to protected data
 - Responsibility for security must be assigned to a specific person or department. This responsibility includes the management and oversight of data protection and personnel conduct with respect to data protection. Frequently, a Chief Security Officer position is established to fulfill this requirement. This position typically reports to executive level management.
 - Controls must govern the introduction and removal of hardware and software from the network. (When equipment is retired it must be disposed of properly to ensure that PHI is not compromised.)
 - Access to equipment containing health information should be carefully controlled and monitored.
 - Access to hardware and software must be limited to properly authorized individuals.
 - Required access controls consist of facility security plans, maintenance records, and visitor sign-in and escorts.
 - Policies are required to address proper workstation use. Workstations should be removed from high traffic areas and monitor screens should not be in direct view of the public.
 - If the covered entities utilize contractors or agents, they too must be fully trained on their physical access responsibilities.
- **Technical Safeguards** - controlling access to computer systems and enabling covered entities to protect communications containing PHI transmitted electronically over open networks from being intercepted by anyone other than the intended recipient
 - Information systems housing PHI must be protected from intrusion. When information flows over open networks, some form of encryption must be utilized. If closed systems/networks are utilized, existing access controls are considered sufficient and encryption is optional.
 - Each covered entity is responsible for ensuring that the data within its systems has not been changed or erased in an unauthorized manner.

- Data corroboration, including the use of check sum, double-keying, message authentication, and digital signature may be used to ensure data integrity.
- Covered entities must also authenticate entities it communicates with. Authentication consists of corroborating that an entity is who it claims to be. Examples of corroboration include: password systems, two or three-way handshakes, telephone callback, and token systems.
- Covered entities must make documentation of their HIPAA practices available to the government to determine compliance.
- In addition to policies and procedures and access records, information technology documentation should also include a written record of all configuration settings on the components of the network because these components are complex, configurable, and always changing.
- Documented risk analysis and risk management programs are required. Covered entities must carefully consider the risks of their operations as they implement systems to comply with the act. (The requirement of risk analysis and risk management implies that the act's security requirements are a minimum standard and places responsibility on covered entities to take all reasonable precautions necessary to prevent PHI from being used for non-health purposes.)

- **NPS Billing- Level of Care**

For the purposes of NPS EMS Transport billing document the level of patient care. BLS, ALS-1 (One ALS intervention only) and ALS-2 (More than one ALS intervention). These levels correspond to the accepted levels used within the medical billing industry.

- **Drug Disposal**

To document the disposal of unused narcotics, record witnessed amount disposed, name of the drug, time disposed, signature of witness and printed name.

NATIONAL PARK SERVICE- PATIENT CARE RECORD C.I. # _____

Date		Location		GPS Coordinate:		Provider Name:		Level/Certification				
MEDICAL <input type="checkbox"/> or TRAUMA <input type="checkbox"/>		Level of Care Provided: FA <input type="checkbox"/> BLS <input type="checkbox"/> ALS <input type="checkbox"/> ACLS <input type="checkbox"/>		Time of Onset		SAR Number		Additional Team/Certification				
Age	DOB	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Weight	SSN		Initial Call- Time Received		Base Hospital Contact: Yes <input type="checkbox"/> No <input type="checkbox"/>				
Patient Name					First Unit- Time Arrive On Scene		Time of Contact		Mutual Aid Response Yes <input type="checkbox"/> No <input type="checkbox"/>			
Address					Ambulance- Time Arrv On Scene		Hospital Name		Service or Agency			
					Ambulance- Time Depart Scene		Contact Name		Time Called			
Phone					Ambulance- Time Arrv Destination		NPS Mileage Transported		Time Arrived			
CHIEF COMPLAINTS / SYMPTOMS					GLASGOW COMA (GCS)							
					Verbal Response		Motor Response		Eye Opening			
MECHANISM OF INJURY / HISTORY OF PRESENT ILLNESS					5 Oriented & Converses	6 Obey Verbal Command	4 Open Spontaneously					
					4 Disoriented & Converses	5 Localizes Pain	3 Open to Verbal					
					3 Inappropriate Words	4 Withdraws from Pain	2 Open to Pain					
					2 Incomprehensible	3 Inappropriate Flexion	1 No Response					
					1 No Response	2 Inappropriate Extension	1 No Response					
Allergies Denied <input type="checkbox"/> Unknown <input type="checkbox"/>					Loss of Consciousness? Yes <input type="checkbox"/> No <input type="checkbox"/>		Duration (min):		Initial GCS:			
Medications Denied <input type="checkbox"/> Unknown <input type="checkbox"/>									Time:			
Past Medical History Denied <input type="checkbox"/> Unknown <input type="checkbox"/>					PHYSICAL EXAMINATION							
Last Meal / Drink / Urination / Menstruation Denied <input type="checkbox"/> Unknown <input type="checkbox"/>					General Appearance: Comfortable, Pale, Distressed, Sleepy							
Events of Incident / Prior Care / Anticipated Problems Denied <input type="checkbox"/> Unknown <input type="checkbox"/>					Head/Face: Atraumatic, Pupils PERL, Face Symmetrical							
NARRATIVE					Neck: Atraumatic, Full ROM, Non-tender, Crepitus, JVD							
					Chest: Atraumatic, Non-tender, Crepitus, Sub Q Air, Lung Sounds Clear Bilaterally							
					Abdomen: Atraumatic, Soft, Non-tender, Firm, Distended, Bowel Sounds							
					Pelvis: Atraumatic, Stable, Non-tender, Negative Incontinence							
					Extremities: Atraumatic, Non-tender, Edema, Deformity, Full ROM							
					CSM: Intact x4 <input type="checkbox"/> CSM Intact Pre-Splint <input type="checkbox"/> CSM Intact Post-Splint <input type="checkbox"/> Peripheral Pulses Intact <input type="checkbox"/>							
TREATMENT / RESPONSE					Cont'd On Back- Yes <input type="checkbox"/> No <input type="checkbox"/>							
Time	Position	Blood Pressure	Pulse	Respirations	Lung Sounds	Temp	Skin	SPO ₂	Glucose	EKG/ECG	GCS	Time / Drug / Dose / Route /
		/						RA O ₂				
		/						RA O ₂				
		/						RA O ₂				
		/						RA O ₂				
		/						RA O ₂				
		/						RA O ₂				
		/						RA O ₂				
AIRWAY PROCEDURES		IV/IO THERAPY		METHOD OF TRANSPORT		DISPOSITION						
(Show Provider Initials)		Time		Transport Yes <input type="checkbox"/> No <input type="checkbox"/>		Transfer To: MD/RN <input type="checkbox"/> ALS <input type="checkbox"/> BLS <input type="checkbox"/>						
<input type="checkbox"/> Oropharyngeal (OPA)	<input type="checkbox"/> Combitube	Fluid		<input type="checkbox"/> Patrol Car		Receiving Signature: _____						
<input type="checkbox"/> Nasopharyngeal (NPA)	<input type="checkbox"/> BVM	Lock		<input type="checkbox"/> Ambulance		Time of Transfer: _____ Location: _____						
<input type="checkbox"/> ETT Intubation- Size: _____ mm	<input type="checkbox"/> Nasal Cannula	Gauge		<input type="checkbox"/> Helicopter		Signature of Provider: _____						
<input type="checkbox"/> Cricothyrotomy	<input type="checkbox"/> Non-Rebreather	Total Infused		<input type="checkbox"/> Vessel								
<input type="checkbox"/> Airway Suction	<input type="checkbox"/> Other: _____	Site		<input type="checkbox"/> Private Auto								
<input type="checkbox"/> Thoracostomy	Oxygen Liters/Min: _____	Provider		<input type="checkbox"/> Mule / Horse								
<input type="checkbox"/> Gastric Tube		Number of Attempts: _____		<input type="checkbox"/> Refusal / AMA								
<input type="checkbox"/> Foley Catheter				<input type="checkbox"/> Treat and Release								

NPS Form 342
February 2006



NATIONAL PARK SERVICE FOLLOW-UP INSTRUCTIONS

CASE # _____ PATIENT NAME: _____		
SPECIAL INSTRUCTIONS: _____ _____ _____		
PROVIDER NAME: _____		
MEDICAL CONTROL CONTACTED: YES <input type="checkbox"/> NO <input type="checkbox"/> Reason not contacted: _____ _____		
<p>I hereby acknowledge receipt of the instructions as indicated. I understand that I have had emergency first aid treatment only, and that I am requesting to be released before all of my medical problems are known or treated. I will arrange for follow-up care as instructed above. I understand I may recontact the National Park Service at the number listed below to obtain additional assistance.</p>		
Date	Signature of responsible party	Relationship
HEAD INJURY	OPEN WOUNDS	
<p>Although no evidence of serious injury is found at this time, careful observation for 24-48 hours is advised. You should contact you doctor, the National Park Service, or an emergency department if you develop the following:</p> <ul style="list-style-type: none"> • Vomiting (more than two times) • Severe headaches which are getting worse. • Increased drowsiness or stupor • Difficulty with thinking or speech • Unequal pupils or convulsions <p>Alertness should be checked hourly during waking hours and every two hours when sleeping for 24 hours. Rarely problems occur after several days; if so, you should be seen by a doctor at that time. Alcohol should be avoided for 24 hours to avoid masking symptoms.</p>	<p>The wound care you have received is of a first aid nature. Any gaping wounds should be evaluated at your emergency department for suturing and or damage to tendons, nerves, and vessels. Wounds needing suturing should be seen within 6-12 hours. Wounds should be observed as soon as possible for signs and symptoms of infection: which include redness, increased-pain, swelling, red streaks, pus, or fever. At any sign of infection, you should see your doctor or go to your emergency department immediately. If you have not had a tetanus booster within 5 years, you should see your doctor within 72 hours for one. Tetanus (lockjaw) may result from even minor wounds and can be fatal. For complex wounds, which could require surgical repair, you should not eat or drink anything in transit to the hospital.</p>	
BLUNT TRAUMA	SPRAINS, STRAINS, FRACTURES	
<p>Although serious internal injury is not apparent at this time, observation for internal injury or bleeding should follow any significant blow to the body. You should go to your emergency department immediately if you develop:</p> <ul style="list-style-type: none"> • Increasing pain or extending pain • Increasing weakness, increasing light-headedness, or any fainting when trying to stand upright • Pale skin color • Cold, sweaty skin 	<p>It is not possible to determine the full extent of injury to bones without x-rays. You are advised to go to your emergency department for further examination. Splinting devices should remain in place to immobilize the injury while in transit to the emergency department. Elevation and intermittent ice application to the injury site is beneficial. Before highly suspicious injuries are determined negative for fractures, you should not eat or drink due to the possibility of surgery.</p>	
TREATMENT/ ADVISE: _____ _____		
NATIONAL PARK SERVICE DISPATCH: Phone Number: _____		

Exhibit 4

Annual Emergency Medical Services Report
Year _____

PARK:	REGION:	
EMS COORDINATOR:	PHONE:	
ADDRESS:	FAX:	
	E:Mail:	
HUMAN RESOURCES:	National Registry	State
	Perm Seas.	Perm. Seas.
First Responders		
EMT-Basics		
IEMTs/Parkmedics		
Paramedics		
Other (RNs,PA,NP,DR)	XXXXXXXXXXXX	
TOTAL		
EMS WORKLOAD:	Basic Life Support	Advanced Life Support
Trauma		
Medical (Non-Cardiac)		
Cardiac		
First Aid Only		XXXXXXXXXXXX
TOTAL		
CARDIAC ARRESTS		
# of Patients AED Shock Delivered		
# Survival (Hospital Release)		
FATALITIES:		
Traumatic		
Non-traumatic		
TOTAL		
TRANSPORTATION:	NPS	Other
# ground transports		
# of helicopter transports		
# of fixed wing transports		
# of vessel transports		
# of NPS Responses outside Park		XXXXXXXXXXXX
TOTAL		
CAPITALIZED EQUIPMENT:	NPS	
Ambulance (DOTKKK specs)		
Rescue Vehicles (non-ambulance)		
Helicopters used in EMS/SAR		

# AED's	
TRAINING:	NPS Other
Training Person/days (CY) All levels	
ALS	
BLS	
Funds expended EMS Training NPS ONLY (no salaries)	
PROGRAM MANAGEMENT:	
EMS Funding (CY) (except training)	
Park Medical Director	

Data Dictionary

Park: enter full name and four-letter designator

Region: self-explanatory

EMS Coordinator: Need name, phone number, address, fax and cc:Mail address

Human Resources

Enter the number of first Responders, Emergency Medical Technicians, Intermediate EMTs or parkmedics (NPS designation), Paramedic or other higher level of providers. Indicate whether they are National Registry certified or State and whether they are seasonal or permanent. If the employees are both NR and state, credit them as national registry for this report. Attach list of names of all parkmedics and paramedics. We will not be surveying first aid trained employees

EMS workload:

Each category is divided into Basic Life Support and Advanced Life Support intervention. Advanced Life Support is defined as EMS calls that required ALS skill intervention. For example, an IV was started, patient received medications, patient intubated, etc.... . These skills can be performed by either NPS ALS providers or outside providers. However, having an ALS provider on scene does not constitute an ALS call, they must either perform an ALS skill or attempt to. Everything else is considered a BLS call.

Sudden Death Cardiac Arrest: The number of sudden death cardiac arrests Sudden death is defined as death occurring unexpectedly and instantaneously or within 1 hour of the onset of symptoms in a patient with or without known pre-existing heart disease.

AED Used: The number of incidents in which the AED was used. In other words, in how many cardiac arrest calls was the AED applied to the patient?

Utstein Survival: Utstein survival is defined as survival from a sudden cardiac arrest death. Survival is further defined as patient being discharges from hospital.

Minor Cases: Number of minor first aid, visitor assists of a first aid nature. No EMS run sheet was generated nor did ambulance, etc transport the patient.

Mutual Aid: Emergency assistance rendered to agencies outside the boundaries of the NPS

Fatalities:

Traumatic: Due to accident, injury or self inflicted injury

Non-traumatic: Due to a medical cause or natural death

Saves: Likelihood that without intervention by the NPS the victim would not have survived the incident.

Transportation: Number of NPS and non-NPS transports in each category

Capitalized Equipment:

We will be conducting an inventory of the listed capitalized equipment. The number of ambulances meeting DOT requirements, the number and brief description of other types of rescue vehicles the parks might use (for example: suburbans with attachment for litters, etc., heavy rescue vehicles, multi-casualty vehicles). Use attachments as needed.

Training:

Training person days: (# Of training hours) x (# of trainees) divided by 8 = training person days

EMS Funding for CY: Include salary time of EMS Coordinator if appropriate.

Medical Director: Name and all pertinent information to contact for follow-up.

Chapter 10

AUTOMATED EXTERNAL DEFIBRILLATORS

- 10.1 Introduction
 - 10.2 Overview
 - 10.3 Guidelines
-

10.1 Introduction

An AED is a device designed to improve the survival rate for victims of cardiac arrest. The AED is applied to the chest to administer an electric shock to the heart. This is done to terminate lethal cardiac rhythms and allow the heart to resume normal pumping activity.

Built-in computers assess the patient's heart rhythm, judge whether defibrillation is needed, and then administer the shock. Prompts provided on a screen and audibly, guide the rescuer through the appropriate sequence of steps to follow.

Because of the wide variety of situations in which it will typically be used, the AED is designed with multiple safeguards and warnings before any energy is released. The AED is programmed to deliver a shock only when it has detected ventricular fibrillations or other specific abnormal heart rhythms. However, potential dangers are associated with AED use. Training, safety and maintenance are important components of any AED program.

AEDs are designed to be used by both medical and non-medical personnel who have been properly trained. NPS employees trained to provide CPR and automated external defibrillation may greatly increase sudden cardiac arrest survival rates of visitors and employees.

10.2 Overview

The goal of an AED program is to increase the rate of survival of people suffering from sudden cardiac arrest. The key is to minimize the time from the onset of cardiac arrest to defibrillation. This can only be accomplished when the site has an appropriate number of AEDs placed in strategic and easily accessible locations and the appropriate number of people trained to use them.

10.3 Guidelines

10.3.1 Determining the Need

As part of the overall EMS Needs Assessment, the following criteria should be considered in determining the need for an AED program:

- Probability of use of an AED due to cardiac arrest is at least one use in 5 years.
- Is the EMS call-to-shock time interval of less than 5 minutes reliably achieved with conventional EMS services and if not, can NPS AEDs be brought to the same location within that time frame?
- Do large numbers of people frequent the area?
- Does this location have an at-risk workforce and/or visitor population?
Risk factors include:
 1. Men age 40 or older
 2. Post-menopausal women
 3. High blood pressure
 4. High cholesterol
 5. Sedentary lifestyle
 6. Diabetes
 7. Personal history of heart disease
 8. Family history of heart disease
- Is this location considered a high-risk location? High-risk locations include:
 1. High activity/recreation area
 2. Areas where people experience high levels of stress
 3. Areas where people spend long periods of time
- Hazardous materials/conditions (chlorine, electrical, etc).
- Physical layout of the facility.
 1. Multiple floors
 2. Size of office space or number of rooms

10. 3.2 Medical Oversight

All park units that have an AED will have a Medical Advisor that provides oversight to the AED program. The Medical Advisor's duties are as follows:

- Provide medical direction for determining equipment selection and use of the AED.
- Write a prescription for new AED purchases. The Food and Drug Administration has classified the AED as restricted, prescription devices.
- Provide and review guidelines for emergency procedures related to the use of the AED.
- Evaluate and review all AED patient encounters

10.3.3 Training

AED and CPR training is vital because early CPR and AED use is an integral part of providing lifesaving aid to people suffering from sudden cardiac arrest. To provide victims of sudden cardiac arrest with the greatest opportunity for survival, it is recommended that all NPS employees be certified in CPR/AED.

Training and re-certification requirements are established by NPS-approved organizations listed in Chapter 6, *Certifying Organizations, Training, and Levels of Care*. Parks may also develop their own, more frequent training and review schedules. Periodic scenario based training is highly recommended as a component of an AED providers continuing education.

