CHAPTER 41

ADVANCED LIFE SUPPORT SERVICES; MOBILE INTENSIVE CARE PROGRAMS, SPECIALTY CARE TRANSPORT SERVICES AND AIR MEDICAL SERVICES

Authority

N.J.S.A. 26:2K–7 through 20 and 35 through 38.

Source and Effective Date

R.2004 d.109, effective April 19, 2004.
See: 35 N.J.R. 2059(a), 36 N.J.R. 1965(a).

Chapter Expiration Date

Chapter 41, Advanced Life Support Services; Mobile Intensive Care Programs, Specialty Care Transport Services and Air Medical Services, expires on April 19, 2009.

Chapter Historical Note

Chapter 41, Mobile Intensive Care Programs, was adopted as R.1987 d.112, effective February 17, 1987. See: 18 N.J.R. 602(a), 19 N.J.R. 357(a).

Pursuant to Executive Order No. 66(1978), Chapter 41, Mobile Intensive Care Programs, was readopted as R.1992 d.113, effective February 13, 1992. See: 23 N.J.R. 3734(a), 24 938(a). Chapter 41 expired on February 13, 1993.

Chapter 41, Mobile Intensive Care Programs, was adopted as new rules by R.1993 d.202, effective June 21, 1993. See: 24 N.J.R. 3255(b), 25 N.J.R. 2721(b). Subchapter 11, Paramedic Clinical Training Objectives, was adopted as R.1994 d.35, effective January 18, 1994. See: 25 N.J.R. 2665(a), 26 N.J.R. 355(a). Pursuant to Executive Order No. 66(1978), Chapter 41expired on June 21, 1998.

Chapter 41, Mobile Intensive Care Programs, was adopted as new rules by R.1998 d.433, effective August 17, 1998. See: 30 N.J.R. 1549(a), 30 N.J.R. 3089(a). Chapter 41, Mobile Intensive Care Programs, expired on August 17, 2003.

Chapter 41, Advanced Life Support Services, Mobile Intensive Care Programs, Specialty Care Transport Services and Air Medical Services, was adopted as new rules by R.2004 d.109. See: Source and Effective Date.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. AUTHORITY, SCOPE AND DEFINITIONS

8:41–1.1 Authority

These rules are promulgated pursuant to N.J.S.A. 26:2K–7 through 20 and 26:2K–35 through 38, which authorize the Commissioner to adopt rules pertaining to the operation of programs and services providing, or seeking to provide, advanced life support care.

8:41–1.2 Scope and purpose

(a) These rules shall apply to any person, public or private institution, agency, entity, corporation, acute care hospital and/or business concern that operates, or seeks to operate, a mobile intensive care program, specialty care transport service and/or air medical service within the State of New Jersey. These rules serve to define the operational requirements of these services, to provide for a uniform application of standards, and to specify the personnel, equipment, organization and other resources required to successfully operate such services.

(b) N.J.A.C. 8:41–1 through 9 and 12 shall apply to mobile intensive care programs.

(c) N.J.A.C. 8:41–1 through 8, 10 and 12 shall apply to specialty care transport services.

(d) N.J.A.C. 8:41–1 through 8, 11 and 12 shall apply to air medical services.

8:41–1.3 Definitions

The following words and terms, as utilized in this chapter, shall have the following meanings, unless the context in which they are utilized clearly indicates otherwise:

"ACLS certification" or "certification in ACLS" means valid certification in Advanced Cardiac Life Support as issued by the American Heart Association.

"Acute care hospital" means any hospital, validly licensed by the Department, which maintains and operates organized facilities and services for the diagnosis, treatment or care of persons suffering from acute illness, injury or deformity and in which all diagnoses, treatment and care are administered by or performed under the direction of persons who, in accordance with N.J.S.A. 45:9–6, are validly licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners.

"Advanced life support" or "ALS" means an advanced level of pre-hospital, inter-facility or emergency medical care that includes basic life support functions, cardiac monitoring, cardiac defibrillation, telemetered electrocardiography, administration of anti-arrhythmic agents, intravenous (IV) therapy, administration of specific medications, drugs and solutions, utilization of adjunctive ventilation devices, trauma care and other techniques and procedures authorized in writing by the Commissioner.

"Advanced practice nurse" means a person who is validly licensed by the New Jersey Board of Nursing in accordance with the standards set forth at N.J.S.A. 45:11–45 et seq.

"Advertising" means any information directly or indirectly issued, distributed, hand-delivered or implied through any medium and utilized for the purpose of promoting the service of a provider.

"AHA CPR Guidelines" means the "Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care" as published by the American Heart Association, National Center, 7272 Greenville Avenue, Dallas, TX 75231–4596, incorporated herein by reference, as amended and supplemented. A copy of the guidelines is on file and available for inspection at the Office of Emergency Medical Services.

"Aircraft" means a device that is utilized, or intended to be utilized, for flight in the air, and shall include both airplanes and helicopters.

"Air medical service" means an entity that is validly licensed by the Department to provide pre-hospital advanced life support care to accident or trauma victims or ALS inter-facility transfers of acutely ill or injured patients requiring specialty medical care by way of a specially equipped and specially staffed air medical unit.

"Air medical unit" or "AMU" means a specially equipped helicopter or airplane that is validly licensed by the Department and operated in accordance with the standards set forth in this chapter.

"Airplane" means, as defined at 14 C.F.R. 1.1, an engine-driven fixed-wing aircraft heavier than air, which is supported in flight by the dynamic reaction of the air against its wings.

"ALS crewmember" means:

1. A registered nurse who meets the requirements set forth at N.J.A.C. 8:41–9.9 or 10.8(d)1 through (d)5vii; and/or

2. An EMT–Paramedic, who staffs a mobile intensive care unit, specialty care transport unit or air medical unit.

"ALS inter-facility transfer" means the transportation of a patient in need of advanced life support care or medical monitoring that is beyond the capabilities of BLS ambulances and their crewmembers from one health care facility to another (such as a nursing home, rehabilitation facility or other facility as provided for at N.J.S.A. 26:2H–2a) via a specialty care transport unit or air medical unit.

"AMD Standard" means the ambulance design and construction specifications (KKK–A–1822E) published by the Ambulance Manufacturers Division of the Truck Body and Equipment Association. Copies of the standards may be obtained from the Truck Body and Equipment Association, Suite 1220, 5530 Wisconsin Avenue, Washington, D.C. 20015.

"APLS certification" or "certified in APLS" means valid certification in Advanced Pediatric Life Support as issued by the American College of Emergency Physicians and the American Academy of Pediatrics.

"Automated external defibrillator or AED" means a device that can be attached to a patient in cardiopulmonary arrest, analyze an electrocardiogram for the presence of potentially lethal dysrhythmias (specifically, ventricular fibrillation and fast ventricular tachycardia), deliver an electrical defibrillation to the patient in accordance with the requirements of standard treatment protocols, and produce an event summary that documents significant events in the utilization of the device, specifically events prior to and after an electrical defibrillation.

"Available" means ready for immediate utilization (pertaining to equipment, vehicles and personnel) or immediately accessible (pertaining to records).

"Base station" means the actual communications console that permits the receiving of voice communications as well as telemetered electrocardiograms. Such base station shall be readily accessible to the medical command physician.

"Basic life support" or "BLS" means a basic level of pre-hospital care that includes patient stabilization, airway clearance and maintenance, cardiopulmonary resuscitation (CPR) (to the level of the Professional Rescuer or Health Care Provider as issued by either the American Heart Association, the American Red Cross, the National Safety Council or other entity determined by the Department to comply with AHA CPR Guidelines), hemorrhage control, initial wound care, fracture stabilization, victim extrication and other techniques and procedures as defined in the

United States Department of Transportation (U.S.D.O.T.) EMT–Basic National Standards Curriculum (obtainable from The National Highway Traffic Safety Administration, 400 7th Street S.W., Washington, D.C. 20590, by accessing their website at www.nhtsa.dot. gov/people/injury/ems or by calling (888) 327–4236).

"Basic life support ambulance" or "BLS ambulance" means an emergency medical services vehicle that is validly licensed by the Department and operated in accordance with the standards set forth at N.J.A.C. 8:40.

"Basic life support ambulance service" or "BLS ambulance service" means an entity that is validly licensed by the Department to provide pre-hospital basic life support care; and/or BLS inter-facility transfers.

"BLS inter-facility transfer" means the transportation of a patient not in need of advanced life support care from one health care facility to another via a basic life support ambulance.

"BTLS certification" or "certification in BTLS" means valid certification in Basic Trauma Life Support as issued by the American College of Emergency Physicians.

"Cardiac defibrillation" means the discharge of electrical current through the fibrillating myocardium for the purpose of restoring a perfusing cardiac rhythm.

"Certificate of need" means the formal written approval of the New Jersey Department of Health and Senior Services to construct or expand a health care facility or to institute a new health care service, in accordance with requirements set forth at N.J.A.C. 8:33.

"Certified" or "certification" means official documentation that a person has completed all the requirements of an approved training program and has demonstrated competence in the subject matter to the satisfaction of the certifying agency.

"Commissioner" means the Commissioner of the New Jersey Department of Health and Senior Services.

"Communicable disease" means an illness due to a specific infectious agent or its toxic products, specifically including, but not limited to, those pathogens defined in the Federal bloodborne pathogen standards found at 29 C.F.R. 1910.1030(b), and which occurs through transmission of that agent or its toxic products from a reservoir to a susceptible host.

"Communications failure," when applied to medical command, means circumstances that prevent ALS crewmembers from engaging in two-way communications with the medical command physician due to technical difficulties.

"Communications failure protocols" means the specific course of treatment to be followed by ALS crewmembers in the event that two-way communications with the medical command physician cannot be made. Communications failure protocols shall first be approved by the Department, in accordance with N.J.A.C. 8:41–3.21.

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

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

"Controlled dangerous substance" means a drug, substance or immediate precursor identified in Schedules I through V of the New Jersey Controlled Dangerous Substances Act (N.J.S.A. 24:21–5 through 24:21–8.1). The term shall not include distilled spirits, wine or malt beverages, as those terms are defined or utilized in N.J.S.A. 33:1–1 et seq., or tobacco and tobacco products.

"Convicted" or "conviction" means a finding of guilt by a judge or jury, a guilty plea, a plea of nolo contendere or non-vult or entry into a pre-trial intervention program, or other diversionary program authorized under the statutes of the State of New Jersey or under any other state's statutes.

"CPR certification" means valid certification in cardiopulmonary resuscitation to the level of the Professional Rescuer or Health Care Provider as issued by either the American Heart Association, the American Red Cross, the National Safety Council or other entity determined by the Department to comply with AHA CPR Guidelines.

"Crashworthy" means that all supplies, equipment, oxygen systems and patient litters carried on the vehicle shall remain firmly in place and shall not present a hazard to any vehicle occupant in the event of an accident or sudden change in vehicle speed or direction. Crashworthy retention systems shall not incorporate rubber straps, "shock cords" or Velcro® type closures. Crashworthy retention systems for some items are covered by specific Federal standards. The Department's test for crashworthiness of other retention systems is whether the item can be removed from place without unlatching or unbuckling the retention system.

"Crewmember" means any person (including, but not limited to, an EMT–Basic, EMT–Paramedic or registered nurse, excluding pilots) who staffs a mobile intensive care unit, specialty care transport unit or air medical unit.

"Crime" means, in accordance with the New Jersey Code of Criminal Justice, specifically N.J.S.A. 2C:1–4, any offense for which a sentence of imprisonment in excess of six months is authorized.

"Department" means the New Jersey Department of Health and Senior Services.

"Department–Initiated–Out–of–Service" or "DIOOS" means the immediate removal from service of a vehicle by Department staff, such that the vehicle may not be utilized for the provision of any basic and/or advanced life support care. Vehicles removed from service in this manner shall be identified by the placement of an official Department "Out-of-Service" sticker on at least one of the vehicle's windows.

"Director" means the person responsible for all activities of a mobile intensive care program or air medical service. The criteria for directors differ for mobile intensive care programs and air medical services. The specific criteria for each is set forth at N.J.A.C. 8:41–9.3 and 11.3, respectively.

"Disorderly persons offense" or "petty disorderly persons offense" shall have the same meaning as the definition provided by the New Jersey Code of Criminal Justice at N.J.S.A. 2C:1–4, incorporated herein by reference, as amended and supplemented. Generally, such offenses are under the jurisdiction of municipal courts, carry out a maximum jail term of six months or less, and are characterized by being minor in nature, not giving rise to the rights of trial by jury or indictment by grand jury. Examples of these offenses include harassment, obstructing a public passage, and fighting in a public place.

"Emergency" means a person's perceived need for immediate medical care in order to prevent death or aggravation of physiological or psychological illness or injury.

"Emergency medical services" or "EMS" means a system for the provision of emergency care and transportation of persons who are sick or injured and in need of immediate medical care.

"Emergency Medical Technician–Basic" or "EMT–Basic" means a person trained in basic life support care and validly certified or recognized by the Commissioner in accordance with the standards for Emergency Medical Technician–Basic certification as set forth at N.J.A.C. 8:40A.

"Emergency Medical Technician–Paramedic" or "EMT–Paramedic" means a person trained in advanced life support care and validly certified or recognized by the Commissioner in accordance with the standards for Emergency Medical Technician–Paramedic certification as set forth at N.J.A.C. 8:41A.

"Emergency response" means the provision of pre-hospital basic life support care by crewmembers staffing a basic life support ambulance, and includes those services that are provided after a call has been received by a 9–1–1 dispatcher requiring an immediate response (for example, automobile accidents, mass gatherings, special events and stadium/arena EMS services) as well as emergent responses to long-term care facilities that may or may not be routed through a 9–1–1 dispatcher.

"EMS educator" means the person responsible for coordinating all activities associated with the clinical portion of an EMT–Paramedic training program. The specific responsibilities required of an EMS educator are set forth at N.J.A.C. 8:41A–2.4(c)1 through 8.

"EMT–Paramedic student" means a person enrolled in an approved EMT–Paramedic training program, as provided for at N.J.A.C. 8:41A. An EMT–Paramedic student shall not be utilized to meet the minimum staffing requirements set forth at N.J.A.C. 8:41–9.8, 10.7 or 11.7.

"EMT–Paramedic training program" means a course of study, as provided for at N.J.A.C. 8:41A, consisting of both didactic and clinical instruction, designed for the purpose of preparing a person to sit for the National Registry of Emergency Medical Technicians–Paramedic Certification Examination.

"Federal Specification, KKK–A–1822" means the Federal Specification for the Star-of-Life Ambulance KKK–A–1822E, Edition E, June 1, 2002, incorporated herein by reference, as amended and supplemented. Copies of the standards may be obtained from the General Services Administration, Centralized Mailing List Service (TCAFL) P.O. Box 6477, Fort Worth, Texas 76115.

"Flight nurse" means a registered nurse who meets the criteria set forth at N.J.A.C. 8:41–9.9 and who has successfully completed specialized training in air medical care. Flight nurses are given a unique identification number.

"Flight paramedic" means an individual certified by the Department as an Emergency Medical Technician–Paramedic in accordance with the standard set forth in N.J.A.C. 8:41A and who has successfully completed specialized training in air medical care. Flight paramedics are given a unique identification number.

"FMVSS" means Federal Motor Vehicle Safety Standards, as set forth at 49 C.F.R. 571, incorporated herein by reference. Copies of the standards may be obtained from the Superintendent of Documents, Washington, D.C.

"Health care facility" means a facility so defined in the Health Care Facilities Planning Act, N.J.S.A. 26:2H–1.1 et seq.

"Helicopter" means a heavier-than-air aircraft that depends principally for its support in flight on the lift generated by one or more rotors.

"Impervious" means not allowing liquids or dirt to penetrate the surface of the material. For the purposes of this chapter, impervious surfaces do not include coverings made of or containing carpet, velour or cloth.

"In-service" means the presence of a mobile intensive care unit, specialty care transport unit or air medical unit at a sending or receiving health care facility; the picking up, transporting or discharging of any patient; or any instance where the mobile intensive care unit, specialty care transport unit or air medical unit is ready to accept patients and perform advanced life support care.

"JEMS (Jersey Emergency Medical Services) Communications Plan" means the authorized communications plan for emergency medical services, as issued by the Department. Copies of the plan are available, for a fee, from the Office of Emergency Medical Services.

"License" or "licensed" means validly licensed by the Commissioner in accordance with the standards for licensure as set forth in this chapter.

"Medical command" means the medical direction provided to ALS crewmembers by a medical command physician. The criteria for medical command differ for mobile intensive care units, specialty care transport units and air medical units. The specific criteria for each is set forth at N.J.A.C. 8:41–9.6, 10.6 and 11.6, respectively.

"Medical command physician" means a physician validly licensed by the New Jersey Board of Medical Examiners or another state's board of medical examiners (or equivalent licensing agency) who provides medical direction to ALS crewmembers via radio, telephone or other direct means of communications. The criteria for medical command physicians differ for mobile intensive care units, specialty care transport units and air medical units. The specific criteria for each is set forth at N.J.A.C. 8:41–9.5, 10.5 and 11.5, respectively.

"Medical control" means the general medical oversight provided to the operations of a mobile intensive care program, specialty care transport service or air medical service, including written protocols, quality assurance and other medical supervision of the service's operations.

"Medical director" means the physician responsible for the medical oversight of the operations of a mobile intensive care program, specialty care transport service or air medical service. The specific criteria required of a medical director are set forth at N.J.A.C. 8:41–9.4, 10.4 and 11.4, respectively.

"Medical record" means any information and/or reports (including, but not limited to, patient care reports) that describe a person's physical condition and/or medical history.

"MICU Advisory Council" means the advisory council charged with advising the Commissioner on matters regarding the provision of pre-hospital advanced life support care, as defined at N.J.S.A. 26:2K–16.

"Mobile intensive care hospital" means an acute care hospital authorized by the Commissioner, by way of a certificate of need, to develop and maintain a mobile intensive care program for the purpose of providing advanced life support care to a specific population, geographic region or political subdivision.

"Mobile intensive care nurse" or "MICN" means a registered nurse who meets all of the criteria set forth at N.J.A.C. 8:41–9.9.

"Mobile intensive care program" means a program, operated by a mobile intensive care hospital, which is validly licensed by the Department to provide pre-hospital advanced life support care by way of a specially equipped and staffed mobile intensive care unit. The mobile intensive care hospital shall be vested with the ultimate responsibility for the delivery of services and shall be held accountable for the actions of all of its crewmembers in the event that there are violations of any State or Federal licensing standards.

"Mobile intensive care unit" or "MICU" means a specialized emergency medical services vehicle that is validly licensed by the Department and operated in accordance with the standards set forth in this chapter.

"Mobility assistance vehicle" or "MAV" means a specialized transport vehicle that is validly licensed by the Department and operated in accordance with the standards set forth at N.J.A.C. 8:40.

"Neonatal" means the period of time from the moment of birth up to and including the 28th day following birth.

"Office of Emergency Medical Services" or "OEMS" means the Office of Emergency Medical Services in the New Jersey Department of Health and Senior Services, PO Box 360, Trenton, New Jersey 08625–0360. The telephone number for OEMS is (609) 633–7777.

"PALS certification" or "certification in PALS" means valid certification in Pediatric Advanced Life Support as issued by the American Heart Association.

"Patient" means any person who is ill or injured, living or deceased and with whom a crewmember has established physical or verbal contact.

"Patient care report" means the written documentation completed each time a crewmember makes physical or verbal contact with a patient.

"Pediatric" means the period of time beginning with the 29th day following birth up to, but not including, a person's thirteenth birthday.

"Petty disorderly persons offense" shall have the same meaning as the definition provided by the New Jersey Code of Criminal Justice at N.J.S.A. 2C:1–4, incorporated herein by reference, as amended and supplemented. Generally, such offenses are under the jurisdiction of municipal courts, carry a maximum jail term of six months or less, and are characterized by being minor in nature, not giving rise to the rights of trial by jury or indictment by grand jury. Examples of these offenses include harassment, obstructing a public passage, and fighting in a public place.

"Physician" means a person who is validly licensed by the New Jersey State Board of Medical Examiners in accordance with the standards set forth at N.J.S.A. 45:9–6.

"Physician assistant" means a person who is validly licensed by the New Jersey State Board of Medical Examiners in accordance with the standards set forth at N.J.S.A. 45:9–27.13.

"PHTLS certification" or "certification in PHTLS" means valid certification in Pre–Hospital Trauma Life Support as issued by the National Association of EMTs.

"Positive latching mechanism" means a latching mechanism that requires the manual release of the latching device. This does not include magnetic or friction-type latches.

"Pre-hospital" means the period of time prior to the delivery of a patient to a physician or registered nurse at an acute care hospital or satellite emergency department.

"Provider" means a mobile intensive care program, specialty care transport service or air medical service. By virtue of such status, the provider shall assume full legal responsibility for the delivery of services and shall be held accountable for the actions of its crewmembers in the event that there are violations of any State or Federal licensing standards.

"Provider–Initiated–Out–of–Service" or "PIOOS" means the temporary removal from service of a vehicle by the provider. A provider may choose to remove a vehicle from service for various reasons including, but not limited to, when the vehicle is in transit for repairs, when being utilized for official administrative duties or when being utilized in a parade or similar ceremony. Vehicles removed from service in this manner shall be identified by the placement of a placard in one of the vehicle's windows.

"Receiving health care facility" means a licensed health care facility, such as a nursing home, rehabilitation facility or other facility as provided for at N.J.S.A. 26:2H–2a, to which a patient is transferred following evaluation and/or treatment.

"Regional dispatch center" means a facility that provides coordinated dispatching of emergency services for a given area.

"Regional trauma center" means a State designated Level One hospital-based trauma center equipped and staffed to provide emergency medical services to accident or trauma victims.

"Registered nurse" means a person who is validly licensed by the New Jersey State Board of Nursing in accordance with the standards set forth at N.J.S.A. 45:11–26.

"Regulated medical waste" means, as defined at N.J.A.C. 7:26–3A.5, those medical wastes that have been listed or meet the waste characteristic classification criteria described at N.J.A.C. 7:26–3A.6 and that must be managed in accordance with the requirements of N.J.A.C. 7:26–3A.

"Respiratory care practitioner" means a person who is validly licensed by the New Jersey State Board of Respiratory Care in accordance with the standards set forth at N.J.S.A. 45:14E–10.

"Revocation" or "revoked" means the permanent voiding, withdrawal and/or cancellation of a license or certification.

"Satellite emergency department" means a facility that is owned and operated by an acute care hospital, which provides emergency care and treatment.

"Sending health care facility" means a licensed health care facility such as a nursing home, rehabilitation facility or other facility as provided for at N.J.S.A. 26:2H–2(a), incorporated herein by reference as amended and supplemented, from which a patient is transferred by the patient's attending physician for treatment or services not available at the sending licensed health care facility.

"Specialty care coordinator" means the person responsible for the general operation of a specialty care transport service. The criteria for a specialty care coordinator is set forth at N.J.A.C. 8:41–10.3.

"Specialty care transport service" means an entity that is validly licensed by the Department to provide ALS interfacility transfers, by way of a specially equipped and staffed specialty care transport unit, between a sending health care facility and a receiving health care facility (such as a nursing home, rehabilitation facility or other facility as provided for at N.J.S.A. 26:2H–2a) of patients requiring specialized medical intervention or medical monitoring that is beyond the capabilities of BLS ambulances and their crewmembers.

"Specialty care transport unit" or "SCTU" means a specialized transport medical service vehicle that is validly licensed by the Department and operated in accordance with the standards set forth in this chapter.

"Specialty staff" means validly licensed or certified persons such as physicians, specially trained nurses or respiratory care practitioners that may accompany the required crewmembers on a mobile intensive care unit, specialty care transport unit or air medical unit.

"Specific order" means an order by a medical command physician with regard to the treatment of a patient, whether directly transmitted by the physician or relayed through a registered nurse.

"Standing orders" means specific treatment protocols, authorized by the Commissioner, that occur prior to any communications with the medical command physician.

"Star of Life" means the symbol described in certification of registration number 1,058,022, which the United States Commissioner of Patents and Trademarks has issued to the National Highway Traffic Safety Administration.

"Therapeutic agent" means any drug or agent which is utilized in the treatment of the sick or injured, including those authorized in accordance with N.J.A.C. 8:41–6.1.

"Untreated regulated medical waste" means regulated medical waste, as defined in this subchapter, which has not been treated to substantially reduce or eliminate its potential for causing disease.

"Valid" or "validly" means original (not a photo copy), current, up-to-date, not expired, in effect and/or not past the renewal date required by the issuer.

"Vehicle" means a mobile intensive care unit, specialty care transport unit or air medical unit, as defined in this subchapter.

8:41–1.4 Waivers

(a) The Commissioner or his or her designee may grant a waiver of any part of this chapter if, in his or her opinion, such a waiver would not:

1. Endanger the life of any person;

2. Endanger the public health, safety or welfare; or

3. Adversely affect the provision of advanced life support care.

(b) A provider or applicant, as applicable, seeking a waiver shall apply, in writing, to OEMS.

(c) An application for waiver shall include the following:

1. The nature of the waiver requested;

2. The specific standards for which a waiver is requested;

3. Reasons for requesting a waiver, including a statement of the type and degree of hardship that would occur if the waiver is not granted;

4. An alternative proposal that would ensure public safety; and

5. Documentation to support the waiver application.

(d) The Department reserves the right to request additional information before processing an application for waiver.

SUBCHAPTER 2. LICENSURE, INSPECTIONS AND AUDITS

8:41–2.1 Application for licensure

(a) Any person, public or private institution, agency, entity, corporation, acute care hospital or business concern seeking to be licensed to operate a mobile intensive care program, specialty care transport service or air medical service shall:

1. Fully complete an OEMS application for licensure, listing the name(s), home addresses and telephone numbers of all persons with an ownership interest in the proposed service. However, applicants that are publicly held corporations need only list the person, corporation and/or entity with the controlling interest and those persons, corporations and/or entities holding five percent or more of the available shares of the corporation;

i. Incomplete applications shall not be processed and shall be returned to the applicant with no action taken. Incomplete applications may be completed and returned to the Department within six months from the date on which the application was returned to the applicant without the requirement of a second application fee. Once an applicant has been notified that the application is complete, the applicant shall have six months within which to request an initial provider audit and vehicle inspections. Failure to comply with these time frames shall require submission of a new application and fee;

ii. No application shall be processed if the proposed trade name of the service duplicates or is essentially similar to a licensed service's trade name or the proposed trade name of an applicant that has an application pending before the Department;

2. Provide the Department with the specific street address of the principal place of business of the proposed service. The principal place of business shall be located on an actual piece of real property and shall not be a post office box or mail drop. Applications listing a post office box or mail drop as the principal place of business shall be rejected;

3. Make available to the Department upon request a copy of the standard operating procedures (SOP) manual, which addresses all of the areas identified at N.J.A.C. 8:41–3.12. No provider shall develop policies that are contrary to any applicable law, rule and/or regulation;

4. Demonstrate that it maintains crewmember personnel files that meet the standards set forth at N.J.A.C. 8:41–3.13;

5. Demonstrate that it shall have at least one licensable vehicle in each class of service for which it is applying for licensure;

6. Provide the Department with proof that insurance has been purchased and is in force, as outlined at N.J.A.C. 8:41–3.16; and

7. Provide the Department with a signed "Request For Criminal History Record Information For A Non-criminal Justice Purpose" (SBI 212B Form), for submission by OEMS to the New Jersey State Police, State Bureau of Identification. The form shall be accompanied by payment in the form and amount specified at N.J.A.C. 13:59, Criminal History Record Background Checks, as amended and supplemented;

i. A separate form must be submitted for each person with an ownership interest of five percent or more;

ii. Acute care hospitals and governmental entities (such as municipalities and State agencies) shall be exempt from this requirement; and

8. Applicants seeking licensure as a specialty care transport services and all non-governmental air medical service applicants shall provide OEMS with a copy of valid incorporation papers and a valid government issued photo I.D. (for example, a passport or a state-issued driver's license) that can be utilized to verify the applicant's identify.

(b) Applicants seeking licensure as a mobile intensive care program or air medical service shall provide OEMS with documentation that, consistent with N.J.A.C. 8:41–9.19 or 11.17, as applicable, it has entered into a dispatch agreement with, and has secured the services of, a regional dispatch center.

(c) The ownership of any public or private institution, agency, entity, corporation or business concern applying for licensure shall be disclosed to the Department at the time of application in accordance with (a) above.

1. Acute care hospitals shall list the chief executive officer of record.

2. Publicly held corporations (that is, corporations whose stock is publicly traded) shall list the person, corporation and/or entity with the controlling interest, as well as all persons, corporations and/or entities owning five percent or more of the shares of the corporation.

(d) An applicant shall not knowingly file any record or document that is falsified, fraudulent or untrue. The filing of such false records or documents shall be sufficient cause for refusal to issue or renew a license and/or revocation of any existing provider and/or vehicle licenses.

8:41–2.2 Track record review

(a) The Department shall conduct a track record review of each proposed owner to determine whether the applicant or applicants have a demonstrated capacity to provide a high quality of care and to operate a mobile intensive care program, specialty care transport service and/or and air medical service in accordance with the rules contained in this chapter.

1. This review shall encompass the previous licensing track record of the applicant, both in New Jersey and in any other state. This evaluation shall include all other health care facilities and/or services owned, operated or managed by the applicant and any such facilities and/or services owned, operated or managed by any entity affiliated with the applicant.

(b) The Department may refuse to issue a license if the applicant cannot demonstrate that the equipment, personnel, finances, policies, procedures and standards of health care are fit and adequate and that there is a reasonable assurance that the service will be operated in accordance with the standards required by these rules. In making this determination, the Department may take into consideration:

1. Conviction of Medicare, Medicaid or insurance fraud (regardless of the amount of the monetary penalty, term of imprisonment or other penalty imposed);

2. Conviction of any crime;

3. Conviction of any disorderly persons offense;

4. Conviction of a petty disorderly persons offense;

5. Revocation of a license or certification as a physician, physician assistant, registered nurse, advanced practice nurse, EMT–Basic and/or EMT–Paramedic;

6. Revocation of a license to operate a health care facility or service (including, but not limited to, a BLS or ALS ambulance, MAV or similar transport or emergency response service) either in New Jersey or in any other state;

7. Licensure violations representing serious risk of harm to patients; and/or

8. The applicant's compliance with the standards of accreditation or membership of any and all nationally recognized professional organizations and/or associations.

