RICHLAND COUNTY

DEVELOPMENT & SERVICES COMMITTEE AGENDA

TUESDAY, OCTOBER 24, 2017

5 P.M.

DECKER CENTER
2500 DECKER BOULEVARD
COLUMBIA, SC 29206

RICHLAND COUNTY COUNCIL 2017-2018

VICE CHAIR
Bill Malinowski
District 1

CHAIR
Joyce Dickerson
District 2

Yvonne McBride
District 3

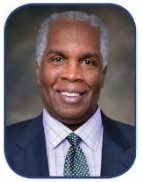
Paul Livingston
District 4

Seth Rose
District 5

Greg Pearce
District 6

Gwendolyn Kennedy
District 7

Jim Manning
District 8



Calvin "Chip" Jackson
District 9

Dalhi Myers
District 10

Norman Jackson
District 11

Richland County Development & Services Committee

October 24, 2017 – 5:00 PM
Decker Center
2500 Decker Center Boulevard
Columbia, SC 29206

Yvonne McBride	Gwen Kennedy	Seth Rose (Chair)	Chip Jackson	Dalhi Myers
District 3	District 7	District 5	District 9	District 10

1. **CALL TO ORDER** — The Honorable Seth Rose, Chair, Development & Services Committee

2. **APPROVAL OF MINUTES** — The Honorable Seth Rose
   a. Development & Services Committee Meeting: September 26, 2017 [PAGES 1 - 4]

3. **ADOPTION OF AGENDA** — The Honorable Seth Rose

4. **ITEMS FOR ACTION** — The Honorable Seth Rose

   a. Council Motion: Require that all municipal utility service providers must request consent and approval from Richland County Council prior to extending or accepting water and sewer infrastructure within the unincorporated boundaries of Richland County [Malinowski] [PAGE 5]

   b. Council Motion: If an employee is in need of sick leave, any employee can donate that leave to a specific person and not just a sharing pool [Malinowski] [PAGES 6 - 17]

   c. Council Motion: Move to examine the EMS Department and receive a report on its current status [Rose] [PAGES 18 - 91]

   d. Council Motion: If Developers, Builders, etc. cause any hardship on any community due to poor workmanship or unapproved or unpermitted work of any kind that fails, all of their building permits should be pulled and the builder not allowed to build until they fix the problem(s). The homeowners, nor the citizens, should have to pay to fix poor workmanship [N. Jackson] [PAGES 92 - 93]

   e. Council Motion: HOA's operated by developers or management firms should be fined if due to their poor management, and not that of the homeowners, it causes a hardship on the homeowners or community. NOTE: There are improperly maintained detention ponds that have trees growing

in them which causes flooding during a bad storm [N. Jackson] [PAGE 94]

f. To simplify the emergency preparedness process in the future, I move that Richland County coordinate with the City of Columbia and other municipalities to identify different types of emergency shelters/facilities and certify them, meaning what is required and the readiness of the facility factoring in accessibility due to potential obstructions i.e. impassible bridges, roads etc. Working with recreation centers, school districts, churches and other civic centers to qualify and certify these facilities to accommodate citizens in need during certain crisis. In this process each certified facility would be updated annually. Working with Councilmembers willing to participate from each district would also improve the process.
Note: Shelters to include overnight stay, storage and accommodate the Red Cross and other agencies. Facilities to include storage for distribution to designated areas [N. Jackson] [PAGES 95 – 96]

5. **ITEMS PENDING ANALYSIS – PAGE 97**

a. Council Motion: Develop an emergency plan with SCDOT to immediately repair Rabbit Run Road and Bitternut Road. Developers' constant neglect to repair the storm drainage system causes dangerous flooding. A school bus almost overturned in the flood this morning (April 24, 2017) on Rabbit Run Road. We cannot afford to endanger the lives of citizens, especially school children because of neglect [N. Jackson]

b. Council Motion: Direct staff to research changing the ordinance relating to water runoff so in the future it will require environmental studies and not allow any runoff that exceeds the current runoff from the undeveloped property. This motion should be reviewed/completed and provided to the Planning Commission no later than their June meeting [Malinowski]

c. Council Motion: Direct Legal to research what is required to enact a parking ordinance in communities/subdivisions [McBride]

d. Council Motion: I move that we re-allocate some of the funding we used to increase the general fund balance farther above the minimum policy amount than it already was, and given that the FY16-17 budget produced a surplus, to EMS [Manning]

6. **ADJOURN**

Special Accommodations and Interpreter Services Citizens may be present during any of the County's meetings. If requested, the agenda and backup materials will be made available in alternative formats to persons with a disability, as required by Section 202 of the Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12132), as amended and the federal rules and regulations adopted in implementation thereof. Any person who requires a disability-related modification or accommodation, including auxiliary aids or services, in order to participate in the public meeting may request such modification, accommodation, aid or service by contacting the Clerk of Council's office either in person at 2020 Hampton Street, Columbia, SC, by telephone at (803) 576-2061, or TDD at 803-576-2045 no later than 24 hours prior to the scheduled meeting.

Richland County Council

DEVELOPMENT AND SERVICES COMMITTEE
September 26, 2017 – 5:00 PM
4th Floor Conference Room
2020 Hampton Street, Columbia, SC 29201

COMMITTEE MEMBERS PRESENT: Seth Rose, Chair; Yvonne McBride, Gwen Kennedy, Chip Jackson, and Dalhi Myers

OTHERS PRESENT: Bill Malinowski, Brandon Madden, Michelle Onley, Sandra Yudice, Jamelle Ellis, Jennifer Wladischkin, Larry Smith, and Quinton Epps

1. **CALL TO ORDER** – Mr. Rose called the meeting to order at approximately 5:00 PM.

2. **APPROVAL OF MINUTES**
   a. July 25, 2017 – Mr. C. Jackson moved, seconded by Ms. Kennedy, to approve the minutes as submitted. The vote in favor was unanimous.

3. **ADOPTION OF AGENDA** – Ms. Myers moved, seconded by Mr. C. Jackson, to adopt the agenda as published. The vote in favor was unanimous.

4. **ITEMS FOR ACTION**

   a. Quit-Claim Deed: 1209 Whitney Street – Mr. Madden stated the property owner, David Hodge, is requesting to quitclaim a portion of vacant property that abuts their lot. Historically, the Olympia neighborhood has vacant lots between properties that that were once used for deliveries, trash pickup, etc.

      Mr. C. Jackson inquired if the "red line" on the map in the agenda packet notated the property being quit claimed.

      Mr. Madden stated ½ of the property would be deeded over to Mr. Hodge.

      Mr. C. Jackson inquired if there would be a problem with the owner restricting access once the property is quit claimed.

      Mr. Madden stated he does not believe so. The alleyway is not currently being used.

      Mr. Malinowski inquired if the County is giving the property owner ½ or the whole the thing.

      Mr. Madden stated the County will be giving them ½ and contacting the other property owner(s) to inquire if they want the additional property. If they do not want the additional property, it will be given to Mr. Hodge.

Ms. Myers moved, seconded by Mr. Rose, to forward to Council with a recommendation to approve the request to approve the quit claim deed. The vote in favor was unanimous.

5. **ITEMS PENDING ANALYSIS**

a. Council Motion: Require that all municipal utility service providers must request consent and approval from Richland County Council prior to extending or accepting water and sewer infrastructure within the unincorporated boundaries of Richland County [MALINOWSWKI] – Mr. Rose suggested scheduling a work session on this item. The committee members are to contact the Clerk's Office with their availability.

Ms. Myers apologized on the record to Mr. McLeod for not attending the meeting referenced in his letter. She stated she did not receive a calendar invite for the meeting. She further stated the concerns are important and the committee is not ignoring the matter.

Mr. C. Jackson stated to not be able to be at the meeting was also a disappointment for him as well.

Mr. Rose requested the Clerk's Office to publicly advertise the meeting to ensure those that wish to have input are able to do so.

Mr. Malinowski inquired if there is a State law and Council does not want to abide by the law what does Council have to do? Is Council allowed to not abide by it?

Mr. Smith stated the law provides certain rights for Council to exercise and Council can decide to exercise those rights or not. He stated he believes Mr. Malinowski is referencing the statute that relates to consent for municipalities and the question is whether Council wants to exercise the right.

Mr. Malinowski stated, as with any ordinance the County wishes to change, you continue with the existing ordinance until the change takes place. This is the matter currently before the committee, there is an ordinance and a State law that says the County is to receive a request from the City of Columbia and be granted permission before water lines are run in the unincorporated area.

Ms. Myers requested when the information is provided to Council that the remedies under the law are also provided.

b. Council Motion: Develop an emergency plan with SCDOT to immediately repair Rabbit Run Road and Bitternut Road. Developers' constant neglect to repair the storm drainage system causes dangerous flooding. A school bus almost overturned in the flood this morning (April 24, 2017) on Rabbit Run Road. We cannot afford to endanger the lives of citizens, especially school children because of neglect [N. JACKSON and MALINOWSKI] – No action was taken.

c. Council Motion: Direct staff to research changing the ordinance relating to water runoff so in the future it will require environmental studies and not allow any runoff that exceeds the current runoff from the undeveloped property. This motion should be reviewed/completed and provided to the Planning Commission no later than their June meeting [MALINOWSKI] – Mr. Madden stated the Transportation and Public Works Departments are working on.

d. Council Motion: If Developers, Builders, etc. cause any hardship on any community due to poor workmanship or unapproved or unpermitted work of any kind that fails, all of their building permits should be pulled and the builder not allowed to build until they fix the problem(s). The homeowners, nor the citizens should have to pay to fix poor workmanship. [N. JACKSON] – Mr. Madden stated Ms. Hegler is working on this item with the Stormwater Division.

e. Council Motion: HOA's operated by developers or management firms should be fined if due to their poor management, and not that of the home owners, it causes a hardship on the homeowners or community. NOTE: There are improperly maintained detention ponds that have trees growing in them which causes flooding during a bad storm [N. JACKSON] – Mr. Madden stated Ms. Hegler is currently working on this item.

f. Council Motion: Direct Legal to research what is required to enact a parking ordinance in communities/subdivisions [McBRIDE] – Mr. Madden stated the Legal Department is currently working on this item.

Ms. Hegler stated Mr. N. Jackson requested the weeds and rank vegetation ordinance be included as a part of this motion.

Ms. Myers inquired if the committee, at any point, is going to go back and discuss these motions. She does not necessarily agree with and she is unclear what is meant when Mr. Madden states staff is "working on" them.

Mr. Madden stated that many of these motions touch more than one department and can become complicated; therefore, we want to make sure we have a comprehensive briefing document to augment the deliberations.

Ms. Kennedy inquired if the County can legally instruct subdivisions to change their covenants.

Mr. Smith stated some subdivisions that have covenants/restrictions, which may cover the issues being presented to the committee, but the County cannot change their covenants/restrictions. Legal has been working with Ms. McBride to understand what the needs of her districts are.

Ms. McBride stated Ms. Hegler was looking at the different areas of the County to see if an ordinance can be developed to address concerns in the various zoning designations.

Mr. C. Jackson stated the bigger issue is a code enforcement issue because the current codes do not allow the Sheriff's Department to cite the residents or allow the HOA to address the issue(s) with residents.

g. Council Motion: If an employee is in need of sick leave, any employee can donate that leave to specific person and not just a sharing pool [MALINOWSKI] – Mr. Madden stated this item was before the committee last month. There was a request for specific data that staff is in the process of gathering.

h. Council Motion: Move to examine the EMS Department and receive a report on its current status [ROSE] – Mr. Rose requested a written report because sometimes Council members are contacted by EMS works regarding particular concerns. He further stated he has specific questions he would like to have answered by Mr. Byrd and would encourage other Committee/Council members to submit their questions to Mr. Madden.

1. How many positions do we have unfilled?
2. Why do we have unfilled positions?
3. How many ambulances are currently running vs. what DHEC suggests?
4. How do we maintain inventory of supplies?
5. Do we have the latest technology?
6. What avenues do EMS workers have to voice a complaint?

7. What is the communication between the EMS employees and superiors handled?
8. What are the department's current needs?

i. To simplify the emergency preparedness process in the future, I move that Richland County coordinate with the City of Columbia and other municipalities to identify types of emergency shelters/facilities to certify them, meaning what is required and the readiness of the facility factoring in accessibility due to potential obstructions i.e. impassible bridge, roads, etc. Working with recreation centers, school districts, churches and other civic centers to qualify and certify these facilities to accommodate citizens in need during certain crisis. In this process each certified facility would be updated annually. Working with Councilmembers willing to participate from each district would also improve the process. Note: Shelters to include overnight stay, storage and accommodate Red Cross and other agencies. Facilities to include storage for distribution to designated areas [N. JACKSON] – Mr. Madden stated staff is in the process of identifying specific shelters in the County.

6. **ADJOURNMENT** – The meeting adjourned at approximately 5:22 PM.

Development & Services Committee Meeting
October 24, 2017
Briefing Document

Agenda Item
Municipal utility service providers extending or accepting water and sewer infrastructure within the unincorporated boundaries of Richland County

Background
At the April 4, 2017 Council meeting, Vice-Chairman Malinowski brought forth the following motion:

> "I move to require that all municipal utility service providers must request consent and approval from Richland County Council prior to extending or accepting water and sewer infrastructure within the unincorporated boundaries of Richland County."

Issues
This motion is related to the issue of Annexation

Fiscal Impact
There is no apparent financial impact to the County associated with this request.

Past Legislative Actions
- The D&S Committee recommended Council approval of this motion during its May 23, 2017 deliberations.
- Council referred this item back to the Committee for review during its June 6, 2017 deliberations.
- The D&S Committee approved having a work session on this item to obtain input from developers and other interested parties on this motion during its June 27, 2017 deliberations
- The D&S Committee work session was held on October 19, 2017.

Alternatives
1. Consider the motion and approve accordingly.

2. Consider the motion and do not approve.

Staff Recommendation
Council's discretion. Staff will proceed as directed by County Council.

Submitted by: Vice-Chairman Malinowski, Council District 1
Date: April 4, 2017

Development & Services Committee Meeting
October 24, 2017
Briefing Document

Agenda Item
Sick leave pool

Status Update: This motion was brought forth by Vice-Chairman Malinowski during Council's July 17, 2017 meeting deliberations. This item was considered by the Committee during its July 25, 2017 Committee meeting and was deferred for further staff research.

Background
On May 16, 2017, Vice-Chairman Bill Malinowski brought forth the following motion:

> If an employee is in need of sick leave, any employee can donate that leave to a specific person and not just a sharing pool [Malinowski]

This item was considered by the Committee during its July 25, 2017 Committee meeting and was deferred for further staff research. The additional research has been completed (see attached report).

Pursuant to the County Handbook, the County's Catastrophic Leave policy is as follows:

Catastrophic Leave

The Catastrophic Leave Program is a voluntary program that allows eligible employees to donate a portion of their accrued annual leave and sick leave to assist other eligible employees who are experiencing a catastrophic illness and/or injury. The Catastrophic Leave Program provides eligible Regular, full-time employees the opportunity to receive 67% of their gross pay and continue in pay status for up to thirty (30) days (225 hours for 37.5 hours –7 day period employees and 255 hours for 85 hour-14 day period employees) in a rolling twelve-month period.

Donations and Requests will be processed in the order in which they are received. If time is available within ninety (90) days, it will be allocated accordingly. If time is not available, requests will be kept for ninety (90) days. During that time frame, if time becomes available and if the employee still qualifies, time will be distributed. If time does not become available, requests will be considered void and requesting employee and Department Head notified.

Donors may not donate directly to an individual employee. Donations must be made in hour increments after an initial 37.5 hour donation. An employee may donate his/her accrued annual or sick leave to the catastrophic leave program only if the employee has at least seventy-five (75) total hours of accrued sick and/or accrued annual leave remaining after the donation. A donor may not donate accrued leave that exceeds the maximum annual carry over limitation for the respective type of leave (leave that would be lost due to maximum accrual limitations). Once the donation is approved, the donor may not revoke the donation.

Issues
Employee sick leave

Fiscal Impact
N/A

Past Legislative Actions
None.

Alternatives
1. Consider the motion and approve accordingly.

2. Consider the motion and do not approve.

Staff Recommendation
Council discretion as this a Councilmember initiated initiative

Submitted by: Vice-Chairman Malinowski, District 1

Date: May 16, 2017

CATASTROPHIC LEAVE POOL DESIGNATED BY EMPLOYEE RECOMMENDATIONS:

HRD has been requested to evaluate the issue of whether or not Catastrophic Leave Pool (CLP) should be allowed to be designated for donations by individual instead of to a leave pool.

HRD does not recommend that we move from a Leave Pool process to an individualized donation pool for the following reasons:

- **Currently, the CLP is distributed based on qualifiers that the County has designated and based on whether or not there is any leave available in the leave pool. If we move to an individual donation process, the following instances are likely to occur:**
  - **People will only designate leave to their friends**
  - **Employees who have more friends will have leave donated directly to them.**
  - **This will turn the program from a County-wide benefit, to a popularity contest.**
- **If we allow employees to donate to individuals, we lose the concept of a County-wide benefit as we are now allowing friends to donate to their individual friends.**
- **Individual donations would cause significant additional accounting processes for the Finance (Payroll) Department.**
- **Similar jurisdictions, in our current evaluation group, have the following programs in place:**

	CLP	Individualized Leave Pool	No Leave Pool
State of SC	X	X	
Greenville County		X	
Lexington County			X
Charleston County			X
York County	X		
City of Columbia			X

In response to Specific Council Member questions/comments from the July D&S Committee, HRD has the following responses:

- **Changing the rules would only require a sentence or two change to the policy, but would require a re-vamp of the guideline and the procedures and much more administrative work.**
- **FMLA rules are governed by the federal government and HRD abides by those rules. Eligible employees are allowed up to 12 weeks in a rolling calendar year period.**
- **Statements under final recommendations belong to HRD??**

- **There are no known tax consequences associated for the leave other than the leave is considered paid wages and the employee has to pay taxes on wages.**

CURRENT COUNTY LEAVE POLICIES

Holidays

The County observes the following holidays:

New Year's Day	January 1
Martin Luther King, Jr., Day	3rd Monday in January
Presidents' Day	3rd Monday in February
Memorial Day	Last Monday in May
Independence Day	July 4
Labor Day	1st Monday in September
Veterans' Day	November 11
Thanksgiving Holiday	4th Thursday and following Friday in November
Christmas Holiday	Christmas Eve, Christmas Day, and the day after Christmas
Floating Holiday	Scheduled in advance on any regular workday, subject to supervisory approval

Only employees working in Regular, full-time positions are eligible for Observed Holiday Pay.

Holidays which fall on Saturday are generally observed the preceding Friday. Holidays which fall on Sunday are generally observed the following Monday.

County Council may declare additional days as holidays.

An eligible employee must be in active pay status on his/her normal or scheduled workday before and after the observed holiday to receive holiday pay.

Exempt employees who are required to work on a holiday may request administrative leave with pay (not to exceed 7.5 hours per pay period) as their schedules allow and Department Heads authorize. The administrative time off may or may not fall in the same pay period as the holiday and does not necessarily equal or exceed the time worked on the holiday.

At the discretion of the supervisor, non-exempt employees who are scheduled to work on a holiday receive an additional day's pay or are provided with an alternate day off to be scheduled by the supervisor.

Annual Leave

The County strives to support the wellbeing of eligible employees by providing the opportunity to accrue and take accrued annual leave. The County encourages all employees with accrued annual leave to take approved vacation annually. Annual leave is a benefit, not a right, which must be accrued.

Regular full-time employees accrue annual leave as follows:

75- hour Work Schedule	Hours Accrued Per Pay Period	Hours Accrued Per Year
0 - 5 years	2.89	75
6 - 10 years	4.33	112.5
11 or more years	5.77	150

85-hour Work Schedule	Hours Accrued Per Pay Period	Hours Accrued Per Year
0 - 5 years	3.27	85
6 - 10 years	4.90	127.5
11 or more years	6.54	170

An employee must request and receive prior approval from his/her supervisor or Department Head in order to utilize accrued annual leave. Annual leave may not be used during new hire probationary period unless approved (in writing) by the Department Head.

Under normal circumstances, annual leave should be requested by the employee in writing well in advance of the date that the leave is scheduled, or as prescribed by Department procedures. Annual leaves will be scheduled as much as practical in accordance with employee requests. The County's workload demands, however, are paramount.

When more employees request particular days off than can be accommodated, supervisors will make annual leave assignments taking into account the date the requests were made, special needs for particular annual leave dates, and the employees' lengths of service.

The maximum number of annual leave days that can be accumulated and carried over from year to year is 45.

An employee who has completed his/her new hire probationary period and who is terminated shall be compensated in a lump sum for the balance remaining of his/her accrued annual leave at the time his/her final check is cut, unless the reason for termination is gross misconduct or resigning or retiring to avoid termination. This lump sum will be minus any funds the employee has authorized in writing for the County to deduct and will not exceed forty-five (45) days. No employee on annual leave at the time of termination of employment shall accrue any leave credit

Sick Leave

The County strives to support the wellbeing of eligible employees by providing the opportunity to accrue and take accrued sick leave. Sick leave is a privilege granted by the County, not a right. The County strives to provide employees with sufficient paid sick leave. Sick leave may be approved for the following reasons:

- Illness, injury, or disability of the employee.
- Obtaining professional services from a health practitioner for treatments for which arrangements cannot reasonably be scheduled outside of working hours.
- Illness, injury, or disability of an employee's immediate family member (up to a maximum of six (6) days of sick leave per year).

Employees may be required to submit a physician's statement before being eligible for sick leave payment. A physician's statement will be required if the employee is absent from work for 3 or more consecutive days and/or where the employee has previously been counseled or disciplined for excessive use or abuse of sick leave. In some circumstances, employees may be required to provide certification from their physician that they are able return to work before being allowed to return to work. Abuse of leave or failure to call in as required may result in denial of paid sick leave.

Only Regular, full-time employees accrue sick leave, and they may carry over a maximum number of hours as follows:

Work Schedule	Hours Accrued Per Pay Period	Hours Accrued Per Year	Maximum Accrual Limitation
75-hour work schedule	3.46	90	675
85-hour work schedule	3.93	102	765

Employees are required to contact their supervisor as soon as possible prior to the start of work, (no later than two [2] hours after the start of the work shift) when requesting an absence unless other arrangements have been made with the supervisor.

An employee who has accrued at least 150 or more sick leave hours (170 for 85-hour/14-day work schedules) and who resigns or retires voluntarily, will, at the time of his/her separation (providing employee gives and works a two-week notice and is terminated without cause), be paid for 1/4 of his/her accrued, but unused, sick leave hours (up to the maximum number of allowed hours).