10.3.4 Placement and Number of AEDs

Optimal locations and numbers of AEDs are such that trained individuals can access them and reach the patient within a target response time of three to five minutes (3 minutes is optimal, 5 minutes is considered acceptable). This is defined as the time it takes a responder to go from his/her work area to retrieve an AED and then, walking at a rapid pace, to reach the victim.

When locating an AED, the responder should consider placing them in areas where the risk assessment is highest (i.e., visitor centers, administration buildings, campgrounds, etc). Consider equipping all EMS first response vehicles and ambulances with an AED that are not already equipped with an ALS defibrillator.

Specific considerations to be made for AED locations are:

- An easily accessible position (e.g., placed at a height so those shorter individuals can reach and remove, unobstructed access, etc.)
- A secure location that prevents or minimizes the potential for tampering, theft, and/or misuse, and precludes access by unauthorized users
- A location that is well marked, publicized, and known among trained staff
- A nearby telephone or radio that can be used to call EMS

Limited vs. Open Accessibility: Limited accessibility restricts access to the AED to a defined individual or group. This means the general public can not easily obtain and use the AED. Access to AEDs may be limited to park personnel or may be expanded to include defined trained rescuers (rescuers not a part of the park unit but who are properly trained in CPR and AED.) Open accessibility is the placement of AEDs so that they are available to the general public.

Automatic Notification System: This type of system automatically notifies a responding entity when the AED is removed or the cabinet is opened. This

notification may be sent directly to the local EMS agency or to an in-house communication center that will then notify the appropriate responders. Where automatic notification of the opening of an AED storage cabinet or removal of an AED from a cabinet is not implemented, emphasis should be placed on notification procedures and equipment placement in close proximity to a telephone or radio. There may also be an audible alarm that is activated by the removal of the AED. This will alert other persons within hearing distance.

10.3.5 Supplies

A supply inventory to include a razor, barrier device, spare battery, disposable gloves, and two sets of electrodes are stored in the case with each device. Also consider including a biohazard bag, small towel, and a set of concise instructions for performing CPR, and pen and paper.

10.3.6 Maintenance Procedures

Maintenance and performance checks of all AEDs and associated equipment are to be performed per manufacturer's recommendations. Each NPS area will designate a person(s) responsible for this task.

Each AED should have a written checklist to assess the preparedness of the AED and supplies. Per the NPS Records Schedule, A7615 Health and Safety, completed checklists should be kept on file in the park for a minimum of 15 years. (See Exhibit 5 for a sample AED Log). This checklist may be used as a supplement to regularly scheduled, more detailed maintenance checks recommended by the manufacturer.

At minimum, the checklist should include the following:

- Date of inspection
- Verification of placement
- Verification of battery installation
- Checking status/service indicator light
- Inspecting exterior components and sockets for damage
- Inventory of supplies
- Name of the person who inspected the unit

10.3.7 AED Policy

Each NPS area must have a current written policy available to all participants that contains the protocols and procedures for their AED program. This policy should address roles and responsibilities, protocols, and procedures for program. (See sample AED Policy in Exhibit 6.)

10.3.8 Post-Event Considerations

The following measures are to be taken:

- Return the AED to a state of readiness as soon as possible with the replacement of the pads, pocket mask, and other peripheral supplies as necessary.
- Provide the data to the Park EMS Medical Advisor.
- Review the case with the AED Medical Advisor, Park EMS Coordinator and involved rescuers within 30 days of the incident. The information gathered from the incident review process is intended to be used to help improve the AED program. At a minimum, the review should include protocol and procedure implementation, scene safety, and a review of the AED recorded data.

10.3.9 Sources of Information Regarding AEDs and AED Programs

American Heart Association (www.americanheart.org)

National Center for Early Defibrillation (www.early-defib.org)

General Services Administration (www.gsa.gov)

Exhibit 6

Sample AED Policy

(Insert Park Name) National Park
Automated External Defibrillator Policy

1. National Park Responsibilities

- Assure qualifications and training of responders as required.
- Coordinate training of responders.
- Coordinate equipment and maintenance.
- Coordinate with Medical Advisor on all issues related to AED program.
- Review and revision of this policy as required.

2. AED Medical Advisor Responsibilities

- Provide medical direction for use of AEDs.
- Provide a prescription for AED purchases.
- Provide and review guidelines for emergency procedures related to the use of AEDs.
- Evaluate and review of all AED patient encounters.

3. EMS Coordinator Responsibilities

- Maintain training records.
- Maintain log of AED repairs.
- Liaison between AED manufacture(s) and (Insert Park Name) National Park.
- Liaison with AED Medical Advisor and (Insert Park Name) National Park coordination of post-event reviews.
- Liaison with hospital that receives patients.

4. AED Responders Responsibilities

- Possess and maintain a current CPR/AED certification by an organization that is recognized by the NPS.

5. Indications for Use

- The AED shall be applied per the attached protocols.

6. Location(s) of the AED(s)

- Location(s) of the AED(s) as determined by a Needs Assessment are as follows: (list)
- Each AED will contain the following supplies: (list)

7. Refresher Training

- AED providers will renew their CPR/AED certifications as required by the organization providing the initial training (i.e., American Heart Association, American Red Cross, American Safety Health Institute, or National Safety Council).
- Each authorized user will refresh their AED skills using either computer based training or direct observation/hands on from an authorized AED instructor on an annual basis.

8. Documentation

- An NPS PCR shall be completed for all incidents involving the application/use of an AED.
- Any documentation generated by the AED shall be submitted for review with the PCR.
- The PCR and any additional documentation shall be routed per park protocol.

9. Equipment Maintenance

- All equipment necessary for support of medical emergency response with an AED shall be maintained in a state of readiness.
- Specific maintenance requirements include equipment and maintenance checks, and cleaning and decontamination consistent with the guidelines of the AED manufacturer. Immediate notification will be made to the EMS Coordinator in the event of a malfunction or unavailability of an AED.
- AED Coordinators will be responsible for ensuring that monthly inspections of AEDs are made and that the AED is fully functional.
- A log shall be maintained indicating the results of the inspection including all deficiencies and actions taken to repair them.

(Insert Name), MD Date
AED Medical Program Advisor

(Insert Name) Date
Superintendent

Chapter 11

SUPPLIES AND EQUIPMENT

- 11.1 General
 - 11.2 Controlled Substances
 - 11.3 Military Supply
 - 11.4 Other Supplies and Equipment
-

11.1 General

Each park will fund its own basic supply and equipment costs. Part of these costs may be defrayed through donations and payment for services as covered in Chapter 13, *Payment for Services*. Park areas that provide ALS programs may consider minimizing costs by arranging with assisting hospitals to issue them supply and equipment inventories such as heart monitors, intubation instruments, and medications.

In cases where a hospital supplies ALS equipment to a park, the Park EMS Coordinator will maintain records of all hospital property.

11.2 Controlled Substances

With the approval of the Park EMS Medical Advisor, the Drug Enforcement Agency recommends that parks utilize the Park EMS Medical Advisors Controlled Substances Registration Certificate to acquire their initial medication inventory. In addition to the acquisitions of medications, a replacement and disposal policy should be developed between the park and the Park EMS Medical Advisor.

In cases where assisting hospitals do not provide drug inventories to the parks, but will give medical orders for the administration of drugs by trained individuals, the park will need to purchase controlled substances. In order to purchase many of the drugs required, the park must obtain a Controlled Substance Registration Certificate from the Drug Enforcement Agency. The purchase of controlled substances does not imply that there is approval to administer these medications. Approval for administration rests solely with the physician either through direct order or previously approved protocols that contain standing orders for the administration of medications.

Applications for registration with Drug Enforcement Agency and online forms may be found at www.deadiversion.usdoj.gov/drugreg/reg_apps/index.html.

Other useful information is also included on the Drug Enforcement Agency website.

In either of the above cases, it is mandatory that the Park EMS Coordinator keep current and accurate inventories of all ALS medications and that proper measures are taken to ensure the security of these substances. Drug Enforcement Agency security measures may be found in 21 CFR 1301.72.

11.3. Military Supply

Significant savings to the government can be accomplished by purchasing basic and ALS supplies and equipment through military supply centers. Park EMS Coordinators, through appropriate channels, can contact the medical supply officer at the nearest military installation for detailed information. The military has established procurement procedures for dealing with other government agencies.

11.4. Other Supplies and Equipment

- Oxygen Cylinders

Oxygen cylinders may be obtained by a park in several ways. The park may choose to purchase cylinders, and refill them by contract with a private oxygen supplier. Alternatively, the park may enter into a rental agreement or contract for the cylinders with a private company. Typically, these companies charge a rental fee for the cylinders, which are then picked up by the company or dropped off at a company collection center when empty. The company may or may not include the price of refilling the cylinders in the rental price. Parks may also enter into agreements with hospitals, ambulance companies, and other EMS providers to use or rent oxygen cylinders.

There are two types of materials used to manufacture oxygen cylinder, steel and aluminum. By far, aluminum cylinders are the most common, least expensive and lightest. Nearly all oxygen cylinders have a working pressure of 2150 pounds per square inch. All oxygen cylinders need to be labeled with a large green oxygen label and/or need to be painted green.

The use, maintenance and handling of these high pressure cylinders is of utmost importance to protect NPS employees and visitors from accidents and to ensure patients are receiving the highest quality oxygen service.

1. Cylinders are required to be protected from falling and are to be placed in a labeled, protective case or padded carrying pack.
2. Cylinders standing upright against a wall are to be secured with a chain or strap to prevent them from falling.

3. Cylinders in emergency response vehicle such as a patrol trucks and cars, fire trucks, ambulances and in aircraft are to be secured to prevent them from becoming airborne in the unlikely event of an accident.
4. Parks are required to maintain a list of oxygen cylinders to include the make, size, serial number, location, date of last hydro, purchase date and condition at last inspection.
5. All cylinders, regardless of the material from which they are made, are required to undergo periodic professional testing at a Department of Transportation certificated hydro testing facility. All high pressure cylinders submit to a hydro test every 5 years as per the month and year date stamped on the cylinder head. Hydro testing entails over-pressurizing the cylinder under very a controlled environment to test the cylinder integrity and expandability. The cylinder valve is also inspected.
6. Do not refill any cylinder that has lost internal pressure for no apparent reason, as this may be an indication that defects have developed. Immediately remove it from service and conduct inspections.
7. Use only certified oxygen clean equipment to refill oxygen cylinders
8. Receive training in handling and filling high pressure oxygen cylinders from a reputable training organization before allowing NPS employees to fill oxygen cylinders.
9. Refrain from filling cylinders quickly as this creates heat that could weaken the cylinder or cause a failure of the tank value or seals.
10. Do not fill cylinders that have an expired hydro date or have evidence of damage or abuse.
11. Label the cylinder as to the date the cylinder was filled. Oxygen cylinders should be drained and refilled every 2 years if not used.

Procedures for inspecting high-pressure aluminum cylinders can be obtained by contacting Luxfer Gas Cylinders at www.luxfercylinders.com, (909) 684-5110, or Compressed Gas Association at www.cganet.com, (703) 412-0900, ext. 799.

The National Institute for Occupational Safety and Health and the Department of Transportation recommend the following safety precautions for users of high-pressure aluminum seamless and aluminum composite hoop-wrapped cylinders made of *aluminum alloy 6351-T6*. Some of these cylinders are susceptible to sustained load cracking in the shoulder and neck area, which could cause cylinder ruptures, resulting in injury or death. The cylinder head will be stamped with a AL 6351 mark indicting the alloy used to manufacture the cylinder. Parks that have aluminum cylinders made from this alloy are advised to replace them with

new aluminum cylinders made of the latest alloy. Any other alloy number indicates the cylinder is made from a different alloy.

1. Increase the frequency of visual inspections. An internal visual inspection should be performed on an annual basis by a qualified inspector.
2. Inspections should be performed by qualified individuals who are able to follow Visual Inspection guidelines and who have been trained in visual inspection. Parks that have dive programs can follow the same procedures for annual Visual Inspections that Scuba cylinders must follow.

- Glucometers

The use of these devices is covered in the NPS Field Manual. However, glucometers are generally made for diabetics that use the device daily or several times a week. NPS EMS providers would use the device far less frequently, therefore requiring that the unit be inspected several times a month to ensure the batteries, test strips and data chip are current and operational. Extra batteries and supplies should be carried in the case storing the device.

- Pulse Oximeters

The use of these devices is covered in the NPS Field Manual. These devices are valuable in that they can help evaluate the patient's oxygen saturation in percentage. These devices require batteries and periodic testing to ensure the device is operational. These devices are not inexpensive and should be properly cleaned and stored in a protective case.

- AEDs

The AED is covered in Chapter 10, *Automatic External Defibrillators*, of this manual plus the NPS Field Manual. Some manufactures have 5-year lithium batteries in the units and internal self-test software that tests the units' battery and functions. These units need to be periodically inspected to ensure proper placement. For user replaceable batteries such as the Zoll units, an extra set of batteries and pads is recommend to be carried with the case storing the unit.

- EMS Kits

EMS kits contain an large assortment of dated products from over the counter medications to simple bandages. Periodic inspection of EMS trauma kits and drugs kits and the removal and replacement of dated and unclean or non-sterile dressing, drugs, ointments, blood pressure cuffs, scissors, excreta, is

important in maintaining the quality and integrity of medical care and to the whole kit to ensure it is operational during an emergency response.

- ALS

ALS parks will carry a wide array of devices and equipment in ambulances, patrol vehicles and in storage, in addition to the equipment mentioned above. Periodic and routine inspection of these devices and equipment is needed to maintain the quality and integrity of the equipment and to ensure it is operational during an emergency response.

Chapter 12

PATIENT TRANSPORT AND EMERGENCY VEHICLES

- 12.1 Introduction
 - 12.2 Policy
 - 12.3 Guidelines
-

12.1 Introduction

If local ambulance services do not exist, or are not available to serve the park in a timely manner, the park may select to provide that service.

An emergency response to an emergency medical incident, performed in an ambulance or other emergency vehicle, should be based on a reasonable belief that immediate assistance is required to safeguard a person's life. An ambulance operator is responsible for the safety and efficient transport of the patient(s) and crew, and the safety of the public. While the operation of an emergency vehicle often occurs during times of crisis, the operator needs to remain aware that they are legally accountable for their actions.

12.2 Policy

Vehicles used for the normal ground transportation of patients will meet or exceed Federal ambulance specifications KKK-A-1822. In special circumstances, other means of transportation may be used, such as aircraft, boats, sleds, etc. The means selected for conveyance should be in the patient's best interest, given the circumstances and other means available. Every effort will be made to minimize the risk to patients during transport, regardless of mode, device or vehicle utilized.

Aircraft dedicated for use in patient transportation shall meet applicable standards for aircraft as required by the Department of the Interior, and the Commission on Accreditation of Medical Transport Systems. Aircraft not configured for emergency medical transport, such as helicopters used for fire management, may be used in special circumstances where immediate transport is in the patient's best interest.

All NPS employees who operate a government vehicle will possess a valid state license for the class of vehicle being operated.

After proper orientation and instruction, and with supervisory approval, an NPS employee or volunteer who has a valid state driver's license for the class of vehicle being operated may operate an EMS vehicle in a non-emergency mode

(no emergency lights or siren). The driver of an EMS vehicle being operated in a non-emergency mode, will obey all traffic regulations, and travel without activation of emergency lights and siren.

To operate an EMS vehicle in the emergency mode, an NPS employee or volunteer must have received documented orientation and instruction in the operation of that vehicle for that purpose, and will have completed the NHTSA Emergency Vehicle Operations Course (EVOC) for Ambulances (available at www.nhtsa.dot.gov), or an emergency vehicle operations course at FLETC, an EVOC course at an approved seasonal law enforcement training school, or equivalent course. (For a sample of an ambulance driver requirements check-sheet, see Exhibit 7).

All emergency vehicle responses will be carried out in accordance with applicable state laws. While the operator of the emergency vehicle remains responsible for operating the vehicle with due regard for the safety of persons and property, during emergency operation (i.e., with lights and siren based on a reasonable belief that immediate attention to a patient is required based on the serious nature of their condition) may:

- Operate the vehicle in excess of the posted speed limit in a reasonable and prudent manner given the prevailing conditions of the roadway, weather, and traffic conditions,
- Obstruct traffic to the extent that it is necessary to carry out the operation and such activities do not unnecessarily endanger human life or property,
- Proceed through an intersection past a red or stop signal or stop sign, but only after slowing down as may be necessary for safe operation,
- Disregard regulations governing direction of movement or turning in specified direction, and
- Shall operate the vehicle in such a manner so as not to further compromise or aggravate the condition of the patient(s) on board.

Patients may be transferred from a Park EMS provider to an equal, or higher, trained provider who will complete transport to a medical facility. The patient may also be transferred to a "lower level" of care based on the nature of the patient's illness/injuries, the treatment provided, and the approval of medical control (base hospital).

12.3 Guidelines

Ambulance specifications can be found by selecting "ambulance" at the GSA website at www.fss.gsa.gov/vehicles/buying.

The responsibility for transporting patients may be fulfilled by entering into agreements with other agencies or organizations; or, through contract with other agencies or private services.

Costs incurred by the government for ambulance transportation may be charged to the patient, in accordance with applicable laws, agreements, and contracts. See Chapter 13, *Payment For Services*, for details.

On a periodic basis, park ambulances and other emergency services vehicles will be inventoried to ensure that they are properly supplied (see Exhibit 8).

A periodic check will be conducted on park ambulance(s) to confirm that all equipment is in working order (Exhibit 9). Each vehicle operator will ensure that all mechanical, safety, and special equipment are operational at all times. Any deficiencies will be immediately corrected or reported through channels for repair or replacement.

Not all patients require transportation to a medical care facility in an ambulance. Park EMS Medical Advisors may establish protocols for allowing patients, to be transported by privately owned vehicles or similar methods.

Exhibit 7

Ambulance Driver Training Requirements National Park Name _____

The following must be signed off before an individual may be permitted to operate the ambulance unsupervised.

