



Inland Counties Emergency Medical Agency

Serving San Bernardino, Inyo, and Mono Counties

Tom Lynch, EMS Administrator

Reza Vaezazizi, MD, Medical Director

DATE: September 9, 2014

TO: EMS Providers - ALS, LALS, BLS, EMS Aircraft
Hospital CEOs, ED Directors, Nurse Managers and PLNs
EMS Training Institutions and Continuing Education Providers
Inyo, Mono and San Bernardino County EMCC Members
Medical Advisory Committee (MAC) Members
Systems Advisory Committee (SAC) Members

FROM: Tom Lynch  EMS Administrator
Reza Vaezazizi, MD  Medical Director

SUBJECT: POLICIES/PROTOCOLS FOR 30-DAY COMMENT

The following policies/protocols have been reviewed and revised by ICEMA and are now available for public comment and recommendations.

ICEMA Reference Number and Name

- 6070 - Cardiovascular ST Elevation Myocardial Infarction Receiving Centers Criteria and Destination Policy
- 6100 - Neurovascular Stroke Receiving Centers Criteria and Destination Policy
- 8120 - Continuation of Care (San Bernardino County Only)
- 11110 - Stroke Treatment - Adult
- 15020 - Trauma - Pediatric (Less than 15 years of age)

ICEMA encourages all system participants to submit recommendations, in writing, to ICEMA during the comment period. **Written comments will be accepted until October 9, 2014, at 5:00 pm.** Comments may be sent via hardcopy, faxed to (909) 388-5850 or via e-mail to Chris.Yoshida-McMath@cao.sbcounty.gov. Comments submitted and any revisions made will be presented at the Medical Advisory Committee meeting on October 23, 2014.

TL/RV/jlm

Enclosures

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**POLICIES/PROTOCOLS CHANGES FOR 30-DAY COMMENT PERIOD
September 9, 2014**

Reference #	Name	Changes
NEW		
None		
1000 ACCREDITATION AND CERTIFICATION		
None		
2000 DATA COLLECTION		
None		
3000 EDUCATION		
None		
4000 QUALITY IMPROVEMENT		
None		
5000 MISCELLANEOUS SYSTEM POLICIES		
None		
6000 SPECIALTY PROGRAM/ PROVIDER POLICIES		
6070	Cardiovascular ST Elevation Myocardial Infarction Receiving Centers Criteria and Destination Policy	<ul style="list-style-type: none"> • Policy title change for clarification. • Addition of SRC requirements for semi-annual CE opportunities for EMS providers and personnel requirement of an Emergency Department Liaison Nurse for non base hospitals. • Additional language added to Continuation of STEMI patients regarding diversion and detailed case review requirement. • Addition of mandatory SRC base hospital contact for sustained ROSC patients. • Deleted reference to re-designation criteria; reference made to agreement. • Formatting and grammatical revisions for consistency.
6100	Neurovascular Stroke Receiving Centers Criteria and Destination Policy	<ul style="list-style-type: none"> • Policy title change for clarification. • This policy reflects the change to a single-tiered system. EMS provider will transport mLAPSS positive patients to the closest NSRC. • Deletion of NSRC-I and NSRC-II definitions. Clarification of NSRC definition. • Addition of NSRC requirements for semi-annual CE opportunities for EMS providers. • Deletion of NSRC specific criteria. • Reference to air transport deleted.

**POLICIES/PROTOCOLS CHANGES FOR 30-DAY COMMENT PERIOD
September 9, 2014**

Reference #	Name	Changes
		<ul style="list-style-type: none"> Deleted reference to re-designation criteria; reference made to agreement. Change to EMS destination criteria and removal of the "Stroke Patient Destination Decision Tree." Formatting and grammatical revisions for consistency.
7000 STANDARD DRUG & EQUIPMENT LISTS		
None		
8000 TRANSPORT/TRANSFERS AND DESTINATION POLICIES		
8120	Continuation of Care (San Bernardino County Only)	<ul style="list-style-type: none"> Additional clarification to Specialty Care Center diversion. Reference to air transport deleted. Additional policy references added for consistency. Formatting and grammatical revisions for consistency.
9000 GENERAL PATIENT CARE POLICIES		
None		
10000 SKILLS		
None		
11000 ADULT EMERGENCIES		
11110	Stroke Treatment - Adult	<ul style="list-style-type: none"> Revised mLAPSS criteria from sentences to table format. NSRC base hospital contact for suspected stroke patients that are mLAPSS negative. Obtain and document on scene family phone number. Consideration of 12-lead ECG for ALS. Deleted "Stroke Patient Destination Decision Tree." Formatting and grammatical revisions for consistency.
12000 END OF LIFE CARE		
None		
13000 ENVIRONMENTAL EMERGENCIES		
None		
14000 PEDIATRIC EMERGENCIES		
None		
15000 TRAUMA		
15020	Trauma - Pediatric (Less than	<ul style="list-style-type: none"> Added axial spinal immobilization indication and clearance criteria.

