Pre-Hospital Stabilization Plan

Scope of Document

This document describes the plan for using pre-hospital stabilization sites (PHSS) to assist with disaster response. This document does not cover:

- Medical support of emergency evacuation which ensures that patients receive ALS care during the actual rescue operation (see plan for medical support of rescue operations);
- EMS staging site which provides for EMS surge capacity with standard ambulances and multi-patient transport vehicles (e.g., buses) at a central dispatch site (see medical transportation plan).
- Temporary medical acute care sites such as DMAT, medical shelter, federal medical station, military field hospital or any other site which is capable of providing definitive care (see health care plan or plan specific to entity).

Concepts

Pre-Hospital Stabilization Site (PHSS) is a ground-based EMS site which provides an ALS level of care to multiple patients until they can be transported to a point of definitive care (e.g., hospital emergency department). The PHSS functions as an adjunct to the EMS system. An EMS staging site would be expected to be setup in most circumstances requiring a PHSS; however, an EMS staging site is a completely separate entity

Pre-Hospital Stabilization Kit (PHSK) is a set of pre-packaged material to be used to set up a PHSS or used as the core of an emergency department or possibly as core for a new clinic site.

Mission

The mission of the PHSS is to provide acute ALS level stabilization. It is not a substitute for either a mobile ambulance or an acute care emergency department. Circumstances in which it a PHSS site may be needed include:

- Maintain rapid offload time for EMS units assigned to rescue operations (e.g., bringing persons needing medical attention from rescue drop point);
- Hold patients in stabilized environment pending transport to definitive care hospital;
- Hold patients in stabilized environment pending hospital ER response; however, it would not be appropriate for it to serve as temporary inpatient capacity (e.g., for admitted patients waiting for an inpatient bed).

The PHSS would not

- Be a preferred source for assignment of providers to rescue operations.
- Compete with local health care for patients (if patients are moved out of the community, it would be with the knowledge, and hopefully agreement, of the local hospitals to ease overload and ensure optimal medical care for all patients.
- Provide ongoing care for patients already admitted to the hospital when inadequate beds are available in that community.
- Provide decontamination.

Deployment Scenarios for PHSK

1. Community with a functioning hospital emergency room which is overwhelmed
    a. Provide core for accessory ER.
    b. Provide PHSS for immediate offload and short term stabilization, sending most critical patients forward to the ER as soon as it could handle them.
    c. Stage patients for transport to distant hospital when time to care at local hospital is prolonged.
2. Community with a damaged ER or evacuated hospital

a. Provide for establishment of accessory or replacement ER
b. Provide PHSS for stabilization, holding and transport of patients to alternate ER in city or other city

3. Community with no hospital
    a. Provide PHSS as point of immediate care
    b. Provide for establishment of an accessory clinic
    c. Provide for establishment of an ER only in the circumstance where an out of community hospitals assumes responsibility for providing that service

Authority to Operate and Liability

A PHSS site would operate under the authority of NDDoH which would be responsible for its establishment and support. Persons working in a PHSS would fall under state tort protections as a disaster responder working for state government. In the event that a PHSK is mobilized in support of an accessory ER, the material would be turned over to a licensed hospital for use and the ER would function as organizational unit belonging to the hospital. Liability would belong to the hospital. If used to establish a new clinic site, in most circumstances it would be expected that a health care facility would staff and operate it and it would fall under the liability of that facility.

Incident Command

A PHSS would function under the NDDoH Department Operations Center (DOC) Operations Section, led by a site commander.

Mobilization

A PHSK can be transported from the state warehouse to the point of use using a towable trailer with a ramp. A pallet jack would accompany the material on the trailer. Time targets for completion of tasks:

- Assembly of sufficient staff at the site to set up the unit – 2 hours
- Travel time – 30 minutes to 5 hours. Distance dependent. Units will be pre-staged to the area for events which give advance warning.
- Tent setup (if required) – 1.5 hours
- Unpacking and site setup 1.5 hours

Total target time for recognition of need to operational unit – 4-7 hours.

