



EMT CERTIFICATION

I. PURPOSE

To define requirements for certification/recertification of an eligible applicant as an Emergency Medical Technician (EMT) recognized in the State of California.

II. ELIGIBILITY

To be eligible for initial certification, an applicant shall meet the following requirements:

1. Be eighteen (18) years of age or older.
2. Complete a criminal record clearance by the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI). Refer to ICEMA Reference #1090 - Criminal History Background Checks (Live Scan) prior to application for certification.
3. Meet one of the following criteria:
 - a. Pass the National Registry of Emergency Medical Technicians (NREMT) - EMT written and skills examination, possess a current and valid NREMT - EMT card and documentation of successful completion of an initial EMT course (California or out-of-state) within the last two (2) years.
 - b. Pass the NREMT - EMT written and skills examination and possess a current and valid out-of state EMT certification card.
 - c. Possess a current and valid NREMT - EMT certification card.
 - d. Possess a current and valid California EMT - Paramedic (EMT-P) license or Advanced EMT (AEMT) or EMT-II certificate. Applicants with licenses and/or certifications under suspension are not eligible.
 - e. Possess a current and valid out-of-state or NREMT - EMT Intermediate or paramedic certification card.

NOTE: *An EMT shall only be certified by one (1) certifying entity during a certification period.*

III. PROCEDURES

Initial Certification

1. Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at <http://www.ICEMA.net>, that includes:
 - a. A copy of a valid government issued photo identification.
 - b. A copy of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent. Online course is acceptable with written documentation of skills portion.
 - c. A copy of completed Live Scan form.
 - d. A copy of a valid NREMT - EMT card.
 - e. Confirmation the applicant is not precluded from certification for reasons defined in the California Health and Safety Code, Section 1798.200.
 - f. Disclosure of any certification or licensure action taken against any health related certification or license, i.e. EMT, Advanced EMT (AEMT), EMT-II or paramedic (EMT-P). This includes any denial of certification by a local EMS agency (LEMSA), or in the case of an EMT-P, licensure denial/action by the State EMS Authority (EMSA), active investigations and actions taken in other states.
2. Submit the established ICEMA and State EMSA fee. Fees paid for certification are not refundable or transferable.
3. The EMT shall be responsible for notifying ICEMA of any and all changes in name, employer, email and/or mailing address within thirty (30) calendar days of change. This notification/change may be made through the ICEMA EMS Credentialing portal found on the ICEMA website at <http://www.ICEMA.net>.
4. The EMT shall be responsible for notifying ICEMA of any and all subsequent arrests and/or convictions, during the certification period.
5. Comply with other requirements as may be set forth herein.

Effective Dates

1. Applicants meeting requirements above in Section II, Item 3.a:

The effective date of certification shall be the date the card is issued. The expiration date shall be the last day of the month two (2) years from the effective date.

2. Applicants meeting requirements above in Section II, Item 3.b - e:

The effective date of certification shall be the date the card is issued. The expiration date shall be the lesser of the following:

- a. The last day of the month two (2) years from the effective date of the initial certification, or
- b. The expiration date of the certificate or license used to establish eligibility.

Recertification

To recertify as an EMT, an applicant shall:

1. Possess a current EMT certification issued in California.
2. Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at <http://www.ICEMA.net>, that includes:
 - a. Copy of a valid government issued photo identification.
 - b. Copy of valid EMT certificate issued in California, unless certified by ICEMA.
 - c. Copy of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent. Online course is acceptable with written documentation of skills portion.
 - d. Copy of completed skills competency verification form, EMSA-SCV (08/10).

Skills competency shall be verified by direct observation of an actual or simulated patient contact. Competency shall be verified by an applicant who is currently certified or licensed as an EMT, AEMT, EMT-P, Registered Nurse, Physician's Assistant, or Physician approved by ICEMA. Verification of skills competency shall be

valid for a maximum of two (2) years for the purpose of applying for recertification.

- e. Proof of at least twenty-four (24) hours of continuing education hours (CEH) from an approved continuing education (CE) provider or complete a twenty-four hour refresher course from an approved EMT training program.
 - f. Confirmation the applicant is not precluded from certification for reasons defined in the California Health and Safety Code, Section 1798.200.
 - g. Disclosure of any certification or licensure action taken against any health related certificate or license, i.e., EMT, AEMT, EMT-II certificate or EMT-P license. This includes any denial of certification by a LEMSA, or in the case of an EMT-P, licensure denial/action by the EMSA, active investigations and actions taken in other states.
3. If required, complete a criminal record clearance by the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI). Refer to ICEMA Reference #1090 - Criminal History Background Checks (Live Scan).
 4. Submit the established ICEMA and State EMSA fee. Fees paid for certification are not refundable or transferable.

NOTE: *If the applicant is not currently an ICEMA certified EMT, the EMSA will require a new Live Scan for ICEMA and an initial State EMSA fee.*

5. The EMT shall be responsible for notifying ICEMA of any and all changes in name, employer, email and/or mailing address within thirty (30) calendar days of change. This notification/change may be made through the ICEMA EMS Credentialing portal found on the ICEMA website at <http://www.ICEMA.net>.
6. The EMT shall be responsible for notifying ICEMA of any and all subsequent arrests and/or convictions, during the certification period.
7. Comply with other requirements as may be set forth herein.

Effective Dates

1. If the EMT recertification requirements are met within six (6) months prior to the expiration date, the effective date of recertification shall be the date immediately following the expiration date of the current certificate. The

certification expiration date will be the last day of the month, two (2) years from the effective date.

2. If requirements are met more than six (6) months prior to the expiration date, the effective date of recertification shall be the date the applicant satisfactorily completes all recertification requirements and has applied for certification. The certification expiration date will be the last day of the month two (2) years from the effective date.

EMT Certification with a Lapsed California EMT, AEMT, EMT-II Certification or EMT-P License

The following requirements apply to applicants who wish to be eligible for recertification after their California EMT certificates have expired:

1. Lapse of less than six (6) months:

Complete all requirements in Items 2 - 7 under Recertification above.
2. Lapse of six (6) months or more, but less than twelve (12) months:
 - a. Complete all requirements in Items 2 - 7 under Recertification above.
 - b. Complete an additional twelve (12) hours of CE for a total of thirty-six (36) hours of training.
3. Lapse of twelve (12) months or more, but less than twenty-four (24) months:
 - a. Complete all requirements in Items 2 - 7 under Recertification above.
 - b. Complete an additional twenty-four (24) hours of ICEMA approved CE for a total of forty-eight (48) hours, *and*
 - c. Pass the NREMT - EMT written and skills examination and acquire a NREMT - EMT card.
4. Lapse of twenty-four (24) months or more:
 - a. Complete an entire EMT course, *and*
 - b. Comply with all requirements of Initial Certification as set forth in this policy.

Expiration While Deployed for Active Duty

A California certified EMT who is a member of the Armed Forces of the United States and whose certification expires while deployed on active duty, or whose certification expires less than six (6) months from the date they return from active duty deployment, with the Armed Forces of the United States, shall have six (6) months from the date they return from active duty deployment to complete requirements for recertification noted above.

In order to qualify for this exception, the applicant shall:

1. Comply with Recertification requirements listed above, except Item 1.
2. Submit proof of membership in the Armed Forces of the United States and documentation of deployment starting and ending dates.
3. Provide documentation of twenty-four (24) hours of CE. Documentation must include proof that CEHs were not obtained more than thirty (30) calendar days prior to effective date of certification prior to activation of duty or greater than six (6) months from the date of deactivation/return from duty.

NOTE: *Applicants whose active duty required the use of EMT skills, may be given CE credit for documented training that meets the requirements of Chapter 11, EMS CE Regulations (Division 9, Title 22, California Code of Regulations) while the applicant was on active duty. The documentation shall include verification from the commanding officer attesting to the classes attended.*

Effective Dates

The effective date of certification shall be the date the card is issued. The expiration date shall be the last day of the month two (2) years from the effective date.

IV. REFERENCES

| Number | Name |
|---------------|--|
| 1090 | Criminal History Background Checks (Live Scan) |
| 3030 | EMT Continuing Education Requirements |
| 5090 | ICEMA Fee Schedule |



EMT-P ACCREDITATION

I. PURPOSE

To define the accreditation requirements for an eligible applicant to practice as an Emergency Medical Technician - Paramedic (EMT-P) within the counties of Inyo, Mono and San Bernardino.

II. ELIGIBILITY

Possess a current California State Paramedic EMT-P License.

III. PROCEDURE

Initial EMT-P Accreditation

1. Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at <http://www.ICEMA.net> that includes:
 - a. Copy of a valid government issued photo identification.
 - b. Copy of a valid California EMT-P license.
 - c. Copy of an EMT-P course completion certificate.
 - d. Copy of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent. Online course is acceptable with written documentation of skills portion.
 - e. Copy (front and back) of a current American Heart Association Advanced Cardiac Life Support (ACLS) card. ACLS cards that are obtained online must have hands on skills evaluation with an approved American Heart Association instructor.
2. Submit the appropriate ICEMA fee. Fees paid for accreditation are not refundable or transferable.
3. Submit verification of employment or intent to employ as an EMT-P by an authorized Advance Life Support (ALS) service provider or by an EMS provider that has formally requested ALS authorization in the ICEMA region.

4. A provisional card may be issued upon receipt of Items 1 - 3 above. The provisional EMT-P may function using the approved State Basic Scope of Practice while working with a partner who is fully accredited as an EMT-P within the ICEMA region for thirty (30) calendar days from receipt of completed application. The ICEMA Medical Director may extend this provisional status for just cause.
5. Complete an ALS provider conducted orientation (not to exceed eight (8) classroom hours) of ICEMA protocols, policies and optional scope of practice skills. This requirement is waived for EMT-P accreditation applicants who graduate from an approved EMT-P training institution in the ICEMA region.
6. Pass the ICEMA accreditation written examination with a minimum score of eighty percent (80%).
 - a. A candidate who fails to pass the ICEMA accreditation exam on the first attempt will have to pay the ICEMA approved fee and re-take the exam with a minimum passing score of eighty-five (85%).
 - b. A candidate who fails to pass the ICEMA accreditation exam on the second attempt will have to pay the ICEMA approved fee, and provide documentation of eight (8) hours of remedial training in ICEMA protocols, policies/procedures given by their EMS/QI Coordinator and pass the ICEMA exam with a minimum passing score of eighty-five (85%).
 - c. If the candidate fails to pass the ICEMA accreditation exam on the third attempt, the candidate will be ineligible for accreditation for a period of six (6) months, at which time candidate must reapply and successfully complete all initial accreditation requirements.
7. Successfully complete a supervised field evaluation to consist of no less than five (5), but no more than ten (10) ALS responses. This requirement is waived for applicants who graduate from an approved EMT-P training institution in the ICEMA region, and meet **all** of the following conditions:
 - a. Course completion was within six (6) months of the date of application for accreditation.
 - b. Field internship was obtained within the ICEMA region with an ICEMA approved EMT-P preceptor.
8. The Medical Director shall evaluate any candidate who fails to complete the field evaluation and may recommend further evaluation or training as required. Failure to complete the supervised field evaluation may constitute failure of the entire process.

9. The EMT-P shall be responsible for notifying ICEMA of any and all changes in name, employer, email and/or mailing address within thirty (30) calendar days of change. This notification/change may be made through the ICEMA EMS Credentialing portal found on the ICEMA website at <http://www.ICEMA.net>.

Reverification

1. Possess a valid California EMT-P license and ICEMA accreditation. If ICEMA accreditation has lapsed for more than one (1) year, the applicant must comply with the initial accreditation procedures.
2. Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at <http://www.ICEMA.net> that includes:
 - a. Copy of a valid government issued photo identification.
 - b. Copy of a valid California EMT-P license.
 - c. Copy of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent. Online course is acceptable with written documentation of skills portion.
 - d. Copy (front and back) of a valid American Heart Association Advanced Cardiac Life Support (ACLS) card. ACLS cards that are obtained online must have hands on skills evaluation with an approved American Heart instructor.
3. Submit the appropriate ICEMA fee. Fees paid for accreditation are not refundable or transferable.
4. Submit verification of employment or intent to employ as an EMT-P by an authorized ALS service provider or by an EMS provider that has formally requested ALS authorization by ICEMA.
5. The EMT-P shall be responsible for notifying ICEMA of any and all changes in name, employer, email and/or mailing address within thirty (30) calendar days of change. This notification/change may be made through the ICEMA EMS Credentialing portal found on the ICEMA website at <http://www.ICEMA.net>.

IV. REFERENCE

| <u>Number</u> | <u>Name</u> |
|----------------------|--------------------|
| 5090 | ICEMA Fee Schedule |



MICN AUTHORIZATION - Base Hospital, Administrative, Flight Nurse, Critical Care Transport

I. PURPOSE

To define the requirements required for a Registered Nurse (RN) to obtain a Mobile Intensive Care Nurse (MICN) authorization within the ICEMA region.

II. DEFINITIONS

Advanced Life Support (ALS): Special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of a local EMS system at the scene of an emergency, during transport to an acute care hospital, during interfacility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital.

Mobile Intensive Care Nurse (MICN): A Registered Nurse (RN) who has been deemed qualified and authorized by the ICEMA Medical Director to provide ALS services or to issue physician directed instructions to EMS field personnel within an Emergency Medical Services (EMS) system according to ICEMA developed standardized procedures and consistent with statewide guidelines.

Mobile Intensive Care Nurse - Base Hospital (MICN-BH): An ICEMA authorized MICN who has applied for, completed and achieved all ICEMA requirements for “MICN-BH” designation and qualifies as a MICN-BH to issue physician directed instructions to EMS field personnel while working for a recognized base hospital within the ICEMA region.

Mobile Intensive Care Nurse - Administrative (MICN-A): An ICEMA authorized MICN who has applied for, completed and achieved all ICEMA requirements for “MICN-A” designation and qualifies as a MICN-A to work in an administrative/supervisory capacity for an ALS provider approved by ICEMA.

Mobile Intensive Care Nurse - Flight (MICN-F): An ICEMA authorized MICN who has received additional training related to flight operations applied for, completed and achieved all ICEMA requirements for “MICN-F” designation and qualifies to provide ALS services during flight operations aboard air ambulances and/or air rescue aircraft.

Mobile Intensive Care Nurse - Critical Care Transport (MICN-C): An ICEMA authorized MICN who has received additional training related to critical care transport and achieved all ICEMA requirements for “MICN-C” designation and qualifies to provide ALS services during critical care ground transports by approved EMS providers.

III. POLICY

1. All RNs working in a capacity that will require them to provide ALS services or to issue physician directed instructions to prehospital emergency medical care personnel within the ICEMA region shall submit a completed application and meet criteria established by the ICEMA Medical Director to provide services of a MICN in the ICEMA region.
2. All MICNs are responsible to notify ICEMA of any and all changes in name, email and/or mailing address within thirty (30) calendar days of change. This notification/change may be made through the ICEMA EMS Credentialing portal found on the ICEMA website at <http://www.ICEMA.net>.
2. All MICNs are responsible to notify ICEMA immediately of termination of their employment with an approved entity and/or employment by another ICEMA approved base hospital and/or non-base hospital employer. If employment with an approved EMS provider is terminated, the MICN authorization will be rescinded unless proof of other qualifying employment is received by ICEMA within thirty (30) days.
3. MICNs may hold authorization in multiple categories but must apply and submit all required documentation and fees. MICN authorization may be added to or converted to another MICN category by meeting all requirements for authorization in that category.

IV. PROCEDURE

General Procedures for Authorization

1. Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at <http://www.ICEMA.net> for each MICN category applied for that includes:
 - a. Copy of a valid government issued photo identification.
 - b. Copy of a valid California RN license.
 - c. Proof of completion of an ICEMA approved MICN course with a passing score of at least eighty percent (80%).

- d. Copy of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent. Online course is acceptable with written documentation of skills portion.
 - e. Copy (front and back) of a valid American Heart Association Advanced Cardiac Life Support (ACLS) card. ACLS cards that are obtained online must have hands on skills evaluation with an approved American Heart Association instructor.
2. Submit the established ICEMA fee. Additional categories may be applied for without additional fee. Authorization cards issued within six (6) months of nursing license expiration is exempt from reauthorization fee. Fees paid for authorization are not refundable or transferable.
 3. Submit verification of employment from a designated Base Hospital or authorized EMS Aircraft, Air Rescue or Critical Care Transport provider within the ICEMA region.
 4. Pass the ICEMA written examination with a minimum score of eighty percent (80%).
 - a. An applicant who fails to pass the ICEMA written examination on the first attempt with a minimum score of 80% must pay the ICEMA approved fee, re-take the examination and pass with a score of at least 85%.
 - b. An applicant who fails to pass the ICEMA written examination on the second attempt must pay the ICEMA approved fee, provide documentation of eight (8) hours of remedial training given by their Paramedic Liaison Nurse (PLN) or Medical Director relating to ICEMA protocols, policies or procedures and pass the ICEMA written examination with a minimum score of 85%.
 - c. An applicant who fails to pass the ICEMA written examination on the third attempt may be allowed to retest at the discretion of the ICEMA Medical Director.
 5. All authorization cards issued by ICEMA will be effective from the date all requirements are achieved and expire on the same date as the California RN License, provided all requirements continue to be met.

MICN-BH Initial Authorization

1. Submit items listed in Items 1 - 4 above (General Procedures for Authorization) within six (6) months of course completion.

2. Upon passing the ICEMA written examination, ICEMA will issue a provisional MICN card.
3. A provisional MICN-BH may function under the direct supervision of the base hospital physician, PLN or ICEMA approved designee for a maximum of six (6) months. The supervising individual must sign all MICN call forms. This timeframe may be extended upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.
4. The PLN will choose three (3) recordings for review (one trauma, one medical and one other) and submit them to their partnered base hospital PLN for review.
5. When three (3) recordings have been approved as noted in Item 4 above, *ICEMA will issue a MICN card with the same expiration date as the candidate's RN license.*
6. Failure to complete the entire process within one (1) year of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

MICN-BH Continuous Authorization

1. Submit items listed in Items 1 - 3 above (General Procedures for Authorization). Upon submission of a completed application, ICEMA will issue a MICN card with the same expiration date as the candidate's RN license.

MICN-BH Authorization by Challenge Examination

1. Meet one (1) of the following eligibility requirements:
 - a. MICN in another county if approved by the ICEMA Medical Director.
 - b. An eligible RN who has been a MICN in ICEMA region who has let authorization lapse longer than six (6) months.
2. Submit items listed in Items 1 - 4 above (General Procedures for Authorization) and Items 2 - 5 above (MICN-BH Initial Authorization).
3. Failure to complete the entire process within six (6) months of application date constitutes failure of the entire process. The timeframe may be extended by the ICEMA Medical Director upon receipt of a request in writing from either the candidate or PLN outlining any extenuating circumstances.

MICN-A Authorization/Reauthorization for RNs Working in a Non-Base Hospital

Submit items listed in Items 1 - 3 above (General Procedures for Authorization).

MICN-F Initial Authorization

1. Submit items listed in Items 1 - 4 above (General Procedures for Authorization). The ICEMA Medical Director may waive requirements for testing for MICNs currently authorized in another category or otherwise qualified by knowledge and experience in the ICEMA region.
2. Complete and submit proof of additional training related to flight operations and an orientation of ICEMA protocols and policies provided by the employing EMS aircraft provider.

MICN-F Reauthorization

Submit items listed in Items 1 - 3 above (General Procedures for Authorization).

MICN-C Initial Authorization

1. Submit items listed in Items 1 - 4 above (General Procedures for Authorization). The ICEMA Medical Director may waive requirements for testing for MICNs currently authorized in another category or otherwise qualified by knowledge and experience in the ICEMA region.
2. Complete and submit proof of additional training related to critical care transport operations and an orientation (not to exceed eight (8) classroom hours) of ICEMA protocols and policies provided by the employing ALS provider agency.

MICN-C Reauthorization

Submit items listed in Items 1 - 3 above (General Procedures for Authorization).

V. REFERENCE

| <u>Number</u> | <u>Name</u> |
|----------------------|--------------------|
| 5090 | ICEMA Fee Schedule |



EMT/AEMT INCIDENT INVESTIGATION, DETERMINATION OF ACTION, NOTIFICATION, AND ADMINISTRATIVE HEARING PROCESS

I. PURPOSE

To establish a policy and procedure governing reportable situations and the evaluation and determination regarding whether or not disciplinary cause exists.