Advanced Sick Leave

The County provides the opportunity for Regular, full-time employees with a serious medical condition who have used all of their accrued sick and annual leave the opportunity to borrow sick leave. Sick leave may be advanced up to twenty-four (24) work days upon Department Head, the Human Resource Department, and County Administrator approval in order to help support the recovery of employees who are seriously ill, injured, or disabled.

Upon returning to work, an employee who has been granted advanced sick leave will have deducted from his/her accruals all accrued sick leave to be applied to the existing deficit, until such time as the deficit in the employee's sick leave account no longer exists.

If an employee who has been advanced sick leave has his/her employment with the County terminated for any reason prior to accruing sick leave equivalent to the amount advanced, the Finance Department will cause an appropriate amount of money (equal to the employee's daily rate of pay times the number of unrepaid sick hours) to be deducted from the employee's final paycheck, and/or the employee may be billed for the amount of outstanding monies due to the County.

Employees should notify their supervisor immediately of request and reason for advanced sick leave request.

Administrative Leave with Pay

To provide for leave with pay under circumstances that do not fall under the guidelines of any other paid leave procedure, in unusual or emergency circumstances, Regular full-time employees may be granted administrative leave with pay; but only by the County Administrator.

No employee has any right or entitlement to administrative leave with pay, regardless of the circumstances of his/her absence. Among those unusual situations to which administrative leave with pay may apply:

- Absences due to a County-ordered fitness-for-duty examination.
- Absences due to pending investigations or reviews of alleged improper conduct.
- Absences due to any other unusual or emergency circumstance that the County Administrator determines warrants a leave with pay.

Employees should notify their supervisor of dates and reason a leave with pay is being requested if leave is voluntary.

Catastrophic Leave

The Catastrophic Leave Program is a voluntary program that allows eligible employees to donate a portion of their accrued annual leave and sick leave to assist other eligible employees who are experiencing a catastrophic illness and/or injury. The Catastrophic Leave Program provides eligible Regular, full-time employees the opportunity to receive 67% of their gross pay and continue in pay status for up to thirty (30) days (225 hours for 37.5-hour/7-day period employees, and 255 hours for 85-hour/14-day period employees) in a rolling twelve-month period.

Donations and Requests will be processed in the order in which they are received. If time is available within ninety (90) days, it will be allocated accordingly. If time is not available, requests will be kept for ninety (90) days. During that time frame, if time becomes available and if the employee still qualifies, time will be distributed. If time does not become available, requests will be considered void and requesting employee and Department Head notified.

Donors may not donate directly to an individual employee. Donations must be made in hour increments after an initial 37.5-hour donation. An employee may donate his/her accrued annual or sick leave to the catastrophic leave program only if the employee has at least seventy-five (75) total hours of accrued sick and/or accrued annual leave remaining after the donation. A donor may not donate accrued leave that exceeds the maximum annual carry-over limitation for the respective type of leave (leave that would be lost due to maximum accrual limitations). Once the donation is approved, the donor may not revoke the donation.

To be eligible for catastrophic leave, an employee must be a Regular, full-time employee and must not have been the subject of disciplinary action due to attendance in the preceding two (2) years. The recipient must have had a minimum of seventy-five (75) hours of combined sick and annual leave time available at the beginning of the illness or injury. Recipients must exhaust all annual and sick leave; and they must request, be approved for, and use advanced sick leave before participating in the catastrophic leave program. The recipient employee may not compensate the donor employee for time donated. The maximum request for leave from the catastrophic leave program may not be more than thirty (30) days requested in a rolling twelve-month period. In any pay period, recipients may use donated hours only up to 67% of their normal scheduled work hours.

Military Leave

Employees are entitled to such leave of absence and reinstatement upon return from leave of absence for military service (including Reserve and National Guard duty) as may be provided by applicable state and federal law. The provisions of such laws change from time to time, and for that reason no effort is made to set forth the law in this policy.

Jury Duty

Employees who work in Regular, full-time positions are entitled to a paid leave of absence for their regular rate of pay on all work days during which they are required to appear in any court to serve as jurors.

An employee receiving notice of a call for jury duty should immediately notify his/her supervisor. The employee must provide the supervisor with all pertinent information, including a copy of the official notification of selection for duty.

If jury duty extends for less than half the daily scheduled work period, the employee is required to report for work at the conclusion of jury duty, unless departmental directives specify otherwise. If jury duty is required for more than half the scheduled daily work period, the employee is not required to report for work on that day.

To receive paid jury duty leave, the employee must turn in to the Finance Department any compensation received for serving on a jury (excluding mileage). That is, an employee eligible for paid jury duty leave may receive either his/her regular rate of pay for days served on jury duty or the juror fees/allowances paid by the court for his/her jury service, but not both.

Bereavement Leave

An employee working in a Regular, full-time position will be paid for time actually lost from straight-time scheduled work up to 3 days of funeral leave due to attendance at the funeral of a member of his/her immediate family, which is defined as spouse, parent, child, grandparent, grandchild, brother, sister, parent-in-law, grandparent-in-law, brother-in-law, or sister-in-law. The immediate family will be considered to include step-parents, step-children, and step-brothers and step-sisters only when the employee and the deceased had lived together regularly in the same household at or prior to the time of death. The County requires proof of relationship and attendance at the funeral by requiring an obituary or documentation from the funeral home that states the relationship of the deceased to the employee.

Employees may be excused from work to attend the funerals of other family members and, upon request, may be paid for such absences from accrued annual leave balances.

Disability and Personal Leave

Leave for Employees Employed Less Than 12 Months; for Employees Who Have Worked Fewer Than 1250 Hours in Preceding 12 Months; and for Employees with Reasons for Leave Are Not Covered by the Family and Medical Leave Act

An employee who has completed his/her initial probation (and any extension thereof) may request a leave of absence for up to 6 months when unable to work because of sickness, pregnancy, or injury on or off the job. Such an employee may also apply for leave of absence for personal reasons. Personal leaves are granted only at the discretion of the County Administrator upon recommendation by the employee's Department Head and/or the Human Resources Department.

Employees are requested to apply for leaves of absence as far in advance of need as is possible, but an employee may be placed on leave status without application when the circumstances warrant such action.

Disability leave begins on the first day of absence.

After the employee has exhausted any annual and/or sick leave, as a general rule, an employee on leave of absence is not entitled to wages or fringe benefits and does not accrue fringe benefits. Certain exceptions may be established by law.

Employees on leave of absence may not engage in other employment.

Employees desiring to return to work from an unpaid leave of absence should notify their supervisor in writing at least 5 days prior to their desired return date. If the County finds that the employee is fit to resume his/her duties, the employee may be recalled to his/her former job if a vacancy exists which is to be filled. If no such vacancy exists, the employee may be recalled to any job in which there is a vacancy and for which he/she is qualified. If no such vacancy exists at the time the employee desires to return to work, the employee's leave of absence may be continued. Any employee who has not been reinstated within six (6) months following the commencement of a leave of absence is terminated. This action does not affect the employee's eligibility to be considered for hire as a new employee at some future time.

Disability and Personal Leave

Family & Medical Leave Act – (Applies Only to Employees Who Have Been Employed 12 Months or Longer and Who Have Worked 1250 Hours or More in the Preceding 12 Months— Both Prior to Commencement of Leave)

Employees who meet the length of service and hours worked requirement described above have rights under the Family and Medical Leave Act. As a general rule, employees must request leaves of absence under this law and policy; but in appropriate situations, employees may be placed on leave status without application.

Reason for Leave of Absence
An eligible employee will be granted a leave of absence under this law and policy if a serious health condition, including disability resulting from an on-the-job injury, prevents the employee from being able to perform his/her job; if the employee's spouse, child, or parent has a serious health condition and the employee must be absent from work in order to care for that relative; or to care for a natural child, adopted child, or formally placed foster child, provided that entitlement to leave to care for a child who is newly born or newly received into the employee's household will end 12 months after a natural child is born or 12 months after an adopted or foster child is received into the employee's household. **Proof of need for leave of absence may be required.**

Length of Leave
An eligible employee is entitled to the equivalent of a total of 12 work weeks of leave during any 12 consecutive months. The County uses a “rolling” twelve months for determining leave availability. Leave to care for a newly born or newly received child must be taken consecutively. Leave required because of the employee's own serious health condition or that of a spouse, child, or parent may be taken intermittently or by means of a modified work schedule when necessary.

Effect of Leave on Paid Time Off
An employee who must be absent due to his/her own serious health condition or that of a parent, spouse, or child will be paid for time lost from work first from accrued sick leave balances and then from accrued annual leave balances and similar balances. An employee who takes leave for any other reason will be paid for time lost from work from his/her annual leave balance. Leave taken under this policy counts towards the employee’s 12 weeks of leave regardless of whether all or part of the employee’s leave is paid.

FMLA time will run concurrently with the employee’s accrued sick and/or annual leave, as well as any advanced sick leave or any leave pool time paid to the employee during the FMLA leave.

Effect of Leave on Accrual of Fringe Benefits
Employees taking leave under this policy must continue to pay their portion of health benefit plan premiums on the same date that such portion of premiums would be deducted from the employees’ wages.

Unpaid time lost from work due to leave granted under this policy is not considered time worked for the purpose of accrual of paid time off.

Employee Responsibility
Employees who request leave under this policy must give 30 days advance notice or such lesser amount of notice as is possible in the particular circumstances.

Employees may not engage in other employment while on leave of absence.

Modified Light Duty
Employees who accept a modified light duty assignment because of a condition which qualifies them for FMLA leave have a right to restoration to their regular positions for only 12 weeks counting both FMLA leave and time spent on modified light duty.

Termination of Leave of Absence
A leave of absence under this policy ends when the need for the leave of absence ends or when the maximum leave described above has been taken, whichever occurs sooner.

Reinstatement
At or before the conclusion of the FMLA leave of absence (or 12-week combination of leave of absence and time spent on light duty), the employee is entitled to reinstatement to his/her former position or to a position equivalent to his/her former position. The employee must demonstrate that s/he is fit for duty and must give reasonable notice of intent to return to work. Key Employees as defined by the FMLA (salaried employee in highest paid 10% of all employees) may be denied reinstatement rights if reinstatement would cause substantial and grievous economic injury to operations.

Extension of Leave Without Benefits
Employees who have exhausted their FMLA leave under other circumstances, but who continue to require leave which would qualify for FMLA leave if such leave had not been exhausted, may apply for a Leave of Absence without Pay. Such extended leaves are granted only at the discretion of the County Administrator upon recommendation of the employee's Department Head.

Automatic Termination of Employment
Employment automatically terminates if an employee does not return to full active employment status at the conclusion of his/her leave of absence or extended leave of absence.

Special Situations
When both spouses are employed by Richland County, their combined right to a leave of absence to care for a child or parent is 12 weeks in a 12-month period.

Development & Services Committee Meeting
October 24, 2017
Briefing Document

Agenda Item
EMS Department

Background
During its September 12, 2017 Council meeting, Councilman Rose brought forth the following motion:

> Move to examine the EMS Department and receive a report on its current status [Rose]

This item was forwarded to the Development and Services Committee for review. During the September 26, 2017 Development and Services Committee deliberations, Councilmembers raised several questions regarding this motion and forwarded the following questions to staff for responses.

1. Positions-How many unfilled? – Why?
2. How many ambulances are currently running vs. DHEC suggests should be running?
3. Supplies- How do we:
    a. Inventory/Maintaining proper inventory so we don't run out?
    b. Do we have the latest technology? i.e."Thumper"?
4. Communication
    a. Avenues for complaints
    b. Communication from "higher-ups" to dept employees?
5. What are the Dept.'s needs at this time?
    a. How are we addressing?
6. How modern is Richland County's "medical care protocol"?
   When was:
    a. Last time updated?
    b. How does RC medical care protocol compare to neighboring Counties?
7. What are ways to improve dept. morale if morale is low?
    a. Addressing concerns but also maybe outside functions?
8. How many employees have left Richland County EMS in last two years?

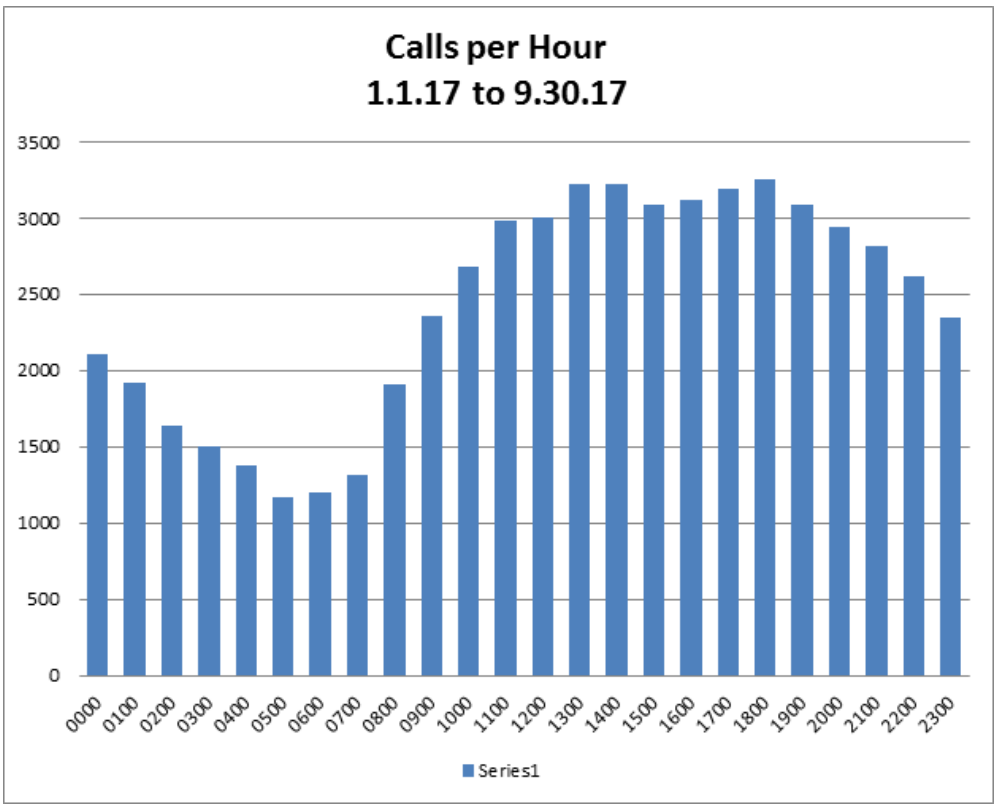
Responses to those questions are listed below:

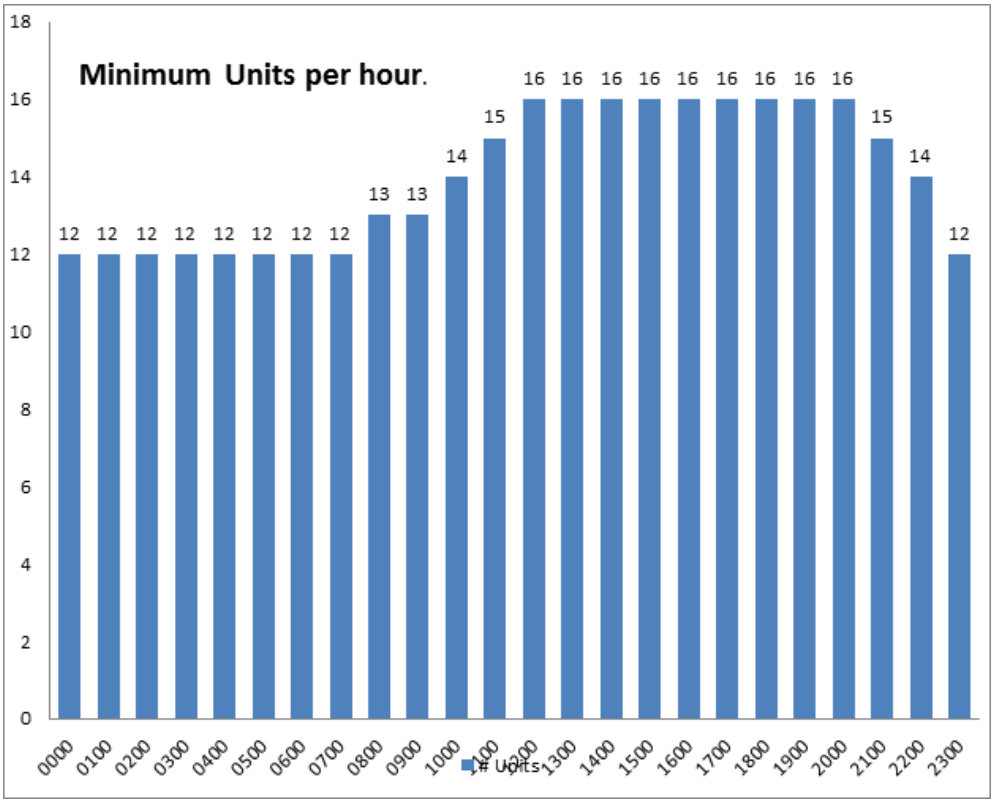
1. **Positions - How many unfilled - Why?** As of 10/16/17, EMS has 10 applicants scheduled to attend New Employee Orientation. This will give us 186 of the 187 authorized employees. In addition, Administration has given EMS eight additional positions that can be filled with Paramedics/EMT's. Even though we are close to being full, we need additional paramedics to meet the challenges of the call volume and work load.

Why ? There is a state-wide shortage of Paramedics. In order to attract and retain Paramedics we must have more positions to reduce the work load per crew, and increase salaries. Of the 13 new employees scheduled to start three of those are paramedics.

2. **How many ambulances are currently running versus what DHEC suggests should be running?** The "rules and regulations" outlining EMS requirements in South Carolina is DHEC's Regulation 61-7. (A copy is attached) There are NO DHEC requirements for staffing a specific number of response ambulances. Due to being under-staffed for the high volume of EMS calls, EMS uses a system status management approach to decrease response times. The system uses historical data to project call volumes in specific areas. Ambulance crews cross-cover those areas to minimize response times as much as possible. EMS deploys as many staffed ambulances as possible with existing employees during "peak call times."

   The first chart below illustrates the average call volume per hour. The second chart illustrates the minimum number of staffed ambulances by hour. More staffed ambulances are in-service during "peak times." Employees on vacation leave, sick leave and injured employees, influence daily staffing. Ideally, more than the minimum number is desirable and numbers above the minimum are often achieved. Employees on overtime are used to meet the minimum if needed. If you overlap the two charts you can see that more ambulances are in-service during peak times.





3. **Supplies - How do we:**

   A. Inventory/Maintaining proper inventory so we don't run out?

   The cost of equipment, supplies and medications have increased and many have tripled in cost. Also, national backorders of some supplies and medications create issues. Over the last 14 months, changes have been made to streamline the equipment and supply process. The equipment and supply staff maintain real time inventory measurements and threshold levels for supplies based on historical usage data. All items are reordered at such time that the available on-hand inventory is 90 days. Barring any backorders, EMS will have at least 90 days of inventory. Threshold levels are continually monitored and reevaluated for accuracy and any trends of higher usage or seasonal peaks in usage are noted. Several improvements have been made. Expansion of secured supply storage capacity has been made through the installation of a large storage cage. Staff recently implemented a real-time inventory system. A new distribution system with designated shift supply clerks shortens restocking time. Installation of two dispensing machines (similar to vending machines) provides access to supplies and provides real time inventory data. Ongoing evaluation of what equipment is needed (over the required DHEC equipment) and how equipment and supplies are carried on ambulances is underway. Through improved fiscal management, staff will ensure these expenses are adequately funded.

   B. Do we have the latest technology? i.e. Thumper.

   Richland County EMS utilizes FDA approved equipment that far exceeds the minimum equipment required by DHEC in an effort to provide superior patient care. While new technology is constantly emerging, not all new items provide a measurable difference in

patient outcomes. EMS recently held a series of meetings for staff to provide insight on their equipment recommendations. The EMS equipment and supply staff, in conjunction with stakeholders and our Medical Control Physicians, routinely evaluate newer technology(s) and strive to remain current when the decision to implement new technology is supported by data.

The Thumper was a major innovation introduced in the 1970's with many improvements over the years. Some mechanical CPR devices have limitations. All devices are currently being reviewed as well as available product data and existing research. The Thumper fits larger patients and does not rely on batteries. So far there is no indication that one mechanical CPR device is better that any other. However, the evaluation is continuing. The cost to replace Thumpers is estimated to be $2,000,000. Updating equipment is often costly because of the number of units we must purchase to equip all vehicles.

4. Communication – Want to know:

A. Avenue for complaints?

Complaints are handled using the chain-of-command and are coordinated by the EMS Division Manager and Assistant Director for EMS. Anyone can implement a medical call review under the EMS Quality Assurance program. Those are reviewed by the Division Manager for EMS, Assistant Director for EMS, the EMS Training Coordinator and Medical Control Physicians. Issues requiring further action are reviewed with the Director. Outside complaints are handled by the EMS Division Manager, Assistant Director, Communications Manager, Training coordinator or others, as appropriate.

All complaints from patients or families are directed to the EMS Division Manager who does a review and responds to the complainant. Complaints from employees can be made in person, by email, or by Administrative Memo through Aladtec. The EMS Division Manager reviews complaints and responds appropriately.

B. Communications with higher ups.

Communication occurs through E-mail, memos, phone calls, meetings and in person one-on-one. Each month, the Director, Command staff and support staff attend each EMS in-service training meeting. All EMS employees must attend one of the meetings. The Director provides information and answers questions. Any EMS employee can ask questions, make comments or voice concerns. The Director and command staff meet with employees whenever they request a meeting or there is an issue that needs to be addressed. Medical Control Physicians are available for meetings or to answer questions. A new software system has been installed so that each EMS employee can communicate directly over their smart phone. Text and e-mail is used to distribute information. Memos and important information are posted in hardcopy. EMS employees can direct questions or messages to specific managers confidentially. All managers are available for employee meetings. Recently, the County Administrator has been meeting with EMS staff to discuss concerns and corrective actions.

5. What are the Department needs?

- Because of the call volume and work load, in order to attract and retain Paramedics we need to make improvements.
- An additional 24 new employees need to be added each year, for the next three years, to decrease the work load per crew. After year three, additional personnel should be added annually to compensate for the yearly increase in call volume and work load.
- Improvement of the total compensation package provided to employees.
- Improvement of internal processes to streamline operations. This effort is ongoing.
- Improvement fiscal management related to the capital improvement and equipment replacement plan. The review of the county's capital improvement plan is ongoing.
- Improved mental health referral program (other than the EAP) designed for EMS workers.
- Improve personal protective equipment.
- ESD facility and space needs assessment.
- Decrease the time it takes to receive an application, interview, obtain background checks, received authorization to hire and schedule into a New Employee Orientation (NEO) session.