Location

A PHSS may be located in either a permanent structure or in a temporary tent structure. While use of an existing structure if preferable, particularly if the structure has continued access to utilities, PHSS setup delay pending identification of a building in an appropriate location would not be considered in an emergent situation. An existing structure would be expected to have more room for receiving and processing patients, greater stability and variety of communications equipment, better quality utility access and allow for faster setup. Structures in which a PHSS might be placed include health care facilities (particularly a hospital) or non-health care facilities (e.g., community building or school). The PHSS is prepared to function as a self-supporting unit within a tent without access to utilities. The tent can be set on any smooth, dry surface such as lawn or a parking lot and is suitable for all weather conditions except very high winds.

The site must be located away from the disaster zone or hot zone, the margins of which may not be known pre-event. While the PHSS can be relocated, it is not highly portable. It should be located in an area far enough from the affected area that relocation would not be necessary (e.g., due to rising flood waters). With events which have a long lead time, such as spring flooding, it is possible to designate some likely sites in high risk cities.

The PHSS site should be reasonably proximal (i.e., a distance which could be covered rapidly) to any drop zone where rescue patients would be dropped off from rescue vehicles. It should also have ready access to the EMS vehicle staging area although proximity would not have to be as close. If the PHSS is working closely with an existing hospital that is overwhelmed, it may within the hospital building or on the hospital grounds if that placement gives it adequate proximity to the affected area.

Scenario Example

A PHSS would need to be established very quickly. In an example scenario, water inundation of an area which has not been evacuated, available flood rescue vehicles would begin to immediately pull residents out of the flood zone, preferably dropping them at a designated drop zone on dry ground. Local ambulances would have to be used immediately to transport patients needing medical care from the drop zone to a hospital. If the number of patients to be transported is large or the distance to the nearest functioning hospital emergency room is large, community EMS resources would rapidly be exhausted. As soon as an EMS need is anticipated, NDDoH would mobilize EMS units from nearby communities to assist in the ALS stabilization and transport while drawing in EMS units from a greater distance to form an EMS vehicle staging area. NDDoH would also mobilize a PHSS which would allow those ambulances available in the local area to drop patients quickly and return for additional patients.

Activation

Need for activation of a PHSS might occur through any of the following:

- Setup of a pre-staged unit for an event being tracked by the DOC. Determination of the time for setup would be based on situational awareness and consultation with local public health.
- Mobilization in response to a notification received by the Case Manager that an event has occurred with
    - A request for assistance;
    - Evidence that local health care may be impaired;
    - Lack of acute point of care in a small community; or,
    - Evidence of an event of sufficient magnitude to potentially overwhelm local health care.

NDDoH would not have to receive a request for assistance in order to mobilize the resource, but would ensure any hospital in the area knows that NDDoH is responding and that activity would be conducted in cooperation with the local hospital.

To be of greatest value a PHSS should be setup within four hours of the recognition of a possible event for which its use might be needed. EMS personnel located across the state are identified before the event if possible or immediately upon event recognition if necessary, who could immediately travel to the affected area to establish a PHSS. At the same time, the NDDoH warehouse would load and move trailers containing necessary setup supplies (e.g., beds, medical equipment, oxygen, medications) and a Reeves tent system unless it is definitively known that setup outside of a fixed building would not be needed. (In an anticipated event (e.g., spring flooding), PHSS kits and Reeves tent systems would be pre-positioned in disaster-prone cities pre-event.)

Upon recognition of possible need to setup the facility, the DOC would identify a setup site through local public health (or local emergency management if local public health is not available). NDDoH staff accompanying the material would move the PHSS materials trailer to the setup area and commence setup of the site.

EMS personnel arriving at the scene to establish the PHSS would also have received training in site setup and would assist NDDoH personnel. A single, pre-designated paramedic (or nurse or physician) would

assume the role of site commander for the first shift and direct the completion of the setup and preparedness to receive the first patients.

