Issues and Concerns at RCEMS
September 2016

Management

- Director that hides from his employees, he comes and goes from the back entrance.
    - Has been on scene to one call in recent memory, and he was apparently within a block as he arrived on scene almost immediately after unit dispatched
    - Other than in service training once a month, for 5-8 minutes, he never sees or is seen by field personnel
- New Division Manager that has been here weeks and at first in-service says nothing to inspire the staff
    - Hasn't talked to anyone on the streets to ask for input
- Manager, newly promoted major, states that no vacation will be granted on home football Saturdays and this was decided weeks ago, just not communicated to personnel until someone actually tried to take one of those days off.
    - When EOT members threaten to leave team, then told they would then have to work the streets
    - When asked about not being on standby, told that he can make employees work whenever he wants to include overtime and make it a condition of employment.
    - Then asked about poor morale and this type of attitude won't make it better… Stated that morale is from the street not a management issue, and if we don't like it we can leave
    - Later that day brought a copy of county policy showing where he can make employees work out to same crew working on a unit
- Members of night shift had a group picture on Facebook, after the BLM protest a Black Panther had posted to the picture threatening the lives of EMS personnel. When printed and taken to management the personnel expressed interest in body armor for their protection, it was said to them that it was unnecessary since they could still shoot you in the head. They were also told if they don't feel safe then they don't have to work here.
- Promotion to Major without it being advertised, Is this not Illegal?
    - There were several people planning to apply and were never given the opportunity
- Creation of position and hiring of 3rd motorcycle medic without advertising position and giving current employees a chance to apply. Also is this not illegal?
    - This individual only had minimal motorcycle skills, needing extensive training and time to acclimate
    - To this day it is understood that this person does not wish to ride bike anywhere but on pavement. Many special events are held off of pavement limiting where this person is willing to ride bike at that event.
- Announced months ago there would opportunities for employees to participate in round table discussions to bring issues and suggestions to management. These have never materialized.
- Employee late in excess of 20 times in a year, sometimes by hours, and never written up, while others in the past have had disciplinary action. Inconsistent management
- LT that regularly slept in QRV in parking lot, apparently addressed after a year
- Lazy employees even when written up and called to office are then allowed to continue without remedy.

- Nepotism
- Favoritism that is blatant and obvious
    - People called in on standby are supposed to be sent first to dedicated events to lessen their fatigue, but many times put on streets and favored crews get to work the dedicated events
        - Asked to come in to work a pair of special events, one in particular was a high school football game that crewmember was an alum and wanted to attend. After coming in the next day to work it, told no, you are going to a different game, a higher manager decided that a street crew would work that game since one of them was (also) an alum. That is wrong to entice someone to come in to work a specific event and then take it away that day.
    - When an employee became un-favored, dispatch told to keep that individual in town to run more calls and push others out to the outer stations
- Barely can keep 14 trucks on road with call volume that DHEC recommends 22 trucks as a minimum. This is causing extreme workloads and employee exhaustion which then sets up potentially poorer performance to the citizens expecting exceptional care.
    - Employees are scheduled for two standby days per month. Must be available for whole shift and able to report to work within one hour. No compensation for this availability (also possibly illegal?) unless called in to work. Other area county services that still have standby days pay their employees for this availability. An average month has 14 off days of which 2 are standby and one is Continuing Education day. Effectively leaving employees with 11 days off in a month. Employees regularly are asked to work additional days to cover sporting events and special events, while voluntary (for now assuming based on manager statement that he can make employees work and make a condition of employment)
- During floods of 2015, many counties (approximately 12) offered staffed EMS units to assist in the response. They were turned down. Richland County Employees had to work excessive hours most of the 45 days to keep the truck count higher for the response. This made for exhausted employees. Seeing fire units from across the state and the national guard helping the fire department did not help with EMS morale.
- Employment Retention and Hiring
    - Turnover is extremely high this year, with hiring rates much slower increasing the workload on those remaining.
    - Apparently the word is out and the number of qualified paramedics is almost non-existent. Latest group of 10 new hires only added one medic.
    - Without paramedics soon the county will have numerous 3 man units (1 paramedic and 2 EMTs) because there are more EMTs than paramedics
- No electronic method to communicate with all employees. Even employees that do have e-mail, must access when at headquarter and not from any non-county computer. Memos taped to doors and walls, many times covering door and extensive areas of the wall. Even if something new, and potentially important, is added, it is easily missed because of the number already there.