8:41–2.3 General licensing information

(a) Upon finding that an applicant has met all of the requirements for licensure as set forth at N.J.A.C. 8:41–2.1 and 2.2, the Department may issue the applicant a provider and/or applicable vehicle licenses. The provider license shall be prominently displayed at the provider's principal place of business. For MICUs that have authorization to transport patients and SCTUs, the original vehicle license shall be affixed to the lower right corner of the window of the rear (curbside) door of the patient compartment in such a manner that it is readable from outside the vehicle. For AMUs and non-transport MICUs, the original vehicle license shall be kept in the glove compartment or similar storage area within the vehicle, and shall be made available to Department staff upon demand.

1. In order to facilitate the licensure of a new vehicle in the field, Department staff may issue a Certificate of Inspection. This Certificate of Inspection shall be valid for not more than 30 calendar days from the date of issue, and shall serve as authorization for operation of the vehicle while the provider is awaiting delivery by OEMS of the computer-generated vehicle license.

(b) Providers with trade names beginning with the letters "A" through "L" shall be issued licenses that shall expire on December 31st of the next year that ends in an even number (for example, December 31, 2002). Applicants with trade names beginning with the letters "M" through "Z" shall be issued licenses valid for a period not to exceed 24 months, which shall expire on December 31st of the next year that ends in an odd number (for example, December 31, 2003).

(c) Provider and vehicle licenses shall be valid for a period not to exceed 24 months. Provider and vehicle licenses, except those that have been suspended, revoked or otherwise invalidated, shall be renewed prior to the expiration date noted on the license, contingent upon the provider submitting an application for renewal and maintaining full compliance with all the requirements contained in this chapter. No vehicle license shall extend beyond the expiration date of the provider license.

(d) Provider and vehicle licenses are the property of the Department, and shall be immediately surrendered to Department staff upon demand. All licenses shall become immediately null and void and shall be returned to the Department concurrent with the revocation or surrender of a provider's license or when a vehicle is sold, becomes unusable, is retired from service or has been in PIOOS or DIOOS status for six or more consecutive months. Licenses shall not be assignable or transferable. Rights afforded to a provider under this chapter are not assignable to any other person, public or private institution, agency, entity, corporation or business concern.

(e) A provider shall contact the Department to ascertain if new provider and vehicle licenses are needed prior to making any changes in its scope of services.

8:41–2.4 Exemptions from licensing requirements

(a) Any person, public or private institution, agency, entity, corporation or business concern providing pre-hospital advanced life support care in any form or manner and/or ALS inter-facility transfers, where the transport originates within the State of New Jersey, shall first be licensed by the Department in accordance with the provisions of this chapter. For the purpose of this paragraph, areas of exclusive Federal jurisdiction shall not be considered "within the State of New Jersey." However, the licensing requirements of this chapter shall not apply to providers that are based in other states and that provide service in New Jersey when the provider is:

1. Transporting a patient through New Jersey from an out-of-State location to another out-of-State location;

2. Transporting a patient from an out-of-State location to a New Jersey location and returning that same patient to an out-of-State location on the same day; or

3. Transporting a patient on a one-way trip from an out-of-State location to a New Jersey location.

(b) The licensing requirements contained in this chapter shall not apply to services operated directly by an agency of the government of the United States. However, providers holding United States government contracts are not exempt from licensure unless the provider only provides services within an area of exclusive Federal jurisdiction (for example, providing emergency response services within the confines of a United States military base or transporting a patient from a United States military base hospital to a Veterans Administration hospital).

8:41–2.5 Licensure and administrative fees

(a) Licensure fees shall be due when the application is filed, and shall be non-refundable. The application shall be accompanied by a single certified bank check (for example, a cashier's check), corporate check or money order in the correct amount, and shall be made payable to "Treasurer, State of New Jersey." Personal checks shall not be accepted.

(b) The fees for licensure as a new provider shall be as follows:

1. Specialty care transport service: $1,500 plus $100.00 per licensable vehicle.

2. Air medical service: $1,500 plus $100.00 per licensable vehicle.

3. Mobile intensive care program: $100.00 per licensable vehicle.

4. Specialty care transport service and mobile intensive care program: $1,500 plus $200.00 per licensable vehicle.

5. Specialty care transport service and BLS ambulance service: $1,500 plus $200.00 per licensable vehicle.

6. Specialty care transport service, BLS ambulance service and mobile intensive care program: $1,500 plus $300.00 per licensable vehicle.

(c) The fees for licensure as a new provider for applicants making application anytime during the second year of the two-year cycle set forth at N.J.A.C. 8:41–2.3(b) shall be as follows:

1. Specialty care transport service: $1,250 plus $50.00 per licensable vehicle.

2. Air medical service: $1,250 plus $50.00 per licensable vehicle.

3. Mobile intensive care program: $50.00 per licensable vehicle.

4. Specialty care transport service and mobile intensive care program: $1,250 plus $10.00 per licensable vehicle.

5. Specialty care transport service and BLS ambulance service: $1,250 plus $10.00 per licensable vehicle.

6. Specialty care transport service, BLS ambulance service and mobile intensive care program: $1,250 plus $150.00 per licensable vehicle.

(d) The fees for licensure of a new vehicle by a provider at any time during the second year of the two-year cycle set forth at N.J.A.C. 8:41–2.3(b) shall be $50.00 per vehicle.

(e) The fee for renewal of a provider license shall be as follows:

1. Specialty care transport service: $500.00 plus $100.00 per licensable vehicle.

2. Air medical service: $500.00 plus $100.00 per licensable vehicle.

3. Mobile intensive care program: $100.00 per licensable vehicle.

4. Specialty care transport service and mobile intensive care program: $500.00 plus $200.00 per licensable vehicle.

5. Specialty care transport service and BLS ambulance service: $500.00 plus $200.00 per licensable vehicle.

6. Specialty care transport service, BLS ambulance service and mobile intensive care program: $500.00 plus $150.00 per licensable vehicle.

(f) License renewal fees shall be due on or before the date on which the license expires. Applications for renewal submitted after the date on which the license expires shall be accompanied by a late fee in the amount of $500.00; however, applications for renewal submitted 10 or more calendar days after the date on which the license expired shall not be accepted, and the applicant shall be required to submit an application and the appropriate fee for licensure as a new provider. In addition, a provider that allows its license to expire shall be subject to monetary penalties for operation of an unlicensed entity, as provided for at N.J.A.C. 8:41–12.5(a)2ii.

(g) Any and all proposed changes in ownership interest shall be reported to the Department at least 30 calendar days prior to the actual change, except that providers owned by publicly held corporations need only report stock redistributions of five percent or more.

1. Changes in ownership interest that do not involve a change in the controlling interest of a provider, or changes in ownership where an existing owner is assuming the controlling interest, shall be accompanied by a cashier's check or money order in the amount of $250.00 to cover the administrative costs associated with updating the provider's file. The check shall be made payable to "Treasurer, State of New Jersey."

2. All other changes to the controlling interest of a provider shall constitute a complete change in ownership and shall require the submission of an application for licensure by the proposed owner, as set forth at N.J.A.C. 8:41–2.1 and 2.2. No services shall be provided until such time as the applicant has been granted the required provider and vehicle licenses.

3. All licenses shall be immediately void if the controlling interest of a provider is changed without first notifying the Department and receiving all necessary provider and/or vehicle licenses.

(h) Once licensed, it shall be the provider's responsibility to notify the Department of any change of trade name, license plate or vehicle recognition number and to provide appropriate documentation as may be required by the Department. The Department shall charge a nonrefundable fee of $250.00 to process a change of trade name for a provider license where no change of ownership has occurred. The Department shall charge a nonrefundable fee of $20.00 per vehicle to process a change of trade name, vehicle license plate or vehicle recognition number for a vehicle license. Revised vehicle licenses shall be issued only for the vehicle that bears the exact same manufacturer-issued vehicle identification number (VIN).

(i) Governmental entities, such as municipalities and State agencies, are exempt from paying the fees contained in this section, but shall be required to file all appropriate applications.

8:41–2.6 Vehicle inspections and provider audits

(a) Authorized representatives of the Department may conduct periodic vehicle inspections and provider audits to determine compliance with this chapter. Representatives from the Department shall carry and have visible Department-issued identification at all times.

1. The Department may conduct scheduled inspections of each vehicle at least once every year.

2. The Department may conduct unscheduled vehicle inspections and/or provider audits at its discretion.

i. Unscheduled inspections and/or audits may be conducted by an authorized representative of the Department at any time, at any of the provider's places of business or at any place a vehicle is located, provided that patient care is not compromised. Department staff shall not stop any vehicle when it is traveling on a public roadway.

(b) The scope of an inspection and/or audit shall be determined by the representative conducting the inspection and/or audit and may include, but is not limited to, an

examination of all documents and records (including patient records, certification and training credentials, vehicle insurance card, vehicle registration card, crewmember driver's license, crewmember photo I.D., etc.), a review of all equipment, and interviews with crewmembers and patients.

(c) The provider and its employees shall afford Department representatives unimpeded access to the provider's premises and vehicles during the course of such inspections and audits, and shall produce all documents and credentials requested by Department staff upon demand.

(d) The Department shall notify the provider in writing of the results of any vehicle inspection and/or provider audit, including any deficiencies found.

SUBCHAPTER 3. GENERAL ADMINISTRATIVE, CREWMEMBER AND VEHICLE REQUIREMENTS

8:41–3.1 Minimum crewmember requirements

(a) Each MICU and SCTU crewmember that is operating the vehicle shall possess a valid driver's license, as required by N.J.S.A. 39:3–10. Each person piloting an AMU shall possess a valid pilot's license as issued by the Federal Aviation Administration. Licenses shall be made available to Department staff upon demand.

(b) Each crewmember that serves on a MICU, SCTU or AMU shall:

1. Be at least 18 years old;

2. Wear identification clearly setting forth his or her first and last name and the name of the provider on whose behalf he or she is providing care; and

3. Dress in clothing, including any outerwear, of a similar uniform appearance that presents a professional appearance.

i. With respect to AMUs only, each pilot and crewmember shall wear a uniform consisting of a fire-retardant flight suit (for example, a Nomex® flight suit), leather boots that cover the person's ankles and a flight helmet that meets or exceeds all applicable FAA standards.

(c) Identification may be displayed that identifies the person's level of training, completion of training courses and/or membership in a professional association or society; however, identification shall not be displayed that indicates a level of training that the person has not attained.

(d) A person recognized by the Department as a flight nurse, flight paramedic or MICN (MICN defined at N.J.A.C. 8:41–9.9) shall not wear any patches that suggest that they are in any way licensed or certified by the Department or OEMS.

(e) Each crewmember shall possess and shall make available to Department staff upon demand, original and valid certification for the type or level of patient care he or she is providing. No person shall be allowed to provide a type or level of patient care beyond the level he or she is lawfully eligible to provide in the State of New Jersey. In addition, each crewmember shall, upon request by Department staff, produce a valid driver's license and a photo I.D., which Department staff may utilize in order to verify the validity of the required certification credentials. A valid photo driver's license or hospital issued photo ID shall satisfy the photo I.D. requirement.

8:41–3.2 Crewmember competency

(a) Each ALS-certified crewmember shall have knowledge of and/or skills in the following:

1. Application, operation, care and removal of the on-board medical equipment, as well as knowledge of potential in-transport complications which may arise from the utilization of the equipment and the treatment of these complications;

2. The policies and procedures for the operation of a MICU, SCTU or AMU, as applicable;

3. Safety operations for vehicle accident and incident procedures;

4. All communications equipment;

5. All applicable laws, rules and/or regulations including, but not limited to, those set forth at N.J.S.A. 26:2K–7 through 20, N.J.S.A. 26:2K–35 through 38 and N.J.A.C. 8:40, 8:40A, 8:41 and 8:41A; and

6. The scope of practice applicable to his or her respective profession.

i. No crewmember shall draw a patient's blood for the purpose of determining blood alcohol levels to be solely utilized for legal purposes. Blood drawn by a crewmember shall not be provided to any law enforcement agency, except under the order of a court of competent jurisdiction.

ii. No crewmember shall perform phlebotomy for the purpose of collecting a blood specimen to determine the alcohol content solely for legal purposes in the Emergency Department of an acute care hospital, nor shall any crewmember draw any blood sample to be utilized for law enforcement purposes.

iii. Nothing in this chapter shall be construed to prohibit an ALS crewmember from providing any care or treatment that is construed to be a BLS function. This shall include all skills and procedures incorporated in the U.S.D.O.T. EMT–Basic National Standards Curriculum as adopted by the Department in accordance with N.J.A.C. 8:40A. These functions may be performed prior to and without the order of a physician.

(b) Since equipment varies from provider to provider, the provider shall have in each personnel file documentation that the ALS-certified crewmember has completed an orientation for all invasive medical devices carried on the provider's unit prior to utilization on a patient. The orientation shall cover all the operational aspects of the devices for their intended utilization. This review shall be dated and shall contain both the crewmember's and the EMS Educator's signatures.

(c) The documentation identified in (b) above, shall become part of the employee's permanent file and shall be made available to Department staff upon demand.

8:41–3.3 Crewmember duties

(a) The collective duties of the crewmembers staffing a MICU, SCTU or AMU shall include, but are not limited to:

1. Assuring that all required and necessary equipment and supplies are onboard the vehicle and in working order prior to departure;

2. Operating the vehicle in a safe manner, starting and stopping the vehicle slowly and smoothly and complying with all applicable motor vehicle laws, rules and/or regulations (MICUs and SCTUs only). The responsibility for the safe operation of an AMU shall rest with the pilot;

3. Providing the patient with prompt, effective and appropriate medical care;

4. If necessary, assisting to extricate the patient from confinement (MICUs and AMUs only);

5. Loading and unloading the patient from the vehicle or aircraft;

6. Assuring that all ground personnel who may help to load or unload the patient, equipment or supplies observe appropriate safety procedures (AMUs only);

7. Assuring that the patient is attended to by at least one ALS crewmember at all times;

8. Continually monitoring the patient's condition and equipment while providing necessary intervention according to the medical command physician, written protocols and/or standing orders;

9. For seriously ill or injured patients, notifying the receiving health care facility prior to arrival that special professional services and assistance will be needed;

10. Complying with all applicable laws, rules and/or regulations pertaining to universal precautions, body substance isolation procedures and the handling of the deceased;

11. Supervising the well being of the patient and ensuring the patient's privacy and comfort;

12. Assuring that all vehicle occupants (patients, passengers and crewmembers) over eight years of age or under eight years of age but weighing 80 pounds or more are properly restrained, as medically appropriate, either on a stretcher or in an automotive safety belt that meets all State standards including those set forth at N.J.S.A. 39:3–76.2 et seq. All children under eight years of age weighing less than 80 pounds, whether patients or passengers, shall be properly restrained, as medically appropriate, either in a Federally-approved child restraint system as provided for at N.J.S.A. 39:3–76.2a or on a stretcher. The crewmembers need not wear an automotive safety belt when providing essential life support such as CPR;

13. Assuring that all equipment and patient transport devices are safely and properly stored and/or restrained in a crashworthy manner;

14. Prohibiting smoking within the vehicle at all times (MICUs and SCTUs) or within 100 feet of the aircraft at all times (AMUs);

15. Completing the patient care report; and

16. Reporting verbally and leaving a complete copy of the patient care report with an authorized representative of the receiving health care facility no later than 24 hours after completion of the call. Additions to the original report shall not be made once a copy has been delivered to the receiving health care facility, unless such changes are initialed and dated by the person making the change and the receiving health care facility is provided with a copy of the changes.

8:41–3.4 Basic equipment and supplies

(a) When "in-service," each MICU, SCTU and AMU shall be equipped with the following equipment and supplies:

1. An external pacemaker and a cardiac monitor with a DC or biphasic defibrillator that can provide both defibrillation and synchronized cardioversion and is capable of producing a paper recording of cardiac rhythms;

2. Assorted needles, syringes and IV supplies to include:

i. IV tubing and catheters; and

ii. Needle and syringe disposal containers that meet the requirements set forth at N.J.A.C. 8:41–4.2(i);

3. Adult airway management materials including:

i. At least five oropharyngeal and nasopharyngeal airways in assorted sizes and a water-soluble lubricant for utilization with the airways;

ii. Laryngoscope blades, handles, endotracheal tubes, stylets, spare batteries and bulbs;

iii. Oxygen masks and cannulas;

iv. A 1,600 mL sized bag-valve-mask device;

v. Any bag that has a "pop off valve" shall have a device to easily defeat the valve;

vi. A pulse-oximeter; and

vii. End-tidal CO_2 monitors;

4. Transparent domed resuscitation facemasks (at least one each in adult, pediatric and infant sizes) with 22 mm fittings for utilization with the bag-valve-mask device and/or positive pressure device;

5. All medications and solutions set forth at N.J.A.C. 8:41–6.1;

6. An IV infusion pump;

7. A blood glucose monitoring system, either electronic or visual;

8. Adult sized blood pressure cuffs (at least one each in small, medium and large sizes);

9. Six rigid cervical collars of a type approved by the FDA for pre-hospital utilization by EMTs–Basic (for example, StifNeck® or Philadelphia-type) in at least three different sizes, one of which shall be of a size to accommodate pediatric patients;

10. Equipment to perform needle chest decompression;

11. Back-up medications and other equipment needed to provide for uninterrupted service;

12. A sterile obstetrical emergency delivery kit. The items may be individually wrapped or be contained in a "pack." Any pack shall have an exterior itemized list of contents. The kit shall contain the following items:

i. Four towels;

ii. Twelve sterile gauze compresses measuring four inches by four inches;

iii. Four sterile umbilical cord clamps;

iv. One sterile bulb syringe made of soft rubber (for newborn aspiration);

v. One receiving blanket;

vi. One pair of sterile scissors or a sterile scalpel;

vii. At least one set of eye protection or goggles; and

viii. Four pairs of sterile surgical gloves;

13. Wound dressing and burn treatment supplies, to include:

i. Two conforming roller bandages, measuring at least three inches wide by five yards long;

ii. Two triangular bandages (cravats) measuring 36 inches by 36 inches by 51 inches when unfolded;

iii. Four sterile, individually wrapped universal (or multi-trauma) dressings measuring at least nine inches by 30 inches when unfolded;

iv. Ten sterile, individually wrapped gauze pads measuring at least four inches by four inches;

v. Two rolls of medical adhesive type tape;

vi. Four sterile, individually wrapped occlusive dressings or one sterilized roll of aluminum foil; and

vii. Two sterile, individually wrapped burn sheets;

14. Personal protective gear for each required crewmember, to include isolation garments (including respiratory protection masks that are effective in filtering airborne pathogens and gowns), goggles (in addition to any set utilized in the obstetrical emergency delivery kit) and disposable, single-use "biohazard" type examination gloves which are impervious to bodily fluids and provide adequate barrier protection in accordance with 29 C.F.R. 1910.1030, incorporated herein by reference. Gloves and masks shall meet the standards for personal protective equipment set forth at 29 C.F.R. 1910.1030 and shall be disposed of after utilization in accordance with all applicable laws, rules and/or regulations;

15. A copy of the provider's communications failure protocols; and

16. A copy of approved standing orders pursuant to N.J.A.C. 8:41–7 and 8.

(b) In accordance with N.J.A.C. 8:41–6.3, each provider shall devise a plan for maintaining inventory control over medications, including all substances identified in Schedules II and III of the New Jersey Controlled Dangerous Substances Act (N.J.S.A. 24:21–6 and 24:21–7).

(c) Expended supplies and/or damaged equipment shall be replaced as soon as possible after utilization. Equipment may be temporarily left on/with a patient, when medically necessary.

(d) Supplies stored in the cabinets of emergency ambulances and specialty care transport units' shall either be clearly visible through the door of the cabinet or identifiable by way of a list of contents posted on that cabinet.

(e) To the extent possible, all providers shall equip their vehicles with latex-free equipment and supplies in order to accommodate those patients that may have latex allergies.

(f) Each provider may, within the limits and exclusions set forth in this chapter, equip its vehicles with such other equipment and supplies as it deems necessary for the provision of ALS treatment, provided that no equipment or supplies shall be carried that would permit a crewmember to render care beyond his or her scope of practice and/or in violation of the New Jersey Medical Practice Act, N.J.S.A. 45:9–1 et seq.

8:41–3.5 Physical behavioral restraints

(a) Patients shall not be placed and/or transported in physical behavioral restraints unless:

1. A physician or court has authorized the placement of the restraints;

2. The patient is in the custody of a law enforcement officer; or

3. The medical condition of the patient mandates transportation to, and treatment at, a health care facility, and the patient manifests such a degree of behavior that he or she:

i. Poses serious physical danger to himself or herself or to others; or

ii. Causes serious disruption to ongoing medical treatment that is necessary to sustain his or her life or to prevent disability.

(b) Patients placed in physical behavioral restraints shall not be restrained for a period greater than one hour unless:

1. A physician or court has authorized the utilization of the restraints for longer than one hour; or

2. The patient is personally accompanied by a law enforcement officer.

(c) Physical behavioral restraints shall not be of a type, or utilized in a manner, that causes undue physical discomfort, harm or pain to a patient. Hard restraints, such as handcuffs, are specifically prohibited unless a law enforcement officer accompanies the patient. A patient placed in any type of restraint shall be closely monitored to ensure that his or her airway is not compromised in any way. In no circumstance shall a patient be placed prone (that is, face-down) on a stretcher while in restraints.

1. If a crewmember reasonably believes that his or her personal safety is in jeopardy, the crewmember should retreat from the scene and call for police assistance. The crewmember should return to the scene in order to assess and treat the patient only when the scene has been secured. Such retreat shall not be considered patient abandonment unless the crewmembers leave the scene and/or advise the dispatch center that they are available for other calls.

(d) Crewmembers shall not wear or carry any weapons or explosives while on duty. For the purpose of this chapter, the terms "weapons" and "explosives" include not only offensive weapons, but also defensive weapons such as stun guns, stun batons, air tasers, pepper spray, mace defensive spray and/or telescopic steel batons.

(e) The rationale for placing and/or transporting a patient in physical behavioral restraints, and the type of restraints utilized, shall be clearly stated in the patient care report.

8:41–3.6 Pneumatic testing

(a) All respiratory equipment shall be pneumatically tested by the provider at least once a year and, if required by the manufacturer, at more frequent intervals. Standards for performance of all required and optional respiratory equipment are as follows:

1. Each oxygen system shall be capable of delivering oxygen to a patient at a rate of at least 15 liters per minute during the entire time the patient is aboard the vehicle.

2. Each oxygen system shall have an oxygen flowmeter. Each flowmeter shall have a gauge or dial with a range of at least 0 to 15 liters per minute (lpm) in calibrated increments. The flowmeter on portable systems shall not be gravity dependent. Flowmeters shall be accurate to within 1 lpm when at a setting equal to or less than 5 lpm, 1.5 lpm when at a setting between 6 lpm and 10 lpm and within 2 lpm when at a setting equal to or greater than 11 lpm. Non-dial-type flowmeters shall take at least one full turn to go from 0 to 15 lpm. Indicators on dial-type flowmeters shall be securely seated at each flow rate position. If oxygen administration equipment is carried on the vehicle, there shall be at least four clear non-rebreathing valve inhalation masks (two adult-sized and two pediatric-sized) with oxygen reservoir of the single service type as approved for pre-hospital utilization and four single service cannulas (two adult-sized and two pediatric-sized). If oxygen humidifiers (or nebulizers) are utilized, a new, single service humidifier (or nebulizer) shall be utilized for each patient.

3. Each oxygen cylinder shall:

i. Contain only medical grade oxygen;

ii. Be color-coded green;

iii. Be contained in a U.S. Department of Transportation (U.S.D.O.T.) approved cylinder that has a valid hydrostatic testing date on it, in accordance with U.S.D.O.T. regulations; and

iv. Be tagged ("Full," "In Use," "Empty") or have a pressure indicating gauge attached to the cylinder.

4. Any installed oxygen system shall be capable of safely storing and supplying a minimum of 3,000 liters of medical oxygen. The oxygen cylinder controls shall be accessible from inside the vehicle. Cylinder opening handles or wrenches shall be affixed to, or shall be chained and clipped with, the oxygen cylinder. Any oxygen piping

and/or hose shall be nonferrous and shall be suitable for medical oxygen. Any installed oxygen cylinder shall be retained in an oxygen tank holder certified by the manufacturer to comply with AMD Standard 003–Oxygen Tank Retention System.

5. Any portable oxygen system shall be capable of safely storing and supplying 300 liters of medical oxygen. Cylinder opening handles or wrenches shall be chained to the regulator or affixed to the cylinder. All oxygen storage arrangements shall comply with applicable provisions of Federal Specifications for Ambulances, KKK–A–1822, "Portable Oxygen Unit."

6. The portable oxygen system, reserve oxygen cylinder and any portable positive pressure flow-restricted oxygen-powered ventilation devices shall be stored in a crashworthy manner.

(b) Each vehicle shall be equipped with at least one each adult, pediatric and infant sized bag-valve-mask devices.

1. Each bag-valve-mask device shall:

i. Have a self-refilling bag without sponge rubber inside;

ii. The mask shall be constructed of clear material, shall be clean and free of contamination and leaks, shall have an oxygen supply (reservoir) system and shall be capable of providing adequate resuscitation pressures. Bag-valve-mask devices for adult patients shall be capable of deflating/refilling at least 20 times per minute at room temperature and shall have a minimum volume of 1,600 mL. Bag-valve-mask devices for pediatric patients shall be capable of deflating/refilling at least 30 times per minute at room temperature and shall have a minimum volume of 1,000 mL. Bag-valve-mask devices for infant patients shall be capable of deflating/refilling at least 40 times per minute at room temperature and shall have a minimum volume of 450 mL. If transporting neonatal patients, the bag-valve-mask devices for neonatal patients shall be capable of deflating/inflating at least 40 times per minute at room temperature and shall have a minimum volume of 250 mL;

iii. Any bag-valve-mask device that has a "pop off valve" shall have a device to easily defeat the valve; and

iv. Be equipped with a true non-rebreathing valve and have 15/22 mm fittings.

(c) All positive pressure devices shall:

1. Provide 100 percent oxygen;

2. Have an instantaneous flow rate between 35 and 45 liters per minute;

3. Deliver an inspiratory pressure between 55 and 65 cm water pressure; and

4. Have standard 15/22 mm fittings.

(d) Periodic pneumatic testing may be conducted by the provider or by an outside agency. All tests should be conducted in accordance with the Department's pneumatic testing guide, entitled "Pneumatic and Oxygen Delivery Testing Standards." The guide are available for a fee from OEMS.

(e) The results of all pneumatic tests shall be kept on file at the provider's principal place of business.

(f) Pneumatic testing shall be a part of any annual or biennial inspection for the purpose of licensure of a vehicle, and shall be performed prior to the initial licensure of any vehicle. Pneumatic testing may also be a part of any vehicle inspection, at the discretion of Department staff.

8:41–3.7 Biomedical equipment testing and maintenance

(a) Each provider shall develop and maintain a testing and maintenance schedule for its biomedical equipment in accordance with the manufacturer's recommendations or in compliance with Federal standards, whichever is more frequent. All biomedical equipment and devices shall comply with all applicable provisions set forth by the Federal Food and Drug Administration for safe care, utilization and maintenance of medical devices.

(b) For the purposes of this section, biomedical equipment includes, but is not limited to:

1. Cardiac resuscitators (that is, Thumpers®);
2. Cardiac defibrillators and/or pacers;
3. Automatic ventilators;
4. Incubators;
5. Specialized respirators;
6. External pacemakers;
7. IV pumps; and
8. Balloon pumps.

(c) The required testing and maintenance shall be conducted by:

1. Qualified employees of the firm that manufactured the equipment;

2. Qualified employees of a firm approved or authorized by the manufacturer;

3. Biomedical engineering staff of an acute care hospital;

4. Biomedical engineering staff of the New Jersey Hospital Association (or of an affiliate);

5. A recognized independent laboratory; or

6. Crewmembers or other employees of the provider who have been qualified by the equipment manufacturer to perform such testing and maintenance.

(d) The requirements of (a) above shall not apply to biomedical equipment that is:

1. In the physical possession of an acute care hospital or other validly licensed health care facility;

2. Is placed in the provider's vehicle for treatment, during transportation, of that hospital's or facility's patient; and

3. Is operated by that hospital or facility's personnel.

(e) The results of the biomedical equipment tests shall be kept on file at the provider's principal place of business and shall be made available to Department staff upon demand.

8:41–3.8 Patient care reports

(a) The provider shall develop a patient care report to be utilized each time a crewmember makes physical or verbal contact with a patient.

1. A separate patient care report shall be prepared for each patient transported in the same vehicle.

2. The patient care report shall be signed by all of the ALS crewmembers who made direct contact with the patient.

(b) Each patient care report shall be multi-copy, shall be typed, printed or written in ink and shall contain the following information:

1. The patient's name and home address;

2. The location of the call;

3. The patient's date of birth or approximate age;

4. For MICUs, the location of the MICU intercept (if different from the location of the call);

5. Statistical information to include the patient's sex and weight;

6. Information as to the patient's chief complaint, prior medical history, medications and allergies, findings obtained during the physical exam, treatment rendered, time the treatment was rendered and any response to treatment, medications administered (including dosage), route and time of administration (that is, flow sheet);

7. A description of care given to the patient at the scene and in transit;

8. Electrocardiogram documentation in those instances where a patient's cardiac rhythm was monitored;

9. Any other information the provider deems necessary, including insurance information;

10. Voice recording number, if applicable;

11. Date and times as follows:

i. The time of dispatch;

ii. The time the vehicle is en route;

iii. The time at which contact was made with the medical command physician, if applicable;

iv. The time the vehicle arrived at the scene or sending health care facility, as applicable;

v. The time the patient is en route to the receiving health care facility; and

vi. The time the patient arrived at the receiving health care facility;

12. The names and certification numbers of each attending crewmember;

13. Any treatment rendered to the patient prior to the arrival of the MICU, SCTU or AMU crewmembers;

14. The vehicle recognition number;

15. The BLS squad name and vehicle recognition number (if applicable);

16. The provider-assigned call number;

17. The type of communications utilized for medical command;

18. The printed name of the medical command physician;

19. For MICUs and AMUs, the signature of the medical command physician within 60 days from the date of service;

20. For SCTUs, a copy of the patient's transfer orders signed by the patient's physician or a verbal order to transfer signed by a registered nurse at the sending facility including the level of care to be provided during transfer and the name of the receiving health care facility;

21. The name of the receiving health care facility and the time that care was transferred to the receiving health care facility; and

22. The receiving health care facility's disposition of the patient to include admission or discharge diagnosis and type of admission (for example, critical care unit).