Patient Assignment

The PHSS may receive patients by ambulance or possibly by walk-in. Movement to the hospital directly would be preferable as long as travel and offload times were brief and the ER could rapidly triage and treat patients. To determine which if any patients should be directed to the PHSS, the local site commander would initiate conversation with the following prior to the facility be ready to receive patients:

- DOC (the unit should have been in frequent communication with the DOC to this point);
- Local EMS and vehicle staging area manager
- Local hospital
- Local public health / EPR.

The decision re: using the PHSS as a destination would depend on the answer to several questions:

- Is there a local ER functioning and what is its capacity to receive additional patients?
- What is the transport time to the nearest ER and what is the offload time?
- What is the ambulance capacity in the area compared to need? Can ambulance availability be increased by using the PHSS as a rapid drop point?
- Are BLS ambulances picking up patients which need a higher level of care such that drop off at a more proximal ALS site (the PHSS) is advantageous?
- Does health care system overload indicate that patients need to move out of the community and is the local hospital in agreement with this? (NOTE: Situations could arise in which the local hospital did not wish patients to be removed from the community, but system overload and delay in time to care indicate that that needs to occur nevertheless.)
- Are there certain patients that should bypass the PHSS to be taken directly to the nearest hospital? This would generally be the most severely injured or ill patients and presumes that
    - The hospital is reasonably close and able to provide immediate care, or
    - Sufficient ALS ambulance capacity is available for dispatch to distant sites in situations where immediate local hospital services are not available.

The allocation of patients to specific destinations should be able to be made locally by EMS and the supporting health care structures, but if the situation is complex, the DOC or a DOC-designated medical consultant may need to engage to assist with these determinations.

Patients that are sent to the PHSS as initial destination will still need a disposition. Patients who needed immediate hospital-based stabilization (e.g., placement of chest tubes, blood transfusion) would be prioritized to go to the nearest hospital preferentially to those for whom ALS stabilization was sufficient until definitive treatment was available. If patient outcome would not be compromised, a PHSS might hold patients until the local hospital could process them. However, in a situation in which substantial numbers of patients continued to arrive from the disaster zone or when the ER offload or patient care time was great, the PHSS site would arrange transport through the DOC to a distant definitive hospital care site.

Organization

The PHSS Site Commander would designate personnel and work areas to specific functions. Patients arriving from an ambulance for drop off would be received in the designated receiving area in the PHSS, transferred to a bed in the PHSS and any documentation received. Each patient would be given an ID barcode wrist band and name wrist band and entered into a log form (see document PHSS Log Form) with run sheet generation according to EMS protocol. In addition, the patients ID barcode would be scanned into the patient tracking system. No additional patient information would need to be entered at that time if facility is under pressure.

It is possible that after acute evaluation and stabilization that some patients may no longer be in need of care (e.g., mild hypothermia), but unless the PHSS received specific instructions to the contrary (either based on waiver by the Governor of medical practice acts or close oversight by a physician), the patient would still be transported for evaluation[1]. A small separate area of the PHSS would be set aside for communication, administration and documentation including arranging transport to a definitive facility through the DOC, communication with a hospital in the community, patient tracking, time keeping, re-supply, staffing and shift change.

Triage

Some patients evacuated from the disaster zone may not be stabilized by the time they reach the PHSS. The PHSS may assume stabilization of the patient from the ambulance staff although the PHSS will not be able to offer a higher level of care if the arriving ambulance is ALS capable. Depending on the available resources at the time, the PHSS may have to implement patient triage, potentially including triage to non-treatment for low survival conditions. This is a decision that would be discussed with the DOC as soon as possible, since the DOC would be working to move enough resources into the area that usual standard of care could be maintained for all patients. Allocation of available ambulance resources to bringing patients to the PHSS and carrying patients from the PHSS to definitive care would be made by the DOC. If a patient needed immediate emergency care beyond ALS care, the PHSS would alert the DOC and the DOC would try to allocate resources to immediately transport that patient to the nearest available emergency room. Since the PHSS has limited capacity, it would need to begin assessing a definitive care disposition as soon as the patient was stable enough for transport (which may be immediately).

