



ICEMA MEDICAL ADVISORY COMMITTEE

MEETING NOTICE

**April 24, 2014
1300 - 1500**

**ICEMA
Training Rooms A & B
1425 South "D" Street
San Bernardino, CA 92408**

ICEMA
1425 South "D" Street
San Bernardino, CA 92415-0060
(909) 388-5811 FAX (909) 388-5850



AGENDA

ICEMA MEDICAL ADVISORY COMMITTEE

April 24, 2014

1300 - 1500

Purpose: Information Sharing

Meeting Facilitator: Todd Sallenbach

Timekeeper: Danielle Ogaz

Record Keeper: Danielle Ogaz

| AGENDA ITEM | | PERSON(S) | DISCUSSION/ACTION | TIME |
|-------------|--|---|---|-------------|
| I. | Welcome/Introductions | Todd Sallenbach | | 1300 - 1301 |
| II. | Approval of Minutes | All | Discussion | 1301 - 1303 |
| III. | Discussion/Action Items | | | |
| | A. Standing EMS System Updates | All | Discussion | 1303 - 1320 |
| | <ol style="list-style-type: none"> 1. Review of Action Items 2. Trauma Program 3. STEMI Program: STEMI Data 4. Stroke Program: Stroke Data 5. State Stroke Center Regulation Taskforce 6. Drug Shortage Update 7. QI Report Update 8. SAC Update | <ol style="list-style-type: none"> 1. Todd Sallenbach 2. Chris Yoshida-McMath 3. Chris Yoshida-McMath 4. Chris Yoshida-McMath 5. Reza Vaezazizi 6. Reza Vaezazizi 7. Todd Sallenbach 8. Todd Sallenbach | <ol style="list-style-type: none"> 1. Discussion/Action 2. Discussion 3. Discussion 4. Discussion 5. Discussion 6. Discussion 7. Discussion 8. Discussion | |
| | B. Bylaws Review | | | 1320 - 1330 |
| | <ul style="list-style-type: none"> • Quorum | All | Discussion/Action | |
| | <ul style="list-style-type: none"> • Co-Chair | All | Discussion/Action | |
| | C. CPAP in the young | Leslie Parham | Discussion | 1330 - 1345 |
| | D. Committees/Task Force | | Discussion/Action | 1345 - 1355 |
| | <ol style="list-style-type: none"> 1. Data Duplication and Accountability 2. Education Requirement | <ol style="list-style-type: none"> 1. Joe Powell 2. Leslie Parham | | |
| | E. CARES Project Update | Chris Yoshida-McMath | Discussion | 1355 - 1400 |
| | F. EMS System Readiness | ALL | Discussion | 1400 - 1415 |
| | <ol style="list-style-type: none"> 1. Procedures for EMS Monitoring of Multiple Patients | | | |

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| | G. Protocol Review | ALL | Discussion/Action | 1415 - 1445 |
|-------|---|-----------------|-------------------|-------------|
| | <ol style="list-style-type: none"> 1. 3010 - Annual Review Class (ARC) DELETE 2. 5030 - Procedure for Adoption of Protocols and Policies 3. 6140 - Smoke Inhalation/CO Exposure/Suspected Cyanide Toxicity (NEW) 4. 7010 - BLS/LALS/ALS Standard Drug and Equipment List 5. 7020 - MS Aircraft Drug and Equipment List 6. 7030 - Controlled Substance Policy 7. 8130 - Destination Protocol (NEW) 8. 9090 - Patient Refusal of Care Guidelines - Adult 9. 9100 - Patient Refusal of Care Guidelines - Adult (DELETE) 10. 10190 - ICEMA Approved Skills (NEW) 11. 11070 - Cardiac Arrest - Adult 12. 11080 - Altered Level of Consciousness/Seizures - Adult 13. 14040 - Cardiac Arrest - Pediatric (Less than 15 years of age) 14. 14050 - Altered Level of Consciousness - Pediatric (Less than 15 years of age) | | | |
| IV. | Public Comment | All | Discussion | 1445 - 1450 |
| V. | Round Table/Announcements | All | Discussion | 1450 - 1455 |
| VI. | Future Agenda Items | All | Discussion | 1455 - 1458 |
| VII. | Next Meeting Date: June 26, 2014 | All | Discussion | 1458 - 1500 |
| VIII. | Adjournment | Todd Sallenbach | Action | 1500 |



MINUTES

MEDICAL ADVISORY COMMITTEE

February 27, 2014

1300 to 1500

| AGENDA ITEM | | DISCUSSION/FOLLOW UP | RESPONSIBLE PERSON(S) |
|-------------|--|--|-----------------------|
| I. | WELCOME/INTRODUCTIONS | Meeting called to order at 1303. | Todd Sallenbach |
| II. | APPROVAL OF MINUTES | The December 11, 2013, minutes were approved. Motion to approve. MSC: Susie Moss/Joe Powell APPROVED Ayes: Debbie Bavel, Sam Chua, Micheal Guirguis, Susie Moss, Michael Neeki, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Todd Sallenbach | |
| III. | DISCUSSION ITEMS | | |
| | A. Bylaw Review | | Todd Sallenbach |
| | <ul style="list-style-type: none"> Committee Responsibilities | <ul style="list-style-type: none"> Committee responsibilities were reviewed and endorsed. <p>Motion to endorse. APPROVED MSC: Michael Neeki/ Joy Peters Ayes Debbie Bavel, Sam Chua, Micheal Guirguis, Susie Moss, Michael Neeki, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Todd Sallenbach</p> <ul style="list-style-type: none"> Lance Brown was endorsed as the Pediatric Critical Care Physician. <p>Motion to endorse. MSC: Debbie Bavel/Joe Powell APPROVED Ayes: Debbie Bavel, Sam Chua, Micheal Guirguis, Susie Moss, Michael Neeki, Leslie Parham,</p> | |

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| | | Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Todd Sallenbach | |
| | <ul style="list-style-type: none"> Committee/Task Force Structure | Committee/task force structure was reviewed. | Todd Sallenbach |
| | B. Standing EMS System Updates | | |
| | 1. Review of Action Items | Action Items were reviewed. | Todd Sallenbach |
| | 2. Trauma Program | Trauma Audit Committee continues to review spinal immobilization. | Chris Yoshida-McMath |
| | 3. STEMI Program: STEMI Data | No update. Data on ICEMA website. | Chris Yoshida-McMath |
| | 4. Stroke Program: Stroke Data | No update. Data on ICEMA website. | Chris Yoshida-McMath |
| | 5. State Stroke Center Regulation Taskforce | No update. | Reza Vaezazizi |
| | 6. Drug Shortage Update | No update. | Reza Vaezazizi |
| | 7. QI Report Update | No update. | Reza Vaezazizi |
| | 8. SAC Update | <ul style="list-style-type: none"> SAC recommended that Rancho Cucamonga Fire and the San Bernardino Sheriff Department present a scaled down version of their Active Shooter presentation to MAC, focusing on the treatment modalities Status of the Triage Tag Task Force was presented. | Todd Sallenbach |
| | C. Continuous Quality Improvement | | Reza Vaezazizi |
| | 1. Process | The process for quality improvement by the standing subcommittees (STEMI, Stroke, and Trauma) was reviewed. | |
| | 2. Endorsement of Ongoing QI Committees (STEMI, Stroke, Trauma) | No endorsement of committees is needed as they are requirements of the specialty programs. | |
| | D. Administration of Epinephrine in Pediatric Anaphylaxis IM verses Sub Q | <p>Discussed the route of administration for Epinephrine. MAC recommended changing protocols to reflect route of administration to IM instead of Sub Q.</p> <p>Motion to endorse. APPROVED MSC: Michael Neeki/Susie Moss Ayes: Debbie Bervel, Lance Brown, Sam Chua, Micheal Guirguis, Susie Moss, Michael Neeki, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Todd Sallenbach</p> | Reza Vaezazizi |
| | E. EMS Education Grid | ICEMA's draft education grid was presented. Following group discussion, a task force was created to offer recommendations to modify the draft educational requirements. | Ron Holk |

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February 27, 2014

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| | | <p>Task Force Chair will be Leslie Parham. Members include Susie Moss, Dr. Neeki, Joy Peters, and others to be appointed as needed.</p> <p>Recommendations will be made to ICEMA and presented at the next MAC meeting.</p> | |
| | <p>F. TXA Trail Study</p> | <p>Arrowhead Regional Medical Center and Rialto Fire's proposed trial study was presented. The trial is open to all agencies in the area to have a multi-agency study. Participation in ICEMA's data system will be a requirement to participate in this trial study. The goal is to have an 18 month trial period.</p> <p>Chris Yoshida-McMath will be the ICEMA contact for any agency interested in participating.</p> | <p>Chris Yoshida-McMath</p> |
| | <p>G. Patient Care Documentation</p> | <p>Dr. Vaezazizi discussed the importance of accurate patient care documentation and the possible ramifications of inaccurate/duplicate documentation. Examples of documentation processes that create duplicates in the database were presented.</p> <p>MAC recommended that the grid which transfers procedures and treatments between agencies be turned off immediately. MAC also recommended that the provider cease documenting across agencies and document for their agency only.</p> <p>Motion to endorse. MSC: Michael Neeki/ Stephen Patterson APPROVED Ayes: Debbie Bervel, Lance Brown, Sam Chua, Micheal Guirguis, Susie Moss, Michael Neeki, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Todd Sallenbach Nays: Leslie Parham</p> <p>Following group discussion, a task force was created to evaluate the operational issues such as team charting and duplication of data in the ePCR when care is transferred to another agency. The task force will make recommendations for changes to MAC at the April 24, 2014, meeting.</p> <p>Task Force Chair will be Joe Powell. Members include Leslie Parham, Susie Moss and others</p> | <p>Ron Holk</p> |

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|-------|-------------------------------|--|-----------------|
| | | to be appointed as needed. Motion to endorse. MSC: Kevin Parkes/Leslie Parham APPROVED Ayes: Debbie Bervel, Lance Brown, Sam Chua, Micheal Guirguis, Susie Moss, Michael Neeki, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Todd Sallenbach | |
| IV. | PUBLIC COMMENT | Diana McCafferty requested that the Patient Documentation Task Force pull additional members from the ImageTrend working group. Ray Ramirez thanked Dr. Vaezazizi for raising the patient documentation issue. | |
| V. | ROUND TABLE/ ANNOUNCEMENTS | | |
| VI. | FUTURE AGENDA ITEMS | - Active Shooter - Ontario Fire Data Software | |
| VII. | NEXT MEETING | April 24, 2014 | |
| VIII. | ADJOURNMENT | The meeting adjourned at 1503. | Todd Sallenbach |

MINUTES - MEDICAL ADVISORY COMMITTEE

February 27, 2014

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Attendees:

| NAME | MAC POSITION | EMS AGENCY STAFF | POSITION |
|--|--|--|-----------------------|
| <input type="checkbox"/> VACANT <input type="checkbox"/> Jeff Grange - LLUMC | Trauma Hospital Physicians (2) | <input checked="" type="checkbox"/> Reza Vaezazizi, MD | Medical Director |
| <input type="checkbox"/> Phong Nyugen - RDCH <input checked="" type="checkbox"/> Todd Sallenbach - HDMC (Chair) | Non-Trauma Base Physicians (2) | <input type="checkbox"/> Tom Lynch | EMS Administrator |
| <input checked="" type="checkbox"/> Aaron Rubin - Kaiser | Non-Base Hospital Physician | <input checked="" type="checkbox"/> Denice Wicker-Stiles | Assist. Administrator |
| <input checked="" type="checkbox"/> Michael Neeki - Rialto FD | Public Transport Medical Director | <input checked="" type="checkbox"/> George Stone | Program Coordinator |
| <input checked="" type="checkbox"/> Sam Chua - AMR | Private Transport Medical Director | <input checked="" type="checkbox"/> Ron Holk | EMS Nurse Specialist |
| <input checked="" type="checkbox"/> Debbie Bervel - SB City FD | Fire Department Medical Director | <input type="checkbox"/> Chris Yoshida-McMath | EMS Nurse Specialist |
| <input checked="" type="checkbox"/> Joy Peters - ARMC | EMS Nurses | <input checked="" type="checkbox"/> Danielle Ogaz | EMS Specialist |
| <input checked="" type="checkbox"/> Joe Powell - Rialto FD | EMS Officers | | |
| <input checked="" type="checkbox"/> Leslie Parham | Public Transport Medical Rep (Paramedic/RN) | | |
| <input checked="" type="checkbox"/> Susie Moss | Private Transport Medical Rep (Paramedic/RN) | | |
| <input type="checkbox"/> VACANT | Specialty Center Medical Director | | |
| <input type="checkbox"/> Joanna Yang - LLUMC | Specialty Center Coordinator | | |
| <input type="checkbox"/> Troy Pennington | Private Air Transport Medical Director | | |
| <input checked="" type="checkbox"/> Stephen Patterson - Sheriff's Air Rescue | Public Air Transport Medical Director | | |
| <input checked="" type="checkbox"/> Micheal Guirguis - SB Comm Center | PSAP Medical Director | | |
| <input type="checkbox"/> Andrew Stevens | Inyo County Representative | | |
| <input type="checkbox"/> Rosemary Sachs | Mono County Representative | | |
| <input checked="" type="checkbox"/> Kevin Parkes | SAC Liaison | | |
| <input checked="" type="checkbox"/> Lance Brown | Pediatric Critical Care Physician | | |

| GUESTS | AGENCY |
|---------------------|-----------------------------|
| Robert Bradbury | Morongo Basin Ambulance |
| Sandy Carnes | Rancho Cucamonga FD |
| Patti Eickholt | SACH |
| Lee Fonseca | Cal Fire |
| Nathan Foster | Upland FD |
| Ryan Harold | Big Bear FD |
| Lisa Higuchi | AMR |
| Bill Jones | San Manuel FD |
| Christopher Linke | AMR |
| Pam Martinez | Ontario FD |
| Diana McCafferty | AMR |
| Melissa McMurphy | Morongo Basin Ambulance |
| Sara Morning | Redlands Community Hospital |
| Ray Ramirez | Ontario FD |
| Stephanie Rasmussen | Upland FD |
| Shawn Reynolds | LLUMC |
| Andrea Thorp | LLUMC |
| Bob Tyson | Redlands FD |

**ICEMA
MEDICAL ADVISORY COMMITTEE
BYLAWS
December 10, 2013**

| REPRESENTING | NUMBER OF REPS | APPOINTING AUTHORITY |
|--|-----------------------|---|
| Trauma Hospital Physician | 2 | Each Trauma Center |
| Non-Trauma Base Physician | 2 | Non-Trauma Base Hospitals |
| Non-Base Hospital Physician | 1 | Non-Base Hospitals |
| Public Transport Medical Director | 1 | Public Transport Providers |
| Private Transport Medical Director | 1 | Private Transport Providers |
| Fire Department Medical Director | 1 | SB County Fire Chiefs Association |
| EMS Nurses | 1 | EMS Nurses Committee |
| EMS Officers | 1 | EMS Officers Committee |
| Rural Paramedic | 1 | Ambulance Association and Fire Chiefs Association |
| Urban/Suburban Paramedic | 1 | Ambulance Association and Fire Chiefs Association |
| Specialty Center Medical Director | 1 | Specialty Centers |
| Specialty Center Coordinator | 1 | Specialty Centers |
| Private Air Transport Medical Director | 1 | Private Air Transport |
| Public Air Transport Medical Director | 1 | Public Air Transport |
| PSAP Medical Director | 1 | PSAPs |
| Inyo County Representative | 1 | Inyo County EMCC |
| Mono County Representative | 1 | Mono County EMCC |
| SAC Liaison | 1 | SAC Membership |
| Others, as needed | | ICEMA Medical Director |

Purpose: The Medical Advisory Committee (MAC) advises the ICEMA Medical Director on all matters pertaining to the clinical or medical aspects of the Emergency Medical Services (EMS) in the ICEMA region.

Examples of MAC responsibilities include:

- Development, review, and updating of patient treatment/skills protocols and medical control policies
- Approval of medical equipment, medications and supplies, including specifications of items and complements
- EMT certification, Paramedic accreditation and MICN authorization policies
- Development, review and approval of BLS, L-ALS and ALS Continuing Education and Field Training curriculum, including skills competency training
- Monitoring of ICEMA CQI processes and projects including trial studies and State Core Measures
- Development of policies and processes associated with designation and monitoring of specialty care centers (Trauma, STEMI, and Stroke) in conjunction with specific subcommittees

The ICEMA Medical Director may establish the subcommittee and task force structure and functions, as necessary, to facilitate assigned tasks. Sub-committees and task forces serve at the convenience of MAC and the ICEMA Medical Director accordingly or for a time necessary to complete the assignment. Membership on subcommittees or task forces is not limited to regular committee members.

