



CRIMINAL HISTORY BACKGROUND CHECKS (LIVESCAN)

PURPOSE

To provide information for Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) background checks for individuals applying for certification/recertification as an Emergency Medical Technician (EMT) recognized in the State of California by the ICEMA Medical Director.

AUTHORITY

Section 1797.107, Health and Safety Code; California Code of Regulations, Title 22, Chapter 10, 100347.

GENERAL INFORMATION

Effective July 1, 2010 all Emergency Medical Technicians (EMTs) must have a criminal background check (LiveScan) on file with the certifying entity.

LiveScan Forms

Live Scan forms can be printed from the ICEMA website. **It is important that the information be entered onto the form exactly as outlined in the instructions. Failure to do so will require LiveScan resubmission and additional fees.**

Forms are also available at the LiveScan agencies. If printing from the ICEMA website, applicant must print three (3) completed copies: one for the Live Scan agency, one for ICEMA and one for the applicant.

Fees

Currently, fees include a \$36 DOJ fee and a \$17 FBI fee. Additionally, each LiveScan agency charges a "rolling fee" that varies but averages approximately \$20. Applicant is required to pay these fees to the LiveScan agency when submitting fingerprints. Be sure to confirm methods of payment (personal checks, money orders, or cash); there are differences as to what agencies will accept. Also, remember to bring a picture ID.

Live Scan Agencies

A complete listing is available on the ICEMA website and is listed by county and includes hours of operation, cost, whether an appointment is necessary, and acceptable methods of payment.

Confidentiality

Privacy and confidentiality of criminal history record information is the responsibility of ICEMA. Once a response is received from LiveScan, ICEMA is obligated to destroy that information immediately, once a decision is made on certification status. In addition, only preauthorized EMS Agency staff is permitted to review this information. All submitted material will be held in strict confidence.

Conviction History

Conviction of a crime does not necessarily mean that an applicant will be denied certification. The appropriate EMS staff, along with the County legal department, if appropriate, will review each individual case where the applicant has a criminal conviction. Decisions will be based on applicable State statutes and regulations and a careful review of documentation. If an applicant is denied, he/she has the right to request a hearing. In addition to certification actions, an EMT certificate may be suspended or revoked based upon criminal history information. Applicants with a criminal conviction or who are involved in an active prosecution can expect a delay in the processing of their application. Submitting a letter explaining the case and copies of court documents can help in the decision process. For further information please see *Protocol #1070, EMT Investigations and Disciplinary Actions*.

What to Submit with Your Certification Application

Applicants must submit a copy of the Live Scan form with their certification paperwork. For additional certification information, please see *Protocol #1030, EMT Certification/Recertification Requirements*.



MEDICAL RESPONSE TO A MULTI-CASUALTY INCIDENT

PURPOSE

To outline and coordinate the responses by EMS system participants to Multi-Casualty Incidents (MCI) and to standardize definitions, as outlined in the Firescope Field Operations Guide (FOG) and the responsibilities of each participating entity.

PRINCIPLES

1. Field responses to a MCI will follow the procedures/guidelines consistent with the Incident Command System (ICS) as outlined in Firescope.
2. Hospitals shall receive as much advanced notice as possible to prepare for arriving patients.

SCOPE

A MCI is any incident where personnel on scene have requested additional responses to care for all victims.

- Incident requires five (5) or more ambulances; and/or
- Incident involves ten (10) or more patients; and/or
- Requires utilization of triage tags; and/or
- May require patient distribution to more than one (1) hospital.

PROCEDURE

General Operational Procedures

1. First arriving resource with the appropriate communications capability shall declare an MCI; establish command, name the incident and request hospital bed availability through the Coordinated Communication Center (CCC). This resource shall remain in command until relieved by the public safety agency having jurisdictional authority.
2. All operation functions and procedures on scene will be in accordance with Firescope.
3. The Incident Commander (IC) will assign the first available resource to triage. Adults shall be triaged according to START as outlined in Firescope. Pediatric patients shall be triaged according to JumpSTART (see definitions) developed by California Emergency Medical Services for Children.

4. The IC or designee shall establish communications with the CCC on the Med Comm Talk Group for situation update and to obtain hospital bed availability.
5. The Medical Communications Coordinator (Med Comm), when initially communicating with the CCC, will provide the following information:

Name of Incident type, location and agency in charge.
6. Patients should generally be transported to the appropriate hospitals as provided to the Med Comm by the CCC.
7. The Med Comm shall notify the CCC with the following information for all patients departing the scene:
 - a. Transport method (air, ground, bus)
 - b. Transport agency and unit
 - c. Number of patients (adult and pediatric)
 - d. Classification of patients (Immediate, Delayed, Minor)
 - e. Destination (in accordance with CCC destination availability)
8. Transporting units shall make attempts to contact the receiving hospital enroute to provide patient(s) report using the incident name to identify the patient and provide the following information:
 - a. Incident name
 - b. Transporting ~~name~~agency and unit number
 - c. Age/sex
 - d. Mechanism of injury
 - e. Chief complaint and related injuries that may need specialty services, e.g. respiratory, neuro, vascular or decontamination
 - f. Glasgow Coma Scale
 - g. ETA
9. If the destination is changed en route from that provided by the Med Comm, the transporting unit shall notify the CCC through its dispatch ~~or directly to the hospital,~~ and shall make ~~attempts to~~ contact ~~the to~~ revised receiving hospital ~~enroute~~. The CCC will notify the original destination that the transporting unit has

- been diverted by the base station physician or that the patient condition has deteriorated.
10. ~~The base station has the option to inform scene personnel making initial contact to call CCC for determination of bed availability.~~

Special Operational Procedures - Use of Non-Emergency Vehicles

The Patient Transportation Unit Leader (PTUL), in coordination with the IC, may utilize non-emergency vehicles to transport patients triaged as “minor.” The Med Comm will work with the receiving facilities to coordinate the destinations. In such cases, the following conditions shall apply:

1. Non-emergency vehicles may be requested through the CCC or by special arrangement made on scene by the PTUL; however, in the event arrangements are made on scene, the PTUL shall notify the CCC.
2. If resources allow at least one ALS team (minimum of one paramedic and one EMT) with appropriate equipment will accompany each non-emergency transport vehicle.
3. Generally, the ratio of patients to ALS team should not exceed 15:1.
4. In the event of deterioration of a patient enroute, the non-emergency unit shall immediately call for an ALS emergency ambulance and transfer care for transport to the closest emergency department.

Responsibilities of the County Communications Center (CCC)

1. Upon field notification of an MCI, the CCC shall immediately poll hospitals via the ReddiNet for bed availability.
2. The CCC shall advise other 9-1-1 dispatch centers of the MCI, including the name and location.
3. The CCC shall dispatch all air resources for the MCI.
4. The CCC shall notify the EMS Agency when five or more ambulances are requested.
5. The CCC will confirm patient departure from scene with Med Comm by providing the departure time.
6. The CCC will advise receiving hospitals of the number/categories of patients en route via ReddiNet or other approved method.
7. The CCC will notify all involved hospitals when the MCI is concluded.

Responsibilities of the Receiving Hospital

1. All hospitals shall respond immediately to the ReddiNet poll.
2. A receiving facility may not change the destination of a patient.
3. A designated Trauma Hospital Base Station physician may change a patient destination only if a patient condition deteriorates.
4. Hospitals shall enter all required information into the ReddiNet, including, but not limited to, names, age ~~and~~ sex and triage tag number of patients transported from the MCI.
5. Each hospital that received patients from the MCI shall participate in after action reviews as necessary.

Medical Control

1. EMS ~~Personnel~~ personnel shall operate within ICEMA “prior to contact” protocols for both medical and trauma patient(s).
2. If base station consultation is necessary, medical control refers to a specific patient(s) and not to the incident as a whole (operational aspects).
- ~~3. Medical Control has the option of referring the agency establishing radio contact to the CCC for bed availability.~~

Field Documentation

1. The Med Comm maintains responsibility to ensure the following:
 - a. Utilization of the ~~approved ICEMA/MCI Med Com log patient care report~~. This form will include:
 - i. Name and location of the Incident
 - ii. Triage tag number for each patient and their hospital destination
 - iii. Brief description of the Incident
 - b. Completion of ~~an individual patient care report for each deceased individual at the incident~~ as much information as available will be documented on the triage tag.
 - c. A completed individual patient care report for all patients with a chief complaint who “refuse treatment” and desire to sign a release of liability or AMA.

2. Each transporting unit is responsible for generating a patient care report for each patient transported excluding patients transported by non-emergency vehicles. Those transported in non-emergency vehicles will be identified by triage tags. This should include patient tracking tag/number and will indicate the incident name and location.

ADDENDUM

Firescope Operations Procedures of a Multi-Casualty Incident

Operational System Description

The Multi-Casualty organizational module is designed to provide for the necessary supervision and control of essential functions required during a Multi-Casualty Incident. The primary functions will be directed by the Medical Group Supervisor, if activated (or Operations), who reports to the Multi-Casualty Branch Director, if activated, or in most cases, the Incident Commander. Resources having direct involvement with patients are supervised or coordinated by one of the functional leaders or coordinators.

The Medical Branch structure in the ICS system is designed to provide the Incident Commander with a basic, expandable modular system for managing the incident. The system is designed to be set up consistent in all incidents involving mass casualties and has the ability to expand the incident organization as needed.

Initial Response Organization: Initial response resources are managed by the Incident Commander, who will handle all Command and General Staff responsibilities. The resources will respond based on the **operational procedures** (as outlined in this protocol).

Reinforced Response Organization: In addition to the initial response, the Incident Commander establishes a Triage Unit Leader, a Treatment Unit Leader, Patient Transportation Unit Leader and Ambulance Coordinator. Also patient treatment areas are established.

Multi-Group Response: All positions within the Medical Group are now filled. The Air Operations Branch may be designated to provide coordination between the Ambulance Coordinator and the Air Operations Branch. The Extrication Group is established to free entrapped victims.

Multi-Branch Incident Organization: The complete incident organization shows the Multi-Casualty Branch and other Branches. The Multi-Casualty Branch now has multiple Medical Groups (geographically separate) but only one Patient Transportation Group. This is because all patient transportation must be coordinated through one point to avoid overloading hospitals.

Operational Principles

1. First arriving resource with the appropriate communications capability shall declare an MCI, establish command, name the incident, and request bed availability. This

resource will remain in command until relieved by the public safety agency having jurisdictional authority.

2. The IC will assign the first available resource to triage. Victims shall be triaged according to START/JumpSTART criteria, and ICS shall be implemented according to Firescope.
3. The IC will assign the resource with the appropriate communications capability to establish communications with CCC situation update and to obtain bed availability.
4. Treatment areas are set up based upon needs and available resources according to classification of patients (immediate, delayed and minor.) The Treatment Unit Leader will notify Patient Transportation Unit Leader when a patient is ready for transportation and of any special needs (e.g. Burns, Pediatrics, etc.)
5. Patients are transported to the appropriate facilities based upon patient condition, bed availability, and transport resources. The Patient Transportation Unit Leader and the Medical Communications Coordinator will work together to transport the patients using the appropriate methods to the most appropriate destinations.
6. The Patient Transportation Unit Leader/Medical Communications Coordinator will determine all patient destinations.
7. The Incident Commander will designate a staging area (s). Transportation personnel should stay with their vehicle to facilitate rapid transport, unless reassigned by the Incident Commander or his designee.
8. The Patient Transportation Unit Leader will then call for an ambulance or other designated transportation vehicle to respond to the loading area.
9. The Patient Transportation Unit Leader, in coordination with the Incident Commander, may put in a request through the Communications Center for busses to transport minor or uninjured patients.
10. The Patient Transportation Unit Leader will copy the information from the triage tag onto a Patient Transportation Log, and confirm destination with the ambulance crew.
11. The Patient Transportation Unit Leader will notify Medical Communications Coordinator of patient departure.
12. The transporting unit should contact the receiving facility en route with a patient report, using the Incident name to identify the patient.



MEDICAL RESPONSE TO HAZARDOUS MATERIALS/TERRORISM INCIDENT

PURPOSE

To supplement the Operational Area Plan Hazardous Material Response Policy. To provide a more detailed medical perspective and serve as a guide to dispatch centers, EMS response agencies, (both public and private) and acute care hospitals and to outline a plan of coordinated medical response to victims of hazardous materials incidents and suspected or actual acts of terrorism for decontamination, protective measures and treatment.

DEFINITIONS

“Exclusion Zone” or “Hot Zone”: That area immediately around the spill where contamination does or could occur. It is the innermost of the three zones of a hazardous materials site. It is the zone where mitigation measures take place. Special protection is required for all personnel operating in this zone. All personnel exiting this zone will require decontamination.

“Contamination Reduction Zone” or “Warm Zone”: That area between the Exclusion Zone and the Support Zone. This zone contains the Contamination Reduction Corridor where the decontamination team decontaminates the personnel leaving the Exclusion Zone. This zone may require a lesser degree of protective equipment than the Exclusion Zone. This area separates the contaminated area from the clean area and acts as a buffer to reduce contamination of the clean area. No contamination should pass through to the clean area.

“Support Zone” or “Cold Zone”: The clean area outside of the Contamination Control Line. Special protective clothing is not required. This is the area where resources are assembled to support the hazardous materials operation.

PROCEDURE

Operational Principles for First Responders

1. There is a direct relationship between the type and amount of material and the resultant illness. Exposure may lead to injury and death. Risk to personnel is directly related to the type of contaminant and length of exposure.
2. A single small release, with any degree of personal carelessness, could disable an entire emergency medical system.
3. On scene personnel safety takes priority over any immediate rescue/resuscitation concerns.

4. Prehospital healthcare providers will be unable to respond to other emergencies until decontamination of involved equipment and personnel is accomplished.

Response and Activation

1. Immediate notification to the County Interagency Hazardous Materials Emergency Response Team through appropriate dispatch center. Suspected terrorist activity should also be reported to the appropriate public safety agency having primary investigative authority.
2. Information (if known) to be provided to responding agencies:
 - a. Name of substance (this could include basic information such as container information, placards, color/size/odor descriptions and should be obtained from a safe distance); do not make an effort to smell any chemical. If you smell the chemical you have been exposed, as this could result in an adverse exposure to response personnel.
 - b. Physical state of material (liquid, gas, solid, powder, etc.).
 - b.c. What is the product doing, i.e., melting, bubbling, off-gassing, still leaking.
 - e.d. Extent of contamination.
 - d.e. Lay of the land.
 - e.f. Wind direction, other weather conditions.
 - f.g. Staging area (up-wind, upstream, uphill).
 - g.h. Alternate travel route.
 - h.i. Consider activation of Multi-Casualty Incident (MCI) if appropriate.

Hospital Notification

1. Hospitals should immediately be made aware of any hazardous materials/terrorism incident through the ReddiNet System or by phone. This early alert will allow the hospital(s) to prepare for the eventuality of receiving patients from the incident.
2. This notification should be made even if it appears no victims have received exposure or contamination. In some cases, individuals may arrive at local hospitals without going through decontamination. These victims have the potential for exposure risk and contamination of personnel and facilities and would result in the lengthy shutdown of a facility while specialized decontamination teams render the facility safe.

3. Consider requesting additional hazmat and/or decon equipment from local Fire jurisdiction to assist with larger numbers of walk-ins.

First Responding Ambulance

1. If an ambulance is the first responder, upon suspicion of a hazardous material release, the crew should:
 - a. Advise the appropriate dispatch center of the situation. This information will minimize unnecessary and inadvertent exposure to other public safety personnel and equipment.
 - b. The ambulance crew shall await arrival of appropriate resources prior to rendering any treatment.
2. Medical responders will always work in the Support Zone. They should never enter the Exclusion or Contamination Reduction Zones.
3. The Incident Commander (IC) will determine the level of personal protective equipment (PPE) needed in each zone.
4. Only personnel who are wearing proper PPE shall make contact with victims in the Exclusion or Contamination Reduction Zones.
5. The IC or designee will make all decisions regarding the mode of transportation for injured persons.

On Site Treatment

1. Within the Exclusion and Contamination Reduction Zones

Self-contamination potential and restrictions caused by PPE make definitive treatment within these zones difficult. Only those public safety responders trained in providing medical care in a hazardous environment, and limited to basic life support (BLS) procedures should provide medical treatment within these zones. This treatment should be followed by rapid transportation to the Containment Reduction Zone/Decon. Any ambulatory victims need to be directed to an Ambulatory Decon Area/Line for decontamination. It is possible some of these people can decontaminate themselves.