(c) If a patient refuses care, the refusal shall be documented on the patient care report and an attempt shall be made to obtain the signature of the patient (or guardian) on a "Refusal of Care" statement.

(d) A copy of the patient care report shall be delivered to an authorized representative of the receiving health care facility. This shall be done no later than 24 hours after completion of the call. Additions to the original report shall not be made once a copy has been delivered to the receiving health care facility, unless such changes are initialed and dated by the person making the change and the receiving health care facility is provided with a copy of the changes.

(e) The provider shall keep a record of all calls answered or transports provided, as applicable, and shall track the

destination, diagnosis and disposition of each patient evaluated by the crewmembers. The receiving health care facility shall supply the provider with the information needed to comply with this section.

(f) Every provider of mobile intensive care and air medical services shall develop and maintain a means for recording cancelled or recalled calls, missed calls, and other activity that does not result in patient contact, but did result in a dispatch.

(g) The provider shall keep all patient care reports in accordance with the provisions for the retention of medical records set forth at N.J.A.C. 8:41–3.11.

8:41–3.9 Pronouncement of death

(a) All pronouncements of death shall be made in accordance with the New Jersey State Board of Medical Examiners' rules, which are set forth at N.J.A.C. 13:35–6.2, as amended and supplemented.

1. All patients who appear dead shall be checked for vital signs (including any cardiac activity) and, where appropriate, given a complete external examination. An ALS crewmember shall then contact the medical command physician and relay all findings. These findings shall include a telemetered electrocardiogram sent when requested by the medical command physician unless the condition of the patient precludes the application of electrocardiogram tracing leads.

(b) In the event of communications failure, no pronouncement shall be made.

(c) No vehicle shall be placed in PIOOS status or be deemed unavailable for response to an emergency call for the sole purpose of performing a pronouncement of death.

8:41–3.10 Reportable events

(a) Providers shall notify the Department by telephone, followed by written confirmation, of:

1. Any death or injury that occurred to a patient, passenger or crewmember while being treated, transported, riding in the provider's vehicle or while on duty as a result of an accident or unusual occurrence;

2. Any accident reportable pursuant to N.J.S.A. 39:4–129 et seq. in which one or more of the provider's vehicles is involved, regardless of whether or not the accident is actually reported to the police as required pursuant to N.J.S.A. 39:4–129 et seq.;

3. Any event occurring on or within the provider's vehicle(s) or place of business that results in any damage to any medical records;

4. Any instance where a crewmember acts outside of his or her approved scope of practice;

5. Any and all incidents or series of incidents which, upon objective evaluation, lead to the good faith belief that the conduct of a crewmember is in violation of any law, rule and/or regulation (including, but not limited to, any instances of child abuse or neglect, elder abuse, domestic violence and/or the utilization of physical behavioral restraints);

6. The loss of any controlled dangerous substance identified at Schedules I through V, as set forth at N.J.S.A. 24:21–1 et seq. This does not relieve the provider of any responsibility for reporting as required at N.J.A.C. 8:65; and/or

7. For AMUs and MICUs only, any instance when an interruption in service occurs for more than six hours.

(b) The initial telephone report shall be made to OEMS during regular business hours before the end of the next business day following the incident.

(c) The written confirmation shall be in the form as set forth in chapter Appendix G, Reportable Events, incorporated herein by reference, and shall include all information known to the provider or crewmembers, including the condition of, and prognosis for, any injured persons, as well as copies of any official reports (such as a police report) and the provider's estimate of the degree of disruption of services, as applicable. This confirmation shall be delivered to OEMS no later than 14 calendar days after the incident.

(d) Department staff shall investigate all reports of unusual occurrences and/or unlawful or prohibited conduct in a timely manner.

8:41–3.11 Maintenance of records

(a) The provider shall maintain full, complete and accurate records as required by this chapter. Records shall not be falsified, altered or destroyed. Records may be stored in a computer format, provided that adequate safeguards are in place to prevent unauthorized access and tampering, and adequate provisions for back-up data are in place.

(b) The provider shall keep a copy of each required record, including patient care reports at its principal place of business. The records shall be made available to Department staff upon demand.

(c) The provider shall retain and safely store all patient medical records, including patient care reports, for at least 10 years. However, in those instances where a patient is less than 18 years of age at the time of treatment, the patient medical records shall be retained and stored until the patient's 23rd birthday or for 10 years, whichever is greater. The provider shall retain and safely store all other required records for at least five years. In the event the provider ceases operation for any reason, the provider shall arrange for the safe storage of required records at a place, and in a manner, that will ensure their safety, integrity, legibility, and accessibility will not be in jeopardy.

8:41–3.12 Standard operating procedures manual

(a) Each provider shall develop and maintain a written standard operating procedures (SOP) manual. The SOP manual shall reflect the methods of daily operation, and shall be consistent with the provisions of this chapter. A copy of the SOP manual shall be available at each location where a vehicle is garaged, shall be readily accessible to all crewmembers and shall be made available to Department staff upon demand.

(b) The SOP manual shall contain, but is not limited to, policies addressing the following:

1. Crewmember functions in the emergency department of an acute care hospital;

2. Narcotic control, storage and procurement;

3. Medication control (both vehicle and station);

4. Pronouncement of death;

5. Air medical service utilization;

6. Triage to regional trauma centers, including trauma triage policies;

7. Hospital diversions;

8. State HAZ–MAT Annex and local policies for responding to HAZ–MAT incidents;

9. Mass casualty incidents, which shall include a copy of the Emergency Operating Plan (EMS Annex);

10. Physician and nurse orientation to the base station curriculum;

11. A current copy of N.J.A.C. 8:41;

12. The quality assurance plan;

13. Vehicle sanitation and maintenance, including the provider's procedures for both DIOOS and PIOOS status;

14. The required reporting of certain events as set forth at N.J.A.C. 8:41–3.10;

15. Communicable disease guidelines;

16. Patient rights;

17. Abuse reporting, such as child, elder and domestic;

18. A nondiscrimination statement, outlining the provider's willingness to transport and treat patients regardless of a person's race, sex, creed, national origin, sexual preference, age, disability, medical condition (including, but not limited to, patients with AIDS/HIV,TB, Hepatitis B or other communicable diseases) or ability to pay;

19. Procedures for handling patients with physician issued "Do not resuscitate" orders and/or a living will; and

20. Employees' responsibilities including, but not limited to, cooperating with Department staff during inspections, the possibility of incurring monetary penalties in case of licensure violations, the importance of having all required credentials available for inspection by Department staff, approved scope of practice and the performance of duties in a professional manner.

(c) Each provider shall develop a policy to ensure that all patient information, including patient identifiable data, remains confidential and private. This policy shall be part of the SOP manual, and shall be provided to each of the provider's employees. Patient information shall only be disclosed or released:

1. If the patient, guardian, executor or other legally authorized person has requested in writing that the information be released to a specific person, entity or company;

2. In compliance with a subpoena, judicial order or applicable law, rule and/or regulation;

3. To process a claim for insurance, including Medicare or Medicaid;

4. To Department staff in the performance of their duties and/or while conducting inspection, audit and/or investigation; and

5. To effect the transfer of the patient to another health care professional receiving the patient.

8:41–3.13 Personnel files

(a) A provider shall maintain a personnel file for each crewmember. Each file shall contain, at a minimum:

1. The name and home address of the crewmember;

2. A copy of the crewmember's valid driver's license;

3. A copy of the crewmember's photo I.D. (a valid photo driver's license may be utilized);

4. A copy of the crewmember's EMT–Basic certification card, EMT–Paramedic certification card or in the case of a registered nurse, a provider shall have written documentation that the registered nurse's license was physically presented to the provider;

5. Copies of the crewmember's certification cards in CPR, ACLS, PALS and either PHTLS or BTLS, as applicable;

6. With respect to EMTs–Paramedic, documentation of continuing education hours and skills for the previous recertification period if applicable; and

7. With respect to MICNs, official correspondence from the mobile intensive care program with regard to the person's endorsement status. The MIC program must submit an endorsement letter, endorsing the registered nurse for every certification period as an MICN.

(b) All personnel files shall be maintained at the provider's principal place of business, shall be maintained in a

readily accessible manner and shall be made available to Department staff upon demand.

(c) A provider shall not knowingly verify or accept a record or document that is falsified, fraudulent or untrue. The knowing verification of such false records or documents shall be sufficient cause for refusal to issue or renew a license and/or revocation of any existing provider and/or vehicle licenses.

8:41–3.14 Quarterly reports

(a) Each provider shall file a report with the Department outlining all activities for that quarter. The reports shall be made on a form and in the manner specified by the Department (Appendices A, B and C, incorporated herein by reference) and shall be delivered to OEMS on or before the due date. The reporting periods and due dates are as follows:

Period	Due
January 1 through March 31	April 30
April 1 through June 30	July 31
July 1 through September 30	October 31
October 1 through December 31	January 31

(b) The Department shall keep the data on file and shall generate a yearly report reflecting the activities of the providers. Yearly reports shall be available at OEMS for public inspection.

8:41–3.15 Quality assurance

(a) A continuous quality improvement structural organization shall be made a part of a provider's organizational structure.

1. The governing authority of the hospital (such as the board of trustees) or provider shall have ultimate responsibility for the continuous quality improvement program.

2. The provider shall have a continuous quality improvement program based on a written continuous quality improvement plan that is implemented and that monitors the quality of patient care.

3. Each provider shall have continuous quality improvement activities that are part of the overall quality assurance plan.

(b) A continuous quality improvement program shall contain the following policies and procedures:

1. The continuous quality improvement plan shall be reviewed at least annually and revised as necessary. Responsibility for reviewing and revising the plan shall be designated in the plan itself.

2. The continuous quality improvement plan shall delineate lines of communication between the continuous quality improvement program and the medical staff, chief executive officer or administrator, and governing authority.

3. The provider's continuous quality improvement plan shall specify procedures for the development, implementation, and coordination of quality reviews. The plan shall also establish a mechanism for the evaluation of the continuous quality improvement program.

4. The provider shall disseminate its findings and results of continuous quality improvement activities internally, as defined in the continuous quality improvement plan.

(c) A continuous quality improvement program shall be coordinated by a designated staff member.

1. There shall be an individual responsible for coordinating all aspects of the continuous quality improvement program.

(d) A continuous quality improvement program shall evaluate the following patient services:

1. There shall be an ongoing process of monitoring patient care. Evaluation of patient care is criteria-based, so that certain review actions are taken or triggered when specific quantified, predetermined levels of outcomes or potential problems are identified.

2. The continuous quality improvement coordinator shall be available to provide ongoing consultation to employees including assistance with the development of specific indicators used to evaluate service outcome.

3. The program shall follow up on its findings to assure that effective corrective actions have been taken, including at least policy revisions, procedural changes, educational activities, and follow-up on recommendations, or that additional actions are no longer indicated or needed.

4. The continuous quality improvement program shall provide information that is utilized in the evaluation of the clinical competence of all clinical practitioners.

(e) Each provider shall develop and maintain a quality assurance plan that is consistent with the standards set forth at N.J.A.C. 8:43G–27.1 through 27.5.

(f) The provider's medical director (or his or her physician designee meeting the requirements for medical command physicians found at N.J.A.C. 8:41–9.5, 10.5 and 11.5) shall be responsible for the coordination of all aspects of the quality assurance program and shall be available to provide ongoing consultation to the provider, including assistance with the development of specific indicators utilized to evaluate service outcomes on the MICU, SCTU or AMU.

(g) There shall be an ongoing process of monitoring patient care. Evaluation of patient care on the MICU, SCTU or AMU shall be criteria-based, so that certain review actions are taken or triggered when specific quantified, predetermined levels of outcomes or potential problems are identified.

(h) The provider shall follow up on its findings to assure that effective corrective action is taken, including, at a minimum, policy revisions, procedural changes, educational activities and follow-up on recommendations, or shall establish that additional actions are no longer indicated or needed.

(i) The quality assurance program shall identify and establish indicators of quality care specific to the MICU, SCTU or AMU that are monitored and evaluated that encompass, as applicable:

1. Medical calls;
2. Trauma calls;
3. Pediatric calls;
4. Cardiac/respiratory arrest incidents;
5. Patients triaged to BLS;
6. Utilization of communications failure protocols;
7. Utilization of, and adherence to, standing orders;
8. On-scene times;
9. Utilization of special procedures;
10. Triage to specialty care facilities; and
11. Other areas the medical director finds necessary to track in this manner.

(j) The director or specialty care coordinator, as applicable, shall ensure that all patient medical records meet the following standards:

1. Completeness of the patient care report;
2. Adherence to policies regarding treatment and triage of patients including the guidelines for pediatric and adult patients in Chapter Appendices E and F, incorporated herein by reference, as applicable;
3. Compliance with the requirements of this chapter;
4. Documentation of excessive time spent at the scene or receiving health care facility, as applicable, based on the nature of the call, deviations from established protocols, unsuccessful procedures, communications failure, and other unusual incidents; and
5. The conditions set forth in (i) above.

(k) The medical director or his or her physician designee shall review at least 10 percent of all calls during which a patient was evaluated by the crewmembers (excluding the calls listed in (m) below). The method of determining which 10 percent of the calls will be reviewed shall be at the discretion of the medical director. The review shall determine:

1. Consistency with accepted treatment and triage protocols, as applicable;
2. Consistency of the written record with any voice recording of the call;
3. Appropriateness of orders issued by the medical command physician;
4. Appropriateness of the carrying out of orders received by the ALS crewmembers; and
5. Completeness of the patient care report.

(*l*) The quality assurance review shall be completed within 120 calendar days from date of service and shall encompass at least 10 percent of all calls, excluding cancelled calls.

(m) The quality assurance review for rapid sequence inductions, percutaneous needle cricothyrotomy, needle chest decompression, central venous access, intraosseous access and any patient who is triaged to BLS and subsequently admitted to a critical care unit shall be completed by the medical director within 120 calendar days from date of service and shall encompass 100 percent of the calls (not to be included into the 10 percent of calls required in (k) above).

1. Quality assurance reviews for rapid sequence inductions shall be maintained for the first 24 months that the procedure is utilized by a provider's ALS crewmembers. The patient care report shall be sent to the Department for review within 14 days after the procedure is conducted.

(n) Each provider shall keep written records of medical director reviews and shall produce them upon demand to an authorized representative of the Department. Medical director reviews shall include the comments of the medical director or his or her physician designee in accordance with (i) and (j) above. The provider shall keep quality assurance reviews for a period of one year from the date of the review.

8:41–3.16 Insurance coverage

(a) Prior to initial provider licensure and upon subsequent license renewal, an applicant shall be required to arrange for each insurance carrier or agent to submit an official "Certificate of Insurance" form, issued by the insurance carrier. Each such form shall show that insurance has been purchased and is in force.

(b) The "Certificate of Insurance" shall include the following information:

1. The name of the insurance company or companies issuing each policy;

2. The name of the policyholder, which shall include the provider's trade name;

3. All policy numbers;

4. The Vehicle Identification Number or FAA number for each vehicle;

5. The expiration date of each policy; and

6. The types and limits of coverage for each policy.

(c) Once licensed, a provider shall maintain the required minimum insurance as outlined in (c)1 through 3 and (d) below, plus such additional insurance as the provider may deem necessary in order to be eligible to provide services under this chapter. The provider shall immediately discontinue any and all SCTU and/or BLS ambulance services in the event any portion of the required insurance is cancelled, expires or otherwise becomes null or void.

1. At least $500,000 per occurrence of combined bodily injury/ property damage coverage for each vehicle;

2. At least $300,000 of single limit coverage of "premises and operations" type general liability insurance; and

3. At least $300,000 per occurrence coverage of "malpractice" type professional liability insurance, if operating a BLS ambulance service, or regular professional liability insurance, if operating an MAV service.

(d) The general liability and malpractice and professional liability insurance required in (c)2 and 3 above may be combined in a single policy of at least $500,000 per occurrence.

(e) Consistent with N.J.S.A. 39:3–29, the driver shall be in possession of the vehicle insurance card (or it shall be kept in the vehicle at all times so as to be accessible to the crewmembers). Vehicle insurance cards shall be made available to Department staff upon demand. In addition, copies of all insurance policies shall be kept at the provider's principal place of business and made available to Department staff upon demand.

8:41–3.17 Vehicle registration

(a) Each MICU and SCTU shall be registered, maintained and operated in accordance with N.J.S.A. 39:1–1 et seq. The vehicle registration card shall be made available to Department staff upon demand.

1. Vehicles registered as a motor vehicle in New Jersey shall display a valid motor vehicle inspection decal issued by the New Jersey Motor Vehicle Commission (NJMVC). The vehicle shall only be utilized to provide service after it has successfully passed all motor vehicle tests conducted by the NJMVC, or by an authorized Reinspection Station. No vehicle shall be utilized to provide services while it bears an expired inspection sticker or a "Reject" sticker issued by the NJMVC.

2. Vehicles registered as motor vehicles in other states shall display a valid motor vehicle inspection decal issued in accordance with the requirements of the state registering the vehicle. The vehicle shall only be utilized to provide service after it has successfully passed all tests conducted in accordance with the requirements of the state registering the vehicle.

(b) Each AMU shall be registered with the Federal Aviation Administration and operated in accordance with applicable portions of the Federal Aviation Regulations (FAR), including the manufacturer's approved manuals and instructions. The aircraft shall be certified to the aircraft manufacturer's standards and to FAA standards.

8:41–3.18 Vehicle PIOOS logs

A provider shall keep a log for each vehicle, specifying PIOOS time, the cause of the problem and its resolution. Additionally, a provider shall develop and maintain a program of preventive maintenance for each vehicle.

8:41–3.19 Vehicle safety

(a) The vehicle shall be maintained in a safe operating condition. The vehicle and all required equipment shall be functional and operable when the MICU, SCTU or AMU is "in-service."

(b) The responsibility for the safe operation of each MICU or SCTU shall rest with the crewmembers staffing that vehicle. The responsibility for the safe operation of each AMU shall rest with the pilot.

(c) No crewmember shall operate any vehicle without due regard for the safety of the general public or without adhering to all applicable laws, rules and/or regulations. No provider shall allow the operation of any vehicle that is patently unsafe to drive or fly, presents a hazard to personnel and/or bystanders, has not passed New Jersey Motor Vehicle Commission (NJMVC) inspection or Federal Aviation Administration (FAA) requirements (as applicable) or does not display a valid NJMVC or FAA inspection sticker (as applicable).

(d) No person shall staff or operate, or be allowed to staff or operate, a MICU, SCTU or AMU:

1. While under the influence of alcohol, narcotics or any substance that substantially compromises a person's decision-making abilities;

2. In a reckless manner;

3. At an excessive rate of speed; or

4. While engaging in any illegal conduct.

(e) Each vehicle shall be equipped with the following minimum safety equipment:

1. One flashlight, two D-cell size or larger;

2. One fire extinguisher, U.L. rated at least 2A 10BC or 3A 40BC. The extinguisher shall have either a valid inspection tag or a gauge indicating that it is fully charged. The fire extinguisher shall be securely mounted in a bracket on the wall, floor or ceiling; and

3. MICUs and SCTUs shall be equipped with three portable red emergency reflective safety triangles or three battery-operated flashers. Due to their flammable nature, ground and/or safety flares of any type shall not be carried on any vehicle.

8:41–3.20 Communications performance standards

(a) All communications equipment utilized for the purpose of medical command shall:

1. Provide for clear, concise voice communications between the medical command physician and the crewmembers;

2. Provide adequate coverage to the vehicle's service area; and

3. With respect to MICUs and AMUs only, produce an auditable recording of the conversation and electrocardiogram tracings at least 90 percent of the time.

(b) With respect to MICUs and AMUs only, all equipment utilized for obtaining medical command shall meet the standards set forth at N.J.A.C. 8:41–3.22 in regard to the production of voice recordings and the ability to send telemetered electrocardiogram tracings.

(c) Each provider shall provide for the repair and maintenance of all communications equipment. In the event that medical communications or dispatch equipment fails, the provider shall:

1. Immediately provide alternate communications equipment to allow contact with the medical command physician or arrange for another medical command site to provide medical command to the crewmembers; and

2. Notify the Department if the outage lasts longer than three hours.

8:41–3.21 Communications failure protocols

(a) Communications failure exists only when:

1. Standard biotelemetry communications equipment fails;

2. Back-up biotelemetry equipment fails, including cellular and/or wireless telephones;

3. The crewmembers cannot access any medical command physician by the Hospital Emergency Ambulance Radio (HEAR) system;

4. Telephone service is not available or is inoperative; and

5. The crewmembers cannot access any medical command physician by any means.

(b) In the event of communications failure, attempts shall be made to immediately correct the problem. If correction is successful and contact is established, the medical command physician shall be advised as to all treatments or procedures that occurred during the period of communications failure.

(c) Each provider shall develop and maintain communications failure protocols that are to be followed in the event of communications failure. These protocols shall bear the approval signature of the provider's medical director and shall be approved by the Department prior to implementation, in accordance with the requirements of this chapter. Additional protocols may be adopted based upon the recommendations of the United States Department of Transportation and the American College of Emergency Physicians provided such protocols do not conflict with the requirements of this Chapter. Communications failure protocols shall be reviewed annually and updated as necessary. The medical director shall confirm that such review has been accomplished by signing and dating the protocols following each annual review and update.

(d) In the event that communications failure protocols are utilized, the crewmember who utilized the protocols shall prepare a report indicating the call on which the protocols were utilized, treatment rendered, a description of the communications problem(s), a list of alternate means attempted, problems encountered, and attempts to remedy the problem. This report shall be forwarded to the provider's director or specialty care coordinator, as applicable, within 24 hours of the incident.

(e) The director or specialty care coordinator, as applicable, shall maintain a file of all communications failure reports for a period of one year, and shall make such reports available to Department staff upon demand.

8:41–3.22 Biomedical telemetry communications: MICUs and AMUs only

(a) Each provider of mobile intensive care and air medical services shall ensure that each of its vehicles has operational biomedical telemetry communications as may be required to meet the requirements of N.J.S.A. 26:2K–10 and this chapter.

(b) Each provider shall ensure that there is a working communications base station at the medical command site that shall permit the receiving of voice communications as well as telemetered electrocardiograms. Such base station shall be readily accessible to the medical command physician.

1. Each provider of mobile intensive care and air medical services shall make sure the base station has the proper number of channels to ensure that all units can

have telemetry with the base station at one time form the field.

i. Mobile intensive care and air medical services adding addition units or temporary units shall ensure the base station has the ability to receive telemetry from the additional unit without interference of other units in-service.

(c) Each time an ALS crewmember makes contact with the medical command physician, a voice recording of the call shall be made. This shall be done regardless of whether the means of two-way communications is radio (including HEAR), telephone (regular, cellular and/or wireless) or any other approved means.

(d) Each provider shall have the capability of providing voice recordings (both transmitted and received), as well as any telemetered electrocardiograms. All voice recordings and telemetered electrocardiograms shall be retained for a period of at least three years. However, in those instances where a patient is less than 18 years of age at the time of treatment, the orders shall be retained and stored until the patient's 23rd birthday or for three years, whichever is greater.

(e) Each provider shall be able to retrieve an auditable voice recording for at least 90 percent of the calls where the medical command physician is contacted.

8:41–3.23 Business locations

(a) The provider shall maintain a principal place of business at one location. The Department shall be informed of the specific location of the principal place of business and shall be notified 14 calendar days in advance of any change in the location of the principal place of business.

1. Consistent with N.J.A.C. 8:41–2.1(a)2, the principal place of business shall be located on an actual piece of real property and shall not be a post office box or mail drop.

(b) The Department shall also be informed of the location of any satellite offices and vehicle storage sites maintained by the provider. The Department shall be notified at least 14 calendar days prior to commencement of business at any proposed satellite location.

8:41–3.24 Advertising restrictions

(a) No provider shall advertise or represent that it provides any health care services other than those services for which it is licensed.

(b) Mobile intensive care programs, specialty care transport services and air medical services may advertise under generic headings such as "Ambulances" in the Yellow Pages(and similar publications. The actual advertisement under such a generic heading shall clearly advertise only those services for which the provider is licensed.

(c) Advertisements by specialty care transport services shall not give the impression that the provider is capable of providing emergency medical services and shall be void of any word or expression indicating emergency medical services, including, but not limited to, "Emergency," "9–1–1," or "Emergency Response."

(d) The words "24–hour service," "Immediate Response," "Eliminate Delay" or similar expressions shall appear in advertisements only if the provider is capable of providing continuous, around-the-clock answering of telephone requests for service by a person qualified to:

1. Promptly summon crewmembers (if necessary); and/or

2. Dispatch assistance.

(e) Consistent with N.J.A.C. 17:24–10.3, a provider shall not advertise any telephone number for emergency response service other than 9–1–1.

(f) The words "Paramedic," "EMT–Paramedic," "Mobile Intensive Care," "Intensive Care," "MICU," "Critical Care Transport Unit," "CCTU," "Coronary Care," "Special Care," "Specialty Care," "SCTU," "Specialty Care Transport Unit," "ALS," "Advanced Life Support" or abbreviations of such words, shall only appear in advertisements when the provider is licensed to provide those services.

(g) All advertisements shall include the name under which the provider is licensed by the Department.

SUBCHAPTER 4. SPECIFIC VEHICLE AND EQUIPMENT REQUIREMENTS: SCTUs, AMUs AND TRANSPORT–APPROVED MICUS

8:41–4.1 Patient compartment safety

(a) The interior of the vehicle shall be designed for the safety of patients and crewmembers and the patient compartment shall have the following safety features:

1. There shall be no protruding edges;

2. Exterior corners (corners that point-out) shall be rounded or covered with a padded material;

3. The ceiling shall be finished with a padded material or with a flat, even and unbroken surface;

4. The floor shall have a flat, even, unbroken and impervious surface and shall be covered with a slip resistant material;

5. Any seats with under seat storage shall have a positive latching mechanism that holds the seat closed;

6. All cabinet doors, except a sliding door, shall have a positive latching mechanism that shall hold the door securely closed and shall prevent the contents of the cabinet from pushing the door open from the inside;

7. All equipment and supplies carried on the vehicle shall be stored in a crashworthy manner (that is, they shall remain firmly in place and shall not present a hazard to any vehicle occupant in the event of an accident or sudden change in vehicle speed or direction). There shall be sufficient cabinets and other storage spaces within the vehicle so as to meet this requirement. Crashworthy retention systems shall not incorporate rubber straps, "shock cords" or Velcro® type closures.

i. While the vehicle is in motion, all transport device accessories such as IV poles and monitor trays shall be installed per manufacturer's guidelines and utilized per manufacturer's standards and safety recommendations. All equipment shall be secured to these devices while being utilized; and

8. The bench seats in all vehicles manufactured after July 1, 2002 shall have a passive barrier at the forward end of the bench.

(b) Automotive safety belts shall be provided for each vehicle occupant (patient, passenger or crewmember) over eight years of age or under eight years of age but weighing more than 80 pounds and shall meet all State standards, including those set forth at N.J.S.A. 39:3–76.2 et seq. Each vehicle occupant shall be properly restrained either in an automotive safety belt or on a stretcher, as medically appropriate. All children under eight years of age weighing less than 80 pounds, whether patients or passengers, shall be properly restrained in a Federally-approved child restraint system as provided for at N.J.S.A. 39:3–76.2a or on a stretcher, as medically appropriate.

1. SCTUs may, but need not, store the child restraint system on board the vehicle when the system is not being utilized. If not stored on the vehicle, the system shall be immediately accessible on the provider's premises.

2. Approved transport capable MICUs shall carry the child restraint system on board the vehicle at all times.

(c) Signs shall appear in both the patient and driver's compartments that clearly indicate that smoking is prohibited anywhere in the vehicle.

8:41–4.2 Vehicle sanitation

(a) The interior of the vehicle, including all areas utilized for storage, and the equipment and supplies within the vehicle, shall be kept clean and sanitary. A disinfectant shall be routinely applied to all contact surfaces. The floor, walls and equipment shall be free of stains, dirt, debris and odors and insect infestation.

(b) All interior surfaces shall be covered with stain resistant material that is impervious to blood, vomitus, grease, oil and common cleaning materials.

(c) Blankets and mattresses shall be kept clean and in good repair. All mattresses shall have protective, waterproof and stain resistant covers.

(d) Clean linens shall be utilized in the transport of stretcher patients. All linens shall be changed after each patient. Disposable linens may be utilized, so long as they are disposed of after each patient.

(e) There shall be adequate, clean, dustproof storage for clean linens.

(f) Plastic bags and/or covered containers or compartments shall be provided and shall be utilized for all soiled supplies (including linens and blankets) carried within the vehicle.

(g) In order to protect the safety of the general public and emergency response personnel, after a vehicle has been occupied by or used to transport a patient known or suspected to have a communicable disease the vehicle shall, prior to transportation of another patient, be cleaned and all contact surfaces, equipment and blankets shall be disinfected according to the applicable standards set forth by the Occupational Safety and Health Administration (OSHA) at 29 C.F.R. 1910.120, incorporated herein by reference, and adopted in New Jersey by the Public Employees Occupational Safety and Health Act, N.J.S.A. 36:6A–25 et seq., incorporated herein by reference.