The Committee shall appoint a chair person and vice chair.

Committee membership is recommended for two (2) years; however, it may be extended or shortened at the appointing authority's discretion.

Committee members shall attend at least four (4) of each consecutive six (6) meetings or be subject to removal for non-attendance.

The Committee shall meet at least quarterly or more often, if necessary, to achieve the intended goals.

A quorum is requisite for the transaction of any business of this committee. Fifty percent (50%) plus one (1) of the seated members must be present for a quorum to be established.



PROCEDURES FOR EMS MONITORING OF MULTIPLE PATIENTS (San Bernardino County Only)

I. PURPOSE

Establish procedures that will allow the monitoring of multiple patients by EMS providers while waiting to offload patients in hospitals during extended ambulance offload delay intervals. To maintain sufficient resources to respond to additional emergency calls.

II. AUTHORITY

California Health and Safety Code Division 2.5, Chapter 4, Article 1707.220

Code of Regulations Title 22, Division 9, Chapter 4, Article 7, Sections 100128 and 100146

III. DEFINITIONS

Ambulance Transport: Transport of a patient from the prehospital EMS system by emergency ambulance to an approved EMS receiving hospital.

Advanced Life Support (ALS) Ambulance Transport Providers: Ambulance that transports ALS patients from the prehospital EMS system to an approved EMS receiving hospital.

Ambulance Patient Offload Time Interval Standard: In the ICEMA region, the established ambulance patient offload time interval standard is twenty-five (25) minutes.

Ambulance Arrival at the ED: The time the ambulance stops at the location outside the hospital emergency department (ED) where the patient is unloaded from the ambulance.

Ambulance Patient Offload Time: The actual time that the patient is physically removed from the ambulance gurney to the hospital equipment and the hospital representative signs the ePCR receiving the patient.

Ambulance Patient Offload Delay Interval: The resulting period of time produced when the ambulance patient offload time interval exceeds the established ambulance patient offload time interval standard.

IV. POLICY

All ALS ambulance transport providers are authorized to assign multiple patients to be monitored by a single EMS crew during periods of delayed ambulance patient offload time intervals that impact the ability of the EMS provider to respond to additional calls. These procedures may be activated only by the transport provider and their designated supervisor in consultation with the EMS crews in the hospital.

V. PROCEDURE

- One (1) EMS crew (paramedic and EMT) may monitor only the number of patients determined to be safe by the supervisor and the EMS crew.
- Patients must be stable and require no additional medications or procedures while being monitored by an EMS crew or until transferred to a hospital gurney under hospital care.
- Patients must be in the same vicinity of the hospital and within sight of the assigned EMS crew at all times and the EMS crew may not be split up.
- Patients may be on an ambulance or hospital gurney, surge bed, cot or on chairs that allows appropriate monitoring and patient safety.
- Patient vital signs, condition and changes must be monitored and documented every thirty (30) minutes.
- An EMS Crew may continue to monitor multiple patients until all patients have been transferred to hospital care. Additional patients may be assigned to an EMS crew at the discretion of the supervisor provided all of these procedures continue to be met.
- If patient's condition deteriorates, the EMS crew will notify ED staff immediately and transfer care to the hospital.
- Transport agency supervisors will check crews monitoring multiple patients regularly and assist with monitoring patients as required.
- The transport provider must notify the ICEMA EMS Duty Officer (EMSDO by e-mail whenever this process occurs. The notification must include the name of the hospital, the number of units and the duration of the offload delay for each unit where an EMS crew will be caring for multiple patients.

VI. REQUIRED DOCUMENTATION

- Documentation will be maintained on each patient via the electronic patient care record (ePCR).
- Patient care information will be transferred to the monitoring EMS crew via electronic transfer to maintain continuity of documentation.
- Agencies using paper patient care records (01As) will leave a completed green sheet with the EMS crew monitoring the patient.

PROTOCOLS FOR 30-DAY COMMENT FORM

**ICEMA Reference #s: 5030, 6140 (NEW), 7010, 7020, 7030, 8130 (NEW), 9090, 10190 (NEW), 11070, 11080, 14040, 14050
Deleted: 3010, 9100**

DEADLINE TO SUBMIT COMMENTS: April 13, 2014, at 5:00 pm

| PROTOCOL # | AGENCY | COMMENT | RESPONSE |
|---|------------|---|--|
| 5030 - Procedure for Adoption of Protocols and Policies | CVMC | Concern that Local QI is not recognized as a source for protocol changes or suggestions for revision. It is noted that "any person" may request (section VIII) but local level QI committee is where protocol and performance discussions are identified and discussed. | Changes and suggestions are encouraged. They may be forwarded directly to ICEMA or for consideration in MAC or SAC. |
| | CVMC | Training time prior to implementation dates should be considered. | Agreed, see # 9 in the protocol. |
| | Ontario FD | <p>Changing the protocol review from bi-annual to annual - will all protocols be reviewed annually or only those that are expiring? Will there be a set month this takes place so we can plan training appropriately?</p> <p>Is there a continued plan to get through the entire manual every two-three years as previously?</p> <p>Changes to maintain medical control or system integrity do not seem to fit under MINOR changes. These should go through the regular process (MAC/SAC/Comments) or they should be an emergency protocol and follow this process.</p> <p>The Ontario Fire Department's concern is the removal of the end users voice from the protocol review process. Removing the PEC committee removes the initial voice and practical application that is very necessary to write good protocols. Removing the EMCC from the approval process due to time concerns as voiced in the last meeting, should not be an issue if protocol are only changed annually. This body serves a very important role in the County and should not be minimized.</p> | <p>All protocols will be reviewed annually. ICEMA anticipates this will be a January 1st effective date.</p> <p>The plan is to review protocols annually.</p> <p>Agreed, remove minor. Other changes will continue through the appropriate process.</p> <p>MAC and/or SAC consider policies and protocols in a public venue where end user comments are encouraged. MAC and/or SAC may assign a task force to consider specific protocol changes.</p> <p>EMCC bylaws allow for their review and comment of protocols and policies adopted by ICEMA.</p> |

PROTOCOLS FOR 30-DAY COMMENT FORM

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| PROTOCOL # | AGENCY | COMMENT | RESPONSE |
|------------|--------|---|--|
| | RCFD | <p>Changing the protocol review from bi-annual to annual – this is a very lofty goal, the bi-annual goal it usually not met. We agree that the fewer times they are changed during the year, the better, however, it should be a goal that is obtainable as well.</p> <p>What is the plan? Will different sections be worked on throughout the year and brought to committees for in-put and then saved for a single implementation period? Will there be a training piece developed for the implementation?</p> <p>We support continuing to bring the protocols through EMCC for final review and recommendation since this is the only committee appointed by the Board to make recommendations to ICEMA.</p> <p>If protocols are only implemented/changes annually or bi-annually, time should not be a factor. The only situation where time should be a factor is when they are implemented in an “emergency” and then it is a moot point do to the manner of the process.</p> | <p>Agreed</p> <p>As protocols are streamlined they will require less time to review and change. Proposed changes will be open for public comment.</p> <p>MAC and/or SAC consider policies and protocols in a public venue where end user comments are encouraged. MAC and/or SAC may assign a task force to consider specific protocol changes.</p> <p>All protocols will be reviewed annually. Other changes will occur as noted in the policy. ICEMA anticipates biannual updates, if needed. Emergency protocols/policies may be introduced only when required as noted in Section V.</p> |

PROTOCOLS FOR 30-DAY COMMENT FORM

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Deleted: 3010, 9100**

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| PROTOCOL # | AGENCY | COMMENT | RESPONSE |
|------------|-----------------------|---|--|
| | San Manuel Fire Dept. | <p>We regret the EMCC will not be given the opportunity to discuss the new protocols and will be limited to making comments by email. The EMCC's input is valuable as it is a multidisciplinary committee that has contributed to this process greatly in the past.</p> <p>We feel strongly that the process will suffer due to the lack of field level input that has traditionally been involved. The SAC and MAC, while they afford a more streamlined process should allow input from field level and supervisory level providers on the front side of protocol creation, not just on the back side in the 30 day comment period.</p> | EMCC may continue to review and comment on protocols and policies. Both MAC and SAC are multidisciplinary committees. Both are also public meetings and will continue to encourage comments from the public. |
| | Mel Standon | III. Suggest including a definition and composition of TAC | Will add definition of TAC. |
| | | IV. Now that EMCC has been removed from the loop of policy and protocol review, when do the EMCC members (as well as those that regularly attend) have an opportunity to participate in public discussion? More importantly, what is the purpose of the EMCC? | EMCC may continue to review and comment on protocols and policies. |

PROTOCOLS FOR 30-DAY COMMENT FORM

**ICEMA Reference #s: 5030, 6140 (NEW), 7010, 7020, 7030, 8130 (NEW), 9090, 10190 (NEW), 11070, 11080, 14040, 14050
Deleted: 3010, 9100**

DEADLINE TO SUBMIT COMMENTS: April 13, 2014, at 5:00 pm

| PROTOCOL # | AGENCY | COMMENT | RESPONSE |
|--|--------------------|--|---|
| | Upland FD | <p>Thank you for making this an annual occurrence. Frequent changes to protocols make it difficult for our providers to stay abreast of all of the changes and our training division will thank you. We suggest that ICEMA select a month in the year where an annual update of protocols can be planned, and training offered prior to the protocols becoming effective. This will streamline the process and minimize confusion. It may (hopefully) ease some workload and confusion for the ICEMA staff as well.</p> <p>We would suggest that even “minor:” changes to protocols are evaluated by field providers to be sure that those changes do not have an impact on the day to day delivery of patient care.</p> <p>We have concern that removing the EMCC from the process can have a negative effect. There are multiple stakeholders represented there where their input would be of much value, especially if an annual event.</p> | <p>All protocols will be reviewed annually. ICEMA anticipates this will be a January 1st effective date. Changes to protocols will occur as necessary and ICEMA anticipates that this will continue to occur biannually, if needed.</p> <p>ICEMA recognizes that provider collaboration is an essential component of protocol and policy development and will continue to include all providers in the change process.</p> <p>EMCC may continue to review and comment on protocols and policies. Both MAC and SAC are multidisciplinary committees. Both are also public meetings and will continue to encourage comments from the public.</p> |
| 6140 - Smoke Inhalation/ CO Exposure/ Suspected Cyanide Toxicity (NEW) | ARMC/ J. Molino | Who is part of this program? | This is currently an expanded scope specialty program that must be applied for by providers. |
| | Ontario FD | This is a great protocol we should add the CO monitoring device to the optional equipment list. | This is currently an expanded scope specialty program that requires ICEMA approval. Equipment is mandatory for program participants. |

PROTOCOLS FOR 30-DAY COMMENT FORM

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Deleted: 3010, 9100**

DEADLINE TO SUBMIT COMMENTS: April 13, 2014, at 5:00 pm

| PROTOCOL # | AGENCY | COMMENT | RESPONSE |
|--|-----------------------|---|--|
| | RDCH | Include: the SpCo level should be provided in the radio call in and documented on the MICN run sheet for "In-field" levels or will there be a treatment area to document this on the ePCR for later ER reference? | Training for the use of this protocol includes requirements for Base Hospital reports. |
| | RCFD | Recommend adding CO monitoring to the optional equipment list. | This is currently an expanded scope specialty program that requires ICEMA approval. Equipment is mandatory for program participants. |
| | San Manuel Fire Dept. | We strongly agree with this new protocol. Due to the specific mention of carbon monoxide monitoring in this protocol and the separation of CO and Cyanide toxicity, we urge that a separate carbon monoxide protocol be formed. This new protocol should expand on the signs symptoms monitoring and treatment of carbon monoxide poisoning. It should include specific treatment parameters, E.G.(measured in SpCO %) which have been widely accepted internationally. | This is currently an expanded scope specialty program that requires ICEMA approval. Equipment is mandatory for program participants. |
| | Upland FD | Thank you for providing this protocol. | This is currently an expanded scope specialty program that requires ICEMA approval. Equipment is mandatory for program participants. |
| 7010 - BLS/LALS/ALS Standard Drug and Equipment List | Ontario FD | Add CO Monitoring device under optional | This is currently an expanded scope specialty program that requires ICEMA approval. Equipment is mandatory for program participants. Will add as required specialty program equipment. |

PROTOCOLS FOR 30-DAY COMMENT FORM

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DEADLINE TO SUBMIT COMMENTS: April 13, 2014, at 5:00 pm

| PROTOCOL # | AGENCY | COMMENT | RESPONSE |
|---|-----------------------|---|--|
| | RCFD | <p>Add CO monitoring to optional</p> <p>Inconsistent terms for Magnesium Sulfate (mg/gms)</p> <p>C-collars, would it meet the same intent to read “adjustable rigid cervical collar”, if so, it would be much more simplistic.</p> <p>For consistency, suggest using the same terminology for the line between adult and peds. The terminology is not always the same (15 and older, older than 15, 15 and under....)</p> | <p>This is currently an expanded scope specialty program that requires ICEMA approval. Equipment is mandatory for program participants. Will add as required specialty program equipment.</p> <p>Magnesium Sulfate is listed as 10 GM vials in this protocol. There isn't an inconsistency in this protocol.</p> <p>ICEMA allows either rigid or adjustable Cervical Collars for flexibility. Will add (all sizes) to the requirement for rigid collars.</p> <p>Age isn't pertinent to this protocol. Agreed, will add consistency to other protocols.</p> |
| | San Manuel Fire Dept. | Agree | |
| | SBSO | <p>EZ IO Driver and 15 mm needles need to be added to LALS equipment list.</p> <p>Arrow chamber and MDI for Albuterol.</p> | <p>Prior discussions requested this not to be added as mandatory due to cost.</p> <p>Agreed, will add to protocol.</p> |
| | Upland FD | <p>Add CO monitoring device to optional list</p> <p>Consider D10 if approved by MAC/SAC</p> | <p>This is currently an expanded scope specialty program that requires ICEMA approval. Equipment is mandatory for program participants. Will add as required specialty program equipment.</p> |
| 7020 - EMS Aircraft Drug and Equipment List | Ontario FD | Magnesium needs to be changed to grams | Will revise this protocol to be consistent with ICEMA Reference #7010. |

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| | RCFD | <p>Add CO monitoring to optional</p> <p>Inconsistent terms for Magnesium Sulfate (mg/gms)</p> <p>C-collars, would it meet the same intent to read “adjustable rigid cervical collar”, if so, it would be much more simplistic.</p> <p>For consistency, suggest using the same terminology for the line between adult and peds. The terminology is not always the same (15 and older, older than 15, 15 and under....)</p> | <p>This is currently an expanded scope specialty program that requires ICEMA approval. Equipment is mandatory for program participants. Will add (all sizes) to the requirement for rigid collars.</p> <p>ICEMA allows either rigid or adjustable Cervical Collars for flexibility.</p> <p>Age isn’t pertinent to this protocol. Agreed, will add consistency to other protocols</p> |
| | San Manuel Fire Dept. | Agree | |
| | Mel Standon | <p><i>Magnesium Sulfate</i>--Inconsistent. Listed as “Magnesium Sulfate 10 mg” but required to carry 10 grams. Do you anticipate carrying 10 vials of 10 mg each? It’s not generally supplied in the 10 mg concentration.</p> <p><i>Lidocaine 2% (Viscous)</i> -- Why so many mL? It would be more cost-effective to carry a few smaller tubes rather than the large 2 oz container that must be disposed of after each use.</p> <p><i>Air occlusive dressing</i>—recommend deleting brand name of Vaseline and describe as petrolatum gauze instead</p> <p><i>Cervical collars</i>- You list both rigid and adjustable, but don’t require multiple sizes of rigid. There are at least four sizes of non-adjustable rigid collars for adults. All “adjustable” extrication collars are rigid. Suggest clarifying either multiple sizes or adjustable rigid cervical collar.</p> | <p>Will revise this protocol to be consistent with ICEMA Reference #7010.</p> <p>Agreed</p> <p>ICEMA allows either rigid or adjustable Cervical Collars for flexibility. Will add (all sizes) to the requirement for rigid collars.</p> |

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| | | Both antiseptic and provodone swabs are listed. Suggest listing as either/or. There are numerous disadvantages to provodone, including allergies and diminished antibacterial properties when not used properly of allowing to dry prior to piercing the skin. If an agency elects to carry chlorhexidine instead of provodone, they should not be required to carry provodone simply to meet this requirement. | |
| | Upland FD | Magnesium sulfate listed as 10mg but required to carry 10 grams. It is not generally supplied in 10 mg concentration. Please clarify Viscous xylocaine allow for smaller tubes rather than 2 oz Containers. These are one time use only Use generic verbiage such as Air occlusive dressing Versus brand names Cervical collars: recommend list rigid and adjustable But not require multiple sizes. Please clarify Suggest list antiseptic swabs generic instead of specific types | Will revise this protocol to be consistent with ICEMA Reference #7010. ICEMA allows either rigid or adjustable Cervical Collars for flexibility. |
| 7030 - Controlled Substance Policy | ARMC | How can two field EMS personal sign for narcotic waste in the hospital? Can a nurse cosign for waste? | Will change protocol to read...Provider medical directors must determine the manner by which unused and expired controlled substances are discarded. The practice must be in compliance with all applicable local, state, and federal regulations and the process should be clearly stated in the EMS provider's controlled substances policy. |