POLICIES/PROTOCOLS CHANGES FOR 30-DAY COMMENT PERIOD
September 9, 2014

Reference #	Name	Changes
	15 years of age)	Unifies the language between the adult and pediatric trauma protocol. <ul style="list-style-type: none"> • Formatting and grammatical revisions for consistency.
DELETIONS		
None		
Below are some of the policies/protocols designated for review in the next few months. If there are specific policies/protocols recommended for review, please contact ICEMA.		



CARDIOVASCULAR ~~ST ELEVATION MYOCARDIAL~~ INFARCTION “~~STEMI~~”-RECEIVING CENTERS ~~CRITERIA AND~~ DESTINATION POLICY

I. PURPOSE

A Cardiovascular ST Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) will be the preferred destination for patients who access the 9-1-1 system meeting defined criteria and show evidence of a ~~ST-elevation-myocardial infarction~~STEMI on a 12-lead electrocardiogram (ECG). These patients will benefit from rapid interventions via cardiac catheterization interventions.

II. DEFINITIONS

- ~~1. —STEMI—ST Elevation Myocardial Infarction.~~
- ~~2. —PCI—Percutaneous Coronary Intervention.~~
- ~~3. —STEMI Receiving Center (SRC) - A licensed general acute care hospital~~Facilities that has~~ve~~ emergency interventional cardiac catheterization capabilities.
- ~~4. —STEMI Referring Hospital (SRH) - A licensed general acute care hospital~~Facilities that does not have emergency interventional cardiac catheterization capabilities.
- ~~5. —STEMI Base Station—Hospital - A licensed general acute care hospital~~Facilities that has~~ve~~ emergency interventional cardiac catheterization capabilities that also function as a ~~B~~base hospitalstation.
- ~~6. —CQI—Continuous Quality Improvement.~~
- ~~7. —EMS—Emergency Medical Services.~~
- ~~8. —CE—Continuous Medical Education.~~

III. POLICY

The following requirements must be met for a hospital to be designated as a ~~Cardiovascular STEMI Receiving Center~~SRC by ICEMA:

- ~~1. —An ICEMA approved paramedic—receiving hospital which is a full service acute care~~ hospitalfacility.
- ~~2. —Licensure as a Cardiac Catheterization Laboratory.~~

- ~~3.~~ Intra-aortic balloon pump capability.
- ~~4.~~ Cardiovascular surgical services permit.
- ~~5.~~ An alert/Communication system for notification of incoming STEMI patients, available twenty-four (24) hours per day, seven (7) days per week (i.e., in-house paging system).
- ~~6.~~ Provide continuing education (CE) opportunities twice per year for emergency medical services (EMS) field personnel in areas of 12-lead ECG acquisition and interpretation, as well as assessment and management of STEMI patients.

IV. STAFFING REQUIREMENTS

The hospital will have the following positions ~~designated and~~ filled prior to becoming a SRC:

- ~~1.~~ Medical Directors

The hospital shall designate two (2) physicians as co-directors of its SRC program. One (1) physician shall be a board certified interventional cardiologist with active Percutaneous Coronary Intervention (PCI) privileges. The co-director shall be a board certified emergency medicine physician with active privileges to practice in the emergency department.

- ~~2.~~ Nursing Coordinator~~Director~~

The hospital shall designate a SRC Nursing Coordinator~~Director~~ who is trained or certified in Critical Care nursing.

- ~~3.~~ On-Call Physician Consultants and Staff

A daily roster of the following on-call physician consultants and staff that must be promptly available within thirty (30) minutes of notification.

- ~~a.~~ Cardiologist with ~~percutaneous coronary intervention (PCI)~~ privileges.
- ~~b.~~ Cardiovascular Surgeon.
- ~~c.~~ Cardiac Catheterization Laboratory Team.
- ~~d.~~ Intra-aortic balloon pump nurse or technologist.
- 4. Emergency Department Liaison Nurse

The non-base hospital shall designate an SRC Emergency Department Liaison Nurse who has a minimum of two (2) years emergency department experience to facilitate communication and education between the cath lab, emergency department and prehospital personnel.

V. INTERNAL HOSPITAL POLICIES

The hospital shall develop internal policies for the following situations:

- ~~1. Fibrinolytic therapy protocol to be used only in unforeseen circumstances when PCI of a STEMI patient is not possible.~~
- ~~2. Acknowledgement that STEMI patients may only be diverted during the times Diversion of STEMI patients only during times of Internal Disaster in accordance to ICEMA Reference protocol #8060 - Requests for Hospital Diversion Policy (applies to physical plant breakdown threatening significant patient services or immediate patient safety issues, i.e., bomb threat, earthquake damage, hazardous material or safety and security of the hospital facility.) A written notification describing the event must be submitted to ICEMA within twenty-four (24) hours.~~
- ~~3. Prompt acceptance of STEMI patients from other SRHs STEMI referral centers that do not have PCI capability. STEMI diversion is not permitted except for internal disaster. Refer to ICEMA Reference #8120 - Continuation of Care (San Bernardino County Only). However, STEMI base hospitals are allowed to facilitate redirecting of STEMI patients to nearby SRCs when the closest SRC is over-capacity to avoid prolonged door to intervention time. SRC and base hospitals shall ensure physician to physician contact when redirecting patients. Refer to ICEMA Policy Reference #8040, Interfacility Transfer of STEMI Patient.~~
- ~~4. Cath Lab Team activation policy which requires immediate activation of the team upon EMS notification when there is documented STEMI patient en route to the STEMI center, based on machine algorithm interpretation.~~

VI. DATA COLLECTION

All required data elements shall be collected and entered in an ICEMA approved STEMI registry on a regular basis and submitted to ICEMA for review.