II. POLICY

Any information received from any source, including discovery through medical audit or follow-up on complaints, which suggests a violation of, or deviation from, State or local EMS laws, regulations, policies, procedures or protocols will be evaluated pursuant to this policy and consistent with the California Code of Regulations, Title 22, Division 9, Chapter 6.

III. DEFINITIONS

Certificate: A valid Emergency Medical Technician (EMT) certificate issued pursuant to the California Health and Safety Code, Division 2.5.

Certifying Entity: The ICEMA Medical Director, a public safety agency or the office of the State Fire Marshal if the agency has a training program for EMT or Advanced EMT (AEMT) personnel that is approved pursuant to the standards established in the California Health and Safety Code, Section 1797.109.

Certificate Holder: For the purpose of this policy, shall mean the holder of a certificate, as that term is described above.

Discipline: Either a disciplinary plan taken by a relevant employer pursuant to the California Code of Regulations, Section 100206, or certification action taken by a medical director pursuant to the California Code of Regulations, Section 100204, or both a disciplinary plan and certification action.

Disciplinary Cause: An act that is substantially related to the qualifications, functions, and duties of an EMT or AEMT and is evidence of a threat to the public health and safety, per California Health and Safety Code, Section 1798.200.

Disciplinary Plan: A written plan of action that can be taken by a relevant employer as a consequence of any action listed in California Health and Safety Code, Section 1798.200 (c).

Functioning Outside of Medical Control: Prehospital emergency medical care which is not authorized by, or is in conflict with ICEMA policies, procedures, or

protocols, or any treatment instructions issued by the base hospital providing immediate medical direction.

Model Disciplinary Orders (MDO): The Recommended Guidelines for Disciplinary Orders and Conditions of Probation (EMSA Document #134) which were developed to provide consistent and equitable discipline in cases dealing with disciplinary cause.

Notification of Defense: Notification sent to ICEMA by certificate holder that states certificate holder intends to defend actions through an administrative hearing process.

Prehospital Emergency Medical Personnel: People who have been certified, authorized or accredited as qualified to provide prehospital emergency medical care pursuant to California Health and Safety Code, Division 2.5.

Relevant Employer(s): Employers who provide ambulance services and/or a public safety agency where the EMT or AEMT works or was working for at the time of the incident under review, either as a paid employee or a volunteer.

IV. PROCEDURE

Responsibilities of Relevant Employer

1. Under the provisions of the California Code of Regulations and this policy, relevant employers:
 - a. May conduct investigations to determine disciplinary cause.
 - b. Upon determination of disciplinary cause, the relevant employer may develop and implement, a disciplinary plan, in accordance with the MDOs.
2. The relevant employer shall submit that disciplinary plan to ICEMA along with the relevant findings of the investigation related to disciplinary cause, within three (3) working days of adoption of the disciplinary plan.
3. The employer's disciplinary plan may include a recommendation that the medical director consider taking action against the holder's certificate to include denial of certification, suspension of certification, revocation of certification, or placing a certificate on probation.
4. The relevant employer shall notify the ICEMA Medical Director within three (3) working days after an allegation has been validated as potential for disciplinary cause.

5. The relevant employer shall notify the ICEMA Medical Director within three (3) working days of the occurrence of any of following:
 - a. The employee is terminated or suspended for a disciplinary cause,
 - b. The employee resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause, or
 - c. The employee is removed from employment-related duties for a disciplinary cause after the completion of the employer's investigation.

Jurisdiction of the ICEMA Medical Director

1. The ICEMA Medical Director, or in the case where the certificate was issued by a non-local EMS agency (LEMSA) within the ICEMA region, shall conduct investigations to validate allegations for disciplinary cause when the EMT or AEMT is not an employee of a relevant employer or the relevant employer does not conduct an investigation. Upon determination of disciplinary cause, the ICEMA Medical Director may take certification action as necessary against a certificate holder.
2. The ICEMA Medical Director may, upon determination of disciplinary cause and according to the provisions of this policy, take certification action against an EMT or AEMT to deny, suspend, revoke, or place a certificate holder on probation, upon the findings of any of the actions listed in the California Health and Safety Code, Section 1798.200 (c) and for which any of the following conditions are true:
 - a. The relevant employer, after conducting an investigation, failed to impose discipline for the conduct under investigation, or the ICEMA Medical Director makes a determination that discipline imposed by the relevant employer was not in accordance with the MDOs and the conduct of the certificate holder constitutes grounds for certification action.
 - b. The ICEMA Medical Director determines, following an investigation conducted in accordance with this policy, that the conduct requires certification action.
3. The ICEMA Medical Director, after consultation with the relevant employer or without consultation when no relevant employer exists, may temporarily suspend, prior to a hearing, a certificate holder upon a determination of the following:

- a. The EMT or AEMT has engaged in acts or omissions that constitute grounds for revocation of the certificate; and
 - b. Permitting the EMT or AEMT to continue to engage in certified activity without restriction poses an imminent threat to the public health and safety.
4. If the ICEMA Medical Director takes any certification action, ICEMA shall notify the State EMS Authority of the findings, the certification action taken and enter the information into the State Registry.

Evaluation of Information

1. A relevant employer who receives an allegation of conduct listed in the California Health and Safety Code, Section 1798.200 (c) and the allegation is validated, shall notify the ICEMA Medical Director, within three (3) working days, of the certificate holder's name, certification number, and the allegation(s).
2. When ICEMA receives a complaint against a certificate holder, ICEMA shall forward the original complaint and any supporting documentation to the relevant employer for investigation, if there is a relevant employer, within three (3) working days of receipt of the information. If there is no relevant employer or the relevant employer does not wish to investigate the complaint, the ICEMA Medical Director shall perform the investigation.
3. The relevant employer or ICEMA Medical Director shall conduct an investigation of the allegations in accordance with the provisions of this policy, if warranted.

Investigations Involving Firefighters

1. The rights and protections described in Chapter 9.6 of the Government Code shall only apply to a firefighter during events and circumstances involving the performance of his or her official duties.
2. All investigations involving certificate holders who are employed by a public safety agency as a firefighter shall be conducted in accordance with Chapter 9.6 of the Government Code, Section 3250 et. seq.

Due Process

The certification action process shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

Determination of Action

1. Certification action shall be taken as a result of the findings of the investigation.
2. Upon determining the disciplinary or certification action to be taken, the relevant employer or ICEMA Medical Director shall complete and place in the personnel file or any other file used for any personnel purposes by the relevant employer or ICEMA, a statement certifying the decision made and the date the decision was made. The decision must contain findings of fact and a determination of issues, together with the disciplinary plan and the date the disciplinary plan shall take effect.
3. In the case of a temporary suspension order pursuant to the California Code of Regulations, Section 100209 (c), it shall take effect upon the date the notice required by the California Code of Regulations, Section 100213, is mailed to the certificate holder.
4. For all other certification actions, the effective date shall be thirty (30) days from the date the notice is mailed to the applicant for, or holder of, a certificate unless another time is specified or an appeal is made.

Temporary Suspension Order

1. The ICEMA Medical Director may temporarily suspend a certificate prior to hearing if, the certificate holder has engaged in acts or omissions that constitute grounds for denial or revocation according to Section 100216(c) of the California Code of Regulations and if in the opinion of the ICEMA Medical Director permitting the certificate holder to continue to engage in certified activity would pose an imminent threat to the public health and safety.
2. Prior to, or concurrent with, initiation of a temporary suspension order of a certificate pending hearing, the ICEMA Medical Director shall consult with the relevant employer.
3. The notice of temporary suspension pending hearing shall be served by registered mail or by personal service to the certificate holder immediately, but no longer than three (3) working days from making the decision to issue the temporary suspension. The notice shall include the allegations that allowing the certificate holder to continue to engage in certified activities would pose an imminent threat to the public health and safety. Within three (3) working days of the initiation of the temporary suspension by ICEMA, ICEMA and relevant employer shall jointly investigate the allegation in order for the ICEMA Medical Director to make a determination of the continuation of the temporary suspension.

- a. All investigatory information, not otherwise protected by the law, held by ICEMA and the relevant employer shall be shared between ICEMA, the relevant employer and the certificate holder via facsimile transmission or overnight mail relative to the decision to temporarily suspend.
- b. ICEMA shall serve within fifteen (15) calendar days an accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code (Administrative Procedures Act).
- c. The temporary suspension order shall be deemed vacated if ICEMA fails to serve an accusation within fifteen (15) calendar days or fails to make a final determination on the merits within fifteen (15) calendar days after the Administrative Law Judge (ALJ) renders a proposed decision.

Final Determination of Certification Action

Upon determination of certification action following an investigation, and appeal of certification action pursuant to Section 100211.1 of the California Code of Regulations, if the respondent chooses, the ICEMA Medical Director may take the following final actions on an EMT or AEMT certificate:

1. Place the certificate holder on probation
2. Suspension
3. Denial
4. Revocation

Placement of a Certificate Holder on Probation

The ICEMA Medical Director may place a certificate holder on probation any time an infraction or performance deficiency occurs which indicates a need to monitor the certificate holder's conduct in the EMS system, in order to protect the public health and safety. The term of the probation and any conditions shall be in accordance with the MDOs. The ICEMA Medical Director may revoke the EMT or AEMT certificate if the certificate holder fails to successfully complete the terms of probation.

Suspension of a Certificate

1. The Medical Director may suspend an individual's EMT or AEMT certificate for a specified period of time for disciplinary cause in order to protect the public health and safety.

2. The term of the suspension and any conditions for reinstatement shall be in accordance with the MDOs.
3. Upon the expiration of the term of suspension, the individual's certificate shall be reinstated only when all conditions for reinstatement have been met. The ICEMA Medical Director shall continue the suspension until all conditions for reinstatement have been met.
4. If the suspension period will run past the expiration date of the certificate, the EMT or AEMT shall meet the recertification requirements for certificate renewal prior to the expiration date of the certificate.

Denial or Revocation of a Certificate

1. The ICEMA Medical Director may deny or revoke any EMT or AEMT certificate for disciplinary cause that has been investigated and verified by application of this policy.
2. The ICEMA Medical Director shall deny or revoke any EMT or AEMT certificate if any of the following apply to the applicant:
 - a. Has committed any sexually related offense specified under Section 290 of the Penal Code.
 - b. Has been convicted of murder, attempted murder, or murder for hire.
 - c. Has been convicted of two (2) or more felonies.
 - d. Is on parole or probation for any felony.
 - e. Has been convicted and released from incarceration for said offense during the preceding fifteen (15) years for the crime of manslaughter or involuntary manslaughter.
 - f. Has been convicted and released from incarceration for said offense during the preceding ten (10) years for any offense punishable as a felony.
 - g. Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to the use, sale, possession, or transportation of narcotics or addictive or dangerous drugs.
 - h. Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to force, threat, violence, or intimidation.

- i. Has been convicted within the preceding five (5) years of any theft related misdemeanor.

NOTE: *“Felony” or “offense punishable as a felony” refers to an offense for which the law prescribes imprisonment in the state prison as either an alternative or the sole penalty, regardless of the sentence the particular defendant received.*

4. The ICEMA Medical Director may deny any application for certification or revoke an EMT or AEMT certificate if any of the following apply to the applicant:
 - a. Has committed any act involving fraud or intentional dishonesty for personal gain within the preceding seven (7) years.
 - b. Is required to register pursuant to the California Health and Safety Code, Section 11590.
5. Sections 1 and 2 above shall not apply to convictions that have been pardoned by the Governor, and shall only apply to convictions where the applicant/certificate holder was prosecuted as an adult.
6. Sections 1 and 2 shall not apply to those EMT or AEMTs who obtain their EMT or AEMT certificate prior to July 1, 2010; unless:
 - a. The certificate holder is convicted of any misdemeanor or felony after July 1, 2010.
 - b. The certificate holder committed any sexually related offense specified under Section 290 of the Penal Code.
 - c. The certificate holder failed to disclose to the certifying entity any prior convictions when completing his/her application for initial EMT or AEMT certification or certification renewal. Nothing in this Section shall negate an individual’s right to appeal a denial of an EMT certificate pursuant to this policy.
7. Certification action by the ICEMA Medical Director shall be valid statewide and honored by all certifying entities for a period of at least twelve (12) months from the effective date of the certification action. An EMT or AEMT whose application was denied, or an EMT or AEMT whose certification was revoked by a medical director shall not be eligible for EMT or AEMT application by any other certifying entity for a period of at least twelve (12) months from the effective date of the certification action. EMT or AEMTs whose certification are placed on probation must complete their probationary requirements with the LEMSA that imposed the probation.

Notification of Final Decision of Certification Action

1. For the final decision of certification action, the ICEMA Medical Director shall notify the applicant/certificate holder and his/her relevant employer(s) of the certification action within ten (10) working days after making the final determination.
2. The notification of final decision shall be served by registered mail or personal service and shall include the following information:
 - a. The specific allegations or evidence which resulted in the certification action;
 - b. The certification action(s) to be taken, and the effective date(s) of the certification action(s), including the duration of the action(s);
 - c. Which certificate(s) the certification action applies to in cases of holders of multiple certificates;
 - d. A statement that the certificate holder must report the certification action within ten (10) working days to any other LEMSA and relevant employer in whose jurisdiction s/he uses the certificate.



FLIGHT NURSE AUTHORIZATION

PURPOSE

To define the requirements for EMS Aircraft Flight Nurse Authorization within the ICEMA Region.

PROCEDURE

Initial Authorization

1. Fee as set by ICEMA. The fee is not refundable or transferable.
2. Written verification of employment with an authorized EMS Aircraft provider within the ICEMA Region.

If employment with authorized EMS Aircraft provider is terminated, Flight Nurse Authorization will be rescinded unless proof of other qualifying EMS Aircraft employment is received by ICEMA within thirty (30) days.

3. Copy of current government issued photo identification (i.e. Drivers License).
4. Copy of front and back of a current, signed ACLS Card.
5. Copy of front and back of current California RN License.
6. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.
7. Proof of attendance of four (4) hour Flight Nurse Orientation course.
8. Upon passing the local authorization written examination with a minimum score of eighty percent (80%), a Flight Nurse Authorization card will be issued with the same expiration date as the candidate's RN license.
9. Flight Nurse Authorizations issued within six (6) months of nursing license expiration are exempt from reauthorization fee.

REAUTHORIZATION

Submit the Flight Nurse Reauthorization application form with the following:

1. Fee as set by ICEMA. The fee is not refundable or transferable.
2. Written verification of employment with an authorized EMS Aircraft provider within the ICEMA Region.

If employment with authorized EMS Aircraft provider is terminated, Flight Nurse Authorization will be rescinded unless proof of other qualifying EMS Aircraft employment is received within thirty (30) days.

3. Copy of current government issued photo identification (i.e. Drivers License).
4. Copy of front and back of a current, signed ACLS Card.
5. Copy of front and back of current California RN License.
6. Photo taken at ICEMA when application is submitted. Applicant may submit a driver's license size photo (no tinted glasses or hats) with their application.



CRIMINAL HISTORY BACKGROUND CHECKS (LIVE SCAN)

I. PURPOSE

To provide information for Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) background checks for applicants applying for certification/recertification as an Emergency Medical Technician (EMT) or Advanced Emergency Medical Technician (AEMT) recognized in California.

II. GENERAL INFORMATION

Effective July 1, 2010, all EMTs/AEMTs must have a criminal history background check (Live Scan) on file with the certifying entity.

Live Scan Forms

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

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

Fees

For a list of current fees charged by the DOJ/FBI, go to <http://oag.ca.gov/fingerprints/publications/contact.php>. Fees related to certification are listed under "Certificates/Licenses/Permits". Additionally, each Live Scan agency charges a "rolling fee" that varies. Applicant is required to pay these fees to the Live Scan agency when submitting fingerprints.

Live Scan Agencies

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

Conviction History

ICEMA will review all criminal convictions to determine EMT/AEMT certification eligibility. Decisions will be based on applicable State statutes and regulations and a careful review of documentation. If an applicant is denied, he/she has the right to request a hearing. In addition to certification actions, an EMT/AEMT certificate may be suspended or revoked based upon criminal history information. Applicants with a criminal conviction or who are involved in an active prosecution may

experience a delay. Applicants should submit a written explanation explaining the case and copies of court documents to facilitate the decision process. For further information, refer to ICEMA Reference #1070 - EMT/AEMT Incident Investigations, Determination of Action, Notification, and Administration Hearing Process.

What to Submit with Your Certification Application

Applicants must submit a copy of the Live Scan form with their certification paperwork. For additional certification information, refer to ICEMA Reference #1030 - EMT Certification and #1100 - AEMT Certification.

III. REFERENCES

| <u>Number</u> | <u>Name</u> |
|----------------------|---|
| 1030 | EMT Certification |
| 1070 | EMT/AEMT Incident Investigations, Determination of Action, Notification, and Administration Hearing Process |
| 1100 | AEMT Certification |



AEMT CERTIFICATION

I. PURPOSE

To define requirements for the certification/recertification of an eligible applicant as an Advanced Emergency Medical Technician (AEMT) recognized in the State of California by the ICEMA Medical Director.

II. ELIGIBILITY

To be eligible for initial certification, an applicant shall meet the following requirements:

1. Possess a current EMT certificate in the State of California and an AEMT course completion record or other documented proof of successful completion of the topics contained in an approved AEMT training program.
2. Complete a criminal record clearance by the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI). Refer to ICEMA Reference #1090 - Criminal History Background Checks (Live Scan).
3. Meet one of the following criteria:
 - a. Pass the National Registry of Emergency Medical Technicians (NREMT) - AEMT written and skills examination, possess a current and valid NREMT - AEMT card and documentation of successful completion of an AEMT course.
 - b. Pass the National Registry of Emergency Medical Technicians (NREMT) - AEMT written and skills examination and possess a current and valid out-of state AEMT certification card.
 - c. Possess a current and valid NREMT - AEMT card.
 - d. Possess a current and valid out-of-state or NREMT - AEMT certification or EMT-P license.
 - e. Possess a valid California license as a Physician, Registered Nurse, or a Physician Assistant and:
 - 1) Documentation that applicant's training included the required course content contained in the U.S. Department of Transportation (DOT) National EMS Education Standards.

- 2) Documentation of five (5) ALS contacts in a prehospital field internship.

NOTE: *An applicant currently licensed in California as an EMT-P is deemed to be certified as an AEMT with no further testing required EXCEPT when the EMT-P license is under suspension. In the case of an EMT-P license under suspension, the EMT-P shall apply to ICEMA for AEMT initial certification.*

III. PROCEDURES

Initial Certification

1. Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at <http://www.ICEMA.net>, that includes:
 - a. Copy of a valid government issued photo identification.
 - b. Copy of valid EMT certification card issued in California.
 - c. Copy of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent. Online course is acceptable with written documentation of skills portion.
 - d. Copy of completed Live Scan form.
 - e. Copy of valid NREMT - AEMT card.
 - f. Confirmation the applicant is not precluded from certification for reasons defined in the California Health and Safety Code, Section 1798.200
 - g. Disclosure of any certification or licensure action taken against any health related certification/license (EMT, AEMT, EMT-II or EMT-P). This includes any denial of certification by a local EMS agency (LEMSA), or in the case of an EMT-P, licensure denial/action by the State EMS Authority (EMSA), active investigations and actions taken in other states.
2. Submit the established ICEMA and EMSA fee. Fees paid for certification are not refundable or transferable.

NOTE: *If the applicant is not currently an ICEMA certified EMT, the State EMSA will require a new Live Scan for ICEMA and an initial State EMSA fee.*

3. The AEMT shall be responsible for notifying ICEMA of any and all changes in name, employer, email and/or mailing address within thirty (30) calendar days of change. This notification/change may be made through the ICEMA EMS Credentialing portal found on the ICEMA website at <http://www.ICEMA.net>.
4. The AEMT shall be responsible for notifying ICEMA of any and all subsequent arrests and/or convictions, during the certification period.
5. Comply with other reasonable requirements, as may be established by ICEMA.

Effective Dates

The effective date of certification shall be the date the card is issued. The expiration date shall be the last day of the month two (2) years from the effective date.

Recertification

To recertify as an AEMT, an applicant shall:

1. Possess a current AEMT certification issued in California.
2. Submit a completed online application using the ICEMA EMS Credentialing portal found on the ICEMA website at <http://www.ICEMA.net>, that includes:
 - a. Copy of a valid government issued photo identification.
 - b. Copy of valid AEMT certification card issued in California, unless certified by ICEMA.
 - c. Copy of a valid American Heart Association BLS Healthcare Provider, American Red Cross Professional Rescuer CPR card or equivalent. Online course is acceptable with written documentation of skills portion.
 - d. Copy of completed AEMT skills competency verification form, EMSA-AEMT.