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| | LLUMC | Section V. 3 Are we taking hospital staff out of the equation (they will not witness wasting) | Will change protocol to read...Provider medical directors must determine the manner by which unused and expired controlled substances are discarded. The practice must be in compliance with all applicable local, state, and federal regulations and the process should be clearly stated in the EMS provider's controlled substances policy. |
| | CVMC | Section V 3 "Waste of Narcotics" does not include hospital/ED staff (nurses or MD's) | Will change protocol to read...Provider medical directors must determine the manner by which unused and expired controlled substances are discarded. The practice must be in compliance with all applicable local, state, and federal regulations and the process should be clearly stated in the EMS provider's controlled substances policy. |
| | Victor Aguirre Mammoth Hosp. | Section V (required documentation) point 3, it reads as if the both the witnesses to wasted narcs have to sign the log. If so does that mean we have to take log into hospital and have nurse sign it, as well as the ePCR? | <p>Will change protocol to read...Provider medical directors must determine the manner by which unused and expired controlled substances are discarded. The practice must be in compliance with all applicable local, state, and federal regulations and the process should be clearly stated in the EMS provider's controlled substances policy.</p> <p>Maintain the patient care record with the logs or at least the document the incident number.</p> |
| | Ontario FD | Please clarify if shift is 48 hrs can they check at change of shift or is daily required. Also a typo using the word minimum twice. | Will correct the typo; however, narcotics must be counted daily (within a 24 hour period) or at shift change (12 hour shifts). |

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| | | All wasted portions of controlled substances must be witnessed and documented by at least two licensed EMS providers (either field providers or ED RN/MD) and both must sign the appropriate sections of the PCR or ePCR. (There are no logs in the field – we use the log for daily checks or restocking from a safe). Please advise on the ICEMA recommended method of documenting the controlled substance given and wasted for consistency with all providers. | Documentation will take place on the ePCR for waste or on the paper O1A if the provider is still using them. The references to the logs are for the ones used for restock and daily checks. |
| | RDCH | In witnessing the wasting of narcotics, am I to understand that ER Nurses will no longer be required or asked to witness and sign for EMS waste? | Will add “or hospital personnel.” |
| | RCFD | Does the length of “shift” matter? It is not specified in the protocol with a minimum or maximum. “Minimum” is misspelled | Narcotics should be counted every 24 hours at a minimum or at every shift change (12 hour shifts). Will correct. |
| | SACH | Section V. –Required documentation #3-States two licensed “EMS field personnel” must sign log for wasting. <ul style="list-style-type: none"> • What if the medic is titrating the medication; for example broken hip using Morphine. The field medic doesn’t always transport with the transporting medic. “How can he co-sign if he is not there?” • My question is can the protocol be changed to “two licensed personal” to co-sign waste” example RN and medic? <p>Revised comment-04/10/14-Can we add in the protocol for both medics to ride in with patient, when the medic that is giving narcotics is titrating? That takes the RN out of the picture with the waste.</p> | Will change protocol to read...Provider medical directors must determine the manner by which unused and expired controlled substances are discarded. The practice must be in compliance with all applicable local, state, and federal regulations and the process should be clearly stated in the EMS provider’s controlled substances policy. |

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| | San Manuel Fire Dept. | Procedure Line 4; redundant word "minimum". | Will correct. |
| | Mel Standon | <i>Sample Daily Log</i> Suggest changing heading to "Paramedic" instead of "Medic". This is the universal, professional language... "Medic" implies a military component. | Log is just a sample and may be modified by the agencies as needed. |
| | Upland FD | Clarify shift check or daily check. There are different shift schedules for varying agencies All controlled substances must be wasted and witnessed/documentated by at least two licensed EMS Providers (field/ED RN/MD) and both must sign in the ePCR. There are no logs in the field. We are requesting direction on how ICEMA would like us to document the controlled substance given and wasted in ePCR order to establish a standard for all providers. | Narcotics should be counted every 24 hours at a minimum or at every shift change (12 hour shifts). Will change protocol to read...Provider medical directors must determine the manner by which unused and expired controlled substances are discarded. The practice must be in compliance with all applicable local, state, and federal regulations and the process should be clearly stated in the EMS provider's controlled substances policy. |
| 7040 - Medication Standard Orders | Mono County EMS (not on list for Public Comment) | 7040 Morphine First item under M.S. has no description of what for. Just states dose, increments and limits but not what for. No burns reference. Same with Peds. 7040 Narcan Why? How about 0.5-2.0 to allow for slow or fast changes as needed on scene. 7040 Too many changes too often. Don't understand why there is so much little and big changes to doses so often. Needs to stabilize. | This protocol was not up for review at this time. The general dose is listed without an indication. If there are special conditions or specific indications, they are listed. The dose requirements was discussed and changed by MAC. The correct does is 0.5 mg. Changes are made as protocols are reviewed. Agreed, simplifying the protocols will require fewer changes. |

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| 8130 - Destination Protocol (NEW) | ARMC | Patients with unmanageable airway or traumatic cardiac arrest should be transported to the closest receiving hospital if indicated. Once the patient goes to a non-trauma hospital for airway control the hospital feels they are violating EMTALA | This is allowed by CMS and the exception is specifically stated in EMTALA. |
| | LLUMC | Section VI. Psych Holds 3 rd bullet point - Release to law enforcement with no medical complaints.... Since every patient while on a 5150 requires at a minimum a medical screening prior to entering a psych facility, should they not be transported to the closest emergency department for a screening? Are we only referring to patients that will be placed in police custody and transport to jail? | Law enforcement routinely transports individuals on a 5150 hold without medical complaints to a receiving facility. This policy requires a patient on a 5150 hold who has a medical complaint to be transported by ambulance to the closest facility. |
| | CVMC | Destination protocol part VIII - do we really want to send all cardiac arrests "with or without ROSC" to a STEMI center? Would like to see greater emphasis on treating and call on scene if no response to care. | Patients with ROSC should go to a STEMI Center due to a potentially higher survival rate. Some systems currently require all OHCA patients with ROSC to be transported to STEMI Centers. Similar discussions underway for possible future similar changes in ICEMA protocols. |
| | CVMC | Please define IFT. I have identified and requested revision due to patients showing up unannounced because "nursing facility and psychiatric hospital' patients are being considered IFT"S | Definition is the transfer of a patient from one healthcare facility to another. We encourage transport providers to call as a courtesy to the receiving hospital. |
| | Ontario FD | Adult Trauma patient to remain consistent needs to be 15 years of age and older ALS has always stood for Advanced life support. Acute life support is not consistent with any other protocols | The age on adult trauma has not changed. It has always been 15 and above. Agreed, will change to Advanced Life Support (ALS). |

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| | RDCH | <p>Patients on a psychiatric hold with no medical complaints or conditions may be released to LE for transport directly to a psych facility that has the capacity to accept the patient...</p> <p>Can the receiving facility receive at minimal a "receiving facility report" or an MD to MD report so the receiving facility has a heads up on what was done previously and the results of the testing to avoid repeating the same testing? <i>We have had LE pull up in front of our lobby, open the patrol unit doors, and tell the psych patient to "Walk in and tell them you want to hurt yourself."</i> This is a way around any LE being requested to remain in the ED for staff safety and 5150 monitoring. If there is no confirmation or indication this pt has been medically cleared previously, the repetition is a waste of time and resources.</p> | <p>All interfacility transfers are subject to EMTALA regulations and outside of the scope of any ICEMA protocol. Please follow EMTALA compliant transfer processes.</p> |
| | RCFD | Agree with changes | |
| | SACH | <p>Section VI-Psychiatric Holds-</p> <ul style="list-style-type: none"> • Who will determine if the patient has a medical compliant?-Base Station MD? • Or can we add in Medical Clearance Criteria? For example: • Transport patients to a closest most appropriate receiving hospital, if there is a suspected acute medical or traumatic condition requiring emergent or urgent attention in an Emergency Department. For Example- Patients "in extremis" (those with a potential life-threatening illness or injury) Patients who are unconscious, unresponsive, have chest or abdominal pain, significant bleeding, or suspected shock, Patients who shows signs of potential | <p>This would be included on the patient care report or by the EMS provider assessment.</p> |

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| | | <ul style="list-style-type: none"> • significant toxicity from illicit drugs or alcohol, which may include the following findings: <ul style="list-style-type: none"> ▶ depressed mental status ▶ inability to ambulate ▶ diaphoresis, agitation <ul style="list-style-type: none"> • Patients with combative behavior or whose combativeness prevents assessment (vital signs or examination) • Patients with abnormal vital signs or findings: <ul style="list-style-type: none"> ▶ Systolic blood pressure over 190 mm/Hg or diastolic blood pressure over 110 mm/Hg ▶ Pulse rate sustained over 120 ▶ Blood glucose under 60 mg/dL or over 250 mg/dL <ul style="list-style-type: none"> • Patients with a suspected overdose of medication. <p>I believe if we have more direction with 5150 patients in our County, we will have fewer patients waiting for psychiatric treatment. This will benefit the patients.</p> <p>We should also add in specific destination locations for the non-medical psychiatric treatment. List the facilities in the protocol. Example-</p> <ul style="list-style-type: none"> • Redlands Community Hospital • Arrowhead Regional Medical Center • San Bernardino Community Hospital <p>Loma Linda University</p> | |
| | San Manuel Fire Dept. | <p>Definitions, adult patient and pediatric patients. Both descriptions exclude 15 year old persons. Add the 15 year old to the adult description (based on the pediatric trauma center age requirements).</p> <p>The ADC is not specified. Does this include com-center, San Bernardino City dispatch, Cal Fire...?</p> | <p>The adult definition states a person who <u>is</u>, or is appearing to be older than 15. This is the current definition in use.</p> <p>This is intentionally left generic in the event the current ADC changes or additional ADCs are added in the future.</p> |

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| | Mel Standon | <p><i>III. Definitions</i></p> <p>Adult—Age (“older than 15 years of age”) is inconsistent with previous protocols of 15 years of age and older AND the definition of an Adult Burn Patient in the very next paragraph AND the definition of a pediatric patient (“appearing to be under 15 years of age”). So, if the patient is 15 y/o, they are not an adult and they are not a pediatric, what are they?</p> <p><i>VII Diversion</i></p> <p>4th Bullet—When did ALS become “Acute Life Support” and not Advanced Life Support? And L-ALS become Limited Acute Life Support? Inconsistent with the other protocols (Specifically Reference 2020)</p> | <p>The adult definition states a person who <u>is</u>, or is appearing to be older than 15. This is the current definition in use.</p> <p>Already corrected.</p> <p>Agreed, will change to Advanced Life Support (ALS).</p> |
| | Upland FD | Clarify Definitions Adult pt (?older than 15) and Adult burn patient along with the pediatric patient definitions. | Adult is 15 years of age or older. |
| 9090 - Patient Refusal of care Guidelines - Adult | Victor Aguirre Mammoth Hosp. | Section VII (documentation) point 6, do we have a “refusal advice sheet” to give to patients? | The provider agencies may have them based on their legal counsel. The most important aspect of AMA is the documentation of discussion of risk, benefits and alternatives in ePCR. The exact form that patient signs generally add little value. There are many boiler plate forms that providers can review and adopt for use. |
| | Ontario FD | Under the principle section it advises that if the patient insists on being transported to a more distant facility and the transport provider agrees then a signature must be obtained. Please advise on where to capture this signature on the ePCR. | Patient signs the AMA. The most important aspect of AMA is the documentation of discussion of risk, benefits and alternatives in ePCR. The exact form that patient signs generally add little value. There are many boiler plate forms that providers can review and adopt for use. |
| | RCFD | Agree with changes | |

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| | San Manuel Fire Dept. | Agree | |
| | Upland FD | Seeking direction from ICEMA on where to have the patient sign on ePCR if patient insists on being transported to distant facility and requires signature | Patient signs the AMA. The most important aspect of AMA is the documentation of discussion of risk, benefits and alternatives in ePCR. The exact form that patient signs generally add little value. There are many boiler plate forms that providers can review and adopt for use. |
| 10190 - ICEMA Approved Skills (NEW) | LLUMC | Pg. 2 of 3 Needle Thoracostomy correction (patient airway) change to (patent airway) Have cuffed tubes been approved as an optional item and can they be utilized in the less than eight populations? | Will correct. The use of cuffed tubes for pediatrics has been approved as an ICEMA Specialty Program only. |
| | Ontario FD | The Ontario FD believes there is significant value in leaving the individual skills protocols in the manual. The combined method for medication works, however the combining the skills removes the “standard method of treatment or standard of care”. Individual skills sheets are used to verify skills competencies and need to be specific. NG/OG - Is viscous Lidocaine replacing lubricant or can either be used? Should viscous Lidocaine be mentioned in the nasotracheal intubation since it is listed in the NG/OG? | ICEMA agrees that skill proficiency is necessary. However, Most of the skills are now part of the standard scope of practice for paramedics. ICEMA specific criteria that deviates from the standard scope of practice is outlined in this protocol. The current protocol descriptions could be saved for training and reference or a checklist could be provided. Either Viscous Lidocaine or lubricant can be used we are not replacing either. |

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| | RCFD | It was explained at a meeting by ICEMA staff that the intent of this protocol was to take the place of the individual skill protocols. We are requesting this be reconsidered if this is the intent. The skill protocols are referenced on a routine basis during training and QI. They are a more thorough tool than this protocol for practicing/training/referencing specific skills. This is a nice list to use to for discussion of additional items allowed by ICEMA in conjunction with some skills and/or procedures but not sure it is a protocol. As a protocol alone it offers less than the several skill protocols and can be confusing in addition to the current protocols. Again, it is good informational material but not sure it is a "protocol". | ICEMA agrees that skill proficiency is necessary. However, Most of the skills are now part of the standard scope of practice for paramedics. ICEMA specific criteria that deviates from the standard scope of practice is outlined in this protocol. The current protocol descriptions could be saved for training and reference. |
| | San Manuel Fire Dept. | We are unclear as to the need of this protocol. Each skill exists in the 10,000 series in the protocol manual. Is this a quick reference guide or a replacement of the 10,000 series? It is not complete and should not be used as a replacement. It could serve as an enhancement of the current skills sheets. | The 10,000 series will be going away. This will be the only protocol for skills. |
| | SBSO | Typo on page 2 of 3 with Needle Thor, line 2 states "patient" airway – should be "patent" | Will correct. |
| | | Typo on page 2 of 3 with Oral Intubation, item #2 should read "end-tidal" CO2, not "end-title" CO2 | Will correct. |
| | | Shouldn't we be monitoring ETCO2 for peds also? | Yes, will correct. There is no age restriction on capnography. |

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| | Mel Standon | <p>What is the purpose of this reference? It touches on topics, but doesn't cover them efficiently or usefully. It seems like a "hey, don't forget" type of protocol, but those "don't forget" items should rightfully be in the actual skill reference. If this is intended to be similar to the proposed medication reference, it falls short. If it's just a "don't forget" reference, it's repetitive and not necessary.</p> <p>Also, in the initial pages of this document, you stated there are no changes to the 10000 section of the reference manual, but clearly this is a change.</p> <p><i>Axial Spinal Stabilization</i> First bullet—Suggest adding a phrase to clarify that precautions should be placed in these instances. Simply adding "Should be placed if the patient meets the..." would clarify.</p> <p><i>King Airway and King Airway – Pediatric</i> Why is "Suspected ALOC" listed as a contraindication in the pediatric population, but not the adult population? And what exactly is "suspected" ALOC, anyway? How is that different than plain ol' ALOC?</p> <p><i>Oral Endotracheal Intubation – Pediatric</i> Suggest deleting phrase of uncuffed tubes in the less than 8 y/o population, as you have now elected to allow air transport providers to utilize cuffed tubes in this population.</p> | <p>ICEMA agrees that skill proficiency is necessary. However, Most of the skills are now part of the standard scope of practice for paramedics. ICEMA specific criteria that deviates from the standard scope of practice is outlined in this protocol. The current protocol descriptions could be saved for training and reference.</p> <p>The 10,000 series will be removed in the near future. Will change to note the addition of the new ICEMA Approved Skills - ICEMA Reference #10190.</p> <p>Will consider adding a clarifier.</p> <p>The statement about suspected ALOC is the same as for pediatric intubation. It is included to remind the medic to look for a cause that maybe reversible prior to intubation. Review ICEMA Reference #14050.</p> <p>Using cuffed tubes on pediatric patients is a specialty program only. Will add cuffed tubes as optional equipment to the drug and equipment list.</p> |