(h) Where possible, only single-service implements shall be inserted into the patient's nose or mouth. These single-service items shall be wrapped and properly stored and disposed of after utilization. Non-disposable patient care equipment shall be decontaminated after each patient utilization in a manner consistent with the sending or receiving health care facility's requirements for equipment decontamination. No airway, tube, catheter or other similar device shall be utilized on more than one patient unless first sterilized in accordance with manufacturer's recommendations.

(i) Each vehicle shall be equipped with at least one container for the disposal of contaminated sharps, such as a Sharps® container, that is rigid, leak-proof, puncture-proof and of a size large enough to accommodate needles and syringes up to 10 inches in length and an inch and a half in diameter.

1. Consistent with N.J.A.C. 7:26–3A.14, disposal containers shall have a water-resistant label affixed to or printed on the outside of the container, which shall include the words "MEDICAL WASTE" or "INFECTIOUS WASTE," or display the universal biohazard symbol as shown at 29 C.F.R. 1910.145(f)(8)(ii).

2. Disposal containers shall be wiped with a suitable disinfectant if blood or other bodily fluids are spilled on the outside of the container.

3. Disposal containers shall be disposed of in accordance with all applicable laws, rules and/or regulations.

(j) Exterior surfaces of the vehicle shall be routinely cleaned.

8:41–4.3 Vehicle heater/air conditioner

(a) Each vehicle shall have a functional heater and air conditioner:

1. When the outside temperature is below 65 degrees Fahrenheit, the heater shall, within 20 minutes after initial engine start up, provide an inside ambient patient compartment temperature of 68 to 72 degrees Fahrenheit.

2. The air conditioner shall, within 45 minutes after engine start up, provide an inside ambient patient compartment temperature of:

i. Sixty-eight degrees to 72 degrees Fahrenheit when the outside temperature is between 75 and 85 degrees Fahrenheit; and

ii. At least 13 degrees Fahrenheit below the outside temperature when the outside temperature is over 85 degrees Fahrenheit.

8:41–4.4 Vehicle chassis, body and components (SCTUs and transport-approved MICUs only)

(a) The motor vehicle chassis, body and components shall be standard commercial products and shall comply with all Federal Motor Vehicle Safety Standards (FMVSS) and Federal regulations applicable or specified for the year of manufacture.

(b) The curb weight and payload weight shall not exceed the gross motor vehicle weight rating as determined by the manufacturer.

(c) Tires shall be appropriate for the gross vehicle weight of the vehicle and shall not be damaged or have excessive tread wear. Radial and non-radial tires shall not be mixed on the vehicle.

(d) The completed/modified vehicle's center of gravity shall be within the parameter recommended by the chassis manufacturer.

(e) All seats shall comply with 49 C.F.R. 571.207 (FMVSS No. 207). Automotive safety belts and anchorages for seats shall comply with 49 C.F.R. 571.208, 209 and 210 (FMVSS Nos. 208, 209 and 210).

(f) All glazing shall comply with 49 C.F.R. 571.205 (FMVSS No. 205).

(g) The provider shall, with the approval of the Department, permanently assign a unique nonduplicated recognition number to each vehicle. The recognition number shall consist of at least one, but not more than six, characters. For the purpose of this paragraph, a character shall mean either an Arabic number, an Arabic letter, a space or a dash. At least one of the characters in the recognition number shall be either an Arabic letter or Arabic number.

8:41–4.5 Vehicle carbon monoxide concentrations (SCTUs and transport-approved MICUs only)

(a) In order to minimize the amount of carbon monoxide, noxious gases, diesel exhaust, fumes and contaminants entering the vehicle:

1. The vehicle exhaust system, as well as the vehicle exterior, doors, windows and related gaskets shall be in good condition and free of leaks; and

2. The vehicle exhaust system shall extend beyond the sides of the vehicle and away from the fuel tank filler pipes and doors.

(b) The vehicle shall not be utilized to transport patients if the exhaust system has:

1. Loose or leaking joints;

2. Holes, leaking seams, or patches;

3. A tail pipe end that is pinched or damaged; or

4. A tail pipe end that does not extend beyond the edge of the vehicle body.

8:41–4.6 Guide dogs

In accordance with the New Jersey Law Against Discrimination, N.J.S.A. 10:5–1 et seq., seeing-eye dogs, service dogs, hearing ear dogs, companion dogs and/or guide dogs trained by a recognized agency or school to assist a blind, handicapped or hearing impaired person shall be permitted on any MICU, SCTU or AMU where their presence is necessary to perform the duties for which they are trained.

SUBCHAPTER 5. RESEARCH PROPOSALS

8:41–5.1 Research proposals

(a) As utilized in this subchapter, the following terms are defined as follows:

1. "Research" means a scientific investigation designed to establish facts and to analyze their significance, including:

i. Any study directed at systemizing data related to the causes, mechanisms, diagnosis and treatment of injuries;

ii. Data collection for purposes other than EMS management or evaluation; and

iii. Any other utilization of EMS client data, unless specifically authorized by this chapter;

2. "Principal investigator" means the person responsible for proposing and coordinating the research project;

3. "Human subject" means the person under consideration who is affected with a disease or condition that is being treated or observed with medical and surgical procedures and about whom the researcher obtains:

i. Historical data (for example, initial symptoms, circumstances surrounding the event, associated medical conditions) through intervention or interaction with the patient or their family; and

ii. Identifiable private and/or confidential client data as recorded in any pre-hospital, acute care hospital and/or health care facility medical record;

4. "The Institutional Review Board (IRB)" means the board established by an acute care hospital to review biomedical and/or behavioral research using human subjects that is conducted at or supported by that hospital, in order to protect the rights of the human subject, and to approve said research; and

5. "Participating organizations" means volunteer, municipal or proprietary BLS ambulance services, mobile intensive care programs, specialty care transport services, air medical services and/or acute care hospitals.

(b) No provider shall engage in any prospective research activity involving drug trials or invasive procedures, unless first authorized to do so by the Commissioner.

(c) The procedure to request approval to conduct research projects shall be as follows:

1. The principal investigator shall first meet the requirements of all applicable Federal regulations including, but not limited to, those at 42 U.S.C. § 6a, III, G289;

2. The principal investigator shall obtain the approval of the IRB at the acute care hospital sponsoring or endorsing the study;

i. If the principal investigator is not a member of that sponsoring hospital's medical staff, the proposal shall include the name of the hospital's principal investigator responsible for the conduct of the study;

3. The principal investigator shall obtain approval of the provider's medical director. The medical director has ultimate authority and responsibility for the conduct of the research project;

4. The application shall also include specification of any procedure or drug that is proposed that is not manifestly approved by this chapter;

5. If the proposal is directed to operational systems and is not directly related to human subjects, the principal investigator shall submit documentation that IRB approval is not necessary;

6. Forty copies of the proposal shall be submitted to OEMS no later than 30 calendar days before the scheduled meeting of the MICU Advisory Council at which the principal investigator wishes to present the proposal;

7. The proposal shall be reviewed at the MICU Advisory Council meeting or by a research subcommittee as appointed by the chair of the MICU Advisory Council. The MICU Advisory Council or subcommittee shall review the proposal, make any comments it deems necessary, and make a recommendation with regard to approval or disapproval of the proposal. The recommendation, comments and proposal shall be forwarded to the Commissioner by OEMS; and

8. The Commissioner shall have final authority in the approval or disapproval of all research studies. The Department shall notify the principal investigator of its determination via mail. The study shall not be started until approval is obtained from the Commissioner.

(d) The format of the proposal shall include:

1. Background information, including rationale and relevant literature;

2. Specific aims and objectives, which shall be clearly stated, including the hypothesis and data to be gathered or tested;

3. Significance, relevance, benefits of and justification of the research;

4. Details of the methods utilized, including research design, how results shall be analyzed, number and type of clients, research tools utilized, amount of time necessary and any risks involved;

5. If patient procedures or drugs are needed, an explanation of the procedures, risks, frequency, duration and precautions in detail, and a summary of the competence of personnel performing the procedure and the time frames of the study;

6. A detailed description of the mechanisms of patient protection, including:

i. How confidentiality of client data shall be maintained, including methods of safeguarding client-identifiable data; and

ii. If the research directly involves human subjects, how consent shall be obtained and documented; and

7. Administrative details, including budget, facilities utilized, and personnel issues.

(e) The Commissioner retains the right to revoke or suspend approval for any research project, regardless of

stage of the research, for violations of the terms of the approval, violations of any part of this chapter or any applicable law, rule and/or regulation, violations of patient's rights or confidentiality or for reasons of patient safety.

(f) The principal investigator shall submit interim reports as required by the approval notice to the MICU Advisory Council. These reports shall include:

1. A brief summary of the project with the methodology of the study;
2. The objectives of the study;
3. The results of the study, to date;
4. The amount and type of work remaining; and
5. Any conclusions reached to date.

(g) The principal investigator shall submit a final report to the Commissioner, OEMS and the MICU Advisory Council, including a one page abstract.

(h) If the proposal involves a therapeutic agent not approved in accordance with N.J.A.C. 8:41–6.1, the Commissioner may authorize the utilization of said agent in his or her approval of the study. The Commissioner's approval shall specify the length of time the agent may be utilized, and shall be subject to the terms and conditions imposed in the approval notice. Thereafter, if the medication is to be continued, it must be added to N.J.A.C. 8:41–6.1 in accordance with the rulemaking provisions of the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq. and the Rules for Agency Rulemaking, N.J.A.C. 1:30. Only programs officially designated by the principal investigator and authorized by the Commissioner shall utilize any medication under study.

SUBCHAPTER 6. ADMINISTRATION AND STORAGE OF MEDICATIONS

8:41–6.1 Medications and therapeutic agents

(a) The following medications and therapeutic agents are approved for utilization by ALS crewmembers. Each vehicle shall be equipped with the following medications and therapeutic agents in sufficient quantities to allow for the administration of therapeutic doses of the medication or agent:

1. Acetylsalicylic acid;
2. Adenosine;
3. Atropine Sulfate;
4. Benzodiazapine agent, either Ativan and/or Valium;
5. Calcium Chloride;
6. Dextrose, 50 percent;
7. Dextrose (5 percent in water, 10 percent in water and 25 percent in water);
8. Diphenhydramine Hydrochloride;
9. Dopamine Hydrochloride;
10. Epinephrine 1:1,000 solution;
11. Epinephrine 1:10,000 solution;
12. Furosemide;
13. Lidocaine Hydrochloride;
14. Magnesium Sulfate;
15. Morphine Sulfate;
16. Naloxone Hydrochloride;
17. Nitroglycerin;
18. Normal saline solution;
19. Oxygen;
20. Ringer's lactate solution;
21. Thiamine; and
22. At least one of the following:
    i. Albuterol solution for inhalation;
    ii. Isoetharine solution for inhalation; or
    iii. Metaproterenol solution for inhalation.

(b) The following medications and therapeutic agents are approved for utilization by ALS crewmembers. A provider may choose to carry any of the following medications or therapeutic agents on its vehicles. A provider shall notify and keep OEMS up to date as to which of these medications and/or therapeutic agents are carried on its vehicles.

1. Activated charcoal;
2. Amiodarone;
3. Aminophylline;
4. Bumetanide;
5. Captopril;
6. Cyanide poisoning kit (prepackaged and sealed, to contain Amyl Nitrate, Sodium Nitrate, Sodium Thiosulfate and syringes);
7. Dexamethasone sodium phosphate;
8. Diltiazem hydrochloride;
9. Dobutamine hydrochloride;
10. Etomidate;
11. Flumazenil;
12. Glucagon;

13. Haloperidol;
14. Heparin sodium;
15. Insulin;
16. Ipecac syrup;
17. Ipratropium Bromide;
18. Isoproterenol hydrochloride;
19. Ketamine;
20. Lorazepam;
21. Metoprolol tartrate;
22. Methylprednisolone sodium succinate;
23. Midazolam hydrochloride;
24. Nalbuphine hydrochloride;
25. Nalmefene (to be utilized when Naloxone Hydrochloride is unavailable);
26. Nifedipine;
27. Norepinephrine bitartrate;
28. Pralidoxine chloride (or a Mark–1® kit);
29. Procainamide hydrochloride;
30. Sodium bicarbonate;
31. Sodium thiosulfate;
32. Succinylcholine;
33. Terbutaline sulfate;
34. Vasopressin;
35. Vecuroniun;
36. Verapamil hydrochloride; and
37. Xylocaine Jelly.

8:41–6.2 Applicability of laws, rules and/or regulations

(a) All providers and crewmembers shall be subject to all applicable laws, rules and/or regulations regarding the control and administration of medications, controlled dangerous substances and medical waste.

(b) Policies and procedures regarding the disposal of hypodermic needles and syringes shall be in accordance with all applicable laws, rules and/or regulations.

8:41–6.3 Medication controls, inventory, storage and recordkeeping

(a) Each provider shall devise a plan for maintaining inventory control over medications, including all substances identified in Schedules II and III of the New Jersey Controlled Dangerous Substances Act (N.J.S.A. 24:21–6 and 24:21–7). The following information shall be recorded:

1. The name of the patient receiving the medication;
2. The name of the prescribing physician;
3. The name and strength of the drug;
4. The date the vehicle received the drug for each Schedule I through V (inclusive) drug received by the provider;
5. The date the drug was administered;
6. The dosage administered;
7. The method of administration;
8. The signature of the ALS crewmember administering the drug;
9. The amount of medication wasted, if any; and
10. The co-signature of the crewmember witnessing the waste.

(b) A written narcotics log shall be maintained, which sets forth the date, time, drugs or therapeutic agents administered, route of administration, the name of the medical command physician ordering the drug or therapeutic agent, and the quantity and strength administered. All entries shall be typewritten or written in ink, legible, dated and signed by all crewmembers.

(c) All medications are to be kept in a locked storage box or compartment when not under the direct control of an ALS crewmember. All substances identified in Schedules I through V of the New Jersey Controlled Dangerous Substances Act (N.J.S.A. 24:21–5 through 8.1) shall be kept under a double lock system that requires two separate keys for access, except when under the direct control of an ALS crewmember responsible for their custody. Keys to the medications box or compartment shall be available only to ALS crewmembers or as allowed by applicable law, rule and/or regulation.

(d) EMT–Paramedic students shall have access to all substances identified in Schedules I through V of the New Jersey Controlled Dangerous Substances Act (N.J.S.A. 24:21–5 through 8.1) only while in the presence of an EMT–Paramedic, registered nurse or physician. All student signatures shall be countersigned by the supervising EMT–Paramedic, registered nurse or physician.

(e) A report shall be written and signed by all crewmembers and any witnesses present in the event that any controlled dangerous substances of a particular vehicle cannot be verified or drugs are lost, contaminated or destroyed. This report shall be in addition to any other reports required by any applicable law, rule and/or regulation. Copies of the report shall be sent for review to the provider's director or specialty care coordinator, as applicable. Copies of the report shall be forwarded to OEMS in the event of loss of any substance identified in Schedules I through V of the New Jersey Controlled Dangerous Substances Act (N.J.S.A. 24:21–5 through 8.1).

(f) The provider shall notify OEMS if any EMT–Paramedic, EMT–Basic or EMT–Paramedic student affiliated with the vehicle is relieved of duty due to improper handling of any medication or controlled dangerous substance. The notification shall be made by telephone during regular business hours on or before the next business day, followed by written confirmation within 14 calendar days of the action.

(g) No vehicle shall carry any medication, solution, supplies or equipment beyond the sterility or expiration date printed or affixed to the item by the manufacturer or processor.

(h) All medications and solutions shall be stored so as to ensure that each item meets its respective manufacturer's recommendations for the maintenance of that medication or solution's efficacy. A provider shall not utilize any medication or solution whose efficacy has been compromised.

SUBCHAPTER 7. STANDING ORDERS FOR ADULT PATIENT

8:41–7.1 Scope

The following treatment protocols shall be considered standing orders when treating adult patients. For the purpose of this subchapter, adult patients are defined as those persons who have attained the age of 13 years or older (that is, from the date of the person's thirteenth birthday and beyond).

8:41–7.2 Applicability and restrictions

(a) The standing orders set forth in this subchapter shall be adopted in their entirety by the provider's medical director with the exception of the standing order for cyanide poisoning and standing order for nerve agent poisoning, after notification of OEMS. Except where specifically noted, these standing orders shall not be altered, abbreviated, or enhanced in any manner.

(b) The standing orders contained in this subchapter are initial treatment protocols that may be utilized by ALS crewmembers. These protocols apply only to adult patients, and may be implemented prior to contact with the medical command physician. In the event the implementation of these standing orders is delayed for any reason, the medical command physician shall be contacted immediately following the delay.

(c) Any situation other than those specifically identified in this subchapter requires the ALS crewmembers to contact the medical command physician before providing any ALS treatment.

(d) These standing orders shall not be interpreted as a requirement to administer ALS treatment prior to contact with the medical command physician. ALS crewmembers may elect to contact the medical command physician at any time during the provision of therapy. Unless otherwise provided in these rules, standing orders cease to be operative once contact is made with the medical command physician.

(e) The standing orders contained in this subchapter shall not be considered to represent total patient management. Contact with the medical command physician shall be established at the point indicated in the standing order, unless established sooner in accordance with (d) above. At no time shall communications with the medical command physician be delayed due to difficulty in intubating the patient and/or initiating an IV line.

(f) The presence of an allergy to any medication or therapeutic agent set forth in these standing orders shall be deemed to be a contraindication to the administration of that medication or therapeutic agent. In such instances, the medication or therapeutic agent shall not be administered.

(g) Each case utilizing these standing orders shall be fully documented on the patient care report. The provider's quality assurance plan shall include provisions for review of calls where standing orders are utilized, in accordance with the standards set. Cases that do not follow the standing orders as set forth in this chapter or where contact is never made with the medical command physician shall be forwarded to the medical director for a mandatory review.

8:41–7.3 Standing orders for endotracheal intubation

(a) The following standing orders for endotracheal intubation are authorized in the event that an adult patient presents:

1. In respiratory arrest;

2. In respiratory failure with associated inadequate spontaneous ventilatory volume; and/or

3. Unconscious with absent protective gag reflex.

(b) Advanced interventions shall only be attempted after all BLS interventions have been instituted, at which point the patient may be intubated by either the orotracheal or nasotracheal route.

(c) It is imperative that the ALS crewmembers initiate contact with the medical command physician as soon as possible after the above treatment has been rendered. These procedures shall not delay the transportation of a patient in the event of a difficult intubation, nor shall contact with the medical command physician be delayed by a difficult intubation.

8:41–7.4 Standing orders for IV therapy

(a) The following standing orders for the initiation of IV therapy are authorized in those cases where an emergent or potentially emergent condition exists and current ALS treatment protocols require the initiation of IV therapy. In such cases, ALS crewmembers may establish IV access at keep vein open (KVO) rate or establish IV access with a saline port prior to contacting the medical command physician.

(b) ALS crewmembers shall contact the medical command physician as soon as possible after the establishment of an IV line. Contact with the medical command physician shall not be delayed by, or as a result of, unsuccessful IV attempts in the field.

(c) The time of the initiation of IV therapy and the time of contact with the medical command physician shall be recorded on the patient care report.

(d) The provider's medical director shall notify the Department as to the solution to be utilized for IV therapy when established under this section.

8:41–7.5 Standing orders for ventricular fibrillation and pulseless ventricular tachycardia

(a) The following standing orders are authorized in the event that an adult patient presents with ventricular fibrillation or pulseless ventricular tachycardia:

1. Initiate CPR;
2. Defibrillate at 200 joules or equivalent biphasic;
3. Defibrillate at 300 joules or equivalent biphasic;
4. Defibrillate at 360 joules or equivalent biphasic;
5. Assess and secure airway, oxygenate and intubate;
6. Establish IV access with normal saline solution;
7. Administer Epinephrine 1 mg IV or 2 mg ET of a 1:10,000 concentration. Repeat every three minutes to a total of three administrations, or Vasopressin 40 units IV one time only. The choice between Epinephrine or Vasopressin shall be at the discretion of the program's medical director, as confirmed by a letter to OEMS;
8. Perform CPR for one minute and defibrillate at 360 joules or equivalent biphasic;
9. Administration Lidocaine 1.5 mg/kg IV or 300 mg IV Amiodarone. The choice between Lidocaine or Amiodarone shall be at the discretion of the program's medical director, as confirmed by a letter to OEMS;
10. Perform CPR for one minute and defibrillate at 360 joules or equivalent biphasic; and
11. Contact the medical command physician.

(b) Check rhythm after each shock. Check the patient's pulse after the final shock in the sequence, or if the patient's cardiac rhythm should change. If ventricular fibrillation recurs after transiently converting to another rhythm, utilize whatever energy level was previously successful on the patient and defibrillate again.

(c) Should ventricular fibrillation recur after contact is made with the medical command physician, an ALS crewmember may deliver a shock at the energy level that was previously successful, without contacting the medical command physician, if such contact would significantly delay the delivery of the shock.

(d) In the event that an AED has been applied and utilized prior to the arrival of an ALS crewmember, the ALS crewmember shall continue the treatment protocol with regard to last energy level of defibrillation and next step in the treatment algorithm.

(e) Total amount of solutions given via ET not to exceed 50 cc.

8:41–7.6 Standing orders for asystole

(a) The following standing orders are authorized in the event that an adult patient presents with asystole:

1. Initiate CPR;
2. Confirm asystole in a second lead. If this is a bradysytolic arrest, immediately proceed to pacing. If rhythm is still unclear and possibly ventricular fibrillation, defibrillate and, if indicated, follow protocol for ventricular fibrillation;
3. Assess and secure airway, oxygenate and intubate;
4. Establish IV access with 0.9 percent normal saline solution;
5. Administer Epinephrine 1 mg IV or 2 mg ET of a 1:10,000 solution. Repeat every three minutes for a total of three administrations;
6. Administer Atropine Sulfate 1 mg IV or 2 mg ET. Repeat every three minutes up to a total of 0.04 mg/kg; and
7. Contact the medical command physician.

(b) Termination of efforts shall be considered only with the input of the medical command physician if asystole/agonal rhythms continue after successful intubation and initial medications and no reversible causes are identified. The time interval since arrest shall be considered.

(c) The total amount of solutions given via ET shall not exceed 50 cc.

8:41–7.7 Standing orders for pulseless electrical activity (PEA):

(a) The following standing orders are authorized in the event that an adult patient presents with pulseless electrical activity:

1. Initiate CPR;

2. Assess and secure airway, oxygenate and intubate;

3. Establish large bore IV access;

4. Administer 300 cc fluid challenge, 0.9 percent normal saline solution;

5. Administer Epinephrine 1 mg IV or 2 mg ET of a 1:10,000 solution. Repeat every three minutes, for a total of three administrations;

6. If PEA rate is slow (that is, less than 60 beats per minute), give Atropine 1 mg IV or 2 mg ET. Repeat every three minutes to a total of 0.04 mg/kg; and

7. Contact the medical command physician.

(b) The total amount of solutions given via ET shall not exceed 50 cc.

8:41–7.8 Standing orders for multiple trauma

(a) The following standing orders are authorized in the event that an adult patient presents with multiple traumatic injuries:

1. Provide basic life support as necessary;

2. Assess and secure airway;

3. Provide cervical spine precautions;

4. Assist ventilation, providing high flow oxygen at 100 percent by non-rebreather mask and/or performing intubation utilizing cervical spine precautions when indicated;

5. Transport the patient as soon as possible to the most appropriate facility according to the adult trauma triage guidelines; transportation shall not be delayed due to difficulty in intubating the patient and/or initiating an IV line, except at the specific direction of the medical command physician;

6. Enroute to the hospital, establish two large bore IV lines of Ringer's lactate solution or normal saline solution. Titrate the IV fluid administration rate to maintain a systolic blood pressure of greater than 90 mmHg and a pulse rate of less than 120 per minute, to a maximum dose of one liter; and

7. Contact the medical command physician.

8:41–7.9 Standing orders for bradycardia

(a) The following standing orders are authorized in the event that an adult patient presents with bradycardia (heart rate less than 60 beats per minute) in which the patient displays hypotension, shock or other significant symptoms consistent with hemodynamic instability:

1. Assess and secure airway;

2. Establish IV access;

i. If IV access cannot be established, proceed directly to transcutaneous pacing;

3. Administer Atropine Sulfate 1 mg IV;

4. If there is no response to the Atropine Sulfate, administer transcutaneous pacing at a rate of 70, at the lowest amount of energy necessary to obtain capture;

i. Note: Denervated hearts will not respond to Atropine Sulfate. In such cases, consider external cardiac pacing; and

5. Contact the medical command physician.

(b) In stable patients with Type II second degree or third degree AV block, transcutaneous pacemaker should be applied as a precaution.

8:41–7.10 Standing orders for pulmonary edema/congestive heart failure

(a) The following standing orders are authorized in the event that an adult patient presents with pulmonary edema/congestive heart failure with systolic blood pressure greater than, or equal to, 110 mmHg:

1. Assess and secure airway;

2. Administer 0.4 mg Nitroglycerin sublingually every five minutes, to a maximum dose of 1.2 mg (which is three tablets or sprays of 0.4 mg each), provided the systolic blood pressure is greater than or equal to 110 mmHg;

3. Establish IV access;

4. Administer Furosemide 1 mg/kg IV;

i. A provider's medical director may elect to substitute Bumetanide 2 mg IV for Furosemide. The medical director shall notify the Department if he or she elects to utilize this substitution; and

5. Contact the medical command physician.

8:41–7.11 Standing orders for suspected acute myocardial infarction/chest pain

(a) The following standing orders are authorized in the event that an adult patient presents with acute myocardial infarction/chest pain with systolic blood pressure greater than, or equal to, 110 mmHg:

1. Assess and secure airway;

2. Administer at least 4 lpm nasal oxygen;

3. Administer 0.4 mg Nitroglycerin sublingually every five minutes, to a maximum dose of 1.2 mg (which is three tablets or sprays of 0.4 mg each), provided the systolic blood pressure is greater than or equal to 110 mmHg;

4. Administer Acetylsalicylic Acid by mouth after the first dose of Nitroglycerin; The provider's medical director shall notify the Department whether the program will administer 81 mg or 324 mg of Acetylsalicylic Acid;

5. Establish IV access;

6. If time and clinical condition of the patient allows, obtain a 12–lead electrocardiogram tracing;

7. If the patient is having an acute myocardial infarction, review patient's eligibility for thrombolytic therapy as determined by the provider's medical director; and

8. Contact the medical command physician.

8:41–7.12 Standing orders for sustained ventricular tachycardia

(a) The following standing orders are authorized in the event that an adult patient presents with a stable ventricular tachycardia (that is, with a systolic blood pressure greater than or equal to 110 mmHg):

1. Assess and secure airway;

2. Establish IV access;

3. Perform patient assessment, including medical history and allergies;

4. Continue to assess the patient and monitor the cardiac rhythm;

5. Administer Lidocaine 1 mg/kg IV or Amidarone 150 mg IV over 10 minutes. The antiarrhythmic agent shall be predetermined by the medical director, who shall notify OEMS of his or her choice prior to utilization on any vehicle; and

6. Contact the medical command physician.

8:41–7.13 Standing orders for unstable ventricular tachycardia

(a) The following standing orders are authorized in the event that an adult patient presents with an unstable ventricular tachycardia where the patient is unconscious or hemodynamically compromised:

1. Assess and secure airway;

2. Establish IV access;

3. If the patient is conscious, strongly consider contacting the medical command physician for an order for sedation prior to cardioversion;

4. Perform a synchronized cardioversion at 100 joules or equivalent biphasic. Check the patient's pulse and cardiac rhythm after the shock;

i. If the rhythm fails to convert, perform a synchronized cardioversion at 200 joules or equivalent biphasic. Check the patient's pulse and cardiac rhythm after the shock;

ii. If the rhythm fails to convert, perform a synchronized cardioversion at 300 joules or equivalent biphasic. Check the patient's pulse and cardiac rhythm after the shock;

iii. If the rhythm fails to convert, perform a synchronized cardioversion at 360 joules or equivalent biphasic. Check the patient's pulse and cardiac rhythm after the shock;

5. If the rhythm is converted at any point, administer 1 mg/kg Lidocaine or Amiodarone 150 mg IV over 10 minutes. The antiarrhythmic agent shall be predetermined by the medical director, who shall notify OEMS of his or her choice prior to utilization on any vehicle; and

6. Contact the medical command physician.

8:41–7.14 Standing orders for stable narrow complex tachycardia (non-atrial fibrillation or non-atrial flutter)

(a) The following standing orders are authorized in the event that an adult patient presents with a stable narrow complex tachycardia with systolic blood pressure greater than or equal to 110 mmHg:

1. Assess and secure airway;

2. Establish IV access;

3. Perform a patient assessment, including medical history and allergies;

4. Perform a 12–lead electrocardiogram tracing, if applicable, and continue to assess the patient and monitor the cardiac rhythm;

5. Attempt vagal maneuver;

6. Administer 6 mg Adenosine rapid IV push over a period of one to three seconds, followed by a 20 cc bolus of normal saline solution rapid IV push; and

7. Contact the medical command physician.

8:41–7.15 Standing orders for unstable narrow complex tachycardia (non-atrial fibrillation or non-atrial flutter)

(a) The following standing orders are authorized in the event that an adult patient presents with an unstable narrow complex tachycardia where the patient is unconscious or hemodynamically unstable:

1. Assess and secure airway;

2. Establish IV access (in the antecubital fossa, if possible);

3. If the patient is conscious and IV access has been established, administer Adenosine 6 mg rapid, followed by 20 cc normal saline solution rapid bolus;

4. If IV access cannot be established, if the patient is unconscious or if there is no response to the Adenosine, perform a synchronized cardioversion at 50 joules or equivalent biphasic. Check the patient's pulse and cardiac rhythm after the shock;

i. If the rhythm fails to convert, perform a synchronized cardioversion at 100 joules or equivalent biphasic. Check the patient's pulse and cardiac rhythm after the shock;

ii. If the rhythm fails to convert, perform a synchronized cardioversion at 200 joules or equivalent biphasic. Check the patient's pulse and cardiac rhythm after the shock;

iii. If the rhythm fails to convert, perform a synchronized cardioversion at 300 joules or equivalent biphasic. Check the patient's pulse and cardiac rhythm after the shock;

iv. If the rhythm fails to convert, perform a synchronized cardioversion at 360 joules or equivalent biphasic. Check the patient's pulse and cardiac rhythm after the shock; and

5. Contact the medical command physician.

8:41–7.16 Standing orders for allergic reaction/anaphylactic shock

(a) The following standing orders are authorized in the event that an adult patient presents with signs of generalized allergic findings such as urticaria with signs of acute significant respiratory distress and/or profound hypotension (systolic blood pressure less than or equal to 80 mmHg) with clinical evidence of shock, including altered mental status; cool, clammy or mottled skin; and/or delayed capillary refill.

