Village of Owego, EMS Department

PO Box 22
Owego, New York 13827
Business Phone: 607-687-1201/Fax: 607-689-0098
www.Owegoems.org

Emergency Dial 911

Controlled Substance Operational Plan

Revised: March 27, 2019

TABLE OF CONTENTS

Village of Owego, EMS Department

PO Box 22
Owego, New York 13827
Business Phone: 607-687-1201/Fax: 607-689-0098
www.Owegoems.org

Emergency Dial 911

1. Organizational Information

1.1. Purpose

To define the procurement, documentation, storage and use of controlled substances that are stored on Owego Emergency Squad EMS (VOEMS) vehicles. Controlled substances are maintained for the sole purpose of administration by qualified VOEMS– Critical Care Technicians and Paramedics while providing patient care in accordance with the current Susquehanna Regional Emergency Medical Services (SREMS) protocols.

1.2. Scope

This policy applies to the VOEMS Controlled Substance Officer and all VOEMS Paramedics, Critical Care Technicians, Crew Chiefs, Aides, Drivers or any other class of membership or employment regarding the procurement, documentation, storage and use of all controlled substances.

1.3. VOEMS Agency Information

ALS Agency:	Owego Emergency Squad
NYS EMS Agency Code:	5317
NYS Cert. Expires:	01/31/2020
Mailing Address:	PO Box 22, Owego, N.Y. 13827
Physical Address:	87 North Ave, Owego, N.Y. 13827
Chief Executive Officer:	Michael Baratta, Mayor Village of Owego
EMS Chief/Captain:	Robin Shaver

1.4. Physician Medical Director Information

James R Raftis Jr, DO
92 East Beecher Hill Rd
Owego, NY 13827
Telephone: (607) 738-4655
NYS License #189448
US DEA Federal Drug Enforcement Administration # BR 3997903

1.5. Controlled Substance Agent/Supplier

The licensed Institutional Dispenser, class (Hospital) to serve as the initial source and replenishment source of controlled substances used by VOEMS shall be:

Agent**:** Robert Schmidt
Pharmacy Director
UHS Hospitals
Wilson Memorial Regional Medical Center
33-57 Harrison Street
Johnson City, N.Y. 13790
(607) 763-6000

Supplier**:** UHS Hospitals
Wilson Memorial Regional Medical Center
NYS Institutional Dispenser: Class 3 License Number: 0300932
US Federal DEA License Number: AC0552605

Written Agreement between VOEMS and UHS Hospitals (Included as Appendix A)

Controlled Substances will be acquired, stored, administered and replaced in strict accordance with the agreement between VOEMS and UHS Hospitals. UHS Hospitals is the sole supplier of controlled substances to VOEMS. In the event that a change in supplier is planned, VOEMS shall first enter into a new written agreement with a proposed agent/supplier and submit such to the NYS Department of Health and the Bureau of Controlled Substances for approval.

1.6. VOEMS Controlled Substances Officer:

Name of Controlled Substance Officer:	Stephanie Cole
Resident address of Controlled Substance Officer:	1460 Montrose Turnpike Owego, NY 13827
Telephone Numbers:	Cell: (607) 972-7750
NYS AEMT Certification:	EMT-CC
Level and Number:	NYS Certification Number #268623

- The Chief Executive officer and the EMS Chief/Captain shall appoint the Controlled Substance Officer and the Medical Director shall approve this appointment.

- The Controlled Substance Officer reports to the Controlled Substance Agent.

- The Controlled Substance Officer and Chief of Operations will insure that all Paramedics and Critical Care Technicians authorized to administer controlled substances have a valid photo ID illustrating level of care and expiration date.

- The Controlled Substance Officer and the EMS Chief/Captain in conjunction with the agent shall insure that training required by the Agency Medical Director and REMAC is provided to all authorized Critical Care Technicians and Paramedics. Each authorized personnel shall

attend an annual refresher training conducted by the Controlled Substance Officer and approved by the agency Medical Director. The minimum content of the annual training program (Appendix E provided as a representative example) shall include a review of this document, applicable SREMS protocols, and authorized medications. A written test will be completed every year. Each Critical Care Technician or Paramedic shall receive a copy of the Controlled Substance Operational Plan and sign an attestation that he/she has read it.

- The Controlled Substance Agent will complete and submit any and all reports required by the issuing pharmacy at Wilson Memorial Regional Medical Center/UHS Hospitals, NYS Department of Health and the Bureau of Controlled Substances.

- The Controlled Substances Officer will monitor the procurement of controlled substances by VOEMS personnel from the Hospital Supplier, addressing any breach of procedure for obtaining replacement immediately. In the case, the Agency Controlled Substance Officer, Chief of Operations and appropriate representative from the Hospital shall meet immediately or at least by phone conference.

- The NYS-DOH must approve the Controlled Substance Officer for VOEMS.

2. Stocked Controlled Substances

2.1. Medications Authorized to Stock (per ambulance and ALS response vehicle, 4 total vehicles)

Morphine Sulfate
Two (2) 10mg single dose units of morphine Sulfate-injection, vials only

Midazolam
Four (4) 5mg single dose units of Midazolam injection, vials only

Fentanyl
Two (2) 100mcg single dose units of Fentanyl injection, ampoules or vials only

Ketamine
Two (2) 100mg/ml 5ml Single Dose Units of Ketamine injection, vials only
"PARAMEDIC ONLY"

All doses will be tamper evident

2.2. Location of Controlled Substances

Controlled substances shall only be secured in VOEMS owned and operated vehicles that are approved by the NYS-DOH as ambulances or emergency ambulance service vehicles (first response vehicle). No Controlled Substances shall be carried in any personal vehicles. VOEMS will limit the amount of Controlled Substances stocked to each vehicle's controlled substance safe

in accordance with section 2.1 of this document. All Controlled Substances stored in any vehicle shall be removed and placed in the Controlled Substances Safe at the VOEMS station before leaving VOEMS premises if it is unavailable for EMS response. In no case shall controlled substances be stocked or stored in any non-agency vehicle or premises.

2.3. Storage/Security of Controlled Substances

Mounted on the interior cabinet wall of each ambulance is an enclosure constructed entirely of hi-grade metal called the Controlled Substance Safe. The controlled substance safe has the electronic lock mounted in the door. The electronic lock uses a HID proximity and individually assigned pin numbers to allow access.

Within the controlled substance safe is the medication box. This box is also made of hi-grade plastic with a flip top that is key access controlled, separate from all the other keyed locks on the vehicle. This box stores the controlled substances, acting as a transport and storage container and is sealed with a numbered seal provided by the agent each time the box is opened.

2.3.1. VOEMS Station Storage

An alternate storage point will be located at the VOEMS station located at 87 North Av, Owego NY. This controlled substance safe will be constructed of the same material as the controlled substance safes in the vehicles and with the same Lock for identical tracking as in the vehicles. The station safe remains empty unless an VOEMS vehicle is out of service or otherwise unable to respond to calls at which point its medication box will be placed in the station safe.

2.3.2. Environmental Controls

All controlled substances will be stored compliant with the manufacturer's specifications. Every effort will be made to maintain a temperature of 75 degrees Fahrenheit in the controlled substance safe area on each vehicle. Vehicles remaining outside during extremes of heat or cold will be left running, if necessary, to maintain an acceptable storage temperature. Any controlled substance that has or is believed to have been subject to a temperature extreme shall be taken immediately to Wilson Hospital Pharmacy and replaced.