VII. CONTINUOUS QUALITY IMPROVEMENT PROGRAM (CQI)

SRC shall develop an on-going CQI program which monitors all aspect of treatment and management of suspected STEMI ~~cardiac~~ patients and identify areas needing improvement. The program must, at a minimum, monitor the following parameters:

- ~~1.~~ Morbidity and mortality related to procedural complications.
- ~~2.~~ Detail review of cases requiring emergent rescue Coronary Artery Bypass Graph (CABG).
- ~~3.~~ Tracking of door-to-dilation time and adherence to minimum performance standards set by this policy.
- Detailed review of cases requiring redirection of EMS STEMI patients to other SRCs as a result of SRC over capacity and prolonged delay of door-to-intervention time.
- Active participation in each ICEMA STEMI CQI committee and STEMI regional peer review process. This will include a review of selected medical records as determined by CQI indicators and presentation of details to peer review committee for adjudication.

VIII. PERFORMANCE STANDARD

~~In accordance with D2B: An Alliance for Quality guidelines,~~ SRCs must achieve and maintain a door-to-balloon (D2B) time of less than or equal to ninety (90) minutes in 75% of primary PCI patients with a STEMI, in accordance with D2B: An Alliance for Quality Guidelines. If this standard is not achieved, the SRC may be required to submit an improvement plan to ICEMA addressing the deficiency with steps being taken to remedy the problems.

IX. DESIGNATION

- ~~1.~~ The ~~Cardiovascular STEMI Receiving Center~~SRC applicant shall be designated after satisfactory review of written documentation and an initial site survey by ICEMA or its designees and completion of an agreement between the hospital and ICEMA.
- ~~2.~~ Documentation of current accreditation from The Society of Chest Pain Centers as “Chest Pain Center with PCI” shall be accepted in lieu of a formal site visit by ICEMA.
- ~~3.~~ Initial designation as a SRC shall be in accordance with terms outlined in the agreement, for a period of two (2) years. Thereafter, re-designation shall occur every four (4) years, contingent upon satisfactory review.
- ~~4.~~ Failure to comply with the agreement, criteria and performance standards outlined in this policy may result in probation, suspension or rescission of SRC designation.

X. PATIENT DESTINATION

- 1. — The ~~STEMI base station~~SRC should be considered as the destination of choice if all of the following criteria are met:
 - a. — Identified STEMI patients based on machine interpretation of field 12-lead ECG, verified by ~~paramedics-EMT-Ps~~ and approved by a base ~~station-hospital~~ physician.
 - b. — Total transport time to the base ~~station-hospital~~ SRC is thirty (30) minutes or less. Base hospital physician may override this requirement and authorize transport to the SRC with transport time of greater than thirty (30) minutes.
 - c. — STEMI base ~~station-hospital~~ contact is **mandatory** for all patients identified as possible STEMI patient. The STEMI base ~~Station-hospital~~ confirms a SRC as the destination.
 - d. — The STEMI base ~~station-hospital~~ is the only authority that can direct a patient to a SRC. The destination may be changed at SRC base hospital discretion.
 - e. — The STEMI base ~~station~~hospital, if different from the SRC, will notify the SRC of patient’s pending arrival as soon as possible, to allow timely activation of Cardiac Cath Lab Team at the SRC.
 - f. — If the patient chooses to bypass the recommended ~~system STEMI-center~~SRC, EMS field personnel must obtain an AMA and notify the STEMI base ~~hospital~~station.
- 2. — The following factors should be considered with regards to choice of destination for STEMI patients. STEMI Base ~~Station-hospital~~ contact and consultation is mandatory in these and similar situations:
 - a. — Patients with unmanageable airway, unstable cardiopulmonary condition, or in cardiopulmonary arrest should be transported to the closest receiving hospital.
 - b. — Patients with malignant ventricular fibrillation, ventricular tachycardia, second degree type II heart block and third degree heart blocks should be considered for transport to the closest receiving hospital.
 - c. — Patients with obvious contraindication to thrombolytic therapy should be strongly considered for transport to the closest SRC.

- d.—Patients with hemodynamic instability as exhibited by blood pressure less than 90 systolic and/or signs of inadequate tissue perfusion should be transported to the closest receiving hospital.
- e.—Patients with *sustained* ROSC should be strongly considered for transport to the closest SRC. STEMI base hospital contact must be made.