Name _____

Section 1: General Topics:

Complete descriptions of the topics are covered in the US Dept of Transportation, Emergency Vehicle Operators Course, National Standard Curriculum
www.nhtsa.dot.gov/people/injury/ems/products.htm

Topic	Date	Signature and Printed Name of Proctor\Instructor
1. Ambulance inspections		
2. Backing with a ground guide		
3. Seat belts		
4. Accelerating smoothly		
5. Braking smoothly		
6. Anticipation of other vehicles		
7. Obey all State traffic regulations		
8. Emergency Signaling Devices—appropriate use		
9. Parking and placement at the scene		
10. Use of emergency (vehicle) equipment (triangles, jack, fire extinguisher, etc)		
11. Scene safety (i.e. down power lines, flammable liquids, crowds, traffic, etc)		
12. Response to emergencies		
13. Use and location of all equipment (including radio)		
14. Pre-departure from Scene		
15. Local issues/considerations/protocols		
16. Post-run procedures		

Section 2: Driving Course:

Shall be done in the ambulance. The following skills must be performed, but are not limited to:

Driving Course	Date Completed	Signature and Printed Name of Proctor\Instructor
1. Diminished Clearance		
2. Serpentine Course		
3. Straight line breaking		
4. U-turn		
5. Braking While Turning		
6. Three point turn		
7. Right side road turn		
8. Left side road turn		
9. Slow Speed Lane Change		
10. Perpendicular Parking		

Section 3: Driving on an Ambulance call:

May ONLY be done after section 1 and section 2 have been completed

Case Number	Date	Location Drove to	Signature and Printed Name of Proctor\Instructor

Final Approval By EMS Coordinator _____ **Date** _____

Exhibit 8

Ambulance Inventory

Date _____ Ranger _____

Ambulance Mileage _____ Next Service Due _____

Replace all O₂ at 500 PSI

Engine Compartment

- Coolant level
- Brake fluid
- Power steering fluid
- Transmission fluid
- Oil level
- Windshield wiper fluid
- Left air filter
- Right air filter

Drivers Compartment

- Spot light
- RPM control
- A/C (run for a minute)
- Heater (run for a minute)
- Fuel level is full
- P/A - siren
- Hazardous materials book
- Binoculars
- Lodge fire key

Outside of Ambulance

Headlights

- High beams
- Low beams

Turn Signals

- Front
- Rear
- Reverse lights
- Reverse alarm
- Primary lights
- Secondary lights

Flood Lights

- Left
- Right
- Rear

Wall Mounted Spare O₂ Tanks

Left _____ PSI

Right _____ PSI

Oxygen Kit

Right Side Compartment

- Adult BVM, reservoir and tube
- Infant BVM, reservoir and tube
- Adult blob face mask
- Infant blob face mask

Left Side Compartment

- Manual suction (assembled)
- Esophageal airway (mask, tube and syringe)
- Rubber gloves (20)

Front Compartment

- Set of airways (8 different sizes)
- Bag of extra size 10 airways
- Nasopharyngeal airways (2)
- K-Y Jelly

Center Compartment

- O₂ wrench

O₂ tank _____ PSI

- Adult nasal cannula (2)
- Adult non rebreather masks (3)
- Ped non rebreather masks (2)
- O₂ Tubing (2)
- Pocket face mask

Road Crash Compartment

- Speed straps (8)
- Nylon straps (8)
- Spare head rolls (3 pair)
- KED
- MAST
- Spare O₂ tanks (2)

Road Crash Kit

- 6 cervical collars—different sizes
- Spider strap
- Duct tape
- Head rolls (2 pair)
- Triangular bandages - straps(10)
- 3 inch tape roll

Cabinet #1 – ALS

- Assorted size needles
- Veni-guards (5)
- Primary IV sets (3)
- Alcohol preps (10)
- Iodine preps (10)
- Endotracheal tubes (6)
- Pre made IV sets (2)
- Irrigation (5)

Wall Unit

- Suction Unit
- Main wall O₂ _____ PSI

Clipboard

- Run sheets (5)
- Hospital directions (5)
- EMS field guide
- Extra pen
- Speedy Spanish guide
- High dome lights
- Medium dome lights
- Low dome lights
- Box of gloves
- Positive flow O₂ tube
- Fan (at rear)
- Air conditioning

Chapter 13

PAYMENT FOR SERVICES

- 13.1 Introduction
 - 13.2 Overview
 - 13.3 Guidelines
-

13.1 Introduction

This chapter provides the authorities and guidance for the NPS to collect monies to defray the costs of its EMS Program.

13.2 Overview

Title 16, Sections 12 and 17c of the USC, are the statutory provisions enabling park areas to bill at cost for emergency supplies and services provided to visitors. Section 1b(5) of Title 16 USC allows for cooperating medical services (ambulance providers and hospitals) to bill for, and make payment to, reimbursable accounts established by the parks; the funds do not need to be deposited in miscellaneous receipts. Further, Title 31 USC, Section 9701 (user charge statute) provides that no person should receive the benefit of any service provided by the United States without charge. Although these statutes provide the legal means to recover the costs of EMS and help them to be self-sustaining, they do not require parks to charge for these services.

In most park areas, ambulance services are provided by local communities. Expendable supplies are "loaned back" in kind either by the ambulance companies or the local hospitals. Park areas that provide their own ambulance service have found this to be a considerable cost savings to their operations.

13.3 Guidelines

13.3.1 General

The level of care, caseload, and number of patient transports provided by a park area may be useful factors in determining whether to enter into a cost-recovery program for medical supplies and services.

13.3.2 Cooperative Agreements (third-party billing)

Some park areas have found that agreements with cooperating medical organizations are an effective means of providing EMS to park visitors and

recovering the cost of delivered care. Many parks are located in remote areas where ambulance and hospital services are not immediately available. In these areas it has proven advantageous for trained EMS personnel from the park to respond to emergency medical incidents and provide treatment, supplies, and transportation as needed. Park personnel then transport the patient either to a rendezvous with a private or municipal ambulance service or to a receiving medical facility.

Patient billing to recover costs for services, transportation and supplies can be made directly by the park or through a cooperating medical service. Generally it is most efficient to allow the cooperating service to charge the patient because the billing procedures, personnel, and facilities are already in place.

If a cooperating service is utilized, a Memorandum of Agreement should clearly state how the billing and collection is to be accomplished. In most of these agreements, the receiving medical facility or ambulance service will restock the park with any medical supplies and medications expended in caring for the patient. Generally, this is done in kind without procurement transactions taking place, and the patient is charged for those items by the cooperating service. This leaves only the park's transportation costs to be recovered. In parks that do not transport patients, the in-kind replacement of supplies generally meets the park's needs without additional agreements or billing procedures.

In most third-party billing arrangements, the medical facility or ambulance service assumes all responsibility for calculating medical expenses incurred by each patient, and bills them accordingly. The park is then reimbursed for its share of the medical expenses based on a supply list and/or odometer readings as recorded by the park EMS personnel for the medical services. It is recommended that DO-20 and RM-20 be consulted for additional information on instruments of agreement.

Cooperative agreements for reimbursement must contain the following information:

- A statement identifying both parties in the agreement
- Purpose of the agreement
- Period of performance
- Maximum funding amount
- Name and phone number of the NPS project manager
- Name and phone number of project manager for the other agency or business
- Agency Location Code
- Name and address where the bills should be sent
- Frequency of billings

- Type of bills (i.e., OPAC, 1080 or bill for collection)
- A statement regarding how amendments are handled
- Authorized signatures

Once the agreement is finalized, two copies must be sent to the region.

The cooperating service keeps records of the NPS activity provided to them on the ambulance run sheet. The collected funds are then remitted to a reimbursable account established by the park, on an agreed upon time interval (monthly, quarterly, etc.). These receipts will assist the park in obtaining medical equipment, supplies and training.

Examples of Memorandums of Agreement are available on request to park managers through the Branch Chief, Emergency Services. One example is shown in Exhibit 10.

13.3.3 Donations

Park areas may accept donations for medical rescue services provided by park operations. An account may be established and earmarked specifically for the purchase of medical rescue supplies and equipment. Donated accountable property must be recorded on the area's personal property records. The details are contained in NPS Staff Directive #84-1, *Donations Policy and Procedures*.

Visitor information about making a donation may be printed on a card and handed to them upon request. An example is shown in Exhibit 11.

13.3.4 Direct Billing

As noted above, the authority exists for parks to bill at cost for medical supplies and services. Once medical care has been rendered, the park prepares a bill of collection that is sent directly to the patient. When payment is received either from the patient or their insurance company, funds are deposited into an account earmarked for EMS. These funds can then be used to pay for expenses related to providing EMS services.

Fee schedules should be designed to recover expenses, but not to derive profit. Therefore, fees charged may be comparable to local EMS services, but may be higher or lower depending on factors including the remoteness of the park, the level of care provided, etc.

It is possible for parks to obtain Medicare provider numbers in order to be paid for patients who are Medicare recipients. Medicare payments are typically less than actual costs billed.

Because direct billing requires an administrative workload and potential non-payment losses, parks need to carefully weigh factors such as call-volume, ability to arrange third-party billing, and the availability of administrative support before undertaking a direct billing program.

13.3.5 Ambulance Restocking

Ambulance restocking is a common practice in many parts of the country, with hospitals and other healthcare providers replacing ambulance supplies that are used when a patient is either transferred to another ambulance or to the hospital facility. This allows the ambulance to be ready immediately in the event they are needed for another emergency.

On December 4, 2001, the Department of Health and Human Services Office of Inspector General issued a final safe harbor rule addressing ambulance restocking arrangements under the anti-kickback statute. By issuing this safe harbor regulation, healthcare entities that participate in ambulance restocking, and structure their arrangements according to the final rule, are exempt from liability or prosecution under the anti-kickback statute. The final safe harbor regulations outline three categories of restocking and most parks that provide ambulance service will qualify under the first category called “general restocking.” Refer to the final rule for details at www.access.gpo.gov/nara (Office of the Federal Register).

Exhibit 10

**GENERAL AGREEMENT
between
NATIONAL PARK SERVICE
SEQUOIA AND KINGS CANYON NATIONAL PARKS
and
THREE RIVERS AMBULANCE SERVICE**

This General Agreement is entered into between the US Department of the Interior, National Park Service, Sequoia and Kings Canyon National Parks (hereinafter referred to as "Park Service") and Three Rivers Ambulance Service, Three Rivers, California (hereinafter referred to as "Ambulance Service").

ARTICLE I. BACKGROUND AND OBJECTIVES

WHEREAS, the National Park Service is authorized under 16 USC 12 to render emergency assistance to visitors; and,

WHEREAS, National Park Service Management Policies, Chapter 7, Page 25, mandates the National Park Service to assure adequate emergency care and transportation services are available for visitors who are injured or ill; and,

WHEREAS, the National Park Service and local ambulance companies cooperate to provide emergency care and transportation services for visitors; and,

WHEREAS, the National Park Service contacts the local county emergency dispatcher (California Department of Forestry (CDF) in Tulare County), which dispatches the closest available ambulance service depending on geographic location and priority; and,

WHEREAS, 16 USC 1b5 allows for cooperating medical services (ambulance providers and hospitals) to bill patients and make payment to reimbursable accounts established by the Parks; and,

WHEREAS, this Agreement does not grant the Ambulance Service exclusive rights to provide ambulance or other emergency services, and similar agreements with other ambulance companies may be entered into by mutual agreement.

NOW, THEREFORE, the parties agree as follows:

ARTICLE II. STATEMENT OF WORK

1. The National Park Service and the Ambulance Service will transport and transfer sick and injured patients by the most efficient and expedient means possible. In a majority of circumstances, this means that patients will be transferred from the National Park Service's ambulance to the Ambulance Service's ambulance at various locations within Sequoia and Kings Canyon National Parks.
2. When such a patient transfer occurs, the crew of the National Park Service's ambulance will provide a Patient Pre-Hospital Incident/Medical Summary, commonly referred to as a "run sheet," to the staff of the Ambulance Service's ambulance. This run sheet will document the patient's medical condition from the time that care and transportation first began until the time of transfer to the Ambulance Service, and will include circumstances surrounding the medical incident. The run sheet will also include the one-way trip mileage of the National Park Service's ambulance for that particular trip.
3. The Ambulance Service will replace in kind medical supplies that are used by the National Park Service during the pre-hospital care and transportation of each patient. This included intravenous fluids, injection needles, medications and drugs, nasal cannulas, etc. Charges for these items will be levied against each patient's account.
4. The National Park Service will adopt the Ambulance Service payment schedule, including the Tulare County MIA, medicare, medical and any and all penalties for late payments. The National Park Service does not expect reimbursement when the Ambulance Service has not been paid. Any changes to the Ambulance Service ambulance rates will automatically be adopted into this agreement.
5. Within 30 days of the end of each quarter, the Ambulance Service will issue a financial statement to the Administrative Office, Sequoia and Kings Canyon National Parks. This statement will show the number of ambulance runs which occurred the previous quarter which involved the National Park Service ambulance by listing the patients name, the mileage of the particular run, and the charges for the National Park Service ambulance. This statement will also show any Balance Due to the National Park Service and an appropriate check for that amount will be enclosed and made out to the "National Park Service." Any collected funds will be placed in a reimbursable account of Sequoia and Kings Canyon National Parks.
6. The National Park Service assumes no responsibility for the collection and investigation of overdue accounts other that would normally be assumed under criminal or civil legal process. The National Park Service does not hold the Ambulance Service responsible for the collection of overdue accounts beyond their normal means and procedures.
7. The National Park Service shall retain liability responsibility pursuant to the Federal Tort Claims Act prior to transfer of said patients to the Ambulance Service.

8. The National Park Service will require each park medical personnel to conform to all applicable Hospital and Park Service policies, procedures and regulations. It is the hospital's responsibility to inform the National Park Service of all applicable hospital policies, procedures and regulations.

ARTICLE III. TERM OF AGREEMENT

The term of this Agreement is November 17, 1998 through November 16, 2003. Unless terminated pursuant to ARTICLE VIII below, this Agreement shall cover a period of five years at which time it will be reviewed to determine whether it should be renewed, modified or terminated.

This agreement shall be amended only by the mutual consent of the parties.

ARTICLE IV. KEY OFFICIALS

For Park: Superintendent
Sequoia and Kings Canyon National Parks
Three Rivers, California 93271
Telephone: 209-565-3101 Fax: 209-565-3730

Key Contact: Emergency Medical Services Coordinator
Sequoia and Kings Canyon National Parks
Three Rivers, California 93271
Telephone: 209-565-3790 (summer); 209-335-5545 (winter)

For Service: President, Board of Directors
Three Rivers Ambulance Service
P.O. Box 253
Three Rivers, California 93271
Telephone: 209-561-4264

ARTICLE V. PROPERTY MANAGEMENT AND DISPOSITION - Not used.

ARTICLE VI. PRIOR APPROVAL - Not used.

ARTICLE VII. REPORTS

The National Park Service agrees to provide records of medical incidents in individual and/or summary form as requested by the Ambulance Service for purposes of teaching and research and to provide annual summary statements as requested by the Ambulance Service.

ARTICLE VIII. TERMINATION

Either party may terminate this agreement upon sixty days advance written notice to the other party.

ARTICLE IX. STANDARD CLAUSES

1. Civil Rights

During the performance of this agreement, the participants agree to abide by the terms of USDI-Civil Rights Assurance Certification, nondiscrimination and will not discriminate against any person because of race, color, religion, sex, or national origin. The participants will take affirmative action to ensure that applicants are employed without regard to their race, color, religion, sex or national origin.

2. Officials Not to Benefit

No member or delegate to Congress, or resident Commissioner, shall be admitted to any share or part of this agreement, or to any benefit that may arise therefrom, but this provision shall not be construed to extend to this agreement if made with a corporation for its general benefit.

3. Promotions

The Ambulance Service shall not publicize, or otherwise circulate promotional material (such as advertisements, sales brochures, press releases, speeches, still and motion pictures, articles, manuscripts or other publications) which states or implies Governmental, Departmental, bureau or Government employee endorsement of a product, service, or position which the Ambulance Service represents. No release of information relating to this agreement may state or imply that the government approves of the Ambulance Service's work product, or considers the Ambulance Service's work product to be superior to other products or services.

4. Public Information Releases

The Ambulance Service must obtain prior government approval from the Service for any public information releases which refer to the Department of Interior, any bureau, park unit, or employee (by name and title), or this agreement. The specific text, layout, photographs, etc., of the proposed release must be submitted with the request for approval.

ARTICLE X. AUTHORIZING SIGNATURES

IN WITNESS HEREOF, the parties hereto have signed their names and executed this Memorandum of Agreement.

THREE RIVERS AMBULANCE SERVICE

NATIONAL PARK SERVICE

President
Board of Directors
Parks

Superintendent
Sequoia and Kings Canyon National
Parks

Date: _____

Date: _____

Exhibit 11

DONATION CARD



Thank you for your inquiry concerning a donation for Medical Rescue Services provided by National Park Service Rangers. If you would like to make a contribution to a fund established for medical rescue equipment, please send your gift to:

Superintendent
(PARK ADDRESS)

or call (PARK PHONE NUMBER)

Thank You from The Staff at (YOUR PARK)

Chapter 14

ASSISTANCE TO OTHER AGENCIES OUTSIDE OF PARK BOUNDARIES

- 14.1 Introduction
 - 14.2 Policy
 - 14.3 Guidelines
-

14.1 Introduction

The NPS is often called upon to provide emergency assistance outside the National Park System. Emergency assistance may include EMS being provided by NPS EMS providers. The following policy and guidelines are provided to help park managers understand how this assistance may be provided.

14.2 Policy

The authority for providing EMS assistance to neighboring communities and outside agencies is specifically provided for in 16 USC 1b (1), which allows the "Rendering of emergency rescue, fire fighting, and cooperative assistance to nearby law enforcement and fire prevention agencies and for related purposes outside of the National Park System."

The NPS may provide emergency assistance to other agencies outside of the park boundaries, so long as:

- The incident is an emergency,
- The incident it is in the vicinity or near the park,
- NPS personnel or resources have been requested,
- NPS personnel and resources have the proper certifications and authorizations needed to provide care, and
- The ability to provide appropriate emergency medical care within NPS areas is maintained.

14.3 Guidelines

NPS EMS providers assisting other agencies outside of the park must ensure that their certifications and authorizations allow them to do so. There are several ways that this can be accomplished:

- NPS providers may be certified and authorized by the state or other local agency.