Skills competency shall be verified by direct observation of an actual or simulated patient contact. Skills competency shall be verified by an applicant who is currently certified or licensed as an AEMT,

EMT-P, Registered Nurse, Physician Assistant, or Physician and who shall be designated as part of a skills competency verification process approved by ICEMA.

- e. Proof of at least thirty-six (36) hours of continuing education (CE) hours from an approved CE provider.
 - f. Confirmation the applicant is not precluded from certification for reasons defined in the California Health and Safety Code, Section 1798.200.
 - g. Disclosure of any certification or licensure action taken against any health related certification/license (EMT, AEMT, EMT-II or EMT-P). This includes any denial of certification by a local EMS agency (LEMSA), or in the case of an EMT-P, licensure denial/action by the State EMS Authority (EMSA), active investigations and actions taken in other states.
3. Submit the established ICEMA and State EMSA fee. Fees paid for certification are not refundable or transferable.

NOTE: *If the applicant is not currently an ICEMA certified EMT, the EMSA will require a new Live Scan for ICEMA and an initial State EMSA fee.*

4. The AEMT shall be responsible for notifying ICEMA of any and all changes in name, employer, email and/or mailing address within thirty (30) calendar days of change. This notification/change may be made through the ICEMA EMS Credentialing portal found on the ICEMA website at <http://www.ICEMA.net>.
5. The AEMT shall be responsible for notifying ICEMA of any and all subsequent arrests and/or convictions, during the certification period.
6. Comply with other requirements as may be set forth herein.

Effective Dates

If the AEMT recertification requirements are met within six (6) months prior to the expiration date, the effective date of certification shall be the date immediately following the expiration date of the current certificate. The certification expiration date will be the final day of the final month of the two (2) year period.

If the AEMT recertification requirements are met greater than six (6) months prior to the expiration date, the effective date of certification shall be the date the card is issued. The expiration date shall be the last day of the month two (2) years from the effective date.

Expiration While Deployed for Active Duty

An applicant who is deployed for active duty with a branch of the Armed Forces of the United States, whose AEMT certificate expires during the time the applicant is on active duty or less than six (6) months from the date the applicant is deactivated/released from active duty, may be given an extension of the expiration date of his/her AEMT certificate for up to six (6) months from the date of the applicant's deactivation/release from active duty in order to meet the renewal requirements for his/her AEMT certificate upon compliance with the following provisions:

1. Provide documentation from the respective branch of the Armed Forces of the United States verifying the applicant's dates of activation and deactivation/release from active duty.
2. If there is no lapse in certification, meet the requirements of "Recertification" section of this policy. If there is a lapse in certification, meet the requirements listed in the "Recertification After Lapse in Certification" section of this policy.
3. Provide documentation showing that the CE activities submitted for the certification renewal period were taken not earlier than thirty (30) days prior to the effective date of the applicant's AEMT certificate that was valid when he/she was activated for duty and not later than six (6) months from the date of deactivation/release from active duty.

For an applicant whose active duty required him/her to use his/her AEMT skills, credit may be given for documented training that meets the requirements contained in ICEMA Reference #3030 - EMT Continuing Education Requirements while the applicant was on active duty. The documentation shall include verification from the applicant's Commanding Officer attesting to the classes attended.

Recertification After Lapse in Certification

The following requirements shall apply to an applicant whose AEMT certification has lapsed to be eligible for recertification:

1. Lapse of less than six (6) months:

Complete all requirements in Items 2 - 6 under AEMT Recertification above.
2. Lapse of six (6) months or more, but less than twelve (12) months:
 - a. Complete all requirements in Items 2 - 6 under AEMT Recertification above.

- b. Complete an additional twelve (12) hours of continuing education for a total of forty-eight (48) hours of training.
- 3. Lapse of twelve (12) months or more, but less than twenty-four (24) months:
 - a. Complete all requirements in Items 2 - 6 under AEMT Recertification above.
 - b. Complete an additional twenty-four (24) hours of continuing education for a total of sixty (60) hours of training.
 - c. Pass the NREMT - AEMT certifying exam.
- 4. Lapse of twenty-four (24) months or more:
 - a. Complete an entire AEMT course, *and*
 - b. Comply with all requirements of Initial Certification as set forth in this policy.

Effective Dates

The effective date of certification shall be the date the card is issued. The expiration date shall be the last day of the month two (2) years from the effective date.

IV. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|--|
| 1090 | Criminal History Background Checks (Live Scan) |
| 3030 | EMT Continuing Education Requirements |
| 5090 | ICEMA Fee Schedule |



2014/2015 FEE SCHEDULE

PURPOSE

To establish the ICEMA fee schedule for 2014 - 2015.

FEE SCHEDULE

ADMINISTRATION

1. Transportation (annual)
 - A. EMS Prehospital Provider Permit/Authorization\$2,000.00
 - B. EMS Prehospital Provider Permit/Authorization -
Late Penalty\$315.00
 - C. EMS Drug and Equipment Inspection \$400.00/unit
2. EMS Certification/Authorization Fees (bi-annual)
 - A. Mobile Intensive Care Nurse (MICN)
 1. Authorization\$100.00
 2. Reauthorization\$100.00
 3. Challenge\$225.00
 - B. Flight Nurse (FN)
 1. Authorization\$60.00
 2. Reauthorization\$60.00
 - C. Emergency Medical Technician - Paramedic (EMT-P)
 1. Accreditation\$100.00
 2. Re-verification\$60.00
 3. Failure to Complete EMT-P Continuing Education -
Penalty Fee (per course)\$100.00

- D. Emergency Medical Technician (EMT)
 - 1. Certification\$60.00
 - 2. Recertification\$60.00
 - 3. EMT Skills Verification.....\$75.00
- E. Emergency Medical Services Dispatcher (EMSD)
 - 1. Certification\$45.00
 - 2. Recertification\$45.00
 - 3. Challenge\$60.00
- F. Emergency Medical Responders (EMR)
 - 1. Certification\$60.00
 - 2. Recertification\$60.00
 - 3. Challenge\$75.00
- G. Accreditation/Authorization Re-test\$75.00
- H. Certification/Accreditation/Authorization Card Replacement\$20.00
- I. Certification/Accreditation/Authorization Card Name Change\$20.00
- 3. Training Program Approval Fees (every four years)
 - A. MICN\$400.00
 - B. EMR.....\$650.00
 - C. EMT\$650.00
 - D. EMT-P\$1,500.00
 - E. Continuing Education Provider\$500.00

4. Hospitals
 - A. Base Hospital Application Fee.....\$5,000.00
 - B. Base Hospital Re-designation Fee (bi-annual)\$5,000.00
 - C. Trauma Hospital Application Fee\$5,000.00
 - D. Trauma Hospital Re-designation Fee (annual)\$25,000.00
 - E. ST Elevation Myocardial Infarction (STEMI) Receiving
Center Designation Application Fee\$5,000.00
 - F. ST Elevation Myocardial Infarction (STEMI) Receiving
Center Designation Fee (annual)\$17,445.00
 - G. Neurovascular Stroke Receiving Center Designation
Application Fee.....\$5,000.00
 - H. Neurovascular Stroke Receiving Center Designation
Fee (annual)\$19,045.00
5. EMS Temporary Special Events
 - A. Minor Event Application\$125.00
 - B. Major Event Application\$375.00
6. Protocol Manual
 - A. With Binder\$40.00
 - B. Inserts Only\$25.00
 - C. CD\$10.00
7. Equipment Rental
 - A. Standard Equipment \$10.00/item
 - B. Deluxe Equipment \$25.00/item
8. Statistical Research\$100.00/hour

This rate schedule shall take effect July 1, 2014.



MEDICATION - STANDARD ORDERS

Adenosine (Adenocard) - Adult (ALS)

Stable narrow-complex SVT or Wide complex tachycardia:

Adenosine, 6 mg rapid IVP followed immediately by 20 cc NS bolus, and
Adenosine, 12 mg rapid IVP followed immediately by 20 cc NS bolus if patient
does not convert. May repeat one (1) time.

Reference #s 7010, 7020, 11050

Albuterol Aerosolized Solution (Proventil) - Adult (LALS, ALS)

Albuterol nebulized, 2.5 mg, may repeat two (2) times.

Reference #s 6090, 7010, 7020, 11010, 11100, 14030

Albuterol Metered-Dose Inhaler (MDI) (Proventil) - Specialty Programs Only Adult (LALS, ALS)

Albuterol MDI, four (4) puffs every ten (10) minutes for continued shortness of
breath and wheezing.

Reference #s 6090, 6110, Sheriff's Search and Rescue

Albuterol - Pediatric (LALS, ALS)

Albuterol nebulized, 2.5 mg, may repeat two (2) times.

Reference #s 7010, 7020, 14010, 14030, and 14070

Aspirin, chewable (LALS, ALS)

Aspirin, 325 mg PO chewed (one (1) adult non-enteric coated aspirin) or four (4)
chewable 81 mg aspirin.

Reference #s 2020, 6090, 6110, 7010, 7020, 11060

Atropine (ALS)

Atropine, 0.5 mg IVP. May repeat every five (5) minutes up to a maximum of 3 mg
or 0.04 mg/kg.

Organophosphate poisoning:

Atropine, 2 mg IVP, repeat at 2 mg increments if patient remains symptomatic.

Reference #s 6090, 6110, 7010, 7020, 11040, 12020, 13010

Calcium Chloride (ALS)

Calcium Channel Blocker Poisonings:

Calcium Chloride, 1 gm (10 cc of a 10% solution), base hospital order only.

Reference #s 2020, 7010, 7020, 13010

Dextrose - Adult (LALS)

Dextrose 50% 25 gm IV of 50%

Reference #s 2020, 6090, 6110, 7010, 7020, 8010, 11050, 11070, 11080, 13020, 13030

Dextrose - Adult (ALS)

Dextrose 50% 25 gm IV/IO of 50%

Reference #s 2020, 6090, 6110, 7010, 7020, 8010, 11050, 11070, 11080, 13020, 13030

Dextrose - Pediatric (LALS, ALS)

For neonates (0 - 4 weeks), if blood glucose < 35 mg/dL:

Dextrose 25% (0.25 gm/ml) Diluted 1:1, give 0.5 gm/kg (4 ml/kg) IV/IO

For patient < 10 kg and > 4 weeks, if blood glucose < 60 mg/dL:

Dextrose 25% (0.25 gm/ml), give 0.5 gm/kg (2 ml/kg) IV/IO

For patient > 10 kg and < 25kg, if glucose less than 60 mg/dL:

Dextrose 50% (0.5 gm/mL) Diluted 1:1, give 0.5 gm/kg (2 ml/kg) IV/IO

For patient > 25 kg, if glucose less than 80 mg/dL:

Dextrose 50% (0.5 gm/mL) Diluted 1:1, give 0.5 gm/kg (2 ml/kg) IV/IO

Reference #s 2020, 7010, 7020, 13020, 13030, 14040, 14050, 14060

Diphenhydramine - Adult (ALS)

Diphenhydramine, 25 mg IV/IO

Diphenhydramine, 50 mg IM

Reference #s 6090, 6110, 7010, 7020, 11010, 13010

Diphenhydramine - Pediatric (ALS)

Diphenhydramine, 1 mg/kg slow IV/IO, not to exceed adult dose of 25 mg, or

Diphenhydramine, 2 mg/kg IM not to exceed adult dose of 50 mg IM

Reference #s 7010, 7020, 14030

Dopamine - Adult (ALS)

Dopamine, infusion of 400 mg in 250 ml of NS, titrated between 5 - 20 mcg/kg/min to sustain a systolic blood pressure greater than 90 mmHG for signs of inadequate tissue perfusion/shock.

Reference #s 7010, 7020, 8010, 8040, 10140, 11070, 11090, 14080

Dopamine - Pediatric (ALS)

Post resuscitation continued signs of inadequate tissue perfusion:

9 to 14 years

Dopamine, 400 mg in 250 ml of NS to infuse at 5 - 20 mcg/kg/min IV titrated to maintain signs of adequate tissue perfusion.

Reference #s 7010, 7020, 14040

Epinephrine (1:1000) - Adult (LALS, ALS)

Acute Asthma, Bronchospasm, Allergic reaction, Anaphylaxis:

Epinephrine, 0.3 mg IM

Epinephrine (1:10,000) - Adult (ALS)

For Persistent severe anaphylactic shock:

Epinephrine (1:10,000), 0.1 mg slow IVP. May repeat as needed to total dosage of 0.5 mg.

Cardiac Arrest, Asystole, PEA:

Epinephrine, 1 mg IV/IO

Reference #s 2020, 6090, 6110, 7010, 7020, 11010, 11070, 12020

Epinephrine (1:1000) - Pediatric (LALS, ALS)*Allergic Reactions:*

Epinephrine, 0.01 mg/kg IM not to exceed adult dosage of 0.3 mg.

Reference #s 2020, 6090, 7010, 7020, 11010, 14010, 14030

Epinephrine (1:10,000) - Pediatric (ALS)*Anaphylactic Shock (no palpable radial pulse and depressed level of consciousness):*

Epinephrine (1:10,000), 0.01 mg/kg IV/IO, no more than 0.1 mg per dose. May repeat to a maximum of 0.5 mg.

Cardiac Arrest:

1 day to 8 years Epinephrine (1:10,000), 0.01 mg/kg IV/IO (do not exceed adult dosage)

9 to 14 years Epinephrine (1:10,000), 1.0 mg IV/IO

Newborn Care:

Epinephrine (1: 10,000), 0.01mg/kg IV/IO if heart rate is less than 60 after one (1) minute after evaluating airway for hypoxia and assessing body temperature for hypothermia.

Epinephrine (1:10,000), 0.005 mg/kg IV/IO every ten (10) minutes for persistent hypotension as a base hospital order or in radio communication failure.

Post resuscitation continued signs of inadequate tissue perfusion:

1 day to 8 years Epinephrine (1:10,000), 0.5 mcg/kg/min IV drip

Reference #s 2020, 7010, 7020, 14030, 14040, 14090

Glucose - Oral - Adult (BLS, LALS, ALS)

Glucose - Oral, one (1) tube for patients with an intact gag reflex and hypoglycemia.

Reference #s 7010, 7020, 11080, 11090, 11110, 13020

Glucose - Oral - Pediatric (BLS, LALS, ALS)

Glucose - Oral, one (1) tube for patients with an intact gag reflex and hypoglycemia.

Reference #s 7010, 7020, 14050, 14060

Glucagon - Adult (LALS, ALS)

Glucagon, 1 mg IM/SC/IN, if unable to establish IV. May give one (1) time only.

Betablocker Poisoning:

Glucagon, 1 mg IVP (base hospital order only)

Reference #s 6090, 6110, 7010, 7020, 11080, 13010, 13030

Glucagon - Pediatric (LALS, ALS)

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.

Reference #s 7010, 7020, 13030, 14050, 14060

Ipratropium Bromide Inhalation Solution (Atrovent) - Adult (ALS) use with Albuterol

Atrovent, 0.5 mg

Reference #s 7010, 7020, 11010, 11100

Ipratropium Bromide Metered-Dose Inhaler (MDI) (Atrovent) - Specialty Programs Only Adult (ALS) use with Albuterol

Atrovent MDI, four (4) puffs every ten (10) minutes for continued shortness of breath and wheezing.

Reference #s 6090, 6110, 7010, 7020

Ipratropium Bromide Inhalation Solution (Atrovent) - Pediatric (ALS) use with Albuterol

1 day to 12 months Atrovent, 0.25 mg

1 year to 14 years Atrovent, 0.5 mg

Reference #s 7010, 7020, 14010, 14030, 14070

Lidocaine - Adult (ALS)*Intubation, King Airway, NG/OG, for suspected brain injury:*

Lidocaine, 1.5 mg/kg IV

VT/VF:

Lidocaine, 1.5 mg/kg

Repeat 0.75 mg/kg every five (5) to ten (10) minutes; maximum total dose of 3 mg/kg.

Refractory VF:

Lidocaine, 0.75 mg/kg IV, repeat in five (5) to ten (10) minutes; maximum three (3) doses or total of 3 mg/kg.

VT/VF Infusion:

Lidocaine, 1 - 4 mg/min (30 - 50 mcg/kg/min)

V-Tach, Wide Complex Tachycardias:

Lidocaine, 1 mg/kg slow IV, repeat at 0.5 mg/kg every ten (10) minutes until maximum dose of 3 mg/kg given.

Initiate infusion of Lidocaine 2 mg/min.

Reference #s 2020, 6090, 7010, 7020, 8010, 8040, 10030, 10080, 11050, 11070, 15010

Lidocaine - Pediatric (ALS)*Intubation, King Airway, NG/OG, for suspected brain injury:*

Lidocaine, 1.5 mg/kg IV

Cardiac Arrest:

1 day to 8 years Lidocaine, 1.0 mg/kg IV/IO

9 to 14 years Lidocaine, 1.0 mg/kg IV/IO

May repeat Lidocaine at 0.5 mg/kg after five (5) minutes up to total of 3.0 mg/kg.

Reference #s 2020, 7010, 7020, 14040

Lidocaine 2%*Pain associated with IO insertion:*

Lidocaine 2%, 0.5 mg/kg slow IO push not to exceed 50 mg total.

Reference #s 2020, 7010, 7020, 10140

Magnesium Sulfate (ALS)*Polymorphic Ventricular Tachycardia:*

Magnesium Sulfate, 2 gm in 100 ml of NS over five (5) minutes for polymorphic VT if prolonged QT is observed during sinus rhythm post-cardioversion.

Eclampsia (Seizure/Tonic/Clonic Activity):

Magnesium Sulfate, 4 gm diluted with 20 ml NS, IV/IO slow IV push over three (3) to four (4) minutes.

Magnesium Sulfate, 2 gm in 100 cc of NS at 30 cc per hour IV/IO to prevent continued seizures.

Reference #s 2020, 7010, 7020, 8010, 14080

Midazolam - Adult (ALS)*Seizure:*

Midazolam, 2.5 mg IN/IV/IO. May repeat in five (5) minutes for continued seizure activity, or

Midazolam, 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 base hospital for additional orders and to discuss further treatment options.

Pacing, synchronized cardioversion:

Midazolam, 2 mg slow IV push IV/IN

Reference #s 6090, 6110, 7010, 7020, 10110, 10120, 11080, 13020, 14080

Midazolam - Pediatric (ALS)*Seizures:*

Midazolam, 0.1 mg/kg IV/IO with maximum dose 2.5 mg. May repeat Midazolam in five (5) minutes. Do not to exceed adult dosage, or

Midazolam, 0.2 mg/kg IM/IN with maximum dose of 5 mg. May repeat Midazolam in ten (10) minutes for continued seizure. Do not to exceed adult dosage. IN dosage of Midazolam is doubled due to decreased surface area of nasal mucosa resulting in decreased absorption of medication.

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 base hospital for additional orders and to discuss further treatment options.

Reference #s 7010, 7020, 14060

Morphine Sulfate - Adult (ALS)

Morphine Sulfate, 2 mg IV. May repeat in 2 mg increments every three (3) minutes, not to exceed 10 mg IV.

Isolated Extremity Trauma, Burns:

Morphine Sulfate, 5 mg IV. May repeat every five (5) minutes to a maximum of 20 mg for adequate tissue perfusion, or

Morphine Sulfate, 10 mg IM.

Pacing, synchronized cardioversion:

Morphine Sulfate, 2 mg IV. May repeat in 2 mg increments every three (3) minutes, titrated to pain, not to exceed 10 mg IV.

Reference #s 2020, 6090, 6110, 7010, 7020, 7030, 9120, 10110 10120, 11060, 11100, 13030, 15010

Morphine Sulfate - Pediatric (ALS)

Morphine Sulfate, 0.1 mg/kg IV not to exceed 2 mg increments, for a total of 5 mg, or

Morphine Sulfate, 0.2 mg/kg IM for a total of 10 mg IM, titrated for pain relief

Burns:

Morphine Sulfate, 0.1 mg/kg IV not to exceed 5 mg increments, for a total of 20 mg, or

Morphine Sulfate, 0.2 mg/kg IM for a total of 10 mg IM, titrated for pain relief

Reference #s 2020, 7010, 7020, 7030, 14070, 15020

Naloxone (Narcan) - Adult (LALS, ALS)*Resolution of respiratory depression related to suspected narcotic overdose:*

Naloxone, 0.5 mg IV/IM/IN may repeat Naloxone 0.5 mg IV/IM/IN every two (2) to three (3) minutes if needed.