2. The Safe Zone

Paramedic medical interventions should begin only after the decontamination process. Treatment should be in accordance with prevailing medical standards of care and by consultation with the Base Station, if indicated. One hospital should act as the coordinating hospital using resources such as Regional Poison Control Center and/or Toxic Information Center.

Medical Transportation

1. Ground Ambulance Preparation

- a. If a victim is contaminated, there will be no ambulance transport until gross decontamination is performed.
- b. If transport is deemed necessary by the IC or designee then:
 - i. A plastic sheet should be placed on the ambulance floor prior to transport.
 - ii. Adequate ventilation should be provided to avoid accumulation of toxic chemical levels in the ambulance.

2. Helicopter Consideration

- a. A decision to utilize helicopter services should be decided by the collaboration of the IC, or designee, and the flight crew.
- b. Guidelines outlined in Item 1b. above should be applied to preparing a helicopter prior to transporting patients.
- c. Air transport of patients should be considered as a last resort.

Determination of Destination Hospital and Related Preparation

1. Destination Hospital

The destination hospital should be determined by the standard of the closest and most appropriate. When information indicates the hazardous material possesses a significant threat to hospital personnel, consideration should be given in consultation with the Base Hospital-Station physician to triage the patients to a single hospital. This decision should be made based on the potential danger to attending staff, threatened facility closure and the ability of the hospital to handle such cases.

2. Preparation by Receiving Hospital(s)

- a. Internal preparation according to hospital policies and procedures.
- b. Anticipate walk-in contaminated patients.
- c. Anticipate the need for fine detail decontamination (e.g., fingernail beds and ear canals of persons who were field decontaminated). Check for contact lenses.

- d. In the event contaminated victims arrive at the hospital, the hospital should be prepared to decontaminate victims in a pre-designated area outside of the Emergency Department. Some accessories may include:
 - i. Temperature controlled water hose (low pressure).
 - ii. ~~Kiddie pool or other a~~Acceptable catch basin.
 - iii. Expendable or easily decontaminated gurney.
 - iv. Towels and sheets for patient.
 - v. Movable screens for privacy.
 - vi. Plastic lined garbage receptacles for contaminated clothes and equipment. Personal effects of victims involved in a terrorist event should be bagged and labeled as possible evidence for collection by law enforcement.
 - vii. Consider requesting assistance from local hazmat teams for additional assistance.
 - viii. A current contract with a State licensed hazardous materials contractor to dispose of contaminated materials and properly perform area decontamination should already be in place.

Base Hospital-Station Medical Control Roles and Responsibilities

1. Assignment of a Mobile Intensive Care Nurse (MICN)/Emergency Department physician or designee to the ReddiNet System, if available, throughout the duration of the incident.
2. Collaboration of Base Hospital-Station physician and the IC/Technical Reference Team Leader as to the best method of decontamination.
3. Provide to paramedics, online information regarding prodromal symptoms that may be expected as a result of exposure to hazardous materials or weapons of mass destruction (WMD) agents.
4. Anticipate walk-in contaminated patients and initiate appropriate action.
5. Assist in consultation and determination of destination.

Decontamination of Prehospital Equipment and Personnel

Proper protection of equipment and supplies should minimize equipment and personnel out of service due to any contamination that may occur during transport. If the vehicle and equipment are contaminated during transport, they should not return to service until adequately decontaminated by qualified personnel. In addition, the following procedure should be followed:

1. Personal protective garments should be discarded in designated receptacles at hospital facilities as soon as practical.
2. Decontamination should take place under the direction of designated hazardous materials personnel.
3. Decontamination should take place in an area where wastewater can be contained.
4. No medical vehicle, associated hardware, or supplies shall be released for service until clearance is received from designated hazardous materials personnel.



PARAMEDIC VACCINATION POLICY

POLICY STATEMENT Move to Administrative Manual

The decision to activate this policy will be incident dependent, time limited and based on guidance from the ICEMA Medical Director and/or designee, and in collaboration with the local Health Officer as deemed necessary or essential for successful vaccination programs in emergency situations.

AUTHORITY

Under a declared Public Health Emergency by the local Public Health Officers within the ICEMA region (Inyo, Mono and San Bernardino Counties), California Health and Safety Code, Section 101080.

PURPOSE

To develop a program that utilizes ICEMA accredited paramedics (EMT-Ps) during an H1N1 Public Health Emergency to administer H1N1 and/or seasonal flu vaccine injections.

OBJECTIVE

Train EMT-Ps to administer H1N1 and/or seasonal flu vaccinations to qualified EMS healthcare workers quickly and efficiently. Qualified EMS healthcare workers are defined as those EMS personnel who have direct patient care responsibilities.

TRAINING

1. H1N1 flu prophylaxis and vaccination training for the EMT-P will be provided by EMS provider agencies and consist of a self-directed review of EZIZ or EMSA developed training modules that cover:
 - Infectious Diseases and Influenza
 - Principles of Vaccinations
 - Medication Profile - Vaccinations
 - Review of Anaphylaxis
 - Required Documentation
 - Related Policies, Protocols and Procedures
 - Role of EMS in a Public Health Emergency Vaccination Program
 - Vaccine Handling and Storage

2. All records will be maintained by the continuing education (CE) provider for four (4) years, and shall include:
 - a. Complete outlines for the course given, including a brief overview, instructional objectives, comprehensive topical outline, method of evaluation and a record of participant performance.
 - b. Record of time, place and date each course is given and the number of CE hours granted.
 - c. An ICEMA approved roster signed by course participants to include name and license number of the individuals.
3. After completing the training and successfully passing a written exam, the EMT-P will be certified to administer H1N1 prophylaxis flu medications and/or seasonal flu vaccinations within the ICEMA region. EMT-Ps will not be allowed to administer the vaccine until rosters are sent to ICEMA. The rosters may be faxed or e-mailed to ICEMA.

QUALITY IMPROVEMENT

ICEMA, Public Health or EMS provider agency's supervisory staff will monitor EMT-Ps to ensure that individuals receiving medications/vaccinations are being assessed for any adverse effects or allergic reactions at each vaccination location.

Proper use of personal protective equipment (PPE) by the vaccinators will be monitored by the supervisors at each vaccination location.



PARAMEDIC BLOOD DRAW FOR CHEMICAL TESTING AT THE REQUEST OF A PEACE OFFICER

Specialty Program

Move to Administrative Manual

PURPOSE

To allow ICEMA accredited paramedics (EMT-Ps), not employed by fire departments, to withdraw blood samples at the request of a sworn peace officer for the purpose of chemical testing from persons suspected of driving under the influence.

Per California Vehicle Code 23158 (k): paramedics employed by fire departments are not allowed to draw blood for a peace officer.

AUTHORITY

California Code of Regulations, Title 22; Division 9, Chapter 4, Section 100145.

~~Vehicle Code Section 23158~~

~~California Vehicle Code, Section 23158, sub. (d);~~

~~Notwithstanding any other provision of law, no . . . certified paramedic . . . shall incur any civil or criminal liability as a result of the administering of a blood test in a reasonable manner in a hospital, clinical laboratory, medical clinic environment, jail, or law enforcement facility, according to accepted venipuncture practices, without violence by the person administering the test, and when requested in writing by a peace officer to administer the test.~~

POLICY

Upon completion of an agreement with the employing ALS agency and with the approval of ICEMA, allow EMT-Ps to draw blood at the request of law enforcement for chemical testing.

At no time will the request for blood draw for alcohol level take precedence over the medical treatment of the patient.

PROCEDURE

An EMT-P, at the request of law enforcement, may draw blood for chemical testing if the following conditions are met:

1. The employing ALS agency received ICEMA approval following submittal for a Specialty/Optional Scope Program to draw blood at the request of law enforcement.
2. The request must be in writing from the peace officer.
3. Blood draw kits will be supplied by the law enforcement agency.

4. The procedure will be performed based on standard practice, pursuant to the directions on the supplied kit (Benzalkonium Chloride) and documented as such. The obtained sample will be the property of the arresting officer.
5. A patient care record must be completed for all requests and include, at a minimum, the following information:
 - a. Patient name
 - b. Sex
 - c. Date and time
 - d. Name of requesting peace officer
 - e. Brief medical history including medications and allergies.
 - f. Vital signs
 - g. Brief narrative including the kit number, skin preparation used, and location of the blood draw.
 - h. If a second needle stick is required, the site and skin preparation will be documented.
 - i. The patient's consent for the procedure and the peace officer's request for the procedure will also be documented with the name and badge number of the peace officer.
6. Base Station contact is not required unless there is a medical necessity.

CONTRAINDICATIONS

1. Patient history of an allergy to the antiseptic used in the kit, or to Betadine. The EMT-P must refuse the request to draw and inform the peace officer of the situation.
2. If the patient is on anti-coagulant therapy, direct pressure will be held on the site for at least one (1) full minute. A pressure dressing will be applied.
3. No blood draws will be performed on patients with hemophilia.
4. No blood draws will be performed on combative persons.
5. If the patient refuses the blood draw for any reason, the EMT-P will document and stop procedure immediately. The EMT-P is not allowed to draw blood on a struggling or restrained patient. The patient must be cooperative.

TRAINING

EMT-Ps will be required to participate in a training program focusing on proper preparation of the blood draw site and required documentation.

Additional documentation:

1. A log will be kept of all blood draws for DUI by the EMT-P's employer for quality improvement (QI) purposes.
2. The EMT-P should provide his or her name and any other information needed to complete the *Blood Draw Request Form* from the law enforcement agency.



TACTICAL MEDICINE PROGRAM

PURPOSE

To provide medical oversight and continuous quality improvement and establish policies and procedures for EMS personnel assigned to Tactical Medicine Programs within the ICEMA region.

DEFINITION

Tactical medicine, for the purpose of this policy, is defined as the delivery of emergency medical care during law enforcement special operations.

AUTHORITY

California Penal Code, Section 13514.1; California Health and Safety Code, Sections 1797.218, 1797.220, 1797.222, and 1798 - 1798.6; California Code of Regulations, Title 22, Division 9, Chapter 4, Sections 10145, 100169, and 100170; *Tactical Medicine: Operational Programs and Standardized Training Recommendations* (POST, 2010)

POLICY

1. Tactical Medicine Programs shall be developed and utilized in accordance with the “California POST/EMSA Tactical Medicine Operational Programs and Standardized Training Recommendations” document that can be located on the EMSA website at: <http://www.emsa.ca.gov/personnel/files/TacticalMedicine.pdf>.
2. Tactical Medicine Programs and their medical personnel (Emergency Medical Technicians (EMTs), **Advanced EMT (AEMTs)**, Paramedics (EMT-Ps), and Registered Nurses (RNs)) shall be integrated into the local EMS system, in coordination with ICEMA, the local Emergency Medical Services (EMS) Agency (POST, 2010).
3. Tactical medicine programs shall be reviewed and approved by ICEMA.
4. Administration of this policy applies to EMTs, **AEMTs**, EMT-Ps, and RNs providing medical services within an established EMS Agency and as part of a recognized Tactical Medical Program.
 - a. The medical scope of practice for EMTs, **AEMTs** and EMT-Ps is consistent with Title 22, Division 9 and all ICEMA protocols.

5. Tactical Medicine Programs should designate a Tactical Medicine Program Director as defined within POST and EMSA guidelines.
6. Tactical Medicine Programs should designate a physician as a Tactical Medicine Medical Director “to provide medical direction, continuous quality improvement, medical oversight, and act as a resource for medical contingency planning” (POST, 2010).
7. Tactical Medicine Operational Programs should have components pertaining to planning, medical oversight, quality improvement and training as defined in *Tactical Medicine Operational Programs and Standardized Training Recommendations* (POST, 2010; Section 2.2.1-7).
- ~~7-8.~~ Tactical Medicine Programs should include tactical medical personnel in mission planning and risk assessment to ensure appropriate assets are available for the identified mission as defined in *Tactical Medicine Operational Programs and Standardized Training Recommendations* (POST, 2010; Section 2.2.2).

PROCEDURE

1. All ~~law enforcement~~ agencies that intend to provide a Tactical Medicine Program will:
 - a. Submit an ICEMA approved application for a Specialty Program for review by ICEMA.
 - b. Submit a copy of the proposed program to include all information as listed on the application.
 - c. Provide a list of all RNs, EMTs and EMT-Ps assigned to the Tactical Medicine Program.
 - d. Tactical medical personnel must be:
 - 1) EMT-Ps must be California licensed and accredited by ICEMA.
 - 2) EMTs and AEMTs must be California certified.
 - 3) RNs must be licensed as a Registered Nurse in California and an approved Flight Nurse, MICN, or EMT-P within the ICEMA region.
 - e. ~~Include ICEMA Representative in Continuous Quality Improvement and Medical Contingency Planning meetings and participate~~ Participate in ICEMA approved Continuous Quality Improvement process.

TRAINING

Designated Tactical Emergency Medical Support (TEMS) personnel shall successfully complete all initial and ongoing recommended training provided by an approved tactical medicine training program as listed in the “California POST/EMSA *Tactical Medicine Operational Programs and Standardized Training Recommendations* - March 2010 document.

DRUG AND EQUIPMENT LISTS

Equipment and supplies carried and utilized by Tactical Emergency Medical Support (TEMS) personnel shall be consistent with the items listed in the California POST / EMSA *Tactical Medicine Operational Programs and Standardized Training Recommendations* document. Equipment and supplies shall be based on the appropriate level of personnel utilized for the particular Tactical Medicine Program (TEMS BLS or TEMS ALS).

The Tactical Medicine Program standard list of drugs and equipment carried by TEMS BLS or TEMS ALS medical personnel must be reviewed and approved by ICEMA prior to issue or use by EMT or EMT-P personnel.