- NPS providers may be certified by the National Registry of EMTs, and the state or local agency may recognize National Registry of EMTs credentials.
- The state may grant NPS EMS providers certification based upon reciprocity of National Registry of EMTs credentials, the credentials of another state, or the NPS EMS White Card.

NPS providers assisting other agencies outside of the Park remain Federal employees acting within the scope of their employment. Accordingly, NPS EMS providers must always act within their scope of practice and certification, even if that differs from other providers on the scene.

In order to provide external assistance, the NPS areas will establish written agreements with the agencies of jurisdiction. These agreements will specify that the NPS unit must maintain the ability to provide appropriate emergency medical care within the park, remain under the direction of the Park EMS Medical Advisor, follow NPS Field Manual of protocols and procedures, and include required certification, authorizations, and limitations specific to the agency with whom the agreement is made.

NPS EMS providers may be dispatched to an incident through the Interagency Incident Coordination System and may be assigned directly to a crew or to the Medical Unit. Those personnel assigned to provide EMS must be authorized by a Federal agency with jurisdiction or by the state in which the incident is occurring. This may be accomplished in the same manner as outlined above in sections 14.1-14.3.

Chapter 15

INSTRUMENTS OF AGREEMENT

- 15.1 Introduction
 - 15.2 Overview
 - 15.3 Procedures
-

15.1 Introduction

It is often necessary for parks to enter into agreements with physicians, medical groups, hospitals, ambulance providers and other entities in order to facilitate management of an EMS Program. Some EMS Programs, including ALS, EMT-Basic, and AED programs, require an agreement with a local Park EMS Medical Advisor. In other cases, it may be advantageous for the park to enter into a relationship with one or more local entities for purposes of online medical control, training, cooperative response, patient transportation, acquisition of equipment, and other forms of assistance. The appropriate type of instrument of agreement may differ in each case. This chapter outlines procedures for developing agreements and provides examples.

15.2 Overview

The NPS is authorized by law to enter into agreements with other agencies, organizations, and individuals to establish formal relationships that allow the NPS to more efficiently and economically accomplish its mission (DO-20, *Agreements*, Section 1.2, page 1). The NPS is not only allowed, but is encouraged, to enter into such agreements. According to DO-20 (Section 3.1, page 1), “NPS park and program managers should actively seek opportunities to efficiently and economically accomplish the NPS mission by entering into advantageous relationships with Federal and non-Federal entities.”

These relationships are formalized through the use of several different Instruments of Agreement that are outlined in this chapter. Specific policies and procedures regarding agreements not covered in this chapter can be found in DO-20 and RM-20, *Agreements*.

15.3 Procedures

The Instruments of Agreement currently authorized under DO-20 and RM-20 are the Cooperative Agreement, the Interagency Agreement, and the General Agreement, which include the agreements previously referred to as the Memorandum of Understanding and Memorandum of Agreement.

15.3.1 Interagency Agreements

According to DO-20, “the NPS will use Interagency Agreements only to document arrangements that entail the transfer of funds, goods, property, or services between the NPS and another Federal agency. When the purpose of the agreement is merely to document mutually-agreed-to policies, procedures, objectives, and/or relationships, with no funds, goods, property, or services exchanged, a General Agreement will be the instrument of choice.” (Section 3.4, page 2)

Interagency Agreements, which involve the receipt of funds from another Federal agency, do not require the signature of the NPS Contracting Officer (unless the other Federal agency requires it). Interagency Agreements which obligate NPS funds, however, must be reviewed and signed by a Level IIB Contracting Officer, and any obligation of NPS funds over \$250,000 must be reviewed by the Manager, Contracting and Procurement Program Office, WASO.

15.3.2 Cooperative Agreements

New statutory authorities (16 USC 1g, 16 USC 5933, and 16 USC 1a-2j) allow the NPS to make greater use of Cooperative Agreements than was possible in the past. In general, a Cooperative Agreement is used to “transfer money, property, services, or anything else of value from the NPS to a partner,” where the principal purpose of that assistance is “to carry out a public purpose of support or stimulation” between “the NPS and a state, local government, tribal government, or other non-Federal entity,” or “to carry out the public purpose of any National Park Service program,” or “to develop adequate, coordinated, cooperative research and training programs,” and “the NPS anticipates substantial involvement” in carrying out the proposed activity.

If an agreement does not meet the above definition, it will be a General Agreement rather than a Cooperative Agreement. In cases where the park does not anticipate participating to a great extent in the process, a contract may be a more appropriate instrument.

15.3.3 Cooperative Management Agreements

Cooperative Management Agreements are used for the acquisition or provision of supplies and services between the NPS and a state or local government agency when the purpose of that acquisition is cooperative management of an NPS, state or local resource. Policy guidelines are being developed for Cooperative Management Agreements and will be found in RM-20 when available.

15.3.4 General Agreements (previously Memoranda of Understanding and Memoranda of Agreement)

According to DO-20, a General Agreement is “a generic instrument used to document a wide range of mutually-agreed-to-policies, procedures, objectives, understandings and/or relationships with Federal and non-Federal entities” (Section 7.1, page 4). The term may be applied to any agreement that does not fit one of the definitions of Instruments of Agreement above. DO-20 provides a list of examples of General Agreements in Section 7.1 a-g, on page 4.

A General Agreement can not obligate the NPS to provide financial assistance or transfer NPS goods or services to any other entity (including Federal). However, a General Agreement may establish a working outline or framework of a program under which a future Cooperative Agreement or Interagency Agreement will be developed. General Agreements do not have to be reviewed or signed by a Contracting Officer (DO-20, Section 7.4, page 4). However, if the park or program manager developing the General Agreement has questions regarding legal implications of the agreement, they are “encouraged to consult with the office of the Solicitor” (Section 7.5, page 4). Solicitor’s Office review is also required for any fundraising agreement (Section 7.5, page 4).

Description

The term General Agreement covers the two agreements previously referred to as the Memorandum of Understanding and the Memorandum of Agreement. According to RM-20, Chapter 7, *Memoranda of Understanding*, “document a handshake” agreement by parties to use cooperative management policies or procedures, to provide mutual assistance, or to exchange results for promotion of common endeavors. A Memorandum of Understanding “must not commit the NPS to provide financial assistance in any form, nor transfer NPS property, goods, or services.” (RM-20, Chapter 7, page 167).

A Memorandum of Agreement allows a non-Federal entity to reimburse the NPS for supplies, property, or services. As noted above (Section D, paragraph 2), an Memorandum of Agreement can provide a framework that will allow the park to subsequently enter into a more expansive agreement, such as a Cooperative Agreement, but it can not, in and of itself, be used to expend NPS funds.

A General Agreement may be used in any situation in which either an Memorandum of Understanding or Memorandum of Agreement would previously have been the correct instrument of agreement.

Elements of a General Agreement

RM-20 provides a list of essential elements that must be included in every General Agreement in Chapter 7, Section 7.3 (page 169). For a detailed description of each element, refer to that chapter.

- General Agreement Number
- Background and Objectives
- Legislative Authority
- Statement of Work
- Term of Agreement
- Key Officials
- Prior Approval (if required)
- Reports and/or other deliverables
- Property Utilization (if any)
- Modification and Termination Clause
- Standard Clauses (see Section 7.4, RM-20)
- Signature and Dates of both parties

A General Agreement that involves receipt of funds must also include Award and Payment Information, including an Agreement Information Sheet (found in Attachment 7.6, RM-20), which must be provided to the Accounting Operations Center.

Other Considerations

RM-20 details signature requirements, reporting requirements, post-award administration, and agreements involving fundraising in Chapter 7. These sections should be carefully reviewed during the development of the General Agreement.

RM-20, Chapter 7 also includes a number of examples of General Agreement s and a sample Agreement Information Sheet.

Volunteers and Volunteer Agreements in EMS

Physicians and/or other medical personnel who are under contract with the Federal Government, charge for medical control or directorship, or are compensated in any other manner for (during) their assistance may not be appointed as VIPs. However, those providing medical assistance while in private practice may participate in the VIP program. If the physician is working outside the scope of his/her employment, (i.e., SAR) then the physician should be covered under a VIP agreement.

Compensation agreements with one park do not exclude medical personnel from entering into VIP (non-compensated) relationships with other parks.

Public Law 91-357 established that VIPs shall be considered employees for the purposes of the Federal Employee's Compensation Act relating to compensation of Federal employees for work injuries, and for claim provisions of the Federal Tort Claims Act.

The VIP may be issued a government drivers license and operate government vehicles if park management determines it to be in the best interest of the program. The program also authorizes the NPS to provide payment to the VIP for incidental expenses.

Exhibit 12

**SAMPLE GENERAL AGREEMENT
EMERGENCY MEDICAL SERVICES**

Agreement Number XX123450005

Page _____ of _____

**General Agreement
between
The United States Department of the Interior
National Park Service
and the
Life Support Company, Inc.**

[The introductory section should contain the name of the National Park and the name of the company as well as the signature officials. For example:

“This agreement is entered into by and between the National Park Service (hereinafter “NPS”), United States Department of the Interior, acting through the Superintendent of Example National Park, and Life Support, Inc. (hereinafter “the Company”), a private company located in Townville, acting through its CEO.]”

ARTICLE I - BACKGROUND AND OBJECTIVES

This section should explain what the objectives of the General Agreement are [i.e., to establish the standards, terms and conditions under which a company will perform certain tasks for the NPS]. Explain why this agreement is necessary. Explain what each party hopes to accomplish through this Agreement.

This section can be worded in a readable format. Unless requested or required by the private party with whom the NPS is making the Agreement, terms such as “Whereas” can be eliminated.

ARTICLE II – AUTHORITY

State the statutory authority simply: “The authority for this Agreement is 16 USC Section 12 (date), etc., etc.” You may summarize the authority in a statement as well.

ARTICLE III - STATEMENT OF WORK

State in simple outline form what each party has agreed to do:

A. The Company will:

- 1.
- 2.

B. The Park will:

- 1.
- 2.

ARTICLE IV - TERM OF AGREEMENT

“This Agreement will be effective for a period ...from the date of final signature, unless it is terminated earlier by one of the parties pursuant to Article IX that follows.”

ARTICLE V - KEY OFFICIALS

“All communications and notices regarding this agreement will be directed to the following key official(s) for each party:

- | | |
|--|--|
| A. For the NPS:
[Superintendent]
[Example National Park]
[Address]
[Contact numbers] | B. For the Company
[Insert Title]
[Insert Company Title] [Address]

[Contact numbers]” |
|--|--|

ARTICLE VI – PRIOR APPROVAL

Outline, in this section, what actions of either party require prior approval from the other party. This section may be used when one party uses equipment or supplies belonging to the other party; for example, use of a specific ambulance or rescue equipment may require prior approval. Specify whether there are laws or regulations affecting approval.

Specify whether it may be verbal or in writing and to whom it should be addressed. Include any other factors that may affect approval, such as time of day or year. If no prior approvals are required in the scope of this Agreement, specify “Not Applicable”.

ARTICLE VII – REPORTS AND/OR OTHER DELIVERABLES

Reports may include Patient Care Reports, billing reports, or other reports specific to the EMS field, but a report may also be the end product of the Agreement. “Other Deliverables” are products expected to be provided by the Company or the NPS to the other party under the terms of the Agreement. If not applicable, state “Not Applicable”.

ARTICLE VIII – PROPERTY UTILIZATION

Define how each party can use property of the other, if this is a factor in the Agreement. Make sure this section agrees with Section VI, Prior Approval, and Section VII, Reports and Other Deliverables. If not applicable, state “Not Applicable.”

ARTICLE IX – MODIFICATION AND TERMINATION

Specify whether modification or termination requires a written instrument. Specify how each party may terminate the Agreement, the time period required for termination, and any agreement regarding resolution of differences. Specify what will occur once the Agreement is terminated: must property be returned, purchased, replaced, or otherwise accounted for?

ARTICLE X – STANDARD CLAUSES

These clauses are required in every Agreement:

A. Civil Rights

During the performance of this Agreement, the participants agree to abide by the terms of U.S. Department of the Interior – Civil Rights Assurance Certification, non-discrimination, and will not discriminate against any person because of race, color, religion, sex, or national origin. The participants will take affirmative action to ensure that applicants are employed without regard to their race, color, sexual orientation, national origin, disabilities, religion, age, or sex.

B. Promotions

The Company will not publicize, or otherwise circulate, promotional material (such as advertisements, sales brochures, press releases, speeches, still and motion pictures, articles, manuscripts, or other publications), which states or implies governmental, Departmental, bureau, or government employee endorsement of a product, service or position, which the Company represents. No release of information relating to this Agreement may state or imply that the Government

approves of The Company's work product, or considers the Company's work product to be superior to other products or services.

C. Public Information Release

The Company will obtain prior Government approval from the NPS Superintendent for any public information releases which refer to the Department of the Interior, any bureau, park unit, or employee (by name or title), or this Agreement. The specific text, layout, photographs, etc., of the proposed release must be submitted with the request for approval.

The text of the above three standard clauses can be found in RM-20, Agreements, Chapter 7, Attachment 7.4. Other standard clauses may be required in Fundraising Agreements, for example: Liability, Non-discrimination, or Lobbying Prohibition. Text for these clauses can be found in RM-20, Agreements, Chapter 7, Attachment 7.3.

ARTICLE XI – SIGNATURES

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the date(s) set forth below.

FOR THE NATIONAL PARK SERVICE:

Signature: _____

Name: _____

Title: _____

Date: _____

FOR THE COMPANY:

Signature: _____

Name: _____

Title: _____

Date: _____

[Add the number and title of any following attachments at the bottom of this page

Chapter 16

LEGAL ASPECTS OF EMERGENCY MEDICAL SERVICES

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-

16.1 Introduction

Laws, statutes, regulations, policies, and procedures, as well as training and certification levels, have been established to protect patients as they move through the emergency care system. All of these considerations can affect how the Service operates, the equipment and supplies used, and the procedures we follow. NPS EMS providers have a responsibility to act in a manner that both ensures appropriate patient care and minimizes NPS and personal liability.

16.2 Overview

Monies may be awarded as a result of claims for damage or loss of property or for personal injury or death caused by the negligent or wrongful act or omission of an employee, or by violation of the Constitution or Federal statutes by an employee. Depending on the circumstances of the case, such damages may be awarded against the United States or against the employee.

This chapter defines terms and outlines procedures for assuring proper documentation and reporting, complying with OSHA and other Federal regulations, and assuring the rights of patients who come under the care of employees of the NPS.

16.3 Definitions and Descriptions

16.3.1 Malpractice

Malpractice cases are civil wrongs (suits or torts) alleging negligent action on the part of a professional such as a doctor, nurse, or EMS provider. Four specific elements must be proved:

- A duty to act
- Breach of that duty
- Compensable damages
- Proximate cause (the act or omission caused the damages)

16.3.2 Duty to Act

A duty to act is an obligation on behalf of the provider to provide treatment to a patient. The duty to act exists if the provider is functioning as an EMS provider as part of his/her job with a designated agency and is on-duty in the location in which the designated agency is responsible for EMS response. Duty to act may also be created by mutual aid agreements, formal or otherwise. The actions of acknowledging a call and agreeing to respond may be sufficient to create a duty to act (Cohn, 1998).

If a provider is not on-duty, a duty to act may still exist in some circumstances. If the provider responds to a call-out or offers services at an incident, a duty to act has been created. Some state statutes may also obligate anyone using state highways to stop and ascertain if aid is required at the scene of an accident (Cohn, 1998).

16.3.3 Abandonment

In EMS, abandonment means that the provider terminated care that he/she had a duty to provide. In the case of an EMS provider, the situation usually arises when the provider fails to assure that the patient has been formally turned over to another agency or professional when that patient requires ongoing care (Cohn, 1998).

In some cases, it is acceptable to turn a patient over to a provider with a lower level of qualification than the initial responder. This situation may arise when the patient's care needs clearly do not include the techniques possessed solely by the initial responder (i.e., ALS certification is not required for a patient with isolated bumps and bruises). The responder with a more advanced level of certification may be needed elsewhere. Turning a patient over to a provider with a lower level of qualification is not in itself abandonment.

16.3.4 Breach of Duty to Act and Standard of Care

A breach of duty to act is a "departure or derivation from good and accepted practice" (Cohn, 1998). The law asks what a "reasonably prudent person" would do in the same situation. The "good and accepted practice" is also referred to as the Standard of Care. Standard of Care differs depending on the level of certification of the provider. There are often several alternatives in a specific situation. The standard is defined through the used of textbooks; level of care provided by like providers in the community; state, Department of Transportation, and local protocols; and the agency's own operating procedures, policies, and rules.

16.3.5 Negligence

Simple negligence is “a failure to adhere to reasonable standards of care” (Cohn, 1998). It may also be an act or failure to act as another reasonable provider of the same level would have acted. Gross negligence occurs when the provider intentionally goes beyond his/her scope of practice and thus intentionally causes harm to the patient. It goes beyond simple negligence to the point of being reckless or dangerous.

16.3.6 Consent and Refusal

The informed consent of a patient is necessary before an EMS provider renders treatment (Cohn, 1998). Patients have the right to refuse treatment, except in certain special circumstances (detailed below). There are three essential elements that must be considered regarding consent:

- Legal capacity: Is the patient legally capable of consenting? The patient must be of legal age to consent (see exceptions below).
- Mental capacity: Can the patient understand his/her medical condition and the consequences of not being treated?
- Information: Has the patient been provided with sufficient information to make a reasonable decision?

There are three categories of consent:

- Informed consent: voluntary and based on the three factors above
- Expressed consent: the patient actually agrees, verbally or otherwise, to specific treatments
- Implied consent: not expressed, but implied from the conduct of the patient, because the patient is incompetent, or because the patient is a minor with no guardian available.

Patients do not have to consent to treatment. If a patient refuses treatment, evaluate the patient on the three elements above. If the patient is competent and informed, he/she can legally refuse treatment. There are several elements of refusal:

- Document the situation thoroughly, and have witnesses document it as well, if possible.
- Ask the patient again and enlist family and friends to help convince the patient to accept treatment.
- Advise the patient that he/she can change his/her mind at any time and suggest that he/she seek other medical help or advise.