Do not exceed 10 mg of Naloxone total regardless of route given.

Reference #s 6110, 7010, 7020, 11070, 11080

Naloxone (Narcan) - Pediatric (LALS)*Resolution of respiratory depression related to suspected narcotic overdose:*

1 day to 8 years Naloxone, 0.1 mg/kg IV/IO

9 to 14 years Naloxone, 0.5 mg IV

Do not exceed the adult dosage of 10 mg IV/IM/IN.

Reference #s 7010, 7020, 14040, 14050

Naloxone (Narcan) - Pediatric (ALS)

Resolution of respiratory depression related to suspected narcotic overdose:

1 day to 8 years Naloxone, 0.1 mg/kg IV/IO

9 to 14 years Naloxone, 0.5 mg IV/IO

Do not exceed the adult dosage of 10 mg IV/IM/IN.

Reference #s 7010, 7020, 14040, 14050

Nitroglycerin (LALS, ALS)

Nitroglycerin, 0.4 mg sublingual/transmucosal

One (1) every three (3) minutes as needed. May be repeated as long as patient continues to have signs of adequate tissue perfusion. **If a Right Ventricular Infarction is suspected, the use of nitrates requires base hospital contact.**

Nitroglycerin is contraindicated if there are signs of inadequate tissue perfusion or if sexual enhancement medications have been utilized within the past forty-eight (48) hours.

Reference #s 6090, 6110, 7010, 7020, 11010, 11060

Ondansetron (Zofran) - Patients four (4) years old to Adult (ALS)

Nausea/Vomiting:

Ondansetron, 4 mg slow IV/ODT

All patients four (4) to eight (8) years old: may give a total of 4 mgs of Ondansetron prior to base hospital contact.

All patients nine (9) and older: may give Ondansetron 4 mg and may repeat twice, at ten (10) minute intervals, for a total of 12 mgs prior to base hospital contact.

May be used as prophylactic treatment of nausea and vomiting associated with narcotic administration.

Reference #s 6110, 7010, 7020, 9120, 10100, 15010, 15020

Phenylephrine HCL (ALS)

Phenylephrine, 0.5 mg metered dose may be repeated once prior to additional attempt

Reference #s 7010, 7020, 10050

Procainamide (ALS)

SVT, V-Tach or Wide Complex Tachycardias:

Procainamide, 20 mg/min IV; may repeat until arrhythmia suppressed, symptomatic hypotension, QRS widens by more than 50% or maximum dose of 17 mg/kg given. If arrhythmia suppressed, begin infusion of 2 mg/min.

Reference #s 7010, 7020, 8010, 8040, 11050

Sodium Bicarbonate (ALS)

Tricyclic Poisoning:

Sodium Bicarbonate, 1 mEq/kg IVP

Reference #s 2020, 7010, 7020, 13010

Verapamil (ALS)

SVT if adenosine is ineffective:

Verapamil, 5 mg slow IV over three (3) minutes, may repeat every fifteen (15) minutes to a total dose of 20 mg.

Reference #s 7010, 7020, 11050



BURN DESTINATION AND CRITERIA POLICY

PURPOSE

To ensure the appropriate destination of patients sustaining burn injuries.

AUTHORITY

Health and Safety Code Sections 1797.220, 1797.222 & 1798. California Code of Regulations, Title 22, Division 9, Sections 100144, 100304, 100107, 100128, 100175A2.

DEFINITIONS

Adult Patients: A person appearing to be \geq fifteen (15) years of age.

Pediatric Patients: A person appearing to be $<$ fifteen (15) years of age.

Burn Patients: Patients meeting ICEMA's burn classifications, minor, moderate or major.

Critical Trauma Patients (CTP): Patients meeting ICEMA's Critical Trauma Patient Criteria

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

POLICY

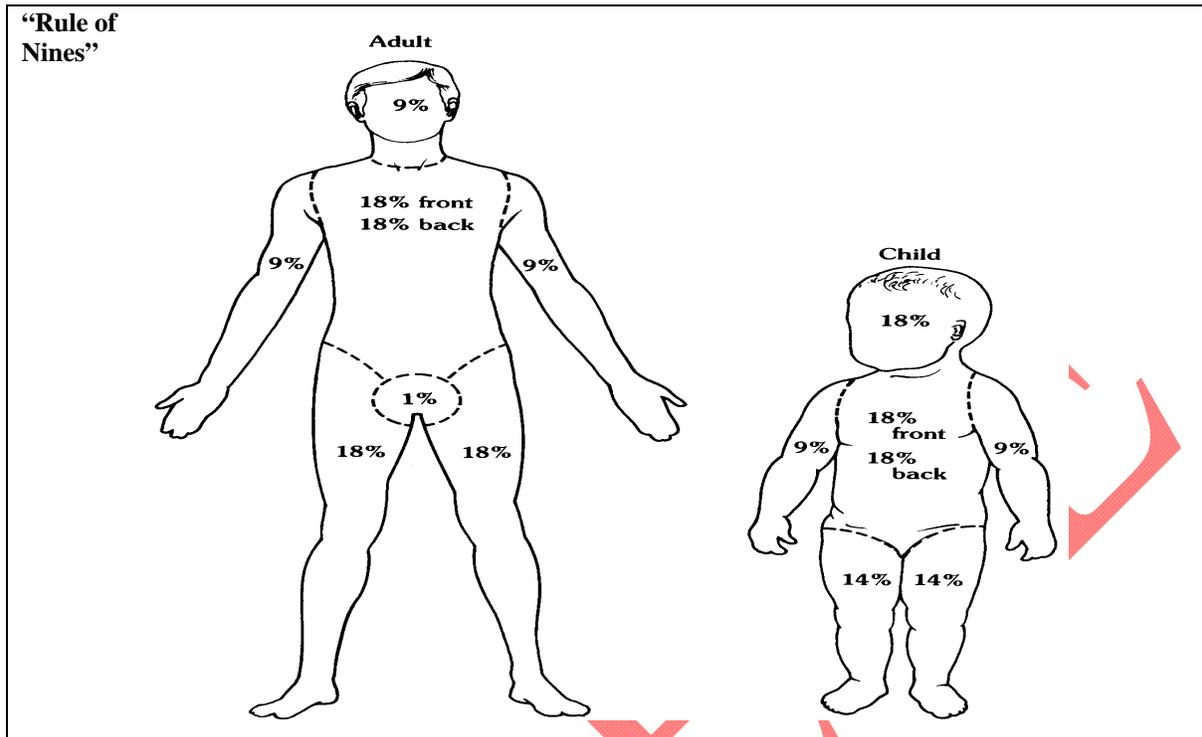
A. TRANSPORTATION

1. Burn patients meeting minor or moderate classifications will be transported to the closest receiving hospital.
2. Burn patients meeting major burn classification will be transported to the closest most appropriate burn center (in San Bernardino County contact ARMC).
3. Burn patients meeting the physiologic or anatomic criteria for CTP will be transported to the most appropriate trauma hospital, Refer to Protocol #15030, Trauma Triage Criteria and Destination Policy.

4. 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.
5. When estimated transport to the most appropriate trauma hospital (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. If an EMS aircraft is dispatched, adherence to Protocol #8070 Aircraft Destination Policy (in San Bernardino County) is mandatory.
6. Burn patients with respiratory compromise, or potential for such, will be transported to the closest receiving hospital for airway stabilization.
7. Hospital trauma diversion status: Refer to Protocol #8060 San Bernardino County Requests for Hospital Diversion Policy.
8. Paramedics may contact the base station or trauma base station for destination consultation on any patient that does not meet any of the above criteria, but who, in the paramedic's opinion, would be more appropriately serviced by direct transport to a burn center.

B. BURN CLASSIFICATIONS

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



C. EXCEPTIONS

The burn patient who presents with the following:

| | |
|---|---|
| <p>Airway Stabilization: <u>Transport to the closest receiving hospital for airway stabilization when the patient:</u></p> | <ul style="list-style-type: none"> • has respiratory compromise, or potential for compromise |
| <p>Transport to the closest most appropriate receiving hospital when the patient:</p> | <ul style="list-style-type: none"> • has deteriorating vital signs • is pulseless and apneic |
| <p>EMS Aircraft Indications: <u>An EMS aircraft may be dispatched for the following events:</u></p> | <ul style="list-style-type: none"> • MCI • Prolonged extrication time (> twenty (20) minutes) • Do Not Delay Patient Transport waiting for an enroute EMS aircraft |
| <p>EMS Aircraft Transport Contraindications: <u>The following are contraindications for EMS aircraft patient transportation:</u></p> | <ul style="list-style-type: none"> • Patients contaminated with Hazardous Material who cannot be decontaminated and who pose a risk to the safe operations of the EMS aircraft and crew. • Violent patients with psychiatric behavioral problems and uncooperative patients under the influence of alcohol and/or mind altering substances who may interfere with the safe operations of an EMS aircraft during flight. |

| | |
|--------------------------|---|
| | <ul style="list-style-type: none">• Stable patients• Ground transport is < 30 minutes• Traumatic cardiac arrest• Other safety conditions as determined by pilot and/or crew |
| Remote Locations: | <ul style="list-style-type: none">• Remote locations may be exempted from specific criteria upon written permission from the EMS Medical Director. |

D. CONSIDERATIONS

1. Scene time should be limited to ten (10) minutes under normal circumstances.
2. Burn patients with associated trauma, in which the burn injury poses the greatest risk of morbidity or mortality, should be **considered** for transport to the closest most appropriate Burn Center. Trauma base station contact shall be made.

E. RADIO CONTACT

1. If not contacted at scene, the receiving trauma hospital must be notified as soon as possible in order to activate the trauma team.
2. For patients meeting Trauma Triage Criteria (Physiologic, Anatomic, Mechanism of Injury, and/or Age and Co-Morbid Factors), a trauma base station shall be contacted in the event of patient refusal of assessment, care, and/or transportation.
3. In Inyo and Mono Counties, the assigned base station should be contacted for CTP consultation.



ADULT RESPIRATORY EMERGENCIES

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

- Maintain airway with appropriate adjuncts, including advanced airway if indicated. Obtain O₂ saturation on room air or on home oxygen if possible.
- Nebulized Albuterol per ICEMA Reference #7040 - Medication - Standard Orders.

IV. ALS INTERVENTIONS

- Maintain airway with appropriate adjuncts, including advanced airway if indicated. Obtain O₂ saturation on room air or on home oxygen if possible.
- Albuterol with Atrovent per ICEMA Reference #7040 - Medication - Standard Orders.
- Place patient on Continuous Positive Airway Pressure (CPAP), refer to ICEMA Reference #10190 - ICEMA Approved Skills.
- Consider advanced airway, refer to ICEMA Reference #10190 - ICEMA Approved Skills.
- Base hospital physician may order additional medications or interventions as indicated by patient condition.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|------------------------------|
| 7040 | Medication - Standard Orders |
| 10190 | ICEMA Approved Skills |

ACUTE ASTHMA/BRONCHOSPASM/ALLERGIC REACTION/ANAPHYLAXIS**I. FIELD ASSESSMENT/TREATMENT INDICATORS**

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

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

- Maintain airway with appropriate adjuncts, obtain O₂ saturation on room air if possible.
- Nebulized Albuterol per ICEMA Reference #7040 - Medication - Standard Orders.
- For signs of inadequate tissue perfusion, initiate IV bolus of 300 cc NS. If signs of inadequate tissue perfusion persist may repeat fluid bolus one (1) time.
- If no response to Albuterol, administer Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders. Contact base hospital for patients with a history of coronary artery disease, history of hypertension or over 40 years of age prior to administration of Epinephrine.
- May repeat Epinephrine, per ICEMA Reference #7040 - Medication - Standard Orders, after 15 minutes one (1) time.
- Base hospital physician may order additional medications or interventions as indicated by patient condition.

IV. ALS INTERVENTIONS

- Maintain airway with appropriate adjuncts, obtain O₂ saturation on room air if possible.

- Albuterol, with Atrovent per ICEMA Reference #7040 - Medication - Standard Orders.
- For signs of inadequate tissue perfusion, initiate IV bolus of 300 cc NS. If signs of inadequate tissue perfusion persist may repeat fluid bolus until signs of improved tissue perfusion.
- Place patient on Continuous Positive Airway Pressure (CPAP), refer to ICEMA Reference #10190 - ICEMA Approved Skills.
- If no response to Albuterol, administer Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders. Contact base hospital for patients with a history of coronary artery disease, history of hypertension or over 40 years of age prior to administration of Epinephrine.
- May repeat Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders after 15 minutes one (1) time.
- For suspected allergic reaction, consider Diphenhydramine per ICEMA Reference #7040 - Medication - Standard Orders.
- For persistent severe anaphylactic shock, administer Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders.
- Consider advanced airway, refer ICEMA Reference #10190 - ICEMA Approved Skills.
- Base hospital physician may order additional medications or interventions as indicated by patient condition.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|------------------------------|
| 7040 | Medication - Standard Orders |
| 10190 | ICEMA Approved Skills |

ACUTE PULMONARY EDEMA/CHF

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

- Reduce anxiety, allow patient to assume position of comfort.

- Administer oxygen as clinically indicated. For pulmonary edema with high altitude as a suspected etiology, descend to a lower altitude and administer high flow oxygen with a non re-breather mask.
- Be prepared to support ventilations as clinically indicated.

III. LIMITED ALS (LALS) INTERVENTIONS

- Maintain airway with appropriate adjuncts, obtain O₂ saturation on room air if possible.
- Nitroglycerine per ICEMA Reference #7040 - Medication - Standard Orders. Do not use or discontinue NTG in presence of hypotension (SBP <100).
- Albuterol per ICEMA Reference #7040 - Medication - Standard Orders, if nitro is not working.

IV. ALS INTERVENTIONS

- Maintain airway with appropriate adjuncts, obtain O₂ saturation on room air if possible.
- Nitroglycerine per ICEMA Reference #7040 - Medication - Standard Orders.
- Place patient on Continuous Positive Airway Pressure (CPAP), refer to ICEMA Reference #10190 - ICEMA Approved Skills.
- Consider advanced airway, refer to ICEMA Reference #10190 - ICEMA Approved Skills.
- Base hospital physician may order additional medications or interventions as indicated by patient condition.
- In radio communication failure (RCF), the following medications may be utilized:
 - Dopamine per ICEMA Reference #7040 - Medication - Standard Orders.
 - Albuterol with Atrovent per ICEMA Reference #7040 - Medication - Standard Orders after patient condition has stabilized.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|------------------------------|
| 7040 | Medication - Standard Orders |
| 10190 | ICEMA Approved Skills |



AIRWAY OBSTRUCTION - ADULT

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTION

RESPONSIVE

- Assess for ability to speak or cough (e.g., “Are you choking?”).
- If unable to speak, administer abdominal thrusts (if the rescuer is unable to encircle the victim’s abdomen or the patient is in the late stages of pregnancy, utilize chest thrusts) until the obstruction is relieved or patient becomes unconscious.
- After obstruction is relieved, reassess and maintain ABC’s.
- Administer oxygen therapy; obtain O₂ saturation.
- If responsive, place in position of comfort. If uninjured but unresponsive with adequate respirations and pulse, place on side in recovery position.

UNRESPONSIVE

- Position patient supine (for suspected trauma, maintain in-line axial spinal stabilization).
- Begin immediate CPR at a 30:2 ratio for two (2) minutes.
- Each time the airway is opened to ventilate, look for an object in the victim’s mouth and if found, remove it.
- If apneic and able to ventilate, provide one (1) breath every five (5) to six (6) seconds.
- Place AED on patient.

IV. LIMITED ALS (LALS) INTERVENTION

UNRESPONSIVE

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

V. ALS INTERVENTION

UNRESPONSIVE

- If apneic and able to ventilate, establish advanced airway.
- If obstruction persists, visualize with laryngoscope and remove visible foreign body with Magill forceps and attempt to ventilate.
- If obstruction persists and unable to ventilate, consider Needle Cricothyrotomy, refer ICEMA Reference #10190 - ICEMA Approved Skills.

VI. REFERENCE

| <u>Number</u> | <u>Name</u> |
|----------------------|-----------------------|
| 10190 | ICEMA Approved Skills |



BRADYCARDIAS - ADULT

STABLE BRADYCARDIA

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Heart rate less than 60 bpm.
- Signs of adequate tissue perfusion.

II. BLS INTERVENTIONS

- Recognition of heart rate less than 60 bpm.
- Reduce anxiety, allow patient to assume position of comfort.
- Administer oxygen as clinically indicated.

III. LIMITED ALS (LALS) INTERVENTIONS

- Establish vascular access if indicated. If lungs sound clear, consider bolus of 300 cc NS, may repeat.
- Monitor and observe for changes in patient condition.

IV. ALS INTERVENTIONS

- Establish vascular access if indicated. If lungs sound clear, consider bolus of 300 cc NS, may repeat.
- Place on cardiac monitor and obtain rhythm strip for documentation with copy to receiving hospital. If possible, obtain a 12-lead ECG to better define the rhythm.
- Monitor and observe for changes in patient condition.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|------------------------------|
| 7040 | Medication - Standard Orders |
| 10190 | ICEMA Approved Skills |

UNSTABLE BRADYCARDIA

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Signs of inadequate tissue perfusion/shock, ALOC, or ischemic chest discomfort.

II. BLS INTERVENTIONS

- Recognition of heart rate less than 60 bpm.
- Reduce anxiety, allow patient to assume position of comfort.
- Administer oxygen as clinically indicated.

III. LIMITED ALS (LALS) INTERVENTIONS

- Establish vascular access if indicated by inadequate tissue perfusion.
 - Administer IV bolus of 300 cc NS, may repeat one (1) time.
 - Maintain IV rate at TKO after bolus.
- Monitor and observe for changes in patient condition.
- Contact base hospital if need for further medical control.

IV. ALS INTERVENTIONS

- Administer IV bolus of 300 cc. Maintain IV rate at 300 cc per hour if lungs remain clear to auscultation.
- Place on cardiac monitor and obtain rhythm strip for documentation. If possible, obtain a 12-lead ECG to better define the rhythm. Provide copy to receiving hospital.
- Administer Atropine per ICEMA Reference #7040 - Medication -Standard Orders.
- If Atropine is ineffective or, for documented MI, 3rd degree AV Block with wide complex and 2nd degree Type II AV Block, utilize Transcutaneous Cardiac Pacing, per ICEMA Reference #10190 ICEMA Approved Skills.
- Consider Dopamine per ICEMA Reference #7040 - Medication - Standard Orders.
- Contact base hospital if interventions are unsuccessful.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|------------------------------|
| 7040 | Medication - Standard Orders |
| 10190 | ICEMA Approved Skills |



TACHYCARDIAS - ADULT

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Signs and symptoms of poor perfusion.
- Heart rate greater than 150 beats per minute (bpm).

II. BLS INTERVENTIONS

- Recognition of heart rate greater than 150 bpm.
- Reduce anxiety; allow patient to assume position of comfort.
- Administer oxygen as clinically indicated.
- Consider transport to closest hospital or ALS intercept.

III. LIMITED ALS (LALS) INTERVENTIONS

- Recognition of heart rate greater than 150 bpm.
- Place AED pads on patient as a precaution in the event patient has sudden cardiac arrest.
- Initiate an IV with normal saline and administer 300 cc bolus to patient exhibiting inadequate tissue perfusion.
- Obtain blood glucose. If indicated administer:
 - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders,
or
 - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders.
 - May repeat blood glucose. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.

IV. ALS INTERVENTIONS

Determine cardiac rhythm, obtain a 12-lead ECG to better define rhythm if patient condition allows, establish vascular access and proceed to appropriate intervention(s).

Narrow Complex Supraventricular Tachycardia (SVT)

- Initiate NS bolus of 300 ml IV.
- Valsalva/vagal maneuvers.
- Adenosine per ICEMA Reference #7040 - Medication - Standard Orders.
- If adenosine is ineffective, consider Verapamil per ICEMA Reference #7040 - Medication - Standard Orders.
- Consider Procainamide per ICEMA Reference #7040 - Medication - Standard Orders for suspected Wolf-Parkinsons White.
- Synchronized cardioversion, refer to ICEMA Reference #10190 - ICEMA Approved Skills.
- Contact base hospital.