3. Authorizing/Revoking Privileges

3.1. Granting Providers Privileges

Each paramedic or critical care technician will review and attest to their understanding of the operational procedures, protocols, and medications that will be administered. Upon successful completion the user will be provided a medication box key, key fob and the user will supply a unique pin number that only the user will know.

3.1.1. Authorization to Restock

Upon successful completion of the written test the critical care technician or paramedic will be placed on the Controlled Substance Roster (Appendix D). This roster will be updated as needed and shall be sent to the Agent upon any updates. This roster shall serve as notification to the agent that the paramedic or critical care technician has passed the written exam and has been granted privileges to administer controlled substances. The roster will serve as the list containing all approved critical care technicians and paramedics authorized to replenish/exchange controlled substances.

3.1.2. Identification

Critical Care Technicians, or Paramedics approved to administer controlled substances shall always have a current Tioga County Pre-Hospital System ID badge on their person while on-duty with VOEMS. This is the only acceptable form of ID to replenish/exchange controlled substances at UHSH - Wilson Pharmacy.

3.2. Revoking Privileges

Upon any Critical Care Technician or Paramedic leaving VOEMS, or otherwise no longer being approved to administer controlled substances, the Controlled Substance Officer will deactivate the provider's key fob and pin number from each VOEMS lock within 24 hours. The controlled substance safe key fob and medication box key shall be immediately returned to the Controlled Substance Officer and a receipt given for such.

3.2.1. Notification to the Agent

Written notification will be made to the Agent in order to inform the Agent that a specific paramedic or critical care technician no longer has privileges to administer, replenish, or exchange controlled substances. This paramedic or critical care technician will be removed from the Controlled Substance Roster (Appendix D), and therefore removed from the approved list of personnel authorized to replenish/exchange controlled substances.

3.3. Medication HID Keys

Controlled substance safe entry access codes are confidential and are to be protected by all authorized personnel. All persons with authorization to access controlled substances are strictly forbidden to share keys and access codes with any other person. Revealing a code to any person, loaning of keys or copying of keys is strictly prohibited. This provision will be strictly enforced such that any violation may be punishable by immediate termination of employment or membership. Anyone knowingly possessing another person's code or in possession of a medication HID key, must immediately contact the Controlled Substance Agent (or in his/her absence, the Chief of Operations).

3.3.1. Issuance of Keys

Entry key fobs for controlled substance safes and entry keys for the medication box are issued to VOEMS personnel who are NYS Paramedics or Critical Care Technicians with current privileges to practice at the Critical Care or Paramedic level with VOEMS. Keys will be changed, as needed, for individual users or all users whenever the security of the keys it thought to have been compromised. The Controlled Substance Officer will keep a key distribution list.

3.3.2. Loss or Theft of Keys

Loss or theft of keys is to be reported immediately to the Controlled Substances Officer, who upon notification shall immediately examine the inventory of all vehicles with controlled substances. These same controlled substances are to be removed from the applicable enclosures until the locks to these enclosures are changed or modified to prevent access. The Controlled Substances Officer shall immediately report the loss or theft of keys, as well as any associated loss or theft of controlled substances, to the Bureau to Controlled Substances, Pharmacy Director UHS Hospitals, Chief of Operations and the Chief Operating Officer. A record will be kept of all key losses and associated loss or theft of controlled substances.

4. Accessing Vehicle Safes

The controlled substance safe may be opened at any time to inspect the status of the medication box. Only when treating a patient will the medication box be opened (seal broken) and controlled substances removed. If while inspecting the medications box the seal is found damaged or missing the following procedures should be adhered to.

4.1. On-duty Checks

Authorized personnel may open the vehicles controlled substance safe to inspect the medication box and verify it is present and the seal is intact.

4.1.1. Seal in place

Inspect the medication box. If the seal is in place and the box appears to be tamper free, then replace it in the safe and close the door.

4.1.2. Seal is Broken or Missing

If the seal is broken or missing, do not touch the medication box, summon another VOEMS member/employee, preferably a line officer or another Paramedic or Critical Care Technician. Explain to them that you need to conduct a detailed inventory and that you need them to witness this. If no one is available to witness an inventory, for example a Paramedic is assigned alone to an ALS first response vehicle, then contact the Controlled Substance Officer and make him/her aware of the situation and then go ahead and

perform the inventory check. If the controlled substance safe or medication box appears to be tampered with in any way, first take a picture if able.

The lot numbers on the vials of medications present must be compared with the lot numbers listed on the Inventory Controlled Sheet. The controlled substances officer must be contacted immediately if there is a discrepancy. The Paramedic or Critical Care Technician conducting the inventory shall complete an incident report. The Paramedic or Critical Care technician must proceed directly to Wilson Hospital Pharmacy and present the medication box, inventory control form and controlled substances incident report form to the on duty pharmacist.

4.2. Broken/Damaged Vials

If a vial is broken or damaged at any time while removed from the medication box or on an EMS call, the Critical Care Technician or Paramedic must take every reasonable effort to save remnants of the broken vial. Any broken or damaged vials and medication shall be placed in a plastic bag. The bag should be sealed with the date, time, name where the vial was broken or damaged. The medication box and plastic bag with any contents will be taken immediately to the Wilson Hospital Pharmacy for replacement. An incident report will be made detailing the circumstances.

The individual should not put himself or herself at risk attempting to clean up the broken sharps of the vial but use a piece of paper, plastic or other means.

4.3. Off-Duty Response

If personnel respond to a back-up call, they do not have to perform a controlled substance safe inspection, unless the controlled substance safe is opened during the course of the call.

Medication boxes must always remain locked in the controlled substance safe inside the ambulance/ALS first response vehicle cabinet except when being used for patient care. The Paramedic or Critical Care Technician is allowed to have the medication box on his/her person when administering to a patient or when transferring to another ambulance as in an ALS assist (e.g., meets Apalachin for an ALS Assist on the highway.).

When at a scene, arriving at a hospital or any location other than the patient care compartment of an ambulance, the medication box must remain in direct control of the Critical Care Technician or Paramedic.

5. Loss/Theft/Diversion

5.1. Reporting

Any loss, theft or diversion of controlled substances shall be dealt with immediately. A Loss/Theft of Controlled Substances Report shall be completed. All instances where loss, theft or

diversion of a controlled substance is suspected will be reported to the NYS Department of Health immediately. A report will be prepared using the Loss of Controlled Substances report form (DOH-2094, Appendix C).

5.2. Prevention

All VOEMS member/employees, officers and Board of Directors must be vigilant in preventing the loss/theft of controlled substances. If anyone knows, sees or suspects controlled substances have been lost, stolen, left unsecured or in anyway not properly safeguarded, they shall report this to the Controlled Substance Officer immediately.

5.3. Prosecution

The Controlled Substance Agent shall be notified of any loss, theft or diversion of controlled substances. The NYS Police or appropriate Sheriff's Department shall be called by the controlled substance officer or the Chief of Operations or their designees. Any individual(s) found diverting, using or tampering with controlled substances, safes or entry devices shall be prosecuted to the fullest extent of the law.

6. Administration of Controlled Substances

6.1. Protocols

The Susquehanna Regional Emergency Medical Services (SREMS) provides the ALS Treatment Protocols, current revision. Relevant protocols are provided as Appendix B.

6.2. Preparation

Draw up from the vial, only the prescribed amount to be given to the patient. Multiple doses for the same patient may be drawn from the same vial using aseptic technique. Once any amount has been drawn from a vial, it must be replaced after the transport. A single vial may not be drawn from for more than one patient. Keep the vial if it is empty or has waste to present to the pharmacist at the time of restock.