~~ICEMA Drug and Equipment list for REFERENCE~~ **TACTICAL MEDICINE OPERATIONAL EQUIPMENT RECOMMENDATIONS**

Medications	BLS	ALS
Acetaminiph en Acetaminophen		
Albuterol 2.5mg with Atrovent 0.5mg MDI		<u>1</u>
Aspirin 81mg		<u>1 bottle</u>
Atropine Sulfate 1mg preload		<u>1</u>
Dextrose 50% 25gm preload		<u>1</u>
Diphenhydramine 50mg		<u>2</u>
Epinephrine (1:1000) 1mg		<u>2</u>
Epinephrine (1:10,000) 1mg preload		<u>2</u>
Glucagon 1mg		<u>1</u>
Naloxone 2mg preload		<u>2</u>
Nerve Agent Antidote (DuoDote)		<u>1</u>
Nitroglycerine 0.4 metered dose or tablets (tablets to be discarded 90 days after opening)		<u>1</u>
Normal Saline 500ml		<u>2</u>
Ondansetron 4mg IV/IM/oral tabs		<u>4</u>

CONTROLLED SUBSTANCE MEDICATIONS

Controlled Substance Medications MUST BE DOUBLED LOCKED	BLS	ALS
Midazolam – vials of 10mg/2cc, 2mg/2cc, or 5mg/5cc		<u>20 mgs</u>
Morphine Sulfate vials of 10mgs		<u>20 mgs</u>

AIRWAY EQUIPMENT

Airway Equipment	BLS	ALS
Adult non-rebreather mask		
Chest seal and Flutter Valve		<u>1</u>
End Tit Tidal CO2 (device may be integrated into bag)		<u>1</u>
Endotracheal Tubes - 6.0 and/or 6.5, 7.0 and/or 7.5, and 8.0 and/or 8.5 with stylet		<u>1 each</u>
ET Tube holder		<u>1</u>
King LTS-D Size 4 and 5	<u>1 each if approved</u>	<u>1 each</u>
Laryngoscope Kit		<u>1</u>
Nasal cannula		
Nasopharyngeal Airways Adult	<u>1set</u>	<u>1set</u>
Needle Cricothyrotomy Device		<u>1</u>
Needle Thoracostomy Kit		<u>1</u>
Oxygen source		

Airway Equipment	BLS	ALS
Suction (hand held)	<u>1</u>	<u>1</u>
Ventilation Bag collapsible (BVM)	<u>1</u>	<u>1</u>

IV/MONITORING EQUIPMENT

IV/Needle/Syringes	BLS	ALS
AED (with waveform monitoring preferred)	<u>1</u>	<u>1</u>
AED Pads	<u>1</u>	<u>1</u>
Blood Pressure Cuff	<u>1</u>	<u>1</u>
IO Device and Needles		<u>1</u>
IV Needles <u>14-20 Gauge</u>		<u>1 of each</u>
IV Start Kit		<u>1</u>
IV Tubing		<u>1</u>
Pulse Ox (optional)		
Saline Flush		<u>2</u>
Saline Lock		<u>2</u>
Stethoscope	<u>1</u>	<u>1</u>
Syringes 3cc,5cc,10cc		<u>1 each</u>

DRESSING AND SPLINTING

Dressing/Splints	BLS	ALS
CoTCCC - Recommended Tourniquet system	<u>1</u>	<u>1</u>
Elastic compression dressing	<u>1</u>	<u>1</u>
Latex free gloves	<u>1</u>	<u>1</u>
<u>N95 Mask</u>	<u>1</u>	<u>1</u>
Occlusive dressing	<u>1</u>	<u>1</u>
Roller bandage	<u>1</u>	<u>1</u>
Splint - semi-ridged moldable	<u>1</u>	<u>1</u>
Sterile gauze pads	<u>1</u>	<u>1</u>
Tape	<u>1</u>	<u>1</u>
Trauma dressing	<u>1</u>	<u>1</u>
Trauma shears	<u>1</u>	<u>1</u>
Triangle bandage	<u>1</u>	<u>1</u>
<u>Hemostatic impregnated gauze non-exothermic, i.e. Combat Gauze</u>		

MISCELLANEOUS EQUIPMENT

Miscellaneous Equipment	BLS	ALS
Litter	<u>1</u>	<u>1</u>
Patient care record	<u>1</u>	<u>1</u>
PPE	<u>1</u>	<u>1</u>
Triage tags	<u>10</u>	<u>10</u>

Miscellaneous Equipment	BLS	ALS
<u>Tactical Light</u>	<u>1</u>	<u>1</u>
<u>Eyewear</u>	<u>1</u>	<u>1</u>
<u>Rescue Blanket</u>	<u>1</u>	<u>1</u>
<u>Self-heating Blanket</u>	<u>1</u>	<u>1</u>



BLS/LALS/ALS STANDARD DRUG & EQUIPMENT

Each ambulance and first responder unit will be equipped with the following functional equipment and supplies. **This list represents mandatory items with minimum quantities** excluding narcotics, which must be kept within the range indicated. All expiration dates must be current. All packaging of drugs or equipment must be intact. No open products or torn packaging may be used.

All ALS (transport and non-transport) and BLS transport vehicles shall be inspected annually.

MEDICATIONS/SOLUTIONS

Exchanged Medications/Solutions	BLS	LALS Non-Transport	ALS Non-Transport	ALS Transport
Adenosine (Adenocard) 6mg			1	1
Adenosine (Adenocard) 12mg			2	2
Adrenaline (Epinephrine) 1:1000 1 mg		2	2	2
Adrenaline (Epinephrine) 1:10,000 1 mg preload			3	3
Albuterol Aerosolized Solution (Proventil) - unit dose 2.5mg		4 doses	4 doses	4 doses
Aspirin, chewable - 81mg tablet		2	1 bottle	1 bottle
Atropine 1 mg preload			4 2	4 2
Calcium Chloride 1gm preload			1	1
Dextrose 25% 2.5gm preload			2	2
Dextrose 50% 25gm preload		2	2	2
Diphenhydramine (Benadryl) 50mg			1	1
Dopamine 400mg			1	1
Epinephrine 1:1000 1mg		2	2	2
Epinephrine 1:10,000 1 mg preload			3	3
Glucagon 1mg		1	1	1
Glucose paste	1 tube	1 tube	1 tube	1 tube
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5mg			4	4
Irrigating Saline and/or Sterile Water (1000cc)	2	1	1	2
Lidocaine 100mg			3	3
Lidocaine 1gm or 1 bag pre-mixed 1gm/250cc D5W			1	1
Lidocaine 2% (Viscous) bottle			1	1
Magnesium Sulfate 10gm			1	1
Naloxone (Narcan) 2mg preload (needle less)		2	2	2

Exchanged Medications/Solutions	BLS	LALS Non-Transport	ALS Non-Transport	ALS Transport
Nitroglycerine – Spray 0.4mg metered dose and/or tablets (tablets to be discarded 90 days after opening)		2	1	2
Normal Saline for Injection (10cc)		2	2	2
Normal Saline 100cc			1	2
Normal Saline 250cc			1	1
Normal Saline 500 ml and/or 1000ml		2000 ml	3000 ml	6000 ml
Ondansetron (Zofran) 4mg Oral Disintegrating Tablets (ODT)			4	4
Ondansetron (Zofran) 4 mg IM/ IV			4	4
Phenylephrine HCL - 0.5mg per metered dose			1 bottle	1 bottle
Procainamide 1 gm			1	2
Sodium Bicarbonate 50 mEq preload			2	2
Verapamil 5 mg			3	3

CONTROLLED SUBSTANCE MEDICATIONS

Non-Exchange Controlled Substance Medications MUST BE DOUBLE LOCKED	BLS	LALS Non-Transport	ALS Non-Transport	ALS Transport
Midazolam			20-40mg	20-40mg
Morphine Sulfate -vials of 10mg			20-60mg	30-60mg

AIRWAY/SUCTION EQUIPMENT

Exchanged Airway/Suction Equipment	BLS	LALS Non-Transport	ALS Non-Transport	ALS Transport
Adult non-rebreather mask	2	2	2	2
BAAM Device			1	2
CPAP circuits - all manufacture's available sizes			1 each	2 each
End Title CO2 device – Pediatric and Adult (may be integrated into bag)			1	1
Endotracheal Tubes cuffed – 6.0 and/or 6.5, 7.0 and/or 7.5 and 8.0 and/or 8.5 with stylet			2 each	2 each
Endotracheal Tubes, uncuffed – 2.5, 3.0, 3.5 with stylet			2 each	2 each
Endotracheal Tubes, uncuffed – 4.0 or 4.5, 5.0 or 5.5 with stylet			2 each	2 each
ET Tube holders – pediatric and adult		1 each	1 each	2 each
Infant Simple Mask	1	1	2	2
King LTS-D Adult: Size 3 (yellow) Size 4 (red) Size 5 (purple)	SPECIALTY PROGRAMS ONLY 2 each	1 each	1 each	2 each
King Ped: 12-25 kg: Size 2 (green)	SPECIALTY PROGRAMS		1 each	2 each

Exchanged Airway/Suction Equipment	BLS	LALS Non-Transport	ALS Non-Transport	ALS Transport
25-35kg: Size 2.5 (orange)	ONLY 2 each	1 each		
Nasal cannulas - pediatric and adult	2 each	2 each	2 each	2 each
Naso/Orogastric feeding tubes - 5fr or 6fr, and 8fr			1 each	1 each
Naso/Orogastric tubes - 10fr or 12fr, 14fr, 16fr or 18fr			1 each	1 each
Nasopharyngeal Airways - (infant, child, and adult)	1 each	1 each	1 each	1 each
Needle Cricothyrotomy Device - Pediatric and adult or Needles for procedure 10, 12, 14 and/or 16 gauge			1 each 2 each	1 each 2 each
One way flutter valve with adapter or equivalent			1	1
Oropharyngeal Airways - (infant, child, and adult)	1 each	1 each	1 each	1 each
Pediatric non-rebreather oxygen mask	2	2	2	2
Small volume nebulizer with universal cuff adaptor		2	2	2
Suction Canister	1		1	1
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each		1 each	1 each
Ventilation Bags - Infant 250ml, Pediatric 500ml (or equivalent) Adult	1 each 1 each	1 each 1 each	1 each 1 each	1 each 1 each
Water soluble lubricating jelly		1	1	1
Yankauers tonsil tip	1		1	1

Non-Exchange Airway/Suction Equipment	BLS	LALS Non-Transport	ALS Non-Transport	ALS Transport
Ambulance oxygen source -10L/min for 20 minutes	1			1
Flashlight/penlight	1	1	1	1
Laryngeal blades - #0, #1, #2, #3, #4 curved and/or straight			1 each	1 each
Laryngoscope handle with batteries - or 2 disposable handles			1	1
Magill Forceps - Pediatric and Adult			1 each	1 each
Manual powered suction device		1		
Portable oxygen with regulator - 10L/min for 20 minutes	1	1	1	1
Portable suction device (battery operated)	1		1	1
Pulse Oximetry device	(SEE OPTIONAL EQUIPMENT SECTION, PG. 5)	1	1	1
Stethoscope	1	1	1	1
Wall mount suction device	1			1

IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT

Exchanged IV/Needles/Syringes/Monitor Equipment	BLS	LALS Non-Transport	ALS Non-Transport	ALS Transport
Conductive medium or Pacer/Defibrillation pads			2 each	2 each
Disposable Tourniquets		2	2	2
ECG electrodes			20	20
EZ-IO Needles and Driver 15mm, 25mm, and 45mm			2 each 1 each	2 each 1 each
Glucose monitoring device with compatible strips and OSHA approved single use lancets		1	1	1
3-way stopcock with extension tubing			2	2
IV Catheters - sizes 14, 16, 18, 20, 22, 24		2 each	2 each	2 each
Macro drip Administration Set (10 drops/cc)		3	3	3
Micro drip Administration Set (60 drops/cc)		1	1	2
Mucosal Atomizer Device (MAD) for nasal administration of medication		2	4 ₂	4
Pressure Infusion Bag (disposable)		1	1	1
Razors		1	2	2
Safety Needles - 20 or 21 gauge and 23 or 25 gauge		2 each	2 each	2 each
Saline Lock Large Bore Tubing Needleless		2	2	2
Sterile IV dressing		2	2	2
Syringes w/wo safety needles - 1cc, 3cc, 10cc catheter tip		2 each		
Syringes w/wo safety needles - 1cc, 3cc, 10cc, 20cc, 60cc catheter tip			2 each	2 each

Non-Exchange IV/Needles/Syringes/Monitor Equipment	BLS	LALS Non-Transport	ALS Non-Transport	ALS Transport
12-lead ECG Monitor and Defibrillator with TCP and printout			1	1
Blood pressure cuff - large adult or thigh cuff, adult, child and infant	1	1	1	1
Needle disposal system (OSHA Approved)		1	1	1
Thermometer - Mercury Free with covers	1	1	1	1

OPTIONAL EQUIPMENT/MEDICATIONS

Non-Exchange Optional Equipment/Medications	BLS	LALS Non-Transport	ALS Non-Transport	ALS Transport
AED/defib pads	2	2		

Non-Exchange Optional Equipment/Medications	BLS	LALS Non-Transport	ALS Non-Transport	ALS Transport
Ammonia Inhalants			2	2
Approved Automatic CPR device	1	<u>1</u>	1	1
Approved Automatic ventilator			1	1
Backboard padding	1	1	1	1
Buretrol			1	1
Capnography monitor and supplies, may be integrated in the cardiac monitor			1	1
Chemistry profile tubes			3	3
EMS Tourniquet	1		1	1
Gum Elastic intubation stylet			2	2
Hemostatic combat gauze	1		1	1
IO Needles - Manual, Adult and Pediatric, Optional			1 each	1 each
IV infusion pump			1	1
IV warming device		1	1	1
Manual IV Flow Rate Control Device			1	1
Manual powered suction device	1	1	1	1
Multi-lumen peripheral catheter			2	2
Needle Thoracostomy Kit (prepackaged)			2	2
Pitocin			20 units	20 units
Pulse Oximetry device	1			
Translaryngeal Jet Ventilation Device			1	1
Vacutainer			1	1

DRESSING MATERIALS/OTHER EQUIPMENT/SUPPLIES

Exchanged Dressing Materials/Other Equipment/Supplies	BLS	LALS Non-Transport	ALS Non-Transport	ALS Transport
Adhesive tape - 1 inch	2	2	2	2
Air occlusive dressing (Vaseline gauze)	1	1	1	1
Ankle & wrist restraints, soft ties acceptable	1		0	1
Antiseptic swabs/wipes		10	10	10
Bedpan or fracture pan	1			1
Urinal	1			1
Cervical Collars - Rigid Pediatric & Adult or Cervical Collars - Adjustable Adult & Pediatric	2 each 2 each	2 each 2 each	2 each 2 each	2 each 2 each
Cold Packs	2	2	2	2
Emesis basin or disposable bags & covered waste container	1	1	1	1
Head immobilization device	2	2	2	2
OB Kit	1	1	1	1

Exchanged Dressing Materials/Other Equipment/Supplies	BLS	LALS Non-Transport	ALS Non-Transport	ALS Transport
Pneumatic or rigid splints capable of splinting all extremities	4	2	2	4
Providence/Iodine swabs/wipes		4	10	10
Roller bandages - 4 inch	6	3	3	6
Sterile bandage compress or equivalent	6	2	2	6
Sterile gauze pads – 4x4 inch	4	4	4	4
Sterile Sheet for Burns	2	2	2	2
Universal Dressing 10x30 inches	2	2	2	2

Non-Exchange Dressing Materials/Other Equipment/Supplies	BLS	LALS Non-Transport	ALS Non-Transport	ALS Transport
Ambulance gurney	1			1
Bandage Shears	1	1	1	1
Blood Borne Pathogen Protective Equipment - (nonporous gloves, goggles face masks & gowns meeting OSHA Standards)	2	1	2	2
Drinkable water in secured plastic container or equivalent	1 gallon			1 gallon
Long board with restraint straps	1	1	1	1
Pediatric immobilization board	1	1	1	1
Pillow, pillow case, sheets & blanket	1 set			1 set
Short extrication device	1	1	1	1
Straps to secure patient to gurney	1 set			1 set
Traction splint	1	1	1	1
Triage Tags - CAL Chiefs or ICEMA approved	20	30 <u>20</u>	20	20



CONTINUATION OF CARE OF A STEMI PATIENT (San Bernardino County Only)

THIS POLICY IS FOR HOSPITAL-TO-HOSPITAL STEMI TRANSPORT ONLY AND SHALL NOT BE USED FOR ANY OTHER REQUESTS FROM OTHER ENTITIES.

PURPOSE

To develop a system of care that is consistent with standards of achieving a door to balloon (D2B) time of less than 90 minutes. This system of care consists of STEMI Receiving Centers (SRC), STEMI Referral Hospitals (SRH), EMS field providers, ICEMA and EMS leaders combining their efforts to achieve this goal.

INITIAL TREATMENT GOALS

Patients arriving at SRH by non-EMS:

- <30 minutes at SRH Emergency Department (ED) (door in/door out).
- ECG obtained within 10 minutes of patient arrival.
- Consider transferring all STEMI patients who are candidates for primary PCI.
- First hospital D2B < 90 minutes.

TIMELINES

- <30 minutes at SRH (door in/door out).
- <30 minutes to complete paramedic interfacility transport.
- <30 minutes at SRC before balloon inflation.

If there are significant delays in transport to a SRC, administration of lytic agents may be considered in patients.

PROCEDURE FOR A CONTINUATION OF CARE OF A STEMI PATIENT TO SRC

CONTACT SRC ED PHYSICIAN DIRECTLY WITHOUT CALLING FOR AN INPATIENT BED ASSIGNMENT. Refer to attachment *SRH-SRC Buddy System Table*.

- The ED physician will be the accepting physician at the SRC.
- The SRC ED physician will contact the SRC interventional cardiologist panel per SRC facility protocol. SRC ED physicians and cardiologists have agreed to accept STEMI patients at all times irrespective of payer source unless the SRC is on internal disaster diversion in accordance with ICEMA Reference #8060 - San Bernardino County Requests for Hospital Diversion Policy.

1. Simultaneously call 9-1-1 and utilize following verbiage to dispatch:

“This is a STEMI CONTINUATION OF CARE from _____
to _____ (Hospital)
(STEMI Hospital)

Dispatchers will only dispatch transporting paramedic units without any fire apparatus.