1. Assess and secure airway;

2. Fifteen lpm of oxygen via NRB should be placed;

3. Administer 0.5 cc Epinephrine 1:1,000 subcutaneous and vigorously rub the area of injection;

4. Establish IV access and administer normal saline solution and initiate 300 cc fluid bolus. The bolus should be repeated once if blood pressure remains less than 100 systolic;

5. Administer 0.25 mg Epinephrine 1:10,000 IV over the course of one minute;

6. Administer 50 mg Diphenhydramine HCL IV;

7. If wheezing is present, administer 2.5 mg Albuterol/3 cc normal saline solution via nebulizer; and

8. Contact the medical command physician.

8:41–7.17 Standing orders for respiratory distress with wheezing due to COPD or bronchoconstriction

(a) The following standing orders are authorized in the event that an adult patient presents with dyspnea where the signs and symptoms are consistent with asthma, COPD or any other dyspnea associated with wheezing or suspected bronchospasm:

1. Assess and secure airway;

2. Administer 2.5 mg Albuterol/3 cc normal saline solution via nebulizer;

i. A provider's medical director may elect to substitute Metaproterenol or Isoetharine for Albuterol. This substitution shall be declared at the time these standing orders are authorized by the medical director and approved by the Department.

3. Establish IV access;

4. Administer additional 2.5 mg Albuterol/3 cc normal saline solution treatments via nebulizer, up to a total of three treatments; and

5. Contact the medical command physician.

8:41–7.18 Standing orders for unconscious person/altered mental status

(a) The following standing orders are authorized in the event that an adult patient is unconscious or presents with altered mental status. The treatment of an unconscious person/altered mental status patient shall be directed by the suspected etiology of the event. Specific orders may be omitted by an ALS crewmember if the order does not pertain to the suspected etiology of the medical emergency:

1. Assess and secure airway;

2. Evaluate a blood glucose reagent strip;

3. Establish IV access;

4. Draw blood, if possible;

5. If the blood reagent strip indicates a blood glucose level less than 60 mg/dl;

i. Administer 25 gm of 50 percent Dextrose in water intravenously;

(1) If unable to establish IV access, administer 1 mg Glucagon intramuscularly; and

ii. Administer 100 mg Thiamine IV;

iii. If there is no response to (a)5i and ii above, or if the blood glucose level is greater than 60 mg/dl, administer up to 2 mg Naloxone IV. Start with 1 mg and titrate the dose to reversal of any respiratory depression;

iv. If IV access is unobtainable administer Naloxone 2 mg IM; and

6. Contact the medical command physician.

8:41–7.19 Standing orders for nontraumatic hypotension

(a) The following standing orders are authorized in the event that an adult patient presents with significant and symptomatic hypotension (systolic blood pressure less than 90 mmHg) unaccompanied by bradycardia or trauma, with patient exhibiting signs of shock due to dehydration, sepsis, and nontraumatic hemorrhage (for example, gastrointestinal bleeding):

1. Assess and secure airway;

2. Establish at least one large bore IV line of Ringer's lactate solution or normal saline solution, and administer a 300 cc bolus of IV solution;

3. Reassess vital signs and the condition of the patient; and

4. Contact the medical command physician.

8:41–7.20 Standing orders for active seizures

(a) The following standing orders are authorized in the event that an adult patient presents with active seizures:

1. Assess and secure airway;

2. Establish IV access and administer normal saline solution at KVO rate;

3. Follow unconscious protocol as directed by the suspected etiology of the event; and

4. Contact the medical command physician.

8:41–7.21 Standing orders for cyanide poisoning (optional, at medical director's discretion)

(a) The following standing orders (optional, at the medical director's discretion) are authorized in the event that an adult patient presents with cyanide poisoning:

1. Do not enter or attempt to rescue a person in an area suspected or documented to be contaminated with cyanide poison;

2. Before making patient contact, ensure that appropriate decontamination has been performed;

i. If the patient has been exposed to liquid cyanide, ensure that all of the patient's clothing has been removed;

ii. No decontamination is needed for pure vapor exposure;

3. Determine the level of exposure;

i. If the level of exposure is mild (that is, the patient is conscious and breathing):

(1) Assess and secure the airway;

(2) Administer high concentration oxygen; and

(3) Observe the patient for respiratory distress;

ii. If the level of exposure is severe (that is, the patient is unconscious or if respirations are severely compromised):

(1) Assess and secure the airway;

(2) Administer high concentration oxygen;

(3) Provide suctioning (if necessary);

(4) If Cyanide kit is available, break and hold an aspirol of Amyl Nitrite in front of the patient's nose for 15 seconds, followed by removal for 15 seconds; use a new aspirol of Amyl Nitrite approximately every three minutes thereafter until IV access has been established. If the patient is unconscious, place the aspirol of Amyl Nitrite in the mask of the bag-valve-mask device or in the bag-valve-mask device itself;

(5) Establish IV access;

(6) Administer Sodium Thiosulfate 12.5 grams IV; and

4. Contact the medical command physician.

8:41–7.22 Standing orders for nerve agent poisoning (optional, at medical director's discretion)

(a) The following standing orders (optional, at medical director's discretion) are authorized in the event that an adult patient presents with nerve agent poisoning:

1. Do not enter or attempt to rescue a person in an area suspected or documented to be contaminated with nerve agent poison;

2. Before making patient contact, ensure that appropriate decontamination has been performed. No decontamination is need for pure vapor exposure;

3. Assess the patient for signs of nerve agent toxicity (SLUDGE) and constricted pupils (miosis);

i. SLUDGE stands for:

(1) Salivation (excessive production of saliva);

(2) Lacrimation (excessive production of tears);

(3) Urination (uncontrolled urine production);

(4) Defecation (uncontrolled bowel movements);

(5) Gastrointestinal distress (cramps, hyperactive bowel sounds); and

(6) Emesis (excessive vomiting);

4. Determine the level of exposure;

i. If the level of exposure is mild (that is, the patient is conscious and breathing):

(1) Assess and secure the airway;

(2) Administer high concentration oxygen;

(3) Observe the patient for respiratory distress; and

(4) Establish IV access;

ii. If the level of exposure is severe (that is, the patient is unconscious or if respirations are severely compromised):

(1) Assess and secure the airway;

(2) Administer high concentration oxygen;

(3) Establish IV access;

(4) Administer Atropine 2 mg/kg IV; and

(5) Administer Pralidoxime Chloride 1 gram IV;

iii. If unable to establish IV access, administer Nerve Agent Antidote Kit (NAAK), consisting of auto injectors of Atropine 2 mg and Pralidoxime Chloride 600 mg intramuscularly; and

5. Contact the medical command physician.

SUBCHAPTER 8. STANDING ORDERS FOR PEDIATRIC PATIENTS

8:41–8.1 Scope

With the exception of N.J.A.C. 8:41–8.4, the following treatment protocols shall be considered standing orders for treating pediatric patients. The standing orders set forth at N.J.A.C. 8:41–8.4 are for the exclusive utilization in resuscitating neonatal patients. As defined at N.J.A.C. 8:41–1.3, "neonatal" means the period of time from the moment of birth up to and including the 28th day following birth and "pediatric" means the period of time beginning with the 29th day following birth up to, but not including, a person's 13th birthday.

8:41–8.2 Applicability and restrictions

(a) The standing orders established in this subchapter shall be adopted in their entirety by the provider's medical director, after notification to OEMS. Except where specifically noted, these standing orders shall not be altered, abbreviated or enhanced in any manner.

(b) The standing orders contained in this subchapter are initial treatment protocols for unstable patients that may be utilized by ALS crewmembers. These protocols apply only to pediatric patients and may be implemented prior to contact with the medical command physician. In the event the implementation of these standing orders is delayed for any reason, the medical command physician shall be contacted immediately following the delay.

(c) Any situations other than those specifically identified in this subchapter requires ALS crewmembers to contact the medical command physician before providing any ALS treatment.

(d) These standing orders shall not be interpreted as a requirement to administer ALS treatment prior to contact with the medical command physician. The ALS crewmembers may elect to contact the medical command physician at any earlier time during the provision of therapy. Unless otherwise provided in these rules, standing orders cease to be operative once contact is made with the medical command physician.

(e) The standing orders contained in this subchapter shall not be considered to represent total patient management. Contact with the medical command physician shall be established at the point indicated in the standing order, unless established sooner in accordance with (d) above. At no time shall communications with the medical command physician be delayed due to difficulty in intubating the patient and/or initiating IV access.

(f) The presence of an allergy to any medication or therapeutic agent set forth in these standing orders shall be deemed to be a contraindication to the administration of that medication or therapeutic agent. In such instances, the medication or therapeutic agent shall not be administered.

(g) Each case utilizing these standing orders shall be fully documented on the patient care report. The provider's quality assurance plan shall include provisions for review of calls where standing orders are utilized, in accordance with the standards set. Cases that do not follow the standing orders as set forth in this chapter or where contact is never made with the medical command physician shall be forwarded to the medical director for a mandatory review.

8:41–8.3 Standard terms

(a) As utilized in this subchapter, the term "stable" means vital signs, cardiovascular parameters and level of response within the ranges defined in Appendix D, incorporated herein by reference.

(b) As utilized in this subchapter, the term "unstable" means vital signs, cardiovascular parameters and level of response not within the ranges defined in Appendix D.

8:41–8.4 Standing orders for neonatal resuscitation

(a) The following shall constitute standing orders for the resuscitation of neonatal patients:

1. As to the airway:

i. If meconium is present:

(1) If stable, suction the mouth, pharynx and nose with a bulb syringe or a large-bore catheter (12 or 14F) as soon as the head is delivered;

(2) If unstable, intubate the patient and extubate while applying suction at a vacuum pressure no greater than–100 mmHg until little meconium is recovered or heart rate and/or respirations become severely depressed;

ii. If no meconium:

(1) Position the infant and suction the mouth then the nose with a bulb syringe;

2. Dry the infant;

3. Maintain normal body temperature;

4. Provide tactile stimulation;

5. If infant is unstable (cyanotic, apnea, gasping respirations, a heart rate less than 100 beats per minute) administer 100 percent oxygen at a flow rate of at least five L/minute;

6. If no improvement, begin bag-valve-mask ventilation at a rate of 40 to 60 breaths per minute with sufficient volume to cause visible chest expansion. Reassess after 30 seconds;

7. Assess heart rate;

i. If the heart rate is greater than 100 beats/minute, contact the medical command physician;

ii. If the heart rate is 60 to 100 beats/minute, assist ventilations and contact the medical command physician;

iii. If the heart rate is less than 60 beats per minute, intubate, begin a 3:1 ratio of chest compressions to ventilations at a rate of 120 compressions per minute. Reassess every 30 seconds;

(1) If no change following intervention in (a)7iii above, establish IV/IO access with normal saline solution at a KVO rate;

(A) If no change following intervention described in (a)7iii(1) above, administer epinephrine: IV/IO/ET dose 0.01 mg/kg (0.1 mL/kg) of a 1:10,000 solution;

8. If no change, administer a fluid bolus of 10 mL/kg of normal saline over five to 10 minutes;

9. Determine blood glucose;

i. If equal to or greater than 40, contact the medical command physician; and

ii. If less than 40, administer 0.5 g/kg (5 mL/kg) of a 10 percent dextrose solution, contact the medical command physician.

8:41–8.5 Standing orders for pediatric endotracheal intubation

(a) The standing orders in (b) below for endotrachael intubation are authorized in the event that a pediatric patient presents:

1. In respiratory arrest;

2. In respiratory failure with associated inadequate spontaneous ventilatory volume; and/or

3. Unconscious with absent protective gag reflex.

(b) Advanced interventions shall only be attempted after all BLS interventions have been instituted, at which point the patient may be intubated by the orotracheal route. Nasotracheal intubation shall not be performed on pediatric patients.

1. It is imperative that ALS crewmembers initiate contact with the medical command physician as soon as possible after the above treatment has been rendered. These procedures shall not delay the transportation of a patient in the event of a difficult intubation, nor shall contact with the medical command physician be delayed by a difficult intubation.

8:41–8.6 Standing orders for pediatric IV/IO therapy

(a) The following standing orders for the initiation of pediatric IV therapy are authorized in those cases where an emergent or potentially emergent condition exists and current ALS treatment protocols require the initiation of IV therapy. In such cases, ALS crewmembers may establish IV access at keep vein open (KVO) rate, establish IV access with a saline port, or establish intraosseous infusion prior to contacting the medical command physician.

1. ALS crewmembers shall contact the medical command physician as soon as possible after the establishment of an IV/IO line. Contact with the medical command physician shall not be delayed by, or as a result of, unsuccessful IV/IO attempts in the field.

2. The time of the initiation of IV/IO therapy and the time of contact with the medical command physician shall be recorded on the patient care report.

3. The provider's medical director shall notify the Department as to the solution to be utilized for IV/IO therapy when established under this section.

8:41–8.7 Standing orders for pediatric cardiac arrest

(a) The following standing orders are authorized in the event that a pediatric patient presents with ventricular fibrillation and/or pulseless ventricular tachycardia:

1. Determine pulselessness and begin CPR;

2. Secure the airway;

3. Hyperventilate with 100 percent oxygen;

4. Maintain normal body temperature;

5. Defibrillate at 2 J/kg or equivalent biphasic;

6. If no change in rhythm, defibrillate at 4 J/kg or equivalent biphasic;

7. If no change in rhythm, defibrillate at 4 J/kg or equivalent biphasic;

8. Establish IV/IO access with normal saline solution at a KVO rate;

9. Administer epinephrine:

i. 0.01 mg/kg (0.1 mL/kg) of a 1:10,000 solution via IV/IO; or

ii. 0.1 mg/kg (0.1 mL/kg) of a 1:1,000 solution via ET (diluted with normal saline to 5 ml);

10. If no change in rhythm, defibrillate at 4 J/kg or equivalent biphasic; and

11. Contact the medical command physician.

(b) The following standing orders are authorized in the event that a patient presents with asystole and/or pulseless electrical activity (PEA):

1. Determine pulselessness and begin CPR;

2. Secure the airway;

3. Hyperventilate with 100 percent oxygen;

4. Maintain normal body temperature;

5. If asystole, confirm cardiac rhythm in more than one lead. If PEA, identify causes;

6. Establish IV/IO access with normal saline solution at a KVO rate;

7. Administer epinephrine:

i. 0.01 mg/kg (0.1 mL/kg) of a 1:10,000 solution via IV/IO; or

ii. 0.1 mg/kg (0.1 mL/kg) of a 1:1,000 solution via ET (diluted with normal saline to 5 ml);

8. Administer a rapid fluid bolus of 20 ml/kg of normal saline via IV/IO; and

9. Contact the medical command physician.

8:41–8.8 Standing orders for pediatric trauma

(a) The following standing orders are authorized in the event a pediatric patient presents with traumatic injuries:

1. Immobilize the spine if indicated;

2. Assess and secure the airway;

3. Administer 100 percent oxygen;

4. Control hemorrhage and bleeding;

5. Maintain normal body temperature;

6. Begin transport to the appropriate facility according to the pediatric trauma guidelines in Appendix E;

7. Establish IV/IO access with Ringer's Lactate solution at a KVO rate. If trauma is accompanied by burns, substitute normal saline for Ringers Lactate solution;

8. Administer a rapid fluid bolus of Lactated Ringers 20 ml/kg via IV/I or normal saline 20 ml/kg (if trauma is accompanied by burns); and

9. Contact the medical command physician.

8:41–8.9 Standing orders for pediatric seizures

(a) The following standing orders are authorized in the event a pediatric patient presents with active seizures:

1. Assess and secure the airway;

2. Administer 100 percent oxygen;

3. Maintain normal body temperature;

4. Obtain a rapid glucose test;

i. If blood glucose is greater than or equal to 60, contact the medical command physician;

ii. If blood glucose is less than 60:

(1) Establish IV/IO access with normal saline at a KVO rate.

(A) For patients less than one month of age, administer 0.5 g/kg of a 10 percent dextrose solution via IV/IO.

(B) For patients greater than or equal to one month of age, administer 0.5 g/kg of a 25 percent dextrose solution via IV/IO.

(C) If unable to establish an IV/IO, administer Glucagon 0.1 mg/kg (0.1 ml/kg) to a maximum of 1 mg via IM or SC routes (1mg=1ml=1 unit); and

5. Contact medical command.

8:41–8.10 Standing orders for pediatric allergic reaction and/or anaphylaxis

(a) The following standing orders are authorized in the event a pediatric patient presents with an allergic reaction and/or anaphylaxis:

1. Assess and secure the airway;

2. Administer 100 percent oxygen;

3. Maintain normal body temperature;

4. Administer Epinephrine 0.01 mg/kg (0.01 ml/kg) of a 1:1,000 solution to a maximum of 0.5 mg via SC route;

5. If the patient is wheezing, administer albuterol 2.5 mg via nebulizer;

6. Establish IV access with normal saline solution at a KVO rate (if patient is severely unstable, establish intraosseous access);

7. If patient remains hemodynamically unstable, administer a rapid fluid bolus of normal saline solution at a dose of 20 ml/kg via IV/IO;

8. If no improvement, administer Diphenhydramine hydrochloride at a dose of 1 mg/kg (to a maximum dose of 50 mg) slowly via IV/IO; and

9. Contact the medical command physician.

8:41–8.11 Standing orders for pediatric altered mental status

(a) The following standing orders are authorized in the event that a pediatric patient presents with altered mental status:

1. Assess and secure the airway;

2. Administer 100 percent oxygen;

3. Maintain normal body temperature;

4. If evidence of trauma, refer to N.J.A.C. 8:41–8.8, Standing orders for pediatric trauma;

5. Establish IV access with normal saline solution at a KVO rate or, if patient is severely unstable, establish IO access;

6. Obtain a rapid glucose test. If blood glucose is less than 60:

i. For patients less than one month of age, administer 0.5 g/kg of a 10 percent dextrose solution via IV/IO;

ii. For patients greater than or one month of age, administer 0.5 g/kg of a 25 percent dextrose solution via IV/IO;

iii. If unable to establish an IV/IO, administer Glucagon 0.1 mg/kg (0.1 ml/kg) to a maximum of 1 mg via IM or SC routes (1mg=1ml=1 unit);

7. If no change in the patient's status, administer Naloxone 0.1 mg/kg, with a maximum dose of 2 mg via IV/IO/ET;

8. If there is a history of dehydration, administer a fluid bolus of normal saline at 20 ml/kg via IV/IO; and

9. Contact the medical command physician.

8:41–8.12 Standing orders for pediatric asthma

(a) The following standing orders are authorized in the event that a pediatric patient presents with asthma:

1. Assess and secure the airway;

2. Administer 100 percent oxygen;

3. Maintain normal body temperature;

4. Administer Albuterol 2.5 mg via nebulizer;

5. If patient condition becomes more unstable:

i. Administer epinephrine 0.01 mg/kg (0.01 ml/kg) of a 1:1,000 solution to a maximum of 0.5 mg via SC route;

ii. Establish IV access of normal saline solution at a KVO rate; and

6. Contact the medical command physician.

8:41–8.13 Standing orders for pediatric bradycardia

(a) The following standing orders are authorized in the event that a pediatric patient presents with bradycardia:

1. Assess and secure the airway;

2. Administer 100 percent oxygen;

3. Maintain normal body temperature;

4. Perform chest compressions at a rate of 100 compressions per minute;

5. Establish IV/IO access with normal saline at a KVO rate;

6. Administer epinephrine:

i. 0.01 mg/kg (0.1 mL/kg) of a 1:10,000 solution via IV/IO; or

ii. 0.1 mg/kg (0.1 mL/kg) of a 1:1,000 solution via ET (diluted with normal saline to 5 ml); and

7. Contact the medical command physician.

8:41–8.14 Standing orders for pediatric burn management

(a) The following standing orders are authorized in the event that a pediatric patient presents with burns:

1. Stop the burning process;

2. If hazardous materials are suspected, take proper precautions and contact medical command physician for guidance on treatment protocols;

3. Immobilize the spine if indicated;

4. Assess and secure the airway;

5. Consider endotracheal intubation if indicated for airway burns and/or respiratory compromise;

6. Administer 100 percent oxygen;

7. Cover the burns with a dry dressing;

8. Maintain normal body temperature;

9. Begin transportation of patient to the appropriate facility;

10. If evidence of trauma, refer to N.J.A.C. 8:41–8.8, Standing orders for pediatric trauma;

11. Establish IV access with normal saline at a KVO rate or, if patient is severely unstable, establish IO access; and

12. Contact the medical command physician.

8:41–8.15 Standing orders for pediatric croup

(a) The following standing orders are authorized in the event that a pediatric patient presents with croup:

1. Assess and secure the airway;

2. Administer 100 percent oxygen;

3. Maintain normal body temperature and position of comfort;

4. Mild to moderate distress (barking cough, inspiratory stridor):

i. Administer 3 cc normal saline via nebulizer with simple mask; and

ii. Contact the medical command physician;

5. Moderate to severe distress (stridor at rest, retractions, tripoding, accessory muscle use):

i. Administer epinephrine 3 mg (3 cc) 1:1,000 solution via nebulizer;

ii. If no change, establish IV/IO access with normal saline at a KVO rate; and

iii. Contact the medical command physician.

8:41–8.16 Standing orders for pediatric non-traumatic shock

(a) The following standing orders are authorized in the event that a pediatric patient presents with non-traumatic shock:

1. Assess and secure the airway;

2. Administer 100 percent oxygen;

3. Maintain normal body temperature;

4. Establish IV/IO access with normal saline solution at a KVO rate;

5. Administer a rapid fluid bolus of normal saline at a dose of 20 mL/kg;

6. Obtain a rapid glucose test. If blood glucose is less than 60:

i. For patients less than one month of age, administer 0.5 g/kg of a 10 percent dextrose solution via IV/IO;

ii. For patients greater than one month of age, administer 0.5 g/kg of a 25 percent dextrose solution via IV/IO.

7. If unable to establish an IV/IO, administer Glucagon 0.1 mg/kg (0.1 ml/kg) to a maximum of 1 mg via IM or SC routes (1mg=1ml=1 unit);

8. If no change, administer a rapid fluid bolus of normal saline solution at a dose of 20 mL/kg; and

9. Contact the medical command physician.

8:41–8.17 Standing orders for pediatric tachycardia

(a) The following standing orders are authorized in the event that a pediatric patient presents with narrow complex tachycardia:

1. Assess and secure the airway;

2. Administer 100 percent oxygen;

3. Maintain normal body temperature;

4. If rhythm is sinus or supraventricular in nature, attempt vagal maneuvers;

5. If no change, establish IV/IO access with normal saline solution at a KVO rate;

6. Administer adenosine 0.1 mg/kg IV/IO (maximum dose of 6 mg);

7. If no change, administer adenosine 0.2 mg/kg IV/IO (maximum dose of 12 mg); and

8. Contact the medical command physician.

(b) The following standing orders are authorized in the event that a pediatric patient presents with wide complex tachycardia:

1. Assess and secure the airway;

2. Administer 100 percent oxygen;

3. Maintain normal body temperature;

4. If rhythm is sinus or supraventricular in nature, attempt vagal maneuvers;

5. If no change, establish IV/IO access with normal saline solution at a KVO rate;

6. If no change, cardiovert with 0.5 J/kg; and

7. Contact the medical command physician.

8:41–8.18 Standing orders for sudden infant death syndrome

(a) The following standing orders are authorized in the event that sudden infant death syndrome is suspected:

1. Form a general impression of the patient's condition;

2. Establish responsiveness;

3. Assess airway and breathing and confirm apnea;

4. Assess pulselessness and initiate cardiac monitoring;

5. If patient does not exhibit lividity and/or rigor, go to cardiac arrest guidelines found at N.J.A.C. 8:41–8.7;

6. If patient exhibits lividity and/or rigor, contact medical command physician for pronouncement;

7. Provide supportive measures and New Jersey SIDS Center (800) 545–7437 telephone number for caregivers;

8. Obtain patient history; and

9. Reassess the environment, documenting:

i. Where was the patient located on arrival;

ii. Description of objects located near the child upon arrival; and

iii. Unusual environmental conditions (that is; high room temperature, abnormal odors, etc.).

SUBCHAPTER 9. SPECIFIC MOBILE INTENSIVE CARE PROGRAM REQUIREMENTS

8:41–9.1 Scope and purpose

(a) These rules shall apply to any acute care hospital that operates, or seeks to operate, a mobile intensive care program within the State of New Jersey. These rules serve to define the operational requirements of such a program, to provide for a uniform application of standards, and to specify the personnel, equipment, organization and other resources required to successfully operate the program.

(b) No acute care hospital shall operate a mobile intensive care program in any form or manner or utilize any vehicle as a MICU within the State of New Jersey until licensed by the Department. In addition, as provided for at N.J.A.C. 8:41–9.2(a), a license to operate a mobile intensive care program shall not be issued unless a certificate of need has first been granted in accordance with the requirements set forth at N.J.A.C. 8:33.

8:41–9.2 Certificate of need requirements and patient restrictions

(a) An acute care hospital shall not be issued a license to operate a mobile intensive care program unless approval has first been granted by the Department's Certificate of Need Program. Following approval by the Certificate of Need Program, an acute care hospital desiring to operate a mobile intensive care program shall make application in accordance with the process for licensure set forth in this chapter.

1. Consistent with N.J.A.C. 8:33, a certificate of need shall not be required for the permanent addition of full-time or part-time MICUs to a mobile intensive care program's primary service area in excess of those MICUs authorized pursuant to the original certificate of need approval letter. In such instances, the mobile intensive care program need only apply for licensure of those vehicles, in accordance with the standards for licensure as set forth at N.J.A.C. 8:41–2.1 and 2.2.

2. Consistent with N.J.A.C. 8:33, a certificate of need shall not be required to increase the hours of operation of an existing MICU or to increase the number of licensed vehicles. In the case of an increase in the hours of operation, the mobile intensive care program need only notify OEMS, in writing, of the new hours. In the case of an increase of the number of licensed vehicles, the provider shall first license any new vehicles in accordance with the procedures for licensure set forth at N.J.A.C. 8:41–2.1 and 2.2.

3. Consistent with N.J.A.C. 8:33, a certificate of need shall not be required to decrease the hours of operation of an existing MICU or for the permanent removal of a MICU from service. However, in such instances, the mobile intensive care program shall first notify, and receive approval from, OEMS.

(b) The terms and conditions set forth in the certificate of need, and any subsequent conditions, shall be binding upon the mobile intensive care program. Failure to comply with any such conditions shall be deemed cause for action against the mobile intensive care program.

(c) Except as provided for at N.J.A.C. 8:41–9.16(c), a mobile intensive care program shall not utilize its MICUs to provide advanced life support care in any geographical area of the State for which it does not hold certificate of need approval to do so.

(d) MICUs may be utilized to provide pre-hospital basic or advanced life support emergency medical care. Except as provided for at N.J.A.C. 8:41–9.16(b), a MICU shall not be utilized to transport patients unless the mobile intensive care program has been granted prior and specific approval, pursuant to the terms of its original certificate of need, to utilize its vehicles as transport vehicles. Under no circumstances shall a MICU be utilized to provide ALS inter-facility transfers.

(e) A mobile intensive care program shall not refuse, or fail to respond to, an emergency call or refuse or fail to provide emergency treatment to any person because of that person's race, sex, creed, national origin, sexual preference, age, disability, medical condition or ability to pay.

8:41–9.3 Director

(a) Each mobile intensive care program shall have a director who shall be responsible for all activities of that program.

(b) The person who serves as the director shall be either an EMT–Paramedic or a registered nurse with at least one year of critical care experience or who has demonstrated by education or experience the ability to manage health care organizations.

(c) A representative of the mobile intensive care program shall notify the Department, in writing, of any change of director within 14 calendar days after the change.

8:41–9.4 Medical director

(a) Each mobile intensive care program shall have a medical director who shall be responsible for all medical matters that affect that program, its personnel and its vehicles.

(b) The qualifications necessary to serve as the medical director of a mobile intensive care program shall be as follows:

1. Physician status;
2. Possession of CPR and ACLS certifications;
3. Possession of PALS or APLS certification;
4. Successful completion of the Advanced Trauma Life Support course to the standards of the American College of Surgeons; and
5. Experience in the provision of emergency care.

(c) Physicians who are board certified in emergency medicine need not have completed the course in Advanced Trauma Life Support or possess ACLS, PALS or APLS certification.

(d) Any physician who was serving in the capacity of mobile intensive care program medical director on June 21, 1993 shall continue in that capacity, regardless of compliance with (b)2, 3, 4 and 5 above.

(e) The medical director shall oversee the general medical direction provided to the ALS crewmembers by medical command physicians. The medical director shall be responsible for overseeing the quality control activities of the mobile intensive care program as required by this chapter, as well as overseeing both medical control and medical command activities.

(f) The medical director shall be responsible for determining the competency of all crewmembers that are performing under the mobile intensive care program's authority.

1. The medical director shall maintain reports attesting to each crewmember's competency in the crewmember's personnel file. These reports shall be made available to Department staff upon demand.

(g) The medical director shall be responsible for developing criteria for ALS crewmembers to contact the medical command physician for specific medical conditions (for example, chest pain) prior to the release of a patient to BLS personnel for transport to a receiving health care facility.