V-Tach or Wide Complex Tachycardias (Intermittent or Sustained)

- Consider Adenosine, per ICEMA Reference #7040 - Medication - Standard Orders, if the rate is regular and the QRS is monomorphic. Adenosine is contraindicated for unstable rhythms or if the rhythm is an irregular or polymorphic wide complex tachycardia.
- Procainamide per ICEMA Reference #7040 - Medication - Standard Orders.
- If Procainamide administration is contraindicated or fails to convert the rhythm, consider Lidocaine per ICEMA Reference #7040 - Medication - Standard Orders.
- Polymorphic VT should receive immediate unsynchronized cardioversion (defibrillation). Consider infusing Magnesium per ICEMA Reference #7040 - Medication - Standard Orders.
- Precordial thump for witnessed spontaneous VT, if defibrillator is not immediately available for use.
- Synchronized cardioversion, refer to ICEMA Reference #10190 - ICEMA Approved Skills.
- Contact base hospital.

Atrial Fib/Flutter

- Transport to appropriate facility.
- For patients who are hemodynamically unstable, proceed to synchronized cardioversion, refer to ICEMA Reference #10190 - ICEMA Approved Skills.
- Contact base hospital.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|----------------------|------------------------------|
| 7040 | Medication - Standard Orders |
| 10190 | ICEMA Approved Skills |



SUSPECTED ACUTE MYOCARDIAL INFARCTION (AMI)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

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

III. LIMITED ALS (LALS) INTERVENTIONS

- Aspirin per ICEMA Reference #7040 - Medication - Standard Orders.
- Consider early vascular access.
- For patients with chest pain, signs of inadequate tissue perfusion and clear breath sounds, give 300 ml NS bolus, may repeat.
- Nitroglycerin per ICEMA Reference #7040 - Medication - Standard Orders.
- Consider establishing a saline lock enroute on same side as initial IV.
- Complete thrombolytic checklist, if time permits.
- Contact base hospital.

IV. ALS INTERVENTIONS

- Aspirin per ICEMA Reference #7040 - Medication - Standard Orders.
- Consider early vascular access.
- For patients with chest pain, signs of inadequate tissue perfusion and clear breath sounds, give 300 ml NS bolus, may repeat.
- 12-Lead Technology:
 - Obtain 12-lead ECG. Do not disconnect 12-lead cables until necessary for transport.
 - If signs of inadequate tissue perfusion or if inferior wall infarct is suspected, obtain a right-sided 12-lead (V4R).
 - If right ventricular infarct (RVI) is suspected with signs of inadequate tissue perfusion, consider 300ml NS bolus, may repeat. Early consultation with base hospital or receiving hospital in rural areas is recommended. (Nitrates are contraindicated in the presence of RVI or hypotension.)
 - With documented ST segment elevation in two (2) or more contiguous leads, contact STEMI base hospital for destination decision while preparing patient for expeditious transport, refer to ICEMA Reference #6070 - Cardiovascular “STEMI” Receiving Centers. In Inyo and Mono Counties, the assigned base hospital should be contacted for STEMI consultation.
 - Repeat 12-lead at regular intervals, but do not delay transport of patient. If patient is placed on a different cardiac monitor for transport, transporting provider should obtain an initial 12-lead on their cardiac monitor and leave 12-lead cables in place throughout transport.
 - EMS field personnel shall ensure that a copy of the 12-lead ECG is scanned or attached as a permanent part of the patient’s ePCR or OIA and submit to ICEMA if patient is going to a SRC as a suspected STEMI.
- Nitroglycerin per ICEMA Reference #7040 - Medication - Standard Orders. Utilize Morphine Sulfate for pain control when Nitroglycerin is contraindicated.

- Morphine Sulfate per ICEMA Reference #7040 - Medication - Standard Orders. Consider concurrent administration of Nitroglycerin with Morphine Sulfate if there is no pain relief from the initial Nitroglycerin administration. Contact base hospital for further Morphine Sulfate orders.
- Consider establishing a saline lock as a secondary IV site.
- Make early STEMI notification to the STEMI Receiving Center.
- In Radio Communication Failure (RCF), may give up to an additional 10 mg Morphine Sulfate in 2 mg increments with signs of adequate tissue perfusion.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|--|
| 6070 | Cardiovascular “STEMI” Receiving Centers |
| 7040 | Medication - Standard Orders |



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.
- Place patient on AED. 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 chest compressions. 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).
- Refer to ICEMA Reference #12010 - Determination of Death on Scene.
- Obtain blood glucose level, if indicated administer:
 - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
 - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.

- If suspected narcotic overdose with severely decreased respiratory drive administer:
 - Naloxone per ICEMA Reference #7040 - Medication - Standard Orders.

NOTE: Base hospital 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 chest compressions. After advanced airway established, compressions would then be continued at 100 per minute 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, for confirmation and monitoring of endotracheal tube placement and for assessment of ROSC and perfusion status. Document the shape of the wave and the capnography number in mmHG.
- Insert NG/OG Tube to relieve gastric distension per ICEMA Reference #10190 - ICEMA Approved Skills.
- Obtain blood glucose level. If indicated administer:
 - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
 - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.
- If suspected narcotic overdose with severely decreased respiratory drive administer:
 - Naloxone per ICEMA Reference #7040 - Medication - Standard Orders.

- If ROSC is achieved, obtain a 12-lead ECG and contact a STEMI base hospital for destination decision, refer to ICEMA Reference #8130 - Destination Policy.
- Utilize continuous waveform capnography, to identify loss of circulation.
- For continued signs of inadequate tissue perfusion after successful resuscitation, administer:
 - Dopamine per ICEMA Reference #7040 - Medication - Standard Orders 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 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.
- If patient remains in pulseless VF/VT after five (5) cycles of CPR, consult base 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 during each two (2) minute cycle of CPR after each rhythm evaluation.

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 contact is required to terminate resuscitative measures. A copy of the ECG should be attached to the patient care report for documentation purposes.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|---------------------------------|
| 7040 | Medication - Standard Orders |
| 8130 | Destination Policy |
| 10190 | ICEMA Approved Skills |
| 12010 | Determination of Death on Scene |



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 per ICEMA Reference #15010 - Trauma - Adult (15 years of age and older).
- 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 indicated administer:
 - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders, **or**
 - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to establish IV. May give one (1) time only.
 - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.

- If suspected narcotic overdose with severely decreased respiratory drive administer:
 - Naloxone per ICEMA Reference #7040 - Medication - Standard Orders.
- Assess and document response to therapy.
- Base hospital may order additional medication dosages and fluid bolus.

IV. ALS INTERVENTIONS

- Obtain vascular access and place on monitor.
- Obtain blood glucose level. If indicated administer:
 - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders, **or**
 - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to establish IV. May give one (1) time only.
 - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.
- For tonic/clonic type seizure activity, administer:
 - Midazolam per ICEMA Reference #7040 - Medication - Standard Orders.
 - Assess patient for medication related reduced respiratory rate or hypotension.
- If suspected narcotic overdose with severely decreased respiratory drive administer:
 - Naloxone per ICEMA Reference #7040 - Medication - Standard Orders.
- Assess and document response to therapy.
- Base hospital may order additional medication dosages and fluid bolus.

V. REFERENCES

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



SHOCK (NON-TRAUMATIC)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Patient exhibits signs/symptoms of shock.
- Determine mechanism of illness.
- History of GI bleeding, vomiting, diarrhea.
- Consider hypoglycemia or narcotic overdose.

II. LIMITED ALS (LALS) INTERVENTIONS

- Maintain airway with appropriate adjuncts, including perilyngeal airway adjunct if indicated.
- Obtain O₂ saturation on room air or on home oxygen if possible.
- Place AED pads on patient as precaution in event patient goes into sudden cardiac arrest.
- Place in trendelenburg position if tolerated.
- Obtain vascular access.
- If hypotensive or have signs or symptoms of inadequate tissue perfusion, give fluid challenges:
 - ADULT
 - Administer 500 ml IV bolus, may repeat one (1) time until tissue perfusion improves
 - PEDIATRIC
 - Administer 20 ml/kg IV bolus, may repeat one (1) time for tachycardia, change in central/peripheral pulses, limb temperature transition, or altered level of consciousness.
- For patients with no respiratory difficulties and adequate signs of tissue perfusion:
 - ADULT/PEDIATRIC
 - Maintain IV at TKO.

III. ALS INTERVENTIONS

- Maintain airway with appropriate adjuncts, including advanced airway if indicated. Obtain O₂ saturation on room air or on home oxygen if possible.
- Place on cardiac monitor.
- Place in trendelenburg if tolerated.
- Obtain vascular access.
- If hypotensive or has signs or symptoms of inadequate tissue perfusion give fluid challenges:
 - ADULT
 - Administer 500 ml IV bolus, may repeat one (1) time to sustain a BP > 90 mmHg or until tissue perfusion improves.
 - PEDIATRIC
 - Administer 20 ml/kg IV bolus, may repeat one (1) time for tachycardia, change in central/peripheral pulses, limb temperature transition, or altered level of consciousness.
- For BP > 90 mmHg and no respiratory difficulties and adequate signs of tissue perfusion:
 - ADULT
 - Maintain IV rate at 150 ml per hour.
 - PEDIATRIC
 - Maintain IV at TKO.

Base Hospital May Order

- Establish 2nd large bore IV enroute.
- Dopamine per ICEMA Reference #7040 - Medication - Standard Orders.

IV. REFERENCE

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



BURNS - ADULT (15 years of age and older)

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

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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to ICEMA Reference #8130 - Destination Policy.

II. BLS INTERVENTIONS

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

A. Manage Special Considerations

- **Thermal Burns:** Stop the burning process. Do not break blisters. Cover the affected body surface with dry, sterile dressing or sheet.
- **Chemical Burns:** Brush off dry powder, if present. Remove any contaminated or wet clothing. Irrigate with copious amounts of saline or water.
- **Tar Burns:** Cool with water, do not remove tar.
- **Electrical Burns:** Remove from electrical source (without endangering self) with a nonconductive material. Cover the affected body surface with dry, sterile dressing or sheet.

- **Eye Involvement:** Continuous flushing with NS during transport. Allow patient to remove contact lenses if possible.
- **Determination of Death on Scene:** Refer to ICEMA Reference #12010 - Determination of Death On Scene.

III. LIMITED ALS (LALS) INTERVENTIONS

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

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

- IV access (warm IV fluids when available).
 - *Unstable:* BP <90mmHG and/or signs of inadequate tissue perfusion, start 2nd IV access.
IV NS 250 ml boluses, may repeat to a maximum of 1000 ml.
 - *Stable:* BP >90mmHG and/or signs of adequate tissue perfusion.
IV NS 500 ml/hour.
 - Transport to appropriate facility.
 - *Minor Burn Classification:* Transport to the closest most appropriate receiving hospital.
 - *Moderate Burn Classification:* Transport to the closest most appropriate receiving hospital.
 - *Major Burn Classification:* Transport to the closest most appropriate Burn Center (San Bernardino County contact ARMC).
 - *Critical Trauma Patient (CTP) with Associated Burns:* Transport to the most appropriate Trauma Center.
- Burn patients with associated trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.

A. **Manage Special Considerations**

- **Electrical Burns:** Place AED on patient.
 - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
- **Respiratory Distress:** Use BVM as needed and transport to the nearest facility for airway control. Contact receiving hospital ASAP. Nebulized Albuterol with Atrovent per ICEMA Reference #7040 - Medication - Standard Orders.
- **Deteriorating Vital Signs:** Transport to the closest most appropriate receiving hospital. Contact base hospital.
- **Pulseness and Apneic:** Transport to the closest most appropriate receiving hospital and treat according to ICEMA policies. Contact base hospital.
- **Determination of Death on Scene:** Refer to ICEMA Reference #12010 - Determination of Death on Scene.
- **Precautions and Comments:**
 - High flow oxygen is essential with known or potential respiratory injury. Beware of possible smoke inhalation.
 - Contact with appropriate advisory agency may be necessary for hazardous materials, before decontamination or patient contact.
 - Do not apply ice or ice water directly to skin surfaces, as additional injury will result.
- **Base Hospital Orders:** May order additional fluid boluses.

IV. **ALS INTERVENTIONS**

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

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

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

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

IV/IO NS 500 ml/hour.
- Treat pain as indicated.

Pain Relief: Morphine Sulfate per ICEMA Reference #7040 - Medication - Standard Orders. Document BPs every five (5) minutes while medicating for pain and reassess the patient.
- Transport to appropriate facility:
 - *CTP with associated burns*, transport to the closest Trauma Center.
 - Burn patients with associated trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.
- Insert nasogastric/orogastric tube as indicated.
- Refer to Section V - Burn Classifications below.

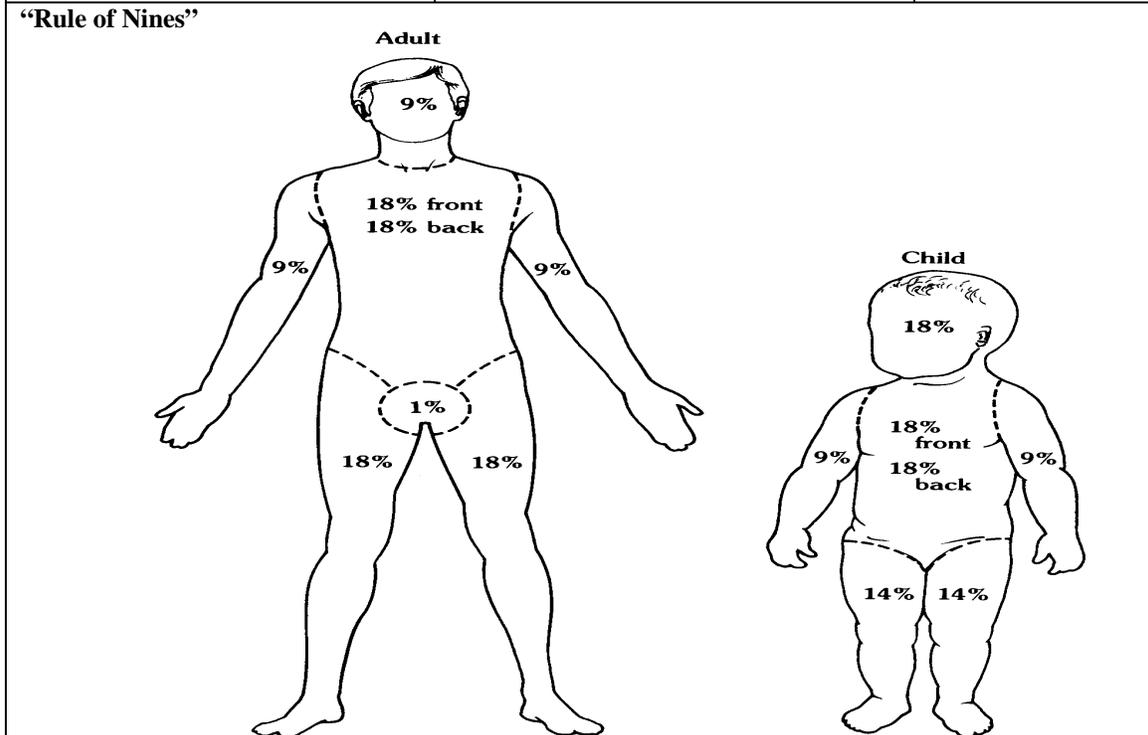
A. Manage Special Considerations

- **Electrical Burns:** Monitor for dysrhythmias, treat according to ICEMA protocols.
 - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
- **Respiratory Distress:** Intubate patient if facial/oral swelling are present or if respiratory depression or distress develops due to inhalation injury.
 - Albuterol with Atrovent per ICEMA Reference #7040 - Medication - Standard Orders.
 - Administer humidified oxygen, if available.

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

V. BURN CLASSIFICATIONS

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



VI. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|---|
| 7040 | Medication - Standard Orders |
| 9010 | General Patient Care Guidelines |
| 10190 | ICEMA Approved Skills |
| 11070 | Adult Cardiac Arrest |
| 12010 | Determination of Death on Scene |
| 15030 | Trauma Triage Criteria and Destination Policy |



STROKE TREATMENT - ADULT

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Patient exhibiting signs/symptoms of a possible stroke. These signs may include: speech disturbances, altered level of consciousness, parasthesias, new onset seizures, dizziness unilateral weakness and visual disturbances.

II. BLS INTERVENTIONS

- Oxygen therapy as clinically indicated.
- Position patient as tolerated. Consider left lateral position, if indicated.
- 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)/ALS INTERVENTIONS

- Obtain vascular access and place on monitor.
- Obtain blood glucose. If hypoglycemic, refer to ICEMA Reference #11080 - Altered Level of Consciousness/Seizures - Adult.
- For tonic/clonic type seizure activity, refer to ICEMA Reference #11080 - Altered Level of Consciousness/Seizures - Adult.

A. Modified Los Angeles County Prehospital Stroke Screen (mLAPSS): A screening tool used by prehospital care providers to assist in identifying patients who may be having a stroke.

- **mLAPSS CRITERIA**

- Ask when “last seen normal” or without stroke symptoms. Refer to Section V - Stroke Patient Destination Decision Tree below.
- No history of seizures or epilepsy.
- Age greater than or equal to 40. If less than 40, with suspected stroke, continue mLAPSS assessment, make NSRC base hospital contact for destination.

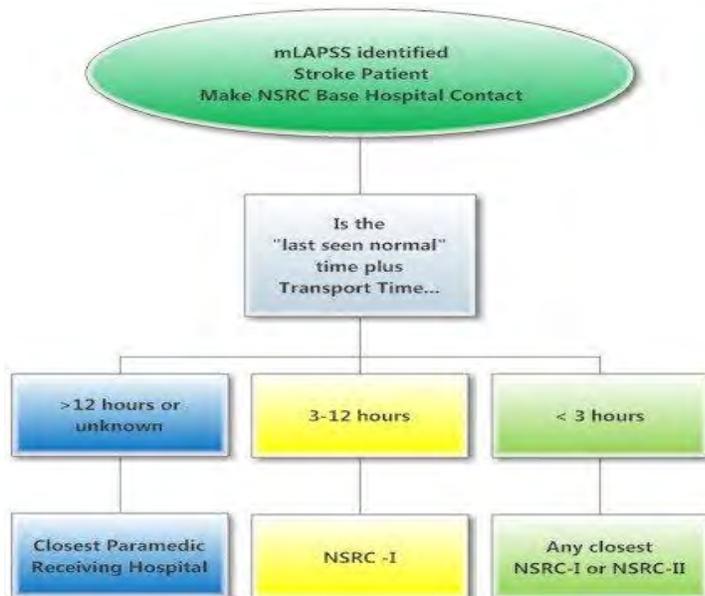
- At baseline, patient is not wheelchair bound or bedridden.
- Blood glucose between 60 - 400 mg/dl.
- Motor Exam: Examine for obvious asymmetry-unilateral weakness (exam is positive, if one (1) or more of the following are present).
 - Facial smile/Grimace asymmetry
 - Grip asymmetry
 - Arm strength asymmetry
- In San Bernardino County, if Stroke Scale is positive, initiate “Stroke Alert”, contact NSRC base hospital and transport immediately.

B. Thrombolytic Assessment

If time is available, and the patient or family can provide the information, assess the patient using the criteria listed below and report to ED personnel:

| | | |
|---|-----|----|
| Onset greater than 4 hours? | Yes | No |
| History of recent bleeding? | Yes | No |
| Use of anticoagulant? | Yes | No |
| Major surgery or serious trauma in the previous fourteen (14) days? | Yes | No |
| Sustained systolic blood pressure above 185 mm Hg? | Yes | No |
| Recent stroke or intracranial hemorrhage? | Yes | No |

V. STROKE PATIENT DESTINATION DECISION TREE



IV. REFERENCE

| <u>Number</u> | <u>Name</u> |
|---------------|---|
| 11080 | Altered Level of Consciousness/Seizures - Adult |



DETERMINATION OF DEATH ON SCENE

I. PURPOSE

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

II. POLICY

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

III. DETERMINATION OF DEATH CRITERIA

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

PROCEDURE

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

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

LIMITED ALS (LALS) PROCEDURE

- All terminated LALS resuscitation efforts must have an AED event record attached to the patient care report.
- All conversations with the base hospital must be fully documented with the name of the base hospital physician who determined death, times and instructions on the patient care report.