XI. REFERENCE PROTOCOLS

<u>Number</u>	<u>Name</u>
8040	Interfacility Transfer of STEMI Patient
8060	<u>San Bernardino County</u> Requests for Hospital Diversion Policy (<u>San Bernardino County Only</u>)
<u>8120</u>	<u>Continuation of Care (San Bernardino County Only)</u>



NEUROVASCULAR STROKE “NSRC” RECEIVING CENTERS CRITERIA AND DESTINATION POLICY

(San Bernardino County Only)

I. PURPOSE

To provide developing guidelines to rapidly transport stroke patients who access the 9-1-1 system to a designated Neurovascular Stroke Receiving Center (NSRC) when indicated. Patients transported to NSRC will benefit from rapid assessment, intervention and treatment at a dedicated stroke specialty center. Patients will meet the defined criteria for triage as an acute ischemic or hemorrhagic cerebral vascular event.

II. DEFINITIONS

Interventional Neuroradiologic Capabilities: A licensed general acute care hospital with qualified interventional radiologists and/or neurosurgeons able to administer inter-arterial tissue plasminogen activator and/or perform mechanical clot retrieval.

mLAPSS: Modified Los Angeles County Prehospital Stroke Screening Scale.

Neurovascular Stroke Base Station(s): A licensed general acute care hospital that has TJC or HFAP Primary Stroke Center accreditation ~~that also function as and designated as a base hospital~~ Paramedic Base Station.

Neurovascular Stroke Receiving Centers (NSRC): A twenty-four (24) hours per day, seven (7) days per week licensed general acute care hospital that has successfully completed and maintains The Joint Commission (TJC) or Healthcare Facilities Accreditation Program (HFAP) accreditation as a Primary Stroke Center and enters into an agreement with ICEMA, ICEMA-designated Level I or Level II receiving hospital for patients triaged as having a cerebral vascular event requiring hospitalization for treatment, evaluation and/or management of this event.

Neurovascular Stroke Referral Hospital(s) (NSRH): A licensed G general acute care hospitals that refer s possible stroke patients to NSRC.

~~**NSRC Level I (NSRC-I):** A twenty-four (24) hours per day, seven (7) days per week acute care hospital that has successfully completed and maintains The Joint Commission (TJC) or Healthcare Facilities Accreditation Program (HFAP) accreditation as a Primary Stroke Center, has interventional neuroradiologic and neurosurgical capabilities and enters into a memorandum of understanding with ICEMA relative to being a Stroke Center.~~

~~**NSRC Level II (NSRC-II):** A twenty four (24) hours per day, seven (7) days per week acute care hospital that has successfully completed and maintains The Joint~~

~~Commission (TJC) or Healthcare Facilities Accreditation Program (HFAP) accreditation as a Primary Stroke Center and enters into a memorandum of understanding with ICEMA relative to being a Stroke Center.~~

III. POLICY

The following requirements must be met for a hospital to be an ICEMA designated NSRC ~~I or NSRC II~~:

- An ICEMA approved ~~paramedic~~ receiving hospital which is a full service acute care ~~hospital facility~~.
- Accreditation as a Primary Stroke Center by TJC or HFAP and proof of re-accreditation every two (2) years.
- An ~~facility~~ alert/communication system for notification of incoming stroke patients, available twenty-four (24) hours per day, seven (7) days per week (i.e., in-house paging system).
- Provide continuous education (CE) opportunities twice per year for NSRC, NSRH and emergency medical services (EMS) field personnel in areas of pathophysiology, assessment, triage and management for stroke patients and report annually to ICEMA.
- Lead public stroke education efforts at the appropriate educational level and report annually to ICEMA.

IV. STAFFING REQUIREMENTS

The hospital will have the following positions filled prior to becoming a NSRC ~~I or NSRC II~~:

- Medical Directors

The hospital shall designate two (2) physicians with hospital privileges as co-directors of its NSRC program. One (1) physician shall be board certified or board eligible by the American Board of Medical Specialties or American Osteopathic Association, neurology or neurosurgery board. The co-director shall be a board certified or board eligible emergency medicine physician.

- Nursing Coordinator

The hospital shall designate a NSRC Nursing Coordinator who has experience in critical care or emergency nursing, and ~~who~~ has advanced education in stroke physiology or at least has two (2) years² dedicated stroke

patient management experience. Certification in critical care or emergency nursing is preferred.

- On-Call Physicians Specialists/Consultants

A daily roster of the following on-call physician consultants and staff must be promptly available within thirty (30) minutes of notification of “Stroke Alert” twenty-four (24) hours per day, seven (7) days per week.

- Radiologist experienced in neuroradiologic interpretations.
- On-call Neurologist and /or tele-neurology services available twenty-four (24) hours per day; seven (7) days per week.
- Additional requirements for: If neurosurgical services are not available in-house, the hospital must have a rapid transfer agreement in place with a hospital that provides this service. The agreement must be on file with the ICEMA. NSRCs must promptly accept rapid transfer requests from NSRCs. Additionally, the hospital must have a rapid transport agreement in place with an ICEMA permitted transport provider for that EOA.