Ask the patient to sign the Patient Refusal of Treatment on the Patient Care Report (included at the end of this chapter). In order to be valid, the refusal must be based upon adequate information regarding possible consequences and the elements of refusal listed above.

Special cases of consent and refusal

Minors

In general, EMS providers must obtain consent to treat a minor from the legal guardian. However, if the guardian is not present and there is a clear need to provide emergency care to prevent serious injury or death, consent is implied. A minor may also be emancipated in certain situations. A minor parent can consent to the treatment of his/her child, for example. In some cases, minors can be termed “mature,” or reasonable enough to consent to treatment despite chronological age.

Parental refusal to allow a child to be treated should be dealt with in the same way as any other refusal to allow care.

Incompetent adults

A patient is incompetent when he/she is unable to make a rational, informed decision regarding his/her condition or medical care. Causes of incompetence include head injury, shock, alcohol or drug use, mental illness, and other situations. Providers have an obligation to treat patients, but are not required to endanger themselves in order to do so. If a true emergency exists, assistance should be requested in order to transport an incompetent adult who is refusing treatment.

Do Not Resuscitate Orders (DNR)

A valid DNR is the same as any other patient refusal. However, when there is doubt as to the validity or applicability of a DNR, the provider should initiate care and document the situation thoroughly. The provider should also attempt to validate the DNR by contacting local medical control.

Prisoners in Custody

Competent prisoners have the same rights to accept or refuse treatment as anyone else. Incompetent prisoners may be treated as any other incompetent adult.

16.4 Policies and Procedures

16.4.1 Liability

The possibility always exists that a lawsuit may be filed against an NPS EMS provider for negligent or wrongful acts or omissions. However, the Federal Torts

Claims Act, 28 USC 2672 et seq., provides that no lawsuit for common law torts may lie against a Federal employee for damages to property or personal injury or death which results from the employee's negligent or wrongful conduct and which is within the scope of the employee's employment. The act provides absolute immunity for Federal employees from personal liability for common law torts within the scope of their employment and mandates that the exclusive remedy for common law torts is through an action against the United States.

The exclusive remedy provisions of the act do not extend to lawsuits that allege constitutional torts or violations of Federal statutes. In those situations, the Federal employee may be sued personally, and although the United States may represent the Federal employee, if there is an adverse judgment, it is the employee who is personally liable.

The Department of the Interior has taken steps to provide protection for its employees. The Department has adopted a statement of policy concerning indemnification of employees sued in their individual capacity. It is the policy of the Department, at the discretion of the Secretary, to settle or compromise lawsuits against employees by the payment of available funds, provided that the alleged conduct which gave rise to the personal damage claim was within the employee's scope of employment, and that it is in the interest of the Department to indemnify the employee. This policy is codified in 43 CFR 22.6.

16.4.2 Bloodborne Pathogens

The Occupational Safety and Health Administration (OSHA) is responsible for developing standards and guidelines to provide a safe working environment. The regulations promulgated by OSHA are codified in 29 CFR 1900-1999.

29 CFR 1910.1030 contains regulations pertaining to bloodborne pathogens. The purpose of the section is to limit occupational exposure to potentially infectious body fluids. It covers all employees who may be reasonably anticipated to have occupational exposure to body fluids.

The standard requires that each employer have the following:

- An Exposure Control Plan identifying employees who may have occupational exposure and the tasks performed by those employees that may create the exposure.
- The plan must detail methods of compliance, including mandating universal precautions, engineering and workplace controls, and appropriate personal protective equipment.
- The employer must make the Hepatitis B vaccine available to all employees with occupational exposure risks within 10 days of their assignment to the job

duties which place them at risk. A declination form must be signed by each employee who refuses the vaccination. The series must be offered at no cost to the employee.

- The employer must detail a post-exposure evaluation and follow-up procedure for exposed employees.
- The employer must use easily identifiable labels on containers used to transport or store biohazard.
- The employer must provide training at the time the employee is hired and annually thereafter. All employees must attend the training.
- Medical records must be kept confidential and kept on file for the term of employment plus 30 years.

Each park should develop its own Bloodborne Pathogens and Infectious Disease Control Plan, which may be included in the Park Safety Plan, Emergency Incident Management Plan, or EMS plan.

16.4.3 Mandatory Reporting Requirements

Virtually every state mandates that emergency services providers report certain specific types of incidents and conduct. Each park should provide a summary of the state's applicable reporting requirements to its EMS providers. All EMS providers should become familiar with state statutes regarding reporting requirements.

Incidents which must be reported in most states include:

- Suspected child or elder abuse
- Wounds from guns or knives
- Assaults
- Deaths
- Dog bites
- Rape and sexual assault and abuse
- Possession of controlled substances

In general, personnel who properly report suspected incidents or conduct meeting the above definitions are protected from civil liability arising from that reporting requirement or process.

16.4.4 Patient Confidentiality

Medical information about a patient will not be shared with any third party without the consent of the patient unless there is a legitimate medical or legal need to do so. Confidentiality applies to the written PCR, any other written notes,

and oral statements made by the patient (Cohn, 1998). However, only information necessary for the care and treatment of the patient is confidential.

Many states have specific statutes regarding patient confidentiality and what information may or may not be released, to whom. EMS providers should become familiar with the regulations and statutes in their respective states.

It is not necessary to obtain patient consent to release information necessary for proper patient care and transport during an incident, such as a patient status conveyed over the radio. PCR copies may also be given to other care providers. In addition, patient information may be reviewed for QA/QI by formal committees or QA/QI personnel. However, information may be shared among health-care providers only when it is necessary to provide appropriate patient care. This does not apply to informal discussions of patient injuries and care as long as the patient is not identified.

A patient may authorize the release of a PCR or other records by providing the NPS with a written request. This information may be forwarded to an attorney, physician, or other party if specifically requested by the patient in writing. Otherwise, it should be forwarded to the patient.

If the park bills for services, the patient usually must sign a release form directing payment. It may be necessary to release certain information regarding the incident to a third-party payer, such as an insurance company. Only the information necessary for billing should be provided.

Some states have laws requiring that PCRs be turned over to law enforcement personnel investigating criminal conduct that is related to the incident. If such a law is not present in the state, PCRs should be obtained via subpoena. EMS providers who are called to testify regarding events at which they provided EMS care may, upon advice of an attorney, refuse to answer questions which would violate patient confidentiality. These requirements differ from state to state and it is essential that EMS providers become familiar with the regulations in their respective state.

Without written consent, any use of photographs in which the patient can be identified may constitute an invasion of privacy. Photographs used to show nature of injury or mechanism of injury to emergency department personnel for medical purposes may not constitute an invasion of privacy.

Patient care reports and other reports that include patient information that can be connected to a specific patient may not be posted in public files.

Specific state laws may limit the release of HIV information, above and beyond the requirements for release of other patient information. EMS providers should become familiar with the state's statutes regarding HIV information.

16.4.5 Equipment

Unexpected failures of patient care and medical monitoring equipment can occur and have the potential for legal consequences. It is the responsibility of the provider to reduce potential liability by assuring that everything is in working order. Following are suggested steps:

- Analyze the intended use of a piece of equipment, the abilities of the end users, and the advantages and disadvantages of a variety of types or models before purchase or lease. Consider the track-record of the company providing the equipment and the equipment itself.
- Obtain all documentation regarding the equipment and use it for training and familiarization purposes. Keep it in a location where it is accessible to personnel using the equipment.
- Train personnel in all aspects of the equipment, including its use, indications for its use, contraindications, storage location, and maintenance requirements. Train on the actual model that will be used to eliminate operator error.
- Maintain maintenance records, inspections records, and records of service, parts replacements, breakdowns and problems, and how the problems were solved. Maintain equipment according to manufacturers' specifications. This includes vehicles. Develop a course of preventative maintenance for all equipment.
- Use up-to-date and modern equipment that meets the current industry standard.
- Develop standards for shift checks of equipment. (See Chapter 12, *Patient Transport and Emergency Vehicles*, for Exhibits.)

Make sure all operators of any equipment have the necessary licenses or certifications for that equipment and that they remain current.

16.4.6 Medical Control

Potential liability arising out of medical control communications and direction exists for both the online physician and the provider in the field (Cohn, 1998, page 133). The failure of an EMS provider to provide the emergency physician with complete and accurate assessment information may make it difficult for the physician to provide meaningful direction and may result in liability on the part of the provider. Other examples include failing to follow medical control's directions, administering medications or treatments without authorization, and failure to update assessment information.

The Medical Advisor can also be held liable, if he/she issues incorrect orders, refuses to authorize necessary treatments which it is within the provider's capability to perform, or directs the patient to the wrong facility.

Providers may refuse the Medical Advisor's directions under certain specific situations.

- The provider has been directed to perform procedures or administer treatments or medications which are beyond his/her scope of practice/level of certification or beyond the established protocols.
- The provider reasonably believes that the order would cause harm to the patient

In these cases, the provider must clarify the reported assessment information and indications the provider is observing and discuss treatment options with the online medical control. The circumstances involved in the refusal of the Medical Advisor's directions will be documented on the Patient Care Report (10-342) by the EMS provider.

16.4.7 Instructors

Instructor or training facility liability falls into several categories. Claims may be filed against instructors or facilities if students are subjected to discrimination, sexual harassment, or other actions illegal under Federal anti-discrimination law.

Claims for injuries suffered during classes may be made if the injury can be shown to be the result of negligence on the part of the instructor in some way (Cohn, 1998).

Patients who are injured by EMS providers may attempt to claim that the injury was the result of improper training of the provider by an instructor; however, these cases are very difficult to prove. Instructors can limit their own liability and the liability of the NPS by following official curricula and documenting each student's participation and proficiency in the class (Cohn, 1998).

16.4.8 Physicians on Scene

Occasionally a physician may be at or arrive at a scene of a medical emergency within the park. It is necessary to establish that such a physician has the qualifications to assume control, if that is their intention, and that they fully understand the consequences of such action. Most states have statutes covering such eventualities, and in general they include the following:

- The physician must be licensed in that state.
- The physician must accompany the patient to the hospital.
- Medical control must authorize the EMS providers to operate under the physician's control.
- The physician must sign the PCR accepting control of patient care.

If a physician takes control of patient care, the rest of the incident should continue to be managed by the park or cooperating agency incident response-trained personnel.

16.4.9 Hospital Selection

The selection of facility to which the patient will be transported can be based on many factors. In some parks, only one hospital may be available within a reasonable distance and time for patient transport, or only one hospital in the area may meet the obvious needs of the patient (i.e., one trauma center).

In other parks, a protocol or procedure may be developed containing an algorithm helpful for making destination decisions. In cases where selection of the destination is an issue, medical control should be contacted.

In some cases, patients may be able to choose their own destination based on reasonable information and advice. Problems arise when the patient chooses a facility outside the transport range of the park or transport service provider. In this case, the park may transport the patient to a specific location or transfer the patient to another service provider in order to facilitate eventual arrival of the patient at the facility of his/her choice. Options such as this should be based on area facilities and transport service agreements and should be discussed with medical control before the situation arises.

16.4.10 Dispatch

Park areas use a wide variety of dispatch services, ranging from in-park through county and other Federal agencies. In general, it is the responsibility of the dispatch office to obtain accurate and complete information, interpret that information to determine the nature of the emergency, contact and dispatch appropriate services, provide responders with accurate information, assist the caller in providing aid, and document the call accurately and in a timely manner.

16.4.11 Responding to Incidents While Off-Duty

In many cases, EMS responders may utilize park areas while off-duty and may therefore respond to in-park incidents while technically off-duty. In general, once an off-duty EMS provider has responded to an in-park emergency, he/she will be

considered on-duty, with a duty to respond and act within park protocols and policies, given the fact that usual equipment may not be available. The provider will be covered under the Federal Tort Claims Act for suits alleging simple negligence.

EMS providers may also encounter incidents outside park boundaries while off-duty. In these cases, the EMS provider should identify him/herself to citizens and providers on-scene, and should repeat that identification whenever a new provider arrives. This identification should include level of certification, and scene control and patient care should be released to an on-duty responder with a higher level of certification when that responder arrives. The EMS provider will follow the directions of the on-scene control and stay on-scene if requested until released, and not interfere if the offer of help has not been accepted.

The NPS EMS provider may request to use equipment at the scene, but in general the on-scene providers must contact their medical control before giving such permission, and their medical control may refuse to accept intervention, as skills and certification of the EMS provider cannot be verified by them or may not be valid in that jurisdiction.

The EMS provider should document everything he/she did and observed at the scene afterwards. The EMS provider also may want to make an official report to his/her supervisor or park, depending on the circumstances and location of the incident.

“Good Samaritan” laws have been passed in nearly every state. These statutes limit the liability of passersby and in some cases trained professionals in emergency assistance situations (Cohn, 1998). They typically provide that a person who renders emergency care voluntarily to another person (as in the case of an off-duty EMS provider on non-NPS property) is liable only for gross negligence (see above).

In *Flynn v. United States* (10th Cir. 1990), the 10th Circuit held that off-duty NPS officers who rendered assistance at an accident outside of the boundaries of the park, benefited from the Utah Good Samaritan statute. In that situation, the officers were under no duty to act and did so voluntarily, and thus were covered by their state’s Good Samaritan Act against negligence claims.

Literature Cited

Cohn, Bruce M., JD, EMT-CC, and Alan J. Azzara, JD, EMT-P. *Legal Aspects of Emergency Medical Services*. W.B Saunders Company, 1998.

Chapter 17

PRINCIPLES AND CODE OF ETHICS

- 17.1 Principles
 - 17.2 Goals
 - 17.3 EMS Code of Ethics
 - 17.4 Basic Obligation of Public Trust
-

17.1 Principles

17.1.1 Objectivity

All action taken by EMS providers should be directed toward accomplishing the mission of the NPS. EMS is one method to achieve this goal but is not a goal unto itself.

17.1.2 Adaptability

NPS EMS Programs offer as many unique assignments as there are areas within the system. It is essential that the EMS provider develop the confidence and flexibility necessary to adjust to the different attitudes and procedures that exist throughout the country. Rangers should be able to cultivate the support and cooperation of the public in the Service's operations, as citizen approval is essential to an effective program.

17.1.3 Integrity

Public respect is essential to any EMS Program. To establish this respect, the provider must always render care in good faith and within the scope of training.

17.1.4 Versatility

National Park rangers are much more than EMS providers; they are protectors of park resources and the public welfare. They must possess the ability to perform other visitor services and be adept in all facets of visitor use management and resource protection required by their current assignment.

17.1.5 Compatibility

The role of the EMS provider is just one of several directed at the same mission. The ranger must have the capacity to understand the purpose and function of these

other activities, and must be able to work in concert with others in pursuit of the common goal.

17.2 Goals

The goals of the NPS EMS Program are as follows:

To preserve life, to alleviate suffering, to promote health, to do no harm, while ensuring the quality and equal availability of EMS. This service will be provided based on human need with respect for human dignity, unrestricted by considerations of nationality, race, creed, color, religion, sex, disability or status.

17.3 EMS Code of Ethics

I will faithfully abide by all laws, rules, regulations and policies governing the performance of my duties and I will commit no act that violates these laws or regulations, or the spirit or intent of such laws and regulations while on or off duty.

In my personal and official activities, I will never knowingly violate any local, state, or Federal law or regulation, recognizing that I hold a unique position of public trust that carries an inherent personal commitment. I understand that this code places special demands on me to preserve the confidence of the public, my peers, my supervisors, and society in general.

I will commit no act in the conduct of official business or in my personal life that subjects the Department of the Interior or the National Park Service to public censure or adverse criticism.

While an EMS provider, I will neither accept outside employment nor make any display, representative of the Department of the Interior or the National Park Service that will in any way conflict with the interests or jeopardize the activities or mission of the Department of the Interior or the National Park Service, or give the appearance of conflict.

As an EMS provider, I will maintain professional competence and demonstrate concern for the competence of other members of the EMS health care team.

I will always place the safety and welfare of a patient, and my safety above all else during an emergency medical services incident.

As a representative of the Department of the Interior and National Park Service, I will render emergency care impartially and in good faith, and document the results thereof fully, objectively, and accurately.

As an EMS provider, I will work harmoniously with, and sustain confidence in, other members of the emergency medical services health care team.

In all cases, I will refuse to participate in unethical procedures, and assume the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner.

In the course of rendering care and throughout the incident I will be judicious at all times and I will release information pertaining to my official duties, orally or in writing, only in accordance with the law and established policy.

I will respect and hold in confidence all information of a confidential nature obtained in the course of my duties unless required by law to release such information.

In connection with my official duties, I will accept no gift, gratuity, entertainment or loan except as provided by Departmental regulations.

Chapter 18

PERFORMANCE AND CONDUCT

- 18.1 Policy
 - 18.2 Boards of Inquiry
 - 18.3 Boards of Review
-

18.1 Policy

Board of Inquiry

When an EMS provider's performance does not indicate compliance with Servicewide policies or established standards of care, or any behavior that calls into question his/her suitability to perform EMS, supervisors must take prompt action. Such actions may include training, counseling, suspension of authority to perform EMS (White Card), or disciplinary or adverse action as appropriate. This action may also include the recommendation to convene a Board of Inquiry.

Boards of Inquiry are convened for the purpose of making a focused inquiry into allegations of misconduct on the part of one or more individuals, or other work-related behavior that impairs operational efficiency or causes the loss of public confidence in the NPS.

Findings and recommendations of Boards of Inquiry should be applied, where appropriate, to bring about needed changes or modifications to the NPS EMS Program, and where appropriate, should be incorporated into incident summaries and training bulletins disseminated to the field to facilitate learning through the documented experiences of others.

The requirements to conduct such a board, under certain specific circumstances, do not relieve supervisors or managers of their responsibilities to provide ongoing review and evaluation of NPS EMS Programs and the individual actions of EMS providers.

Copies of all Boards of Inquiry will be provided to the Branch Chief, Emergency Services.

Boards of Review

Significant EMS incidents require a thorough and objective review. These actions or incidents should be the subject of a Board of Review.

A Board of Review differs from a Board of Inquiry in that it is not a fault-finding exercise and is not focused on the actions or conduct of individuals. A Board of Review is a fact-finding body that objectively reviews significant EMS actions or incidents. It serves the same function (and may otherwise be known) as an “incident critique,” “incident review,” or “after-action review.” The primary purpose of the review is to identify organizational strengths and weaknesses, to take corrective program action where appropriate, and to build upon successes.