- Many time when an issue comes up for management to address, the response is told to us at in-service, never in writing. Sometimes it is written and all employees, at that time, sign a sheet saying they have seen it. New employees do not know what said at in-service before they became employed, nor the read and signs, also before their employment. However, they are expected to follow these directives.
- Every situation where contact to management is required or just requested requires a memo to be written, which can only be typed at headquarters. Hand written memos are discouraged.
- Coordinated with Sgt and Cpl in the Logistics office, to bring in most of county issued items on the Wednesday prior to last shift on Saturday as no one from that office works weekends. They said that would be fine. The items were gathered and brought in. The Captain was there, and became upset that not everything was brought in at the same time. When pointed out that office is closed on Saturday, her response was "then you need to bring everything in on Monday". The response to that was "I will be at my new job on Monday". She then with a very unpleasant attitude then stated "well then, fine, just leave it all there and we'll get to it". It was very unprofessional and even felt threatening.

Practice

- Why does it take so long to adopt newer industry standard evidenced based protocols?
    - Less spine board usage, newer c-collars out there that are advanced to standard that offer immobilization without the negatives of the spine board.
    - Pain management without having to call for orders
        - When management asked specifically about this one, told "Oh hell no, that would increase the likelihood of pilferage". The controls would not change, just having to call a doctor on the radio for permission to administer. This is a state sanctioned acceptable protocol and most other area counties can do this.
    - Sepsis protocol, it has been proven even if the patient is across the street from the hospital it has positive time benefits to starting treatment by EMS prior to hospital
    - Why are there still MAST trousers on every unit and checked off every day? They are not in the protocols and are an antiquated tool that is no longer recommended
    - RCEMS does not carry an antiemetic, this would be extremely beneficial with nausea as well as when morphine is administered when nausea is a common side effect.
    - Additional options for more serious respiratory distress, such as Duoneb and solumedrol.
    - Vast majority of EMS services use EZ-IO for IO access only small percentage use the BIG, EZ-IO is also what the hospitals use. It offers more options for placement, such and humeral, which flows better that other sites and is closer to the heart which helps in cardiac events.
    - With failing thumpers and new trucks to equip, is the county just going to keep buying old technology or begin the transition to newer and more effective mechanical compression devices, such as the Lucas, which is proven to be more effective.
    - Most times when management is asked about newer medications and treatments, the standard answer is that we are too close to the hospital for them to be of any benefit.

Yes, there are more people that do live closer to the hospitals than those in the outer reaches of the county. For those that do live out there it can be over 30 minutes to the hospital, therefore management must not believe that these people are worthy of providing the best possible care, just because they live farther away.