2. Consider use of air ambulance if ground transportation is > 60 minutes. Requests for air ambulance shall be made to 9-1-1 and normal dispatching procedures will be followed; however, air ambulance STEMI patients will be transported to the SRC identified by the transferring ED.
3. Assess stability of airway and breathing, and intubate those at risk for respiratory failure prior to or during transport.
4. Patient must be kept NPO.
5. Provide continuous cardiac monitoring.
6. Send all required transfer paperwork including diagnostic lab, x-ray, physician and nursing notes with the transport team. However, do not delay transfer waiting for charting or lab results; these may be faxed to SRC later.

NOTE: CRITICAL CARE TRANSPORTS

EMT-Ps may transport patients on Dopamine, Lidocaine and Procainamide drips only. Heparin and Integrillin drips are not within the paramedic scope of practice and require a critical care transport nurse to be in attendance. At times, SRH may consider sending one of its nurses with the transporting paramedic unit if deemed necessary due to patient’s condition. Nurse staffed critical care transport units may be available; however, they are subject to availability and delays. Unless medically necessary, avoid using medication drips that are outside of the paramedic scope of practice to avoid any delays in transferring of STEMI patients. Requests of nurse staffed critical care transfers must be made directly to the ambulance transporter.

REFERENCE

<u>Number</u>	<u>Name</u>
8060	San Bernardino County Requests for Hospital Diversion Policy



STEMI REFERRAL HOSPITAL (SRH) - STEMI RECEIVING CENTER (SRC)

BUDDY SYSTEM

STEMI RECEIVING CENTER (SRC)	STEMI REFERRAL HOSPITAL (SRH)
Desert Valley Hospital	<ul style="list-style-type: none"> • Barstow Community Hospital • Victor Valley Community Hospital • Weed Army Hospital at Fort Irwin
Loma Linda University Medical Center	<ul style="list-style-type: none"> • Arrowhead Regional Medical Center • Bear Valley Community Hospital • J. L. Pettis VA Hospital (Loma Linda VA) • Redlands Community Hospital
Pomona Valley Hospital Medical Center	<ul style="list-style-type: none"> • Chino Valley Medical Center • Montclair Hospital
San Antonio Community Hospital	<ul style="list-style-type: none"> • Chino Valley Medical Center • Kaiser Ontario • Montclair Hospital
St. Bernadine Medical Center	<ul style="list-style-type: none"> • Colorado River Medical Center • Community Hospital of San Bernardino • Kaiser Fontana • Mountains Community Hospital
St. Mary Medical Center	<ul style="list-style-type: none"> • Barstow Community Hospital • Bear Valley Community Hospital • High Desert Medical Center • Robert E. Bush Naval Hospital-29 Palms • Victor Valley Community Hospital



REQUESTS FOR HOSPITAL DIVERSION POLICY

(San Bernardino County Only)

PURPOSE

To define policy and procedures for hospitals to request temporary diversion of advanced life support (ALS) ambulances.

AUTHORITY

California Health and Safety Code, Division 2.5, Chapter 6, Sections 1798(a), 1798.2, and 1798.102; California Code of Regulations, Title 22, Division 9, Chapter 4, Section 100169.

PRINCIPLES

1. A request for diversion of ALS ambulances should be a temporary measure.
2. Final authority relating to destination of ALS ambulances rests with the Base Station physician.
3. This policy applies to the 9-1-1 emergency system and is not intended for utilization to determine destination for interfacility transports, including higher level of care transports.
4. A hospital's request to divert in the approved categories shall be made by the Emergency Department (ED) attending physician or by the trauma surgeon for trauma hospital diversion, in consultation with the hospital CEO or delegated responsible administrative representative. The consultation with the administrative officer must be documented and available for review.
5. Hospitals must maintain a hospital diversion policy that conforms to the ICEMA's Request for Hospital Diversion Protocol Policy. The policy should include plans to educate all appropriate staff on proper utilization of diversion categories, internal procedures for authorizing diversion and procedures for notification of system participants.
6. ICEMA may perform unannounced site visits to hospitals on temporary diversion status to ensure compliance with the ICEMA Request for Hospital Diversion Policy.
7. ICEMA may randomly audit Base Station records to ensure diverted patients are transported to the appropriate destination.

8. When possible, ICEMA staff will contact the hospital to determine the reasons for Internal Disaster Diversion, under Policy, Item #3.
9. ICEMA reserves the right and responsibility to advise any hospital that the diversion is not appropriate for a 9-1-1 system and may remove the hospital from diversion through the ReddiNet System.

POLICY

A request for diversion of ALS ambulances may be made for the following approved categories:

1. Neuro/CT Diversion

~~(DOES NOT APPLY FOR TRAUMA CENTERS FOR TRAUMA DIVERSION)~~

- a. The hospital's CT scanner is not functioning and, therefore, is not the ideal destination for the following types of patients:
 - 1) New onset of altered level of consciousness for traumatic or medical reasons. ** Does not apply to trauma centers for trauma diversion. Refer to ICEMA Reference #15030 - Trauma Triage Criteria and Destination Policy.
 - 2) Suspected stroke. ** Does not apply to neurovascular stroke receiving centers. Refer to ICEMA Reference #6100 - Stroke "NSRC" Receiving Centers.

2. Trauma ~~Center Hospital~~ Diversion (*for use by designated Trauma Centers only*)

- a. The general surgeon for the trauma service and other designated trauma team resources are fully committed and are NOT immediately available for incoming patients meeting approved trauma triage criteria.
- b. The request for Trauma Center Diversion should only be applicable if the general surgeon and back-up general surgeon are committed. The ability to request Trauma ~~hospital-Center~~ Diversion cannot be used in cases of temporary unavailability of subspecialists.
- c. **When all designated trauma ~~Hospitals-centers~~ are on Trauma Center Diversion, trauma centers shall accept all trauma patients.**
- d. **Designated Trauma Centers may not divert patients meeting trauma triage criteria to a non-designated hospital except in instances of Internal Disaster Diversion.**

3. Internal Disaster Diversion

- a. Requests for Internal Disaster Diversion shall apply only to physical plant breakdown threatening the Emergency Department or significant patient services.

Examples of Internal Disaster Diversion include bomb threats, explosions, power outage and a nonfunctional generator, fire, earthquake damage, hazardous materials exposure, incidents involving the safety and/or security of a facility.

Internal Disaster Diversion shall not be used for staffing issues.

- b. Internal Disaster Diversion shall stop all 9-1-1 transports into the facility.
- c. The hospital CEO or AOD shall be notified and that notification shall be documented in the ReddiNet.
- d. If the hospital is also a designated Base Station, the hospital should consider immediately transfer of responsibility for on-line control to another Base Station based upon prearranged written agreement and notification to the 9-1-1 provider.
- e. Internal Disaster Diversion status shall be entered immediately into the ReddiNet System.
- f. If capability exists, hospital shall notify all primary 9-1-1 dispatching agencies.
- g. Within seventy-two (72) hours, hospital shall advise ICEMA and the State Department of Health Services in writing (e-mail is acceptable) of the reasons for internal disaster and how the problem was corrected. The written notification shall be signed by the CEO or delegated responsible individual.

EXCEPTIONS TO NEURO/CT AND TRAUMA DIVERSION ONLY

1. Basic life support (BLS) ambulances shall not be diverted.
2. Ambulances on hospital property shall not be diverted.
3. Patients exhibiting unmanageable problems, e.g., unmanageable airway, uncontrolled hemorrhage, cardiopulmonary arrest, in the field shall be transported to the closest Emergency Department regardless of diversion status.

REFERENCES

<u>Number</u>	<u>Name</u>
6100	Stroke "NSRC" Receiving Centers
15030	Trauma Triage Criteria and Destination Policy



AIRCRAFT ROTATION POLICY (San Bernardino County Only)

PURPOSE

To establish EMS Aircraft dispatch rotation criteria for San Bernardino County Communication Center (COMM Center).

AUTHORITY

California Health and Safety Code **Division 2.5, Chapter 4 and 5; California Code of Regulations.**

POLICY

1. All EMS Aircraft requests from the field in San Bernardino County will be dispatched by the San Bernardino County COMM Center.
2. At time of dispatch, COMM Center will inform the EMS Aircraft of destination based on the following:
 - a. Destination will alternate between ARMC and LLUMC ~~in~~ as determined by ICEMA. ~~predetermined number as agreed upon by ICEMA and COMM Center~~ manner approved by ICEMA.
 - b. The destination may be changed by the EMS providers based on patient requirements for specialty centers.
 - c. Cancellation or destination change of an EMS Aircraft will not alter the rotation of dispatched aircraft.
 - d. Approved Diversion will alter the rotation of EMS aircraft (ICEMA Reference #8060 - San Bernardino County Requests for Hospital Diversion Policy.)
3. An EMS Aircraft going to ~~another~~ destination other than the one assigned by Comm Center, ~~for medical reasons other than trauma,~~ will notify COMM Center and the receiving facility. Notification maybe made by ground or air crews, whichever is the most expeditious for information to be given to the receiving facility.
4. Changes to EMS Aircraft rotation may be reviewed for potential QI issues.



GENERAL PATIENT CARE GUIDELINES

PURPOSE

To provide guidelines for providing the minimum standard of care for all patient contacts.

AUTHORITY

California Health and Safety Code, Title 22, Division 9, Chapter 4, Sections 100145, 100146 and 100147.

DEFINITIONS

Patient: An individual with a complaint of pain, discomfort or physical ailment. An individual regardless of complaint, with signs and/or symptoms of pain, discomfort, physical ailment or trauma. These signs/symptoms include, but are not limited to:

1. Altered level of consciousness.
2. Sign and/or symptoms of skeletal or soft tissue injuries.
3. Altered ability to perceive illness or injury due to the influence of drug, alcohol or other mental impairment.
4. Evidence that the individual was subject to significant force.

Patient Contact: Determined to be achieved when any on duty BLS, LALS, or ALS field provider comes into the presence of a patient as defined above.

BLS INTERVENTIONS

1. Obtain a thorough assessment of the following:
 - a. Airway, breathing and circulatory status.
 - b. Subjective assessment of the patient's physical condition and environment.
 - c. Objective assessment of the patient's physical condition and environment.
 - d. Vital signs.
 - e. Prior medical history and current medications.

- f. Any known medication allergies or adverse reactions to medications, food or environmental agents.
2. Initiate care using the following tools as clinically indicated or available:
 - a. Axial spinal immobilization.
 - b. Airway control with appropriate BLS airway adjunct.
 - c. Oxygen.
 - d. Assist the patient into a physical position that achieves the best medical benefit and maximum comfort.
 - e. Automated External Defibrillator (AED).
 - f. Consider the benefits of early transport and/or intercept with ALS personnel if clinically indicated.
3. Assemble necessary equipment for ALS procedures under direction of EMT-P.
 - a. Cardiac monitoring.
 - b. IV/IO.
 - c. Endotracheal intubation.
4. Under EMT-P supervision, assemble pre-load medications as directed, excluding controlled substances.

LIMITED ALS (LALS) INTERVENTIONS

1. Evaluation and continuation of all BLS care initiated.
2. Augment BLS assessment with an advanced assessment including, but not limited to the following:
 - a. Qualitative lung assessment.
 - b. Blood glucose monitoring.
3. Augment BLS treatment measures with LALS treatments as indicated by LALS protocols.
4. Initiate airway control as needed with the appropriate LALS adjunct.
5. Initiate vascular access as clinically indicated.

ALS INTERVENTIONS

1. Evaluation and continuation of all BLS [and/or LALS](#) care initiated.
2. Augment BLS [and/or LALS](#) assessment with an advanced assessment including but not limited to the following:
 - b. Qualitative lung assessment.
 - c. Cardiac monitor.
 - d. Blood glucose monitoring.
3. Augment BLS [and/or LALS](#) treatment with advanced treatments as indicated or available.
4. Initiate airway control as needed with the appropriate ALS adjunct.
5. Initiate vascular access as clinically indicated.



PHYSICIAN ON SCENE

PURPOSE

To establish criteria for an advanced emergency medical technician (AEMT), and paramedic (EMT-P) during situations in which a physician is physically present at the scene of a 9-1-1 response.

AUTHORITY

California Code of Regulations, Division 9, Chapter 4, Article 2, Section 100147 and Article 8, Section 100175.

POLICY

Medical responsibility for patient care is the responsibility of the Base Station physician. Within the ICEMA region, an AEMT or EMT-P may only follow medical orders given by the Base Station physician or MICN.

PROCEDURE

In the event that an AEMT or EMT-P arrives at the scene of a medical or a trauma emergency and a physician on scene wishes to direct the care of the patient and assume medical responsibility for the patient, the following conditions apply:

1. The physician must be informed that Base Station contact must be made, and the final decision regarding the assumption of medical responsibility for patient care will be made by the Base Station physician.
2. The physician must show proper identification and a current California physician's license.
3. The physician must agree to sign the patient care record-report agreeing to take full responsibility for the care and treatment of the patient(s) involved in the incident and accompanies the patient(s) in the ambulance to the most appropriate receiving medical facility~~most appropriate to receive the patient(s)~~. This statement is available on the ICEMA e-PCR and on the back of the first (white) copy of the ICEMA Standard Run Report Form (01A). Prehospital EMS agencies using software not totally integrated with ICEMA software must provide a form stating the above and obtaining physician signature.
4. Care of the patient must be transferred to a physician at the receiving facility.

| **AEMT and EMT-P RESPONSIBILITIES**

The AEMT or EMT-P has the following responsibilities in the event that the physician on scene assumes responsibility for patient care:

- |
1. Notify Base Station that a physician has requested to take over patient.~~is taking charge of the patient(s).~~
 2. Maintain control of drugs and equipment from the LALS or ALS unit. Inform the physician of drugs and equipment available.
 3. Offer assistance to the physician on scene. The AEMT or EMT-P may only perform procedures that are within the ICEMA scope of practice.
 4. Document on patient care ~~record~~-report all necessary information and obtain physician signature.
- |



RESPONSIBILITY FOR PATIENT MANAGEMENT POLICY

PURPOSE

To define the responsibility for patient care management in the prehospital setting. Within the ICEMA region, in the event both public and private emergency medical services (EMS) personnel arrive on the scene with the same qualifications, patient care management responsibility will rest with the first to arrive.

AUTHORITY

California Health and Safety Code, Division 2.5, Chapter 5, Section 1798.6 (a and c). ~~see below:~~

~~a) Authority for patient health care management in an emergency shall be vested in that licensed or certified health care professional, which may include any paramedic or other prehospital emergency personnel, at the scene of the emergency who is most medically qualified specific to the provision of rendering emergency medical care.~~

~~b) If no licensed or certified health care professional is available, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency.~~

~~c) Authority for the management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority. Public safety officials shall consult emergency medical services personnel or other authoritative health care professionals at the scene in determination of relevant risks.~~

PROCEDURE

1. An A-EMT or EMT-P may transfer patient management responsibility to an EMT for transportation, **without Base Station direction**, only under the following conditions:
 - a. When the patient does not meet criteria for Base Station contact and has not received ALS care.
 - b. When operating under ~~the MCI Protocol policy~~, ICEMA Reference #5050 - Medical Response to a Multi-Casualty Incident.
 - c. When operating under ICEMA Reference #the-9060 - Local Medical Emergency Protocol Policy, Reference #9060.

2. The Base Station should be contacted if at any time transfer of patient management responsibility is in question or for any patient not meeting the above criteria.
3. In the event of radio communication failure, an LALS or ALS unit may not transfer patient management responsibility to an EMT for transportation.

REFERENCES

<u>Number</u>	<u>Name</u>
5050	Medical Response to a Multi-Casualty Incident
9060	Local Medical Emergency Policy



REPORTING INCIDENTS OF SUSPECTED ABUSE POLICY

PURPOSE

Prehospital personnel are required to report incidents of suspected neglect or abusive behavior towards children, dependent adults or elders. These reporting duties are individual, and no supervisor or administrator may impede or inhibit such reporting duties and no person making such report shall be subject to any sanction for making such report.

When two or more persons who are required to report are present at scene, and jointly have knowledge of a suspected abuse, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single written report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so, shall thereafter make the report.

Information given to hospital personnel does not fulfill the required reporting mandated from the state. The prehospital caregivers must make their own report.

CHILD ABUSE/NEGLECT

Suspicion of child abuse/neglect is to be reported by prehospital personnel by telephone to the Child Abuse Hotline immediately or as soon as possible. Be prepared to give the following information:

1. Name of person making report.
2. Name of child.
3. Present location of child.
4. Nature and extent of the abuse/neglect.
5. Location where incident occurred, if known.
6. Other information as requested.