Boards of Inquiry and Boards of Review will be conducted in accordance with the procedures specified in this chapter.

18.2 Board of Inquiry

18.2.1 Convening a Board of Inquiry

18.2.1.1 Authority to Establish

A Board of Inquiry may be convened only upon approval of a one of the following:

- Director
- Regional Director
- Chief, Law Enforcement and Emergency Services
- Superintendent

18.2.1.2 Membership

A Board of Inquiry will consist of at least three but not more than seven voting members. The immediate supervisor of the employee whose actions are being reviewed will not be included as a member of the board. Board members will be chosen as follows:

The employee whose actions are being scrutinized may select one other NPS employee as a member of the board. This employee may be anyone within a 500-mile radius who was not involved in the incident. If the employee whose actions are being reviewed declines to select a board member, the convening official will appoint an EMS provider who is of the same grade and whose duties are similar to those of the employee whose actions are being reviewed.

- One member will be a park manager selected by the convening official.
- A qualified personnelist.
- All other voting board members will be EMS personnel from within or outside of the NPS.
- Where training may be an issue or factor, one member will be a recognized

training specialist selected by the Park Superintendent.

18.2.2 Functions and Procedures of a Board of Inquiry

18.2.2.1 Functions of Board

At a minimum, the functions of a Board of Inquiry include the following:

- Finding the facts and circumstances of the incident, situation, or conduct being reviewed and those that may have contributed to it.
- Identifying legal and policy requirements that apply to the facts of the incident, situation, or conduct and determining compliance with those requirements by all individuals involved.
- Conducting an objective critique of the incident, situation, or conduct, including a review of applicable operational procedures.
- Making written findings to the convening official for the purpose of recommending corrective action, including disciplinary action. The board's recommendations may address, as appropriate, the areas of policy, procedures, equipment, training, counseling, the continuation of the suspension of a White Card, or the revocation of a White Card.

18.2.2.2 Preliminary Arrangements

The convening official is responsible for coordinating and making all necessary arrangements for the board. This includes making all board assignments, consistent with policy.

18.2.2.3 Scheduling

The convening official is responsible for scheduling the board as soon as practical, considering the circumstances of the incident, situation, or conduct, but no later than 60 days from the date a determination is made that a Board of Inquiry is required.

18.2.2.4 Consultation

In a case where there is a reasonable likelihood of criminal prosecution or tort claim action as a result of the incident, the regional solicitor's office and the U.S. Attorney's Office will be consulted before the board is convened. The directions of the Solicitor or U.S. Attorney may, as necessary, affect compliance with other sections of this chapter (especially with respect to time lines).

18.2.2.5 Chairperson

When convening a Board of Inquiry, the convening official will appoint a chairperson to lead its deliberations.

18.2.2.6 Record Keeping

The chairperson is responsible for ensuring that a record is maintained of all information gathering proceedings of the board, including all testimony presented and all written material reviewed by the board. Oral testimony will be tape recorded for the board's later use in its deliberations and for the record. Internal discussions and deliberations of the board that occur after all relevant information has been presented "may" be off the record. The record must reflect the issues, findings, rationale for findings, and recommendations of the board.

18.2.2.7 Notification to Employee

The chairperson will inform the employee, whose actions are being reviewed, in writing, of the specific allegations being made against him/her, including citation of relevant sections of DO-51 and RM-51, specific incidents, or patterns of behavior. This notification will occur as soon as possible, but no fewer than 2 weeks before the board holds its first meeting.

18.2.2.8 Employee Rights

The employee whose actions are being reviewed has the following rights:

- The employee may remain present during all meetings of the board, but will be excluded from the board's decision-making deliberations.
- The employee may be accompanied by an attorney, provided at the employee's expense, during all meetings of the board. The attorney's role, however, is limited to that of an observer and an advisor to his/her client. The attorney may not question witnesses, may address the board only with the consent of the chairperson, and will not be present during the board's deliberations.
- The employee may request the testimony before the board of any NPS employee, including his/her supervisor or subordinate, who has knowledge of facts related to the case being reviewed. If the employee is covered by a bargaining unit, a representative of that organization may be present, at the employee's request, during the meetings of the board. The representative's role, however, is limited to that of an observer and an advisor to the employee. The representative may not question witnesses, may address the board only with the consent of the chairperson, and will not be present during the board's deliberations.

18.2.2.9 Witnesses

Subject only to other legal precedence, the board is authorized to require the appearance and testimony of any NPS employee who has knowledge of facts related to the case being reviewed. The board is also authorized to bring in subject matter experts to assist in its review.

18.2.2.10 Past Record

When considering the revocation of a White Card, the board may consider the employee's past record of performance and professional conduct, including previous performance appraisals, awards, and disciplinary actions received.

18.2.2.11 Exigent Circumstances

Deviation from policies, directives, and other restrictions articulated in DO-51 and RM-51 may be warranted in certain emergency situations. Boards evaluating such actions may exercise reasonable discretion in finding that non-compliant actions on the part of an EMS provider were, nevertheless, reasonable under existing emergency conditions. Where such a finding is rendered, the involved employee may, at the board's recommendation, be held free from fault and/or disciplinary action.

18.2.2.12 Disclosure

Internal deliberations of a board are confidential, consistent with the Privacy Act and other administrative procedures designed to protect all employees. The board's open record and final report, however, are public documents and should be prepared accordingly. Additionally, the Branch Chief, Emergency Services may edit and utilize selected materials from the board to develop case summaries for distribution in training applications.

18.3 Board of Review

18.3.1 Convening a Board of Review

18.3.1.1 Authorization to Convene

A Board of Review may be convened by one of the following or their designees:

- Chief Park Ranger
- Superintendent
- Regional Director
- Chief, Law Enforcement and Emergency Services, WASO

18.3.1.2 Membership

The convening official will designate the membership of the board. The board will consist of at least three, but not more than seven members.

18.3.2 Functions and Proceedings of a Board of Review

18.3.2.1 Functions of a Board

At a minimum, the functions of a Board of Review include the following:

- Finding the facts and circumstances of the incident, situation, or actions being reviewed and those that may have contributed to it.
- Identifying legal and policy requirements that apply to the facts of the incident, situation, or action evaluating compliance with those requirements by all individuals involved.
- Conducting an objective critique of the incident, situation, or conduct, including a review of applicable operational procedures.
- Based upon the facts of the incident, situation, or action, making written findings and recommendations to the Park Superintendent for the purpose of recommending corrective action. The board's recommendations may address, as appropriate, the areas of policy, procedures, equipment, training, or other general EMS Program issues.
- Where a Board of Review is initially convened but findings revealed during or as a result of the hearings disclose that disciplinary actions may be warranted against an EMS provider, the board may proceed but will include within its report a recommendation that a Board of Inquiry subsequently be convened. This report will state the reason(s) for the Board of Inquiry.

18.3.2.2 Preliminary Arrangements

The Park Superintendent of the affected park is responsible for coordinating and making all necessary arrangements for the board.

18.3.2.3 Scheduling

The convening official will schedule the board as soon as practical, considering the circumstances of the incident, situation, or action, but no later than 60 days from the date a determination is made that a Board of Review is called for.

18.3.2.4 Consultation

In a case where there is reasonable likelihood of tort claim action as a result of the incident, the Solicitor's Office, the U.S. Attorney's Office, and the state prosecuting attorney's office (if that office is to assume jurisdiction) will be consulted before the board is convened.

18.3.2.5 Chairperson

When convening a Board of Review, the Park Superintendent will appoint a chairperson to lead its deliberations.

18.3.2.6 Record Keeping

The Chairperson is responsible for ensuring that a record is maintained of all information gathering proceedings of the board, including all testimony presented and all written material reviewed by the board. Oral testimony may be tape recorded for the board's later use in its deliberations and for the record. At the discretion of the chairperson, internal discussions and deliberations of the board that occur after all relevant information has been presented may be off the record.

18.3.2.7 Witnesses

The board is authorized to require the appearance of any NPS employee who has knowledge of facts related to the case or incident being reviewed. The board is also authorized to bring in subject matter experts to assist in its review.

18.3.2.8 Disclosure

Except where otherwise directed by the Regional Solicitor or the U.S. Attorney's Office, deliberations, conclusions, and records of a board are considered internal documents and confidential during the investigation. The board's final report, at the conclusion of the investigation, is public document and should be prepared accordingly.

Chapter 19

PUBLIC INFORMATION AND EDUCATION

- 19.1 Introduction
 - 19.2 Overview
 - 19.3 Guideline
-

19.1 Introduction

The Freedom of Information Act, 5 USC 552, and Department of the Interior regulations, 43 CFR 2.13, are based upon a long standing recognition of the public's right to obtain information about government operations and activities. This right is balanced by limitations contained in the Freedom of Information Act and further restricted by provisions of the Privacy Act, 5 USC 301, 552, and 552(a) and 43 CFR Part 2, Subpart D.

While there is no distinction made between the general public and representatives of the news media concerning the criteria to withhold or release information, a distinction is applicable with respect to the gathering of information in the field by the news media and others. Concerns for the safety of field personnel, media representatives and others, must guide public information strategies in field situations.

The purposes of this chapter are to:

- Ensure regulatory and policy compliance with respect to information release,
- Establish appropriate guidelines concerning relations with representatives of the media,
- Promote education of EMS related subjects, and
- Ensure that methods of obtaining follow-up patient information are established as part of a Continuing Quality Improvement program.

19.2 Overview

The NPS shall provide information to the public and the news media, consistent with applicable laws, Departmental Policy, and NPS Guidelines.

Relationships with media representatives shall be based on the right of the public to obtain access to information, the effective discharge of EMS responsibilities and the safety of all persons involved in EMS incidents.

19.3 Guidelines

19.3.1 Public Information Officer

The Park Superintendent shall designate one or more staff members to be responsible for responding to EMS information requests. These staff members shall familiarize themselves with the regulations codified in 43 CFR Part 2 and should establish close cooperation and liaison with representatives of the news media in order to foster sound working relationships and to communicate NPS policies effectively, in advance of actual incidents.

19.3.2 Document Search

A request for information must be in writing and specific to the point of being sufficient to identify the particular record(s) sought. If a request requires an inordinate amount of time and effort to make a response, the Park Superintendent may elect to charge for the services as provided for in 43 CFR Part 2.

19.3.3 Disclosure Guidelines

Persons requesting information are entitled to view the document and/or receive a copy in which the information is contained. If there is information in the document that is to be withheld, it should be covered over on the original or deleted from the copy. The requestor must be informed that a deletion has been made.

The PCR, whether a dedicated form or a 10-343/344, is subject to patient confidentiality requirements. They may not be open to Freedom of Information requests. Contents of the records can be given out only when the patient authorizes a release, when subpoenaed by courts for evidence, or when state law requires the reporting of certain incidents. EMS run sheets should not be routinely attached to law enforcement forms.

If park practice requires the EMS provider to submit a Case Incident Record in addition to the run sheet, details of the patient assessment and treatment should be left out. A brief synopsis of the type of medical call is all that should be included. The following information also should not be made available:

- The names of deceased or seriously injured persons, until the next-of-kin are notified
- Grisly details that are not necessary to publicize and that do not alter the basic facts of an incident
- The home address or home telephone number of NPS personnel or others involved in the incident

- Information from individual personnel files and/or medical records of employees
- Requests for information contained in reports of concern to other bureaus or agencies, shall be immediately referred to the Park Superintendent
- Information requests in criminal cases where EMS was involved such as homicides, sex crimes, etc., should be treated as per the law enforcement guidelines in NPS 9, Section III, Chapter 11

19.3.4 Media Relations

At the scene of an accident, legitimate representatives of the news media shall be allowed access to areas normally and legally restricted from the general public as long as access does not interfere with EMS operations and, in criminal cases, the preservation of evidence.

If the safety of media representatives would be jeopardized, they should be informed and restricted from the scene. If the safety of NPS personnel would be jeopardized by media presence in a hazardous area or situation, justification exists to restrict media representatives from the scene.

19.3.5 Park EMS Quality Assurance and Patient Follow-up Information

Personal information such as the patient's name, address, etc., should be deleted from records when the incident is reviewed for quality improvement and educational training.

19.3.6 Education

Parks may use a variety of ways to educate park users by utilizing historical data from past incidents. Slide programs using some details and photos from careless situations or other activities might be considered. Information or photos about incidents should be used in a manner that appropriately considers privacy rights. Climbing, boating, hiking or other such recreation programs should emphasize EMS skills whenever necessary.

Public Education responsibilities of EMS systems are addressed in the NHTSA publication *Agenda for the Future*. It states, "Public education, as a component of health promotion, is a responsibility of every health care provider and institution. It is an effort to provide a combination of learning experiences designed to facilitate voluntary actions leading to health.... Public education is an essential activity for every EMS system."

Parks are encouraged to participate in community health care activities. This could include: providing community EMS education training, participating in

community Health Fairs, soliciting appropriate volunteers in EMS and fostering close working relationships with community health care providers.

Chapter 20

The National Park Service EMS Field Manual

- 20.1 Introduction
 - 20.2 Overview
 - 20.3 Policy
 - 20.4 Guidelines
-

20.1 Introduction

The purpose of this chapter is to establish the NPS EMS Field Manual as a series of procedures, protocols and drugs (NPS EMS Standard of Care) that are approved for use by all employees of NPS performing EMS at the Basic EMT, (Level VI) and EMT Intermediate/Parkmedic (Level V). The U.S Park Police Aviation Unit will develop Paramedic Procedures and Protocols separate from the NPS EMS Field Manual.

20.2 Overview

NPS areas that provide patient care at Level IV, V and VI are required to have a Medical Advisor to oversee the Park EMS Program. Park EMS Medical Advisors will require that EMT's perform at a standard of care that is consistent with local, regional and national standards of care. The NPS EMS Field Manual is an effort to standardize drugs, procedures and protocols over all NPS units with emergency medical programs.

20.3 Policy

All parks (not including the U.S. Park Police Aviation Unit) with Level IV and above EMS services, working with Park Medical Advisors and Park EMS Coordinators will become familiar with the NPS Field Manual. The Field Manual will be an integral part of the continuing education process along with the semi-annual 24-hour EMT Refresher.

Park EMS Coordinators and Park Medical Advisors will ensure that EMT's are held accountable for the knowledge, skills and practices outlined in the NPS Field Manual. This will be accomplished through written and practical periodic examinations designed by the Park EMS Coordinators and Park Medical Advisors.

Signature of Approval of the NPS EMS Field Manual will be delegated to the Branch Chief, Emergency Services.

20.4 Guidelines

20.4.1 National Park Service EMS Field Manual

The NPS EMS Field Manual will be administered by the Branch Chief, Emergency Services with the recommendations of the National EMS Medical Advisors. The two National EMS Medical advisors will work closely with the Branch Chief, Emergency Services to ensure that the NPS Field Manual stays current and that corrections, additions and deletions are distributed to the field.

20.4.2 Making changes, corrections, deletions and deviations from the NPS Field Manual

There will likely be instances in which parks will want to deviate from the NPS EMS Field Manual. Parks need to have the ability to develop levels of patient care that are consistent with local and regional standards of care. Further parks need to have the option to develop procedures, protocols and drugs that are designed to meet the needs of the individual park since there are a wide range of needs, environments and types of EMS incidents in the NPS system.

A Park EMS Coordinator, working with the advice and direction of the Park EMS Medical Advisor can put forth a written proposal to add, change or delete a protocol or procedure or drug from the NPS Field Manual.

The Park EMS Coordinator will submit the proposal to the Branch Chief, Emergency Services. The Branch Chief, Emergency Services will consult with the National EMS Advisors and based on their recommendation, the Branch Chief, Emergency Services will approve or disapprove the proposal with a written justification. The process will occur within 30 days of the Branch Chief, Emergency Services receiving the proposal (preferably in electronic format)

20.4.3 The Appeal Process

Proposals not approved may be appealed in writing within 60 days. A seven-member Appeals Board will be established by the National EMS Advisory Group. The Appeals Board will consist of four Park Medical Advisors and three Park EMS Coordinators selected from unaffected parks. The Board will select a Chairman. The Board will review the proposal and either sustain, overturn or send the proposal back to the Branch Chief, Emergency Services for further review. No appeal is available beyond the Appeals Board. The Appeals Board decision is final. The decision of the board will be recorded for historical purposes in a memorandum to the Branch Chief, Emergency Services and filed with the WASO EMS Office.

Chapter 21

Medical Advisors Manual

- 21.1 Introduction
 - 21.2 Policy
 - 21.3 Guidelines
-

21.1 Introduction

A key element of the NPS EMS Program is the recruitment, development and retention of Park Medical Advisors. Park Medical Advisors are the backbone of the Park EMS system providing critical advice and direction to park EMS systems and programs.

21.2 Policy

Parks with Level IV and above EMS systems, parks with AED's and parks with Level III programs that have skill sets that require medical control (such as an epinephrine or oxygen protocol) will recruit and retain the services of a Park EMS Medical Advisor. Park EMS Medical Advisors need to have a guideline to define the task of a Medical Advisor and assist the Medical Advisor with understanding the park and national EMS system.

This Reference Manual authorizes the development of a Medical Advisors Manual. The manual will be maintained and authorized by the Branch Chief, Emergency Services with the guidance and council of the National EMS Medical Advisors.

21.3 Guidelines

The Medical Advisors Manual is designed to assist Park EMS Medical Advisors and Park EMS Coordinators by delineating and describing the duties and responsibilities of a Park EMS Medical Advisor. It describes the levels of NPS EMS providers and their scopes of practice, provides advice on how training, continuing education, quality improvement, and operational issues can be addressed. It provides references for more detailed information and resources available to the Park EMS Medical Advisor. It should ideally be reviewed in conjunction with the DO-51 and this Reference Manual. This Reference Manual also includes the NPS EMS Field Manual, containing the Protocols, Procedures and Drugs approved for use at the EMT Basic and Parkmedic levels.