Protocols

Not all EMS services in the state use the same care protocols; however, all protocols in use statewide are similar. The default protocols for use in the PHSS will be the state-recommended protocols; however, this does not preclude staffing personnel from providing appropriate care in the manner in which they are most familiar. An NDDoH designated physician would be providing oversight for the protocol and changes to the protocol would need to be approved by him or her. It is not anticipated that protocols differences between services would pose a problem.

Outgoing Transport and Destination Determination in the DOC

All patients arriving at the PHSS must be transported from the PHSS, whether their destination is a hospital in the same community, a distant hospital, an intermediate stop hospital en route to a final care site, or a morgue. When a patient is ready for transport to definitive care, the assigned staff member in the PHSS, which might be the care provider or a person assigned to be administrator or clerk, will contact the DOC. The DOC will determine the destination and will use a standard form (see document DOC Rapid Triage Form for PHSS Transfer) to collect information about the patient required for making a determination of transport.

During a period in which the PHSS is operational, the DOC will maintain the following information:

- Bed availability;
- Nearby hospitals with emergency rooms capable of offering short term stabilization en route;
- Number of patients already dispatched to receiving hospitals and the capacity of receiving hospitals to handle the volume of patients being sent;
- Availability of specialty care likely to be needed by the patient (e.g., neurosurgery, orthopedic surgery);

[1] Patients can still refuse treatment at any time.

- Route safety (e.g., road closures).

If the patient needs immediate hospital stabilization, the DOC will make the contact to a nearby hospital (e.g., critical access hospital) to provide that service and notify the PHSS to transport immediately. The DOC will then arrange for a hospital to subsequently receive the patient that is capable of providing definitive care. The DOC would work with the stabilizing hospital to determine destination since standard referral patterns may not be functioning normally due to patient overload. Once the patient has arrived at the stabilization hospital, the ambulance will return to the community with the disaster. Additional transport from the stabilization hospital to the definitive care hospital may be arranged by the hospital using local EMS resources or can be arranged by the DOC. The DOC will track patients sent to specific destinations using HC Standard.

Patients known by the DOC to be of lower acuity may be dispersed over a large distance if the number of patients is large and regional hospitals are being stressed. For low acuity patients, the DOC may arrange with the PHSS to transport more than one patient to a single destination for evaluation, including use of an Ambus to transport many patients. Multiple patient transportation would not be a preferable option for high acuity patients. Use of multiple acute patient transport for multiple destinations would not be preferable but would depend on availability of ambulances. If many high acuity patients need to be moved and tertiary care centers in the state are overwhelmed, the DOC will arrange air transport to more distant tertiary care.

Once the PHSS has received a destination for a patient, it will not be necessary for the PHSS to make contact with that destination[2]. PHSS will make contact with the ambulance staging area to arrange transport. In the event that the EMS staging area is not available or has no vehicles to spare, the DOC may need to arrange transport, balancing the need to move patients to definitive care with the need to pick up patients from disaster zone drop off areas. Particularly early in the event, sufficient ambulances may not be available to fully resource all transport tasks, in which case resources will be utilized to maximize patient outcomes.

Death

EMS determination of death would follow state EMS protocols unless over-ridden by a Governor declaration with alternate instructions provided by the DOC. The number of declared deaths that the PHSS would deal with would be likely to be small since most patients would have to be declared by a physician or by law enforcement at the scene. In the event that a patient is determined to be dead, the PHSS will contact the coroner for instructions. Once the coroner has given his or her approval, a funeral home can be contacted to pick up the remains. If the patient identify is known and the PHSS is not time stressed, a PHSS team member will contact family[3]. The DOC can be contacted to assist with family notification if needed.

If the deceased patient's identity is not known, the PHSS will request instructions from the coroner. The PHSS should not look through patient possessions without instructions from a coroner. If law enforcement is available, an officer can be requested to examine personnel possessions for identification.

Communications

[2] The ambulance en route to that facility will make contact with the receiving hospital according to usual EMS protocol.

[3] The PHSS may need to contact the DOC and request the DOC make contact with the family, but the DOC will need access to any contact information with the remains.