San Bernardino County: 1-800-827-8724 24-hour number **or** 1-909-384-9233

Inyo County: 1-760-872-1727 M-F 8am - 5pm **or** 911 after hours

Mono County: 1-800-340-5411 M-F 8am - 5pm **or** 1-760-932-7755 after hours

The phone report must be followed within 36 hours by a written report on the “**Suspected Child Abuse Report**” form. Mail this to:

San Bernardino County: CPS
412 W. Hospitality Lane
San Bernardino, CA 92408

Inyo County: CPS
162 Grove St. Suite “J”
Bishop, CA 93514

Mono County Department of Social Services
PO Box 576
Bridgeport, CA 93517

The identity of any person who files a report shall be confidential and disclosed only between child protective agencies, or to counsel representing a child protection agency, or to the district attorney in a criminal prose.

DEPENDENT ADULT AND ELDER ABUSE/NEGLECT

Suspicion of dependent adult and elder abuse/neglect should be reported as soon as possible by telephone. Be prepared to give the following information:

1. Name of person making report.
2. Name, address and age of the dependent adult or elder.
3. Nature and extent of person’s condition.
4. Other information, including information that led the reporter to suspect either abuse or neglect.

San Bernardino County: 1-877-565-2020 24-hour number

Inyo County: 1-760-872-1727 M-F 8am - 5pm **or** 911 after hours

Mono County: 1-800-340-5411M-F 8am - 5pm **or** 1-760-932-7755 after hours

The phone report must be followed by a written report within 48 hours of the telephone report on the “**Report of Suspected Dependent Adult/Elder Abuse**” form. Mail this report to:

San Bernardino County: Department of Aging/Adult Services
 881 West Redlands Blvd. *Attn:* Central Intake
 Redlands, CA 92373
 Fax number 1-909-388-6718

Inyo County: Social Services
 162 Grove St. Suite “J”
 Bishop, Ca. 93514

Mono County: Department of Social Services
 PO Box 576
 Bridgeport, Ca. 93517

The identity of all persons who report shall be confidential and disclosed only by court order or between elder protective agencies.

San Bernardino County Department of Aging and Adult Services Long-Term Care Ombudsman Program

Ombudsmen are independent, trained and certified advocates for residents living in long-term care facilities. Certified Ombudsmen are authorized by Federal and State law to receive, investigate and resolve complaints made by or on behalf of residents living in skilled nursing or assisted living facilities for the elderly. Ombudsmen work with licensing and other regulatory agencies to support Resident Rights and achieve the best possible quality of life for all long-term care residents. Ombudsman services are confidential and free of charge.

<p>Administrative Office Receives All Reports of Abuse: San Bernardino County Department of Aging and Adult Services 686 E. Mill St. San Bernardino, CA 92415-0640 909-891-3928 Office 1-866-229-0284 Reporting Fax 909-891-3957</p>	<p>The State CRISIS line number: 1-800-231-4024 This CRISIS line is available to take calls and refer complaints 24 hours a day, 7 days a week.</p>
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~~Administrative Office
 Receives All Reports of Abuse
 686 E. Mill St.
 San Bernardino, Ca 92415-0640
 909-891-3928 Office~~

~~1-866-229-0284 Reporting
Fax 909-891-3957~~

~~The State CRISIS line number:~~

~~1-800-231-4024~~

~~This CRISIS line is available to take calls and refer complaints 24 hours a day, 7 days a week.~~



ORGAN DONOR INFORMATION

PURPOSE

To comply with State legislation requiring emergency medical services (EMS) field personnel to search for organ donor information on adult patients for whom death appears imminent.

AUTHORITY

California Health and Safety Code, Section 7152.5 (b).

DEFINITIONS

Reasonable Search: A brief attempt by EMS field personnel to locate documentation that may identify a patient as a potential organ donor, or one who has refused to make an anatomical gift. This search shall be limited to a wallet or purse that is on or near the individual to locate a driver's license or other identification card with this information. A reasonable search shall not take precedence over patient care/treatment.

Imminent Death: A condition wherein illness or injuries are of such severity that in the opinion of EMS field personnel, death is likely to occur before the patient arrives at the receiving hospital.

POLICY

Existing law provides that any individual who is at least eighteen (18) years of age may make an anatomical gift and sets forth procedures for making that anatomical gift, including the presence of a pink dot on their driver's license indicating enrollment in the California Organ and Tissue Donor Registry.

1. When EMS field personnel encounter an unconscious adult patient for whom it appears death is imminent, a reasonable search of the patient's belongings should be made to determine if the individual carries information indicating status as an organ donor. This search shall not interfere with patient care or transport. Any inventory of victim's personal effects should be on the patient care record and signed by the person who receives the patient.
2. All EMS field personnel shall notify the receiving hospital if organ donor information is discovered.

3. Any organ donor document discovered should be transported to the receiving hospital with the patient unless the investigating law enforcement officer requests the document. In the event that no transport is made, any document should remain with the patient.
4. EMS field personnel should briefly note the results of the search, notification of hospital and witness name(s) on the patient care report.
5. No search is to be made by EMS field personnel after the patient has expired.



AXIAL SPINAL STABILIZATION

FIELD ASSESSMENT/TREATMENT INDICATORS

Any patient in which axial spinal stabilization is clinically indicated, including but not limited to the following:

1. Patient meets Mechanism of injury as described in ICEMA Reference #15030 - Trauma Triage Criteria and Destination Policy.
2. Soft tissue damage associated with trauma and/or blunt trauma above the clavicles.
3. Unconscious patients where the mechanism of injury is unknown.
4. All intubated neonatal and pediatric patients.
5. Cervical pain or pain to the upper one-third (1/3) of the thoracic vertebrae. Spinal tenderness or pain, with or without movement of the head or neck, distal numbness, tingling, weakness or paralysis.
6. Altered mental status.
7. Appear to be under the influence of alcohol or other drugs (even if the patient is alert and oriented).
8. Additional sites of significant distracting pain or is experiencing emotional distress.
9. Less than four (4) years of age with appropriate injuries requiring axial spinal stabilization.
10. Unable to adequately communicate with the EMS personnel due to a language barrier or other type of communication difficulty.
11. Any other condition that may reduce the patient's perception of pain.

ALS and or LIMITED ALS personnel may remove patients placed in axial spinal stabilization by Emergency Medical Responders and BLS personnel if the patient does not meet **any** of the above indicators after a complete assessment and documentation on the patient care record.

INTERVENTIONS

1. Apply manual axial stabilization.
2. Assess and document distal function before and after application.
3. For pediatric patients: If the level of the patient's head is greater than that of the torso, use an approved pediatric spine board with a head drop or arrange padding on the board to keep the entire lower spine and pelvis in line with the cervical spine and parallel to the board.
4. For patients being placed on a board, consider providing comfort by placing padding on the backboard.
5. Any elderly or other adult patient who may have a spine that is normally flexed forward should be stabilized in patient's normal anatomical position.
6. When a pregnant patient in the third trimester is placed in axial spinal stabilization, place in the left lateral position to decrease pressure on the Inferior Vena Cava.
7. Certain patients may not tolerate normal stabilization positioning due to the location of additional injuries. These patients may require stabilization in their position of comfort. Additional materials may be utilized to properly stabilize these patients while providing for the best possible axial spinal alignment.

~~LIMITED ALS INTERVENTIONS~~

~~Limited ALS personnel may remove patients placed in axial spinal stabilization by Emergency Medical Responders and BLS personnel if the patient does not meet any of the above indicators after a complete assessment and documentation on the patient care record.~~

REFERENCE

<u>Reference #</u>	<u>Name</u>
15030	Trauma Triage Criteria and Destination Policy



ADULT RESPIRATORY EMERGENCIES

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

FIELD ASSESSMENT/TREATMENT INDICATORS

Symptoms of chronic pulmonary disease, wheezing, cough, pursed lip breathing, decreased breath sounds, accessory muscle use, anxiety, ALOC or cyanosis.

BLS INTERVENTIONS

1. Reduce anxiety, allow patient to assume position of comfort.
2. Administer oxygen as clinically indicated, obtain O₂ saturation on room air, or on home oxygen if possible.

LIMITED ALS (LALS) INTERVENTIONS

1. Maintain airway with appropriate adjuncts, including advanced airway if indicated. Obtain O₂ saturation on room air or on home oxygen if possible.
2. Nebulized Albuterol 2.5 mg, ~~with Atrovent 0.5mg~~ may repeat ~~twicetimes two (2)~~.

ALS INTERVENTIONS

1. Maintain airway with appropriate adjuncts, including advanced airway if indicated. Obtain O₂ saturation on room air or on home oxygen if possible.
2. Nebulized Albuterol 2.5 mg, with Atrovent 0.5 mg may repeat twice.
3. Place patient on Continuous Positive Airway Pressure (CPAP) as per protocol.
4. Consider advanced airway per ICEMA Reference #10050 - Nasotracheal Intubation.
5. Base Station physician may order additional medications or interventions as indicated by patient condition.

ACUTE ASTHMA/BRONCHOSPASM

FIELD ASSESSMENT/TREATMENT INDICATORS

History of prior attacks, possible toxic inhalation or allergic reaction, associated with wheezing, diminished breath sounds or cough.

BLS INTERVENTIONS

1. Reduce anxiety, allow patient to assume position of comfort.
2. Administer oxygen as clinically indicated, humidified oxygen preferred.

LIMITED ALS (LALS) INTERVENTIONS

1. Maintain airway with appropriate adjuncts, obtain O₂ saturation on room air if possible.
2. Nebulized Albuterol 2.5mg, ~~with Atrovent 0.5mg~~ may repeat ~~twicetimes two (2)~~.
3. For signs of inadequate tissue perfusion, initiate IV bolus of 300 cc NS. If signs of inadequate tissue perfusion persist may repeat fluid bolus.
4. If no response to Albuterol, give Epinephrine 0.3 mg (1:1,000) SC. Contact Base Station for patients with a history of coronary artery disease, history of hypertension or over 40 years of age prior to administration of Epinephrine.
5. May repeat Epinephrine 0.3 mg (1:1,000) SQ after 15 minutes.
6. Base Station physician may order additional medications or interventions as indicated by patient condition.

ALS INTERVENTIONS

1. Maintain airway with appropriate adjuncts, obtain O₂ saturation on room air if possible.
2. Nebulized Albuterol 2.5 mg, with Atrovent 0.5 mg may repeat twice.
3. For signs of inadequate tissue perfusion, initiate IV bolus of 300 cc NS. If signs of inadequate tissue perfusion persist may repeat fluid bolus.
4. Place patient on Continuous Positive Airway Pressure (CPAP) as per protocol.
5. If no response to Albuterol, give Epinephrine 0.3 mg (1:1,000) SC. Contact Base Station for patients with a history of coronary artery disease, history of hypertension or over 40 years of age prior to administration of Epinephrine.
6. May repeat Epinephrine 0.3 mg (1:1,000) SQ after 15 minutes.
7. For suspected allergic reaction, consider Diphenhydramine 25 mg IV, or 50 mg IM.
8. For persistent severe anaphylactic shock, administer Epinephrine 0.1 mg (1:10,000) slow IV push. May repeat as needed to total dosage of 0.5 mg.

9. Consider advanced airway per ~~protocol~~ [ICEMA](#) Reference #10050 - Nasotracheal Intubation.
10. Base Station physician may order additional medications or interventions as indicated by patient condition.

ACUTE PULMONARY EDEMA/CHF

FIELD ASSESSMENT/TREATMENT INDICATORS

History of cardiac disease, including CHF, and may present with rales, occasional wheezes, jugular venous distention and/or peripheral edema.

BLS INTERVENTIONS

1. Reduce anxiety, allow patient to assume position of comfort.
2. Administer oxygen as clinically indicated. For pulmonary edema with high altitude as a suspected etiology, descend to a lower altitude and administer high flow oxygen with a non re-breather mask.
3. Be prepared to support ventilations as clinically indicated.

LIMITED ALS (LALS) INTERVENTIONS

1. Maintain airway with appropriate adjuncts, obtain O₂ saturation on room air if possible.
2. Nitroglycerine 0.4 mg sublingual/transmucosal with signs of adequate tissue perfusion. May be repeated as long as patient continues to have signs of adequate tissue perfusion. Do not use or discontinue NTG in presence of hypotension (SBP <100).
3. Nebulized Albuterol 2.5 mg, ~~with Atrovent 0.5 mg~~ may repeat ~~twice~~ ~~two (2)~~, if nitro is not working.

ALS INTERVENTIONS

1. Maintain airway with appropriate adjuncts, obtain O₂ saturation on room air if possible
2. Nitroglycerine 0.4mg sublingual/transmucosal one every three (3) minutes as needed. May be repeated as long as patient continues to have signs of adequate tissue perfusion. **If a Right Ventricular Infarction is suspected, the use of nitrates requires Base Station contact.**
3. Place patient on Continuous Positive Airway Pressure (CPAP) as per protocol.

4. Consider advanced airway per ICEMA Reference #10050 - Nasotracheal Intubation.
5. Base station physician may order additional medications or interventions as indicated by patient condition.
6. In radio communication failure (RCF), the following medications may be utilized.
 - a. Dopamine 400 mg in 250 cc NS titrated between 5 - 20 mcg/min to maintain adequate tissue perfusion.
 - b. Nebulized Albuterol 2.5 mg with Atrovent 0.5 mg after patient condition has stabilized.

REFERENCE

<u>Number</u>	<u>Name</u>
10050	Nasotracheal Intubation



AIRWAY OBSTRUCTION - ADULT

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Universal sign of distress.
2. Alteration in respiratory effort and/or signs of obstruction.
3. Altered level of consciousness.

BLS INTERVENTION - RESPONSIVE

1. Assess for ability to speak or cough (e.g., "Are you choking?").
2. If unable to speak, administer abdominal thrusts (if the rescuer is unable to encircle the victim's abdomen or the patient is in the late stages of pregnancy, utilize chest thrusts) until the obstruction is relieved or patient becomes unconscious.
3. After obstruction is relieved, reassess and maintain ABC's.
4. Administer oxygen therapy; if capable obtain O₂ saturation, per ICEMA Reference #10170 - Pulse Oximetry.
5. If responsive, place in position of comfort. If uninjured but unresponsive with adequate respirations and pulse, place on side in recovery position.

BLS INTERVENTION - UNRESPONSIVE

1. Position patient supine (for suspected trauma, maintain in-line axial spinal stabilization).
2. Begin immediate CPR at a 30:2 ratio for two (2) minutes.
3. Each time the airway is opened to ventilate, look for an object in the victim's mouth and if found, remove it.
4. If apneic and able to ventilate, provide one (1) breath every five (5) to six (6) seconds.
5. If available, place AED per ICEMA Reference #10130 - Automatic External Defibrillation (AED) - BLS.

LIMITED ALS (LALS) INTERVENTION - UNRESPONSIVE

1. If apneic and able to ventilate, establish advanced airway.
2. Establish vascular access as indicated.

ALS INTERVENTION - UNRESPONSIVE

1. If apneic and able to ventilate, establish advanced airway.
2. If obstruction persists, visualize with laryngoscope and remove visible foreign body with Magill forceps and attempt to ventilate.
3. If obstruction persists and unable to ventilate, consider Needle Cricothyrotomy per ICEMA Reference #10070 - Needle Cricothyrotomy.

REFERENCES

<u>Number</u>	<u>Name</u>
10070	Needle Cricothyrotomy
10130	Automatic External Defibrillation (AED) - BLS
10170	Pulse Oximetry



SUSPECTED ACUTE MYOCARDIAL INFARCTION (AMI)

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Chest pain (typical or atypical).
2. Syncopal episode.
3. History of previous AMI, Angina, heart disease, or other associated risk factors.

BLS INTERVENTIONS

1. Recognition of signs/symptoms of suspected AMI.
2. Reduce anxiety, allow patient to assume position of comfort.
3. Oxygen as clinically indicated.
4. Obtain O₂ saturation.
5. May assist patient with self-administration of Nitroglycerin and/or Aspirin.