A. How are we addressing?

- Improvement plans are being drafted. We have advertised locally and nationally for Paramedics.
- Recently, the County initiated a 5% salary increase for incumbents and a 10% increase in starting pay. Additionally, the compensation and class study is ongoing. EMS management and the County Administrator's Office are reviewing a number of other actions to facilitate improvement, including "gap" pay, "shift differential" pay, "stand-by" pay and "signing bonus" paid over the first year of employment, and tuition reimbursement.
- Continue to refine internal operations to improve the equipment and supply function.
- ESD will begin training employees to reactivate a Critical Incident Stress Debriefing Team.
- Conducting space needs assessment for ESD
- Implementation of employee committees meet to make recommendations for uniforms, equipment and other topics is ongoing.
- Council recently voted to absorb the dependent insurance increase.
- Fast tracking EMS applications, interviews, background check, drug screen has been initiated via requests by EMS NEO as needed.

6. How modern is Richland County's "medical care protocol?"

EMS medical protocols are written in accordance with current DHEC, ACLS and other standards.

A. Last time updated?

May 1, 2017

B. How does RC medical care protocol compare to neighboring Counties?

All counties are different. Our protocols are based upon the recommended SC DHEC State Protocols and are adapted to specifically recognize our "medical community standards." Richland County patients can be transported to seven different area hospitals including the Level One

Trauma Center and three STEMI centers. While we have some parts of the county 45 minutes away from a hospital, overall patient transport times to the hospital are short compared to counties with one hospital or none at all. Protocols are designed by the medical control physicians to meet patient care needs during treatment and transport, state protocol guidelines and the state drug formulary. It is significant that our protocols are quite progressive in comparison to current EMS Scope of Practice. Richland County EMS Protocols:

- Have 25 medications within our formulary
- Allow for Off-Line administration of pain control.
- Allow for Selective Spinal Motion restriction and clearance of spinal precaution when indicated
- Contain the current Tactical Emergency Casualty Care guidelines
- Are compliant with the most current American Heart Association guidelines including field termination of CPR in certain cases.
- Compliant with current trauma guidelines.

It is difficult to compare specific elements of one 911 service against another in that many variables must be considered to make an accurate comparison. For example, an agency's protocols are built upon many factors to include average transport time, call volume, system structure, and proximity to receiving hospitals and their relative capabilities. While there may be different protocols, medications, and equipment used in surrounding counties, Richland County's protocols meet the requirements of the medical community standards. Our Paramedics have the equipment needed to provide patient care and we are currently planning to obtain additional equipment and upgrade technology as funding is available.

7. **What are ways to improve dept. morale if morale is low?**
    - Providing a competitive total compensation package (e.g., wages, insurance, work environment, training, incentives)
    - Increase staffing level to reduce the work loads.
    - Implement initiatives to increase equipment and supply levels.
    - Create an employee mental health referral program for Paramedics and EMT's.
    - Address space and facility needs of ESD.
    - Employee recognition programs.
    - Continue to engage employees.

    A. Addressing concerns but also maybe outside functions?

    County Administration is planning ways to recognize all county employees through outside events. EMS will also be exploring ways to organize events to recognize employees.

8. **How many employees have left Richland County EMS in the last two years?**
    A total of 83 employees have resigned over the last two years - 44 EMT's and 39 Paramedics.
    A total of 91 employees have been hired over the last two years – 72 EMT's and 19 Paramedics.

9. **Why with the continuous posting of these jobs (Paramedic and EMT) have these jobs not been filled?** The postings continue because we always have openings. Each application is pre-screened to make sure they meet the minimum qualifications. Applicants are notified their application has

been received and is pending. Those applicants meeting the minimum qualifications will be interviewed in the order they are received. Applicants with issues meeting the certification requirements, driving record or background, will be disqualified. If an applicant meets the minimum qualification and is not hired, their application will remain on file if they so desire. In the previous system, paper applications were used. The current electronic application process improves the ability to track applications through the system. EMS has advertised locally and nationally for Paramedics with some success. However, when the work load is high and the pay is below other EMS services, Paramedics may take positions with other agencies. Also, the length of time it takes to interview, drug test, get the background complete and schedule the applicant into a New Employee Orientation session (offered twice a month) may take up to four weeks. Often, applicants take another position while they are waiting.

Issues

Status of Emergency Services Department

Fiscal Impact

The fiscal impact will be determined by any action Council takes on these issues.

Administration has proposed allocating $2.5 million from unspent bond funds for equipment. That item is pending 3rd reading approval from Council. The cost of EMS strategic initiatives will be addressed by the County Administrator through improved fiscal management..

Past Legislative Actions

There have been no past legislative actions.

Alternatives

1. Consider this motion and proceed accordingly.
2. Consider this motion and do not proceed accordingly.

Staff Recommendation

Council discretion as this is a Councilmember sponsored motion.

Submitted by: Councilman Seth Rose, District 5

Date: September 12, 2017

REGULATION NUMBER 61-7
EMERGENCY MEDICAL SERVICES

Effective June 24, 2016
(This regulation replaces and supersedes any former regulations)

Bureau of Emergency Medical Services and Trauma
S.C. Department of Health and Environmental Control
2600 Bull Street
Columbia, SC 29201

D H E C
PROMOTE PROTECT PROSPER
South Carolina Department of Health
and Environmental Control

DISCLAIMER

This copy of the regulation is provided by DHEC for the convenience of the public. Every effort has been made to ensure its accuracy; however, DHEC reserves the right to withdraw or correct this text if deviations from the official text, as published in the S.C. State Register, are found.

PROMULGATION HISTORY

This Regulation was promulgated pursuant to 1976 S.C. Code Sections 44-61-30 and 44-78-65.

June 24, 2016 - R.61-7, Emergency Medical Services, was amended by Document 4610 in State Register Volume 40 Issue 6 effective June 24, 2016. This amendment supersedes and replaces in entirety all former versions of this Regulation.

R.61-7. EMERGENCY MEDICAL SERVICES

Statutory Authority: 1976 Code Sections 44-61-30 and 44-78-65

TABLE OF CONTENTS

SECTION 100.

SCOPE AND PURPOSE

Section 101. Scope of Act 1118 of 1974 as amended.

A. Establishment of EMS program.

B. General licensing, certification, inspection and training procedures.

C. Establishment of an Emergency Medical Service Council and duties of the Council.

D. Establishment of the Department of Health and Environmental Control authority for enforcement of these rules and regulations.

SECTION 200.

DEFINITIONS

A. Advanced Life Support (ALS): An advanced level of prehospital, interhospital, and emergency service care which includes but is not limited to the treatment of life-threatening medical emergencies through the use of techniques such as endotracheal intubation, administration of medications or intravenous fluids, cardiac monitoring, and electrical therapy by a qualified person pursuant to these regulations.

B. Advanced Life Support Service: A service provider that in addition to basic life support minimum standard, provides at least two (2) EMTs, one of which is a Paramedic and demonstrates the capability to provide IV therapy, advanced airway care, approved medication therapy, cardiac monitoring and defibrillation capability.

C. Air ambulance: Any aircraft that is intended to be used for and is maintained or operated for transportation of persons who are sick, injured or otherwise incapacitated.

1. Fixed Wing: Any aircraft that uses fixed wings to allow it to take off and fly.

2. Rotorcraft: A helicopter or other aircraft that uses a rotary blade to allow vertical and horizontal flight without the use of wings.

D. Basic Life Support Service: A service provider that meets all criteria for basic life support minimum standard and is able to provide one EMT to one hundred percent (100%) of all calls and the ability to provide blind insertion airway devices (BIADs) and defibrillation capability.

E. Commission on Accreditation of Allied Health Education Programs (CAAHEP): A programmatic accreditor in the health sciences field. In collaboration with its Committees on Accreditation, CAAHEP reviews and accredits educational programs in health science occupations.

F. Committee on Accreditation of Educational Programs for the Emergency Medical Service Professionals (CoAEMSP): The national accreditation organization specific to Paramedic education programs. Paramedic education programs must have CoAEMSP accreditation or a letter of review from CoAEMSP in order for their students to qualify for the National Registry examination.

G. Condition Requiring an Emergency Response: The sudden onset of a medical condition manifested by symptoms of such sufficient severity, including severe pain, which a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect without medical attention, to result in:

1. Serious illness or disability;

2. Impairment of a bodily function;

3. Dysfunction of the body; or

4. Prolonged pain, psychiatric disturbance, or symptoms of withdrawal.

H. Continuing Education: An educational program designed to update the knowledge and skills of its participants by attending conventions, seminars, workshops, educational classes, labs, symposiums, and the like. Points toward recertification may be awarded for successful completion of approved activities.

I. Credentialing Information System (CIS): Database managed by EMS Performance Improvement Center (EMSPIC) which tracks EMS information and data such as certifications, licenses, permits, and inspections.

J. Driver: In the EMS context, the vehicle operator of an ambulance. This person may be a certified EMT of any level or an uncertified individual who meets the minimum requirements as a driver by this regulation in Section 403.

K. Electronic Patient Care Reports (ePCR): Patient care reports authored and submitted electronically into PreMIS which is compliant with the National EMS Information System (NEMSIS).

L. Emergency: For the purposes of this regulation, an emergency is an acute situation in which a prudent layperson has identified a potential medical threat to life or limb such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of bodily organs.

M. Emergency Transport: Services and transportation provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity, including severe pain, that the absence of medical attention could reasonably be expected to result in the following:

1. Placing the patient's health in serious jeopardy;

2. Causing serious impairment of bodily functions or serious dysfunction of bodily organ or part; or

3. A situation resulting from an accident, injury, acute illness, unconsciousness, or shock, for example, requiring oxygen or other emergency treatment, or requiring the patient to remain immobile.

N. EMT: Emergency Medical Technician. When used in general terms for emergency medical personnel, an individual possessing a valid EMT, Advanced EMT (AEMT), or Paramedic certificate issued by the State of South Carolina pursuant to the provisions of this regulation and applicable governing statute.

1. Emergency Medical Technician (EMT): Formerly called an "EMT-Basic," this nationally credentialed level of prehospital emergency medical providers is a person who is specially trained and certified to administer basic emergency services to victims of trauma or acute illness before and during transportation to a hospital or other healthcare facility.

2. Emergency Medical Technician – Intermediate (EMT-I): A nationally credentialed mid-level of prehospital emergency medical providers. The EMT-I is intended to deliver augmented prehospital critical care and provide rapid on-scene treatment, working in conjunction with EMTs and Paramedics. The EMT-I is authorized to provide more advanced medical treatment than the EMT. According to the NREMT, after March 31, 2017, EMT-I certifications are being replaced by the Advanced Emergency Medical Technician (AEMT) credential with a greater scope of practice than the EMT-I.

3. Advanced Emergency Medical Technician (AEMT): A nationally credentialed mid-level of prehospital emergency medical providers. The AEMT is intended to deliver augmented prehospital critical care and provide rapid on-scene treatment, working in conjunction with EMTs and Paramedics. The AEMT is authorized to provide more advanced medical treatment than the EMT.

4. Paramedic: The highest nationally credentialed level of prehospital emergency medical providers. The Paramedic is intended to provide leadership and to deliver prehospital emergency care and provide rapid on-scene treatment. The Paramedic is authorized to provide the highest level of prehospital care in accordance with standards set by the Department.

O. EMT Rapid Responder Agency: Formerly known as "EMT First Responder Service," a licensed agency providing medical care at the EMT level or above as a nontransporting rapid responder.

P. FAA: Federal Aviation Administration. The agency of the federal government that governs aircraft design, operations, and personnel requirements.

Q. Flight Nurse: A licensed registered nurse who is trained in all aspects of emergency care who has been so designated by the Department.

R. Ground Ambulance: A vehicle maintained or operated by a licensed provider who has obtained the necessary permits and licenses for the transportation of persons who are sick, injured, wounded, or otherwise incapacitated. Ambulances provide both emergent and non-emergent transport.

1. Special purpose ambulance: An ambulance equipped and designated to transport by medical necessity only patients in need of specific specialized types of care and staffed by appropriate specialty care attendant(s). Examples may include special purpose ambulances such as neonatal units, and critical care ambulances.

S. HIPAA: Health Insurance Portability and Accountability Act of 1996.

T. Intermediate Life Support Service: A service provider that, in addition to basic life support minimum standard, provides at least two (2) EMTs, one of which is an EMT-I, AEMT or Paramedic and demonstrates the capability to provide IV therapy, blind insertion airway devices (BIADs), and defibrillation capability.

U. Joint Policy Statement on Equipment for Ground Ambulances (JPS): National document drafted and published on January 1, 2014, by the American Academy of Pediatrics, American College of Emergency Physicians, American College of Surgeons Committee on Trauma, Emergency Medical Services for Children, Emergency Nurses Association, National Association of EMS Physicians, and the National Association of State EMS Officials to serve as a referenced standard for equipment needs of emergency ground ambulance services in the United States.

V. Medical Control: Medical Control is usually provided by a licensed agency's physician who is responsible for the care of the patient by the provider's medical attendants. Actual medical control may be direct by two-way voice communications (on-line) or indirect by standing orders or protocols (off-line) control.

1. Off-Line Medical Control Physician: A provider's Medical Control Physician who actually takes responsibility for treatment of patients in the prehospital setting by standing orders, protocols, or patient care guidelines.

2. On-Line Medical Control Physician: The physician who directly communicates with EMTs regarding appropriate patient care procedures en-route or on-scene. An on-line Medical Control Physician must be available for all EMTs performing procedures designated by the Department.

W. Moral Turpitude: Behavior that is not in conformity with and is considered deviant by societal standards.

X. National Emergency Services Information System (NEMSIS): NEMSIS is the national repository of EMS data that is collected from across the United States. The data is used to define EMS and prehospital care, improve patient care, determine the national standard of care, and help design EMS curriculum.

Y. National Registry of Emergency Medical Technicians (NREMT): A national certification agency which establishes uniform standards for training and examination of personnel active in the delivery of prehospital emergency care. Individuals possessing a valid NREMT certification have successfully demonstrated competencies in their level of prehospital provider.

Z. Nonemergency Transport: Services and transportation provided to a patient whose condition is considered stable. A stable patient is one whose condition by caregiver consensus can reasonably be expected to remain the same throughout the transport and for whom none of the criteria for emergency transport has been met. Prearranged transports scheduled at the convenience of the service, the patient, or medical facility will be classified as a nonemergency transport.

AA. Patient: A patient is defined as any person who meets any of the following criteria:

1. Receives basic or advanced medical or trauma treatment;

2. Is physically examined;

3. Has visible signs of injury or illness or has a medical complaint;

4. Requires EMS specific assistance to change locations and/or position;

5. Identified by any party as a possible patient because of some known, or reasonably suspected illness or injury;

6. Has a personal medical device evaluated or manipulated by EMS; or

7. Requests EMS assistance with the administration of personal medications or treatments.

BB. Prehospital Care: Assessment, stabilization, and care of a patient, including, but not limited to the transportation to an appropriate receiving facility.

CC. Prehospital Medical Information System (PreMIS): A state mandated internet based EMS information system that collects data on each EMS call report made within South Carolina.

DD. Revocation: The Department has permanently voided a license, permit, or certificate and the holder no longer may perform the function associated with the license, permit, or certificate. The Department will not reissue the license, permit, or certificate for a period of two (2) years for a license or permit and four (4) years for a certificate. At the end of this period, the holder may petition the Department for reinstatement.

EE. Special Purpose EMT: A state credentialed prehospital emergency medical provider. This person is a South Carolina licensed registered nurse (RN) or a Nurse Licensure Compact (NLC) State RN who works in a critical care hospital setting such as neonatology, pediatrics, or cardiac care. These Special Purpose EMTs provide a continuance of critical care during transport while aboard special purpose ambulances permitted by the State and equipped for their specialty area.

FF. Specialty Care: Advanced care skills provided by an appropriately credentialed attendant in their specific specialty area. These may include but are not limited to Paramedics, Special Purpose EMTs in their area of specialty, RNs, and respiratory therapists.

GG. "Star of Life": A six (6) barred blue cross outlined with a white border of which all angles are sixty (60) degrees and upon which is superimposed the staff of Aesculapius in white. This is a registered trademark of the U.S. Department of Transportation.

HH. Suspension: The Department has temporarily voided a license, permit, or certificate and the holder may not perform the function associated with the license, permit, or certificate until the holder has complied with the statutory requirements and other conditions imposed by the Department.

II. The Department: The administrative agency known as the South Carolina Department of Health and Environmental Control.

JJ. Vocational School: Also called a trade school, is a higher-level learning institution that specializes in providing students with the vocational education and technical skills they need in order to perform the tasks of a particular job.

KK. Volunteer EMS Provider: A not-for-profit EMS provider which serves its local community with emergency medical service coverage at any level and is staffed by at least ninety percent (90%)

non-paid staff. For the purpose of this regulation, token stipends received by volunteer EMS providers are not considered paid remuneration or a primary wage.

SECTION 300.

ENFORCING REGULATIONS

Section 301. General.

A. The Department shall utilize inspections, investigations, consultations, and other pertinent documentation regarding an EMT, training facility, instructor, Medical Control Physician, or provider in order to enforce these regulations.

B. The Department reserves the right to make exceptions to these regulations where it is determined that the health and welfare of those being served would be compromised.

Section 302. Inspections and Investigations.

A. An inspection shall be conducted prior to initial licensing of a provider and subsequent inspections conducted as deemed appropriate by the Department.

B. All providers, permitted vehicles, equipment used for rapid response by licensed agencies, EMTs, training facilities, and instructors are subject to inspection or investigation at any time without prior notice by individuals authorized by the Department.

C. Individuals authorized by the Department shall be granted access to all properties and areas, objects, equipment, and records, and have the authority to require that entity to make photo and/or electronic copies of those documents required in the course of inspections or investigations. These copies shall be used for purposes of enforcement of regulations and confidentiality shall be maintained except to verify the identity of individuals in enforcement action proceedings.

Section 303. Enforcement Actions.

When the Department determines that an EMT, provider, instructor, or training facility is in violation of any statutory provision, rule, or regulation relating to the duties therein, the Department may, upon proper notice to that entity, impose a monetary penalty and/or deny, suspend, and/or revoke its certification, license, or authorization or take other actions deemed appropriate by the Department. The schedule of fines and monetary penalties is noted in Section 1501.

Section 304. Violation Classifications.

Violations of standards in this regulation are classified as follows:

A. Class I violations are those that the Department determines to present an imminent danger to the health, safety, or well-being of the persons being served, other employees, or the general public; or a substantial probability that death or serious physical harm could result therefrom. A physical condition or one or more practices, means, methods, operations, or lack thereof may constitute such a violation. Each day such violation exists may be considered a subsequent violation.

B. Class II violations are those other than Class I violations the Department determines to have a negative impact on the health, safety or well-being of those being served, other employees, or the

general public. A physical condition or one or more practices, means, methods, operations, or lack thereof may constitute such a violation. Each day such violation exists may be considered a subsequent violation.

C. Class III violations are those that are not classified as Class I or II in these regulations or those that are against the best practices as interpreted by the Department. A physical condition or one or more practices, means, methods, operations, or lack thereof may constitute such a violation. Each day such violation exists may be considered a subsequent violation.

D. Class IV violations are those that are specific to vehicle reinspection failures. These violations can escalate based on frequency and point value accrued per deficiency identified in the vehicle inspections conducted by the Department.

E. The notations "(I)" or "(II)", placed within sections of this regulation, indicate that those standards are considered Class I or II violations, if they are not met, respectively. Standards not so annotated are considered Class III violations. Class IV violations are specific to vehicle reinspections which may escalate to Class III violations.

F. In arriving at a decision to take enforcement actions, the Department shall consider the following factors: specific conditions and their impact or potential impact on the health, safety, or well-being of those being served, other employees and the general public, efforts by the EMT, provider, training facility or instructor to correct cited violations; behavior of the entity in violation that reflects negatively on that entity's character, such as illegal or illicit activities; overall conditions; history of compliance; and any other pertinent factors that may be applicable to current statutes and regulations.

G. A schedule of all monetary penalties is delineated in Section 1501.

H. Any enforcement action taken by the Department may be appealed pursuant to the Administrative Procedures Act beginning with S.C. Code Section 1-23-310.

SECTION 400.

LICENSING PROCEDURES

Section 401. Application.

A. Application for license shall be made to the Department by private firms, public entities, volunteer groups or non-federal governmental agencies. The application shall be made upon forms in accordance with procedures established by the Department and shall contain the following:

1. The name and address of the owner of the licensed provider or proposed licensed provider;

2. The name under which the applicant is doing business or proposes to do business;

3. A copy of the licensed provider or proposed licensed provider's business license (if applicable) for the location of the service;

4. A description of each ambulance, and/or rapid response vehicle, including the make, Vehicle Identification Number (VIN), model, year of manufacture or other distinguishing characteristics to be used to designate applicant's vehicle;

5. The location and description of the place or places from which the licensed provider is intended to operate. The Department shall be notified within five (5) working days of any expansion or contraction of the service, level of care (upgrade or downgrade), or if the headquarters, director or any substation locations are changed;

6. Personnel roster representing all employees, volunteers, and affiliates associated with the service including but not limited to EMTs, non-certified drivers (if applicable), pilots, RNs, certification numbers and expiration dates of their South Carolina and NREMT credentials (if applicable);

7. Type of license applied for;

8. Name, email address, and phone number of Medical Control Physician;

9. Name, email address, and phone number of the following, if applicable;

a. EMS Director;

b. EMS Assistant Director;

c. Training Officer;

d. Data Manager; and

e. Infection Control Officer.

10. Number of vehicles and level of service provided from each fixed station location;

11. Insurance information, to include name of insurance company, agent, phone number and type of coverage. A copy of insurance policy(ies) shall be furnished to the Department upon request. The minimum limits of coverage shall be six hundred thousand dollars ($600,000) liability and three hundred thousand dollars ($300,000) malpractice per occurrence.

12. A copy of the EMS Non-dispensing Drug Permit from the South Carolina Board of Pharmacy. If out-of-state provider, the respective home state equivalent;

13. A copy of the agency's current Drug Enforcement Agency license (both South Carolina and federal), when applicable. If out-of-state provider, the respective home state equivalent;

14. A copy of the agency's Clinical Laboratory Improvement Act (CLIA) waiver from the Centers for Medicare & Medicaid Services (CMS) if agency is providing field laboratory testing such as blood glucose readings or cardiac markers; and

15. Such other information as the Department shall deem reasonable and necessary to make a determination of compliance with this regulation.