(h) A representative of the mobile intensive care program shall notify the Department, in writing, of any change of medical director within 14 calendar days after the change, verifying that the designated person meets the requirements for a medical director as defined in this subchapter.

8:41–9.5 Medical command physician

(a) The qualifications necessary to serve as the medical command physician of a mobile intensive care program shall be as follows:

1. Physician status, or status as a permit holder as defined at N.J.A.C. 8:43G–16.2(f) (a person authorized by the New Jersey State Board of Medical Examiners to engage in the practice of medicine in the second year of a graduate medical education program or beyond);
2. Possession of CPR and ACLS certifications, and either PALS or APLS certification; and
3. Receipt of instruction in the proper utilization of the base station and the provision of medical command to ALS crewmembers, including viewing of the Department's "Medical Command in New Jersey" videotape.

(b) Physicians who are board certified in emergency medicine need not possess ACLS, PALS or APLS certifications.

8:41–9.6 Medical command

(a) The provision of advanced life support care by ALS crewmembers staffing a MICU is deemed a delegated medical practice. The medical command physician provides the authority for the ALS crewmembers to act.

(b) The medical command physician shall provide medical command to ALS crewmembers in a timely fashion and without undue delay.

1. All orders shall be prefaced with the name of the physician ordering the treatment.

(c) In the event that a MICU not affiliated with the mobile intensive care program seeks medical command from the medical command physician, the physician shall provide medical command as if the MICU was one of the program's own.

(d) In the instance where a physician arrives on the scene prior to the arrival of the crewmembers, the on-scene physician is deemed to have assumed medical command and shall remain in charge of the care of the patient until such time as he or she decides to relinquish control. The crewmembers shall inform the on-scene physician as to the policy for contact with the medical command physician and request that the on-scene physician initiate contact so as to coordinate patient care. If it is appropriate that the on-scene physician remain in charge, he or she must be physically present with the crewmembers through transport to the receiving health care facility and shall sign off on the patient care report.

(e) In the instance where a physician arrives on the scene after the arrival of the crewmembers, the crewmembers shall advise the physician that they are operating under the direct supervision of a medical command physician. If the on-scene physician feels that he or she may be helpful in the patient's medical treatment, he or she should speak to the medical command physician to relay information and discuss care. The medical command physician may then, as he or she deems appropriate, either retain medical command or turn over medical command to the on-scene physician. If the on-scene physician assumes medical command, he or she must be physically present with the crewmembers throughout the transport to the receiving health care facility and shall sign off on the patient care report.

(f) Except as provided for in the event of communications failure or standing orders authorized by this chapter, no ALS crewmember shall perform any skill or procedure, administer any pharmaceutical agent or engage in any other activity within his or her approved scope of practice unless the crewmember has first received the direct and specific order of the medical command physician or physician directed registered nurse.

(g) All orders given to ALS crewmembers shall be specific with regard to treatments ordered or medications and dosages to be given and the sequence in which the treatment is to be performed.

(h) ALS crewmembers shall provide the medical command physician or physician directed registered nurse with an appropriate report of patient assessment, patient condition, patient updates after treatment has been rendered and any other information required by the physician.

(i) Communications with the ALS crewmembers shall be performed directly by the medical command physician unless prevented by emergent patient care duties. In that case, a physician directed registered professional nurse may relay the report and orders if the registered nurse:

1. Possesses CPR and ACLS certifications;

2. Possesses PALS certification or has successfully completed the Emergency Pediatric Nurse Course to the standards of the Emergency Nurses Association;

3. Has been trained in the proper use of the base station; and

4. Personally relays the report to the medical command physician and any orders or direction to the ALS crewmembers. All orders shall be prefaced with the name of the medical command physician ordering the treatment.

(j) No medical command physician or physician directed registered nurse shall order any crewmember to perform any treatment or administer any medication outside of the crewmember's approved scope of practice.

(k) The medical command physician shall review the patient care report and affix his or her original signature to it, in accordance with established institutional policies, but not later than 30 calendar days after providing the medical direction. The medical command physician shall inform the medical director of any discrepancies in the patient care report.

(*l*) In an instance where patient care is provided in accordance with approved communications failure protocols, the authority for such treatment shall be deemed to emanate from the medical director.

(m) In every instance where an ALS crewmember has treated a patient, the medical command physician who provided the medical direction to the ALS crewmember shall ensure that the receiving health care facility is notified as soon as possible after providing medical command. The report shall be relayed to either a physician or registered nurse at the receiving health care facility, and shall contain:

1. The patient's chief complaint and presenting signs and symptoms;

2. Treatment ordered for the patient; and

3. The estimated time of arrival of the patient.

8:41–9.7 Medical treatment protocols

Each mobile intensive care program shall develop and maintain written medical treatment protocols that cover most common medical emergencies for patients of all ages. These protocols shall be kept at the base station, where they shall be immediately accessible to all physicians. These protocols shall serve as a guide to the physicians, but shall not be deemed to restrict the treatment ordered in the best judgment of the physicians and within the scope of practice of the ALS crewmembers. The protocols shall be reviewed and signed off by the medical director at least once every 12 months.

8:41–9.8 Required crewmembers

(a) When "in-service," each MICU shall be staffed by at least two persons, as follows:

1. Two EMTs–Paramedic;

2. Two registered nurses who meet the requirements set forth at N.J.A.C. 8:41–9.9; or

3. One registered nurse who meets the requirements set forth at N.J.A.C. 8:41–9.9 and one EMT–Paramedic.

8:41–9.9 Mobile intensive care nurses

(a) No provider shall allow a registered nurse to serve on one of its MICUs in the capacity of a MICN unless that person:

1. Has completed at least one year of full-time nursing care performing advanced clinical skills in the critical care unit or emergency department of an acute care hospital;

2. Possesses EMT–Basic, CPR and ACLS certifications;

3. Possesses PALS or PEPP–Advanced certification or has successfully completed the Emergency Nurse Pediatric Course to the standards of the Emergency Nurses Association;

4. Possesses either PHTLS or BTLS certification;

5. Has successfully completed at least a MICU field internship consisting of at least 100 hours, has successfully intubated at least five patients and has demonstrated proficiency in pre-hospital ALS treatment to the satisfaction of the mobile intensive care program's medical director;

6. Is physically capable of performing the duties of a MICN; and

7. Is endorsed by the medical director of a mobile intensive care program.

i. The director shall forward a letter to OEMS verifying the endorsement to the Department as soon as practical after the endorsement has been issued. The letter shall include a statement attesting to the competency of the person to perform all skills required of EMTs–Paramedic and compliance with the requirements for EMT–Paramedic recertification set forth at N.J.A.C. 8:41A–4.3.

ii. The director shall notify OEMS, in writing, in the event that the medical director revokes, cancels or otherwise rescinds endorsement. Notification shall be made to OEMS within 14 calendar days of the medical director's action.

(b) A person whose MICN endorsement has been revoked, canceled or otherwise rescinded shall not serve on a MICU in the capacity of a MICN.

8:41–9.10 Additional basic equipment and supplies: MICUs

(a) In addition to the equipment and supplies required at N.J.A.C. 8:41–3.4, when "in-service," each MICU shall be equipped with the following:

1. Equipment capable of producing a 12–lead electrocardiogram tracing;

2. Equipment to perform needle chest decompression;

3. Pediatric airway management materials including:

i. Airways, endotracheal tubes and stylets;

ii. Pediatric and infant sized laryngoscope blades;

iii. Pediatric and infant sized oxygen masks; and

iv. 1,000 mL and 450 mL sized bag-valve-mask devices;

4. Pediatric-sized electrodes for the monitor/defibrillator;

5. Pediatric-sized paddles or defibrillation pads for the monitor/defibrillator;

6. Pediatric and infant-sized IV catheters and/or winged infusion sets;

7. Pediatric Intraosseous infusion sets;

8. Pediatric and infant sized blood pressure cuffs;

9. Pediatric sized rigid cervical collars;

10. A pediatric height/weight medication and equipment guide (for example, Broslow Tape);

11. At least two protective multi-use jackets that are both fire and tear resistant, as well as two sets of gloves, head and eye protection that, at a minimum, meet the requirements set forth at 29 C.F.R. 1910.132 et seq., incorporated herein by reference;

12. Nasogastric tubes and irrigation syringes;

13. A long spine board made of impervious, inflexible material, 72 inches long by 16 inches wide with associated strap holes and full-length three-quarter inch runners, or another configuration that protects the crewmembers' hands from injury during patient movement;

14. A set of binoculars;

15. At least 25 disaster tags (that is, Met Tags®);

16. At least four red "biohazard" type bags utilized for disposal of untreated regulated medical waste as defined at N.J.A.C. 7:26–3A.5 and 3A.6. The "biohazard" bags shall meet the requirements set forth at N.J.A.C. 7:26–3A.11 and shall only be utilized for untreated regulated medical waste materials and shall be disposed of after utilization in accordance with all applicable laws, rules and/or regulations; and

17. A current copy of the U.S. Department of Transportation (U.S.D.O.T.) Emergency Response Guidebook (obtainable from The National Highway Traffic Safety Administration, 400 7th Street S.W., Washington, D.C., 20590 or by calling (888) 327–4236 or accessing their website at www.nhtsa.dot.gov/people/injury/ems).

8:41–9.11 Optional equipment and supplies

(a) Each MICU may be, but is not required to be, equipped with the following equipment and supplies:

1. An esophageal gastric tube airway, a laryngeal mask airway and other commercial airways of similar design or function;

2. A Doppler-type stethoscope;

3. A commercially available vest-type upper spinal immobilization device (for example, K.E.D.®);

4. Adult and pediatric-sized pneumatic anti-shock garments (PASG);

5. An automatic blood pressure manometer and one each adult, obese adult and pediatric size cuffs;

6. Doughnut magnets;

7. Blood tubes for laboratory specimens;

8. Phlebotomy equipment; and

9. Percutaneous needle cricothyrotomy equipment to permit transtracheal catheter ventilation if the MICU elects to perform rapid sequence induction (RSI).

(b) Medications and/or solutions other than those listed at N.J.A.C. 8:41–6.1 must be approved, in writing, by the Department prior to being carried and/or utilized on the vehicle.

1. The Chairman of the MICU Advisory Council may request permission for a program's vehicles to carry a drug(s) in addition to those specified at N.J.A.C. 8:41–6.1. Such request shall be directed to the Office of Emergency Medical Services, and shall include the specific drug(s) to be added, the public health considerations supporting the addition of the drug(s), the specific period of time the additional drug(s) is to be carried (not to exceed six months) and any other supporting information the Chairman of the MICU Advisory Council believes would be useful to the Department in making its determination. Any permission granted by the Department under this subsection shall include specific conditions determined by the Department to be necessary in the interest of safety. Should the public health considerations cited in the initial application extend beyond the six months approved under this subsection and if rulemaking has not been finalized, the Chairman of the MICU Advisory Council may reapply for an additional six-month period, and approval of the extension shall not be unreasonably denied.

8:41–9.12 Oxygen administration

(a) Each MICU shall be equipped with a portable oxygen system in accordance with the standards for such equipment as set forth at N.J.A.C. 8:41–3.6.

(b) In addition, each MICU shall be equipped at all times with at least one reserve oxygen cylinder with a capacity of at least 300 liters.

(c) The MICU may, but need not, carry a portable positive pressure device. If carried, the positive pressure device shall meet all of the standards set forth at N.J.A.C. 8:41–3.6(c).

(d) The portable oxygen system, reserve oxygen cylinder and any portable positive pressure oxygen powered resuscitators shall be stored in a crashworthy manner.

8:41–9.13 Automatic transport ventilators

(a) A MICU may, but need not, be equipped with a portable, automatic transport ventilator of the type approved by the FDA for pre-hospital utilization, which meets the minimum standards of the American Heart Association, as described in the Cardiac Life Support Guidelines, 1997 edition, published by the American Heart Association, incorporated herein by reference, as amended and supplemented. Copies may be obtained by writing to the American Heart Association, National Center, 7272 Greenville Avenue, Dallas, Texas 75231–4596.

(b) Automatic transport ventilators shall be capable of:

1. Giving an oxygen concentration between 21 and 100 percent;

2. Adjustable peak pressures;

3. Adjustable inspiratory and expiratory times;

4. Adjustable minute ventilatory rates;

5. Adjustable tidal volume; and

6. Adjustable high and low pressure alarms.

(c) This shall not include positive pressure oxygen powered ("demand valve") resuscitators (that is, Autovent®).

8:41–9.14 Aspirator/suction equipment

(a) Each MICU shall be equipped with a portable aspirator.

1. The portable aspirator shall be powered by an integral battery and shall be capable of providing adequate suction to clear a patient's airway. The aspirator shall provide a flow rate of at least 25 liters per minute at the end of the suction tube and a vacuum pressure of at least 300 mmHg within four seconds and a maximum vacuum pressure of at least 400 mmHg for at least 20 minutes. MICUs that utilize aspirators that are powered by field replaceable batteries shall carry a sufficient supply of batteries to permit the device to operate continuously and, in accordance with Federal Specifications for Ambulances, KKK–A–1822, "Portable Suction Aspirator," to meet the flow and vacuum pressure requirements for at least 20 minutes.

2. The portable aspirator shall be equipped with an unbreakable collection bottle and at least three feet of transparent or translucent non-collapsible suction tubing with an interior bore of at least one-quarter inch. A three-eighths inch bore is recommended. There shall be at least one Yankauer-type suction instrument and at least eight suction catheters in not less than four assorted adult and pediatric sizes. At least one catheter shall be a size "8" and one shall be a size "18." An infant bulb syringe shall also be carried.

8:41–9.15 Patients triaged to BLS ambulances

(a) Patients with whom a crewmembers make physical or verbal contact shall be evaluated to determine the nature of their illness and/or injury. This exam shall be detailed enough to provide:

1. At least one complete set of vital signs;

2. Documentation of chief complaint, past history and medications;

3. A clinical picture of the patient's status; and

4. Sufficient information to provide a reasonably complete narrative of the patient's medical condition.

(b) There shall be a patient care report completed for every patient with whom a crewmember makes physical or verbal contact. This patient care report shall contain the same information that an ALS completed call would contain, including any BLS treatment rendered by the ALS crewmembers or other responders.

(c) The policies and procedures for release of a patient to BLS by an ALS crewmember shall be determined by the program's medical director.

(d) In the event that the medical command physician orders the patient released to BLS ambulance crewmembers, the ALS crewmembers shall so indicate on the patient care report, and the physician shall affix his or her signature to that patient care report.

(e) In order to ensure compliance with this chapter and to achieve quality assurance goals, the medical director shall review 100 percent of the calls triaged to a MICU or BLS provider where the patient was subsequently admitted to a critical care unit.

8:41–9.16 Transport restrictions

(a) The transportation of critically ill or injured patients in need of ALS treatment shall occur in the dispatched BLS vehicle responding or on scene at the time.

(b) MICUs may be utilized to transport critically ill or injured patients only in the following limited circumstances:

1. In the event of a life-threatening emergency;

2. In the event that a BLS ambulance is not responding and is not expected to arrive at the scene;

3. Where all of the appropriate on-scene ALS treatments have been rendered, the patient is ready for immediate transport and no BLS ambulance is present on the scene or where an appropriate dispatch center has confirmed that no BLS ambulance is responding;

4. When its services are requested during the course of a mass casualty incident; or

5. When a mobile intensive care program has been granted the right, pursuant to the terms of its original certificate of need or a subsequent waiver granted in accordance with N.J.A.C. 8:41–1.4, to utilize its vehicles as transport vehicles.

i. In those instances where a mobile intensive care program has been granted the right to utilize its vehicles to transport patients, those vehicles shall also meet and comply with all of the requirements set forth at N.J.A.C. 8:41–4, 8:41–10.10 (SCTU "Neonatal patient equipment supplies"), 8:41–10.11 (SCTU "Optional equipment and supplies"), 8:41–10.14 (SCTU "Aspirator/suction equipment") as it relates to installed aspirators, 8:40–6.5 (BLS ambulance "Basic equipment and supplies"), 8:40–6.8 (BLS ambulance "Patient transport devices"), 8:40–6.9 (BLS ambulance "Spine boards, orthopedic litter and splints"), 8:40–6.10 (BLS ambulance "Patient compartment requirements and dimensions"), 8:40–6.11 (BLS ambulance "Vehicle certification to Federal specifications") and 8:40–6.12 (BLS "Vehicle markings and emergency warning devices").

(c) A mobile intensive care program shall not utilize its MICUs to provide advanced life support care in any geographical area of the State for which it does not hold certificate of need approval to do so, except in the following limited circumstances:

1. In the case where there exists a pre-existing mutual aid agreement with the mobile intensive care program that holds certificate of need approval for that area;

2. As requested during a mass casualty incident; or

3. As requested for special details, such as protection of dignitaries, tactical support or other special situations where a particular provider has a unique status, so long as the mobile intensive care program that holds certificate of need approval for that area has first granted its approval.

(d) When the vehicle is not being utilized as an MICU, all ALS equipment, supplies and medications shall be locked and secured so as to be unavailable to non-ALS crewmembers.

8:41–9.17 Vehicle markings and emergency warning devices

(a) Each MICU shall bear the following markings:

1. The name of the mobile intensive care hospital approved to operate the mobile intensive care program. In the event that the mobile intensive care program consists of more than one hospital, all participating hospitals named in the certificate of need shall be identified;

2. The trade name as it appears on the Department issued vehicle license shall be visible on the two exterior sides of the vehicle in a size not less than four inches high;

3. The vehicle recognition number shall be visible on the rear and the two exterior sides of the vehicle in a size not less than three inches high;

4. The words "Ambulance" or "Emergency Medical Services" shall be in mirror image, centered above the grill, on the front of the vehicle in a size not less than four inches high and on each side and on the rear of the vehicle body in a size not less than six inches high; and

5. The words "Paramedic(s)," "EMT–Paramedic(s)," "Mobile Intensive Care Unit," "MICU," "Emergency Medical Services," "ALS" and/or "Advanced Life Support" may be located anywhere on the vehicle.

i. If any wording associated with advance life support or mobile intensive care services is located anywhere on the vehicle, staffing of the vehicle shall be maintained at that level at all times.

(b) Each MICU shall be equipped with emergency warning devices, including red lights and a siren, so that it meets the definition of an emergency vehicle as defined at N.J.S.A. 39:1–1 and N.J.A.C. 13:24–1.1. Emergency warning devices shall only be utilized in strict compliance with N.J.A.C. 13:24–2.8.

8:41–9.18 Two-way communications

(a) Each MICU shall maintain a primary and a separate and distinct secondary means of communications equipment that allows the crewmembers to:

1. Directly contact the regional dispatch center while in or away from the vehicle;

2. Directly contact any acute care hospital's Emergency Department via utilization of the HEAR system (155.340 mHz);

3. Directly contact the MICUs that operate in the area immediately bordering that MICU's territory;

4. Directly contact the medical command physician while in or away from the MICU and to send telemetered electrocardiograms when requested;

5. Interface with appropriate disaster control agencies in accordance with local and county emergency plans;

6. Directly capable of transmitting and receiving on the EMS Statewide coordination on JEMS 3 with a frequency of 155.280 mHz; and

7. Directly capable of transmitting and receiving on the Spen 4 or JEMS 4 with a frequency of 153.785 mHz.

(b) A provider shall not operate on any frequency in violation of any applicable law, rule and/or regulation, including those of the Federal Communications Commission.

(c) Each mobile intensive care program shall develop and maintain a communications plan. This plan shall be consistent with the JEMS Communications Plan or other plans promulgated by either the Federal Communications Commission or the Department.

(d) All voice or telemetered orders between medical command and a MICU shall be monitored by a recording device and retained by that health care facility for a period of at least three years. However, in those instances where a patient is less than 18 years of age at the time of treatment, the orders shall be retained and stored until the patient's 23rd birthday or for three years, whichever is greater.

8:41–9.19 MICU dispatch

(a) Each mobile intensive care program shall utilize a regional dispatch center for the dispatching of its MICUs. All proposed dispatch agreements shall be subject to approval by the Department. The provider shall notify the Department of any proposed change in the dispatch agreement and/or the choice of regional dispatch center at least 14 calendar days prior to implementing any such changes.

(b) The Department shall not approve a mobile intensive care program's choice of regional dispatch center unless that center is capable of providing:

1. Coordinated dispatch activity among various MICUs, BLS ambulances and first responders;

2. Dispatching of MICUs that is in compliance with the service area designations as determined by the certificate of need;

3. Adequate two-way communications coverage to the MICUs that the regional dispatch center serves;

4. Other emergency services that may be required, including coordination of mass casualty incidents and disasters; and

5. Record retention, including a log of all requests received for service, times as recorded by the regional dispatch center, the MICU assigned to the request, requests not assigned to the primary MICU for that area due to the vehicle being unavailable, and voice recording, either digital or analog, of required frequencies as determined by the regional dispatch center and the Department.

(c) A mobile intensive care program may choose a regional dispatch centers that is consortium-based, region-based or county-based.

8:41–9.20 Back-up vehicles

(a) Each provider shall secure a sufficient number of vehicles in order to comply with the following schedule for adequate back-up vehicles. For the purposes of this section, a part-time vehicle shall constitute a full operational vehicle. For example, a mobile intensive care program operating a full-time vehicle and part-time vehicle has two approved vehicles, and would require one back-up vehicle.

Approved Operational Vehicles	Back-up Vehicles Required
1 or 2	1
3 or 4	2
5 or 6	3
7 or 8	4
9 or more	5

(b) Back-up vehicles need not have the required equipment as listed in this chapter at all times, provided that, when the vehicle is utilized as a MICU, all required equipment shall be in place and operational.

8:41–9.21 Hours of operations

(a) Each mobile intensive care program shall operate its MICUs so that coverage is maintained at least to the level required by the terms set forth in the program's original certificate of need. In the event that the mobile intensive care program is unable to meet this requirement and coverage is interrupted, the program shall:

1. Assure that the service area is covered by another approved mobile intensive care program to the level of service that would normally be provided when there is an interruption in service of greater than three hours; and

2. Notify OEMS by telephone on the next business day during regular business hours, followed by written confirmation, when there is an interruption in service of greater than three hours.

8:41–9.22 Temporary utilization of back-up MICUs

(a) A mobile intensive care program may temporarily place a back-up MICU "in-service" if public safety concerns necessitate additional coverage for a limited period of time. This shall include:

1. Events where a large number of people are expected to gather;

2. A temporary change in the accessibility of the service area (for example, bridge or road closures);

3. A mass casualty incident, natural and/or man-made disasters, inclement weather, an emergency situation, as a part of an organized emergency preparedness action or drill; and/or

4. Other situations that are not covered by this section, but which have been approved in advance by OEMS.

(b) Excluding the situations listed in (a)3 above, a mobile intensive care program shall not temporarily operate a back-up MICU without first obtaining approval from OEMS. The procedure for such obtaining such approval shall be as follows:

1. The director shall make a request to OEMS in writing. Each request shall include:

i. Details of the special event, including the reason for the temporary addition;

ii. Assurances that, while in-service, the back-up MICU shall meet all of the standards required of a standard "in-service" MICU;

iii. Documentation that the program's primary service area coverage shall not be affected; and

iv. If the site at which the back-up MICU is to be utilized is not within the mobile intensive care program's primary service area, an agreement signed by the program that is the primary provider of advanced life support care at that location.

2. If circumstances arise that leave insufficient time for the director to apply in writing, he or she may apply by telephone during regular business hours, Monday through Friday (9:00 A.M. to 5:00 P.M.), provided that written request is made as soon as is practical.

3. Where a back-up MICU is temporarily utilized in accordance with the situations described in (a)3 above, such that application by telephone is not practical, a representative of the mobile intensive care program shall notify OEMS of such utilization by telephone during regular business hours on the next business day.

(c) OEMS shall review all requests for the temporary utilization of a back-up MICU and, when appropriate, issue approvals in consideration of specific circumstances and in the interest of public health and safety. These approvals shall set forth the number of MICUs approved, hours of operation and the duration of the approval. Each mobile intensive care program operating the temporary MICU shall adhere to the terms and conditions of the approval.

8:41–9.23 Specialty units

(a) A mobile intensive care program may utilize bicycle or tactical teams for the purpose of attending special events and/or special operations. All bicycle and/or tactical teams shall be associated with a dedicated MICU. For purposes of this chapter, a dedicated MICU means the vehicle to which the bicycle or tactical team crewmembers are assigned or associated shall be utilized for any calls so long as the bicycle or tactical team is "in-service."

(b) The director of the mobile intensive care program shall ensure that all bicycle or tactical team members are provided with appropriate safety equipment and supplies (that is, helmets, reflective outerwear, etc.).

SUBCHAPTER 10. SPECIFIC SPECIALTY CARE TRANSPORT SERVICE REQUIREMENTS

8:41–10.1 Scope and purpose

(a) These rules shall apply to any person, public or private institution, agency, entity, corporation and/or business concern that operates, or seeks to operate, a specialty care transport service within the State of New Jersey. These rules serve to define the operational requirements of such a service, to provide for a uniform application of standards, and to specify the personnel, equipment, organization and other resources required to successfully operate the service.

(b) No person, public or private institution, agency, entity, corporation or business concern shall provide specialty care transport services in any form or manner or utilize any vehicle as an SCTU within the State of New Jersey until licensed by the Department.

8:41–10.2 Patient restrictions

(a) When "in-service," SCTUs may be utilized to provide ALS inter-facility transfers of patients requiring specialized medical intervention or medical monitoring that is beyond the capabilities of BLS ambulances and their crewmembers. This shall include, but is not limited to, those persons who require:

1. Transportation in a prone or supine position;

2. Constant attendance due to a medical and/or mental condition;

3. Aspiration;

4. Management or observation of intravenous fluids and/or intravenous medications;

5. An automatic ventilator or whose breathing is ventilator assisted; or

6. Cardiac monitoring.

(b) Wheelchairs (occupied or unoccupied) shall not be utilized or transported in an SCTU.

(c) An SCTU may be utilized as a BLS ambulance or MICU, provided that the vehicle is licensed, staffed and equipped in accordance with the standards for a BLS ambulance or MICU, as applicable, as set forth in this chapter.

1. When the vehicle is not being utilized as an SCTU or an MICU, all ALS equipment, supplies and medications shall be locked and secured so as to be unavailable to non-ALS crewmembers.

8:41–10.3 Specialty care coordinator

(a) Each specialty care transport service shall have a specialty care coordinator who shall be responsible for all activities of that service.

(b) The person who serves as the specialty care coordinator shall be a registered nurse with at least two years of critical care experience and who has demonstrated by education or experience the ability to manage health care organizations.

(c) A representative of the specialty care transport service shall notify the Department, in writing. of any change of specialty care coordinator within 14 calendar days after the change.

8:41–10.4 Medical director

(a) Each specialty care transport service shall have a medical director who shall be responsible for all medical matters that affect that service, its personnel and its vehicles.

(b) The qualifications necessary to serve as the medical director of a specialty care transport service shall be as follows:

1. Physician status or possession of a valid license as a physician by any state's board of medical examiners or equivalent physician licensing agency;

2. Possession of ACLS certification, and either PALS or APLS certifications;

3. Experience in the provision of emergency and/or critical care; and

4. Knowledge of the scope of care, capabilities and limitations of specialty care transport services.

(c) Physicians who are board certified in emergency medicine or critical care need not possess certification in ACLS, PALS or APLS.

(d) The medical director shall oversee the general medical direction provided to the ALS crewmembers by medical command physicians. The medical director shall be responsible for overseeing the quality control activities of the specialty care transport service as required by this chapter, as well as overseeing both medical control and medical command activities.

(e) The medical director shall be responsible for determining the competency of all crewmembers that are performing under the specialty care transport service's authority.

1. The medical director shall maintain reports attesting to each crewmember's competency in the crewmember's personnel file. These reports shall be made available to Department staff upon demand.

(f) A representative of the specialty care transport service shall notify the Department, in writing, of any change of medical director within 14 calendar days after the change, verifying that the designated person meets the requirements for a medical director as defined in this subchapter.

(g) The medical director may be employed by the provider either directly or contracted from an agency.

(h) The medical director shall oversee the development and implementation of patient care transfer protocols to be utilized by nursing personnel.

8:41–10.5 Medical command physician

(a) The qualifications necessary to serve as the medical command physician of a specialty care transport service shall be as follows:

1. Physician status or possession of a valid license as a physician by any state's board of medical examiners or equivalent physician licensing agency; or

2. Status as a permit holder as defined at N.J.A.C. 8:43G–16.2(f) (a person authorized by any state's board of medical examiners, or equivalent physician licensing agency, to engage in the practice of medicine in the second year of a graduate medical education program or beyond).

(b) The medical command physician shall provide medical command to ALS crewmembers in a timely fashion, without undue delay and with an understanding of the urgent need for medical direction with this classification of patient.

8:41–10.6 Medical command

(a) The provision of advanced life support care by ALS EMT–P crewmembers staffing an SCTU is deemed a delegated medical practice. The medical command physician provides the authority for the ALS EMT–P crewmembers to act.