ALS PROCEDURE

- All patients in ventricular fibrillation should be resuscitated and transported unless otherwise determined by the base hospital physician/designee.
- Severe blunt force trauma, pulseless, without signs of life (palpable pulses and/or spontaneous respirations) and cardiac electrical activity less than 40 bpm or during EMS encounter with the patient meets Determination of Death criteria.

- All terminated ALS resuscitation efforts must have an ECG attached to the patient care report.
- All conversations with the base hospital must be fully documented with the name of the base hospital physician who determined death, times and instructions on the patient care report.

IV. SUSPECTED SUDDEN INFANT DEATH SYNDROME (SIDS) INCIDENT

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

PROCEDURE

- Follow individual department/agency policies at all times.
- Ask open-ended questions about incident.
- Explain what you are doing, the procedures you will follow, and the reasons for them.
- If you suspect a SIDS death, explain to the parent/caregiver what SIDS is and, if this is a SIDS related death nothing they did or did not do caused the death.
- Provide the parent/caregiver with the number of the California SIDS Information Line: **1-800-369-SIDS (7437)**
- Provide psychosocial support and explain the emergency treatment and transport of their child.
- Assure the parent/caregiver that your activities are standard procedures for the investigation of all death incidents and that there is no suspicion of wrongdoing.
- Document observations.

V. REFERENCES

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



POISONINGS

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. PRIORITIES

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

III. BLS INTERVENTIONS

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

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

IV. LIMITED ALS (LALS) INTERVENTIONS PRIOR TO BASE HOSPITAL CONTACT

- Assure and maintain ABCs.
- Oxygen therapy as clinically indicated, obtain O₂ saturation on room air, unless detrimental to patient condition.
- Obtain vascular access at a TKO rate or if signs of inadequate tissue perfusion, administer 500 cc fluid challenge and repeat until perfusion improves.
- For pediatric patients with signs of inadequate tissue perfusion, administer 20 cc/kg IVP and repeat until perfusion improves.

V. ALS INTERVENTIONS PRIOR TO BASE HOSPITAL CONTACT

- Assure and maintain ABCs.
- Oxygen therapy as clinically indicated, obtain O₂ saturation on room air, unless detrimental to patient condition.
- Monitor cardiac status.
- Obtain vascular access at a TKO rate or if signs of inadequate tissue perfusion, administer 500 cc fluid challenge and repeat until perfusion improves.
- For pediatric patients with signs of inadequate tissue perfusion, administer 20 cc/kg IVP and repeat until perfusion improves.
- For phenothiazine “poisoning”, administer Diphenhydramine per ICEMA Reference #7040 - Medication - Standard Orders for ataxia and/or muscle spasms.
- For known organophosphate poisoning, administer Atropine per ICEMA Reference #7040 - Medication - Standard Orders.

VI. BASE HOSPITAL MAY ORDER THE FOLLOWING

- 1.* For tricyclic poisonings, administer Sodium Bicarbonate per ICEMA Reference #7040 - Medication - Standard Orders.
- 2.* For calcium channel blocker poisonings, administer Calcium Chloride per ICEMA Reference #7040 - Medication - Standard Orders, if hypotension or bradycardic arrhythmias persist.
- 3.* For beta blocker poisonings, administer Glucagon per ICEMA Reference #7040 - Medication - Standard Orders.
- 4.* Repeat Atropine in 2 - 4 mg increments until symptoms are controlled.

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

VII. REFERENCE

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



HEAT RELATED EMERGENCIES

I. FIELD ASSESSMENT/TREATMENT INDICATORS

MINOR HEAT ILLNESS SYNDROMES

- Environmental conditions.
- Increased skin temperature.
- Increased body temperature.
- General weakness.
- Muscle cramps.

HEAT EXHAUSTION (Compensated)

- All or some of the symptoms above.
- Elevated temperature.
- Vomiting.
- Hypotension.
- Diaphoresis.
- Tachycardia.
- Tachypnea.

HEAT STROKE (Uncompensated)

- All or some of the symptoms above.
- Hyperthermia.
- ALOC or other signs of central nervous system dysfunction.
- Absence or decreased sweating.
- Tachycardia.

- Hypotension.

HEAT EXHAUSTION/ HEAT STROKE

- Dehydration.
- Elevated temperature, vomiting, hypotension, diaphoresis, tachycardia and tachypnea.
- No change in LOC.

II. BLS INTERVENTIONS

- Remove patient from heat source, position with legs elevated and begin cooling measures.
- Oxygen as clinically indicated.
- Rehydrate with small amounts of appropriate liquids as tolerated. Do not give liquids if altered level of consciousness.
- If patient has signs of Heat Stroke, begin rapid cooling measures including cold packs placed adjacent to large superficial vessels.
- Evaporative cooling measures.

III. LIMITED ALS INTERVENTIONS

- Obtain vascular access.
 - ADULT
 - Fluid bolus with 500 cc NS. Reassess and repeat fluid bolus if continued signs of inadequate tissue perfusion.
 - PEDIATRIC
 - Patients less than nine (9) years of age: Initial 20 cc/kg IV bolus; reassess and repeat fluid bolus if continued signs of inadequate tissue perfusion.
- If clinically indicated, obtain blood glucose. If hypoglycemic administer:
 - ADULT/PEDIATRIC
 - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.

- Glucagon per ICEMA Reference #7040 - Medication - Standard Orders.
- Seizure precautions, refer to ICEMA Reference #11080 - Altered Level of Consciousness/Seizures - Adult.
- Contact base hospital for destination and further treatment orders.

IV. ALS INTERVENTIONS

- Obtain vascular access.
 - ADULT
 - Fluid bolus with 500 cc NS. May repeat fluid bolus if continued signs of inadequate tissue perfusion.
 - PEDIATRIC
 - Patients less than nine (9) years of age: Initial 20 cc/kg IV/IO bolus; reassess and repeat fluid bolus if continued signs of inadequate tissue perfusion.
- If clinically indicated, obtain blood glucose. If hypoglycemic administer:
 - ADULT/PEDIATRIC
 - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
 - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders.
- Base hospital may order additional medication dosages and additional fluid boluses.
- Obtain rhythm strip for documentation with copy to receiving hospital.
- For tonic/clonic type seizure activity administer:
 - ADULT/PEDIATRIC
 - Midazolam per ICEMA Reference #7040 -Medication - Standard Orders.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|---|
| 7040 | Medication - Standard Orders |
| 11080 | Altered Level of Consciousness/Seizures - Adult |



COLD RELATED EMERGENCIES

I. FIELD ASSESSMENT/TREATMENT INDICATORS

MILD HYPOTHERMIA

- Decreased core temperature.
- Cold, pale extremities.
- Shivering, reduction in fine motor skills.
- Loss of judgment and/or altered level of consciousness or simple problem solving skills.

SEVERE HYPOTHERMIA

- Severe cold exposure or any prolonged exposure to ambient temperatures below 36 degrees with the following indications:
 - Altered LOC with associated behavior changes.
 - Unconscious.
 - Lethargic.
- Shivering is generally absent.
- Blood pressure and heart sounds may be unobtainable.

SUSPECTED FROSTBITE

- Areas of skin that is cold, white, and hard to touch.
- Capillary refill greater than two (2) seconds.
- Pain and/or numbness to affected extremity.

II. BLS INTERVENTIONS

- Remove from cold/wet environment; remove wet clothing and dry patient.
- Begin passive warming.

- Insulate and apply wrapped heat packs, if available, to groin, axilla and neck. This process should be continuous.
- Maintain appropriate airway with oxygen as clinically indicated (warm, humidified if possible).
- Assess carotid pulse for a minimum of one (1) to two (2) minutes. If no pulse palpable, place patient on AED. If no shock advised, begin CPR.
- Insulate to prevent further heat loss.
- Elevate extremity if frostbite is suspected.
- Do not massage affected extremity.
- Wrap affected body part in dry sterile gauze to prevent further exposure and handle with extreme care.

III. LIMITED ALS INTERVENTIONS

- Advanced airway as clinically indicated.
- Obtain vascular access.
- Obtain blood glucose level, if indicated administer:
 - ADULT/PEDIATRIC
 - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
 - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
 - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders if unable to establish IV.
- Obtain vascular access and administer fluid bolus.
 - Nine (9) years and older: 300 ml warmed NS, may repeat.
 - Birth to eight (8) years: 20 ml/kg warmed NS, may repeat.
- Contact base hospital.

IV. ALS INTERVENTIONS

- Obtain vascular access.

- Cardiac monitor.
- If clinically indicated, obtain blood glucose. If hypoglycemic administer:
 - ADULT/PEDIATRIC
 - Dextrose per ICEMA Reference #7040 -Medication - Standard Orders.
 - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to establish IV.
- For complaints of pain in affected body part:
 - ADULT/PEDIATRIC
 - Morphine Sulfate per ICEMA Reference #7040 -Medication - Standard Orders.
- In Radio Communication Failure, may repeat above dosage of Morphine Sulfate.
- Advanced airway as clinically indicated.
- Obtain vascular access and administer fluid bolus.
 - Nine (9) years and older: 500 ml warmed NS, may repeat.
 - Birth to eight (8) years: 20 ml/kg warmed NS, may repeat.
- Obtain rhythm strip for documentation.
- For documented VF, Pulseless V-Tach:
 - Defibrillate one (1) time at manufacturer recommended dose. Do not defibrillate again until patient has begun to warm.
- For documented asystole:
 - Begin CPR.
 - May give additional fluid bolus.
- Contact base hospital.

V. REFERENCE

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



RESPIRATORY EMERGENCIES - PEDIATRIC (Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Asthma
- Toxic Inhalation
- Difficult Breathing

II. BLS INTERVENTIONS

- Assess environment and determine possible causes.
- If safe remove patient from any suspected contaminant.
- Recognize signs and symptoms of respiratory distress for age.
- Reduce anxiety, assist patient to assume position of comfort.
- Oxygen administration as clinically indicated (humidified oxygen preferred).

III. LIMITED ALS (LALS) INTERVENTIONS

- Maintain airway with appropriate adjuncts, obtain oxygen saturation on room air if possible.
- Nebulized Albuterol per ICEMA Reference #7040 - Medication - Standard Orders.
- If no response to Albuterol, consider Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders.
- Obtain vascular access at a TKO rate.
- If allergic reaction suspected, refer to ICEMA Reference #14030 - Pediatric Allergic Reaction (Less than 15 years of age).
- Base hospital physician may order additional medications or interventions as indicated by patient condition.

IV. ALS INTERVENTIONS

- Maintain airway with appropriate adjuncts, obtain O₂ saturation on room air if possible.
 - Nebulized Albuterol with Atrovent, per ICEMA Reference #7040 - Medication - Standard Orders.
- If no response to Albuterol and Atrovent, consider Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders. Obtain vascular access at a TKO rate.
- If allergic reaction suspected, refer to ICEMA Reference #14030 - Allergic Reactions - Pediatric (Less than 15 years of age).
- Base hospital physician may order additional medications or interventions as indicated by patient condition.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|--|
| 7040 | Medication - Standard Orders |
| 14030 | Allergic Reactions - Pediatric (Less than 15 years of age) |



AIRWAY OBSTRUCTION - PEDIATRIC (Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Universal sign of distress.
- Sudden alteration in respiratory effort or signs of obstruction - coughing, gagging, stridor, wheezing, or apnea.
- Altered level of consciousness (for younger children this is measured by the inability to recognize caregiver, no aversion to being cared for by EMS field personnel, limp and/or ineffective cry).

II. BLS INTERVENTIONS

RESPONSIVE

- Assess for ability to cry, speak or cough (e.g., “are you choking?”).
- Administer abdominal thrusts (repeated cycles of five (5) back slaps and five (5) chest thrusts for infant less than one (1) year), until the foreign body obstruction is relieved or until patient becomes unresponsive.
- After obstruction is relieved, reassess and maintain ABCs.
- Obtain O₂ saturation.
- Administer oxygen.
- If responsive, place in position of comfort, enlisting help of child’s caregiver if needed. If child is uninjured but unresponsive with adequate breathing and a pulse, place in recovery position.

UNRESPONSIVE

- Position patient supine (for suspected trauma maintain in-line axial stabilization). Place under-shoulder support to achieve neutral cervical spinal position if indicated.
- Begin CPR, starting with thirty (30) compressions.
- Open airway using the head tilt-chin lift method (for suspected trauma, use jaw thrust). Remove object if visible.

- If apneic, attempt two (2) ventilations with bag-valve mask. If no chest rise or unable to ventilate, continue cycles of thirty (30) compressions to two (2) ventilations until obstruction is relieved or able to ventilate.
- If apneic and able to ventilate, provide one (1) breath every three (3) to five (5) seconds. Confirm that pulses are present and reassess every two (2) minutes.

III. LIMITED ALS (LALS) INTERVENTIONS

- If apneic and able to ventilate, consider King Airway placement per ICEMA Reference #10190 - ICEMA Approved Skills.
- If obstruction persists continue with compressions until obstruction is relieved or arrival at hospital.
- Transport to closest receiving hospital for airway management.

IV. ALS INTERVENTIONS

- If apneic and able to ventilate, consider intubation per ICEMA Reference #10190 - ICEMA Approved Skills.
- If obstruction persists and unable to ventilate, visualize with laryngoscope and remove visible foreign body with Magill forceps and attempt to ventilate.
- If obstruction persists, consider Needle Cricothyrotomy per ICEMA Reference #10190 - ICEMA Approved Skills.

V. REFERENCE

| <u>Number</u> | <u>Name</u> |
|---------------|-----------------------|
| 10190 | ICEMA Approved Skills |



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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

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

II. BLS INTERVENTIONS

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

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

- Maintain airway with appropriate adjuncts, obtain O₂ saturation on room air if possible.
- Albuterol per ICEMA Reference #7040 - Medication - Standard Orders.
- If no response to Albuterol, consider Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders.
- For symptomatic hypotension with poor perfusion, consider fluid bolus of 20 ml/kg of NS not to exceed 300 ml NS and repeat as indicated.
- Establish additional IV access if indicated.
- Base hospital may order additional medication dosages and additional fluid boluses.

IV. ALS INTERVENTIONS

- Maintain airway with appropriate adjuncts, obtain O₂ saturation on room air if possible.
- Albuterol with Atrovent per ICEMA Reference #7040 - Medication - Standard Orders.
- If no response to Albuterol and Atrovent, consider Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders.
- For symptomatic hypotension with poor perfusion, consider fluid bolus of 20 ml/kg of NS not to exceed 300 ml NS and repeat as indicated.
- Diphenhydramine per ICEMA Reference #7040 - Medication - Standard Orders.
- Establish additional IV access if indicated.
- For anaphylactic shock (e.g., no palpable radial pulse and a depressed level of consciousness), administer Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders.
- Base hospital may order additional medication dosages and additional fluid boluses.

V. REFERENCE

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



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; 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.

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

- Obtain blood glucose level, if indicated administer;
 - Dextrose as per ICEMA Reference #7040 - Medication - Standard Orders.
 - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.
 - Administer Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to start an IV.
- If suspected narcotic overdose with severely decreased respiratory drive administer:
 - Naloxone per ICEMA Reference #7040 - Medication - Standard Orders.
- Base hospital 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.
- Insert NG/OG tube after advanced airway is established or if not placed with BLS airway.
- 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, for confirmation and monitoring of endotracheal tube placement and for assessment of ROSC and perfusion status.

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 not to exceed the adult dose.
- 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, during each two (2) minute cycle of CPR after each defibrillation unless capnography indicates possible ROSC.
- 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, may repeat.
- If patient remains in pulseless VF/VT after five (5) cycles of CPR, consult base hospital.

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, per ICEMA Reference #7040 - Medication - Standard Orders, during each two (2) minute cycle of CPR after each rhythm evaluation.

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, base hospital contact is required.

- Insert NG/OG tube to relieve gastric distention if the patient has been intubated with an advanced airway, or if the patient has a BLS airway, per ICEMA Reference #10190 - ICEMA Approved Skills.

- 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.
 - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.
 - Naloxone for suspected opiate overdose per ICEMA Reference #7040 - Medication - Standard Orders.

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

- Utilize continuous waveform capnography, to identify loss of circulation.
- For continued signs of inadequate tissue perfusion **after** successful resuscitation:
 - Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders.
 - 9 to 14 years: Dopamine per ICEMA Reference #7040 - Medication - Standard Orders.
- Base hospital physician may order additional medications or interventions as indicated by patient condition.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|-------------------------------|
| 7040 | Medications - Standard Orders |
| 10190 | ICEMA Approved Skills |



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 patient temperature. Begin cooling measures if temperature is elevated or warming measures if temperature is decreased.

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.
- Obtain blood glucose level, if indicated administer:
 - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
 - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.
 - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to start an IV.

- If suspected narcotic overdose with severely decreased respiratory drive administer:
 - Naloxone per ICEMA Reference #7040 - Medication - Standard Orders.
- Base hospital 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.
- Obtain blood glucose level, if indicated administer:
 - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
 - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders, if indicated.
 - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to start an IV.
- If suspected narcotic ingestion with severely decreased respiratory distress administer:
 - Naloxone per ICEMA Reference #7040 - Medication - Standard Orders.
- Base hospital physician may order additional medication dosages and additional fluid boluses.

V. REFERENCE

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



SEIZURE - PEDIATRIC (Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Tonic/clonic movements followed by a brief period of unconsciousness (post-ictal).
- Suspect status epilepticus for frequent or extended seizures.
- History of prior seizures, narcotic dependence or diabetes.
- Febrile seizures (patients under four (4) years of age).
- Traumatic injury.

II. BLS INTERVENTIONS

- Protect patient from further injury; axial-spinal stabilization if indicated.
- Assure and maintain airway patency after cessation of seizure, with oxygen therapy as indicated.
- Airway management as indicated (OPA/NPA, BVM Ventilation).
- Position patient in left lateral position in absence of traumatic injury; watch for absent gag reflex.
- Remove excess clothing and begin cooling measures if patient is febrile.
- Protect patient during transport by padding appropriately.

III. LIMITED ALS (LALS) INTERVENTIONS

- Advanced airway as clinically indicated.
- Obtain vascular access.
- Obtain blood glucose level, if indicated administer:
 - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.

- May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.
- Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to start an IV.

IV. ALS INTERVENTIONS

- Establish advanced airway as needed.
- Obtain vascular access and place on cardiac monitor if indicated.
- Obtain blood glucose level, if indicated administer:
 - Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
 - May repeat blood glucose level. Repeat Dextrose per ICEMA Reference #7040 - Medication - Standard Orders if indicated.
 - Glucagon per ICEMA Reference #7040 - Medication - Standard Orders, if unable to start an IV.
- For tonic/clonic type seizure activity administer:
 - Midazolam per ICEMA Reference #7040 - Medication - Standard Orders.
 - Assess and document response to therapy.
 - Base hospital may order additional medication dosages or a fluid bolus.

V. REFERENCE

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



BURNS - PEDIATRIC (Less Than 15 Years of Age)

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

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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to ICEMA Reference #8130 - Destination Policy.

II. BLS INTERVENTIONS

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

A. Manage Special Considerations

- **Thermal Burns:** Stop the burning process. Do not break blisters. Cover the affected body surface with dry, sterile dressing or sheet.
- **Chemical Burns:** Brush off dry powder, if present. Remove any contaminated or wet clothing. Irrigate with copious amounts of saline or water.
- **Tar Burns:** Cool with water, do not remove tar.
- **Electrical Burns:** Remove from electrical source (without endangering self) with a nonconductive material. Cover the affected body surface with dry, sterile dressing or sheet.

- **Eye Involvement:** Continuous flushing with NS during transport. Allow patient to remove contact lenses if possible.
- **Determination of Death on Scene:** Refer to ICEMA Reference #12010 - Determination of Death on Scene.

III. LIMITED ALS (LALS) INTERVENTIONS

- Airway Stabilization (as indicated). Burn patients with respiratory compromise or potential for such, will be transported to the closest receiving hospital for airway stabilization.
- IV/IO Access (warm IV fluids when available).
 - *Unstable:* Vital signs (age appropriate) and/or signs of inadequate tissue perfusion consider starting a second IV or saline lock. Administer 20 ml/kg NS bolus IV/IO, may repeat one (1) time.
 - *Stable:* Vital signs (age appropriate) and/or signs of adequate tissue perfusion.
 - < 5 years of age: IV NS 150 ml/hour
 - > 5 years of age - < 15 years of age: IV NS 250 ml/hour
- Transport to appropriate facility:
 - Critical trauma patients with associated burns or burn patients sustaining critical trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.
- Refer to Section V - Burn Classifications below.