B. The Department shall issue a license valid for a period of two (2) years when it is determined that all the requirements of this regulation have been met. If disapproved, the applicant may appeal in a manner pursuant to the Administrative Procedures Act beginning with S.C. Code Section 1-23-310.

C. Subsequent to issuance of any license, the Department shall cause to be inspected each licensed provider (vehicles, equipment, personnel, records, premises, and operational procedures) whenever that service is initially licensed. Thereafter, services will be inspected by the Department on a random basis. These random inspections may be conducted dependent upon past compliance history. The schedule of fines and monetary penalties is noted in Section 1501.

D. The Department is herein authorized pursuant to S.C. Code Section 44-61-70, to suspend or revoke a license so issued at any time it determines that the holder no longer meets the requirements prescribed for operating as a licensed provider.

E. Renewal of any license issued under the provision of this Act shall require conformance with all the requirements of this Act as upon original licensing.

F. The Department shall be notified within five (5) working days when changes of ownership of a licensed provider are impending or occur so that a new license may be issued.

G. Conditions which have not been covered in these regulations shall be handled in accordance with the standard practices as interpreted by the Department.

Section 402. Medical Control Physician. (I)

Each licensed provider that provides patient care shall retain a Medical Control Physician to maintain quality control of the care provided, whose functions include the following:

A. Quality assurance (QA) of patient care including development of protocols, standing orders, training, policies, and procedures; and approval of medications and techniques permitted for field use by direct observation, field instruction, in-service training (IST) or other means including, but not limited to:

1. Patient care report review;

2. Review of field communications recordings;

3. Post-run interviews and case conferences; and

4. Investigation of complaints or incident reports.

B. The Medical Control Physician shall serve as medical authority for the licensed provider, to perform in liaison with the medical community, medical facilities, and governmental entities.

C. The Medical Control Physician shall have independent authority sufficient to oversee the quality of patient care for the agency.

D. Providers shall register their Medical Control Physician with the Department and provide a copy of their current standing orders and authorized medication list signed and dated by Medical Control Physician.

E. The Department must be notified of any change in Medical Control Physician, drug list, or standing orders within ten (10) days of the change.

F. The Medical Control Physician may withdraw at his or her discretion, the authorization for personnel to perform any or all patient care procedure(s) or responsibilities.

G. All initial Medical Control Physicians must attend a Medical Control Physician Workshop conducted by the Department within twelve (12) months of being designated Medical Control Physician. Failure to attend the above mentioned workshop will result in immediate dismissal from that position.

H. Medical Control Physicians shall complete Department mandated continuing education updates to maintain their status.

I. Medical Control Physicians may respond to scene calls to render care, function as medical providers, provide medical direction, and/or exercise their medical oversight authority.

J. Providers may have multiple Medical Control Physicians especially if they have multiple regional locations.

Section 403. Non-Credentialed Ambulance Operator or Driver. (II)

A. An ambulance driver shall:

1. Be at least eighteen (18) years old;

2. Be physically able to drive;

3. Possess a valid (non-disqualified) driver's license from South Carolina or home state of provider. In the event of suspension or revocation of the driver's license, the individual shall notify their agency and the agency must notify the Department;

4. Have a criminal background check required on initial hire and thereafter every four (4) years which meets the same requirements as certified EMS personnel as noted in Section 902.B; and

5. Display a picture ID in a manner visible to the public all times while on duty.

B. An ambulance driver shall complete a nationally accredited safety driving course, such as Certified Emergency Vehicle Operator (CEVO), specific to emergency vehicles within the first six (6) months of hire.

C. In emergencies that may require a third crew member, such as multiple casualty incidents (MCIs), disasters, or where immediate local EMS resources are taxed, an ambulance may, out of necessity, be driven to the hospital by a member of a fire department, law enforcement agency, or rescue squad. These out-of-necessity drivers are exempt from Section 403.A and B in this limited context.

D. Each EMS agency shall maintain its EMS drivers' records and submit those credentials upon its initial agency license application and bi-annual agency license renewal.

Section 404. Criteria for License Category Basic Life Support (Ambulance). (II)
(Minimum Standard):

A. Shall have ambulances that are permitted pursuant to these regulations.

B. Shall have no less than five (5) currently credentialed South Carolina EMTs associated with the provider.

C. Shall have staffing patterns, policy and procedure, and if necessary, mutual aid agreements to ensure that an ambulance is en route with at least one (1) EMT and one (1) driver onboard to all emergent responses within five (5) minutes or the next closest staffed ambulance must be dispatched, excluding prearranged transports. Volunteer Services (services not utilizing paid personnel) without onsite personnel must have staffing patterns, policy and procedures, and if necessary, mutual aid agreements to ensure that an ambulance is en route with at least one (1) EMT and one (1) driver onboard to all emergent calls within ten (10) minutes or have the closest staffed ambulance dispatched.

D. Vehicle operators or attendants shall not utilize emergency lights and sirens unless the service is responding to a patient with a condition requiring emergency response, as defined in Section 200.G. Vehicle operators or attendants shall not utilize emergency lights and sirens from a call unless the service is conducting an emergency transport, as defined in Section 200.L.

E. The provider must demonstrate sufficient equipping and staffing capability to ensure that basic life support consisting of at least automatic defibrillation (AED), basic airway management, obstetrical care, and basic trauma care are onboard the ambulance.

F. The Department will, upon request, be furnished with staffing patterns, policy and procedure, and mutual aid agreements that ensures compliance with the en route times noted in Section 404.C.

G. Industries that provide ambulance service or rapid medical response for their employees may exempt the minimum number of EMTs noted in Section 404.B, as long as they meet en route times and staffing requirements of the regulations.

H. The provider maintains accurate records that include, but are not limited to, approved patient care reports, employee / member rosters, time sheets, CIS rosters, call rosters, training records and dispatch logs that show at least the time call was received, the type of call, and the time the unit was en route. Such records shall be available for inspection by the Department with copies furnished upon request.

Section 405. Criteria for License Category – Intermediate Life Support: (Ambulance). (II)

A. To be categorized as an intermediate life support (ILS) provider, the provider must meet all criteria established for basic life support (BLS), minimum standard. Additionally, the provider must demonstrate sufficient equipping to ensure that life support consisting of at least IV therapy, blind insertion airway devices (BIADs), and defibrillation capability (either manual or by AED) are onboard the ambulance. The minimum staffing of an ILS ambulance shall consist of two (2) EMTs, one (1) of which must be an EMT-I, AEMT or Paramedic, at least ninety-five percent (95%) of the time. B. An ILS licensed provider may elect to participate in a tiered response system. The provider must have a process in place to identify the acuity of the incoming EMS request in order to properly triage the response and dispatch the appropriate level unit(s). Triaging calls may take place with assets such as Emergency Medical Dispatching (EMD) or other means that identifies whether the request is classified as an "ILS" or "BLS" level of response. BLS personnel may operate on an ILS equipped ambulance in the case where an ILS credentialed responder may intercept the unit. In the case where an ILS responder intercepts a BLS unit with a Quick Response

Vehicle (QRV), all equipment needed to raise the level of permitting to ILS must be transferred to the BLS unit prior to commencing patient transport.

Section 406. Criteria for License Category - Advanced Life Support: (Ambulance). (II)

A. To be categorized as an advanced life support (ALS) provider, the provider must meet all criteria established for basic life support, minimum standard. Additionally, the provider must demonstrate sufficient equipping to ensure that life support consisting of IV therapy, advanced airway care, cardiac monitoring, defibrillation capability and drug therapy, approved by the Department and the unit Medical Control Physician, are onboard the ambulance. The minimum staffing of an ALS ambulance shall consist of a minimum of two (2) EMTs, one (1) of which must be a Paramedic at least ninety-five percent (95%) of the time. B. An ALS licensed provider may elect to participate in a tiered response system. The provider must have a process in place to identify the acuity of the incoming EMS request in order to properly triage the response and dispatch the appropriate level unit(s). Triaging calls may take place with assets such as Emergency Medical Dispatching (EMD) or other means that identifies whether the request is classified as an "ALS" or "BLS" level of response. BLS personnel may operate on an ALS equipped ambulance in the case where an ALS credentialed responder may intercept the unit. In the case where an ALS responder intercepts a BLS unit with a QRV, all equipment needed to raise the level of permitting to ALS must be transferred to the BLS unit prior to commencing patient transport.

Section 407. Criteria for License Category - Special Purpose Ambulance Provider: (Ambulance). (II)

A. Have an approved vehicle that is in compliance with Section 200.R.1 and meets minimum equipment requirements, as delineated in Section 704.

B. Have a Medical Control Physician as delineated in Section 402.

C. Provide the Department with copies of policy and procedures for the operation of the special purpose ambulance.

D. Provide a list, approved by the Medical Control Physician, of special purpose equipment carried on the special purpose ambulance for review and approval by the Department.

E. Provide other license information delineated in Section 401.

F. Except during extenuating circumstances, special purpose ambulances shall be used for interfacility transports only.

Section 408. Advanced Life Support Information. (II)

A. Ambulance service providers professing to provide ALS level of care, whether licensed at the ALS level or not, must at all times transport an ALS patient in an ambulance which is fully equipped as an ALS unit, per these regulations, with a Paramedic, physician or RN, as delineated in these regulations, in the patient compartment.

B. The minimum staffing for any transport above the BLS level (for BLS licensed providers), shall be two (2) certified EMTs, one (1) of which must be an EMT-I, an AEMT, or a Paramedic one hundred percent (100%) of the time. A BLS licensed agency may only deviate from this staffing pattern when responding to a mutual aid call for service. At that time, the units must be staffed with

two (2) EMTs, one (1) of which must be a Paramedic ninety-five percent (95%) of the time for ALS responses.

Section 409. Advertising Level of Care. (II)

Ambulance service providers may not advertise that they provide a level of life support above the category for which they are licensed.

Section 410. Criteria for License Category - EMT Rapid Responder. (II)

A. Personnel assigned to Rapid Responder duty must be currently certified EMTs with no less than five (5) EMTs associated with the provider. The certification level of the responder must coincide with the agency's level of licensure. If the Rapid Responder agency is requested to respond, an EMT must respond on calls for an EMT licensed agency and a Paramedic must respond on calls for a Paramedic licensed agency eighty percent (80%) of the time.

B. Must have staffing patterns, policy and procedures, to ensure that a Rapid Responder unit is en route with at least one (1) EMT to all emergent calls within five (5) minutes. Volunteer units (services not utilizing paid personnel) without onsite personnel must have staffing patterns, policy and procedures to ensure that a Rapid Responder unit is en route with at least one (1) EMT to all emergent calls within ten (10) minutes.

C. The Department will, upon request, be furnished with staffing patterns, policy and procedures to ensure compliance with the en route times noted in Section 410.B.

D. The provider maintains records that include, but are not limited to, approved patient care report forms, employee/member rosters, time sheets, call rosters, training records and dispatch logs that show at least time call received, type call and time unit is en route. Such records are to be available for inspection by the Department with copies furnished upon request.

Section 411. Special Exemptions for Volunteer EMS Providers Squads.

A. A volunteer EMS provider must have an EMT or higher, attending to the patient at the scene and in the ambulance while transporting the patient to the hospital.

B. If a volunteer EMS provider has a written response policy in place in which an EMT is allowed to respond directly to the scene from home or work, the ambulance may respond to the scene of the emergency even if an EMT is not on board. If the EMT does not arrive at the scene and another service is immediately available with appropriate staffing, the patient shall be transported by that service. If no other service is immediately available, the patient shall not be transported without at least one (1) EMT on board. Continual and repeated failure of a service to ensure an EMT arrives at the scene to provide care and transport may result in the Department taking disciplinary action against the agency.

C. If only one (1) EMT is available to staff the ambulance crew, that EMT must be the patient care provider and/or supervise the patient care being provided. The EMT may not be the driver of the ambulance when a patient is being transported.

D. An ambulance shall not respond to the scene of an emergency if it is known in advance that an EMT is not available. All ambulance services shall preplan for the lack of staffing by written mutual aid agreements with neighboring agencies and by alerting the local Public Safety Answering

Point (PSAP) as early as possible when you know that EMT level staffing is not available. Careful preplanning, mutual aid agreements, and continual recruitment programs are necessary to ensure sufficient EMT staffing.

E. In all cases where the level of care is either EMT-I, AEMT, or Paramedic, the transporting unit shall be fully equipped to perform at that level of care.

SECTION 500.

PERMITS, AMBULANCE (I)

Section 501. Vehicle and Equipment.

A. Before a permit may be issued for a vehicle to be operated as an ambulance, its registered owner must apply to the Department for an ambulance permit. Prior to issuing an original or renewal permit for an ambulance, the Department shall determine that the vehicle for which the permit is issued meets all requirements as to design, medical equipment, supplies and sanitation as set forth in these regulations of the Department. Prior to issuance of the original permit, if the ambulance does not meet all minimum requirements and loses points during the inspection, no permit will be issued.

B. Permits will be issued for specific ambulances and will be displayed on the upper left-hand interior corner of the windshield of the ambulance or in the aircraft portfolio, whichever is applicable.

C. No official entry made upon a permit may be defaced, altered, removed or obliterated.

D. Permits may be issued or suspended by the Department.

E. Permits must be returned to the Department within ten (10) business days when the ambulance or chassis is sold, removed from service, or when the windshield is replaced due to damage.

F. The Department must be notified within seventy-two (72) hours of any collision (including pedestrians) involving any licensed provider's vehicle or aircraft used to provide emergency medical services including rapid response, that results in any degree of injury to personnel, patients, passengers, observers, students, or other persons. The licensed agency must submit to the Department the vehicle's issued permit (if applicable) if the damage renders the permitted vehicle out of service for more than two (2) weeks. The investigating law enforcement agency's accident report shall also be forwarded to the Department when received by the agency when the above situations occur and the incident is reportable to the Department.

G. Licensed transport agencies may utilize Quick Response Vehicles (QRVs) which are non-permitted, first-response type vehicles. A QRV will be staffed with a minimum of one (1) provider that is credentialed at a level determined by the local Medical Control Physician (BLS, ILS, ALS) and equipped with locally adopted and Medical Control Physician authorized equipment, also in accordance with the level of credentialing as determined by the Medical Control Physician. For the purpose of this regulation, associated special event vehicles such as motorcycles, watercraft, all-terrain vehicles (ATVs), and bicycles fall under the QRV umbrella.

H. The Department shall not issue a vehicle or aircraft permit to an EMS provider that is unlicensed in South Carolina.

Section 502. Temporary Assets.

A. In cases where a short-term solution to an ambulance resource is needed (temporary rentals or loaner ground or air transport units), the Department may issue a temporary permit to a short-term asset. These temporary assets shall meet all initial equipment requirements for classification as specified in this regulation for the level of intended service.

B. Temporary permits shall be issued for a period not to exceed ninety (90) days and may only be renewed for extraordinary circumstances on a case-by-case basis.

C. Minimum exterior markings.

1. Illumination devices shall meet Section 601.F.1 and F.2.

2. Emblems and markings shall meet or exceed Section 601.B.1 and B.2 and may be affixed on vehicle with temporary markings.

3. The name of the service as stated in the provider's license shall be of lettering not less than three (3) inches in height and may be affixed with temporary markings.

4. Temporary permitted air transport units are exempt from the minimal exterior markings requirements.

SECTION 600.

STANDARDS FOR AMBULANCE PERMIT

Section 601. Ambulance Design and Equipment.

The following designs are hereby established as the minimum criteria for ambulances utilized in South Carolina and are effective with the publication of these regulations. Any ambulance purchased after publication of these requirements must meet the following minimum criteria.

A. Based Unit: Chassis shall not be less than three quarter ton. In the case of modular or other type body units, the chassis shall be proportionate to the body unit, weight and size; power train shall be compatible and matched to meet the performance criteria listed in the Federal KKK-A-1822 Specification, NFPA 1917, or similar specification standards accepted by the Department; maximum effective sized tires; power steering; power brakes; heavy duty cooling system; heavy duty brakes; mirrors; heavy duty front and rear shock absorbers; seventy (70) amp battery; one hundred (100) amp alternator; front end stabilizer; driver and passenger seat belts; padded dash; collapsible steering wheel; door locks for all doors; inside mirror; inside control handles on rear and side doors; all applicable safety-related upgrades on timetables to be determined by the Department after release by the appropriate federal authority.

B. Emblems and Markings: All items in this section shall be of reflective quality and in contrasting color to the exterior painted surface of the ambulance.

1. There shall be a continuous stripe, of not less than three (3) inches on cab and six (6) inches on patient compartment, to encircle the entire ambulance with the exclusion of the hood panel.

2. Emblems and markings shall be of the type, size and location as follows:

a. Side: Each side of the patient compartment shall have the "Star of Life" not less than twelve (12) inches in height. The word "AMBULANCE", not less than six (6) inches in height, shall be under or beside each star. The name of the licensee as stated on their provider's license shall be of lettering not less than three (3) inches in height.

b. Rear: The word "AMBULANCE", not less than six (6) inches in height, and two (2) "Star of Life" emblems of not less than twelve (12) inches in height.

c. Out-of-state licensed ground transport units shall meet the same markings and standards as in-state licensed units, unless specifically forbidden by the unit's home state of licensure.

3. Prior to private sale of ambulance vehicles to the public, all emblems and markings in Section 601.B must be removed.

C. Interior Patient Compartment Dimensions:

1. Length: The compartment length shall provide a minimum of twenty-five (25) inches clear space at the head and fifteen (15) inches at the foot of a seventy-six (76) inch cot. Minimum inside length will be one hundred sixteen (116) inches.

2. Width: Minimum inside width is sixty-nine (69) inches.

3. Height: Inside height of patient compartment shall be a minimum dimension of sixty (60) inches from floor to ceiling.

D. Access to Vehicle:

1. Driver Compartment.

a. Driver's seat will have an adjustment to accommodate the 5th percentile to 95th percentile adult male.*

*Note: This means that the driver's area will accommodate the male drivers who are ninety percent (90%) of the smallest and largest in stature, which includes weight and size.

b. There shall be a door on each side of the vehicle in the driver's compartment.

c. Separation from the patient area is essential to afford privacy for radio communication and to protect the driver from an unruly patient. Provision for both verbal and visual communication between driver and attendant will be provided by a sliding shatterproof material partition or door. The bulkhead must be strong enough to support an attendant's seat in the patient area at the top of the patient's head and to withstand deceleration forces of the attendant in case of accident.

2. Patient Compartment:

a. There shall be a door on the right side of the patient compartment near the patient's head area of the compartment. The side door must permit a technician to position himself at the patient's head and quickly remove him from the side of the vehicle should the rear door become jammed.

b. Rear doors shall swing clear of the opening to permit full access to the patient's compartment.

c. All patient compartment doors shall incorporate a holding device to prevent the door closing unintentionally from wind or vibration. When doors are open the holding device shall not protrude into the access area. Special purpose ambulances are exempt as long as access/egress is not obstructed due to wheelchair ramps or other specialized equipment.

d. Spare tire, if carried, shall be positioned such that the tire can be removed without disturbing the patient.

E. Interior Lighting:

1. Driver Compartment: Lighting must be available for both the driver and an attendant, if riding in the driving compartment, to read maps, records, or other. There must be shielding of the driver's area from the lights in the patient compartment.

2. Patient Compartment: Illumination must be adequate throughout the compartment and provide an intensity of forty-foot (40-foot) candles at the level of the patient for adequate observation of vital signs, such as skin color and pupillary reflex, and for care in transit. Lights shall be controllable from the entrance door, the head of the patient, and the driver's compartment. Reduced lighting level may be provided by rheostat control of the compartment lighting or by a second system of low intensity lights.

F. Illumination Devices:

1. Illumination Devices: Flood and load lights. There shall be at least one (1) flood light mounted not less than seventy-five (75) inches above the ground and unobstructed by open doors located on each side of the vehicle. A minimum of one (1) flood light, with a minimum of fifteen (15) foot candles, shall be mounted above the rear doors of the vehicle.

2. Warning lights. At a minimum alternating flashing red lights must be on the corners of the ambulance so as to provide three hundred sixty (360) degrees conspicuity.

G. Seats:

1. A seat for both driver and attendant will be provided in the driver's compartment. Each seat shall have armrests on each side of driver's compartment.

2. Technician (Patient Compartment): Two (2) fixed seats, padded, eighteen (18) inches wide by eighteen (18) inches high; to head of patient behind the driver, the other one may be square bench type located on curb (right) side of the vehicle. Space under the seats may be designed as storage compartments.

H. Safety Factors for Patient Compartment:

1. Cot Fasteners: Crash-stable fasteners must be provided to secure a primary cot and secondary stretcher.

2. Cot Restraint: If the cot is floor supported on its own support wheels, a means shall be provided to secure it in position under all conditions. These restraints shall permit quick attachment

and detachment for quick transfer of patient. All newly-manufactured ambulances purchased for use in South Carolina after July 1, 2017, shall meet all seating and cot restraint mandates outlined in the Federal KKK-A-1822F, all change notices included.

3. Patient Restraint: A restraining device shall be provided to prevent longitudinal or transverse dislodgement of the patient during transit, or to restrain an unruly patient to prevent further injury or aggravation to the existing injury.

4. Safety Belts for Drivers and Attendants:

a. Quick-release safety belts will be provided for the driver, the attendants, and all seated patients (squad bench). These safety belts will be retractable and self-adjustable.

5. Mirrors:

a. There shall be two (2) exterior rear view mirrors, one mounted on the left side of the vehicle and one (1) mounted on the right side. Location of mounting must be such as to provide maximum rear vision from the driver's seated position.

b. There shall be an interior rear view mirror or rear view camera to provide the driver with a view of occurrences in the patient compartment.

6. Windshield Wipers and Washers:

a. Vehicle is to be equipped with two (2) electrical windshield wipers and washers in addition to defrosting and defogging systems.

7. Sun Visors:

a. There shall be a sun visor for both driver and attendant.

I. Environmental Equipment: Driver/Patient Compartment.

1. Heating: Shall be capable of heating the compartment to a temperature of seventy-five (75) degrees Fahrenheit within a reasonable period while driving in an ambient temperature of zero degrees Fahrenheit. It must be designed to recirculate inside air, also be capable of introducing twenty percent (20%) of outside air with minimum effect on inside temperature. Fresh air intake shall be located in the most practical contaminant-free air space on the vehicle.

2. Heating Control: Heating shall be thermostatically or manually controlled. The heater blower motors must be at least a three (3) speed design. Separate switches will be installed in patient compartment.