- Paramedics in field are not trusted to make a decision about the use of a helicopter, they must wait for supervisor to make that decision
- Even if educated (from paramedic school training) deviation from protocol is justifiable even to the receiving MD the paramedic is written up for not following protocol.
    - Relative hypoglycemia
    - Repeat EKG after AMI alert on monitor after seeing improper attachment of leads and after corrected is a clean EKG.
- State requirements are for there to be thermometers on ambulances, there are none
- Out of supplies regularly and for extended periods
    - Nitroglycerine tablets, critical medication for chest pain patients
    - Veiniguards – to secure and minimize infection potential of IV sites
        - Told to make do with less sterile tape
        - Told not to obtain from hospitals as that is considered stealing
        - Hospitals are dumbfounded with this
    - IOs – Alternative to IV when line is needed and no veins visible or available.
        - Still out of pedi IOs after many months
    - Syringes – out of 12ml for months, then had to use 6ml and then ran out of those and even had to use 3ml for short time before it was finally remedied
    - Gloves, many days out of needed size and either have to find on another truck or wear improperly sized gloves
    - Spine boards have to be taken off other trucks to be able to go in service on most days
    - Narcan – to treat respiratory depression (or absence) in overdose patients
    - Sodium Bicarb – used in many cardiac arrest patients as a potential remedy to imbalances in the body.
    - D-50 – IV administered sugar to reverse a hypoglycemic patient's condition
    - Electrodes – if the monitor cannot be attached to patient, no diagnostic can be performed
    - Nine foot straps, used to be regular shortage, but most boards do have attached straps now, but there are still not many straps available which can be beneficial with larger patients
    - Pediatric stylets used for intubation are expired, by years
    - Betadine wipes are expired, by years
    - D-sheets – the paper sheets that cover the stretcher for sanitary reasons at one point were completely out and told they had to borrow some from another agency to hold us over until a rush shipment could be procured and delivered
- Equipment failures
    - Monitors regularly now having intermittent issues
        - Batteries not always enough to have charged batteries at beginning of shift
        - Not always able to perform 12 lead EKGs

  - Computers are falling apart
    - most locks are missing
    - many keys missing
    - screens hard to read especially in sunlight because of rough surface
  - Some trucks are going in service without glidescopes
  - Not enough thumpers any longer to have one on each unit, having to move from truck to truck
  - Jump bags, many have failed zippers and have to be carefully moved so as not to lose contents, or compartments just cannot be used.
- When uniforms and boots are needed it can take months and in some cases up to a year to obtain
- Rain gear – the county used to issue proper rain coats, but switched to what is essentially a hooded wind breaker. These are not waterproof garments. When asked about this, told to buy o can of scotch guard and spay the coat and then it will work better. The true raincoat is black in color with a small amount of reflective tape. The new garment is also black in color with no reflective ability. Working in the dark with these garments are dangerous to the crews as it limits the ability to be seen. Most if not all the other area services (to include police and Fire) have highly visible rain gear and in most cases are high visibility yellow.
- Stations are in terrible condition; furniture has been falling apart for years.
  - Told that was being taken care of for months. We have seen just 2-3 recliners replaced
  - Supplies are inadequate to properly clean, not always replaced in timely fashion
  - Floors are beyond disgusting, need to be professionally stripped
  - Many times per year card readers stop working and it take weeks to months to repair
    - Most recently all 3 doors to Jackson creek inoperable, unable to use needed bathroom facilities because of this condition
  - Several stations cause allergic reactions to the crew members, potentially due to mold, crews must remain in unit instead of going inside.
- Pagers are not always functional or do not go off even when paged, they are placed on the morning stack of equipment for use that day knowing they do not work or are even charged. Crew has to make sure of status and swap batteries prior to leaving to start shift.
- **Failed patient care**, particular case ended in **death of that patient**, swept under rug to not have record of the event in case family caught wind and wanted to sue. (Told this specifically by then Captain (same new Major as mentioned earlier)) Therefore, no repercussions or remediation to the medic and a year later same paramedic promoted to Sr. Paramedic.
- Firefighter drivers
  - Not all firefighters are allowed drive thus are hit and miss as to being able to use
  - Firefighters are not allowed to ride in back of unit to assist in patient care, many are EMTs
  - Specific event where firefighters could have made a difference
    - Cardiac arrest in Irmo. IFD can't (and wouldn't) drive the unit. CFD would not respond into Irmo to just drive. Motorcycle medic not allowed to leave bike on scene to drive (he broke the protocol to save 20 minutes of waiting for a driver)