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| | Upland FD | Highly recommend keeping these procedures within the protocol. This allows for ease of QI/QA and a standard approach to these procedures. Along with training check lists that reflect the protocol in order to provide standardized training approach | ICEMA agrees that skill proficiency is necessary. However, Most of the skills are now part of the standard scope of practice for paramedics. ICEMA specific criteria that deviates from the standard scope of practice is outlined in this protocol. The current protocol descriptions could be saved for training and reference. |
| 11070 - Cardiac Arrest -Adult | Victor Aguirre Mammoth Hosp. | Are they trying to make these hard to read! It seems like they took out the medication dosages and instead now you have to go to another protocol (medication standard orders) to look them up. | The Medication Standard Orders provide a convenient reference for medications. |
| | Ontario FD | Please clarify the Narcan dose for cardiac arrest with suspected narcotic overdose. Should it be 2 mg or 0.5 mg as stated in the Medication protocol? Under ALS Interentions, You reference a skills protocol for NG/OG tube #10080 – not #10190. Again we think it best to leave the individual skills protocols. Under ALS Interventions you state to utilize continuous waveform capnography – need to remove the “if available”. | The Medication Standard Orders supersede the protocols until the dosages are removed from the protocols. Will change to ICEMA Reference #10190. Agreed, capnography is now mandatory. |
| | RDCH | Can the protocol state: If ROSC is achieved, obtain a 12-lead ECG <i>and contact a STEMI base for destination decision per protocol 8130 pg. 5 of 7.</i> | Agreed, will add to this protocol if ROSC is achieved |
| | RCFD | Agree with changes | |

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|--|------------------------------|---|---|
| | San Manuel Fire Dept. | <p>We applaud the use of capnography/capnometry for the recognition of ROSC and the need for 12-lead assessment with ROSC.</p> <p>Consider removing the joules settings for monophasic defibrillators.</p> <p>Termination of efforts criteria Page 4 of 4, states Consider terminating resuscitative efforts ...”if no shock delivered”. There are times when this criteria is not consistent with trauma protocols. Consider removing the reference to shocks being delivered.</p> | <p>Monophasic defibrillators have lower setting so this will remain as a guideline.</p> <p>This protocol only includes non-traumatic cardiac arrest.</p> |
| | Mel Standon | <p><i>ALS Interventions</i> 5th bullet—Suggest adding “perfusion status” after “ROSC.” ETCO₂ is an effective tool to measure both the quality of chest compressions and potential ROSC</p> | <p>There are current studies that suggest this may be a useful tool. However, future studies need to validate the value of this in the EMS arena before we can incorporate into our protocols as standard practice.</p> |
| | Upland FD | <p>Seek clarification from ICEMA on narcan dose. Cardiac arrest protocol states 2 mg and Medication protocol shows 0.5mgs</p> <p>Thank you for taking our input. We believe it is imperative that field providers be represented since they are the hands, feet, eyes and brains (and compassion) that effect patient care.</p> | <p>Naloxone has been changed in this protocol to reference the Medication Standard Orders.</p> |
| 11080 - Altered Level of Consciousness/ Seizures - Adult | Victor Aguirre Mammoth Hosp. | <p>Are they trying to make these hard to read! It seems like they took out the medication dosages and instead now you have to go to another protocol (medication standard orders) to look them up.</p> | <p>The Medication Standard Orders puts all the medications in one protocol which reduces the chance of inconsistencies between protocols. It also simplifies the change process if a route or dose changes.</p> |

PROTOCOLS FOR 30-DAY COMMENT FORM

**ICEMA Reference #s: 5030, 6140 (NEW), 7010, 7020, 7030, 8130 (NEW), 9090, 10190 (NEW), 11070, 11080, 14040, 14050
Deleted: 3010, 9100**

DEADLINE TO SUBMIT COMMENTS: April 13, 2014, at 5:00 pm

| PROTOCOL # | AGENCY | COMMENT | RESPONSE |
|--|------------------------------|---|--|
| | Ontario FD | On the Glucagon, Midazolam, and Naloxone you reference #7040 Medication Standing orders but then you include dose details. Those details are outlined in the medication protocol example “Do not exceed 10 mgs of Naloxone total regardless of route”. It would be cleaner if no stated in the protocol if stated in the medication standing orders protocol. | Agreed, will remove the reference to the maximum dose from this protocol. It is listed on the Medication Standard Orders. |
| | RCFD | On some medications the info from the medication standing orders protocol is repeated, no need to repeat. Recommend only listing info after the reference to the medication protocol if it is unique to this situation. | Agreed, will remove the reference to the maximum dose from this protocol. It is listed on the Medication Standard Orders. |
| | San Manuel Fire Dept. | BLS interventions change “Place patient in axial spinal stabilization if trauma is suspected”. To Place pt in spinal stabilization per the trauma protocol 15010. | Agreed, will make change. |
| | Mel Standon | <i>ALS Intervention</i> 4th Bullet—Suggest adding the phrase “with severely decreased respiratory drive.” Otherwise, it’s implied that you should give someone Narcan if they have utilized a narcotic, which isn’t necessarily required, and may be harmful. | Agreed, will make change. |
| 14040 - Cardiac Arrest - Pediatric (Less than 15 years of age) | Victor Aguirre Mammoth Hosp. | Are they trying to make these hard to read! It seems like they took out the medication dosages and instead now you have to go to another protocol (medication standard orders) to look them up. | The Medication Standard Orders puts all the medications in one protocol which reduces the chance of inconsistencies between protocols. It also simplifies the change process if a route or dose changes. |
| | Ontario FD | Nicely done. All medications referenced #7040 no repetition. 10080 NG/OG is reference instead of 10190 | Agreed, will change the reference # to 10190. |

PROTOCOLS FOR 30-DAY COMMENT FORM

ICEMA Reference #s: 5030, 6140 (NEW), 7010, 7020, 7030, 8130 (NEW), 9090, 10190 (NEW), 11070, 11080, 14040, 14050 Deleted: 3010, 9100

DEADLINE TO SUBMIT COMMENTS: April 13, 2014, at 5:00 pm

| PROTOCOL # | AGENCY | COMMENT | RESPONSE |
|--|------------------------------|--|--|
| | RCFD | Agree with changes | |
| | San Manuel Fire Dept. | Page 4 of 5 Treatment Modalities. NG/OG. Consider referencing that the NG or OG should be placed with a BLS airway as well as an ALS airway, for ALS providers. | Agreed, will make the suggested change. |
| | Mel Standon | <p><i>IV. ALS Interventions</i></p> <p>4th bullet—If you're going to put in this much information, you might as well stress that ventilations are asynchronous with compressions.</p> <p>5th bullet— Suggest adding “perfusion status” after “ROSC.” ETCO₂ is an effective tool to measure both the quality of chest compressions and potential ROSC</p> <p><i>Ventricular Fibrillation</i></p> <p>1st bullet—Suggest changing “10 j/kg” to “10 j/kg not to exceed adult dose”</p> | <p>This information will be removed as the protocols are streamlined. These changes will start with the next review of protocols.</p> <p>Agreed</p> <p>Agreed</p> |
| 14050 - Altered Level of Consciousness - Pediatric (Less than 15 years of age) | Victor Aguirre Mammoth Hosp. | Are they trying to make these hard to read! It seems like they took out the medication dosages and instead now you have to go to another protocol (medication standard orders) to look them up. | The Medication Standard Orders puts all the medications in one protocol which reduces the chance of inconsistencies between protocols. It also simplifies the change process if a route or dose changes. |
| | Ontario FD | No comment | |
| | RCFD | Agree with changes | |
| | San Manuel Fire Dept. | Page 1 of 3 BLS interventions. “Obtain core temperature”. Change to “obtain patient temperature”. Core temp is not a field skill. | Agreed, will make the suggested change. |

PROTOCOLS FOR 30-DAY COMMENT FORM

**ICEMA Reference #s: 5030, 6140 (NEW), 7010, 7020, 7030, 8130 (NEW), 9090, 10190 (NEW), 11070, 11080, 14040, 14050
Deleted: 3010, 9100**

DEADLINE TO SUBMIT COMMENTS: April 13, 2014, at 5:00 pm

| PROTOCOL # | AGENCY | COMMENT | RESPONSE |
|---|-------------|--|---|
| | Mel Standon | <p><i>BLS Interventions</i> Last bullet—Suggest adding direction for decreased core temp (including referencing #13030) as well since both could cause ALOC</p> <p><i>L-ALS Interventions</i> 4th bullet-Suggest making Dextrose and Glucagon sub-bullets under “Check blood glucose level” since they both apply to blood glucose. This would maintain consistency with your adult protocol.</p> <p><i>ALS Interventions</i> 4th bullet—Suggest making Dextrose and Glucagon sub-bullets under “Check blood glucose level” since they both apply to blood glucose. This would maintain consistency with your adult protocol.</p> <p>6th bullet—Suggest adding the phrase “with severely decreased respiratory drive.” Otherwise, it’s implied that you should give someone Narcan if they have utilized a narcotic, which isn’t necessarily required, and may be harmful.</p> | <p>Agreed, will make the suggested change.</p> |
| 3010 - Annual Review Class (ARC) | Delete | No comments received. | |
| 9100 - Patient Refusal of Care Guidelines - Adult | Delete | No comments received. | |



ANNUAL REVIEW CLASS (ARC)

PURPOSE

To define the eligibility and procedural requirements for the mandatory yearly Annual Review Class (ARC) for the Paramedic (EMT-P) applying for Continuous Accreditation and/or the Mobile Intensive Care Nurse (MICN) applying for Continuous Certification or Inactive MICN status within the ICEMA Region. The Annual Review Class is developed by a multidisciplinary task force and the curriculum approved by the ICEMA Medical Director.

PROCEDURE

1. The authorized class is valid from January 1 through December 31 of each year.
2. It is the responsibility of the individual to take the class during each year of accreditation or certification.
3. Failure to take two (2) different Annual Review Classes during your two (2) years accreditation or certification period will result in the EMT-P or MICN having to successfully pass the ICEMA EMT-P Accreditation/MICN Certification Written Exam with a minimum score of eighty percent (80%). Additionally, financial penalties will apply.
4. The EMT-P or MICN must register and pay the exam fee to ICEMA prior to the scheduled deadline.

CRITERIA FOR TEACHING THE ANNUAL REVIEW CLASS

1. Approved C.E. providers shall request approval from ICEMA to provide the class:
 - a. Submit a completed application to be approved as a training program.
 - b. Application must include a list of your proposed trainers with copies of their resumes attached.
 - c. Pay the ICEMA approved Training Program approval fee.
 - d. Approval is granted for a period of one (1) year.

2. ICEMA should be notified thirty (30) days in advance of the class offering in order to be able to post the class dates, times and locations on the ICEMA website and newsletter.
3. Within fifteen (15) days of class completion, the provider will send the original C.E. roster to ICEMA with the Instructor Evaluation and any other material requested. All other course materials and records will be maintained, for a period of four (4) years, by the approved training program per Protocol Reference #3020, policy for CE Provider Requirements.
4. Continuing Education hours will be granted for the class in accordance to Protocol Reference #3020 Continuing Education Provider Requirements.

DELETED



PROCEDURE FOR ADOPTION OF PROTOCOLS AND POLICIES

I. PURPOSE

To establish procedures for the adoption, ~~amendment-revision~~ or repeal of ICEMA medical control protocols ~~and/or~~ policies and procedures.

~~ICEMA recognizes that stakeholder advice and review~~collaboration is an essential component of protocol and policy, ~~procedure and protocol~~ development. The EMS stakeholder review process is advisory to ICEMA for the formulation of prehospital care these policies and procedures. ~~Policy~~ICEMA accepts protocol or policy ~~input and/or draft policies are accepted from~~ are accepted from standing ICEMA committees, sub-committees, task forces and other individuals and/or interested parties. The ICEMA Medical Director and EMS Administrator are responsible for the development and approval of protocols and/or policies, remain the responsibility of the ICEMA Medical Director and EMS Administrator.

II. AUTHORITY

California Health and Safety Code, Sections 1797.220 and 1798.101(1)

California Code of Regulations, Title 22, Division 9, Chapter 4 Article 2, Sections 100145, 100146, 100148, and 100170

III. DEFINITIONS

Medical Advisory Committee (MAC): Primary committee that advises the ICEMA Medical Director on the clinical or medical aspects of Emergency Medical Services (EMS) within the ICEMA region.

Protocols: Medical standards that provide the framework for the medical treatment and care routinely provided to patients within the ICEMA region.

Policy: Non-medical objectives, principal functions and mode of operations for providers and health care facilities within the ICEMA region.

System Advisory Committee (SAC): Primary committee that advises the ICEMA EMS Administrator on the operational aspects of Emergency Medical Services (EMS) within the ICEMA Region.

IV. POLICY

1. ICEMA will review all protocols ~~on a bi-annual basis~~once a year, annually or more often if as-necessary, to ensure time critical and appropriate policy changes.
2. ~~Policy-Minor~~ changes to protocols and/or policies may occur without specific review from the public or specific committees. Changes include, but are not limited to:
 - a. Changes in wording necessary to clarify the objective.
 - b. Changes in the listed order for clarity or better flow.
 - c. Changes to assure protocol or policy continuity and consistency.
 - d. Changes required ~~to comply~~ to comply with State and local laws and/or regulations to maintain public health and safety.
 - e. Correction of typographical, grammar, spelling or formatting errors.
 - e.f. Changes required to maintain medical control or system integrity.
3. ICEMA staff shall change, develop, or delete ~~develop an initial protocols and/or policies~~ draft with when needed or requested and/or solicit input from appropriate external agencies, organizations or ~~other from~~ established advisory committees such as those listed below:
 - a. MAC
 - b. SAC
 - c. ST Elevation Myocardial Infarction QI Committee (STEMI QI)
 - d. Neurovascular Stroke QI Committee (Stroke QI)
 - e. Trauma System Advisory Committee (TSAC)
 - f. Trauma Advisory Committee (TAC)
(i.e. TSAC, STEMI, Stroke) ~~as subject matter dictates, and present proposed protocols to the Medical Advisory Committee~~ Protocol Education Committee (PEC) for review.
54. ICEMA may forward protocols and policies to The MACPEC will and/or SAC for additional review prior to public comment. MAC or SAC may provide additional input assign to a task force or ad hoc committee and to review and make recommendations on proposed changes to ICEMA its

~~authorizing committee. MAC will determine if draft needs further review by taskforce or ad hoc committee. The review will be completed within the timeframe determined by MAC.~~

- ~~5. If MAC determines no further committee review is required, the protocols will be released for public comment. Following review by appropriate committees, draft protocols will be submitted to the Medical Advisory Committee (MAC).~~
- ~~6. For protocols that do not have significant changes or impact to training, they will be released for public comment prior to going to MAC. The comments will be collected and presented at the next scheduled MAC meeting. Following MAC review, protocols will be released for public comment period.~~
5. ICEMA shall consider all relevant matter presented to it before accepting, amending or repealing any protocol or policy, but the authority for final determination remains with the Medical Director and EMS Administrator.
6. Policies will be released ~~for fifteen (15) to thirty (30) day public comment period. The public comment period may be shortened to 15 days if ICEMA determines the policy or protocol to be time sensitive.~~for a predetermined public comment period as noted under Section VI - Public Comment Period below.
7. Upon closure of the public comment period, ICEMA will prepare a final draft ~~policies/procedures of the protocols/policies (including accepted changes)~~ with a detailed spreadsheet showing the public comment for presentation at the Emergency a subsequent scheduled MAC or SAC meeting for endorsement. Medical Care Committee (EMCC) meetings held in all three counties. Spreadsheet shall include all comments received and ICEMA's response to the comments.
8. Protocols and/or policies that are endorsed by MAC and/or SAC will be presented to the ICEMA Medical Director and EMS Administrator for signature and enactment.
9. Protocols and/or policies, approved by the Medical Director and EMS Administrator, shall become effective no later than thirty (30) days after the date of approval and incorporated into the appropriate protocol/policy manual.
- ~~10. Following endorsement by the EMCC's, policies will be presented to the ICEMA Medical Director and ICEMA Executive Director for signature.~~

- ~~11. Protocols and/or policies approved by the Medical Director and Executive Director shall become effective no sooner than thirty (30) days after the date of approval.~~

V. EMERGENCY PROTOCOLS/POLICIES

1. If ICEMA determines that an emergency protocol or policy is necessary for the immediate preservation of the public health and safety or general welfare, a protocol and/or policy may be adopted, amended or repealed as an emergency action.
2. Any finding of an emergency will include a written statement describing the specific facts showing the need for immediate action. The statement and the protocol or policy shall be immediately forwarded to the MAC and/or SAC and EMS provider agencies (as appropriate) ~~Medical Advisory Committee and appropriate EMS provider agencies~~. The emergency protocol and/or policy will become effective ~~immediately unless otherwise specified~~, no sooner than five (5) days following dissemination to the ICEMA Medical Advisory Committee.
3. Protocols and/or policies adopted under the emergency provision shall remain in effect for approximately one hundred and twenty (120) days to allow for appropriate committee review and public comment period.