6.3. Documentation

A PCR must be completed for each patient contact in accordance with VOEMS Policies, Procedures, and Guidelines Manual. Included in this documentation will be all aspects of the administration and waste of controlled substances. Document the use of the medication in accordance with section 8 of this document.

6.4. Signatures

VOEMS pre-hospital care reports are written electronically. The ordering medical control physician's signature should be acquired using the supplied electronic equipment (i.e. tablet)

and the physician's signature will automatically be entered into the patient's electronic pre-hospital care report.

6.4.1. Medical Control Order Form Use

In extenuating circumstances it may not be feasible to acquire the medical control physician's signature electronically (i.e. electronic equipment failure). In this case the medical control order form (Appendix C) should be used and electronically scanned and added as an attachment to the PCR before completion. If the medical control order form needs to be used the controlled substance officer will be contacted at the earliest convenience and an incident report will be completed outlining the need for its use.

6.4.2. Different Hospitals

If for some reason the physician that ordered the medication is at another hospital than the one that was transported to then every attempt should be made to acquire that ordering physician's signature including driving to that hospital immediately after patient care is transferred. If it is unreasonable to acquire that signature then a signature should be acquired from a medical control physician at the destination hospital who agrees with the orders and has been made familiar with the patient and the original ordering physician who gave the order. It is good practice to have the signing physician confirm the order with the original order physician by telephone.

6.4.3. Absent Physician

If the ordering physician has left the hospital prior to the patient arriving at the hospital (i.e. his/her shift ended) then another medical control physician may substitute for the ordering physician provided the signing physician was briefed prior to the ordering physician's departure and/or the signing physician has been made familiar with the order and patient.

6.4.4. Standing Orders

In the event a controlled substance is administered by the paramedic or critical care technician on standing orders in accordance with SREMS protocols the paramedic or critical care technician should inform a medical control physician at the destination hospital of the care given and ask for a signature for acknowledgement. The same signature guidelines should apply.

6.4.5. Unwilling Physician

In the event that a medical control physician is not willing to sign for the administration of a controlled substance then an incident report (appendix C) will be completed and the controlled substance officer must be notified immediately in order to proceed with a follow up. This PCR will go directly to the Medical Director for review. There is no time where a controlled substance can be administered to a patient and a medical control physician's signature not be acquired.

7. Restocking

7.1. Documentation

Take the vial, empty or with any unused portion and go directly to the pharmacy at Wilson Hospital to receive replacement stock of the controlled substance. The correct documentation must also be brought to the pharmacy in order to restock. The Paramedic/Critical Care Technician must show the ordering physician's signature, a County issued photo ID card, and the inventory control form to obtain replacement-controlled substances.

7.2. Empty Vial(s)

The empty vial is given to the on-duty Wilson Hospital pharmacist ONLY. The Critical Care Technician or Paramedic and pharmacist sign electronically into the patients PCR or on the medical control order form attesting the vial is empty.

7.3. Waste

The vial with remaining drug is given to the on-duty Wilson Hospital pharmacist ONLY. The Critical Care Technician or Paramedic and pharmacist sign electronically into the patients PCR, or on the medical control order form, and inventory control sheet attesting to the amount remaining in the vial. The vial is now in custody of the Pharmacist. The vial may be randomly tested by the pharmacy.

7.4. Replacement Vial(s)

The replacement vial is received into inventory, control LOT numbers are recorded on the inventory control sheet and the vial(s) are placed in the medication box. The Critical Care Technician or Paramedic closes and locks the medication box and the Pharmacist places a seal on it. The seal number is recorded on the inventory control sheet.

8. Pre-Hospital Care Reports

8.1. Electronic PCR's

VOEMS uses electronic means to complete pre-hospital patient care reports. All patient care information is stored electronically and may be printed. All signatures should be acquired electronically directly into the patients PCR. On occasion it may not be feasible to acquire signatures electronically due to equipment failure or other substantial reason. In this case a medical control order form should be used (Appendix C) under the provisions outlined in section 6.4 of this document.

8.2. Required PCR Information

Each administration of controlled substances shall be documented on the PCR, including but not limited to the following information:

- Name or Medical Control number (MD#) of physician ordering administration.
- Date, time and run number.
- Patient's name.
- ALS Agency's name.
- Name and NYS Paramedic or Critical Care Technician number of who administered the controlled substance.
- Name of each controlled substance administered to the patient during the call.
- Dosage and route of administration.
- Name of hospital receiving patient.
- Amount of Controlled Substance wasted.
- A clear narrative defining the patients presenting problem(s).
- Patient's reaction to the medication

8.3. Medical Control

Administration of any controlled substance shall be in strict accordance with the SREMS ALS Patient Care Protocols. Deviation from these protocols can only occur by a direct verbal or written order by a Medical Control Physician. A signature from the ordering physician must be acquired under the provisions set in section 6.4 of this document.

9. Quality Assurance

9.1. VOEMS Quality Assurance

It shall be the policy of the agency for the controlled substance officer to perform a quality assurance review of all of the EMS calls involving the pre-hospital administration of controlled substances and, if available, calls where controlled substances were requested but not administered. The controlled substance officer will not evaluate his/her own documentation. Other members qualified within the agency to perform quality assurance at the ALS level up to and including the medical director will perform a review of the controlled substance officer's documentation. Such reviews will consider and evaluate:

- Compliance with protocols and other applicable standards of care.
- The quality, completeness, and accuracy of the PCR documentation.
- The response time to the scene of the call, and the amount of time spent on the scene.
- Complaints, concerns, or grievances filed by patients, their families, or emergency care providers, related to any of the calls being reviewed.
- Opportunities for improvement, such as modification of agency policies and procedures, staffing patterns, or equipment and supplies.
- Inventory and security control systems

A written record shall be made of each PCR reviewed when controlled substances were administered. The record shall include the call by PCR number and agency run number. The review shall consider whether or not such administration was appropriately indicated under the protocol for the documented patient presentation, and whether the patient's response to the controlled substance was documented and was within that which would be reasonably expected. These individual call review records shall be kept on file by the agency, in a secure and confidential quality assurance file, for a minimum of five years and shall be made available at any time to the Medical Director, the controlled substance agent or the New York State Department of Health.

9.2. Medical Director QA Review

The Medical Director shall, on a quarterly basis, review all PCR's relating to the actual administration of controlled substances, requests to Medical Control for controlled substance administration and, if available, all refusals by Medical Control after a request to administer a controlled substance has been made. The Medical Director shall review the PCR for each one of these calls, along with any related documentation. The Medical Director will pay specific attention to the documentation pertaining to wasting a controlled substance. A summary report of the PCR's reviewed shall be made and kept on file with the agency's controlled substances paperwork.

The Medical Director shall consider the appropriateness of any action taken or recommended by the agency quality assurance committee, and shall, if he/she deems appropriate, prescribe additional action, including restriction or revocation of the ALS practice privileges of Paramedic's or Critical Care Technician's or specific remedial education and/or supervision of Paramedics or Critical Care Technicians involved. Any such restriction, or any commendation for exceptional care, shall be communicated in writing to the Controlled Substances Agent, controlled substance officer, advanced life support supervisor of the agency, as well as any Paramedic or Critical Care Technicians affected. The controlled substances officer and/or ALS supervisor shall then be responsible for any follow up action including making required progress reports or updates on prescribed remedial action to the Medical Director.