(b) Physician medical command may be accomplished in one of four ways:

1. Direct control: Direct observation and voice orders, which may be given by a physician who is physically present on the vehicle during the transfer.

i. In the case where a physician accompanies a patient during the actual transfer, that physician shall be deemed the medical command physician;

2. Written orders, which shall be prepared by the sending physician and shall include the information and material in (b)2i through vi below. The ALS crewmember(s) shall review all orders with the sending physician or his or her nurse and indicate a thorough understanding of those orders prior to the transfer of the patient. All orders given to the registered nurse staffing the SCTU shall be specific with regard to treatments ordered or medications and dosages to be given and the sequence in which the treatment is to be performed.

i. Authorization to transfer the patient to a receiving facility which has agreed to accept the patient;

ii. Identification of the method of transportation to be utilized;

iii. A list of medical personnel who shall accompany the patient during the transfer;

iv. Medical treatment and drug orders for the duration of the transfer;

v. Documentation of any foreseeable complications which might occur during transfer; and

vi. The sending and receiving physicians' names and telephone numbers. In the event that an ALS crewmember needs immediate and/or emergent medical direction, and where it is impractical or impossible to make contact with the sending or receiving physicians, the ALS crewmember shall contact the medical command physician at the closest available mobile intensive care hospital;

3. Patient care transfer protocols.

i. Each specialty care transport service shall develop and maintain written patient care transfer protocols that cover most common medical emergencies for patients of all ages. These protocols shall be kept on file at each provider's principal place of business and shall be immediately accessible to all crewmembers and physicians. These protocols shall serve as a guide to the physicians, but shall not be deemed to restrict the treatment ordered in the best judgment of the physicians and within the scope of the practice of the crewmembers. There shall be patient care transfer protocols for the ALS crewmember(s) to start treatment until the medical command physician can be contacted for additional orders. The patient care transfer protocols shall be reviewed and signed off by the medical director at least once every 12 months;

ii. When in service, each specialty care transport service shall keep a copy of the patient care transfer protocols in each specialty care ambulance that is licensed as an SCTU; or

4. Direct on-line contact by means of radio or cellular technology.

8:41–10.7 Transfer restrictions

(a) A sending health care facility may request a patient to be transferred according to N.J.A.C. 8:43G–12.2(c) and the Federal regulations at 42 C.F.R. 489.24. The provider shall have the following requirements met prior to the actual transfer of the patient from the sending facility:

1. The name and telephone number of the sending physician shall be documented on the transfer record;

2. The name and telephone number of the receiving physician shall be documented on the transfer record;

3. The sending physician shall make direct contact with a physician at the receiving facility for an agreement to transfer the patient in an SCTU;

4. The sending physician shall write a transfer order, included in which shall be the specific services to be provided by the ALS crewmember(s);

5. The receiving facility shall accept the patient and provide a bed assignment for the patient;

6. A copy of the patient's medical records shall accompany the patient at the time of transfer. The records shall include a complete medical record chart, x-rays and other pertinent patient care test results; and

7. A copy of the patient's medical records, including any patient care report, shall be left with the receiving facility.

8:41–10.8 Required crewmembers

(a) When "in-service," each SCTU shall be staffed with a minimum of:

1. One registered nurse who meets the requirements set forth at (d) below, and two EMTs–Basic; or

2. One registered nurse who is also an EMT–Basic and who meets the requirements set forth at (d) below, and one EMT–Basic.

(b) If the provider is also a mobile intensive care program, the SCTU may, in the alternative, be staffed with:

1. One registered nurse who meets the requirements set forth at (d) below, one EMT–Basic and one EMT–Paramedic; or

2. One registered nurse who is also an EMT–Basic or an EMT–Paramedic and who meets the requirements set forth at (d) below, and one EMT–Paramedic.

(c) Under no circumstances shall an EMT–Paramedic be allowed to take the place of the registered nurse required by (a) or (b) above.

(d) No provider shall allow a registered nurse to serve on any of its SCTUs unless that person has:

1. Completed at least one year of full time nursing care performing advanced clinical skills in an acute care hospital's critical care unit or emergency department and possesses valid certification as either a critical care registered nurse and/or a certified emergency nurse;

2. Certification in CPR and ACLS;

3. Certification in PALS or has successfully completed the Emergency Nurse Pediatric Course to the standards of the Emergency Nurses Association;

4. Additional training in endotrachael intubation and has been deemed competent by the medical director; and

5. Documented completion of competencies for ALS equipment, including, but not limited to:

i. Cardiac monitor/defibrillator;

ii. External pacemaker;

iii. IV pump;

iv. Ventilator;

v. Intra-aortic balloon pump;

vi. Specialized respirators; and

vii. Incubators.

(e) Additional specialty staff may accompany the required crewmembers during any transport. However, additional specialty staff, as determined by the sending physician, shall accompany the required crewmembers when transporting patients with special needs. Examples of patients with special needs would include, but are not limited to:

1. Patients receiving assistance from an intra-aortic balloon pump;

2. Patients in active labor whose pregnancy has been deemed high-risk; or

3. Neonatal patients.

(f) When the specialty staff are employees of the sending or receiving health care facility, the provider shall make all reasonable attempts to verify, prior to transport, that each specialty staff person is validly licensed, certified or otherwise appropriately qualified, as indicated by the patient's acuity, to care for the patient being transported.

8:41–10.9 Additional basic equipment and supplies: SCTUs

(a) In addition to the equipment and supplies required at N.J.A.C. 8:41–3.4, when "in-service," each SCTU shall be equipped with the following:

1. A Doppler-type instrument;

2. At least four red "biohazard" type bags utilized for disposal of untreated regulated medical waste as defined at N.J.A.C. 7:26–3A.5 and 3A.6. The "biohazard" bags shall meet the requirements set forth at N.J.A.C. 7:26–3A.11 and shall only be utilized for untreated regulated medical waste materials and shall be disposed of after utilization in accordance with all applicable laws, rules and/or regulations;

3. Four towels;

4. Two cloth blankets and two cloth or disposable sheets at least 60 inches by 80 inches in size; and

5. Two penlights suitable for patient examination.

(b) There shall be an adequate supply of any medications and therapeutic agents that are being infused at the time of departure from the sending facility, such that the crew could complete a transport that might take two times the normal expected transport time.

(c) Additional medications and solutions not listed at N.J.A.C. 8:41–6.1 may be utilized during the transport of a patient. The registered nurse shall monitor these agents and shall be knowledgeable of the side effects, contraindications, dosage and therapeutic ranges.

(d) A specialty care transport service may request a waiver of the BLS supply requirements set forth at N.J.A.C. 8:41–3.4 if the SCTU is dedicated solely to the transport of pediatric and/or neonatal patients.

8:41–10.10 Pediatric patient equipment and supplies

(a) When transporting a patient less than 13 years of age, each SCTU shall be equipped with the following items:

1. Pediatric airway management materials including:

i. Airways, endotracheal tubes and stylets;

ii. Pediatric and infant sized laryngoscope blades;

iii. Pediatric and infant sized oxygen masks; and

iv. 1,000 mL and 450 mL sized bag-valve-mask devices;

2. Pediatric-sized electrodes for the monitor/defibrillator;

3. Pediatric-sized paddles or defibrillation pads for the monitor/ defibrillator;

4. Pediatric and infant-sized IV catheters and/or winged infusion sets;

5. Intraosseous infusion sets;

6. Pediatric and infant sized blood pressure cuffs;

7. Pediatric sized rigid cervical collars; and

8. A pediatric height/weight medication and equipment guide (that is, Broslow Tape).

8:41–10.11 Neonatal patient equipment and supplies

(a) When transporting a neonatal patient, each SCTU shall be equipped with the following items:

1. Resuscitation methods, including advanced airway;

2. 250 mL sized bag-valve-mask devices;

3. Pharmacological agents suitable for the treatment of neonatal patients;

4. Neonatal sized cardiac monitoring equipment;

5. Neonatal sized hemodynamic monitoring equipment;

6. Neonatal sized IV monitoring equipment; and

7. An isolette.

(b) The neonatal patient team at the sending or receiving health care facility may supply this equipment, provided that all required equipment and supplies are on board during the actual transport.

(c) In addition to the crewmembers required at N.J.A.C. 8:41–10.7, when transporting a neonatal patient, the SCTU shall be also be staffed with either a registered nurse who has been specially trained to care for neonatal patients or a physician.

8:41–10.12 Optional equipment and supplies

(a) Each SCTU may be, but is not required to be, equipped with the following equipment and supplies:

1. An esophageal gastric tube airway, a laryngeal mask airway and other commercial airways of similar design or function;

2. Adult and pediatric-sized pneumatic anti-shock garments (PASG);

3. An automatic blood pressure manometer and one each adult, obese adult and pediatric size cuffs;

4. Percutaneous needle cricothyrotomy equipment to permit transtracheal catheter ventilation;

5. An installed and/or portable air system;

i. The availability shall be for isolette and/or ventilated patients that have the need for an oxygen/air concentration blend; and

6. Doughnut magnets.

8:41–10.13 Oxygen administration

(a) Each SCTU shall be equipped with both an installed and a portable oxygen system in accordance with the standards for such equipment as set forth at N.J.A.C. 8:41–3.6.

(b) In addition, each SCTU shall be equipped at all times with at least two reserve oxygen cylinders with a capacity of at least 300 liters each.

(c) The SCTU may, but need not, carry an installed and/or portable positive pressure device. If carried, the positive pressure device shall meet all of the standards set forth at N.J.A.C. 8:41–3.6(c).

(d) The portable oxygen system, reserve oxygen cylinder and any portable positive pressure oxygen powered resuscitators shall be stored in a crashworthy manner.

8:41–10.14 Automatic transport ventilators

(a) Each SCTU shall be equipped with a portable, automatic transport ventilator of the type approved by the FDA for pre-hospital utilization, which meets the minimum standards of the American Heart Association, as described in the Advanced Cardiac Life Support Guidelines, 1997 edition, published by the American Heart Association, incorporated herein by reference, as amended and supplemented. Copies may be obtained by writing to the American Heart Association, National Center, 7272 Greenville Avenue, Dallas, Texas 75231–4596.

(b) Automatic transport ventilators shall be capable of:

1. Giving an oxygen concentration between 21 and 100 percent;

2. Adjustable peak pressures;

3. Adjustable inspiratory and expiratory times;

4. Adjustable minute ventilatory rates;

5. Adjustable tidal volume; and

6. Adjustable high and low pressure alarms.

(c) This shall not include positive pressure oxygen powered ("demand valve") resuscitators (that is, Autovent®).

(d) Disposable, single use, semi-rigid, non-collapsible tubing shall be used on SCTUs.

8:41–10.15 Aspirator/suction equipment

(a) Each SCTU shall be equipped with both an installed and a portable aspirator.

1. Each aspirator shall be equipped with a non-breakable collection bottle, at least three feet of transparent or translucent non-collapsible suction tubing with an interior bore of at least one-quarter inch. Three-eighths of an inch bore is recommended. There shall be at least one Yankauer-type suction instrument and at least eight suction catheters for each aspirator, in not less than four assorted adult and pediatric sizes. At least one catheter shall be a size "8" and one shall be a size "18." An infant bulb syringe shall also be carried.

(b) The installed aspirator shall be powered by the vehicle's electrical system and shall be securely mounted and located so as to allow easy access for aspiration of any stretcher bound patient. The aspirator shall provide a flow rate of at least 30 liters per minute at the end of the suction tube and a vacuum pressure of at least 300 mmHg within four seconds and a maximum vacuum pressure of at least 400 mmHg during the entire normal range of vehicle operation.

(c) The portable aspirator shall be powered by an integral battery. The aspirator shall provide a flow rate of at least 25 liters per minute at the end of the suction tube and a vacuum pressure of at least 300 mmHg within four seconds and a maximum vacuum pressure of at least 400 mmHg for at least 20 minutes. SCTUs that utilize aspirators that are powered by field replaceable batteries shall carry a sufficient supply of batteries to permit the device to operate continuously and, in accordance with Federal Specifications for Ambulances, KKK–A–1822, "Portable Suction Aspirator," to meet the flow and vacuum pressure requirements for at least 20 minutes.

8:41–10.16 Patient transport devices

(a) Each SCTU shall be equipped with a wheeled patient litter for the transport of stretcher-bound patients. The litter shall be at least 72 inches long (when flat) and at least 20 inches wide. The litter shall have a commercially manufactured stretcher mattress. The litter and mattress shall be adjustable from a flat to a semi-sitting position. The litter shall be adjustable from a minimum height of nine to 18 inches to a maximum height of 33 to 40 inches measured to the top of the mattress. There shall be clean linens on the litter.

(b) Each patient litter and portable stretcher shall have three sets of two-inch wide patient restraints with quick release buckles positioned at the chest, waist and knees. The quick release buckles may be of the "slide through" or "metal to metal" type. (Reeves®-type stretchers may have other types of buckles.) Each stair-chair shall have two sets of two-inch wide safety restraints with quick release metal buckles. Velcro®-type closures shall not be utilized.

(c) When necessitated by the patient's medical condition and ordered by a physician, a patient may be transported in a special device such as, but not limited to, a "Stryker"® frame or specially designed isolette.

1. The standard patient transport devices identified in (a) above may be temporarily removed from the vehicle during the time that the special transport device is being utilized.

2. Special patient transport devices shall fit properly into the present litter fastener(s) with less than an inch of movement when secured in the transporting position. Adaptations for isolettes are acceptable so long as they meet or exceed the manufacturer's guidelines.

(d) When the vehicle is in motion, the litter shall be restrained by a litter fastener. The litter fastener shall be certified by the manufacturer to comply with the AMD Standard 004 Litter Retention System in effect at the time of manufacture. Special transport devices shall be restrained in a crashworthy manner and in accordance with the intent of AMD Standard 004 and all applicable motor vehicle safety laws, rules and/or regulations. When isolettes are utilized for transport of neonatal patients, all additional equipment added onto the isolette shall be secured in a crashworthy manner.

8:41–10.17 Ramps and lifts

(a) There may, but need not, be a ramp, lift or other device for the safe entry and exit of occupied standard size stretchers and/or isolettes. Any such device shall be permanently fastened to the vehicle and be capable of accommodating a load of at least 500 pounds. When the vehicle is in transit, the device shall be secured in a crashworthy manner and shall be positioned so as not to obstruct both of the patient compartment exterior doorways.

1. Any such ramp, lift or other device shall have a slip resistant surface, be structurally sound, free from defects and provide a rigid interlocking surface when being utilized.

2. Any ramp, lift or other device that relies on electric, hydraulic or other power for its operation shall be capable of manual operation by an unassisted person or there shall be a manually operated backup device. The manual backup device shall be capable of both lifting and lowering the patient and shall perform either function within five minutes.

(b) Portable ramps may be utilized, provided that:

1. The ramp is certified by the manufacturer for the type of duty for which it is to be utilized (for example, loading isolette stretchers not to exceed a total of 300 pounds);

2. The ramp is attached to the vehicle body by a mechanism that prohibits the ramp from moving or dislodging when the ramp is being utilized; and

3. The ramp is stored in compliance with the standards for crashworthy storage of equipment set forth at N.J.A.C. 8:41–4.1. Storage of the ramp shall not interfere with the crewmembers' ability to access the patient or move about the patient compartment.

8:41–10.18 Patient compartment requirements and dimensions

(a) Each vehicle utilized as an SCTU shall have a distinct patient compartment. The patient compartment shall be separated from the driver's seating area by a bulkhead or partition, which may include a passageway.

(b) The patient compartment shall have the following interior dimensions:

1. Height: At least 54 inches between the floor and the ceiling when measured at, or near, the center of the patient compartment;

2. Width: At least 56 inches between the vehicle interior sides when measured at any point 52 inches above the floor. The width of cabinets, etc., shall be included when measurements are made;

3. Length: At least 116 inches between the interior surface of the rear door and the rear surface of the bulkhead or partition, when measured at floor level; and

4. There shall be an aisle at least 10 inches wide next to the required patient litter.

(c) The patient compartment shall have at least two exterior doorways:

1. The two doorways shall not be adjacent to each other. One doorway shall be at the rear of the vehicle; the other at the curbside of the vehicle. The curbside doorway shall be within the front half of the vehicle;

2. Each doorway opening shall be at least 28 inches wide and at least 44 inches high;

3. At least one patient compartment doorway shall be available for utilization as an emergency exit at all times. Access to any patient compartment doorway shall not be obstructed by any immovable objects, except as permitted at N.J.A.C. 8:41–10.16(a);

4. The doors to each patient compartment doorway shall be capable of being opened and utilized from both inside the patient compartment and from the exterior of the vehicle, using a standard automotive industry door handle; and

5. There shall be a window in each door in the patient compartment. Rear windows shall be fixed and non-opening.

(d) The patient compartment shall be equipped with a built-in lighting system. The lighting system shall utilize white or clear lenses. The lighting system shall not interfere with the driver's vision and shall be located so that no glare is reflected into the driver's eyes or line of vision.

(e) The patient compartment shall be equipped with two seats, one of which shall be at the head of the required patient litter and face rearward and the other of which shall be alongside the patient litter. Both seats shall be equipped with an automotive safety belt.

(f) The cardiac monitoring equipment shall be stored in such a manner that the display is accessible and visible from all seats.

(g) All IV pumps shall be stored in such a manner that the operational panel is accessible and visible from all seats.

(h) Once a vehicle is licensed by the Department, there shall be no further changes to the vehicle's interior configuration unless and until such changes have been approved, in writing, by OEMS.

(i) Each vehicle shall meet all applicable requirements set forth in the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101.

8:41–10.19 Vehicle certification to Federal specifications

(a) Each SCTU shall be certified to meet the version of Federal Specifications for Ambulances, KKK–A–1822, that was current at the time the vehicle was manufactured. The certification shall be made by the vehicle manufacturer or converter in accordance with applicable paragraphs of the Federal KKK–A–1822 specifications.

(b) Each SCTU shall be equipped with the following items:

1. A solid-state inverter for on-board 115 volt AC power (KKK–A–1822D, Section 3.7.8.3);

2. Electrical 115 volt AC receptacles (KKK–A–1822D, Section 3.7.8.2); and

3. An appropriate number of electrical receptacles for medical equipment utilization.

(c) The following exceptions to the Federal KKK–A–1822 specifications are permitted. Inclusion of these items on an SCTU is optional:

1. Spare tire and storage;

2. Tools for changing a tire;

3. 115 volt AC utility power;

4. Utility power connector;

5. Spotlight;

6. Exterior storage accommodation;

7. Extrication equipment and storage;

8. Color, paint and finish; and

9. Color standards and tolerances.

(d) The following exceptions to the Federal KKK–A–1822 specifications are permitted, within the parameters noted:

1. Emergency lighting: The provider may specify emergency lights other than those required in the Federal specifications, but all exterior lighting shall be in accordance with standards for authorized emergency vehicles, as set forth at N.J.A.C. 13:24;

2. Suction aspirators: The installed and portable aspirators (suction units) shall meet the standards of this chapter; and

3. Emblems and markings: The purchaser of the vehicle may specify the location of additional lettering and markings beyond those required under the Federal specifications, so long as they are consistent with the limitations set forth in this chapter.

8:41–10.20 Vehicle markings and emergency warning devices

(a) Each SCTU shall bear the following markings:

1. The trade name as it appears on the Department issued vehicle license shall be visible on the two exterior sides of the vehicle in a size not less than four inches high; and

2. The vehicle recognition number shall be visible on the rear and the two exterior sides of the vehicle in a size not less than three inches high.

(b) Providers that contract with an acute care hospital to provide a vehicle for the exclusive utilization of a program or service provided by that hospital may place the name of the facility on the vehicle dedicated to that program or service, subject to the following:

1. The vehicle is utilized exclusively for that hospital;

2. The name of the hospital appears in letters no larger than three inches high;

3. The name of the hospital appears on the lower half of the vehicle; and

4. The name of the hospital is preceded by the words "associated with" or similar language that permits the public to identify the provider.

(c) The word "Specialty Care Transport," "SCTU" or "Emergency Medical Services" in a size not less than six inches high shall appear on each side and on the rear of the vehicle body. The word "Ambulance" or "Emergency Medical Services" may be separate from, or may be incorporated in, the trade name required in (a)1 above.

(d) The words or abbreviations "Mobile Intensive Care Unit" or "MICU" shall appear only when the vehicle is also licensed as a MICU.

(e) SCTUs that are not also licensed as MICUs may utilize alternative wording of a dedicated unit to be labeled for specific transportation identification such as "Specialty Care Transport Unit," "SCTU" or "Neonatal Unit" if:

1. The vehicle is utilized for the sole purpose of that specific service;

2. The vehicle is utilized exclusively for that specific hospital;

3. The name of the hospital appears in letters no larger than three inches high;

4. The name of the hospital appears on the lower half of the vehicle;

5. The name of the hospital is preceded by the words "associated with" or similar language that permits the public to identify the provider; and

6. Written approval is obtained from the Department for each vehicle.

(f) Each SCTU shall be equipped with emergency warning devices, including red lights and a siren, so that it meets the definition of an authorized emergency vehicle as defined at N.J.S.A. 39:1–1 and N.J.A.C. 13:24–1.1.

8:41–10.21 Two-way communications

(a) Each SCTU shall have communications equipment, including both a primary and a separate and distinct secondary means, which allows the crewmembers to:

1. Directly contact the sending or receiving health care facility via utilization of a cellular and/or wireless telephone or similar technology;

2. Directly contact the medical command physician;

3. Directly contact any acute care hospital's Emergency Department via utilization of the JEMS 2 (HEAR) system (155.340 mHz);

4. Interface with appropriate disaster control agencies in accordance with local and county emergency plans;

5. Directly capable of transmitting and receiving on the County or Regional Communication Center on the frequencies in the JEMS 1 Plan for the region or regions in which the provider primary operates;

6. Directly capable of transmitting and receiving on the EMS Statewide coordination on JEMS 3 with a frequency of 155.280 mHz; and

7. Directly capable of transmitting and receiving on the Spen 4 or JEMS 4 with a frequency of 153.785 mHz.

(b) A provider shall not operate on any frequency in violation of any applicable law, rule and/or regulation, including those of the Federal Communications Commission.

(c) Each specialty care transport service shall develop and maintain a communications plan. This plan shall be consistent with the JEMS Communications Plan or other plans promulgated by either the Federal Communications Commission or the Department.

SUBCHAPTER 11. SPECIFIC AIR MEDICAL SERVICE REQUIREMENTS

8:41–11.1 Scope and purpose

(a) These rules shall apply to any person, public or private institution, agency, entity, corporation and/or business concern that operates, or seeks to operate, an air medical service within the State of New Jersey. These rules serve to define the operational requirements of such a service, to provide for a uniform application of standards, and to specify the personnel, equipment, organization and other resources required to successfully operate the service.

(b) No person, public or private institution, agency, entity, corporation or business concern shall provide air medical services in any form or manner or utilize any AMU within the State of New Jersey until licensed by the Department.

8:41–11.2 Patient restrictions

(a) When "in-service," an AMU may be utilized to provide pre-hospital advanced life support emergency medical care and transportation or ALS inter-facility transfers of patients requiring specialized medical intervention or medical monitoring that is beyond the capabilities of BLS ambulances and their crewmembers. This shall include, but is not limited to, those persons who require:

1. Transportation in a prone or supine position;

2. Constant attendance due to a medical and/or mental condition;

3. Aspiration;

4. Treatment in the emergency department of an acute care hospital (for other than a set appointment or routine non-emergency follow-up care of a previously diagnosed condition);

5. Treatment in, or admission to, the obstetrical unit (labor and delivery suite) or the intensive and/or coronary care unit of an acute care hospital;

6. Management or observation of intravenous fluids and/or intravenous medications;

7. An automatic ventilator or whose breathing is ventilator assisted; or

8. Cardiac monitoring.

(b) When not "in-service" as an AMU, aircraft utilized to provide air medical services may be utilized to provide non-health care services provided the aircraft, equipment, supplies and crewmembers comply with the requirements of this chapter when the aircraft is "in-service" as an AMU.

(c) An air medical service shall not refuse, or fail to respond to, an emergency call or refuse or fail to provide emergency treatment to any person because of that person's race, sex, creed, national origin, sexual preference, age, disability, medical condition or ability to pay.

(d) All patient care reports (PCR) will be forwarded to the Department within 120 days of date of service.

8:41–11.3 Director

(a) Each air medical service shall have a director who shall be responsible for all activities of that service.

(b) The person who serves as the director shall be either an EMT–Paramedic or a registered nurse with at least one year of critical care experience or who has demonstrated by education or experience the ability to manage health care organizations.

(c) A representative of the air medical service shall notify the Department, in writing, of any change of director within 14 calendar days after the change.

8:41–11.4 Medical director

(a) Each air medical service shall have a medical director who shall be responsible for all medical matters that affect that service, its personnel and its vehicles.

(b) The qualifications necessary to serve as the medical director of an air medical service shall be as follows:

1. Physician status;

2. Successful completion of the Advanced Trauma Life Support course to the standards of the American College of Surgeons;

3. Possession of CPR and ACLS certifications, and either PALS or APLS certification; and

4. Experience in the provision of emergency care.

(c) Physicians who are board certified in emergency medicine need not have completed the course in Advanced Trauma Life Support or possess certification in ACLS, PALS or APLS.

(d) The medical director shall oversee the general medical direction provided to the ALS crewmembers by medical command physicians. The medical director shall be responsible for overseeing the quality control activities of the air medical service as required by this chapter, as well as overseeing both medical control and medical command activities.

(e) The medical director shall be responsible for determining the competency of all crewmembers that are performing under the air medical service's authority.

1. The medical director shall maintain reports attesting to each crewmember's competency in the crewmember's personnel file. These reports shall be made available to Department staff upon demand.

(f) A representative of the air medical service shall notify the Department, in writing, of any change of medical director within 14 calendar days after the change, verifying that the designated person meets the requirements for a medical director as defined in this subchapter.

8:41–11.5 Medical command physician

(a) The qualifications necessary to serve as the medical command physician of an air medical service shall be as follows:

1. Physician status, or status as a permit holder as defined at N.J.A.C. 8:43G–16.2(f) (a person authorized by the New Jersey State Board of Medical Examiners to engage in the practice of medicine in the second year of a graduate medical education program or beyond);

2. Possession of CPR and ACLS certification and either PALS or APLS certifications; and

3. Receipt of instruction in the proper utilization of the base station and the provision of medical command to ALS crewmembers, including viewing the Department's "Medical Command in New Jersey" videotape.

(b) Physicians who are board certified in emergency medicine and/or trauma need not possess certification in ACLS, PALS or APLS.

8:41–11.6 Medical command

(a) The provision of advanced life support care by ALS crewmembers staffing an AMU is deemed a delegated medical practice. The medical command physician provides the authority for the ALS crewmembers to act.

1. In the instance where a physician arrives on the scene prior to the arrival of the crewmembers, the on-scene physician is deemed to have assumed medical command and shall remain in charge of the care of the patient until such time as he or she relinquishes control to the medical command physician or until such time as the patient is loaded onto the AMU. The crewmembers shall inform the on-scene physician as to the policy for contact with the medical command physician and request that the on-scene physician initiate contact so as to coordinate patient care.

2. In the instance where a physician arrives on the scene after the arrival of the crewmembers, the crewmembers shall advise the physician that they are already operating under the direct supervision of a medical command physician. If the on-scene physician has relevant knowledge about a particular patient and feels that he or she may be helpful in the patient's medical treatment, he or she should speak to the medical command physician to relay information and discuss care. The medical command physician may then, as he or she deems appropriate, either retain medical command or turn over medical command to the on-scene physician, who shall relinquish medical command at such time as the patient is loaded onto the AMU.

(b) The medical command physician shall provide medical command to ALS crewmembers in a timely fashion and without undue delay.

(c) Except as provided for in the event of communications failure or standing orders authorized by this chapter, no ALS crewmember shall perform any skill or procedure, administer any pharmaceutical agent or engage in any other activity patently within his or her approved scope of practice unless that person has received the direct and specific order of a physician.

(d) All orders given to ALS crewmembers shall be specific with regard to treatments ordered or medications and dosages to be given and the sequence in which the treatment is to be performed.

(e) ALS crewmembers shall provide the medical command physician with an appropriate report of patient assessment, patient condition, patient updates after treatment has been rendered and any other information required by the physician.

(f) Communications with the ALS crewmembers shall be performed directly by the medical command physician unless prevented by emergent patient care duties. In that case,

a physician directed registered nurse may relay the report and orders if the registered nurse:

1. Possesses CPR and ACLS certifications;

2. Possesses PALS certification or has successfully completed the Emergency Pediatric Nurse Course to the standards of the Emergency Nurses Association;

3. Has been trained in the proper use of the base station; and

4. Personally relays the report to the medical command physician and any orders or direction to the ALS crewmembers. All orders shall be prefaced with the name of the medical command physician ordering the treatment.

(g) A medical command physician shall not order any crewmember to perform any treatment or administer any medication outside of the crewmember's approved scope of practice.

(h) The medical command physician shall review the patient care report and affix his or her original signature to it, in accordance with established institutional policies, but not later than 30 calendar days after providing the medical direction. The medical command physician shall inform the medical director of any discrepancies in the patient care report.

(i) In an instance where patient care is provided in accordance with approved communications failure protocols, the authority for such treatment shall be deemed to emanate from the medical director.

(j) In every instance where an ALS crewmember has treated a patient, the medical command physician who provided the medical direction to the ALS crewmember shall ensure that the receiving health care facility is notified as soon as possible after providing medical command. The report shall be relayed to either a physician or registered nurse at the receiving health care facility, and shall contain:

1. The patient's chief complaint and presenting signs and symptoms;

2. Treatment ordered for the patient; and

3. The estimated time of arrival of the patient.

8:41–11.7 Required crewmembers

(a) When "in-service," each AMU shall be staffed by at least two persons, in addition to the pilot(s), as follows:

1. Two registered nurses who meet the standards set forth at N.J.A.C. 8:41–9.9 and who have received additional specialized training in air medical care (that is, persons recognized by the Department as flight nurses); or

2. One registered nurse who meets the standards set forth at N.J.A.C. 8:41–9.9 and one EMT–Paramedic, both of whom have received additional specialized training in air medical care (that is, persons recognized by the Department as flight nurses and flight medics).

(b) Additional specialty staff may accompany the two required crewmembers identified in (a) above during the transport. When the specialty staff are employees of the sending or receiving health care facility, the provider shall make all reasonable attempts to verify, prior to transport, that each specialty staff person is validly licensed, certified or otherwise appropriately qualified, as indicated by the patient's acuity, to care for the patient being transported.