VI. PUBLIC COMMENT PERIOD

ICEMA will:

1. Open all changed protocols or policies to public comment for a period of ~~fifteen (15) to~~ thirty (30) days except in instances where the ICEMA ~~Executive Director~~ EMS Administrator and ICEMA Medical Director deem it necessary to shorten the period to protect and/or improve public health and safety or maintain medical control and/or operational integrity.
2. Post proposed changes to protocols and/or policies on the ICEMA website at www.ICEMA.net.
3. E-mail proposed changes to ~~voting~~ members of the Emergency Medical Care Committees, Medical Advisory Committee and/or Systems Advisory Committee.
4. E-mail proposed changes to each EMS provider agency.
5. E-mail proposed changes to ~~every~~ any person who ~~m~~ has filed a request for notification with ICEMA.

6. Make copies of the proposed protocols and/or policies available to the public and stakeholders ~~which is~~ consistent with a policy of encouraging the widest possible notice distribution to interested persons.
7. Any oversight in notification described above shall not invalidate any action taken by ICEMA pursuant to this policy.

VII. CONTENTS OF PUBLIC COMMENT PERIOD NOTIFICATION

1. The notice of proposed adoption, amendment, or repeal of a protocol or policy shall include:
 - a. A statement of the time and place of proceedings for adoption, amendment or repeal of a protocol or policy.
 - b. The name and telephone number of the agency contact person to whom inquiries concerning the proposed action may be directed.
 - c. A date by which comments submitted must be received in writing in order for them to be considered by ICEMA before it adopts, amends, or repeals a protocol or policy.
 - d. The provisions of this section shall not be construed in any manner to invalidate a protocol or policy due to perceived inadequacy of the notice content if there has been substantial compliance with this requirement.

VIII. REQUEST FOR ADOPTION, AMENDMENT OR REPEAL OF PROTOCOL

1. Any ~~interested~~ person may request, ~~in writing,~~ the adoption, amendment, or repeal of a protocol or policy as provided in this section. Such petition shall be in writing and state clearly and concisely state:
 - a. The substance or nature of the protocol or policy, amendment or repeal requested.
 - b. The reason for the request.
 - c. Any supporting documentation and/or research that would support the request.
2. Upon receipt of a written request for the adoption, amendment or repeal of a protocol or policy, ICEMA will notify the petitioner or group in writing of the receipt of the request and then shall, within thirty (30) days, either deny the request, in writing, indicating why the agency has reached such a decision or schedule the protocol/policy for review in accordance with this policy.

3. ICEMA may grant or deny such a request or take such other action as it may determine to be warranted and will notify the petitioner in writing of such action.



SMOKE INHALATION/CO EXPOSURE/SUSPECTED CYANIDE TOXICITY (Expanded Scope Specialty Program)

I. PURPOSE

To identify and treat smoke inhalation and suspected cyanide toxicity.

II. AUTHORITY

California Health and Safety Code, Sections 1797.172 and 1797.185

California Code of Regulations, Title 22, Division 9, Chapter 4

III. FIELD ASSESSMENT/TREATMENT INDICATORS

- Indicators
 - Exposure to fire and smoke particularly in an enclosed-space structure fires.
 - Hydrogen cyanide concentration measured in the air does not accurately correlate to patient's level of exposure and toxicity. Consider possibility of carbon monoxide (CO) and cyanide exposure/toxicity in any patient (or unprotected EMS field personnel) with smoke inhalation.
- Cyanide Toxicity
 - Initial signs and symptoms are non-specific and may include; headache, dizziness, nausea, vomiting, confusion, and syncope.
 - Worsening signs and symptoms may include; altered level of consciousness (ALOC), hypotension, shortness of breath, seizures, cardiac dysrhythmias, and cardiac arrest.
 - The "bitter almond" smell on the breath of a cyanide-poisoned patient is neither sensitive nor specific and should not be considered in making the assessment.
- Carbon Monoxide Poisoning
 - Initial signs and symptoms are non-specific and may include; flu like symptoms, dizziness, severe headache, nausea, sleepiness, weakness and disorientation.

- Worsening signs and symptoms may include; blurred vision, shortness of breath, and altered level of consciousness.

IV. ALS INTERVENTIONS

- Remove patient from exposure area.
- Administer 100% oxygen via non-rebreather mask.
- Monitor pulse oximetry (SpO₂) though values may be unreliable in patients suffering from smoke inhalation.
- Monitor Carboxyhemoglobin (SpCO) levels. (SpCO monitor is required for participation in this Specialty program.)
- IV access, consider fluid bolus of 300cc NS.
- Patients exhibiting signs and symptoms of cyanide toxicity which persist after treatment with 100% oxygen therapy should be treated rapidly with the Cyanokit.
 - Administer Hydroxocobalamin.
 - Dosage: 5 gm IV over 15 minutes. May repeat one (1) time with base hospital orders. Second dose given over 15 minutes to 2 hours depending on the response to the first dose.
 - Reconstitute: Place the vial in an upright position. Add 200 mL of 0.9% Sodium Chloride Injection (not included in the kit) to the vial using the transfer spike. Fill to the line.
 - Mix: The vial should be repeatedly inverted or rocked, not shaken, for at least 60 seconds prior to infusion.
 - Infuse Vial: Use vented intravenous tubing, hang and infuse over 15 minutes.
- Use BVM with airway adjuncts as needed. Consider advanced airway if indicated.
- Refer to ICEMA Reference #11010 - Adult Respiratory Emergencies, for treatment of bronchospasm as indicated by wheezing
- Ensure rapid transport to closest receiving emergency department. In patients with SpCO of > 25% (> 15% if pregnant) or signs and symptoms of worsening CO poisoning, consider transport to a hyperbaric facility.

V. REFERENCE

| <u>Number</u> | <u>Name</u> |
|---------------|-------------------------------|
| 11010 | Adult Respiratory Emergencies |



BLS/LALS/ALS STANDARD DRUG & EQUIPMENT LIST

Each ambulance and first responder unit ~~will~~shall 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 | ALS Non-Transport | ALS Transport |
|---|--------|---------|-------------------|---------------|
| Adenosine (Adenocard) 6mg | | | 1 | 1 |
| Adenosine (Adenocard) 12mg | | | 2 | 2 |
| 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 | | | 2 | 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 10 gm | | | 1 | 1 |
| Naloxone (Narcan) 2 mg preload (needle less) | | 2 | 2 | 2 |
| Nitroglycerine - Spray 0.4 mg metered dose and/or tablets (tablets to be discarded 90 days after opening) | | 2 | 1 | 2 |
| Normal Saline for Injection (10 cc) | | 2 | 2 | 2 |
| Normal Saline 100 cc | | | 1 | 2 |

| Exchanged Medications/Solutions | BLS | LALS | ALS Non-Transport | ALS Transport |
|---|-----|---------|-------------------|---------------|
| Normal Saline 250 cc | | | 1 | 1 |
| Normal Saline 500 ml and/or 1000 ml | | 2000 ml | 3000 ml | 6000 ml |
| Ondansetron (Zofran) 4 mg Oral Disintegrating Tablets (ODT) | | | 4 | 4 |
| Ondansetron (Zofran) 4 mg IM/ IV | | | 4 | 4 |
| Phenylephrine HCL - 0.5 mg 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 | ALS Non-Transport | ALS Transport |
|--|-----|------|-------------------|---------------|
| Midazolam | | | 20-40mg | 20-40mg |
| Morphine Sulfate -vials of 10 mg | | | 20-60mg | 30-60mg |

AIRWAY/SUCTION EQUIPMENT

| Exchanged Airway/Suction Equipment | BLS | LALS | ALS Non-Transport | ALS Transport |
|---|-----------------------------------|--------|-------------------|---------------|
| 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 each | 1 each |
| 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 |
| 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) 25-35 kg: Size 2.5 (orange) | SPECIALTY PROGRAMS ONLY 2 each | 1 each | 1 each | 2 each |
| Mask - Adult & Pediatric non-rebreather oxygen mask | 2 each | 2 each | 2 each | 2 each |
| Mask - Infant Simple Mask | 1 | 1 | 1 | 1 |
| Nasal cannulas - pediatric and adult | 2 each | 2 each | 2 each | 2 each |

| Exchanged Airway/Suction Equipment | BLS | LALS | ALS Non-Transport | ALS Transport |
|--|-------------|-------------|--------------------------|----------------------|
| 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 |
| 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 250 ml Pediatric 500 ml (or equivalent) Adult | 1 1 1 | 1 1 1 | 1 1 1 | 1 1 1 |
| Water soluble lubricating jelly | | 1 | 1 | 1 |
| Yankauers tonsil tip | 1 | | 1 | 1 |

| Non-Exchange Airway/Suction Equipment | BLS | LALS | ALS Non-Transport | ALS Transport |
|--|---|-------------|--------------------------|----------------------|
| Ambulance oxygen source -10 L /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 - 10 L /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 | 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 15 mm, 25 mm, and 45 mm | | | 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 | 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 - 1 cc, 3 cc, 10 cc catheter tip | | 2 each | | |
| Syringes w/wo safety needles - 1 cc, 3 cc, 10 cc, 20 cc, 60 cc catheter tip | | | 2 each | 2 each |

| Non-Exchange IV/Needles/Syringes/Monitor Equipment | BLS | LALS | 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 |
| Capnography monitor and supplies, may be integrated in the cardiac monitor | | | <u>1</u> | <u>1</u> |
| 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 | ALS Non-Transport | ALS Transport |
|---|-----|------|-------------------|---------------|
| AED/defib pads | 2 | 2 | | |
| Ammonia Inhalants | | | 2 | 2 |
| Approved Automatic CPR device (FDA approved) | 1 | 1 | 1 | 1 |
| Approved Automatic ventilator (ICEMA approved) | | | 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 |
| <u>CyanoKit (Specialty Program Only)</u> | | | 1 | 1 |
| EMS Tourniquet | 1 | | 1 | 1 |
| Gum Elastic intubation stylet | | | 2 | 2 |
| Hemostatic Dressings * | 1 | 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 |

* Hemostatic Dressings

- Quick Clot®, Z-Medica®
Quick Clot®, Combat Gauze® LE
Quick Clot®, EMS Rolled Gauze, 4x4 Dressing, TraumaPad®
- Celox®
Celox® Gauze, Z-Fold Hemostatic Gauze
Celox® Rapid, Hemostatic Z-Fold Gauze

Note:

- The above products are “packaged” in various forms (i.e., Z-fold, rolled gauze, trauma pads, 4”x4”pads) and are authorized provided they are comprised of the approved product.
- Hemostatic Celox Granules, or granules delivered in an applicator, are not authorized.

DRESSING MATERIALS/OTHER EQUIPMENT/SUPPLIES

| Exchanged Dressing Materials/Other Equipment/Supplies | BLS | LALS | 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 |
| 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 |
| 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 | ALS Non-Transport | ALS Transport |
|--|------------|-------------|--------------------------|----------------------|
| <u>\$00 MHz Radio</u> | | <u>1</u> | <u>1</u> | <u>1</u> |
| 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 |

| Non-Exchange Dressing Materials/Other Equipment/Supplies | BLS | LALS | ALS Non-Transport | ALS Transport |
|---|------------|-------------|--------------------------|----------------------|
| Traction splint | 1 | 1 | 1 | 1 |
| Triage Tags - CAL Chiefs or ICEMA approved | 20 | 20 | 20 | 20 |



EMS AIRCRAFT STANDARD DRUG & EQUIPMENT LIST

Each Aircraft ~~will~~shall be equipped with the following functional equipment and supplies. This list represents mandatory items with minimum quantities, to exclude 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.

| MEDICATIONS/SOLUTIONS | AMOUNT |
|---|----------|
| Adenosine (Adenocard) 6 mg | 30 mg |
| Adrenaline (Epinephrine) 1:1,000 | 2 mg |
| Adrenaline (Epinephrine) 1:10,000 | 3 mg |
| Albuterol Aerosolized Solution (Proventil) - unit dose 2.5 mg | 4 doses |
| Aspirin, chewable - 81 mg tablet | 1 bottle |
| Atropine 1 mg preload | 3 mg |
| Calcium Chloride | 1 gm |
| Dextrose 25% | 5 gm |
| Dextrose 50% | 50 gm |
| Diphenhydramine (Benadryl) 50 mg | 50 mg |
| Glucagon | 1 mg |
| Glucopaste | 1 tube |
| Intropin (Dopamine) | 200 mg |
| Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5 mg | 4 |
| Lidocaine | 300 mg |
| Lidocaine 1 gm or 1 bag pre-mixed 1 gm/250 cc D5W | 1 gm |
| Lidocaine 2% (Viscous) | 2 oz |
| Magnesium Sulfate 10 mg | 10 gms |
| Naloxone (Narcan) | 4 mg |
| Nitroglycerin - Spray 0.4 mg metered dose and/or tablets (tablets to be discarded 90 days after opening.) | 1 |
| Normal Saline for Injection (10 cc) | 2 |
| Normal Saline 250 ml | 1 |
| Normal Saline 500 ml and/or 1000 ml | 4000 ml |
| Ondansetron (Zofran) 4 mg Oral Disintegrating Tablets (ODT) | 4 |
| Ondansetron (Zofran) 4 mg IM/ IV | 4 |
| Phenylephrine HCL - 0.5 mg per metered dose | 1 bottle |
| Procainamide | 1 gm |
| Sodium Bicarbonate | 100 mEq |
| Verapamil (Isoptin) | 15 mg |

| CONTROLLED SUBSTANCE MEDICATIONS-MUST BE DOUBLE LOCKED | AMOUNT |
|---|---------------|
| Midazolam | 20-40 mg |
| Morphine Sulfate - vials 10 mg | 20-60 mg |

| AIRWAY/SUCTION EQUIPMENT | AMOUNT |
|---|---------------|
| Aircraft Oxygen source -10 L /min for 20 minutes | 1 |
| BAAM Device | 1 |
| C-PAP circuits - all manufacture's available sizes | 1 each |
| End-title CO2 device - pediatric and adult (may be integrated into bag) | 1 each |
| Endotracheal tubes, uncuffed - 2.5, 3.0, 3.5 with stylet | 2 each |
| Endotracheal Tubes, uncuffed - 4.0 or 4.5, 5.0 or 5.5 with stylet | 2 each |
| 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 |
| ET Tube holders - pediatric and adult | 1 each |
| Flashlight/penlight | 1 |
| King LTS-D Adult: Size 3 (yellow) Size 4 (red) Size 5 (purple) | 1 each |
| King Ped: 12-25 kg: Size 2 (green) 25-35 kg: Size 2.5 (orange) | 1 each |
| Laryngoscope handle with batteries - or 2 disposable handles | 1 |
| Laryngeal blades - #0, #1, #2, #3, #4 curved and/or straight | 1 each |
| Magill Forceps - Pediatric and Adult | 1 each |
| Nasal Cannulas - infant, pediatric and adult | 2 each |
| Naso/Orogastric tubes - 10fr or 12fr, 14fr, 16fr or 18fr | 1 each |
| Naso/Orogastric feeding tubes - 5fr or 6fr, and 8fr | 1 each |
| Nasopharyngeal Airways - infant, child, and adult | 1 each |
| Needle Cricothyrotomy Device (Approved) - Pediatric and adult <i>or</i> | 1 each |
| Needles for procedure 10, 12, 14 and/or 16 gauge | 2 each |
| Non Re-Breather O ₂ Mask - Pediatric and Adult, Infant Simple Mask | 2 each |
| One way flutter valve with adapter or equivalent | 1 |
| Oropharyngeal Airways - infant, child, and adult | 1 each |
| Portable Oxygen with regulator - 10 L /min for 20 minutes | 1 |
| Portable suction device (battery operated) <i>and/or</i> Wall mount suction device | 1 each |
| Pulse Oximetry device | 1 |
| Small volume nebulizer with universal cuff adaptor | 2 |
| Stethoscope | 1 |
| Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr | 1 each |
| Ventilation Bags - Infant 250 ml, Pediatric 500 ml and Adult 1 L | 1 each |
| Water soluble lubricating jelly | 1 |
| Yankauers tonsil tip | 1 |

| IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT | AMOUNT |
|---|-------------------|
| 12-Lead ECG Monitor and Defibrillator with TCP and printout | 1 |
| 800 MHz Radio | 1 |
| Blood pressure cuff - large adult or thigh cuff, adult, child and infant | 1 set |
| Capnography monitor and supplies, may be integrated in the cardiac monitor | 1 |
| Conductive medium <i>or</i> Adult and Pediatric Pacer/Defibrillation pads | 2 each |
| ECG - Pediatric and Adult | 20 patches |
| EZ IO Needles and Driver 15 mm, 25 mm, and 45 mm | 2 each 1 each |
| 3-way stopcock with extension tubing | 2 |
| IO Needles - Manual, Adult and Pediatric, Optional | 1 each |
| IV Catheters - sizes 14, 16, 18, 20, 22, 24 | 2 each |
| Glucose monitoring device | 1 |
| Macro drip Administration Set (10 drops/ml) | 3 |
| Micro drip Administration Set (60 drops/ml) | 1 |
| Mucosal Atomizer Device (MAD) for nasal administration of medication | 4 |
| Needle disposal system (OSHA approved) | 1 |
| Pressure infusion bag | 1 |
| Safety Needles - 20 or 21 gauge and 23 or 25 gauge | 2 each |
| Saline Lock | 2 |
| Syringes w/wo safety needles - 1 ml, 3 ml, 10 ml, 20 ml, 60 ml catheter tip | 2 each |
| Thermometer - Mercury free with covers | 1 |

| OPTIONAL EQUIPMENT/MEDICATIONS | Amount |
|---|-------------------|
| Ammonia Inhalants | 2 |
| Automatic ventilator (Approved) | 1 |
| Backboard padding | 1 |
| BLS AED/defib pads | 1 |
| Capnography monitor and supplies, may be integrated in the cardiac monitor | 1 |
| Chemistry profile tubes | 3 |
| CyanoKit (Specialty Program Only) | 1 |
| D5W in bag | 1 |
| Hemostatic Dressing * | 1 |
| IV infusion pump | 1 |
| IV warming device | 1 |
| Manual powered suction device | 1 |
| Medical Tourniquet | 1 |
| Needle Thoracostomy Kit (prepackaged) | 2 |
| Pitocin | 2 |
| Translaryngeal Jet Ventilation Device | 1 |
| Vacutainer | 1 |