NSRC-I

- ~~Interventional neuroradiologist or Interventional vascular neurosurgeon and an angiogram suite available twenty-four (24) hours per day; seven (7) days per week.~~
- ~~Neurosurgeon available twenty-four (24) hours per day; seven (7) days per week.~~

NSRC-II:

- ~~If neurosurgical services are not available in house, the facility must have a rapid transfer agreement in place with a facility that provides this service. The agreement must be on file with the ICEMA. NSRC Is must promptly accept rapid transfer requests from NSRC IIs. Additionally, the facility must have a rapid transport agreement in place with an ICEMA permitted transport agency for that EOA.~~

V. INTERNAL HOSPITAL POLICIES

The hospital shall develop internal policies for the following situations:

- Stroke Team alert response policy upon EMS notification of a “Stroke Alert”.

- Rapid assessment of stroke patient by Emergency and Neurology Teams.
- Prioritization of ancillary services including laboratory and pharmacy with notification of “Stroke Alert”.
- Arrangement for priority bed availability in Acute Stroke Unit or Intensive Care Unit (ICU) for “Stroke Alert” patients.
- Acknowledgement that stroke patients may **only** be diverted during the times of Internal Disaster in accordance to ICEMA Reference #8060 - Requests for Hospital Diversion Policy; (applies to physical plant breakdown threatening significant patient services or immediate patient safety issues, i.e., bomb threat, earthquake damage, hazardous material or safety and security of the hospital facility.) A written notification describing the event must be submitted to ICEMA within twenty-four (24) hours.
- Additional requirements for Emergent thrombolytic and tele-neurology (if waiver is approved) protocol to be used by Neurology, Emergency, Pharmacy and Critical Care Teams.
- Readiness of diagnostic computed tomography (CT) and magnetic resonance imaging (MRI), upon notification of Stroke Team.

NSRC-I

- ~~Emergent thrombolytic and mechanical therapy protocol to be used by Neurology, Emergency, Pharmacy, Interventional and Critical Care teams.~~
- ~~Maintaining readiness of diagnostic computed tomography (CT), magnetic resonance imaging (MRI) and therapeutic resources such as an interventional suite upon notification of Stroke Team.~~
- ~~Prompt acceptance of stroke patients from any NSRH as well as referral from NSRC II to NSRC I when interventional skills are required.~~

NSRC-II

- ~~Emergent thrombolytic and tele-neurology (if waiver is approved) protocol to be used by Neurology, Emergency, Pharmacy and Critical Care teams.~~
- ~~Maintaining readiness of diagnostic computed tomography (CT) and magnetic resonance imaging (MRI), upon notification of Stroke Team.~~

VI. DATA COLLECTION

Data will be reported to the ICEMA Medical Director on a monthly basis using an ICEMA approved registry.

VII. CONTINUOUS QUALITY IMPROVEMENT PROGRAM

NSRC shall develop an on-going CQI program which monitors all aspects of treatment and management of stroke patients and identifies areas needing improvement. The program must, At a minimum, the program will monitor the following parameters:

- Morbidity and mortality related to procedural complications.
- Tracking door-to-intervention times and adherence to minimum performance standards.

ICEMA will determine current performance indicators. Any specific or additional performance indicators will be determined in collaboration with the Stroke CQI Committee.

- Active participation in ICEMA Stroke CQI Committee activities.

VIII. PERFORMANCE STANDARDS

Compliance with the American Stroke Association Performance Measures as a Primary Stroke Center.