If the PHSS is located in a fixed structure, it will use the communication systems at that site. If availability of communication systems is uncertain, the DOC will provide communication equipment. The PHSS would be provided with cell phones as the first option, but if the PHSS may be in location where cell service has been lost or overwhelmed, the PHSS would be supplied with a communications kit which will provide the following communication capability:

- Cell phone;
- Satellite phone;
- P25 radio;
- Satellite internet connection and computer.

In the event that the PHSS is located in an existing facility, the site will potentially have access to any other communications which are part of that building (e.g., wire or wireless internet, landline phone, IP phone, BTWAN or StageNet). As part of the facility setup, communications would be established with the DOC, local incident command, a local hospital if it exists and the ambulance staging area (as soon as it exists). If the ambulance staging site is not set up, the PHSS may need to communicate with individual ambulances using State Radio or work through the DOC to make contact with individual ambulances.

PHSS Size and Staffing

The standard setup for the PHSS is a ten bed unit with beds arranged in two rows. The PHSS can be expanded with ten additional beds if needed. (A single Reeves tent is limited to 10 beds but a second tent may be connected end to end or side to side.) The PHSS is not intended to hold patients very long so it is unlikely that a facility of more than 20 beds would be needed. Staffing for a 10 bed facility would include the following:

- Site Commander – paramedic or nurse or physician
- 3 EMS patient care staff - paramedic or nurse or physician
- 3 EMS patient care staff –EMT basic
- Clerk – EMT basic

Additional staff could be added if needed. Need for additional staff might occur if patient flow rate through the 10 bed unit were very high, if a high percentage of those being seen are high acuity patients requiring stabilization or if the PHSS expands the bed count.

Staff would work for 12 hour shifts, consequently, identification of additional staff for a second shift would be an early action taken by the DOC. Once designated PHSS staff are on site in the community, the PHSS team would assume the task of staff scheduling locally. It is expected that the staff would come from outside the affected community and would require accommodations. Alternatives for accommodations include local hotel rooms or a staff shelter. If neither of these is an option, the DOC can mobilize a tent to be used specifically for sheltering response staff.

Staff Care and Facility Logistics

Staff would be able to obtain meals from local vendors or use other warehouse resources to support meal preparation. If nearby food vendors are not available, the DOC will provide MRE type meals for use by staff. Water is provided as bottled water. In some settings, toileting in the community may be a problem (e.g., flooded sewer system). The Reeves tent system will come with a toileting facility which would likely remain in the trailer (heated). Likewise if at a fixed structure and utilities are available, handwashing will not be a problem. If that is not available, then portable, self-contained handwashing stations will be used.

Solid Waste, Medical Waste amd Laundry

Tasks related to cleaning of the facility will be assigned by the Site Commander. Waste will be stored until it can be disposed of. Medical waste will be kept separate from non-medical waste. When medical waste needs to be disposed of, the DOC should be contacted to arrange with a nearby public health or

health care provider to accept the waste. Almost all materials will be disposable thereby minimizing laundry needs. If laundering is necessary, the PHSS site should arrange with the DOC to ensure this need is met.

Forms

Form documents needed by the PHSS team would be those used in the regional response plan.

PHSS Site Commander

You Report to:	Operations Chief, DOC
Site:	Local community PHSS
Job Shift(s):	12 hour shifts, 12 on-12 off
Supervise:	All PHSS staff

Mission: Assume command for all aspects of local operations

Qualifications:

- ☐ Paramedic or nurse or physician with active license
- ☐ Training in use of PHSS equipment and procedures
- ☐ Familiarity with state standard protocols
- ☐ Assigned by DOC

Equipment:

- ☐ EMS personal identification
- ☐ Material located in the PHSS

Immediate Duties:

- ☐ Read this entire job action sheet
- ☐ Be familiar with the PHSS plan
- ☐ Arrive on scene and ensure complete site setup for patient receipt
- ☐ Establish communications links with DOC, local hospital (if applicable), local EMS vehicle staging site when available.
- ☐ Assign tasks and work areas to individual staff
- ☐ Supervise patient care providers and ensure completion of all administrative tasks
- ☐ Ensure all staff understand their roles and the safety rules
- ☐ Notify DOC, local hospital (if applicable) and local EMS when ready to receive patients