Any issues or discrepancies identified by the agency or the Medical Director, involving possible diversion or abuse/misuse of controlled substances, or any other violations of Part 80 or Part 800 shall immediately be referred by the discovering entity to the appropriate bureau(s) of the New York State Department of Health Bureau of Controlled Substances and/or Emergency Medical Services. This notification shall be made as soon as possible (next business work day if 24 hour contact information is available, at once) by telephone, followed by written notification within 24 hours of the identification of the problem or potential problem. If the discovery is made by the agency, parallel notification shall be made to the Medical Director. Any directives received from an official of the State Health Department regarding the restriction of personnel or of controlled substance access shall immediately be carried out by the agency and/or the Medical Director.

9.3. Regional Quality Assurance

VOEMS, by regulation, participates in regional quality assurance activities. VOEMS electronically submits to SREMS a copy of the PCR from each EMS call it performs. VOEMS will fulfill any reasonable request for information relating to quality assurance activities.

10. Comprehensive Audits

Within 30 days of July 1st and January 1st of each year the controlled substance Agent shall conduct a comprehensive audit of all controlled substance activity during the preceding six month period. These audits shall include a physical inventory of all vehicles' stock, as detailed in section 2, examination of all inventory and administration records for the half-year period. The total quantity of each type of controlled substance obtained, stocked, distributed, administered to patients, and lost or destroyed will be detailed on form DOH-4352 (Appendix C). These forms will be signed by the Chief executive Officer and the controlled substance agent. The audit report shall be provided to the area office of the NYS Department of Health and the Bureau of Controlled Substances. Copies of this report will also be submitted to the Medical Director, the director of UHS pharmacies and added to VOEMS permanent controlled substances records.

11. Retention of Records

All record related to the VOEMS Controlled Substance Program will be retained for a minimum of 5 years. Records will be maintained by VOEMS and accessible only to those authorized persons of VOEMS, to include the Chief Executive Officer, Controlled Substance Officer, the Pharmacy Directory of UHS Hospitals, NYS Dept. of Health and Bureau of Controlled Substances.

12. Changes to VOEMS Controlled Substance Policy

Any and all changes to the VOEMS Controlled Substance Plan shall have the approval of the Controlled Substances Officer, Chief Operating Officer, Agency Medical Director, the Controlled Substance Agent, the New York State Department of Health Bureau of Emergency Medical Services and the Bureau of Controlled Substances.

APPENDIX A
Controlled Substance Agreement
(See separate agreement)

Relevant Protocols

APPENDIX B

(3-9) Pediatric: Overdose / Toxic Exposure

EMT

ADVANCED

- ABCs and vital signs
- Airway management and appropriate oxygen therapy
- Determine what was taken, when and how much, if possible
- Check blood glucose level, if equipped. If abnormal, refer to the "Pediatric: Hyperglycemia" or "Pediatric: Hypoglycemia" protocol, as indicated
- Suspected opioid overdose with hypoventilation or respiratory distress:
  - Naloxone (Narcan) 1 mg IN, 0.5 mL per nare
  - May repeat in 3-5 minutes

EMT AND ADVANCED STOP

CC

- Cardiac monitor
- Suspected opioid overdose with hypoventilation or respiratory distress:
  - Naloxone (Narcan) 0.1 mg/kg IM or IN. Max 2 mg
- See the "Toxicology: Suspected Smoke Inhalation – Symptomatic" protocol, if needed

CC STOP

PARAMEDIC

- Vascular access, if indicated (General: Vascular Access)
- Suspected opioid overdose with hypoventilation or respiratory distress:
  - Naloxone (Narcan) 0.1 mg/kg IV, IM, or IN. Max 2 mg

PARAMEDIC STOP

MEDICAL CONTROL CONSIDERATIONS

- CC vascular access

For a symptomatic patient with:

- Organophosphate poisoning:
  - Atropine 1 mg IV every 3 – 5 minutes, until secretions dry
- Dystonic reaction:
  - Diphenhydramine (Benadryl) 1 mg/kg IV or IM
- Sympathomimetic ingestion (cocaine/amphetamine):
  - Midazolam (Versed) 0.1 mg/kg IV, IM, or IN
- Calcium channel blocker OD:
  - Calcium chloride 20 mg/kg IV

Key Points/Considerations

- Advise the receiving hospital as soon as possible
- This protocol includes patients who are unconscious/unresponsive without suspected trauma or other causes
- If suspected WMD, refer to the "General: Nerve Agent – Suspected" protocol or the NYS Advisory on Mark I Kits, #03-05

(3-10) Pediatric: Pain Management

EMT

ADVANCED

- ABCs and vital signs
- Airway management and appropriate oxygen therapy

EMT AND ADVANCED STOP

CC

- Cardiac monitor
- Morphine 0.1 mg/kg IM
    - Morphine may be repeated after 5 minutes; maximum total dose of 10 mg
- Fentanyl 1-1.5 mcg/kg IN
    - Fentanyl may be repeated after 5 minutes once; maximum total dose of 100 mcg

CC STOP

PARAMEDIC

- Vascular access, if indicated (General: Vascular Access)
- Morphine 0.05 mg/kg IV or 0.1 mg/kg IM
    - Morphine may be repeated after 5 minutes; maximum total dose of 10 mg
- Fentanyl 1-1.5 mcg/kg IV or IM
    - Fentanyl may be repeated after 5 minutes; maximum total dose of 100 mcg

PARAMEDIC STOP

MEDICAL CONTROL CONSIDERATIONS

- CC vascular access
- Additional Fentanyl IN, IV, or IM
- Additional Morphine IV or IM

Key Points/Considerations

- Morphine or fentanyl, up to the maximum dose, may be given via standing orders
- **ONE** pain medication may be given under standing orders. For dosing that exceeds the standing order maximum, or to switch to another agent, you must consult medical control
- Contraindications to standing order pain management: altered mental status, hypoventilation, and/or hypoperfusion
- Fentanyl should be used if there is concern for potential hemodynamic instability
- For ease of administration, if clinically appropriate: consider approximating the dose of fentanyl and administer either 25 or 50 mcg; consider approximating the dose of morphine and administer either 2.5 or 5 mg
- Refer to the "Pediatric: Nausea and/or Vomiting (>2 y/o)" protocol, if needed

(3-11) Pediatric: Procedural Sedation

EMT

ADVANCED

- ABCs and vital signs
- Airway management and appropriate oxygen therapy

EMT AND ADVANCED STOP

CC

- Cardiac monitor

CC STOP

PARAMEDIC

- Vascular access, if indicated (General: Vascular Access)

PARAMEDIC STOP

MEDICAL CONTROL CONSIDERATIONS

- CC vascular access
- Morphine 0.1 mg/kg IV or IM
- Fentanyl 1-1.5 mcg/kg IV, IM, or IN
- Midazolam (Versed) 0.1 mg/kg IV, IM, or IN
- Ketamine* 1 mg/kg IV or IM

Key Points/Considerations

- ***Ketamine may be administered by paramedics only**
- Consult medical control as soon as possible

(3-12) Pediatric: Seizures

EMT

ADVANCED

- ABCs and vital signs
- Airway management and appropriate oxygen therapy
- Check blood glucose level, if equipped. If abnormal, refer to the "Pediatric: Hyperglycemia" or "Pediatric: Hypoglycemia" protocol, as indicated

EMT AND ADVANCED STOP

CC

- Cardiac monitor
- Midazolam (Versed) 0.1 mg/kg IM or IN. Maximum dose 5 mg

CC STOP

PARAMEDIC

- Vascular access, if indicated (General: Vascular Access)
- If patient continues to seize:
    - Midazolam (Versed) 0.1 mg/kg IV, IM, or IN. Maximum dose 5 mg