A. Manage Special Considerations

- **Respiratory Distress:**
 - Albuterol per ICEMA Reference #7040 - Medication - Standard Orders.
 - Administer humidified oxygen, if available.
- **Deteriorating Vital Signs:** Transport to the closest receiving hospital. Contact base hospital.

- **Pulseness and Apneic:** Transport to the closest receiving hospital and treat according to ICEMA protocols. Contact base hospital.
- **Determination of Death on Scene:** Refer to ICEMA Reference #12010 - Determination of Death on Scene.
- **Precautions and Comments:**
 - Contact with appropriate advisory agency may be necessary for hazardous materials, before decontamination or patient contact.
 - Do not apply ice or ice water directly to skin surfaces as additional injury will result.
 - Do not apply cool dressings or allow environmental exposure, since hypothermia will result in a young child.

IV. ALS INTERVENTIONS

- Advanced airway (as indicated).
 - **Airway Stabilization:** Burn patients with respiratory compromise or potential for such, will be transported to the closest receiving hospital for airway stabilization.
- Monitor ECG.
- IV/IO Access (Warm IV fluids when available).
 - *Unstable:* Vital signs (age appropriate) and/or signs of inadequate tissue perfusion consider starting a second IV or saline lock. Administer 20 ml/kg NS bolus IV/IO, may repeat one (1) time.
 - *Stable:* Vital signs (age appropriate) and/or signs of adequate tissue perfusion.
 - < 5 years of age: IV NS 150 ml/hour
 - > 5 years of age - < 15 years of age: IV NS 250 ml/hour
- Treat pain as indicated.
 - Morphine Sulfate per ICEMA Reference #7040 - Medication - Standard Orders.

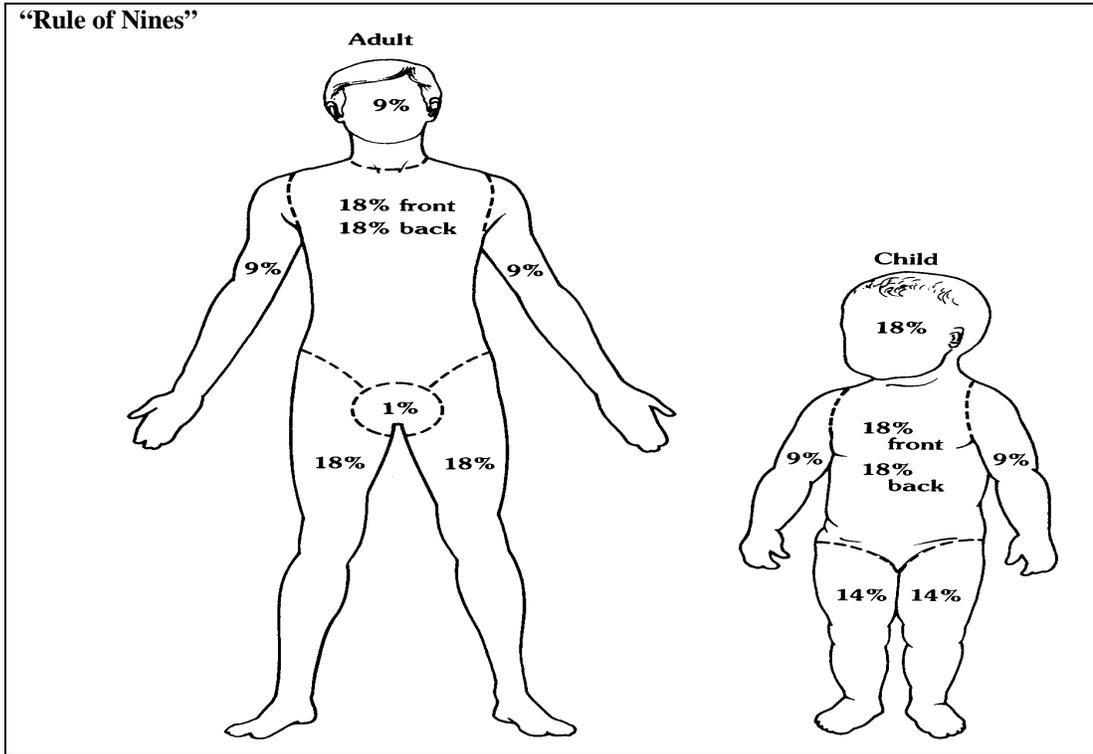
- Document vital signs every five (5) minutes while medicating for pain, and reassess the patient.
- Transport to appropriate facility:
 - Critical trauma patients with associated burns or burn patients sustaining critical trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.
 - Insert nasogastric/orogastric tube as indicated.
- Refer to Section V - Burn Classifications below.

A. Manage Special Considerations

- **Respiratory Distress:** Intubate patient if facial/oral swelling are present or if respiratory depression or distress develops due to inhalation injury.
 - Albuterol per ICEMA Reference #7040 - Medication - Standard Orders.
 - Administer humidified oxygen, if available.
- **Deteriorating Vital Signs:** Transport to the closest receiving hospital. Contact base hospital.
- **Pulseness and Apneic:** Transport to the closest receiving hospital and treat according to ICEMA protocols. Contact base hospital.
- **Determination of Death on Scene:** Refer to ICEMA Reference #12010 - Determination of Death on Scene.
- **Precautions and Comments:**
 - Contact with appropriate advisory agency may be necessary for hazardous materials, before decontamination or patient contact.
 - Do not apply ice or ice water directly to skin surfaces as additional injury will result.
 - Do not apply cool dressings or allow environmental exposure, since hypothermia will result in a young child.

V. BURN CLASSIFICATIONS

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



VI. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|---------------------------------|
| 7040 | Medication - Standard Orders |
| 8130 | Destination Policy |
| 12010 | Determination of Death on Scene |



OBSTETRICAL EMERGENCIES

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Obstetrical emergencies (field delivery) with or without complications.

II. BLS INTERVENTIONS

UNCOMPLICATED DELIVERY

- Administer oxygen as clinically indicated.
- Prepare for delivery.
- Massage fundus if placenta delivered.

COMPLICATED DELIVERY

- Excessive vaginal bleeding prior to delivery:
 - Attempt to control bleeding. Do not place anything into vagina.
 - Place in trendelenberg position.
- Prolapsed Cord:
 - Elevate hips.
 - Gently push presenting part of head away from cord.
 - Consider knee/chest position for mother.
- Postpartum Hemorrhage:
 - Massage fundus to control bleeding.
 - Encourage immediate breast feeding.
 - Place in trendelenburg position.
- Cord around infant's neck:
 - Attempt to slip cord over the head.

- If unable to slip cord over the head, deliver the baby through the cord.
- If unable to deliver the baby through the cord, double clamp cord, then cut cord between clamps.
- Breech presentation and head not delivered within three (3) to four (4) minutes:
 - Administer oxygen.
 - Place in trendelenburg position.
 - Transport Code 3 to closest appropriate facility.
- Pregnancy Induced Hypertension and/or Eclampsia:
 - Initiate and maintain seizure precautions.
 - Attempt to reduce stimuli.
 - Limit fluid intake.
 - Monitor and document blood pressure.
 - Consider left lateral position.

III. LIMITED ALS (LALS) INTERVENTIONS

COMPLICATED DELIVERY

- Obtain IV access, and maintain IV rate as appropriate.
- Excessive vaginal bleeding or post-partum hemorrhage:
 - Give fluid challenge of 500 ml, if signs of inadequate tissue perfusion persist may repeat fluid bolus.
 - Maintain IV rate at 150 ml per hour.
 - Establish second large bore IV enroute.
- Pregnancy Induced Hypertension and/or Eclampsia:
 - IV TKO, limit fluid intake.
 - Obtain O₂ saturation on room air, if possible.

- Place in left lateral position, and obtain blood pressure after five (5) minutes.
- Consider immediate notification of base hospital physician.

IV. ALS INTERVENTIONS

COMPLICATED DELIVERY

- Obtain IV access, and maintain IV rate as appropriate.
- Excessive vaginal bleeding or post-partum hemorrhage:
 - Administer fluid challenge of 500 ml. If signs of inadequate tissue perfusion persist may repeat fluid bolus.
 - Maintain IV rate at 150 ml per hour.
 - Establish second large bore IV enroute.
- Pregnancy induced hypertension:
 - Administer IV TKO. Limit fluid intake.
 - Obtain O₂ saturation on room air, if possible.
 - Place in left lateral position, and obtain blood pressure after five (5) minutes.
 - Obtain rhythm strip with copy to receiving hospital.
- Eclampsia (Seizure/Tonic/Clonic Activity):
 - Magnesium Sulfate per ICEMA Reference #7040 - Medication - Standard Orders.
 - Midazolam per ICEMA Reference #7040 - Medication - Standard Orders.
- Consider immediate notification of base hospital physician.
- Base hospital physician may order or in Radio Communication Failure:
 - Dopamine infusion per ICEMA Reference #7040 - Medication - Standard Orders.

V. REFERENCE

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



NEWBORN CARE

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Field delivery with or without complications.

II. BLS INTERVENTIONS

- When head is delivered, suction mouth then the nose, and check to see that cord is not around baby's neck.
- Dry infant and provide warm environment. Prevent heat loss (remove wet towel).
- Place baby in supine position at or near the level of the mother's vagina. After pulsation of cord has ceased double clamp cord at approximately seven (7) inches and ten (10) inches from baby and cut between clamps.
- Maintain airway, suction mouth and nose.
- Provide tactile stimulation to facilitate respiratory effort.
- Assess breathing if respirations < 20 or gasping, provide tactile stimulation and assisted ventilation if indicated.
- Circulation:
 - Heart Rate < 100 ventilate BVM with 100% oxygen for thirty (30) seconds and reassess. If heart rate is still < 100 /min, begin CPR with ventilations at a 3:1 ratio of compressions to ventilations (approximately 100 compressions and 30 ventilations /min).
- If central cyanosis is present, utilize supplemental oxygen at 10 to 15 L /min using oxygen tubing close to infant's nose and reassess. If no improvement is noted after thirty (30) seconds assist ventilation with BVM.
- Obtain Apgar scoring at one (1) and five (5) minutes. Do not use Apgar to determine need to resuscitate.

APGAR SCORE

| SIGN | 0 | 1 | 2 |
|----------------------------|--------------|------------------|-----------------|
| Heart Rate | Absent | < 100 /minute | > 100 /minute |
| Respirations | Absent | < 20 /irregular | >20 /crying |
| Muscle Tone | Limp | Some Flexion | Active Motion |
| Reflex Irritability | No Response | Grimace | Cough or Sneeze |
| Color | Blue or pale | Blue Extremities | Completely Pink |

III. LIMITED ALS (LALS) INTERVENTIONS

- Obtain vascular access via IV if indicated.
- Obtain blood glucose by heel stick.
 - If blood glucose < 35 mg/dL, administer Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
- Contact base hospital if hypovolemia is suspected. Base hospital may order 10 ml/kg IV NS over five (5) minutes. If unable to contact base hospital and transport time is extended, administer 10 ml/kg IV NS over five (5) minutes, may repeat one (1) time.

IV. ALS INTERVENTIONS

- Obtain vascular access via IV/IO if indicated.
- Consider advanced airway, per ICEMA Reference #10190 - ICEMA Approved Skills, if BVM is ineffective or tracheal suctioning is required. Utilize Waveform Capnography to assess efficacy of compressions and ventilations. Place orogastric tube after advanced airway is in place. Reassess placement after every intervention.
- Obtain blood glucose by heel stick.
 - If blood glucose < 35 mg/dL, administer Dextrose per ICEMA Reference #7040 - Medication - Standard Orders.
- Evaluate airway for hypoxemia and assess body temperature for hypothermia then consider Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders , if heart rate < 60 after one (1) minute.
- Contact base hospital if hypovolemia is suspected. Base hospital may order 10 ml/kg IV NS over five (5) minutes. If unable to contact base hospital and transport time is extended, administer 10 ml/kg IV NS over five (5) minutes, may repeat.

- For persistent hypotension despite adequate ventilation and fluid resuscitation, base hospital may order Epinephrine per ICEMA Reference #7040 - Medication - Standard Orders, every ten (10) minutes. If unable to contact base hospital and transport time is extended, give indicated dosage and contact base hospital as soon as possible.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|------------------------------|
| 7040 | Medication - Standard Orders |
| 10190 | ICEMA Approved Skills |



TRAUMA - ADULT (15 years of age and older)

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

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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to ICEMA Reference #15030 - Trauma Triage Criteria and Destination Policy.

II. BLS INTERVENTIONS

- Ensure thorough initial assessment.
- Ensure patent airway, protecting cervical spine.
- Oxygen and/or ventilate as needed, O₂ saturation (if BLS equipped).
- Keep patient warm.
- For a traumatic full arrest, an AED may be utilized, if indicated.
- Transport to ALS intercept or to the closest receiving hospital.

A. Manage Special Considerations

- **Axial Spinal Immobilization:** If the patient meet(s) any of the following indicators using the acronym (NSAID):

N-euro Deficit(s) present?
S-pinal Tenderness present?
A-ltered Mental Status?
I-ntoxication?
D-istracting Injury?

- Consider maintaining spinal alignment on the gurney, or using spinal axial immobilization on an awake, alert and cooperative patient, without the use of a rigid spine board.

- Penetrating trauma without any NSAID indicators are not candidates for spinal immobilization using long board.
- **Abdominal Trauma:** Cover eviscerated organs with saline dampened gauze. Do not attempt to replace organs into the abdominal cavity.
- **Amputations:** Control bleeding. Rinse amputated part gently with sterile irrigation saline to remove loose debris/gross contamination. Place amputated part in dry, sterile gauze and in a plastic bag surrounded by ice (if available). Prevent direct contact with ice. Document in the narrative who the amputated part was given to.

Partial Amputation: Splint in anatomic position and elevate the extremity.
- **Bleeding:**
 - Apply direct pressure and/or pressure dressing.
 - To control life-threatening bleeding of a severely injured extremity, consider application of tourniquet when direct pressure or pressure dressing fails.
- **Chest Trauma:** If a wound is present, cover it with an occlusive dressing. If the patient's ventilations are being assisted, dress wound loosely, (do not seal). Continuously reevaluate patient for the development of tension pneumothorax.
- **Flail Chest:** Stabilize chest, observe for tension pneumothorax. Consider assisted ventilations.
- **Fractures:** Immobilize above and below the injury. Apply splint to injury in position found except:
 - **Femur:** Apply traction splint if indicated.
 - **Grossly angulated long bone with distal neurovascular compromise:** Apply gentle unidirectional traction to improve circulation.
 - **Check and document distal pulse before and after positioning.**
- **Genital Injuries:** Cover genitalia with saline soaked gauze. If necessary, apply direct pressure to control bleeding. Treat amputations the same as extremity amputations.

- **Head and Neck Trauma:** Place brain injured patients in reverse Trendelenburg (elevate the head of the backboard 15 - 20 degrees), if the patient exhibits no signs of shock.
 - **Eye:** Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe, stabilize it in place with sterile saline soaked gauze. Cover uninjured eye.
 - **Avulsed Tooth:** Collect teeth, place in moist, sterile saline gauze and place in a plastic bag.
- **Impaled Object:** Immobilize and leave in place. Remove object if it interferes with CPR, or if the object is impaled in the face, cheek or neck and is compromising ventilations.
- **Pregnancy:** Where axial spinal stabilization precaution is indicated, the board should be elevated at least 4 inches on the right side for those patients who have a large pregnant uterus, usually applies to pregnant females ≥ 24 weeks of gestation.
- **Traumatic Arrest:** CPR if indicated. May utilize an AED if indicated.
- **Determination of Death on Scene:** Refer to ICEMA Reference #12010 - Determination of Death on Scene.

III. LIMITED ALS (LALS) INTERVENTIONS

- Advanced airway (as indicated).
 - **Unmanageable Airway:** Transport to the closest most appropriate receiving hospital when the patient requires advanced airway and an adequate airway cannot be maintained with a BVM device.
- Apply AED.
- IV Access (warm IV fluids when available).
 - **Unstable:** BP<90mmHG and/or signs of inadequate perfusion, start 2nd IV access.
 - **Stable:** BP>90mmHG and/or signs of adequate tissue perfusion.

Blunt Trauma:

- *Unstable:* IV NS open until stable or 2000 ml maximum is infused.
- *Stable:* IV NS TKO

Penetrating Trauma:

- *Unstable:* IV NS 500 ml bolus one (1) time.
- *Stable:* IV NS TKO

Isolated Closed Head Injury:

- *Unstable:* IV NS 250 ml bolus, may repeat to a maximum of 500 ml.
- *Stable:* IV NS TKO

- Transport to appropriate hospital.

A. Manage Special Considerations

- **Axial Spinal Immobilization:** LALS personnel should remove axial spinal immobilization devices from patients placed in full axial spinal immobilization precautions by first responders and BLS personnel if the patient does not meet any of the following indicators using the acronym (NSAID):

N-euro Deficit(s) present?
S-pinal Tenderness present?
A-ltered Mental Status?
I-ntoxication?
D-istracting Injury?

- Consider maintaining spinal alignment on the gurney, or using spinal axial immobilization on an awake, alert and cooperative patient, without the use of a rigid spine board.
- Penetrating trauma without any NSAID indicators are not candidates for spinal immobilization using long board.

- **Fractures:**

- **Isolated Extremity Trauma:** Trauma without multisystem mechanism. Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured, e.g., dislocated shoulder, hip fracture or dislocation.

- Administer IV NS 250 ml bolus one (1) time.
 - **Impaled Object:** Remove object upon Trauma base hospital physician order, if indicated.
 - **Traumatic Arrest:** Continue CPR as appropriate.
 - Apply AED and follow the voice prompts.
- B. Determination of Death on Scene:** Refer to ICEMA Reference #12010 - Determination of Death on Scene.
- *Severe Blunt Force Trauma Arrest:* If indicated, transport to the closest receiving hospital.
 - *Penetrating Trauma Arrest:* If indicated, transport to the closest receiving hospital.
 - If the patient does not meet the “Obvious Death Criteria” in ICEMA Reference #12010 - Determination of Death on Scene, contact the Trauma base hospital for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.
 - Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without Trauma base hospital contact.
 - **Precautions and Comments:**
 - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
 - Consider cardiac etiology in older patients in cardiac arrest with low probability of mechanism of injury.
 - If the patient is not responsive to trauma-oriented resuscitation, consider medical etiology and treat accordingly.
 - **Unsafe scene may warrant transport despite low potential for survival.**
 - Whenever possible, consider minimal disturbance of a potential crime scene.

- **Base Hospital Orders:** May order additional fluid boluses.

IV. ALS INTERVENTIONS

- Advanced Airway (as indicated):
 - Unmanageable Airway: If an adequate airway cannot be maintained with a BVM device; **and** the paramedic is unable to intubate or perform a successful needle cricothyrotomy (if indicated), **then** transport to the closest receiving hospital and follow ICEMA Reference #8120 - Continuation of Care.
- Monitor ECG.
- IV/IO Access (Warm IV fluids when available).
 - *Unstable:* BP <90mmHG and/or signs of inadequate perfusion, start 2nd IV access.
 - *Stable:* BP >90mmHG and/or signs of adequate tissue perfusion.

Blunt Trauma:

- *Unstable:* IV NS open until stable or 2000 ml maximum is infused.
- *Stable:* IV NS TKO

Penetrating Trauma:

- *Unstable:* IV NS 500 ml bolus one (1) time.
- *Stable:* IV NS TKO

Isolated Closed Head Injury:

- *Unstable:* IV NS 250 ml bolus, may repeat to a maximum of 500 ml
- *Stable:* IV NS TKO
- Transport to appropriate hospital.
- Insert nasogastric/orogastric tube as indicated.

A. **Manage Special Considerations**

- **Axial Spinal Immobilization:** ALS personnel should remove axial spinal immobilization devices from patients placed in full axial spinal immobilization precautions by first responders and BLS personnel if the patient does not meet any of the following indicators using the acronym (NSAID):

N-euro Deficit(s) present?

S-pinal Tenderness present?

A-ltered Mental Status?

I-ntoxication?

Distracting Injury?