IX. DESIGNATION

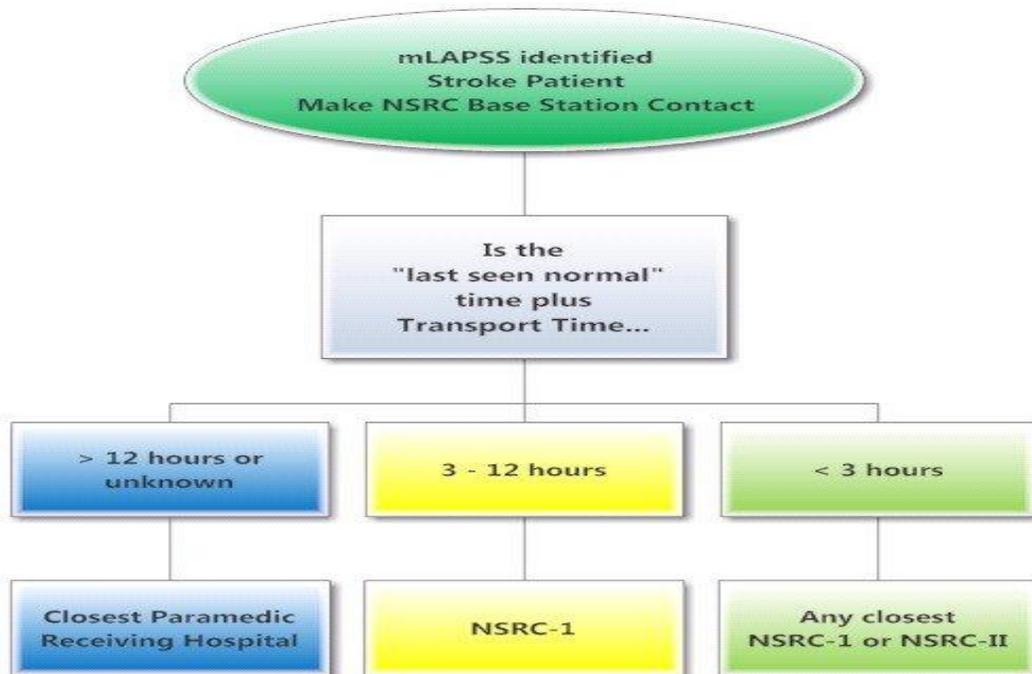
- The NSRC applicant shall be designated by ICEMA after satisfactory review of written documentation, a potential site survey and completion of an agreement between the hospital and ICEMA.
- Documentation of current accreditation as a Primary Stroke Center by TJC or HFAP shall be accepted in lieu of a formal site visit by ICEMA. ~~NSRC-I shall submit Primary Stroke Center accreditation as well as supplemental documentation verifying neurovascular interventional service capabilities.~~
- Initial designation as a NSRC shall be in accordance with terms outlined in the agreement for a period of two (2) years. Thereafter, redesignation shall occur every two (2) years contingent upon satisfactory review.
- Failure to comply with the agreement, criteria and performance standards outlined in this policy may result in probation, suspension or rescission of the NSRC designation.

X. PATIENT DESTINATION

- The NSRC should be considered as the destination of choice if all of the following criteria are met:
 - Stroke patients eligible for transport to NSRC (~~suspected~~identified stroke patients) will be identified using the mLAPSS triage criteria.
 - Identified acute stroke patients with “last seen normal” time plus transport time equaling greater than twelve (12) hours, or if “last seen normal” time is unknown, transport to the closest paramedic receiving hospital.
 - ~~Identified stroke patients with “last seen normal” time plus transport time between three (3) to twelve (12) hours will be transported to NSRC-I.~~
 - Identified stroke patients with “last seen normal” time ~~plus transport less than twelve (12) hours, or a “wake-up stroke” time less than (3) hours will be transported~~ transport to ~~any~~ closest NSRC ~~I or NSRC-II.~~
 - NSRC ~~Base-base Station-hospital~~ contact is **mandatory** for all patients identified as a possible stroke patient.
 - The NSRC ~~Base-base Station-hospital~~ is the only authority that can direct a patient to a NSRC. The destination may be changed at NSRC base ~~station-hospital~~ discretion.
 - The NSRC ~~b~~Base Stationhospital, if different from the NSRC will notify the NSRC of the patient’s pending arrival as soon as possible, to allow timely notification of Stroke Team.
- ~~— Air transport may be considered if ground transport is greater than thirty (30) minutes.~~
- The following factors should be considered in determining choice of destination for acute stroke patients. NSRC ~~Base-base Station-hospital~~ contact and consultation is mandatory in these situations:
 - Patients with unmanageable airway, unstable cardiopulmonary condition, or in cardiopulmonary arrest should be transported to the closest paramedic receiving hospital.
 - Patients with obvious contraindication to thrombolytic therapy should be strongly considered for transport to closest NSRC ~~I.~~

- Patients with hemodynamic instability and exhibiting signs of inadequate tissue perfusion should be transported to the closest **paramedic** receiving hospital.

XI.—STROKE PATIENT DESTINATION DECISION TREE





CONTINUATION OF CARE (San Bernardino County Only)

I. PURPOSE

To develop a system that ensures the rapid transport of patients at the time of symptom onset or injury, to receiving the most appropriate definitive care. This system of care consists of public safety answering point (PSAP) providers, EMS providers, referral hospitals (RH), Specialty Care Centers (Trauma, Cardiovascular ST Elevation Myocardial Infarction (STEMI) or Stroke), ICEMA and EMS leaders combining their efforts to achieve this goal.

This policy shall only be used for:

- Rapid transport of Trauma, STEMI and Stroke patients from RH to Specialty Care Center.
- Specialty Care Center to Specialty Care Center when higher level of care is required.
- EMS providers transporting unstable patients requiring transport to a Specialty Care Center to stop at any closest **paramedic** receiving hospital for airway stabilization, and continue on to a Specialty Care Center.

It is not to be used for any other form of interfacility transfer of patients.

~~II. AUTHORITY~~

~~California Health and Safety Code, Division 2.5, 1797.204
California Code of Regulations, Title 22~~

III. DEFINITIONS

Neurovascular Stroke Receiving Centers (NSRC): A licensed general acute care hospital designated by ICEMA's Governing Board as a NSRC.

Referral Hospital (RH): Any licensed general acute care hospital that is not an ICEMA designated TC, SRC or NSRC.