PARAMEDIC STOP

MEDICAL CONTROL CONSIDERATIONS

- CC vascular access
- Additional Midazolam (Versed) 0.1-0.2 mg/kg IV, IM, or IN

Key Points/Considerations

- Consult medical control, if seizures persist, as soon as possible
- Protect the patient and EMS crew from injury during the seizure
- Any EMS provider may assist the patient's family or caregivers with the administration of rectal diazepam (Valium/Diastat), if available (see "General: Prescribed Medication Assistance" protocol)

(2-31) General: Overdose / Toxic Exposure

For the pediatric patient, "Pediatric: Overdose / Toxic Exposure"

Criteria

- This protocol is intended for the undifferentiated toxic exposure
- For a suspected carbon monoxide exposure, see the "General: Carbon Monoxide Exposure – Suspected" protocol
- For a suspected nerve agent exposure, see "General: Nerve Agent – Suspected" protocol
- For an opioid overdose, see the "General: Opioid (Narcotic) Overdose" protocol
- For an organophosphate exposure, see "General: Organophosphate Exposure" protocol
- For smoke inhalation, see "General: Smoke Inhalation – Symptomatic" protocol

EMT

- Decontamination, as needed
- ABCs and vital signs
- Airway management and appropriate oxygen therapy
- Determine what and how much was taken, along with the time, if possible
- Check a blood glucose level, if equipped. If abnormal, refer to the "General: Hyperglycemia" or "General: Hypoglycemia" protocol, as indicated

EMT STOP

ADVANCED

- Vascular access

ADVANCED STOP

CC

- Cardiac monitor
- Consider a 12-lead ECG, especially if the patient is bradycardic or tachycardic. (Evaluate for QRS widening or long QT)
- Sympathomimetic OD (cocaine/amphetamines):
  - Consider midazolam (Versed) 2.5mg IV or 5mg IM or IN; may repeat x 1 in 5 minutes

CC STOP

PARAMEDIC

For symptomatic patients with:

- Organophosphate poisoning: See the "General: Organophosphate Exposure" protocol
- Dystonic reaction:
  - Diphenhydramine (Benadryl) 50 mg IV or IM
- Tricyclic antidepressant OD (if tachycardic and wide complex QRS)
  - Sodium bicarbonate 1 mEq/kg IV every 5 minutes until QRS complex normalizes (< 0.12 sec / 120 milliseconds / 3 small boxes)

PARAMEDIC STOP

MEDICAL CONTROL CONSIDERATIONS

- Calcium channel blocker OD:
    - Calcium chloride 1 gram IV slow push over 10 minutes

Key Points/Considerations

- Dystonic reaction is a reaction to medication resulting in uncontrolled muscle contractions of the face, neck, or tongue. Extrapyramidal side effects may also include extreme restlessness and may be treated as a dystonic reaction

(2-40) General: Seizures

For the pediatric patient, "Pediatric: Seizures"

EMT

- ABCs and vital signs
- Airway management and appropriate oxygen therapy
- Check a blood glucose level, if equipped. If abnormal, refer to the "General: Hyperglycemia" or "General: Hypoglycemia" protocol, as indicated

EMT STOP

ADVANCED

- Vascular access

ADVANCED STOP

CC

PARAMEDIC

- Cardiac monitor
- Midazolam (Versed) 5 mg IV, IM, or IN; may repeat x 1 in 5 minutes
- Magnesium 4 grams IV over 20 minutes, if patient is pregnant

CC AND PARAMEDIC STOP

MEDICAL CONTROL CONSIDERATIONS

- Additional midazolam (Versed) 2.5 – 5 mg IV, IM, or IN

Key Points/Considerations

- Seizures secondary to eclampsia in pregnancy occur because of a different mechanism than typical epileptic seizures
    - Pre-eclampsia is typically described as BP > 140/90 mmHg with severe headache, confusion, and/or hyperreflexia in a pregnant patient, or in one who has given birth within the past month
    - Pre-eclampsia may progress to eclampsia
- Protect the patient and EMS crew from injury during the seizure
- Any EMS provider may assist the patient's family or caregivers with the administration of rectal diazepam (Valium/Diastat), if available. (General: Prescribed Medication Assistance)

(2-18) General: Excited Delirium

Criteria

- For patients who are extremely combative and are at immediate risk of causing physical harm to emergency responders, the public, and/or themselves
- Excited delirium syndrome involves the clinical triad of psychomotor agitation, physiologic excitation, and delirium in the setting of destructive, erratic, bizarre, or violent behavior. Common features include:
    - Unusual strength
    - Lack of tiring
    - Unnatural pain tolerance
    - Tachypnea
    - Diaphoresis
    - Psychomotor agitation
    - Tactile hyperthermia
    - Altered mental status
- For the agitated patient who requires treatment and does not meet the above criteria, refer to the "General: Agitated Patient" protocol

EMT

ADVANCED

- Call for law enforcement
- ABCs and vital signs, as tolerated
- Airway management and appropriate oxygen therapy, if tolerated
- Check blood glucose level, if equipped, as soon as you are able to safely do so. If abnormal, refer to the "General: Hyperglycemia" or "General: Hypoglycemia" protocol, as indicated
- Apply soft restraints, such as towels, triangular bandages, or commercially available soft medical restraints, only if necessary to protect the patient and others from harm

EMT AND ADVANCED STOP

CC

PARAMEDIC

- Midazolam (Versed) 10 mg IM or ketamine* 250 mg IM
- May administer ketamine 250 mg IM after 5 minutes (as a single repeat dose or as a single dose after midazolam [Versed]), should the patient remain uncontrolled

CC AND PARAMEDIC STOP

MEDICAL CONTROL CONSIDERATIONS

- Additional Midazolam (Versed) 2.5 to 10 mg IV or IM
- Haloperidol (Haldol) 2.5 to 5 mg IV or IM
- Additional ketamine* up to 0.5-2 mg/kg IV or 3-5 mg/kg IM
    - Use caution when ordering >250 mg IM of ketamine after midazolam (Versed) because apnea may occur

Key Points/Considerations

- ***Ketamine may be administered by paramedics only**
- **Patient must NOT be transported in a face-down position**
- If the agitated patient goes into cardiac arrest, consider possibility of acidosis in the appropriate cardiac arrest protocol
- Pharmacologic management of behavioral emergencies is only to be utilized for situations in which environmental modification and verbal de-escalation (utilizing interpersonal communication skills) is not successful or not possible
- A team approach should be attempted at all times for the safety of the patient and the providers. Monitor surroundings and utilize the assistance of law enforcement for crowd control
- Ketamine and haloperidol may not be available in all regions
- If the patient is in police custody and/or has handcuffs on, a police officer should accompany the patient in the ambulance to the hospital; the provider must have the ability to immediately remove any mechanical restraints that hinder patient care at all times
- Excited delirium is frequently associated with drug abuse
- Excited delirium does not frequently occur in the elderly
- All uses of this protocol may require Agency Medical Director review or regional QA, depending on regional procedure

(2-32) General: Pain Management

For the pediatric patient, "Pediatric: Pain Management"

Criteria

- Contraindications to standing order pain management: altered mental status, hypoventilation, SBP < 100 mmHg
- Consider consultation with medical control prior to pain management in the third trimester pregnant women with pain complaints

EMT

- ABCs and vital signs
- Airway management and appropriate oxygen therapy

EMT STOP

ADVANCED

- Vascular access
- Nitrous oxide by self-administered inhalation, if equipped

ADVANCED STOP

CC

PARAMEDIC

- Morphine 0.05 mg/kg IV or 0.1 mg/kg IM
  - Morphine may be repeated after 5 minutes; maximum total dose of 10 mg
- Fentanyl 1-1.5 mcg/kg IN, IV, or IM
  - Fentanyl may be repeated after 5 minutes; maximum total dose of 200 mcg
- For nausea or vomiting see "General: Nausea and/or Vomiting" protocol