* Hemostatic Dressings

- Quick Clot®, Z-Medica®
Quick Clot®, Combat Gauze® LE
Quick Clot®, EMS Rolled Gauze, 4x4 Dressing, TraumaPad®
- Celox®
Celox® Gauze, Z-Fold Hemostatic Gauze
Celox® Rapid, Hemostatic Z-Fold Gauze

Note:

- The above products are “packaged” in various forms (i.e., Z-fold, rolled gauze, trauma pads, 4”x4”pads) and are authorized provided they are comprised of the approved product.
- Hemostatic Celox Granules, or granules delivered in an applicator, are not authorized.

| DRESSING MATERIALS/OTHER EQUIPMENT SUPPLIES | AMOUNT |
|---|--------|
| Adhesive tape - 1 inch | 2 |
| Air occlusive dressing (Vaseline gauze) | 1 |
| Aircraft stretcher or litter system with approved FAA straps that allows for Axial Spinal Immobilization | 1 |
| Ankle & wrist restraints, soft ties acceptable | 1 |
| Antiseptic swabs/wipes | |
| Bandage Shears | 1 |
| Blanket or sheet | 2 |
| Blood Borne Pathogen Protective Equipment - (nonporous gloves, goggles face masks & gowns meeting OSHA Standards) | 2 |
| Cervical Collars - Rigid Pediatric & Adult <i>or</i> | 2 each |
| Cervical Collars - Adjustable Adult & Pediatric | 2 each |
| Emesis basin or disposable bags & covered waste container | 1 |
| Head immobilization device | 2 |
| OB Kit | 1 |
| Pediatric immobilization board | 1 |
| Pneumatic or rigid splints capable of splinting all extremities | 4 |
| Providence/Iodine swabs/wipes | |
| Roller bandages - 4 inch | 3 |
| Short extrication device | 1 |
| Sterile bandage compress or equivalent | 6 |
| Sterile gauze pads - 4x4 inch | 4 |
| Sterile Sheet for Burns | 2 |
| Traction splint | 1 |
| Universal Dressing 10x30 inches | 2 |



CONTROLLED SUBSTANCE POLICY

I. **PURPOSE**

To establish minimum requirements and accountability for ICEMA approved ALS providers to procure, stock, transport, and use controlled substances in compliance with the Federal Controlled Substances Act.

II. **AUTHORITY**

[California Code of Regulations Title 22, Division 9, Chapter 4, Article 7, Section 100168](#)

III. **POLICY**

All ICEMA approved ALS providers shall have a formal agreement with a qualified Medical Director or a drug authorizing physician who agrees to purchase controlled substances using the appropriate DEA registration number and forms. This physician will retain ownership, accountability and responsibility for these controlled substances at all times.

All ALS providers ~~will~~ shall develop policies compliant with [The Controlled Substances Act Title 21, United States Code \(USC\) and California Code of Regulations Title 22, Division 9, Chapter 4, Article 7, Section 100168.](#) ~~Chapter 13 of the Federal Controlled Substance Act.~~ These policies must ensure that security mechanisms and procedures are established for controlled substances, including, but not limited to: clearly outline the procedure for procurement, receipt, distribution, waste management and associated record keeping for the controlled substances purchased under their DEA registration number.

- [Controlled substance ordering and order tracking](#)
- [Controlled substance receipt and accountability](#)
- [Controlled substance master supply storage, security and documentation](#)
- [Controlled substance labeling and tracking](#)
- [Vehicle storage and security](#)
- [Usage procedures and documentation](#)
- [Reverse distribution](#)
- [Disposal](#)
- [Re-stocking](#)

Additionally, the policies must ensure that mechanisms for investigation and mitigation of suspected tampering or diversion are established, including, but not limited to:

- Controlled substance testing
- Discrepancy reporting
- Tampering, theft and diversion prevention and detection
- Usage audits

The ALS provider's medical director or drug authorizing physician must be a physician licensed to practice medicine in the State of California and must apply and obtain a valid DEA registration number for the ALS provider they propose to purchase controlled substances for. If a physician has agreements with multiple ALS providers, separate DEA registration numbers are required for each individual EMS provider-agency. Physicians should not use their personal DEA registration number that they use for their clinical practice.

IV. PROCEDURE

All controlled substances ~~will~~shall:

1. Be purchased and stored in tamper evident containers.
2. Be stored in a secure and accountable manner.
3. Be kept under a “double lock” system at all times.
4. Be ~~reconciled~~counted a minimum of daily at a minimum or at any change of shift or change in personnel.

V. REQUIRED DOCUMENTATION

1. ALS providers must maintain a log of all purchased controlled substances for a period of no less than two (2) years.
2. All controlled substance usage will be documented ~~in~~on all patient care ~~records~~records (PCR) or electronic patient care reports (ePCR).
3. All wasted portions of controlled substances must be witnessed and documented by at least two (2) licensed EMS field personnel~~providers~~ (both ~~providers~~ must sign the log~~).~~ and appropriate sections of the PCR or ePCR.
4. In the event of breakage of a narcotic container an incident report will be completed and the damage reported to the appropriate supervisor.
5. Discrepancies in the narcotic count will be reported immediately to the appropriate supervisor and a written report must be submitted.

SAMPLE DAILY LOG

Agency: _____

Month: _____ Year: _____

Double Lock

Shift Change Medic

Date

In Place

Midazolam 5mg

On

| | DATE | DOUBLE LOCK IN PLACE? | MIDAZOLAM 5MG | MORPHINE 10MG | DRUG ADMINISTERED - AMOUNT GIVEN / WASTED O1A # PATIENT NAME DATE/TIME MEDIC NAME | DUTY MEDIC | CAPTAIN OR SUPERVISOR |
|---|------|-----------------------|---------------|---------------|---|---------------------------|---------------------------|
| 1 | | Yes / No | Amount _____ | Amount_____ | | Can Not Be Same Signature | Can Not Be Same Signature |
| 2 | | Yes / No | Amount _____ | Amount_____ | | Can Not Be Same Signature | Can Not Be Same Signature |
| 3 | | Yes / No | Amount _____ | Amount_____ | | Can Not Be Same Signature | Can Not Be Same Signature |
| 4 | | Yes / No | Amount _____ | Amount_____ | | Can Not Be Same Signature | Can Not Be Same Signature |
| 5 | | Yes / No | Amount _____ | Amount_____ | | Can Not Be Same Signature | Can Not Be Same Signature |
| 6 | | Yes / No | Amount _____ | Amount_____ | | Can Not Be Same Signature | Can Not Be Same Signature |
| 7 | | Yes / No | Amount _____ | Amount_____ | | Can Not Be Same Signature | Can Not Be Same Signature |
| 8 | | Yes / No | Amount _____ | Amount_____ | | Can Not Be Same Signature | Can Not Be Same Signature |

SAMPLE - Master Controlled Substance Inventory Log

| Date/Time | Lot Number | Midazolam Quantity | Morphine Quantity | Outdated Destroyed | Action Inventory, Restock, Dispensed, Inventory Total | Signatures of Personnel | |
|-----------|------------|--------------------|-------------------|--------------------|---|--|-----------|
| | | | | | | I certify that we have counted and found correct all controlled substances listed. | |
| | | | | | | Signature | Signature |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |



DESTINATION POLICY

I. PURPOSE

To ensure the transportation of 9-1-1 patients to the most appropriate receiving facility that has the staff and resources to deliver definitive care to the patient.

II. AUTHORITY

California Health and Safety Code, Division 2.5, [Chapter 4, Section 1797.220](#),

California Code of Regulations, Title 22 Chapters 4, 7 and 8

III. DEFINITIONS

Aircraft Dispatch Center (ADC): An ICEMA designated dispatch center which dispatches and coordinates air ambulance and/or air rescue aircraft response to the scene of a medical emergency within the ICEMA region.

Adult Patient: A person who is or is appearing to be older than 15 years of age.

Burn Patient: Patients meeting ICEMA's burn classifications minor, moderate or major, [per ICEMA Reference #11100 - Burn - Adult \(15 years of age or older\) and #14070 - Burn - Pediatrics](#).

~~**CME:** Continuous Medical Education.~~

~~**CQI:** Continuous Quality Improvement.~~

Critical Trauma Patient (CTP): Patients meeting ICEMA's trauma triage criteria ~~(anatomic, physiologic, and/or mechanism of injury)~~ [per ICEMA Reference # 15030 – Trauma Triage Criteria and Destination Policy following a traumatic event](#).

~~**EMS:** Emergency Medical Services.~~

~~**Inadequate Tissue Perfusion:** Evidenced by the presence of cold, pale, clammy, mottled skin, and/or capillary refill time greater than two (2) seconds. Pulse rate will increase in an attempt to pump more blood. As the pulse gradually increases (tachycardia), it becomes weak and thready. Blood pressure is one of the last signs to change (hypotension). Altered level of consciousness may also be an indicator to inadequate tissue perfusion, especially in the very young.~~

Neurovascular Stroke Receiving Center (NSRC): A licensed acute care hospital designated by ICEMA's Governing Board as a receiving hospital for patients triaged as having a cerebral vascular event requiring hospitalization for treatment, evaluation and /or management of stroke.

~~**NSRC-Neurovascular Stroke Base Hospital:** Facilities that have been designated by ICEMA's Governing Board as a Neurovascular Receiving Hospital that also function as a base hospital.~~

~~**PCI: Percutaneous Coronary Intervention.**~~

Pediatric Patient: A person who is or is appearing to be under 15 years of age.

Pediatric Trauma Center: A licensed acute care hospital which usually treats (but is not limited to) persons under 15 years of age, designated by ICEMA's Governing Board that meets all relevant criteria, and has been designated as a pediatric trauma hospital, according to California Code of Regulations, Title 22, Division 9, Chapter 7, Section 100261.

~~**ST Elevation Myocardial Infarction (STEMI): A medical term for a type of myocardial infarction that results in an elevation of the ST Segment on a 12-Lead electro-cardiogram (ECG).**~~

STEMI Base Hospital: Facilities that have emergency interventional cardiac catheterization capabilities that also function as a base hospital.

STEMI Receiving Center (SRC): A licensed general acute care hospital designated by ICEMA's Governing Board as a STEMI Receiving Center that has emergency interventional cardiac catheterization capabilities.

STEMI Referring Hospital: Facilities that do not have emergency interventional cardiac catheterization capabilities.

~~**STEMI: ST Elevation Myocardial Infarction.**~~

Trauma Center: A licensed general acute care hospital designated by ICEMA's Governing Board as a trauma hospital in accordance with State laws and regulations.

IV. POLICY

If the patient's condition is stable, the most appropriate destination may be the facility associated with their healthcare plan and primary care physician.

If a patient requires specialty care at an ICEMA designated STEMI, Stroke, Trauma or other approved specialty center, the EMS provider may bypass closer facilities for another facility having the specialty services needed by the patient. Destination for specialty patients requires contact with an appropriate specialty base hospital.

All destination decisions should be based on patient condition or patient and/or family request. Patients unable to, or without a preference should be taken to the closest hospital unless their condition requires specialty services as described below.

If directed by the base hospital physician, an EMS transport provider may bypass a closer facility.

V. GENERAL CONSIDERATIONS

- Closest Hospital
 - All patients requiring immediate medical attention for life threatening conditions.
 - Patients without destination preference.
- Patient Request
 - Patient requests should be honored if possible and appropriate.
 - Patient requests for specific destination may be accommodated if patient is medically stable and the destination is not outside of the unit's response area.
- Protocol
 - Destination may be determined by considering special care needs such as Trauma, STEMI or Stroke listed in the appropriate protocol.
- Higher Level of Care
 - May be dictated by patient condition and base hospital direction.
 - Allows ALS providers to bypass a closer facility in favor of a facility that has the capability of a specialty response to the patient's condition.
- Base Hospital
 - Final authority for destination determination is the base hospital.
 - Base hospital physician may override prior destination decisions made by the paramedic (EMT-P) or protocol.

VI. PSYCHIATRIC HOLDS

- All patients on a psychiatric hold (5150) who require medical evaluation and treatment shall be transported to the closest ~~facility~~ acute care hospital for medical clearance.
- Any acute care hospital is capable of medically clearing psychiatric patients.
- Patients on a psychiatric hold with no medical complaints or conditions may be released to law enforcement for transported directly to a psychiatric facility that has the capacity to accept the patient.

VII. DIVERSION (Refer to ICEMA Reference #8060 - Requests for Hospital Diversion Policy - San Bernardino County Only)

- Diversion of ALS ambulances is limited by ICEMA, refer to ICEMA Reference #8060 - Requests for Hospital Diversion Policy (San Bernardino County Only).
- Ambulance diversion to another acute care hospital is not allowed in the ICEMA region based on hospital census or staffing.
- A patient may be directed to a hospital on diversion if it is in the best interest of the patient and the hospital has not declared an internal disaster.
- ~~Final destination of a LALS or ALS ambulance rests with the base hospital.~~
 - The base hospital determines final destination of Acute Life Support (ALS) or Limited Acute Life Support (L-ALS) patients.
 - BLS ambulances may not be diverted from their intended destination unless the hospital is on internal disaster.

VIII. SPECIALTY SERVICES

- SRCs: ~~ST Elevation Myocardial Infraction (STEMI) Receiving Centers~~ Refer to ICEMA Reference #6070 - Cardiovascular STEMI Receiving Centers.
 - A Cardiovascular STEMI Receiving Center (SRC) ~~will be~~ the preferred destination for patients who access the 9-1-1 system meeting defined criteria and show evidence of a ST elevation myocardial infarction (STEMI) on a 12-lead electrocardiogram (ECG). These patients will benefit from rapid interventions via cardiac catheterization interventions.
 - Once a patient with STEMI has been identified, contact a STEMI base hospital ~~contact should be made~~ for destination decision ~~while and preparing~~ prepare the patient for expeditious transport. In Inyo and Mono Counties, the assigned base hospital should be contacted for STEMI consultation.