Specialty Care Center: ICEMA designated Trauma, STEMI or Stroke Center.

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

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

III.V. INCLUSION CRITERIA

- Any patient meeting ICEMA Trauma Triage Criteria, (refer to ICEMA Reference #15030 - Trauma Triage Criteria and Destination Policy) arriving at a non-trauma hospital by EMS or non-EMS transport.
- Any patient with a positive ~~STEMI~~ ~~ST-elevation-MI~~ requiring EMS transport to a SRC (refer to ICEMA Reference #6070 - Cardiovascular ST Elevation Myocardial Infarction "STEMI" Receiving Centers Criteria and Destination Policy).
- Any patient with a positive mLAPSS or stroke scale requiring EMS transport to ~~a the~~ NSRC (refer to ICEMA Reference #6100 - Neurovascular Stroke Receiving Centers Criteria and Destination Policy).

IV. INITIAL TREATMENT GOALS AT RH

- Initiate resuscitative measures within the capabilities of the facility.
- Ensure patient stabilization is adequate for subsequent transport.
- Do not delay transport by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.

➤ TIMELINES

< 30 minutes at RH (door-in/door-out).

< 30 minutes to complete ALSparamedic continuation of care transport.

< 30 minutes door-to-intervention at RC Specialty Care Center.

- RH shall contact the appropriate Specialty Care Center ED physician directly without calling for an inpatient bed assignment. Refer to Section IV - attachment SRH-SRC Buddy System Table.
- EMS providers shall make Specialty Care Center ~~Base Station~~ base hospital contact.
- The Specialty Care Centers shall accept all referred trauma, stroke and STEMI patients unless they are on Internal Disaster as defined in ICEMA Reference #8060 - Requests for Hospital Diversion Policy (San Bernardino County Only).

- The Specialty Care Center ED physician is the accepting physician at the Specialty Care Center and will activate the internal Trauma, STEMI, or Stroke Team according to internal TC, SRC or NSRC policies or protocols.
- RH ED physician will determine the appropriate mode of transportation for the patient. ~~If ground transportation is > 30 minutes consider the use of an air ambulance. Requests for air ambulance shall be made to 9-1-1 and normal dispatching procedures will be followed; however, the air ambulance Continuation of Care patient will be transported to the Specialty Care Center identified by the RH.~~
- Simultaneously call 9-1-1 and utilize the following script to dispatch:

“This is a Continuation of Care run from ___ hospital to ___ Trauma, STEMI or Stroke Center”

Dispatchers will only dispatch transporting paramedic units without any fire apparatus.
- RH must send all medical records, test results, radiologic evaluations to the Specialty Care Center. DO NOT DELAY TRANSPORT - these documents may be FAXED to the Specialty Care Center.

VI. SPECIAL CONSIDERATIONS

- If the patient has arrived at the RH via EMS field personnel, the RH ED physician may request that the transporting team remain ~~with patient~~ and immediately transport the patient~~them~~ once minimal stabilization is done at the RH.
- EMT-Ps may only transport patients on Dopamine, Lidocaine and Procainamide drips. Heparin and Integrillin drips are not within the ~~paramedic-EMT-P~~ scope of practice and require a “critical care transport” nurse to be in attendance. Unless medically necessary, avoid using medication drips that are outside of the ~~paramedic-EMT-P~~ scope of practice to avoid any delays in transferring of patients.
- The RH may consider sending one of its nurses with the transporting ~~paramedic-ALS~~ unit if deemed necessary due to the patient’s condition or scope of practice.
- _____ Nurse staffed ~~ALS critical care (ground or air) transport~~ units (ground or air) maybe used; but may create a delay due to availability. Requests ~~for a~~ nurse staffed ~~critical care ALS transport~~ units must be made directly to the Critical Care ~~†~~Transporter agency (CCT) provider by landline.
- Specialty Care Center diversion is not permitted except for internal disaster. However, Specialty Care Center base hospitals are allowed to facilitate

redirecting of EMS patients to nearby SRCs, NSRCs or TCs when the closest Specialty Care Center is over capacity to avoid prolonged door-to-intervention times. Specialty Care Center base hospitals shall ensure physician to physician contact when redirecting patients.

VII. SPECIALTY CARE CENTER - REFERRAL HOSPITAL BUDDY SYSTEM TABLE

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

VIII. REFERENCES

<u>Number</u>	<u>Name</u>
6070	Cardiovascular <u>ST Elevation Myocardial Infarction “STEMI”</u> Receiving Centers <u>Criteria and Destination Policy</u>
<u>6100</u>	<u>Neurovascular Stroke Receiving Centers “NSRC” Criteria and Destination Policy</u>
8060	Requests for Hospital Diversion Policy (San Bernardino County <u>Only</u>)
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. LIMITED ALS (LALS)/ALS INTERVENTIONS

- Vascular access.
- Obtain blood glucose.
- **Modified Los Angeles County Prehospital Stroke Screen (mLAPSS):** A screening tool used by EMS field personnel~~prehospital care providers~~ to assist in identifying patients who may be having a stroke.