LIMITED ALS (LALS) INTERVENTIONS

1. Aspirin 162 mg.
2. Consider early vascular access.
3. For patients with chest pain, signs of inadequate tissue perfusion and clear breath sounds, give 300 ml NS bolus, may repeat.
4. Nitroglycerin 0.4 mg sublingual/transmucosal, may repeat in three (3) minute intervals if signs of adequate tissue perfusion are present. Nitroglycerin is contraindicated (signs of inadequate tissue perfusion or recent use of sexual enhancement medications).
5. Consider establishing a saline lock enroute on same side as initial IV.
6. Complete thrombolytic checklist, if time permits.
7. Contact Base Station.

ALS INTERVENTIONS

1. Aspirin 162 mg.
2. Consider early vascular access.
3. For patients with chest pain, signs of inadequate tissue perfusion and clear breath sounds, give 300 ml NS bolus, may repeat.
4. 12-Lead Technology:
 - a. Obtain 12-lead ECG. Do not disconnect 12-lead cables until necessary for transport.
 - b. If signs of inadequate tissue perfusion or if inferior wall infarct is suspected, obtain a right-sided 12-lead (V4R).
 - c. If right ventricular infarct (RVI) is suspected with signs of inadequate tissue perfusion, consider 300ml NS bolus, may repeat. Early consultation with Base Station or receiving hospital in rural areas is recommended. (Nitrates are contraindicated in the presence of RVI or hypotension).
 - d. With documented ST segment elevation in two (2) or more contiguous leads, contact STEMI Base Station for destination decision while preparing patient for expeditious transport, per ICEMA Reference #6070 - Cardiovascular "STEMI" Receiving Centers. In Inyo and Mono Counties, the assigned Base Station should be contacted for STEMI consultation.
 - e. Repeat 12-lead at regular intervals, but do not delay transport of patient. If patient is placed on a different cardiac monitor for transport, transporting provider should obtain an initial 12-lead on their cardiac monitor and leave 12-lead cables in place throughout transport.
5. Nitroglycerin 0.4 mg sublingual/transmucosal, may repeat in three (3) minute intervals if signs of adequate tissue perfusion are present. Nitroglycerin is contraindicated if there are signs of inadequate tissue perfusion or if sexual enhancement medications have been utilized within the past forty-eight (48) hours. Utilize Morphine Sulfate for pain control when Nitroglycerin is contraindicated.
6. Morphine Sulfate 2 mg IV, may repeat every three (3) minutes to total 10mg. Consider concurrent administration of Nitroglycerin with Morphine Sulfate if there is no pain relief from the initial Nitroglycerin administration. Contact Base Station for further Morphine Sulfate orders.

7. Consider establishing a saline lock as a secondary IV site.
8. Make early STEMI notification to the STEMI Receiving Center.
9. In Radio Communication Failure (RCF), may give up to an additional 10 mg Morphine Sulfate in 2 mg increments with signs of adequate tissue perfusion.

REFERENCE

<u>Number</u>	<u>Name</u>
6070	Cardiovascular “STEMI” Receiving Centers



CARDIAC ARREST - ADULT

FIELD ASSESSMENT/TREATMENT INDICATORS

Cardiac arrest in a non-traumatic setting.

BLS INTERVENTIONS

1. Assess patient, begin CPR according to current AHA Guidelines, and maintain appropriate airway.
 - a. Compression rate shall be 100 per minute utilizing 30:2 compression-to-ventilation ratio for synchronous CPR prior to placement of advanced airway.
 - b. Ventilatory volumes shall be sufficient to cause adequate chest rise.
2. If available, place AED ~~and follow Protocol~~ per ICEMA Reference #10130 - Automatic External Defibrillation (AED) - BLS. CPR is **not** to be interrupted except briefly for rhythm assessment.

LIMITED ALS (LALS) INTERVENTIONS

1. Initiate CPR while applying the AED.
2. Establish advanced airway when resources are available, with minimal interruption to CPR. After advanced airway established, compressions would then be continued at 100 per minute without pauses during ventilations.
3. Establish peripheral intravenous access and administer a 300ml-500 ml bolus, ~~with signs and symptoms of inadequate tissue perfusion, may repeat fluid bolus.~~
4. ~~Protocol~~ See ICEMA Reference #12010, ~~AEMT~~ Determination of Death on Scene ~~policy.~~

Utilize the following treatment modalities while managing the cardiac arrest patient:

1. Obtain blood glucose, if indicated; administer Dextrose 50% 25 g IV.
2. Naloxone 2.0 mg IM/IN for suspected opiate overdose.

NOTE

Base Station contact is required to terminate resuscitative measures.

ALS INTERVENTIONS

1. Initiate CPR while applying the cardiac monitor.
2. Determine cardiac rhythm and defibrillate if indicated. Begin a two (2) minute cycle of CPR.
3. Obtain IV/IO access.
4. Establish advanced airway when resources are available, with minimal interruption to CPR. After advanced airway established, compressions would then be continued at 100/min without pauses during ventilations. Ventilations should be given at a rate of one (1) breath every six (6) to eight (8) seconds.
5. Utilize continuous quantitative waveform capnography, if available, for confirmation and monitoring of endotracheal tube placement and for assessment of ROSC. For agencies with waveform capnography, document the shape of the wave and the capnography number in mmHG.

Ventricular Fibrillation/Pulseless Ventricular Tachycardia

1. Defibrillate at 360 joules for monophasic or biphasic equivalent per manufacture. If biphasic equivalent is unknown use maximum available.
2. Perform CPR for two (2) minutes after each defibrillation, without delaying to assess the post-defibrillation rhythm.
3. Administer Epinephrine 1.0 mg IV/IO during each two (2) minute cycle of CPR after every defibrillation unless capnography indicates possible ROSC.
4. Reassess rhythm after each two (2) minute cycle of CPR. If VF/VT persists, defibrillate as above.
5. After two (2) cycles of CPR, consider administering Lidocaine 1.5 mg/kg IV/IO. May repeat at 0.75 mg/kg every five (5) minutes to maximum dose of 3.0 mg/kg.
6. If patient remains in pulseless VF/VT after five (5) cycles of CPR, consult Base Station.

Pulseless Electrical Activity (PEA) or Asystole

1. Assess for reversible causes and initiate treatment.
2. Continue CPR with evaluation of rhythm every two (2) minutes.
3. Administer fluid bolus of 300 ml NS IV, may repeat.

4. Administer Epinephrine 1.0 mg IV/IO during each two (2) minute cycle of CPR after each rhythm evaluation.

Utilize the following treatment modalities while managing the cardiac arrest patient:

1. Insert NG/OG Tube to relieve gastric distension per ~~ICEMA Protocol~~ Reference #10080 -; Insertion of Nasogastric/Orogastric Tube.
2. Obtain blood glucose. If indicated, administer Dextrose 50% 25 gms IV.
3. Naloxone 2.0 mg IV/IO/IM for suspected opiate overdose.

Termination of Efforts in the Prehospital Setting

1. The decision to terminate efforts in the field should take into consideration, first, the safety of personnel on scene, and then family and cultural considerations.
2. Consider terminating resuscitative efforts in the field if ALL of the following criteria are met:
 - a. No shocks were delivered.
 - b. No ROSC after a minimum of ten (10) minutes of advance cardiac life support (ACLS).
3. Base Station contact is required to terminate resuscitative measures. A copy of the ECG should be attached to the patient care report for documentation purposes.

NOTE

1. If ROSC is achieved, obtain a 12-lead ECG.
2. Utilize continuous waveform capnography, if available, to identify loss of circulation.
3. For continued signs of inadequate tissue perfusion after successful resuscitation a Dopamine infusion of 400 mg in 250 ml of NS may be initiated at 5 - 10 mcg/kg/min IV to maintain signs of adequate tissue perfusion.
4. Base Station physician may order additional medications or interventions as indicated by patient condition.

REFERENCES

<u>Number</u>	<u>Name</u>
10080	Insertion of Nasogastric/Orogastric Tube
10130	Automatic External Defibrillation (AED) - BLS
12010	Determination of Death On Scene



BURNS - ADULT 15 Years of Age and Older

Burn patient requires effective communication and rapid transportation to the closest receiving hospital.

In Inyo and Mono Counties, the assigned Base Station should be contacted for determination of appropriate destination.

FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to ICEMA Reference #8030 - Burn Destination and Criteria Policy.

BLS INTERVENTIONS

- Break contact with causative agent (stop the burning process).
- Remove clothing and jewelry quickly, if indicated.
- Keep patient warm.
- Estimate % TBSA burned and depth using the “Rule of Nines”.
 - An individual’s palm represents 1% of TBSA and can be used to estimate scattered, irregular burns.
- Transport to ALS intercept or to the closest receiving hospital.

Manage Special Considerations

- **Thermal Burns:** Stop the burning process. Do not break blisters. Cover the affected body surface with dry, sterile dressing or sheet.
- **Chemical Burns:** Brush off dry powder, if present. Remove any contaminated or wet clothing. Irrigate with copious amounts of saline or water.
- **Tar Burns:** Cool with water, do not remove tar.
- **Electrical Burns:** Remove from electrical source (without endangering self) with a nonconductive material. Cover the affected body surface with dry, sterile dressing or sheet.
- **Eye Involvement:** Continuous flushing with NS during transport. Allow patient to remove contact lenses if possible.
- **Determination of Death on Scene:** Refer to ICEMA Reference #12010 - Determination of Death On Scene.

LIMITED ALS (LALS) INTERVENTIONS

- Advanced airway as indicated
- King Airway contraindicated in airway burns.
- Airway Stabilization:

Burn patients with respiratory compromise or potential for such, will be transported to the closest most appropriate receiving hospital for airway stabilization.

- ~~Monitor ECG~~

- IV access (warm IV fluids when available).
 - *Unstable:* BP <90mmHG and/or signs of inadequate tissue perfusion, start 2nd IV access.

IV NS 250 ml boluses, may repeat to a maximum of 1000 ml.
 - *Stable:* BP >90mmHG and/or signs of adequate tissue perfusion.

IV NS 500 ml/hour.
- Transport to appropriate facility.
 - *Minor Burn Classification:* Transport to the closest most appropriate receiving hospital.
 - *Moderate Burn Classification:* Transport to the closest most appropriate receiving hospital.
 - *Major Burn Classification:* Transport to the closest most appropriate Burn Center (San Bernardino County contact ARMC).
 - *Critical Trauma Patient (CTP) with Associated Burns:* Transport to the most appropriate trauma center.
- Burn patients with associated trauma, should be transported to the closest Trauma Center. Trauma Base Station contacted shall be made.
- ~~Burn patients with associated trauma, in which the burn injury poses the greatest risk of morbidity or mortality, should be considered for transport to the closest most appropriate Burn Center. Trauma Base Station contacted shall be made.~~

Manage Special Considerations

- **Electrical Burns:** Place AED according to ICEMA protocols.
 - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
- **Respiratory Distress:** Use BVM as needed and transport to the nearest facility for airway control. Contact receiving hospital ASAP. Nebulized Albuterol 2.5 mg with Atrovent 0.5 mg, may repeat two (2) times.
- **Deteriorating Vital Signs:** Transport to the closest most appropriate receiving hospital. Contact Base Station.
- **Pulseness and Apneic:** Transport to the closest most appropriate receiving hospital and treat according to ICEMA policies. Contact Base Station.
- **Determination of Death on Scene:** Refer to ICEMA Reference #12010 - Determination of Death on Scene.
- **Precautions and Comments:**
 - High flow oxygen is essential with known or potential respiratory injury. Beware of possible smoke inhalation.
 - Contact with appropriate advisory agency may be necessary for hazardous materials, before decontamination or patient contact.
 - Do not apply ice or ice water directly to skin surfaces, as additional injury will result.
- **Base Station Orders:** May order additional fluid boluses.

ALS INTERVENTIONS

- Advanced airway (as indicated).
- Airway Stabilization:

Burn patients with respiratory compromise or potential for such, will be transported to the closest most appropriate receiving hospital for airway stabilization.
- Monitor ECG.

- IV/IO Access (Warm IV fluids when available).
 - *Unstable:* BP<90mmHG and/or signs of inadequate tissue perfusion, start 2nd IV access.

IV/IO NS 250 ml boluses, may repeat to a maximum of 1000ml.
 - *Stable:* BP>90mmHG and/or signs of adequate tissue perfusion.

IV/IO NS 500 ml/hour.

- Treat pain as indicated.

IV Pain Relief: Morphine Sulfate 5 mg IV slowly and may repeat every five (5) minutes to a maximum of 20 mg when the patient maintains a BP >90mmHG and signs of adequate tissue perfusion. Document BPs every five (5) minutes while medicating for pain and reassess the patient.

IM Pain Relief: Morphine Sulfate 10 mg IM. Document vital signs and reassess patient.

- Transport to appropriate facility:
- *CTP with associated burns:* Transport to the closest Trauma Center.
- Burn patients with associated trauma, should be transported to the closest Trauma Center. Trauma Base Station contacted shall be made.
- Insert nasogastric/orogastric tube as indicated.
- Refer to Burn Classification table.

Manage Special Considerations

- **Electrical Burns:** Monitor for dysrhythmias, treat according to ICEMA protocols.
 - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
- **Respiratory Distress:** Intubate patient if facial/oral swelling are present or if respiratory depression or distress develops due to inhalation injury.
 - Nebulized Albuterol 2.5 mg with Atrovent 0.5 mg, may repeat two (2) times.
 - Administer humidified oxygen, if available.

- Consider capnography, if available.
- Awake and breathing patients with potential for facial/inhalation burns are not candidates for nasal tracheal intubation. CPAP may be considered, if indicated, after consultation with Base Station.
- **Deteriorating Vital Signs:** Transport to the closest receiving hospital. Contact Base Station.
- **Pulseness and Apneic:** Transport to the closest receiving hospital and treat according to ICEMA policies. Contact Base Station.
- **Determination of Death on Scene:** Refer to ICEMA Reference #12010 - Determination of Death on Scene.
- **Precautions and Comments:**
 - Contact with appropriate advisory agency may be necessary for hazardous materials, before decontamination or patient contact.
 - Do not apply ice or ice water directly to skin surfaces, as additional injury will result.
- **Base Station Orders:** May order additional medications, fluid boluses and CPAP.

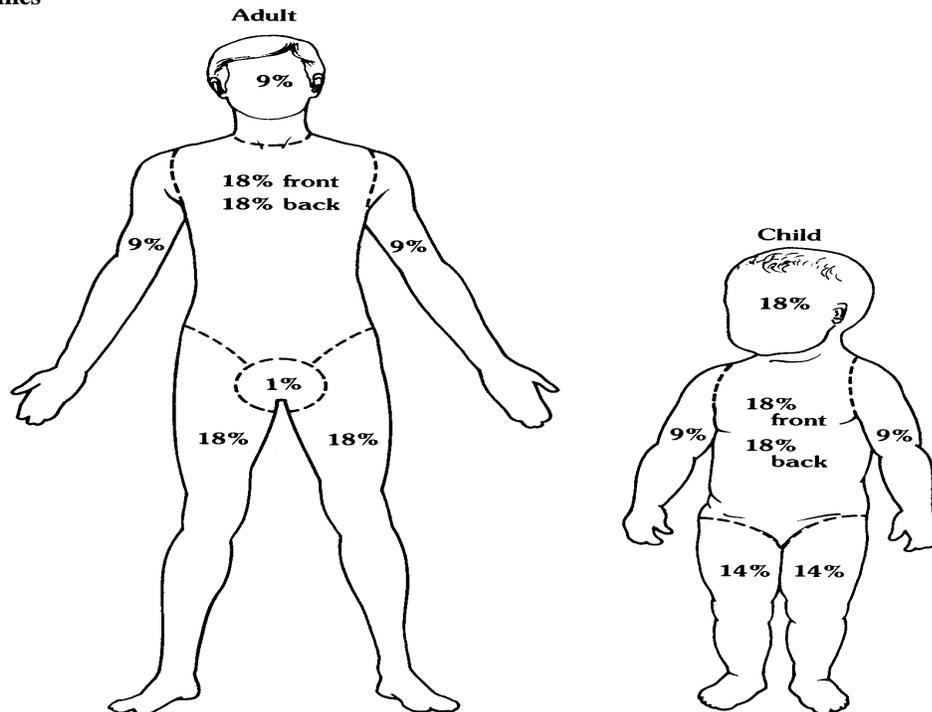
REFERENCES

<u>Number</u>	<u>Name</u>
8030	Burn Destination and Criteria Policy
9010	General Patient Care Guidelines
10010/10020	King Airway Device
10030/10040	Oral Endotracheal Intubation
10050	Nasotracheal Intubation
10060	Needle Thoracostomy
10070	Needle Cricothyrotomy
10080	Insertion of Nasogastric/Orogastric Tube
10140	Intraosseous Infusion IO
10150	External Jugular Vein Access
10160	Axial Spinal Stabilization
11070	Adult Cardiac Arrest
12010	Determination of Death on Scene
15030	Trauma Triage Criteria and Destination Policy

BURN CLASSIFICATIONS

ADULT BURN CLASSIFICATION CHART	DESTINATION	
<p>MINOR - ADULT</p> <ul style="list-style-type: none"> • < 10% TBSA • < 2% Full Thickness 	<p>CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL</p>	
<p>MODERATE - ADULT</p> <ul style="list-style-type: none"> • 10 - 20% TBSA • 2 - 5% Full Thickness • High Voltage Injury • Suspected Inhalation Injury • Circumferential Burn • Medical problem predisposing to infection (e.g., diabetes mellitus, sickle cell disease) 	<p>CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL</p>	
<p>MAJOR - ADULT</p> <ul style="list-style-type: none"> • >20% TBSA burn in adults • > 5% Full Thickness • High Voltage Burn • Known Inhalation Injury • Any significant burn to face, eyes, ears, genitalia, or joints 	<p>CLOSEST MOST APPROPRIATE BURN CENTER</p> <p>In San Bernardino County, contact: Arrowhead Regional Medical Center (ARMC)</p>	

“Rule of Nines”





DETERMINATION OF DEATH ON SCENE

PURPOSE

To identify situations when an EMT, AEMT or EMT-P may be called upon to determine death on scene.