Section 1 of the Medical Advisors Manual references resources for those who have limited or no EMS Medical Advisor experience. The remainder of the handbook focuses on the more unique aspects of providing EMS Medical Direction within the NPS. The Medical Advisors Manual is not designed to be all encompassing, but rather, a resource that will direct the reader to other sources and references for questions that are not answered in the body of the text. Several appendices are included for reference purposes:

- NPS EMS Field Manual - Table of Contents
- Sample Continuing Education Schedule
- National Park Service Hierarchy
- EMS Coordinator Job Description

See the NHTSA website and search for the document titled *Guide for Preparing Medical Directors*, for additional references, or ask the Branch Chief, Emergency Services for a copy of the publication.

APPENDIX A

Medical Advisor Manual

1. Introduction
 2. General EMS Medical Direction
 3. Terminology and Definitions
 4. Levels of EMS provider in the NPS
 5. Training, Continuing Education and Scope of Practice
 6. Continuous Quality Improvement
 7. Operations
 8. Administration
 9. Resources/Information
-

1. Introduction

This manual is designed to assist Park EMS Medical Advisors and EMS Coordinators by delineating and describing the duties and responsibilities of a Park EMS Medical Advisor. It describes the levels of NPS EMS providers and their scopes of practice, provides advice on how training, continuing education, quality improvement, and operational issues can be addressed and provides references for more detailed information and resources available to the Park EMS Medical Advisor. It should ideally be reviewed in conjunction with a copy of DO-51 and RM-51. RM-51 includes the NPS EMS Field Manual, containing the Protocols, Procedures and Drugs approved for use at the EMT-Basic and Parkmedic levels. (See sections 3 and 4 below and Appendix 1, the Table of Contents from the NPS EMS Field Manual.) These documents can be obtained through your Park EMS Coordinator.

Section 1 of this manual references resources for those physician that have limited EMS Medical Direction experience. The remainder of the handbook focuses on the more unique aspects of providing EMS Medical Direction within the NPS. This handbook is neither definitive nor exhaustive, but designed as a resource and as such, is not intended to restrict Park EMS Medical Advisors in how they operate. Several appendices are included for reference purposes:

- NPS EMS Manual Table of Contents
- Sample Continuing Education Schedule
- National Park Service Hierarchy
- EMS Coordinator Job Description

2. General EMS Medical Direction

Familiarity with the basics of EMS Medical Direction is key to successfully fulfilling the role of a Park EMS Medical Advisor. If needed, information on general EMS Medical Direction can be obtained through the following resources. It is recommended that new Park EMS Medical Advisors review at least one of the Medical Direction publications listed below if they are not already familiar with this information.

American College of Emergency Physicians (ACEP)

Website.....www.acep.org

Publications.....Medical Direction of Prehospital Emergency Medical Services, (also see the joint publication listed below)

National Association of EMS Physicians (NAEMSP)

Website..... www.naemsp.org

Publication..... see the joint publication listed below

Courses..... Medical Direction: National Standard Curriculum

National Highway Transportation and Safety Authority (NHTSA)

Website..... www.nhtsa.dot.gov

Publications..... 1. Guide for Preparing Medical Directors

This is the recommended resource if you are new to the role of EMS Medical Direction. It is a joint publication of NHTSA, ACEP, AEMSP and Health Resources and Services Administration and can be ordered or downloaded through NHTSA at

www.nhtsa.dot.gov/people/injury/ems/products.htm

2. A Leadership Guide to Quality Improvement for EMS Systems Courses.....Several are sponsored by NHTSA and are usually offered through state or local EMS Authorities. Specific courses and dates are listed on their website. Some you might consider are those on EMS Medical Direction, continuous quality improvement in EMS Systems and Data Management

3. Terminology and Definitions

Park EMS Medical Advisor: Within the Federal government, “Directors” are employees. As the vast majority of Medical Advisors are working as volunteers in unpaid positions, this term is more accurate. Additionally, and perhaps more importantly, designation as a Medical Advisor allows Volunteer-in-Park status to

be extended to the Medical Advisor, thus giving him/her significant tort claim protection.

EMS Coordinator: This position is held by a Park Ranger who has been tasked with managing the EMS system within a park or sometimes multiple small parks/park areas. He/she is the primary link between the park and the Park EMS Medical Advisor. The assignment as an EMS Coordinator is most often a collateral duty designated a percentage of the ranger's time, typically 10 to 20%. (See Appendix 4)

*More detailed descriptions of these positions, as well as additional related positions, can be found in RM-51, Chapter 3, and Section 3. Also the unique Parkmedic (Level V) designation is detailed in Section 4 below.

4. Levels of EMS provider in the NPS

- Level 1: CPR AED Provider
- Level 2: Basic First Aid Provider
- Level 3: First Responder
- Level 4: EMT-Basic
- Level 5: Parkmedic (Parkmedic Cardiac)
- Level 6: Paramedic

* Detailed descriptions of each of these positions can be found in RM-51, Chapter 6, Section 3.

5. Training, Continuing Education and Scope of Practice

Whenever possible the NPS strives to adopt nationally recognized certification standards at each level. Chapter 6 of RM-51 outlines the specific course of training and certifying organizations that the NPS has approved for each level of care. The NPS utilizes the National Registry for medic certification testing at the EMT-Basic level and above (www.nremt.org). Refreshers, as defined below, need to conform to the NREMT curricular outlines. However, other continuing education can be tailored to specific park needs, ideally identified through the continuous quality improvement process.

Due to the unique environments often faced by NPS EMS providers, some specific scope of practice expansions have been authorized for the EMT-Basic, Parkmedic/Parkmedic Cardiac, and Paramedic levels. These are briefly summarized below:

A. EMT-Basic

When approved by the Park EMS Medical Advisor and after successful completion of the appropriate training modules (see training below). EMT-

Basic providers are allowed to use or perform the following procedures, as delineated in the NPS EMS Field Manual:

- Epinephrine – Auto-injectors
- Dislocation reductions
- Gamow Bag - (Portable hyperbaric chamber)
- NAAK/Mark I (Atropine/2PAM Auto-injector)

Some individual parks have authorized an expanded scope of practice for EMT-Basics, including IVF and/or a Drug module, typically (Nitroglycerine, Aspirin, Albuterol, Glucose). These are not uniform and do not currently fall under the approved NPS scope of practice. Parks that have chosen these expanded scopes of practice items are doing so under the local or state scope of practice in their areas or under the medical license of their Park EMS Medical Advisor. Parks needing expanded scopes of practice are encouraged to consider moving to the Parkmedic level.

Training: EMT-Basics obtain training at a variety of sites and need state and/or National Registry certification to function within the NPS EMS System (check with your park EMS Coordinator regarding the specifics in your park).

The specific EMT-Basic training modules, bulleted above, are taught and approved at the local park level as per the Park EMS Medical Advisor.

Continuing Education: EMT-Basics must obtain adequate hours of continuing education to maintain their certification. National Registry requires 72 hours every 2 years (a 24-hour refresher plus 48 hours additional continuing education). This is most often provided by a combination of periodic practice and lecture sessions, led by the Park EMS Medical Advisor and coordinated by the EMS Coordinator plus a 24-hour refresher. These refreshers are often provided by the larger parks and attended by EMT-Basics from neighboring smaller parks. Additionally, at the EMT-Basic level, continuing education is often obtained through local EMS agencies.

B. Parkmedic

When approved by the Park EMS Medical Advisor and after successful completion of the appropriate training modules, Parkmedic level providers are allowed to do all the expanded scope of practice items listed in the EMT-Basic SOP. Additionally they have an expanded drug module and procedural skill set, uniquely tailored to NPS needs. This can be found in the NPS EMS Field Manual.

Training: Paramedics are trained to this unique level at a biannual training and certification course provided at University Medical Center in Fresno, California. This "January Course" is attended by Park Rangers from national parks all over the United States. Lectures, small group sessions, and clinical rounds are provided by faculty and residents as well as other staff. The course includes 4 weeks of didactics and additional clinical time. RN precepted, (ED time) and Prehospital, Paramedic precepted, (Ride along) time. The course teaches from the NPS EMS Field Manual and graduates obtain a certification at the NPS Parkmedic level and the NREMT I-85 level. They subsequently need to obtain authorization to practice in their designated park under the license of the Park EMS Medical Advisor.

Continuing Education: Paramedics must obtain adequate hours of continuing education to maintain their certification. Although the National Registry does not specifically recognize the Parkmedic level of training, currently they are certified at the EMT-Intermediate (I-85) level. Thus they are required to obtain 72 hours of continuing education every 2 years (a 36-hour refresher plus 36 hours additional continuing education). This is most often provided by a combination of periodic practice and lecture sessions, led by the Park EMS Medical Advisor and coordinated by the EMS Coordinator plus a 36-hour refresher every 2 years. These refreshers are often provided by the larger parks and attended by Parkmedics from neighboring smaller parks. See Appendix 2 for a sample continuing education schedule for a park with Parkmedic and EMT-Basic providers. Although the Parkmedic scope of practice is somewhat unique, it is tailored specifically for the needs of the NPS and is standardized through the NPS EMS Field Manual. Some specific suggestions regarding continuing education sessions:

- Keep the sessions 3-4 hours each (1 hour didactics, 1 hour procedural practice, 1 hour quality improvement and Q&A)
- The EMS Coordinator does most/all of the logistics
- Protocol based case scenarios are well received and more interactive
- Include procedural review and practice sessions, i.e., Combitube placement in mannequins, IV practice
- Mandate attendance and use testing for absentees
- Limit formal lecture format when possible
- Include a segment for quality improvement – Feedback from their PCR review. Hand out sample PCRs and critique the care and documentation
- Use local field experience and continuous quality improvement to focus emphasis and topic selection

C. Refreshers

Both the EMT-Basic and Parkmedic refreshers are multi-day training sessions that are designed to cover the entire scope of practice for the level of the provider. Parkmedics are often able to provide much of the instruction for the EMT-Basic Refresher. Additionally, local EMS Systems can often be tapped for instruction and training equipment for the Parkmedics. Format for these refreshers is highly variable, but often morning didactics and afternoon hands on practice sessions work well. National Registry Curriculum requirements provide an excellent framework, modified and tailored to the specific needs of your park/providers.

Updated continuing education requirements and curricula are available at www.nremt.org

Current Hours:

- EMT-B- Refresher (24 hours) plus 48 hours additional continuing education every 2 years
- EMT-I85 (Parkmedic) Refresher (36 hours) plus 36 hours additional continuing education every 2 years

D. Multi Casualty Incidents Drill

The NPS EMS Field Manual includes a procedure using START/Jump START for triaging patients in disaster or MCI. Procedure 1100 in the NPS EMS Field Manual, is a reference document for the use of Park EMS Medical Advisors and Park EMS Coordinators, should you wish to practice for an MCI in a drill format.

E. Parkmedic Cardiac

This entity exists in some of the large parks. In an attempt to standardize the scope of practice for this level, it has been defined as equivalent to the NREMT Intermediate-99 (I-99). The main differences between a Parkmedic and a Parkmedic Cardiac are the use and training in cardiac monitors, some additional ACLS drugs, and endotracheal intubation. For specific details of how these providers fit into the NPS EMS System, contact the WASO office. The I-99 curriculum is available through the NREMT or NHTSA at their websites.

F. Paramedics

Most parks that utilize Paramedics do so through contracted personnel or mutual aid agreements with local EMS Systems. Hence, these parks (often

in urban settings) may have frequent calls run within their boundaries as part of a larger EMS system. Contract agreements are usually seasonal or designated to cover a specific region within a park, typically those areas with high visitation or population density. These medics are usually not NPS personnel and the typical Park EMS Medical Advisor has minimal interaction with them as they often function within their local protocols and/or medical control. If your park utilizes Paramedics, contact your EMS Coordinator for specifics on how they fit into the parks EMS System. For more general information on how these providers fit into the NPS EMS System, contact the WASO office.

6. Continuous Quality Improvement

Compared to most urban EMS Systems, the typical NPS EMS provider has a low number of patient contacts. Many will go through an entire season with less than 10. Thus PCR, (run sheet) review with/without the EMS Coordinator, is critical to continuous quality improvement. In many parks 100% review is feasible, as the total EMS contacts for the year is in the 100-300 range. Weighted sampling of PCRs for review, with the emphasis on ALS calls, can be accomplished with the assistance of the EMS Coordinator. For example, all ALS airway, IV fluid, AED uses plus a percentage of the remainder might be a first query.

Feedback should be separated into two major categories, individual and group. Feedback to specific providers should have the goal of remediation and education of that individual. Group feedback is designed to cover educational points uncovered during investigations of specific incidents or via continuous quality improvement data trends.

This is often accomplished as part of regularly scheduled continuing education sessions and can be augmented with electronic bullet point feedback via the EMS Coordinator and the park bulletin board. For continuity the EMS Coordinator needs to be included in all types of feedback. Regardless, due to medico-legal concerns, patient and to a lesser extent provider, identities need to remain confidential*.

Most parks require a significant amount of data collection by the EMS Coordinator and review of what they already collect is often a pleasant surprise to a new Park EMS Medical Advisor. There are ongoing projects to compile a more complete EMS/SAR database that will allow better decision making, needs assessments and resource allocation in the future, as well as national and/or local research opportunities.

* Note: Typically the continuous quality improvement process is shielded from legal inquiry. However, continuous quality improvement requires a level of protection and confidentiality that complies with both Federal and

your state legislation. Be sure to maintain patient confidentiality and use communication forms that remain protected from discoverability, i.e., email is often discoverable, while written communications with the local state statutes cited on the forms remain undiscoverable in most circumstances. Often the practices followed by your local urban EMS system(s) are a good resource for the best way for this to be accomplished.

Operations

Operational issues are predominantly the responsibility of the EMS Coordinator. However, to understand the Medical Advisor and EMS System issues faced, this section is included to address some of the unusual circumstances that arise. What follows is a list of some relevant issues:

- The typical Park Ranger wears many hats. These may include fire, law enforcement, interpretive duties, administration and EMS. This comes into play with continuing education issues as it is often difficult to free up large numbers of staff to attend multiple sessions. This also affects transport decisions as the prolonged transport of medical patients may leave large areas of the park uncovered for medical responses, but also for fire and law enforcement. Therefore, air evacuations or rendezvous are often the norm as opposed to the exception.
- Patient contacts are often few and far between, but may be significant in length (occasionally running into days). Thus the protocols and scope of practice decisions are designed to allow for this eventuality.
- Patients are often park employees, their families and concessionaires. Thus the providers often know their patients personally. This, along with the EMS providers' potential law enforcement role, can result in some controversial, occasionally difficult situations for all parties involved.
- With the increasing mobility of the elderly, terminal and disabled, there have been several incidences of NPS EMS providers needing to deal with advance directives. Often patients have stated they simply wish to die in a beautiful place. Having a policy and contingency plan for such situations can avoid numerous headaches.
- Park Rangers are often temporarily assigned to a specific area or transferred after a single year or season in a specific park. Thus the training, continuous quality improvement and continuing education components are key to keeping a handle on what is happening within the park.

- Communications are usually well developed and highly professional, often incorporated within the fire and law enforcement systems. However, due to terrain and remote locations, there are often large communication failure areas mandating protocol and scope of practice decisions that allow operations to continue without base contact. This also illustrates the need for a thorough continuous quality improvement process. Additionally a variety of communication devices may be in use within the same park. Familiarity with the capabilities and limitations of communications within your park(s) is key to good medical oversight.
- Some parks are geographically large enough to have more than one base hospital, while others have no on line medical control. Both of these situations may affect communications, scope of practice, continuous quality improvement processes, transport and treatment decisions. Familiarity with the jurisdiction, mutual aid agreements, if any, base hospitals, park policy and geography are often key to smooth functioning of the NPS EMS System.
- Along with the Standardized NPS EMS Field Manual and consequent Parkmedic scope of practice, there is also an approved NPS PCR. This has been designed and updated to address the field needs as well as the data collection requirements needed on a regional and/or national level. Unless the local situation mandates differently, this standardized form should be used whenever possible.
- The NPS holds EMS conferences on a periodic basis. Attendees are NPS Park EMS Medical Advisors and EMS Coordinators. Agenda items include issues germane to NPS EMS and discussion is focused on what future direction should be taken. The past four conferences have been heavily focused on standardizing Scopes of Practice, Policy, Protocols, Procedures, Drugs, and Documentation when and wherever possible. This handbook is one example of an attempt to have a standardized reference for Park EMS Medical Advisors and EMS Coordinators.
- One very useful relationship to develop, outside of the EMS Coordinator, is that with your local EMS System. Good relations in this arena can be beneficial to both sides from nearly every aspect of EMS. This is particularly true with training, drills, equipment, transport and communications.

8. Administration

As a Park EMS Medical Advisor, there is a minimum of administrative work as these duties primarily fall to the EMS Coordinator. Periodically the EMS Coordinator will need a physician signature on recertification paperwork. In

some unique settings there may be a call for a specific protocol or policy to be developed. Interagency relationships may also involve the Park EMS Medical Advisors from time to time, usually in the form of advice to the EMS Coordinator. Although infrequent, some examples of how a Park EMS Medical Advisors might be involved include:

- Review of the Park Emergency Action Plan
- National vs State vs Park – Jurisdiction issues
- Mutual Aid agreements*
- WASO (Washington DC) – Park EMS Medical Advisors interface
- Local EMS interface*
- National EMS Medical Advisor – Park EMS Medical Advisors interface
- State EMS interface*
- Park EMS Medical Advisors – EMS Coordinator interface
- Hospital interface*
- Trauma/Burn center destination designation
- Billing/Reimbursement – mostly in the form of an occasional letter to an insurance carrier
- Medico-legal advice

*These items often involve a Memorandum of Agreement or Understanding. These should be reviewed in conjunction with your EMS Coordinator. Your input is predominantly from the medical content perspective and theirs from the operational. The actual document writing is done mostly by the park and agency attorneys.

NPS Hierarchy

Appendix 3 shows the chain of command from the President down to the typical EMS Coordinator in a national park. As a Park EMS Medical Advisors, you serve as an advisor and consultant to the EMS Coordinator and the vast majority of the typical interactions will be through this individual. EMS Coordinators rarely, if ever, have this as their only assigned duty. EMS is most often a small percentage “collateral duty.” Typically this is 10 to 20 % of their assigned time. Appendix 4 is the DO-51 and RM-51 description of the EMS Coordinator position and required duties.