- Consider transporting patients that suffer out-of-hospital cardiac arrest, with or without return of spontaneous circulation (ROSC), to the closest STEMI receiving hospital, after contact with a STEMI base hospital for destination determination.
- ~~Refer to ICEMA Reference #6070 – Cardiovascular STEMI Receiving Centers.~~
- NSRCs: Refer to ICEMA Reference #11110 - Stroke Treatment - Adult (15 years of age and older).
 - A NSRC should be considered as the destination of choice for all patient meeting Stroke triage criteria.
 - Once a patient with a stroke has been identified, contact a NSRC base hospital ~~contact should be made~~ for destination decision ~~while and preparing~~ prepare the patient for expeditious transport. In Inyo and Mono Counties, the assigned base hospital should be contacted for stroke consultation.
 - ~~Refer to ICEMA Reference #11110 – Stroke Treatment – Adult (15 years of age and older).~~
- Trauma: (Refer to ICEMA Reference #15030 -Trauma Triage Criteria and Destination Policy.)
 - Adult patients meeting trauma triage criteria shall be transported to the closest Trauma Center.
 - Transport pPediatric patients meeting trauma triage criteria shall be transported to a pediatric Trauma Center when there is less than a twenty (20) minute difference in transport time ~~to~~ between the pediatric Trauma Center ~~versus~~ and the closest Trauma Center.
 - ~~Patients~~ Transport patients meeting the physiologic and/or anatomic criteria ~~will be transported~~ to the closest Trauma Center.
 - Patients meeting the mechanism of injury and either the physiologic or anatomic criteria will be transport to the closest Trauma Center.
 - If there are no associated physiologic or anatomic criteria and the potential trauma patient meets one or more of the mechanisms of injury contact a trauma base hospital to determine patient destination. Patient may be directed to a non-trauma receiving hospital.

- Make trauma base hospital contact to determine if a Trauma Center should be the destination for patients not meeting the trauma triage criteria ~~above~~ but meeting ing age and/or co-morbid factors.
- Patients with unmanageable airway or traumatic cardiac arrest should be transported to the closest receiving hospital if indicated. Trauma base hospital contact shall be made.
- ~~➤ Trauma triage criteria is established per ICEMA Reference #15030 - Trauma Triage Criteria and Destination Policy.~~
- ~~➤ Hospital trauma diversion status, refer to ICEMA Reference #8060 - Requests for Hospital Diversion Policy (San Bernardino County Only).~~
- ~~➤ Multi-Casualty Incident, refer to ICEMA Reference #5050 - Medical Response to a Multi-Casualty Incident Policy.~~
- ~~➤ When estimated transport to the most appropriate Trauma Center (for patients identified as a CTP) is thirty (30) minutes or less, ground ambulance shall be the primary means of transport. EMS Aircraft transport shall not be used unless ground transport is expected to be greater than thirty (30) minutes and EMS Aircraft transport is expected to be significantly more expeditious than ground transport.~~
- Burn: (Refer to ICEMA Reference #15030 - Trauma Triage Criteria and Destination Policy.)
 - Burn patients meeting the physiologic or anatomic criteria for CTP shall be transported to the closest Trauma Center. ~~Refer to ICEMA Reference #15030 - Trauma Triage Criteria and Destination Policy.~~
 - Burn patients meeting minor or moderate classifications shall be transported to the closest receiving hospital.
 - Burn patients meeting major burn classification may be transported to the closest burn center (in San Bernardino County contact ARMC Arrowhead Regional Medical Center).
 - Pediatric burn patients identified as a CTP should always be transported to the closest Trauma Center with or without burn capabilities. When there is less than twenty (20) minutes difference in transport time, a pediatric Trauma Center is the preferred destination.
 - Burn patients with respiratory compromise, or potential for such, will be transported to the closest receiving acute care receiving hospital for airway stabilization.

IX. INTERFACILITY TRANSFER (Refer to ICEMA Reference #8010 - Interfacility Transfer Guidelines)

- Patients will go to the designated destination facility regardless of patients' prior condition. ~~Change of destination to closer facility is warranted only in the event of the~~Patients may only be diverted if—patients' condition ~~deteriorating~~ deteriorates significantly while in the care of EMS.
- ~~If the patient's condition deteriorates, AEMTs-Advanced EMTs~~ and EMT-Ps may start prior-to- contact protocols before contacting the base hospital for change of destination if the patient's condition deteriorates significantly.
- ~~Refer to ICEMA Reference #8010—Interfacility Transfer Guidelines.~~

X. EMS AIRCRAFT ROTATION AND DESTINATION (San Bernardino County Only)

- All EMS Aircraft requests from the field in San Bernardino County will be dispatched by the ICEMA designated Aircraft Dispatch Center (ADC).
- The destination may be changed by the EMS providers based on patient requirements for specialty centers.
- Refer to ICEMA Reference #8070 - Aircraft Rotation Policy (San Bernardino County Only).

XI. REFERENCE

| <u>Number</u> | <u>Name</u> |
|---------------|--|
| 5050 | Medical Response to a Multi-Casualty Incident Policy |
| <u>6070</u> | <u>Cardiovascular STEMI Receiving Centers.</u> |
| 8010 | Interfacility Transfer Guidelines |
| 8060 | Requests for Hospital Diversion Policy (San Bernardino County Only). |
| 8070 | Aircraft Rotation Policy (San Bernardino County Only) |
| <u>11100</u> | <u>Burn - Adult (15 years of age or older)</u> |
| 11110 | Stroke Treatment - Adult |
| <u>14070</u> | <u>Burn - Pediatrics</u> |
| 15030 | Trauma Triage Criteria and Destination Policy |



PATIENT REFUSAL OF CARE - ADULT

I. PURPOSE

To provide ~~guidance~~ direction for EMS ~~field P~~ personnel when an individual refuses their advice that treatment and/or transport is indicated. ~~whose advice to an individual for treatment and/or transport is being refused~~

II. AUTHORITY

California Health and Safety Code, Division 2.5, Section 1797.220

III. DEFINITIONS

Against Medical Advice (AMA): A term used to when an individual refuses treatment and/or transport after EMS field personnel advise that it is indicated.

Consent: Consent is defined as the agreement and acceptance as to opinion or course of action.

Emergency: A condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by emergency medical personnel or a public safety agency. (California Health and Safety Code, Division 2.5, Section 1797.70) ~~The American Ambulance Association (AAA) defines an “emergency” as “unforeseen condition of a pathophysiological nature, which a prudent layperson, possessing an average knowledge of health and medicine, would judge to require urgent and unscheduled medical attention.”~~

IV. PRINCIPLE

If a competent, conscious patient or legal guardian refuses care offered, or requests to be transported to a hospital other than the nearest, medically appropriate facility, the patient's request should be honored, when possible.

All AMAs shall be fully documented to acknowledge that the individual may benefit from assessment, treatment and/or transport refused the advice of EMS field personnel. Documentation shall acknowledge that the advice is to protect the individual and the EMS services and that the decision was that of the individual.

EMS field personnel Providers may refuse a request to transport a patient to a more distant facility that is outside of their service area provided they offer transportation to an appropriate medical facility. In the event the patient or legal guardian insists upon transport and the transporting ambulance agrees to transport to a more distant

facility, the signature of the patient or legal guardian must be obtained on the patient care record and base hospital contact made.

V. CONSENT

1. Immediately required treatment should not be delayed to obtain consent.
2. An individual has the responsibility to consent to or refuse treatment. If he/she is unable to do so, consent is then considered implied.
3. In non-emergency cases, consent should be obtained from the individual.
4. For treatment of minors or a definition of emancipated minors refer to ICEMA Protocol Reference #9080 - Care of Minors in the Field.

VI. MENTAL COMPETENCE

1. An individual is mentally competent if he or she:
 - a. Is capable of understanding the nature and consequences of the proposed treatment.
 - b. Has sufficient emotional control, judgment and discretion to manage his or her own affairs.
2. An individual having an understanding of what may happen if treated or not treated, and is oriented to person, place, time and purpose.
3. An individual with an altered level of consciousness will be unlikely to fulfill these criteria.
4. If the individual is not deemed mentally competent, the person should be treated and transported. Attempt to obtain law enforcement concurrence in these circumstances.

VII. REFUSAL OF CARE DOCUMENTATION

The following information should be carefully documented on the patient care record:

1. The individual's chief complaint, mechanism of injury, level of orientation/level of consciousness.
2. Base ~~hospital~~ Station ~~C~~contact per ICEMA Protocol Reference #5040 - Radio Communication Policy.
3. Any medical treatment or evaluation needed and refused.

4. The need for emergency transportation; also if transport by means other than an ambulance could be hazardous due to the individual's injury or illness.
5. Individual advised that potential harm could result without emergency medical treatment and/or transport.
6. Individual provided with a refusal advice sheet, and if he or she would accept the refusal advice sheet.
7. A copy of the patient care record with the individual's signature of refusal will be kept by the EMS provider agency per ICEMA Protocol Reference #2010 - Requirements for Patient Care Records.

DEFINITIONS

~~**AMA:** A term used to designate "against medical advice".~~

~~**Consent:** Consent is defined as the agreement and acceptance as to opinion or course of action.~~

~~**Emergency:** The American Ambulance Association (AAA) defines an "emergency" as "unforeseen condition of a pathophysiological nature, which a prudent layperson, possessing an average knowledge of health and medicine, would judge to require urgent and unscheduled medical attention."~~

V. REFERENCE

| <u>Number</u> | <u>Name</u> |
|---------------|--|
| <u>2010</u> | <u>Requirements for Patient Care Records</u> |
| <u>5040</u> | <u>Radio Communication Policy</u> |
| <u>9080</u> | <u>Care of Minors in the Field</u> |



PATIENT REFUSAL OF CARE OR OTHER PATIENT REQUEST

Prehospital personnel should be sensitive to the needs and concerns of the patient and the patient's family. In the event that a competent, conscious patient or legal guardian refuses care offered, or requests to be transported to a hospital other than the nearest, medically appropriate facility, the patient's request should be met.

In the event that a patient refuses treatment, transport, or transport to a medically appropriate destination, the signature of the patient or legal guardian must be obtained on the patient care record. Base Hospital Contact should be made if in the EMT-P's judgment the patient's condition warrants the treatment and/or transport being refused. All patient contacts must be documented on the appropriate patient care record. Patient care records shall be reviewed by the provider agency in accordance with the EMS Quality Improvement Plan and subsequently forwarded to ICEMA.

Providers may refuse a request to transport a patient to a more distant facility if it lies outside of their service area provided they offer transportation to an appropriate medical facility. In the event the patient or legal guardian insists upon transport and the transporting ambulance agrees to transport to a more distant facility, the signature of the patient or legal guardian must be obtained on the patient care record and Base Hospital Contact made.

~~DELETED~~



ICEMA APPROVED SKILLS

I. POLICY

To provide a list of ICEMA approved skills and affected scope of practice.

II. AUTHORITY

California Health and Safety Code, Sections 1797.214

California Code of Regulations, Title 22, Division 9, Chapters 2, 3, and 4

III. SKILLS

12-lead Electrocardiography (EMT-P)

- ECG should be performed prior to medication administration.

Axial Spinal Stabilization (EMT, AEMT and EMT-P)

- If patient meets the Neuro deficits present, Spinal Tenderness, Altered Mental status, Intoxication, Distracting Injury (NSAID) criteria per ICEMA Reference #15010 - Trauma - Adult (15 years of age or older).
- An AEMT and/or EMT-P may remove if placed by BLS crew and it does not meet criteria.

Continuous Positive Airway Pressure Device (CPAP) - Adult (EMT, AEMT and EMT-P)

- Start at lowest setting and increase slowly until patient experiences relief or until a maximum of 15 cm H₂O is reached.

External Jugular Vein Access (AEMT and EMT-P)

- Not indicated for patients eight (8) years of age and younger.

Intraosseous Infusion (AEMT pediatric patients only and EMT-P)

- EMT-Ps may administer Lidocaine slowly per ICEMA Reference #7040 - Medication - Standard Orders, for pain control.

King Airway Device (Perilaryngeal) - Adult (EMT Specialty Program, AEMT, EMT-P)

- Patients 15 years or older.
- Anyone over four (4) feet in height.

King Airway Device (Perilaryngeal) - Pediatric (EMT Specialty program, AEMT, EMT-P)

- Patients less than 15 years of age.
- May initially be contraindicated with suspected ALOC.

Nasogastric/Orogastric Tube (EMT-P)

- Use viscous Lidocaine gel per ICEMA Reference #7040 - Medication - Standard Orders, for conscious patients.
- Required for all full arrest patients.

Nasotracheal Intubation (EMT-P)

- Absolute contraindication: Apnea.
- Base hospital contact required: Facial trauma, anticoagulant therapy, airway burns, failed CPAP.
- Prophylactic Lidocaine per ICEMA Reference #7040 - Medication - Standard Orders, for suspected head/brain injury.

Needle Cricothyrotomy (EMT-P)

- Absolute contraindication: Transection of the trachea.

Needle Thoracostomy (EMT-P)

- In blunt chest trauma consider bilateral tension pneumothorax if pulse oximetry (SpO₂) reading remains low with a patent airway or with poor respiratory compliance.

Oral Endotracheal Intubation - Adult (EMT-P)

- Consider Lidocaine prophylactically per ICEMA Reference #7040 - Medication - Standard Orders, for head injury.
- Monitor end-titile CO₂ with capnography.
- After three (3) unsuccessful attempts consider Needle Cricothyrotomy.

Oral Endotracheal Intubation - Pediatric (EMT-P)

- Uncuffed tubes for patients under eight (8) years old.
- Base hospital contact is required after two (2) failed intubation attempts.

Synchronized Cardioversion (EMT-P)

- Consider medication for pain and anxiety.
- If rhythm deteriorates to v-fib turn off the sync button and defibrillate.

Transcutaneous Cardiac Pacing (EMT-P)

- Consider medication for pain and anxiety.
- Contact the base hospital if rhythm persists.

Vagal Maneuvers (EMT-P)

- Use with caution for patients with hypertension, suspected STEMI, or suspected head/brain injury.

IV. REFERENCE

| <u>Number</u> | <u>Name</u> |
|---------------|---|
| 7040 | Medication - Standard Orders |
| 15010 | Trauma - Adult (15 years of age or older) |



CARDIAC ARREST - ADULT

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Cardiac arrest in a non-traumatic setting.

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

- Initiate CPR while applying the AED.
- 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.
- Establish peripheral intravenous access and administer a 500 ml bolus of normal saline (NS).
- See ICEMA Reference #12010 - Determination of Death on Scene.

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

- Obtain blood glucose level, if indicated; administer Dextrose 50% per ICEMA Reference #7040 - Medication - Standard Orders 25-g IV.
- Naloxone ICEMA Reference #7040 - Medication - Standard Orders 2.0-mg IM/IN for suspected opiate overdose.

NOTE: Base ~~hospital~~Station contact is required to terminate resuscitative measures.

IV. ALS INTERVENTIONS

- Initiate CPR while applying the cardiac monitor.
- Determine cardiac rhythm and defibrillate if indicated. Begin a two (2) minute cycle of CPR.
- Obtain IV/IO access.
- 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.
- 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.
- Insert NG/OG Tube to relieve gastric distension per ICEMA Reference #10080 - Insertion of Nasogastric/Orogastric Tube.
- Obtain blood glucose level. If indicated, administer Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
- Naloxone per ICEMA Reference #7040 - Medication - Standard Orders ~~2-0 mg IV/IO/IM~~ for suspected opiate overdose.
- If ROSC is achieved, obtain a 12-lead ECG.
- Utilize continuous waveform capnography, if available, to identify loss of circulation.
- For continued signs of inadequate tissue perfusion after successful resuscitation, Dopamine per ICEMA Reference #7040 - Medication - Standard Orders ~~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.
- Base hospital physician may order additional medications or interventions as indicated by patient condition.

Ventricular Fibrillation/Pulseless Ventricular Tachycardia

- Defibrillate at 360 joules for monophasic or biphasic equivalent per manufacture. If biphasic equivalent is unknown use maximum available.
- Perform CPR for two (2) minutes after each defibrillation, without delaying to assess the post-defibrillation rhythm.
- Administer Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders 1.0 mg IV/IO during each two (2) minute cycle of CPR after every defibrillation unless capnography indicates possible ROSC.
- Reassess rhythm after each two (2) minute cycle of CPR. If VF/VT persists, defibrillate as above.
- After two (2) cycles of CPR, consider administering Lidocaine per ICEMA Reference #7040 - Medication - Standard Orders 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.
- If patient remains in pulseless VF/VT after five (5) cycles of CPR, consult Base Station/hospital.