- Consider maintaining spinal alignment on the gurney, or using spinal axial immobilization on an awake, alert and cooperative patient, without the use of a rigid spine board.
- Penetrating trauma without any NSAID indicators are not candidates for spinal immobilization using long board.
- **Chest Trauma:** Perform needle thoracostomy for chest trauma with symptomatic respiratory distress.
- **Fractures:**
 - **Isolated Extremity Trauma:** Trauma without multisystem mechanism. Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured, e.g., dislocated shoulder, hip fracture or dislocation.
 - **Pain Relief:**
 - Morphine Sulfate per ICEMA Reference #7040 - Medication - Standard Orders.
 - Consider Ondansetron per ICEMA Reference #7040 - Medication - Standard Orders.
 - Patients in high altitudes should be hydrated with IV NS prior to IV pain relief to reduce the incidents of nausea, vomiting, and transient hypotension, which are side effects associated with administering IV Morphine. Administer IV NS 250 ml bolus one (1) time.
- **Head and Neck Trauma:** Immediately prior to intubation, consider prophylactic Lidocaine per ICEMA Reference #7040 - Medication - Standard Orders.

- **Base Hospital Orders:** When considering Nasotracheal intubation (≥ 15 years of age) and significant facial trauma, trauma to the face or nose and/or possible basilar skull fracture are present, Trauma base hospital contact is required.
- **Impaled Object:** Remove object upon Trauma base hospital physician order, if indicated.
- **Traumatic Arrest:** Continue CPR as appropriate.
 - Treat per ICEMA Reference #11070 - Cardiac Arrest - Adult.

B. Determination of Death on Scene: Refer to ICEMA Reference #12010 - Determination of Death on Scene.

- *Severe Blunt Force Trauma Arrest:* If indicated, pronounce on scene.
- *Penetrating Trauma Arrest:* If indicated, transport to the closest receiving hospital.
- If the patient does not meet the “Obvious Death Criteria” per ICEMA Reference #12010 - Determination of Death on Scene, contact the Trauma base hospital for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma with documented asystole in at least two (2) leads, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.
- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without Trauma base hospital contact.
- **Precautions and Comments:**
 - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
 - Consider cardiac etiology in older patients in cardiac arrest with low probability of mechanism of injury.
 - **Unsafe scene may warrant transport despite low potential for survival.**
 - Whenever possible, consider minimal disturbance of a potential crime scene.

- **Base Hospital Orders:** May order additional medications and/or fluid boluses.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|---------------------------------|
| 7040 | Medication - Standard Orders |
| 8120 | Continuation of Care |
| 11070 | Cardiac Arrest - Adult |
| 12010 | Determination of Death on Scene |



TRAUMA - PEDIATRIC (Less than 15 years of age)

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

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

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to ICEMA Reference #15030 - Trauma Triage Criteria and Destination Policy.

II. BLS INTERVENTIONS

- Ensure thorough initial assessment.
- Ensure patient airway, protecting cervical spine.
- Axial spinal stabilization as appropriate.
- Oxygen and/or ventilate as needed, O₂ saturation (if BLS equipped).
- Keep patient warm and reassure.
- For a traumatic full arrest, an AED may be utilized, if indicated.
- Transport to ALS intercept or to the closest receiving hospital.

A. Manage Special Considerations

- **Abdominal Trauma:** Cover eviscerated organs with saline dampened gauze. Do not attempt to replace organs into the abdominal cavity.
- **Amputations:** Control bleeding. Rinse amputated part gently with sterile irrigation saline to remove loose debris/gross contamination. Place amputated part in dry, sterile gauze and in a plastic bag surrounded by ice (if available). Prevent direct contact with ice. Document in the narrative who the amputated part was given to.

Partial amputation: Splint in anatomic position and elevate the extremity.

- **Blunt Chest Trauma:** If a wound is present, cover it with an occlusive dressing. If the patient's ventilations are being assisted, dress wound loosely, (do not seal). Continuously re-evaluate patient for the development of tension pneumothorax.
- **Flail Chest:** Stabilize chest, observe for tension pneumothorax. Consider assisted ventilations.
- **Fractures:** Immobilize above and below the injury. Apply splint to injury in position found except:
 - **Femur:** Apply traction splint if indicated.
 - **Grossly angulated long bone with distal neurovascular compromise:** Apply gentle unidirectional traction to improve circulation.
 - **Check and document distal pulse before and after positioning.**
- **Genital Injuries:** Cover genitalia with saline soaked gauze. If necessary, apply direct pressure to control bleeding. Treat amputations the same as extremity amputations.
- **Head and Neck Trauma:** Place brain injured patients in reverse Trendelenburg (elevate the head of the backboard 15 - 20 degrees), if the patient exhibits no signs of shock.
 - **Eye:** Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe - stabilize it in place with sterile saline soaked gauze. Cover uninjured eye.
 - **Avulsed Tooth:** Collect teeth, place in moist, sterile saline gauze and place in a plastic bag.
- **Impaled Object:** Immobilize and leave in place. Remove object if it interferes with CPR, or if the object is impaled in the face, cheek or neck and is compromising ventilations.
- **Pediatric Patients:** If the level of the patient's head is greater than that of the torso, use approved pediatric spine board with a head drop or arrange padding on the board so that the ears line up with the shoulders and keep the entire lower spine and pelvis in line with the cervical spine and parallel to the board.

- **Traumatic Arrest:** CPR if indicated. May utilize an AED if indicated.
- **Determination of Death on Scene:** Refer to ICEMA Reference #12010 - Determination of Death on Scene.

III. LIMITED ALS (LALS) INTERVENTIONS

- Advanced airway (as indicated).
 - **Unmanageable Airway:** Transport to the closest most appropriate receiving hospital when the patient requires an advance airway. An adequate airway cannot be maintained with a BVM device.
- Apply AED.
- IV Access (warm IV fluids when available).
 - *Unstable:* Vital signs (age appropriate) and/or signs of inadequate tissue perfusion, start 2nd IV access.

Administer 20ml/kg NS bolus IV. May repeat once.
 - *Stable:* Vital signs (age appropriate) and/or signs of adequate tissue perfusion.

Maintain IV NS rate at TKO.
- Transport to appropriate hospital. Pediatric patients identified as CTP will be transported to a pediatric trauma hospital when there is less than a 20 minute difference in transport time to the pediatric trauma hospital versus the closes trauma hospital.

A. Manage Special Considerations

- **Fractures**
 - **Isolated Extremity Trauma:** Trauma without multisystem mechanism. Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured, e.g., dislocated shoulder, hip fracture or dislocation.
 - Administer IV NS 250 ml bolus one (1) time.
- **Impaled Object:** Remove object upon trauma base hospital physician order, if indicated.

- **Traumatic Arrest:** Continue CPR as appropriate.
 - Apply AED and follow the instructions.
- **Determination of Death on Scene:** Refer to ICEMA Reference #12010 - Determination of Death on Scene.
 - *Severe Blunt Force Trauma Arrest:* If indicated, transport to the closest receiving hospital.
 - *Penetrating Trauma Arrest:* If indicated, transport to the closest receiving hospital.
- If the patient does not meet the “Obvious Death Criteria” in ICEMA Reference #12010 - “Determination of Death on Scene”, contact the Trauma base hospital for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.
- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without trauma base hospital contact.
- **Precautions and Comments:**
 - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
 - Confirm low blood sugar in children and treat as indicated with altered level of consciousness.
 - Suspect child maltreatment when physical findings are inconsistent with the history. Remember reporting requirements for suspected child maltreatment.
 - **Unsafe scene may warrant transport despite low potential for survival.**
 - Whenever possible, consider minimal disturbance of a potential crime scene.
- **Base Hospital Orders:** May order additional fluid boluses.

IV. ALS INTERVENTIONS

- Advanced airway (as indicated).
 - Unmanageable Airway: If an adequate airway cannot be maintained with a BVM device; **and** the paramedic is unable to intubate or perform a successful needle cricothyrotomy (if indicated), **then** transport to the closest receiving hospital and follow ICEMA Reference #8100 - Continuation of Trauma Care.
- Monitor ECG.
- IV/IO Access (Warm IV fluids when available).
 - *Unstable:* Vital signs (age appropriate) and/or signs of inadequate tissue perfusion, start 2nd IV access.

Administer 20ml/kg NS bolus IV/IO, may repeat once.
 - *Stable:* Vital signs (age appropriate) and/or signs of adequate tissue perfusion.

Maintain IV NS rate at TKO.
- Transport to Trauma Center: Pediatric patients identified as CTP will be transported to a pediatric trauma hospital when there is less than a 20 minute difference in transport time to the pediatric trauma hospital versus the closest trauma hospital.
- Insert nasogastric/orogastric tube as indicated

A. Manage Special Considerations

- **Blunt Chest Trauma:** Perform needle thoracostomy for chest trauma with symptomatic respiratory distress.
- **Fractures**
 - **Isolated Extremity Trauma:** Trauma without multisystem mechanism. Extremity trauma is defined as those cases of injury where the limb itself and/or the appendicular skeleton (shoulder or pelvic girdle) may be injured - e.g. dislocated shoulder, hip fracture or dislocation.

- **Pain Relief:**
 - Morphine Sulfate per ICEMA Reference #7040 - Medication - Standard Orders.
 - For patients four (4) years old and older, consider Ondansetron per ICEMA Reference #7040 - Medication - Standard Orders.
 - Patients in high altitudes should be hydrated with IV NS prior to IV pain relief to reduce the incidents of nausea, vomiting, and transient hypotension, which are side effects associated with administering IV Morphine. Administer 20ml/kg NS bolus IV/IO one time.

- **Head and Neck Trauma:** Immediately prior to intubation, consider prophylactic Lidocaine per ICEMA Reference #7040 - Medication - Standard Orders for suspected head/brain injury.

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

- **Impaled Object:** Remove object upon Trauma base hospital physician order, if indicated.

- **Traumatic Arrest:** Continue CPR as appropriate.
 - Treat per ICEMA Reference #14040 - Cardiac Arrest - Pediatric.

- **Determination of Death on Scene:** Refer to ICEMA Reference #12010 - Determination of Death on Scene.
 - *Severe Blunt Force Trauma Arrest:* If indicated, transport to the closest receiving hospital.
 - *Penetrating Trauma Arrest:* If indicated, transport to the closest receiving hospital.

- If the patient does not meet the “Obvious Death Criteria” in ICEMA Reference #12010 - Determination of Death on Scene, contact the Trauma base hospital for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma with documented asystole in at least two (2) leads, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.

- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without Trauma base hospital contact.
- **Precautions and Comments:**
 - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
 - Confirm low blood sugar in children and treat as indicated with altered level of consciousness.
 - Suspect child maltreatment when physical findings are inconsistent with the history. Remember reporting requirements for suspected child maltreatment.
 - **Unsafe scene may warrant transport despite low potential for survival.**
 - Whenever possible, consider minimal disturbance of a potential crime scene.
- **Base Hospital Orders:** May order additional medications and/or fluid boluses.

V. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|---|
| 7040 | Medication - Standard Orders |
| 10160 | Axial Spinal Stabilization |
| 12010 | Determination of Death on Scene |
| 14040 | Cardiac Arrest - Pediatric |
| 15030 | Trauma Triage Criteria and Destination Policy |



TRAUMA TRIAGE CRITERIA AND DESTINATION POLICY

I. PURPOSE

To establish Trauma Triage Criteria that is consistent with the American College of Surgeons standards that will help identify trauma patients in the field, and based upon their injuries, direct their transport to an appropriate Trauma Center.

II. DEFINITIONS

Adult Patients: A person appearing to be > 15 years of age.

Pediatric Patients: A person appearing to be < 15 years of age.

Critical Trauma Patients (CTP): Patients meeting ICEMA's Critical Trauma Patient Criteria.

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.

Pediatric Trauma Center: A licensed acute care hospital which usually treats (but is not limited to) persons <15 years of age, designated by ICEMA's Governing Board, 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.

Inadequate Tissue Perfusion: Evidenced by the presence of cold, pale, clammy, mottled skin, and/or capillary refill time > 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.

III. POLICY

A. Transportation For Patients Identified as a CTP

- Adult patients will be transported to the closest Trauma Center.
- Pediatric patients will be transported to a Pediatric Trauma Center when there is less than a 20 minute difference in transport time to the Pediatric Trauma Center versus the closest Trauma Center.

- Helicopter transport shall not be used unless ground transport is expected to be greater than 30 minutes and EMS aircraft transport is expected to be significantly more expeditious than ground transport. If an EMS aircraft is dispatched, adherence to ICEMA Reference #8070 - Aircraft Rotation Policy (in San Bernardino County) is mandatory.
- Patients with an unmanageable airway shall be transported to the closest receiving hospital for airway stabilization. Trauma base hospital contact shall be made.
- Hospital Trauma Diversion Status: Refer to ICEMA Reference #8060 - San Bernardino County Hospital Diversion Policy.
- Multi-Casualty Incident: Refer to ICEMA Reference #5050 - Medical Response to a Multi-Casualty Incident Policy.
- CTP meeting physiologic or anatomic criteria with associated burns will be transported to the closest Trauma Center.

B. Trauma Triage Criteria of the CTP

A patient shall be transported to the closest Trauma Center when any one of the following physiologic and/or anatomic criteria is present following a traumatic event (Trauma base hospital contact shall be made):

1. Physiologic Indicators:

- **Glasgow Coma Scale (GCS)/Level of Consciousness (LOC)**
 - **Adult**
 - GCS \leq 13
 - LOC > 3 minutes
 - nausea/vomiting in the setting of significant head trauma
 - **Pediatric**
 - GCS \leq 13
 - any LOC
 - nausea/vomiting in the setting of significant head trauma
- **Respiratory**
 - **Adult**
 - requiring assistance with ventilation **or**

- hypoxic = O₂ saturation that is consistently < 90% **and a**
- RR < 10 or > 29
- **Pediatric**
 - requiring assistance with ventilation **or**
 - hypoxic = O₂ saturation that is consistently < 90% **and a**
 - < 10 years: RR < 12 or > 40
 - < 1 year: RR < 20 or > 60
- **Hypotension**
 - **Adult**
 - exhibits inadequate tissue perfusion
 - BP < 90 mmHG
 - tachycardia
 - **Pediatric**
 - exhibits inadequate tissue perfusion
 - abnormal vital signs (according to age)

2. Anatomic Indicators:

- **Penetrating injuries to:**
 - head
 - neck
 - chest
 - abdomen/pelvis extremity proximal to the knee or elbow
- **Blunt chest trauma resulting in:**
 - ecchymosis
 - unstable chest wall
 - flail chest
- **Severe tenderness to:**
 - head
 - neck
 - torso
 - abdomen
 - pelvis

- **Paralysis:**
 - traumatic
 - loss of sensation
 - suspected spinal cord injury
- **Abdomen:**
 - tenderness with firm and rigid abdomen on examination
- **Amputations:**
 - above the wrist
 - above the ankle
- **Fractures:**
 - evidence of two or more proximal long bone fractures (femur, humerus)
 - open fractures
 - two or more long bone fractures
- **Skull Deformity**
- **Major Tissue Disruption**
- **Suspected Pelvic Fracture**

3. Mechanism of Injury:

If a patient has one or more of the following mechanisms of injury **with** any of the above physiologic or anatomic criteria transport to the closest Trauma Center.

If there are no associated physiologic or anatomic criteria and the potential CTP meets one or more of the following mechanisms of injury, contact a Trauma base hospital for physician consultation to determine the patient destination. In some cases, a Trauma base hospital may direct a patient a non-trauma receiving hospital.

- **High Speed Crash:**
 - initial speed > 40 mph
 - major auto deformity > 18 inches
 - intrusion into passenger space compartment > 12 inches

- unrestrained passenger
- front axle rearward displaced
- bent steering wheel/column
- starred windshield
- **Vehicle Rollover:**
 - complete rollover
 - rollover multiple times
 - unrestrained
 - restrained with significant injuries or high rate of speed
- **Motorcycle Crash:**
 - 20 mph **and/or**
 - separation of rider from the bike with significant injury
- **Non-Motorized Transportation (e.g., bicycles, skate boards, skis, etc.):**
 - with significant impact > 20 mph and/or
 - pedestrian thrown > 15 feet or run over
- **Pedestrian:**
 - auto-pedestrian with significant impact > 10 mph
 - pedestrian thrown > 15 feet or run over
- **Blunt Trauma to:**
 - head
 - neck
 - torso
- **Extrication:**
 - 20 minutes with associated injuries
- **Death of Occupant:**
 - in same passenger space
- **Ejection:**
 - partial or complete ejection of patient from vehicle

- **Falls:**
 - **Adult**
 - ≥ 15 feet
 - **Pediatric**
 - 3 times the child's height or > 10 feet
- **Submersion with Trauma**

4. Age and Co-Morbid Factors

If the patient does not meet any of the above criteria, make Trauma base hospital contact to determine if a Trauma Center should be the destination for the following patients:

- pediatric < 9 years of age
- adult > 65 years of age
- history of respiratory, cardiac, liver disease, or diabetes
- history of hematologic or immunosuppressive conditions
- isolated extremity injury with neurovascular compromise (time sensitive injury)
- pregnant (> 20 weeks in gestation)
- inability to communicate, e.g., language, psychological and/or substance impairment

C. Exceptions

The patient is identified as a CTP or a potential CTP, but presents with the following:

- **Unmanageable Airway:**
 - Transport to the closest receiving hospital when the patient **requires intubation:**
 - an adequate airway cannot be maintained with a BVM device; **and**
 - the paramedic is unable to intubate or if indicated, perform a successful needle cricothyrotomy.
- **Severe Blunt Force Trauma Arrest:**
 - Refer to ICEMA Reference #12010 - Determination of Death on Scene.
 - Severe blunt force trauma, pulseless, without signs of life and cardiac electrical activity less than 40 bpm).

- If indicated, pronounce on scene.
 - If patient does not meet determination of death criteria, transport to closest receiving hospital.
- **Penetrating Trauma Arrest:**
 - Refer to ICEMA Reference #12010 - Determination of Death on Scene.
 - If the patient does not meet the “*Obvious Death Criteria*” in the ICEMA Reference #12010 - Determination of Death on Scene, contact the Trauma base hospital for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma with documented asystole in at least two (2) leads, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.
 - Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without Trauma base hospital contact.
 - If indicated, transport to the closest receiving hospital.
- **Burn Patients:**
 - Refer to ICEMA Reference #8030 - Burn Criteria and Destination Policy.
 - Burn patients meeting CTP, **transport to the closest Trauma Center.**
 - Burn patients not meeting CTP, **transport to the closest receiving hospital or a Burn Center.**
- **EMS Aircraft Indications:**
 - An EMS aircraft may be dispatched for the following events:
 - MCI
 - Prolonged extrication time (> 20 minutes)
 - **Do Not Delay Patient Transport** waiting for an en route EMS aircraft.

- **EMS Aircraft Transport Contraindications:**
 - The following are contraindications for EMS aircraft patient transportation:
 - Patients contaminated with Hazardous Material who cannot be decontaminated and who pose a risk to the safe operations of the EMS aircraft and crew.
 - Violent patients with psychiatric behavioral problems and uncooperative patients under the influence of alcohol and/or mind altering substances who may interfere with the safe operations of an EMS aircraft during flight.
 - Stable patients.
 - Ground transport is < 30 minutes.
 - Traumatic cardiac arrest.
 - Other safety conditions as determined by pilot and/or crew.

- **Remote Locations:**
 - Remote locations may be exempted from specific criteria upon written permission from the ICEMA Medical Director.

D. Considerations

- Scene time should be limited to 10 minutes under normal circumstances.
- Burn patients with associated trauma, should transported to the closest Trauma Center. Trauma base hospital contact shall be made.

E. Radio Contact

- If not contacted at scene, the receiving Trauma Center must be notified as soon as possible in order to activate the trauma team.
- CTP meeting all Trauma Triage Criteria (physiologic, anatomic, mechanism of injury, and/or age and co-morbid factors), a Trauma base hospital shall be contacted in the event of patient refusal of assessment, care and/or transportation.
- In Inyo and Mono Counties, the assigned base hospital should be contacted for CTP consultation and destination.

IV. REFERENCES

| <u>Number</u> | <u>Name</u> |
|---------------|---|
| 5050 | Medical Response to a Multi-Casualty Incident Policy |
| 8030 | Burn Criteria and Destination Policy |
| 8060 | San Bernardino County Hospital Diversion Policy |
| 8070 | Aircraft Rotation Policy (San Bernardino County Only) |
| 12010 | Determination of Death on Scene |