CC AND PARAMEDIC STOP

MEDICAL CONTROL CONSIDERATIONS

- Additional morphine IV or IM
- Additional fentanyl IV, IM, or IN
- Ketamine* 25 mg IV over 5 minutes or 50 mg IM
  - May consider weight-based dosing ketamine 0.1-0.3 mg/kg IV
  - Use caution when ordering >250 mg IM of ketamine after midazolam (Versed) because apnea may occur
- Midazolam (Versed) IV, IM, or IN
- Ketorolac (Toradol) 30 mg IV or 30 - 60 mg IM

Key Points/Considerations

- ***Ketamine may be administered by paramedics only**
- **ONE** pain medication may be given under standing orders. For dosing that exceeds the standing order maximum, or to switch to another agent, you must consult medical control
- For ease of administration, if clinically appropriate: consider approximating the dose of fentanyl to the nearest 50 mcg; consider approximating the dose of morphine to the nearest 5 mg

- Morphine or fentanyl up to the maximum dose may be given via standing orders
- **Nitrous oxide, ketamine, and ketorolac (Toradol) are not required formulary items**
- Ketorolac (Toradol) should not be administered in renal failure/to dialysis patients, to patients > 60 years of age, in pregnancy, or in patients for whom active bleeding is a concern
    - Lower dosing of ketorolac (Toradol) should be considered for those weighing less than 50 kg
- Contraindications to nitrous oxide include: suspected bowel obstruction, pneumothorax, hypoxia, or the inability to self-administer
- Fentanyl should be considered if there is an allergy to morphine, or potential hemodynamic instability
- Morphine often produces a normal localized histamine reaction which manifests as urticaria (hives) immediately surrounding the IV site, and is not considered a sign of allergy. More extensive involvement of urticaria or other signs of allergic reaction should be treated (See: the "General: Allergic Reaction and Anaphylaxis" protocol)
- Fentanyl must be pushed *slowly*

(2-37) General: Procedural Sedation

For the pediatric patient, "Pediatric: Procedural Sedation"

EMT

- ABCs and vital signs
- Airway management and appropriate oxygen therapy

EMT STOP

ADVANCED

- Vascular access

ADVANCED STOP

CC

- Cardiac monitor with continuous pulse oximetry and waveform capnography

CC STOP

PARAMEDIC

- Midazolam (Versed) 2.5 mg IV or 5 mg IM
  - May be repeated every 5 minutes, as needed, if SBP > 100 mmHg or MAP > 65 mmHg.
- Fentanyl 1-1.5 mcg/kg IN, IV, or IM
  - Fentanyl may be repeated after 5 minutes; maximum total dose of 200 mcg

PARAMEDIC STOP

MEDICAL CONTROL CONSIDERATIONS

- Morphine IV or IM
- Midazolam (Versed) IV, IM, or IN
- Ketamine* 0.5-2 mg/kg IV or 3-5 mg/kg IM
  - Use caution when ordering > 250 mg IM of ketamine after midazolam (Versed) because apnea may occur
- Etomidate (Amidate) 0.1 mg/kg IV (if regionally approved)
  - Should not be administered more than once
  - Note: 0.3 mg/kg IV is the dose typically reserved for induction

Key Points/Considerations

- ***Ketamine may be administered by paramedics only**
- This protocol may only be used for intubation upon medical control order
- Etomidate is not a required formulary medication and may not be available in all regions
- For ease of administration, if clinically appropriate: consider approximating the dose of fentanyl to the nearest 50 mcg
- For patients with the following anxiety-producing or painful procedures including:
  - Cardioversion
  - Transcutaneous pacing
- For post-intubation sedation, see the "General: Post Intubation Management" protocol
- If additional sedation is required after giving a dose of etomidate (Amidate), midazolam (Versed) may be used on standing order
- **Utilize waveform capnography with proper sampling equipment for conscious patients (i.e. nasal prong $EtCO_2$ monitoring device)**

(2-39) General: Rapid Sequence Intubation (RSI)

INDICATIONS

- Regional policy/procedure determines credentialing of paramedics authorized to utilize this protocol, and any additional directives pertaining to rapid sequence intubation
- Rapid Sequence Intubation (RSI) may be utilized on standing orders when definitive airway control is necessary in an adult, ***and*** both of the following exist:
    - GCS ≤ 8
    - Patient's weight at least 30 kg (66 pounds)
- Above restrictions to standing order do not apply to air medical services

CONTRAINDICATIONS / PRECAUTIONS

- Patients who cannot be ventilated with a bag-valve-mask (BVM) because of anatomy, facial/airway trauma, or other reasons

PROCEDURE

- Position the patient, appropriately
- Attach SaO_2, NIBP, and cardiac monitor
- Oxygenate via non-rebreather mask (NRB) or utilize a BVM, as indicated, while preparing for the procedure
- Consider high flow nasal oxygen during intubation (15 LPM via nasal cannula)
- Consider use of a Bougie on the initial attempt
- Prepare a continuous $EtCO_2$ device
- Prepare for post intubation management (General: Post Intubation Management)
- Assemble and test all basic and advanced airway equipment, including suction
- Ready backup airway devices
- Draw up appropriate medications
- Have a second rescuer assist with laryngeal manipulation, as indicated
- Administer an induction agent: (Select one medication)
    - Etomidate (Amidate) 0.3 mg/kg rapid IV push
        - Etomidate (Amidate) is dosed on the ***total*** body weight
        - May round etomidate (Amidate) dose to the nearest 10 mg for adults (Max 40 mg)
    - Ketamine* 2 mg/kg rapid IV push
        - Ketamine* is dosed based on the ***ideal*** body weight
        - May round to the nearest 50 mg for adults (Max 500 mg)
- Administer Paralytic: (Select one medication)
    - Succinylcholine 1.5 mg/kg rapid IV push
        - Succinylcholine is dosed on the ***total*** body weight (Max 200 mg)
        - May round succinylcholine dose to the nearest 50 mg for adults
    - Rocuronium 1 mg/kg (only if succinylcholine is contraindicated)
        - Rocuronium is dosed based on the ***ideal*** body weight (Max 100 mg)
        - May round rocuronium dose to the nearest 20 mg for adults
- If the intubation is missed (3 attempts maximum) manage the airway and ventilate; consider inserting an alternative airway device
- If unable to adequately oxygenate and ventilate the patient with any other method, perform a cricothyroidotomy
- Attach a continuous $EtCO_2$ monitor, confirm advanced airway placement, and secure the

airway, as indicated
- See "General: Post Intubation Management"

MEDICAL CONTROL CONSIDERATIONS

- RSI in patients weighing < 30 kg
- RSI when other standing order criteria are not met

Key Points/Considerations

- ***Ketamine may be administered by paramedics only**
- Rocuronium is to be used for paralysis only when succinylcholine is contraindicated. For example:
    - Known or suspected hyperkalemia (e.g. crush injuries, rhabdomyolysis, dialysis patients, severe burns > 24 hours old, pre-existing spinal cord injuries, and neuromuscular disorders, including ALS [amyotrophic lateral sclerosis / Lou Gehrig's disease] and MS [multiple sclerosis])
    - Known history of malignant hyperthermia
- Consider hyperkalemia in patients who develop ventricular dysrhythmia after administration of succinylcholine. (General: Hyperkalemia, Cardiac Arrest: Ventricular Fibrillation or Pulseless Vent. Tachycardia)
- Consider time to definitive care when electing to utilize RSI procedure
    - In some cases, it may be more beneficial to implement BLS airway interventions and call ahead so the receiving hospital can prepare for RSI upon the patient's arrival