POLICY

An EMT, AEMT or EMT-P may determine death on scene if **pulselessness and apnea** are present with any of the following criteria. The EMT-P is authorized to discontinue BLS CPR initiated at scene if a patient falls into the category of obvious death. If any ALS procedures are initiated, only the Base Station physician/designee may determine death in the field. In any situation where there may be doubt as to the clinical findings of the patient, BLS/CPR must be initiated and the Base Station contacted, per ICEMA Reference #12020 - Withholding Resuscitate Measures Policy. When death is determined, the County Coroner must be notified along with the appropriate law enforcement agency.

DETERMINATION OF DEATH CRITERIA

1. Decomposition.
2. Obvious signs of rigor mortis such as rigidity or stiffening of muscular tissues and joints in the body, which occurs anytime after death and usually appears in the head, face and neck muscles first.
3. Obvious signs of venous pooling in dependent body parts, lividity such as mottled bluish-tinged discoloration of the skin, often accompanied by cold extremities.
4. Decapitation.
5. Incineration of the torso and/or head.
6. Massive crush injury.
7. Penetrating injury with evisceration of the heart, and/or brain.
8. Gross dismemberment of the trunk.

PROCEDURE

1. If the patient does not meet the Determination of Death criteria, appropriate interventions must be initiated.
2. Resuscitation efforts shall not be terminated enroute per Government Code 27491. The patient will be transported to the closest facility where determination of death will be made by hospital staff.
3. Most victims of electrocution, lightning and drowning should have resuscitative efforts begun and transported to the appropriate Hospital/Trauma Center.
4. Hypothermic patients should be treated per ICEMA Protocol Reference #13030 - Cold Related Emergencies under Severe Hypothermia.
5. A DNR report form must be completed, if applicable per ICEMA Reference #12020 - Withholding Resuscitative Measures.

San Bernardino County Only

A copy of the patient care ~~record~~ report must be made available for the ~~coroner~~ Coroner. This will be transmitted to them, when posted, if the disposition is marked "Dead on Scene" and the Destination is marked "Coroner, San Bernardino County" on the electronic patient care report (ePCR). If unable to ~~post, print~~ a printed copy of the ePCR electronic patient care record, O1A or a completed *Coroners Worksheet of Death* must be left at the scene. ~~Completed~~ The completed ePCR or O1A must be posted or faxed to the Coroner before the end of the shift.

LIMITED ALS (LALS) PROCEDURE

- ~~1. All patients in ventricular fibrillation should be resuscitated and transported unless otherwise determined by the Base Station Physician/designee.~~
- ~~2. Traumatic cardiac arrest in the setting of severe blunt force trauma, documented asystole in at least two (2) leads and no reported Vital signs (palpable pulses and/or spontaneous respirations) during EMS encounter with the patient meet Determination of Death Criteria.~~
- ~~31. All terminated Limited ALS/LALS resuscitation efforts must have an AED event record attached to the patient care record report.~~
- ~~42. All conversations with the Base Station must be fully documented with the name of the Base Station physician who determined death, times and instructions on the patient care ~~record~~ report.~~

ALS PROCEDURE

1. All patients in ventricular fibrillation should be resuscitated and transported unless otherwise determined by the Base Station physician/designee.
2. Traumatic cardiac arrest in the setting of severe blunt force trauma, documented asystole in at least two (2) leads and no reported vital signs (palpable pulses and/or spontaneous respirations) during EMS encounter with the patient meet Determination of Death Criteria.
3. All terminated ALS resuscitation efforts must have an ECG attached to the patient care ~~record~~ report.
4. All conversations with the Base Station must be fully documented with the name of the Base Station physician who determined death, times and instructions on the patient care ~~record~~ report.

SUSPECTED SUDDEN INFANT DEATH SYNDROME (SIDS) INCIDENT

PURPOSE Purpose

It is imperative that all prehospital personnel in ICEMA be able to assist the caregiver and local police agencies during a suspected SIDS incident.

PROCEDURE

1. Follow individual department/agency policies at all times.
2. Ask open-ended questions about incident.
3. Explain what you are doing, the procedures you will follow, and the reasons for them.
4. If you suspect a SIDS death, explain to the parent/caregiver what SIDS is and, if this is a SIDS related death nothing they did or did not do caused the death.
5. Provide the parent/caregiver with the number of the California SIDS Information Line:

1-800-369-SIDS (7437).
6. Provide psychosocial support and explain the emergency treatment and transport of their child.

7. Assure the parent/caregiver that your activities are standard procedures for the investigation of all death incidents and that there is no suspicion of wrongdoing.

8. Document observations.

REFERENCES

<u>Number</u>	<u>Name</u>
12020	Withholding Resuscitative Measures
13030	Cold Related Emergencies



POISONINGS

PRIORITIES

1. Assure the safety of EMS personnel.
2. Assure and maintain ABCs.
3. Determine degree of physiological distress.
4. Obtain vital signs, history and complete physical assessment including the substance ingested, the amount, the time substance was ingested and the route.
5. Bring ingested substance to the hospital with patient.
6. Expeditious transport.

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Altered level of consciousness.
2. Signs and symptoms of substance ingestion, inhalation, injection or surface absorption.
3. History of substance poisoning.

DEFINITIVE CARE/BLS INTERVENTIONS

1. Assure and maintain ABCs.
2. Place patient on high flow oxygen as clinically indicated.
3. Contact poison control (1-800-222-1222).
4. Obtain accurate history of incident:
 - a. Name of product or substance.
 - b. Quantity ingested, and/or duration of exposure.
 - c. Time elapsed since exposure.

- d. Pertinent medical history, chronic illness, and/or medical problems within the last twenty-four (24) hours.
 - e. Patient medication history.
5. Monitor vital signs.
 6. Expeditious transport.

LIMITED ALS (LALS) INTERVENTIONS SUPPORT PRIOR TO BASE STATION CONTACT

1. Assure and maintain ABCs.
2. Oxygen therapy as clinically indicated, obtain oxygen saturation on room air, unless detrimental to patient condition.
3. Obtain vascular access at a TKO rate or if signs of inadequate tissue perfusion, administer 500cc fluid challenge and repeat until perfusion improves.
4. For pediatric patients with signs of inadequate tissue perfusion give 20cc/kg IVP and repeat until perfusion improves.

~~Obtain vascular access at a TKO rate or if hypotensive administer 500cc fluid challenge to sustain a systolic B/P greater than 90mmHg. For pediatric patients with a systolic B/P less than 80mmHg give 20cc/kg IVP and repeat as indicated.~~

- ~~4. Charcoal 50gms for adult (pediatrics 1gm/kg). Administer P.O. if alert with a gag reflex. Charcoal is contraindicated with caustic ingestions.~~

ALS INTERVENTIONS PARAMEDIC SUPPORT PRIOR TO BASE STATION CONTACT

1. Assure and maintain ABC's.
2. Oxygen therapy as clinically indicated, obtain oxygen saturation on room air, unless detrimental to patient condition.
3. Monitor cardiac status.
4. Obtain vascular access at a TKO rate or if signs of inadequate ~~perfusion~~ administer tissue rperfusion, administer 500cc fluid challenge and repeat until perfusion improves. -

5. For pediatric patients with signs of inadequate tissue perfusion, give 20 cc/kg IVP and repeat until perfusion improves. -
6. For phenothiazine “poisoning”, administer Diphenhydramine 25 mg IVP or 50 mg IM for ataxia and/or muscle spasms.
7. For known organophosphate poisoning, give Atropine 2 mg IVP, repeat at 2 mg increments if patient remains symptomatic (i.e., excessive salivation, lacrimation, urination, diarrhea, vomiting, and/or constricted pupils).

BASE STATION MAY ORDER THE FOLLOWING

- 1.* For tricyclic poisonings, administer Sodium Bicarbonate 1 mEq/kg IVP for tachycardia, widening QRS or ventricular arrhythmias.
- 2.* For calcium channel blocker poisonings, administer Calcium Chloride 1gm (10 cc of a 10% solution), if hypotension or bradycardic arrhythmias persist.
- 3.* For ~~betablocker~~beta blocker poisonings, administer Glucagon 1 mg IVP.
- 4.* Repeat Atropine in 2 - 4 mg increments until symptoms are controlled.

* May be done during radio communication failure (RCF).



ALLERGIC REACTIONS - PEDIATRIC (Less than 15 years of age)

FIELD ASSESSMENT/TREATMENT INDICATORS

1. Signs and Symptoms of an acute allergic reaction.
2. History of Exposure to possible allergen.

BLS INTERVENTIONS

1. Recognize s/s of respiratory distress for age.
2. Reduce anxiety, assist patient to assume POC.
3. Oxygen administration as clinically indicated, (humidified oxygen preferred).
4. Assist patient with self-administration of prescribed Epinephrine device.
5. Assist patient with self-administration of prescribed Diphenhydramine.

~~LIMITED ALS INTERVENTIONS - ADULT~~

- ~~— Maintain airway with appropriate adjuncts, obtain oxygen saturation on room air if possible.~~
- ~~— Epinephrine (1:1,000) 0.3mg SQ. Contact Base Station for patients with a history of coronary artery disease, history of hypertension or over 40 years of age prior to administration of Epinephrine.~~
- ~~— Nebulized Albuterol 2.5mg with Atrovent 0.5mg via handheld nebulizer for wheezing. May repeat times two (2).~~
- ~~— Establish peripheral intravenous access. If patient's systolic blood pressure <90mm Hg, then given a bolus of 500ml normal saline. May repeat the fluid bolus as needed to sustain a BP of >90 mm Hg systolic. Monitor lung sounds and decrease flow rate as needed.~~

LIMITED ALS (LALS) INTERVENTIONS - PEDIATRIC (Less than 15 years of age)

1. Maintain airway with appropriate adjuncts, obtain oxygen saturation on room air if possible.

2. Nebulized Albuterol 2.5 mg may repeat twice.
~~1 day to 12 months - Atrovent 0.25mg~~
~~1 year to 14 years - Atrovent 0.5mg~~
3. If no response to Albuterol ~~and Atrovent~~, consider Epinephrine (1:1,000) 0.01 mg/kg SC not to exceed adult dosage of 0.3 mg. (with Base Station contact).
4. For symptomatic hypotension with poor perfusion, consider fluid bolus of 20 ml/kg of NS not to exceed 300 ml NS and repeat as indicated.
5. Establish additional IV access if indicated.
6. Base Station may order additional medication dosages and additional fluid boluses.

ALS INTERVENTIONS

1. Maintain airway with appropriate adjuncts, obtain oxygen saturation on room air if possible.
2. Nebulized Albuterol 2.5 mg with Atrovent may repeat ~~twice times two (2)~~.
 - a. 1 ~~d~~Day to 12 months - Atrovent 0.25 mg
 - b. 1 year to 14 years - Atrovent 0.5 mg
3. If no response to Albuterol and Atrovent, consider Epinephrine (1:1,000) 0.01 mg/kg SC not to exceed adult dosage of 0.3mg.
4. For symptomatic hypotension with poor perfusion, consider fluid bolus of 20 ml/kg of NS not to exceed 300 ml NS and repeat as indicated.
5. Diphenhydramine 1mg/kg slow IV or 2 mg/kg IM, not to exceed adult dose of 25 mg IV/IO or 50 mg IM.
6. Establish additional IV access if indicated.
7. For anaphylactic shock (e.g., no palpable radial pulse and a depressed level of consciousness), administer epinephrine dose 0.01 mg/kg (1:10,000) IV/IO, no more than 0.1 mg per dose. May repeat to a maximum of 0.5 mg.
8. Base Station may order additional medication dosages and additional fluid boluses.



SUSPECTED SUDDEN INFANT DEATH SYNDROME INCIDENT

PURPOSE

It is imperative that all prehospital personnel in ICEMA be able to assist the caregiver and local police agencies during a suspected SIDS Incident.

PROCEDURE

1. Follow individual department/agency policies at all times.
2. Ask open-ended questions about incident.
3. Explain what you are doing, the procedures you will follow, and the reasons for them.
4. If you suspect a SIDS death, explain to the parent/caregiver what SIDS is and, if this is a SIDS related death nothing they did or did not do caused the death.
5. Provide the parent/caregiver with the number of the California SIDS Information Line:

1-800-369-SIDS (7437).
6. Provide psychosocial support and explain the emergency treatment and transport of their child.
7. Assure the parent/caregiver that your activities are standard procedures for the investigation of all death incidents and that there is no suspicion of wrongdoing.



TRAUMA - ADULT (15 Years of Age and Older)

Any critical trauma patient (CTP) requires effective communication and rapid transportation to the closest trauma center. If not contacted at scene, the receiving trauma center must be notified as soon as possible in order to activate the trauma team.

In Inyo and Mono Counties, the assigned base station should be contacted for determination of appropriate destination.

FIELD ASSESSMENT/TREATMENT INDICATORS

Trauma Triage Criteria and Destination Policy #15030.

ADULT TREATMENT PROTOCOL: TRAUMA Base Station Contact Shaded in Gray

BLS INTERVENTIONS	ALS INTERVENTIONS
<ul style="list-style-type: none"> • Ensure thorough initial assessment • Ensure patent airway, protecting cervical spine • Axial spinal stabilization as appropriate • Oxygen and/or ventilate as needed, O₂ saturation (if BLS equipped) • Keep patient warm • For a traumatic full arrest, an AED may be utilized, if indicated • Transport to ALS intercept or to the closest receiving hospital 	<ul style="list-style-type: none"> • Advanced airway as indicated. <i>Unmanageable Airway:</i> -If an adequate airway cannot be maintained with a BVM device; AND -The paramedic is unable to intubate or if indicated, perform a successful needle cricothyrotomy, Then, transport to the closest receiving hospital and follow Continuation of Trauma Care, Protocol Reference #8100. • Monitor ECG. • IV/IO Access: Warm IV fluids when avail <i>Unstable:</i> -BP<90mmHG and/or signs of inadequate perfusion, start 2nd IV access. <i>Stable:</i> -BP>90mmHG and/or signs of adequate tissue perfusion.