Pulseless Electrical Activity (PEA) or Asystole

- Assess for reversible causes and initiate treatment.
- Continue CPR with evaluation of rhythm every two (2) minutes.
- Administer fluid bolus of 300 ml NS IV, may repeat.
- Administer Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders 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 Reference #10080 Insertion of Nasogastric/Orogastric Tube.~~
- ~~2. Obtain blood glucose. If indicated, administer Dextrose 50% 25-gms IV.~~
- ~~3. Naloxone per 2.0 mg IV/IO/IM for suspected opiate overdose.~~

Termination of Efforts in the Prehospital Setting

- 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.
- Consider terminating resuscitative efforts in the field if ALL of the following criteria are met:
 - No shocks were delivered.
 - No ROSC after a minimum of ten (10) minutes of advance cardiac life support (ACLS).
- Base hospital 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

- ~~• If ROSC is achieved, obtain a 12-lead ECG.~~
- ~~• Utilize continuous waveform capnography, if available, to identify loss of circulation.~~
- ~~• For continued signs of inadequate tissue perfusion after successful resuscitation a Dopamine per 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.~~
- ~~• Base Station physician may order additional medications or interventions as indicated by patient condition.~~

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|----------------------|--|
| <u>7040</u> | <u>Medication - Standard Orders</u> |
| <u>10080</u> | <u>Insertion of Nasogastric/Orogastric Tube</u> |
| <u>10130</u> | <u>Automatic External Defibrillation (AED) - BLS</u> |
| <u>12010</u> | <u>Determination of Death on Scene</u> |



ALTERED LEVEL OF CONSCIOUSNESS/SEIZURES - ADULT

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Patient exhibiting signs/symptoms of a possible altered level of consciousness.
- Suspected narcotic dependence, overdose, hypoglycemia, traumatic injury, shock and alcoholism.
- Tonic/clonic movements followed by a brief period of unconsciousness (post-ictal).
- Suspect status epilepticus for frequent or extended seizures.

II. BLS INTERVENTIONS

- Oxygen therapy as clinically indicated.
- Position patient as tolerated. If altered gag reflex in absence of traumatic injury, place in left lateral position.
- Place patient in axial spinal stabilization if trauma is suspected.
- If patient history includes insulin or oral hypoglycemic medications, administer Glucose sublingual.

III. LIMITED ALS (LALS) INTERVENTIONS

- Obtain vascular access.
- Obtain blood glucose level. If hypoglycemic administer:
 - Dextrose 50% per ICEMA Reference #7040 - Medication - Standard Orders 25-gms (50-cc) IV, or
 - Glucagon ICEMA Reference #7040 - Medication - Standard Orders 1-mg IM/SC/IN, if unable to establish IV. May give one (1) time only.
 - May repeat blood glucose. Repeat Dextrose if extended transport time.
- If suspected narcotic overdose administer:

- Naloxone per ICEMA Reference #7040 - Medication - Standard Orders ~~2 mg IV/IM/IN~~. May repeat Naloxone per ICEMA Reference #7040 - Medication - Standard Orders ~~2 mg IV/IM/IN~~ every two (2) to three (3) minutes if needed.
- Do not exceed 10 mgs of Naloxone total regardless of route given.
- Assess and document response to therapy.
- Base ~~Station~~hospital may order additional medication dosages and fluid bolus.

IV. ALS INTERVENTIONS

- Obtain vascular access and place on monitor.
- Obtain blood glucose level. If hypoglycemic administer:
 - Dextrose 50% per ICEMA Reference #7040 - Medication - Standard Orders ~~25 gms (50 cc) IV/IO~~, or
 - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders ~~1 mg IM/SC/IN~~, if unable to establish IV. May give one (1) time only.
 - May repeat blood glucose. Repeat Dextrose if extended transport time.
- For tonic/clonic type seizure activity administer:
 - Midazolam, per ICEMA Reference #7040 - Medication - Standard Orders ~~2.5 mg IN/IV/IO~~. May repeat in five (5) minutes for continued seizure activity, or
 - Midazolam per ICEMA Reference #7040 - Medication - Standard Orders ~~5 mg IM~~. May repeat in ten (10) minutes for continued seizure activity.
 - Assess patient for medication related reduced respiratory rate or hypotension.
 - Maximum of three (3) doses using any combination of IM/IN/IV/IO may be given for continued seizure activity. Contact ~~b~~Base Stationhospital for additional orders and to discuss further treatment options.

- If suspected narcotic overdose administer:
 - Naloxone per ICEMA Reference #7040 - Medication - Standard Orders~~2 mg IV/IM/IN~~. May repeat Naloxone per ICEMA Reference #7040 - Medication - Standard Orders~~2 mg IV/IM/IN~~ every two (2) to three (3) minutes if needed.
 - Do not exceed 10 mgs of Naloxone total regardless of route given.
- Assess and document response to therapy.
- Base ~~Station~~hospital may order additional medication dosages and fluid bolus.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|-------------------------------------|
| <u>7040</u> | <u>Medication - Standard Orders</u> |



CARDIAC ARREST - PEDIATRIC (Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Cardiac arrest in a non-traumatic setting. Consider the potential causes of arrest for age.

II. BLS INTERVENTIONS

- Assess patient, maintain appropriate airway; ~~if~~ begin CPR according to current AHA Guidelines.
 - Ventilate at rate of 12 to 20 per minute. Ventilatory rate will decrease as patient age increases. Ventilatory volumes shall be the minimum necessary to cause chest rise.
 - Compression rate shall be a minimum of 100 per minute.
- If patient one (1) year of age or older, utilize AED per ICEMA Reference #10130 - Automatic External Defibrillation (AED) - BLS.

III. LIMITED ALS (LALS) INTERVENTIONS

- Initiate CPR while applying the AED.
- Follow the instructions from the AED to determine if shock is needed.
- Obtain IO/IV access (IO is preferred for under nine (9) years of age).
- Establish advanced airway when resources are available, with minimal interruption to CPR.
- For continued signs of inadequate tissue perfusion, administer fluid bolus of NS. Reassess after each bolus. May repeat two (2) times for continued signs of inadequate tissue perfusion. In RCF, may give two (2) additional fluid boluses if indicated.
 - 1 day to 8 years: 20 ml/kg NS
 - 9 to 14 years: 300 ml NS

- ~~_____~~ Check blood glucose level.
- Administer Dextrose as per ICEMA Reference #7040 - Medication - Standard Orders.
 - ~~_____~~ For neonates (0–4 weeks), if blood glucose < 35 mg/dL:
~~_____~~ Dextrose 25% (0.25 g/ml) Diluted 1:1 Give 0.5 g/kg (4 ml/kg) IV/IO.
 - ~~_____~~ For patient < 10 kg and > 4 weeks, if blood glucose < 60 mg/dL:
~~_____~~ Dextrose 25% (0.25 g/ml) Give 0.5 g/kg (2 ml/kg) IV/IO.
 - ~~_____~~ For patient > 10 kg and < 25 kg, if glucose less than 60 mg/dL:
~~_____~~ Dextrose 50% (0.5 g/mL) Diluted 1:1 Give 0.5 g/kg (2 ml/kg) IV/IO.
 - ~~_____~~ For patient > 25 kg, if glucose less than 80 mg/dL:
~~_____~~ Dextrose 50% (0.5 g/mL) Diluted 1:1 Give 0.5 g/kg (2 ml/kg) IV/IO.
 - May repeat blood glucose. Repeat Dextrose if extended transport time.
 - Administer Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, 0.025 mg/kg IM/IN, if unable to start an IV. ~~May be repeated one (1) time after twenty (20) minutes for a combined maximum dose of 1 mg.~~
- For suspected narcotic ingestion, may give Naloxone per ICEMA Reference #7040 - Medication - Standard Orders, Narean 0.1 mg/kg IV/IM/IN/IO. ~~Do not exceed the adult dosage of 10 mg IV/IM/IN.~~
- Base hospital/Station physician may order additional medication dosages and additional fluid boluses.

IV. ALS INTERVENTIONS

- Initiate CPR while applying the cardiac monitor.
- Determine the cardiac rhythm and defibrillate at 2 j/kg (or manufacturer's recommended equivalent) if indicated. Begin a two (2) minute cycle of CPR.
- Obtain IO/IV access (IO is preferred).
- Establish advanced airway when resources are available, with minimal interruption to CPR. After advanced airway established, insert NG/OG tube. Continue CPR with compressions at a minimum of 100 /min without pauses during ventilations. Ventilations should be given at a rate of one (1) breath every six (6) to eight (8) seconds.
- Utilize continuous quantitative waveform capnography, ~~if available~~, for confirmation and monitoring of endotracheal tube placement and for assessment of ROSC.

Ventricular Fibrillation/Pulseless Ventricular Tachycardia

- Initial defibrillation is administered at 2 j/kg (or manufacturer's recommended equivalent). Second defibrillation is administered at 4 j/kg. Third and subsequent defibrillation attempts should be administered at 10 j/kg.
- Perform CPR for two (2) minutes after each defibrillation, without delaying to assess the post-defibrillation rhythm.
- Administer Epinephrine ~~(1:10,000)~~ [per ICEMA Reference #7040 - Medication - Standard Orders](#), during each two (2) minute cycle of CPR after each defibrillation unless capnography indicates possible ROSC.
 - ~~1 day to 8 years: 0.01 mg/kg IO/IV (do not exceed adult dosage).~~
 - ~~9 to 14 years: 1.0 mg IV/IO.~~
- Reassess rhythm after each two (2) minute cycle of CPR. If VF/VT persists, defibrillate as indicated above.
- After two (2) cycles of CPR, consider administering Lidocaine [per ICEMA Reference #7040 - Medication - Standard Orders](#);
 - ~~1 day to 8 years: 1 mg/kg IO/IV.~~
 - ~~9 to 14 years: 1 mg/kg IV/IO.~~
- May repeat Lidocaine [per ICEMA Reference #7040 - Medication - Standard Orders](#) ~~at 0.5 mg/kg after five (5) minutes up to total of 3.0 mg/kg.~~
- If patient remains in pulseless VF/VT after five (5) cycles of CPR, consult [Base hospital Station](#).

Pulseless Electrical Activity/Asystole

- Assess for reversible causes and initiate treatment.
- Continue CPR with evaluation of rhythm every two (2) minutes.
- Administer initial fluid bolus of 20 ml/kg [NS](#) for all ages, may repeat at:
 - 1 day to 8 years: 20 ml/kg [NS](#)
 - 9 to 14 years: 300 ml [NS](#)

- Administer Epinephrine ~~(1:10,000)~~ per ICEMA Reference #7040 - Medication - Standard Orders, during each two (2) minute cycle of CPR after each rhythm evaluation.
 - ~~1 day to 8 years: 0.01 mg/kg IO/IV.~~
 - ~~9 to 14 years: 1.0 mg IV/IO.~~

Treatment Modalities for Managing Pediatric Cardiac Arrest Patient

Whenever possible, provide family members with the option of being present during the resuscitation of an infant or a child. For any termination of efforts, ~~b~~Base ~~hospital~~Station contact is required.

- Insert NG/OG tube to relieve gastric distention if the patient has been intubated with an advanced airway, per ICEMA Reference #10080 - Insertion of Nasogastric/Orogastric Tube.
- For continued signs of inadequate tissue perfusion, administer fluid bolus of NS. Reassess after each bolus. May repeat twice for continued signs of inadequate tissue perfusion. In RCF, may give two (2) additional fluid boluses if indicated.
 - 1 day to 8 years: 20 ml/kg NS
 - 9 to 14 years: 300 ml NS
- Obtain blood glucose level. If indicated administer Dextrose per ICEMA Reference #7040 - Medication - Standard Orders~~according to ICEMA Reference #14050 - Pediatric Altered Level of Consciousness.~~
- Naloxone for suspected opiate overdose per ICEMA Reference #7040 - Medication - Standard Orders~~;~~ ~~may repeat once as clinically indicated.~~
 - ~~1 day to 8 years: 0.1 mg/kg IO/IV. Do not exceed adult dosage.~~
 - ~~9 to 14 years: 2 mg IV/IO.~~

If ROSC is achieved, obtain a 12-lead ECG.

- Utilize continuous waveform capnography, if available, to identify loss of circulation.
- For continued signs of inadequate tissue perfusion **after** successful resuscitation;
 - Epinephrine ~~(1:10,000)~~ per ICEMA Reference #7040 - Medication - Standard Orders. ~~0.5 mcg/kg/min IO/IV push.~~

- 9 to 14 years: Dopamine per ICEMA Reference #7040 - Medication - Standard Orders. ~~400 mg in 250 ml of NS to infuse at 5–20 mcg/kg /min IV titrated to maintain signs of adequate tissue perfusion.~~
- Base ~~hospital~~Station physician may order additional medications or interventions as indicated by patient condition.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|------------------|---|
| 7040 | Medications - Standard Orders |
| 10080 | Insertion of Nasogastric/Orogastric Tube |
| 10130 | Automatic External Defibrillation (AED) - BLS |
| 14050 | Pediatric Altered Level of Consciousness |



ALTERED LEVEL OF CONSCIOUSNESS - PEDIATRIC (Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Patient exhibits inappropriate behavior for age.
- History or observation of an Apparent Life Threatening Event (ALTE).

II. BLS INTERVENTIONS

- Assess environment and determine possible causes for illness.
- Axial-spinal stabilization, if clinically indicated.
- Oxygen therapy, if clinically indicated.
- Airway management, as indicated (OPA/NPA, BVM Ventilation).
- Obtain core temperature, if elevated begin passive cooling measures.

III. LIMITED ALS (LALS) INTERVENTIONS

- Establish advanced airway as needed.
- Obtain vascular access.
- For symptomatic hypotension with poor perfusion, consider fluid bolus of 20 ml/kg of NS not to exceed 300 ml NS.
- Check blood glucose level.
- Administer ~~Give~~ Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
 - ~~For neonates (0-4 weeks), if blood glucose < 35 mg/dL:
Dextrose 25% (0.25 g/ml) Diluted 1:1 Give 0.5 g/kg (4 ml/kg) IV/IO~~
 - ~~For patient < 10 kg and > 4 weeks, if blood glucose < 60 mg/dL:
Dextrose 25% (0.25 g/ml) Give 0.5 g/kg (2 ml/kg) IV/IO~~
 - ~~For patient > 10 kg and < 25kg, if glucose less than 60 mg/dL:
Dextrose 50% (0.5 g/mL) Diluted 1:1 Give 0.5 g/kg (2 ml/kg) IV/IO~~

- ~~For patient > 25 kg, if glucose less than 80 mg/dL:
Dextrose 50% (0.5 g/mL) Diluted 1:1 Give 0.5 g/kg (2 ml/kg) IV/IO~~
- May repeat blood glucose. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders, if extended transport time.
- Administer Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to start an IV.
 - ~~Glucagon 0.025 mg/kg IM/IN, , if unable to start an IV. May be repeated one (1) time after twenty (20) minutes for a combined maximum dose of 1 mg.~~
- For suspected narcotic ingestion, may give Naloxone, per ICEMA Reference #7040 - Medication - Standard Orders. ~~Narecan 0.1 mg/kg IV/IM/IN. Do not exceed the adult dosage of 10 mg IV/IM/IN.~~
- Base hospital Station physician may order additional medication dosages and additional fluid boluses.

IV. ALS INTERVENTIONS

- Establish advanced airway as needed.
- Obtain vascular access and place on cardiac monitor.
- For symptomatic hypotension with poor perfusion, consider fluid bolus of 20 ml/kg of NS not to exceed 300 ml NS. May repeat twice for continued signs of inadequate tissue perfusion.
- ~~Check blood glucose level.~~
- Administer Give Dextrose per ICEMA Reference #7040 - Medication - Standard Orders. May repeat blood glucose. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders, if extended transport time.
 - ~~For neonates (0 - 4 weeks), if blood glucose < 35 mg/dL:
Dextrose 25% (0.25 g/ml) Diluted 1:1 Give 0.5 g/kg (4ml/kg) IV/IO~~
 - ~~For patient < 10 kg and > 4 weeks, if blood glucose < 60 mg/dL:
Dextrose 25% (0.25 g/ml) Give 0.5 g/kg (2 ml/kg) IV/IO~~
 - ~~For patient > 10 kg and < 25kg, if glucose less than 60 mg/dL:
Dextrose 50% (0.5 g/mL) Diluted 1:1 Give 0.5 g/kg (2 ml/kg) IV/IO~~
 - ~~For patient > 25 kg, if glucose less than 80 mg/dL:~~

~~———— Dextrose 50% (0.5 g/mL) Diluted 1:1 Give 0.5 g/kg (2 ml/kg) IV/IO~~

~~➤ ——— May repeat blood glucose. Repeat Dextrose if extended transport time.~~

- ~~Administer Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to start an IV.~~

~~➤ ——— Glucagon 0.025 mg/kg IM/IN, if unable to start an IV. May be repeated one (1) time after twenty (20) minutes for a combined maximum dose of 1 mg.~~

- For suspected narcotic ingestion, may give Naloxone per ICEMA Reference #7040 - Medication - Standard Orders ~~Narcan 0.1 mg/kg IV/IM/IN. Do not exceed the adult dosage of 10 mg IV/IM/IN.~~

- Base hospital Station physician may order additional medication dosages and additional fluid boluses.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|--------------------------------------|
| <u>7040</u> | <u>Medications - Standard Orders</u> |