(2-30) General: Organophosphate Exposure

EMT

- Decontamination as needed
- ABCs and vital signs
- Airway management and appropriate oxygen therapy
- Determine what and how much was taken, along with the time, if possible
- Check blood glucose level, if equipped. If abnormal, refer to the "General: Hyperglycemia" or "General: Hypoglycemia" protocol, as indicated

EMT STOP

ADVANCED

- Vascular access

ADVANCED STOP

CC

- Cardiac monitor
- Consider a 12-lead ECG, especially if bradycardic or tachycardic. (Evaluate for QRS widening or long QT)

CC STOP

PARAMEDIC

- For symptomatic patients with organophosphate poisoning:
  - Atropine 2 mg (per dose) IV, every 5 minutes until secretions dry
  - Midazolam (Versed) 5 mg IV, IM, or IN for seizures (See also the "General: Seizures" protocol)

PARAMEDIC STOP

Key Points/Considerations

- If suspected WMD, refer to the "General: Nerve Agent – Suspected" protocol or NYS Advisory on Mark I Kits, #03-05
- For severe exposure or multiple patients, the atropine supply may quickly be exhausted. Diligent airway management, including suctioning and/or patient positioning, is imperative

(2-34) General: Post Intubation Management

INDICATION

- For use on standing order, unless otherwise specified, by critical care or paramedic providers (regardless of RSI credentialing) in patients who have been intubated

PROCEDURE

- Elevate the head of the bed when possible to decrease risk of aspiration
- Continuously monitor capnography and ventilate with a target $EtCO_2$ of 35-45 mmHg
- Administer continual analgesia and, if necessary, sedation:
    - Fentanyl 100 mcg IV once, and then 50 mcg IV every 5 minutes, as needed
    - Midazolam (Versed) up to 5mg IV every 10 minutes, as needed
        - May substitute ketamine* up to 100 mg every 5 minutes, as needed
- Ongoing paralysis is a standing order ***ONLY for air medical services***
    - Consider vecuronium up to 10 mg every 30 minutes, as needed, if necessary for patient or crew safety
        - Paralytics are not substitutes for adequate sedation and pain management
        - Use of paralytics requires ongoing sedation and pain management
- Continuously monitor ETT placement, including effectiveness of oxygenation and ventilation
- Consider placement of an orogastric (OG) tube, if equipped and regionally approved
- Refer to "Resource: Automatic Transport Ventilator," as indicated

MEDICAL CONTROL CONSIDERATIONS

- Additional sedation and/or pain management
- Consider long-term paralysis with rocuronium or vecuronium, if available, ***ONLY*** if necessary (e.g. for patient or crew safety)
    - Paralytics are not substitutes for adequate sedation and pain management
    - Use of paralytics ***requires*** ongoing sedation and pain management
    - Inadequate response to sedation and pain management may be secondary to insufficient sedation and/or analgesia

Key Points/Considerations

- ***Ketamine may be administered by paramedics only**
- In cases of inadequate ventilation or oxygenation of the intubated patient, consider the DOPE mneumonic:
    - Displacement
    - Obstruction
    - Pneumothorax (tension)
        - Patients who are being ventilated (with positive pressure) have an increased risk of developing a tension pneumothorax
    - Equipment failure

APPENDIX C

Attestation of Understanding

I _____ understand that by signing this document I attest that I have read and understand the Controlled Substance Plan/Policy document. I understand my role as a Paramedic/Critical Care Technician within the document. I understand that any theft or diversion of a controlled substance by a Paramedic/Critical Care Technician will be prosecuted to the fullest extent of the law. I understand that my signature on this form is only valid for one year from the date signed. Annual training is required and a new form will be signed after every training to serve as my understanding of the Controlled Substance Plan/Policy document as well as a record of my attendance to the annual training.

Print Name

Signature Date

Controlled Substance Officer Signature Date

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services
Bureau of Narcotic Enforcement

Controlled Substances Usage Verification

Name Controlled Substance

Submitted to (Hospital/Pharmacy) Date

mg.
Beginning Inventory

Date	Run ID/Number	PCR or Tracking Number if applicable	Amount Administered or Destroyed
			mg.
			mg.
			mg.
			mg.
			mg.
			mg.
			mg.
			mg.
			mg.
			mg.
			mg.
			mg.
			mg.
			mg.
			mg.
			mg.
			mg.
			mg.
			mg.
			mg.
Total Quantity Administered to Patients			
Total Quantity Wasted or Destroyed			

mg.
Ending Inventory Balance

Agency Name | NYS EMS Agency Code | NYS CS License No.

Print Name of Agent Print | Signature of Agent | Date

DOH-4004 (11/14)

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Emergency Medical Services and Trauma Systems
Bureau of Narcotics Enforcement

Controlled Substance Report for Emergency Medical Services Agencies

- This report must be submitted pursuant to PHL Article 33 and 10NYCRR Part 80 within 30 days following end of each required reporting period.
- Complete a separate report for each controlled substance carried
- Retain a copy of this report for a minimum of 5-years

Reporting Period

All Controlled Substances (Semi-Annual)
January 1 - June 30, 20____
July 1 - December 31, 20____

Fentanyl and Ketamine (Quarterly)
January 1 - March 31, 20____
April1 - June 30, 20____
July 1 - September 30, 20____
October 1 - December 31, 20____

Controlled Substance Information

Name

Dosage Supplied (mg/ml or mcg/ml)

How Supplied (ampule, vial, syringe, etc.)

Agency Information

Name | NYS Agency Code | NYS CS License No. | Business Phone

Address | City | State | Zip | County

Inventory Record		Response/Transport History		
Total Quantity at Start of Reporting Period	Stock: Sub-Stock: Total of Above:	Total Number of EMS Responses and Transports this Period	Responses	Transports
Total Quantity Received Through DEA Registrant		Total Number of Patients Receiving this CS Medication	Adult	Pediatric
Total Quantity Administered and Wasted		Number of Quality Assurance Reviews Conducted by the Service Medical Director*	Adult	Pediatric
Total Quantity Returned to Pharmacy or Reverse Distributor		Number of Adverse Reactions to Administration	Adult	Pediatric
Total Quantity Lost (attach copy of DOH-2094)		Total Number of EMS Providers Authorized to Administer CS Medications	EMT-P	EMT-CC
Total Quantity Accounted from Records (stocks and sub-stocks) **Paper Tally**		Quantity Carried in Each Sub-Stock		
Physical Inventory Count (stocks and sub-stocks) **Physical Tally**				

*** 100% Agency Medical Director Review Required for Fentanyl and Ketamine Administrations**
Do NOT Attach PCRs to this Form

DOH-4352 (12/16) p 1 of 2

Attach

- Any Unusual Incident Reports Involving Controlled Substance Medications and/or Loss (DOH Form-2094)
- Any Reports or Findings of Significant Increases or Decreases in CS Medication Administrations

Comments (attach additional pages as needed)

Any Experienced Shortages of this CS Medication? (If yes, describe)

I _____ (name of CS Agent), certify that on _____ (date),

I conducted an actual physical inventory of the controlled substance recorded on this document. Losses have been reported on a "Loss of Controlled Substance Report" DOH-2094 and have been submitted to BNE and a copy of the form has been enclosed. Overages are explained on a separate attached report.

I affirm that this is a true and accurate record of the controlled substance utilization by the agency.