3. Air Conditioning: Air Conditioning shall have a capacity sufficient to lower the temperature in the driver's and patient's compartment to seventy-five (75) degrees Fahrenheit within a reasonable period and maintain that temperature while operating in an ambient temperature of ninety-five (95) degrees Fahrenheit. The unit must be designed to deliver twenty percent (20%) of fresh outside air of ninety-five (95) degrees Fahrenheit ambient temperature while holding the inside temperature specified. All parts, equipment, workmanship, shall be in keeping with accepted air conditioning practices.

4. Air Conditioning Controls: The unit air delivery control may be manual or thermostatic. The reheat type system is not required in the driver's compartment unit. Switches or other controls must be within easy reach of the driver in his normal driving position. Air delivery fan motor shall be at least a three (3) speed design. Switches and other control components must exceed in capacity the amperage and resistance requirements of the motors.

5. Environmental Control and Medications: The temperature in the patient compartment or anywhere medications are stored (QRVs, fire apparatus, rapid response vehicles, carry-in bags, and other) shall be monitored for temperature extremes to prevent drug adulteration. Medications (excluding oxygen) and IV fluids will be removed and discarded if the temperatures reach or exceed one hundred (100) degrees Fahrenheit (thirty-eight (38) degrees Celsius). Medications and IV fluids shall also be removed and discarded if temperatures in the drug storage area drop below twenty (20) degrees Fahrenheit (negative seven (-7) degrees Celsius).

6. Insulation: The entire body, side, ends, roof, floor, and patient compartment doors shall be insulated to minimize conduction of heat, cold, or external noise entering the vehicle interior. The insulation shall be vermin and mildew-proof, fireproof, non-hygroscopic, non-setting type. Plywood floor when undercoated will be considered sufficient insulation for the floor area.

J. Storage Cabinets: All cabinets must meet the criteria as stated in the most current edition of the Federal KKK-A-1822 Specification, NFPA 1917, or similar specification standards accepted by the Department as to types of surfaces, design and storage. Cabinets must be of sufficient size and configuration to store all necessary equipment. All equipment in interior cabinets must be accessible to attendant at all times.

K. Two-Way Radio Mobile: Two-way radio mobile equipment shall be included which will provide a reliable system operating range of at least a twenty (20) mile radius from the base station antenna. The mobile installation shall provide microphones for transmitting to at least medical control and receiving agencies, at both the driver's position and in the patient's compartment. Selectable speaker outputs, singly and in combination, shall be provided at the driver's position, in the patient's compartment, and through the PA system.

1. All radio frequencies utilized by a licensed service will be provided to the Department.

2. In the event technological advancements render the above components obsolete, the Department shall make determinations as to the efficacy of proposed technology on an individual basis prior to allowing their use.

L. Siren-Public Address: Siren and public address systems shall be provided. If a combined electronic siren and public address system is provided, in siren operation, the power output shall be minimum one hundred (100) watts. In voice operation the power output shall be at least forty-five (45) watts through two (2) exterior mounted speakers. The public address amplifier shall be independent of the mobile radio unit.

M. Antenna: Mounted with coaxial or other appropriate cable.

N. Glass Windows: All windows, windshield and door glass must be shatterproof.

O. Smoking Policy: Use of tobacco products or tobacco-like products (such as electronic cigarettes) is prohibited in the patient compartment and in the operator compartment of ambulances by all occupants.

P. The EMS provider shall establish a means to immediately identify that a vehicle is out of service for any operator who might have reason to use the vehicle. Any vehicle that is "out of service" whether for mechanical or staffing issues must be readily identifiable to the public and the Department. Out of service apparatus shall be identified by one (1) of the following means:

1. Sign on outside of the driver's door near the door handle, minimum eight and one half inches by eleven inches (8.5" x 11") and red in color;

2. Special bag that covers the steering wheel, red in color, and labeled "Out of Service;"

3. Large sign on the driver's window, red in color, reading "Out of Service," laminated, or a permanent, commercially manufactured type, minimum eight and one half inches by eleven inches (8.5" x 11"). If the unit is being driven and is out of service, the sign may be placed in the far right hand corner of the front window so as to not obstruct the driver's vision but so as to be visible from the exterior of the vehicle; or

4. Highly visible mechanism at the driver's position on the vehicle that all members of the EMS provider recognize as an out of service indicator and is identified by a provider policy or standard operating procedure.

SECTION 700.

EQUIPMENT (II)

Section 701. Minimum Ambulance Medical Equipment.

The Joint Policy Statement on Equipment for Ground Ambulances (JPS) provides a recommended core list of supplies and equipment that shall be stocked on all ambulances to provide the accepted standards of patient care. For the purposes of this regulation, the following definitions from the JPS have been used:

Neonate: zero to twenty-eight (0-28) days of age;
Infant: twenty-nine (29) days to one (1) year; and
Child one (1) year old to eighteen (18), with delineations as follows:
Toddlers: one to two (1-2) years old;
Preschoolers: three to five (3-5) years old;
Middle childhood: six to eleven (6-11) years old; and
Adolescents: twelve to eighteen (12-18) years old.

Starting July 1, 2016, all ambulances shall be equipped with, but not limited to, all of the following:

A. Minimum of two (2) stretchers;

1. One (1) multilevel, elevating, wheeled cot with elevating back. Two (2) patient restraining straps (chest and thigh) minimum, at least two (2) inches wide shall be provided.

2. One (1) secondary patient transport stretcher, with a minimum of two (2) patient restraining straps. Minimum acceptable stretcher is vinyl covered, aluminum frame, folding stretcher.

B. Suction Devices;

1. An engine vacuum operated or electrically powered, complete suction aspiration system, shall be installed permanently on board to provide for the primary patient. It shall have wide bore tubing.

2. Portable suction device with regulator with at least a six (6) ounce reservoir.

3. Wide-bore tubing, rigid pharyngeal curved suction tip; tonsil and flexible suction catheters, 6 Fr–16 Fr, are commercially available must have two (2) between 6F and 10F and two (2) between 12 Fr and 16 Fr.

C. Oxygen Equipment;

1. Portable Oxygen Equipment: Minimum "D" size (360 Liter) cylinder, two (2) required (one (1) in service and one (1) full and sealed). Liter flow gauges shall be non-gravity, dependent type. Additionally, when the vehicle is in motion, all oxygen cylinders shall be readily accessible and securely stored.

2. Permanent On-Board Oxygen Equipment: The ambulance shall have a hospital grade piped oxygen system, capable of storing and supplying a minimum of 2400 liters of humidified medical oxygen.

3. Single-use, individually wrapped, non-rebreather masks and cannulas in adult and pediatric sizes shall be provided (three (3) each).

4. A "No Smoking" sign shall be prominently displayed in the patient compartment.

5. Pulse oximeter with adult and pediatric capabilities. Special Purpose Ambulances shall also maintain infant pulse oximetry capabilities.

D. Bag Mask Ventilation (BVM) Units;

1. One (1) adult, one (1) pediatric, one (1) infant: hand-operated. Valves must operate in all weather, and unit must be equipped to be capable of delivering ninety to one hundred percent (90-100%) oxygen to the patient. BVMs must include safety pop-off mechanism with override capability. Three (3) additional masks sizes small adult, toddler, and neonate shall be carried.

E. Nonmetallic Oropharyngeal (OPA) (Berman type) and Nasopharyngeal Airways (NPA);

1. All airways shall be clean and individually wrapped.

2. "S" tube-type airways may not be substituted for Berman type airways.

3. One each of the following sizes: NPA: 14 Fr-34 Fr and OPA sizes to accommodate neonate through large adult.

F. Bite sticks commercially made (clean and individually wrapped);

G. Eight (8) sterile dressings (minimum size five (5) inches by nine (9) inches);

H. Twenty-four (24) sterile gauze pads four (4) inches by four (4) inches;

I. Ten (10) bandages, self-adhering type, minimum three (3) inches by five (5) yards. Bandages must be individually wrapped or in clean containers;

J. A minimum of two (2) commercial sterile occlusive dressings, four (4) inches by four (4) inches;

K. Adhesive Tape, hypoallergenic, one (1) inch, two (2) inch, and three (3) inches wide;

L. Burn sheets, two (2), sterile;

M. Splints;

1. Traction type, lower extremity, overall length of splint minimum of forty-three (43) inches, with limb support slings, padded ankle hitch, traction device and heel stand. Either the Bi-polar or Uni-polar type is acceptable.

2. Padded type, two (2) each, three (3) feet long, of material comparable to four-ply wood for coadaptation splinting of the lower extremities.

3. Padded wooden type, two (2) each, fifteen (15) inches by three (3) inches, for fractures of the upper extremity. Commercially available arm or leg splints may be substituted for items in Section 701.M.2 above, such as cardboard, metal, pneumatic, vacuum, or plastic.

N. Spinal immobilization devices;

1. Commercially available vest type KED, XP1 or other equivalent is acceptable.

2. Child backboard or pediatric board or any type commercially available spinal immobilization device sized for the pediatric patient.

3. Long spine board, at least sixteen (16) inches by seventy-two (72) inches constructed of three-quarter (3/4) inch impervious material and having at least three-quarter (3/4) inch runners on each side for lifting with appropriate straps. If not equipped with runners, board must be designed so handholds are accessible with work gloves.

4. Cervical collars to accommodate the infant, child, adolescent, and adult sizes. Collars must be manufactured of semi-rigid or rigid material. Commercially available adjustable collars may be substituted, must carry two (2) of each child adjustable and adult adjustable.

5. Six (6) patient restraint straps or commercially available disposable straps to accommodate patients from large adult to child sizes.

6. Head immobilization device, commercially available or towel or blanket rolls.

O. Three (3) each triangular bandages;

P. Two (2) blankets;

Q. Bandage shears, large size or trauma shears;

R. Obstetrical kit, sterile. The kit shall contain gloves, scissors or surgical blades, umbilical cord clamps or tapes, dressings, towels, perinatal pad, bulb syringe and a receiving blanket for delivery of infant;

S. Blood pressure manometer, cuff and stethoscope;

1. Blood pressure set, portable, both pediatric and adult.

2. Stethoscopes (adult and pediatric capable).

T. Emesis basin or commercially available emesis container;

U. Bedpan and urinal;

V. Two (2) functional battery operated, hand-carried flashlights or electric lanterns, suitable for illuminating both a localized work area or a walkway. Penlights do not meet this requirement;

W. Minimum of one (1) fire extinguisher, CO2 or dry chemical, five (5) pound capacity, type ABC;

X. Working gloves, two (2) pair with leather palms and reflective vests that meet American National Standard (ANSI 201) for High Visibility Public Safety Vests for each crew member;

Y. Minimum of 1000 cc of sterile water or normal saline solution for irrigation;

Z. Protective head gear and eye protection devices (minimum two (2) each) must be carried on each ambulance. Standard fire helmet face shield is not acceptable;

AA. Latex-free personal protective equipment including gloves, masks, gowns and eye shields;

BB. Automated External Defibrillator (AED) unless staffed by ALS personnel who are utilizing a manual monitor or defibrillator. Monitor may be utilized by BLS personnel if "AED Mode" is an available setting. The AED shall have pediatric capabilities, including child sized pads or a dose attenuator with adult pads;

CC. Flameless Flares: Three (3) red reflectorized (such as reflective triangles) or chemically induced illumination devices may be substituted for flares. Combustible type flares are not acceptable;

DD. One (1) set battery jumper cables, minimum 04 gauge copper, 600 amp rating;

EE. Glucometer with a minimum of five (5) test strips (Medical Control Option);

FF. One (1) commercially available arterial tourniquet device; and

GG. Five (5) adhesive bandages.

Section 702. Intermediate and Advanced Equipment.

Ambulances providing intermediate and advanced life support must, in addition to meeting all other requirements of Section 701 must have the following equipment:

A. Butterfly or scalp vein needles between nineteen (19) and twenty-five (25) gauge, a total of four (4) (Medical Control Option);

B. Four (4) each fourteen (14), sixteen (16), eighteen (18), twenty (20), twenty-two (22), and twenty-four (24) gauge IV cannulae;

C. Two (2) macro drip sets;

D. Two (2) micro drip sets;

E. Three (3) twenty-one (21) or twenty-three (23) and three (3) twenty-five (25) gauge needles, total six (6) as an MCO;

F. Three (3) intravenous (IV) tourniquets;

G. Laryngoscope handle with batteries;

H. Laryngoscope blades, adult, child, and infant sizes;

1. 0-4 Miller.

2. 1-4 Macintosh.

I. One (1) each disposable endotracheal tubes sizes as well as intubation stylettes sized for each tube;

1. 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5 mm cuffed or uncuffed.

2. 6.0, 6.5, 7.0, 7.5, 8.0 mm.

J. Equipment for drawing blood samples as an MCO;

K. Syringes, two (2) each 1 ml, 3 ml, 10 ml, 20 ml, and one (1) greater than or equal to 50 ml;

L. Twelve (12) alcohol and iodine preps for preparing IV injection sites;

M. A minimum of four (4) liters of normal saline or other appropriate IV solution;

N. Intraosseous devices;

1. Pediatric – minimum of two (2) sizes.

2. Adult – Minimum of one (1) size as an MCO.

O. Ambulances providing advanced cardiac life support must be equipped with a battery powered (DC) portable monitor-defibrillator unit, appropriate for both adult and pediatric patients with ECG printout and capable of transcutaneous pacing. The monitor-defibrillator equipment utilized by the service must have the capability of producing hard copy of patient's ECG, a 12-lead ECG, and performing continuous monitoring of end tidal carbon dioxide (EtCO2) output. Portable EtCO2 devices that meet the same criteria as above may be substituted;

P. Such medications or fluids as may be approved by the Department for possession and administration by EMTs trained and certified in their use and authorized by the provider's Medical Control Physician, as documented to the Department;

Q. Magill Forceps;

1. Adult.

2. Pediatric.

R. Blind Insertion Airway Devices (BIADs) such as dual lumen or LMA airways, age and weight appropriate;

S. Portable sharps container; and

T. Pediatric length-based, weight-based, or age-based medication dose chart or tape.

Section 703. EMT Rapid Responder Equipment.

A. All licensed Rapid Responder agencies operating within the state shall carry equipment required in the following sections. Protocols submitted must indicate areas where Medical Control Option (MCO) equipment is being authorized.

B. The Rapid Responder agency's vehicle must be properly marked as to identify the vehicle as an emergency vehicle.

C. The Rapid Responder agency shall follow the exact equipment cleanliness guidelines as outlined for transporting providers in Section 800.

D. All Rapid Responder vehicles will be equipped with at least the following items from Section 701: B.2, B.3, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, V, W, X, Y, Z, AA, BB.

E. Age and weight appropriate BIADs (Section 702.R) are an MCO for all Rapid Responder licenses.

F. Equipment in addition to Section 703.E to be carried by EMT-I or AEMT Rapid Responders:

1. Four (4) each, fourteen (14), sixteen (16), eighteen (18), twenty (20), and twenty-two (22) gauge IV cannulae;

2. Two (2) macro drip sets;

3. Two (2) micro drip sets;

4. One (1) sharps container;

5. A minimum of four (4) liters of normal saline or other appropriate IV solution;

6. Three (3) IV tourniquets;

7. Twelve (12) each, alcohol and iodine preps for preparing IV injection sites;

8. Five (5) adhesive bandages; and

9. Such medications or fluids as may be approved by the Department for possession and administration by EMTs trained and certified in their use and authorized by the provider's Medical Control Physician, as documented to the Department.

G. Equipment in addition to Section 703.F to be carried by Paramedic Rapid Responders:

1. Rapid Responders providing ALS must be equipped with a battery powered (DC) portable monitor-defibrillator unit, appropriate for both adult and pediatric patients with ECG printout and capable of transcutaneous pacing. The monitor-defibrillator equipment utilized by the service must have the capability of producing a hard copy of the patient's ECG and performing continuous monitoring of end tidal carbon dioxide (EtCO2) output;

2. Such medications or fluids as may be approved by the Department for possession and administration by EMTs trained and certified in their use and authorized by the provider's Medical Control Physician, as documented to the Department;

3. As an MCO, ALS Rapid Responders may carry the following equipment from Section 702: G, H, I, P, S; and

4. ALS Rapid Responder agencies not providing laryngoscopic intubation must carry age and weight appropriate BIADs for airway management.

H. Any ALS agency not performing laryngoscopic intubations, and only providing BIADs for airway management, is not required to provide continuous monitoring of end tidal carbon dioxide (EtCO2) output.

Section 704. Special Purpose Ambulance Equipment.

A. All special purpose ambulances shall be equipped with at least the following items from Section 701: A.1, B, C, D (appropriate size), E, F, T, U, V, W, X, AA, BB, CC in addition to the special purpose equipment that is documented to the Department as enumerated in Section 407. Section 407.A.1 can be replaced by a specialized patient transfer device so long as there is a provision to safely secure the device in the special purpose ambulance.

B. Special purpose equipment as documented to the Department as enumerated in Section 407 must be on the special purpose ambulance when it is in use and is subject to inventory and inspection by the Department as provided for in Section 407.

SECTION 800.

SANITATION STANDARDS FOR LICENSED PROVIDERS

Section 801. Exterior Surfaces.

A. The exterior of the vehicle shall have a reasonably clean appearance.

B. All exterior lighting shall be kept clear of foreign matter (insects, road grime, or other) to ensure adequate visibility.

Section 802. Interior Surfaces Patient Compartment-Ambulance.

A. Interior surfaces shall be of a nonporous material to allow ease of cleaning. Carpet-type materials shall not be used on any surface of the patient compartment.

B. Floors shall be free from sand, dirt and other residue that may have been tracked into the compartment.

C. Wall, cabinet, and bench surfaces shall be kept free of dust, sand, grease, or any other accumulated surface matter.

D. Interiors of cabinets and compartments shall be kept free from dust, moisture or other accumulated foreign matter.

E. Bloodstains, vomitus, feces, urine and other similar matter must be cleaned from the unit and all equipment after each call, using an agent or sodium hypochlorite solution described in Section 802.H.

F. Window glass and cabinet doors shall be clean and free from foreign matter.

G. A receptacle shall be provided for the deposit of trash, litter, and all used items.

H. An EPA recommended germicidal/viralcidal agent or a hypochlorite solution of ninety-nine (99) parts water and one (1) part bleach must be used to clean patient contact areas. For surfaces where such an EPA solution is not recommended, alcohol or sodium hypochlorite solution can be used.

I. A container specifically for the deposit of contaminated needles or syringes and a second container for contaminated or infectious waste shall be provided and will be easily accessible from the patient compartment.

J. All licensed providers must carry sufficient, appropriate cleaning supplies in their vehicles so that the crews are able to clean their unit between calls and be in compliance with Sections 802.A through G.

Section 803. Linen.

A. Storage area for clean linens shall be provided in such configuration so that linens remain dry and clean. (Ambulance)

B. Freshly laundered or disposable linens (minimum of six (6) sets) shall be used on cots and pillows, and shall be changed after each patient is transported. (Ambulance)

C. Soiled linen is to be transported in a closed plastic bag or container and removed from the ambulance as soon as possible.

D. Blankets and towels shall be clean and stored in such a manner to ensure cleanliness.

1. Towels and sheets shall not be used more than once between laundering.

2. Blankets shall be laundered or cleaned as they become soiled. Blankets shall preferably be of a hypoallergenic material designed for easy maintenance.

Section 804. Oxygen Administration Apparatus. (II)

A. Oxygen administration devices such as masks, cannulas, and delivery tubing shall be disposable and once used shall be disposed of and not reused.

B. All masks and cannulas and tubing shall be individually wrapped and not opened until used on a patient.

C. Oxygen humidifiers shall be filled with distilled or sterile water upon use only. Reusable humidifiers must be cleaned after each use. Disposable, single-use humidifiers are acceptable in lieu of multiuse types.

D. All units that carry portable oxygen must have a non-sparking oxygen wrench for use with the oxygen tanks on that unit.

Section 805. Resuscitation Equipment. (II)

A. Bag mask assemblies and masks shall be free from dust, moisture, and other foreign matter and stored in the original container, jump kit, or a closed compartment to promote sanitation of the unit. Additional equipment needed to facilitate the use of a bag valve mask, such as a syringe, shall be stored with the bag mask assembly. Masks, valves, reservoirs, and other items or attachments for bag mask assemblies shall be clean. Manufacturer's recommendations on single-use equipment shall be followed where indicated.

B. An EPA recommended germicidal/viralcidal agent or a sodium hypochlorite solution of ninety-nine (99) parts water and one (1) part bleach must be used to clean equipment not specifically addressed as single-use. For surfaces where such an EPA solution is not recommended, alcohol or sodium hypochlorite solution shall be used.

Section 806. Suction Unit.

A. Suction hoses shall be clean and free from foreign matter. Manufacturer's recommendations on single-use equipment must be followed where indicated.

B. Suction reservoir shall be clean and dry.

C. Suction units shall be clean and free from dust, dirt or other foreign matter.

D. Tonsil tips and suction catheters shall be of the single-use, disposable type, stored in sealed, sterile packaging until used.

E. Suction units with attachments shall be cleaned and sanitized after each use. (See Section 805.B).

Section 807. Splints.

A. Padded splints shall be neatly covered with a non-permeable material and clean. When the outside cover of the splint becomes soiled, they shall be thoroughly cleaned or replaced.

B. Pneumatic trousers, if used, shall be clean and free from dust, dirt or other foreign matter.

C. Commercial splints shall be free of dust, dirt or other foreign matter.

D. Traction splints with commercial supports shall be clean and free from accumulated material.

E. All splinting materials must be stored in such a manner as to promote and maintain cleanliness.

F. All splints must be in functional working order with the recommended manufacturer's attachments.

G. Manufacturer's recommendations on single-use equipment must be followed where indicated.

Section 808. Stretchers and Spine Boards.

A. Pillows, mattresses and head immobilization devices (HIDs) shall be covered with a non-permeable material and in good repair. (Single-use items are exempt.)

B. Stretchers, cots, pillows, HIDs and spine boards shall be clean and free from foreign material.

C. Canvas or neoprene covers on portable type stretchers shall be in good repair.

D. All restraint straps and/or devices shall be kept clean and shall be washed immediately if soiled.

E. Spinal immobilization boards shall be manufactured from an appropriate material to facilitate cleaning.

F. All spinal immobilization boards shall be free from rough edges or areas that may cause injury.

Section 809. Bandages and Dressings. (II)

A. Bandages need not be sterile, but they must be clean. They shall be individually wrapped or stored in a closed container or cabinet to ensure cleanliness.

B. Dressings must be sterile, individually packaged and sealed, and stored in a closed container or compartment. If the seal is broken or wrap is torn, the dressing is to be discarded.