Ongoing Duties:

- ☐ Keep DOC informed of actions, needs and situation
- ☐ Ensure rapid offload of all inbound EMS vehicles
- ☐ Anticipate additional resource needs and secure them through request to DOC or assignment to staff member to secure locally
- ☐ Ensure supplies are used only for purposes intended in completion of PHSS duties
- ☐ Act as safety officer ensuring all actions keep patients and staff safe, including supervision of all patient identification procedures and emotional, mental and physical health of staff
- ☐ Reassign patient care resources as needed to manage all patients
- ☐ Supervise application of patient triage to ensure maximal patient
- ☐ Communicate with local hospital emergency room for purposes of patient allocation between hospital and PHSS
- ☐ Approve patients for transport and supervise actions taken by the clerk for securing patient destinations from the DOC and obtaining transport resources
- ☐ Supervise evacuation of facility if site should become threatened
- ☐ Respond to all directives from the DOC

- [ ] Communicate with medical director for PHSS regarding all issues related to any need to deviate from EMS protocols and medical oversight of specific patients
- [ ] Contact family regarding a death or ensure that it is done by referral to DOC with needed contact information
- [ ] Supervise all death procedures to ensure respect for and appropriate disposition of remains and necessary notifications are completed.
- [ ] Supervise scheduling, ensuring replacement staff are available for change of shift and current staff know when to return to duty
- [ ] Brief incoming Site Commander at shift change
- [ ] Supervise demobilization of facility including notification of DOC, local hospital and local EMS of functional status, release of staff, completion of documentation, return of all recoverable materials to the control of DOC representatives and return of site to pre-use condition

PHSS Patient Care – Senior Provider

You Report to:	Site Commander, PHSS or alternate supervisor assigned by Site Commander
Site:	Local community PHSS
Job Shift(s):	12 hour shifts, 12 on-12 off
Supervise:	None unless specifically assigned by Site Commander

Mission: Provide ALS level care to patients brought to the PHSS

Qualifications:

- ☐ Paramedic or nurse or physician with active license
- ☐ Training in use of PHSS equipment and procedures
- ☐ Familiarity with state standard protocols
- ☐ Assigned by DOC

Equipment:

- ☐ EMS personal identification
- ☐ Material located in the PHSS

Immediate Duties:

- ☐ Read this entire job action sheet
- ☐ Arrive on scene and report to Site Commander
- ☐ Be familiar with assigned tasks and work areas for which you are responsible
- ☐ Supervise any staff specifically assigned to you for supervision
- ☐ Know and follow all safety rules and EMS standard state protocols

Ongoing Duties:

- ☐ Assist with patient arrival and departure as directed by Site Commander
- ☐ Remain responsible for the care of any patient assigned to you until the patient leaves the PHSS or the patient is assigned to some other provider and fully care is assumed
- ☐ Provide ALS care for patients under the care of EMT basic providers
- ☐ If necessary to leave PHSS for any length of time, ensure patients are signed out to other providers and that permission to leave site is obtained from Site Commander
- ☐ Ensure ongoing fitness for duty by caring for emotional, mental and physical needs, including seeking relief from duty if necessary
- ☐ Keep supervisor informed of needs of patients under your care and change in condition or situation
- ☐ Assist evacuation of facility if site should become threatened
- ☐ Brief incoming provider assigned to your patients at shift change and do not leave until care has been fully transitioned to new provider
- ☐ Assist with demobilization of facility
- ☐ Other duties as assigned, including cleaning, maintenance or duties outside PHSS site if so assigned

PHSS Patient Care EMT Basic

You Report to:	Site Commander, PHSS or alternate supervisor assigned by Site Commander
Site:	Local community PHSS
Job Shift(s):	12 hour shifts, 12 on-12 off
Supervise:	None

Mission: Provide BLS level care to patients brought to the PHSS

Qualifications:

- ☐ EMT Basic with active license
- ☐ Training in use of PHSS equipment and procedures
- ☐ Familiarity with state standard protocols
- ☐ Assigned by DOC

Equipment:

- ☐ EMS personal identification
- ☐ Material located in the PHSS

Immediate Duties:

- ☐ Read this entire job action sheet
- ☐ Arrive on scene and report to Site Commander
- ☐ Be familiar with assigned tasks and work areas for which you are responsible
- ☐ Know and follow all safety rules and EMS standard state protocols
- ☐ Work under the supervision of a senior provider (paramedic, nurse or physician) if so assigned

Ongoing Duties:

- ☐ Assist with patient arrival and departure as directed by Site Commander
- ☐ Remain responsible for the care of any patient assigned to you until the patient leaves the PHSS or the patient is assigned to some other provider and fully assumed
- ☐ Provide BLS care to patients and request ALS care assistance if needed by a patient under your care
- ☐ If necessary to leave PHSS for any length of time, ensure patients are signed out to other providers and that permission to leave site is obtained from Site Commander
- ☐ Ensure ongoing fitness for duty by caring for emotional, mental and physical needs, including seeking relief from duty if necessary
- ☐ Keep Site Commander informed of needs of patients under your care and change in condition or situation
- ☐ Assist evacuation of facility if site should become threatened
- ☐ Brief incoming provider assigned to your patients at shift change and do not leave until care has been fully transitioned to new provider
- ☐ Assist with demobilization of facility
- ☐ Other duties as assigned, including cleaning, maintenance or duties outside PHSS site if so assigned

PHSS Clerk EMT Basic

You Report to:	Site Commander, PHSS or alternate supervisor assigned by Site Commander
Site:	Local community PHSS
Job Shift(s):	12 hour shifts, 12 on-12 off
Supervise:	None

Mission: Provide administrative services to PHSS

Qualifications:

- ☐ EMT Basic with active license
- ☐ Training in use of PHSS equipment and procedures
- ☐ Familiarity with state standard protocols
- ☐ Assigned by DOC

Equipment:

- ☐ EMS personal identification
- ☐ Material located in the PHSS

Immediate Duties:

- ☐ Read this entire job action sheet
- ☐ Arrive on scene and report to Site Commander
- ☐ Setup communications equipment, obtaining any assistance needed to establish links; confirm links have been established and notify Site Commander
- ☐ Be familiar with assigned tasks and work areas for which you are responsible
- ☐ Know and follow all safety rules and EMS standard state protocols

Ongoing Duties:

- ☐ Leave clerical duties to assist with any patient care if so directed by supervisor
- ☐ Ensure all staff are signed in and out of facility
- ☐ Prepared duty roster for future shifts and, when necessary, contact PHSS staff not on duty to ensure their timely arrival
- ☐ Keep supply room orderly and know location of all patient care materials for rapid access
- ☐ Notify supervisor if any material resources are running low
- ☐ Secure supplies from supply room on request from patient care provider
- ☐ Contact the DOC to determine destinations for patients which have been designated as ready for discharge to transport vehicle
- ☐ Contact EMS vehicle staging to arrange transport to a destination hospital or contact the DOC if EMS vehicle staging is unavailable
- ☐ Ensure appropriate documentation goes with patient when discharged from the facility
- ☐ Ensure each patient goes onto correct transport bound for correct destination
- ☐ Order additional patient care materials through DOC or secure additional materials from EMS cache
- ☐ Request DOC to assign additional staff to PHSS if so requested by supervisor

- [ ] Secure materials from outside the PHSS if so directed by supervisor
- [ ] Set up additional beds and space if needed to expand PHSS
- [ ] Log each patient into and out of the PHSS, ensuring each patient receives a tracking wrist band and the number if recorded
- [ ] Contact the coroner and/or law enforcement if so directed for processing of a death and contact a funeral home when cleared to do so by the coroner
- [ ] Maintain communication links and communication equipment
- [ ] Other duties as assigned, including cleaning, maintenance or duties outside PHSS site if so assigned