- Halfhearted attempt to follow NIMS (National Incident Management System) and radio communication practices
    - Many times, especially on AVLs 10 codes are still used and crews do not understand what they mean and either ask for clarification or worse just ignore that information which could be important, such as a gun on scene
- In the last year an active shooter drill was held at Baptist Hospital, CFD and CPD were involved but not EMS… Is EMS not going to be involved in a real life situation? Training needs to occur for this and other scenarios to be better prepared.
    - What if the county had a catastrophic event and communication were down? There is no training or even discussion for this scenario
    - Recent bus drill involved just a few personnel, most crews get no training for any special types of events that they could be called upon to respond to.
- RCEMS utilizes old technology for IV drip sets. All the hospitals use a needless system, Leur-lok, to make their use safer for the patient and the providers. Having to use needles in the back of moving vehicle increases the possibility for an unfortunate needle stick event. All other services use the same system and the hospitals are able to uses their IVs immediately. RCEMS sets require the use of needles and the hospital either has to change it out or in many cases they just start an additional IV and discontinue the EMS initiated IV.
- Most other services use what known as prefills for medications that are used in the most life threatening situations. RCEMS does provide the medications used for cardiac arrest in this form, but other medications used for serious conditions that are regularly provided in other services in prefills, are not and thus the medic must take time, often in short transports to draw up medications prior to administration. This also has needle stick potential because of having to do this in a moving vehicle.
- Emergency Operations Team (EOT) when developed were trained to deal with additional emergency situations, such as hazardous materials. Now it is just a rite of passage, for paramedics. It is a short lecture and then assigned a radio, some protective clothing and a gas mask. No training even provided other than a laminated card in the bag how to put on the protective clothing. The benefit to the employee is having their own radio, a cool looking shirt and being allowed to work at Carolina football games. Benefits to the county is virtually zero. If not trained to do anything more than before becoming a team member, then unable to do anything additional after becoming a team member.
- Crewmembers are expected to complete a document, called a patient care transfer sheet, that contains information about the patient, the vital signs, allergies, medical history, insurance information, etc that is to be left with the receiving medical staff. The county has been out for many months and when asked at the monthly in-service training the Captain over logistics states she will take care of this. There are still currently no transfer sheets available for use. These sheets assist in an organized radio report to the hospital as well as a guide to providing a verbal report to the receiving nurse or doctor which is then left with them as to a record of what was told to them.
- When the system is busy and crews are in the emergency room, there are times when dispatch is trying to rush the crew out of the hospital to take another call. A manager may come over the radio and say “drop your stretcher”, which means, lower the stretcher to the lowest level,

remove the battery and inform the staff that you are leaving the patient on the stretcher. No signature receiving the patient is expected by management, told we can go back later and obtain. Based on our education, this is considered abandonment, which is illegal. The crew is then expected to run the call they are being rushed to without a stretcher and carry the patient out manually and place on the bench seat to transport.

- There are times management does not take the safety of the crew seriously. Recently a crew was responding to a GSW call, told patient laying road in front of house with the shooter still inside. The crew responded and stopped a couple blocks away and informed dispatch that they would be staging until law enforcement arrived and cleared the scene. A manager came on the radio and said to proceed in to the call. The crew then stated on the radio that law enforcement was not on scene. The response was to just proceed in carefully.

System

- Why does county own 49 inspected ambulances and 14 more sitting at county shed not inspected? If all positions staffed and came to work, there would only be 20 trucks on road. If each shift used separate trucks and a few spares are available, then 45 trucks should be more than sufficient.
- Those new trucks are almost a year old and just sit there. Are they not going to dry rot just sitting there?
- The EMS policy manual is dated August 3, 1998. There are great amounts of it do not apply to modern operations. There are functions that have been added that are not addressed. Employees are told about things that would be considered policy but are not provided in writing or updates to the policy manuals. Therefore, if there are new policies, employees do not have access to them to know what the policy is. New employees are even more in the dark because they have not been there to hear the directive.
- Dispatch has several dispatchers that crumble under pressure
- AVLs have been going down more frequently
    - This challenges some dispatchers
- AVL updates take extended time
    - During the floods of 2015, it was many days before closed roads were entered to have system navigate units around road closures. Every shift and crew entering an area had to learn for themselves many times before figuring out a route to get to a scene.
    - There are still unusual routes appearing in system because roads marked closed in the storm have not been removed to allow for best routing
- Internet access
    - Most stations do have access but many are difficult to connect, broken cables and some are extremely slow. Crews do not spend much time at stations because of the call volume so accessing internet to upload and lock calls is limited.
    - Due to the lack of time to connect and upload this is generally completed at end of shift after returning to headquarters, in most cases requiring the crew to stay longer, incurring extra/overtime pay for the crew to stay and complete the paperwork