Name of Agent (print)	Signature of Agent	Date
Name of CEO (print)	Signature of CEO	Date
Name of Medical Director (print)	Signature of Medical Director	Date

Send Completed Report to:

New York State Department of Health
Bureau of Emergency Medical Services and Trauma Systems
875 Central Avenue
Albany, New York 12206

DOH-4352 (12/16) p 2 of 2

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Narcotic Enforcement

Loss of Controlled Substances Report

Article 33 of the New York State Public Health Law requires that all losses of controlled substances be reported promptly. A copy of the report must be maintained for five years in accordance with Section 3370 of the Public Health Law.

This form is to be used to report all losses of controlled substances due to diversion (unknown, suspected, or possible).
The completed form must be sent to:

NEW YORK STATE DEPARTMENT OF HEALTH
BUREAU OF NARCOTIC ENFORCEMENT
RIVERVIEW CENTER
150 BROADWAY
ALBNY, NY 12204
PHONE (866) 811-7957

CENTRAL OFFICE USE ONLY

Incident Number _____

Reviewed by _____

Date ____/____/____

Referred for Investigation

A. Report Information

1. Business Name	3. Telephone Number ( )
2. Business Address	4. Article 33 License Number
City State Zip	5. DEA Number (if applicable)
County	Person Completing Report

Business Type : ☐ Pharmacy ☐ Practice ☐ Hospital ☐ Clinic ☐ Nursing Home ☐ Vet ☐ Manufacturer

☐ Distributor ☐ Methadone Program ☐ Other (specify) _____

B. Incident Description

1. Date of Incident / /

2. Time of Incident

Reported to DEA? ☐ YES ☐ NO

3. Incident Type:
- ☐ Theft
  - ☐ Employee
  - ☐ Customer
- ☐ Loss (unusable)
- ☐ In-Transit Loss (complete Sec. C on page 2)
- ☐ Armed Robbery
- ☐ Burglary Pt. of entry_____
- ☐ Missing

Reported to Law Enforcement? ☐ YES ☐ NO

Agency_____

Telephone Number_____

Report Number_____

Copy Attached: ☐ YES ☐ NO

Describe detailed circumstances. Attach additional pages as needed.

Do not send broken glass as proof of breakage to this bureau, the manufacturer or distributor.

C. In-Transit Losses

Complete this section only if controlled substances were lost in transit. Note the loss on your inventory record and attach copies of pertinent documents.

1. Sender's Name	1. Shipper's Name
2. Sender's Street Address	2. Shipper's Street Address
City State Zip	City State Zip
3. Date Sender Notified of Loss	3. Date Sender Notified of Loss
4. Contact Name	4. Contact Name
5. Contact Telephone Number ( )	5. Contact Telephone Number ( )

D. Lost/Stolen Controlled Substance Listing

List the brand name of the controlled substances lost/stolen. For generic brands, include the manufacturer's name. (Attach additional sheets if necessary.)

Name of Controlled Substance	Dosage Form	Strength	Quantity
		TOTAL VALUE	

Additional Information or Remarks:

Security measures taken to prevent future incidents:

E. Certification

I certify that the information contained herein is correct to the best of my knowledge and belief.

Name (please print)	Article 33 License Number
Signature	DEA Number (if applicable)
Title	Professional License Number (if applicable)
Date	Telephone Number

False statements made herein are punishable as a Class A misdemeanor pursuant to Section 210.45 of the Penal law of New York State.

Bureau of Emergency Medical
Bureau of Controlled Substances

Substock Inventory

Use ONLY one line for each administration/use OR inventory replenishment.

EMS Agency Name: _Apalachin__ Location of Substock: Ambulance #: _____ Seat/Lock#_____

Beginning Balance in Substock:

Date	Run No.	Amount (mg.) Issued (+) to Stock Drug/Lot #	Amount (mg.) Destroyed, Administered, or Lost (-) From Substock	AEMT, ID & Signature	Reason (Pt. Admin-Restock – etc)	NEW Inventory Balance (mg.)	Exp. Date
	XXX	Morphine #	XXXXXXXXXXXXX		Restock	10 mg/ml	
	XXX	Morphine #	XXXXXXXXXXXXX		Restock	10 mg/ml	
	XXX	Fentanyl#	XXXXXXXXXXXXX		Restock	100mcg/2 ml	
	XXX	Fentanyl #	XXXXXXXXXXXXX		Restock	100mcg/2 ml	
	XXX	Midazolam #	XXXXXXXXXXXXX		Restock	5 mg/5 ml	
	XXX	Midazolam #	XXXXXXXXXXXXX		Restock	5 mg/5 ml	
	XXX	Midazolam #	XXXXXXXXXXXXX		Restock	5 mg/5 ml	
	XXX	Midazolam #	XXXXXXXXXXXXX		Restock	5 mg/5 ml	
	XXX	Ketamine#	XXXXXXXXXXXXX		Restock	500mg/5ml	
	XXX	Ketamine#	XXXXXXXXXXXXX		Restock	500mg/5ml	

Instructions:

Issue:
1) A new Inventory Sheet is issued. Complete: Date, Amt, and Drug/Lot #, AEMT Signature, Restock, Inventory Balance and Exp. Date for each vial.
2) Close and lock narcotics box with key.
3) Pharmacist will place a seal/lock on the box. Record seal/lock # on the inventory sheet.
4) Place this sheet on the holder on the outside of the box.

Return:
1) Medic presents PCR, Continuation Form and the narcotics box to the Pharmacist.
2) Give entire box, inventory sheet and used vial (s) to the Pharmacist.
3) Fill out a line above for each vial used. Complete Date, Run#, Amount administered/Amount returned, AEMT signature, Administration, and Inventory balance.
4) Medic and Pharmacist sign below.

Medic Signature: _____ Print Name: _____ _____mg of _____ wasted down sink.
Pharmacist Signature: _____ Print Name: _____ Date _____ Time _____

Medical Control Order Form

Date	Vehicle ID	Run #	Receiving Hospital
Patient Name		DOB/Age	Receiving Hospital ID

Medication	Dose	Route	Waste	Provider
Medication	Dose	Route	Waste	Provider
Medication	Dose	Route	Waste	Provider
Medication	Dose	Route	Waste	Provider
Medication	Dose	Route	Waste	Provider

Miscellaneous Orders:

On Line Med Control Physician Name-Print	On Line Med Control Physician Name-Signature	Date

Drug Destroyed By	Date	Witness Signature

APPENDIX D

VOEMS controlled Substance Roster

VILLAGE of OWEGO EMS PERSONNEL AUTHORIZED FOR CONTROLLER SUBSTANCE MEDICATIONS

EFFECTIVE 04-01-2019

PROVIDER NAME	LEVEL	CERT #
WILLIAM BALSHUWEIT	EMT-P	273738
AMANDA BARKER	EMT-P	335152
BEN BARONE	EMT-P	407150
SONYA BEMENT	EMT-P	134486
PAUL COLE	EMT-CC	204132
STEPHANIE COLE	EMT-CC	268623
KEVIN CUMM	EMT-CC	117664
ADAM JOHNSON	EMT-CC	429993
BRYAN KELLER	EMT-P	307362
JENNIFER KOTSKI	EMT-CC	238386
JAMES KING	EMT-P	009857
REBECCA MONACHELLI	EMT-CC	421385
TOM MUNDT	EMT-CC	050055
RICHARD PERKINS	EMT-CC	301181
JUSTIN SCHMIDT	EMT-CC	425979
ROBIN SHAVER	EMT-CC	358193
LYNDA VANDUSEN	EMT-CC	202091
CHRISTINA VANWAGENEN	EMT-P	194372
DANIEL WOODY	EMT-CC	251761