9. Resources/Information

- DO-51
- RM-51
- NPS EMS Field Manual, Appendix 3, is the Table of Contents from this document to give you an idea of the Parkmedic scope of practice.

- EMS Coordinator
- WASO – EMS/SAR office in Washington DC
- National EMS Medical Advisors *
- Fellow/Neighbor Parks/ Park EMS Medical Advisors *
- NPS EMS Advisory Committee* – This is a group of Park EMS Medical Advisors who have met several times over the last 8 years to discuss and advise the NPS via the Branch Chief, Emergency Services.

* These can all be accessed through the WASO office

Appendix #1

NPS EMS FIELD MANUAL

General

0000 **General Information**

Procedure

1010	Automatic External Defibrillator (AED)
1020	Base Hospital Contact Criteria
1030	Blood Glucose Determination
1040	Combitube
1045	Epinephrine Auto-Injector
1050	Fracture / Dislocation Management
1060	Gamow Bag
1070	Intraosseous (IO) Access
1080	IV Access and IV Fluid Administration
1090	MAST (Antishock Trousers)
1100	Multi-Casualty Reporting Format/START/Jump START Triage
1105	NAAK/Mark I (Nerve Agent Antidote Kit)
1110	Nasogastric/Orogastric Tube Insertion
1120	Needle Thoracostomy
1130	Oxygen Administration
1140	Rectal Drug Administration
1150	Spine Immobilization
1160	Standard Reporting Format (Call-In)
1170	Transtracheal Jet Insufflation
1180	When to Initiate a PCR (Patient Care Report/Run Sheet)
1190	Wound Care

Protocol

2000	Abdominal Pain
2010	Allergic Reactions
2020	Altered Mental Status/Altered Level of Consciousness (ALOC)
2030	Altitude Illness
2040	Bites and Stings
2050	Burns
2060	Cardiac Arrest (Adult Medical)
2070	Chest Pain – Cardiac
2080	Childbirth
2090	Electrical and Lightning Injuries
2100	Eye Trauma
2110	Frostbite
2120	Heat Illness
2130	Hypothermia

2140	Ingestion/Poisoning
2150	Major Trauma – Adult
2160	Minor or Extremity Trauma
2170	Near Drowning
2180	Pediatric – Major Trauma
2190	Pediatric – Medical Arrest
2200	Pediatric – Medical Illness/Fever
2210	Pediatric – Neonatal (Newborn) Resuscitation
2220	Pediatric – Vital Signs
2230	Respiratory Distress
2235	SCUBA/ Dive Injury
2240	Seizures
2250	Shock Without Trauma
2260	Trauma Arrest (Adult and Pediatric)
2270	Vaginal Bleeding

Drugs

3000	Acetaminophen (Tylenol)
3010	Acetazolamide (Diamox)
3020	Activated Charcoal
3030	Albuterol or Metaproterenol sulfate (Alupent, Metaprel, Albuterol)
3040	Aspirin (Acetylsalicylic acid)
3050	Atropine Sulfate
3055	Bacitracin Ointment
3060	Cefazolin Sodium (Ancef)
3070	Dexamethosone (Decadron)
3080	Dextrose 50% (D50)
3090	Diphenhydramine (Benadryl, Benacine)
3100	Epinephrine (AnaGaurd)
3110	Furosemide (Lasix)
3120	Glucagon
3130	Glucose Paste or Gel (Glucose)
3135	Ibuprofen (Motrin, Advil)
3140	Ipecac
3145	Ipratropium (Atrovent)
3150	Lidocaine (Xylocaine)
3155	Magnesium Sulfate 50%
3157	Metoclopramide (Reglan)
3160	Midazolam (Versed)
3170	Morphine Sulfate
3180	Naloxone (Narcan)
3185	Neosporin Ophthalmic Ointment (Eye)
3190	Nifedipine (Adalat, Procardia)
3200	Nitroglycerine
3210	Oxytocin (Pitocin)
3215	Pralidoxime Chloride (2 PAM)
3220	Sodium Bicarbonate

Appendix # 2

Sample Parkmedic Yearly continuing education Calendar

Date	Instructor	Topics/Protocols	Procedures	Medications
8/13		Documentation Allergic Reactions Respiratory Distress	Combitube Epinephrine Auto-Injector Nebulizer Oxygen Administration Pulse Ox Vital Signs	Albuterol or Metaproterenol sulfate (Alupent, Metaprel, Albuterol) Dexamethosone (Decadron) Diphenhydramine (Benadryl, Benacine) Epinephrine (AnaGuard) Glucagon Ipratropium (Atrovent) Oxygen Administration
9/10		Abdominal Pain Childbirth Vaginal Bleeding	Intraosseous (IO) Access IV Access and IV Fluid Administration	Magnesium Sulfate 50% Metoclopramide (Reglan) Oxytocin (Pitocin)
10/8		Altered Mental Status/Altered Level of Consciousness (ALOC) Seizures Shock Without Trauma Syncope	Automatic External Defibrillator (AED) Blood Glucose Determination Combitube Drug Calculations	Dextrose 50% (D50) Glucagon Glucose Paste or Gel (Glucose) Midazolam (Versed) NAAK/Mark I (Nerve Agent Antidote Kit) Naloxone (Narcan)
11/12		Chest Pain - Cardiac Frost Bite Hypothermia Respiratory Distress	Intraosseous (IO) Access IV Access and IV Fluid Administration	Aspirin (Acetylsalicylic acid) Furosemide (Lasix) Nitroglycerine Oxygen Administration
3/11		Cardiac Arrest (Adult Medical)	BVM Combitube	Lidocaine (Xylocaine) Epinephrine (Anaguard)

Ingestions/Poisoning
Pediatric issues
(2180 – 2220)

Nasogastric/Orogastric Tube
Insertion
Rectal Drug Administration
Transtracheal Jet Insufflation

Atropine Sulfate
Activated Charcoal
Ipecac
Sodium Bicarbonate

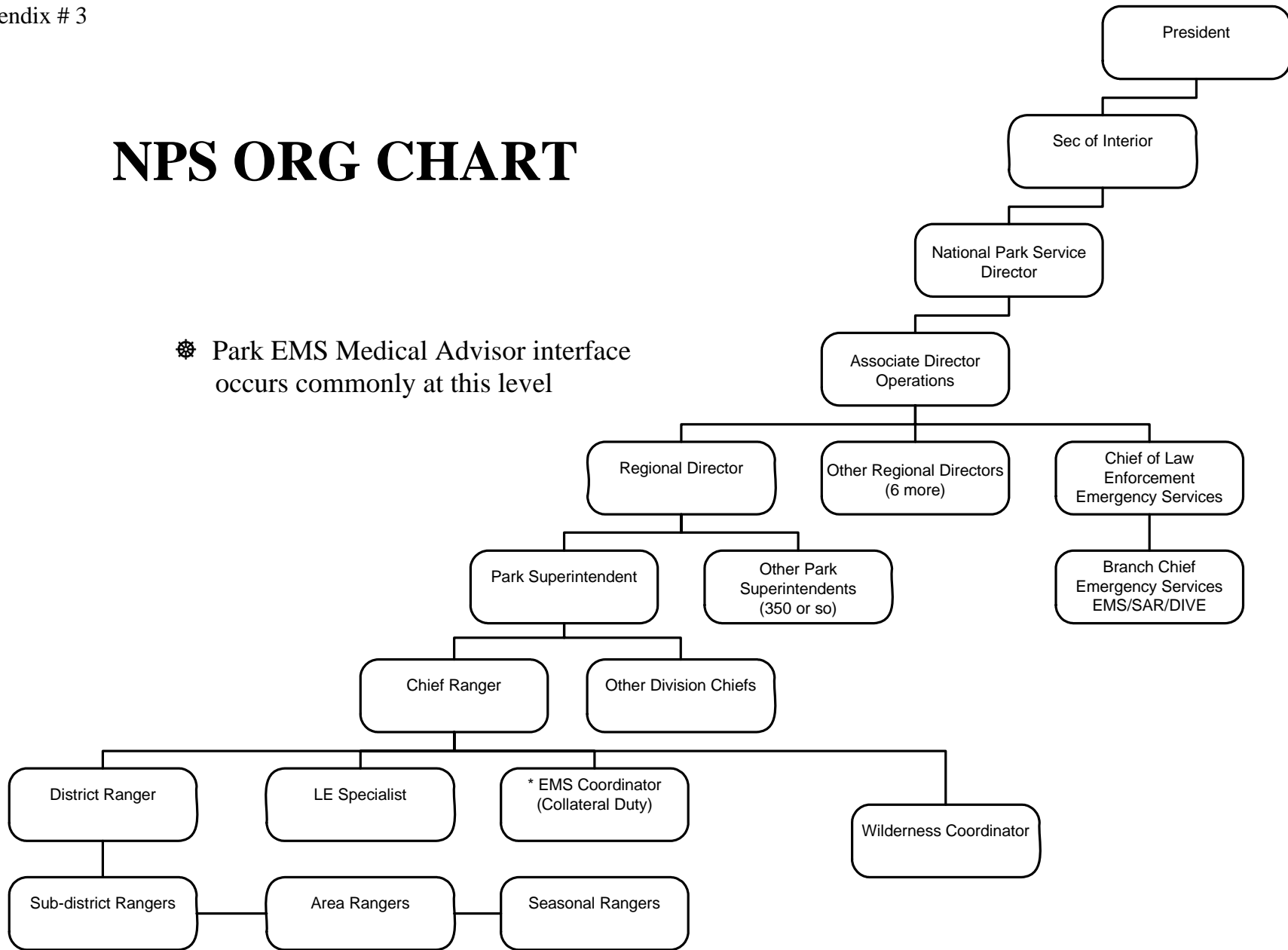
4/8	Eye Trauma Major Trauma – Adult Minor or Extremity Trauma	Fracture/Dislocation Management MAST (Anti-shock Trousers) Needle Thoracostomy Spine Immobilization Splinting Wound Care	Cefazolin Sodium (Ancef) Intraosseous (IO) Access IV Access and IV Fluid Administration Morphine Sulfate Neosporin Ophthalmic Ointment (Eye)
5/23 – 5/27 (Every 2 years)	Parkmedic refresher	All (1010 – 1190)	All (3000 – 3220)
6/10	Bites and Stings Burns Near Drowning	Epinephrine Auto Injector	APAP Bacitracin Ointment Ibuprofen (Motrin, Advil) Oxygen Administration Peds dosing
6/24 – 6/26	EMT Refresher	All EMT-B Scope	All EMT-B Scope
7/8	Altitude Illness Electrical and Lightning Injuries Heat Illness	Gamow bag	Nifedipine (Adalat, Procardia) Dexamethasone (Decadron) Acetazolamide (Diamox)
7/23	MCI Drill	Multi-Casualty Reporting Format / START / Jump START Triage	

Other topics covered on an as needed basis. ie; SCUBA/Dive Injury, Cave Rescue issues, etc.

Appendix # 3

NPS ORG CHART

⊗ Park EMS Medical Advisor interface occurs commonly at this level



Appendix #4

From Director's Order - 51

Park EMS Coordinator

The day-to-day management and funding of park EMS programs resides at the park level. It is the responsibility of each superintendent to ensure that the park EMS program is in compliance with DO-51 and RM-51. Superintendents will appoint Park EMS Coordinators to ensure that their programs are compliant with Service-wide policy and regulation, as well as applicable laws.

From Reference Manual – 51 (RM-51)

1. Overview

The day-to-day management and funding of park EMS programs resides at the park level. It is the responsibility of each park's superintendent to ensure that the park EMS program is in compliance with DO-51 and RM-51. Superintendents will appoint Park EMS Coordinators, who will work with Park EMS Medical Advisors to ensure that their programs are in compliance with Service-wide policy and regulation, as well as applicable laws. The Washington and Regional Offices will provide guidance and assistance to the parks.

3.4. Park EMS Coordinator (PEMS-C)

The day-to-day management of EMS programs in the individual units of the NPS resides at the park level, and it is the responsibility of park superintendents to ensure that their programs are in compliance with the Director's Order and this Reference Manual. Superintendents will appoint an EMS Coordinator to fulfill these obligations.

Duties of the PEMS-C may include:

- Liaison with the Park's EMS Medical Advisor (PEMS-MA).
- Evaluate the welfare and effectiveness of the EMS program and apprise park management and the PEMS-MA.
- Ensure that the area EMS plans are consistent and in compliance with DO-51 and RM-51.
- Coordinate park EMS training and serve as EMS training officer.
- Coordinate the purchase of controlled substances, EMS supplies and equipment.
- Maintain necessary records such as personnel resources, and supply and equipment inventories.
- Issue White Cards (EMS Provider authorizations) and ensure that appropriate credentials are maintained.
- Prepare and submit a summary of park EMS activities and the number of Level III, IV, V and VI EMS Providers to the NEMS-MA and REMS-C at the end of each calendar year.
- Provide for as necessary, critical incident stress management (CISM) follow-up for all employees and supervisors who may be involved in emergency response and/or support. The specific details regarding Critical Incident Stress Management is to be published in Reference Manual 57 *Occupational Medical Standards and Health and Fitness Guidelines*.
- Conduct EMS Needs Assessment for the park every 3 years.

APPENDIX B

EMS COURSE INSTRUCTORS AND COURSE COORDINATION GUIDE

I. Introduction

The purpose of this guide is to summarize the need for NPS EMS instructors, to establish Servicewide policy for requirements to provide course instruction and for the coordination of EMS courses provided within the National Park System.

The EMS courses required for the various levels of training and certification are available in most states through colleges, national, state, and local agencies and organizations. One exception is the Parkmedic course (Level V) that was designed specifically for, and by the NPS.

While many of these courses may be available to NPS employees through other sources as described above, several park areas have found that they are limiting in terms of frequency and time of year offered, space availability for NPS personnel, cost, distance to the course location, and in some cases, the course content does not meet the minimum National Standard Curriculum requirements. As a result, some parks have identified the need to provide their own courses either by contracting instructors from outside the park, or to have their own personnel qualified as instructors.

II. Policy

EMS Coordinators (in collaboration with the Park EMS Medical Advisor for Levels IV and V), may authorize instructors and coordinate the primary courses of instruction for Levels I-IV, and continuing education for Levels I-V, as long as the following standards for instruction are met and the need has been identified. Persons with expertise in a specific subject area may provide course presentations without meeting the following requirements, as long as they are under the supervision of the primary course instructor. Procurement and contractual arrangements for instructors that are not NPS employees will be in compliance with the Servicewide policies for contract employees.

A. Levels I and II (AED, CPR and First Aid) Course Instructor Requirements

For courses administered by the American Red Cross, the American Heart Association, American Safety and Health Institute, and the National Safety Council, an instructor candidate must have completed an

instructor course and be currently certified as an instructor by the respective organization.

B. Level III (First Responder) Course Instructor Requirements

For a candidate to become an NPS instructor for courses administered by the American Red Cross and the National Safety Council, they must have completed the respective organizations instructor course and be currently certified as an instructor by that organization.

The Park EMS Coordinator may also designate a prospective candidate as a First Responder Instructor. As a minimum, the course instructor shall have the following:

1. Documented training and experience as an educator or instructor of a skill that may be applied to the presentation of the First Responder course or has had previous documented experience as a First Responder (or greater) Instructor.
2. Current certification as an EMT-Basic (Level IV) with a minimum of 3 years of field experience is required.
3. Current Certification as a CPR instructor. This requirement may be waived as long as a currently certified CPR instructor is utilized to teach that component of the class.

Copies of these documents will be maintained in the files of the Park EMS Coordinator.

The course of instruction provided by NPS or contract instructors will use the NHSTA Standard Curriculum for First Responder and First Responder Refresher Training. Those documents and the Instructors Lesson Plans are available at www.nhtsa.dot.gov/people/injury/ems/nsc.htm .

C. Level IV (EMT-Basic) Course Instructor Requirements

At this level of training, and for purposes of quality assurance, it is recommended that supplemental medical personnel be incorporated into the training program (physicians, nurses, and paramedics) in order to provide a pool of expertise for the diverse subject matter and skills that comprise the course. As a minimum, the prospective NPS EMT-Basic instructor will have:

Documented training and experience as an educator or instructor of a skill that may be applied to the presentation of the EMT Basic

1. Documented training and experience as an educator or instructor of a skill that may be applied to the presentation of the EMT Basic Course or has had previous documented experience as a EMT Basic (or greater) Instructor.
2. Current certification as a Parkmedic or greater, with a minimum of 3 years field experience at that level.
3. Current certification as a CPR instructor. This requirement may be waived as long as a currently certified CPR instructor is utilized to teach that component of the class.
4. A letter of recommendation by the Park EMS Medical Advisor.
5. Copies of these documents will be maintained in the files of the Park EMS Coordinator.

D. Parkmedic Course Coordinator Requirements

Most Parkmedic courses have been administered by hospitals designated by the NPS to instruct the course curriculum. However, the Parkmedic course may be sponsored by a park area as long as the following criteria are met:

1. The park area has or anticipates having a Level V EMS Program.
2. The park area has a medical sponsor that will act as course director. He/she may appoint a coordinator to administer the course. The coordinator will develop a participant list and provide for the documentation of attendance, all examination scores, and clinical and field internships.
3. The teaching facility (usually a hospital) has a staff qualified to instruct all parts of the Parkmedic curriculum (National Standard Curriculum for EMT-Intermediate and the pharmacology and/or cardiac module if included).
4. A hospital is available to provide a clinical rotation for the participants and can provide the necessary supervision.
5. The participant's park area can provide the required hours for a field internship.

Once these criteria are met, approval must be obtained through the Branch Chief, Emergency Services. The application for approval to sponsor this course is included in Exhibit 2. A White Card is not issued for this one time approval.

The following guide is available to the course instructor/coordinator. It may be obtained at the same addresses as listed under section D of this chapter.

Emergency Medical Technician-Intermediate: Instructor's Lesson Plans

Emergency Medical Technician-Intermediate: Course Guide

E. Paramedic Course Instructor Requirements

At the present time, the NPS has not identified the need to instruct or coordinate a paramedic training course.