C. Dressings or burn sheets must be sterile and single-use only.

D. Triangular bandages must be single-use disposable type.

E. All bandages or dressings that have been exposed to moisture or otherwise have become soiled must be replaced.

Section 810. Obstetrical (OB) Kits. (II)

A. All OB kits must be sterile and wrapped with cellophane or plastic. If the wrapper is torn or the kit is opened but not used, the items in the kit that are not individually wrapped must be resterilized or discarded and replaced.

B. OB kits must be single-use only.

C. Items that have an expiration date in OB kits may be replaced individually if other items are individually sealed and sterile.

Section 811. Oropharyngeal Appliances. (II)

Instruments inserted into a patient's mouth or nose that are single-use only shall be individually wrapped and stored properly. All instruments inserted into a patient's mouth (such as laryngoscope blades) that are not intended for single-use only must be cleaned and decontaminated following manufacturer's guidelines.

Section 812. Communicable Diseases. (II)

A. When an ambulance or transport vehicle has been contaminated in the transport of a patient known to have a blood-borne or respiratory droplet-borne pathogen, the vehicle must be taken out of service until cleaning and decontamination is completed.

B. Linen must be removed from the cot and properly disposed of, or immediately placed in a plastic bag or container and sealed until properly cleaned.

C. Patient contact areas, equipment and any surface soiled during the call, must be cleaned in accordance with Section 802.H of these guidelines.

Section 813. Miscellaneous Equipment.

Miscellaneous equipment such as scissors, stethoscopes, blood pressure cuffs and/or other items used for direct patient care shall be cleansed as they become soiled. Items shall be kept clean and free from foreign matter.

Section 814. Equipment and Materials Storage Areas.

Equipment not used in direct patient care shall be in storage spaces that prevent contamination or damage to direct patient care equipment or materials.

Section 815. Personnel.

A. All personnel functioning on the vehicle shall present themselves in a clean appearance at all times. This includes both the certified EMS attendants and the non-certified drivers if applicable.

B. Hands and forearms shall be thoroughly washed according to Standard 1910.1030 set forth by the Occupational Safety and Health Administration (OSHA).

C. Uniforms and clothing shall be clean or changed if they become soiled, contaminated, or exposed to vomitus, blood or other potentially infectious material (OPIM).

SECTION 900.

EMERGENCY MEDICAL TECHNICIANS

Section 901. General.

A. All ambulance attendants shall have a valid Emergency Medical Technician (EMT, EMT-I, AEMT, or Paramedic) certificate. No person shall provide patient care within the scope of an Emergency Medical Technician (EMT, EMT-I, AEMT, or Paramedic) without having proper South Carolina certification from the Department. (I)

B. EMTs (EMT, EMT-I, AEMT, or Paramedic) shall only engage in those practices for which they have been trained and are within the scope of their Department-issued certification. Students currently enrolled in a Department-approved EMT, AEMT, or Paramedic program under the supervision of an appropriately credentialed preceptor may practice advanced skills for which they have been authorized in their respective training program. (I)

C. EMTs (EMT, EMT-I, AEMT, or Paramedic) shall perform procedures under the supervision of a physician licensed in South Carolina. The means of supervision shall be direct, by standing orders or by electronic or voice communications. (I)

D. All Department-certified EMTs (EMT, EMT-I, Special Purpose EMT, AEMT, or Paramedic) shall maintain an up-to-date profile in the South Carolina Credentialing Information System (CIS). (III)

E. A pocket ID card shall be issued along with the South Carolina certificate. The original pocket card must be in the possession of the EMT (EMT, EMT-I, Special Purpose EMT, AEMT, or Paramedic) at all times that the EMT is on-duty or patient care is being rendered. (III)

F. Except in cases of a disaster or catastrophe, when licensed services in the locality are insufficient to render the required services and/or mutual aid is requested, a South Carolina EMT certification (all levels) is limited in its scope of practice to South Carolina. (III)

Section 902. Initial EMT, AEMT, and Paramedic Certification. (I)

A. Any person seeking certification as an EMT, AEMT, or Paramedic shall complete the appropriate Department-approved training program, pass the National Registry of Emergency Medical Technicians (NREMT) examination for the level of certification desired, possess a current NREMT credential, and meet the requirements established by the Department as provided by S.C. Code Section 44-61-80(C).

B. A person seeking certification as an EMT, AEMT, or Paramedic must undergo a state criminal history background check, supported by fingerprints by the South Carolina Law Enforcement Division (SLED), and a national criminal history background check, supported by fingerprints by the Federal Bureau of Investigation (FBI).

1. The results of these criminal history background checks are reported to the Department. SLED is authorized to retain the fingerprints for certification purposes and for notification to the Department regarding criminal charges.

2. The cost of the state criminal history background check is delineated in S.C. Code Section 44-61-80(D).

3. The state and national criminal history background checks are required for all EMTs when the EMT applies for certification or recertification. The results of these criminal history background checks are only valid for forty-five (45) days from the date the results are received by the Department from SLED and the FBI.

4. Applications for certification of individuals convicted of or under indictment for the following crimes shall be denied in all cases:

a. Felonies involving criminal sexual conduct;

b. Felonies involving the physical or sexual abuse of children, the elderly, or the infirm including, but not limited to, criminal sexual conduct with a minor, making or distributing child pornography or using a child in a sexual display, incest involving a child, or assault on a vulnerable adult; or

c. Crimes against vulnerable populations (such as, but not limited to, children, patients, or residents of a healthcare facility) including abuse, neglect, theft from, or financial exploitation of a person entrusted to the care or protection of the applicant.

C. Applications from individuals convicted of, or under indictment for, other offenses not listed above will be reviewed by the Department on a case by case basis.

D. All Certifications are valid for a period not exceeding four (4) years from the date of issuance as provided in S.C. Code Section 44-61-80(E).

Section 903. Recertification of EMT, AEMT, and Paramedic Certification.

A. EMTs, AEMTs, and Paramedics shall recertify their Department-issued certification by submitting the following to the Department a minimum of thirty (30) days prior to expiration of their certificate:

1. A properly completed and signed application for recertification;

2. Documentation of current NREMT credentials for the appropriate level of certification; and

3. Other credential(s) as required by the Department (state-approved CPR credential and/or Advanced Cardiac Life Support (ACLS) credential).

4. An individual who was certified in this state before October 1, 2006, and has continuously maintained a South Carolina state EMT certification at any level without lapse, may continue to renew that certification without a NREMT credential.

5. An individual who has gained a NREMT credential on or after October 1, 2006, must maintain their NREMT credential to be certified, recertified, and maintain their South Carolina certification.

B. EMTs, AEMTs, and Paramedics seeking recertification shall undergo a state and national criminal history background check as provided for in S.C. Code Section 44-61-80(D).

Section 904. Special Purpose EMT.

A. A person seeking a South Carolina Special Purpose EMT credential shall meet all requirements established by the Department.

B. All South Carolina certified individuals shall maintain an up-to-date profile in the South Carolina Credentialing Information System (CIS).

C. A person seeking a certification or recertification as a Special Purpose EMT must undergo a state criminal history background check as provided in S.C. Code Section 44-61-80(D).

D. In order to be issued a valid Special Purpose EMT certificate, an individual must meet all of the following criteria:

1. The Special Purpose EMT must be a South Carolina licensed registered nurse (RN) or a Nurse Licensure Compact (NLC) State RN who works in a critical care hospital setting such as neonatology, pediatrics, or cardiac care;

2. The Special Purpose EMT must have completed an acceptable training program for delivery of the special area or possess experience in that special care area satisfactory to the Department;

3. The Special Purpose EMT must be employed by the medical service which utilizes the special purpose ambulance and recommended by the director of the medical service which utilizes the special purpose ambulance;

4. The medical service by which the Special Purpose EMT is employed must have operational procedures and medical protocols directing the daily operations of the Special Purpose EMT and special purpose ambulance. These medical protocols must be in written or electronic form, approved, and signed by the Medical Control Physician of the licensed EMS agency which operates the special purpose ambulance in order for the Special Purpose EMT to administer the special medical treatment required by these protocols;

5. A South Carolina Special Purpose EMT certificate shall be in force no more than four (4) years;

6. A pocket ID card shall be issued along with the South Carolina certificate. The original pocket card must be in the possession of that Special Purpose EMT individual all times that the person is on-duty or patient care is being rendered; and

7. Special Purpose EMTs shall only engage in those practices for which they have been trained and have been approved by the Department.

E. Special purpose EMTs may be assisted by other healthcare professionals who are determined qualified and approved by the Department to assist in attendance of the patient during transportation in a special purpose ambulance.

Section 905. Reciprocity.

A. Candidates seeking reciprocity in South Carolina must hold either a NREMT credential or a current certification from another state for the level for which they are applying.

B. Candidates seeking reciprocity as an EMT, AEMT, or Paramedic must undergo the required criminal history background check in accordance with S.C. Code Section 44-61-80(D). The results of these criminal history background checks are only valid for forty-five (45) days from the date the results are received by the Department from SLED and FBI.

C. Candidates not certified in South Carolina who hold a current and valid NREMT certification may apply for direct reciprocity at the level of the NREMT credential they hold by creating (and maintaining) an up-to-date profile in the South Carolina Credentialing Information System (CIS) and submitting the following:

1. A properly completed and signed reciprocity application;

2. A copy of their current NREMT certification for the level of reciprocity for which they are making application; and

3. All other requirements as established by the Department.

D. South Carolina EMT certificates for all levels of direct reciprocity shall expire four (4) years from the date the Department approves the candidate's application.

E. A pocket ID card shall be issued along with the South Carolina certificate. The original pocket card must be in the possession of that individual at all times that the EMT is on-duty or patient care is being rendered.

F. EMT certifications (EMT, AEMT, and Paramedic) must maintain a NREMT credential to be certified, recertified, and maintain their current South Carolina certification.

G. Candidates not certified in South Carolina who hold a current and valid EMT certification from other states may apply for a one (1) year provisional reciprocity at the level of the certification they hold by creating (and maintaining) an up-to-date profile in the South Carolina Credentialing Information System (CIS) and submitting the following:

1. A properly completed and signed reciprocity application;

2. A properly completed out-of-state certification verification form;

3. A copy of their current state certification pocket card for the level of provisional reciprocity for which they are making application. The pocket card must show their out-of-state certification expiration date. All provisional reciprocity candidates must have a minimum of six (6) months remaining on their out-of-state certification by the time the Department receives all required documentation necessary for certification. Exceptions will be granted on a case-by-case basis; and

4. All other requirements as established by the Department.

H. South Carolina EMT certificates for all levels of provisional reciprocity will expire on the fifteenth (15th) of the month one (1) year from the date of issue. Provisional certifications are non-renewable and extensions are not permitted.

I. A pocket ID card will be issued along with the South Carolina certificate. The original pocket card must be in the possession of that individual all times that patient care is being rendered.

J. To convert a provisional certification to a regular South Carolina certification a reciprocity candidate must complete all requirements necessary to obtain a NREMT certification. All recertification requirements must meet all conditions stated in Section 903.

K. EMT certifications (EMT, AEMT, and Paramedic) must maintain a current NREMT credential to be certified, recertified, and maintain their current South Carolina certification.

Section 906. Certification Examinations.

A. Any candidate desiring EMT certification in South Carolina must successfully pass the NREMT examinations and obtain a NREMT certification.

B. The Department is responsible for the approval and location of all EMT psychomotor examination sites in South Carolina.

C. In accordance with NREMT guidelines, the psychomotor portion of the NREMT examinations for the EMT may be delegated to the approved training institutions to be conducted as part of the EMT course or may be conducted as a separate psychomotor examination approved by the Department. This psychomotor examination must be monitored by either a NREMT testing representative or a Department representative. The ability of a training institution to conduct an NREMT psychomotor examination may be revoked at any time should the Department discover such examinations are not being held in accordance with NREMT guidelines.

D. The AEMT and Paramedic psychomotor portion of the NREMT examination shall be conducted in accordance to the NREMT guidelines.

Section 907. Emergency Medical Technician Training Programs. (II)

A. These programs, which include initial and refresher EMT, AEMT, and Paramedic, are established by the Department and offered in approved technical colleges, other colleges and universities, vocational schools, and State Regional EMS training offices. The curricula for these training programs are the most current National EMS Education Standards (“Standards”) or any other curricula approved by the Department. Paramedic programs must be CAAHEP accredited or hold a CoAEMSP Letter of Review.

1. An application must be filed with the Department for a training institution to receive approval. No EMT, AEMT, or Paramedic training program may be conducted without approval by the Department.

2. All approved training institutions must designate one (1) person as the EMT program coordinator. This person shall be responsible to the Department for compliance with all applicable requirements pertaining to the training program.

3. Upon recommendation of the South Carolina EMS Training Committee and approval of the South Carolina EMS Advisory Council, a list of required equipment for the training programs will be maintained by the Department and updated as necessary.

4. Training institutions will be granted approval for no more than four (4) years at which time a re-approval may be granted to training institutions which have been compliant with all

requirements and have actively conducted initial EMT training programs. An institution shall not conduct courses with expired institution credentials.

5. Department-approved Training Centers in existence prior to the effective date of these regulations shall continue to provide EMT training in accordance with the provisions of this article.

6. All EMS training institutions must be granted approval by the Department prior to advertising or beginning any EMT course.

7. Any EMT course offered through an approved institution shall be an open course, with the exception of classes which are closed due to associated security concerns and/or requirements. Regardless of the location of the course, any candidate who satisfies the eligibility requirements shall be granted a seat in the course on a first-come, first-served basis until all seats have been filled.

8. EMT teaching institutions that instruct ALS shall retain a Medical Control Physician to provide medical oversight over their program.

B. Continuing Education Program or CE (formerly In-Service Training (IST) Program) – This program is established by the Department and is granted to approved South Carolina licensed EMS agencies for the sole purpose of recertification of South Carolina credentialed EMTs on their roster.

1. EMS agencies seeking approval for a CE program must file an application with the Department.

2. Upon recommendation of the South Carolina EMS Training Committee and approval of the South Carolina EMS Advisory Council, a list of required equipment for the CE programs will be maintained by the Department and updated as necessary.

3. CE programs will be granted approval for no more than four (4) years at which time reapproval may be granted to IST programs which have been compliant with all requirements.

4. All CE programs must meet or exceed all requirements established by the NREMT for recertification.

5. No South Carolina licensed EMS provider may begin a CE program prior to receiving approval by the Department.

6. CE programs may verify skills for currently credentialed state and NREMT personnel on their CIS roster. Provisional credentialed EMTs must have their NREMT skills verified at a Department approved NREMT testing site.

C. Continuing Education Units (CEUs) – The Department may approve additional CEUs on a case-by-case basis from medical schools, hospitals, simulation centers, Department credentialed teaching institutions, formal conventions, seminars, workshops, educational classes, and symposiums. All Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS) approved courses are accepted by the Department for CE credit in accordance with NREMT standards.

1. Requests for state approved CEUs are made through the Department and must be received by the Department in writing at least thirty (30) days prior to the scheduled event.

2. Requests for state approved CEUs must include the following:

a. Date, times, and agenda of the event;

b. Topics covered;

c. List of speakers and their credentials; and

d. Any additional information which may be requested by the Department.

D. Pilot Programs – The Department may authorize providers to initiate pilot programs which provide training in new and innovative procedures that have potential for lifesaving care.

1. Under no circumstances shall pilot programs be initiated without prior approval by the Department.

2. Those who wish to initiate a pilot program must provide in writing to the Department a detailed proposal of the program and any supporting materials. Upon recommendation by the South Carolina Medical Control Committee and with approval by the South Carolina EMS Advisory Council, the Department may authorize the program.

3. The EMTs who participate in these programs are allowed to perform the pilot procedures, under Medical Control Physician oversight, during the period of the pilot program.

4. At the conclusion of the pilot program, a study must be submitted to the Department describing the outcome or results of the program. Research gained from the pilot programs may be used to revise and upgrade existing EMT programs and scope of practice.

E. All training programs shall be taught by Department-certified instructors. Instructors that meet all requirements and satisfactorily complete the Department's instructor orientation of the EMT Course Administration and Policy Guidelines shall be certified by the Department. Instructor certifications shall expire on the last day of the month in which their State EMT certification expires.

F. To be certified as an EMT instructor, all new candidates must meet the following requirements:

1. Be twenty-one (21) years of age or older;

2. Possess high school diploma or GED;

3. Possess a current State and NREMT Paramedic credential;

4. Successfully completed a forty (40) hour state, National Association of EMS Educators (NAEMSE), International Fire Service Accreditation Congress (IFSAC), ProBoard or Department of Defense (DOD) fire instructor, or South Carolina Criminal Justice Academy instructor methodology course;

5. Possess a current and valid CPR instructor credential;

6. Must submit a properly completed and signed instructor application; and

7. Meet all other requirements for their level of instructor certification as required by the Department.

G. Instructor certificates may be renewed by submission of the following:

1. A properly completed and signed instructor recertification application;

2. A copy of a current South Carolina and NREMT Paramedic certification;

3. A copy of a current and valid CPR instructor credential;

4. Satisfaction of all teaching requirements as determined by the Department; and

5. Satisfaction of all other requirements as determined by the Department.

H. An EMT Instructor authorization may be suspended or revoked for any of the following reasons:

1. Any act of misconduct as outlined in Section 1100;

2. Suspension or revocation of the holder's South Carolina or NREMT certification;

3. Failure to maintain required credentials necessary for instructor designation;

4. Any act of proven sexual harassment toward another instructor or candidate;

5. Use of profane, obscene or vulgar language while in the presence of candidates or the EMT program coordinator during the context of class or related functions;

6. Conducting class without the minimum required equipment available and in working condition;

7. The use of any curricula not approved by the Department;

8. Gross or repeated violations of policy pertaining to the EMT training program;

9. Multiple instructor reprimands within a given period of time as established by the Department; or

10. Any other actions determined by the Department that compromises the integrity of the program. Those actions may include, but are not limited to the following:

a. Unprofessional behavior in the classroom;

b. Failure to notify the EMT program coordinator when classes must be cancelled or rescheduled;

c. Consistently starting class late or dismissing class early;

d. Conducting classes while under the influence of alcohol;

e. Conducting classes while under the influence of drugs that negatively impair the ability to instruct (prescribed, non-prescribed, or illegal);

f. Falsification of any documents pertaining to the course (such as attendance logs, equipment checklist); or

g. Repeated class results on the written and/or practical portion(s) of candidate examinations reflecting a class pass rate on the NREMT cognitive or psychomotor examinations of less than fifty percent (50%) (first-time pass rate) for two (2) consecutive same level classes or two (2) classes of the same level in three (3) years.

Section 908. Endorsement of Credentials.

A. The Department is tasked by S.C. Code Section 44-61-30(A) with developing standards and promulgating regulations for the improvement of emergency medical services.

B. There are areas of specialized practice in EMS which require further education, training, and clinical experience to receive credentials in those specialized areas of care and practice. The Department has an obligation to the public to recognize, endorse, and regulate these specialized practices to ensure a uniform scope of practice across the state.

C. The Department shall establish minimum educational and clinical guidelines for these endorsed credentials beyond a Paramedic certification.

D. The Department-endorsed credential shall include, but is not limited to, the following areas of specialized training:

1. Community Paramedic;

2. Critical Care Paramedic; and

3. Tactical Paramedic.

E. Endorsement of South Carolina credentials shall only be granted by the Department to Paramedics that are currently certified by the Department and hold an unencumbered current South Carolina certification. If a Paramedic's South Carolina certification is expired, suspended, or revoked by the Department, the endorsement follows the same status as their certification.

F. The specially endorsed South Carolina Paramedics shall only practice their skills within the scope of practice of their Department-approved agency, under a South Carolina licensed Medical Control Physician. Specially endorsed Paramedics are not independent healthcare practitioners.

G. The specially endorsed South Carolina Paramedics shall require additional specialty continuing education as determined by the Department.

H. The types of care rendered by the specially endorsed Paramedics shall include, but are not limited to, critical care interfacility services, prehospital services, preventative care, social service referrals, chronic care support, follow-up care and maintenance, and tactical medical support of law enforcement.

I. Licensed agencies using these specialized services shall have specific protocols by their Medical Control Physician and approved by the Department.

Section 909. Certification Patches.

A. An individual initially certified in South Carolina at any level shall receive a complimentary patch for the level which he or she received his or her certification.

B. Additional patches may be purchased for individuals for services which meet the following criteria:

1. The individual holds a current South Carolina certification; or

2. The individual is an EMS agency director, logistics officer, or training officer and is purchasing patches in bulk for his or her service.

SECTION 1000.

PERSONNEL REQUIREMENTS (I)

A. During the transportation of patients, there shall be an EMT, EMT-I, AEMT or Paramedic in the patient compartment at all times. The crew member with the highest level of certification shall determine which crew member will attend the patient during transport. If advanced life support procedures are in use, the responsible EMT-I, AEMT or Paramedic shall attend the patient in the patient compartment during transport.

B. Exception: Transferring or receiving medical facilities' registered nurses and physicians are authorized as ground ambulance attendants when assisting EMTs in the performance of their duties when all of the following requirements are met:

1. The required medical care of the patient is beyond the scope of practice for the certification level of the EMT.

2. When the ambulance transport is between medical facilities or from medical facility to the patient's residence.

3. When the responsible physician, transferring or receiving, assumes responsibility of the patient and provides appropriate orders, written preferred, to the registered nurse for patient care.

4. The registered nurse is on duty with the appropriate medical facility during the ambulance transport.

C. No person under the age of eighteen (18) shall operate any emergency vehicle owned or operated by the licensed provider.

D. No person shall act or serve in the capacity of attending a patient while under felony indictment or with certain past felony convictions as listed in Section 902.B.4.

E. All licensed providers must notify the Department immediately should they become aware of a felony indictment or conviction of any person on their roster.

SECTION 1100.

REVOCATION OR SUSPENSION OF CERTIFICATES OF EMERGENCY MEDICAL TECHNICIANS (I)

A. The Department shall, upon receiving a complaint of misconduct as herein defined, initiate an investigation to determine whether or not suitable cause exists to take action against the holder of an emergency medical technician certificate.

1. The initial complaint shall be in the form of a brief statement, dated and signed by the person making the complaint, which shall identify the person or service that is the subject of the complaint and contain a summary as to the nature of the complaint. The Department is also authorized to initiate an investigation based upon information acquired from other sources.

2. Information received by the Department through inspection, complaint or otherwise authorized under S.C. Code Sections 44-61-10 et seq. shall not be disclosed publicly except in a proceeding involving the question of licensing, certification or revocation of a license or certificate.