8:41–11.8 Additional basic equipment and supplies: AMUs

(a) In addition to the equipment and supplies required at N.J.A.C. 8:41–3.4, when "in-service," each AMU shall be equipped with the following:

1. Pediatric airway management materials including:

i. Airways, endotracheal tubes and stylets;

ii. Pediatric and infant sized laryngoscope blades;

iii. Pediatric and infant sized oxygen masks; and

iv. 1,000 mL and 450 mL sized bag-valve-mask devices;

2. Pediatric-sized electrodes for the monitor/defibrillator;

3. Pediatric-sized paddles or defibrillation pads for the monitor/defibrillator;

4. Pediatric and infant-sized IV catheters and/or winged infusion sets;

5. Pediatric Intraosseous infusion sets;

6. Pediatric and infant sized blood pressure cuffs;

7. Pediatric sized rigid cervical collars;

8. A pediatric height/weight medication and equipment guide (that is, Broslow Tape);

9. Percutaneous needle cricothyrotomy equipment to permit transtracheal catheter ventilation;

10. An automatic blood pressure manometer and one each adult, obese adult and pediatric size cuffs;

11. A stethoscope that does not cause electromagnetic interference to aircraft equipment; and

12. A current copy of the U.S. Department of Transportation (U.S.D.O.T.) Emergency Response Guidebook (obtainable from The National Highway Traffic Safety Administration, 400 7th Street S.W., Washington, D.C., 20590 or by calling (888) 327–4236 or accessing their website at www.nhtsa.dot.gov/people/injury/ems);

(b) There shall be an adequate supply of any medications and therapeutic agents that are being infused at the time of departure from the sending facility, such that the crew could complete a transport that might take two times the normal expected transport time.

(c) Registered nurses may use medications and solutions not listed at N.J.A.C. 8:41–6.1 during the transport of a patient. The registered nurse shall monitor these agents and shall be knowledgeable of the side effects, contraindications, dosage and therapeutic ranges.

8:41–11.9 Oxygen administration

(a) Each AMU shall be equipped with both an installed and a portable oxygen system in accordance with the standards for such equipment as set forth at N.J.A.C. 8:41–3.6.

(b) In addition, each AMU shall be equipped at all times with at least one reserve oxygen cylinder with a capacity of at least 300 liters.

(c) The AMU may, but need not, carry an installed and/or portable positive pressure device. If carried, the positive pressure device shall meet all of the standards set forth at N.J.A.C. 8:41–3.6(c).

(d) When the aircraft is in motion, the portable oxygen system and any portable positive pressure oxygen powered resuscitators shall be secured in a safe, crashworthy manner. In addition, all oxygen cylinders shall be secured in oxygen tank holders affixed to the aircraft frame which meet the same "g" requirements as those contained in Federal Aviation Regulations (FAR) 14 C.F.R. § 27.561, "Airworthiness Standards: Normal Category Rotorcraft/Emergency Landing Conditions: General" or 14 C.F.R. § 29.561, "Airworthiness Standards: Transport Category Rotorcraft/Emergency Landing Conditions: General" for seats.

(e) Each oxygen system shall comply with the requirements of N.J.A.C. 8:41–3.6, except that the installed system may not provide less than 1,500 liters capacity. Liquid oxygen systems are permitted, provided the system is capable of meeting all other standards with regard to oxygen flow rates and pressures.

(f) Any protruding outlets or flowmeters shall be padded, flush mounted or located so as to prevent injury to crewmembers and patients, or other catastrophic failure of the outlet port.

8:41–11.10 Automatic transport ventilators

(a) Each AMU shall be equipped with a portable, automatic transport ventilator of the type approved by the FDA for pre-hospital utilization, which meets the minimum standards of the American Heart Association, as described in the Advanced Cardiac Life Support Guidelines, 2000 edition, published by the American Heart Association, incorporated herein by reference, as amended and supplemented. Copies may be obtained by writing to the American Heart Association, National Center, 7272 Greenville Avenue, Dallas, Texas 75231–4596.

(b) Automatic transport ventilators shall be capable of:

1. Giving an oxygen concentration between 21 and 100 percent;
2. Adjustable peak pressures;
3. Adjustable inspiratory and expiratory times;
4. Adjustable minute ventilatory rates;
5. Adjustable tidal volume; and
6. Adjustable high and low pressure alarms.

(c) This shall not include positive pressure oxygen powered ("demand valve") resuscitators (that is, Autovent®).

8:41–11.11 Aspirator/suction equipment

(a) Each AMU shall be equipped with both an installed and a portable aspirator.

1. Each aspirator shall be equipped with a non-breakable collection bottle, at least three feet of transparent or translucent non-collapsible suction tubing with an interior bore of at least one-quarter inch. Three-eighths of an inch bore is recommended. There shall be at least one Yankauer-type suction instrument and at least eight suction catheters for each aspirator, in not less than four assorted adult and pediatric sizes. At least one catheter shall be a size "8" and one shall be a size "18." An infant bulb syringe shall also be carried.

(b) The installed aspirator shall be powered by the aircraft's electrical system and shall be securely mounted and located so as to allow easy access for aspiration of any stretcher bound patient. The aspirator shall provide a flow rate of at least 30 liters per minute at the end of the suction tube and a vacuum pressure of at least 300 mmHg within four seconds and a maximum vacuum pressure of at least 400 mmHg during the entire normal range of aircraft operation.

(c) The portable aspirator shall be powered by an integral battery. The aspirator shall provide a flow rate of at least 25 liters per minute at the end of the suction tube and a vacuum pressure of at least 300 mmHg within four seconds and a maximum vacuum pressure of at least 400 mmHg for at least 20 minutes. AMUs that utilize aspirators that are powered by field replaceable batteries shall carry a sufficient supply of batteries to permit the device to operate continuously and, in accordance with Federal Specifications for Ambulances, KKK–A–1822, "Portable Suction Aspirator," to meet the flow and vacuum pressure requirements for at least 20 minutes.

1. In recognition of aircraft weight limitations, the portable aspirator may also be utilized as the installed

aspirator, provided it meets the flow rate and vacuum pressure requirements of (b) above.

8:41–11.12 Patient transport devices

(a) Each AMU shall be equipped with a litter for the transport of stretcher bound patients. The litter shall be at least 72 inches long (when flat) and at least 20 inches wide. The litter shall have a commercially manufactured stretcher mattress. There shall be clean linens on the litter.

(b) The litter shall have three sets of two-inch wide patient restraints with quick release buckles positioned at the chest, waist and knees. The quick release buckles may be of the "slide-through" or "metal to metal" type. Velcro®-type closures shall not be utilized.

(c) The litter shall be restrained by a litter fastener whenever the aircraft is in motion. The litter fastener shall be securely fastened to the aircraft, shall be installed under a FAA Supplemental Type Certificate and shall meet the same "g" requirements as those contained in FAR Part 27.561, "Airworthiness Standards: Normal Category Rotorcraft/ Emergency Landing Conditions: General" or FAR Part 29.561, "Airworthiness Standards: Transport Category Rotorcraft/Emergency Landing Conditions: General" for seats.

8:41–11.13 Patients triaged to MICUs or BLS ambulances

(a) Patients with whom a crewmember makes physical or verbal contact shall be evaluated to determine the nature of their illness and/or injury. This exam shall be detailed enough to provide:

1. At least one complete set of vital signs;

2. Documentation of chief complaint, past history and medications;

3. A clinical picture of the patient's status; and

4. Sufficient information to provide a reasonably complete narrative of the patient's medical condition.

(b) There shall be a patient care report completed for every patient with whom a crewmember makes physical or verbal contact. This patient care report shall contain the same information that an ALS completed call would contain, including any BLS treatment rendered by the ALS crewmembers or other responders.

(c) The policies and procedures for release of a patient to BLS by an ALS crewmember shall be determined by the program's medical director.

(d) In the event that the medical command physician orders the patient released to a BLS ambulance crewmembers or a transport-approved MICU, the ALS crewmembers shall so indicate on the patient care report, and the physician shall affix his or her signature to that patient care report.

(e) In order to ensure compliance with this chapter and to achieve quality assurance goals, the medical director shall review 100 percent of the calls triaged to a MICU or BLS provider where the patient was subsequently admitted to a critical care unit.

8:41–11.14 Patient compartment requirements

(a) The AMU shall have a distinct patient compartment. If the patient compartment is not separate from the pilot's seating area, the pilot shall be protected from the movements of the personnel, patient and equipment contained within the patient compartment by a partition, bulkhead or similar device.

(b) The patient compartment shall have the following interior dimensions:

1. Height: At least 30 inches (40 inches preferable) between the top of the required litter and the ceiling;

2. Width: At least 24 inches from the inboard side of the required litter to the other side of the aircraft interior; and

3. Length: At least long enough to accommodate the required litter.

(c) The patient compartment shall have at least two exterior doorways.

1. At least one doorway shall be large enough to allow for the loading and unloading of an occupied stretcher without rotating it more than:

i. Thirty degrees about the longitudinal (roll) axis; and

ii. Forty-five degrees about the lateral (pitch) axis.

2. The other doorway shall be large enough to permit the entrance and exit of an ambulatory person.

3. The doors to each doorway shall be capable of being opened and being utilized from inside the patient compartment and from the exterior of the aircraft. The exterior of each doorway shall be marked with a sign that explains how the door can be opened.

(d) The patient compartment shall be equipped with a built-in lighting system supplied by the aircraft power supply. The lighting system shall not interfere with the pilot's vision and shall be located so that glare is not reflected into the pilot's eyes or lines of vision.

(e) There shall be space and seating for at least two crewmembers within the patient compartment. Each seat shall be equipped with a device similar to an automotive safety belt. Velcro®-type closures shall not be utilized.

(f) Once an aircraft is licensed by the Department, there shall be no further changes to the vehicle's interior configuration unless and until such changes have been approved, in writing, by OEMS.

8:41–11.15 Vehicle markings and exterior lighting

(a) Each AMU shall be identified with a unique FAA-issued tail number.

(b) Each AMU shall be equipped with a forward-facing, high intensity searchlight or floodlight.

8:41–11.16 Two-way communications

(a) Each AMU shall have communications equipment that allows the crewmembers to:

1. Directly contact the regional dispatch center while in or away from vehicle;

i. Reginal dispatch centers for air medical units are: Gloncester County Communications (GCC) and New Jersey Regional Emergency Medical Communication Center (REMCS);

2. Directly contact any acute care hospital's emergency department via utilization of the HEAR system (155.340 mHz);

3. Directly contact the MICUs, BLS ambulances and health care facilities that operate in the area;

4. Directly contact the medical command physician while in or away from the AMU and to send telemetered electrocardiograms when requested;

5. Interface with appropriate disaster control agencies in accordance with local and county emergency plans;

6. Directly capable of transmitting and receiving on the County or Regional Communication Center on the frequencies in the JEMS 1 Plan for the region or regions in which the provider primary operates;

7. Directly capable of transmitting and receiving on the EMS Statewide coordination on JEMS 3 with a frequency of 155.280 mHz; and

8. Directly capable of transmitting and receiving on the Spen 4 or JEMS 4 with a frequency of 153.785 mHz.

(b) A provider shall not operate on any frequency in violation of any applicable law, rule and/or regulation, including those of the Federal Communications Commission.

(c) Each air medical service shall develop and maintain a communications plan. This plan shall be consistent with the JEMS Communications Plan or other plans promulgated by either the Federal Communications Commission or the Department.

(d) All voice or telemetered orders between a sending or receiving health care facility and an AMU shall be monitored by a recording device and retained by that health care facility for a period of at least three years. However, in those instances where a patient is less than 18 years of age at the time of treatment, the orders shall be retained and stored until the patient's 23rd birthday or for three years, whichever is greater.

(e) All communications shall comply with the rules and regulations of the Federal Communications Commission (FCC). The Department shall be provided with a copy of any FCC license(s) issued to the provider.

8:41–11.17 Dispatch

(a) Each air medical service shall utilize a designated center for the dispatching of its AMUs. The air medical service shall obtain the Department's approval of its choice of regional dispatch center prior to utilizing that center's services.

1. Regional dispatch centers for air medical units are: Gloucester County Communications (GCC) and New Jersey Regional Emergency Medical Communication Center (REMCS).

(b) Regional dispatch centers shall maintain:

1. A log of all AMU service calls, in which the regional dispatch center shall record the following information:

i. The time at which the dispatch center received the request for service;

ii. The time at which an AMU is dispatched to respond to the request;

iii. The AMU assigned to the service request; and

iv. If the primary AMU is unavailable to respond, the fact of the unavailability that primary AMU; and

2. A verbatim recording of all communications on required frequencies relating to the service request.

8:41–11.18 Air medical unit PIOOS logs

A provider shall keep a log for each air medical unit indicating the cause of the problem and its resolution. Additionally, a provider shall develop and maintain a program of preventive maintenance for each vehicle.

8:41–11.19 Special prohibitions

(a) In recognition of the potential hazards of the aircraft environment, the following activities are specifically prohibited while the AMU is in "in-service":

1. Conducting a flight contrary to the recommendations of the aircraft pilot or in violation of any applicable law, rule and/or regulation;

2. Refueling the aircraft while a patient is on board, unless prompt refueling is necessary to sustain human life;

3. Any patient care procedure or the utilization of any equipment that causes, or may cause, electromagnetic interference with the aircraft equipment; and

4. Cigarette/cigar/pipe smoking with 100 feet of the aircraft.

(b) In recognition of the potential hazards of the aircraft environment, the following equipment is strictly prohibited on board the AMU:

1. Protruding IV hooks or holders in patient or air medical crew head-strike areas, unless such hooks or holders conform to N.J.A.C. 8:41–11.9(f);

2. Free swinging traction weights; and

3. Glass or rigid plastic IV containers, unless properly padded and vented.

SUBCHAPTER 12. SCOPE OF PRACTICE, ENFORCEMENT ACTIONS AND HEARINGS

8:41–12.1 Scope of practice for EMT–Paramedics

(a) EMT–Paramedics shall operate within their approved scope of practice.

(b) The following skills and procedures are within the approved scope of practice for an EMT–Paramedic, an EMT–Paramedic student (provided that the student is under the direct supervision of an EMT–Paramedic, registered nurse, physician or in-hospital skilled clinician) or a provisionally certified EMT–Paramedic (within the limits set forth at N.J.A.C. 8:41A–4.2(a)2):

1. Performance of all of the skills and procedures approved for EMT–Basic, as set forth at N.J.A.C. 8:41–12.2;

2. Performance of history taking and physical examination of patients in order to obtain necessary information to permit the rendering of appropriate medical care;

3. Utilization of telemetry and proper communications procedures in the field, as defined by the Federal Communications Commission and good professional practice;

4. Visualization of the airway by utilization of the laryngoscope and removal of foreign bodies with forceps;

5. Application of electrodes and monitoring of cardiac electrical activity, including electrocardiograms;

6. Utilization of mechanical cardiopulmonary resuscitation devices; and

7. Assessing and managing patients in accordance with the U.S. Department of Transportation EMT–Paramedic National Standards Curriculum (EMT–P), 1998 edition, published by the National Highway Traffic Safety Administration, incorporated herein by reference, as amended and supplemented. Copies may be obtained by writing to the National Highway Traffic Safety Administration, EMS Division, 400 Seventh Street, SW (NTS 14), Washington, D.C. 20590.

(c) In addition, with medical command authorization or utilizing the standing orders set forth at N.J.A.C. 8:41–7.1 through 7.22 and 8:41–8.1 through 8.16, the persons identified in (b) above may:

1. Initiate IV therapy, either by direct infusion, IV catheter plug or other cannulae-IV lines;

2. Perform venipuncture for the purpose of obtaining blood samples (excluding blood alcohol levels drawn solely for legal purposes);

3. Prepare and administer approved medications and solutions (that is, those set forth at N.J.A.C. 8:41–6.1) by intravenous, intramuscular, subcutaneous, intraosseous, intranasal, oral, sublingual, topical, inhalation, rectal or endotracheal routes;

4. Administer oxygen therapy, including nebulizer treatments in accordance with N.J.A.C. 8:41–6.1, non-invasive positive pressure ventilation, and the provide ventilatory support using approved equipment as specified in this chapter;

5. Perform cardiac defibrillation, synchronized cardioversion and transcutaneous cardiac pacing;

6. Perform electrocardiogram monitoring, including taking of 12–lead electrocardiogram tracings;

7. Perform endotracheal intubation (oral and nasal) and nasogastric tube insertion and aspiration;

8. Perform pulmonary ventilation by the utilization of oral, nasal, endotracheal or tracheostomy intubation;

9. Perform intraosseous infusion;

10. Perform needle chest decompression; and

11. Perform Valsalva maneuvers;

(d) In addition to the skills and procedures identified in (b) and (c) above, a program or service's medical director may choose to allow EMT–Paramedics to perform the following procedures, subject to approval by the Department:

1. The insertion of esophageal airways, laryngeal mask airways or other commercial airways of similar design and function;

2. Access of established central venous catheters and subcutaneous indwelling catheters;

3. Access of AV fistulas or shunts;

4. Percutaneous needle cricothyrotomy; and

5. Rapid sequence induction.

(e) The persons identified in (b) above may perform any of the skills and procedures identified in (b) and (c) above in the emergency department of a mobile intensive care hospital provided that the EMT–Paramedic:

1. Is performing under the direct order of a physician;

2. Records the treatment on the patient's chart and signs the chart in compliance with institutional policy;

3. Is providing medical treatment strictly within the approved scope of practice for an EMT–Paramedic;

4. Is present in the emergency department for the sole purpose of meeting training requirements and maintaining the skills necessary for recertification;

5. Does not perform the duties or fill the position of another health care professional employed by the hospital;

6. Does not delay a response to any dispatch as a result of his or her duties in the emergency department; and

7. Is not be utilized to meet any personnel requirement for in-hospital purposes as required by N.J.A.C. 8:43G.

8:41–12.2 Scope of practice for EMT–Basic

(a) An EMT–Basic shall operate within his or her approved scope of practice.

(b) The following skills and procedures are within the approved scope of practice for an EMT–Basic:

1. Patient assessment, including vital signs and ongoing evaluation;

2. Pulmonary or cardiopulmonary resuscitation and foreign body airway obstruction management;

3. Oxygen administration;

4. Oropharyngeal or nasopharyngeal airway insertion;

5. Oropharyngeal and nasopharyngeal suctioning;

6. Assessment and management of cardiac, respiratory, diabetic shock, behavioral and heat/cold emergencies, as prescribed within the U.S. Department of Transportation EMT–Basic National Standards Curriculum (EMT–B), 1994 edition, published by National Highway Traffic Safety Administration, incorporated herein by reference, as amended and supplemented. Copies may be obtained by writing to the National Highway Traffic Safety Administration, EMS Division, 400 Seventh Street, SW (NTS 14), Washington, D.C. 20590.

7. Emergency treatment for bleeding, burns, poisoning, seizures, soft tissue injuries, chest-abdominal-pelvic injuries, muscle and bone injuries, eye injuries and childbirth (including care of the newborn), as prescribed within the National Standard Curriculum for EMTs–Basic;

8. Application of spinal immobilization devices and splinting materials, including traction splints;

9. Basic triage and basic maneuvers to gain access to the patient;

10. Patient lifting and moving techniques;

11. AED utilization;

12. Assisting an EMT–Paramedic, registered nurse or physician;

13. Assisting a patient to administer drugs previously prescribed for that patient, limited to:

i. Prescribed metered dose inhaler;

ii. Sublingual nitroglycerin; or

iii. Epinephrine auto injector; and

14. Able to transport patients without ALS with self contained, self maintained medical devices that require no intervention from an EMT–Basic.

8:41–12.3 Enforcement actions

(a) In order to protect the public health, safety and welfare, an authorized representative of the Department may remove any or all of a provider's vehicles from service when, in his or her opinion, the vehicle, equipment or crewmembers pose an imminent threat to the health, safety or welfare of the public or to patients utilizing the service. Removal of a vehicle from service shall be accomplished by placing an official Department "Out-of-Service" sticker on at least one of the vehicle's windows. Placement of a vehicle in DIOOS status may be done simultaneously with an action to suspend or revoke the provider's license and/or impose a monetary penalty.

1. For the purpose of this section, imminent threat may include, but is not limited to:

i. Serious and apparent automotive defects such as faulty brakes, exhaust system or tires;

ii. Serious and apparent equipment defects such as absent or faulty oxygen, resuscitation or aspiration equipment;

iii. Missing required equipment, supplies and/or medications; and/or

iv. Lack of vehicle registration as issued by the New Jersey Motor Vehicle Commission, driver's license, proof of valid vehicle insurance and/or vehicle license as issued by the Department.

2. The provider shall immediately cease to utilize the vehicle to provide any and all services once an official Department "Out-of-Service" sticker has been placed on the vehicle. The provider shall ensure that the "Out-of-Service" sticker is not removed from the vehicle, except as provided in (a)4 below.

3. The provider shall notify OEMS by telephone when it believes that a deficiency has been corrected. OEMS shall make arrangements to reinspect the vehicle in the field within five business days.

4. The "Out-of-Service" sticker shall only be removed by an authorized representative of the Department, or by the provider when the provider has been given written

authorization by the Department to do so, upon a finding that the applicable deficiencies have been corrected. Correction of deficiencies could include, but is not limited to:

i. The vehicle has been repaired or has successfully passed all tests conducted by the New Jersey Motor Vehicle Commission when there was an apparent automotive defect; or

ii. The equipment has been repaired or replaced when there was an apparent equipment defect.

(b) The Commissioner or his or her designee may summarily suspend the license of any provider when, in his or her opinion, the continued licensure of that provider poses an immediate or serious threat to the public health, safety or welfare.

i. A provider whose license has been summarily suspended shall have the right to apply for emergency relief, as provided for at N.J.A.C. 8:41–12.4(a).

(c) Violation of any portion of this chapter by a provider may be cause for action against the provider, including but not limited to, a formal written warning, monetary penalty, suspension, revocation, placing the provider's vehicle in "Department–Initiated–Out-of-Service" (DIOOS) status, placing of conditions for continued operation by the provider, refusal to issue or renew a license, the reassignment of medical command and/or any combination thereof.

1. No provider shall have any action taken against its license, excluding an emergent situation as described in (b) above, unless that provider has first been afforded an opportunity for a hearing in accordance with N.J.A.C. 8:41–12.4(b).

2. Any actions taken under this section shall be separate from any civil, criminal or other judicial proceeding, including actions against licenses of health care professionals issued by other departments or boards. All matters of professional misconduct shall be referred to the appropriate licensing boards, and all matters of a criminal nature shall be forwarded to the appropriate authorities for disposition. Action taken against a provider does not preclude any action that may be taken against an EMT–Basic or EMT–Paramedic for the same infraction.

(d) Action shall be taken to revoke a provider's license if any person with an ownership interest of five percent or more has been convicted of:

1. Medicare, Medicaid or insurance fraud (regardless of the amount of the monetary penalty, term of imprisonment or other penalty imposed);

2. Any crime;

3. Any disorderly persons offense; and/or

4. A petty disorderly persons offense involving the possession, utilization, sale and/or distribution of any controlled dangerous substance; representing a risk of harm to the health, safety or welfare of patients; and/or involving patient abuse or patient neglect.

(e) In accordance with N.J.S.A. 26:2K–15, the Department may impose a monetary penalty in the amount of $200.00 per calendar day, per infraction for violation of any of the rules contained in this chapter, including, but not limited to:

1. Actions that are the cause or proximate cause of injury to a patient, passenger, crewmember or other person (including, but not limited to, a pedestrian, police officer or other on-scene EMS personnel);

2. Actions involving the fraudulent procurement of licenses, certifications and/or other credentials, the filing of false reports or tampering with official or required records. Such violations may also result in an action to revoke the provider's license. Further, the Department may refer the matter to any and all appropriate authorities for further investigation and prosecution;

3. Violations of any rule pertaining to minimum crewmember requirements, crewmember duties, crewmember training, endorsement and/or certification requirements;

4. Violations of any rule pertaining to patient, passenger and/or crewmember restraint or the safe transport of patients or passengers that do not result in injury, but have the potential to cause injury;

5. Violations of any vehicle licensure requirements or utilization of a vehicle ordered or placed in DIOOS status;

6. Destruction, distortion and/or removal of the "Out-of-Service" sticker from a vehicle that has not yet been placed back "in-service" by Department staff;

7. Violations of the rules requiring portable oxygen and portable aspirator/suction devices;

8. Violations of any notification requirements (for example, change of name, address, license plate number, vehicle identification number, trade name, etc.);

9. Violations of any transport restrictions; and/or

10. Violation of the rules pertaining to the provision of advanced life support care in any geographical area of the State for which the provider does not hold Certificate of Need approval or where there does not exist a mutual aid agreement with the mobile intensive care program that holds Certificate of Need approval for that area (mobile intensive care programs only).

(f) Violations shall be considered as a single, different occurrence for each calendar day the violation occurs or remains uncorrected.

(g) Subsequent violations of the same type that occur within one year of the previous violation shall, in accordance with N.J.S.A. 26:2K–15, be subject to a penalty of $500.00 per calendar day/per infraction.

(h) In the event a provider is in arrears of any monetary penalty or penalty greater than 60 calendar days, the Department may:

1. Refuse to issue any license or renewal;

2. Refer the delinquent account to the Office of the Attorney General for collection; and/or

3. Take such other action as authorized by law, rule and/or regulation, including actions to suspend and/or revoke the provider's license.

8:41–12.4 Hearings

(a) A provider whose license has been summarily suspended shall, consistent with N.J.A.C. 1:1–12.6, have the right to apply to the Commissioner for emergency relief.

1. A request for emergency relief shall be submitted in writing and shall be accompanied by a response to the charges contained in the "Notice of Summary Suspension." Failure to submit such written notice shall result in the provider forfeiting all rights to emergency relief.

2. All applications for emergency relief will be handled in accordance with N.J.A.C. 1:1–12.6(c).

3. Unless emergency relief is granted, the summary suspension shall remain in effect until such time as Department staff has conducted a full investigation into the circumstances that formed the basis for the summary suspension. Nothing in this section shall be construed to prevent the Commissioner from simultaneously or thereafter moving to suspend or revoke the provider's license, issuing a formal written warning and/or imposing a monetary penalty.

(b) If the Department proposes to issue a formal written warning, assess a monetary penalty, suspend, revoke or refuse to issue or renew a license, the applicant or provider, as applicable, shall be afforded an opportunity for hearing at the New Jersey Office of Administrative Law to contest the proposed action.

1. All warnings, monetary assessments, suspensions (excluding summary suspensions) and revocations shall become effective 30 calendar days after mailing of a notice of the proposed action unless the applicant or provider, within such 30–day period, gives written notice to the Department of its desire for a hearing. Failure to submit such written notice shall result in the applicant or provider, as applicable, forfeiting all rights to such a hearing.

i. Upon the filing of such written notice, the warning, assessment, probationary period, suspension (excluding summary suspensions) or revocation shall be held in abeyance until such time as the hearing has been concluded and a final decision has been rendered.

2. Refusals to issue or renew a license shall become effective immediately. In the event that an applicant or provider, as applicable, desires to contest the Department's refusal to issue or renew a license, that applicant or provider shall give written notice to the Department within the 30–day period immediately following that refusal of its desire for a hearing. Failure to submit such written notice shall result in the applicant or provider, as applicable, forfeiting all rights to such a hearing.

i. In the event that an applicant or provider requests a hearing, the license shall not be issued or shall remain invalid, as applicable, until such time as the hearing has been concluded and a final decision has been rendered.

(c) The procedures governing all hearings shall be in accordance with the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq. and the New Jersey Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(d) All enforcement shall be considered public information and shall be posted on the OEMS website (www.state.nj.us/health/ems) as a public notice.

1. Monetary penalties, proposed suspensions and proposed revocations shall not be posted until the 30–day hearing request period has elapsed. Summary suspensions shall be posted 10 days after the notice of suspension is sent. In those instances where a hearing has been requested, the enforcement action shall not be posted to the OEMS website until such time as the hearing has been concluded and a final decision has been rendered.

2. Once posted, enforcement actions shall remain on the OEMS website as follows:

i. Monetary penalties: One year from the date on which the notice is posted;

ii. Suspensions (Summary and Non-summary): One year from the date on which the notice is posted or for the duration of the suspension, whichever is greater; and

iii. Revocations: Permanently.

8:41–12.5 Action against an unlicensed entity

(a) Consistent with N.J.A.C. 8:41–9.1, 10.1 and 11.1, no person, public or private institution, agency, entity, corporation, acute care hospital or business concern shall operate a mobile intensive care program, specialty care transport service or air medical service within the State of New Jersey until licensed by the Department.

1. Upon notice or discovery that a person, public or private institution, agency, entity, corporation, acute care hospital or business concern is providing mobile intensive care, specialty care transport and/or air medical services

without having first obtained the required provider and vehicle licenses, after revocation or suspension of a license previously issued by the Department or after having allowed an existing license to lapse, the Commissioner or his or her designee may issue an order directing the operation of the unlicensed service to immediately cease and desist.

i. Failure to comply with an order to cease and desist may result in an action by the Department for injunctive relief in the Superior Court of New Jersey.

ii. The order to cease and desist shall constitute a final agency decision. As such, pursuant to New Jersey Court Rule 2:2–3, any appeal from the Commissioner's order to cease and desist shall be filed with the Superior Court of New Jersey, Appellate Division.

iii. Orders to cease and desist shall be considered public information and shall be posted on the OEMS website (www.state.nj.us/health/ems) as a public notice. Orders to cease and desist shall remain posted on the OEMS website permanently or until such time as a license is issued by the Department.

2. In addition to the issuance of an order to cease and desist, the Commissioner or his or her designee may:

i. Place a vehicle in DIOOS status and place an official Department "Out-of-Service" sticker on the window of any vehicle it knows or has reason to believe is being operated by any person, public or private institution, agency, entity, corporation, acute care hospital or business concern that is not licensed to operate a mobile intensive care program, specialty care transport service or air medical service in New Jersey. Utilization of the vehicle shall immediately cease once an "Out-of-Service" sticker has been placed on the vehicle. The "Out-of-Service" sticker shall not be removed except by an authorized representative of the Department upon the issuance of a provider license and a vehicle license;

ii. Impose a monetary penalty in the amount of $200.00 per calendar day for each day that a service is found to have operated without a license. In addition, the Department may impose a penalty in the amount of $200.00 per calendar day/per vehicle for each day that each unlicensed vehicle is utilized, as well as an additional $500.00 per calendar day/per vehicle if the "Out-of-Service" sticker has been destroyed, distorted and/or removed from the vehicle; and/or

iii. Refuse to issue or renew any subsequent licenses.

APPENDIX A