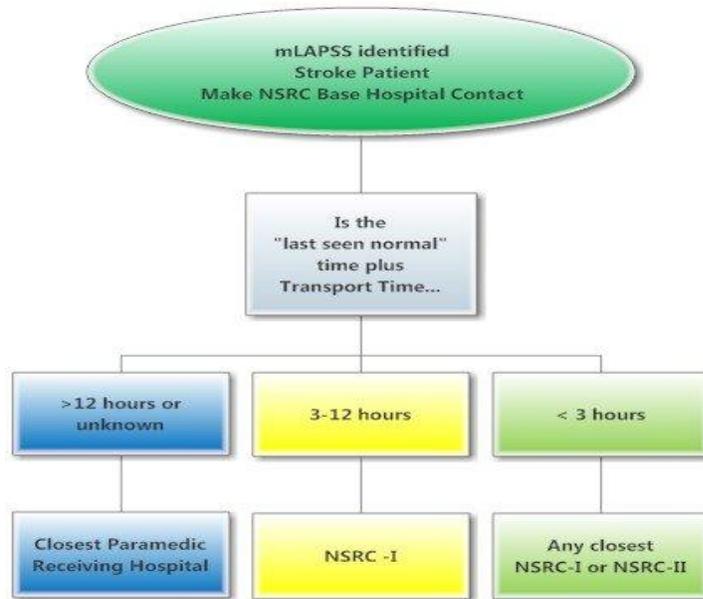
mLAPSS Criteria: The patient is mLAPSS positive, if “yes” on Criteria #1 - 5 and exhibits unilateral weakness on Criteria #6.

<u>mLAPSS Criteria</u>	<u>Yes</u>	<u>No</u>	
<u>1. Age over 40 years?</u>			
<u>2. No prior history of seizure disorder?</u>			
<u>3. New onset of neurologic symptoms in last 24 hours?</u>			
<u>4. Patient was ambulatory at baseline prior to event?</u>			
<u>5. Blood glucose between 60 and 400?</u>			
<u>6. Exam (look for obvious asymmetry):</u>	<u>Normal-Bilaterally</u>	<u>Right</u>	<u>Left</u>
• <u>Facial Smile/Grimace</u>	<input type="checkbox"/> <u> </u>	<input type="checkbox"/> <u>Droop</u> <input type="checkbox"/> <u>Normal</u>	<input type="checkbox"/> <u>Droop</u> <input type="checkbox"/> <u>Normal</u>
• <u>Grip</u>	<input type="checkbox"/> <u> </u>	<input type="checkbox"/> <u>Weak Grip</u> <input type="checkbox"/> <u>Normal</u>	<input type="checkbox"/> <u>Weak Grip</u> <input type="checkbox"/> <u>Normal</u>
	<input type="checkbox"/> <u> </u>	<input type="checkbox"/> <u>No Grip</u> <input type="checkbox"/> <u>Normal</u>	<input type="checkbox"/> <u>No Grip</u> <input type="checkbox"/> <u>Normal</u>
• <u>Arm Weakness</u>	<input type="checkbox"/> <u> </u>	<input type="checkbox"/> <u>Drifts Down</u> <input type="checkbox"/> <u>Normal</u>	<input type="checkbox"/> <u>Drifts Down</u> <input type="checkbox"/> <u>Normal</u>
		<input type="checkbox"/> <u>Falls Down Rapidly</u> <input type="checkbox"/> <u>Normal</u>	<input type="checkbox"/> <u>Falls Down Rapidly</u> <input type="checkbox"/> <u>Normal</u>

- ~~Ask when “last seen normal” or without stroke symptoms. Refer to Section V–Stroke Patient Destination Decision Tree below.~~
- ~~If “last seen normal” plus transport time is greater than twelve (12) hours, transport to the closest receiving hospital.~~
- ~~If “last seen normal” plus transport time is less than twelve (12) hours, or a “wake-up stroke”, transport to closest NSRC.~~
 - ~~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.~~
- ~~If mLAPSS negative and stroke is still suspected, contact NSRC base hospital.~~
- ~~Obtain and document on scene family phone number.~~
- ~~Consider 12-lead ECG (ALS only).~~
- **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:

Thrombolytic Assessment Criteria	Yes	No
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~~



III. REFERENCE

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



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

- Axial Spinal Immobilization: Using age appropriate assessments, 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 spine board.

• **Axial Spinal Immobilization with use of Rigid Spine Board:** If the use of a rigid, spine board is indicated, and 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.

• **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.
- **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**

- **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 while considering age-appropriate assessments when 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.
- **Axial Spinal Immobilization with use of Rigid Spine Board:** If the use of a rigid, spine board is indicated, and 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.

- **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

- **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 while considering age-appropriate assessments when 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.

- **Axial Spinal Immobilization with use of Rigid Spine Board:** If the use of a rigid, spine board is indicated, and 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.
- **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 or Fentanyl 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