B. "Misconduct" constituting grounds for a revocation or suspension or other restriction of a certificate means while holding a certificate, the holder:

1. Used a false, fraudulent, or forged statement or document or practiced a fraudulent, deceitful, or dishonest act in connection with any of the certification requirements or official documents required by the Department;

2. Was convicted of a felony or another crime involving moral turpitude, drugs, or gross immorality;

3. Was addicted to alcohol or drugs to such a degree as to render the holder unfit to perform as an EMT;

4. Sustained a physical or mental disability that renders further practice by him dangerous to the public;

5. Obtained fees or assisted in the obtaining of such fees under dishonorable, false or fraudulent circumstances;

6. Disregarded an appropriate order by a physician concerning emergency treatment and transportation;

7. At the scene of an accident or illness, refused to administer emergency care on the grounds of age, sex, race, religion, creed or national origin of the patient;

8. After initiating care of a patient at the scene of an accident or illness, discontinued such care or abandoned the patient without the patient's consent or without providing for the further administration of care by an equal or higher medical authority;

9. Revealed confidences entrusted to him in the course of medical attendance, unless such revelation is required by law or is necessary in order to protect the welfare of the individual or the community;

10. By action or omission and without mitigating circumstance, contributed to or furthered the injury or illness of a patient under his care;

11. Was careless, or reckless, or irresponsible in the operation of an emergency vehicle;

12. Performed skills above the level for which he was certified or performed skills that he was not trained to do;

13. Observed the administration of sub-standard care by another EMT or other medical provider without documenting the event and notifying a supervisor;

14. By his actions, or inactions created a substantial possibility that death or serious physical harm could result;

15. Did not take or complete remedial training or other courses of action as directed by the Department;

16. Was found guilty of the falsification of any documentation as required by the Department;

17. Breached a section of the Emergency Medical Services Act of South Carolina or a subsequent amendment of the Act or any rules or regulations published pursuant to the Act.

18. Failed to provide a patient emergency medical treatment of a quality deemed acceptable by the Department.

C. The Department may take enforcement action, including suspending or revoking certifications or assessing a monetary penalty against the holder of a certificate at any time it is determined that the holder no longer meets the prescribed qualifications for being a certified EMT as provided in this regulation and the EMS Act.

D. The suspension or revocation of the emergency medical technician certificate shall include all levels of certification.

E. Any adverse action or event related to credentialed personnel shall be reported as required to the National Practitioner Data Bank, in accordance with federal law.

SECTION 1200.

AIR AMBULANCES

Section 1201. Licensing. (I)

It shall be unlawful for any ambulance service provider, agent or broker to secure or arrange for air ambulance service originating in the State of South Carolina unless such ambulance service meets the provisions of South Carolina Emergency Medical Services Act and regulations.

A. Air Ambulance Licensing and Insurance Requirements:

1. Air ambulance licensing procedures must meet the requirements in Section 400. Air ambulance permit procedures are contained in Section 500. A Department issued permit is required for each aircraft;

2. As part of the licensing procedure, every air ambulance operator shall carry an air ambulance insurance policy. The coverage amounts shall ensure that;

a. Each aircraft shall be insured for the minimum amount of one million dollars ($1,000,000) for injuries to, or death of, any one (1) person arising out of any one (1) incident or accident;

b. The minimum amount of three million dollars ($3,000,000) for injuries to, or death of, more than one (1) person in any one (1) accident;

c. The minimum amount of five hundred thousand dollars ($500,000) for damage to property from any one (1) accident;

d. Submit proof that the provider carries professional liability coverage in the minimum amount of five hundred thousand dollars ($500,000) per occurrence, with a company license to do business in the aircraft's home assigned state; and

e. All listed insurance shall provide a thirty (30) day cancellation notice to the Department. In accordance with Section 303, an agency is subject to enforcement action including but not limited to revocation or fines for laps of coverage for any period of time. A schedule of fines is listed in Section 1501.

3. Submit a copy of current FAA operational certificate and include designation for air ambulance operations, Administration Air Taxi and Commercial Operator Certification, ACTO;

4. Submit a letter of agreement that all aircraft shall meet the specifications of all applicable subsections of Section 501, if the aircraft is leased from a pool;

5. Proof that the Medical Control Physician meets the qualifications of Section 402;

6. The operator or firm must conform to all Federal Aviation Regulations (FARs), which are rules prescribed by the Federal Aviation Administration (FAA) Part 135; and

7. Each aircraft must be inspected and issued a permit by the Department prior to use.

B. Out-of-State Air Ambulances.

1. Out-of-state air ambulances transporting patients from locations originating in South Carolina must obtain a license in South Carolina prior to engaging in operations and must have a current and valid license in their home state, if applicable, except where exempt pursuant S.C. Code Section 44-61-100(D).

2. Out-of-state air ambulances operating in a state where no license is available must obtain a license in South Carolina and meet all requirements in Section 1200.

3. Out-of-state air ambulances transporting patients initiating in South Carolina must have the patient care report submitted into the South Carolina PreMIS system within seventy-two (72) hours of completing the transport.

C. Air Ambulance Categories:

1. Prehospital Transport Air Ambulance. Air ambulance services that transport patients in the prehospital setting will be permitted as either an advanced or basic life support service. In addition each prehospital service shall be required to meet the requirements and be licensed accordingly. Each such service shall contract with a Medical Control Physician.

2. Special Purpose Air Ambulance. The interfacility transportation of a critically injured or ill patient by an air ambulance (fixed-wing or rotary-wing aircraft) that includes the provision of medically necessary supplies and services, at a level of service beyond the normal scope of practice of a Paramedic. The Special Purpose air unit is necessary when a patient's condition requires ongoing care that must be furnished by one (1) or more healthcare professionals in an appropriate specialty area (such as neonate, critical care nursing, respiratory care, cardiovascular care), or a Paramedic with additional training approved by the Department. It is the responsibility of the provider's Medical Control Physician to ensure that the level of patient care required in any given transport is adequate for that patient's medical needs.

D. Air Ambulance Aircraft Requirements. The aircraft operator shall, in all operations, comply with all federal aviation regulations which are adopted by reference, FAA Part 135. The aircraft shall meet the following specifications:

1. Be configured in such a way that the medical attendants have adequate access for the provision of patient care within the cabin to give cardiopulmonary resuscitation and maintain patient's life support;

a. The aircraft or ambulance must have an entry that allows loading and unloading without excessive maneuvering (no more than forty-five (45) degrees about the lateral axis and thirty (30) degrees about the longitudinal axis) of the patient.

b. The configuration does not compromise functioning of monitoring systems, intravenous lines, and manual or mechanical ventilation.

2. A minimum of one (1) stretcher or cot must be provided that can be carried to the patient and allow loading of a supine patient by two (2) attendants;

a. The maximum gross weight allowed on the stretcher or cot (inclusive of patient and equipment) as consistent with manufacturer's guidelines.

b. Aircraft stretchers, cots, and the means of securing it in-flight must be consistent with national aviation regulations.

c. The stretcher or cot must be sturdy and rigid enough that it can support cardiopulmonary resuscitation.

d. The head of the cot is capable of being elevated at least thirty (30) degrees for patient care and comfort.

e. The patient placement must allow for safe medical personnel egress.

3. Have appropriate communication equipment to ensure both internal crew and air to ground exchange of information between individuals and agencies appropriate to the mission, including at least medical control, air traffic control, emergency services (EMS, law enforcement agencies, and fire), and navigational aids;

4. Be equipped with radio headsets that ensure internal crew communications and transmission to appropriate agencies;

5. Pilot is able to control and override radio transmissions from the cockpit in the event of an emergency situation;

6. Lighting. Supplemental lighting system shall be installed in the aircraft or ambulance in which standard lighting is insufficient for patient care;

a. A self-contained lighting system powered by a battery pack or a portable light with a battery source must be available.

b. There must be adequate lighting for patient care. Use of red lighting or low intensity lighting in the patient care area is acceptable if not able to isolate the patient care area from effects on the cockpit or on a pilot.

c. For those flights meeting the definition of "long range," additional policies must be in place to address how adequate cabin lighting will be provided during fueling and or technical stops to ensure proper patient assessment can be performed and adequate patient care provided.

7. Have hooks and/or appropriate devices for hanging intravenous fluid bags;

8. Helicopters must have an external landing light and tail-rotor position light;

9. Design must not compromise patient stability in loading, unloading, or in-flight operations;

10. Temperature; and

a. The interior of the aircraft must be climate controlled to avoid adverse effects on patients and personnel on board.

b. Thermometer is to be mounted inside the cabin.

c. Cabin temperatures must be measured and documented every fifteen (15) minutes during a patient transport until temperatures are maintained within the range of fifty to ninety-five (50 to 95) degrees Fahrenheit (ten to thirty-five (10 to 35) degrees Celsius) for aircraft.

11. Electric power outlet. Must be provided with an inverter or appropriate power source of sufficient output to meet the requirements of the complete specialized equipment package without compromising the operation of any electrical aircraft or ambulance equipment. Extra batteries are required for critical patient care equipment.

E. Aircraft Flight Crew Manning Requirements. The aircraft operator shall, in all operations, comply with all federal aviation regulations which are adopted by reference, FAA Part 135.

1. Rotorcraft Pilot:

a. The pilot must possess at least a commercial rotorcraft-helicopter and instrument helicopter rating 05.07.02.

b. The pilot in command must possess two thousand (2000) total flight hours (or total flight hours of at least fifteen hundred (1500) hours and recent experience that exceeds the operator's pre-hire qualifications such as current air medical and/or search and rescue experience or Airline Transport Pilot, ATP, rated) prior to an assignment with a medical service with the following stipulations:

i. A minimum of twelve hundred (1200) helicopter flight hours;

ii. At least one thousand (1000) of those hours must be as Pilot-in-Charge (PIC) in rotorcraft;

iii. One hundred (100) hours unaided (if pilot is not assigned to a Night Vision Goggles (NVG) base or aircraft);

iv. One hundred (100) hours unaided or fifty (50) hours unaided as long as the pilot has one hundred (100) hours aided (if assigned to an NVG base or aircraft); and

v. A minimum of five hundred (500) hours of turbine time.

c. The pilot must be readily available within a defined call-up time to ensure an expeditious and timely response.

2. Rotorcraft mechanic:

a. The helicopter mechanic is vital to mission readiness and, as such, shall possess at least two (2) years of experience and must be a certified air frame and power plant mechanic.

b. The mechanic must be properly trained and FAA certified to maintain the aircraft designed by the flight service for its aeromedical program.

3. Fixed-Wing Pilot:

a. A fixed-wing pilot must possess two thousand (2000) airplane flight hours prior to assignment with a medical service with the following stipulations:

i. At least one thousand (1000) of those hours must be as Pilot-in-Charge (PIC) in an airplane;

ii. At least five hundred (500) of those hours must be multi-engine airplane time as PIC. (Not required of single-engine turbine aircraft);

iii. At least one hundred (100) of those hours must be night flight time as PIC; and

iv. Both pilots in a two-pilot aircraft must be ATP rated.

b. In aircraft that require two (2) pilots, both pilots must be type rated for that make and model, and both pilots must hold first class medical certificates if the certificate holder operates

internationally. Both pilots must have training on Crew Resource Management (CRM), or Multi-pilot Crew Coordination (MCC).

4. Fixed-Wing Mechanic:

a. The mechanic is vital to mission readiness and must be a certified air frame and power plant mechanic.

b. The mechanic must be properly trained and FAA certified to maintain the aircraft designated by the flight service for its aeromedical program.

c. The mechanic must obtain and maintain a current Airframe and Powerplant (A&P) certificate.

F. Off-Line Medical Control Physician (Medical Director). The off-line Medical Control Physician of air ambulance services shall be responsible for:

1. Being knowledgeable of the capabilities and limitations of the aircraft used by his service;

2. Being knowledgeable of the medical staff's capability relative to the patient's needs;

3. Being knowledgeable of the routine and special medical equipment available to the service;

4. Ensuring that each patient is evaluated prior to a flight for the purpose of determining that appropriate aircraft, flight and medical crew and equipment are provided to meet the patient's needs;

5. Ensuring that all medical crew members are adequately trained to perform in-flight duties prior to functioning in an in-flight capacity; and

6. Must meet all requirements, duties and responsibilities listed in Section 402.

G. Aircraft Medical Crew Requirements:

1. Each basic life support air ambulance must be staffed with at least one (1) currently certified South Carolina EMT.

2. Each advanced life support air ambulance must be staffed with at least one (1) currently certified South Carolina Paramedic or South Carolina flight nurse as may be required by the patient's condition.

3. Each special purpose air ambulance must be staffed with at least one (1) Special Purpose EMT, Paramedic or RN with specialty training, as approved by the Department.

4. Each crew member must wear a flame retardant uniform with reflective striping.

5. Each crew member must display a legible photo identification with first name and certification level (for example, pilot, RN, or other) while patient care is anticipated to be rendered.

H. Orientation Program:

1. All medical flight crew members must complete a base level flight orientation program approved by the Department and supervised by the service's Medical Control Physician.

2. The flight orientation program shall be of sufficient duration and substance to cover all patient care procedures, including altitude physiology, and flight crew requirements.

Section 1202. Medical Supplies and Equipment. (II)

A. Local Medical Control Option (MCO) items are required equipment, unless the Medical Control Physician declines to carry suggested equipment. The MCO items must be stated in writing (such as incorporated into SOPs or Standing Orders) and submitted to the Department within ten (10) days of change.

B. Delivering Oxygen. Oxygen shall be installed according to national aviation regulations (FAA Part 135.91). Medical transport personnel can determine how oxygen is functioning by pressure gauges mounted in the patient care area.

1. Each gas outlet shall be clearly identified.

2. "No Smoking" sign shall be included.

3. Oxygen flow must be stoppable at or near the oxygen source from inside the aircraft or ambulance.

4. The following indicators shall be accessible to medical transport personnel while en route:

a. Quantity of oxygen remaining; and

b. Measurement of liter flow.

5. Adequate amounts of oxygen for anticipated liter flow and length of transport with an emergency reserve must be available for every mission.

6. When the vehicle is in motion, all oxygen cylinders shall be affixed to a wall or floor with crash stable, quick release fittings.

C. Sanitation. The floor, sides, ceiling and equipment in the patient cabin of the aircraft or ambulance must be a nonporous surface capable of being cleaned and disinfected by the standards listed in Section 800.

D. Basic Life Support (BLS) Equipment. BLS Air Ambulances shall have all the following equipment on board:

1. Automatic External Defibrillator (AED);

a. An AED shall be secured and positioned for easy access to the medical attendant(s).

b. Adult and Pediatric paddles, pads, and cables shall be available.

2. Suction Device. A portable suction device, age and weight appropriate, with wide bore tubing and at least a six (6) ounce reservoir;

a. Wide-bore, rigid pharyngeal curved suction tip: Minimum, two (2) each.

b. Sterile, single-use, flexible suction catheter between 6 Fr – 16 Fr: Minimum, two (2):

i. One (1) must be between 6 Fr – 10 Fr.

ii. One (1) must be between 12 Fr – 16 Fr.

3. Airway Equipment;

a. Nasal Cannulas (NC): Adult and pediatric with adequate length tubing, two (2) each.

b. Non-Rebreather Mask (NRB): Adult and pediatric with adequate length tubing, two (2) each.

c. Nasopharyngeal airways (NPAs): 16 Fr-34 Fr adult and child sizes, one (1) each. All airways shall be stored in a manner to maintain cleanliness.

d. Nonmetallic oropharyngeal airways (OPAs): sizes 0-5, one (1) each. All airways shall be stored in a manner to maintain cleanliness.

e. Bag Valve Ventilation Units (BVMs):

i. One (1) adult, hand operated. Valves must operate in all weather, and unit must be equipped to be capable of delivering ninety to one hundred (90 to 100) percent oxygen to the patient.

ii. One (1) child, hand operated. Valves must operate in all weather and unit must be equipped to be capable of delivering ninety to one hundred (90 to 100) percent oxygen to the patient. The BVM must include safety pop-off mechanism with override capability.

iii. One (1) infant, hand operated. Valves must operate in all weather and unit must be equipped to be capable of delivering ninety to one hundred (90 to 100) percent oxygen to the patient. The BVM must include safety pop-off mechanism with override capability.

iv. In conjunction with the ventilation units above, 0, 1, 2, 3, 4, 5 masks will be carried (either the disposable or non-disposable types, local MCO).

f. Adult and Pediatric Magill forceps, one (1) each (local MCO).

g. Blind Insertion Airway Device (BIAD): meet all age and weight size categories as defined by Food and Drug Administration (FDA). Syringe(s) needed to inflate bulbs shall be included in packaging, if not appropriate size(s) must be carried by provider (local MCO).

4. Bandage Material;

a. ABD pad five (5) inches by nine (9) inches, or larger, two (2) minimum.

b. Individually wrapped, sterile four (4) inches by four (4) inches gauze pad, fifteen (15) minimum.

c. Gauze bandage rolls individually wrapped and sterile in three (3) varieties of sizes (for example, 4.5 inches x 4.1 yards, 3.4 inches x 3.6 yards), one (1) each.

d. Commercial sterile occlusive dressing, minimum size four (4) inches by four (4) inches, two (2) each.

e. Adhesive tape, hypoallergenic, one (1), two (2), and three (3) inches wide, one (1) each.

f. Sterile burn sheet, one (1) each (local MCO).

g. Triangular bandages, minimum two (2) each (local MCO).

h. Large trauma bandage shears, one (1) each.

i. Minimum of 250 mL of sterile water or normal saline for irrigation.

5. Splints;

a. Traction-type, lower extremity splint. Uni-polar or bi-polar type is acceptable (local MCO).

b. Padded, wooden-type splints, two (2) each, fifteen (15) inches by three (3) inches and thirty-six (36) inches by three (3) inches, or other approved commercially available splints for arm or leg fractures (local MCO).

6. Spine Boards;

a. One (1) Long Spine Board (at least sixteen (16) inches by seventy-two (72) inches). The use of folding backboards is acceptable as a substitute for the long spine board (local MCO).

b. Cervical collars for adult and pediatric adjustable or available in sizes of short, regular, or tall; minimum one (1) each. Each cervical collar shall be manufactured with rigid or semi-rigid material (local MCO).

c. Adult and Pediatric head immobilization device, commercially or premade: One (1) each (local MCO).

d. Nine (9) foot straps, minimum three (3) each, or one set of 10-point spider straps (local MCO).

7. Obstetrical kit: The kit shall be sterile, latex free and contain the following: gloves, scissors or surgical blades, umbilical cord clamps or tapes, dressing, towels, perinatal pad, bulb syringe and a receiving blanket for delivery of infant (local MCO);

8. Assessment tools; and

a. Adult and Pediatric blood pressure sphygmomanometer, cuff, bladder, and tubing must be clean and in good repair.

b. Stethoscope with membrane(s) and tubing in good repair.

c. Adult and Pediatric pulse oximeter with numeric reading.

d. Glucometer or blood glucose measuring device (local MCO).

9. Miscellaneous Equipment:

a. Eye protection or face shield, one (1) for each medical crew member (local MCO).

b. Non-sterile, latex free exam gloves in two (2) variations of size, labeled; minimum of five (5) pairs each.

c. Waterless hand cleanser, commercial antimicrobial.

d. EPA recommended germicidal/viralcidal agent or a sodium hypochlorite solution of ninety-nine (99) parts water and one (1) part bleach used for cleaning equipment.

e. A clearly marked sharps container (may be fixed or portable) with locking mechanism.

f. Emesis basin, one (1) (local MCO).

g. Bedpan and urinal, one (1) each (local MCO).

h. Two (2) dependable flashlights or electric lanterns.

i. One (1) fire extinguisher approved for aircraft use. Each shall be fully charged with valid inspection certification and capable of extinguishing type A, B, or C fires. At least one (1) hand fire extinguisher must be provided and conveniently located on the flight deck for use by the flight crew.

j. Additional equipment. Equipment not found in this regulation is subject to inspection and must be stored and operate to the manufacturer's recommendations. If any fault is found, the equipment must be immediately removed for repair and/or replacement.

E. Advanced Life Support (ALS) Equipment. Air ambulances providing ALS in the Prehospital or Special Purpose category must have all the following equipment and supplies on board in addition to Section 1202.D:

1. Cardiac monitor;

a. Must be secured and positioned so that displays are visible to the medical attendant(s) and;

b. Must have printable four (4) lead waveform, twelve (12) lead/EKG, SpO2 waveform with numeric reading, and invasive pressure monitor port(s) for adult and pediatric (including neonate, if applicable) and;

c. One (1) extra roll of printer paper;

d. Have an internal rechargeable battery pack(s);

e. Extra battery or AC adapter and cord available;

f. Defibrillator, which may be integrated into cardiac monitor modular to include:

i. Adult and Pediatric paddles and pads are available; and

ii. Appropriate size pads and settings must be available for neonatal transports (if neonatal transports are conducted); and

g. Adult and Pediatric capabilities to Transcutaneous Pace. Either stand-alone unit or integrated in to cardiac monitor modular.

2. Advanced airway and ventilatory support equipment;

a. One (1) laryngoscope handle with extra set of batteries and bulbs, if applicable.

b. Laryngoscope blades, adult, child, and infant sizes.

i. 0-4 Miller.

ii. 1-4 Macintosh.

c. One (1) each disposable endotracheal tubes sizes as well as intubation stylettes sized for each tube.

i. 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5 mm cuffed or uncuffed.

ii. 6.0, 6.5, 7.0, 7.5, 8.0 mm.

iii. Other sizes (local MCO).

d. Water soluble lubricating jelly, four (4) each.

e. Adult and Pediatric Magill forceps, one (1) each.

f. Blind Insertion Airway Device (BIAD) that meet all age and weight size categories as defined by FDA. Syringe(s) needed to inflate bulbs shall be included in packaging, if not appropriate size(s) must be carried by provider.

g. Age appropriate Positive End-Expiratory Pressure (PEEP) valve (may be incorporated into BVMs).

h. A mechanical ventilator and circuit appropriate to age/weight, including neonate (if applicable) which must include measurement of:

i. Fraction of inspired oxygen (FiO2);

ii. Tidal volume (Vt);

iii. Respiratory rate (RR) or frequency; and

iv. Positive End-Expiratory Pressure (PEEP).

i. Continuous Positive Airway Pressure (CPAP), able to be incorporated within the mechanical ventilator; appropriate settings and attachments (such as face masks) for adults and pediatric patients, and neonate patients (if applicable).

j. Bi-level Positive Airway Pressure (BiPAP), which may be incorporated within the mechanical ventilator; appropriate settings and attachments for adults and pediatric; neonate (if applicable).

k. Printable waveform End-tidal CO2 continuous monitoring capabilities, which may be incorporated within cardiac monitor modular.