    - This process could be improved, by incurring some additional up front cost, by having wifi available on each unit, allowing crews to complete paperwork, upload and lock while enroute to calls and assignments. The savings from the reduced overtime would go a long way towards paying for this.
    - If there were internet access on trucks, patient lookups could be completed for patients that have been transported before. This would bring up patient information, medical history, medications, allergies and insurance information. Saving time and increasing accuracy both in patient charting and insurance billing.
- Use of retreads on front wheels of ambulances, had one blow out while traveling at 40-45 mph. Luckily were able to keep it under control and upright, could have rolled and been a serious event.
- There are four shifts and each one is run differently. When working on a different one than normal can get scolded or worse for something that is acceptable on regular shift.
- Does very little to promote the service and crews are encouraged to get off a scene or park away from the press to avoid being caught on camera.
- While recently remedied, paramedics once cleared for crew chief role were run as a crew chief, many time for years without promoting those individuals, calling them “acting crew chief”
- Code 4 – this practice is hardly used anymore elsewhere. This practice of running a non-emergent call emergent to speed up availability is not based on patient need and places the patient, crew and the public at greater danger. There are several accidents a year involving units while running code 4. This is an attempt to remedy the lack of available units without regard to safety.
- Response times can be manipulated. During peak times, occasionally the county does not even have available units, units can be dispatched extreme distance because of the shortage of trucks. In these cases, it can take 25-35 minutes running emergent to cross the county for a call. Motorcycle medics can first respond to calls and this erases that extended ETA for a unit. The motorcycles are equipped with minimal supplies and gear and cannot fully treat a patient like a fully stocked ambulance and more importantly cannot transport. But the response time shows arrival in much less time than reality of ambulance arrival. This is not to say it is not better than no response, but the citizens deserve better response.
- Continuing Education (formerly In-service Training) has never been truly a learning experience. A generally canned lecture by a physician. Before training, a quiz paper is given out and the answers are projected on screens to be copied onto the paper. The time spent in training is usually counted as double what is actually spent in the training. We are there on average 1.5 hours but get credit for 3. There are no hands on skills review like most other services, with the exception of every other year’s CPR recertification.
    - The county is also overspending on the amount of training time provided. The number of hours has been lowered for EMTs and there is supposed to be self-directed training in the new method devised by the National Registry and adopted by the state. We are in the classroom being paid for far more hours every two years than is required and the employees have no choices to make for self-directed training. If we come to all the training, we will have the required hours but not with the intended benefits of the new method of recertification.

- Crew Chief is sole entity responsible for every possible scenario of that unit.
    - It does not matter who the other crew member is (EMT or paramedic) those people share no responsibility for their own actions, it all falls on the crew chief
    - Example: on a dual paramedic unit, crew chief driving to hospital while another fully qualified paramedic is in the back with the patient. During that transport the paramedic in the back makes a mistake, it is the crew chief that is driving that must accept responsibility for that mistake
    - An EMT was leaning over patient to obtain equipment out of cabinet and radio fell off belt and injured patient, crew chief not anywhere in visibility range was reprimanded, for what was also obviously an accident.
- Supplies procurement for the units
    - During winter not always blanket availability
    - During summer months no blankets generally available, even when shock protocols call for blankets
    - Many times Towels are not available to restock trucks, they come in large batches and then take time to replace when out
    - Another county has placed specialized vending machines in some area hospitals that allow crews to restock at the hospitals, where Richland crews must restock at headquarters. With high volume of calls, it is rare to return to headquarters during a shift. Even when critically low on supplies told to run call and supervisor will bring needed supplies if requested.