<p><u>BLS Continued</u></p> <p>Chest Trauma: If a wound is present, cover it with an occlusive dressing. If the patient's ventilations are being assisted, dress wound loosely, (do not seal). Continuously reevaluate patient for the development of tension pneumothorax.</p> <p>Flail Chest: Stabilize chest, observe for tension pneumothorax. Consider assisted ventilations.</p> <p>Fractures: Immobilize above and below the injury. Apply splint to injury in position found except:</p> <ul style="list-style-type: none"> • Femur: Apply traction splint if indicated. • Grossly angulated long bone with distal neurovascular compromise: Apply gentle unidirectional traction to improve circulation. • Check and document distal pulse before and after positioning. <p>Genital Injuries: Cover genitalia with saline soaked gauze. If necessary, apply direct pressure to control bleeding. Treat amputations the same as extremity amputations.</p>	<p><u>ALS Continued</u></p> <p>Chest Trauma: Perform needle thoracostomy for chest trauma with symptomatic respiratory distress.</p> <p>Fractures:</p> <p>Isolated Extremity Trauma: Trauma <u>without multisystem mechanism</u>. Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured - e.g., dislocated shoulder, hip fracture or dislocation.</p> <p>IV Pain Relief:</p> <ul style="list-style-type: none"> -Morphine Sulfate 5mg IV slowly and may repeat every 5 minutes to a maximum of 20mg when the patient maintains a -BP>90mmHG and signs of adequate tissue perfusion. Document BP's every 5 minutes while medicating for pain and reassess the patient. -Consider Ondansetron 4mg slow IVP/PO as prophylactic treatment of nausea and vomiting associated with narcotic administration. <p><i>NOTE: Patients in high altitudes should be hydrated with IV NS prior to IV pain relief to reduce the incidents of nausea, vomiting, and transient hypotension, which are side effects associated with administering IV Morphine.</i></p> <ul style="list-style-type: none"> -Administer IV NS 250ml bolus one time.
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<p><u><i>BLS Continued</i></u></p> <p>Head and Neck Trauma: Place brain injured patients in reverse Trendelenburg (elevate the head of the backboard 15-20 degrees), if the patient exhibits no signs of shock.</p> <ul style="list-style-type: none"> • Eye: Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe – stabilize it in place with sterile saline soaked gauze. Cover uninjured eye. • Avulsed Tooth: Collect teeth, place in moist, sterile saline gauze and place in a plastic bag. <p>Impaled Object: Immobilize and leave in place. Remove object if it interferes with CPR, or if the object is impaled in the face, cheek or neck and is compromising ventilations.</p> <p>Pregnancy: Where axial spinal stabilization precaution is indicated, the board should be elevated at least 4 inches on the right side for those patients who have a large pregnant uterus, usually applies to pregnant females \geq 24 weeks of gestation.</p> <p>Traumatic Arrest: CPR if indicated. May utilize an AED if indicated.</p> <p>Determination of Death on Scene: Refer to Protocol #12010 Determination of Death on Scene.</p>	<p><u><i>ALS Continued</i></u></p> <p>IM Pain Relief:</p> <ul style="list-style-type: none"> -Morphine Sulfate 10mg IM. Document vital signs and reassess the patient. -Consider Ondansetron 4mg IM/PO as prophylactic treatment of nausea and vomiting associated with narcotic administration. <p>Head and Neck Trauma: Immediately prior to intubation, consider prophylactic Lidocaine 1.5 mg/kg IV for suspected head/brain injury.</p> <ul style="list-style-type: none"> • Base Station Orders: <ul style="list-style-type: none"> -When considering nasotracheal intubation (\geq15 years of age) and significant facial trauma, trauma to the face or nose and/or possible basilar skull fracture are present, trauma base hospital contact is required. <p>Impaled Object: Remove object upon trauma base physician order, if indicated.</p> <p>Traumatic Arrest: Continue CPR as appropriate. Follow Protocol #11070 Cardiac Arrest - Adult.</p> <p>Determination of Death on Scene: Refer to Protocol #12010 Determination of Death on Scene.</p>
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	<p><u><i>ALS Continued</i></u></p> <p>-Severe Blunt Force Trauma Arrest: IF INDICATED: transport to the closest receiving hospital.</p> <p>-Penetrating Trauma Arrest: IF INDICATED: transport to the closest receiving hospital.</p> <p>If the patient does not meet the “Obvious Death Criteria” in the “<i>Determination of Death on Scene</i>” Protocol #12010, contact the trauma base station for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma with documented asystole in at least two (2) leads, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.</p> <ul style="list-style-type: none">• Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without trauma base station contact. <p>Precautions and Comments:</p> <ul style="list-style-type: none">○ Electrical injuries that result in cardiac arrest shall be treated as medical arrests.○ Consider cardiac etiology in older patients in cardiac arrest with low probability of mechanism of injury.○ Unsafe scene may warrant transport despite low potential for survival.○ Whenever possible, consider minimal disturbance of a potential crime scene. <p>Base Station: May order additional:</p> <ul style="list-style-type: none">• medications;• fluid boluses.
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REFERENCE PROTOCOLS

<u>Protocol Number</u>	<u>Protocol Name</u>
8100	Continuation of Trauma Care
9010	General Patient Care Guidelines
10150	External Jugular Vein Access
10030/10040	Oral Endotracheal Intubation
10080	Insertion of Nasogastric/Orogastric Tube
10060	Needle Thoracostomy
10140	Intraosseous Infusion IO
10050	Nasotracheal Intubation
10070	Needle Cricothyrotomy
10160	Axial Spinal Stabilization
10010/10020	King Airway Device
11070	Adult Cardiac Arrest
15030	Trauma Triage Criteria and Destination Policy
12010	Determination of Death on Scene



TRAUMA - PEDIATRIC (Less Than 15 Years of Age)

Any critical trauma patient (CTP) requires effective communication and rapid transportation to the closest trauma center. If not contacted at scene, the receiving trauma center must be notified as soon as possible in order to activate the trauma team.

In Inyo and Mono Counties do not have trauma center designations and the assigned base station should be contacted for determination of appropriate destination.

FIELD ASSESSMENT/TREATMENT INDICATORS

Trauma Triage Criteria and Destination Policy #15030

PEDIATRIC TREATMENT PROTOCOL: TRAUMA Base Station Contact Shaded in Gray

BLS INTERVENTIONS	ALS INTERVENTIONS
<ul style="list-style-type: none"> • Ensure thorough initial assessment • Ensure patient airway, protecting cervical spine • Axial spinal stabilization as appropriate • Oxygen and/or ventilate as needed, O₂ saturation (if BLS equipped) • Keep patient warm and reassure • For a traumatic full arrest, an AED may be utilized, if indicated • Transport to ALS intercept or to the closest receiving hospital 	<ul style="list-style-type: none"> • Advanced airway as indicated. <i>Unmanageable Airway:</i> -If an adequate airway cannot be maintained with a BVM device; AND -The paramedic is unable to intubate or if indicated, perform a successful needle cricothyrotomy, Then, transport to the closest receiving hospital and follow Continuation of Trauma Care Protocol Reference #8100. • Monitor ECG • IV/IO Access: Warm IV fluids when avail <i>Unstable:</i> -Vital signs (age appropriate) and/or signs of inadequate tissue perfusion, start 2nd IV access. -Administer 20ml/kg NS bolus IV/IO, may repeat once.

<u><i>BLS Continued</i></u>	<u><i>ALS Continued</i></u>
<p>MANAGE SPECIAL CONSIDERATIONS:</p> <p>Abdominal Trauma: Cover eviscerated organs with saline dampened gauze. Do not attempt to replace organs into the abdominal cavity.</p> <p>Amputations: Control bleeding. Rinse amputated part gently with sterile irrigation saline to remove loose debris/gross contamination. Place amputated part in dry, sterile gauze and in a plastic bag surrounded by ice (if available). Prevent direct contact with ice. Document in the narrative who the amputated part was given to.</p> <ul style="list-style-type: none">• Partial amputation: Splint in anatomic position and elevate the extremity. <p>Blunt Chest Trauma: If a wound is present, cover it with an occlusive dressing. If the patient's ventilations are being assisted, dress wound loosely, (do not seal). Continuously re-evaluate patient for the development of tension pneumothorax.</p> <p>Flail Chest: Stabilize chest, observe for tension pneumothorax. Consider assisted ventilations.</p>	<p><i>Stable:</i></p> <ul style="list-style-type: none">-Vital signs (age appropriate) and/or signs of adequate tissue perfusion.-Maintain IV NS rate at TKO. <ul style="list-style-type: none">• Transport to trauma hospital: PEDS patients identified as CTP will be transported to a pediatric trauma hospital when there is less than a 20 minute difference in transport time to the pediatric trauma hospital versus the closest trauma hospital.• Insert nasogastric/orogastric tube as indicated <p>MANAGE SPECIAL CONSIDERATIONS:</p> <p>Blunt Chest Trauma: Perform needle thoracostomy for chest trauma with symptomatic respiratory distress.</p>

BLS Continued

Fractures: Immobilize above and below the injury. Apply splint to injury in position found except:

- **Femur:** Apply traction splint if indicated.
- **Grossly angulated long bone with distal neurovascular compromise:** Apply gentle unidirectional traction to improve circulation.
- **Check and document distal pulse before and after positioning.**

Genital Injuries: Cover genitalia with saline soaked gauze. If necessary, apply direct pressure to control bleeding. Treat amputations the same as extremity amputations.

ALS Continued

Fractures:

Isolated Extremity Trauma: Trauma without multisystem mechanism.

Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured – e.g. dislocated shoulder, hip fracture or dislocation.

IV Pain Relief:

-Morphine Sulfate 0.1mg/kg IV/IO slowly, do not exceed 5mg increments, may repeat every 5 minutes to a maximum of 20mg IV/IO when the patient maintains age appropriate vital signs and adequate tissue perfusion.

-Documents vital signs every 5 minutes while medicating pain and reassess the patient.

-For patients 4 years old and older, consider Ondansetron 4mg slow IVP/PO as prophylactic treatment of nausea and vomiting associated with narcotic administration.

-Administer 20ml/kg NS bolus IV/IO one time.

***NOTE:** Patients in high altitudes should be hydrated with IV NS prior to IV pain relief to reduce the incidents of nausea, vomiting, and transient hypotension, which are side effects associated with administering IV Morphine.*

IM Pain Relief: Morphine Sulfate 0.2mg/kg IM, 10mg IM maximum. Document vital signs and reassess the patient.

-For patients 4 years old and older, consider Ondansetron 4mg slow IM/PO as prophylactic treatment of nausea and vomiting associated with narcotic administration.

BLS Continued

Head and Neck Trauma: Place brain injured patients in reverse Trendelenburg (elevate the head of the backboard 15-20 degrees), if the patient exhibits no signs of shock.

- **Eye:** Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe – stabilize it in place with sterile saline soaked gauze. Cover uninjured eye.
- **Avulsed Tooth:** Collect teeth, place in moist, sterile saline gauze and place in a plastic bag.

Impaled Object: Immobilize and leave in place. Remove object if it interferes with CPR, or if the object is impaled in the face, cheek or neck and is compromising ventilations.

Pediatric Patients: If the level of the patient’s head is greater than that of the torso, use approved pediatric spine board with a head drop or arrange padding on the board so that the ears line up with the shoulders and keep the entire lower spine and pelvis in line with the cervical spine and parallel to the board.

Traumatic Arrest: CPR if indicated. May utilize an AED if indicated.

Determination of Death on Scene: Refer to Protocol # 12010 Determination of Death on Scene.

ALS Continued

Head and Neck Trauma: Immediately prior to intubation, consider prophylactic Lidocaine 1.5 mg/kg IV for suspected head/brain injury.

- **Base Station Orders:**
 - When considering nasotracheal intubation (≥ 15 years of age) and significant facial trauma, trauma to the face or nose and/or possible basilar skull fracture are present, trauma base hospital contact is required.

-Impaled Object: Remove object upon trauma base physician order, if indicated.

Traumatic Arrest: Continue CPR as appropriate.

- Treat per Protocol # 14040 Pediatric Cardiac Arrest.

Determination of Death on Scene: Refer to Protocol # 12010 Determination of Death on Scene.

ALS Continued

Severe Blunt Force Trauma Arrest:

-IF INDICATED: transport to the closest receiving hospital.

Penetrating Trauma Arrest:

-IF INDICATED: transport to the closest receiving hospital.

- If the patient does not meet the “Obvious Death Criteria” in the “*Determination of Death on Scene*” Protocol #12010, contact the trauma base station for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma with documented asystole in at least two (2) leads, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.
- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without trauma base station contact.

Precautions and Comments:

- Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
- Confirm low blood sugar in children and treat as indicated with altered level of consciousness.
- Suspect child maltreatment when physical findings are inconsistent with the history. Remember reporting requirements for suspected child maltreatment.
- **Unsafe scene may warrant transport despite low potential for survival.**
- Whenever possible, consider minimal disturbance of a potential crime scene.

Base Station Orders: May order additional:

- medications;
- fluid boluses.

REFERENCE PROTOCOLS

<u>Protocol Number</u>	<u>Protocol Name</u>
8100	Continuation of Trauma Care
9010	General Patient Care Guidelines
10150	External Jugular Vein Access
10030/10040	Oral Endotracheal Intubation
10080	Insertion of Nasogastric/Orogastric Tube
10060	Needle Thoracostomy
10140	Intraosseous Infusion IO
10050	Nasotracheal Intubation
10070	Needle Cricothyrotomy
10160	Axial Spinal Stabilization
10010/10020	King Airway Device
14040	Pediatric Cardiac Arrest
15030	Trauma Triage Criteria and Destination Policy
12010	Determination of Death on Scene



GLASGOW COMA SCALE OPERATIONAL DEFINITIONS

EYE OPENING

Spontaneous: Eye opening is spontaneous if the patient's eyes are already open at the time of the assessment with no stimulation other than that of the existing ambient environment. The patient can close his eyes to command. This eye opening response implies an intact reticular activating mechanism and a functioning arousal mechanism.

To Voice: If the patient's eyes are not open at the time of the assessment, a response to voice is present if the eyes open when the patient's name is spoken or shouted.

To Pain: If verbal stimulation is unsuccessful in eliciting eye opening, a response to pain is present if the eyes open when a standard pain stimulus is applied.

None: No eye response is present if the above attempts at stimulation are unsuccessful.

BEST VERBAL RESPONSE

Oriented: After being aroused, the patient is asked name, place and date. The patient is oriented if the answers given are correct.

Confused: The patient is confused if the individual cannot answer the questions regarding, name, place and date accurately, but is still capable of producing phrases, sentences or conversation exchanges.

Inappropriate: In this state, the patient cannot produce phrases, sentences or conversational exchanges, but can produce an intact word or two. These words may be electable only in response to physical stimulation and may frequently be obscenities or relative's names.

Incomprehensible: In this state, the patient can produce groans, moans or unintelligible mumblings, but cannot produce an intact word in response to stimulation.

None: In this state, the patient does not respond with any phonation to any stimulation no matter how prolonged or repeated.

BEST MOTOR RESPONSE

Obedient: In response to instructions, whether verbal or written, or through gestures, patient shows ability to comprehend the instruction and to physically execute it. A common example is the command to hold up two fingers.

Purposeful: When a standard painful stimulus is applied, the patient may move limb or body away from stimulus in a purposeful manner or attempt to push stimulus away.

Withdrawal: If the patient does not obey commands, the standard pain stimulus is applied. Withdrawal is present if 1) the elbow flexes, 2) the movement is rapid, 3) there is no muscle stiffness and 4) the arm is drawn away from the trunk.

Flexion: Flexion is present if 1) the elbow flexes, 2) the movement is slow, 3) muscle stiffness is present, 4) the forearm and hand are held against the body and 5) the limbs hold a hemiplegic position.

Extension: Extension is present if 1) the legs and arms extend, 2) muscle stiffness is present and 3) external rotation of the shoulder and forearm occurs.

None: Maximum standard pain stimulation produces no motor response.

NOTE: Spinal cord injury may invalidate motor assessment in this form.

Modified Glasgow Coma Scale for Infants and Children

	Child	Infant	Score
Eye opening	Spontaneous	Spontaneous	4
	To speech	To speech	3
	To pain only	To pain only	2
	No response	No response	1
Best verbal response	Oriented, appropriate	Coos and babbles	5
	Confused	Irritable cries	4
	Inappropriate words	Cries to pain	3
	Incomprehensible sounds	Moans to pain	2
	No response	No response	1
Best motor response*	Obeys commands	Moves spontaneously and purposefully	6
	Localizes painful stimulus	Withdraws to touch	5
	Withdraws in response to pain	Withdraws to response in pain	4
	Flexion in response to pain	Abnormal flexion posture to pain	3
	Extension in response to pain	Abnormal extension posture to pain	2
	No response	No response	1

* If patient is intubated, unconscious, or preverbal, the most important part of this scale is motor response. Motor response should be carefully evaluated.