3. Venous Access;

a. Intravenous catheters 14g-20g, two (2) of each.

i. 22g-24g, two (2) each required if pediatric or neonate transports are conducted.

b. Intraosseous needles.

i. Adult and Pediatric needles.

ii. Neonate size required if applicable.

c. Minimum of two (2) macro drip sets, 10-20gtts/mL.

d. Minimum of two (2) independent multi-channel infusion pump that allows fluid and medications to be administered at different rates, sequentially. IV pump, at minimum, must:

i. Have an internal rechargeable battery pack;

ii. Have a AC adapter and cord; and

iii. Display the infusion rate, volume infused, and volume remaining.

e. Two (2) sets of IV pump tubing.

f. 18g-25g needles at least one and one-half inch length, minimum of four (4):

i. Two (2) must be 18g-20g.

ii. Two (2) must be 23g-25g.

g. Syringes.

i. 1mL, two (2) each.

ii. 3-5mL, two (2) each.

iii. 10-20mL, four (4) each.

h. Minimum of three (3) IV start kits containing:

i. Latex free tourniquet.

ii. Antiseptic solution.

iii. Latex free IV catheter dressing.

iv. Intravenous arm boards for pediatric patients, two (2) each (local MCO).

4. Intravenous Fluids;

a. A total of 2000mL of intravenous fluids onboard, may be a combination of:

i. Sizes (such as 100mL-1000mL).

ii. Variety (such as Lactated Ringers, Normal Saline, D5W).

iii. Must have the capability to administer warm fluids.

5. Miscellaneous Equipment; and

a. A current color-coded Pediatric weight and length-based drug dose chart.

b. Alcohol or iodine prep pads for preparing IM injections, minimum six (6).

6. Additional equipment: equipment not found in this regulation is subject to inspection and must be stored and operate to the manufacture recommendations. If any fault is found, the equipment must be immediately removed for repair and/or replacement.

Section 1203. Special Purpose Air Ambulances. (II)

All special purpose air ambulances must be equipped with at least the following items from Section 1202: A, B, C, D, and E.

Section 1204. Medication and Fluids for Advanced Life Support Air Ambulances. (II)

Such medications and fluids approved by the Board for possession and administration by EMTs, and specified by the Medical Control Physician, will be carried on the air ambulance. Medications not included on the approved medication list for Paramedics may be carried on board the air ambulance so long as there is a written protocol which is signed and dated by the Medical Control Physician, for the use of the medications, fluid, or blood product and delineates administration only by a registered nurse or physician.

A. Medications must be easily accessible.

B. Controlled substances are in a double locked system and kept in a manner consistent with state and federal Drug Enforcement Agency (DEA) regulations.

C. Storage of medications allows for protection from extreme temperature changes within the U.S. Pharmacopeia guidelines as listed in Section 601.I.5, if environment deems it necessary.

D. If there is a refrigerator on the vehicle for medications, a temperature monitoring and tracking policy is required, and the refrigerator is used and labeled "for medication use only."

Section 1205. Rescue Exception. (II)

An aircraft without a permit may be used for occasional non routine missions, such as the rescue and transportation of victim/patients, who may or may not be ill or injured, from structures, depressions, water, cliffs, swamps or isolated scenes, when in the opinion of the rescuers or EMS provider present at the scene, such is the preferred method of rescue and transportation incident thereto due to the nature of the entrapment, condition of the victim, existence of an immediate life-threatening condition, roughness of terrain, time element and other pertinent factors:

A. Provided that after the initial rescue, an EMT or higher level EMS technician accompanies the victim-patient en-route with the necessary and appropriate EMS supplies needed for the en-route care of the specific injuries or illness involved.

B. Provided the aircraft is of adequate size and configuration to effectively make the rescue and to accommodate the victim-patient, attendant(s) and equipment.

C. Provided reasonable space is available inside the aircraft for continued victim-patient comfort and care.

D. Provided a permitted aircraft is not available within a reasonable distance response time; and

E. Provided the victim-patient is transferred to a higher level of EMS ground transportation for stabilization and transport if such ground unit is available at a reasonably safe landing area.

SECTION 1300.

PATIENT CARE REPORTS (III)

Section 1301. Patient Care Reports.

A. Each licensed provider must create and submit an electronic patient care report (ePCR) for each patient contact regardless of patient transport decision.

B. The primary care attendant is responsible for documenting all patient contact, care, and transport decision within the ePCR. All required documentation must be completed within twenty-four (24) hours of the conclusion of call.

C. Each licensed provider must submit its ePCRs into PreMIS within seventy-two (72) hours of the conclusion of call.

D. When transporting to an emergency room (ER), patient ePCR shall be submitted to the ER within thirty (30) minutes of the completion of the call. In lieu of that, a paper pre-run information sheet may be substituted until the ePCR is sent. ePCR information shall be sent no later than twenty-four (24) hours from completion of the call.

Section 1302. Data Manager.

A. Each licensed provider that provides patient care shall appoint a Data Manager to ensure accuracy, HIPAA compliance, security, and provide timely submission of ePCRs into PreMIS.

B. The Department must be notified of any change in the Data Manager within ten (10) days.

C. The Data Manager shall ensure that each ePCR submitted reflects all the attendants on the incident including non-certified drivers (if applicable).

Section 1303. Content.

A. Patient care reports shall reflect services, treatment, and care provided directly to the patient by the provider including, but not limited to, information required to properly identify the patient, a narrative description of the call from time of first patient contact to final destination, all providers on the call, and other information as determined by the Department.

B. All patient care reports shall be coherently written, authenticated by the author, and time stamped.

C. Patient care reports involving refusals shall include, but not be limited to the following: details of any assessment performed; information regarding the patient's capacity to refuse; information regarding an informed refusal by the patient; information regarding provider's efforts to convince the patient to accept care; and any efforts by the provider to protect the patient after the refusal if the patient becomes incapacitated.

D. Data submissions from ePCR software shall maintain a quality score no higher than fifty percent (50%) of the average state data quality score, as provided by the Department's vendor. Licensed providers shall have ninety (90) calendar days from the Department's notification to successfully correct data quality. For example, if the average state data quality score is five (5), then the licensed providers must have a quality score of seven and one half (7.5) or lower to meet this requirement.

Section 1304. Report Maintenance.

A. South Carolina utilizes PreMIS, an electronic patient care reporting system that is compliant with the current version of the National EMS Information System (NEMSIS). Data submissions from ePCR software into the state system must meet the Department's requirements as outlined in the South Carolina EMS Data Manager's program manual.

B. The licensed provider shall provide accommodations and equipment adequate for the protection, security, and storage of patient care reports.

C. The Department maintains an electronic data stream of the ePCR with the state-required data elements from the original report. Licensed providers must maintain their copy of the original data, all attachments and appended versions of each ePCR for no less than ten (10) years on all adult patients and thirteen (13) years for minor patients as stated in S.C. Code Section 44-115-120. Attachments to ePCRs include, but are not limited to, EKGs, waveform capnography records, code summaries, short reports, and other forms of recorded media.

D. Prior to closure of business, the licensed provider must arrange for preservation of ePCRs to ensure compliance with these regulations. The provider must notify the Department, in writing, describing these arrangements within ten (10) days of closure.

E. In the event of a change of ownership, all patient care reports shall be transferred to the new owner(s).

F. The patient care report is confidential. Reports containing protected or confidential health information shall be made available only to authorized individuals in accordance with state and federal laws.

G. When patient care is transferred, the receiving agency shall receive the copy of the patient care report within a reasonable amount of time, preferably at the time of transfer, to ensure continuity in quality care.

H. Pursuant to S.C. Code Section 44-61-160, a person who intentionally fails to comply with reporting, confidentiality, or disclosure of requirements in this section is subject to a civil penalty of not more than one hundred dollars ($100) for a violation of the first time a person fails to comply and not more than five thousand dollars ($5000) for a subsequent violation.

SECTION 1400.

DO NOT RESUSCITATE ORDER

Section 1401. Purpose and Authority of Emergency Medical Services Do Not Resuscitate Order.

A. Title 44, Chapter 78 of the 1976 S.C. Code directs the Department to promulgate regulations necessary to provide directions to emergency medical personnel in identifying and honoring the wishes of patients who have executed a Do Not Resuscitate Order for Emergency Services. The Do Not Resuscitate Order for Emergency Services is commonly referred to as the EMS DNR law.

B. The EMS DNR law is applicable only to resuscitative attempts by EMS providers in the pre-hospital setting such as the declarant's home, a long-term care facility, during transport to or from a health care facility and in other locations outside of acute care hospitals.

C. Specific statutory authority is found in S.C. Code Section 44-78-65.

Section 1402. Definitions.

A. The definitions contained in S.C. Code Section 44-78-15 are hereby incorporated by reference.

B. Agent or Surrogate means a person appointed by the declarant under a Health Care Power of Attorney, executed or made in accordance with the provisions of S.C. Code Sections 62-5-504 and/or 44-77-10.

C. Cardiac Arrest means the cessation of a functional heartbeat.

D. Cardiopulmonary Resuscitation or CPR means the use of artificial respirations to support restoration of functional breathing combined with closed chest massage to support restoration of a functional heart beat following cardiac arrest.

E. Department means the South Carolina Department of Health and Environmental Control.

F. Respiratory Arrest (Pulmonary Arrest) means cessation of functional breathing.

G. Do Not Resuscitate Order for Emergency Medical Services marker is a bracelet or necklace that is engraved with the patient's name, the health care provider's name and telephone number and the words "Do Not Resuscitate" or the letters DNR.

Section 1403. General Provisions.

A. The EMS DNR Form. The document which is to be a "Do Not Resuscitate Order" for EMS purposes must be in substantially the following form:

NOTICE TO EMS PERSONNEL

This notice is to inform all emergency medical personnel who may be called to render assistance to

_____
(Name of patient)

that he/she has a terminal condition which has been diagnosed by me and has specifically requested that no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardio-pulmonary arrest.

REVOCATION PROCEDURE

THIS FORM MAY BE REVOKED BY AN ORAL STATEMENT BY THE PATIENT TO EMS PERSONNEL, OR BY MUTILATING, OBLITERATING, OR DESTROYING THE DOCUMENT IN ANY MANNER.

Date:_____

_____
Patient's Signature (or Surrogate or Agent)

_____
Physician's Signature

_____
Physician's Address

_____
Physician's Telephone Number

B. Distribution of the EMS DNR Form. The EMS DNR form, along with instructions for execution and a patient information sheet shall be distributed by the Department to health care

providers. Informational pamphlets shall be prepared by the Department and made available to other interested parties upon request.

C. Location of the Executed EMS DNR Form. The executed EMS DNR Form shall be placed in a location where the document is easily observed and recognized by EMS personnel. The form shall be displayed in such a manner that it will be visible and protected at all times.

D. EMS DNR Marker. The DNR marker shall be a bracelet or necklace as approved by the Department. The marker may be worn upon the execution of the EMS DNR Document. Wearing of the marker shall not be mandatory but is encouraged. The marker will alert EMS personnel of the probable existence of the EMS DNR document. The marker shall be of metallic construction and shall be unique and easily recognizable. The marker shall contain the patient's name, the health care provider's name and telephone number and the words "Do Not Resuscitate" or the letters DNR.

E. No person under the age of eighteen (18) may request or receive a “Do Not Resuscitate Order for Emergency Medical Services” as noted in S.C. Code Section 44-78-50(B).

Section 1404. Revocation of EMS DNR Order.

The EMS DNR Order may be revoked at any time by the oral expression of the patient to EMS personnel or by the mutilation, obliteration or destruction of the document in any manner. If the order is revoked, EMS personnel shall perform full resuscitation and treatment of the patient.

Section 1405. Patient's Assessment and Intervention. (II)

When EMS Personnel report to a scene, they shall do a patient assessment. If an EMS DNR bracelet or necklace is found during the assessment, EMS personnel shall make a reasonable effort to determine that an EMS DNR form exists and to ensure that the EMS DNR form applies to the person on which the assessment is being made. If no DNR form is found, resuscitative measure will be initiated. If after starting resuscitative measures an EMS DNR form is later found, resuscitative measure must be stopped.

Section 1406. Resuscitative Measures to be Withheld or Withdrawn. (II)

In the event that the patient has a valid EMS DNR order, the following procedures shall be withheld or withdrawn:

A. CPR;

B. Endotracheal intubation and other advanced airway management;

C. Artificial ventilation;

D. Defibrillation;

E. Cardiac resuscitation medication; and

F. Cardiac diagnostic monitoring (ONLY withheld in the face of cardiac arrest).

Section 1407. Procedures to Provide Palliative Treatment. (II)

The following treatment may be provided as appropriate to patients who have executed a valid EMS DNR order:

A. Suctioning;

B. Oxygen;

C. Pain medication;

D. Non-cardiac resuscitation medications;

E. Assistance in the maintenance of an open airway as long as such assistance does not include intubation or advanced airway management;

F. Control of bleeding;

G. Comfort care; and

H. Support to patient and family.

Section 1408. DNR Information for the Patient, the Patient's Family, the Health Care Provider and EMS Personnel. (II)

A. Responsibilities of the patient or his or her Surrogate or agent.

The patient and his or her surrogate or agent shall:

1. Make all care givers aware of the location of the EMS DNR Form and ensure that the form is displayed in such a manner that it will be visible and available to EMS personnel.

2. Be aware of the consequences of refusing resuscitative measures.

3. Be aware that if the form is altered in any manner resuscitative measures will be initiated.

4. Understand that in all cases, supportive care will be provided to the patient.

B. Responsibilities of the Health Care Provider (Physician) The patient's physician:

1. Has determined that the patient has a terminal condition.

2. Has completed the patient's EMS DNR Form.

3. Has explained to the patient and family the consequences of withholding resuscitative care; the medical procedures that will be withheld and the palliative and supportive care that will be administrated to the patient.

C. Responsibilities of EMS Personnel.

EMS personnel:

1. Will confirm the presence of the EMS DNR Form and the identity of the patient.

2. Upon finding an unaltered EMS DNR Form, will withhold or withdraw resuscitative measures such as CPR, endotracheal intubation or other advanced airway management, artificial ventilation, defibrillation, cardiac resuscitation medication and related procedures.

3. Will provide palliative and supportive treatment such as suctioning the airway, administration of oxygen, control of bleeding, provision of pain and non-cardiac medications, provide comfort care and provide emotional support for the patient and the patient's family.

4. Must have in his possession either the original or a copy of the DNR Order during transport of the patient.

SECTION 1500.

FINES AND MONETARY PENALTIES

Section 1501. Fines and Monetary Penalties.

A. When a decision is made to impose monetary penalties, the following schedule shall be used as a guide to determine the dollar amount:

MONETARY PENALTY RANGES

FREQUENCY	CLASS I	CLASS II	CLASS III
1st	$300 - 500	$100 - 300	$50 - 100
2nd	$500 – 1,500	$300 – 500	$100 - 300
3rd	$1,000 – 3,000	$500 – 1,500	$300 - 800
4th	$2,000 - 5,000	$1,000 – 3,000	$500 –1,500
5th	$5,000 - 7,500	$2,000 – 5,000	$1,000 – 3,000
6th or more	$10,000	$7,500	$2,000 – 5,000

B. When a licensed agency fails a vehicle reinspection, a Class IV penalty may be levied upon the agency. Pursuant to S.C. Code Section 44-61-70, the following Class IV fine schedule shall be used when a permitted ambulance or licensed rapid responder service loses points upon reinspection:

Frequency of violation of standard within a thirty-six (36) month period:

MONETARY PENALTY RANGES

FREQUENCY	CLASS IV Points/Penalty	
1st	0-24	$25-50
2nd	25-50	$50-100
3rd	51-100	$100-300
4th	101-500	$300-500
5th	501-1000	$500-1500
6th or more	Over 1000	$1000-3000

C. There may be multiple occurrences of a violation (Class I, II, and III) within a one (1) day period that would constitute multiple fineable occurrences. (For example, in allowing uncertified

personnel to render patient care, each patient treated is an "occurrence" and thus a separate fineable offense.)

SECTION 1600.

SEVERABILITY

In the event that any portion of these regulations is construed by a court of competent jurisdiction to be invalid, or otherwise unenforceable, such determination shall in no manner affect the remaining portions of these regulations, and they shall remain in effect, as if such invalid portions were not originally a part of these regulations.

SECTION 1700.

GENERAL

Conditions that have not been addressed in these regulations shall be managed in accordance with best practices as interpreted by the Department.

Development & Services Committee Meeting
October 24, 2017
Briefing Document

Agenda Item
Building permits of Developers and Builders

Background
On May 16, 2017, the Honorable Norman Jackson made the following motion:

> If Developers, Builders, etc. cause any hardship on any community due to poor workmanship or unapproved or unpermitted work of any kind that fails, all of their building permits should be pulled and the builder not allowed to build until they fix the problem(s). The homeowners, nor the citizens, should have to pay to fix poor workmanship [N. Jackson]

The County currently cites and stops work on projects that are unapproved or unpermitted per Sec. 6-31 (Buildings and Building Regulations); 26-272 (Land Development) and the County's DHEC National Pollutant Discharge Elimination System Permit.

However, there is no ordinance that allows the County to halt work by a developer/builder that is properly approved and permitted, even if the developer/builder has citations on other work in the County.

Issues
Unapproved or unpermitted work by developers

Fiscal Impact
N/A

Past Legislative Actions
None.

Alternatives
1. Amend the County's current building and land development enforcement processes.

2. Do not amend the County's current building and land development enforcement processes.

Staff Recommendation
Council discretion, however, staff will continue to enforce current ordinances.

Submitted by: Councilman Norman Jackson, District 11
Date: May 16, 2017

Staff Recommendation
Council discretion, however, staff will continue to enforce current ordinances.

Submitted by: Councilman Norman Jackson, District 11

Date: May 16, 2017

Development & Services Committee Meeting
October 24, 2017
Briefing Document

Agenda Item
Homeowners' Associations

Background
On May 16, 2017, the Honorable Norman Jackson made the following motion:

> HOA's operated by developers or management firms should be fined if due to their poor management, and not that of the homeowners, it causes a hardship on the homeowners or community. NOTE: There are improperly maintained detention ponds that have trees growing in them which causes flooding during a bad storm [N. Jackson]

The County does not have the authority to intervene in private matters between homeowners and their Homeowner's Associations, making the first half of the motion related to "poor management…caus[ing] a hardship on the homeowners or community" difficult to address.

However, the County does enforce its Code of Ordinances against appropriate entities, including HOA's if they are responsible for the maintenance. Thus, if the detention ponds are not being maintained per the maintenance plan associated with the approved set of plans, the County can issue citations per: *PART II, Section 9(d) of the National Pollutant Discharge Elimination System Permit for Discharge to Surface Waters issued by the Storm Water, Construction and Agricultural Permitting Division of DHEC.*

Issues
Management capacity of Homeowners' Associations

Fiscal Impact
N/A

Past Legislative Actions
None.

Alternatives
1. Amend the County's current land development enforcement processes.

2. Do not amend the County's current land development enforcement processes.

Staff Recommendation
Council discretion, however, staff will continue to enforce current ordinances.

Submitted by: Councilman Norman Jackson, District 11
Date: May 16,2017

Development & Services Committee Meeting
October 24, 2017
Briefing Document

Agenda Item
Emergency Shelters / Facilities

Background
On September 12, 2017, the Honorable Norman Jackson made the following motion:

> To simplify the emergency preparedness process in the future, I move that Richland County coordinate with the City of Columbia and other municipalities to identify different types of emergency shelters/facilities and certify them, meaning what is required and the readiness of the facility factoring in accessibility due to potential obstructions i.e. impassible bridges, roads etc. Working with recreation centers, school districts, churches and other civic centers to qualify and certify these facilities to accommodate citizens in need during certain crisis. In this process each certified facility would be updated annually. Working with Councilmembers willing to participate from each district would also improve the process. Note: Shelters to include overnight stay, storage and accommodate the Red Cross and other agencies. Facilities to include storage for distribution to designated areas [N. Jackson]The County currently cites and stops work on projects that are unapproved or unpermitted per Sec. 6-31 (Buildings and Building Regulations); 26-272 (Land Development) and the County's DHEC National Pollutant Discharge Elimination System Permit.

Following Hurricane Matthew in 2016, the County's Executive Committee Team began working with the City of Columbia to identify "Calamity" shelters that could be used during periods of adverse weather to house residents that are in need of shelter and / or assistance. This collaborative effort is ongoing.

Issues
Emergency shelters/facilities

Fiscal Impact
N/A

Past Legislative Actions
None.

Alternatives
1. Consider the motion and proceed accordingly.

2. Consider the motion and do not proceed.

Staff Recommendation
Council discretion, however, staff will continue to enforce current ordinances.

Submitted by: Councilman Norman Jackson, District 11
Date: September 12, 2017

Development & Services Committee Meeting
October 24, 2017
Items Pending Analysis – Status Updates

Items Pending Analysis

a. Council Motion: Develop an emergency plan with SCDOT to immediately repair Rabbit Run Road and Bitternut Road. Developers' constant neglect to repair the storm drainage system causes dangerous flooding. A school bus almost overturned in the flood this morning (April 24, 2017) on Rabbit Run Road. We cannot afford to endanger the lives of citizens, especially school children because of neglect [N. Jackson]

Status Update: This motion was brought forth by Councilman Norman Jackson during Council May 2, 2017 meeting deliberations. Concurrently, this matter is being addressed through a coordinated effort between County Transportation staff and SCDOT. Currently, staff is working to acquiring the needed Right of Way to allow SCDOT to minimize the flooding issue by upsizing the drainage pipes. Staff intends present this item at the November D&S Committee for its consideration.

b. Council Motion: Direct staff to research changing the ordinance relating to water runoff so in the future it will require environmental studies and not allow any runoff that exceeds the current runoff from the undeveloped property. This motion should be reviewed/completed and provided to the Planning Commission no later than their June meeting [Malinowski]

Status Update: This motion was brought forth by Vice-Chairman Bill Malinowski during Council's May 16, 2017 meeting deliberations. Staff is working to complete its research on this motion. Staff intends to present this item to the Planning Commission at its November meeting.

c. Council Motion: Direct Legal to research what is required to enact a parking ordinance in communities/subdivisions [McBride]

Status Update: This motion was brought forth by Councilwoman McBride during Council's April 4, 2017 meeting deliberations. Staff has been working with Councilwoman McBride regarding this motion. Once staff's review is complete, this item will be forwarded to the Committee for consideration.

d. Council Motion: I move that we re-allocate some of the funding we used to increase the general fund balance farther above the minimum policy amount than it already was, and given that the FY16-17 budget produced a surplus, to EMS [Manning]

Status Update: This motion was brought forth by Councilman Manning during Council's October 17, 2017 meeting deliberations. Staff is reviewing this motion and will present a debriefing for the Committee's consideration upon completion of its review.